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

PROPOSAL FORM – ROUND 7

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Round 7 Call for Proposals for grant funding. This Proposal Form should be used by eligible applicants ('Applicants') to submit proposals to the Global Fund. **Please read the accompanying Round 7 Guidelines for Proposals carefully before completing the Proposal Form**.

Applicant Name	Country Coordinating Mechanisms CCM (CCE in El Salvador)
Country/countries	El Salvador
Components included in this Proposal Form *(Check each applicable box below)*	
☒ HIV/AIDS[1]	
☒ Tuberculosis[1]	
☐ Malaria	

Timetable: Round 7

Deadline for submission of proposals: **4 July 2007**

Board consideration of recommended proposals: 14 - 16 November 2007

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

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PROPOSAL SECTIONS FOR COMPLETION BY ALL APPLICANTS

REQUIRED ATTACHMENTS

A checklist of all annexes to be attached to the Proposal Form by an Applicant can be found at the end of sections 3 **and** 5 (per disease component) of the Proposal Form.

REFERENCE DOCUMENTS FOR APPLICANTS

(These and other documents are available at http://www.theglobalfund.org/en/apply/call7/documents/)

Country Coordinating Mechanisms:	The Global Fund's 'Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility' (**CCM Guidelines**) 'Clarifications on CCM Minimum Requirements – Round 7'
Monitoring and Evaluation:	Multi-Agency 'Monitoring and Evaluation Toolkit', Second Edition, January 2006 (**M&E Toolkit**) 'M&E Systems Strengthening Tool', June 2006
Procurement and Supply Management:	The Global Fund's 'Guide to Writing a Procurement and Supply Management Plan', January 2006

How to use this form

1. **Before you start** - Ensure that you have all documents that accompany this form:
   - The Round 7 Guidelines for Proposals
   - A complete copy of this Proposal Form
   - A complete copy of Attachments A, B and C to this Proposal Form

2. **Read the accompanying** Round 7 **Guidelines for Proposals** before completing this Proposal Form.

3. Further guidance for completing specific sections is also included in the Proposal Form itself, printed in *blue italics*. Where appropriate, indications are given as to the recommended maximum length of the answer.

4. To **avoid duplication of effort**, we recommend that you make maximum use of existing information (e.g., national health sector development plans, national monitoring and evaluation frameworks, situation analyses of strengths and weaknesses of the existing responses to the disease(s), and documents written to report to the Global Fund on existing grants and/or work supported by other donors/funding agencies).

5. **Complete the Checklists** at the end of sections 3 and 5 of the Proposal Form to ensure that you are submitting a fully complete application.

6. **Attach all documents** requested throughout the Proposal Form **including** a budget, work plan, and all documents you are requested to annex to the proposal.

7. Consult our "Frequently Asked Questions" link:
   http://www.theglobalfund.org/en/apply/call7/documents

Important notes:

1. Some or all of the information submitted to the Global Fund by Applicants will be made publicly available on the Global Fund website after the Board funding decision for Round 7.

2. The Global Fund Board is currently considering whether to post the evaluation forms prepared by the Technical Review Panel during the proposal review process ('TRP' Review Forms') **on the Global Fund website.** If this decision is taken, the TRP Review Forms for all Round 7 proposals (both approved **and unapproved**) will be published on the Global Fund website after the Board funding decision for Round 7.

How to use this form

WHAT IS DIFFERENT COMPARED TO ROUND 6?

Amendments aimed at improving the ease of completing the Proposal Form include:

1. all **CCM, Sub-CCM and RCM information needs** (including the **eligibility requirements**) **are now** with other 'Applicant Type' information **in section 3A**;

2. **Section 4** has been **re-ordered** to better enable Applicants to describe the overall strategy/country context, how the funding request harmonizes with other in-country actions, and then what will be achieved under this proposal;

3. **Section 4** also requests detailed information **on three key lessons learned arising from the Technical Review Panel's review of Round 6 proposals**. These are:

(a) addressing the **comments of the TRP** from proposals not approved in prior Rounds (section 4.6.1) and **attaching the relevant TRP review form**(s);

(b) explaining a Round 7 request for additional funding for the same key services covered by earlier Global Fund grants, where there are **large undisbursed amounts of money** under those earlier grants, including unsigned Round 6 grants (section 4.6.4(a)); and

(c) describing how bottlenecks in performance experienced by Principal Recipients ('PR') who are again nominated as PR for Round 7 have been addressed in the proposal;

4. **Section 5 requests less complex budget details**, responding to the comments of Applicants and the Technical Review Panel in Round 6;

5. **Attachment A (Targets and Indicators Table)** has been prepared by disease. Applicants may use the pre-filled list of potential indicators where relevant to their proposal, or overwrite the table;

6. **Attachment B (Preliminary List of Pharmaceutical and other Health Products) has been prepared in Microsoft Excel** to assist Applicants to identify key information about products, their pricing and intended suppliers. Again, it has been prepared by disease; and

7. **Contact details and proposal endorsement signatures for CCM, Sub-CCM and RCM Applicants are now located in a new Attachment C**. This is to facilitate an automatic upload of this material into our data base to ensure that we have current contact details accurately displayed on the Global Fund website.

Health Systems Strengthening – Round 7

As in Round 6, there is no separate health systems strengthening (HSS) component in Round 7.

Applicants should request funding support for HSS on a per disease component basis within the disease specific sections of this proposal (section 4 and 5). **Applicants are very strongly encouraged to review the Round 7 Guidelines for Proposal** (sections 4.4 and 4.5) **and this Proposal Form** (introduction in section 4.4) **before they complete these sections**.

1 Proposal Overview

1.1 General information on proposal

Applicant Type

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

☒ National Country Coordinating Mechanism

☐ Sub-national Country Coordinating Mechanism

☐ Regional Coordinating Mechanism (including small island developing states)

☐ Regional Organization

☐ Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

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

	Component	Title
☒	HIV/AIDS[2]	**Expansion of the HIV response to vulnerable groups, establishment of a social protection system for persons living with HIV (PLWHA) and implementation of the Single Monitoring, Evaluation and Epidemiologic Surveillance System in El Salvador**
☒	Tuberculosis[2]	**"Consolidate the STOP-TB Strategy in El Salvador"**
☐	Malaria	

Currency in which the Proposal is submitted

*Please check only **one** box below. **Please note that you must use this same currency throughout the whole Proposal Form** (that is, for all components for which funding is sought). It will be assumed that all financial amounts indicated in your whole proposal are in this **one** currency.*

☒ US$

☐ Euro

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

1 Proposal Overview

Summary of Technical Assistance Provided During Proposal Preparation		
*Please check the applicable box or boxes in the left hand column to indicate whether you received any technical assistance during preparation **of this proposal** for the sections set out below, and then in the other columns also indicate which organization(s) (if any) provided that assistance, and over what duration this was provided. Information on technical and management assistance to be obtained during the proposal term is requested in section 4.11.*		
Section/Component	**Name of organization or organizations providing assistance and type of assistance provided**	**Duration of technical assistance**
☐ Sections 1 to 3B	UNAIDS (consultant) CONASIDA (consultant) Plan International (consultant) Ministry of Health (provided information), UNDP (provided information)	**1 day each**
☐ HIV/AIDS component, and/or budget	National ITS/VIH/SIDA Program (coordinated, formulated, provided information), UNAIDS(internationalconsultant) CONASIDA (national consultant) Plan Internacional (national consultant) RED SALUD (technical suggestions) MINED (technical suggestions) PREVENSIDA (technical suggestions) FUNDASIDA (technical suggestions) PNUD (information & ideas)	4 weeks 12 days 4 Weeks 4 Weeks 1 Week 3 Days 3 Days 3 Days 2 Weeks
☐ Tuberculosis component, and/or budget	National Program on Tuberculosis and Respiratory Diseases (coordinated formulation, contributed information), UNAIDS(international consultant) CONASIDA (national consultant) OPS/OMS (sent officer for technical assistance) Plan International (national consultant & contributed ideas), RED SALUD (technical suggestions) REDSAL + (technical suggestions) ASOCIACION VIDA NUEVA (technical suggestions)	6 weeks 3 days 4 Weeks 1 Week 3 Days 6 Days 3 Days 3 Days
☐ Malaria component, and/or budget		

1 Proposal Overview

1.2 Proposal funding summary per component

Funds requested for each component (i.e. HIV/AIDS, tuberculosis and/or malaria) in table 1.2 below must be the same as the totals of the corresponding budget summary by cost category in table 5.3 for each disease component. The currency in the table below must be the same currency as indicated in section 1.1 above.

Table 1.2 – Total funding summary

Component	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	$5,029,070	$5,589,324	$4,801,091	$4,838,548	$4,608,053	$24,866,086
Tuberculosis	$1,604,392	$1,599,728	$1,519,565	$972,552	$1,172,203	$6,868,440
Malaria						
Total all components	$ 6,633,462	$ 7,189,052	$ 6,320,656	$ 5,811,100	$ 5,780,256	$ 31,734,526

1 Proposal Overview

1.3 Contact details for enquiries by the Global Fund

*Please provide full contact details for two persons **who will be available and duly authorized to provide the Global Fund with responses to any questions about the whole Proposal Form after 4 July 2007** (that is, **all of the components** which are applied for and **not** on a disease by disease basis). This is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes, for a time period of approximately **three months** after the submission of the proposal.*

Table 1.3 – Contact details for enquiries by the Global Fund

Contact Details for Enquiries on the Applicant's Proposal after Submission		
	Primary contact	**Secondary contact**
Name	Dr. Herbert Betancourt	Dra. Ana Isabel Nieto
Title	Focal Point ONUSIDA	Deputy Director for Human Promotion and Habitat
Organization	ONUSIDA	Caritas El Salvador
Mailing address	3ra. Calle Pte. 4048, Col. Escalon San Salvador	Avenida Olímpica y pasaje 3 #130 San Salvador. El Salvador
Telephone	503-2263-0066	503-2298 4302
Fax	503-2263-3501	503- 2298 3035
E-mail address	betancourt@unfpa.org	anieto@caritaselsalvador.org
Alternate e-mail address	betsim@integra.com.SV	

1 Proposal Overview

1.4 Overview Summary of the Applicant's Proposal

Provide a brief overview of the components included in this proposal and the main focus of the work to be undertaken. Applicants applying for more than one disease component should **briefly** refer to **each component here**, but provide a disease specific 'Executive Summary' in section 4.2 for each component.
*(Maximum length of this section is **one page in total**)*

El Salvador proposes to build on the successful results of the HIV/AIDS and Tuberculosis programs that were supported by Global Fund Round 2 grants. These programs will expand their coverage of at-risk groups, take initiatives that strengthen the health system, and meet the challenge of eliminating gaps in key services to reduce the threats that these two epidemics represent to the country's wellbeing.

The HIV/AIDS component aims to *reduce the social and economic impact of the epidemic.*

To do so it will pursue four Objectives:

1. Improve the social protection and quality of life of PLWHAs.
2. Reduce the transmission of HIV.
3. Reduce morbidity and mortality from AIDS.
4. Strengthen the health system.

The results to be obtained include strengthened capacity of PLWHA organizations, improved social and economic opportunities for PLWHAs, and reduced stigmatization. Focused IEC efforts will change behaviors, increasing condom use, voluntary testing and counseling, diagnosis, and treatment. Integrated treatment and care centers staffed with interdisciplinary teams that incorporate PLWHAs will provide ART, prophylaxis and treatment for opportunistic infections, comprehensive care for the chronically ill and varied support services overseen by PLWHA groups. The health system as a whole will benefit from an integrated M&E and surveillance system, and from improved professional training for new and in-service personnel.

The Tuberculosis component has the goal of *extending and expanding the STOP-TB strategy*, to contribute to the control of Tuberculosis and to decrease morbidity/mortality with emphasis in the most vulnerable groups.

The Objectives of the TB component are also four:

1. Continue the expansion and strengthening of DOTS technology with quality
2. Face the TB-HIV co-infection, MDR-TB and other challenges (prisons and migrant populations)
3. Contribute to the strengthening of health systems
4. Empowerment of those affected by Tuberculosis and of the community

The results to be obtained include: a) consolidation of the STOP-TB strategy in the whole country, b) wideining of DOTS and PAL coverage to all health institutions, c) improved detection of cases and adherence to treatment through education, social mobilization and community empowerment and d) promotion of integred care/treatment for cases of TB-HIV co-infection and control of MDR TB.

These resutls will involve all health providers in the country, including trained community volunteers. This implies activities to strengthen the human resources of the health sector with training, to better equip the laboratory network, to improve supervision and compliance with the STOP-TB strategy, to extend PAL to 90% of the system, to incorporate all institutions in the sector and to increase community participation and social mobility.

1 Proposal Overview

1.5 Overview of rationale for multi-country proposal approach

***Only complete this section if your proposal targets more than one country**.*

***Importantly**, the difference between a 'Regional Coordinating Mechanism' and 'Regional Organization' Applicant is explained in the Round 7 Guidelines for Proposals**. Please refer to that material before completing this Proposal Form including, in particular, section 3A.4 (RCM), or 3A.5 (Regional Organization).*

*The Global Fund is very supportive of proposals which respond to cross-border or multi-country issues which are most effectively addressed through a regional/multi-country proposal that has been developed in close consultation with in-country stakeholders from **each of the countries included in the proposal**. Preferably, the CCM of each country will have been involved in identification of relevant issues and the development of the multi-country response from an early time so that the CCMs and RCM or RO Applicants can agree which aspects are appropriate for a multi-country approach.*

In this section, please describe:

(a) the common issue for these countries which presents a strong argument for a regional or cross-border approach;

(b) why a multi-country proposal will be more effective in responding to the issues presented than if each CCM presented the same activities on a country by country basis; and

*(c) how the applicant (RCM or RO) worked with the CCM** of each country during the proposal development process to ensure that the funding requested in this proposal does not merely replace existing financing, but contributes additional financing to increase the regions capacity to respond to the disease(s).*

*(**Where there is no CCM for a specific country included in the multi-country proposal because the country is a small island developing state, the applicant should describe how a broad cross-section of stakeholders were transparently and effectively consulted to ensure that there is broad in-country support and understanding of the multi-country approach in such countries).*

Overview of rationale for multi-country approach *(maximum one page)*
N/A

1 Proposal Overview

1.6 Previous Global Fund grants/proposals recommended for funding

*For each component applied for in Round 7, please provide **specific details of the amounts disbursed by the Global Fund and also expended under existing Global Fund grants** (by Round) as **at 31 March 2007**. For more detailed information, see the Guidelines for Proposals, section 1.6.*

Combined HIV/TB grants from Rounds 1, 2 and/or 3, should be included in only the HIV/AIDS table below, or the TB table below.

Table 1.6.1 – Previous Global Fund HIV/AIDS financial support

HIV/AIDS	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1			
Round 2	$16,467,704	$15,384,318	El Salvador
Round 3			
Round 4			
Round 5			
Round 6			
Total	$16,467,704	$15,384,318	

Table 1.6.2 – Previous Global Fund tuberculosis financial support

Tuberculosis	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1			
Round 2	$ 2,254,048	$ 2,244,002	El Salvador
Round 3			
Round 4			
Round 5			
Round 6			
Total	$ 2,254,048	$ 2,244,002	

1 Proposal Overview

Table 1.6.3 – Previous Global Fund malaria financial support

Malaria	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1			
Round 2			
Round 3			
Round 4			
Round 5			
Round 6			
Total			

Table 1.6.4 – Previous Global Fund HSS and other financial support

HSS or Integrated	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 March 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 March 2007	[For RCM and RO applicants only] List the countries included in the relevant proposal
Round 1			
Main disease targeted			
Round 2	$18,721,752	$17,628,320	El Salvador
Main disease targeted	VIH/SIDA		
Round 5			
Main disease targeted			
Total	$18,721,752	$17,628,320	El Salvador

2 Country Eligibility

Only those applications that meet all applicable eligibility criteria will be reviewed by the Technical Review Panel.

These eligibility criteria are:

- ➔ **Section 2 – *Country eligibility***
- ➔ ***Section 3A – Applicant Type eligibility***
- ➔ ***Section 3B – Proposal signature and endorsement***

Country eligibility *is a multi-step process that depends on World Bank's classification of the income level of the country (or countries) targeted in the proposal* ***at the time of the call for proposals*** *(not the closing date).*

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

2.1 Income Level

Please check the appropriate box(es) in the table below for the relevant country (or countries for multi-country proposals only), and include the country name in the relevant box(es). ***Multi-country applicants*** *(i.e., RCM or Regional Organization Applicants)* ➔ *see the Guidelines for Proposals, section 2.1 regarding eligibility of your proposal, and complete all relevant sections depending on the income levels for the respective countries.*

World Bank classification of Income level of countries/ economies included in proposal	**Country/economy name(s)** *(include the name of each country/economy* ***and*** *its relevant income level for multi-country proposals)*	
☐ Low-income		➔ *Go straight to* ***section 3A****, Applicant Type*
☐ **X** Lower-middle income	El Salvador	➔ *Complete* ***both*** *sections 2.2 and 2.3, and then go to section 3A*
☐ Upper-middle income		➔ *Complete* ***each of*** *sections 2.2 and 2.3* ***and*** *2.4, and then go to section 3A*

2 Country Eligibility

2.2 Counterpart financing and greater reliance on domestic resources

Complete if any country/economy targeted in this proposal is classified as Lower-middle or Upper-middle income under the World Bank's classification of income level.

2.2.1 CCM and Sub-CCM Applicants

The table should be completed for each component included in this proposal. For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section 2.2.1.
***Amounts included in line A and line B in the tables below should be in figures not percentages**.*

Important notes:

1. The field "Total requested from the Global Fund" in tables 2.2.1(a) to (c) below must equal the budget request in section 1.2, section 5 and the budget breakdown by cost category in table 5.3 for each corresponding component.

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

Table 2.2.1(a) – Counterpart financing HIV/AIDS

Financing sources	**HIV/AIDS** *(same currency as selected in section 1.1)*				
	Year 1	**Year 2**	**Year 3 estimate**	**Year 4 estimate**	**Year 5 estimate**
Total requested **from the Global Fund** in Round 7 (A) **[from table 5.3]**	$5,029,070	$5,589,324	$4,801,091	$4,838,548	$4,608,053
Counterpart financing (B) **[linked to the disease control program]**	$28,282,257	$29,833,395	$31,552,832	$33,284,023	$35,273,029
Counterpart financing as a percentage of total financing: [B/(A+B)] x 100 = %	85%	84%	87%	87%	88%

2 Country Eligibility

Table 2.2.1(b) – Counterpart financing tuberculosis

Financing sources	Tuberculosis *(same currency as selected in section 1.1)*				
	Year 1	**Year 2**	**Year 3 estimate**	**Year 4 estimate**	**Year 5 estimate**
Total requested **from the Global Fund** in Round 7 (A) **[from table 5.3]**	**$ 1,604,392**	**$ 1,599,728**	**$ 1,519,565**	**$ 972,552**	**$ 1,172,203**
Counterpart financing (B) **[linked to the disease control program]**	$ 1,600,294	$ 1,712,021	$1,963,070	$ 1,749,287	$1,738,335
Counterpart financing as a percentage of total financing: [B/(A+B)] x 100 = %	50%	52%	56%	64%	60%

Table 2.2.1(c) – Counterpart financing malaria

Financing sources	Malaria *(same currency as selected in section 1.1)*				
	Year 1	**Year 2**	**Year 3 estimate**	**Year 4 estimate**	**Year 5 estimate**
Total requested **from the Global Fund** in Round 7 (A) **[from table 5.3]**					
Counterpart financing (B) **[linked to the disease control program]**					
Counterpart financing as a percentage of total financing: [B/(A+B)] x 100 = %	%	%	%	%	%

2 Country Eligibility

2.2.2 Regional Coordinating Mechanism (RCM) and Regional Organization (RO) Applicants only

RCM and RO Applicants are required to demonstrate compliance with the Global Fund's minimum **counterpart financing** requirements for each Lower-middle income or Upper-middle income country/economy included in the RCM or RO application which is also eligible to apply in Round 7 in its own right. Eligible countries/economies are listed in Attachment 1 to the **Guidelines for Proposals**.

RCM and RO Applicants may either:

(a) **Complete table 2.2.2 below** and **ensure that the CCM endorsements *(required under section 3B.1.3 for RCMs, and 3B.2.1 for ROs)*** for **each** country/economy eligible in Round 7 **include information by that country/economy on its counterpart financing levels**;

If table 2.2.2 is completed, RCM and RO Applicants are reminded that the CCM endorsement letter required under either section 3B.1.3 or 3B.2.1 must also include information validating that country/economy's counterpart financing level for the relevant disease.

OR

(b) **Fully complete the applicable table(s) in section 2.2.1 above** for **each** country/economy listed as eligible in Round 7.

Table 2.2.2 – RCM or Regional Organization summary of Country/Economy Counterpart financing level

Country/Economy	CCM Confirmed Counterpart Financing – first year of proposal term **	CCM Confirmed Counterpart Financing – last year of proposal term **
	%	%
	%	%
	%	%
	%	%
	%	%

** **Note ➔ RCM and Regional Organization** Applicants must show that each of the countries targeted in this proposal are **moving from**:

(a) 10% **to** 20% counterpart financing over the proposal term if a Lower-middle income country; or

(b) 20% **to** 40% counterpart financing over the proposal term if an Upper-middle income country.

2 Country Eligibility

2.3 Focus on poor or vulnerable populations

All proposals which target Lower-middle income and/or Upper-middle income countries/economies (including multi-country proposals which include countries/economies other than Low-income countries/economies) **must demonstrate a focus on poor** or **vulnerable population groups**. *Proposals may focus on both population groups but **must** predominantely focus on at least one of the two groups. Complete this section in respect of each disease component.*

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

HIV Component:

The proposed activities for social protection (Objective 1) and those of integrated care (Objective 3) benefit persons living with HIV (PLWHA). **Preventive activities (Objective 2) are oriented towards persons in conditions of vulnerability who are identified in the national strategic plan:** Men having sex with men, sex workers, mobile populations (drivers, mobile work force and migrants), uniformed personnel, street children, incarcerated and members of gangs, pregnant women, adolescents and young adults 15 to 24 years of age.

The aforementioned groups have been involved in preparing the National Strategic Plan and in the development this proposal to the World Fund, both directly with organizations represented on the Country Coordination Mechanism (CCM), as well as associations of PLWHA, and indirectly through NGO's who defend interests of specific populations who do not have representation (e.g. street children).

A significant portion of the activities will be carried out by PLWHA associations and NGO's as Sub-recipients, consistent with their specific work areas. The role of the Ministry of Health is oriented towards the provision of tests, anti-retroviral treatments and preventive treatment for maternal-child transmission (MTCT), as well as supervision, monitoring and evaluation.

Tuberculosis Component:

El Salvador has committed itself to the elimination of Tuberculosis as a public health problem in the country by the year 2020.

The Tuberculosis component has the following **national objectives:** (i) reduce the case rate of TB of all types from 20 to 15 per 100,000 during the period 2007-2011, (ii) diagnosis of 70% or more of the expected cases of Tuberculosis Bacilli smear-positive (TB+) in the community and (iii) cure 90% of diagnosed Bacilli smear-positive, both respectively, during the period.

These activities will benefit all respiratory symptomatics with the PAL approach, cases of tuberculosis that are detected, treated and cured, vulnerable groups (prisoners, migrants and the poor who live in conditions of crowding) and their communities.

Have participated in the development of the proposal through NGO's in the health sectors who work with communities and groups living in poverty. They will participate in the Project in the same way, as well as through their direct feedback in the health centers.

2 Country Eligibility

2.4 Upper-middle income high disease burden minimum thresholds

Proposals from Upper-middle income countries/economies must also demonstrate that they currently face a high national disease burden. Please complete the section(s) below relevant to each disease component included in your proposal. Please note that if the Applicant falls under the 'small island economy' lending eligibility exception as classified by the World Bank/International Development Association, this requirement does not apply (see section C in Annex 1 to the Guidelines for Proposals).

(a) **HIV/AIDS Current High National Disease Burden**

For Round 7, the Global Fund has determined that the only Upper-middle income countries which may apply for funding for HIV/AIDS *(whether a single country proposal, or as part of a multi-country proposal)* are Botswana, Equatorial Guinea and South Africa. *(See the Guidelines for Proposals, section 2.4 for more information.)*

N/A

(b) **Tuberculosis Current High National Disease Burden**

Confirm that the Upper-middle income country(ies) targeted in this proposal is(are) **currently** facing a high **national disease burden**, as defined by data from WHO. *(See the Guidelines for Proposals, section 2.4 for more information on the definition of high disease burden.)*

N/A

(c) **Malaria Current High National Disease Burden**

Confirm that the Upper-middle income country(ies) targeted in this proposal is(are) **currently** facing a high **national disease burden**, as defined by data from WHO.
(See the Guidelines for Proposals, section 2.4 for more information on the definition of high disease burden.)

N/A

3A Applicant Type and Eligibility for Funding

*This section requires **all Applicants** to:*

(a) Describe what type of applicant they are; and

*(b) Describe how they meet the minimum requirements **to be eligible to submit a proposal**.*

Throughout this section, Applicants are requested to attach documents to support the information summarized below.
At the end of section 3B all Applicants must complete a 'checklist' to ensure that they attach all documents.

***All Coordinating Mechanism Applicants** (whether CCM, Sub-CCM or RCM) **and Regional Organizations must also** complete section 3B of this Proposal Form and provide the documented evidence requested.*

***Non-CCM Applicants** do not complete section 3B. These Applicants must complete section 3A.6 of this Proposal Form and attach documentation supporting their claim to be considered as eligible for Global Fund support outside of a Coordinating Mechanism (whether CCM, Sub-CCM or RCM) structure.*

Confirmation of Applicant Type

Table 3A – Applicant Type

Please check the appropriate box in the table below. Then go to the relevant section in this Proposal Form as indicated on the right hand side of the table as this sets out the road map to fully complete section 3A and 3B.

☒	National Country Coordinating Mechanism	➔ *Complete sections 3A.1 and 3A.4 and 3B.1*
☐	Sub-national Country Coordinating Mechanism	➔ *Complete sections 3A.2 and 3A.4 and 3B.1*
☐	Regional Coordinating Mechanism for multi-country proposals (including small island developing states)	➔ *Complete sections 3A.3 and 3A.4 and 3B.1*
☐	Regional Organization for multi-country proposals	➔ *Complete section 3A.5 and 3B.2*
☐	Non-CCM Applicants for single country proposals only	➔ ***Only** complete section 3A.6*

Importantly ➔

***Each Applicant should only complete one version of the relevant sections set out above** and not a new version for each disease component.*

*Applicants should also **only** complete those sections set out in table 3A above that are indicated as relevant to their application to ensure that they do not expend unnecessary resources on completing sections that do not apply to them.*

3A Applicant Type and Eligibility for Funding

3A.1 National Country Coordinating Mechanism (CCM) Applicants

For more information, please refer to the Guidelines for Proposals, section 3A.1, and the CCM Guidelines.

Table 3A.1 – National CCM: overview information

Name of CCM
Country Coordinating Mechanisms CCM (CCE in El Salvador)

3A.1.1 Mode of operation

Describe how the national CCM operates. In particular:

(a) The extent to which the CCM acts as a functional partnership between government and other key stakeholders, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; and multi-/bilateral development partners in-country; and

(b) How it coordinates its activities with other national structures tasked with responsibility for oversight and harmonization in regard to the disease(s) (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide a diagram setting out the interrelationships between all key actors in the country as an annex to this proposal. Please indicate the applicable annex number in your checklist to sections 1 to 3B before the start of section 4.)

The CCM, due to its own composition and representativeness of its members, allows for the coordination of actions both from government and non-government entities and international cooperation. The CCM has periodic meetings which are categorized as: **a) Regular**, (every 15 days) and, **b) Extraordinary**. A record of all analysis processes, discussion and decisions or agreements is kept in the respective Minutes *(Attachment 3a.1.* CCM *Regulations; Attachment 3ª.2 Organizational Chart)*.

The main functions of the CCM, according to the established **regulations** are: - Selecting and proposing to the Global Forum one or more organizations with technical experience and proven administrative capacity to act as Principal Recipient(s) (PR); - Promote the compliance with agreements signed by the Salvadoran State through international agreements, related to programmatic issues and guidelines established and linked in the country Proposal approved by the Global Fund; - Provide political and strategic guidance to the implementation of the country proposal, propose recommendations and modifications for specific policies during the process of proposal implementation and serve as permanent support in the execution of the project; - Ensure, in coordination with the Principal Recipient, the appropriate and transparent use of the resources assigned to the country by the Global Fund within the framework of monitoring and evaluation, and in agreement with programmatic and financial indicators; - Approve operational plans, and budgets, in terms that do not affect the implementation of the country proposal.

To ensure the political feasibility of the Project, guarantee its complementarity with other initiatives and assure the technical and material support of the Government, the CCM relies upon a **political advisory council,** made up of high-level representatives of the institutions represented.

In order to have a full and permanent consultative process among the institutions represented on the CCM, a number of sector-specific standing committees (SC) have been created – There are six SC's, one for each of the sectors represented on the CCM: Governmental, PLWHA, NGOs,

3A Applicant Type and Eligibility for Funding

Educational-Academic, Religious and Cooperating Agencies. A seventh sector will join the CCM, on July 1, 2007, to provide a voice to the private sector. Each sector carries on consultation within its membership and freely elects its representatives to the Salvadoran CCM. The SC's are entities which operationalize the sector participation on the CCM. The SC's provide guidance to the CCM by providing relevant, sector specific inputs to the decision making responsibilities of the CCM.

In addition, to guarantee that the CCM has the technical links it needs for its deliberative process, the CCM has a Technical Support Committee as well as *ad hoc* committees designed to link CCM's activities with the required scientific and technical resources of the country.

➔ *After completing this section,* ***complete BOTH section 3A.4 AND section 3B.1****.*

3A Applicant Type and Eligibility for Funding

3A.2 Sub-national Country Coordinating Mechanism (Sub-CCM) Applicants

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

Table 3A.2 – Sub-national CCM: overview information

Name of Sub-CCM
N/A

3A.2.1 Mode of operation

Describe how the Sub-CCM operates. In particular:

(a) The extent to which the Sub-CCM acts as a functional partnership at the strategic and implementation levels between government and other key stakeholders in the region in which the Sub-CCM operates, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the disease(s) and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country;

(b) The process by which the Sub-CCM developed under the guidance of a functional CCM and how it became to be formally recognized by that CCM
(Note: if there is evidence of a legal framework for the sub-national entity stating its autonomy please provide such evidence); and

(c) How the Sub-CCM coordinates its activities with other sub-national and national structures tasked with responsibility for oversight and harmonization in regard to the disease(s) (such as Regional and/or National AIDS Councils, Municipal, State or National Parliamentary Health Commissions, Regional and/or National Monitoring and Evaluation Offices and other key bodies).

(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide a diagram setting out the interrelationships between all key actors as an annex to this proposal including, in particular, the interrelationships with the National CCM. Please indicate the appropriate annex number in your checklist to sections 1 to 3B before the start of section 4.)

3A.2.2 Rationale

(a) Explain why a Sub-CCM approach represents an effective approach in the circumstances of your country.
(Maximum of half a page.)

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

➔ *After completing this section,* ***complete BOTH section 3A.4 AND section 3B.1****.*

3A Applicant Type and Eligibility for Funding

3A.3 Regional Coordinating Mechanism Applicants

(includes small island developing states without national CCMs)

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

Table 3A.3 – Regional Coordinating Mechanism: overview information

Name of Regional Coordinating Mechanism (RCM)
RCM Secretariat Office Address

3A.3.1 Mode of operation

Describe how the RCM operates. In particular:

(a) **The extent to which the RCM acts as a functional partnership at the strategic and implementation levels between government and other key stakeholders**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the disease(s) and the organizations that support them; the private sector; religious and faith-based organizations; multi-/bilateral development partners in-country;

(b) **How the RCM coordinates its activities with the national structures of the countries that are included** in the proposal (such as national AIDS councils, national CCMs, national monitoring and evaluation offices, or the national strategies of small island developing states who are not required to have their own national CCM or other national coordinating body); and

(c) **The RCM's governance structure and processes,** and how the implementation strategy and timelines have taken into account the regional context, including the need to coordinate between multiple entities.

(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. ***The recommended length of response is a maximum of one page****. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the RCM, and a diagram setting out the interrelationships between key stakeholders across the included countries as an annex to this proposal. Please indicate the appropriate annex number in your checklist to sections 1 to 3 before the start of section 4.)*

3A.3.2 Rationale

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

3A Applicant Type and Eligibility for Funding

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

➔ *After completing this section,* ***complete BOTH section 3A.4 and section 3B.1****.*

3A Applicant Type and Eligibility for Funding

3A.4 Functioning of Coordinating Mechanism (CCM, Sub-CCM and RCM Applicants)

IMPORTANT NOTE FOR APPLICANTS:

All CCM, Sub-CCM and RCM Applicants must meet, and continue to meet, the Global Fund's minimum requirements for eligibility for funding. This section asks Applicants to describe the operations of their Coordinating Mechanism, and update information provided in Round 6. You will be asked to re-confirm this in the Checklist at the end of sections 1 to 3B of this Proposal Form.

For additional information regarding these requirements, see:

- *The CCM Guidelines; and*
- *'Clarifications on CCM Minimum Requirements'.*

3A.4.1 Round 6 Application History

Table 3A.4.1 – Applicant's Round 6 Application History

Please check the appropriate box in the table below. Then go to the relevant section in this Proposal Form, as indicated on the right hand side of the table to complete other important questions.	
☒ Applied in Round 6 **and** determined as having met the minimum requirements for Round 6	➔ ***Complete section 3A.4.2 and*** *each of* ***Requirements 3(a), 3(b), 4(a) and 5(a)*** *within sections* ***3A.4.5 and 3A.4.6.***
☐ Did not apply in Round 6 **or** determined ineligible in Round 6	➔ ***Complete*** *sections 3A.4.2 to 3A.4.6* ***inclusive****.*

3A.4.2 Changes in CCM, Sub-CCM or RCM from Round 6 Application

Describe **in detail** any changes in the membership or operations of the Coordinating Mechanism (i.e., CCM, Sub-CCM or RCM) since submission of your Round 6 application to the Global Fund. In particular, describe if new processes have been adopted for the selection of members by their own sectors, or to manage conflicts of interest; or oversee the work of implementation partners. *If new processes have been adopted, these must be described, and relevant documents attached as an annex to your Round 7 proposal.*
There are no new processes, there have been only routine changes in the composition of the CCM, according to the current regulations.

3A Applicant Type and Eligibility for Funding

***Please note that the following sections follow the order set out in the document entitled 'Clarifications on CCM Minimum Requirements – Round 7' at**: http://www.theglobalfund.org/en/apply/call7/documents*

***Applicants are reminded that 'Coordinating Mechanism'** ('CM') **for the purposes of this section means either a CCM, Sub-CCM or RCM Applicant as relevant**.*

3A.4.3	**Principle of broad and inclusive membership N/A**
(a)	**Requirement 1 ➔ Selection of non-governmental sector representatives** Provide evidence of how the CM members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, or religious and faith-based organizations),* have been selected by their own sector(s) based on a **documented**, **transparent** process **developed within their own sector**. *Please indicate below (via the check-box below) which documents are relied on to support the Applicant's statement of compliance with this requirement **AND** attach as an annex the documents showing **each sector's transparent process** for CM representative selection, and **each sector's** meeting minutes or other documentation recording the selection of their current representative.*

	Documentation relied on to support compliance with Requirement 1	**Identify which annex to this proposal contains these documents** ***Please indicate the applicable annex number** in your checklist to sections 1 to 3B before the start of section 4.*
☐	Selection criteria for each sector developed by each respective sector	
☐	Minutes of meeting(s) at which the sector transparently determined its representative	
☐	Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member	
☐	Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process	
☐	Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the CCM, Sub-CCM or RCM.	
☐	Other: *(please specify):*	

(b)	**Please briefly summarize how the information provided within the annexes listed above satisfies Requirement 1**

3A Applicant Type and Eligibility for Funding

3A.4.4 Principle of involvement of persons living with and/or affected by the disease(s)

Requirement 2 ➔ People living with and/or affected by the disease(s)

Describe the involvement of people living with and/or affected by the disease(s) in the CM.
(Importantly, Applicants submitting HIV/AIDS and/or tuberculosis components must clearly demonstrate representation of this important group. Please carefully review the Global Fund's 'Clarifications on CCM Minimum Requirements – Round 7' document before you complete this section).

N/A

3A.4.5 Principle of transparent and documented proposal development processes (Requirements 3, 4 and 5)

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

Please describe and provide evidence of the applicant's documented, transparent and established processes to respond to each of the 'Requirements' set out below:

Requirement 3(a) ➔ Process to solicit submissions for possible integration into this proposal.

Ideas were generated for the proposal by means of forums held with participating organizations, both from the Tuberculosis sector (May 2) and of the HIV/AIDS sector (June 8). A total of 26 organizations working in various aspects of the Tuberculosis program were invited (see Attachment 3ª.4.5. – 3(a) which contains the list of organizations invited, the letter of invitation, and a record of those attending.)

A total of 91 organizations working in the HIV/AIDS sector were invited to the forum held on June 8. Of those invited, 34 institutions attended with 44 persons representing them. (Attachment 3A.4.5. -3(a))

In addition to extensive discussion of the the proposal for Round 7, attendees of both forums were asked to submit their comments and suggestion within a deadline of 8 to 10 days, for incorporation into the proposal develoment process.

Requirement 3(b) ➔ Process to review submissions received by the CM for possible integration into this proposal.

Comments and suggestions received from forum attendees were reviewed by the technical teams formulating each proposal (the HIV/AIDS technical team includes one PLWHA representative). All pertinent suggestions were incorporated and in several cases, the organizations were invited to return for full discussion and clarification of their contributions (Attachment 3A 4.5. -3(b): the substance of suggestions made by NGOs, letter of invitation and a list of the organizations participating directly in this process.)

Requirement 4(a) ➔ Process to nominate the Principal Recipient(s) for proposals.

Based upon the results of a consultancy for Round 6, certain institutions were pre-selected to participate in a bidding process by presenting their requests. This short list consisted of 24 institutions with demonstrated experience in Tuberculosis (11) and HIV/AIDS (13). The CCM established norms and procedures for reviewing and ranking the technical merit of each proposal. The process led to a selection of institutions which had been considered as finalists for both components, TB and HIV/AIDS. For more detailed description and documentation, please see the attachment 3A.4.5.-4(a).

Requirement 4(b) ➔ Process to oversee/review program implementation by the Principal Recipient(s) during the proposal term.

N/A

3A Applicant Type and Eligibility for Funding

Requirement 5(a) ➔ **Process to ensure the input** of a broad range of stakeholders, including CCM members **and non-CM members**, in the proposal development process.
Both the CCM and the National Programs (TB and HIV/AIDS) have mechanisms for full, open collaboration with many institutions. The CCM regularly receives reports from the PR and supervises Project progress. It invites observers from pertinent sectors in order to ensure that there are contributions from a wide range of stakeholders. The sub-recipients selected during the first year of the project will also serve as a mechanism for channelling the contributions of a wide range of local level actors (see rules and Internal Regulations, chapter 19, Attachment 3 A .1). Finally, the work with communities, local NGOs and support groups that are included in the projects will facilitate communication with different sectors at local levels.
Requirement 5(b) ➔ **Process to ensure the input** of a broad range of stakeholders, including CCM members **and non-CM members**, in grant oversight processes.
N/A

3A.4.6 Principle of effective management of actual and potential conflicts of interest	
Requirement 6 ➔ Are the Chair **and/or** Vice-Chair of the Coordinating Mechanism from the same entity as the nominated Principal Recipient(s) in this proposal?	☐ Yes ☒ No
If yes, summarize below the main elements of the Applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest **and attach a copy of the Conflict of Interest policy/plan to this proposal as an annex**.	

3A.4.7 Financial Support for Coordinating Mechanism operations	
Does the applicant intend to apply for funding of CCM operations? *Details on the availability of such funding are provided in Section 3A.4.7 of the Guidelines, and Applicants should refer to this information before completing this section.*	☐ Yes *provide details below* ☒ No *go to section 3B.1*
If yes, please specify the amount requested and describe how the amount complies with the **time limitation** and **funding categories available**, as explained in Section 3A.4.7 of the Guidelines for Proposals. **Applicants must ensure that the amount requested is included in the detailed component budget** (section 5.1) **in a separate identifiable budget line.**	

➔ *After completing this section,* ***go to section 3B.1.***

3A Applicant Type and Eligibility for Funding

3A.5 Regional Organization Applicants

(including Intergovernmental Organizations and International Non-Government Organizations)

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

Table 3A.5 – Regional Organization: overview information

Name of Regional Organization	
N/A	
Sector represented by the Regional Organization *(Check the relevant box below)*	
☐	Academic/educational sector
☐	Government
☐	Non-Government Organizations
☐	People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria
☐	Private sector
☐	Religious/faith-based organizations
☐	Other *(please specify)*

3A.5.1 Mode of operation

In addition to answering the questions below, Regional Organizations must provide (as additional annexes to this proposal) documentation describing the organization, such as:

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

Describe below how the Regional Organization operates. In particular:

The manner in which the Regional Organization gives effect to the principles of **inclusiveness and multi-sector consultation** and partnership in the development and implementation of regional cross-border projects;

The extent to which people living with and/or affected by the disease(s) targeted in the Regional Organization's proposal were involved in development of your proposal; and

The coverage and past experience of the Regional Organization's operations, with a particular focus on outcomes relevant to the subject of this proposal
(Maximum of half a page.)

3A Applicant Type and Eligibility for Funding

3A.5.2	Rationale
(a)	Describe how this regional proposal is consistent with and complements the national plans for responding to the disease of each country involved. *(Maximum of half a page.)*
(b)	Explain how the countries targeted in the Regional Organization's proposal represent a natural collection of countries and describe what measures will be taken to maximize operational efficiencies in administrative processes. *(Maximum of half a page.)*

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

3A Applicant Type and Eligibility for Funding

3A.6 Non-CCM Applicants

Non-CCM proposals are only eligible for funding under exceptional circumstances listed in section 3A.6.1 below. For more information, please refer to the Guidelines for Proposals, section 3A.6.

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

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

Name of Non-CCM Applicant	
Business address *(including street, town/state and country)*	

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

Indicate the sector represented (check appropriate box):

- ☐ Academic/educational sector
- ☐ Government
- ☐ Non-government Organization (NGO)/community-based organizations
- ☐ People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria
- ☐ Private sector
- ☐ Religious/faith-based organizations
- ☐ Other *(please specify)*

3A Applicant Type and Eligibility for Funding

3A.6.1 Rationale for applying outside of a CCM, Sub-CCM or RCM

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

(i) Countries without legitimate governments;

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

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

***Describe in detail** which of the **above condition(s)** apply*
(Maximum of two pages. Please refer to the Guidelines for Proposals, section 3A.6.1 for further information on how the Global Fund will interpret these criteria.)

3A.6.2 Attempts to have Non-CCM proposal included in the CCM, Sub-CCM or RCM proposal

(b) Describe **all attempts by your organization to submit this proposal and have it included in the relevant final proposal of a CCM, Sub-CCM or RCM** (as appropriate to the content of your proposal), **providing details of any responses received**.

