PROPOSAL OF THE COUNTRY COORDINATING MECHANISM INDIA

SIXTH CALL FOR PROPOSALS

PROPOSAL SECTIONS (CCM RELATED COMPONENTS) Page

1 Proposal Overview

1.1 General information on proposal

Applicant Name	**INDIA - COUNTRY COORDINATING MECHANISM**
Country/countries	**INDIA**

Applicant Type

☒ **National Country Coordinating Mechanism**

☐ Sub-national Country Coordinating Mechanism

☐ Regional Coordinating Mechanism (including small island developing states)

☐ Regional Organization

☐ Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

	Component	Title
☒	HIV/AIDS[1]	**SCALING UP CARE, SUPPORT AND TREATMENT FOR HIV IN INDIA**
☒	Tuberculosis[1]	**CONSOLIDATING AND SCALING UP OF RNTCP INTERVENTIONS IN ORDER TO ACHIEVE TUBERCULOSIS RELATED MDGS**
☒	Malaria	**ACCELARATED URBAN MALARIA CONTROL PROJECT**

Currency in which the Proposal is submitted

☒ **US$**

☐ Euro

[1] In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

1 Proposal Overview

1.2 Proposal funding summary per component

Table 1.2 – Total funding summary

Component	Total funds requested (US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	35,670,099	40,284,571	49,929,722	60,587,856	72,739,326	259,211,574
Tuberculosis	4,270,531	4,801,932	5,003,913	4,948,361	5,246,816	24,271,553
Malaria	3,792,083	10,971,820	10,161,210	7,720,106	6,622,289	39,267,508
Total	43,732,713	56,058,323	65,094,845	73,256,323	84,608,431	322,750,635

1.3 Previous Global Fund grants

Table 1.3 – Previous Global Fund grants

Component	Previous grants	
	Rounds	Current Amount* (US$)
HIV/AIDS	2, 3**, 4	248,399,892
Tuberculosis	1, 2 & 4	64,300,033
Malaria	4	690,44,954
HSS/Other		

* *Aggregate all past grants, including approved but as yet unsigned amounts. These amounts should include Phase 2 where this has been approved/signed. For more detailed information, see the Guidelines for Proposals, section 1.3.*

** HIV-TB grant of US$ 14,819,773

2 Eligibility

2.1 Technical eligibility

2.1.1 Country income level

Country/countries		
☒	**Low-income**	➔ *Complete section 2.2 only*
☐	Lower-middle income	➔ *Complete sections 2.1.2, 2.1.3 and 2.2*
☐	Upper-middle income	➔ *Complete sections 2.1.2, 1.2.3, 2.1.4 and 2.2*

2.2 Functioning of Coordinating Mechanism

2.2.1 Broad and inclusive membership

a) People living with and/or affected by the disease(s)

Provide evidence of membership of people living with and/or affected by the disease(s). *(This may be done by demonstrating corresponding Coordinating Mechanism membership composition and endorsement in table 3B1.2, and 3B.1.3 in section 3B of the Proposal Form.)*

The current Vice-Chair of the India-CCM is from INP+ which represents the "people living with and/or affected by the disease(s).

The documentation of the appropriateness of the representation is enclosed as ***Annexure CCM-1.***

In addition the civil society organizations and other interest groups working for people affected by Tuberculosis in the country are also represented at the India-CCM by the Tuberculosis Association of India.

b) Selection of non-governmental sector representatives

Provide evidence of how those Coordinating Mechanism (CM) members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, religious and faith-based organizations, and multi-/bilateral development partners in country)* have been selected by their own sector(s) based on a documented, transparent process developed within their own sector.

(Please summarize the process and, for each sector, attach as an annex the documents showing the sector's transparent process for CM representative selection, and the sector's minutes or other documentation recording the selection of their current representative. Please indicate the applicable annex number.)

The India-CCM has been diligently working towards ensuring a comprehensive and inclusive membership pattern readily taking up the suggestions that continue to emerge to achieve the same. The Global Fund's case study report on the functioning of the India-CCM in mid 2004 suggested that the CCM should consider reorganizing itself into a structure that involves additional stakeholder groups in line with GFATM guidelines taking account of the relevance and roles of the groups, as well as difficulties associated with managing a larger number of members. This recommendation of the Global Fund was discussed by the CCM. The CCM was reconstituted in August 2004 with the following changes:

Government Sector:
Central: - Membership of Ministry of Health reduced from 7 to 5 . Program Officers of TB & Malaria Divisions of the Ministry of Health were excluded but were nominated as non-voting invitees to CCM Meetings. The Joint Secretary (FB) replaced the Director (FB) of the Department of Economic Affairs, Government of India at the CCM. The Director General of the Armed Forces Medical Services was

included to represent another key ministry.
Regional: - State Governments representing 5 regions (Northern, Southern, Central, Eastern, Western) appointed on a rotational basis for a period of two years. The Principal Health Secretaries of Delhi, Andhra Pradesh, Bihar, Assam and Gujarat were included to represent the above regions respectively for the first two-year term.

Civil Society Sector:
International – Director of Bill & Melinda Gates Foundation included as member.
Domestic – Increased from 4 to 8. Five NGOs representing various regions of the country were included on rotational basis for a period of two years each. Director, SAHARA, New Delhi; and Director, APAC, Chennai representing Northern and Southern regions respectively were already included in the CCM in February 2004. The following were included in August 2004: Durbar Mahila Samanwaya Samiti, Kolkata to represent the Eastern region; Director, Society for HIV/AIDS And Lifeline Operation in Manipur to represent the North-Eastern region; Administrator, Bel Air Hospital, Satara District, Maharashtra to represent the Western Region.
The Tuberculosis Association of India,New Delhi represents the civil society sector working for people affected by tuberculosis.
In addition INP+, Chennai represents People Living With /Affected by the Diseases .
President of Health India Foundation, Chennai and Former Director, Institute of Thoracic Medicine & Chest Diseases, Chennai represents civil society sector working on TB-HIV convergence issues.

Academic Sector:
Representation increased from 1 to 2 with the inclusion of the Director of the All India Institute of Medical Sciences, New Delhi.

Thus the current members represent the following sectors:
- Academic/Research/Educational Sector
- Civil Society Organizations
- Government – Central and Regional
- People living with and/or affected by HIV/AIDS, TB and/or Malaria
- Private Sector – Business and Foundations
- Multilateral and Bilateral Development Partners in the country

The documentation of the appropriateness of the representation of the Private Sector (Business) at the India-CCM is enclosed as ***Annexure CCM-2.***

In response to further suggestions regarding Board requirements conveyed by the GFATM Secretariat as part of the Phase II extension and applications of some of the GFATM grants to India, the India-CCM act its 18th Meeting held on 11th May, 2006 deliberated extensively upon the issue of representation and the need to enhance representation. At this meeting key decisions were taken in respect of :
- The total number of members, the different types of sectors to be represented in the India-CCM and the sectoral allocation of membership.
- Since the FBO sector could not be explicitly included due to the secular nature of the Indian Constitution, the India-CCM decided to merge the FBO sector and the Civil Society Sector as one constituency, and to facilitate the constituency members to elect their own representatives to the India-CCM.
- A subcommittee was nominated to arrive at the eligibility criteria for representatives of each of the non-governmental sectors and to outline processes that would allow these different sectors to select their own representatives in a transparent manner .

The "Proceedings of the 18th India-CCM meeting" where the above decisions were taken is enclosed as ***Annexure CCM-3.*** *The "Proceedings of the India-CCM Sub-Committee" constituted for the purpose of drafting the eligibility criteria and outlining processes that for the transparent selection of representatives by the sectors themselves is enclosed as* ***Annexure – CCM-4 .***

The processes outlined for selection of the representatives of the various non-governmental sectors are underway and the newly selected representatives of the different non-governmental sectors will take their place in the India-CCM when it is reconstituted by the end of August 2006 when the two-year tenure of the current members comes to an end.

The ongoing electronic process of enrollment and polling for the CSO/FBO and the Private Foundations

sectors may be viewed at the following website: www.indiaccm.org

2.2.2 Documented procedures for the management of conflicts of interest

Where the Chair and/or Vice-Chair of the Coordinating Mechanism are from the same entity as the nominated Principal Recipient(s) in this proposal, describe and provide evidence of the applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest arising in regard to the applicant's operations or responsibilities.

(Please summarize and attach the policy as an annex. Please indicate the applicable annex number.)

The current Chair and Vice-Chair of the India-CCM are from different sectors. The Chair is from the "Government Sector" – (Ministry of Health & Family Welfare) and the Vice-Chair from the "People Living With and/or Affected by the Disease(s) Sector".

The proposed Principal Recipient for the entire Tuberculosis and Malaria components and the major portion of the HIV/AIDS component of this proposal is the Department of Economic Affairs (DEA), Government of India. The DEA only serves as the legal channel for grant funds flow in accordance with the rules and regulations of the Government of India. It does not have a direct policy or operations role in the implementation of the grants. The Central Tuberculosis Division (CTD), the Directorate of the National Vector Borne Diseases Control Programme (Dir-NVBDCP) and the National AIDS Control Organization (NACO) of the Ministry of Health & Family Welfare are the proposed Operational PRs (OPRs) respectively of the components of the proposal mentioned above. The Heads of the CTD and the Dir-NVBDCP are not members of the India-CCM but only Permanent-Invitees without any decision making authority or voting rights. NACO is headed by a Director General who is a member of the India-CCM. The NACO Director General reports to the Secretary, Health & Family Welfare, who is the Chair of the India-CCM. The Secretary, Health & Family Welfare is not involved in the routine implementation details of the programs or projects of NACO but has strategic and policy oversight of the organization.

In order to address the apparent or potential conflicts of interest with the above configuration and also other potential conflicts with respect to any other constituency of the India-CCM vis-à-vis PR status, provisions have been clearly made in *the "Terms of Reference of the India-CCM" in* the last section (No. 51) of which explicitly refers to Conflicts of Interest (enclosed as **Annexure CCM-5)**. The "*India-CCM Plan for Mitigation of Conflicts of Interests"* drafted by a specific India-CCM sub-committee given this responsibility and ratified by the India-CCM after due deliberation at its 19th meeting held on 26th June 2006 *is also enclosed as* ***Annex CCM-6.***

The plan details a four-fold mechanism for mitigating conflicts of interest as summarized below:-

1. Detailed attention paid to the configuration of the general structure and management process of the India-CCM to avoid conflicts of interests from arising,
2. Stipulations for voluntary declaration of conflict of interest(s) by members .Provision for members having conflict of interest to so declare and to recuse themselves from discussion and also for the CCM to take a decision to exclude a Member by vote ,from discussion and decision in the event of failure to voluntarily disclose conflict of interest(s) when such conflict is perceived by the CCM,
3. Provisions for any member of the CCM, PR(s), Operational PR(s), SR(s) and CCM Secretariat to bring to the notice of the CCM any perceived or potential conflict of interest for discussion and resolution; and inclusion of a conflicts of interest clause in all contracts and agreements governing expenditure of GFATM monies in India, and
4. Provision when necessary to institute appropriate independent mechanisms for evaluation of proposals, nomination of PR(s), OPR(s) and SR(s) and evaluation of performance of PR(s), OPR(s) and SR(s).

2 Eligibility

2.2.3 Documented and transparent processes of the Coordinating Mechanism

As part of the eligibility screening process for proposals, the Global Fund will review supporting documentation setting out the CCM's proposal development process, the submission and review process, the nomination process for Principal Recipient(s), as well as the minutes of the meeting where the CCM decided on the elements to be included in the proposal and made the decision about the Principal Recipient(s) for this proposal.

Please describe and provide evidence of the CCM's documented, transparent and established:

a) Process to solicit submissions for possible integration into this proposal.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

Immediately after the Round 6 Call for Proposals by the GFATM, the 18th meeting of the India-CCM was convened on 11th May 2006. The strategies and actions for the formulation of the Round 6 Country Proposal and the discussion and ratification of the focus areas for each of the three disease components by the CCM was one of the agenda items deliberated upon and decided by the CCM at this meeting (***Annexure CCM-3***). Following this, the concept notes and proposal submission formats for the three disease components were drafted by the respective national programme division with inputs from the technical agencies represented on the India-CCM. Once these tools for inviting submissions from all stakeholders in the country for possible inclusion in Round 6 Country proposal were ready, they were placed for viewing and downloading at the web sites of the India-CCM, the Ministry of Health & Family Welfare and of the three national disease control programmes viz., NACO, RNTCP and NVBDCP along with the announcement calling for the civil society, private and other sectors to submit proposals for the consideration of the India-CCM. At the India-CCM website provision was made for enquiries related to the proposal by email and for submission of completed proposals through email.

Copies of the screen shots of the five websites in which the call for proposals were placed along with the announcement are enclosed as ***Annex CCM-7.***

Copies of the disease specific concept notes and application formats are enclosed as ***Annex CCM-8.***

The same announcement was published at the end of May / beginning of June in several languages throughout the country to ensure nation wide coverage. It was published in English in 11 editions each of two news papers with nation wide coverage (The Times of India and The Hindu) and six state level news papers specific to the North-east region of the country where English is predominantly used and in Hindi in 18 and two editions respectively of two news papers (Dainik Bhasker and Dainik Jagran) covering the bulk of the Hindi speaking North and North-western regions of the country. In addition it was published in 11 vernacular Indian language news paper editions to cover the state(s) where these languages are used viz., Bengali in West Bengal and Tripura states; Marathi in Maharashtra state; Gujarati in Gujarat state; Oriya in Orissa state; Telugu in Andhra Pradesh state; Kannada in Karnataka state; Tamil in Tamil Nadu and Pondicherry states; Malayalam in Kerala state; Assamese in Assam state; Mizo in Mizoram state; and Urdu in the state of Jammu & Kashmir.

A copy of the communication from the Department of Advertising and Visual Publicity, Ministry of Information and Broadcasting, Government of India, stating the names and editions (city) of the news papers and the language in which the announcement was published is enclosed as ***Annex CCM-9.***

Sample copies of some of the news paper announcements are enclosed as ***Annex CCM-10.***

b) Process to review submissions received by the CCM for possible integration into this proposal.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

At the 19th meeting of the India-CCM held on 26th June 2006, the process for review of the submissions from the non-governmental sectors received by the CCM for inclusion in the Round 6 Country proposal was discussed. The CCM decided that due to the expectation of a large number of submissions for this round, the CCM Sub / Screening Committee that was operational for the last two rounds would be expanded and instead of a single screening committee there would be three screening committees – one for each of the disease components consisting of the concerned national disease control programme division and the members of the CCM representing the various non-governmental sectors or their nominees.

2 Eligibility

The India-CCM Secretariat was directed to send a formal request to the members of the CCM representing the various non-governmental sectors for nominations to the sub / screening committee of interest by 30th June 2006, the deadline for submission of proposals by the non-governmental sectors to the India-CCM. In response to this formal request, nominations were received from some of the member organizations for the screening committees of the CCM. The specific screening committees were constituted by including the nominees who were readily able to provide the time necessary for detailed review. Nominees from member organisations which had themselves directly or through another entity submitted proposals for consideration were excluded in order to avoid any potential conflict of interest.

The Proceedings of the 19th meeting of the India-CCM and the list of nominees for the CCM Screening committees are enclosed as ***Annexure CCM-11*** *and* ***Annexure CCM-12*** *respectively.*

After the deadline for submission of proposals, the India-CCM Secretariat tabulated the submissions that were received in time for each of the three disease components and combination of disease components both in the form of hard copy / CD and through email. After sorting out the duplicate receipts, the submissions were handed over for review by the respective CCM Screening Committee.

The review criteria formulated by the committees were standardized with the facilitation of the India-CCM Secretariat. The heads of the three national disease control program divisions presented the process and results of the review and the recommendation of the committees on the submissions that were reviewed to the India-CCM at its 20th meeting held on 12th July 2006.

The Proceedings of the 20th meeting of the India-CCM which includes the details on the results of the review process, copies of the presentations and other details submitted for the perusal of the India-CCM are enclosed as ***Annexure CCM-13.***

c) Process to nominate the Principal Recipient(s) and **oversee** program implementation.
(Please summarize and attach documentation as an annex and indicate the applicable annex number.)

Nomination of Principal Recipient(s): As per the rules and regulations of the Government of India, only the Department of Economic Affairs, Ministry of Finance is authorized government entity to receive and disburse funding from external sources. Consequently this entity is the automatic PR for all GFATM grants to India. Nevertheless, this entity while serving as the legal channel for flow of funds, delegates and designates the respective National Disease Control Program Divisions (NACO / CTD / Directorate of NVBDCP) of the Ministry of Health & Family Welfare as the Operational PR / the entity which manages the programmatic aspects of the grant as well as the disbursement and audit of funds to the sub recipients of the grant.

The India-CCM decides on and recommends the nomination of additional PRs who are non-governmental entities through the following process detailed in the Annexure to Section No. 47 of the Terms of Reference of the India-CCM (***Annex CCM-5***) :

1. The non-governmental entity should have submitted a proposal for a disease component that was recommended by the relevant CCM Screening Committee to be included in the country proposal for that disease component and approved by the CCM.
2. It should be a domestic entity possessing the legal status to enter into a grant agreement with a non-domestic / external entity as per the rules and regulations stipulated by the Government of India and not in breach of any central or state specific legal provisions governing the functioning of such entities in the country.
3. The relevant national disease control programme division should present the merits of the concerned non-governmental entity for eligibility to be a functional PR based on
   a. the technical expertise of the entity that would add value to the implementation of the grant and the objectives of the national program, and
   b. the organizational, leadership, managerial and financial expertise to utilize the grant efficiently and cost-effectively to achieve the desired service delivery and outcome targets, and
   c. the adequacy of infrastructure and information system facilities in order to implement the grant, manage and support sub-recipients and monitor performance with reasonable additional overheads.

The process followed by the India-CCM for the nomination of the additional PRs for this proposal is captured in the *Proceedings of the 20th and 21st Meetings of the India-CCM* which are enclosed as ***Annex CCM-13*** and ***Annex CCM-14*** respectively.

2 Eligibility

Oversight on program implementation: Review of the status of implementation of GFATM grants is a key agenda item in all regular meetings of the India-CCM except those that are convened on an emergency basis for a very specific and limited purpose. A comprehensive report on the progress of the implementation of the grant with respect to both financial and service-delivery targets prepared by the PR is circulated to all the CCM members and invitees prior to each CCM meeting by the India-CCM Secretariat. It is the responsibility of the CCM members to share this information with the constituency they represent. In addition, the representative of the PR presents the progress in brief during the meeting and responds to the queries of the members and invitees. The views expressed by the members and invitees, the responses of the PR and the recommendations of the CCM for improving or accelerating performance when relevant are recorded in the Proceedings of the Meeting by the India-CCM Secretariat and circulated to all the members and the invitees. It is again the responsibility of the CCM members to share this information with their respective constituency. The India-CCM Secretariat also responds to queries from any interested stakeholders on the performance of the grant.

The oversight process outlined above is in addition to the detailed evaluation of performance of the grant that is undertaken by the CCM as part of the request for continuation of funding into the Phase 2 of the grant and the regular monitoring of performance that is undertaken internally by the PR and/or the Ministry of Health & Family Welfare on its own and/or in collaboration with other technical partners who may also be represented at the India-CCM.

For GFATM funded programs such as the Round 4 HIV/AIDS grant which has more than one PR, an advisory committee / task force has been constituted co-chaired by the non-governmental PR and the Head of the national disease control program division (NACO in this instance). Meetings of these committees take place at regular intervals wherein the performance of the grant is discussed and recommendations for improvement where necessary are made. The CCM-Secretariat is also invited for these meetings.

d) Process to ensure the input of a broad range of stakeholders, including CCM members and non-CCM members, in the proposal development process and grant oversight process. *(Please summarize and attach documentation as an annex and indicate the applicable annex number.)*

Inclusive proposal development process: The manner in which submissions were requested, received , reviewed from all possible stakeholders including CCM members and non-CCM members and incorporated into the GFATM Round 6 Comprehensive Country Proposal from India which has been described in detail in subsections (a), (b) and (c) above of section 2.2.3. with the relevant documentary support.

In addition, the specific national disease control programmes (National AIDS Control Programme Phase III, Revised National Tuberculosis Programme Phase II and the National Vector Borne Diseases Control Programme) - of which the respective disease components of this proposal are an integral part – have been developed using very participative processes involving a broad range of stakeholders in the country. These inclusive processes are described in detail in the national programme documents that are enclosed as Annexes in the respective Disease Component sections of this proposal.

Inclusive grant oversight process: The process followed by the India-CCM for oversight of implementation of GFATM grants has been detailed in subsection (c) above of section 2.2.3. The members of the CCM are accountable to constituencies they represent and are mandated to convey the concerns and view points of these constituencies to the meetings of the CCM and provide feedback to the constituencies on the discussions and decisions of the CCM on all aspects of the GFATM grant cycle. The CCM-Secretariat facilitates this process by servicing the CCM and by disseminating the necessary information in a timely manner. In order to strengthen the information dissemination and participative oversight processes, the India-CCM at its 18th meeting held on 11th May 2006, approved the prototype of the website of the India-CCM (***Annex CCM-3***). The website was subsequently launched in the beginning of June 2006. The address is www.indiaccm.org. The Agenda and Proceedings of the recent India-CCM meetings are hosted on the website. Updates on all aspects of the performance of the GFATM grants in India and Bulletin Boards to elicit the views from the field are also to be hosted.

3A Applicant Type

This section contains information on the applicant. Please see the Guidelines for Proposals, section 3A, for more information regarding the nature of different applicants.

All Coordinating Mechanism Applicants *(whether national, sub-national, regional (C)CMs) and Regional Organizations* ***must also*** *complete section 3B of this Proposal Form and provide the documented evidence requested.*

Non-CCM Applicants *do not complete section 3B. These applicants must fully complete section 3A.5 of this Proposal Form and provide documentation as an attachment to this proposal supporting their claim to be considered as eligible for Global Fund support outside of a Coordinating Mechanism structure.*

3A.1 Applicant

Table 3A.1 – Applicant

Please tick the appropriate box in the table below, and then go to the relevant section in this Proposal Form, as indicated on the right hand side of the table.

☒	**National Country Coordinating Mechanism**	➔*complete sections 3A.2 and 3B*
☐	Sub-national Country Coordinating Mechanism	➔*complete sections 3A.3 and 3B*
☐	Regional Coordinating Mechanism (including small island developing states)	➔*complete sections 3A.4 and 3B*
☐	Regional Organization	➔*complete section 3A.5 and 3B*
☐	Non-CCM Applicants	➔*complete section 3A.6*

3A Applicant Type

3A.2 National Country Coordinating Mechanism (CCM)

For more information, please refer to the Guidelines for Proposals, section 3A.2, and the CCM Guidelines.

Table 3A.2 – National CCM: basic information

Name of national CCM	**Date of composition** (yyyy/mm/dd)
INDIA - COUNTRY COORDINATING MECHANISM	**2001/12/28**

3A.2.1 Mode of operation

Describe how the national CCM operates. In particular:

- **The extent to which the CCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; and multi-/bilateral development partners in-country; and
- **How it coordinates its activities with other national structures** (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

(For example, address topics including decision-making mechanisms and rules, constituency consultation processes, the structure and key focus of any sub-committees, frequency of meetings, implementation oversight processes, etc. The recommended length of response is a maximum of one page. Please provide terms of reference, statutes, by-laws or other governance documentation relevant to the CCM, and a diagram setting out the interrelationships between all key actors in the country as an annex to this proposal. Please indicate the applicable annex number.)

