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

PROPOSAL FORM – ROUND 8
(SINGLE COUNTRY APPLICANTS)

Applicant Name	COUNTRY COORDINATING MECHANISM TO FIGHT AIDS AND TUBERCULOSIS
Country	BULGARIA
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)*	Lower-middle income

Applicant Type ☒ CCM ☐ Sub-CCM ☐ Non-CCM

Round 8 Proposal Element(s):

	Disease	Title	HSS cross-cutting interventions section *(include in one disease only)*
☐	HIV[1]		☐
☑	Tuberculosis[1]	Strengthen the National Tuberculosis Program in Bulgaria	☐
☐	Malaria		☐

Currency ☐ USD or ☒ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Tuesday 1 July 2008**

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

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

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

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

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

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

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

** *Only to be included in one disease in Round 8. Refer to the Round 8 Guidelines for detailed information.*

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

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

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

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

IMPORTANT NOTE:

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

A number of recent Global Fund Board decisions have been reflected in the Round 8 Proposal Form. The *Round 8 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf.

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

ROUND 8 – Tuberculosis

1. FUNDING SUMMARY AND CONTACT DETAILS

1.1. Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV						
Tuberculosis	2 071 740	1 589 695	1 324 515	2 795 553	2 746 263	10 527 766
Malaria						
HSS cross-cutting interventions within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*						
					Total Round 8 Funding Request ➔:	10 527 766

1.2. Contact details

	Primary contact	Secondary contact
Name	Dr. Tonka Varleva	Ass. Prof. Dencho Osmanliev
Title	CCM Secretary and Director of Prevention and Control of AIDS, Tuberculosis and STIs Directorate	Head of Clinic for Emergency and Intensive Therapy and National Consultant on Pneumology and Phthisiatry
Organization	Ministry of Health	Specialised Hospital for Active Treatment of Lung Diseases "St. Sofia" - Sofia
Mailing address	Bulgaria 1000 Sofia 5 Sveta Nedelja Sq	Bulgaria 1431 Sofia 19 Acad. Ivan Geshov Blvd
Telephone	+ 359-2-9301-243 + 359-2-9301-274	+359-2-952-06-68
Fax	+359 2 9301-274	+359-2-952-06-68
E-mail address	tvarleva@mh.government.bg	dosm@mail.orbitel.bg
Alternate e-mail address	tvarleva@gmail.com	dosmanliev@gmail.com

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
DOTS	Directly observed treatment, Short course
DST	Drug susceptibility testing
GP	General practitioner
HCW	Health care workers
IDU	Injecting drug user
IGRA	Interferon-Gamma Release Assay
IUATLD	International Union against Tuberculosis and Lung Diseases
MDR(-TB)	Multidrug-resistant (Tuberculosis)
MoH	Ministry of Health
NCHI	National Centre of Health Informatics
NGO	Non-governmental organization
NHIF	National Health Insurance Fund
NRL	National Reference Tuberculosis Laboratory
NSI	National Statistical Institute
NTP	National Tuberculosis Programme
PMU	Programme Management Unit
SAR	State Agency for Refugees
SHATP	Specialized Hospitals for Active Treatment of Prisoners
TB	Tuberculosis
WHO	World Health Organization

ROUND 8 – Tuberculosis

2. APPLICANT SUMMARY (including eligibility)

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

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

2.1. Members and operations

2.1.1. Membership summary

	Sector Representation	Number of members
☑	Academic/educational sector	7
☑	Government	14
☑	Non-government organizations (NGOs)/community-based organizations	9
☑	People living with the diseases	1
☑	People representing key affected populations[2]	1
☑	Private sector	2
☐	Faith-based organizations	
☑	Multilateral and bilateral development partners in country	5
☐	Other *(please specify):*	
	Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	39

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

2.1.2. Broad and inclusive membership

Since the last time you applied to the Global Fund (and were determined compliant with the minimum requirements):

(a) Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and ☐ No ☒ Yes

(b) Is there continuing active membership of people living with and/or affected by the diseases. ☐ No ☒ Yes

2.1.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

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

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

The main principle for membership in the CCM Bulgaria (Annex 1 Terms of Reference of CCM Bulgaria) is the experience and knowledge in the field of HIV/AIDS and TB strategic planning and program implementation. All of the CCM members representing academic institutions have the highest level of competency to participate actively in the coordination and national response to the diseases. The representatives from the NGOs sector are selected also by the sector that represented on the competence base according to their experience, knowledge and active involvement over the years in the HIV and Tuberculosis program implementation. The government organizations on the other hand have the needed capacity to analyze the legislative and policy frameworks in the terms of the health system functioning and the linkages between the sectors. The multilateral and bilateral organizations representatives have also very high level capacity and experience. During the meetings many aspects of health care systems and cross-cutting issues are discussed and often, according to Bulgaria CCM Terms of Reference, experts who are not CCM members are invited to take active participation in the discussions. Bulgaria CCM members working in close collaboration with many bodies and organizations which are key for the health care system – expert boards, state agencies, National Assembly, Council of Ministers and others.

Gender awareness

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

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

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

According to CCM Terms of Reference, Bulgaria CCM is the responsible body for coordinating the activities of state bodies for prevention of HIV and Tuberculosis. The analysis of epidemiological data is always a part of the discussions at CCM meetings. The NGO, government and academic sector representatives have an important role in analyzing and assessing major challenges and gender issues. More than 85% of CCM members have the capacity to assess the needed interventions related to ensure gender equality.

Multi-sectoral planning

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

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

All CCM members had taken part in the design and implementation of strategic documents not only in the field of HIV/AIDS and Tuberculosis, but in the field of the health care programmes, prevention of drug addictions and treatment, programmes for sexually transmitted infections, health education programs etc.

ROUND 8 – Tuberculosis

2.2. Eligibility

2.2.1. Application history

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

☉	Applied for funding in Round 6 and/or Round 7 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
○	Last time applied for funding was before Round 6 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' to and complete.*** *(Do not complete sections 2.2.2 to 2.2.4)* ➔ ***Then also complete sections 2.2.5 to 2.2.8 below.***

2.2.2. Transparent proposal development processes

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

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

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

CCM Bulgaria is responsible for ensuring a broad stakeholder input in the development of the proposal according to Art. 10.3 of the CCM Terms of Reference (Annex 1 - CCM Bulgaria Terms of Reference).

The proposal development and submission procedures are laid out in Art. 10.3.1; 10.3.2., and 10.3.3. An official letter was sent to all CCM members to decide through e-voting about the Round 8 application process (Annex 2 - Official letter sent to all CCM members to decide through e-voting process on Round 8 Proposal development). The letter was sent to all CCM members by email on 14 May 2008 to vote and send the suggestions by email to the CCM secretary. The results from the voting were as follows: from 34 addressed members of the CCM-Bulgaria 29 voted FOR or 87,9%, and there were no people voted against (Annex 3 - Written answers by CCM members sent by email regarding the Round 8 Proposal e-voting procedure). The official letter with the results and the final decisions was send after that to all CCM members (Annex 4 – Official letter with the results from e-voting). In accordance with these results the decision for preparation of country project for applying in Round 8 of the Global Fund to fight AIDS, tuberculosis and malaria was taken and the relevant documents for the proposal development were translated and uploaded in both languages to the electronic web-sites of the Country Mechanism (www.ncaids.government.bg), Ministry of Health (www.mh.government.bg) and Program "Prevention and control of HIV/AIDS" (www.aidsprogram.bg).

All stakeholders were publicly invited to take part in the proposal development process for Round 8 applying. The invitation was announced on 29 May 2008 on the abovementioned websites (Annex 5 – CCM Bulgaria invitation, procedure and criteria for small proposals development). According to the CCM Terms of Reference an expert working group was established to prepare the application documents in transparent manner (Annex 6 – Order for Round 8 working group). The announced deadline for submission of small proposals was 13 June 2008.

Also the elected members of CCM informed by email the organizations, that they represent in the CCM about the process to solicit submissions of small proposals. After that the email messages were forwarded to the CCM Secretary (Annex 7– Emails to stakeholders sent by CCM members)

(b) Describe the process(es) used to transparently review the submissions received for possible integration into this proposal. *(If a different process was used for each disease, explain each process.)*	
5 small proposals were submitted from 3 non-governmental organizations, 1 governmental organization and 1 national consultant of pneumology and phthisiatry. (Annex 9 – Cover letters from small proposals sent by stakeholders). The small proposals were evaluated by the expert working group (Annex 10 – Minutes from the working group for evaluation of small proposals). The Minutes from the evaluation process was sent to all CCM members by email. The feedback letters with the evaluation from the expert group were prepared and sent to all stakeholders by fax according to the published procedure (Annex 11- Feedback letters to the stakeholders). It is important to stress on the fact, that the small proposals presented the real inclusion of the non-governmental organizations in Bulgaria.	
(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*	
The coordination of the proposal development process was assigned by Bulgaria CCM to the expert working group (Annex 6 – Order for Round 8 expert group). The members of this group are 24 experts from different sectors and this was published on the web-sites of the CCM Bulgaria, Ministry of Health and Program Prevention and control of HIV/AIDS. Out of them 7 are CCM members. The meeting for analyzing and taking decisions on the scale-up of the activities under the previous GFATM project was conducted on 01 June 2008 and the first draft of the objective goals was prepared (Annex 8 Minutes from the working group decisions on the elements). All of the procedure for invitation to solicit small proposals, evaluation, broad discussion and inclusion were performed in accordance with the GF requirements. All of the received small proposals were evaluated as acceptable according to the procedure and evaluation criteria (Annex 10 – Minutes from the working group for evaluation of small proposals). The minutes and evaluation results were presented to the CCM members before the work meeting on 27.06.2008 via email. (Annex 14 - Minutes from CCM meeting on 27.03.2008)	
(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	Annex 4 – Official letter to CCM Members with the results from e-voting Annex 8 - Minutes from the working group decisions on the elements

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.
CCM Bulgaria has firm regulations regarding the overseeing the implementation of programs funded by the Global Fund. These are laid out in Art. 10.9 of the CCM Terms of Reference and precisely in Art. 10.9.2. (Annex 1 – CCM Bulgaria Terms of Reference) Since the CCM establishment (in 2002), the reports on program and financial implementation of Program "Prevention and Control of HIV/AIDS", the reports on the procurement plan implementation, the reports on the selection of sub-recipients, as well as all other documents relevant to the implementation are presented at the CCM meetings. The Principle Recipient submits a copy of Disbursement Requests and Quarterly Progress Updates and Annual Performance Reports of the Program. The same procedure was already applied for the Program "Improve the TB control in

Bulgaria", started at the end of 2007 after Round 6 approval by the GFATM.
(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.
All of decisions related to oversight the implementation of the GF Grant, taken during the CCM meetings are published on the web-site of the Ministry of Health. Principle Recipient published the Annual reports on the web-site of the Program Prevention and Control of HIV/AIDS. Except this, all copies of the annual Audit Reports are available for each Member of CCM Bulgaria for receiving upon request from the Program Management Unit Staff

2.2.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 8 Guidelines for further explanation of the principles.* .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*	
According to the CCM Bulgaria Terms of Reference there is in place a clear procedure for nominating of Principal Recipient (art. 10.6). The procedure was fully kept under the Round 8 Process. After taking decisions on applying and the CCM members were officially informed on this with letter (see Annex 4 - Official letter sent to the CCM members with results after the e-voting procedure) an invitation was uploaded on the official web-site of the National AIDS Committee to invite the stakeholders to give written suggestions for the Principal Recipient until 26.06.2008 (Annex 12 - CCM invitation for nomination of alternative PR). There were 2 suggestions (Annex 13 Suggestions for PR nomination) made for PR and received within the deadline. The 2 nomination letters were review by the CCM members during the last CCM meeting. The Ministry of Health was nominated both in the letters. According to the ToR of CCM Bulgaria, the Ministry of Health was approved to be nominated under the Project as a Principle Recipient by simple majority voting (Annex 14 - Minutes from CCM meeting on 27.06.2008).	
(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	Annex 13 - Minutes from CCM meeting held on 27 June 2008

2.2.5. Principal Recipient(s)

Name	Disease	Sector**
Ministry of Health	**Tuberculosis**	**Government**

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

2.2.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
Following CCM procedure on Principal Recipient selection, a call for nominations of PRs was announced and only two nominations were received – both on the name of the Ministry of Health.

The recommendation regarding dual tracking financing will be difficult to apply in Bulgaria with regard to legal constraints related to taxes, VAT and duties exemption on the one hand, and with legal constrains non-governmental organizations to implement health programmes with predominant medical activities.

2.2.7. Managing conflicts of interest

(a) Are the Chair **and/or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the diseases in this proposal?

☉ Yes
provide details below

○ No
➔*go to s.2.2.8.*

☑ **Yes**

Annex 1 – ToR of CCM Bulgaria

Annex 19 – Statements of conflict of interests

(b) **If yes, attach** the plan for the management of actual and potential conflicts of interest.

Annex 28 – Minutes from CCM meeting on 01.08.2006

A second Vice-Chair from the NGO sector was elected in 2006 to avoid a conflict of interest between the Principle Recipient and the CCM Chair and/ or Vice-chair (Art. 6.4 from the CCM Terms of Reference).

2.2.8. Proposal endorsement by members

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

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Section	Document description	Annex Number
2	CCM Bulgaria Terms of Reference	1
2	Official letter sent to all CCM members to decide through e-voting process on Round 8 Proposal development	2
2	Written answers by CCM members sent by email regarding the Round 8 Proposal development e-voting procedure	3
2	Official letter sent to the CCM members with results after the e-voting procedure	4
2	CCM invitation, procedure and criteria for small proposal development, published in 3 official web-sites	5
2	Order for establishment of working group to prepare Round 8 Project Proposal	6
2	Emails to stakeholders sent by CCM members for sending small proposals	7
2	Minutes from the work group decisions on the elements to include in Round 8 Project	8
2	Cover letters from small proposals sent by stakeholders	9
2	Minutes from the working group for evaluation of small proposals	10
2	Feedback results from the working group to the stakeholders	11
2	CCM invitation for nomination of PR under the new Round 8 Project Proposal	12
2	Suggestions for PR nomination received after the invitation	13

2	Minutes from CCM meeting held on 27 June 2008	14
2	Letters from CCM members for not attending the meeting held on 27.06.2008	15
2	Minutes from CCM meeting held on 26 March 2008	16
2	Invitation letter for new CCM member selection from the private sector	17
2	Results from nomination of CCM members from the private sector	18
2	Statements on conflict of interest management, signed by CCM members	19
4	National Programme for Prevention and Control of Tuberculosis in the Republic of Bulgaria 2007-2011	20
4	Mission Reports on TB laboratory Services Network in Bulgaria, prepared by WHO consultants, 2006 and 2007	21
4	Manual for TB diagnosis (Bulgarian)	22
4	Manual for TB treatment (Bulgarian)	23
4	Draft National Health Strategy 2008-2013	24
4	Detailed Work plan	25
5	Detailed Proposal Budget	26
4	Procurement Plan	27
Attachment D	Minutes from CCM meeting on 01.08.2006	28
Attachment D	Order of the CCM Bulgaria Vice-Chair for election of new Members in 2006	29
Attachment D	Procedure for election of new CCM members from the constituency of the non-governmental	30

	organizations	
Attachment D	Minutes from the working group reviewing of nomination made by non-governmental organizations in 2006	31
Attachment D	Invitation letters to the NGOs to nominate new representatives for CCM members	32
Attachment D	Emails from the NGOs, participated in the nomination process in July 2006	33
Attachment D	Notification letters to the NGOs for the results after the nomination process for new CCM members	34

ROUND 8 – Tuberculosis

3. PROPOSAL SUMMARY

3.1. Duration of Proposal

	Planned Start Date	To
Month and year: *(up to 5 years)*	01/2010	12/2014

3.2. Consolidation of grants

(a) Does the CCM (or Sub-CCM) wish to consolidate any existing tuberculosis Global Fund grant(s) with the Round 8 tuberculosis proposal?

