GEO-T-2015 - Concept Note Integrated View

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A. Program details

Country / Applicant:	Georgia	Principal Recipients		Total requested amount	
Component:	Tuberculosis			Allocation	USD 11,906,737
Start Month/Year:	July 2016			Above	USD 0

Summary Budget by Module

Module	Allocated/Above	2016	2017	2018	Total
MDR-TB	Allocation	2,281,033	3,369,031	2,169,163	7,819,227
	Above	0	0	0	0
HSS - Policy and governance	Allocation	106,100	585,280	470,730	1,162,110
	Above	0	0	0	0
HSS - Health information systems and M&E	Allocation	343,190	305,530	309,330	958,050
	Above	0	0	0	0
Community systems strengthening	Allocation	56,225	392,450	422,450	871,125
	Above	0	0	0	0
Program management	Allocation	208,383	324,260	206,282	738,925
	Above	0	0	0	0
HSS - Service delivery	Allocation	22,100	131,600	1,800	155,500
	Above	0	0	0	0
Results-based Financing	Allocation	3,600	143,700	54,500	201,800
	Above	0	0	0	0
Total	Allocation	3,020,631	5,251,851	3,634,255	11,906,737
	Above	0	0	0	0

Summary Budget by Principal Recipient

Principal Recipient	Allocated/Above	2016	2017	2018	Total
	Allocation	3,020,631	5,251,851	3,634,255	11,906,737
	Above	0	0	0	0
Total	Allocation	3,020,631	5,251,851	3,634,255	11,906,737
	Above	0	0	0	0

B. Program goals and impact indicators

Goals

1	Decrease the burden of tuberculosis and its impact over the overall social and economic development in Georgia, by ensuring universal access to timely and quality diagnosis and treatment of all forms of TB, thus decrease illness,death and drug resistance.

Linked to goal(s) #	Impact indicator	Country	Baseline			Targets			Comments and Assumptions
			Value	Year	Source	Year 1	Year 2	Year 3	
1	TB I-2: TB incidence rate (per 100,000 population)		116	2014	Reports, Surveys, Questionnaires, etc. (specify)	110	105	102	For all TB cases. Baseline: 2014 estimate based on WHO estimate for 2013 (116 per 100,000; including HIV).
1	TB I-3: TB mortality rate (per 100,000 population)		7.0	2014	Reports, Surveys, Questionnaires, etc. (specify)	6.5	6.2	6.0	Baseline: 2014 estimate based on WHO estimate for 2013 (7.0 per 100,000; excluding HIV)
1	TB I-4: MDR-TB prevalence among new TB patients		11.6	2014	R&R TB system, yearly management report	15.0	15.0	15.0	Baseline source: National Tuberculosis program/National Reference Laboratory. MDR-TB prevalence among new TB patients should be kept under 15%.
1	MDR-TB prevalence among previously treated TB patients		39.2	2014	R&R TB system, yearly management report	40.0	40.0	40.0	Baseline source: National Tuberculosis program/National Reference Laboratory. MDR-TB prevalence among previously treated TB patients should be maintained under 40%.

C. Program objectives and outcome indicators

Objectives:	
1	To provide universal access to early and quality diagnosis of all forms of TB including M/XDR-TB
2	To provide universal access to quality treatment of all forms of TB including M/XDR-TB with appropriate patient support
3	To enable supportive environment and systems for effective TB control
4	To strengthen the health system's cross-cutting functions and performance fot TB and HIV/AIDS control

Linked to objective(s) #	Outcome Indicator	Country	Baseline			Targets			Comments and Assumptions
			Value	Year	Source	Year 1	Year 2	Year 3	
1	TB O-1a: Case notification rate of all forms of TB per 100,000 population - bacteriologically confirmed plus clinically diagnosed, new and relapse cases		82.9	2014	R&R TB system, yearly management report	82.3	81.7	81.2	This indicator refers to all forms of TB cases that are bacteriologically confirmed or clinically diagnosed with active TB by a clinician. It includes- new and relapse cases that are- (1) smear and/or culture positive; or smear positive/culture negative (2) smear and/or culture negative; (3) smear unknown/not done; (4) positive by WHO-recommended rapid molecular diagnostics (e.g. Xpert MTB/RIF); (5) extra-pulmonary cases confirmed by WRD; (6) cases confirmed on the basis of X-Ray abnormalities or suggestive histology; It does not include- retreatment cases such as- (1) treatment after failure patients; (2) treatment after loss to follow-up (previously known as 'treatment after default') (3) other retreatment cases
2	TB O-2b: Treatment success rate - bacteriologically confirmed new TB cases		80.0	2014	R&R TB system, yearly management report	83.0	84.5	86.0	Note: for new smear-positive cases

2	TB O-4: Treatment success rate of MDR-TB: Percentage of bacteriologically confirmed drug resistant TB cases (RR-TB and/or MDR-TB) successfully treated		45.0	2014	R&R TB system, yearly management report	53.0	60.0	65.0	This indicator is measured 24 months after the end of the period of assessment, Final Outcomes will be reported for only laboratory confirmed RR-TB, MDR-TB and XDR-TB cases.
1	Case notification rate of all forms of TB per 100,000 population - bacteriologically confirmed plus clinically diagnosed, all TB cases (new and re-treatment)		103.0	2014	R&R TB system, yearly management report	102.0	101.0	100.1	This indicator refers to all forms of TB cases that are bacteriologically confirmed or clinically diagnosed with active TB by a clinician. It includes all forms new and all re-treatment.

D. Modules

Module: MDR-TB

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline N # / D #	Baseline %	Baseline Year	Baseline Source	Targets	Total Targets N # / D #	Total Targets %	Year 1 N # / D #	Year 1 %	Year 2 N # / D #	Year 2 %	Year 3 N # / D #	Year 3 %
MDR TB-1: Percentage of previously treated TB patients receiving DST (bacteriologically positive cases only)			503.0 / 568.0	88.6	2014	R&R TB system, yearly management report	Allocation + Other Sources	565.0 / 577.0	97.9	565.0 / 576.0	98.1	560.0 / 572.0	97.9		
							Above+Allocation+Other sources								
Comments [1]	Numerator: Number of previously treated TB cases with DST result for both isoniazid and rifampicin during the period of assessment Denominator: Total number of bacteriogically positive previously treated TB patients identified during the period of assessment.														
MDR TB-2: Number of bacteriologically confirmed, drug resistant TB cases (RR-TB and/or MDR-TB) notified			395.0		2014	R&R TB system, yearly management report	Allocation + Other Sources	512.0		521.0		529.0			
							Above+Allocation+Other sources								
Comments [1]	The targets reflect estimated number of bacteriologically confirmed drug resistant TB cases notified. Baseline denominator source:WHO Global TB Report 2014.														
MDR TB-3: Number of cases with drug resistant TB (RR-TB and/or MDR-TB) that began second-line treatment			501		2014	R&R TB system, yearly management report	Allocation + Other Sources	500		510		516			
							Above+Allocation+Other sources								
Comments [1]	This indicator refers to number of cases with drug resistant TB (RR-TB and/or MDR-TB) registered and started on a prescribed MDR-TB treatment regimen during the period of assessment.														
MDR TB-4: Percentage of cases with drug resistant TB (RR-TB and/or MDR-TB) started on treatment for MDR-TB who were lost to follow up at six months			62.0 / 481.0	12.9	2014	R&R TB system, yearly management report	Allocation + Other Sources	60.0 / 500.0	12.0	57.0 / 510.0	11.2	53.0 / 516.0	10.3		
							Above+Allocation+Other sources								
Comments [1]	Numerator: Number of cases with drug resistant TB (RR-TB and/or MDR-TB) registered and started on a prescribed MDR-TB treatment who were lost to follow-up by the end of month 6 of their treatment. Denominator: Number of cases with drug resistant TB (RR-TB and/or MDR-TB) registered and started on treatment for MDR-TB during the period of assessment.														

