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

PROPOSAL FORM – ROUND 9
(SINGLE COUNTRY APPLICANTS)

Applicant Name	**National Tuberculosis and HIV/AIDS Council**		
Country	**Ukraine**		
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 9 Guidelines)*	**Lower-middle income**		
Applicant Type	**X** CCM	☐ Sub-CCM	☐ Non-CCM

Round 9 Proposal Element(s):			
Disease	**Title**	**Does this disease include cross-cutting Health Systems Strengthening interventions in part 4B? *(include in one disease only)***	**Is this a 're-submit' of the same disease proposal not recommended in Round 8?**
HIV[1]			
Tuberculosis[1]	**Reducing the TB burden in Ukraine through expanding and enhancing access to high quality TB services**		**Yes**
Malaria			

If this is a Round 8 proposal being re-submitted, have the TRP Review Form comments been clearly addressed in s.4.5.2?	**X** Yes	☐ No
Are there major new objectives compared to the Round 8 proposal that is being re-submitted? If yes, please provide a summary of the changes in the box below by each disease re-submission and section number	**X** Yes	☐

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

re-submission and section number.		No

Section 3.5: Summary of Round 9 Tuberculosis Proposal and

Section 4.5 Implementation Strategy

In the course of a visit by two international experts in April 2009[2] (Annex 1), it was suggested that the Ukrainian resubmission be slightly changed in its stated objectives. While there are no Totally new objectives *per se*, the names of all four objectives have been modified to reflect evolutionary changes in the current international perceptions of who is vulnerable to TB, since our submission to Round 8.

Thus for Objective 2: To enhance the access of vulnerable groups to high quality TB services, it is being changed ***Objective 2: To improve access to high quality services***[0] ***for people that for whatever reason have limited access to TB Health services.*** In support of this is the concept of vulnerable communities as discussed by Hopewell and Pai:

"…flaws in healthcare practices that lead to substandard tuberculosis care for populations that, sadly, are most vulnerable to the disease and are least able to bear the consequences of such systemic failures. Any person anywhere in the world who is unable to access quality health care should be considered vulnerable to tuberculosis and its consequences. Likewise, any community with no or inadequate access to appropriate diagnostic and treatment services for tuberculosis is a vulnerable community[3]."

The *International Standards for Tuberculosis Care* in 2006[4] *are under revision* and it is anticipated that this concept will be retained in the new Second Edition (2009) of "Standards", which currently nears finalization[5].

As will be seen later, this proposal will seek under Objective 2 to prepare for the introduction of an enhanced access to TB services for those currently with limited access by setting the stage for the introduction in Ukraine of the WHO-developed Practical Approach to Lung Health (PAL)[6] to its DOTS paradigm by enlisting strengthened primary health care clinics to become more engaged in first echelon TB and respiratory services. PAL is a strategy to detect and manage common respiratory disease at Primary Health Care level, which includes TB[7]. This will capitalize on several previous and current international efforts (USAID and EU) to strengthen PHC in Ukraine. The first step, envisioned in this proposal, is to encourage the adoption of PAL clinical standards of care and the preparation of a national plan for PAL introduction. Thus, the introduction of PAL will enhance coherently both Objective 2 (High Quality DOTS) and health system strengthening activities (see Section 3.5, SDA 3.2 and Section 4.4, Priority 4).

Objective 1 is changed to read*:* ***Objective 1: To improve tuberculosis diagnosis by optimizing the TB laboratory network in the civil and penitentiary facilities***

Objective 2 is changed to read: ***Objective 2: To improve access to high quality services for people that for whatever reason, have limited access to TB health services***

Objective 3 is changed to read: ***Objective 3: To strengthen the capacity of the Ukrainian health system to respond to TB by improving governance (leadership, monitoring and evaluation, human resource development) necessary for the successful delivery of the TB program.***

Objective 4 is changed to read: ***Objective 4: To increase overall access to TB diagnosis, treatment and care through awareness raising, mobilization of political support and reduction of stigma.***

Currency	**X** USD	or	☐ EURO

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

[2] Zellweger J-P, Veen J.GFATM Round 9 "*Guidance on Developing a TB proposal for Ukraine*, April 12, 2009.

[3] Hopewell PC, Pai M. Tuberculosis, vulnerability, and access to quality care. *JAMA* 2005;293 (22):2790–3.

[4] Tuberculosis Coalition for Technical Assistance, *International Standards for Tuberculosis Care (ISTC).*The Hague: Tuberculosis Coalition for Technical Assistance, 2006.

[5] Zellweger and Veen *op cit.* Page 4.

[6] Practical Approach to Lung Health: Manual on initiating PAL implementation, WHO, Geneva, 138 pp, 2008.

[7] Murray, J.., Pio, A., Ottman, S. PAL: a new and practical approach to lung health, Int J Tuberrv Lung dis10 (11): 1188-1191, 2006.

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

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

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

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

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

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

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

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

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

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

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

IMPORTANT NOTE:

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

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

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

1. FUNDING SUMMARY AND CONTACT DETAILS

1.1. Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV						
Tuberculosis	11 548 774	23 035 431	19 676 733	24 335 615	24 863 065	103 459 619
Malaria						
HSS cross-cutting interventions section 4B and 5B within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*						
					Total Round 9 Funding Request ➔:	103 459 619

1.2. Contact details

	Primary contact	Secondary contact
Name	Eliot J. Pearlman	Tatyana Bilyk
Title	Facilitator	Project Director
Organization	International HIV/AIDS and TB Institute	Foundation for the Development of Ukraine
Mailing address	38, Predslavynska Str., Office 142 03150 Kyiv, Ukraine	29 G, Yaroslaviv Val Str. 01034 Kyiv, Ukraine
Telephone	+380 44 528 37 14	+380 44 502 52 11
Fax	+380 44 528 57 19	+380 44 502 52 15
E-mail address	eliot@aids-institute.org eliot_pearlman@yahoo.com	tbilyk@fdu.org.ua
Alternate e-mail address	mariya@aids-institute.org	azabolotny@fdu.org.ua

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
AIHA	American International Health Alliance
Alliance	International HIV/AIDS Alliance in Ukraine
ART	Anti-retroviral Therapy
BBC	Behavior Change Communication
CCM	Country Coordinating Mechanism
CIC	Center of integrated care
CMT	Case management team
Committee	Committee on HIV/AIDS and other Socially Dangerous Diseases Control
Coalition	Coalition of HIV/AIDS Service Organizations
COI	Conflict of Interest
Department	State Department for Enforcement of Sentences
DOT	Direct Observation of Treatment
DOTS	Directly Observed Treatment Short-course
DOTS-Plus	Treatment of MDR-TB with 2nd line drugs within a DOTS framework
DRS	Drug Resistance Survey
DST	Drug Sensitivity Testing
EQA	External Quality Assurance
FBO	Faith-based Organization
FDU	Foundation for the Development of Ukraine
Fr.	Father (Priest)
FTE	Full-time equivalent
GDF	Global Drug Facility
GFATM	Global Fund to fight AIDS, Tuberculosis, and Malaria
GLC	Green Light Committee
GOU	Government of Ukraine
HA	Health Administration, *normally Oblast Health Administration*
HPI	Health Policy Initiative
HSS	Health Systems Strengthening
HCW	Community Health Workers
IDU	Injecting drug user
IEC	Information, Education, Communication
IOM	International Organization on Migration
IPT	Isoniazid Preventive Therapy
IPC/C	Interpersonal Communication and Counseling
KAP	Knowledge Attitudes Performance

KAPB	Knowledge, Attitudes, Practices and Behavior
KMU	Cabinet of Ministers of Ukraine
KNCV	Koninklijke Nederlandse Centrale Vereniging TOT bestrijding der Tuberculose (Dutch Tuberculosis Foundation)
MARP	Most-at-risk population
MDR-TB	Multi Drug Resistant TB
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MOE&S	Ministry of Education & Science
MOFY&S	Ministry of Family, Youth and Sport
MOF	Ministry of Finance of Ukraine
MOH	Ministry of Health of Ukraine
M&E	Monitoring and evaluation
MSH	Management Sciences for Health
N/A	Not Applicable
NAP	National AIDS Program
NTBC	The National TB Center
NTP	The National TB Program as a Law of Ukraine: "About approval of All-State Program on TB Counteraction for 2007-2011" passed on February 8, 2007, # *648-V*.
NBU	National Bank of Ukraine
NC	National Tuberculosis and HIV/AIDS Council (Ukrainian equivalent of the CCM)
NCC	National Coordination Council (previous name of the NC before TB was added)
NGO	Non-governmental Organization
NGP Sector	Non government Private Sector
Network	All-Ukrainian Network of People Living with HIV/AIDS
NRL	National Reference Laboratory for TB
OI	Opportunistic infection
Oblast	Equivalent of American "State", German "Lander", or Swiss "Canton"- many times referred to as "region"
OR/IR	Operational research/implementation research
ORSA	Operations Research Systems Analysis
PATH	Program for Appropriate Technology in Health
PDG	Proposal Development Group
PHC	Primary Health Care or primary health care clinic
PLWHA	People Living with HIV/AIDS
PLWTB	People Living with Tuberculosis
PITC	Provider-initiated testing and counseling
PPE	Personal Protective Equipment
PR	Principal Recipient

QA	Quality assurance
Rayon	Administrative district within a Region (Oblast)
Roma	Refers to both a subgroup of the Romani people who live primarily in Central and Eastern Europe and the All-Ukrainian Congress of Roma
SDA	Service Delivery Area
SE	State Enterprise
SES	Normally Sanitary Epidemiology Service, but used occasionally as syringe exchange service
SH	Stakeholder
SI	State Institution
SNRL	Supra-National Reference Laboratory normally referenced to the one in Riga
ST	Substitution therapy
STI	Sexually transmitted infection
SP	Strategic Planning
SR	Sub-Recipient
TA	Technical assistance
TB	Tuberculosis
TOR	Terms of Reference
TOT	Training of Trainers
TRP	Technical Review Panel
Ukrainians against TB	“Ukrainians against TB” Public Movement
URCS	Ukrainian Red Cross Society
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations Emergency Children’s Fund
UNSO	United Nations System of Organizations
URCS	Ukrainian Red Cross Society
USAID	US Agency for International Development
USG	United States Government
VCT	Voluntary Counseling & Testing
WB	World Bank
WHO	World Health Organization
XDR-TB	Extensively drug resistant TB

2. APPLICANT SUMMARY (including eligibility)

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

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

2.1. Members and operations

2.1.1. Membership summary

	Sector Representation	Number of members
X	Academic/educational sector	1: Feshchenko
X	Government	**Total 15 representatives of Government Sector:** **Cabinet of Ministers (2):** Vasyunyk, Lukasyevych, **Ministry of Health:** Knyazevych, **Ministry for Family, Youth and Sport (2):** Lukyanova, Drapushko; **Ministry of Labor & Social Policy:** Ivankevych, **Ministry of Education & Science:** Polyansky, **Ministry of Internal Affairs:** Khomenko , **Ministry of Finance:** Matviychuk; **Ministry of Economy:** Kryuchkova; **State Committee on TV/Radio:** Kurdivovich; **State Department for Enforcement of Sentences:** Kalashnik; **Oblast Cherkassy HA:** Levchenko; **Vyshgorod City:** Reshetnyak; **National AIDS Center:** Shcherbynska
X	Non-government organizations (NGOs)/community-based organizations	**4: Coalition HIV(2)**: Antonyak, Pidlisna , **Stop TB:** Horbasenko, **INGO:** Pearlman
X	People living with the diseases	**3: + HIV:**-Zhovtyak, Borushek
X	People representing key affected populations[8]	**+ TB:** Korzhov
X	Private sector	**1:** Zabolotny
X	Faith-based organizations	**1:** Fr. Nagirnyak

[8] Please use the Round 9 Guidelines definition of *key affected populations*.

X	Multilateral and bilateral development partners in country	**2: USAID:** Perry, **UN:** Hartley
X	Other *(please specify):*	**2: Member of Parliament:** Shevchuk **Trade Union:** Ukrayinets
	Total Number of Members: *(Number must equal number of members in 'Attachment C'[9])*	**29**

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

2.1.2. Broad and inclusive membership

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

2.1.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

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

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

The function of the country coordination mechanism in Ukraine is performed by the National Council on TB and AIDS (NC), established in July, 11, 2007 under the Decree of Cabinet of Ministers of Ukraine # 926 (see Annex 1, Round 8 Proposal).The NC is a permanently acting advisory and counseling body under the Cabinet of Ministers of Ukraine comprising representatives of government, non-government, private organizations and other civil society representatives. The NC performs the function of a country coordination mechanism as part of its powers as the single coordinating body in the national fight against the TB and HIV/AIDS epidemics.

In order to strengthen the role of NC as a coordinating and advisory country mechanism, in 2009 a decision was taken by the NC members to set up a working committee under the MOH that will be responsible for different areas such as budget and monitoring, regional coordination etc. (Please see a fuller description under Governance: **SDA Leadership and governance in TB control, page 50).**

GFATM Round 1 Stewardship Grant was successfully completed on March 31st, 2009. The Round 6 Grants are being successfully implemented in Ukraine, both by NGOs as PRs. They are looking forward to Phase 2. Compared to the previous rounds, TB is now better represented on the NC by a PLWTB and a TB-oriented NGO and in the Committee on HIV/AIDS and Other Socially Dangerous Diseases Control; however, a number of issues is yet to be addressed. In the last two rounds: Round 7, and in Round 8, civil society had been asked to facilitate the process of proposal development. In Round 7, it was a TB-oriented NGO. Again in the current Round 9 resubmission process, there is a NGO as facilitator (Annex 2)[10], These facilitation processes have been used as a "bully pulpit"[11] to stress the broader aspects of sound public health policies practices: integrated health care service delivery issues, especially in the care and treatment of HIV-TB co-infection, and DOTS roll-out; providing a safe environment for patients and health staff; and health care reform by improving access to care. These processes and initiatives will play an evolutionary role in the implementation of a successful Round 9 application. Efforts were undertaken to use the current resubmission as a mechanism for health systems strengthening within several of the pre-existing SDAs. While there is no a specific section in the proposal devoted to HSS, members of the PDG, local WHO staff, and the Facilitator have worked with external WHO consultants and others on this issue.

At the request of the MOH, there have been several visits by WHO external experts to Ukraine. The country needed to receive a quality analysis on the weaknesses of the heath care system related to the TB sector, namely on the laboratory network, state system of procurement of drugs and treatment of MDR-TB, and the recommendations on how to address these weaknesses. In 2007 and 2009, WHO/USAID supported missions to look at the laboratory network (Annexes 3-4). The findings of these reports are being used for the development of the Round 9 proposal. It should be noted that the more recent WHO mission (in early 2009) had noted substantial and positive dynamics in the work of the laboratory network, namely the usage of modern equipment purchased under the World Bank loan, a higher level of bio-hazard control in the laboratories, and a strengthened quality of methods used. All weaknesses identified in the report, which mirrored weaknesses cited by the Round 8 TRP will be addressed in the Round 9 proposal.

Some of the constraints/bottlenecks earlier identified during the Mission are addressed in the proposal while others are already included into the national plan to fight TB and are being currently undertaken. Thus, the resubmitted GFATM 8 Round Proposal includes activities on strengthening the capacity of Ukrainian health system to respond to TB under Objective 3 (**SDA 3.1 Leadership and Governance in TB control; SDA 3.2: M&E System; and SDA 3.3: HSS Workforce.**

In general, there is strong commitment of the NC to have an efficient response to the TB epidemic and a strong willingness to cooperate in a successful Round 9 implementation. Over the last two years the NC

[10] NC Protocol on February, 16 2009.

[11] The bully pulpit can bring issues to the fore that was not initially in debate, due to the office's stature and publicity. This term was coined by President Theodore Roosevelt, who referred to the American presidency as a "bully pulpit," by which he meant a terrific platform from which persuasively to advocate an agenda.

assumed its responsibility for the general national policy concerning the TB and HIV/AIDS epidemics and in determining the responses through national programs as well as externally funded projects.

Gender awareness

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

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

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

The NC has no specific post responsible for gender equity. However, as far as representation is concerned, there is one women PLWA member, two from domestic NGOs, a woman Deputy Minister representing the Ministry of Family, Sport, & Youth, and a woman (USAID) representing bilateral donors. These women members have been very vocal in addressing advocacy issues and matters related to stigma and discrimination. The representative of the bilateral donors has been a constant and consistent voice for gender and all other issues of equality. Parenthetically, she is the second consecutive woman representative from USAID to sit on the NC.

As noted above, the MFY&S, mandated to implement national gender policies and programs and is represented by a Deputy Minister. Among CCM members, UN Resident Coordinator and UNDP Resident Representative in Ukraine as a UN family member may represent the best resource with requisite international knowledge in gender issues, which needs to be more fully utilized by existing NC membership and impact program design. In the recent past, the UNICEF head in Kyiv was the UN representative and quite clearly, he spoke out on behalf of children, especially as Ukraine has a very large MARP population, mainly “street children”. Lately, however, the UN Resident Coordinator/UNDP Resident Representative in Ukraine has represented his group.

In previous GFATM rounds, there have not been any gender-specific interventions or policies that addressed gender issues, because it was believed that gender specific discrimination *per se* did not play a role in access to care. The NC-adopted a slightly modified Strategy (Annex 5)[12] for the resubmission of the Round 8 proposal that contains a list of vulnerable groups targeted by the TB program, among them: people living below poverty level, and representatives of professions vulnerable to TB (health care workers etc.). Since the percentage of women is significantly higher than men in these two categories, it may be viewed as recognition of potential gender and social inequality as factors contributing to expansion of TB epidemic. As a result of international experts providing a gap analysis in April 2009 to the stakeholders, this resubmission will tackle the issue by expanding TB and other respiratory services to vulnerable communities as a whole. The proposal seeks to build upon existing infrastructure for the future implementation of a PAL strategy that will make TB services better accessible at first echelon health care.

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.

Ukraine has a complex, but somewhat fragmented and changing system for TB control activities at national (and regional levels) despite a number of bodies set up explicitly for this purpose. There is a

[12] Strategy on the Development of the Proposal of Ukraine to the Global Fund to Fight AIDS, Tuberculosis and Malaria Round 9: Component “Tuberculosis”

considerable overlap of responsibilities and functions between national and regional bodies. In recent years, several coordination bodies have been established and then abolished. Regional and municipal TB and HIV/AIDS coordination councils have been created in oblast centers and at rayon level (with donor support). Sometimes councils are perceived as artificial and imposed by external donors. Despite these difficulties, harmonization of donor policies and practices and alignment with national policies has begun to emerge in some Oblasts of Ukraine. Currently, the NC now has the mandate to address TB and HIV/AIDS epidemics, whereas previously these were two separate CCMs. As noted in Section 2.1.1. Membership summary, the new NC includes members from both PLWTB A and PLWH communities.

The Chairman of the NC is the Vice Prime Minister of Ukraine on Humanitarian and Social Policy, and one of his deputy chairs is the Chair of the All-Ukrainian Network of People Living with HIV/AIDS. The NC is made up of representatives of different key Ministries and state bodies including MOH, Ministry of Education & Science; Ministry of Finances, Ministry of Economy & European Integration; Ministry of Internal Affairs, State Department for Enforcement of Sentences; Ministry of Family, Youth & Sport; Ministry of Labour & Social Policy; State Committee on Radio & TV, etc. plus representatives of international organizations and civil society. The proportion of non-governmental representatives is 45% with the representation of three individuals from PLWTB/PLWHA, national and international NGOs; a representative of the Federation of Ukraine's Trade Unions; and a representative of the private-sector. The UN System, as noted above, is represented by UN Resident Coordinator/UNDP Resident Representative. The bilateral donors are represented by the US Agency for International Development (USAID). All the NC members serve on a voluntary basis.

The representation described above has been a concerted effort to have a broad diversity of members from the different sectors of society, from bodies and authorities of the government, and people living with the diseases on the NC. This diversity reflects the successful efforts on the part of the government for the highest level of national coordination of actions on TB and HIV-infections. It is an example of efficient cooperation of different institutions, although there is still room for improving the NC's capacity (e.g. strategic planning) within a HSS framework.

One of the main objectives of the NC is "…assistance to coordinated activity of Ministers, other central and local bodies of executive power, local self-governance bodies, international and civil organizations, including those, which unite people, living with TB and HIV-infection/AIDS, representatives of business circles, trade unions and employers and religion organizations with the aim of realization on the state level of projects on TB and HIV/AIDS fighting, including WB Project 'Control on TB and HIV/AIDS in Ukraine'"[13]. Successful realization of this objective is achieved through the cooperation of all the key institutions represented on the NC. The most recent evidence of the NC multi-sectoral coordinated efforts was seen in the development of the new National AIDS Program for 2009-2014, which will be approved by the Verkhovna Rada of Ukraine as a Law. Most of the activities foreseen by this new NAP are cross-cutting and require tight coordination between different sector representatives so that development and implementation were based on efficient multi-sectoral program activity.

NC has a strong general program development capacity which involves: experience in organizing meetings, proposal-writing teams, and technical expert teams, general document preparation, editing, translation, printing etc., developing partnerships, and working relationships, such as a highly proactive approach for the involvement of NGOs etc. However, with regard to specific GFATM grant program design, its capacity is weaker, in particular, in the areas of: providing supporting data, such as specific epidemiological and clinical information about TB and HIV/AIDS that is needed for designing programs against these diseases, developing and conducting needs assessments and operational research to prepare GFATM applications; and support in program design, especially design of innovative or pilot projects, also including design of scale-up programs and national adaptation of successful pilot projects. Ukraine's NC also needs to improve capacity in program planning, including detailed ORSA-related methodologies, as well as design and integration of monitoring and evaluation plans.

As noted in Section 2.1.3 (a), the NC has called upon outside (civil society) facilitators[14] in Round 7 and Round 8 to be responsible for preparing and developing the proposal for submission in its name[15] and on the WHO Mission to Ukraine for TA. By using this out-sourcing, the NC was able to capitalize on broad-based expertise in multi-sectoral planning to stimulate new thinking and new approaches using the. Strategy approved on February 16, 2009. As major directions for inclusion into the Proposal many

[13] Please refer to Annex 1, Round 8.

[14] UNAIDS facilitated in Round 6.

[15] Protocol Decision dated 16 of February, 2009

sectional issues were determined and approved, which is an evidence of the NC's support for and willingness for multi-sectoral program design, although there still is room for improvement.

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

2.2.2. Transparent proposal development processes

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

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

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

As this was a resubmission, there was no formal call for proposals. However, in determining how best to approach this task and to capitalize on the expertise of two international TB experts, a series of stakeholder meetings were held in April and later on May 22nd. (Annexes 6, 7, 8). The group was large and included many members of the PDG. There was also a meeting of the senior local experts (PR, SR, SDA group leaders, WHO staff, and facilitator staff that fully discussed harmonization and integration of the SDAs on May 20th (Annex 9).

The Facilitator presented to the NC on several occasions in the run-up to submission, the game plan for developing the resubmission and the progress made to date. The plan was to have specific groups rework each of the SDAs. In this context, there were open meetings to decide on the various key elements and activities of the SDAs and there were group meetings with the lead drafters of SDAs to track progress and seek harmonization and integration of efforts.

On the matter of SDA: ACSM, there was great interest and a series of meetings conducted by an international expert. In the course of these discussions, the expert gleaned various viewpoints that were discussed and drafted a work plan for the draft proposal. Condensed Minutes of those meetings are included in Annex 10.

The basic operating documents have been the Round 8 proposal, the TRP comments, guidelines from the experts, and a slightly modified Strategy for Round 9 approved by the NC (Please see Annex 5)

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

In drafting the resubmission, several open meetings were held to go over the redrafting process. The final document was reviewed by a representative body of international and domestic stakeholders and presented to the stakeholders for their input. Additionally, several international experts also reviewed the proposal.

Prior to a stakeholder's meeting on May 22nd, an Agenda and a working draft of the proposal in both Ukrainian and English were submitted to the stakeholders for their information and review. At the

stakeholder's meeting on May 22nd, the proposal was discussed and comments accepted as input to the final document that was subsequently submitted to the members of NC for their review prior to the NC meeting on May 28, 2009. At that meeting, the proposal was presented.

After a series of remarks by the Minister of Health and Facilitator staff, the proposal was presented by a senior expert speaking on behalf of the drafting team for each of the four objectives and the subordinate SDAs. An international expert presented his impressions. The floor was open to discussions. The first comments were a short "appreciative thank you address" from the director of the nominated PR to express gratitude to all who participated in the proposal development. Members of the audience expressed interest in discussing vulnerable groups and the section on ACSM. The details of the discussions are captured in the Minutes (Annex 11).

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

In order to ensure an effective and transparent process of preparation of the resubmission, there was a call for stakeholders to attend a series of meetings that were open and free-flowing. Most of the participants were not NC members. Equal weight and opportunity were given to all and those present were allowed to voice their concerns and opinions.

It should be noted that at NC meetings all present are allowed to speak. The term "Observer" does not exist as they are participatory. Discussions are free-flowing and uncensored. As was shared in Round 8, the composition of our TB stakeholder community and PDG are broad-based and diverse. PDG membership (Annex 12) was approved by the NC for the resubmission process. Below is a listing of organizations that sent representatives to participate in the redrafting and resubmission processes. The organizations are listed alphabetically:

- All-Ukrainian NGO "Congress of Roma of Ukraine"
- All-Ukrainian Network of People Living with HIV/AIDS,
- Coalition of HIV/AIDS Service Organizations
- Coalition of organizations "STOP TB together"
- Charity Fund "Renaissance"
- Clinton Foundation
- Committee on HIV/AIDS and other Socially Dangerous Diseases Control within MOH of Ukraine
- Institute of Phthysiatry and Pulmonology named after F.G. Yankovsky under the Academy of Sciences of Ukraine
- International HIV/AIDS Alliance in Ukraine,
- International Organization on Migration
- International Roma Female Fund «Chirikli»
- Ministry of Health of Ukraine,
- Ministry of Internal Affairs of Ukraine,
- National Medical University named after O.O. Bogomoletz;
- PATH
- State Department for Enforcement of Sentences of Ukraine
- Ukrainian Center for AIDS Prevention
- 'Ukrainian Red Cross Society
- Ukrainians Against TB' Public Movement
- UNAIDS Office in Ukraine
- UNDP Office in Ukraine
- WHO Office in Ukraine
- International HIV/AIDS and TB Institute (Acting as Facilitator)

(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	**Annex 6: SH Meeting on April 6, 2009** **Annex 7: SH Meeting on April 10, 2009** **Annex 8: SH Meeting on May 22, 2009**

2.2.3. Processes to oversee program implementation

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

Main cooperation principles and mechanisms are the following:
NC and PR

The principles, mechanisms and procedures for the cooperation of the nominated Principal Recipient and the NC (acting as a CCM) are provided in the relevant *Procedure* on ensuring the oversight of the implementation of the Programme funded by the Global Fund, which is approved by the NC. This Procedure was developed according to the relevant GF requirements (*Revised Guidelines on the Purpose, Structure and Composition of CCM and Requirements for Grant Eligibility*). The Procedure provides the following roles and responsibilities for the NC:

- ✓ To initiate and coordinate the submission of the Country Proposal to the GF.
- ✓ To ensure the general oversight of the implementation of the GF Programme activities.

Main functions of the NC are identified as follows:

- ✓ Initiation of the Country Proposal submission process. Planning of the Programme, Selection of the PR, finalizing and approval of the Proposal to GF, submission of the country proposal to GF.
- ✓ After Proposal approval – the main role is ensuring overall coordination and control over the grant implementation at national country level.

Main functions of the PR are identified as follows:

- ✓ Planning and implementation of the Programme, ensuring control, monitoring and evaluation of the SRs implementing the relevant parts of the Programme, reporting to the GF (LFA) and NC.
- ✓ Nominated Principal Recipient acting as a main implementer of the Programme. Main role is to receive funds from the Global Fund and successfully perform all necessary activities in order to implement the Programme according to the objectives and purposes set in the Grant Agreement with GF.