☐ Yes *(go first to (b) below)*

☉ No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 8 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at: http://www.theglobalfund.org/en/apply/call8/other/#5*

(b) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval?
(List the relevant grant number(s))

3.3. Alignment of planning and fiscal cycles

Describe how the start date:

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

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

In case Bulgaria Round 8 Tuberculosis Proposal is approved, it is planned that implementation start date is 01 January 2010, based on the following considerations:

1) As the fiscal year in Bulgaria starts on 01 January and ends on 31 December, planning, implementation and reporting cycles of the National TB Programme are aligned with the calendar year;

2) Since Global Fund resources are requested as additional to support the implementation of the National TB Programme, payments for taxes and duties accorded to this Proposal will have to be allocated from the state budget which is also aligned with the fiscal and calendar year;

3) Global Fund's decision on approval is expected in November 2008. In case of a positive decision, negotiations on grant agreement are expected to be concluded between six months and twelve months. Furthermore, country experience indicates that after Grant Agreement signature, several months can be needed for ratification on behalf of the National Assembly of the Republic of Bulgaria, without which major procedures essential to implementation cannot be started.

Lessons learned from previous Global Fund grants: due to the delayed ratification of the Round 6 Grant Agreement, Phase 1 ending date was extended from 31 October 2009 to 31 December 2009.

3.4. Program-based approach for Tuberculosis

ROUND 8 – Tuberculosis

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

- ☐ Yes. Answer s.3.4.2
- ☐ No. ➔ *Go to s.3.5.*

3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?

- ☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***
- ☐ No. Do not complete s.5.5

3.5. Summary of Round 8 Tuberculosis Proposal

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

Prepare after completing s.4.

The Government of the Republic of Bulgaria recognizes the need for a uniform national policy to control tuberculosis. In view of continuing the implementation of the disease-specific activities and ensuring efficiency and sustainability of the efforts of the competent state institutions, in 2007, the Government adopted a National Program for Prevention and Control of Tuberculosis in the Republic of Bulgaria for the period 2007-2011 with Decision № 25 of the Council of Ministers of 28.06.2007 (Annex 20). This programme is the natural continuation of the preceding programmes. It was developed to contribute to the achievement of the targets set in WHO Stop TB Strategy, the Global Plan to Stop TB 2006-2015 and the Millennium Development Goals and Stop TB Partnership targets, while in the same time it reflects particular aspects of the health care reform in the country. However, a number of programmatic and financial gaps in the National TB Programme and the existing Round 6 Global Fund grant were found to be challenging with regard to achieving national targets. Therefore, Bulgaria CCM decided to apply for additional Global Fund support in order to address these gaps.

The goal of this proposal is to sustain the implementation of the National TB Programme through high-quality TB diagnosis and treatment and improved control of Multidrug-Resistant Tuberculosis

The major strategies to attain this goal are: 1) a quality-assured network of laboratories with facilities enabling performance of cultures and DST for all TB patients; 2) facilitation of access to medical structures for TB diagnosis of difficult-to-reach patients; 3) facilitation of follow-up of patients during the continuation phase of treatment; 4) active investigation of contacts of TB patients; and 5) improved protection of health-care workers against possible TB infection.

The proposal interventions are centred around the following priorities: 1) all patients with pulmonary TB put under treatment should have culture examination, 2) no case of MDR-TB should remain undetected and untreated; 3) the rate of defaulters should be reduced to a minimum, particularly in groups with a high risk to abandon treatment; 4) contacts of patients with pulmonary TB should be examined and treated if infected; and 5) infection of health-care workers should be avoided.

These strategies should contribute to ensuring a further decrease of the incidence rates in Bulgaria from 39.1/100,000 in 2006 to 27/100,000 in 2014, as well as quality-assured detection and second-line treatment for all MDR-TB cases.

The principles on which the development of the proposal is based:

- Broad participation of various partners in the preparation of the proposal;
- Increasing the coverage of high risk groups through implementation of specific interventions;
- Strengthening DOTS through enhanced coordination and complementarity of TB control and care activities implemented by specialized TB facilities, primary health care network, non-governmental organizations and communities in high risk;
- Highlighting the need of continuous training and monitoring to guarantee high quality of tuberculosis diagnosis and treatment under DOTS, including multi-drug resistant tuberculosis;
- Maintaining the close interaction between the National Tuberculosis Programme and the National Programme for the Prevention and Control of HIV/AIDS and Sexually Transmitted Infections.
- Integrating TB control in the overall National Health Strategy and ensuring its sustainability after the termination of the Global Fund grant;
- Further strengthening the management, implementation, and monitoring and evaluation capacity of the National Tuberculosis Program in Bulgaria.

4. PROGRAM DESCRIPTION

4.1. National programme and strategy

(a) Briefly summarize:

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

According to latest official data included in the "Global Tuberculosis Control 2008" and Country TB Surveillance report to WHO-EuroTB, a total of 3,232 TB cases were notified in 2006 (42 per 100,000 population). 2,115 of all TB patients were male (65%). New pulmonary TB cases were 3,011; out of them 1,307 smear-positive TB cases were notified (17 per 100,000 population), with 94% case detection rate. Relapse cases were 125, and other re-treatment patients were 96. There were 327 cases with extrapulmonary TB. 386 TB patients were died – with mortality rate of 5 per 100,000.

The breakdown of TB patients by gender and age groups (Country Report to WHO EuroTB for 2006) shows that male between 45 to 54 years (467 TB patients) and female more than 65 years (235 TB patients) are most affected. Over the past years there has been an upward trend in TB incidence among the elderly - 18% of all registered TB patients. A trend of slow increase was registered in TB incidence among children. According to data from National Centre of Health Informatics, 286 children with TB were registered in 2006.

Treatment success rate for the 2005 cohort of new registered pulmonary smear-positive patients (n=1,342) is 86%. The proportion of defaulters still remains high – 7%.

According to data from "Global Tuberculosis Control 2008", 53 MDR-TB cases were notified in 2006, but only 35 were confirmed by the NRL. Notified MDR-TB cases among 1, 108 new culture-positive TB patients, who received DST, were 24 (2.2%). Notified MDR-TB cases among 221 re-treatment patients, who received DST, was 29 (13.1%).

Currently, there are no second-line drugs in the country and first supply is expected in 2009 after submission and approval of GLC application for 50 patients planned for in the existing Round 6 Global Fund grant.

At the same time, WHO 2005 and 2006 estimates for Bulgaria show an increase in the percentage of MDR-TB of new TB cases from 5.6% to 11%, and in the percentage of MDR-TB of previously treated TB cases from 29% to 38%. Therefore, it is expected that the number of MDR-TB cases will continue to increase up to 70 in the last two years of the period of this proposal.

According to information provided by the Chief Directorate "Execution of Judgement" under the Ministry of Justice, the number of prisoners in 2006 was 11,289 people. Of these, 53 were diagnosed with active tuberculosis, but only 9 were bacteriologically confirmed. This is a clear sign that diagnostics needs to be improved among this population.

No statistical data is available on high risk groups identified by the National TB Programme – Roma community, prisoners, injecting drug users and alcohol-dependent persons, refugees and asylum seekers, and street children.

The official 2001 census data on the number of Roma population in Bulgaria is 370,908. However, the estimated number of Roma population in Bulgaria varies up 800,000 people or approximately 10% of the country population. Tuberculosis among Roma people often occurs together with other chronic diseases which further increases the risk of transmission of the infection. According to a recent rapid assessment carried out in seventeen big cities in Bulgaria, Roma TB patients represent 50% of all TB cases which suggest two times higher TB incidence and prevalence rate in this community than in the general population.

In 2007, the Council of Ministers of Bulgaria approved the National Programme for Prevention and Control of Tuberculosis in the Republic of Bulgaria (2007-2011), which is the natural continuation of the preceding programs. The National TB Programme and its Action Plan were developed in line with the guidelines of the Stop TB Strategy, the Global plan to Stop TB 2006-2015 and the Millennium Development Goals.

The goal of the Program is to reduce the burden of tuberculosis in the Republic of Bulgaria.

The specific objectives and activities included in this Programme have been developed to eliminate some programmatic and financial discrepancies in previous programs and to ensure an integrated and balanced approach in implementing the national response, which includes prevention, quality diagnosis and treatment, care and support to people affected by the disease. The National Tuberculosis Programme identifies the targets groups at high risk to be reached with specific interventions aiming to increase their access and use of health services.

The National Programme for Prevention and Control of Tuberculosis in the Republic of Bulgaria (2007-2011) puts forward seven operational objectives:

Objective 1. Strengthening the infrastructure, management and coordination

Objective 2. Timely diagnosis and control of tuberculosis

Objective 3. Successful treatment of tuberculosis in Bulgaria

Objective 4. Reducing the transmission of tuberculosis in the prisons in Bulgaria

Objective 5. Restricting the spread of tuberculosis among the Roma community and the vulnerable groups - injecting drug users and alcohol-addicted people; refugees and asylum seekers; children on the street and children living in social homes; people living with HIV/AIDS

Objective 6. Specific immune prophylaxis and chemoprophylaxis of tuberculosis (preventive treatment of latent tuberculosis infection)

Objective 7. Health promotion

These objectives include main activities such as strengthening the infrastructure and developing the capacity of the national health system; establishing a national TB surveillance system; implementing effective strategies for modern diagnosis and quality treatment of TB; targeted TB prevention, care and support activities for high risk groups; establishing a national system of external quality assurance of laboratory diagnosis; monitoring and evaluating the national TB situation and response; and ensuring that a multi-sectoral and participatory approach is adopted in the implementation of the National TB Programme.

Major impact and outcomes expected from the implementation of the National TB Programme include:

- reduced TB incidence from 40.1 per 100,000 in 2005 to 36 per 100,000 at the end of the programme;
- increased treatment success rate from 80% in 2005 to more than 85% at the end of the programme.

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

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

	Document	Proposal Annex Number	Page References
☑	National Health Sector Development/Strategic Plan	Annex 24	pp. 8, 23, 25
☑	National Tuberculosis Control Mid Term Strategy or Plan	Annex 20	

☑	National Tuberculosis Guidelines (medical and laboratory)	Annexes 22, 23
☐	Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	
☑	Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal	Annex 21
☐	National Monitoring and Evaluation Plan (health sector, disease specific or other)	
☐	National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services	

4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal

(a) Do the activities target:

◉ Whole country ○ Specific Region(s) ***If so, insert a map to show where* ○ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

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

(b) **Size of population group(s) targeted in Round 8**

Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	7,640,238	National Statistical Institute	2007
Women > 25 years	2,956,318	National Statistical Institute	2007
Women 19 – 24 years	307,711	National Statistical Institute	2007
Women 15 – 18 years	178,859	National Statistical Institute	2007
Men > 25 years	2,662,093	National Statistical Institute	2007
Men 19 – 24 years	323,273	National Statistical Institute	2007
Men 15 – 18 years	188,575	National Statistical Institute	2007

(b) Size of population group(s) targeted in Round 8			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
Girls 0 – 14 years	497,661	National Statistical Institute	2007
Boys 0 – 14 years	525,748	National Statistical Institute	2007
Other **: prisoners ***Refer to the Round 8 Guidelines for other possible groups*	10,271	Ministry of Justice	2007
Other **: Refugees and asylum seekers applying for status	975	State Agency for Refugees	2007
Other **: Number of Roma population	370,908	National Statistical Institute	2001 census

4.2.2. Tuberculosis epidemiology of target population(s)			
Population Groups	**Number**	**Source of Data**	**Year of Estimate**
Estimated tuberculosis patients – shown as number per 100,000 population (*all ages)*	41 3190 / 7,693 thousands	Global Tuberculosis Control 2008	2006
Female tuberculosis patients > 25 years	862	Euro TB Country Report 2006	2006
Female tuberculosis patients 19 – 24 years	Not available		
Female tuberculosis patients 15 – 18 years	Not available		
Female tuberculosis patients 15 – 24 years	160	Euro TB Country Report 2006	2006
Male tuberculosis patients > 25 years	1830	Euro TB Country Report 2006	2006
Male tuberculosis patients 19 – 24 years	Not available		
Male tuberculosis patients 15 – 18 years	Not available		
Male tuberculosis patients 15 – 24 years	183	Euro TB Country Report 2006	2006
Notified Tuberculosis patients all forms (shown as number per 100,000 population)	42 3232 / 7,693 thousands	Global Tuberculosis Control 2008	2006
Tuberculosis patients all forms tested for HIV (rate among notified	247	Euro TB Country Report 2006	2006

4.2.2. Tuberculosis epidemiology of target population(s)			
Population Groups	**Number**	**Source of Data**	**Year of Estimate**
Estimated number new smear-positive tuberculosis patients (rate per 100,000 habitants)	18 1396 / 7,693 thousands	Global Tuberculosis Control 2008	2006
Notified new smear-positive tuberculosis patients (rate per 100,000 habitants)	17 1307 / 7,693 thousands	Global Tuberculosis Control 2008	2006
Case detection rate of new smear-positive cases	94% 1307 / 1396	Global Tuberculosis Control 2008	2006
Estimated number of multi-drug resistant cases of tuberculosis	Not available		
Estimated percentage of multi-drug resistant cases of new tuberculosis cases	11%	WHO, Bulgaria TB country profile	2006
Estimated number of multi-drug resistant cases of previously treated tuberculosis cases	38%	WHO, Bulgaria TB country profile	2006
Notified number of multi-drug resistant cases bacteriologically confirmed	53	Global Tuberculosis Control 2008	2006
Treatment success rate of new smear-positive cases	86% 1152 / 1342	Global Tuberculosis Control 2008	2005
Defaulter and transfer rate of new smear-positive cases	8% 106/1342	Global Tuberculosis Control 2008	2005
Estimated number of girl (0 – 14 years) tuberculosis patients all forms	Not available		
Notified number of girl (0 – 14 years) tuberculosis patients all forms	95	Euro TB Country Report 2006	2006
Estimated number of boy (0-14 years) tuberculosis patients all forms	Not available		
Notified number of boy (0 – 14 years) tuberculosis patients all forms	102	Euro TB Country Report 2006	2006
Other**: Notified tuberculosis patients among prisoners all forms ***Refer to the Round 8 Guidelines for other possible groups*	53	Euro TB Country Report 2006	2006

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[4] who may have disproportionately low access to tuberculosis diagnosis, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. Tuberculosis program

Describe:

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

The main weaknesses in the implementation of the current National Tuberculosis Programme, including additional support from the existing Round 6 Global Fund grant, have been identified through analysis of the programmatic and financial gaps. Accordingly, a plan has been prepared to address the challenges to achieve national targets in the following service delivery areas:

Improving diagnosis:

1. The rate of bacteriological confirmation of pulmonary TB cases remains low (48%). Medical specialists will be trained to request a bacteriological examination of sputum and culture at diagnosis in all cases before prescribing anti-TB treatment.
2. The real proportion of MDR-TB is not known. Quality-assured Drug Susceptibility Testing will be available for all cases with a positive culture.
3. DST results are available late (after reception of the culture results). To ensure timely detection and appropriate treatment of drug-resistant cases, including MDR-TB, rapid molecular testing of the resistance against H and R will be available in NRL and the 3 Level III laboratories.
4. Health care workers in laboratories and MDR-TB units will be regularly examined with annual Interferon-Gamma testing to monitor latent TB infection.

