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

March 6, 2002

सत्यमेव जयते

J. A. Chowdhury
Health Secretary

भारत सरकार
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GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
(DEPARTMENT OF HEALTH)
NEW DELHI - 110 011

Dated: 4th March, 2002

Dear Dr. Anders Nordstrom,

On behalf of the Country Coordinating Mechanism (CCM) of India, I am pleased to submit this proposal to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM).

Our proposal represents the collaborative efforts of government, non-government, and private sector agencies to expand quality interventions to reduce the burdens of HIV,TB and Malaria in India. Indeed, the interventions contained herein promote stronger partnerships between public and private sector organizations to deliver effective and efficient services.

We are requesting a total of US $ 33.042 million from the GFATM for the first year of operation with a total 3-year request of US $ 111.984 million. The GOI contribution to HIV, TB, and Malaria prevention and treatment totalled approximately to US $ 93.877 million in fiscal year 2001-02, thus indicating that the government is committing the majority of financial and programmatic resources for interventions to fight these three diseases.

The interventions proposed here are urgently needed for India to respond to the combined threats of HIV, TB and Malaria. They represent expansions of successful interventions as well as model programmes which are needed to contribute to an expanded response in the future.

We look forward to a successful working relationship with the GFATM.

With best regards,

Yours sincerely,

(J.A. Chowdhury)

Dr. Anders Nordstrom,
Executive Director,
The Global Fund to Fight AIDS,
Tuberculosis, and Malaria (GFATM),
International Conference Center,
Geneva 9, Rue Varembe (mezzanine level)
CH 1211 Geneva 20,
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SECTION A: OVERVIEW INFORMATION

A.1. Country (or region): India

A.2. Proposal Title:

Expansion of effective public- and private-sector interventions in HIV, tuberculosis, and malaria prevention and treatment in India

A.3. Spell out which of the three health problems or combination of them this proposal aims to address (HIV/AIDS, TB and/or malaria) (*Guidelines para.4*):

HIV, tuberculosis, and malaria

A.4 What are the additional outcomes expected from this proposal? (*Guidelines, para. 8 and Annex 1, II 3*).

The following additional outcomes are highlighted by disease category here and elaborated in the components section of the proposal (Section C):

HIV

- Reduced HIV prevalence among pregnant women aged 15-49 to below 3% in the six high prevalence states and below 1% in the other states by 2005 *(Component C.1.a. PMTCT);*
- Reduced proportion of infants infected with HIV to below 20% of live births by 2005, and below 10% by 2010 among HIV+ women *(Component C.1.a PMTCT);*
- Decreased prevalence of sexually-transmitted infections (STI) nationwide through an expanded Family Health Awareness Campaign currently with limited coverage *(Component C.1.b. Family Health Awareness Campaign (FHAC)); and,*
- Coverage of 3,000 clinically eligible HIV+ patients with anti-retroviral therapy (ART) in a model cost-recovery program *(Component C.1.c. ART model program).*

TB

- Coverage of an additional 56 million population having poor socio-economic indicators and largely underserved in the newly formed States of Chhattisgarh, Jharkhand and Uttaranchal under the Revised National TB Control Programme (RNTCP) to expedite achievement of the global targets for TB control (namely ≥85% treatment success and ≥70% detection of new smear positive pulmonary TB cases) for the country as a whole by the target date of 2005 *(Component C.2.a. DOTS Rapid Scale-up);*
- 115,000 TB patients placed on treatment in the 3 States *(Component C.2.a. DOTS Rapid Scale-up);*
- 20,000 lives saved *(Component C.2.a. DOTS Rapid Scale-up);*
- 230,000 infections prevented *(Component C.2.a. DOTS Rapid Scale-up);and,*
- Establishment of a model public and private sector integrated TB control program in Chennai, Tamil Nadu for possible replication and scale-up in the future *(Component C.2.b. Chennai Model TB Program).*

Malaria

- Additional coverage of a total population of approximately 63.32 million in 48 districts uncovered by the Enhanced Malaria Control Project so as to achieve full coverage for the

intensification of malaria control measures in four states which contribute more than 50% of the malaria burden in the country *(Component C.3.a Malaria Control Expansion).*

Cross-cutting

- Increased investment of the Indian business sector in HIV/TB workplace interventions, resulting in a self-sustaining program *(Component C.4.a Industry Response to HIV/AIDS and TB; and*
- Establishment of a model integrated strategy for HIV, TB, and malaria in 6 rural areas *(Component C.4.b Model Integrated Program).*

A.4. Total Amount Requested from the Global Fund: (in US$ million, by year)

Components (described in Section C)

In $US millions

	(Budget) Year 1	Estimated Year 2	Year 3	Total/3 year
HIV components				
C.1.a. PMTCT	9.010	8.880	11.510	29.400
C.1.b. FHAC	9.300	12.400	15.800	37.500
C.1.c. ART model	1.405	1.015	1.015	3.435
Sub-HIV	*19.715*	*22.295*	*28.325*	*70.335*
TB components				
C.2.a. DOTS scale-up	1.880	3.630	3.080	8.590
C.2.b. Model TB	0.086	0.054	0.054	0.194
Sub-TB	*1.966*	*3.684*	*3.134*	*8.784*
Malaria components				
C.3.a. Expansion of NAMP	11.090	10.450	10.450	31.990
Sub-Malaria	*11.090*	*10.450*	*10.450*	*31.990*
Cross-cutting components				
C.4.a. Business Response	0.156	0.150	0.130	0.436
C.4.b. Integrated project	0.115	0.155	0.169	0.439
Sub-cross-cutting	*0.271*	*0.305*	*0.299*	*0.875*

Total	**33.042**	**36.734**	**42.208**	**111.984**

A.5. Disease burden (Refer to official documentation or sources of epidemiological data on the prevalence and magnitude of HIV/AIDS, TB and/or malaria in the country/region/area) **or potential disease burden** (indicators such as incidence of new infections etc) *(Guidelines para.6)*

HIV

With 3.86 million people living with HIV or AIDS in 2001 (0.7% of the adult population, age 15-49), India has the second highest number of HIV infected people of any single country in the world and the highest number in Asia. The number accounts for almost 11% of the global total and 68% of the total for South and South East Asia. With the HIV prevalence doubling, on average, every one to two years in certain groups, the challenge to keep pace with this rapid increase is immense. Given India's large population, a mere 0.1 percent increase in the prevalence rate would increase the number of adults living with AIDS by over half a million persons.

Ninety percent of the HIV cases reported fall within the most economically productive aged group of 15 to 44, and the main childbearing age group. One in four reported cases are among women. Surveillance data shows that the virus has spread among the general population and from urban to rural areas. There are several sample surveys of antenatal mothers, which indicate infection rates of 4 percent.

The burden of AIDS varies by state. Six states can be considered high prevalence states: Andhra Pradesh, Karnataka, Maharashstra, Manipur, Nagaland and Tamil Nadu. In five of these states, more than one percent of the general population is HIV-positive. HIV prevalence in antenatal women is over 2% in Andhra Pradesh and parts of the other states. Such prevalence rates in the six states alone have the potential to significantly impact on the rates for the country as a whole. The three highest prevalence states each have populations of over 50 million, more than most countries in the world. Together, the six high prevalence states have a population size of 291.7 million, which forms 28% of the population of India and is larger than any other country except China PDR.

The rise in HIV prevalence rates among pregnant women increases the possibility of mother to child transmission of HIV, which in turn will increase the threat to child survival, protection and development, and increases the burden on the health system. The National AIDS Control Organisation (NACO) estimated in 2000 that of the 27 million annual pregnancies in India, at least 100,000 occur in HIV positive women. This leads to an estimated annual cohort of 30,000 infected babies and 70,000 future uninfected orphans. This has enormous consequences for a vast, populous country such as India, in a societal context where child bearing is considered essential for a woman and is accorded a high priority by families. For India, a major challenge for the future is how to keep the prevalence of HIV infection among women low and how to reduce mother to child transmission.

HIV is proving to be one of India's most complex epidemics, a challenge that goes beyond public health, raising fundamental issues of human rights and threatening development achievements in many areas.

TB

Tuberculosis (TB) remains a serious public health problem in India, accounting for nearly 1/3rd of the global burden. Every year there are 2.2 million new cases in the country of which 1 million are infectious smear positive pulmonary cases. One person dies from TB in India

every minute – more than 1,000 every day, 500,000 every year. TB primarily affects people in their most productive years of life and is more common among poor populations. In fact, TB is four times more likely to affect the poor. A preliminary analysis of 4,000 TB patients in India showed that 99% were from below the poverty line.

The TB problem is further compounded by an estimated 3.86 million people infected with human immunodeficiency virus (HIV). As TB is the commonest opportunistic infection amongst HIV-infected individuals, HIV-associated TB will increase the magnitude and severity of the TB epidemic.

TB creates unsustainable economic loss, primarily affecting people in their most productive years of life. A TB patient loses three to four months of work time, equivalent to 20-30% of their annual household income. It also has devastating social costs, with more than 300,000 children estimated to leave school each year because of their parents' TB. More than 100,000 women with TB are rejected by their families.

This continued burden of disease is particularly tragic because TB is nearly 100% curable. Poorly treated patients develop drug resistant and potentially incurable TB. It is estimated that almost an equal number of TB cases are detected and treated by non-governmental organizations and private practitioners as in the public health sector.

Malaria

After a significantly decline in the 1960s, malaria re-emerged as a major health program in India in the late 1970s and presently it poses a major challenge to the country with 2 to 2.5 million cases and 1,000 deaths annually. The *P.falciparum* malaria, which is known to cause major health complications and death, has shown an increasing trend. Approximately 50% of total cases of the country are Pf. cases. The country contributes about 70-75% malaria cases of the SEARO region. The four states which have been selected for this project consist of only 15% of the country's population but contribute 58% of the country's malaria burden and perhaps 65-60% of malaria-related deaths.

Out of reported malaria cases, the proportion of *P. falciparum* ranges between 30-85%. In these states every year approximately 17 million individuals suffer from fever, presumed to be clinical malaria. Malaria is fully preventable if the effective control measures are timely. As pregnant women and children are more vulnerable to malaria so a substantial percentage of these groups suffer from malaria morbidity and mortality.

A.6. Economic situation: (Refer to official indicators such as GNP per capita, HDI or other information on resource availability) (*Guidelines para.6*)

India is the largest country in the South Asia region, both geographically and in population size. India is classified by the World Bank as a country in the Low Income Group and has a Gross National Income per capita rate of US$450, just below that for South Asia ($460). India is a country of striking diversity. Its population of 1.027 million (Census 2001) is predominantly rural (72%), despite rapid urban growth over the past decade. The country has a growing economy, yet 35% of the population are living below the below national poverty line. There is a sizeable amount of poverty-related population mobility, rural-urban, across states and across countries. The annual average labour force growth (2.3%) is outstripping the annual average population growth (1.8%). Rapid urbanisation has resulted in large slum populations.

The country has achieved improvements against some human development indicators over

the past decade. India is currently classified by UNDP (2001) as being a medium human development country; it is ranked 115 out of a range of 49 to 126 in this group. It has a Gender Related Development Index rank of 105. However, many of the development indicators suggest that India's women and numbers of its children still suffer multiple disadvantages. India's maternal mortality rate is incredibly high, at 540 maternal deaths per 100,000 live births. With 16% of the world's population, India accounts for over 20% of the world's maternal deaths. The country's infant mortality rate of 69 per 1,000 live births is still far too high, even though the rate has decreased significantly over the period since 1951 and the sex differentials are narrowing. The under-five mortality rate, which UNICEF uses as the single most important indicator of the state of a nation's children, is even higher at 96 per 1,000 live births. The female adult literacy rate of 42% is very low when compared with the male rate of 69%.

Factors influencing health status, which become even more critical for poor migrants who are unemployed or are lowly paid workers, include inadequate infrastructure in health and social services, illiteracy, low women empowerment, low school enrolment and limited access to information. Only 2% of central government expenditure is allocated to health.

Given its population size, India's fertility rate of 3.2 compares favourably with that of other countries in South Asia, although it is well above the level for East Asia and the Pacific. However, an examination of the fertility rate in the context of antenatal coverage and childbirth, suggests the potential for additional risk to the health of women in the childbearing age group. India had an estimated 25,204 births in 2000. An estimated 50.7% of births are at high risk. Yet, only 42% of births have a skilled attendant at delivery. Only 60% of women aged 15-49 are attended at least once during pregnancy by skilled health personnel, doctors, nurses or midwives.

A.7 Political commitment: (government contribution to the financing of the proposal or public spending on health or existence of supportive national policies or presence of a national counterpart in the proposal, or other indicator) (*Guidelines para. 6*).

HIV

The Government of India's (GOI) commitment to reducing the spread of infection of HIV/AIDS is evident from substantial financial contributions from the national budget and the inclusion of indicators for reducing the spread of HIV/AIDS in both the National Population Policy 2000 as well as the National Health Policy 2001. A National AIDS Committee reports to the Prime Minister who regularly reviews and monitors the progress of all sectors in addressing the epidemic.

The National Development Planning is conducted centrally by the Planning Commission of India. Five year developmental plans are developed. Currently, the country is implementing the Ninth Five Year Plan (1997-2002). The allocations and the expenditures for the National AIDS Control Program during this period were US$ 153.33 million.

The 10th Five Year Plan (2003-2007) major goal for the NACP is to stabilize the HIV infection levels in the country (same as that of the National Health Policy goal). The 10th Plan Working Group recommendations for the NACP are for strengthening and expansion of the components of Phase II and have included the Family Health Awareness Campaign (see Component C.1.b). The suggested budgetary allocation for all the components of the NACP in this plan is Rps 18600 Million (US$372 million).

In March 2000, the National AIDS Control Programme (NACP) initiated a two-year PMTCT Feasibility Study, supported with Government of India and UNICEF funds. The study has a primary objective of assessing the efficacy of short duration antiretroviral regimens in preventing vertical transmission of HIV (See Component C.1.a.). The Government of India (GOI) and UNICEF have together committed funds for the inception phase capacity building segment for the national PMTCT programme. The GOI contribution is included in the budget

of Rs 1425 Crores (US$296million) for the implementation of the five-year National AIDS Control Programme (NACP II, 1999-2004).

TB

The high level of political commitment given by the Government of India (GOI) to TB control is demonstrated by the increased budgetary allocations for TB Control: from US$10.8 million in 1996-97 to US$28.3 million in 2001-02. From a meagre coverage of 18 million by the Revised National TB Control Programme (RNTCP) in 1997, there are currently more than 450 million in coverage areas. The GOI is continuing to take aggressive steps to meet global TB control targets by covering the entire country with RNTCP by the year 2005. Currently, a coverage of 800 million has been approved for RNTCP implementation by 2004 with assistance from the World Bank, DFID and DANIDA. This will ensure 100% coverage in 16 States / Union Territories and partial coverage in the rest of the country.

Malaria

The Government of India is fully committed to the control of malaria. The national malaria control programme was launched in 1953, which was followed by the National Malaria Eradication Programme as one of the vertical programmes with full political commitment. To achieve wide and sustained availability of antimalarial services, the programme has been integrated within the primary health care system. The National Anti Malaria Programme (NAMP) is one of the largest health programmes of the government, with approximately 20% of the budget for the national health programme allotted to the NAMP. Additional support has been obtained from World Bank (WB) for the Enhanced Malaria Control Project (EMCP) in selective hard-core malaria areas of 8 states. This has been in operation since September 1997 and is budgeted at US$200 million. For the 9th Five Year Plan, an outlay of Rs. 13500 million (US$281 million) has been allocated.

A.8 Links with existing activities: (What links are there between this proposal and other current activities supported, for example, through, national health strategies, Poverty Reduction Strategies and Sector-Wide Approaches? Provide copies of these as supporting documentation, noting them in Attachment 1).

The Draft National Health Policy gives overriding importance to ensure a more equitable access to health services across the social and geographical regions of the country so that it helps equitable development and growth. It seeks to make the health system more pro-poor for those who disproportionately bear the high burden of communicable diseases like TB, malaria, and HIV.

The strategy to reduce poverty in India is multi-faceted focusing on direct intervention through poverty alleviation programmes, increasing more employment opportunities, promotion of agriculture and agro-processing, nutritional and food security through subsidised supply of food grains, and better education. The emphasis on expanding the coverage of prevention and treatment for these three diseases contributes to the integrated strategy of better health, particularly for the poor.

Links within each disease category are highlighted below.

HIV

The HIV components have the following linkages:

1) **NACP, National Health and Population Policies**
   The proposal's link to various components of the NACP and the link to the National Health and Population policies are discussed under Section A 4. The proposal will facilitate early diagnosis and treatment of STIs and will thus strengthen the STI treatment and surveillance of STIs as recommended by the 10th Five Year Working Group.
2) **Primary Health Care and RCH programme**
   The proposal will improve the quality of RTI/STI services delivered by the Sub-centres (SCs), Primary Health Centres (PHCs) and First Referral Units (FRUs) and thus ensure sustainability of the activities. This contribution will also improve the quality of family planning services provided as screening for and management of RTI/STI is one of the indicators of quality. The RCH programme funds the drugs for RTIs and STIs at the FRUs.
3) **Women's empowerment**
   The focus on providing information to the women in rural and urban slum areas also contributes to the National Policy for Empowerment of Women as information lays the foundation for empowerment that can lead to actions for prevention of HIV.
4) **Sustainable development**
   The proposal will be contributing to reduced transmission of HIV in the economically productive age group in the rural area, who form the backbone of the economic activities and thus will contributing to economic growth and sustainable development.
5) **Involvement of *Panchayat* (local self government)**
   The involvement of *Panchayati Raj* Institutions in the proposal ensures sustainability of activities as these bodies have the power and the funds to support activities for community's development.

Primary prevention of HIV infection among men and women of reproductive age is a fundamental long-term strategy for prevention of HIV infection in children. Prevention strategies targeting young people and high-risk behaviour groups are already an integral part of the National AIDS Control Programme (NACP II), in all states, and are achieving results. Special emphasis under NACP II is being placed on strengthening health system and community capacity for prevention, care and support. There is a range of awareness-raising activities targeting the general population, including through the Family Health Awareness Campaign. However, the increasing prevalence of HIV among women attending antenatal clinics, especially married women, indicates that additional and more specifically prevention, care and support interventions are needed to reduce mother to child transmission of HIV.

The national PMTCT programme has been designed to be complementary to the NACP II in terms of priority area focus, and specific activities. The programme management will utilise NACP structures and mechanisms. The programme interventions have commonalities with many of those required to be delivered through the national Reproductive and Child Health Programme (RCH) Programme. The programme interventions will therefore be implemented through RCH service delivery units and through partner NGOs for the NACP and RCH programmes.

The PMTCT programme outcomes will contribute to the achievement of the NACP II goals and objectives. They will also contribute to the achievement of national population and health goals, in particular those relating to HIV/AIDS, infant mortality and service integration.

TB

The proposal is an additionality to the current ongoing expansion of RNTCP in the country facilitating meeting the global targets of TB control more rapidly and also trying innovative approaches. As per the original RNCTP plan, about 80% of the population to be covered under RNTCP, were in districts using unsupervised rifampicin containing regimens. Due to the long duration of treatment with standard non-rifampicin containing regimens (SR) leading to low levels of acceptability by patients, programme performance in those districts using SR have been the lowest with poor case holding results. In this proposal, over 80% of the districts to be covered by RNTCP are at the present using SR regimens. Lessons learnt in

implementing RNTCP in these three States which have large tribal populations, “hard to access” populations (e.g. due to difficult geographical terrain) and other underserved populations, will lead to improved RNTCP implementation elsewhere. Involvement of NGOs and the private sector in the process of widening the reach of RNTCP will be actively sought.

In addition to the health sector, RNTCP activities link with other sectors such as the Integrated Child Development Services Scheme of the Department of Women and Child Development, via the Anganwadi Workers who act as DOT providers. Grass-root level elected representatives of the people (Panchayat leaders), cured TB patients, traditional birth attendants and people from the community at large such as tailors, grocers, shoemakers and dhobi-wallahs also participate in the programme as DOT providers.

Malaria

For the control of malaria, area specific strategies have been well identified and are currently being implemented in the country. However, due to resource constraints, the programme has not been able to scale up optimally. In order to fill these gaps and achieve desired impacts, additional inputs are required. Areas where inputs are required have been identified, and the implementation of control measures will be augmented through the existing system. Realizing the importance of the role of community, future emphasis will concentrate on the enhanced involvement of community in the programme. To promote greater involvement and sustainability, linkages have been developed with other sectors such as Reproductive Child Health Care (RCH).

The private sector as well as non-governmental organizations (NGOs) are to play important roles in the programme. This has been a weak link of the programme in the past. The involvement has been already initiated and will be scaled up by identifying appropriate components for such sectors especially in Information, Education and Communication (IEC), re-impregnation, outreach antimalarial treatment for early diagnosis and prompt treatment and effective case management etc.

A.9 Profile **of the Country Coordinating Mechanism (CCM) – If not submitted by a CCM, please move directly to A.12.** *(Guidelines para. 9-14)*

Various agencies and partners (including NGOs and Research Institutions) that are supporting this proposal are co-ordinated and organised through a country coordinating mechanism which is referred to in this document as CCM.

1. **Name of the CCM:** Country Coordinating Mechanism for the Global Fund to fight HIV/AIDS, TB, and Malaria

2. **Date of constitution of the current CCM:** December 28, 2001

3. **Organizational structure (e.g., secretariat, sub-committee, stand-alone):** The CCM is a separate committee created by an executive order. It has set up a sub-committee to screen and evaluate proposals received for funding assistance.

4. **Frequency of meetings (e.g. monthly, quarterly):** Quarterly

5. Major functions and responsibilities of the CCM:

- To promote public – private partnerships in the effort to combat HIV, TB, and malaria specifically and to develop health systems generally;
- To consider all funding proposals received in relation to the above diseases and prepare a comprehensive country proposal for prevention to the fund; and,
- To devise and implement mechanisms (essentially country – driven) for monitoring and evaluation.

