



PROPOSAL FORM – ROUND 8 (SINGLE COUNTRY APPLICANTS)

Applicant Name	Country Coordinating Mechanism (CCM)		
Country	Cambodia		
Income Level <i>(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)</i>	Low Income		
Applicant Type	<input checked="" type="checkbox"/> CCM	<input type="checkbox"/> Sub-CCM	<input type="checkbox"/> Non-CCM

Round 8 Proposal Element(s):			
Disease	Title	HSS cross-cutting interventions section <i>(include in one disease only)</i>	
<input checked="" type="checkbox"/> HIV ¹	Building on Success and Moving Towards Universal Access	<input type="checkbox"/>	
<input checked="" type="checkbox"/> Tuberculosis ¹	Reducing the TB burden in Cambodia and reaching TB-related MDGs	<input checked="" type="checkbox"/>	
<input type="checkbox"/> Malaria		<input type="checkbox"/>	

Currency	<input checked="" type="checkbox"/> USD	or	<input type="checkbox"/> EURO
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Deadline for submission of proposals:

**12 noon, Local Geneva Time,
Tuesday 1 July 2008**

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

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INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

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

1. **Funding Summary and Contact Details**
2. **Applicant Summary (including eligibility)**
 - + **Attachment C: Membership details of CCMs or Sub-CCMs**

Complete the following sections for each disease included in Round 8:

3. **Proposal Summary**
4. **Program Description**
 - 4B. HSS cross-cutting interventions strategy **
5. **Funding Request**
 - 5B. HSS cross-cutting funding details **

** Only to be included in one disease in Round 8. Refer to the [Round 8 Guidelines](#) for detailed information.

- + **Attachment A: 'Performance Framework'** (Indicators and targets)
- + **Attachment B: 'Preliminary List of Pharmaceutical and Health Products'**
- + **Detailed Work Plan:** Quarterly for years 1 – 2, and annual details for years 3, 4 and 5
- + **Detailed Budget:** Quarterly for years 1 – 2, and annual details for years 3, 4 and 5

IMPORTANT NOTE:

Applicants are strongly encouraged to read the [Round 8 Guidelines](#) fully before completing a Round 8 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 8 Documents are available [here](#).

A number of recent Global Fund Board decisions have been reflected in the Round 8 Proposal Form. The [Round 8 Guidelines](#) explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:

<http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf>.

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

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1. FUNDING SUMMARY AND CONTACT DETAILS

Clarified Table 1.1

1.1. Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	\$15,055,785	\$23,228,103	\$31,296,462	\$31,730,098	\$33,204,500	\$134,514,948
Tuberculosis	\$1,699,150	\$1,750,860	\$2,820,134	\$2,918,999	\$4,049,507	\$13,238,650
Malaria						0
HSS cross-cutting interventions within [TB]	\$4,539,904	\$3,459,199	\$3,625,850	\$4,549,419	\$5,273,483	\$ 21,447,854
Total Round 8 Funding Request →:						\$169,201,452

1.2. Contact details

	Primary contact	Secondary contact
Name	H.E Dr. Mam Bun Heng	Dr. Sin Somuny
Title	Secretary of State (Chairman of CCM)	Executive Director, Medicam (Co-Chair of CCCSC)
Organization	Ministry of Health	MEDiCAM
Mailing address	#151-153 Kampuchea Krom Blvd, Phnom Penh, Cambodia	No.4 Street 522, Sangkat Boueng Kak 1,Khan TUol Kok, Phnom Penh, Cambodia
Telephone	012-813 501	012-573 062
Fax	(855) 23 426 841	(855) 23 880 291
E-mail address	Mbh.pcu@online.com.kh	ssin@medicam-cambodia.org
Alternate e-mail address		

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1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
A	Adult
ACSM	Advocacy, communication and social mobilization
ADB	Asian Development Bank
AHEAD	Action for Health and Development
AHF	AIDS Health Care Foundation
AI	Avian Influenza
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
AOCP	Annual Operational Comprehensive Workplan
AOP	Annual Operational Plan
ART	Antiretroviral Therapy
ARV	Antiretroviral
AusAID	Australian Agency for International Development
BCC	Behaviour Change Communication
BMC	Budget Management Centres
BSS	Behavioural Sentinel Surveillance
C-DOTS	Community DOTS
CATA	Cambodian Anti-Tuberculosis Association
CBO	Community Based Organisation
CCM	Country Coordination Mechanism
CCM-SC	Country Coordination Mechanism – sub-committee
CDC	Communicable Disease Control
CDC-GAP	Centres for Disease Control-Global AIDS Program
CDHS	Cambodia Demographic Survey
CENAT	National Centre for Tuberculosis and Leprosy Control
CEPHAM	Centre of excellence for paediatric AIDS management
CHAI	Clinton Foundation AIDS Initiative
CHBC	Community Home Based Care
CHC	Cambodia Health Committee
CHEC	Cambodian HIV/AIDS Education and Care
CHIC	Child health improvement clinic
CMS	Central Medical Stores
CoC	Continuum of Care
CPN+	Cambodia People Living with HIV/AIDS Network
CPT	Co-trimoxazole Preventive Therapy

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CQI	Continuous Quality Improvement
CRC	Cambodian Red Cross
CRIS	Country Response Information System
CRS	Catholic Relief Services
CSO	Civil Society Organization
D&D	Decentralisation and Deconcentration
DDF	Department of Drugs and Food Safety
DFID	Department for International Development
DIC	Drug Information Centre
DOTS	Directly Observed Treatment – short course
DPHI	Department of Planning and Health Information
DR	Drug resistance
DST	Drug Sensitivity Testing
DU	Drug user
EQA	External Quality Assurance
ESTHER	Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau
EU	European Union
EW	Entertainment worker
FHI	Family Health International
FP	Family Planning
FRC	French Red Cross
GDF	Global Drug Facility
GFATM	Global Fund to fight AIDS, TB and Malaria
GLC	Green Light Committee
HACC	HIV/AIDS Coordination Committee
HAART	Highly Active Antiretroviral Therapy
HBC	Home-based care
HC	Health Centre
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPITC	Health Provider Initiated Counseling and Testing
HR	Human Resource
HSP	Health Sector Plan
HSR	Health Sector Review
HSS	HIV Sentinel Surveillance
HSS	Health Service Strengthening
HSSP	Health Sector Support project
IC	Infection Control

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ICT	Information Communication Technology
IDU	Injecting drug user
IEC	Information, Education and Communication
INGOs	International NGOs
IPT	Isoniazid Preventive Therapy
IRD	International Relief Development
ITM	Institute of Tropical Medicine, Antwerp
JAPR	Joint Annual Performance Review
JATA	Japan Anti Tuberculosis Association
JICA	Japan International Cooperation Agency
JFPR	Japan Fund for Poverty Reduction
JICWELLS	Japanese International Corporation of Welfare Services
KFW	Kreditanstalt für Wiederaufbau Entwicklungsbank
KHANA	Khmer HIV/AIDS NGO Alliance
Kg	Kampong
LR	Linked Response
M&E	Monitoring and Evaluation
M&ESST	M&E System Strengthening Tool
MARP	Most at Risk Population
MBI	Merit Based Incentive
MBPI	Merit Based Pay Incentive
MCH	Maternal and Child Health
MDG	Millenium Development Goals
MDM	Médecins du Monde
MDR	Multi-drug resistant
MMM	Mondol Mith Chouy Mith – ‘Friend Help Friend’ Club
MoEYS	Ministry of Education Youth and Sports
MoH	Ministry of Health
MoI	Ministry of Interior
MoVLT	Ministry of Labour and Vocational Training
MoND	Ministry of National Defense
MoP	Ministry of Planning
MoSVY	Ministry of Social Affairs, Vocational Training and Youth Rehabilitation
MoWVA	Ministry of Women’s and Veterans’ Affairs
MSF	Medecins sans Frontiers
MSM	Men who have sex with men
MTR	Mid Term Review
NAA	National AIDS Authority

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NASA	National AIDS Spending Assessment
NBTC	National Blood Transfusion Centre
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NCHADS DMU	National Centre for HIV/AIDS, Dermatology and STDs Data Management Unit
NMCHC	National Maternal and Child Health Centre
NGO	Non-Governmental Organisation
NIPH	National Institute of Public Health
NIS	National Institute of Statistics
NPH	National Paediatric Hospital
NRL	National TB Reference Laboratory
NSDP	National Strategic Development Plan
NSP-II	National Strategic Plan for a comprehensive and multisectoral response to HIV/AIDS 2006-10
NTP	National TB Programme
OD	Operational District
ODDID	Operational District Data Inventory
OI	Opportunistic Infection
OVC	Orphans and vulnerable children
P	Paediatric
PBI	Performance Based Incentive
PAO	Provincial AIDS Office
PCR	Polymerase chain reaction
PEPFAR	President's Emergency Programme for AIDS Relief
PHD	Provincial Health Department
PLHA	Person/People living with HIV or AIDS
PLHIV	Person/People living with HIV
PMTCT	Preventing mother-to-child transmission
PPD	Purified Protein Derivative
PPM	Public-Private Mix
PPN+	Provincial PLHA Network
PSF	Pharmaciens sans Frontiers
PSM	Procurement & Supply Management
QA	Quality Assurance
RACHA	Reproductive and Child Health Association
RGOC	Royal Government of Cambodia
RHAC	Reproductive Health Association of Cambodia
RH	Referral Hospital
SDA	Service Delivery Area
SEAD	Sharing Experience for Adapted Development

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SHC	Social Health Clinic
SHCH	Sihanouk Hospital Centre of Hope
SOA	Specialized Organization Agency
SOP	Standard Operating Procedures
SR	Sub-recipient
SSR	Sub-sub-recipient
SSS	STI Surveillance Survey
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex worker
SWiM	Sector Wide Management
TA	Technical Assistance
TB	Tuberculosis
TRP	Technical Review Panel
TST	Tuberculin Skin Test
TWG	Technical Working Group
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNSW	University of New South Wales
URC	University Research Consultants
USAID	United States Agency for International Development
USG	United States of America Government
VCCT	Voluntary Confidential Counselling and Testing
VHSG	Village Health Support Groups
VHV	Village Health Volunteers
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation
WOMEN	Women Organization for Modern Economy and Nursing
WV	World Vision

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2. APPLICANT SUMMARY (including eligibility)

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

IMPORTANT NOTE:

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

2.1. Members and operations

2.1.1. Membership summary

Sector Representation	Number of members
X Academic/educational sector	2
X Government	11
X Non-government organizations (NGOs)/community-based organizations	5
X People living with the diseases	1
People representing key affected populations ²	0
X Private sector	1
<input type="checkbox"/> Faith-based organizations	0
X Multilateral and bilateral development partners in country	8
<input type="checkbox"/> Other <i>(please specify)</i> :	
Total Number of Members: <i>(Number must equal number of members in 'Attachment C'³)</i>	28

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

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

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2.1.2. Broad and inclusive membership

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

2.1.3. Member knowledge and experience in cross-cutting issues

<p>Health Systems Strengthening</p> <p>The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the CCM or Sub-CCM.</p>
<p>(a) Describe the capacity and experience of the CCM (or Sub-CCM) to consider how health system issues impact programs and outcomes for the three diseases.</p>
<p>The CCM consists of experienced members belonging to government, NGOs, bilateral and multilateral agencies and the programme implementers themselves – especially in the health sector: they are implementers themselves, whether in Government or the NGO sector. And from the DPs there is robust involvement from agencies such as WHO, the World Bank and JICA, all of whom have a good realization of the importance of strengthening health systems. A number of them are, in effect, among the health sector leaders of the country, whose primary responsibility is ensuring the balanced and equitable allocation of resources to improve national health outcomes. As such, they are well aware of health system issues, and interpret the urgency of responding to the burden of disease as a call for strong leadership and effective health systems, and how to work towards that. Moreover, the UNAIDS Representative and the national program managers for HIV/AIDS, TB, and Malaria are there at the CCM. This means that there is a combination of experience of HS and the specific three diseases, which ensures that the support to HSS will ultimately strengthen the outcomes in responding to the three infectious diseases – and vice versa.</p>

<p>Gender awareness</p> <p>The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in:</p> <ul style="list-style-type: none"> methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and the factors that make women and girls and sexual minorities vulnerable.
<p>(b) Describe the capacity and experience of the CCM (or Sub-CCM) in gender issues including the number of members with requisite knowledge and skills.</p>
<p>Within the overall picture of low-but-improving health outcomes, there exist very substantial differences between different groups in Cambodian society in terms of access to services (water, sanitation and health care) and resulting health status. There are also pronounced geographical differences in the patterns of illness and death, not only between rural and urban populations, but also between Provinces. Cambodia's NSP-II for AIDS also recognizes that "gender inequalities need to be addressed and corrected for the national response to be truly effective". There is thus a broad and general awareness</p>

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within the government and civil society of gender and other differentials. Specifically, the Ministry of Women’s Affairs is represented on the CCM. Over the years, the Ministry has prioritized mainstreaming gender into all line ministries as one of their priorities. As such, all ministries have had many training sessions on gender sensitization. This has seen its impact on data collection which gender sensitive and most of the members of the CCM are sensitive and well aware of the factors that create vulnerabilities. In addition, some NGO members of the CCC such as Reproductive Health Association of Cambodia (RHAC), KHANA, and a few others have been actively working to promote gender and equity.

Multi-sectoral planning

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

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

The National Aids Authority is represented in the CCM. They are strongly assisted by UNAIDS. This experience in multi sectoral programming has already been evidenced in the Round 7 proposal which focuses on vulnerable groups, IDUs, MSM and other Ministries apart from Health.

2.2. Eligibility

2.2.1. Application history

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

<input checked="" type="checkbox"/> Applied for funding in Round 6 and/or Round 7 and was determined as having met the minimum eligibility requirements.	<p>→ Complete all of sections 2.2.2 to 2.2.8 below.</p>
<input type="checkbox"/> <u>Last time applied</u> for funding was before Round 6 or was determined non-compliant with the minimum eligibility requirements when last applied.	<p>→ First, go to 'Attachment D' to and complete. (Do not complete sections 2.2.2 to 2.2.4)</p> <p>→ Then also complete sections 2.2.5 to 2.2.8 below.</p>

2.2.2. Transparent proposal development processes

- Refer to the document '[Clarifications on CCM Minimum Requirements](#)' when completing these questions.
- Documents supporting the information provided below must be submitted with the proposal as clearly named and numbered annexes. Refer to the 'Checklist' after s.2.

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

The CCM has been effectively reaching out to a large range of stakeholders for several years now. Different mechanisms are used. In the first place to ensure that the priorities were genuinely owned, CCM members met with civil society organizations, national programmes and umbrella organizations. Advertisements were put in the newspapers and the umbrella organizations such as Medicam, HAAC and CPN+ were galvanized to reach out to their members and encourage them to participate in the process. Once the priorities were decided upon the call for proposals was made (Annex 1). Advertisement were placed in both English and Khmer dailies. Medicam in addition to their network of over 120 members in the HIV, TB, Malaria and Health sectors also works very closely with NGO Forum, the main NGO umbrella network in Cambodia, and thus as large as possible pool of stakeholders is made aware. HAAC is also a CCM member with over 95 organisations. CPN+ is a network of PLHA and they are also on the

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board of the CCM and an avenue for information. (Annexes 4-9)	
(b) Describe the process(es) used to transparently review the submissions received for possible integration into this proposal. <i>(If a different process was used for each disease, explain each process.)</i>	
<p>The review of the proposals is a core activity within the overall process of proposal development. (Annexes 2, 10) A local TRP was formed consisting of specialists in the field of the different proposal submissions. The TRP thoroughly scrutinized the proposals and came up with a detailed critique. CCM members then had detailed consultations. It was decided that some of the components in the HIV proposal, albeit priority, needed considerable more effort to bring them to the standard required. In the normal course with each round being annual, this would have meant intense efforts without any realistic expectation of a major turnaround in a few days. Hence, it was agreed that rather than jeopardize the whole proposal work on these components could continue and they would be submitted in Round 9. The proposal developers received all the comments and then worked intensively to incorporate them into the proposals. These were once again submitted for review by the CCC-SC and then finally to the whole CCC for endorsement.</p>	
(c) Describe the process(es) used to ensure the input of people and stakeholders <u>other than CCM (or Sub-CCM) members</u> in the proposal development process. <i>(If a different process was used for each disease, explain each process.)</i>	
<p>For the proposal development small groups were formed. For TB the WHO technical advisor (funded by TB-CAP / USAID) was involved as was the ICC (inter-agency coordination committee) which includes other partners of the National TB Program (donors and some NGOs). For the HSS WHO and the Health Metrics Network assisted. For the M&E component UNAIDS and the M&E Technical Working Group consisting of M&E experts/staff of NAA and other partners were involved in development of the proposal. For the CoC NCHADS convened a series of meetings of relevant Technical Working Groups; meetings were held with CPN+ and other NGOs; proposal development was supported by WHO and the Clinton Foundation who assisted with the drugs forecasting, working with the NMCH Centre (on the Linked Response) and also on Home Based Care. As also seen in the timeline of proposal development, (Annex 3) both the first and second draft proposals have been sent for wider consultation and getting comments from all members of the Technical Working Group for Health.</p>	
(d) Attach a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	[17]

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.	
<p>The CCM members oversee program implementation both through the PR and by the fact that the National Programmes, responsible for coordination and implementation of grants, are on the CCM. The PR reports bi-annually to the CCM on the grant, including disbursement, problems, bottlenecks etc; and in addition, reports regularly about program implementation. The PR TRT meeting is an avenue for the CCM to go through details of grant implementation. All reprogramming requests are made to the PR and endorsed by the Sub-CCM. To improve this work between the PR and Sub-CCM, draft guidelines have been proposed by the PR; and both the PR and the Sub-CCM will work together to finalize them. In addition “eyeball” monitoring is also done by members visiting and seeing for themselves how the grant is being implemented.</p>	
(b) Describe the process(es) used to ensure the input of stakeholders <u>other than CCM (or Sub-CCM) members</u> in the ongoing oversight of program implementation.	
<p>At the National level there are the TWG for Health (TWGH), the HIV TWG (both under the CDCF), and HIV related TWGs (M&E, PMTCT, MSM, IDU/DU, OVC), which all consist of both CCM and non-CCM members such as NGOs, CSOs and community representatives, UN Joint Team on AIDS members</p>	

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and DFID. TV and radio roundtables bring the managers together with stakeholders where discussions take place on shortcomings. A wide range of voices is heard through the avenue of the Cambodian People Living with HIV/AIDS Network and Cambodian Anti-Tuberculosis Association.