High quality DOTS:

1. Follow-up of TB patients during the ambulatory phase, if necessary with direct supervision of drug intake, is not yet performed. Patronage nurses will be trained for that and will be facilitated with transportation.
2. Contacts of infectious TB patients are not routinely examined. Procedures for contact investigations will be defined and implemented. Contacts will be traced and examined individually through tuberculin skin testing. Cases with suspicion of TB and contacts with a high risk of TB (children, immune suppressed contacts) will be offered a preventive treatment.
3. Paediatric formulation of anti-TB drugs are not available in the country (not registered). The National Tuberculosis Programme will conduct discussion with the Global Drug Facility of WHO and address this challenge accordingly.
4. Some TB treatment facilities are obsolete or inadequate. They will be rehabilitated to provide improved hospitalization conditions and meet national standards for infection control.

MDR-TB:

1. Second-line drugs are not available in the country. A request to the Green Light Committee is being prepared and it is expected to have first patients enrolled on treatment in 2009.
2. Isolation of MDR-TB patients in appropriate rooms is not possible. Rooms fitted with the necessary infection control equipments will be built in Sofia (for adults and children) and in Gabrovo.

[4] Please refer back to the definition in s.2 and found in the *Round 8 Guidelines.*

High risk groups:

1. The screening of prisoners on entry in the penitential system is not generalized. Therefore, plans include scale-up of screening activities in prisons for new prisoners and TB suspects, including active contact investigation among prisoners and prison staff.
2. The laboratory of the Specialized Hospital for Active Treatment of Prisoners in Lovech, where all TB cases are treated, is currently not performing TB diagnosis. It will be rehabilitated and provided with appropriate medical equipment.
3. Geographical coverage of specific community intervention in Roma community is not adequate. Outreach workers and community volunteers for the management of TB in the Roma community will be recruited through NGOs in additional regions. They will be trained for the management of TB cases in the Roma community.
4. Only a part of the refugees and immigrants are screened for TB. The screening in the Admission Centres will be strengthened and civil sector organizations will be actively involved in TB control.
5. Other risk groups have limited access to TB care. Staff members of the NGOs in charge of street children, IDU, homeless, immigrants, will be trained in the detection of patients with suspect TB and will cooperate with the TB network.

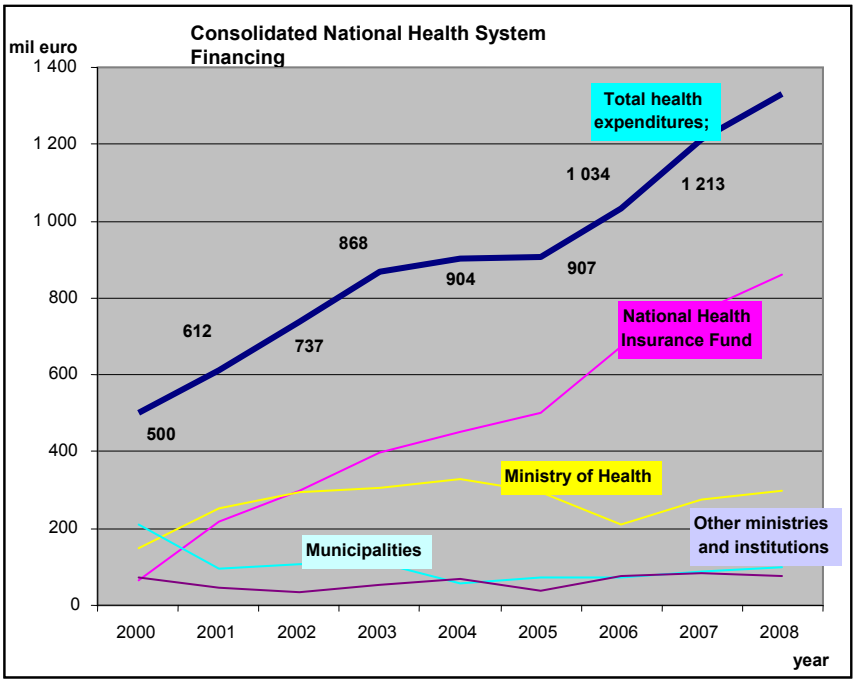
4.3.2. Health System

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

The description can include discussion of:

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

The national financial resources allocated annually for healthcare for the last years have been increasing progressively, but this happened on the background of growing inflation and negative demographic and epidemiological trends in Bulgaria as a result of the socio-economic situation in the country, unhealthy lifestyle Bulgarians lead, mostly smoking, alcohol and substance abuse, unbalanced and unhealthy nutrition (especially among ethnic minorities), etc.



The largest part of national funds (nearly 65%) comes from the National Health Insurance Fund (NHIF). On the second place (nearly 35%) is funding from the State and Municipal budgets. There also are out of pocket payments from patients for which no official data are available.

Currently the organizational structure of TB facilities providing prevention, diagnosis, treatment and care consists of as follows:

- 13 Regional TB Dispensaries for In-Patient Care;
- 7 Specialised Hospitals for Active Treatment of Lung Diseases and TB;
- 5 hospitals for prolonged treatment;
- 10 regional multiprofile hospitals that have TB departments;
- 1 psychiatric hospital with ward for TB patients;
- 1 Specialized hospital for prisoners with TB ward.

Since costs for HIV and TB diagnosis and treatment are not included in the health services reimbursed by NHIF, these are covered by the state budget. The rationale behind this arrangement is that direct financing from the state budget is allocated for diseases with social significance, including HIV/AIDS, Tuberculosis, oncological diseases and others, to ensure free and universal access to all who need it. Furthermore, there is specific legislation regulating the central procurement of medicines for such diseases by the Ministry of Health, as well as strict control over all procedures related to distribution to specialized treatment facilities, storage, prescription, usage, reporting and accounting for these medicines. Thus, all Bulgarian citizens, and foreigners entitled to the rights of Bulgarian citizens have access to free-of-charge HIV and TB treatment, regardless their and health and social insurance status[5].

The main weaknesses and gaps in the health system that affect tuberculosis outcomes are as follows:

- Ineffective coordination between TB facilities at regional and national level;
- Difficult access to quality health services especially for Roma population, street children and immigrants;
- Insufficient payment to motivate medical staff to provide quality services;
- Insufficient funding to provide specific training to medical personnel;
- Delay in establishing a comprehensive information system to monitor activities;
- Insufficient financing for preventive activities among most-at-risk;
- Inadequate infection control measures in the hospitals;
- Limited funds for modern diagnosis techniques according to international standards.

4.3.3. Efforts to resolve health system weaknesses and gaps

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

A draft National Health Strategy for the period 2008-2013 (Annex 24) has been developed in view of eliminating the identified gaps, which also includes a progressive increase in health expenses.

The strategic objectives of the health reforms for the period 2008-2013 are:

- To ensure conditions for health promotion and disease prevention To provide guaranteed health services with high quality and improved access;
- To enhance the provision of outpatient medical care
- To restructure and ensure efficient management of hospital care
- To develop human resources in the health system
- To develop an integrated e-health system
- To ensure financial sustainability of the national health system

National public health programmes, including the National Tuberculosis Programme, are aimed at decreasing incidence and mortality of most frequent diseases of high burden for the country. Still, the successful implementation of some of the planned activities depends on external support.

Implementing partners of the National Health Strategy are: the Ministry of Health, the National Health Insurance Fund, Medical Universities and colleges, the National Centre for Protection of Public Health, Regional Inspectorates for Prevention and Control of Public Health, Regional Health Centres, health facilities, GPs, NGOs, professional organizations, and other.

The goal of the National Health Strategy for the period 2008-2013 is to ensure netter health and prolong life through the principles of accessibility, equity, equality and solidarity with the active participation of all stakeholders. The National Health Strategy aims to integrate the care for the health of Bulgarian citizens in all policies – foreign affairs, national security, financial sustainability policy, social solidarity and equality policy, environment protection, education and sciences, disaster management policy and other.

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ROUND 8 – Tuberculosis

4.4. Round 8 Priorities

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

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

Priority No:	Improved bacteriological diagnosis of TB patients	Historical		Current		Country targets				
Intervention	Increase the rate of bacteriological confirmation at diagnosis for all new TB cases	2006	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		70% 2,108 / 3011	70% 1,987 / 2,839	70% 2,234 / 3,192	70% 2,234 / 3,192	70% 2,128 / 3,040	70% 2,022 / 2,888	70% 1,915 / 2,736	70% 1,701 / 2,430	70% 1,436 / 2,052
B: Extent of need already planned to be met under other programs		43% 1,307 / 3,011	48% 1,367 / 2,839	50% 1,596 / 3,192	52% 1,660 / 3,192	32% 981 / 3,040	36% 1,035 / 2,888	38% 1,039 / 2,736	35% 853 / 2,736	43% 874 / 2,736
C: Expected annual gap in achieving plans		1,704	1,472	1,596	436	2,059	1,853	1,697	1,577	1,178
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*				25% 752 / 3,040	27% 784 / 1,035	28% 766 / 2,736	33% 799 / 2,430	27% 562 / 2,052

Priority No:	Improved detection of MDR-TB	Historical		Current		Country targets				
Intervention	Provide quality-assured Drug Susceptibility Testing (DST) for bacteriologically confirmed pulmonary TB cases	2006	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		1,329	1,367	1,360	1,500	1,724	1,819	1,806	1,652	1,436
B: Extent of need already planned to be met under other programs		4% 50 / 1329	10% 141 / 1367	18% 250 / 1,360	21% 310 / 1,500	18% 310 / 1,724	17% 310 / 1,819	22% 400 / 1,806	24% 400 / 1,652	45% 647 / 1,436
C: Expected annual gap in achieving plans		1,279	1,226	1,110	1,190	1,414	1,509	1,356	1,252	736
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*				32% 560 / 1,724	48% 870 / 1,819	53% 950 / 1,806	61% 1,000 /1,652	45% 645 / 1,436

ROUND 8 – Tuberculosis

Priority No:	Increased number of contacts identified and examined for TB	Historical		Current		Country targets				
Intervention	Intensify contact tracing through increased number of medical specialists and community workers involved in contact tracing activities	2006	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		15,684	16,188	16,320	18,000	20,400	19,800	19,080	18,120	17,040
B: Extent of need already planned to be met under other programs		16% 2,575 /15,684	19% 3,044 /16,188	25% 4,080 /16,320	35% 6,300 /18,000	40% 8,160 /20,400	50% 9,900 /19,800	55% 11,448/19,800	53% 12,322/18,120	60% 12,780/17,040
C: Expected annual gap in achieving plans		13,109	13,144	12,240	11,700	12,240	9,900	7,632	5,798	4,260
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*				5% 1,020 /20,400	5% 990 /20,400	5% 954 /20,400	15% 2,718 /20,400	15% 2,556 /20,400

Priority No:	Improved detection of TB cases among high risk groups (refugees and asylum seekers, immigrants, Roma community)	Historical		Current		Country targets				
Intervention	Implement screening activities to identify TB cases	2006	2007	2008	2009	2010	2011	2012	2013	2014
A: Country target *(from annual plans where these exist)*		195,810	195,627	195,732	195,354	195,959	196,398	196,744	197,099	197,460
B: Extent of need already planned to be met under other programs		No reliable data available	No reliable data available	2% 4,130	6% 11,640	10% 19,200	14% 27,010	18% 35,170	21% 40,870	25% 48,870
C: Expected annual gap in achieving plans		Cannot be calculated	Cannot be calculated	191,602	183,714	176,759	169,388	161,574	156,229	148,590
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*				2% 3,500	6% 11,700	11% 20,700	15% 30,200	20% 40,200

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

4.5. Implementation strategy

4.5.1. Round 8 interventions

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

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

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

Tuberculosis is a socially significant disease leading to reduced capacity for work, higher morbidity and mortality and having negative impact on the financial and social stability of individuals, families and the society. The burden of this disease, and the considerable cost of treatment for severe and multidrug-resistant forms, caused the Bulgarian Government to mobilise the available resources and efforts to fight tuberculosis. Despite the fact that the Government has allocated substantial funds from its budget and the help from the GF, there still exist some resource gaps in different service delivery areas, essential for the successful implementation and achieving the goal of the NTP. In consideration of the above, the Bulgarian Country Coordinating Mechanism made a decision the country to apply under the 8-th Round of proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Objective 1: To ensure efficient management and coordination of the National TB Programme

Objective 1 is aimed at ensuring sustainability of the implementation of the National Tuberculosis Program in Bulgaria and will focus on:

1. Policy framework and partnerships at the national and local level;
2. Sustained resources – human, financial and material resources
3. Strategic planning and monitoring and evaluation activities in the field of TB

SDA 1.1: Monitoring and evaluation

The activities performed by the central management staff of the NTP will be ensure coordination of activities under different objectives, including: (1) assistance in writing and updating national guidelines, (2) training, (3) performing continuous supervision, (4) planning and (5) organizing surveys. These activities will be performed in cooperation with regional DOTS managers, laboratory specialists and national and international experts.