6. **Major strategies to enhance CCM's role and functions in the next 12 months:**

- To strengthen the monitoring and evaluation role
- To ensure accountability (financial and programmatic) for activities which are supported by the fund
- To incorporate need-based changes in the CCM constitution

A.10. Please provide the total number and composition of members of CCM:

People living with HIV/TB/malaria
1
NGOs/Community-based organisation
4
Private Sector
3
Religious/Faith groups
0
Academic/Educational Sector
1
Government Sector
8
Other (explain) United Nations (UNICEF, WHO, World Bank, UNAIDS)
4
Bilateral Donors (DFID, USAID)
2

TOTAL
23

A.10. Signatures:

Members of the Country Coordinating Mechanism (CCM – see following page) sign below to endorse this proposal. Endorsement of this proposal does not imply any financial (or legal) commitment on the part of the partner agency or individual:

Signature,

Chair of Country Coordination Mechanism: _____

Chair Name and Contact Information: Mr. J.A. Chowdhury, Secretary (Health)
Ministry of Health and Family Welfare
Phone 91 11 301 8863
Fax 91 11 301 4252

CCM Member Signatures

Agency/ Organization	Name/Title	Date	Signature
Govt. of India	Dr. S.P. Agarwal, Director General Health Services	28.02.02	
Govt. of India	Mr. J.V.R Prasada Rao, Special Secretary(Health) & Project Director, NACO	28.02.02	
Govt. of India	Mr. Deepak Gupta, Joint Secretary, Ministry of Health	28.02.02	
Govt. of India	Ms. Bhawani Thyagarajan, Joint Secretary, Ministry of Health	28.02.02	
Govt. of India	Ms. Rekha Gupta, Financial Adviser, Ministry of Health	28.02.02	
Govt. of India	Dr. G. R. Khatri, Programme Manager, Dy. Director General (TB)	28.02.02	
Govt. of India	Dr.Ashok Kumar, Director, National Anti-Malaria Programme	28.02.02	
Indian Council for Medical Research	Dr.Lalit Kant, Sr. Deputy Director General, ICMR	28.02.02	
World Bank	Dr. K. Sudhakar, Senior Public Health Specialist	28.02.02	
WHO	Dr. Robert J. Kim-Farley, WHO Representative - India	28.02.02	
UNAIDS	Dr. David Miller, Sr. Country Programme Adviser	28.02.02	
DFID	Mr. Tim Martineau, Senior Adviser, Health	28.02.02	
USAID	Dr. Victor Barbiero, Director, Population, Health, and Nutrition	28.02.02	
UNICEF	Dr. Marzio Babille, Chief, Health Section	28.02.02	
Voluntary Health Association of India	Mr. Alok Mukhopadhya, Chief Executive	28.02.02	
YRG Care Foundation	Dr. Suniti Solomon, Director	28.02.02	

Vivekananda Education Society	Mr. C.G. Chandra, Secretary	28.02.02	
Sevadham Trust	Dr. S.V. Gore, Managing Trustee	28.02.02	
Confederation of Indian Industries	Dr. Sandhya Bhalla, Representative	28.02.02	
Federation of Indian Chambers of Commerce and Industry	Ms. Ranu Kulshrestha, Project Officer	28.02.02	
Associated Chambers of Commerce and Industry of India	Mr. Vikas Mohan, Deputy Secretary	28.02.02	
Indian Network for People living with HIV/AIDS	Mr. Banta Singh, General Secretary	28.02.02	

A.11. In case the Global Fund Secretariat has queries on this submission, please contact:

Name:	Mr. Deepak Gupta	or	Mr. Navreet Singh Kang
Title/Address:	Joint Secretary Ministry of Health & Family Welfare Nirman Bhavan, New Delhi, 110 011 India		Director - Finance NACO/MOHFW 9th Floor, Chandralok 36 Janpath New Delhi, 110001 India
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E-mail:	jsd@nb.nic.in		nskang@vsnl.net

A.12. If submitting not under a CCM, but as an individual or a partnership of non-governmental organizations (NGOs) or from private sector, please explain clearly the circumstances, conditions and/or reasons why not applying under a CCM.

Not applicable

SECTION B: OVERALL PROPOSAL

B.1 Summary of overall proposal: (Synopsis of proposal, describing overall objectives, who will be involved, the beneficiaries, listing the major health components and the synergies between the different components. [more detail on separate components is sought in section C]).

Epidemiologic evidence

This proposal seeks to obtain support for a package of key interventions necessary for an improved and expanded prevention and treatment response to HIV, TB, and malaria in India. These three diseases are responsible for high levels of mortality and morbidity in India and, indeed, the country is a major contributor to the overall global burden. India accounts for one-third of the world's burden of TB, is second only to South Africa in the total number of people with HIV infection, and contributes 70-75% to the SEARO region malaria cases.

Because of India's vast population size, differing socio-economic development between states, and other disease-specific factors, the distribution and burden of HIV, TB, and malaria in the country are highly varied. For example, the six states of Tamil Nadu, Maharashtra, Andhra Pradesh, Karnataka, Manipur, and Nagaland have a combined population size larger than any country in the world other than China and currently have a generalized HIV epidemic, with over 1% of their population infected. The remaining states and territories are currently registering lower HIV epidemic levels. The malaria burden is also highly concentrated, but in different states: Orissa, Madhya Pradesh, Jharkhand, and Orissa contribute 58% of the country's malaria burden but have only 15% of India's population.

This diversity in the geographic distribution of disease in India necessitates differential targeting by disease so that prevention and treatment targets are achieved effectively and efficiently. This proposal reflects this diversity by focusing proposed interventions among sub-population groups in areas where current incidence and future vulnerability are high and where coverage of current programs is deficient. Indeed, the coverage of vulnerable populations in India is the major obstacle to reaching overall national goals in health.

Additional epidemiologic evidence appears in this proposal under Section A. 5. Disease Burden.

Overall proposal strategy

The overall strategy consists of a set of interventions designed to have the most significant impact on the reduction of HIV, TB, and malaria in India. Five major factors were used to determine the overall package of proposed interventions: 1) evidence of intervention impact 2) gaps in coverage and integration with existing services 3) public and private sector partnerships 4) community involvement and 5) feasibility of implementation in terms of both capacity and cost.

This proposal contains components both for the development of new model interventions as well as the scale-up and expansion of tested interventions that do not yet have adequate coverage. Both are necessary if India is to progress in its response to the combined threats of HIV, TB, and malaria. The more established TB and malaria epidemics require greater coverage and new approaches in the public and private sector to achieve efficiency. The

expanding HIV epidemic requires greater coverage as well but also an evolved response that begins to address the huge treatment and care burden of a maturing epidemic. This proposal reflects these priorities.

Proposal process
The interventions proposed here are a product of input from the government, non-government, and private sectors of India in a transparent and open process organized by the CCM. As part of the preparation for this proposal, components went through a technical and management review which addressed the strategic factors mentioned above: evidence of impact, gaps in coverage and integration with existing interventions, public and private sector partnerships, community involvement, and feasibility of implementation in terms of both capacity and cost.

The product of this review was that several components proposed in the initial phase were determined to be lacking in these strategic factors. Some of these have not been included in this submission but were referred for further review and consideration in future submissions if these factors can be adequately addressed. Other components have undergone significant changes in their strategy, resulting in improved designs, partnerships, and planned impact. Those components that lack evidence but instead propose to test new and innovative models that are important for future programming have been included in limited sites.

The final components presented here are designed to meet the most urgent needs of the country which can be feasibly implemented and attain the highest impact on disease burden.

Summary of proposal components
The following provides a short summary of the justification and need under each disease category and descriptions of each of the following for each component: 1) Major objectives 2) Beneficiaries 3) Implementation strategy and 4) Organizational involvement. Further information can be found under each component in Section C.

1. HIV

Justification and need
The HIV epidemic in India is highly diverse, with a generalized epidemic (>1% prevalence in ANC women) currently in six states. However, vulnerability factors including high migration from low prevalence to high prevalence areas, poverty, and low literacy may quickly expand the epidemic to affect even larger populations in the country. Surveillance data suggest that this is already occurring.

Government and non-government interventions have to-date concentrated on targeted interventions among sex workers and their clients, injecting drug users, men who have sex with men, and other vulnerable populations. Behavioural surveillance data suggest that behaviour change in terms of increased condom use between males and their commercial sex partners has begun to occur. While there are still coverage gaps in these interventions, a major expansion of programming is in development.

Because of a maturing epidemic in higher prevalence areas, the general population is now under increased risk of HIV infection, mother-to-child transmission (MTCT) is occurring

among those women already infected, and an increasing number of HIV+ individuals are in need of antiretroviral therapy. For these reasons, we propose a focused package of interventions which seek to:

1) reduce mother-to-child transmission in selected high prevalence areas;
2) reduce behavioural risks and sexually-transmitted infections (STIs) in communities through a community-driven Family Health Awareness Campaign already in operation in selected areas; and,
3) begin an innovative cost-recovery pilot program in anti-retroviral therapy in 4 sites.

The first two benefit from feasibility studies and limited roll-out which have provided lessons learned for effectiveness and feasibility for more expansive coverage. The latter antiretroviral therapy program is proposed in order to provide the country with the development of a feasible model conducted in a focused and limited setting.

1. Prevention of Mother-to-Child-Transmission (PMTCT): From Feasibility to Scale-up (Component C.1.a)

Major objectives

- Increase the proportion of pregnant women accessing quality MTCT prevention to 60% by 2005.
- Increase the proportion of partners of antenatal patients who are provided with MTCT pre- and post-test voluntary and confidential counselling and testing to 50% by 2005.
- Increase the proportion of HIV positive pregnant women and mothers who are provided with quality MTCT secondary prevention to 80% by 2005.
- Increase the proportion of clinically eligible HIV positive mothers who are provided with a complete course of antiretroviral therapy to 30% of those in the six high prevalence states by 2005.

These objectives are expected to lead to the following goals:

- Reduced HIV prevalence among pregnant women age 15-49 to below 3% in the six high prevalence states and below 1% in the other states by 2005; and,
- Reduced proportion of infants infected with HIV to below 20% of live births among HIV+ women by 2005, and below 10% by 2010 among HIV+ women.

Beneficiaries

Pregnant women attending public and private antenatal clinics and diagnosed HIV positive mothers and their families will primarily be the direct beneficiaries of improvements in service coverage, accessibility and quality. The husbands/male partners of these women will also be direct beneficiaries.

Implementation strategy

The design has evolved over the course of the PMTCT Feasibility Study (2000 – 2002), involving eleven medical colleges across six high prevalence states. It reflects and addresses lessons learned from the study, in particular those relating to rates of intervention uptake, return for test results, and adherence and compliance, and also socio-cultural and economic factors influencing those rates. The feasibility study, funded by the Government of India and UNICEF, has demonstrated on a pilot-scale the effectiveness of broad partnerships in catalysing and strengthening health system responses to mother to child transmission.

The PMTCT model is built around a **Three-Pronged Strategy**, encompassing five key elements:

Prong I

1. Prevention of HIV in young people.
2. Prevention of HIV in women of childbearing age.

Prong II

3. Prevention of unintended pregnancies in HIV positive women.

Prong III

4. Prevention of transmission from an HIV positive woman to her infant.
5. Care for the HIV positive mother and her family.

There are a number of major feasibility and sustainability risks for the national PMTCT programme. Overall,

these relate to the sheer magnitude of the scale of country-wide coverage and of the tertiary and secondary health system coverage. Scaling up to a national PMTCT programme has never before been attempted in such a vast and populous country. Strategies to reduce these risks have been built into the design. A decentralized, phased and incremental approach has been adopted for scaling up; in terms of geographical coverage, institutional capacity building (through PMTCT training and infrastructure strengthening) and PMTCT/RCH service implementation and improvement. A multisectoral partnership approach has been adopted for implementation.

Organisational involvement

India has the capacity and partnerships for intensive action to channel resources to significantly reduce MTCT within three to five years. India's decentralised National AIDS Control Programme (NACP II) is well established, with a decentralised structure and strong partnerships. It extends throughout the public health care delivery system. The multisectoral and multi-level partnership for the national PMTCT programme involves a range of other key partners: the Department of Women and Child Development, the 11 PMTCT Centres of Excellence, around 1,000 participating medical colleges, maternity hospitals and district hospitals (in particular their PMTCT core teams and RCH staff), primary health centres and partner NGOs/CBOs. Technical support partners include UNICEF (PMTCT Feasibility Study, capacity building, operational research, policy development, quality assurance for counselling and training, and monitoring and evaluation), the AIDS Resource and Control Centre, Mumbai (ARCON) for training material development, the National AIDS Research Institute (NARI) for technical supervision, monitoring and evaluation), and NACP Technical Resource Groups (coordination, technical supervision, and monitoring and evaluation).

2. Strengthening and expanding the Family Health Awareness Campaign (Component C.1.b.)

Major objective

- To reduce HIV/STI transmission among rural and urban slum communities by improving access to quality STI services and promoting behaviour change strategies such as increased condom use.

Beneficiaries

The main beneficiaries of this intervention are at-risk rural and urban slum women, adolescents and youth.

Implementation strategy

The Family Health Awareness Campaign (FHAC) is named as such to appeal to families so that both men and women attend. However, its major thrust is on behavioural change strategies and the prompt treatment of STIs. The strategy for implementation is through a number of outputs and activities. These include inter-personal communication with rural and urban slum women by health workers at home, peer group discussions with adolescents and youth organized by female and male volunteers, group discussions with men by male health workers to promote male involvement, and the reinforcement of messages through interactive discussions with women and men attendees in the community camps and mass media channels such as wall paintings and posters.

Organisational involvement

The intervention will be jointly implemented by the district level nodal officers of the AIDS Control and the RCH programmes in collaboration with district level officers. While the health sector will focus on increasing access to information among women and men, the National Service Scheme (NSS) and other volunteers will focus on adolescents and youth. The health workers, NSS, and Nehru Yuva Kendra (NYK) are responsible for implementing the activities of the Intervention.

3. Model cost-recovery program in antiretroviral therapy (ART) in 4 sites (Component C.1.c)

Major objectives

- Provide access to ART to at least 3,000 more individuals than currently have access.
- Demonstrate through improved monitoring of CD-4 counts and viral resistance profiles

that sponsored programs are producing no more resistant strains than would occur in model programs in rich countries.
- Provide subsidies for CD-4 counts to be used by private physicians and their patients in the vicinities of sponsored ART programs in order to: a) help private physicians improve patient compliance; b) monitor disease progression and outcome of their ART regimens; and c) monitor the spread of resistant strains among patients not included in the sponsored programs.
- Reinforce prevention programs in the vicinities of sponsored ART programs in order to prevent "backsliding" towards riskier behaviour by the surrounding population and to measure the extent to which such "backsliding" occurs.

Beneficiaries

Approximately 3,000 clinically eligible HIV+ patients will benefit directly from this project. Furthermore, the country will benefit from the establishment of this model for use in planning future programs in anti-retroviral therapy provision.

Implementation strategy

This ART model intervention proposes to introduce the safe and effective use of ART in 4 major cities of India, namely, Mumbai, Chennai, Bangalore and Hyderabad. All sites have wide network of VCT services and have established networking with community-based health and support organisations for home-based care component. It is expected that this intervention, designed as graduated cost-recovery program with an aim of making it financially self-sustainable, will establish benchmarks for best practices of ART in India. The implementing institutions in the 4 cities have the track record and demonstrated capacity to institute, monitor, provide psychosocial support, and good adherence of small number of patients on ART.

Organisational involvement

The major agencies which will be involved in this project include the AIDS Research & Control Centre, (ARCON) in Mumbai; YRG Care, Chennai; the Freedom Foundation, Bangalore; and the Freedom Foundation, Hyderabad.

2. TB

Justification and Need

The creation of three newly created states in India has created infrastructural and coverage needs to a population of over 56 million. Furthermore, recent reviews have suggested that private sector programmes should be expanded. The two components under TB address these priorities.

1. Expansion of the Revised National Tuberculosis Control Programme (RNCTP) (Component C.2.a)

Major Objectives

- To expand RNTCP to cover 56 million population in all 47 districts of the three newly created states of Jharkhand, Uttaranchal and Chhattisgarh under GFATM assistance.
- To improve quality and reach of RNTCP through availability of free and uninterrupted high quality TB diagnostic and curative services, more patient-friendly treatment observation, greater involvement of other government, private and NGO sectors in the RNTCP, addressing gender and childhood issues and enhanced IEC.
- To develop and implement new strategies by building partnerships with non-governmental organisations, private sector and community representatives to ensure availability of diagnostic and treatment facilities in geographically difficult areas which can be replicated in other such areas of the country.

These will contribute to the overall objective to achieve at least 85% treatment success and at least 70% detection of new smear positive cases in these states.

Beneficiaries

- 115,000 patients who will be initiated on treatment.
- 20,000 patients whose lives will be saved.
- 230,000 individuals spared from becoming infected with TB.

Implementation Strategy

RNTCP will continue to be implemented as a centrally sponsored scheme. However, significant decentralization to states is proposed for implementing and monitoring the programme. Considerable flexibility has been introduced in flow of funds and programme management by using the mode of societies at State and District levels. Additionally, these societies embody partnerships because NGO and private sector representatives are their members. Funds will be routed to Districts through the States rather than directly from Govt. of India.

A microscopy centre will be set up for 0.1 million people and a TB unit will be set up for 0.5 million population (this would be lowered according to population dispersion in tribal, hilly areas). Drugs will continue to be procured through an independent procurement agency with adequate quality control mechanisms.

Concerted efforts are being made to involve NGOs and private sector in RNTCP. Five schemes for NGO exist and guidelines for private sector participation are being finalization. Already about 350 NGOs and about 700 private practitioners are participating apart from many private hospitals. The special conditions of these 3 states necessitate further development of new partnerships to implement RNTCP. In order to increase access, on the one hand, all NGO and private sector hospitals will need to be fully involved. On the other, communities will need to play an active role through their own leadership and structures. We will also use organizations such as women's self help groups. This will be particularly true for awareness generation and for provision of DOT centres.

Training is key to success for RNTCP and all health personnel involved in implementation of RNTCP will be trained through specially prepared modules as per the current policy of GOI. NGOs private participants and community leaders will also need to be trained/ sensitised at state and district levels and DOT providers at appropriate facilities within the districts.

Organizational Involvement

The Ministry of Health and Social Welfare in coordination with private sector, NGOs and civil society organizations working in Chhattisgarh, Jharkhand and Uttaranchal.

2. Improving Private Sector TB Treatment in Tamil Nadu, India through expansion of a Model Private-Public Partnership (Component C.2.b)

Major Objective

Achievement of an overall cure rate of 85% at participating clinics.

Beneficiaries

- TB patients; and,
- In addition, other Indian states will benefit from the application of lessons learned drawn from careful monitoring and evaluation of this model private-public collaboration.

Implementation Strategy

The project will be carried out by REACH (Resource Group for Education and Advocacy for Community Health) in collaboration with the Tuberculosis Research Centre (TRC). As a first step, REACH will establish a database of information on current patient, laboratory and provider practices in order to plan, monitor and evaluate project progress.

To equip private health care providers with the knowledge and skills needed to treat TB patients, REACH and TRC will develop a manual for practising physicians on the treatment and management of tuberculosis. To ensure quality level of diagnosis and also to strengthen the laboratories in areas identified through baseline data collection mentioned above, REACH and TRC will identify one state-of-the-art laboratory in each of the ten zones and equip it to become a sputum microscopy centre. REACH will also establish a quality assurance network and accreditation system will be established for these laboratories.

In order to provide directly observed treatment in a time and place convenient to the patient, REACH will recruit various outlets (hospitals, clinics, pharmacies) to serve as DOTS centres. Volunteers will be trained to counsel patients on the various components of the DOTS laying emphasis on treatment, completion and cure. In addition, REACH will strive to reduce stigma and encourage appropriate health seeking behaviour through the application of behaviour change communications (BCC) strategies.

To foster collaboration REACH will promote the establishment of an Apex body consisting of Government and non-Governmental organisations to guide the development of the program and to evaluate outcomes and the potential for replication on a larger scale. Chennai Corporation which is committed ideologically to the RNTCP and the DOTS programme would be an important member of this body.

Organisational Involvement

The project will be carried out by REACH (Resource Group for Education and Advocacy for Community Health) in collaboration with the Tuberculosis Research Centre (TRC). REACH is a non-profit advocacy agency for areas critical to community health, particularly those affecting the lower socio-economic groups. REACH has launched a programme for involving private practitioners and private laboratories in Chennai, India, in the Revised National TB Control Programme, using the DOTS methodology to treat their private patients. This program called ACT–Advocacy for Control of Tuberculosis has been working in Chennai for the past three years.

3. Malaria

Justification and need

The four states which are the geographic concentration of this proposal (Chattisgarh, Madhya Pradesh, Jharkhand and Orissa) consist of only 15% of the country's population but contribute 58% of the country's malaria burden. Out of reported malaria cases, the proportion of *P. falciparum* ranges between 30-85%. In these states every year overall 17 million suffer from fever that is presumed to be clinical malaria.

These states could not be included under the Enhanced Malaria Control Project (EMCP) assisted by the World Bank due to their inability to qualify for one of the inclusion criteria: tribal population more than 25%. These states nevertheless have similar malaria transmission dynamics and require enhanced control measures.

The proposed activities consisted of expanding the strategies of the EMCP under the National Anti Malaria Programme to these areas.

1. Expansion of the Enhanced Malaria Control Project (EMCP) (Component C.3.a)

Major objectives

- Scaling up of anti-malarial services in the uncovered districts under EMCP of the state of Chattisgarh, Madhya Pradesh, Jharkhand and Orissa (63.3 million population) as to consolidate over all achievements of Enhanced Malaria Control Project in these states.

- Enhanced implementation of innovative control methods like insecticide treated mosquito nets (ITMN) by improving community behaviour and the involvement of NGOs.

- Reduction of malaria morbidity and prevention of death so to achieve 25% reduction of morbidity by the end of third year.

- Improved coverage of vulnerable groups like pregnant women and children.

Beneficiaries

Direct beneficiaries: 63.3 million population of the 48 districts in 333 PHCs of the identified 4 states in terms of effective prevention from malaria and access to diagnosis and prompt uninterrupted treatment for malaria

Implementation strategy

Under the project, the components, which have been already identified for EMCP implementation, will be strengthened in the non-EMCP areas of these states. The following will be the main components of the project.

- Early diagnosis and prompt treatment (EDPT).
- Selective vector control.
- Promotion of personal protection methods – ITMN.
- Early detection and containment of epidemics and intersectoral co-ordination. *
- Information, education, and communication. *
- Institutional and management capacity building - Trained Manpower Development, efficient Management Information System (MIS), etc.*

***** These components are already been covered under EMCP for entire country.

Organizational involvement

State Malaria Control Societies will partner with local NGOs for the implementation of the project. These societies operate similar to NGOs and are an innovative government mechanism to promote financial and programmatic efficiency.

4. Cross-cutting programs

Justification and need

Two major projects are proposed which are cross-cutting and seek to integrate multiple disease prevention and treatment strategies into their programming. These include a Confederation of Indian Industries project in workplace settings which will also stimulate financial and programmatic support from industry members as well as an integrated rural health project in 6 vulnerable areas of the country.

1. Industry response to HIV/AIDS & TB – Advocacy to Action in industrial estates (Component C.4.a)

Major Objectives

- Reduce HIV and TB risk behaviours through the implementation of behaviour change interventions including workplace peer education.
- Support the development and implementation of written policies, education programs and non-discriminatory practices among participating industrial estates, both CII and non-CII members.