2.2.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. → Refer to the [Round 8 Guidelines](#) for further explanation of the principles. .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. <i>(If a different process was used for each disease, explain each process.)</i>	
<p>Once the announcement from the Global Fund for Round 8 was made the CCC-SC called a meeting on 13 March to decide on selection criteria for the PRs. It was decided to advertise and allow all stakeholders to participate. An advertisement calling for expressions of interest was finalized and published on 26, 27, 28, 31 March and 1 April. The CCC Secretariat received initial Expressions of Interest for the PR for Round 8 on the 11 April. These were carefully scrutinized and additional secondary data from applicants was requested and received by 16th May. A PR R8 Task Force was created which held their first meeting on 21 May; and each application was examined and the information was provided to the CCC to make their decision.</p> <p>The applicants were CENAT, MoH-PR, NAA, NCHADS from the Government sector and IRD, KHANA, MEDiCAM and the SHCH from the NGO sector. On the 10th June the CCC selected the PRs through a secret balloting process.</p> <p>The CCC on the 27th June endorsed the PR selection and the proposal.(Annex 18) The PRs selected were CENAT for TB, MoH-PR for HSS, and NCHADS and Medicam for HIV. (Annexes 12-15)</p>	
(b) Attach the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	[12]

2.2.5. Principal Recipient(s)

Name	Disease	Sector**
NCHADS	HIV	Government
MEDiCAM	HIV	NGO
CENAT	TB	Government
MOH	HSS	Government

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

2.2.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector <u>and</u> one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
<p>TB is a new area for working with civil society in Cambodia and experience with civil society partners is limited. It was decided by the CCM that under the circumstances, for the present only, one PR would be selected for TB. This position will be reviewed during the course of preparations for Round 8.</p>

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2.2.7. Managing conflicts of interest

<p>(a) Are the Chair and/or Vice-Chair of the CCM (or Sub-CCM) from the same entity as <u>any</u> of the nominated Principal Recipient(s) for any of the diseases in this proposal?</p> <p>Despite the fact that the current CCC chair and the PR for TB, HSS, and HIV/AIDS are from the same entity (Ministry of Health and national programs), the written plan to mitigate conflict of interest developed since round 6 continues to hold, because we are in the same situation as previous rounds, i.e, the function of the CCCSC, which is co-chaired by WHO and civil society (MEDiCAM) has been accepted by GF as a written plan to mitigate conflict of Interest.</p> <p>However, MEDiCAM has now also been elected to become a PR for HIV/AIDS, working with NGO sub-recipients if round 8 will be successful. The co-chair function of the CCCSC is not very much different from all members of the CCCSC which are composed of all national programs who have now become PRs for round 7 and round 8 (if successful). If now, the co-chair of the CCCSC will be considered to be in conflict of interest by the GF, the CCC will review again in order to develop a written plan to mitigate the conflict of interest if round 8 will be successful and GF TRP recommends the country to do so.</p>	<p><input checked="" type="checkbox"/> Yes <i>provide details below</i></p> <p>No → <i>go to s.2.2.8.</i></p>
<p>(b) If yes, attach the plan for the management of actual and potential conflicts of interest.</p>	<p><input checked="" type="checkbox"/> Yes <i>[16]</i></p>

2.2.8. Proposal endorsement by members

<p>Attachment C – Membership information and Signatures</p>	<p>Has 'Attachment C' been completed with the signatures of all members of the CCM (or Sub-CCM)?</p>	<p><input checked="" type="checkbox"/> Yes</p>
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2.2.9. Status of Sub-CCM

<p>Identify if the sub-national coordinating mechanism:</p>	
<p>(a) Operates under the authority of the CCM and focuses on a particular region or issue.</p>	<p><input checked="" type="checkbox"/> <i>Answer s.2.3.2. and s.2.3.3.</i></p>

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Section	Document description	Annex Number
2.2.2a	Announcement of Call for Proposals	1
2.2.2b	Letter to TRP	2
2.2.2c	Timeline for Rd 8 and R5P2 proposals development - 16 May 08	3
2.2.2a	TRP members – 27 May 08	4
2.2.2a	CCC MB membership procedures Jan 07	5
2.2.2a	<i>CCC MB Nominations, Feb 07</i>	6
2.2.2a	CCC Membership succession Feb 07.	7
2.2.2a	Revised CCCSC ToR	8
2.2.2a	MEDICAM's Members 2006	9
2.2.2b	MEDICAM CHARTER Feb 2002.doc	
2.2.2b	TB Response to TRP Minutes - Round 8 TB Proposal	10
2.2.2b	HIV minutes of the meeting to discuss comments from TRP	
2.2.2b	HSS TRP Comments	
2.2.2b	Letters to various TWG about TRP comments	11
2.2.4a, 2.2.4b	Minutes R8 PR Selection	12 + 15
2.2.4a	Selection Criteria PR Round 8 - 28 Apr 08	13
2.2.4a	Announcement call expressions of interest PR R8	14
2.2.7	Written plan to mitigate the conflict of interest	16
2.2.2d	CCC Minutes to agree on priorities R8	17
2.2.4a	Endorsement of Round 8 proposal by CCM	18

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3. PROPOSAL SUMMARY

3.1. Duration of Proposal	Planned Start Date	To
Month and year: <i>(up to 5 years)</i>	1 January 2010	31 December 2014

3.2. Consolidation of grants	
(a) Does the CCM (or Sub-CCM) wish to consolidate any existing tuberculosis Global Fund grant(s) with the Round 8 tuberculosis proposal?	<input type="checkbox"/> Yes <i>(go first to (b) below)</i>
	<input type="checkbox"/> No <i>(go to s.3.3. below)</i>
<p>'Consolidation' refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 8 proposal.</p> <p>→ More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at: http://www.theglobalfund.org/en/apply/call8/other/#5)</p>	
(b) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval? <i>(List the relevant grant number(s))</i>	

3.3. Alignment of planning and fiscal cycles

Describe how the start date:
(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or
(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.
The Ministry of Health annual planning and budgeting processes as well as the Government's fiscal cycle are all by calendar year.
The proposed starting date of 1 January 2010, will make it easier for the National TB Program to develop annual plans and budgets in conjunction with the overall annual planning process and to prepare annual progress and expenditure reports including all sources of funding.

3.4. Program-based approach for Tuberculosis

3.4.1. Does planning and funding for the country's response to tuberculosis occur through a program-based approach?	<input type="checkbox"/> Yes. Answer s.3.4.2
	<input type="checkbox"/> No. → Go to s.3.5.
3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?	<input type="checkbox"/> Yes → Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.
	<input type="checkbox"/> No. Do not complete s.5.5

ROUND 8 – Tuberculosis

3.5. Summary of Round 8 Tuberculosis Proposal

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

Prepare after completing s.4.

This proposal is based on an up-dated analysis of the programmatic and financial needs of the National Tuberculosis Program (NTP) in Cambodia. The analysis was guided by the findings and recommendations of the Joint Program Review of the NTP in Cambodia (August/September 2006), but also by additional information, new initiatives and lessons learned since the Joint Program Review.

Based on this analysis and in line with the National Health Strategic Plan for tuberculosis control in Cambodia (2006-2010) this proposal aims to address the following challenges and needs:

- Strengthening TB prevention and control in prisons and garment factories.
- Engagement of pharmacies and private health care providers in TB control.
- Improved diagnosis for TB in PLHIV and MDR-TB suspects through the use of liquid culture techniques in the National Reference Laboratory and 2 regional laboratories.
- Strengthening the management of TB in children.
- Advocacy, communication and social mobilization (ACSM) for TB control.
- Improved access to services through Community DOTS.

This proposal will be implemented by the National Centre for Tuberculosis and Leprosy Control (CENAT), four national NGOs (including the Cambodian Anti-Tuberculosis Association – CATA) and one international NGO (Family Health International – FHI).

The goal of the proposed program is ***to reduce the tuberculosis burden in Cambodia and to reach tuberculosis related Millennium Development Goals***

The proposed program includes three main objectives:

Objective 1: To engage all care providers by ensuring provision of high quality tuberculosis care of international standards by all relevant public and private health care providers.

This objective focuses on tuberculosis prevention and control in prisons, raising tuberculosis awareness among factory workers and engaging garment factories in the referral and treatment of suspected cases, and engaging pharmacies and private health care providers in the referral of suspected cases through Public-Private Mix approaches.

Family Health International (FHI) will collaborate with the National Tuberculosis Program and the Prison Department of the Ministry of Interior to improve tuberculosis prevention and control services in 11 prisons, with a total population of approximately 7,500 inmates in year 1.

The Cambodian Anti-Tuberculosis Association (CATA) will expand its current activities to another 20 garment factories and raise tuberculosis awareness among the 41,000 factory workers. CATA also plans to train factory health staff in the identification and referral of suspected cases and in treatment (DOTS in factories)

The Cambodia Health Committee (CHC) will work with pharmacies and private health care providers in two provinces to increase the referral of suspected cases to public health facilities for diagnosis and treatment.

Objective 2: To address TB-HIV and other challenges

The second objective focuses on taking to scale tuberculosis liquid culture techniques which will be introduced in one regional lab in 2009, and on strengthening the prevention, diagnosis and treatment of tuberculosis in children. Liquid culture techniques will be used in particular to strengthen the diagnosis of tuberculosis in people living with HIV (PLHIV) and MDR-TB,

CENAT will support capacity building in the Kg Cham regional laboratory in the form of training and the supply of laboratory equipment and will ensure sufficient supply of liquid culture reagents. The number of people screened for tuberculosis through liquid culture will gradually increase from 4,650 in year 1 to almost 8,700 in year 5.

It is estimated that currently only 20% of children infected with tuberculosis is diagnosed and treated by the NTP and CENAT plans to raise the coverage to approximately 60%. Planned activities include raising awareness among health professionals and parents, strengthening the capacity of health professionals to

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diagnose and treat childhood tuberculosis according to the revised national guidelines (2008), undertake contact tracing, and support children and their parents to timely access appropriate health services.

Objective 3: To empower people with tuberculosis and their communities

This last objective focuses on strengthening ACSM and on maintaining and further expanding the coverage of Community DOTS services.

In cooperation with its partners, CENAT plans to develop a strategic plan for ACSM that clearly sets out the goal and objectives, identifies target audiences, and plan activities to reach them. Guidelines will be developed and necessary training imparted for the implementation of ACSM in Cambodia. In addition, the final year of the proposed program will continue several ACSM activities included in Round 7, in particular the production and airing of tuberculosis spots on radio and television and the production and dissemination of printed materials.

Community DOTS is implemented by NGOs in close collaboration with the National Tuberculosis Program and aims to involve communities in providing community-based DOTS services to those with limited access to facility-based DOTS.

Two national NGOs (the Reproductive and Child Health Association – RACHA and the Reproductive Health Association of Cambodia – RHAC) plan to implement and manage Community DOTS services in 5 Operational Health Districts with a population of approximately 750,000 people.

In addition, the proposal plans to continue Community DOTS in nine Operational Health Districts currently funded under Round 5 and expand to two additional districts, by sub-contracting qualified NGOs through competitive bidding (planned to start in year 3).

Summary of HSS Cross-Cutting Proposal

Attached to this proposal there is also a component for cross-cutting HSS interventions. The interventions therein are consistent with priorities in the the new Health Strategic Plan (HSP2). In selecting which of the systems issues identified in the HSP2 to address, priority was given to those problems which (1) disproportionately impact in AIDs, TB and malaria and (2) are not being substantially addressed through the WB/DFID/AUSAID financed Health Sector Support Project (HSSP2) scheduled to commence in 2009.⁴ The result of this prioritization are interventions in the following Service Delivery Areas: **Information** – Strengthening of the Health Information System (HIS); **Leadership and Governance** – Increasing the capacity of NGOs/CBOs and Village volunteers to advocate on behalf of communities and patients, and engaging civil society in oversight of health services; **Service Delivery** – Improving infection control in public health facilities; and **Medical Products and Technologies** – 1) Improving pharmaceutical procurement, supply and management (PSM), and 2) Promoting safe use of pharmaceuticals by both providers and consumers.

These activities will strengthen Round 8 grant performance by (1) increasing the acceptability of public health services and thus increasing uptake of VCCT, ANC/PMTCT and prompt detection and trained treatment of TB and AIDs; (2) ensuring the availability of drugs and medical supplies at service delivery points; and (3) improving the relevance and reliability of health system metrics and better integration of information across vertical program lines. Activities will also directly improve case management of persons with the 3 diseases by reducing the risks of unnecessary co-infection in hospitals and enhancing providers' access to information on the management of drug reactions and interactions, and reduce the risks of hospital acquired TB and HIV.

⁴ The HSSP2 focuses heavily on issues relating to health care financing and improving district and facility level staff performance through the institution of internal performance contracts

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4. PROGRAM DESCRIPTION

4.1. National programme and strategy

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

Overall responsibility for the NTP lies with the CENAT, and current prevention and control strategies are described in the ***National Health Strategic Plan for Tuberculosis Control 2006-2010***, which are in line with Global Plan to Stop TB and the Regional Strategic Plan to Stop TB in the Western Pacific.

The long-term objective of the NTP is to reduce TB prevalence and the number of TB deaths. The Programme's medium-term objectives are (i) to ensure equity and access to quality TB services, and (ii) to maintain a high cure rate of more than 85% and a case detection rate of over 70% during the period 2006-2010. NTP strategies to reduce the transmission of TB include (i) early detection of TB, (ii) prompt and adequate treatment of TB, and (iii) efficient defaulter tracing.

Prevention

The NTP implements a range of prevention activities, including health education for service providers and patients on infection control, training for providers on safe waste disposal, and ***ACSM*** activities such as awareness and TB education campaigns nation-wide, including remote communities with minority population groups, schools, prisons and garment factories.

Diagnosis and treatment

Given the high prevalence of TB throughout the country, the main strategy of the NTP is to identify and treat TB patients through ***quality DOTS services*** at all levels of the public health system. DOTS was introduced in 1994 and is currently available in 5 national hospitals, 70 provincial and district level referral hospitals, all (942) functioning health centres and 47 health posts.

TB suspects are identified in out-patients clinics of public hospitals and health centres and in the communities, while ***diagnosis*** by microscopy is available at 200 TB laboratories. External Quality Assurance (EQA) is currently performed by the National TB Reference Laboratory (NRL) and two regional laboratories. With GFATM Round 5 funding, cross-checking of slides will be expanded to two additional provincial level laboratories.

With a growing proportion of smear negative pulmonary TB and extra-pulmonary cases, which are the most common forms of TB in children and PLHIV, the NTP is now working to improve diagnostic capacity through improved access to X-ray services and training of hospital staff in X-ray reading (GFATM Round 7 funding). Following WHO recommendations, NTP is now planning to introduce diagnosis through liquid culture.

The National Tuberculosis Program is using WHO recommended ***treatment*** regimens. New cases receive 2HRZE/4RH (Category 1) or 2HRZ/4RH (Category III). Retreated cases receive 2HRZES/1HRZE/5RHE (Category 2).

Category 1 regimen switched from 8-month to 6-month in January 2005. Treatment is provided to TB patients under daily direct observation (DOT by a health worker either in the hospital, or on ambulatory basis in TB units or health centers). Community DOTS supporters/watchers trained at the community level assist the TB patients living far from the HCs. DOTS watchers receive training from the HC staff.

In order to overcome the problem of limited access to public health services in most of rural Cambodia, the NTP introduced ***Community DOTS (C-DOTS)***, which is the identification of suspected cases and the provision of DOTS with the active participation of community volunteers. Supported by USAID and Global Fund and other partners, C-DOTS is currently available in approximately 50% of the health centres and coverage will be boosted to over 80% of the health centres with the start of the GFATM Round 7 program.

PPM-DOTS is a relatively new strategy in Cambodia, currently in its first phase and with a focus on the referral of suspected TB cases by private providers to public health facilities for diagnosis and treatment. The planned second phase will include the provision of diagnostic and treatment services by private health care providers.

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TB-HIV

In response to Cambodia's high TB-HIV burden (7.8% of TB patients were HIV-positive in 2007 – HIV Sero-Prevalence Survey Amongst TB Patients) the Ministry of Health endorsed the Standard Operating Procedures (SOP) in 2006, which provides guidance on prompt HIV testing for all TB patients and TB screening for PLHIV in order to provide appropriate care and treatment services in a timely manner. The main challenge is that while TB services are available at health centre level and even in the communities, VCCT and OI/ART sites are not as wide-spread and often only available at the district referral hospital. The NTP focuses on the referral of TB patients and/or blood samples to the nearest VCCT site and on TB screening for PLHIV by making available quality X-ray services.

MDR-TB

MDR-TB is a growing problem in Cambodia with only few cases currently being treated by an NGOs (Cambodia Health Committee (CHC), MSF France and MSF Belgium). The NTP plans to strengthen its capacity to address MDR-TB as part of the GFATM Round 7 programme, which includes assistance for human resource development, laboratory, infection control and the procurement of second-line TB drugs through GLC/GDF.

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

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

Document	Proposal Annex Number	Page References
<input checked="" type="checkbox"/> National Health Sector Development/Strategic Plan	Round 7 – Annex 20	
<input checked="" type="checkbox"/> National Tuberculosis Control Mid Term Strategy or Plan	Round 7 – Annexes 21 & 22	
<input checked="" type="checkbox"/> National Tuberculosis Guidelines (medical and laboratory)	Round 7 – Annexes 23, 24, 26	
<input type="checkbox"/> Important sub-sector policies that are relevant to the proposal (e.g., national or sub-national human resources policy, or norms and standards)		
<input checked="" type="checkbox"/> Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal	Round 7 – Annex 25	
<input type="checkbox"/> National Monitoring and Evaluation Plan (health sector, disease specific or other)		
<input type="checkbox"/> National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services		

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4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal		
(a) Do the activities target:		
<input checked="" type="checkbox"/> Whole country	<input type="checkbox"/> Specific Region(s) <i>**If so, insert a map to show where</i>	<input type="checkbox"/> Specific population groups <i>**If so, insert a map to show where these groups are if they are in a specific area of the country</i>

**** Paste map here if relevant**

(b) Size of population group(s) targeted in Round 8			
Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	14,331,268	Demographic Estimates and Revised Population Projections; National Institute of Statistics (NIS); Ministry of Planning (MoP; June 2005	2007
Women > 25 years (≥ 25yrs)	3,151,459	Demographic Estimates and Revised Population Projections; NIS; MoP; June 2005	2007
Women 19 – 24 years (20-24 yrs)	790,491	Demographic Estimates and Revised Population Projections; NIS; MoP; June 2005	2007
Women 15 – 18 years (15-19 yrs)	853,973	Demographic Estimates and Revised Population Projections; NIS; MoP; June 2005	2007
Men > 25 years (≥ 25yrs)	2,640,193	Demographic Estimates and Revised Population Projections; NIS; MoP; June 2005	2007
Men 19 – 24 years (20-24 yrs)	821,141	Demographic Estimates and Revised Population Projections; NIS; MoP; June 2005	2007
Men 15 – 18 years (15-19 yrs)	889,226	Demographic Estimates and Revised Population Projections; NIS; MoP; June 2005	2007
Girls 0 – 14 years	2,552,814	Demographic Estimates and Revised Population Projections; NIS; MoP; June 2005	2007
Boys 0 – 14 years	2,631,971	Demographic Estimates and Revised Population Projections; NIS; MoP; June 2005	2007
Other **: Prisoners	9,373	Prison Census; Prison Department of the Ministry of Interior	2006
Other **: PLHIV (aged ≥ 15 years)	61,400	HIV Estimates and Projections for Cambodia, 2006-2012; National Centre for HIV/AIDS, Dermatology and STI	2007

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4.2.2. Tuberculosis epidemiology of target population(s)			
Population Groups	Number	Source of Data	Year of Estimate
Estimated tuberculosis patients - shown as number per 100,000 population (<i>all ages</i>)	500	WHO Report 2008 Global Tb Control (incidence for the year 2006)	2006
Female tuberculosis patients > 25 years	N.A.		
Female tuberculosis patients 19 – 24 years	N.A.		
Female tuberculosis patients 15 – 18 years	N.A.		
Male tuberculosis patients > 25 years	N.A.		
Male tuberculosis patients 19 – 24 years	N.A.		
Male tuberculosis patients 15 – 18 years	N.A.		
Notified Tuberculosis patients all forms (shown as number per 100,000 population)	254	CENAT TB Information System	2007
Tuberculosis patients all forms tested for HIV (rate among notified)	39.6% (14,463/36,495)	NCHADS Annual Report & CENAT TB Information System	2007
Estimated number new smear-positive tuberculosis patients (rate per 100,000 habitants)	220	WHO Report 2008 Global Tb Control (incidence for the year 2006)	2006
Notified new smear-positive tuberculosis patients (rate per 100,000 habitants)	135	CENAT TB Information System	2007
Case detection rate of new smear-positive cases	65.4%	CENAT TB Information System	2007
Estimated number of multi-drug resistant cases of tuberculosis	474 (1.3% of 36,495)	Drug Resistance Survey 2006-07, CENAT (interim results)	2007
Notified number of multi-drug resistant cases bacteriologically confirmed	40	Report from pilot implementation sites (MSF & CHC)	2007
Treatment success rate of new smear-positive cases	93%	CENAT TB Information System	2007
Defaulter and transfer rate of new smear-positive cases	3.2%	CENAT TB Information System	2007

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Estimated number of girl (0 – 14 years) tuberculosis patients all forms	N.A. 7,095 for girls and boys combined	Assuming children 0-14 years account for 10% of the total number of incident cases	2007
Notified number of girl (0 – 14 years) tuberculosis patients all forms	N.A. 1,422 for girls and boys combined	CENAT TB Information System	2007
Estimated number of boy (0-14 years) tuberculosis patients all forms	N.A. 7,095 for girls and boys combined	Assuming children 0-14 years account for 10% of the total number of incident cases	2007
Notified number of boy (0 – 14 years) tuberculosis patients all forms	N.A. 1,422 for girls and boys combined	CENAT TB Information System	2007
Other**: Estimated TB patients among prisoners	3,529/100,000	Prevalence Survey in Two Prisons in Phnom Penh; CENAT	2005
Other**: Estimated prevalence of HIV among TB patients	7.8%	HIV Sero-Prevalence Survey Amongst TB Patients; CENAT	2007
Other**:			[use "Tab" key to add extra rows if needed]

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations⁵ who may have disproportionately low access to tuberculosis diagnosis, treatment, and care and support services, including women, girls, and sexual minorities.)