Total number of Xpert MTB/RIF tests performed in medical institutions and coverage of needs.			9,027.0 21,000.0	43.0	2014	TB laboratory register	Allocation + Other Sources	21,183.0 31,258.0	67.8	25,243.0 31,258.0	80.8	27,539.0 30,520.0	90.2			
							Above+Allocation+Other sources									
Comments [1]	Baseline data on the number of tests (2014) includes the NRL (5,606), ZDL Kutaisi (1,989) and ZDL Batumi (1,432), totally 9,027 Xpert tests in 2014.															
Percentage of TB patients (new and previously treated) receiving DST (bacteriologically positive cases only).			1,985.0 2,168.0	91.6	2014	R&R TB system, yearly management report	Allocation + Other Sources	1,934.0 1,974.0	98.0	1,942.0 1,981.0	98.0	1,939.0 1,978.0	98.0			
							Above+Allocation+Other sources									
Comments [1]	Numerator: Number of new and previously treated TB cases with DST result for both isoniazid and rifampicin during the period of assessment Denominator: Total number of bacteriogically positive new and previously treated TB patients identified during the period of assessment.															
Coverage of second-line DST among notified MDR patients			357.0 501.0	71.3	2014	TB laboratory register	Allocation + Other Sources	461.0 512.0	90.0	485.0 521.0	93.1	502.0 529.0	94.9			
							Above+Allocation+Other sources									
Comments [1]																
Number of TB patients on first-line treatment, who receive incentives for treatment adherence			1,459.0 2,115.0	69.0	2014	Administrative records	Allocation + Other Sources	2,517.0 3,146.0	80.0	2,490.0 3,112.0	80.0	2,447.0 3,059.0	80.0			
							Above+Allocation+Other sources									
Comments [1]	The baseline is for June-December of 2014. Numerator: Number of registered TB patients on the 1st line TB treatment who have received cash incentives at least once in the reporting period Denominator: Number of TB cases, enrolled in 1st line TB treatment in the same reporting period. The indicator does not include prisoners. Eligibility: Regular TB patients which comply well with intermittent (3 times per week) DOT sessions at outpatient TB clinics.															
Number of M/XDR-TB patients on treatment, who receive incentives for treatment adherence			498.0 646.0	77.1	2014	Administrative records	Allocation + Other Sources	483.0 500.0	96.6	493.0 510.0	96.7	498.0 516.0	96.5			
							Above+Allocation+Other sources									
Comments [1]	The baseline is established for June-December 2014. Numerator: Number of M/XDR TB patients on out-patient 2nd line TB treatment who have received cash incentives at least once in the reporting period Denominator: Number of M/XDR TB cases, enrolled in out-patient 2nd line TB treatment in the same reporting period The indicator does not include prisoners. Eligibility: M/XDR TB patients for uninterrupted 6- day DOT sessions at outpatient TB clinics															
Interim results of MDR-TB treatment: percentage of patients with culture conversion at six months of treatment				72.0	2014	R&R TB system, yearly management report	Allocation + Other Sources	375.0 500.0	75.0	398.0 510.0	78.0	413.0 516.0	80.0			
							Above+Allocation+Other sources									
Comments [1]																
Proportion of TB patients with known HIV status (percentage of notified TB cases, all forms, tested for HIV)			67.3		2014	R&R TB system, yearly management report	Allocation + Other Sources	75.0		80.0		85.0				
							Above+Allocation+Other sources									
Comments [1]	Numerator: Number of TB patients registered during the reporting period who had an HIV test result recorded in the TB register at the time of TB diagnosis. Denominator: Total number of TB patients registered during the reporting period. NOTE: denominator includes "other re-treatment" as well.															

Module budget - MDR-TB								
Allocated request for entire module	USD 7,819,227				Above allocated request for entire module		USD 0	
Intervention		Intervention budget (request to the Global Fund only)						
	Responsible Principal Recipient(s)	Total Targets	Year 1	Year 2	Year 3	Cost Assumptions [3]	Other funding [4]	
Case detection and diagnosis: MDR-TB				Allocation	1,198,974	1,558,766	921,754	Intervention 1.1. Rollout of Xpert MTB/RIF technology includes the following Activities: 1.1.1. National consultants 1.1.2-1.1.3. Training of staff in Xpert MTB/RIF 1.1.4-1.1.5. Procurement of Xpert MTB/RIF instruments 1.1.6. Other equipment (UPS stations and printers) for Xpert sites 1.1.7. Procurement of cartridges for Xpert MTB/RIF tests 1.1.8. Maintenance and servicing of Xpert MTB/RIF instruments 1.1.9. Warranty extension for Xpert instruments 1.1.10. Supervision / monitoring of Xpert MTB/RIF implementation at district level 1.1.11. Workshops and coordination meetings on Xpert MTB/RIF rollout Intervention 1.2. TB diagnostic investigations at regional and national level The Activities under this Intervention include: 1.2.1. LED equipment for LSSs 1.2.2, 1.2.12. Training of laboratory staff 1.2.3-1.2.4. Equipment and supplies for reference TB laboratories 1.2.5-1.2.6. Laboratory supplies for MGIT and LPA investigations 1.2.7. Maintenance and servicing of laboratory equipment 1.2.8-1.2.11. Strengthening NRL quality management system / support to ISO accreditation (TA, training, national consultants) 1.2.13. Procurement of diagnostic equipment for NCTLD Intervention 1.3. Contacts' investigation, screening and active case finding for TB among high-risk groups including people living with HIV. The vast majority of resources and costs for this NSP Intervention will be covered from domestic sources. The NFM project is expected to contribute by the following Activities: 1.3.1. National consultants, development of national TB screening guidelines 1.3.2. Procurement of mobile MMR unit for intensified active case finding	Starting from 2015-2016, the Government has committed to take over the important programmatic and financial aspects which had been previously supported by the Global Fund and other donors. Besides full coverage of substantial staff and facility running costs at the NRL, ZDLs and LSSs, these activities include procurement of supplies for DSM tests and solid-media culture and DST investigations, support to the specimen transportation system and procurement of individual infection control protection supplies (respirators) for laboratory staff, as well as all civil works and procurement related to finalization of the renovation at the new NRL premises (by the end of 2015). At the same time, the NTP relies on other external support for important interventions outlined in the new NSP, which include strengthening the NRL quality management systems through supporting its accreditation to ISO and procurement of advanced genotyping equipment and test for epidemiology and research purposes.
				Above	0	0	0	
Description of Intervention [2]								