It should be noted that the PR will make public at Stakeholder Meetings and at NC Meetings the results of their reports prior to their submission to the GFATM. As has been the tradition in the past, these meetings will encourage free-flowing and non-time constrained discussions. (Please see Annex 13 and Annex 43 to have a more detailed picture on the reporting lines between NC and PR)

At the local (operational) level, PR, SR, and regional officials will need to set clear guidelines and policies under the existing normative documents on the provision of medical and non-medical services. The CMT Coordinator, hired by the TB rayon-level dispensary and paid for by the GFATM grant, will work closely with the SR, state health officials and staff, NGO service organization staffs, and family members. There will need to be established strong and harmonious working relationships. Those organizations, which will include the URCS and other NGOs actively engaged in the provision of social services and support of DOTS patients in an ambulatory setting, will need timely and proactive cooperation, coordination, and communications. This will include strong working relationships at the TB dispensary level and at the PHC level. Clearly, if there are problems that are not resolvable by this group, then they may be addressed to the next level of supervision/authority for resolution.

(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.

Accountability on the state of program implementation will be highlighted at the meetings of the NC and will also be posted on Websites of the PR and SRs.

More importantly, as pertains to “other than CCM members”, there has been in the past a very strong tradition of periodic (and timely) Stakeholder Meetings in which all sectors have been invited to attend: GOs, NGOs, FBOs, bi/multi-laterals, diplomatic missions, and interested parties. As is well-known to

GFATM portfolio managers, these meetings are timed, if possible, to be held in conjunction with their Program visits to Kyiv. These meetings have been noted for their stimulating and dynamic discussions between GFATM representatives and the stakeholders as well as among the stakeholders themselves. The free-flowing nature of these meetings is very important and it has been noteworthy that they proceed without unwarranted constraints or interference. Minutes from these meetings are produced and disseminated by the PRs. They are also placed on their Websites.

2.2.4. Processes to select Principal Recipients

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

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

Following the decision of the NC to resubmit the Round 8 proposal for GFATM Round 9, there was an expression of interest undertaken by the MOH to identify a potential facilitator. At the NC meeting on February 16th, the NC accepted nominations and then proceeded to select a Facilitator for Round 9 (Please see Annex 2). In spite of active discussions, there was only a single applicant to stand as Facilitator.

The Facilitator (and the individual's organization) was charged with following scrupulously the principles of transparency and accountability in their efforts. They were charged specifically with making a wide-spread dissemination of a "Call for PRs"; proposing members for a Proposal Development Group (PDG); proposing members for a Technical Review Panel (TRP); proposing members for an Appeal Board; and at all times to ensure an avoidance of COI.

The Facilitator was given five days to publish an announcement and to place it on numerous Websites. The announcement was also published in the Ukrainian newspaper "Governmental Courier" on February 20, 2009 (Annex 14) This newspaper is viewed as an official transmitter of printed information and enjoys a strong reputation.

On the day following the Council's approval of the announcement and of the composition of the TRP, the Facilitator had the same announcement placed on the following Websites (and confirmed their presence):
Website of the Ministry of Health;
Website of the International HIV/AIDS Alliance;
Website of the Network of People Living with HIV/AIDS;
Website of the Coalition of HIV-servicing NGOs;
Website of Ukrainians Against TB; and
Website of the International HIV/AIDS and Tuberculosis Institute.

In spite of active discussions, there was only a single submission from a potential PR.

On March 13, the TRP operating under NC-approved TOR (Annex 15) met and was charged with examining the merits of the one announced PR-to-be. It should be noted that NC approved a 15-member TRP; however, the single applicant had made several agreements with GOs and NGOs that were represented initially on the TRP. This raised the issue of COI.

At the beginning of the meeting panel members (12), panel observers (2), and members of the panel secretariat (3) were required to read and sign statements concerning the avoidance of a COI. These statements were provided in both Ukrainian and English. Signed copies are attached as Annexes 16, 17, 18. Three members of the TRP declared that they had a COI, and thus they signed the COI statement to that effect and left prior to the formal start of deliberations.

This resulted in a diminished pool of TRP members. According to the NC-approved TOR, a quorum was eight. Thus, there were present at the start of the review process, eight TRP members, two observers, and three members of the secretariat (members of the facilitating organizations).

After all these procedures were completed, the meeting was declared open and the first business for the TRP was to elect a Head and a Deputy Head.

As concerns the selection of the PR, the TRP evaluated it capacities in a formalized manner. In making their decisions, the members proactively debated the merits of the candidate as to strengths and weaknesses. Because applicant declared that it was relying on a strong team of SRs, TRP members also evaluated the PR's choices of SRs. The ensuing discussions were very robust. Because of a need for additional information from the applicant, the TRP met for several more times. While there were several issues raised concerning the applicant, there were some concerns raised on the management capacity of some SRs. Through very robust discussions, the members arrived at their recommendations. The TRP prepared its findings in the form of an analytical report (Annex 19) and matrix (Annex 20) that was presented at the next NC meeting. Minutes of three TRP meetings are condensed as Annex 21.

The NC met on April 7th; the Head, TRP, presented the Panel's findings. There followed a great deal of animated discussion. There was some opposition not only to the PR, but also a potential SR, which yielded more discussions concerning the issue of nominating any SR's at that time. The NC membership voted in favor of the applicant, The Rinat Akhmetov Foundation for "Development of Ukraine" (FDU), to be the PR. However, the NC membership voted to defer until its next meeting in May, any decision on the issue of SRs Minutes of the NC meeting (Annex 22) are attached.

At the next meeting of the NC, which was held on May 28th, the NC decided on the issue of SRs to approve five SRs: National TB Control Center (MOH), State Department for Enforcement of Sentences, Alliance, PATH, and URCS (see Annex 23 with Conflict of Interest for NC members). The SR to be in charge of ACSM was deferred to selection by open tender after GFATM grant approval. Please refer to Annex 11.

(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	***Annex 21*** ***Annex 22***

2.2.5. Principal Recipient(s)

Name	Disease	Sector**
Foundation for Development of Ukraine	TB	Private
[use "Tab" key to add extra rows if needed]		

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

2.2.6. Non-implementation of dual track financing

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

The TRP's evaluation of the Round 8 submission pointed out two major weaknesses that touched upon this section.

Weakness #1 identified the limited prior experience of the Principal Recipient in managing large grants (even with UNDP support) and Weakness #2 referenced the prior suspension of an HIV grant and how the lessons learned were to be taken into account,

Both these were clear references to the MOH. These were particularly significant as normally, it would be the MOH that would be the most logical choice to be the PR for a TB GFATM grant. However, in the interests of securing a TB grant, without untoward distractions, for the development and implementation of a stronger and significantly broader-based Ukrainian national TB control program, the MOH deferred in proposing itself as a PR. Instead, it agreed to be a SR serving under a financially strong PR with a very strong background, interest, and track record in TB control, especially as relates MDR-TB.

There were no other government entities that expressed an interest in becoming a PR for TB in Round 9.

2.2.7. Managing conflicts of interest

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

2.2.8. Proposal endorsement by members

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

ROUND 9 – Tuberculosis

Section 2: Eligibility		List Annex Name and Number
CCM and Sub-CCM applicants		
2.2.2(a)	Comprehensive documentation on **processes** used to invite submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	**N/A** This is a resubmission; therefore, there was no call or invitation for proposals.
2.2.2(b)	Comprehensive documentation on **processes** used to review submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	**N/A** (See 2.2.3. below)
2.2.2(c)	Comprehensive documentation on **processes** used to ensure the input of a broad range of stakeholders in the proposal development process	Annexes 6-10
2.2.3(a)	Comprehensive documentation on processes to oversee grant implementation by the CCM (or Sub-CCM).	Annex 13 SH Meetings Future reports to SH & NC members that review: Minutes of NC meetings Documentation on MOH, PR, SR Websites Local TB coordinator reports Local service organization reports and billings
2.2.3(b)	Comprehensive documentation on processes used to ensure the input of a broad range of stakeholders in grant oversight process.	Stakeholder Meetings (Quarterly) Minutes of SH meetings Documentation on MOH , PR, SR Websites
2.2.4(a)	Comprehensive documentation on processes used to select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated). If different processes used for each disease, then explain.	Annexes 15-22
2.2.7	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism	**N/A**
2.2.8	Minutes of the meeting at which the proposal was developed and CCM (or Sub-CCM) endorsed.	Annex 11
2.2.8	Endorsement of the proposal by all CCM (or Sub-CCM) members.	**Attachment C to the Proposal Form**

ROUND 9 – Tuberculosis

Other documents relevant to sections 1 and 2 attached by applicant: *(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)*		

3. PROPOSAL SUMMARY

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

3.2. Consolidation of grants	
(a) Does the CCM (or Sub-CCM) wish to consolidate any existing tuberculosis Global Fund grant(s) with the Round 9 tuberculosis proposal?	☐ Yes *(go first to (b) below)* **X** No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 9 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at:*
http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FAQ_GrantConsolidation_en.pdf

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

3.3. Alignment of planning and fiscal cycles

Describe how the start date:

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

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

a.) The national budget year starts on January 1st. With the notification of a successful proposal submission by the GFATM board in November 2009, the Parliament and the local governmental authorities will be able to address national planning and budgeting so that they may adjust their CY 2010 and out-year budgets to take into account the awarding of a GFATM grant to Ukraine for TB. This will enable them to seek targets of opportunities to harmonize their activities, to fund complementary initiatives and activities and to seek synergy. It will assist in jump-starting some initiatives and activities that would otherwise go unfunded or underfunded.

2.) There will be no grant consolidation cases.

3.4. Program-based approach for Tuberculosis

3.4.1. Does planning and funding for the country's response to tuberculosis occur through a program-based approach?	☐ Yes. Answer s.3.4.2

based approach?	X	No. ➔ *Go to s.3.5.*
3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?	☐	Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***
	☐	No. Do not complete s.5.5

3.5. Summary of Round 9 Tuberculosis Proposal

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

Prepare after completing s.4.

This proposal requests **103 459 619 USD** over five years to support the transition to state-of-the-art TB control in Ukraine.

The main goal of the proposal is to contribute to reducing the TB burden in Ukraine through expanding and enhancing access to high quality TB services.

Vulnerable and poor populations are most affected by insufficiencies of the current TB control system in Ukraine. Since first DOTS pilots were started in Ukraine in 2001, the government has made significant strives to re-orient the TB diagnostic and treatment system based on the STOP TB strategy, including the initiation of critical structural changes in the TB control system. DOTS is now fully endorsed and represents the foundation of the "State Program on TB counteraction for 2007-2011", and more than 241 708 253 USD (of central level state budget were allocated for its implementation. Yet, the government recognizes the challenge of implementing the new policy in practice: significant additional financial and technical resources are needed to support the transition process, exceeding the government budget. Through this proposal the National Council seeks funding that will be catalytic for completing the reorientation the Ukrainian health system towards modern TB control. The overall strategy of the proposal is directed towards a synchronized reform of all key areas of the TB control system:

Objective 1: To improve tuberculosis diagnosis by optimizing the TB laboratory network in the civil and penitentiary facilities
Recognizing the fundamental role of reliable and accessible diagnostics, this objective focuses on the establishment of a high quality TB laboratory network.
SDA Improving diagnostics: Under this SDA, support will be provided to implement the government endorsed consolidation of the TB laboratory network, aiming for a reduced number of TB laboratories that are fully equipped and integrated into a tight quality assured network under leadership of a strong National Reference Laboratory, and with support from a Supranational Reference Laboratory. At each echelon of care, laboratories are clearly associated with the corresponding diagnostic and treatment functions of corresponding health facilities.

Objective 2: To improve access to high quality services for people who, for whatever reason, have limited access to TB services
Recognizing low detection and cure rates in Ukraine, this objective focuses on improving quality and acceptability of TB care in a patient centered approach.
SDA Quality DOTS: Focus on capacitating TB and primary health care services to better respond to the particular needs of populations with limited access, by introducing a case management approach to TB care throughout the continuum of care cycle from diagnosis to completion of the continuation phase. Particular emphasis is on strengthening decentralized and integrated TB care down to the Primary Health Care level (including outreach to the patients' home where necessary).
SDA: MDR-TB: Systematic reorganization and roll-out of MDR-TB treatment according to international standards to 15 high burden oblasts in Ukraine, and enrolling up to 2480 patients per year in MDR-TB treatment in the civil and prison sector. MDR improvement is based on a concerted introduction of quality assured laboratory support, training, GLC drug procurement and infection control measures including the necessary infrastructure upgrade (ventilation, UV decontamination)
SDA TB/HIV co-infection: As a complementary effort to TB/HIV funding received through GFATM Round 6, efforts to scale up addressing the TB/HIV co-infection through increased TB/HIV coordination; TB case finding, TB infection control, to increase preventive treatment and HIV test coverage, and to introduce harm reduction services in TB settings.

Objective 3: To strengthen the capacity of the Ukrainian health system to respond to TB by improving the governance (leadership, monitoring and evaluation, human resource development) necessary for the successful delivery of the TB program

Under this objective activities are proposed that will together help to strengthen key elements that make

up the foundation of the National TB Program:
SDA Leadership and governance in TB control: Activities to build capacity among TB program managers at national and regional levels and regional TB/HIV councils; organization of regular National TB conferences.
SDA HSS Monitoring and Evaluation system; Support to building capacity of government funded TB M&E units in all regions and the generation of relevant strategic information.
SDA HSS Workforce: Development of a comprehensive national strategy on human resources for TB. Revision of TB education in 43 pre- and post graduate academics institutions to prepare shift from ad-hoc to regular training. Adaptation of PAL clinical standards of care and preparation of national plan for PAL introduction. Strengthening of the National TB Center role in coordinating all TB related training efforts in Ukraine.

Objective 4: **To increase overall access to TB diagnosis, treatment and care through awareness raising, mobilization of political support and reduction of stigma**

SDA ACSM: Develop and implement a coordinated national ACSM strategy at the national level and in all oblasts; mobilize and build capacity among NGOs and community leaders for greater involvement in the TB response; advocate and to reach out to groups with limited access; increase public awareness and stimulate political will and resources allocation for TB programs at all levels; address TB-related stigma and discrimination in the health care system and in the society; and reach out to vulnerable groups to stimulate them seek access to care and expand the reach of TB services by involving new partners.

It is expected that the combined activities funded by this proposal will complement the ongoing National TB Program, allowing Ukraine to achieve its 5- year targets to increase to 70% case detection rate and 80% treatment success rate. The objectives and activities described in this proposal follow the STOP TB Strategy, and are directed to increasing its efficacy and account for weaknesses identified in the previous GFATM Round 8 Proposal. In particular, they reflect commitment of the government to address structural issues identified in past evaluations as well as results from recent gap analyses and will complement efforts supported by other donors in the TB and TB/HIV field, including USAID projects, the World Bank loan, private philanthropy (Charity Foundation “Development of Ukraine”) as well as GFATM Round 6 activities.

4. PROGRAM DESCRIPTION

4.1. National program and strategy

(a) Briefly summarize:

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

The National TB Program was developed based on the DOTS strategy and approved as a Law of Ukraine "On Approval of the National Program against TB for 2007-2011" (further 'Program') on February 8, 2007[16] (*Law of Ukraine on Approval of the National* All-State Program on TB Counteraction *for 2007 – 2011# 648-V of February 8, 2007*). In the framework of the Program implementation, the Committee on HIV-infection/AIDS and Other Socially Hazardous Diseases (further 'Committee') (governmental body of state direction) and All-Ukrainian Center on TB Control under MOH of Ukraine were established.

This Program aims at the improvement of the epidemiological situation through decreasing TB mortality and morbidity rates among the population, the prevention of MDR-TB, improving treatment effectiveness, institutionalizing the system of training and retraining of health care workers, and improving laboratory diagnostics of TB.

The development of the National TB Plan is based on the findings from piloting the DOTS approach in the Donetsk region, starting in 2001-2005 in a program funded by USAID and implemented by WHO. With USAID support and in collaboration with national and local health authorities, the WHO Project on rolling out DOTS elements in five additional oblasts in Ukraine was launched in 4th quarter of 2005. The Project was planned as a part of DOTS implementation activities of different counterparts and to be synchronised with the official promotion of the adapted DOTS strategy by MOH of Ukraine. DOTS was scaled up in the following regions: Dnipropetrovska, Zaporizhska, Kharkivska, Khersonska Oblasts and Autonomous Republic of Crimea (AR Crimea) with population 2,4 millions, 1,8 millions, 2,5 millions, 1,2 millions and 1,7 millions accordingly. The choice of regions was based mostly on TB epidemic indicators. TB burden and level of primary health system development. For example, TB registration rates in 2005 in Kharkiv oblast was 93/100,000 population with average Ukraine rate 81/100,000.

Generic DOTS implementation was expanded from the pilot regions that received specific donor support to the whole country in 2007/2008 per revision of official treatment guidelines, adaptation of drug procurement, the development of appropriate training materials and the engagement of TB chief specialists in training.

The current National Program is in its second year now. However, similarly to the National AIDS Program for 2004-2008, it represents a framework with many of the funding aspects left unspecified. The main financial gaps of the current National TB Program relate to educational activities, laboratory development and quality assurance (QA), M&E component, needs of vulnerable groups and social mobilization efforts.

The National Program contains 15 Objectives supported by several indicators for each objective with anticipated results by 2011 of a new sputum-smear case detection rate of 60%, treatment coverage of 95% and treatment success rate of 85%. The National TB Program financing for 2007-2011 is determined to be $ 240,000,000 which is not sufficient to cover all the TB response needs.

Implementation of the National Program will enable to address the following problems:

- ~ coordination of the work of ministries, other bodies of the executive power and local governance, civil organizations working in the field of TB control ;
- ~ adherence to approved standards of treatment under direct observation;
- ~ monitoring of the National TB Program implementation at the regional level;
- ~ functioning of the laboratory network;
- ~ provision of TB patients with second line anti-TB drugs;
- ~ improvement of the system for registering and reporting on treatment outcome and functioning of the National TB electronic register (USAID/MSH/PATH);

[16] Law of Ukraine Annex 23

- implementation of activities for the prevention of MDR-TB and TB/HIV transmission;
- provision of timely TB diagnosis by sputum-smear microscopy in all medical facilities
- provision of social services for TB patients;
- training medical personnel of the TB dispensaries and PHC on TB prevention and treatment;
- provision of systematic information for the population on TB prevention and treatment, promotion of a healthy lifestyle.

Realization of the Program will enable to:

- prevent spreading of MDR-TB;
- reduce rate of treatment interruption to 10%;
- ensure identification with smear-sputum microscopy of 60% of all new pulmonary TB patients;
- improve the system of TB care delivery to the population;
- involve more than 80% of medical workers into the training according to the international standards;
- early diagnosis and timely start of treatment of TB patients;
- establish a system of Good Manufacture Practice (GMP) for assuring TB drugs quality.

As a result, the epidemiologic situation will stabilize and subsequently decrease, while a reduction of state budget expenditures on TB control can be expected.

(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this proposal *(or, *identify the specific Annex number from a Round 7or Round 8 proposal when the document was last submitted, and the Global Fund will obtain this document from our files).*

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

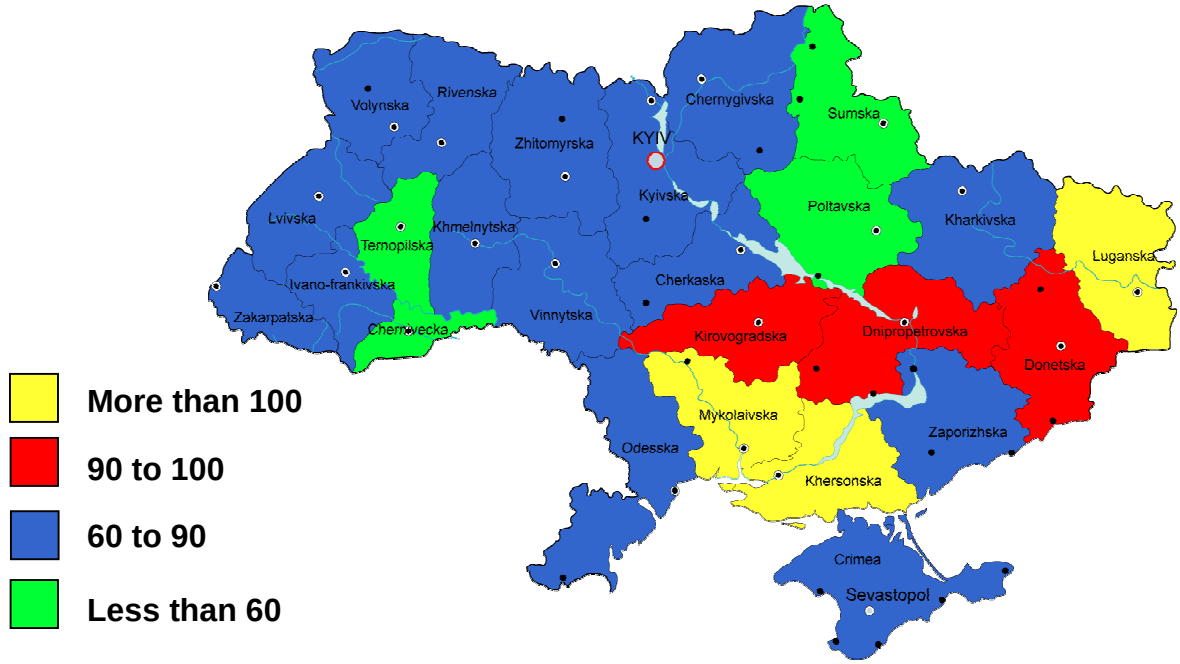
Document	Proposal Annex Number	Page References
☐ National Health Sector Development/Strategic Plan		
X **National Tuberculosis Control Mid Term Strategy or Plan:** Law of Ukraine on approval of the National All-State Program on TB Counteraction for 2007 – 2011# 648-V of February 8, 2007	**Annex 23, Round 8**	
X **National Tuberculosis Guidelines (medical and laboratory):**		
1. Order №45 «On approval of instruction on bacteriologic diagnostic of TB infection", 06 of February, 2002	**Annex 24, Round 8**	
2. Order of MOH № 318 "Protocol on implementation of the DOTS-strategy in Ukraine", 24 of May, 2006	**Annex 24**	
3. Order №384 "On approval of the Protocol of provision of medical health to TB patients" as of 09.06.2006	**Annex 25**	
4. Order №600 "On approval of the clinical protocol of treatment of patients with MDR-TB" as of 22.10.08;	**Annex 26**	
5. Order №276 "On approval of the clinical protocol of provision of medical support to patients with TB and HIV co-infections" as of 28.05.08	**Annex 27**	
6. Order №337/42 MOH and AMSU «On providing functioning of Central Reference Laboratory of MOH and laboratory network on microscopy diagnostic of TB», 20 May, 2009	**Annex 28**	
☐ Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or*		

	norms and standards)		
☐	Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal		
☐	National Monitoring and Evaluation Plan (health sector, disease specific or other)		
☐	National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services		

4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal			
(a)	Do the activities target:		
X	Whole country	☐ Specific Region(s) ***If so, insert a map to show where*	☐ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

TB case notification in Ukraine (per 100,000 populations)



***** Paste map here if relevant***

ROUND 9 – Tuberculosis

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

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

Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	46 143 700	State Statistics Committee of Ukraine	January 1, 2009
Women > 25 years	18 062 837	State Statistics Committee of Ukraine	January 1, 2009
Women 19 – 24 years	1 895 750	State Statistics Committee of Ukraine	January 1, 2009
Women 15 – 18 years	1 655 653	State Statistics Committee of Ukraine	January 1, 2009
Men > 25 years	14 119 642	State Statistics Committee of Ukraine	January 1, 2009
Men 19 – 24 years	1 977 600	State Statistics Committee of Ukraine	January 1, 2009
Men 15 – 18 years	1 737 770	State Statistics Committee of Ukraine	January 1, 2009
Girls 0 – 14 years	3 316 771	State Statistics Committee of Ukraine	January 1, 2009
Boys 0 – 14 years	3 389 668	State Statistics Committee of Ukraine	January 1, 2009
Penitentiary population	143 363	State Department for Enforcement of Sentences Report	January 1, 2009
Prisoners and pre-trial detainees	35 690	Regional (oblasts') reporting	2008
PLWHA	91717	MOH of Ukraine HIV-Infection, Bulletin 29	2008
Roma population	47,587	Data of National Population Census	2001

4.2.2. Tuberculosis epidemiology of target population(s)

Indicators (see the footnote under this table for the references)			Number or rate or percentage	[Calculation] or (reference)
TB estimates, 2007				
a	Estimated number of new TB cases (all forms)		46916	WHO report, 2009
		Male 0-14 (5.4% of Total number)	2 533	WHO report, 2009
		Female 0-14 (6.5% of Total number)	3 049	WHO report, 2009
b	Estimated number of new TB cases (all forms) per 100 000 population		102	WHO report, 2009

ROUND 9 – Tuberculosis

c	Estimated number of new smear-positive cases		20163	WHO report, 2009
d	Estimated number of new smear-positive cases per 100 000 population		44	WHO report, 2009
e	Estimated prevalence of TB cases (all forms)		47008	WHO report, 2009
f	Estimated prevalence of TB cases (all forms) per 100 000 population		102	WHO report, 2009
g	Estimated number of deaths due to TB (all forms)		6744	WHO report, 2009
h	Estimated number of deaths due to TB (all forms) per 100 000 population		15	WHO report, 2009
i	Estimated number of HIV-positive new TB cases (all forms)		9491	WHO report, 2009
j	Estimated number of HIV-positive new TB cases (all forms) per 100 000 population		21	WHO report, 2009
k	Estimated number of multi-drug resistant patients of TB (new and re-treatment cases combined) among estimated SS+ cases		5568	WHO report, 2009
ka	Estimated % of TB cases (new and re-treatment combined) that are multi-drug resistant		26	WHO report, 2009
kb	Estimated number of multi-drug resistant patients of TB among notified SS+ new and re-treatment TB cases combined, including approximately 700 MDR-TB cases in the penitentiary system		3200	Estimate based on DRS in Donetsk Oblast, Ukraine (see sub-objective 2.2,
kc	% of notified new TB cases that are multi-drug resistant % of notified retreatment TB cases that are multi-drug resistant		16 44.6	DRS in Donetsk Oblast, Ukraine (see sub-objective 2.2
TB notifications, 2007				
l	Number of new TB cases (all forms) notified, including TB cases in the penitentiary system		40643, including 6700 in prisons	WHO report, 2009 Ukraine penitentiary system's data
		Male 0-14	334	MOH report, 2009
		Male , 15 and more	25934	MOH report, 2009
		Female 0-14	287	MOH report, 2009
		Female, 15 and more	10540	MOH report, 2009
m	Number of new TB cases (all forms) notified per 100 000 population		81	WHO report, 2009
n	% of estimated new TB cases (all forms) notified		86	WHO report, 2009
o	Number of new smear-positive TB cases notified			
		Male 0-14	14	WHO report, 2009
		Male, 15-44	11269	WHO report, 2009
		Male, 45 and more	8244	WHO report, 2009
		Female 0-14	7	WHO report, 2009
		Female 15-44	3957	WHO report, 2009
		Female, 45 and more	2154	WHO report, 2009
p	Number of new smear-positive TB cases notified per 100 000 population		24	WHO report, 2009]
q	% of estimated new smear-positive TB cases notified - Case detection rate of new smear positive TB		55	WHO report, 2009
s	Number of TB cases all forms (new and retreatment) that were tested for HIV		Not available	

ROUND 9 – Tuberculosis

t	% of TB cases all forms (new and retreatment) that were tested for HIV	Not available	[]
u	Number of notified TB cases all forms (new and retreatment cases) that were found or known to be HIV-positive	2345	WHO report, 2009
v	% of all estimated HIV-positive TB cases that were found or known to be HIV-positive - case detection of HIV+ TB	25	WHO report, 2009
w	Number of notified HIV-positive TB cases (new and retreatment) started or continued on CPT	Not available	
x	% of all notified HIV-positive TB cases (new and retreatment) started or continued on CPT	Not available-	
y	Number of notified HIV-positive TB cases new and retreatment) started or continued on ART	Not available	
z	% of all notified HIV-positive TB cases (new and retreatment) started or continued on ART	Not available	
aa	Number of TB cases (new and retreatment) received diagnostic DST	Not available	
ac	Number of multi-drug resistant TB (MDR-TB) cases notified among new and re-treatment cases	Not available	
ad	% of all estimated MDR-TB cases that were found or known as MDR-TB - case detection MDR-TB	Not available	
Treatment outcome, 2006			
ae	Number of new smear-positive cases registered for treatment	10351	WHO report, 2009
af	% of all notified new smear-positive TB cases that were registered for treatment	93	WHO report, 2009
ag	Number of new smear-positive TB cases that were successfully treated (2006 cohort)	6107	WHO report, 2009
ah	% of all new smear-positive TB cases registered for treatment that were successfully treated (2006 cohort)	59	WHO report, 2009
ai	Number of new smear positive TB cases that failed their treatment	1242	WHO report, 2009
aj	% of all new smear-positive TB cases registered for treatment who failed their treatment (2006 cohort)	12	WHO report, 2009
ak	Number of new smear positive TB cases who died while on TB treatment	1242	WHO report, 2009
al	% of all new smear-positive TB cases registered for treatment who died while on TB treatment (2006 cohort)	12	WHO report, 2009
am	Number of new smear positive TB cases who defaulted	932	WHO report, 2009
an	% of all new smear-positive TB cases registered for treatment who defaulted (2006 cohort)	9	WHO report, 2009
PLWHA (new cases, rate, etc. Possible estimates)		90,685	MOH of Ukraine HIV-Infection, Bulletin 29, 2007
Roma population (new cases, rate, etc. Possible estimates)		47,587	Data of Population Census, 2001

1. Global tuberculosis control: surveillance, planning, financing: WHO report 2008. “WHO/HTM/TB/2008.393”.
2. Anti-tuberculosis drug-resistant in the world. Fourth global report. WHO/HTM/TB/2008.394
3. Data from country TB routine recording and reporting system.