- For industrial estates lacking medical services, identify and refer workers with TB and HIV to appropriate area testing and treatment centres.
- For industrial estates with medical services, provide appropriate care and support to workers and their families affected by TB and/or HIV/AIDS.

Beneficiaries

Workers and their families, affected or at risk of HIV and/or TB, at industrial estates located in the four high prevalence states of Tamil Nadu, Andhra Pradesh, Maharashtra and Gujarat

Implementation Strategy

- Conduct a rapid need assessment of the existing knowledge level and practices within the industrial estates in the high prevalence states.
- The Indian Business Trust would at the outset form a core group of industry members and other stakeholders, at each industrial site.
- Develop an advocacy and an IEC package, for workplace policy and programme development.
- Organize advocacy meetings with captains of industry and trade union representatives.
- Facilitate need assessments in individual companies if required.
- Facilitate workplace programme implementation in companies.
- Help identify and train peer educators in companies.
- Facilitate referral network for counselling for HIV/AIDS and referral for TB to the DOTS centre for complete treatment.
- Facilitate companies, if required for upgrading and improving laboratories for TB testing.
- Facilitating condom programming and availability in the company.

Organisational Involvement

The Confederation of Indian Industry (CII), a non-government, not-for-profit, industry led and industry managed organisation, playing a proactive role in India's development process. Founded over 100 years ago, it is India's premier business association, with a direct membership of over 4200 companies from the private as well as public sectors, and indirect membership of 40,000 companies of over 100 sectoral associations. Recently, CII established the Indian Business Trust for HIV/AIDS (IBT), to focus resources, funds, manpower and time specifically to the effort to reduce and mitigate HIV/AIDS. CII and IBT will collaborate closely with the National AIDS Control Organisation (NACO) and with the Revised National Tuberculosis Control Programme (RNTCP) as well as with other organizations such as the AVERT Society providing HIV/AIDS services within the targeted project states.

2. Integrated TB, malaria, and HIV project in rural areas

Major objectives

- To enhance the capacity of NGO partners and to promote health and prevent diseases particularly Malaria, TB and HIV/ AIDS.
- To orient and mobilize community based groups to actively initiate/ participate in Malaria, TB and HIV/AIDS Control activities in their area
- To enhance the functioning of the public health systems for effective service provision and to improve access to quality health care.
- To promote rational use of drugs in an effort to prevent emergence of drug resistance and complications of the diseases.
- To enhance understanding of the service providers on essentials of the National Health Programmes and to enable them to implement the different components of the Malaria, TB and HIV/ AIDS Control Programmes.

Beneficiaries

Direct beneficiaries will be residents of 6 rural areas (each with a population of about 20,000) who are at risk of TB, malaria, and HIV or who are already infected and require treatment. Indirect beneficiaries will be government and non-government organizations who will learn from this model of service provision.

Implementation Strategy

VHAI (Voluntary Health Association of India) proposes to integrate issues related to Malaria, TB and HIV/ AIDS with the ongoing activities and existing health care systems in partnership with grass-root organizations. The project emphasizes programmes that empower and are empowered by the community and promote community participation through micro-planning. A focus is also on health education and awareness complemented with preventive efforts. The proposed strategy and activities are summarized as:

- Involving community based groups like Self Help Groups and Panchayati Raj Institutions to understand and address the National health Programme comprehensively.
- Coordinate and collaborate with government health institutions and other agencies.
- Improve access of the community to public health services.
- Ensure understanding of the National health programme and its various components by health personnel i.e. beyond diagnosis and drugs e.g. vector control efforts in Malaria; capacity building of the staff.
- Ensure rational drug use based on the therapeutic guidelines and ensure early reliable diagnosis by providing diagnostic facilities directly or through existing facilities.
- Curative service provision for Malaria and TB to be provided in the 6 project areas where the DOTS programme is on/ under preparation for inclusion in the programme.
- Preparation, repackaging and dissemination of relevant IEC material.
- Regular monitoring and evaluation of the programme.

Organisational involvement

The implementation of this project will be conducted by the local branches of the VHAI in collaboration with other NGOS in the project areas and the local district health authorities.

B.2 Programmatic monitoring and evaluation: (*Guidelines para. 34-37*) (The proposal needs to include an outline of the monitoring and evaluation process that will be followed in relation to the overall proposal, including timelines, and baseline data, responsibility for collection, proposed/anticipated use of the information to be collected and involvement of target population with monitoring and evaluation. [Section C requests monitoring and evaluation information on major components])

The CCM of India will appoint a monitoring and evaluation sub-committee to review and finalize feasible process, outcome, and impact indicators and methodologies to obtain those indicators from each project component. (Preliminary indicators are provided under each component.) The sub-committee will also develop a monitoring plan that will specify how projects will be reviewed throughout the course of the project. Beneficiaries of the projects, e.g. people with HIV, TB, and malaria, will be members of this evaluation committee to ensure that target group concerns are addressed.

Projects will submit progress reports every 6 months so that constraints and barriers in implementation can be addressed.

India has established reliable measures of progress in each of the three disease categories that indicate trends in disease or risk behaviours, if applicable. As part of this project, these methodologies will be strengthened in the specific geographic areas of concentration so that the contribution of these interventions

to reductions in disease or risk can be estimated. The major surveillance and evaluation systems in each of the disease categories applicable to this proposal are as follows:

HIV

- A well established 2nd generation HIV and behavioural surveillance system which measures trends in HIV prevalence and risk behaviours is currently in operation in all states. These will be complemented by systematic HIV/STI prevalence surveys in specific population groups.
- A monitoring and evaluation system for prevention of mother-to-child transmission devised through a extensive feasibility project will be used for the expansion proposed in this project.

TB

- Established and tested performance indicators of the RNTCP will be used. These include the percentage of new adult outpatient cases examined for TB by sputum smear microscopy, case detection, smear conversion and treatment success rates. In addition, increased field visits will continue to be the norm to improve field performance.

Malaria

- The monitoring of detection and appropriate treatment are the cornerstones of evaluation for malaria treatment, and this will be conducted in the project areas similar to the NAMP areas.

B.3. Financial management (*Guidelines para. 19-22, 38-40*) (Describe arrangements in place for financial management, including suggested disbursement mechanisms and plans)

Funds for this project will be channelled from the sub-trustee to project implementation organizations through the "multi-check option" suggested by the Transitional Working Group (TWG), subject to approval by the Trustee. Recipients may include state-level AIDS, TB, and malaria control societies that have been established by the Government of India, local NGOs, or private sector companies. The state societies have proven to be an innovative and efficient mechanism to ensure a timely release and use of funds at the state and local levels. The societies have relevant financial and accountability responsibilities and are currently subject to World Bank and Government of India audit requirements.

Funding allocations to participating institutions and NGO/CBO Grant recipients will be against agreed budgets, with release of funds linked to agreed performance milestones. Recipients will submit quarterly and annual progress reports and audit certificates to the CCM or a designated financial monitoring body, with feedback provided back to recipients.

B.4 Statement of Budget Requirements, Financial Commitments and Unmet Needs

(Guidelines para. 8, Annex III.2) (Demonstrate the additionality of the proposal)

(US$ million)

Note: We have provided these statements of requirements, financial commitments and unmet needs by disease category.

HIV
(2002-2003)

	Human Resources	*Logistics & supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or products*	*Data & information systems*	*Other (explain)*	*TOTAL*
Budget Requirements	8.15	3.20	6.20	31.00	7.41	1.81	4.23	62.00 *
Financial commitments, by source								
Government	2.00	0.75	0.30	0.00	1.48	0.36	0.31	5.20
Civil Society	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private Sector	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Donors (USAID, DFID, CIDA, UNDP)	1.52	0.79	0.05	8.32	0.00	0.01	0.11	10.80
.World Bank Loan	2.00	1.51	1.21	15.91	5.93	1.44	1.00	29.00
TOTAL COMMITMENTS	5.52	3.05	1.56	24.23	7.41	1.81	1.42	45.00
UNMET NEEDS	2.63	0.15	4.64	6.77	0.00	0.00	2.81	17.00

**US$62 million represents the amount requested by the National AIDS Control Organization for HIV prevention and treatment for the country. US$45 million is the budgetary outlay that has been provided during fiscal year 2002-2003.*

TB
2002 – 2003

	Human Resources	*Logistics & supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or products*	*Data & information systems*	*Other (explain)*	*TOTAL*
Budget Requirements for 1000 million population	16.95	6.09	6.48	6.67	16.12	0.55	6.30	59.16
Financial commitments, by source (500 million)								
Government	0.19	1.34	0.82	0.44	0.94	0.06	1.11	4.90
Civil Society	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Private Sector	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Donors (DFID & DANIDA	0.62	0.22	0.24	0.24	2.08	0.02	0.23	3.65
Other (WB loan)	9.16	2.02	2.75	3.24	7.09	0.24	2.36	26.86
TOTAL COMMITMENTS	9.97	3.58	3.81	3.92	10.11	0.32	3.70	35.41
UNMET NEEDS	6.98	2.51	2.67	2.75	6.01	0.23	2.60	23.75

Note: The above unmet needs refers to an 'uncovered' population of 200 million. This proposal aims to meet the unmet needs of 56 million out of these 200 million.

**including drugs*

MALARIA

(US$ million)

	Budget Categories (please fill in according to plan)							
	Human Resources	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or products**	*Data & information systems*	*Other (explain)*	*TOTAL*
BUDGET REQUIREMENTS								
Financial commitments, by source								
Government of India	1.09	15.97	0.31	3.25	1.88	-	-	22.50
Civil Society	-	-	-	-	-	-	-	-
Private sector	-	-	-	-	-	-	-	-
Donors	-	-	-	-	-	-	-	-
Others (World Bank Assistance)	0.42	13.52	2.51	2.78	1.26	1.04	0.77	22.29
TOTAL COMMITMENTS	1.51	29.49	2.82	6.03	3.14	1.04	0.77	44.79
UNMET NEEDS**								

**including drugs*

** For effective control of malaria, out of the above central government commitment around $27.05 million is required for the states of Chhattisgarh, Jharkhand, M.P. and Orissa but only around $16 million will be available for the above areas which contributes around 60% of total malaria cases of the country so unmet needs is $11.05 million is required for these areas fro global fund for one year period thereafter $10.5 million annually.

NOTE: 1. Apart from above the state governments meet the expenditure towards the salary and TA/DA of the staff. The unmet needs for the states of Chhattisgarh, Jharkhand, M.P. and Orissa, have been given at Budget Table C 5

2. Above figures does not include $4.21 million that is committed by the Government of India for other vector borne diseases like kala-azar.

B.5 Duration (provide an estimate):

Beginning and end dates*:

From: April 2002 To: March 2005

Period to be covered by this request for financing:

From: April 2002 To: March 2005

*Some variation in start and end dates occur in each project component.

SECTION C.1. HIV
C.1.a. Prevention of mother-to-child transmission

C.1 Description: (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

Vision and Rationale

The vision of India's national PMTCT programme is one of helping India's parents to protect themselves and their childrens' future. The programme rationale is straightforward. The Government's primary strategy for containing the further spread of the HIV epidemic among India's population of 1 billion is one of early prevention. PMTCT is recognised by UNAIDS/WHO as an evidence-based intervention for HIV prevention. In this context, PMTCT is recognised as an additional entry point for prevention in India; one which permits a dual strategy of preventing HIV transmission to women of child-bearing age and reducing mother to child transmission. A national programme will catalyse a rapid and broad-reaching response to this emerging threat. It will provide a framework of prevention and care for the strategic and tactical allocation of limited resources across the country. It will strengthen the capacity of the health system to respond to HIV/AIDS on a long-term basis.

Overall Objectives

The India national PMTCT programme has two overall objectives:

- Reduce HIV prevalence among pregnant women age 15-49 to below 3% in the six high prevalence states and below 1% in the other states by 2005.
- Reduce the proportion of infants infected with HIV to below 20% of live births by 2005, and below 10% by 2010 among HIV+ women.

Achievements against the two overall objectives will directly contribute to the outcomes of the two key project objectives of India's National AIDS Control Programme (NACP II 1999-2004). These are: (a) to reduce the spread of HIV infection in India, and (b) to strengthen India's capacity to respond to HIV/AIDS on a long term basis. The programme will also directly contribute to outcomes for two of the three specific objectives of NACP II: (a) to keep the HIV prevalence rate below 3% of the adult population in Maharashtra, Andhra Pradesh, Karnataka, Manipur, Tamil Nadu, and below 1% in the remaining states by the end of the NACP II project; and (b) to attain an awareness level of not less than 90% among youth and others in the reproductive age group.

The national PMTCT programme objectives are particularly relevant to India's national socio-demographic goals to reduce the infant mortality rate to below 30 per 1,000 live births by 2010 and to contain the spread of AIDS. They are also consistent with the UNGASS global target of reducing the proportion of infants infected with HIV by 20 per cent by 2005 and by 50 per cent by 2010.

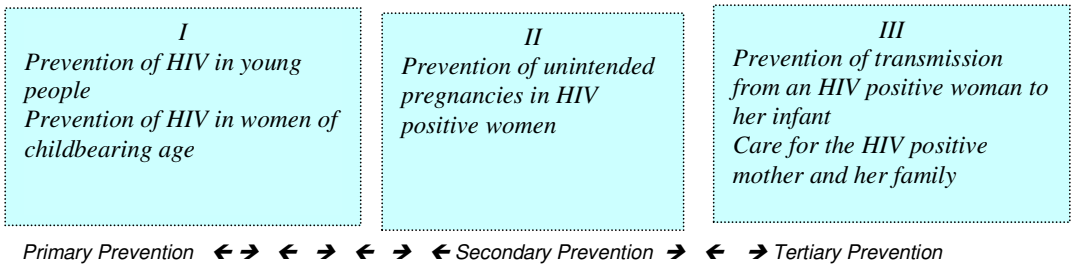
Programme Strategy

The purpose of the national PMTCT programme is to scale up PMTCT to a comprehensive, integrated national programme encompassing public and private sectors, in order to improve access to and use by pregnant women and mothers of quality PMTCT services.

The programme design has been informed by best practice and addresses the Government of India's aim for equitable access to mother to child transmission of HIV (MTCT) prevention and care. This design has evolved over the course of the PMTCT Feasibility Study (2000 – 2002), involving eleven medical colleges across six high prevalence states. It reflects and addresses lessons learned from the study, in particular those relating to rates of intervention uptake, return for test results, and adherence and compliance, and also socio-cultural and economic factors influencing those rates. The Feasibility Study, funded by the Government of India and UNICEF, has demonstrated on a pilot-scale the effectiveness of broad partnerships in catalysing and strengthening health system responses to mother to child transmission.

The process focuses on the application of an implementation model of PMTCT for the public, private and NGO health sectors in India, developed through the Feasibility Study. The application of this model, which has strong commitment from the Government of India (GOI), involves scaling up the PMTCT response from a pilot project to a national programme. In turn, it will generate an evidence - based model for scaling up PMTCT in a vast and populous country.

The PMTCT model is built around a ***Three-Pronged Strategy***, encompassing five key elements:



The model focuses on decentralised comprehensive PMTCT, covering the range from primary prevention in women and men in the childbearing age group to post natal care and support for HIV positive mothers and their families. The need to decentralise and integrate PMTCT into the national Reproductive and Child Health (RCH) programme is recognised by the GOI, as a means of increasing both the coverage for women and men in need of MCTC (mother to child transmission of HIV) interventions and the sustainability of prevention and care services.

The three-pronged strategy is underpinned by a primary focus on improving outcomes for target populations. Its application to the national programme is that of a tool for increasing access to comprehensive and integrated PMTCT services; as a means of empowering pregnant women to protect themselves and their children from HIV and to help HIV positive mothers improve the quality of their life and that of their family. It places value on the active involvement of husbands and male partners, to reduce the vulnerability of women and their families.

Pregnancy provides a window of opportunity for prevention and care, as it is a critical receptive period of life in which messages related to women's protection from HIV infection and to safe delivery and safe childhood are more likely to be accepted by both the mother and father. A cross-cutting theme for an effective PMTCT response is that of rights: women's rights to information, to primary prevention, to knowledge about their HIV status, to quality life and care, and to empowerment in choosing to prevent an HIV infection in their baby when they are infected; children's rights to life and care; and rights for people affected by HIV/AIDS to non-discrimination in the health system as in the community and family.

Components

The national programme has three integrated components:

- Quality MTCT prevention;
- Quality care and support; and,
- Policy, advocacy and enabling action.

The intention is that the combined outcomes of the three components should result in significantly increased availability and use of comprehensive, integrated MTCT prevention, care and support through the national RCH programme in the public, private and NGO health sectors.

Activity 1 focuses on MTCT prevention for women and men of child-bearing age, in particular empowering women and involving men to prevent HIV infection in themselves and in their infants. Additional interventions for encouraging high risk men to seek voluntary counselling and testing and increasing condom use are already being implemented as on going Government of India initiatives. Its main objective is to increase access to and use of quality MTCT prevention. It focuses on key MTCT

interventions such as comprehensive RCH services (antenatal, postnatal and child health), voluntary and confidential counselling and HIV testing, optimal obstetric practice, antiretroviral prophylaxis, counselling and support for infant feeding of choice, and family planning counselling and support.

Activity 2 focuses on care and support, in particular improving quality of life and survival for HIV positive pregnant women and mothers and their families. Its main objective is to increase access to and use of quality PMTCT care and support. The major activities relate to treatment and care, social support (including for orphans) and, in selected Centres of Excellence [four sites only], with good supportive laboratory and other infrastructure antiretroviral therapy will be advised as a Feasibility study for future planning of related interventions.

Activity 3 focuses on cross-cutting activities and national level enabling action for rapid mobilisation for scaling up country-wide. Its main objective is to strengthen the national policy and health system framework for PMTCT. The major activities focus on PMTCT training, operational research, PMTCT policy and strategies development (including communication and infant feeding), advocacy, and quality assurance, monitoring and evaluation systems, and documentation and sharing of lessons learned.

A Phased and Incremental Approach

The programme implementation strategy is one of a coordinated and balanced approach to scaling up and integration. The national PMTCT programme activities will complement and reinforce those of the National AIDS Control Programme Phase II (NACP II).

The national PMTCT programme will be implemented in all 35 States and Union Territories of India over the three-year period 2002 to 2004 with focus on the high prevalence States. Implementation involves the integration of PMTCT interventions in RCH programmes in almost 444 institutions [81 medical college hospitals, 130 selected maternity/private hospitals and 155 district hospitals in high prevalence areas, and 78 medical hospitals in other states].

In the public health system, the main programme activities will be implemented within the national Reproductive and Child Health Programme (RCH) administered by the Department of Family Welfare. Services under the national programme will be provided by existing antenatal, well-baby care, obstetrics and gynaecology units, and also voluntary counselling and testing units in the participating hospitals. These are already key service delivery units for the RCH programme. Primary health services will be involved as peripheral units of district hospitals. Private maternity and other selected hospitals with minimum capability of 100 beds and 1000 deliveries per year and necessary infrastructure and staff will participate in the national programme. Partnerships with NGOs/CBOs will extend the reach to the community to provide follow up and social support.

Geographical Coverage

Priority has been accorded to the six states with high prevalence of HIV as determined by surveillance and epidemiological data. The six high prevalence states (states where HIV prevalence in antenatal women is 1% or more) are Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu. The second phase will cover the 78 medical colleges including private and public in the remaining states.

Beneficiaries

Pregnant women attending antenatal clinics (and their husbands/male partners) and diagnosed HIV positive mothers and their families will primarily be the direct beneficiaries of improvements in service coverage, accessibility and quality.

It is estimated that 27,000,000 live births in the country annually, and of these, approximately 30% occur in institutional settings. The six high prevalence states which this proposal seeks to cover consist of approximately 30% of the country's population. Thus, about 2.5 million women will be the target population and have access to the PMTCT programme. Given an average HIV prevalence of 2% and a mother-to-child transmission rate of 30%, approximately 15,000 HIV+ births could be averted.

Medical, paramedical and auxiliary staff in participating hospitals will be the direct beneficiaries of the PMTCT training and, in the case of public hospitals and selected private hospitals upgrading of facilities, equipment, procurement and logistics. NGOs/CBOs will be the direct beneficiaries of PMTCT training and the NGO grants program. The NGO/CBO activities can be expected to be of benefit to PMTCT target populations through social mobilisation and community outreach.

Available socio-demographic data suggest that the majority of female and male users of PMTCT services will be young (under 29 years), and will come from both urban and rural areas. Many of the women accessing services provided by the public health system are likely to be poor or in the low-income group, and have a low level of literacy. Many will be the wives of mobile workers. The women accessing services provided by the private health system are likely to be from diverse income, literacy and occupational backgrounds. The proportion of HIV positive women is expected to be greater in the six high prevalence states and in higher prevalence major cities in the low prevalence states.

Management and Partnerships

India has the capacity and partnerships for intensive action to channel resources to significantly reduce MTCT within three to five years. India's decentralised National AIDS Control Programme (NACP II) is well - established, with a decentralised structure and strong partnerships that extend throughout the public health care delivery system.

The National AIDS Control Organisation (NACO), which reports to the National AIDS Control Board, will be the country counterpart for the programme, with responsibility for overall programme coordination, monitoring and evaluation for both the public and private sector. Selected resource provision by NACO will be used to help participating hospitals take on the PMTCT workload and improve services. NACO will work in close partnership with the Department of Family Welfare, which has responsibility for the national Reproductive and Child Health (RCH) Programme. At the State level, the State AIDS Societies (SACs), will have responsibility for coordination, monitoring and evaluation, and for channelling funds to participating hospitals, including maternity/private hospitals, and NGOs/CBOs.

The multisectoral and multi-level partnership for the national PMTCT programme involves a range of other key partners: the Department of Women and Child Development, the 11 PMTCT Centres of Excellence, around 444 participating medical colleges, maternity/ private hospitals and district hospitals (in particular their PMTCT core teams and RCH staff), primary health centres and partner NGOs/CBOs. Technical support partners include UNICEF (PMTCT Feasibility Study, capacity building, operational research, policy development, quality assurance for counselling and training, and monitoring and evaluation), the AIDS Resource and Control Centre, Mumbai (ARCON) for training material development, the National AIDS Research Institute (NARI) for technical supervision, monitoring and evaluation), and NACP Technical Resource Groups (coordination, technical supervision, and monitoring and evaluation).

A participatory mid-term review of the programme will be undertaken in the third quarter of 2003, to review progress and achievements and inform planning for the future.

ACTIVITY 1: QUALITY MTCT PREVENTION

Description:

This is the major focus for activities under the national PMTCT programme, encompassing both primary and secondary prevention of MTCT. Its main objective is to increase access to and use of quality MTCT prevention. Action under this component focuses on a dual strategy of introducing MTCT prevention interventions into the national reproductive and child health (RCH) programme and concurrent action to upgrade RCH infrastructure and service delivery to support integration. The approach is one of defining a comprehensive package of MTCT primary and secondary prevention interventions, to be implemented in the context of a continuum of health service capacity in particular states.