<p>4.3.1. Tuberculosis program</p> <p>Describe:</p> <ul style="list-style-type: none"> the main weaknesses in the implementation of current tuberculosis program or strategy; how these weaknesses affect achievement of planned national tuberculosis outcomes; and existing gaps in the delivery of services to target populations. <p>Decentralization of TB services to the health centre level was completed in 2004. However, management and supervision are still insufficiently decentralized, resulting in sub-optimal coordination of activities at provincial and district levels and insufficient follow-up of patients. Important factors in this respect are (i) the limited capacity of health staff at peripheral levels and (ii) the low salaries and lack of incentives for qualified health staff to work at the peripheral level. It should be noted that this especially true for facility level staff and not for management staff of the National Tuberculosis Program at national, provincial and district level as the latter are receiving incentives as part of previous GFATM Rounds.</p> <p>The most obvious effects are that:</p> <ol style="list-style-type: none"> The number of notified cases remains relatively low, although there was an increase in 2007. Communication between care providers and patients is often insufficient, resulting in patients being poorly informed about their condition and treatment. The overall performance of the laboratory network has improved, but requires further strengthening. <p>The National TB Program with support from its partners (including GFATM Round 5 and the forthcoming implementation of Round 7) has responded to these challenges in several ways:</p>

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

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- (i) Soon after completion of the expansion of DOTS to the health center level, the National TB Program started to promote involvement of communities in the referral of suspected cases and in the treatment of diagnosed cases (Community DOTS). Scaling-up of Community DOTS is planned under GFATM Round 7, which is expected to result in increased case finding and treatment adherence.
- (ii) PPM-DOTS involving private pharmacies and health care providers was piloted in several provinces. However, initial results show that only 50% of suspected cases referred by the private sector actually reach the hospitals and health centres that provide TB services.
- (iii) Considerable efforts are planned (amongst others, as part of GFATM Round 7) to further strengthen and improve laboratory services and to further strengthen the capacity of other health staff to correctly diagnose and treat TB.
- (iv) Despite the lack of a well-defined national strategy for ACSM, sustained advocacy efforts have led to strong commitment at all levels, and the nation-wide implementation of World TB Day has helped to raise awareness about TB in communities as well as among health staff.

DOTS is not systematically implemented in prisons and formal collaboration between the National TB Program and the Ministry of Interior Prison Department is just starting. There is an urgent need to develop a strategy plan for TB control in prisons and for standard operating procedures that clearly define the roles and responsibilities of all stakeholders.

Few TB cases are found in children under 15 years of age (approximately 2% of all TB cases, while approximately 10% would be expected based on epidemiology) and it seems that most children are treated in private pediatric hospitals that have limited links and collaboration with the National TB Program.

The collaboration between the National TB Program and the National HIV/AIDS Program has improved and collaborative TB-HIV activities are being implemented in a growing number of Operational Health Districts. Although growing numbers of TB patients are routinely tested for HIV, further improvements are required to improve the prognosis of TB/HIV infected patients.

Despite the progress made, considerable gaps remain:

- There is an urgent need to train prison health staff and to develop protocols for the routine screening of new prisoners and for the effective referral of prisoners under treatment after release or when transferred to another prison.
- Access for PLHIV to TB screening and to preventive therapy (IPT and CPT) remains insufficient and more rapid TB diagnostic methods are required for earlier detection and treatment of TB.
- Pediatric TB drugs are available until 2012, but adequate diagnosis and treatment of TB in children as recommended by recent international guidelines requires capacity building through training and supervision, and making pediatric TB services more accessible at the provincial and district levels.
- Based on the results of the planned assessment (late 2008) current strategies for PPM-DOTS involving pharmacies and private providers need to be reviewed. This will include the design of PPM-DOTS Phase II, which will allow diagnosis and treatment by private providers.
- Despite the planned expansion of Community DOTS, additional districts need to be covered.

4.3.2. Health System

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

The description can include discussion of:

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

The Ministry of Health has just completed its second Health Strategic Plan (HSP2) through a participatory process heavily informed by a Joint Health Sector Review conducted in 2007. Both that review and the HSP2 clearly articulate areas of systemic weakness, falling into the following 5 strategic areas: health information systems, health system governance, health care financing, human resources and health service delivery. The emphasis in the latter is on achieving improvements in the *quality* of services now that a basic public health delivery system is in place. Studies have repeatedly shown that poor quality, including lack of sanitation and irregular supply of drugs and supplies, constrain utilization of public

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facilities and contribute to the prevalent practice of self-medication with drugs bought from largely unregulated outlets – many of which are expired, counterfeit or otherwise sub-standard. Treatment from a range of private practitioners is also common, and unlike treatment in public facilities often does not conform to accepted guidelines. These issues directly affect tuberculosis outcomes – primarily by constraining early case detection – but are not limited to them.

While vertical approaches to TB, HIV/AIDs and malaria have been successful in rapidly containing epidemics and providing effective treatment, they have also contributed to fragmentation of the overall health system, particularly with respect to information systems, with each program having their own and insufficient linkages between them and with the overall national HIS. The Joint Health Sector Review conducted in 2007 described a reform of the HIS as “of fundamental importance”. Strengthening the HIS is one of the 5 strategic foci in the new Health Strategic Plan (HSP2) 2008-2015, which notes that the current system fails to capture the sizable amount of service delivery taking place in the private sector, and that the data it generates is often under-utilized.

Recent health facility assessments conducted by the MoH documented significant gaps and inadequacies in infection control measures and related capacities. Specific problems documented in health facility assessments include: lack of hand washing facilities, lack of isolation of infectious patients (suspected and confirmed TB patients share the same wards; HIV patients are given beds in close proximity to patients with the full range of infectious diseases), re-use of disposable needles and syringes, inadequate sterilization procedures, improper disposal of medical waste and poorly designed drainage and septic systems. These deficiencies create a tangible risk of hospital-acquired TB and HIV. In addition, hospitalized patients are at risk of acquiring other infectious which will complicate their clinical course and may adversely affect their outcomes; this applies across all 3 GF diseases as well as to the broader patient population.

The HSP2 for 2008 – 2015 identified inadequate logistic support for drugs and commodities and weak enforcement of drug quality control measures as significant supply-side constraint to effective service delivery, and lists “*improvement of non-medical support services including maintenance and supply systems for drugs and commodities*” as one of its priority policy directions. The highly desirable increase in patients being treated for TB, AIDs and malaria has increased the demands on the PSM system and highlighted some of its fundamental weaknesses. The HSS component in GF Round 5 helped address some of these, including the fragmentation of functions between the various National Programs and the ODs, the need to upgrade and standardize drug specifications, and alignment of the procurement policies of the various government agents which purchase pharmaceuticals. However, lack of online access still prevents ODs from submitting orders and reports in “real time”, the number and capacity of drug inspectors is inadequate to implement the drug testing guidelines, and there are inadequate resources to support the sampling and testing program. A functional analysis of the PSM system funded through GF Round 5 identified a critical need for more pharmacists and general staff in the Central Medical Stores, which is also lacking with respect to physical infrastructure (space, vehicles, equipment) required for storage and distribution of an expanded quantity of drugs and supplies.

There is also need to strengthen regulation in order to ensure good quality health services and to reduce common malpractices; in particular, self-medication from unregulated private drug outlets often lead to delays in diagnosis and treatment of TB and other diseases. The HSP2 specifically lists “*inappropriate health practices and health seeking behavior, leading people to receive medication/care from drug shops/pharmacies*” as a significant constraint. In addition to its supply side element (inadequate regulation) this problem reflects demand-side issues: there is a need to build the public’s trust in public health services and to improve their perception of the quality of services provided, and to likewise increase the health system’s awareness of and responsiveness to community concerns.

4.3.3. Efforts to resolve health system weaknesses and gaps

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

The new Health Sector Strategic Plan 2008-2015 (HSP2) is the guiding framework for all current and future decisions and interventions in the health sector. HSP2 distinguishes two broader strategic priorities: (i) to address health problems through essential services and (ii) to address challenges in relation to functional areas of the health system, as follows:

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Health service delivery consists of both public health measures against disease – organization of health promotion for reduction of risk behavior and health protection – as well as a general strengthening of health service delivery through general and disease specific policies and plans. Much emphasis is given the subject of quality improvement. An increase in health demand and empowerment of patients are underlined as important ways forward for improved quality and accountability in health service delivery.

Health care financing addresses both increases in investments in health and efforts to remove financial barriers to quality health care. Government allocation to the health sector is singled out thus underlining issues around the balance of financing between donors and government. Private and public sector relations are given attention with a view to get a complete picture of health sector activity and financing, handle the sensitive issue of poaching and to develop contractual arrangements in the private sector for selected forms of economic support to accredited private health providers.

Human resource development covers a comprehensive range of interventions 1) to ensure sufficient staffing levels with adequate professional profiles and competencies, 2) revising content of their training, 3) increasing the intake of students into schools and universities, and 4) strengthened measures to safeguard the quality of training and trainers. Midwives are particularly selected as a target group because of their key role for achieving the general goals of the HSP2. Human resource programming also includes safeguarding professional ethics. Special urgency is associated with implementation of salary reform for health services.

Health information system addresses the need for high quality, accurate, comprehensive and timely data to provide the basis for evidence-based policy making, planning, performance monitoring and evaluation. It emphasizes improved coordination and collaboration both within and outside the health sector through data sharing, management, analysis, dissemination and use and inclusion of private sector information, as well as tracking budgets and expenditures and expanded training to build HIS capacity.

Health system governance. The governance perspective of the NSDP focuses on decentralization and deconcentration. Communes, districts and provinces – with the base in the communes – will be empowered to prioritize resources according to their own needs. Harmonization and Alignment for Results is stressed to achieve a common policy framework between government and development partners for health development. An important element selected is that of an improved comprehensive picture of the government and donor funding as well as harmonized (*coordinating external support to follow national procedures, institutions and systems where possible*) and aligned (*ensuring that priorities identified by Cambodia become the priorities of donors;*) aid architecture in line with the government policies for decentralization and deconcentration and HSP2 priorities.

As can be seen from the forgoing, HSP2 provides a comprehensive blueprint for addressing all of the constraints identified in the forgoing section if sufficient resources are available for its implementation.. Implementation of the HSP2 is being supported by both government and multiple donors, the most significant being the second Health Sector Support Project (HSSP2) co-financed by the WB, AUSAID and DFID at about \$110 million for the five year period 2009-2013 and augmented by assistance in kind (primarily TA and monitoring by NGOs at grassroots level) from USAID, JICA and other bilaterals. Even with this, significant resource gaps remain as follows: (a) HSSP2 resources will primarily support sub-national level activities; (b) they will be phased in gradually since the modalities that will be used (Provincial Block Grants, Service Delivery Agreements etc) are quite new; and (c) Merit Based Performance Incentives -- a critical measure in over-coming the problems posed by inadequate civil service salaries -- are unclear and likely to affect only a limited number of as yet to be determine personnel involved in management functions. The HSS component to this submission seeks GF resources implement HSP2 activities that significantly impact on the 3 diseases and are either not covered under HSSP2 or need a bridging contribution until HSSP2 comes fully online.

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4.4. Round 8 Priorities

Clarified Table 4.4

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

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

Priority No:	1	Historical		Current		Country targets			
Intervention	Tuberculosis in Children	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target (<i>from annual plans where these exist</i>)		6,998	7,095	7,280	7,398	7,517	7,637	7,758	7,882
B: Extent of need already planned to be met under other programs		1,400	1,422	1,456	1,480	1,503	1,527	1,552	1,576
C: Expected annual gap in achieving plans		5,598	5,744	5,824	5,919	6,014	6,109	6,207	6,305
D: Round 8 proposal contribution to total need		<i>(e.g., can be equal to or less than full gap)</i>			1,020	1,457	1,863	2,048	2,314

Priority No:	2	Historical		Current		Country targets			
Intervention	Tuberculosis in Prisons (prison population covered with TB control activities)	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target (<i>from annual plans where these exist</i>)		11,000	12,000	12,600	13,230	13,892	14,586	15,315	16,081
B: Extent of need already planned to be met under other programs			4,000	4,200	4,410	4,631	4,862	5,105	5,360
C: Expected annual gap in achieving plans			8,000	8,400	8,820	9,261	9,724	10,210	10,721
D: Round 8 proposal contribution to total need		<i>(e.g., can be equal to or less than full gap)</i>			4,900	7,665	8,048	8,451	8,873

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Priority No:	3	Historical		Current		Country targets			
Intervention	Community Tuberculosis Care (number of TB patients treated under Community DOTS)	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target (from annual plans where these exist)		42,023	40,777	39,538	38,307	37,085	35,870	34,663	34,663
B: Extent of need already planned to be met under other programs		9,236	11,846	11,490	17,777	20,484	19,794	18,453	18,453
C: Expected annual gap in achieving plans		32,787	28,931	28,048	20,530	16,601	16,086	16,210	16,210
D: Round 8 proposal contribution to total need		<i>(e.g., can be equal to or less than full gap)</i>			1,362	1,416	4,593	5,694	5,713

Priority No:	4	Historical		Current		Country targets			
Intervention	Screening PLHIV through liquid culture (number of PLHIV needing liquid culture, including re-culture)	2006	2007	2008	2009	2010	2011	2012	2013
A: Country target (from annual plans where these exist)		N.A	N.A	7,950	9,315	9,401	9,488	9,574	9,660
B: Extent of need already planned to be met under other programs		-	-	3,760	0	0	0	0	0
C: Expected annual gap in achieving plans		-	-	4,190	9,315	9,401	9,488	9,574	9,660
D: Round 8 proposal contribution to total need		<i>(i.e., can be equal to or less than full gap)</i>			4,658	5,641	6,641	7,659	8,694

Priority No:		Historical		Current		Country targets			
Intervention		2006	2007	2008	2009	2010	2011	2012	2013
A: Country target (from annual plans where these exist)									
B: Extent of need already planned to be met under other programs									
C: Expected annual gap in achieving plans									
D: Round 8 proposal contribution to total need		<i>(i.e., can be equal to or less than full gap)</i>							

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

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4.5. Implementation strategy

4.5.1. Round 8 interventions

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

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

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

The goal of the proposed program is **"to reduce the tuberculosis burden in Cambodia and to reach tuberculosis related Millennium Development Goals"**.

The proposed program has three objectives:

Objective 1: To engage all care providers by ensuring provision of high quality tuberculosis care of international standards by all relevant public and private health care providers.

This objective is implemented by three NGOs (CATA, CHC and FHI), each focusing on a different target group:

- Family Health International (FHI) will cooperate closely with the National TB Program and the Prisons Department of the Ministry of Interior, with the aim to increase case detection and improve the quality of treatment in 11 prisons with a prison population of around 7,400 inmates
- The Cambodia Health Committee (CHC) will implement PPM-DOTS activities with pharmacies and private health care providers in two provinces (Kampot and Svay Rieng). Current pilot projects show that approximately 50% of the tuberculosis suspects referred by pharmacies and private care providers are actually received at a public health facility for diagnosis. CHC aims to increase this referral rate to around 75%.
- The Cambodia Anti-Tuberculosis Association (CATA) will work to raise awareness about tuberculosis in 36 garment factories, covering more than 41,000 factory workers. CATA will also strengthen the capacity of factory health staff to identify and refer suspected tuberculosis case and in treating tuberculosis (DOTS in factories)

This first objective includes 4 Service Delivery Areas (SDA)

- **SDA: High-risk groups**

The high risk group that will be targeted under this SDA is prisoners. FHI, will work in close cooperation with the National Tuberculosis Program and the Prison Department of the Ministry of Interior with the aim to strengthen the prevention and treatment of tuberculosis among prisoners and to facilitate HIV testing for inmates with tuberculosis.

Planned Activities:

- Development of a Memorandum of Understanding between the National Tuberculosis Program and the Prison Department.
- Development of Standard Operating Procedures (SOP) for tuberculosis control in prisons, including measures to guarantee the follow-up of tuberculosis patients after their release from prison before having completed treatment.
- Facilitate increased cooperation on tuberculosis control in prisons through regular meetings between the National Tuberculosis Program and the Prisons Department at national level, and between Provincial Health Departments and Prisons at the sub-national level.

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- Capacity building for health care providers in prisons in case detection, treatment and TB-HIV.
- Introduce a routine recording and reporting system in targeted prisons that is closely linked with the National Tuberculosis Program's system.
- Strengthen infection control in 11 prisons through capacity building as well as small improvements to prison health facilities.
- Regular health education sessions for inmates concerning tuberculosis and TB-HIV.
- Support tuberculosis screening in 11 prisons, treatment for inmates who are diagnosed with tuberculosis as well as HIV testing for inmates with tuberculosis (through referral of blood samples).
- Assist in adequate follow-up of tuberculosis patients after their release from prison before having completed treatment, in line with agreed SOP.
- Facilitate access to OI/ART for inmates that are HIV positive, as well as the referral for HIV-positive inmates for tuberculosis screening through X-ray.

- **SDA: All care providers (PPM/ISTC – Public-Public, Public-Private Mix (PPM) approaches and information standards for care)**

This SDA includes two different initiatives that involve working with the private sector in order to strengthen their capacity to participate in case detection, the referral of patients to the public sector for diagnosis and treatment, and in treatment.

As mentioned, CHC will work with pharmacies and private health care providers in order to strengthen their capacity to identify suspected cases and improve the effectiveness of the referral from the private sector to the public health facilities. CHC will work in the same 6 Operational Health Districts in Svay Rieng and Kampot Provinces where it is already implementing Community DOTS

CATA plan to do similar work with health staff in 36 garment factories and also to strengthen their capacity to supervise treatment through DOTS in factories. Garment factories are targeted due to the large number of mostly young female workers, who are often seen as a mobile population group and who often live in overcrowded dormitory-style accommodation. CATA is currently already working in 16 factories with support from JATA and these factories are also covered by this Round 8 Proposal starting from year 3.

Planned Activities:

- Pharmacies and private health care providers in Kampot and Svay Rieng Provinces will be identified through a mapping exercise.
- Identified pharmacies and private providers will be invited to participate in a one-day advocacy workshop, together with public health staff.
- Pharmacies and private providers will be trained in PPM-DOTS and asked to refer TB suspects to DOTS facilities.
- Strengthen the referral system through proper recording and reporting system, feedback mechanism and follow-up of referred TB suspects who do not show up at the DOTS facilities.
- Support for quarterly meetings at the local level between pharmacies and private providers and public health staff.
- Regular supervision of pharmacies and private providers.
- Health staff in factories will be trained in identification and timely referral of tuberculosis suspects and in the implementation of DOTS in factories.
- Factory team leaders will be trained as peer educators, helping to raise awareness about tuberculosis in their teams of factory workers.
- CATA staff will organize regular (quarterly) health education session in the factories.
- CATA staff will supervise peer educators and factory health staff on a monthly basis.
- Capacity building is planned for staff of the Occupational Health Department of the Ministry of Labour and Vocational Training (MoLVT)

- **SDA: Monitoring and Evaluation**

All three NGOs involved in the implementation of activities under objective 1 have planned activities that will guarantee regular monitoring and evaluation of their activities and in particular of the progress made in achieving intended results. In addition, the National Tuberculosis Program will closely monitor the activities of the NGOs with the aim to learn valuable lessons.

Planned Activities:

- FHI plans a Mid-Term Review of tuberculosis in FHI prisons to take place in year 3
- CHC plans monthly monitoring by senior management, quarterly review meetings with the National

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- Tuberculosis Program and Mid-Term Review (end of year 2) and a Final Evaluation in year 5.
- CATA plans to have quarterly monitoring meetings in each of the factories, a Mid-Term Review towards the end of year 2 and a Final Evaluation in year 5.
 - As mentioned, implementation of tuberculosis control activities by these three NGOs will be closely monitored by the National Tuberculosis Program.

