THAILAND

THA-607-G08-T

General Grant Information

Country	Thailand				
Grant Number	THA-607-G08-T	Component	Tuberculosis	Round	06
Grant Title	Reduction of TB Morbidity among Non-Thai Migrants in Six Border and Adjacent Provinces				
Principal Recipient	World Vision Foundation of Thailand				
Grant Status	Closing out				
Grant Start Date	01 Oct 2007	Grant End Date	30 Sep 2012		
Grant Signed Amount	US$ 8,329,052	Grant Disbursed amount	US$ 7,479,299		

I. Summary of the Program (1 Page)

Rationale

Reduction of TB Morbidity among Non-Thai Migrants in Six Border and Adjacent Provinces (TB-RAM) is a community-based TB programme focusing on non-Thai migrants along the border and adjacent provinces of Thailand. As Thailand continues to be in the WHO 22 High TB burden (and High HIV burden) countries ranking, the needs to address vulnerableand mobile population intensifies where the lack of TB epidemiology and unreliable population data of non-Thai migrants were a norm.

Objectives

TB-RAM has 4 main objectives i) To expend quality TB services to achieve increased case detection and treatment success among non-Thai migrants, ii) To empower non-Thai communities to reduce their TB burden through public awareness, iii) Develop a service delivery system that ensures coordinated TB/HIV care for non-Thai migrants, iv)To increase the capacity of the implementing agencies. The programme adhered to the National TB Plan and followed NTP strategies on i) TB among marginalised population, ii) ACSM, iii) TB/HIV, iv) Operational Research.

Implementation arrangements

The program is written as Goal 3 in the GFATM round 6 TB component in which PR-DDC managed 2 other goals with regards to work place and system strengthening. The model was roughly taken from the project from Global Fund Round 1 by World Vision Foundation of Thailand to fight Tuberculosis among non-Thai migrants in a smaller scale (two provinces) and expanded to 6 provinces working with 2 other SRs, American Refugee Committee and Kwae River Christian Hospital in which World Vision Foundation of Thailand acted both roles, managing the grant as a PR and implementing as an SR. The 2 PRs meet with other members of CCM TB technical committee every 2 months to report progress and receive feedback to implement prior to reporting to CCM.

Major activities and targets achieved

The programme covered about 271,000population of non-Thai migrants in 6 provinces. The project focused on a community-based mobilisation to increase case detection and treatment with DOT partners, access to TB/HIV counselling and testing carried out in various languages (Burmese, Mon, Karen) as the main activities. Health volunteers, both Thai and migrants were trained on TB as communicable diseases, signs and symptoms recognition, DOT as the key treatment, and as a curable disease were key messages provided. Community members became volunteers who referred suspects and trained as DOT providers if suspects turned out to be patients. Community health posts were established to provide meeting and learning places on TB and other health issues and suspects to be identified, referred and DOT provision to take place.

Two outcome indicators were achieved, case notification rate for new smear positive cases maintained at 138/100,000 population and treatment success rate for new smear positive was achieved at 86%, slightly higher than the WHO standard of 85%, a major achievement considering the target population is highly mobile, and mostly illegal. The programme referred 27,037 suspects for screening, out of which, the programme treated 1384 new smear positive cases, and treated 2324 all TB cases.

Financial arrangements

The budget signed with GFATM is 8,329,052.42 USD and GFATM disbursed 7,479,299.28 USD or approximately 90% absorption rate. PR-WVFT disbursed to 2 SRs, American Refugee Committee and Kwae River Christian Hospital as well as WVFT to implement in 6 provinces. The project finished in September 2012 with a 6-month extension using the underspent budget for closing out.

II. Program Accomplishments and Financial Report (4 pages)

Key activities

The programme utilised ACSM approach with the following key activities:

- Behavior change communicationthrough training of migrant health volunteers and community mobilization with gatekeeperssuch as business and factory owners, etc.
- Awareness-raising activities organized such as World TB Day.
- Provide health education and advocacy to reduce stigma and discrimination.
- Establishing health posts for community-based screening for TB and information dissemination.
- Facilitating access to diagnostic services at health posts (e.g. sputum collection, transport and inform results)
- Referral of community members for TB diagnosis from health posts and communities.
- Community-based DOT provision and observation of TB and side-effects
- Ensure treatment adherence through mental support and individual follow-up from DOT partner and NGO staff.
- Provide social and livelihood support (e.g. nutritional package, travel cost, vitamin supplements, rent)
- Home-based care for critical TB patients.

Under ACSM approach, constant advocacy at various levels were carried as a norm: those including gatekeepers, business and factory owners, ship captains, policemen, immigration officers, border control policemen, health officials at sub-district, district, provincial and national levels. Active case finding and household contact finding were utilised to identify suspects from the community, using migrant health volunteers and community health posts as the sources for referral. Community members were trained on TB signs and symptoms recognition and DOTS. Many volunteers were later identified and trained as DOT partners once patients were enrolled. The programme provided DOT partners and monetary support for TB treatment, food, transportation, rent, supplements, etc. In some cases, temporary land-based occupations were arranged for the TB patient especially among fishermen since they would be at sea for 2 months at a time.

