The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Concept Note for Early Applicants

This concept note template is to be completed by early applicants invited to request funding from the Global Fund in 2013 during the transition to the new funding model. For more information on how to complete this template, please refer to the Concept Note Instructions.

The funding request details the applicant's request for Global Fund resources in a disease area (and/or health systems strengthening). Referring as appropriate to relevant sections of the national health sector strategic plan, national disease strategic plans and other appropriate documentation, the funding request allows a country to articulate an ambitious and strategic funding request that will achieve maximum impact.

The sections of the concept note are:

Section 1: Summary information about the request.

Section 2: The application development process and compliance with CCM Eligibility Requirements.

Section 3: The description of the country's epidemiological situation, the national health and disease strategic plans' response, and the community systems and human rights context.

Section 4: The funding request, including a programmatic gap analysis, budget description and rationale, counterpart financing and focus of the funding request requirement.

Section 5: Implementation arrangements, including PR minimum standards.

Section 6: List of abbreviations and acronyms; list of annexes.

This concept note template is specifically designed for early applicants. It does not represent the final template to be used for the full roll-out of the new funding model, and will be revised to reflect feedback received during the transition phase.

SECTION 1: SUMMARY INFORMATION

1.1 Applicant Information

Country	**Kazakhstan**		
Applicant Type	**CCM**	**Component**	**TB**
Funding Request Start Date	**01 July 2014**	**Funding Request End Date**	**31 December 2017**

1.2 Summary Budget

Funding Request Summary			**Currency of Funding Request**		**[USD or Euro]**
Currency of Funding Request			**USD**		
[Inset dates for annual period covered]	**A= Existing (Global Fund grants)**	**B= Indicative Funding Request (incremental)**	**A+B= Existing plus Indicative Funding Request**	**C= Above Indicative Funding Request**	**A+B+C= Full Request**
01 Jul 2014 - 31 Dec 2015	0	14,272,500	14,272,500	7,233,865	21,506,365
01 Jan 2016 - 31 Dec 2016	0	12,844,048	12,844,048	8,438,552	21,282,601
01 Jan 2017 - 31 Dec 2017	0	11,713,451	11,713,451	9,747,721	21,461,173
Years 1-3 Totals:	**0**	**38,830,000**	**38,830,000**	**25,420,139**	**64,250,138**

Note: By the beginning of NFM $ 2 065 915 will remain from implementation of Round 8 according to the budget. This amount is not included to the funding request because it is intended for implementation of objectives of the Round 8 that differ from the objectives indicated in the CN. Find more details in the Section 4.4.

1.3 Confirmation of Program Split for Indicative Funding

During country dialogue, the applicant will propose how best to distribute indicative funding across relevant disease programs and cross-cutting health systems strengthening (HSS). Please provide the original indicative program split as communicated by the Global Fund, and, if relevant, the split approved by the Global Fund following country dialogue.

Program	**Original Indicative Program Split Amount (USD)**	**Approved Program Split Amount (USD)**	
HIV	**0**	HIV	0
		Cross-cutting HSS	0
Malaria	0	Malaria	0
		Cross-cutting HSS	0
Tuberculosis	38,830,000	Tuberculosis	38,830,000
		Cross-cutting HSS	0
Total Indicative Funding	**38,830,000**	**Disease components**	**38,830,000**
		Cross-cutting HSS	**0**

SECTION 2: CCM ELIGIBILITY REQUIREMENTS AND DUAL TRACK FINANCING

Two of the six CCM Eligibility Requirements relate to development of the funding request and Principal Recipient (PR) selection processes and will be assessed as part of the funding request:

a. **Requirement 1** – Funding request development process

b. **Requirement 2** - The Principal Recipient(s) selection process.

For each requirement, applicants must provide evidence of compliance and attach relevant supporting documentation. Please also fill in the **CCM Endorsement (Attachment 1)**.

2.1 Funding Request Development Process (Requirement 1)

Describe:

a. The **documented and transparent process** undertaken by the CCM to engage a broad range of stakeholders, including non-CCM members, in the funding request development process.

b. The efforts made to engage **key populations,** including most-at-risk populations, as active participants in the country dialogue and funding request development process. In your response, please be specific on who has participated.

The Concept Note (CN) development process started in February 2013, and the CCM Kazakhstan coordinates the development of CN through a transparent and open process that engages a broad range of stakeholders, including CCM members and non-members. CCM and Country team (government and non-government stakeholders, most-at-risk populations, key affected people, injecting drug users, people living with HIV (PLHIV), TB patients in the civilian and penitentiary sectors, family members and health specialists) were involved in the solicitation and review of activities to be included in CN. The CCM documented its efforts to engage the affected populations, people living with diseases in the development of CN, including most-at-risk populations.

During the process, the CCM followed TGF eligibility requirements to CCM and, as a follow up to these requirements, the CCM had launched the 'country dialogue' through a broadened CCM meeting; total seven CCM meetings were conducted during the CN development process, which had resulted in the launching of the country dialogue within the TGF NFM, approval of the work plan on the CN development and the plan on implementation of the country dialogue activities, review of the National Strategic Plan (NSP) and TRP feedback to the early draft of CN, WHO comments on NSP as well as the establishment of working group to develop the CN.

The working group has been represented by the government and non-government experts, CCM members and non-CCM members, and key affected population groups. The CCM round table meeting conducted in collaboration with National Center of TB Problems (NCTP) and with participation of the national and international experts, PLHIV, people affected by TB, national NGOs, health specialists, injecting drug users. Seven meetings were held during this period, which resulted in the endorsement of the PR selection criteria, review of proposals from the PR candidates and other CCM issues, including the meetings with the participation of GMS experts. The gaps and problems were discussed through e-mail correspondence, and all supporting documents, in particular, minutes of the meetings, resolution of the broadened meetings the and reports that confirms a transparent process, were published at the CCM website.

In detail, the CN development process is described below. It proves the transparent and open

development process, and clearly demonstrates that it is in line with the country's national disease prevention and control plans.

The following steps were undertaken by the CCM to meet TGF Requirement No. 1:

1. Launching of the Country dialogue through the broadened CCM meeting held on 16-17 May 2013, with participation of the CCM members and partners from different entities who are involved in TB and HIV/AIDS prevention and control. The participants of the meeting included 65 persons representing the government and non-government sectors, including the Minister of Health, Deputy Ministers of Economic Development and Budget Planning, Internal Affairs, Education and Science, Defense. Along with the government stakeholders, CCM members, international experts and representatives of vulnerable groups and civil society organizations took part in the meeting. During the meeting, CCM members and other participants discussed the country needs and future plans to reduce TB and DR-TB burden in the country, which need to be solved through the reform of the tuberculosis activities by implementing the modern and innovative technologies for prevention, diagnostics and treatment of TB), MDR TB and XDR TB, recommended by the WHO. In compliance with the latter the CCM's members adopt the Resolution of the CCM meeting (Annex 1 to Section 2.1) that addressed to the:

a. Development of the «National Strategic Plan of Actions to Fight TB, M/XDR TB in Kazakhstan for 2013-2020», aimed at the reform in civil and penitentiary sectors, based on the outcomes of the healthcare projects implemented by the World Bank, GFATM, government and non-government organizations and peer -reviewed by WHO experts; And to define as prioritized areas: Rational distribution of funding; adequate social support.

b. Development of "Concept Note" which strategic aspects should be in line with the «National Strategic Plan of Actions to Fight TB, M/XDR TB in Kazakhstan and according to the GFATM schedule in the process of elaboration and submission of "Concept Note".

1.3.To incorporate following areas into the Concept Note: 1) «Country-wise expansion of NGO involvement in decision-making process on solving medical, social, and domestic problems of the TB, M/XDR TB patients during the whole treatment course funded by the government budget and GFATM grant; 2) «Enhancement and implementation of a set of tuberculosis activities among the internal and external migrants to ensure their access to a quality medical aid» and strengthening interaction between the national and international partners to expand the prevention and treatment services; 3) «Strengthening of the programmes on TB, M/XDR TB prevention, diagnostics and care among most-at-risk population in the course of expanding of ambulatory treatment of TB patients»…

2. Global fund Country Team Pre-assessment, including the main strategic recommendations to develop a Concept Note have presented by the Global Fund Portfolio Manager at the expanded CCM meeting (Annex 18 to Section 2.1)

3. Development and approval of the Country dialogue plan to meet NFM requirements. National Country Dialogue Plan included 23 activities and describes the appropriate method of engagement and consultation for each stakeholder group and which parts of the process they can most contribute to data collection and validation, to determine the national and sub-national disease situation. Additionally, National Country Dialogue plan identifies the key affected populations, technical partners, experienced service providers and other implementers (representatives of the public sector and civil society organizations), which were engaged in review of the National strategic plan and to update information on existing programs and progress(Annex 2 to Section 2.1)

4. Development of the Consolidation letter - as part of Country Dialogue Plan to increase collaboration and partnership in particular to strengthen efforts in implementation of collaborative HIV/TB activities and to effective coordination and utilization of resources at the country level the Republican Center to Fight AIDS and National Center for TB problems of the Ministry of Health of the RK identified gaps and ways to solve it (Annex 17 Section 2.1);

5. Establishment of the CCM working group to develop the CN. The working group members include experts from the National TB Program, a WHO consultant, Ministry of Internal Affairs, Republican AIDS Center, international NGO - Project HOPE, and organizations representing key affected populations (Annex 3 to Section 2.1);

6. Advertisement in the republican-level newspaper "Kazakhstanskaya Pravda during the period 26 June – 16 July 2013 on the CN development process (Annex 4 to Section 2.1);

7. Collection of proposals from a broad range of stakeholders (Annex 5 to Section 2.1);

8. Focus group discussions (FGDs) with prisoners from Almaty region (Enbek and Taldykorgan), Akmola (Stepnogorsk), IK 167/3 and 167/2 (Karaganda region), TB patients from civilian sector, family members and relatives, PLHIV; NGOs: PF "Shapagat" (Temirtau), "Doverie plus" (Almaty), Association of AIDS Services Organizations (Shymkent), "Moi dom" (Temirtau); internal and external migrants from Astana and Almaty cities, regional, district and national levels of primary health care and TB institutions. Questionnaires for FGDs were developed by the national experts with the involvement of the vulnerable groups' representatives. FGDs were conducted with technical assistance of CDC, Project Hope, NGOs "Shapagat", "Doverie plus" and "Luch Nadezhdy" (Kokshetau) (Annex 6 to Section 2.1);

9. In depth interviews with local authorities: Head of Almaty City AIDS Center, International Organization of Migration (IOM), district TB specialists and roentgenologists (Annex 7 Section 2.1);

10. Review of the proposal activities to be included in the CN, with participation of key affected populations' representatives, people living with diseases, national and international NGOs, CCM members, medical specialists from the national-level and local-level TB facilities, PHC specialists (Annexes 8, 9, 10 and 11to Section 2.1);

11. Review of the Concept Note with the Global Fund experts and Country Team;

12. Approval of the early draft of the Concept Note to get early feedback from the TRP (Annex 12 to Section 2.1)

13. Working group meeting in Almaty with the WHO Consultant on the review of the draft National Strategic Plan on TB (Annex 13 to Section 2.1);

14. Review of the TRP feedback for the early CN and Responses to TRP comments which were agreed by all constituencies (Ministry of Health, CCM, National TB Center with participation of key affected people) (Annex 14 to Section 2.1);

15. Alignment with the National Strategic Plan on TB control (Annex 15 to Section 2.1);

16. Endorsement of the final version of the Concept Note (Annex 16 to Section 2.1).

2.2 Principal Recipient (PR) Nomination and Selection Process (Requirement 2)

Describe:

a. The documented and transparent **process and criteria** used to nominate any new or continuing PR(s).

b. How any **potential conflict of interest** that may have affected the PR(s) nomination process was **managed**.

Along with the launching of the Country Dialogue process for the NFM application, the CCM has discussed the PR nomination, which must follow a transparent and open procedure. During the meeting, the CCM discussed the possibility of dual-track financing that presumes selecting a non-government organization as Principal Recipient of funds along with a government body within the NFM.

In order to successfully nominate one or more PRs, the CCM established a working group to develop the PR selection criteria to identify minimum capacities and systems of the future PR(s). Four CCM meetings were held during the preparation period, which resulted in the review and endorsement of the PR selection criteria, review of the proposals from candidates, selection and preparation of the presentations to the CCM to nominate PRs for TGF NFM grant. The PR selection procedure was based on the CCM regulations and rules. The related supporting documents were published on the CCM website. The implementation of both requirements was

under the control of TGF: FPM and CCM Hub.

For each requirement, applicants had to provide evidence of compliance and attach relevant supporting documentation. Please also refer to the CCM Endorsement of the application (Attachment 1).

a. The documented and transparent process and criteria used to nominate any new or continuing PR(s).

PR nomination process was described in the CCM regulations as of 17 April 2013, which sets up the requirements for the documented and transparent process and criteria used to nominate the PR(s). This process includes the following steps:

1. Establishment of the working group by the CCM to develop the CN. The working group members are represented by the experts from the NCTP, the WHO consultant, Ministry of Internal Affairs, Republican AIDS Center, international NGO - Project HOPE, and representatives of key affected populations (Annex 1 to Section 2.2);

2. Meeting to discuss PR selection criteria and application forms for the potential PRs. As decided by the CCM, two criteria for the government and non-government PRs were developed by the working group (Annex 2 to Section 2.2);

3. Presentation of the PR selection criteria to the CCM (Annex 3 to Section 2.2)

4. Approval of the PR selection criteria, advertisement content and application forms for potential government and non-government PRs (Annex 4 to Section 2.2);

5. Advertisement of the PR selection in the republican newspaper "Kazakhstanskaya Pravda during the period 17 August – 02 September 2013 (Annex 5 to Section 2.2);

6. Collection of applications from the potential PRs. To the CCM Secretariat received two packages of documents submitted by the governmental and non-government organizations. According to the CCM hub consultations, the PR selection process was transparent and eligible for the evaluation of the two PR applications received, since sufficient time (i.e. at least 14 days, as specified in the Screening Template for Eligibility Requirements 1 and 2) was allowed for any interested organization to submit applications.

7. Two working group meetings to review the PR applications in terms of compliance to the approved CCM criteria. Both meetings were held with the participation of TGF Local Fund Agent (LFA) as an observer (Annexes 6 and 7 to Section 2.2);

8. CCM meeting on the nomination of PRs and the division of responsibilities for implementation of the NFM activities; the broadened CCM meeting was held with participation of national and international partners (Annex 8 to Section 2.2);

b. How any potential conflict of interest that may have affected the PR(s) nomination process was managed.

At the CCM meeting on PRs' selection, two CCM members stated a Conflict of Interests issue since one of proposed PRs (NCTP) was an organization directly accountable to MOH; as a result,

they did not take part in the voting (Annex 9 to Section 2.2):

1. Kairbekova S.Z. – CCM Chair, Minister of Health;
2. Esmagambetova A.S. – CCM member, Head of the Committee on Sanitary and Epidemiological Control of the Ministry of Health.

2.3 Dual-track Financing

Dual-track financing refers to a proposed implementation arrangement that involves both government and non-government sector PRs. If this funding request does not reflect dual-track financing, please explain why. **If this funding request includes a dual-track financing arrangement do not complete this section**.

TGF recommendations in the implementation of DTF have been fulfilled. The CCM has nominated two entities as Principal Recipients of the grant funds:

1. National Center of Tuberculosis Problems (NCTP), representing governmental sector, and
2. Project HOPE, representing non-governmental sector.

SECTION 3: COUNTRY CONTEXT

3.1 Country Disease and Health Systems Context

Explain the current and evolving epidemiology of the disease and relevant health system constraints in the country. Refer to the Performance and Impact Profile (PIP) provided by the Global Fund, and provide additional information to highlight the concentration of burden among specific population groups, age groups, gender and/or geographic regions, and any recent disease pattern changes (incidence or prevalence). Describe:

a. **The epidemiological situation and the key populations** that are epidemiologically important, and may have disproportionately low access to prevention and treatment (and for HIV and TB, the availability of care and support services).

b. Factors that may cause **inequity in access to services** for treatment and prevention, such as gender norms and practices, poverty, geography, conflict and natural disasters.

General information

The Republic of Kazakhstan is a country in Central Asia, which regained independence from the Soviet Union in 1991. Kazakhstan is the world's largest landlocked country by land area (2,727,300 sq.km) and the ninth largest country in the world. At the beginning of 2013, the country population was 16,909,776 inhabitants[1].

Over the last decade, the country has achieved significant progress in macroeconomic development; currently Kazakhstan is ranked by the World Bank as an upper-middle income (UMI) country; Gross National Income (GNI) per capita was USD 9,750 per capita[2].

Tuberculosis epidemiology

Tuberculosis (TB) re-emerged as a public health threat in early 1990s, after the breakdown of the

[1] *Source*: Agency of Statistics of the Republic of Kazakhstan, www.stat.kz, as of 01.01.2013.
[2] *Source*: The World Bank, http://data.worldbank.org/country/kazakhstan. Atlas method, in current US dollars.

Soviet Union, and its burden remains high in Kazakhstan. According to the latest WHO estimates for 2012[3], TB incidence is 137 per 100,000, which the third highest level among 53 countries of the WHO European Region.

According to the NTP notifications data, there were a total of 23,455 TB cases, all forms, in 2012 (including penitentiary sector), or 139.7 per 100,000 population; out of these, 14,391 were new cases (85.7 per 100,000).

Drug-resistant tuberculosis

The extremely high burden of anti-TB drug resistance is the key challenge for the NTP and the main obstacle for effective TB control in the country. WHO estimates MDR-TB prevalence at 23% in new cases and 55% - in retreatment cases. The NTP data show even higher burden. The two tables and the graph below present the last four years' NTP data (civilian sector only) on the coverage with drug susceptibility testing (DST) and DST testing results in new and retreatment cases by the oblast level TB reference laboratories and the National Reference Laboratory (NRL)[4].

Table 3.1. DST coverage and drug resistance patterns in new pulmonary culture-positive TB cases (civilian sector), 2009-2012

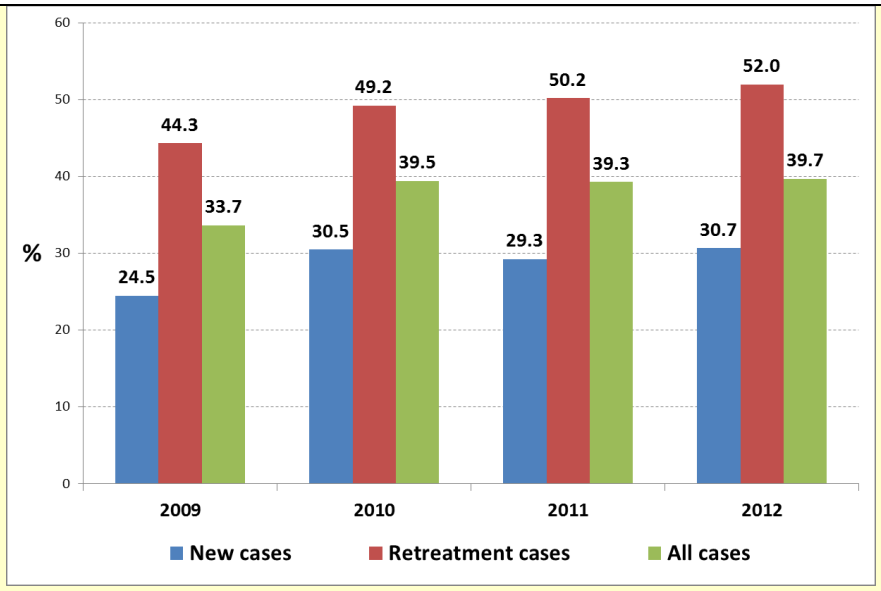
Year	*Total cases*	*DST coverage, %*	*Cases with DST results*	*Drug resistance pattern, %*			
				Sensitive to all FLDs	*Mono-R*	*PDR-TB*	*MDR-TB*
2009	5,111	89.2	4,559	47.3	9.4	18.8	24.5
2010	5,022	92.0	4,619	42.6	8.6	18.3	30.5
2011	5,293	93.8	4,963	42.2	9.9	18.6	29.3
2012	5,819	94.9	5,520	41.6	9.6	18.1	30.7

Table 3.2. DST coverage and drug resistance patterns in previously treated pulmonary culture-positive TB cases (civilian sector), 2009-2012

Year	*Total cases*	*DST coverage, %*	*Cases with DST results*	*Drug resistance pattern, %*			
				Sensitive to all FLDs	*Mono-R*	*PDR-TB*	*MDR-TB*
2009	4,460	88.1	3,928	29.4	7.3	18.9	44.3
2010	4,614	91.4	4,218	24.9	7.1	18.8	49.2
2011	4,862	93.6	4,551	24.3	8.4	17.0	50.2
2012	4,288	94.6	4,056	21.9	8.7	17.4	52.0

Figure 3.1. MDR-TB prevalence among new and previously treated culture-positive TB cases in Kazakhstan (civilian sector), 2009-2012

[3] *Source*: WHO, Global tuberculosis report 2013.
[4] *Source*: *Statistical Overview on Tuberculosis*, Ministry of Health and National Center of Tuberculosis Problems, for 2009-2012



The overall coverage with DST testing in Kazakhstan is high and reaches 95% in both new and retreatment culture-positive cases. The MDR-TB rates are generally increasing with time and are currently as high as 30% among new cases and over 50% – among retreatment culture. In all cases (new and retreatment) with DST results, almost 40% of them have MDR, 27% have other resistance patterns (mono- and poly-resistance), and only about one-third of cases are sensitive to all first-line drugs. This extremely high burden of drug-resistant TB mandates the NTP to mobilize all resources and efforts in order to provide universal access to appropriate care for all TB patients according to their resistance profile.

* * *

Special population groups, which are considered at high risk of contracting TB and DR-TB, and which are addressed in this proposal to the Global Fund, are prisoners, people living with HIV and labor migrants.

Tuberculosis in prisons

Tuberculosis remains an acute problem in the penitentiary sector. During the last decade, a criminal law reform was carried out in Kazakhstan to bring it in line with the norms of international law. This reform included application of alternative sanctions, which allowed to reduce the number of imprisoned population. While in 1998, Kazakhstan had the third-highest rate of prison population in the world, in 2012 it was on the 30th place. The average annual number of detainees in the criminal-executive system (CES) of Kazakhstan was 42.4 thousand in 2012.

The table below presents the absolute numbers and rates for TB registered incidence, prevalence and mortality for the past ten years (2003-2012).

Table 3.3. TB incidence, prevalence and mortality (absolute numbers and rates) in the penitentiary system of Kazakhstan, 2003-2012

Indicator	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
Total prison population, abs.	51,788	49,522	44,234	42,428	44,556	49,272	53,802	52,580	46,629	42,362
New TB cases, abs.	2,137	1,388	1,042	1,230	1,100	1,361	1,287	986	731	629
All TB cases, abs.	6,340	6,042	5,150	4,920	3,665	3,925	3,748	2,634	2,451	1,779
TB mortality, abs.	103	82	45	103	122	160	179	138	86	77
New TB cases, per 100,000	4,126.4	2,802.8	2,355.7	2,899.0	2,468.8	2,762.2	2,392.1	1,875.2	1,567.7	1,484.8

All TB cases, per 100,000	12,242.2	12,200.6	11,642.6	11,596.1	8,225.6	7,966.0	6,966.3	5,009.5	5,256.4	4,199.5
TB mortality, per 100,000	198.9	165.6	101.7	242.8	273.8	324.7	332.7	262.5	184.4	181.8

Over the last decade, as a result of the overall improvement of detention conditions and strengthened TB control interventions, TB incidence and prevalence rates in the penitentiary system have substantially decreased: by 64.0% and 65.7%, respectively. However, these rates remain high and about 20 times exceed the respective rates in the civilian sector.

TB mortality rates in prisons are very high, mainly due to drug-resistant TB forms. According to CES and NTP data, during the last four years, multidrug-resistance in the penitentiary system was found in 29.7-40.6% of new cases and 60.7-72.0% of retreatment cases. Due to high MDR levels, the treatment success rate in new smear-positive cases is just above 50%.

Treatment of MDR-TB cases in prisons in accordance with WHO recommendations started only in 2010, with second-line drugs (SLDs) procured by the Global Fund Round 8 TB project. The Ministry of Internal Affairs (MoIA) / CES procured SLDs for 150 MDR treatment, and will continue procurement at the same level for 2013-2017.

HIV-associated tuberculosis

According to the National AIDS Program (NAP) / Republican AIDS Center, a total of 12,279 HIV-infected individuals were on evidence in the country at the end of 2012, which is 22% higher than the 2010 number. Regarding TB/HIV co-infection, WHO estimates that 2.1% of all TB patients registered in 2012 were HIV-positive, and 58% of them received antiretroviral (ARV) treatment.

At the same time, the NAP documents different data showing a steady increase in TB/HIV cases over the last three years: if in 2010, there were 807 TB cases among PLHIV, this number rose to 983 in 2011 and 1,316 – in 2012 (out of which, new TB cases: 503, 573 and 667, respectively). Therefore, TB/HIV rate increased from 3.2% in 2010 to 4.3% in 2011 and to 6.1% - in 2012. Across the country regions, the highest rates of TB/HIV co-infection are registered in Karaganda oblast, Almaty city and oblast, Kostanay, South Kazakhstan and Pavlodar oblasts. According to the NTP and NAP, ARV therapy was administered in 53.7% of TB/HIV cases, and Co-trimoxazole preventive therapy (CPT) – in 67.3% of cases.

While almost all (98%) of TB patients on treatment are tested for HIV, the coverage by TB screening among PLHIV is low. In 2012, 74% of all PLHIV registered at AIDS Centers were screened by some means (questionnaire, physical examination or X-ray), but X-ray examination was done in only 54.2% of them. Further, only 8.0% of TB suspects who were screened by X-ray, underwent smear microscopy examination at a TB service facility.

Insufficient TB case finding among PLHIV is linked to a number of factors related to stigmatization, behavioral issues and/or bottlenecks in cooperation between the two services leading to limitations in access. About 60% of PLHIV registered at AIDS Centers are represented by injecting drugs' users, persons without fixed abode and migrants; all these categories are often difficult to reach for follow up and care and these problems are additionally complicated by the formal bottlenecks at service delivery level, further limiting access to needed care.

The data on TB testing in PLHIV and TB/HIV cases for the last three years are summarized in the table below.

Table 3.4. Selected data on TB / HIV cases and testing for TB among PLHIV in Kazakhstan (civilian sector), 2010-2012[5]

	2010	*2011*	*2012*
Total number of PLHIV registered at AIDS Centers	10,057	11,359	12,279
PLHIV screened for TB, by any method, abs.	6,589	8,091	9,050
% of PLHIV screened for TB, by any method	65.5	71.2	73.7

[5] *Source*: Republican AIDS Center

PLHIV screened for TB by X-ray, abs.	4,623	5,582	6,654
% of PLHIV screened for TB by X-ray	46.0	49.1	54.2
PLHIV tested for TB by smear microscopy	316	387	529
% of PLHIV tested for TB by smear microscopy (of those screened by X-ray)	6.8	6.9	8.0
Smear positive cases among PLHIV, abs.	120	156	183
% of smear positive cases among PLHIV tested by smear microscopy	38.0	40.3	34.6
Total number of TB/HIV cases	807	983	1,316
Number of new TB cases among PLHIV, detected during the year	503	573	667
Total number of TB cases (civilian sector)	24,847	23,076	21,676
TB/HIV prevalence, %	3.2	4.3	6.1

TB and labor migration

Over the last decade, the external labor immigration to Kazakhstan increased substantially due to the rapid growth of the national economy attracting people from other countries (mainly, neighboring Central Asian countries: Kyrgyzstan, Uzbekistan, Tajikistan) for work. In addition, the internal labor migration is also significant (to the capital city and several industrially developed cities and regions with high demand of workforce).

The data on TB, DR-TB and TB/HIV among labor migrants in Kazakhstan have been very scarce so far; however, the recent estimates (e.g. those developed based on a study by Project HOPE) indicate that the number of TB cases among migrants may add up to 10% to the total number of TB cases in the country, and the burden of DR-TB and TB/HIV in migrants is likely to be higher than that in general population.

The WHO NTP Review 2012 identifies that Kazakhstan faces an important challenge to improve its TB care delivery system in order to address TB control issues among internal and external labor migrants. Formally, internal migrants have all rights to receive TB diagnostic and treatment services, however in reality they often do not benefit from the services due to the lack of information about the necessity to register with a medical institution at the place of their temporary residence. Undocumented external migrants, according to the legislation in force, are legible for medical assistance only in emergency conditions. A Project HOPE study on access of migrants to health care services revealed the problems in terms of legal barriers (difficulties in obtaining registration, fear of deportation), work conditions (high workload, lack of labor hygiene, difficult living conditions) and health system barriers (limitations in access, staff attitudes, language barriers, etc.).

Key issues of access and TB care delivery

The health system in Kazakhstan strives to provide full and equal access to essential services, including diagnosis and treatment of TB, DR-TB and TB/HIV. At the same time, there are a number of barriers in TB service delivery that need to be addressed in order to ensure appropriate TB control including halting the development and spread of drug-resistant TB. These problems are highlighted in the *Complex Plan for Tuberculosis Control in Kazakhstan 2014-2020* and will be addressed by the interventions included in this proposal for TGF financing under NFM.