*(Maximum of one page. Please provide documentary evidence of these attempts and any response from the CCM, Sub-CCM or RCM as an annex to the proposal. Please ensure that your description clearly sets out whether you provided a copy of your proposal for consideration by the CCM**, Sub-CCM** or RCM**,and if not, why not.)*

(** Contact details for CCMs, Sub-CCMs and RCMs are available on the Global Fund website, or by contacting proposals@theglobalfund.org)

(c) If you are aware that a CCM is also submitting a proposal in Round 7 for a country or countries included in your proposal, **provide a detailed explanation of why you believe that your non-CCM proposal merits consideration and recommendation for funding as well as any national CCM proposal**.

(Maximum of one page. In this section, please set out any particular issues which you believe support the submission of a Non-CCM Applicant proposal in circumstances where a CCM has applied.)

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

3A.6.3 Consistency with national policies

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

➔ *After completing this section, complete the checklist for sections 1 to 3B before completing sections 4 and 5 on a per-disease component basis.*

3B Proposal Endorsement

3B.1 Coordinating Mechanism Applicants *(CCM, Sub-CCM and RCM)* membership and endorsement

All national (CCM), sub-national (Sub-CCM) and regional Coordinating Mechanisms (RCM) Applicants must:

(a) ***Fully complete this section****; and*

(b) ***Complete and attach*** ***'Attachment C'*** *to list all of the members of the Coordinating Mechanism, their contact details and email addresses. (This excel file is available for completion by downloading it from the Round 7 documents website of the Global Fund.)*

3B.1.1 Leadership of the Coordinating Mechanism

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

	Chair	Vice Chair
Name	Dr.. Ana Isabel Nieto	Lic. Mirian Henríquez
Title	Sub-director of Human Promotion and Habitat	National Health Advisor
Organization	Caritas El Salvador	Plan Internacional El Salvador
Mailing address	Avenida Olímpica y Pasaje 3 #130 San Salvador, El Salvador	51 Avenida Norte # 2636 y Alameda Roosevelt San Salvador, El Salvador
Telephone	503-2298 4302	(503) 2261 2494
Fax	503-2298 3035	(503) 2260 9164
E-mail address	anieto@caritaselsalvador.org	Mirian.henriquez@plan-international.org
Alternate e-mail address		

➔ *Go to section 3B.1.2 (membership information).*

3B Proposal Endorsement

3B.1.2 Membership information of CCM, Sub-CCM or RCM

Please note that to be eligible for funding, CCM, Sub-CCM and RCM Applicants must demonstrate evidence of membership of people living with and/or affected by the disease(s). Also, it is recommended that the membership of the CCM, Sub-CCM or RCM comprise a minimum of 40% representation from non-governmental sectors. For more information on this, see the Guidelines for Proposals section 3B.1 and the CCM Guidelines.

Table 3B.1.2 – Summary of Coordinating Mechanism members

Summary of Membership of CCM, Sub-CCM or RCM

The table below must be completed by each CCM, Sub-CCM or RCM Applicant. **This table is a summary only of the detailed membership information that must be provided in 'Attachment C' to this Proposal Form**.

*Under the heading '**Sector Representation**' in the left hand column below, please check each box which describes the sectors that have representation on the CCM, Sub-CCM or RCM. In the right hand column below, please indicate, **in figures**, the number of representatives who are included in the corresponding sector.*

***Please make sure that the total number of members in the table below equals the total number of members in 'Attachment C' to your proposal**.*

Sector Representation	Number of members representing the sector
☐x Academic/educational sector	4
☐x Government	4
☐x Non-Government Organizations (NGOs)/community-based organizations	5
☐x People living with and/or affected by HIV/AIDS, tuberculosis and/or malaria	4
☐ Private sector	
☐x Religious/faith-based organizations	1
☐x Multilateral and bilateral development partners in country	5
☐x Other *(please specify):* Principal Recipient	2
Total Number of Members	25

➔ *Go to section 3B.1.3 (proposal endorsement)*

* Academic Sector counts on 2 Proprietary Representatives and 2 Substitute Representatives
* Government Seector counts on 2 Proprietary Representatives and 2 Substitute Representatives
* NGO Sector counts on 3 Proprietary Representatives and 2 Substitute Representatives
* PLWHA Sector counts on 2 Proprietary Representatives and 2 Substitute Representatives
* Religious Sector counts on 1 Proprietary Representative
* International Cooperation Sector counts on 3 Proprietary Representatives and 1 Substitute Representative
* Principal Recipient counts on 1 Proprietary Representative and 1 Substitute Representative

3B Proposal Endorsement

3B.1.3 CCM, Sub-CCM and RCM proposal endorsement

Level 1 Endorsement

CCM, Sub-CCM and RCM members must endorse their own proposal for an application to be eligible.

This is demonstrated by each member of the Coordinating Mechanism (whether CCM, Sub-CCM or RCM) ***signing Attachment C in the final column once all membership information has been completed.***

*Please note that the **original** (not photocopied, scanned or faxed) **signatures of the CCM, Sub-CCM or RCM members** must be provided in **Attachment C**. The minutes of the CCM, Sub-CCM or RCM meeting at which the proposal was considered and endorsed must be attached as an annex to this proposal. The entire proposal, including Attachment C and the minutes, must be received by the Global Fund Secretariat by 4 July 2007.*

Level 1 endorsement	Check this box **only** if the CCM, Sub-CCM or RCM has completed the membership details and **members have signed Attachment C** to the Proposal Form	x☐

Level 2 Endorsement – Sub-CCM and RCM Applicants only

For sub-national (Sub-CCM) and regional Coordinating Mechanism (RCM) Applicants only, the national CCM of the country (or countries for RCM applications) must also endorse the Sub-CCM or RCM proposal.

*This endorsement must be evidenced by providing the Global Fund with written confirmation of the endorsement from the Chair and/or Vice-Chair of the relevant CCM(s) **together with** a copy of the minutes of the CCM meeting at which the Sub-CCM or RCM proposal was **presented for review by the national CCMs and transparently discussed** and endorsed by the membership of the CCM under its transparent documented rules and procedures. Please refer to the Guidelines for Proposals, section 3B.1.3.*

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

Level 2 endorsement of Sub-CCM or RCM proposal by National CCMs

*List below each of the national CCMs that have agreed to this proposal and **provide documented evidence of this endorsement, including copies of the CCM meetings at which the Sub-CCM or RCM proposal was discussed and endorsed**. For Sub-CCM proposals which only cover one part of a country, only that country should be listed.*

Country	Date of CCM Endorsement	Annex number to this proposal
N/A		

➔ *After completing this section, complete the checklist for sections 1 to 3B before completing sections 4 and 5 on a per-disease component basis.*

3B Proposal Endorsement

3B.2 Regional Organization proposal endorsement

3B.2.1 National CCM endorsement of Regional Organization proposal:

*Regional Organizations **must receive** an **endorsement in writing from the CCM for all countries targeted in the proposal** unless the country does not have a CCM (by reason that it is a small island developing state without a CCM, or it is a country which has never been eligible for funding from the Global Fund and does not therefore have a functional CCM). **This endorsement must be evidenced by** written confirmation from the Chair and/or Vice-Chair of all relevant CCMs **and** a copy of the minutes of the CCM meeting at which the Regional Organization's proposal was transparently discussed and, if relevant, endorsed by the membership of the CCM under its transparent documented rules and procedures. Please refer to the Guidelines for Proposals, section 3B.2.*

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

Table 3B.2.1 – Regional Organization proposal endorsement by national CCMs

Country	Date of CCM Endorsement	Annex number to this proposal

➔ *After completing this section, complete the checklist for sections 1 to 3B before completing sections 4 and 5 on a per-disease component basis.*

CHECKLIST OF ANNEXES FOR SECTIONS 1 - 3B TO BE ATTACHED TO YOUR PROPOSAL

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

Relevant item on the Proposal Form	**Description of the information required in the Annex**	**Title of the Document** and **annex number given to each annex**
Section 3A: Applicant Type and Eligibility for Funding		
Coordinating Mechanisms only (CCM, Sub-CCM or RCM Applicants):		
3A.1.1 (CCM), 3A.2.1 (Sub-CCM) **or** 3A.3.1 (RCM)	Documents that describe how the national/sub-national or regional Coordinating Mechanism operates (terms of reference, statutes, by-laws or other governance documentation and a diagram setting out the interrelationships between all key actors).	3 A.1.1a Rules and Regulations of the CCM 3 A.1.1b Organizational Chart of the CCM
Documentation describing compliance with the minimum Coordinating Mechanism requirements (sections 3A.4.3 to 3A.4.6 inclusive):		
Minimum Requirement 1	Comprehensive documentation on processes used to select non-governmental sector representatives of the Coordinating Mechanism.	N/A
Minimum Requirement 3(a)	- solicit submissions for possible integration into the proposal.	Attachment 3A 4.5. - 3(a) Process of requesting contributions for the proposal
Minimum Requirement 3(b)	- review submissions for possible integration into the proposal.	Attachment 3A 4.5. - 3(b) Process used to incorporate the contributions from the sectors
Minimum Requirement 4(a) and 4(b)	- select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated) and to oversee grant implementation.	(See Attachment 3A .4.5.-4(a) Process of selection and approval of Principal Recipient
Minimum Requirement 5(a) and 5(b)	- ensure the input of a broad range of stakeholders in the proposal development process and grant oversight process.	3 A.1.1a Rules and Regulations of the CCM
3A.4.6 – Minimum Requirement 6	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism	N/A

CHECKLIST OF ANNEXES FOR SECTIONS 1 - 3B TO BE ATTACHED TO YOUR PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document and annex number given to each annex
Regional Organization Applicants:		
3A.5.1	Documents that describe the organization such as statutes, by-laws (official registration papers) and a summary of the main sources and amounts of funding.	
Non-CCM Applicants:		
3A.6	Documentation describing the organization such as statutes and by-laws (official registration papers) or other governance documents, documents evidencing the key governance arrangements of the organization, a summary of the organization, including background and history, scope of work, past and current activities, and a summary of the main sources and amounts of funding.	
3A.6.2 b	Documentary evidence of any attempts to include the proposal in the relevant CCM's final approved country proposal and any response from the CCM.	
3A.6.3 *(if submitted for a country where no CCM exists)*	Provide evidence from relevant national authorities that the proposal is consistent with national policies and strategies.	
Section 3B: Proposal Endorsement		
3B.1.3 ***Level 1 Proposal Endorsement*** *(CCMs, Sub-CCMs and RCMs)*	Minutes of the meeting at which the proposal was developed and CCM endorsed..	**Attachment C to the Proposal Form** **Attachment 3 B.1.3** **First-level approval**
3B.1.3 (***Level 2 Proposal Endorsement =*** *Sub-CCMs and RCMs only)*	Documented evidence (including minutes of the CCM meetings) that all national CCM(s) have reviewed and endorsed the proposal.	N/A
3B.2.1 (***Level 2 Proposal Endorsement*** *Regional Organizations only)*	Documented evidence that the national CCMs have reviewed and endorsed the proposal.	
Other documents relevant to sections 1 to 3B attached by Applicant: *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)*		

CHECKLIST OF ANNEXES FOR SECTIONS 1 - 3B TO BE ATTACHED TO YOUR PROPOSAL

Relevant item on the Proposal Form	Description of the information required in the Annex	Title of the Document and annex number given to each annex

4 Component Section *HIV/AIDS*

***PLEASE NOTE THAT SECTION 4 and SECTION 5 MUST BE COMPLETED FOR EACH SEPARATE DISEASE COMPONENT**. This section is only for your HIV/AIDS component, and sections 4 and 5 for tuberculosis and malaria occur later in this Proposal Form (refer to the section headings to find the section relevant to your proposal).*

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

4.1 Requested proposal term for this disease component

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

Important note:

If your proposal term is less than five years, please first refer to the Global Fund's Round 7 'Frequently Asked Questions' (No. 132) at:
http://www.theglobalfund.org/en/apply/call7/documents/documentsfaqs/

Table 4.1.1 – Proposal start time and duration

	From	To
Month and year:	July 2008	June 2013

4.2 Disease specific component executive summary

4.2.1 Executive summary

Describe the overall strategy of the proposal component, by referring to challenges, existing and/or new needs, goals, objectives and planned outcomes and outputs to be achieved through the additional funding requested in this proposal, specifying the main beneficiaries (including target populations and their estimated number). Also specify any institution/facilities that will benefit from any support for health systems strengthening strategic actions.

*(**Maximum of one page in length**, highlighting, in a summary format only, key aspects from information described in your answers to the questions within section 4).*

El Salvador has made significant gains in its fight against HIV/AIDS by adopting internationally recommended strategies and norms for prevention, treatment, and control of the epidemic. With support from Round 2 of the Global Fund since 2003, it has built on the principles embodied in the Three Ones and Universal Access.

Highlights of the advances made over the past four years include

- The advent of widespread access to free testing and counseling.
- Active approaches to target high risk and vulnerable groups.
- Information, education, and communication (IEC) campaigns aimed at priority target groups.
- Availability of ART and integrated treatment/care services in most of the country, greatly lengthening lives and improving their quality.
- Lowering the rate of mother to child infections by 85%.
- Formation of PLWHA support groups at all ART centers and elsewhere.
- Consolidation of a coordinated, interinstitutional, multisectoral approach to the epidemic and securing non-partisan political support at the highest levels.
- Training of almost 5,000 health sector staff, volunteers, and PLWHAs.

Nonetheless, to fully meet the demands of the epidemic the country faces major challenges:

4 Component Section *HIV/AIDS*

- HIV prevalence in adolescents and youth has doubled in five years.
- High risk groups have HIV prevalences many times higher than the general population—e.g., men who have sex with men (MSM, 17.7%), sex workers (SW, 3.6% to 16% depending on locality), and prisoners (6%).
- Many members of high risk and vulnerable groups do not use the health system, including many MSM, SW, and about 20% of pregnant women.
- Training and sensitization on HIV/AIDS has covered fewer than 25% of health sector personnel.
- The numbers of HIV tests and condoms available fall far short of current needs; the supply of ART medications is in danger of falling short of growing demand by 2008 or 2009.
- The national monitoring and evaluation system, has been planned but not implemented.
- The face of the epidemic is substantially unknown: only about 10% have been tested; UNAIDS and WHO estimates are much higher than the number of known cases for at-risk groups; data are not segregated by sex, occupation, or other relevant variables.

These and other challenges will be met through the proposed project. Its goal is to **reduce the social and economic impact of the epidemic.** To achieve this the project will pursue four Objectives:

5. **Improve the social protection and quality of life of PLWHA.**
6. **Reduce the transmission of HIV.**
7. **Reduce morbidity and mortality.**
8. **Strengthen the health system**.

The results to be obtained include strengthened capacity of PLWHA organizations, improved social and economic opportunities for PLWHAs, and reduced stigmatization. Focused IEC efforts will change behaviors, increasing condom use, voluntary testing and counseling, diagnosis, and treatment. Integrated treatment and care centers staffed with interdisciplinary teams that incorporate PLWHAs will provide ART, prophylaxis and treatment for opportunistic infections, comprehensive care for the chronically ill, and varied support services overseen by PLWHA groups. The health system as a whole will benefit from an integrated M&E and surveillance system, and from improved professional training for new and in-service personnel.

The populations benefited include about 1.6 to 1.8 million persons in the nine high risk and vulnerable groups targeted—MSM, SW, prisoners, gang members, street children, migrant/mobile populations, uniformed services, pregnant women, adolescents and youths. They also include about 15,000 health workers and volunteers who will work in a system better enabled to do its job. In the largest sense, all 7 million Salvadorans will be better off from a palpable reduction in the threat they face from HIV/AIDS.

4 Component Section *HIV/AIDS*

4.3 National program context for this component

The information below helps reviewers understand the disease context, what is working well and will be built upon, which problems the proposal will address and the major constraints for the implementation of the proposed component. Please refer to the Guidelines for Proposals, section 4.3.

4.3.1 Indicate whether you have any of the following documents** *(check the appropriate box),* **and if so, please attach them as an annex to your proposal:**

☐X	National Health Sector Development/Strategic Plan
☐X	National Disease Control Strategy or Plan **including national targets and indicators, together with the relevant budget and costings**
☐X	Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards)
☐X	Most recent evaluation reports/technical advisory reviews **directly relevant to the proposal**
☐X	National Monitoring and Evaluation Plan (health sector, disease specific or other)

** *Applicants will be asked to refer to these documents, where they exist, throughout this section 4 as further support for the proposal's overall strategy.*

References on HIV/AIDS in El Salvador for Global Fund Round 7 proposal.

(copies in Annex VIH-1)

Internacional References:

1. WHO. 2007. Report on Global Tuberculosis Control. Surveillance, Planning, Financing. 277 pp.
2. ONUSIDA. 2006. Informe sobre la Epidemia Mundial del SIDA 2006. Anexo 2. Estimaciones y datos sobre el VIH y el SIDA 2005 y 2003.
3. World Bank. 2006. HIV/AIDS Vulnerability Reduction in Central America, El Salvador Chapter. Situation of HIV/AIDS and Response to the Epidemic. [Reduciendo la Vulnerabilidad al VIH-SIDA en Centroamérica, Capitulo El Salvador: Situación del VIH-SIDA y respuesta a la epidemia.]
4. USAID-PASCA-AED. 2006. El Salvador. 2005 AIDS Program Effort Index. In Centroamérica: Medición del Ambiente Político Asociado al SIDA (MEGAS 2005).
5. UNDP, Dichter and Neira. 2006. Stigma and Discrimination Study, El Salvador. [Estudio Estigma y Discriminación, El Salvador.]

National Reports and References

HIV-1.1 Strategic Five Year Plan for the Ministry of Health 2004-2009 (Plan Estratégico Quinquenal 2004-2009 del Ministerio de Salud.)

HIV-1.2 2005-2006 Annual Report of the Ministry of Public Health and Social Assistance (Informe de Labores 2005-2006. Ministerio de Salud Pública y Asistencia Social)

HIV-1.3 National Strategic Plan for Prevention, Care, and Control of STI/HIV/AIDS 2005-2010 (Plan Estratégico Nacional de Prevención, Atención y Control de las ITS-VIH-SIDA 2005/2010).

HIV-1.4 Care Protocols for Persons Living with HIV/AIDS (Protocolos de atención para Personas Viviendo con VIH/SIDA).

HIV-1.5 Care Norms for Sexually Transmitted Infections (Normas de Atención para las InfCCMiones de Transmisión Sexual).

HIV-1.6 Care Guidelines for Sexually Transmitted Infections (Guía de Atención para las InfCCMiones de Transmisión Sexual).

HIV-1.7 Law and Regulations on the Prevention and Control of the Human Immunodeficiency Virus (Ley y Reglamento de prevención y control del Virus de Inmunodeficiencia Humana).

HIV-1.8 Guidelines for Prevention of Vertical Maternal-Infant HIV Transmission (Guía para la prevención de la transmisión Vertical Materno Infantil del VIH).

HIV-1.9 Nutrition Guidelines for Working with Patients who Live with HIV/AIDS (Guía de nutrición para el abordaje de pacientes viviendo con VIH-SIDA).

HIV-1.10 Guidelines for Working with Mobile Populations (Guía para el Abordaje de Poblaciones Móviles).

HIV-1.11 Guidelines for Universal Measures of Biosecurity (Guía de Medidas Universales de Bioseguridad).

HIV-1.12 Manual for Facilitators on Counseling on HIV/AIDS. (Manual para facilitadores sobre consejería para VIH-SIDA).

HIV-1.13 Guidelines for Pre- and Post-Counseling for the HIV/AIDS Test. (Guía para la Consejería Previa y Posterior a la Prueba del VIH-SIDA)

HIV-1.14 Guide to Health Interventions for Persons Deprived of Freedom. (Guía de Intervención en Salud Dirigida a los Privados de Libertad).

HIV-1.15 Guidelines for the Information System on Post Exposition Profilaxis—SIPPE. (Guía para el Sistema de Información de la profilaxis post exposición). (SIPPE).

HIV-1.16 Prevention Manual for HIV/AIDS on the Community Level (Manual de Prevención del VIH-SIDA para el nivel comunitario).

HIV-1.17 Plan for the Eradication of Congenital Syphilis, El Salvador, 2000-2004 (Plan para la Eliminación de la Sífilis Congénita, El Salvador, 2000-2004).

HIV-1.18 Biosecurity Manual for Control of Stomach and STI-HIV/AIDS Related Infections (Manual de Bioseguridad para el Control de InfCCMiones en Estomatología e infCCMiones relacionadas a las ITS-VIH-SIDA).

HIV-1.19 Biosecurity Manual for Clinical Laboratories. (Manual de Bioseguridad de Laboratorio Clínico).

HIV-1.20 Support Manual for the Confidential SIDATEL Telephone Line Operator. (Manual de apoyo para el/la orientador/a de la línea telefónica confidencial SIDATEL).

HIV-1.21 Counseling and Reference Manual for HIV/AIDS Voluntary Testing. (Manual de Consejería y Referencia de la prueba voluntaria para el VIH-SIDA).

HIV-1.22 Manual on Taking, Handling and Sending HIV Viral Load Simples. (Manual de toma, manejo y envío de muestras Carga Viral VIH).

HIV-1.23 Manual on Lymphocites CD4-CD8 and Quality Control in HIV Laboratories. (Manual de Control de Calidad en Laboratorios VIH y Linfocitos CD4-CD8).

HIV-1.24 Methods for Managing PLWHA Support Groups and Educational Modules for PLWHA. (Manual Metodológico para el Manejo de Grupos de Apoyo de Personas Viviendo con VIH-SIDA y Módulos Educativos para Personas Viviendo con VIH-SIDA).

HIV-1.25 Guidelines for Health Personnel on Approaching Sex Workers with Emphasis in the Prevention of HIV/AIDS (Guía para el personal de salud en el abordaje de Trabajadoras (es) del Sexo con énfasis en la prevención del VIH-SIDA).

HIV-1.26 Regional Strategic Plan for Prevention, Care, and Control of STI/HIV/AIDS (Plan Estratégico Regional de Prevención, Atención y Control de las ITS-VIH-SIDA 2005/2010).

HIV-1.27 National Monitoring, Evaluation, and Epidemiological Vigilance Plan 2006-2010 (Plan Nacional de Monitoreo, Evaluación y Vigilancia Epidemiológica 2006-2010).

HIV-1.28 Epidemiological and Operational Situation of Tuberculosis. Ministry of Health, National Program on Tuberculosis and Respiratory Illness. 2007. (Situación Epidemiológica y Operacional de la Tuberculosis. MSPAS, Programa Nacional de Tuberculosis y Enfermedades Respiratorias. 2007.)

HIV-1.29 The Fight Against AIDS in El Salvador: a National Commitment. 2007 [English version]. (La lucha contra el SIDA en el Salvador, un compromiso de Nación. 2006 [Versión en español].)

HIV-1.30 Estimate of Financing and Expenses Flows HIV/AIDS, 2005. (Estimado de Financiamiento y Flujos de Gastos VIH/SIDA, 2005.)

HIV-1.31 Guía metodológica. Prevención del VIH/SIDA para docentes de primer ciclo de educación básica. MINED, 2005.

HIV-1.32 Guía metodológica. Prevención del VIH/SIDA para docentes de segundo ciclo de educación básica. MINED, 2005.

HIV-1.33 Guía metodológica. Prevención del VIH/SIDA para docentes de tercer ciclo de educación básica. MINED, sin fecha.

4.3.2 Epidemiological and disease-specific background

(a) In table 4.3.2 below: (i) identify the total population of the country/countries; **and** (ii) then provide current estimates of the stage of the disease in the listed specific population groups. *The 'source of estimate' (final column in the table below) may be from recent published estimates of UNAIDS or WHO, but may also be published national estimates or statistics.*

Table 4.3.2 – Estimated disease prevalence within key population groups

Population	Estimated number	Year of estimate	Source of estimate
(i) **Total Population** (all ages)	6.9 million	2006	DYGESTIC 2007 (projection based in 1992 census)
(ii) **Current estimates on the stage of the disease in the following population groups**:			
Total people living with HIV *(adults and children)*	18,048 36,000	2006 2005	MOH 2007[3] UNAIDS 2006[4]
Women living with HIV >15 years	5,697 9,900	2006 2005	MOH 2007 [1] UNAIDS 2006 [2]
Pregnant women living with HIV	160	2006	MOH 2007[5]
Children (0-14 years) living with HIV	1,436 1,000	2006 2005	MOH 2007 [1] UNAIDS 2006 [2]
AIDS related deaths per year	455	2005	DYGESTIC 2007
Orphans (0-17 years)	No data		
Injecting drug users	No data (few)		
Sex workers	14,920	2006	MOH based on UNAIDS/WHO6
Men who have sex with men	89,661	2006	MOH based on UNAIDS/WHO[4]
Other: *(identify)* Persons with TB-HIV coinfection	188	2005	WHO 2007

[3] Cases accumulated by the health system of El Salvador, reported in HIV-1.29
[4] Estimated prevalence in UNAIDS 2006. Informe sobre la Epidemia Mundial del SIDA 2006
[5] Cases reported that year, ref. HIV-1.29
6 Calculated according to the Spectrum Book for estimates and projections of UNAIDS/WHO 2005.

(b) **By reference to table 4.3.2 above**, describe any changes in the stage, type or dynamics of the disease, including in the most affected population group(s) over the past three to five years. Also summarize the main treatment regimes in use or to be used during the proposal term and the reasons for their use. Any data on drug resistance should also be included (where relevant). *(Maximum two pages.)*

UNAIDS in its 2006 Annual Report estimates that the number of people living with HIV is 36,000 and classifies El Salvador as a country with a concentrated low-prevalence epidemic in the general population. Higher HIV prevalences are estimated in populations with higher risk and vulnerability, e.g., 3.6% in commercial sex workers and 17.7% in MSM. An estimated 40% to 50% is under registered (World Bank 2006).

According to the projections carried out in 2003 by UNAIDS (2006), based on a prevalence in the general population estimated as 0.7%, a total of 81,904 PLWHA would be expected in El Salvador in 2010, with a prevalence of 1.72%. Stopping the epidemic is crucial for the country.

Improvements in coverage and free access to the HIV diagnostic test, as well as an active search for infected people have allowed for detection of a larger number of cases in early phases of the disease, both in high-risk populations and in general public. In 2006, 241,146 new HIV tests were carried out at the national level, an increase of 10% over 2005 and of more than 130% over 2001. The increase is due to the decentralization of diagnosis laboratories and to the use of rapid tests.

The screening in pregnant women in health centers has increased from 10% in 2001 to 98% in 2006, with 105,564 tests carried out. The comprehensive approach of HIV-positive pregnant women and their newborns has allowed for a reduction of 88% in the number of cases of children infected with HIV, from 129 or more cases per year in 2001-2003 to 20 cases or less in 2004-2006 (ref. HIV-1.28 and World Bank 2006).

Recent studies and estimations at the national level have produced the following milestones (ref HIV-1.29)**:**

- A prevalence of HIV in men having sex with men (MSM) of 17.7% in 2002 (PASCA project).
- 3,6% of prevalence in commercial sex workers (SW) in general, although it is higher in some places: 16% was recorded in the port of Acajutla.
- The prevalence of HIV among adolescents and youths (15-24 years) has increased rapidly, going from 0.15% in 2001 to 0.28% in 2006.
- The epidemic is centered on men, whom constitute 63% of the cases accumulated. The male : female ratio went from 3.2 men per woman in 1991 to 1.7 in 2006.
- The prevalence of HIV in pregnant women has decreased from 145 to 101 per 100,000 pregnancies between 2001 and 2006.
- During 2005, 4.4 persons were infected every day; the prevalence among the population in general was of 0.5% (HIV-1.29).
- In studies carried out in 2005 the following prevalence was found in specific groups: youths with drug addiction problems, 10.6% (but very few used needles); incarcerated population, 6%; men having sex with men (MSM), 3%; sex workers (SW), 1.24%; mobile population, 0.8%.
- According to the National Family Health Survey (FESAL 2002/03), at least three forms of HIV/AIDS prevention are known to 60.2% of women and 46.3% of men. 6.1% of women and 4.9% of men took the test voluntarily and got the results. 5.7% of women and 20.3% of men used a condom in their last sex act. Sexual activity begins in 7% of women before 15 years of age and in 50% before reaching 18. Contraceptives are used in the first sexual relationship by 18% of women and 28% of men. One of every 5 women 15 to 19 years old has at least one living child.
- HIV is transmitted sexually in 86% of the cases. Of these, 91% are self-denominated as heterosexual and 9% as homosexuals and bisexuals.

Anti-retroviral Treatment (ART):

Incidence of AIDS has decreased by 66% between 2001 and 2006 from 17.3 to 5.9 per 100,000, and mortality by 20% (from 8.2 to 6.6 per 100,000). This is due to the availability of antiretroviral medication, the strengthening of integrated health teams, and the decentralization of ART clinics nationally. It has been possible to i) guarantee free ART services to persons living with HIV/AIDS (PLWHA) when they near or enter the AIDS phase (using current protocols), ii) improve adherence, and iii) provide continuity to medical follow-up (World Bank 2006; ref. HIV-1.29).

4.3.3 Disease-prevention and control initiatives and broader development frameworks

Proposals to the Global Fund should be developed based on a comprehensive review of disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases. Please refer to the Guidelines for Proposals, section 4.3.3.

(a) Describe, comprehensively, the current prevention and control strategies for the disease, together with planned outcomes.
Applicants should ensure that the information provided below takes into account the cumulative outcomes based on all current and planned support from all stakeholders (government, major international initiatives, international donors and partnerships etc).

Current strategies for HIV/AIDS prevention and control are defined in the National Strategic Plan for the Prevention and Control of STI/HIV/AIDS 2005-2009 (ref. HIV-1.3), which is consistent with the 5-year Plan of the MOH and is framed within the millennium objectives, specifically No. 6, oriented to the fight against HIV/AIDS. It takes into account the principles of the Three Ones and of universal access.

The strategies of the National Strategic Plan (NSP) are eight:

1. Coordination of the national response with the participation of government, non-government and private organizations and institutions, PLWHA and other groups.

2. Increase in the offer and coverage of comprehensive services for the attention and prevention of HIV/AIDS and STI.

3. Reduction of the prevalence of HIV/AIDS and STI in populations in conditions of higher vulnerability.

4. Increase of the knowledge for the application of measures for the protection, attention and control of HIV/AIDS and STI.

5. Optimization of the epidemiological monitoring system in HIV/AIDS and STI for decision-making in the national response.

6. Strengthening of the Comprehensive Monitoring and Evaluation System for HIV/AIDS and STI operating in El Salvador.

7. Increase the respect to human rights and gender equality in the prevention, attention and control of HIV/AIDS.

8. Application of a legal and regulatory framework that meets the needs of the population in regard to HIV/AIDS.

The current Global Fund (GF) project in El Salvador (Round 2, Phase 2) focuses on strategies 2, 3, and 4, with some activities relevant to strategies 1 and 8. This new project will maintain activities in those areas, but will undertake a number of initiatives related to the remaining strategies (5, 6 and 7).

Besides the financing of the Global Fund, NHAP counts on additional funds from several sources (section 4.5): the Government of El Salvador (by far the largest contributor), the World Bank, USAID, PAHO/WHO, and other international cooperators.

The current project has three objectives:

1. Incorporate innovative approaches to HIV/AIDS prevention in high-risk and vulnerable populations

(MSM, SW, youths, incarcerated and migrant populations, pregnant women), which allow them to adopt risk-reducing behaviors.

2. Strengthen actions that support preventive approaches, non-discrimination, and HIV/AIDS advocacy.

3. Provide comprehensive attention to people living with HIV/AIDS in the different service-providing institutions.

The main areas of intervention of the National HIV/AIDS Program (NHAP) are summarized below:

PREVENTION:

With the GF grant, support has been provided to the development of informatiional, educational, and communications (IEC) campaigns to promote behavioral change in vulnerable groups, as well as to reduce stigma and discrimination. The project has evaluated the impact of the IEC campaigns on the population, showing very satisfactory results and providing ideas for the design and implementation of future IEC strategies. For example, the change in behavior in MSM and SW populations has been significant, with improvement between 2001 and 2004 of 15% for MSM and 2% for SW in terms of the use of condoms in their last sexual relationship (Ref. HIV-1.29).

These activities have provided condoms and promoted their correct and systematic use. During the first phase of the program, 6 million condoms were acquired and distributed among young women and vulnerable populations (ref. HIV-1.2 and data from Executive Unit, UNDP).

Before the GF project, little evidence was available of behavior change in high-risk populations (MSM, SW). Therefore, the positive results achieved can be mainly attributed to the intervention of the Round 2 (R2) project. The growing coverage of the target populations, which will be further increased by the strategy and activities now proposed, helped stimulate and consolidate skills that foster behavioral change in those populations. To achieve this, alliances established with civil society organizations (CSOs) have been important, especially those of PLWHA.

DETECTION: HIV/AIDS Testing

The project has significantly increased access and coverage of free HIV testing at the national level. To decentralize the testing operation, it was necessary to strengthen the capacity of MOH laboratories in several locations. This implied:

- Training,
- Improving infrastructure and equipment,
- Providing reagents and other supplies,
- Updating and simplifying the diagnostic flowchart,
- Implementing an active search for cases through mobile laboratory services.

Two mobile units were built and equipped with GF financing; they entered service in November 2005. With these units, HIV testing is being extended to prisoners, mobile and migrant populations, uniformed services (police, army), college students, SW, and MSM, among others. During 2006, some 20,270 tests were carried out; 7% of the new HIV cases reported for that year were detected by mobile units.

In regard to follow-up tests, the capacity of the HIV/AIDS Section of Laboratorio Central was strengthened with personnel, equipment for Flow Citometry, and new technology for viral load, moving towards automated extraction of genetic material.

PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMCT):

With technical international support and financing form the Global Fund , the following was achieved:

- Development of the PMCT Guide;
- Training of 3,728 health workers (medical and paramedics) and midwives;
- Voluntary testing for HIV detection in 98% of pregnant women in prenatal control (GF Q8 report);
- Implementation and improvement of counseling and availability of educational material, and
- Availability of medication and maternal milk substitutes (ref. HIV-1.29).

These PMCT efforts have reduced HIV(+) births from > 129 per year (2001-2003) to < 20 (2004-2006).

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BLOOD SAFETY:

Donated blood is 100% screened, with rigorous control of quality and of appropriate use. El Salvador belongs to the regional quality control network of CDC in Atlanta and the Hemocentro in Sao Paulo, Brazil. With the collaboration of the MOH Laboratory and the blood banks, HIV transmission through blood transfusions has been eliminated.

MOBILE/MIGRANT POPULATIONS:

The project provided support to preventive actions in several border locations with educational material, informatational activities, social mobilization, training of peer leaders, and free HIV testing (ref. HIV-1.29). Mobile and border units reached a total of 74,632 persons from mobile populations and migrants with prevention activities in 2006 (GF Q12 Report). Currently 6.5 times more border points offer comprehensive attention in HIV/AIDS than in 2001. They cover terrestrial, maritime and aerial customs offices, as well as transportation parking lots and non-official border crossing points (ref. HIV-1.29).

INCARCERATED POPULATION:

The R2 project has brought HIV prevention, testing, and treatment to penal facilities across the country. Civil society support actions have promoted the right to health care and access by prisoners to all HIV/AIDS services (ref. HIV-1.29). The intervention strategy comprises IEC activities, free HIV testing, and access to ART. More than 9,700 inmates have undergone testing; there were 22,783 participants in prevention activities in penal facilities in 2006, including health personnel and inmates (ref HIV-1.29). A cooperative agreement was signed between the MOH and the Ministry of Governance to guarantee the sustained application of this intervention.

ADOLESCENTS AND YOUTHS:

The percentage of adolescents and youths with HIV, while still moderate, has risen dramatically, doubling in the past five years. This justifies an increase in education, prevention, and behavioral change efforts to reduce HIV transmission among the young, both those attending and not attending school. The project promotes proper use of condoms as well as abstinence, delay in onset of sexual activity, and reducing the number of partners.

With support from R2, more sustainable prevention activities were introduced in the educational system, such as using a KAP baseline on HIV/AIDS awareness in adolescents and teachers, incorporating the topic of HIV in their curriculum, developing in-service courses to train educators in HIV prevention with students, and producing a series of educational materials for teachers, youths, and parents. The sensitization strategy that uses art for prevention stood out. These activities have been complemented with actions aimed at youths in high risk conditions (associated with gangs) and that do not attend school. A total of 65,459 youths participated in prevention activities in 2006, 4.3% of the population in that age group (Reports to GF, Q13), and many more heard messages in the mass media.[7]

COMPREHENSIVE INTEGRATED SERVICES:

To meet the challenges of the epidemic, 19 Centers for comprehensive integrated services have been established throughout the country, with upgrading of infrastructure, training of multidisciplinary teams, and provision of computer and M&E equipment, ART and medication for opportunistic infections, as well as laboratories for diagnostic and follow-up tests. In 2006, ART attention was provided to almost 5,000 patients.

MANAGEMENT OF TB-HIV CO-INFECTION:

As a norm, persons diagnosed with tuberculosis or HIV are offered free, voluntary testing for the other infection, with counseling. Comprehensive management of TB-HIV co-infection has made for improved PLWHA health. In 2005 the National Co-Infection Advisory Committee was formed to establish common strategies and to provide follow-up to detect, diagnose and treat the co-infection. Early detection of co-infection cases, proper management of them, and harmonization among the services provided by different purveyors has been facilitated. In 2006, 98% of the people diagnosed as HIV(+) received the TB test with pre- and post-test counseling (ref. HI-1.28). In regard to treatment, 53 cured cases are reported

[7] DIGESTYC. Ministry of Economics. Multi-purpose Household Survey. 2005.

from a total of 74 Bk (+) patients with HIV, with a treatment compliance of 71.6%.

EXPECTED RESULTS:

At the end of 2007, the following results are expected:

Prevention:

- Risky behaviors decrease in the general population, particularly in high-vulnerability groups, through mass media campaigns, peer education and others.
- Distribution of 6 million condoms to high-risk groups, including youths.
- Training of high-risk groups in the proper use of condoms.
- 100% coverage of pregnant women that come for prenatal services with HIV screening.

Detection:

- HIV screening of 4% of the population yearly, with emphasis on high-risk and vulnerable groups.
- Free HIV testing available throughout the country (173 laboratories).
- Active search for cases in highly vulnerable populations to reach more than 20,000 people every year via HIV testing from two mobile units (purchased with GF support).

Vulnerable Populations:

- The prevalence of HIV in SW stays at 3.4% and in MSM at 17.7 %, and in inmates at 0.5%, in spite of a rising trend.
- Inmates at most penal facilities have access to free HIV testing and to ART.

Comprehensive Care:

- Universal access to ART (first and second line) according to current international recommentions.
- Mortality rate due to AIDS reduced to 6.0 per 100,000.
- Diagnosis and treatment of *Pneumocisty carinni* in 92 cases per year.
- Decentralization of comprehensive integrated services to 19 hospitals across the country.

Management of HIV-TB Co-infection:

100% of co-infection cases of TB detected and treated according to current norms (more than 75% recovery rate); prophylactic treatment to prevent TB in AIDS patients

(b) Describe how these disease prevention and control strategies fit within broader developmental frameworks such as Poverty Reduction Strategies, a Health Systems Strengthening Strategy, the Highly-Indebted Poor Country (HIPC) Initiative, and/or the Millennium Development Goals, **emphasizing how the additional support requested in this proposal is aligned with developmental frameworks relevant to the country context**. *(Also include an overview of any links to international initiatives such as the WHO/UNAIDS 'Universal Access Initiative' or the 'Global Plan to Stop Tuberculosis 2006-2015' (e.g., for HIV/TB collaborative activities) or the 'Roll Back Malaria Global Strategic Plan').*

El Salvador signed the Declaration of Millennium Objectives in the Millennium Summit, including objectives with defined goals for fighting HIV. Similarly, the country has adopted the *Three Ones* and *Universal Access* principles to guide design of the National Strategic Plan.

Advances in the achievement of the *Three Ones* include: **1) One National Authority** — the National Commission Against AIDS (CONASIDA) — which coordinates, regulates and integrates the participation of the different social actors; **2) One action framework** for the national response, with multisectoral agreement, the *2005/2009 National Strategic Plan* and **3) One integrated monitoring and evaluation system** to track the national response, the *Monitoring, Evaluation and Epidemiologic Surveillance Plan*,

developed in a broadly participatory manner, but so far implemented only in pilot projects.

The national strategies for controlling the HIV/AIDS epidemic complement government initiatives for the reduction of poverty, with the goal of **Universal Access** and achievement of **Millennium Development Objectives (MDO)**. These international commitments frame the **2004-2009 National Governance Plan** and in the **"Solidary Network" Presidential Program to Eliminate Poverty.**

One of the most important initiatives is the ***National Opportunities Program*** which opens a wide range of areas for interventions in social integration and facilitates focusing those interventions on the needs of the population, as reflected in more than 100 social, economic, health and basic services indicators. This is linked to the ***Program for Extension of Coverage of Basic Essential Health Services***, carried out by the MOH with the integration of civil society and with the ***Modernization and Reform of the Health Sector*** program, which aims to improve the effectiveness, efficiency and quality of the health system. These programs are covered operationally in the **2004-2009 Strategic Plan** of the MOH. (ref HIV-1.1).

This national and international framework has allowed the MOH, through the National STI/HIV/AIDS Program to promote the interventions described above that accelerate the struggle against the infection. The National Strategic Plan (ref HIV-1.3) expresses the objectives, goals, strategies and activities; the assistance requested in this proposal will facilitate their timely achievement, in manners consistent with the development frameworks operant in the country.

(c) Describe how this proposal seeks to: (1) use, to the extent that they exist, country systems for planning and budgeting, procurement and supply management, monitoring and evaluation and auditing; and (2) achieve greater harmonization and alignment of partners to country cycles in regard to procedures for reporting, budgeting, financial management and procurement.

This proposal contmplates a high degree of integration between activities financed by the GF and the systems and processes already existing in the country—both from technical and administrative entities that implement the National STI/HIV/AIDS Strategic Plan, and from those from institutions and regulations that guide and support planning in the public sector, good financial management, contracting and management of human resources, the acquisition and use of goods and the control of processes and results. Creation of parallel structures or proceses is in no way considered.

This close relationship implies a high level of harmonization of the project with the country's cycles and procedures, not only in technical matters, but also with regard to administrative and financial management in all their aspects, including budgets, personnel, materielle, records and reports, monitoring, evaluation, and audit, among others. Some particulars are:

- The National STI/HIV/AIDS Program has the technical lead, coordinating with all key actors, both governmental and NGO, which have participated actively in framing the National Strategic Plan.
- The provision of health services to HIV patients is governed by the HIV Prevention Law (ref. HIV-1.7) and the Regulations for the Care of STIs (ref. HIV-1.5), supported by their guides, protocols and manuals in specific areas (see refs. HIV-1.4 to 1.25).
- Training of adolescents and youths attending school will be done in collaboration with the Ministry of Education, the Youth Secretariat, academic institutions, and civil society.
- Work with support groups, communications, and social mobilization will use established practices and norms, in collaboration with civil society, health sector institutions, professional associations, and academic institutions.
- The planning, preparation of budgets, financial management and management of acquisitions and supplies, the audit, as well as other administrative processes, will be carried out within existing legal and regulatory frameworks.
- Compilation and analysis of data for monitoring and evaluation will be done through the National Monitoring, Evaluation and Epidemiological Surveillance System (SUMEVE) that has been developed by all institutions in the sector and will be established throughout the whole country.