ADVOCACY ACTIVITY PHOTOS **REFERRAL ACTIVITY PHOTOS OR HEALTH POSTS**

<u>Registered vs unregistered migrants</u>

The programme budget was calculated based on the assumption in 2007 that 50% of migrants were registered and the programme would support TB drug cost for Cat I and Cat II, some Cat III (basic TB drug) and no MDR-TB drugs. In reality, the latest data showed an average of 80% of TB patients were unregistered migrants, expecting to receive full medication fee and other support provided. The percentage of registration varied from province to province, based on the occupation. For provinces with easy land crossing (Tak and Kanchanaburi), almost 100% of cases were unregistered migrants. Provinces with high number of agricultural workers such as rubber planters also experienced high unregistered cases (Chumporn and Phang Nga). Registration also varies from one year to another depending on the government registration policy. Furthermore, unregistered migrants face more barriers in accessing TB treatment due to fear of being arrested, difficulty in traveling to health services, language proficiency and lastly, no work means no payment.

Achievements and findings

Despite the obvious obstacles in providing at least a 6-month DOT for migrant TB patients, remarkable TB results could be obtained from the programme as shown in the table below.

Indicator level	Indicator	Target	Achievement	% Achievement
Outcome	Treatment success rate of NSP	80%	86%	108%
Outcome	Case notification Rate	138/100,000	138/100,000	100%
Outcome	% of migrants who identify >2-week cough as key symptom of TB	70%	76%	109%
SDA	No. of suspects including household contact referred	27486	27037	98%
SDA	No. of NSP detected	1560	1548	99%
SDA	No. of NSP enrolled under DOT and supported	1411	1384	98%
SDA	No. of other forms of TB detected	1203	948	79%
SDA	No. of other forms of TB enrolled under DOT and supported	1013	936	92%

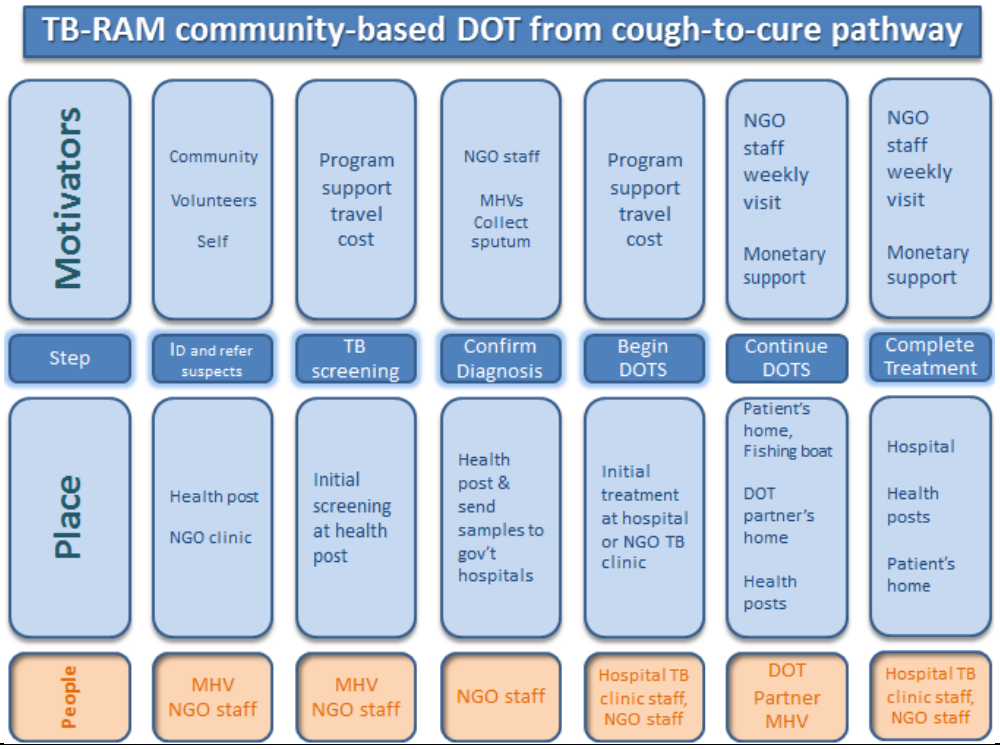
Social mobilisation

Establishing Migrant health volunteers and DOT partners

The programme key activities and achievement were mobilised through the establishment of migrant health volunteers (MHVs) and training of DOT partners. The actual number of active MHVs cannot be measured accurately due to high mobility of the migrant setting but roughly about 3,000 MHVs were recruited and trained; many MHVs trained moved away after a few months, those who stayed tend to be focal points of the community for screening, suspect referral, sputum collection and sometimes as DOT partners.

DOT partners are also mainly from migrant volunteers from communities, despite the reservation from health officials in relying on community-based DOT, many were friends, relatives, business owners and fishing boat managers trained to observe treatment and ensure adherence.

