

**FUNDING REQUEST APPLICATION FORM**

**Full Review**

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| **SUMMARY INFORMATION** | | | |
| **Applicant** | NEPAL | | |
| **Component(s)** | TUBERCULOSIS | | |
| **Principal Recipient(s)** | Save The Children Federation, Inc. | | |
| **Envisioned grant(s) start date** | 16 March 2018 | **Envisioned grant(s) end date** | 15 March 2021 |
| **Allocation funding request** | USD 16,138,548 | **Prioritized above allocation request** | 8,721,737.09 |

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| ***IMPORTANT:***  **To complete this funding request**, please:   * Refer to the accompanying ***Funding Request Instructions: Full Review****;* * Refer to the Information Note for each component as relevant to the funding request, and other guidance available, found on the [Global Fund website](http://www.theglobalfund.org/en/applying/funding/resources/). * Ensure that all mandatory attachments have been completed and attached. To assist with this, an application checklist is provided in the Annex of the *Instructions*; * Ensure consistency across documentation.   **Applicants are encouraged to submit a joint funding request** for eligible disease components and resilient and sustainable systems for health (RSSH).  **Joint TB/HIV submissions are compulsory for a selected number of countries with highest rates of co-infection.** See the related [guidance](http://www.theglobalfund.org/en/applying/funding/resources/#coreinformationnotes) for more information. |

**This funding request includes the following sections:**

**Section 1**: Context related to the funding request

**Section 2**: Program elements proposed for Global Fund support, including rationale

**Section 3**: Planned implementation arrangements and risk mitigation measures

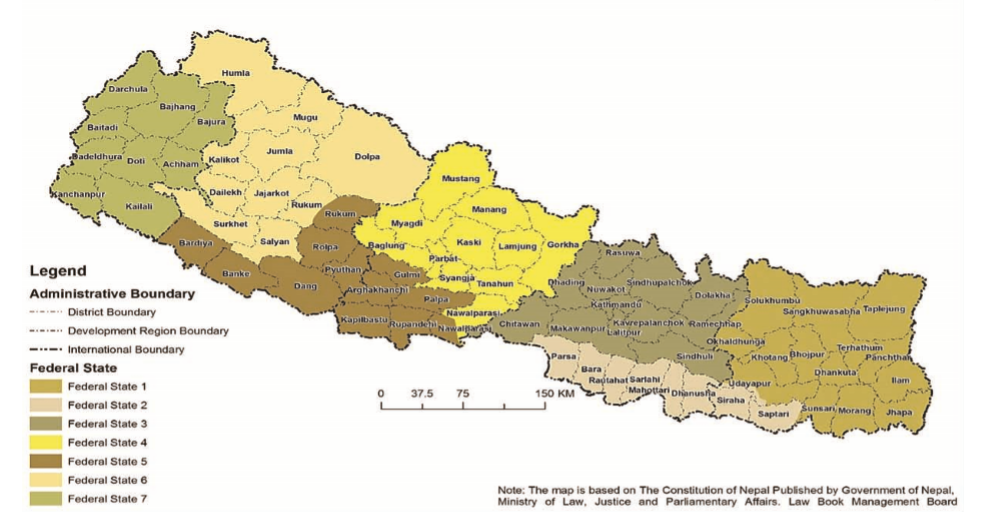
**Section 4**: Funding landscape, co-financing and sustainability

**Section 5**: Prioritized above allocation request

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| **SECTION 1: CONTEXT** |
| This section shouldcapture in a concise way relevant information on the country context. Attach and refer to key contextual documentation justifying the choice of interventions proposed. To respond, refer to additional guidance provided in the *Instructions*. |

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| **1.1 Key reference documents on country context** | | | | |
| List contextual documentation for key areas in the table provided below. If key information for effective programming is not available, specify this in the table (“N/A”) and explain in Section 1.2 how this was dealt with within the context of the request, including plans, if any, to address such gaps.  Applicant response in table below. | | | | |
| **Key area** | **Applicable reference document(s)** | **Relevant section(s) & pages nb.** | **N/A** | |
| **Resilient and Sustainable Systems for Health (RSSH)** | | | | |
| Health system overview | National Demographic Health Survey, 2016 (Annex-26) | Page-23 |  | |
|  | Integrated Health Infrastructure Development, MoH, GoN, 2017 (Annex-4) | Full |  | |
|  | Nepal Health Facility Survey, 2015, (Annex-12) | Pages- 44, 195-201 |  | |
|  | Budget Analysis of Nepal Health Sector-II (Annex-28) | Pages iii-iv, 11, 21-28 |  | |
| Health system strategy | Nepal Health Sector Strategy, 2016-2020 (Annex-1) | Page 6-7 |  | |
|  | Nepal Health Sector Strategy Implementation Plan, 2016-21 (Annex-9) | Pages 105-112 |  | |
| Human rights and gender considerations (cross-cutting) | Operational Guidelines for Gender Equality & Social Inclusion Mainstreaming in the Health Sector, MoH, 2013 (Annex-5) | Page- 4,  9-13 |  | |
| **Disease-specific** | | | | |
| Epidemiological profile (including interventions for key and vulnerable populations, as relevant) | Epidemiological Review of TB Disease in Nepal, 2014 (Annex-21) | Pages 4-5; 18-25 |  | |
| Disease strategy (including interventions for key and vulnerable populations, as relevant) | National Strategic Plan for TB prevention, care and control, 2016-2021 (Annex-7)  NSP Monitoring and Evaluation Plan, 2016-2021 | Pages 4, 51, 55, 58, 65, 68-69  Full |  | |
|  | National Tuberculosis Programme: Clinical Manual, 2017 (Annex-16) | Pages 7, 45, 98, 99 |  | |
|  | National Childhood TB Management Guideline\_2017 (Annex-17) | Pages 2-3 |  | |
|  | Identification and Mapping of Outreach and Vulnerable Tuberculosis Populations in Six Districts of Nepal, 2016 (Annex-15) | Pages 1-8 |  | |
|  | Nepal HIVision: 2020 (Annex-19) | Page-10 |  | |
|  | PPM Strategy and Guidelines for TB control, 2017 (Draft) (Annex-22) | Page-6-11, |  | |
| Operational plan, including budgetary framework | Operationalizing the Community Systems Strengthening (CSS) components within the NSP for Nepal, 2016-2021 (Annex-25) | Pages  16-21 |  | |
| Program reviews and/or evaluations | Annual Review of the NTP, MoH, Nepal, 2016 (Annex-2) | Section-1 |  | |
|  | Annual NTP Report, 2016 (Annex-8) | Page-14, 19,23,31 |  | |
|  | Assessment of Laboratory Support to HIV, TB & Malaria Programmes in Nepal, 2017 (Annex-20) | Section 3.4, Page-10, 21-28 |  | |
|  | PMDT Mission Report, 2016 by the rGLC Secretariat, WHO/ SEARO (Annex-6) | Pages 7-19 |  | |
|  | Mission Report, Nepal, 2016 Supranational Reference Laboratory Munich-Gauting (Annex- 23) | 5.2.2. pg13  5.3.2. pg14 |  | |
|  | GDF Mission Observations, Nepal, 2016 (Annex-18) | Pages 4-5, 8-11 |  | |
| Human rights and gender considerations (disease-specific) | Report of the Focus Group Discussions with key and vulnerable populations, Country Dialogue, Nepal, 2017 (Annex-11) | Full |  | |
| Other documents | WHO Country Cooperation Strategy, Nepal, 2013–2017 (Annex-3) | Page-19 |  | |
|  | Systematic Screening for Active TB: An Operational Guide, WHO, 2015 (Annex-13) | Page-12, 25-27 |  | |
|  | Portfolio analysis and guidance for setting priority for GF investment (Annex-10) | Pages 1-4 |  | |
|  | Report on Thematic Group Meetings (Annex-14) | Full |  | |
|  | National Guidelines for Cervical Cancer Screening & Prevention Nepal, 2016, (Annex-27) | Page-14 |  | |
| **1.2 Summary of country context** | | | |
| To complement the reference documents listed in Section 1.1 above, provide a summary of the critical elements within the context that informed the development of the funding request. The brief description of the context should cover disease-specific and RSSH components, as appropriate, as well as human rights and gender-related considerations.  **(maximum 2 pages per component)** | | | |

Nepal is a low-income sovereign country, located between India and China, with a population of 28.4 million[[1]](#endnote-2) that is scattered over 147,181km2, across three geographically diverse regions: mountains, hills and the *terai* (plains). The complex topographical terrain widens the equity gap in availability, access and utilization of health services (*Annex-1, p6-7*). The terai occupies about 23% of the country but is densely populated (48%); the hills cover 42% with 44% of the population and the mountain zone accounts for 35%, with about 8% of the population (*Annex-2, section1*). Nepal under a federal structure, is divided into 7 provinces (Figure-1).

**Figure-1: Map of the 7 Federal Provinces based on the Constitution of Nepal, 2015**

The country is highly susceptible to climate change risks and ranks 11th globally, in terms of vulnerability to earthquakes. The economic growth rate which had slowed down due to the devastating earthquakes in 2015, is expected to revive to 5.6% in 2017 and continue into 2018 at 5.4%[[2]](#endnote-3). In 2016, the gross domestic product (GDP) per capita was USD 742. The population below the poverty line was 15% in urban areas and 27% in rural areas; the mountain region has the highest proportion of the poor (42%) as compared to the hills and the terai (24% each). The country managed to halve the percentage of people living on less than USD 1.25 a day in only seven years, from 53% (2003-04) to 25% (2010-11)[[3]](#endnote-4). In 2015, out-of-pocket total expenditure on health was 79.9%[[4]](#endnote-5). In 2016, Nepal improved its ranking on the Human Development Index and was placed 144th out of 188 countries[[5]](#endnote-6).