- The NTP ensures universal access to diagnosis of TB and DR-TB, with 95% overall coverage by drug-susceptibility testing (DST), as shown above. However, rapid diagnostic methods are still underused; this results in late diagnosis of the full resistance profile, which prevents from proper separation of patient flows and initiation of a correct treatment regimen according to the resistance status, and, ultimately, contributes to amplification of resistance and transmission of DR-TB strains.
- Inherited from the Soviet times, the TB care delivery system in Kazakhstan holds to a

hospital-based treatment model, when the vast majority of TB cases are hospitalized, for at least intensive phase of treatment. In the absence of appropriate measures for infection control in TB hospitals, this amplifies the risk of nosocomial transmission of TB, including MDR and XDR forms. Besides this threat in terms of DR-TB burden, excessive TB inpatient infrastructure leads to unnecessary hospitalizations and extended duration of the hospital stays, which creates substantial inefficiencies in the utilization of resources in the system. These inefficiencies were revealed in detail within the World Bank program in 2012 (under the oblast Master Plans for hospital restructuring component), which developed detailed recommendations for TB hospitals' downsizing by each region. Between 2008-2013, the number of TB hospital beds in Kazakhstan was reduced from 14,685 to 12,751 (by 13.2%), but MOH and NTP recognize that it is insufficient and further optimization efforts are required.

- There is a stringent need to expand full outpatient treatment of TB patients, including DR-TB cases, as this is seen as a key to interrupting further increase of M/XDR-TB burden and, at the same time, as the means for improving efficiency and facilitating implementation of patient-centered TB care.
- Important regulatory and/or institutional barriers exist that limit access to appropriate TB, DR-TB and TB/HIV care for vulnerable and high-risk population groups (prisoners and ex-prisoners, PLHIV and MARPs, labor migrants), which need to be tackled, inter alia, through multidisciplinary and multisectoral approaches.

3.2 National Health Sector and National Disease Strategic Plans

Describe the current national health sector strategic plan, as well as the relevant national disease strategic plan (and attach these documents), and the implementation of these plans to date, citing any recent evidence from relevant program reviews, evaluations, surveillance data or surveys.

Summarize for each plan:

a. The **key goals, objectives and priority program areas.**

b. The **key implementers** involved, and their main sources of funding.

c. **Main outcomes and impact** achieved to date, noting any limitations in **national data systems** to measure service delivery and/or demonstrate impact.

d. Country processes **for reviewing and revising** these plans. If valid for less than 18 months, explain the process and timeline for the development of a new plan.

e. **Constraints to implementation**, and **lessons learned** that will inform future implementation.

Also summarize:

f. The **main areas of linkage** between the plans, including how implementation of the national health sector strategic plan impacts on HIV, tuberculosis and malaria outcomes.

g. **Key human rights barriers** (including those relating to gender inequalities) that may impede access to health services, and existing programs that address these key constraints.

h. The **main community systems-related constraints** that challenge the achievement of planned outcomes, and existing programs that address these key constraints.

The National TB Program (NTP) started DOTS strategy implementation in Kazakhstan in 1998, followed by the implementation of DOTS-Plus in 2001. The WHO NTP Review (2012) noted documented that the country had achieved significant progress in its TB control program building on WHO-recommended policies and guidance.

Between 2002 and 2012, the rate of all forms of TB in Kazakhstan has decreased by about 40%. During the same period, the registered TB incidence (notifications of new TB cases) has decreased by 49%, and TB mortality – by 67%.

Of particular importance is the Government commitment to fight TB, with continuous increase in the allocated budget every year (between 2009-2013, the annual consolidated state budget expenditures for health have increased by 39.1%).

In addition to this increased financial commitment, the Ministry of Health (MOH) and NTP are striving to increase performance and efficiency of TB services by increased involvement of PHC in TB control, expanded ambulatory (outpatient) treatment, reduction of unnecessary hospitalization of TB patients, and decreasing the duration of TB hospital stays.

During the last years, the health system of Kazakhstan has been subject to reforms and transformation, including that of health financing. The actual situation mandates adjustments in the legislation and the financing system, aimed preparing the conditions for creation of a new rational TB control system within the overall health system reform, with reduction of TB hospital beds and expansion of outpatient treatment of TB patients and increased involvement of primary health care (PHC). Strategic interventions of the proposed Complex Plan are linked to and harmonized with the World Bank recommendations, defined in the Master Plans for each of the country's administrative territories (14 oblasts and 2 cities).

The comprehensive NTP review of the National TB Program, conducted in 2012 by WHO Regional Office for Europe (WHO/EURO) in cooperation with NCPT and other partners, assessment of TB services carried out by Sanigest Internacional (2012-2013) as well as assessments of the laboratory network and infection control, a number of weaknesses and challenges have been identified. The key NTP challenges include: the need for revision of the existing TB care delivery model; revision of protocols and guidelines for prevention, diagnosis and treatment (especially M/XDR-TB), TB in children, infection control; strengthening TB control in prisons and collaboration between the civilian and penitentiary services; addressing TB/HIV, TB in labor migrants and other vulnerable groups; strengthening TB surveillance; improving bacteriological confirmation of TB diagnosis (through scaling-up rapid molecular methods); and increasing involvement of local public authorities in patient adherence support.

In order to address the emerging challenges, first and foremost high burden of anti-TB drug resistance, and in line with WHO recommendations, the country has developed a new National Strategic Plan (NSP) for TB control: *Complex Plan for Tuberculosis Control in Kazakhstan for the Period 2014-2020.* This NSP defines the overarching goal, targets, strategic interventions and activities, with the purpose to inform and guide TB prevention, care and control in the country during the time span it covers.

This NSP is a result of close collaboration between the NTO, other national stakeholders and international partners. The document has been developed in line with the WHO strategic guidance (e.g. *Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015*), as well as with the national strategic documents, such as the *State Program on Health Development for 2011-2015 'Salamatty Kazakhstan'* (Annex 3.3).

The Complex Plan builds on the achievements of international support to TB control in Kazakhstan, including that provided by the Global Fund. The country is determined to continue its progress in fighting the disease. The NSP sets up the *Long-Term Vision* as Kazakhstan free of TB. The overall *Goal* is reduction of TB incidence and mortality by year 2020: incidence – to 55 per 100,000 population and mortality – to 5.8 per 100,000 population. The Plan also emphasizes the need to maintain universal coverage of treatment of all forms of TB including M/XDR-TB cases.

The Master Plan (the core part of the NSP) presents the key activities to be implemented, which are

structures around four main Objectives and thirteen Strategic Interventions.

- *Objective No. 1* deals with the reform of TB control system in the civilian and penitentiary sectors, with primary emphasis on the expansion of outpatient TB treatment including that of DR-TB patients. It includes the improvement of the legislative and regulatory framework, necessary for implementation of the planned changes in the organization of services and financing system during the next seven years. Specific activities are also defined for stronger involvement of PHC services and extension of full ambulatory treatment of TB patients. It is foreseen to reduce the total number of TB hospital beds by 35%, and the average length of hospital stay with TB (to 30 days in 2020).
- *Objective No. 2* focuses on the improved access to modern TB and DR-TB diagnosis and treatment, as well as on the strengthened prevention, including that in penitentiary sector and migrants. It includes interventions aimed at increasing coverage with rapid DST tests to 95%. It is expected that proper implementation of these activities will contribute to reaching treatment success rates of 85% (for sensitive TB forms) and 75% (for MDR-TB patients).
- *Objective No. 3* comprises interventions aiming at improving infection control in TB facilities, including those in the penitentiary sector, upgrade of TB information system, which will provide reliable data for the use by policy-makers and managers at all levels of TB control.
- *Objective No. 4* outlines activities for strengthening of interdepartmental and intersectoral cooperation in the field of TB control. These include definition of standards of social support to high-risk groups. It is expected to improve provision of health care to migrants, strengthen TB/HIV collaborative activities and ensure 100% coverage of needs with HIV testing among TB patients, TB screening among PLHIV, and provision of isoniazid-preventive therapy and antiretroviral treatment.

The Complex Plan includes the Operational Plan, the Technical Assistance Plan, the Monitoring and Evaluation Plan and the Budget Plan for key interventions. The Plan is attached to this application form in Annex 3.4.

3.3 Enhancing TB/HIV Collaborative Activities

All **TB and HIV funding request(s)**, must describe the scope and status of on-going TB/HIV collaborative activities.

Describe:

a. How the funding request will strengthen TB/HIV collaborative activities.
b. The linkages between the respective national TB and HIV programs in the country, including service delivery, reporting systems, and policy development and coordination processes.

The CCM Kazakhstan recognizes that, while TB/HIV is a growing public health concern, there are a number of serious limitations in TB/HIV collaboration in the country, which need to be overcome in order to ensure effective control of TB/HIV co-infection.

The CCM therefore decided to include support to TB/HIV collaborative activities in a distinct component (Objective 4) in NFM proposal. The interventions address the two priority areas for action: i) strengthening interactions and cooperation between TB services and HIV/AIDS services in the country through updating the national legislation, regulation and guidance and aligning them to the up-to-date international policies and practices, and ii) addressing the key bottleneck in decreasing the burden of TB in PLHIV: improving TB case detection among HIV-infected individuals through rolling out rapid TB and MDR-TB diagnostics (Xpert MTB/RIF) to the regional AIDS Centers.

In addition, a number of interventions under other components of the project also address TB/HIV issues. Relevant interventions are foreseen under Objective 5, focused on prisons; Objective 6, aimed at fostering participation of civil society; and Objective 7, which addresses TB, DR-TB and HIV among a large at-risk segment of internal and external labor migrants.

Support to TB/HIV collaboration is part of both 'Indicative' and 'Above Indicative' requests. All interventions included in this proposal, have been developed in close collaboration between the NTP and National AIDS Program (NAP), as well as with participation of NGOs active in the field.

SECTION 4: FUNDING REQUEST TO THE GLOBAL FUND

4.1 Programmatic Gap Analysis

The programmatic gap tables submitted in this section provide the analysis to explain the underlying rationale for the funding request.

a. For the **3-6 priority interventions for which funding is** requested, complete the relevant number of Programmatic Gap Tables (below). The tables describe the extent to which key interventions are supported, and where key gaps remain.

b. If some of these priority interventions are **difficult to quantify** (i.e. not service delivery interventions), explain this in narrative form below, including the types of programs in place, the populations or groups involved, and the current funding sources and gaps.

c. In order to understand the **overall funding landscape** of the national program, briefly describe the program areas currently receiving financial support and the source of such funding (domestic and/or donor). Highlight in particular the areas that are adequately resourced by this funding and are therefore not included in the request to the Global Fund.

The programmatic gap tables are presented below and, additionally, in Excel format in Annex 4.1.

Four priority interventions are presented in this section:

1. Rollout of Xpert MTB/RIF rapid diagnostic technology for TB and MDR diagnosis at the peripheral (district) TB service level
2. Expansion of full outpatient treatment of DR-TB cases
3. Introduction and rollout of Xpert MTB/RIF testing among people living with HIV (at AIDS Centers)
4. Introduction and rollout of Xpert MTB/RIF testing among detainees (in pre-trial isolators of the penitentiary system)

These interventions are considered of high priority and represent a major focus of the NFM application, given the high burden of drug resistance and the need to expand rapid diagnosis, as well as to implement contemporary approaches to case management, with special emphasis on high-risk groups.

The description of related interventions (Activities 2.2, 3.1, 4.2 and 5.2), for both 'Indicative' and 'Above Indicative' amounts, is given in Sections 4.4-4.5 below. The detailed calculations, related to the estimates of the programmatic needs and the coverage during the NFM project years, are part of the Workplan and Budget files for each Objective (Annex 4.2 to this application form).

Interventions 1 (Xpert rollout at district level) and 2 (expansion of full ambulatory treatment of DR-TB cases) are presented by 'Indicative' and 'Above Indicative' amount. The reason of this breakdown is that the project includes different country regions as demonstration areas (four

regions under 'Indicative' request and four regions – under 'Above Indicative' request), which have different target populations and, respectively, different denominators.

The priority intervention related to rolling out of Xpert MTB/RIF at district level aims at ensuring universal (at least 95%) coverage of needs in the demonstration regions. The expansion of outpatient DR-TB case management model is a challenge but at the same time is the key priority for the NTP, as stipulated by the *Complex Plan 2014-2020*. With the Global Fund support under NFM, it is planned, by Year 3, to treat 80% of MDR cases and 90% of PDR cases without hospitalizations in the demonstration areas.

Priority interventions 3 and 4 aim at scaling up rapid diagnosis of TB and MDR-TB by Xpert among the two key population groups at high-risk: PLHIV and prisoners. The 'Indicative' request foresees the coverage of calculated countrywide needs of about 65% in PLHIV and 55% in detainees at pre-trial detention facilities (PTIs). If 'Above Indicative' funding is obtained for these interventions, the needs' coverage will increase to 95% in both groups.

It is expected that, after the Global Fund project is over, the successful experiences and best practices developed with this support, will be replicated in other country regions and settings, and will receive full and sustainable financing from domestic sources (central and oblast budgets).

It should be noted that the domestic programmatic and budgetary support in Kazakhstan is substantial and has been significantly increasing over the last decade. It includes, inter alia, coverage of all needs in terms of first-line TB drugs (FLDs) and the major share of required second-line drugs (SLDs), as well as growing contribution of the local public authorities to adherence support. These areas are considered as adequately resources and therefore, except targeted assistance to MDR treatment in prisons and XDR cohort at NCTP, procurement of drugs is not included in this proposal and, treatment coverage indicators are not included in the below tables.

Intervention 1

PROGRAMMATIC GAP TABLE (Per Priority Intervention) *(create 3-6 programmatic gap tables as needed)*					
Priority Intervention		**2.2. Demonstration projects on Xpert MTB/RIF rollout at district level**			
Selected coverage indicator		**Number and percentage of TB suspects tested with rapid diagnostic technique for TB and MDR-TB (Xpert MTB/RIF) in the demonstration areas. 'Indicative Amount': Zhambyl and Kyzyl-Orda oblasts, Astana and Almaty cities. 'Above Indicative Amount': Aktobe, East Kazakhstan, South Kazakhstan and Almaty oblasts.**			
Rationale for chosen indicator		According to WHO recommendations, Xpert MTB/RIF is strongly recommended as the initial diagnostic method for TB and drug-resistance in countries and settings with high DR-TB burden. It is also a key priority of the National Plan.			
		National targets over next implementation period			
Current National Coverage (latest results)	**0** **0%**	**Year 1** **2014**	**Year 2** **2015**	**Year 3** **2015**	**Comments/ Assumptions**
Current Estimated Country Need					
A. Total estimated population in need		96,520	86,192	86,192	
B. Country targets (from National Strategic Plan)		35,472	69,576	81,924	
		36.8%	80.7%	95.0%	
Needs already covered					
C. Country targets planned to be covered by domestic and other sources		0	0	0	
		%	%	%	
D. Country targets already covered by other existing Global Fund grants		0	0	0	
		%	%	%	
Programmatic Gap					
E. Expected annual gap in achieving need		96,520	86,192	86,192	
A-(C+D)		100.0%	100.0%	100.0%	
F. Contribution of indicative funding request to total need		35,472	39,276	39,276	
(can be equal to, or less than annual gap)		36.8%	45.6%	45.6%	
G. Coverage from indicative, existing Global Fund and other resources		35,472	39,276	39,276	
F+(C+D)		36.8%	45.6%	45.6%	
H. Contribution of 'above indicative' funding to total need		0	30,300	42,648	
(can be equal to, or less than annual gap)		0.0%	35.2%	49.5%	
I. Total coverage (indicative + above indicative + existing + other resources)		35,472	69,576	81,924	
(G+H)		36.8%	80.7%	95.0%	

Intervention 2

PROGRAMMATIC GAP TABLE (Per Priority Intervention) *(create 3-6 programmatic gap tables as needed)*					
Priority Intervention		**3.1. Demonstration projects on full outpatient treatment of DR-TB cases**			
Selected coverage indicator		**Number and percentage of DR-TB patients (PDR and MDR) enrolled in full outpatient treatment in the demonstration areas. 'Indicative Amount': Zhambyl, Kyzyl-Orda and Aktobe oblasts, Astana city. 'Above Indicative Amount': East Kazakhstan, South Kazakhstan, Almaty oblasts and Almaty city.**			
Rationale for chosen indicator		According to WHO recommendations, outpatient treatment of DR-TB cases should be promoted in order to achieve better treatment outcomes, prevention of spread of resistance and efficiency. It is also a key priority of the National Plan.			
		National targets over next implementation period			
Current National Coverage (latest results)	**N / A** **Est. <5%**	**Year 1** **2014**	**Year 2** **2015**	**Year 3** **2015**	**Comments/ Assumptions**
Current Estimated Country Need					
A. Total estimated population in need		2,691	2,691	2,691	Here and below, the numbers include PDR and MDR patients (in Modular Template, they are separated)
B. Country targets (from National Strategic Plan)		431	1,635	2,285	
		16.0%	60.8%	84.9%	
Needs already covered					
C. Country targets planned to be covered by domestic and other sources		0	0	0	
		%	%	%	
D. Country targets already covered by other existing Global Fund grants		0	0	0	
		%	%	%	
Programmatic Gap					
E. Expected annual gap in achieving need		2,691	2,691	2,691	
A-(C+D)		100.0%	100.0%	100.0%	
F. Contribution of indicative funding request to total need		431	777	876	
(can be equal to, or less than annual gap)		16.0%	28.9%	32.6%	
G. Coverage from indicative, existing Global Fund and other resources		431	777	876	
F+(C+D)		16.0%	28.9%	32.6%	
H. Contribution of 'above indicative' funding to total need		0	858	1,409	
(can be equal to, or less than annual gap)		0.0%	31.9%	52.4%	
I. Total coverage (indicative + above indicative + existing + other resources)		431	1,635	2,285	
(G+H)		16.0%	60.8%	84.9%	

Intervention 3

PROGRAMMATIC GAP TABLE (Per Priority Intervention) *(create 3-6 programmatic gap tables as needed)*					
Priority Intervention		**4.2. Screening of PLHIV for TB and MDR-TB by Xpert MTB/RIF**			
Selected coverage indicator		**Number and percentage of TB suspects among PLHIV tested at AIDS Centers with rapid diagnostic technique for TB and MDR-TB (Xpert MTB/RIF)**			
Rationale for chosen indicator		According to WHO recommendations, Xpert MTB/RIF is strongly recommended as the initial diagnostic method for TB and drug-resistance in countries and settings with high DR-TB burden, and growing TB/HIV burden. Prisoners are considered as a key high-risk group.			
		National targets over next implementation period			
Current National Coverage (latest results)	**0** **0%**	**Year 1** **2014**	**Year 2** **2015**	**Year 3** **2015**	**Comments/ Assumptions**
Current Estimated Country Need					
A. Total estimated population in need		13,198	13,198	13,198	
B. Country targets (from National Strategic Plan)		6,075	11,301	12,414	
		46.0%	85.6%	94.1%	
Needs already covered					
C. Country targets planned to be covered by domestic and other sources		0	0	0	
		%	%	%	
D. Country targets already covered by other existing Global Fund grants		0	0	0	
		%	%	%	
Programmatic Gap					
E. Expected annual gap in achieving need		13,198	13,198	13,198	
A-(C+D)		100.0%	100.0%	100.0%	
F. Contribution of indicative funding request to total need		6,075	8,550	8,550	
(can be equal to, or less than annual gap)		46.0%	64.8%	64.8%	
G. Coverage from indicative, existing Global Fund and other resources		6,075	8,550	8,550	
F+(C+D)		46.0%	64.8%	64.8%	
H. Contribution of 'above indicative' funding to total need		0	2,751	3,864	
(can be equal to, or less than annual gap)		0.0%	20.8%	29.3%	
I. Total coverage (indicative + above indicative + existing + other resources)		6,075	11,301	12,414	
(G+H)		46.0%	85.6%	94.1%	

Intervention 4

PROGRAMMATIC GAP TABLE (Per Priority Intervention) *(create 3-6 programmatic gap tables as needed)*					
Priority Intervention		**5.2.Screening of detainees in pre-trial isolators for TB and MDR-TB by Xpert MTB/RIF**			
Selected coverage indicator		**Number and percentage of TB suspects among detainees in pre-trial isolators (PTIs) in the penitentiary system, tested with rapid diagnostic technique for TB and MDR-TB (Xpert MTB/RIF)**			
Rationale for chosen indicator		According to WHO recommendations, Xpert MTB/RIF is strongly recommended as the initial diagnostic method for TB and drug-resistance in countries and settings with high DR-TB burden. Prisoners are considered as a key high-risk group.			
		National targets over next implementation period			
Current National Coverage (latest results)	**0** **0%**	**Year 1** **2014**	**Year 2** **2015**	**Year 3** **2015**	**Comments/ Assumptions**
Current Estimated Country Need					
A. Total estimated population in need		9,708	9,708	9,708	
B. Country targets (from National Strategic Plan)		3,831	8,114	9,222	
		39.5%	83.6%	95.0%	
Needs already covered					
C. Country targets planned to be covered by domestic and other sources		0	0	0	
		%	%	%	
D. Country targets already covered by other existing Global Fund grants		0	0	0	
		%	%	%	
Programmatic Gap					
E. Expected annual gap in achieving need A-(C+D)		9,708	9,708	9,708	
		100.0%	100.0%	100.0%	
F. Contribution of indicative funding request to total need (can be equal to, or less than annual gap)		3,831	5,392	5,392	
		39.5%	55.5%	55.5%	
G. Coverage from indicative, existing Global Fund and other resources F+(C+D)		3,831	5,392	5,392	
		39.5%	55.5%	55.5%	
H. Contribution of 'above indicative' funding to total need (can be equal to, or less than annual gap)		0	2,722	3,830	
		0.0%	28.0%	39.5%	
I. Total coverage (indicative + above indicative + existing + other resources) (G+H)		3,831	8,114	9,222	
		39.5%	83.6%	95.0%	

4.2 Summary of the Funding Request

In order to provide an overview of the entire funding request:

a. Summarize the **programmatic focus and rationale for the request**, including how it contributes to the full expression of demand, and highlight the gains expected from this investment.

b. Explain how the 'above indicative' request builds on the indicative request, and describe the **additional gains** to be expected from further investment.

c. Summarize the community systems strengthening, human rights and/or cross-cutting HSS modules and/or interventions in the request, including **how these specifically address the barriers** identified in the country context, and contribute to the objectives of this funding request.

Kazakhstan is an upper-middle income country in Central Asia, which regained independence after the breakdown of the Soviet Union in 1991. Over the last decade, the country has achieved significant progress in macroeconomic development. However, tuberculosis re-emerged as an important public health problem in early 1990s, and its burden remains high in Kazakhstan. According to the latest WHO estimates, TB incidence is the third highest level in the WHO European Region.

The extremely high burden of anti-TB drug resistance is the key challenge for the NTP and the main obstacle for effective TB control in the country. MDR-TB rates are as high as 30% among new cases and over 50% – among retreatment cases.

Special population groups, which are considered at high risk of contracting TB and DR-TB, and which are addressed in this proposal to the Global Fund, are prisoners, people living with HIV and labor migrants.

TB remains an acute problem in the penitentiary sector. Registered TB incidence and prevalence rates in prisons about 20 times exceed the ones in the civilian sector. TB mortality rates in prisons are very high, mainly due to drug-resistant TB forms. During the last four years, multidrug-resistance in the penitentiary system was found in 29.7-40.6% of new cases and 60.7-72.0% of retreatment cases.

A steady increase in the number and rate of TB/HIV cases was documented over the last three years. HIV prevalence among all TB cases increased from 3.2% in 2010 to 4.3% in 2011 and to 6.1% - in 2012. While almost all TB patients on treatment are tested for HIV, the coverage by TB screening among PLHIV is very low.

External labor immigration to Kazakhstan increased substantially due to the rapid growth of the national economy attracting people from other Central Asian countries. In addition, the internal labor migration is also significant. While the data on TB, DR-TB and TB/HIV among labor migrants in Kazakhstan are scarce, the recent estimates indicate that the number of TB cases among migrants may add up to 10% to the total number of TB cases in the country, and the burden of DR-TB and TB/HIV in migrants is likely to be much higher than that in general population.

A number of barriers in TB service delivery need to be addressed in order to ensure appropriate TB control including halting the development and spread of drug-resistant TB. These problems are highlighted in the *Complex Plan for Tuberculosis Control in Kazakhstan 2014-2020* and will be addressed by the interventions included in the NFM proposal. In particular, rapid diagnostic methods for TB and DR-TB are underused.

The TB care delivery system in Kazakhstan holds to a hospital-based treatment model, which, in the absence of appropriate measures for infection control in TB hospitals, amplifies the risk of nosocomial transmission of TB, including MDR and XDR forms. Excessive TB inpatient infrastructure leads to unnecessary hospitalizations and extended duration of the hospital stays,

which create substantial inefficiencies in the utilization of resources in the system. There is a stringent need to expand full outpatient treatment of TB patients, including DR-TB cases.

Important regulatory and/or institutional barriers exist that limit access to appropriate TB, DR-TB and TB/HIV care for vulnerable and high-risk population groups (prisoners and ex-prisoners, PLHIV and MARPs, labor migrants), which need to be tackled through multidisciplinary and multisectoral approaches.

Kazakhstan was invited by the Global Fund to submit a TB proposal for the NFM Wave 2 of early applicants. The CCM considers that TGF selection decision took account of the disease burden (in particular, drug-resistant TB levels) and, at the same time, was based on the recognition of the progress in TB control in the country and the Government's commitment to follow the international recommendations and apply evidence-based interventions for effective fight against the disease.

The overall ***Goal*** of the project is **to decrease the burden of TB in Kazakhstan through reforming the TB control system and strengthening the management of drug-resistant forms of TB by ensuring universal access to DR-TB diagnosis and treatment and addressing the needs of population groups at risk – prisoners, people living with HIV and labor migrants.**

The project principles and priorities are consistent with the international policies and guidance, including those laid in the *Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015*, as well as with the recently developed national *Complex Plan for Tuberculosis Control in Kazakhstan, 2014-2020.*

The application is constructed around seven main Objectives, listed below with the key Interventions:

1. **To support the reform of TB control services through strengthening the National TB Program management, monitoring and evaluation and capacity building**
   - 1.1. Improvement of legislative and normative framework
   - 1.2. Capacity building for reform implementation
   - 1.3. Strengthening program M&E, supervision and information system
2. **To improve timely case detection and quality diagnosis of TB and DR-TB**
   - 2.1. Scaling up of Xpert MTB/RIF at the regional TB laboratories in the civilian sector
   - 2.2. Demonstration projects on Xpert MTB/RIF rollout at district level
   - 2.3. Rapid WHO-recommended diagnostics for TB and DR-TB: automated MGIT and LPA
3. **To promote quality and evidence-based treatment of DR-TB cases**
   - 3.1. Demonstration projects on full outpatient treatment of DR-TB cases
   - 3.2. Treatment of XDR-TB patients
4. **To strengthen collaboration and response for control of TB/HIV co-infection**
   - 4.1. Capacity building in TB/HIV collaboration
   - 4.2. Screening of PLHIV for TB and MDR-TB by Xpert MTB/RIF
5. **To strengthen TB and DR-TB control in the penitentiary system**
   - 5.1. Capacity building for strengthening TB control and reforming medical services in prisons
   - 5.2. Screening of detainees in pre-trial isolators for TB and MDR-TB by Xpert MTB/RIF
   - 5.3. Treatment of MDR-TB patients in prisons
   - 5.4. Strengthening TB infection control in prisons
6. **To strengthen partnerships with civil society for effective control of TB, DR-TB and TB/HIV**
   - 6.1. Capacity building for NGOs for effective involvement in TB and DR-TB control

6.2. NGO grants' program

6.3. Program management and program support by Sub-recipient, NGO component

7. To address TB, M/XDR-TB and TB/HIV among labor migrants.

7.1. Technical assistance and capacity building for addressing TB, DR-TB and TB/HIV among labor migrants

7.2. NGO projects on TB, DR-TB and TB/HIV in labor migrants

7.3. Program management and program support by Principal Recipient (Project HOPE)

The proposal requests to uphold and scale-up the existing interventions that have been supported by TGF, such as DR-TB testing by the regional level reference laboratories, expansion of MDR treatment in prisons, quality treatment of XDR-TB cases, and key NTP interventions in terms of targeted capacity building, program supervision and M&E. At the same time, it aims to initiate new interventions, such as rolling out Xpert MTB/RIF testing at peripheral (district level) TB facilities in the civilian sector, AIDS Centers and pre-trial isolators in the penitentiary system; innovative approaches for the involvement of civil society in TB control; intensified case finding and case management with patient support among labor migrants; and support to reforming TB control services with expansion of full outpatient treatment, improving financing and allocation mechanisms, optimizing infrastructure and improving performance, and strengthening patient-centered approaches in TB care delivery.

In coordination with TGF Country Team, the NFM project timeline has been aligned with the country financial cycle. The project duration is 3.5 years from 01 July 2014 to 31 December 2017.