The India-CCM is broadly representative of all national stakeholders in the fight against the three diseases. The representative composition of the current India-CCM with 33 members is as follows:

- Academic & Research Sector –2
- Government – 12
  - Central – 7 (Ministry of Health & Family Welfare – 5; Finance – 1; Armed Forces – 1)
  - States – 5 (in rotation for the five regions)
- NGOs/ Community Based Organizations / Faith Based Organizations – 7
- People affected by the Diseases - 1
- Private Sector – 4
  - Domestic Business Associations/Confederations – 3
  - Private Foundation - 1
- Multilateral and Bilateral Developmental Partners - 7
  - United Nations Agencies – 4
  - Multilateral Credit Agencies - 1
  - Bilateral partners - 2

The representation of the non-governmental sector in the India CCM is currently 63.6% (21/33) including multilateral and bilateral developmental partners and 42.4% (14/33) excluding multilateral and bilateral developmental partners.

Since the criterion for membership in the CCM is institutional rather than individual, the composition of the CCM with respect to gender is a reflection of gender representation at the top echelons of the institutional members of the CCM. At present six out of the 33 members i.e., 18% of the India CCM are women.

The changes in the current membership structure and process of selection through transparent and independent processes for the non-governmental sectors that would be completed by the end of August 2006 when the two-year tenure of the current CCM comes to an end and a new CCM would be constituted has been detailed in Section 2.2.1.b. above.

3A Applicant Type

All members of the India CCM are treated as equal partners with full rights to participation, expression and involvement in decision-making in line with their areas of expertise. The roles and responsibilities of the members, the interactions between them and the processes followed for decision making are governed by the Terms of Reference and other related procedural standards of the India-CCM (***Annex CCM-5 and Annex CCM-6***). The India-CCM does not have any standing sub-committees. Adhoc subcommittees are formed as per need, function with clear mandates and terms of reference and are dissolved after the completion of the task assigned. The India-CCM does not have sub-national CCMs.

The India-CCM has been meeting regularly at least once every quarter since its formation. The list of dates of announcement of the meetings and the dates on which these meetings have been held since 2002 is enclosed as ***Annex CCM-15***. These meetings are conducted systematically with clear agendas that are circulated to members before the meeting and meticulous documentation of the proceedings which are communicated to all members soon after the conclusion of the meetings. Email is mostly used as the means of communication but all types of communication facilities and methods are utilized to share agenda notes and proceedings of the meetings with all members.

Institutional members of the CCM representing various non-governmental sectors are reportedly sharing information regarding the Global Fund initiatives and related concerns with other organizations from their sector. It has not been feasible for these members to hold exclusive meetings of their sectors pertaining to GFATM mainly due to cost constraints and also due to the wide spread of some of the sectors as detailed above. Nevertheless, at the CCM meetings it has become clear the current members have been able to strongly represent the prevalent views of their sector.

The India CCM has definitely functioned as a national consensus group to promote true partnership in the development and implementation of Global Fund supported programs. The broad representation of the India CCM has ensured that clear linkage and consistency is established between the Global Fund assistance and other development and health assistance programs in support of national priorities by multilateral, bilateral agencies as well as international private foundations. The role of the multilateral / bilateral developmental partners in the India CCM is clearly driven by country programs and priorities and reflect their roles in the three national disease control programs.

The coordination linkages between the CCM and other entities such as the periodic appraisal missions of the three disease control programs, the National AIDS Advisory Council, the Extended Theme Group on HIV/AIDS and the various knowledge networks on communicable diseases are strong but not formalized. The enhanced linkages and lateral advocacy opportunities are due to the shared memberships between the India-CCM and many of this national policy oversight and advocacy mechanisms in the country. The interrelationships between all such key actors in the country and the CCM and its structures are shown diagrammatically ***in Annex CCM-16.***

A full fledged Secretariat has been established from mid-August 2005 to service the CCM given the increased number of grants the CCM has oversight of currently and additionally to service Constituency and Board relations, a Secretariat. The WHO India office is supporting a full time Public Health Consultant, a Finance Specialist and two Administrative personnel who constitute the India CCM Secretariat and the office equipments. The Ministry of Health and Family Welfare has provided the office space and basic amenities. The running costs for CCM Meetings and the Secretariat are currently borne by the National AIDS Control Organization. The India CCM is cognizant of the key issue of long-term sustainability of the Secretariat. Efforts are currently on to seek support from the bilateral development partners and other multilateral agencies for the longer term.

➔ *After completing this section, complete section 3B.1.*

3B Proposal Endorsement

3B.1 Coordinating Mechanism membership and endorsement:

All national, sub-national and regional Coordinating Mechanisms must complete this section. Regional Organizations must complete section 3B.2.

National/Sub-national/Regional Coordinating Mechanisms

3B.1.1 Leadership of Coordinating Mechanism

Table 3B.1.1 – National/Sub-national/Regional (C)CM leadership information

	Chair	Vice Chair
Name	**Mr. Prasanna Kumar Hota**	**Mr. K.K. Abraham**
Title	Secretary (Health & Family Welfare)	President
Organization	Ministry of Health and Family Welfare, Government of India	Indian Network for People Living with HIV/AIDS
Mailing address	Ministry of Health and Family Welfare, 139-'A' Wing Nirman Bhavan, New Delhi - 110011	Indian Network for People Living with HIV/AIDS, Flat No.6, Kash Towers, 93, South West Boag Road, T. Nagar, Chennai – 600017
Telephone	91-11-23061863	91-44-24329580, 24329581, Mobile: 91-9840066386
Fax	91-11-23061252	91-11-24329582
E-mail address	secyfw@nb.nic.in, secyhlth@nb.nic.in	inpplus@vsnl.com

3B Proposal Endorsement

3B.1.2 Membership information

Please note that to be eligible for funding, national/sub-national/regional Coordinating Mechanisms must demonstrate evidence of membership of people living with and/or affected by the diseases. It is recommended that the membership of the CCM comprise a minimum of 40% representation from non-governmental sectors. For more information on this, see the Guidelines for Proposals section 3B.1, and the CCM Guidelines.
*The table below must be completed for **each** national/sub-national/regional Coordinating Mechanism **member**, and the table will therefore need to be extended to cover numerous members.*
*Under "**Type**", please specify which sector the CCM member represents: academic/educational; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; or multi-/bilateral development partners in country*

Table 3B.1.2 – National/sub-national/regional (C)CM member information

National/Sub-national/Regional (C)CM member details			
Members*			
** Membership is for agency/organization while Date of commencement of membership is for the named rep.*			
Agency/organization	Ministry of Health & Family Welfare, Government of India	Website	www.mohfw.nic.in
Type	Government – Central (Health & Family Welfare)		
Name of representative	**Mr. Prasanna Kumar Hota**	CCM member since*	October 2004
Title in agency/organization	Secretary (Health & Family Welfare)	Fax	91-11-23061252
E-mail address	secyfw@nb.nic.in, secyhlth@nb.nic.in	Telephone	91-11-23061863
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Chair of the CCM with overall policy and strategy oversight	Mailing address	Ministry of Health and Family Welfare, 139-'A' Wing Nirman Bhavan, New Delhi – 110011

Agency/organization	Indian Network for People Living with HIV/AIDS	Website	www.inpplus.net/
Type	People Living With / Affected by the Diseases		
Name of representative	**Mr. K.K. Abraham**	CCM member since*	December, 2001
Title in agency/organization	President	Fax	91-11-23061252
E-mail address	inpplus@vsnl.com	Telephone	91-11-23061863
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Vice-Chair of the CCM. Specific responsibility to ensure inputs and stakes of people living with / affected by the diseases	Mailing address	Indian Network for People Living with HIV/AIDS, Flat No.6, Kash Towers, 93, South West Boag Road, T. Nagar, Chennai – 600017

3B Proposal Endorsement

Agency/organization	National AIDS Control Organization, Ministry of Health & Family Welfare	Website	www.nacoonline.org/
Type	Government – Central (Health & Family Welfare)		
Name of representative	**Ms. K. Sujatha Rao**	CCM member since*	November, 2005
Title in agency/organization	Additional Secretary & Director General	Fax	91-11-23731746
E-mail address	asdg@nacoindia.org	Telephone	91-11-23325331
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Component Coordinator – HIV/AIDS	Mailing address	National AIDS Control Organization (NACO), Ministry of Health and Family Welfare, 9th Floor, Chandralok Building, 36, Janpath, New Delhi-110001

Agency/organization	Ministry of Health & Family Welfare, Government of India	Website	www.mohfw.nic.in
Type	Government – Central (Health & Family Welfare)		
Name of representative	**Mr. Raghuvir Singh**	CCM member since*	May, 2006
Title in agency/organization	Additional Secretary & Financial Advisor	Fax	91-11-23017541
E-mail address	asfa@nb.nic.in	Telephone	91-11-23019673
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Financial Review as Head of the Integrated Finance Division of the Ministry	Mailing address	Ministry of Health and Family Welfare, Government of India, Room No. 258-'A', Nirman Bhavan, New Delhi-110011

Agency/organization	Ministry of Health & Family Welfare, Government of India	Website	www.mohfw.nic.in
Type	Government – Central (Health & Family Welfare)		
Name of representative	**Dr. R.K. Srivastava**	CCM member since*	November,2005
Title in agency/organization	Director General of Health Services	Fax	91-11-23017924
E-mail address	dghs@nic.in	Telephone	91-11-23018438
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical Inputs and Broad Programmatic Oversight	Mailing address	Ministry of Health and Family Welfare, Government of India Room No. 444-'A', Nirman Bhavan, New Delhi-110011

3B Proposal Endorsement

Agency/organization	Ministry of Health & Family Welfare, Government of India	Website	www.mohfw.nic.in
Type	Government – Central (Health & Family Welfare)		
Name of representative	**Ms. Rita Teaotia**	CCM member since*	November, 2003
Title in agency/organization	Joint Secretary	Fax	91-11-23018842
E-mail address	jsrt@nb.nic.in	Telephone	91-11-23019195
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Component Coordinator – Tuberculosis & Malaria	Mailing address	Ministry of Health and Family Welfare, Government of India Room No. 149-'A', Nirman Bhavan, New Delhi-110011

Agency/organization	Ministry of Finance	Website	www.finmin.nic.in
Type	Government – Central (Other Ministry)		
Name of representative	**Mr. Madhusudan Prasad**	CCM member since*	August, 2004
Title in agency/organization	Joint Secretary (FB)	Fax	91-11-23093422
E-mail address	mprasad@nic.in	Telephone	91-11-23094905
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Financial Review and Oversight	Mailing address	Room No. 166-D North Block, Department of Economic Affairs, New Delhi-110001

Agency/organization	Armed Force Medical Services, Ministry of Defense	Website	www.mod.nic.in
Type	Government – Central (Other Ministry)		
Name of representative	**Surgeon Vice Admiral V.K. Singh**	CCM member since*	August 2004
Title in agency/organization	Director General	Fax	91-11-23093115
E-mail address	dgafms@yahoo.co.in	Telephone	91-11-23093331
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical Input	Mailing address	Armed Force Medical Services, Ministry of Defense, M Block, New Delhi-110001

3B Proposal Endorsement

Agency/organization	Government of NCT of Delhi	Website	www.health.delhigovt.nic.in
Type	Government - Regional		
Name of representative	**Mr. D.S. Negi**	CCM member since*	August 2004
Title in agency/organization	Principal Secretary (Health)	Fax	91-11-23392017
E-mail address	pshealth@nic.in	Telephone	91-11-23392017, 23392110
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Oversight on state level issues and implementation	Mailing address	Government of NCT of Delhi, 9th Floor-'A' Wing, Delhi Sachivalaya, I.T.O, New Delhi-110002

Agency/organization	Government of Bihar	Website	www.gov.bih.nic.in
Type	Government - Regional		
Name of representative	**Mr. Deepak Kumar**	CCM member since*	August 2004
Title in agency/organization	Secretary Health and Family Welfare	Fax	91-612-2224608
E-mail address	akcpatna@hotmail.com	Telephone	91-612-2223809
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Oversight on state level issues and implementation	Mailing address	Bureau of Public Enterprises, Main Secretariat, Government of Bihar, Patna-800015

Agency/organization	Government of Assam	Website	www.assamgovt.nic.in
Type	Government - Regional		
Name of representative	**Mr. J. C. Goswami**	CCM member since*	August 2004
Title in agency/organization	Commissioner & Secretary (Health)	Fax	91-361-2261406
E-mail address		Telephone	91-361-2261406
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Oversight on state level issues and implementation	Mailing address	Government of Assam, Health Department Assam Secretariat, DISPUR (Assam) - 781005

3B Proposal Endorsement

Agency/organization	Government of Gujarat	Website	www.gujaratindia.com
Type	Government - Regional		
Name of representative	**Mr. Amarjeet Singh**	CCM member since*	August 2004
Title in agency/organization	Commissioner & Secretary (Health)	Fax	91-79-23254653
E-mail address		Telephone	91-79-23251401
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Oversight on state level issues and implementation	Mailing address	Government of Gujarat, Health & Family Welfare Department, Block 7, 7th Floor, Gujarat Secretariat, Gandhinagar-382010

Agency/organization	Government of Andhra Pradesh	Website	www.ap.gov.in
Type	Government - Regional		
Name of representative	**Mr. I.V. Subba Rao**	CCM member since*	August 2004
Title in agency/organization	Principal Secretary Health, Medical & Family Welfare	Fax	91-40-23457817
E-mail address	prlsecy_hmfw@ap.gov.in	Telephone	91-40-23455824
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Oversight on state level issues and implementation	Mailing address	Government of Andhra Pradesh, AP Secretariat, L-Block, 3rd Floor Hyderabad - 500001

Agency/organization	WHO	Website	www.whoindia.org
Type	UN/Multilateral Development Partner		
Name of representative	**Dr. Salim J. Habayeb**	CCM member since*	December, 2001
Title in agency/organization	WHO Representative to India	Fax	91-11-23012450
E-mail address	wriindia@whoindia.org	Telephone	91-11-23018955, 23017993, 23792179
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical and Financial Inputs	Mailing address	WHO, Room No.-535 'A', Nirman Bhavan, New Delhi-110011

3B Proposal Endorsement

Agency/organization	UNAIDS	Website	www.unaids.org
Type	UN/Multilateral Development Partner		
Name of representative	**Dr. Denis Broun**	CCM member since*	December, 2001
Title in agency/organization	Country Coordinator	Fax	91-11-41354534
E-mail address	bround@unaids.org	Telephone	91-11-41354545
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical and Financial Inputs	Mailing address	UNAIDS, A2/35, Safdarjung Enclave, New Delhi-110029

Agency/organization	UNFPA	Website	www.unfpa.org
Type	UN/Multilateral Development Partner		
Name of representative	**Ms. Sharareh Amirkhalili**	CCM member since*	December 2001
Title in agency/organization	Country Representative (a.i.)	Fax	91-11-24628078, 24627612
E-mail address	amirkhalili@unfpa.org	Telephone	91-11-24628877
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical and Financial Inputs	Mailing address	UNFPA, 55, Lodhi Estate, New Delhi-110003

Agency/organization	UNICEF	Website	www.unicef.org
Type	UN/Multilateral Development Partner		
Name of representative	**Mr. Cecilio Adorna**	CCM member since*	December 2001
Title in agency/organization	Country Representative	Fax	91-11-24622847, 24691410
E-mail address	cadorna@unicef.org	Telephone	91-11-24622847, 24690401
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical and Financial Inputs	Mailing address	UNICEF, 71, Lodhi Estate, New Delhi-110003

3B Proposal Endorsement

Agency/organization	World Bank	Website	www.worldbank.org
Type	Multilateral Development Partner		
Name of representative	**Dr. Suneeta Singh**	CCM member since*	December 2001
Title in agency/organization	Sr. Public Health Specialist	Fax	91-11-24619393
E-mail address	ssingh6@worldbank.org	Telephone	91-11-24617241, 24619491
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Financial Input	Mailing address	World Bank, 70, Lodhi Estate, New Delhi-110003

Agency/organization	DFID-India	Website	www.dfidindia.org
Type	Bilateral Development Partner		
Name of representative	**Ms. Joanna Reid**	CCM member since*	December 2001
Title in agency/organization	Senior Health Adviser	Fax	91-11-26529296
E-mail address	JM-Reid@dfid.gov.uk	Telephone	91-11-26529123
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Financial Input	Mailing address	DFID-India, B-28, Tara Crescent, Qutab Institutional Area, New Delhi-110016

Agency/organization	USAID	Website	www.usaid.gov
Type	Bilateral Development Partner		
Name of representative	**Mr. George Deikun/** **Mr. Robert M Clay**	CCM member since*	December 2001
Title in agency/organization	Mission Director / Director – Office of Population, Health & Nutrition	Fax	91-11-24190017
E-mail address	gdeikun@usaid.gov rclay@usaid.gov	Telephone	91-11-24198000
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Financial Input	Mailing address	USAID, USA Embassy, New Delhi-110021

3B Proposal Endorsement

Agency/organization	Bill & Melinda Gates Foundation	Website	www.gatesfoundation.org
Type	International Private Foundation		
Name of representative	**Mr. Ashok Alexander**	CCM member since*	August 2004
Title in agency/organization	Director-India	Fax	91-11-51003101
E-mail address	ashok.alexander@india.gatesfoundation.org	Telephone	91-11-51003100
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Financial input	Mailing address	Bill & Melinda Gates Foundation, Sanskriti Bhavan, A-10, Qutab Institutional Area, Aruna Asaf Ali Road, New Delhi – 110067

Agency/organization	ASSOCHAM	Website	www.assocham.com
Type	Private Sector - Business		
Name of representative	**Mr. Anil K. Agarwal**	CCM member since*	February 2004
Title in agency/organization	President	Fax	91-11-24604932
E-mail address	ceo@cosmointl.com	Telephone	91-11-24611892
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Private Sector involvement and advocacy	Mailing address	ASSOCHAM, 147-B, Gautam Nagar, Gulmohar Enclave, Behind Indian Oil Bhavan, New Delhi-110049

Agency/organization	FICCI	Website	www.ficci.com
Type	Private Sector - Business		
Name of representative	**Mr. Saroj K. Poddar**	CCM member since*	February 2004
Title in agency/organization	President	Fax	91-11-23314373, 23329369
E-mail address	ficcisg@ficci.com	Telephone	91-11-23738760, 23736192, 23315442, 23320717
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Private Sector involvement and advocacy	Mailing address	FICCI, Federation House, Tansen Marg, New Delhi-110001

3B Proposal Endorsement

Agency/organization	Confederation of Indian Industry (CII)	Website	www.ciionline.org
Type	Private Sector - Business		
Name of representative	**Mr. R. Seshasayee**	CCM member since*	February 2004
Title in agency/organization	President	Fax	91-11-24633168
E-mail address	r.seshasayee@ciionline.org	Telephone	91-11-24621874
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Private Sector involvement, advocacy and financial input	Mailing address	Confederation of Indian Industry (CII), 23, Institutional Area, Lodhi Road, New Delhi-110003

Agency/organization	TB Association of India	Website	
Type	NGO/CBO		
Name of representative	**Dr. M. M. Singh** / **Mr. S.C. Goyal**	CCM member since*	August 2004
Title in agency/organization	Vice-Chairperson / Secretary General	Fax	91-11-23711303
E-mail address	tbassnindia@vsnl.net	Telephone	91-11-23715217
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representation of CSOs working for TB affected people	Mailing address	TB Association of India, No. 3, Red Cross Road, New Delhi – 110001

Agency/organization	SAHARA	Website	www.saharahouse.org
Type	NGO/CBO		
Name of representative	**Mr. Neville Selhore**	CCM member since*	February 2004
Title in agency/organization	Director	Fax	91-11-29219147
E-mail address	sahara@nde.vsnl.net.in	Telephone	91-11-29222418
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representing Civil Society Interests	Mailing address	SAHARA – Center for Residential Care and Rehabilitation, E – 453, Greater Kailash II, New Delhi - 110048

3B Proposal Endorsement

Agency/organization	Durbar Mahila Samanwaya Samiti	Website	www.durbar.org
Type	NGO/CBO		
Name of representative	**Ms. Mrinal Kranti Dutta/ Dr. Debjani Banerjee**	CCM member since*	August 2004
Title in agency/organization	Senior Technical Advisor/ Incharge – Care, Support	Fax	91-33-25437560
E-mail address	sonagachi@sify.com	Telephone	91-33-25437450
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representing Civil Society Interests	Mailing address	Durbar Mahila Samanwaya Samiti, 12/5, Nilmoni Mitra Street, Kolkata-700097

Agency/organization	Society for HIV/AIDS and Lifeline Operation in Manipur (SHALOM)	Website	
Type	NGO/CBO		
Name of representative	**Dr. Vanlalmuana**	CCM member since*	August 2004
Title in agency/organization	Director	Fax	91-3874-234100
E-mail address	vlmuana@rediffmail.com	Telephone	91-3874-233541, 233434
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representing Civil Society Interests	Mailing address	Society for HIV/AIDS and Lifeline Operation in Manipur (SHALOM), Churachandpur Nehru Marg, Rengkai Road, CEPUR (Manipur)-795128

Agency/organization	Bel Air Hospital	Website	www.belairpanchagani.org
Type	NGO/CBO		
Name of representative	**Fr. Tommy Kariyilakulam**	CCM member since*	August 2004
Title in agency/organization	Administrator	Fax	91-2168-240955
E-mail address	belair@vsnl.com	Telephone	91-3874-233541, 233434
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representing Civil Society Interests	Mailing address	Bel Air Hospital, Dalkeith, Panchagani – 412805, Satara District, Maharashtra

3B Proposal Endorsement

Agency/organization	AIDS Prevention and Control (APAC)	Website	www.apacvhs.org
Type	NGO/CBO		
Name of representative	**Dr. P. Krishnamurthy**	CCM member since*	February 2004
Title in agency/organization	Director	Fax	91-44-22541965/048/060
E-mail address	apacvhs@eth.net	Telephone	91-44-22542018
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representing Civil Society Interests	Mailing address	AIDS Prevention and Control (APAC), Adayar, T.T.T.I. Post, Chennai-600113

Agency/organization	Health India Foundation	Website	
Type	NGO/CBO		
Name of representative	**Dr. C.N.Deivanayagam**	CCM member since*	August 2004
Title in agency/organization	President	Fax	91-44-24346233
E-mail address	cdeivanayagam@hotmail.com	Telephone	91-44-24346233
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representing Civil Society Interests	Mailing address	101, Old No. 81, Usman Road, T. Nagar, Chennai-600017

Agency/organization	ICMR	Website	www.icmr.nic.in
Type	Academic/Educational/Research Institution		
Name of representative	**Dr. N.K. Ganguly**	CCM member since*	December 2001
Title in agency/organization	Director General	Fax	91-11-26588204, 26589336
E-mail address	gangulynk@icmr.org.in	Telephone	91-11-26588662
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	ICMR, Ansari Nagar, New Delhi-110029

3B Proposal Endorsement

Agency/organization	All India Institute of Medical Sciences	Website	www.aiims.ac.in
Type	Academic/Educational/Research Institution		
Name of representative	**Dr. P. Venugopal**	CCM member since*	August 2004
Title in agency/organization	Director	Fax	91-11-26588641, 26588663
E-mail address	director@aiims.ac.in	Telephone	91-11-26594800
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Technical input	Mailing address	All India Institute of Medical Sciences, Ansari Nagar, New Delhi-110029

4 Component Section *Tuberculosis*

1.1 General information on proposal

Applicant Name	India CCM
Country/countries	India

Applicant Type

Please tick one of the boxes below, to indicate the type of applicant. For more information, please refer to the Guidelines for Proposals, section 1.1 and 3A.

