Expansion of effective public and private sector Interventions in HIV, tuberculosis, and malaria Prevention and treatment in India

Proposal submitted to
The Global Fund for AIDS, TB, and Malaria

By

The Country Coordinating Mechanism (CCM) of India

May 28, 2003

India May 2003

For the use of the Global Fund Secretariat: *Date Received:*   *ID No:*

PROPOSAL FORM

Before starting to fill out this proposal form, please read the *Guidelines for Proposals* carefully. When completing each question in the proposal form, please note the reference given to the corresponding section of the guidelines.

<u>This form is divided into 4 main parts</u>:

SECTION I is an executive summary of the proposal and *should be filled out only AFTER the rest of the form has been completed*.

SECTION II asks for information on the applicant.

SECTION III seeks summary information on the country setting.

SECTIONS IV to VIII seeks details on the content of the proposal for each component.

<u>How to use this form</u>:

1. **Please read ALL questions carefully**. Specific instructions for answering the questions are provided.
2. Where appropriate, indications are given as to the approximate **length of the answer** to be provided. Please try, as much as possible, to respect these indications.
3. **All answers, unless specified otherwise, should be provided in the form**. If submitting additional pages, please mark clearly on the pages which section and numbered question this relates to.
4. To avoid duplication of efforts, we urge you to **make maximum use of existing information** (e.g., from programme documents written for other donors/funding agencies).
5. When **using tables**, all cells are automatically expanded as you write in them.
   - Should you wish to **add a new row**, place the cursor on the outside of the cell at the bottom right-hand corner of the table and press ENTER.
   - **To copy tables**, select all cells in the table and press CTRL+C. Place cursor where you would like the new table to begin and press CTRL+V.
6. Please DO NOT fill in shaded cells.

SECTION I: Executive summary of Proposal

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global Fund. The proposal once approved becomes public information.
TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED OUT

General information: *Table I.a*

Proposal title (Title should reflect scope of proposal)**:**	**Expansion of effective public and private sector interventions in HIV, tuberculosis, and malaria prevention and treatment in India**			
Country or region covered:	**India**			
Name of applicant:				
Constituencies represented in CCM (write the number of members from each Category)**:**	**7**	**Government – Health Ministry**	**5**	**UN/Multilateral agency**
	1	**Government – Other ministries**	**2**	**Bilateral agency**
	4	**NGO/Community-based organizations**	**1**	**Academic/Educational Organizations**
	3	**Private Sector**		**Religious/Faith groups**
	1	**People living with HIV/TB/Malaria***		**Other** (please specify):
If the proposal is NOT submitted through a CCM, briefly state why:	Not Applicable			

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund:** *Table I.b*

			Amount requested from the GF (USD thousands)					
			Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Component(s) (mark with X)**:**	**X**	**HIV/AIDS**	16630	21760	24340	23610	14865	**109970**
		Tuberculosis						
	X	**Malaria**	20134	22128	20162	13683	12610	**88717**
	X	**HIV/TB**	662	2006	4058	3953	4141	**14820**
		Total	**37426**	**45894**	**48560**	**41246**	**40381**	**213507**
Total funds from other sources for activities related to proposal [1,2,3]			**83230**	**89480**	**97480**			

1 These figures represent budgetary allocation for these diseases in the Central Plan. There is substantial commitment of resources for State Governments, and the private sector, which is difficult to quantify,
2 Year 1 refers to financial year 2004-05
3 Year 4 & 5 extends into the 11th 5-year plan, outlays for which have not yet been finalized.

Please specify how you would like your proposal to be evaluated** (mark with X):

The Proposal should be evaluated as a whole	
The Proposal should be evaluated as separate components	**X**

* According to national epidemiological profile/characteristics
** If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.
*** This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

Brief proposal summary (1 page) (please include quantitative information where possible)**:**
HIV/AIDS COMPONENT

Describe the overall goals, objectives and main activities per component, including expected results and timeframe for achieving these results:

Goal:

The overall goal of this component is to leverage public-private-civil society partnerships in order to integrate a comprehensive HIV/AIDS prevention, care and treatment package into primary health care, at workplaces, at community levels (through innovative IT driven channels), and in two low prevalence states.

Objectives:

1. To provide in the workplace, access to care, support and treatment inclusive of interventions for HIV prevention. **2 (a)** To utilize innovative information technology (IT) driven modalities to deliver a package on education, communication and training that addresses at community levels, the vulnerable groups, people living with HIV/AIDS, as well as health care providers in the 49 high prevalence districts. **2 (b)** To bring about mid-course correction, and move from an exclusive focus on high risk groups in high prevalence states only, to now include two low prevalence but high risk states, BIHAR & JHARKHAND, which contribute large numbers of migrants to high prevalence districts, and to access communities at village levels through three existing networks that will add on the package for HIV/AIDS prevention, care and support on to existing dissemination in respect of reproductive and child health services. **3.** To close the access gap in respect of interventions for prevention with care, support and treatment of HIV/AIDS as a continuum, by (a) expanding VCTCs from district level hospitals and medical colleges to community health centres (CHCs) with strong referral services to district hospitals for treatment, care and support; and (b) by increasing the number of community care centers to one per district in the 49 high prevalence districts which will supplement the ongoing continuum of HIV/AIDS prevention, care, support and treatment through referral linkages with district hospitals. Support of the Global Fund would enable us to operationalise these objectives, and include ART for people living with HIV / AIDS.

Main activities:

1. This proposal covers 49-high prevalence districts in the six high-prevalence states of Manipur Nagaland, Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu, and the main activities include: **(1)** Installing voluntary counselling and testing centres in prominent workplaces in 49 high prevalence districts to access the workforce in the formal and the informal sectors with a comprehensive package on HIV/AIDS prevention, care and support, inclusive of referrals for treatment, in association with networks of people living with HIV/AIDS (PLHAs) . **(2)** Providing voluntary counselling and testing services at Community Health Centres (CHCs) covering a defined population of approximately 200,000 with appropriate training of doctors and outreach workers, involvement of PLHAs, and referrals to district hospitals for treatment. **(3)** Setting up and activating one community care centre in each of the 49 high prevalence districts. **(4)** Utilise the infrastructure (487 community information centres in the north-east, with enormous band-width) created by the Ministry of Information Technology (IT), in order to disseminate accurate and complete knowledge / information on HIV/AIDS prevention, care and support, to communities and health care providers across north eastern states. **(5)** Utilise three existing networks that reach down to village levels in two high risk but low prevalence states of Bihar and Jharkhand, integrating the package on HIV/AIDS prevention, care and support to existing activities on reproductive and child health (RCH). **(6)** Developing protocols for rational use of drugs for Opportunistic Infections (OIs) and Anti Retroviral Therapy (ART) and training of doctors and health care providers across the public and private sectors.

Expected results

1. 10 million people living in rural areas surrounding 49 community health centers of the high prevalence districts will access education, information and advocacy on HIV/AIDS.
2. 10 million people will have access to VCTCs with about 500,000 people actually using these services in rural areas.
3. An estimated 30,000 health care providers, NGOS, CBOs will be trained across the public and private sectors for appropriate implementation of approved strategies and policies.
4. 20,000 cases of full-blown AIDS will receive anti retroviral therapy.
5. Successful demonstration of integrating existing networks on reproductive and child health by adding on HIV/AIDS prevention and care.

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them** (including target populations and their estimated number):

  Overall benefits of the project include national capacity building, increased access to ART, an additionality of nearly 200 VCTCs, increased community awareness and NGO/CBO plus health care provider training and education**.** The primary beneficiaries will be PLHAs, migrant populations, rural communities, workforce in the formal and informal sectors and the providers of health care.

- **Indicate if the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal**

  The proposal intends to scale up VCT services to rural sectors based on the lessons learnt from existing VCTCs in respect of major concerns of the clients, quality of counselling and use of rapid HIV test kits. New initiatives include **(1) application** of IT driven technologies to disseminate education and advocacy about the prevention, care and support of HIV / AIDS in 7 districts in the north – east; **(2)** integration of HIV / AIDS (in two low prevalence states), on to existing networks that access village levels, that are so far delivering only RCH services **(3)** training of NGOs and CBOs, on a large scale to disseminate protocols for prevention, care and support in HIV / AIDS

- **If there are several components, describe the synergies, if any, expected from the combination of different components** (By *synergies*, we mean the added value the different components bring to each other, or how the combination of these components may have effects beyond the effects of each component taken)

  All the three objectives in this component will be implemented through public-private-civil society partnerships with substantial community participation. There will be synergy in capacity building as well as dissemination of information related to disease prevention and control. The component will also strengthen infrastructure within the primary health care system in India. Such synergy would also help in reducing stigma and discrimination against PLHAs, who will be mainstreamed in the implementation.

Brief proposal summary
MALARIA COMPONENT

Describe the overall goals, objectives and main activities per component, including expected results and timeframe for achieving these results:

Goal:

To reduce the burden of malaria morbidity and mortality in predominantly tribal and marginalized sections living in under developed areas covering a population of 124 million and bring it down to the national average of 2 per 1000.

Objectives:

Expand outreach of early diagnosis and treatment in remote inaccessible areas through community participation by using rapid diagnostic kits and blister packs of anti-malarial drugs; improve accessibility to hospitalized care by strengthening peripheral hospitals; increase coverage of insecticide treated bed nets to at least 40% through public/private/NGO partnership and selective and decreasing use of indoor residual spray.

Broad activities:

Rapid diagnostic kits, blister packs for adults and artemisinine derivative injections in small hospitals will be provided. Coverage of insecticide treated bednets will be increased through free and subsidized supply, sale through commercial channels and treatment of community owned bednets. Selected areas will be sprayed with Synthetic Pyrethroids (SP).

Expected results at the end of project (2004-2008): About 1.5 million cases of malaria in 5 years (or 0.3 million annually on an average) and nearly 1000 deaths (or roughly 200 deaths annually) would be prevented and access to prompt health care provided to 124 million poor people leading to better equity and improved health and economic status. ITN coverage would increase to 40%.

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them** (including target populations and their estimated number):

  The direct beneficiaries would be 124 million people including nearly 2.5 million pregnant women and 12 million children less than 5 years of age. Indirectly, there would be the reduced risk of spread of malaria to other parts of the country.

- **Indicate if the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal**

Use of rapid diagnostic kits and blister packs through community volunteers; introduction of artemisinine injections in peripheral hospitals and treatment of community bednets are new initiatives. Distribution of free or subsidized bednets is scaling up of existing efforts. IRS is an ongoing activity but SP has not been used.

The lessons learnt: Blister packs in Maharashtra and treatment of community owned bednets in limited pockets has been successful and there is a public demand for the same.

Best Practices: The proposal is limited to areas, which are under-developed and largely tribal, with priority to people below poverty line, young children and pregnant women. Established national/international standards and World Bank guidelines for procurement will be followed. Civil society and NGOs will be involved in micro planning and operational activities. Funds will be audited.

Innovation: Involvement of community volunteers for treatment and collaboration of the civil society, NGOs and private sector for treatment of community owned bednets.

Brief proposal summary
HIV/TB COMPONENT

Describe the overall goals, objectives and main activities per component, including expected results and timeframe for achieving these results:

HIV Tuberculosis collaborative project expanding VCT services in rural communities of high prevalence states

Goal:

The **overall goal** of this component is reduction in TB related morbidity in people living with HIV/AIDS while preventing further spread of HIV and TB in the rural population of six high HIV burden states.

Objectives:

(i) To **strengthen** AIDS-TB programme collaborations at all levels (national, state, district and sub-district); (ii) To **promote** early diagnosis and treatment of TB in HIV infected persons at the sub-district level; (iii) To **increase coverage** of HIV prevention and care interventions; (iv) To **increase demand** for prevention, care and support for HIV and TB through community mobilization and capacity building at community level.

Broad areas of activities:

(i) **Establishing joint HIV/TB co-ordination committees** and HIV/TB units at the National and State levels for close co-ordination, implementation and monitoring; (ii) **Establishing strong referrals and linkages** on sub district level between existing RNTCP infrastructure and the newly established sub-district level VCT which increases the reach of the NACP; (iii) **Increasing capacity** through infrastructure measures, recruitment, training of health care workers, provision of services in counseling, testing, condom promotion, treatment of opportunistic and sexually transmitted infections, establishing referral linkages with care, including home based and community care, and developing strategies for ART delivery at district level; (iv) **Increasing demand** for health services through awareness raising and mobilization of political leaders, NGOs, CBOs, private practitioners, women's organizations, PLWHAs and faith-based organizations and increasing capacities of communities to provide care

Expected results: (i) Improved monitoring and surveillance of the HIV/TB dual epidemic. (ii) Decreased TB related morbidity and mortality in people living with HIV/AIDS. (iii) Increased access to health services including voluntary counseling and testing, HIV prevention and care. (iv) Reduced social stigma and discrimination in rural communities. (v) Increased involvement and capacities of communities and civil society including PLWHA groups in health including TB and HIV prevention, treatment, care and support.

Timeframe: The project will be over a period of five years from March 2004 to February 2009.

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them** (including target populations and their estimated number):

The immediate beneficiaries of the component are people with HIV/AIDS, people with TB and their families in rural areas of six high HIV prevalence states. There were an estimated 460,000 adults who were living with HIV in the rural communities of the six high burden States in 2001 who will be provided access to services under this component. Overall an estimated 80 million rural adult population will be targeted during the project period with IEC services and provided access to voluntary counseling and testing facilities.
People living with HIV and especially those co infected with *M. tuberculosis*, will have early access to TB diagnosis treatment, HIV counseling and testing, treatment of sexually transmitted infections and opportunistic infections, and care and support.
Beneficiaries will be involved in planning & coordination, service delivery, in IEC and community mobilization. Beneficiaries will be members of the coordination committees at the National, State and District levels will be responsible for planning and implementation of the component and for influencing policy decisions.
Cured TB patients and PLWA will further be involved as outreach workers for home or community based care programmes and in providing treatment support for TB and HIV and will help in strengthening the links between the health centers and the community

Cured TB patients and PLWA will play a crucial role in peer education through counseling and information dissemination. They will be preferred as counselors in the sub-district VCT. This will give a unique opportunity to involve PLWA and to reduce stigma and discrimination in the medical setting as well as in the community.
Both, cured TB patients and PLWA groups and their families will be part of awareness raising and sensitization efforts in the communities and with decision-makers. Formation of self-help groups by PLWA will be encouraged and their active participation will be sought in all HIV/AIDS related activities.
Provision of integrated and well linked HIV counseling and testing (VCT) services close to the community will improve accessibility for rural populations particularly for high risk groups and vulnerable segments of the population such as women, young people and migrant workers.

- **If there are several components, describe the synergies, if any, expected from the combination of different components** (By *synergies*, we mean the added value the different components bring to each other, or how the combination of these components may have effects beyond the effects of each component taken)

All the three components will be implemented through public-private-civil society partnerships and substantial with community participation. There will be synergy in capacity building as well as dissemination of information related to disease prevention and control. The components will also strengthen infrastructure of the primary health care system in the country. Such synergy would also help in reducing stigma and discrimination against PLWAs.

- **Indicate if the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal**

The HIV/TB component builds on the strengths and an experience of a successful TB programme and aims at synergizing efforts between the NACP and the RNTCP**.** It strengthens the collaboration between the National AIDS Control Programme and the Revised National TB Control Programme, which was started in November 2001 with the development of an action plan on HIV/TB co-infection. The VCT facilities are currently available in the district headquarters all over the country. These centres have been innovatively used for developing linkages with DOTS centres and sputum microscopy centres of the RNTCP. This has facilitated early detection and treatment of HIV positive patients with TB disease.
RNTCP has been scaled up to more than half the country covering both rural and urban population. Lessons learned at the district level bringing synergy between RNTCP and NACP programmes will be applied at sub-district level, thus providing an opportunity to the clients to avail services under one roof. A unique feature of the component is the emphasis on strong TB and HIV collaboration and the linking of services on all levels for the benefit of the clients. New HIV/TB collaborative units will be set up at National and State levels for strengthening of the programme co-ordination mechanisms. The component also includes a strong community participation and mobilization part, which is a reflection of a united response to HIV/AIDS and TB between the government and civil society in India.

SECTION II: Information about the applicant

Table II.a serves to help you know which questions you should answer in this Section, reflecting the different types of application mechanisms and proposals.

For further guidance on who can apply, refer to Guidelines para. II.8–33

Table II.a

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal *(Guidelines para. 14–15)*	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition *(Guidelines para. 14–15)*	1–9 and 10
	Small Island States proposal with representation from all participating countries but without need for national CCM *(Guidelines para. 24 and 25)*	
Sub-national CCM	Sub-national proposal *(Guidelines para. 27)*	1–9 and 11
Non-CCM	In-country proposal *(Guidelines para. 28–30)*	12 – 16
Regional Non-CCM	Regional proposal *(Guidelines para. 31)*	12 – 15 and 17

Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines para. 32)

Country Coordinating Mechanism (CCM), (Refer to *Guidelines paragraph 72–78)*

Table II.b

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	Yes
b). Has the composition of the CCM changed since the last submission?	Yes
c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives)**:** Representatives of the Ministry of Finance, and the UNFPA, have been included. There is now only one Joint Secretary from the Health Ministry, against the earlier two**.**	

1. **Name of CCM** (e.g., CCM Country name, National Committee to fight AIDS, TB and Malaria, etc):

   The Country Coordinating Mechanism for the Global Fund – India

2. **Date of constitution of the current CCM** (The date the CCM was formed for the purpose of the Global Fund application. If the CCM builds on or uses existing processes – which is encouraged – please explain this in Question 3)**:**

   28th December 2001

3. **Describe the background and the process of forming the CCM (including whether the CCM is an** entirely new mechanism or building on existing bodies, how the other partners were contacted and chosen, etc.), (1 paragraph):

   The CCM, established in December 2001, is a new mechanism in India. However, it draws upon membership of different committees that have been set up to coordinate and monitor the national response to HIV/AIDS, tuberculosis and malaria. It provides a forum for strengthening efforts in controlling these diseases. In addition to Government of India representatives, the CCM includes representation from the apex medical research organization in India i.e. the Indian Council for Medical Research. This is an autonomous body setup under a statute, and the head of the Council (Director General) is a member of the CCM. There are 4 NGO

representatives on the CCM, each of whom brings diverse experience to this body. They have been active in the area of public health for a considerable period of time. The 4 NGOs also represent the 4 different regions of the country – an important consideration in a country of India's size and diversity. The YRG Care focuses on evidence-based research, and care and support for people living with HIV and AIDS (PLWHA). The Sewadham Trust is an NGO, which is active in the areas of public health, education and women's development; it also runs hospitals and operates mobile clinics in rural areas. The Vivekananda Education Society works in a number of areas related to prevention and treatment of drug abuse, STD and HIV / AIDS control, and also has programmes for women and children. The Voluntary Health Association of India is one of the largest health and development networks in the world and excels at involving communities in the health activities it supports. The private sector is represented on the CCM by the three major industry associations of the country. The Indian Network of Positive People, represented on the CCM is the coordinating body for HIV positive networks in different states of India. The UN and bilateral agencies have been chosen on the basis of their involvement in the 3 disease control programmes in India.