As a part of the implementation of the National TB Monitoring and Evaluation System, there is a need to conduct Drug Resistance Survey (DRS), which will contribute to the efficient implementation of activities under Objective 2 of this proposal.

Major planned outputs include:

- Improved routine recording and reporting and strengthen surveillance analysis;
- First Drug Resistance Survey performed as the evidence base to establish regular drug resistance surveillance in the country.
- Production of quality data and evidence base essential for programme implementation and adaptations;
- Enhanced coordination of partners at regional level

SDA 1.2: Management and supervision

Strengthening the management of the National Tuberculosis Program will ensure the proper coordination among all interventions and partners at the national, international and regional level. Achieving this Objective will facilitate the implementation of all other Objectives under the Proposal.

Major planned outputs include:

- Enhanced coordination of partners at regional level
- National TB communication strategy developed and national campaigns conducted

Beneficiaries will be the health care system, the government, municipal administrations and civil sector participating in TB control and all other partners involved in the implementation of TB control.

Objective 2: To improve the effectiveness of TB diagnosis and treatment in Bulgaria

This objective aims at limiting the spread of tuberculosis among the population by influencing the most important factors contributing to it and addressing programmatic gaps in major service delivery areas of the National TB Programme.

SDA 2.1: Improving diagnosis

An efficient and functioning laboratory network is essential to achieve compliance with WHO requirements. Strengthening the network of microbiological laboratories through establishing a hierarchical structure, including the National Reference TB Laboratory and three levels of laboratories included in the approved Round 6 proposal will contribute to improve the quality of TB diagnosis.

This proposal is intended to complement the technical capacities of the National Reference TB Laboratory (NRL) and the three regional Level III laboratories by introducing MDR molecular diagnosis for M. tuberculosis, fluorescent microscopy and second-line drug susceptibility testing and improving infection control measures. The expected outcome is improved infection control and microbiological diagnosis, increased proportion of patients with pulmonary tuberculosis having culture and quality-assured drug sensitivity testing as well as obtaining reliable figures on drug resistance and number of MDR-TB patients, who will benefit from treatment with second-line drugs.

The expected outputs at the end of the proposal include:

- all laboratories performing TB diagnosis according to highest national standards and under regular External Quality Assurance;
- increased proportion of TB patients with bacteriological confirmation at diagnosis - from 48% in 2007 to 70% in 2014;

SDA 2.2: High quality DOTS

The planned and under implementation network of regional DOTS managers, community nurses and training of GPs will increase the number of cases with early diagnosis and with adequate treatment and decrease the proportion of defaulters. Recruitment of additional nurses is needed to extend coverage in densely populated and hard-to-reach geographical areas, which was identified as a gap in the plans of the National TB Programme and Round 6 Global Fund grant.

This proposal envisages additional regular retraining and monitoring of activities of DOTS managers, nurses, other health care staff and community workers.

Investigation of all contacts of a case of infectious TB will be organised through screening questionnaires, medical examination, tuberculin skin testing, bacteriological and radiological examination if indicated. Those contacts with latent or active TB will benefit from the respective treatment.

Bridging the involvement of GPs and community nurses with key community members from the target groups in TB control activities is expected to result in:

- Improved rate of referrals of suspected TB cases for sputum testing at specialized laboratories and evaluation at the specialized TB network for diagnosis and treatment;
- Expanded screening of household members of smear positive contacts for evaluation, including TB diagnosis in children;
- Assessment of the performance of the programme during the continuation phase

The number of cases with latent TB infection among health care workers (HCW) is increasing and they are defined as an additional risk group in this proposal. A pilot survey will be performed in selected HCW in high risk (laboratory and MDR-TB treatment facility staff) to identify latent TB infection.

Major expected outcomes and outputs include:

- 709 health care workers benefiting from continuous training over the 5-year period of the proposal;
- decrease in the default rate from 7 to 3%;
- 230 laboratory and MDR-TB treatment facility staff benefiting annually from Interferon Gamma Release Assay (IGRA) testing.

SDA 2.3: MDR TB

According to data from “Global Tuberculosis Control 2008”, 53 MDR-TB cases were notified in 2006, but only 35 were confirmed by the NRL. Notified MDR-TB cases among 1, 108 new culture-positive TB patients, who received DST, were 24 (2.2%). Notified MDR-TB cases among 221 re-treatment patients, who received DST, was 29 (13.1%).

Currently, there are no second-line drugs in the country and first supply is expected in 2009 after submission and approval of GLC application for 50 patients planned for in the existing Round 6 Global Fund grant.

At the same time, WHO 2005 and 2006 estimates for Bulgaria show an increase in the percentage of MDR-TB of new TB cases from 5.6% to 11%, and in the percentage of MDR-TB of previously treated TB cases from 29% to 38%. Therefore, it is expected that the number of MDR-TB cases will continue to increase up to 70 in the last two years of the period of this proposal.

It is also imperative to improve infection control in the units for treatment of MDR-TB cases according to highest international standards, including renovation of the units, installation of negative pressure ventilation and procurement of personal respiratory protection for the staff.

Major outputs include:

- Development of national Guidelines for MDR-TB prevention and control;
- Increased proportion of pulmonary TB cases receiving quality-assured drug susceptibility testing – from 10% in 2007 to 90% in 2014.
- Procurement of additional second line drugs to ensure universal access to treatment of MDR-TB patients.

SDA 2.4: TB/HIV

Integration of related activities in the National Programmes for TB and HIV will result in improved care for co-infected patients with HIV and TB. HIV patients with active TB infection should receive adequate treatment for both diseases in the TB treatment facilities. The medical staff should be trained accordingly.

SDA 2.5: Management and supervision

Having a dedicated team in charge of planning, coordination, management and monitoring activities under this Objective will strengthen the management capacity and the monitoring and evaluation capacity of the National TB Programme.

Beneficiaries of the interventions under this objective will be TB patients and their contacts, including MDR-TB cases, household and community members, TB/HIV patients, health care workers.

Objective 3: To reduce the transmission of TB in the prisons in Bulgaria

According to data provided by the Chief Directorate "Execution of Sentences" at the Ministry of Justice, the number of prisoners in 2006 was 11,289 people. Of these, 53 were diagnosed with active tuberculosis, but only 9 were bacteriologically confirmed. This is a clear sign that TB diagnosis among prisoners needs to be improved. In 2007, when the average number of prisoners in the country was 10,271, the number of TB patients increased to 64. New pulmonary TB cases were 53, and of them 22 smear-positive TB cases were notified.

Insufficient number of the new prisoners are screened for TB at entry and TB suspects in prisons still do not benefit from timely detection and quality treatment. In spite of improved microscopy diagnosis, the proportion of bacteriologically confirmed cases among all notified TB cases in the Specialized Hospital for Active Treatment of Prisoners in Lovetch is still lower than the proportion in the general population. This will be addressed through improved screening activities, active contact investigation, training of the staff and enhanced infection control measures, including rehabilitation of the facilities.

Therefore, this Objective aims to further improve TB control at health services in prisons which are managed by the Ministry of Justice, by introducing the DOTS Strategy and ensuring their direct involvement in achieving the goals and objectives of the National TB Programme. TB control in prisons is directed by regulations issued by the Ministry of Justice, in agreement with the Ministry of Health.

SDA 3.1: High risk groups

Main strategy to address the gaps identified with regard to TB control in prisons includes the implementation of regular TB screening activities in prisons through questionnaires, sputum and radiological examination, tuberculin skin testing of all new prisoners at entry and all TB suspects. When a patient with active pulmonary tuberculosis is diagnosed, all contacts will be

examined and treated accordingly.

Major outputs include:

- Updated Guidelines for the TB care and control in prisons, including follow-up mechanisms for prisoners released before the completion of TB treatment;
- 8 000 prisoners annually screened for TB and 800 annually receiving sputum smear examination.

SDA 3.2: Improving diagnosis

The two Specialized Hospitals for Active Treatment of Prisoners (SHATP) in Sofia and Lovech, and the medical centres in all 13 prisons need repairs and equipment in order to improve diagnosis and infection control measures.

Major outputs include:

- Recruitment of specialist laboratory staff;
- Training of medical staff in aspect of TB control;
- Procurement of a fluorescent microscope for the Lovech prison hospital, ventilation systems for the sputum collection rooms, and personal respiratory protection.

SDA 3.3: Management and supervision

Ongoing monitoring and a plan for regular supervision visits will be implemented in order to ensure high quality and efficiency of TB care and control activities in all prisons in the country.

Beneficiaries will be the prison population, prison staff and the general population.

Objective 4: To increase access to TB care for high risk groups – refugees and asylum seekers; immigrants; youth at risk; injecting drug users; alcoholics

Main strategies to achieve this objective are to **increase geographical coverage** with TB screening, treatment and care activities from 13 regions planned in Round 6 Proposal to 26 regions in Round 8, as well as to **include 2 new high risk groups**: immigrants and youth at-risk in specialized institutions. Other main strategy is to achieve an effective cooperation between the NGO staff and the NTP staff at national and local level.

Activities in this proposal will contribute to increase the coverage of street children and refugees and asylum seekers with TB care through increased number of outreach workers and improved quality of services.

Under the project proposal there will also be increase in the geographical coverage of regions for work with street children from 2 (in Round 6) to 7 regions (in Round 8). According to official data (Report of the State Agency for Child Protection for 2007), the number of street children is 688 as of October 2007. In 2006 and 2007, the State Agency of Child Protection gave license to the 14 new daily centres and temporary shelters for youth at-risk in different municipalities in the country.

For the period 1993-2007, the State Agency for Refugees (SAR) reports 5,625 persons having been granted refugee status or subsidiary protection. The average annual number of new coming refugees and asylum seekers is about 1000 people. Main five countries of origin continue to be Iraq, Afghanistan, Armenia and Iran – countries with high Tuberculosis burden.

Most of the applicants for refugee status or seeking asylum, who receive refusal of such status (10,621

till the end of 2007), find ways to remain in the country for different period of time. There is no statistics available how many leave the country soon afterwards, how many remain illegally and how many find a solution to remain legally in the country mainly through a marriage to a Bulgarian citizen.

In addition to the two Reception Centres in the capital of Sofia and in the village of Banya in South Bulgaria, the State agency for Refugees recently opened a Transit Centre for approximately 300 asylum seekers next to the Bulgarian – Turkish border. This proposal will contribute to introduce screening for TB during routine medical check-up in the two centres out of the capital city, and referral for TB treatment and care when necessary.

Immigrants are identified as a target group which needs to be included both in national strategies and policies on HIV and TB prevention and control[6].

According to official data, 55,684 foreigners have been registered as having a permanent residence permit at the end of 2006, and 3,149 were newly granted this status in the same year. The number of illegal migrants though is unknown. TB prevalence in this population is unknown and access to health care is limited for most of them, for individual and structural reasons, in part related to the stigma associated with tuberculosis, poverty and social isolation.

A process of change is going into the Bulgarian institutions for orphans and vulnerable children aimed to reduce the number of institutions and to reorganize them as well as to support foster families to take care of children. More than 4000 children, aged 7-18 live in 86 institutions for children without parents all over the country. (Source: State Agency for Child Protection – Report for 2006). As the end of June 2007 the total number of the children in the specialized social institutions are 8 457. In 2006 there are 15 institutions closed in the country as a part of the decentralization process. The analysis has shown that on the one hand the changes are quite slow in the moment and on the other – the professionals in institutions are not trained in the TB care and support.

This proposal will also contribute to achieve equal access to relevant health and social services by high risk groups and ensure efficient contact investigation among the relatives of TB patients.

SDA 4.1: High-risk groups

The interventions implemented among high risk groups are aligned with the National TB Programme and aimed at facilitating the access to TB care and support activities as well as strengthening collaboration between TB outreach workers and medical specialists from TB facilities.

TB outreach workers will provide motivation, counselling, health promotion, referral and accompanying people from the target groups to TB health facilities. They will support direct observation of drug intake during treatment of TB patients in the continuation phase. Small incentives and food packages will be provided to TB patients to avoid defaulters.

Major outputs include:

- Informational materials will be developed, translated in several languages and distributed throughout the country;
- Around 18 000 people from the target high risk groups will be reached with motivation, information and counselling over the five-year proposal period;
- 8 700 refugees and immigrants will be screened for TB infection.

SDA 4.2: All care providers

Activities aimed at engaging all care providers in the provision of quality TB care will focus on training, legislation change in the area of health and social services, printing and distribution of informational materials for medical specialists and social workers working with the target groups.

It is crucial also to involve social service providers and municipal authorities in the implementation of

the overall activities to reduce the stigma among high-risk groups.

Major outputs include:

- A total of 360 medical staff from state and private methadone maintenance and dependence treatment centres and social workers in specialized institutions for youth at-risk will be trained;
- Legislation related to the provision of TB care in the light of social services will be changed accordingly.

SDA 4.3: Advocacy, communication and social mobilization

Main activities in the areas of peer education and patient empowerment among representatives of the high-risk groups will contribute to achieve the following:

- 120 peer educators prepared to support TB programme activities
- the international Patient's Charter will be translated and disseminated all over the country.

SDA 4.4: Community TB Care

40 community workers from the high risk groups will support screening, treatment and care activities. Community work includes also awareness raising, social mobilization. Training and involvement of representatives of the high-risk groups will further enhance performance of the efforts made by outreach workers and medical staff from the TB facilities.

Major outputs include:

- Development of indicators to measure community involvement, reporting forms and registers;
- 40 community workers will be trained to work specifically with refugees and migrants

SDA 4.5: Management and supervision

Efficient management and coordination of the activities among high risk groups at national level and regional level are essential to achieve the desired outcomes. Supervision visits performed from the national to the regional level will ensure quality of TB care and enhanced performance of local TB outreach workers.

Objective 5: To increase the coverage of the Roma population with efficient community TB care

The official 2001 census data on the number of Roma population in Bulgaria is 370,908. However, the estimated number of Roma population in Bulgaria varies up to 800,000 people or approximately 10% of the country population based on the fact that some of the Roma people identify themselves as Turks or Bulgarians.

The information available indicates Roma community as one of the communities in high risk in Bulgaria. Poverty rate among Roma population is 11 times higher than that among ethnic Bulgarian population. The unemployment level among Roma people is between 70% and 90% and about 46 % of them do not have health insurance which makes their access to medical doctors and health care services very difficult.