- ☒ National Country Coordinating Mechanism
- ☐ Sub-national Country Coordinating Mechanism
- ☐ Regional Coordinating Mechanism (including small island developing states)
- ☐ Regional Organization
- ☐ Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

Please tick the appropriate box or boxes below, to indicate components included within your proposal. Also specify the title for each proposal component chosen. For more information, please refer to the Guidelines for Proposals, section 1.1.

	Component	Title
☐	HIV/AIDS[1]	
☒	Tuberculosis[1]	**Consolidating and scaling up of RNTCP interventions in order to move towards TB related MDGs**
☐	Malaria	

Currency in which the Proposal is submitted

Please tick the appropriate box. Please note that all financial amounts appearing in the proposal should be denominated in the selected currency only.

- ☒ US$
- ☐ Euro

[1] In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

4 Component Section *Tuberculosis*

1.2 Proposal funding summary per component

Funds requested for each component (i.e. HIV/AIDS, tuberculosis and/or malaria) in table 1.2 below must be the same as the totals of the corresponding component budget in table 5.1.

Table 1.2 – Total funding summary

Component	Total funds requested (Euro / US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	0	0	0	0	0	0
Tuberculosis	0	0	0	0	0	0
Malaria	0	0	0	0	0	0
Total	0	0	0	0	0	0

1.3 Previous Global Fund grants

Table 1.3 – Previous Global Fund grants

Component	Previous grants	
	Rounds	Current Amount* (Euro / US$)
HIV/AIDS		
Tuberculosis	Round 1; Round 2; Round 4	USD 64.51 million
Malaria		
HSS/Other		

* *Aggregate all past grants, including approved but as yet unsigned amounts. These amounts should include Phase 2 where this has been approved/signed. For more detailed information, see the Guidelines for Proposals, section 1.3.*

4 Component Section *Tuberculosis*

PLEASE NOTE THAT THIS SECTION AND THE NEXT MUST BE COMPLETED FOR EACH COMPONENT. *Thus, for example, if the proposal targets three components, sections 4 and 5 must be completed three times.*

For more information on the requirements of this section, please refer to the Guidelines for Proposals, section 4.

4.1 Indicate the estimated start time and duration of the component

Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the Proposal Form). The aim is to sign all grants and commence disbursement of funds within six months of Board approval. Approved proposals must be signed and have a start date within 12 months of Board approval.

Table 4.1.1 – Proposal start time and duration

	From (yyyy/mm)	**To** (yyyy/mm)
Month and year:	2007 April	2012 March

4.2 Contact persons for questions regarding this component

Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes, for a time period of approximately six months after the submission of the proposal.

Table 4.2 – Component contact persons

	Primary contact	**Secondary contact**
Name	Dr L S Chauhan	Dr P P Mandal
Title	Deputy Director General (TB)	Chief Medical Officer (TB)
Organization	Directorate General of Health Services	Directorate General of Health Services
Mailing address	Room No 522 'C' Wing, Nirman Bhawan, New Delhi 110011	Room No 529 'C' Wing, Nirman Bhawan, New Delhi 110011
Telephone	+91 11 23063226, 23062980	+91 11 23061107
Fax	+91 11 23063226	+91 11 23063226
E-mail address	ddgtb@tbcindia.org	mandalpp@tbcindia.org

4.3 Component executive summary

4.3.1 Executive summary

Describe the overall strategy of the proposal component, by referring to the goals, objectives and main activities, including expected results and associated timeframes. Specify the beneficiaries and expected benefits (including target populations and their estimated number). *(Please include quantitative information where possible. Maximum of one page.)*

India's population of over 1.1 billion has constitutional provision for universal access to basic health care delivered through public health system as well as private sector (not for profit and for profit). Large burden of infectious diseases including TB accounting for 1/5th of global burden, estimated 5.2 million people infected with HIV and 1.8 million malaria cases annually and other emerging diseases, places a significant burden on the health system.

Every year there are about 1.8 million new TB cases in the country, of which nearly 800,000 are infectious

smear positive pulmonary cases. Every day more than 1,000 people die of TB. The direct and indirect cost of TB to India amounts to an estimated $3 billion annually. Estimates suggest that ~ 40% of the adult population of India is infected and the national Annual Risk of Tuberculous Infection (2000-03) is 1.5%. The TB problem is further compounded by an estimated 5.20 million people in India infected with HIV as TB is the most common opportunistic infection in PLWHA. The prevalence of Multi-Drug Resistant - TB (MDR-TB) is relatively low (3% in new cases and 12% in retreatment cases).

The Revised National TB Control Programme (RNTCP) is the successful application of DOTS strategy to India. The RNTCP is being implemented with allocations from national health budget including credit from World Bank and grants from GFATM, DFID and USAID. The GFATM supports the national Programme through Rd 1, 2 and 4 projects amounting to about US$ 64.51 million covering a population of about 285 million. RNTCP has been consistently achieving treatment success rate of over 85% and the case detection rates are close to 70%. Enhancing access and maintaining quality of RNTCP services is a priority of the national programme. Sustained efforts over next decade and resultant achievements will markedly decrease the number of new TB cases in the country. The estimated cost for implementation of DOTS in the country is about USD 342 million for fiscal years 2007-12. The committed funds presently available for the period from various sources amount to USD 308 million.

RNTCP is being implemented in the three newly created states (Chhattisgarh, Jharkhand and Uttaranchal) with support from Global Fund since 2003. The programme is implemented by the respective states through their public health system with technical support from Central level. In the initial phase of implementation of DOTS in these states, health care facilities have been upgraded, state and district manpower have been trained and their management skills improved. It is envisaged that by continuing to implement the DOTS programme in the 3 states with greater involvement of other sectors, strengthening of ACSM, enhanced supervision and monitoring, the global targets of 85% success rate and 70% case detection rate of new sputum positives will be achieved and maintained and thus would help achieve the TB related Millennium Development Goals.

This proposal is set within the context of India's successful RNTCP, and seeks continue implementation of RNTCP in these three states with a total population of 62.3 million. Over 40% of the population in these states resides in socio-economically backward, hard to reach and tribal areas. The other sub project seeks to recruit the professional support of Indian Medical Association in an additional 6 states to synergize efforts towards important public health goal of TB control. The budgeted amount for the proposal is USD 24.27 million over five years and includes RNTCP project and the IMA sub-project.

The goal of this project is ***'To decrease mortality & morbidity due to TB and to expand the reach of RNTCP through enhanced coordination with private health providers'***. The Objectives of the project are as follows:

- To consolidate services with maintenance and improvement in quality of RNTCP;
- To expand and increase the reach of RNTCP;
- To introduce DOTS Plus in a phased manner;
- To train and involve private practitioners in RNTCP-DOTS, in order to improve the availability and quality of TB control services through a sustainable Public Private Mix (PPM) approach; and
- To contribute towards national efforts in measuring impact of RNTCP in relation to the TB related MGD targets.

The Project over a period of five years envisages detecting and registering a total of over 440,000 TB patients on treatment under DOTS and successfully treating over 85% of these TB patients. This would save an additional 80,000 lives and prevent about 900,000 new infections. As part of the project 600 MDR-TB patients would be enrolled under DOTS-Plus. The project would establish and strengthen TB HIV collaborative activities between the RNTCP and National AIDS Control Programme (NACP) through a functional cross referral mechanism. This collaboration would improve access of TB HIV co infected patients to DOTS, ART and CPT. Based on the current prevalence (<1% in ANC clinics) it is expected that 4500 clients will be referred from VCTC to RNTCP facilities for TB diagnosis and equal number of TB patients referred from RNTCP facilities for VCT services.

The private health sector in India is one of the largest in the world. Private practitioners are the first point of contact for nearly 60% of TB patients. Proactive involvement of this sector would reduce diagnostic

delay with a concurrent reduction in transmission of TB infection. The IMA sub-project will train and involve private practitioners in 167 districts of 6 states in India in RNTCP-DOTS through the network of 532 sub-district level branches. This would result in widening the health-provider base and improve the availability of quality TB services. The IMA sub-project would sensitize over 40,000 private practitioners (PPs) by organizing Continuing Medical Education and thereafter formally train over 7000 in TB management guidelines established by RNTCP and International Standard of Care. IMA would facilitate PPs to get involved under the various formal Private Practitioners (PP) Schemes established under the Programme.

TB prevalence surveys will be undertaken in 4 sentinel sites and TB mortality survey in one state, to assess the impact of RNTCP on TB burden in the country and the progress of India towards achieving the MDG goals relating to TB by 2015.

4.3.2 Synergies

If the proposal covers more than one component, describe any synergies expected from the combination of different components—for example, TB/HIV collaborative activities. *(By synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact.)*

The proposal covers all the three disease components. The activities under respective programmes proposals are independent of each other and there is no duplication of efforts nor are thioer any expenditure overlaps. The services under the TB programme are delivered through the existing public health system at all levels including Sub-centres, Primary Health Centres, Community Health Centres, district hospitals etc. These facilities provide preventive and curative services for all locally endemic diseases including malaria, as well as family welfare services.

Strengthening of health facilities and building capacity of the public health care system through disease specific interventions/projects with grants from GFATM would have a wider consequential long term and systemic beneficial effect on the health system in general and on each of the specific disease intervention in particular.

These primary health care facilities are also the entry point for HIV prevention, care and support services. TB/HIV collaboration is achieved through convergence of TB and HIV services at the facility level. The joint action plan of the National TB control programme and the National AIDS Control Programme for strengthening cross referrals between the two Programmes envisages identifying and adequately treating HIV positive TB cases under DOTS, ART and CPT therapy within respective programmes.

4.4 National program context for this component

The information below helps reviewers understand the disease context, and which problems the proposal will address. Therefore, historical, current and projected data on the epidemiological situation, disease-control strategies and broader development frameworks need to be clearly documented. Please refer to the Guidelines for Proposals, section 4.4.

4.4.1 Indicate whether you have any of the following documents (tick appropriate box), and if so, please attach them as an annex to the Proposal Form:

- ☒ National Disease Specific Strategic Plan
- ☒ National Disease Specific Budget or Costing
- ☒ National Monitoring and Evaluation Plan (health sector, disease specific or other)
- ☒ Other document relevant to the national disease program context (e.g. the latest disease surveillance report)
  Please specify:

4 Component Section *Tuberculosis*

- RNTCP Technical and Operational Guidelines
- RNTCP guidelines for involvement of NGOs
- RNTCP guidelines for involvement of Private Practitioners
- TB India 2006-RNTCP Status Report
- Tribal Action Plan
- Health Communication Strategy for RNTCP

4.4.2 Epidemiological and disease-specific background

Describe, and provide the latest data on, the stage and type of epidemic and its dynamics (including breakdown by age, gender, population group and geographical location, wherever possible), the most affected population groups, and data on drug resistance, where relevant. With respect to malaria components, also include a map detailing the geographical distribution of the malaria problem and corresponding control measures already approved and in use. Information on drug resistance is of specific relevance if the proposal includes anti-malarial drugs or insecticides. In the case of TB components, indicate, in addition, the treatment regimes in use or to be used and the reasons for their use.

India accounts for nearly 1/5 of the global burden of tuberculosis (TB).[1] Every year there are about 1.8 million new TB cases in the country, of which nearly 800,000 are infectious smear positive pulmonary cases. The burden of TB in India is indeed staggering by any measure.

Every day more than 20,000 people get infected with the tuberculosis bacillus, more than 5,000 people develop TB disease, and more than 1,000 people die of TB. In 2005, about 1.3 million TB cases were reported by the Revised National Tuberculosis Control Programme (RNTCP).[2] The direct and indirect cost of TB to India amounts to an estimated $3 billion annually.[3] Studies suggest that on an average 3 to 4 months of work time is lost as result of TB, resulting in an average lost potential earning of 20-30% of the annual household income. This leads to increased debt burden, particularly for the poor and marginalized sections of the population.

The TB problem is further compounded by an estimated 5.2 million people in India infected with the human immunodeficiency virus (HIV), TB being the commonest opportunistic infection among HIV-infected individuals.[4]

It is estimated that that up to 40% of the adult population of India is already infected with TB. A nation wide Annual Risk of Tuberculosis Infection (ARTI) survey conducted through 2000-2003, has found that the national ARTI is 1.5 i.e. 75 new smear positive pulmonary TB cases are expected annually per 100,000 population.[5] The rate at which the RNTCP expands over the next few years and is able to maintain the existing quality TB services provided over the next few years, will markedly change the number of new TB cases at any level of HIV prevalence.[6]

TB remains a serious public health problem in India, primarily affecting people in their most productive years of life and more common among the poorest and marginalized sections of the community. Almost 70% of TB patients are aged between the ages of 15 and 44 years of age. While two thirds of the cases are male, TB takes a disproportionately larger toll among young females, with more than 50% of female cases occurring before 34 years of age.[3] This all comes with in addition a devastating social cost – more than 300,000 children are forced to leave school because their parents have TB, and more than 100,000 women with TB are rejected by their families.[4]

The National TB Control Programme was started in the country in 1962. However, a review conducted in 1992 found that the programme had not made any impact on the disease epidemiology. The combined review of the Programme concluded that there were managerial weaknesses, inadequate funding, over reliance on x ray and lack of systematic recording of treatment outcomes. Based on these findings and evidence on the role of 'direct observation' on treatment outcome and efficacy of intermittent regimens,

the Revised National Tuberculosis Control Programme (RNTCP) was developed and initiated in 1997 with support from World Bank and other development partners. Nation wide coverage achieved in March 2006 with nearly 1.3 million patients placed on treatment under RNTCP in 2005. The Phase II of RNTCP was launched from October 2005 with additional new initiatives and emphasis on consolidating and further improving the quality of DOTS services. The RNTCP Phase II is in line with the Stop TB Partnership strategy for TB control and covers all the activities proposed under the strategy including pursuing high-quality DOTS expansion and enhancement; addressing TB/HIV, MDR-TB and other challenges; engaging all care providers; empowering people with TB and communities; enabling and promoting research and contribute to health systems strengthening.

Under the RNTCP, primary healthy care facilities have been strengthened to provide standardized TB care through the public health care system established by the states. The treatment regimen used under the RNTCP is based on the WHO recommended DOTS regimens adapted to the country context and needs, and is detailed in tabular form below:

Category of Treatment	Type of Patient	Regimen
Category I	New sputum smear-positive Seriously ill new sputum smear-negative Seriously ill new extra-pulmonary HIV+ TB patients	$2H_3R_3Z_3E / 4H_3R_3$
Category II	Sputum smear-positive Relapse Sputum smear-positive Failure Sputum smear-positive Treatment After Default, Others	$2H_3R_3Z_3E_3S_3$ / $1H_3R_3Z_3E_3$ / $5H_3R_3E_3$
Category III	New Sputum smear-negative, New Extra-pulmonary, not seriously ill	$2H_3R_3Z_3 / 4_3H_3R_3$

In the column on Regimens: the number before the letters refers to the number of months of treatment. The subscript after the letters refers to the number of doses per week. H: Isoniazid (600 mg), R: Rifampicin (450 mg), Z: Pyrazinamide (1500 mg), E: Ethambutol (1200 mg), S: Streptomycin (750 mg). Patients who weigh 60 kg or more receive additional rifampicin 150 mg. Patients more than 50 years old receive streptomycin 500 mg. Patients who weigh less than 30 kg, receive drugs as per body weight. Patients in categories I and II who have positive sputum smear at the end of the initial intensive phase receive an additional month of intensive phase treatment. From mid 2006, there would be paediatric patient wise boxes in two weight bands and would be used along with additional loose drugs.

Another challenge to TB control in India is multi-drug resistant TB (MDR-TB). The data available to date shows that levels of MDR-TB remain relatively low, at around 3%, amongst new patients and 12% in re-treatment cases. However these relatively low percentage figures translate into a large absolute number of MDR-TB cases, who can transmit their drug resistant disease to others and require effective treatment. The large pool of private practitioners who have been documented to use non-standardized, unobserved and in many cases irrational TB treatment regimens contribute significantly to the problem of acquired MDR-TB in the community.

In RNTCP II, it is envisaged to first establish an network of RNTCP accredited quality assured Intermediate Reference Laboratories (IRL), providing culture and drug sensitivity testing services for RNTCP and to have a network of DOTS Plus sites, as per international guidelines, capable of enrolling and providing care and management for up to 5000 “new” multi-drug resistant tuberculosis cases each year in the country. The guidelines for treatment of MDR-TB patients have been developed in consultation and consensus with national and international experts, including experts from Green Light Committee. There is consensus that based on the epidemiology and technical feasibility, India should use a Standard Treatment Regimen using Kanamycin, Pyrazinamide, Ofloxacin, Ethionamide, Ethambutol and PAS. Two IRLs have been have been made functional and IRLs in the three states under the proposal are in advanced

stages of preparedness, with civil works completed and staff in place. In this proposal, the IRLs would be made fully functional carrying out Mycobacterial culture and drug sensitivity testing. DOTS-Plus for the treatment of MDR-TB patients would be undertaken from identified sites in the 3 states.

[1] WHO. WHO Report 2006. Global Tuberculosis Control. Surveillance, Planning, Financing. WHO/HTM/TB/2005.
[2] Central TB Division (CTD), Directorate General of Health (DGHS), Ministry of Health & Family Welfare, Government of India (GoI). TB India 2006. RNTCP annual status report. New Delhi: CTD, 2006.
[4] TB Research Centre, Chennai. Socio-economic impact of TB on patients and family in India. *Int J Tub Lung Dis* 1999; **3**: 869-877
[5] Dte GHS, GoI. Annual risk of tuberculous infection in different zones of India. A national sample survey, 2000-2003. Bangalore: National TB Institute, 2004.
[6] Regional Office for South-East Asia, WHO. Joint Tuberculosis Programme Review, India, February 2000. SEA-TB 24. New Delhi: SEARO WHO, 2000, p12.

4.4.3 Disease-control initiatives and broader development frameworks

Proposals to the Global Fund should be developed based on a comprehensive review of disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases. Please refer to the Guidelines for Proposals, section 4.4.3.

a) Describe comprehensively the current disease-control strategies and programs aimed at the target disease, including all relevant goals and objectives with regard to addressing the disease. (Include all donor-financed programs currently implemented or planned by all stakeholders and existing and planned commitments to major international initiatives and partnerships.)

The erstwhile National TB Control Programme was initiated in India as early as 1962. Based on research by the Tuberculosis Research Centre, Chennai and the National TB Institute, Bangalore, the national Programme was designed using domiciliary treatment with self administered standard drug regimens. A large network of District TB Centres were created with trained staff and infrastructure. However, in 1992 a combined review of the Programme concluded that there were managerial weaknesses, inadequate funding, over reliance on x ray and lack of systematic recording of treatment outcomes. Based on these findings and evidence on role on 'direct observation' on treatment outcome and efficacy of intermittent regimens the Revised National Tuberculosis Control Programme (RNTCP) was developed in India. RNTCP was built upon the infrastructure already established by the NTP, whilst incorporating the elements of the WHO recommended Directly Observed Treatment, Short course (DOTS) strategy.

1993, the DOTS strategy was piloted at five sites in India to document its feasibility and effectiveness in the country context. Encouraged with the success of the pilot project, the Revised National TB Control was launched in 1997 and was expanded in the country in a phased manner (to ensure that quality of services is maintained) with allocations from the national health budget including credit from World Bank and also supported by the GFATM, DFID and USAID. On March 24, 2006, all districts in the country are implementing RNTCP, allowing access of DOTS to all TB patients in the country.

Goal:

The goal of TB control Programme is to decrease mortality and morbidity due to TB and cut transmission of infection until TB ceases to be a major public health problem in India.

The goal would be achieved by the implementation of the new Stop TB Strategy of TB Control which has the following components:

- Pursue high quality DOTS expansion and enhancement
- Address TB HIV, MDR-TB and other challenges

- Contribute to health system strengthening
- Engage all care providers
- Empower people with TB and communities
- Enable and promote research

Objectives:

a. To achieve and maintain a case detection of at least 70% of new sputum positive TB patients.
b. To achieve and maintain a cure rate of at least 85% in such patients

Phase II of RNTCP (2006-2010) is expected to maintain at least 70% case detection rate of new smear positives and maintain a cure rate of at least 85%.

It aims to further increase the access of services to marginalized groups in hard-to-reach areas through continuation of all proposed activities and with intensive monitoring, supervision and evaluation. To provide standardized, good-quality service in a patient-friendly environment to all patients, the programme will strengthen inter-sectoral collaboration, involve medical colleges and conduct need-based, focused and people-centric Information, Education and Communication (IEC) activities.

Decentralised service delivery and strengthening of the existing infrastructure and staffing levels: The diagnostic and treatment services have been decentralized, with treatment given under the support of DOT (directly observed treatment) providers. The decentralization process of programme implimentation has been achieved through the formation of state and district TB societies, which are being integrated into the state/ district health societies. The states have the responsibility for planning, logistics management, printing and budgeting of the programme within the framework of the National policy. The important change of the routing of funds to the districts through the state has been implemented throughout the country. The programme has given flexibility to the districts in the areas of budgeting, planning, procurement (except drugs) and logistics management. Furthermore, management flexibility has been given to the states by providing them, for example the autonomy of taking the decision to increase the number of designated microscopy centres and TUs up to a maximum of 10% of the existing total, of recruiting contractual Laboratory Technicians up to 20% and Medical Officers at the District TB Centre up to 15%, wherever it is felt programmatically essential.

Establishment of a District TB Centre (DTC) where non-existent, State Drugs Stores, up-gradation and / or renovation of the laboratory and drug stores in the districts, supply of binocular microscopes to each RNTCP Designated Microscopy Centre and office equipment for the DTC, has strengthened the infrastructure to implement the programme. A special sub-district unit for supervision, the TB Unit (TU), manned by a designated Medical Officer TB Control (MO-TC) full-time RNTCP Senior TB Treatment Supervisor (STS) and a full-time RNTCP Senior TB Laboratory Supervisor (STLS), was established for a population of 500,000 (250,000 in tribal and hilly areas). Sub-district level supervision by the STS and STLS has been a key factor in the success of the RNTCP. The quality of diagnosis of TB patients under RNTCP has improved by giving the highest priority to the provision of quality assured sputum smear microscopy services through a network of RNTCP Designated Microscopy centres (DMCs) established for every 100,000 population (50,000 in tribal and hilly areas) and monitored under an routine External Quality Assessment (EQA) process.

Ensuring full-time State and District TB officer are in post, monitoring the vacancy position of key contractual support staff at the State and Districts, and ensuring mobility of staff by provision of vehicles and POL (Petrol-Oil-Lubricants) to enable staff to carry out their assigned roles has further helped in achieving the desired results.

One of the unique innovations under RNTCP has been the development of Patient-Wise Boxes, which contain the full course of treatment for one individual patient, ensuring that treatment of that patient cannot be interrupted due to a lack of drugs. RNTCP has effectively decentralized supervision via the sub-district TB Units, with in-built systems for monitoring and evaluation. RNTCP promotes advocacy, political and administrative commitment, as well as community participation at the grass root level, to

ensure adequate funds, staff, and other key inputs. RNTCP invites the participation in the programme of all other stake holders – NGOs, Private practitioners, Medical Colleges, Other ministries, health institutes and the corporate sector. Moreover RNTCP firmly believes in devising future strategies and actions based on the results of systematic monitoring, evaluation and operational research.