3.1 If the CCM is or includes an already existing body, briefly describe the work previously done, programmes implemented and results achieved (1 paragraph):

As explained in paragraph 3 above, the CCM draws upon membership of existing committees already set up to coordinate the national response to the three diseases. Three national disease control programmes are being implemented with assistance from the World Bank, and bilateral and UN agencies, and have achieved considerable success in their respective programs.

4. Describe the organizational processes (e.g., secretariat, sub-committee, stand-alone; describe the decision making mechanism. Provide Terms of Reference, operating rules or other relevant documents as attachments), (1 paragraph):

The CCM has been created by an executive order and is headed by the Secretary (Health) of the Government of India. Its terms of reference are to prepare India's application for the Global Fund, to assume responsibility for programme implementation out of the assistance received from the Fund, to ensure monitoring and evaluation thereof, and to assume accountability for the above towards the Board of the Global Fund. The Secretariat of the CCM is located within the Ministry of Health & Family Welfare of the Government of India. No formal rules have been prescribed, and the CCM is free to devise and finalize its operating procedures and formalities.

A copy of the order constituting the CCM and laying down its Terms of Reference is attached.

5. Describe the mode of operation of the CCM (e.g., frequency of meetings, functions and responsibilities of the CCM. Provide the minutes or records of previous meetings as attachments), (1 paragraph):

The CCM is to meet as often as required, and has held 8 meetings so far. Its functions and responsibilities are included in the order attached. The minutes of the previous meetings are also attached.

A Core Group of experts has been formed to assist the CCM in scrutiny of proposals received for inclusion in the Comprehensive Country Proposal. The members of the Group are WHO; Indian Council for Medical Research; the NGO, Voluntary Health Association of India (all are also members of the CCM); and a representative of the Centre for Disease Control. Since the last round of funding, this Core Group has met on 3 different occasions to consider individual applications, and has made suitable recommendations to the CCM.

6. Describe plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required (1 paragraph):

The constitution of the CCM has been changed to reflect a wider range of stakeholders. A representative of the Ministry of Finance has been included in place of one from the Health Ministry. In addition, the UNFPA has also been included as a member of the CCM.

It is also proposed to form sub-groups of the CCM on the following issues: proposal development, programme implementation, and monitoring and evaluation. Once these sub- groups are in place the functioning of the CCM would be streamlined further. It is also proposed that these sub groups may also associate subject experts from outside the CCM to assist in their work.

To address the concerns of NGOs and CBOs, a series of consultation have been held since submission of India's application for the last round of funding assistance. These are, *in seriatim*:

1. National Consultation with NGOs organized by the CCM on 24th Jan. 2003. A copy of the proceeding is attached.
2. Interaction of NGOs with the Executive Director of the Global Fund organized at Mumbai on 6th March 2003.
3. Meeting of NGOs, including a teleconference with Mr. Taufiqur Rahman of the Global Fund, facilitated by UNAIDS on 8th April 2003.

The Consultations have also been useful in identifying priority areas for seeking Global Fund assistance. This process is proposed to be continued, and also to be further decentralised with regional-level consultations.

7. Members of the CCM (*Guidelines para. II.16 – 22)*:

Please note: All representatives of organizations included in the CCM must sign this page to be included in the original, hard-copy proposal sent to the Secretariat. The signatures must reach the Secretariat before the deadline for submitting proposals. Please print additional pages if necessary, including the following statement:

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Table II.7

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Health & Family Welfare (Gov Sector)	Mr. S K Naik	Secretary (Health)		
Main role in CCM				
Heads the CCM and coordinates the work of managers of the various disease control programmes				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Directorate General of Health Services (Gov Sector)	Dr S P Aggarwal	Director General of Health Services		
Main role in CCM				
Heads the technical wing of the CCM, and responsible for integrating inputs of technical managers of the HIV, Malaria and TB programmes				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
National AIDS Control Organization (Gov Sector)	Ms. Meenakshi Datta Ghosh	Additional Secretary & Project Director, NACO		
Main role in CCM				
Programme Manager of the National AIDS Control Program				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Health and Family Welfare (Gov Sector)	Mr. Deepak Gupta	Joint Secretary		
Main role in CCM				
Programme manager of the Malaria and Tuberculosis Control Programmes				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Health and Family Welfare (Gov Sector)	Shri Rakesh Behari	Joint Secretary and Financial Advisor		
Main role in CCM				
Manager of the finances of the CCM				

* E.g. People living with HIV/ TB/ Malaria, NGOs/ Community-based Organisations, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

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Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Finance	Mr. Ajay Seth	Director		
Main role in CCM				
Representative of the Ministry Of Finance on the CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Indian Council Medical Research & Ministry of Health & Family Welfare (Gov Sector)	Dr N K Ganguly	Director General		
Main role in CCM				
Review proposals, and provide recommendations for improvement; identify links to ongoing research				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Directorate General of Health Services (Gov Sector)	Dr L S Chauhan	Deputy Director General (TB)		
Main role in CCM				
Technical manager of the Tuberculosis Control Programme				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Directorate of National Anti Malaria Programme (Gov Sector)	Dr Jotna Sokhey	Director		
Main role in CCM				
Technical manager of the National Anti-Malaria Programme				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Vivekananda Education Society (NGO)	Shri C G Chandra	Secretary		
Main role in CCM				
Brings NGO perspective of NGOs working with women and children, IDUs. Represents eastern part of country				

Agency /Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Y R G Care (NGO)	Dr Suniti Solomon	Director		
Main role in CCM				
Helps evaluate the functioning of the CCM based on experience in epidemiologic surveillance, clinical care and support of people living with HIV/AIDS and PMTCT. Represents southern part of country				

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Sevadham Trust (NGO)	Dr S V Gore	Managing Trustee		
Main role in CCM				
Brings NGO perspective of NGOs working with vulnerable including tribal populations. Representative of central India.				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Indian Network for People Living with HIV / AIDS	Shri K.K.Abraham	President		
Main role in CCM				
Represents the concerns and interests of people living with HIV/AIDS in India				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Voluntary Health Association of India (NGO)	Shri Alok Mukhopadhyay	Chief Executive		
Main role in CCM				
Represents activist umbrella organizations of NGOs working at the grass-roots in different parts of India. VHAI will help monitor the sustainability, cost effectiveness of the projects and good governance of the CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
FICCI (Federation of Private Sector Organizations)	Mr. Vivek Bharti	Advisor		
Main role in CCM				
Represents the private sector on the CCM				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Confederation of Indian Industries (CII) (Private Sector)	Dr Sandhya Bhalla	Programme Director		
Main role in CCM				
To foster collaboration between the CCM and private sector industries				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
The Associated Chambers of Commerce and Industry of India (ASSOCHAM) (Private Sector)	Shri Sanjay Bechan	Advisor (Projects)		
Main role in CCM				
To foster collaboration between the CCM and private sector industries				

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
UNAIDS	Nandini Kapoor Dhingra	National Programme Officer		
Main role in CCM				
Provide technical support for proposal development, review and monitoring				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
DFID (Bilateral)	Mr Tim Martineau	Senior Advisor, Health		
Main role in CCM				
Provide technical inputs and represent DFID on CCM, to help identify gaps and areas of synergy				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
USAID (Bilateral)	Dr Victor Barbiero	Director- Population, Health and Nutrition, India		
Main role in CCM				
Provide technical inputs and represent USAID on CCM, to help identify gaps and areas of synergy				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
World Bank	Dr K Sudhakar	Senior Public Health Specialist		
Main role in CCM				
Provide technical inputs, monitoring and represent World Bank on the CCM, to help identify gaps and areas of synergy				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
WHO	Dr. Salim J. Hebayab	WR (India)		
Main role in CCM				
Provide technical input to proposal development and monitoring and to help identify gaps and areas of synergy for projects				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
UNICEF	Dr Anne Vincent	Project Officer Health/ O/c HIV/AIDS Programme		
Main role in CCM				
Provide technical input to proposal development and monitoring, in particular women and children and to integrate CCM activities with UNICEF supported projects in India				
Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
UNFPA	Mr. Francois M. Farah	Representative		
Main role in CCM				
Provide technical input to proposal development and monitoring, and to integrate CCM activities with UNFPA supported projects in India				

7.1 Provide as attachment the following documentation for private sector and civil society CCM members:

- Statutes of organization (official registration papers)
- A presentation of the organization, including background and history, scope of work, past and current activities
- Reference letter(s), if available
- Main sources of funding

These were provided with the application for the second round of assistance. Here has been no change in the composition of this constituency.

7.2 If a CCM member is representing a broader constituency, please provide a list of other groups represented.

8. Chair of the CCM and alternate Chair or Vice-Chair

Table II.8

	Chair of CCM	**Alternate Chair/Vice-Chair**
Name	Shri S K Naik	
Title	Secretary (Health)	
Address	Nirman Bhavan, Maulana Azad Road New Delhi	
Telephone	91 11 23018863	
Fax	91 11 23014252	
E-mail	secyhealth@nb.nic.in	
Signature		

9. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.9

	Primary contact	**Second contact**
Name	Shri Deepak Gupta	Shri K.K. Gupta
Title	Joint Secretary, Ministry of Health	Asst. Director (Finance), NACO
Address	Nirman Bhavan, Maulana Azad Road New Delhi	9th Floor, Chandralok Building 36, Janpath, New Delhi
Telephone	91 11 3019195	91 11 3731958
Fax	91 11 3018842	91 11 3731746
E-mail	jsd@nb.nic.in	kkgupta@nacoindia.org

10. For coordinated regional proposals and Small Island States proposals describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve *(Guidelines para. II.24),* (1 paragraph):

Not Applicable.

10.1. For coordinated regional proposals, provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment (e.g., letter of endorsement from Chair/Alternate of CCM or equivalent documentation).

Not Applicable.

11. Sub-national Proposal from Large Countries

Not Applicable.

11.1. Explain why a sub-national CCM mechanism has been chosen (1 paragraph):

Not Applicable

11.2. Describe how this proposal is consistent and fits with nationally formulated policies and/or how it fits with the national CCM plans *(Guidelines para. II.27),* (1 paragraph):

Not Applicable.

11.3. Provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment *(Guidelines para. II.27),* (e.g., letter of endorsement or equivalent documentation).

Not Applicable.

Non-CCM applicant

12. Name of applicant:

13. Representative of organization applying:

Table II.13

	Representative	Alternate
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

14. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.14

	Primary contact	Secondary contact
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

15. Description of applying organization

15.1. Indicate what type of organization the applicant is (mark with X):

Table II.15.1

	Non-Governmental Organization (NGO) or network of NGOs
	Community based Organization (CBO) or network of CBOs
	Private Sector
	Academic/ Educational Sector
	Faith-based Organization
	Regional Organization

15.2. Provide as attachment the following documentation:

- **Statutes of organization** (official registration papers)

- **A presentation of the organization, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

16. Justification for applying outside the CCM

16.1. Indicate reasons for not applying through the CCM (Explain clearly the circumstances, conditions and reasons; *Guidelines para. II.28–29*), (1–2 paragraphs):

16.2. Have you been in contact with the CCM in your country or other relevant governmental agencies (e.g. Ministry of Health, National AIDS Council)**? If so, what was the outcome? If not, why?**

16.3 Include letters from supporting organizations (e.g. human rights groups, NGO networks, bilateral or multilateral organizations, etc) supporting your reasons for not applying through a CCM as attachment.

17. For regional proposals from Regional Organizations or International Non Governmental Organizations, describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve *(Guidelines para. II.24),* (1 paragraph):

17.1. Provide signed letters of endorsement from the national CCMs or, if there is none, from other relevant national authority for the countries covered by the proposal as attachment.

SECTION III: General information about the country setting

*Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country.*
*For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.*
For further guidance, refer to Guidelines Part III

18. Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria: (Describe current epidemiological data on prevalence, incidence or magnitude of the diseases; its current status or stage of the diseases; major trends of the diseases disaggregated by geographical locations and population groups, where this data is available and/or relevant*)* (1 – 2 paragraphs per disease covered in proposal):

TB, HIV/AIDS and Malaria together account for almost 30% of the annual mortality due to infectious and parasitic diseases in India (World Health Report, 1999). Almost 4 million people are currently infected with HIV in India (UNAIDS, Global report 2002). Each year, there are an estimated 2 million new TB cases and between 2 and 2.5 million new cases of malaria in India.

HIV/AIDS

With an estimated 4 million people infected with HIV (0.8% of the adult population, age 15-49), India has the second highest number of people living with HIV in the world after South Africa and the highest number in South Asia. HIV/AIDS in India accounts for nearly 10% of the global HIV/AIDS burden and 68% of the total burden for South Asia. Given India's large population, a mere 1 percent increase in HIV prevalence increases the number of people infected with HIV by around 5 million.

The burden of HIV/AIDS, and major modes of transmission vary throughout India. The highest prevalence rates (general epidemic) are reported from six states, four in the South with a predominantly sexual mode of transmission and two States in the North-East, with an epidemic driven predominantly by injecting drug use. These six states with a population of 291 million account for almost 90% of all infections in the country. Each state has at least one district in which HIV prevalence rates among pregnant women exceed 2% and some reach as high as 5%. UNAIDS has estimated that there are more than 170,000 children under the age of 15 living with HIV. More than 90% of people with HIV infection do not know that they are infected.

There is also disturbing evidence that the epidemic is increasing in other states. The epidemic is moving from high-risk groups to the general population and from urban to rural areas. Factors that contribute to this increase include heavy migration to high prevalence areas for employment (35 million people migrate every year in search of employment), high rates of sexually transmitted infections, low condom use, and high levels of ignorance and sexual promiscuity among young people.

Although only 49,196 AIDS cases were reported in by April 2003, the burden of disease is being felt in the high prevalence states, and hospitals caring for people living with HIV have noted that many come from rural areas where awareness is low, stigma, particularly against women is common, and options for care and treatment are limited.

MALARIA

Malaria is a major public health problem in India with around 2 million laboratory confirmed cases being reported annually. India contributes more than three –fourth of the total cases in the South East Asia region (estimated 1,424,240 DALYs lost annually). Although the high transmission areas are currently limited to 20% of the population, the risk of spread to other areas with low endemicity remains many risk factors such as suitable ecological conditions, large pace of developmental and industrial activities, urbanization and high migration of people. The areas of high burden are remote, under-developed, with poor health infrastructure and difficult terrain. There are 9 major vectors with different bionomics and insecticide susceptibility. Pockets of drug resistance to chloroquine have also been recorded, although these are fortunately small and focalized except in parts of the northeast along international borders with Nepal, Myanmar and Bangladesh where the problem is more acute.

The annual parasite incdence has declined from the high of 11.2 per 1000 population in 1976 to less than 2 in 2002. 6.75 million cases were reported in 1976, the highest since the resurgence of malaria in the 1970s. The central government provides technical and material support to the state governments who bear the entire operational costs and also procure additional supplies, if required. The diagnosis of malaria is based on the examination of blood smears from cases of fever; nearly 100 million fever cases are screened annually. There does not appear to be a gender or age bias in the cases reported; about 60% of the cases are in patients 15 years and above. The proportion of *P.falciparum* cases is around 48%. These rates are much higher in Assam, Mizoram and Tripura in the northeast. In 1994, the government of India increased its assistance to the northeastern states by meeting operational expenditure in addition to supply of antimalarial drugs and insecticides. An Enhanced Malaria Control Project (EMCP) was started in September 1997 in tribal areas of 100 districts in 8 states. The five-year Project has been extended by one year till March 2004. A significant decline has been recorded in 55 of the 100 districts from 0.49 million cases in 1997 to 0.29 million cases in 2001 with a corresponding decline in the API from 12.8 to 6.9. 22 districts have reached the national average of 2 per 1000.

The 113 districts included in the proposal, out of 585 districts, reported 0.67 million cases or 44% of the total 2.09 million cases and 427 deaths out of a total of 1005 deaths due to malaria in 2001. The API, based on blood slide examination of fever cases to confirm diagnosis of malaria was 5.38 against the national average of 2.12. The surveillance system is inadequate in the areas covered in the proposal and it is likely that the API is higher than reported.

The 113 districts have been segregated into 2 groups. **Group I** areas comprise of 49 districts in 5 states with a population of about 85 million (9% of India's population) contributing 22% of total malaria cases in the country. Major malaria vectors in these areas are *Anopheles culicifacies* and *An. fluviatilis*. *An. stephensi* is the only malaria vector in the urban areas, although in peri-urban areas *An. culicifacies* also transmits malaria. *An. culicifacies* is resistant to DDT; *An. fluviatilis* is susceptible to DDT and other insecticides. In case of *An. stephensi* the approach to vector control is the killing of aquatic stages of the mosquitoes.

Group II comprises of 7-northeastern states. The risk of malaria is high in this region due to ecological factors like excessive rainfall, floods and geographical factors like hilly and forested terrain. The population of these states is predominantly tribal with habitations scattered over large distances. Malaria is transmitted by highly efficient vectors like *An. dirus, An. minimus and An. fluviatilis. An. dirus* inhabits deep jungles, while *An. minimus* colonizes the degraded forests. Both *An. minimus* and *An. fluviatilis* breed in slow running streams, which are in abundance all over the northeastern region because of hilly terrain. As some of the vectors here are exophillic and others endophillic, a mix of strategies has to be adopted to provide relief from malaria. Map showing proposed districts is given in the Attachment 1.

HIV/TB

Tuberculosis (TB) is a serious public health problem in India. It is estimated that 40% of the Indian population is infected with Mycobacterium tuberculosis accounting for nearly 1/3rd of the global TB burden.[1,2] Every year there are about 2 million new TB cases of which nearly 1 million are infectious smear positive pulmonary cases.[1,3] More than 1,000 people die of TB every day.[4]

The problem of TB in India is further compounded by HIV. **Active TB disease** is the commonest opportunistic infection amongst HIV-infected individuals.[6] Amongst all AIDS cases reported so far in India, 55-60% had TB (NACO India Country Report, 2001). With an estimated 40% of the population already infected with TB, and a 7% annual breakdown rate amongst those co-infected with HIV, HIV-associated TB will increase the magnitude and severity of the TB epidemic.[7]

Unlike for HIV/AIDS, a low cost cure for TB exists and is provided through the internationally accepted DOTS strategy. DOTS is the WHO-recommended technical and management package aimed at achieving the twin goals of more than 85% cure rate and 70% case-detection rate of new infectious TB cases. The Revised National TB Control Programme (RNTCP) adopted the DOTS strategy and diagnosis and treatment of TB are free for all patients. Standard regimens of RNTCP, particularly if supervised properly, are equally effective in HIV positive and HIV negative people (Perriens et al, NEJM 1995; 332: 779-784). Treatment of TB disease in HIV-infected people using DOTS has shown to improve survival (Alwood et al, AIDS 1994; 8:1103-8). Since the start of the RNTCP more than 1.8 million people with TB have been diagnosed and treated under DOTS. The cure rate in the 4th quarter of 2002 ending March 2003 was 85%

[1,2] For references please see proposal round 2, Attachment TB5 which is enclosed as Attachment GD 7

19. Describe the current economic and poverty situation (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource

availability; highlight major trends and implications of the economic situation in the context of the targeted diseases*)* (1–2paragraphs):

India has most recently been classified as a middle income country (UNDP, 2002) reflecting some significant development gains made over the past decades. However, several indicators such as level of education and access to health care are reflective of major discrepancies in the country between men and women, rich and poor, rural and urban. With 16% of the world's population, India accounts for over 20% of the world's maternal deaths.