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[17] who may have disproportionately low access to tuberculosis diagnosis, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. Tuberculosis program

Describe:

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

Based on the report of a joint program review of tuberculosis control in Ukraine (Annex 27, Round 8), reports of two missions on laboratory in Ukraine (Annex 3 – WHO Lab mission in 2007, Annex 4 – WHO Lab mission in 2009) and conclusions of a national workshop on HSS for TB control (Annex 29), the following weaknesses and gaps in implementation of the current National TB Program and more specifically in implementation of the Stop TB strategy were identified:

Weaknesses:

1. Insufficient capacity of newly established coordination and management structures of the National Program governance concerning central planning for TB control activities, use of strategic information procurement planning and supervision of the National TB control implementation process.
2. Although priorities for financing are defined in the National TB Control program, almost half of the identified activities lack financial resources. The same situation is mirrored at the local level where regional TB Control programs lack necessary resources. The available resources are not always allocated in a cost -effective manner in accordance with the international standards and best practices.
3. Legal and regulatory documents on TB issues are not properly matched. As of January 1, 2006, the adapted DOTS-strategy was introduced in all the territory of Ukraine. However, this does not mean that high quality DOTS-oriented services exist. Several critical protocols for medical care provision for TB patients were approved in 2006, based on the adapted DOTS-strategy and international recommendations (MOH: Order #384 – Annex 24, Order # 45 – Annex 24, Round 8). However, these and other official TB orders have not yet been fully translated into a coherent TB control program. Likewise, the new policy is not yet reflected in the numerous pre-existing TB relevant regulations. Absence of the national TB-related regulations to reflect the Stop TB strategic components and up-to-date standards of care jeopardize the provision of TB control services. No use of WHO qualified drugs.
4. Insufficient interaction and coordination between the MOH and other government and non-government bodies and organizations, specifically with the State Department of Ukraine for Enforcement of Sentences. Prisoners on TB treatment whose sentences end before the TB treatment is finished may discontinue treatment for a number of personal, social and organizational reasons. Ensuring Continuum of Care in this group is insufficient.
5. The TB laboratory network is weak in terms of the excessive number of laboratories, lack of up-to-date rapid methods of TB/ MDR-TB diagnosis and insufficient laboratory quality control.
6. Lack of modern infection control in TB medical facilities.
7. Although there is a wide network of PHC facilities and PHC workers and they are involved in detecting TB suspects and in preliminary diagnosis of TB cases, the PHC providers are insufficiently involved in providing TB treatment at the follow on (ambulatory) stage to TB patients. Proper referral and information exchange between PHC and TB services is lacking.
8. Opportunities for M&E are limited and TB patient registration and monitoring is still paper-based. The developed M&E system of TB case and TB control program performance has not been fully implemented and supervised, as well as epidemiologic surveillance based on the international standards. The lack of the electronic M&E system slows the analysis of collected data and implementation of corrective actions, as well as makes the control over the program more difficult.

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

Moreover case definitions are not yet uniformly used. Previous and new definitions are used in parallel, making reliable analysis almost impossible.
9. An electronic register has been developed (USAI/MSH/PATH), but has seen only limited introduction.
10. Insufficient public awareness on TB issues.

Consequences:

1. Weak national program governance leads to ineffective or absent strategic planning, human resources Development (HRD) Plan, analysis of strategic Information, inadequate procurement of drugs and equipment and budgeting processes.
2. Lack of funding jeopardizes Program implementation including interrupted supplies of TB drugs. No funds are available for activities that are not directly related to service delivery, but essential for increasing the capacity of the TB system to implement the new TB policy (including additional training, strategy development, laboratory consolidation, PSM reform etc.)
3. The National TB Program (including DOT-treatment), despite its official adoption, has not been adequately implemented, leading to compromised and suboptimal quality of TB-related services, thus contributing to further MDR-TB transmission.
4. Lack of coordination between the civilian TB program and TB services in other government systems (e.g. penitentiary system, military services and internal affairs, migration services) impedes the implementation of DOTS and integrated treatment approaches.
5. Inaccurate TB laboratory testing leads to delayed or incorrect diagnosis of both regular and MDR-TB and the delivery of ineffective treatment regimens.
6. Lack of up-to-date infection control leads to nosocomial transmission of TB and MDR-TB strains exposing other patients, in particular HIV –infected persons, and medical staff to TB infection resulting in increased burden of disease and staff attrition.
7. Lack of a patient-oriented approach in the delivery of TB treatment at the PHC level contributes to the large number of treatment defaults which may lead to a growing TB and MDR-TB burden.
8. Difficulties in tracking Program roll-out and success; programmatic decisions are at times based on poor evidence because of an underdeveloped M&E system and poor surveillance, including MDR-TB and TB/HIV co-infection.
9. Public awareness is low, contributing to sub-optimal health seeking behavior and to stigma and discrimination of people affected by TB.

Gaps in the delivery of TB services:

1. Currently, only a few laboratories are externally quality controlled, limiting severely access to high quality TB diagnostic services.
2. The DOTS strategy is the basis for the NTP, but essential support for the implementation of the DOTS approach has been limited to 10 oblasts that receive external technical assistance, together accounting for 50% of the Ukrainian population. In all oblasts, significant challenges remain in implementing a patient centered approach to TB treatment and care, particularly during the continuation phase in the periphery of the health care system. Access to treatment for groups with multiple health problems and social needs in particular is limited due to lack of coordination and referral between the social and medical TB and HIV vertical systems this applies in particular to people with TB/HIV co-infection.
3. While MDR-TB treatment protocols have been updated to international standards, treatment of MDR-TB is not up to GLC standards due to persisting deficiencies in some of its aspects (in particular lab and PSM). As a consequence, access to high quality treatment for people with MDR-TB is inadequate.
4. The potential of primary health care services is underutilized; outreach and social support are unavailable. The lack of patient orientation and case management at the periphery of the system affect poor and/or vulnerable segments of the population in particular, including people with co-infections and people living under precarious social conditions, or in special settings (settings for pre-trial detention).
5. TB information and awareness is low in the general population, the health sector and among vulnerable groups. As a result, stigma and discrimination prevails among professionals and the general population, and demand for diagnosis and treatment is low, particularly among the vulnerable groups.

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.*

At present, the Ukrainian health system is in transition from outdated over-hospitalization and verticalization to a more integrated and out-patient oriented services with strong focus on primary health care level treatment for common diseases. This transition is occurring against a background of the entire health care system suffering from poor infrastructure, lack of modern equipment and understaffing, and a weak and out-dated educational system to prepare new medical specialists. While the totality of the health care system is challenged, a number of specific aspects directly impact on TB outcomes:

Leadership and governance: Poor Program planning and implementation

The Ukrainian health care system has been traditionally based on an input rather than output based approach to planning and financing, leading to unclear accountability for the achievement of health outcomes. Health Program development and implementation are further challenged by at times overlapping mandates of different institutions and lack of coherence between Program implementation and associated normative decrees at different levels of the health care system. Staff in government institutions has received little training in modern management approaches.

Health workforce: Absence of human resources planning and relative lack of human resources

Ukraine has experienced a decrease in the number of health personal due to less admissions into education (particularly pronounced in the area of nurse training) and high attrition of existing staff to other sectors and abroad. The development of salaries and work conditions has not kept pace with improvements in the private sector, and compromises largely the attractiveness of health professions. Existing human resources are not used efficiently due to sub-optimal distribution of tasks between various cadres and levels of the system. Overall human resources planning including forecasting of needs per specialization and region is absent. Regular education mechanisms (including post-graduate education) have difficulties to adapt to rapidly changing treatment approaches.

Impact on TB: TB is particularly affected by those factors due to poor infrastructure of many TB services, lack of modern infection control, little task delegation to lower levels and outdated educational curricula. As a result, there is a significant absolute and related shortage of TB specialists, with currently 40% of all official TB specialist positions being vacant. As a result, TB services have entered a vicious cycle of work force depletion and deterioration of working conditions – while the potential of PHC services has been underused.

Financing: Lack of financial resources

The global financial crisis has hit Ukraine hard, and government expenditures are under strict scrutiny at all levels. The budget for health has significantly been reduced (24%) and the budget for investment and maintenance of infrastructure for the next year is nil. Funding for TB control is secured by the national budget and local budgets. The national budget covers primarily procurement of drugs and medical equipment for all regions. Local budgets continue to finance facilities, staff salaries and other core expenses according to distributional principles that are input (in particular based on number of beds), rather than output oriented. The fragmentation of pooling mechanisms induces an over-supply of beds and facilities. Input-based budgets induce unnecessarily long lengths of stay.

Impact on TB: Complicated national level / regional level co-financing mechanisms and continued emphasis on input based budgeting provide strong incentives for treating TB patient in hospitals for long periods of time. While current funds are used to cover maintenance of care treatment Programs, no funding is available for supporting the transition phase in applying the new TB policy. Significant financial investments are made into preventive activities of limited value including mass screening and microscopy in poorly selected and suspected individuals and BCG revaccination.

Medicinal Products: Suboptimal access to quality TB drugs

Only recently, GMP compliance and attestation of bioequivalence have been introduced as a precondition for drug registration in Ukraine, but some drugs on the market were registered prior to this regulatory change. With the exception of narcotics, all drugs are freely available in pharmacies. Essential drugs are usually financed by state budget, but stockouts are frequent. It is because of incorrect calculation of regional needs, and the lack of an electronic data base for drug management in all levels.

Impact on TB: This applies in particular to the availability of some 2nd line TB drugs due to limited financing. Drug stockouts, out-of pocket payments, and/or use of some drugs of uncertain quality may result in decreased treatment efficacy, adherence and completion, particularly among the poorest segments of the population.

Laboratory Network

The TB laboratory network's functionality is limited due to the absence of an (until recently) operational National Reference Laboratory, excess number of TB laboratories, deficiency in staffing and equipment of the laboratory network, and uncertain quality of reagents used. There is not systematic program for internal and external laboratory quality assurance, and no plan for human resource development including staffing and training within the laboratory network exists.

Impact on TB: Deficiencies in the TB bacteriological network directly compromise TB diagnosis and timely detection of MDR-TB.

Service delivery: Lack of decentralized and integrated service provision.

The Ukrainian health system is characterized by a high degree of verticalisation in which different parallel structures provide specialized care, e.g. through AIDS Centers, TB dispensaries, STI clinics, Narcological Centers etc. Collaboration between such structures is generally sub-optimal. Equally, linkages between the various echelons of care are weak, as is collaboration between health and social services. A slow shift to involvement of PHC is taking place.

Impact on TB: TB patients are particularly affected by these deficiencies, due to a high need for concomitant and integrated care (clustering of TB, HIV, drug dependency), the necessity to closely link intensive and continuation phase in different health care settings for successful treatment completion, and the need for DOT in close proximity to patients' place of living. Current overemphasis on hospitalization and sub-optimal involvement of primary health care and social services in TB control directly contribute to low and delayed TB detection and low cure rates.

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 government has taken significant action to tackle above mentioned health systems challenges for TB control. These were based on a critical analysis and report on the implementation of the National TB Program prepared in 2007, as well as a number of external evaluation missions. While these actions addressed some of the priorities, additional activities proposed in this application to the GFATM are intended to contribute to their full implementation.

Leadership and governance: Poor Program planning and implementation

Over the past years, the government has reformed the TB planning coordination and management structure in line with international recommendations: A national TB Program 2007-2011 was developed based on the STOP TB strategy with a focus on defined outcomes, and treatment guidelines and protocols were revised accordingly. Existing orders relating to TB control are being reviewed to eliminate contradictions, to give priority to cost-effective interventions, and to ensure agreement with current international knowledge and recommendations.

With a goal of comprehensive coordination of implementing the national TB program, a governmental body of the state administration was formed in 2007 – the National Committee on HIV, TB and other Socially Dangerous Diseases. (Further "Committee"). **Health workforce: Absence of human resources planning and relative lack of human resources**

In 2008 based on input from the Committee, an order regulating principles of workforce distribution was revised, opening the door for a shift from population/bed based to disease/outcome oriented distribution

of health care workers. This order needs to be complemented with an operational "health workforce plan" in various areas of health that include an assessment of current and forecasted supply and national needs (including number and skill mix of the workforce, job description or terms of reference, geographic distribution), motivations and incentive structures (competitive remuneration, non-financial incentives, system support, safety/health of workers), and competence building (education for skills, training and learning, leadership and entrepreneurship). In 2008, a new human resource department at the Ministry of Health was established to address the growing deficit of the professional staff at national and regional levels. This department will be involved in the process of assigning all needed health specialists to the unfilled positions in the health system nationwide. The MOH is also concentrating on increasing personnel in rural health care facilities, by annually distributing 56% of newly graduated medical professionals whose training was state-funded to rural areas. In doing so, more than 6000 physician posts in rural health facilities were filled in recent years.
Specific steps were taken to increase the attractiveness of a career in the TB area, in particular by uniting the specialties "Pulmonology" and "Phthisiology" in one specialty such as "Phtysiopulmonology", and by promoting task shifting, amongst others by developing a coordination plan to engage non-governmental organizations in provision of social shadowing and psycho-social support of TB patients at the ambulatory continuation phase of TB treatment.
It is recognized that priority needs to be given to the development of a comprehensive human resource plan, especially for the TB services and to adapting the pre- and post graduation educational lung disease curricula. The MOH tasked the TB Center to do so, but it needs external support.

Financing: Lack of financial resources
Shortening inpatient treatment and prioritizing outpatient care represent a cornerstone of the new TB plan, revising the number of beds downwards with a focus on quality instead of quantity (less crowded wards, improved sanitary conditions, separation of patients with different forms of tuberculosis). Successful implementation of the plan will create opportunities for a reallocation of TB budget from hospital-based to ambulatory care services, and for aligning financial incentives to earlier discharges. The government has also expressed strong interest in optimizing the cost effectiveness of the TB bacteriological network. There are plans to reduce the number of labs performing TB diagnostics by more than 50%, in an effort to decrease costs and increase service quality. Equally, there is interest to make better use of international mechanisms for drug procurement, in particular in view of reducing costs for second line TB drugs. The government realizes that the implementation of structural changes that will lead to increased cost-efficiency will depend on additional efforts for which external support is sought.

Medicinal Products: Suboptimal access to quality TB drugs
GMP compliance and demonstration of bioequivalence were introduced as a precondition of drug registration. Technical assistance in form of an evaluation mission on improving the PSM system for TB and HIV drugs was provided by WHO/USAID/EU (July 2008), and efforts to implement their recommendations initiated. The country engaged with the Global Drug Facility to procure first line TB drugs, and Donetsk oblast developed a Green Light Committee proposal to procured second line TB drugs. GLC approval was granted, however, and then withdrawn due to a lack of registration of some of the second line drugs in Ukraine. The government is interested in a switch to GLC procurement of government budget drugs based both on economic and quality considerations.
Key additional efforts that need to be undertaken to accelerate PSM reform and to render the proposed TB bacteriological network functional are included in this proposal.

Service delivery: Lack of decentralized and integrated service provision.
The government has committed to shift emphasis of health care delivery from specialized to primary health care level, in particular through the introduction of the family physician approach. The evolving network of PHC physicians lack specific training enabling them to better support TB detection and treatment. There is now interest to strengthen PHC involvement based on introducing the PAL approach (Practical Approach to Lung Health). Initial steps to introduce PAL are in this GF proposal.
To ensure the patients' adherence to treatment an education Program for patients was developed and is being currently implemented in 10 Oblasts with further plan to roll-out this program to the other regions. A system of direct observation of TB treatment is being implemented but needs further strengthening that would include the assessment of needs in DOT units, staffing and development of guidelines. A number of integrated treatment models for people with concomitant health conditions (including HIV, TB, and drug dependence) have been developed and are currently being piloted, amongst others with support by GFATM.

ROUND 9 – Tuberculosis

TB-related ACSM has been sporadic, most notably in form of an ad-hoc, country wide mass media awareness campaign on TB implemented by the Charity Foundation “Development of Ukraine” in 2007. A multi stakeholder approach to ACSM is still pending.

ROUND 9 – Tuberculosis

4.4. Round 9 Priorities

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

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

Priority No:1	ACSM	Historical		Current		Country targets			
Intervention	Number of people with limited access receiving intensified support on outreach basis	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*				9000	9000	9000	9000	9000	9000
B: Extent of need already planned to be met under other programs				1000	1000	1000	1000	1000	1000
C: Expected annual gap in achieving plans				8000	8000	8000	8000	8000	8000
D: Round 9 proposal contribution to Total need		*(i.e., can be equal to or less than full gap)*			3000	4000	4300	4700	5000

Priority No:2	Improve diagnostics	Historical		Current		Country targets			
Intervention	Total # of level III, II, and I TB laboratories operating with quality assurance Program (28, 86, 653)	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*					767	767	767	767	767
B: Extent of need already planned to be met under other programs		200	250	310	360	360	360	360	360
C: Expected annual gap in achieving plans					407	407	407	407	407
D: Round 8 proposal contribution to Total need		*(e.g., can be equal to or less than full gap)*			50	150	280	407	407

ROUND 9 – Tuberculosis

Priority No:3	High quality DOTS	Historical		Current		Country targets			
Intervention	Number of people to receive high quality DOTS (70% of estimated need)	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*				33000	33000	33000	33000	33000	33000
B: Extent of need already planned to be met under other programs				11500	13000	16500	16500	16500	16500
C: Expected annual gap in achieving plans					20000	16500	16500	16500	16500
D: Round 9 proposal contribution to Total need		*(i.e., can be equal to or less than full gap)*			5000	9000	13000	16500	16500

Priority No: 4	Treatment of MDR-TB conform to international standards (GLC)	Historical		Current		Country targets			
Indicator name	*Number of patients receiving MDR-TB treatment according to GLC standards*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*						3200	3400	3400	3200
B: Extent of need already planned to be met under other programs		0	0	0	0	0	0	0	0
C: Expected annual gap in achieving plans		0	0	0	0	3200	3400	3400	3200
D: Round 9 proposal contribution to Total need		*(e.g., can be equal to or less than full gap)*			0	120	960	2000	2480

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

4.5. Implementation strategy

4.5.1. Round 9 interventions

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

Where there are planned activities that benefit the health system that can easily be included in the tuberculosis program description (because they predominantly contribute to tuberculosis outcomes), include them in this section only of the Round 9 proposal.

***Note**: If there are other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes beyond the three diseases), and these are not easily included in a 'disease program' strategy, they can be included in s.4B **in one disease proposal** in Round 9. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 9 Guidelines (s.4.5.1.) for information on this choice.*

Since first DOTS pilots were started in Ukraine in 2001, significant progress was made in reorienting the TB diagnostic and treatment system based the STOP TB strategy, with DOTS now representing the foundation of the "State Program on TB counteraction for 2007-2011" (approved by the Government of Ukraine in February 2008). While DOTS has now been fully endorsed at the political level and treatment guidelines have been revised, it has become clear that the new TB Program can only be fully implemented if supported by a number of critical structural changes in the TB control system.

The government has reacted by creating in 2008 a central "Committee on TB and HIV" to steer the reorientation of the TB Program, and by allocating an overall amount of 1 207 330, 26 UAH for the Program's implementation. Yet, Program funds are insufficient to cover the totality of service provision envisaged by the Program (e.g. all 2nd line drugs), nor were funds allocated for specific investments into upgrading the existing TB system according to new approaches (e.g. retraining of health workers).

The political will of the Government of Ukraine to expedite the transition to a modern TB control system is at its high, testified among others by Ukraine's pro-active participation in the Ministerial meeting on "Global M/XDR TB Tuberculosis Control and Patient Care" in Beijing in April 2009. Ukraine realizes that vulnerable and poor populations are most affected by insufficiencies of the current system. To this end, the proposal has a strong focus on poor and vulnerable populations, including those listed in Round 8 submission: homeless people, extra-low income populations, PLWHA, prisoners and pre-trial detainees, migrants and refugees, Roma population, and representatives of professions vulnerable to TB. According to the vulnerability definition proposed by the new "International Standards of Care," the proposal recognizes that improving the situation of vulnerable and poor groups must be founded on increasing 'adequate access to appropriate diagnostic and treatment services for tuberculosis' as the chief criterion for vulnerability.

Through this proposal, the National Council seeks funding that will be catalytic for completing the re-orientation of the Ukrainian health system towards modern TB control. Key elements of this process include: building TB Program management capacities at central and regional levels; consolidation of the laboratory structure and introduction of external quality assurance; strengthening DOT provision supported by case management and outreach; successive roll-out of MDT TB treatment based on GLC standards; systematic human resource management and introduction of TB relevant content in regular postgraduate education of TB specialists and primary health care physicians.

In this, this proposal is complementary to the government funded State Program (both complementing budget gaps for service provision and allowing implementation of transitional support), and complementary to other donor funding (most notably by the Foundation for Development of Ukraine, the USAID, and a loan provided by the World Bank), who have provided significant (but insufficient) support to initiate the transition process.

Funding requested through this grant will render TB control as a whole more efficient and will allow the country to achieve 70% detection and 80% cure rate. In particular, the Program as a whole will help to avoid occurrence of M/XDR TB and to alleviate its impact – a high priority for the government. As the measures for which funding is requested focus on financing the effort of transition to a new TB approach (some of them actually leading to increased cost efficiencies), it is expected that following the five year funding continuation of activities can be mostly financed through the regular TB budget.

The main goal of the proposal is to contribute to reducing the TB burden in Ukraine through expanding and enhancing access to high quality TB services.

The Objectives and Service Delivery Areas (SDA) described in this proposal are in line with the Stop TB Strategy, address the issues identified in several evaluations and gap analysis exercises and correspond to the objectives of the Ukrainian National TB Program 2007-2011. This proposal has four objectives covering eight SDAs:

Objective 1: To improve tuberculosis diagnosis by optimizing the TB laboratory network in the civil and penitentiary sector

SDA: Improving diagnosis

External evaluations of the TB laboratory structure in Ukraine (most recently: WHO assessment mission of TB laboratory network in Ukraine February 25, 2009[18] - Annex 4)) have pointed repeatedly to significant, structural shortcomings of the present TB laboratory system, including:

- Presence of a too extensive TB laboratory network with at times overlapping functions, particularly between Level II and III.
- Lack of an operational National Reference Laboratory to oversee TB laboratory network
- Insufficient external and internal quality control
- An inappropriate excessive demand of tests (sputum and DST) by clinical services
- Persistent lack of some essential equipment and/or appropriate maintenance.
- Deficiencies in staffing and training.

As a consequence, the Government has undertaken significant steps to reorganize and strengthen the TB laboratory network in Ukraine::

- An order (Order # *50")* describing the correct laboratory task distribution at each level, based on WHO recommendations has been developed.
- The Microbiology Laboratory of the Yanovsky National TB Institute has been instituted as the National Reference Laboratory (NRL).The MOH signed a Memorandum of Understanding with the National Academy of Medical Science regarding the responsibilities and functions of the NRL. The NRL is housed on the premises of the Yanovsky National TB Institute. All necessary equipment has been procured from the National Budget and through the World Bank loan.
- The NRL agreed with the Supra National Reference Laboratory (SNRL) in Riga, Latvia to collaborate on external QA, technical assistance and trainings for NRL staff.

Most notably, the Ministry of Health together with NRL has agreed on a strategic vision of the laboratory network reorganization in accordance with WHO recommendations. Main features include:

- To provide access to high quality smear microscopy at primary health care facilities; level I laboratories will be restructured in accordance with a rayon approach (one laboratory per rayon). During 2009-2010, the number of level I laboratories will be reduced from 1837 to 653. This restructure is based on geographical and case load criteria. It will reduce cost and staff positions and will contribute to high quality diagnosis. The remaining level I laboratories have been provided with essential equipment through the WB loan and the National Budget. Staff of these laboratories will be trained and external quality assessment (EQA) will be established. This process will contribute to the improved quality of TB case management for the individual patients in an efficient and cost-effective way within existing health care systems.

- The number of level II laboratories will be reduced from 109 to 86 by end of 2011. Level II laboratories will perform smear microscopy and culture on solid media for follow-up of treatment and will be localized near rayon and city TB dispensaries with large concentrations of TB patients. The laboratories will function in accordance with Order # 50 and will send positive sputum from new cases to level III laboratories for DST.
- The number of level III laboratories in the civilian sector will be reduced from 47 to 28 (one in each oblast, 2 in Kyiv City) during 2010-2011. DST will be performed in accordance with international recommendations and the MOH will organize procurement of chemically pure substances for proper DST preparations. The need for this will disappear when all level III laboratories have been equipped with MGIT 960 liquid culture systems. Implementation of the MGIT systems will follow the gradual roll out as described under Objective 2. All level III laboratories will be included in EQA for DST and extensive training will be provided to all main specialists on quality control and methodology. Appropriate rehabilitation of the premises, if needed and infection control measures will be considered in each laboratory.
- The use of line-probe assays for rapid detection MDR-TB will be introduced in the NRL and then gradually introduced in other level III laboratories, which will give earlier results for clinical treatment and allow better selection of specimens for further DST. During the project period 5 more laboratories will be provided with this methodology.
- The Penitentiary System will use culture and DST facilities of the MOH. To that end a Memorandum of Understanding (MOU) between these two departments will be signed.
- Performing DST in a limited amount of laboratories will contribute to a reliable surveillance of drug resistance at oblast level.

While the above outlined initiatives are critical for the development of a sustainable and high quality laboratory network, the successful transition depends on a number of specific efforts for which regular government budgetary support is unavailable. Some of these extra budgetary investments have already been covered by other external support, mostly the World Bank loan for TB and HIV. Through this proposal funding is sought for final activities/investments that will enable to country to complete the transition process. These include:

1.1. Strengthening the National Reference Laboratory:

Additional staff is needed in the NRL but those will be paid from the government budget.

- Six specialists in total will be trained at the Supranational Reference Laboratory in Latvia on quality assurance systems, liquid culture and rapid testing for MDR-TB
- Revision of the present normative guidelines is needed. In order to properly implement the laboratory component national guidelines on TB case management, laboratory diagnosis and bio-safety will be revised in accordance with international recommendations, in particular to ensure the elimination of excess culture and drug susceptibility testing.
- Office equipment (computer/printer etc) will be procured.