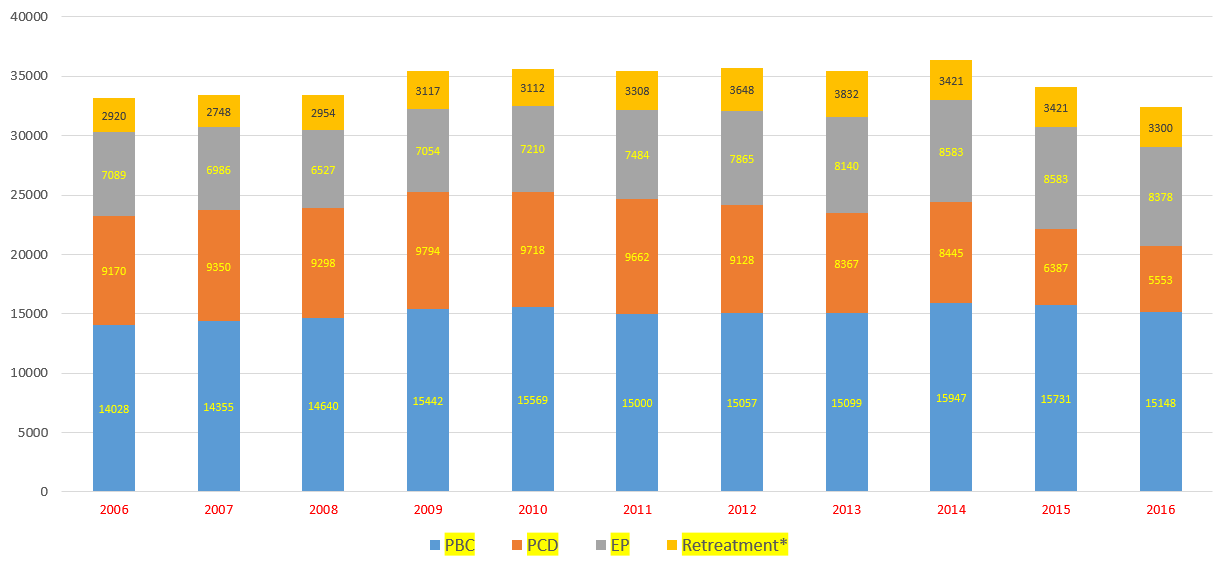
Health is enshrined as a fundamental right in the new Constitution and the investment on health by the Government of Nepal (GoN) is relatively high (10.5%) when compared with other countries in the Region except Bhutan (13.5%) according to WHO (*Annex-3, p19*). The four pillars of the Nepal Health Sector Strategy (2016-2020) are: (i) equitable access to health services; (ii) quality health services; (iii) health systems reform and (iv) multi-sectoral approach.

In May 2017, the Ministry of Health (MoH) presented an Integrated Health Infrastructure Development Plan (*Annex-4*) to fulfil the constitutional obligations, ensure equitable distribution of health facilities and improve accessibility. The national development efforts are also shaped by the operational guidelines for gender equality and social inclusion (GESI) in the health sector. The Local Self-Governance Act (LSGA) has made provisions for inclusive representation in health facility operation management committees (*Annex-5, p9*).

Nepal is a medium TB burden country with estimated rates of incidence and mortality being 156 and 20 per 100,000 population, respectively[[6]](#endnote-7). The TB prevalence (all forms) declined from 348 in 1990 to 211 per 100,000 population (55% reduction) in 2014; TB incidence (all forms) declined from 164 to 156 per 100,000 population and mortality declined from 52 to 20 per 100,000 population (62% reduction)[[7]](#endnote-8).

Nepal’s true TB incidence and mortality will become clear when the planned TB prevalence survey is completed. In 2016, a total of 32,056 TB cases were notified; 64% were males and 36% were females and 37% of TB patients were in the age group of 15-34 years. The proportion of childhood TB (all forms) was around 6% (*Annex-8, p14*).

**Figure-2: TB case notification trend from 2006-2016**   
(Data source: WHO global data and for 2015-16 from NTP)



Case notification was almost flat over past several years, but there was a significant decline in the last two years, particularly in pulmonary clinically diagnosed notifications (smear negative TB), probably due to (i) expansion of molecular diagnostic services; (ii) shift from clinical diagnosis to bacteriological confirmation. In 2015-2016, proportion of pulmonary bacteriologically confirmed (PBC) cases was 47%, pulmonary clinically diagnosed (PCD)-17%, extra-pulmonary (EP)- 26% and retreatment- 10% (Figure-2). TB notification rates in the hills and mountains of Nepal were significantly less than those in the *terai* which reported 56% of the cases, making it likely that TB was under-diagnosed in the hills (40%), and particularly in the mountains which accounted for 4% (*Annex-7, p4*).

Drug-resistant TB cases (MDR and XDR) totalled 403 with about 10% mortality. The treatment success rate (67%) of treated MDR-TB cases is below the global target of 75% (*Annex-8, p31*). In 2015, the estimated number of people living with HIV (PLHIV) was 39,397, with an adult HIV prevalence of 0.2%. HIV prevalence among TB patients was 1.8% and prevalence of TB among PLHIV was 8.5%. Among the registered TB cases, only 18% were tested for HIV, 4.5 % of them were positive for HIV and 89% of them were put on ART (*Annex-8, p23*).

In line with the Sustainable Development Goals[[8]](#endnote-9) (SDGs), the government’s vision “has moved beyond the Stop TB strategy to the End TB strategy[[9]](#endnote-10), by placing at the centre, all people vulnerable for TB, with a focus on community empowerment and private sector involvement in TB management, as a key strategy for moving forward” (*Annex-9, p105*). The goal of the NSP is to “to reduce the TB incidence by 20% by the year 2021 compared to 2014 and increase case notifications by a cumulative total of 20,000 cases by July 2021, compared to 2015/16”. The NTP envisaged to treat over 190,000 TB cases including 13,500 cases of childhood TB; 5,000 TB/HIV co-infected cases; 3,360 with MDR-TB and 116 with XDR-TB. Around 2.2 million smear examinations would be carried out, with 290,000 cultures, 26,000 drug-susceptibility tests and 570,000 GeneXpert (GX) tests. The total estimated cost of the NSP (2016-2020) was USD 105,142,115.

The prioritization of Global Fund (GF) investment guided by an extensive and inclusive country dialogue process would be on high impact interventions to intensify TB case finding, strengthen management of DR-TB patients, childhood TB, TB/HIV collaboration and build resilient and sustainable systems for health (RSSH). The RSSH module would focus on establishing highly synergistic integrated services with the Family Health Division (FHD) and the Child Health Division (CHD), consolidating community health structures, strengthening the specimen transportation system and improving the health management information system (*Annex-10, p1-4)*. The newly developed strategy and guidelines for public-private mix (PPM) would engage the dominant private health sector in a partnership with the NTP (*Annex-22*).

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| **1.3 Past implementation and lessons-learned from Global Fund and other donor investments** |
| 1. List recent disease-specific Global Fund grants from the 2014-16 allocation period and summarize key lessons learned from their implementation. 2. Include lessons-learned from specific HSS grants or any HSS investments embedded in the disease-specific grant(s) from the 2014-16 allocation period as applicable. 3. Outline lessons learned from investments by other donors as applicable.   For each of the above, explain how these lessons learned are taken into account in this funding request. **(maximum 1 page per component)** |

**a)** After the completion of National Strategic Application (NSA) phase in 2014/15, the Global Fund grant to Nepal for 2015/16 was routed through the costed extension plan of the NSA phase with the approved budget of USD 3.57 million. This was followed up by the current GF grant (July 2016-March 2018) for a total of USD 7,244,235.

Summary of key lessons learned

**1. TB case detection and diagnosis:**

TB diagnostic services were mostly concentrated at the primary health care centre (PHCC) level and above, hence a major barrier for people living in remote areas as reported in the country dialogue (*Annex-11*).

**Lessons learned**: Need for targeted ACF strategies, mapping of key and vulnerable populations, using newer diagnostic tools effectively and engaging the private health sector

**(i)** reinforce mandatory TB contact tracing, include the elderly and children; **(ii)** expand facility-based ACF of PLHIV to also screen women attending ante-natal care (ANC) clinics, malnourished children and diabetic patients; **(iii)** switch from passive case finding to ACF in 5 prisons in Kathmandu valley; scale up to cover the remaining (69 prisons); **(iv)** introduce “cough surveillance” and triage in out-patient departments of 74 major hospitals (*Annex-13, p12*); **(v)** organize ACF mobile teams to screen KAP based on mapping of KAP and those identified during the country dialogue, (*Annex-14, Annex-15 p1-8*); **(vi)** expedite implementation of PPM activities; **(vii)** invest in capacity building of lab staff to increase the optimum utilisation of diagnostic services (*Annex-16, p7,45,98,99*). **(viii)** implement an efficient logistic system for sputum transportation; (Annex-7, p58). **(ix)** Reinforce supportive supervision of TB services from all levels.