India occupies 124th position on the HDI among 173 countries. This is the second successive year since 1999 that India has improved its HDI rank. India was ranked 130 in the HDI index in 1990; this is an improvement of 10 ranks in a decade. As is clear from the table the HDI value for India has been steadily improving since 1975. UNDP reports state that India is on the track to achieve eradication of poverty by 2015 as India's per capita income has increased sharply over past two decades. In 1980 India's per capita income was 1/14th as compared to the OECD nations, today this has improved to 1/10th.

Table III 19.1

Indicator	**India**	**Source**
Human Development Index (HDI) value and rank	0.577 (rank124 / 173)	1
HDI Trends	1975 0.406	1
	1980 0.433	1
	1985 0.472	1
	1990 0.544	1
	1999 0.571	1
Total Population (millions), 2000	1,008.9	1
GDP per capita	460 USD	2
GDP per capita annual growth rate (%), 1990-2000	4.1	1
Population below national poverty line, 1987-2000	35	1
Adult literacy rate (% age 15 and above), 2000	57.2 (m: 68.4 / f: 45.4)	1
Life expectancy at birth (years), 1995-2000	63.3 (m: 62.8 / f: 63.8)	1
Infant Mortality Rate/ per 1000 live births (99 SRS)	70*	3
Maternal Mortality Rate/ per 100,000	408	3
Crude Birth Rate (99 SRS)	26.1	3
Crude Death Rate (99 SRS)	8.7	3

* 64.6(RGI) in NHP 2002
1: HDR 2002: Human Development Report, UNDP, 2002
2: WDR 2001/02: World Development Report, 2002
3: HP 2002: National Health Policy 2002

India's population is 72% rural despite rapid urban growth over the past decade. The country has a growing economy, yet 35% of the population lives below the national poverty line. There is a sizeable amount of poverty-related population mobility, rural-urban, across states and across countries in the region. Rapid urbanization has resulted in large slum populations.

Poverty and social and economic inequalities increase vulnerability to HIV/AIDS, TB and malaria, which in turn increase poverty unless controlled. These 3 diseases affect people in their most productive years of life and have a devastating impact on children, families and communities.

20. Describe the current political commitment in responding to the diseases (indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislation, etc.; *Guidelines para. III.40),* (1–2 paragraphs):

The budgetary allocation for the Health sector has shown a significant increase over the years, This allocation for the 10th five-year plan (2002-07) is -----, compared to ---------- for the previous five-year plan. The National Health Policy accords great importance to ensuring equitable access to health services to foster balanced development and growth, and to alleviate the impact of the high burden communicable diseases including TB, HIV/AIDS and malaria. To respond more effectively to the three diseases, separate programmes and agencies have been established within the Health Ministry.

HIV / AIDS & HIV-TB

The budget of the National AIDS Control Programme (NACP II -1999 to 2004), is three times greater than the budget of Phase I, (increasing from of US $100 million to $ 300 million). For its implementation, a loan has been procured from the World Bank, thus indicating a sense of National urgency. Three national policies, the National AIDS Prevention & Control Policy (2001), the National Population Policy (2000), and the National Health Policy (2001) specifically address HIV/AIDS.

A high level of political commitment to combat HIV/AIDS is reflected in several statements by the Prime Minister Sri Atal Behari Vajpayee. Recently he stated that "HIV/AIDS is a disease that has the potential to become an epidemic with catastrophic social and economic consequences…I am concerned at the rapid rise in the number of people affected by HIV/AIDS in our country… concern equally shared by the Central and State Governments, as also by all political parties".

Several Chief ministers from high HIV prevalence States are regularly monitoring the epidemic and efforts made to combat it.

A Government – Business Partnership on HIV/AIDS spearheaded by the Prime Minister was initiated in December 2000 to involve the private sector in the response to HIV/AIDS such as through workplace interventions across the country

Recently, a Parliamentarians AIDS Forum (PAF) has been established, with an Executive Committee comprising of Members of Parliament and an MP as Convenor. The PAF has enrolled nearly 200 of the 542 Members of Parliament. It aims to reach out to all elected MPs from the center to state legislators to elected representatives at village Panchayat levels. Advocacy, social mobilization, the dissemination of complete and accurate information, and linking interventions for prevention with care and support will be the primary emphasis in the Parliamentarians AIDS Forum.

The Union Minister for Health and Family Welfare met all Project Directors and other officers of the National AIDS Control Organization on 10th May 2003 to discuss the status of implementation of the NACPII.

MALARIA

Malaria has figured prominently in the list of priorities of successive governments since the independence of the country in 1947. The National Malaria Control Program was one of the first and the largest public health programmes launched in the country in 1953. The Government of India (Central and State) contributes about 51 million USD annually towards malaria control. This amounts to nearly 35% of health budget of the Central government and more than 35% of the health budget for the states. The National Development Council of the Government of India had enhanced the central assistance to northeastern states from 50 to 100 % covering all 64 districts. The Government of India has taken loan from IDA (World Bank) of USD 164.8 million to implement the Enhanced Malaria Control Project to protect 70 million tribal populations in 8 states.

An indicator of the commitment to malaria at the highest political level is the review of the malaria situation and programme by successive Prime Ministers of India. Malaria control was identified as one of the main points in the erstwhile 20-point program of the Prime Minister of India Mrs. Indira Gandhi in the late 1970s. Following malaria epidemic in the state of Rajasthan in 1994, the then Prime Minister of India Shri P.V. Narasimha Rao reviewed the malaria situation in the country and suggested a focus on revised malaria control strategy. As a result an expert committee was appointed which undertook a thorough review of the malaria programme and recommended a Malaria Action Programme (MAP) in 1995.

21. Countries classified as "Lower-Middle Income" or "Upper-Middle Income" by the World Bank is eligible to apply only if they meet additional requirement (Guidelines Para 8). The sections below are required for proposals from these countries.

21.1 Co-financing: describe in both narrative and quantitative terms how domestic or external resources will be used to co-finance the activities described in this proposal, indicating the source and the extent of co-financing (i.e., what percentage of the budget for the proposal is covered by other resources and what percentage is being requested from the Global Fund) (2–3 paragraphs)

Not Applicable

21.2. Focus on poor or vulnerable populations: describe how underserved populations of poor and vulnerable groups will be targeted by the proposal (2–3 paragraphs)

Not Applicable

21.3. Greater reliance on domestic resources: describe in both narrative and quantitative terms how over the duration of the proposal the activities described will be increasingly financed using domestic resources, including the changes in the percentage of the budget covered by domestic vs. Global Fund resources (2–3 paragraphs)

Not Applicable

22. National context

22.1. Indicate the percentage of the total government budget allocated to health (optional for NGO applicants)**:**

0.9 % of GDP

22.2 Indicate national health spending for 2001, or latest year available, in the Table III.22.2 (optional for NGO applicants):

National health spending for 2001 --

Table III.22.2[1]

	Total national health spending Specify year: (USD) 1998-1999	**Spending per capita** (USD)
Public	3524 million	4
Private	16030 million	18
Total	19454 million	22
From total, how much is from external donors?[2]	110 million	

[1] *Source: Derived from the National Health Policy 2002*

[2] *110 million of central funds are contributed from external sources, unable to obtain figures for state and private spending*

22.3. Specify in Table III.22.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors)**:**

Table III.22.3

Total earmarked expenditures from government, external donors, etc. Specify Year: 2003-2004 (budgetary outlay)	**In US dollars:**
HIV/AIDS	47 million
Tuberculosis	24 million
Malaria	51 million
Total	122 million*

**The above figure represents spending earmarked by the Central Government; State governments also spend money out of their own resources on these diseases. The spending by the States is in addition to the totals in Table 11.21.3.*

21.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives*, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs)**:

External support is available from World Bank or Bilateral funded projects. HIPC or Sector-Wide Approaches are not applicable in India.

22.5. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.) (2–3 paragraphs):

Human resources and health infrastructure
Under the Indian Constitution, health is a state responsibility. India has a vast health care delivery infrastructure at the primary, secondary and tertiary levels with referral linkages between them. There is a total of 600 district hospitals, 4000 Community health centers, 25,000 primary health centers, 137,000 sub-centers and 160 medical colleges throughout the country.

HIV/AIDS & HIV-TB
The National AIDS Control Organization (NACO) is an autonomous body within the Ministry of Health and Family Welfare and is responsible for implementation of training, research, surveillance, program management, intersectoral collaboration with other ministries and with large government owned enterprises, advocacy and resource mobilization.

Under the National AIDS Control Programme phase II, the programme has been decentralized to the States. NACO grants funds to the State AIDS Control Societies (SACS) for targeted interventions, blood safety, IEC and youth campaigns, voluntary counselling and testing, capacity development for care and support, intersectoral collaboration, social mobilization and advocacy.

The SACS contract NGOs to implement programme activities and are presently working with more than 600 NGOs and PLWHAs are represented on the Executive Committees of the SACS. At the District levels, District Nodal Officers are appointed for AIDS to oversee the activities of the programme in their districts. Local expertise is utilized in monitoring of the programme with support of experts from academic and research institutions, and NGOs.

Voluntary Counseling and Testing Centres (VCTCs) are being set up in the 600 district hospitals. 25 Community Care Centres have been established. To address the needs of people living with HIV/AIDS the government has taken several initiatives including training of health care providers and providing drugs for the treatment of opportunistic infections in all public sector hospitals.

Mechanism to Channel Funds:
A special account is being maintained in the Reserve Bank of India, and operated by the Department of Economic Affairs (DEA) of Government of India. Withdrawal of funds from the World Bank (IDA) credit account is on the basis of actual expenditure reported in statement of expenditures (SOE).

The World Bank funds are channeled to the project through the Ministry of Finance (Department of Economic Affairs) and the Ministry of Health and Family Welfare. Replenishments for the project to the DEA are made on a quarterly basis based on the actual Statement of Expenditure received from SACS, and other implementing agencies. NACO provides funds to SACS and other implementing agencies in two installments. Accounting for the project is as per GOI regulations and has been adapted to the World Bank requirements.

MALARIA
The national anti malaria programme is implemented through the primary health care system through a vast network of primary and secondary level health facilities. There are more than 0.13 million subcentres, which are the most peripheral units. Each sub-centre covers 5 –7 villages with a population of 5000 or more. These sub-centers have 2 paramedical personnel, one of whom is a female. A primary health centre is the first level of contact with a medical doctor; each centre caters to a population of 30,000 or more. There are 22,975 Primary Health Centres functioning in the country. About 3000 community health centers, which are 30-bedded hospitals, provide referral care. There is one district hospital and one or more sub-district hospitals. There are more than 135 medical colleges and several specialized institutions. The Indian Council of Medical Research

* HIPC is a debt-relief initiative for highly indebted poor countries through the World Bank
** Optional for NGOs

has several institutions, including the Malaria Research Centre and the Vector Control Research Centre, dedicated to operational research on malaria and other vector borne diseases.

0.17 million-community volunteers have been trained and provided with sufficient quantities of chloroquine so that it is within easy reach to patients with fever in the high-risk areas.

Although, the programme implementation is through the primary health care, these are supported by specialized teams for undertaking entomological surveys, insecticide and drug resistance studies. The programme has a network of 58 functional entomological units under state government, where trained entomologists monitor variables like insecticide resistance while 13 *P.falciparum* monitoring central teams along with 15 state teams monitor drug resistance. The Malaria Research Centre (MRC), Indian Council of Medical Research has a network of 14 field stations across the country that conduct research into various aspects like vector biology, vector bionomics, resistance studies, etc. In addition to these, a number of autonomous regional institutions, state government institutions and medical colleges provide inputs for malaria control efforts.

Every state has a state programme officer looking after malaria and there are malaria officers (DMO) in charge of malaria control programme at the district level. The DMO is assisted by a number of malaria supervisors and inspectors. The directorate of NAMP is the apex body at the centre providing technical help to the states in implementation of the programme. The organizational structure at the central level of the Directorate of the National Anti Malaria Programme consists of Director, assisted by 22 senior officers specialized in public health and entomology and 17 Regional Directors in the country. Additional support of consultants for procurement, financial monitoring, social sciences, entomology and training and services on contract from specialized institutions in the public/private sector for activities such as procurement, community needs assessment and communication strategies are available under the World Bank Project.

Antimalaria drugs, insecticides, bed nets and diagnostic kits are available from indigenous sources meeting international standards.

The strategies for malaria control are holistic including early diagnosis and prompt treatment (EDPT) and integrated vector control (selective use of IRS, use of ITNs and larvivorous fish, use of larvicides in urban areas and minor engineering and environmental measures). Human resource development, capacity building, intersectoral collaboration and community participation are important strategy components.

Mechanisms to channel funds:
A financial adviser in the Ministry of Health in the central government and at the state level is responsible for the utilization of funds as per the government rules. All purchases require the clearance at various levels depending on the amount involved and are made in accordance with government approved rules and procedures.

In order to expedite flow and management of funds, health/malaria societies have been established in eight states and hundred districts under the World Bank aided project at the state and district levels. The state health secretary and the district collector act as the chairman of these societies at the state and district level respectively. For externally aided project funds received by the central government are channeled through these health societies up to the district level. The societies include non-officials and NGOs as members. In order to maintain accountability and transparency in management of funds, accountants approved by the Comptroller and Auditor General of India audit accounts of all these bodies annually.

22.6. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes (NGO applicants should specify partner organisations):

HIV/AIDS

Table III. 22.2

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period)
NACO: -Govt. of India -IDA Credit	Government	Comprehensive HIV/AIDS prevention	 **$38.8 million** **$191 million** (1999-2004)

USAID	Bilateral	Comprehensive HIV / AIDS Control in States of Tamil Nadu, Maharashtra (APAC & AVERT projects)	$**51.5 million** (1999-2004)
DFID	Bilateral	Prevention and control of HIV/AIDS and other sexually transmitted infections in States of Andhra Pradesh, Gujarat, Kerala, Orissa (PSH project)	$**21.67 million** (1999-2004)
CIDA	Bilateral	Comprehensive HIV / AIDS control in Rajasthan and Karnataka	$**7.7 million** (2001 – 2006)
UNDP	Multilateral	Strengthening effective responses to HIV/AIDS in 6 states	**$1.5 million** (2002-2004)

TUBERCULOSIS

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify Time period)
Government of India (Central Government)	Government	DOTS expansion to 700 million population	US $ 21.8 (1997-2004)
State Governments	Government	DOTS expansion in the respective States	see note below
Danish International Development Assistance (DANIDA)	Bilateral	DOTS expansion in the State of Orissa (36 million population)	110 million DKK (1997 to 2006)
Department For International Development (DFID)	Bilateral	DOTS expansion in the State of Andhra Pradesh (75 million population)	US$30 million (for 5 years)
World Bank	Multilateral	DOTS expansion in other areas of the country (about 700 million population)	US$ 142.4 million (1997-2004)
Global Fund for AIDS TB and Malaria (GFATM) *	Multilateral	DOTS expansion in 3 States of Jharkhand, Chhattisgarh, and Uttaranchal (56 million population)	US $ 8.6 million (for 3 years: 2002-05)

** Decision regarding disbursement mechanism pending*

MALARIA

Name of Agency	**Type of Agency** (e.g., Government, NGO, Private, bilateral, Multilateral, etc.)	**Main programs** (for example, Comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify Time period)
National Anti Malaria Control Programme	Government	Malaria Control	129.4 Million USD (Domestic component) 81.84 million USD Externally aided component
			400 million USD

State Health Departments	Government	Malaria Control	(It is estimated that states and local bodies roughly contribute 3 times the central contribution through infrastructure, personnel, etc
Local Government (Towns)	Local Self Government	Sanitation, Mosquito control	
Ministry of Defense	Government	Malaria control	Estimated around 50 million USD
Ministry of Railways	Government	Malaria control	
Public Sector Undertakings	Government owned	Mosquito control	
Name of Agency	**Type of Agency** (e.g., Government, NGO, Private, bilateral, Multilateral, etc.)	**Main programs** (for example, Comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify Time period)
National Anti Malaria Control Programme	Government	Malaria Control	129.4 million USD (Domestic component) 81.84 million USD Externally aided component
State Health Departments	Government	Malaria Control	**400 million USD** (It is estimated that states and local bodies roughly contribute 3 times the central contribution through infrastructure, personnel, etc
Local Government (Towns)	Local Self Government	Sanitation, Mosquito control	
Ministry of Defense	Government	Malaria control	**Estimated around 50 million USD**
Ministry of Railways	Government	Malaria control	
Public Sector Undertakings	Government owned	Mosquito control	

22.7. What is the total budget required for the different diseases, list the sources and amounts available and needed including amount requested from the Global Fund.

Table III. 22.7

Source/Agency	**Amount In US dollars (in million):**						
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
HIV/AIDS & HIV-TB							
Government	30.21	37.05	46.88	50.22	52.25	53.17	56.03
Global Fund request	00.00	00.00	17.29	23.76	28.40	27.56	27.77
Unmet need	26.06	16.70	17.29	23.76	28.40	27.56	27.77
Total need	56.27	53.75	64.17	73.98	80.65	80.73	83.80
MALARIA							
Government	36.70	38.54	40.46	42.48	44.60	46.83	49.17
Global Fund request	00.00	00.00	20.13	22.13	20.16	13.68	12.61
Unmet need	18.65	19.58	20.13	22.13	20.16	13.68	12.61
Total need	55.35	58.12	60.59	64.61	64.76	60.51	61.78

22.8. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (2-3 Paragraphs)

HIV/AIDS

The phase II programme has seen rapid implementation of programmes in every state. The main components have been targeted interventions for populations at high risk, preventive interventions for the general population, low cost care for people living with HIV/AIDS, institutional strengthening and capacity building and intersectional collaboration.