The diagram below shows the majority of TB-RAM programme based on “from cough-to-cure pathway” in which the community and migrant health volunteers play vital roles in the success of the programme. Most steps occurred either at the community, health posts or patient’s or DOT partner’s homes. Public-Private Mix occurred mainly at the diagnosis and treatment completion in which sputum samples were sent to the hospital for AFB and initial treatment started and completed with the hospital TB clinic staff. Otherwise, all other processes occurred between MHVs and patients in the community. NGO staff played a key role as motivators, providing mental support to patients to complete their treatment.



TB Control

Case notification

Number of new smear positive TB cases notified 1548, out of which, 1384 were enrolled to receive DOT. The calculated Case Notification Rate (CNR) for migrants in 2012 was 138/100,000 population. (NB: migrant population collected from community mapping and unofficial sources). Thailand CNR for 2011 for Thai population was at 47/100,000. When compared new cases notified between country data to the programme, it was found that the percentage of smear positive cases among non-Thai migrants was higher than that of the country data (60% vs 52%). Migrant male to female ratio is 1.65 compared to Thai national of 2.4.

TB Case notification (%) of new cases (TH data 2012 vs programme cumulative)		
New cases	Country	Programme
smear positive	52%	60%
smear negative	32%	29%
extrapulmonary	16%	4%
Other		7%

Treatment Success

Treatment success rate for new smear positive for 2011 was 86% while for all TB cases was higher at 87%, both were higher than the Thailand country data. Most DOT occurred at either the patient's or DOT partner's homes, some in the established community health posts. In some provinces, the health officials insisted that DOT had to be carried out in the hospital TB clinic only. The surprising result was from the fishermen new smear positive treatment success rate at 86% in which most fishermen patients receive DOT in fishing boats with their friends as DOT partners. Almost all of the patients enrolled for DOT received weekly or bi-monthly visit from the NGO staff to ensure treatment adherence. All received some kind of monetary support from the programme. Constant visit from staff and monetary support were the key motivators for the patients to complete their treatment.

Treatment Success Rate (TH data 2010 vs programme 2011)		
	Country	Programme
smear positive	85%	86%
All TB	79%	87%

TB/HIV co-infection

Out of 2324 TB patients, 2020 patients were provided with Patient-Initiated HIV testing and counselling (PITC). Percentage TB patients with known HIV status is 87%, in which 14% were HIV positive. The higher percentage of TB/HIV co-infection was found in the southern provinces (Phang Nga, Ranong and Chumporn at 23%), most likely due to high number of fishermen in these areas and their preference to visit sex workers in their free time and less access to HIV prevention (from Global Fund Round 2 – PHAMIT programme).

% TB/HIV co-infection (TH data 2012 vs programme cumulative)		
	Country	Programme
TB patients with known HIV status	74%	87%
HIV-positive patients	15%	14%

Multi-Drug Resistance-TB (MDR-TB)

Although the programme did not plan to provide treatment or support for MDR-TB cases among migrants, the programme initially required culture for all new smear positive cases to be tested for drug sensitivity. In reality the system for culture testing was yet to be developed and expanded to the whole country. Within the programme, only under Kwae River Christian Hospital (KRCH) that drug sensitivity was carried out. Out of 91 patients under KRCH, 7 were identified as resistant to more than 2 antibiotics or 7.7% MDR-TB mainly in Kanchanaburi province. WVFT identified 21 cases in Ranong and Tak.

Contribution to national health programme

There is no clear indicator that the programme directly contributed to Thai TB results in the past 5 years. The recording and reporting of migrant data was provided to the health district and provincial offices on a quarterly basis but it was unclear ifNTP included migrant TB data in the routine recording and reporting at the national level. However, considering the past accomplishment with regards to treatment success (both national programme and GF6 TB-RAM achieving higher than WHO standard), the programme hoped to have

contributed to the achievement in Thailand and the lowered incidence and prevalence rate of the country.

Financial Report:

Provide a summarized financial report by cost category and by financing source. Explain deviations from planned financing. (1 page)

PR-WVFT signed the budget of US$ 8,329,052 with GFATM and was disbursed US$ 7,479,299 in which actual expenditures were US$7,217,635. The remaining disbursed amount US$ 242,777 was partially requested to carry-over to the close-out phase (Oct 2012-Mar 2013).