**2. Childhood TB:**

**Lessons learned:** **(i)** Training of staff on childhood TB management (*Annex-17,p2-3*); **(ii)** establish Childhood TB unit at national level; **(iii)** collaborate with the private health sector; **(iv)** screenall malnourished children for TB and refer to hospitals for management; **(v)** provide Isoniazid preventive treatment (IPT) for children (<5 years) in contact with TB cases (*Annex-18, p4*).

**3. Lost to follow up**: There are over 4,000 TCs but only 589 MCs, TB diagnostic and treatment services together were available only in 30% of facilities (*Annex-12, p195-201*).

**Lessons learned**: **(i)** To accelerate the implementation of the eTB register through which tracking of ‘lost to follow up’ patients, from both in public and private health sectors; **(ii)** sensitizehealth staff and community volunteers to track ‘lost to follow up’ cases who are initially diagnosed or in the treatment phase.

**4. MDR-TB**: **Lessons learned**: **(i)** All presumptive DR TB cases needs to be diagnosed through rapid DST (GX), hence expansion of GX network and sputum transportation system must be in place; **(ii)** for all rifampicin resistant (RR) cases, culture and DST (LPA) for FLD and SLD needs to be done. **(iii)** Short treatment regimen (STR) and new drugs must be available to increase treatment success rate from 67% to at least 75%.

**5. TB/HIV**: **Lessons learned: (i)** Reinforce coordination between NTP and the National HIV Programme at all levels and ART is available for all PLHIV and co-infected cases; **(ii)** High-level advocacy required to mobilize government resources for TB/HIV as domestic funding is not allocated.

**b) HSS investments embedded in the funding request**

**Human resources**: Currently, the Project Management Unit (PMU) based at the National TB Centre (NTC) supported by global fund grant is providing the technical and operational assistance to the NTP. However, this is not adequate to improve clinical and administrative management processes at central and sub-national levels under the new federal structure (*Annex-7, p65*). Only 17% of facilities offering TB diagnosis and/or treatment services had staff with any recent in-service TB training (*Annex-12, p195-201*).

**Lessons learned**: **(i)** Additional reinforcement of technical staff is required to improve programme oversight, coordination, management and capacity building as the GoN will establish provincial TB units under the federal set up; **(ii)** similarly, a focal point will be designated for TB at every palika (>744 across country); **(iii)** support from GF for human resources during the initial period would be required for capacity building of the staff at provincial and palika (>744) levels through the technical assistance units based in provinces.

**Monitoring and Evaluation**: The primary challenges of the system include the inappropriate storage of aggregated, national and sub-national level TB surveillance data and lack of capacity for routine analysis of TB data and systematic feedback (*Annex-21, p4-5*).

**Lessons learned: (i)** The health management information system (HMIS) of the MoH collects aggregate health information from the districts, but it does not provide information on individual patients; **(ii) t**he NTC on the other hand, requires a software for individual monitoring of TB patients monthly which covers all aspects of TB- diagnosis, case management including follow up and completion of treatment; **(iii)** there is a need to harmonize the two streams of data.

**Public-Private-Mix**: The private health sector is very dominant in Nepal. Studies showed that 80% of pharmacies have presumptive TB patients. In the absence of a formal collaborative mechanism between the public and private sectors, the referral of TB cases from the private sector has been low (18%); community referrals accounted for 21% (*Annex-8, p19*).

**Lessons learned**: **(i)** Setting up of a task force at national and sub-national levels will strengthen the partnership between the dominant private health sector and the NTP; **(ii)** the PPM strategy and guidelines should be steered by the National Task Force and led by NTP **(iii)** government legislation of the TB Act making TB notification mandatory from the private sector must be implemented (*Annex-22, p7*).

**c) Investment by other technical partners were essential for annual reviews, surveys, development of guidelines, capacity building and quality assurance (QA)**

WHO has been the main technical partner of the NTP to provide key support in developing the National Strategic Plan, Annual Reports and reviews which are essential for the assessment of the NTP. The next drug resistance survey (DRS) has been planned in 2018-2019 by WHO.

LHL International (LHLI) TB Foundation (Norway) has invested in improving the communication skills of health workers which has created a respectful environment in treatment centres, particularly when stigma and discrimination still exists and staff attitude has been widely criticized. LHLI supported the expansion of Community-based DOT (CB-DOT) in in 5 districts in 2016-2017.

KNCV Tuberculosis Foundation (The Netherlands), has provided an International Long Term Technical Advisor to support the effective implementation of Global Fund grant. In 2017, KNCV and Save the Children International (SCI) jointly conducted two major activities: **(i)** a childhood TB assessment using benchmarking tools followed by the development of the strategy, guidelines and training module for Childhood TB and **(ii)** development of the PPM strategy and guidelines; implementation of both are critical for the NTP.

Kuratorium Tuberkulose in der Welt (KTW), a humanitarian NGO from Germany, associated with the WHO Supranational Reference Laboratory (SRL) for TB in Munich-Gauting, periodically provides technical and financial support to the German Nepal Tuberculosis Project (Genetup) which is closely linked to the NTC being one of the two National TB Reference Laboratories (NRL). Recent assessment has provided guidance and direction for strengthening the NRL to shift gears and perform better (*Annex 23, p13-14*).

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| **SECTION 2: FUNDING REQUEST (Within Allocation)** |
| This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget**, and refer to national strategy documents as applicable.  To respond, refer to additional guidance provided in the *Instructions.*  Ensure that the funding request as described in questions 2.1 and/or 2.2 meets the focus of application requirement as outlined in section 2.3. |

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| **2.1 Disease-specific funding request**  *Not applicable if the application is a standalone RSSH request.* |
| Given the context and lessons learned outlined in Section 1,   1. Describe the disease-specific funding request(s), the rationale for prioritizing modules and interventions, and how these choices ensure the highest possible impact with a view to ending the three diseases and removing human rights and gender-related barriers to accessing services.   For any priority modules for which gaps are difficult to quantify in the programmatic gap tables, explain here the barriers being addressed, the proposed interventions and the population or groups involved.   1. Explain how the funding request addresses the key funding gaps reflected in the Funding Landscape Table(s) for the disease program(s) in the current allocation cycle, and specify other actions planned to cover remaining gaps.   For funding requests including both HIV and TB components:   1. Describe the coordination of joint TB and HIV strategies, policies and interventions at different levels of the health system, including community systems, and expected impact and efficiencies from the joint programming.   Ensure the answer appropriately reflects the separate disease programs in addition to cross cutting modules where appropriate.  **(maximum 4 pages per component)** |

**a)** The overall Country Dialogue process, played a significant role in identifying the barriers to access services including stigma and discrimination, which were to be addressed to increase TB case notifications. There were 10 thematic group meetings with stakeholders, policy makers and key affected populations, followed by 9 community-based focus group discussions to engage marginalized groups, refugees, migrant workers, community volunteers and frontline health workers. However, it was clear that high-level interventions through the catalytic funding would also be required to remove the barriers and ensure universal health coverage. In addition, several in-depth discussions took place with key staff of the NTC, MoH, DoHS, CCM, prison, army and professional associations (medical, nursing and paramedical).

Hence, the following modules and interventions were prioritized based on the country’s need as listed during the inclusive country dialogue.

**A. Module: TB Care & Prevention**

National Strategic Plan envisions to strengthen the case detection with additional 20,000 cases to be notified during the NSP period. In 2016, the TB case notification rate was 112 per 100,000 population. With a decrease in the last two years, the rationale for selecting this module is to invest in high impact interventions to detect, diagnose and treat effectively all the TB cases, including the missing cases among the key and vulnerable populations.

**Case detection and diagnosis**

Intensify case finding: The rationale is to invest in high impact interventions based on WHO evidence-based strategies (*Annex-13, p12, 25-27*) to meet the proposed targets and effectively find the annual missing 12,000 cases (Figure-6). NSP envisaged to detect 84% of TB cases in year-1, 86% in year-2 and 92% in year-3 during the GF grant allocation period (2018-2021) including child TB cases- 8% in year-1, 9% in year-2 and 10% in year-3.

Activities to address the key gaps include (ACF in 40 districts, 2087 health facilities (GF):

**(i)** capacity building of health workers (7,120) and volunteers including cured TB patients (3,640) to provide patient-centred care; **(ii)** systematically screen all household contacts (51,048), especially children and other close contacts of the bacteriologically confirmed index case, (as TB prevalence in contacts- 3.1%)[[10]](#endnote-11), to get approximately 1,459 TB cases; **(iii)** training of NTC staff to become master trainers on NTP strategy, ACF, management, etc; **(iv)** sensitization meeting conducted by master trainers at 74 hospitals with OPD attendance >70% to implement “cough surveillance” and triage, identification of volunteers for “cough surveillance” followed by training; (Annex-13, p25-27); **(v)** supervision, monitoring and participation visits to programme implementing districts (national to community levels).

The NTP supported by domestic resources (GoN) will conduct ACF in the remaining districts (35), with focus on marginalized communities through mobile teams and microscopy camps complemented by sputum transportation systems. The microscopy centres (MCs) are mostly in the southern *terai*; while the Western Region and the mountain areas are underserved. The installation of 31 GeneXperts (GX) were mostly in the Central and Eastern Regions. Functioning X-Ray units were in 97% of zonal and above hospitals, 86% of district hospitals and 87% of private hospitals as compared with 11% of PHCCs *(Annex-12, p44).* Therewas no proper logistic system for sputum transportation and referrals from health facilities to MCs and to GX sites (*Annex-7, p58*).