The ongoing TGF TB grant (from Round 8) will come to an end in December 2014, therefore there is no duplication or overlap of the activities between Round 8 grant and the forthcoming grant; the great majority of NFM interventions are planned to start in early 2015. The Global Fund support will be complementary to substantial financial resources allocated by the Government to TB control.

Following TGF recommendations on dual-track financing, two Principal Recipients have been nominated by the CCM: the National Center of Tuberculosis Problems (government sector) and Project HOPE (non-governmental sector).

The budget of the proposal includes USD 38,830,000 for 'Indicative' request and USD 25,420,139 for 'Above Indicative' request (full amount USD 64,250,138).

4.3 Modular Template and Summary Budget by Module (Indicative and Above Indicative)

The **Modular Template (Attachment 2)** is to be completed as the core document for this funding request.

a. For the indicative request, list **modules and interventions in order of priority**, associated indicators and targets, plus costs and budget assumptions for each intervention.

b. For requesting funds **above the indicative amount**, add any additional modules and/or interventions (listed in order of priority) and include the associated indicators and targets, as well as costs and budget assumptions for each intervention.

In the summary table below,

c. Provide an **overview of the total funding request** budget by module, as detailed in the Modular Template, for both the indicative and the 'above indicative' request. Present the modules in decreasing order, by funding amount.

Modules	Sum of indicative budget for three years	Sum of 'above indicative' budget for three years	Total of full request budget for three years	Percentage of indicative request	Percentage of full request
MDR-TB package	31,050,620	21,604,600	52,655,220	80.0%	82.0%
TB/HIV package	723,631	2,626,485	3,350,115	1.9%	5.2%
Program management	7,055,749	1,189,054	8,244,803	18.2%	12.8%
Total	**38,830,000**	**25,420,139**	**64,250,138**	**100.0%**	**100.0%**

The Modular Template has been completed and attached to the application in Attachment 2.

As drug-resistant TB is the major challenge for effective control of TB disease in the country, the great majority of interventions were included under 'MDR-TB package' module. Funding-wise, they account for 80.0% of 'Indicative' budget and 82.0% of the 'full' request.

At the same time, it should be noted that many interventions described below in Section 4.4, cut across different areas which could have been attributed to other 'standard' TGF modules (such 'Monitoring and Evaluation' – M&E activities are integral part of all interventions included under Objectives 1-7; 'Human Rights' – a number of interventions address the rights to access appropriate diagnosis, treatment and support services, with special attention to vulnerable and high-risk population groups, in particular, under Objectives 4, 6 and 7).

An important focus of the proposal is the rollout of novel rapid diagnostic technology – Xpert MTB/RIF, which allows to simultaneously diagnose TB and resistance to Rifampicin (close proxy of MDR in Kazakhstan settings), which, therefore, may be attributed to both 'DOTS-based package' and 'MDR-TB package' modules. However, in order to ensure consistency and emphasize the need of drug resistance prevention and management, the above interventions were included under 'MDR-TB package' module.

The second module is 'TB-HIV package that includes priority activities aimed at strengthening TB/HIV collaboration and improving diagnosis of TB among PLHIV (see below under Objective 4).

The third module is 'Program management', which includes activities and costs aimed at ensuring proper implementation of the Global Fund project. These cover grant administration, project

management and program support costs by the two nominated Principal Recipients (NCTP and Project HOPE) as well as by Population Services International (PSI), which will act as Sub-recipient of the grant funds for the NGO component (Objective 6).

The performance indicators and budget figures, presented in the Modular Template, are based on detailed estimates of programmatic and financial needs. These assumptions and calculations are to be found in the Workplan and Budget files for each Objective (Annexes 4.2 to this application form).

4.4 Indicative Funding Request

Referring to the modular template:

a. Provide an overview for the indicative request, and how the proposed investment maximizes impact. Explain of the **rationale for the selection and prioritization** of these modules and interventions.

b. Describe expected **impact and outcomes** of the request (with reference to modular template and the programmatic gap tables). Please refer to any available evidence of effectiveness of the interventions being proposed.

The indicative request includes the indicative amount, plus any existing Global Fund financing that will be invested (or reprogrammed) during the funding request period.

c. For these **consolidated funding requests** (i.e. where there is existing Global Fund support for the component requested) explain how current grants will be adapted, discontinued or extended to maximize impact.

Kazakhstan was invited by the Global Fund to submit a tuberculosis (TB) proposal for the New Funding Mechanism (NFM) Wave 2 of early applicants. The CCM considers that TGF selection decision took account of the disease burden (in particular, drug-resistant TB levels) and, at the same time, was based on the recognition of the progress in TB control in the country and the Government's commitment to follow the international recommendations and apply evidence-based interventions for effective fight against the disease.

Over the last decade, Kazakhstan achieved substantial progress in the overall macroeconomic and social development which rendered for visible improvements in the health system performance and the consolidation of TB control efforts, e.g. due to the increased Government financial commitments. At the same time, TB remains an important public health problem. Similar to other former Soviet Union (FSU) countries, drug-resistant TB (DR-TB) is the very acute challenge. TB/HIV co-infection is becoming a growing public health concern as well.

Problems persist in terms of limited access to essential TB diagnostic and treatment services for vulnerable and at-risk population groups, such as prisoners and ex-prisoners, people living with HIV (PLHIV), internal and external labor migrants. The Ministry of Health and NTP recognize that the health care system does not function fully effectively and efficiently to ensure proper TB control, and requires substantial reshaping in line with the contemporary strategies for TB and DR-TB control and modern models for care delivery to ensure access, quality and efficiency. This project is seen by the Government as a very important means for assisting Kazakhstan in its efforts of consolidating the TB control system in the country and aligning it to the up-to-date international policies, strategies and practices.

The overall ***Goal*** of the project is **to decrease the burden of TB in Kazakhstan through reforming the TB control system and strengthening the management of drug-resistant forms of TB by ensuring universal access to DR-TB diagnosis and treatment and addressing the needs of population groups at risk – prisoners, people living with HIV and labor migrants.**

The project principles and priorities are consistent with the international policies and guidance,

including those laid in the *Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015*, as well as with the recently developed national *Complex Plan for Tuberculosis Control in Kazakhstan, 2014-2020.*

Given the fact that the high burden of DR-TB represents the major obstacle to control the epidemic and achieve the TB control targets, 'MDR-TB modules' in the modular template were selected for the majority of the interventions included in this proposal. At the same time, it should be noted that the NFM interventions generally cover the full spectrum of TB control issues including the overall performance of TB control services and intersectoral approaches to for TB, DR-TB and TB/HIV control with emphasis on the needs of vulnerable and at-risk populations.

The application is constructed around seven main Objectives:

1. To support the reform of TB control services through strengthening the National TB Program management, monitoring and evaluation and capacity building
2. To improve timely case detection and quality diagnosis of TB and DR-TB
3. To promote quality and evidence-based treatment of DR-TB cases
4. To strengthen collaboration and response for control of TB/HIV co-infection
5. To strengthen TB and DR-TB control in the penitentiary system
6. To strengthen partnerships with civil society for effective control of TB, DR-TB and TB/HIV
7. To address TB, M/XDR-TB and TB/HIV among labor migrants.

The proposal for NFM 'Indicative Amount' requests to:

- Uphold and scale-up the existing interventions that have been supported by TGF, such as DR-TB testing by the regional level reference laboratories, expansion of MDR treatment in prisons, quality treatment of XDR-TB cases, and key NTP interventions in terms of targeted capacity building, program supervision and M&E, etc.; and
- Initiate new interventions, such as Xpert MTB/RIF testing at peripheral (district level) facilities, AIDS Centers and pre-trial isolators in the penitentiary system; innovative approaches for the involvement of civil society in TB control; intensified case finding and case management with patient support among labor migrants; and support to reforming TB control services with expansion of full outpatient treatment, improving financing and allocation mechanisms, optimizing infrastructure and improving performance, and strengthening patient-centered approaches in TB care delivery.

In coordination with TGF Country Team, the NFM project timeline has been aligned with the country financial cycle. The project duration is 3.5 years from 01 July 2014 to 31 December 2017, that is, Year 1 of the grant will be extended to 1.5 years (6 quarters from 01 July 2014 to 31 December 2015).

The ongoing TGF TB grant (from Round 8) will come to an end in December 2014, therefore there is no duplication or overlap of the activities between Round 8 grant and the forthcoming grant; the great majority of NFM interventions are planned to start in early 2015.

Basic activities of the Round 8 for the second half-year of 2014 are directed to:

- Training of PHC specialists on principals of DR TB management ($ 86 152),
- Monitoring of resistance to drugs ($ 83 439),
- Procurement of consumables for Hain-tests and BACTEC to the second line TB drugs ($ 264 298) for routine work. Other purchases under the Round 8 are not stipulated by the plan.

- Rendering of social support of 3680 MDR TB patients ($ 202 400)
- Transport expenses for patients and treatment advisers ($ 296 632)

Funding of activities indicated in the Concept Note for the period of July-December 2014 is mostly referred to:

1. Category of expenses "medical products and equipment" - $ 1 402 167, that is 65% of all expenses for this period ($ 2 151 583).
2. Category "Infrastructure and other equipment" ($ 147 340)
3. Category "Trainings" ($ 128 690). 2 trainings on introduction of Xpert MTB/RIF for the oblast specialists and 6 trainings for the laboratory specialists of the district level in the pilot regions are planned. 2 trainings for NGOs and 1 training for the penitentiary system are planned. In the plan of GF Round 8 activities such trainings in this period are not indicated.

Besides "new" activities will be funded (for example, preparation work for introduction of experts at the district level, introduction of the outpatient MDR TB treatment model, migration component).

The Global Fund support will be complementary to substantial financial resources allocated by the Government to TB control. For example, the needs in procurement of first-line drugs and major part of second-line drugs are fully covered from domestic sources, as well as the substantial human resources and facility costs.

The project follows TGF recommendations on dual-track financing. Two Principal Recipients (PRs) have been nominated by the CCM: the National Center of Tuberculosis Problems (NCTP, government sector) and Project HOPE (non-governmental sector).

A brief description of proposed Interventions by each Objective is given below.

Objective 1. To support the reform of TB control services through strengthening the National TB Program management, monitoring and evaluation and capacity building

The progress in TB control in the country largely depends on the pace and scope of the structural changes in the current TB care delivery system, which requires substantial reconfiguration in order to meet the emerging challenges, in particular in terms of halting further spread of drug-resistant TB. An ample effort is therefore required from the Government to integrate TB control services in the overall health system reform framework and processes, which are currently ongoing in Kazakhstan with the support by the international partners including the World Bank.

As stipulated in the *Complex Plan 2014-2020*, Kazakhstan will implement substantial changes in TB care delivery, of which the key ones are rolling out rapid molecular diagnostics for TB and DR-TB (e.g. Xpert MTB/RIF at peripheral service level) and expanding full outpatient treatment of TB cases including DR-TB cases. Both initiatives are of utmost importance for effective case management and thus for prevention of drug resistance. In addition, emphasis on outpatient treatment will not only create conditions for implementation of patient-centered care but will free up additional funding resources as a result of the optimization of excessive TB hospital capacities. In this regard, however, the MOH and NTP are faced with the challenge to undertake decisive and complex systemic actions targeting the main health system functions – governance, financing and allocation, resource development, and service delivery.

In order for these measures to be effective, the NTP is in need of further support to strengthening its potential in developing policies and regulations, program oversight and M&E, and capacity building. For this purpose, the interventions under this Objective include targeted support in key areas of program management; TGF support will be complementary to the ongoing assistance from

other partners and activities supported from the national funding resources.

Interventions:

1.1. Improvement of legislative and normative framework

1.2. Capacity building for reform implementation

1.3. Strengthening program M&E, supervision and information system

With the new TGF project support, a working group will be established to perform a comprehensive analysis of the existing national legislation, regulations and guidelines related to TB control and organization of TB control services in the country; identify gaps and inconsistencies that require need revision in line with the latest international strategies and practices; propose modifications in the existing documents or develop new ones and discuss them in depth with relevant MOH departments (especially in terms of the changes aimed at expanding outpatient TB and DR-TB treatment); ensure appropriate intersectoral participation and coordination and perform other relevant tasks. The group will be hosted by the NTP central unit at NCTP and will include representatives of the governmental and non-governmental stakeholders as well as international partners active in the field.

In addition, four national consultants will be engaged in supporting the working group in the tasks above and in practical work related to updating the set of regulations and guidelines. They will also ensure communication to and participation of the regional (oblast) NTP units and other health system stakeholders. The four main areas of focus for the consultants are:

i) program management, financing and allocation, human resources;

ii) reorganization of TB care delivery with infrastructure optimization and transition to full outpatient treatment;

iii) TB case detection and diagnosis; and

iv) clinical TB case management and systems for patient adherence support.

This Objective also includes WHO technical assistance. A position of National Professional Officer at the WHO Country Office in Kazakhstan will be supported; the NPO will assist the NTP in the revision of legislative and regulatory framework and will facilitate communication and collaboration between the national stakeholders as well as with international partners (starting 2015).

Under the capacity building component, training will be provided for TB and general health service managers from the regions (two training courses annually during Years 2-3) on the implementation of new strategies in view of the changing TB care delivery system, with emphasis on:

i) implementation of rapid techniques for TB and DR-TB diagnosis and service implications;

ii) case management strategies including revised criteria for hospitalization and discharge;

iii) modalities, roles and responsibilities of different services in outpatient treatment of TB cases including DR-TB cases;

iv) ensuring effective infection control, including that in outpatient settings; and

v) addressing the needs of risk groups including PLHIV, prisoners and ex-prisoners and labor migrants, etc.

Training will also be organized for the oblast level NTP coordinators and key TB service staff on practical aspects related to the implementation of the revised regulations and guidelines and measures for improving the TB service delivery, including rollout of rapid diagnostics (Xpert

MTB/RIF) at district level, optimization of TB hospitals' infrastructure and improving their performance, and expanding the outpatient case management model (two training courses annually during Years 1-3).

Staff of regional TB reference laboratories will receive training / retraining in technical and programmatic matters related to ensuring universal access to and high quality of modern rapid diagnostic techniques, linked to the overall changes in TB service delivery. One training course will take place in Year 1, and two training courses will be conducted annually during Years 2-3 (at NCTP / NRL).

In order to reemphasize the importance of prevention of nosocomial transmission and development of drug resistance, training on modern vision of TB infection transmission and evidence-based, internationally recommended strategies for control of TB infection (in hospitals and, particularly, outpatient settings) will be provided for key TB service staff from the regions and from the medical service of the penitentiary system; in total, four training courses will be supported during the NFM project lifetime.

Monitoring and evaluation is an essential function of the NTP and its importance substantially increases taking into account the scope of planned reform. The NFM application includes support to the NTP program supervision and improvement of the national TB information system.

Regular NTP supervision / M&E visits are conducted to oversee program implementation including innovative DR-TB management interventions that will be implemented with the TGF project assistance. Support is included for the visits of the central NTP unit teams to the regions; each oblast will be visited twice a year. Biannual program coordination meetings will be convened at NCTP to summarize and discuss the supervision results and plan for the next steps.

It is planned to upgrade the existing national TB electronic information system to align it to the latest WHO recommendations (revised TB recording and reporting forms and registers, 2012) and increase its utility and relevance for performance analysis for decision making by incorporating health system elements (related to delays between diagnosis and treatment, appropriateness of hospitalization practices, adherence support, etc.), which are important in view of reforming the TB care delivery system.

For this purpose, two national consultants will work on the revision of indicators, recording and reporting forms and classifications to align them with the new WHO requirements. Specific tasks will include integration of new diagnostic technologies (e.g. Xpert MTB/RIF) and linking the traditional TB reporting to the service performance (e.g. financing and hospitalization data).

An IT company will be contracted to develop software for the electronic TB database, test and install it in all regions. It is expected that the upgraded system will be fully operational by the end of Year 2 of the NFM project (2015). A national IT consultant will be responsible for regular maintenance of the system. In Year 3, after completion of the above tasks, training will be provided for M&E staff from all regional NTP units on the use of the upgraded TB information system (two training courses in Q11).

Objective 2. To improve timely case detection and quality diagnosis of TB and DR-TB

Ensuring universal access to rapid TB laboratory diagnostics is of utmost importance for Kazakhstan as a country with extremely high burden of drug resistance. It is reflected as one of the main priorities in the *Complex Plan 2014-2020*. Rapid detection of TB and full pattern of resistance allows for timely separation of patient flows and initiation of correct treatment regimen according to the patient's resistance status, which will provide to prevent amplification of resistance and, ultimately, to decrease the circulation of drug-resistant strains in the community.

During the last five years, the NTP achieved substantial progress in scaling up the implementation of rapid WHO-recommended diagnostics (WRDs): automated MGIT technology and LPA

technology (functional at the NRL and regional reference laboratories). In 2012, Kazakhstan started introduction of the novel Xpert MTB/RIF technology (automated real-time nucleic acid amplification technology for rapid and simultaneous detection of tuberculosis and rifampicin resistance). At the moment, there are a total of 13 Xpert instruments in the country (supplied by TB-CARE and TGF Round 8 project), and 6 other machines are expected to arrive by the end of 2013 (through EXPAND-TB).

At the same time, the coverage with the above techniques, especially Xpert MTB/RIF, is far below the necessities given the size of the country and magnitude of DR-TB problem. The three Interventions under this Objective include scaling up Xpert testing at the regional level, implementation of demonstration projects of Xpert rollout to peripheral (district) service delivery level, and support to MGIT and LPA Hain testing.

The support for scaling up the use of rapid WRDs, included in this proposal, will not only increase access to timely and quality diagnosis of TB and DR-TB, but will also trigger performance changes in the TB care delivery system thus being a key prerequisite for the success of the reform of TB control in the country. Activities under this component are reliant on the increasing Government commitment in further upholding the programmatic and financial needs of the TB laboratory service.

Interventions:

2.1. Scaling up of Xpert MTB/RIF at the regional TB laboratories in the civilian sector

2.2. Demonstration projects on Xpert MTB/RIF rollout at district level

2.3. Rapid WHO-recommended diagnostics for TB and DR-TB: automated MGIT and LPA

A key priority of this application is to assist the country to achieve a dramatic increase in the coverage of needs in rapid diagnosis of TB and rifampicin resistance (close proxy of MDR-TB in Kazakhstan) by Xpert MTB/RIF.

Oblast-level reference laboratories play an important role and high workload in primary diagnosis of TB and DR-TB in respective regions as they serve the population of large oblast center cities and, in addition, a substantial number of suspects referred for diagnosis by the district TB units. With the forthcoming EXPAND-TB supply, 4-module Xpert instruments will operate in 18 out of 20 regional TB reference laboratories by the end of 2013. Based on detailed analysis of the needs and projected workload, procurement of 17 additional Xpert MTB/RIF instruments (4-module: 10; 2-module: 7) for the regional reference laboratories (except those in four demonstration regions, see below) was included in this NFM application.

The number of cartridges for Xpert tests to be procured was calculated on the basis of detailed estimates of the number of TB suspects to be tested by each region. The need for a gradual increase in productivity is taken into consideration. It is expected that the full functionality of Xpert MTB/RIF technology (i.e. meeting at least 95% of the estimated needs) will be achieved in all regions by October 2015 (beginning of Q6 of the project). In terms of population coverage, it is expected that needs in Xpert as primary diagnostic test for TB and MDR-TB will be covered for almost half (48.6%) of the population in the regions with the NFM support under 'Indicative Request'.

Appropriate training program in Xpert MTB/RIF is included for TB specialists and staff from the regional reference laboratories. Two initial training courses will be organized at NCTP / NRL in Q1 and Q2, and two training courses / workshops will be held annually during Years 2-3, for follow-up and experience sharing.

In addition to supply of Xpert instruments and tests for the oblast centers, the proposal includes an innovative intervention (2.2) aiming at rollout of Xpert MTB/RIF technology to the district level. District TB units are the basic management units visited by the suspects for TB diagnosis. Rolling

out Xpert to this level meets the WHO recommendations for using it as the initial diagnostic test in high MDR-TB settings: 'Xpert MTB/RIF should be used rather than conventional microscopy, culture and DST as the initial diagnostic test in adults presumed to have MDR-TB or HIV-associated TB (strong recommendation, high-quality evidence)' [*Automated real-time nucleic acid amplification technology for rapid and simultaneous detection of tuberculosis and rifampicin resistance: Xpert MTB/RIF system for the diagnosis of pulmonary and extrapulmonary TB in adults and children: policy update. WHO, October 2013*].

For this purpose, it is planned to carry out demonstration projects on Xpert use at peripheral service level in urban and rural settings in four country regions: Zhambyl and Kyzyl-Orda oblasts, Astana and Almaty cities. The selection of these regions was made by the NTP on the basis of several criteria including the burden of disease and DR-TB, geographical and population characteristics (e.g. the district population to allow for an appropriate workload of Xpert machines at district TB units), as well as the capacity of management and service providers.

It is thus planned to meet the Xpert diagnostic needs for the entire population of the four regions (totally 4,118.1 thousands[6]). Under this Activity, a total of 26 Xpert instruments will be procured: Zhambyl – 11, Kyzyl-Orda – 9, Astana – 3 and Almaty – 3. The number of Xpert tests in the demonstration areas was calculated on the basis of detailed estimates per each district. It is planned that the first tests at district level will be done in October 2014, and the full 'productivity' (95% of the estimated required workload) will be reached within one year (i.e. by October 2015).

The project will provide external technical assistance in implementing the demonstration program in the above regions: one mission will take place in Year 1 for setting up and the second mission – in Year 3 to follow up on the progress, M&E of early implementation and next steps in expanding country-wide. Local consultants will be engaged in each of the regions to facilitate and monitor implementation.

Training on practical aspects of implementation of Xpert MTB/RIF technology at peripheral TB service level will be organized for key staff from four demonstration areas: managers (of TB and PHC service institutions), TB specialists and laboratory staff (in oblast centers, initial training in Q1-Q2 and follow-up training in Q5-Q6 and Q9-10).

The NTP will ensure close oversight and monitoring of Xpert rollout activities at district level. For this purpose, besides the national consultants above, the proposal includes support to regular supervision / monitoring visits by oblast NTP units to district level TB units in the demonstration areas. Two coordination workshops per year will be held with at central level, with participation of key staff from the four demonstration regions, for following up on the implementation progress and experience sharing for quality improvement and further scaling up to other country regions.

The table below illustrates that support to Xpert testing under this project component ('Indicative Amount Request'), will ensure coverage of over 60% of country-wide needs in the civilian sector, compared to an estimated about 5% coverage at the time of submission of this application). The NTP will actively work on further expanding the use of Xpert MTB/RIF; besides including scale-up plans in 'Above Indicative' request, it is deemed that in the medium-term perspective the Government will allocate sufficient public funding for ensuring universal access to Xpert testing.

Table 4.1. Expected coverage of population Xpert MTB/RIF diagnostic needs with NFM project support ('Indicative Amount Request'), Xpert instruments in the civilian sector

Regions	*Total population*	*Population covered by Xpert MTB/RIF*	*% coverage by Xpert MTB/RIF*
Four demonstration regions with Xpert rollout to district level	4,118.1	4,118.1	100.0

[6] *Source*: Agency of Statistics of the Republic of Kazakhstan, www.stat.kz, as of 01.10.2013 (in thhousands): Zhambyl oblast - 1,081.9, Kyzyl-Orda oblast – 737.1, Astana city – 804.1, Almaty city – 1,494.6.

Other country regions	12,980.5	6,302.2	48.6
Country total	**17,098.5**	**10,420.3**	**60.9**

The application also includes support to procurement of uninterrupted power supply (UPS) stations and printers for all regional and district Xpert sites. In addition, provisions for appropriate maintenance and servicing, including calibration and module replacement costs, are included in the workplan and budget. Xpert manufacturer, Cepheid, entrusted Medical Marketing Group (MMG) to provide such services in Kazakhstan.

Overall, the NFM request for 'Indicative Amount' includes procurement of 59 Xpert instruments and 355,600 tests. Besides regional and district TB service units in the civilian sector above, the testing will be done in the regional AIDS Centers, pre-trial penitentiary facilities and among labor migrants; these are included under other Objectives and are described below. The following table summarizes the total numbers of Xpert instruments and tests to be procured, by setting / Objective.

Table 4.2. Number of Xpert MTB/RIF instruments and tests to be procured under NFM project ('Indicative Amount Request'), all Objectives

Setting	*Xpert instruments*		*Xpert tests*			
	4-module	*2-module*	*Year 1*	*Year 2*	*Year 3*	***Total***
Regional TB reference laboratories (*Objective 2*)	10	7	76,365	63,612	63,612	**203,589**
District TB units in 4 demonstration regions (*Objective 2*)	6	20	35,472	39,276	39,276	**114,024**
Regional AIDS Centers (*Objective 4*)	2	7	6,075	8,550	8,550	**23,175**
Pre-trial isolators in the penitentiary system (*Objective 5*)	1	6	3,831	5,392	5,392	**14,616**
Total	**19**	**40**	**121,743**	**116,830**	**116,830**	**355,403**

For budgeting Xpert-related procurement for NFM, the latest FIND-negotiated prices were used for instruments and cartridges, as well as delivery costs (http://www.finddiagnostics.org/about/what_we_do/successes/find-negotiated-prices/xpert_mtb_rif.html and http://www.stoptb.org/global/awards/tbreach/bet.asp).

Activity 2.3 under this Objective includes support to the NRL and regional reference laboratories at oblast level in implementing other WHO-recommended diagnostic techniques: automated MGIT technology for rapid isolation of strains in liquid culture and accelerated DST, and automated LPA technology for rapid identification of M.Tb and detection of H/R resistance.

As mentioned above, these technologies are functional in the country, however, the coverage of needs is not complete and Government has not yet been able to take over the costs of these technologies. Therefore, the CCM decided to seek additional support from the Global Fund in the NFM application, to ensure universal coverage and sustainability while the Government increasingly allocates financial resources for this purpose with the aim to take over full costs beyond the Global Fund support.

In terms of equipment, no procurement of automated MGIT instruments is necessary, as all reference laboratories are equipped with Bactec-960 instruments (procured by the Government or with earlier TGF support). At the same time, only 9 out of 20 regional laboratories have LPA Hain instruments, and the application foresees procurement of additional 11 machines to meet the needs for the whole country.

The needs in MGIT culture and DST as well as LPA Hain tests were estimated in accordance with the updated diagnostic algorithm (see Annex 4.5 to this application). The calculations are based on epidemiological projections, planned increases in diagnostic coverage and expected DR-TB rates

by patient category. Please refer to detailed calculations in a separate Excel sheet of the Workplan and Budget file for Objective 2.

The Government has committed to take an increasing share of funding for WRDs. While for 2014 the gap is covered by the ongoing Round 8 TB project, over the three years that follow (2015-2017), TGF NFM project is expected to contribute to the coverage of actual needs as follows:

- Automated MGIT tests:
    - Year 1 (2015) - 60%
    - Year 2 (2016) - 40%
    - Year 3 (2017) - 20%
- LPA Hain tests:
    - Year 1 (2015) - 100%
    - Year 2 (2016) - 80%
    - Year 3 (2017) - 50%

The following table presents the number of MGIT and LPA tests to be supported by the project.

Table 4.3. Number of automated MGIT and LPA Hain tests to be procured under NFM project ('Indicative Amount Request')

Test	*Year 1*	*Year 2*	*Year 3*	***Total***
Automated MGIT (culture only)	53,988	37,580	19,216	**110,784**
Automated MGIT (culture and DST)	14,644	10,888	5,696	**31,228**
LPA Hain (MTBDRPlus)	14,924	15,472	11,116	**41,512**
LPA Hain (MTBDRsl)	8,592	8,908	6,396	**23,896**

Appropriate support to maintenance and servicing of MGIT and LPA equipment is also included under this component.

Objective 3. To promote quality and evidence-based treatment of DR-TB cases

Over the recent years, the Government of Kazakhstan applied substantial efforts for managing costs related to treatment of all forms of TB, including (centralized) procurement of first-line drugs and second-line drugs as well covering other substantial costs related to TB treatment. As a result, the country now has reliable systems for uninterrupted anti-TB drugs' supply, although it is not yet fully ensured in the penitentiary system (for second-line drugs), and there is no systematic approach in place for treatment of XDR-TB patients countrywide.

In addition, the *Complex Plan 2014-2020* stipulates the stringent need for strengthening programmatic TB case management with primary focus on expanding full outpatient treatment, including that of DR-TB cases, and putting in place mechanisms for increased involvement of local public authorities for comprehensive patient support to ensure adherence. Both strategic directions require adjusting relevant regulations and guidelines and redefining the roles of different layers of health service provision, as well as involving other partners in the public sector and beyond.

The interventions included in this proposal are closely connected across different Objectives; support to institutionalization of new forms of TB care delivery is included under Objective 1 and has an important focus on promoting outpatient case management. Under this Objective, the application includes two main Interventions: implementation of the demonstration projects on full

outpatient treatment of drug-resistant TB cases and development of an evidence-based model for clinical management of extensively drug-resistant TB (XDR-TB).

Interventions:

3.1. Demonstration projects on full outpatient treatment of DR-TB cases

3.2. Treatment of XDR-TB patients

One of the key components of the NFM project is support to the implementation of demonstration projects on full outpatient treatment of DR-TB cases. The MOH and NTP proposed four country regions to be the first-line implementers of this approach: Zhambyl, Kyzyl-Orda and Aktobe oblasts and Astana city.