5-year summarized financial Report by Cost Category

Cost category	Cumulative Budget	Cumulative Expenditures	Cumulative Variance	% Variance	Reasons for deviation
HR	4,134,997	3,682,273	452,725	11%	The cumulative underspending is due to positions at PR and SR level not fully satisfied in Phase 1.
TA	102,528	36,970	65,558	64%	The cumulative underspending is due to budget reallocation across cost category to OR under "M&E" and delayed end term project is carried over to close-out period approved by GF.
Training	740,260	662,581	77,679	10%	
HP/HE	98,475	88,858	9,617	10%	
MED	-	-	-	0%	
PSM	-	-	-	0%	
I/O	319,195	312,176	7,019	2%	
CM	159,260	167,098	- 7,838	-5%	The cumulative overspending is due to a carry forward from Year 2 to Year 3, using budget reallocation from HR budet underspending.
M&E	435,481	416,003	19,479	4%	
LS	1,389,357	1,070,908	318,450	23%	The underspending is due to: on-going patients yet to be supported; increased number of registered migrant not requiring support for treatment cost; and underachievement of the TB patients notification and the patients who received treatment subsequently.
PA	427,093	371,971	55,122	13%	Underspending incurred at PR WVFT as PR WVFT shared facilities with WVFT national office and part of the budget not fully utilized to convene stakeholder meetings and underspending incurred at PR and SR WVFT due to less actual audit fees than planned from phase I and phase II.
OH	522,406	408,798	113,607	22%	Underspending incurred at PR WVFT due to PR WVFT shared overhead costs with WVFT national office. And SRs underspending from Phase 1.
Total	**8,329,052**	**7,217,635**	**1,111,417**	**13%**	Main underspending results from staff vacancy in both PRs and SRs (HR), more migrants could access free TB medicines from health insurance scheme (LS) and shared overhead cost between PR and WVFT office (OH).

5-year summarised financial report by financing sources.

PR/SR	Name	Type of implementing entity	Budget	Expenditures	Variance	% Variance	Reasons for Deviation
PR	World Vision Foundation of Thailand (WVFT)	FBO	5,266,892	4,466,987	799,905	15%	PR and SR-WVFT underspent due to staff vacancy in Phase 1, and shared costs with World Vision national office. SR-WVFT underspent due to most migrant TB patients are getting legal documents like temporary passport, work permit and can accessed 30 baht scheme under Thai government policy for anti TB TB treatment and related investigations
SR	American Refugee Committee (ARC)	NGO/CBO/Academic	2,792,431	2,510,461	281,969	10%	There's a noted overall cumulative underspending related to treatment follow-up cost of patients during the entire treatment procedures (admission cost and TB drugs) as well as the actual expenses made (transportation) for case/ suspect identification. However, there were less cases notified and enrolled compared to targets, therefore related activities are also underspent.
SR	Kwai River Christian Hospital (KRCH)	FBO	269,730	240,187	29,543	11%	The underspending is due to most of the patients receiving DOT at home with DOT partners rather utilizing the cost of accommodation at the TB house, therefore less patient support was required.
Total			8,329,052	7,217,635	1,111,417	13%	Main underspending resulted from WVFT implementing team due to frequent staff vacancy and less more registered migrants accessing free TB medication.

III. Sustainability Plan (2 pages)

Discuss PR and CCM plans to sustain the program. What activities need to be undertaken and how will the PR and CCM finance and implement these?

Community-based TB approach is still considered a new approach in Thailand therefore, sustainability plan of the programme is still on-going after 5-year of implementation. As migrant patients fall under various ministries e.g. Ministry of Labour, Ministry of Public Health, Ministry of Interior, government policy and its enabling environment is the key factor in the programme sustainability.

Institutional sustainability

As of 17 March, 2013 (about 6 months after the programme ended), Ministry of Public Health announced its plan to follow the Ministry Cabinet resolution in providing the migrant health insurance to 4 groups of migrants in Thailand. The 4 groups of migrants include 1) Migrant workers from Myanmar, Laos and Cambodia (TB-RAM target group) 2) Dependents of migrant workers (TB-RAM target group) 3) Migrants crossing border to be treated in hospitals along the border (TB-RAM target group) 4) Tourists in Thailand (non-TB-RAM target group). The Cabinet resolution also allowed unregistered migrant workers to register to work in Thailand, and therefore, decreasing the number of unregistered migrants and increasing access to health care. TB and malaria has been specifically mentioned to ensure complete treatment adherence among migrant workers.

CCM members had been informed of the new development by MoPH and PR and TB CCM Technical committee would take the opportunities to advocate and raise awareness with other CCM members from Ministry of Labour, Ministry of Interior and Ministry of Foreign Affairs regarding the new development. PR-DDC and will continue to advocate with WVFT and other migrant stakeholders to inform and request CCM for further ensure TB treatment among migrants. With this new MoPH plan, the programme and CCM hope to see a more sustained TB programme among migrants, their dependents and those who cross the border for TB treatment.

At the national level, the community-based TB model has been developed and proven to be successful as seen from the high treatment success rate. The programme has shared the model and the results to TB Technical Committee. The model has been discussed between WVFT and PR-DDC to take the compact model and continued in the future projects by WVFT and other implementing agencies. Future GFATM grants will be incorporated to provide treatment to new TB cases in the grant catchment areas.

As the project is finished in September 2012 with a 6-months close out period, the project has been integrated with the Single Stream Funding in order to support the remaining patients. At the provincial level, the provincial health offices and hospitals have taken over TB cases detected and treated by the programme to continue treatment until completion. New cases would continue to be diagnosed and treated at the government hospitals as established by the programme. However, a follow-on migrant TB project is needed to address these sustainability concerns.

Social sustainability

At the community level, migrant community-based networks (CBN) established and volunteers trained by the programme continued to exist in the community to provide education, screening and referral of

suspects identified in the community with minimal assistance from the SRs. CBNs had taken TB and other health issues into their awareness and continued to support their community members in raising awareness on TB diseases and prevention and treatment adherence.