- **SDA: Programme Management and Administration Costs**

All activities related to program management and administration are included under this SDA. The three NGOs have included a range of different items under this SDA, including a fee for program management and administration, costs of office facilities, utilities, supplies and communication costs, annual audit and the procurement office furniture equipment.

Objective 2: To address TB-HIV and other challenges

This objective is implemented by CENAT and focuses on the following aspects to tuberculosis prevention and control:

- CENAT plans to strengthen and expand the capacity for liquid tuberculosis cultures and to screen an increasing number of PLHIV and MDR-TB suspects using this technique.
- The current detection rate of tuberculosis in children is estimated to be around 20% and the planned program aims to increase this to close to 50% of all children infected with tuberculosis.

This objective includes the following SDAs:

- **SDA: TB-HIV**

The proposed program will build capacity for tuberculosis liquid culture in the national program's regional laboratory in Kg Cham. The proposed program will also provide the necessary supplies to the National Reference Laboratory and 2 regional laboratories (Kg Cham and Battambang) to screen an increasing number of PLHIV for tuberculosis; 4,650 in year 1, gradually increasing to almost 8,700 in year 5.

Planned Activities:

- CENAT plans to procure the required laboratory equipment, including 3 BD MGIT instruments.
- Minor renovations to laboratory facilities of the National Reference Laboratory and the regional laboratory in Kg Cham.
- Procurement of liquid culture and DST reagents for a growing number of PLHIV and TB retreatment cases.
- Training in specimen processing, tuberculosis culture and DST for 3 staff in the Kg Cham regional laboratory.
- Technical assistance (6 weeks per year in years 1 and 2) to provide further technical support to the National Reference Laboratory and both regional laboratories.
- Quarterly supervision by staff of the National Reference Laboratory to both regional laboratories.
- A proficiency testing program with a Supra-National Reference Laboratory
- Timely transport of specimen from the provinces to the National Reference Laboratory and the regional laboratories.
- CENAT plans to repeat the HIV Sero-Prevalence Survey among Tuberculosis patients in years 2 & 4.

- **SDA: Tuberculosis in Children**

The planned nation-wide program aims to increase the detection rate of tuberculosis in children by raising awareness concerning tuberculosis in children among health professionals and parents, capacity building for health care providers based on the revised guidelines (2008 – see annex 5), introducing contact tracing and management, and support to children and their parents to access health services.

Planned activities:

- Awareness-raising among physicians (including private health care providers) concerning management of tuberculosis in children through workshops and seminars.
- Training and refresher training for 450 physicians in management of tuberculosis in children.
- Training and refresher training for 240 nurses on Tuberculin Skin Test (TST).
- Regular supervision by central level National Tuberculosis Program staff.

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- Annual workshop to review progress made in tackling tuberculosis in children.
- Financial support for children that are referred for further diagnosis and treatment to cover travel and other expenses.
- Contact tracing and Isoniazid Preventive Therapy for children living in households with active tuberculosis cases.
- Procurement of PPD, Isoniazid, and several medical equipment items, such as syringes for TST, syringes for lumbar puncture and tubes for gastric aspiration.
- Procurement of pediatric first line anti-tuberculosis medicines (in years 4 and 5; continued from Round 7, which includes procurement of pediatric medicines during the first 4 years of the program).

- **SDA: M&E**

Planned activities:

- CENAT plans to recruit an M&E officer in order to further strengthen its monitoring and evaluation capacity and to deal with the growing amount of work in this area

- **SDA: Program Management and Administration Costs**

Planned activities:

- CENAT plans to recruit a finance officer in order to further strengthen its financial management capacity and to deal with the growing amount of work in this area
- The planned program includes long-term technical assistance for CENAT for years 1 to 5. The technical advisor will be employed by WHO and based at CENAT.

Objective 3: To empower people with tuberculosis and their communities

This final objective includes Community DOTS activities that are implemented by and managed by NGOs and ACSM activities implemented by CENAT,.

- **SDA: ACSM (Advocacy, Communication and Social Mobilization)**

The proposed program will support CENAT to develop a strategic plan and guidelines for ACSM and will help to strengthen the capacity of CENAT and of its staff at provincial and district levels to implement plans and guidelines. The strategic plan will clearly set out the goal and objectives for ACSM, identify target audiences, plan appropriate activities to reach them, and include M & E components to measure impact.

The Round 7 program includes considerable support for the production and airing of radio and television spots and for the design, production and dissemination of printed materials. This Round 8 proposal aims to continue these activities during its final year, when Round 7 will have ended

Planned Activities:

- Development of strategic plan, implementation guidelines and an M&E framework for ACSM. CENAT plans to recruit short-term international technical assistance for this purpose.
- The National TB Program will appoint a focal person for ACSM to facilitate coordination with all stakeholders.
- Training for provincial and district level tuberculosis program supervisors on the implementation of the strategic plans and guidelines for ACSM
- Support for the organization of the World TB Day activities across the country (national and sub-national level)
- The production and airing of health education spots on radio and television
- The production and dissemination of printed materials, such as leaflets, posters, calendars, etc.

- **SDA: Community TB Care**

The implementation of Community DOTS will expand further to cover around 95% of the Operational Health Districts. RACHA and RHAC will implement Community DOTS activities in 5 Operational Health Districts during years 1 to 5 covering a total population of more than 750,000.

Planned Community DOTS activities also include the continuation of this service in 9 Operational Health Districts currently funded under Round 5 and a further expansion to 2 additional Districts in years 3 to 5. Community DOTS in these 11 Operational Health Districts will be implemented by NGOs, which will be sub-contracted by CENAT through a competitive and transparent bidding process.

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Community DOTS activities in the 16 planned Operational Health Districts will cover almost 2.9 million people. During the five years of the proposed program, more than 18,700 registered tuberculosis patients will be served by Community DOTS in these 16 Operational Health Districts. It should be noted that this is in addition to the tuberculosis patients that will be treated at health facility level (facility DOTS).

Community DOTS guidelines will be reviewed and revised by CENAT. CENAT will ensure that all Community DOTS activities will be implemented in line with these guidelines, i.e. in close collaboration with DOTS in health facilities, other intervention implemented in the same geographical area, such as PPM-DOTS with pharmacies and private health care providers, and will incorporate ACSM activities that are in line with CENAT's strategic plan and guidelines for ACSM.

Planned activities:

- Development of revised Guidelines for Community DOTS by CENAT. The revised guidelines will become available in year two.
- RACHA and RHAC will implement and manage Community DOTS activities in 5 Operational Health Districts in Kampot, Kep and Takeo Provinces.
- Sub-contracting NGOs for the implementation and management of Community DOTS in 11 Operational Health Districts, starting from year 3. This includes continued support for Community DOTS services in 9 Operational Health Districts currently funded under Round 5 (expected to end in quarter 4 of the year 2011).
- Community DOTS activities include the training of health centre staff as Community DOTS supervisors and the training of community volunteers as DOTS watchers.
- The NGOs implementing Community DOTS also support the referral of poor tuberculosis suspects to public health facilities for further diagnosis as well as the referral of poor tuberculosis patients for HIV testing

• **SDA: M&E**

Planned activities:

- CENAT plans to evaluate Community DOTS activities in the first quarter of year 2. The evaluation will be conducted by external consultants and the findings and recommendations will be used (i) to revise the Guidelines for Community DOTS and (ii) to guide the process of sub-contracting NGOs for the implementation and management of Community DOTS in 11 Operational Health Districts in years 3 to 5
- The implementation of Community DOTS includes regular supervision and monitoring of Community DOTS supervisors and DOTS watchers and 10% of the budget for sub-contracting NGOs is reserved for monitoring and evaluation.

• **SDA: Program Management and Administration Costs**

Planned activities:

- All activities related to program management and administration are included under this SDA. The two NGOs have included a range of different items under this SDA, including a fee for program management and administration, costs of office facilities, utilities, supplies and communication costs, and annual audit.
- CENAT plans to recruit an additional procurement and logistics officer in order to further strengthen its procurement capacity and to deal with the additional work in this area as a result of sub-contracting NGOs for the implementation and management of Community DOTS.

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

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

N.A.

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4.5.3. Lessons learned from implementation experience

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

As a result of its routine recording and reporting system, which generates quarterly and annual data of outstanding quality, and the analysis of data as part of quarterly and annual review and planning processes, the National Tuberculosis Program is in a good position to learn lessons from implementation and to engage in evidence-based planning.

Through its partners as well as through participation in and membership of international meetings, conferences and forums, the National Tuberculosis Program is well positioned to benefit from lessons learned in other countries and the latest innovations in tuberculosis prevention and control.

Several activities included in the planned program build on existing and/or planned implementation of similar activities, while other planned activities may be relatively new and hence, untested in Cambodia.

PPM-DOTS with pharmacies and private providers is an existing strategy that has been piloted with varying levels of success by NGOs in different parts of the country. The activities planned in two provinces will draw on previous experiences and apply a revised and more intensive approach with the aim to dramatically increase the number of suspected cases referred by the private sector that are received by the public sector for further diagnosis and treatment.

Tuberculosis in factories is a relatively new activity that is currently implemented by CATA in a small number of factories and hence, there is only limited information available concerning the outcomes of this activity.

Although a relatively new activity, tuberculosis control activities in prisons have been planned based on the prison survey conducted by CENAT in 2005 and the findings of a recent assessment of the TB situation and control program in national penitentiaries in Cambodia in early 2008 (TB-CAP).

The planned introduction and taking to scale of liquid culture systems is in line with recent recommendations by WHO and the Global TB partnership. Furthermore, the US Centers for Disease Control (CDC) will implement and build capacity for tuberculosis liquid culture in one of the regional laboratories starting 2009. Activities proposed in this Round 8 proposal were developed in close collaboration with CDC technical experts who are currently in the planning stage of their planned activities in this area.

Tuberculosis control in children is not a new activity, but rather an area that has been given insufficient attention in the past due to a lack of resources and capacity to diagnose childhood TB. The proposed activities will build the capacity and provide the necessary resources to implement the revised national guidelines that conform to recent international recommendations and take to scale pilots that are planned for 2009 with TBCAP support.

Although still relatively new, Community DOTS is an existing strategy of the National Tuberculosis Program that is currently implemented in approximately 50% of all health centres. Despite the fact that the vast amount of information available concerning the implementation and management of Community DOTS by NGOs requires further analysis and study, Community DOTS is considered to be a tested approach that has resulted in a significantly increased case finding and improved treatment services.

Furthermore, financial data from current and planned implementation of Community DOTS has been used to estimate the per capita cost of this service. Based on this information, the proposed program includes a budget of almost \$2.2 million for the implementation of Community DOTS in 11 Operational Health by NGOs that will be sub-contracted by CENAT through a competitive and transparent bidding process.

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4.5.4. Enhancing social and gender equality

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

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

With the exception of the poor, there is no compelling evidence that certain populations groups face barriers in accessing tuberculosis diagnosis, treatment and care and support services in Cambodia.

Tuberculosis affects the poor more than other populations groups, and it has been well documented in Cambodia that the poor are less likely to access and use available health services. This despite the fact that tuberculosis diagnosis and treatment are provided free of charge by all functioning health centres throughout the country. Travel and other (opportunity) costs are important barriers that prevent the poor from accessing services that are available at local health centres. This is especially true in remote and sparsely populated provinces where it is usually more difficult and hence, more costly to travel to and from local health services.

Limited access to TB services, especially for the poor and in more remote rural areas, is the main rationale for the current and planned investments in Community DOTS (C-DOTS). C-DOTS also provides access to treatment for other groups that often find it difficult to access TB services available in the health centres, such as the elderly and the disabled. With the help of community-based DOTS watchers, these disadvantaged groups will be able to receive treatment in their communities.

When sick, the majority of Cambodians will seek health care from pharmacies and private health care providers. Most of these providers have not been trained in diagnosis and treatment and are ill-equipped to provide DOTS. The National TB Program aims to work with the pharmacies and private providers to increase their capacity to identify suspected TB cases and to refer to the nearest public health facility for further diagnosis. This proposal supports the taking to scale of the PPM-DOTS strategy in 2 provinces, resulting in increased access to TB services in these largely rural provinces.

Prisoners in most of the 27 prisons in Cambodia have limited access to TB services (and health services in general) due to the poor quality of the prison health services available to them. The National TB Program aims to step up its collaboration with the Prison Department of the Ministry of Interior and to improve TB diagnosis and treatment services available to inmates.

The stigma that previously existed concerning tuberculosis is believed to have diminished during recent years. This is partly the result of the fact that the general population has more information about tuberculosis, but also because treatment has become more readily available, ensuring better outcomes. However, tuberculosis is still a stigmatizing illness, especially for TB-HIV patients who face a double burden of stigma. Planned ACSM activities aim to raise awareness and knowledge about tuberculosis, which will contribute to further reduction in stigma and discrimination.

4.5.5 Strategy to mitigate initial unintended consequences

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

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

N.A.

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4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

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

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

This Round 8 proposal aims not only to complement activities under earlier Global Fund grants (Rounds 2, 5 and the newly approved Round 7 proposal), but also to address and/or take to scale relatively new interventions, such as tuberculosis in prisons, tuberculosis in children, and the introduction of liquid culture to diagnose tuberculosis.

Previous Global Fund grants (Rounds 2 and 5 as well as Round 7) include resources for taking to scale Community DOTS (C-DOTS). This Round 8 proposal will help to expand C-DOTS to another 3 Operational Health Districts (38 health centres and a population of 500,000 people) and to maintain C-DOTS activities in another 13 Districts (171 health centres and a population of almost 2.4 million), including 9 Districts currently funded under Round 5. As a result, C-DOTS coverage will become almost universal, leaving only three out of 77 Operational Health Districts uncovered.

PPM-DOTS activities with pharmacies and private health care providers have been piloted in several areas with the assistance of partners of the National TB Program. These pilot projects have produced mixed results and there is a need for further experimentation with this approach in order to learn lessons that can be used to fine-tune the PPM-DOTS strategy. This Round 8 Proposal will take to scale PPM-DOTS in two provinces and with the help of an NGO with extensive experience in various aspects of the National TB Program (CHC).

PPM-DOTS in garment factories is currently implemented by CATA and with financial support from JATA in 16 factories. Under Round 7, 20 additional factories will be added and this Round 8 proposal will expand this activity to another 20 factories (10 factories in year 1 and another 10 in year 3). This will bring the total number of factories implementing PPM-DOTS to a total of 56 by year 3. This number is believed to be large enough to allow the collection of data that is representative and can be used for a substantial review of PPM-DOTS in garment factories.

ASCM included in existing Global Fund grants mainly focus on health education activities, special events such as World TB Day and the production and dissemination/airing of general IEC materials. This Round 8 proposal aims to assist the National TB Program in development and implementation of a long-term ASCM strategy, led by CENAT and in collaboration with the Inter-agency Coordination Committee (ICC). The national ASCM strategy will integrate specific approaches to target high risk groups (e.g. children, PLHIV, etc), to promote public-private and public-public collaboration and to mobilize political commitment and resources for tuberculosis prevention and control.

4.6.2. Links to non-Global Fund sourced support

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

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

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This Round 8 Proposal includes several tuberculosis prevention and treatment activities that are partly supported by and/or build on initiatives that were started by other partners of the National TB Program.

Community DOTS is implemented throughout the country by a number of NGOs with USAID funding. Although USAID is expected to stop funding community DOTS in a few Operational Health District, they will continue funding this activity during their next phase of funding, which will also support the expansion community DOTS to at least 1 additional Operational Health District that is currently without this service.

In a similar way, PPM DOTS with pharmacies and private providers is implemented in several parts of the country with support from various donors, including USAID. Support for PPM-DOTS included in this activity will help a national NGO with long-term experience in tuberculosis prevention and control (CHC) to take PPM DOTS to scale in the two provinces they are working (Kampot and Svay Rieng).

The U.S. Centers for Disease Control / Global AIDS Program Cambodia (CDC) will implement TB liquid culture in one of the 3 TB culture labs by the beginning of 2009. CDC will fund the required renovations, equipment and supplies as well as capacity building for staff of the Battambang provincial TB laboratory. The available funds will only be sufficient for procurement of supplies until the end of 2009. This Round 8 Proposal aims to build on the initial work by CDC and will help to provide the necessary supplies starting from 2010 (year 1). In addition, it is planned to expand the use of liquid culture to the National Reference Lab and a second laboratory, the TB lab in Kampong Cham province. This is in line with WHO recommendations to have one TB culture laboratory per 5 million population.

TBCAP, a consortium of agencies funded by USAID, delivers technical assistance and implements activities in various areas of TB control in selected countries. In Cambodia, the TBCAP project is a three year initiative (2006-2009) that supports the NTP in strengthening the DOTS program and its management, in improving diagnostic capacity, and in the area of TB/HIV collaboration. TBCAP conducted an assessment of the TB situation and control program in national penitentiaries in Cambodia in early 2008. This assessment report, along with the prison survey conducted by CENAT, has informed the activities planned for TB control in prisons, included in this proposal. Other planned activities related to this proposal include piloting TB service in prisons, pilots to implement the new guidelines for TB in children, a national review workshop on Community DOTS and evaluation of PPM pilots. Interventions planned through Global Fund support will be taken into consideration in planning future activities of TBCAP, should the project be extended over the same term as this proposal.

4.6.3. Partnerships with the private sector

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

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

N.A.

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

Population relevant to Private Sector co-investment <i>(All or part, and which part, of proposal's targeted population group(s)? →</i>							
Contribution Value (in USD or EURO) <i>Refer to the Round 8 Guidelines for examples</i>							
Organization Name	Contribution Description <i>(in words)</i>	Year 1	Year 2	Year 3	Year 4	Year 5	Total

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

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved tuberculosis outcomes

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

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

This Round 8 Proposal includes several activities that contribute to further development of public, private and community level institutions.

A main objective of this proposal is to further strengthen the Ministry of Health's National Tuberculosis Program, in particular in the following areas:

- Prevention and control of tuberculosis in children
- Improved diagnosis of TB-HIV co-infected patients through the introduction of tuberculosis liquid culture
- The development and implementation of a national ACSM strategy and plan

NGOs play an important role in the prevention and control tuberculosis in Cambodia and the National Tuberculosis Program works in close partnership with a number of NGOs. Previous GFATM programs focused mainly on the partnership between the National Tuberculosis Program and NGOs in the implementation of Community DOTS. In this Round 8 proposal, this partnership is extended to the SDAs *Tuberculosis in Prisons* and *All Care Providers*:

- Family Health International (FHI) will assist the National Tuberculosis Program and the Prisons Department of the Ministry of Interior in strengthening the tuberculosis prevention and control in prisons, an area that is in desperate need of improve tuberculosis related services.
- Proposed activities under SDA *All Care Providers* include the work of Cambodian Health Committee (CHC) in 2 provinces to establish and strengthen the role of pharmacies and private providers in tuberculosis prevention and control.
- The same SDA (*All Care Providers*) includes activities in 36 garment factories implemented by the Cambodian Anti-Tuberculosis Association (CATA). CATA will raise tuberculosis awareness among the mostly female factory workers and will strengthen the role of factory health clinics and factory health staff in tuberculosis prevention and control.

Community DOTS is an important strategy of the National TB Program to raise awareness in more remote rural areas and to provide tuberculosis treatment to populations with limited access to health centres and referral hospitals. This proposal will further strengthen this strategy and will further strengthen community services in the form of community DOTS watchers in 16 Operational Health Districts, covering a population of 2.9 million people in rural areas.

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4.7.2. Alignment with broader developmental frameworks

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

National Strategic Development Plan 2006-2010:

The National Social Development Plan (NSDP) 2006-2010 is the single and overarching document containing the Royal Government's priority goals and strategies to reduce poverty rapidly, and to achieve other Cambodia Millennium Development Goals (CMDGs) and socio-economic development goals for the benefit of all Cambodians

The NSDP recognizes that the health sector has a crucial part to play in poverty reduction and that the absence of good health is both a cause and consequence of poverty. The NSDP acknowledges the successes in terms of increased TB detection and cure rates, but also states that the (prevalence and incidence) rates continue to be among the highest in the region.