Intervention 1.1. Rollout of Xpert MTB/RIF technology aims to support the WHO's strong recommendation to the national programs with high burden of DR-TB, that patients at risk for drug resistance should have rapid molecular Xpert MTB/RIF test performed as the initial diagnostic investigation for TB. The rollout of Xpert MTB/RIF technology is a mainstay of the new TB laboratory strategy. Xpert MTB/RIF is applied in Georgia as an integral part of the national diagnostic algorithm. During the coming two years, it is foreseen to roll out Xpert MTB/RIF technology to district level. While to ensure appropriate population coverage and perform the necessary number of investigations of TB suspects, a total of 54 instruments are needed countrywide, the first-stage rollout will include procurement of 18 additional instruments with TGF NFM support in 2016 (thus reaching the total number of 35 machines, which will serve the diagnostic needs on a 'point-of-care' basis). In the penitentiary system, Xpert testing will continue in the Prison TB Hospital in Ksani (Shida Kartli region) and in the Central Prison Hospital in Gldani (Tbilisi). Xpert will also serve the needs of testing TB suspects among PLHIV. During the NFM period (2.5 years), it is planned to perform about 65,560 Xpert MTB/RIF investigations countrywide and achieve the increase in needs' coverage from 67% in 2016 to 82% in 2017 and over 95% - in 2018. Intervention 1.2. TB diagnostic investigations at regional and national level aims at sustaining the quality implementation of WHO-recommended diagnostics (WRDs) at the reference laboratories. Although the country plans to rapidly roll out Xpert MTB/RIF the regional level laboratories (LSSs) will continue to perform DSM in combination with Xpert MTB/RIF testing, in accordance to the revised diagnostic algorithm. Georgia aims at shifting its laboratories to LED fluorescence microscopy by the middle of the next NSP program period. Capacities for DST to first-line and second line TB drugs in liquid media will be developed at the ZDL Kutaisi, which will serve all needs of Western Georgia. The planned developments of TB laboratory network aim at expanding the use of rapid methods for culturing and DST (by automated MGIT and LPA techniques). The country aims to ensure that rapid DST to second-line drugs is in place in all laboratory-confirmed RR/MDR-TB patients; the NFM proposal builds on further supporting this scale-up. The NTP also relies on TGF support to strengthening the NRL quality management systems through supporting its accreditation to ISO and procurement of advanced genotyping equipment and test for epidemiology and research purposes. Starting from 2015-2016, the Government has committed to take over the important programmatic and financial aspects which had been previously supported by the Global Fund and other donors. Intervention 1.3. Contacts' investigation, screening and active case finding for TB among high-risk groups including people living with HIV aims to support active TB case finding that is an important activity that has been outlined in the Georgian TB NSP, according to the latest WHO recommendations. The Plan identifies the following five risk groups for systematic screening for active TB in the country: 1) Household contacts and other close contacts of patients with active TB; 2) People living with HIV (PLHIV); 3) Persons detained in penitentiary institutions; 4) People with selected medical conditions that constitute risk factors for TB, who seek health care for other reasons; and 5) Other subpopulations with estimated high levels of undetected TB or/and limited access to health care services. Intensified active case finding activities in above groups will be performed in full conformity to the revised diagnostic algorithm.						
					Intervention 2.1 . Supply of anti-TB drugs and drug management system include the following activities: 2.1.1-2.1.4. Procurement of anti-TB drugs 2.1.5. In-country supply management of anti-TB drugs 2.1.6. Training in drug management, international 2.1.7. In-country quality assurance of TB drugs 2.1.8. Operational research support to introduction of shorter MDR-TB treatment regimens 2.1.9. Clinical supervision of implementation of new drugs and treatment regimens for M/XDR-TB: mobile	(1) The Government of Georgia is committed to ensure uninterrupted supply of anti-TB drugs for treatment of patients with all forms of TB. The Government will allocate additional financial resources to the National TB Program, which will be sufficient to ensure effective takeover from the Global Fund during the first two years of the NSP: first-line drugs – 100% from the state budget starting 2016, and second-line drugs – 35% in 2017 and at 75% in 2018. External funding (through the Global Fund) will still be required for procurement of drugs for DR-TB treatment during the period covered by this application. With USAID funding support through Management Sciences for Health (MSH), starting June 2015, MoLHSA will scale up the application of active pharmacovigilance methods in the TB program, such as cohort event monitoring (CEM). CEM will be applied for post-marketing surveillance of the new anti-TB drugs (Bedaquiline and Delamanid) using the standardized approach and protocols, which will be implemented by all TB service units. In particular, MSH assistance includes: establishing of the Cohort Event Monitoring (CEM) committee; development of the protocol for CEM; development of the data collection forms; adaptation of the electronic information system; training of the clinical staff on management in ADRs' of the new anti-TB medicines; training in data recording, data collection and data reporting; training of staff on the causality analyzes; data analysis; management and supervision. (2)The Government increasingly takes over the cash incentives for MDR-TB patients (besides covering all income tax payments currently provided by TGF to all patients, during the NFM project period the Government is committed to scale up the

Treatment: MDR-TB		Allocation	1,082,059	1,810,265	1,247,409	consilium Intervention 2.2.Patient support to improve adherence to TB treatment includes the following 2.3.1-2.3.2. Training of TB service staff in HIV counseling and testing 2.3.3 Training in TB and diabetes management Intervention 2.3.Treatment monitoring, management of adverse drug reactions and comorbidities While most of the interventions under this NSP component will be covered from domestic sources (including the provision of rapid HIV tests for peripheral TB service units), the NFM application seeks support for the following two activities: 2.3.1-2.3.2. Training of TB service staff in HIV counseling and testing 2.3.3 Training in TB and diabetes management Intervention 2.4. TB infection control in health care facilities This intervention includes two activities 2.4.1 National consultants, TB infection control 2.4.2 Environmental infection control measures (UVGI devices) for TB treatment institutions Intervention 2.5. Management of latent TB infection The NFM project support is expected to contribute by the following activities: 2.5.1. National consultants, development of national LTBI management guidelines and protocol 2.5.2-2.5.3. Training on	provision of monetary incentives to MDR patients: 225 cases in 2016, 300 cases in 2017 and 375 cases (about 75% of all needs) in 2018. Further, according to the new NSP, these practices will be sustained beyond TGF support and further expanded through implementation of effective patient-centered approaches, which will have impact on adherence and treatment outcomes. (3) The Government will ensure availability of all necessary clinical laboratory tests and other investigations for diagnosing undesired effects of TB drugs, as well as pharmaceuticals to treat ADR-induced morbidities, in accordance to the international evidence and guidance. These tests and drugs will be provided free of charge to all TB patients, regardless the form of disease or setting where the cases are managed. The Government will take over this program component from the Global Fund in 2016. (4) Most of the costs for TB related infection control are borne by the Government. (5) MoLHSA will place special emphasis on reinforcing TB prevention as an essential component of the national TB control
		Above	0	0	0		

						LTBI diagnosis and preventive treatment for general health care providers 2.5.4. Diagnostic tests for LTBI	program, including its coverage in the universal health care program and allocation of dedicated financial resources.