Several programmatic gaps remain including the need for:

1. Strengthening public private partnerships.
2. Strengthening interventions in and around the workplace.
3. Scaling up targeted interventions to increase coverage among high-risk groups.
4. Expanding VCTCs in high prevalence areas and rural communities, and non-traditional sites.
5. Building capacity for use of ARVs in the public and private sector. Although anti-retroviral drugs are available in the country, most people living with HIV/AIDS cannot afford them. Currenlty none are available through the national program. Funding from the Global fund (round 2) will provide, for the first time, antiretrovirals to a limited number of PLWHA (PMTCT plus in key high prevalence areas).
6. Strengthening capacity in the public and private sector for HIV/AIDS care and support including prompt treatment of RTIs, STIs.
7. Scaling up PMTCT in high prevalence areas and building capacity for PMTCT in low prevalence areas.
8. Integrating TB and HIV programmes.
9. Promoting behavior change beyond high-risk groups in the general population.

Funding gaps

When the NACP II was developed, private sector involvement, workplace interventions and provision of ARVs were not foreseen as strategic priorities. Since scientific, technical and pricing breakthroughs have made these programmes more feasible, it is critical that the country integrate these into the national programme. Similarly with the advance of rapid HIV tests, provision of VCT services on a sub district level is feasible and can complement TB efforts to reduce HIV/AIDS morbidity and mortality.

MALARIA

There are many pockets in the districts covered under the proposal, which are difficult to reach and become inaccessible during the monsoons. The risk of malaria and proportion of *P.falciparum* is high. Funds are limited in the national budget for the procurement of rapid diagnostic kits for early diagnosis and radical treatment of malaria. Peripheral hospitals are ill equipped to provide efficient case management of severe and complicated cases of malaria for which with arteether injections will be provided. Though bednet use is high in some communities, there is a lack of coordinated efforts to promote the use of nets and participation of the community in insecticide treatment. Additional funds are being requested to substantially increase the coverage of insecticide treated bednets by free and subsidized supply of 9 million bednets over 5 years, treatment of these bednets at least once a year and treatment of community owned bednets through public/private/NGO collaboration. This being a cost-effective and sustainable intervention, the project will focus on community empowerment with GFATM support. Limited quantities of synthetic pyrethroids have been proposed for DDT resistant, drug resistant and other high-risk pockets.

22.9. If a SWAP or a similar fund pooling mechanism exists in your country, briefly describe how it is functioning and if you anticipate using it to administer the Global Fund grant

No SWAP or fund pooling mechanism.

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, so the proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 26.

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component.

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X)**:**		**HIV/AIDS**
		Tuberculosis
		Malaria
	X	**HIV/TB**

24. Provide a brief summary of the component **(Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) 2-3 paragraphs):**

Rationale

TB is the most common opportunistic disease among HIV positive people in India and a major cause of morbidity and mortality. Approximately 55 - 60% of reported AIDS cases in India have active TB. Early diagnosis of HIV and TB and effective treatment of TB disease and other opportunistic infections can improve quality of life and prevent transmission of both, TB and HIV in the community.

The global and regional WHO HIV/TB strategies (SEARO, 2003, attachment HTB 1) recommend collaboration between National TB and AIDS Programmes to strengthen the response to the dual epidemic. The strategy relies on full implementation of the internationally recommended DOTS strategy, and on specific HIV prevention and care interventions.

In November 2001, before WHO's HIV/TB strategy was developed, an Action Plan on HIV/TB co-infection (attachment HTB 2) was jointly developed between the National AIDS Control Organization (responsible for implementation of the National AIDS Control Programme- NACP) and the Central TB Division (responsible for implementation of the Revised National TB Control Programme- RNTCP). As part of the action plan, mechanisms for closer collaboration between the NACP and the RNTCP were developed on national, state and district level. The plan is currently implemented in the six high HIV prevalence states Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Manipur and Nagaland,

which together account for more than 80% of reported AIDS cases in the country (NACO, March 2003).

The Government of India, through the Revised National TB Control Programme (RNTCP) has adopted the DOTS strategy since 1998 and is currently implementing DOTS in 370 districts covering a population of 655 million (RNTCP, March 31, 2003).

Under the RNTCP, Microscopy Centers (MC) have been established up to the sub district level, each serving a population of 0.1 million (0.05 million in hilly/tribal areas). These MCs are located in health centers that are part of primary health care structure of the three-tier public health care delivery system in the country. As of March 31, 2003, more than 6,500 MCs have been established in the country (attachment HTB 3 / HTB 4).

Under the NACP phase II, initiated in 1999, more than 540 VCTCs have been established in India, mostly in urban areas. It is planned that by 2004 at least one VCTC will be established in all 600 districts in the country. As districts in India have an average population of 2 million, the reach of district level VCTs is limited.

More than 70% of India's population lives in rural areas (63% in the high HIV prevalence States) and there is now increasing evidence that the gap in HIV prevalence rates between rural and urban areas is closing rapidly (attachment HTB 17: HIV Sentinel Surveillance, 2001, NACO).

This component therefore envisages improving access to health services at sub district level by establishing VCTs in sub-district health centers in rural areas of the six high HIV prevalence states (Sub-districts in India are in rural areas). These sub district level VCTs integrated within the health system and with strong linkages with the TB programme, other health services and community health facilities, will act as an entry point for prevention, care and support, and facilitate early diagnosis and initiation of anti-TB therapy for HIV positive people with TB disease.

Similarly, given the severity of immunodeficiency among patients with HIV-related TB and the proven efficacy of ART in reversing HIV-induced immunodeficiency, the use of ART in cured TB patients can substantially improve clinical outcomes, reduce TB related morbidity in HIV-infected individuals and prevent TB relapse after treatment.

This component contributes to the Government of India's goal to achieve 70% case detection of new infectious TB cases and 0% level growth of HIV/AIDS by the year 2007.

Goal
The **overall goal** is the reduction in TB related morbidity in people with HIV/AIDS while preventing further spread of HIV and TB in rural populations of six high HIV burden states

Objectives:
1. To **strengthen** AIDS-TB programme collaborations at all levels (national, state, district and sub-district);
2. To **promote** early diagnosis and treatment of TB in HIV infected persons at the sub-district level;
3. To **increase coverage** of HIV prevention, treatment and care interventions;
4. To **increase demand** for prevention, care and support for HIV and TB through community mobilization and capacity building at community level.

Broad areas of activities

(i) **Establishing joint HIV/TB co-ordination committees** and HIV/TB units at the National and State levels for close co-ordination, implementation and monitoring; (ii) **Establishing strong referrals and linkages** on sub district level between existing RNTCP infrastructure and the newly established sub-district level VCT which increases the reach of the NACP; (iii) **Increasing capacity** through infrastructure measures, recruitment, training of health care workers, provision of services in counseling, testing, condom promotion, treatment of opportunistic and sexually transmitted infections, establishing referral linkages with care, including home based and community care, and developing strategies for ART delivery at district level; (iv) **Increasing demand** for health services through awareness raising and mobilization of political leaders, NGOs, CBOs, private practitioners, women's organizations, PLHAs and faith-based organizations and increasing capacities of communities to provide care.

Expected results

1. Improved monitoring and surveillance of the HIV/TB dual epidemic.
2. Decreased TB related morbidity and mortality in people living with HIV/AIDS.
3. Increased access to health services including voluntary counseling and testing, HIV prevention, treatment and care.
4. Reduced social stigma and discrimination in rural communities
5. Increased involvement and capacities of communities and civil society including PLHA groups in health including TB and HIV prevention, treatment, care and support.

Implementation strategy

The Ministry of Health & Family Welfare, Government of India will have overall responsibility. Within the ministry, the national HIV/TB unit will be formalized and strengthened for programme co-ordination, implementation, monitoring and evaluation. The HIV/TB unit will report to the programme coordination committee (PCC), which is responsible for programme planning and policy development. Similarly, state HIV/TB units will be responsible for project implementation under the guidance of state co-ordination committees (SCC).

329 VCTs will be established in sub-district health centers in rural districts of the six high HIV prevalence States for a population of on average 500,000 (1:250,000 in hilly/difficult to access areas) closely linked to microscopy centers (MC). Sub-district VCT will be established in a phased manner, co-ordinated with RNTCP implementation of MCs in the high HIV prevalence States, which is expected to be completed by 2004.

A baseline assessment will establish sites for sub-district VCT implementation. It will also establish training, capacity, and infrastructure needs, implementation tools (guidelines, modules, etc) and the capacities of civil society [NGOs, CBOs, private practitioners (PP), women's groups, PLHA groups] in mobilization and health service delivery in each state.

Based on the assessment, sub-district VCTs will be established, staff recruited and trained, infrastructure strengthened and referrals and linkages established. District level VCT will be strengthened to provide technical, coordination and supervisory support to sub-district VCTs. Increased demand for the services provided will be achieved by community mobilization by partnering with and capacity building of NGOs/CBOs/ private practitioners.
The process will be monitored through national and state HIV/TB units

Partners involved
National level: National AIDS Control Organization (NACO), Central TB Division (CTD), HIV/TB unit. A Project Co-ordinating Committee will be formed under the chairpersonship of the Additional Secretary and Project Director, NACO who is in charge of both the programmes.

State level: State AIDS Control Societies (SACS) in co-ordination with the State TB Control Society (STCS), TB/HIV Consultant (WHO), NGOs
District level: District Nodal Officers for AIDS, District TB Control Society, HIV/TB supervisor, NGOs, CBOs, faith-based organizations, private practitioners and people living with HIV/AIDS
Sub-district level: NGO, CBOs, faith-based organizations, panchayats, local governments, PLWAs

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year)**:**	March 2004	**To** (month/year)**:**	Feb 2009

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

Indicators: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Where applicable this set of indicators should include the core indicators as listed in Annex A.

Baseline data: Baseline data should be given in absolute numbers and percentage. If baseline data is not available, please refer to Guidelines. Baseline data should be from the latest year available, and the source must be specified.

Targets: Clear targets should be provided in absolute numbers and percentage.

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.) (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

The overall goal of the component is reduction in TB related morbidity in people living with HIV/AIDS in the rural population of high HIV burden States, while preventing further spread of HIV and TB in the community.

TB is the most common serious opportunistic disease among people living with HIV in India. **55-60% of reported AIDS cases had been diagnosed with active TB** *(NACO*

India Country report 2001). In India, the risk of developing TB disease in people living with HIV is 6.9/100 person-years *(Swaminathan et al, Int J Tubercl Lung Dis 2000: 4(9): 839-844).* In addition, due to low immunity, recent HIV infection may rapidly lead to TB disease, which increases transmission of TB in the community and adds to the overall TB burden.

TB accelerates the progression of HIV to AIDS and is the cause of death in one out of every three AIDS deaths globally. Delays in diagnosis of TB disease have been associated with worse outcomes. Hence, early diagnosis and effective treatment of TB disease in people living with HIV are important. This can improve the quality of life by curing TB and minimizing the negative effects of TB on the course of HIV, and interrupting the transmission of *M. tuberculosis* to the community.

Unlike for HIV/AIDS, a low cost cure for TB exists and is provided through the internationally accepted DOTS strategy. DOTS is the WHO-recommended technical and management package aimed at achieving the twin goals of more than 85% cure rate and 70% case-detection rate of new infectious TB cases. The Revised National TB Control Programme (RNTCP) incorporates the DOTS strategy and **diagnosis and treatment of TB are free for all patients under the programme**. Since the start of the RNTCP more than 1.8 million people with TB have been diagnosed and treated under DOTS. The cure rate in the 4th quarter of 2002 was 85%. Standard regimens of RNTCP, particularly if supervised properly, are equally effective in HIV positive and HIV negative people *(Perriens et al, NEJM 1995; 332: 779-784).* Treatment of TB disease in HIV-infected people using DOTS has shown to improve survival *(Alwood et al, AIDS 1994; 8:1103-8).*

Globally, around 90% of people living with HIV infection are unaware of their HIV status, and may therefore not avail treatment services and may continue to spread HIV in the community. Provision of integrated and well linked HIV counseling and testing (VCT) services close to the community improves health service accessibility. Community mobilization and capacity building for care at community level will increase demand for health services and will reduce stigma and discrimination.

Prevention, treatment and care services will reduce the spread of HIV in rural areas, as measured by the annual rounds of sentinel surveillance. Earlier detection of TB will reduce TB transmission and contribute to improved TB case detection rates.

Table IV.26.1

Goal	**Reduction** in TB related morbidity in people living with HIV/AIDS in the rural population of high HIV burden States, while preventing further spread of HIV and TB in the community.	
Impact Indicators	**Baseline**	**Target** (last year of proposal)
	March 2004	**Feb 2009**
Reduction in TB related morbidity among people living with HIV/AIDS in the rural community of high HIV prevalence States *	**50%**[1]	**37%**
Reduction in annual rate of increase of HIV infection among 15-24 year olds in the rural community of high HIV prevalence States**	**N/A**	**By 25%**

* AIDS case surveillance will be extended to cover all sub-district health centers where the project will be implemented and the format of AIDS case surveillance will be suitably modified for measuring TB related morbidity

[1] AIDS case surveillance data, NACO , 2001-2002

** The data generated in the annual sentinel surveillance round 2003 will be compared with the round 2002 and the annual rate of increase determined to be used as baseline. The data will be compared using the same assumptions and methodologies.

26.2. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal) (1 paragraph per specific objective):

Question 26.2 must be answered for each objective separately. Please copy Question 26.2 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.26.2 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 1: To strengthen AIDS-TB programme collaborations at all levels (national, state, district and sub-district).

As part of the existing NACP and RNTCP collaboration, a national HIV/TB Unit will be in charge of programme co-ordination, implementation, monitoring and evaluation. It will report to the programme co-ordination committee (PCC) comprising of the National AIDS Control Organization (NACO), the Central TB Division (CTD), representatives of the Country Co-ordination Mechanisms (CCM), Non Governmental Organizations (NGOs), States, People Living with HIV/AIDS (PLWA), and technical experts from TB and AIDS research institutes in India, international agencies such as WHO, UNAIDS, World Bank.

A joint state HIV/TB Unit in each high prevalence state will be responsible for implementation and effective co-ordination between the two programmes. State HIV/TB Co-ordination Committees consisting of the State AIDS Control Society (SACS) and the State TB Control Society (STCS) and nodal State NGOs will plan, implement, monitor and supervise activities. The State TB Programme Officer will be a member of the executive committee of the State AIDS Control Society and vice versa. WHO TB/HIV consultants will render technical support and advise.

District Co-ordination Committees will be responsible for monitoring and quarterly review of the implementation at the sub-district level. The committees will comprise of the Chief Medical Officer (CMO), District Nodal Officer for AIDS, District TB Officer, district HIV/TB supervisor, and District health education officer (DHEO), representatives from NGOs, CBOs, faith-based organizations and people living with HIV/AIDS. Similar district level coordination committees are currently operating successfully in the State of Maharashtra and have contributed to strengthening of HIV/TB programme coordination.

A District HIV/TB supervisor will be responsible for HIV/TB programme implementation at the district and sub-district level. He/She will be responsible for an average of 8 VCT (district+ sub-district) (attachment HTB 5).

Based on current experience from a pilot HIV/TB surveillance project in the Western Indian state of Maharashtra, data management systems will be implemented by the HIV/TB Units at the National and State levels for the overall programme monitoring, including patient monitoring of ART. Compilation and analysis of the data will contribute to future programme policy and strategy.

Objective: 1	To **strengthen** AIDS-TB programme collaborations at all levels (national, state, district and sub-district).				
Outcome/coverage indicators	**Baseline**	**Targets**			
	Mar-04	**Year-2 Feb- 06**	**Year-3 Feb- 07**	**Year-4 Feb- 08**	**Year-5 Feb- 09**
National HIV/TB unit strengthened	0	1	1	1	1
State HIV/TB units strengthened	0	6	6	6	6
District coordination committees established	0	60	132	132	132
Data management systems implemented	0	6 states	6 states	6 states	6 states

26.3 Broad activities related to each specific objective and expected output

(Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.26.3 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.26.3 who the implementing agency or agencies will be.

Objective 1: To strengthen AIDS-TB programme collaborations at all levels (national, state, district and sub-district).

Broad activity 1:
Identification of national and state personnel to coordinate the HIV/TB collaborative activities
The National HIV/TB unit will be staffed by an epidemiologist assisted by a technical officer, a data manager and secretarial support. He/she will be assisted by nodal HIV/TB officers based at NACO and CTD.

A state HIV/TB consultant will be appointed and will be assisted by a data manager and secretarial support. The WHO HIV/TB Consultant will provide technical assistance and monitoring support.

A district level HIV/TB supervisor will be responsible for programme implementation, counseling support, monitoring and supervision of on average eight VCTs (district and sub-district), for HIV/TB linkages and for reporting.

Broad activity 2:
Capacity building and development of tools
One training and capacity building of the 8 HIV/TB Unit staff at National and State levels in programme planning and management skills and technical aspects of the NACP and RNTCP.

The National HIV/TB Unit will be responsible for

- Guidelines/modules:
  - developing curricula for different cadres of staff,

- updating existing National treatment guidelines (including ARV), guidelines on home based care (examples, see attachment HTB 19, 20, 21)
- development of algorithms for diagnosis and treatment of common OIs at the sub-district level and the cutoff for timely referral to secondary or tertiary level hospitals,
- development of modules for community mobilization,
- review of the training modules for different categories of staff,
- development of guidelines for monitoring and supervision.

- Co-ordination of training of different staff cadres of both the programmes on HIV/TB.
- Monitoring and evaluation
- Revision and strengthening of the existing MIS systems through a private agency,
- Ensuring timely procurement of drugs and commodities in collaboration with NACO and CTD
- Co-ordination of baseline assessment

Broad activity 3:
Baseline assessment
A baseline assessment (mapping) will be carried out by an independent agency under guidance from the National and State HIV/TB unit. Information will be shared with District Co-ordination committees (DCC) and State HIV/TB units. Information collected will focus on:

- Mapping districts for implementation, status of RNTCP, existing political will and commitment; (20 districts in 1st year, 40 districts in 2nd year, 72 districts in 3rd year)
- Mapping existing capacities of health centers with respect to infrastructure and personnel, staffing patterns, training needs, etc.
- Mapping of NGOs, CBOs, PLHA groups, care and support facilities available in the districts and for mobilization and outreach work
- Mapping of District hospitals for ART delivery

Broad activity 4:
Supervision, monitoring and evaluation

One HIV/TB supervisor will be appointed for approximately eight VCTs (district and sub district). HIV/TB supervisors will be responsible for monitoring and supervision of VCT operations, at district and sub-district level. The HIV/TB supervisor will conduct supervisory visits to each VCT at least once in two weeks, compile VCT reports on a monthly basis and report to the State HIV/TB unit.

The HIV/TB supervisor will be located in the district VCT and will report to the District Nodal Officer of one designated district with written reports to other districts. Essential qualifications required are trained Psychologist or a medical officer with five-year experience. Tasks of an HIV/TB supervisor include:

- **Counseling support and supervision**
- **Laboratory supervision**
- **Supervision of logistics**
- **VCT Linkages with TB programme, community and medical services**
- **Recording and reporting system**
- **Monitoring information systems (MIS) data collection**
- **Maintenance of a tour diary.**

Indicators in the current data management system (MIS) will be updated (referrals, outcomes of referrals), recording and reporting systems will be formulated and data collection systems and data flow will be determined.