The selection criteria, inter alia, took account of the capacities and readiness of TB and general health services in these areas for implementation of innovative approaches in service delivery. Importantly, three of the above regions will also participate in the demonstration program for rolling out Xpert MTB/RIF diagnostics to district level (Objective 2) and will be part of the NGO grants' program for increased civil society involvement in provision of patient support (see below under Objective 6). It is deemed that this comprehensive approach to management of DR-TB cases will render tangible and rather rapid results, which will facilitate replication of the best practices in other areas of the country and will trigger commitment and increased financial support by the local authorities beyond the Global Fund project lifetime.

After a preparatory phase, it is foreseen to start enrollment of PDR and MDR patients in Q3 of the NFM project (starting January 2015). Totally during 3 years, it is planned to enroll 2,084 patients with drug-resistant TB forms (PDR-TB: 756, MDR-TB: 1,328) in full outpatient treatment in four areas. The detailed estimates of the expected number of DR-TB patients and the pace of enrollment are presented for each region, by quarter, in the Workplan and Budget file for Objective 3.

The next two tables give the breakdown of patients to be enrolled, by type of resistance, region and project Year.

Table 4.4. Number and percentage of PDR-TB patients to be enrolled in full outpatient treatment in the demonstration regions, by NFM Project Years

Region	*Total expected annual No. of PDR-TB patients*	*Estimated No. of PDR-TB patients that can be enrolled in full outpatient treatment*	*Number of PDR-TB patients to be enrolled*			
			Year 1	*Year 2*	*Year 3*	***Total***
Zhambyl oblast	156	140	75	122	128	**325**
Kyzyl-Orda oblast	76	68	36	58	60	**154**
Aktobe oblast	80	72	38	61	64	**163**
Astana city	57	51	27	43	44	**114**
Total	**369**	**331**	**176**	**284**	**296**	**756**
Percentage of PDR-TB cases on full outpatient treatment			**53.2%**	**85.8%**	**89.4%**	

Table 4.5. Number and percentage of MDR-TB patients to be enrolled in full outpatient treatment in the demonstration regions, by NFM Project Years

Region	*Total expected annual No. of MDR-TB patients*	*Estimated No. of MDR-TB patients that can be enrolled in full outpatient treatment*	*Number of MDR-TB patients to be enrolled*			
			Year 1	*Year 2*	*Year 3*	***Total***
Zhambyl oblast	184	147	51	100	116	**267**
Kyzyl-Orda oblast	227	182	64	123	144	**331**

Aktobe oblast	273	218	76	147	176	**399**
Astana city	228	182	64	123	144	**331**
Total	**912**	**729**	**255**	**493**	**580**	**1,328**
Percentage of MDR-TB cases on full outpatient treatment			**35.0%**	**67.6%**	**79.6%**	

As seen from the tables above, the NFM support is expected to contribute to a dramatic increase in the share of DR-TB cases that will be managed without hospitalizations. By the end of the project, the regional NTP units in four demonstration areas are expected to treat at least 90% of PDR patients and 80% of MDR cases in fully ambulatory settings.

The proposal includes a number of supportive activities that will enable the NTP to carry out the demonstration projects with success. During Year 1, support will be provided to a working group, which will develop practical guidance on implementing the outpatient treatment model for DR-TB patients (in urban and rural settings) and will oversee its early implementation in four demonstration areas. Special attention will be paid to measures for TB infection control in outpatient settings. Local consultants (two per each of the four regions) will be engaged for the entire duration of the project to facilitate, supervise and monitor implementation.

Training will be organized for key health service staff (managers, TB service staff, PHC service staff) in the demonstration regions on practical aspects of implementation of full outpatient model for DR-TB treatment, at oblast level. Two training courses per quarter will be organized during Q2-Q6 and one course per quarter – during Q7-Q10. Two coordination workshops per year will be held at the central level (NCTP) for following up, M&E and sharing experiences across the three demonstration areas.

Support is also included for regular supervision / monitoring visits, which will be conducted by the regional NTP units in Zhambyl, Kyzyl-Orda and Aktobe to district level facilities to ensure close oversight and support for outpatients in respective areas. Each district will be visited at least once per quarter or more often if required.

Ensuring compliance and adherence to lengthy and complex DR-TB treatment is a key challenge and the utmost important part of programmatic DR-TB management. Besides close monitoring and supervision by the health care staff, this component contains a comprehensive patient support program. It includes provision of incentives and enablers to the patients, enablers for DOT supporters and intensified outreach patient support and follow-up by mobile teams.

PDR and MDR patients on full outpatient treatment in four demonstration regions will be provided with incentives to strengthen adherence. The form of incentives (food parcels, hygienic and other packages, vouchers, mobile communication support or direct monetary incentives) will depend on the local and individual context. Based on the current experience, estimated proportion of patients in need of such support, and taking into account the rates of potential unfavorable outcomes (default, failure, complications / adverse drug reactions requiring hospitalization, etc.), it is estimated that incentives will be provided to about 90% of both PDR and MDR patients enrolled, for 85% of the entire treatment duration in PDR cases and 80% - in MDR cases.

Part of the patients on ambulatory treatment reside remotely from the health care units that provide drugs under DOT, and will need to cover substantial distances and incur substantial transport expenses. In such cases, enablers in the form of reimbursement of transportation expenses will be provided. It is expected that about 20% of all enrolled PDR and MDR patients will require transportation enablers.

Transportation enablers will also be provided for health care staff (PHC providers in rural areas and district centers) who will visit DR-TB patients at home to dispense drugs under DOT and follow up on patient conditions. It is estimated that home visits will be needed in about 10% of enrolled cases.

In addition to adherence support measures above, the project intends to implement the intensive

follow-up and support to patients on ambulatory DR-TB treatment in urban areas, by establishing mobile outreach teams in the cities of Taraz (capital of Zhambyl oblast), Kyzyl-Orda, Aktobe and Astana. Successful practices of the similar *Sputnik* project in Tomsk, Russian Federation, will be studied and replicated with adjustment to local context. The outreach program will start in mid-2015. Besides provision of anti-TB drugs under full DOT, the mobile teams are expected to play a key role in tracking of defaulters and psychological support to persons with comorbidities and behavioral disorders who are at risk of defaulting, especially in poor people slum-and-shanty suburbs and persons without fixed abode.

Limited support for program support costs / operational expenses is included for Sub-recipients (regional NTP units) that will implement the interventions on full outpatient DR-TB treatment in the three demonstration regions.

It is important to mention that, besides activities receiving direct support from the Global Fund, the NTP has engaged in carrying out a number of measures, which will facilitate implementation of outpatient treatment model in the regions. These include implementation of a system for early detection, management and prevention of adverse drug effects of second-line TB drugs (ADRs are seen as an important limitation for outpatient DR-TB case management by many TB and PHC service providers); management of serious comorbidities (hepatitis, diabetes, renal diseases) including revision of relevant MOH regulations for ensuring appropriate provision of symptomatic and pathogenetic drugs during outpatient treatment; development of performance indicators and motivation system for PHC related to management of TB cases; work with public administration on introducing a voucher motivation system for disadvantaged population segments, and other measures.

The second component under Objective 3 aims at developing a systematic approach, evidence-based national guidance and a clinical excellence model for treatment of XDR-TB patients. XDR-TB is of an growing concern in Kazakhstan, and the number of such patients will inevitably grow during the coming years as the universal coverage with MDR-TB treatment is being reached but a part of these patients will fail the regimen and develop XDR. At the same time, there growing but still limited international evidence in XDR-TB treatment, which need further development and application in practical conditions of the country with specific pattern of resistance and clinical characteristics of the patients.

The project intends to enroll 200 XDR patients in the demonstration cohort at the National Center of Tuberculosis Problems in Almaty (100 patients will be enrolled in Year 1 and 100 patients – in Year 2). The NCTP will be responsible for clinical management of these cases in the hospital and further follow-up in outpatient conditions (it is presumed that the patients will undergo continuation phase of treatment in Almaty or one of the three demonstration regions for outpatient treatment where the full range of supervision and patient support measures will be available).

The tasks of the NCTP team will develop: selection / exclusion criteria; algorithm for selection of a treatment scheme based on the full resistance profile; standards for clinical and bacteriological investigations to monitor treatment progress; register of ADRs and standard for their management including guidance for changing dosages and discontinuation / change of second-line and third-line agents; indications and guidance on surgical treatment of patients with advanced pulmonary disease; register of common comorbidities and guidance for their clinical management in XDR cases; guidance for duration of hospitalization and criteria for discharge; special considerations for outpatient treatment and patient support during continuation phase; and complete other tasks as needed. It is foreseen that the experience gained in treatment of this cohort will be summarized and included, being added to the available international evidence, in a comprehensive XDR-TB guideline to be further used by the TB treatment facilities at oblast level.

NCTP has developed a scheme of treatment that will be used in this cohort. The average total duration of treatment is 30 months (12 months injectable phase, 18 months continuation phase). The drugs to be used, percentage of patients to receive each drug in the cohort, dosages and months of intake are presented in the table below. The composition of the regimen is indicative and may change depending on the variety of factors during implementation.

Table 4.6. Preliminary treatment regimen for XDR-TB cohort (200 patients), to be supported by NFM project

Drug	*% of patients to receive the drug*	*No. of patients to receive the drug*	*Strength / unit*	*No. of units per day*	*Months of intake*	
					Intensive phase	*Continuation phase*
Capreomycin	30%	60	1 g	1	12	0
Amikacin	70%	140	0.5 g	2	12	0
Moxifloxacin	100%	200	250 mg	3	12	18
Prothionamide	50%	100	250 mg	3	12	18
Cycloserine	95%	190	250 mg	3	12	18
PASER	80%	160	4 g	2	12	18
Pyrazinamide	100%	200	500 mg	4	12	0
Amoxicillin / Clavulanic acid	90%	180	875 mg / 125 mg	2	12	18
Linezolid	100%	200	600 mg	1	6	0
Clofazimine	100%	200	100 mg	2	12	18

Based on the recent (June 2013) publication of *'The use of bedaquiline in the treatment of multidrug-resistant tuberculosis. Interim policy guidance'* by WHO, the NTP intends to include this drug in the treatment schemes for MDR and XDR cases; however, at the time of submission of the application the drug is available for compassionate use only, and its pricing is unknown, which make the planning and budgeting difficult at this stage. Therefore, it was decided to include provisions for the use of Bedaquiline in the 'Above Indicative' NFM request.

External technical assistance will be provided to the NCTP in the introduction of new treatment schemes for XDR-TB patients taking into account the latest evidence and international experience including the use of new drugs. Two missions of an external expert are foreseen in Q2 (development of the protocol, cohort formation, etc.) and in Q6 (evaluation of early results, adjustment measures, next steps). In addition, two national consultants will be employed to coordinate, supervise and monitor XDR-TB treatment in the cohort (starting Q3).

The project will procure second-line drugs and third-line TB drugs above for 200 patients in the cohort. Procurement will be done through GDF / IDA. The average cost of drugs is about USD 9,560 per treatment course, including delivery and other PSM-related costs. Detailed cost calculations are given in a separate sheet in the Workplan and Budget file for this Objective. The costs related to the post-registration quality control of the drugs, will be borne locally (this applies also to drugs to be procured for MDR treatment in prisons, see below under Objective 5).

The proposal also includes training in TB drug management with emphasis on second-line drugs and third-line anti-TB drugs, which will be organized at the central level, with participation of the regional NTP coordinators and drug management specialists from all regions (two training courses during Year 2).

Objective 4. To strengthen collaboration and response for control of TB/HIV co-infection

As indicated in section 3.1 above, TB/HIV co-infection is a growing public health concern in Kazakhstan. At the same time, it is recognized that overall, TB/HIV collaboration is insufficient and needs strengthening and alignment to the international policies and standards. The high burden of drug-resistant TB poses additional threat of disease and death to people living with HIV (PLHIV) and most-at-risk populations (MARPs).

One of the main bottlenecks is the insufficient screening for TB among PLHIV; while the majority

of registered HIV-infected individuals undergo screening for TB and other pulmonary disease at AIDS Centers, due to stigma and various service barriers a very small percentage of them reach TB institutions for bacteriological examination and establishment / confirmation of TB diagnosis. As a result, in many cases appropriate TB treatment is not provided or is initiated with significant delays, which adds on the risk of death.

The response to TB/HIV needs reinforcement and this will be an integral component within the reformed system for TB control in the country. While the NTP and the National AIDS Program (NAP) increasingly collaborate in a number of areas at the central and regional levels, the CCM has decided to include support to TB/HIV collaboration in this NFM application as it deemed to facilitate the ongoing processes and address a number of priority problems in the field. It should be also noted that TB/HIV issues are also addressed throughout the proposal in activities presented under other Objectives, including NGO component (Objective 6) and labor migration component (Objective 7).

Under this Objective, the proposal seeks support in two key areas: fostering collaboration between TB services and HIV/AIDS services in order to put in place internationally recommended and evidence-based practices for TB/HIV control, and intensified TB and MDR-TB case finding among PLHIV.

Interventions:

4.1. Capacity building in TB/HIV collaboration

4.2. Screening of PLHIV for TB and MDR-TB by Xpert MTB/RIF

The capacity building activities will be conducted in line with the latest international guidance, i.e. *WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders* (WHO, 2012, http://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/index.html).

The application includes support to a working group on strengthening TB/HIV collaborative activities. This working group will be established jointly by the NTP and NAP and will be responsible for assessing the current practices in terms of their relevance to the current epidemiological situation in the country on one hand and, on the other hand, in terms of compliance to the international standards. The group will carry out work on updating the regulations, case management protocols and guidance / instructions and procedures related to practical aspects of collaboration between the two services. The group will also advise the experts on the development / update of curricula and training materials on TB/HIV for different target audiences (graduate and postgraduate medical students, refresher trainees from TB and HIV service and general health care services).

Two national consultants will be engaged to update of guidelines and protocols, draft joint regulations and instructions to streamline cooperation between the two services at different levels, review and revise relevant performance indicators, and integrate TB/HIV information in the TB information system, which will be upgraded with the NFM project support (see Objective 1).

Training for prospective trainers in programmatic and clinical management of TB/HIV co-infection will be organized at the central level for regional specialists from the civilian sector TB services, HIV/AIDS services and the penitentiary sector. Two training courses will be held jointly by leading specialists in TB and HIV during Year 1 and Year 2.

Additionally, national level workshops (about 60 participants from the central level and all regions) will be supported annually, which will discuss priority issues of TB/HIV collaboration including progress towards implementation of internationally recommended strategies and practices, rollout of new rapid methods for diagnosing TB and MDR-TB among PLHIV, and relevant practical issues related to collaboration between the two services.

The key intervention that need to be strengthened in the field of TB/HIV is WHO-recommended

measures to intensify TB case-finding in HIV-infected individuals (one of 'the Three I's for reducing the burden of TB among PLHIV), using a clinical algorithm followed by rapid diagnosis with Xpert MTB/RIF in symptomatic persons. According to the recently updated (October 2013) WHO policy guidance on Xpert, the use of this method is strongly recommended in PLHIV suspect for TB (now supported by high-quality evidence); this is particularly relevant for the very high MDR-TB setting in Kazakhstan.

To comply with the above recommendations, this application intends to establish intensified screening for TB and MDR-TB by Xpert MTB/RIF by placing the instruments and initiating testing at the regional AIDS Centers. The NTP and NAP rely on the fact that provision of this 'one-stop' service at AIDS Centers, which are visited by PLHIV on a regular basis, will provide for appropriate use of technology and lead to improved TB case detection among PLHIV.

An analysis of estimated need and workload was performed for all regions of the country, based on 2010-2012 data provided by the Republican AIDS Center, which included the overall number of PLHIV registered in each oblast, the volume of screening for TB and the number of identified TB cases. As a result, under 'Indicative Amount' request, it is suggested to initiate Xpert MTB/RIF testing at 8 Regional AIDS Centers in Karaganda, Almaty city, East Kazakhstan, South Kazakhstan, Almaty oblast, Pavlodar, Kostanay and Astana city. One more Xpert instrument will be placed at the Republican AIDS Center (totally 9 instruments to be procured: 2 with 4 modules and 7 – with 2 modules).

These regions have the highest burden of HIV in Kazakhstan (number of PLHIV registered in the above regions accounts for 86% of all PLHIV registered in the country), therefore they are in greatest need for TB testing and, in addition, appropriate workload on Xpert machines will be secured.

The number of Xpert tests to be done was estimated for each AIDS Center. It is planned that, after necessary preparations are completed in terms of procurement, installation, training of staff, etc., the testing will start in the first quarter of 2015 (Q3 of the NFM project), and the full functionality of Xpert instruments (about 95% of the needs) will be achieved by October 2015 (beginning of Q6 of the project). The expected needs' coverage is 67% for Year 1 and 94% - for Years 2 and 3.

The target numbers of HIV-infected individuals, in whom Xpert testing will be done with the support of NFM project, are given the table below; more details are to be found in the Workplan and Budget file for Objective 4.

Table 4.7. Number of TB suspects among PLHIV to be screened with Xpert MTB/RIF at the regional AIDS Centers, by NFM Project Years

Region	*Estimated annual No. of PLHIV in need of TB screening at AIDS Centers*	*Year 1*	*Year 2*	*Year 3*	***Total***
Karaganda	1,370	891	1,254	1,254	**3,399**
Almaty city	1,460	972	1,368	1,368	**3,708**
East Kazakhstan	1,160	810	1,140	1,140	**3,090**
South Kazakhstan	1,110	729	1,026	1,026	**2,781**
Almaty oblast	870	567	798	798	**2,163**
Pavlodar	910	648	912	912	**2,472**
Kostanay	510	324	456	456	**1,236**
Astana city	990	648	912	912	**2,472**
Republican AIDS Center	750	486	684	684	**1,854**
Total	**9,130**	**6,075**	**8,550**	**8,550**	**23,175**
Coverage of needs (share of PLHIV in need of TB		**66.5%**	**93.6%**	**93.6%**	

screening who are tested with Xpert MTB/RIF)				

Prior to and during implementation, training on Xpert MTB/RIF will be organized for staff from all AIDS Centers from eight regions and the Republican AIDS Center (at NCTP / NRL). Two initial training courses will be conducted in Q2 and Q3, and one training annually for follow up and experience sharing in Year 2 and Year 3.

The project will provide support to procurement of uninterrupted power supply (UPS) stations and printers for all Xpert machines at AIDS Centers. In addition, provisions for appropriate maintenance and servicing, including calibration and module replacement costs, are included in the workplan and budget.

Objective 5. To strengthen TB and DR-TB control in the penitentiary system

During the last decade, a criminal law reform was carried out in Kazakhstan to align it to the norms of international law. It included, in particular, application of alternative sanctions, which allowed for reducing the size of imprisoned population. Although TB incidence and prevalence in the criminal-executive system (CES) has substantially decreased over the last decade, TB mortality remains high rate at over 100 per 100,000, mainly due to very high MDR-TB rates among both new and retreatment cases.

The main challenges in TB and DR-TB control in the penitentiary system are: limited access to rapid methods of testing for drug resistance, leading to lack or delays in appropriate separation of patient flows and in initiating correct treatment regimen according to resistance status; insufficient coverage with second-line treatment and poor adherence of patients to uninterrupted drug intake; insufficient TB infection control measures; poor physical infrastructure of prison TB facilities; and a number of bottlenecks in medical services including understaffing.

Given the general focus of the proposal which emphasizes addressing the needs of most-at-risk population groups, and taking into account the TRP recommendations at 'early involvement' phase, the CCM has decided to request TGF support to a number of priority interventions for improving TB and DR-TB control in the penitentiary sector. For this purpose, a separate Objective was identified; at the same time, there are cross-cutting activities included under other components of the application that address the needs of prisoners and ex-prisoners, such as NGO projects under Objective 6 below.

Under this Objective, the proposal includes four interventions aimed at increasing CES capacities for reforming TB control services in prisons, scaling up rapid testing for TB and DR-TB, supporting treatment of MDR-TB patients in prisons, and strengthening infection control.

Interventions:

5.1. Capacity building for strengthening TB control and reforming medical services in prisons

5.2. Screening of detainees in pre-trial isolators for TB and MDR-TB by Xpert MTB/RIF

5.3. Treatment of MDR-TB patients in prisons

5.4. Strengthening TB infection control in prisons

CES carries out the reform of TB control system in the penitentiary institutions on the basis of a comprehensive analysis of the epidemiological situation and in-depth assessment of the performance and needs of the medical services. The priority task, in cooperation with the authorities and TB service in the civilian sector, is to improve the legal and regulatory framework for the organization of TB control interventions in prisons, which in the future will allow for successful transfer of the medical service to the Ministry of Health. The objective of the planned changes is to ensure equal access for detainees to the guaranteed package of medical care, which

will include all necessary measures for quality diagnosis and treatment of all forms of TB including drug-resistant TB.

The NFM application foresees external technical assistance to CES and NTP, which will include in-depth analysis of TB epidemiological situation and trends in the penitentiary sector; estimate and planning of medium-term programmatic and financial needs; identification of priority measures to be taken in regard to diagnosis, treatment, infection control, M&E / information system, cooperation with civilian services for follow-up of ex-prisoners with TB who need to complete treatment after discharge; and development of a detailed plan for implementation. Two consultancy missions are planned for Year 1 and Year 3; the second mission is intended for following-up and evaluation of the implementation progress.

Two national consultants will be employed to facilitate the work related to update of regulations, guidelines and protocols for TB and DR-TB control in the penitentiary system, development of relevant CES orders and instructions (including joint documents with the civilian authorities), upgrade and integration of information systems and other relevant tasks.

The project will support procurement of IT equipment for strengthening capacities of CES medical service in TB monitoring and evaluation (for central level CES medical service, regional departments, TB hospitals and pre-trial isolators implementing rapid testing for TB and MDR-TB by Xpert MTB/RIF).

National level workshops will be organized annually which will discuss priority issues of TB control in prisons including progress towards implementation of internationally recommended strategies and practices, rollout of new diagnostic techniques, scaling up MDR treatment, and relevant practical issues related to the collaboration between the penitentiary and civilian TB services, as well as with non-state actors including NGOs implementing the small grants' program supported by TGF NFM project.

The NFM project will contribute to intensified TB and MDR-TB case finding among detainees. The key problem in case detection and diagnosis in the penitentiary system is the lack of access to rapid diagnostic methods in the pre-trial detention facilities (pre-trial isolators, PTIs, or *SIZO*). It results in the increased risk of nosocomial infection in PTIs, which often present with substantial congregation of people. In line with the up-to-date WHO recommendations, the NTP and CES intend to use the novel Xpert MTB/RIF technology for rapid detection of TB and rifampicin resistance in pre-trial detention sites, which will render for timely detection of cases, including MDR cases, at the level of entry in the penitentiary system, and will allow the medical service to timely isolate the bacteriologically confirmed cases from other detainees, separate them by resistance status and arrange for full resistance testing and initiation of a correct treatment regimen. It is expected that this interventions will, rather rapidly, have a positive impact over the development and spread of drug resistance in the system.

Under 'Indicative Amount' request, Xpert MTB/RIF instruments will be placed in seven large pre-trial isolators: Almaty city, Ust-Kamenogorsk (East Kazakhstan oblast), Karaganda, Shymkent (South Kazakhstan oblast), Astana, Kostanay and Taraz (Zhambyl oblast). The estimated needs and workload was performed taking into account the turnover of detainees at each site and the expected ratio of TB suspects. A 4-module machine will be procured for the largest PTI in Almaty city and 2-module machines – for other sites.

The actual testing is planned to start in the beginning of 2015 (Q3 of the NFM project), and the full estimated workload will be reached by October 2015 (beginning of Q6). The planned coverage of needs is 67.5% for Year 1 and 95% - for the following two project Years. The target number of tests in seven PTIs by Year is presented in the table below.

Table 4.8. Number of TB suspects among detainees in pre-trial isolators to be screened with Xpert MTB/RIF, by NFM Project Years

Region / city	*Estimated annual No. of detainees in PTIs in need of TB screening*	*Year 1*	*Year 2*	*Year 3*	***Total***
Almaty city	1,428	964	1,357	1,357	3,677
East Kazakhstan (Ust-Kamenogorsk)	1,044	705	992	992	2,688
Karaganda	744	502	707	707	1,916
South Kazakhstan (Shymkent)	720	486	684	684	1,854
Astana city	696	470	661	661	1,792
Kostanay	540	365	513	513	1,391
Zhambyl (Taraz)	504	340	479	479	1,298
Total	**5,676**	3,831	5,392	5,392	14,616
Coverage of needs (share of detainees in PTIs in need of TB screening who are tested with Xpert MTB/RIF)		**67.5%**	**95.0%**	**95.0%**	

The project will provide training for penitentiary system's staff (TB officers from CES medical services and staff from seven PTIs above) on screening detainees for TB and DR-TB by Xpert at the demonstrations sites. In total, three training courses will be held at NCTP / NRL during the project's lifetime: an initial training in Q3 and one training annually in Years 2 and 3 for follow up and experience sharing.

Similar to other Xpert MTB/RIF activities (see Objectives 2 and 4 above), the project will provide support to procurement of UPS devices and printers for the instruments at PTIs. Provisions for maintenance and servicing, including calibration and module replacement costs, are also included in the workplan and budget.

The project foresees support to treatment of MDR-TB patients in the penitentiary system. The annual number of prisoners in need of second-line treatment is about 450. While the Ministry of Internal Affairs / CES committed funding for procurement of drugs for treatment of 150 MDR patients annually for the coming three years, TGF is expected to cover 300 MDR-TB treatments per year (totally 900 during NFM), at the main prison DR-TB treatment site in Karaganda.

CES will use the MDR-TB treatment scheme according to the NTP protocol, which is in line with the latest WHO recommendations (August 2011). The average total duration of the treatment course is 20 months (8 months injectable phase, 12 months continuation phase), with 26 days per month of drug intake. The drugs to be used, percentage of patients to receive each drug in the cohort, dosages and months of intake are presented in the table below.

Table 4.9. Treatment regimen for MDR-TB cases in the penitentiary system (900 patients), to be supported by NFM project

Drug	*% of patients to receive the drug*	*No. of patients to receive the drug*	*Strength / unit*	*No. of units per day*	*Months of intake*	
					Intensive phase	*Continuation phase*
Capreomycin	70%	630	1 g	1	8	0
Amikacin	30%	270	0.5 g	2	8	0
Levofloxacin	100%	900	250 mg	3	8	12
Prothionamide	90%	810	250 mg	3	8	12

Cycloserine	95%	855	250 mg	3	8	12
PASER	80%	720	4 g	2	8	12
Pyrazinamide	100%	900	500 mg	4	8	0

Training for TB specialists from the penitentiary service in contemporary approaches in MDR-TB case management will be organized at NCTP. Two training courses will be conducted in Year 1 and one course per year – during Years 2-3. Two national consultants (a TB specialist and a drug management specialist) will coordinate, supervise and monitor implementation of MDR-TB treatment in the penitentiary system.

The project will procure second-line drugs above for 900 MDR patients in prisons. Procurement will be carried out through GDF / IDA. The average cost of drugs is about USD 4,440 per treatment course, including delivery and other PSM-related costs. Detailed cost calculations are given in a separate sheet in the Workplan and Budget file for Objective 5. The costs related to the post-registration quality control of the drugs, will be borne locally.

Ensuring appropriate TB infection control in penitentiary facilities is an important challenge for the authorities. While CES is engaged in mobilizing resources for substantial investments in infrastructure improvements, Global Fund support is expected to contribute to strengthening capacities in implementation of administrative measures for infection control.

A national consultant will be employed to develop a special set of guidance and instructions related to TB infection control at different levels of the penitentiary system. Training of prisons' administration officers and TB service staff in contemporary practices in TB infection control will be conducted at NCTP (one training course per year during Years 2-3).

Upper-level ultraviolet germicidal irradiation (UVGI) devices will be procured for DR-TB patient wards and areas of high risk of contamination at seven TB treatment institutions in the penitentiary system (in Year 1). In addition, procurement of individual measures of infection control (N95 / FFP-2 respirators) for prisons' staff at high risk is included in this application.

Objective 6. To strengthen partnerships with civil society for effective control of TB, DR-TB and TB/HIV

The CCM and NTP recognize that the involvement of non-state actors, first and foremost that of civil society organizations, is of key importance to the success of TB control efforts. All planned TB control system reform interventions rely on reinforcement of patient-centered care, which becomes of special relevance for the management of drug-resistant TB and, on the other hand, for ensuring access to essential interventions for the disadvantaged and at-risk population segments.

The revised TB care delivery model foresees increased collaboration between the public health services and non-state actors in different aspects of TB control including advocacy, communication and social mobilization (ACSM) for enhanced population knowledge and awareness of TB and reducing TB-related stigma, patient support and follow up for improving adherence to TB treatment, and addressing the needs of vulnerable / at-risk population groups. In this regard, the NTP pays an increasing attention to strengthening partnerships with the civil society establishments, especially in the face of the high burden of DR-TB and limited capacity of TB services and general health care services to accompany the patients during their entire case management pathway. The needy emphasis on outpatient treatment requires an intensified effort for patient support.