Starting in October 1993, the RNTCP was implemented in a population of 2.35 million in 5 pilot sites to document effectiveness and feasibility of scaling up of RNTCP. Following on from the success of these pilot sites, the programme was expanded to a population of 20 million by 1996. Large-scale implementation of the RNTCP began in 1998, following the successful negotiation of a World Bank credit of US$ 142 million. In addition, the RNTCP has been supported by the GFATM, Danish International Developmental Agency (DANIDA), Department for international Development (DFID), the Global TB Drug Facility (GDF) and United States Agency for International Development (USAID) in different time frames. The World Health Organization (WHO) provides technical support to the RNTCP, via a country-wide network of medical consultants based from the central to district level. In March 2006 the entire population of 1114 million in the country has been covered under the DOTS strategy.

The joint Government of India (GOI)-WHO RNTCP review conducted in September 2003 observed that RNTCP had achieved extraordinarily rapid expansion (more than 5-fold increase from 135 million in February 2000 to 740 million at the time of the second review), had placed large numbers of patients on treatment (>2 million), and had maintained high levels of treatment success (>84%). The review acknowledged that the RNTCP had expanded faster than any other effective TB control programme in the history of DOTS, and its visibility had increased both nationally and internationally. The RNTCP was found to be highly economical, costing on an average less than Rs 2 (US 5 cents) per capita per year. Good infrastructure and management systems for TB control had been established and more than 500,000 staff had been trained. The review also found that there was an increased consensus in the country about the effectiveness of the DOTS strategy, in comparison to that in the early years of implementation. Significant initiatives at central, state and local levels had resulted in greater involvement of non-governmental organizations (NGOs), private practitioners, and medical colleges. Co-ordination of activities between the RNTCP and the National AIDS Control Programme (NACP) was under way in the six high HIV-burden states. The next Joint Mission is scheduled to commence in Oct 2006 and recommendations coming out of the Mission would be implemented in the National Programme including in this Project.

The rapid expansion of RNTCP in India, whilst maintaining quality services and results, has demonstrated that it is operationally feasible to run a technically sound TB control programme based on the DOTS strategy in a populous country, with wide regional and cultural diversities, such as India. However to make an epidemiological impact of the burden of TB in India, the good results obtained to date needs to be both maintained and improved on over the coming decade or more.

The National TB Programme of India has applied successfully to three previous rounds for GFATM funding. In Round 1, TB control activities have been undertaken in the three states of Chhattisgarh, Jharkhand and Uttaranchal, with a combined population of 56 million, and a NGO (REACH) in Chennai, South India (total budget of US$ 8.6 million). All these 3 states have difficult terrain, large concentrations of tribal or indigenous peoples, and poor infrastructural development. With Round 2 funds (US$ 29 million), RNTCP is being implemented in a population of 120 million in districts of Bihar and Uttar Pradesh, two of the most populous and economically backward states of India. This project also includes public-private mix TB (PPM) sub-component in four urban sites. In Round 4, the proposal submitted by the TB programme was approved (US$ 26 million), and the initial disbursement has been made by GFATM. Under the Round 4 proposal, RNTCP activities are being consolidated and maintained in the states of Andhra Pradesh and Orissa with a combined population of almost 120 million. In addition, state representative Annual Risk of TB infection (ARTI) and Drug Resistance Surveillance (DRS) surveys, and mortality due to TB surveys are being conducted to provide baseline state specific data in these 2 states. The total funding approved in the three round is about US$64.512 million over different time frames. The Phase II of Round 1 has been approved by GFATM, based on the good performance of the TB control Programme in the three states of Chhattisgarh, Jharkhand and Uttaranchal. Also the Phase II of the Rd 2 project has been approved by GFATM.

4 Component Section *Tuberculosis*

Over the years, the programme has consistently achieved the global target of over 85% treatment success and has shown significant gains in new smear positive case detection. In 2005, about 1.3 million TB cases were registered under DOTS in the country and the national annual smear positive case detection was 66% and a national treatment success rate of 86% had been achieved. Presently, DOTS is being implemented through 632 reporting units and the entire population of the country 1114 million have access to DOTS services under RNTCP.

b) Describe the role of HIV/AIDS-, tuberculosis- and/or malaria-control efforts in broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative, the Millennium Development Goals or Sector-Wide Approaches. Outline any links to international initiatives such as the WHO/UNAIDS 'Universal Access Initiative' or the Global Plan to Stop TB or the Roll Back Malaria Initiative.

There is no PRSP or HIPC in India. Poverty reduction is India's most compelling challenge; indeed it is a challenge of global significance. According to World Bank figures (World Development Indicators 2000), India has some 433 million people living on less than US$1 a day, 36% of the total number for poor in the world. According to a 2003 report on Selected World Development Indicators, India is spending under the public sector, 0.9% of its GDP on health care. An additional 4% is spent in the private sector. The average annual health expenditure per capita is US$19. India has developed elaborate consultative and consensus-building processes for the formulation of economic and social policies. The Planning Commission and the Five Year Plans it produces have a special role in this process and in articulating the country's poverty reduction strategy.

It is estimated that on an average a TB patient loses 20 to 30 % of his annual household income. Control of TB is significantly contributing to reduction of poverty at both the individual and national level. Improved productivity of workers by reducing absenteeism, preventing incapacity from ill health, and by averting TB deaths among these workers, add to the productivity capacities of the economy. India contributes 20% to the global burden load of TB. By implementing the programme, significant numbers of patients will be treated and cured, thereby contributing to the reduction in mortality and morbidity due to TB. The Programme would contribute in alleviation of poverty and hunger.

This proposal would ensure continued implementation of the RNTCP activities in the states of Chhattisgarh, Jharkhand and Uttaranchal, which will benefit over 63 million population of these 3 states. As per the list released by the Planning Commission in India, nearly 42% of the population in these 3 states reside in the 100 most poor and backward districts of the country. Nearly one-fifth of the population in these three states reside in tribal areas.

TB control activities are being implemented in these states with grant assistance from Global Fund Round 1 funding. This funding is approved up to September 2006. Further financial commitment is required to sustain the programme in these three states. The programme would contribute significantly towards the larger country context related to TB control efforts and help attain the MDGs and related targets concerning the disease. Through the implementation of the Programme, TB would be managed effectively and patients especially in the productive age group would return to the work force, thus contributing to the economic development of the community and the country. The families of such persons would be dually benefited. Firstly they would not have to spend scarce family resources on the treatment of the person – a major factor leading to debt especially in the lowest income families. And secondly, when these persons are successfully cured, they would in turn help replenish the family finances.

The proposal will assist India in achieving the goals set out at the twenty-sixth G8 Summit in Okinawa, Japan, June 2000, to reduce TB deaths and TB prevalence by 50% by 2010 compared with levels in the year 2000. And also to achieve the Millennium Development Goals related to the "combat of HIV/AIDS, malaria and other diseases". Specially target 8 that says 'Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases', where major diseases includes TB.

The programme has been supporting research to estimate the incidence, prevalence, and mortality due to TB. The national ARTI survey in 2000-03 has estimated an ARTI of 1.5% for the country. A repeat

national ARTI survey is being planned in 2007-10 to study the trends in incidence. The TB expert committee in the country, based on sample surveys undertaken by TRC and NTI, have estimated the prevalence of TB disease in India in 2000 at 3.8 million bacillary positive cases. As it was felt that a national sample survey would not be feasible due to cost and resource constraints – disease prevalence surveys at select sentinel sites have been planned in each of the 4 zones of the country to study the trends in disease prevalence. Like-wise mortality surveys have been planned to obtain a fair estimate of TB mortality in the country. Early trends based on analysis of available information and WHO estimates, shown that India is on track towards achieving the TB related MDG indicators by 2015.

In order to achieve the global targets, India has been a front runner in shaping the international policies for TB control and is also currently implementing a majority of the components of the new global Stop TB Strategy. The components of the new strategy described above have been incorporated in the phase II of RNTCP and would be included in the current project proposal.

4.4.4 National health system

a) Briefly describe the (national) health system, including both the public and private sectors, as relevant to reducing the impact and spread of the disease in question.

India is a federation of states. The Constitution provides guidelines for responsibilities that are to be carried out by the Central (Federal) Government and the individual State Governments, with the exception of Union Territories which are governed by the Federal government. Health is a state subject and the responsibility of health care delivery is the responsibility of the respective state government. Individual states plan, implement and micro-monitor all health related projects, including DOTS implementation, in their respective states. The manpower, infrastructure and administrative resources are entirely the responsibility of the state governments and the expenditure for these are met from the State budget. This expenditure is significantly larger than the additional funds proposed to be provided to the states from the GFATM project which supplements the fund requirement to carry out specific priority programme activities. The support proposed for the state and districts in the Project are for further strengthening and building capacity of the states to effectively plan, implement and monitor the project activities.

However, the Central Government provides leadership, policy guidelines and technical support for ensuring that citizens get standard health care. For health issues of national priority including TB control, the Central Government supports the state government financially to undertaken activities as per national policies and guidelines.

Health care in India is provided by a multitude of agencies both public and private, using many systems of medicine such as modern allopathic medicine, ayurveda, unani, homeopathy, siddha etc. These services are provided through the public health system, the unregulated and vast private and NGO sectors and also by the health facilities in other government sectors and service industry– like the Railways, the Army, Coals & mines, ESI etc, and the corporate sector.

India has a well structured public health system. The TB control Programme is integrated into the general public health care services in the country. The country has a vast network of primary health care facilities. The Primary Health centres established for every 25-30,000 population are the first point of contact between the patient and the health system. Sub-centres established for every 3000-5000 population and manned by a paramedical worker provide outreach services closer to the community. The Community Health Centres, for every 80-120,000 population act as the first level referral units. In addition, there are sub-district hospitals, district hospitals, and medical colleges providing tertiary care to the populations.

The Government has in the present fiscal year launched the National Rural Health Mission (NRHM), with an objective to provide accessible, affordable and accountable health care in rural areas. Its primary focus is on making the public health system fully functional at all levels. The focus is in the 18 priority states including the three states to be covered under this proposal. The Mission envisages higher allocations for primary health care by the states as well as the Central government. The major thrust is to strengthen the

public health care delivery systems in these identified states, build capacity of effective decentralized need based planning and implementation starting from the village level. The existing disease control Programmes, including TB Control Programme, now would be operating from under the NRHM umbrella mechanism, thereby bringing in synergy and convergence of all public health care system. The participation of communities, local self governments (Panchayati Raj Institutions), NGOs and other stake holders is expected to be further enhanced under the Mission.

India also has a large private health sector consisting of authorized practitioners as well as a considerable proportion of unregulated private health providers. However, private providers are often the first contact for majority of the TB patients, both in the urban and rural areas.

According to experts, the private health sector in India is one of the largest in the world. 80% of all qualified doctors, 75% of the dispensaries and 60% of the hospitals in the country belong to the private sector. Estimated private health expenditure is 87% of the total health expenditure (Health systems: improving performance, WHO report 2000). India has the highest burden of TB and also has the largest private sector that possible manages as many as half of the prevalent cases.

In India, with a vibrant private health sector, it is therefore necessary to engage and involve the private sector so as to have any significant impact on the TB epidemiology in the country. The few available studies suggest that in many low-income TB endemic countries with large private sectors, private physicians and other health-care providers such as, traditional healers and private pharmacies, play a significant role in the initial stages of health-care sought by patients with symptoms of TB. This is in keeping with the private sector presence in ambulatory care and the fact that the initial symptoms of TB are virtually indistinguishable from those of other chest illnesses. The additional cost is not a deterrent for most of these patients in the early stages. In most instances, there is a delay in diagnosis of TB. This is due to the inability of the provider to recognize and suspect TB rather than a delay in health-seeking by the patient. This leads to increase in transmission of the disease. Also non-standard treatment, poor completion of treatment increase transmission and risk of development of drug resistance.

The private practitioner is often more easily accessible, has suitable timings, better communication and greater confidentiality than public health-care professionals. Since private practitioners are the first point of contact for a significant proportion of patients with tuberculosis, there is an opportunity to reduce diagnostic delay, with a concurrent reduction in transmission. Involvement of this sector in the RNTCP can improve patient access and acceptance and thereby improve treatment outcomes; avoid unnecessary diagnostic delay, and encouraging all health care providers to adopt standardized treatment regimens under RNTCP, would also help in reducing the risk of emergence of drug resistant forms of TB.

In the light of the above situation, there is a felt need to make concerted and coordinated efforts to involve the private sector in the delivery of DOTS and mainstreaming their contribution towards the larger public good. One way that this can be done is through a catalytic or facilitator organization, with a large base of health-care providers, such as the Indian Medical Association (IMA). Such a strategy has the potential to reduce diagnostic delays, increase case detection rates, improve treatment outcomes and reduce the cost of TB management to the patient.

Health care is also delivered through health facilities under other government sectors/ministries notably the Employees State Insurance which caters to the health needs of the workers in large industrial units and their families; the Army, police, railways, ports, mines etc; NGOs both for-profit and voluntary; the corporate sector, and medical colleges. The national strategy for TB control gives utmost priority and importance to delivery of TB care through a coordinated effort by all such sectors involved in health care so as to achieve the desired impact and reduce the burden of TB in the country.

b) Given the above analysis, explain whether the current health system will be able to achieve and sustain scale up of HIV/AIDS, tuberculosis and/or malaria interventions. What constraints exist?

Studies have established that over 40% of the population of India is infected with *Mycobacterium*

tuberculosis. The life time risk of breakdown from TB infection to disease is 10% in non-HIV infected and 50% in HIV co-infected. Considering this epidemiological characteristic of TB, the control of this disease will require sustained efforts for over two-three decades before TB ceases to be a public health problem in the country.

The current national strategy envisages establishing and supporting a health care system that would be able to provide quality TB care over the decades, while giving TB control interventions the priority it demands. Since its inception, the RNTCP in a phase-wise manner has focused on building capacity at the state and district level for effective implementation of the National TB Control Programme. At the health care delivery level, staff are being trained in DOTS and infrastructural improvement supported so that quality diagnostic facilities are available to all clients.

The constraints that exist in the three states include shortfall in the availability of staff at all levels but particularly at the health care delivery level. Moreover there are gaps in manpower requirements at management positions at both the state and district levels. The three states that are to implement this project have been created from earlier existing large and populous states. During the redrawing of the state borders, the resource distribution has been skewed more in favour of the large states. Thus the three smaller states have proportionately got lesser numbers of health manpower. The health allocation in these low resource states is not at par with the actual requirements, which is the reason for gaps in manpower and infrastructure requirements. However, in the years since their formation, these states are incrementally building up their health systems with support from the Government of India and other development partners including World Bank, GFATM and others. With such additional support, infrastructure is being upgraded and the capacity of the existing manpower built and additional human resources acquired. The previous GFATM project has supported development of management and programme implementation capacity at the state level. However, as these states have an overall resource crunch, the allocation for health is relatively lower than the requirement for priority disease control initiatives, including TB. Given the high levels of motivation and achievements of targets in Round 1 GFATM project, the three states would undoubtedly be able to sustain the scale up of TB control activities beyond the proposed project period.

The WHO 2003 Global TB Report has noted that while the case finding by DOTS programmes is increasing, the increase is small and to reach global targets, many countries will have to introduce innovative ways to find and treat cases not yet notified. The programme has piloted and is implementing a novel PPM (Public-Private Mix) project to involve all other health care providers under the programme. Though significant gains have been made in terms of involvement (over 10,000 private practitioners; 2000 NGOs, 100 corporate houses, 200 Medical colleges), the programme views that there is still an immense untapped potential of this sector towards contributing to the overall goal of TB control. The absence of a common platform to reach the vast network, the years of unregulated practice, lack of feasible/acceptable opportunities for Continuing Medical Education (CMEs), and the resistance of academicians to the RNTCP DOTS strategy are some of the challenges which the programme is constantly working at.

c) Please describe national health systems strengthening plans as they relate to these constraints. If this proposal includes a request for resources to help overcome these constraints, describe how the proposal will contribute to strengthening health systems.

The Government of India (GoI) has recently launched the National Rural Health Mission (NRHM) with the objective of strengthening the public health care delivery system from the grass roots level facilities to tertiary care institutes. The Mission envisages increasing the health expenditure of the GoI and the states in a phased manner to the levels that are recommended by WHO and mandated under different global commitments. As part of the Mission, the government has formulated - 'Indian Public Health Standards', which will ensure a minimum acceptable levels of infrastructure, human resource, facilities and services at all levels of the public health system. This Health System Strengthening (HSS) initiative will form the base from which high quality care, including TB care, will be made available to communities in rural areas.

Under the Rd 6 TB project, it is envisaged to maintain the health care facilities that have been already

established through the Rd 1 project. This would supplement the efforts that are being undertaken in the NRHM. Essentially the activities that would be sustained with GFATM funds include; civil maintenance of the microscopy centres that have already been established, support to the key staff hired on contractual basis against the gaps in state system provided manpower and financing all the new initiatives that are part of the DOTS programme including enhanced M&E, ASCM/IEC activities, management of MDR-TB cases, sustaining TB HIV collaborative linkages etc.

The WHO 2006 Global TB report identified the building and sustaining of NTP capacity to coordinate and manage the involvement of wide range of public and private providers as a major challenge and highlighted the involvement of professional organizations such as IMA as a means to achieve the desired objectives.

The Indian Medical Association is a national voluntary organization of doctors of modern scientific system of Medicine, with the objectives of promotion and advancement of medical and allied sciences in all their different branches, and improvement of public health & Medical education in India. The IMA has a nationwide network of 23 state branches, 9 territory branches and 1700 local branches, and a wide membership base of more than 140,000 allopathic medical practitioners - approximately 30% of all such practitioners in the country, with the majority of them practicing in the private sector.

The IMA sub-project proposes to implement Public–Private Mix (PPM) activities on a larger scale in the country than at present. The IMA will facilitate PPM activities in 167 districts of 6 states (Andhra Pradesh, Chandigarh, Haryana, Maharashtra, Punjab and Uttar Pradesh) through its network of 532 local branches present in these states. The objective is to train and involve private practitioners in RNTCP-DOTS so as to widen the health-provider base and improve the availability and quality of TB control services. And by doing so, to make available the benefits of the DOTS strategy to a larger number of TB patients through a sustainable PPM-DOTS approach and to thereby assist the nation in its commitment to reduce the burden of TB.

4.5 Financial and programmatic gap analysis

Interventions included in relation to this component should be identified through an analysis of the gaps in the financing and programmatic coverage of existing programs. Such an analysis should also recognize gaps in health systems, related to reducing the impact and spread of the disease. Global Fund financing must be additional to existing efforts, rather than replacing them, and efforts to ensure this additionality should be described. For more information on this, see the Guidelines for Proposals, section 4.5.

Use table 4.5.1-3 to provide in summarized form all the figures used in sections 4.5.1 to 4.5.3.

4.5.1 Overall needs assessment

a) Based on an analysis of the national goals and careful analysis of disease surveillance data and target group population estimates for fighting the disease component, describe the overall **programmatic** needs in terms of people in need of these key services. Please indicate the quantitative needs for the 3-5 major services that are intended to be delivered (e.g. anti-retroviral drugs, insecticide-treated bed nets, Directly Observed Treatment Short-Course for TB treatment). Also specify how much of this need is currently covered in the full period of the proposal by domestic sources or other donors. *Please note that this gap analysis should guide the completion of the Targets and Indicators Table in section 4.6. When completing this section, please refer to the Guidelines for Proposals, section 4.5.1.*

India accounts for nearly 1/5 of the global burden of tuberculosis (TB). Every year there are about 1.8 million new TB cases in the country, of which nearly 800,000 are infectious smear positive pulmonary cases. Every day, more than 1,000 people die of TB. It is estimated that that up to 40% of the adult population of India is already infected with TB. As per the ARTI survey conducted through 2000- 2003, the national ARTI is 1.5 i.e. 75 new smear positive pulmonary TB cases are expected per 100,000 population every year. The TB problem is further compounded by an estimated 5.20 million people in

India infected with HIV.

The National TB control programme is supported through the World Bank credit and grants from development partners including GFATM. The support is for undertaking various activities under the DOTS strategy including sputum microscopy, anti TB drug supply, ASCM activities, monitoring and supervisor etc. The manpower and the infrastructural support are provided by the states which are responsible for the implementation of the programme activities. The support of the development partners is based on geographical coverage viz. GFATM grants are presently being used for programme implementation in seven states of the country of which in two states the support is partially from World bank as well; USAID is supporting one state and in other parts World Bank funds are being utilized.

The three states of Chhattisgarh, Jharkhand and Uttaranchal are presently receiving GFATM grants from the Rd 1 that would cease in September 2006. Implementation of DOTS activities as mentioned in section 4.4.3 for a population of 62.3 million in these three states is the gap that is being addressed under this project. The estimated annual total TB cases in this population is over 120,000, out of which over 46,700 are sputum positive infectious cases. The project would ensure quality TB care to this group, which would further lead to decreasing transmission of the infection among the vulnerable groups. The populations in these three states, which is largely socio-economically backward and living in hard to reach tribal and hilly areas, would through this project have obtained the dual benefits, firstly of getting easily accessible high quality TB care free at point of use and secondly drastically reduce out of pocket expenditure and reduce treatment delays.

The National TB Control Programme is implemented by the states which are responsible for the provision of the necessary health manpower and health care infrastructure at all levels. The Central Government provides the essential resources including anti-TB drugs, support for M&E and requirement of additional staff on contractual basis, ACSM etc, items that are unique to the programme and where these resources are not available within the budgetary provisions of the states.

Based on the national TB strategy framework, expenditure patterns and established norms for expenditure under the national TB control programme; the fund requirement for continued implementation of the RNTCP in the years 2007-08 to 2011-12 has been worked out. This amounts to a total need of USD 342 million and is reflected in the Table 4.5.1-3 – 'Financial contributions to national response'.

The present committed funding from various sources, including the domestic sources which include credit assistance from World Bank, and grant assistance from GFATM and DFID amounts to USD 308 Million for the period 2007-08 to 2011-12. The details of this are given in Table 4.5.1-3

In the fiscal years 2010-11 and 2011-2012 GFATM funding through the Phase II of the Rd 4 TB component project in the states of Andhra Pradesh and Orissa will cease. The overall national need assessment includes the gaps resulting due to termination of the Rd 4 project as mentioned above. The present proposal seeks to address the funding gap in the respective three states for the five years starting in the fiscal year 2007-08. The additional funding gaps that remain in the years 2010-11 and 2011-2012 for the states of Andhra Pradesh and Orissa would be addressed eventually through domestic or external fund sources.

b) Based on an analysis of the national goals and objectives for fighting the disease component, describe the overall **financial** needs. Such an analysis should recognize any required investment in health systems linked to the disease. Provide an estimate of the costs of meeting this overall need and include information about how this costing has been developed (e.g., costed national strategies, medium term expenditure framework). *(Actual targets for past years and planned and estimated costing for future years should be included in table 4.5.1-3 [line A].)*

The overall country needs for TB control activities for the period of the proposal is expected to be USD 342 million in the period 2007-08 to 2011-12. These needs are based on the present goal, objectives and approved strategies. The year wise estimates of needs of the country for TB Control activities is given in the section 4.5.3 below. The country has developed costing norms based on population, after costing the

activities based on programme experience and detailed analysis of programme data from the preceding years of project implementation, in consultation with key partners and implementing agencies i.e. state and district TB control units, which have also been approved at the highest administrative levels in the central and federal government. The norms provide for enhanced provisions for hilly, tribal and other difficult areas requiring special interventions. The overall country strategy, objectives and activities along with the costing norms have been developed for the World Bank supported RNTCP Phase II project and are applicable for all project sites in the country from 01 October 2005. The IMA sub-project is expected to cost about USD 4 million, which has been estimated based on the TB control programme implementation experience and the IMA experience in this regard.