The same entities that have successfully managed the funds of Phase 2 of the GF grant from Round 2 are nominated as Principal Recipients.

4.3.4 National health system

(a) Briefly describe the main health systems constraints related to this component by focusing on the strengths, weaknesses, opportunities and threats of the health system.

Please consider the list of health systems strengthening strategic actions ('HSS Strategic Actions') outlined in section 4.4.2 of the Guidelines for Proposal when providing this description.

In El Salvador, the national health system is formed by two subsectors: the public one, comprising the Ministry of Public Health and Social Assistance (MOH), the Salvadorean Institute of Social Security (ISSS), Teachers Welfare, Military Health, National Civilian Police, National Directorate of Penal Facilities and others; and the private sector which includes both for-profit and non-profit entities. The MOH, as the lead organization and coordinator of the health sector, is responsible for implementing the 5-year Strategic Plan, which in turn is part of the 2004-2009 "Secure Country" Governance Plan. It is supported by a network of health establishments that care for 80% of the population, geographically organized in five regions and 17 Basic Integrated Health Systems (SIBASI). The ISSS covers 17% and the remaining 3% is cared for by other public and private institutions.

The analysis carried out in the national system allows to identify the following strengths, weaknesses, opportunities and threats:

Strengths of the system:

Commitment to the "THREE ONES" principles:

- The "National Commission Against AIDS" (CONASIDA) has been established,
- A single action framework is used: the National Strategic Plan for HIV/AIDS (ref HIV-1.3).
- A National Monitoring, Evaluation and Epidemiological Surveillance System (SUMEVE) has been designed, which is in the initial phase of socialization and implementation.

Policy frameworks and regulatory documents, consensus-based, are in use: laws and regulations, rules and agreements, protocols for care, guides to treatment, etc.

Specific government budget line items for activities related to HIV

Inter- and intra-sectoral coordination established.

Installed capacity:

- A network of 702 health establishments of MOH, ISSS and other entities, with 25% of the personnel trained in HIV prevention, diagnosis, and care.
- Network of NGOs working on HIV prevention, in coordination with the National STI/HIV/AIDS Program.
- 18 hospitals and one clinic providing comprehensive integrated care with multidisciplinary teams.
- 22 teams integrated by personnel on the first level of care and at penal facilities.
- A network of 229 laboratories at the national level (MOH 159; ISSS 16; Teachers Welfare 52; Military Health 2) that do testing, with five centers of confirmation of diagnoses and one quality control center.
- Two mobile units to actively search out HIV cases, supported by media campaigns motivating the population to undergo testing.

Management of HIV/AIDS cases with internationally recommended standardized schemes, including ART and treatment of opportunistic infections and HIV-TB co-infection.

Availability of first and second line anti-retroviral medication, financed by the government and the Global Fund.

National Monitoring, Evaluation and Epidemiologic Epidemiologic Surveillance System: in its start-up phase, pending socialization and implementation.

Community leaders and volunteers trained by NGOs

Training of facilitators with peer education methodology for work with SW, MSM, and prisoners.

IEC strategies in the initial phase at health establishments around the country.

Weaknesses:

Growing demand for comprehensive services versus limited resources (financial, technical, and human).

Several treatment centers without adequate infrastructure to guarantee privacy.

Leadership role of MOH little recognized by the for-profit private sector**.**

Insufficient PLWHA participation many aspects of prevention, screening, care, counseling, advocacy, and planning.

Low community participation in HIV prevention: limited community outreach and peer education.

Training and sensitization have covered only 25% of the personnel responsible for the prevention and treatment of HIV/AIDS.

Lack of specialized human resources to provide comprehensive, integrated HIV care and treatment in the national network (lab personnel, psychologists, nurses, doctors, nutritionists, social workers, etc.).

Monitoring, evaluation and surveillance system still not implemented at the national level; there is no fluid, complete and uniform information available, which would allow adequate feedback and planning.

Limited access of vulnerable groups to health services.

Not all public, autonomous and private institutions provide information about persons diagnosed with HIV/AIDS, nor about deaths caused by the infection.

Problems for the diagnostic of opportunistic infections: deficit of supplies, diagnostic equipment, and follow-up tests with their preventive and corrective maintenance.

Lack of operations research to measure impact of prevention efforts and the trends of the epidemic.

Some warehouses and drugstores lack adequate conditions to preserve medication.

Coverage of IEC strategies is mostly limited to the vulnerable groups that visit health services.

Weak financial sustainability: the Government's budget for the health sector is limited. It does not allow assignment of adequate resources to the HIV program. Among the sub-financed areas are:

- Acquisition of equipment and supplies for HIV diagnosis.
- Maintenance of equipment.
- Purchase of anti-retroviral medication and medicines for opportunistic infections.
- Printing technical support and educational materials for the population.
- Execution of communications campaigns through the mass media.
- Acquisition and updating of computer equipment.
- Training of human resources in the sector (public and private)

Loss of personnel familiarized with HIV/AIDS due to rotation.

Little supervision at operational level by intermediate levels due to lack of transportation.

Poor information on HIV/AIDS in those finishing health-related degree programs.

Opportunities:

Form a National Training Committee to improve the teaching about HIV/AIDS in health-related degree programs.

Strengthen PLWHAs to become trainers, members of the multidisciplinary teams, and leaders of outreach activities around ART centers, especially targeting high risk groups.

Finish the expansion of the National Monitoring, Evaluation and Epidemiologic Surveillance System to serve all government entities, NGOs, the social sector and international cooperation agencies.

Increase the active search for HIV cases through mobile units among vulnerable groups and in places of difficult access.

Strengthen links to civil society to diversify the struggle against HIV/AIDS, through local committees, health sector NGOs, professional associations and others, including PLWHA entities.

Management capacity and political support to attract resources, external technical assistance, and cooperation from other sectors.

Existing agreements between MOH and other institutions, with possibility of incorporating others.

Support of FOSALUD, both financial and for strengthening of specific activities.

Threats:

"Natural" risks at the national level such as epidemics, earthquakes and floods.

Abrupt political changes affecting priorities and public policies.

Increased immigration into the country or massive deportations of Salvadorean emmigrants.

Loss of continuity of actions being carried out in penal facilities and mobile populations.

Interruption in the flow of medication and supplies.

Inadequate equipment and infrastructure due to deterioration: e.g. lab equipment and vehicles.

(b) Describe the national priorities in addressing these constraints.

The national priority in the area of HIV/AIDS is to promote the Three Ones strategy and Universal Access. Specific priorities deriving from the Strategic Plan (ref. HIV-1.3) include the following:

- Train health system personnel and PLWHAs.
- Increase access to diagnosis among the most vulnerable populations.
- Expand coverage to reduce the gap between the prevalence estimated by WHO and the cases diagnosed in the country.
- Reduce the risk of HIV transmission, with priority given to the most vulnerable populations.
- Work jointly with schools forming human resources in health areas to improve the training in the area of HIV/AIDS.
- Improve the capacity of monitoring, evaluation and surveillance in the health sector.
- Increase the participation and empowerment of PLWHAs.
- Strengthen coordination among public and private health sector institutions.
- Provide supplies and equipment to the network of laboratories and maintain quality control.

Expand the epidemiologic surveillance and comprehensive attention of the HIV-TB co-infection.

(c) **Coordination and Synergies**

Briefly describe how disease specific programs are coordinated within the framework of the National Health Sector Development Plan, where one exists. For instance how the proposed component relates to (where appropriate) the national communicable disease strategy and to priorities in the plan.

If the Applicant's proposal covers more than one component, also describe any synergies expected from the combination of different components. For example, HIV/TB collaborative activities, or linkages between HIV and malaria prevention and control strategies. *(By synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact.)*

The 5-year Strategic Plan of the MOH frames the national strategy against HIV. The "Impact indicators, strategic actions and commitments for the 5-year period" section contemplates:

- "Movilization of all necessary resources for …. children, adolescents and adults to know and be aware of the best strategies to prevent diseases such as HIV/AIDS…[and other diseases], thus avoiding that more Salvadoreans become infected ….
- "Improving the knowledge, attitudes and practices of the population with respect to … HIV/AIDS … [and others].
- "Strengthening the strategy of early detection and personalized attention to … [treat]… HIV… [in]… all health establishments in the country and… in the communities.

- "Increase the diagnosis and treatment of cases of HIV/AIDS."

This project will support these country goals, stated in the National Strategic Plan, which involves all institutions of the health sector, other sectors related to the fight against AIDS (e.g., Ministries of Education, Governance and Labor) and civil society.

The HIV-TB co-infection has been the object of close coordination between the respective National Programs, including the formation of an specific intersectoral committee. There has been synergy with the R2 GF funds that both components have received. Supplies are acquired to diagnose HIV in TB patients with funds from the HIV component, while medications are purchased with TB funds to treat TB in co-infected people. Among the synergistic activities are:

- Formation and effetive participation of a National HIV-TB Co-Infection Committee.
- Joint preparation of a counseling manual.
- Udating of the personnel of both programs in comprehensive treatment of the coinfection.
- Preventative treatment to 100 % of TB cases in PLWHAs.
- Availability of chemoprophylaxis for TB to PLWHA.

4.3.5	**Common funding mechanisms** *This section seeks information on funding requested in this proposal that is **intended to be contributed through a common funding mechanism** (such as Sector-Wide Approaches (SWAp), basket or pooled funding (whether at a national, sub-national or sector level).*	
(a)	Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism?	☐ Yes ➔ *answer questions below.* ☐X No ➔ *go to section 4.4*
(b)	Will the funding requested be channeled to implementation partners/beneficiaries through a common funding mechanism for all years of the proposal, and in regard to all proposed interventions/activities? If not, which years, what activities, and why this approach?	
	N/A	
(c)	**Describe the common funding mechanism, whether it is already operational and the way it functions**. In your response, identify development partners who are part of the common funding mechanism and their respective level of financial contribution (in percentage terms) to the common funding mechanism. *(Please also provide documents that describe the functioning of the mechanism as an annex. These documents may include: the agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*	
	N/A	

(d)	Describe the process for independent supervision of the performance of the common funding mechanism. Also describe the outcomes of any recent assessment of the common funding mechanism undertaken according to these processes. **In particular, Applicants should fully explain any adverse outcomes, and what actions were taken to respond to these findings**. ***Attach,*** *as an annex to your proposal****, the most recent external assessment of the operations of the common funding mechanism****.*
	N/A
(e)	Describe the Applicant's assessment (**including by reference to any criteria used during the assessment process**) of the capacity of the common funding mechanism to absorb the additional funds generated by this proposal **and** ensure effective supervision of the work that is proposed. *Where relevant, provide details of any changes that have been agreed with the common funding mechanism as a result of this proposal to ensure that the funding (if approved) will be used in a* ***transparent, efficient and timely manner****.*
	N/A
(f)	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 common funding mechanism is broader than this disease component, Applicants must explain the process by which they will ensure that funds requested will be used for HIV/AIDS activities during the proposal term*.
	N/A

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4.4 Overall Needs Assessment

The outputs and outcomes planned to be achieved under this proposal (if approved) **should be based on an analysis of financial and programmatic gaps in national plans/programs to prevent and control the disease**.

To help Applicants identify these gaps:

Step 1 **Section 4.4.1** requests Applicants to identify gaps in the main programmatic areas targeted by this proposal, and the **level of additional coverage that is requested through this proposal**. *This is a summary of the main gaps only. Applicants must still describe the specific interventions/activities planned under this proposal (in section 4.6) and the targets and indicators that are proposed to evaluate performance during the proposal term (in the 'Targets and Indicators Table', Attachment A)*;

Step 2 **Section 4.4.2** requests Applicants to describe any health systems strengthening strategic actions ('**HSS Strategic Actions**') that are essential to ensure that the planned outputs and outcomes of this proposal will be achieved, **and to identify how much support for these actions is requested in this proposal**. HSS Strategic Actions are more fully discussed in the Round 7 Guidelines for Proposal (section 4.4.2). *Section 4.4.2 below also requests information on other current and planned levels of support for these same actions; and*

Step 3 **Section 4.5** requests Applicants to identify the overall disease specific financial need for the country/countries targeted in this proposal. **This table asks Applicants to identify,** on a national disease specific basis, **the overall financial needs required to prevent and control the disease**. **Thus 'Line A' in table 4.5 should include both program and essential disease specific health systems needs. All other lines in the table should also include both program and health systems needs if these are essential to the national disease prevention and control plan.** *This is a summary of the financial needs only. Applicants must provide a detailed budget request by disease component (within section 5) and summarize this request in table 1.2.*

Thereafter, in section 4.6, Applicants should fully describe the specific interventions/activities which are included in this proposal to ensure that the programmatic needs targeted by this proposal are fully met.

See the Guidelines for Proposals, sections 4.4 and 4.5, for further explanation.

4.4.1 Programmatic Needs Assessment

4.4.1	**Overall programmatic needs assessment**
(a)	**Based on an existing Health Sector Strategic Plan** *(or, if not in existence, an analysis of national/regional goals, together with careful analysis of disease surveillance data and target group population estimates for relevant prevention and control strategies)*, **describe the overall programmatic needs in terms of people in need of these key services**. Please indicate the quantitative needs for three to five main services that are intended to be delivered for this disease component (e.g., provision of first and second line anti-retroviral treatment, or prevention services for specific population groups most at risk of HIV infection). Also specify clearly how much of this need is currently covered (or will be covered) over the proposal term by domestic sources or other donors. *Please note that this gap analysis should guide the completion of the Targets and Indicators Table required under section 4.6. When completing this section, please refer to the Guidelines for Proposals, section 4.4.1.*

The key services selected represent core aspects of the first three objectives of the project.

PLWHAs reporting better quality of life.

Detection of HIV infections – persons screened with free tests.

Cases receiving first and second line ART.

The fourth objective, the introduction of the Single Epidemiological Monitoring, Evaluation and Surveillance System (SUMEVE) will prove its usefulness and efficiency by measuring these three results. For example, without the SUMEVE, there would be no capacity to measure the

opinion of PLWHA about the effect on the quality of life that they have felt as a result of the Social Protection System. There would be no capacity either to distinguish how many different persons received HIV testing, subtracting the cases of duplicate testing during the year. Likewise, there would be lack of capacity to remove dead people from the list of HIV+ people.

(b) **Complete table 4.4.1**

Table 4.4.1 is designed to assist Applicants to clearly illustrate overall programmatic needs in terms of people in need of key services. Applicants should note that this gap analysis should be used to guide the completion of the Targets and Indicators Table in Attachment A to the Proposal Form (see section 4.6 of the Guidelines for Proposals).

In addition, please specify below relevant information concerning the groups targeted and any assumptions including target size.

The hypotheses on target populations and how the numbers have been calculated for the four parts of Table 4.4.1 are summarized below:

- **PLWHAs reporting better quality of life.** *Part A*. Those who need to improve quality of life with the activities of Objective 1 (socio-economically–medical attention is covered in Objective 3) are taken as the number of cases of HIV infection detected by the health system, projected until 2013. *Part B*. The population to be served with present resources is nil, since the activities proposed to improve quality of life are new. *Part C*. The gap is the difference between A & B, in this case the same as A. *Part D*. It is estimated that activities that support Objective 1 will be able to improve quality of life for a number of PLWHAs that grows from 1,100 in 2008 to almost 8,000 in 2012. The effect of the interventions will be measured in two ways: 1) through questionnaires (surveys) given by support groups in the ART centers to the PLWHA who attend their medical check-ups, providing regular feedback on results and opportunities, and 2) with in-depth studies in the second and fourth year.
- **Detection of HIV infections–people screened with free tests.** *Part A.* The target population is assumed to be the total of high risk groups priorized in Objective 2 (4.6.2.b), including youth 15-24 years old, as a manner of approximating the amount of testing that ought to be done. If a group of this size--one fourth of the country--could be screened every year, most cases would soon be found. *Part B*. The population to be screened with present resources is projected based on the number of tests given before the current GF project, which continues into first half of 2008. *Part C*. The gap is A less B. *Part D*. The increase in tests performed is projected based on the 2003-2006 trend, growing to 360,000 additional tests in 2012 (21% of the gap), for a total of 458,000 people screened that year (base plus additional, totalling25% of the target population)
- **Cases receiving 1st & 2nd line ART.** *Part A*. The population needing ART is projected until 2012 with the ONUSIDA methodology (2006), including cases that should be under treatment but have not been found or have not come to the health system. *Part B*. The number that would receive treatment with present resources is projected as those presently covered by GOES funds: 70% of cases in 2007. *Part C*. The gap is the difference. *Part D*. With the funding requested, the network of ART centers will increase, and ART will again cover all cases in health system that need it. The percentage of coverage (table below) will increase gradually from 81% to 88% as improved screening and social communications are able to find mre cases and attract them to be treated.

The following table shows the level of total coverage by each key service to be attained in its target population (A), including the baseline (Part B) and the additional coverage due to the funding (Part D).

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Total Coverage of Key Services (with the resources proposed)					
	2008	**2009**	**2010**	**2011**	**2012**
PLWHA reporting better quality of life	5%	10%	15%	20%	25%
Persons screened with free tests	18%	22%	23%	23%	25%
Cases receiving first and second line ART	81%	81%	83%	85%	88%

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Please refer to the M&E Toolkit when completing this table for information on key services and service delivery areas.

Important Note: For at least three (but not more than five) "key service" areas targeted by this proposal, list the size of the target group in Part A of table 4.4.1 below, and then complete Parts B, C and D for the same "key service" area. [For example, if the country's planned outcome by 2012 is 30,000 people on ARVs (Part A in the table below), and current and planned support, including all existing Global Fund and other donor support, is expected to ensure that 23,000 people will be on ARVs by end 2012 (Part B in the table below), the overall unmet need will be 7000 (Part C in the table below). In Part D of this table, Applicants should then describe the extent of additional coverage for this key service targeted by this proposal.]

Table 4.4.1 – Overall programmatic needs assessment

		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Part A: People in NEED of Key Services (i.e. Country desired/planned outcomes up to 2012)									
Key Service 1	PLWHAs reporting better quality of life.	16,237	18,018	19,995	22,101	24,337	26,701	29,188	31,798
Key Service 2	Persons screened with free testing	1,639,264	1,656,073	1,673,054	1,694,079	1,715,281	1,784,381	1,805,583	1,811,013
Key Service 3	Cases getting first- and second-line ART	4,323	5,111	6,043	7,418	9,430	11,027	12,734	14,759
Key Service 4									
Key Service 5									
Part B: People CURRENTLY RECEIVING or EXPECTED TO RECEIVE Key Services relevant to this proposal as financed by current or anticipated resources:									
Key Service 1	PLWHAs reporting better quality of life.	0	0	0	0	0	0	0	0
Key Service 2	Persons screened with free testing	217,748	241,000	284,000	181,000	98,000	98,000	98,000	98,000
Key Service 3	Cases getting first- and second-line ART	2,235	3,447	4,840	3,388	3,388	3,388	3,388	3,388
Part C: TOTAL UNMET NEED for people in need of the 'Key Services' relevant to this proposal' ($A^1 – B^1 = C^1$, $A^2 – B^2 = C^2$ etc.)									
Key Service 1	PLWHAs reporting better quality of life.	16,237	18,018	19,995	22,101	24,337	26,701	29,188	31,798

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		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Key Service 2	Persons screened with free testing	1,421,516	1,415,073	1,389,054	1,513,079	1,617,281	1,686,381	1,707,583	1,713,013
Key Service 3	Cases getting first- and second-line ART	2,088	1,664	1,203	4,030	6,042	7,639	9,346	11,371
Part D: PORTION OF UNMET NEED COVERED BY THIS PROPOSAL									
Key Service 1	PLWHAs reporting better quality of life.	*Information provided in the adjacent columns should be consistent with the annual targets for these "key services" in the 'Targets and Indicators Table' (**Attachment A**) to the Applicant's proposal.*			5%	10%	15%	20%	25%
Key Service 2	Persons screened with free testing				6%	11%	12%	15%	20%
Key Service 3	Cases getting first- and second-line ART				34%	49%	54%	58%	62%
Key Service 4									
Key Service 5									

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4.4.2 Strategic actions to strengthen health systems

***As explained at the start of section 4.4**, certain '**HSS Strategic Actions**' may be essential (dependent on country specific contexts) to ensure achievement of the outputs and outcomes targeted by this proposal. These HSS Strategic Actions may include actions to improve grant performance, address current or anticipated barriers, and/or support and sustain expansion/scale-up of interventions to prevent and control the disease.*

***The Global Fund therefore strongly encourages Applicants to include in their proposal a request for support of relevant HSS Strategic Actions which are coordinated with the national disease control strategy**.*

Before completing this section, Applicants should refer to the Round 7 Guidelines for Proposals, section 4.4.2. where significantly greater detail is provided on HSS Strategic Actions supported in Round 7.

4.4.2 Description of HSS Strategic Actions included in this component

(a) **Complete table 4.4.2 below to describe for up to five actions** *(copy the table as many times as relevant)*:

(i) the **HSS Strategic Actions** that are **essential to achieve the planned outputs and outcomes of this disease component**;

(ii) **how the actions link to the planned work during the program term** and **address** key points arising from the analysis of the health system referred to in your response to question 4.3.4 above; and

(iii) **what other support is currently available or planned for the same actions** to ensure achievement of the planned outputs and outcomes of this proposal.

Ensure that the HSS Strategic Action(s) is/are consistent with (where one exists) the national Health Sector Development Plan/Strategic Plan and its time frame *(please also ensure you provide this Plan as an annex to the proposal as requested in section 4.3.1)*.

To clearly demonstrate the link requested in (ii) above, Applicants should relate proposed HSS Strategic Actions to disease specific goals and their impact indicators. ***Refer to the information on the revised indicators for HSS in the Guidelines for Proposal at section 4.4.2.*** *(Where only one strategic action is proposed, Applicants must explain the rationale behind this decision with reference to the guidance provided in the Guidelines for Proposals.)*

***Remember to expand the table for up to five HSS Strategic Actions**.*

Table 4.4.2A – Summary of essential HSS Strategic Actions requested in Round 7

4.4.2A Summary of funding requested for HSS Strategic Actions in Round 7

In the table below summarize, on a per year basis, the total of the funding requested for HSS Strategic Actions in this proposal for this disease component. *This will be the sum of the 'Funding Request' for each year for each HSS Strategic Action included in this disease component, as detailed by you in table 4.4.2 (**on the following page, copied for up five HSS Strategic Actions**). Applicants are reminded that they must ensure that the overall funding needs (table 4.5) include both program and essential disease specific health systems needs to ensure that the financial gap analysis reflects all available, planned and required resources.*

Total funds for essential HSS Strategic Actions requested over proposal term					
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
$831,585	$1,014,765	$610,060	$559, 284	$473,746	$3,489,440

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Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 1	*(Description of the HSS Strategic Action, its rationale and linkages to this proposal **– not more than half a page for each HSS Strategic Action**)* The National Monitoring and Evaluation Plan for HIV/AIDS covers the entire health system but has yet to be implemented. Doing so will require improvements in information management capacity, training, and related aspects that will benefit the health system as a whole. The HIV/AIDS SUMEVE system will serve broadly as a working model, complemented by parallel improvements in the TB program M&E capabilities (if the TB component is also funded) and other programs. Highlights will include ○ Improving the information system: strengthing the central MOH computing unit, increasing the number of regional and local centers served, upgrading technological capabilities with improved equipment (servers, back-up systems, etc.) and highly secure connections with greater bandwidth (required to handle anticipated levels of traffic), among others. ○ Development and introduction of systems and norms for the collection, validation and management of data from the entire system. ○ Establishing interinstitutional relatonships to share and support information gathering, technical capacity building, analysis and dissemination of results. ○ Inauguration of SUMEVE, initially for HIV/AIDS (and potentially TB), but which will serve as model and training grounds for other areas of health services. Improved staffing in the regions (data input, supervisors) and training of users to expand participation and the benefits of the M&E system, opening new panoramas to other health sub-sectors.

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*

Year 1	Year 2	Year 3	Year 4	Year 5
Assembly of components and trials in three pilot locations	Installation in 20 centers; training of users	Evaluation and adjustments; use of products in publications	Expansion to 40 centers which serve the rest of them	Full operation; final evaluation
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
$676,385	$860,165	$455,460	$404,684	$319,146

Describe below other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as this proposal)*	**Expected outcomes from existing and planned support**
Government	2008 - 2012	Budgetary support via public health sector institutions, valued at over $4,000,000 (staff, IT resources, programming,,	Integration of most staff and the basic MOH online information system with

		infrastructure, supplies, equipment, etc. that will contribute to starting and consolidating SUMEVE)	gradual absorption of new elements; support in management, supplies, others
Other Global Fund Grants (with HSS elements)			
Other: *(identify)*			
Other: *(identify)*			
Other: *(identify)*			
Other: *(identify)*			
Action 2	*(Description of the HSS Strategic Action, its rationale and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action)*** **Strengthen professional training for the health sector**. In cooperation with schools training personnel for the sector (doctors, nurses, lab personnel, psychologists, etc.), the contents and methods of the academic programs will be systematized and provided with improved access to equipment and practical experience, to form professionals that can start working with a minimum of additional training. Postgraduate courses and refresher courses for in-service personnel will be developed. The process will be organized around the formation of an Inter-institutional Academic Committee on HIV/AIDS, emulating the succesful model in the area of TB that has been supported by the Global Fund (R2)		

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*

Year 1	Year 2	Year 3	Year 4	Year 5
Form the Academic Committee, needs analysis and design pilot programs; acquire equipment and supplies	Trials of pilot programs; design of other programs; design and validation of in'service postgrad courses ("diplomates") and refresher courses	Evaluation and adjustments; digitization of programas	Programs operating normally, with adjustments according to needs	Final evaluation
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
$155,200	$154,600	$154,600	$154,600	$154,600

Describe below other current and planned support for this action over the proposal term

In the left hand column below, please identify the name of ***other providers*** *of HSS strategic action support. In the*

other columns, please provide information on the type of outputs.

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as this proposal)*	**Expected outcomes from existing and planned support**
Government	2008 - 2012	budgetary support for public sector health training programs that support the battle against HIV/AIDS, approx. $6,000,000	in-kind provision of teaching and admin staff, infrastructure, labs, supplies, etc. in support of activities to strengthen professional training in the health sector on HIV/AIDS and related topics
Other Global Fund Grants (with HSS elements)			
Other: *(identify)* Private academic institutions	2008 - 2012	Routine budgetary support to own degree programs, many of which train staff for the health sector (lack basis to estimate amount)	Infrastructure, laboratories, regular teaching supplies, administrative, management, etc

Other Actions (3)	*(Description of the HSS Strategic Action, its rationale and linkages to this proposal* ***– not more than half a page for each HSS Strategic Action****)* Several of the actions to improve the HIV/AIDS program will have favorable effects for the entire health sector, but their limited scope does not justify treating them as strategic actions. Examples: ○ **Remodeling laboratories** will also benefit other departments that use the same laboratories for separate purposes. ○ Installation of **air conditioning in storage facilities** for medications will help preserve many types of medicines, not only those used for HIV/AIDS. ○ **Personnel training** in other departments on subjects related to HIV/AIDS will strengthen the response of the system as a whole. ○ G**reater availability of transportation** between central, regional and local facilities will help improve supervision, the remittance of samples and medictations in priority cases, etc., making for better treatment and care in many fields.

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, <u>as a total only</u>, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*

Year 1	Year 2	Year 3	Year 4	Year 5
N/A	N/A	N/A	N/A	N/A
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
N/A	N/A	N/A	N/A	N/A

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Describe below other current and planned support for this action over the proposal term			
*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*			
Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as this proposal)*	**Expected outcomes from existing and planned support**
Government	N/A	N/A	N/A
Other Global Fund Grants (with HSS elements)			
Other: *(identify)*			

4.4.2 HSS Strategic Actions continued
Risks arising from support for the actions and cross-cutting issues

Applicants are strongly encouraged to refer to the Guidelines for Proposals before completing (b) to (g) below.

(b) Describe your consideration of the broader implications of the proposed strategic actions and their potential impact on the functioning and performance of the health system, key institutions and stakeholders and other health programs (through a SWOT or other similar exercise). Describe, especially, any risk mitigation strategies in response to potential threats to the health system, and proposed options for ensuring long-term sustainability of the strategies built into this proposal.

The actions proposed respond to an opportunity to widely benefit the health system, without noticeable risks.

The introduction of the SUMEVE system is already considered as a goal of the entire health sector. Its implementation will improve the flow of information for purposes both technical and managerial, increasing the effectiveness, efficiency and transparency of the sector. The plan is already agreed by all institutions of the health sector. It builds on already existing systems, with personnel that is in general familiarized with the subject, even if in a limited way. There are, naturally, internal risks common to any implementation process, such as a deficient performance, not being able to train users effectively, not establishing an uniform data colletion operation, not meeting deadlines, etc. Flexibility to accomodate such risks is taken into account in the plans for introduction and operation of the system, to avoid having shortcomings in one area mushroom into greater failures.

By the same token, strengthening professional training for the health sector, not only for in-service staff but also for students of health-related degree programs, represents an advance over processes that already exist, where there is favorable consensus on the changes to be introduced.

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(c)	Are there cross-cutting HSS Strategic Actions integrated within **this component** that will benefit any other disease component **also** submitted for funding in Round 7?	☒ Yes ➔ *complete (d) and (e), and then (f)* ☐ No ➔ *go to section 4.4.2(f)*
(d)	**If yes to (c)**, provide a short description of which component(s) and how the HSS Strategic Actions in this component will benefit achievement of the outputs and outcomes targeted in the other component(s).	
(e)	If relevant, provide a detailed justification (*with clear information on direct linkages to this disease component)* for those cross cutting HSS Strategic Actions in this component which you believe should still be funded even if one or both (as relevant) of the other components submitted in Round 7 are not recommended for funding. *(**Two page maximum**, including summary details of relevant actions and budget amounts. Also ensure that the budget amounts for HSS Strategic Actions are clearly indicated in the detailed budget required in section 5 for this component). Refer to the Guidelines for Proposals, section 4.4.2(d) for additional guidance.*	
	N/A	
(f)	Are there any cross-cutting HSS Strategic Actions integrated within **another component** in your Round 7 proposal that will benefit this component? *Applicants should ensure that the detailed budget in the other component(s) clearly identify the costs of the HSS Strategic Actions. Applicants must also ensure that there is no duplication of costs included in the various components.*	☒ Yes, Tuberculosis ☐ Yes, Malaria ☐ No

The improvements to laboratories, warehouses and transportation of TB and HIV components are complementary; they will serve in different locations and purposes.

(g)	**CCM and RCM Capacity for Health Systems Strengthening Issue identification**. Describe below how the CCM(s) and RCM(s) of countries targeted in this proposal are ensuring that they have, or are developing and/or strengthening, their capacity and experience in the identification of strengths, weaknesses, threats and opportunities in the health system relevant to national plans to prevent and control the disease(s). Applicants must also describe if there have been any changes in the relative capacity of the CCM(s) or RCM(s) since Round 6. ➔ *Refer to the Guidelines for further information,, section 4.4.2(g)*
The CCM of El Salvador has not focused on that matter to date, partly because it is not structured in such a way to facilitate the required overview. However, it considers that it woulld be pertinent to develop an analysis of the suggested type within the next year. The CCM would gladly receive more information from the Global Fund about the scope of the this matter and about the expectations of the Fund.	

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4.5 Financial Needs Summary

4.5.1 Overall Financial Needs Assessment

Based on an analysis of the national goals and objectives for preventing and controlling the disease, describe the overall disease specific financial needs. Include information about how this costing has been developed (e.g., through costed national strategies, Medium Term Expenditure Framework [MTEF] or other basis).

Summarize the overall financial need in table 4.5.

Based on the National Strategic Plan (NSP), the global financial needs for the 2008 - 2012 period reach the sum of **$212,914,308** (see table below and line A, table 4.5).

The National Strategic Plan (ref HIV-1.3) presents the annual costs for the prevention, attention and control of AIDS until 2010. These costs represent the sum of the costs of the activities considered under its eight objectives (see 4.3.3.a). For this presentation, they have been extended in two ways. First, they have been linearly projected to 2011 and 2012; those figures appear in the first row in the table below. Second they have been adjusted to include the administrative costs required by the Ministry to carry out these programmatic activities, which were not included in the NSP. These costs are conservatively estimated at 6%; the adjusted amounts are in the second row. The total for 2008 to 2012 is in the bottom row.

Year	2005	2006	2007	2008	2009	2010	2011	2012
NSP	$32,726,751	$34,437,144	$36,221,684	$38,131,886	$40,191,874	$42,436,771	$44,765,701	$47,388,076
NSP + 6%	$34,690,356	$36,503,373	$38,394,985	$40,419,799	$42,603,386	$44,982,977	$47,451,643	$50,231,361
				2008-2012 total = $212,914,308				

4.5.2 Current and planned sources of funding

(a) **Domestic Sources**

Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. Please also explain the process of prioritization of such funding to ensure that resources are utilized efficiently and on a timely basis (e.g., explain if there are significant available in-country resources, such as HIPC [Heavily Indebted Poor Country] debt relief or other such resources which are available to support disease prevention and control strategies, and how these resources are being efficiently used).

Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line B.

With regard to the current and foreseen domestic sources, a total of US **$131,313,167** in national funding resources is estimated for the financing of the HIV component for the 2008 – 2012 period. HIPC debt relief or or such resources are not available.

NATIONAL FINANCING SOURCES	CURRENT		PLANNED		ESTIMATED			TOTAL
	2006	2007	2008	2009	2010	2011	2012	2008-2012
	$21,066,234	$22,263,405	$23,462,387	$24,753,142	$26,188,824	$27,625,638	$29,283,176	**$131,313,167**

(b) **External Sources**

Describe current and planned financial contributions anticipated from all relevant external sources relating to this component (including, based on section 1.6, existing grants from the Global Fund and any other external donor funding).

Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line C.

External contributions for the 2008 – 2012 are estimated in a total of US **$16,520,341**. A minimum part comes from the Global Fund (R2); international cooperation has been contributing more than $ 3 million per year. As the sources are very diverse and change from year to year, this item is relatively robust. It has been projected as a whole based on the tendency of previous years, those specific commitments for most of this amount are not yet available. Among the most consistent donors are OPS, UNFPA, UNICEF, UNDP and USAID.

EXTERNAL FINANCING SOURCES	CURRENT		PLANNED		ESTIMATED			TOTAL 2008-2012
	2006	2007	2008	2009	2010	2011	2012	
INTERNATIONAL COOPERATION	$ 2,639,607	$2,789,613	$2,939,846	$3,101,578	$3,281,470	$3,461,503	$3,669,193	**$16,453,590**
AMOUNT OF GLOBAL FUND	$ 2,787,852	$1,948,488	$ 66,751	**0**	**0**	**0**	**0**	**$ 66,751**
TOTAL EXTERNAL SOURCES	$ 5,427,459	$4,738,101	$3,006,597	$3,101,578	$3,281,470	$3,461,503	$3,669,193	**$16,520,341**

4.5.3 Overview of Financial Gap

In table 4.5, Line E, provide a calculation of the gap between the estimated overall need (Line A, table 4.5) and **current and planned available resources for this component** (Line D, table 4.5).

*This table is a summary **only** of overall funding gap. Applicants must provide a detailed budget (see section 5) to identify the amount requested in this proposal in section 5.*

4.5.4 Additionality

Describe how Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources. Explain plans to ensure that this will continue to be true for the entire proposal term.

El Salvador has increased the budgetary amounts destined to the HIV/AIDS program from $9,353,444 in 1999 to $21,066,234 in 2006. The resources requested here from the Global Fund are additional to the existing and planned national resources. They will not replace nor substitute those sources. The availability of national resources has been estimated based on the expense levels and commitments expressed in the National Strategic Plan for the prevention, treatment, and control of HIV/AIDS and ITS 2005 – 2010 in El Salvador, with linear projections to 2011 and 2012. The country has maintained a gradual increase in its budgets for this area to cover the absorption of human resources and acquisitions initiated with the funds from the first GF grant (R2); that is the basis for the increase in the counterpart funding for the grant proposed here that is indicated above in (a).

Given the broader policy of the Salvadoran government to resist growth in public sector staffing levels,due to budget constraints, a strategy used to increase human resources in the HIV/AIDS area has been to initially cover growth from external funding and then use that to leverage the assignment of permanent positions once the decided support of users, PLWHA groups, local governments, and the general public has been generated. This project proposes to use GF funding to bring on a limited number of human resources on an interim basis (short term contracts, consultants, etc.) to attend to the new ART/integrated care centers, the more descentralized testing and counseling programs, and other key elements during their first two to three years. That will allow the HIV/AIDS program to negotiate commitments from the government to progressively absorb the new staff in permanent positions.

4.5.5 Strategy for achieving sustainability

Describe the strategies and approaches that will be used during the proposal term to ensure that the interventions/activities initiated and/or expanded by this proposal will more likely be sustainable (continue) beyond the proposal term. *(See section 4.5.5 of the Guidelines for Proposals.)*

Note ➔ Applicants are not required to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term. Rather, their description should include how the country/countries targeted in the proposal are addressing their capacity to absorb increased resources and recurrent expenditures, and how national planning frameworks are seeking to increase available financial and non-finanical resources to ensure effective prevention and control of the disease(s).

The strategy to achieve sustainability has six axes:

1. Political support

Following up on the *Three Ones*, El Salvador has worked intensely to consolidate its strategies for the fight against AIDS. One of the most outstanding achievements has been to gain the determined support of Salvadorean authorities of the highest level in regard to the epidemic.

This is clearly reflected in the *2005 AIDS Program Effort Index* (API; USAID/PASCA/AED 2006), which evaluates the efforts made by NGOs, GOs and cooperation agencies in response to the epidemic in the countries of the region. It covers areas such as political support, legal environment, planning, organizational structure, resources, M&E and human rights, as well as prevention, treatment, and care. El Salvador's rating improved by 20 points between 2003 and 2005, rising from 59 to 79 points. The components of political support and policy formulation received the highest ratings, with an index of 91 points. Other components showed great improvement: the human rights score increased by 192%, legal environment by 83%, prevention programs by 73%. El Salvador has the highest API average in its region (USAID/PASCA/AED 2006).

The level of political support reached an unprecedented level in 2005 with the signature, at the initiative of the country, of the **"Declaration of San Salvador"** in which the Central American heads of state committed to redoubling efforts in the fight against AIDS, to support the welfare of PLWHA and to reduce the vulnerability of the population to this infection.

The National Commission for the Fight Against AIDS, **CONASIDA**, gained new momentum in 2004 thanks to the support of the incoming President of the Republic, who upgraded its leadership, drawn from government (Ministers, Presidents and Executive Directors), NGOs, private enterprise, and PLWHA groups. An important product of its work is the **"Policy for the Comprehensive Attention to the HIV/AIDS Epidemic"**, a solid statement of the current and future commitment that El Salvador assumes in response to the epidemic. This policy contains ten overall lines of action, with strategies developed for the national struggle against AIDS that respond to international guidelines for addressing the epidemic.

2. Economic Commitment:

Political support has translated into economical support. For example:

- The Government has assumed the commitments acquired within its agreement with the Global Fund (R2), absorbing to date 80% of the cost of the 43 new human resources initially hired on a temporary basis; the remaining 20% will be absorbed by the end of phase II. (The rest of the staff providing HIV/AIDS services in public sector health establishments—over 95%—is government financed.)

- Addressing the challenge of providing universal access to HIV testing and to ART for PLWHA, the government has provided an increasing share of the resources for the purchase of tests and medication, going from 45% in 2004 to 71% in 2006.

3. Regulatory Environment

In the last five years, regulations have been strengthened through preparation and updating of 25 documents (Guides, Protocols, Regulations, Plans and Manuals) which guide the behavior of professionals in the integral approach to HIV/AIDS (see references, Attachment TB-1).

Among the key documents is the National Strategic Plan (NSP), agreed through wide national consultation with 75 institutions. It will guide El Salvador's response to HIV/AIDS through 2010, providing follow-up on the previous strategic plans (1995-1999, 1999-2001 and 2001-2004).

The current NSP has a focus on human rights and on gender equality. It establishes guidelines to improve the knowledge of HIV/AIDS and its effects on the population, strengthen measures for prevention and protection, and widen the coverage of testing and comprehensive integrated services for PLWHAs, with emphasis on the most vulnerable groups.

4. Legal Framework and Human Rights

The *Law and Regulations for the Prevention and Control of the Infection caused by HIV* was approved in 2004, with reforms to the *Labor Code* as well. The law guarantees respect and confidentiality for PLWHA and protects their job security.

The Strategic Alliance for Legislation on HIV/AIDS has been formed to strengthen the legal environment and protect PLWHA human rights. This alliance is formed by civil society institutions, cooperation agencies, MOH and UNAIDS, and PLWHA organizations.

The country has provided follow-up to the **"Declaration of UNGASS"** to achieve the millennium objectives, which implies starting a reduction in the incidence of HIV/AIDS for 2015. The commitment of the country shown in the 2006 meeting of UNGASS, with the attendance of the President of El Salvador as a spokesperson of his Central American counterparts, the only Latin American head of state present.

Special coordination agreements for the sustainability of the strategies developed include:

a) Cooperation Agreement for the strengthening of the regional human rights and HIV/AIDS network, El Salvador Chapter*, which promotes human rights related to HIV/AIDS among official entities and NGOs, and* ***b) Cooperation Agreement for the initiative for the prevention of HIV/AIDS aimed at Inmates in national penal facilities****, to support the integral approach of HIV/AIDS in penal facilities.*

5. Comprehensive Treatment and Care

In regard to the sustainability of ART for PLWHA, the government has assumed responsibility for guaranteeing universal access. To achieve economies of scale in the acquisition of medication, there is an agreement among the public sector institutions for joint purchase. In addition, alliances are being formed with cooperation agencies such as the Clinton Foundation and AIDS for AIDS to reduce costs in the acquisition of antiretrovirals. Agreements with the ESTHER project of Spain, Brazilian cooperation, and the St. Jude Children's Hospital provide technical assistance and training.

Within the on-going health sector reform process, MOH leadership has been strengthened, opening space for the harmonized handling and treatment of HIV/AIDS. The country has a Technical Advisory Committee, supported through Ministerial Resolution 1224, whose main function is to standardize and update attention protocols, schemes for treatment, and counseling for the National HIV/AIDS Program.

6. Monitoring and Evaluation

The National Monitoring, Evaluation and Epidemiological Surveillance System is being introduced (see 4.9) to measure and evaluate performance under the NSP goals. It will support institutional strengthening and provide decision makers with timely, accurate data to evaluate options and to prepare strategies.