Activities to address the key gaps include (strengthening the diagnostic capacity):

1. Invest in the capacity building of the National Reference Laboratory (NTC) in collaboration with the Supranational Reference Laboratory (KTV, Munich-Gauting).
2. Strengthen the capacity of the laboratory technicians in the national TB microscopy network including basic skills in the maintenance of diagnostic equipment
3. Technical support to improve utilization of diagnostic services of GeneXpert (GX) centres and digital X-Rays (d/CXR) at strategic health facilities.
4. Reinforce the integrated supervision of the labs and strengthen the QA system
5. Strengthen Infection prevention and control and waste management practice at all labs
6. Strengthen the referral and tracking of diagnosed TB case to prevent lost to follow up.
7. Strengthen recording and reporting and fast track results

(viii)Strengthen the specimen transportation system from community to health facilities (1053) and then to diagnostic centre building up on lessons learned from the past

(ix)“Pay for performance” to lab technicians in hill and terai districts for sputum microscopy

(x) Procure 12,500 cartridges for GX and consumables for sputum transport.

**Treatment**

The rationale is to maintain at least 90% treatment success among new PBC TB cases by strictly ensuring treatment adherence and follow up.

Activities to address key gaps include: **(i)** capacity building of care givers including skills in counselling and ‘patient-centred care’; **(ii)** ensure uninterrupted supply of anti-TB drugs: first line drugs (FLDs) and paediatric formulations including isoniazid; **(iii)** ensure treatment supervision in both facility and community-based treatment adherence; **(iv)** support management of adverse drug reactions for FLDs; **(v)** Nutritional & transportation support for retreatment cases through GoN; **(vi)** treatment follow up & joint monitoring by involvement of microscopy centres; **(vii)** expansion of CB-DOTS in 9 additional districts (with GF grant).

**Prevention**

The rationale is to prevent the transmission of the disease in the community through awareness of the disease through advocacy, communication and social mobilization (ACSM) and at the same time, focus on enforcement of infection control activities at household, community and health facility levels.

Activities to address key gaps include: **(i)** community awareness on infection control at household and community levels through ‘cough etiquette’, prevention of indiscriminate coughing and spitting, proper disposal of sputum, etc. **(ii)** provision of isoniazid preventive therapy (IPT) for child contacts of index TB cases; **(iii)** infection and prevention control (IPC) measures based on the SOP to be developed will be enforced at all health facilities managing DR-TB patients including laboratories; **(iv)** capacity building of laboratory staff on IPC.

**Engaging all care providers**

The rationale is to engage the dominant private health sector which provides approximately 70% of doctors in the terai and the main cities. A systematic mechanism and strategic approach to engage all care providers using structures established in collaboration with the NTP can have a sustained long-term positive impact on access to quality and affordable TB care, leading to early case finding and high treatment success.

Activities to address key gaps include:

**1**) Support operationalization of public-private-mix (PPM) task force at national and sub-national levels: **(i)** establish national level PPM task force under MoH; **(ii)** conduct regular meeting/WS to establish PPM unit at provincial level; **(iii)** develop, update and revise PPM strategy document, guidelines and model; **(iv)** develop concise manual for private providers and update; **(v)** develop and implement result-based financing mechanism for engaged private providersin 15 metropolitan and sub-metropolitan cities, expecting 7,200 TB case notifications annually; **(vi)** the eTB register would be customized as a user-friendly tool for private providers (*Annex-22, p6-11*).

**2**) Establish partnership with 22 selected medical colleges (Annex-13, p25-27)

Activities to address the key gaps include:

**(i)** Development of the medical college task force at National level and core-committee at medical college level and regular review of program activities; **(ii)** capacity building with TOT available across country through medical college; **(iii)** sensitization meetings with 4,000 faculty members and students on International Standards of TB Care (ISTC) and PPM strategies; **(iv)** develop master trainers on ISTC and PPM to expand to other institutions; **(v)** maintain regular interaction through meetings to update progress, and **(vi)** provide support for the college level operation research.

**3**) Targeted interventions in Army hospitals to shift from passive to active TB case finding as the estimated population under their care is about 9,00,000, which includes army personnel and their families including pensioners; in addition, the army screens thousands of youth, both male and female, for recruitment into the army and would provide data on presumptive TB for further management. This is of particular interest to the NTC, as 37% of TB case notifications are among the 15-34 years age group. Above all, the army hospital also provides health care to the civilian population in the cantonment area.

Major activities at the army hospital to address the key gaps include:

**(i)** conduct orientation meeting on ACF for 25 staff and medical students; **(ii)** the army would screen recruits for TB and refer those diagnosed as TB to the nearest health facility for treatment and share the data with NTC for follow up; **(iii)** conduct active contact tracing of index TB cases among soldiers and their families, through community-based ACSM activities; **(iv)** notify all forms of diagnosed TB to the NTC on a regular basis.

**Community TB care**

The rationale is to improve accessibility to TB care and treatment for remote and hard-to-reach populations to ensure 100% treatment adherence. Expansion of Community DOTS to 9 more districts during 2018-2021.

Activities to address the key gaps include:

**(i)** printing and distribution of IEC materials; **(ii)** TB orientation for KAP group; **(iii)** orientation to district health supervisors on TB -DOTS; **(iv)** orientation to treatment centres focal persons;

**(v)** orientation to the DOT providers; **(vi)** prepare and distribute counselling material on TB-DOTS; **(vii)** meeting orientation with relevant stakeholders at the district for mapping of CBOs, FBOs, at the local levels; **(viii)** sensitisation meeting with FCHV and other volunteers for establishing community referral mechanism; **(ix)** organize review and planning meeting at local level for effective operation of TB DOTS programme.

**Key populations** (based on the recommendations from the country dialogue):

**1)** Prisoners: targeted interventions in 74 prisons in Nepal:

Activities to address the key gaps include:

**(i)** WS to develop strategy -TB in prisons’ and training curriculum; **(ii)** organize training for prison health staff on early TB screening and diagnosis; orientation for *naike* and *bhainaike* (focal points among prisoners); **(iii)** entry/annual screening of inmates/prison staff; **(iv)** facility-based ACF jointly with HIV programme at the Central Jail Hospital, Kathmandu; **(v)** ACF in prisons outside Kathmandu; **(vi)** supervision from central prison to other prisons;

**2)** Marginalized groups in districts and slum dwellers in Kathmandu valley

Activities to address the key gaps include:

**(i)** coordination meetings with community leaders and volunteers; **(ii)** awareness raising in the community; **(iii)** ACF activities, screening and microscopy camps; **(iv)** printing and distribution of materials on advocacy, communication and social mobilization (ACSM);

**(v)** organization of sputum transportation;

**3)** Migrants, refugees and IDPs (based on country dialogue):

Activities to address the key gaps include:

**(i)** seasonal migrant workers will be screened for TB and HIV as a meaningful collaborative activity in cluster camps to be organized 2-3 times in a year in specific areas by the HIV programme and will also target their families; **(ii)** the focal point for TB will be responsible for mapping of TB diagnostic facilities, ensuring proper referral mechanisms, including recording and reporting of TB presumptive and notification of TB cases from seasonal migrant workers and their dependents; **(iii)** screening of Tibetan refugees (mostly in camps) will be conducted through community volunteers and diagnosed TB cases will be under CB-DOTS and **(iv)** similarly screening of internally displaced persons (IDPs) through community volunteers and diagnosed TB cases will be under CB-DOTS.

**Collaborative activities with all other programmes and sectors**

**1)** Childhood malnutrition and TB

Activities to address the key gaps include:

**(i)** sensitization meetings and collaborative activities for TB screening in malnourished children: severe acute malnutrition (SAM), moderate acute malnutrition (MAM) and integrated management of neonatal and childhood illness (IMNCI) in outreach units and health facilities; **(ii)** support accommodation and travel costs of family members of malnourished children referred for TB screening; **(iii)** support for consultation fees in major hospitals for TB screening among children; **(iv)** support 2 district level staff for supervisory visits for TB screening among children in major hospitals; **(v)** introduce FNAC for diagnosis of childhood TB in at least one in each district and link with the transportation system; **(vi)** initiate IPT in children;

**2)** Co-morbidity (TB and Diabetes): The linkage between TB and diabetes has been demonstrated and WHO strongly advocates the fight against the dual epidemic[[11]](#endnote-12). In Nepal, the pooled urban prevalence of type 2 diabetes was 8.1% (95% CI: 7.3–8.9%; I2=99.5%; P<0.001) and rural prevalence of type 2 diabetes was 1.0% (95% CI: 0.7–1.3%; I2=94.2%; P<0.001). Being a woman is a significant risk factor for diabetes in Nepal[[12]](#endnote-13).

In Nepal, there are no current programmes coordinating TB and diabetes care. In 2015, it was estimated that about 526,000 diabetics were in Nepal. Only 1 in 5 health facilities offer services for diabetes (DM), either diagnosis and/or management of DM. Hence, TB/DM co-morbidity programme will therefore be included in the PPM project in collaboration with major hospitals and medical colleges initially in Kathmandu valley (*Annex-7, p51*).

Activities to address the key gaps include:

**(i)** Orientation training for health care workers on DM; **(ii)** orientation meeting with endocrinologists for TB screening of diabetic patients; **(iii)** consultation fees for doctors; **(iv)** provision of anti-TB treatment for patients with co-morbidity (TB and DM) at preferred health facility after notification to NTC.