VCTs will report on a monthly basis in the approved format to the responsible HIV/TB supervisor who will compile the reports and submit them to the State HIV/TB unit.

District co-ordination committees will review the HIV/TB programme collaboration in their district on a quarterly basis. The meeting minutes will be forwarded to the State HIV/TB unit for information.

Table IV 26.3

Objective : 1	To **strengthen** AIDS-TB programme collaborations at all levels (national, state, district and sub-district).				
Broad Activities	**Process / Output** **Indicators** (indicate one per activity)	**Baseline**	**Targets**		**Responsible / Implementing agency or agencies**
		March 2004	**End Year 1: Feb 2005**	**End Year2: Feb 2006**	
Selection of personnel for HIV/TB units	Personnel appointed	0	22	22	PCC*, SCC**
Capacity building and tools develop-ment	Number of national and state HIV/TB unit staff trained	0	8	8	PCC
	Number of guidelines / modules updated	20	8	20	National HIV/TB unit
Baseline assessment	Baseline assessment completed in implementing districts	0	20	60	Private agency National HIV/TB unit
Supervision, M&E	Number of trained HIV/TB supervisors in place	0	10	30	State HIV/TB unit
	Number of monthly reports received from States	6	From all 6 states	From all 6 states	State HIV/TB unit
	Number of DCC# meetings per district for pro-gramme review	0	4	4	District Collector, Chief Medical Officer (CMO)

*PCC: Programme co-ordination committee
**SCC: State co-ordination committee
#DCC: District co-ordination committee

26.2. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal) (1 paragraph per specific objective):

Question 26.2 must be answered for each objective separately. Please copy Question 26.2 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.26.2 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 2: To promote early diagnosis and treatment of TB in HIV infected persons at the sub-district level

Most people living with HIV infection are unaware of their HIV status. As a result, most HIV positive people present to the health care facilities at a later stage of their infection when signs and symptoms of opportunistic infections are apparent. Improved access to VCT facilities and development of referral linkages with the TB programme will promote early detection of TB disease and early initiation of TB therapy for people living with HIV with TB disease. Mobilization of communities and building capacity for care at community level will generate demand for health services. Early diagnosis of TB as a result of referral from VCTs and effective TB treatment of HIV positive people through the TB programme will contribute to a decrease in mortality, morbidity and improvement quality of life.

Table IV.26.2

Objective: 2	To **promote** early diagnosis and treatment of TB in HIV infected persons at the sub-district level				
Outcome/coverage indicators	**Baseline**	**Targets**			
	Mar-04	**Year-2 Feb- 06**	**Year-3 Feb- 07**	**Year-4 Feb- 08**	**Year-5 Feb- 09**
Total number of sub-district level units established	0	150	329	329	329
Proportion of VCTC attendees counseled on HIV/TB	0	80%	90%	>90%	>90%
Proportion of VCTC attendees with TB symptoms referred to MCs for early diagnosis	0	80%	90%	>90%	>90%
TB treatment completion rate	0	75%	80%	80%	>80%

26.3. Broad activities related to each specific objective and expected output

(Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.26.3 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.26.3 who the implementing agency or agencies will be.

Objective 2: To promote early diagnosis and treatment of TB in HIV infected persons at the sub-district level

Broad activities related to specific objective and expected output

Broad activity 1:
Selection of sites for phased implementation
On average, one VCT will be established per 500,000 population at sub-district level health centers where microscopy centers (MCs) exist under the RNTCP. Under the RNTCP, microscopy centers have been

established at a maximum of one per 100,000 population (1: 50,000 in difficult / hilly areas). The site for the sub-district VCT will be based on the findings of the baseline assessment of infrastructure and capacity needs. The following broad selection criteria apply:

- **Facilities for TB diagnosis and treatment under the RNTCP programme already exist;**
- **Space for setting up VCT exists.**
- **Existing laboratory technicians in the health center are available for conducting HIV tests**

Sub-district VCT will be established in a phased manner where MCs exist, co-coordinated with RNTCP expansion in the high HIV prevalence States. The target of RNTCP is to cover 85% of the country by 2004 and the entire country by 2005. Hence, it is envisaged that by 2007, HIV/TB activities at sub district level will be established in all districts of the six States.

Phasing of implementation:
As of March 2003, of the 132 districts in the six high HIV prevalence States, 114 districts are implementing the RNTCP. It is envisaged that 329 sub-district VCT will be established in health centers with already established microscopy centers in the following manner:

1st year: 50 sub-district VCT
2nd year: 100 sub-district VCT
3rd year: 179 sub-district VCT
4th and 5th year: consolidation, strengthening and integration of sub district VCT with the health care delivery system in these districts.

The following preparatory activities will precede the initiation of the project:

In the planning phase, a district co-ordination committee will be formed under the chairmanship of the District Collector and will comprise of the Chief Medical Officer (CMO), District Nodal Officer-AIDS, District TB Officer (DTO), District Health Education Officer (DHEO), District HIV/TB supervisor, representatives of NGOs/CBOs, faith-based organizations and PLWA groups. This committee will be responsible for the HIV/TB implementation at the district level and will assist in the baseline assessment.

VCTs will be established at sub-district level where RNTCP infrastructure such as TB diagnostic and treatment units is in place and strong referrals and linkages with the TB control programme will be developed. State HIV/TB unit and the district co-ordination committees will select the health centers where sub district VCT will be established based on the baseline assessment.

High HIV prevalence State wise census data and status of NACP and RNTCP implementation **(March 31, 2003). (For table details see attachment HTB 6)**

State	Total Population	Rural Population	No. of Districts	Existing RNTCP MCs	Status of RNTCP	No. of existing VCT	Planned Sub district VCT
Andhra Pradesh	**75,727,541**	**55,223,944**	**23**	**472**	15 districts implementing	**89**	64
Karnataka	**52,733,958**	**34,814,100**	**27**	**387**	**20 districts implementing**	**32**	70
Maharashtra	**96,752,247**	**55,732,513**	**35**	**956**	**33 districts implementing**	**35**	111
Manipur	**2,388,634**	**1,818,224**	**9**	**35**	**9 districts implementing**	**9**	7
Nagaland	**1,988,636**	**1,635,815**	**8**	**28**	**7 districts implementing**	**10**	7
Tamil Nadu	**62,110,839**	**34,869,286**	**30**	**606**	**30 districts implementing**	**37**	70
Total	291,701,855	184,093,882	132	2484	**114 districts implementing**	212	329

Broad activity 2:
Capacity building:

Recruitment of additional staff at sub district level and training

One counselor per VCT will be appointed and trained in HIV, TB, and HIV/TB co-infection. Counselors will be appointed through NGOs / authorised institutions after receiving NACO counseling training, which includes training on HIV/TB issues. PLWAs with equal qualification will be given preference. This will give a unique opportunity to involve PLWAs and to reduce stigma and discrimination in the medical setting as well as in the community. Programme priority is to train existing laboratory technicians in HIV testing procedures (rapid tests). A provision for hiring of contractual laboratory technicians will be made limited to a maximum of 20% of the total number of sub district VCTs where existing laboratory technicians are not available / cannot be utilised. Laboratory technicians will also assist in other laboratory procedures at the health center including sputum microscopy and malaria detection.

Two medical officers from each selected sub-district health center, including the medical officer in charge of the tuberculosis center, will be trained in HIV/AIDS, diagnostic and treatment issues related to HIV and TB, syndromic management of sexually transmitted infections, management of opportunistic infections (OIs), and early recognition of signs and symptoms of serious OIs. Training will be conducted at district / state headquarters depending on the number of trainees.

Other medical officers and health care staff of the health centers will be sensitized on HIV/TB under the ongoing training activities of the NACP and RNTCP.

All training will be conducted as per the training materials prepared by both programmes on HIV/AIDS, TB and HIV/TB. These modules will be reviewed and updated by the National HIV/TB unit.

Broad activity 3:

Provision of additional infrastructure and logistics:

- To ensure confidentiality for counseling, quality diagnosis and proper storage of testing kits, civil works will be undertaken in the identified health centers.
- Strengthening of the laboratory facilities by provision of additional equipment: refrigerator (for storage of HIV testing kits), needle cutter, centrifuge, microscopes
- Supply of Rapid HIV testing kits to facilitate reporting on the same day.
- Supply of consumables – syringes & needles, condoms, gloves, hypochlorite solution.
- Supply of drugs: for syndromic management of STI and for management of common opportunistic infections.
- Supply of IEC material after translation into the locally acceptable regional language
- Stock management system in the selected health centers will be established (storage, shelf life, stock)

Broad activity 4:

Appraisal for start of service delivery:

A team comprising a representative of the State HIV/TB co-ordination committee and district co-ordination committee will assess completion of preparatory activities prior to starting VCT service delivery, based on the principles of the World Bank approved RNTCP appraisal criteria.

Broad activity 5:

Development of referrals and linkages

A referral mechanism between the sub-district VCT and RNTCP microscopy centers will be established through training of health care staff and ongoing monitoring and supervision. Clients referred to the RNTCP will be diagnosed and treated under that programme. Drugs for TB treatment will be provided free of cost by the RNTCP. Referral formats currently in use will be reviewed and implemented.

VCT clients will be referred to the medical officer within the health center for further investigations and treatment of OIs; to NGOs and CBOs for care and support; and to secondary and tertiary levels of care if required.

Clients will be referred to the VCT from within the health center, from village health centers and from NGOs and CBOs.

The sub district level VCTs will be linked to the district level VCT, as this will act as their nodal point for backup technical support.

TableIV.26.3

Objective : 2	**To promote early diagnosis and treatment of TB in HIV infected persons at the sub-district level**				
Broad Activities	**Process / Output Indicators** (indicate one per activity)	**Baseline**	**Targets**		**Responsible / Implementing Agency or agencies**
		March 2004	**End Year 1: Feb 2005**	**End Year2: Feb 2006**	
Selection of sites for phased implementation	Health centres Identified	0	50	150	DCC#, State HIV/TB unit
Capacity building	Recruitment of contractual staff	0	Completed in 50 sites	Completed in 150 sites	State HIV/TB unit
	Number of health center staff trained (1 counselor, 1 LT, 2 MOs per site)	0	200	600	State HIV/TB unit
Infrastructure development	Civil works completed	0	Completed in 50 sites	Completed in 150 sites	SCC*, DCC
	Laboratories strengthened	0	Completed in 50 sites	Completed in 150 sites	SCC, DCC
	Consumables and drugs supplied	0	Completed in 50 sites	Completed in 150 sites	SCC, DCC
	Stock management systems established	0	Completed in 50 sites	Completed in 150 sites	SCC, DCC
Appraisal for start of programme activities	Assessment completed and successful outcome	0	Completed in 50 sites	Completed in 150 sites	SCC, DCC
Development of referrals and linkages	Number of monthly HIV/TB reports received from sub-district VCT	0	From all 50 sites	From all 150 sites	District HIV/TB supervisor

#DCC: District co-ordination committee
***SCC: State co-ordination committee**

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26.2 Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective):

Question 26.2 must be answered for each objective separately. Please copy Question 26.2 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.26.2 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 3: To increase the coverage of HIV prevention, treatment and care interventions

Establishing VCTs on sub-district, rural community level will increase people's access to HIV counseling and testing services and will lead to earlier detection and treatment of HIV infection and of TB disease in HIV positive people. Sub district level VCTs will increase access to the 'tools of prevention' such as accurate information, education and to condoms. Sub district level VCTs will also reduce stigma and discrimination and will strengthen linkages to community care, support and other health services, including early referral of rural pregnant HIV positive mothers to Prevention of Parent to Child Transmission (PPTCT). The PPTCT expansion programme is currently being established with support from the Government of India and the Global Fund.

A feasible and sustainable strategy for integrating ART as part of the HIV/AIDS continuum of care in district health services targeting HIV-infected TB patients after completion of treatment will be developed. Lessons will be drawn for 'observed treatment' with ART, ART monitoring and treatment adherence. This part of the component will be linked with the HIV component that foresees the provision of ART in 49 districts in high HIV prevalence states.

Most patients with HIV-related TB have advanced immuno-suppression and high plasma HIV RNA levels at the time of diagnosis. Given the severity of immunodeficiency among patients with HIV-related TB and the efficacy of ART in reversing HIV-induced immunodeficiency, use of ART in this population has the potential to substantially improve clinical outcomes. Therefore ART will be provided to HIV positive TB patients after successful completion of anti TB treatment (DOTS), which may result in better adherence than in other groups.

This will have a significant and cumulative impact on the prevention and control of the spread of HIV in the community and will help to achieve the Government of India's goal of "Zero level growth of HIV/AIDS by the year 2007".

Table IV.26.2

Objective: 3	To **increase** the coverage of HIV prevention, treatment and care interventions				
Outcome/coverage indicators	**Baseline**	**Targets**			
	Mar-04	**Year-2 Feb- 06**	**Year-3 Feb- 07**	**Year-4 Feb- 08**	**Year-5 Feb- 09**
Total number of clients attending each sub district VCT for pre test counseling	0	500/ year*	1200/ year	1800/ year	2200/ year
Proportion of VCTC clients given condoms	0	70%	80%	>80%	>80%
Proportion of symptomatic VCTC attendees referred for diagnosis and treatment	0	80%	90%	>90%	>90%

Number of districts hospitals equipped for providing ART	0	3	6	12	24
Number of new HIV positive patients receiving ART after successful completion of TB treatment	0	75 (25/site)	150	300	600

* Based on selected experience from district VCTs established in predominantly rural districts. It was noticed that in the second year of operations the number of VCT attendees had increased two and half times.

26.3 Broad activities related to each specific objective and expected output

(Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.26.3 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.26.3 who the implementing agency or agencies will be.

Objective 3: To increase the coverage of HIV prevention, treatment and care interventions

Broad activity 1:
Counseling and testing

Counseling and testing will be carried out as per recommended National guidelines of pre-test and post-test counseling (NACO, Handbook for Counselors, attachment HTB 7), confidentiality and informed consent. Pregnant women will be counseled on prevention of parent to child transmission and referred to the nearest PPTCT center.

Continued follow-up counseling for people living with HIV/AIDS will provide ongoing psychological support, reinforce safe behaviour and ensure increased uptake of the services, thus contributing to reducing the spread of HIV in the community. PLHA networks will support counseling, peer education and community mobilization. Linkages with community support groups will ensure care and psychosocial support to HIV positive individuals.

Rapid HIV testing methodology will be followed in order to provide same day results. This will improve demand for VCT services at the sub-district level and facilitate an increase in voluntary clients to the VCT. Sub district VCTs will be included in the existing external quality assurance programme to ensure accuracy of HIV test results.

Broad activity 2:
HIV prevention interventions

An adequate supply of free condoms from the National programme will be made available at the VCT for distribution to all clients. An increase in condom usage by people with high-risk behavior will reduce the spread of STIs and HIV in the community.

A sufficient supply of drugs for treatment of STIs will be provided to all the health centers from the National AIDS Control programme. Training of the medical officers in syndromic management of STIs has already been detailed in objective 2. Syndromic management of STIs at the sub district health center and behavior modification to prevent recurrent episodes will decrease risk factors for HIV infection.

Existing IEC materials on HIV/AIDS and HIV/TB developed by SACS such as posters, pamphlets, leaflets, handouts, flip charts in the regional language will be available at the VCTs and distributed to all clients accessing VCT services. IEC material will be provided from the National programmes.

Broad activity 3:
Treatment and care interventions
Management of common opportunistic infections (OIs) and early recognition of signs and symptoms of serious OIs will be important for early and timely referral to secondary and tertiary levels of care. Algorithms developed by the National HIV/TB unit on diagnosis and treatment of OIs (based on National guidelines) will be followed. Training of medical officers in diagnosis and treatment of OIs has already been detailed in objective 2.

Outreach teams including trained home care workers will be attached to each sub-district health center for patient follow-up in the community and for providing follow-up counselling and home based care including advice on diet, nutrition, hygiene. (Details in objective 4)

Provision of treatment services (OI and STI) - at the sub-district health centers will further increase the uptake of VCT and health care facilities.

Broad activity 4:
District level ART delivery
Identification of sites for phased implementation
The National HIV/TB unit will determine criteria for the identification of three rural districts to provide ART as part of a continuum of care. (This will be undertaken in close coordination with the proposed activities in the HIV/AIDS component). The state level HIV/TB coordinating committee will identify one district hospital in each of three districts (1 in north-eastern and 2 in southern states) where HIV positive patients with active TB can be referred from District tuberculosis centers (DTCs).

The National HIV/TB unit will determine criteria for expansion. It is envisaged that the number of model districts providing ART will be expanded as follows: 1st and 2nd year: 3 sites, 3rd year 6 sites, 4th year 12 sites, 5th year 24 sites.

ART baseline assessment at identified sites
Baseline assessment will analyze the situation of TB and HIV diagnostic and treatment services, referral linkages, tools available, capacity of health services for HIV management

Development of tools and capacity building
An expanded package of care and support, which includes ART will be defined. NGO, community care and PLWA groups will play a significant role in ensuring equitable access to basic HIV/AIDS care in particular OI treatment and adherence to drug regimens. Effective mechanisms to integrate ART delivery at district level will be identified. First and second line ART, means of clinical and simplified biomedical monitoring will be selected according to WHO SEARO ART guidelines (The Use of Antiretroviral Therapy: A Simplified Approach for Resource-Constraint Countries, Regional Office for South-East Asia, New Delhi, July 2002, attachment HTB 8), [(1st line 3TC+ d4T+NVP. 2nd line 3TC+d4T+INV/r)] and management flow charts, patient diaries developed. Standard Operating Procedures (SOP) for the collection, storage and transportation of samples for CD4 count will be developed.

Training of health care providers, counselors, laboratory technicians and pharmacists, will be conducted on prevention and treatment of OI and ART, collection, transportation and storage of samples for CD4 count, stock management, etc. Special attention will be given to treatment adherence. Home care teams will be identified and trained in HIV management including ART.

Infrastructure development

Linkages will be established from the district ART delivery hospitals to the hospitals where CD4 testing facilities exist and specimens will be transported for testing. Stock management system in hospital will be established (storage, shelf life, stock).

State AIDS Control Society will procure and supply drugs for prevention and treatment of common OI and ART from national generic manufacturers.

Patient follow-up and monitoring

PLHA will visit the district hospital on a weekly basis to collect drugs for the first three months and thereafter on a monthly basis. Patients will have to visit the district hospital once monthly for clinical and biomedical monitoring. CD4 count will be conducted twice a year.

Each center will have one home care team attached to provide on-going counseling, follow-up, ensure treatment adherence and defaulter tracing.

Linkages will be established with the District tuberculosis center to ensure referral from TB programme for HIV-infected patients to receive ART after successful completion of TB treatment.