Tuberculosis among Roma people often occurs together with other chronic diseases which further increases the risk of transmission of the infection. According to a recent rapid assessment carried out in seventeen big cities in Bulgaria, Roma TB patients represent 50% of all TB cases which suggest high TB incidence and prevalence rate in this community.

These challenges will be addressed through a specific strategy for provision of community TB care and

enhanced mechanisms for cooperation with

SDA 5.1: Community TB care

Ensuring professional standards and recruitment procedures will be performed by a team of experts contracted by the Principal Recipient.

40 Roma community workers from NGO sub-recipients in 18 new regions will perform screening to identify TB suspects; referral to TB health facilities for detection of new smear positive cases in Roma community; support to DOT for TB patients in the continuation phase; specific counselling and motivation to families and close contacts; education activities in Roma community with respect to TB treatment, prevention and support.

Incentives and transport vouchers will be provided to TB patients on treatment in the continuation phase in order to substantially decrease the number of defaulters.

Major expected outputs include:

- Provision of continuous training of service provision to maintain the quality and efficiency of TB care in Roma community;
- 31 000 Roma people will be screened for TB risk over the five-year period of the proposal;
- 4 600 Roma are expected to be referred to TB health facilities for sputum or other medical examination;
- 2 950 TB patients form Roma community are expected to be supported during treatment in the continuation phase.

SDA 5.2: Management and supervision

Roma community workers will be employed by local NGO sub-recipients with relevant implementing capacities.. They will work in close cooperation and under the supervision of the relevant regional TB health facilities.

Ongoing monitoring and supervision visits once per year for the new 18 regions will be provided by a team of experts appointed by the Principal Recipient.

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

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

Not applicable.

4.5.3. Lessons learned from implementation experience

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

The implementation plans and activities outlined in the detailed proposal strategy are designed so as to address main challenges to achieve national targets identified through a comprehensive review of the National TB Programme and the existing Round 6 Global Fund grant in the country.

Round 6 TB Grant Agreement was signed on 3 September 2007 has start date 01 November 2007 which made it impossible to align GF-funded programme planning, implementation and reporting cycle to the fiscal year in the country and the planning and budgeting periods of the National Tuberculosis Program. Though a lot of preparatory work was performed (drafting

national guidelines, drafting reporting and recording tools, preparation of procedures for selection of sub-recipients and other), actual implementation of most of the activities as procurement of essential goods and contracting services (translation and printing of materials, organization of training and consensus meetings) could start only in April 2008 after the ratification of the Grant Agreement by the Parliament. Due to this reason, Phase 1 ending date was extended from 31 October 2009 to 31 December 2009.

Furthermore, several important preparatory outputs, as restructuring the laboratory network in three levels, and adoption of new national guidelines for diagnosis and treatment are dependent on time-consuming legislative changes.

The Round 6 proposal includes a number of preparatory activities essential to assure the implementation and efficient programmatic management. Therefore, the Round 8 proposal is designed not to double these activities.

An important bottleneck in the implementation of the Round 6 grant is the staffing levels which are critical in some regions. The National Reference TB Laboratory is also understaffed which makes it difficult to implement a full roll-out of on-site supervision to the regional level. Therefore, Round 8 proposal plans include recruitment of additional laboratory staff in NRL and the 3 Level III Laboratories which will perform quality-assured DST. Recruitment of 10 additional nurses is planned to extend coverage of TB care in densely populated and hard-to-reach geographical areas.

Geographical coverage with service delivery for high risk groups was insufficiently planned in Round 6 and will be increased in Round 8 in order to cover all country regions as needed. 40 members of the Roma community will be engaged to work among the Roma population and provide such services in the rest 18 regions not covered in Round 6.

A number of implementation bottlenecks were encountered in the Round 6 grant when analyzing the targets and coverage of the activities. There are 3 new high risk groups not included in Round 6 proposal: health care workers, immigrants and youth at risk. They have been included in the new proposal and indicators have been put to measure the progress of the

One of the major weaknesses identified in the NTP is the capacity to generate and use quality surveillance data for continuous program improvement. While improvements have been made, this weakness still exist.

4.5.4. Enhancing social and gender equality

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

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

Increasing access to TB care for high risk groups under this proposal is essential for achieving national strategic goals.

Major barriers to access to health care services for refugees and immigrants, and particularly women, are related to cultural, religious, and language differences. They often do not seek medical services due to lack of knowledge about the disease, lack of information about the healthcare system in the country and cultural constraints. To ensure better access and gender equality in service provision for this group, men and women among immigrants will be recruited as community workers. Informational materials in different languages will further contribute to increase awareness and understanding of the TB disease, the risks connected with it, and the places where specialized TB care services can be provided.

In the Roma community, women face more vulnerabilities than men. Empowerment of women and emphasis on their role to care for their own health, the health of their children and families, will be one of the aspects of outreach work. Support to TB patients and their contacts and relatives

will be largely scaled-up in terms of geographical and population coverage.

Stigmatization of TB patients, low level of literacy and insufficient patient counselling and motivation are often among the causes of termination of treatment and unfavourable treatment outcomes. These issues will be firstly addressed through the training curriculum of the medical specialists, outreach and community workers. Networking between public health services, NGOs and community representatives, as well as targeted national campaigns and mass media events will further address issues related to insufficient information, stigma and discrimination both to high risk groups and TB patients.

Ensuring free-of-charge TB diagnosis and treatment for the general population, and particularly for high risk groups, is the basis to ensure social equality in service delivery.

4.5.5 Strategy to mitigate initial unintended consequences

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

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

The main reasons to proceed with a request on a disease specific basis may be outlined as follows: finding some programmatic gaps after the review of the approved NTP 2007-2011 and the still insufficient capacity of the existing network of health care facilities and personnel directly involved in the management and control of TB with regard to:

(1) planning and coordination of TB related activities, (2) need of further updating equipment in diagnostic laboratories, (3) increasing deficiency of qualified microbiologists and technicians in TB laboratories, (4) lack of trained and motivated health care (managers, nurses), social and community workers involved in tracing and follow-up of treatment of TB cases, (5) need of extended coverage, better defined focused activities in the risk groups, and partnership building at the community level.

As a consequence of these existing gaps incidence of TB is 39.1 / 100 000 in 2006 compared with 25 / 100 000 in 1990, culture confirmation is in less than 50% of all TB cases, quality-assured DST (<15%) is more an exception than a rule, tracing and coverage by examination of contacts remains unacceptably low, default rate is 7%.

The means of motivation and the improved working conditions of DOT managers, patronage nurses and community workers in this proposal may be considered as having potentially disruptive consequences. This is expected to cause only minor difficulties in the collaboration with the others involved in TB control in the same health care facilities. However, this approach in unavoidable and justified in view of the current structure of the health care facilities for TB management in the country.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

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

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

The activities planned under the round 8 are based on the gaps analysis for the implementation of Round 6 Proposal and the National TB programme. The newly requested support is related to improvement of the effectiveness of TB diagnosis and treatment in Bulgaria, TB care for the risk groups, infection control and care for TB patients in prisons. Certain programmatic gaps were identified after detailed review of the planned activities and outputs.

Objective 1: To ensure efficient management and coordination of the National TB Programme

The main activities under Round 6 will be continued during year 4 and year 5 under Round 8 and there is no overlap of the two proposals. While Round 6 Global Fund grant aims at establishing the basis for the overall management, coordination, monitoring and evaluation systems, Round 8 proposal aims to ensure sustainability, effective implementation of the NTP and improved coordination between all stakeholders in the country.

Objective 2: To improve the effectiveness of TB diagnosis and treatment in Bulgaria

Microscopy laboratories play a key role in TB diagnosis. An efficiently functioning laboratory network, as established under Round 6, should be maintained according to WHO requirements. This will be done by a hierarchical structure comprising a National TB Reference Laboratory, three regional Level III laboratories for DST and two further levels of laboratories for traditional cultures and smears only.

The most important steps to improve laboratory diagnosis identified in Round 8 proposal include: intensifying staff training and supervision, providing additional equipment and medical supplies, aiming at assessing the sensitivity of strains from all TB patients. The quality of laboratory work will be ensured by adhering to well-established standard operating procedures, setting up a National system for external quality assurance, and linkage with a Supranational Laboratory. The infection control measures for the protection of the staff working in the laboratories should be reinforced.

A major problem is the identification and late detection of infectious cases. This issue has been addressed in the approved Round 6 proposal through the involvement of GP's in referral and timely detection of new cases and patronage nurses in tracing the contacts and ensuring the adequate treatment during the continuation phase. However, an insufficient number of nurses have been planned for the largest densely populated urban areas (Sofia city, Sofia district, Plovdiv, Bourgas and Varna). Another problem, arising from unforeseen and uncontrollable circumstances is the decreasing number of nurses as a whole in the country, increasing the demand and incentives from other health care facilities and as a result - lack of motivation to work in the field of TB control. In Round 8 proposal, it is planned to resolve these issues through extended training, retraining and motivation of additionally recruited staff, which was not originally planned. TB contact tracing will be scaled-up and intensified through networking of patronage nurses and key community members in the target groups.

An important aspect in achieving the goals and objectives of the National TB Programme /NTP/ is the planned decentralizing of its management. The assigned 28 regional managers have to receive regular re-training in the high-quality provision of DOTS. A provision has also to be made for training of new regional managers replacing those already trained and leaving the system for

different reasons. These points have not been included in the approved Round 6 proposal.

Multi-drug resistance is an important and a very serious challenge to TB control that has been addressed in the existing Round 6 grant. However, certain issues have not been planned for. One of them is the need to prepare and distribute Guidelines for the management of MDR-TB patients as well as provide regular training of the medical staff in charge of these patients. Another issue which is addressed in Round 8 proposal is the need to ensure separate hospitalization rooms and proper renovation of the hospitals where the MDR-TB cases will be treated. An important consideration in facing the challenge of MDR-TB, is to perform a national drug resistance survey. Round 6 application to the Green Light Committee will be presented in 2008 to ensure access to second-line drugs that have not been included in the Bulgarian Positive List. Round 8 proposal plans include procurement of second-line drugs for the last two years or beyond the timeframe of the Round 6 proposal.

Objective 3: To reduce the transmission of TB in the prisons in Bulgaria

This objective aims to sustain tuberculosis control in medical services in prisons by expanding the DOTS strategy and continuing the activities started under Round 6 Global Fund grant.

Round 8 will contribute through updating the Guidelines for the management of TB in prisons with additional aspects of TB care.

In addition to the establishment of separate sputum collection rooms in Round 6, diagnosis of TB cases will be improved in Round 8 by rehabilitation of the laboratory at the Lovech Prison hospital and by procurement of fluorescent microscope for performance of bacteriologic tests. The laboratory will be staffed with a laboratory specialist, who is currently not available to perform the tests.

In Round 8 proposal, case detection will be improved by active screening through a TB questionnaire, tuberculin skin test and routine radiological examination among the new coming prisoners and TB suspects among the inmates, which were not well-planned in Round 6. All contacts of the smear-positive patients will be examined and treated if needed.

Financial resources for repairs and equipment in the two specialized hospitals for active treatment of prisoners (SHATP) in Sofia and Lovech, were not adequately planned in the Round 6 proposal. Therefore, additional repairs and medical equipment are planned under Round 8 to improve infection control measures (such as ventilation systems for sputum collection rooms and personal respiratory protection for the medical specialists and prison staff).

Round 8 proposal activities under this Objective will extend training, and continue to support coordination, management and monitoring activities after expiration of the Round 6 grant.

Objective 4: To increase access to TB care for high risk groups – refugees and asylum seekers; immigrants; youth at risk; injecting drug users; alcoholics

Activities targeting high risk groups will increase the coverage of the targeted population under Objective 4 of Round 6 Proposal through covering new country regions. In the Round 8 proposal, two new groups are also included – immigrants and youth at-risk in specialized institutions. The new high risk groups that will benefit from the proposed activities are: immigrants (in 6 regions) and youth-at risk in specialized institutions. The geographical coverage for refugees and street children under the Round 6 Proposal will be enhanced - refugees and asylum seekers from 1 region to 3 regions (all over the country), street children from 2 regions to 7 regions (5 new regions under Round 8).

Round 6 outreach activities targeting injecting drug users and alcoholics will not be extended geographically. However, Round 8 activities will focus on human resources development and updated information materials. in order to achieve sustainability in the field of TB control in these groups.

Round 8 further plans for facilitating the access of high risk groups to health care by recruiting community workers, health promotion, provision of information, development of ACSM strategies, sensitization of the community and appropriate use of media are considered

necessary to address cultural, language and other barriers. The activities will be implemented in close cooperation with the activities under the Objective 2 of the Proposal.

Objective 5: To increase the coverage of the Roma population with efficient community TB care

All planned activities to the benefit of the Roma community under Objective 5 of this project proposal are intended to extend but not duplicate activities planned under Round 6 Global Fund grant. Funding from Round 6 is sufficient to cover only 10 regions. The activities under Round 8 proposal are planned to increase geographical coverage interventions in 18 additional regions. The coverage of Roma communities in all 28 regions will contribute to decreasing the TB burden in Bulgaria.

At the same time, there are activities performed during Round 6 proposal which will be the adequate basis for further activities under Round 8 proposal, such as the development of guidelines for Roma community workers; development of guidelines for screening for TB the Roma community; development of a health education strategy for the Roma community based on the situation analysis in this community; publishing educational materials. These rules and instructions specially developed under Round 6 proposal will be used in Round 8 proposal.

There are some links with other activities directed to risk groups¸ such as the currently implemented Programme Prevention and Control of HIV/AIDS, funded by the Global Fund. Under Objective 5 (HIV Prevention among the Roma Community) were established health and social centres in the Roma neighbourhoods in the eight largest Roma communities. Some of them will serve as supportive environment for the activities provided in this project.

4.6.2. Links to non-Global Fund sourced support

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

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

No other external funding or donor resources are allocate to support TB activities in the country.

4.6.3. Partnerships with the private sector

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

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

Not applicable.

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

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?*) ➔	***Not applicable.***
Contribution Value (in USD or EURO) *Refer to the Round 8 Guidelines for examples*	

Organization Name	Contribution Description (in words)	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Not applicable	*Not applicable*	*Not applicable*	*Not applicable*	*Not applicable*	*Not applicable*	*Not applicable*	*Not applicable*

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved tuberculosis outcomes

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

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

Each objective of this Proposal has a substantial role in contributing for the overall strengthening of the capacity to achieve improved tuberculosis outcomes, as follows:

Objective 1 “To ensure efficient management and coordination of the National TB programme” has the crucial role in sustainability of the policy frameworks; surveillance system; human resources at national level and strategic planning.