1.2. Strengthening of the TB Laboratory Network:

Laboratories at various levels have been partially equipped recently with support of the state budget and the World Bank loan. Likewise, the majority of essential consumables for diagnosis and infection control are covered by state funds. This proposal seeks funding for essential but lacking equipment at level III laboratories in order to provide high quality DST and ensure safe occupational environment in level III laboratories, including bio-safety cabinets, autoclaves, incubators and others enumerated on the laboratory procurement list. To strengthen the laboratory network the following activities are planned with the GF support:

- Improving management: Annually the heads of Level III laboratories will meet at the NRL to share experience and lessons learned. International experts, including the ones from the supranational laboratory, will be invited to participate in these meetings to consult Ukrainian laboratory specialists.
- Training: Level I laboratory staff of the designated 653 laboratories has been partly trained within the framework of WHO and PATH projects. The remaining staff, in particular in oblasts not previously covered with other donor support, will be trained with GF support requested in this proposal, reaching 360 persons over the five year period. Emphasis will be on quality performance and bio-safety with particular attention to infection control. To achieve this target selected lab specialists will be trained to become trainers (TOT) in order to expeditiously implement training for Level I laboratories

countrywide. To advance TB diagnosis, a group of national and international experts will work on the development of training materials on EQA for lab specialists of level-1/2 laboratories; and on quality assurance, culture, DST and molecular testing for lab specialists of level-2/3 laboratories. Heads of Level III laboratories will be trained in advanced TB laboratory testing at the supranational laboratory. Participation of selected Ukrainian laboratory experts in international conferences will allow their familiarization with international lab updates.

- Equipment: Of the level III laboratories six still need to be equipped with MGIT liquid culture systems. Of the level II and III laboratories, 73 laboratories still need equipment that was not covered by the World Bank loan. Most existing equipment is very old and need replacement. A needs assessment was done by the head of the NRL.
- Rapid MDR testing: Taking into account the high level of MDR-TB cases in Ukraine (16% among new cases, see Objective 2) rapid molecular MDR-TB tests (GenoType MTBDR test) will be introduced for the NRL and 5 level III labs during years 2-4. This will improve access to rapid and high quality diagnostics of MDR-TB cases for both the civil and penitentiary population. Diagnostic algorithms including rapid molecular tests will be developed and introduced to TB specialists to assure appropriate and cost effective usage.
- Prison laboratory network: The prison system has 10 large TB hospitals with a Total bed capacity of 5,000. Each TB hospital has a laboratory, where sputum smears and cultures are done. Additionally 68 level I laboratories have been equipped by the World Bank loan. To assure quality performance, DST will be done by the nearest civilian Level III laboratory. Sputum will be transported for which boxes will be procured and transportation costs are budgeted. A MOU between regional health and prison authorities will be signed.

1.3. Introduction of a Quality Assurance (QA) System:

All laboratories will be involved in an internal and external Quality Assurance System, following international guidelines to improve the quality of performance. Supervision and QA will use a cascade approach guided by the NRL under supervision of the SRL.

- Guidelines and standards adapted to the situation in Ukraine will be developed with international assistance.
- Training: Following training of Laboratory Heads at the SNL, a comprehensive training program on quality assurance, culture, DST and molecular TB testing for laboratory specialists of level-2/3 laboratories (incl. prison) will be implemented in all oblasts.
- Blind rechecking methodology for sputum smear microscopy will be introduced and boxes for storage procured.
- Panel testing for DST of 1st and later 2nd line drugs will be introduced and boxes for bio-hazardous transportation procured. The SNRL will participate in QA

The successful reduction of the excess TB laboratory capacity coupled with a rigorous QA program in Ukraine will have a sustainable impact on the laboratory structure in terms of increasing its professionalism, the quality of its services and its cost-effectiveness.

Objective 2: To improve access to high quality services for people who, for whatever reason, has limited access to TB services.

Sub-objective 2.1

To improve access to high quality services for people who, for whatever reason, has limited access to DOTS services.

SDA: Expanding high quality DOTS

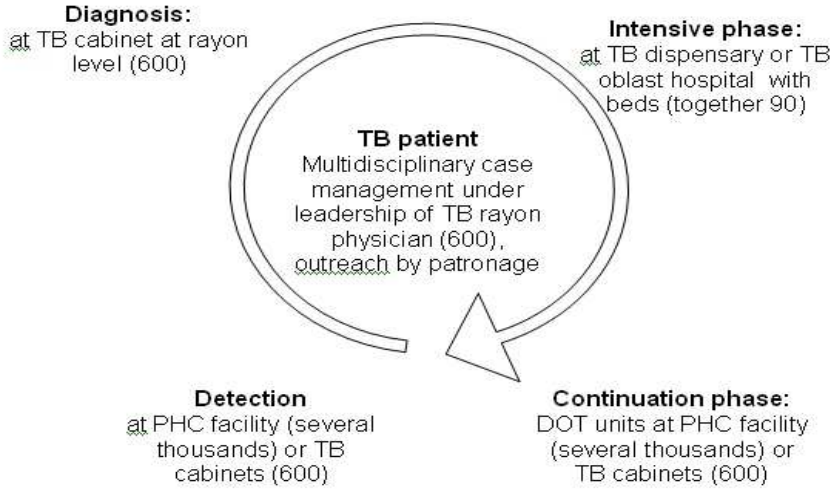
While the DOTS strategy has been officially adopted in Ukraine as a basis for the national policy, significant challenges persist in its implementation, in particular the weak system for ensuring direct observation of treatment at the continuation ambulatory phase. This situation has the worst effects on those who find it difficult to adhere to TB treatment in the continuation phase due to a combination of socio-economical problems. As a result, the success rate of current treatment is low (around 59%), caused by high defaulter rates of 19%, and multi-drug resistance is prevalent (16% in new cases).

ROUND 9 – Tuberculosis

Based on the DOTS scale-up experience in 10 regions (8 oblasts and 2 cities, supported by USAID/PATH, FDU, WHO and EU/KNCV), the Ministry of Health has refined the regulatory framework for TB treatment aiming to ensure a continuum of care, including:

- *Detection of TB suspects:* Emphasis at the PHC level, with physicians and nurses at outpatient clinics, family doctors, and/or health workers at village health stations ("Feldshers") clarifying symptoms, assessing clinical manifestations, collecting sputum (only partially at village health stations), performing microscopy and X-ray. Associated with level I Labs. Based on the results, patients are referred for further evaluation and diagnosis.
- *Diagnosis of TB:* Established at rayon level by the TB rayon doctor, who works together with a TB nurse at the TB unit (cabinet) in the central rayon general hospital (PHC facility, 600 in Ukraine), and/or a TB dispensary. TB Rayon physician starts the intensive phase of outpatient treatment (for SS-negative cases) or refers patients to a TB hospital for the intensive phase (SS-positive cases) Associated with Level I or Level II Labs.
- *Intensive treatment phase:* Treatment provided in TB dispensaries or TB oblast hospitals (120, of which 90 are with inpatient wards, staffed with TB physicians and nurses). Associated with Level II or Level III labs.
- *Continuation phase:* Continuation of treatment after intensive phase on an ambulatory basis commonly at an ambulatory department of TB dispensaries (120), or through TB units at rayon level (600), or through DOT rooms at general outpatient clinics (closer to patients residences, under development, currently very limited), or by family doctors / village health posts.

Diagram: Continuum of TB Care in Ukraine



Illustrative Diagram of the Expansion of DOTS and Supporting Services

While the regulatory framework has been well developed, a new approach to patient management has been implemented mostly in oblasts that are receiving specific external technical support, i.e. 10 oblasts that were supported by PATH, FDU, and /or WHO. In these oblasts, the regulatory framework was used to promote a case management approach to TB treatment, in which the TB physician at rayon level assumes a central role by tracking the patient from diagnosis through to completion of treatment, and in which health and social workers work together to ensure that every patient receives individual attention and support as needed to adhere to TB treatment.

This proposal seeks to further support the scale-up of this approach to reach all 27 oblasts and 600 rayons in Ukraine, including those that have not yet benefited from such support, and to enable all oblasts and rayons to continue the provision of a case management approach to TB care.

ROUND 9 – Tuberculosis

The GF-supported program will scale up gradually implementation of quality DOTS starting first in regions most prepared with external donor support. In these regions, particular attention will be given to strengthening direct observation of treatment at the ambulatory phase with increased psychological and social support to TB patients with limited access to promote treatment adherence until completion. Additional regions will be then involved to the program by Year V following the below roll-out plan:

Year I – Donetsk, Dnepropetrovsk, Kharkiv, Zaporizhzhya, Kiev City, Kiev Oblast;
Year II – Kherson, Lugansk, Crimea, Sevastopol City, Odesa, Lviv, Kirovograd, Nikolaev;
Year III – Zhitomir, Chernigov, Sumy, Poltava, Volyn, Rovno, Khmelnitsky; Cherkassy;
Year IV - .Ternopol, Ivano-Frankovsk, Zakarpattya, Chernovtsy, Vinnitsa

This DOTS enrollment plan provides a platform and correlates with a gradual MDR-TB enrollment plan. To this end, the following specific activities are planned:

2.1.0. Support to increased detection and diagnosis:

As described under Objective 3, steps will be taken to introduce the Practical Approach to Lung Health (PAL) to primary health care and referral level physicians as a main tool for increasing PHC involvement in TB detection and diagnosis. Activities are budgeted under Objective 3

2.1.1. Case management support during intensive treatment phase:

In each of the 90 hospitals patients are cared for by TB physicians and nurses. Through this proposal, hospitals will be funded to employ a psychosocial worker to counsel patients on their needs and perception for enhanced adherence to treatment and to prepare patients proactively for the ambulatory phase of their therapy, and 50 TB facilities will be supported to furnish psychosocial / patient education rooms. Also, funding will be provided to TB hospitals to remunerate for necessary consultations by other specialists (in particular: HIV, substitution treatment mental health, etc. (on a fee for service basis)), and/or transportation to services. Together, TB specialists, nurses, and psychosocial workers will manage TB cases. Ensuring coordination with other services. Training in TB case management and training courses on interpersonal communication / patient support will be provided to reach all 90 TB dispensaries with inpatient wards to eventually implement this approach in all oblasts). These activities will complement similar interventions undertaken in 10 regions with other donor support (USAID/PATH TB Control project). Regional level specialists will provide technical assistance through supervision/mentoring visits (commonly to include three specialists in charge of TB treatment, lab diagnosis and M&E activities) to peripheral facilities, including the prisons. Supervision over TB program performance will benefit of experience and knowledge of international experts who will annually contribute to monitoring activities.

2.1.2. Case management during the continuation phase:

Government-employed TB rayon physicians and nurses will be trained in case management approaches (partial training for 10 oblasts complementary to on-going activities under the USAID/PATH TB Control project, full training for 17 oblasts) and will oversee treatment during the continuation phase provided at DOT units at TB dispensaries or PHC facilities. As the introduction of case management and coordination efforts represents an additional task not covered by their TOR, TB physicians will receive a small case management fee to compensate for this extra work load and upon institutionalization to be handed over to the GOU. As noted above, other specialists (in particular HIV, substitution treatment, mental health), who are involved for on-site consultations will receive a fee per consultation. In addition, provisions are made to remunerate qualified PHC staff for ensuring direct observation of treatment and providing psychosocial support services to TB patients on a one time (after treatment completion of a TB patient) fee per patient basis. As a result, a multi-disciplinary case management approach can be broadly implemented.

2.1.3. Intensified support through outreach:

Building on the experience of Red Cross Visiting Nurses, in particular on their involvement in provision of DOT to disadvantage TB patients at risk for interrupting treatment, that was pilot under the USAID/PATH TB Control project, a subset of 4000 patients (estimated number of patient at risk of defaulting) per year will receive intensified support by URCS nurses or other NGO staff in order to reach out to patients' place of living, if needed on a daily basis. A pool of 1400 nurses / volunteer will be prepared for this role in specific trainings in year 1 and 2. Representing additional work, they will be remunerated on a per visit basis. Patients will receive incentives in the form of food packages.

Particular attention will be paid to the development of appropriate mechanisms for ensuring continuity of care after release from prison. Local NGOs will be invited to pilot in the form of 3 small grant projects.

2.1.4. Normative work:

While the MOH regulations provide a framework for the above outlined approach, and while PATH and other organizations have already developed a number of training modules, a certain amount of further work is needed to make the case management and referral approach operational, including a training strategy. Specific efforts to prepare normative documentation for including the remuneration of TB case management approaches (case management fee, consultation expenses, and outreach by nurses) in future government budgets will be undertaken by the National TB Center - aiming to ensure their long-term sustainability. Roll-out of the care management approach will be evaluated by two operational research studies in year 1 and 5. A regulatory basis and beta-testing of models of uninterrupted provision of TB services at the pre-detention phase of criminal investigation and in alternative correction camps will be developed.

It is expected that activities funded under this component, in particular together with complementary consolidation of the TB laboratory system and the ACSM component, will result in a significant increase in treatment completion and success, particularly amongst those with limited access to quality health services.

PATH has been nominated as sub-recipient for this component, particularly in view of their previous engagement in the development and support of this model. In particular, PATH will ensure that all training provided through GFATM support is complementary to training already provided over the last years.
The Ukrainian Red Cross Society will improve social support and outreach to patients with limited access to high quality TB services.

Sub-objective 2.2

To improve access to high quality services for MDR-TB patients

SDA: MDR-TB

At present routine data on the MDR-TB burden countrywide is unavailable. The current understanding of the MDR-TB situation in Ukraine is based on a quality controlled drug resistance survey (DRS) conducted in Donetsk Oblast in 2005/06 with one-tenth of the Ukraine's population, indicating 16% MDR-TB in new TB patients and 44.6% MDR-TB in previously treated TB cases in the civil population. In the prison population, the data showed 21.8% and 52.8%, correspondingly.[19] Having in mind a representative scale of the survey and that these data are concordant with findings in other FSU countries, the survey findings allow forecasting the number of MDR-TB cases that will be diagnosed annually. The estimated annual number of MDR-TB cases in both new and previously treated TB patients is approximately 3200 cases. These figures underline the urgency of addressing the system's capacity to assess and respond to MDR-TB.[20]

In addition, drug resistance patterns similar to those identified by the Donetsk DRS (Annex 30) were confirmed in patients receiving MDR-TB treatment at the National Institute of Phthysiatry and Pulmonology, the Chernigiv Oblast TB dispensary and the Kyiv City TB Hospital. This provides a platform for approximating MDR-TB treatment regiments, as well as for planning a need in 2nd line drugs.

In the last year a number of significant results have been achieved by the National TB program in tackling MDR-TB issues. These included:

- The first national DR TB case management guidelines (protocol) were endorsed in 2008. This document is based on the WHO guidelines for the programmatic management of DR TB.
- DR TB case recording and reporting forms following international recommendations were approved in 2009. Collection of data on DR TB through regular surveillance has been launched countrywide. An electronic TB Registry including a DR TB component is currently being developed with technical assistance provided by USAID, MSH and PATH.
- In 2009, the Ukraine NRL was designated. An assessment of Ukraine's NRL and regional TB

laboratories and hands-on training of the NRL's Head at the supranational laboratory was conducted as a start-up of collaborative activities with the supranational laboratory in Latvia.
- In 2008, a National Inspectorate on Pharmaceuticals was established to ensure that available pharmaceuticals are GMP compliant and to update drug registration procedures in Ukraine.
- MDR-TB/HIV patients receive ARV treatment according to the new national TB/HIV protocol.
- The MOH has played an active part in the Ministerial Meeting on X/MDR-TB in Bejing in April 2009, and prepared a draft plan on MDR-TB prevention and treatment.

Yet, major weaknesses persist in the implementation of a coordinated approach to MDR treatment in full compliance with the new national standards and international recommendations:

- Laboratory TB network lacks capacity to diagnose timely and accurately all cases and does not have regular laboratory quality assurance following international standards
- Not all first and second line anti-TB drugs meet international quality standard and the state budget is insufficient to procure all 2nd line drugs
- Workforce's capacity is insufficient to provide quality MDR-TB case management.
- There are no centers of excellence for training of human resources in MDR-TB case management.
- TB infection control measures are insufficient in all components.
- Drawbacks in implementing DOTS, deficient outpatient direct observation of treatment (DOT) and lack of social support to TB patients in need, jeopardize adherence to treatment of MDR-TB patients at the ambulatory phase, in particular among people with limited access.

Further strengthening of the essential DOTS components described above will be the main instrument for preventing resistance (see objective 2.1). The TB laboratory network will be strengthened to provide timely diagnosis of DR TB cases (see objective 1). Along with overall strengthening of TB surveillance, specific attention will be paid to maintaining and scaling up routine drug-resistance surveillance (see objective 3).

Based on this foundation, activities budgeted under this service delivery area will lead to the systematic gradual expansion of quality DR TB case management to 15 oblasts with heavy MDR-TB burden – covering cumulatively 90% of all estimated MDR-TB cases countrywide.

The GF-supported program will initially cover new MDR-TB cases, and from year 4 onwards also retreatment cases. Inpatient MDR-TB treatment will be provided in 15 Oblast TB hospitals and in the National Institute of Phthysiatry and Pulmonology in Kiev, each enrolling 60 new patients every 6 months according to the gradual implementation plan, and 40 patients each month in prison hospitals. A plan for enrollment of regions is as follows (Also see Annex 31 and 32)

	Year 2, Q3	Year 3	Year 4	Year 5
Oblasts improving MDR-TB treatment	National TB Institute (Kyiv), Donetsk	Dnepropetrovsk, Zaporizhzhya, Kharkiv, Lviv:	Kherson, Odesa, Lugansk, Crimea, Nikolaev, Kirovograd:	Khmelnitsky, Chernovtsy, Rovno, Zhitomir.
Cumulative # of oblasts improving MDR-TB treatment	1	5	11	15
Cumulative # of facilities	2	6 civil 3 prisons	12 civil 7 prisons	16 civil 7 prisons
Number of new Patients /year	120	960	2000	2480

Roll-out of quality MDR-TB case management will build on existing experience and expertise in Ukraine, particularly on the pilot DR TB management program that is currently being carried out in Donetsk oblast with support of FDU and WHO. This Program had already received GLC approval, which was later withdrawn due to drug registration problems. Donetsk region and the National TB Institute will be first enrolled to the GF-supported program as the most prepared sites. Experience that will be gained while

implementing quality DR TB management activities at the central level TB Institute will be disseminated beyond the selected regions countrywide.

Following coordinated activities will be performed in implementation of the above outlined scale-up plan:

2.2.1. Normative guidance and coordination on MDR-TB

It is planned to update and refine the existing regulatory documents on DR TB case management by the end of Year 1 with international assistance. Standard operational procedures will be developed as a part of the general guidelines on DR TB. The latter will be further revised in year 3 to account for changes from standardized to individualized MDR-TB treatment following improved laboratory diagnosis.

Along with establishing an electronic TB registry planned for 2009-2010, training of regional and district TB coordinators and monitoring/statistical personnel will be provided. Such training is complementary to technical assistance provided by international organizations (i.e. PATH) in analyzing DR TB regional data. TB institutions of both the civil and penitentiary systems will be covered by these interventions. This will allow obtaining reliable data on the DR TB magnitude for planning, drug procurement, treatment and other purposes. Based on routine MDR/XDR TB data, planning for drug procurement will be significantly strengthened in all regions.

2.2.2. Training for MDR-TB treatment

Patients will be treated in an MDR-TB department in each selected Regional TB hospital by specialized staff. The first three sites - in the National TB Institute, Donetsk and Dnipropetrovsk – already received technical assistance from international donors (PATH, WHO) and will be developed into Centers of Excellence. They include hospital based and outpatient DR TB services and are affiliated with TB departments of institutions of higher medical education. Selected TB specialists (in Total 25 persons from both the civil and penitentiary systems) will be trained as trainers on MDR-TB management (TOT) at the Latvia WHO Collaborative DR TB Center of Excellence and WHO training Center in Tartu, Estonia. Subsequently, 20 trainings will be provided to MDR-TB physicians and nurses in order to increase their competency following the above outlined roll-out plan.

2.2.3. Infection control

Infection control (IC) measures in MDR-TB in-patient departments including the penitentiary system will be strengthened. An overall assessment of the IC situation and practices in TB facilities will be undertaken in the second quarter of the first year to inform the development of a the National TB Infection Control Program, as well as an IC evaluation mission in Year III. A working group on the TB IC Program to oversee implementation of IC measures will be established and a National Coordinator appointed in the National TB Center in the second quarter of the first year (see Objective 3). The proposal seeks GF support for regular proceedings of this National Working group to include regional specialists. In the third quarter the National IC program will be developed. A national conference for 50 participants to present results of the initial assessment, draft national IC program will be convened to launch the development of regional and facility-based IC programs.

Specialized MDR-TB departments will be gradually upgraded – following the above described enrollment plan- to install infection control/environmental protection equipment (ventilation system, UV lamps). Procurement of respirators for personal protection is planned with GF support. Staff of MDR-TB treatment facilities will receive specific training in TB Infection control.

2.2.4. Second line drugs supplies

In Ukraine 2nd line drugs are procured at the central level (national budget) for all regions. These drugs are of local and foreign origin. 2nd line anti-TB drugs which are manufactured in Ukraine do not have a GMP Certificate. Most of these drugs are not WHO pre-qualified. The GOU is yet to establish a system to ensure quality of available pharmaceuticals, a task taken on by the newly formed State Pharmaceutical Inspectorate.

Currently, Ukraine cannot cover 100% of its needs for 2nd -line anti-TB drugs. Therefore, to meet the country's need in providing comprehensive quality treatment to new MDR-TB cases and in order to prevent relapses and XDR TB, the proposal includes a procurement plan to cover in Total 5560 new MDR-TB cases over a 4-year period. Ukraine will approach the Green Light Committee (GLC) requesting GLC-provided drugs to supply entirely the appropriate treatment regimens attached to this proposal (Annexes 33, 34, 35, and 36). In the second quarter of 2010 the GLC mission will be invited to evaluate

the existing situation with MDR-TB and assist in preparation of the application to GLC.

A number of GLC drugs have not been registered in the country because the manufacturer has not been interested to do so. With scaling-up of the MDR-TB program the increase in bulk procurement may make it more interesting for companies to get their drugs registered. The MOH will initiate the registration procedures in 2009 with other donor support. A policy/legislative initiative will be exercised to stop availability of 2nd line anti-TB drugs in pharmacies without prescription.

2.2.5. MDR-TB case management and adherence support

The aim of MDR-TB case management during the ambulatory phase is to ensure that a treatment plan is developed and implemented for each patient, ensuring that treatment delivery is as convenient and acceptable for each patient as possible. Reflecting that case management represents an additional task to primary health care providers, they will receive per patient premium for every six month of successful adherence to MDR-TB treatment. During the ambulatory phase, a subset of MDR-TB patients at high risk of defaulting (20%) will receive social and adherence support by outreach nurses and regular food packages (see DOT model under objective 2.1). Regular supervision by regional specialists of outpatient TB district and primary health care services provided to MDR-TB patients, counseling and social support will be strictly implemented following a model described above under *DOTS expansion* activities. Personal support will be complemented by educational material for patients and families.
The Ministry of Health of Ukraine (MOH), PATH, the National Red Cross Society and HIV Alliance will be responsible for achievement of this objective and implementation of the outlined activities.

Sub-objective 2.3
To improve access to high quality services for TB patients who are co-infected with HIV

SDA: Scaling Up Efforts to Address HIV-TB Co-infection

Two parallel epidemics TB and HIV hit Ukraine simultaneously. As per Ukrainian AIDS Center report TB is the leading cause of death in PLWHA and the most frequent AIDS-indicative disease. Unfortunately, evidence on real TB/HIV co-infection prevalence in Ukraine is limited due to insufficient surveillance data. One of the hardest HIV epidemics in Europe as well as high prevalence of TB is leading to annual increasing in number of TB/HIV patients and require urgent need to overcome burdens of both epidemics. The activities under this service delivery area aim at strengthening TB services and primary health care to meet specific needs of vulnerable groups and PLWH specifically. Activities will be coordinated in line with the «STOP TB Interim Policy of Collaborative TB/HIV Activities» and comprise three major areas:
a) strengthen the mechanism of collaborations;
b) decrease the burden of TB in PLWHA;
c) decrease the burden of HIV in TB patients.

This SDA contains advocacy, workforce and infection control activities, that using the Public Health System approach will strengthen capacity of existing services and introduce innovative models of care for co-infected patients. To this effect, the following activities will be implemented:

2.3.1: Strengthen the Mechanism of Collaboration at National, Regional and Local Levels.

The National Council (CCM) has been reformed recently, covers both diseases but mainly focuses on political decision making. To support the technical capacity of the NC and the MOH Committee on HIV and TB a joint multidisciplinary TB/HIV Working Group will be established. At oblast and rayon levels the work of coordination councils will be financially facilitated to improve performance to develop joint TB/HIV plans, to encourage an innovative care model for co-infected patients and to mobilize civil society and affected populations. These activities will be complimentary to and coordinated with the Round 6 Project that focused on integrated services delivery to vulnerable populations and enhancing DOTS for PLWHA in HIV services. (Budgeted under sub-objective 3.1) Two joint biennial review meetings on TB and HIV programs with other stakeholders will be conducted to highlight main achievements, identify gaps and lessons learnt as well as to plan further steps. Consequently it is anticipated that decision makers, health care managers and stakeholders will be sensitized to effectively engage in TB/HIV collaboration at all levels. (SDA ACSM)
Decisions have to be made on reliable data analysis. HIV testing among TB patients and screening for TB among PLWHA is routine in TB services. Yet reliable data on co-infection in Ukraine are not available. To

help decision making, technical assistance on improving data collection and harmonisation between vertical services will be provided and operational research be undertaken in aspects of service delivery in TB clinics and AIDS Centers. Both TB and HIV services in Ukraine operate their own monitoring systems, which are in line with international recommendations and WHO adopted standards. The proposal targets joint M&E activities and aims to increase effectiveness by sharing experience and exchange of data. A set of national indicators for the implementation of collaborative TB/HIV activities will be developed by the HIV/TB working group through national consensus, and a series of joint trainings on data management for TB and HIV services will be implemented. Collection of data and analysis will be the task of the M&E Units (SDA Monitoring and Evaluation).

2 3.2: Decrease the burden of TB in PLWHA

2.3.2.1 Intensified Case finding

Under Round 6 TB case finding is intensified by increasing the technical capacity of staff. This proposal addresses the lack of awareness, knowledge and skills among medical professionals, social workers and PLWHA on TB/HIV co-infection.

The proposal will support the revision of National HIV/TB policies and protocols and printing and distribution of revised documents to health care providers. Specific job aids on the adoption of routine TB screening and diagnosis by HIV services will be developed. Newly established and revised policies will be reflected in updated training modules on HIV/TB-related topics.

Training sessions under this activity will include refresher modules, TOTs and a mentoring program. The proposal will follow Round 6 approaches on incorporation of training modules into post-graduate medical education, accreditation and national certification. Acquired knowledge and improved skills of medical staff will contribute to reinforcement of early diagnosis of active TB among HIV positives as well as non-infected most at risk populations (MARP). To improve the referral system and increase access of PLWHA to TB services; the diagnostic capacity for TB will be reviewed every 2 years and communicated to the HIV services and PLWHA community.

Also the proposal will target PLWHA to generate community demand for TB services. Specific information materials will be developed, printed and delivered to PLWHA to increase awareness on HIV/TB co-infection with understandable direction what patients should do in case of TB suspicion.

2.3.2.2 Isoniazid Preventive Therapy

Isoniazid preventive therapy is the cornerstone of effective care for co-infected persons. The proposal will facilitate the review of national TB policies and protocols to include IPT as a core part of HIV services. With help of national and international experts, it is planned to develop standardized tools and policy guidance regarding the implementation of IPT. The HIV/TB Working Group will be responsible for development of an operational plan for IPT implementation into routine work of medical facilities providing care for PLWHA. It will weigh the balance of the false-positive tuberculin test results in a population with a nearly 100% BCG vaccination coverage and false-negative results among HIV infected persons with a low CD4 count.

The proposal will support the development of information materials for health workers and PLWHA on the effectiveness, efficiency and safety of isoniazid intake to prevent TB. The TB/HIV Working Group will facilitate the provision of Isoniazid that will be procured by the National TB program to the HIV services.