Cambodia Millennium Development Goals:

The Cambodia Millennium Development Goals (CMDGs) Report (2003) includes a section on Tuberculosis under Goal 6; Combat HIV/AIDS, Malaria, and Other Diseases. The report identifies 4 strategies to overcome the main challenges to TB control in Cambodia:

- Increased funding and more efficient use of existing resources
- Capacity building for staff at all levels, especially in planning, management and implementation of DOTS
- Expanding DOTS to reach the community level
- IEC campaigns for the general population on proper TB prevention, detection and treatment.

In line with above strategy, the policy of the National TB Program has been to ensure that DOTS will be "pro-poor" by providing "free of charge" services. Furthermore the increased accessibility of TB services through the expansion of DOTS to the Health Centres and the communities reduces direct and opportunity costs for patients, thereby removing important barriers for the poor to access DOTS. In this manner, the prevalence of TB in the communities can be further reduced, which is expected to contribute significantly to increasing economic productivity.

The current proposal for Round 7 will increase access to DOTS for rural and remote populations, as well as co-infected populations (TB with HIV-AIDS). Through collaboration with NGOs community representatives, some innovative approaches to more efficient and cost-effective delivery of C-DOTS will be tested. This proposal will build on work initiated through funding obtained in GFATM Round 5, as well as on existing partnerships, such as the collaboration with the World Food Program (WFP) to ensure food supplement to all TB patients.

Global Plan to Stop TB (2006-2015):

The Global Plan to Stop TB (2006-2015) clearly sets out the activities to achieve the Stop TB Partnership's global targets of halving TB prevalence and mortality by 2015. It is also in line with the Millennium Development Goals to reduce the incidence of TB (having halted... and begun to reverse the incidence of TB).

The goal of the National TB Program as stated in the National Strategic Plan for TB Control in Cambodia (2006-2010) is to reduce morbidity and mortality due to tuberculosis in line with the CMDGs, the Global Stop TB Plan (2006-2015) and the Strategic Plan to Stop TB in the Western Pacific (2006-2010).

The objectives of this proposal (as listed below) are closely linked to the above strategies:

- To engage all care providers by ensuring provision of high quality TB care of international standards by all relevant public and private health care providers
- To address TB-HIV and other challenges
- To empower people with tuberculosis and their communities

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4.8. Measuring impact

4.8.1. Impact Measurement Systems

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

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

The National TB Program routine recording and reporting system generates quarterly data from all health facilities that provide TB diagnosis and care. This system has been in existence for several years and has been strengthened over time with the support of technical assistance provided by the national program's partners.

- The Joint Program Review notes that the National TB Program *generates outstanding quality information from routine data compile through its information system* and that *records and registers are well kept and of good quality.*
- The routine recording and reporting system provides data on most of the outcome and output indicators included in Attachment A.
- In line with WHO recommendations, the recording and reporting system has been updated to capture TB-HIV and MDR-TB data

Another strength of the existing M&E framework are the regular surveys that have been conducted by the National TB Program:

- The 2002 TB Prevalence Survey will be repeated in 2009.
- The National HIV Sero-Prevalence Survey amongst TB Patients has been conducted every 2 years since 2003. The last survey was conducted in 2007 and the next one is already being planned for 2009.
- The Drug Resistance Surveys has been conducted twice and the last survey took place in 2006/07.

The NGO sub-recipients included in this Round 8 proposal have extensive experience in implementing TB activities, either with funding under previous GFATM Rounds or from other donor agencies. As a result, they have the required systems in place to monitor their contribution to achieving national tuberculosis targets. This is demonstrated by the M&E frameworks (Attachment A) prepared by them as part of the Round 8 proposal development process:

- NGO sub-recipients included indicators that are aligned with and will be measured through the National TB Program's routine recording and reporting system.
- Additional indicators are complementary to the data generated by the national program's recording and reporting system. These indicators allow assessment of the contribution made by these sub-recipients to achieving the national program's outcome and impact indicators.
- National Drug Resistance Survey (latest 2006/2007)

A possible weakness of the existing in-country M&E systems may be in the fact that certain on-going activities, such as C-DOTS and PPM-DOTS, are not sufficiently analyzed and reviewed, despite the fact that most of the required data and information is routinely collected and available. A systematic analysis and regular review of program activities would result in valuable lessons and best practices learned, that could be used to further strengthen these interventions.

For reasons mentioned above, this Round 8 Proposal includes an external review of ongoing C-DOTS activities in year 2. The aim of the planned review is to identify the successes of the C-DOTS strategy and to make recommendation on how to further strengthen this strategy.

4.8.2. Avoiding parallel reporting

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

Several of the indicators included in Attachment A of this Round 8 proposal are standard tuberculosis prevention and control indicators, and the National TB Program routine recording and reporting system generates timely and good quality data for these indicators. In order to avoid duplication and parallel reporting, the Principal Recipient and all Sub-Recipients of this Round 8 proposal will rely on data

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provided by the National TB Program routine recording and reporting.

Sub-Recipients have included additional indicators that will allow them and the Principal Recipient to closely monitor program implementation. When several Sub-Recipients are implementing similar activities, these indicators and their definitions were harmonized as part of the Round 8 proposal development process.

Furthermore, indicators, their definitions and reporting channels and cycles have been aligned with existing M&E arrangements already used in the implementation of other Global Funds grants or of programs implemented with support from other agencies. A good example are the indicators proposed to monitor progress of Community DOTS activities, which are in line with indicators included in Global Fund Rounds 5 and 7 as well as with indicators used by NGOs that are implementing Community DOTS with USAID funding.

4.8.3. Strengthening monitoring and evaluation systems

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

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

This Round 8 Proposal does not include specific improvements to the M&E system. It was demonstrated in section 4.8.1 that the National TB Program routine recording and reporting system has been in existence for several years and is reported to generate data of outstanding quality. The system has been strengthened over time with the support provided by the national program's partners, including previous Global Fund Rounds (Rounds 2 and 5). In addition, the National TB Program generates additional data through regular surveys, such as the National Prevalence Survey and the HIV Sero-Prevalence Survey among Tuberculosis patients.

It was already mentioned that the NGOs included as Sub-Recipients in this Round 8 Proposal have extensive experience in implementing TB activities, either with funding under previous GFATM Rounds or from other donor agencies. As a result, they have the required systems in place to monitor their contribution to achieving national tuberculosis targets.

It follows that most of the budget allocated for M&E is planned to be used for the routine implementation of M&E tasks, such as regular supervision, data collection and reporting. It is worthwhile to mention here that this Round 8 Proposal includes funding to repeat the HIV Sero-Prevalence Survey in 2011 and 2013 (years 2 and 4). Furthermore, an extensive review of ongoing Community DOTS activities is planned for early 2011 (year 2).

M&E by the Principal Recipient will largely build on and utilize the M&E systems and procedures that will have been put in place by CENAT as the Principal Recipient for Round 7. Round 7 includes both human resources and national and international technical assistance for this purpose and hence, only minimal additional efforts are required in terms of strengthening the Principal Recipient's M&E systems.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

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

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

PR 1	National Centre for Tuberculosis and Leprosy Control (CENAT)
Address	No.1, Corner Street 278/95; Sangkat Boeung Keng Kang II; Khan Chamkar Mon; Phnom Penh; Cambodia

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	Tel.: +855 12 916503 Fax: +855 23 218090 E-mail: mao@online.com.kh
<p>In terms of technical capacity, CENAT is the leading agency with overall responsibility for Tuberculosis control in Cambodia. Through the years, CENAT staff have been able to increase their technical capacity due to the longstanding support and technical assistance from partners such as WHO, CDC and JICA.</p> <p>CENAT also has longstanding experience in managing the National Tuberculosis Program, which includes several large donor-funded programs, including 2 GFATM grants (Rounds 2 and 5). More than 4 years of experience in managing these GFATM grants has allowed CENAT to further strengthen its management capacity, including M&E, financial management and procurement.</p> <p>Capacity assessments conducted by the Principal Recipient for Rounds 2 and 5 found CENAT's capacity in the areas of M&E, financial management and procurement to be satisfactory. Furthermore, the most recent Grant Performance Reports rates the performance of the Round 2 and 5 TB components as A and B1 respectively.</p> <p>Finally, it needs to be noted that CENAT has been selected as the Principal Recipient for Round 7 and is presently going through the preparation process for implementation (grant negotiation and agreement). It is expected that by the time implementation of the proposed Round 8 program will start, CENAT will already have 1 year of experience as the Principal Recipient for Round 7.</p> <p>It is recognized, however, that taking on the responsibility of managing an additional grant requires additional managerial and financial capacity and will require the recruitment of some additional staff. These needs have been addressed in the proposed budget for the Principal Recipient. In addition, this Round 8 Proposal bears the full Principal Recipient costs in year 5, because Round 7 implementation will have been completed by that time.</p>	

PR 2	[Name]
Address	[street address]
[Description]	

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

→ Copy and paste tables above if more than three Principal Recipients

4.9.2 Sub-Recipients	
(a) Will sub-recipients be involved in program implementation?	<input checked="" type="checkbox"/> Yes
	<input type="checkbox"/> No
(b) If no , why not?	
(c) If yes , how many sub-recipients will be involved?	<input checked="" type="checkbox"/> 1 – 6
	<input type="checkbox"/> 7 – 20

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	<input type="checkbox"/> 21 – 50
	<input type="checkbox"/> more than 50
(d) Are the sub-recipients already identified? <i>(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)</i>	<input checked="" type="checkbox"/> Yes <i>[Insert Annex Number for list]</i> See Annex ?? for list of SRs
	<input type="checkbox"/> No Answer s.4.9.4. to explain
(e) If yes , comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program delivery at the sub-recipient level, please explain why.	
<p>This Round 8 Proposal includes 6 Sub-Recipient, including the CENAT/National Tuberculosis Program. The budget for the five non-governmental organizations included in this proposal amounts to almost \$2.84 million or 21.5% of the total budget. The budget allocations for each of these NGOs is as follows:</p> <ul style="list-style-type: none"> • Cambodian Anti-Tuberculosis Association - CATA (tuberculosis prevention and control in factories): \$396,553 or 3% of the total budget. • Cambodia Health Committee - CHC (PPM-DOTS with pharmacies and private health care providers): \$571,270 or 4.3% of the total budget. • Family Health International - FHI (Tuberculosis prevention and control in prisons): \$1,012,513 or 7.7% of the total budget. • Reproductive and Child Health Association - RACHA (Community DOTS in 2 Operational Health Districts): \$225,422 or 1.7% of the total budget. • Reproductive Health Association of Cambodia - RHAC (Community DOTS in 3 Operational Health Districts): \$632,246 or 4.8% of the total budget. <p>The budget for CENAT (\$9,663,220 – excluding the budget for CENAT at the Principal Recipient) includes \$2.16 million or 16.3% of the total budget for sub-contracting NGOs to implement community DOTS activities in 11 Operational Health Districts. This bring the proportion of the budget to be implemented by NGOs (five NGOs already identified and additional NGOs to be sub-contracted by CENAT starting from year 3) to 37.8%.</p> <p><u>HSS Cross-Cutting Proposal</u></p> <p>The cross-cutting HSS Component attached to this proposal has 2 NGO sub-recipients:</p> <ul style="list-style-type: none"> • University Research Corporation (URC) (infection control), an international NGO. • MEDiCAM (leadership and governance), a local Cambodian NGO. 	

4.9.3. Pre-identified sub-recipients

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

The proposal includes five national and international NGOs and the National Centre for TB and Leprosy Control (CENAT).

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CENAT has long-term experience in managing the National TB Program, including several donor funded programs:

- The World Bank started funding the National TB Program almost a decade ago, the first few years directly and since 2003 through the multi-donor funded Health Systems Support Program (HSSP). HSSP is currently in its final year and it is anticipated that the next project will not include direct support to the National TB Program
- CENAT has been managing GFATM grants as the single Sub-Recipient under Round 2 and the largest Sub-Recipient under Round 5. This gives CENAT more than 4 years experience in managing GFATM funded programs. Furthermore, CENAT will be the Principal Recipient for Round 7 and is currently going through the necessary preparations that are needed before implementation can begin.

Four of the NGOs (CATA, CHC, FHI and RHAC) are also Sub-Recipients under Round 7, while CHC is also a Sub-Recipient under the un-going Round 5 program. Both FHI and RHAC have extensive and long-term implementation experience as recipients of USAID funding and are Sub-Recipients under Round 2 (RHAC) and Round 5 (RHAC and FHI) HIV programs in Cambodia.

CATA is currently funded by JATA and involved in the implementation of TB activities in factories and for elderly people.

RACHA has no previous experience in implementing GFATM funded programs, neither will it be part of Round 7 implementation starting later this year. However, RACHA has long-term experience (more than 10 years) in implementing USAID funded health projects in Cambodia, with an annual budget of more than \$3 million.

Pre-identified Sub-Recipients for the HSS Cross-Cutting Proposal

The cross-cutting HSS component attached to this proposal has one international and one local NGO SR. URC has been a leader in quality of care since the early '90s when it launched USAID's first global project on service quality, and has worked in HSS in Cambodia since 2002. URC's work in Cambodia has included assisting the MoH in development/implementation of a system of Quality Assurance and provision of technical assistance and resources -- including infrastructure and equipment -- to improve service quality. URC has not previously managed GFATM funded programs, but has several decades of experience implementing USAID and other donor-funded programs worldwide.

MEDiCAM is an umbrella membership organization representing health sector in Cambodia, particularly in an advocacy role. MEDiCAM provided the main channel for NGO input into the HSP and is currently developing a Community Participation Policy in consultation with grassroots NGOs/CBOs/CSOs in different regions of the country. In addition to its role as a representative of the overall health NGO community, MEDiCAM has directly implemented several programs, including a UNICEF-funded Community-based approach to Avian Influenza control and a WHO-funded study of the current and future role of NGOs in addressing demand-side constraints. MEDiCAM has successfully managed GFATM resources under Round 5 where in partnership with the MoH it conducts "Annual Sharing Events" in which grassroots NGOs and provincial and OD level MoH managers meet to discuss best practices and enhance cooperation and partnership, and CBO/NGO Planning Forums to familiarize same with the Annual Operational Plan (AOP) process. Support from Round 5 also enabled MEDiCAM to establish additional regional offices to assist in the coordination of NGOs and PHDs.

4.9.4. Sub-recipients to be identified

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

This Round 8 Proposal includes \$2.16 million for the implementation of Community DOTS in 11 Operational Health Districts (nine of which are currently funded under Round 5) in years 3-5. The budget has been calculated based on a per capita cost for the implementation of Community DOTS by NGOs and using actual costs of current and planned (including under Round 7) Community DOTS activities.

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Allowing an 10% price increase between now and 2012 (year 3 of this Round 8 Proposal, the per capita cost for implementation of Community DOTS activities through NGOs is estimated to be \$0.30. Furthermore, the year 3 budget (first year of implementation) includes 35% to cover start-up costs.

The NGOs (Sub-Recipients) that will implement Community DOTS in these 11 Operational Health Districts have not yet been identified. The National TB Program will identify and contract qualified Sub-Recipients through a competitive and transparent bidding process, which is planned to take place as part of the process of preparing detailed work plans and budgets for Phase II of Round 8. Potential (short-listed) Sub-Recipients will be invited to submit detailed work plans, budgets and M&E plans that are in line with the revised Guidelines for Community DOTS and available funding as calculated based on population numbers and estimated per capita costs.

Submissions will be assessed by a technical committee consisting of the National TB Program, its partners and the Principal Recipient and the assessment will be based on technical as well as financial criteria

4.9.5. Coordination between implementers

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

Comment on factors such as:

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

CENAT has been selected as the Principal Recipient for the TB component of the Round 8 proposal, while the Principle Recipient Office of the Department of Communicable Disease Control of the Ministry of Health will manage the proposed HSS cross-cutting activities.

TB component:

The management approach with respect to planning, implementation, and monitoring will be based on principles of coordination and participation between the Principal Recipient and the Sub-Recipients. This is in line with the already strong harmonization and alignment between the National Tuberculosis Program and its partners (bi- and multi-lateral donors and civil society).

CENAT will have overall responsibility for management and implementation and will enter contractual agreements with the Sub-Recipients, based on agreed work plans, budgets and M&E plans. CENAT will also provide technical supervision and guidance to the NGO partners included in this Round 8 Proposal.

The six Sub-Recipients (five NGOs and the National Tuberculosis Program) included in this proposal will have responsibility for day-to-day management and implementation of their respective work plans and budgets as well as for monitoring results against agreed targets specified in their respective M&E plans.

CENAT as the PR will oversee the work of the Sub-Recipients and assess on a regular basis the performance of individual Sub-Recipients as well as of the grant as a whole. In order to do so, CENAT will put in place the following mechanisms:

(i) Quarterly Meetings:

It is envisaged that CENAT and the NGO partners (Sub-Recipients) will have joint quarterly meetings with the aim:

- To closely monitor progress made in implementing agreed work plans and in achieving stated objectives and targets
- To plan (jointly) future implementation, based on lessons learned
- To facilitate exchange of experiences and lessons learned between the National TB Program and the various Sub-Recipients

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(ii) Quarterly Supervision:

In addition to these quarterly monitoring/planning meetings, CENAT will supervise each of the Sub-Recipients on a regular basis in the form of field visits. The purpose of these field visits is not only to verify whether work is being implemented as planned, but also to assess the quality of services provided and to provide technical and management (M&E, finance) support to each of the Sub-Recipients and their staff.

(iii) Regular Reporting:

Sub-Recipients will submit regular (quarterly or six-monthly) progress reports and request for disbursement, based on which CENAT will prepare consolidated progress reports and requests for disbursement.

The performance of the PR will be monitored by the CCM and its sub-committee (CCC-SC), based on an analysis of the six-monthly progress reports. These progress reports will need to be approved and cleared by the CCM before submission to the LFA and GFATM. Furthermore, the CCC will ensure that the PR has adequate (M&E, financial and procurement) systems and procedures in place that are in line with and meet GFATM requirements.

Progress reports will be also be shared with and reviewed by the TRP for TB, which includes representatives of several of CENAT's long-term partners, such as JICA, WHO, and USAID. This will ensure that the Round 7 program will be planned, implemented and monitored as part of the overall TB control efforts in Cambodia.

4.9.6. Strengthening implementation capacity

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

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

- (a) the assistance that is planned;**
- (b) the process used to identify needs within the various sectors;
- (c) how the assistance will be obtained on competitive, transparent terms; and
- (d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

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

This Round 8 Proposal includes long-term technical assistance for the National TB Program to be recruited and managed by the World Health Organization (WHO). Similar technical assistance has been in place for several years either directly funded by WHO or through other partners, such as World Bank or TB-CAP.

JICA has been providing long-term technical assistance to the National TB Program. However, with the JICA project coming to an end in the third quarter of 2007 and with TB-CAP funding for the current WHO technical advisor guaranteed until September 2007, it is essential for the National TB Program to secure funding for a long-term technical advisor.

It is noted that this does not overlap with long-term technical assistance to CENAT under Round 7 as the latter concern technical assistance in M&E and Program Management to assist CENAT in implementing the role and responsibilities of the Principal Recipient for the TB Component of the Round 7 grant.

As mentioned, the long-term technical advisor will be recruited and employed by WHO and for the full duration of Round 8 (2010 – 2014). WHO recruitment systems and procedures will guarantee a competitive and transparent recruitment process and will ensure technical assistance according to the highest international standards. Furthermore, the technical advisor will be managed by WHO and will be

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able to draw on additional technical expertise and resources available at WHO's Regional Office (WPRO) and at the Geneva Headquarters.

In addition, this Round 8 proposal includes short-term technical assistance for specific tasks:

- Technical support and follow-up for National Reference Laboratory and two regional laboratories – 45 days in years 1 and 2
- Consultant to conduct review of Community DOTS – 30 days in year 2
- Consultant to review and revise Guidelines for Community DOTS – 20 days in year 2

The proposal also includes technical assistance to assist CENAT in its role of the Principal Recipient for Round 8. Given the fact that technical assistance will already be provided to the Principal Recipient under Round 7, only limited additional technical assistance has been requested for the years 1-4. Year 5 of this Round 8 proposal coincides with the completion of Round 7 implementation and hence, full-time M&E and Program Management technical assistance and 3 months technical assistance in Procurement has been included in year 5 of this proposal.