Objective 2 is aimed at strengthening the technical capacities of the laboratory network in order to ensure reliable identification of TB infection, assessment and control of TB drug resistance; enhancement of the networks of regional DOTS managers and community nurses aiming to increase the number of cases with early diagnosis; scale-up the activities related to medical education for laboratory staff and nurses.

Under objective 3, 4 and 5 will be achieved sustainable TB outcomes for high risk groups in the country. The activities planned under objective 4 and 5 are linked to the implementation of the overall goal of the proposal. The work among high risk groups will be performed together with the medical staff from the local TB facilities, civil society, governmental organizations and municipal authorities. The key output will be establishment of supportive and coordinated partnership at local level and ensuring access to TB diagnosis and care for high risk groups. The main strategies that will be applied are training for different specialists; community work; support for the TB patients among high risk groups; enhancing the capacity of the NTP staff.

The above mentioned steps to be undertaken aim to achieve:

Financial Sustainability - the mechanisms and approaches will be introduced to increase the level of state and local funding for diagnosis, treatment and support services for TB patients and their relatives.

Monitoring and evaluation system strengthening - this will be achieved in different aspects between all stakeholders at all level – governmental sector, municipal authorities and civil sector. A strong emphasis will be put on establishing and rolling out a National Surveillance and M&E System, in which all key stakeholders from government and civil society will participate.

Civil society involvement – the main focus will be put on the strengthening of the institutional and managerial capacity of NGOs through training of the key staff in TB case motivating, counseling, support during the continuation phase, human rights protection, community development; specific knowledge and attitudes on the vulnerable groups etc.

4.7.2. Alignment with broader developmental frameworks

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

This Proposal has been aligned with the targets in Bulgaria's Millennium Development Goals and the WHO Stop TB Strategy and the Global Plan to Stop TB 2006-2015.

In 2003, the first National Report "Millennium Development Goals – Bulgaria 2003" was released and presented; it adapts the Millennium Goals to the Bulgarian context and sets forth concrete targets till 2015 as well as the indicators for measuring the results.

The Millennium Development Goals Report sets the Goal 1: Halve extreme poverty and malnutrition. This will have significant effects on achieving TB control.

There are two major targets for TB included in Goal 6: Limit the spread of HIV/AIDS, syphilis and tuberculosis:

- to reduce incidence from 48 per 100,000 in 2002 to 20 per 100,000 in 2015;
- to increase the number of successfully cured TB patients under DOTS from 70% in 2002 to 83% in 2015 while ensuring complete coverage of the country and high-quality application of DOTS.

The Millennium Development Goals Report sets the specific tasks to improve TB control in Bulgaria which are also included in the National Tuberculosis Programme 2007-2011. These include:

- Improving quality control and bacteriology laboratories
- Improving the flow of information from the periphery to the centre
- Decreasing the number of retreatment cases and defaulters in order to control the spread of the disease
- Preventing the development of MDR-TB by providing adequate treatment of all patients with anti-TB drugs and follow-up of all TB patients until the final completion of treatment.

The National Programme for TB Prevention and Control in Bulgaria (2007-2011) and its Action Plan are being developed in line with the WHO Stop TB Strategy and the Global Plan to Stop TB 2006-2015.

Bulgaria participated the WHO European Ministerial Forum "All against Tuberculosis" on 22 October 2007 in Berlin, Germany, and signed the Declaration on Tuberculosis, which describes the disease as "an increasing threat to health security in the WHO European Region". The agenda of the Forum addressed current challenges facing health systems in responding to TB and achieving Target 8 of Millennium Development Goal (MDG) 6: to have halted and begun to reverse the incidence of TB by 2015.

Bulgaria is included in "The Plan to Stop TB in 18 High-priority Countries in the WHO European Region, 2007–2015", prepared by the WHO Regional Office for Europe. It describes the main challenges, opportunities, strategies and interventions to control TB in the Region's 18 high-priority countries: Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, the Republic of Moldova, Romania, the Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan. The Plan aims to reduce illness and death caused by TB, while contributing to poverty reduction, by:

1. achieving, sustaining and exceeding the targets of 70% detection of sputum-smear positive cases and 85% treatment success rate of these cases under DOTS; and
2. ensuring universal access to high-quality care for all people with TB, especially the poor and marginalized.

Bulgaria will also implement the Framework Action Plan to fight TB in the European Union. This plan was developed by the European Centre for Diseases prevention and Control (ECDC) and provides direction on what needs to be done in the EU Member States, Norway, Iceland and

Liechtenstein (EEA/EFTA countries), whether at national or at the Community level. It is in line with the United Nations' Millennium Development Goals and the WHO Stop TB Strategy.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

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

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

Major activities to strengthen in-country systems to monitor progress towards tuberculosis outcomes have already been planned and started under the Round 6 TB Global Fund grant. These are as follows:

- Draft recording and reporting tools to improve and timely data collection and analysis have been developed in compliance with the latest recommendations of WHO, the IUATLD and the Stop TB partnership
- The development of National TB Monitoring and Evaluation Plan in close collaboration with all stakeholders will contribute to measuring the progress in achieving the Millennium Development Goals;
- The establishment and support of an Expert Group on TB Monitoring and Evaluation will ensure a transparent and comprehensive consultative process, guidance and coordination with other national monitoring and evaluation strategies;
- Key technical assistance is included under Objectives 1 and 2 to strengthen the monitoring and evaluation capacity of the National TB Control Programme;
- Close linkage will be established between the information systems to monitor performance of the National TB Control Programme, the National Program for Prevention and Control of HIV/AIDS, and the National Health Strategy;
- Improved TB surveillance will ensure reliable data for evidence-based planning and management decision taking.

Major weakness remains the collection of aggregate data from the regional to the central level. The development of operational procedures for data collection, case notification and reporting from the peripheral to the central level will be developed and an information system for TB surveillance based on individual data will be established. The information system will also contribute to obtain more reliable data on TB incidence rate and treatment success rate, sputum conversion rate at the end of the initial phase.

4.8.2. Avoiding parallel reporting

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

This proposal is designed so as to use and contribute to the update of Round 6 reporting tools, information flows and systems, which will form the basis of the national TB surveillance and programmatic progress monitoring system.

The selected indicators in the Performance Framework (Attachment A to this proposal) are constructed to be fully aligned with national TB programme and Round 6 GF grant measurement indicators. Target setting for most process and output indicators will allow:

- Both reporting separately on each grant and cumulating the results under the two grants and feeding them into the national TB M&E system;
- Ensuring unified reporting on outcome and impact indicators.

4.8.3. Strengthening monitoring and evaluation systems

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

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

Further improvements to the M&E system in the country are included under Objective 1 of this proposal and consist of:

- Updating recording and reporting tools, guidelines and systems;
- Continuous training of Principal Recipient and Sub-Recipients staff in M&E, data collection, storage and analysis;
- Conducting the first Drug Resistance Survey as the evidence base to establish regular drug resistance surveillance in the country;
- Receiving international technical assistance in survey design and data analysis;
- Performing continuous supervision to verify data and quality of service provision.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

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

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

PR 1	Ministry of Health of the Republic of Bulgaria
Address	5 Sveta Nedelia Sq., Sofia 1000, Bulgaria

Currently, the Principal Recipient has already established an adequate capacity to manage Grant financed by the Global Fund grants in five major areas as follows:

1) With regard to Financial Management and Systems, the Principal Recipient has ensured:

- A well-established organizational structure for financial management and reporting, as well as documented roles and responsibilities for the management of Global Fund resources
- Qualified, experienced and motivated staff at the Financial Management and Reporting Unit at the Program Management Unit, supported on a daily basis from the MoH „Budget and Accounting" Directorate;
- Specialized software modules for financial management and procurement and supply management for separate GF grants operate effectively and this allows control over the funds disbursed to the numerous sub-recipients
- Mechanisms are in place to manage properly all financial documents according the requirements of the Global Fund
- Strict and properly documented rules and procedures are in place for costing and detailed budgeting; the budget includes breakdowns for each Sub-recipient
- Mechanisms are in place for regular inventories of tangible assets acquired with Global Fund funds, as well as an adequate level of insurance
- Efficient mechanisms are in place to hire an independent auditor for the annual financial audit of the Principal Recipient and Sub-recipients; in addition, external control on the GF Grant management is exercised by the National Audit Office and the Public Internal Financial Control Agency;

2) With regard to Institutional and Programmatic Capacity, the Principal Recipient has ensured:

- The Minister of Health is the authorized representative of the Principal Recipient, and the Ministry of Health Secretary is responsible for administrative control over Global Fund Programmes which ensures political support. A mechanism for signing Grant Agreements with the Global Fund, adoption of Grant Agreements by the Parliament and promulgation in the State Gazette is in place
- The Program Management Unit works in close cooperation with the key bodies like Expert Boards, National

Committees and Agencies related to the national Tuberculosis policies
- Detailed job descriptions of the key PMU staff are in place and also operational procedures were developed for communication with Sub-recipients and rules for annual plans and budgets;
- Coordination of programme activities with other national, regional and international initiatives implemented in the country;

3) With regard to the Sub-recipients management
- the PR has built management capacity of to evaluate sub-recipients under GF grants, to provide training and build on technical support to improve their capacity to provide better quality of services;
- PR gained experience in establishment and using of management system that assures control over the sub-recipients and allows transparent partnership and support between the SRs and the PR;
- Mechanisms and experience in carrying out the regular supervision of Sub-recipients in order to ensure the quality of services provided to target groups

4) With regard to Procurement and Supply Management, the Principal Recipient has ensured:
- A well-established unit responsible for Global Fund Grant procurement is working in close cooperation with the „Investment Policy" Directorate under the Ministry of Health, which is in charge of procurement and supply under the National TB Programme
- Experience gained in contracting and procurement management under the Public Procurement Act, including tools to implement the VAT exemption according to the Grant Agreement with the Global Fund and this is very important strength of the unit with respect to supply centrally procured goods and health products to Sub-recipients
- Well-established mechanisms for product quality assurance at the lowest procurement prices;
- A well-established Procurement Management Information System for Global Fund grant resources;
- Sufficient storage facilities for the storage of drugs and medical consumables at all levels of the chain of distribution

5) With regard to Monitoring and Evaluation, the Principal Recipient:
- Monitoring and Evaluation Unit within the PMU is responsible for coordinating M&E efforts under the Programme with national and international M&E efforts
- The M&E unit has experience in the collection and analysis of data on programme progress, including well-established mechanisms for reporting and flow of information at various levels;
- The PR developed various registration and reporting tools in place which guarantee confidentiality and informed consent in the provision of specific services and carrying out surveillance research;
- The PR is experienced in organizing and conducting continuous supervision to ensure quality of service provision under Global Fund grants.

PR 2 [Name]

Address [street address]

[Description]

PR 3 [Name]

Address [street address]

[Description]

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

4.9.2 Sub-Recipients

(a) Will sub-recipients be involved in program implementation? ☒ Yes ☐ No

(b) **If no**, why not?

(c) **If yes**, how many sub-recipients will be involved?

- ☐ 1 – 6
- ☐ 7 – 20
- ☐ 21 – 50
- ☒ more than 50

(d) Are the sub-recipients already identified?
(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)

- ☒ Yes
  [Insert Annex Number for list]
- ☐ No
  Answer s.4.9.4. to explain

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

28 TB health facilities (one in each country region) that will be contracted as Sub-recipients are identified. NGOs to be involved in implementation at regional level have to be selected according the procedure described in section 4.9.4.

4.9.3. Pre-identified sub-recipients

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

It is envisaged that **28 health facilities, which currently participate in TB control, as key sub-recipients** will be contracted to implement activities set in this proposal in order to achieve national coverage of TB patients.

The **main challenge for key sub recipients** is to reach high risk groups and trace TB suspects; to perform direct observation in the continuation phase of treatment for all TB patients; motivation and counselling of families and relatives of TB patients to help avoid defaulters; motivation and follow-up of the chemoprophylaxis of all TB contacts. The abovementioned difficulties for TB facilities are planned to be overcome through active involvement of experienced outreach workers from the NGO sector.

4.9.4. Sub-recipients to be identified

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

In order to ensure that reliable and efficient NGOs are contracted as Sub-recipients, and that processes related allocation grant funds are transparent and documented, the following NGO selection procedures will be followed:

- a call of interest for NGOs will be organized to implement proposal activities broadcast through national and local media;
- a selection committee established to this purpose will evaluate the document packages received by NGOs based on the principle of open competition and according to clear set of criteria;
- NGOs selected to implement proposal activities will be approved by CCM.

To meet selection criteria, NGO Sub-recipients will generally have to:

- Provide documented evidence of their legal status;
- Provide strong evidence of implementing and management capacity, including internal operational procedures;
- Demonstrate prior successful implementation of donor-funded projects;
- Demonstrate ability to absorb increased financial resources and evidence mechanisms for ensuring financial accountability;
- Evidence sufficient staffing to implement proposal activities and cover the target group;
- Evidence relevant experience in the work with the target groups;
- Demonstrate understanding of and readiness to address issues related to human rights, gender equality and equity in access to services, including approaches to stigma reduction;
- Demonstrate that the implementation of proposal activities related to risk groups will focus community involvement;
- Demonstrate ability for networking with other key implementing partners from other sectors;

This selection process has already been applied to NGOs Sub-recipients of Program “Prevention and Control of HIV/AIDS”, implemented with a Round 2 Global Fund grant, and has proven to be successful and efficient approach for selecting among 85 applications. The same procedure is currently prepared for selection NGO Sub-recipients under the Round 6 Tuberculosis Global Fund grant.

4.9.5. Coordination between implementers

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

Comment on factors such as:

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

this proposal, if relevant).

Since the Ministry of Health is the only Principal Recipient selected, it will be responsible for:

- day-to-day organisation and management of the proposal activities;
- financial management and reporting, including accountability and control over funds disbursed to Sub-recipients;
- centralized system for procurement and supply management in order to ensure payments for duties and taxes from the State Budget;
- monitoring and evaluation of the programme implementation, including development and improvement of tools to track programmatic progress achieved by sub-recipients;
- prepare quarterly and annual reports on the program performance, and to present them to CCM and GF, and prepare periodic disbursement requests.

Several mechanisms for coordination between the Principal Recipient and Sub-Recipients have been identified and put in place in order to ensure timely and transparent programme performance:

- quarterly meetings between the Principal Recipient (PMU) and Sub-recipients to discuss challenges and achievement in programme implementation;
- annual national consensus meetings to discuss National TB Programme performance;
- regular on-site supervision visits to directly observe service provision and help problem solving at the local level;
- enhanced networking between public regional health institutions subsidiary to the Ministry of Health and non-governmental organizations.