Description of Intervention [2]
Intervention 2.1 . Supply of anti-TB drugs and drug management system This Intervention aims at maintaining universal access to TB treatment according to the needs, by ensuring availability of TB drugs in sufficient quantities for each category of TB cases, assuring appropriate quality of medicines, and enabling the effective drug management system. It is assumed that the annual number of cases will be stable during years 2016-2018 (about 3,800 TB cases, all forms, in both civilian and penitentiary sectors). During the period covered by NFM (July 2016 – December 2018), it is expected that a total of about 9,500 TB cases, all forms, will need anti-TB treatment in Georgia. Out of these, about 1,300 cases are expected to have advanced drug resistance (M/XDR-TB) and will thus require second-line and third-line TB drugs. TB treatment regimens will be administered in line with the latest WHO guidance. Standard WHO-recommended MDR regimens, for a total treatment duration of 20 months in most instances, will be administered in patients without resistance to second-line agents, which currently account for about two-thirds of all laboratory-confirmed MDR-TB cases. In cases with resistance to SLDs ('pre-XDR' and XDR-TB), the treatment will be extended to up to 24 months. Newly developed anti-TB drugs – Bedaquiline and Delamanid – will be used in M/XDR treatment regimens in accordance to WHO guidance. At the same time, the Georgian NTP will gradually introduce modified, shortened MDR-TB regimens, which will be applied in MDR-TB cases without resistance to SLDs and will last 9-12 months. For application of shorter MDR regimens, the NTP will ensure that relevant WHO requirements are met in this regard. To ensure effective drug supply, a set of measures will be put in place to strengthen the supply chain and all components of drug management. Special emphasis will be placed at improving the pharmacovigilance system for anti-TB drugs, as part of the overall pharmacovigilance system in the country. Intervention 2.2 . Patient support to improve adherence to TB treatment Adherence support is a key component of the TB program. It is especially relevant for patients with M/XDR-TB, who need to undergo lengthy treatment, have daily visits to health facilities and often suffer from serious adverse effects caused by TB medicines. A patient-centered approach to TB treatment is instrumental for promoting adherence to the therapy, improve quality of life and relieve suffering. Ensuring proper adherence to the regimen implies direct observation of treatment (DOT), which also allows for timely recognition and proper management of ADRs and other complications during treatment, along with identification of the needs for additional social support. A comprehensive patient support measures should be in place to motivate the patients to accept and adhere to treatment particularly in outpatient settings, including provision of incentives and enablers to the patients, psychosocial support, peer assistance and innovative approaches such as those using mobile telephony technologies. Intervention 2.3. Treatment monitoring, management of adverse drug reactions and comorbidities The system for early recognition and proper management of Adverse Drug Reactions (ADR) will be strengthened by the NTP as an important prerequisite for improving the effectiveness of DR-TB treatment. The Government will ensure availability of all necessary clinical laboratory tests and other investigations for diagnosing undesired effects of TB drugs, as well as pharmaceuticals to treat ADR-induced morbidities. This intervention will also focus on intensified case finding among PLHIV and improving management of diabetes among TB patients. Intervention 2.4 . TB infection control in health care facilities The new NSP includes provisions that aim at strengthening management capacities of health care institutions at all levels for effective implementation of all three categories of TB infection control measures: administrative controls, environmental controls, and individual protection measures. Intervention 2.5. Management of latent TB infection (LTBI) NTP will implement WHO recommendations on management of LTBI. The following seven groups have been identified for systematic testing and treatment of latent tuberculosis infection: 1) People living with HIV; 2) Child and adult contacts of pulmonary TB cases; 3) Persons detained in correctional facilities (prisoners); 4) Patients with the following diseases or treatment conditions: silicosis, renal dialysis, treatment with anti-tumor necrosis factor (TNF) inhibitors, and preparation for organ or hematologic transplantation; 5) People who inject drugs 6) Health care workers and 7)Immigrants from high TB burden countries.

Programmatic Gap

Coverage Indicator : MDR TB-1: Percentage of previously treated TB patients receiving DST (bacteriologically positive cases only)

Current National Coverage	Year	Source	Latest Results
	2014	R&R TB system, yearly management report	88.56

	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	CCM Comments
Current Estimated Country Need				
A. Total estimated population in need/ at risk	577	576	572	Projected number of culture positive cases (among previously treated TB patients)
B. Country targets	565 97.92 %	565 98.09 %	560 97.90 %	
Country Need Already Covered				
C. Country need planned to be covered by domestic and other sources	0 0.00 %	0 0.00 %	0 0.00 %	
Programmatic Gap				
D. Expected annual gap in meeting the need A-C	577 100.00 %	576 100.00 %	572 100.00 %	
Country need planned to be covered by domestic & other sources				
E. Targets to be financed by allocation amount	565 97.92 %	565 98.09 %	560 97.90 %	
F. Coverage from Allocation amount and other resources C+E	565 97.92 %	565 98.09 %	560 97.90 %	
G. Targets to be potentially financed by above allocation amount	0 0.00 %	0 0.00 %	0 0.00 %	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	565 97.92 %	565 98.09 %	560 97.90 %	

Coverage Indicator : MDR TB-3: Number of cases with drug resistant TB (RR-TB and/or MDR-TB) that began second-line treatment

Current National Coverage	Year	Source	Latest Results
	2014	R&R TB system, yearly management report	501.0

	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	CCM Comments
Current Estimated Country Need				
A. Total estimated population in need/ at risk	512	521	529	
B. Country targets	500 97.66 %	510 97.89 %	516 97.54 %	
Country Need Already Covered				
C. Country need planned to be covered by domestic and other sources	0 0.00 %	177 33.97 %	387 73.16 %	MDR-TB patients for whom SLDs will be procured by the Government (commitment: 2017 - 35%, 2018 - 75%)
Programmatic Gap				
D. Expected annual gap in meeting the need A-C	512 100.00 %	344 66.03 %	142 26.84 %	MDR-TB patients for whom SLDs will be procured by TGF NFM project
Country need planned to be covered by domestic & other sources				
E. Targets to be financed by allocation amount	500 97.66 %	333 63.92 %	129 24.39 %	
F. Coverage from Allocation amount and other resources C+E	500 97.66 %	510 97.89 %	516 97.55 %	
G. Targets to be potentially financed by above allocation amount	0 0.00 %	0 0.00 %	0 0.00 %	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	500 97.66 %	510 97.89 %	516 97.55 %	

Coverage Indicator : MDR TB-4: Percentage of cases with drug resistant TB (RR-TB and/or MDR-TB) started on treatment for MDR-TB who were lost to follow up at six months

Current National Coverage	Year	Source	Latest Results
	2014	R&R TB system, yearly management report	12.89

	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	CCM Comments
Current Estimated Country Need				
A. Total estimated population in need/ at risk	500	510	516	
B. Country targets	60 12.00 %	57 11.18 %	53 10.27 %	
Country Need Already Covered				
C. Country need planned to be covered by domestic and other sources	0 0.00 %	0 0.00 %	0 0.00 %	While the Government increasingly takes over costs of treatment (including SLDs) and adherence support (including cash incentives for MDR patients), it is impossible to quantify this contribution for this specific indicator.
Programmatic Gap				
D. Expected annual gap in meeting the need A-C	500 100.00 %	510 100.00 %	516 100.00 %	
Country need planned to be covered by domestic & other sources				
E. Targets to be financed by allocation amount	60 12.00 %	57 11.18 %	53 10.27 %	
F. Coverage from Allocation amount and other resources C+E	60 12.00 %	57 11.18 %	53 10.27 %	
G. Targets to be potentially financed by above allocation amount	0 0.00 %	0 0.00 %	0 0.00 %	
H. Total coverage (allocation amount, above allocation amount and other resources) F+G	60 12.00 %	57 11.18 %	53 10.27 %	