Besides these general axes of sustainability, specific elements that increase sustainability are considered in the Service Delivery Areas. For example:

a. By improving access of PLWHA to basic social protection services, the project will strengthen the links between the government, community and civil society. PLWHA and community health organizations will be trained and strengthened. This becomes an important source of personal sustainability for PLWHAs and their families, which will be expressed as political support through their support groups. By having access to productive activities, they will have the possibility of leading a stable life that allows them to bear the weight of the infection, reducing the demands on the State and increasing sustainability.

b. On the other hand, the strengthened educational community and civil society will improve the formal and informal curriculum contents on HIV/AIDS, influencing students and their relatives and thus expanding the coverage of people that are informed about the epidemic, its prevention and control. The coordination of the Ministry of Education has been forthcoming and effective and there is a curricular design that addresses the problem from the early ages (refs HIV-1.31, 1.32 , and 1.33).

c. The Government, while increasing and descentralizing coverage of existing services like ART, will gradually assume the functions of social programs. Through the MOH, it has already substantially assumed the expense of HIV/AIDS in general and of medication in particular.

Sustainability will be also supported by activities such as the development of human resources in health, curricular integration at the university level and primary and secondary schooling, with the development of knowledge and of favorable attitudes between the population in general and the political class. These factors will contribute to assure that the fight against HIV/AIDS is sustained.

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Table 4.5 - Financial contributions to national response

Financial gap analysis *(same currency as selected in section 1.1)*								
Refer back to instructions under section 4.4, step 3	**Actual**		**Planned**		**Estimated**			
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Line A ➔ Overall disease specific needs costing including essential disease specific health systems needs	$34,690,356	$36,503,373	$38,394,985	$40,419,799	$42,603,386	$44,982,977	$47,451,643	$50,231,361
Domestic source **B1**: Loans and debt relief (*provide donor name*)								
Domestic source **B2**: National funding resources	$20,615,711	$22,003,614	$22,263,405	$23,462,387	$24,753,142	$26,188,824	$27,625,638	$29,283,176
Domestic source **B3:** Private Sector contributions (national)				$4,819,870	$5,080,253	$5,364,008	$5,658,385	$5,989,853
Total of Line B entries ➔ Total current & planned domestic resources	$20,615,711	$22,003,614	$22,263,405	$28,282,257	$29,833,395	$31,552,832	$33,284,023	$35,273,029
External source **C 1**: All current & planned Global Fund	$7,109,197	$2,787,852	$1,948,488	$66,751				
External source **C 2** (*provide donor name*)	$2,388,991	$2,639,607	$2,789,613	$2,939,846	$3,101,578	$3,281,470	$3,461,503	$3,669,193
External source **C4**: Private Sector grants/ contributions (International)								
Total of Line entries C ➔ Total current & planned external resources	$9,498,188	$5,427,459	$4,738,101	$3,006,597	$3,101,578	$3,281,470	$3,461,503	$3,669,193
Line D ➔ Total current and planned resources ➔ (i.e. Line D = Line B Total +Line C Total)	$34,011,010	$30,846,548	$31,579,927	$31,288,854	$32,934,973	$34,834,302	$36,745,526	$38,942,222
Line E ➔ Total Unmet need (Line A – Line D) -	**$ 679,346**	**$5,656,825**	**$6,815,058**	**$9,130,945**	**$9,668,413**	**$10,148,675**	**$10,706,117**	**$11,289,139**
The table above is provided for planning purposes to identify the ceiling of funding needs. The Global Fund recognizes that the proposal term (if approved) may straddle calendar years depending on the start date of the grant agreement that may be signed.								

4 Component Section *HIV/AIDS*

4.6 HIV/AIDS component/implementation strategy

This section describes the strategic approach of the proposal, and the activities that are intended to be supported over the proposal term. Section 4.6 contains important information on the goals, objectives, service delivery areas and activities, as well as the indicators that will be used to measure performance. For more detailed information on the requirements of this section, see the Guidelines for Proposals section 4.6.

In support of this section 4.6, all applicants must submit by disease component:

1. A **Targets and Indicators Table** ➔ This is included as **Attachment A** to the Proposal Form. *When setting targets in this table, **please refer explicitly to the programmatic needs analysis** in section 4.4. All targets should be measurable and identify the current baseline. **Importantly, this table will be utilized to measure performance of the program over the whole proposal term.** For definitions of the terms used in this table, see the 'Explanatory Note' provided on the first sheet in 'Attachment A' (Targets and Indicators Table) to the Proposal Form. Refer to the Guidelines for Proposals, section 4.6.*

and

2. A **Work Plan** ➔ which must meet the following criteria. *(Refer to the Guidelines for Proposals, section 4.6):*

   a. *Structured along the same lines as the Component Strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.*

   b. *Covers the first two years only of the proposal term and is:*
      i detailed for year 1, with information broken down by quarters;
      ii indicative for year 2, with information at least half yearly.

   c. ***Consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above.*

***Please note that other documents are also required to be submitted to ensure a complete application for Round 7 funding**. Applicants are strongly encouraged to use the by-disease checklist after section 5 to ensure that all necessary documents are attached to the proposal submitted to the Global Fund.*

IMPORTANT INFORMATION FOR APPLICANTS RE-SUBMITTING A PREVIOUSLY UNAPPROVED ROUND 5 or ROUND 6 PROPOSAL FOR THIS SAME DISEASE COMPONENT

4.6.1 Re-submission of an unapproved Round 5 and/or Round 6 proposal

If this proposal is a resubmission of proposal for the same disease component from either Round 5 and/or Round 6 that was not approved, **attach the 'TRP Review Form'** provided by the Global Fund to the Applicant after the Board decision for the earlier Round(s). *(The TRP Review Forms should be listed as an annex to the proposal in the checklist at the end of section 5 of this disease component).*

In the section below, please describe what specific adjustments have been made to this proposal to take into account each of the 'weaknesses' listed by the TRP in the 'TRP Review Form'. *(Maximum two pages. Applicants should ensure that they clearly detail which earlier proposal is being referred to, and what specific actions have been taken to remedy issues raised by the TRP. Applicants should provide details on what has been strengthened about this proposal, compared to an earlier unapproved proposal.)*

Weaknesses [from TRP Review Form - Round 6]

- "Several sections do not provide sufficient detail, such as an outline of existing synergies between TB and HIV components, programmatic and financial gap, gender issues, and technical assistance and others.

This has been corrected. More detail is provided and more discussion of synergies is included.

- "Strategies to reach the target population were not explained.

Strategies to reach the target populations are discussed in section 4.6.3 (b) and elsewhere.

- "There is no link between the planned activities and the 100 poorest and most affected municipalities.

Given that poverty has not been shown to contribute to the risk of HIV infection (rather, HIV/AIDS contributes to poverty) this focus has been eliminated.

- "Inappropriate choice of indicators: Some indicators will not be able to measure activities they refer to.

The indicators have been revised.

- "Most of the targets are not well addressed (the target in year 5 is 70% of the target reached ?) and are sometimes too ambitious.

Goals and benchmarks have also been re-done.

- "There is no ART schemes (treatment and PMTCT), just a list of drugs with the information–first or second line;

The ART schemes appeared in the protocols in an annex. In this proposal they are in Attachment B.

- "The number of people that will receive ARVs has not been adequately specified.

The number of people to receive ART is now shown in section 4.4.1.

- "The rational behind the budget items is not presented. Costs relating to the planned activities are not sufficiently detailed: There is no breakdown to show what each activity is composed of. The only items that are coasted with details are the ARVs, condoms and lubricants (in Annex B) but there are problems with the totals and the totals are not reflected into the general budget."

More care has been taken to make the detailed budget self-explanatory.

4.6.2 Goals and objectives and service delivery areas

Referring to your overall needs assessment in section 4.4.1 above, provide a summary of the proposal's overall goal(s), objectives and service delivery areas. *(The information below should be **no longer than a one page summary**, and Applicants should provide **detailed quantitative information in Attachment A** ('Targets and Indicators Table') **to this Proposal Form**).*

Purpose: **reduce the social and economic impact of the epidemic.** This will be achieved reducing the transmission, morbidity and mortality, and improving PLWHA quality of life.

The objectives and Service Delivery Areas (SDA) are the following:

Objective 1: Improve the social protection and quality of life of PLWHA.

The corresponding Service Delivery Areas (SDA) are:

SDA 1.a Strengthening of the civil society and creation of institutional capacity.
SDA 1.b Improvement of the social protection of PLWHA.
SDA 1.c Reduction of stigmatization.

Objective 2: **Reduce the transmission of HIV**, increasing coverage and the range of activities for the prevention of the infection due to HIV and the promotion of sexual and reproductive health in vulnerable groups.

4 Component Section *HIV/AIDS*

The corresponding Service Delivery Areas are:

SDA 2.a Communications to change behavior (CCB).
SDA 2.b Condom distribution.
SDA 2.c Consultancy and testing, diagnosis and treatment (VCT).

Objective 3: **Reduce morbidity and mortality**, facilitating the availability, access and quality of comprehensive attention to PLWHA.

The main Service Delivery Areas are:

SDA 3.a Antiretroviral therapy.
SDA 3.b Prophylaxis and treatment of opportunistic infections.
SDA 3.c Comprehensive attention and support to the chronically sick.

Objective 4: Strengthen the health system.

There are two Service Delivery Areas:

SDA 4.a Consolidation of the monitoring, evaluation and epidemiological surveillance system.
SDA 4.b Strengthening professional training for the health sector.

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4 Component Section *HIV/AIDS*

4.6.3 Specific Interventions, Target Groups and Equity

(a) **Specific Interventions/Activities supported by this proposal**

Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. Please include an overview of all the activities proposed, how these will be implemented, and by whom. *(Where actions to strengthen health systems are planned, applicants are also required to provide additional information at section 4.4.2.)*

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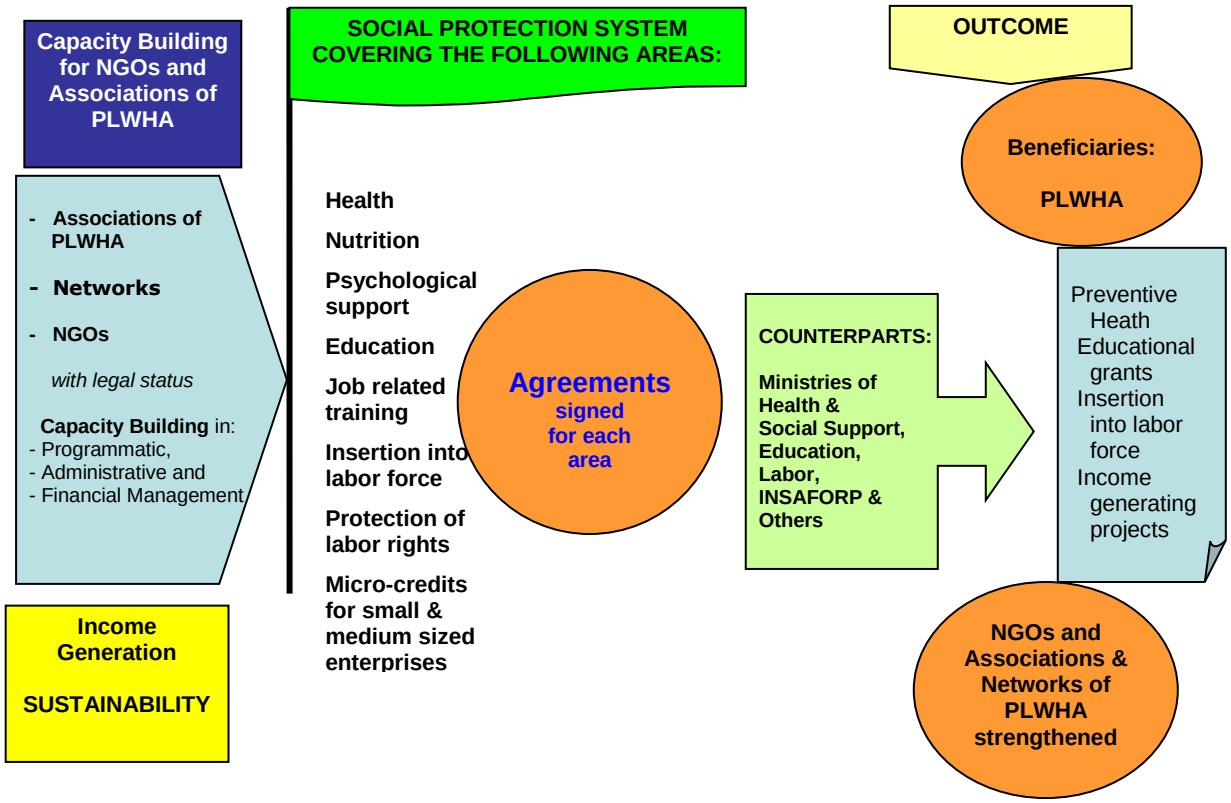
Objective 1: To improve social protection and the quality of life of the PLWHA.

Under this objective PLWHA, their relatives and their organizations will be empowered to fully participate in the establishment, management, and better use of social protection services. The benefits will translate into better quality of life for PLWHA through improved health and psychological care, nutritional security, job training, opening of economic opportunities for economic integration (employment, micro enterprises, etc.) and a sense of incorporation and empowerment, among others.

The basic concepts that guided the development of this objective were agreed to in a series of workshops with groups of PLWHA, who validated the following scheme, on which the activities described below are based, as well as the work plan and the budget.



SERVICE DELIVERY AREA	ACTIVITIES	MEANS OF IMPLEMENTATION	RESPON-SIBLE
SDA 1.a Civil society strengthening and institutional capacity building	1.a.i Reinforce/ establish support groups and NGOs that manage information, provide support and facilitate access to services to PLWHA for their integration into a productive life.	Arrange from 3 to 5 consultancies (national or international) to design effective and sustainable programs for PLWHA training and incorporation and their organizations. Advise and accompany the creation of related NGOs and GOs associations with legal status to allow self-management and funds management. Annually subsidize between five and ten NGOs and NGO networks to carry out action plans in HIV prevention among high risk groups (MSM, SW, etc.; competitive selection). Raise PLWHA capacity to run support groups working as part of the multidisciplinary teams at clinics and ART centers, including support for counseling and adherence to treatment.	MOH, NGOs, PR through the Executive Unit hiring, procurement, etc. PLWHA groups

		Train PLWHA to participate in support teams that work in HIV/AIDS care clinics as part of the multidisciplinary teams, including strengthening adherence topics. Strengthen skills to prepare PLWHA groups and NGOs to support social protection activities. ✓ Integrated health care ✓ Use of incentives with patients ✓ Development of educational, job training and legal support projects. ✓ Development of economic projects ✓ Other initiatives: nutrition, housing, etc. Facilitate the active cooperation of PLWHA organizations and their families and of related NGOs. Socialize the new support teams' handbook at national level. Contract PLWHA facilitators at each ART center to work with the multidisciplinary team, foster support group activeties and encourage PLWHA attendance, develop strategies for approaching at-risk groups, etc. Initiate a Scholarship program for children of PLWHAs with private sector backing. Hold an annual gathering of PLWHA self-support groups at national level.	
	…… 1.a.ii To develop administrative and financial capacity in PLWHA organizations.	…… Provide technical assistance and training to GOs, NGOs, and PLWHA to develop managerial, administrative, financial, accounting, and negotiation skills to make them better organized and able to bid on and implement service contracts. Arrange training workshops on project formulation and management. Develop PLWHA trainers to train NGOs and PLWHA groups on their rights, social monitoring and advocacy strategies and procedures, and legal, administrative, and educational resources available.	
SDA 1.b Improved social protection for PLWHA	1.b.i To develop and adopt policies that support PLWHA and their insertion in the workplace.	Hire technical advice from national or international entities to support planning of Social protection system (SPS) development. Concert cooperative agreements and promote PLWHA social protection policies, legal frameworks and regulations for government, civil society, and private employers. Exercise political influence to advocate the legalization of PLWHA organizations and the establishment of legal and administrative frameworks that support them. Organize with GOs, NGOs, and PLWHA a Social Protection System (SPS), decentralized and based on existing institutions and programs, including counseling, rights advocacy, access to education, sexual and reproductive health, job training and insertion, credit facilities, and business development skills. As a first step towards a SPS, improve access to health services, including sexual health, nutrition and	PR through Executive Unit regarding hiring, procurement, etc. PLWHA groups

		psychological support by strengthening public service provider institutions and NGOs. Establish agreements with government institutions, private enterprises, NGOs, churches, and international cooperation to recognize and promote PLWHA' rights and duties, to facilitate their social participation and SPS support. Support IEC campaigns through support teams and NGOs in order to achieve KAP changes among PLWHA. Verify through social monitoring and control the compliance with social protection policies and PLWHA' quality of life.	
SDA 1.c Reduction of stigma	Focus and reduce stigma in all areas	Expand continuing education on HIV topics highlighting aspects such as stigma and discrimination, homophobia, human rights and legislation. Measure and disseminate KAP factors on the perception of the infection, stigma and discrimination among target population with pre and post activity studies Conduct mass media campaigns addressing issues on prevention, stigma and discrimination. Organize educational campaigns with business people and their employees through trade associations.	PR through Executive Unit regarding hiring, procurement, etc. PLWHA groups

Objective 2: To reduce HIV transmission by expanding coverage and the range of activities on HIV infection prevention and health promotion among vulnerable groups.

Prevention interventions and timely detection of HIV infections will be emphasized among those groups considered most vulnerable (see Target Groups, section (b) below). These groups have been focused under the national strategy, but budgetary constraints have hindered the follow-up and evaluation of actions. Monitoring processes will be established in conjunction with Objective 4 in order to better characterize the impact of the epidemic in those groups and to evaluate the effects of preventive interventions on kind of high risl population, working through alliances with government agencies and NGOs that attend this population. Certain innovatives will be made, like introduction of the femine condom.

SERVICE DELIVERY AREA	ACTIVITIES	MEANS OF IMPLEMENTATION	RESPONSIBLE
SDA 2.a Communication of behavioral changes.	2.a.i Strengthen IEC strategies with emphasis on the most vulnerable groups:	Design, validation and reproduction of educational material specific for highly vulnerable groups (9 groups prioritized: see 4.6.3.b). Bids for material design and manufacturing. Two annual three-day workshops on the design and validation of educational material for each target population. Reproduction of existing educational material. Placement of billboards with prevention messages Implement annual campaign on HIV prevention aimed at the general population and at most vulnerable groups using mass media (contracting experts on certain aspects of the topic). Advertising agencies bidding. Contracting of consultancy firm.	MOH NGO GO PLWHA

		Evaluation of campaign results: biannual qualitative studies to measure impact of campaigns. Training and sensitization of health staff from different institutions on how to address most vulnerable groups (sexual and reproductive health, stigma and discrimination, law, etc.) Two workshops to train facilitators aimed at: GOs, Regional MOH, NGOs, on how to address most vulnerable population. 20 replication workshops aimed at health staff on how to address most vulnerable groups. Train 22 multidisciplinary teams in penitentiaries on HIV preventive measures, law, human rights, stigma, and discrimination. Advocacy and intersectorial coordination at decision maker level (GOs, NGOs and other key actors). Continue with advocacy and intersectorial coordination at decision maker level in institutions responsible for attending vulnerable groups, involving local and national authorities, and the press. Biannual coordination meetings with different institutions or organizations that work with most vulnerable groups. Training workshops and HIV/AIDS sensitization aimed at decision makers. Interventions with mobile units to address HIV/AIDS prevention in discotheques, dark rooms, gay bars, universities, youth and migrants' concentrations, factories, etc. Strengthen support teams with active participation of paid PLWHA staff that mentor the Support Groups and train members at each integral care/ART center. Strengthen the promotion of sexual health and STI/HIV/AIDS prevention, working with the national network of health promoters in the country's rural areas. Education program at each penitentiary (22 including 3 ISNA)—cine forum, talks, interactive workshops, peer delivery of educational material on HIV/AIDS prevention –to ensure the distribution of condoms to men and women inmates through peer facilitators. Annual workshops to define and validate specific interventions on addressing HIV/AIDS in each most vulnerable (9 groups prioritized; see list in 1.1).	

		Evaluations of intervention needs in each prioritized group. Workshops for health staff located in establishments related to these groups on counseling, STI clinic approach, sensitization, and legal framework. Workshops aimed at prioritized groups and related entities, such as companies, NGOs, support teams, etc., on prevention, sensitization, and legal framework. Strengthen installed capacity of the confidential AIDS-TEL phone service Acquisition of modern telephone equipment. Updating of database. Contracting human resources to work the confidential line. Training of new volunteers. Reinforce advertising and expand clinic resources for the vertical transmission prevention program (PMIT), involving PLWHA support teams in the active search for positive pregnant women from vulnerable populations. Strengthen links with the Ministry of Education and coordination around strategies for formal, non-formal, and informal education of children, adolescents, and parents on HIV/AIDS risks and prevention. Coordinate with MINED training of teachers. Train departmental technical teams to establish alliances with MOH and civil society technical staff.	
SDA 2.b Distribution of condoms	2.b.i Strengthen distribution of condoms to most vulnerable population.	Purchase and distribution of female condoms, male condoms, and lubricants to most vulnerable groups, including PLWHA. Procurement of anatomic models for demonstrations on the correct use of condoms for health establishments and sector NGOs. Quarterly delivery of condoms to NGOs and other institutions that work with highly vulnerable groups Adaptation of 6 MOH warehouses (central and regional areas) to store condoms. Conduct educational campaigns on the proper use and distribution of condoms in strategic points of highest concentration of the vulnerable groups.	MOH NGO GO PLWHA
SDA 2.c Counseling and test	2.c.i Strengthen advisory services to the general population with emphasis on most vulnerable groups (with their active participation)	Training of new PLWHA and other advisors in government and non-government levels. Feedback workshops on advisory services to 100% of trained advisors nationwide. Systematic quality control on the use of advisors in health sector establishments, through the simulated client methodology. Adapt and reproduce tools that facilitate the advisory process	MOH NGO GO PLWHA

	…… 2.c.ii Strengthen the capacity of the National Laboratory Network to perform diagnostic tests and to follow-up on HIV, STI and opportunistic infections …… 2.c.iii Strengthen quality management and Biosafety in National Laboratory Network …… 2.c.iv Strengthening mobile units and border points for HIV rapid testing.	(flowchart, handbooks, and guides). Adapt 25 % of advisory areas in the sector's health establishments, prioritizing those with higher user demand. …… Contracting staff to open laboratories that are currently equipped but lack human resources. Procurement of equipment, materials and supplies to perform diagnostic tests and to follow-up on HIV, STI and opportunistic infections. Training workshops to new staff and updating for trained Laboratory staff, to perform diagnostic HIV, STI, and opportunistic infection tests. Improve existing infrastructure conditions of the National Laboratory Network and the Central HIV Reference Laboratory. …… Review and update existing regulations for diagnostics of STI and opportunistic infections, and biosafety. Train and/or update laboratory staff on quality management and biosafety standards. Systematic implementation of the use of internal quality controls to perform HIV and STI diagnostic tests. Conduct external performance evaluation events at least twice a year, aimed at all laboratories and clinics in the National Network. …… Purchase of a third Mobile Unit to expand coverage among most vulnerable population. Maintenance and repair of mobile units. Implementation of 14 HIV prevention areas at border points, with remodeling, basic staff (physician, nurse, and health promoter) and purchase of furniture and equipment.	

Objective 3: **To reduce morbidity and mortality**, facilitating availability, access and quality of integral care for PLWHA.

An increase in coverage for Antiretroviral Therapy (ART) requires an integral approach from the health sector, identifying 6 new sites with capacity to provide ART. The selected establishments will be remodeled and adapted to provide quality and private services. This will increase the total number of facilities that provide ART from 19 to 25, including two in penitentiaries where most PLWHA inmates are. The new multidisciplinary teams will be trained, including physicians, nurses, psychologists, social workers, nutritionists, and others that support the treatment. Support will be also provided to training and clinical management of opportunistic infections, mainly the TB/HIV co-infection, which will be addressed jointly with the TB program. As part of the integral care services to improve adherence to ART, the creation and training of more support teams is included, involving civil society, including PLWHA associations, GOs and NGOs; also nutritional assistance for persons undergoing treatment. Laboratory staff will be trained on bio-safety and quality, as will as technical-administrative staff on the use of the National Monitoring, Evaluation and Epidemiological Surveillance System (SUMEVE). The purchase of laboratory equipment and the capacity to follow-up and monitor individuals that receive ART and evaluation of drug resistance are needed.

4 Component Section *HIV/AIDS*

SERVICE DELIVERY AREA	ACTIVITIES	MEANS OF IMPLEMENTATION	RESPONSIBLE
SDA 3.a Anti-retroviral therapy	3.a.i Expand ART coverage …….. 3.a.ii Improve adherence to ARV treatment: …… 3.a.iii Support adherence to post exposure prophylaxis.	Open new 6 integral care centers—4 by MOH (Usulután, The Paz, Cabañas, Cuscatlán) and 2 in penitentiaries (Apanteos and Mariona)—with proper infrastructure, training of multidisciplinary teams, information and M&E systems, purchase of ART and opportunistic infection medication, more diagnostic laboratories and transportation for follow-up tests. Initiate new patients on ART at penitentiaries and MOH integrated treatment/care centers Train 22 multidisciplinary teams on integral treatment/care for penitentiaries, clinics. and ISNA. Continue screening for HIV in penitentiaries, mobile units, border points, and other places that attend target groups (in coordination with Objective 2 on prevention) …… Train multidisciplinary teams, support teams and those responsible for the medication's logistic chain in relation to ART adherence. Train PLWHA NGOs to promote adherence among their peers including HSH groups, inmates, TCS, etc. Conduct annual sensitization and advocacy workshops in each CP, with authorities, those in charge of clinics, custodians, others, on the importance of PLWHA' adherence to treatment and use of incentives. …… Train on protocols for post exposure prophylaxis following sexual abuse and on the job risks. Availability of medication for HIV post exposure prophylaxis in sector institutions including jails.	PR through Executive Unit regarding hiring, procurement, etc. MOH; MINISTRY OF SECURITY AND JUSTICE.
SDA 3.b Prophylaxis and treatment of opportunistic infections (OI)	3.b.i Provide prophylaxis to main opportunistic infections (OI) in PLWHA. …… 3.b.ii Facilitate timely access to treatment of main OI and prevent consequences.	Medication availability for frequent OI in El Salvador. Diagnostic test availability for most frequent OI in El Salvador. Physician training or continuing education on sub-specialization at MOH care centers and penitentiary clinics. PLWHA and PLVVS training on OI prevention. …….. Train on better identification of OI. Purchase proper medication for the treatment of main OI. Train PLWHA including vulnerable groups on OI and treatment adherence (PLWHA, juveniles in process of re-adaptation, sex workers, etc.)	PR through Executive Unit regarding hiring, procurement, etc.
SDA 3.c Integral care	3.c.i Strengthen integral care for	Strengthen and creation of new support teams (MOH and CP)	PR through Executive Unit regarding hiring,

and support of chronic patients.	PLWHA.	Identify strategies for PLWHA nutritional support including PLVVS. Guarantee psychological support and hiring of resources. Train facilitators with peer strategy in support teams that attend vulnerable population, trying to identify and hire PLWHA. Strengthen the dentistry component with equipment and training aimed at dentists for proper PLWHA care. Promote healthy life styles in support teams that attend vulnerable population.	procurement, etc.

Objective 4: To strengthen the health system with improved monitoring and evaluation capacity and professional training.

Implementation of the 2006-2010 National Monitoring, Evaluation and Epidemiologic Surveillance plan to put the last of the Three Ones ineffect. This entails strengthening the health system's information systems, epidemiologic monitoring, and M&E. At the same time, professional training for the sector's human resources will be strengthened on HIV/AIDS knowledge, as well as their skills to contribute to its prevention, control, and treatment. The models implemented, both to strengthen the information systems and M&E as well as to systematize the professional training, will have direct applications in many other health areas. Both will also be addressed in the TB component; other areas are expected to follow suit.

The MOH started in 2005 to modernize the integrated health information system, with proper technology and security systems. It has established a new on-line information system on morbidity and mortality that operates in 30 of the national network's hospitals. It is a user friendly system that provides timely information for monitoring and analysis. It was created by Ministry's staff with the support of PAHO. Technical support is provided by the MOH.

Starting in January 2007, the National STI/HIV/AIDS Program, in cooperation with the PAHO has prepared on-line software for HIV/AIDS using this system's platform. Concurrently, the health sector has standardized the gathering of information, for example with the HIV test application and confirmation sheet. This has been agreed to by the different health sector institutions and not only within the MOH, with the purpose of supporting the implementation and development of the National Monitoring and Evaluation Plan.

This system's implementation requires human resources, computational resources, and access to networks or Internet, data storage equipment, and increased band width, in addition to data capture forms for the good operation of the new National Monitoring, Evaluation and Epidemiologic Surveillance (SUMEVE) System for HIV/AIDS.

Once implemented in all government and non-government institutions that carry out actions against HIV/AIDS, this system will become a resource management tool and will generate data for integral analysis and decision making in technical, administrative, and operation areas.

In parallel, the health sector staff's professional training will be strengthened by working both with human resource training centers (i.e., university and para-professional schools of medicine, nursing, microbiology, public health, etc.) as well as with training programs during service (in-service diploma courses, post graduate, internships training, professional meetings and congresses, among others). Focusing on HIV/AIDS needs and following the successful example of the National Tuberculosis Program with support of the Global Fund (Round 2), a model will be established that may be expanded afterwards into professional training in the fight against other diseases.

With the proposed strengthening of the Health System, the goal is to consolidate the implementation of SUMEVE for HIV/AIDS to be used by all health sector institutions, NGOs and others that carry out preventive and curative HIV/AIDS actions. As this system is consolidated the Ministry of Health will gradually assume its sustainability.

4 Component Section *HIV/AIDS*

SERVICE DELIVERY AREA	ACTIVITIES	FORM OF EXECUTION	RESPONSIBLE
SDA 4.a Consolidation of the health sector monitoring, evaluation and epidemiologic survey system	4. a.i Updating and standardization of information gathering from different system components	Incorporation of the new of monitoring, evaluation and epidemiologic surveillance system to the on-line platform of the MOH morbidity/mortality system. Development and validation of other data capturing standardized forms, coordinated with related institutions in workshops (3 by form) a) PLWHA and ART prophylaxis care form. b) Follow-up laboratory patient test form. c) Health expenses estimation form. d) Preventive action forms. Development of regulations on the use of the system a) Five workshops to prepare, validate b) Reproduction of regulations for SUMEVE and workshops to socialize them in all health sector institutions. ……	MOH, ISSS, BM, SM, FOSALUD, NGOs PR through Executive Unit regarding hiring, procurement, etc. ..... MOH ISSS Bienestar Magisterial
	…… 4.a.ii Create and implement the monitoring, evaluation, and epidemiologic monitoring network	…… …….. Pilot in three health sector establishments (MOH, ISSS and BM) to use standardized form to for HIV testing. Create 20 networks at institutional level for data gathering, entry, and information referencing, distributed in the country's 14 departments. By the third year expand thos functionss to 40 institutions.	MOH, ISSS, BM, SM, FOSALUD, RHESSA, NGO, Ministries of labor, Education CONASIDA Agencies, Civil society
	…….. 4.a.iii. Staff training on system use	Strengthen technological capacity at remote sites. a) Purchase computer and communications equipment. b) Fund remote data gathering points via Internet (pay for fast, high security channel) c) Provide for maintenance services Strengthen the central IT unit at MOH, where the centralized database will store data gathered on HIV/AIDS a) Enhance band width (service payment) b) Fund links to remote capturing points c) Database storage server Operational capacity strengthening. a) Staffing for data entry and supervision (salaries to be gradually absorbed by MOH). b) Reproduction and distribution of forms, etc. …… ……..	PR through Executive Unit regarding hiring, procurement, etc.

	…… 4.a.iv. Formalization of links to SUMEVE from institutions contemplated in the National Strategic Plan (NSP).	Spreading and implementation of the new epidemiologic monitoring, evaluation and surveillance system a) Training (users, IT staff, regional supervisors, etc.—see detail in budget) b) Analysis workshops (2 annually by region) with training in data triangulation coming from different sources. c) Evaluation meetings (one per region each year and one national with the entire health sector) Training/orientation of regional supervisors/ trainers and part time data entry staff Routine data gathering for services provided to the population through health services trained in service and monitoring in form filling, flow of information Courier services to transport forms to data entry points	PR through Executive Unit regarding hiring, procurement, etc.
	…….. 4.a.v Special studies	…… Agreements to use the epidemiologic monitoring, evaluation, and surveillance system, especially with ministries, NGOs, donors, cooperation agencies contemplated in the STI, HIV/AIDS Prevention and Control Strategic Plan. Technical assistance by MOH to all government and non-government institutions for the use of SUMEVE system Annual meetings to review and evaluate progress in national program implementation and results. a) 1 annual meeting with government and non-government institutions to prepare health expenses report (preventive, curative, and social support) b) Preparation and reproduction of reports for distribution.	…… MOH, National Education Committee
…….. SDA 4.b Strengthen professional training for the health sector.	…… 4.b.i Improve preparation and updating of human resources for the health system	…….. Conduct surveys in health establishments and among target population every two years for baselines and quantitative evaluations. Baseline and quantitative evaluation studies: with PLWHAs (on quality of life), in health establishments (on quality of care), in schools (impact of messages on children and adolescents) and in companies (on discrimination, etc.) Three operational research studies on: adherence, link between prevention and treatment, and costs. Implementation of watchdog vigilance on STI in 5 health establishments and in high risk populations (MSM, SW, etc).	

		Prevalence study of HIV in child victims of sexual abuse. Study on the impact of actions carried out with inmates. Situation of orphan girls and boys infected and affected by HIV/AIDS. Evaluation of knowledge, attitudes and practices among youth and adolescents about HIV/AIDS. …… Situation/needs analysis on professional training of human resources in STI/HIV/AIDS area within the health sector. Create and support a National Education Committee to improve and standardize curricula of staff training schools regarding sexual and reproductive health, STI/HIV/AIDS prevention and care, and social protection of PLWHA. Strengthening of opportunities for continuing professional training of human resources on STI/HIV/AIDS area: specialization programs, specific courses, congresses and events, among others. Annual recognition to five outstanding entities in the fight against HIV/AIDS for excellence in preparation, services, and results.	

(b) **Target groups**

Provide a description of the target groups (and, where relevant, the rationale for inclusion or exclusion of certain groups). In addition, describe how the target groups were involved during planning, implementation and evaluation of the proposal prior to submission to the Global Fund. Describe the impact that the program will have on these group(s).

Target groups match population priorities in the National Strategic Plan. It focuses on the most vulnerable populations or those with high infection load. For Objectives 1 and 3, the target groups are the PLWHA. The nine target population prioritized by prevention (Objective 2) are school adolescents and youth, especially those that are threatened with exploitation and sexual violence; men that have sex with men (MSM); sex workers (SW); inmates; migrants (mobile workers, frequently undocumented and in overcrowded conditions); uniformed staff (police, military); street children and youth; gang members; and pregnant women (see estimated numbers 2008-20012 in Annex HIV/8). To a lesser extent, the country's entire population will be the target for general messages in some IEC campaigns.
Members of these groups, both those that participate in the CCM (country MCP) and those not represented directly, but that in many cases do participate in the permanent consultation tables, have had a role in preparing this proposal, beginning with its original formulation for Round 6. These groups, through their representatives in meetings and workshops, have had a strong influence in the formulation and orientation of objectives, activities, and methods.

The National HIV/AIDS Program has projected estimates of the populations sizes of the main target groups (PLWHA, MSM, TS, inmates, youth, and pregnant women) using UNAIDS methodologies. These projections are found in Annex HIV-8. There are no reliable data on gang members or street children; numbers estimated by government agencies are used.

- **People Living with HIV/AIDS (PLWHA)** are the focus of activities in objectives 1 and 3. They not only live with the infection and their risks, but also suffer directly the social impact. They are the target of activities to promote social protection, reduce stigma and discrimination, as well as to provide opportunities to live productive lives and with better quality. They are also the subject of integral care and access to ART. The purpose is to contribute to improve their quality of life; at the same time activities are aimed at supporting the family, especially their children. To be able to monitor aspects regarding gender equality, PLWHA data was segregated by sex.

- **Men that have sex with men (HSH)** is also one of the most vulnerable groups because of their sexual practices and the high level of discrimination to which they are subjected. Often they are mistreated and ignored in health centers, workplaces, etc. They are estimated at 83,000 people (UNAIDS 2003). According to studies in El Salvador, HIV prevalence among this population is 17.7%.

- **Sex workers (SW)** are considered one of the most vulnerable group because of their occupation, social discrimination, poverty conditions, the low level of schooling, their exposure to violence, exploitation and abuse, sexual relations many times are forced and without protection. Their number is estimated at 27,434. HIV prevalence in this population group varies according to geographic location from 3.6% to 16%. SW data will be kept segregated by sex.

- **Pregnant women** are another priority group, considering the fact that at national and international levels the feminization of the epidemic occurs and thus increases the risk of vertical transmission. Prevalence among pregnant women was registered in 0.14% in 2001 and fell to 0.10% in 2006.

- **Adolescents and youth, both women and men**, given the characteristics of their bio-psycho-social development and the environment they are in, generate demands and needs that are not currently met. Thus they are exposed to risk, violence, school dropout, early onset of sexual relations, teenage pregnancies, drug addiction, etc. Many are in school and can be reached through Ministry of Education programs and their collaborators.

- **Street youth and children** are another group with high level of risk and vulnerability, not in schools and imperfectly known in the country, which demand prioritized care. Some of them alternate between the street and their homes (frequently abusive). Others permanently sleep in the street; these are estimated around 2,000.

- **Gang members** are mostly youth or children in vulnerable situation and high level of risk. Several NGOs and public programs work with them, estimating their numbers at 8,000.

- **Inmates, men and women** are, by their imprisonment situation, at risk of HIV, since many are forced to have sexual relations, often unprotected, within the penitentiary and with their visiting partners. In El Salvador this population has grown to 15,600 plus a similar number of external contacts.

- **Mobile/migratory workers** are in more vulnerable conditions than non-mobile population. Many live temporarily in farms and other temporary workplaces. They may have casual sexual relations and carry the infection to their homes, they face more obstacles in accessing health services because of their mobility and lack of documentation, and the tend to have weakened support networks.

- **Uniformed population** (army, police) is a group in vulnerable conditions due to risk behavior identified in some studies, associated with the characteristics of their jobs, cultural stereotypes, the construction of masculinity, and other socio-cultural factors. Prevalence among National Civilian Police population (PNC) was 0.3%.

A suite of strategies to reach each of these populations has been developed. Among the main approaches are working through PLWHA groups and NGOs, using peer approach and education methods adapted to the needs of each group (MSM, SW, youth, prisoners, gang members, street children, mobile and uniformed populations). Design and implementation of approach strategies relies heavily on inputs from members of the group. The use of mobile units in coordination with local peer campaigns has greatly increased effectiveness. One of the most basic strategies is to improve the training, sensitivity, and response of health clinic staff who have diect contact with incoming clients on HIV/AIDS and can address their needs and issues most effectively.

(c) **Equitable access to services**

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

The need for equity is taken in consideration very explicitly, both regarding the universal access principle as well as regarding the integrated treatment/care approach. Inequality in the risks faced is acknowledged, as is access and quality of services against geographic, economic, gender, and factors such as belonging to marginalized groups that often are at high risk. Thus, efforts are made to provide services in a way that ensures access to discriminated groups. For example, with 86% of coverage for pregnant women, coverage expansion is aimed mainly at rural and slum areas where women may not go in for prenatal exams. Clinical protocols set forth criteria to start antiretroviral therapy (ART), with resource allocation to achieve treatment adherence by poor people that receive ART, as a “Staple Foods Basket” to improve individual and family nutrition; or delivery of maternal milk substitutes for babies born to HIV positive mothers.

(d) **Social inequalities targeted in this proposal**

Describe how this proposal addresses the needs of specific marginalized groups in the country/countries targeted in this proposal. *For example, if your proposal targets a gender, age-group or other demographic presently excluded or underrepresented in existing service delivery activities, identify this and describe how the group(s) will be targeted.*

Please ensure that you include appropriate targets and indicators to monitor performance against these strategies in '**Attachment A**' (Targets and Indicators Table).

See also 4.6.3.b and 4.6.3.c. Proposed activities will reduce social inequalities by facilitating access to groups traditionally discriminated and thus more vulnerable, as are women, youth, residents of rural areas, mobile/migrant populations, sex workers, men that have sex with men, inmates, gang members, street children, and PLWHA.

By reaching individuals that do not usually go to the Health System, active search activities of new cases through mobile units or through community organizations will reduce social inequality regarding the opportunity of taking diagnostic tests and to have access to support and treatment programs.

(e) **Stigma and discrimination**

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

The proposal as a whole is aimed at reducing stigma and discrimination. Objective 1 focuses on developing the ability of PLWHA to start a productive and active life. For this, an important activity is the sensitization of not affected sectors, such as business people, national and local government offices, and communities, about the transmission of the infection and the rights of PLWHA, to be able to appreciate that there are no reasons for discriminating or creating stigma against them. In addition, this objective contemplates IEC activities through mass media to inform and sensitize the general population. It also will train PLWHA groups in rights oriented approaches and social auditing, enabling them to defend themselves. Objective 2 contemplates prevention training activities aimed at leaders and key staff in institutions and companies, as well as information through mass media about the way the infection is transmitted and the mistaken beliefs that lead to discrimination of PLWHAS. Objective 3 will address the stigma and discrimination in health system, with training aimed at at health and support staff and volunteers. Addressing stigma and discrimination will also include the families of PLWHAs, since that is one of the most important aspects regarding acceptance and rejection that affect the quality of life of the PLWHA.

Linkages to other programs

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

(a) If this proposal is asking for support for the same "Key Services" or interventions supported by earlier Global Fund grants (including unsigned Round 6 grants), explain in **detail** why.

*Applicants should specifically refer to the Programmatic Gap Analysis Table in section 4.4 when completing this section, and clearly indicate if the goals, objectives and service delivery areas in this proposal represent an **expansion of planned outputs and outcomes** already supported through earlier Global Fund grants, **complementary** but not overlapping interventions, or **new and independent** interventions. Applicants are strongly encouraged to include a diagram to explain expansion-focused interventions where relevant.*

Applicants are strongly encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants (including 'Phase 2' amounts anticipated to become available) in this section. The reason(s) why a Round 6 grant remains unsigned at the time of submission of this proposal should also be explained.

Objetives 1 and 4 break new ground that was not part of the R2 project, though they build on that work and on the preconditions that were met (like the vetting of the social protection services concept with the PLWHA organizations, and the development and pilot testing of the computer programs and data gathering instruments for the on-line M&E system).

The focus on quality of life is an innovation born in the heat of the PLWHA consultations, when it became clear that the medical treatment and care under Objective 3 would not be enough. The focus on implementing SUMEVE was similarly born of a consultative process, this one with all the institutions of the health sector. Both were carried out as part of institution building and planning initiatives under R2.

The other two Objectives consist of interventions based on those of R2, but that represent extensions rather than repetitions. Coverage is extended to new at-risk populations (e.g., gang members, street children, uniformed personnel) and to new areas of the country (with development of six new integrated care/ART centers and the addition of a mobile unit to reach areas previously lacking access), with increasingly active, targeted screening for new cases and better support of adherence (via greater involvement of PLWHA groups and community volunteers). Goals have been correspondingly increased.