The programme activities relating to MTCT primary education will target women and men of childbearing age who are of unknown HIV status. Within this target population priority will be given to pregnant women and their partners. Emphasis will be placed on empowering women and involving

men to prevent HIV infection in themselves and in their infants. Primary prevention includes preventive education, ensuring early access to adequate antenatal care and providing access to voluntary and confidential counselling and HIV testing (VCTC). Antenatal care, in particular, is a key entry point for PMTCT, and equally PMTCT is an entry point for prevention of HIV infection in women of childbearing age and their children. Other activities relevant to HIV prevention include: STI screening, treatment, counselling and referral, family planning counselling and support, and action to ensure blood safety and use of sterile equipment.

Activities relating to secondary prevention will target women diagnosed as HIV positive, in particular pregnant women. MTCT secondary prevention includes: psychosocial counselling and support, counselling and support for infant feeding of choice, good obstetric practice and antiretroviral prophylaxis.

Action under Activity 1 will be complementary to prevention activities under the NACP II; the national PMTCT programme provides for a more targeted focus on pregnant women and their partners and HIV positive mothers. The program to improve the quality, accessibility and utilisation of comprehensive MTCT prevention services will focus on technical support, advocacy, provision of drugs (for antiretroviral prophylaxis) and selected medical supplies to support both the upgrading of existing services and the integration of MTCT interventions.

Activity 1 Outputs

Activities under this relate to three component outputs:

- Program of skills training in MTCT prevention education and counselling for RCH staff, private hospital staff and partner NGOs/CBOs completed.
- Program to improve the quality, accessibility and utilisation of MTCT primary prevention services completed.
- Program to improve the quality, accessibility and utilisation of MTCT secondary prevention services completed.

Skills training in MTCT prevention education and counselling will be provided for RCH medical and paramedical staff and for relevant partner NGOs/CBOs of district hospitals and selected private hospitals , to increase access to quality counselling.

Under Activity 1, particular emphasis is placed on VCTC, as it is a critical component of a comprehensive PMTCT programme. It is essential for identifying:

- HIV-negative pregnant women who could benefit from support to help them take steps to prevent becoming infected;
- HIV-infected husbands/male partners of pregnant women who can take steps to prevent their HIV-negative wives/partners becoming infected; and,
- HIV-infected pregnant women who could benefit from treatment, care and support interventions, and whose unborn children could benefit from secondary prevention interventions.

Action to improve VCTC services is relevant to the outcomes of both main Activities 1 and 2. It is addressed, however, under Activity 2, as it is a key entry point for HIV prevention and also an entry point to referral systems for secondary prevention and care for pregnant women testing HIV positive. Strategies for improving MTCT counselling and support will include a focus on needs to increase the uptake of voluntary counselling and testing and the return rate for test results, to improve couple counselling, and to increase the uptake of antiretroviral prophylaxis.

Strategies for expanding VCTC services are already a part of the NACP II and are functional. Resource allocation under the national PMTCT programme will be prioritised and carefully targeted to increase the capacity of existing units in high prevalence areas to take on the extra workload associated with the PMTCT programme. The program to improve VCTC services will include: recruitment of additional counsellors. Community referral networks for ongoing counselling and psychological support will be developed and strengthened. There will also be counselling skills

upgrading for obstetrics teams. The programme will also include: recruitment of additional laboratory technicians, provision of laboratory equipment, training in HIV testing procedures, supply of rapid test kits, and advocacy to ensure 24 hour availability of testing services. The salaries and on-costs will be met by the GOI.

The programme approach on infant feeding policy will be to train counsellors on infant feeding as a critical intervention for MTCT secondary prevention, to promote exclusive breast-feeding for the general population and not to recommend replacement feeding. Strategies will be developed to address risks to the programme effort on infant feeding, such as the predominant local norm of mixed feeding and stigma attached to decisions not to breast-feed.

Community strategies targeting hard-to-reach pregnant women and their husbands/male partners are needed to increase the uptake of antenatal care in the context of a continuum of care. The NGO/CBO grants program will provide time-limited support for innovative approaches and the development of locally appropriate models to increase access by pregnant women and their husbands/male partners to MTCT prevention.

Good obstetric practice, which is a desired standard under the RCH programme, will be promoted as a MTCT prevention measure. Caesarean delivery will not be promoted as a norm for MTCT prevention as it represents too great a risk of maternal mortality in low socio-economic populations. The supply of Nevirapine for antiretroviral prophylaxis will be addressed at national level to ensure that this secondary prevention intervention is available to all diagnosed positive pregnant women, at the very least through referral to medical colleges, district hospitals, maternity and selected private hospitals with the required clinical capacity. Currently, antiretroviral prophylaxis is only being provided in the 11 Centres of Excellence under the PMTCT Feasibility Study.

Programs to improve the quality, accessibility and utilisation of prevention services will be planned and implemented by each participating hospital. This will allow for flexibility in PMTCT integration to ensure that there is not a detrimental impact on RCH facilities, staff time and other essential service delivery.

An indicative schedule for major sub activities under Activity 1 is provided below.

Sub Activity Area	High Prevalence States		Medium and Low Prevalence States	
	Start	Start	Start	End
MTCT prevention education & counselling skills training: RCH staff & NGOs/CBOs	July 2002	June 2003	April 2003	December 2003
Expand and improve VCTC counselling facilities	April 2002	Dec 2003	April 2003	April 2004
PMTCT counselling skills training for VCTC counsellors	April 2002	Dec 2003	April 2003	April 2004
HIV testing training for additional laboratory technicians	April 2002	Dec 2003	April 2003	April 2004
Improve HIV testing laboratory equipment & supplies and service availability	April 2002	Dec 2003	April 2003	April 2004
Improve VCTC referral & provision for partners	July 2002	Dec 2003	April 2003	April 2004
Improve psychosocial counselling referral & provision for HIV discordant couples	July 2002	Dec 2003	April 2003	April 2004
Improve MTCT prevention referral systems and use (in continuum of care)	July 2002	Dec 2003	April 2003	April 2004
Improve RCH services (antenatal, post natal and child health)	July 2002	Dec 2003	April 2003	April 2004
Expand and improve PMTCT group education for couples	July 2002	Dec 2003	April 2003	April 2004
Improve STI screening, counselling, treatment and referral	July 2002	Dec 2003	April 2003	April 2004
Improve family planning counselling & referral, and condom provision	July 2002	Dec 2003	April 2003	April 2004
Advocate for use of safe blood supplies and sterile equipment in RCH services	July 2002	Dec 2003	April 2003	April 2004
Expand provision of antiretroviral prophylaxis for HIV positive pregnant women	Sept 2002	Dec 2003	April 2003	April 2004
Improve obstetric practice, to reduce HIV transmission	Sept 2002	Dec 2003	April 2003	April 2004
Improve infant feeding counselling and support	July 2002	Dec 2003	April 2003	April 2004
NGO grants for prevention initiatives	Sept 2002 -Dec 2004			

Note: End date of December 2004 refers to the end of the three-year period for the national PMTCT programme.

C.2 Objectives and Indicators

Main Objective:

To increase access to and use of quality MTCT prevention.

Specific Objectives:

Specific Objective 1.1

Increase the proportion of pregnant women accessing quality MTCT prevention to 60% by 2005.

Indicators

1.1.1 Proportion of pregnant women accessing antenatal care who have been provided with quality MTCT prevention services.

1.1.2 Proportion of pregnant women accessing antenatal care who have been provided with pre- and post-test voluntary and confidential counselling and HIV testing.

1.1.3 Proportion of VCTC counsellors with PMTCT counselling skills training.

1.1.4 Proportion of district hospitals, maternity/ selected private hospitals and medical college hospitals able to provide quality MTCT prevention services.

1.1.5 Proportion of district hospitals, maternity/ selected private hospitals and medical college hospitals with voluntary counselling and HIV testing units with a referral system.

Specific Objective 1.2

Increase the proportion of partners of antenatal patients who are provided with MTCT pre- and post-test voluntary and confidential counselling and testing to 50% by 2004.

Indicators

1.2.1 Proportion of male partners of HIV negative pregnant women who know that they can reduce the risk of infecting their partner by using condoms or by having sex only with their partner.

1.2.2 Proportion of male partners of antenatal patients who participate in voluntary and confidential counselling and HIV testing.

1.2.3 Proportion of pregnant women accessing quality antenatal care.

Specific Objective 1.3

Increase the proportion of HIV positive pregnant women and mothers who are provided with quality MTCT secondary prevention to 80% by 2005.

Indicators

1.3.1 Proportion of HIV positive pregnant women who are provided with antiretroviral prophylaxis.

1.3.2 Proportion of HIV positive pregnant mothers who choose and practice exclusive breast-feeding for at least the first 4 months.

1.3.3 Proportion of HIV positive pregnant women and mothers who are provided quality MTCT secondary prevention services.

1.3.4 Proportion of district hospitals, maternity/ selected private hospitals and Medical college hospitals able to provide quality MTCT secondary prevention services.

INDICATOR	Baseline			
	2001	2002	2003	2004
1.1.1	2.2%	40%	70%	95%
1.1.2	2.2%	20%	40%	50%
1.1.3	16%	60%	100%	100%
1.1.4	1.3%	30%	65%	95%
1.1.5	15%	30%	65%	95%
1.2.1	70%	80%	90%	95%
1.2.2	20%	30%	50%	70%
1.2.3	33%	40%	50%	70%
1.3.1	0.04%	30%	65%	95%
1.3.2	20%	40%	70%	80%
1.3.3	2.2%	40%	70%	95%
1.3.4	18%	39%	70%	95%

C.3 Programmatic Monitoring and Evaluation Plans:

Targets and monitoring data requirements will be determined jointly by the CCM and PCC, based on advice from a technical working group established by NACO by end April 2002. Baseline data will be obtained from participating hospitals by end June 2002 and from selected baseline studies commissioned by NACO at the request of the CCM/PCC.

Demographic data will be obtained from census data (the last census was in 2001). Estimates of the number of pregnant women will be derived from birth records and RCH service delivery records (antenatal and obstetric).
Data on service capacity and utilisation will be drawn from programme progress reports, quality assurance reports and independent M & E reports, and qualitative studies.
Data on total number of hospitals will be based on the number of hospitals advised by State Directors of Medical education/ Health services; data on participating hospitals will be drawn from programme progress reports.
Reporting against targets will include data disaggregated by state by hospital category (medical college, maternity hospital, district hospital/public, private) by programme participation.

Currently, only the 11 Centres of Excellence have PMTCT secondary prevention programmes. Data on their programmes is available.

C.4 Duration: (provide an estimate)

Beginning and end dates:

From: 1 April 2002 To: 31 December 2004

Period to be covered by this request for financing:

From: 1 April 2002 To: 31 December 2004

C.5 Implementation Plans including resource allocations to partners

	Budget Categories and Amounts (US in million $)							
Implementing Partner	*Human Resources*	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or Products**	*Data & information systems*	*Other (explain)*	***TOTAL***
Government								
Civil Society								
Private sector								
Donors/UNICEF								
Other/Unmet								
TOTAL								

**Including drugs*
Note: government training includes partner NGOs/CBOs

(See end of section for budget category allocation)

ACTIVITY 2: QUALITY CARE AND SUPPORT

Summary:
Care and support are also fundamental elements of an effective PMTCT programme. Activity 2 focuses on care and support, in particular improving quality of life and survival for HIV positive mothers and their children. Its main objective is to increase access to and use of quality PMTCT care and support. Action under Activity 2 encompasses integrated packages of PMTCT care and support, to be implemented in the context of a continuum of health service capacity in particular states. The major activities relate to treatment and care for HIV positive pregnant women and mothers, and their children and families; social support for HIV positive pregnant women and mothers and their families (including orphans); and, in four well equipped Centres of Excellence antiretroviral therapy as a Feasibility study.

This will include the development and documentation of a PMTCT Plus model by the four Centres of Excellence in the high prevalence states. The PMTCT Plus model provides quality-controlled antiretroviral therapy in addition to core PMTCT care and support. Clinical eligibility for antiretroviral therapy for HIV positive mothers is based on a minimum CD4 count of 250. Antiretroviral therapy is not currently available in the public health system.

Care and support strategies are already part of the NACP II and being supported by Government of India.
The national PMTCT programme will, however, enable a more targeted focus on the primary target population of HIV positive mothers and their children. Interventions under Activity 2 relate to tertiary prevention, and as such they will reinforce prevention efforts under Activity 1.

Activity 2 Outputs

Activities under this relate to three outputs:

- Program of PMTCT psychosocial and nutritional counselling skills upgrading for RCH staff, selected private hospital staff and partner NGOs/CBOs completed.
- Program to improve the quality, accessibility and utilisation of comprehensive care and support services by HIV positive women and their families.
- Model for PMTCT Plus, as a Feasibility study, for the public health sector evaluated and documented.

Skills upgrading for PMTCT psychosocial and nutritional counselling will be provided for RCH medical and paramedical staff and for relevant partner NGOs/CBOs of district hospitals, maternity/private hospitals to increase access to quality counselling for HIV positive mothers and their families.

Care and support strategies will address the need for a significant improvement in psychosocial counselling and community support, to improve couple and family counselling, to increase the uptake of nutritional counselling and support, and to improve follow-up of babies born to HIV positive women (including HIV testing between age 18 months to 2 years), and to improve referral along the continuum of care. There will be a focus on measures to ensure locally appropriate, supportive environments for HIV positive mothers and their families.

Technical support will be provided for improving procurement and logistics systems to ensure the availability of low cost drugs for the prevention and treatment of HIV related opportunistic infections and palliative care in public/maternity/private hospitals. Such support may include PMTCT-related gap analysis, planning, advocacy to the Department of Family Welfare for use of available RCH programme funds, skills upgrading and procedures modification. Drugs for opportunistic infections are already provided cost-free to public hospitals.

Hospital initiated action to improve service delivery and impact will include strengthening of referral systems for community care and support, and for tertiary referral in cases where the level and quality of required service is not available in a particular health care facility. Hospitals (in collaboration with partner NGOs/CBOs) will develop and implement strategies to combat HIV-related stigma and social exclusion and eliminate discrimination against HIV positive women and their families, including respecting their privacy and confidentiality. Action will be taken to improve care and support and community referral for

children orphaned by the death of an HIV positive mother. The mobilisation of the health care system on PMTCT – related care and support (through PMTCT training and the NGO/CBO grants program), and the implementation of strategies to combat HIV-related stigma and social exclusion and eliminate discrimination, can be expected to reinforce the efforts of NGOs/CBOs in creating a more supportive environment for HIV positive mothers and their families. The NGO/CBO grants program will provide time-limited support for innovative approaches and the development of locally appropriate models to improve community based care and support for HIV positive mothers and their families in poor urban and rural communities.

Feasibility study of PMTCT Plus Model in 11 Centres of excellence will build on the lessons learned and institutional capacity building under the earlier PMTCT Feasibility Study. The delivery of the comprehensive range of services requires the level of clinical and psychosocial support capacity presently available only in the 11 Centres of Excellence in the high prevalence states. The implementation of this element of Activity 2, including the period of operational research scheduled for July 2002 to June 2003. It requires an efficient follow-up system (clinical and biological), strengthened linkages with NGOs/CBOs for community mobilisation and for effective referral systems, both for referral of HIV positive women to the Centres and for community-based support and care for which a strong NGO component has been developed and will be available at the eleven existing centres of excellence as a feasibility study. Efficacy, cost-benefit, sustainability and ethical issues relating to the introduction and the ceasing of antiretroviral therapy will be addressed.

An indicative schedule for sub activities under Activity 2 is provided below.

Sub Activity Area	National		HP States		LP States	
	Start	End	Start	End	Start	End
PMTCT skills training in psychosocial & nutritional counselling: RCH staff, private hospital staff & NGOs/CBOs			Sept 2002	June 2003	June 2003	June 2004
Improve health system procurement and logistics for drugs and medical supplies			Sept 2002	Dec 2004	June 2003	Dec 2004
Strengthen care and support referral systems (in continuum of care)			July 2002	Dec 2004	April 2003	Dec 2004
Strategies and measures to combat HIV-related stigma and discrimination			July 2002	Dec 2004	April 2003	Dec 2004
Improve infant feeding counselling and support			Sept 2002	Dec 2004	June 2003	Dec 2004
HIV testing for children of HIV positive mothers			Sept 2002	Dec 2004	June 2003	Dec 2004
Improve PMTCT psychosocial counselling and support			Sept 2002	Dec 2004	June 2003	Dec 2004
Improve PMTCT family planning counselling and condom distribution			Sept 2002	Dec 2004	June 2003	Dec 2004
Improve PMTCT nutritional counselling and support			Sept 2002	Dec 2004	June 2003	Dec 2004
Improve treatment for HIV related opportunistic infections and palliative care			Sept 2002	Dec 2004	June 2003	Dec 2004
Improve community social support for HIV positive mothers & families (incl orphans)			Sept 2002	Dec 2004	June 2003	Dec 2004
NGO grants for care & support initiatives	Sept 2002	Dec 2004				
Provide quality-controlled antiretroviral therapy as a feasibility study in eleven PMTCT Centres of Excellence			April 2002	Dec 2004		
Document the PMTCT Plus model			April 2003	Dec 2004		

Note: End date of Dec .2004 refers to the end of the 3-year national PMTCT programme.

C.2 Objectives and Indicators

Main Objective:

To increase access to and use of quality PMTCT care and support.

Specific Objectives:

Specific Objective 2.1

Increase the proportion of HIV positive pregnant women and mothers who are provided with quality PMTCT care and support to 80% in the high prevalence states and 50% in the low prevalence states by 2005.

Indicators

2.1.1 Proportion of medical college hospitals, maternity hospitals, selected private hospitals and district hospitals with a constant supply of low- or no-cost drugs for treatment of HIV related opportunistic infections and palliative care.

2.1.2 Proportion of HIV positive pregnant women and mothers who are provided with quality psychosocial and nutritional counselling and support.

2.1.3 Proportion of medical college hospitals, maternity hospitals, selected private hospitals and district hospitals able to provide quality PMTCT care and support.

Specific Objective 2.2

Increase the proportion of clinically eligible HIV positive mothers who are provided with a complete course of antiretroviral therapy to 30% of those in 11centers of excellence located in five high prevalence states by 2005.

Indicators

2.2.1 Proportion of clinically eligible HIV positive mothers identified who are provided with a complete course of antiretroviral therapy.

2.2.2 Proportion of medical college hospitals able to provide quality-controlled antiretroviral therapy.

INDICATOR	Baseline	Targets				
	2001	2002	2003	2004	2005	2006
2.1.1	70%	90%	95%	100%		
2.1.2	3%	30%	70%	80%		
2.1.3	11/444	100/444	200/444	300/444		
2.2.1	0	30%	90%	100%		
2.2.2	0/148	-	-	11/148		

C.3 Programmatic Monitoring and Evaluation Plans:

Indicators 2.1.1 to 2.1.3: Data on total number of hospitals will be based on the number of hospitals advised by State Directors of Medical education/ Health services; data on participating hospitals will be drawn from programme progress reports. Reporting against targets will include data disaggregated by state by hospital category (medical college, maternity hospital, district hospital/public/ private) by programme participation. Data on drugs supply, counselling and service capacity will be drawn from programme progress reports, quality assurance reports and independent M & reports, and qualitative studies.

Data for 2.2.1 and 2.1.2 will be drawn from programme progress reports, formative research reports and independent M & E reports. Data on HIV positive mothers will be based firstly on state totals (based on hospital reports) of numbers testing positive, and numbers offered and accepting enrolment in ARV

therapy programme and relevant medical college reports on numbers assessed as clinically eligible.

Currently, only the 11 Centres of Excellence have PMTCT care and support programmes. Data on their programmes is available. No ARV therapy is provided in the public hospital system.

C.4 Duration: (provide an estimate)

Beginning and end dates:

From: 1 April 2002 To: 31 December 2004

Period to be covered by this request for financing:

From: 1 April 2002 To: 31 December 2004

C.5 Implementation Plans Including Resource Allocations to Partners

	Budget Categories and Amounts (US$)							
Implementing Partner	*Human Resources*	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or Products**	*Data & information systems*	*Other (explain)*	***TOTAL***
Government								
Civil Society								
Private sector								
Donors								
Other								
TOTAL								

**Including drugs for ARV therapy*
Note: government training includes partner NGOs/CBOs

Figures shown in the Final Table C-5 (activity)

ACTIVITY 3: POLICY, ADVOCACY AND ENABLING ACTION

C.1 Description:

Activity 3 focuses on cross-cutting activities and national level enabling action for rapid mobilisation for scaling up country-wide. Its main objective is to strengthen the national policy and health system framework for PMTCT. It will help to build high-level political commitment, by raising the awareness of decision makers about PMTCT evidence-based approaches. At the operational level, Activity 3 will contribute to service improvement by facilitating training and technical assistance; by strategic use of advocacy; by undertaking operational research; through the development of policies, strategies and guidelines; through quality assurance, monitoring, evaluation and programme review; through the documentation and sharing of lessons learned; and through selected funding support.

Activity 3 Outputs

Activities under Activity 3 relate to four outputs:

- PMTCT training program for medical colleges, maternity colleges, district hospitals, selected private hospitals ,primary health units and partner NGOs/CBOs of district hospitals completed.
- Program to strengthen the evidence-based national policy and programming framework for PMTCT completed.
- Program of advocacy and support for integration of PMTCT into RCH and ICDS curricula and training completed.
- NGO/CBO grants program established and operational.

The PMTCT training program activities will include: training for PMTCT core teams from medical colleges, maternity colleges, selected private hospitals and district hospitals; preparation of a PMTCT training plan by each participating hospital; full-site PMTCT orientation in each participating hospital; and training by the district hospital core teams of RCH primary health staff and partner NGOs/CBOs. The programme will fund the costs of the core team training, provide the national PMTCT training manual and other training materials, and provide funding to participating hospitals to support on-site PMTCT training.

Advocacy and technical support will be provided for the integration of PMTCT into the curricula and training of the Reproductive and Child Health Programme (RCH) of the Department of Family Welfare and the Integrated Child Development Services (ICDS) under the Department of Women and Child Development.

Policy and advocacy activities will include: periodic awareness-raising for all NACP and RCH Boards, committees and key programmers to increase their knowledge and understanding of evidence-based approaches to PMTCT policy and practice; development of a national PMTCT policy; formative research and development of a national PMTCT communication strategy; operational research and development of national guidelines on infant feeding. Other activities include establishment of a monitoring and evaluation system, establishment of a quality assurance system for PMTCT counselling and training; documentation and dissemination of PMTCT scaling up lessons learned (including through PMTCT core team workshops, and annual interstate and biannual intrastate seminars); and a mid-term programme review.