4.5.2 Current and planned sources of funding

a) Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line B].)*

In table 4.5.1-3, the current estimates are shown for the year 2007-08 and estimated expenditure is shown for the year 2008-09 upto March 2012. The committed fund from various partners are given below.

The Phase I project of RNTCP has been completed by 30 September 2005. The total credit available from the World Bank during RNTCP Phase I was uSD 142.4 million. The GoI has commenced with the RNTCP Phase II project for a period of five years from 01 October 2005 with a total outlay of USD 256.9 million. The GoI has negotiated a credit from the World Bank for USD 170 million from Oct 2006 to Sept 2011. The DFID will be providing commodity assistance through WHO in the form of first line anti TB drugs for 500 million population for USD 44.3 million (WHO has concluded a contract with DFID for two years for USD 63.7 million for the same). The rest i.e. USD 42.5 million will be provided by GoI. The funds for the period after 30th September 2011 will be sought from the partners at a later stage.

The year wise break ups of the financial contribution from various domestic sources is given in Table 4.5.1-3.

b) Describe current and planned financial contributions, anticipated from all relevant external sources (including existing grants from the Global Fund and any other external donor funding) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line C].)*

The other funding partners in the RNTCP Phase I project were DANIDA, DFID, USAID and GDF. GFATM is providing grant support through three rounds of funding totaling over USD 64 Million over varying time frames. WHO also provides technical assistance for the Programme in the form of medical consultants who provide technical assistance to the state and district officials for effective implementation of the Programme.

In the RNTCP Phase II, DFID is providing drugs for 500 million population, estimated to be USD 44.3 million. In addition, DFID is funding Technical assistance to the project through WHO for a period of five years, which amounts to USD 14 million.

4.5.3 Financial gap calculation

Provide a calculation of the gap between the estimated overall need and current and planned available resources for this component in table 4.5.1-3 and provide any additional comments below.

Based on the national TB strategy framework, expenditure patterns and established norms for expenditure under the national TB control Programme- the fund requirement for continued implementation of the RNTCP in the years 2007-08 to 2011-12 has been worked out. This amounts to a total need of USD 342 million and is reflected in the Table 4.5.1-3 – 'Financial contributions to national response'.

The present committed funding from various sources including the domestic sources which include credit assistance from World Bank, GFATM and DFID, amounts USD 308 Million for the period 2007-08 to 2011-12. The details of this are given in Table 4.5.1-3

In the fiscal years 2010-11 and 2011-2012 GFATM funding through the Phase II of the Rd 4 TB component project in the states of Andhra Pradesh and Orissa would cease. The overall national need assessment includes the gaps resulting due to cessation of the Rd 4 project as mentioned above. The present proposal seeks to address the funding gap in the three states for the five years starting in the fiscal year 2007-08. The additional funding Gaps that remain in the years 2010-11 and 2011-2012 for the states of Andhra Pradesh and Orissa would be addressed eventually through domestic or external fund sources.

The country has a need for funding of about USD 20.4 million to bridge the gap in the availability of funds for the TB Control activities in the three states under consideration of this proposal, to enable the RNTCP to maintain and sustain its activities and undertake the planned initiatives during the project period. This will enable the proposed sites to make the expected contribution to the epidemiology of TB in the country and to move towards MDGs related to TB.

4 Component Section *Tuberculosis*

Please summarize the information from 4.5.1, 4.5.2 and 4.5.3 in the table below.

Table 4.5.1-3 - Financial contributions to national response

	Financial gap analysis : *USD Millions*							
	Actual		Planned		Estimated			
	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-2012
Overall needs costing (A)	46.00	73.58	68.21	67.00	67.24	68.50	68.90	70.50
Current and planned sources of funding:								
Domestic source: **Loans and debt relief (World Bank)**	24.23	56.53	10.5	28.2	29.5	35.9	38.4	43.0
Domestic source: **National funding resources (Govt of India)**	8.85	5.95	32.6	7.7	6.8	8.2	9.8	11.0
Total domestic sources of funding(B)	***33.07***	***62.49***	***43.09***	***35.9***	***36.3***	***44.1***	***48.2***	***54***
External source 1: **GFATM**	4.00	4.89	12.6	14.0	14.5	7.0	-	
External source 2: **DFID**	1.67	1.63	7.88	8.10	8.56	9.16	10.50	
External source 3: **USAID**	0.88	1.14	1.8	1.9	-	-	-	
External source 4: **DANIDA**	0.52	0.85						
External source 5: **GDF**	3.56							
External Source 6: **WHO Technical Assistance**	2.3	2.6	2.8	2.9	3.1	3.2	3.2	3.5
Total external sources of funding : C	***12.93***	***11.10***	***25.12***	***26.94***	***26.17***	***19.40***	***13.70***	***3.50***
Total resources available (B+C)	46.00	73.58	68.21	62.84	62.47	63.50	61.90	57.50
Unmet need (A) - (B + C)	**0.00**	**0.00**	**0.00**	**4.2**	**4.8**	**5.00**	**7.00**	**13.00**

4.5.4 Additionality

Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this will continue to be true for the entire proposal period.

By design, the RNTCP is integrated with and implemented through the general health services utilizing the existing available infrastructure in the health system. This infrastructure in the general health system is established and maintained by the respective state governments, and the state health facilities implement the programme activities. All this infrastructure and governmental staff are paid for by the respective state governments and the initial investment as well as the recurring costs for maintaining the basic services under the programme are also provided for by the state government. RNTCP only funds the additionalities like the costs for essential drugs and for activities as per international guidelines, and supervision and monitoring of these activities, which would be provided for under this proposal. Thereby, any fund commitment by GFATM to the programme would be in addition to the ongoing efforts being made by the public health system and there would be no replacement of allocations of the state or central government.

The provision of services under RNTCP, with a renewed emphasis on quality TB control services, to the whole of India, with its population of over 1114 million, is in itself a challenging and is a resource-intensive task. As described earlier, several external agencies have supported the GOI in expansion of TB control activities in the whole country, and thereafter, having achieved national coverage, have are also committed to contribute towards the maintenance of quality services until such time that the desired epidemiological impact is attained. The RNTCP is in the process of signing the credit agreement with the World Bank to implement the programme for five more years. This proposal, along with other external resources, would provide assistance in meeting the costs for focused TB control initiatives of the country. RNTCP is presently being implemented in the three newly created states of Chhattisgarh, Jharkhand and Uttaranchal, with support from GFATM in Round 1. Continued funding is sought from the Global Fund to maintain and improve the existing quality TB services for a population of over 62 million people in these states. Thus, the funding sought under this proposal is an additional resource requirement to meet the efforts being made by the GoI to provide quality DOTS services to the entire country and to help realize the MDG of halting and reversing TB.

As the RNTCP services are fully integrated with the general health services, any contribution to RNTCP will also lead to a strengthening of the general public health system of these states. To illustrate, the Laboratory Technician provided by RNTCP on a contractual basis at the RNTCP designated microscopy centres under the programme provides additional technical manpower to the state and is usually deployed in areas where regular technicians are not available. Thus, this contractual technician is useful in the provision of laboratory services to the area in general and not just sputum examination services, leading to strengthening of the health infrastructure particularly in the hard-to-reach and remote areas. Strengthening of the laboratory infrastructure shall, similarly, contribute to strengthening the general health system.

4 Component Section *Tuberculosis*

4.6 Component strategy

This section describes the strategic approach of this component of the proposal, and the activities that are intended in the course of the program. Section 4.6 contains important information on the goals, objectives, service delivery areas and activities, as well as the indicators that will be used to measure performance.

For more detailed information on the requirements of this section, see the Guidelines for Proposals section 4.6.

In support of this section, all applicants must submit:

- A **Targets and Indicators Table.** This is included as **Attachment A** to the Proposal Form. *(When setting targets in this table, please refer explicitly to the programmatic need and gap analysis in section 4.5.1 a. All targets should show clearly the current baseline. For definitions of the terms used in this table, see the M&E Toolkit provided by the Global Fund. Please also refer to the Guidelines for Proposals, section 4.6.*

  and

- A component **Work Plan** covering the first two years of the proposal period. The Work Plan should also be integrated with the detailed budget referred to in section 5.2.

  *The **Work Plan** should meet the following criteria (Please refer to the Guidelines for Proposals, section 4.6):*

  a. *It should be structured along the same lines as the Component Strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.*

  b. *It should cover the first two years of the proposal period and should:*
     - ***i be detailed for year 1, with information broken down by quarters;***
     - ***ii be indicative for year 2.***

  c. *It should be **consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above.*

  d. *It should be integrated with the first two years of the **detailed budget** (please refer to section 5.2).*

Please note that narrative information in this section 4.6 should refer to the Targets and Indicators Table (Attachment A to this Proposal Form), but should not consist merely of a description of the table.

4.6.1 Goals, objectives and service delivery areas

Provide a clear description of the program's goal(s), objectives and service delivery areas (provide quantitative information, where possible).

The TB component of the proposal that is to be implemented in the respective three states will be part of the overall RNTCP in India. The proposal also contains a sub-component with the Indian Medical Association, an NGO representing professionals from the allopathic (modern) system of medicine. Thus the goal of this project is in line with the national TB control goal and is ***'To decrease mortality & morbidity due to TB and to expand the reach of RNTCP through enhanced coordination with private health providers'***.

The objectives of the project are as follows:

- Consolidation of services with maintenance and improvement in quality of RNTCP
- Expand and increase the reach of RNTCP.
- Introduce DOTS Plus in a phased manner.
- To train and involve private practitioners in RNTCP-DOTS, in order to improve the

availability and quality of TB control services through a sustainable Public Private Mix (PPM DOTS) approach.

- To contribute towards national efforts in measuring the impact of RNTCP in relation to the MDG TB targets.

The project envisages to detect and register a total of 440,000 TB patients on treatment under DOTS. This would save an additional 80,000 lives. As part of the project, 600 MDR-TB patients would be enrolled under DOTS-Plus.

Since 2003, RNTCP has been implemented in the three states with funds from Global Fund Rd 1. All the three states have been covered under DOTS. In the initial phase of implementation of DOTS in these areas, facilities in terms of microscopy centres, Intermediate Reference Laboratories, sub-district level and state level drug stores have been upgraded. The available manpower at the state and district level have been trained in activities that are undertaken under the programme, including TB diagnosis and management. Managerial and programme monitoring capacity of key staff at state and district level has been built.

The RNTCP is an application of the DOTS strategy which advocates case finding by sputum smear microscopy and treatment under direct observation. The treatment success rates have increased 3-fold and the death rates among TB patients has decreased 7-fold as compared to the previous programme. Learning from past experiences it is envisaged that by continuing to implement the programme in the 3 states with a greater involvement of other sectors, strengthening of IEC and enhanced supervision and monitoring, the global targets of 85% success rate and 70% case detection rate of new sputum positives would be maintained and further improved so as to have the desired epidemiological impact on the disease burden.

The interventions to be strengthened are derived from the need to sustain case finding and improve the quality of the existing programme. These include – Enhancement of administrative support by improving supervisory and monitoring capabilities of the states; Improving the quality of diagnostic services by implementing the sputum microscopy external quality assurance system, and by M& E of lab services; continuing to provide good quality drugs under the programme and take steps to offer second-line drugs to MDR-TB cases; offering DOT services and supportive supervision of patients under treatment; and strengthening of the reporting, monitoring and evaluation of programme activities by continued training of turnover staff, retraining of existing staff and by ensuring touring of the field by the programme managers at the state and district levels.

The Indian Medical Association (IMA) has a nationwide network of 23 state branches, 9 territory branches and 1700 local branches, and a wide membership base of more than 140,000 allopathic medical practitioners. This accounts for approximately 30% of all such practitioners in the country, with the majority of the members practicing in the private sector. IMA has the objectives of the promotion and advancement of medical and allied sciences in all their different branches, and to strive to improve public health and medical education in India. The IMA has the potential to engage with other important health providers including medical colleges and NGOs. The IMA is recognized by the GoI as an important body of health providers with membership from all health sectors, and with having the motivating power to help change the mindset of practitioners of modern medicine.

The IMA proposes to undertake the project in 167 districts in 6 states to significantly scale-up the public-private mix TB activities (PPM DOTS) towards TB efforts in these districts. The objective will be to train and involve private practitioners in these 167 districts, so as to widen the health-provider base and improve the availability and quality of TB control services; and by doing so, to make available the benefits of the DOTS strategy to a larger number of TB patients through a sustainable PPM approach. This project would bring about a behaviour change in the private practitioners which would have long lasting effect on their TB management practices and would thereby, in the long run assist the nation in its commitment to reduce the burden of TB.

Private practitioners from the selected districts would be contacted, sensitized and trained in RNTCP, and subsequently facilitated to sign Memorandum of Understanding (MoUs) with the state and district TB

Control Societies under the RNTCP PP Schemes. The RNTCP has formal schemes for involvement of private practitioners under 6 different schemes which have delineated cash and commodity assistance that is provided through the respective TB control societies. Through the IMA activities, the health-provider base for the TB control programme will be widened. The process of training and involvement would be in collaboration with RNTCP approved personnel and according to national training guidelines. It is therefore expected that a larger number of patients will have easier access to better quality TB management, including medicines, with a provider of their choice.

It is felt that, at present, inter-sectoral collaboration on health issues is sub-optimal and that a lot can be achieved in the country by establishing and improving the quality of effective and meaningful public-private partnerships. This project aims to bridge some of the gaps that exist between the public and private sectors, allay misunderstandings and improve trust, and partnerships through a sustainable and synergistic PPM approach.

4.6.2 Link with overall national context

Describe how these goals and objectives are linked to the key problems and gaps arising from the description of the national context in section 4.4. Demonstrate clearly how the proposed goals fit within the overall (national) strategy and how the proposed objectives and service delivery areas relate to the goals and to each other.

TB is a major public health problem in India and the RNTCP is being implemented through out the country based on the DOTS strategy recommended by the WHO. This DOTS-based TB Control Programme needs to be implemented in the project sites for many years so that the Millennium Development Goals are meet and ultimately that the disease will be brought under control in the country.

The project states are presently implementing the national strategy with support from Global Fund and are contributing towards the national TB control goals in terms of case detection and successful treatment of TB cases. The service delivery areas in TB would be focusing on an improvement in case detection, better management of TB cases, including management of MDR-TB cases and TB patients co-infected with HIV/AIDS, and improved coordination with partners from the private health care sector.

It has been documented that a large number of patients seeking health-care from private providers belong to poorer socio-economic groups. By involving a significant number of private providers in RNTCP-DOTS, especially those with a higher TB-patient load, the proposal seeks to also decrease diagnostic delays and cost of treatment, thereby reducing the spread, morbidity and mortality of the disease and the burden on individuals, families and the country at large.

India is committed to reduce the burden of TB in the country, reduce its morbidity and mortality and decrease the transmission of the disease to a level where it ceases to be a public health problem. The country is also committed to improving the quality of RNTCP management to bring the programme closer to patients so as to make it more accessible and acceptable to them. Finally India is committed to achieving the Millennium Development Goals, where the increase of TB is to be halted and the incidence of the disease reversed by the year 2015. This proposal looks to help India stick to its commitments to reduce the burden of TB in the country.

All the national disease control Programmes including the TB programme provides their services through the public health system at all levels in all parts of the country. However, in many parts of the country the public health system has not been in a satisfactory state (Report of the National Commission on Macro Economics and Health). The National Rural Health Mission that has been recently initiated with highest possible political commitment envisages to strengthen the public health institutions. The budgetary allocation for health is being dramatically increased at both federal and state level.

4.6.3 Activities

Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. Please include all the activities proposed, how these will be implemented, and by whom. *(Where activities to strengthen health systems are planned, applicants are also required to provide additional information at section 4.6.6.)*

To have an impact on the TB burden in the country, the national targets for TB control have to be firstly met and then maintained for 2-3 decades. Under the RNTCP in 2005, the annual new smear case detection rate was 66% and success rate 86%, compared to the global objective of 70% and 85% respectively. This level of performance has to be achieved nation-wide so as to firstly reduce the prevalent cases and then decrease the incidence cases, and in the long run achieve the MDGs related to TB and control the disease.

As explained earlier, the RNTCP has been implemented in the country in a phased manner since 1998, and in the three proposed project states since 2003 with grant assistance from GFATM Round 1. As per the guidelines for TB Control formulated by the Government of India (GoI), and followed throughout the country, a wide range of activities would need to be continued under the project by the State TB Control Society/ District TB Control Societies along with new initiatives viz. MDR TB management, TB HIV collaborative activities etc. **The Objectives and SDAs are detailed in the attached TB Component Work Plan** and the description of the activities undertaken in the RNTCP given below should be read in context of the broad objectives and SDAs stated in the workplan.

- Each district in the project state has formed a District TB Control Society(DTCS) to plan, manage, implement, supervise and monitor TB control activities with funds routed through the central government and State TB Control Societies which would be the Sub-Recipients of GFATM support.

- District TB Centre is the nodal agency which implements the programme under guidance from the DTCS. The District TB Officer is the nodal person and is responsible for all TB control activity in the district. The STCS at the state level is overall responsible for all TB control activity in the state. The Central TB Division at the central level would continue providing the leadership and policy directives for TB control activities, and would supervise and monitor the state and districts.

- Under the RNTCP, TB Units (TU) have been established at the sub-district level to supervise and monitor the programme. Such TUs have been established for a population of 500,000 and in hilly/tribal and difficult areas for 250,000 population. RNTCP Designated Microscopy Centres (DMCs) have been established for every 100,000 population, and in hilly/tribal and difficult areas for 50,000 population. DOTS centres are identified in a way so that DOT can be provided to the TB patient closest to their home and most conveniently by a person acceptable to the person.

- Identification, recruitment and training of health personnel is undertaken by the respective DTCS as per their Annual Action Plan and under the overall leadership of the STCS. Training is a key component of the RNTCP and all health personnel involved in the implementation of RNTCP are trained through specially prepared modules as per the current policy of GOI. State and District TB Officers (STO and DTO) are trained at the central level institutes, while other staff are trained at the most appropriate facility at their respective levels. A large number of the staff in the three states have already been trained under the Round 1 Global Fund support. However turn-over staff and refresher training of key staff on new initiatives, will be undertaken under this proposal. A total of 550 staff, including State and District TB Officers, supervisory staff and Laboratory Technicians are planned to be trained.

- Most of the civil works at the local, sub-district and district levels have been completed under the current proposal, and only essential maintenance and up-gradation of new facilities required

for catering to additional populations, would be undertaken in the new proposal.

- Laboratory facilities have been upgraded in the RNTCP DMCs so as to facilitate high quality sputum microscopy services.

- TUs and DTC have also been upgraded so as to ensure proper storage of anti-TB drugs and efficient functioning of the implementing unit at the district and sub-district levels.

- To ensure high quality sputum microscopy under the programme, the External Quality Assurance protocol has been developed and will be implemented in the proposal sites.

- Detailed diagnostic algorithms for diagnosis of sputum positive, sputum negative, extrapulmonary TB cases and for diagnosis of TB in pediatric patients have been developed. Facilities available under the general public health system in the secondary and tertiaty health care facilities would provide services for diagnosing extrapulmonary/ HIV infected/ pediatric TB cases.

- When a patient is diagnosed as having TB, the concerned treating medical officer is responsible for deciding the appropriate regimen from the three categories of treatment available under the programme, which depends on the history of previous treatment, the results of investigations and the severity of illness (for sputum negative and extrapulmonary TB cases). All new HIV positive TB cases irrespective of sputum positivity or site of disease would receive category I TB treatment.

- Under the RNTCP, an individual 'Patient Wise Box' containing anti-TB drugs for that Category of regimen for the entire duration of treatment, is earmarked for each registered patient, thereby ensuring complete availability of drugs for that patient.

- Supervision and monitoring is given highest priority under the Programme to ensure high quality of sputum microscopy and DOT services. A robust system of recording and reporting has been established from the most peripheral level to the district, state and central levels.

- Electronic connectivity has been established at the district level and would continue to be maintained to facilitate reporting and monitoring.

- To further improve case detection and increase reach of RNTCP, health facilities under private and other sectors, including NGOs, are being involved under the RNTCP.

- Information, Education and Communication (IEC) activities play an important role in case detection, case holding and successful treatment of TB cases. IEC would follow a holistic approach by providing relevant information to each target group of patients and providers, and would employ appropriate and effective communication especially through improved interpersonal communication.

- Under the current proposal, efforts have been made to establish state level quality assured mycobacterial culture and drug sensitivity testing (DST) facilities in each of the three states. The laboratories will be further strengthened and their capacity developed so that they can undertake routine DST for their respective states.

- Guided by the Strategy Paper developed for five years by the RNTCP, DOTS-Plus sites would be established in the three states in the first year of the project. From the 2nd year onwards 50 "new" MDR-TB patients would be enrolled per year in each of the sites to assess operational feasibility and also to gradually build capacity of the health system to operationalise the complex challenges involved in MDR-TB management.

- The HIV epidemic in the country has the potential to worsen the TB situation because HIV increases the risk of re-activation in people with latent TB infection. Also TB is the commonest opportunistic infectious disease in people with HIV infection. The three states presently have low prevalence of HIV among general population. However, activities under the Joint Action Plan formulated by the respective TB and HIV/AIDS control Programmes would be implemented so that optimum synergy is established between the two National Disease control Programmes for effective prevention and control of both TB and HIV. Activities would include:

  - To operationalize and monitor the TB HIV collaborative activities; state and district coordination committees have been formed which meets at delineated intervals. The committess include members from the RNTCP and NACP programme besides representatives from the NGO including those working with PLWHA and TB patients. Efforts would be made by the two programmes to identify such organizations working in the state/district and due participation would be sought to provide quality care and support to PLWHA.

  - Key staff including Medical Officers and Counselors working with RNTCP and NACP would be trained on TB HIV using modular training material developed jointly by the programmes.

  - The three states under the project have low prevalence of HIV (<1% in ante-natal clinics). Initially referral linkages will be established between existing VCT facilities/ART centres in the states and DOTS centres so that TB suspects can be rapidly managed and individuals at higher risk of HIV offered VCT services. With the expansion of the VCT network by National AIDS Control Organisation in these states the additional referral linkages would be established. Clients from the VCT facilities would be referred to the RNTCP diagnostic centre existing either in the same health facility or to the nearest DMC for diagnosis. Diagnosed HIV positive TB cases would receive DOT through an accessible, acceptable and accountable DOT provider.

  - TB-HIV Coordinator will be provided to each state to facilitate the collaborative activities and ensure timely reporting. Project states would be provided technical assistance and joint training on TB/HIV would be conducted for staff of respective Programmes.

  - RNTCP will facilitate referral linkages for eligible HIV positive TB patients to ART and CPT services provided by the existing NACP systems as per prevailing national policy.

  - Key staff from both the RNTCP and NACP would be trained on TB HIV using modular training material developed jointly by the programme.

  - Referral linkages would be established between VCT facilities existing in the states and DOTS centres so that TB suspects can be rapidly managed and individuals at higher risk of HIV offered VCT services. Co-ordination Committees would be formed to ensure the Joint Action Plans.

  - TB-HIV Coordinator would be provided to each state to facilitate the collaborative activities and ensure timely reporting. Project states would be provided technical assistance and joint training on TB/HIV would be conducted for staff of respective Programmes.

  - RNTCP would facilitate provisions of ART and CPT to eligible HIV positive TB patients through the existing NACP systems preventing avoidable duplication.