2.3.2.3. Infection control for TB

The high prevalence of infectious TB in the community and especially among groups at risk, combined with immune-suppression in HIV infection, make PLWHA very susceptible to (nosocomial) TB infection. This risk is very high at TB clinics, but also at other places where PLWHA get together (outpatient reception at AIDS Centers, harm reduction and substitution therapy sites). Therefore, the National Strategy for Infection Control should contain guidelines not only for TB services, but also for related services.

The proposal will also support performance monitoring visits and operational research to evaluate the benefits of infection control compliance at the workplace.

PLWHA (AIDS patients) with symptoms of cough but otherwise unknown or unclear diagnosis are referred to national or regional HIV/AIDS Centers for further diagnosis and treatment.. Until the diagnosis has been established, PLWHA with a cough should be separated from other HIV patients. To this end, the proposal supports the establishment of separate isolation rooms for

PLHA who are suspects for (MDR) TB at 4 AIDS Centers and one penitentiary system institution. Appropriate IC measures will encompass the separation of patients' flows, and installation of UV lamps in places of PLWHA gathering and ensuring appropriate ventilation conditions in isolation rooms.

Particular attention will be given to personal protection for PLWHA and health professionals and procurement of respirators for staff.

2.3.3: Decrease the burden of HIV in TB patients

2.3.3.1. Provision of HIV testing and counseling.

Timely and comprehensive HIV testing and counseling is an urgent need for TB services. While there are no shortages in HIV test-kits the quality of counseling is the major challenge. Scale-up of counseling and testing through provider initiated testing and counseling requires the development of PITC standards, protocols and guidelines, in accordance with the international PITC guidelines that were developed in 2007 by WHO[21]. An international expert will assist in the adaptation of these international PITC guidelines to local policies and realities, and develop a plan for their roll-out in the context of TB services, printing and distribution of new guidelines. The proposal will also contribute to minor renovation in 27 sites for pre-and post-test counseling room, as well as small group discussion at TB clinics. PITC will be organized with involvement of NGOs and will serve as a part of comprehensive care package which will also include organizational activities, e.g. holding informational events on HIV/TB issues, advocacy campaign, etc.

3.3.2. Introducing Harm Reduction activities at TB services

The level of HIV co-infection among TB patients is estimated at 20%; of those approximately half are intravenous drug users. Harm reduction is an effective preventive approach to counteract the concentrated epidemic. High levels of drug abuse among TB patients require innovative interventions; therefore, the proposal introduces harm reduction through complementary grants to NGOs to expand their existing harm reduction outreach to TB service.

2.3.3.3. Introduction of co-trimoxazole preventive therapy.

The progression of HIV-infection is characterized by the decrease in CD4 cell count. When CD4 cell count goes down below 200 the risk of opportunistic infections rapidly increases. Based on the past evidences co-trimoxazole is proven to be an effective method for prevention of bacterial and pneumocystic carini pneumonia, toxoplasmosis, enteric infections, etc. Within the framework of these activities, it is planned to develop a policy on co-trimoxazole preventive therapy for TB/HIV patients, development of guidelines and clinical standards, procurement and drug distribution, as well as monitoring of its administration.

2.3.3.4. Access to comprehensive services for co-infected TB patients

There is no plan to procure ARVs for co-infected patients under this proposal. ARVs will be available through the state budget and Round 6 project and already introduced in TB clinics. The proposal will aim to develop a referral mechanism to share ARV and TB drugs between vertical services and involving each other into forecasting and planning process. The proposal will also aim to develop and implement a referral mechanism to ensure uninterrupted substitution maintenance therapy for patients treated at the in-patient TB dispensaries Improvement of inventory management and drug stock reporting mechanism will be a part of the multi sector collaboration.

Objective 3*: *To strengthen the capacity of the Ukrainian health system to respond to TB by improving the governance (leadership, monitoring and evaluation, human resource development) necessary for the successful delivery of the TB program.

Sub-objective 3.1
To strengthen capacity of the health system by improving governance

SDA Leadership and governance in TB control

Over the last years, Ukraine has developed a structure of controlling and coordinating bodies both at the

national and regional levels that are responsible for TB control in the country:

- The Ministry of Health in 2007 established a departmental Committee on HIV/AIDS and other Socially Dangerous Diseases Control (the Committee) to guide and coordinate control of infectious diseases, among which tuberculosis, in Ukraine.
- In the relationship between the MOH TB/HIV Committee, its subordinate National TB Control Center was revisited and realigned in 2009: While the TB/HIV Committee has overall strategic responsibility and oversight over the implementation of the national TB Program, the National TB Center will takes operational responsibility for the TB Program's implementation through coordinating methodological support, monitoring, supervision, surveillance and training. The recent realignment of responsibilities and functions has been set out in a statute that will be approved by ministerial order.
- The Government of Ukraine in 2007 formed a National Council (NC) on Fighting Tuberculosis and HIV/AIDS to ensure participation of a wide range of national and international partners in consensus building and decision-making. The NC serves as the Country Coordinating Mechanism (CCM) for supervision and coordination of TB and HIV/AIDS program implementation. The Committee serves as the Secretariat of the National Council. In late 2008, a NC member, representing civil society, proposed the resurrection of several previously existing committees with a more robust mandate, to be supportive to both the Secretariat of the Council and the MOH's Committee (the same entity). An Organizational Chart as presented to the Council is attached (Annex 37) to show a broader holistic approach to the TB, HIV, and drug-related epidemics. At the regional level the regional governments set up a similar system of coordination councils for HIV and TB-related issues that are multi-sectoral and are inclusive by engaging the public sector and civil society. Together with the health department the regional coordination councils coordinate the work of the executive agencies and bodies of the local government and of the NGO sector.
- In each of the 27 administrative regions, government funded positions of regional TB coordinators will be set up with appropriate authority and responsibility to coordinate TB efforts at the regional level.
- In order to strengthen the coordination between the MOH Committee, the Department of Penal Implementation and the Ministry of Internal Affairs an inter-sectoral group will be set up and approved by the MOH order.

All these efforts reflect a growing political commitment of the government of Ukraine to address weaknesses in the leadership and governance of the TB response in Ukraine.

While the new structure is deemed to significantly improve TB control governance and coordination, additional efforts are needed to align all existing regulations within this new structure and to increase the competency of the newly appointed individuals to optimally perform their functions. To this end, funding is sought for the following specific activities:

3.1.1 Building capacity at national and regional levels

To increase the competency of the staff of the National TB Control Center and the State Department for Enforcement of Sentences who are involved in TB control in prisons, joint trainings will be organized. The training will include issues of program and financial management, recording and reporting, monitoring and evaluation, supervision and mentorship, needs assessment methods, etc.

In addition, select top level managers of the government, TB/HIV Committee and the State Department for Enforcement of Sentences will be trained on management of national TB programs with a specific focus on strategic planning, implementation, control and monitoring, and be supported to participate in key international conferences. Relevant guidelines related to good governance and Program implementation will be produced at the national level and disseminated to all regions.

Under relevant SDAs of this proposal, the TB Control Center and the State Department for Enforcement of Sentences are receiving support to manage implementation of activities for which they act as sub-recipients and/or for which they are important partners. To fulfill their management and coordination responsibilities the Penitentiary Department will ensure participation of its specialists in all TB-related technical components and implementation of quality services, including transportation of materials for laboratory testing, monitoring activities, interventions to enhance adherence to treatment and others. Together, such support will allow both key TB control bodies to upgrade their existing capacity to fulfill their functions. As the overseeing entity in the Ministry of Health, the TB/HIV Committee will receive specific support to plan and implement yearly supervisory visits to the regions. Ongoing assistance to ensure technical integrity of all aspects of program implementation will be provided by the WHO office in Ukraine.

While the establishment and staffing of the coordination council committees at the regional level

represented an important step in strengthening the systems' capacity to address TB, it was not accompanied by structured efforts to ensure capacity development of newly hired staff. Throughout the grant period, all 27 regional TB coordinators will be brought together quarterly for coordination and capacity building, and they will be equipped with a small activity budget. Training components of these meetings will cover program development, budgeting, implementation, monitoring and evaluation, operations research and systems analysis (ORSA).
The secretariats of the regional coordination councils will be provided with computers and Internet connections in the regions where these are not yet available. Strategic planning practice workshops will be implemented in all regions to produce operational plans on TB and TB/HIV control, and "high potential" staff will be supported to attend advanced training.
Finally, once a year a National TB Conference will be organized to provide platform for scientific debate, capacity building and sharing of results and experience in implementing the national TB Program.

3.1.2 Revision and harmonization of legislation relevant to the adopted STOP TB strategy:
The implementation of the National TB Program (Annex 23, Round 8) is guided by the existing legislative and regulatory framework in Ukraine. While the recent adoption of the DOTS-based TB strategy for the whole country provides an important foundation for the transition to a modern TB treatment approach, a great deal of legislation and regulations persists that is not yet in harmony with this approach, and thus prevents the Committee from effective implementation of the National TB Program. The proposal envisages local and international expert support to the review and revision of TB relevant legislation and regulations. As a result of these activities, the central TB and HIV Committee and regional health departments will be better equipped to efficiently fulfill their coordination and management task, supported by an appropriate legal and regulatory framework.

3.1.3 Evaluation of the current National TB Control Program and development of a new TB control program for 2012-2017:
With the help of an international expert, under the leadership of the Committee and with a wide involvement of stakeholders, the current TB program (Annex 23, Round 8) will be evaluated. Based on the evaluation results and previous lessons learned, a new TB program for 2012 – 2017 will be developed and prepared for its further approval by Verkhovna Rada (Parliament) and implementation.

Sub-objective 3.2

To strengthen the capacity of the Ukrainian health system to respond to TB by improving governance through improved monitoring and evaluation capacity that are necessary for the successful delivery of a high quality TB program.

SDA: M&E System

A well-functioning M&E system constitutes a critical component of modern TB control programs, allowing managers to track progress and success in controlling TB, including MDR-TB, TB/HIV co-infection along with decision making based on appropriate and reliable data. However, no funds have been allocated for such M&E system in the national budget.

Over the last years, the government has made significant efforts to improve the TB M&E situation, including:

- Elaboration of a reliable functioning system of data collection and reporting
- DOTS and DOTS plus forms for quarterly reporting implemented (cohort analysis)
- The National Medical Statistical Department of the MOH gathers the data
- An M&E unit within the national TB Center established that collects and analyzes data regarding cohort analysis

Yet, a number of weaknesses persist, including:
- Absence of a National M&E plan
- M&E Unit under the National TB Center does not perform the full range of its assignments because of lack of funding
- DOTS and DOTS-plus forms are not mandatory for all agencies and ministries of the country,

including the penitentiary system.

- Newly implemented forms are not correctly used in the country because there were no DOTS trainings for non pilot regions specialists.
- Lack of proper coordination between agencies involved in TB case detection and treatment (supervision visits, data exchange between TB and penitentiary systems)
- Absence of National register of TB cases

Activities in this proposal are aimed to address all the weaknesses above:

3.2.1 Building capacity of M&E units:

While M&E Units under the NTBC and at all oblast TB hospitals have fully staffed statistical departments, there is a lack of strategic and normative guidance, equipment, and training for them to fulfill their tasks effectively. Through this proposal a set of comprehensive capacity building activities are proposed that will help these departments to develop into functional TB monitoring and evaluation units.

An M&E plan will be created and regulations and operational guidelines will be developed. Round tables will be organized to achieve consensus among the M&E staff.

The Units will be equipped with computers, copiers and internet connection.

The staff of the M&E units will be trained in M&E, for which training materials based on the WHO modules will be developed. Training will include M&E supervision and mentoring.

Heads of the Units will be internationally trained in data management, statistical analysis and interpretation.

As already indicated and budgeted under sub-objective 2.1.1, regular supervision visits will be made from Oblast level to the peripheral levels to ensure quality data recording and reporting. Feedback will be provided through supervision reports. To build staff capacity results will be discussed at Round tables where experiences and lessons learned will be shared.

3.2.2 Implementation of the National TB register at national ands oblast level

The existing standardized monitoring tools will be reviewed and revised with emphasis on analytical cohort analysis.

The TB register is a comprehensive tool for data collection and routine data analysis but is not functional yet. Although a hard copy of the register will be used in the peripheral centers, from Oblast level onward an electronic version of the register will be used. (Probably e-TB, developed by MSH). The current proposal includes maintenance and implementation of the electronic TB register.

3.2.3 Operational research and epidemiological surveys:

Data generated by the monitoring units will help to assess case finding and treatment outcomes (based on cohort analysis). Such routine data collection will be complemented by targeted epidemiological surveys and operational research into program performance (e.g. patient delay, doctor's delay, defaulter studies) and institutional performance (e.g. length of stay, occupation rate, availability of pharmaceuticals, follow-up in ambulatory settings, number of patients visits and times, rate of patient hospitalization). Strategic information generated will be fed into iterative cycles of real time data analysis and program improvement in order to maximize their impact (see ORSA Checklist as an Annex 38).

Sub-objective 3.*3*

To strengthen the capacity of the Ukrainian health system by developing its TB workforce

SDA: HSS Workforce

As described, Ukraine is facing problems related to recruiting and retaining new health workers as well as to the competencies and skills of the existing "graying" staff in the TB sector and among primary health care physicians. To date, Ukraine is lacking sufficient institutional capacity to address these challenges. This (sub) objective includes distinct activities to address the availability of human resources for TB; to modernize both the regular medical education and post-graduate training of TB specialists; to increase the involvement of primary health care physicians in TB care; and to build the necessary institutional capacity for successful human resource development and coordination in the TB sector.

3.3.1 Human Resource Assessment and Planning for TB

In Ukraine, there is a major lack of TB specialists, nurses and laboratory technicians. Around 40% of the

TB specialist positions are vacant and 60 to 70% of doctors are approaching retirement age without any proactive measures to address the situation. This holds true also for nurses and laboratory staff. Options for better adjusting the demand and supply of the workforce need to be analyzed.
Based on a similar approach taken in the area of HIV/AIDS, a comprehensive review will be organized to undertake a situation and gap analysis and to identify potential solutions. The assessment will position the TB sector within the broader health system context and be in line with ongoing efforts in the area of overall planning for health care reform and human resources-related issues such as recruitment, an occupational safe working environment, job satisfaction and retainment. By the use of strategic planning and projection, the assessment will: compare current numbers with the forecast of human resources supply with the anticipated demand over the next years; the current and forecasted geographical distribution; look at career opportunities among specialties and cadres; address strategies to improve the attractiveness and prestige of the TB professions; propose strategies to tackle occupational hazards; review the task distribution between various professional categories (physicians, nurses, social workers, lab technicians, and procurement specialists); and identify measures to match supply with demand (for instance, greater use of task-shifting from more to less specialized cadres and/or facilities; greater involvement of social workers and psychologists in social service support; and the mobilization of existing human resources including a reorientation of nurses, who were previously in charge of mass screenings will be reduced and targeted toward at risk populations). The assessment will assist in the preparation of a TB sector national human resource development plan guiding the recruitment and retention, distribution, and training of human resources for TB-related care and support in Ukraine. Implementation of the assessment, development of the plan and oversight of its implementation will be coordinated by an Intersectoral working group on Human Resources for TB.

3.3.2 Modernizing routine pre- and post-graduate training for TB

While it is recognized that during the DOTS introduction phase significant in-service training needs to occur to rapidly upgrade existing TB specialists (budgeted under various SDAs), initial and continued education of health workers needs to rely on the state-financed routine pre- and post-graduate educational institutions for professionals. This proposal seeks funding for the pre- and postgraduate academic system for TB specialists and primary health care (PHC) physicians to fully adapt its teaching practices to the new national TB treatment approach.
Reforming the current TB specific education in universities and relevant schools will be founded on a review of content of existing curricula for pre- and postgraduate education for all relevant cadres (including TB specialists, nurses, social workers, psychologists), based on a number of standard curricula developed on basis of international guidelines and best practices. Curricula revision and subsequent training of academics covering 22 nursing schools, 18 medical school and 3 academies for post-graduate education in Ukraine will support ongoing reform of the medical educational system in the context of EU integration (including Bologna process), in particular with regard to the transition of TB specialization to a wider respiratory disease specialization.

3.3.3 Introducing PAL for primary health care physicians

For primary health care physicians, a process will be launched leading to the adaptation of the WHO-supported Practical Approach to Lung Health (PAL) for Ukraine in view of integrating of PAL training into regular post-graduate training for primary health care physicians and TB specialists in Ukraine. This proposal seeks funding for the creation of a PAL Task Force and a PAL focal point at ministerial level, a PAL assessment mission, the adaptation of PAL standards of care and its review for clinicians. It will lead to the development of a country implementation strategy for PAL, starting with pilot projects, capitalizing existing resources (in particular the routine post graduate education system for PHC physicians) and specifying additional resources as needed.

3.3.4 Building institutional capacity for TB coordination

Following recent strengthening of government leadership in TB (also see objective 3.1), the National TB Control Center is mandated to coordinate efforts related to human resource development and training. While a core staff position is funded by the state budget, additional consultant support is needed throughout the phase of human resource planning and curricula development (including PAL instruction) to put the human resource planning and training agenda on track for later follow-up by core TB staff.

It is expected that the combination of planning for increased human resource availability, improving regular education for generalists and TB specialists, and strengthening institutional capacity of the TB Center for capacity building will improve significantly the recruitment and availability of a sufficiently

qualified health workforce. In particular, the development of post graduate training capacity and planning will pave the way for sustainable, long term and state- funded continued TB education following the current phase of in-service trainings implemented by key partners to rapidly train existing staff in newly adopted approaches to TB control. The phased introduction of PAL will be a key component for strengthening PHC involvement in TB control, particularly in view of increased access to TB services for vulnerable and poor populations.

The Ministry of Health of Ukraine (MOH) is responsible for the achievement of this objective and performance of the mentioned activities, and collaborates with the Ministry of Education & Science and the Ministry of Labor & Social Services, as appropriate.

Objective 4: To increase overall access to TB diagnosis, treatment and care through awareness raising, mobilization of political support and reduction of stigma

SDA: Advocacy, Communication and Social Mobilization (ACSM)

ACSM is an essential element of the STOP TB strategy and plays a critical role for creating a supportive societal, political and service delivery environment for TB control. Yet, to date ACSM efforts on TB in Ukraine have been sporadic. The following weaknesses characterize the current situation:

- Absence of national and regional ACSM coordination and strategic/operational planning
- Absence of appropriate funding mechanism
- Lack of social and civil society mobilization and NGO capacity
- Lack of political commitment, in particular at regional level
- Lack of awareness among the general population
- Prevailing stigma and discrimination among social workers and health professionals

While the provision of ACSM has been enshrined in the National TB Program, no funds are available for such activities from the state budget. This proposal hence includes a number of critical ACSM interventions that will together constitute a core ACSM Program of work.

4.1 ACSM strategy development and coordination

A National ACSM Task Force will be established and coordinated by the NGO sector, including representatives from NGOs, vulnerable communities, clinical services, and relevant government institutions (TB Center, TB/HIV Committee, Social Services), working closely with the Regional TB Coordinators (government funded). In each of the 27 oblasts, NGOs will be identified and supported to take on a regional ACSM coordination role, including the development and implementation of ACSM plans.

In the first year, a comprehensive ACSM strategy and operational plan will be developed under oversight of the Task Force, based on a comprehensive survey of knowledge, attitudes, and practices (KAPB) among clients and providers, and based on a TB response needs assessment. The strategy will be designed to meet global targets for TB control and be coordinated and leveraged with other ACSM efforts including TB projects by national and international (PATH) NGOs. The *Patient's Charter for Tuberculosis Care* will serve as the foundation for all ACSM efforts.

The initial KAPB survey will use qualitative and quantitative approaches and include groups with limited access to TB services, health workers, prison administrators, and NGO staff to find gaps in services; social barriers to access to diagnosis and treatment; determine client satisfaction with current TB services and how they could be improved; determine reasons why certain populations (e.g. PLWHAs, the socioeconomic disadvantaged, *Roma,* prisoners) delay seeking treatment and/or default on treatment; and the necessary motivation for patients to adhere to treatment. While the first KAPB study will provide a baseline of information on which to build the ACSM strategy. The strategy helps in setting priorities among the interventions, planning, budgeting, decision making on messages etc. It avoids overlapping activities of the many NGOs. A second KAPB in year 3 will evaluate and inform changes to (adjust) approaches for the next two years.

To avoid duplication, an initial needs assessment will review lessons learned and availability of existing ACSM research data and IEC/BCC materials resulting from current Ukraine TB projects. The needs assessment will focus on the quantification of needs and the mapping of existing financial, institutional and human resources for ACSM provision. The assessment will focus on five oblasts that represent the

various geographic regions.
The National Task Force and will meet regularly with partner organizations to identify progress, results, identify issues/solutions and to coordinate action plans. Once per year meetings of NGOs involved in regional ACSM coordination will be organized for joint strategy development, information dissemination, capacity building and exchange of experience.

4.2 Civil society and social mobilization

Both NGOs and individual community leaders will be mobilized to promote increased access to high quality TB services among vulnerable groups.
Local NGO representatives (25 annually) will be trained in advocacy and social mobilization, and receive support in the preparation of grant applications for those mentioned in this proposal, as well as for other grant mechanisms such as the Civil Society Challenge Facility (CSCF) project run by the Stop TB Partnership.
Likewise, annually 30 individual community leaders and representatives of local governments (with emphasis on those representing groups with limited access to TB services) will be provided with the opportunity to go through a social mobilization Program that includes an introduction, an implementation and an experience sharing phase.
Following the roll-out of case management for TB DOT (see Objective 2), local NGOs that have already well established relationships with vulnerable groups will be supported to develop and implement intensified TB case finding Programs among vulnerable groups through outreach activities.
A specific effort will be undertaken from year 2 onwards to train and remunerate annually 75 representatives of Roma communities to act as TB mediators in their respective home and neighboring communities.
Recognizing the high rate of loss to follow-up among prisoners on TB treatment following to release (estimated at 30%), a special focus is to develop/strengthen patient-centered case management approaches and social support services that are designed to improve post release treatment adherence. NGOs will be enabled to provide patient support and counseling to about 1830 prisoners yearly in order to facilitate their successful transfer to civilian life and continued TB care, including motivational and social support, administrative support and pro-active liaison with the 'receiving' TB service and case manager (see objective 2).

4.3 Mobilizing political commitment

A number of advocacy interventions aim to increase political commitment by addressing lawmakers, key stakeholders and donors in order to strengthen political commitment and budgets to support the international TB best standards of practice. These interventions will build on past efforts that have helped at national and regional levels to establish the NTP and to increase civil-society involvement in TB care. Key efforts include the organization of public hearings in the Ukrainian Parliament, press conferences at the national level, round tables on priority TB issues at the regional level and advocacy events at the local level. The coordinated efforts of national, regional and local governments and national and international NGOs will result in building a strong Partnership at all levels.

4.4 Increase public awareness

A variety of communication interventions will be conducted at national and regional levels to raise awareness of the general population:
Limited IEC/BCC materials have already been produced by PATH and other groups. To avoid duplication and support value added activities, the need for new IEC/BCC materials for specific target audiences will be determined through the initial needs analysis and KAPB survey. Existing materials will be reviewed and updated based on the formative research from the KAPB study and reprinted. New IEC/BCC materials will be developed for specific populations, such as prisoners about to be released, to encourage continued treatment adherence.
Awareness campaigns throughout the year will culminate in the organization of public events on the occasion of World TB Day that will be supported both at a national level and in all 27 oblasts.
TB introduction workshops will be provided for journalists based on a successful model developed in the last years in Donetsk Oblast by FDU, and journalistic competitions will be launched as an incentive for the production and publication of good features.
Building on opportunities for free public social advertising in mass media created by respective legislation in Ukraine, a concept and logo for social mass communication will be designed.
A series of public service announcements (TV, radio) as well as social advertising media (posters, billboards) will be developed and produced for free-of-charge placement. Such mass communication will

improve TB knowledge and attitudes among general and specific populations, contribute to reduced stigma and discrimination by clarifying misperceptions and support positive behavioral change to increase early detection and treatment adherence.
As of year 2 in all 27oblasts, key persons of local/regional authorities and public institutions that act as opinion leaders and resources in their respective organizations, will be invited to a seminar on TB and TB control. Providing them with proper information to distribute further will help reducing stigma.
Job aids (desk top consultations) in the form of a flip chart to support medical staff during patient counseling will help to motivate and support people affected by TB to seek early diagnosis, adhere to treatment and promote client-centered care.
Additionally, training provided to health care workers, concurrent with mass media TB efforts, will contribute to decrease the stigma and discrimination among health workers (PATH, 2007).
As an important complement to mass media, specific support will be provided for the nationwide expansion of an already existing TB Hotline in Donetsk Oblast (funded by FDU), and the expansion and regular maintenance of a TB internet portal for the general public (www.stoptb.in.ua).

References:

1. PATH Support to Ukraine to Implement the National Tuberculosis Program: Final Report, PATH, Seattle, 2006.
2. Assessment of the work of pilot facilities of Donetsk Oblast' on DOTS strategy implementation, WHO Country Office in Ukraine, Kiev, 2006.
3. Monitoring Mission to Ukraine, Donetsk Oblast, WHO Stop TB Department. March 14-19, 2005.
4. Joint review of Tuberculosis Control Program in Ukraine for 2001-2005. Report 13-24 February 2006. Rayevsky Scientific Publishers, Kyiv, 2006
5. Fabrice Gerard. Tuberculosis Plan for GF8 Application. Laboratory services. O8 June 2008.
6. Advocacy, Communication and Social Mobilization (ACSM) for Tuberculosis Control. A Handbook for Country Programs. WHO-2007.

4.5.2. Re-submission of Round 8 (or Round 7) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 8 (or, Round 7, if that was the last application applied for and not recommended for funding).

Weakness 1: Limited prior experience of the Principal Recipient in managing large grants, nevertheless they will be supported by UNDP
In the case of the Round 8 submission, there were designated two PRs: The MOH and URCS. The MOH had entered into a financial support agreement with UNDP for managerial and financial management support. In the resubmission of the Round 8 proposal, neither one requested to be a PR, but rather wanted to be a SR.
A unique situation presented itself for Round 9. A charitable foundation requested to be a PR, was scrutinized by the TRP, and nominated by the NC. This charitable foundation was established by a Ukrainian philanthropist with a very strong interest in TB control, especially MDR-TB. Currently, it has a cooperative five-year $20 million grant agreement with the Donetsk Oblast Administration.
However, in order to compensate for this lack of managing significantly larger nation-wide grants, it has allied itself with a strong group of potential SRs, which have more extensive experience.
In particular, the International HIV/AIDS Alliance in Ukraine had successfully managed the Round 1, Stewardship Grant in HIV (2004 – March2009) with the total budget of *ca.* $100 million and since August 2007 is one of the Round 6 (HIV) co-PRs, completing implementation of the Phase 1 with a $15 million budget (by mid-2009) and looking towards Phase 2 with maximum possible budget of over $66 million USD. The Alliance will support PSM-related activities, SDA_3 (HIV-TB co-infection), and capacity building for the Foundation. Another strong partner will be PATH, which will be engaged as a SR in managing SDA_2 (DOTS services) and SDA_7 (MDR).
Future partners (SRs) approved by the NC are the National TB Center at the MOH, Prison Department, Alliance, PATH, and the URCS. Others yet to be named will join their ranks as partners.

Weakness 2: Prior suspension of an HIV grant is not mentioned in this proposal and how the lessons learned would be taken into consideration
The suspension of the Round 1 grant was a wake-up call for many here in Ukraine as well as the GFATM in Geneva. Members of Ukrainian civil society that played the key role in that suspension have continued

to play on-going proactive roles as the proverbial watch dogs for society and have continued to demand transparency and accountability. Since Round 1 there have been several more complaints of inappropriate expenses and/or tenders brought to the GFATM's attention. These are the result of that continued diligent vigilance.
A recent proposal by civil society this year for the NC to resurrect its pre-existing, but dormant, committees is another step forward in that process. The proposal seeks to bring better governance to the managing of national HIV/TB programs by combining in a systematic manner the Committee (MOH)/Secretariat (NC), the NC Committees, and the supporting TWGs. Its ultimate purposes are to provide for a greater inclusion of stakeholders in oversight processes leading to greater transparency in all national HIV/TB programs. The NC's quick and positive response to this request is a positive sign.