In this context, NGO participation in TB control in Kazakhstan needs further development and strengthening. For this purpose, and in line with WHO and TGF recommendations, a specific strategic intervention for strengthening NGO involvement was included in the *Complex Plan 2014-2020*. Further, the CCM has decided to include NGO interventions in this NFM application to the

Global Fund under a distinct Objective.

Objective 6 aims at implementing patient-centered approaches through different models of the local NGOs' involvement in TB care and support; it is deemed that the successful practices of the project will be expanded beyond TGF support and further supported by the Government (especially, through local budget support).

The key component of this Objective is support to NGO grants' program, aimed at strengthening the civil society role and participation in TB, DR-TB and TB-HIV control with emphasis on vulnerable and at-risk population groups. This program, supported by appropriate capacity building interventions, is expected to develop and implement innovative approaches, which will be further upheld and replicated in the country.

Population Services International (PSI) has been identified as Sub-recipient of grant funds for implementation of activities under Objective 6. PSI is a renowned global health organization specializing in the fields of HIV and TB, family planning and social marketing. PSI has extensive experience of work in Central Asia; the activities in this region focus on creating new and innovative methods for the implementation of health interventions.

Interventions:

6.1. Capacity building for NGOs for effective involvement in TB and DR-TB control

6.2. NGO grants' program

6.3. Program management and program support by Sub-recipient, NGO component

The project will support, in accordance to WHO and TGF recommendations (e.g. NTP Review in May 2012 by WHO/EURO) the establishment of the National Stop TB Partnership. This platform will, as one of the primary roles, foster the involvement of different non-state actors (non-governmental organizations, professional associations, private sector) in TB and DR-TB control activities in the country.

Within this grant, it is proposed to support the Secretariat of this partnership. Two consultants will be engaged to disseminate relevant information to national NGOs, facilitate their participation in TB decision making, consult on potential ways and options for obtaining funding, and to facilitate implementation of NGO TB interventions under this Objective of the TGF grant.

While PSI will take the lead at the initial stages in proposing the terms of reference and modus operandi for the Partnership, it is expected that other national and international partners will contribute to its operations. It is planned to start the activity in early 2015 (Q3 of the NFM project).

Under the auspices of the National Stop TB Partnership, a working group will be established, comprising representatives of the civil society organizations, which are active in the field of health (including organizations currently providing HIV prevention, care and support services) and/or in working with vulnerable population groups and promoting human and patient rights to access to health and social care. It is intended that, in collaboration with the NTP and other relevant governmental structures, this working group will streamline advocacy efforts for increasing political commitment to effective TB control, develop and promote initiatives aimed at inclusion of people affected by the diseases in decision making related to TB and HIV care, and assist MOH, NTP and other partners in developing practical approaches and tools for involving non-state actors in provision of adherence support and social adaptation services for TB patients as well as the groups at high risk (e.g. PLHIV, prisoners, labor migrants).

The working group will be facilitated by the Kazakhstan Association of NGOs 'Equal-to-Equal' ('*Равный-равному*') in coordination with PSI, KNCV and other national and international partners in the field.

Prior to starting the NGO small grants' program implementation (Activity 6.2), training for

implementing NGOs will be organized by the NTP and PSI with participation of other partners, which will focus on priority problems in the target regions and groups, contemporary approaches for patient support and the roles of civil society and local actors for strengthening adherence and other types of support in conditions of the changing TB care delivery model with priority focus on outpatient treatment and implementation of patient-centered approaches. In addition, the training will address the requirements for grant management (financial management, procurement, monitoring and evaluation, reporting). Additional training courses and workshops will be also conducted for implementing NGOs on the way of grants' implementation. It is planned to carry out three training courses per year, at central level.

A set of informational and educational materials will be developed by the members of the working group with the support from PSI, which will tailor the beneficiaries of NGO support from vulnerable and high-risk groups as well as the members of civil society organizations that will potentially be involved in TB control. These materials will be used within the NGO grants' implementation in target territories as well as in other relevant activities during the project implementation period.

The NGO capacity-building component also includes provisions for technical expertise and assistance by KNCV Tuberculosis Foundation. This assistance will be provided to civil society organizations to increase their role and facilitate participation in TB control, with special emphasis on improving access to diagnosis, treatment and support for vulnerable and high-risk population groups (with special emphasis on prisoners and ex-prisoners in need of TB care). The support will include development of relevant protocols other guiding documents for improved cooperation across the governmental institutions and NGOs.

The project will support two national-level conferences for civil society organizations active, or with a potential to become active, in TB control field, which will be organized in Year 2 and Year 3. The conferences will provide a forum for discussing and analyzing the results of the current grant implementation (NGO component), identifying potential for further involvement of civil society beyond TGF support through partnerships with public authorities and private sector, and to share innovative experiences across the country regions.

The main intervention under this Objective is support to the NGO grants' program for control of TB, DR-TB and TB/HIV. The design of this program was proposed by the Sub-recipient (PSI) and agreed with the partner national organizations, CCM members and NTP. It is foreseen that these NGO grants will work in three main areas: innovative approaches in adherence support for TB and DR-TB patients, TB / DR-TB care and support in prisoners and ex-prisoners, and TB / DR-TB case detection and case management in PLHIV and MARPs.

- *NGO grants for innovative approaches in adherence support for TB and DR-TB patients* will place special emphasis on supporting patients from vulnerable groups and communities during ambulatory TB and DR-TB treatment. This is to be addressed through intensified psychological support, involving families and community actors, information / education, following up on referrals and mitigating the risks of defaulting.

- *NGO grants for improving TB and DR-TB care and support in prisoners and ex-prisoners* will implement intensified and innovative interventions aimed at improving compliance to treatment and treatment outcomes in prisoners and ex-prisoners with TB, including DR-TB cases. Special attention will be paid to strengthening referrals between the penitentiary and civilian services, social accompaniment after discharge from prisons, psychological support, involving local public authorities and community actors, information / education and mitigating the risks of defaulting.

- *NGO grants for improving TB and DR-TB case detection and case management in PLHIV and MARPs* will implement outreach interventions in high-risk population segments (PLHIV and PWID). The activities will include information and education work through peer support, motivating the beneficiaries to seek counseling and testing for HIV (or regular checkups for immune status by HIV-infected individuals) and TB diagnostic

services by symptomatic persons, psychological support and facilitating links between TB and HIV services.

Across all grants, a number of special interventions and approaches will be encouraged, such as:

- *Multidisciplinary teams* for comprehensive approach to the patient and improved coordination with relevant public services;
- *Social accompaniment* for beneficiaries at high risk of defaulting;
- *Voucher referral system* for persons from vulnerable groups to receive necessary medical services; and
- *Promotion of patient rights and equal access* to essential services.

It is planned to implement NGO grants in seven country regions: Zhambyl, Kyzyl-Orda, East Kazakhstan, Karaganda and South Kazakhstan oblasts, and the cities of Almaty and Astana. The table below presents the preliminary distribution of the future grants by type above and target region.

Table 4.10. Tentative distribution of NGO grants by type and region under NFM 'Indicative Amount' request

Region	*Innovative approaches in adherence support*	*Prisoners and ex-prisoners*	*PLHIV and MARPs*
Zhambyl oblast	X	X	X
Kyzyl-Orda oblast	X		X
East Kazakhstan oblast		X	
Karaganda oblast		X	
South Kazakhstan oblast		X	X
Almaty city	X		X
Astana city	X		X

All grants will be awarded on competitive basis. PSI will be responsible for managing the entire procurement process including development of the detailed scope of work, formulation of Requests for Proposals (RFPs), conducting tenders among local NGOs, contract negotiation and award. It is tentatively proposed that the duration of each project will be 1.5 years, that is, 13 grants will be implemented in the first half of the project lifetime, and 13 grants – in the second half. The estimated money size of the projects is between USD 45,000-80,000 per grant per year (see details in the Workplan and Budget file for Objective 6).

As indicated just above, appropriate training will be provided to the grants' implementers, which will cover both technical disease control issues and grant management aspects in order to ensure compliance to the Global Fund rules and standards. PSI will also be responsible for monitoring and oversight of grants' implementation.

PSI will carry out an operational research study at the later stages of NFM project, which will look into the main findings, challenges and opportunities for civil society involvement and innovative approaches regarding NGO interventions in TB, DR-TB and TB/HIV control, based on the implementation experience of the small grants' program implemented with TGF support.

Program management and program support component under this Objective includes PSI costs of the headquarters and Almaty office staff, travel, consultancy services, IT equipment, other direct operational expenses and PSI administrative overhead.

Objective 7. To address TB, DR-TB and TB/HIV among labor migrants

The problem of TB control among internal and external migrants affects the epidemiology of TB and M/XDR-TB in Kazakhstan, a country facing significant growth in internal and external migration. There are limited data on migrants and those available from difference sources vary significantly. As identified by the WHO NTP Review 2012 and mentioned in the gap analysis section, Kazakhstan faces a challenge to improve its TB care delivery system to address TB control issues among internal and external labor migrants. A Project HOPE study on access of migrants to health care services revealed the problems in terms of legal barriers (difficulties in obtaining registration, fear of deportation), work conditions (high workload, lack of labor hygiene, difficult living conditions) and health system barriers (limitations in access, staff attitudes, language barriers, etc.)[7].

Formally, internal migrants have all rights to receive TB diagnostic and treatment services, however in reality they often do not benefit from the services due to the lack of information about the necessity to register with a medical institution at the place of their temporary residence. Undocumented external migrants, according to the legislation in force, are eligible for medical assistance only in emergency conditions. At present, migrants have limited access to TB diagnostics and treatment, including in TB facilities. The existing regulations restrict provision of services to migrants and make them unable to exercise one of the principal human rights – right to health.

Therefore, the proposed rationale is prioritizing implementation of interventions that are focused on: a) removing legal barriers to access to care for internal and external migrants; b) assuring TB prevention and care for migrants; c) strengthening community systems and increasing role of civil society.

Project HOPE has been nominated as the second Principal Recipient and will be responsible for implementation of activities for Objective 7.

Interventions:

7.1. Technical assistance and capacity building for addressing TB, DR-TB and TB/HIV among labor migrants

7.2. NGO projects on TB, DR-TB and TB/HIV in labor migrants

7.3. Program management and program support by Principal Recipient (Project HOPE)

The interventions under this Objective are designed in line with the *Minimum Package for Cross-Border TB Control and Care in the WHO European Region: a Wolfheze Consensus Statement (2012)* and will contribute to the national TB program efforts in the area laid down in the *Complex Plan for TB and MDR/TB Control in the Republic of Kazakhstan for Years 2014-2020*.

In 7 pilot sites rapid situation assessment and mapping of districts with highest concentration of migrants will be conducted at the beginning of the program to get reliable information about number of migrants, key barriers for accessing TB services, links within migrant community and with civil society groups. Initial activities will also include establishment of a cross-sector working group on TB and migration supported by national and international technical experts. The working group and consultants will focus on four key components: governance, service delivery, monitoring and surveillance, supporting environment.

The governance component includes legal framework, financing and development of mechanisms to share information with the country of origin of external migrants as well as improvement of data

[7] Structural Influences on Migrant Vulnerability. Huffman, S.A, et al, *Exploitation, vulnerability to tuberculosis and access to treatment among Uzbek labor migrants in Kazakhstan.* Social Science & Medicine (2011) doi:10:1016/j.soccimed.2011.07.019 – in press

management system for internal migrants with TB. The working group will develop guidelines on TB and M/XDR-TB control in migrants by reference to minimum service package recommended by WHO (Wolfheze Consensus Statement). In program pilot regions revision of existing regulatory documents and issuing of relevant orders are expected to ensure access to TB diagnostic and treatment for migrants including undocumented ones. Working group will also host meetings with representatives of CAR countries and develop documents for inter-country dialogue. Project HOPE in partnership with WHO, International Organization of Migration (IOM) and International Federation of Red Cross and Red Crescent Societies (IFRC) will work through their representative offices in CAR and on-going programs there to initiate discussions with national TB programs, Ministries of Health and other relevant authorities. CCM meetings will be also used as a platform for communication on country level.

To promote regional (inter-country) cooperation program will support organization of annual high-level meetings with participation of CAR governmental officials, representatives of WHO, IOM and other partners. These meetings will be hosted and chaired by Kazakhstan aiming to facilitate development of Regional TB Control Action Plan in the Central Asia including mechanisms for information exchange and development of bilateral and multilateral agreements for cross-border cooperation.

TB detection and treatment will be provided through existing network of TB and migrant-friendly PHC facilities. List of facilities to provide services for migrants will be agreed with NTP and approved by MOH order to ensure access to diagnostic services including molecular technology rapid diagnostic. Treatment will be mostly provided on outpatient basis to reduce financial burden on hospitals and to be in line with overall reform for TB services. This approach will also better fit migrants' needs as they can continue working if health condition allows. For improving surveillance, it is planned to develop specific indicators and integration of migration-related data in the routine TB M&E system.

Financial mechanism (medical social fund) will be developed to reimburse facilities for additional services associated with migrants - diagnostic, full treatment of sensitive cases and few months of MDR-TB treatment for external migrants. Continuity of treatment after migrant's return to the country of permanent residence will be secured through CAR current programs and budgets. This issue has been discussed by Project HOPE with managers of national programs in CAR during the preparatory phase and from a perspective of potential collaboration within the framework of proposed program. All countries expressed interest and provisional agreement is confirmed by letters of support from NTP managers.

It is anticipated that bilateral and multilateral agreements for cross-border TB control will develop financial mechanisms for reimbursement of services between countries later on. In addition, feasibility of establishing special insurance fund for TB will be assessed involving international and national experts as during focus groups discussions migrants expressed interest to get insurance.

Enabling environment and referral of migrants to the health facilities will be organized involving local NGOs such as Kazakhstan Association of people living with HIV/AIDS, "Umit", "Answer", "You are not alone", PSI and others, and network of seven migrant centers operated by IFRC/Kazakhstan RC and funded by European Union. It is planned to offer competitive grants for the NGOs in 7 pilot sites with highest concentration of migrants – Almaty and Almaty oblast, Astana, Karaganda, Aktobe, Atyrau, Shymkent. These grants will aim at timely detection of TB among migrants and its effective treatment to decrease the incidence and deaths, to prevent the spread of drug resistance in this high-risk group and ultimately among the general population. Selected NGOs will provide patient support models that have proven their effectiveness in improving treatment adherence among vulnerable and high-risk groups. In particular, the projects are expected to contribute to: improvement of collaboration between the public health services, NGOs and migration centers; increasing the effectiveness of TB treatment in outpatient settings; ACSM activities among labor migrant workers and their families as well as their employers and local authorities for reducing stigma, dissemination of information about migrant's rights, increasing access to services and ensuring patient and human rights.

For each of pilot sides Project HOPE will provide ToT for a three people team representing migrant centers, NGO and medical facilities. They will be taught in TB control and prevention, involvement of migrant community, skills in communication, mobilization and advocacy related to TB. This team with support from Project HOPE will further provide cascade training to NGO staff, outreach workers and volunteers with special attention on infection control measures and use of individual protective equipment.

As pre-departure orientation has been proved to be effective tool in TB control Project HOPE will work with IOM and IFRC/RC network in CAR disseminating information about program in Kazakhstan. Pre-departure package will be developed by Project HOPE using program funds and provided to migrants through CAR migrant centers (4 in Kyrgyzstan, 7 in Tajikistan and 4 in Uzbekistan) operated by IFRC and funded by EU. Please, see Annex 4.8 for details related to pre-departure package.

Special attention will be paid to ACSM activities targeting migrants and relevant public sector structures involved. These include integration of the migrants' component in the national communication strategy, development of special information / education materials targeting migrants, information session for employers, work with mass media and law enforcement institutes such as police and migration service.

8. Project management and administration (PR NCPT)

The program management component includes staffing, office management, communication and other relevant activities and costs of the Principal Recipient – Project Implementation Unit (PIU) of the National Center of Tuberculosis Problems (NCTP).

8.1. Communications

8.2. Office equipment

8.3. PIU staff

8.4. Other

* * *

Please refer to more details in the table below summarizing the activities to be implemented, and to Workplan and Budget files for each Objective.

Table 4.11. Kazakhstan TB NFM application: Interventions / Activities by Objective

Objective 1. To support the reform of TB control services through strengthening the National TB Program management, monitoring and evaluation and capacity building

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
1.1	**Improvement of legislative and normative framework**															
1.1.1	Working Group on revision of TB regulations and guidelines	A working group will be established to perform a comprehensive analysis of the existing national legislation, regulations and guidelines related to TB control and organization of TB control services in the country; identify gaps and inconsistencies which need revision in line with the latest international strategies and practices; propose modifications and obtain opinions from MOH on these for further official approval (especially in terms of changes in TB care delivery network aimed at expanding outpatient treatment); ensure relevant intersectoral participation and coordination, and perform other tasks as required. The group will be hosted by the NTP central unit at NCTP and will include representatives of national governmental and non-governmental stakeholders as well as international partners. Starting Q1.															
1.1.2	National consultants, revision of TB regulations and guidelines	Four national consultants will be engaged in supporting the working group in the tasks above and in practical work related to updating the set of regulations and guidelines. They will also ensure communication to and participation of regional NTP units and other health system stakeholders, and provide training for managers and service providers (see below). The four main areas of activity are: i) overall management, financing and allocation, human resources; ii) organization of TB care delivery with infrastructure optimization and transition to full outpatient treatment; iii) case detection and diagnosis; and iv) clinical TB case management and systems for patient adherence support. Starting Q1.														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
1.1.3	WHO technical assistance: National Professional Officer	The project will support a position of WHO Professional Officer (NPO-C) at the WHO Country Office in Kazakhstan, who will assist the NTP in the revision of legislative and regulatory framework and will facilitate communication and collaboration between the national stakeholders as well as with international partners. Starting 2015.														
1.2	**Capacity building for reform implementation**															
1.2.1	Training for health care managers	Training will be provided for TB and general health service managers from the regions on implementation of new strategies and guidance in view of the changing TB care delivery system, including: i) implementation of rapid methods for TB and DR-TB diagnosis, ii) case management strategies including revised criteria for hospitalization and discharge; iii) modalities, roles and responsibilities of different services in outpatient treatment of TB cases including MDR-TB cases; iv) infection control, e.g. that in outpatient settings; and v) addressing the needs of risk groups including PLHIV, prisoners and ex-prisoners and labor migrants, etc. Two training courses annually during Years 2-3 (at central level, 3 days).							1		1		1		1	
1.2.2	Training for regional NTP coordinators and key TB service staff	Training will be provided for oblast level NTP coordinators and key TB service staff on priority issues related to implementation of the revised regulations and guidelines and practical steps for improving the TB care delivery system, including implementation of rapid diagnostic techniques at peripheral level, optimization of hospital infrastructure and improving performance, and expanding the outpatient case management model. Two training courses annually during Years 1-3 (at central level, 5 days).				1		1		1		1		1		1
1.2.3	Training for TB laboratory staff	Training will be provided for staff of regional (oblast level) TB reference laboratories on technical and programmatic aspects related to ensuring universal access to and high quality of modern rapid diagnostic techniques, linked to the overall changes in TB service delivery. One training course in Year 1, two training courses annually during Years 2-3 (at NCTP /					1		1		1		1		1	

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		NRL, 4 days).														
1.2.4	Training in infection control	Training on modern vision of TB infection transmission and evidence-based internationally recommended strategies for control of TB infection (in hospitals and outpatient settings) will be provided for key TB service staff from the regions and penitentiary system medical service. Four training courses will be supported by the project (Year 1 - 1, Year 2 - 2, Year 3 - 1), at the central level (3 days).						1		1		1		1		
1.3	**Strengthening program M&E, supervision and information system**															
1.3.1	NTP supervision visits	Support will be provided for regular NTP supervision /M&E visits to oversee program implementation including innovative DR-TB management interventions that will be implemented within the NFM TGF project. By the NTP central unit to oblasts. Each of 15 oblasts (Almaty city not counted) will be visited twice a year (two persons).														
1.3.2	NTP program coordination meetings	Program coordination meetings will be convened twice a year at the NTP central unit (NCTP), to summarize and discuss the supervision results and plan for the next steps (3 days).				1		1		1		1		1		1
1.3.3	National consultants, improvement of TB information system	Two national consultants will work on revision of the current indicators, recording and reporting forms and classifications to align them with the latest (2012) WHO recommendations. Specific tasks will include integration of new diagnostic technologies (e.g. Xpert MTB/RIF) and linking financing and performance data (e.g. hospitalizations). During Q1-Q6.														
1.3.4	Upgrade of electronic TB information system	The existing national electronic database needs upgrade to correspond to the new requirements e.g. in terms of performance analysis for decision making and incorporating health system elements (e.g. financing, delays between diagnosis and treatment, hospitalization data, etc.), which are important in view of reforming the TB care delivery system. An IT company will be contracted to develop new software for the national electronic TB database, test and install it in all regions (in Year 2).														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
1.3.5	National consultant, maintenance of national TB database	A national consultant will be employed to perform maintenance of the new electronic national TB information system (in Year 3).														
1.3.6	Training on upgraded TB information system	After upgrade of the electronic TB database is completed and the system is operational at all levels, training will be organized for M&E staff from all regional NTP units. Two training courses will be organized in Q11 (4 days).											2			

Objective 2. To improve timely case detection and quality diagnosis of TB and DR-TB

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
2.1	**Scaling up of Xpert MTB/RIF at the regional TB laboratories in the civilian sector**															
2.1.1	Training of regional TB laboratories' staff in Xpert MTB/RIF implementation	Training will be provided in Xpert MTB/RIF use and scale up (at NCTP / NRL, for 2-3 staff from 16 regions (12 oblasts), lab and TB service staff, 3 days). Number of training courses: 2 initial in Q1 and Q2, 2 for follow up and experience sharing annually in Yr 2 and Yr 3.	1	1					1		1		1		1	
2.1.2	Xpert MTB/RIF instruments for regional TB reference laboratories in the civilian sector, 4-module	10 additional Xpert instruments (4-module) will be procured for regional laboratories according to the needs (see details in separate sheet in this file). Procurement in Year 1.														
2.1.3	Xpert MTB/RIF instruments for regional TB reference laboratories in the civilian sector, 2-module	7 additional Xpert instruments (2-module) will be procured for regional labs according to the needs (see details in a separate sheet in this file). Procurement in Year 1.														
2.1.4	UPS stations for	UPS stations will be procured for 17 additional Xpert														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
	Xpert instruments at regional TB reference laboratories in the civilian sector	instruments at regional labs procured by the project. Procurement in Year 1.														
2.1.5	IT equipment (printers) for Xpert instruments at regional TB reference laboratories in the civilian sector	Printers will be procured for all Xpert instruments newly procured for the regional TB reference laboratories in the civilian sector.														
2.1.6	Xpert MTB/RIF cartridges for regional reference laboratories in the civilian sector	Procurement of Xpert MTB/RIF tests (cartridges) for testing of TB suspects at the regional TB reference laboratories in the civilian sector. Number of tests: see detailed estimates in a separate sheet in this file, based on needs and productivity forecasts. Number of tests: see detailed estimates in a separate sheet in this file, based on needs and productivity forecasts. Number of tests in this sheet is given by quarter; delivery of cartridges: 2 times a year.														
2.1.7	Maintenance and servicing	Calibration, module replacement and other services for Xpert instruments (Cepheid's agent, MMG). Starting 2015.														
2.2	**Demonstration projects on Xpert MTB/RIF rollout at district level (Zhambyl and Kyzyl-Orda oblasts, Astana and Almaty cities)**															
2.2.1	External technical assistance, rollout of Xpert MTB/RIF technology at district level	External technical assistance will be provided to the NTP in setting up the demonstration program for rolling out Xpert MTB/RIF technology to the peripheral TB service delivery level (district TB units) in the demonstrations regions (in Year 1). The second mission (in Year 3) will focus on the follow up of the project progress, M&E of early implementation and next steps e.g. regarding expanding countrywide.	1										1			
2.2.2	National consultants, Xpert MTB/RIF implementation at district level	Eight local consultants (2 per each of 4 demonstration areas) will be engaged to facilitate implementation, supervise and monitor demonstration projects on Xpert MTB/RIF at peripheral (district) level of TB service delivery. Starting Q2.														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
2.2.3	Training of staff in Xpert MTB/RIF implementation at district level in demonstration areas	Training on practical aspects of implementation of Xpert MTB/RIF technology at peripheral (district) level of TB service will be organized for key staff from four demonstration areas - managers (TB service, PHC service), TB specialists, lab specialists. In oblast centers, 2 days; initial training in Q1-Q2, follow-up training in Q5-Q6 and Q9-10. Number of people to be trained per 'round': 120.	3	3			3	3			3	3				
2.2.4	Xpert MTB/RIF instruments for district-level TB units in demonstration areas, 4-module	6 Xpert instruments (4-module) will be procured for district level TB units / labs (Astana city - 3, Almaty city - 3), see details in a separate sheet in this file). Procurement in Year 1.														
2.2.5	Xpert MTB/RIF instruments for district-level TB units in demonstration areas, 2-module	20 Xpert instruments (2-module) will be procured for district level TB units / labs (Zhambyl oblast - 11, Kyzyl-Orda oblast - 9), see details in a separate sheet in this file). Procurement in Year 1.														
2.2.6	UPS stations for Xpert instruments in demonstration areas	UPS stations will be procured for 26 Xpert instruments at district level in 4 demonstration areas. Procurement in Year 1.														
2.2.7	IT equipment (printers) for Xpert instruments at district-level TB units in demonstration areas	Printers will be procured for all Xpert instruments newly procured for the district-level TB units in four demonstration areas.														
2.2.8	Xpert MTB/RIF cartridges for district-level demonstration areas in the civilian sector	Procurement of Xpert MTB/RIF tests (cartridges) for testing of TB suspects at the peripheral TB service units in four demonstration areas in the civilian sector. Number of tests: see detailed estimates in a separate sheet in this file, based on needs and productivity forecasts. Number of tests in this sheet is given by quarter; delivery of cartridges: 2 times a year.														
2.2.9	Maintenance and servicing	Calibration, module replacement and other services for Xpert instruments in 4 demonstration areas (Cepheid's agent,														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		MMG). Starting 2015.														
2.2.10	Supervision / monitoring of Xpert MTB/RIF rollout project to district level	Regular supervision / monitoring visits by oblast NTP units to district level TB units in the demonstration areas (Zhambyl and Kyzyl-Orda), totally 20 sites.														
2.2.11	Workshops / coordination meetings, Xpert MTB/RIF rollout to district level	Two meetings per year will be help with at central level, with participation of key staff from the four demonstration regions implementing Xpert MTB/RIF rollout to the peripheral TB service delivery level, for the project M&E, follow up and experience sharing for quality improvement and country-wide scale-up (at NCTP, 5 people from each of 4 demonstration sites, 3 days).			1		1		1		1		1		1	
2.3	**Rapid WHO-recommended diagnostics for TB and DR-TB: automated MGIT and LPA**															
2.3.1	Laboratory equipment: automated MGIT	No procurement is necessary at the moment as all 20 regional TB reference laboratories are equipped with MGIT Bactec-960 instruments (procured by either the government or TGF).														
2.3.2	Laboratory supplies / consumables: culture in liquid media (automated MGIT)	The number of tests was calculated according to the updated diagnostic algorithm. TGF NFM project will contribute to the coverage of actual needs as follows: Year 1 (2015) - 60%, Year 2 (2016) - 40%, Year 3 (2017) - 20%, with the increasing coverage of needs by domestic funding. See detailed calculations in a separate sheet in this file.														
2.3.3	Laboratory supplies / consumables: culture and DST to first-line drugs in liquid media (automated MGIT)	The number of tests was calculated according to the updated diagnostic algorithm. TGF NFM project will contribute to the coverage of actual needs as follows: Year 1 (2015) - 60%, Year 2 (2016) - 40%, Year 3 (2017) - 20%, with the increasing coverage of needs by domestic funding. See detailed calculations in a separate sheet in this file.														
2.3.4	Maintenance and servicing, automated MGIT equipment	Maintenance, servicing and minor repairs for 20 automated MGIT Bactec-960 instruments at the regional TB reference laboratories.														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
2.3.5	Laboratory equipment: line probe assay (LPA Hain)	Procurement of 11 LPA Hain instruments for the regional reference laboratories (the other 9 are equipped with these instruments, procured earlier by TGF or through domestic sources).														
2.3.6	Supplies / consumables: identification and DST to H&R, line probe assay (LPA Hain)	The number of tests was calculated according to the updated diagnostic algorithm. TGF NFM project will contribute to the coverage of actual needs as follows: Year 1 (2015) - 100%, Year 2 (2016) - 80%, Year 3 (2017) - 50%, with the increasing coverage of needs by domestic funding. See detailed calculations in a separate sheet in this file.														
2.3.7	Supplies / consumables: DST to second-line drugs, line probe assay (LPA Hain)	The number of tests was calculated according to the updated diagnostic algorithm. TGF NFM project will contribute to the coverage of actual needs as follows: Year 1 (2015) - 100%, Year 2 (2016) - 80%, Year 3 (2017) - 50%, with the increasing coverage of needs by domestic funding. See detailed calculations in a separate sheet in this file.														
2.3.8	Maintenance and servicing, LPA Hain equipment	Maintenance, servicing and minor repairs for 20 instruments at the regional TB reference laboratories.														