An indicative schedule for sub activities under Activity 3 is provided below.

Sub Activity Area	National		HP States		LP States	
	Start	End	Start	End	Start	End
Training program for PMTCT core teams						
➢ Medical colleges and maternity hospitals			Feb 2002	June 2002	July 2002	March 2003
➢ District hospitals			July 2002	Dec 2002	July 2003	March 2004
➢ Private hospitals						

Preparation & annual revision of hospital PMTCT implementation plan ➢ Medical colleges and maternity hospitals ➢ District hospitals ➢ Private hospitals			July 2002 Jan 2003	Dec 2004 Dec 2004	April 2003 April 2004	Dec 2004 Dec 2004
Full-site PMTCT orientation in each participating hospital ➢ Medical colleges and maternity hospitals ➢ District hospitals ➢ Private hospitals			July 2002 Jan 2003	Sept 2002 March 2003	April 2003 April 2004	June 2003 June 2004
PMTCT training: RCH primary health staff and partner NGOs/CBOs			Jan 2003	May 2003	April 2004	Aug 2004
Advocacy and support for integration of PMTCT into RCH and ICDS curricula and training			Jan 2003	Dec 2004		
Evidence-based PMTCT policy education for Boards, committees & programmers			Feb 2003	Dec 2004		
Develop a national PMTCT policy			Jan 2003	Dec 2003		
Formative research and development of a national PMTCT communication strategy			March 2002	Feb 2003		
Operational research on infant feeding			July 2002	June 2004		
Develop national guidelines on infant feeding			July 2004	Dec 2004		
Establish quality assurance, monitoring & evaluation systems			April 2002	Dec 2004		
Document and disseminate PMTCT scaling up lessons learned			Jan 2003	Dec 2004		
Mid-term programme review			Oct 2003	Nov 2003		

Note: End date of December 2004 refers to the end of the three-year period for the national PMTCT programme.

C.2 Objectives and Indicators

Main objective:

To strengthen the national policy and health system framework for PMTCT.

Specific Objectives:

Specific Objective 3.1

Integrate quality PMTCT prevention, care and support into the national reproductive and child health programme at tertiary and secondary health levels by 2005.

Indicators

3.1.1 Proportion of medical colleges, maternity hospitals, private hospitals and district hospitals with trained PMTCT core teams.

3.1.2 Proportion of medical colleges, maternity hospitals, private hospitals and district hospitals with PMTCT implementation plans.

3.1.3 Proportion of public medical colleges and district, private/ maternity hospitals able to utilise their RCH facilities, services and referral networks to provide quality MTCT prevention, care and support.

3.1.4 Documentary evidence of inclusion of PMTCT in RCH curricula and training.

Specific Objective 3.2

Strengthened national policy framework for PMTCT scaling up by 2005.

Indicators

3.2.1 Endorsed national PMTCT policy document.
3.2.2 Endorsed national PMTCT communication strategy.
3.2.3 Endorsed national guidelines on infant feeding.
3.2.4 Endorsed PMTCT scaling up lessons learned summary report.

INDICATOR	Baseline	Targets				
	2001	2002	2003	2004	2005	2006
3.1.1	11/444	300/444	340/444	444/444		
3.1.2	11/444	300/444	350/444	444/444		
3.1.3	11/444	118/444	175/444	444/444		
3.1.4				Achieved		
3.2.1	0		Achieved			
3.2.2	0		Achieved			
3.2.3	0			Achieved		
3.2.4	0			Achieved		

C.3 Programmatic Monitoring and Evaluation Plans:

Indicators 3.1.1 to 3.1.4: Data on total number of hospitals will be based on the number of hospitals advised by State directors of medical education; data on participating hospitals will be drawn from programme progress reports. Reporting against targets will include data disaggregated by state by hospital category (medical college, maternity hospital, district hospital/public, private) by programme participation. Currently, only the 11 Centres of Excellence have PMTCT core teams and programmes. Data for 3.1.3 and 3.1.4 will be drawn from programme progress reports, quality assurance reports and independent M & reports.
Indicators 3.1.1 to 3.2.4: Endorsements will be by the National AIDS Control Board.

C.4 Duration: (provide an estimate)

Beginning and end dates:

From: 1 January 2002 To: 31 December 2004

Period to be covered by this request for financing:

From: 1 January 2002 To: 31 December 2004

C.5 Implementation Plans Including Resource Allocations to Partners - 2002

	Budget Categories and Amounts (US$ in million)							
Implementing Partner	*Human Resources*	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or Products**	*Data & information systems*	*Other (explain)*	***TOTAL***
Government		1.00			1.00			2.00
Civil Society		0.72		5.64	0.65			7.01
Private sector								
Donors								
Other								
TOTAL		1.72		5.64	1.65			9.01
**Including drugs*								

SECTION C. 1. HIV
C.1.b. Family Health Awareness Campaign

C.1 Description: (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

The overall objective of the proposal is to assist the NACO, GoI to strengthen and expand the ongoing strategy of Family Health Awareness Campaign (FHAC) to contribute to the national goal of reducing the spread of HIV infection and of building the capacity to deal with the epidemic through the following interventions (details in Section C). The three interlinked interventions focus on reaching the women, adolescents and youth in rural and urban slum communities as they are the most vulnerable groups. The interventions are a) promotion of behaviours that reduce sexual transmission of STIs and HIV among rural and urban slum areas, b) increase in utilisation of quality RTI/STI services at the primary health care facilities in rural and urban slum areas leading to decreased risk of transmission of HIV, and c) creation of a supportive environment for sustaining the behavioural change efforts at the community and district level through intra-sectoral and inter-sectoral collaboration.

The proposal has three major interventions:

Intervention 1: Promotion of behaviours that reduce sexual transmission of STIs and HIV among rural and urban slum communities.

Intervention 2: Increase in utilisation of quality RTI/STI services in the primary health care facilities in rural and urban slum areas leading to decreased risk of transmission of HIV.

Intervention 3: Creation of a supportive environment for sustaining the behavioural change efforts at the community and district level through intra-sectoral and inter-sectoral collaboration.

Intervention 1: Promotion of behaviours that reduce sexual transmission of STIs and HIV among rural and urban slum communities

The objective of this intervention is to promote behaviours that reduce sexual transmission of STIs and HIV among rural and urban slum communities by improving access to information about RTIs. STIs and HIV/AIDS and their prevention among the reproductive age group 15-49 years in the rural and urban slum areas with special focus on women, adolescents and youth. The successful implementation of this intervention should result in adoption of preventive practices such as safe sexual practices, early recognition and treatment of RTIs/STIs including partner referral especially among women, adolescents and youth. It will also promote male responsibility. As discussed under Section A 5 and B1, the population in the rural areas and urban slum areas especially the women are most vulnerable to STIs and HIV infection due to the reasons listed below. Increasing migration of men to urban areas and the opportunities for practising risky behaviours increase the prevalence of STIs and HIV in this group who in turn transmit the infection to their wives/partners in the rural areas. The prevalence of RTIs is high among women due to unhygienic practices during childbirth and menstruation. Post-abortal sepsis is another factor. Repeated pregnancies increase the risks of exposure to infections. These factors and their social vulnerability put the women at double risk. This intervention is critical for preventing the spread of infection in the rural areas even in high HIV prevalent states and also for achieving the indicators of Intervention 2, which again contributes to reducing the transmission of STIs and HIV. The Intervention should help to decrease the vulnerability of adolescents and youth to STI/HIV by improved access to information and reducing the barriers to accessing care. The degree of vulnerability is higher in the urban slum areas due to the added dimension of social exploitation.

The main beneficiaries of this intervention are rural and urban slum women, adolescents and youth.

The intervention will be jointly implemented by the district level nodal officers of the AIDS Control and the RCH programmes in collaboration with the NYK and NSS district level officers. While the health sector will focus on increasing access to information among women and men, the NYK and NSS will focus on the adolescents and youth. The HWs, the NSS and NYK are responsible for implementing the activities of the Intervention.

The strategy for implementation is through a number of outputs and activities listed below. These include inter-personal communication with rural and urban slum women by the HWs (F) at home, peer group discussions with adolescents and youth organised by female and male NSS and NYK volunteers, group discussions with men by HWs (M) to promote male involvement and reinforcement of messages through interactive discussions with women and men attendees in the community camps and mass media channels such as wall paintings and posters.

The outputs and activities are listed below.

Output 1: Increased access to information about RTIs, STIs and HIV/AIDS by women through interpersonal communication by HWs (F) through home visits and reinforcement of messages through interactive group discussions during the community camp.

Activities:

1. Visit each family/household in the community, a fortnight before the proposed date of the community camp to distribute the FHAC card to eligible population aged 15-49 and hold discussions on RTIs, STIs and HIV/AIDS using the 10 messages on the FHAC card, their prevention and importance of seeking early treatment and provide information about the camp encouraging women to attend the camp especially those with problems.
2. Contact the village/slum *Pradhan* (Chief) to discuss the arrangements for the camp and to seek assistance in encouraging women to attend the camp.

Reinforce messages through interactive discussions during the community camps with women attendees about RTIs, STIs and HIV/AIDS, their prevention and importance of seeking care.

Output 2: Increased access to information about RTIs, STIs and HIV/AIDS by adolescents and youth through peer group discussions by NYK and NSS volunteers.

Activities:

1. Identify adolescents and youth, a month before the community camp, through home visits by female and male NSV and NSS volunteers.
2. Hold peer group discussions, separately for females and males, in a suitable location (home, school) about RTI, STI, HIV/AIDS and its prevention, provide information about the camp and encourage them to seek care if needed.

Output 3: Increased involvement of males in through group discussions by HWs (M) held in the community and reinforcement through interactive discussions in the camps.

Activities:

1. Organise meetings with males aged 15-49 years in various locations of the community a month prior to the campaign to discuss RTIs, STIs and HIV/AIDS, their prevention, men's role in preventing STIs and HIV, importance of partner treatment and provide information about the camp encouraging men and their partners to attend the camp
2. Reinforce messages through interactive discussions during community camps with male attendees on topics discussed above and encouraging them to seek care.

C2. Objectives and Indicators

Main objective

To promote behaviours that reduce sexual transmission of STIs and HIV among rural and urban slum communities

Indicator	Baseline	Targets		
	2000/ 2001	2003	2004	2005
1. Increase in consistent condom use with non-regular partners to 60%	26%[1]	40%	50%	60%
2. Increase in consistent use of condoms Among sexually active adolescents and Youth	5% [4] (approx.)	20%	30%	40%
3. Increase in level of awareness about RTI and d STI/HIV prevention to above 60% among rural and urban slum women	32%[2]	40%	50%	60%
4. Increase in level of awareness about RTI and STI/HIV prevention to above 60% among rural and urban slum adolescents and youth	Not available	20%	40%	60%

Specific Objectives

1. To increase access to information about RTIs, STIs and HIV/AIDS by women through interpersonal communication by HWs (F) through home visits and reinforcement of messages through interactive group discussions during the community camp.

Indicator	Baseline	Targets		
	2000	2003	2004	2005
90% of the rural and urban slum women aged 15-49 years provided information by HWs through home visits	20%[3] (approx.)	40%	60%	90%

2. To increase access to information about RTIs, STIs and HIV/AIDS by adolescents and youth through peer group discussions by NYK and NSS volunteers.

Indicator	Baseline	Targets		
		2003	2004	2005
Over 80% of the rural and Urban slum adolescents and Youth received information Through NYK and NSS volunteers	Not avail.	40% of adolescents & youth	60%	80%

3. To increase involvement of males in through group discussions by HWs (M) held in the community and reinforcement through interactive discussions in the camps.

Indicator	Baseline	Targets

[1] GoI: National Baseline General Population Behavioural Surveillance Survey 2001. National AIDS Control Organisation.
[2] Refers to knowledge about STIs (Source: GoI: National Baseline General Population Behavioural Surveillance Survey 2001. National AIDS Control Organisation).
[3] IndiaCLEN: Coverage Evaluation of Family Health Awareness Campaign –2000 (average of rural and urban).

	2000	2003	2004	2005
1. Increased number of males and their spouses/partners attend the camp	Not avail.	20%	30%	30%
2. Over 60% of the rural and urban slum men aged 15-49 receive information through HWs (M)	13%[4] (approx.)	40%	60%	70%

C.3 Programmatic Monitoring and Evaluation Plans:

Specifically for this Intervention, the monitoring will be done by the district officials responsible for the AIDS control programme and RCH and the District level Supervisor for NYK and NSS. In addition, the District Coordination Committee chaired by the District Magistrate (DM)/District Collector (DC) also monitors the state of preparedness before the FHAC.

a. The existing checklists for monitoring the implementation of the FHAC by the supervisors of the health, NSS and NYK at block level and district level will be used.

b. Checklists will be developed for NSS and NYK supervisors at block level and district level.

Evaluation of the Intervention will be done through concurrent and end of the project evaluations by independent agencies as part of the national level evaluation.

C.4 Duration: (provide an estimate)

Beginning and end dates:

From : December 2002 To: December 2005

Period to be covered by this request for financing:

From: December 2002 To: December 2005

Intervention 2 : Increase in utilisation of quality RTI/STI services in the primary health care facilities in rural and urban slum areas leading to decreased risk of transmission of HIV.

The objective of this Intervention is to increase utilisation of services for RTIs and STIs by providing quality services. Through Intervention 1, the increased level of awareness about the importance of seeking early treatment of RTIs/STIs will contribute to increasing utilisation of services for RTIs /STIs. The presence of RTIs and STIs increases the risk of HIV transmission and have other consequences. In women, pelvic inflammatory disease, which could lead to life threatening ectopic pregnancy or cause infertility, is a major complication.

Successful implementation of this Intervention will contribute to reduced transmission rates of HIV as has been found in other countries, prevent complications/death due to ectopic pregnancy, prevent infertility and reduce the morbidity associated with these infections. Treatment of RTIs contributes to improving the quality of life of women who have been suffering with the infection for years.

Programmatically, the Intervention will strengthen and improve the quality of RTI/STI services provided at the SCs, PHCs and FRUs. It benefits family planning programmes especially insertion of intrauterine devices. One of the major accomplishments of this Intervention will be integration of services provided under the AIDS control and RCH programmes.

The main beneficiaries of this programme are women and men of reproductive age group in the rural and urban slum areas. The health system benefits are described above.

The Intervention will be jointly implemented by the district level nodal officers of the NACO and the RCH.

The strategy for achieving the objectives of this Intervention is through number of outputs and activities that include strengthening the SCs, PHCs and FRUs for early recognition and management of RTIs and STIs, increased access to RTI/STI screening and management at the community/SC level and at PHCs and FRUs and improved quality of services.

The outputs and activities are listed below.

Output 1: Increased access to RTI/STI screening and management at the community and SC level using the NACO guidelines for Syndromic Management of RTIs/STIs.

Activities:

1. Refer women and men in the community camps who need services for RTIs and STIs to the appropriate level for management.
2. Strengthen SCs for screening women for RTIs and RTIs and managing them as per NACO guidelines (based on need).
3. Screen women for RTIs/STIs at the SCs using the NACO guidelines and manage as per NACO guidelines.
4. Identify cases that need referral and refer them to the appropriate facility.
5. Refer all cases of STIs in men to the appropriate facility.

Output 2: Increased access to RTI/STI screening and management at the PHC / FRU level using the NACO guidelines for Syndromic Management of RTIs/STIs.

Activities:

1. Strengthen PHCs and FRUs for laboratory diagnosis of selected infections.
2. Screen and treat women and men for RTIs/STIs using NACO guidelines.
3. Refer cases to the appropriate facility.

Output 3: Improved quality of RTI/STI services provided at the SC, PHC and FRU level.

Activities:

1. Provide competency based training to all staff at the SC/PHC/FRU in screening for RTIs and STIs and its management and partner referral as per NACO guidelines in collaboration with the RCH training programme at the district level. The training will include development of skills in interpersonal communication, interactive discussions, counselling and relevant recording and reporting.
2. Institute mechanisms for partner referral as per NACO guidelines

Ensure regular supply of medicines, diagnostic kits and reagents.

C.2 Objectives and Indicators

Main objective:

To increase utilisation of quality RTI/STI services at the primary health care level in rural and urban slum areas.

Indicator	Baseline	Targets		
	2000	2003	2004	2005
1. 50% increase in utilisation of services for RTIs and STIs at the SC, PHC and FRU	10%[4]	30%	40%	50%
2. 30 % increase in women utilising services for RTIs/ STIs	Not avail.	10%	20%	30%

Specific Objectives

1: To increase access to RTI/STI screening and management at the community and SC level using the NACO guidelines for Syndromic Management of RTIs/STIs.

Indicator	Baseline	Targets		
	2000	2003	2004	2005
1. 100% of the community camps refer RTI & STI cases	70%[4]	80%	90%	100%
2. 80% of the SCs strengthened for speculum examination	Not avail.	30%	50%	80%
3. 80 % of the SCs screen women for RTIs/STIs and manage them as per NACO guidelines	Not avail.	30%	50%	80%
4. 100 % of the cases of RTIs/STIs provided Condoms	Not avail.	80%	90%	100%

2. To increase access to RTI/STI screening and management at the PHC/FRU level using the NACO guidelines for Syndromic Management of RTIs/STIs.

Indicator	Baseline	Targets		
		2003	2004	2005
1. 100% of the PHCS/ FRUs screen and Manage RTIs&STIs As per NACO Guidelines	Not avail.	80%	100%	100%
2. 80% of the PHCs/FRUs provide laboratory services for selected infections	Not avail.	40%	60%	80%

3. To improve quality of RTI/STI services provided at the SC, PHC and FRU level.

Indicator	Baseline	Targets		
	2000	2003	2004	2005
1. 80% of cases referred from the community utilize the PHC/FRU facility	25%[4]	40%	60%	80%
2. 100% of facilities manage RTIs/STIs as per NACO guidelines	Not avail.	60%	80%	100%
3. 100 % of the cases counselled	Not avail.	60%	80%	100%
4. 100 % of the partners of cases needing partner treatment referred	Not avail.	60%	80%	100%
5. 100% of the cases followed	Not avail.	60%	80%	100%

up				
6. 100% of the facilities do not report stock outs	Not avail.	60%	80%	100%
7. 50% of the PHCs/FRUs refer cases for VCT and prevention of MTCT	Not avail.	20%	30%	50%

C.3 Programmatic Monitoring and Evaluation Plans:

1) Specifically for this intervention, the monitoring will be done by the district officials responsible for the AIDS control programme and RCH.
   - The relevant checklists will be modified or new checklists developed to include information on strengthening facilities, cases followed up, partners referred and management of stocks.
   - As mentioned under B2, the current SC, PHC and FRU reports will be reviewed to ensure that they include data specifically on the utilisation of RTI/STI services.
   - Evaluation of the intervention will be done through concurrent and end of the project evaluations by independent agencies as part of the national level evaluation.

C.4 Duration: (provide an estimate)

Beginning and end dates:

From: December 2002 To: December 2005

Period to be covered by this request for financing:

From: December 2002 To: December 2005

Intervention 3 : Creation of a supportive environment for sustaining the behavioural change efforts at the community and district level through intra-sectoral and inter-sectoral collaboration.

The objective of this Intervention is to create a supportive environment for sustaining the efforts at the community/district level to reduce the spread of HIV infection through intra-sectoral and inter-sectoral collaboration and partnerships with *Panchayats*, women's groups, CBOs, NGOs and private sector. The successful implementation of this Intervention would ensure sustaining the inputs provided under Interventions 1 and 2 and contribute to sustained reduction in the spread of HIV. The Intervention also helps to build accountability in the health system to provide quality services.

The main beneficiaries of this programme are women and men of reproductive age group in the rural and urban slum areas. In addition, the civil society, NGOs, CBOs and private sector is benefited as their awareness about the problem increases.

The District Coordination Committee, chaired by the DM/DC will be mainly responsible for the implementation of this Intervention. All the district level officers of the various sectors and the District *Panchayat* will have the main responsibility for their sectors.

The strategy for implementation of this Intervention will be through a number of outputs and activities that promote intra-sectoral and inter-sectoral collaboration and partnership with civil society, NGOs and CBOs. The outputs and activities are listed below.

Output 1: Strengthened the capacity of the SACs to manage/implement the FHA campaign.

Activities:
1. Orient the State Project Co-ordinator in planning and managing the FHAC as per guidelines of NACO.
2. Train in financial management of the FHAC.

Output 2: Strengthened the capacity of the District level to manage/implement the FHA campaign as per guidelines of NACO.

Activities:
1. Train district level officers responsible for AIDS control and RCH officers on RTIs, STIs and HIV/AIDS, planning and managing FHAC, funding for various Interventions of the FHAC, monitoring and supervision.
2. Train district level officers of the NSS and NYK and ICDS about RTIs, STIs and HIV/AIDS and their prevention, coordinated planning with the health department and organising the awareness programmes by NSS and NYK volunteers.
3. Train NSS and NYK volunteers about RTIs, STIs and HIV/AIDS and their prevention, the vulnerability of adolescents and youth and communicating the messages.
4. Train *anganwadi workers* (ICDS functionaries) about RTI/STI/HIV/AIDS prevention.
5. Orient the district officers responsible for mass media, education and rural development about RTI, STI and HIV/AIDS and their prevention, FHAC campaign and how to collaborate with the key implementers.
6. Orient the *Panchayat,* women's groups, CBOs, specifically MSS (women's health groups) and literacy mission volunteers and NGOs about RTIs, STIs and HIV/AIDS.

Output 3: Strengthened the collaboration with private practitioners of Allopathy and ISM through training, referral of cases and assistance in partner tracing.

Activities:
1. Train practitioners of Allopathy and Indigenous System of Medicine and Homeopathy (ISM&H) in Syndromic Management of RTIs, STIs and HIV/AIDS.
2. Refer cases of RTIs/STIs to the PHC/FRU.
3. Provide assistance in partner tracing and treatment.

C.2. Indicators and Objectives

Main Objective:
To create a supportive environment for sustaining the behavioural change efforts at the community and district level through intra-sectoral and inter-sectoral collaboration.

Indicator	Baseline	Targets		
		2003	2004	2005
1. Evidence of collaborative planning for FHA campaigns between the district officer of AIDS control and RCH in 100% of the districts	Not avail.	50%	80%	100%
2. Participation of all the sectors identified in the FHAC in 100% of the districts	Not avail.	50%	80%	100%

Specific Objectives

1. To strengthen the capacity of the SACs to manage/implement the FHA campaign.

Indicator	Baseline	Targets		
		2003	2004	2005
1. 100% of the SACs manage / implement the FHAC satisfactorily as per guidelines	Not avail.	60%	80%	100%

2. To strengthen the capacity of the District level to manage/implement the FHA campaign as per guidelines of NACO.

	Indicator	Baseline	Targets		
			2003	2004	2005
1.	100% of the district & RCH officers trained	Not avail.	80%	100%	100%
2.	100% of the district officers of the NSS, NYK and ICDS trained	Not avail.	60%	80%	100%
3.	80% of the NSS&NYK volunteers trained	Not avail.	40%	60%	80%
4.	100% of the *Anganwadi* workers trained	Not avail.	50%	60%	100%
5.	80% of the district officers of mass media, education and rural development oriented	Not avail.	40%	60%	80%
6.	80% of the *Panchayats* oriented	Not avail.	40%	60%	80%
7.	60% of *women's* groups, CBOs, and NGOs oriented	Not avail.	20%	40%	60%

3. To strengthen the collaboration with private practitioners of Allopathy and ISM &H through training, referral of cases and assistance in partner tracing.