Weakness 3: The number of laboratories at all levels is too large when compared to the number of cases. For example, there are 21 level-2 and 4 level-3 labs in one oblast
Sparked by the Round 8 TRP report and findings of external WHO laboratory-related consultations, this issue has remained a source of concern. Because this stagnation dilutes efforts at establishing an integrated and more professional nation-wide network of TB laboratories, there have been intensive lobbying efforts by international organizations and civil society following the WHO's recommendations to downsize the existing laboratory network, while boosting their professional competencies. As a result, MOH agreed to consolidate the laboratories structure at all levels, leading to an overall reduction of number of labs involved in TB of around 70% (see objective 1). Goals are to provide QA/QC at all levels, increased mentoring and supervision, targeted training, and a better and safer work environment.

Weakness 4: The budget for laboratories is very large. For example, the number of safety cabinets requested seems excessive.
In his February 2009 visit, the GFATM Portfolio Manager rigorously talked on this topic. The useful guidance of more attention to detail in activities and purchases (more line-items) was both well-received and duly noted. Efforts were undertaken to translate this into reality for the Round 9 budget. For example, as a result an overall commitment to downsizing the number of laboratories and scrutinizing equipment for each laboratory, the overall budget for the Laboratory Diagnosis Service Delivery Area was reduced by close to 50% compared to the Round 8 submission.

Weakness 5: The costs of the case management teams are excessive. For example, it is questionable whether each team needs a lawyer.
Regrettably, this was clearly an inadvertent misunderstanding and/or misinterpretation, especially as concerns the lawyer. The lawyer was to have been an on-call asset for legal assistance. However, in order to rectify it, we have been even more scrupulous in describing the composition of the case management teams and their associated costs. In addition to core staff of case management team paid by government funds (physicians and nurses), only social workers at hospitals are budgeted as full time positions (FTE), who will be hired by the health care facility and paid for by the GFATM. Additional input to the case management team by outside resources providing consultations and support services, as well as case management support provided at the peripheral level are budget as "fees for service" . These are scaled to be very modest in nature and in concert with acceptable compensation. As a result, the budget for service delivery area High Quality DOT was reduced by around 30%.

Weakness 6: The costs of developing and revising guidelines and protocols are excessive
Each cost item related to the development and/or revision of guidelines and protocols been scrutinized with regard to its necessity and added value. Consequently, it was possible to significantly lower associated costs. Due to the work of many partners over the past years, available guidelines, protocols and training material is plentiful – hence there is little need for the development of new guidelines from scratch. Rather, recognizing the importance of common approaches to treatment and training, emphasis will be placed on the harmonization and standardization of the existing guidelines and material between different implementing partners and across different levels and regions.

Weakness 7: Activity 3.5: Development, printing and distribution of materials at US$ 1.2 million is excessive
The development and production of printed information material has been limited to specific information for vulnerable groups to be used in the context of outreach and social support. The elaboration of this material builds on existing brochures and leaflets, and the associated budget has been kept below 300,000 USD. Other costs that have been categorized as "communication" refer to the implementation of

advocacy efforts and include activities such as press conferences, roundtables, journalist competitions, social advertising, internet site and a telephone hotline. These are deemed to be essential parts of the TB program's ACSM component.

Weakness 8: No indicators measuring results among vulnerable groups
Indicator 2.1 measuring the defaulter rate predicts a significant decrease as immediate results of efforts to improve enrollment of vulnerable groups into TB care (Objective 4) and of the introduction of case management and outreach with a focus on vulnerable groups (Objective 2).

Weakness 9: The indicators on leadership governance, advocacy, communication and social mobilization (ACSM) and workforce need to be further developed
Based on consultation with international experts, indicators in all three areas were further developed as follows: (1) Leadership: An additional indicator was introduced (# of supervisory visits from central to regional and regional to district level) to measure actual increases in guidance for Program implementers. This is complementary to the training indicator that was retained. (2) ACSM: The indicator of number of patients trained was changed to a more strategic indicator of development of regional ACSM strategies, reflecting the leadership of local TB council in ACSM. (3) Workforce: A combination of two capacity building indicators was chosen, with one (# of health and social workers trained in case management and/or patient support) reflecting the roll-out of in-service training, while the other (# of medical and nursing schools having revised their TB curricula) reflecting efforts to reform the pre-service education.

Weakness 10: No reference to the national framework for salaries and allowances
This weakness was identified by the Global Fund with regard to the Principle Recipient for Round 8, namely the Ministry of Health, which is a state structure.

In the Round 9 proposal the nominated Principle Recipient is not a governmental structure but the charitable foundation, therefore the Weakness 10 is not directly applicable.

With regard to the nature of the weakness the following principles and documents were used for calculations of salaries and allowances of the nominated PR for Round 9:

- Figures provided by the FDU Staff List calculations, which reflect the existing organizational structure and level of remuneration;
- Planned Salary Grid which is going to be introduced by FDU as a part of remuneration review based on the fair market price (independent salary survey) and relevant organizational needs.

It should be noted that both documents are available upon request.

In Addition:

- The FDU is aware of the "current going rate" for services (fee for service), consulting fees for both senior international and domestic experts (based on UN, USAID, and EU scales) in order to be competitive. It is also aware of what other PRs are currently paying staff.
- For calculating costs of food and lodging for mission travel and training travel, the FDU has researched the available USG, UN, and EU tables for deciding on appropriate travel-related costs.

Weakness 11: Unclear why it is reported that there are too few Tuberculosis specialists and many generalists
The proposal wanted to highlight that this was a major concern for the future of TB control activities. The population of current TB physicians, nurses, and laboratory personnel are "graying" and recruitment efforts are not meeting the exodus of these workers through retirement or moving into other non-health related occupations. Working in the TB sector has become unattractive to young professionals. It is seen to be dangerous occupationally and unrewarding professionally. Therefore, in looking ahead, the proposal tried to address the situation in Round 8 and now more vigorously in this resubmission. Throughout this proposal there are initiatives directed towards remedying the situation, in particular with regard to paving the way for redistribution of work between echelons of care (task shifting, reduction of hospitalization rates, increasing ambulatory care and PHC involvement) and hence redressing the relative shortage of TB staff.

Weakness 12: Lack of information on operational research which will be carried out by

academics, NGOs and CBOs
The Round 8 submission proposed Operations Research/Systems Analysis (ORSA) that was directed towards GOs monitoring and managing DOTS-related roll-out activities, e.g. the setting up and using of Program Evaluation and Review Technique (PERT). In this resubmission, training on operational research is expanded to also include other groups (NGOs, CBOs, and Academia). Specific provisions to undertake operational research are made in the areas of HIV/TB surveillance, TB infection control, MDR-TB, HIV testing and counseling for people with TB, and under monitoring and evaluation (see paragraph 3.2.3. in section 4.5.1. and Annex 38).

Weakness 13: Given that under the Global Fund's grant agreement the Principal Recipient is strongly encouraged to ensure that the purchase of any goods or service using grant funds by the Principal Recipient and any Sub-recipients are free from taxes and duties, there is a need to disaggregate customs, insurance, storage and distribution costs and to justify or remove custom fees
With the Alliance tapped to be the lead agency in PSM In the Round 9 Application set up of the Principal Recipient and a set of Sub-Recipients, the Alliance Ukraine is envisaged to be the sub-recipient responsible for the procurement and supply of pharmaceuticals and other health-related products. Over the period of the Round1 Stewardship and Round 6 HIV Grants to Ukraine, the Alliance has achieved an excellent track record in PSM. To ensure that goods purchased with GFATM grant money are free of taxes and duties, the Alliance intends to apply the same legal framework for exemptions that was developed and used for GFATM Round 6 grant. The details of this strategy are seen in Annex 39 and letter from Commission on Humanitarian Aid under KMU (see Annex 40).
It should be noted that this mechanism is fully supported by the Ministry o**f** Health of Ukraine.

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)?

Many of the "lessons learned" were based on the activities of WHO, PATH, the Alliance, and other organizations that have moved the process forward on the nation-wide implementation of the DOTS strategy, MDR-TB issues, and issues related to HIV/AIDS co-infection.

In general: There remains the constant factor that many of the clinical approaches and preventive practices were based on previous Soviet experiences. In an unconstrained resource system such inefficiency could persist. However, in the current resource-constrained situation, this will not work.

As has been addressed previously, many are greatly concerned with the "graying population" in the TB sector. Yet doctors, nurses, and laboratory staff at (or beyond) retirement age, as products of the old system, have a natural tendency in times of uncertainty to revert back what was quite comfortable. It is becoming difficult to justify two "stovepipe" or vertical systems. Thus, this current economic climate presents an opportunity to adapt to changing environments with "new" methodologies (DOTS), integrated services for co-infected, and disciplined therapeutic approaches to MDR-TB. Efforts by PATH (USAID-funded) introduced new approaches for dealing with the two interrelated epidemics: HIV and TB. PATH proactively supported in several oblast and district coordination councils for the coordination of plans and services stimulating functional coordination councils and physician exchanges between AIDS Center and TB Dispensaries. Physicians have welcomed these new opportunities and challenges to work together to lessen the burden of HIV/TB confections. All understand that TB is the causative agent in over 50% of AIDS-related deaths. Concurrent with this is enhancement of the CMT approach and the effective use of URCS nurses in the Continuation Phase of DOTS. Initial results of increasing successful completion rates are encouraging. PATH is expanding into a Total of 10 Oblasts.

Additionally, the Round 6 experiences of the Network in dealing with co-infection will form the basis for a broader-based approach and the institution of drug prophylaxis against TB and other lung diseases.

Continuing with the "graying" theme, there is an increasing number of younger and more energetic physicians working in primary health care clinics. Based on successful introduction of the WHO-developed PAL program in this geographical region, this proposal takes steps towards the introduction of PAL, leading to the development of a national implementation plan. Ultimately, we will seek over time to have better trained and informed primary care physicians operating out of PHCs who will provide

improved access to TB services for those with previous limited access.

An emphasis on ambulatory care, treatment and support: This proposal follows the "lessons learned" from the PATH pilot noted above will have the engagement of URCS nurses and NGO social servicing staff, in addition to clinical staff. As a centerpiece of this will be the Case Management Team, where there is be a greater engagement by the other health care and social service partners in attending to the clinical and social care needs of the patients. This approach directly stems from experience in pilot projects in providing case-based adherence support to vulnerable populations, demonstrating an impressive reduction in defaulter rates (e.g. in Red Cross project, Zaporizhya region). Such experience is confirmed by similar success in case-based adherence support to ART in the GFATM Round 6 grant. It has been shown that the introduction of case management contributes to timely discharge of DOTS patients and in the ambulatory phase facilitates better patient therapeutic adherence, which leads to high levels of treatment completion. By meeting or exceeding the expectations of these vulnerable populations, it is desired that an add-on benefits will be patients sharing their positive experiences and others, who suspect that they may have TB, will step forward for evaluation and treatment.

Previous pilots demonstrated a lack of preparedness to provide good basic microscopy: one based on a high level of confidence. At the time many microscopes were old and monocular (leading to eye strain and inefficiencies over time); however, with the benefit of the World Bank loan most of these instruments were converted over to binocular. There are high expectations that the introduction of a QA/QC program in this grant will raise the professional level of microscopic examinations.

Most critical; however, in the past has been the lack of a clearly defined National Reference Laboratory (NRL) with its liaison upwards to a supranational laboratory and downwards to its oversight of Level 1- 3 laboratories. With the institutionalization of a functional NRL and subsequent real laboratory network providing support to the smaller TB laboratories, there can be the introduction of a viable and stimulating QA/QC system.

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).*

In Ukraine, as in nearly all European countries, males predominate among TB cases[22]. The higher proportion of male cases reported by TB programs may reflect a greater prevalence among men, or it may be a result of persisting socioeconomic, cultural, and health service-access barriers that disproportionately affect timely diagnosis and treatment in women. Many individuals with TB experience discrimination because TB is considered a disease of poverty, associated with the homeless, drug users, alcoholics, and prisoners.[23]

Some of internationally-recognized findings on gender and TB control are:

- The incidence rates for TB are higher in adult men; the reason is poorly understood.
- Disease progression and fatality of TB is higher for women of reproductive age.
- While men are better able to access TB treatment, they are less likely to successfully complete their treatment.[24]
- Diagnostic delay is more problematic for women.
- Frequent and intense reports of psychological and emotional distress with gender-specific features indicate serious effects on mental health of women.
- Women experience greater TB-related stigma than men.
- Costs associated with access to TB diagnostics and treatment, may appear higher for women than for men, as their perceived roles vary within a household.

Gender relations in Ukraine are complex and their influence on health is not yet clear. Socio-economic and cultural factors play important roles in determining overall gender differences in rates of infection and progression to disease; access to case detection and successful treatment of TB. Therefore, TB control and research programs need to be gender-sensitive and take the necessary measures in all their efforts.

ROUND 9 – Tuberculosis

To date, there has been no specific research to investigate the link between TB and gender in Ukraine. Attitude studies reflect comparable levels of knowledge about TB in men and women[25]. Health statistics disaggregate most data according to gender; however, gender interpretation of statistical data is insufficient. There is a need for inter-disciplinary research to establish the link between gender, age, income, ethnicity and vulnerability to TB, access to case detection, treatment and care systems. New epidemiological surveys need to include standardized indicators that would help establish a standard of sex-ratios.

Under concrete objectives, following gender specific aspects are included:

In Objective 1: Improve detection of TB cases in laboratory: maintain routine disaggregation of lab detection data on gender, age, income, type of population unit, etc. as determined by program strategy

In Objective 2: Enhance access to TB services for groups with limited access: Country wide introduction of a case management approach based on specific training for health and social TB services providers provides an opportunity to better understand and address gender aspects impacting on enrollment into, and adherence to, TB care..

In Objective 3: Contribute to Health Systems Strengthening: Opportunity to implement operational research on gender-sensitive TB control, publish, disseminate and discuss results in national meetings.

In Objective 4: Systematically address gender and social disparity through ACSM by specifically including gender into the development of ACSM strategies in all 27 oblasts and by developing advocacy materials and activities that specifically address gender and TB.

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.

Human resources

Staff-turn over / brain drain: There will great efforts undertaken to train professional and technical staff in the diagnosis, treatment, and care of people living with TB and PLWHA. Yet this workforce labors under very poorly paid, poorly maintained and poorly functional working conditions, and poorly staffed conditions.

In conditions of economic crisis this threat is minimized, but still persist. The urgency of this risk can increase towards years 3 – 5 of project implementation. The Government of Ukraine's strategy has been to examine the possibility to introduce pay differentials for physicians. Many times this has been attempted without constant success. Local government has become more pragmatic in their recruitment efforts for professional staff by proposing that apartments be given to physicians for long-term contracts. However, the focus of these efforts is on physicians and not on nurses or laboratory technicians. Ukraine is not suffering from an absolute shortage of health workers, but rather from migration of health workers to other sectors. Hence, while it is hoped that improvements in working conditions budgeted under this proposal will attract more health professionals into TB, it is not expected that such would be at the detriment of other parts of the health sector, but rather counteract movement to other sectors. However, a human resources task force will be launched and convened regularly throughout the implementation phase to monitor the situation and mitigate risks as appropriate.

Program management

The National TB program is more input-oriented rather than outcome-oriented. The program does not identify outcome indicators, which in the course of GFATM-funded project can lead to different approaches towards the National program implementation. Consequently it may give rise to the opposition at the national level, the oblast level and the level of TB facilities.
Through this proposal, involvement and collaboration of partners at the national and regional level will be improved, providing and opportunity to dialogue and agree on shared approaches to Program planning and implementation. In addition, a substantial training Program on modern Program planning and management will be rolled-out contribution to a diffusion of internationally accepted management approaches.

Monitoring and evaluation are formalized. In general, the M&E system does not provide an objective picture, and there are cases when evaluations performed by the government bodies in oblasts produced absolutely different results from those of international organizations and Ukrainian NGOs.

The government has a political will and seeks to improve the situation. A TB Center is being established with the functions and responsibility to develop adequate evaluation frameworks and structures, as well as introduction of evaluation criteria regarding performance at the regional and local levels. National Council is currently involved in this activity, receiving reports from oblasts. Regional TB monitoring will receive specific training to play an active role in the critical assessment of data generated by routine surveillance, Program monitoring and additional research.

Financial resources

Funding at the National level: There is a danger that the Ministry of Finance may see a situation by which the GFATM grant will have a greater responsibility for a greater part of the TB program and the MOF will distance itself from a credible degree of co-sharing. Therefore, sufficient funding may not be forthcoming to have a fully functioning program at the national level, which would have an adverse

influence on the *infrastructure* that will affect many of the co-related MOH functions.

The National TB program includes annual budgetary commitments that will be monitored closely by both the Presidential Council and the National Council on TB and HIV/AIDS. As "watchdogs" both councils have a main role in assure the additionally of GFAMT funding.

Funding at lower echelons of government: Financial constraints at the regional levels will hinder the implementation of activities of the National TB program at the regional, rayon, and local levels. This will lead to a situation; whereby, the GFATM proposal will appear as a stand-alone initiative and become increasing.

Clearly, local government must strive to meet the expectations of its citizens and make the difficult resource allocations. This is not done in a static environment, but is subject to the degree of political will and other societal issues. Substantial provision are made in this proposal to ensure full involvement of regional governments in the implementation of this Program and to create a sense of ownership.

NGO-related issues: There is a near drought of qualified individuals to join the ranks of the NGOs. As the number of programs increase and, consequently the demand for staff increases, the pool of young professional's available shrinks. Within the NGO community itself, there has been a substantial salary scale established by the larger NGOs in contrast to the smaller NGOs. Their ability to recruit is hampered by their inability to match the higher salaries and benefits paid by the larger NGOs. This inequality of payment for similar work has a negative effect not only on morale, but hampers efforts to have a greater degree of diversity in the NGO community. One may foresee a continuation of this situation in the NGO-TB sector, as a consequence, of a *ca.* $100 million grant. After all, NGOs fulfill a public service function.

Pay scales for NGOs used in this proposal have been established at comparable basis between NGOs in order to avoid undue distortion. Flows of human resources from the government to NGP sector will be monitored by the Human Resource Task Force and corrective actions proposed as appropriate.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

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

Proposals should clearly explain if this proposal requests support for the same interventions that are already planned under an existing grant or approved Round 7 or Round 8 proposal, and how there is no duplication. Also, it is important to comment on the reason for implementation delays in existing Global Fund grants, and what is being done to resolve these issues so that they do not also affect implementation of this proposal.

Two GFATM projects have been implemented in Ukraine since 2003. Both grants were applied for HIV/AIDS component. The goal of Round 1 was to provide HIV-positive people in Ukraine to basic services for prevention, treatment, care and support. The development of HIV services also targeted the introduction of TB screening for PLWH but did not get sufficient due to main focus on scaling up access to antiretroviral therapy. Round 1 also included development of National Treatment Guidelines on Management of HIV/TB co-infection and conducting a series of trainings for HIV-specialist to highlight specific features of TB in PLWH. Round 1 was officially completed (finished) on March 31, 2009.

The Round 6 proposal targets vulnerable populations with a special focus on HIV/TB co-infection. The main goal of the Round 6 activities is to strengthen capacity for treatment sites to specifically address HIV/TB co-infection, based on the internationally-recommended DOTS strategy and best practices for management of TB/HIV co-infection. The key challenges on early diagnosis and effective management of HIV/TB co-infection in Ukraine addressed in Round 6 proposal are as follow:

- lack of knowledge and skills among TB and HIV specialists on management of TB/HIV co-infection
- limited access of vulnerable populations mainly IDUs to TB services due to their remoteness, and solitude;
- verticalization of TB services as well as HIV services (with limited access to specific services such as sputum test, TB diagnosis and TB treatment provision

- no access to other than TB treatment services at TB facilities such as substitution therapy and ART
- high level of stigma, discrimination rejection of PLWH and vulnerable populations at medical institution outside of AIDS system.

The challenges mentioned above are resolving through procurement and delivery TB consumables such as sputum containers, ELISA test-kits for TB diagnosis culture tests to ensure early diagnosis of TB in PLWH. Those diagnosed with active TB are referred for treatment to TB institution. To the date, 4556 PLWHs benefited from the Program. 1360 of them were diagnosed with active TB and started TB treatment under supervision of care and support projects. At the same time Phase I outcomes have forced the Working Group to revise its strategy due to low sensitivity of ELISA tests and ineffectiveness of utilization high tech tests for PLWH. The only sputum containers will be procured to cover up to 20,000 PLWHA until mid-2012 with diagnostic of smears positive TB. Other procurements are replanned to ensure PLWH's access to other diagnostic technique such as X-ray, lymph node biopsy, CT scan and others.

Round 6 has also requested integration of HIV and TB services. Using outreach programs as an entry point for IDU clients with TB/HIV co-infection, the Round 6 is supporting the introduction and implementation of integrated and comprehensive care for PLWH including DOT, ART, substitution treatment and social support. A new care model is piloted in 5 regions of Ukraine and will be gradually being expanded across the country. TB treatment has not been covered under any of Global Fund grants as medications for TB treatment are provided under the National TB program.

Round 6 grants have also addressed policy and training imperatives related to increasing capacity of national postgraduate education through development of an HIV National Training Center, upgrade and certification of trainings module according to national legislation as well as related issues (harm reduction program, social support, and multidisciplinary team approach). Further training will support the reduction of stigma and discrimination among health care workers both medical professionals and social workers who are mandated to provide integrated TB/HIV treatment and care services based on a client-centered approach. Appropriate supervision follows the training session through training performance scoring and on-site mentoring by experienced national experts on HIV, TB, and ST.

Round 6 has continued support for the development/revision of a National treatment protocol integrated treatment for HIV, ST and TB, based on international standards. Currently 4000 copies of the new protocol are distributed to end-users and the next revision is planned for 2010. The protocol includes standards for case management, referral systems and check list for TB suspicion in PLWH. Launching of TB-DOTS, ART and ST at one site for triple affected patients is another objective of Round 6. Close monitoring and appropriate TA are provided by PRs and national experts to ensure quality, timeliness and effectiveness of TB/HIV services to improve performance of the program.

Round 9 applications aim to cover the missing elements of «STOP TB Interim Policy of Collaborative TB/HIV Activities» and do not duplicate the activity of Round 6. In particular, the following activities are planned: introduction of innovative harm reduction programs in TB clinics, CD4 diagnostic for TB patients co-infected with HIV for timely enrollment on ART and improvement of infection control at HIV services. Increasing awareness of PLWH on TB symptoms will facilitate timely presentation to medical institutions. Round 9 will also support enhancing the knowledge of health workers to intensify TB case detection in PLWHA through training session. This activity is coordinated with Round 6 and is scheduled to pick up after its completion.

4.6.2. Links to non-Global Fund sourced support

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

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

ROUND 9 – Tuberculosis

The main non-Global Fund source of support for TB control in Ukraine comes from the United States Agency for International Development (USAID) through its main implementing partner, PATH, which has been active in TB control in the country since 2001. As part of its continuing commitment to TB control in Ukraine, USAID extended its support to PATH through a new four-year contract, initiated in 2008. Funding provided may be up to $9.6 million.

The goal of program is to continue improving TB case detection and management and to reduce the TB-related burden of disease in Ukraine. Its overall approach is to

- Determine a strategy for DOTS roll out that maximizes improved TB detection and treatment success rates and secures sustained national and local support,
- Reach "hot spots" of TB and HIV as well as large population groups for an impact on the epidemic
- Collaborate closely with local managers and staff (both free and incarcerated populations) to ensure capacity building at the Oblast and Rayon level.

Specifically, PATH is supporting Ukraine in expanding international standards for TB control and improving the quality of TB services in 10 administrative territories of Ukraine (7 oblasts: Khersonska, Zaporizhska, Dnipropetrovska, Donetska, Odesska, Luganska, Kharkivska; Autonomic Republic of Crimea; and 2 cities: Kyiv and Sevastopol). To ensure sustainability of effective TB-related interventions at national and regional levels, the project seeks to enable the Government of Ukraine (GOU) to make critical, technically sound policy and program decisions to improve TB and TB/HIV control in accordance with international best practices. The project also intensifies efforts to assist the GOU in building the adequate capacity of the TB control system to address the growing MDR/XDR-TB burden. The project also partners with Ukraine's civil society groups active in the TB and TB/HIV to bolster GOU's commitment to improving TB control and to catalyze the establishment of GOU-civil society partnerships in monitoring and evaluating the implementation of the National TB Control Plan for 2007- 2011.

Planned Achievements

The four specific objectives, which encompass activities in DOTS expansion, laboratory strengthening, information systems improvement, ACSM, X/MDR-TB control, and TB/HIV, are as follows:

- Roll-out and improve the quality of DOTS -based services to 50% of the Ukrainian population;
- Introduce and scale-up DOTS Plus services - the detection and treatment of MDR-TB and XDR-TB- in the project regions by 2011
- Provide access to TB/HIV co-infection services to 30% of the Ukrainian population by 2011
- Create an enabling environment for DOTS implementation by removing or reducing existing policy and attitudinal barriers.

During the remaining term of its contract, which would overlap with Global Fund R9 support if successful, PATH will continue expanding high-quality DOTS services to cover the entire population of those administrative areas. This includes ongoing training of health care practitioners. During the past year, PATH organized an assessment of TB facilities, including laboratories, by specialists from the Latvia State Agency for Tuberculosis and Lung Diseases, with the goal of selecting an Oblast TB Dispensary to become a multidrug resistant (MDR) TB Center of Excellence in Ukraine. The project expects to establish and support this Center in the coming year and throughout the duration of the project. PATH intends to continue collaborating with Futures Group International and others to build the capacity of the Regional Coordination Councils on TB and HIV/AIDS to improve coordination and quality of services for co-infected individuals. Within the framework of these joint efforts, PATH will continue providing technical support to strengthen the Regional Coordination Councils' functions in guiding and monitoring TB/HIV collaborative activities at local and regional levels in the project oblasts. In addition, PATH intends to conduct operational research regarding ex-prisoners' social support and health protection needs related to TB and TB/HIV issues, the findings of which will support strategic planning and decision-making processes within the Regional Coordination Councils. In addition, with PATH technical support, the MOH Advisory Group on monitoring and effective implementation of the national TB program approved revisions of the temporary TB statistical forms provided by specialists from project regions and PATH will assist in rolling out the use of these revised forms within the civil, penitentiary, and military health care systems and improving routine TB surveillance at primary health facility, district, regional, and central levels. PATH also will assist in the implementation of Ukraine's first protocol on drug resistant TB case management, which was drafted with PATH technical assistance.

It is important to note that all USAID-supported activities are concentrated in the 10 administrative regions noted above. In each of these regions, efforts funded through this proposal are building on already implemented or planned activities funded by USAID. Thus, Global Fund support will largely complement these efforts by extending reforms to TB control in the 17 other regions, while support to the 10 regions will be limited to activities not yet covered by the USAID funded Program.

4.6.3. Partnerships with the private sector

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

*(Refer to the Round 9 Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

Development of Ukraine, Rinat Akhmetov's private charitable foundation, is one of the key players in the fight against TB epidemic. Total investments in 2007-2011 on TB will amount to around 11 million USD (100 million UAH). It is important that private investments in this case are integrated in the development of the general anti-TB service system, actions are coordinated and concerted on a necessary level (regional or national), may be regarded as a contribution in the country system of TB control, and is complimentary to the National Strategy and the Global Fund grant.

In the program for Donetsk oblast, the financial contribution is intended to: strengthen laboratory service, train specialists (physicians), strengthen healthcare institutions (repair, equipment, infection control, etc.), develop a staff motivation system, and provide public awareness. At the national level, it includes lobbying and advocacy, public control over quality of preparations and their provision, and support for scientific research. About 80% actions on the STOP TB project supplement actions within the framework of this application to the GF and are therefore considered by the applicants as a contribution in the application.