For example, in R2 screening with rapid tests was increased from less than 100,000 per year to more than 250,000 (2007). Now it will be raised to 360,000 (2012; see section 4.4.1) and aimed more precisely at the nine prioritized target populations, using a combination of methods (peer facilitators, mobile units, better trained health center workers, better targeted IEC campaigns, etc.). Further descentralization of facilities and capacity will facilitate service to remote locations far from the capital

city, so that fewer PLWHAs have to choose betseen disrupting their lives and getting treatment.

In regard to vertical transmission, which under R2 fell from over 80% to under 20%, the new goal will be to reach a level of less than 8% transmission.

Pilot experiences under R2 with MSM, SW, and inmates have given rise to proposed interventions that are much more ambitious and more effectively targeted, using PLWHA support groups and NGOs to change behaviors, lower incidence, and insure adherence, lowering prevalence where previously the goal was merely to slow the rate at which it was rising.

The development of universal access to ART and of integrated treatment and care protocols during R2 provides the basis for proposing now to carry through to the rest of the country, to improve capacity to follow up on HIV cases and get them into treatment when they should (especially those who move to another place—currently too many drift out of sight and come in for ART at a late stage), to descentralize more and improve capacity to treat ARV patients near their homes, and to increase the options for treatment of opportunistic infections. The MOH has increased its financial share to over 70% of the costs of medication; this R7 application is for funding to cover new cases only.

In sum, the R7 proposal builds on the achievements and lessons learned from R2, which will be finished in early 2008, but proposes not to repeat them but to go beyond

(b) Where there are any linkages in this proposal to planned interventions already supported by Global Fund grants, **describe, by reference to information generated in regard to those existing grants**,** how implementation bottlenecks and lessons learned have been incorporated into the implementation strategy for this proposal to better ensure the overall feasibility of the planned interventions*(maximum one page).*

*(**Applicants should refer to, for example, the most recent 'Progress Updates and Disbursement Requests' from a Principal Recipient, or the 'Grant Scorecard' published by the Global Fund after a grant has completed Phase 1.)*

Objetives 1 and 4 break new ground that was not part of the R2 project, though they build on that work and on the preconditions that were met (like the vetting of the social protection services concept with the PLWHA organizations, and the development and pilot testing of the computer programs and data gathering instruments for the on-line M&E system).

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follow up on HIV cases and get them into treatment when they should (especially those who move to another place—currently too many drift out of sight and come in for ART at a late stage), to descentralize more and improve capacity to treat ARV patients near their homes, and to increase the options for treatment of opportunistic infections. The MOH has increased its financial share to over 70% of the costs of medication; this R7 application is for funding to cover new cases only.

In sum, the R7 proposal builds on the achievements and lessons learned from R2, which will be finished in early 2008, but proposes not to repeat them but to go beyond

4.6.5	**Performance of and Linkages to other donor funding for the same disease**
	Provide an overview of the main achievements (in terms of outcomes and impact on the disease) which are planned over the same term as this proposal through the support of other external donors, whether bilateral or multi-lateral. Also describe if there are any major bottlenecks to implementation in those grants/programs which may be relevant to the implementation strategy for this proposal, and if so, what steps will be taken to mitigate such challenges.
	There is no overlap with projects approved by other donors; but there is complementarity. For example, substantial amounts of media time will be donated by the private sector to accommodate IEC programming to be developed under R7. The majority of comdoms distributed will continue to come from PASMO and other private sector sources; most international technical assistance will continue to be underwritten by PAHO/WHO and UNAIDS. No obstacles to this sort of collaboration have emerged.

Private Sector Contributions

4.6.6	**Private Sector contributions**
(a)	If the Private Sector is intended to be a contributor/co-investor to the overall objectives of this proposal, describe below a summary of the main contributions *(whether financial or non-financial)* anticipated from the Private Sector during the proposal term, and how these contributions are important to the achievement of the outcomes and outputs. ➔ *Refer to the 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 purpose is to receive contributions from the private sector similar to those in the list of the next section (4.6.6.b). Most are modest and many are in kind; often they are material and other support to work with employees of the same businesses. This is a way to educate and involve companies and their leaders in the fight against AIDS. Contributes to a wider reproduction of messages, when business people and employees share experiences with their peers and families, motivating other companies and groups to participate in similar activities. It also contributes to sustainability, with companies willing to continue supporting their employees' education.

(b)	Refering to the population group(s) that will be the focus of the Private Sector co-investment partnership, identify in the table below the annual amount of the anticipated contribution. (For non-financial contributions, please attempt to provide a monetary value if at all possible, and at a minimum, a description of that contribution.)	
	Size of population group that is the focus of the Private Sector contribution ➔	Varies greatly depending on the particular situation. Mass media campaigns supported by empresarios transmit messages to millions. A small church that "adopts" a PLWHA is helping four to a dozen persons.
	Refer to Guidelines for examples on 'Contribution	**Contribution Value**

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Description' ** Add extra rows below to identify each main Private Sector contributor		(same currency as selected in section 1.1)					
**** Private Sector Contributor Name**	**Contribution Description** *(in words)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Unilever, several printing facilities, etc.	Reproduction of educational material and prevention protocols aimed at employees, etc.	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
APEX, TCS, ASDER and other advertising firms	Donation of radio, press, and television spots	$400,000	$400,000	$400,000	$400,000	$400,000	$2,000,000
ADOC, IUSA and other companies	School supplies, shoes, uniforms, etc., so HIV children may attend school.	$150,000	$150,000	$150,000	$150,000	$150,000	$750,000
PASMO (NGO)	Condoms and social marketing (external AID funds)	$2,900,000	$2,900,000	$2,900,000	$2,900,000	$2,900,000	$14,500,000
Fundation Inocencia	Supports children with HIV and families: shelters, transportation, clothing, staff incentives, etc.	$80,000	$80,000	$80,000	$80,000	$80,000	$400,000

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4.7 Principal Recipient information

In this section, Applicants should describe their proposed implementation arrangements, including the nominated Principal Recipient(s). See the Guidelines for Proposals, section 4.7, for more information.

Where the Applicant is a Regional Organization or a Non-CCM Applicant, the term 'Principal Recipient' should be read as the planned implementing organization.

The Applicant may nominate one or several Principal Recipients to lead implementation and undertake reporting to the Global Fund during the proposal term.

*To be eligible for funding in Round 7, CCM, Sub-CCM and RCM Applicants must ensure that each Principal Recipient has been **transparently selected** (refer to section 3A.4.5 of this Proposal Form)*

Table 4.7: Nominated Principal Recipient(s)

Indicate whether implementation will be managed through one or several Principal Recipients.	☐ One
	☐ Several

Responsibility for implementation			
Name of Nominated Principal Recipient(s)	**Sector Represented**	**Name of Contact person**	**Address, telephone, fax numbers and e-mail address of contact person**
Ministry of Public Health and Social Assistance(MOH)	Nominated for activities of the Objectives 3 and 4 and some activities del Objective 2	Dr. Guillermo Maza	Calle Arce No. 827, San Salvador, El Salvador Tel. (503) 2205 7000 jgmaza@MOH.gob.sv
United Nations Development Program (UNDP)	Nominated for Objective 1 and some Objective 2 activities	Sra. Jessica Faieta	3ª Calle Poniente 4048 Entre 77 y 79 Av. Norte Colonia Escalón San Salvador, El Salvador Tel. (503) 2263-0066 Fax: (503) 2263-3501 jessica.faieta@undp.org

4.8 Program and financial management

4.8.1 Management approach

Describe the proposed approach of management with respect to planning, implementation and monitoring the program. Explain the rationale behind the proposed arrangements.
(Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM, Sub-CCM, or RCM where relevant. Maximum one page.)

El Salvador Coordination Committee (CCE), as Country Coordinating Mechanism (CCM) organizes national initiatives in order to have access to Global Fund resources, based on the needs of El Salvador in relation to HIV/AIDS and Tuberculosis. To that end, the CCM has defined its organizational structure, bylaws and internal regulations, and their program and functional provisions.

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The CCM's organic structure includes a Political Advisory Office as a higher strategic element. The CCM is operated by a Secretariat, Permanent Consulting Table and a support Technical Committee for proposal preparation. The two nominees for Principal Recipient, the Ministry of Health (MOH, for both components) and the United Nations Development Program (UNDP, only the HIV/AIDS component), will become the program managers and act as CCM's executive entities.

To this end both MOH and UNDP have Program Executive Units with expertise from managing the Phase II of the R2 grant, coordinating the programmatic and financial areas. Both PRs have capacity to effectively and efficiently manage the project hereby proposed. The financial resources provided through the agreement will be managed based on the Global Fund's own provisions and regulations.

These Program Executive Units have mechanisms and procedures approved by Global Fund for contracting and transferring resources to Program components.

Financial processes are carried out by the accounting and financial units of each institution, according to current standards and regulations. This will bring about competent administration and detailed monitoring of the project income and expenses.

The Executive Units will define the budgetary components for the HIV/AIDS component. The MOH will be solely responsible for the Tuberculosis component. Each component has the managerial and technical resources to formulate and develop work plans, stating activities to be carried out and the required funding in established timetables to carry out the respective investment plan.

4.8.2 Principal Recipient capacities

*Please note that if there are multiple Principal Recipients, section 4.8.2 below **must be completed separately for each one**.*

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

Principal Recipient # 1:

MINISTRY OF PUBLIC HEALTH AND SOCIAL ASSISTANCE (MOH)

(PR for public sector, with links to communities and civil society)

The first Principal Recipient, MOH, has proven administrative and technical capability to assume the administration and financial responsibility for the Program through its Program Executive Unit that manages part of the present Global Fund in El Salvador (R2) program. Its performance has been rated "A", according to Global Fund evaluations.

It has experience in developing the procedures established by the Global Fund, receiving this technology transfer for the prior Executive Unit in 2006 and beginning of 2007. Starting in January 2007 it has been in charge of the two program components (HIV/AIDS and TB), with the development of all related activities and processes. It coordinates joint execution of legal actions with the Institutional Procurement and Contracts Unit (UACI) in MOH and with CCM.

Administrative activities linked to the procurement of goods and hiring of services will be based on the work plan for each component (HIV/AIDS and TB) according to which the bidding, evaluation, and award recommendation, contracting and payment processes will be carried out.

The good performance of the PR is due substantially to the leadership of its staff. Among them:

- General coordination is the responsibility of a physician with clinical, epidemiological and administrative experience in the TB and HIV/AIDS components.
- The project procurement and purchasing processes are the responsibility of a prominent and qualified Business Administrator.
- The financial area is the responsibility of a professional Administrator-Accountant.
- The Monitoring Unit is under the charge of a prominent Information Engineer, with Post Graduate degree in WEB pages and Navigation.

Other specialized units in the Ministry also support the Executive Unit, including External Funding Unit, External Cooperation Unit, Accounting, Information Technology, Engineering, and Transportation, as well as the Administrative Directorship that helps with storage and maintenance.

One of the aspects that the MOH has been able to contribute due to the fact of being a government instance, is the reconciliation of policies and regulations established by the Global Fund with the laws and regulations applicable to the management of the country's financial resources.

(b) Has the nominated PR previously managed a Global Fund grant?	x☐x Yes
	☐ No

If yes to (b), explain the rationale for nominating the same PR(s) to manage the activities in this proposal.

The successful performance of the Executive Unit, reflected in the positive evaluations by Global Fund, and the close technical relation with the program's technical team justify continuing with the MOH as Principal Recipient.

(c) Is the nominated PR currently managing a large program funded by another donor?	☐ Yes ☐xx No

(d) Identify the total budget (current and planned) under management by **each nominated Principal Recipient**.

The above grant for the two joint components reached the amount of approximately $7 million annually in the first years, but currently it has been reduced. This year the budget for the HIV/AIDS component is $1,948,488 and $473,286 for the TB component, for a total of $2,421,774 (2007). Of that amount, the MOH Executive Unit manages $2,421,774 million.

The planned budget for R7 for both components is $31 million, of which $214 million is for the HIV/AIDS component. Of that, MOH would handle about 65% (just under $16M) and UNDP about 35% (just over $8M).

Regarding the MOH, the amounts of medication to manage and distribute for TB and HIV/AIDS components are modest in comparison with the amounts managed by the public health system as a whole and will not present a major challenge.

(e) Describe the performance history of the nominated PR in managing these programs/grants.

Specifically, where the nominated PR(s) management of a prior program/grant has not been fully satisfactory, describe the changes that will be made to the implementation arrangements by the PR under this, and the earlier grants, to ensure more consistent, transparent and effective performance towards the planned outputs and outcomes.

MOH Executive Unit was conceived to strengthen the administration of Global Fund's grants from a perspective of expediting the management of national legal and administrative frameworks, and a major link with Program's technical area. It started operations in January 1st, 2007, after a period of observation, learning and technology transfer with the prior PR, UNDP. The UNDP will continue as PR, now with emphasis on activities that require hiring consultants and sub-recipients.

(f) Describe how the Applicant has satisfied itself **(including by reference to any assessment criteria)** that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a **transparent, efficient and timely manner**.

Global Fund has continued to rate MOH's Executive Unit management with a deserving "A". It has prepared a development plan in order to address an increase in demand.

While returning to levels above $6 million a year, the Executive Unit will adapt easily. It has planned an expansion in management capability by hiring six more people, three management technicians and three in general services (secretary, janitorial, transportation), as well as technical training for the staff. Equipment and physical space will be readapted to accommodate this growth.

The TB and HIV/AIDS National Programs and the CCM are completely satisfied with the MOH management as PR of the current Global Fund project.

4.8.2 Capacidades del Receptor Principal

Tenga en cuenta que si son varios los Receptores Principales, la sCCMión 4.8.2 deberá rellenarse tantas veces como receptores haya.

(a) Describa las capacidades técnicas, gerenciales y financieras destacables de cada Receptor Principal ("RP") designado. Describa también cualquier inconveniente técnico, gerencial y financiero que se prevea que estos mecanismos puedan tener y cómo se abordarán. Indique las evaluaciones de los RP que se hayan hecho para el Fondo Mundial o para otros donantes (por ejemplo, fortalecimiento de la capacidad, requisitos de personal y de formación, etc.).

b. Receptor Principal # 2:
United Nations Development Program (UNDP)

(RP para sector no gubernamental: sociedad civil y sector privado)

The second Principal Recipient, UNDP, has its own organizational structure, policies, and procedures guiding the day-to-day operation of the institution. Its financial systems are corporate systems and are the basis for sending information to headquarters. The field operations manual is regularly updated to reflect changes at the world level.

The operations manual is divided in sections, with two main ones: the program and the operations sections. Each section establishes the policies and procedures to be followed at the corporate level, but does not prevent the existence of local-level procedures that support the transparency of its operations.

Currently, it counts on its own team of auditors that provide support to and verify that the activities carried out are within the policies and procedures of the institution. Every two years, or when the auditors require so, the matrixes for the segregation of functions are updated, to ensure that conflicts or irregularities are not generated at the internal level. It has a comprehensive enough chart of accounts to classify all areas of program and operative attention.

It has its own vehicle fleet and the essential furniture and equipment to carry out its activities.

Its income basis is through sponsorship and donations, with the first one prevailing. This allows for labor stability and continuity in its programs.

It has a department of national consultants in the program area that verify that its activities are carried out within the strategic Plan approved by headquarters, and that carry out appropriate evaluations in the projects that are under their area of specialization.

1.1.1 (b) ¿Ha administrado el RP alguna subvención del Fondo Mundial con anterioridad?	X☐X Sí ☐ No

Si la respuesta a (b) es afirmativa, indique la justificación de la designación del mismo RP para gestionar las actividades de la propuesta.

UNDP has been operating as Principal Recipient of the funds of the previous grant from the Global Fund (Round 2) with positive evaluations. The Global Fund has evaluated the performance of the Executing Unit of UNDP with ratings of "A". This successful performance, along with positive evaluations from the CCM and the technical team of the HIV/AIDS Program justify that UNDP continues as a Principal Recipient.

(c) Is the nominated PR currently managing a large program funded by another donor?	(c) Is the nominated PR currently managing a large program funded by another donor?

(d) Identify the total budget (current and planned) under management by **each nominated Principal Recipient**.

In Round 2, UNDP managed around $ 20 million (2003-2008) and the MOH, $2 million (2007-2008). For Round 7, it is anticipated that UNDP will manage around $8 million and MOH around $16 million.

(e)	Describe the performance history of the nominated PR in managing these programs/grants. **Specifically**, where the nominated PR(s) management of a prior program/grant has not been fully satisfactory, describe the changes that will be made to the implementation arrangements by the PR under this, and the earlier grants, to ensure more consistent, transparent and effective performance towards the planned outputs and outcomes.
Previously, UNDP was the sole PR (= BP) of the grant from the Global Fund to El Salvador, ($22 M, 2003-2008). Its performance was satisfactory, eraning good ratings in GF's evaluations. However, to build national managerial capacity and to get the Executing Unit closer to the technical persons in charge, it was decided to design a second PR – the Ministry of Health – as of January 2007. PNUD continues executing a good part of the grant from Round 2 of the GF.	
(f)	Describe how the Applicant has satisfied itself **(including by reference to any assessment criteria)** that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a **transparent, efficient and timely manner**..
PNUD managed the entire grant from Round 2 with good results without the support of another Executing Unit until 2007, managing funds for up to $7 million per year. This is higher than the level anticipated for the management of UNDP of the grant requested in Round 7.	

4.8.3	**Sub-Recipient information**	
(a)	Are sub-recipients expected to play a role during the term of the proposal? *(Only in the very rarest of cases would the Global Fund expect there to be no sub-recipients.)*	x☐x **Yes** ➔ ***complete the rest of 4.8.3***
		☐ No ➔ *go to 4.9*
(b)	How many sub-recipients will or are expected to be involved in the implementation?	☐ 1 – 5
		x☐x 6 – 20
		☐ 21 – 50
		☐ more than 50
(c)	Have the sub-recipients already been identified?	☐ Yes ➔ *complete 4.8.3. (d) –(e) and (f) and then go to 4.9*
		x☐x No ➔ *go to 4.8.3. (g) – (h)*
(d)	Describe: (i) The **transparent** process by which sub-recipients were identified, the rationale for the number of sub-recipients **and the criteria** that were applied in the identification process. (ii) Referring to sub-paragraph (b) above, describe the past implementation experience of sub-recipients who will **either** receive a significant proportion of the funding from this proposal **or** who will be involved in on-granting of funding to sub-sub-recipients *(Also identify significant potential bottlenecks to **transparent strong performance** by these sub-recipients, and actions that will be taken by the PR during implementation to alleviate such risks).*	
N/A		

4 Component Section *HIV/AIDS*

(e)	**Attach a list of sub-recipients** that have been nominated, which includes: (i) the name of the sub-recipient; (ii) the sector they represent (civil society, NGO, private sector, government, academic/educational etc); and (iii) by reference to table 5.2 in the budget section, the primary service delivery area(s) relevant to their work under the proposal. **Below** please **comment on the relative proportion of interventions** that will be undertaken by sub-recipients outside of the government and the reason for this apportionment of work. *(maximum two pages).*
N/A	
(f)	**Only if relevant, describe why sub-recipients were not identified prior to submission of the proposal**. *(Applicants are reminded that only in rare cases should sub-recipients not be identified. The identification of these key implementation partners assists the assessment of implementation capacity and feasibility.)*
To formally select sub-recipients under the funding of R7, a transparent process is required governed by legal and administrative standards established in the country and the Principal Receptor. This cannot be accomplished until the formal approval of the Receptor Principal is received, on negotiating the Global Fund grant. Once the grant contract is signed, the PR Executive Unit will organize the respective competition and will supervise the selection process of sub-recipients. However, the process has progressed informally. To formulate this proposal, a public invitation was made to health sector organizations, including those that work at community level, to get to know the project and to submit their insights. As a result, two NGOs networks responded and their members could opt to apply as sub-recipients under Objectives 1 and 2 (see list in Annex HIV-4). Suggestions from these networks on the project design have been incorporated. The target population has been currently addressed with the purpose of ensuring their interest and participation, defining exact places and scope of the work and to establish the technical basis for an impartial and transparent selection process during the first year of the project.	
(g)	**Where sub-recipients have not been identified prior to proposal submission**, **describe in detail the process that will be used to select sub-recipients** if the proposal is approved. Include details of the criteria that will be applied in the selection process, the timeframe during which that selection process will take place, and why the Applicant believes this selection process will not adversely impact planned outputs and outcomes during the initial two year period of any grant which is approved.
During the first project semester work with local population and PLWHA leaders will take place in prioritized communities to determine the level of interest, to measure key knowledge, attitudes, and practices (baseline) and to define communication and educational needs, as well as community work, and social mobilization needs. This will allow the preparation of terms of reference and to invite NGOs to participate in bids with specific proposals to cover different areas. A selection process governed by the PR Executive Unit and supervised by the CCM (MCP), following the corresponding administrative and legal guidelines will designate the sub-recipients. They will be incorporated in the second project semester, or later as needed.	

4 Component Section *HIV/AIDS*

4.9 Monitoring and evaluation framework

The Global Fund encourages the development of nationally owned monitoring and evaluation (M&E) plans and M&E systems, and the use of these systems to report on grant program results in the overall context of country priorities and movement towards reaching the Millennium Development Goals. When completing the section below, applicants should clarify how and in what ways monitoring and evaluating implementation of the work supported by this proposal relates to existing data-collection efforts.

Applicants are strongly encouraged to refer to the M&E Toolkit when completing this section.

4.9.1 Monitoring and evaluation plan

Describe how the data relating to performance against planned outputs and outcomes set out in the 'Targets and Indicators Table' *(required to be annexed as 'Attachment A' to your proposal, see section 4.6)* will be accurately collected, collated and reported by implementing partners during the proposal term to the Applicant (if CCM, Sub-CCM or RCM), the Global Fund and the body responsible for national monitoring and evaluation.

Please also identify any surveys which are planned to be supported (in whole or part) by the funding requested in this proposal, the rationale for such surveys, and how the surveys (and their outcomes) support and feed into single national data collection systems.

(Where a National M&E plan exists, Applicants may attach this to their application as a clearly named and numbered annex.)

The National STI/HIV/AIDS Program (PNVIH/S) responsible for the epidemiologic monitoring and of keeping records since the appearance in El Salvador of the first AIDS case in 1984. Under the 2006-2010 HIV/AIDS National Monitoring, Evaluation and Epidemiologic Surveillance program, the PNVIH/S consolidates the information generated by the Ministry's health establishments, as well as of the other institutions of the health sector in the country. Once the information is consolidated, it undergoes a quality control process: duplicity of cases is checked, excluding known cases. All the information is entered into Epi-info 2002. Once the analysis of the information takes place, epidemiologic reports and bulletins are generated, which are distributed to different public and private institutions.
Other sources of information are:

- ✓ The General Statistical and Census Directorship (DIGESTYC) responsible for reporting the country's vital statistics.[8] The reports consolidate the total number of deaths reported by the 262 municipalities in the country; this information is available up to one year after the closing of the calendar year.
- ✓ The new MOH's Morbidity/mortality System via the Web, which operates since 2005 in the 30 hospitals of the Ministry of Health. In that year only institutional hospitalizations and deaths were recorded, and since 2006 all ambulatory care is incorporated to the registry.
- ✓ AIDS Expense Measurement study (MEGAS), which studies the funding and expense in HIV/AIDS care. These data show that El Salvador is a country with limited budgetary resources in the health area, worsening its situation regarding the HIV/AIDS issue. This epidemic's care and prevention competes with financial and human resource allocation and with other priority health programs also (e.g., vaccination, mother-infant control, dengue).

The National Program has started strengthening this information registry and has developed an automated system for HIV/AIDS epidemiologic monitoring, evaluation and surveillance, with the objective of improving the response to the needs of the health system and international commitments, as well as to support the decision making, the design and implementation of HIV/AIDS care and prevention policies.

This system in addition to having a registry on HIV/AIDS morbidity and mortality will also have a sub-system to register prevention activities. Both registries will enable the segregation of data by sex. This will facilitate the processes of integrating activities, products and the country's indicators based on the 2005-2010 National Strategic Plan (NSP). The NSP consists in a description of the status quo, the

[8] http://www.digestyc.gob.sv/

working concepts, and the model of implementation under the Three Ones and Access Universal.

For the implementation and follow-up of the new National Monitoring, Evaluation and Epidemiological Surveillance System, (SUMEVE) a national Sub-Commission has been created, administratively dependent of CONASIDA and technically of the National STI-HIV/AIDS Program.

Among the Institutions that currently form the Sub-commission are the PNVIH/S, local UNAIDS, Global Fund (AIDS-TB), PAHO/WHO Local and Regional, PREVENSIDA, Ministry of Education, ISSS, Military Sanitation, National Youth Secretariat, UNFPA, Social Central American Integration Secretariat, (SISCA/SICA-Regional HIV/AIDS Project), the units of Epidemiology, Health Information and the National Tuberculosis Program, all in the MOH. The objective is to monitor and evaluate the achievement of the NSP's general goals. The sub-commission's functions are to standardize policies and guidelines on monitoring and epidemiologic monitoring for sectors involved in HIV response and to support the institutional strengthening in these processes, with the purpose of providing decision makers with timely and valuable data.

The National Monitoring and Evaluation Plan is based on programmatic objectives and goals already defined in the NSP and in the UNAIDS documents referring to monitoring of an epidemic in low prevalence countries. The National Plan establishes the country's information gathering mechanisms (MOH, ISSS, Military Sanitation, PNC), other Ministries (MINED, GOVERNANCE, LABOR, among others), private entities, NGOs and cooperation agencies, to provide timely epidemiologic information and report the HIV/AIDS and other STI prevention, care and control actions. A more timely and precise data gathering system is in the pipeline.

To have a timely on-line information system that will comply with 3 of the 8 strategic Objective (5, 6 and part of 2) contemplated in the 2005-2010 National Strategic Plan, it is necessary to have data gathering mechanisms and human resources to implement such a plan. This will require data entry staff and supervisors, proper Internet services and computer equipment in some place.

To implement the National Monitoring and Evaluation Plan, the following processes have already started:

- Monitoring, Evaluation and Epidemiologic Surveillance Sub-commission, already formed and is operated by several institutions from different sectors,
- The Monitoring and Evaluation Unit: team formed.
- Development of the SUMEVE system to share strategic information is in progress. This will require hiring the necessary human resources to enter data, field supervision, and adequate locations, Internet service contract, and computer equipment.

In addition to these processes, three more will be implemented by the proposed project:

- Preparation of SUMEVE regulations.
- Spreading of the Plan at national level.
- Training on Monitoring and Evaluation and use of the health sector system, other government entities, and NGOs that work in the fight against AIDS.

It is important to highlight that the software for the new system is ready—there is no need to pay for consultancies to update it or to purchase additional licenses.

4.9.2 M&E Systems Capacity Assessment

Where there is no National M&E plan **or** the work anticipated under this proposal is anticipated to place additional burden on existing national, regional and/or sub-regional M&E systems, **Applicants are strongly encouraged to review the '*M&E Systems Strengthening Tool*' and provide, in only a summary format below, a description of the major gaps identified and how this proposal incorporates a plan to overcome those gaps to support an effective monitoring and evaluation framework in the country.**

In particular, Applicants should comment on how gaps and potential/actual bottlenecks identified that are relevant to this proposal will be managed or mitigated during the proposal term. Budgetary implications arising from this assessment should be included in the budget information required in section 5.

The Global Fund recommends that between 5 to 10% of the total component budget is utilized to strengthen M&E systems.

The National Monitoring and Evaluation Plan has prioritized impact indicators and processes comparable to those of other countries, based on guidelines of the UNAIDS M&E Toolkit (2006). They need to be operated throughout the entire health system.

DATA GATHERING AND ANALYSIS

The data gathering and analysis is done in different ways by the different institutions and not uniformly, inconsistent throughout the system and time. Certain capabilities are missing, for example maintaining data segregated by gender, cleansed data from the deceased in the PLWHA list or provide personalized follow-up to patients that use more than one health establishment.

The implementation of SUMEVE will remedy this situation. Workshops will be held on data gathering, and standardization of information gathering from the different system components,

- a local epidemiologic monitoring, evaluation, and surveillance network will be formed and implemented,
- human resources will be trained on system use,
- data entry staff and field supervisors will be hired, Internet service will be contracted, increasing bandwidth and transmission security, to the benefit of the MOH network, and
- the SUMEVE link with other ministries, NGO, donors, and cooperating agencies contemplated in the Strategic STI/HIV/AIDS Prevention and Control Plan will be strengthened.

The analysis of the information gathered by SUMEVE, will be carried out by the Monitoring, Evaluation and Epidemiologic surveillance unit.

DATA SPREADING

There is a nationwide data spreading plan, of basic data available in a timely and transparent way. Periodic meetings are scheduled to this end and spreading is done through written reports, including via the Web. The SUMEVE will feed into and systematize the spreading of key information on the changing face of the epidemic in the country, the efficient national response and the risks and emerging topics.

SPECIAL STUDIES

Currently, studies are carried out on a customized basis. The SUMEVE will put order into that process, conducting priority results/evaluation studies, qualitative studies according to need and required operational research to improve the performance of the health system.

4 Component Section *HIV/AIDS*

4.10 Procurement and supply management of health products

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

4.10.1 Roles and responsibilities for procurement and supply management of health products

(a) In the table below, describe the planned roles and responsibilities for procurement and supply management.
If a function is planned to 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 MOH Department of Disease Control, or MOF, non-governmental partner, technical partner).*	In this proposal what is the role of the organization responsible for this function? *(Identify if PR, SR, Procurement Agent, Storage Agent, Supply Management Agent, etc).*	Indicate if there is need for additional staff or technical assistance
Procurement policies & systems	MOH/ UACI; UNDP	RP/controllor; RP	X☐ Yes ☐ No
Quality assurance and quality control of pharmaceuticals	MSPAS/UTMIN	ente controllor	X☐ Yes ☐ No
International and national laws (patents)	MOH/UACI; UNDP; PAHO	RP; RP; purchase agent	X☐ Yes ☐ No
Coordination	MOH; UNDP	RP; RP	☐ Yes X☐ No
Management Information Systems (MIS)	MOH/PNVIH/S	RP/purchase agent	☐ Yes X☐ No
Product selection	MOH/PNVIH/S	RP/technical mgmt	☐ Yes X☐ No
Forecasting	MOH/PNVIH/S	RP/technical mgmt	☐ Yes X☐ No
Procurement and planning	MOH/PNVIH/S	RP/technical mgmt	☐ Yes X☐ No
Storage and Inventory management	MOH/UTMIN/PNVIH/S /Stores	RP/technical mgmt	X☐ Yes ☐ No
Distribution to other stores and end-users	MOH/PNVIH/S Warehouse	RP/technical mgmt	☐ Yes X☐ No
Ensuring rational use	MOH/PNVIH/S / SUMEVE	RP/technical mgmt	☐ Yes X☐ No

(b)	Briefly describe the organizational structure of the unit with overall responsibility under this proposal for procurement and supply management of health products, including medicines. Indicate how it coordinates its activities with other entities such as the National Drug Regulatory Authority, Ministry of Finance (for budgeting and planning), Ministry of Health, drug storage facilities, distributors, etc.

To manage supplies and contracts related with medication and sanitary products, the Program's Executive Units will establish links and will coordinate technical and administrative elements with the representation in the country (as OPS/OMS), or with other international organizations that facilitate such purchases. This entity will offer its organizational structure and will fulfill its functions in terms of good practices to achieve the procurement of pharmaceutical products of OPS/OMS, the Global Fund's policy on pharmaceutical products and other public health supplies, and the procedures and regulations of procurement of the country. The functions are described below:

1. Selection of pharmaceutical products: the MOH shall make sure that the products are included in the national treatment standards, or otherwise in the official list of basic medication of the country, or in the list of essential medication of the OMS. In case that the MOH wishes to acquire products not included in one of the above lists, it shall request approval from the Global Fund in writing before going ahead with the purchase.
2. Estimation of need: the MOH shall make sure that the quantities of products requested are based on morbidity data and in historic consumption data, taking also in consideration the expanded coverage and reserve stock required at each care level.
3. Selection of the suppliers: with official petition from MOH, the OPS/OMS will request prices from pre-qualified suppliers of pharmaceutical products. The quality of the product will be guaranteed through the strict application of criteria on the selection of suppliers as per source of origin.
4. Price request and procurement: in case of a MOH order, the OPS/OMS will request prices from different suppliers as a way to guarantee effective competition, with transparency and responsibility, according with the OPS/OMS Procurement Procedures and Regulations. It will be MOH's responsibility to ensure that the selected products comply with national regulations in the protection of patents.

Delivery of products acquired: all pharmaceutical products acquired through the OPS/OMS will be consigned to MOH, which will follow customs procedures and associated costs. The MOH will receive copies of the purchase orders and of customs documents before the delivery of the product. If the international organization selected were OPS/OMS in El Salvador, this office will coordinate the

4.10.2 Procurement capacity

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

(b) For each organization planned to be involved in the procurement of medicines and other health products, provide details of the current volume of medicines and other health products procured on an annual basis in the table below. *Use the "tab" button on your computer to add extra rows at the bottom of the table if more than four organizations will be involved in procurement.*

Organization Name	**Total value of medicines and other health products procured during last financial year** *(In same currency as this proposal)*
Fondos de Fondo Mundial, R2:	

UNDP/Unidad Ejecutora del Programa (2004-2007) MSPAS/ Unidad Ejecutora del Programa (2007)	<table><tr><th>Source</th><th>2004</th><th>2005</th><th>2006</th><th>2007</th><th>2004-2007</th></tr><tr><td>GOES</td><td>$1,906,652</td><td>$1,660,831</td><td>$1,286,058</td><td>$1,688,650</td><td>$6,542,191</td></tr><tr><td>GF–R2</td><td>$2,401,733</td><td>$1,100,000</td><td>$1,100,000</td><td>$ 700,000</td><td>$5,301,733</td></tr><tr><td>TOTAL</td><td>$4,308,385</td><td>$2,760,831</td><td>$2,386,059</td><td>$2,388,650</td><td>$11,843,924</td></tr><tr><td>% GOES</td><td>44%</td><td>60%</td><td>54%</td><td>71%</td><td>55%</td></tr></table> Please see GF – R2 line in table
Fondos MSPAS (GOES, Gobierno de El Salvador) (2004-2007)	Please see GOES line in table above

4.10.3 Coordination

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

2003-2007: PNUD, 86.5%: $15,578,226 ($13,029,192 Fase I + $2,549,034 Fase II)

2007: MSPAS, 13.5%: $ 2,421,975 (Fase II)

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

The international NGO PASMO has donated condoms, lubricants, and support for social marketing of condom use at a rate of just under $2M yearly from a USAID/Washington funded multi-country project. It is not known whether PASMO´s funding will be continued.

4.10.4 Supply management (storage and distribution)

(a)	Has an organization already been nominated to provide the supply management (storage and distribution) functions for medicines and other related health products during the proposal term?	X☐X Yes ➔ *continue to (b)* ☐ No ➔ *go to 4.10.5*
(b)	**If yes to (a) above**, indicate, which types of organizations will be involved in the supply management of medicines and other related health products during the proposal term. If more than one of the adjacent boxes is checked, also briefly describe the inter-relationships between these entities when answering (c) and (d) below.	XX☐ National medical stores or equivalent ☐ Sub-contracted national organization(s) *(specify which one(s))* XX☐ Sub-contracted international organization(s) *(specify which one(s))* PAHO/OMS;PNUD ☐ Other *(specify)*

(c)	Describe each organization's current **storage capacity** for medicines and other related health products, and indicate how the increased requirements under this proposal will be transparently and effectively managed.
	Supplies storage will be the responsibility of the MOH that has a Technical Unit for Medication and Medical Supplies (UTMIN), with infrastructure, equipment and technical and operational staff necessary to develop storage related processes: i) reception, ii) storage and ii) inventory management and control. The latter process will enable the HIV/AIDS component coordinator to evaluate consumption and to estimate the needs to conduct subsequent procurement processes. The MOH has central storage facilities and others around the country.
(d)	Describe each organization's **current distribution capacity** for medicines and other related health products and indicate how the increased coverage will be managed, and potential challenges addressed if any. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal, and the extent of incremental increase that is on existing distribution arrangements.
	The component HIV/AIDS coordinator will participate **In the medication distribution**, who, based on health establishment requirements, will authorize the UTMIN the supply and distribution of the medication. The distribution of the medication will be carried out in MOH's transportation vehicles. The UTMIN will be responsible for systematically supplying departmental storage facilities to prevent medication and health supplies scarcity. Medication requirements, through a consumption analysis and the projection of progressive expansion of ART coverage will enable the coordinator to request to the Executive Unit to arrange medication supplies through PHO/WHO representatives in the country.

4.10.5	**Pharmaceutical products selection**
	Do you plan to utilize national standard treatment guidelines ('STG') that are in line with the World Health Organization's ('WHO') STG during the proposal term? **If not**, describe below the STG that are planned to be utilized, and the rationale for their use. In section 5.4.1, Applicants are requested to complete '**Attachment B**' **to this Proposal Form** on a per disease component basis to provide more detail on the STG, and also the expected prices for medicines.
	Yes, the STG of El Salvador coincide with those of WHO.

[For tuberculosis and HIVAIDS components only:]

4.10.6	**Multi-drug-resistant tuberculosis**	
	Does the proposal request funding for the treatment of multi-drug-resistant tuberculosis?	XX☐ Yes ☐ No
	If yes, please note that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made or is in progress. For more information, please refer to the GLC website, at http://www.who.int/tb/dots/dotsplus/management/en/. Also see the Guidelines for Proposals, section 4.10.6. **Applicants should also ensure that for each year of the proposal term, an amount equivalent to US$ 50,000 should be transparently budgeted in section 5 of the proposal for contribution towards fees incurred by the Green Light Committee**. *Applicants should note that this money must be reserved for the Green Light Committee and can not be transferred for other implementation activities.*	

4 Component Section *HIV/AIDS*

MDR-TB treatment is covered in the TB component, which works closely with the Green Light Committee

4.11 Technical and Management Assistance and Capacity-Building

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

4.11.1 Capacity building and training

Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further strengthen national capacity, capacity of Principal Recipients and sub-recipients, as well as any target group. Ensure that these activities are included in the detailed budget in section 5.

It is estimated that for the implementation and development of actions in the HIV/AIDS component within the health sector, technical assistance will be necessary during the entire process, starting with management intervention in the design of the strategies, documents, campaigns, operational research, but mainly their monitoring and evaluation; strengthening the information system and epidemiologic monitoring at all levels.

At the government and non-government organizations level, including the governing entity (STI/HIV/AIDS, Tuberculosis National Program, and others) technical assistance is needed in management areas, to allow the maximization of intersectorial interventions, likewise in the design of strategic plans, quality of care and the operation of HIV/AIDS related monitoring and evaluation.

People living with HIV AIDS (including inmates living with HIV/AIDS) will be the main actors in the present strategy since they will have to be trained as facilitators in the different areas.

Another important aspect that will require assistance is the design and implementation of Information, education and communication strategies aimed at the most vulnerable population.

Furthermore, it is important to consider the strengthening of an automated information system to register all interventions developed in different areas through all health sector institutions.

Strengthened operational research area to become aware of the current situation of HIV/AIDS in El Salvador obtaining the true profile of the epidemic, and to have the capability to design the right intervention strategies aimed at the most vulnerable people and to aspects that need improvement.

Due to economic restriction and scarce resources, health service providers in the country do not carry out management activities as part of their practice in order to improve efficiency and quality of sanitation interventions, but instead limit themselves to operational activities directly related with the supply of health services.

For the HIV/AIDS component it is necessary for those responsible for resource administration, as well as recipients, to have technical cooperation (counseling, technical assistance, training, research and evaluation) not just to improve the management capabilities, that has a negative balance, but also for those responsible for conducting the health service network to have precise knowledge of the scenarios and the circumstances that shall address in order to control the epidemic with a set of efficient, effective, and quality services.

4.11.2 Technical and management assistance

(a) **Needs Assessment**

Describe any needs for technical assistance, including assistance to enhance management capabilities to support the attainment of the planned outputs and outcomes under this proposal. Where relevant, link your response in this section to the potential capacity constraints of the Principal Recipient and/or other implementing partners under this proposal. (*Please note that technical and management assistance should be quantified and reflected in the component budget section, in section 5).* ***In your description, identify the process by which needs were assessed and evaluated****.*

The purpose is to strengthen the country's capacity to improve efficiency in planning, organization, management, and control of the resources. The needs for technical assistance mentioned in above paragraph states the need to hire technical assistance, counseling, training, and studies, for their respective supplies in order to be able to achieve optimal technical and administrative training conditions for solving management problems in the component, to strengthen the sustainable solution capacity of the services, and to produce modern administrative good practices regarding the following aspects: human resources, finances, supplies and/or provision, and information system for control and supervision of component actions. At the supplier level, the component will support the development of capabilities and skills with the purpose of strengthening planning, processes management, and resource supervision and control.

The changes to be produced by the component will allow: (i) to develop organizational strategies to improve guidance of ART coverage in a complex and changing environment; (ii) to apply and supervise the technical and legal order of the actions of health sector suppliers in the control of HIV/AIDS; and (iii) to control the good use of resources through existing management systems

(b) **Planned sources and mechanisms for procurement of services**

Describe how technical and management assistance is planned to be obtained during the proposal term in a transparent and efficient manner. In particular, identify whether local, national and/or international assistance will be obtained, the scheduled timeframe (short term or longer term) and the rationale for this approach. Also describe how the provision of the planned assistance will contribute to long term increased capacity to respond effectively to the disease.

Technical and management assistance will come through international cooperation, international consultants, and national consultants and firms. PAHO/WHO, UNAIDS, and World Bank have the principal providers in recent years, as have other bilateral and multilateral organizations and projects (e.g., PASCA/USAID). Operational research and qualitative studies will use national talent or in some cases international consultants, always with a local counterpart to absorb the knowledge provided and pass it on.

Contracting of technical assistance will be done through the Executive Units, following the norms of the co;untry and the GF.

5 Component Budget *HIV/AIDS*

5. HIV/AIDS Component Budget - Overview and general guidance

This section 5 is where Applicants detail their funding request which is summarized in table 1.2. **Section 5 must be completed for each disease component included in your proposal**.

For Round 7, section 5 has been restructured to adopt the following order:

1. **prepare a detailed component budget** (section 5.1);
2. from that detailed budget, **prepare a summary by objective and service delivery area** (section 5.2);
3. from that detailed budget, **prepare a summary by cost category** (section 5.3); and
4. then provide details about **key budget assumptions** (section 5.4).

Funding to be contributed through a common funding mechanism
If part or all of the funding requested for this component is to be contributed through a common funding mechanism *(relevant for Applicants who completed section 4.3.5)*, **Applicants must:**

(a) compile the Budget information in sections 5.1 to 5.3 on the basis of the anticipated use, attribution, or allocation of the requested funds within the common funding mechanism; **and**

(b) provide, as an annex to your proposal, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request in a covering page to that plan.

5.1 Detailed Component Budget

A detailed per-disease component budget covering the proposal period must be attached as an annex to your proposal.
The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

The Detailed Component Budget *should meet the following criteria (Please refer to the Guidelines for Proposals, section 5.1):*

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

(b) It should cover the full term of the proposal, and:
*(i) be **detailed for year 1 and year 2**, with financial information broken down by **quarters for the first year, and at least half yearly for the second year**;*
(ii) provide summarized information and assumptions for the balance term of the proposal period (year 3 and beyond).