Supervision and monitoring

One medical officer of the district hospital will be designated in charge of ART.

A data and information systems will be established for patient monitoring of ART. Recording and reporting forms and data flow will be determined. Guidelines for monitoring and supervision will be developed. The HIV/TB supervisor will visit the district hospital on a monthly basis to ensure regular data flow.

Midterm evaluation will be conducted at 12 months and 24 months of model development and the further expansion undertaken according to criteria for expansion and scale up.

Table IV.26.3

Objective: 3	To **increase** the coverage of HIV prevention, treatment and care interventions				
Broad Activities	**Process/Output Indicators** (indicate one per activity)	**Baseline**	**Targets**		**Responsible / Implementing Agency or agencies**
		March 2004	**End Year 1 Feb 2005**	**End Year 2 Feb 2006**	
Counseling and Testing	Total number of clients counseled at the sub-district level	0	6,250	50,000	DCC*, HIV/TB Supervisor, MO I/c health center
	Total number of people receiving HIV testing at the sub-district level	0	4,375 (70% of counselled)	35,000 (70% of counselled)	State HIV/TB unit, DCC, HIV-TB supervisor
HIV Prevention Interventions	Total number of condoms distributed at the sub-district level (5/ client.)	0	21,875	175,000	State HIV/TB unit, DCC, HIV/TB Supervisor
	Total number of STI cases treated at the sub-district level	0	6,250	50,000	State HIV/TB unit, District Nodal Officer-AIDS, District HIV/TB Supervisor
	Total number of IEC leaflets distributed at sub-district health centers	0	6,250	50,000	State HIV/TB unit, District Nodal Officer, MO I/c health center

Treatment and Care interventions	Total number of cases of OI treated at the sub-district health centers	0	625	5,000	State HIV/TB unit, District Nodal Officer, MO I/c health center
	Total number of trained home care teams in place at the sub-district level (1/sub-district health center)	0	50	150	State Nodal NGOs
District level ART delivery	Rural district hospitals identified for ART delivery	0	3	3	SCC**
	Baseline assessment completed at identified ART sites	0	3	3	Private agency, National HIV/TB unit
	Number of hospital staff trained in identified ART sites (2 MOs, 2 counselors, 2 lab technicians, 1 pharmacist in each site)	0	21	21	State HIV/TB unit
	Stock management systems established	0	3	3	State HIV/TB unit
	Percentage timeout of ART drugs at the identified ART sites	0	< 10	< 10	State HIV/TB unit
	Home care teams identified at district level and trained	0	3 (1 at each site)	3 (1 at each site)	State HIV/TB unit, State Nodal NGOs
	Midterm evaluation conducted	0	0	1	Private agency, National HIV/TB unit

* DCC: District Co-ordination committee
**SCC: State Co-ordination committee

26.2 Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective):

Question 26.2 must be answered for each objective separately. Please copy Question 26.2 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.26.2 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 4: To increase demand for prevention, care and support for HIV and TB through community mobilization and capacity building at community level

NGOs, CBOs, women's groups, private practitioners, and PLWA groups play a crucial role in the community response to HIV/AIDS. Women's groups like "Mahila Mandals" in the southern States of Tamil Nadu and Maharashtra and "Naga Mothers" in the north-eastern State of Nagaland are particularly active. Several successful NGO experiences with outreach workers for community-based care will be replicated. These include NGOs such as Samraksha in Bangalore, Karnataka (attachment HTB 11), which involves volunteers in home care or the 'Neighborhood Networks' for the provision of palliative care in Malappuram district, Kerala, (Pain and Palliative Care Clinic, Medical College, Calicut,

Kerala, WHO Demonstration Project, attachment HTB 9) which is based on local volunteers supported by a home visit team.

The government will partner with similar organizations to increase the reach of sub-district health centers, raise general health awareness, mobilize communities to access services (increase demand) and build capacities in communities to provide care and support. Ten Nodal State NGOs will be responsible for implementation. The core elements include

- 5 member outreach teams attached to each VCT for awareness raising, home based care and for patient follow up
- Specific information leaflets that indicate location and availability of health services
- Interactive communication such as folk media and traveling theaters
- Training of NGO / CBO / community and care and support programmes in home based care

The expected outcomes of the objective are:

- Increased demand to access health services (including VCT and MCs).
- Increased capacities of community level organizations (NGOs, CBOs, private practitioners, women's groups, PLHA groups) to provide care and support for people infected with TB or HIV.
- Improved linkages between community organizations / private practitioners (PP) and sub district and district health centers.
- Reduced stigma and discrimination in the community

The objective complements and will incorporate ongoing IEC efforts of the state health departments.

Table IV: 26.2

Objective: 4	**To increase demand for prevention, care and support for HIV and TB through community mobilization and capacity building at community level**				
Outcome/coverage indicators	**Baseline**	**Targets**			
	Mar-04	**Year-2 Feb- 06**	**Year-3 Feb- 07**	**Year-4 Feb- 08**	**Year-5 Feb- 09**
Number of sub district VCTs with a minimum of 500 clients per year	0	40	100	200	>250
Increased capacity of NGOs / CBOs to provide care and support for HIV and TB	N/A	+10%	+ 20% (compared to baseline)	+ 20% (compared to baseline)	+ 20% (compared to baseline)
Proportion of private practitioners (PP) referring clients to health center	N/A	20%	40%	60%	>60%

26.3 Broad activities related to each specific objective and expected output

(Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.26.3 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.26.3 who the implementing agency or agencies will be.

Objective 4: To increase demand for prevention, care and support for HIV and TB through community mobilization and capacity building at community level

This objective was developed in consultation with NGOs currently working in the six high HIV prevalence States with the NACP or RNTCP. Their inputs and feedback were incorporated while formulating the activities (attachment HTB 11).

Broad activity 1:
Selection of Nodal State level NGOs
Each state co-ordination committee will identify state level NGOs that are responsible for implementation and coordination of activities in collaboration with the district coordination committees and under the guidance from the HIV/TB unit. For the two smaller north-eastern States, one nodal NGO per state will be identified, for the four larger southern States, two NGOs will be identified per State. The total number of State level NGOs will be around 10.

NGOs will be requested to submit proposals with clear terms of reference, targets and expected outcomes. Selection of Nodal NGOs will be a transparent process. NGOs will either implement the outreach activities in their own capacity or outsource activities to smaller NGOs in the State.

NGO eligibility criteria

- NGOS working with RNTCP/NACP
- Proven track record (3 years) of rural / underserved service delivery preferably in the health sector.
- Good understanding of the communities / districts for which services are proposed
- Good skills and capacities (staffing, infrastructure) to carry out the activities,
- Audited accounts for the past 3 years for projects handled by the organization
- Annual reports of the past 3 years

Broad activity 2:
Training of outreach workers
NGOs will form 5 member outreach teams attached to each VCT. Team members should include PLHA and cured TB patients and will be trained and sensitized for three days by the NGO in health issues especially HIV and TB and in home care with support from government institutions and the State HIV/TB unit.
Outreach teams are responsible for health sensitization of decision makers and mobilization of other NGOs / CBOs and private practitioners.
Outreach teams can provide DOT for TB, provide home-based care, supervise ART, and provide follow-up counseling through peer counselors and PLWA groups.

Broad activity 3:
Development of Information Leaflets
District Coordination Committees and nodal NGOs design and print sensitive and culturally appropriate information leaflets with referral information (addresses of the nearest health center). The information leaflets will be short and concise and sensitize on health issues including HIV, TB, STI, reproductive health, and family planning.

Broad activity 4:
Health sensitization

- **Decision makers at community and village level**

Through health meetings conducted by outreach teams and health officials, Panchayat leaders, elected representatives, religious leaders, women's groups will be sensitized on the importance of health for development of the community and on signs and symptoms of ill health. Information leaflets will be distributed.

- **NGOs / CBOs and private practitioners**

Sensitization of existing health and development NGOs / CBOs / private practitioners through outreach workers and health officials. Health information on signs and symptoms of TB and HIV will be discussed. IEC information leaflets with referral information will be provided.

Broad activity 5:
Raising general health awareness in villages and communities
NGOs will establish folk media / 3-5 member traveling theater groups (either themselves or through other NGOs) responsible for raising general awareness in communities. The group members will be trained by the NGO in health issues especially HIV and TB to be able to respond to questions from the audience. The content of the interactive media will be developed by the NGO and reviewed by members of the SCC.

Through interactive communication such as traveling theaters and folk media the general population in villages and communities will be reached. The content of the awareness campaigns will focus on the importance of health for community and village development and signs and symptoms of ill health. Information leaflets will be distributed.

Interactive communication such as folk media and traveling theater groups have been used successfully in the RNTCP DOTS programme for example in the eastern Indian state of Orissa (in collaboration with DANIDA). In the implementing districts, Orissa had reached one of the highest TB case detection rates in the country.

Broad activity 6:
Building capacity for care at community level
Capacity Building of care NGO / CBO / PP / PLWA groups, community and home based care and support programmes, (including harm reduction in relevant districts) through training. The training will be conducted by the NGO in collaboration with State HIV/TB unit based on national guidelines and address home based care, community care, HIV treatment, DOTS, diet and nutrition, peer counseling, harm reduction.

Linkages and referrals will be strengthened from health centers to community programmes (NGOs, CBOs, women's groups, Private Practitioners, PLWA groups) and vice versa.
After completion of medical investigations in the health center, if required, clients will be referred for care and follow-up counseling to community care programmes. Clients initially referred from private practitioners, CBOs, NGOs, PLWA groups will be treated at the health center and referred back for follow-up.

Broad activity 7:
Monitoring and Evaluation
Internal M&E will be undertaken by the State HIV/TB unit by analysis of the monthly reports on referrals provided by the VCT and by the district co-ordination committee by an assessment of care and support services in selected districts.

External evaluation will be undertaken after two years of by an external agency such as a national NGO consortium advisory group or Private Corporation under the guidance of the National HIV/TB unit.

Table IV.26.3

Objective: 4	**To increase demand for prevention, care and support for HIV and TB through community mobilization and capacity building at community level**				
Broad Activities	**Process/Output Indicators** (indicate one per activity)	**Baseline**	**Targets**		**Responsible / Implementing Agency or agencies**
		March 2004	**End Year 1 Feb 2005**	**End Year 2 Feb 2006**	
Selection of State level NGOs	State level NGOs appointed	0	10	10	SCC*

Training of outreach workers	Number of outreach workers (including home care) identified and trained	0	250 (5 per sub-district health center)	750 (5 per sub-district health center)	Nodal NGO State HIV/TB unit
Development of information leaflets	Printed leaflets	0	12,500 per sub-district	100,000 per sub-district	Nodal State NGO in collaboration with DCC** and SCC
Health Sensitization	Proportion of decision makers sensitized at sub district level	N/A	5%	25%	State NGO in collaboration with DCC
Raising general awareness in communities and villages	Number of villages visited by theater groups	0	1250 (5% in each sub-district level)	15,000 (25% in each sub-district level)	State NGO in collaboration with DCC
Building capacity for care	Number of training programmes conducted for care NGOs/ CBOs/ PPs / community and home based care programmes for increased capacity	0	0	120 (2 in each district)	State NGO in collaboration with State HIV/TB unit and DCC
M & E	External evaluation	0	0	1	Private agency National HIV/TB unit

* SCC: State Co-ordination committee
**DCC: District Co-ordination committee

27. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.) (2–3 paragraphs):

The component strengthens the collaboration between the National AIDS Control Programme and the Revised National TB Control Programme, which was started in November 2001 with the development of an action plan on HIV/TB co-infection. Through this component, recently developed structures and mechanism for coordination on national, state and district level will be strengthened.

The proposal fits within both the RNTCP plan for DOTS expansion and the NACP plan for extending VCT services countrywide. In addition, the proposal strengthens the reach of the NACP to sub-district level in coordination with the RNTCP, which is already operating on a sub-district level. It will add to improved and early TB case detection and prevent the further spread of HIV especially in rural populations. Increasing the outreach of the National AIDS Control Programme to the sub-district level will improve access to information, leading to an increase in awareness in the rural community. Provision of drugs will ensure that there is access to treatment services for TB, common opportunistic infections and STIs. Counselling will facilitate behaviour change, leading to a reduction of transmission of HIV in the community; it will also facilitate compliance to treatment provided.

Through this process, local capacities of the NACP and RNTCP will be increased on a rural sub-district level. It will also support the preparation of strategies for ART delivery in rural districts outside the ongoing PPTCT plus. As the HIV/AIDS epidemic matures, strengthening the capacity of the public and private health care systems will be the key to a sustainable response to care at the community level.

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The component further envisages a strong involvement of civil society and communities both in increasing demand for services and in providing services.

External donors are currently supporting strengthening of HIV/TB linkages through HIV/TB consultants, VCT expansion, and expansion of the PPTCT programme. These efforts will be complemented and strengthened by the component.

Through the component, health services will be extended to mainly rural and underserved population groups. This will contribute to an improved health status and lessen the impact of ill health on development opportunities and prosperity of rural families and communities.

28. Describe innovative aspects to the component: **(1–2 paragraphs)**

The component builds on the strengths and experiences of a successful TB programme and aims at synergizing efforts between the NACP and the RNTCP.

A unique feature of the component is the emphasis on strong TB and HIV collaboration and the linking of services on all levels for the benefit of the clients. New HIV/TB collaborative units will be established at National and State levels for strengthening of the programme co-ordination mechanisms.

Services are being extended to rural and often underserved population groups. These services include treatment for STIs, opportunistic infections and access to ART for cured TB patients.

Cured TB patients and PLWA will be involved in all aspects of the programme.

The component also includes a strong community participation and mobilization part, which is a reflection of a united response to HIV/AIDS and TB between the government and civil society in India.

29. Briefly describe how the component addresses the following issues **(1 paragraph per item):**

29.1. The involvement of beneficiaries such as people living with HIV/AIDS**:**

The immediate beneficiaries of the component are people with HIV/AIDS, people with TB and their families.

The crucial involvement of beneficiaries in the component will take place in planning & coordination, service delivery, in IEC and community mobilization:

PLWA as members of the coordination committees at the National, State and District levels will be responsible for planning and implementation of the component and for influencing policy decisions.

Cured TB patients and PLWA will further act as outreach workers for home or community based care programmes and in providing treatment support for TB and HIV and will help in strengthening the links between the health centers and the community

Cured TB patients and PLWA will play a crucial role in peer education through counseling and information dissemination. They will be preferred as counselors in the sub-district VCT. This will give a unique opportunity to involve PLWA and to reduce stigma and discrimination in the medical setting as well as in the community.

Both, cured TB patients and PLWA groups and their families will be part of awareness raising and sensitization efforts in the communities and with decision-makers. Formation of self-help groups by PLWA will be encouraged and their active participation will be sought in all HIV/AIDS related activities. Their effective involvement in IEC activities will bring a face to the epidemic.

29.2. Community participation**:**

The proposal was developed in consultation with NGOs currently working in the six high HIV prevalence States with the NACP or RNTCP (attachment HTB 10). Their inputs and feedback were incorporated while formulating the objective 4 activities (List of NGOs that provided inputs, attachment HTB 11).

Communities will participate in the following ways:
Representatives from CBOs will be involved in the planning and implementation of the component in state and district level coordination committees.

The component promotes social mobilization and community participation at every level for the success of the interventions. Community organizations will be involved in mobilization and sensitization activities of the component. Participation of the community will be encouraged via sensitization of elected representatives, opinion leaders, Panchayati Raj system, local self government and faith-based groups, involvement of NGOs, CBOs, women's groups, youth groups and private practitioners.

Staff in sub district health centers will be trained and recruited from the communities. Health centers will have strong linkages to community organizations for referrals to and from the health centers to treatment, care and support at the community level.

29.3. Gender equality issues

Several elements in the component will empower rural women by increasing their access to information and services.

Improving and extending health services for HIV prevention, treatment and care, including treatment of STIs to the sub district level will drastically increase health care access for rural women who may not be able to access district level health services.

Through community outreach and mobilization programmes, health information, including information on TB and HIV will become more accessible to rural women.

Women's groups will be involved in community mobilization as outreach workers and service delivery as counselors or laboratory technicians in the health centers, and in home care teams.

The component therefore contributes to a more equitable access to information and services.

29.4. Social equality issues

Ill health and disease disproportionately impact on the poor and underserved. Improving and extending health services for HIV testing and counseling to rural areas, focusing on promotion of early detection and provision of free treatment for TB disease and providing HIV prevention and care services, will improve access to services by poor, underserved and vulnerable population groups.

This will contribute to more equitable access to health care between rural and urban populations across the country, and it will contribute to the reduction of ill health and poverty among people with TB disease or HIV infection.

The component will also contribute to more equality by reducing stigma and discrimination for people with TB or HIV and improving their acceptance in society.

29.5. Human Resources development:

The component will strengthen the capacity of staff in the primary health care system on sub-district level. Medical officers, counselors and laboratory technicians will be trained in HIV and TB in their respective areas of work including in ART delivery, enhancing their skills and capacities. Laboratory and counseling skills will be reinforced and ongoing refresher training provided on a yearly basis.

The component will also strengthen M&E and financial monitoring capacities at national, state and district level.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category:

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Human Resources	138,000	424,625	826,531	938,625	938,625	3,266,406
Infrastructure/ Equipment	162,188	223,958	400,885	0	0	787,031
Training/ Planning	101,741	212,221	328,767	292,170	250,941	1,185,839
Commodities/ Products	3,646	29,167	110,688	228,754	337,458	709,713
Drugs	23,590	244,285	567,025	872,383	901,338	2,608,620
Monitoring and Evaluation	102,042	160,375	326,208	150,604	213,104	952,333
***Administrative* Costs**	60,976	104,751	186,115	162,030	191,447	705,318
Other (NGO activities)	69,531	606,250	1,312,063	1,308,333	1,308,333	4,604,510
Total	**661,713**	**2,005,632**	**4,058,282**	**3,952,899**	**4,141,246**	**14,819,771**

The budget categories may include the following items:
Human Resources: *Consultants, recruitment, salaries, etc.*
Infrastructure/Equipment: *Building infrastructure, cars, microscopes, etc.*
Training/Planning: *Training, workshops, meetings, etc.*
Commodities/Products: *Bednets, condoms, syringes, educational material, etc.*
Drugs: *ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.*
Monitoring & Evaluation: *Data collection, analysis, reporting, etc.*
Administrative: *Overhead, costs for Principal Recipients associated with managing the project, audit costs, etc*
Other (please specify):

31. For drugs and commodities/products, specify in the table below the use of the commodity, unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Please indicate the International Non-proprietary Name of the medicines, rather than the brand names.

Please indicate what the commodity/drug will be used for (e.g., whether antiretrovirals are for prevention of mother-to-child transmission or adult treatment; whether insecticides are used for net treatment, retreatment or indoor residual spraying).