Technical sustainability

WVFT, ARC and KRCH central staff had been trained and retrained on TB monitoring and supervision skills, Data and Cohort analysis skills. Field staff had been trained and implemented on TB screening, recognition referral of TB drug side-effects, TB/HIV counseling, TB case management, stigma reduction and recording and reporting, implementation of DOTS, External Quality Assurance (EQA) Standards, implementing a supervisory system, schedule and checklists for migrant health volunteers for DOTS, TB/HIV care and support, establishing community-based referral system and health posts. Staff skills, guidelines and SOPs are invaluable and would continue to be utilized in future TB grants.

WVFT also planned to release and share its Operational Research documents and 5-year project document with both domestic and international TB stakeholders including NTP and STOP TB Partnership. WVFT is producing a documentary about TB-RAM programme in Thai with English subtitle to disseminate and further advocate the NTP and provincial-level health officials on the model and success stories. This hopes to provide a learning opportunity to others and sustain the success attained by the programme.

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IV. Lessons Learned (4 pages)
For each of the items, discuss facilitating or constraining factors that have been encountered including approaches that have been applied to address:

Grant implementation arrangements;

Grant implementation

Implementing with hard-to-reach population especially mobile and illegal migrants is not a short-term (5-year) programme. Stakeholders had to be advocated in earlier years (phase 1) to be sensitised and receptive in dealing with the issues. Lack of epidemiological and population data of migrant population made planning of indicator and budget difficult, and covering the estimated number of patients and population maybe a difficult task as it was a labour-intensive programme due to language and geographical barriers. Good collaboration with national-level MoPH could provide a strong platform for local partnerships between GO and civil societies.

Community-based TB control with civil society engagement

This approach is still a new topic in Thailand and not widely understood by health officials. Successful TB control results need to be shared at different levels to ensure the effectiveness of the approach, not increasing burden to the system. Models could be learned and developed to share, using the latest STOP TB Partnership ENGAGE-TB guideline as a basic document.

M&E and technical support

TB control, as mentioned earlier, requires strict recording and reporting system by NTP. NGO-PR may not be technically equipped in providing M&E in the early stages and required both technical and M&E support from NTP. Early technical orientation by NTP personnel to both PR and SRs in Phase 1 provided introductory background for the staff but frequent trainings could be beneficial. TB control requires strict recording and reporting, therefore developing and implementing a comprehensive M&E plan can assist in providing the needed consistency and quality for all key TB prevention M&E players countrywide. Additionally, regular M&E meetings at the provincial level with health officials provided an opportunity to improve the system.

Protocols and R&R system

Working with the migrant target group requires specific languages for various guidelines, tools, education materials. Developing various documents in Burmese required time and efforts but were worthwhile in reaching the target audience. Community-based TB control protocols and guidelines including R&R system had to be developed which could be adapted further for NTP even for the Thai population.

Working in a migrant setting

Adopting community-based TB control from the host community setting to migrant setting required adaptation, including cost per cure recalculation. Certain approaches may not be applicable for migrant groups such as using former patients as future DOT partners due to their livelihood. Furthermore, addressing an illegal and different culture/language target groups is labour-intensive and dangerous at times, resulting in high turnover of field staff and less performance demonstrated.Regular supervision by NGO non-Thai staff and monetary support by the project were key motivators to ensure diagnosis and treatment completion.

Partnerships (with donors, civil society, private sector, etc.)

With donors

Partnership with GFATM had been a learning curve for WVFT as an organisation. Expectations and standards within the organisation increased along with GFATM's. Regular face-to-face dialogues between PR and FPM provided a platform for discussion and decision-making on real-time. LFA should be encouraged to attend face-to-face meetings between FPM and PR to align understanding and reduce communication gap.

With GO

Health officials at national level

Regular and built-in technical and M&E support from NTP and DDC would have been an ideal setting for the programme. Budget management also required input from NTP and DDC to ensure a feasible and sustainable approach to support migrant TB patients in long-term. GFATM insistence on a national and comprehensive M&E guideline was an attempt to unite the TB R&R system between GO and civil society but further policy and financial commitment from both sides should be included.

Health officials at implementing level

Time allocation by CCM is crucial for planning a proposal to include all stakeholders. Limited stakeholders applying in Round 6 resulted in limited coordination and input to formulate and standardise GO and civil society partnership during proposal planning and later on, implementation. Many stakeholders would like to be included in the discussion during proposal writing, however,only those applied during "GFATM Call for Proposal" were accessible to attend proposal writing workshops organised. Due to certain limitations, the field government officials were not present during proposal writing and could not provide feasible input for budget and programme management. Later regular advocacy and meetings with government officials reduced tension between partners but not completely. Compensation for lab technicians or ensuring adequate staff in the lab was crucial for case detection as migrants were considered additional workload.

Other government officials at implementing level

Regular formal and informal meetings with local policemen, immigration officers, border control police and community leaders were vital to implement programme. Activities planned, especially advocacy activities with migrants had to be informed in advance to avoid arrest.