All positions (for short-term consultants and for short- and long-term technical assistance) will be advertised and potential candidates will be reviewed, shortlisted and interviewed by a panel consisting of the National TB program, its partners and technical advisors and the Principal Recipient.

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4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 proposal	
Does this proposal seek funding for any pharmaceutical and/or health products?	<input type="checkbox"/> No → Go to s.4B if relevant, or direct to s.5.
	<input type="checkbox"/> Yes → Continue on to answer s.4.10.2.

4.10.2. Table of roles and responsibilities			
Provide as complete details as possible. (e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.			
Activity	Which organizations and/or departments are responsible for this function? <i>(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)</i>	In this proposal what is the role of the organization responsible for this function? <i>(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)</i>	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	Ministry of Economy and Finance (MoEF) and Ministry of Health (MOH)	Responsible for procurement policies and systems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intellectual property rights	Ministry of Health	Responsible for adherence to international and national laws, including those concerning property rights	<input type="checkbox"/> Yes <input type="checkbox"/> No
Quality assurance and quality control	Department of Drugs and Food Safety (DDF) and Central Medical Store (CMS) of the Ministry of Health	Responsible for quality assurance and control of all pharmaceuticals	<input type="checkbox"/> Yes <input type="checkbox"/> No
Management and coordination <i>More details required in s.4.10.3.</i>	CENAT	PR	<input type="checkbox"/> Yes <input type="checkbox"/> No
Product selection	CENAT	PR / SR	<input type="checkbox"/> Yes <input type="checkbox"/> No
Management Information Systems (MIS)	CENAT CMS	PR Storage and supply management agent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Forecasting	CENAT	PR / SR	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Procurement and planning	CENAT	PR	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Storage and inventory management <i>More details required in s.4.10.4</i>	CMS	Storage and supply management agent	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Distribution to other stores and end-users <i>More details required in s.4.10.4</i>	CMS	Storage and supply management agent	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Ensuring rational use and patient safety (pharmacovigilance)	CENAT DDF	PR / SR Rational use of all pharmaceuticals, including regular supervision of health facilities	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

4.10.3. Past management experience

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

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year <i>(Same currency as on cover of proposal)</i>
CENAT	Sub-Recipient	2007: 1,228,000 (including 657,000 under Round 5)
Central Medical Store (CMS)	Storage & supply management agent	N.A. CMS handles storage and distribution of all pharmaceuticals and health products in the public health sector, including for tuberculosis
Department of Drugs and Food Safety (DDF)	Quality control & rational use of drugs	N.A. DDF is responsible for quality assurance and control and rational use of all pharmaceuticals and health products in the public health sector, including for tuberculosis
<i>[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]</i>		

ROUND 8 – Tuberculosis

4.10.4. Alignment with existing systems

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

As explained in section 4.10.5, the management of the health products that are included in this Round 8 proposal will be managed by the existing Ministry of Health institutions that are responsible for the management of all pharmaceuticals

With respect to the management of tuberculosis related pharmaceuticals and health products in this proposal, the Principal Recipient will be responsible for procuring the items in accordance with the national procurement guidelines and the Global Fund requirements. The Central Medical Store (CMS) will be responsible for the storage and distribution of all health products, while the Department of Drugs and Food (DDF) will be responsible for following-up adverse drug reactions and promoting rational drug use. The coordination and integration of all national program data inventory activities into the Operational District Data Inventory (ODDID) system will allow stakeholders at all levels to capture, record, and report usage of drugs and supplies.

Recently, the DDF has set-up a pharmacovigilance unit to cater to the needs of national programs and to monitor adverse drug reactions. A national drug information centre has been established which besides being a resource centre on un-biased drug information, will facilitate the process of monitoring and documenting adverse drug reactions in order to prevent their occurrence in the future, thereby contributing to the overall improvement in patient safety.

4.10.5. Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?	<input checked="" type="checkbox"/> National medical stores or equivalent
	<input type="checkbox"/> Sub-contracted national organization(s) <i>(specify)</i>
	<input type="checkbox"/> Sub-contracted international organization(s) <i>(specify)</i>
	<input type="checkbox"/> Other: <i>(specify)</i>
(b) For storage partners, what is each organization's current storage capacity for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.	
<p>The Ministry of Health Central Medical Store (CMS) is responsible for the storage and distribution of all medicines and related supplies for the public health centre (National Hospitals, Provincial and District Referral Hospitals and Health Centres).</p> <p>CMS has a proven track record in efficiently managing the storage of TB medicines and related supplies in Cambodia, and is currently handling all anti-tuberculosis drugs and related supplies in a transparent and effective manner with the benefit of GFATM support under Round 5.</p> <p>Continuation of key aspects of that support as well as additional measures to further expand CMS's storage and distribution capabilities are included in the cross-cutting HSS Component of this submission.</p>	
(c) For distribution partners, what is each organization's current distribution capacity for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.	
<p>Similar to what was said concerning the storage capacity (4.10.5 – b), the Central Medical Store (CMS) is already handling the distribution of all medicines and health products to all public health facilities in the</p>	

ROUND 8 – Tuberculosis

country. This includes the distribution of all anti-tuberculosis drugs and related supplies to all 24 Provinces and 77 Operational Health Districts on a quarterly basis.

Starting from 2007, the CMS has also been handling the storage and distribution of first-line anti-tuberculosis drugs procured under Round 5, aided by HSS inputs included in that round.

Continuation of key aspects of that support as well as additional measures to further expand CMS's storage and distribution capabilities are included in the cross-cutting HSS Component of this submission.

4.10.6. Pharmaceutical and health products for initial two years

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

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

Attachment B-Tuberculosis, lists all the pharmaceutical and health products that are requested to be funded through this proposal. All products except for liquid culture systems and purified protein derivative (PPD) are included in the national guidelines or essential medicines lists.

Expanding culture capacity is urgently needed particularly to address challenges of TB and drug-resistant TB. Liquid culture systems are the standard of care for TB diagnosis and patient management in the developed world. Liquid culture systems are more sensitive for detecting mycobacteria, may increase the yield by 10% over solid media, and reduce the delays in results to days rather than weeks, thereby contributing to improve patient management. WHO and the Stop TB Partnership recommend the use of liquid culture and rapid species identification to address the needs for cultures and DST (1).

The NTP is now revising its guidelines for the management of TB in children to conform to recent international recommendations (2). Accordingly, tuberculin skin testing using purified protein derivative (PPD) will be used and included in the recommended approach to diagnose TB in children.

Reference:

1. World Health Organization: Use of liquid TB culture and drugs susceptibility testing in low- and medium-income settings. <http://www.who.int/tb/dots/laboratory/policy/en.print.html>

2. World Health Organization. Guidance for national TB programmes on the management of TB in children. http://whqlibdoc.who.int/hq/2006/WHO_HTM_TB_2006.371_eng.pdf

4.10.7. Multi-drug-resistant tuberculosis

Is the provision of treatment of multi-drug-resistant tuberculosis included in this tuberculosis proposal?

Yes

In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.

No

Do not include these costs

ROUND 8 – Tuberculosis

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

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

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

Read the [Round 8 Guidelines](#) to consider including HSS cross-cutting interventions.

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

ROUND 8 – Tuberculosis

5. FUNDING REQUEST

Clarified Table 5.1

5.1. Financial gap analysis - Tuberculosis

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

NOTE: HEADINGS HAVE BEEN ADJUSTED TO REFLECT THE PERIOD FOR WHICH FUNDING IS REQUESTED, 2010 - 2014

Financial gap analysis <i>(same currency as identified on proposal coversheet)</i>								
Note → Adjust headings (as necessary) in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods								
	Actual		Planned		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
Tuberculosis program funding needs to deliver comprehensive diagnosis, treatment and care and support services to target populations								
Line A → Provide annual amounts	9,102,769	9,288,900	10,790,473	11,776,051	12,086,550	12,319,499	12,490,068	12,707,463
Line A.1 → Total need over length of Round 8 Funding Request						<i>(combined total need over Round 8 proposal term)</i> Years 2010-2014: 61,379,631		
Current and future resources to meet financial need								
Domestic source B1 : Loans and debt relief <i>(provide name of source)</i>								
Domestic source B2 National funding resources	975,000	1,000,000	1,050,000	1,100,000	1,150,000	1,200,000	1,250,000	1,300,000
Domestic source B3 Private Sector contributions (national)								
Total of Line B entries → Total current & planned DOMESTIC (including debt relief) resources:	975,000	1,000,000	1,050,000	1,100,000	1,150,000	1,200,000	1,250,000	1,300,000
External source C 1 HSSP/WB	998,116	500,000						

ROUND 8 – Tuberculosis

Financial gap analysis <i>(same currency as identified on proposal coversheet)</i>								
Note → Adjust headings (as necessary) in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods								
	Actual		Planned		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
External source C2 JICA	350,000	350,000	175,000					
External source C3 WHO	40,000	40,000	40,000	40,000	40,000	40,000	40,000	40,000
External source C4 TB-CAP (excl. TA and Office Costs)	575,000	575,000	575,000	575,000	575,000	575,000	575,000	575,000
External source C4 USAID	1,970,000	2,400,000	2,000,000	2,000,000	2,000,000	2,500,000	2,500,000	2,500,000
External source C7 Private Sector contributions (International)								
Total of Line C entries → Total current & planned EXTERNAL (non-Global Fund grant) resources:	3,933,116	3,865,000	2,790,000	2,615,000	2,615,000	3,115,000	3,115,000	3,115,000
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	2,758,174	2,745,514	6,646,614	6,133,459	6,371,772	4,767,063	4,206,884	
Line E → Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	7,666,290	7,610,514	10,486,614	9,848,459	10,136,772	9,082,063	8,571,884	4,415,000
Calculation of gap in financial resources and summary of total funding requested in Round 8 (to be supported by detailed budget)								
Line F → Total funding gap (i.e. Line F = Line A – Line E)	1,436,479	1,678,386	303,859	1,927,592	1,949,778	3,237,436	3,918,184	8,292,463

ROUND 8 – Tuberculosis

Financial gap analysis <i>(same currency as identified on proposal coversheet)</i>								
Note → Adjust headings (as necessary) in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods								
	Actual		Planned		Estimated			
	2007	2008	2009	2010	2011	2012	2013	2014
Line G = Round 8 tuberculosis funding request <i>(same amount as requested in table 5.3 for this disease)</i>				1,699,150	1,750,860	2,820,134	2,918,999	4,049,507

Part H – 'Cost Sharing' calculation for Lower-middle income <u>and</u> Upper-middle income applicants	
<i>In Round 8, the total maximum funding request for tuberculosis in Line G is:</i>	
<p>(a) <i>For Lower-Middle income countries, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and</i></p> <p>(b) <i>For Upper-Middle income countries, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.</i></p>	
<p>Line H → Cost Sharing calculation as a percentage (%) of overall funding from Global Fund</p> <p>Cost sharing = $\frac{\text{(Total of Line D entries over 2009-2013 period + Line G Total)}}{\text{Line A.1}} \times 100$</p>	57 %

ROUND 8 – Tuberculosis

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

Explain how the annual amounts were:

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

Financial needs as presented in Line A in table 5.1 were calculated based on actual expenditures in the years 2005-2007 and cost estimates included in the National TB Program's Strategic Plan 2006-2010.

Existing cost estimates were up-dated, based on new information and taking into consideration the additional costs of emerging priorities and planned new activities:

- The projected costs of TB drugs was originally estimated at \$800,000 per year, but was increased to \$1.1 million per year because of the need to procure MDR-TB drugs.
- Financial needs were adjusted to include the costs of scaling-up TB-HIV activities
- Cost estimates have been adjusted to include the cost of introducing and going to scale with tuberculosis liquid culture.
- Original costing did not include costs of going to scale with community DOTS. Financial needs presented in table A include the costs of the gradual expansion of community DOTS to more than 80% of the health centres.
- Under this Round 8 proposal, the National TB Program plans to put more emphasis on TB in prisons and TB in children.

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

Explain the processes used in country to:

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

Domestic financial contributions to the National TB Program are allocated as part of the Ministry of Health planning and budgeting processes. The Ministry of Health has two main planning tools that play a key role in decisions concerning the allocation of the national health budget:

- The Three-Year Rolling Plan gives a medium-term perspective of resource needs, which is updated every year.
- The Annual Operational Plan (AOP) is the main instrument used by the Ministry of Health for the annual allocation of the available national health budget.

All Budget Management Centres (BMCs)(i.e. health institutions/programs with control over their budget) have to submit monthly and annual expenditure reports (including the National TB Program). The Ministry of Health compiles these reports into a consolidated report for the public health sector as a whole. The consolidated expenditure report gives a good overview of:

- Budget access for all BMCs.
- Expenditures by each BMC.
- Changes over time in budget and expenditures for each BMC.

In addition to expenditure reports, the National TB Program also needs to prepare quarterly and annual progress reports. These reports show the progress made in achieving agreed objectives and targets.

Financial and programmatic progress of the various health institutions and programs is reported and discussed every year during the Ministry of Health Joint Annual Performance Review (JAPR). The

ROUND 8 – Tuberculosis

JAPR provides an opportunity for the Ministry of Health and its partners not only to review progress made, but also to set new priorities which will guide decisions concerning the allocation of the national health budget.

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

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

Since the start of Round 5 (4th quarter, 2006), Global Fund has become the single largest external source of funding, contributing almost \$2.76 million or 30% of the total financial need in 2007. Round 2 will be completed later this year, while at the same time Round 7 implementation is expected to start. For the coming three years (2009-2011), Global Fund contributions are expected to range from 62% of the total financial need in 2009 to around 53% in 2011. With the end of Round 5 towards the end of 2011, this percentage will fall back to 39% in 2012 and 34% in 2013 (the final year of Round 7 implementation).

JICA has provided long-term support to the National TB Program. This support will come to an end in 2009, which is a decision that was made at the beginning of the current phase of funding.

Support from the World Bank, through the Health Sector Support Program (HSSP), has been extended for 1 year (no cost extension with remaining funds carried forward from 2007 budget), but will come to an end by December 2008. The next phase of HSSP is currently being developed and it is not yet clear whether it will include financial support to the National TB Program.

It should be noted that financial support from other external sources (WHO, TB-CAP and USAID) for 2009 and subsequent years, was not yet known at the time of proposal development. The figures given in table 5.1 are estimates based on levels of funding during previous years.

5.2. Detailed Budget

Suggested steps in budget completion:

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

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

Clarified Table 5.3

Objective Number	Service delivery area <i>(Use the same numbering as in program description in s.4.5.1.)</i>	Year 1	Year 2	Year 3	Year 4	Year 5	Total
3	ACSM (Advocacy, communication and social mobilization)	124,087	70,301	58,541	60,341	650,901	964,171
1	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	191,285	103,812	123,590	112,976	108,028	639,691
3	Community TB care	120,899	139,870	1,015,399	776,306	795,883	2,848,357
1	High-risk groups	141,924	145,172	123,187	116,009	116,009	642,301
1,2,3	M&E	23,161	63,547	49,795	39,050	48,042	223,595
1,2,3	Programme management and Administration cost	378,670	366,479	372,770	372,774	392,914	1,883,607
2	TB in Children	209,549	390,034	677,558	902,778	1,100,385	3,280,304
2	TB/HIV	408,670	366,775	316,732	464,373	462,648	2,019,198
	Sub-Total	1,598,245	1,645,990	2,737,572	2,844,607	3,674,810	12,501,224
	Principal Recipient Budget (5.9% of the sub-total)	100,905	104,870	82,562	74,392	374,697	737,426
Round 8 tuberculosis funding request:		1,699,150	1,750,860	2,820,134	2,918,999	4,049,507	13,238,650

ROUND 8 – Tuberculosis

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

Avoid using the "other" category unless necessary – read the [Round 8 Guidelines](#).

	<i>(same currency as on cover sheet of Proposal Form)</i>					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	298,539	366,383	654,549	734,892	935,174	2,989,537
Technical and Management Assistance	308,000	293,500	206,750	197,750	317,750	1,323,750
Training	233,891	235,427	380,003	344,319	374,503	1,568,143
Health products and health equipment	286,844	208,619	272,812	342,245	454,243	1,564,763
Pharmaceutical products (medicines)	6,255	12,510	18,764	48,539	57,819	143,887
Procurement and supply management costs	10,000	10,000	10,000	10,000	10,000	50,000
Infrastructure and other equipment	195,410	44,780	265,964	28,940	28,940	564,034
Communication Materials	63,649	53,649	73,023	73,023	662,383	925,727
Monitoring & Evaluation	38,082	159,341	173,101	262,163	204,022	836,709
Living Support to Clients/Target Populations	89,712	161,015	300,638	381,086	445,447	1,377,898
Planning and administration	97,720	135,512	315,020	352,991	415,513	1,316,756
Overheads	71,048	70,124	149,510	143,051	143,713	577,446
Other: <i>(Use to meet national budget planning categories, if required)</i>	0	0	0	0	0	0
Round 8 tuberculosis funding request <i>(Should be the same annual totals as table 5.2)</i>	1,699,150	1,750,860	2,820,134	2,918,999	4,049,507	13,238,650

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5.4.1. Overall budget context

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

The total budget for years three and four is significantly higher than for the first two years due to the fact that starting from year three the National TB Program will contract with NGOs to implement Community DOTS in 9 Operational Health Districts that are currently funded under Round 5 and 2 additional Districts that currently do not have Community DOTS services. The year three budget for this activity amounts to almost \$872,000 and includes a 35% mark-up to cover start-up costs of NGOs contracted to provide Community DOTS services. This also explains the increased budget starting from year three for a number of cost categories, such as human resources (estimated at 30% of the amount budgeted for contracting NGOs to implement Community DOTS), training (20%), planning and administration (20%) and infrastructure and other equipment (\$226,000 in year 3 to cover start-up costs and initial investments required).

The year 5 budget shows another increase in comparison with years 3 and 4, which is mainly due to the fact that this Round 8 proposal plans to continue several activities after the end of Round 7 (end of year for of this Round 8 Proposal). The main Round 7 activities that have been included in year 5 of this Round 8 proposal are under the SDA ACSM and consists of activities such as the production and airing of TB related messages on radio and television and the design, production and dissemination of printed materials such as posters, leaflets, calendars, etc.

Finally, it should be noted that Principal Recipient costs have been kept to a minimum by sharing the resources that will be available to CENAT as the Principal Recipient for Round 7. As a result, the budget for the Principal Recipient in years 1-4 is limited (ranging from \$100,000 in year 1 to just over \$74,000 in year 4. The budget for year 5, however, covers the full costs of the Principal Recipient (almost \$375,000) as Round 7 implementation will have come to an end by then.

5.4.2. Human resources

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

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

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

The cost category human resources represents 22.6% of the total budget (\$2.99 million). This includes the following items:

- Staff employed by the five NGOs included in this Round 8 proposal: CHC (PPM-DOTS with pharmacies and private health care providers), CATA (tuberculosis in factories), FHI (tuberculosis in prisons), RACHA and RHAC (Community DOTS in 5 Operational Health Districts)
- The budget for contracting NGOs to implement community DOTS in 11 Operational Health Districts in years 3-5 includes a 30% (\$580,000 or approximately one-third of the human resources' budget) budget allocation for human resources.
- Most of the activities will be implemented in close cooperation of public health staff and in the case of CENAT in close cooperation with health staff at the provincial and district level and hence, modest incentives have been included in the form of per diems (based on UN and Government agreed rates).
- The National Tuberculosis Program will strengthen its management capacity by the recruitment of 4 additional staff: M&E Officer, Finance Officer, Procurement Officer and a Laboratory Coordinator. Employment of these additional 4 staff is budgeted at just under \$60,000 for years 1-5.

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- Human resources employed by CENAT as the Principal Recipient, including 5 staff for 20% of their time (including a Chairperson, manager and M&E, finance and procurement officers) and 4 full-time staff (including an assistant manager, IT officer, data management officer and an administrative officer). The human resource budget for the Principal Recipient amounts to \$406,274 or 13.6% of the total budget for human resources.

5.4.3. Other large expenditure items

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

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

Other cost categories that represent relative important amount in the summary budget are training (11.8%), health products and health equipment (11.8%), living support to clients/target population (10.4%) and technical and management assistance.