Module: HSS - Policy and governance

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline				Targets								
								Year 1		Year 2		Year 3			
			N # / D #	%	Year	Source	Total Targets	N # / D #	%	N # / D #	%	N # / D #	%	N # / D #	%

Percentage of TB cases, all forms, receiving the entire treatment in outpatient (ambulatory) setting			30.0	2014	R&R TB system, yearly management report	Allocation + Other Sources	35.0	40.0	45.0		
						Above+Allocation+Other sources					
Comments [1]											
Number of PHC providers (doctors and nurses) trained in priority issues of TB control			2,573		Other (specify)	Allocation + Other Sources	20	1,300	1,300		
						Above+Allocation+Other sources					
Comments [1]	USAID TB Prevention Project supported training for 1275 family physicians and 1298 primary care nurses in various regions of Georgia through a two-day course on TB detection and management in 2012-2015. The baseline indicates the cumulative number of physicians and nurses trained over the last three years. The USAID project has achieved almost 60% coverage with this training of primary care providers (estimated at 4400). Capacity building of PHC providers (doctors and nurses) within NFM includes refresher training as continuation of previous activities supported by TGF and USAID (TPP URC project). More than 50% PHC providers will be covered by this program during the NFM lifetime.										
Number of people trained in priority legal and ethical aspects of TB control			0		Training records	Allocation + Other Sources		320	40		
						Above+Allocation+Other sources					
Comments [1]	Training in legal / ethical issues will be organized in view of the amended legal framework, for managers of TB service provider institutions, lawyers, national bureau of enforcement and staff of district public health units.										
Government expenditure for TB control services as percentage of general government expenditure for health care			2.2	2014	National Health Account	Allocation + Other Sources	2.5	3.0	3.5		
						Above+Allocation+Other sources					
Comments [1]											
Number of TB doctors trained in priority issues of TB control			126	2014	Training records	Allocation + Other Sources	80	120	120		
						Above+Allocation+Other sources					
Comments [1]	USAID TB Prevention Project supported training for 126 TB specialists in 2014. The training was focused on MDR TB treatment mental side effects management (126 physicians took the course) and introducing new treatment schemes as per latest WHO guidelines (63 physicians trained). The training programs will target the full cohort 230 TB physicians practicing currently countrywide. In addition to the unified training programs for all physicians on priority topics, specific needs based training will be conducted for selected groups.										
Number of TB nurses trained in priority issues of TB control			53	2014	Training records	Allocation + Other Sources	96	192	192		
						Above+Allocation+Other sources					
Comments [1]	in 2014 USAID TB Prevention project supported training of 53 nurses in management of TB treatment related mental side effects. Within NFM in year one the training program will target nurses working at a central level. The entire cohort of 200 TB nurses will be targeted with training programs on selected priority topics during the following two years. The target takes into consideration training "no-show" rate estimated at 5%.										
Number of performance appraisal visit conducted to family physicians and general practice nurses			500	2014	Other (specify)	Allocation + Other Sources		210	140		
						Above+Allocation+Other sources					
Comments [1]	USAID TB Prevention Project supported performance appraisal and on-site mentoring for more than 500 family physicians and 500 nurses in five regions of Georgia in 2013-2015. The NFM target is 350 teams composed of a physician and a nurse in year 2 and 3.										

Module budget - HSS - Policy and governance			
Allocated request for entire module	USD 1,162,110	Above allocated request for entire module	USD 0

Intervention	Intervention budget (request to the Global Fund only)						
	Responsible Principal Recipient(s)	Total Targets	Year 1	Year 2	Year 3	Cost Assumptions [3]	Other funding [4]
						The Activities under the NFM Intervention 3.1	

Development and implementation of health legislation, strategies and policies		Allocation	106,100	585,280	470,730	"Strengthening core health system functions for TB control" include: 3.1.1. External technical assistance will be sought in priority areas related to strengthening the health system's functions for TB control, in particular in revising financing and provider payment mechanisms, human resources planning and medical education, improving TB service delivery with expanding outpatient case management, and strengthening the links to health services' performance in the national TB information system. 3.1.2. National consultants will be engaged in practical work on revision / update of the relevant legislative and regulatory documents for improving the health services' performance for effective TB control, including support to symptomatic treatment / palliative care. 3.1.3. International training and support to attendance of key international TB events abroad (conferences, high-level meetings and consultations) will be provided for NTC and MoLHSA staff, NTP coordinators and leading TB specialists from both civilian and penitentiary sectors. 3.1.4. Training of health care managers from private provider organizations will be conducted, to facilitate the implementation of new approaches and changes for effective TB care delivery. 3.1.5-3.1.9. Capacity building will be supported by training of TB service staff, as well as PHC staff at the central and regional level. The training program will focus on managerial aspects to support the planned reorganization of TB service delivery with emphasis on coordination of services across different levels of care, expanding quality treatment in ambulatory conditions and implementation of patient-centered approaches. 3.1.10. National consultants in TB legal and ethical issues will be engaged in the organization of policy dialogue and technical discussions among key stakeholders, introducing amendments to the existing laws and development of new legislation and regulations. 3.1.11. Training in legal / ethical issues will be organized in view of the amended legal framework, for managers of private health care provider institutions, public health professionals and NTP staff. 3.1.12. PHC onsite performance appraisal and mentoring.It is proposed to continue performance appraisal for PCPs and target additional 350 teams trained with USAID TB Project support in 2015. 3.1.13.Developing 3 e-learning program on MDR TB management 3.1.14.Elaborate and support implementation of palliative care model through international and local technical assistance 3.1.15.Training programs for physicians in	
		Above	0	0	0		Not applicable.

						borderline specialties. This training will build on experience of USAID TB prevention project, use already available training resources and target additional 400 physicians over the 2.5 years period. 3.1.16.Training programs for epidemiologists in various aspects of TB detection and management. The NFM proposes to continuously support capacity building of epidemiologist and organize refresher training course in 2017 on most important aspects of TB case management in line with their responsibilities. .	