With civil society

With SRs

Supportive and participatory approach between PR and SRs was a key success to the programme. Regular physical meetings, virtual meetings and communication between key players provided opportunities to review, revise and ensure programme success. A similar grading system from GFATM was applied to SRs to provide feedback suggestions and opportunities to improve performance on a quarterly basis. Commitment from SR staff at all levels, especially the head of organisation, was crucial to improve and respond to PR's and subsequently GFATM's demands. However, high turnover rate of PR staff resulted in miscommunication and lacking corporate memory in which knowledge management system could have been put in place to reduce knowledge gaps.

With other civil societies

TB control among civil societies in Thailand was still limited mainly to GF6 implementers. However, in the field level, some civil society network was formed and referral of TB patients to receive ART, MDR-TB medicine or other psychosocial support was implemented in many provinces.

With business owners and gatekeepers

Regular meetings and advocacy activities with business owners were vital to access migrant communities. Many business owners became sensitized and acted as DOT partners, referred suspects or allowed TB patient to complete treatment while receiving payment.

CCM functioning and oversight challenges

CCM functioning

Thailand CCM is a large body comprised of almost 30 members from various stakeholders, mainly government officials from different bodies. HIV/AIDS seems to lead the interest of CCM members, followed by TB and Malaria grants according to the size of the grants and number of implementing agencies involved. As HIV is the only chronic disease and incurable, only PLHIV representative is present in the CCM. It is difficult to inspire the interest of TB patients once treatment completed to become representatives.

In Thailand, TB Technical Committee comprised of DDC, NTP, Bangkok Metropolitan Administration, Anti-TB Association oversee GFATM TB grants. Technical issues, progress, and discussions on grant implementation were on the agenda. M&E visits had not been carried out by the CCM technical committee or CCM members in the 5-year period due to unavailability of budget for technical committee members and time allocation for CCM members.

Thailand CCM restructuring in early 2012 had additional proposal-writing and oversight committee to designate CCM members and other stakeholders to provide closer look at the grants than attending CCM meetings every 2 months. Lack of new GFATM grants reduced the frequency of CCM meetings and subsequently, progress report meetings.

PR, a key beneficiary of CCM meetings but not a member of CCM committee due to transparency policy, has less weight in encouraging frequency of meetings and influencing the agenda. Frequent staff turnover of PR managers resulted in gaps in attending CCM and Technical committee meetings, hence decreased oversight and communication between two PRs and other national TB stakeholders.

Between CCM committee and TB Technical committee, the latter was a good advocacy platform for PR on policy implementation and gaps encountered as key NTP stakeholders were present and more enabling environment (about 10 members) for in-depth discussion.

Further grant proposal at the PR level should include M&E visit budget for technical committee for closer inspection and understanding of the programme. Field-level advocacy with government officials by CCM technical members could also be carried out to assist SRs or implementing agencies on difficult or sensitive issues.

Global Fund grant management process including working relationships with Global Fund Secretariat and LFA.

Proposal writing

GFATM proposal is the longest and most complicated and ever-changing format encountered by implementers. The document required concerted efforts by GO, NGOs and various organisations to complete in a limited period. Since the proposal format seemed to constantly change, it is a challenge for the applicants to prepare in advance.

PR arrangement and management

Global Fund Round 6 grant had been an interesting proposition to have two PR's for one disease component, the first of its kind in the country and in the world. After the grant approval, this model was hailed as best practice while one PR is from the government and another from civil society. It was a positive set-up in which the government managed government implementation (DDC managed NTP) and their existing SR (from round 1) while WVFT managed NGOs. However, without the joint committee between the two PRs (originally proposed by WVFT), there was a gap of communication and lack of regular supervision and support from DDC and NTP as felt by both PRs and SRs.

On PR management, PR level is also a high-profile and high-responsibility team with many expectations from all partners. Staff recruitment and retention has been the biggest challenge during the whole 5-year period, resulting in delayed decision-making processes with SRs and confusion in the community at times.

SR selection and project management

SR selection had to be selected from all candidates at the "CCM Call for Proposal" to demonstrate transparency in the selection process. SR assessment is as critical as PR assessment, or even more, as SRs are the implementing agencies and accountable in all accounts especially in achieving targets and financial management to reduce misappropriation of funds. Therefore, selecting competent SRs to implement the programme is most vital to the programme success. Moreover, TB control system especially in recording and reporting is complicated. Without adequate and continuous technical training and support from PR and NTP, TB control by SRs may neither be measurable nor standardised. On the positive side, as WVFT had NGOs as SRs that understood the importance of performance-based funding and were responsive to PR suggestions and support.

Relationship with FPM

In the past 5 years, PR-WVFT had both smooth and slow progress with GFATM on grant signing, disbursement, implementation, depending on FPM. Five Fund Portfolio Managers (FPM) in 5 years demonstrated low personnel retention ability of GFATM, or lack of commitment to maintain relationship with PR, resulting in staggered communication between GF and PR at various stages. PR-WVFT experienced difficulties in Phase1 and 2 grant signing periods; delayed discussion and decision making, unclear protocols, and later on late grant signing due to FPM which resulted in delayed disbursement and subsequently, delayed grant implementation. 40 per cent of the experience in dealing with FPM found them to be experienced and decisive grant managers, responsive and sensitive to PR's needs while the other 60% per cent could be improved.