Objective 3. To promote quality and evidence-based treatment of DR-TB cases

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
3.1	**Demonstration projects on full outpatient treatment of DR-TB cases (Zhambyl, Kyzyl-Orda and Aktobe oblasts, Astana city)**															
3.1.1	Working Group on expanding outpatient treatment of DR-TB patients	Support will be provided to a working group, which will develop /update guidance on implementation of the outpatient treatment model for DR-TB patients (in urban and rural settings) and will oversee its early implementation in three demonstration areas (Zhambyl, Kyzyl-Orda, Aktobe oblasts and Astana city). Special attention will be paid to measures for														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		control of TB infection in outpatient settings. During Year 1.														
3.1.2	National consultants, outpatient treatment of DR-TB patients in demonstration areas	Eight local consultants (two per each of the three regions) will be engaged to facilitate implementation, supervise and monitor demonstration projects on full outpatient treatment of DR-TB cases. Starting Q3.														
3.1.3	Training of staff on full outpatient treatment of DR-TB cases	Training will be organized for key health service staff (managers, TB service, PHC service) in 4 demonstration regions on practical aspects of implementation of full outpatient treatment model for DR-TB patients, starting Q2, at oblast level. Two training courses per quarter during Q2-Q6, one course per quarter during Q7-Q10.		2	2	2	2	2	1	1	1	1				
3.1.4	Coordination workshops for demonstration projects	Two coordination workshops per year will be held at the central level for M&E, follow up and experience sharing across the three demonstration areas implementing full outpatient treatment model for DR-TB cases (3 days, at NCTP).			1		1		1		1		1		1	
3.1.5	Supervision / monitoring of demonstration projects on outpatient DR-TB treatment	Regular supervision / monitoring visits will be conducted by oblast NTP units (Zhambyl, Kyzyl-Orda and Aktobe) to district level TB units to ensure close oversight and support for outpatient DR-TB case management in respective areas. Starting Q3.														
3.1.6	Incentives for PDR-TB patients	PDR patients on full outpatient treatment in four demonstration regions will be provided with incentives (twice a month) to ensure adherence. It is foreseen to provide incentives to at least to 90% of all outpatient cases, for at least of 85% of treatment duration (given the expected proportion of need for hospitalization, default, failure etc.). The form (food parcels, hygienic and other packages, vouchers, mobile communication support or direct monetary incentives) will depend on local and individual context. Incentives Number of patients to receive incentives: see estimates in a separate sheet in this file).														
3.1.7	Enablers for PDR-TB patients	PDR patients on full outpatient treatment in four demonstration regions will be provided with enablers														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		(reimbursement of transportation expenses to reach a DOT spot for drugs intake) to ensure adherence to treatment. It is estimated that about 20% of enrolled patients will require such enablers, for at least of 85% of treatment duration (given the expected proportion of need for hospitalization, default, failure etc.). Number of patients to receive enablers: see estimates in a separate sheet in this file).														
3.1.8	Incentives for MDR-TB patients	MDR patients on full outpatient treatment in four demonstration regions will be provided with incentives (twice a month) to ensure adherence. It is foreseen to provide incentives to at least to 90% of all outpatient cases, for at least of 80% of treatment duration (given the expected proportion of need for hospitalization, default, failure etc.). The form (food parcels, hygienic and other packages, vouchers, mobile communication support or direct monetary incentives) will depend on local and individual context. Incentives Number of patients to receive incentives: see estimates in a separate sheet in this file).														
3.1.9	Enablers for MDR-TB patients	MDR patients on full outpatient treatment in four demonstration regions will be provided with enablers (reimbursement of transportation expenses to reach a DOT spot for drugs intake) to ensure adherence to treatment. It is estimated that about 20% of enrolled patients will require such enablers, for at least of 80% of treatment duration (given the expected proportion of need for hospitalization, default, failure etc.). Number of patients to receive enablers: see estimates in a separate sheet in this file).														
3.1.10	Enablers for health care staff	Enablers (in the form of reimbursement of transportation expenses) will also be provided for health care staff (PHC level, in rural areas and district centers) who will visit DR-TB patients at home to provide drugs under DOT. It is foreseen that about 10% of PDR and MDR patients will need to be visited at home for this purpose, for at least of 80-85% of treatment duration. Number of patients to receive enablers: see estimates in a separate sheet in this file).														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
3.1.11	Vehicles for mobile teams	Procurement of vehicles for 8 mobile teams which will be engaged in intensive patient follow-up ('Sputnik'-type activities) in urban areas (Taraz, Kyzyl-Orda, Aktobe and Astana cities - 2 teams per each city), in Q3.														
3.1.12	Intensive outreach patient support and follow-up	Intensive follow-up and support to patients on outpatient DR-TB treatment will be provided by mobile outreach teams. It is foreseen to pilot this approach in three cities in the demonstration areas: Taraz, Kyzyl-Orda, Aktobe and Astana. Starting mid-2015.														
3.1.13	Program support costs, outpatient DR-TB treatment component	Operational expenses (PR, SRs) for implementation of activities 3.1.1-3.1.12 above														
3.2	**Treatment of XDR-TB patients**															
3.2.1	External technical assistance, clinical management of XDR-TB cases	External technical assistance will be provided to the NTP in introduction of new treatment schemes for XDR-TB patients taking into account the latest evidence and international experience including the use of new drugs. Two missions of an external expert are foreseen in Q2 (development of the protocol, cohort formation, etc.) and in Q6 (evaluation of early results, adjustment measures, next steps).		1				1								
3.2.2	National consultants, clinical management of XDR-TB cases	Two national consultants will be employed to coordinate, supervise and monitor implementation of XDR-TB treatment regimen in the cohort at NCTP. Starting Q3.														
3.2.3	Second-line and third-line anti-TB drugs for XDR patients	It is planned to enroll a total of 200 patients in the cohort (Year 1 - 100, Year 2 - 100), at NCTP. The average duration of treatment is 30 months (12 months intensive phase, 18 months continuation phase). The treatment scheme includes Cm (30% of cases) / Amk (70%), Mfx (100%), Pto (50%), Cs (95%), PAS (100%), Z (100%), E (if no resistance to E is														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		found) and Amx/Clv (90%) [to be procured via GDF]. Clofazimine and Linezolid (600 mg / day, for 6 months) will be added. In addition, the project will consider administration of Bedaquiline (Bdq) in a limited number of patients when the drug becomes available for procurement.														
3.2.4	Training in drug management (second-line and third-line TB drugs)	Training in TB drug management with emphasis on second-line and third-line anti-TB drugs will be organized at the central level (NCTP), with participation of regional NTP coordinators and drug management specialist from all regions. Two training courses during Year 2 (3 days).							1	1						

Objective 4. To strengthen collaboration and response for control of TB/HIV co-infection

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
4.1	**Capacity building in TB/HIV collaboration**															
4.1.1	Working Group on strengthening TB/HIV collaboration	Support to a working group on strengthening TB/HIV collaborative activities will be provided (update of regulations, case management protocols, practical aspects of collaboration between the two services, development of training materials, etc.). Starting Q1.														
4.1.2	National consultants on TB/HIV collaboration	Two national consultants will be employed to facilitate the work related to update of regulations, guidelines and protocols, development of joint orders and instructions regulating collaboration between the two services, upgrade and integrate information systems and other relevant tasks. Starting Q1.														
4.1.3	Training-of-trainers (ToT) in TB/HIV management	Training for prospective trainers in programmatic and clinical management of TB/HIV co-infection will be organized at the central level, for regional specialists from the civilian sector					1			1						

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		TB services, HIV/AIDS services and the penitentiary sector. Two training courses during Years 1-2 (5 days).														
4.1.4	National workshops on TB/HIV collaboration	National level workshops will be organized annually which will discuss priority issues of TB/HIV collaboration including progress towards implementation of internationally recommended strategies and practices, rollout of new rapid methods for diagnosing TB and MDR-TB among PLHIV, and relevant practical issues related to collaboration between the two services. About 60 participants from the central level and all regions, 2 days.				1				1				1		
4.2	**Screening of PLHIV for TB and MDR-TB by Xpert MTB/RIF**															
4.2.1	Training of AIDS service staff in Xpert MTB/RIF use in PLHIV	Training will be organized for AIDS Center's staff from the demonstration areas (at NCTP / NRL, for staff from each of 9 AIDS Centers (8 regions and Republican AIDS Centers, where Xpert instruments will be placed for Xpert testing in PLHIV, 3 days). Number of training courses: 2 initial trainings in Q2 and Q3, 1 for follow up and experience sharing annually in Yr 2 and Yr 3.		1	1				1				1			
4.2.2	Xpert MTB/RIF instruments for AIDS Centers, 4-module	2 Xpert instruments (4-module) will be procured for AIDS Centers in Karaganda oblast and Almaty city according to the needs (see details in relevant sheet in this file). Procurement in Year 1.														
4.2.3	Xpert MTB/RIF instruments for AIDS Centers, 2-module	7 Xpert instruments (2-module) will be procured for AIDS Centers in East Kazakhstan, South Kazakhstan, Pavlodar, Kostanay and Almaty oblasts, Astana city and Republican AIDS Center, according to the needs (see details in a separate sheet in this file). Procurement in Year 1.														
4.2.4	UPS stations for Xpert instruments at AIDS Centers	UPS stations will be procured for 9 Xpert instruments at AIDS Centers, which will be procured by the project. Procurement in Year 1.														
4.2.5	IT equipment (printers) for Xpert stations at AIDS	Printers will be procured for all Xpert instruments place at AIDS Centers at the regional level.														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
	Centers															
4.2.6	Xpert cartridges for AIDS Centers	Procurement of Xpert MTB/RIF tests (cartridges) for testing of TB suspects among PLHIV at AIDS Centers. Number of tests: see detailed estimates in a separate sheet in this file, based on needs and productivity forecasts. Number of tests in this sheet is given by quarter; delivery of cartridges: 2 times a year.														
4.2.7	Maintenance and servicing	Calibration, module replacement and other services for Xpert instruments (Cepheid's agent, MMG). Starting mid-2015.														

Objective 5. To strengthen TB and DR-TB control in the penitentiary system

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
5.1	**Capacity building for strengthening TB control and reforming medical services in prisons**															
5.1.1	External technical assistance for strengthening TB and DR-TB control in prisons	External TA will be provided to the NTP and CES covering in-depth analysis of epidemiological situation and trends; estimate and planning of medium-term programmatic and financial needs; identification of priority measures to be taken in regard to diagnosis, treatment, infection control, M&E / information system, cooperation with civilian services for follow-up of ex-prisoners with TB etc.; and development of detailed plan for implementation. Two consultancy missions are planned for Years 1 and 3 (the second mission is intended for follow-up and evaluation of progress).				1								1		
5.1.2	National consultants on TB and DR-TB control in prisons	Two national consultants will be employed to facilitate the work related to update of regulations, guidelines and protocols for TB and DR-TB control in the penitentiary system, development of relevant orders and instructions (including joint documents with the civilian authorities), upgrade and integration of information systems and other relevant tasks.														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		Starting Q1.														
5.1.3	IT equipment for strengthening TB M&E in prisons	Procurement of IT equipment for strengthening capacities of CES medical service in TB monitoring and evaluation (for central level CES medical service, regional departments, TB hospitals, PTIs implementing Xpert MTB/RIF). Totally 34 sets will be procured (a set includes a desktop PC, a laptop PC, an 'all-in-one' (printer / copier / scanner / fax), and a multimedia device), in Year 1.														
5.1.4	National workshops on TB and DR-TB control in prisons	National level workshops will be organized annually which will discuss priority issues of TB control in prisons including progress towards implementation of internationally recommended strategies and practices, rollout of new diagnostic techniques, scaling up MDR treatment, and relevant practical issues related to collaboration between the penitentiary and civilian TB services. About 60 participants from the central level and all regions.						1				1				1
5.2	**Screening of detainees in pre-trial isolators for TB and MDR-TB by Xpert MTB/RIF**															
5.2.1	Training of penitentiary service staff in Xpert MTB/RIF	Training for penitentiary system's staff will be organized at NCTP / NRL on screening detainees for TB and DR-TB by Xpert at the demonstrations sites (2-3 persons from each of 7 pre-trial isolators in the penitentiary system where Xpert instruments will be placed for Xpert testing in detainees, 3 days). Number of training courses: 1 initial training in Q3, 1 for follow up and experience sharing annually in Yr 2 and Yr 3.														
5.2.2	Xpert MTB/RIF instruments for pre-trial isolators in the penitentiary system, 4-module	1 Xpert instrument (4-module) will be procured for the largest PTI in Almaty city according to the needs (see details in relevant sheet in this file). Procurement in Year 1.			1					1				1		
5.2.3	Xpert MTB/RIF instruments for pre-trial isolators in the	6 Xpert instruments (2-module) will be procured for large PTIs in East Kazakhstan (Ust-Kamenogorsk), Karaganda, South Kazakhstan (Shymkent), Zhambyl (Taraz) and														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
	penitentiary system, 2-module	Kostanay oblasts and Astana city, according to the needs (see details in a separate sheet in this file). Procurement in Year 1.														
5.2.4	UPS stations for Xpert instruments in PTIs	UPS stations will be procured for 7 Xpert instruments at PTIs Centers, which will be procured by the project. Procurement in Year 1.														
5.2.5	IT equipment (printers) for Xpert stations in PTIs	Printers will be procured for all Xpert instruments place at PTIs in the penitentiary system.														
5.2.6	Xpert cartridges for PTIs	Procurement of Xpert MTB/RIF tests (cartridges) for screening of detainees for TB and DR-TB in 7 PTIs in the penitentiary system. Number of tests: see detailed estimates in a separate sheet in this file, based on needs and productivity forecasts. Number of tests in this sheet is given by quarter; delivery of cartridges: 2 times a year.														
5.2.7	Maintenance and servicing	Calibration, module replacement and other services for Xpert instruments (Cepheid's agent, MMG). Starting mid-2015.														
5.3	**Treatment of MDR-TB patients in prisons**															
5.3.1	Training of penitentiary service staff in MDR treatment	Training of prisons TB specialists in contemporary approaches in MDR-TB treatment will be conducted at NCTP (2 training courses in Year 1, 1 training course per year during Years 2-3, 5 days).		1	1				1				1			
5.3.2	National consultants, MDR-TB treatment in prisons	Two national consultants (a TB specialist and a drug management specialist) will be employed to coordinate, supervise and monitor implementation of MDR-TB treatment in the penitentiary system. Starting Q3.														
5.3.3	Second-line anti-TB drugs for MDR patients in prisons	The project will procure second-line drugs for 900 MDR-TB patients in prisons (300 a year). Additional needs (150 patients per year) will be covered from the domestic sources (MoIA budget). In total, 450 patients will be enrolled in MDR treatment in prisons annually. Treatment will be conducted according to the national protocol. The average duration of treatment is 20 months (8 months intensive phase, 12 months continuation phase). The regimen includes Cm (80% of cases)														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		/ Amk (20%), Lfx (100%), Pto (90%), Cs (95%), PAS (80%), Z (100%), E (if no resistance to E is found) [to be procured via GDF].														
5.4	**Strengthening TB infection control in prisons**															
5.4.1	National consultant, TB infection control in prisons	A national consultant will be employed to develop a special set of guidance and instructions related to TB infection control at different levels of the penitentiary system in Kazakhstan. During Q5-Q10.														
5.4.2	Training of penitentiary service staff in infection control	Training of prisons' administration staff and TB specialists in contemporary practices in TB infection control will be conducted at NCTP (1 training course per year during Years 2-3, 3 days).								1				1		
5.4.3	Environmental measures for infection control: UVGI devices	Upper-level UVGI devices will be procured for DR-TB patient wards and areas of high risk of contamination at 7 TB hospitals in the penitentiary system, totally 280 lamps. Procurement in Year 1.														
5.4.4	Individual measures for infection control: respirators	Procurement of N95 / FFP-2 respirators for 140 staff at high risk of infection at TB treatment sites in prisons: 140 staff x 1 mask per week x 46 full working weeks per year = 6,440 pcs per year. Starting 2015.														

Objective 6. To strengthen partnerships with civil society for effective control of TB, DR-TB and TB/HIV

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
6.1	**Capacity building for NGOs for effective involvement in TB and DR-TB control**															
6.1.1	Support to the National Stop TB Partnership	It is intended, in accordance to WHO and TGF recommendations (e.g. NTP Review May 2012), to establish the National Stop TB Partnership that will, as one of the primary roles, foster the involvement of different non-state actors (non-governmental organizations, professional associations, private sector) in TB and DR-TB control														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		activities in the country. Within this grant, it is proposed to support the Secretariat of this partnership. Two consultants will be engaged to disseminate relevant information to national NGOs, facilitate their participation in TB decision making, consult on potential ways and options for obtaining funding, and to facilitate implementation of NGO TB interventions under this Objective of the NFM grant. At the same time, it is expected that other national and international partners will contribute to the activities of the Partnership. Starting early 2015 (Q3).														
6.1.2	Working Group on strengthening civil society involvement in TB control	A working group will be established, comprised by representatives of the civil society organizations, which are active in the field of health (e.g. organizations currently providing HIV prevention and support services) and/or in working with vulnerable population groups and promoting human and patient rights to access to health and social care. It is intended that, in collaboration with the NTP and other relevant governmental structures, this working group will foster advocacy efforts for increasing political commitment to effective TB control, develop and promote initiatives aimed at inclusion of people affected by the diseases in decision making related to TB and HIV care, and assist MOH, NTP and other partners in developing practical approaches and tools for involving non-state actors in provision of adherence support and social adaptation services for TB patients as well as the groups at high risk (e.g. PLHIV, prisoners, labor migrants). The working group will be facilitated by the Association of NGOs 'Equal-to-Equal' in coordination with PSI, KNCV and other partners involved in implementation of interventions under this Objective. Starting Q1.														
6.1.3	Training for NGOs in TB and DR-TB control	Prior to starting small grants' implementation (see the next Activity), training for implementing NGOs will be organized by the NTP and PSI with participation of other partners, which will focus on priority problems in the target regions and groups, contemporary approaches for patient support and the roles of civil society and local actors for strengthening		2			1			2		1		2		1

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		adherence and other types of support in conditions of the changing TB care delivery model and priority development of outpatient treatment and patient-centered approaches. In addition, the training will include requirements for grant management (financial management, procurement, M&E). Training / workshops on the way of grants' implementation will be also conducted. It is planned to carry out three training courses per year, at central level (5 days).														
6.1.4	ACSM and promotional materials for NGO component	A set of informational and educational materials will be developed by the members of the working group with the support from the Sub-recipient for this component (PSI), which will tailor the beneficiaries of NGO support from vulnerable and high-risk groups as well as the members of civil society organizations that will potentially be involved in TB control. These materials will be used within the NGO grants' implementation in target territories as well as in other relevant activities during the project implementation period.														
6.1.5	KNCV technical support to NGO involvement in TB and DR-TB control	KNCV will provide technical expertise and assistance to civil society organizations to increase their role and facilitate participation in TB control, with special emphasis on improving access to diagnosis, treatment and support for vulnerable and high-risk population groups (including prisoners and ex-prisoners). The support will include development of relevant protocols and orders / guidance for improved cooperation across the governmental institutions and NGOs. Starting Q3.														
6.1.6	National NGO conferences on TB control	Two national-level conferences for civil society organizations active, or with a potential to become active, in TB control field, will be organized in Years 2 and 3. The conferences will provide a forum for discussing and analyzing the results of the current grant implementation (NGO component), identifying potential for further involvement of civil society (beyond TGF support) through partnerships with public authorities and private sector, and to share innovative experiences across the country regions. About 100 participants, 2 days.							1				1			

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
6.2	**NGO grants' program**															
6.2.1	NGO grants for innovative approaches in adherence support for TB and DR-TB patients	During NFM project, it is planned to offer a total of eight grants to NGOs (in two rounds of four grants x 1.5 years duration each) to develop and implement innovative approaches for adherence support to TB and DR-TB patients in ambulatory settings. Special emphasis is to be placed on patients from vulnerable groups and communities, which are to be addressed through intensified psychological support, involving families and community actors, information / education and following up on referrals mitigating the risk of defaulting. The following areas are proposed: Astana city, Almaty city, Zhambyl and Kyzyl-Orda oblasts. The grants will be awarded on competitive basis. See the list of grants in a separate sheet in this file.														
6.2.2	NGO grants for improving TB and DR-TB care and support in prisoners and ex-prisoners	During NFM project, it is planned to offer a total of eight grants to NGOs (in two rounds of four grants x 1.5 years duration each) to implement intensified and innovative interventions aimed to improve compliance to treatment and treatment outcomes in prisoners and ex-prisoners with TB (including DR-TB forms). Special emphasis is to be placed on strengthening referrals between the penitentiary and civilian services, social accompaniment after discharge from prisons, psychological support, involving families and community actors, information / education and mitigating the risk of defaulting. The following areas are proposed: East Kazakhstan, Karaganda, Zhambyl and South Kazakhstan oblasts. The grants will be awarded on competitive basis. See the list of grants in a separate sheet in this file.														
6.2.3	NGO grants for improving TB and DR-TB case detection and case management in PLHIV and MARPs	During NFM project, it is planned to offer a total of ten grants to NGOs (in two rounds of four grants x 1.5 years duration each) to implement outreach interventions aimed at high-risk population segments (PLHIV and PWID) for TB and DR-TB. Special emphasis is to be placed on information and education work through peer support, motivating the beneficiaries to seek counseling and testing for HIV (or regular checkups for														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
		immune status by HIV-infected individuals) and TB diagnostic services by suspects, psychological support and facilitating links between TB and HIV services. The following areas are proposed: Astana city, Almaty city, Zhambyl, Kyzyl-Orda and South Kazakhstan oblasts. The grants will be awarded on competitive basis. See the list of grants in a separate sheet in this file.														
6.2.4	Operational research, NGO involvement in TB control	An operational research study will be carried out by PSI during Years 2-3 on the main findings, challenges and opportunities for civil society involvement and innovative approaches regarding NGOs' interventions in TB, DR-TB and TB/HIV control, based on the implementation experience of the NGO grants' program implemented within NFM.														
6.3	**Program management and program support by Sub-recipient, NGO component**															
6.3.1	Salaries, PSI staff	Salaries of Sub-recipient staff - PSI (Headquarters and Almaty office).														
6.3.2	Fringe benefits, PSI staff	Fringe benefits of Sub-recipient staff - PSI (Headquarters and Almaty office).														
6.3.3	Travel, PSI staff and consultants	International and in-country travel, PSI staff and consultants														
6.3.4	Consultancy services, PSI	Professional consultancy services for PSI														
6.3.5	IT equipment and furniture, PSI	IT equipment and furniture, PSI														
6.3.6	Other direct operational expenses, PSI	Other direct operational expenses of the Sub-recipient (PSI)														
6.3.7	Administrative overhead, PSI	Administrative overhead, PSI														

Objective 7. To address TB, DR-TB and TB/HIV among labor migrants

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
7.1	**Technical assistance and capacity building for addressing TB, DR-TB and TB/HIV among labor migrants**															
7.1.1	External technical assistance (WHO and other international organizations)	WHO EURO technical assistance on development of legal and procedural frameworks and minimum package of services for migrants; IOM HQ technical assistance on development of legal and procedural frameworks														
7.1.2	National consultants and WGs	WG on TB & migration - development of legal and procedural frameworks; development of "minimum package" guideline														
7.1.3	Workshops / trainings	Development and printing of education materials (modules) for organizations involved in work with migrants; Training for NGO Partners and migrant centers' staff on Materials Development and Pre-testing; ToT for team of trainer on basic TB, its prevention, migrant community involvement, communication skills and mobilization for TB prevention and TB advocacy; Cascade training for migrant centers' staff and NGO outreach/social workers: TB knowledge, communication skills and social support for migrants with TB and their families, adherence to TB treatments; Cascade training for HCWs communication skills and social support for migrants with TB and their families, adherence to TB treatments; Training workshops for migration service, border service workers and police on TB, migrant TB minimum package/new regulations on migrant TB; Training workshops for mass media on TB issues; Training on TB prevention in workplace; Refresh ToT for National team of trainers (covering on minimum package, new regulations on migrant TB).														
7.1.4	CAR high level meetings (annually)	High level meetings with participation of representatives from CAR countries, WHO and partners				1				1				1		

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
7.1.5	Development of information exchange mechanisms & indicators	Organization of intersectoral coordination meetings on national level with stakeholders and relevant organizations; TA on development of program indicators and their integration in M&E system.														
7.1.6	Development of financial mechanism for TB services and establishment of Medical Social Fund	Technical assistance for establishment of a medico-social fund for diagnosis and treatment of undocumented migrants; Local expert to work to work with international expert during TA on establishment of a medico-social fund; Technical assistance to assess feasibility of developing a special insurance fund; Local expert to work to work with international expert during TA on assess feasibility of developing a special insurance fund; Establishment of Medical Social Fund														
7.2	**NGO projects on TB, DR-TB and TB/HIV in labor migrants**															
7.2.1	Social support of external migrants	Incentives for treatment adherence ($50 per patient per month); Pre-departure packages (Incentives for migrant follow-up and ACSM via cell phones)														
7.2.2	NGO projects on TB & migration	Sub-grants to local NGO for outreach and community work among migrant communities (HR costs); Sub-grants to local NGO for outreach and community work among migrant communities (education sessions & meetings); Sub-grants to local NGO for outreach and community work among migrant communities (planning and administration costs); Sub-grants to local NGO for outreach and community work among migrant communities (overheads).														
7.2.3	ACSM (development and printout of information materials, audio/video	Development of information materials targeting specific needs of migrant population; Development of information materials targeting specific needs of migrant population;														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
	materials)	Development of TB informational and educational materials: audio and video/broadcasting; Organization of press conference on Migrant day involving trained journalists; Organization of public awareness campaigns devoted to World TB day.														
7.2.4	Monitoring & evaluation of program activity	Supportive supervision/M&E visits to project sites														
7.3	**Program management and program support by Principal Recipient (Project HOPE)**															
7.3.1	Direct PR costs	Direct PR costs														
7.3.2	Overheads	Overheads														

8. Project management and administration

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
8.1	Communications															
8.2	Office equipment															
8.3	PIU staff															
8.4	Other															

4.5 'Above Indicative' Funding Request

Further to the indicative funding request in Section 4.4, describe and rank in order of priority the 'above indicative' funding request. In the response:

a. Provide an **overview for the 'above indicative' request**, including the additional modules and/or interventions requested. Clearly describe the **rationale for their selection and rank them in order of prioritization**.\

b. Describe expected **impact and outcomes** and any **additional gains** from this request, including how these have been estimated (with reference to the modular template). Please refer to any available evidence of effectiveness of the interventions being proposed.

Kazakhstan's request for 'Above Indicative' funding is for USD 25.4 million. It includes i) scaling up priority interventions that are part of the 'Indicative' request above; and ii) new interventions. A brief description of activities is presented below, by Objective.

Objective 1

- Upgrade of IT equipment at the NTP central unit and regional units.

Objective 2

- It is intended to scale up Xpert MTB/RIF interventions at peripheral (district) level of TB care delivery. In addition to four demonstration areas included under 'Indicative' funding, it is proposed to include four other regions: Aktobe, East Kazakhstan, South Kazakhstan and Almaty oblasts. A total of 60 Xpert instruments are required for district level TB units in these regions (all with 2 modules). It is intended to start testing early in Year 2 of NFM project (2016) and reach at least 95% coverage of needs by the beginning of Year 3. The total estimated number of tests during this period is about 73,000.

- In cooperation with Imperial College and the National Mycobacterium Reference Laboratory (NMRL) in London, NCTP plans to carry out an operational research study: *TB Molecular Epidemiological Study in Kazakhstan: Investigating role of reinfection in treatment failures and spread of drug-resistant TB in Kazakhstan.* By means of modern laboratory techniques (including Next Generation Sequencing, NGS), the study aims at revealing the patterns of transmission of M/XDR-TB strains, which will provide evidence for the country (as well as for other countries and settings in the region) for decision making e.g. regarding hospital care of TB and DR-TB patients. The draft study proposal is in included in Annex 4.9.

Objective 3

- With support of 'Above Indicative' funding, the NTP intends to expand the demonstration projects on full ambulatory treatment of DR-TB cases, by including four additional country regions using the same approach, which was described in section 4.4 just above. The proposed regions are East Kazakhstan, South Kazakhstan, Almaty oblast and Almaty city. The enrollment of patients is planned to start in early 2016, and the total number of patients to be enrolled in these areas during two years is 2,267 (707 PDR cases and 1,560 MDR cases).

- This request also foresees to increase the number of XDR-TB treatments by including additional 200 XDR cases per year. It is intended to include Bedaquiline in the treatment scheme in relevant cases.

Objective 4

- The 'Above Indicative' funding will be used to expand Xpert MTB/RIF testing among PLHIV to all regional AIDS Centers, not included under 'Indicative' request. Eight 2-module machines will be provided for these Centers, the testing will start in the beginning of Year 2, and the planned number of tests is 6,615.