- The project also envisages to measure the impact on RNTCP on TB burden in the country. The current national estimate of 3.8 million bacillary cases has been calculated from surveys undertaken by TRC in a subdistrict population of Tamil Nadu and national ARTI surveys. As a national sample survey is resource intensive and operationally not feasible, the national expert

committee has recommended for conducting TB prevalence surveys at 1-2 select sentinel sites in each of the 4 zones of the country to obtain a precise estimate of the TB prevalence at these sites and monitor these sites over the next decade to see the impact of RNTCP and progress towards Millennium Development Goals. The current project proposes to support the initial round of the TB prevalence surveys at 4 such sites in the country. Other surveys would be supported from domestic funds.

- TB mortality surveys have been undertaken in the states of Andhra Pradesh (south) and Orissa (East) under the GFATM Rd 4 project. Additional survey in the state of Uttaranchal (North) has been proposed in the project. A baseline survey would be undertaken in the first year of the project. The survey would be repeated in the last year (year 5) of the project to obtain trends in TB related mortality.

The Indian Medical Association (IMA) has been collaborating with the RNTCP for several years. This collaboration was formalised at the national level in 2004 when the National IMA endorsed RNTCP. Many pilot projects have been implemented by the IMA at district and state levels. There is a need for expanding the collaboration to have country wide impact which would improve access to the diagnostic and treatment services of DOTS. In this project, IMA would have structured TB cells and activities at national, state and district levels in 6 states/ union territory. It will also advocate the DOTS strategy to the private health sector and undertake training of private practitioners in RNTCP. The objective is to improve access to the diagnostic and treatment services of DOTS and thereby improve the quality of care for patients suffering from Tuberculosis in five states and one union territory of India, namely, Andhra Pradesh, Chandigarh, Haryana, Maharashtra, Punjab and Uttar Pradesh with a total population of over 401 Million.

The strategy to be adopted under this project is to provide impetus to the private health care sector in joining and participating in RNTCP by using the DOTS strategy for patients suffering from TB by:

i Advocating DOTS to private medical practitioners through:
  - Periodical newsletters and medical journals
  - Sensitisation of key practitioners and motivators
  - CME Programmes and workshops
  - Training of private providers

ii Conducting workshops where Public-Private dialogue and interaction would be made effective

iii Linking the private sector with the RNTCP at national, state and district levels

iv Coordinating with the public sector in training of private providers

v Facilitating supervision, monitoring and evaluation of private providers practicing DOTS

- IMA will advocate the principles of DOTS to the private sector. Involvement of the IMA leadership is expected to provide the impetus to practitioners from the private sector. Even though all doctors are not members of the IMA and not all doctors subscribe to the endorsements of the organisation, IMA reaches out to a significantly large number and percentage of the medical community and medical practitioners working with various health care sectors.

- At the national level, leadership for the project will be provided by the IMA National TB Cell comprising of the National President, the Secretary General, the National coordinator (TB), the National consultant (TB) and State coordinators (TB) of all the IMA states. They will all contribute their time, efforts and resources for the project. Space for this office will also be contributed by IMA while some basic equipment would be procured through the project.

- The initial activity at the national level will be to conduct a workshop on PPM-DOTS for state IMA leaders. This workshop would facilitate increased understanding of the DOTS strategy among the IMA leadership and detailed state wise work plan/schedule would be formulated at this workshop. This would be followed up by annual review cum workshop meetings to be

organized annually.

- The IMA National TB Cell will publish a dedicated quarterly newsletter to be sent to all the IMA members in the project states, numbering around fifty five thousand, and also to leaders and opinion makers of other states. The IMA will also publish articles, especially those of academic interest such as studies, in the national IMA journal. This will be carried out each quarter (every 3 months). Another contribution at the national level will be to reproduce and distribute IEC kits for targeted medical practitioners, especially chest physicians, general physicians and general practitioners(GP), including family physicians in the project states. Other activities of the national IMA will include participation, at the national level, in World TB Day Programmes and also in some of the National RNTCP Review meetings

- At the state level, lMA State TB Cell will be formed at all the five state and one UT branch headquarters. This body will consist of the IMA State President, the State Secretary, the State TB coordinator, the State Technical Consultant(s) and all district TB coordinators. With the exception of the technical consultants, all the other members of the cell are honorary members and will contribute their time, efforts and resources for the project. As with the national office, space for these offices will be contributed where an IMA building exists.

- The initial activity at the state level will be to conduct workshops on PPM-DOTS. The main aim of the initial workshop is to motivate, educate and sensitise the IMA leadership, with representatives from all the districts within the state, to PPM-DOTS. It is also to develop a micro plan of action for individual states and to initiate the project activities.

- The state IMA shall coordinate sensitisation of private practitioners and also facilitate the monitoring and evaluation of those practitioners involved in the programme. During the early period/years it will guide and direct the local IMA branches in their efforts to conduct CMEs for their members and also help organise the training of medical practitioners at the district level in close coordination with and the support of state and district RNTCP officials. It will also help in carrying out advocacy through involvement at the state level in World TB Day activities. The documentation of the processes and outcomes of the project will be carried at the state level.

- The IMA does not have offices at the district level. Instead, after the state branch, there are local IMA branches which do not necessarily conform to the political or administrative boundaries of the district. There are 532 branches in the project states. The contribution of the IMA District Coordinator (TB) as well as that of the branch Presidents and Secretaries will be honorary. They will contribute their time, efforts and resources for the programme. No additional human resources or equipment are being procured at this level from the project.

- The IMA branches in the districts will organise CMEs and carry out sensitisation of physicians and General Practitioners (GPs). Identified medical practitioners would undergo one-day training in RNTCP organised and conducted by the IMA with assistance from the DTO (and district TB cell) and WHO Consultants.

- Following their training, the medical practitioners will be involved in RNTCP as doctors referring, diagnosing and/or treating TB patients using the DOTS strategy. IMA will facilitate their involvement in the programme and ensure that they are accredited and certified. Monitoring and evaluation will be carried out by the public sector and IMA will assist by facilitating M & E activities. Monthly RNTCP review meetings of the district TB cell will be attended by the district IMA TB coordinator. Feedback and interaction during these and other meetings will help guide the TB control programme in the district move in the right direction. In addition to the above, local IMA branches and representatives of the state IMA TB cell will support the public sector in local district level advocacy Programmes, including World TB day activities. The IMA state branch will also document the processes and activities of the project in the districts and local branches.

- Presently, 14 PPM –DOTS projects are being implemented with support from WHO to document the contribution and impact of PPM DOTS to the NTP case finding. In these pilot sites special recording and reporting systems have been put in place, without disturbing the national reporting mechanism, in order to document referral of TB suspects by PPs to DMCs and number of TB patients being provided DOT by PPs, along with other parameters. The three of these pilot sites are in the area under the IMA project. Findings from these pilot PPM-DOTS sites would be used to extrapolate contribution of PPs in terms of case finding and case holding in the IMA sites.

4.6.4 Performance of and linkages to current Global Fund grant(s)

This section refers to any prior Global Fund grants for this disease component and requests information on performance to date and linkages to this application. For more information, please refer to the Guidelines for Proposals, section 4.6.4.

a) Provide an update of the current status of previous Global Fund grants for this disease component, in the table below.

Table 4.6.4. Current Global Fund grants

	Grant number	Grant amount*	Amount spent
GF Grant 1	IDA-102-Go1-T-00	USD 8.655 Million	USD 6.132 million till March 2006
GF Grant 2	IDA-202-Go3-T-00	USD 29.10 million for five years. Phase I budget was USD 7.08 million)	USD 5.788 million till March 2006
GF Grant 3	Not Applicable	Not Applicable	Not Applicable
GF Grant 4	IDA-405-G08-T	USD 6.819 Million	Expenditure till Mar 2006: USD 0.724 million (SOE of Orissa awaited)

* *For grants in Phase 1, this is the original two year grant amount. For grants that have been renewed into Phase 2, this is the total amount, inclusive of Phase 1 and Phase 2. For unsigned Round 5 grants this is the two year TRP approved maximum budget.*

b) Please identify for each current grant the key implementation challenges and how they have been resolved.

GF Grant 1: This project is for scale up of DOTS in the three newly created states of Chhattisgarh, Jharkhand and Uttaranchal with a total population of 56 million. All the three states have been carved out of existing large states. The three states have low socio-economic and other health indicators. The states face great challenges in terms of sub-optimal resource allocation and lacks adequate health care manpower. Further more two of these states namely Jharkhand and Uttaranchal have difficult and mountainous terrain which poses difficulties in mobility and logistics management. The state also have a high proportion of populations that are tribal who are located in difficult to access forested areas which make provision of health care rather challenging. The major challenges faced in implementation of RNTCP in these areas include inadequate capacity of health staff in TB care, lack of manpower and inadequate facilities for conducting sputum smear microscopy, limited capacity for decentralized procurement of quality anti-TB drugs, inadequate financial and managerial capacity at district and state level. These challenges were identified along with the state health officials and other stakeholders and interventions were designed to address these identified issues. Necessary key staff were hired on

contractual basis to overcome manpower gaps. All levels of staff involved in TB care were provided training in TB care using standardized modules. Accounts and communications officers were provided. District and state level officials were given focused training in programmatic and financial management. State and district TB Control management units were provided necessary office equipment to facilitate communication and data management. Mobility for supervision and monitoring was ensured. Minor civil works were undertaken to upgrade laboratories at peripheral level for conducting sputum smear microscopy. Intermediate Reference Laboratories were established at the state level for supporting EQA for sputum microscopy. The procurement of anti-TB drugs were done from the central level to ensure highest quality at most competitive prices. Systems were developed and staff trained to manage drug logistics at the district and peripheral health facility level.

The LFA for this project is the World Bank which in its various Aide Memoires following Supervisory Missions to these states have suggested actions for better implementation of the project. All such suggestions have been acted upon by the project states and CTD, and the LFA has thereafter found the overall implementation progress satisfactory.

GF Grant 2: Rd 2 project sites are in two of the most socio-economically deprived states in India. The Phase I of the project ended in March 2006. GFATM has approved Phase II of the project based on the achievements of the project and demonstrated evidence of capacity to implement the project in an efficient and effective manner. In some areas progress has been just short of satisfactory, mainly due to the poor health infrastructure and less than optimum administrative commitment. However, in spite of the weakness in the system, SRs have shown high levels of motivation and commitment and performance has slowly but surely improved in last few quarters. Most of the implementation challenges are similar to those mentioned under Grant 1. Moreover, there was a period of political uncertainty in the state which had deleterious effect on the programme implementation. To overcome these challenges the PR initiated intensive monitoring of the programme implementation in the two states along with the highest administrative authorities of the states. Supervision and monitoring was strengthened at state, district and sub-district level by way of training, skill building and provisos of necessary logistics. Necessary manpower inputs in terms of contractual Medical Officers, Lab technicians, Data Entry operators, etc were provided. Financial management was a critically weak area at the state level, an issue that had also been pointed out by the LFA (UNOPS). Additional qualified accountants were put in the state TB management units which has substantially improved fiscal management and ensured smooth flow of funds and expenditure reports.

GF Grant 4: This project was initiated in April 2005. To improve baseline information on mortality and TB infection in the community surveys are being undertaken in the Year 1. Similar surveys would be undertaken at the end of the project to assess impact on the TB epidemiology. The state specific Annual Risk of Tuberculous Infection is being conducted in Andhra Pradesh under the technical supervision of National Tuberculosis Institute, Bangalore and State TB Demonstration Centre, Andhra Pradesh. TB mortality surveys are being conducted in both Andhra Pradesh and Orissa. The Tuberculosis Research Centre, Chennai is providing technical guidance to the states for conducting the surveys. Detailed protocols were developed, field research assistants and research supervisors trained. Data collection has been completed and presently analysis of data and report writing has been initiated. However, progress with regards to the Drug Resistance Surveillance in the two states has been slow due to absence of both technical capacity and lack of necessary infrastructure and equipment to undertake such challenging surveys. To overcome this available specialists have been trained and wherever applicable additional resources have been provided. Procurment of Mycobacterial culture and sensitivity testing equipment has been initiated from the central level so that such equipment is made functional at the state level at the earliest.

Further, implementation of all RNTCP activities in two states namely Andhra Pradesh and Orissa with a total population of 119 million is now being undertaken under this grant. RNTCP was being earlier implemented in the state of Andhra Pradesh with support from DFID till project termination in October 2005, and in the state of Orissa with support from DANIDA till project termination in December 2005. The programme implementation in these two states poses managerial and logistics challenges. In these states the general health care delivery system has weakness that are being addressed. Additional

manpower has been provided for strengthening supervision and monitoring at the sub-districts level to ensure high quality sputum microscopy activities and to ensure treatment as per national guidelines. Staff with need for refresher training has been identified and retrained using specially developed training modules. Involvement of other health sectors viz NGOs, Private providers is also a weak areas in these two states. Many strategic actions have been initiated to improve case detection in the private health sector. Support of the Indian Medical Association and other forums is being proactively solicited to improve case finding and treatment adherence. The initiatives that have been operationalised are giving promising results. 63,893 patients have been put on treatment since implementation in GFATM Round IV project, of them 25,182 were new smear positive cases. NSP case detection rate 52/lakh population (69%) was achieved in 2005. 288 NGO and PPs are involved under the Programme undertaking awareness generation activities, referring TB suspects to RNTCP facilities, acting as DOT providers and operating DMCs/TUs.

c) Are there any linkages between the current proposal and any existing Global Fund grants for the same component? (e.g. same activities, same targeted populations and/or the same geographical areas.)	☒ Yes ➔ *complete d)* ☐ No ➔ *go to 4.6.5.*

d) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided under current Global Fund grants.

To provide quality TB services to the whole of India, with its population of over 1114 million, is in itself is a challenging task. As described earlier, several external agencies have supported the GOI in firstly expanding TB control activities in the whole country and thereafter having achieved national coverage, in maintaining the quality services until such time that the desired epidemiological impact is attained. The RNTCP is in the process of negotiating further credit support from the World Bank to implement the programme for five more years. This proposal, along with other external resources, would provide assistance in meeting the costs for focused TB control initiatives of the country. RNTCP is presently being implemented in the three newly created states of Chhattisgarh, Jharkhand and Uttaranchal, with support from GFATM in Round 1. Continued funding is sought from Global Fund to maintain and improve the existing quality TB services to the population of over 61 million in these states. Thus the funding sought under this proposal is an additional resource requirement to meet the efforts being made by the GoI to provide quality DOTS services to the entire country and help in realizing the MDG of halting and reversing TB. As the RNTCP services are fully integrated with the general health services, any contribution to RNTCP, will lead to a strengthening of the general public health system in India.

4.6.5 Linkages to other donor funded programs

a) Are there any linkages between the current proposal and any other donor funded programs for the same disease	☒ Yes ➔ *complete b)* ☐ No ➔ *go to 4.6.6.*

b) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided by other donors, including in respect of health system strengthening activities.

This proposal is for implementation of the RNTCP in the three states of Chhattisgarh, Jharkhand and Uttaranchal is integral to the National TB control efforts which are being supported by the World Bank, GFATM and DFID. However, there is no duplicity of funding as all fundings under the national Programme are based on geographical demarcations and there is no dual funding in any state. Urban PPM projects are being undertaken in 14 urban sites where PPM efforts are being intensively implemented as pilots and documentation of these enhanced efforts are being facilitated. This documentation is providing

additional information on certain indicators that are not part of the regular reporting system and is thus providing critical sentinel information on contribution of PPM efforts especially in the areas of referral of TB suspects, case detection and DOT provision. These informations would be relied upon in the IMA sub-project to measure effectiveness of the PPM efforts and its contribution to the national initiative and specially the GFATM project.

The mass media activities undertaken from the Central level contribute significantly to the IEC/ACSM efforts of the national programme. A media agency contract through the World Bank support would be responsible for carrying out mass media campaigns to create awareness on availability of TB services under DOTS strategy in the entire country including the states under this project. Though the cost of hiring of the agency is budgeted in the World Bank project, the benefits of such activities would be available in the GFATM project sites.

4.6.6 Activities to strengthen health systems

Certain activities to strengthen health systems may be necessary in order for the proposal to be successful and to initiate additional HIV/AIDS, tuberculosis, and/or malaria interventions. Similarly, such activities may be necessary to achieve and sustain scale-up.

Applicants should apply for funding in respect of such activities by integrating these within the specific disease component(s). Applicants who have identified in section 4.4.4 health system constraints to achieving and sustaining scale-up of HIV/AIDS, tuberculosis and/or malaria interventions, but do not presently have adequate means to fully address these constraints, are encouraged to complete this section. For more information, please refer to the Guidelines for Proposals, section 4.6.6.

a) Describe which health systems strengthening activities are included in the proposal, and how they are linked to the disease component. *(In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. See the Multi-Agency M&E Toolkit.)*

The project envisages consolidating the TB control programme being implemented in the country through focusing on the three states where fund gap exists due to reasons explained in relevant sections. Heath systems strengthening are required to ensure delivery of quality TB care from the facilities at various levels. As detailed in section 4.4.4 c, the Project would be consolidating and maintaining the gains made in the project areas through earlier GFATM funding. The Health System Strengthening initiatives include in the project include civil maintenance of the microscopy centres, drug stores at sub-district, district and state level; continuation key staff hired on contractual basis against gaps in essential manpower; training/retraining of all levels of staff involved in TB care delivery, supervision, management of programme and on all new initiative that are to undertaken under this project; maintenance of the HMIS and monitoring and supervision activities. Another vital area which is covered under the project are the IEC/ACSM activities, especially activities that focus on increasing ownership of the health Programmes by the communities. Supporting the Intermediate Reference Laboratories in the three states would develop the capacity of the states to undertake not only EQA activities but also undertake mycobacterial culture and sensitivity testing. These would provide the necessary impetus to implement the MDR-TB treatment in the states which presently lack such services.

b) Explain why the proposed health systems strengthening activities are necessary to improve coverage to reduce the impact and spread of the disease and sustain interventions. *(When completing this section, applicants should refer to the Guidelines for Proposals, section 4.6.6.)*

As mentioned in earlier sections, the three proposed project states are among the most socio-economically challenged states in the country. All the three states have been formed half a decade back having being carved out of erstwhile large states. The states inherited a poor crumbling health system with large gaps in the manpower needs. Combined with this the persistently very low per capital expenditure on health and health systems, resulted in further degradation of the health facilities. The manpower needs and overall management weaknesses compounded the matters and the health of the people suffered.

The health systems strengthening efforts detailed in the above sections would help the staff and the health system in general to provide much needed health care to these vulnerable communities. The Project would increase access to quality health care for the communities residing in difficult to reach hilly and tribal

populations in these three states. Sustained involvement of other sectors providing health care would help improve access even to communities including from the organized and unorganized labour sector living in urban and peri-urban areas.

c) Describe how activities to strengthen health systems, integrated within this component, will have positive system-wide effects and how it is designed in compliance with the surrounding context and aligned with government policies.

All the Health System Strengthening initiative envisaged to be undertaken in this project will have larger system wide beneficial effect. Specific improvement in the health care infrastructure including maintenance of the upgraded laboratory facilities and drug storage facilities lead to quality laboratory services and strengthened drug logistics management being available at the peripheral levels for all delivery of health care in general. Key staff provided through the project on contractual basis would help support the health care facilities to be optimally staffed at all time and ensure continuous availability of quality health care even in the most difficult areas. Training in TB care, supervision and management would build the capacity of the staff to not only provide high quality TB care but will also help them to manage other health programme efficiently. The IPC skills built through RNTCP triaging would help the staff communicate better with the communities and patients leading to improved acceptance and utilisation of public health care.

The TB programme strategies and policies have been formulated within the overall framework of the national health policy document. The National Health Policy (NHP) 2002 prescribes reduction of various types of inequities and imbalances including intra-regional, urban-rural and between economic classes through increased sectoral outlays and strengthening the primary health care system. The NHP 2002 also emphasis leadership role of the Central Government in provision of resources, technical support, M&E etc relating to the priority diseases control programmes, to the state governments, especially to the focus states. Convergence and integration of various disease Programmes at the primary level is envisaged under the NHP 2002 to optimize utilisation of the public health infrastructure inputs. The Policy document envisages larger role of local self governments and civil society in health care which has been also addressed in the national TB control policy.

d) Are there cross-cutting health systems strengthening activities integrated within this component that will benefit any other component included in this proposal?	☐ Yes ➔ *complete e) and f)* ☒ No ➔ *go to g)*

e) If you answered yes for d), describe these activities and the associated budgets and identify and explain how the other components will benefit. *Please refer to the Round 6 HSS Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

f) If you answered yes for d), confirm that funding for these activities has not also been requested within the other component. *Please refer to the Round 6 HSS Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

g) Is this component reliant on any cross-cutting health systems strengthening activities that have been included within other components of this proposal?	☐ Yes ➔ *complete h)* ☒ No ➔ *go to 4.6.7.*

h) If you answered yes for g), describe these activities and the associated budgets and identify and explain how this component will benefit. *Please refer to the Round 6 HSS Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

4 Component Section *Tuberculosis*

4.6.7 Common funding mechanisms

This section seeks information on funding requested in this proposal that is intended to be contributed through a common funding mechanism (such as Sector-Wide Approaches (SWAp), or pooled funding (whether at a national, sub-national or sector level).

a) Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism?	☐ Yes ➔ *answer questions below.* ☒ No ➔ *go to 4.8*

b) Indicate in respect of each year for which funds are requested the amount to be funded through a common funding mechanism.

c) Describe the common funding mechanism, whether it is already operational and the way it functions. Identify development partners who are part of the common funding mechanism. Please also provide documents that describe the functioning of the mechanism as an annex. *(This may include: The agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*

d) Describe the process of oversight for the common funding mechanism and how the CCM will participate in this process.

e) Provide an assessment of the incremental impact on projected targets as a consequence of the funds being requested for this component, which are to be contributed through the common funding mechanism.

f) Explain the process by which the applicant will ensure that funds requested in this application, that are contributed to a common finding mechanism, will be used specifically as proposed in this application.

4.6.8 Target groups

Provide a description of the target groups, and their inclusion during planning, implementation and evaluation of the proposal. Describe the impact that the program will have on these group(s).

The project would be targeting TB suspects and cases in the three newly created states that are in the process of strengthening their health care delivery systems. The communities in these predominately hilly/tribal states with poor socio-economic status, would have access to quality TB care through this project. A bottom up approach has been adopted for the planning of the project. Prior to the proposal formulation the concerned state had prepared a strategic vision document in consultation with key stakeholders like the District TB Control Societies, NGOs and civil society representatives championing the TB patients. Based on that Strategy paper and further consultations with DTCS and civil society partners, specifically with regard to the Global Fund proposal resulted in the formulation of the proposal. The implementing agencies at the state and district level are the State/District TB Control Societies, and all constituencies including civil society, local self government, professional associations etc are represented in these Societies. The monitoring and evaluation of the activities undertaken in the project

sites would also be done by these groups. The IMA sub component of this proposal has been planned in consultation with private practitioner's member of this national association and would be monitored and evaluated at the national level.

4.6.9 Social stratification

Provide estimates of how many of those expected to be reached are women, how many are youth, how many are living in rural areas and other relevant categories. The estimates must be based on a serious assessment of each objective.