Relationship with LFA

Working with LFA had been the most challenging in all aspects of grant management felt by PR and SRs. Although some LFA representatives seemed sympathetic to grant implementation, 90% of the discussions or dealings with LFA found PR and SR team members in despair. As LFA in Thailand had been an audit company, all representatives (except one) were accountants with no experience in grant implementation and no background in general issues about Thai society or humanitarian efforts in any aspects. Their interest in achieving targets (performance-based) refers to all the numbers achieved/not achieved and less understanding on the how or why deviations occurred. Although this grant had mainly received A1's and A2's, continuous stream of new LFA team members made it a challenging task at every report submission. GFATM's good intention in country-owned and local knowledge approach may be diminished via the selection of LFA in the process.

V. Conclusions and Recommendations (1/2 -1 page)
- Conclude and provide final recommendations on the program.

The TB control among migrants programme was proposed without solid epidemiological and population data which proved difficult for achieving targets established 5-6 years earlier. In-depth discussion and planning between government and civil society prior to programme proposal is recommended to initiate partnership, establish committee and various systems and agreed on the best-way forward. Field implementers (government health officials) should be invited for inputs prior to proposal writing with government (NTP) funding to support such meetings to ensure collaboration during implementation and later, sustainability of the programme. Best practices, lessons learned and model different grant implementation should be shared with government and latter, by GFATM among different implementers.

Migrant TB control programme may require a longer implementation period than the national programme country due to the variety of stigma and fear needed to overcome with many stakeholders in the initial phase. When the preparatory phase takes longer to complete, the latter phase may not cover as many target groups as planned and sustainability takes longer time due to the migratory nature of the target groups and the issues faced with the authorities. Cross-border GFATM disease control grant should be considered especially in the light of the new ASEAN Economic Community in 2015 to provide extensive coverage for patients from both sides of the border.

On remote grant management by GFATM, CCM in the country is established only to serve GFATM grant for 3 diseases, in which MoPH argues that its responsibility covers more than 3 diseases, although important to the country. Using the CCM and LFA to provide oversight and feedbacks to the PR alone may not be the best solution especially during rush period e.g. proposal approval, grant signing, etc. FPM should work more closely with PR in grant management, rather than leave key issues to LFA to decide on GFATM's behalf. Other than that, LFA selection should be more opened and LFA orientation and capacity building should be provided by GFATM to provide opportunities for other organisations to apply for LFA.

Annex 1
Table of Acronyms

ACSM	Advocacy, Communication and Social Mobilisation
ARC	American Refugee Committee
ART	Anti-retroviral treatment (for HIV/AIDS patients)
CCM	Country Coordinating Mechanism
DOT	Directly-Observed Treatment
DOTS	Directly-Observed Treatment, Short-course
FPM	Fund Portfolio Manager
GF6	Global Fund round 6 (TB-RAM programme)
GFATM	Global Fund against AIDS, TB and Malaria
GO	Government Organisations
HIV	Human-immunodeficiency virus
KRCH	Kwae River Christian Hospital
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MDR-TB	Multi-Drug Resistance TB
MHV	migrant health volunteers
MoPH	Ministry of Public Health
NGO	Non-Governmental Organisation
NSP	New Smear Positive
NTP	National Tuberculosis Programme
PHAMIT	Prevention of HIV/AIDS among Migrants in Thailand programme
PITC	Provider-Initiated HIV testing and counselling
PLHIV	People living with HIV
PR	Principal Recipient
PR-DDC	Department of Disease Control as Principal Recipient
PR-WVFT	World Vision Foundation of Thailand as Principal Recipient
R&R	Recording and Reporting system
SR	Sub-Recipient
TB	Tuberculosis
TB/HIV	Co-infection of both TB and HIV in a patient
TB-RAM	Reduction of TB Morbidity among Non-Thai Migrants in Six Border and Adjacent Provinces
WHO	World Health Organisation
WVFT	World Vision Foundation of Thailand