*Unit prices for pharmaceutical products should be the **lowest** of: prices currently available locally; public offers from manufacturers; or price information for public information sources.[2] If prices from sources other than those specified above are used, a rationale must be included.*

Volumes indicated in the table below should be consistent with activity targets specified in section 26 when these activities involve procurement.

The Total Cost of Drugs and Commodities/Products should equal the sum of the Commodities/Products and Drugs lines for Year 1 in the table above.

Table V.31

Item/unit (using International Non-proprietary Names for pharmaceuticals)	**Purpose**	**Unit cost** (USD)	**Volume** (specify measure)	**Total cost** (USD)
HIV tests	For HIV testing	0.83/patient tested	4375 persons tested	3646
OI drugs	For management of opportunistic infections	31.25 / patient / year	625 patients treated	19531
Trimethoprim+ Sulphamethoxazole				
Nystatin				
Fluconazole				
Doxycycline				
Benzathine Penicillin				
Erythromycin				
Acyclovir				
Spiramycin				
Antiretroviral drugs	Treatment of HIV-infected TB patients after successful completion of anti TB treatment			
Regimen 1: Lamivudine + Stavudine +		401	10 patients started on ARV therapy	1002

[2] Sources and Prices of Selected Drugs and Diagnostics for People Living With HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, 3rd edition, May 2002 (attachment HTB 12) (http://www.who.int/medicines/library/par/hivrelateddocs/prices-eng.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)

Nevirapine				
Regimen 2: Lamivudine + Stavudine + Indinavir		1821	5 patients started on ARV therapy	2276
Ziduvudine				
3TC				
Nevirapine				
ddI				
d4T				
INV/r				
CD4 tests (6 monthly) + laboratory tests (3 monthly)		104 / patient / year	15 patients monitored	780
Total Cost of Drugs and Commodities/Products				**27,235**

31.1. Budget justification: Please indicate assumptions or formulas used to calculate volume of drug/commodity necessary to achieve coverage targets specified in section 26.

Commodity	**Assumptions/formulae**
HIV test kits	70% of the VCT attendees will opt for HIV testing after pre-test counselling. Total number of VCT attendees is calculated based on experience from the district VCTs established in predominantly rural districts of high HIV prevalence States. It was noticed that in the second year of operations the number of VCT attendees had increased two and half times.
Condoms *(resources provided by the Govt of India- GOI)*	Proportion of VCT attendees receiving condoms: 70% in 1st year and 80% in second year. 5 condoms per person.
IEC material *(resources*	Each VCT attendee will receive 1 IEC pamphlet

provided by the Govt of India- GOI)	
Drugs	**Assumptions/formulae**
STI drugs *(resources provided by the Govt of India- GOI)*	Prevalence of STIs in the rural population of the high prevalence States was calculated based on the findings of the Behavioural surveillance survey conducted in 2001. The indicator selected - Percentage of patients interviewed reporting presence of genital ulcer or discharge. The median of the high HIV prevalence States was 4%. It is proposed to target 5% of this population in the 1st year, 7.5% in the 2nd year, 10% in the third year and maintain a t 10% in the 4th and 5th year of the project. The budget is calculated based on the assumption that in the first year, a cohort of patients with STI may have 3 episodes of break through infections while in the later years, this same cohort of patients may have at the maximum 1 episode of STI per year due to behaviour modification measures undertaken as a result of follow-up counselling and condoms provided at the VCTs
OI drugs	Average prevalence of HIV infection in the general population of the high HIV prevalence States has been taken as 1.5%. Requirement of STI drugs is based on the assumption that 10-15% of these people will develop OIs on an annual basis.
Anti-retroviral therapy (ARVT)	In the first 2 years of the project 3 district hospital sites will be identified for delivery of ART services to HIV-infected TB patients after successful completion of anti TB treatment. A maximum of 25 new patients per site will be started on treatment under the project every year. Further expansion of sites will be undertaken according to criteria for expansion. It is proposed that the total number of sites will be increased to 6 in the 3rd year, 12 in the 4th year and 24 in the 5th year. Cost of ARVT has been calculated for 5 years based on the assumption that there would a 20% price reduction of drugs per year. Cost of patient monitoring has been included in the total cost for ARVT and will include CD4 testing on a 6-monthly basis and recommended 3 monthly routine laboratory tests and X-rays.

31.2 In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR 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 (1 paragraph):

Currently voluntary counseling and testing facilities are not available at the sub-district levels. Establishment of such facilities will enhance skills and capacity of health care staff as well as NGOs in the management of HIV/AIDS, HIV/TB as well

as sexually transmitted infections. This will reduce stigma and increase general understanding and awareness and lead to a snowballing effect in education and motivation of frontline workers in dissemination of positive messages about these diseases.

During the project period efforts will be made to integrate voluntary counseling and testing as well as care and support to HIV/AIDS and TB cases as an integral part of existing health care systems. The Government of India will bear the expenditure on salaries of the extra manpower after the proposal period is over.

32. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars:

Table V.32

Domestic (public and private)	**1999**	**2000**	**2001**	**2002**	**2003**	**2004****	**2005****
HIV/AIDS							
TB							
External*			50,000	50,000	125,000	230,000	250,000
Total			**50,000**	**50,000**	**125,000**	**230,000**	**250,000**

* for salaries of WHO HIV/TB consultants
** Projected

Please note: The sum of yearly totals of Table V.32 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labelled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

33. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.

(attachment HTB 13)

34. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u>:

Table V.34

Resource allocation to implementing partners* (%)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Government	80.43	66.75	63.72	65.62	66.64	**65.92**

NGOs/ Community-Based Org.	10.51	30.23	32.33	33.10	31.59	**31.07**
Private Sector	9.06	3.02	3.95	1.28	2.77	**3.01**
People living with HIV/TB/ malaria						
Academic/ Educational Organisations						
Faith-based Organisations						
Others (please specify)						
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total in USD	**661,713**	**2,005,632**	**4,058,282**	**3,952,899**	**4,141,246**	**14,819,771**

- **If there is only one partner, please explain why.**

Please note that a detailed one year work plan and an indicative work plan for the second year need to be provided with detailed budget. See template in Annex B to this form.

A detailed one-year work plan and an indicative work plan for the second year with detailed budget are provided in attachment HTB 14 and HTB 15.

Please note: The following three sections (VI, VII and VII) are all related to proposal/component implementation arrangements.

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines Para. VI. 67 – 74, including the main responsibilities and roles of the Principal Recipient (PR).

35. Identify your Principal Recipient(s) (PR)

Table VI.35

Name of PR	Ministry of Health and Family Welfare National AIDS Control Organization (NACO)	
Name of contact	Ms. Meenakshi Datta Ghosh Additional Secretary & Project Director	
Address	Ministry of Health and Family Welfare National AIDS Control Organization (NACO) 9th floor, Chandralok Building 36, Janpath New Delhi 110 001 India	
Telephone	+91 2332 5331	
Fax	+91 2332 5331	

E-mail	mdg@nacoindia.org	

Please note: If you are suggesting having several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organisation(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc) (1–2 paragraphs)

The National AIDS Control Organization is responsible for implementation and management of the National AIDS Control Programme. It has an established programme management system including a dedicated wing of programme finance management unit with trained and experienced persons with long experience in the distribution of funds, maintaining accounts and its audit. Central activities focus on capacity enhancement at State levels, including training in managerial and financial matters, provision of technical advice, monitoring trends, quality assurance, evaluation of programme performance, identification and dissemination of lessons learned across States. Annual performance and expenditure review (APER) and National Performance Review (NPR) is conducted by the National AIDS Control Board on an annual basis.

The Additional Secretary and Project director, NACO is the administrative head of both the programmes and can ensure an effective co-ordination.

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.) (1 paragraph)

The suggested PR is already a member of the CCM. The PR is directly linked to the State AIDS Control Societies for the day-to-day monitoring of the programme. Funds will flow from NACO to SACS and from SACS the funds will be disbursed to implementing agencies like State Nodal NGOs. Reporting will similarly be from the districts to State HIV/TB units to National HIV/TB unit. Annual audits will be done at the State levels and sent to NACO. NACO will submit annual financial status reports based on reported expenditures.

36. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations) (1–2 paragraphs)

The Ministry of Health & Family Welfare will have overall responsibility for the programme
At the **National level,** a programme co-ordination committee (PCC) will be formed under the Chairpersonship of Additional Secretary and Project Director, NACO. There will be adequate representation from NACO, CTD, CCM, NGOs, SACS, State TB Control Societies, PLWA and technical experts from premier AIDS and TB research

institutes in India as well as international agencies such as WHO, World Bank, UNAIDS.
A national HIV/TB unit will be in charge of programme co-ordination, implementation, monitoring and evaluation

At the **State level**, a State co-ordination committee will be established under the Chairpersonship of the secretary Health. A joint state HIV/TB unit will be responsible for implementation and effective co-ordination between the two programmes on state level.

At the **District level**, a district co-ordination committee will be responsible for overseeing the implementation. Chief Medical Officer, District programme officers for AIDS and TB, HIV/TB supervisor, NGOs, CBOs, faith based organizations, PLWA and select private practitioners will be members of this committee which will be headed by the District Collector. A District HIV/TB supervisor will be responsible for HIV/TB programme implementation at the district and sub-district level.

At the **sub-district** health center, the medical officer in charge will be responsible for the collaborative activities between both the programmes and the smooth functioning of the VCT.

36.1. Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement) (1 paragraph)

The Additional Secretary and Project Director is in charge of administration of both AIDS and TB programmes under the Ministry of Health & Family Welfare.

At the State level, the Secretary (Health) is the person in charge of both the programmes

At the District level, the District Collector is responsible for implementation of all the Government programmes and policies.

37. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity** (1–2 paragraphs)

The existing arrangements between the principal recipient i.e. NACO and other implementing agencies i.e. State AIDS Control Societies and Nodal NGOs shall continue.

NACO would continue to be the apex organization at the national level, and responsible for implementing (a) financial management, allocation of resources and ensuring proper utilization, (b) training, (c) programme management; (d) monitoring and evaluation; (e) and overall advocacy and mobilization.

States and Municipal societies would be responsible for implementing project activities including (i) building infrastructure and procurement of equipment (ii) procurement of drugs (iii) related IEC activities including mobilization and advocacy.

Reporting deadlines: the existing arrangements for submission of statement of expenditure for claiming reimbursement as prescribed for the World Bank and other bilateral agencies would continue in which the quarterly statement of expenditure is to be sent to funding agencies within one month from the close of quarter ending on June, September, December and March.

Similarly, all implementing agencies including NACO are required to send their audited financial statements including the prescribed audit certificate and management letter within six months from the close of the financial year (12 month period from 1st April of the year to 31st March of the following year)

SECTION VII – Monitoring and evaluation information

38. Outline the plan for conducting monitoring and evaluation including the following information (1 paragraph per sub-question).

38.1. Explain the overall approach to M&E

M & E will be the joint responsibility of the State and Centre. As members of the co-ordination committees, the TB and HIV/AIDS Programme will come together to jointly monitor the Programme

Operational responsibility for ongoing M&E will lie with HIV/TB units at central and state levels. The data management and information systems will be established by the National and State HIV/TB Units for the overall programme through a private agency. Indicators for inclusion in the Management Information System (referrals, outcomes of referrals), recording and reporting systems and data collection systems will be determined.

The HIV/TB supervisor will supervise VCT operations and linkages in his/her district. He/she receives technical support from the HIV/TB Consultant based at the SACS. Monthly reporting in approved format from sub-district units to the District HIV/TB Supervisor will be implemented. Intensive technical monitoring of the sub-district and district VCTCs will be performed by the HIV/TB supervisor. The HIV/TB supervisor will compile the reports from the district, analyze them (progress monitoring) and forward them to the State HIV/TB unit as a part of Management Information System (MIS). At the State level all data will be analyzed by the State HIV/TB Consultant, who will give feedback to the district and sub-district level. From the State, the data will be forwarded as a part of the current CMIS (computerized management information systems) to the National HIV/TB unit. The identified HIV/TB indicators will be included in the current NACP II Computerized Monitoring Information System (CMIS).

The data will be analyzed and evaluated at the State and National levels and will be reviewed at the meetings of the State HIV/TB co-ordination committee and the Programme co-ordination committee respectively. Findings will be fed back to the HIV/TB supervisors for implementation of operational improvements.

On a quarterly basis the district co-ordination committees (DCC), the State co-ordination committees (SCC) and the Programme co-ordination committee (PCC) at the National level will review and monitor the programme implementation. Midterm evaluation at 12 months of ART model development will be conducted and further expansion determined by the PCC. Internal evaluation modeled on the RNTCP will be carried out after the 2nd year of functioning of the VCTs.

External review and evaluation

All programme aspects will be reviewed after 2 years and at the end of the project by an independent agency. The evaluation will include review of reports, meeting minutes, and site visits, stakeholder interviews etc.

38.2. Describe how the beneficiaries will be involved in M&E

Representatives of PLWA groups or networks, cured TB patients will be a member of the District co-ordination committee and will be involved in review of reports and monitoring for policy direction at the district level. They would form a part of focus groups and help in mobilizing other members of their community, help in designing referral plans and patterns for follow up of PLWA in the community.

PLWA representatives are already members of the existing executive committee of the SACS and have say in the policy decisions at the State level.
PLWA representatives will be a part of the Programme Co-ordination Committee at the National level, which will have the overall responsibility for co-ordination, implementation, monitoring, and evaluation of the project.

Beneficiaries including DOTS patients and PLWA will be part of the bi-annual review and evaluation through stakeholder meetings

38.3. Describe how the CCM or other partners will be involved in M&E (e.g., oversight, data review, capacity building, quality control and validation of data).

- The CCM will have overall responsibility;
- The PCC, reporting to the CCM, will have overall technical responsibility for M & E system planning and review;
- HIV/TB Units at the National and State levels will have operational responsibility.
- State HIV/TB Units will have the responsibility for cross-checking and validation of data from districts. Checklists will be developed for periodic cross verification. District HIV/TB Supervisor to be responsible for validation of data prior to forwarding to the State level.
- Reporting formats will be provided to the partner NGOs/CBOs & submissions monitored at the level of the State;
- CMIS has inbuilt mechanisms for checking consistency of data.
- Independent evaluations of the programme will be conducted by external agencies used for this purpose by the NACP II. These evaluations will be carried out after 2 years of the project implementation and at the end of the project period. A participatory approach will be used for evaluation studies.

38.4. Describe what already exists. How does the existing health information system work and how it will be used to manage and/or report proposal data (e.g., Demographic Health Surveys, Living Standards Measurement Surveys)

Monitoring and Evaluation is an integral part of both the National AIDS and TB Control Programmes.

NACP: For effective monitoring and evaluation of implementation of the Phase-II of the National AIDS Control Project at National and State level, the following mechanism has been developed.

a Establishment of a **Computerized Management Information System** (CMIS) at the National and State levels: All information is being transferred electronically to

NACO from the States on a monthly basis since January 2002. M&E Officers based at SACS have complete responsibility for CMIS. The data from the districts is sent on a monthly basis to the SACS where it is compiled and forwarded to NACO in an electronic format. This is a powerful tool for the programme managers at the National and State levels for effective monitoring of the programme. As mentioned above, The identified HIV/TB indicators will be included in the current NACP II Computerized Monitoring Information System (CMIS).

b Conducting base line, mid term and final evaluation of the programme. Base line **Behavioural Surveillance Survey** has already been conducted in year 2001 through out the country. This base line survey covered both the general population (15-49 years age group) and as well as high risk groups of population like Female Sex Workers, Intravenous Drug users and Men having Sex with Men. The bridge groups of clients of female sex workers were also covered. In the general population Behavioural Sentinel Survey covered about 85,000 population while in the high-risk groups, 12,000 people were surveyed. The findings of the survey will act as a baseline for monitoring the effectiveness of National AIDS Control Programme activities over the next 5 years. These surveys will be repeated twice over the next five years and will be used to monitor impact of the interventions.

c **National Sentinel Surveillance:** Every year from August to October, a round of survey is conducted at designated sites to assess trends of HIV prevalence rates in high-risk and general population. In 2002, the survey was conducted in 384 sites.

d Conducting the Annual Performance and Expenditure Review (APER); and

e Conducting the National Performance Review (NPR), National AIDS Control Board.

Survey reports:
National Behavioural Surveillance report India 2001 (attachment HTB 16)
National Sentinel Surveillance-2001 (attachment HTB 17)

RNTCP: The reporting system utilized by the RNTCP has been proven to be robust. To monitor and evaluate the performance of the RNTCP, performance indicators are monitored on a quarterly basis by analysis and feedback on the quarterly reports for the districts already implementing the RNTCP. Performance indicators include percentage of new adult outpatient cases examined for TB by sputum smear microscopy, case detection, smear conversion and treatment success rates etc. In addition, field visits are the norm to improve the field performance, and review meetings are held at the State level and at Central level quarterly and six-monthly respectively.
Performance in relation to any one indicator is easily verifiable via cross-checking of records and registers. Indicators are inter-linked and the reporting of one indicator can be used to project accurately other performance indicators (e.g. smear conversion results to treatment outcomes) and needs (e.g. number of cases detected to usage of sputum containers and thereby logistic needs). Reporting of such indicator as smear negative to smear positive ratio gives a good indication of the quality of diagnostic services being provided.

38.5. Prepare a table showing the following for each impact, coverage and process indicator listed in section 26: i) the source of data, ii) periodicity of data collection, iii) how the quality of data will be determined/ensured, iv) who (the entity) will be primarily responsible for each indicator, v) and what indicators will be reported through partner organisations.