**Outcome:** Investments of USD 5.727 million in this module will help in 29,842 cases (28%) out of 107,000 cases targeted by the programme. This includes active case finding across 40 districts covering 79% of the country’s population. Institutionalization of the PPM task force mechanisms at national and provincial levels with systematic involvement of 22 medical colleges reaching >5,000 doctors, professional organizations (NMA, NCDA, NEPAS, MELAN) targeting to reach >10,000 prioritized providers through CMEs/conferences. The investments also includes support for FLDs for child formulations and IPT. This would cover screening and testing of 24,236 malnourished children across 607 prioritized health facilities and 74 major hospitals and enablers for families of 4,500 children receiving IPT. This investment also includes a high-end technical support at provincial levels to ensure capacity building of the 7 provincial units and >744 local units (palikas) to achieve the proposed outcome.

**B. Module: TB HIV collaborative interventions**

Based on the NSP targets of the estimated TB cases: 36,992 (2018), 37,855 (2019) and 40,524 (2020), the planned targets under the grant period are 33,500, 35,500 and 38,000 for the above 3 years. The prevalence of HIV among TB is calculated as 5%, 4% and 3% for the period of three years (2018-2020) respectively. The NSP envisioned to screen 50% of the TB patients for HIV in year-1, 70% in year-2 and 92% in year-3. There is a strong correlation of migration with HIV/AIDS, Nepal’s 1.5 to 2 million labour migrants account for 46% of the country’s PLHIV (*Annex-5, p4*). Hence, TB/HIV collaborative activities would include screening of seasonal migrant workers for both HIV and TB. Most antiretroviral therapy (ART) centres in public health facilities have adopted ‘one-stop-shop-approach’ (*Annex-19, p10).* The HIV test kits required for the HIV test of notified TB patients are covered from the procurement by NCASC through the GF; 52% of total requirement of ARV will be under the GF grant and the rest through domestic funds. Procurement of GX cartridges is included in the funding request.

Activities to address the key gaps include:

1. Meeting to develop and design implementation framework and SOP jointly with NCASC to facilitate cross-referral mechanisms for testing of TB patients for HIV and PLHIV for TB
2. Participate in the cluster camps to screen seasonal migrant workers for TB and HIV
3. Conduct bi-annual evaluation of the collaboration at the national level to discuss technical and management issues.
4. Orientation meeting on TB/HIV for the HIV network (KAP)
5. Train lab staff (NTC and NCASC) on GX including maintenance

**Outcome:** The investment of US$ 430 K in this module will help in reaching additional 87,120 TB patients to know their HIV status from current 18% to reach out to 95% of TB patients for having access to HIV counselling and testing services by end of the project. This will enable to reach 100% of the co-infected patients to access to ARV services from the base line of 89% and enable 48% of the total co-infected patients to access to ARV services through GF investment, while the remaining (52%) will be supported by GoN funds. The investments also include provision of 26,000 GeneXpert cartridges for rapid molecular diagnostics for TB testing among PLHIV. Collaborative activities essentially include 525 meetings at local, provincial and national level for improved coordination to achieve 10-fold increase in diagnosis and treatment of co-infected patients.

**C. Module: MDR-TB**

Investments in MDRTB is crucial to cut the chain of transmission of drug-resistant bacilli. The rationale for selecting the activities for early detection, proper management and introduction of the newer drugs and regimen for patient and community benefits. Among the MDR patients, 8% further developed XDR (*Annex 6, p7).*

**Case detection and diagnosis:**

Activities to address the key gaps include:

**(i)** screening and testing of all DR presumptive patients with support for 49,500 patients for collection of sputum & transport; **(ii)** mandatory screening of all household contacts and other close contacts of DR TB (MDR & XDR TB) index case, as the prevalence of TB is 3.4%[[13]](#endnote-14). **(iii)** Maintaining uninterrupted quality diagnostic services of culture & DST laboratories; **(iv)** procurement of 14,000 GX cartridges.

**Treatment**

Activities to address the key gaps include:

**(i)** Procurement of SLDs including for STR and support DR TB treatment centres;**(ii)** Palliative care in Referral Hospital; **(iii)** support and accommodation facilities for MDR-TB patients treated away from home; (iv) hazard allowance for the staff working at DR-TB centre/sub-centre and laboratories

Others: includes annual visit from the Regional Green Light Committee (rGLC) and technical advice for MDR-TB management.

**Outcome:** The investments of USD 2.979 million in this module will help the country in enabling management of 2,406 DR-TB patients over three years from baseline of annual 403 DR-TB patients. It will enable to reach additional 1,197 DR-TB patients from current baseline rates during the project period. The investments will continue support to the DR-TB referral centres, palliative care and DR-TB patient support for investigations and management of ADRs with a proposed budgetary provision of USD 1.33 million through sub-recipients (SRs). This also includes support for SLDs, USD 1.13 million for approximately 38% of the country’s requirement.

**D. Program management**

Investments of USD 4.4 million in this module will enable for ensuring efficient implementation of the high impact activities proposed under funding request. This will support the program management unit based in NTC for ensuring capacity building of the systems at National and proposed provincial (7) and administrative units or palika (>744) levels. This essentially includes support for establishment of the provincial level monitoring units, support for the implementing agencies / Sub-recipients (6) across the country. Operational cost for the high end-technical support at provincial level for capacity building and smooth transition of the reporting system from 75 districts to >744 palikas is also supported through the investment. It includes stringent supervision, monitoring and evaluation of the activities from PR level to SR level for ensuring proper implementation to achieve the proposed targets. Procurement of one closed vehicle for integrated supply of drugs and other supplies will facilitate delivery in a timely and efficient manner to health facilities, etc. (*Annex-18, p22*).

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| **2.2 RSSH funding request** | |
| The Global Fund strongly encourages funding requests for RSSH investments to be submitted within a ***single*** application, and preferably to be requested in the first submission. | |
| **Does this funding request include an RSSH component?** | Yes  No |
| **If yes**, describe the request below and how it is strategically targeted.  Referring to the national health strategy, gaps and lessons learned outlined in the previous section, describe the funding request for RSSH and how the investment is strategically targeted to strengthen systems for health and achieve greater impact on the diseases. In your explanation, refer to the Funding Landscape Table on ‘government health spending’, Performance Framework and Budget as appropriate. Note that it is optional to complete a Programmatic Gap Table for RSSH.  **(maximum 3 pages)** | |

In the 2014-2016 allocation period, the GF budgeted investment related to cross-cutting resilient and sustainable systems for health (RSSH) interventions was US$2,656,992, representing 6.2% of the grant. However, for this funding request, the average RSSH investment in GF grant for Nepal is expected to be about 16% to achieve greater impact.

The overall goal of the Nepal Health Sector Strategy (2015-2020) is “improved health status of all people through accountable and equitable health service delivery system”. The NHSS prioritizes “health to be at the centre of overall socio-economic development to fulfill the government’s vision to transform Nepal into a middle-income country by 2022”. To strengthen decentralization, planning and budgeting, NHSS prioritizes the implementation of the Collaborative Framework for Strengthening Local Health Governance in Nepal. It includes expansion of state and non-state partnership by building mutually beneficial partnerships between the public and private sectors. The Nepal Health Sector Strategy Implementation Plan (NHSSIP) 2016-2021, describes several interventions aimed to strengthen the NTP including improving access to health services for unreached populations, strengthening social health protection mechanisms, fulfilling shortages in human resources, building capacity to diagnose childhood TB and developing policy and legislation for TB services in the private sector (*Annex-9,* *p105-112*).

**Integrated synergistic service delivery**: The proportion of women receiving ANC from a skilled provider varies from 73% in Province 6 to 91% in Province 7. Women in Province 2 and Province 6 are least likely to receive four or more ANC visits (only just over half) as compared with more than 74% of women in the other Provinces (*Annex-26*, *p23*). Female community health volunteers (FCHV) would be engaged in the above 2 provinces to motivate and encourage pregnant women to attend ANC clinics and at the same time sensitize them to be screened early for TB, to avoid later complications to both mother and child. As cervical cancer is the leading cancer among women in Nepal with 50% mortality rate, combining cervical cancer screening (VIA) with TB screening, followed by appropriate referrals to higher treatment centres would strengthen the cervical cancer screening and prevention programme. The age-specific (34-54 years), high-risk female population eligible for cervical cancer screening estimated in 2016 was 4,525,416[[14]](#endnote-15) (*Annex-27, p14*).

Based on the national strategy, gaps and lessons learned, and to maximize the impact of the GF grant, this funding request will focus on the following strategic areas which would facilitate better access to treatment and follow up of patients in the community.

**RSSH: Community responses and systems**

a) Under the intervention- community-based monitoring, (i) the mapping of CBOs and FBOs at the grass-roots level for engagement in supervision & M&E will strengthen the CB-DOTS in existing 21 districts and (ii) 9 new districts where expansion of CB-DOTS will take place during proposed grant period and this will reduce barriers for KAP, increase contact tracing and ensure treatment adherence.

b) Under the intervention-other community responses and systems intervention(s), orientation to school children on TB through 5 trainings per district every year to cover 40 districts in 3 years would result in 48,000 trained children who as “agents of change” would raise TB awareness among their families, neighbors in the community and assist in contact tracing.