Annex 2

Glossary of Terms

ACSM or Advocacy, Communication and Social Mobilisation	A STOP TB Partnership approach in combating TB using methods successfully implement through advocacy at different levels, communication of TB diseases and social mobilisati of the communities.
CCM or Country Coordinating Mechanism	Country-level multi-stakeholder partnerships develop and submit grant proposals to the Global Fund based on priority needs at the national level. After grant approval, they oversee progress during implementation. (from http://www.theglobalfund.org)
Cat I or Category I TB drug	TB drugs for new smear positive TB patients, seriously ill smear negative and seriously ill EP patients (adults) constituting of a 6-month treatment, 2 months of intensive phase (4 drugs taken daily) and 4 months of continuation phase (2 drugs taken daily).
Cat II or Category II TB drug	TB drugs for Sputum smear positive positive relapse, Sputum smear positive failure and sputum smear positive treatment after default cases (adults) constituting of a 8-month treatment, 2 months of intensive phase (5 drugs taken daily), 1 month of intermediate phase (3 drugs taken daily) and 5 months of continuation phase (3 drugs taken daily).
Cat III or Category III TB drug	TB drugs for Sputum smear negative not seriously ill or children constituting of a 6-mont treatment, 2 months of intensive phase (3 drugs taken daily) and 4 months of continuati phase (2 drugs taken daily).
Cat IV or Category IV TB Drug or DOTS Plus	An extensive drug regimen mainly for MDR-TB cases usually takes 2 years to complete treatment.
CNR or case notification rate	Notifications are defined as the number of cases notified to the national TB-programmes expressed per 100,000 population
Community-based DOT	Provision of patient-centered DOT in the community, either at home, work place or othe convenient location. Community volunteers are identified and trained as DOT providers
DOT or Directly-Observed Treatment	A way of helping patients take their TB medicines by meeting with a health care worker every day or several times a week at a place both agree on. This can be the TB clinic, hon or work, or any other convenient location. Patient will take medicine while the health ca worker watches
EP or extrapulmonary	TB disease in any part of the body other than the lungs (for example, the kidney, spine, brain, or lymph nodes).
FPM or Fund-Portfolio Manager	FPM is part of the GFATM secretariat responsible for day-to-day operations, including mobilizing resources from the public and private sectors, managing grants, providing financial, legal and administrative support, and communicates directly with PR and LFA. (from http://www.theglobalfund.org)
GFATM, GF or the Global Fund	An international financing institution dedicated to attracting and disbursing resources to prevent and treat HIV and AIDS, TB and malaria. (from http://www.theglobalfund.org)
Health post	An area in the community either an MHV's home or work place designated as a health post and equipped with documents and leaflets about health issues including TB manne by MHVs. Health posts had been the key referral system for TB screening and diagnosis TB suspect and patients.
Incidence rate	The frequency with new TB cases appear in a particular population expressed per 100,00 population

LFA or Local Fund Agents	GFATM hires Local Fund Agents to oversee, verify and report on grant performance. Loca Fund Agents are selected through a competitive bidding process. (from http://www.theglobalfund.org)
MDR-TB or Multi-Drug Resistance TB	TB disease caused by bacteria resistant to two or more of the most important medicines Isoniazid and Rifampicin.
MHVs or migrant health volunteers	Health volunteers from the migrant communities who can communicate with the migran target groups with ease.
NSP or new smear positive	New patients diagnosed with TB in the lung and tested sputum using Acid-Fast Bacilli method and found to be positive.
NTP or National TB Programme	Country's key responsible programme to eliminate TB.
PHAMIT programme	A GFATM Round 2 programme in Thailand focused on prevention of HIV among migrants in which WVFT had implemented prior to GF round 6.
PR or Principal Recipient	Principal Recipient receives Global Fund financing directly, and then uses it to implement prevention, care and treatment programs or passes it on to other organizations (sub-recipients) who provide those services. (from http://www.theglobalfund.org)
Prevalence rate	The number of existing cases at a certain point in time expressed per 100,000 population
smear negative	Patients diagnosed with TB in the lung and tested sputum using Acid-Fast Bacilli method and found to be negative
SR or Sub-Recipient	Sub-Recipient receives fund from PR and implement prevention, care and treatment programme to provide services.
SSF or Single-Stream Funding	Single Stream of Funding per Principal Recipient per disease or cross-cutting health systems strengthening program. Global Fund will maintain one funding agreement for each Principal Recipient per component, which will then be amended each time addition funding in the same component is approved and at the time of Periodic Review. (from http://www.theglobalfund.org)
Treatment success rate	A proportion of TB patients who either completed their TB treatment and were confirmed as smear-negative at the end of the treatment (cured) or just completed their treatment.
WHO 22 High TB burden countries	A list of countries with high TB burden reported by WHO annually to monitor National TB Programme progress.

Annex 3

TB-RAM TB results	Year 1		Year 2		Year 3		Year 4		Year 5		Overall	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Population	96574		138977		235944		271459		271495		271495	
Suspects referred	1172		3879		6996		7150		7840		27037	
Cases notified (NSP)	106	9%	343	9%	347	5%	376	5%	376	5%	1548	6%
Cases enrolled (NSP)	98	92%	292	85%	316	91%	343	91%	335	89%	1384	89%
Treatment success (NSP)	81	83%	262	90%	257	81%	297	87%	N/A		897	86%
Cases notified (All)	179	15%	541	14%	557	8%	603	8%	616	8%	2496	9%
Cases enrolled (All)	168	94%	496	92%	523	94%	569	94%	568	92%	2324	93%
Treatment success (All)	143	85%	433	87%	437	84%	498	88%	N/A		1511	86%
Access to PITC	143	85%	436	88%	498	95%	541	95%	501	88%	2119	87%
TB/HIV co-infection	21	15%	49	11%	75	15%	54	10%	85	17%	284	14%