Table

Indicator	Source	Periodicity	Quality control	Responsible for collection	Indicators by partners
Impact Indicator					
Reduction in TB related morbidity among people living with HIV/AIDS in the rural community of high HIV prevalence States	AIDS case surveillance	Monthly	National HIV/TB unit	NACO	
Reduction in annual rate of increase of HIV infection among 15-24 year olds in rural community of high HIV prevalence States	Annual sentinel surveillance round 2003	Yearly	National HIV/TB unit	NACO	
Outcome/coverage indicators					
Objective: 1					
National HIV/TB unit strengthened	PCC	One Time		PCC*	
State level HIV/TB units strengthened	SCC reports	One Time	PCC	SCC**	
District coordination committees established	DCC# reports	One Time	PCC	SCC	
Data management systems implemented	National and state HIV/TB unit report	One Time	PCC	National and state HIV/TB unit	
Objective: 2					
Total number of sub-district level units established	DCC reports	Monthly	SCC	District Nodal Officer AIDS	
Proportion of VCTC attendees counseled on HIV/TB	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Proportion of VCTC attendees with symptoms (< 1 month) of TB referred for early diagnosis	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
TB treatment completion rate	Sub district VCT reports	Monthly	HIV/TB supervisor	RNTCP MC	
Objective: 3					
Total number of clients attending each sub district VCT for pre test Counselling	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Proportion of VCTC clients given condoms	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Proportion of symptomatic VCTC attendees referred for diagnosis and treatment	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Number of districts hospitals equipped for providing ART	District Hospital report	Monthly	State HIV/TB unit	District Nodal Officer AIDS	
Number of new HIV positive patients receiving ART after successful completion of TB	District Hospital report	Monthly	State HIV/TB unit	MO in charge of ART in District	

treatment				Hospital	
Objective: 4					
Number of sub district VCTs with a minimum of 500 clients per year	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Number of NGOs with increased capacity to provide care and support for HIV and TB	State Level NGO report	Quarterly	DCC	NGO	NGO
Proportion of PPs referring clients to health center	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	

Indicator	Source	Periodicity	Quality control	Responsible for collection	Indicators by partners
Process Indicators					
Objective: 1					
Personnel appointed	PCC report	One Time	PCC	PCC and SCC	
Number of national and state HIV/TB unit staff trained	PCC report	One Time	PCC	PCC	
Number of guidelines / modules updated	National HIV/TB unit report	Quarterly	PCC	National HIV/TB unit	
Baseline assessment completed in implementing districts	State HIV/TB unit report	Monthly	SCC	DCC	
Number of trained HIV/TB supervisors in place	State HIV/TB unit report	Quarterly	SCC	State HIV/TB unit	
Number of monthly reports received from States	State HIV/TB unit report	Monthly	SCC	State HIV/TB unit	
Number of DCC meetings per district for programme review	HIV/TB supervisor report	Monthly	SCC	District Nodal Officer AIDS	
Objective: 2					
Health centers identified	District Nodal Officer AIDS report	Monthly	State HIV/TB unit	DCC	
Recruitment of contractual staff	State HIV/TB unit report	Monthly	SCC	State HIV/TB unit	
Number of health center staff (counselors, LTs, MOs) trained	State HIV/TB unit report	Monthly	SCC	State HIV/TB unit	
Civil works completed	HIV/TB supervisor report	Monthly	State HIV/TB unit	District Nodal Officer AIDS	
Laboratories strengthened	HIV/TB supervisor report	Monthly	State HIV/TB unit	District Nodal Officer AIDS	
Consumables and drugs supplied	HIV/TB supervisor report	Monthly	State HIV/TB unit	District Nodal Officer AIDS	
Stock management systems established	HIV/TB supervisor report	Monthly	State HIV/TB unit	District Nodal Officer AIDS	
Appraisal completed and successful outcome	HIV/TB supervisor report	Monthly	State HIV/TB unit	District Nodal Officer AIDS	
Number of monthly HIV/TB reports received from sub-district VCT	Sub district health center reports	Monthly	State HIV/TB unit	HIV/TB supervisor	
Objective: 3					
Total number of clients	Sub district	Monthly	HIV/TB	VCT	

counseled at the sub-district level	VCT reports		supervisor	Counselor	
Total number of people receiving HIV testing at the sub-district level	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Total number of condoms distributed at the sub-district level (5/ client.)	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Total number of STI cases treated at the sub-district level	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Total number of IEC leaflets distributed at sub-district health centers	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Total number of cases of OI treated at the sub-district health centers	Sub district VCT reports	Monthly	HIV/TB supervisor	VCT Counselor	
Total number of trained home care teams in place at the sub-district level (1/sub-district health center)	NGO reports	Quarterly	DCC	NGO	NGO
Rural district hospitals identified for ART delivery	Baseline assessment report	Annual	SCC	Private agency	Private agency
Baseline assessment completed at identified ART sites (is this from earlier baseline assessment)	State HIV/TB unit assessment report	One Time	SCC	State HIV/TB unit	
Number of hospital staff trained in identified ART sites (Per site: 2 MOs, 2 counselors, 2 lab technicians, 1 pharmacist)	State HIV/TB unit assessment report	One Time	SCC	State HIV/TB unit	
Stock management systems established	State HIV/TB unit report	One Time	SCC	State HIV/TB unit	
Percentage timeout of ART drugs at the identified ART sites	State HIV/TB unit report	Monthly	SCC	State HIV/TB unit	
Home care teams identified at district level and trained	NGO report	Quarterly	State HIV/TB unit	NGO	NGO
Midterm evaluation conducted	State HIV/TB unit Mid term report	Annual	SCC	State HIV/TB unit	
Objective: 4					
Nodal State level NGOs appointed	State HIV/TB unit report	Monthly	PCC	State HIV/TB unit	
Training of outreach workers	NGO report	Monthly	State HIV/TB unit DCC	NGO	NGO
Printed leaflets	NGO report	Monthly	DCC	NGO	NGO
Proportion of decision makers sensitized at sub district level	NGO report	Monthly	DCC	NGO	NGO
Number of villages visited by theater groups per district	NGO report	Monthly	DCC	NGO	NGO
Number of care NGOs/ CBOs/ community and home based care programmes with increased care capacity	NGO report	6 monthly	DCC	NGO	NGO
External evaluation	Evaluation report	After two years and	SCC	Private agency	Private Agency

		five years (end of project period)			

* PCC: Programme co-ordination committee
**SCC: State co-ordination committee
#DCC: District co-ordination committee

38.6. Describe how data will be analyzed and used by the PR, CCM, and others

Timely use of M & E data and lessons learnt will be used for constructive feedback to the States and Districts. Reasons for poor performance in the concerned areas will be analyzed and appropriate suggestions made to rectify them and improve performance.

As no baseline data on HIV/TB at the sub-district level is available at the moment, the data generated in the first year will be used as baseline data for the succeeding years.

The data will be shared by both programmes. This will help improvement of collaborative activities and also influence future policy development by both programmes. It will also help in identifying priority areas for operational research for both programmes.

39. Recognizing that M & E plans will make use of existing monitoring systems especially for impact and coverage indicators, national information systems may require strengthening. Please specify activities, partners and resource requirements for strengthening M&E capacities.

Please note: Total requested from Global Fund should be consistent with the resources needed for Monitoring and Evaluation as indicated in Table V.30. Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.39

Activities (aimed at strengthening Monitoring and Evaluation Systems)	**Partner(s)** (which may help in strengthening M&E capacities)	**Resources Required** (USD)					
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Review and revision of the existing Monitoring, information systems (MIS)	Private agency	31250	0	0	0	0	**31250**
Baseline assessment	Private agency	20833	41667	62500	0	0	**125000**
Travel costs for supervision, monitoring & evaluation		25000	62500	100000	100000	100000	**387500**
Review meetings- at District, state and National level		24958	56208	101208	50604	50604	**283583**
External evaluation	Private agency	0	0	62500	0	62500	**125000**
Global Fund M&E request		**102041**	**160375**	**326208**	**150604**	**213104**	**952333**
Unmet need		**0**	**0**	**0**	**0**	**0**	**0**
Total resources needed		**102041**	**160375**	**326208**	**150604**	**213104**	**952333**

SECTION VIII – Procurement and supply-chain management information

40. Describe your plans for procurement and supply chain management of health products (including pharmaceutical products, diagnostic technologies and other supplies related to the use of medicines, bednets, insecticides, aerial sprays against mosquitoes, other products for prevention [e.g., condoms], and laboratory equipment and support products [e.g., microscopes and reagents]) integral to this component's proposed disease interventions. The plan should include.

i. Procurement responsibilities: A description of whether existing national systems, international or other outsourced procurement agencies, or a mix of both will be used for procurement;

There are rate contracts awarded by Director General of Supplies & Disposals (DGS&D), under the Ministry of Civil supplies, Government of India for various items of common use. In addition at State level many states have similar rate contracts under respective health systems. It would be useful and convenient to avail these rate contract systems at least for small values (at prescribed threshold limits). In case the procurements are of large value services of procurement agencies selected through competitive process would be utilised.

ii. .Procurement practices: A description of how the Interagency Operational Principles for Good Pharmaceutical Procurement will be adhered to, including competitive purchasing from qualified manufacturers and suppliers to obtain the lowest prices for products of acceptable quality; and a description of how performance of suppliers with respect to the quality of goods and services they supply will be monitored;

The Good Manufacturing Practices (GMP) of WHO would be a standard reference for quality assurance along with available National Standards like those of Bureau of Indian Standards (BIS). The services of national laboratories would be availed to test the goods procured both before despatch/delivery to consignees, and after they are received at destinations to ascertain the quality adherence till the last point of use.

In case of bidding procedures and guidelines the established norms of the World Bank like it's Standard Bidding Documents (SBD), 'Guidelines on Procurement' and 'Guidelines on Selection of Consultants' would be followed. Wherever it is found be prudent, the procurement mechanisms existing at national level and states level could also be adopted.

iii. Supply chain management: A description of how reliability, efficiency, and security will be assured throughout the supply chain;

Throughout the supply line quality and quantity checks would be made with appropriate documentation to help any post review to address quality assurance.

In the process the services of national laboratories would be availed. In addition existing statuary requirements like drug licenses issued by Drug Controller General of India (DCGI) would be insisted upon. For transportation only those transporters who are approved by the Indian Banks Association (IBA) or registered with government ministries would be considered. Proper transit insurance would also be taken till destination.

iv. Avoidance of diversion: A description of inventory management, stock control systems, audit systems, and other means to ensure the avoidance of diversion of products;

All supplies would be issued/delivered to specific consignees identified of that project. The supplies would be effected through existing nodal institutions like AIDS Control Societies, government stores, etc. The goods would be issued to authorized centres only as per their allocations fixed after a careful evaluation of their requirements. Inventories would be maintained and monitored with appropriate documentation both at Society and centre level.

v. Forecasting and inventory management: A description of how forecasts of the quantities of health products needed for the programme will be systematically and regularly updated, and how these forecasts will be monitored and regularly compared with actual consumption of these products;

A detailed programme wise requirements of the items, based on past data and accepted norms of consumption, would be projected. In addition a reasonable buffer stock would be recommended at the State level. As a precautionary measure Societies/State level institutions would be authorized to procure locally to meet any emergency situations. These consumptions would be monitored on quarterly basis for stocks. At the end of every year actual consumptions would be reviewed, and modifications in allocations/projections if required would be resorted to.

vi. Product selection: A list of health products to be procured, including reference to the relevant standard treatment guidelines and essential medicines lists of the World Health Organization, host country government or applicant;

The existing technical expert groups and institutions of excellence would be consulted periodically. The available formulary at national level and with WHO would be used as reference.
For antiretroviral therapy, drugs manufactured by the National generic manufacturers and approved by the Food and Drug Authority of India (FDA) will be used.

vii. Donation programmes: A description of any donation programmes that are currently supplying health products (or which have been applied for), including the Global TB Drug Facility and drug donation programmes by pharmaceutical companies, multilateral agencies, and NGOs;

Presently UNICEF is providing Nevirapine for the PPTCT (prevention of parent to child transmission) programme through the drug company CIPLA.

viii. Compliance with quality standards: A description of how compliance with quality standards for both multisource and single- or limited-source pharmaceutical products will be assured, including a description of how random samples of pharmaceutical products will be tested for compliance with applicable quality standards;

As described under point no. 2

ix. Adherence to treatment protocols, drug resistance, and adverse drug reactions: A description of how patients will be encouraged to adhere to prescribed treatment (e.g., use of fixed-dose combinations, once-a-day formulations, blister packs, and peer education and support), how drug resistance will be monitored and contained, and how adverse drug reactions will monitored;

Treatment of TB disease in HIV infected patients will be as per the standard RNTCP protocol (attachment HTB 18). At present, the RNTCP in India uses intermittent short course chemotherapy (i.e. rifampicin containing regimens for all patients). Treatment under RNTCP in India is free for all patients. Under the RNTCP, intermittent short course chemotherapy (i.e. rifampicin containing) regimens are used for all patients, with Category I and III cases receiving 6-7 month regimens and Category II cases an 8-9 month regimen (see table below). All the RNTCP drugs are provided in blister packs to ensure adherence. During the intensive phase of treatment of treatment, each and every dose of medicine is taken under direct observation of the health care worker / community volunteer. During the continuation phase, patient collects his drug blister packs from the DOT center on a weekly basis and returns the empty strip / blister pack of the drugs consumed at the time of next week's collection. If the patient does not present as scheduled during treatment, home visits are made by health staff / community volunteers to bring him back under treatment. There is a Senior treatment supervisor in each Tuberculosis Unit (serves a population of 500,000) and is responsible for ensuring that the policies of RNTCP are followed.
Once TB treatment is started, regular follow-up sputum examinations are done by the programme at 2-monthly intervals. If the patient remains sputum positive despite therapy, then sputum is sent for sputum culture and antibiotic sensitivity to rule out/confirm drug resistance.
Under the project, outreach workers will be trained in home care and visit the homes of the PLWA. In case of any adverse drug reactions, the patients will be immediately brought to the nearest health center for evaluation and treatment.

Category of Patient	Regimen
I	$2H_3R_3Z_3E_3$ / H_3R_3
II	$2S_3H_3R_3Z_3E_3$ / $1H_3R_3Z_3E_3$ / $5H_3R_3E_3$
III	$2H_3R_3Z_3$ / $4H_3R_3$

Treatment of STIs **will be based on syndromic management using WHO/NACO protocols. The protocols will be taught to the medical officers during their training, and treatment algorithms and flow charts will be provided.**

Treatment of opportunistic infections: The following spectrum of OIs has been reported in AIDS patients in India between 1986-2001: tuberculosis (59%),

candidiasis (51%), cryptosporidiasis (32%), pneumocystis carinii pneumonia (24%), herpes zoster (18%), toxoplasmosis (14%), bacterial pneumonia (13%), cryptococcal meningitis (9%), etc.*(NACO India Country report 2001).*

Medical officers will be trained in essential principles of management of OIs. Treatment algorithms will be developed by the National HIV/TB cell in consultations with experts for diagnosis and treatment of OIs at the sub-district level and early identification of symptoms and signs of serious OIs for timely referral to secondary or tertiary level hospitals.

Antiretrovirals: Use of fixed dose combinations of antiretroviral drugs, low pill burden, peer counselling and community support will ensure treatment compliance.
At each district hospital where ART will be administered, a 2-member home care team will be attached. These home care teams will be trained by NGOs under the supervision of the State HIV/TB Unit. These teams will be responsible for follow-up of the PLWA in the community and ensure treatment adherence, defaulter tracing, early detection of side effects, provide follow-up counseling, and provide advice on home-based care. These teams will liaise with outreach workers at the sub-district level to ensure follow up of the clients in their respective areas.
Adherence will be measured by patient self-report, pill count, and the reports of the home care team members.
The efficacy of antiretroviral drugs will be monitored by clinical and biochemical monitoring and 6 monthly CD4 counts.

Regimen		Number of pills / day
1st Line: 2 NRTIs + 1 NNRTI	Lamivudine (3TC) 150 mg + Stavudine (d4T) 30 mg + Nevirapine (NVP) 200 mg	2
2nd Line: 2 NRTIs + 1 PI	Lamivudine (3TC) 150mg + Stavudine (d4T) 30 mg + Indinavir (INV/r) 400 mg	8 (2+6)

x. National and international laws: A description of how national laws and applicable international obligations in the field of intellectual property rights will be complied with, including a description of how the flexibilities provided in the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and referred to in the Doha Declaration on the TRIPS Agreement and Public Health will be used in a manner that achieves the lowest possible prices for products of assured quality;

India as a signatory to TRIPS, is required to introduce a product patent provision by 2005, however, India will make use of optimum flexibility, which is available under TRIPS, and build adequate safeguards into the patent law in the interest of the protection of public health.

The Government of India has announced a New National Health Policy (NHP-2002 (attachment GD2) n which it addressed several of the patent issues. Pharmaceutical drugs have always been available in the country at extremely inexpensive prices and India has established a reputation around the globe for the innovative development of original process patents for the manufacture of a wide-range of drugs and vaccines within the ambit of the existing patent laws. To protect the citizens of the country from the effects of rising prices of medicines, the NHP-2002 envisages a national patent regime which, while being consistent with the TRIPS Agreement, avails of all opportunities to secure for the country, under its patent laws, affordable access to the latest medical and other therapeutic discoveries. The policy also sets out that the Government will bring to bear its full influence in all international for a – UN, WHO, WTO, etc. – to secure commitments to relax the restrictive features of TRIPS in its application to the health care sector.

Safeguards such as compulsory licensing and parallel imports in a wide range of situations are considered. Mechanism within the Ministry of Health and Family Welfare as well as within NGOs are considered in order to monitor access to drugs and their prices so that these safeguards could be used immediately when required. The Ministry of Health and Family Welfare will co-ordinate with the National Pharmaceutical Pricing Authority to monitor prices of vital drugs.

xi. Procurement and supply management indicators: A description of indicators to be used to monitor procurement and supply management (e.g., average lead time between product orders and receipt of goods, average percentage of time out of stock of products at principle warehouses and sentinel treatment facilities, price of products in the latest procurement in comparison with prices from the previous procurement of the same products and with median prices reported in international drug price indicators), with baselines if available.

All desired indicators for procurement and supply chain management e.g., time lines for each activity of procurement and supplies proposed and actually adhered to; quantum & periods of stock-outs and over- stocks; procured price vis-à-vis market price/estimated price would be set forth for each category of items like drugs, test

kits, equipment, reagents, etc. This would be prepared as part of procurement plans, and the individual schedules proposed.

41. All procurement of medicines to treat multi-drug resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee of the Stop TB Partnership. Please for a Green Light Committee application form in Annex C.

LIST OF ATTACHMENTS

Please note:
The list of attachments is divided into two parts: the first part lists the attachments requested by the Global Fund as support for Sections III and IV.
The second part is for applicants to list attachments related to other Sections such as the Information on applicants (Section II), Detailed Budget (Section IV), or other relevant information.

Please note which documents are being included with your proposal by indicating a document number.

General documentation:	**Attachment #**
1. Poverty Reduction Strategy Paper (PRSP)	_____
2. Medium Term Expenditure Framework	_____
3. Sector strategic plans	_____
4. Any reports on performance	_____
HIV/AIDS specific documentation:	**Attachment #**
5. Situation analysis	
6. Baseline data for tracking progress[3]	
7. National strategic plan for HIV/AIDS, with budget estimates	_____
8. Results-oriented plan, with budget and resource gap indication (where available)	
TB specific documentation:	**Attachment #**
9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control	_____
10. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents	_____
11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form)	_____
12. Most recent independent assessment/review of national TB control activities	_____

[3] Where baselines are not available, plans to establish baselines should be included in the proposal.

Malaria specific documentation:	**Attachment #**
13. Situation analysis	_____
14. Baseline data for the tracking of progress	_____
15. Country strategic plan to Roll Back Malaria, with budget estimates	_____
16. Result oriented plan, with budget and resource gap indication (where available)	_____
General documentation:	**Attachment #**
	_____
	_____
	_____
	_____
HIV/AIDS specific documentation:	**Attachment #**
	_____
TB specific documentation:	**Attachment #**
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Malaria specific documentation:	**Attachment #**
	_____
	_____

Crosscutting documents/activities	**Attachment #**