**RSSH: Health management information systems & M&E**

a) Under the intervention- analysis, review and transparency, (i) external technical assistance for an in-depth review of the NTP in selected districts would enhance the quality of the NTP assessment, identify gaps and recommend interventions; (ii) Data Quality Review (DQR) of NTP in 3 districts of each of the 7 provinces and in each district, 5 health facilities would be selected to assess and enhance data quality.

b) Under the intervention- other health information systems and M&E intervention(s), training of focal person (health) in each local body (>744) would strengthen the HIMS including M&E

c) Under the intervention- program and data quality, two activities will improve data quality: (i) supportive supervision visits to health facility having inconsistent/error reporting and (ii) workshop for data validation and entry in HMIS.

d) Under the intervention- routine reporting, the following activities would be strengthened: (i) revise and develop existing recording and reporting (R&R) tools in user-friendly manner; (ii) update of R&R tools for lab- GX, MDR-TB, harmonizing R&R data with HMIS; (iii) training on eTB register for private practitioners (18 metro & sub-metro cities; 10 private health facilities per metro/sub metro (total=180); (iv) follow up visit to ensure the diagnosis and notification of TB from private practitioners; (v) update eTB register for private practitioners; (vi) TA to update eTB register; (vii) TA to strengthen/develop a MDR eTB register; (viii) conduct training on MDR e-TB register; (ix) conduct Workshop to evaluate the HMIS against the NTC data for accuracy, timeliness and consistency; (x) update online software for GX and lab to fast-track dissemination of result; and (xi) support monthly internet fees for data entry on ETB register.

e) Under the intervention- surveys, the following will be conducted which are critical for the NTP: (i) GIS mapping of vulnerable/high risk populations and hard to reach areas in 21 districts to improve access to TB services; (ii) update GIS mapping of NTP treatment and diagnostics services in the 75 districts to facilitate referrals and reduce lost to follow up; and (iii) conduct TB Prevalence Survey to assess the burden of TB and health seeking-behavior in Nepal.

**RSSH: Integrated service delivery and quality improvement**

a) Under the intervention- laboratory systems for disease prevention, control, treatment and disease surveillance, the following activities will improve infection and prevention control (IPC) practices in labs based on updated guidelines, (i) TOT on Infection control management; and (ii) training on IPC and waste management for lab staff (7 provinces)

b) Under the other service delivery intervention(s), the following activities will establish integrated service delivery approach to strengthen the programmes under Family Health Division (FHD) and Child Health Division (CHD): (i) orientation on diabetes screening among TB patients to increase case notification; (ii) orientation to health workers on TB screening among pregnant women visiting ANC and children attending IMCI clinic; (iii) orientation to health workers on screening of cervical cancer among women visiting OPD or enrolled for treatment in DR Centers; (iv) workshop with FHD and CHD to develop and incorporate TB screening algorithm in their regular activities of ANC and CB-IMNCI and primary health care-outreach clinic (PHC-ORC); (v) training on visual inspection with acetic acid (VIA) for health care providers working in Urban DOTS Centres; (vi) technical assistance (TA) for providing VIA training for health care providers working in Urban DOTS Centres; (vii) procurement of consumables (cotton swap, acidic acid, speculum set) for VIA screening.

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| **If no**:   1. Indicate when the RSSH funding request was/will be submitted; and, 2. **If the RSSH funding request has not yet been submitted**, highlight below the elements of the planned RSSH investment that will directly support the disease program in this funding request.   **(maximum ½ page)** | |
| **2.3 Focus of application requirement *[[15]](#footnote-2)***  This question is required for Lower-Middle Income (LMI) and Upper-Middle Income (UMI) countries. It is not applicable for Low-Income (LI) countries.  To respond, refer to guidance provided in the *Instructions.* | |
| **For LMI countries:**   * Does the funding request focus at least 50% of the budget on: disease-specific interventions for key and vulnerable populations; programs that address human rights and gender-related barriers and vulnerabilities; and/or highest impact interventions? * For RSSH, does the funding request primarily focus on improving overall program outcomes for key and vulnerable populations in two or more of the diseases, and is it targeted to support scale-up, efficiency and alignment of interventions? | Yes  No |
| Yes  No |
| **For UMI countries:**   * Doesthe funding request focus 100% of the budget on interventions that maintain or scale-up evidence-based approaches for key and vulnerable populations, including programs that address human rights and gender-related barriers and vulnerabilities? | Yes  No |
| **SECTION 3: OPERATIONALIZATION AND RISK MITIGATION** | | |
| This section describes the planned implementation arrangements and foreseen risks for the proposed program(s). Applicants are encouraged to **attach an updated Implementation Arrangements Map.** To respond, refer to additional guidance provided in the *Instructions.* | | |

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| **3.1 Implementation arrangements summary** | |
| Do you propose major changes from past implementation arrangements, e.g. in key implementers, flow of funds or commodities? | Yes  No |
| If **yes**, provide an overview of the new implementation arrangements and elaborate how these changes affect the operationalization of the grant.  If **no**, provide a summary of high-level implementation arrangements focusing only on lessons learned for the next period.  In **both cases**, detail how representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation.  Include a description of procurement mechanisms.  **(maximum 1 page)** | |

There will be no major changes from the past implementation arrangements as reflected in the implementation arrangements map (*Annex 24*). In 2015, the Global Fund had placed Nepal under additional safe-guard policy when the Country Coordination Mechanism (CCM) was declared ineligible and Save the Children was appointed as the Principal Recipient for the National TB Programme. However, subsequently the process to review and revive the CCM was actively undertaken with external technical assistance to fulfil the eligibility norms.

As in the past, the Principal Recipient (PR) during the process for selection of Sub-Recipients (SRs), normally conducts consultations with key populations, existing partners and women-led organizations which provides an opportunity for their active participation in the implementation of the activities. Even during the ongoing country dialogue, representatives from key populations: TB-affected families and PLHIVs; prisoners; marginalized communities eg. PLHIV; seasonal migrant workers and women-led organizations (eg. mother’s groups) participated in the consultations especially in focus group discussions to identify barriers and constraints, including exploration of feasible solutions. There is representation of women’s organizations, key populations and PLHIV representatives in the CCM and CCM oversight committee which continuously monitors the PR activities and thus these organizations also participate in program implementation.

ACF activities in the provinces would be implemented by Sub-Recipients with a budget allocation of USD 5,127,977 which is 32% of the proposed funding request. There are three referral centres for the diagnosis, management and follow up of DR-TB patients at Kathmandu, Biratnagar and Nepalgunj and one hostel for admission of DR-TB cases at Dhangadi. The earmarked budget for implementation of all MDR-TB related activities would be USD 1,332,622 which is 8% of the total budget.

There will be no changes in the current procurement mechanisms (PPM) of the Principal Recipient (Save the Children). As PR, the budget for Save the Children would be USD 6,093,436 which cover the following major activities (i) TB Prevalence Survey; (ii) Technical support from national office, (iii) development of guidelines, manuals and SOP; (iv) upgrading of eTB register and online recording and reporting system; (v) technical assistance from WHO (through national professional officer); (vi) mapping of vulnerable populations including treatment and diagnostic services delivery points; (vii) evaluation of NTP, eg. mid-term and in-depth assessment; (viii) international and national TA to support specific interventions, (ix) procurement of accessories and consumables related to case detection and diagnosis through SRs and (x) for operational research in collaboration with medical colleges. In addition, PR will procure IT equipment, vehicle, infrastructure items, consumables

The GoN policy regarding procurement will apply for all items procured mainly from government funds, namely: anti-TB drugs (100% of FLD except pediatric formulations and 62% of SLD); laboratory equipment, cartridges, materials and consumables. The Ministry of Health as the lead implementer would have a budget of USD 3,584,512 (22%) which would cover the following major activities: (i) training of health workers; (ii) community systems strengthening including CB-DOTS; (iii) integrated service delivery eg. FHD and CHD; (iv) implementation of PPM related activities including collaboration with major hospitals and medical colleges; (v) collaborative activities with other programmes and sectors, eg. TB/HIV, TB and diabetes; (vi) infection control and waste management; (vii) monitoring and supervision; (viii) collaboration with army hospital and medical college; (ix) quality assurance (QA) in labs; (x) expansion of DOT services; (xi) strengthening the health information system.