All components of this Round 8 proposal have a strong emphasis on training and on strengthening the capacity of various groups and individuals to play an important role in tuberculosis prevention and control. This includes pharmacies and private health care providers, health staff that work in garment factories, prison health staff and DOTS watchers in the communities covered by Community DOTS. Furthermore, this Round 8 proposal puts emphasis on tuberculosis in children and includes a wide range of training in this area for public health staff at health centres and referral hospitals.

Most of the budget for health products and health equipment concerns the introduction and taking to scale of tuberculosis liquid culture in the National Reference Laboratory and the two regional laboratories. This budget includes the initial investments in the form of procurement of laboratory instruments and equipment (almost \$140,000) as well as the procurement of liquid culture and DST reagents for the full duration covered by this proposal (just over \$1.2 million).

Living support to clients/target populations is included to support the referral of children that are suspected to be infected with tuberculosis. In most cases, proper diagnosis of tuberculosis in children is possible only at one of the 69 District and Provincial level Referral Hospitals. This Round 8 proposal will support the referral of children suspected of having tuberculosis, by reimbursing part of the travel costs. In addition, similar support is provided for children on Isoniazid Preventive Therapy.

Technical and management assistance includes a full-time WHO technical advisor for the years 1-5 and technical assistance required by CENAT in its role as the Principal Recipient. The latter is limited to:

- International TA Program Management: Full-time and in year 5 only (management TA during years 1-4 is already provided under Round 7)
- International TA Finance: Part-time (3 months per year) in years 1 and 2 (additional TA already provided under Round 7)
- International TA Procurement: Part-time (3 months per year) in year 5 (additional TA already provided under Round 7)

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

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

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

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5.5.1. Operational status of common funding mechanism
Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners. → <i>Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.</i>
N.A.
5.5.2. Measuring performance
How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.
N.A.
5.5.3 Additionality of Global Fund request
Explain how the funding requested in this proposal (<i>if approved</i>) 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. <i>If the focus of the common fund is broader than the tuberculosis program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on tuberculosis outcomes during the proposal term.</i>
N.A.

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

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

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

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

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

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Section	Document description	Annex Number
	Detailed Work Plan Round 8 TB Proposal	Annex 1
	Detailed Budget Round 8 TB Proposal	Annex 2
	Attachment A	Annex 3
	Attachment B	Annex 4
	National Guidelines for Diagnosis and Treatment of TB in Children – CENAT 2008	Annex 5
	Assessing the Tuberculosis Situation and Control Program in National Penitentiaries in Cambodia (Report by Dr. Mayra S. Arias)	Annex 6
	Tuberculosis Report 2007 - CENAT	Annex 7
	Section 4B – Round 8 HSS Cross-Cutting Proposal	
	Section 5B – Round 8 HSS Cross-Cutting Proposal	
	<i>[use the "Tab" key to add extra rows if needed]</i>	

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4B. Program description - HSS cross-cutting interventions

4B.1 Description of 'HSS cross-cutting interventions'	
Title: Intervention 1	Expanding coverage and improving the quality and use of health information.
Beneficiary Diseases:	HIV, TB, Malaria
WHO "Building Block" category	Information
(a) Description of <u>rationale for</u> and <u>linkages to</u> improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:	
<p>Cambodia's Health Information System (HIS) shows relative strength in the area of population surveys, but facility-based information systems are fragmented, with separate vertical systems for TB, HIV/AIDs, malaria, immunization and maternal health care, and yet another channel for reporting on general curative care (consultations and hospitalizations), the latter including persons who are HIV positive but not yet receiving ART, undiagnosed AIDs patients presenting with OIs, and undiagnosed cases of TB, particularly in children. Current data sources are largely confined to the public sector which accounts for less than 50% of health services delivered in the country. In addition, with the notable exception of vertical reporting systems established for identified TB and HIV cases, the quality of information obtained from the public sector is poor, primarily as a result of (1) inadequate ICT infrastructure at service delivery points (data entry and analyses is done manually); and (2) lack of systematic validity checks, causing transcription errors to go largely undetected. Reporting formats and monitoring indicators across different programs are not standardized, and the current list of indicators is unwieldy in length and not optimally relevant; for example, they are not so constructed as to highlight consultations and hospitalizations of children with conditions which may be indicative of pediatric TB nor to readily identify cases of TB-HIV co-infection. In addition to constraining information that is available, outdated and unwieldy indicators and duplicative reporting (due to multiple vertical formats) increases the workload of HIS staff and, together with low pay, contributes to a very high turnover rate among HIS officers (over 50% at all levels). A 2006 HIS assessment conducted with support from the Health Metrics Network showed that investment in human resources for HIS was the weakest aspect of the system, scoring only 23%.</p> <p>This intervention will strengthen the range and reliability of health system metrics and improve the ability of policy-makers, health system managers and health care providers to effectively use data for evidence-based decision-making and policy formulation in efforts to prevent, control and treat the 3 diseases and better identify and respond to TB-HIV co-infection, pediatric TB (currently underdiagnosed) and OIs in both diagnosed and undiagnosed HIV+ persons. Strengthening the HIS is one of the 5 strategic foci in the new Health Strategic Plan (HSP2) 2008-2015. Specific activities are derived from the Health Information System Strategic Plan 2008-15 and relate to (i) HIS Policy and Resources (ii) Health Service Administrative and Support Systems (iii) Data Management, Dissemination and Use.</p> <p>Measures to improve data quality and availability will be introduced and program managers trained in effective use of information for health policy, planning and management. In latter years the HIS system will be expanded to encompass the NGO and for-profit private sectors. The list of monitoring indicators and performance metrics will be streamlined and upgraded to ensure relevance to the needs of public, NGO and private sector health facilities, and better coordination and linkages between the TB, HIV and malaria programs and the general public health care system; data collation forms will be revised or developed accordingly. Feedback to provincial, district and facility level will be strengthened and those entities trained in the use of data for decision-making. Guidelines for data quality assurance will be revised and systemic validity checks instituted along with intensified facilitative supervision. Standardization of reporting formats and indicators and better integration by making use of the strengths of the various vertical program information systems will reduce workload while the expansion of ICT will facilitate data transfer, analysis and accuracy, providing a cost-effective way of enhancing the completeness and accuracy of health information and improving feedback to various stakeholders. Data management will be strengthened through computerization of HIS units along with internet access from central down to district level, allowing linkage to an MOH website for real-time transfer of data and receipt</p>	

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of feedback. . Human resource capacity will be strengthened through short term in-service training and graduate-level courses, and productivity/retention through MBPI for key personnel.				
(b) Planned outputs/outcomes.				
Year 1	Year 2	Year 3	Year 4	Year 5
21% of ODs conduct HIS Validity checks	45% of ODs conduct HIS Validity checks	60% of ODs conduct HIS Validity checks	75% of ODs conduct HIS Validity checks	100% of ODs conduct HIS Validity checks
220 persons trained in HIS reporting and quality control at PHD/OD and facility levels	1,220 persons trained in HIS reporting and quality control at PHD/OD and facility levels	1,220 persons trained in HIS reporting and quality control at PHD/OD and facility levels	1,860 persons trained in HIS reporting and quality control at PHD/OD and facility levels	2,480 persons trained in HIS reporting and quality control at PHD/OD and facility levels
HIS software updated & installed	n/a	n/a	HIS software updated & installed	n/a
(c) Describe below <u>other</u> current and planned support for this action over the proposal term				
Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term	Expected outcomes from this support	
Government	2009-13	In-kind	Payment of civil service salaries for HIS staff Recurrent costs of Central MOH, PHD and OD offices	
Other Global Fund Grants	Round 5	\$19,800	MBPI for Project Director and Program Director for years 1 and 2	
Other: Health Sector Support Project 2	2009 - 2014	Negotiation on-going	Performance-based pay for OD and facility personnel	

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Title: Intervention 2	Strengthening the capacity of communities to advocate for clients and influence health service delivery
Beneficiary Diseases:	HIV, TB, Malaria
WHO "Building Block" category	Governance
(a) Description of <u>rationale for</u> and <u>linkages to</u> improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:	
<p>The new Health Strategic Plan (HSP2) calls for efforts to “<i>improve interactions between communities, consumers and suppliers at the operational level through establishment of forums and other mechanisms with support from NGOs and CSOs to advocate for policy dialogue and policy reforms</i>”. This intervention will strengthen community participation and influence with respect to the 3 diseases by (1) empowering local NGOs/ CBOs and village volunteers to advocate on behalf of community and individual client concerns; (2) increasing dialogue between consumers and health care providers/managers.; and (3) bringing community-level concerns into the national policy arena in a transparent and participative manner. This will contribute to reducing demand side constraints that currently inhibit utilization of public health services, thereby increasing TB case detection rates, utilization of antenatal services including PMTCT, VCCT, and early treatment of TB and malaria by trained providers.</p> <p>Through the umbrella membership organization MEDICAM, local NGOs/CBOs have begun to work in concert on policy issues relating to TB, HIV, malaria and other health concerns at national level. However, to date each organization has tackled that challenge on its own at the sub-national level where services are actually provided, in varying ways and with varying degrees of success. At village level, MoH-sanctioned “Village Health Support Groups” (VHSG) have been chosen by the community to serve as liaisons with the health system. The ability of VHSGs to fulfill their advocacy mandate is often hampered by lack of assertiveness in dealing with health care professionals/managers who are perceived as having a higher social standing, lack of training in communication techniques and advocacy, and concerns about possible personal repercussions. The capacity of CBO/NGO staff to be effective patient and community advocates at provincial, OD and health facility/community levels will be strengthened through training and follow-up coaching in advocacy, using a curriculum specifically designed for the Cambodian context. While taking into account the important role of VHSGs in advocacy, the round 8 proposal will focus first on advocacy training CBOs/NGOs as both active advocates and resource persons for the VHSGs. Consideration will be given in future proposals for advocacy training of the VHSGs themselves.</p> <p>Community Forums will be held in collaboration with the national TB, HIV and Malaria programs and the National Center for Health Promotion to bring together consumers and health care providers/managers to raise awareness of service availability for the 3 diseases on the one hand, and make providers and managers aware of consumers’ concerns regarding quality and accessibility on the other. This approach applies to AIDS, TB and malaria a highly successful model initially developed to control Avian Influenza (AI) in which forums between the local community and the health system resulted in an improved response to AI prevention and control. Applying this same model to AIDS, TB and malaria will create a much-needed linkage between home-based and facility-based care and ensure that the latter is responsive to the needs of the former. It will also help providers understand the reasons for consumer preferences for home based care in contexts which run counter to public health interests, e.g .self-medication with drugs bought without trained consultation. Both the Advocacy training and the Community Forums will be implemented in the provinces of Siem Reap, Preah Vihea, Oddor Meanchey, Kratie, Steng Treng, Rattankiri, Mondulkiri, Pursat, Battambang, Banteay Meachey and Pailin. 8 out of these 11 provinces are unusually underserved, with health indicators far below the national norm and an unusually low rate of TB case detection, and all have higher than average prevalence of either HIV and/or malaria.</p> <p>This intervention will also increase the awareness and involvement of the broader public in policy issues surrounding HIV/AIDS, TB, and malaria through high level policy debates on national television. More than 50% of Cambodians – and a significantly higher percent of the critical 15-24 year old demographic – regularly watch television and its reach and influence is steadily increasing. Topics will reflect issues raised in Community Health Forums, with priority given to those most relevant to implementation of this Grant e.g. TB case detection and spousal transmission of HIV.</p>	

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(b) Planned outputs/outcomes				
Year 1	Year 2	Year 3	Year 4	Year 5
75 NGO/CBO staff Have increased ability to provide community input/feedback and advocate with the health system.	175 NGO/CBO staff have increased ability to provide community input/feedback and advocate with the health system.	300 NGO/CBO staff have increased ability to provide community input/feedback and advocate with the health system.	400 NGO/CBO staff Have increased ability to provide community input/feedback and advocate with the health system.	500 NGO/CBO staff Have increased ability to provide community input/feedback and advocate with the health system.
12 Community forums held	36 Community forums held	60 Community Forums held	84 Community Forums held	108 Community Forums held
2 televised policy debates held	15% increase over baseline in community satisfaction with health services 5 televised policy debates held	20% increase over baseline in community satisfaction with health services 8 televised policy debates held	25% increase over baseline in community satisfaction with health services 11 televised policy debates held	30% increase over baseline in community satisfaction with health services 14 televised policy debates held
(c) Describe below <u>other</u> current and planned support for this action over the proposal term				
Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term	Expected outcomes from this support	
Government	n/a			
Other Global Fund Grants (with HSS elements <i>(if applicable)</i>)	Round 5	Phase 1: \$117,800 Phase 2 under negotiation	Regional MEDiCAM offices in to assist with implementation and monitoring of these activities Improved NGO/health system partnership through annual meetings between gathering of grassroots NGOs and provincial/district health authorities.	
Other: NGOs and CBOs	Years 1-5	In-kind	Salaries of staff who will be trained as advocates	

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Title: Intervention 3	Improved Infection Control in Health Facilities
Beneficiary Diseases:	HIV and TB
WHO "Building Block" category	Service Delivery
(a) Description of <u>rationale for</u> and <u>linkages to</u> improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:	
<p>HSP2 identifies improvements in <i>quality</i> as the key priority for health service delivery. Recent health facility assessments conducted by the MoH documented significant gaps and inadequacies in infection control measures and related capacities, both in terms of the care of patients with known HIV or TB and with the application of universal precautions. Specific problems include: lack of hand washing facilities, lack of isolation of infectious patients (suspected and confirmed TB patients share the same wards; HIV patients are given beds in close proximity to patients with the full range of infectious diseases), re-use of disposable needles and syringes, inadequate sterilization procedures, improper disposal of medical waste and poorly designed drainage and septic systems. Although an infection control program must by its nature be facility-wide, failures in infection control disproportionately impede efforts to both prevent and treat TB and HIV/AIDs. In addition immuno-compromised AIDs patients are at especially high risk in settings where other infectious diseases are readily spread from patient to patient.</p> <p>These problems in turn result from (1) Lack of adequate infrastructure, equipment, and supplies: a recent survey of 54 health centers found that 55% had no running water in the consultation and minor surgery rooms , and old, rusted surgical instruments and delivery kits have been kept in use well beyond their normal life expectancy; (2) Insufficient guidelines for infection control: the current national protocol for infection control does not address routine cleaning of facilities, isolation of patients, cleaning of equipment, sterilization procedures, or waste management; (3) Low provider awareness of correct procedures and the consequences of poor infection control; and (4) Poor hygienic practices on the part of patients and their relatives, particularly in hospitals.</p> <p>This intervention will work in tandem with the MoH Hospital Department, CENAT and NCHADs to assist the MoH IC Committee in development and dissemination of updated IC Guidelines, training of managers and providers in its application, and regular monitoring of compliance. Once guidelines have been developed and disseminated, on-the-job training and coaching of health facility personnel will be undertaken with special emphasis on waste management, sterile technique, sterilization, and isolation/transmission of disease. In addition, hospital staff will be trained in conducting hygiene/sanitation behavior change communication with patients and their families.</p> <p>This intervention will also upgrade water, sewage and isolation facilities in hospitals and Health Centers (HCs) in 12 Operational Districts (ODs)⁶ to be selected on the basis of having successfully introduced use of the RH QA tools, an average or better hospital bed occupancy rate and above average prevalence of at least one of the 3 diseases. GF resources are sought to finance renovations of the hospitals and approximately 2./3 of each OD's HCs; Provincial Health Departments will be assisted to finance the remaining HC upgrades through the government budget and HSSP2 resources and will receive TA in including same in their Annual Operational Plans. Each OD will be worked in intensively for two years. During the first year the adequacy of water, drainage, separation of patients, waste management, sterilization procedures and equipment will be surveyed and customized plans for upgrading developed. In the second year minor renovations will be performed s such as improvements to water supply, drainage, waste disposal and subdivisions within existing wards to allow for isolation of infectious patients and provide a central location for sterilization. These will be followed by staff training, mentoring, supervision and monitoring to ensure adherence to the updated and newly disseminated IC guidelines. Simultaneously, the hospitals will be assisted in formation of IC committee and training of their members. An evaluation of this combined "hardware and software" approach will be undertaken in year 5 and compared to results in ODs where training was provided without infrastructural upgrades. .</p>	

⁶ . An OD contains, on average, one RH and 13 HCs.

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(b) Planned outputs/outcomes				
Year 1	Year 2	Year 3	Year 4	Year 5
Infection Control guidelines updated and disseminated nationwide	RH and HCs in 3 ODs meet IC guideline infrastructure standards	RH and HCs in 6 ODs meet IC guideline infrastructure standards	RH and HCs in 9 ODs meet IC guideline infrastructure standards	RH and HCs in 12 ODs meet IC guideline infrastructure standards
IC Committees formed in all RHs.	IC-related scores using MoH QA tool increased $\geq 25\%$ over baseline in 3 RHs	IC-related scores using MoH QA tool increased $\geq 25\%$ over baseline in 6 RHs	IC-related scores using MoH QA tool increased $\geq 25\%$ over baseline in 9 RHs	IC-related scores using MoH QA tool increased $\geq 25\%$ over baseline in 12 RHs

(c) Describe below <u>other</u> current and planned support for this action over the proposal term			
Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term	Expected outcomes from this support
Government	Years 1 – 5	In-kind In-kind To be negotiated with respective PHDs	Civil service salaries of members of MoH and RH IC Committees and of health facility personnel Meeting space for IC Working Group and RH IC Committees Partial costs of HC renovations
Other Global Fund Grants (with HSS elements (<i>if applicable</i>))	n/a		
Other: Health Sector Support Project 2 (HSSP)	2009 - 2014	Negotiation on-going	Performance-based pay for OD and facility personnel Partial costs of HC renovations (through Provincial block grants)

Title: Intervention 4	Strengthen forecasting, storage, distribution and quality control of Pharmaceuticals and Medical Supplies
Beneficiary Diseases:	HIV, TB, Malaria
WHO "Building Block" category	Medical Products, Vaccines and Technology
(a) Description of <u>rationale for</u> and <u>linkages to</u> improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:	
The purpose of this intervention is to strengthen the pharmaceutical PSM system, with a particular focus	

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on TB, Malaria and HIV-related drugs, in order to ensure uninterrupted availability of drugs and consumable supplies of acceptable quality, efficacy and safety at the point of service delivery. Previous GF rounds have greatly enhanced the availability of anti-retroviral drugs, anti-tubercular agents, and anti-malarial drugs. These and the spectrum of drugs used to manage Opportunistic Infections (OI) in AIDS patients are stored and delivered through the same national system that provides all pharmaceutical supplies for obvious reasons of economy of scale and cost-efficiency. The highly desirable increase in patients being treated for these three diseases has increased the demands on the PSM system and highlighted some of its fundamental weaknesses.

GF Round 5 inputs addressed the fragmentation of PSM functions between the various National Programs and the ODs and are enhancing skills in forecasting requirements, but lack of online access still prevents submission of requests and reports in “real time”. Round 5-funded functional analyses of the PSM system identified a critical need for more pharmacists and general staff in the Central Medical Store (CMS).

Guidelines for inspection of drugs developed with Round 5 support lack an adequate number and capacity of drug inspectors for implementation, and there are inadequate resources to support the sampling and testing program, including post-marketing surveillance of GF funded procurements. The Joint Health Sector review in 2007 and the HSP2 identify inadequate logistic support for drugs and commodities and weak enforcement of drug quality control measures as significant supply-side constraint to effective service delivery. Health Service Delivery strategic intervention 2.3 of the HSP2 is to “*Strengthen skills and competencies in forecasting and quantification of health commodities, and strengthen quality assurance and control of health commodities through sampling and testing of incoming products and post-marketing surveillance*”, while intervention 2.4 is to “*strengthen logistical systems to ensure availability of drugs and supplies at health centers and referral hospitals.*” Although these recommendations apply throughout the health system, their applicability to appropriate management of AIDS, TB and malaria is self-evident, as management of all three are reliant upon the consistent availability of appropriate drugs and consumable supplies.