*(c) It should state all key assumptions, including those relating to **units and unit costs (avoid using lump-sum amounts)**, and should be consistent with the assumptions and explanations included in section 5.4.*

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

(e) Details on HSS Strategic Actions should be clearly identified.

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

5 Component Budget *HIV/AIDS*

5.2 Summary by objective and service delivery area

Please provide a breakdown of the annual budget by objective service delivery area (SDA) derived from your detailed component budget (section 5.1). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form). Totals should be provided in this table both for each Year (vertical total) and for each SDA (horizontal total).

The totals requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.3 (budget breakdown by cost category).

Table 5.2: Budget breakdown by service delivery area and objective.

5 Component Budget *HIV/AIDS*

Table 5.2: Budget breakdown by service delivery area and objective

Objective Number	Service delivery area	Budget breakdown by SDA (same currency as in section 1.1 of the Proposal Form)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
1: Improve social protection and quality of life of PLWHA	1.1. Strengthening of the civil society and creation of institutional capacity	$ 213,980.00	$ 205,560.00	$ 182,560.00	$ 130,560.00	$ 107,560.00	**$ 840,220.00**
	1.2. Improvement of the social protection of PLWHA	$ -	$ 20,000.00	$ -	$ -	$ -	**$ 20,000.00**
	1.3. Reduction of stimatization	$ -	$ 20,000.00	$ -	$ -	$ -	**$ 20,000.00**
SUB TOTAL		**$ 213,980.00**	**$ 245,560.00**	**$ 182,560.00**	**$ 130,560.00**	**$ 107,560.00**	$ 880,220.00
2: Reduce HIV transmission, expanding coverage and the range of activities for the prevention of HIV infection and health promotion in vulnerable groups	2.1. Counseling and testing, diagnosis and treatment (VCT)	$ 1,327,431.54	$ 1,367,043.06	$ 1,017,963.46	$ 1,039,936.58	$ 853,087.74	**$ 5,605,462.38**
	2.2 Communications for behavioral change (IEC/BCC)	$ 1,037,402.31	$ 1,099,207.12	$ 1,027,232.12	$ 1,098,107.12	$ 1,077,232.12	**$ 5,339,180.79**
SUB TOTAL		**$ 2,364,833.85**	**$ 2,466,250.18**	**$ 2,045,195.58**	**$ 2,138,043.70**	**$ 1,930,319.86**	$ 10,944,643.17
3: Reduce morbidity and mortality facilitating the availability, access and quality of comprehensive attention of patients	3.1.Antiretroviral therapy (ART)	$ 1,264,057.20	$ 1,476,422.20	$ 1,621,565.20	$ 1,702,830.00	$ 1,795,943.78	**$ 7,860,818.38**
	3.2. Comprehensive attention and support to the chronically ill	$ 69,950.00	$ 69,950.00	$ 69,950.00	$ 33,950.00	$ 39,650.00	**$ 283,450.00**
SUB TOTAL		**$ 1,334,007.20**	**$ 1,546,372.20**	**$ 1,691,515.20**	**$ 1,736,780.00**	**$ 1,835,593.78**	$ 8,144,268.38
4 : Strengthen the health system with improvements in the monitoring and evaluation capacity	4.1. Consolidation of the monitoring, evaluation and epidemiological surveillance system	$ 831,585.00	$ 1,014,765.00	$ 610,060.00	$ 559,284.00	$ 473,746.00	**$ 3,489,440.00**
SUB TOTAL		$ 831,585.00	$ 1,014,765.00	$ 610,060.00	$ 559,284.00	$ 473,746.00	**$ 3,489,440.00**
OBJECTIVES 1,2,3 AND 4 TOTAL		**$ 4,744,406.05**	**$ 5,272,947.38**	**$ 4,529,330.78**	**$ 4,564,667.70**	**$ 4,347,219.64**	$ 23,458,571.55
ADMINISTRATIVE COSTS OF PROGRAM OPERATION		**$ 284,664.36**	**$ 316,376.84**	**$ 271,759.85**	**$ 273,880.06**	**$ 260,833.18**	$ 1,407,514.29
TOTAL AMOUNT HIV COMPONENT		**$ 5,029,070.41**	**$ 5,589,324.22**	**$ 4,801,090.63**	**$ 4,838,547.76**	**$ 4,608,052.82**	$ 24,866,085.87

5 Component Budget *HIV/AIDS*

5.3 Summary by cost category

In table 5.3 ***on the following page***, provide a breakdown of the annual budget by cost category *derived from your detailed component budget (section 5.1)*

(a) Different from Round 6, the cost categories in table 5.3 have been expanded to provide greater clarity between different cost categories.

(b) Guidance on the budget categories and the expenses falling within each category is provided in the **Guidelines for Proposal** section 5.3.

(c) The total requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.2 (breakdown by 'service delivery area').

(The "Total funds requested from the Global Fund" must also be consistent with the amounts entered in table 1.2 relating to this component.)

5 Component Budget *HIV/AIDS*

Table 5.3 – Budget breakdown by cost category

Use the "HIVTable53Line" button in the standard toolbar to insert row at the end of table	**Breakdown by cost category** *(same currency as in section 1.1 of the Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	$ 429,242.04	$ 551,278.56	$ 472,947.96	$ 285,574.08	$ 88,243.90	$ 1,827,286.54
Technical Assistance	$ 125,760.00	$ 238,760.00	$ 103,760.00	$ 183,760.00	$ 86,504.00	$ 738,544.00
Training	$ 118,270.00	$ 127,395.00	$ 88,845.00	$ 85,245.00	$ 103,820.00	$ 523,575.00
Health products and Health Equipment	$ 95,850.00	$ 95,850.00	$ 5,700.00	$ 5,700.00	$ 11,400.00	$ 214,500.00
Medicines and pharmaceutical products	$ 2,380,409.01	$ 2,607,053.82	$ 2,597,873.82	$ 2,654,098.62	$ 2,710,899.40	$ 12,950,334.67
Procurement and supply management costs	$ 30,000.00	$ 30,000.00	$ 15,000.00	$ 15,000.00	$ 15,000.00	$ 105,000.00
Infrastructure and other equipment	$ 337,034.00	$ 412,852.30	$ 114,142.80	$ 167,099.80	$ 172,696.00	$ 1,203,824.90
Communication Materials	$ 535,000.00	$ 525,000.00	$ 510,000.00	$ 505,000.00	$ 500,000.00	$ 2,575,000.00
Monitoring & Evaluation	$ 585,000.00	$ 575,000.00	$ 510,000.00	$ 555,000.00	$ 550,000.00	$ 2,775,000.00
Living Support to Clients/Target Populations	$ 102,000.00	$ 105,000.00	$ 102,000.00	$ 105,000.00	$ 102,000.00	$ 516,000.00
Planning and administration	$ 284,313.90	$ 316,091.38	$ 271,216.17	$ 273,688.65	$ 260,433.80	$ 1,405,743.91
Overheads	$ 6,191.46	$ 5,043.16	$ 9,604.87	$ 3,381.61	$ 7,055.72	$ 31,276.82
Total funds requested from Global Fund	$ 5,029,070.41	$ 5,589,324.22	$ 4,801,090.62	$ 4,838,547.76	$ 4,608,052.82	$ 24,866,085.87

5 Component Budget *HIV/AIDS*

5.4 Key budget assumptions

The detailed component budget (section 5.1) should contain all key budget assumptions. Below, Applicants are requested to highlight their budget assumptions for year 1 and year 2 in relation to three key areas.

5.4.1 Pharmaceuticals and other health products and equipment

Applicants must complete Attachment B to this Proposal Form *(Preliminary List of Pharmaceuticals and other Health Products)* ***to provide details of the budget assumptions for years 1 and 2 in respect of health products (including consumables), medicines, health equipment and services directly tied to procurement and supply management of health products.*** *Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed component budget. If prices from sources other than those specified below are used, a rationale must be included.*

(a) **Provide a list (by generic product name) of anti-retroviral (ARVs) medicines** to be used in years 1 and 2, and identify which essential medicines list those medicines are included, and whether WHO's standard treatment guidelines are being followed. **See also section 4.10.5 above**.
(Please complete table B.1 in Attachment B to the Proposal Form.)

(b) **Identify the average cost per person per year (or average cost per treatment course) for these medicines**.
(Please complete table B.2 in Attachment B to the Proposal Form.)

(c) Provide **the total cost** for all other medicines to be used over years 1 and 2. It is not necessary to itemize each product in the category.
(Please complete table B.2 in Attachment B to the Proposal Form.)

(d) Provide a list of other health products (e.g., condoms, diagnostics, hospital and medical supplies), health and non-health equipment, and services directly tied to procurement and supply management. Unit costs are requested for Health Products (i.e., consumables).
(Please complete tables B.3 and B.4 in Attachment B to the Proposal Form.)

Information on appropriate unit costs is available at, for example:

- *Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS.* Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2005, http://www.who.int/medicines/areas/access/med_prices_hiv_aids/en;
- Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mas/mns.htm);
- *International Drug Price Indicator Guide on Finished Products of Essential Drugs,* Management Sciences for Health in Collaboration with WHO (published annually) (http://www.msh.org/what_msh_does/cpm/index.html*); and*
- *First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility http://www.stoptb.org/gdf/drugsupply/drugs_available.asp.)*

Provide any additional information on unit costs below

Estimated costs are based upon experience with activities and procurements which are similar to the previous project (R2). Notwisthstanding, current prices will in general, be established in bidding processes. Estimated costs of drugs in particular follow those provided by PAHO, the Global Fund, international foundations in the HIV/AIDS area and recent experience in the country. These costs tendo to lower in accordance with wther the government approves and certifies generic drugs, and these become part of the lists issued for use in the country.

5.4.2 Human resources costs

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

(Useful information to support the budget includes: a diagram/organigram of the PR; a list of proposed positions showing title, function and planned annual salary; and proportion (in percentage terms) of time that will be allocated to the work under this proposal. Please attach such information as an annex to your proposal and indicate the appropriate annex number.)

The contracting of human resources will be carried out by means of consultancies or short term contracts of up to one year. It will not involve the establishment of positions until the functions and funding are assumed by the government. The financial contributions for the contracting of human resources does not consist of a percentage greater than the total budget; for this reason, positions, functions and salaries are not specified. More than 95% of the expenditure for human resources for support of the project will be absorbed by government funds, for existing and new positions to absorb the contracted personnel by the project on a temporary basis

The principal expenditures in the area of human resources are for training and improvements to professional development which directly suuport the Areas of Service Delivery. The improved education and training will strengthen the health system in various ways, from the professional education of medical personnel, counselors, and laboratory staff, to the training in integrated approaches for these, the PLWHA and support groups, the communities and volunteers.

5.4.3 Other key expenditure items

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

All expenditures have been budgeted on the basis of experience gained in Round 2, on the basis of what performs best programmatically, the costs and the total amounts of goods and services that are required.

Infrastructure has been budgeted on the minimum improvements needed for the application of the ART, tests and counseling, conservation of medicines, and laboratory activities. All are based upon the experience and costs involved in similar activities.

Equipment has been budgeted taking into account the median useful life of the equipment, the degree of need (to overcome the gaps in terms of key services, see Table 4.4.1) and recommendations for continuance of the broadening and decentralization of services.

Regarding the method of budgeting for communications materials and activities, experience in similar activities and populations were taken into account, as well as the population coverage needed to achieve the proposed goals as based upon the results of prior evaluations, to transmit the information to the population, to PLWHA and to high risk groups in ways that change their knowledge, attitudes and practices.

CHECKLIST OF ANNEXES FOR SECTIONS 4 AND 5 TO BE ATTACHED TO YOUR PROPOSAL – *HIV/AIDS*

The table below provides a list of the various annexes that should be attached to the proposal after completing sections 4 and 5. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Section 4: Component Strategy – HIV/AIDS		**Annex Number to your proposal**
4.3.1	Documentation relevant to the national disease program context.	HIV-1
4.3.5(c) *(**only** if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism.	N/A
4.3.5(d) *(**only** if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism.	N/A
4.6	**A completed 'Targets and Indicators Table' Refer to the M&E Toolkit for help in completing this table.**	**Attachment A – HIV/AIDS**
4.6	**A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year).	HIV-2
4.6	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 5 or Round 6 proposals.	HIV-3
4.8.3 (c)	List of sub-recipients identified (including name, **sector they represent, and SDA(s) most relevant to their activities during the proposal term**)	HIV-4
4.9.1	National Monitoring and Evaluation Plan/Strategy (if one exists)	see ref. HIV-1.27 2006-2010 National Monitoring and Evaluation Plan in Annex 1
Section 5: Component Budget – HIV/AIDS		**Annex Number to your proposal**
5.1	**Detailed component Budget**	HIV-5
5.1 *(if HSS strategic actions are included – see section 4.4.2)*	Details of cross-cutting HSS amounts (if not clearly identifiable from the detailed component budget).	N/A
5.4.1 *(and section 4.10.5)*	Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3)	**Attachment B – HIV/AIDS**
5.4.2	Human resources costs.	

CHECKLIST OF ANNEXES FOR SECTIONS 4 AND 5 TO BE ATTACHED TO YOUR PROPOSAL – *HIV/AIDS*

5.4.3	Other key expenditure items.	
5.1 - 5.3 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	
Other documents relevant to sections 4-5 attached by Applicant:		**Annex Number to your proposal**

4 Component Section *Tuberculosis*

***PLEASE NOTE THAT SECTION 4 and SECTION 5 MUST BE COMPLETED FOR EACH SEPARATE DISEASE COMPONENT**. This section is only for your tuberculosis component, and sections 4 and 5 for HIV/AIDS and malaria are separately identified in this Proposal Form (refer to the section headings to find the section relevant to your proposal).*

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

4.1 Requested proposal term for this disease component

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

Important note:

If your proposal term is less than five years, please first refer to the Global Fund's Round 7 'Frequently Asked Questions' (No. 132) at:
http://www.theglobalfund.org/en/apply/call7/documents/documentsfaqs/

Table 4.1.1 – Proposal start time and duration

	From	To
Month and year:	July 2008	June 2013

4.2 Disease specific component executive summary

4.2.1 Executive summary

Describe the overall strategy of the proposal component, by referring to challenges, existing and/or new needs, goals, objectives and planned outcomes and outputs to be achieved through the additional funding requested in this proposal, specifying the main beneficiaries (including target populations and their estimated number). Also specify any institution/facilities that will benefit from any support for health systems strengthening strategic actions.

*(**Maximum of one page in length**, highlighting, in a summary format only, key aspects from information described in your answers to the questions within section 4).*

El Salvador has achieved important advances in its fight against Tuberculosis (TB) and complies with all national and international strategic plans for its control. With the support of Round 2 (R2) of the Global Fund (GF), it has adopted the new strategy STOP TB and has set a firm basis for its implementation.

Nevertheless, to fully implement STOP TB, the country faces important challenges:

- Although diagnosis and treatment is efficient in most cases that come to the health system (passive reception), an important part of the cases in the country goes undetected. The World Health Organization estimate of prevalence (WHO 2007) suggests that undetected cases may be more than those detected; however the study needs to be updated.
- One fourth of persons with respiratory symptoms (RS) that reach the system are not fully investigated. It is necessary to offer active follow-up, involve and upgrade all laboratories.
- The Practical Approach to Lung Health (PAL) is applied in less than 10% of health establishements in the country.
- There is a need to integrate more institutions of the health sector to the STOP-TB initiative, especially in the private sector.
- Community support is still minimal; there is still a need to have active community participation;

involvement of civil society and the patient; and support for education to control tuberculosis.

- Most TB deaths result from co-infection TB-HIV.

These and other needs will be faced through the proposed project, which has the goal *"to extend nationally the STOP TB strategy, to contribute to TB control and decrease morbi-mortality with emphasis on the most vulnerable groups."*

The proposal contemplates four Objectives:

9. Continue expanding and strengthening Direct Observational Therapy (DOTS) with quality.
10. Address the TB-HIV coinfection, muti-drug-resistant tuberculosis (MDR-TB) and other challenges (e.g. high risk populations such as prisoners and migrant populations).
11. Contribute to strengthening the health system.
12. Empower those affected by tuberculosis and their communities.

The results to be obtained with the Round Seven (R7) grant include: a) consolidation of the STOP-TB in the whole country, b) wideining of DOTS and PAL coverage to all health institutions, c) increased training and operations research on RS, case detection and adherence to treatment through education, social mobilization and community empowerment and d) promote an integrated approach to TB-HIV coinfection and MDR TB control.

These results will involve all health providers in the country, including trained community volunteers. This implies activities to strengthen health sector staff with training, equip laboratory networks, improve supervision and compliance with the STOP-TB strategy, widen PAL coverage to 90% of the system, incorporate all institutions in the sector and increase community participation and social mobility.

The population benefited includes over 80,000 RS persons to investigate over five years, yielding some 2,400 more cases of TB; vulnerable populations such as prisoners and their contacts (62,000); the 18,000 to 36,000 people living with HIV/AIDS (PLWHA) and communities in extreme poverty with a high rates of TB (around 400,000 inhabitants); a yearly flow of 60,000 RS people (by 2012) that will receive attention with PAL, strengthening of the health system in the country (see 4.4.2); and the entire country to the degree that TB is reduced as a threat to health and wellbeing (7 million). More importantly, the country's capacity to contine battling TB in an effective, sustainable manner will be enhanced.

4 Component Section *Tuberculosis*

4.3 National program context for this component

The information below helps reviewers understand the disease context, what is working well and will be built upon, which problems the proposal will address and the major constraints for the implementation of the proposed component. Please refer to the Guidelines for Proposals, section 4.3.

4.3.1 Indicate whether you have any of the following documents** *(check the appropriate box),* **and if so, please attach them as an annex to your proposal:**

X☐ National Health Sector Development/Strategic Plan *[See reference #TB-1.12, Plan Estratégico Quinquenal del MSPAS (Five Year Strategic Plan of MOH).]*

X☐ National Disease Control Strategy or Plan **including national targets and indicators, together with the relevant budget and costing** *Ref. TB-1.11, Plan de Eliminación de la Tuberculosis como Problema de Salud Pública en El Salvador (Plan Elimination of TB as a Public Health Problem in El Salvador) and Ref. TB 1.17, WHO—Stop TB Workbook.]*

X☐ Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards) *[Ref. TB-1.8, Norma Nacional de Prevención y Control de la Tuberculosis (National Standard for the Prevention and Control of Tuberculosis).]*

X☐ Most recent evaluation reports/technical counseling reviews **directly relevant to the proposal** *[See refs. # TB 1.2; 1.4; 1.7; 1.13; 1.16; 1.18]*

X☐ National Monitoring and Evaluation Plan (health sector, disease specific or other) *[There are registration norms and procedures, result analysis and process and quality control – which jointly constitute a national system for monitoring and evaluation.]*

References on TB in El Salvador for Global Fund Round 7 proposal.

(copies in Annex TB-1)

International References:

6. WHO Report 2007. Global Tuberculosis Control. Surveillance, Planning, Financing. 277 pp.
7. WHO/IUATDL. 2004. Global Projecty on Anti-tuberculosis Drug Resistence Surveillance. Anti-tuberculosis Drug Resistence in the World. Third Global Report. 201 pp.

National Reports and References

TB-1.1 Cohort study for new cases with TBP-BK (+) HIV-AIDS. 2003-2005. 19 pp.

TB-1.2 Risk Factors of Mortality in Co infection Patients with TB/HIV en El Salvador. Tan, K.; Abraham, M.; Laserson, K.; Wells, C.; Garay, J.; Soto M; USAID/CDC, no date. 34 slides.

TB-1.3 Technical guide for the diagnosis of Tuberculosis in Direct Microscopy. MOH, National Program for the Prevention and Control of Tuberculosis. 2005. 39 pp.

TB-1.4 Implementation of Tuberculosis Control in Jails. MOH, National Program for the Prevention and Control of Tuberculosis. No date. 5 pp.

TB-1.5 Report on detection of tuberculosis cases for SIBASI. Consolidated January-December 2006. MOH, National Program for Tuberculosis and Respiratory Illnesses. 2007. 3 pp.

TB-1.6 Quality Control Manual for the Tuberculosis Laboratory Network. MOH, Central Laboratory Unit “Dr. Max Bloch”. 2004. 51 pp.

TB-1.7 Memoirs. Phase 1 of the Global Fund project, TB Component. National Program for the Prevention and Control of TB. 2006.

TB-1.8 National Prevention and Control of Tuberculosis. MOH, National Program for the Prevention and Control of Tuberculosis. 2007. 154 pp.

TB-1.9 Implementation Plan for the APP Strategy in El Salvador. National Program for the Prevention and Control of Tuberculosis. 2006. 9 pp.

TB-1.10 Tuberculosis as a Public Health Problem Elimination Plan in El Salvador. 2005-2020. Strategic Plan. San Salvador: MSPAS, 2005. 66 pp.

TB-1.11 National Plan for the Implementation of the Strategy Practical Approach to Lung Health (PAL). MOH, National Program for the Prevention and Control of Tuberculosis. 2005. 23 pp.

TB-1.12 Five Year Plan of MOH. 2004-2009.

TB-1.13 Final Report. Prevalence and Yearly Risk of the Infection by Tuberculosis in School Children in El Salvador (2004-2005). El Salvador, April 2006. 46 pp.

TB-1.14 National Program for the Prevention and Control of Tuberculosis. MOH, National Program for the Prevention and Control of Tuberculosis. 2005. 27 pp.

TB-1.15 Epidemiological and Operational Situation of Tuberculosis, Garay Ramos, July; MOH, National Program for Tuberculosis and Respiratory Illnesses. 2007. 42 slides.

TB-1.16 Epidemiological Situation of Tuberculosis in Prisons in El Salvador 2002- 2006. Garay Ramos, July; MOH, National Program for the Prevention and Control of Tuberculosis, 2007. 24 slides.

TB-1.17 WHO—Stop TB Workbook on Planning & Budgeting for TB Control in El Salvador. MOH, National Program for the Prevention and Control of TB. 2006. Template Spreadsheet / "Template", 22 pp.

TB-1.18 Green Light Committee. Monitoring Mission to the MDR TB Project of El Salvador. March 2007. Armengol, Raimond & José Caminero Luna, International Union Against Tuberculosis and Lung Diseases (La Union), Green Light Committee.

** *Applicants will be asked to refer to these documents, where they exist, throughout this section 4 as further support for the proposal's overall strategy.*

4.3.2 Epidemiological and disease-specific background

(a) In table 4.3.2 below: (i) identify the total population of the country/countries; **and** (ii) then provide current estimates of the stage of the disease in the listed specific population groups. *The 'source of estimate' (final column in the table below) may be from recent published estimates of WHO, but may also be published national estimates or statistics.*

Table 4.3.2 – Estimated disease prevalence within key population groups

Population	Estimated number	Year of estimate	Source of estimate
(i) **Total Population** (all ages)	6,900,000	2005	DIGESTYC
(ii) **Current estimates on the stage of the disease in the following population groups**:			
People living with all forms of tuberculosis	4,688	2005	WHO 2007
People with new smear-positive tuberculosis	1794 1615	2005 2006	WHO 2007 PNT [9] El Salvador 2007
People treated for new smear-positive tuberculosis	1794 1615	2005 2006	WHO/2007 PNT El Salvador 2007
Tuberculosis related deaths per year	562	2005	WHO 2007
Number of cases of multi-drug resistance	2 12	2001 2005	WHO/IUADTL 2004 WHO 2007

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4 Component Section *Tuberculosis*

Population	Estimated number	Year of estimate	Source of estimate
per year			
Case detection rate of new smear-positive cases	51 / 100,000	2005	WHO 2007
DOTS treatment success rate	90%	2004	WHO 2007
Other: *(identify)*	72%	2004	WHO 2007

(b) **By reference to table 4.3.2 above**, describe any changes in the stage, type or dynamics of the disease, including in the most affected population group(s) over the past three to five years. Also summarize the main treatment regimes in use or to be used during the proposal term and the reasons for their use. Any data on drug resistance should also be included (where relevant). *(Maximum two pages.)*

The data from the *WHO Report 2007, pp. 189- 201* covers the year 2005 and are the most recent published. The following summary is also based on the document *Epidemiological Situation of Tuberculosis in El Salvador, 2007* (ref TB 1.15), which covers 2006 and will be submitted to WHO.

According to WHO, El Salvador presents a moderate prevalence of infection with an estimate of Yearly Risk for Tuberculosis Infection of 1%. Nevertheless, the National Program on Tuberculosis and Respiratory Diseases PNT considers that this number is over-estimated, because it is based on regional projections of several years back. A 2005 study of El Salvador (ref TB-1.13) gave a yearly risk of 0.63%, corresponding to a total prevalence of TB lower than that estimated by WHO. One of the activities to be developed in this project is to confirm this prevalence measurement.

The total prevalence estimated by WHO of TB is 51 per 100 thousand inhabitants, that provides an upper limit (probably over-estimated). A lower limit would be the rate of diagnosed cases in the country (an under-estimation, because not all potential cases go to the health system). The incidence of TB registered has been edging downward, from 2,367 to 1,794 cases between 1990 and 2005, reducing the notified incidence rate from 46 to 26 per 100,000 in 15 years. This trend continued in 2006 with 1,615 cases, equivalent to a rate of 23 for 100 thousand.

Nevertheless, it can be expected that the actual rate is between 28 to 35 cases per 100 thousand, when increasing the coverage of the health system. Some 70,000 RS patients arrive every year to the health establishments, but one fourth of these do not complete the diagnostic process, and another unknown number do not go to the health system at all. The project will emphasize the use of active capture technicques (community mobilization, mobile units, education, contacts investigtion, others) to detect additional cases in those populations or to reach those who initially go but do not finish the diagnostic tests. This will be based on the results of the present project supported by the round 2 of the Global Fund, where an increase in the cases detected have been noticed, due to a better diagnosis capacity, greater access by the population, a national radio and TV campaign, and better coordination between the Ministry of Public Health and Social Assistance (MOH), and the other institutions in the sector.

In 1997, El Salvador adopted the DOTS strategy. Its present coverage reaches 90% of the health system. The cure rate increased from 66% in 1997 to 91% by 2005, and labandonment of treatment has dropped from 11% in 1997 to 2.4% in 2005. The use of smear microscopy has grown to over 80% between 1997 and 2005, from 85,347 to 154,790 sputum tests. In 2005 the MOH started implementation of the new STOP-TB strategy.

Regardless of achievements obtained in the fight against tuberculosis, there are still challenges and gaps:

- The main challenge is to diagnose and treat the TB and TB/HIV coinfection cases in those populations without appropriate access or who do not use health services.

- In jails, the incidence of TB has increased markedly, from 72 per 100 thousand in the year 2002 to 664 per 100 thousand by 2006 -- 29 times higher than that of the general population.
- In the populations with HIV/AIDS, the incidence of TB increased from 6% to 10% between 2004 and 2006. There were 21.6% of deaths in the year 2005 in new cases of co-infection of TB/HIV.
- The cases of MDR TB increased from 2 in 2001 to 12 in 2005. The challenge stems in systematically widening the diagnosis methods, of culturing and typifying resistance in order to detect early the MDR TB to treat it in a timely fashion and prevent tuberculosis with extended resistance (XDR-TB).
- It is still necessary to appropriately equip 25 of the 199 laboratories in the country for TB diagnosis.
- PAL has only been implemented in 10% of the health establishments.

With the support of the Global Fund, starting in 2003, almost 6,000 persons have been trained at the national level, at the MOH as well as other institutions in the health sector. The functioning of the laboratory network has also improved, as well as the detection and treatment of cases, developing strategies and interventions that not only need to be maintained, but also need to be widen. The project proposed to Round 7 will widen the application of the STOP-TB in all its components and in all the institutions of the sector, while addressing and overcoming the challenges mentioned.

4.3.3 Disease-prevention and control initiatives and broader development frameworks

Proposals to the Global Fund should be developed based on a comprehensive review of disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases. Please refer to the Guidelines for Proposals, section 4.3.3.

(a) Describe, comprehensively, the current prevention and control strategies for the disease, together with planned outcomes.
Applicants should ensure that the information provided below takes into account the cumulative outcomes based on all current and planned support from all stakeholders (government, major international initiatives, international donors and partnerships etc).

The Salvadoran strategies to control TB are derived from the international strategy STOP-TB and the Regional Plan of the Americas for TB Control. They are specified in the Strategic Plan for the Elimination of Tuberculosis as a Public Health problem in El Salvador, 2005-2020 (ref. TB-1.10). The basic strategy consists in rapid detection and efficient treatment of cases to break the transmission chain.

The Ministry of Public Health and Social Assistance (MOH), through its National Program against Tuberculosis and Respiratory Diseases PNT has prioritized the control of TB through the application of the STOP TB strategy, which includes the DOTS Strategy, besides the focus as a Public-Public Mixed alliance (PPM), PAL, MDR-TB and the integrated management of the TB/HIV co-infection among others, which must extend to the whole health sector to reach a sustained reduction of TB prevalence morbidity.

MOH has performed the institutional changes (policy, mission, vision, structural and functional re-organization) necessary to reinforce its leadership in the coordination and development of policies and strategies addressed to control TB as a public health problem, to develop the capacity to transparently manage resources allotted to TB control, and strengthen capacity of decentralized management of these resources with autonomy and efficiency.

DOTS strategy is being implemented in over 90% of the sector network establishments, including MOH, Salvadoran Institute for Social Security, Teachers Wellbeing, Military Hygiene, and Jails. However, it is necessary to expand its coverage in said sector and institutions providing health services (National Civilian Police, NGOs, clinics and private hospitals).

Political Support:

- There is a governmental commitment to comply with the Millennium Goals.
- There is a national commitment towards the compliance of the STOP TB strategy.
- TB is integrated in the Five Year Strategic Plan 2004-2009 of MOH (ref TB-1.12).
- As a political strategy for the adoption of the DOTS focus in all health sectors, in 2001 the Inter-

institutional Counseling Committee was created for the Program for Prevention and Control of Tuberculosis in El Salvador, through the Ministry Resolution 205. The goal was to integrate the different institutions which are part of the health sector, ratifying the leadership of the MOH and assigning it as exclusive agent for the acquisition of TB drugs. This has favored coordination, harmonization of therapy, and economies of scale.

The Solidarity Fund for Health (FOSALUD in Spanish) of the MOH supports the STOP-TB strategy by financing expanding coverage, longer work hours, detection of symptoms, supervision of DOTS and the purchase of drugs and supplies for PAL.

There is a National Teaching Committee in the academic sector that has been incorporating TB in the curricula for the training of health professionals.

The financial support of Round 2 of the GF has facilitated important achievements: laboratory equipment, personnel training and the provision of supplies. There has been technical assistance from CDC, PAHO, La Unión, Green Light Committee (GLC), and others. Until 2004 there were USAID funds for training, equipment acquisition, and DOTS implementation.

The following initiatives started with the support of the World Bank still need to be strengthened:

- The Practical Approach to Lung Health (PAL) has been implemented in 10% of the heal establishments of the MOH network. The goal is to reach 90% by the year 2012, as established in the national plan (ref TB-1.11).
- The management of MDR TB is being integrated with DOTS, under the international guidelines and the monitoring of the Green Light Committee (GLC) (ref TB-1.18).
- The management of TB/HIV co-infection is coordinated closely with the HIV/AIDS Program.
- The initiative Public-Public, Public-Private and Mixed Alliance (PPA) was started in 2006; in order to strengthen it and widen it at the national level. At present the PPA has been consolidated in the public sector and is in the planning stages to foster agreement with private suppliers in health services.
- The incorporation of civil society, communities and patients has been practiced widely, involving professional associations, NGOs in the sector, community and municipal organizations ant the national board on TB, among others. Given the importance of TB/HIV co-infection, a close collaboration with PLWHA organizations has been initiated.

Foreseen Results: with the financial support of the GF Second Round, the Project for the Reconstruction of Hospitals and Extension of Health Services (RHEHS with a loan from the World Bank), GOES and FOSALUD, the foreseen results are expected by the end of the year 2008:

- DOTS implemented according to national guidelines and norms at all levels of health establishments in the sector (goal: 98%, 539 of 550).
- Workers in the health establishments trained and updated in DOTS (goal: at least 3 trained per service in 98% of the establishments).
- Increase success of tuberculosis patients treated (90% of cases cured).
- Greater adherence to anti-tuberculosis treatment (goal: abandonment of less than 2% of the cases).
- Increase in the cure of patients re-treated for tuberculosis (goal: 75% cured).
- Decrease of discordance in bacilloscopy tests in local laboratories and quality control (goal: concordance of 99%).
- Local laboratories with quality control of bacilloscopies at the national level (goal: 98% of laboratories).
- Adult population with knowledge ot TB, its transmission and prevention (goal: 75% of adults).
- Health promoters and community health volunteers strengthened in the DOTS strategy (goal: 5,766 trained).
- Patients with TB/HIV co-infection cured of TB according to standards and guidelines at MOH (goal: 80% cured).

TB patients treated in health establishments, receiving counselling on TB and HIV for the voluntary

testing for HIV (goal: 95% of TB patients take the test).

(b) Describe how these disease prevention and control strategies fit within broader developmental frameworks such as Poverty Reduction Strategies, a Health Systems Strengthening Strategy, the Highly-Indebted Poor Country (HIPC) Initiative, and/or the Millennium Development Goals, **emphasizing how the additional support requested in this proposal is aligned with developmental frameworks relevant to the country context**. *(Also include an overview of any links to international initiatives such as the WHO/UNAIDS 'Universal Access Initiative' or the 'Global Plan to Stop Tuberculosis 2006-2015' (e.g., for HIV/TB collaborative activities) or the 'Roll Back Malaria Global Strategic Plan').*

El Salvador approved the Declaration of Millennium Development Goals at the Millennium Summit, including objectives with defined targets to fight TB. In the same manner, the country has adopted the guidelines of the Amsterdam Declaration "STOP-TB" (2005). El Salvador also assumed the commitments of the World Plan to Stop TB 2006-2015, of the World Objectives for the Fight Against TB, the Plan of the Americas to Control TB and that of the World Health Organization/Pan-American Organization for Health (WHO/PAHO) to eliminate TB as a public health problem. These commitments are reflected in the Government's National Plan from the Government and Solidarity Network to Eliminate Poverty.

This international framework of commitments has allowed the MOH through the PNT to propose a series of health interventions, in order to accelerate the fight against TB. Based on this, the Strategic Plan for the Elimination of Tuberculosis as a Public Health Problem in El Salvador (ref TB-1.10) defines the objectives, goals, strategies and activities to comply with the STOP-TB strategy. The assistance requested in this proposal will fill gaps, and will ensure the timely achievement of these objectives and goals.

(c) Describe how this proposal seeks to: (1) use, to the extent that they exist, country systems for planning and budgeting, procurement and supply management, monitoring and evaluation and auditing; and (2) achieve greater harmonization and alignment of partners to country cycles in regard to procedures for reporting, budgeting, financial management and procurement.

This proposal contemplates a high degree of integration between the activities financed by the Global Fund, and the systems and processes already existing in the country–as well as the institutions that implement the National Program on Tuberculosis and Respiratory Illnesses, and those of wider scope that guide and support the planning and managing of finances, the hiring of human resources, acquisitions, and thecontrol of processes and results. At no point does this plan to create parallel structures or activities.

This close relationship implies a high degree of harmonization of the project with the cycles and procedures of the country, not only on technical matters, bul also on the administrative and financial management in all of its facets. This includes budgets, acquisitions and supplies, registration forms and reports, monitoring, evaluation and audit, among others. Some of the key aspects are:

- The National Program against Tuberculosis and Respiratory Diseases, internationally ackonwledged as a model, has gathered technical leadership of the project in coordination with all active entities in similar areas.
- The provision of health services to the patient is ruled by the National Standard on TB Prevention and Control (2007; ref TB-1.8), supported by current handbooks and technical guides.
- Communication and social mobilization work will be done according to established practices and standards, collaborating with civil society, institutions from the health sector, professional associations and academic institutions.
- The planning, preparation of budgets, financial negotiation and acquisitions and supplies, audits, as well as the other administrative processes will be done following the existing legal frameworks in the country.

The data collection for monitoring, preparation of reports and evaluation activities will be done through the national registry and information system established

4.3.4 National health system

(a) Briefly describe the main health systems constraints related to this component by focusing on the strengths, weaknesses, opportunities and threats of the health system.

Please consider the list of health systems strengthening strategic actions ('HSS Strategic Actions') outlined in section 4.4.2 of the Guidelines for Proposal when providing this description.

In El Salvador the national health system is made up of two sub-sectors: the public, integrated by the Public Health and Social Assistance Ministry (MOH), the Salvadoran Institute of Social Security (ISSS), Teachers Wellbeing, Military Hygiene, National Civilian Police (PNC), General Directorate of Jails (DGCP) and others. The private sub-sector includes profit and not for profit entities. The MOH, as a ruling and coordinating entity in the health sector and greater supplier of services, is responsible for implementing the Five Year Strategic Plan, which is framed within the Government Plan 2004-2009 "Secure Country". It is supported in a network of health establishments that serves 80% of the population, organized geographically in five regions and 17 Basic Systems of Integral Health (SIBASI in Spanish). Twenty percent of the population is served by the other public and private institutions.

Strengths:

- **Existing capacity**:
  - A network of 550 health establishments from MOH, Social Security and other entities, with trained personnel in the detection, treatment and prevention of TB.
  - A network of 199 laboratories at the national level performing diagnosis; 6 centers of quality control
  - A nurses network supporting the TB program
  - A National Counseling Committee for TB/HIV/PAL made up by specialists who represent the MOH, social Security, Pneumology Society and the private sector.
  - A National Teachers Committee to improve teaching of tuberculosis in the health training schools.
- **TB cases management with standards** at the world wide level. including MDR TB and the co-infection TB/HIV.
- **Drugs availability** of First Line (individualized and combined) purchased with funds from the central government through PAHO and GLC, and second line drugs purchased with the support of the Round 2 of the Global Fund
- **Norm updated** and applied by all health providing institutions
- **Pilot work with PAL, PPA,** and other initiatives have established conditions for their expansion
- **Systematized and standardized health registry** for other institutions in the sector
- **Quality Control** under national and international standards
- **Effective intersectorial and intrasectorial coordination** for PPA initiatives
- **Train community leaders and volunteers** ; training methods and materials are adapted and validated for health personnel and community participants (so far a low % has been trained).

Weaknesses:

- **Detection of TB cases is passive;** there is lack of active search for cases that do not reach the health system.
- **Deficit in diagnosis equipment** poor corrective and preventive maintenance of it.
- **Inadequate infrastructure** in some laboratories of the national network.
- **Some warehouses lack the adequate conditions** for the optimal preservation of drugs.
- **PAL is applied in only 10%** of the health establishments of MOH and is without being applied in any other institutions of the health sector.
- **Weak financial sustainability:** the Government budget for health is limited. The TB program has

an insufficient amount for the different needs. Among these sub-financed areas, are:

- acquisition of equipment and supplies for TB diagnosis
- preventive and corrective maintenance for diagnostic equipment
- purchase of second line medication
- printing of technical support material and educational material for the general population
- execution of communication campaigns through collective means
- acquisition of computers to timely manage information
- training of human resources in the whole sector (public and private).

- **Not all personnel is familiar with STOP-TB**
- **Personnel with knowledge are lost to turnover** and lack of resources to train new.
- **Low percentage of trained personnel in** TB-MDR and infections control
- **Little supervision** at the intermediate field level, due to lack of transportation; lack of MIS to supervise co-infection TB/HIV follow-up
- **Inadequate physical space** for the care of patients with tuberculosis, in some health establishments
- **Lack of curriculum and training** on TB among schools for health personnel
- **Lack of mechanisms to track internal migrants** (agricultural and other) to improve access to health services of those populations, especially in the metropolitan area (migrant shelters) and agriculture (sugar cane cutters and coffee pickers)
- **Little community participation in the detection of cases and treatment supervision** (of TB, MDR TB and TB/HIV co-infection); There are some materials that still need adaptation to STOP-TB.

Opportunities:

- **Widening the STOP-TB focus** that has been validated, such as, PAL, PPA, MDR TB, TB/HIV co-infection, and communities and patients empowerments.
- **Deepen relationships with civil society** to diversify the fight against TB through professional associations, local committees and NGOs from the health sector, etc.
- **Use the program's prestige** to attract external resources and assistance, and to better coordinate with the other public sectors, such as Education and Governance.
- **Existence of Covenants** between the MOH and other institutions with the possibility to incorporate others.
- **Support from FOSALUD,** financial and in the strengthening of human resource.

Threats:

- **Natural risks** at the national level such as earthquakes and floods
- **Drastic political changes** or priority changes in the government
- **Increase in migrating populations** agricultural workers arriving from neighboring countries to work with sugar cane and coffee live in overcrowded conditions and many without legal documents that preculde them to use the health system, increasing the risk for TB).
- **Deportations** of Salvadorans from Mexico and USA
- **Loss of continuity** of care in jails
- **Interruption** of the flow of drugs and other products

Deterioration of equipment in laboratories and lack of transportation means for supervision

(b) Describe the national priorities in addressing these constraints.

The national priority in the area of TB is to promote the STOP-TB strategy with its six components. Specific priorities that derive from the TB Strategic Plan (ref TBN-1.11) include the following:

- Train the health sector on the STOP-TB strategy in order to have all tuberculosis cases detected and treated (according to the National TB Prevention and Control Norm 2007)
- Increase access to diagnosis access in the most vulnerable populations with a high prevalence of diseases (prisoners, persons with HIV/AIDS, etc)
- Widen the coverage to reduce the gap between estimated prevalence by WHO and actual cases diagnosed in the country
- Decrease the risk of primary and secondary resistance by increasing surveillance and early detection of cases and as a result, decrease complications and/or deaths.
- Work as a whole with training institutions dedicated to health providers to improve the strategic approach of STOP-TB
- Train health personnel in the field to operationalize the STOP-TB strategy
- Improve the capacity to monitor, supervise and evaluate constantly in the health sector
- Empower community to participate in the support of patients to detect the respiratory symptoms and the treat the cases of TB
- Coordinate with private doctors and laboratories for notifying TB cases
- Provide equipment and supplies to the network of laboratories and keep quality control of the same
- Expansion of the PAL focus and PPA initiative
- Widen epidemiologic surveillance and integrated care of TB/HIV-AIDS co-infection.

(c) **Coordination and Synergies**

Briefly describe how disease specific programs are coordinated within the framework of the National Health Sector Development Plan, where one exists. For instance how the proposed component relates to (where appropriate) the national communicable disease strategy and to priorities in the plan.

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

The Five Year Strategic Plan of the MOH provides the framework where specific programs are coordinated. TB is covered at the national strategy through the section "Impact indicators, strategic actions and commitments for the five years".

It covers:

- Mobilization of all necessary resources so that children, adolescents and adults become aware of the best strategies to prevent TB in order to avoid more infections.
- Increase the knowledge, attitudes and practices of the population related to ... tuberculosis ....
- Strengthen early detection and personalized attention to treat TB in all health establishments in the country.
- Increase diagnosis of Tuberculosis BK (+) cases.
- Maintain tuberculosis cases cured.

This proposal is designed to support these goals of the country, with emphasis on vulnerable populations and those with high tuberculosis prevalence.