As key partners TB facilities, will be supported by NGOs. With view to more effective coordination at regional level it is envisioned TB health facilities to contract NGOs as sub-sub recipients and to be responsible for outreach activities. In this way the effectiveness of program implementation will be increased and at the same time the non-governmental sector will be actively involved.

The role of the NGO sector is very important in terms of outreach work to reach high risk groups who are not covered by TB treatment facilities in order to trace TB suspects in these groups; support screening for TB cases among high risk groups; tracing, counselling and referral, including accompanying, of TB suspects and cases among the risk groups, to specialised TB facilities for further examination and treatment; support to TB health facilities to perform direct observation in the continuation phase of treatment for all TB patients; motivation and counselling of families and relatives of TB patients to help avoid defaulters; motivation and follow-up of the chemoprophylaxis of all TB contacts.

4.9.6. Strengthening implementation capacity

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

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

(a) the assistance that is planned;**

(b) the process used to identify needs within the various sectors;

(c) how the assistance will be obtained on competitive, transparent terms; and

(d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

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

Major assistance to enhance implementation capacity includes:

- provision of international consultancy in specific areas on a competitive basis;
- intensified training in different aspects of TB programme management and TB service delivery;
- strengthening of local networks between public health institutions, NGO, other civil organizations and representatives of high risk groups.

The processes to identify needs of various sectors include in particular:

- meeting with representatives of the State Agency for Child Protection to identify needs related to TB care among youth at risk in specialized institutions;
- meetings with representatives of the State Agency for Refugees and the Refugee-Migrant Services at the Bulgarian Red Cross to identify needs related to TB care for the group of refugees and migrants;
- comprehensive review of reports and small proposals submitted for integration in the country Round 8 proposal to identify specific activities, resources and indicators for TB care in Roma community to be implemented both by health facilities and civil sector organizations.

To evaluate the effectiveness of the assistance to strengthen implementation capacity, client satisfaction will be introduced and measured as part of standard supervision and quality assurance.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 proposal

Does this proposal seek funding for any pharmaceutical and/or health products?

☐ **No**
➔ ***Go to s.4B if relevant, or direct to s.5.***

☉ **Yes**
➔ ***Continue on to answer s.4.10.2.***

4.10.2. Table of roles and responsibilities

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

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	Ministry of Health	Principal Recipient	☐ Yes ☉ No
Intellectual property rights	Patent Administration	Principal Recipient	☐ Yes ☉ No
Quality assurance and quality control	Ministry of Health Bulgarian Drug Agency	Principal Recipient	☐ Yes ☉ No
Management and coordination ***More details required in s.4.10.3.***	Ministry of Health Project Management Unit	Principal Recipient	☐ Yes ☉ No
Product selection	Ministry of Health Project Management Unit	Principal Recipient	☐ Yes ☉ No
Management Information Systems (MIS)	Ministry of Health Program Management Unit	Principal Recipient	☐ Yes ☉ No
Forecasting	Program Management Unit	Principal Recipient	☐ Yes

			☒	No
Procurement and planning	Program Management Unit	Principal Recipient	☐	Yes
			☒	No
Storage and inventory management *More details required in s.4.10.4*	Program Management Unit	Principal Recipient	☐	Yes
			☒	No
Distribution to other stores and end-users *More details required in s.4.10.4*	Program Management Unit	Principal Recipient	☐	Yes
			☒	No
Ensuring rational use and patient safety (pharmacovigilance)	Ministry of Health Program Management Unit Health institutions	Principal Recipient	☐	Yes
			☒	No

4.10.3. Past management experience

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

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
Program "Prevention and control of HIV/AIDS" at the Ministry of Health	PR	ARV & OI Drugs **174 215 EUR** Med. consumables and tests **65 382 EUR** Medical Equipment **116 522 EUR**
Ministry of Health	PR	Drugs (Total) **21 297 576 EUR**

[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]

4.10.4. Alignment with existing systems

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

The health products procured under the Program are in full compliance with the Essential Medicines List of the WHO (EML of WHO) and the List of Health Products permitted for distribution on the territory of the country by the Bulgarian Drug Agency (http://www.bda.bg/web_engl/main.htm), which guarantees the quality, effectiveness, and safety of these medicines.

The Bulgarian Drug Agency has signed a contract with the European Medicines Executive Agency (EMEA) within the framework of the PHARE Program and carries out the following activities in strict compliance with all international standards in this area, such as GMP, CPP, etc.:

- issues permits or licenses for the manufacturing of medicinal drugs;
- tables proposals to the Minister of Health for the issuance of licenses for the use of medicines and their wholesale trade;

- carries out chemical and pharmaceutical examinations for the purposes of quality assessment in connection with the issuance of licenses for the use of medicines, and registers the clinical trials of drugs held in this country;
- carries out the registration of pharmacies;
- coordinates drugs imports and issues the respective home sales permission;
- issues pharmaceuticals certificates and certificates for the origin of pharmaceuticals;
- effects control over drugs manufacturing, the wholesale and retail trade with the pharmaceuticals, over the clinical trials of pharmaceuticals and drugs advertising;
- carries out laboratory analyses in cases of doubt as to possible quality, effectiveness, and drugs safety deviations, and undertakes the measures provided for by the law;
- organizes the system of registration, analysis, and annotation of undesirable responses to drugs, as well as of the consequences from the interaction of drugs emerging during drugs use, and undertakes the respective measures;
- performs the functions of a national coordinator and consultant on the issues related to the quality, effectiveness, and safety of drugs;
- carries out consulting, research, information and publishing activities within the framework of the pharmaceutical sector of the economy;

participates in various drugs-related activities in connection with the work of international bodies, organizations, and treaties, to which Bulgaria is a signatory country

4.10.5. Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?

- [x] National medical stores or equivalent
- [ ] Sub-contracted national organization(s) *(specify)*
- [ ] Sub-contracted international organization(s) *(specify)*
- [ ] Other: *(specify)*

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

The PR disposes with enough storage capacity for pharmaceutical and health products storage at all levels of the distribution chain and therefore there is no need to assure additional storage space for those planned to be procured with GF funds.

Concerning health equipment delivery and installation, it is carried out directly to the correspondent health center by the Supplier.

(c) For distribution partners, what is each organization's **current distribution capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

The PR makes regularly orders to the Suppliers, according to the current needs of End-Recipient that deliver the pharmaceutical and health products directly. In case of additionally arisen needs, a mini-bus on Round 6 has been procured, in order to assure full distribution capacity

4.10.6. Pharmaceutical and health products for initial two years

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

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

The expected GF funds will be used only for the procurement of 2nd line ANTI-TB drugs for treatment of multi-resistant TB of 70 patients per year amounting to 320 000 EUR for the 5 years period. The PR will apply for procurement from the Green Light Committee.

The selection of products takes into account the following conditions:

- The WHO Essential Medicines List (the EML of WHO);
- The List of the Bulgarian Drug Agency for medicines permitted for distribution on the territory of Bulgaria;
- The requirements of the Human Medicine Medication and Pharmacies Act and Ordinance №34 concerning the order for prescribing and obtaining costly medication, tuberculostatics included;

The Standard Treatment Manual of the WHO and the National Manual with operative procedures for the treatment of tuberculosis.

4.10.7. Multi-drug-resistant tuberculosis

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

☉ Yes

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

☐ No

Do not include these costs

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

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

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

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

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

ROUND 8 – Tuberculosis

5. FUNDING REQUEST

5.1. Financial gap analysis - Tuberculosis

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

Financial gap analysis *(EUR)*										
	Actual		Planned		Estimated					TOTAL
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2010-2014
Tuberculosis program funding needs to deliver comprehensive diagnosis, treatment and care and support services to target populations										
Line A ➔ Provide annual amounts	**4 771 252**	**5 785 908**	**10 204 540**	**10 704 768**	**12 619 262**	**12 076 212**	**12 107 180**	**11 244 447**	**11 535 779**	**59 582 880**
Line A.1 ➔ Total need over length of Round 8 Funding Request										
Current and future resources to meet financial need										
Domestic source **B1**: Loans and debt relief (*provide name of source*)										
Domestic source **B2** National funding resources	**4 771 252**	**5 722 782**	**6 478 804**	**7 444 793**	**7 471 575**	**7 786 019**	**8 121 258**	**8 448 894**	**8 789 516**	**40 617 262**
Domestic source **B3** Private Sector contributions (national)										
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	**4 771 252**	**5 722 782**	**6 478 804**	**7 444 793**	**7 471 575**	**7 786 019**	**8 121 258**	**8 448 894**	**8 789 516**	**40 617 262**
External source **C 1 (provide source name)**										
External source **C2 (provide source name)**										

ROUND 8 – Tuberculosis

Financial gap analysis *(EUR)*										
	Actual		Planned		Estimated					TOTAL
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2010-2014
External source **C3** Private Sector contributions (International)										
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:										
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years		**63 126**	**3 725 736**	**3 259 975**	**3 075 947**	**2 700 497**	**2 661 407**			**8 437 851**
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	**4 771 252**	**5 785 908**	**10 204 540**	**10 704 768**	**10 547 522**	**10 486 517**	**10 782 665**	**8 448 894**	**8 789 516**	**49 055 114**
Calculation of gap in financial resources and summary of total funding requested in Round 8 *(to be supported by detailed budget)*										
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)					**2 071 740**	**1 589 695**	**1 324 515**	**2 795 553**	**2 746 263**	**10 527 766**
Line G = Round 8 tuberculosis funding request *(same amount as requested in table 5.3 for this disease)*					**2 071 740**	**1 589 695**	**1 324 515**	**2 795 553**	**2 746 263**	**10 527 766**

ROUND 8 – Tuberculosis

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants	
In Round 8, the total maximum funding request for tuberculosis in Line G is: *(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and* *(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*	
Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund **Cost sharing = (Total of Line D entries over 2009-2013 period + Line G Total) X 100** **Line A.1**	**32%**

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

Explain how the annual amounts were:

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

Based on the estimates of planned implementation of the activities and the necessary financial resource for achievement of national objectives, the overall needs for the period 2010-2014 are calculated up to 59,582,880 EUR. For the five-year period of this Proposal, 68% in average or 40,617,262 EUR of the total country needs will be assured from the State budget for first-line drugs, chemoprophylaxis, vaccines and tests, including subventions for treatment of patients with active TB, continuing treatment and rehabilitation.

The requested amount from the Global Fund for the remaining 32% is to guarantee necessary TB activities that the State can not currently cover or in total 10,527,766 EUR.

The proposal annual allocations are developed in order to overcome the financial gaps in the currently implemented National TB Program and Round 6 Global Fund Grant.

The budget for the first three years is prepared taking into consideration the necessity of additional financing for the activities that are not included in the current GF Grant. The estimates have been made on the basis of the analysis of the operational environment, summarizing the proposals from the implementing partners at national and regional level, and taking into account other factors that may have a substantial influence on the disease programme outcomes.

Year 4 and Year 5 budget follows the logic of the program implementation in accordance with the established organization, in order to minimize the emerging problems in the course of implementing ongoing activities.

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

Explain the processes used in country to:

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

Notwithstanding the fact that financing for tuberculosis from Bulgarian State budget is increasing significantly during the last years (from 3,251,000 EUR in 2004 to 6,478,800 EUR in 2008, tending to further increase), it is still not sufficient to implement the disease control.

Due to insufficient funds, the State and Municipal budgets allocate financing primarily for anti-TB drugs, vaccines, chemoprophylaxis and hospital treatment.

Treatment of TB patients in Bulgaria is completely free, according to WHO recommendations and country legislation in force, observing the principles of equality and transparency. The Ministry of Health is providing financing according to Ordinance No34 of 25.11.2005 on the order of payment from State budget Bulgarian citizens' treatment of diseases out of the range of the Obligatory health insurance and the affirmed "Methods for funding reorganized health facilities for hospital aid having State or Municipal participation".

Financial and material resources for TB testing and treatment are significant - only for hospital treatment of TB for 2007 from State and Municipal budgets have been allocated more than

5,2 million euro and around 0,5 million EUR for drugs, consumables and chemoprophylaxis.

Nevertheless, State funding is still not enough for assuring contemporary laboratory equipment, corresponding to international standards; facilitating access to medical structures for TB diagnosis of patients form risk groups who are difficult to reach; helping to follow-up patients during the continuous treatment phase; active screening of contacts of TB patients; improving infectious control of the medical staff against possible TB infection. Funding is also insufficient for rehabilitation, repairs and maintenance of the old material base in health facilities, as well as for the expensive MDR-TB treatment.

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

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

Except for Global Fund Grants, no other external funding is anticipated to be received.