Description of Intervention [2]
In line with the principles and priorities of the health system Concept, the Government will ensure that the needs of TB control are properly integrated in the planned health system transformation process. For this purpose, a set of actions will be undertaken for strengthening the main health system functions in this regard: governance and management, financing and allocation, resource development, and service delivery. MoLHSA will apply specific measures to strengthen the governance and management arrangements of the national program. The new NSP outlines four priority areas for improving the NTP governance and management for 2016-2020: 1) Strengthening the NTP governance arrangements at the central level; 2) Ensuring harmonization of key legislation and regulations in line with NSP priorities; 3) Enabling effective program management at sub-national (regional and district) level; and 4) Improving program supervision, monitoring and evaluation. A functional NTP central unit is a key requirement for effective implementation of complex TB control interventions. To ensure effective program management and coordination, the arrangements instituted in late 2014 will be operationalized and further developed. The National TB Council (NTC) will act in the capacity of the central coordination body for the national TB program. The NTC will oversee the implementation of the NSP, carry out strategic and operational planning of key activities, support mobilization of required resources for TB control, and facilitate the mainstreaming of legislation, regulations and standards in line with best international practices. The NTC will be responsible for monitoring and evaluating the progress towards achieving the objectives and targets of the national TB response. The NTC will accord special attention to proper integration of TB control interventions in the civilian and penitentiary sectors, as well as to strengthening the collaboration between TB services and HIV services. For this purpose, the NTC will ensure the effective involvement of the Ministry of Corrections (MoC) and the National HIV/AIDS Program (NAP). During the first two years of NSP and NFM project implementation, MoLHSA will lead a comprehensive revision of the key legislation and regulations, in order to align them with the NSP priorities and enable effective implementation of the planned interventions. Besides the new law on tuberculosis which will be adopted in 2015, specific amendments will be made to other laws of Georgia and bylaws regulating public health. TB-related provisions will be integrated in the regulations related to Universal Health Care program and other acts regulating service provision, with special attention to enabling the private health care providers for executing the expected functions in TB control and, on the other hand, to ensuring appropriate oversight and monitoring by the State. During the next five years covered by the new NSP, outpatient model of TB care delivery will be further prioritized, including that for treatment of M/XDR-TB cases. For this purpose, all programmatic and financial instruments will take special account of the need to expand outpatient case management and improve its quality. Appropriate provisions will be included in the guidelines, provider payment schemes, diagnostic approaches at peripheral service level (including the use of Xpert MTB/RIF technology), drug management system including pharmacovigilance and management of ADRs, supervision and recording and reporting system. Taking into account re-emphasis on primary health care level, articulated in the recent health care development Concept, contemporary approaches for TB prevention, care and control will be further integrated into PHC training curricula, regulations and payment schemes. Special emphasis is placed on strengthening the collaboration between the NTP and the National HIV/AIDS Program. Both National Strategic Plans for TB and HIV have been developed in close coordination between the two programs, to ensure appropriate inclusion of collaborative activities as recommended by WHO and UNAIDS, such as interventions to reduce TB burden in HIV-infected prisoners (‘the Three I’s for HIV/TB’) and administration of ART in patients with HIV-associated TB. All TB/HIV interventions will be implemented in close coordination between the NTP and NAP, including integration of information systems.

Module: HSS - Health information systems and M&E							
Module budget - HSS - Health information systems and M&E							
Allocated request for entire module	USD 958,050			Above allocated request for entire module		USD 0	
Intervention		Intervention budget (request to the Global Fund only)					
	Responsible Principal Recipient(s)	Total Targets	Year 1	Year 2	Year 3	Cost Assumptions [3]	Other funding [4]

Analysis, review and transparency		Allocation	0	19,150	22,950	The NFM proposal includes the following Activities under the Intervention 4.2 “To improve the Health Information System to monitor the access to necessary health services for the general and key affected populations": 4.2.1. External technical assistance 4.2.2. Results dissemination / consensus workshop.	Field work for this survey will be funded by the state.
		Above	0	0	0		

Description of Intervention [2]

The requested financial support from the Global Fund will allow procuring the international technical assistance for the methodology revision and performing the data analysis and reporting for the next HUES to be conducted in 2017 that will help to bridge the existing information gap and obtain necessary information on access to essential health services for the key affected populations. The field work for HUES 2017 is expected to be financed by the Government. Additional financial support for external and local technical assistance is requested as a necessary input for production of the first SHA and further institutionalization of the new system that will help to routinely track and account for the financial resources devoted to HIV/AIDS and TB, which was never performed in the past. It encompasses support to the implementation of the next wave of the Health Utilization and Expenditure Survey (HUES) to measure the utilization and access to essential and specialized health services for the general and key affected populations and support to the production and institutionalization of the first SHA 2011 in Georgia. HUES 2007, 2010 and 2014 has served as a sole source of the nationally representative information on health services utilization and expenditures. To obtain reliable information on access to essential and specialized health services for the gneral and the HIV/AIDS and TB key affected populations for the next HUES planned in 2017, the Government plans to revise methodology to capture in more detail the utilization and expenditure patterns for these target groups. While the field work for HUES 2017 is expected to be financed by the Government, the requested financial support from the Global Fund will allow procuring the international technical assistance for the methodology revision and performing the data analysis and reporting. Georgia is producing the national health accounts to track the health expenditures since 2007, however TB and HIV/AIDS sub-accounts were never produced. From the year 2016, Georgia plans to transition to WHO recommended System of Health Accounts (SHA) 2011 methodology that distributes all health care expenditures by diseases/condition (including HIV/AIDS and TB). Production of individual sub-accounts is no longer recommended with SHA 2011. Accomplishing this task will allow the country to better track and account for the financial resources devoted to HIV/AIDS and TB.

Program supervision, monitoring and evaluation		Allocation	343,190	286,380	286,380	The NFM support is sought for the following Activities under the Intervention 3.2 "Supervision, monitoring and evaluation of the National TB Program": 3.2.1. Central NTP supervision 3.2.2. Regional NTP supervision 3.2.3. NTP supervision in the penitentiary system 3.2.4. NTP program coordination meetings 3.2.5. National consultants, TB information system 3.2.6. Printing of TB guidelines, R&R forms and registers 3.2.7. Human resources support to program supervision, M&E 3.2.8. Vehicles' maintenance and insurance 3.2.9.Nine vehicles will be purchased one for each region and one for Tbilisi.	Not applicable
		Above	0	0	0		

Description of Intervention [2]

Program supervision, monitoring and evaluation is an essential public health function, and is an integral part of the national program’s governance and management setup. While supportive NTP supervision will be maintained as a key instrument for oversight and implementation support, its scope and tasks will be further expanded in the process of taking over from the Global Fund, taking account of the national TB control priorities. Supervision will cover all aspects related to implementation of TB control interventions at the regional, district and institutional level: case detection, diagnostic activities and laboratory support (with separate supervision of rollout of molecular diagnostics at peripheral service level, see Intervention 1.1); screening for active TB among contacts and other risk groups; treatment / case management; patient adherence support and defaulter tracking activities; drug management including pharmacovigilance and management of ADRs; management of comorbidities; LTBI testing and preventive treatment; TB/HIV related activities; and recording and reporting. It is planned to continue the current successful setup for NTP supervision: central supervision visits by NCTLD staff to the regions 2 times a year, and regional supervision visits to districts within the regions on a quarterly basis. For effectiveness and relevancy of supervision, the checklists and format of reports will be updated to accommodate for NSP requirements and new interventions, ensure delivery of evidence for service improvement decisions at the spot, and provide for effective data analyses and evidence generation for decision making at the national level. Importantly, supervision will pay an increasing attention to the service performance through addressing such aspects as delays in diagnosis, referral issues, delays between diagnosis and treatment initiation, etc. The national TB information system will be further strengthened. The new individualized electronic information system (development supported by USAID / URC) was endorsed for use by the Government in April 2015 and will become operational at all peripheral TB service delivery sites by the end of this year. All indicators and data collection tools have been aligned to the latest WHO standards. Diagnostic / laboratory data, including Xpert MTB/RIF data, will be integrated with the rest of the database; data related to TB/HIV collaborative activities, as well as drug management data (including those related to ADRs and pharmacovigilance) will be appropriately included by end-2016. Further, integration of health service performance data (such as hospital activity indicators, data on contacts’ investigation and delays in service provision), as well as links to expenditure data, will be completed (by end-2018).