	Indicator	Baseline	Targets		
			2003	2004	2005
1.	60% of the private practitioners of Allopathy and ISM& H trained	0%	20%	40%	60%
2.	80% of the trained practitioners refer cases	0%	40%	60%	80%
3.	50% of the trained practitioners assist with partner notification	0%	10%	30%	50%

C.3 Programmatic Monitoring and Evaluation Plans

Specifically for this Intervention, the monitoring will be done by the District Coordination Committee, and State Steering Committee. The relevant checklists will be modified or new checklists developed to include indicators of intra-sectoral and inter-sectoral collaboration and partnerships. NACO will monitor the overall performance of this Intervention.

Evaluation of the Intervention will be done through concurrent and end of the project evaluations by independent agencies as part of the national level evaluation**.**

C.4 Duration: (provide an estimate)

Beginning and end dates:
From: December 2002 To: December 2005

Period to be covered by this request for financing:
From: December 2002 To: December 2005

C.5 Implementation Plans Including Resource Allocations to Partners *(Guidelines para. 40)*

(US$ in millions)

	Budget Categories (please fill in according to your plan)							
Implement-ing Partner	*Human Resources*	*Logistics and supplies*	*Training & Super-vision*	*Outreach Services*	*Com-modities or Products**	*Data & infor-mation systems#*	*Other (ex-plain)*	***TOTAL***
Government		1.02			3.00	0.40	1.00	5.40
Civil Society			1.20	0.52	1.32		0.38	3.4
Private sector				0.50				0.5
Donors								
Other								
TOTAL		1.02	1.20	1.02	4.32	0.40	1.38	9.3

**Including drugs # including monitoring and evaluation*

HIV Prevalence levels State wise – Round 2000

S.No	Name of State/UT	Number of sites	*HIV Prevalence (%)*
1.	Andhra Pradesh	STD 3 ANC 6	30.00 2.60
2.	Arunachal Pradesh	STD 2 ANC 1	0.10 0.00
3.	Assam	STD 2 ANC 2	0.61 0.00
4.	Bihar	STD 8 ANC 3	0.50 0.10
5.	Delhi	STD 3 ANC 3 IVDU 1	3.26 0.25 5.00
6.	Goa	STD 2 ANC 2 CSW 1	12.02 1.17 53.20
7.	Gujarat	STD 6 ANC 6	4.65 0.50
8.	Haryana	STD 4 ANC 3	2.75 0.00
9.	Himachal Pradesh	STD 5 ANC 4	0.40 0.89
10.	Jammu & Kashmir	STD 2 ANC 3	0.40 0.12
11.	Karnataka	STD 7 ANC 6 *IVDU 1*	12.80 1.68 4.23
12.	Kerala	STD 3 ANC 3	5.20 0.00
13.	Madhya Pradesh	STD 8 ANC 6	1.60 0.12
14.	Maharashtra	STD 7 ANC 11	18.40 1.12
	Mumbai	STD 2 ANC 5 IDU 1 MSM 1 CSW 1	33.33 2.00 23.68 23.94 58.67
15.	Manipur	IDU 3 STD 2 ANC 5	64.34 11.60 0.75
16.	Meghalaya	IVDU 1 STD 2 ANC 2	1.41 0.00 0.00
17.	Mizoram	STD 1 ANC 2 IDU 1	2.00 0.37 9.61
18.	Nagaland	IVDU 1 STD 1 ANC 4	7.03 6.90 1.35
19.	Orissa	STD 4 ANC 2	2.60 0.27
20.	Punjab	STD 2 ANC 2	0.80 0.00
21.	Rajasthan	STD 4 ANC 4	2.84 0.25

22.	Sikkim	STD 1 ANC 2	0.00 0.00
23.	Tamil Nadu	STD 3 ANC 6 IVDU-1 MSM -1	16.80 1.00 26.70 4.00
24.	Tripura	STD 1 ANC -	1.34 -
25.	Uttar Pradesh	STD 7 ANC 6	1.80 0.12
26.	West Bengal	STD 5 ANC 4 IDU 1	1.96 0.50 -
27.	A & N Islands	STD 1 ANC 3	1.20 0.25
28.	Chandigarh	STD 2 ANC 1	3.35 0.80
29.	D & N Haveli	STD - ANC 1	- 0.00
30.	Daman & Diu	STD - ANC 2	- 0.00
31.	Lakshdweep	STD - 1 ANC 2	0.00 0.00
32.	Pondicherry	STD 3 ANC 1	4.1 0.25

Note: HIV Prevalence levels in States with 3 or more sites are median values, while in States/UTs with less than 3 sites , the values are mean values.

Overall Monitoring and Evaluation of the FHAC Proposal

Process	Responsibility	Time / frequency	Use of information collected	Involvement of stakeholders
Monitoring				
Monitoring of the state of preparedness for the FHAC	Below district – MOs and Health Supervisors Supervisors of NYK, NSS District – District officials responsible for AIDS Control and RCH and NYK and NSS State – Project Director SACS State Steering Committee State Media Coordination Committee National Steering Committee National Media Coordination Committee	January-March and June – August of every year	For ensuring that all activities as per FHAC guidelines are implemented	Secondary stake holders
CMIS	NACO and SACS	Monthly	For monitoring implementation	Secondary stakeholders
SC/PHC/ FRU reporting on RTIs/STIs, cases referred for VCT and for prevention of MTCT activities	HWs, Mos	Monthly	For monitoring the progress in utilisation indicators for RTI/STI services	Secondary stakeholders
Annual Performance Review	NACO	Yearly	For monitoring the progress of activities (timeliness, coverage)	
National Performance Review	National AIDS Control Board	Yearly	For monitoring the progress of the activities of NACO	

Process	Responsibility	Time / frequency	Use of information collected	Involvement of stakeholders
Evaluation				
Baseline level of indicators	Independent agency	Prior to implementation Will be included in the ongoing Behavioural Surveillance Survey and Concurrent Evaluation	Baseline status of proposal indicators	Primary and secondary stakeholders
Concurrent	Independent agency	Every six months	For improving the coverage and quality of services	Primary and secondary stakeholders
End of the project	Independent agency along with representatives of the CCM	End of the project	For assessing the achievement of the objectives	Primary and secondary stakeholders

SECTION C.1. HIV
C.1.c. Improved Access to Care & Support, including Anti-retroviral Therapy (ART)

C.1 Description: (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

Background. The HIV epidemic continues to be a major public health and developmental problem. Of the estimated 38.2 million people living in the world with HIV/AIDS, 3.97 million (10%) of them are in India (NACO, Govt of India estimates, 2001).

HIV/AIDS epidemic in India is predominantly heterosexual and geographically uneven. Consequently, although 0.9% of adults are HIV-infected across the country, some states like Maharashtra, Karnataka, Andhra Pradesh and Tamil Nadu are high prevalence states. The antenatal sentinel surveillance in 2001 revealed HIV seroprevalence of 3.5% in Mumbai, 1.5% in Bangalore, 2.1% in Hyderabad and 1.1% in Chennai. AIDS is documented as a major cause of death among 16-49 year olds in Mumbai; an annual excess of 4,120 deaths attributed to HIV/AIDS (Hira et al, The Lancet 1999).

The current situation of HIV/AIDS in India is estimated to be as follows: Of an estimated 3.86 million infected persons, only a few hundred are estimated to be on consistent ART. An additional 8,000-10,000 are transient users, poorly adherent or intermittent users (Personal communication from a leader of Indian Pharmaceutical industry, 2002). The latter category are likely to be on "wild ART" through general practitioners and likely to cause more harm than good. There is therefore a critical need to establish successful models of well-administered ART programmes so that this problem can be reduced. This will be even more important once access to ART drugs increases as prices fall, and drugs become available to larger sections of the populations.

Because the cost of anti-retroviral therapy (ART) has fallen and the private Indian health care sector is so large and dynamic, there are an estimated eight to ten thousand AIDS patients currently receiving ART in settings which do not facilitate patient compliance. Furthermore, it is anticipated that this "wild" provision of ART will expand rapidly in coming years, leading to the selection for and transmission of resistant strains of virus with severe negative consequences for the Indian HIV epidemic. If the Indian population responds in ways similar to populations made aware of AIDS treatment possibilities in other countries, expanded availability of ART is also likely to lead to setbacks in prevention campaigns, increased risk-taking by all segments of society and potentially an acceleration of the AIDS epidemic.

On the other hand, experience in a few model ART programs suggests that with proper infrastructure support and with careful attention to patient concerns, ART can reduce the infectiousness of HIV infected patients. Through appropriate combination of strengthened prevention programs coupled with expanded ART availability in specific locations and to specific target populations, it is hoped that the risk of reversal of positive trends in condom use and other indices of safe behaviour can be averted.

Government policy context: In many states of India with high prevalence of HIV, provision of clinical care and management of opportunistic infections has been limited and until recently, only few thousand people with HIV/AIDS were able to access antiretroviral therapy (ART). The Government of India's draft national policy on HIV/AIDS is committed to the fact that prevention and care are sides of the same coin, provision of care improves credibility of preventive strategies, and that provision of care reduces stigma and discrimination against persons living with HIV/AIDS.

The Indian national AIDS control program has strong elements of prevention/ interventions and low cost care and support. Also, the generic production of antiretroviral (ARV) drugs in India has improved the potential availability and affordability of ARV drugs. A pilot longitudinal study in Mumbai comprising of 137 patients on ART and 377 patients who could not afford ART showed a 2-year mortality rate of 3% and 52%, respectively (Hira et al, Asia-Pacific AIDS Conference, Melbourne, 2001). The annual mean cost of ART at US$680 versus cost of management of opportunistic infections

at US$1450 (Ian Anderson, The World Bank study 1999 in 4 cities of India) gives cost benefit ratio of 1450/680=2.1.

Although generic drug development in India has occurred over the past 2 years and currently 8 pharmaceutical companies have developed 10 of the 13 ARV drugs that are currently available in most western countries, the uptake by HIV patients has been limited. Instead of an ordered system of ART prescribing and monitoring, in the relatively few patients who have accessed ARTs at reduced prices, there has been a phenomenon of "wild ART" by general practitioners. This practice involves ad-hoc prescribing by general practitioners and inconsistent compliance by patients who may take their therapies for only several weeks or months. In fact there is anecdotal evidence to suggest that up to 80% of patients will discontinue their ART within the first 12 months of treatment. This practice is of serious concern to the medical fraternity because of inherent risk of emergence of ARV resistant strains, adverse effects and concerns about adherence.

NACO has developed guidelines for ARV therapy and is currently engaged in expanding the PMTCT program to national level using a Nevirapine intervention. NACO proposes to provide ART to women who participated in a MTCT program at 11 Government Centres of Excellence (cities identified for ART intervention are included in the list of 11 MTCT sites) that have developed capacity and experience in administration of ART. This proposal chooses four sites that are not Government institutions to test a model to make ART available to eligible patients on a unique concept of stratified cost recovery. It will target a different population than the NACO PMTCT programme to be selected upon different levels of ability to pay.

Objectives

The objectives of the present project are to:

1. Establish a demonstration model for appropriately administered ART.

2. Demonstrate through improved monitoring of CD-4 counts and viral resistance profiles that sponsored programs are producing no more resistant strains than would occur in model programs in rich countries.

3. Provide subsidies for CD-4 counts to be used by private physicians and their patients in the vicinities of sponsored ART programs in order to: a) help private physicians improve patient compliance; monitor disease progression and outcome of their ART regimens; and c) monitor the spread of resistant strains among patients not included in the sponsored programs.

4. Reinforce prevention programs in the vicinities of sponsored ART programs in order to prevent "backsliding" towards riskier behaviour by the surrounding population and to measure the extent to which such "backsliding" occurs.

Implementation Strategy

This ART model intervention proposes to introduce the safe and effective use of ART in 4 major cities of India, namely, Mumbai, Chennai, Bangalore and Hyderabad. All sites have wide network of VCT services and have established networking with community-based health and support organisations for home-based care component. It is expected that this intervention, designed as graduated cost-recovery program with an aim of making it financially self-sustainable, will establish benchmarks for best practices of ART in India. The implementing institutions in the 4 cities have the track record and demonstrated capacity to institute, monitor, provide psychosocial support, and good adherence of small number of patients on ART.

Implementing Institution	Type of Institution	ART since which year	Number currently being followed	Number of new beneficiaries under GFATM
AIDS Research &	Autonomous institution of			

Control Centre, (ARCON)Mumbai	Govt of Maharashtra & The University of Texas	1996	140	1000
YRG Care, Chennai	NGO	1997	90	1000
Freedom Foundation, Bangalore	NGO	1998	30	500
Freedom Foundation, Hyderabad	NGO	1999	20	500

Currently, patients at all these institutions buy ARV drugs from chemist shops and pay for monitoring tests (CD4/CD8 and viral load) performed at private/NGO laboratories. Of late, capability for CD4/CD8 test has been established at government-run teaching hospitals in these cities and patients get tests done for cost-reimbursement fee of Rs500 (US$10) per test. While these institutions have acquired experience in administering ART and obtained good adherence of their clients who are able to pay for the cost of ARV drugs and tests, the patients belonging to low socio-economic status (LSES) and those below poverty line (BPL) have been left out due to their inability to buy drugs and to pay for monitoring. It is the latter groups that constitute 40% of sick patients with HIV/AIDS and experience of ART response, socio-economic impact, adherence, biomedical and behavioural effects that are lacking. The experience of full spectrum of clientele is vital for the national program to develop policy options. Hence, ART intervention project based on graduated cost-recovery concept is developed for funding by GFATM.

Worksheet for graduated cost recovery for 1000 patients at each institution:
Annual cost of commodity per patient per year is as follows:
Mean cost triple ART (50% on 2NRTI + 1NNRTI; 50% on 2NRTI + 1PI)=$650
Baseline CD4/CD8 and repeat at 6 and 12 months =$ 30
Total annual cost of commodities =$680

SES strata	Number Beneficiaries at each Centre n=1000	Annual Cost of drugs US$	Annual Cost of CD4 US$	Total ART cost paid by each PLWHA/yr US$
Wealthy (20%)	200	650	30	680
Middle class (40%)	400	488	30	518
Low SES (20%)	200	325	Free	325
BPL (20%)-poor	200	Free	Free	Free

The graduated cost-recovery by generic pharmaceutical company, selected by the project by tender process, will agree to the following scale: 20% of rich clients will pay the actual cost of commodities for quality management, 40% of middle-class clients will pay 25% less of actual cost of drugs, 20% of low SES class will pay half the actual cost, and the remaining 20% who are poor (below poverty line-BPL) will be provided ARV therapy at no cost. The key question in this concept is whether a generic pharmaceutical company will accept the graduated cost recovery program? The institution will be able to negotiate, by a tender process, with one of the generic drug manufacturer to supply directly to the patients ARV drugs at much reduced cost for project patients and lower costs for CD4/CD8 tests will be made available from participating centres. Hence, there will be no additional monetary burden on rich clients, the 40% clients in the middle-class will actually save on their current cost of ART, the 20% clients in LSES will now be able to afford ART and laboratory monitoring which otherwise was unaffordable for them, and 20% of poor clients in BPL will also benefit at no cost.

The cost-analysis of this intervention shows that at end of first year of the project, the drug company will break even as cost-neutral. The incentive for the participating drug company will be increased overall sales of ARV and establishment of structured ART. Funds during years 1-5 will be required from GFATM for monitoring and evaluation of the project, for operational research, documenting experience for national policy, and for infrastructural facilities (e.g. increased space for additional patient load). The important rate limiting step to this cost-recovery projection is the number of patients enrolled in the program per month. A conservative estimate is that it will take six months to establish the program and to enrol subjects. This initial six months is regarded as the preparatory phase, after which the actual project will commence.

The graduated intervention at all 4 sites will be implemented by autonomous institutions and NGOs. ARCON will be the umbrella organisation for this project and will co-ordinate the M & E activity of Centres in Chennai, Bangalore & Hyderabad. Based on lessons learnt, the intervention may be replicated by other NGOs and in government institutions.

Critical Questions:

1. What is the evidence that patients will be willing to pay graduated cost?

All institutions listed in this proposal have experience of several years wherein the patients in various categories have purchased ARV and tests. The existing patients on follow-up list can be conveniently transferred to the new project. Hence, we do not envisage difficulty in recruiting patients who will pay three times the cost.

2. Considering that number of patients eligible for ART in the 4 cities of India will be large, what process will be followed for patient selection in this project, especially those in LSES and BPL groups?

The project will have Steering Committee comprising of NACO, state government officials, members of civil society, representatives of PLWHA, and technical experts. Criteria for selection of patients in all groups will be evolved and adhered to by the implementing agency. As this project is viewed as a pilot, limiting patient numbers is acceptable.

3. Lack of adherence and loss to follow-up?

It is likely that patients in LSES and BPL groups might have poor adherence to ART and unduly large loss to follow-up. This experience will demonstrate reasons for such health seeking behaviours and initiate search for solutions. However, patients will be counselled about consequences of such defaults in ART and the possibility of their enrolment being nullified within weeks of no show. These patients will then be replaced by new ones within a reasonable period of time, in accordance with the guidelines designed by the Scientific Committee of the institutions.

4. Issues of Equity and equal opportunity.

This is an important component of the project. The feasibility project needs to build experience with best efforts of equity within the constraints of certain number of beneficiaries. Replication of successes over period of time will provide opportunity to more patients for ART. The dynamic nature of this pilot project will allow assessment of its utility and implementation, such that more patients may be enrolled in each group as times goes on.

5. How will the PLWHA community know about ART intervention project and how will the enabling environment be prepared?

Enabling environment will be prepared by the public support of ART project by NACO and the Steering Committee. Information to PLWHA will be through word of mouth and media attention. The latter has been fairly proactive in all 4 cities and topics of AIDS care and support are frequently encountered.

6. How will the project improve the performance of private sector treatment in the vicinity of project sites?

In each year, the project will subsidize CD4/CD8 counts for 3000 patients being treated in the private sector. In addition to helping private sector physicians monitor their patients, this component will provide data on therapeutic success and adherence in the private (“wild”) treatment sector.

7. How will the project help prevent backsliding among HIV negative people in the vicinity of project sites?

Project staff who are expert in ART will conduct training workshops within nearby prevention programs in order to convey to sero-negative risk groups the disadvantages of HIV infection and the limited success of ART. Project staff will also work with prevention program staff to design M&E instruments which can detect any backsliding which might be due to the somewhat expanded availability of ART.

C.2 Objectives and Indicators

Main Objectives:

This project will establish rational use of ART and other essential care services through active partnership of Civil Society, the Government, and the pharmaceutical industry, while reducing the negative consequences of “wild” treatment and “backsliding.” The end situation will demonstrate improvement in quality of life of PLWHA and thus, reduce stigma and discrimination. It will also demonstrate through improved monitoring of CD-4 counts and viral resistance profiles that sponsored programs are producing no more resistant strains than would occur in model programs in rich countries. Efficient monitoring and evaluation and operational research will provide information for future use in planning.

Specific Objectives:

Indicator	Baseline	T A	R G	E T S
	2001	2002	2003	2004
1. Expanded self-financed ART: Number of new patients	300 at 80% of variable costs	1000 at 100% of variable costs	1500 at 100% of variable costs	500 at 100% of variable costs
2. Improved CD4 counts of enrolled patients: Proportion of patients above 350	Recruited patients: 0%	Recruited patients: 0%	Followed patients: 20 %	Followed patients: 40%
3. Information on characteristics of private patients: Number of private patients monitored	0	500	2000	3000
4. Strengthen prevention in vicinity of ART programs: . Workshops by ART specialists . Person-days input to M&E of prevention programs in vicinity	 7 0	 8 50	 12 75	 16 100
Training health care workers in rational use of ART	80	200	400	800
Epidemiologic Impact studies	2	4	8	15
Socio-economic Impact studies	None	2	4	6
Monitoring & Evaluation	None	4	4	4
Mentor improvement of HIV/AIDS clinics/labs in the vicinity	4	5	10	15

C.3 Programmatic Monitoring and Evaluation Plans

This component is critical to the successful implementation of the ART intervention program. It includes continual evaluation of therapeutic success of the proposed structured expansion of ART, of the nearby independent private provision of ART, of the impacts of extended ART on nearby prevention efforts. Close monitoring and evaluation of the program will help identify and rectify potential problems on an ongoing basis and will assist in answering the following questions:

1. What are appropriate criteria (clinical, biologic, social, economic) for starting, switching and stopping ART?
2. What are appropriate tools (clinical, biologic) for monitoring effectiveness of ART in resource-limited setting?
3. What is the feasibility of ART program in resource-limited setting?
4. What is the willingness to pay for ART intervention?
5. What are determinants for improving adherence?
6. What is cost-effectiveness of ART program?
7. Are there regional variations in implementation of the program?
8. What is the feasible way to implement surveillance for drug resistance for the current HIV clades?
9. What is the most efficient way to order, stock, distribute and use ART?
10. To determine efficiency of graduated cost-recovery.
11. How to replicate the program in formal health sector?
12. What is the effect of ART program on sexual behaviour changes?
13. What is the impact of ART program on the community perception of HIV or on stigma?