Table 4.6.9 Social stratification

	Estimated number and percentage of people reached who are:			
	Women	Youth (<18)	Living in rural areas	Other*
SDA 1	28 Million (45%)	12.5 Million (20%)	50 Million (80%)	26 Million (42%)
SDA 2	132305 (30%)	88203 (20%)	352814 (80%)	185227 (40%)
SDA 3	360000 (30%)	240000(20%)	960000 (80%)	504000 (40%)
SDA 4	28 Million (45%)	12.5 Million (20%)	50 Million (80%)	26 Million (42%)
SDA 5	NA	NA	NA	NA
SDA 6	28 Million (45%)	12.5 Million (20%)	50 Million (80%)	26 Million (42%)
SDA 7	1800 (20%)	900 (10%)	2700 (30%)	1800 (20%)
SDA 8	180 (30%)	120 (20%)	480 (80%)	250 (40%)
SDA 9	85 Million (30%)	57 Million (20%)	198 Million (70%)	57 Million (20%)
SDA 10	NA	NA	NA	NA

* *"Other" to include target groups according to country setting, e.g. indigenous populations, ethnic groups, underprivileged regions, socio-economic status, etc. Targets should be defined according to country disease programs.*

4.6.10 Gender issues

Describe gender and other social inequities regarding program implementation and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities.

A constant feature in the case notifications under the RNTCP is that more male patients are detected than female patients, with the ratio of being 1.8: 1. A number of epidemiological studies have demonstrated that in all age groups, pulmonary TB is predominantly a male disease. In fact, it is male cases that may have lesser access compared to females. It is also seen that male patients are more likely to default from treatment and have slightly worse treatment outcomes than female patients. However there is greater stigma attached to the disease amongst female patients than males.

It is seen that there are gender-based issues both for male and females in relation to TB control activities. The provision of country-wide available and accessible TB services as close to the patients as possible, is an important first step in beginning to address this issue. In relation to the three states in the proposal, geographical coverage is already 100%. However there is recognition that accessibility to services needs to be increased. Important to this is increased inter-sectoral collaboration with sectors outside of the public health services. With increased accessibility to RNTCP services, some of the gender based issues will be addressed e.g. difficulty of working males to attend public health services for DOT due to inconvenient opening hours addressed by DOT provision via NGO or private sector health facilities, or by community

volunteers.

The Central TB Division has already taken steps to address some of the gender-based issues. One area addressed was the lack of readily available gender-based information from the routine programme health information management system. The recording/reporting system has been redesigned to collect stratified data by sex and now provides readily obtainable data on the proportions of males and females being registered under the programme and their treatment outcomes.

A major area of programme activity that will address some of the gender-based issues highlighted to date is the RNTCP Information Education and Communication (IEC) strategy. The IEC strategy encompasses efforts both to encourage more men and women to present to facilities for examination if ill with symptoms of TB, but also once diagnosed the importance of completing treatment.

4.6.11 Stigma and discrimination

Describe how this component will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis and/or malaria, as applicable, and other types of stigma and discrimination that facilitate the spread of these diseases.

Through intensified IEC activities and greater accessibility of quality free TB services, community members with symptoms of TB will be encouraged to present to the health facilities for examination and treatment if necessary. Through the provision of quality decentralized free TB services resulting in the presence of increasing numbers of cured TB patients in the community, it is hoped that the stigma related to TB in the community will decrease. Cured patients acting as DOT providers to future patients and advocates for the programme, will act as potent symbols to the community of the fact that TB is a curable disease and should be seen as just another infection that needs antibiotic treatment for cure

4.6.12 Equity

Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs).

RNTCP services will be available to all cases diagnosed as TB under the health system and associated sectors and will not exclude any section of the population. It has been mentioned above that the norms for establishment of Microscopy Centres and Tuberculosis Units have been relaxed for communities living in hilly, tribal and difficult areas. Considering the geographical barriers in such areas, sputum collection and transportation systems would be established, and convenient DOT through community volunteers would be ensured. Mobility in such areas is costly due to larger distances and non- availability of local transport therefore, staff working in such areas would be given additional funds for mobility and provisions would be made to compensate the patients suitably and reduce out of pocket expenditure.

Urban areas and urban slums in particular are another challenging area. The public health care system is not well established in such areas though tertiary care is more readily available. To improve access of communities living in such slums and in the urban areas in general, there would be increased efforts made to involve private sector and support staff (TB Health Visitors) would be provided.

4.6.13 Sustainability

Describe how the activities initiated and/or expanded by this proposal will be sustained at the end of the program term. *(When completing this section, applicants should refer to the Guidelines for Proposals, section 4.6.13.)*

The Government of India (GOI) gives the highest priority to TB control and is committed to supporting the TB control activities in the states for as long as it takes to achieve a situation where TB ceases to be a major public health problem in the country. There is commitment from highest echelons of authority that GOI would make necessary fund arrangements from domestic or other sources, after the end of the GFATM grant period. Considering the situation prevailing at that time, GOI would make available funds and resources from either domestic health allocation or could consider approaching bilateral agencies for credit/grants.

The IMA sub-project would bring in the required behaviour change among the private practitioners in the project areas through intensified behaviour change approaches and communication. After completion of this sub-protect, maintenance level activities would be sustained by the volunteers of IMA with resource inputs from IMA state branches and other affiliates at district level. Lessons learned would be replicated in different areas of the country in coordination with the NTP and other partners.

4.7 Principal Recipient information

In this section, applicants should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals, section 4.7, for more information. Where the applicant is a Regional Organization or a Non-CCM, the term 'Principal Recipient' should be read as implementing organization.

4.7.1 Principal Recipient information

Every component of your proposal can have one or several Principal Recipients. In table 4.7.1 below, you must nominate the Principal Recipient(s) proposed for this component.

Table 4.7.1: Nominated Principal Recipient(s

Indicate whether implementation will be managed through a single Principal Recipient or multiple Principal Recipients.	☒ Single
	☐ Multiple

Responsibility for implementation			
Nominated Principal Recipient(s)	**Area of responsibility**	**Contact person**	**Address, telephone, fax numbers and e-mail address**
Deputy Director General (TB) Directorate General of Health Services, Govt. of India	Facilitating the SRs in implementation of the project. Macro monitoring and ensuring fund flow from GFATM to SRs	Dr L S Chauhan	Room No 522, 'C' Wing, Nirman Bhawan, New Delhi 110001 +91 11 23063226, 23062980 ddgtb@tbcindia.org

4 Component Section *Tuberculosis*

4.8 Program and financial management

4.8.1 Management approach

Describe the proposed approach of management with respect to planning, implementation and monitoring the program. Explain the rationale behind the proposed arrangements. *(Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM. Maximum of half a page.)*

The CCM India has nominated the Central TB Division headed by a Deputy Director General (TB) as the operational PR for the purposes of implementation of this TB control project. . The India CCM will be monitoring the performance of the project through reviews at regular intervals and would provide overall guidance to the Central TB Division.

The Central TB Division is responsible for providing strategic directions to the states and districts for effective implementation of the TB control Programme. It also sets the frame work for the implementation of the TB control activities; provides technical inputs, funds and monitors the efforts of the states and districts. The overall approach adopted under the RNTCP and the earlier GFATM funded project under the RNTCP, has been a decentralized management approach for ensuring enhanced ownership of the project as well as to ensure sustainability of the TB control Programme.

India is a federation of states, which are further divided into administrative districts. States prepare their own annual plans for implementing the programme, based on the national guidelines and norms adopted in concurrence with key stakeholders.

The Centre focuses on capacity building, technical expertise, policy formulation, lesson sharing, monitoring and evaluation. States would monitor the programme not only at the district level but also at the sub-district tuberculosis unit level. In order to strengthen the implementation capacity of the States, State TB officer have undergone training in management and finance, as well as technical matters. State TB Societies have being strengthened with accountants, IEC officers and data entry operators on contract basis and all necessary office equipment.

Project monitoring – CTD would be monitoring the three States which shall be the primary unit of accountability as well as the IMA sub-project. There will be State-wise quarterly review meetings with DTOs, some attended by central representatives, to provide detailed feedback to each District on a fixed date each quarter. Feedback letters and supervisory visits will – be done by the State level. Central Government will provide technical assistance to States and in occasional cases to districts in order to enable them to effectively ensure these functions by holding 6 monthly meetings nationally with STOs. States in turn will monitor RNTCP implementation. Intensive technical monitoring at district and TB Unit level by States and State by Centre will be ensured.

Public Private Partnership- To broaden reach of the programme and continue its successfully implementation, involvement of Private Practitioners assumes great importance. The IMA sub-project envisages to improve coordination and communication with the private health sector and provide training to the private practitioners so as to improve their skill in proper TB management.

Information, education and communication (IEC) would focus on advocating for priority to the programme, improving awareness of available services at the local level, and improving the interpersonal communication skills of health workers at all levels of the RNTCP.

Under RNTCP, the project funds are disbursed to the State TB Control Societies (STCS) in two tranches based on annual allocation and state annual action plan. The STCS further disburse funds to the District TB Control Societies for undertaking the Programme activities. RNTCP has put in place a robust financial reporting and auditing system which are detailed in the 'Financial Management Module' (enclosed with this proposal) and has been disseminated to all concerned units. Quarterly Statements of Expenditure, annual audit, Certificate of Utilisation are some of the mandatory documentations required under the Programme. Other mandatory checks and balances as are required under GFATM fudiciary system are

also in place. Fund flow to Civil Society Organisations (CSOs) which are SRs under the various rounds is through the PR and a similar system as mentioned with relation to the STCSs are followed. A detailed Memorandum of Understanding (MOU) is signed with the concerned CSOs. This MOU in line with the caveats laid down in the Grant Agreement that is signed between PRs and GFATM and includes programmatic targets, financial details and reporting requirements.

Please note that if there are multiple Principal Recipients, section 4.8.2 below has to be repeated for each one.

4.8.2 Principal Recipient capacities

a) Describe the relevant technical, managerial and financial capacities for each nominated Principal Recipient. Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, please refer to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).

The PR has been assessed at various times with regard to earlier rounds of Global Fund grants as well as other agencies notably the WHO, the World Bank, DFID and GDF. The PR is receiving grants from Global Fund in rounds 1, 2 & 4. Assessments have been conducted by the Global Fund through its nominated LFAs on areas of Institutional arrangements, Monitoring & Evaluation Systems, Procurement Systems, and Financial Systems etc at both the PR as well as different SR level. These assessments have been to the satisfaction of the Global Fund. Based on such assessments, the Phase II for both Round 1 and Rd 2 have been approved by GFATM. Therefore, is can be confidently stated that the PR has the relevant technical, managerial and financial management capacity to implement this present proposal.

b) Has the nominated Principal Recipient previously administered a Global Fund grant?	☒	Yes
	☐	No
c) Is the nominated PR currently implementing a large program funded by the Global Fund, or another donor?	☒	Yes
	☐	No

d) If you answered yes for b) or c), provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous grants (Global Fund or other donor).

The PR is presently administering the RNTCP with support from World Bank, GFATM and DFID. The Phase I of the World Bank project has been successfully completed and the Programme performance and managerial capacity as assessed by the World Bank in their Implementation Completion Report has been rated as 'Satisfactory' also the entire credit has been fully utilized. Phase II of the World Bank project is a follow up and envisages to scale up the new global Stop TB strategy in the country.

Projects under three GFATM rounds of funding are being managed by the PR. The total approved grant for the three previous grants amounts to USD 64.5 million. The Round 1 GFATM grant is for USD 8.65 million for TB control activities in three states with 56 million population and a NGO in Chennai namely REACH. Round 2 GFATM grant is for USD 29.1 million for TB control activities in 120 million population in districts of Uttar Pradesh and Bihar, two of the most populated and economically backward states of India. Round 4GFTAM grant is for USD 26.63 million for TB control projects in the states of Andhra Pradesh and Orissa.

The Rd 1 project is in the third year of implementation after the Phase II was approved by the Board of GF based on the satisfactory performance of the project in the Phase I.

Rd 2 project sites are in two of the most socio-economically deprived states in India. The Phase I of the project ended in March 2006. GFATM has approved Phase II of the project based on the achievements of the project and demonstrated evidence of capacity to implement the project in an efficient and effective manner. Though in some areas progress has been just short of satisfactory mainly due to poor health infrastructure and less than optimum administrative commitment. However, in spite of the weakness in the

system, SRs have shown high levels of motivation and commitment and performance has slowly but surely improved in last few quarters.

Rd 4 project has started in April 2005 and disbursement has been received from the GF. To improve baseline information on mortality and TB infection in the community surveys are being undertaken in the Year 1. The programme performance in the two state where DOTS programme is being implemented with support under the particular Round of GF funding is satisfactory and national targets are being generally being achieved.

e) If you answered yes for b) or c), describe how the PR would be able to absorb the additional work and funds generated by this proposal.

The PR has over the years since the inception of the DOTS programme, in a phased manner developed capacity to provide leadership, plan and monitor this very technically and administratively challenging DOTS programme being implemented through the state management units in the entire country. The PR during the Programme expansion has been steadily building up technical and managerial capacity and is presently structurally well organized to implement the current proposal. Human resource has been developed and the PR now has necessary expertise in policy formulation, supervision & monitoring, finance management and procurement. There are units within the Central TB Division with necessary experts and support staff that deal with specific areas of the programme like training, monitoring and evaluation, procurement, IEC and advocacy, and Finance. With this organizational support the Central unit has been able to scale up DOTS implementation in the country and achieve the global targets. The PR also receives technical assistance from WHO at the central and state level through a network of about 120 consultants. The PR is thus in a position to effectively absorb the additional work and funds generated by this proposal

4.8.3 Sub-Recipient information	
a) Are sub-recipients expected to play a role in the program?	☒ Yes ➔ *complete the rest of 4.8.3*
	☐ No ➔ *go to 4.9*
b) How many sub-recipients will or are expected to be involved in the implementation?	☒ 1 – 5
	☐ 6 – 20
	☐ 21 – 50
	☐ more then 50
c) Have the sub-recipients already been identified?	☒ Yes ➔ *complete 4.8.3. d) -e) and then go to 4.9*
	☐ No ➔ *go to 4.8.3. f) – g)*

d) Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g., open bid, restricted tender, etc.).

The India CCM after detailed deliberations had recommended that for Rd 6 there would multiple SRs and had identified the National TB programme to take leadership in formulation of the TB component proposal. The three states in the proposal are SRs related to the national Programme. For inclusion of civil society SRs, the CCM had advertised the call for GFATM Rd 6 funding on various websites and has also advertised in leading newspapers requesting interested entities to submit proposals. Consultative processes were initiated at the state level and among other key constituencies. The Central TB Division on the

directions from CCM had directed state authorities to disseminate the request for proposal for GFATM and facilitate interested entities/partners to formulate proposals for submission to the CCM based on the guidelines circulated
An expert group with experts from the field of TB and public health was established on the directions of the CCM, which scrutinized the received proposals and recommended the inclusion of the selected proposals to the CCM.
.

e) Where sub-recipients applied to the Coordinating Mechanism, but were not selected, provide the name and type of all organizations not selected, the proposed budget amount and reasons for non-selection in an annex to the proposal.

A total of 26 proposals were received from NGOs, professional bodies and civil society. The details are given in the annexure. One proposal has been approved by India CCM for inclusion in this proposal. 4 proposals were of sound strategy but unrealistic given the capacity of the NGOs. These have been recommended for support from the national Programme after modification including scaling down based on capacity of the NGOs. Rest of the 21 proposals which have not been selected, are either technically inappropriate, incomplete or not in line with the national disease control strategy.

f) Describe why sub-recipients were not selected prior to submission of the proposal.

Not applicable

g) Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process.

Not applicable

4.9 Monitoring and evaluation

The Global Fund encourages the development of nationally owned monitoring and evaluation plans and monitoring and evaluation systems, and the use of these systems to report on grant program results. By completing the section below, applicants should clarify how and in what way monitoring the implementation of the grant relates to existing data-collection efforts.

4.9.1 Plans for monitoring and evaluation

Describe how the targets and activities indicated in the Targets and Indicator Table (attached as Attachment A to this proposal, see section 4.6) will be monitored and evaluated. Please identify any surveys to which this proposal is contributing.

The national reporting system under RNTCP is a quarterly reporting system from TB Unit level (approximately covering 500,000 population) to District level to State and Central level. The programme implementation and performance would be monitored through analysis of routine surveillance data, supervisory visits, review meetings at various levels and periodic in-depth internal evaluations. Measurable indicators for quality control, programme outcomes and operational effectiveness would be the basis for programme monitoring.

The reporting formats have been developed and include case finding, smear conversion rates, treatment outcomes, logistics and programme management, and financial reports detailing statement of expenditure etc. The broad areas related to TB control programme to be monitored include: programme indicators; logistics and quality control; progress in filling up key posts and training; involvement of medical colleges, partners and stakeholders; expenditure and budget utilization; and IEC activities. Detailed feedback on programme activities and achievements to each district are given by the State level, supplemented by additional feedback from the central level, by a fixed date of each quarter. A quarterly and annual programme performance report is published by the programme, and widely disseminated to programme officers and is available in the public domain (available in hard copy or downloadable version

from the RNTCP web-site www.tbcindia.org).

As the programme refocuses from "expansion/preparatory mode" to "maintenance/ consolidation" mode, there is a need for an intense supervision and monitoring strategy. An exhaustive supervision and monitoring strategy document was developed and is currently being implemented in the entire the country as national guidelines.

Crucial to the implementation of the supervision and monitoring strategy is the strengthening of human resources at the centre, state and districts, as highlighted by the Joint Monitoring Mission in September 2003. A supervision, monitoring and surveillance cell exists at the national (Central TB Division) level. In addition, strengthening of the programme monitoring teams at the State TB Training and Demonstration Centres (STDC) or at the State TB Cell, and capacity building of programme officers at all levels, will be done.

WHO supports the RNTCP through a nation-wide network of over 120 medical consultants with a public health back ground, to provide technical assistance to the states and districts. Each consultant is assigned several districts, covering around 10 million population. They assist the STOs and DTOs in planning, training, and supervision and monitoring of the TB control activities. This network has been one of the major innovations of RNTCP, and has been shown to have made an important contribution to the success of the programme to date.

4.9.2 Integration with national M&E Plan

Describe how performance measurement for this program is proposed to contribute to and/or strengthen the national Monitoring and Evaluation Plan for this component. If a national Monitoring and Evaluation strategy exists, please attach it as an annex to the proposal, and provide a summary of key linkages with the national Monitoring and Evaluation Plan and data collection methods.

The DOTS performance in the proposed three states would be part of the national TB control efforts. The achievement under the project would be assimilated in the national achievement. The National monitoring plan is inclusive of the plans for monitoring and evaluation in the three proposed project states. The RNTCP accords great importance to the 'Three One' strategy and accordingly a similar and standardized monitoring system is used in the entire country irrespective of the funding source in a particular state. Further this has helped in the harmonization of reporting requirements to various development partners. GF in the earlier projects has been instrumental in convincing other development partners to agree to this harmonization efforts. Regular evaluations are conducted at the state and district level using standardized protocols developed for use by the central and state levels. Over and above these regular evaluations, RNTCP facilitates evaluation of the programme performance, financial management system and procurement supply management systems at various level conducted independently by development partners and international experts. Based on the recommendations and suggestions of these evaluations, corrective actions are taken for further improvement of the programme.

4 Component Section *Tuberculosis*

4.10 Procurement and supply management of health products

In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of drugs and health products in the country. When completing this section, applicants should refer to the Guidelines for Proposals, section 4.10.

4.10.1 Organizational structure for procurement and supply management

Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.

Organizational structure – Procurement of anti-TB drugs, binocular microscopes, culture and drug sensitivity testing equipment etc., for the RNTCP are done at the central level. The Procurement Unit within the CTD handles issues related to procurement of drugs and logistics. They are supported by an independent procurement agency selected through International Competitive Bidding (ICB) and a central level contracted support unit which looks after management of drugs, logistics and equipment.

Procurement systems – Procurements for the RNTCP are done as per World Bank guidelines. Items to be procured are categorized based on the value of the procurement as for ICB, National Competitive Bidding (NCB) or for National Shopping. Anti TB drugs, binocular microscopes (BM) and PPD and culture and drug sensitivity testing equipment are procured out at central level. Most anti TB drugs and BMs are procured through ICB. The procurement agency floats tenders, processes bid documents and at every stage seeks approval of the Ministry. Procurement is reviewed by the Purchase Committee of the Ministry and finally approved by the MOHFW. All other procurements are done by National Shopping and include office equipment, vehicles, laboratory consumables, printing, IEC etc by the states/ districts. No objection of the World Bank is sought at each stage of procurement through ICB.

Procurement plan development – Under the RNTCP, all procurement is identified at the outset in the procurement plan and included in a project implementation plan which is then put up for government approval. Estimates are based on epidemiology and morbidity patterns, case detection rates, existing stock in the stores, ten months buffer stock, district level seasonality factors and drugs utilization rate. The procurement plan is reviewed and revised periodically and shared with the funding agency concerned.

Quality assurance and quality control – The Drug Controller General of India is the authority dealing with issues related to quality control in the country and is the competent National Drug Regulatory Authority. To ensure quality, procurements are made only through firms who have a valid 'Good Manufacturing Practices' (GMP) certificate issued as per WHO guidelines. The quality assurance is also ensured by pre-delivery testing of all the batches of drugs. This is undertaken by the procurement agency at the manufacturer's premises before clearing the goods for dispatch. Besides this, within the RNTCP, Government Medical Stores Depots (GMSDs) take samples of the drugs stored on a random basis for checking quality. Central and State Drugs inspectors also take drug samples from districts regularly for random testing, and also on receiving specific complaints. To assist the programme's own internal quality testing mechanism, an independent testing lab has been contracted by CTD to carry out drug testing at the field level. Samples in each quarter are taken from one GMSD, one State Drug Store and five districts and got tested for quality at the laboratory contracted by CTD. After testing, the reports are sent by the lab to Central TB Division.

Distribution and inventory management – The drugs are supplied to the states and districts by the GMSDs situated in various parts of the country. All districts have TB drug stores. To decentralize drug and logistic management, it is proposed that each large state has its own State Drug Stores (SDS). Presently, 29 SDSs are functional under the programme. Monitoring of drug supplies with regard to the requirement and consumption is done through a two-tier monitoring system - a central system at Central TB Division (CTD) and a decentralised system by the State TB Officers (STOs) and the District TB Officers (DTOs). A central level support unit (Strategic Alliance) supports the CTD to review and ensure State and district-level drug adequacy, whereas the STOs and DTOS do the same to the level of the DOT Centre. CTD ensures drug adequacy at districts by analyzing Quarterly Programme Management Reports

(QPMR) received from the districts and issuing drugs as per norms. CTD continuously verifies these quarterly reports including the details of patients put on treatment during the quarter, quantities consumed, stock received during the quarter, closing stock and drug requirements of the district. This process enables CTD to continuously monitor the drug stock position throughout the programme.

A buffer stock level of 4 months at each district is maintained across the programme. Moreover drug stock supplies at each GMSD and SDS is also monitored at CTD through a system of monthly statements from them to CTD which provides details of quantities issued during the month, stock in hand and expiry details of the stocks.

Appropriate use – TB drugs under the RNTCP in India are supplied in Patient-wise Boxes, wherein the required amounts of drugs as per the regimen, are provided in a single box for each patient. This also ensures rational use of drugs. The patient-wise box facilitates ensuring uninterrupted supply of drugs and proper intake of drugs in adequate dosages for a patient initiated on treatment. In the TB drug stores, the principles of FEFO (First expiry, First Out) are used to ensure proper utilization.