Co-infection TB/HIV has been subject of a close coordination between the National Tuberculosis Program (NTP) and the STI/HIV/AIDS National Program. There has been a synergy with the R2 funds from the GF received by the two programs. Supplies were acquired to diagnose HIV in patients with TB with funds from the HIV component, while with the funds for TB drugs are purchased to treat TB in co-infected

patients TB/HIV. Among synergic activities we find:

- Forming and effective operation the interinstitutional National Committee on Co-Infection TB/HIV.
- Drafting, between the two programs, of a Handbook on pre- and post- counselling HIV testing.
- Updating of pesonnel in both programs for integrated care of co-infection through field training, including attention to different age groups in the work force, social, community and health services.
- Antiphimic treatment to 100% of the TB cases among people with HIV/AIDS (PLWHA)
- Availabiity of chimioprofilaxis for TB for PLWHA who have a negative diagnosis.
- Epidemiological and operational research on the co-infection.

4.3.5	**Common funding mechanisms** *This section seeks information on funding requested in this proposal that is **intended to be contributed through a common funding mechanism** (such as Sector-Wide Approaches (SWAp), basket or pooled funding (whether at a national, sub-national or sector level).*	
(a)	Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism?	☐ Yes ➔ *answer questions below.* x☐x No ➔ *go to section 4.4*
(b)	Will the funding requested be channeled to implementation partners/beneficiaries through a common funding mechanism for all years of the proposal, and in regard to all proposed interventions/activities? If not, which years, what activities, and why this approach?	
(c)	**Describe the common funding mechanism, whether it is already operational and the way it functions**. In your response, identify development partners who are part of the common funding mechanism and their respective level of financial contribution (in percentage terms) to the common funding mechanism. *(Please also provide documents that describe the functioning of the mechanism as an annex. These documents may include: the agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*	
(d)	Describe the process for independent supervision of the performance of the common funding mechanism. Also describe the outcomes of any recent assessment of the common funding mechanism undertaken according to these processes. **In particular, Applicants should fully explain any adverse outcomes, and what actions were taken to respond to these findings**. ***Attach,** as an annex to your proposal**, the most recent external assessment of the operations of the common funding mechanism**.*	

(e)	Describe the Applicant's assessment (**including by reference to any criteria used during the assessment process**) of the capacity of the common funding mechanism to absorb the additional funds generated by this proposal **and** ensure effective supervision of the work that is proposed. *Where relevant, provide details of any changes that have been agreed with the common funding mechanism as a result of this proposal to ensure that the funding (if approved) will be used in a **transparent, efficient and timely manner**.*
(f)	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 common funding mechanism is broader than this disease component, Applicants must explain the process by which they will ensure that funds requested will be used for tuberculosis activities during the proposal term*.

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4.4 Overall Needs Assessment

The outputs and outcomes planned to be achieved under this proposal (if approved) **should be based on an analysis of financial and programmatic gaps in national plans/programs to prevent and control the disease**.

To help Applicants identify these gaps:

Step 1 **Section 4.4.1** requests Applicants to identify gaps in the main programmatic areas targeted by this proposal, and the **level of additional coverage that is requested through this proposal**. *This is a summary of the main gaps only. Applicants must still describe the specific interventions/activities planned under this proposal (in section 4.6) and the targets and indicators that are proposed to evaluate performance during the proposal term (in the 'Targets and Indicators Table', Attachment A)*;

Step 2 **Section 4.4.2** requests Applicants to describe any health systems strengthening strategic actions ('**HSS Strategic Actions**') that are essential to ensure that the planned outputs and outcomes of this proposal will be achieved, **and to identify how much support for these actions is requested in this proposal**. HSS Strategic Actions are more fully discussed in the Round 7 Guidelines for Proposal (section 4.4.2). *Section 4.4.2 below also requests information on other current and planned levels of support for these same actions; and*

Step 3 **Section 4.5** requests Applicants to identify the overall disease specific financial need for the country/countries targeted in this proposal. **This table asks Applicants to identify,** on a national disease specific basis, **the overall financial needs required to prevent and control the disease**. **Thus 'Line A' in table 4.5 should include both program and essential disease specific health systems needs. All other lines in the table should also include both program and health systems needs if these are essential to the national disease prevention and control plan.** *This is a summary of the financial needs only. Applicants must provide a detailed budget request by disease component (within section 5) and summarize this request in table 1.2.*

Thereafter, in section 4.6, Applicants should fully describe the specific interventions/activities which are included in this proposal to ensure that the programmatic needs targeted by this proposal are fully met.

See the Guidelines for Proposals, sections 4.4 and 4.5, for further explanation.

4.4.1 Programmatic Needs Assessment

4.4.1 Overall programmatic needs assessment

(a) **Based on an existing Health Sector Strategic Plan** *(or, if not in existence, an analysis of national/regional goals, together with careful analysis of disease surveillance data and target group population estimates for relevant prevention and control strategies)*, **describe the overall programmatic needs in terms of people in need of these key services**. Please indicate the quantitative needs for three to five main services that are intended to be delivered for this disease component (e.g., Directly Observed Treatment Short-Course for tuberculosis treatment). Also specify clearly how much of this need is currently covered (or will be covered) over the proposal term by domestic sources or other donors.

Please note that this gap analysis should guide the completion of the Targets and Indicators Table required under section 4.6. When completing this section, please refer to the Guidelines for Proposals, section 4.4.1.

Table 4.4.1 summarizes the projections for five "Key Services."These are derived from the main programatic needs to promote the STOP-TB strategy that is found in the TB Strategic Plan (ref TB-1.11). See 4.4.1.b to estimate the population that requires each key service, the number who would receive it without this project, the non-satisfied needs ("the gap") and the portion of this gap that is proposed to be covered.

Improved Detection. TB detection depends from the respiratory symptomatic (RS) that reach the health system (passive capture). To improve the outreach of RS, active methods will be implemented including the use of mobile units collaborating with the HIV program.

TB and MDR TB Case Treatment It is proposed to incrase the number of cases in treatment to reach

45% of the cases presently not being detected with a prevalence study.

Integrated management of TB/HIV co-infection. A coordinated effort will be organized to reduce TB/HIV mortality, concentrted in PLWHA.

Strengthening the health system trough PAL. With an initial coverage of 10% of health establishments of MOH, using R2 resources from the GF, the goal is to reach a coverage of at least 90% of the whole health system for 2012.

Population education. It is proposed to keep the level of knowledge of TB among the overall population and increase it to 87%, in order to support community mobilization and civil society to form support groups that help increase case detection and improve supervised treatment.

(b) **Complete table 4.4.1**

Table 4.4.1 is designed to assist Applicants to clearly illustrate overall programmatic needs in terms of people in need of key services. Applicants should note that this gap analysis should be used to guide the completion of the Targets and Indicators Table in Attachment A to the Proposal Form (see section 4.6 of the Guidelines for Proposals). **In addition, please specify below** relevant information concerning the groups targeted and any assumptions including target size.

Populations and goals for these "key services" have been trageted as follows:

- **Improved Detection**: *Part A.* The population of people who need a diagnosis are persons with "respiratory symptoms" (RS) that visit the health system. *Part B.* Represent the part of the RS flow that finishes the research phase, based on 2005-2006 data and growth projection of new cases in the population (from Template: WHO—Stop TB).The project will increase: 1) the portion receiving diagnosis with improved laboratory facilities; 2) laboratory improvement and 3) the size of the RS flow that arrives with active capture. *Part D.* The portion of the gap served (additional) cases is consistent with the goals of the indicator #7 (adding present and additional) cases.
- **TB and MDR TB Case Treatment**: *Part A.* The population needing treatment is taken as the number of total cases estimated by WHO (2005) and projected until 2013, with a slow reduction based on the calculation of the Template WHO-Stop TB. *B.* Population to be served with the present resources is projected based on the number of TB cases diagnosed in 2005 as 3% of the number of RS followed (Key service 1, part B). *Part C.* The gap is the difference between A and B; nevertheless, it is considered that WHO estimates on which part A were based are over-estimated (see point 4.3.2.b) and the real gap is smaller. *Part D.* The real gap was calculated based on the YRTI study in El Salvador (2005; see ref TB-1.13) and the outreach estimated increase in the number of cases that are feasible to be detected with active outreach capture, expressing it as a percentage of C.
- **Integrated Management of TB/HIV co-infection:** *Part A*. The population of TB-HIV co-infected is taken according to the growing relationship observed in the total of TB cases 2002, (3.6% of the TB cases being treated; 2003, 7.2%); 2004, 6.0%; 2005, 11.6%; 2006, 9.8% (see ref TB-1.15, Epidemiological Situation). For 2005 and 2006, the percentages observed to the number estimated of TB cases in the country were applied (Key Service 2, part A). For 2007 12% is estimated among TB cases, and starting 2008, 15% are estimated. *Part B.* The number of co-infected receiving treatment at present is estimated applying these percentages to the number of TB cases in treatment (key service 2, part B). *D*. The percentage of the gap to be served is calculated 15% of the number of cases of TB that will be under treatment (taking Key Service 2, part B, plus Key Service 2, part C, multiplied by part D).
- **Strengthening the health system through PAL**: *Part A.* The population who needs PAL is (RS) who reach health systems. This number is taken from the Key Service 1 data, part A. *Part B*. The aim of the government is to keep present coverage of 10% of PAL during 2007 to 2012. *Part D*. The portion of gap (part C) to be covered with this proposal has been calculated to reach the goals of the #5 indicator (coverage PAL) in Attachment A. For example, it ends in 2012 with a 90% coverage in the country, requiring to cover 89% of the gap (part C), plus 10% already covered in part B.
- **Population Education**: *Part A*. The population to be educated on TB is taken as an 85% of the population 8excluding minors). *Part B*. The population present knowledge TB is calculated based on impact evaluation (2007) of the campaign supported by the GF (R2), that calculated that 75% of those who know about TB among the target population. By 2008 to 2012, a decrease of 10% is calculated

per year in this population, if message reinforcement does not continue. *Part D*. The portion of the gap is calculated (part C) to be covered to reach the goals of indicator 6 (% of the population with basic knowledge of TB).

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Please refer to the M&E Toolkit when completing this table for information on key services and service delivery areas.

Important Note: For at least three (but not more than five) "key service" areas targeted by this proposal, list the size of the target group in Part A of table 4.4.1 below, and then complete Parts B, C and D for the same "key service" area. [For example, if the country's planned outcome by 2012 is that 10,000 HIV positive tuberculosis patients received CPT during their tuberculosis treatment (Part A in the table below), and current and planned support, including all existing Global Fund and other donor support, is expected to ensure that 3,000 patients will receive CPT by 2012 (Part B in the table below), the overall unmet need will be 7000 (Part C in the table below). In Part D of this table, Applicants should then describe the extent of additional coverage for this key service targeted by this proposal.]

Table 4.4.1 – Overall programmatic needs assessment

		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Part A: People in NEED of Key Services (i.e. Country desired/planned outcomes up to 2012)									
Key Service 1	Improved Detection: Capture of RS for TB diagnosis	68809	69987	71156	72316	73466	74608	75740	76863
Key Service 2	TB and MDR TB Case Treatment:	4688	4604	4516	4336	4084	3855	3636	3432
Key Service 3	Integral Management of TB/HIV co-infection	544	451	542	650	613	578	545	515
Key Service 4	Strengthening the health system through PAL	68809	69987	71156	72316	73466	74608	75740	76863
Key Service 5	Population education (knowledge on TB)	5848900	5948900	6048300	6146800	6244600	6341700	6437900	6533300
Part B: People CURRENTLY RECEIVING or EXPECTED TO RECEIVE Key Services relevant to this proposal as financed by current or anticipated resources:									
Key Service 1	Improved Detection: Capture of RS for TB diagnosis	57754	50557	53367	54237	44079	44764	45444	46117

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		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Key Service 2	TB and MDR TB Case Treatment	1794	1615	1601	1627	1322	1343	1363	1383
Key Service 3	Integral Management of TB/HIV co-infection	208	158	192	244	198	201	204	207
Key Service 4	Strengthening the health system through PAL	0	6999	7116	7232	7347	7461	7574	7686
Key Service 5	Population education (knowledge on TB)	3801800	4164200	4657200	4191500	3772300	3395100	3055600	2750000
Part C: TOTAL UNMET NEED for people in need of the 'Key Services' relevant to this proposal ($A^1 – B^1 = C^1$, $A^2 – B^2 = C^2$ etc.)									
Key Service 1	Improved Detection: Capture of RS for TB diagnosis	11055	19430	17789	18079	29387	29844	30296	30746
Key Service 2	TB and MDR TB Case Treatment	2894	2989	2915	2709	2762	2512	2293	2049
Key Service 3	Integral Management of TB/HIV co-infection	336	383	350	406	415	377	341	308
Key Service 4	Strengthening the health system through PAL	68809	62988	64040	65084	66119	67143	68166	69177
Key Service 5	Population education (knowledge on TB)	2047100	1784700	711273	1955300	2472300	2946600	3382300	3783300

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		Programmatic Gap Analysis							
		Actual		Anticipated					
		2005	2006	2007	2008	2009	2010	2011	2012
Part D: PORTION OF UNMET NEED COVERED BY THIS PROPOSAL									
Key Service 1	Improved Detection: Capture of RS diagnosis of TB (indicator 7)	*Information provided in the adjacent columns should be consistent with the annual targets for these "key services" in the 'Targets and Indicators Table' (**Attachment A**) to the Applicant's proposal.*			12%	57%	64%	69%	75%
Key Service 2	Treatment of TB and MDR TB Cases (indicator waits for YSTI study)				18%	24%	27%	29%	30%
Key Service 3	Integral Management of TB/HIV co-infection (indicator 4)				41%	23%	27%	30%	37%
Key Service 4	Strengthening the health system through PAL (indicator 5)				11%	33%	56%	78%	89%
Key Service 5	Population education (incl. ACMS and community participation) (Knowledge of TB & measures (ind 6)				34%	52%	63%	71%	78%

4.4.2 Strategic actions to strengthen health systems

***As explained at the start of section 4.4**, certain '**HSS Strategic Actions**' may be essential (dependent on country specific contexts) to ensure achievement of the outputs and outcomes targeted by this proposal. These HSS Strategic Actions may include actions to improve grant performance, address current or anticipated barriers, and/or support and sustain expansion/scale-up of interventions to prevent and control the disease.*

***The Global Fund therefore strongly encourages Applicants to include in their proposal a request for support of relevant HSS Strategic Actions which are coordinated with the national disease control strategy**.*

Before completing this section, Applicants should refer to the Round 7 Guidelines for Proposals, section 4.4.2. where significantly greater detail is provided on HSS Strategic Actions supported in Round 7.

4.4.2 Description of HSS Strategic Actions included in this component

(a) **Complete table 4.4.2 below to describe for up to five actions** *(copy the table as many times as relevant)*:

(iv) the **HSS Strategic Actions** that are **essential to achieve the planned outputs and outcomes of this disease component**;

(v) **how the actions link to the planned work during the program term** and **address** key points arising from the analysis of the health system referred to in your response to question 4.3.4 above; and

(vi) **what other support is currently available or planned for the same actions** to ensure achievement of the planned outputs and outcomes of this proposal.

Ensure that the HSS Strategic Action(s) is/are consistent with (where one exists) the national Health Sector Development Plan/Strategic Plan and its time frame *(please also ensure you provide this Plan as an annex to the proposal as requested in section 4.3.1)*.

To clearly demonstrate the link requested in (ii) above, Applicants should relate proposed HSS Strategic Actions to disease specific goals and their impact indicators. ***Refer to the information on the revised indicators for HSS in the Guidelines for Proposal at section 4.4.2.*** *(Where only one strategic action is proposed, Applicants must explain the rationale behind this decision with reference to the guidance provided in the Guidelines for Proposals.)*

***Remember to expand the table for up to five HSS Strategic Actions**.*

4.4.2A Summary of funding requested for HSS Strategic Actions in Round 7

In the table below summarize, on a per year basis, the total of the funding requested for HSS Strategic Actions in this proposal for this disease component. *This will be the sum of the 'Funding Request' for each year for each HSS Strategic Action included in this disease component, as detailed by you in table 4.4.2 (**on the following page, copied for up five HSS Strategic Actions**). Applicants are reminded that they must ensure that the overall funding needs (table 4.5) include both program and essential disease specific health systems needs to ensure that the financial gap analysis reflects all available, planned and required resources.*

Total funds for essential HSS Strategic Actions requested over proposal term					
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
$ 159,751	$ 116,876	$ 158,876	$ 123,876	$ 118,876	$ 678,255

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Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 1	*(Description of the HSS Strategic Action, its rationale and linkages to this proposal **– not more than half a page for each HSS Strategic Action**)* **Extend the application of PAL to more than 90% of the health system** through the strengthening of the capacity for diagnosis in respiratory diseases in primary health care, and the standardized management of cases through the PAL initiative, incorporating health establishments, to go from a 10% to a 90% of coverage between 2008 and 2012. This is an integral part of the STOP TB strategy, and at the same time strengthens the entire system.

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*

Year 1	Year 2	Year 3	Year 4	Year 5
PAL covers 20%	PAL covers 40%	PAL covers 60%	PAL covers 80%	PAL covers 90%
Round 7 Funding Request Year 1	Round 7 Funding Request Year 2	Round 7 Funding Request Year 3	Round 7 Funding Request Year 4	Round 7 Funding Request Year 5
$ 104,000	$ 88,850	$113,850	$103,850	$98,850

Describe below other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as this proposal)*	**Expected outcomes from existing and planned support**
Government	2008-2012	$ 350,000	Provides personnel, infrastructure, operative support and others

Action 2	*Description of the HSS Strategic Action, its rationale and linkages to this proposal **– not more than half a page for each HSS Strategic Action**)* **Strengthening of infection control in health establishments and jails** These are two parts: 1) improving facilities, areas, equipment and personnel training; 2) changes in the norm, through international technical assistance (with a national counterpart) to do a legal technical analysis to finalize and validate a proposal for the Legislative Assembly. This will require advocacy and communications activities to achieve their adoption. Both aspects will benefit the TB programs (including MDR TB), HIV and the integrated management of co-infection TB/HIV, MDR-TB, as well as other areas of health.

Describe below the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term, and, as a total only, the amount requested for each year. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget).*

Year 1	Year 2	Year 3	Year 4	Year 5

Strengthening of infection control	Strengthening of infection control	Strengthening of infection control	Strengthening of infection control	Strengthening of infection control
Funds requested for the year 1 – Seventh Call	Funds requested for the year 2 – Seventh Call	Funds requested for the year 3 – Seventh Call	Funds requested for the year 4 – Seventh Call	Funds requested for the year 5 – Seventh Call
$ 55,751	$ 28,026	$ 45,026	$ 20,026	$ 20,026

Describe below other current and planned support for this action over the proposal term

*In the left hand column below, please identify the name of **other providers** of HSS strategic action support. In the other columns, please provide information on the type of outputs.*

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as this proposal)*	**Expected outcomes from existing and planned support**
Government	2008-2012	$ 3,785,000	norm application

4.4.2 HSS Strategic Actions continued
Risks arising from support for the actions and cross-cutting issues

Applicants are strongly encouraged to refer to the Guidelines for Proposals before completing (b) to (g) below.

(b) Describe your consideration of the broader implications of the proposed strategic actions and their potential impact on the functioning and performance of the health system, key institutions and stakeholders and other health programs (through a SWOT or other similar exercise). Describe, especially, any risk mitigation strategies in response to potential threats to the health system, and proposed options for ensuring long-term sustainability of the strategies built into this proposal.

These actions respond to opportunities to widely benefit the health system, without noticeable risks, besides the risk that the increase in service demand may exceed during some time the system's capacity to supply the service. Implementation of PAL is foreseen as a sector goal, as well as the improvement of infections control: both will agree with the interested parties.

(c) Are there cross-cutting HSS Strategic Actions integrated within **this component** that will benefit any other disease component **also** submitted for funding in Round 7?

☐ Yes
➔ *complete (d) and (e), and then (f)*

xx☐ No
➔ *go to section 4.4.2(f)*

(d) **If yes to (c)**, provide a short description of which component(s) and how the HSS Strategic Actions in this component will benefit achievement of the outputs and outcomes targeted in the other component(s).

N/A

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(e)	If relevant, provide a detailed justification (*with clear information on direct linkages to this disease component)* for those cross cutting HSS Strategic Actions in this component which you believe should still be funded even if one or both (as relevant) of the other components submitted in Round 7 are not recommended for funding. *(**Two page maximum**, including summary details of relevant actions and budget amounts. Also ensure that the budget amounts for HSS Strategic Actions are clearly indicated in the detailed budget required in section 5 for this component). Refer to the Guidelines for Proposals, section 4.4.2(d) for additional guidance.*	
	N/A	
(f)	Are there any cross-cutting HSS Strategic Actions integrated within **another component** in your Round 7 proposal that will benefit this component? *Applicants should ensure that the detailed budget in the other component(s) clearly identify the costs of the HSS Strategic Actions. Applicants must also ensure that there is no duplication of costs included in the various components.*	☐ Yes, Tuberculosis ☐ Yes, Malaria X☐ No

(g)	**CCM and RCM Capacity for Health Systems Strengthening Issue identification**. Describe below how the CCM(s) and RCM(s) of countries targeted in this proposal are ensuring that they have, or are developing and/or strengthening, their capacity and experience in the identification of strengths, weaknesses, threats and opportunities in the health system relevant to national plans to prevent and control the disease(s). Applicants must also describe if there have been any changes in the relative capacity of the CCM(s) or RCM(s) since Round 6. ➔ *Refer to the Guidelines for further information,, section 4.4.2(g)*
	MCP in El Salvador has not focused on this subject to date, partly because it has not structured to facilitate an overview. Nevertheless, it is considered important to develop an analysis of the type during the next year. The MCP will happily complete more information from the GF on this subject.

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4.5 Financial Needs Summary

4.5.1 Overall Financial Needs Assessment

Based on an analysis of the national goals and objectives for preventing and controlling the disease, describe the overall disease specific financial needs. Include information about how this costing has been developed (e.g., through costed national strategies, Medium Term Expenditure Framework [MTEF] or other basis). As described in step 3 under section 4.4, such analysis should recognize any required investment in the HSS Strategic Actions described in section 4.4.2 above.

Summarize the overall financial need in table 4.5.

Based on the objectives of the TB component, a calculation was performed of the comprehensive financial needs of the health sector per year between 2008 and 2012, and the proposal period. They add a comprehensive estimate of US$18,841,144 (data from the WHO STOP-TB Workbook, ref TB-1.17). The comprehensive financial needs for one year, are the following:

Actual: 2007: $ 2,772,784]

Planned: 2008: $ 3,102,691; 2009: $ 4,361,954

Estimated: 2010: $ 4,027,875; 2011: $ 3,844,314; 2012: $ 3,504,310

The spending level planned for 2009-2010 is higher than the investment required in laboratories and equipment

The contributions with national financing for the same period (2008-2012 from point 4.5.2.a) is calculated in $8,763,007, while the external contribution is $318,147 (from point 4.5.2.b), that add an availability of funds of $9,081,154, obtaining a financial gap of $9,759,990 during the project period.

4.5.2 Current and planned sources of funding

(a) **Domestic Sources**

Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. Please also explain the process of prioritization of such funding to ensure that resources are utilized efficiently and on a timely basis (e.g., explain if there are significant available in-country resources, such as HIPC [Heavily Indebted Poor Country] debt relief or other such resources which are available to support disease prevention and control strategies, and how these resources are being efficiently used).

Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line B.

On these actual and foreseen national sources, it is evident that the financing for the Tuberculosis Component with national financing resources, which are estimated in a total of US$8,760,007 for the 2008-2012 period, which is distributed per year as follows:

NATIONAL FINANCING SOURCES	*ACTUAL*		PLANNED		FORESEEN			TOTAL 2008-2012
	2006	*2007*	**2008**	**2009**	**2010**	**2011**	**2012**	
	$1,817,898	*$1,712,455*	**$1,600,294**	**$1,712,021**	**$1,963,070**	**$1,749,287**	**$1,738,335**	**$8,763,007**

(b) **External Sources**

Describe current and planned financial contributions anticipated from all relevant external sources relating to this component (including, based on section 1.6, existing grants from the Global Fund and any other external donor funding).

Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line C.

External contributions come from the Global Fund Round 2 and only cover the year 2008 during the period 2008-2012: $318,147.

4.5.3 Overview of Financial Gap

In table 4.5, Line E, provide a calculation of the gap between the estimated overall need (Line A, table 4.5) and **current and planned available resources for this component** (Line D, table 4.5).

*This table is a summary **only** of overall funding gap. Applicants must provide a detailed budget (see section 5) to identify the amount requested in this proposal in section 5.*.

4.5.4 Additionality

Describe how Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources. Explain plans to ensure that this will continue to be true for the entire proposal term.

The activities planned extend and complement those that are budgeted by the MOH and other entities in the health sector. There is a commitment at the government level in the sector (Ministry of Health, ISSS, ISRI, etc.) of not decreasing, but incrementing the public financial level of this sector.

4.5.5 Strategy for achieving sustainability

Describe the strategies and approaches that will be used during the proposal term to ensure that the interventions/activities initiated and/or expanded by this proposal will more likely be sustainable (continue) beyond the proposal term. *(See section 4.5.5 of the Guidelines for Proposals.)*

Note ➔ *Applicants are not required to demonstrate financial self-sufficiency for the targeted interventions by the end of the proposal term. Rather, their description should include how the country/countries targeted in the proposal are addressing their capacity to absorb increased resources and recurrent expenditures, and how national planning frameworks are seeking to increase available financial and non-finanical resources to ensure effective prevention and control of the disease(s).*

The government is already taking the following actions:

- Absorption of human resources contracted through the funds from the second round of the GF by the Salvadoran Government, as well as vehicles and infrastructure.
- Human resources at the national level for the monitoring, supervision and evaluation of the execution of the project.
- Human resources from the health services network for the detection, diagnosis and treatment of TB, MDR TB and co-infection TB/HIV.
- Infrastructure logistic and operative support (health establishments network)
- Laboratory network in the sector supporting the diagnosis.
- Incorporation of Reference Centers in the sector for quality control of bacilloscopy to diagnose TB.

Within this context, sustainability refers to the capacity of El Salvador to continue executing strategies and actions with efficiency and quality, sensitive to the needs of the country, once the

financial support from the GF has ended. This will become evident with the development of the following aspects: (1) national capacity to address the organization of the prevention services, attention and control of TB; (2) application of the new strategy of STOP-TB at the national level;)3) develop special interventions for the detection of cases and follow-up of DOTS, especially among the migrant sectors (seasonal agricultural); and (4) negotiation for greater financing for the fight against TB in El Salvador, considering it a public health priority.

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Table 4.5 - Financial contributions to national response

Financial gap analysis *(same currency as selected in section 1.1)*								
Refer back to instructions under section 4.4, step 3	**Actual**		**Planned**		**Estimated**			
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Line A ➔ Overall disease specific needs costing including essential disease specific health systems needs	$ 2,607,338	$ 2,744,567	$2,772,784	$3,102,691	$4,361,954	$4,027,875	$3,844,314	$3,504,310
Domestic source **B1** : Loans and debt relief (*provide donor name*)								
Domestic source **B2** : National funding resources	$ 1,664,258	$ 1,817,898	$ 1,712,455	$ 1,600,294	$ 1,712,021	$1,963,070	$ 1,749,287	$1,738,335
Domestic source **B3:** Private Sector contributions (national)								
Total of Line B entries ➔ Total current & planned domestic resources	1,664,258	$ 1,817,898	$ 1,712,455	$ 1,600,294	$ 1,712,021	$1,963,070	$ 1,749,287	$1,738,335
External source **C 1**: All current & planned Global Fund	$ 691,194	$ 661,525	$473,286	$ 318,147				
External source **C2** (*provide donor name*)								
External source **C3** (*provide donor name*)								
External source **C4**: Private Sector grants/ contributions (International)								
Total of Line C entries ➔ Total current & planned external resources	$ 691,194	$ 661,525	$473,286	$ 318,147				
Line D ➔ Total current and planned resources ➔((i.e. Line D = Line B Total +Line C Total)	$ 2,355,452	$2,479,423	$2,185,741	$1,918,441	$ 1,712,021	$1,963,070	$ 1,749,287	$1,738,335

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Financial gap analysis *(same currency as selected in section 1.1)*								
Refer back to instructions under section 4.4, step 3	**Actual**		**Planned**		**Estimated**			
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Line E ➔ Total Unmet need (Line A – Line D) -	$ 251,886	$265,144	$587,043	$1,184,250	$2,649,933	$2,064,805	$2,095,027	$1,765,975
The table above is provided for planning purposes to identify the ceiling of funding needs. The Global Fund recognizes that the proposal term (if approved) may straddle calendar years depending on the start date of the grant agreement that may be signed.								

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4.6 Tuberculosis component/implementation strategy

This section describes the strategic approach of the proposal, and the activities that are intended to be supported over the proposal term. Section 4.6 contains important information on the goals, objectives, service delivery areas and activities, as well as the indicators that will be used to measure performance. For more detailed information on the requirements of this section, see the Guidelines for Proposals section 4.6.

In support of this section 4.6, all applicants must submit by disease component:

1. A **Targets and Indicators Table** ➔ This is included as **Attachment A** to the Proposal Form. *When setting targets in this table, **please refer explicitly to the programmatic needs analysis** in section 4.4. All targets should be measurable and identify the current baseline. **Importantly, this table will be utilized to measure performance of the program over the whole proposal term.** For definitions of the terms used in this table, see the 'Explanatory Note' provided on the first sheet in 'Attachment A' (Targets and Indicators Table) to the Proposal Form. Refer to the Guidelines for Proposals, section 4.6.*

and

2. A **Work Plan** ➔ which must meet the following criteria. *(Refer to the Guidelines for Proposals, section 4.6):*

   d. Structured along the same lines as the Component Strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.

   e. Covers the first two years only of the proposal term and is:
   i detailed for year 1, with information broken down by quarters;
   ii indicative for year 2, with information at least half yearly.

   *f. **Consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above.*

***Please note that other documents are also required to be submitted to ensure a complete application for Round 7 funding**. Applicants are strongly encouraged to use the by-disease checklist after section 5 to ensure that all necessary documents are attached to the proposal submitted to the Global Fund.*

IMPORTANT INFORMATION FOR APPLICANTS RE-SUBMITTING A PREVIOUSLY UNAPPROVED ROUND 5 or ROUND 6 PROPOSAL FOR THIS SAME DISEASE COMPONENT

4.6.1 Re-submission of an unapproved Round 5 and/or Round 6 proposal

If this proposal is a resubmission of proposal for the same disease component from either Round 5 and/or Round 6 that was not approved, **attach the 'TRP Review Form'** provided by the Global Fund to the Applicant after the Board decision for the earlier Round(s). *(The TRP Review Forms should be listed as an annex to the proposal in the checklist at the end of section 5 of this disease component).*

In the section below, please describe what specific adjustments have been made to this proposal to take into account each of the 'weaknesses' listed by the TRP in the 'TRP Review Form'. *(Maximum two pages. Applicants should ensure that they clearly detail which earlier proposal is being referred to, and what specific actions have been taken to remedy issues raised by the TRP. Applicants should provide details on what has been strengthened about this proposal, compared to an earlier unapproved proposal.)*

Weaknesses (in TRP comments to R6 application)

- The description of activities in Section 4.6.3 is incomplete and vague. It therefore does not give a clear picture of the activities to be undertaken.

This has been corrected. Activities are now described more explicitly.

- Training targets are too high and no feasibility discussion is provided. The work plan, for example,

for year 1 calls for training a total of 7335 persons: 4 000 doctors, 600 nurses, 600 health promoters, 1500 leaders and community professionals, 135 laboratory staff and 500 professionals on counseling regarding HIV.

Goals and methods for training have been adjusted and clarified.

- The work plan and the budget for year 1 show different numbers of targeted trainees in some training activities. The work plan, for example, proposes to train 500 professionals and update 1500 professionals in DOTS strategy in Year, where as the budget lists 800 and 1000 (first two activities under Objective 1).

An effort has been made to be more consistent in this request.

- Four rows of figures of the Table 4.5 1-3 on the financial gap analysis are inaccurate. Exact figures are found in the small tables provided on page 13.

Consistency among tables has improved in this request.

- The work plan and budget include research activities and lacks detailed information on set objectives and scope of such activities. There is no information on how their cost was estimated.

Although no investigation is included as such, operational studies proposed are mentioned among the activities and characterized in the detailed budget, with information on how the budget was calculated.

- The activities to control multi-drug resistance are not included in the description of activities under the different objectives mentioned in Section 4.6.3. The budget allocates US$ 44, 000 to these activities in year 1, without specifying the number of cases that are to be treated.

Again, there has been an effort to be more consistent in this proposal. MDR TB activities have been specified, and the budget details the costs calculation.

- The budget foresees the purchase of drugs for respiratory diseases other than tuberculosis under the PAL initiative. The work plan, however, fails to describe activities under this initiative. It is not known how many patients, which diseases and with which drugs will be treated.

Ditto. Same as above.

- The budget on supervision is based on proportions of health units to be visited but does not provide absolute numbers relating to how many visits can be performed with the assigned budget.

Ditto.

- There is no information on which kind of incentives will be provided to health workers and patients In Year 1 sets aside a budget of US$ 65000 for this activity.

These incentives are described in the budget notes. They cover transportation expenses to community promoters and patients in extreme poverty, as well as provision of back packs to promoters and community volunteers, and patients who comply faithfully with their treatment.

- Figures regarding the cost of monitoring and evaluation (M and E) activities are confusing. For instance for Year 1: Tables 5.1 allocates $ 239 212 for M and E plus training and supervision. Table 5.6 allocates the same amount only for M and E. The detailed Quarterly Budget for Year 1 allocates only US$ 35,000 for the component on Monitoring, Evaluation and Institutional Strengthening Activities.

This has been corrected

- Cotrimoxazole prophylaxis is not included in the case management of HIV positive TB patients

  Cotrimoxazole prophylaxis is covered by the HIV component and appears in the corresponding protocol for co-infected patients.

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4.6.2 Goals and objectives and service delivery areas

Referring to your overall needs assessment in section 4.4.1 above, provide a summary of the proposal's overall goal(s), objectives and service delivery areas. *(The information below should be **no longer than a one page summary**, and Applicants should provide **detailed quantitative information in Attachment A** ('Targets and Indicators Table') **to this Proposal Form**).*

Goal: **Expand the STOP TB strategy to the national level**, to control TB and decrease morbi/mortality with emphasi in the most vulnerable groups.

OBJECTIVES:

1. Continue expanding and strengthening DOTS.
2. Address TB/HIV, MDR TB and other challenges (e.g. jails, migrant populations)
3. Contribute to strengthening the health system.
4. Empower those affected by TB and their community.

Objective	SERVICE DELIVERY AREAS
1	1.1 Improved diagnosis
1	1.2 Standardized treatment and support to patients.
1	1.3 Management of purchases and supplies.
1	1.4 Monitoring and evaluation.
1	1.5 Management and supervision of program.
1	1.6 Human resources.
2	2.1 Collaborative management of TB/HIV co-infection.
2	2.2 MDR TB prevention and control.
2	2.3 Treatment of prisoners, migrants and other high risk groups
3	3.1 Active participation to improve the health system.
3	3.2 Practical focus on Lung Health. (PAL).
4	4.1 Advocacy, communication and social mobilization (ACSM).
4	4.2 Community participation in the care of TB patients.

4.6.3 Specific Interventions, Target Groups and Equity

(a) **Specific Interventions/Activities supported by this proposal**

Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. Please include an overview of all the activities proposed, how these will be implemented, and by whom. *(Where actions to strengthen health systems are planned, applicants are also required to provide additional information at section 4.4.2.)*

Objective 1: Continue the expansion and strengthening of DOTS quality strategy. [Pursue high-quality DOTS expansion and enhancement.]

Service Delivery Areas	Activity	How it will be performed	Responsible
roved gnosis	1. Improve laboratory infrastructure: a. Central laboratory. b. Three regional laboratories for culture. c. 21 peripheral bacilloscopy laboratories.	1. Contract services to improve these laboratories, according to technical specifications in the National Tuberculosis Program (NTP).	PR through Executive Unit contracts, procurement a others.

		2. Provide equipment, supplies and laboratory maintenance 3. Strengthen quality control at the national and international levels.	2. With NTP technical specifications, purchase equipment & supplies and maintenance (for X rays, culture, PPD, etc). 3. Guarantee delivery of samples to national and international labs via courier enterprises.	For technical issues, public and private suppliers of health services.
Standar-dized treatment and care.		1. Improve infrastructure in 5 areas for patient service. 2. Provide incentives to patients to stimulate them to adhere to treatment. 3. Support health workers to facilitate community participation.	1. Contract services to improve facilities in priority areas. 2. Subsidize transportation subsidy to patients in extreme poverty (15%) and reward with a back pack or bags those who finish their treatment. 3. Provide transportation and back packs to communities without access to public transportation.	PR through the Executive Unit. MOH, ISSS, ISRI, Teachers Wellbeing, Jails, Military Hygiene and NGOs, among others.
Procure-ment and Supply Manage-ment		1. Assure storage capacity for medicines and supplies at the local and regional levels. 2. Second line drugs procurement.	1. Contract services to improve priority warehouses. 2. Direct purchase through the Green Light Committee.	PR through the Executive Unit. PR through the Executive Unit. Service suppliers
Monitoring & evaluation		1. Measure TB prevalence at the national level and other studies to monitor the implementation of the STOP TB strategy. 2. Improve program information systems. 3. Strengthen analysis capability at the national and local levels.	1. Through prevalence studies of Yearly Rate of Infection due to Tuberculosis and others. 2. Purchase equipment and computers for the integration of information systems on TB to the national information system, and analytical areas not yet supplied. 3. Contract external and/or national technical assistance.	PR through the Executive Unit. . Public and private suppliers in the health sector, NGOs and community organizations.
Program manage-ment and supervision.		1. Improve supervision of new STOP TB implementation from the central to the regional to the local level. 2. Carry out periodical meetings at the national, regional and local levels. 3. Strengthen national infrastructure.	1. Purchase 2 vehicles and supplies for supervision at central, regional and local levels; pay per-diem and registry fees. Vehicles will also support M&E and medicine distribution. 2. Rent space and purchase supplies for meetings, as well as per-diem and national technical assistance. 3. Improve offices, purchase equipment and supplies.	PR through the Executive Unit.
Human Resources		1. Strengthen human resources for implementation of the STOP TB strategy.	1. Through 1) Course "Integral Attention to Tuberculosis and TB/HIV co-infection"; 2) specific training courses for new personnel; 3) design and production of training material; 4)	PR through the Executive Unit.

		2. Standardize TB content in curricula of schools for health personnel training.	attend national and international events according to TBNP priorities. 2. Through workshops, documentation, provision of supplies and materials.	National Teaching Committee
Objective 2: Address TB/VIH Co-infection, MDR TB and other challenges (high risk populations).				
Collabor-ative manage-ment of TB/VIH.		1. Develop a Collaborative Plan to Control TB/HIV Co-Infection. 2. Establishment of the monitoring and evaluation system for TB/HIV Co-Infection.	1. Through workshops of the TB/HIV co-infection committee, publication and dissemination of plan; training key personnel. 2. Meetings to measure indicators with follow-up and information analysis.	PR through the Executive Unit National Counseling Committee TB/TB-VIH/PAL
MDR TB prevention and control		1. Surveillance of resistance to primary and secondary anti-TB drugs. 2. Strengthen human resource for MDR TB.	1. Purchase equipment and supplies, publish and disseminate findings; hire an advisor for data analysis and final report. 2. Hire a specialist for MDR management.	PR through the Executive Unit.
Treat prisoners, migrants, other groups at high risk		1. Develop a program for high risk populations (migrants, prisoners and others) for TB, MDRTB and TB/HIV.	1. Locate and screen prisoners, migrant groups, seasonal workers, support asylum for the early detection of TB in internal population, etc; (share mobile units of the HIV/AIDS program).	PR through the Executive Unit.
Objective 3: Contribute to strengthen health systems.				
Active participation to improve the health system.		1. Update legal standards on infection control. 2. Strengthen infection control.	1. Hire an expert to carry out a situational analysis. 2. Prepare a National Plan for Infection Control with the support of international technical assistance. Improve infrastructure for better ventilation, purchase equipment and supplies, and implement personal protection measures. .	PR through the Executive Unit.
PAL		1. Training to implement PAL in 296 health establishments of MOH, ISSS and others to increase coverage of MOH, ISSS and others to increase coverage to 90% according to the existing national plan. 2. Provide equipment and supplies to establish PAL 3. Measure impact of PAL on the health system.	1. Purchase materials and supplies for training, using developed and verified methods. 2. Purchase equipment and supplies to implement PAL. 3. Provide technical assistance to evaluate PAL's impact	PR through the Executive Unit. National Counseling Committee TB/VIH/PAL

Objective 4: Empowerment of those affected by TB and their communities.				
Advocacy, communications and social mobilization (ACSM).	1. Strengthen political and inter-institutional commitment to control TB. 2. Change attitudes and behaviors in health providers and the population. 3. Involvement of civil society and patients in TB control 4. Measure effects and impacts of ACSM activities.	1. Design and execute an advocacy plan, contracting the services of a specialist. 2. Execution of an IEC plan: design and execution of campaigns through the media, design and production of material, congresses, others. 3. Social mobilization and organization of support groups for TB patients 4. Contract experts for operations research studies	PR through the Executive Unit.	
Community participation in TB care.	1. Involve high risk communities in the active search of persons with respiratory symptoms (RS) and strengthen their capacity to continue and support TB patients. 2. Support to TB patients in communities	1. Train volunteers and leaders in prioritized communities (jails, PLWHA), municipalities with high TB prevalence, others); cover training and related expenses. 2. Counsel patients and others through NGOs and development of processes towards the reduction of stigma and discrimination.	PR through the Executive Unit. .	

(b) **Target groups**

Provide a description of the target groups (and, where relevant, the rationale for inclusion or exclusion of certain groups). In addition, describe how the target groups were involved during planning, implementation and evaluation of the proposal prior to submission to the Global Fund. Describe the impact that the program will have on these group(s).

Principal target groups are:

- Persons with respiratory symptoms, who will get more complete diagnostic and treatment services due to expansion of PAL and active capture and follow-up on cases.
- Those ill withTB, who experience more evfective detection, diagnosis, and treatment.
- Populations with high prevalence of TB, such as jails, homes for the elderly, PLWHA, and some communities living in extreme poverty.
- Patients MDR TB and patients with TB/HIV co-infection, who will receive better treatment and follow-up and lower mortality rates..

These groups were represented in project design and proposal development through the health sector and development NGOs that participated in meetings and submitted written and verbal suggestions. Some of those NGOs are represented also in CCM (CCM). They will continue to be involved in the implementation phase as potential sub-recipients.

(c) **Equitable access to services**

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

TB program services are offered to all living in El Salvador without discrimination or cost. Diagnosis and treatment is free. It is proposed to expand coverage of services through active capture and the implementtion of the PAL strategy, thus reducing the traditionally underserved

segments of the population that do not receive treatment.