14. How can this ART introduction program be up-scaled?

C.4 Duration

Beginning and end dates
From: June 2002 (first six months are preparatory and enrolment phase. To: May 2007
Period to be covered by this request for financing
From: June 2002 To: May 2007

C.5 Implementation Plans for Global Fund Resource Allocations to Partners at 4 Sites:

Year 2002
US$ millions

Implementing Partner	Human Resources	Logistics Supplies	Training Supervision	Outreach Services	Commodities / Products Excluding drugs	Data & Information	Other *M & E *Operational Research *Infrastructure *Consultants	**Total**
Government								
Civil Society	0.210	0.420	0.180	0.060	0.030	0.030	0.450	1.380
Private Sector					0.010	0.015		0.025
Donors								
Other								
Total								1.405

SECTION C.2. Tuberculosis
C.2.a. GFATM-Assisted Expansion of the Revised National Tuberculosis Control Programme (RNCTP) to Fully Cover the States of Chhattisgarh, Jharkhand and Uttaranchal in India

C.1 Description: (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

RNTCP incorporates the DOTS strategy, the WHO recommended strategy for TB control. India has expanded this strategy to cover 450 million people currently, which is proposed to reach 800 million by March 2004 and cover the balance 200 million by end 2005 as recommended by WHO. RNTCP has already demonstrated its feasibility and has made substantial and measurable impact. The present proposal extends service coverage, further reflects political commitment and seeks to cover resource gaps. RNTCP is currently being expanded to cover areas with short course chemotherapy. This covers only a few areas in the 3 new states of Chhattisgarh, Jharkhand and Uttaranchal. These states were only recently created, and therefore have a somewhat leaner health infrastructure. In addition, Uttranchal is almost wholly composed of hilly areas, much of it difficult to access and the other two are largely tribal – Chhattisgarh (33%); Jharkhand (28%). Poverty levels there are lower than the national average. Consequently, the GOI aims to cover these on a priority basis. Thus, the proposal is to expand RNTCP to cover 56 million population in all 47 districts of the three newly created states of Jharkhand, Uttaranchal and Chhattisgarh.

Accomplishments Sought

1. To expand RNTCP to cover 56 million population in all 47 districts of the three newly created states of Jharkhand, Uttaranchal and Chhattisgarh under GFATM assistance.

2. To improve quality and reach of RNTCP through availability of free and uninterrupted high quality TB diagnostic and curative services, and more patient-friendly treatment observation.

3. To develop and implement new strategies by building partnerships with non-governmental organizations, private sector and community representatives to ensure availability of diagnostic and treatment facilities in geographically difficult asses which can be replicated in other such areas of the country.

Beneficiaries

Direct beneficiaries:

- 115,000 patients who will be initiated on treatment.
- 20,000 patients whose lives will be saved.
- 230,000 individuals spared from becoming infected with TB.
- Number of families falling into the cycle of debt and poverty caused by a family member having TB disease reduced.
- Community at large by having access to free and uninterrupted high quality diagnostic and curative TB services.

Indirect beneficiaries:

- Community at large by having access to free and uninterrupted high quality diagnostic and curative TB services, better access of women to health care and improved socio- economic conditions because of significantly reduced morbidity and mortality due to TB.
- Economy of the 3 states with the return of cured TB patients to productive.

Implementation Strategies

The expansion of the RNTCP envisaged within this proposal will, as in the ongoing programme, be implemented as a Centrally sponsored scheme. Deputy Director General (TB) in the Directorate General of Health Services will continue to implement the project under overall administrative supervision of the Ministry of Health & Family Welfare. RNTCP will be implemented in the States through the State TB Control Society (STCS) that will plan, monitor and supervise all RNTCP activities at the State level. At the District level, District TB Control Societies will implement the RNTCP. However, significant decentralization to states is proposed for implementing and monitoring the programme. Funds will be routed to Districts through the States not directly from the Government of India. Considerable flexibility has been introduced in flow of funds and programme management by using the mode of societies at State and District levels. Additionally, these societies embody partnerships because NGO and private sector representatives are their members. States will have authority to sanction additional units and contractual appointments as required by special conditions subject to ceilings of up to10-20%.

All existing RNTCP norms and protocols will be followed. Successful appraisal of each preparing district will continue to be a prerequisite for starting of RNTCP service delivery. Following on from successful experiences with the involvement of NGOs (e.g. self help women's group in urban slums, a NGO in difficult riverine areas and a media group for advocacy and DOT providers) and private sector (e.g. Private Hospital in Hyderabad and Ajmer) in RNTCP, involvement of these sectors will be sought. Other important features of RNTCP will be as follows:

1. For accessible and quality diagnosis, a microscopy centre will be established per every 100,000 population and in tribal and hilly areas per every 50,000 population, which can further be relaxed in exceptional circumstances. A full time laboratory technician, trained under RNTCP, is to be working in each microscopy centre;
2. Creation of a sub-district level, the "TB Unit", staffed by a Senior Treatment Supervisor (STS) and Senior TB Laboratory Supervisor (STLS) per 500,000 population and in tribal/difficult areas per 250,000 population, which can further be relaxed in exceptional circumstances. The STS and STLS will be appointed on a contractual basis and be responsible for assisting District TB Officer (DTO) / Medical Officer–TB unit (MO-TC) in supervision and monitoring of the various programme activities;
3. To fill up vacancies there is provision for contractual lab technicians; TB health visitors for urban areas; Medical officers in DTCs, staff in Medical College.
4. A 4-wheeler would be made available for all DTOs (25% purchase and hiring of the remaining) and a 2-wheeler for both STS and STLS to ensure mobility. MO-TCs would have the option of hiring a 4-wheeler.
5. Drugs will be provided free of cost to all patients under the RNTCP;
6. In order to ensure efficient drug management, State Drug Stores will be strengthened;
7. Capacity building of the State TB Training & Demonstration Centres (STDC) will be undertaken;
8. To ensure quality diagnosis, proper storage of drugs and availability of essential service facilities, civil works will be supported at the State TB Training & Demonstration Centres, District TB Centres, TB Units and Microscopy Centres.

9. Wherever necessary provision will be made for contractual hiring of one TB Health Visitor per every 150,000 urban population for effective outreach to urban slum populations.
10. States will have authority to increase TB Units and Microscopy Centres by 10% for specific reasons without referring matter to GOI.
11. To facilitate the process of decentralisation, capacity building and strengthening of the State (STCS) and District TB Control Society (DTCS) will be undertaken.
12. Due to the situation existing in the 3 States, up to 20% contractual hiring of laboratory technicians will be permitted, to be decided by State to enable services to reach underserved areas. However, in exceptional circumstances 50% hiring can be supported by CTD.
13. Similarly, up to 15% of the second medical officers at the District TB Centre can be hired by the State on contractual basis.
14. To aid information storage, quick retrieval and rapid communication, the TB reporting systems will be computerised at the State and District levels through an electronic connectivity programme. Submission, analysis and feedback of reports will be encouraged via e-mail and the Internet.
15. Involvement of NGOs and private sector in RNTCP under approved schemes.
16. Provision of patient-friendly services by decentralisation of DOT to peripheral health workers, anganwadi workers, panchyat leaders, and other community members.
17. Keeping in view the recommendation of the World Bank and GOI-WHO joint review of February 2000 there has been decentralization of programme in a phased manner which includes release of funds/drugs to the State Societies instead of District Societies, monitoring of technical performance of Districts by State and other activities.
18. Within District and State Action Plans, special relaxed norms included to facilitate effective service provision for tribal and under-served populations.

The above activities will facilitate greater access and ensure proper monitoring and supervision.

Training

Training is key to success for RNTCP and all health personnel involved in implementation of RNTCP will be trained through specially prepared modules as per the current policy of GOI. STO and DTOs will be trained in central level institutes, while other staff at the appropriate facilities at their respective levels.

Information, Education and Communication (IEC)

The role of IEC is to be viewed in the context of the RNTCP's long-term goal of curing TB patients so that TB ceases to be a major public health problem. Low level of community awareness and knowledge about TB, inadequate IEC material, insufficient skill enhancement activities, discrimination against females and the absence of a well coordinated campaign at national and local level are issues that shall be addressed through the IEC strategy. Increased commitment at national and local levels through the involvement of the key opinion makers, NGOs and the private sector to keep TB control at the forefront of national priorities will be ensured.

IEC strategy would follow a holistic approach by providing relevant information, employing appropriate and effective communication for motivation, empowering people by supporting their ability to access services and fostering an enabling environment through improved interpersonal communication to achieve RNTCP's long term goals. Activities will include enhanced advocacy around events (e.g. World TB day), training of health providers in inter-personal communication and awareness raising amongst

patients and general public. Different media such as mass communication media, sensitisation workshops, seminars, wall paintings, street plays, banners, hoarding and kiosks etc would be used.

Partnerships

Concerted efforts are being made to involve NGOs and the private sector in the RNTCP. Currently five schemes for NGO exist and guidelines for private sector participation are under finalization. Already about 300 NGOs and about 500 private practitioners are participating in addition to many private hospitals. The special conditions of these 3 states necessitate further development of new partnerships to implement RNTCP. In order to increase access all NGO and private sector hospitals will need to be fully involved. Moreover, communities will need to play an active role through their own leadership and structures. We will also use organizations such as women's self help groups. This will be particularly true for awareness generation and for provision of DOT centres.

C.2 Objectives and indicators (Provide information on objectives for this component.)

- **Main objective** (Describe the expected end situation)

Coverage under RNTCP of all the 47 districts in three newly created States of Chhattisgarh, Jharkhand and Uttaranchal, and achieving treatment success rates of at least 85% and case detection rates of at least 70% of new smear positive pulmonary TB cases.

- **Specific objectives:** (Related to indicators, including baseline data, current situation and annual targets) (*Guidelines para. 34-37*)

INDICATOR	**Baseline**	**Targets**		
	2001	**2002**	**2003**	**2004**
Process				
Population coverage by RNTCP	4.9 million	4.9 million	20 million	56 million
Formation and registration of DTCS	NA	All identified districts for year	All identified districts for year	All identified districts for year
Identification of TB Units	NA	All identified districts for year	All identified districts for year	All identified districts for year
Identification of Microscopy Centres	NA	All identified districts for year	All identified districts for year	All identified districts for year
Identification of DOT Centres	NA	All identified districts for year	All identified districts for year	All identified districts for year
Identification of MO-TCs	NA	All identified districts for year	All identified districts for year	All identified districts for year
Initiation of hiring process for contractual staff	NA	All identified districts for year	All identified districts for year	All identified districts for year
Submission of finalised district action plan	NA	All identified districts for year	All identified districts for year	All identified districts for year
Performance				
% of new adult OPD cases examined by sputum microscopy	>2% *	>1.5%	>1.8%	2%
Case detection rate of new sm+ve cases per 100,000	40 *	50	45	>50
Ratio of sm-ve to sm+ve cases	0.9 *	<1.2	<1.2	<1.2
% of TB patients residing within district put on DOTS	100% *	90%	90%	≥90%
Smear conversion rate of new sm+ve cases at 3 months	92% *	≥90%	≥85%	≥90%
Treatment success rate of new sm+ve cases	83% *	≥85%	≥80%	≥85%
Involvement of NGOs in RNCTP	NA	5	15	25
Involvement of PPs in RNCTP (number per 2 million population)	NA	5	10	20

* For the other 51 million population covered by the National TB Programme (NTP), treatment success and case detection rates were 40% and 21 per 100,000 population respectively. Data on the other performance indicators are not available for the 51 million covered by the NTP.

C.3 Programmatic monitoring and evaluation plans: (An outline of the monitoring and evaluation process that will be followed for this component.) (*Guidelines para. 34-37*)

Monthly reporting from peripheral units to the TB Unit and from there to the District TB Centre will be implemented. Intensive technical monitoring at the Microscopy Centres will be performed by the TB Unit at the District TB Centre (DTC), which in turn will be monitored by the State level. Quarterly RNTCP review meetings will be held at the State level, with all the District TB officers in attendance. The State level is the prime responsible authority in monitoring the implementation of the RNTCP. The Central level will provide technical assistance to States and on need basis to districts. To enable the State level to effectively ensure its functions, a 6-monthly meeting of all the State TB Officers will be held at the national level.

The existing RNTCP quarterly reporting system from Districts to State to Central level whose reporting proformae have been reviewed based on experience of WHO-GOI review will be utilized in the districts implementing RNTCP activities through GFATM assistance. Reports submitted include Programme Management Reports detailing case finding, smear conversion rates, treatment outcomes, logistics and microscopy services, and Financial Reports detailing statement of expenditure etc. Detailed feedback on programme activities and achievements to each District will be given by the State level, supplemented by additional feedback from the central level, by a fixed date of each quarter. Via an on-going electronic connectivity project, it is foreseen that submission of, analysis and feedback on the quarterly reports from and to all levels (Central, State and District) will move into the electronic domain utilising the Internet.

The reporting system utilised by the RNTCP has been proven to be robust. Performance in relation to any one indicator is easily verifiable via crosschecking 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.

C.4 Duration: (provide an estimate)

Beginning and end dates:

From: April 2002 To: March 2005

Period to be covered by this request for financing:

From: April 2002 To: March 2005

C.5 Implementation Plans including resource allocations to partners *(Guidelines para. 40)*

For Year 2002-2003
(USD million)

	Budget Categories (please fill in according to your plan)							
Implementing Partner	*Human Resources*	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or Products**	*Data & information systems*	*Other (explain)*	***TOTAL***
Government	0.32	0.12	0.35	0.17	0.20	0.07	0.65	1.88
Civil Society								
Private sector								
Donors								
Other								
TOTAL	0.32	0.12	0.35	0.17	0.20	0.07	0.65	1.88
**Including drugs*								

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SECTION C.2 Tuberculosis

C.2.b. Improving Private Sector TB Treatment in Tamil Nadu, India Through Expansion of a Model Private-Public Partnership

C.1 Description: (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

Summary

Chennai, Tamil Nadu's largest urban area, is home to approximately 6 million people. In Chennai, similar to other cities in India, approximately 50% of TB patients seek private practitioners as their primary health care providers.[4] Both laboratory and treatment services in the private sector vary widely in their adherence to RNTCP recommended practice including use of sputum smear exams for diagnosis and referral of patients to Directly Observed Treatment.[5]

In order to improve treatment outcomes, this project proposes to upgrade practitioner and laboratory skills, expand the number of DOTS centres, increase appropriate treatment seeking behaviour, increase TB knowledge within the community at large, and provide a forum for collaboration among of government, NGO and commercial sectors.

The project will be carried out by REACH (Resource Group for Education and Advocacy for Community Health) in collaboration with the Tuberculosis Research Centre (TRC). REACH is a non-profit advocacy agency for areas critical to community health, particularly those affecting the lower socio-economic groups. REACH has launched a programme for involving private practitioners and private laboratories in Chennai, India, in the Revised National TB Control Programme, using the DOTS methodology to treat their private patients. This program called ACT –Advocacy for Control of Tuberculosis has been working in Chennai for the past three years. Program data collected (i.e., sputum conversion, cure and completion rates) is promising. An evaluation of the project has also recently been conducted by the WHO-SEARO Office and a report is awaited.

TRC is a world-renowned institution and has been associated with major milestones in TB research over the decades, and has now launched into the exercise of involving the private sector in sharing their rich knowledge and expertise in evolving methodologies for TB control. For this project TRC will provide technical guidance in areas of data collection, evaluation, training and supervision. In addition to REACH and TRC, the Chennai Corporation, the Tamil Nadu State government's health care functionary, will provide drug boxes. Finally, select hospitals, and clinics will be recruited as DOTS centres. The project intends over the three-year project period to cover 2-3 of Chennai

[4] M.W.Uplekar's Study on "Behaviour Profile of Tuberculosis Patients in Private Clinics " Ind.J.Tub.1998,45,95

[5] M.W.Uplekar et al TB management in private practice and its implications: Ind.J.Tub,1996,43,19

Corporation's zones in North Chennai (approximately 1 million population).

Because the existence of private practitioners and laboratories does not depend on external donors it is anticipated that the project in addition to resulting in immediate benefits (i.e. improved treatment outcomes, lowered drug resistance, etc.) will continue to result in improved treatment outcomes after the project ends. In addition, REACH anticipates that the programme will bring down patient costs in the private sector due to reduction of diagnostic delays and unwarranted investigations, provision of free drugs, and reduction from indirect costs such as travel expenses and wages lost.

Beneficiaries

Direct beneficiaries:

- TB patients seeking services in the private sector effectively treated
- Reduction in TB transmission and TB drug resistance will benefit the community at large.

Indirect beneficiaries:

- Other Indian states will benefit from the application of lessons learned drawn from careful monitoring and evaluation of this model private-public collaboration.

Implementation Strategies

1. **Establish project baseline data**
   - REACH will establish a database of information on current patient, laboratory and provider practices in order to plan, monitor and evaluate project progress. For the database TRC and REACH will assemble (through secondary and primary research) the following baseline information in Chennai:
   - General Treatment Practice & Outcomes: Number of new smear positive TB patients identified, Number of new smear positive TB patients started on DOTS, Number and proportion of patients placed on non-DOTS Proportion of patients cured or completing treatment; proportion of patients failing treatment/transferred out
   - DOTS infrastructure: Number of DOTS centres, number of DOTS providers trained, monitored and active
   - Private practitioners: number of private practitioners practising in each zone, number/proportion of private practitioners currently: referring patients for TB treatment, providing TB treatment, referring patients to DOTS; number/proportion of private practitioners adhering to RNTCP guidelines including diagnosis based on sputum smear exam, regimen for new smear positive pulmonary TB cases, monitoring treatment progress based on sputum smear results. Willingness to participate in ACT project.
   - Laboratories: Number of existing private laboratories, existing infrastructure, number and proportion of private diagnostic laboratories providing sputum exams, number and proportion of laboratory technicians trained in sputum microscopy, number and proportion of private diagnostic laboratories doing sputum microscopy as per RNTCP guidelines, number and proportion of private diagnostic laboratories participating in an independently monitored quality assurance program or intervention, willingness to participate in the program in

particularly to set up the laboratory as a sputum microscopy centre, participate in trainings and in the quality assurance program.

- Patient treatment behaviours: Number/proportion of patients aware that they have TB number/proportion of patients practicing appropriate treatment seeking and adherence behaviour (median duration in weeks between onset of chest symptoms and consulting the first provider, Median duration in weeks between first seeking care and diagnosis of TB, Proportion of patients who continued with the same doctor from diagnosis of TB to the end of treatment, proportion of patients defaulted, number/proportion of patients completing therapy. Patient costs including median expenses incurred by patients on consultation, investigations, treatment and travel for diagnosis and treatment of TB and indirect costs to patients due to wages loss during diagnosis and treatment of TB.
- Social stigma and awareness: Proportion of patients stating that there was a change in attitude by family members since they were diagnosed with TB Proportion of patients facing fear of rejection from friends or peers due to TB

Data collection for each zone will be done in a period of six weeks each covering a total time duration of 12-18 weeks. Data will be collected through various methodologies including questionnaires, clinical records, and/or observation.

2. Private sector treatment services strengthening

To equip private health care providers with the knowledge and skills needed to treat TB patients, REACH and TRC will adapt the RNTCP manual for practising physicians on the treatment and management of tuberculosis.

Materials will be disseminated through various venues including for example continuing medical education, training, and pamphlets. In particular practitioners will update their skills in use of standardised diagnostic methods, treatment regimens, DOTS and the systematic follow up and documentation procedures in the management of tuberculosis patients.

Training for doctors will be carried out for a period of six weeks each thus covering a total period of 12-18 weeks.

3. Reducing stigma and encouraging appropriate health seeking behaviour through behaviour change communications (BCC)

Based on the data collected from each zone, BCC materials have to be prepared to encourage appropriate health seeking behaviour among patients and to increase knowledge among the general public.

Patient, family and general public informational materials will be formulated with the expert guidance from Government bodies like Tuberculosis Research Centre and Chennai Corporation.

Packaging the message to specific target groups will require the skills of a professional body thus REACH will work with a professional advertising agency to prepare and promote the required messages. REACH has already approached an agency that has agreed to support this effort at minimal cost as part of their corporate commitment to the community. Baseline findings will assist REACH and the agency to select a strategy that identifies partner laboratories and providers to potential patients through a common logo or other device (i.e.,

accreditation certificate). The electronic and print media will be used as channels of communication. In addition pamphlets and brochures will be circulated among the patients and general public. All training and IEC materials will be pretested among appropriate target audiences.

4. Improving patient adherence to treatment through DOTS

In order to provide directly observed treatment in a time and place convenient to the patient, REACH will recruit various outlets (i.e., hospitals and clinics) to serve as DOTS centres. Additional DOTS centres and community volunteers will be recruited through advocacy and networking and will be trained to counsel patients on the various components of the DOTS laying emphasis on treatment, completion and cure. REACH offers support to other family members based on the RNTCP's protocol for patient contact and prophylaxis.

In addition REACH through already established links with several private centres will refer, as necessary, patients for HIV Voluntary Counselling and Testing.

*Patient intake will stop six months prior to completion of program to ensure that patients enrolled in the program will complete their six months of treatment

5. Strengthening private sector laboratory services

Quality of laboratory services in Chennai's private sector varies greatly. Currently there does not exist a system for mandatory quality testing and accreditation of medical laboratories. Therefore the spectrum of quality standards ranges from laboratories that voluntarily participate in quality assurance to labs, which have no quality assurance programmes.

To ensure quality level of diagnosis and also to strengthen the laboratories in areas identified through baseline data collection mentioned above, REACH and TRC will:

- Identify one state-of-the-art laboratory in each of the participating zones and equip it to become a sputum microscopy centre. All neighbouring laboratories can be sensitised to act as sputum collection centres to be directed towards the main laboratory.
- Establish in coordination with TRC a quality assurance network and accreditation system will be established for these laboratories.

Using adapted RNTCP training materials, REACH and TRC will equip laboratory staff with the skills needed to do sputum smear microscopy. In addition, the project will provide as needed binocular microscopes, reagents, slides and disposal materials. The private laboratories in the existing REACH programme currently bear the cost of recurring expenses. For this proposal REACH intends to explore further leveraging private sector inputs by negotiating a cost share for microscopes and other needed equipment.

Training for the laboratories selected from the participating zones will be carried out for a period of six weeks each thus covering a total period of 12-18 weeks. Periodic site visits by TRC and REACH staff subsequent to the workshops will support on-going quality improvement. Each laboratory involved in the program will be subject to assessment every 3 months, i.e., 4 times during each year. In addition, collection of AFB smears will be done at periodic intervals by TRC to independently assess the quality of smears done. Reports on the assessment will be submitted to TRC and also to the doctor/owner of the laboratory. Based on the results feedback additional support training etc. will be provided.

6. Strengthening collaboration between private and public sector partners in TB treatment

To foster collaboration REACH will promote the establishment of an Apex body consisting of Government and non-Governmental organisations to guide the development of the program and to evaluate outcomes and the potential for replication on a larger scale. The Apex body will have representation from the Chennai Corporation, the State TB Society, Medical Associations, NGOs and Industry. Based on consultations with the Tamil Nadu chapter of the Confederation Of Indian Industries (CII). REACH will utilise the CII network to recruit member industries to implement the RNTCP in their medicare facilities.

C.2 Objectives and indicators (Provide information on objectives for this component.)

A. Main objective (Describe the expected end situation)

Achievement of an overall cure rate of 85% among TB patients seeking treatment at participating clinics (number of TB patients to be determined after baseline).