Module: Community systems strengthening

Measurement framework for module

Coverage/Output indicator	Responsible PR(s)	Tied to	Baseline				Targets							
							Total Targets	Year 1		Year 2		Year 3		
			N # / D #	%	Year	Source		N # / D #	%	N # / D #	%	N # / D #	%	

Number of NGO projects implemented (in innovative approaches in adherence support; and case detection, case management and prevention among risk groups)			6	2014	Other (specify)	Allocation + Other Sources	0	5	5
						Above+Allocation+Other sources			
Comments [1]	Six NGO project were implemented aimed at adherence support, early TB detection and case management with USAID TB Prevention Project Support in 2014-2015.								
Number of mass media representatives trained in ACSM issues related to TB control			40	2014	Other (specify)	Allocation + Other Sources	120	120	120
						Above+Allocation+Other sources			
Comments [1]	40 Journalists were training on TB related issues in 2013, training for additional 30 media representatives will take place in Julu 2015. This activity has been supported by USAID Georgia TB Prevention Project.								

Module budget - Community systems strengthening			
Allocated request for entire module	USD 871,125	Above allocated request for entire module	USD 0

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only) Total Targets	Year 1	Year 2	Year 3	Cost Assumptions [3]	Other funding [4]
Social mobilization, building community linkages, collaboration and coordination		Allocation	56,225	392,450	422,450	The Activities to be supported by TGF under the Intervention 3.3 "Civil society engagement, advocacy, communication, social mobilization (ACSM) for TB control" include: 3.3.1. NGOs projects for innovative approaches in adherence support 3.3.2. NGOs projects for case detection, case management and prevention among risk groups 3.3.3. National NGO workshops on TB control, civil society involvement and community response 3.3.4. TB knowledge, attitude and practice (KAP) study 3.3.5. TB informational and educational materials 3.3.6-3.3.7. Training and briefings for mass-media on TB (at central level) 3.3.8. ACSM activities during the World TB Days 3.3.9. Sub Recipient management and administration costs	Not applicable
		Above	0	0	0		

Description of Intervention [2]

The Government of Georgia recognizes the need for strengthening the partnerships with the civil society establishments and the involvement of non-state actors as a key prerequisite for the success of the nationwide TB response. This Intervention aims at implementing patient-centered approaches through fostering the local NGOs' involvement in TB care, through implementing innovative models for ensuring adherence to TB treatment, tailored to the specific local conditions and to the needs of individual patients. The NGO projects are expected to employ a number of common interventions, such as multidisciplinary teams for comprehensive approach to the patient and improved coordination with relevant public and private services; social accompaniment for beneficiaries at high risk of defaulting; and promotion of patient rights and equal access to essential services. Special attention will be paid to facilitating access to TB prevention, diagnosis and care for hard-to-reach groups at high risk, such as prisoners and ex-prisoners, PLHIV, people who inject drugs (PWID) and other risk groups. The NTP will encourage the involvement of NGOs that have experience working with the above population segments, including that in delivering HIV prevention and harm reduction services. The recent developments in TB control strategies and technologies call for the adaptation and upgrade of informational and educational activities, implemented within the TB control program. Proper information and education work with TB patients and households is an integral part of the patient-centered TB care. Comprehensive ACSM approaches imply active involvement of different non-state partners such as civil society organizations, church, patient advocates, peer supporters, mass media and others. The NTP will use the updated information packages and will diversify approaches that are tailored to different audiences.

Module: Program management

Module budget - Program management			
Allocated request for entire module	USD 738,925	Above allocated request for entire module	USD 0

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only) Total Targets	Year 1	Year 2	Year 3	Cost Assumptions [3]	Other funding [4]

Grant management		Allocation	208,383	324,260	206,282	The program management component includes staffing, office management, communication and other relevant activities and costs of the nominated Principal Recipient – the National Center for Disease Control and Public Health (NCDCPH).	Not applicable
		Above	0	0	0		

Description of Intervention [2]

National Center for Disease Control and Public Health will act as principle recipient for this program.

Module: HSS - Service delivery

Module budget - HSS - Service delivery

Allocated request for entire module	USD 155,500	Above allocated request for entire module	USD 0

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only)				Cost Assumptions [3]	Other funding [4]
		Total Targets	Year 1	Year 2	Year 3		
Service organization and facility management		Allocation	22,100	131,600	1,800	The NFM proposal includes the following Activities under the Intervention 4.1 "Ensuring service availability and enhancing the integration of TB and HIV/AIDS services into the wider health system and across the care continuum": 4.1.1. External technical assistance 4.1.2. National consultants 4.1.3. Results dissemination / consensus workshop.	Not applicable
		Above	0	0	0		

Description of Intervention [2]

This intervention aims to enhance the integration of TB and HIV/AIDS services into the wider health system and across the care continuum. Funding from the Global Fund is requested to produce and disseminate the long-term master plan for the integrated model of HIV/AIDS and TB services that will encompass several scenarios for integration of these services at all levels of care. Accomplishing this task is essential for defining the long term vision and planning for the implementation of the integrated service model for HIV/AIDS and TB patients in the country and to mitigate any potential risks related to the TB services gaps that may arise as a result of the expiration in 2017 the obligation to provide TB services imposed on private health providers. The Activities under this Intervention focus on the critical planning measure for the implementation of the integrated model for delivery of HIV/AIDS and TB services. The GHSC 2014-2020 envisions improving referrals, coordination and other aspects of integration between the levels of care (inpatient care, outpatient specialized care, PHC) and services (such as, TB service and HIV service) and strengthening quality control and quality assurance in TB and HIV/AIDS diagnostic, curative and preventive services at all levels. Establishment of this new integrated service model for HIV/AIDS and TB services will require long-term master planning that would entail: • Assessing future needs for HIV/AIDS and TB services based on epidemiological projections and several possible scenarios involving varying degree and levels of service integration; • Service Availability and Readiness Assessment (SARA) of currently available facilities and human resources at all levels of care • Providing recommendations for infrastructure optimization and human resources planning in medium (3-5 years) to long term (5-10 years) perspective considering the several scenarios for service integration, in the light of possible termination of TB services provision by some private providers in future The resulting master plan is expected to be socialized and ownership solicited from wide range of stakeholders. The master plan exercise will help to clearly define the long term vision for the integrated model of HIV/AIDS and TB services in the country and serve as a basis for the investment planning in service infrastructure and human resources for HIV/AIDS and TB control national programs.