5.2. Detailed Budget

Suggested steps in budget completion:

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

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/apply/call8/single/#budget

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

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

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

5. Do not include any CCM or Sub-CCM operating costs in Round 8. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/apply/mechanisms/guidelines/

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

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	Objective 1: To ensure efficient management and coordination of the National TB Program	**83 640**	**75 800**	**60 000**	**608 720**	**567 600**	**1 395 760**
1	SDA 1.1: Monitoring and evaluation	23 640	11 600	0	86 020	74 900	196 160
1	SDA 1.2: Management and supervision	60 000	64 200	60 000	522 700	492 700	1 199 600
	Objective 2: To improve the effectiveness of TB diagnosis and treatment in Bulgaria	**1 309 165**	**922 915**	**625 885**	**1 519 033**	**1 500 893**	**5 877 891**
2	SDA 2.1: Improving diagnosis	894 665	414 595	411 965	432 595	429 965	2 583 785
2	SDA 2.2: High quality DOTS	237 860	504 120	209 720	817 628	811 488	2 580 816
2	SDA 2.3: MDR-TB	173 270	4 200	4 200	196 200	196 200	574 070
2	SDA 2.4: TB/HIV	3 370	0	0	3 370	0	6 740
2	SDA 2.5: Management and supervision	0	0	0	69 240	63 240	132 480
	Objective 3: To reduce the transmission of TB in the prisons in Bulgaria	**226 290**	**78 310**	**87 290**	**95 450**	**93 450**	**580 790**
3	SDA 3.1: High risk groups	47 790	42 310	46 090	34 550	34 550	205 290
3	SDA 3.2: Improving diagnosis	178 500	36 000	36 000	36 000	36 000	322 500
3	SDA 3.3: Management and supervision	0	0	5 200	24 900	22 900	53 000

ROUND 8 – Tuberculosis

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	Objective 4: To increase access to TB care for high risk groups – refugees and asylum seekers; immigrants; youth at risk; injecting drug users; alcoholics	**167 125**	**224 650**	**239 320**	**248 690**	**260 660**	**1 140 445**
4	SDA 4.1: High risk groups	43 145	58 880	78 650	83 980	97 980	362 635
4	SDA 4.2: All Care Providers	5 660	11 360	8 260	8 460	7 630	41 370
4	SDA 4.3: ACSM	0	3 500	2 900	2 900	1 700	11 000
4	SDA 4.4: Community TB Care	7 180	13 990	12 590	12 590	12 590	58 940
4	SDA 4.5: Management and supervision	111 140	136 920	136 920	140 760	140 760	666 500
	Objective 5: To increase the coverage of the Roma population with efficient community TB care	**285 520**	**288 020**	**312 020**	**323 660**	**323 660**	**1 532 880**
5	SDA 5.1: Community TB care	162 600	254 060	278 060	266 060	266 060	1 226 840
5	SDA 5.2: Management and supervision	122 920	33 960	33 960	57 600	57 600	306 040
Round 8 tuberculosis funding request:		**2 071 740**	**1 589 695**	**1 324 515**	**2 795 553**	**2 746 263**	**10 527 766**

ROUND 8 – Tuberculosis

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

Avoid using the "other" category unless necessary – read the Round 8 Guidelines.	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	374 390	431 790	431 590	949 590	948 190	**3 135 550**
Technical and Management Assistance	42 690	43 400	30 000	176 600	175 600	**468 290**
Training	116 040	78 660	89 040	115 070	93 380	**492 190**
Health products and health equipment	867 615	413 315	413 315	497 763	497 763	**2 689 771**
Pharmaceutical products (medicines)	0	0	0	160 000	160 000	**320 000**
Procurement and supply management costs	0	0	0	0	0	**0**
Infrastructure and other equipment	496 160	303 000	3 000	69 600	31 600	**903 360**
Communication Materials	7 700	15 300	6 200	66 200	65 000	**160 400**
Monitoring & Evaluation	14 380	14 380	19 580	17 340	17 340	**83 020**
Living Support to Clients/Target Populations	41 900	120 400	166 800	168 800	182 800	**680 700**
Planning and administration	110 865	169 450	164 990	562 590	562 590	**1 570 485**
Overheads	0	0	0	12 000	12 000	**24 000**
Other: *(Use to meet national budget planning categories, if required)*						
Round 8 tuberculosis funding request (*Should be the same annual totals as table 5.2*)	**2 071 740**	**1 589 695**	**1 324 515**	**2 795 553**	**2 746 263**	**10 527 766**

5.4.1. Overall budget context

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

The most significant change during the 5-year period of this proposal is foreseen to be in the "Human resources" category which total relative part from 18% in Year 1 goes up to 35% in Year 5. This is due to the fact that the largest part of the activities are supported with Round 6 Grant for the first three years. The expenses in this field are much higher in Year 4 and Year 5, when Round 6 financing will be over.

Due to the same reason there is an increase in "Planning and Administration" (mainly for transportation costs to reach target population) where from a relatively 5% in Year 1 of this expenditure increases up to 20% from the total budget in Year 4 and Year 5.

There is a clear trend of decrease in relative shares in „Health Products and Health Equipment" and „Infrastructure and Other Equipment". In Year 1 procurement of medical equipment is foreseen, especially for laboratory needs, as well as rehabilitation of some TB facilities that were not included in the approved Round 6 proposal and that can not be assured from other sources.

The share of the expenditures for medical consumables and self protective materials stays relatively constant during the years.

5.4.2. Human resources

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

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

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

The Human resources expenses represents a significant part of the total requested funds (29.78% average for the term of the Proposal), as the State budget is not enough to ensure adequate payment to medical care providers. As for the outreach workers costs at this stage the government can not provide funding. The main part – 1.5 mill euro or 48% of total for Human recourses for the proposal term are payment to stimulate health care workers – DOT managers, patronage nurses and lab technicians. Planned expenditures for outreach workers - 1.1 mill euro which represents nearly 36% of total cost for Human recourses. Relatively small shear – 11 % with in this category during the proposal term represents envisioned payment for national management and coordination of the Program and at last place is planed for training related human resources cost (less than 5% of the total for HR).

During the first three years are envisioned staff expenditures for following positions: outreach workers - 300 euro monthly salary, biologists (laboratory specialist)- 400 euro per month; 10 additional nurses for ¼ work day – 100 euro per month; DOT managers – 300 euro additional to Rd 6 remuneration as in the existing Grant are envisioned 100 euro per month for DOT managers witch is not enough to motivate skilled doctors and to increase their assignments in respect to regional coordination of outreach activities. For those reason monthly payments has to be increased. As for Y4 and Y5 the planed remuneration of outreach workers keeps the level of 300 euro, for the patronage nurses it is envisioned 400 euro and for DOT managers – 500 euro monthly salary. Only in Y4 and Y5 payments for the management staff to coordinate the Program at national level are included.

Low payment to highly skilled healthcare workers is not only demotivating to offer additional services to vulnerable people, but forces them to find other job in other economy sectors or abroad. From this point of view payment of additional work of qualified specialist is of great importance for

motivating them to fulfil activities and to achieve national goals

5.4.3. Other large expenditure items

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

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

After the Human Resources expenditures (30%), next large share of the proposal budget (26%) represent the funds planned for health products and medical equipment. The major part of this amount is envisioned for the procurement of contemporary lab equipment and appliances, corresponding to world standards and for part of the medical consumables for diagnostic.

Third place in the total expenditures' structure (15%) goes for "Planning and Administration". The major part of the expenditures in this category goes for transport (fuel for the needs of patronage nurses to reach target population, for motivating vulnerable groups to visit specialised TB facilities and transportation costs for outreach workers).

All other categories have less than 10% share of the total budget of the Proposal.

For all expenditures categories should be underlined that the unit prices are calculated excluding the value of the taxes and duties. It is envisioned all expenditures for goods and services for which taxes should be paid, to be done in a centralized way by the Principal Recipient – Ministry of Health in order to assuring tax-exemption, as well as competition grounds in Suppliers selection.

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

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

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

5.5.1. Operational status of common funding mechanism

Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners.

➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*

Not applicable.

5.5.2. Measuring performance

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

Not applicable.

5.5.3 Additionality of Global Fund request

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

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

Not applicable.

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

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

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

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

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

Round 8 - Tuberculosis

Section	Document description	Annex Number
	[use the "Tab" key to add extra rows if needed]	

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	Bulgaria
Disease:	Tuberculosis
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
1	Sustain the implementation of the National TB Programme through high-quality TB diagnosis and treatment and improved control of Multidrug-resistant Tuberculosis
2	
3	
4	
5	

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	Reported annual TB incidence rate: Number of registered new TB cases (all forms) occurring per year, per 100,000 population	39.1	2006	National Centre of Health Informatics	40/ 100,000	38/ 100,000	36/ 100,000	32/ 100,000	27/ 100,000	
outcome	Treatment success rate: Number and percentage of new smear-positive pulmonary TB cases registered during the year that were cured plus the number that completed treatment among the new smear-positive pulmonary TB cases registered during the year	86% 1152 / 1342	2005	Global Tuberculosis Control 2008, WHO	83% 1410 / 1700	84% 1385 / 1650	>85% 1355 / 1590	>85% 1320 / 1510	>85% 1240 / 1420	
outcome	Default rate: Number and percentage of new smear positive pulmonary TB cases registered during the year that interrupted treatment for than 2 consecutive months among the new smear positive pulmonary TB cases registered during the year	7% 92 / 1342	2005	Global Tuberculosis Control 2008, WHO	6% 102 / 1700	5% 83 / 1650	4% 64 / 1590	3% 45 / 1510	3% 43 / 1420	
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* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	To ensure efficient management and coordination of the National TB Programme	
2	To improve the effectiveness of TB diagnosis and treatment in Bulgaria	
3	To reduce the transmission of TB in the prisons in Bulgaria	
4	To increase access to TB care for high risk groups – refugees and asylum seekers; immigrants; youth at risk; injecting drug users; alcoholics	
5	To increase the coverage of the Roma population with efficient community TB care	
6		
7		
8		
9		
10		
11		
12		
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14		
15		

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	M&E	Number and percentage of TB treatment facilities (from total of 35) submitting timely quarterly data according to the national guidelines as defined in the proposal, among the total TB treatment facilities*	0% 0 / 35	2007	Ministry of Health	100% 35 / 35	100% 35 / 35	100% 35 / 35	100% 35 / 35	100% 35 / 35	100% 35 / 35	100% 35 / 35	N	N	N - not cumulative	N/A	Health services statistics; quarterly reports
1.2	M&E	Drug Resistence Survey performed	No DRS survey conducted	2007	Ministry of Health		Drug Resistence Survey in progress	Drug Resistence Survey completed	Survey report available	-	-	-	Y	N	N - not cumulative	N/A	Program monitoring system: upon completion
2.1	Improving diagnosis	Number and percentage of laboratories performing regular EQA for culture and DST semi-annually	3% 1 / 30	2007	Administrative records	100% 30 / 30	100% 30 / 30	100% 30 / 30	100% 30 / 30	100% 30 / 30	100% 30 / 30	100% 30 / 30	N	N	N - not cumulative	N/A	National Reference TB Laboratory; semi-annually
2.2	Improving diagnosis	Number of health care workers in TB laboratories and treatment facilities screened for TB infection	0	2007	Administrative records	0	230	0	460	690	920	1150	Y	N	Y - over program term	N/A	Health services statistics; semi-annually
2.3	Improving diagnosis	Number and percentage of new TB cases with bacteriological confirmation at diagnosis among all new TB cases registered during the year	48% 1367 / 2839	2007	National Centre of Health Informatics	57% 866 / 1520	57% 1724 / 3040	63% 910 / 1444	63% 1819 / 2888	66% 1806 / 2736	68% 1652 / 2430	70% 1436 / 2052	N	N	Y - cumulative annually	N/A	Health services statistics; quarterly reports
2.4	Improving diagnosis	Number and percentage of TB laboratories performing cultures that implement infection control measures according to national guidelines	3% 1 / 30	2007	Ministry of Health	50% 15 / 30	50% 15 / 30	80% 24 / 30	80% 24 / 30	100% 30 / 30	100% 30 / 30	100% 30 / 30	N	N	N - not cumulative	N/A	National Reference TB Laboratory; semi-annually
2.5	High Quality DOTS	Number of health staff trained in TB case management (including laboratory staff, regional DOT managers, nurses, lung disease specialists and paediatric TB specialists)	11	2007	Training records	102	179	253	261	365	569	709	Y	N	Y - over program term	N/A	Targets for number of staff trained are combined across SDA 2.1: Improving diagnosis; SDA: 2.2: High quality DOTS; and SDA 2.3: MDR-TB Program monitoring system training records
2.6	High Quality DOTS	Number of new smear positive cases detected under DOTS among the general population	1307	2006	Global Tuberculosis Control 2008, WHO	850	1700	825	1650	1590	1510	1420	N	N	Y - cumulative annually	N/A	Health services statistics; quarterly reports
2.7	High Quality DOTS	Number of new smear-positive cases registered under DOTS who are successfully treated	1152	2005	Global Tuberculosis Control 2008, WHO	705	1410	692	1385	1355	1320	1240	N	N	Y - cumulative annually	N/A	Health services statistics; quarterly reports
2.8	High Quality DOTS	Number of contacts identified and examined for TB	3044	2007	Ministry of Health	3500	8160	4950	9900	11448	12322	12780	N	N	Y - cumulative annually	N/A	Health services statistics; quarterly reports
2.9	MDR-TB	Number and percentage of bacteriologically confirmed pulmonary TB cases receiving quality-assured drug susceptibility testing, among all bacteriologically confirmed pulmonary TB cases	10% 141 / 1367	2007	National Reference Laboratory		50% 862 / 1724		695% 1182 / 1819	75% 1354 / 1806	85% 1404 / 1652	90% 1364 / 1436	N	N	Y - cumulative annually	N/A	National Reference TB Laboratory; quarterly
2.1	MDR-TB	Number of MDR-TB patients enrolled on DOTS plus treatment	0	2007	Global Tuberculosis Control 2008, WHO	25	50	25	55	65	70	70	N	N	N - not cumulative	N/A	MDR-TB treatment facilities; quarterly
3.1	High-risk groups	Number of prisoners screened for TB (through TB questionnaire, chest X-ray and tuberculin skin test)	0	2007	please select…	3'000	8'000	12'000	16'000	24'000	32'000	40'000	Y	N	Y - over program term	N/A	Medical sector, Ministry of Justice; quarterly
3.2	High-risk groups	Number of prisoners receiving sputum smear examination	146	2007	Ministry of Health	300	800	1'200	1'600	2'400	3'200	4'000	Y	N	Y - over program term	N/A	Medical sector, Ministry of Justice; quarterly
4.1	High-risk groups	Number of health professionals, outreach workers and community workers trained to participate in TB control in high risk groups	0	2007	please select…	122	187	251	336	423	510	572	Y	N	Y - over program term	N/A	Targets for number of staff trained are combined across SDA 4.1: High risk group; SDA 4.4: Community TB care, and SDA 5.1: Community TB care Program monitoring system training records

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
4.2	High-risk groups	Number of people from risk groups screened for TB risk	No data available	2007	please select…	0	500	1'100	1'700	3'700	6'200	9'200	N	N	Y - over program term	N/A	Program monitoring system; quarterly
4.3	High-risk groups	Number of people from the risk groups refrred to TB health facitilities due to TB risk for smear sputum examination	No data available	2007	please select…	0	100	220	340	740	1'240	1'840	Y	N	Y - over program term	N/A	Program monitoring system; quarterly
5.1	Community TB care	Number of Roma people screened for TB risk	No data available	2007	please select…	0	3'000	6'500	10'000	17'000	24'000	31'000	Y	N	Y - over program term	N/A	Program monitoring system; quarterly
5.2	Community TB care	Number of Roma people referred to TB health facilities due to TB suspicion	135	2007	Program "Prevention and Control of HIV/AIDS", Ministry of Health	0	600	1'100	1'600	2'600	3'600	4'600	Y	N	Y - over program term	N/A	Program monitoring system; quarterly
5.3	Community TB care	Number TB patients with DOT in the continuation phase supported by community workers	No data available	2007		0	150	450	750	1'550	2'250	2'950	Y	N	Y - over program term	N/A	Program monitoring system; quarterly
5.4	Community TB care	Number of persons from the Roma communities reached for a positive change of behavior with respect to TB prevention, treatment and support (education activities)	No data available	2007	please select…	0	6'000	18'500	31'000	58'000	86'500	116'500	Y	N	Y - over program term	N/A	Program monitoring system; quarterly
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