A nonmaterial contribution is also important. The Development of Ukraine Foundation funded the following activities: development of legislative framework, development of training modules for specialists, evaluation of the Donetsk oblast's laboratory service and infection control, creation of a MDR protocol, establishment of a monitoring center in Donetsk oblast, and guides for journalists.

Besides, the Foundation possesses unique experience in management of comprehensive social projects involving governmental and nongovernmental organizations, including experience of private-public partnership with Ukraine's key state institutions (Ministry of Health and the relevant Verkhovna Rada committee) as well as private-public partnership to overcome TB epidemic in Donetsk oblast in the framework of which a system of single management, coordination of all actions, and co-funding operates. This partnership has a contractual basis and is consolidated by bylaws on the oblast level.

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

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?*) ➔	

Contribution Value (in USD or EURO)

Refer to the Round 9 Guidelines for examples

Organization Name	**Contribution Description** *(in words)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Foundation for the Development of Ukraine	strengthening laboratory service, specialist training, strengthening healthcare institutions, public awareness, lobbying and advocacy	1300000	2100000	1000000	N/A	N/A	N/A

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved tuberculosis outcomes

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

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

The last decade has seen an unprecedented mobilization of Ukrainian civil society for the improvement of public service provision. In the health area, this development was lead by an extensive network of HIV-service NGOs and activists. Civil society has not only assumed a key role in filling gaps in public service provision, but was also a driver for reform of government approaches to service delivery. As a result, government policies and institutions have accelerated transition from a vertically and specialized to and integrated and decentralized health system.

Activities proposed in this document seek to further catalyze this development by strengthening capacity of the health system relevant to improving TB outcomes. They have been identified based on a report of a joint Program review of tuberculosis control in Ukraine (2006, annexed), a reports on laboratory control in Ukraine (2007 and 2009, annexed), and conclusions of a national workshop on health systems strengthening for TB control (2008, annexed). They include:

- Building management and governance capacity: While the establishment of the National Council on TB and HIV/AIDS as well as the ratification of the National TB Plan represents pre-conditions for DOTS roll-out, deficits in management and implementation capacity prevail. Capacity building activities planned in response address both the central and regional level and target core government staff remaining in their positions beyond the project period.
- Laboratory Infrastructure consolidation: Based on recommendation of WHO laboratory missions in 2007 and 2009, Ukraine has started to consolidate the TB laboratory structure under leadership of a National Reference Laboratory aiming to reduce excess capacity and to increase quality. Funds provided through this proposal will support the consolidation process by updating equipment and staff skills based on a transition plan, leaving behind a sustainable and more cost effective laboratory network. Investments in infrastructure and equipment in this grant complement previously received international donor support, i.e. in form of the World Bank loan.
- Primary health care strengthening: Decreasing excess hospitalization rates in TB in Ukraine depends critically on the existence of functional structures for maintaining high quality ambulatory treatment during the continuation phase. Funds requested through this proposal will contribute significantly to implementing government policies on decentralization of TB services by introducing a case management approach to TB treatment and by introducing an outreach component to ambulatory care at the periphery of the health system. It is expected that both components lead increase the rational use of existing capacities by redistributing basic TB care from specialized, hospital based to decentralized, ambulatory services.
- Capacity of community services: Informed by experience of NGO support in HIV treatment adherence support, the proposal includes a major element aiming to extend the relevance of TB services at the community level. In this, activities build on both NGO and GO resources by drawing on the extensive network of Red Cross nurses and volunteers for the provision of social mobilization and support, and on the network of general practitioners in primary health care services. Both represent sustainable pillars of the community health system and it is expected that TB specific capacity building will have a lasting effect that possibly extends beyond the provision of TB services themselves.
- Strategic information: Limited availability of reliable strategic information and/or its under-use have been repeatedly identified as a bottleneck for Program planning and implementation monitoring. Government has responded by the launch of specific TB M&E units at central and regional levels. In this proposal it is planned to contribute to building the capacity of these units to effectively perform their tasks. Again, the approach is to provide support to government structure in their nascent phase with the expectation to have a sustainable impact.

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.

Ukraine is signatory to the Millennium Declaration and adopted the Millennium Development Goals (MDGs), thus committed to building economic and social conditions to improve the welfare of Ukraine's people. The Ukrainian Millennium Development Goals (UMDGs) are quantified and monitored guidelines for the country's long-term development, which have been adapted to the specifics of Ukraine's development. They comprise 6 goals, 13 targets and 23 indicators.

UMDG 1: Poverty Reduction
UMDG 2: Quality life-long education
UMDG 3: Sustainable environmental development
UMDG 4: Improved maternal health and reduced child mortality
UMDG 5: Reducing and slowing down the spread of HIV/AIDS and tuberculosis
UMDG 6: Gender equality

Under UMDG 5, Ukraine set an ambitious Target 1 "To reduce the spread of HIV/AIDS by 13%", and Target 2 "To reduce the number of new TB cases by 42%" by 2015.

Ukraine has also recognized the STOP TB Partnership targets of reducing prevalence and mortality to half of 1990 levels by 2015, and ratified the European Plan 2007-2015 to stop TB in 18 High-priority Countries in the European Region, reiterating global targets and adapting them to the European context (including: to reach 100% DOTS population coverage in all eastern European countries; to increase the case detection rate of new infectious (sputum smear-positive) TB cases to at least 73%; to achieve treatment success in at least 85% of detected new infectious TB cases; to provide treatment according to internationally recommended guidelines for 100% of multidrug-resistant TB cases (new and previously treated).

Based on these commitments, the Government of Ukraine has developed a National TB Program 2007-2011 that is in line with the WHO-recommended Stop TB Strategy and the Global Plan to Stop TB, 2006-2015. Further, the Government of Ukraine has adopted a number of programs within the national development framework that are directly relevant to TB. These include Program of Action of the Cabinet of Ministers of Ukraine "The Ukrainian Breakthrough: for people, not for politicians", the National Plan for Healthcare Development for the period until 2010; and the Ukraine-EU Action Plan.

Reaching ambitious global and national targets represents a serious challenge for Ukraine as both TB and HIV continue to spread. While Ukraine has observed a stabilization of TB incidence and mortality over the last years, indicators are still far above 1990 levels (estimated TB incidence increased from 41 to 102, prevalence of all TB forms increased from 67 to 102, and mortality increased from 6 to 15 per 100,000 in 1990 and 2007). The reported detection rate was 55% (new ss+) and cure rate was 54% (59% success rate) in 2007.

The relevant sections of these and other national programs have been carefully reviewed in preparation of this proposal in order to ensure their consistency with the goals, objectives and SDAs of this proposal. The majority of national Programs contain only limited resources for achieving the overall goals outlined in the national response, with explicit provisions to encourage external and other nongovernmental partners to contribute. This proposal explicitly builds on such provisions to scale up TB diagnosis, treatment, and care and support, while specifically aiming to facilitate the transition to modern TB control and resulting coverage for most vulnerable populations

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.

In 2008, the national M&E system for TB control was reviewed with the application of the *Monitoring and Evaluation Systems Strengthening Tool*. This exercise was supported by PATH and involved both central and regional level representatives who discussed the M&E system, evaluated ongoing activities (suggested scoring was applied) and developed recommendations for improvement of the TB M&E system.at a 3 day workshop. These recommendations are addressed in this proposal. The following strengths and weaknesses were identified (see also sub-objectivie 3.2) :

Strengths:

- TB data are regularly generated at district level and aggregated at regional and national levels. Reports are produced on a regular basis, published in statistical bulletins and data is fed into international reporting mechanisms.
- TB statistical forms were adapted in 2006 using as a basis WHO-recommended TB recording and reporting forms. Ukraine has revised these forms in 2009 to improve routine TB surveillance in the country and reporting to international bodies. First cohort data (2006 cohort) were generated and reported to WHO. A reduced set of previously used statistical forms was adapted for up-to-date TB case registration and monitoring of TB program performance, generating health system–related information not covered by the WHO forms, including the number of TB phsycians, facilities etc.
- Statistical units for TB have been created both at national level and in all regions with dedicated staff (located at oblast TB hospitals).
- As a component of monitoring visits to districts, TB indicators, medical records and reporting is checked at facility level and qualitative Program data are generated.

Weaknesses:

- There is little feedback on data from national to regional and to district level.In particular, data is not sufficiently used in an analytical way for Program planning and corrective actions.
- In the absence of an electronic system, data quality control through cross checking remains challenging and there is a risk of double counting when patients move between health facilities
- The central TB monitoring unit is understaffed; staff in TB units at national and regional levels need to build their capacity, and TB units at oblast level lack essential equipment and internet connection.
- Insufficient funding for implementation of regular monitoring visits (partially covered by external donors) result in lack of quality control and guidance at district level

4.8.2. Avoiding parallel reporting

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

The majority of efforts funded through this proposal will be implemented as an integral part of the existing, government system of TB detection, treatment and care. Likewise, specific support to M&E activities proposed in this project will serve to enhance the existing M&E system for TB case recording and reporting as well as for monitoring and evaluation of TB control program performance at all levels, As a consequence, outcome and impact indicators relevant to activities funded by this proposal will also be captured by the “one M&E system”, and there is no risk of duplication or parallel reporting. Only where the existing system is unable to generate relevant data for monitoring the grant’s implementation (i.e. mostly programmatic monitoring (output) data with regard to TB treatment at the periphery and related community interventions), mechanism will be put in place to ensure that the project is able to report on progress to the National Council on TB and HIV/AIDS, the GFATM; and other interested partners on a regular and transparent basis. The organization of such additional Program monitoring will build on the successful experience GFATM Rd 1 and 6 monitoring in Ukraine.

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.

There is no formal national M&E plan for the health sector in Ukraine. Based on the above mentioned gap analysis and the framework for analysis suggested in the *Monitoring and Evaluation Systems Strengthening Tool*, the following activities to strengthen the M&E system capacity were identified for each of the three levels:

1. Develop and Implement National monitoring and evaluation plan for TB

1.1 The MOH will develop a National M&E Plan for TB (and further ensure its coordination with the M&E plan for HIV/AIDS) which will include the M&E component of this proposal. Round tables will be organized to achieve consensus among relevant entities.

1.2 The National M&E Plan will provide a framework for a patient oriented approach to TB treatment and care, community involvement and orientation of the health services towards the clients. Relevant national indicators will be developed based on international experience and integrated into the existing system of TB diagnosis, treatment and care, which is currently under transition to DOTS.

1.3 In addition to M&E resources provided from the Global Fund and other external sources, the project will support the Ministry of Health to identify additional domestic resources to ensure sustainability of the national M&E system for TB in the future.

2. Enhance data management capacities

2.1 Although most of the required processes are in place, the project will assist the MOH to further formalize them and develop clear written procedures for all M&E aspects, including the feedback to the reporting entities.

2.2 The project will facilitate more staff time to be allocated to M&E at national level taking into account the increasing complexity of the National TB Program (i.e. because of expanding DOTS framework and introducing routine surveillance and management of drug resistance). Relevant part of GFATM funding and additional domestic resources will be allocated for this purpose.

2.3 A range of capacity building activities will be implemented to ensure appropriate competence of government employed M&E staff in all TB M&E units. Heads of M&E units will be internationally trained in data management, statistical analysis and interpretation.

2.4 The project will support visits of the supervisory team at the national-to-district, district-to-regional, regional-to-local levels for onsite monitoring and analysis of data.

3. Enhance quality and capacity of data reporting systems

3.1 *Health facilities.* The project will help to finalize the switch to the new, unified reporting system and eliminate parallel reporting systems (DOTS system on one hand and elements of old Soviet system on the other), thus improving the quality of data and decreasing unnecessary workload on the institutions.

3.2 *Oblast and national level.* The project will support the intermediate (oblast) level of the National TB Program to be strengthened and become responsible for monitoring and evaluation of Program performance in respective districts. In addition, the proposal includes maintenance and implementation of an electronic TB register.

3.3 *Community settings.* There is currently no M&E system at community level. The relevant Sub recipient will develop a set of programmatic (process and output) indicators to be monitored at this level and mechanisms for data collection, transmission and analysis as this is necessary for the social / patient support components that are part of this proposal.

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	The Foundation for the "Development of Ukraine"
Address	117, Postysheva Street, Donetsk 83481 29 G, Yaroslaviv Val, Kyiv 01034

The Foundation for the "Development of Ukraine" (hereinafter – the Foundation, or FDU) is a nonprofit organization, organized by System Capital Management Company in Donetsk in 2005. In 2008, the Foundation was reorganized as a personal charitable foundation of the Ukrainian Benefactor Rinat Leonidovych Akhmetov, the National Deputy of Ukraine, the President of System Capital Management.

The FDU's mission is to lay the foundations for the successful and sustainable development of the Ukrainian society by investing in the education of future generations, the nation's health, preservation and development of the Ukrainian culture.

The Foundation is governed by the President and other governance bodies, namely:

- The General Meeting is the highest governance body of the FDU, which identifies the mission, strategy, core activities of the Foundation.
- The Supervisory Committee is an oversight body, which is responsible for recommendations to other governance bodies.
- The Board is an executive body, which shares the responsibility with the Director.
- The Executive Directors (Director) are an administrative and executive body of the Foundation, responsible for the implementation of the General Meeting's resolutions.

Speaking about the major principles incorporated in the management system, the Foundation implements its own projects and participates in funding programs of other charitable organizations, and supports public initiatives. The Board and the Supervisory Committee of the Foundation review the FDU's strategic decisions, including, in particular, the ones related to the introduction of new areas of activities and projects, and, if necessary, external independent experts are involved. Executive Directors and Managers in Activity Areas are responsible for the implementation of the Board's resolutions.

The Foundation carries out program activities in the following 4 principle areas:

1. **Modern Education and Care** (Projects: Digital Future of Journalism, Doctorate Program, Foster Care Promotion and Family Building, Large Families)
2. **Nation's Health** (Projects: Cancer can be Cured. Timely Cancer Diagnosis and Treatment; Stop TB; UNIAN-Health; Children Hospital of the Future)
3. **Cultural Heritage** (Projects: Reconstruction of the Museum in the Pirogovo Village; Reconstruction of the Metropolitan's House in Sofia Kyivska National Reserve)
4. **Targeted Assistance/Assistance in Emergencies.**

Today, the Foundation is implementing various projects, which differ by their target, scope, implementation methods, objectives and tasks. This allows gaining extensive experience in solving challenging system problems, including, in particular, lack of grant recipients' experience, non-transparent and corrupted systems of state authorities, working under uncertainty when research studies of social problems are not sufficient and pre-tested solution methods are not available. The Foundation collaborates with partners in the following forms:

- By project type: grants, operational projects, combined projects.
- By implementers: international organizations, state institutions, public organizations at the local level, national organization networks, culture and art establishments, research institutions.
- By impact: systemic changes, care delivery in response to acute or extreme situations.

Inasmuch as the program activity of the Foundation expands, the Kyiv Office was established in 2007. Currently, 33 employers work in Donetsk and Kyiv Offices responsible for the implementation of program activities.

As far as the health activities are concerned, the Foundation sees implementation and support of modern methods and techniques, reinforcing institutional changes and promoting responsible commitment of the Ukrainian population to their own health as the Foundation's mission in this area. The major projects implemented within the framework of this area include: Cancer can be Cured. Timely Cancer Diagnosis and Treatment, and Stop TB.

The latter was launched in 2007. The activities are carried out at the national level by implementing national special-purpose projects and at the regional level by implementing the Program on TB Control in Donetsk Oblast.

The Total budget of the Stop TB project amounts to 100 million UAH. At the national level the Foundation collaborates with relevant national institutions, solving the most burning TB-related issues, which the country is not able to handle independently. The Director of the FDU is a member of the National Council on TB and HIV/AIDS as a representative of the business sector set in the quota. The Foundation operates at the national level in the following areas: improvement of TB-related legislation; monitoring of anti-tuberculosis pharmaceutical quality; support of TB research studies; treatment and rehabilitation of children with TB and TB patients; professional training of TB specialists; outreach and awareness raising activities among the population.

In 2007, the Foundation jointly with specialists of the Donetsk oblast developed the Program on TB Control in Donetsk Oblast for Years 2007-2011 (hereinafter – the Program). This complex Program, as approved by the Resolution of the local authority and financed by the Foundation (the budget Totals 50 million UAH), is implemented jointly with the Council of the Donetsk oblast. The objective of the Program is to decrease TB incidence (by 5 per cent each year) and mortality rate (by 5 per cent during 5 years). The indicators of the social and economic development of the regions (ISEDR) chosen include the following ones: TB treatment efficacy; TB detection and treatment interruption; what encourages local authorities to have a responsible commitment to TB control in the oblast. Within the framework of this Program the Foundation is developing a model to combat the TB epidemic at the level of an oblast with following replication of such a model in other Ukrainian regions which are the most affected with the TB epidemic.

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

4.9.2 Sub-Recipients	
(a) Will sub-recipients be involved in program implementation?	**X** Yes
	☐ No
(b) **If no**, why not?	
(c) **If yes**, how many sub-recipients will be involved?	**X** 1 – 6
	☐ 7 – 20
	☐ 21 – 50
	☐ more than 50

(d) Are the sub-recipients already identified? *(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)*	**X** Yes ***[Insert Annex Number for list]***
	☐ No **Answer s.4.9.4. to explain**

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

In order to have a strong implementation team that will be able to reach the Program results under any circumstance, the nominated principle recipient has suggested to the NC the structure of 6 main sub-recipients, which are the Ministry of Health of Ukraine, the State Department of Ukraine for Enforcement of Sentences, the Ukrainian Red Cross Society, the International Charitable Foundation "International HIV/AIDS Alliance in Ukraine", PATH (Program for Appropriate Technology in Health) and the Coalition of HIV-service Organizations. Together with the nominated PR this team presents a huge and unique experience in TB and related sectors, which will be used for the benefit of the GF Program.
It should be noted that the TRP has recommended revising the proposed sub-recipient for the component "Advocacy, Communication and Social mobilization" (see TRP Analitical Report – Annex 19). On May 28, 2009 the National Council has approved a scheme of GF Grant implementation (see the scheme as Annex 13) which includes 5 sub-recipients. Sub-recipient for the ACSM component will be identified on the basis of an open competition after the positive decision of the Global Fund regarding the Ukraine proposal (see NC Minutes as an Annex 11)

The pre-identified list of sub-recipients (SR) include:

- 2 state authorities – the National TB Control Center and the State Department of Ukraine for Enforcement of Sentences;
- 1 Ukrainian non-governmental organization - the Ukrainian Red Cross Society;
- 2 international organizations – the International Charitable Foundation "International HIV/AIDS Alliance in Ukraine" and PATH (Program for Appropriate Technology in Health).

National TB Control Center: The main role is to implement the relevant Program components including (Annex 41):

- Improving TB lab diagnostics
- Expending high quality DOTS
- HSS Monitoring and evaluation system
- MDR -TB
- HIV/TB treatment
- Development of capacity of the state TB services in Ukraine

This SR will be supported by the HIV/TB Committee at the strategic managerial level, which will be fixed in the *Trilateral Sub-grant Agreement* between PR, TB Center and Committee.

Political support and overall strategic support to this particular sub-recipient as well as for other sub-recipients will be granted by the Ministry of Health. Ministry of Health will also provide the overall political support to PR at national level at the stage of the Program implementation under the *Memorandum of Understanding* and collaboration between MOH and PR. The support will include the issuance and approval of the main regulating documents required for successful Program implementation such as official orders, regulations, protocols and treatment standards etc.

State Department of Ukraine for Enforcement of Sentences: The main role is to implement the relevant Program components within objectives 1-3 under the sub-grant agreement with PR. The sphere of responsibility includes improving TB diagnostics and treatment in penitentiary system by implementing the projects directly and in collaboration with other SRs, like PATH and HIV/AIDS Alliance, which will be managing projects for the Penitentiary Department. It should be noted that most of programmatic activities within the prisons' system will be organized directly by other sub-recipients, such as training of

medical staff and psycho-social specialists, establishment of isolation rooms with appropriate IC measures, procurement of drugs and medical equipment, etc. It is done on purpose, since the capacity of this state institution to manage effectively TB programs is not sufficient. But as the same time it is planned to support a small group within the Penitentiary Department, that will be involved in coordination and monitoring of all activities directed at TB patients and staff in prisons, both managed directly by the Department, and managed for the Department by other sub- recipients. Support to the Penitentiary Department will include capacity building for the GF project implementation team, monitoring visits to the regions within the penitentiary system, etc.

PATH: The main role is to implement the relevant Program components within Objectives 1-3 under the sub-grant agreement with PR in close collaboration with National TB Center, HIV/TB Committee and other state institutions. Program components includes:

- Improving TB laboratory diagnostics
- Expending high quality DOTS
- Monitoring and evaluation system
- MDR -TB
- Providing range of program technical assistance to the National TB Control Center.

The Ukrainian Red Cross Society: The main role is to implement the relevant Program component within Objective 2 under the sub-grant agreement with PR. Program components includes:

- Provision of social services for TB patients
- Forming adherence of TB patients to completion of treatment

The International HIV/AIDS Alliance in Ukraine: The main role is to implement the relevant Program component within Objective 2 under the sub-grant agreement with PR. Program components includes:

- Scaling up efforts to address the HIV/TB co-infection
- Procurement of all health related pharmaceutical products and drugs under the Program.

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 structure of the GF grant management, proposed by the Foundation for “Development of Ukraine”, is designed to have a single Principal Recipient, which is the Foundation itself. It is explained by a necessity to create a single management and oversight center, which will be also responsible for reporting on the project implementation. However, it is understood that the GF project will work depending largely on the partners with the most powerful capacity (experience, potential, powers and authorities) involved to implement specific project components, so the Foundation performed a work to build a team of sub-recipients.

The pre-identified sub-recipients include:

- 2 state authorities – the TB Control Center under the Ministry of Health of Ukraine, the State Department of Ukraine for Enforcement of Sentences;
- 1 Ukrainian non-governmental organization - the Ukrainian Red Cross Society;
- 2 international organizations – the International Charitable Foundation “International HIV/AIDS Alliance in Ukraine” and PATH (Program for Appropriate Technology in Health).

The sub-recipients were pre-identified based on the following criteria:

The general criteria for the selection of sub-recipients designed to evaluate their capacity in the following areas:

- Financial Management: a legal status, capacity to provide transparent and efficient utilization of funds; capacity to prepare and timely submit financial statements.
- HR Management and Organizational Capacity: strengthening of effective organizational leadership, a transparent decision-making procedure, and a responsibility system.
- Project Management: collection and recording of program information by relevant quality control indicators; support and preparation of regular relevant program reports; provision with relevant

data to conduct evaluation and other surveys.

Speaking about the peculiarities of the organizations identified as sub-recipients, it should be noted that the state organizations are unique partners. If they were not involved, the vitality of important program activities would seem doubtful. The primary responsibility for TB detection and treatment is imposed on the National TB Control Center under the MOH of Ukraine, considering the peculiarity of this infectious disease. Which is why the National TB Control Center was selected as the principal sub-recipient for the treatment and diagnosis component, and it will be assigned the key responsibilities as a central and oversight authority. One of the groups which are the most susceptible to TB is persons kept in detention facilities of the penitentiary system; hence the State Department of Ukraine for Enforcement of Sentences was identified among state authorities as a sub-recipient for the component of treatment and diagnosis within the framework of the penitentiary system. It is important to involve these 2 state organizations in order to sustain the results of the GF program after its completion. Other criteria for the selection of sub-recipients among non-governmental organizations included the following ones:

- Having previous successful experience in the area, which the sub-recipient will be eventually responsible for.
- Transparent and open activity.
- Having previous experience of successful management and/or implementation of grants (programs) of the Global Fund.
- Powerful representation in Ukrainian regions.

Therefore, the Alliance-Ukraine was selected as a sub-recipient among non-governmental organizations, as it has successful experience of implementing 2 GF projects in the HIV/AIDS area, in particular, the activities of procurement and supply management. **The area, in which the Alliance-Ukraine will be engaged**, is HIV/TB service delivery area; procurement of medical goods within the framework of the GF project. Furthermore, the Alliance-Ukraine is identified as an organization which will help develop the PR's capacity in M&E and procurement related to the GF project.

Another sub-recipient is PATH, which has considerable experience in TB control; in particular, related to infectious disease control, reinforcement of the National TB Program, introduction of latest TB-related M&E standards, advanced training of health care workers, etc. **The area, in which PATH will be engaged**, is infectious disease control, MDR-TB, M&E (a clinical component), DOTS expansion.

The Ukrainian Red Cross Society is an organization that has a well-developed network of trained nurses in each oblast of Ukraine, which is especially valuable as it allows providing access to vulnerable groups. Furthermore, nurses who received special training work in the Red Cross Society, and they may carry out social management and non-medical patient care as well as other activities to promote adherence to TB treatment. **The area, in which the Red Cross Society will be engaged**, is care and support, non-medical management of TB patients.

The detailed project management structure with the PR's responsibility areas and sub-recipients indicated is attached in Annex 43 and Annex 13.

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.

In order to have a strong implementation team that will be able to reach the Program results under any circumstance, the nominated principle recipient has suggested to the NC the structure of 6 main sub-recipients, which are the Ministry of Health of Ukraine, the State Department of Ukraine for Enforcement of Sentences, the Ukrainian Red Cross Society, the International Charitable Foundation "International HIV/AIDS Alliance in Ukraine", PATH (Program for Appropriate Technology in Health) and the Coalition of HIV-service Organizations. Together with the nominated PR this team presents a huge and unique experience in TB and related sectors, which will be used for the benefit of the GF Program.

It should be noted that the TRP has recommended revising the proposed sub-recipient for the component "Advocacy, Communication and Social mobilization" (see TRP Analitical note Annex 19). On May 28, 2009 the National Council has approved a scheme of GF Grant implementation (see the scheme as

Annex 13) which includes 5 sub-recipients. Sub-recipient for the ACSM component will be identified on the basis of an open competition after the positive decision of the Global Fund regarding the Ukraine proposal (see NC May 28, 2009 Minutes as an Annex 11)

PR`s strategy of involvement different implementation partners is based on the principles of transparency and maximum involvement of organizations with high level of managerial and programmatic potential. At the stage of Proposal development and designing of the structure of grant implementation the PR has undertaken the following steps in order to identify potential sub-recipients:

- The Foundation held numerous open consultations with representatives of NGOs and international organizations operating in Ukraine to discuss a possible grant management structure and partners' commitment to the participation in the GF grant implementation.
- A number of partners were identified as interested in participation in the GF project for TB in prospect. Meetings were held with a number of organizations to determine the form of a partner's participation, experience of TB-related work, a partner's commitment to the work in this or that area (based on the strategy and areas of activities identified in the Round 8 Proposal with the TB component), and the Foundation's suggestion of the grant management structure.
- Besides, consultations were held with representatives of the USAID which is a strategic partner of the Foundation on TB control Also consultations were held with the WHO being a key strategic partner of the Foundation in TB control with the latter having experience in implementing programs in the Donetsk oblast jointly with the WHO.
- Criteria for the selection of prospective sub-recipients were developed.
- The 2nd round of negotiations with the prospective sub-recipients (according to the grant management structure) was completed. The negotiations allowed identifying the area of interest of prospective sub-recipients with regard to the program core activities, experience in the relevant program area, and the Foundation's vision and need related to who could ensure implementation of this or that area.
- Consultations were held with regional TB specialists and regional NGOs to discuss their experience of collaboration with the prospective sub-recipients in oblasts.
- The 3rd round of negotiations with the prospective sub-recipients is completed with agreements reached with regard to the collaboration within the framework of the GF project.
- The Memorandum of Collaboration for the GF Project was signed to set out the agreements reached (see Annex 42).

As it was stated earlier, NC agreed the structure of grant implementation includes 1 PR and 5 sub-recipients and recommended to conduct an open competition after receiving the positive decision of the GF on Ukraine's proposal (see NC May 28, 2009 Minutes as an Annex 11)). The PR will follow this decision. There are a number of organizations potentially interested in implementation of ACSM component; PR will organize an open and transparent competition with involvement of independent national and international experts. A set of criteria and the format of the competition will be developed based on the best world experience and will be agreed at the NC. Regarding the timeframe it is planned to start a process of selection of the sub-recipient for the ACSM component in the second quarter of 2010 (Nov 2009 – decision of the GF; planned start of the program – June 2010).