Module: Results-based Financing

Module budget - Results-based Financing

Allocated request for entire module	USD 201,800	Above allocated request for entire module	USD 0

Intervention	Responsible Principal Recipient(s)	Intervention budget (request to the Global Fund only)				Cost Assumptions [3]	Other funding [4]
		Total Targets	Year 1	Year 2	Year 3		

Results-based financing		Allocation	3,600	143,700	54,500	The NFM proposal includes the following Activities under the Intervention 4.3 "To improve financing mechanisms to support the integration and increase in coverage, effectiveness and quality of the TB and HIV/AIDS services": 4.3.1. External technical assistance 4.3.2. National consultants.	Not applicable.
		Above	0	0	0		

Description of Intervention [2]
Funding is requested from the Global Fund to support the introduction of the Results Based Financing (RBF) mechanism for the improvement of the utilization and quality of TB and HIV/AIDS services and address current challenges in financing these services. The requested funding will be used to procure international and local technical assistance for the design and piloting of the RBF schemes on the PHC level and the design and implementation of the new financing methods at hospital level. Introducing the RBF mechanism for the improvement of the utilization and quality of TB and HIV/AIDS services is expected to address current challenges in financing HIV/AIDS and TB services: low salaries for TB personnel, low motivation of PHC providers to detect and refer HIV/AIDS and TB patients for diagnosis and provide case management, follow-up and adherence support to TB patients. The RBF is also expected to introduce financial incentives for private provider organizations to: (a) retain the TB services and (b) properly manage and monitor the TB services provided by the contracted TB specialists and PHC providers. Following activities are envisioned to accomplish this objective: • Design and piloting of the performance based service delivery contracts with private health providers and their networks; • Design and support to the pilot implementation of the Pay For Performance (P4P) schemes for outpatient service providers (both PHC and TB specialists) rewarding improved coverage with TB preventive, detection, referral, treatment and adherence support services) and HIV/AIDS detection/referrals; • Design of the new provider payment mechanism for inpatient TB services (global budgets based on the case mix with incorporated performance incentives for improved efficiency and quality of care).

E. Financial Gap Analysis and Counterpart Financing

Country: Georgia	Currency: USD
Component: Tuberculosis	Cycle: January - December
Year of CN Submission: 2015	

	Current and previous			Estimated					
Part One: National Strategic Plan Funding Needs and Resources									
Total Funding Needs									Data Sources/Comments
	01/2013 - 12/2013	01/2014 - 12/2014	01/2015 - 12/2015	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	01/2019 - 12/2019	01/2020 - 12/2020	
Total Funding needs for the National Strategic Plan (provide annual amounts)	14,135,666	14,363,431	15,500,000	16,533,167	20,110,112	19,207,261			Source: National TB Strategic Plan 2016-2020 (July 2015)
LINE A: Total Funding needs for the National Strategic Plan	43,999,097			55,850,540					

Domestic Resources									Data Sources/Comments
	01/2013 - 12/2013	01/2014 - 12/2014	01/2015 - 12/2015	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	01/2019 - 12/2019	01/2020 - 12/2020	
Total Resources									
Domestic source B1: Loans									
Domestic source B2: Debt relief									
Domestic source B3: Government revenues	8,736,596	8,980,010	6,290,627	7,595,460	7,777,270	7,913,640			Data sources: NHA, MTEF/BDD, TB Expenditures Assessment report (2015)
Domestic source B4: Social health insurance									
Domestic source B5: Private sector contributions national									
LINE B: Domestic Resources	8,736,596	8,980,010	6,290,627	7,595,460	7,777,270	7,913,640	0	0	

External Resources									Data Sources/Comments
	01/2013 - 12/2013	01/2014 - 12/2014	01/2015 - 12/2015	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	01/2019 - 12/2019	01/2020 - 12/2020	
Other				300,000	300,000	300,000			
United States Government (USG)	1,060,012	857,716	950,000	300,000	300,000	250,000			
World Health Organization (WHO)	11,124	9,740	25,000	50,000	50,000	50,000			
Medicins Sans Frontiers (MSF)	506,476	868,055	1,500,000	2,083,660	2,083,660	2,083,660			
LINE C: External Resources	1,577,612	1,735,511	2,475,000	2,733,660	2,733,660	2,683,660	0	0	

Global Fund Resources									Data Sources/Comments
	01/2013 - 12/2013	01/2014 - 12/2014	01/2015 - 12/2015	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	01/2019 - 12/2019	01/2020 - 12/2020	
GEO-T-GPIC	5,078,692	0	0	0	0	0			
GEO-T-NCDC	0	5,210,719	5,313,392	1,319,227	0	0			
LINE D: Global Fund Resources	5,078,692	5,210,719	5,313,392	1,319,227	0	0	0	0	

Total Request									
	01/2013 - 12/2013	01/2014 - 12/2014	01/2015 - 12/2015	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	01/2019 - 12/2019	01/2020 - 12/2020	
Total anticipated resources (annual amounts)	15,392,900	15,926,240	14,079,019	11,648,347	10,510,930	10,597,300	0	0	
LINE E : Total anticipated resources (Line B+C+D)	45,398,159			32,756,577					
Annual Anticipated Funding Gap (Total funding need - Total anticipated funding gap)	0	0	1,420,981	4,884,820	9,599,182	8,609,961	0	0	
LINE F: Total anticipated funding gap (Line A - E)	-1,399,062			23,093,963					
LINE G: Total Funding Request to the Global Fund			0	3,020,631	5,251,852	3,634,254	0	0	
LINE H: Funding request within the Allocated Amount			0	3,020,631	5,251,852	3,634,254	0	0	
LINE I: Funding request above the Allocated Amount			0	0	0	0	0	0	

Part Two: Overall Health Sector - Government Health Spending

Government Health Spending									Data Sources/Comments
	01/2013 - 12/2013	01/2014 - 12/2014	01/2015 - 12/2015	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	01/2019 - 12/2019	01/2020 - 12/2020	
Domestic source J1: Loans									
Domestic source J2: Debt Relief									
Domestic source J3: Government funding resources	324,979,410	408,238,295	365,490,623	374,731,775	392,757,625	411,003,932			Data sources: NHA, MTEF/BDD
Total government health	324,979,410	408,238,295	365,490,623	374,731,775	392,757,625	411,003,932	0	0	

Part Three: Counterpart Financing

Low income = 5% low income, lower lower-middle income = 20%, upper lower-middle income (high level) = 40%, upper-middle income = 60%

Counterpart Financing									
	01/2013 - 12/2013	01/2014 - 12/2014	01/2015 - 12/2015	01/2016 - 12/2016	01/2017 - 12/2017	01/2018 - 12/2018	01/2019 - 12/2019	01/2020 - 12/2020	
Total government resources	8,736,596	8,980,010	6,290,627						
Average of government resources	8,002,411								
Average of request within allocated	4,408,655								
Counterpart financing based on existing commitments	64.48%								
Average of total request	4,341,987								
Counterpart financing based on total funding request	64.83%								

Footnotes

1 - Target Assumptions :

Please describe:
1) overall assumptions used in calculating targets,
2) anticipated rate of scale-up,
3) population size estimates,
4) description of indicator/package of services,
5) data source,
6) other relevant information

2 - Description of Intervention :

Please describe:
1) rationale for Global Fund support,
2) linkages to national strategic plan,
3) target population and geographic scope,
4) implementation approach, and
5) other relevant information.
Please differentiate between scope of allocated and above allocated request

3 - Cost Assumptions for the request of the Global Fund

Please describe:
1) cost assumptions and data sources,
2) key activities,
3) other relevant information.
Please differentiate between allocated and above allocated

4 - Other funding received for this intervention (including scope of activities funded)