Efficient ordering, storage and distribution of drugs and supplies for the treatment of TB, HIV/AIDS (including OIs) and malaria will be enhanced under this intervention by (1) improving infrastructural and human resource capacities and systems for forecasting requirements, storage and distribution; and (2) improving the management performance of the MoH departments/units responsible for PSM. The forecasting, storage and distribution capacities of the CMS and OD Pharmacies will be increased through internet access for real-time communications; provision of storage equipment, additional delivery trucks and additional personnel to meet staffing shortfalls; improved procedures for storage and distribution; improved staff capacity through training/coaching/monitoring, and improved staff motivation/productivity and retention through merit-based performance incentives, the latter beginning after the final year of support from GF Round 5 in 2011.

Quality assurance mechanisms for drugs and supplies used in public facilities will be strengthened by expanding the scope of quality assurance activities and authorities to include sampling and testing of TB, Malaria and HIV commodities both upon receipt and on the market (post-marketing surveillance), and increasing the number and capacity of government drug inspectors.

CMS will be upgraded to Specialized Organization Agency (SOA) status operating under contract with the MoH, enabling it to recruit the number and caliber of personnel needed and providing greater autonomy and objectivity in the exercise of inspection/oversight functions.

(b) Planned outputs/outcomes

Year 1	Year 2	Year 3	Year 4	Year 5
CMS and OD pharmacy facilities upgraded	70% Percentage of health facilities surveyed have full stock of specified medicines and medical supplies	74% Percentage of health facilities surveyed have full stock of specified medicines and medical supplies	78% Percentage of health facilities surveyed have full stock of specified medicines and medical supplies	80% Percentage of health facilities surveyed have full stock of specified medicines and medical supplies
CMS obtains SOA status	Average interval	Average interval	Average interval	Average interval

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Number and capacity of drug inspectors increased	between receipt of drug order at CMS and delivery ≤ 35 days	between receipt of drug order at CMS and delivery ≤ 28 days	between receipt of drug order at CMS and delivery ≤ 25 days	between receipt of drug order at CMS and delivery ≤ 22 days
	Service level (number/quantities of items ordered vs number /quantities supplied)= 60%	Service level (number/quantities of items ordered vs number /quantities supplied)= 75%	Service level (number/quantities of items ordered vs number /quantities supplied)= 85%	Service level (number/quantities of items ordered vs number /quantities supplied)= 95%
	28% of drug batches received by CMS tested for quality	35% of drug batches received by CMS tested for quality	42% of drug batches received by CMS tested for quality	50% of drug batches received by CMS tested for quality

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

Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term	Expected outcomes from this support
Government	Years 1-5	In-kind	Civil service salaries of DDF personnel, OD staff
Other Global Fund Grants (with HSS elements)	Round 5 2006 – 2010	US\$2,002,500/5years - includes salaries and activities. Phase 1 grant (US\$726,000) has been 95% expended. Phase 2 grant amounting to US\$1,276,500 is being negotiated.	Motivated staff through MBPI; Procurement, Storage and distribution policies/ guidelines. . Staff trained in quantification of needs for health products
HSSP2	2009-2013	Under negotiation	Performance based contracts for OD staff (gradual phase in)

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Title: Intervention 5	Improved Safety in Use of Pharmaceuticals
Beneficiary Diseases:	HIV, TB, Malaria
WHO "Building Block" category	Medical Products, Vaccines and Technology
(a) Description of <u>rationale for</u> and <u>linkages to</u> improved/increased outcomes in respect of HIV, tuberculosis and/or malaria:	
<p>A number of problems surround the use of pharmaceuticals in Cambodia which directly impact on the appropriate treatment of AIDs and related OIs, TB and malaria. These include lack of ready access to information on drug protocols, indications, side effects and interactions which limits the ability of trained providers to optimally manage patients, marketing efforts by pharmaceutical companies and their distributors which lead to distorted prescribing practices, and the widespread availability of counterfeit, expired or otherwise sub-standard drugs on a largely unregulated open market which, combined with a marked consumer preference for self-treatment, result in ineffective and at times even harmful treatment. The Health Sector Plan for 2008-2015 (HSP2) specifically lists "<i>inappropriate health practices and health seeking behavior, leading people to receive medication/care from drug shops/pharmacies</i>" as a significant "demand side" constraint.</p> <p>These problems, while sector-wide, are of particular concern in the management of AIDs, TB and malaria. The comparatively high toxicity profile and numerous adverse interactions of anti-tubercular and anti-retroviral agents and the need for their extended use increases the likelihood of adverse reactions or interactions, especially when other preparations are prescribed for concurrent conditions. The high market value of these drugs makes them particular targets for counterfeiters; numerous deaths from counterfeit malaria drugs, in particular, have been documented.</p> <p>This intervention will target both health care providers (public and private sector) and consumers with information on the appropriate and safe use of pharmaceuticals.</p> <p>To improve the ability of providers to recognize and management of adverse drug effects and prevent or manage drug-drug interactions, reliable information on drugs (indications, dosages, side effects, drug interactions and contraindications and other pharmaco-vigilance data related to the three diseases) will be made available through a strengthened Drug Information Center (DIC). A user-friendly Khmer-language website maintained by the DIC with KFW support ending in year 4 will be continued and expanded to meet new needs, such as the increasing use of second line ART and MDR TB.</p> <p>The wide-spread commercial availability of counterfeit, expired or otherwise sub-standard drugs will be addressed through mass media campaigns to improve public awareness and knowledge of the dangers, and by expanding the scope of government drug inspectors to include surveillance of drugs sold by private vendors through an increasing the number and capacity of drug inspectors, mapping out of drug outlets and periodic inspection and sample collection. IEC efforts will also stress that anti-TB and ART medications are only available through the public health system (and any private physicians that may subsequently be authorized by CENAT or NCHADs to treat TB or HIV) and that any such drugs found in commercial outlets are likely to be counterfeit and should be reported.</p> <p>The regulatory framework for drug promotion by pharmaceutical representatives will be revised, revised and disseminated, and periodic evaluations of their activities conducted to ensure compliance.</p> <p>These activities will contribute to all over grant performance by reducing the dangerous tendency of consumers to self-medicate, discourage the commercial sale of counterfeit or misappropriated anti-TB medications and ART, and improve the quality of TB, HIV and malaria case management by increasing provider pharmacological knowledge and resources.</p>	

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(b) Planned outputs/outcomes				
Year 1	Year 2	Year 3	Year 4	Year 5
DIC capacities strengthened Khmer-language drug information accessible online IEC campaign initiated	Improved case management and recognition of drug interactions/ adverse effects 40% of population surveyed aware of dangers of counterfeit and substandard drugs	Improved case management and recognition of drug interactions/ adverse effects	Improved case management and recognition of drug interactions /adverse effects 60% of population surveyed aware of dangers of counterfeit and substandard drugs	Improved case management and recognition of drug interactions/ adverse effects
(c) Describe below <u>other</u> current and planned support for this action over the proposal term				
Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term	Expected outcomes from this support	
Government	Years 1-5	In-kind	Civil service salaries of DDF personnel	
Other Global Fund Grants (with HSS elements)	Round 6 2008 - 2012	US\$630,440 under the Malaria Component	Interventions to combat counterfeit malaria drug use on the Thai-Cambodian border. Running costs of the DIC and 2 staff.	
Other: RACHA with funding from KFW	2009-2011	28,800 for 2010-2011	Support for Drug Info Website: 4 IT staff through 2011.	

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4B.2 Engagement of HSS Key Stakeholders in Proposal Development	
<p>(a) Briefly describe which and how important HSS stakeholders (e.g., ministries of planning, finance etc) have been involved in the identification and development of appropriate HSS cross-cutting interventions for this Round 8 proposal, and how coordination of the proposed HSS cross-cutting interventions has been ensured across the three diseases (and, where relevant, beyond).</p> <p>In 2007, the MoH led a participatory Health Sector Review. The process was assisted by external consultants and conducted in close collaboration with the full range of development partners, including donor agencies and NGOs. The findings from this review in turn informed the participatory development of the 2009 – 2014 Health Sector Plan (HSP2). The problems addressed under this component were identified in the Sector Review and interventions 1,2,4 and 5 are all explicitly planned for in the HSP2.</p> <p>Coordinators of the national TB, HIV/AIDs and Malaria control programs were consulted regarding the Infection Control intervention (intervention 3) and endorsed the effort to reduce the potential for facility acquired HIV, TB and malaria and cross infection of TB to HIV+ patients. The chairperson and other members of the IC Task Force and working groups similarly endorse this intervention, which was developed in consultation with relevant staff in the MoH Hospital Department.</p> <p>The specific process for development of the HSS component was an open advertisement in March 2008 followed by a WHO-facilitated meeting of interested partners. These consisted of 2 MoH Departments, DPPI and DDF, the NGO URC and the NGO/CBO coordinating body MEDiCAM. Initial interest expressed by a third NGO was subsequently withdrawn. The general areas for inclusion in the component were discussed and tentatively agreed upon at the initial meeting and the separate interventions then developed by the respective proposed implementing agencies. These then re-convened at a brain-storming session on 12 May attended by staff from URC, MEDiCAM, DPPI, DDF, and WHO at which time the final list of interventions and approximate resource allocation was agreed upon. An external consultant was retained by WHO to consolidate the submissions of these various agencies and ensure conformity with proposal guidelines.</p>	
<p>(b) Has the CCM (or Sub-CCM) ensured that:</p> <p>(i) the HSS cross-cutting interventions in this proposal do not repeat any request for funding under <u>any</u> of the specific disease components (section 4.6 of each disease)?; and</p>	<p><input type="checkbox"/> Yes</p>
<p>(ii) the <u>detailed work plan</u>** and the 'Performance Framework'** (Attachment A) for this disease includes separate worksheets which clearly identify the HSS cross-cutting interventions by objective, SDA, and activity for the initial two years of the proposal?</p> <p>** Applicants may prepare a separate work plan for the HSS cross-cutting interventions <u>and</u> a separate 'Performance Framework' (Attachment A) if they prefer.</p>	<p><input type="checkbox"/> Yes</p>

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4B.3 Strategy to mitigate initial unintended consequences

Intervention 1: Initial adoption of new reporting formats will increase the workload of health service providers. Awareness building workshops will serve to inform facility heads in public, NGO and private sectors on the benefits of standardized reporting tools. Another risk is poor compliance by the traditionally unregulated private sector. This will be addressed through consensus building and participation of multiple stakeholders in the revision of information management tools and indicators, along with training of staff, provision of HIS software to participating health facilities, and enforcement of regulations linking data reporting to issuance/renewal of licenses.

Intervention 2: The intervention to strengthen community participation/governance may potentially create political tension if negative feedback is taken personally by local authorities; training will stress constructive approaches and means of addressing defensive reactions. Linking VHSGs with NGOs/CBOs will also help to provide them with a support network to reduce their vulnerability as lone individual advocates, and linkages created between the NGOs/CBOs in the course of joint training and their links to the broader NGO community via MEDiCAM will likewise provide these grass-roots groups with support systems that can be called upon if and as necessary.

Intervention 3: Risks identified with regard to the IC intervention are (1) transitory inconveniences associated with health facility renovation; the scope of the renovations envisioned should not require the closure of any facility but might require temporary closure of specific wards; and (2) the possible inadequacy/unavailability of government budget and HSSP2 resources to augment the required facility infrastructure renovations. The first problem will be handled through assisting OD managers in temporarily re-structuring space utilization. The second will be addressed through advocacy at Provincial level and provision of TA to PHDs in requesting resources for renovation through their AOP. If necessary, the MoH Hospital Department's assistance will be sought in encouraging PHDs to allot resources to IC.

Interventions 4 and 5: Pharmaceutical quality control interventions which regulate private markets activities and the actions of medical sales representatives will potentially anger persons who incur financial loss as a result. The assistance of high level MoH officials and local government will be sought as necessary, and dissemination efforts will help ensure wider understanding of the law.

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5B.1 Detailed Budget

PLEASE SEE Excel Workbook :

ANNEX 4 GFATM R8_HSS Detailed BUDGET TABLE 5B.1

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5B.2 Summary of detailed budget for HSS cross-cutting interventions by objective and service delivery area

Table 5B.2 – Summary of detailed budget by objective and service delivery area

Objective Number	Service delivery area <i>(Use the same numbering as the detailed work plan for HSS cross-cutting interventions)</i>	Budget breakdown by SDA					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	HSS: Information	\$827,130	\$577,669	\$363,089	\$342,542	\$1,057,787	\$3,168,216
2	HSS: Leadership and Governance	\$230,870	\$266,192	\$200,692	\$197,209	\$211,107	\$1,106,070
3	HSS: Service Delivery Organization and Management	\$815,779	\$1,198,538	\$1,423,206	\$1,474,833	\$1,049,563	\$5,961,919
4	HSS: Medical Products, Vaccines and Technologies	\$2,314,265	\$1,267,180	\$1,281,150	\$1,592,184	\$1,771,248	\$8,226,027
5	HSS: Medical Products, Vaccines and Technologies	\$217,060	\$46,880	\$59,910	\$36,908	\$55,110	\$415,868
1-5	Program Management and Administration	\$134,800	\$102,740	\$297,803	\$905,743	\$1,128,668	\$2,569,754
Total funds requested from Global Fund for HSS cross-cutting interventions (i.e., total for all the interventions described on a programmatic basis in s.4B.1, where included in Round 8)		\$4,539,904	\$3,459,199	\$3,625,850	\$4,549,419	\$5,273,483	\$21,447,854

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5B.3 Summary of detailed budget by cost category

Summary information provided in the table below should be supplemented with additional detail in section 5B.4 below.

Table 5B.3 – Summary of detailed budget by cost category

Avoid using the "other" category unless necessary – read the [Round 8 Guidelines](#).

	Breakdown by cost category (same currency as selected by Applicant on face sheet of the Proposal Form)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	\$1,047,128	\$1,037,790	\$1,031,076	\$1,261,854	\$2,318,753	\$6,696,601
Technical and Management Assistance	\$642,879	\$404,514	\$542,099	\$734,007	\$662,153	\$2,985,652
Training	\$165,059	\$216,151	\$165,047	\$223,625	\$270,943	\$1,040,824
Health products and health equipment	\$34,059	\$107,286	\$135,535	\$135,535	\$90,357	\$502,772
Pharmaceutical products (medicines)	\$0	\$0	\$0	\$0	\$0	\$0
Procurement and supply management costs	\$726,713	\$98,519	\$117,904	\$94,384	\$41,231	\$1,078,752
Infrastructure and other equipment	\$824,010	\$589,090	\$615,453	\$1,015,413	\$822,475	\$3,866,440
Communication Materials	\$171,325	\$138,791	\$77,591	\$118,740	\$88,135	\$594,583
Monitoring & Evaluation	\$128,320	\$77,080	\$75,093	\$71,491	\$144,057	\$496,041
Living Support to Clients/Target Populations	\$0	\$0	\$0	\$0	\$0	\$0
Planning and administration	\$636,960	\$638,758	\$639,152	\$647,834	\$651,556	\$3,214,260
Overheads	\$163,451	\$151,220	\$226,900	\$246,537	\$183,822	\$971,930
<i>Other: (To be further defined to meet national budget planning categories)</i>	\$0	\$0	\$0	\$0	\$0	\$0
Total funds requested from Global Fund for HSS cross-cutting interventions (s.4B.1)	\$4,539,904	\$3,459,199	\$3,625,850	\$4,549,419	\$5,273,483	\$21,447,854

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5B.4.1. Overall budget context

Total health financing in Cambodia in 2006 was an estimated \$40 per capita with the majority financed out-of-pocket spending and by donors. Government contribution has increased steadily in the past 5 years, from below 10% to over 15% of the total, but remains inadequate to the need and will certainly continue to be so for the duration of the proposed grant. The salaries of civil service personnel, in particular, present a significant obstacle to service delivery as current rates are well below a living wage. While true across all sectors this is most acutely felt in health due to the comparatively higher market wage earning capacity of health care providers and managers.

A WB/AUSAID/DFID-financed Health Sector Support Project 2 (HSSP2) will provide \$110 million in assistance to the health sector between 2009-2013 through a sector-wide approach. The exact scope and modality of this assistance is still under negotiation, but is expected to include the following HSS-relevant components: (1) Block grants to Provincial Health Departments (PHDs) to provide complementary resources activities approved in the Annual Operational Plan (AOP). This provision of resources at provincial level is consistent with ongoing decentralization and deconcentration reforms underway, and will be phased in gradually; (2) Service Delivery Agreements (SDAs) between PHDs and Operational Districts (ODs) whereby the latter receive payment for delivery of specified outcomes and have the flexibility to utilize resources as they see fit in order to achieve them. This too will be phased in gradually; and (3) support for merit-based performance incentives although the number basis for selection of recipients is unclear at this stage. Estimated HSSP2 contributions are articulated in the assumption column of 5B.1 and represent the best available conservative estimate; actual contributions may vary.

5B.4.2 Human resources

Human Resources comprise 31.2 % of the HSS component. For interventions 1 and 5, most human resource expenses reflect either MBPIs or per diems for MoH personnel. The inadequacy of civil service salaries in Cambodia is widely recognized and Government and Development Partners are jointly working towards a harmonised system for adequate remuneration for civil servants. Sub-decree 29 which provides temporary rates for MBPI has been used in calculating the rates shown in Section 5B.1.

Adjustment of these rates is anticipated during the course of the grant and GF-funded MBPI rates will be adjusted when and as these are issued by Government. The WB consortium HSSP2, details of which are still under negotiation, is expected to finance MBPIs for as yet to be selected personnel. In the absence of information as to which personnel will be selected, GF funds have been requested for national and provincial level staff directly involved in implementation of this component for a full 5 years. If any of these personnel are included under HSSP2 financed MBPIs, these funds will be reprogrammed. In addition, HSSP2 will support an internal performance-based contracting mechanism between Provinces and Operational Districts (ODs) whereby ODs will receive lump sum payments against achievement of specified outputs. This aspect of HSSP2 support will come online gradually starting with a small number of ODs and the actual number of ODs that will receive this support each year is not known, but has been estimated and factored into the GF budget in order to avoid duplication of resources, as shown in the "assumption" column of section 5B.1. Actual HSSP2 support may vary and funds will be reprogrammed accordingly. By linking incentives to performance and bringing MoH personnel's remuneration up to a living wage, Government and Development Partners are likewise working to standardize per diem rates for government personnel. The per diem rates proposed in Section 5B.1 are based on the rates set forth in Sub-Decree 10 as well as specific health sector stipulations provided by the Ministry of Finance. An update to Sub-Decree 10 is anticipated soon, and actual payments will be adjusted to align with same.

MBPIs will greatly enhanced the MoH's capacity to attract and retain qualified staff, and achieve high levels of work performance. The provision of per diems in accordance with established rates will ensure the ability and willingness of staff to undertake activities requiring field travel.

Human Resource costs in intervention 4 include MoH staff MBPI, per diems and also a significant number of contract staff to be hired to fill gaps in Central Medical Store personnel (pharmacists and general staff) identified in a GFATM Round 5-funded assessment. The planned conversion of CSM to an SOA will give it the authority to establish its own staffing pattern and salary scales. During the course of the grant, CSM will negotiate annual contracts with the MoH and negotiate for an amount sufficient to absorb some or all of these personnel, but as the outcome of such negotiations is unknown they have been budgeted under the GF for the full 5 years. These funds will be reprogrammed to the extent that the funds provided to CMS as an SOA are sufficient to cover them.

Human resource costs for interventions 2 and 3 primarily reflect salaries for NGO personnel recruited to

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carry out specific time-bound tasks. Salaries have been estimated based on prevalent market rates; actual payments will be adjusted based on qualification and salary history.

5B.4.3. Other large expenditure items

The other large cost category is Infrastructure and Equipment (18%).

Infrastructure and Equipment costs include the upgrading of Central Medical Stores storage and distribution capacities; over ¾ of such costs in year 1 reflect the addition of 6 large delivery trucks which are critical to ensuring the capacity to make timely delivery of drug orders and are expected to substantially reduce the current lag time between order and receipt from its current average of 45 days to less than 25 by the end of the grant period, a substantial improvement which will remove a significant case of interruptions in TB and ART and anti-TB medication supply. It will also serve to reduce waiting time for newly identified patients meeting ART criteria to enroll in treatment.

In years 2-5, infrastructure costs primarily reflect upgrades to Health Centers and Referral Hospitals for to meet minimum standards of infection control, e.g. improvements in water supply, sewage and waste disposal and creation of isolation wards and central sterilization rooms.