Despite the fact that the structure of the grant implementation based on the pre-identified sub-recipients, the competitions will be held by PR and all sub-recipients for all program components in order to ensure a wide involvement of NGOs at the national and regional levels for the GF program implementation. For all competitions there will be selected organizations that are able and capable to deliver results and are willing to use the high standards in their work which are in compliance with the GF requirements.

4.9.5. Coordination between implementers

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

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** *(e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems)*; and

- **The extent to which partners will support program implementation** *(e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant)*.

The principles, mechanisms and procedures for the cooperation of the nominated Principal Recipient and the NCC (acting as a CCM) are provided in the relevant *Procedure* on ensuring the oversight of the implementation of the Program funded by the Global Fund, which is approved by the NC. This Procedure was developed according to the relevant GF requirements (*Revised Guidelines on the Purpose, Structure and Composition of CCM and Requirements for Grant Eligibility*). The Procedure provides the following roles and responsibilities for the NCC:

- To initiate and coordinate the submission of the Country Proposal to the GF.
- To ensure the general oversight of the implementation of the GF Program activities.

a) Sub-Recipients coordination mechanism – SRs Coordination Group

During the Country Proposal development stage the nominated PR suggested the comprehensive grant management and implementation scheme which provides pre-identifying (pre-selection) of **5 main** implementing partners – main Sub-Recipients (2 governmental and 3 non-governmental organizations) responsible for implementation of the different Program components. In order to properly organize and manage the implementation of SR's activity it was decided to create the relevant coordination mechanism – SRs Coordination Group. The nominated PR has developed the *Regulations* which define the main principles and functions of this group. The functions of this group are the following:

- To ensure the proper coordination between the main Sub-Recipients at the operational level.
- To coordinate annual workplans, monitoring plans and budgets.
- To conciliate decisions related to the Program implementation.

In addition to this a number of other working groups might be created as a part of the coordination mechanisms for different Program purposes in accordance with the relevant Program objectives. One of these groups will be the following:

- *Joint HIV/TB Working Group* (SDA #3) in order to coordinate and conciliate the implementation of the relevant HIV and TB Program activities;

b) Coordination of the State Public Health Institutions involvement into the grant implementation

Due to the nature of the problem the involvement of the relevant governmental institutions is one of the crucial issues, as well as the key factor for the successful implementation of the Program "Overcoming tuberculosis epidemic in Ukraine". Therefore, it is planned that the following organizations will be engaged in the grant oversight and implementation at different levels:

- The Ministry of Health of Ukraine (MOH) will provide the overall political support to the PR and SRs in order to ensure the implementation of those Program components which can only be implemented through the public health system. The relevant *Memorandum of Understanding* stating main principles, responsibilities and nature of cooperation (including the list of main objectives and indicators to be achieved, as well as the list of health products to be procured) will be signed between the MOH and FDU as the PR of the GF grant.
- HIV/TB Committee (the Committee) is a relevant sub-structure of the MOH primarily responsible for HIV and TB. It will be involved at the implementation level as a supervisory/governing body for one of the main Sub-Recipients – National TB Control Center (TB Center). The Committee will

play the main planning and coordinating role in the implementation of the relevant Program activities within objectives 1-3 whereas the National TB Center will be a sub-recipient of the funds and will implement the majority of Program components at the operational level. These cooperation levels, principles and responsibilities will be fixed in the *Trilateral Grant Agreement* between FDU (PR), Committee and TB Center.

- The State Penitentiary Department (the Department) is one of the pre-identified Sub-Recipients primarily responsible for all Program components to be implemented within the state penitentiary system. Therefore, it was decided that the relevant coordination mechanism in the form of the Interagency Task Force workgroup consisting of the Department and Committee (TB Center) representatives will be established. This group will be established on the basis of the relevant MOH's Order and the main purpose of its functioning is to ensure regular and effective coordination and conciliation of the issues related to the relevant sub-recipients components implementation.

b) Management approach at operational level

On operational level the management approach to grant implementation of the PR, as well as main Sub-Recipients should be guided by their own statutory documents, approved organizational policies and procedures, relevant donor's (GF) requirements and conditions, local Ukrainian legislation.

Please see Annex 13 and Annex 43 attached for a getting a more structured understanding of all coordination mechanisms.

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.)*

With regard to the PR, it plans to grow substantially (please see Annex 44) to learn of a new office structure with the GF project) over the period of the grant implementation. The growth will start after receiving the positive decision of the Global Fund, and will start with the Foundation own funding, The Foundation has already made a self-assessment exercise based on the tools of GF and has already identified the areas in which it has to strengthen its capacity. The Foundation development and growth plan is already developed and will be revised after the LFA assessment. It is planned to hire new staff, train new and existing staff who will be involved in the GF program implementation, all Fund's policies and procedures will be revised for the compliance to the GF standards. Ongoing assistance to PR and all main SRs to ensure technical integrity of all aspects of program implementation will be provided by the WHO office.

Ministry of Health of Ukraine carries out the main responsibility for control over the National TB program in Ukraine and is responsible for the implementation for the overcoming TB epidemic in the country. Its overall political support at the national level is important for an effective implementation of the GF project. This political support is obtained through the signing of the initial Memorandum of Understanding (MOU) between the nominated Prime Recipient (PR) and MOH. After the positive decision of the Global Fund on

support of the Ukraine proposal, a more detailed MOU will be signed between the mentioned parties.

Under relevant service delivery areas of this proposal, the TB Control Center and the Prison Department are receiving support to manage implementation of activities for which they act as sub-recipients and/or for which they are important partners. Together, such support will allow both key TB control bodies to upgrade their existing capacity to fulfill their functions.

The National TB Center will be supported by the State HIVTB Committee at the strategic managerial level, which will be fixed in the Trilateral Sub-grant Agreement between FDU, TB Center and Committee. It is crucial to build a strong team of the National TB Center under the Leadership of HIV/TB Committee. It is planned to grow the Center during the 1st phase with the structure as per attached Annex 45. This strong team of state employees will remain after the completion of the GF project that will ensure the project result sustainability in the area of state capacity to control the TB epidemic.

To increase the competency of the staff of the National TB Control Center and the State Department of Ukraine for Enforcement of Sentences who are involved in TB control in prisons, joint trainings will be organized. The training will include issues of program and financial management, recording and reporting, monitoring and evaluation, supervision and mentorship, needs assessment methods, etc.

In addition, select top level managers of the government, TB/HIV Committee and the Prison Department will be trained on management of national TB programs with a specific focus on strategic planning, implementation, control and monitoring, and be supported to participate in key international conferences.

It is also envisaged that during the 5-year period of GF program the PR and such sub-recipients as PATH and Alliance will be providing technical assistance to the National TB Center by involving the best national and international experts and sharing experience.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 9 proposal	
Does this proposal seek funding for any pharmaceutical and/or health products?	☐ No ➔ *Go to s.4B if relevant, or direct to s.5.*
	X Yes ➔ *Continue on to answer s.4.10.2.*

4.10.2. Table of roles and responsibilities

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

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	Alliance IDA	Sub-recipient Procurement Agent	X Yes ☐ No
Intellectual property rights	Alliance	Sub-recipient	X Yes ☐ No
Quality assurance and quality control	Alliance IDA	Sub-recipient Procurement Agent	X Yes ☐ No
Management and coordination *More details required in s.4.10.3.*	Alliance National Tb Control Center CF "Development of Ukraine"	Sub-recipient Sub-recipient Principle recipient	X Yes ☐ No
Product selection	National Tb Control Center	Sub-recipient	X Yes ☐ No
Management Information Systems (MIS)	"Ukrvaktsina"	Sub-contractor for storage and distribution of drugs	X Yes ☐ No
Forecasting	National Tb Control Center	Sub-recipient	X Yes ☐ No
Procurement and planning	Alliance IDA	Sub-recipient Procurement Agent	X Yes ☐ No

Storage and inventory management *More details required in s.4.10.4*	Alliance, National Tb Control Center, State Enterprise "Ukrvaktsina"	Sub-recipients, Sub-contractor for storage and distribution of drugs	X Yes ☐ No
Distribution to other stores and end-users *More details required in s.4.10.4*	Alliance, National Tb Control Center, State Enterprise "Ukrvaktsina"	Sub-recipients, Sub-contractor for storage and distribution of drugs	X Yes ☐ No
Ensuring rational use and patient safety (pharmacovigilance)	National Tb Control Center	Sub-recipient	X ☐ Yes ☐ No

4.10.3. Past management experience

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

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
Alliance Ukraine	sub-recipient	$8,565,000
National Tb Control Center	sub-recipient	----
IDA Foundation	sub-contractor for pooled procurement and QA of second line drugs	
State Enterprise "Ukrvakstina"	Sub-contractor for storage and distribution of drugs	$103,000,000
use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]		

4.10.4. Alignment with existing systems

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

The project will aim to strengthen TB diagnostics and MDR prevention and treatment by providing the existing national TB laboratory system with diagnostics, equipment, and consumables and TB dispensaries with second line drugs. It also will assist TB clinics by providing them with infection control systems and consumables.

This proposal foresees complementary functioning of existing country's systems and the project implementation. This means that standard national procedures and resources will be used for product selection, quality control and rational use of health products. Storage and distribution of equipment and consumables is planned to be also organized using public systems, i.e. State Enterprise "Ukrvaktsina", among others.

Procurement of medical products will be organized in accordance with the Alliance's Ukraine procurement rules and guidelines in order to ensure the best value for money; fairness, integrity, transparency; and

effective international competition.

To ensure that goods purchased with the grant money are free of taxes and duties, Alliance intends to apply the same legal framework of exemption that was developed and used for GFATM R1 and R6 grants.

GLC is a recognized and recommended mechanism to provide quality assured preferentially-priced second line anti-TB drugs. As per GLC 2007 Annual Report, the GLC approved MDR projects for a TOTal of 30206 MDR patient Cohorts and 95 applications in the world.

IDA is procurement agent who was competitively selected to provide second line anti-TB drugs for Projects approved by GLC. IDA has a strong presence for pooled procurement of drugs in the world and has established systems for in-house QA. Besides, Alliance has 4 years experience of successful cooperation with IDA and has on-going supply contracts.

4.10.5. Storage and distribution systems	
(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?	**X** National medical stores or equivalent ***State institution "Ukrvaksina"*** *Address: 01021, Kyiv, Grushevskogo Str., 7* E-mail: vaccine@iptelecom.net.ua E-mail: vaccine@i.kiev.ua *Tel./ fax: +38 044 530 05 24, +38 044 501-39-95* *Base of medicines –Kyiv oblast, Obuhiv, Kashtanova str., 61A* *Tel.:+38 044 725 18 80*
	☐ Sub-contracted national organization(s) *(specify)*
	☐ Sub-contracted international organization(s) *(specify)*
	☐ Other: *(specify)*
(b) For storage partners, what is each organization's current **storage capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.	
State institution "Ukrvaksina" has the base of medicines with two storage facilities with the total area of 2,500 square meters that are equipped with 13 refrigerators with the total area of 500 square meters for the storage of medicines in the low temperature conditions, which is provided by stationary refrigerators built in special machinery departments. The base of medicines is equipped with an autonomous power supply. Material and technical base of State institution "Ukrvaksina" matches the level of accreditation standards.	
(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.	
State institution "Ukrvaksina" possesses specialized vehicles: 11 automobiles, including auto-refrigerators "Scania" (with carrying capacity of 10 tones), machines with isothermic body (with carrying capacity up to 5 tones). All the automobiles are certificated by Ukrmetrtreststandard.	

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.

Please, see 'Attachment B-Tuberculosis'

4.10.7. Multi-drug-resistant tuberculosis	
Is the provision of treatment of multi-drug-resistant tuberculosis included in this tuberculosis proposal?	**X** Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.* It is planned to procure 10 second line drugs via GLC mechanism with the grant funds. Currently only 2 out of 10 drugs to be procured out of the GLC/GDF range are registered in Ukraine. The registration will be initiated after the positive decision of the GF on the R9 proposal from Ukraine. Prime recipient with support from 2 main-sub-recipients such as International HIV/AIDS Alliance in Ukraine and National TB Center will be responsible for registration of 8 drugs, which is planned to finish by the end of the 1st year of 1st phase. The MDR-TB treatment is expected to start in the middle of second year of First Phase at best. Funds for the packages of services provided by the GLC are included in the budget.
	☐ No *Do not include these costs*

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 9 and only if:

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

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

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

ROUND 9 – Tuberculosis

5. FUNDING REQUEST

5.1. Financial gap analysis - Tuberculosis

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

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Tuberculosis program funding needs to deliver comprehensive diagnosis, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	**132 116 701**	**113 965 681**	**113 965 681**	**113 965 681**	**113 965 681**	**113 965 681**	**113 965 681**	**113 965 681**
Line A.1 ➔ TOTal need over length of Round 9 Funding Request *(combined TOTal need over Round 9 proposal term)*								**569 828 405**
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*World Bank*)	4 579 966	465 687						
Domestic source **B2** State Budget (Central)	118 442 469	40 434 234	20 670 532	31 080 509	31 080 509	31 080 509	31 080 509	31 080 509
Domestic source **B3** Private Sector contributions (CF "Development of Ukraine"	1 063 535	4 091 235	1 173 975	1 300 000	2 100 000	1 000 000		
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	124 085 970	44 991 156	21 844 507	32 380 509	33 180 509	32 080 509	31 080 509	31 080 509
External source **C 1** USAID	1 000 000	2 138 000	3 397 169	3 343 299				

ROUND 9 – Tuberculosis

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
External source **C2** (*provide source name*)								
External source **C3** Private Sector contributions (International)	[redacted]	[redacted]	[redacted]					
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	1 000 000	2 138 000	3 397 169	3 343 299				
In line D below, insert additional separate lines for each separate Global Fund grant. This will ensure that you show information on different Global Fund grants.								
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years								
Line E ➔ Total current and planned resources (i.e. Line E = Line B Total + Line C Total + Lind D Total)	125 085 970	47 129 156	25 241 676	35 723 808	33 180 509	32 080 509	31 080 509	31 080 509
Calculation of gap in financial resources and summary of Total funding requested in Round 9 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	7 030 731	66 836 525	88 724 005	78 241 873	80 785 172	81 885 172	82 885 172	82 885 172
Line G = Round 9 tuberculosis funding request *(same amount as requested in table 5.3 for this disease)*				**11 548 774**	**23 035 431**	**19 676 733**	**24 335 615**	**24 863 065**

ROUND 9 – Tuberculosis

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

In Round 9, the Total maximum funding request for tuberculosis in Line G is:

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

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

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

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

(0 + 103 459 619) x100 / 569 828 405 = **18 %**

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.

When developed in 2006, the National TB Programme 2007-2011 was initially costed at a total budget of USD 587 mln (2007 exchange rate) for the period of 5 years.

This budget represented at the time the estimated need of state investment into the TB response, and excluded expected contributions from the non-governmental sector and external donors. It was hence an underestimate of the anticipated real total need.

A comprehensive costing of the National TB Response covering the totality of needed efforts and partners involved has not been undertaken to date and is unavailable. For the purposes of calculating the cost sharing indicator it was agreed to use the originally calculated financial need of the State National TB Programme 2007-2011, and extrapolated until 2014.

Considering increased deficit of budget funds and aggravation of crisis in the national economy, the financial support of the National TB Program in Ukraine in 2009 and 2010 will be reduced substantially in comparison with 2008.

The main contributions for TB control from the non-governmental organizations come from the Charitable foundation of Rinat Akhmetov “Development of Ukraine and international donor-organization USAID. The data on actual and planned funding of TB activities by these organizations provided in LINES B and C.

So, the comparison of financial needs and planned/actual funding shows that current funding of activities to overcome such large-scale issue as TB in Ukraine is insufficient. Moreover, Ukraine has no additional resources to tackle this issue. Funds distribution indicator once again confirms serious lack of funds at the governmental level to address this problem.

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.

The National TB Program was adopted as a law on 7 February 2007 by the Parliament of Ukraine after observation of the appropriate deliberations procedures with an approved budget of USD 239 mln. Confirmed / approved state funding is reflected in line B2.

It is complemented by substantial funding availed for the TB response at the regional level, covering amongst other salaries of medical personnel, consumables, maintenance of infrastructure, as well as select medicines. However, the totality of regional funding is unknown. Both funding at the central and regional level are prioritized by decision of the parliament upon advice of the respective government structures.

National health budget allocations are controlled by the Treasury and the Tender Committee of the Ministry of Health. Furthermore, the MoH is subject to regular audits by the Accounting Chamber of the Parliament of Ukraine, and the Control and Revision Department of the Ministry of Finance. Reports by the Accounting Chamber are published.

Technical guidance affecting the efficient and equitable use of funding is providing by the MoH, if appropriate in form of order adopted by the Cabinet of Minister of Ukraine.

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)).
Following a no cost extension, the World Bank loan project ended at the end of 2008.

5.2. Detailed Budget

Suggested steps in budget completion:

1. **Submit a detailed proposal budget *in Microsoft Excel format as a clearly numbered annex*.** Wherever possible, use the same numbering for budget line items as the program description.

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/rounds/9/single/#budget

2. Ensure the detailed budget is consistent with the detailed workplan of program activities.

3. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (s.5.3.)

4. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (s.5.4.)

5. Do not include any CCM or Sub-CCM operating costs in Round 9. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/ccm/

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

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	TOTal
1	**SDA: Improving diagnostics**	544 756	10 183 116	887 614	514 588	569 758	**12 699 831**
2	**SDA: Expanding high quality DOTS**	3 238 138	5 301 439	5 234 773	5 748 836	3 698 818	**23 222 004**
2	**SDA: MDR-TB**	670 957	1 130 407	6 841 735	11 547 735	14 795 062	**34 985 897**
2	**SDA: Scaling Up Efforts to Address HIV-TB Co-infection**	1 656 932	647 093	1 208 676	1 202 929	1 206 594	**5 922 224**
3	**SDA: Leadership and governance in TB control**	693 354	971 969	945 827	957 067	986 954	**4 555 171**
3	**SDA: M&E System**	1 292 829	573 857	494 634	473 010	426 470	**3 260 799**
3	**SDA: HSS Workforce**	228 752	369 157	121 923	65 328	44 784	**829 945**
4	**SDA: Advocacy, Communication and Social Mobilization**	1 345 653	2 126 509	2 225 741	2 084 261	1 385 786	**9 167 950**
	SDA: Program Management and Administrative Costs	1 877 402	1 731 885	1 715 811	1 741 862	1 748 838	**8 815 798**
Round 9 tuberculosis funding request:		11 548 774	23 035 431	19 676 733	24 335 615	24 863 065	**103 459 619**

ROUND 9 – Tuberculosis

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

Avoid using the "other" category unless necessary – read the Round 9 Guidelines

	(same currency as on cover sheet of Proposal Form)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**TOTal**
Human resources	1 965 909	2 200 062	2 251 901	2 264 493	2 147 493	**10 829 858**
Technical and Management Assistance	1 111 042	1 879 220	2 400 517	2 917 598	1 816 621	**10 124 998**
Training	1 024 882	2 555 371	1 926 908	1 406 901	1 184 786	**8 098 847**
Health products and health equipment	199 454	7 649 721	406 482	488 109	509 904	**9 253 670**
Pharmaceutical products (medicines)	26 743	496 378	3 753 900	7 675 349	9 651 905	**21 604 274**
Procurement and supply management costs	56 030	475 654	392 321	735 122	907 714	**2 566 841**
Infrastructure and other equipment	1 082 466	436 165	1 299 877	1 306 955	1 319 302	**5 444 764**
Communication Materials	573 958	720 414	611 037	617 003	326 430	**2 848 842**
Monitoring & Evaluation	323 080	274 123	287 470	319 932	262 282	**1 466 888**
Living Support to Clients/Target Populations	1 083 944	1 831 721	1 897 988	2 038 690	2 206 952	**9 059 296**
Planning and administration	3 714 374	4 074 387	4 022 768	4 117 213	4 077 986	**20 006 728**
Overheads	386 892	442 216	425 566	448 249	451 689	**2 154 612**
Other: *(Use to meet national budget planning categories, if required)*						
Round 9 tuberculosis funding request (*Should be the same annual Totals as table 5.2)*	**11 548 774**	**23 035 431**	**19 676 733**	**24 335 615**	**24 863 065**	**103 459 619**

5.4.1. Overall budget context

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

There are no significant variations, except those provided for at the start of any project designed for several years.

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*

A significant portion of the budget is allocated for human resources.

(i) The program budget for the first two years includes expenditures on the salaries for the Principal Recipient employees (both programmatic and financial and administrative ones), who will be involved in the GF program implementation. A draft organizational structure of the Principal Recipient was developed at the planning stage (please, see organigram attached in Annex 44, which suggests the need to expand the staff through the creation of new jobs and recruitment of personnel at the first stages of the program implementation in Ukraine. These expenses on the staff employees of the Principal Recipient include salaries, social packages, personnel training and development expenses, and are calculated on the basis of the following principles:

- current staff list for already existing employees, who will be involved in the GF program implementation on a full-time, or part-time basis;
- previously approved scale of salaries for the new staff employees.

These documents are not attached to the Application due to their confidential content, but can be provided by the Principal Recipient upon request. At the same time, both the existing level of salaries of the Principal Recipient's employees, and the previously approved scale of salaries for the new employees were developed in accordance with the existing trends in the demand and offer on the labor market in the non-profit sector.

Expenditures on the employees, who are not directly related to the implementation of certain kinds of program activities and operations (financial and administrative and general management staff) were determined in the budget on the basis of the planned share of participation of each employee in the program implementation. This share is within the range of 17%-53% of the official salary. Detailed information about labor resources can be provided upon request.

(ii) The method of calculation of the salaries of the Principal Recipient's employees for the next three years of the program implementation is similar to the calculations for the first stage (first two years) – on the basis of existing salaries and planned scale of salaries for all organization employees. In accordance with the established practice and planned personnel policies, one of the principles of the budgeting of the long-term program is the calculation of salaries taking into account the general growth of salary fund of the organization by 5% per year, which is reflected in the salary calculations for 5 years of the program implementation.

During this period it is also planned to perform the labor market research in the non-profit sector in order to optimize the existing tariff models for the salaries. The data collected in the research will be reflected in the comprehensive review of the salary payment terms in order to harmonize and optimize them; they will be covered through the planned increase of the salary fund as described above.

(iii) Efficiency of the personnel performance is closely related to the expenditures on personnel.

Adequate expenses on personnel reflecting their efforts will ensure the increased quality of service provision to all target groups of the program. Involvement of highly qualified and well trained employees will increase the efficiency of program implementation and will open the prospects for further introduction of such best charitable practice. It is planned to establish different by composition specialized teams with the involvement of human resources of sub-recipients, the qualification and motivation of which is also significant to overcome TB epidemic in Ukraine to ensure case management of vulnerable patients, who moved from their permanent treatment sites, and other causes related to direct TB treatment.

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*

In addition to the Human Resources cost category there are three other important expenditure items: "Health Products and Health Equipment", "Training" and "Infrastructure and Other Equipment".

"Health Products and Health Equipment" finances procurement of laboratory equipment and medical products for bacteriological diagnostics; consumables for laboratory network; boxes for transportation of samples; UV lamps for TB medical facilities and laboratories; and means for personal respiratory protection in TB facilities and laboratories. For details, please refer to Annex B to this Application.

Health Products and Health Equipment are an important component of TB control in the country, because the new and high quality equipment will help to ensure quality TB diagnostics, the hospitals will establish infection control, which will help to reduce the number of infection cases among health care workers and reduce the spread of MDR TB.

"Infrastructure and Other Equipment" will finance the procurement of office equipment, including the purchase of computers for monitoring sites in the regions and on the national level to ensure an efficient introduction of electronic registry of TB patients to inform the efficient planning of TB activities and to monitor their efficiency throughout the country. Also it is planned to purchase office equipment for the education rooms for patients on the basis of health care facilities in order to create proper conditions for work with patients and their relatives, which, in its turn, will contribute to the development of treatment adherence. Such rooms will be also created in the penitentiary system. Also, it is planned to purchase office equipment to support the Regional Coordination Councils in all regions of Ukraine to improve the efficiency of their performance, as well as communication and links with the National Coordinating Council.

"Training" cost category will cover a complex education campaign for laboratory specialists on EQA, culture and DST; for case management teams on integrated approach to service provision; for TB medical staff on Stop TB strategy, patient education, HIV testing and counseling, and MDR TB; for social mobilization of, and support to the nurses and volunteers on Stop TB strategy; for general practitioners on Stop TB strategy; for health care managers on planning, management, monitoring and evaluation of TB programs; for supervision teams (monitoring and evaluation units) on monitoring and evaluation; for facilities on Stop TB strategy; for community leaders and for journalists. Such comprehensive approach is planned to ensure a robust capacity development of all stakeholders engaged in the overcoming of TB epidemic. Details of calculation of this cost category are proposed in the budget.

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

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

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

5.5.1. Operational status of common funding mechanism
Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners. ➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*
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 (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the focus of the common fund is broader than the tuberculosis program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on tuberculosis outcomes during the proposal term.*
N/A

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

Applying for funding for HSS cross-cutting interventions is optional in Round 9

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

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

Download 'Section 5B' from the Global Fund website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions') ***in Round 9 and has completed section 4B and included that section in the Tuberculosis proposal sections.***

Proposal checklist - Section 1 and 2

Section 3 and 4: Program Description		List Annex Name and Number
4.1	Supporting documentation for National Strategy	Annex 23, Round 8
4.2.1	Map if proposal targets specific region/population group	See 4.2.1
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	Annex 1 Annex 4 Annex 29
4.4	Document(s) that explain basis for coverage targets	See 4.2.1 and information under that
4.5.1	**A completed '*Performance Framework*' by disease** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**
4.5.1	**A detailed component Work Plan** (quarterly information for the first two years and annual information for years 3, 4 and 5) by disease.	**Work plan**
4.5.2	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 7 or Round 8 proposals (only if relevant).	Annex 46
4.8.1	A recent evaluation of the 'Impact Measurement Systems' as relevant to the proposal (if one exists)	**N/A**
4.9.1	**A recent assessment of the Principal Recipient capacities** (other than Global Fund Grant Performance Report).	Annex 19 Annex 20 Annex 21
4.9.1 *(for non-CCM applicants)*	**Document describing the organization such as: official registration papers, summary of recent history of organization, management team information**	**N/A**
4.9.2	**List of sub-recipients already identified** (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)	Annex 43
4.10.6	**A completed 'List of Pharmaceutical and Health Products'** by disease (if applicable).	**Attachment B**
Section 4B: HSS Cross-cutting (once only in whole country proposal)		**List Annex Name and Number**
4B.2	**A completed separate HSS cross-cutting '*Performance Framework' (or add a separate "worksheet" to the disease 'Performance Framework' under which s. 4B is submitted)*** **Refer to the M&E Toolkit for help in completing this table**.	**N/A**
4B.2	**A detailed separate HSS cross-cutting Work Plan *(or add a separate "worksheet" to the disease Work Plan under which s. 4B is submitted)*** (quarterly information for the first	**N/A**

Proposal checklist - Section 1 and 2

	two years and annual information for years 3, 4 and 5).	
Section 5: Financial Information		**List Annex Name and Number**
5.2	**A 'detailed budget' (quarterly information for the first two years, and annual information for years 3, 4 and 5)**	**Detailed Budget**
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	Annex 44
5.4.3	Information on basis of costing for 'large cost category' items	**N/A**
5.5.1 *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism	**N/A**
5.5.2 *(if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism	**N/A**
Section 5B: HSS Cross-cutting financial information		**List Annex Name and Number**
5B.1	**A separate HSS cross-cutting 'detailed budget' *(or add a separate "worksheet" to the disease 'detailed budget' under which s. 4B is submitted).* Quarterly information for the first two years, and annual information for years 3, 4 and 5).**	**N/A**
5B.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	**N/A**
5B.4.3	Information on basis of costing for 'large cost category' items	**N/A**
Other documents relevant to sections 3, 4 and 5 attached by Applicant:		**List Annex Name and Number**
Attachment B	Procurement and treatment list	Annex 47