- Anti-retroviral (ARV) treatment will be provided for 160 TB/HIV patients annually, who have limited access to services, such as foreign citizens (mainly labor migrants). For this purpose, the project intends to procure ARV drugs and tests for ARV treatment monitoring (biochemistry tests, viral load and immunological tests – CD4/CD8).

Objective 5

- Xpert MTB/RIF will also be scaled up in the penitentiary system, by including all pre-trial isolators in the country. Nine additional Xpert instruments will be procured under 'Above Indicative' funding, and the target number of tests in these newly enrolled PTIs is 6,552 (starting Year 2).

Objective 6

- Under NGO component, 'Above Indicative' funding will be used to expand the NGO grants program. Eight additional grants will be implemented, which will cover new regions (tentatively, Aktobe, Akmola and Pavlodar oblasts). Relevant provisions for NGO capacity building are also included.

Objective 7

- It is also intended to increase the number of NGO grants targeting TB, DR-TB and TB/HIV among labor migrants. This application seeks support to five NGO projects under 'Above Indicative' funding.

For more details, please refer to the table after this section and to Workplan and Budget file for 'Above Indicative' request.

In terms of prioritization, requested by TGF for 'Above Indicative' component, the CCM deems that all the interventions listed above will bring an important contribution to scaling up TB and DR-TB control efforts in the country. At the same time, it is acknowledged that rolling out Xpert testing to the peripheral service delivery level and expansion of outpatient model for treatment of DR-TB cases, will have the greatest impact as these are systemic interventions rendering for successful and accelerated reform of TB control system in the country and, ultimately, for halting the spread and further development of drug resistance.

Table 4.12. Kazakhstan TB NFM application: 'Above Indicative' Amount Request: Interventions / Activities by Objective

Objective 1. To support the reform of TB control services through strengthening the National TB Program management, monitoring and evaluation and capacity building

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
1.3	**Strengthening program M&E, supervision and information system**															
1.3.7 (New)	IT equipment for central and regional NTP units	Upgrade of IT equipment at the central and regional NTP units (4 sets for NTCP / NRL, 20 sets for regional units, totally 24 sets). In Year 1.														

Objective 2. To improve timely case detection and quality diagnosis of TB and DR-TB

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
2.2	**Demonstration projects on Xpert MTB/RIF rollout at district level (Aktobe, East Kazakhstan, South Kazakhstan and Almaty oblasts)**															
2.2.2	National consultants, Xpert MTB/RIF implementation at district level	Local consultants (2 per each of 4 demonstration areas). Starting Year 2.														
2.2.3	Training of staff in Xpert MTB/RIF implementation at district level in demonstration areas	Training on Xpert MTB/RIF for staff from 4 regions					1	2	2		1		1		1	
2.2.5	Xpert MTB/RIF instruments for district-level TB units in demonstration areas, 2-module	60 Xpert instruments (2-module) for district level TB units in 4 regions (Aktobe, East Kazakhstan, South Kazakhstan and Almaty oblasts). Procurement in Year 1.														
2.2.6	UPS stations for	UPS stations will be procured for 60 Xpert instruments at														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
	Xpert instruments in demonstration areas	district level in 4 regions. Procurement in Year 1.														
2.2.7	IT equipment (printers) for Xpert instruments at district-level TB units in demonstration areas	Printers for all Xpert instruments procured for the district-level TB units in four demonstration areas.														
2.2.8	Xpert MTB/RIF cartridges for district-level demonstration areas in the civilian sector	Procurement of Xpert MTB/RIF tests (cartridges) for testing of TB suspects at the peripheral TB service units in four regions. Number of tests: see estimates in a separate sheet in this file.														
2.2.9	Maintenance and servicing	Calibration, module replacement and other services for Xpert instruments in 4 demonstration areas (Cepheid's agent, MMG). Starting mid-2015.														
2.2.10	Supervision / monitoring of Xpert MTB/RIF rollout project to district level	Supervision / monitoring visits by oblast NTP units to district level TB units in the demonstration areas. Starting Year 2														
2.2.11	Workshops / coordination meetings, Xpert MTB/RIF rollout to district level	Two additional meetings per year. Starting Year 2.								1		1		1		1
2.4 (New)	**Operational Research.** ***TB Molecular Epidemiological Study in Kazakhstan: Investigating role of reinfection in treatment failures and spread of drug-resistant TB in Kazakhstan***															
2.4.1	Human resources	UK and Kazakhstan staff participating in the study														
2.4.2	Laboratory equipment	Sequencer, deep freezers														
2.4.3	Laboratory reagents	For MGIT, LPA Hain, VNTR, NGS														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
2.4.4	Travel costs	Between UK and Kazakhstan and within Kazakhstan														
2.4.5	Specimen transportation	Transportation of cultures and DNA (in country and to UK)														
2.4.6	IT equipment	For NCTP / NRL														

Objective 3. To promote quality and evidence-based treatment of DR-TB cases

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
3.1	**Demonstration projects on full outpatient treatment of DR-TB cases (East Kazakhstan, South Kazakhstan, Almaty oblast and Almaty city)**															
3.1.2	National consultants, outpatient treatment of DR-TB patients in demonstration areas	Eight local consultants (two per each of the four regions) for East Kazakhstan, South Kazakhstan, Almaty oblast and Almaty city. Starting Year 2.														
3.1.3	Training of staff on full outpatient treatment of DR-TB cases	Training for staff in four regions (East Kazakhstan, South Kazakhstan, Almaty oblast and Almaty city). Year 1: 4 training courses, Year 2 - 4, Year 3 - 2.					2	2	2	1	1		1		1	
3.1.4	Coordination workshops for demonstration projects	Two additional coordination workshops per year during Years 2-3 (3 days, at NCTP).								1		1		1		1
3.1.5	Supervision / monitoring of demonstration projects on outpatient DR-TB treatment	Regular supervision / monitoring visits for East Kazakhstan, South Kazakhstan and Almaty oblasts. Starting Year 2.														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
3.1.6	Incentives for PDR-TB patients	Incentives for PDR patients on full outpatient treatment in four regions (East Kazakhstan, South Kazakhstan, Almaty oblast and Almaty city)														
3.1.7	Enablers for PDR-TB patients	Enablers for PDR patients on full outpatient treatment in four regions (East Kazakhstan, South Kazakhstan, Almaty oblast and Almaty city)														
3.1.8	Incentives for MDR-TB patients	Incentives for MDR patients on full outpatient treatment in four regions (East Kazakhstan, South Kazakhstan, Almaty oblast and Almaty city)														
3.1.9	Enablers for MDR-TB patients	Enablers for MDR patients on full outpatient treatment in four regions (East Kazakhstan, South Kazakhstan, Almaty oblast and Almaty city)														
3.1.10	Enablers for health care staff	Enablers (reimbursement of transportation expenses) for health care staff in four regions (East Kazakhstan, South Kazakhstan, Almaty oblast and Almaty city)														
3.1.11	Vehicles for mobile teams	Procurement of vehicles for 8 mobile teams ('Sputnik'-type activities) in urban areas (Ust-Kamenogorsk - 2, Shymkent - 2, Almaty city -2, Taldykorgan - 1, Talgar - 1), in Year 1.														
3.1.12	Intensive outreach patient support and follow-up	Intensive follow-up and support to patients on outpatient DR-TB treatment by mobile outreach teams ('Sputnik'-type activities in urban areas, 8 mobile teams: Ust-Kamenogorsk - 2, Shymkent - 2, Almaty city -2, Taldykorgan - 1, Talgar - 1). Starting Year 2.														
3.1.13	Program support costs, outpatient DR-TB treatment component	Operational expenses (PR, SRs) for implementation of activities 3.1.2-3.1.12 above. Starting Q5.														
3.2	**Treatment of XDR-TB patients**															

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
3.2.3	Second-line and third-line anti-TB drugs for XDR patients	Treatment of additional 200 XDR-TB patient per year (e.g. with addition of Bedaquiline). Starting Year 1.														

Objective 4. To strengthen collaboration and response for control of TB/HIV co-infection

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
4.2	**Screening of PLHIV for TB and MDR-TB by Xpert MTB/RIF**															
4.2.1	Training of AIDS service staff in Xpert MTB/RIF use in PLHIV	Additional training courses for AIDS Centers' staff on Xpert MTB/RIF.						2	1	1			1			
4.2.3	Xpert MTB/RIF instruments for AIDS Centers, 2-module	8 Xpert instruments (2-module) for regional AIDS Centers not covered by the 'Indicative Amount' request. Procurement in Year 1.														
4.2.4	UPS stations for Xpert instruments at AIDS Centers	UPS stations will be procured for additional 8 Xpert instruments at AIDS Centers. Procurement in Year 1.														
4.2.5	IT equipment (printers) for Xpert stations at AIDS Centers	Printers will be procured for additional Xpert instruments place at AIDS Centers at the regional level.														
4.2.6	Xpert cartridges for AIDS Centers	Procurement of Xpert MTB/RIF tests (cartridges) for testing of TB suspects among PLHIV at AIDS Centers. Number of tests: see estimates in a separate sheet in this file.														
4.2.7	Maintenance and servicing	Calibration, module replacement and other services for Xpert instruments. Starting mid-2016.														
4.4	**Screening of PLHIV for TB and MDR-TB by Xpert MTB/RIF**															

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
4.3.1	ARV treatment for TB/HIV patients	ARV drugs for TB/HIV patients with limited access to care (e.g. foreign citizens, migrants, etc.). For 160 patients per year.														
4.3.2	Tests for ARV treatment monitoring	A set of clinical / biochemistry, viral load and immunological (CD4 / CD8) investigtions for ARV treatment monitoring.														

Objective 5. To strengthen TB and DR-TB control in the penitentiary system

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
5.2	**Screening of detainees in pre-trial isolators for TB and MDR-TB by Xpert MTB/RIF**															
5.2.1	Training of penitentiary service staff in Xpert MTB/RIF	Additional training courses for PTIs' staff on Xpert MTB/RIF.						2	1	1			1			
5.2.3	Xpert MTB/RIF instruments for pre-trial isolators in the penitentiary system, 2-module	9 Xpert instruments (2-module) for PTIs not covered by the 'Indicative Amount' request. Procurement in Year 1.														
5.2.4	UPS stations for Xpert instruments in PTIs	UPS stations will be procured for additional 9 Xpert instruments at PTIs. Procurement in Year 1.														
5.2.5	IT equipment (printers) for Xpert stations in PTIs	Printers will be procured for additional Xpert instruments placed at PTIs.														
5.2.6	Xpert cartridges for PTIs	Procurement of Xpert MTB/RIF tests (cartridges) for testing of TB suspects among detainees at PTIs. Number of tests: see estimates in a separate sheet in this file.														
5.2.7	Maintenance and	Calibration, module replacement and other services for Xpert														

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
	servicing	instruments. Starting mid-2016.														

Objective 6. To strengthen partnerships with civil society for effective control of TB, DR-TB and TB/HIV

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
6.1	**Capacity building for NGOs for effective involvement in TB and DR-TB control**															
6.1.3	Training for NGOs in TB and DR-TB control	3 additional training courses per year for NGOs - grant implementers.		2			1			2		1		2		1
6.1.4	ACSM and promotional materials for NGO component	IEC materials for beneficiaries and NGO implementers of small grants' program.														
6.2	**NGO grants' program**															
6.2.1	NGO grants for innovative approaches in adherence support for TB and DR-TB patients	3 additional grants per year (Aktobe, Akmola and Pavlodar oblasts)														
6.2.2	NGO grants for improving TB and DR-TB care and support in prisoners and ex-prisoners	2 additional grants per year (Aktobe and Akmola oblasts)														
6.2.3	NGO grants for improving TB and DR-TB case detection and case management in PLHIV and MARPs	2 additional grants per year (Akmola and Pavlodar oblasts)														

Objective 7. To address TB, DR-TB and TB/HIV among labor migrants

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
7.2	**NGO projects on TB, DR-TB and TB/HIV in labor migrants**															
7.2.2	NGO projects on TB & migration	5 additional NGO grants on TB, DR-TB and TB/HIV among labor migrants														
7.2.3	ACSM (development and printout of information materials, audio/video materials)	Development and printing of education materials (modules) for organizations involved in work with migrants														

8. Project management and administration

No.	Intervention / Activity	Description	Year 1 (Jul 2014 – Dec 2015)						Year 2 (Jan-Dec 2016)				Year 3 (Jan-Dec 2017)			
			Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
8.1	Communications															
8.2	Office equipment															
8.3	PIU staff															
8.4	Other															

4.6 Commitment to Financial Sustainability and Additionality

Financial sustainability is important to ensure continuity of impact. In particular, implementing country governments must fulfill their obligations to sustain and increase contributions to the national response. The counterpart financing requirements of the Global Fund are set forth in the Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization (ECFP).

Please complete the Financial Gap Analysis and Counterpart Financing Table in Attachment 3.

a. Indicate whether the counterpart financing requirement has been met. If not, provide a justification that includes actions planned during implementation to reach compliance

b. Describe whether and how this funding request to the Global Fund will be complemented by additional funding commitments from the Government.

c. Describe how this funding request to the Global Fund can leverage other donor resources.

This proposal has been developed in line with the counterpart financing requirements of the Global Fund, which are set forth in the *Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization.*

The Government of Kazakhstan is committed to uphold financial sustainability of priority public health interventions as it is key to ensuring continuity of impact. Over the last decade, the Government has substantially increased financial allocations to the health sector, including TB control interventions, while the contributions of external partners in this area have been decreasing substantially during this period of time. At the moment, the Global Fund is the main (and sole in many instances) external source of support to TB control in the country.

The Financial Gap Analysis and Counterpart Financing Table was been completed (see Attachment 3 to the application form). The counterpart financing requirements have been met: the Government counterpart financing share of the overall requires funding amounts to 94% (when bridged with 'Indicative' NFM request only) and 91% ('full' NFM request including 'Above Indicative' budget).

As shown by the financial figures over the last years (e.g. this was reflected by the WHO NTP Review 2012), the Government increasingly allocates financial resources to TB control, and this trend will continue in the coming years. In addition, as mentioned above, MOH and NTP are set to optimize the infrastructure and performance of TB control services, which will increase efficiency in the use of resources and will allow for reallocating additional funding for priority patient-centered interventions such as promotion of outpatient treatment model in general and intensive adherence support to the patients, including those with drug-resistant TB forms, in particular.

Financial Gap Analysis and Counterpart Financing Table				Country:	Kazakhstan	Component:	TB	Year of submission	2013
				Currency:	USD	Amount expressed in:	Units	Reporting Cycle	Calendar Year
Current Year corresponds to Year of sumbission.Year-2 and Year-1 correspond to years preceeding current year. Year 1, 2 and 3 correspond to proposed implementation years of the funding request	Current and previous			Estimated			Data Source / Comments		
	2012	2013	2014	2015	2016	2017			
Specify duration if fiscal or program year (for example: June11-May12)	Jan-Dec 2012	Jan-Dec 2013	Jan-Dec 2014	Jan-Dec 2015	Jan-Dec 2016	Jan-Dec 2017			
Part One: National Strategic Plan Funding Needs and Resources									
Total Funding needs for the National Strategic Plan (provide annual amounts)				272,000,000	291,040,000	302,681,600	MOH / NTP estimates based on the current level of spending and the identified gap, taking into account the need to expand new diagnostic rechniques and treatment of all forms of TB (including XDR-TB and increased coverage among risk-groups: PLHIV, prisoners and migranrs), with increasing use of outpatient care delivery model		
LINE A: Total Funding needs for the National Strategic Plan				865,721,600					
LINES B, C and D: Previous, current and anticipated resources to meet the funding needs of the National Strategic Plan									
Domestic source B1: Loans	0	0	0	0	0	0	No loans / debt relief funding is provided currently or forecasted, which can be attributed to TB control		
Domestic source B2: Debt relief	0	0	0	0	0	0	No loans / debt relief funding is provided currently or forecasted, which can be attributed to TB control		
Domestic source B3: Government funding resources	210,272,500	224,991,600	228,896,500	234,973,100	256,590,600	275,578,300	Source: MOH. Includes all consolidated state budget resources (central-level budget and oblast-level budgets). For 2015-2017 - forecasted		
Domestic source B4:Private sector contributions (national)	0	0	0	0	0	0	Private sector contributions are insignificant and difficult to quantify		
LINE B: Total previous, current and anticipated DOMESTIC resources	210,272,500	224,991,600	228,896,500	234,973,100	256,590,600	275,578,300			
Government of Germany / KfW	1,285,800	663,350	2,660,000	0	0	0	No commitments beyond 2014		
United States Government (USG) / USAID	1,000,000	1,500,000	1,000,000	800,000	0	0	USAID planning cycles are annual, so it is impossible to obtain longer-term estimates or forecasts.		
World Health Organization (WHO)	60,000	60,000	75,000	75,000	75,000	80,000	Assistance is provided within the Biennial Collaborative Agreements (BCAs)		
LINE C: Total previous, current and anticipated EXTERNAL Resources (non-Global Fund)	2,345,800	2,223,350	3,735,000	875,000	75,000	80,000			
KAZ-809-G04-T	11,366,300	9,313,750	4,406,270	0	0	0	Grant end date: 31 December 2014		
Provide grant number D2									
Provide grant number D3									
Provide grant number D4									
LINE D: Total previous, current and anticipated Global Fund Resources from existing grants and approved proposals	11,366,300	9,313,750	4,406,270	0	0	0			
Total anticipated resources (annual amounts)				235,848,100	256,665,600	275,658,300			
LINE E : Total anticipated resources (Line B+C+D)				768,172,000					
Annual Anticipated Funding Gap (Total funding need - Total anticipated funding gap)				36,151,900	34,374,400	27,023,300			
LINE F: Total anticipated funding gap (Line A - E)				97,549,600					
LINE G: Total Funding Request to the Global Fund				21,506,365	21,282,601	21,461,173			
LINE H: Funding request within the Indicative Amount				14,272,500	12,844,048	11,713,451	The proposed NFM period is 3.5 years (01 July 2014 - 31		
LINE I: Funding request above the Indicative Amount				7,233,865	8,438,552	9,747,721	The proposed NFM period is 3.5 years (01 July 2014 - 31		
Part Two: Overall Health Sector - Government Health Spending									
Domestic source J1: Loans									
Domestic source J2: Debt Relief	0	0	0	0	0	0			
Domestic source J3: Government funding resources	5,024,434,000	5,325,900,000	5,538,936,000	5,732,798,800	5,904,782,800	6,052,402,400			
LINE J: Total previous, current and anticipated Government health sector spending	5,024,434,000	5,325,900,000	5,538,936,000	5,732,798,800	5,904,782,800	6,052,402,400			
Part Three: Counterpart Financing									
Low income = 5% low income, lower lower-middle income = 20%, upper lower-middle income (high level) = 40%, upper-middle income = 60%									
LINE K: Total government resources towards the National Strategic Plan in current and previous years *Line K = B1 + B2 + B3 entries in current and past 2 years*	210,272,500	224,991,600	228,896,500						
LINE L: Yearly average of government resources towards the National Strategic Plan in current and previous years *Line L = Average of Line K entries for past 3 years*	221,386,867								
LINE M: Yearly average of Global Fund Funding Request within the Indicative Amount (including existing commitments) *Line M = Average of Line D and Line H entries for upcoming Y1, Y2, Y3 funding request*				12,943,333					
Line N: Counterpart financing based on existing Global Fund commitments and indicative financing = (calculation of government contribution)	*[Average of total government resources for past 3 years (Line L)]* / *[Average Global Fund resources for upcoming Y1, Y2, Y3 (Line M)] + [Average of total government resources for past 3 years (Line L)]*						X 100	94%	
LINE O: Yearly average of Total Funding Request to the Global Fund (including existing commitments) *Line O = Average of Line D and Line G entries for upcoming Y1, Y2, Y3 funding request*				21,416,713					
Line P: Counterpart financing based on existing Global Fund commitments and total funding request = (calculation of government contribution)	*[Average of total government resources for past 3 years (Line L)]* / *[Average Global Fund resources for upcoming Y1, Y2, Y3 (Line O)] + [Average of total government resources for past 3 years (Line L)]*						X 100	91%	

4.7 Focus on Key Populations and/or Highest Impact Interventions

This question is <u>not</u> applicable for Low Income Countries.

Describe whether the Global Fund focus of proposal requirement has been met as listed below:

a. If the applicant is a **Lower-Middle Income Country,** describe how the Funding request focuses at least 50% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

b. If the applicant is an **Upper-Middle Income Country,** describe how the Funding request focuses 100% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

Kazakhstan is ranked by the Global Fund as a country with severe burden of TB and, at the same time, as an Upper-Middle Income (UMI) country, therefore the proposal requires a 100% focus of the budget on underserved and most-at-risk populations and highest-impact interventions. In addition, TGF requirement for cost sharing mandates at least 60% of counterpart co-funding, primarily from domestic sources. While TGF ranks Kazakhstan as a country with the overall severe TB burden, the prevalence of MDR-TB is one of the highest in the world.

In this application, the majority of activities aim at supporting special groups or specific interventions, i.e. those targeting diagnosis and treatment of drug-resistant TB cases. DR-TB patients, out which the majority are present with M/XDR-TB forms, are especially prone to service barriers and are likely, if not provided with an appropriate support to receive the needed package of care, to incur catastrophic financial expenditures and indirect losses (e.g. being away from the family, economic gain activity and, generally, normal mode of life for a long of period of time required for DR-TB treatment).

It is therefore considered that all, or almost all, DR-TB patients fall under TGF categorization of 'underserved population segments' likely to be deferred access to modern diagnosis, quality treatment and adherence support, and being, therefore, at high risk of DR-TB amplification and default from treatment, with the resulting treatment failure and death.

At the same time, the proposal includes the high-impact interventions, such as rolling out modern molecular diagnostic technologies (Xpert MTB/RIF) to the lowest service delivery level with the scope of rapid diagnosis of TB and rifampicin resistance (close proxy to MDR-TB in our settings), and promotion of outpatient treatment of DR-TB cases instead of hospital treatment. Both key interventions of the project are expected to produce an important and quick impact on the service performance, which, in turn, will contribute to the alleviation of the overall burden of TB DR-TB.

Additionally, the project proposal includes specific interventions, which aim at increasing access and improving quality of TB, DR-TB and TB/HIV care among the most vulnerable and at-risk population groups: PLHIV and MARPs for HIV such as PWID, prisoners and ex-prisoners, internal and external labor migrants. All these groups are considered as having limited access to care, and NFM project is expected to have an important impact on service delivery in this regard and uptake of successful practices by the national / local authorities, e.g. through sustainable involvement of civil society organizations and ensuring appropriate patient support.

The activities aimed at improvement of regulatory and normative framework, as well as those for capacity building at different levels, are seen as fully legible in the above context. The CCM therefore considers that the TGF requirements regarding the focus on key populations and/or high-impact interventions have been fully met in this application.

SECTION 5: IMPLEMENTATION ARRANGMENTS

5.1 Principal Recipient (PR) Information

Complete this section for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.

PR 1 Name	**National Center for Tuberculosis Problems (NCTP)**	**Sector**	Government
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?		☒ **Yes**	☐No

Minimum Standards	CCM assessment
1. The Principal Recipient demonstrates effective management structures and planning	NCPT has 14 oblast, 2 city and 4 regional branches in Kazakhstan participating in the management of the National TB program and implementation of TB Grant. NCPT is the Principal Recipient of Round 6 and Round 8 TGF TB grants. NCPT has 663 staff members, including 16.5 positions of scientific research staff and 102 medical doctors. NCTP takes part in the international workshops and training courses to improve TB program management competences and skills.
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)	During the implementation of Round 6 and Round 8 TGF TB grants, NCTP has accumulated substantial experience in the management of Sub-recipients (oblast level TB institutions, national and international NGOs). The SR selection procedure presumes detailed criteria development and open and transparent review and evaluation process. The SR selection process is described in the Grant Implementation Manual (2009 version, recently updated with the assistance of GMS experts). The SRs' program implementation and performance are regularly monitored and evaluated through collection of data according to the program indicators, verification of data during M&E / oversight visits and regular consultations. All program implementation aspects are described in detail in the Terms of Reference for the SRs, which is the integral part of the Grant Agreements between the PR and the SRs. Audit of grants takes place on an annual basis, after which the PR develops a plan for implementation of the audit recommendations as an internal control. Funding of SRs is based on the agreed budget, which is also a part of the Grant Agreements. The PR transfers funds to the SRs account to carry out project activities.
3. There is no conflict-of-interest for the selection of the Principal Recipient(s) and Sub-Recipients	There are no conflicts of interest in the selection of PRs and potential SRs. In line with the CCM Guidelines, approved by the Global Fund in May 2011 (Requirement 6), there are no representatives from the regional TB institutions (SRs in Round 8 project) in the CCM. The mitigation of conflicts of interest is carried out according to the CCM rules as of 17 April 2012.

4. The program-implementation plan provided in the funding request is sound	The workplan for the NFM project (Concept Note) has been synchronized with the Complex Plan for TB Control for 2014-2020. Both documents were presented during the National Coordinating Council meeting in September 2013 and were developed taking account of WHO NTP Review 2012 and WHO Roadmap for M/XDR-TB control in the European Region 2011-2015. Strategic aspects included in the Concept Note, are in line with the Government Health Development Program "Salamatty Kazakhstan for 2011-2015". The Concept Note was developed also on the basis of the recommendations of the World Bank to expand ambulatory treatment and implementation of the patient-oriented approaches with involvement of NGOs and communities to reach most-at-risk population groups (prisoners, PLHIV, labor migrants). The NFM project will not duplicate funding available from the domestic budget.
5. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	The system of internal control includes financial controls, regular inventory and physical protection of assets (equipped and secured assets, stocks and money) and assigns specific responsibilities to the PR staff. Monitoring PRs' internal controls is carried out by the Local Fund Agent (LFA). External audit is conducted according to the national legislation and the conditions laid down in the Grant Agreement.
6. The financial management system of the Principal Recipient is effective and accurate	The PR's financial accounting system is based on automated software '1C Accountant', version 7.7., which is accessible only to the financial staff. NCPT has separate accounts for TGF grant in different currencies. The supporting documents, related to the payments, are archived and kept by the PR. Payments to cover services costs are based on the results of the provided services and submitted documents. Final payments to the supplier are effectuated only after receipt of such documents; full prepayments of the suppliers are not practiced.
7. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	The warehouses have sufficient stock capacities. All central and regional warehouses are equipped with air conditioners and equipment to monitor temperature and humidity. The required parameters are recorded in the special registers. The specially assigned staff monitor the storage facilities and are responsible for maintaining appropriate conditions.
8. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions	The PR: • Analyzes the inventory balances and needs in each region • Identifies the availability of products obtained from various sources; • Prepares distribution lists; • Holds for packaging of each region and other regions. • Ensures that appropriate sanitary standards are met during transportation and delivery; • During the transportation of health products and

	pharmaceuticals, ensures the integrity of goods, proper conditions of storage and insurance, packing of goods that protects from external influences and labeling in accordance with applicable legal and regulatory acts. • Records the dispatch and further stores in the archive: the date of shipment, the customer's name and address and a description of the product (title, quantity strength (where applicable) and lot number; • Maintains a warehouse database for drugs, laboratory reagents and other products supplied within the grant • Performs monthly reporting analyses; • Maintains a database to determine the forecasts and the needs for the future deliveries.
9. Data-collection capacity and tools are in place to monitor program performance	Monitoring and evaluation is performed according to the methodological recommendations on M&E of TB control activities in the Republic of Kazakhstan, endorsed by the Ministry of Health (2008). There is a single TB M&E system that applies to all projects including TGF grants. The M&E unit at NCTP has highly qualified staff possessing all necessary technical skills in data input, collection and analysis. The budget for TB M&E is not less than 5% of the consolidated budget TB expenditure. The single M&E system provides transparent data management at all levels of the national TB program. As a central NTP unit, NCTP uses different methods for M&E: the constant system of monitoring through direct contacts and consultations; supportive supervision, surveillance and inspection visits; country situational analysis; external program reviews, etc.
10. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	In 2001, the NTP started the national electronic register for TB. This register is integrated with two republican databases: 'Register of dispensary patients' (includes information on persons ever registered for a disease / condition according to the existing dispensary list) and 'Register of outpatients' (contains data on all individuals attached to the territorial PHC institutions). The information about TB cases is entered through a sequential search of the patient in 3 databases above. The patient search can be performed by surname, name and IIN (tax number). The national TB register allows to generate standardized aggregated reports according to the indicators selected, and to retrieve all data for an individual case.
11. The CCM actively oversees the implementation of the grant, and intervenes where appropriate	The CCM annually establishes the Oversight Committee and approves its Terms of Reference and the CCM Oversight Plan. Project oversight visit is one of the key functions of the CCM to ensure effective use of TGF resources. The Oversight Committee members during the oversight visits have meetings with the SRs, clients, partners and local stakeholders (according to the schedule of visits), review programmatic reports, identify gaps in the implementation of TGF project activities and put forward proposals to improve quality of services provided. During the implementation of TGF TB support in Rounds 6 and 8, fourteen oversight visits were conducted (2011 - 2, 2012 - 5 and 2013 - 7). The reports are presented at the CCM meetings and published on the CCM website (www.ccmkz.kz) . The Oversight Committee has participated in the

	LFA briefings on the reviews of interim and annual program and financial reports of PRs. The Minutes of CCM meetings and LFA briefings are also published on the CCM website.
12. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	Monitoring and evaluation of the Global Fund programs in Kazakhstan are based on TGF instructions and recommendations. Product selection is carried out according to the clinical protocol and national regulations. Control of quality of TB drugs includes the following steps: selection of laboratories for quality control for sampling and testing; delivery of samples to the laboratory; obtaining the results and reports on quality control testing. This quality control is scheduled for all pharmaceutical products procured within TGF grants to meet international requirements of ISO-17025. The NTP currently employs quality control of anti-TB drugs in collaboration with CDC, through the use of a portable 'minilab' system that allows to perform qualitative analyses. To ensure cost-effectiveness of a tender to select a quality control laboratory, request for tenders are developed to determine the technical requirements and invitations are send to the applicants to supply information on the cost.