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| **3.2 Key implementation risks** | | | | |
| Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding over the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context.  Applicant response in table below. | | | | |
| **Risk Category**  **(Functional area)** | **Key Risk** | **Mitigating actions** | **Timeline** |
| Programmatic-  HRH | Newly introduced federal system can pose challenge with decentralization of the program management from 75 districts to >744 urban and rural municipalities. | The GoN will set up Provincial TB units to improve programme coordination, systematic program management, oversight and capacity building. However, staff costs of the Provincial TB units would be in the funding request during the initial period | 2018 onwards |
| Programmatic-  Logistics | Poorly organized specimen transport system | NTP to develop and implement a standard operating procedure. This would be supported by local government and stringently monitored by NTP. | 2018 onwards |
| Programmatic-  Referral system | ‘Loss to follow up’ of diagnosed TB patients due to lack of clear instructions and referral mechanisms | NTP to develop SOP and train health staff to track TB patients to prevent ‘loss to follow up’ (i) from MC to TC, (ii) when released from prisons, (iii) when referred from Army Hospital to public health care facilities; HFOMC members could be engaged to develop mechanisms to assist in follow up activities. | 2018-2020 |
| Programmatic-  Diagnostic services | Lab staff lack skills for calibration and maintenance of GX machines presently, 25% of modules not functioning | NTP would outsource to an agency for maintenance to maximize the utilization of GX machines with simultaneous capacity building of the national laboratory staff | 2018-2020 |
| Programmatic-  HMIS | Gaps between NTP data and health management information system and data quality. | NTP will do capacity building of staff to improve data quality and need to evaluate the HMIS against the NTC data for accuracy, timeliness and consistency | 2018 onwards |
| Political restructuring of the country | Integration of the health system into the new federal structure will pose operational challenges during the implementation phase | The MoH has been engaged in developing federal policy guidelines for the smooth transition of the health system into the federal structure up to the community level. | 2017 onwards |
| Natural hazards and calamities | Country highly susceptible to climate change risks and ranks 11th in the world in terms of vulnerability to earthquakes | Although vulnerability to climate change and other natural hazards is a big challenge, the GoN with technical support from WHO is engaged in strengthening the disaster preparedness and management capacity at national and sub-national levels. | 2017 onwards |
| Other-  Public-Private-Mix (PPM) | Weak enforcement of government regulations on the private health sector; low TB notification rate (18%) from private health sector | GoN would approve the TB Act under the new Health Policy and enforce mandatory notification of TB from the private health sector; PPM guidelines will be approved and implementation initiated. | 2017-2018 |
| *Add rows for additional key risks as necessary* | | | |

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| **SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY** |
| This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability. Refer to the **Funding Landscape Table(s)** and supporting documents as applicable. To respond, refer to additional guidance provided in the *Instructions.* |

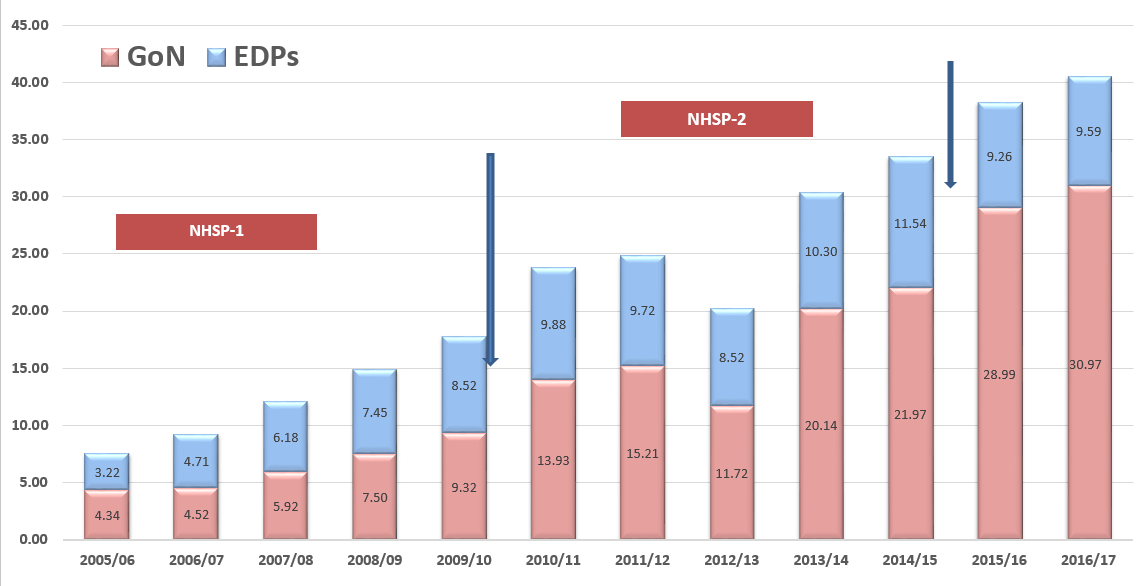
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| **4.1 Funding Landscape and Co-financing** | |
| 1. Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? **If yes,** provide details below. | Yes  No |
| 1. Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health-financing reforms? **If yes,** provide a brief description below. | Yes  No |
| 1. Have previous government commitments for the 2014-16 allocation been realized? **If not**, provide reasons below. | Yes  No |
| 1. Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy?[[16]](#footnote-3) **If not**, provide reasons below. | Yes  No |
| 1. Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, **specify** below how realization of co-financing commitments will be tracked and reported. | Yes  No |
| **(maximum 2 pages)** | |

**a)** **Yes**. - The National Planning Commission (NPC), the Ministry of Finance (MoF), Ministry of Health (MoH) and the various departments and programme units are responsible for MoH’s annual planning and budgeting process. Guided by the lessons learned from the implementation of the Nepal Health Sector Programme (NHSP1 and 2), the MoH will move forward to improve its planning and budgeting practices and its capacity to absorb its annual budget by formally involving finance sections of the MoH and DoHS in budget preparation and progress monitoring (*Annex-28, p25-27*). In 2010, the MoH introduced its Health Gender Equality and Social Inclusion (GESI) Strategy. In 2012, the institutional mechanism for mainstreaming GESI in the health sector was developed (*Annex-5, p9*).

During the last ten years (NHSP-1 and NHSP-2), the budget allocated for capital expenditure increased by just under three times (from NPR 1.6 billion to NPR 4.5 billion) while the amount allocated for recurrent expenditure increased almost five times (from NPR 5.9 billion to NPR 29 billion (*Annex-28, pages iii-iv*).

The MoH was able to secure more than 7% of the national budget in NHSP-1 and NHSP-2 periods and would develop and implement a National Health Financing Strategy to identify and prioritize the resource mobilization required to deliver universal health coverage. To improve absorption of contributions from External Donor Partners (EDP) the MoH to incorporate the reporting of direct funds from External Development Partners (EDP) in the Transaction Accounting and Budget Control System (TABUCS) based on the agreements between the MoH and the EDP under the Joint Financing Arrangement. As there is no national mechanism to capture local revenues and expenditures that occur in health facilities, hence capacity building of hospitals is required to capture local revenues and local resources in the TABUCs to give a more comprehensive picture of income and expenditure. The MoH would develop a standard budget allocation policy for the allocation of resources to districts by central units[[17]](#endnote-16).

**Figure-4: Funding trend (GoN vs EDP) from 2005-06 to 2016/17 (NPR in billions)**



There was a regular increase of the EDPs’ budgets over the NHSP-1 period, while under NHSP-2 there was a decrease in 2012/13 (Figure-4). The absorption of EDP funding was relatively better in NHSP-1 than NHSP-2. This could be due to weak or no reporting of EDP direct funding, which is reflected in the Red Book but is not captured in government expenditure records (*Annex-28, page 11*). In NHSP-1 and NHSP-2 period the government’s budget allocation for MoH increased more than five times while the amount allocated by EDPs increased by less than four times.

**b)** **No**.

**c)** **No**. - During 2014-2016, the government faced a several challenges, including natural disasters, political unrest and an embargo at the Indo-Nepal border, which slowed the economic progress. The GDP growth crawled to 0.8% in 2016 after the devastating earthquake in previous fiscal year (2015). In 2012, Nepal ranked third globally for the remittances it received from abroad as a percentage of its gross domestic product (GDP), accounting for 24.7% equivalent of Nepal’s GDP; remittance earnings were estimated at more than USD 5.2 billion[[18]](#endnote-17). However, during 2014-2015, remittances from workers employed abroad diminished, leading to further deficit[[19]](#endnote-18). In addition, a weak monsoon affected agriculture which accounts for 34% of the GDP[[20]](#endnote-19). At the same time, MoH’s budget decreased from 6.29% of the national budget to 5.42% in 2014/15. This was mainly because the GoN increased the budget for other sectors, especially education and social security.

**d)** **Yes.**

**e)** **No. -** The Ministry of Finance has developed the Line Ministry Budget Information System (LMBIS) for budgeting and projection for next two years of all line ministries The Electronic Annual Work Planning and Budgeting (e-AWPB 1.0) tool designed for the MoH is used to facilitate the annual work planning and budgeting process, the e-AWPB also generates analytical tables in a systematic way from different perspectives and provides information on budget and expenditure by trimester and programme[[21]](#endnote-20). TABUCs is used for tracking expenditure.

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| **4.2 Sustainability** |
| Describe below how the government will increasingly take up health program costs, and actions to improve sustainability of Global Fund financed programs. Specifically,   1. Explain the costs, availability of funds and the funding gap for major program areas. Specify in particular how the government will increasingly take up key costs of national disease plans and/or support health systems; including scaling up investments in programs for key and vulnerable population, removal of human rights and gender-related barriers and enabling environment interventions. 2. Describe actions to improve sustainability of Global Fund financed programs. Specifically, highlight key sustainability challenges of the program(s) covered by the funding request, and any current and/or planned actions to address them.   **(maximum 1 page)** |

The proposed NSP (2017-21) has estimated the requirement of increasingly massive investments of USD 105.14 million for the NSP period, out of which USD 89.12 million is for the fiscal years of the grant period. The domestic resources for TB are increasing and would be around USD 48.24 million for the same period. The funding gap is for USD 40.87 million (Table-1). Apart from the existing GF grant of USD 4.30 million, this funding request is being submitted for USD 16.13 million to the Global Fund. Thus, the effective funding gap from 2018-2021 would be USD 20 million to achieve the targets envisaged under the NSP (Table-2).