In the RNTCP II, DOTS Plus is planned to be initiated in a phased manner after strengthening of the state level laboratories for culture sensitivity testing. The Programme envisages to develop capacity to initiate 5000 MDR-TB patients on DOTS Plus treatment by the year 2010. The GLC mechanism would be used for procurement of 2nd line TB drugs. Detailed guidelines have been developed for roll out of DOTS plus and includes details on technical and operational aspects.

4.10.2 Procurement capacity

a) Will procurement and supply management of drugs and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of these products?	☒	Principal Recipient only
	☐	Sub-recipients only
	☐	Both

b) For each organization involved in procurement, please provide the latest available annual data (in Euro/US$) of procurement of drugs and related medical supplies by that agency.

The Central TB Division (PR) undertook procurement of health related products amounting USD 17.00 million in the fiscal year 2005-06. This does not include health products provided by other donors such as GDF, DANIDA and USAID.

4.10.3 Coordination

a) For the organizations involved in section 4.10.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc

In the financial year 2004-05 the procurements of drugs and health related products under the RNTCP with funds from various sources are as follows:

Sl No.	Source	Percentage
1	World Bank Credit/National Programme	60%
2	DFID	20%
3	GFATM	18%
4	USAID	2%

b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal.

RNTCP is supported by the World Bank, the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), DFID, the Global TB Drug Facility (GDF), and the United States Agency for International Development (USAID). The Global TB Drug Facility (GDF) is providing anti-TB drugs for the state of Orissa, and also for an additional 200 million population as a commodity grant valued at over US$ 2 million per year up to 2005.

4.10.4 Supply management (storage and distribution)

a) Has an organization already been nominated to provide the supply management function for this grant?

☒ Yes
➔ *continue*

☐ No
➔ *go to 4.10.5*

b) Indicate, which types of organizations will be involved in the supply management of drugs and health products. If more than one of the boxes below is ticked, describe the relationships between these entities.

☒ National medical stores or equivalent

☒ Sub-contracted national organization(s) *(specify which one(s))*
M/S RITES

☐ Sub-contracted international organization(s) *(specify which one(s))*

☒Other *(specify)*

Procurement done by the states/districts include office equipment, vehicles, laboratory consumables, printing, IEC etc following the World Bank procedures for National Shopping/Local Shopping.

c) Describe the organizations' current storage capacity for drugs and health products and indicate how the increased requirements will be managed.

The 6 Government Medical Stores Depots (GMSDs) in the country have adequate capacity to handle drug storage of all National Health Programmes. The drug requirement in the coming years would only be

marginally higher than the current levels, it is assumed that the GMSDs would be able to manage the increased requirements of drug and logistics systems. To ensure long term sustainability of the programme, drug and logistic management has been decentralize to states by establishing State Drug Stores in all major states of the country including the three SRs. SDSs facilitate the distribution of drugs within the state by sharply reducing lead times for fulfilling drug requests, there by ensuring uninterrupted supply of drugs. All districts have a drug store handle the requirements in the district. Adequate buffer stocks are maintained at all levels (A buffer stock of 4 months is maintained in all districts).

d) Describe the organizations' current distribution capacity for drugs and health products and indicate how the increased coverage will be managed. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal.

As stated above the GMSDs, State drug stores and the district drug stores would have the capacity to maintain an uninterrupted supply chain of drugs and heath products. One SDS in each of these three states is functional. The current proposal would cover 62.3 million population (5.5%) out of the country population of 1114 million (projected population based on 2001 Census), in the 3 states of Chhatisgarh, Jharkhand and Uttaranchal

[For tuberculosis and HIVAIDS components only:]

4.10.5 Multi-drug-resistant TB

Does the proposal request funding for the treatment of multi-drug-resistant TB?	☒ Yes
	☐ No

If yes, please note that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made or is in progress. For more information, please refer to the GLC website, at http://www.who.int/tb/dots/dotsplus/management/en/. Also see the Guidelines for Proposals, section 4.10.5.

4.11 Technical and Management Assistance and Capacity-Building

Technical assistance and capacity-building can be requested for all stages of the program cycle, from the time of approval onwards, including in respect of , development of M&E or Procurement Plans, enhancing management or financial skills etc. When completing this section, applicants should refer to the Guidelines for Proposals, section 4.11.

4.11.1 Capacity building

Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further develop national capacity, capacity of principal recipients and sub-recipients, as well as any target group. Please ensure that these activities are included in the detailed budget.

The programme has gained valuable experience since the expansion of RNTCP in 1997. Over these years, the system has honed institutional and managerial capacity to implement a good quality programme.
Phased, progressive decentralization has enhanced the capacity of states to fully take up the responsibility of planning, executing and supervising TB control activities. Decentralization has covered the programmatic, financial and logistics management of the project. The strengthening of the State TB Control Societies and District TB Control Societies has been undertaken to enhance their capacities.

Overall objective of human resource development under RNTCP is to have available at all time, adequate numbers of staff at the different levels of health system, who have the skills, knowledge and attitudes necessary to successfully implement and sustain TB control activities. These staff are expected to implement new and revised strategies and tools like Supervision & Monitoring, External quality assurance, Paediatric TB guidelines, DOTS Plus etc. The programme is being implemented through the general health system by the states. To provide technical assistance and build capacities at the district and

sub district level, the programme would continue to support the availability of key staff under RNTCP – the STS to ensure quality of treatment, STLS to monitor microscopy quality, TBHV (TB health visitor) for 1 million population in urban areas, who provides directly observed treatment, LTs (upto 20% of the total) who provide accurate microscopic diagnosis of infection, and contractual DTC-MO (upto 15%) to assist DTO in supervisory activities under contractual services. The programme envisages providing Microbiologists at state level Intermediate reference laboratories (IRLs) to monitor quality of microscopy in the state as per External Quality Assurance (EQA) protocol and conduct culture sensitivity for diagnosing MDR cases or Drug resistance surveys, Pharmacists for State Drug stores, besides accountants, data entry operators and drivers for implementation of good quality services by the programme. Provision has been made for hiring of an agency or expert as Communication facilitator for coordinating and facilitating IEC activities across 5 districts in the state. Adequate budgetary provisions as per national guidelines/ norms for the different contractual staff have been built into the proposal.

Capacity of the State/district staff is updated and further enhanced through regular training so that they can undertake supervision and monitoring of all activities. States analyse performance reports from districts and give necessary feedback in a timely manner. A supervision, monitoring and surveillance cell is functional at the national (Central TB Division) level headed by a Chief Medical Officer (CMO) with expertise in this area and supported by 2-3 WHO Consultants. Strengthening programme monitoring teams at the State TB Training and Demonstration centres (STDC) or at the STC and capacity building of programme officers at district and sub district levels is an ongoing regular process under the national programme.

To strengthen procurement, supply and logistic capabilities of CTD and states/districts and facilitate timely processing of procurement issues it is proposed to appoint a procurement officer trained in materials management on a contractual basis at the central level. The officer would work under the concerned CMO heading the Procurement unit of the Central TB Division.

The programme is also supported by network of WHO RNTCP Consultants in the field throughout the country. The role of these Consultants is to provide technical assistance at the central, state and district level and facilitate smooth implementation of the programme. Each Consultant in the field is assigned about 10-15 million population. This network has been one of the major innovations of RNTCP and the Consultants act as independent observers of the programme activities in the field.

In the IMA sub-project, major human input is through the IMA members and volunteers who would provide necessary support but as they are most practicing doctors, they would not be able to give all their time to the project, To address this constraint, bare minimum additional manpower would be hired to facilitate implementation of the project effectively.

4.11.2 Technical and management assistance

Describe any needs for technical assistance, including assistance to enhance management capabilities. (*Please note that technical and management assistance should be quantified and reflected in the component budget section, section 5.6)*

The present proposal has the national Programme component and the IMA component. In the national Programme component, additional technical assistance in form of medical specialist, microbiologist and coordinators would be hired on contractual basis by the states/districts through the processed delineated under the national guidelines and budgets have been earmarked for these manpower. Over and above this TA is also provide through WHO support. WHO has approved funding available for next five years from DFID for this activity.

The IMA component budget also incorporates provision for technical manpower to be hired as Consultants for the project. The WHO consultants in the states which are also IMA sites, would provide necessary TA for training, documentation and evaluation under the IMA project.

5 Component Budget *Tuberculosis*

PLEASE NOTE THAT THIS SECTION IS TO BE COMPLETED FOR EACH COMPONENT.

In this section, applicants will need to provide summary budget information for the proposed duration of the component. Applicants are also required to provide a more detailed budget as an annex to the proposal. For more information on budget requirements, please refer to the Guidelines for Proposals, section 5.

If part or all of the funding requested for this component is to be contributed through a common funding mechanism (consistent with section 4.6.7), **applicants should provide:**

- Compile the Budget information in sections 5.1 – 5.6 on the basis of the anticipated use, attribution or allocation of the requested funds within the common funding mechanism; and
- Provide, as an annex, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request.

5 Component Budget *Tuberculosis*

5.1 Component budget summary

Insert budget information for this component broken down by year and budget category, in table 5.1 below.
(The "Total funds requested from the Global Fund" should be consistent with the amounts entered in table 1.2 relating to this component.)

The budget categories and allowable expenses within each category are defined in the Guidelines for Proposal, section 5.1. The total requested for each year, and for the program as a whole, must be consistent with the totals provided in sections 5.1.

Table 5.1 – Funds requested from the Global Fund

	Funds requested from the Global Fund (in US$ Million)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	1.20	1.25	1.32	1.38	1.45	**6.60**
Infrastructure and equipment	0.10	0.13	0.15	0.18	0.18	**0.74**
Training	0.19	0.20	0.20	0.20	0.21	**0.99**
Commodities and products	0.71	0.76	0.77	0.77	0.78	**3.80**
Drugs	0.63	1.10	1.20	1.30	1.41	**5.63**
Planning and administration	0.67	0.67	0.67	0.77	0.78	**3.57**
Other (Outreach services including IEC, strengthening involvement of Medical Colleges and NGOs; Counseling charges, and Consultancy and research)	0.77	0.69	0.70	0.34	0.45	**2.95**
Total funds requested from the Global Fund	**4.27**	**4.80**	**5.00**	**4.95**	**5.25**	**24.27**

5 Component Budget *Tuberculosis*

5.2 Detailed Component Budget

The Component Budget Summary (section 5.1) must be accompanied by a more detailed budget covering the proposal period, attached as an annex to the proposal. The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

The Detailed Component Budget *should meet the following criteria (Please refer to the Guidelines for Proposals, section 5.2):*

a) It should be ***structured along the same lines as the Component Strategy****—i.e., reflect the same goals, objectives, service delivery areas and activities.*

b) It should cover the term of the proposal period and should:
- *i) be* ***detailed for year 1 and year 2*** *of the proposal term, with information broken down by* ***quarters for the first year****;*
- *ii) provide summarized information and assumptions for the balance of the proposal period (****year 3 through to conclusion of proposal term****).*

c) It should state all key assumptions, including those relating to ***units and unit costs****, and should be consistent with the assumptions and explanations included in section 5.3.*

d) It should be integrated with the detailed ***Work Plan*** *for year 1 and indicative Work Plan for year 2 (please refer to section 4.6).*

e) It should be ***consistent*** *with other budget analyses provided elsewhere in the proposal, including those in this section 5.*

5.3 Key budget assumptions

Without limiting the information required under section 5.2, please indicate budget assumptions for year 1 and year 2 in relation to the following:

5.3.1 Drugs, commodities and products

Please use Attachment B (Preliminary Procurement List of Drugs and Health Products) in order to compile the budget request for years 1 and 2 in respect of drugs, commodities and health products. Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed budget. If prices from sources other than those specified below are used, a rationale must be included.

a) Provide a list of anti-retroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. *(Please complete table B.1 in Attachment B to the Proposal Form.)*

b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. *(Please complete table B.2 in Attachment B to the Proposal Form.)*

c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. *(Please complete table B.3 in Attachment B to the Proposal Form.)*

(For example: Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2003, (http://www.who.int/medicines/organization/par/ipc/sources-prices.pdf); Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); *International Drug Price Indicator Guide on Finished Products of Essential Drugs,* Management Sciences for Health in Collaboration with WHO (published annually) (http://www.msh.org); *First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (*http://www.stoptb.org/GDF/drugsupply/drugs.available.html*).)*

An uninterrupted supply of good quality anti-TB drugs is one of the five components of DOTS strategy being followed for implementation of RNTCP. India has developed a unique system of providing drugs in

patient wise boxes (PWBs) which contain drugs for the entire duration of treatment for each category of patient. RNTCP has three types of treatment categories and there are patient wise boxes for each category. For paediatric cases there are two types of patient wise boxes based on weight bands of such cases.

The volumes for drugs have been based on the population covered by the programme in these three states and the annualized total case detection rate estimated at around 140 per lakh population. Thus it is expected that there will be a total of over 441,000 TB cases put on treatment in the entire five years of the project (in the initial two years this would be about 154,900). Of all patients treated, 46% are Category I, 18% are Category II and 36% are Category III. Therefore, the estimation of drugs has taken into account the population as well the ratio in which patients will be treated in order to arrive at the total volume required. Costing for patient wise boxes for different categories of treatment, based on recent procurement under the RNTCP and including possible increase in costs, are: Cat I : US$ 8; Cat II : US$ 15 and Cat III : US$ 7. The costing for paediatric patient wise boxes has been done at the rate of around US$ 5. Provisions have been made in the proposal budget to cater for possible escalation of these costs.

A total of 600 MDR-TB patients would be put on DOTS-Plus treatment in the project. Costing for second line anti-TB drugs to be used in the DOTS Plus sites have been done based on consultation with experts from Stop TB Partnership, institutions who have been approved by GLC and current national prices of such drugs. The costing for treating one MDR-TB patient has been done at the rate of US$ 2575, based on experiences from the GLC approved project site and this does not include cost for investigation.

The volumes for the different types of commodity/products have been based on the following assumptions:
Binocular Microscopes (BM) – As the both the States will be fully covered by 2005, there would be minimal procurement of binocular microscopes, however, as the population is growing there will a need to increase the number of microscopy centres for which additional microscopes will be needed and some new binocular microscopes would be required for replacing old and non-functional BMs supplied earlier. Therefore, the number of binocular microscopes to be procured is based on the additional increase in population by 2005. Costing has been done based on the rates of BMs procured in 2005. The unit price of each BM is around US$ 220.

Lab Materials – The cost of laboratory materials has been estimated on the number of smears which would be tested in a year at each microscopy centre and programme implementation experiences. One MC covers a one hundred thousand population where an estimated 2000 smears ware examined annually. This has been budgeted on a population norm and amounts to US$3400 per million population.

5.3.2 Human resources costs

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over. *(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)*

The RNTCP is integrated with and implemented through the general health services utilizing the available infrastructure. The infrastructure in the general health system are established and staffed by the local state governments and these facilities implement the programme. The infrastructure and regular staff are paid for by the state governments and all investment costs for the basic services under the programme have already been provided for by the state government. The additional human resource in the states is limited to undertaking supervision, monitoring and quality assurance desired under RNTCP. The programme strengthens the states capacity by providing technical supervisory staff as the STS, STLS, TBHVs etc on contractual basis. GFATM Round 1 has helped to built in the capacity and provided adequate human resource at all levels.

Govt. of India and the state governments are committed for providing a high quality patient friendly DOTS services to its people, and would ensure adequate funding for continuation of provision of essential

drugs and services under RNTCP from domestic and other sources.

As already stated above, the states would be fully covered by 2005, therefore the amount budgeted under human resources have taken into account additional technical assistance required to maintain the program over the next five years of the project. In the first two years, fund requirement would be around 2/5th of the total of the total amount budgeted under human resources for the entire project.

The details of various categories of staff to be hired on contractual basis at state/district and sub-district level including numbers and remuneration are detailed in the Annexure 5 and related sheets in the Detailed Budget attached.

5.3.3 Other key expenditure items

Explain how other expenditure categories (e.g., infrastructure, equipment), which form an important share of the budget, have been budgeted for the first two years. *(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)*

Planning and administration has an important share of the proposed budget as it has, cost for monitoring and evaluation, which includes the cost of supervisory staff. A characteristic feature of the Indian TB Control Programme is the de-centralization to the sub-district level with availability of supervisory staff at that level and provision for their extensive touring the field including patients' home visits. Other amounts that have been included in the planning and administration component of the budget are cost towards awareness generation, office operations and involvement of non-governmental sectors.

Under the GFATM Rd 1 project, infrastructure has been upgraded to optimal standards as laid down in the national programme guidelines. Maintenance of these has been budgeted under the present proposal especially for the microscopy centres, drug stores etc. Provision has been made for upgrading additional DMCs that would have to be established due to increase in population in the project areas. The details can be seen in the attached budget sheets under 'Civil Works'.

Office equipment including computers are available at the state and district TB cells which would now be maintained through this proposal. Budgeting has been done for upgradation/replacement for minimal numbers of equipment that may break down during the proposal period. Costs for procurement of equipment for conducting the TB prevalence studies have been included in the total cost of the surveys.

The details of types and numbers of equipment to be procured are given in the attached detailed budget sheets under the head of 'Office equipment' and 'Lab equipment'

5 Component Budget *Tuberculosis*

5.4 Breakdown by service delivery area

Please provide an approximate allocation of the annual budget for each service delivery area (SDA). The objectives and service delivery areas listed should resemble those in the Targets and Indicators Table (Attachment A to the Proposal Form). It is anticipated that this allocation of the budget across SDAs should be derived from the detailed component budget (see section 5.2).

Table 5.4: Estimated budget allocation by service delivery area and objective.

		Budget allocation per SDA (in US$)				
Objectives	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
OBJECTIVE 1: Consolidation of services with maintenance and improvement in quality of RNTCP	SDA 1: Identification of Infectious cases	83,062	87,155	87,982	88,809	92,943
	SDA 2: TB: Timely detection and quality treatment of cases	994,542	1,096,718	1,203,203	1,423,438	1,536,321
	SDA 3: Supportive Environment; Laboratory	225,911	244,779	260,371	263,321	259,479
	SDA 4: Supportive Environment; Human Resources	1,197,259	1,241,425	1,303,395	1,361,820	1,426,390
	SDA 5: TB: Information System and OR	291,464	296,646	300,560	304,415	308,215
OBJECTIVE 2: Expand and increase reach of RNTCP	SDA 6: Supportive Environment: Community TB Care	211,615	216,867	221,255	225,615	233,845
	SDA 7: TB/HIV collaborative activities: Intensified case-finding among PLWHA	20,699	21,050	21,360	21,664	22,713
OBJECTIVE 3: Introduce DOTS Plus in a phased manner	SDA 8: Treatment of multi-drug resistant TB	68,663	469,206	469,484	469,758	479,128
OBJECTIVE 4: To train and involve private practitioners in RNTCP-DOTS, so as improve the availability and quality of TB control services through a sustainable Public Private Mix (PPM) approach.	SDA 9: TB: PPM (Public Private Mix)	732,870	772,530	780,748	789,521	798,893
OBJECTIVE 5: To contribute towards national efforts in measuring impact of RNTCP in relation to the MDG TB targets.	SDA 10: TB: Information System and OR	444,444	355,556	355,556	0	88,889
Total:		**4,270,531**	**4,801,932**	**5,003,913**	**4,948,361**	**5,246,816**

5 Component Budget *Tuberculosis*

5.5 Breakdown by implementing entities

Indicate in table 5.5 below how the resources requested in table 5.1 will, in percentage terms, be allocated among the following categories of implementing entities.

Table 5.5 – Allocations by implementing entities

	Fund allocation to implementing partners (in percentages)				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Academic/educational sector	8.3%	5.6%	5.3%	0.0%	1.7%
Government	72.5%	76.6%	77.4%	82.3%	81.4%
Nongovernmental / community-based org.	19.2%	17.8%	17.3%	17.7%	16.9%
Organizations representing people living with HIV/AIDS, tuberculosis and/or malaria					
Private sector					
Religious/faith-based organizations					
Multi-/bilateral development partners					
Others. *Please specify:*					
Total	100.00%	100.00%	100.00%	100.00%	100.00%

5.6 Budgeted funding for specific functional areas

The Global Fund is interested in knowing the funding being requested for the following three important functional areas—monitoring and evaluation; procurement and supply management; and technical and management assistance. Applicants are required in this section to separately identify the costs relating to these functional areas. In each case, these costs should already be included in table 5.1. Therefore, the tables below should be subsets of the budget in table 5.1., rather than being additional to it. For example, the costs for monitoring and evaluation may be included within some of the line items in table 5.1 above (e.g., human resources, infrastructure and equipment, training, etc.).

Table 5.6 – Budgets for specific functional areas

	Funds requested from the Global Fund (in US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Monitoring and Evaluation	1,007,383	1,026,318	1,047,136	1,177,578	1,187,565	5,445,980

5 Component Budget *Tuberculosis*

	Funds requested from the Global Fund (in US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Procurement and Supply Management	78,018	86,636	96,411	106,608	118,176	485,849
Technical and Management Assistance	155,047	150,761	153,866	139,412	147,988	747,075

Monitoring and Evaluation: *This includes: data collection, analysis, travel, field supervision visits, systems and software, consultant and human resources costs and any other costs associated with monitoring and evaluation.*

Procurement and Supply Management: *This includes: consultant and human resources costs (including any technical assistance required for the development of the Procurement and Supply Management Plan), warehouse and office facilities, transportation and other logistics requirements, legal expertise, costs for quality assurance (including laboratory testing of samples), and any other costs associated with acquiring sufficient health products of assured quality, procured at the lowest price and in accordance with national laws and international agreements to the end user in a reliable and timely fashion. Do not include drug costs, as these costs should be included in section 5.3.1.*

Technical and Management Assistance: *This includes: costs of consultant and other human resources that provide technical and management assistance on any part of the proposal—from the development of initial plans, through the course of implementation. This should include technical assistance costs related to planning, technical aspects of implementation, management, monitoring and evaluation and procurement and supply management.*

LIST OF ANNEXES TO BE ATTACHED TO PROPOSAL *Tuberculosis*

The table below provides a list of the various annexes that should be attached to the proposal. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Section 4 (Component specific): Component Strategy		
4.4.1	Documentation relevant to the national disease program context, as indicated in section 4.4.1.	1. RNTCP-Technical and Operational Guidelines for TB control 2. RNTCP- Programme implementation Plan II 3. Financial Management Guidelines 4. TB India 2006-RNTCP Status Report 5. Tribal Action Plan 6. Vision Document 7. Health Communication Strategy for RNTCP 8. RNTCP Guidelines for the involvement of Private Practitioners 9. RNTCP Guidelines for the involvement of NGOs
4.6	**A completed Targets and Indicators Table**	Attachment A to the Proposal Form
4.6	**A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year).	TB Annexure 1: detailed work plan with budget attached.
4.6.7 c) *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism.	Not Applicable
4.8.3 e) *(where SRs applied but were not selected)*	Name and type of all Sub-Recipients not selected, the proposed budget amount and the reasons for non-selection.	TB Annexure 2: Review of proposal received in RD 6 for TB component
4.9.2	National Monitoring and Evaluation strategy (if exists)	Strategy document for Supervision and Monitoring of RNTCP
Section 5 (Component specific): Component Budget		
5.2	**Detailed component Budget**	TB Annexure 3: Detailed component budget work sheets including NGO (IMA) component
5.3.1	Preliminary Procurement List of Drugs and Health Products (tables B1 – B3)	Attachment B for TB Component
5.3.2	Human resources costs.	Given in the TB Annexure 3 – Annex 5 to 5(ix)
5.3.3	Other key expenditure items.	Given in the TB Annexure 3 – Annex 2 and 6

5.1 - 5.6 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	
Other documents relevant to sections 4-5 attached by applicant:		