PR 2 Name	**Project HOPE**	**Sector**	International NGO
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?		☐Yes	**☒ No**
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		Project HOPE submitted a list of staff that includes 17 staff members with substantial experience in the implementation TB programs and projects. The key experts have extensive technical knowledge on TB and many years in the management of TB programs. Decision-making procedures concerning the operation of Project HOPE in Kazakhstan include regulations that cover three main areas: human resources, financial management and program execution. The instructions are endorsed by the agency's Representative in Kazakhstan. Coordination and approval by the Regional Director is conducted according to the procedures of Project HOPE. For solutions that require additional discussions, a temporary committee is established. The committee formation principles as well as its accountability are based on the overall policies and procedures of Project HOPE. The key decisions are made by the Headquarters or Regional offices of Project HOPE and are coordinated with the representatives of the country through Memorandums and other formal correspondence, as well as through online meetings and conference calls. The Procurement Specialist of Project HOPE has 7 years of experience in international health procurement including procurements within the projects funded by USAID, the World Bank and the Global Fund, and has the necessary competence and skills in procurement procedures.	
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-		The experience in the implementation of grants is based on the close collaboration with the national partners and established procedures for selection of applications and grant management.	

Recipients (and relevant Sub-Sub-Recipients)	The procedures are carried out in several stages and include the establishment of clear selection criteria for sub-grantees, establishment of a Grants Management Group (GMG), consisting of key stakeholders and responsible for pre-selection of proposals and their submission to the Grant Review Committee (GRC), which takes the final selection decisions. The GRC invites relevant national and international partners. The selection of grantees is subject to the general policies and procedures aimed at ensuring the full transparency of the process. Project HOPE provides technical assistance to the grantees to strengthen their capacity to carry out grant activities according to the Terms of Reference and implementation schedule. Project HOPE led the consortium for the five-year USAID-funded Central Asia Partnership for TB in the five countries of the region.
3. There is no conflict-of-interest for the selection of the Principal Recipient(s) and Sub-Recipients	The potential conflicts of interest were eliminated during the process of selection of PRs and nomination of potential SRs. In line with the CCM Guidelines, approved by the Global Fund in May 2011 (Requirement 6), there are no representatives from Project HOPE in the CCM or its Oversight Committees. The mitigation of conflicts of interest is carried out according to the CCM rules as of 17 April 2012.
4. The program-implementation plan provided in the funding request is sound	The workplan for the NFM project (Concept Note) has been synchronized with the Complex Plan for TB Control for 2014-2020. This synchronization has been achieved through a number of meetings and in-depth discussions. The program activities related to TB in migrants, for which Project HOPE will be PR for the NFM project, were agreed upon with the Ministry of Health and NCTP (central NTP unit), who bear the overall responsibility for the implementation of the National TB Program, and within the CCM. They were also presented to other donors and partners from the international organizations, in order to avoid duplication in funding and programmatic coverage. The representative of Project HOPE (Senior Technical Advisor for TB issues), was invited by the CCM to participate in the working group on the CN development. The interventions included in the workplan under Objective 7, are in line with the national strategic plan and international guidance, in particular, the Stop TB Strategy, the Roadmap to Prevent and Control M/XDR-TB in the European Region, the 'Minimum Package for Cross-border TB and TB care in WHO European Region: a consensus statement' and the WHO initiative ENGAGE-TB, with emphasis on ensure appropriate access to prevention, diagnosis and treatment among labor migrants, who are considered as one of the key vulnerable and at-risk population groups.
5. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	The internal control system is based on the Project HOPE database 'Integrated Internal Control Committee of Sponsor Organizations'. The internal audit is carried out by the internal audit unit at the head office of Project HOPE. The purpose, authority and responsibility of the internal audit are defined in the Internal Audit Charter, approved by the President, Executive Director and Audit Committee of the Board of Directors of the organization. Internal audits of country offices are carried out by the officers of of the internal audit unit on a regular basis, to ensure compliance of local

	laws and internal policies and procedures of Project HOPE. The Director of Internal Audit reports to the Board of Directors. As per request of funders and U.S. Government, Project HOPE conducts annual financial audits and annual state audits in accordance with the auditing standards generally accepted in the United States, and also in accordance with the standards applicable to financial audits contained in the State Auditing Standards, authorized by the General Inspector of the United States. For audit purposes, the financial information about activities at the country offices is sent to the main control and verified along with the activities carried out in the main office.
6. The financial management system of the Principal Recipient is effective and accurate	Financial management at the Project HOPE office in Kazakhstan is carried out in accordance with the financial policies of the organization. The financial policy of the organization is developed and systematically reviewed in order to comply with the best international practices in the field of financial management and accounting. As an organization legally registered in Kazakhstan, Project HOPE follows the financial management requirements and practices on accounting and financial reporting in accordance to the country legislation: Tax Code of the Republic of Kazakhstan, the National Financial Reporting Standards, the Law 'On Accounting and Financial Reporting' from 28 February 2007, and other regulations on financial management. The office accounting uses an automated system '1C: Enterprise Version 7.7' for reporting to the tax authorities, and the program QuickBooks Pro-2010 – for reporting to the head office. The possibility of opening additional accounts and sub-accounts in these programs allows separate accounting of revenues and expenditures for projects of different donors, so the inclusion of the same expenses in reports to various donors is excluded. The organization has two bank accounts: one in the national currency and another one – in multi-currency (in USD and EUR). The payments for services are largely cashless payments. The cash transactions are regulated by the domestic policy and rules of the organization. The agency's expenditures are made according to the approved program budget. The copies of financial reports are sent monthly to the head office financial management (Global Operations Accountant) for verification, documentation and is subject to verification by the internal auditors every six months. Tax accounting in the organization is based on the accounting data. Fixed assets are subject to the systematic inventory of the organization. The transfer of funds to suppliers follow the Project HOPE policies on procurement and financial management. Cash transactions in the organization are minimized. The transfers of funds to the suppliers are made only after verification of the presence of the stated budget to procure goods or services and compliance to the approved annual procurement plan, as well as to the required authorization by the relevant program management level.
7. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and	Not applicable, as the planned Project HOPE activities within NFM do not include procurement of medicines or medical supplies.

security of health products	
8. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions	Not applicable, as the planned Project HOPE activities within NFM do not include procurement of medicines or medical supplies. At the same time, Project HOPE has the established systems for procurement and supply management of medicines, medical and non-medical products, which are set forth in the relevant Project HOPE documents, developed at the headquarters' level and adapted for the use by the country office in Kazakhstan.
9. Data-collection capacity and tools are in place to monitor program performance	Project HOPE is committed not to use parallel data collection systems and use the data of the national systems as appropriate. In order to ensure proper monitoring and evaluation of interventions to be implemented within NFM project, Project HOPE will define the target indicators for program implementation; prepare regular reports (monthly, quarterly, annual) with defined frequency of data collection and quality assurance; perform routine checks; perform initial and follow-up assessments; implement capacity building interventions for the program staff and grantees for effective data management. Regular reporting forms will be used for follow up the progress of indicators. In addition, relevant information will be collected and analyzed during monitoring visits in order to ensure the quality and reliability of the reported data. Project HOPE program staff were trained on data quality control, which includes ensuring the confidentiality and security of storage of registration documentation by restricting access to the data source, use of passwords to protect electronic data storage and data catalogs. The staff engaged to surveys have been trained to ensure the protection of privacy and confidentiality of data belonging to the study participants.
10. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	One of the key elements of M&E is an integrated data system and quarterly reporting. A special software tool (Program Design Tool) and guidance for its application have been developed. The tool includes all basic components needed for tracking indicators, activities and progress in achieving the goals and objectives of the program, identify problems and gaps, and make recommendations for their solution – in the program design, program monitoring plan (e.g. regarding regular data collection, to ensure their quality and consistency), workplans, and production of quarterly program implementation reports. This tool fits in the prepared software application (along with the required donor M&E plan) and is approved by the Director of M&E division at Project HOPE headquarters. The Senior Technical Advisor for TB is involved in the development of the M&E plan and the implementation of the program, and regularly provides technical advice and oversees the implementation of the program activities. This tool will be supplemented in accordance with the criteria and requirements of the Grant Agreement. During the program, this tool (Reporting Form) will be completed on a quarterly basis by the program manager and submitted for the review and approval by the TB Senior Technical Adviser and the Regional Director. Based on these reports, the progress of the program implementation, achievements and problems / challenges will be reported on a quarterly basis to the First Vice-President of the organization and discussed with the participation of the key technical specialists and

	executive staff.
11. The CCM actively oversees the implementation of the grant, and intervenes where appropriate	The CCM annually establishes the Oversight Committee and approves its Terms of Reference and the CCM Oversight Plan. Project oversight visit is one of the key functions of the CCM to ensure effective use of TGF resources. The Oversight Committee members during the oversight visits have meetings with the SRs, clients, partners and local stakeholders (according to the schedule of visits), review programmatic reports, identify gaps in the implementation of TGF project activities and put forward proposals to improve quality of services provided. During the implementation of TGF TB support in Rounds 6 and 8, fourteen oversight visits were conducted (2011 - 2, 2012 - 5 and 2013 - 7). The reports are presented at the CCM meetings and published on the CCM website (www.ccmkz.kz) . The Oversight Committee has participated in the LFA briefings on the reviews of interim and annual program and financial reports of PRs. The Minutes of CCM meetings and LFA briefings are also published on the CCM website.
12. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	Not applicable, as the planned Project HOPE activities within NFM do not include procurement of medicines or medical supplies. To ensure adherence to treatment, motivation packages for migrants are included in the application. Project HOPE has substantial experience in quality assurance and monitoring of the use of medicines and health products throughout the supply chain.

5.2 Overview of Implementation Arrangements

Please provide an overview of the proposed implementation arrangements for the funding request. In the response, please describe as appropriate:

a. If more than one PR is nominated, how co-ordination will occur between PR(s).
b. Whether Sub-Recipients (SRs) have been identified and the type of management arrangements likely to be put into place.
c. How coordination will occur between each nominated PR and its respective SR(s).

The Country Coordination Mechanism (*National Coordination Council for TB and HIV/AIDS*) oversees the overall implementation of the project and ensures proper coordination between different sectors as well as different programs implemented by other external partners. The CCM will monitor the project progress to ensure that the activities are carried out according to the workplan and indicators of programmatic and financial performance are accomplished. It will make the key financial and programmatic decisions and will have the responsibility to address the main problems and challenges related to the project.

The CCM meetings will be convened quarterly or more frequently as necessary. Technical working groups for each component will work with the stakeholders between the CCM meetings and prepare the documentation to be endorsed by the CCM. The CCM and the Ministry of Health will carry out the role of coordination with other programs and development initiatives. The CCM will ensure practical coordination and collaboration with all local partners involved.

On an annual basis (or more frequently as requested by the CCM), the Principal Recipients (National Center of Tuberculosis Problems and Project HOPE) will prepare the project progress reports for review by the CCM. These reports will present the current state of the epidemic, project implementation progress, financial expenditures and implementation challenges and problems. The CCM will use this information to approve the changes in the program setup and resource allocation when necessary. The CCM will negotiate the recommended changes with TGF through the

country's Fund Portfolio Manager (FPM) and the Country Team.

The two Principal Recipients will execute their functions and apply procedures in accordance to the Global Fund requirements and in compliance with the national legislation. The grant funds will be transferred to the special accounts of the PRs. The PRs will be responsible for all practical issues related to the project implementation including oversight of the Sub-recipients (SRs). The PRs will undertake the functions of procurement (of health and non-health products, equipment, civil works and services), financial management, project-related monitoring and evaluation and reporting to TGF.

The PRs will develop the work plans for project implementation and will present project performance reports to the CCM. Financial and activity progress reports will be forwarded to the CCM members for review. On an annual basis, the CCM will review the project performance and proposed work plans for the upcoming year and will approve additional disbursements.

The following potential SRs have been preliminarily identified for NFM project:

- Regional NTP units (oblast level TB institutions) in Zhambyl, Kyzyl-Orda, Aktobe oblasts and Astana city – to implement demonstration projects on full outpatient treatment of DR-TB cases in respective territories (under Objective 3)
- Republican AIDS Center (RAC) – to implement part of interventions related to TB/HIV collaboration (under Objective 4)
- Population Services International (PSI) – to implement NGO interventions under Objective 6
- International Federation of the Red Cross and Red Crescent Societies (IFRC) – to assist Project HOPE in the implementation of the field activities on TB, DR-TB and TB/HIV among labor migrants (under Objective 7).

While the above organizations have been identified as potential SRs, the SR selection process will be carried out by the PRs on competitive basis, in full accordance to TGF requirements, rules and procedures in this regard.

Before signing the SR agreements, the PRs will carry out the assessments of prospective SRs in terms of their correspondence to TGF requirements vis-a-vis the capacities for financial management, procurement, M&E and other aspects. The activities of SRs will be continuously monitored on the basis of verification of programmatic and financial indicators towards project implementation progress, including visits to SR project sites.

The CCM Secretariat and the PRs will communicate with the Global Fund on the project progress. Progress Updates and Disbursement Requests will be forwarded to TGF FPM on a semi-annual basis or as otherwise agreed; other documentation will be provided as requested by TGF.

The NTP central unit (NCPT) is the main technical partner of the project. It will ensure practical coordination and collaboration with oblast-level NTP units and all other partners involved.

The Local Fund Agent (currently Price Waterhouse Coopers, PWC) will act within the Terms of Reference agreed upon with the Global Fund, including on-site verifications (OSV) of project performance. External audits evaluating the project performance and financial management are an integral part of the proposed management arrangements.

5.3 Current or Anticipated Risks to Program and PR(s) Performance

In reference to the Minimum Standards above and risk assessments conducted (if applicable), describe current or anticipated risks to the program and nominated PR(s) performance, as well as the proposed mitigation measures (including technical assistance) included in the funding request.

The proposed Principal Recipients have extensive experience of implementation of externally funded programs and projects under high standards of performance and stringent controls, therefore

no major risks that may affect the project implementation are anticipated.

The National Center of Tuberculosis Problems (NCPT) has been Principal Recipient of TGF funds since Round 6. The Center has appropriate mechanisms and systems in place for effective grant management in terms of planning, financial management, procurement, monitoring and evaluation, reporting, etc. (see section 5.1 just above for detail). NCTP has passed through the audit by the TGF's Office of Inspector-General (OIG) and currently benefits from technical support, which is being provided by Grant Management Solutions (GMS), aimed at further development of capacities to successfully comply with the complex interventions to be implemented, and with the increasing requirements and controls by the Global Fund.

The second nominated PR, Project HOPE, is an organization with vast experience in managing health development programs and projects all over the world, with established structures and mechanisms for monitoring and oversight, which ensure effective mitigation of risks of under-performance or mismanagement. Project HOPE has extensive experience in the FSU and CAR region, including that in the function of PR for TGF grant funds (e.g. Tajikistan, Kyrgyzstan). The organization has substantial and long-lasting experience in health care development work in Kazakhstan including that in the area of TB control; therefore, no major issues in terms of risks to PR / program performance are expected.

5.4 Major External Risks

Describe any major external risks (beyond the control of those managing the implementation of the program) that might negatively affect the implementation and performance of the proposed interventions.

The political, macroeconomic and social situation in Kazakhstan has been stable over the last two decades. No major external risks are anticipated that may negatively affect the implementation of the proposed interventions.

5.5 Addressing Implementation Efficiencies

Describe how the funding requested here links to any existing Global Fund grants or other funding requests being submitted by the CCM.

In particular, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

The ongoing Global Fund TB support (Round 8) will expire on 31 December 2014. There is a six-month overlap between the Round 8 grant and the proposed timeline of NFM grant, however, none of the interventions proposed for NFM project duplicate those currently supported by the Round 8 project in terms of procurement of medical and non-medical items, human resources, training, M&E, etc.

The decision to set the start date for NFM project of 1 July 2014 was made by the CCM taking into account the need for preparatory work prior to starting new interventions under NFM (e.g. rapid rollout of Xpert technology to district level, demonstration projects on full outpatient DR-TB treatment, NGO grants, etc.). At the same time, it is envisaged that Year 1 of the project will be extended until 31 December 2015 (i.e. it will last 1.5 years) in order to align with the country and TGF financial cycles.

This application presents with the detailed description of activities and budget costs; the CCM is ready to discuss and reconsider all substantial issues during the process of grant making before signing the Grant Agreement.

5.6 Women, Communities and Other Key Populations

Please describe how representatives of women's organizations, people living with the three diseases and other key affected populations will actively participate in the implementation of this funding request, including in interventions that will address legal or policy barriers to service access.

The Constitution and laws of Kazakhstan stipulate equal access to health care, including TB care, to all citizens irrespective of gender, ethnicity, social status or other factors. In particular, the Government implements practical measures to ensure equal participation of women in decision making including appropriate representation in public governance and management structures.

At the same time, MOH and NTP recognize the existence of a number of service-level barriers that create issues with access to care for vulnerable and at-risk populations, such as internal and, especially, external labor migrants, ex-prisoners in need of TB treatment, PLHIV and MARPs such as PWID. The latter groups, despite continuous efforts by the Government and civil society establishment, continue to experience a range of problems related to stigma and discrimination in terms of access to and use of medical services.

As described above in section 4.4, the proposal pays specific attention to issues of access to care and patient rights. All interventions in the field, and activities aiming at reforming the TB control system in the country, supported by this TGF project, will have explicitly focus on the needs of vulnerable and at risk population groups. The mainstay of the ongoing and forthcoming reform is the implementation of patient-centered care closer to the clients' residential and work environment. The above measures are expected to further contribute to decreasing inequalities and removing organizational barriers to essential services related to TB, DR-TB and TB/HIV diagnosis, treatment, care and support.

In addition, interventions included in the proposal under Objective 6, will specifically support development of a framework for sustainable participation and involvement of non-state actors, including communities affected by the diseases, in decision making and implementation of TB control efforts in the country.

SECTION 6: LISTS OF ABBREVIATIONS AND ANNEXES

6.1 List of abbreviations and acronyms used by the applicant

Please list below all abbreviations and acronyms used in this funding request

ACSM	Advocacy, communication and social mobilization
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral
CAR	Central Asian Republics
CCM	Country Coordination Mechanism
CDC	Centers for Disease Control
CES	Criminal-Executive System
CN	Concept Note
CPT	Co-trimoxazole preventive therapy
DRS	Drug Resistance Survey
DR-TB	Drug-resistant tuberculosis
DST	Drug susceptibility testing
DTF	Dual-Track Financing
EU	European Union
FGD	Focus group discussion
FLDs	First-line (anti-TB) drugs
FPM	Fund Portfolio Manager
FSU	Former Soviet Union
GDF	Global Drug Facility
GMS	Grant Management Solutions
GNI	Gross National Income
HCWs	Health care workers
HIV	Human Immune Deficiency Virus

HQ	Headquarters
HSS	Health systems strengthening
IDA	International Dispensary Association
IEC	Information, education and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
IT	Information technology
KNCV	Royal Dutch Tuberculosis Foundation
KZT	Kazakhstan Tenge
LFA	Local Fund Agent
LPA	Line Probe Assay
M&E	Monitoring and evaluation
M. Tb	Mycobacterium Tuberculosis
MARPs	Most at-risk populations
MDR-TB	Multidrug-resistant tuberculosis
MGIT	Mycobacterium Growth Indicator Tube
MMG	Medical Marketing Group
MOH	Ministry of Health
MoIA	Ministry of Internal Affairs
NAP	National AIDS Program
NCTP	National Center of Tuberculosis Problems
NFM	New Funding Mechanism
NGO	Non-governmental organization
NGS	Next Generation Sequencing
NMRL	National Mycobacterium Reference Laboratory (UK)
NRL	National Reference Laboratory
NSP	National Strategic Plan (for TB control)

NTP	National Tuberculosis Program
OIG	Office of Inspector-General
OSV	On-site verification
PDR-TB	Polydrug-resistant tuberculosis
PHC	Primary Health Care
PLHIV	People living with HIV
PR	Principal Recipient
PSI	Population Services International
PWC	Price Waterhouse Coopers
PWID	People who inject drugs
RFP	Request for Proposals
SLDs	Second-line (anti-TB) drugs
SR	Sub-recipient
SRL	Supranational Reference Laboratory
TB	Tuberculosis
TGF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
ToT	Training of trainers
TRP	Technical Review Panel
UMI	Upper-middle level (country income)
USD	United States' Dollar
WB	The World Bank
WHO	World Health Organization
WHO/EURO	World Health Organization Regional Office for Europe
WRDs	WHO-recommended diagnostics
XDR-TB	Extensively drug-resistant tuberculosis

6.2 List of Annexes	
List all relevant supporting documentation attached to this funding request	
Annexes to Sections 1-2	
Annex #	Annex Name
Att. 1	Attachment 1. CCM Endorsement of the Concept Note
2.1.1	Annex 1 to Section 2.1 “Resolution of CCM meeting as of May 16 -17, 2013”
2.1.2	Annex 2 to Section 2.1 “Country Dialogue Plan”
2.1.3	Annex 3 to Section 2.1 “List of working group members”
2.1.4	Annex 4 to Section 2.1 “Copy of advertisement from newspaper, UNDP and CCM web-sites”, national email distribution list
2.1.5	Annex 5 to Section 2.1 “Proposals from stakeholders, Letters from partners”;
2.1.6	Annex 6 to Section 2.1 “Package of Minutes of focus groups held between June - July 27, 2013”
2.1.7	Annex 7 Section 2.1 “Presentation report on the results of interview”
2.1.8	Annex 8 to Section 2.1 “Agenda of the Round table, list of participants, three presentations, Minutes of the Round table as of July 27, 2013”
2.1.9	Annex 9 to Section 2.1 “Minutes of meeting as of July 11, 2013 to review proposals with experts from International organizations”
2.1.10	Annex 10 to Section 2.1 “Minutes of meeting in Almaty with GF experts participation”
2.1.11	Annex 11 to Section 2.1 “Minutes of meeting on NGOs contribution” as of September 30, 2013 and October 02, 2013”
2.1.12	Annex 12 to Section 2.1 “Minutes of meeting as of June 27, 2013”
2.1.13	Annex 13 to Section 2.1 “Minutes of meeting as of July 15, 2013”
2.1.14	Annex 14 Section 2.1 “Review of the TRP feedback for the early CN”
2.1.15	Annex 15 to Section 2.1 “Minutes of meeting with Ministry of Health specialists and Vice – Minister of Health as of September 12, 2013”
2.1.16	Annex 16 to Section 2.1 “Minutes of meeting as of December 13, 2013”
2.1.17	Annex 17 to Section 2.1 “Consolidation Letter RCAIDS and NCTP”
2.1.18	Annex 18 to Section 2.1 “GFATM Country team Pre assessment to KAZ-809-G04-T -NFM”

2.2.1	Annex 1 to Section 2.2. “Minutes of CCM meeting as of June 27, 2013 and list of working group members“
2.2.2	Annex 2 to Section 2.2. “Minutes of CCM meeting as of July 03, 2013”
2.2.3	Annex 3 to Section 2.2. “Minutes of CCM meeting as of August 06, 2013”
2.2.4	Annex 4 to Section 2.2. “Minutes of CCM meeting as of August 26, 2013”
2.2.5	Annex 5 to Section 2.2 “Copy of advertisement from newspaper, UNDP and CCM web-sites”, national email distribution list are attached
2.2.6	Annex 6 to Section 2.2. “PRs proposals”
2.2.7	Annex 7 to Section 2.2 “Minutes of working group meetings as of September 03 and 06, 2013”
2.2.8	Annex 8 to Section 2.2 “Minutes of meeting as of September 10, 2013”
2.2.9	Annex 9 to Section 2.2 “Declaration on the Conflict of Interests as of September 10, 2013” for CCM Chair and CCM member from MoH

Annexes to Sections 3 and 4

Annex #	Annex Name
3.1	Statistical TB Overview in the Republic of Kazakhstan for 2012 (NCTP, MOH, 2013) (in Russian)
3.2	Data on DST (2009-2012), TB in prisons and TB/HIV (Excel)
3.3	State Program for Health Care Development ‘Salamatty Kazakhstan’ for Years 2011-2015 (in Russian)
3.4	Complex Plan for Tuberculosis Control in Kazakhstan for the Period 2014-2020
3.5	Action Plan (Roadmap) for TB service activities to control M/XDR-TB for 2013 (in Russian)
3.6	Report on WHO/EURO NTP Review in Kazakhstan, May 2012 (in Russian)
3.7	Green Light Committee Monitoring Mission Report for Kazakhstan (WHO/EURO, August 2013)
3.8	Awareness of Tuberculosis and Access to Health Services and Tuberculosis Treatment among Uzbek Labor Migrants in Kazakhstan. Final Report (Project HOPE, June 2009)
Att. 2	Attachment 2. Modular Template
4.1	Programmatic Gap Analysis tables (Excel), for Section 4.1
4.2	Detailed Workplan and Budget for each Objective (‘Indicative Amount’) (8 Excel files)

4.3	Summary Budget (‘Indicative Amount’)
4.4	Workplan and Budget (‘Above Indicative Amount’)
4.5	Laboratory algorithm for TB and DR-TB diagnosis and treatment monitoring (updated September 2013) (in Russian)
4.6	Guidelines on implementation of rapid diagnostic methods for TB and DR-TB (NCTP, 2011) (in Russian)
4.7	Report: Impact of Xpert MTB/RIF in Kazakhstan and lessons learned during its pilot implementation (TB CARE, KNCV, December 2013)
4.8	Additional information and explanations on interventions under Objective 7 (Project HOPE)
4.9	Operational Research Proposal (Intervention 2.4 for ‘Above Indicative’ request). Tuberculosis Molecular Epidemiological Study in Kazakhstan: investigating role of reinfection in treatment failures and spread of drug-resistant TB in Kazakhstan (November 2013)
4.10	TGF Budget Template (Objectives 1-6, and 8)
4.11	TGF Budget Template (Objective 7)
4.12	TGF Budget for PSM 2013-12-25
Att. 3	Attachment 3. Financial Gap Analysis and Counterpart Financing Table

ATTACHMENT 1 - CCM Endorsement of Concept Note	
Fill in the CCM endorsement form, signed by all CCM members, and list all relevant CCM related supporting documentation.	
Attached.	
Annexes to Section 2	
Annexes to Section 2.1	Annex Name
2.1.1	"Resolution of CCM meeting as of May 16 -17, 2013
2.1.2	"Country Dialogue Plan" i
2.1.3	"list of working group members"
2.1.4	"Copy of advertisement from newspaper, UNDP and CCM web-sites", national email distribution list"
2.1.5	"Proposals from stakeholders, Letters from partners"
2.1.6	"Package of Minutes of focus groups held between June - July 27, 2013"
2.1.7	"Presentation report on the results of interview"
2.1.8	"Agenda of the Round table, list of participants, three presentations, Minutes of the Round table as of July 27, 2013"
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2.1.11	"Minutes of meeting on NGOs contribution" as of September 30, 2013 and October 02,2013"
2.1.12	"Minutes of meeting as of June 27, 2013"
2.1.13	"Minutes of meeting as of July 15, 2013"
2.1.14	"Minutes of meeting as of August 22, 2013"
2.1.15	"Minutes of meeting as of September 10, 2013"
2.1.16	Minutes of meeting as of December 13, 2013"
Annexes to Section 2.2	Annex Name
2.2.1	"Minutes of CCM meeting as of June 27, 2013 and list of working group members"

2.2.2	"Minutes of CCM meeting as of July 03, 2013"
2.2.3	"Minutes of CCM meeting as of August 06, 2013"
2.2.4	"Minutes of CCM meeting as of August 26, 2013"
2.2.5	"Copy of advertisement from newspaper, UNDP and CCM web-sites", national email distribution"
2.2.6	"PRs proposals"
2.2.7	"Minutes of working group meetings as of September 03 and 06, 2013"
2.2.8	"Minutes of meeting as of September 10, 2013"
2.2.9	"Declaration on the Conflict of Interests as of September 10, 2013" for CCM Chair and CCM member from MoH"

ATTACHMENT 2 – Modular Template
The ''modular template' is a core document of the funding request. It can either be completed as an Excel template, or it can filled in using an online tool (Salesforce).
Attached.

ATTACHMENT 3 - Financial Gap Analysis and Counterpart Financing Table
The Financial Gap Analysis and Counterpart Financing Table is a required attachment to be completed as an Excel template, or it can filled in using an online tool (Salesforce).
Attached.