**Table-1: Funding for the major programmatic areas and funding gaps from 2018-2020**

|  |  |  |  |
| --- | --- | --- | --- |
| **Program Areas (NSP Cost categories)** | **Funding requirement (NSP)** | **Domestic resources expected** | **Funding gap in USD** |
|  |  |  |
| 1.1 Improving diagnosis | 20.87 | 16.58 | 4.30 |
| 2.1 Patient support | 5.75 | 1.76 | 3.99 |
| 2.2 First-line drugs procurement and management | 6.38 | 3.46 | 2.93 |
| 2.3 Collaborative TB/HIV activities | 0.37 | - | 0.37 |
| 3.1 MDR-TB drugs and management | 17.17 | 6.77 | 10.41 |
| 4.1 Involving all care providers: PPM/ISTC | 3.08 | 0.44 | 2.64 |
| 5.2 Community involvement | 7.65 | 1.60 | 6.05 |
| 6.1 HRD: Staff | 4.22 | 3.08 | 1.13 |
| 6.2 HRD: International technical assistance | 0.55 | - | 0.55 |
| 6.3 HRD: Training | 7.32 | 3.14 | 4.18 |
| 6.4 Infection control | 0.45 | 0.14 | 0.31 |
| 6.5 Operational research | 0.03 | - | 0.03 |
| 7.1 M&E | 4.19 | 3.40 | 0.79 |
| 7.2 Programme management and supervision | 11.08 | 7.87 | 3.21 |
| **Total in USD** | 89.12 | 48.24 | 40.87 |

The GoN almost tripled its budget allocation for TB between 2013/14 and 2017/18, from USD 3.2 million to USD 9.78 million (Table-2). This upward trend despite financial limitations due to natural disasters, political unrest in the previous 3-4 years, clearly demonstrates the government’s commitment to increasing its financial investment for TB program to ensure sustainability.

**Table-2: Funding Landscape from 2017-2021**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Particulars** | **Amount in Million (USD)** | | | | | | |
| **2017** | **2018** | **2019** | **2020** | **2021** | **TOTAL** | **%** |
| Total Funding needs for the National Strategic Plan (in USD) | 16.02 | 19.8 | 22.13 | 22.88 | 24.29 | **105.14** | 100% |
| Domestic source: Government revenues | 8.01 | 9.78 | 11.2 | 12.76 | 14.49 | **56.24** | 54% |
| Total previous, current and anticipated GF resources from existing grant | 2.94 | 4.3 | 0 | 0 | 0 | **7.24** | 7% |
| Funding request within the country allocation | 0 | 4.36 | 6.06 | 5.18 | 0.53 | **16.13** | 15% |
| **Funding Gap (in million in USD)** | **5.17** | **1.35** | **4.86** | **4.94** | **9.28** | **25.62** | **24%** |

As evident from the Funding Landscape Table, GF proposed investments of USD 16.13 million would be matched with increasing domestic funding, indicating the commitment of the GoN to invest in TB prevention, care and control.

The GoN has taken steps to facilitate the long-term sustainability of financing of the National TB Program in accordance with the expectations of the Global Fund (*Annex-10, p1-4*). The MoH over the next five years would fill the vacancies in the NTP; 35% (year-1), 45% (year-2), 55% (year-3), 65% (year-4) and 75% (year-5) with focus on rural retention and recruitment to ensure availability of human resources both medical and laboratory staff at sub-national and peripheral levels for the provision of rapid and accurate diagnosis and prompt treatment services (*Annex-9, p105-112*).

The level of investment from the government sources for procurement of first line drugs (FLD) has tremendously increased from 50% to 100%. In the case of second line drugs (SLD), previously, 100% was procured with GF grant. Henceforth, the GoN would purchase 62% of SLD for the next three years, while 38% will be through the GF grant. Paediatric formulations for treatment of childhood TB will be procured from the Global Drug Facility (GDF) through the GF grant. The GoN is committed to earmark its resources for the procurement of diagnostic equipment (GX and d/CXR) and other laboratory consumables and materials.

The government has appointed GESI focal persons in all divisions and centres to ensure that activities for underserved areas and unreached groups are identified and costed. In all health sector plans and programmes, it will be the responsibility of all levels of technical working groups to ensure that GESI will address gender equality and social inclusion in the health sector to mainstream GESI into sectoral policies, health institutions, the project cycle of health programmes, service delivery and supervision and reporting (*Annex-28, page 28*). The TB Act under the new Public Health Policy currently scheduled for endorsement by the GoN will ensure the rights of the TB patients and the care givers including the mandatory notification to health authorities.

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| **SECTION 5: PRIORITIZED ABOVE ALLOCATION REQUEST / UPDATE** |

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| **Prioritized Above Allocation Request** |
| Provide in the table below a prioritized above allocation request which, if deemed technically sound and strategically focused by the TRP, could be funded using savings or efficiencies identified during grant-making, or put on the Register of Unfunded Quality Demand to be financed should additional resources become available from the Global Fund or other actors (e.g. private donors and approved public mechanisms such as UNITAID and Debt2Health). This above allocation request should include clear rationale and should be aligned with the programming of the allocation for maximum impact. The request should reflect the order in which interventions will be funded if additional resources become available. In line with the Global Fund’s Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the allocation amount). |

|  |  |  |  |
| --- | --- | --- | --- |
| **[C*omponent]*** *– Copy the table as needed, if your funding request includes more than one component* | | | |
| **Module** | **Interventions** | **Amount requested**  **In USD** | **Brief Rationale, including expected outcomes and impact**  (how the request builds on the allocation) |
| TB care and prevention | Provision of Senior Laboratory Expert to provide capacity building & improve lab quality at NRL & expand coordination and oversight with TB laboratory network | 252,000.00 | Capacity building of the staff & improvement of the facilities would boost the NRL capacity to perform up to 10,000 smears, 5,000 cultures, 1,000 – 2,000 LPAs, and 500 DSTs per year (Annex-23, p13-14). This is important considering wide network of rapid molecular diagnostics, DR-TB management with newer regimen and newer drugs requiring quality assured uninterrupted culture/DST facilities. |
| TB care and prevention | Expansion of PPM activities with introduction of pay for performance for diagnostics | 1,000,000.00 | For improving access, enabling early diagnosis with introduction of the pay for performance for the diagnosis, DOT provision and further expansion to the remaining districts. This can further improve the notification of additional 5,000 cases over 3 years. |
| TB care and prevention | Expansion of ACF activity with replacement of smear microscopy with GX in high work-load settings | 853,786.66 | GeneXpert expansion to the remaining inaccessible districts is required though the testing load is less, but access remains a challenge. Additional 15 machines with provision of 3,000 cartridges for grant period can enable access to major parts of remaining districts. This will enable 45,000 presumptive TB patients to get the rapid molecular test with expected 4,000 notifications of TB patients. |
| Program Management | TA (international position-1) | 1,180,000.00 | To provide high-end international technical assistance to the NTP. |
| TB care and prevention | SMS to mobiles on key TB messages- public awareness program | 18,732.26 | Reaching the community with mobile messages (9 million SMS) across three years effectively covering the population. This can contribute to an enabling environment with education of community for early diagnosis, complete treatment and reducing lost to follow-up cases. |
| TB care and prevention | Expansion of Community DOT in remaining districts (37) | 781,111.11 | To improve accessibility to TB services and make treatment adherence ‘user-friendly’ in the remaining districts; districts with sparse population would require more investments then the existing districts, but important from patient perspective. |
| TB care and prevention | Extension of the ACF in remaining 35 districts in prioritized groups | 3,000,000.00 | ACF in remaining districts with very less population will be relatively costlier, but will be crucial from patient and community perspective. Investment will provide an opportunity to this population for early diagnosis, prompt treatment initiation and reduce morbidity and mortality. |
| MDRTB | Additional support for the remaining 600 DRTB patients | 1,200,000.00 | Additional support for the remaining gap of 600 DR-TB patients for diagnosis and treatment and associated activities through the private sector involvement. |
| Program Management | Mid-term evaluation of NSP | 78,300.00 | To review the implementation of the NSP, recommend mid-course corrections and provide inputs for better planning and preparation for the next phase. |
| RSSH: Community responses and systems | Conduct orientation workshops to empower the newly elected members of the local *palikas* | 297,807.06 | Under the decentralized federal process, investment in institutional capacity building of 744 *palika*s by training ~10,500 members every 3 years to ensure political commitment, budget allocation and management of community-based health activities. |
| RSSH: Community responses and systems | Conduct Patient Satisfaction Surveys periodically | 60,000.00 | Under community-based monitoring by HFOMC to assess stigma, discrimination and staff attitude toward patients at selected health facilities. |
| **TOTAL AMOUNT in USD** | | **8,721,737.09** |  |

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| **Relevant Additional Information (optional)** |
| Provide any additional contextual information relevant to the prioritized above allocation request (e.g. any explanations that further clarify linkages to the allocation funding; any considerations or data that informed the request or updates of the request; etc.) |

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14. National Guidelines for Cervical Cancer Screening in Nepal: <https://phaseworldwide.org/publications/national-guideline-cervical-cancer-screening-prevention-nepal/> [↑](#endnote-ref-15)
15. Refer to the [Global Fund 2017 Eligibility List](http://www.theglobalfund.org/en/fundingmodel/process/eligibility/) for income level. LMI and UMI countries have specific requirements in terms of the focus of applications as set forth in the Global Fund [Sustainability, Transition and Co-Financing Policy](http://www.theglobalfund.org/en/fundingmodel/process/cofinancing/). [↑](#footnote-ref-2)
16. Refer to the [Sustainability, Transition and Co-Financing Policy](http://www.theglobalfund.org/en/fundingmodel/process/cofinancing/). [↑](#footnote-ref-3)
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