(d) **Social inequalities targeted in this proposal**

Describe how this proposal addresses the needs of specific marginalized groups in the country/countries targeted in this proposal. *For example, if your proposal targets a gender, age-group or other demographic presently excluded or underrepresented in existing service delivery activities, identify this and describe how the group(s) will be targeted.*

Please ensure that you include appropriate targets and indicators to monitor performance against these strategies in '**Attachment A**' (Targets and Indicators Table).

The activities of Objective 4, "empowerment of those affected by TB and their communities" – is signaling towards the education of other groups in civil society through massive media, as well as social mobilization. These activities will allow the active identification of RS, detection and treatement of TB. It shall also strengthen the capacity to work with the PLWHA communities to deal with TB/HIV co-infection as well as working with prisoners populations, their relatives and other contacts.

(e) **Stigma and discrimination**

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

Mass education campaigns, community participation, social mobilization, and empowerment will incorporate messages and lessons to fight stigmatization and reduce discrimination. The campaigns will be undertaken with with technical assistance to focus on specific groups, with support of patients, communities and civil society.

Linkages to other programs

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

(a) If this proposal is asking for support for the same "Key Services" or interventions supported by earlier Global Fund grants (including unsigned Round 6 grants), explain in **detail** why.

*Applicants should specifically refer to the Programmatic Gap Analysis Table in section 4.4 when completing this section, and clearly indicate if the goals, objectives and service delivery areas in this proposal represent an **expansion of planned outputs and outcomes** already supported through earlier Global Fund grants, **complementary** but not overlapping interventions, or **new and independent** interventions. Applicants are strongly encouraged to include a diagram to explain expansion-focused interventions where relevant.*

Applicants are strongly encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants (including 'Phase 2' amounts anticipated to become available) in this section. The reason(s) why a Round 6 grant remains unsigned at the time of submission of this proposal should also be explained.

Interventions proposed have as a base activities supported by Round 2 of GF and will build on the progress made. Nevertheless, this project will extend and deepen the R2 activities, and add major new elements. For R7 it is proposed to widen the coverage to other populations, through social mobilization and civil society involvement; to improve outreach and detection, to capture cases actively; to better supervise treatments and assure services, as well as approaching MDR TB cases more efficiently and with an integrated approach to TB/HIV co-infection cases. In summary, the target populations, products and results will be widened.

(b)	Where there are <u>any linkages</u> in this proposal to planned interventions already supported by Global Fund grants, **describe, by reference to information generated in regard to those existing grants**,** how implementation bottlenecks and lessons learned have been incorporated into the implementation strategy for this proposal to better ensure the overall feasibility of the planned interventions*(maximum one page).* *(**Applicants should refer to, for example, the most recent 'Progress Updates and Disbursement Requests' from a Principal Recipient, or the 'Grant Scorecard' published by the Global Fund after a grant has completed Phase 1.)*

The execution of the Round 2 project of the Global Fund for the TB component has been evaluated with an "A" (as of December 2006, per letter of 18 april 2007 from Luca Ochini), with the comment that global performance reflects a very high level of implementation compared with the goals established. .

The current R2 project will serve as a rich source of lessons and technical experience for the project proposed; no major problems or obstacles have arisen.

4.6.5	**Performance of and Linkages to other donor funding for the same disease**
	Provide an overview of the main achievements (in terms of outcomes and impact on the disease) which are planned over the same term as this proposal through the support of other external donors, whether bilateral or multi-lateral. Also describe if there are any major bottlenecks to implementation in those grants/programs which may be relevant to the implementation strategy for this proposal, and if so, what steps will be taken to mitigate such challenges.

No donors are anticipated

Private Sector Contributions

4.6.6	**Private Sector contributions**
(a)	If the Private Sector is intended to be a contributor/co-investor to the overall objectives of this proposal, describe below a summary of the main contributions *(whether financial or non-financial)* anticipated from the Private Sector during the proposal term, and how these contributions are important to the achievement of the outcomes and outputs. ➔ *Refer to the Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.*

No contributions are anticipated from the private sector, other than the cooperation of the private sector health services providers and NGOs in the sector.

(b) Refering to the population group(s) that will be the focus of the Private Sector co-investment partnership, identify in the table below the annual amount of the anticipated contribution. (For non-financial contributions, please attempt to provide a monetary value if at all possible, and at a minimum, a description of that contribution.)

Size of population group that is the focus of the Private Sector contribution ➔	Variable—the majority of NGO's work in one or more localities, with a few hundred several thousand beneficiaries in each location.

Refer to Guidelines for examples on 'Contribution Description' *** Add extra rows below to identify each main Private Sector contributor*	**Contribution Value** *(same currency as selected in section 1.1)*

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** Private Sector Contributor Name	Contribution Description *(in words)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
NGO`s/ Organi-zations	Participation with already existing resources for the fight against TB and HIV	$80,000	$80,000	$80,000	$80,000	$80,000	$400,000

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4.7 Principal Recipient information

In this section, Applicants should describe their proposed implementation arrangements, including the nominated Principal Recipient(s). See the Guidelines for Proposals, section 4.7, for more information.

Where the Applicant is a Regional Organization or a Non-CCM Applicant, the term 'Principal Recipient' should be read as the planned implementing organization.

The Applicant may nominate one or several Principal Recipients to lead implementation and undertake reporting to the Global Fund during the proposal term.

*To be eligible for funding in Round 7, CCM, Sub-CCM and RCM Applicants must ensure that each Principal Recipient has been **transparently selected** (refer to section 3A.4.5 of this Proposal Form)*

Table 4.7: Nominated Principal Recipient(s)

Indicate whether implementation will be managed through one or several Principal Recipients.	x☐x One
	☐ Several

Responsibility for implementation			
Name of Nominated Principal Recipient(s)	**Sector Represented**	**Name of Contact person**	**Address, telephone, fax numbers and e-mail address of contact person**
Ministry of Public Health and Social Assistance(MOH)	Nominated for activities of the Objectives 3 and 4 and some activities del Objective 2	Dr. Guillermo Maza	Calle Arce No. 827, San Salvador, El Salvador Tel. (503) 2205 7000 jgmaza@MOH.gob.sv

4.8 Program and financial management

4.8.1 Management approach

Describe the proposed approach of management with respect to planning, implementation and monitoring the program. Explain the rationale behind the proposed arrangements.
(Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM, Sub-CCM, or RCM where relevant. Maximum one page.)

The CCM, as a Country Coordinating Mechanism, based on the needs of El Salvador's HIV/AIDS and Tuberculosis program, coordinate national initiatives to be included in the proposal to guarantee access to financial resources of the GF. To comply with this purpose, CCM has a defined organizational structure, internal regulation and programmatic and administrative functions.

To comply with this proposal, the MOH has the Project Executive Unit that has coordinated, developed and efficiently executed the second phase of the tuberculosis component of the present project (Strategy of the Fight against HIV-AIDS, Tuberculosis and Malaria in vulnerable populations as co-helper in poverty reduction of El Salvador (2003-2008). For these functions, they will comply with the provisions and regulations corresponding to the Global Fund for the management of financial resources.

Said Executive Unit will develop the mechanisms and procedures established by the Global Fund for the contracting and transfer of funds to the Program component. The financial activities will be handled through the accounting and finance unit of the Ministry of Health, which according to norms and regulations established, provides careful monitoring of project income and expenses. The Executive Unit

will define two budgetary components, one for HIV/AIDS and the other for TB. They will apply the procedures for administrative and financial management, according to norms and regulations established for the negotiation of the program. Each Program component has the managerial and technical resources to formulate and develop work plans, delineating those activities to be developed, as well as financing required for its execution; A chronogram for each project component will be approved in very close coordination with CCM, for the subsequent development of the investment plan for each year of program management.

4.8.2 Principal Recipient capacities

Please note that if there are multiple Principal Recipients, section 4.8.2 below ***must be completed separately for each one****.*

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

Principal Recipient:

MINISTRY OF PUBLIC HEALTH AND SOCIAL ASSISTANCE (MOH)

The Principal Recipient, MOH, has proven administrative and technical capability to assume the administration and financial responsibility for the program through its Program Executive Unit that manages part of the present Global Fund in El Salvador (R2) program. Its performance has been rated "A", according to Global Fund evaluations.

It has experience in developing the procedures established by the Global Fund. Since January 2007 it has had charge of the two program components (HIV/AIDS, partially; TB, fully), with all related activities and processes. It coordinates joint execution of legal actions with the Institutional Procurement and Contracts Unit (UACI) in MOH and with CCM.

Administrative activities linked to the procurement of goods and hiring of services will be based on the work plan for each component (HIV/AIDS and TB) according to which the bidding, evaluation, and award recommendation, contracting and payment processes will be carried out.

The good performance of the PR is due substantially to the leadership of its staff. Among them:

- General coordination is the responsibility of a physician with clinical, epidemiological and administrative experience in the TB and HIV/AIDS components.
- Procurement and purchasing processes are handled by a well qualified Business Administrator.
- The financial area is the responsibility of a professional Administrator-Accountant.
- The Monitoring Unit is under the charge of a prominent Information Engineer, with Post Graduate degree in WEB pages and Navigation.

Other specialized units in the Ministry also support the Executive Unit, including External Funding Unit, External Cooperation Unit, Accounting, Information Technology, Engineering, and Transportation, as well as the Administrative Directorship that helps with storage and maintenance.

One of the aspects that the MOH has been able to contribute since it pertains to the public sector, is the reconciliation of policies and regulations established by the Global Fund with the laws and regulations applicable to the management of the country's financial resources.

(b) Has the nominated PR previously managed a Global Fund grant?	x☐x Yes
	☐ No

If yes to (b), explain the rationale for nominating the same PR(s) to manage the activities in this proposal.

The present PR has performed activities of R2, ending in 2008; therefore, the proposal is to maintain its functions. The successful performance of the Executive Unit, reflected in the positive evaluations of the Global Fund and the close technical relationship with the technical team in the program amply justify contining with the MOH as Principal Recipient.

(c)	Is the nominated PR currently managing a large program funded by another donor?	☐ Yes xx☐ No

(d)	Identify the total budget (current and planned) under management by **each nominated Principal Recipient**.

The R2 grant for the two components reached the amount of approximately $7 million annually in the first years, but currently it has been reduced. This year (2007) the budget for the HIV/AIDS component is $1,948,488 and $473,286 for the TB component, for a total of $2,421,774, managed by the MOH Executive Unit.

The planned budget for R7 for both components is $31 million, of which $24 million is for the HIV/AIDS component and just under $7 million is for TB. Of that, MOH would handle 100% of the TB component ands about 65% (just under $16M) of the HIV/AIDS component (about 23 million) over the five years of the grant .

Regarding the amounts of medication to manage and distribute for the TB and HIV/AIDS components, they are modest in comparison with the amounts managed by MOH for the public health system as a whole and will not present a major challenge.

(e)	Describe the performance history of the nominated PR in managing these programs/grants. **Specifically**, where the nominated PR(s) management of a prior program/grant has not been fully satisfactory, describe the changes that will be made to the implementation arrangements by the PR under this, and the earlier grants, to ensure more consistent, transparent and effective performance towards the planned outputs and outcomes.

MOH Executive Unit was conceived to strengthen the administration of Global Fund's grants from a perspective of expediting the management of national legal and administrative frameworks, and a major link with Program's technical area. It started operations in January 1st, 2007, after a period of observation, learning and technology transfer with the prior PR, UNDP..

(f)	Describe how the Applicant has satisfied itself **(including by reference to any assessment criteria)** that the nominated PR will be able to absorb the additional work and funds generated by this proposal in a **transparent, efficient and timely manner**.

Global Fund has continued to rate MOH's Executive Unit management with an "A" rating. MOH/UEP has prepared a development plan in order to address an increase in demand.

While returning to levels above $6 million a year (including the HIV component), the Executive Unit will adapt easily. It has planned an expansion in management capability by hiring six more people, three management technicians and three in general services (secretary, janitorial, transportation), as well as technical training for the staff. Equipment and physical space will be readapted to accommodate this growth.

4.8.3	**Sub-Recipient information**	
(a)	Are sub-recipients expected to play a role during the term of the proposal? *(Only in the very rarest of cases would the Global Fund expect there to be no sub-recipients.)*	xx☐ **Yes** ➔ ***complete the rest of 4.8.3*** ☐ No ➔ *go to 4.9*

(b)	How many sub-recipients will or are expected to be involved in the implementation?	xx☐ 1 – 5
		☐ 6 – 20
		☐ 21 – 50
		☐ more than 50
(c)	Have the sub-recipients already been identified?	☐ Yes ➔ *complete 4.8.3. (d) –(e) and (f) and then go to 4.9*
		xx☐ No ➔ *go to 4.8.3. (g) – (h)*

(d) Describe:

(i) The **transparent** process by which sub-recipients were identified, the rationale for the number of sub-recipients **and the criteria** that were applied in the identification process.

(ii) Referring to sub-paragraph (b) above, describe the past implementation experience of sub-recipients who will **either** receive a significant proportion of the funding from this proposal **or** who will be involved in on-granting of funding to sub-sub-recipients *(Also identify significant potential bottlenecks to **transparent strong performance** by these sub-recipients, and actions that will be taken by the PR during implementation to alleviate such risks).*

(e) **Attach a list of sub-recipients** that have been nominated, which includes: (i) the name of the sub-recipient; (ii) the sector they represent (civil society, NGO, private sector, government, academic/educational etc); and (iii) by reference to table 5.2 in the budget section, the primary service delivery area(s) relevant to their work under the proposal.

Below please **comment on the relative proportion of interventions** that will be undertaken by sub-recipients outside of the government and the reason for this apportionment of work. *(maximum two pages).*

(f) **Only if relevant, describe why sub-recipients were not identified prior to submission of the proposal**.
(Applicants are reminded that only in rare cases should sub-recipients not be identified. The identification of these key implementation partners assists the assessment of implementation capacity and feasibility.)

The TB component in Round 2 has not worked with the sub-recipients. To chose them formally under R7 financing, a transparent process will be necessary, governed by legal and administrative norms established by the country and Principal Recipient. Thus a formal approval of the PR is necessary. Once the donation contract is signed, the PR's Executive Unit will organize the competition and supervise the sub-receptors selection process.

Nevertheless, the process has been informally advanced. To formulate this proposal, a public invitation was sent to health sector organizations, including those working at the community level, to study the pre-project and present their ideas. As a result, two NGO networks among the respondants have been active and their members may opt to be incorporated as sub-receptors under Objective 4 on the activities with communities, advocacy, communciation and social mobilization (see list in Annex TB-5). Suggestions have been incorporated on these networks and the project design. At present, target populations have started to be approached to assure their interest and participation, definition of places and exact scopes of work, and specify technical basis for an imparcial and transparent selection process during the first year of the project.

(g)	**Where sub-recipients have not been identified prior to proposal submission**, **describe in detail the process that will be used to select sub-recipients** if the proposal is approved. Include details of the criteria that will be applied in the selection process, the timeframe during which that selection process will take place, and why the Applicant believes this selection process will not adversely impact planned outputs and outcomes during the initial two year period of any grant which is approved.

The first semester of the project work will be done with local priority populations and leaders to determine the level of interest, measure knowledge, attitudes and practices (baseline), and precise the needs of communication and education, community work and social movement. This will allow preparation of terms of reference and invitations to the NGOs to compete with specific proposals to cover the different areas. The sub-receptors will be selected through a process managed by the Executive Unit of PR and supervised by CCM (MCP), following administrative and legal guidelines that correspond. This will allow to start the incorporation since the second semester of the project.

4.9 Monitoring and evaluation framework

The Global Fund encourages the development of nationally owned monitoring and evaluation (M&E) plans and M&E systems, and the use of these systems to report on grant program results in the overall context of country priorities and movement towards reaching the Millennium Development Goals. When completing the section below, applicants should clarify how and in what ways monitoring and evaluating implementation of the work supported by this proposal relates to existing data-collection efforts.

Applicants are strongly encouraged to refer to the M&E Toolkit when completing this section.

4.9.1 Monitoring and evaluation plan

Describe how the data relating to performance against planned outputs and outcomes set out in the 'Targets and Indicators Table' *(required to be annexed as 'Attachment A' to your proposal, see section 4.6)* will be accurately collected, collated and reported by implementing partners during the proposal term to the Applicant (if CCM, Sub-CCM or RCM), the Global Fund and the body responsible for national monitoring and evaluation.

Please also identify any surveys which are planned to be supported (in whole or part) by the funding requested in this proposal, the rationale for such surveys, and how the surveys (and their outcomes) support and feed into single national data collection systems.

(Where a National M&E plan exists, Applicants may attach this to their application as a clearly named and numbered annex.)

Monitoring and Evaluation of the project will be the responsibility of MOH through the Executive Unit, establishing processes and milestones to monitor implementation and measure the advance of the Program as a whole. Generally, the Executive Unit responsibilities will be the following: 1) design information flows and formats for recollection according to objectives and indicators established; 2) process and feed the data base, 3) analyze information systematically and participatively; 4) edit indicators, tables and feedback to the corresponding levels.

The Executive Unit will prepare and implement the surveillance system for the project, along with its monitoring and evaluation, based on guidelines already used in R2; it will also guarantee the representation and active participation of the beneficiaries. Monitoring and compliance will be reviewed in each area of the Program according to the yearly working plan.

The Executive Unit will present periodic reports to MOH, CCM and GF on results and progress towards goal compliance; It will also hire external consulting services according to terms of reference previously approved, to carry out the project evaluation.

A monitoring and evaluation plan will be prepared with indicators and established goals according to the programmatic tasks per activity. The studies in special groups which periodically carry out other international organizations and academic scientific groups, will be complementary to the advance reports

and intermediate evaluations, and project impact in vulnerable groups, especially those at greatest risk.

The advance reports and mid term evaluation process will be part of the basis for requesting phase two financing from the Global Fund and for defining the working plan for the third year of Project execution; it shall include any modification or required review. To measure project impact, a final evaluation will be carried out. This will have as a base the goals and indicators for follow-up and results agreed in the proposal, taking as a reference the established base line.

There will be a monitoring and evaluation plan with indicators and goals established according to the programmatic tasks per activity. The studies in special groups which periodically will be performed by other international and scientific academic organizations, will be complementary to the advance reports, intermediate evaluations and project impact in vulnerable groups, especially those at greatest risk.

4.9.2 M&E Systems Capacity Assessment

Where there is no National M&E plan **or** the work anticipated under this proposal is anticipated to place additional burden on existing national, regional and/or sub-regional M&E systems, **Applicants are strongly encouraged to review the '*M&E Systems Strengthening Tool*' and provide, in only a summary format below, a description of the major gaps identified and how this proposal incorporates a plan to overcome those gaps to support an effective monitoring and evaluation framework in the country.**

In particular, Applicants should comment on how gaps and potential/actual bottlenecks identified that are relevant to this proposal will be managed or mitigated during the proposal term. Budgetary implications arising from this assessment should be included in the budget information required in section 5.

The Global Fund recommends that between 5 to 10% of the total component budget is utilized to strengthen M&E systems.

The national registries, reports and results analysis framework of the health sector, according to the country's norm, covers the needs for basic monitoring and evaluation of the system and its results, and contemplates monitoring and evaluating projects. This substantially coincides with the recommendations of the M&E Guide, with deficiencies in some areas. In particular, the system is not online, and data entry is not uniform, especially at remote sites. The proposal includes funding to improve those aspects of the M&E system, building , in a form that parallels the improvements proposed in the HIV/AIDS component.

4 Component Section *Tuberculosis*

4.10 Procurement and supply management of health products

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

4.10.1 Roles and responsibilities for procurement and supply management of health products

(a) In the table below, describe the planned roles and responsibilities for procurement and supply management.
If a function is planned to 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 MOH Department of Disease Control, or MOF, non-governmental partner, technical partner).*	In this proposal what is the role of the organization responsible for this function? *(Identify if PR, SR, Procurement Agent, Storage Agent, Supply Management Agent, etc).*	Indicate if there is need for additional staff or technical assistance
Procurement policies & systems	MOH/UACI	PR/controller	☐ Yes XX☐ No
Quality assurance and quality control of pharmaceuticals	MOH/UTMIN, Quality control laboratory	PR/quality control	☐ Yes XX☐ No
International and national laws (patents)	MOH/UACI, PAHO	PR/controller, purchase agent	☐ Yes XX☐ No
Coordination	MOH/UACI, PAHO	PR/controller, purchase agent	☐ Yes XX☐ No
Management Information Systems (MIS)	MOH/PNT	PR/technical lead	☐ Yes XX☐ No
Product selection	MOH/PNT	PR/technical lead	☐ Yes XX☐ No
Forecasting	MOH/PNT	PR/technical lead	☐ Yes XX☐ No
Procurement and planning	MOH/UACI	PR/controller	☐ Yes XX☐ No
Storage and Inventory management	MOH/UTMIN, WAREHOUSES, PATRIMONIAL UNIT	PR/supply agencies/controler/technical lead	☐ Yes XX☐ No
Distribution to other stores and end-users	MOH/UTMIN/PNT	PR/supply agency/technical lead	☐ Yes XX☐ No
Ensuring rational use	MOH/PNT	PR/technical lead	☐ Yes XX☐ No

(b)	Briefly describe the organizational structure of the unit with overall responsibility under this proposal for procurement and supply management of health products, including medicines. Indicate how it coordinates its activities with other entities such as the National Drug Regulatory Authority, Ministry of Finance (for budgeting and planning), Ministry of Health, drug storage facilities, distributors, etc.

MOH will establish links and coordinate technical and administrative elements with the representation of the PAHO/WHO in El Salvador or any other appropriate agency in the country through its Executive Unit related to management of supply and contracts of medicines and hygienic products. The functions to be performed are:

5. Pharmaceutical products selection. Here MOH must make sure the products are included in the national norms for treatment, or in the official list of essential drugs in the country, or in the list of essential drugs for WHO. In case MOH needs to acquire products not included in one of the previous lists, it must request the approval of GF in writing before it proceeds with the acquisitions.
6. Needs estimate. Where MOH projects assure amounts of products required based on morbidity data and historic consumption data, and also range of coverage and reserve stocks required at each level of attention.
7. Supplier selection. With the official request from MOH, PAHO will request prices from pre-qualified suppliers of pharmaceutical products. Product quality will be assured through the rigorous application of criteria in the selection of suppliers according to the source of origin.
8. Price request and acquisitions. In case of an order from the Ministry of Health, PAHO will request prices from different suppliers to assure efficient competition with transparency and responsibility, according to "Procedures and Regulations for PAHO Procurement". It shall be the responsibility of the Ministry of Health to assure that the selected products comply with national regulations for the protection of patents.
9. Delivery. All pharmaceutical products acquired through PAHO will be consigned to MOH, who will be in charge of customs procedures and associated costs. MOH will receive copies of purchase orders and customs documents before delivery of the product. PAHO will coordinate delivery to destinations, normally through the PAHO office in the country.

4.10.2 Procurement capacity

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

(b) For each organization planned to be involved in the procurement of medicines and other health products, provide details of the current volume of medicines and other health products procured on an annual basis in the table below. *Use the "tab" button on your computer to add extra rows at the bottom of the table if more than four organizations will be involved in procurement.*

Organization Name	**Total value of medicines and other health products procured during last financial year** *(In same currency as this proposal)*
MOH	1st line drugs $69,331 (2006)
MOH	Laboratory supplies $ 492,016 (2006)

MOH	Hospitalization $131,515 (2006)

4.10.3 Coordination

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

1st line anti-tuberculosis drugs, 100% with GOES funds

2nd line anti-TB drugs 10% with GOES funds and 90% with GF funds.

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

There is no donation of any kind for anti-tuberculosis pharmaceutical products, first or second line

4.10.4 Supply management (storage and distribution)

(a)	Has an organization already been nominated to provide the supply management (storage and distribution) functions for medicines and other related health products during the proposal term?	xx☐ Yes ➔ *continue to (b)* ☐ No ➔ *go to 4.10.5*
(b)	**If yes to (a) above**, indicate, which types of organizations will be involved in the supply management of medicines and other related health products during the proposal term. If more than one of the adjacent boxes is checked, also briefly describe the inter-relationships between these entities when answering (c) and (d) below.	xx☐ National medical stores or equivalent ☐ Sub-contracted national organization(s) *(specify which one(s))* ☐ Sub-contracted international organization(s) *(specify which one(s))* ☐ Other *(specify)*

(c) Describe each organization's current **storage capacity** for medicines and other related health products, and indicate how the increased requirements under this proposal will be transparently and effectively managed.

Storage of supplies will correspond to MOH through its Technical Unit for Medicines and Medical Products (UTMIN) with partial infrastructure, equipment, and technical and operational personnel necessary to develop reception, warehousing, management and control of inventory processes.

(d)	Describe each organization's **current distribution capacity** for medicines and other related health products and indicate how the increased coverage will be managed, and potential challenges addressed if any. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal, and the extent of incremental increase that is on existing distribution arrangements.
	Drug distribution will be authorized by the TB component coordinator, based on requirements of health establishments. UTMIN (see above) will be in charge of dispention and distribution. UTMIN will be responsible to distribute systematically to regional warehouses and avoid scarcity of drugs and materials. The requirements, consumption analysis and progressive coverage extension projection for DOTS will allow coordination time for requests through the Program Executive Unit.

4.10.5	**Pharmaceutical products selection**
	Do you plan to utilize national standard treatment guidelines ('STG') that are in line with the World Health Organization's ('WHO') STG during the proposal term? **If not**, describe below the STG that are planned to be utilized, and the rationale for their use. In section 5.4.1, Applicants are requested to complete '**Attachment B**' **to this Proposal Form** on a per disease component basis to provide more detail on the STG, and also the expected prices for medicines.
	STG from PAHO/WHO, GDF, FG will be used.

[For tuberculosis and HIVAIDS components only:]

4.10.6	**Multi-drug-resistant tuberculosis**
Does the proposal request funding for the treatment of multi-drug-resistant tuberculosis?	xx☐ Yes ☐ No
	If yes, please note that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made or is in progress. For more information, please refer to the GLC website, at http://www.who.int/tb/dots/dotsplus/management/en/. Also see the Guidelines for Proposals, section 4.10.6. **Applicants should also ensure that for each year of the proposal term, an amount equivalent to US$ 50,000 should be transparently budgeted in section 5 of the proposal for contribution towards fees incurred by the Green Light Committee**. *Applicants should note that this money must be reserved for the Green Light Committee and can not be transferred for other implementation activities.*

4.11 Technical and Management Assistance and Capacity-Building

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

4.11.1 Capacity building and training

Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further strengthen national capacity, capacity of Principal Recipients and sub-recipients, as well as any target group. Ensure that these activities are included in the detailed budget in section 5.

Health services providing entities in the country generally do not perform development activities and/or administration to improve efficiency and quality of hygienic interventions due to economic restrictions. Instead, they perform operational activities directly related to health service provision. In this context, capacity building is essential, not only in medical and technical areas, but also in organizational and communications skills to be able to interface effectively with communities, patients, and civil society organizations.

To implement the TB component it is also necessary that instances responsible for resource administration and receptors and beneficiaries of the same, have access to technical cooperation (counseling, technical assistance, training, and M&E processes).

4.11.2 Technical and management assistance

(a) **Needs Assessment**

Describe any needs for technical assistance, including assistance to enhance management capabilities to support the attainment of the planned outputs and outcomes under this proposal. Where relevant, link your response in this section to the potential capacity constraints of the Principal Recipient and/or other implementing partners under this proposal. (*Please note that technical and management assistance should be quantified and reflected in the component budget section, in section 5).* ***In your description, identify the process by which needs were assessed and evaluated****.*

The acquisition of short and medium term national and international technical assistance is anticipated in the following areas:

1. Epidemiologic and operational studies (RAIT, prevalence, etc.):
2. Improvement of the training methods.
3. Use of techniques and strategies in advocacy, IEC, social and community participation.
4. Evaluation of program and project.
5. Management, administration and design of projects.
6. Technical-legal study of infection control
7. Assistance for the preparation of technical-legal and regulatory documents.

The objective to strengthen national capacity, is to improve planning efficiency, organization, direction and resource control; therefore, the need to acquire technical assistance is proposed to acquire optimal conditions of technical and administrative capacity, strengthen resolution capacity of the services in a sustainable manner, and implement modern administration practices in areas such as human resources, finances, supplies and/or materials.

Changes the component will generate, will allow: (1) to develop organizational strategies to orient best the way to cover DOTS in a complex and changing environment; (2) apply and see for the technical and legal order of the actions of the suppliers in the health sector, for the control and elimination of tuberculosis as a problem of public health; and (3) control the good use of resources through the existing administrative systems.

(b)	**Planned sources and mechanisms for procurement of services** Describe how technical and management assistance is planned to be obtained during the proposal term in a transparent and efficient manner. In particular, identify whether local, national and/or international assistance will be obtained, the scheduled timeframe (short term or longer term) and the rationale for this approach. Also describe how the provision of the planned assistance will contribute to long term increased capacity to respond effectively to the disease.
Hiring of services will be done through the coordinating unit, following country standards, and these will be in the number and time allotted, depending on the required needs, besides those established in the work plan.	

5 Component Budget *Tuberculosis*

5. Tuberculosis Component Budget - Overview and general guidance

This section 5 is where Applicants detail their funding request which is summarized in table 1.2. **Section 5 must be completed for each disease component included in your proposal**.

For Round 7, section 5 has been restructured to adopt the following order:

1. **prepare a detailed component budget** (section 5.1);
2. from that detailed budget, **prepare a summary by objective and service delivery area** (section 5.2);
3. from that detailed budget, **prepare a summary by cost category** (section 5.3); and
4. then provide details about **key budget assumptions** (section 5.4).

Funding to be contributed through a common funding mechanism
If part or all of the funding requested for this component is to be contributed through a common funding mechanism *(relevant for Applicants who completed section 4.3.5)*, **Applicants must:**

(a) compile the Budget information in sections 5.1 to 5.3 on the basis of the anticipated use, attribution, or allocation of the requested funds within the common funding mechanism; **and**

(b) provide, as an annex to your proposal, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request in a covering page to that plan.

5.1 Detailed Component Budget

A detailed per-disease component budget covering the proposal period must be attached as an annex to your proposal.
The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

The Detailed Component Budget *should meet the following criteria (Please refer to the Guidelines for Proposals, section 5.1):*

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

(h) It should cover the full term of the proposal, and:
*(i) be **detailed for year 1 and year 2**, with financial information broken down by **quarters for the first year, and at least half yearly for the second year**;*
(ii) provide summarized information and assumptions for the balance term of the proposal period (year 3 and beyond).

*(i) It should state all key assumptions, including those relating to **units and unit costs (avoid using lump-sum amounts)**, and should be consistent with the assumptions and explanations included in section 5.4.*

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

(k) Details on HSS Strategic Actions should be clearly identified.

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

5 Component Budget *Tuberculosis*

5.2 Summary by objective and service delivery area

Please provide a breakdown of the annual budget by objective service delivery area (SDA) derived from your detailed component budget (section 5.1). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form). Totals should be provided in this table both for each Year (vertical total) and for each SDA (horizontal total).

The totals requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.3 (budget breakdown by cost category).

Table 5.2: Budget breakdown by service delivery area and objective.

5 Component Budget *Tuberculosis*

Objective 1: Pursue high-quality DOTS expansion and enhancement							
No.	**SDA**	**Detailed Budget by SDA 5.2**					
		Year1	**Year 2**	**Year3**	**Year4**	**Year5**	**Total**
1	Improving diagnosis	$ 141,071.00	$ 340,246.00	$ 163,896.00	$ 87,296.00	$ 86,396.00	**$ 818,905.00**
1	Standardized Treatment and Patient Support	$ 78,050.00	$ 123,150.00	$ 63,150.00	$ 63,150.00	$ 63,150.00	$ 390,650.00
1	Purchases and Supply Management	$ 119,500.00	$ 110,000.00	$ 142,000.00	$ 50,000.00	$ 74,000.00	$ 495,500.00
1	Monitoring and Evaluation	$ 164,060.00	$ 208,035.00	$ 149,660.00	$ 135,360.00	$ 106,860.00	$ 763,975.00
1	Management and Supervision of the Program	$ 171,450.00	$ 133,700.00	$ 128,900.00	$ 128,900.00	$ 125,300.00	$ 688,250.00
1	Human Resources	$ 172,870.00	$ 159,380.00	$ 212,620.00	$ 127,130.00	$ 104,320.00	$ 776,320.00
	Total Objective 1	**$ 847,001.00**	**$ 1,074,511.00**	**$ 860,226.00**	**$ 591,836.00**	**$ 560,026.00**	**$ 3,933,600.00**
Objective 2: Address issues of TB-VIH, MDR-TB and other challenges (prisons and migrant populations).							
No.	**SDA**	**Detailed Budget by SDA 5.2**					
		Year1	**Year 2**	**Year3**	**Year4**	**Year5**	**Total**
2	1. Collaborative Management of TB/VIH	$ 13,000.00	$ 2,125.00	$ 2,125.00	$ 2,125.00	$ 2,125.00	**$ 21,500.00**
2	2. Prevention and Control of MDR/TB	$ 8,400.00	$ 8,400.00	$ 8,400.00	$ 8,400.00	$ 88,400.00	**$ 122,000.00**
2	3. Treat prisoners, migrants and other high-risk groups	$ 90,660.00	$ 24,000.00	$ 90,660.00	$ 24,000.00	$ 30,660.00	**$ 259,980.00**
	Total Objective 2	**$ 112,060.00**	**$ 34,525.00**	**$ 101,185.00**	**$ 34,525.00**	**$ 121,185.00**	**$ 403,480.00**
Objective 3: Contribute to Strengthening of Health Systems							
No.	**SDA**	**Detailed Budget by SDA 5.2**					
		Year1	**Year 2**	**Year3**	**Year4**	**Year5**	**Total**
3	1. Active participationfor for health system improvement	$ 55,751.00	$ 28,026.00	$ 45,026.00	$ 20,026.00	$ 20,026.00	**$ 168,855.00**
3	2. Practical Approach of Pulmonary Health (PAL)	$ 104,000.00	$ 88,850.00	$ 113,850.00	$ 103,850.00	$ 98,850.00	**$ 509,400.00**
	Total Objective 3	**$ 159,751.00**	**$ 116,876.00**	**$ 158,876.00**	**$ 123,876.00**	**$ 118,876.00**	**$ 678,255.00**
Objective 4: Empowerment of persons affected by TB and their communities							
No.	**SDA**	**Detailed Budget by SDA 5.2**					
		Year1	**Year 2**	**Year3**	**Year4**	**Year5**	**Total**
4	1. Advocacy, communication and social mobilization (ACSM)	$ 365,750.00	$ 159,250.00	$ 284,250.00	$ 108,250.00	$ 251,750.00	**$ 1,169,250.00**
4	2. Community participation in care and treatment of TB	$ 29,015.00	$ 124,015.00	$ 29,015.00	$ 59,015.00	$ 54,015.00	**$ 295,075.00**
	Total Objective 4	**$ 394,765.00**	**$ 283,265.00**	**$ 313,265.00**	**$ 167,265.00**	**$ 305,765.00**	**$ 1,464,325.00**
	Grand Total (Objectives 1 through 4)	**$ 1,513,577.00**	**$ 1,509,177.00**	**$ 1,433,552.00**	**$ 917,502.00**	**$ 1,105,852.00**	**$ 6,479,660.00**
	Administrative Expenses for the Project Coordination Unit (PCU/RP)	$ 90,814.62	$ 90,550.62	$ 86,013.12	$ 55,050.12	$ 66,351.12	$ 388,779.60
	Total Tuberculosis Component	**$ 1,604,391.62**	**$ 1,599,727.62**	**$ 1,519,565.12**	**$ 972,552.12**	**$ 1,172,203.12**	**$ 6,868,439.60**

5 Component Budget *Tuberculosis*

5.3 Summary by cost category

In table 5.3 ***on the following page***, provide a breakdown of the annual budget by cost category *derived from your detailed component budget (section 5.1)*

(d) Different from Round 6, the cost categories in table 5.3 have been expanded to provide greater clarity between different cost categories.

(e) Guidance on the budget categories and the expenses falling within each category is provided in the **Guidelines for Proposal** section 5.3.

(f) The total requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.2 (breakdown by 'service delivery area').

(The "Total funds requested from the Global Fund" must also be consistent with the amounts entered in table 1.2 relating to this component.)

5 Component Budget *Tuberculosis*

Table 5.3 – Budget breakdown by cost category

Use the "TBTable53Line" button in the standard toolbar to insert row at the end of table	**Breakdown by cost category** *(same currency as in section 1.1 of the Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	262,800	228,535	261,775	216,285	193,475	1,162,870
Technical Assistance	81,225	44,000	55,000	35,000	25,000	240,2250
Training	17,550	36,300	56,300	16,300	16,300	142,750
Health products and Health Equipment	278,497	390,722	280,922	172,772	157,922	1,280,835
Medicines and pharmaceutical products	74,000	50,000.	74,000	50,000	74,000	322,000
Procurement and supply management costs	22,800	22,800	22,800	22,800	22,800	114,000
Infrastructure and other equipment	197,060	268,125	155,260	98,150	64,160	782,755
Communication Materials	356,010	230,010	276,010	130,010	268,510	1,260,550
Monitoring & Evaluation	128,745	155,795	168,595	93,295	200,795	747,225
Living Support to Clients/Target Populations	75,150	63,150	63,150	63,150	63,150	327,750
Planning and administration	19,740	19,740	19,740	19,740	19,740	98,700
Administrative costs for Project Coordination Unit (PCU/RP)	**90,814.62**	**90,550.62**	**86,013.12**	**55,050.12**	**66,351.12**	**388,779.60**
Total Tuberculosis Component	**$1,604,391.62**	**$1,599,727.62**	**$1,519,565.12**	**$972,552.12**	**$1,172,203.12**	**$6,868,439.60**

5 Component Budget *Tuberculosis*

5.4 Key budget assumptions

The detailed component budget (section 5.1) should contain all key budget assumptions. Below, Applicants are requested to highlight their budget assumptions for year 1 and year 2 in relation to three key areas.

5.4.1 Pharmaceuticals and other health products and equipment

Applicants must complete Attachment B to this Proposal Form *(Preliminary List of Pharmaceuticals and other Health Products)* ***to provide details of the budget assumptions for years 1 and 2 in respect of health products (including consumables), medicines, health equipment and services directly tied to procurement and supply management of health products.*** *Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed component budget. If prices from sources other than those specified below are used, a rationale must be included.*

(a) **Provide a list (by generic product name) of anti-tuberculosis medicines** to be used in years 1 and 2 (**including for multi-drug resistant tuberculosis**), and identify which essential medicines list those medicines are included, and whether WHO's standard treatment guidelines are being followed. **See also section 4.10.5 above**.
(Please complete table B.1 in Attachment B to the Proposal Form.)

(b) **Identify the average cost per person per year (or average cost per treatment course) for these medicines**.
(Please complete table B.2 in Attachment B to the Proposal Form.)

(c) Provide **the total cost** for all other medicines to be used over years 1 and 2. It is not necessary to itemize each product in the category.
(Please complete table B.2 in Attachment B to the Proposal Form.)

(d) Provide a list of other health products (e.g., condoms, diagnostics, hospital and medical supplies), health and non-health equipment, and services directly tied to procurement and supply management. Unit costs are requested for Health Products (i.e., consumables).
(Please complete tables B.3 and B.4 in Attachment B to the Proposal Form.)

Information on appropriate unit costs is available at, for example:

- *Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS.* Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2005, http://www.who.int/medicines/areas/access/med_prices_hiv_aids/en;
- Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mas/mns.htm);
- *International Drug Price Indicator Guide on Finished Products of Essential Drugs,* Management Sciences for Health in Collaboration with WHO (published annually) (http://www.msh.org/what_msh_does/cpm/index.html*); and*
- *First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility http://www.stoptb.org/gdf/drugsupply/drugs_available.asp.)*

Provide any additional information on unit costs below

With contributions from the Global Fund, only second line drugs are bought. Unit costs for these have been estimated according to the last purchase with Round 2 funds. The purchases are done according to guidelines from the Gree Light Committee, besides the national and institutional norms for procurement.

5.4.2 Human resources costs

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

(Useful information to support the budget includes: a diagram/organigram of the PR; a list of proposed positions showing title, function and planned annual salary; and proportion (in percentage terms) of time that will be allocated to the work under this proposal. Please attach such information as an annex to your proposal and indicate the appropriate annex number.)

Personnel does not constitute a significative percentage of the total budget of this project. Therefore no positions, functions, and salaries are itemized because this expense will be absorbed by the government funds counterpart. Expenses in the area of human resources are mostly for training supported directly for the various Service Delivery Areas, not for contracts. Training will strengthen the health system in several ways, from medical personnel training on PAL focus and infections control, to the best management of TB-HIV co-infection cases.

5.4.3 Other key expenditure items

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

All expenses have been budgeted based on the experience of Round 2 about what works best programmatically, lowers costs, and are necessary amounts of goods and services.

Infrastructure has been budgeted based on the minimum necessary adequacy for DOTS application, infection control, conservation of medicines and activities in the laboratory, based on the experience and prices of similar works.

Equipment has been budgeted taking into consideration middle life of equipment, degree of need (overcoming gaps on key services, table 4.4.1) and recommendation for implementation of new diagnostic methods to improve surveillance in MDR TB.

For budgeting of materials and communication activities, experiences from similar activities and population to be covered were considered. The starting point was a level of results from previous evaluation. The goal, to take information to high risk groups and general population in ways that change their knowledge, attitudes and practices.

CHECKLIST OF ANNEXES FOR SECTIONS 4 AND 5 TO BE ATTACHED TO YOUR PROPOSAL – *Tuberculosis*

The table below provides a list of the various annexes that should be attached to the proposal after completing sections 4 and 5. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Section 4: Component Strategy – Tuberculosis		**Annex Number to your proposal**
4.3.1	Documentation relevant to the national disease program context.	TB-1, números TB-1.1 a TB-1.15
4.3.5(c) *(**only** if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism.	N/A
4.3.5(d) *(**only** if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism.	N/A
4.6	**A completed 'Targets and Indicators Table' Refer to the M&E Toolkit for help in completing this table**.	**Attachment A – Tuberculosis**
4.6	**A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year).	TB-3
4.6	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 5 or Round 6 proposals.	TB-4
4.8.3 (c)	List of sub-recipients identified (including name, **sector they represent, and SDA(s) most relevant to their activities during the proposal term**)	TB-5
4.9.1	National Monitoring and Evaluation Plan/Strategy (if one exists)	N/A
Section 5: Component Budget – Tuberculosis		**Annex Number to your proposal**
5.1	**Detailed component Budget**	TB-6
5.1 *(if HSS strategic actions are included – see section 4.4.2)*	Details of cross-cutting HSS amounts (if not clearly identifiable from the detailed component budget).	N/A
5.4.1 *(and section 4.10.5)*	Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3)	**Attachment B – Tuberculosis**
5.4.2	Human resources costs.	

CHECKLIST OF ANNEXES FOR SECTIONS 4 AND 5 TO BE ATTACHED TO YOUR PROPOSAL – *Tuberculosis*

		N/A
5.4.3	Other key expenditure items.	N/A
5.1 - 5.3 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	N/A
Other documents relevant to sections 4-5 attached by Applicant:		**Annex Number to your proposal**

CHECKLIST OF ANNEXES FOR SECTIONS 4 AND 5 TO BE ATTACHED TO YOUR PROPOSAL *Malaria*