B. Specific objectives: (Related to indicators, including baseline data, current situation and annual targets)

The effectiveness of the ACT project expansion will be evaluated using the following criteria process and outcome indicators:

Process Indicators (Will be adjusted according to baseline findings)

- At least 50% of the private health care providers approached participate in skills building activities
- Establishment of sputum microscopy centres
- Percentage of existing private laboratories that participate in skills building activities
- Establishment of DOTS centres
- Training of DOTS volunteers
- Quality assurance and accreditation system established

Outcome Indicators (Will be adjusted according to baseline findings)

- Percentage increase from baseline of participating practitioners following RNTCP algorithm for diagnosis and treatment
- Percentage increase from baseline of laboratories correctly using sputum smear diagnosis
- Percentage increase from baseline in level of TB knowledge among the general public*

*A study on the awareness level of general public in Chennai has been carried out by REACH interviewing 500 respondents, the results of which are being analysed currently. This study covered under a separate budget will serve as a baseline for this indicator.

- A treatment success rate of 85% among participating patients
- Reduction in patient costs from baseline

C.3 Programmatic monitoring and evaluation plans: (An outline of the monitoring and evaluation process that will be followed for this component.) (*Guidelines para. 34-37*)

Monitoring and evaluation will be jointly managed by REACH, TRC and the Chennai Corporation. Data will be entered and subsequently analysed through the current management information system with increases measured annually through follow-up surveys against the baseline described in previous sections. Epidemiological data will be reported, as it is now, to the Chennai Corporation that in turn reports to the RNTCP on a quarterly basis.

Through the APEX body described above, REACH will establish a project monitoring subcommittee that advises on overall project progress and serves as an independent review panel for the above monitoring and evaluation studies.

C.4 Duration: (provide an estimate)

Beginning and end dates:
From: June 2002 to May 2005

Period to be covered by this request for financing:
From: June 2002 to May 2005

C.5 Implementation Plans including resource allocations to partners

(USD million)
2002-2003

	Budget Categories (please fill in according to your plan)							
Implementing Partner	*Human Resources*	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or Products**	*Data & information systems*	*Other (explain)**	**TOTAL**
Government								
Civil Society	0.017	0.014	0.018	0.019		0.003	0.015	0.086
Private sector								
Donors								
Other								
TOTAL	0.017	0.014	0.018	0.019		0.003	0.015	0.086

**Drugs will be provided by the Government programme.*

**Other refers to incidental patient support (i.e., food supplements, transport between clinical centres, treatment for concomitant illnesses).*

SECTION C.3. Malaria
C.3. Expansion of Enhanced Malaria Control Project (EMCP)

Description: (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

C.1 Description:

An integrated malaria control strategy is proposed for specific districts of the most affected states of Orissa, Jharkhand, Chhattisgarh and Madhya Pradesh. In these states, the predominantly tribal areas are being covered under the Enhanced Malaria Control Project (EMCP) with World Bank assistance. However, other areas which are almost equally malarious but non-tribal or less than 25% tribal could not be included in the project because they did not meet project inclusion criteria. These non-EMCP districts will be covered under this proposed project with the following coverage of districts, public health clinics, and population size.

Name of state	No. of non-EMCP districts	No. of PHCs in non-EMCP district	Population in non-EMCP areas (000's)
Orissa	9	76	11183
Jharkhand	9	73	11778
Madhya Pradesh	27	166	37138
Chhattisgarh	3	18	3219
Total	**48**	**333**	**63318**

Therefore, the total population coverage for this project will be approximately 63.32 million.

A. Accomplishments Sought

- To strengthen overall malaria prevention efforts with an emphasis on integration of malaria control, capacity building, community participation, and inter-sectoral collaboration and involvement of NGOs as to protect 63.3 million population and screen around 17 million population annually.

- To enhance early detection of malaria cases and treat promptly through the establishment of a management information system. Based on current malaria positivity rate, the estimated number of case detection in the early part of the project will be around 0.3 million annually.

B. Implementation Strategy

Under the project, the components, which have been already identified for EMCP implementation, will be strengthened in the non-EMCP areas of these states. The following will be the main components of the project.

- Early diagnosis and prompt treatment (EDPT)
- Selective vector control

- Promotion of personal protection methods - ITMN
- Early detection and containment of epidemics and intersectoral co-ordination*
- Information Education and Communication*
- Institutional and management capacity building - Trained Manpower Development, efficient Management Information System (MIS), etc.*

* These components are already been covered under EMCP for entire country.

The project will emphasize proper strategic planning and its implementation as to make the project cost effective, sustainable and environmentally friendly. The project will implement the approved policies of national programme and EMCP. The involvement of other sector and NGOs will be done effectively.

C. Location

- Project is proposed to be implemented in 48 districts of four states namely Chattisgarh, Madhya Pradesh, Jharkhand and Orissa, which consists of 63.32 million population. Out of these states 2 are newly created. These states are tribal predominant having difficult inaccessible areas with poor health infrastructure.
- Chhattisgarh: Three districts consisting of 3.2 million population in 18 PHCs, which were not included in the EMCP.
- Madhya Pradesh: Twenty-seven districts consisting of 37.1 million population in 166 PHCs.
- Jharkhand: Nine districts consisting of 11.79 million population in 73 PHCs.
- Orissa: Nine districts consisting of 11.18 million population in 76 PHCs.

D. Beneficiaries

Direct beneficiaries:

- 63.32 million population of the 48 districts in 333 PHCs of the identified 4 states in terms of effective prevention from malaria and access to diagnosis and prompt uninterrupted treatment for malaria.

Indirect beneficiaries:

- Overall socio-economic development by prevention of man-hour loss due to malaria.

The main highlights of policies and strategic approach under the project are given below:

a. Early Diagnosis and Prompt Treatment (EDPT)

a.1. Strengthening of Surveillance

- As due to resource problem the states are not in the position to deploy the surveillance workers as per the norms hence the Malaria Link Volunteers (MLV) will be provided through project at 1 per 2000 population by making a provision of Rs. 500/- per month to meet the transport cost.

- Provision of mobility for supervision by providing a vehicle at district level.

a.2. Strengthening of Case Detection and Treatment

- Provision of microscope and trained microscopist for each of 30,000 population. Contractual lab. technicians will be provided through the project.
- Establishment of Drug Distribution Centres (DDCs)/ Fever Treatment Depots (FTDs) through village functionaries as to ensure continuous availability of Chloroquine.
- Establishment and strengthening of referral centres by providing I/V drip set and parental glucose, injectable artimisinin derivatives, and other antimalarials
- Providing of rapid diagnostic test for selective use
- Involvement of Private/General practitioners by sharing the laboratory services and advocacy.

b. Selective Vector Control by Indoor Residual Spray

- Identification of areas required to be sprayed through microanalysis. Under the project only those areas will be sprayed with insecticide which are recording API 5 and more i.e. five or more cases per thousand population annually.
- For the project area entire cost of insecticides (presently DDT & Malathion), transport and operational wages for spraying will be met through the project. The WHO has given concurrence that the use of DDT can be continued for the control of malaria and other vector borne diseases in the developing countries, as it is most cost effective insecticide (copy at appendix II).

c. Insecticide Treated Mosquito Nets (ITMNs)

- Promotion of use of ITMNs, especially for pregnant women and children.
- Provision of re-impregnation of community bednets.

d. Epidemic Preparedness and Rapid Response

- Developing of mechanism for detecting Early Warning Signals and prediction of outbreaks at all levels.
- Development of effective epidemic response mechanism at Primary Health Centre (PHC) level onwards.
- Strengthening of capacity of states for Epidemic Preparedness Response (EPR)
- Development of Management Information System (MIS) and GIS with the built-in EPR component through EMCP.

e. Trained Manpower Development (under EMCP)

- Identification of training needs of all levels of functionaries.
- Identification of institution with the capacity of imparting trainings at PHC/district/state/centre levels.
- Development of core trainers at various level.

f. Information, Communication and Education (IEC) (under EMCP)

- Needs-based assessment and identification of community media habits.
- Development of target-group oriented IEC materials.
- Intensification of IEC campaign.
- Involvement of other sectors including CBOs/NGOs for the development of IEC materials and campaign.

g. Management Information Systems (MIS)

- Development of quick information flow, fast analysis and appropriate decision systems.
- Built-in EPR, logistic reports, etc. in the MIS.

E. Project Operations

The project will be operated in the identified districts of the four states through the administrative mechanism already in place for operating the Enhanced Malaria Control Project (EMCP). This includes the following:

- Utilization of State Malaria Control Societies for project implementation.
- Formulation of District Malaria Control Societies for facilitating implementation of this project.
- The experience/agencies already gained/hired during EMCP implementation will be optimally utilized.
- Guidelines from District Implementation Plans used for procurement, hiring of agencies, engaging of experts and other support staff will also be applicable for this project.
- The mechanism developed for the monitoring project implementation, the reporting system, and formats developed under the EMCP, will be utilized.
- The operational research findings of EMCP will optimally be utilized for guidance in the effective implementation of GFATM-Malaria.

C.2 Objectives and indicators (Provide information on objectives for this component.)

- **Main objective** (Describe the expected end situation)

1. To cover entire state of Chhattisgarh, Madhya Pradesh, Jharkhand and Orissa by adding 48 left out districts to scaling up the achievements of EMCP being implemented in these states.

2. Perceptible improvement in the implementation of the control strategies.

3. Detection and appropriate treatment of around 0.3 million malaria cases annually in the initial years of the project in the identified areas.

- **Specific objectives:** (Related to indicators, including baseline data, current situation and annual targets) (*Guidelines para. 34-37*)

INDICATOR		Baseline 2002	Target 2003	Target 2004	Target 2005
Annual Blood Examination rate		**Minimum 10% of population i.e. 6.33 million**	**Minimum 10% of population i.e. 6.45 million**	**Minimum 10% of population i.e 6.59 million**	**Minimum 10% of population i.e 6.72 million**
Vector Control	**Indoor Residual Spray**	**7.7million**	**7.7million**	**7.7million**	**Focal Spray wherever required.**

C.3 Programmatic monitoring and evaluation plans: (An outline of the monitoring and evaluation process that will be followed for this component.) (*Guidelines para. 34-37*)

Continuous monitoring through monthly reports and returns on the formats of the programmes. Report analysis, feed back and required action at all level.

Annual reports and returns on the structured formats of the programme.

C.4 Duration: (provide an estimate)

Beginning and end dates:
From: April 2002 To: March 2005

Period to be covered by this request for financing:
From: April 2002 To: March 2005

C.5 Implementation Plans including resource allocations to partners *(Guidelines para. 40)*

For 3-Year
(US$) in million

	Budget Categories (please fill in according to your plan)							
Implementing Partner	*Human Resources*	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or Products**	*Data & information systems*	*Other (explain)*	**TOTAL**
Government	0.23	10.99		13.12	3.8		3.85	31.99
Civil Society								
Private sector								
Donors								
Other								
TOTAL	0.23	10.99		13.12	3.8		3.85	31.99
**Including drugs*							**approx 32 million US $**	

SECTION C.4 CROSS-CUTTING

C.4.a. Industry response to HIV/AIDS & TB: Advocacy to Action in industrial estates located in the high prevalence states of Tamil Nadu, Andhra Pradesh, Maharashtra and Gujarat

C.1 Description: (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

Summary

The Confederation of Indian Industry (CII), a non-governmental, not-for-profit, industry led and industry managed organization, is India's premier business association. CII, with a direct membership of over 4200 companies and indirect membership of 40,000 companies through over 100 sectoral associations, is uniquely positioned to bring together industry and government to address HIV/AIDS and TB in the workplace. Recently, CII established the Indian Business Trust for HIV/AIDS (IBT) to focus resources specifically on HIV/AIDS. The proposed three-year project will build on CII's membership base (both direct and affiliated) and experience implementing workplace interventions and will be administered by the Indian Business Trust.

CII and IBT will collaborate closely at national and state levels with the National AIDS Control Organisation (NACO), the National Tuberculosis Programme (NTP) as well as with affiliate sectoral associations and NGOs to expand workplace HIV/AIDS and TB interventions in the four high prevalence states of Tamil Nadu, Andhra Pradesh, Maharashtra and Gujarat. CII's current direct membership within these four states includes 1,807 companies with approximately 1.5 million employees. Interventions including workplace policy development, behaviour change communications, clinical service provision and referrals, condom promotion and distribution will be expanded for these member employees and their immediate families, as well as the employees and families of other affiliate associations estimated to total at least 5.3 million people.

Beneficiaries

Workers and their families affected or at risk of HIV and/or TB, at industrial estates located in the four high prevalence states of Tamil Nadu, Andhra Pradesh, Maharashtra and Gujarat

Strategic Activities

1. Facilitate Private-Public Sector Collaboration in Prevention and Care of TB and HIV/AIDS

IBT and CII will establish a "core group" in each state that will include Industry members, employee and PLWA representatives, State AIDS and TB societies, the AVERT Society, and NGOs active in both disease areas. This steering group will meet quarterly to plan strategies and review progress of the proposed initiative. The core group will be the mechanism for channelling the creativity of business executives and their public and NGO partners as they work together to formulate shared solutions to expanding effective STI/HIV/AIDS and TB prevention and care programmes in the workplace. Importantly the core group will enable the private sector to build relationships with NGOs and public entities that offer services unlikely to be sought by employees through their workplace – such as HIV voluntary counselling and testing, and PLWA support groups. In addition, through the core group planning, the initiative will benefit from the research (such as behavioural and biological surveillance surveys) conducted by others. In particularly the involvement of the State AIDS and TB Societies

will facilitate shared training and quality monitoring programs between government and private industry.

2. Conduct State Level Rapid Needs Assessment and Planning

The IBT project manager will lead each State core group through an initial rapid needs assessment. Conducted primarily through secondary research the needs assessment will help to identify existing knowledge, beliefs and attitudes of employees as well as employers, service availability and utilization. The rapid needs assessments will help inform the strategic planning of the initiative for each state and provide the baseline data necessary to measure impact.

3. Advocacy and Information Dissemination

IBT will implement an advocacy strategy utilising the prestigious business leaders that are trustees on the IBT board. In addition to an IBT trustee speaker's bureau, other tactics such as workshops, press placement, and meetings with community leaders will be employed. In addition to encouraging other businesses to establish and expand workplace programmes, this advocacy strategy will also contribute to the reduction of stigma surrounding AIDS and TB.

To help persuade business managers to understand the impact AIDS has on productivity, CII is currently undertaking a socio economic impact study of HIV/AIDS on Industry. The study is looking at factors such as chronic illness among employees, health costs, absenteeism – man hours/days lost, replacement costs, compensation and insurance costs. IBT and CII will also through the advocacy strategy build on their current efforts to sensitise industry for the prevention of TB among employees. To support these efforts, CII has persuaded businesses to distribute leaflets on prevention and care of TB. Industry has been organizing interactive sessions for employees on the same. Also, TB cases are monitored by the company to ensure that the full course of treatment is taken by the concerned employee.

Additionally, CII through its monthly journal, *"Communiqué"*, will update industry and other partners about the activities of participating companies. CII has published written workplace policies of member companies in the journal and the latest one in the forthcoming issue is of India's largest public sector steel company, Steel Authority of India. This is important, as it is the first public sector to endorse a written HIV/AIDS workplace policy for all its units, across the country.

4. Mobilise Workplaces to Develop Written HIV/AIDS and TB Policies

A key objective of the above mentioned advocacy efforts is to encourage more businesses to formulate written HIV/AIDS and TB policies. Currently only five of CII members have written policies. CII has created several materials to aid companies in this process and also utilises materials made available through international agencies such as the International Labour Organisation (ILO).

5. Encourage Condom Distribution and Behaviour Change Communications

In CII's experience two effective interventions to promote in the workplace are condom distribution and behaviour change communications. IBT and CII will work with participating industries to resource condoms and to plan behaviour change strategies including peer education and counselling. In particular CII has worked with industry to recruit DOTS volunteers. Through CII's encouragement companies have sponsored a variety of informative entertainment for employees and their surrounding communities including street plays and folk music shows.

6. Skills Building and Training Workshops

To support companies to undertake the above interventions IBT will provide a range of training and workshops including for example: How to start a workplace program/The Basics, Establishing a peer education program, Developing a Behaviour change strategy, and Developing a workplace HIV/AIDS and TB Policy. To facilitate this effort IBT will seek to form a trainer network within each state.

In addition to training in the above areas, IBT will work closely with the State TB and AIDS Societies to identify training needs of industry owned hospitals, clinics, and laboratories. Through these efforts companies will have access to state of the art learning in areas such as STI and TB management and testing. IBT will explore training activities related to HIV/AIDS care and treatment of opportunistic infections. Given reluctance by staff to attend work owned HIV VCT centres, IBT will also explore linking companies with local HIV VCT facilities such as through an anonymous referral arrangement.

7. Leveraging Private Sector Contributions Toward Sustainability

A key objective of the proposed initiative will be to leverage industry resources as much as possible to ensure that activities continue. As described in the budget to follow IBT and individual companies will both support the initiative with their own resources. Over the three-year project, it is anticipated that together IBT and industry will contribute approximately 0.25 $US million in staff time, venue costs, and IEC materials, making a total project of 0.68 US$ million. In addition, industry through its private hospitals and laboratories will effectively share in the cost of clinical services including and especially TB and STI diagnosis and treatment.

C.2 Objectives and indicators (Provide information on objectives for this component.)

- **Main objective** (Describe the expected end situation)

Increase in the number of workplaces initiating workplace HIV/AIDS and TB prevention and control programmes in four states.

- **Specific objectives:** (Related to indicators, including baseline data, current situation and annual targets) (*Guidelines para. 34-37*)

Final objectives and indicators will be decided based on the rapid needs assessments conducted in each of the participating states. However, below are illustrative examples of indicators for the initiative:

(Baseline = Current CII members within the 4 states plus other industries identified through affiliate association partners and the rapid needs assessments).

- Increase from baseline in the percentage of companies approached that:

  Start or expand a workplace programme.
  Establish peer educator programmes.
  Distribute condoms
  Develop a written HIV/AIDS and TB workplace policy.

- At workplace owned clinics and hospitals an increase from baseline in:

  Number of people with TB treated
  Number of people with STIs treated

- At workplaces without clinical facilities:

  Number of TB cases referred to TB testing and treatment centres and DOTS centres
  Number of STI referred to the government centre

C.3 Programmatic monitoring and evaluation plans: (An outline of the monitoring and evaluation

Continuous assessment and evaluation of the activities initiated by the company would be started by the project officer of IBT. The monitoring of the project will be done as a collaborative process between the IBT and CII. IBT and CII together would formalize the monitoring plan, using the standardized reporting format at each intervention site, prior to the starting of the project. The programme officer of each state will be responsible for putting together activity reports from the industrial estates. The project officer would meet regularly with the core group as well as the IBT team.

IBT and CII officers would regularly meet with the project officers, to further plan activities and gather current issues or lessons learned that need to be or can be used to support advocacy effort as well as handle any problem that may come up. Activity reports would include the process indicators mentioned above.

IBT and CII together would:

- Do a cost analysis for each site, the number of people reached and services used by the target population

- Do site visits to review the project progress with the project officer and participating companies.

- Self-assessment/ evaluation by the company on its workplace programme.

C.4 Duration: (provide an estimate)

Beginning and end dates:

From: 2002 to 2005

Period to be covered by this request for financing:

From: 2002 to 2005

C.5 Implementation Plans including resource allocations to partners *(Guidelines para. 40)*
For Year 2002-2003
(USD million)

	Budget Categories (please fill in according to your plan)							
Implementing Partner	*Human Resources*	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or Products**	*Data & information systems*	*Other (explain)*	***TOTAL***
Government								
Civil Society								
Private sector	IBT Staff	0.0380	0.0849	-	0.0208	0.0094	0.0025	0.156
Donors								
Other								
TOTAL	IBT Staff	0.0380	0.0849	-	0.0208	0.0094	0.0025	0.156

**Including drugs*

Other (explain): civil works and office operation

SECTION C.4. Cross-cutting
C.4.b Integrated strategy for the control of malaria, TB, and HIV in difficult rural areas

C.1 Description: (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

The strategy proposed by VHAI is to integrate its efforts in the fight against Malaria, TB and HIV/ AIDS, with the ongoing endeavours and existing systems. It intends to work through its partnership with grass root level implementing member organizations and their existing infrastructure. Emphasis would be on adherence to the guidelines specified under the National Health Programmes with creation of innovative mechanisms and processes, empowering and empowered by the community. On an interim basis, quality preventive, promotive and curative services would be provided while addressing the health awareness requirements.

A major component of the strategy is involvement and enhancement of community participation and strengthening of community leadership. To enable the community to become better aware of their own situation and to understand existing structures and processes as the basis for community participation, VHAI attempts to encourage their participation in the micro planning processes; promote community based care and support patients in completing their treatment. It also aims at creating community awareness by a steady flow of information on how to access services and prevent ill- health by facilitating timely health action at the individual, household and community levels. This would include procurement and repackaging of available information and developing new material based on local needs and sensitivities. The processes would involve sensitisation of the community on preventive and promotive aspects of health to avoid economic loss.

Envisioning the vital role of the Panchayati Raj Institutions and the Community Based groups, VHAI intends to involve Panchayat representatives, Self Help Groups, Women's groups and other special common interests groups in the process. Such interventions would ensure that the marginalized sections, especially women are organized and have their interests adequately represented. Panchayat representatives can also play an important part in facilitating collaboration with the Government to encourage community to launch and support people’s initiatives.

The strategy has been designed in an attempt to help develop and strengthen simple, accountable and effective service delivery systems with close monitoring mechanisms. It is an endeavour to establish a coordinating mechanism with all concerned partners and to ensure adequate and regular quality services including drug supply by better collaborations and interactions with the government. The project strives to help health personnel to understand communities better and to improve the health services delivery system based on their needs; to improve access of the community to public health programs instead of setting up parallel systems to the existing ones.

While on one hand the project intends to support the public health services and the functionaries, it also needs to look at the private sector, which is a major provider of services across the country. Remoteness of the public health services, apathy and unavailability of the service providers, medicines and equipment and factors affecting the accessibility and utilization of health services force the community to seek the more easily accessible private service providers. Through this project VHAI strives to enhance the understanding of the service providers on essentials of the National Health Programmes and to enable them to implement the different components of the Malaria, TB and HIV/ AIDS Control Programmes.

Through this collaborative process and interphase between the community, project implementing agencies and the service providers, the project would attempt to promote community participation and develop linkages. VHAI perceives that the awareness in the community on rights and entitlements would grow and there would be a gradual improvement in utilization of public health services.

VHAI does not propose to replace or duplicate Government efforts but it intends to make efforts to supplement and complement existing efforts and systems. The emphasis will be primarily around enhancing response and participation of the community and strengthening of the general public health infrastructure and delivery systems with special emphasis on Malaria, TB and HIV/ AIDS.

VHAI is a National Health Association, which is secular and non-profit making. It is a federation with 24 state VHAs and 5 new State Voluntary Health Associations with its head quarters in Delhi.

VHAI has been working for more than 7 years in 20 most difficult and remote areas of the country for comprehensive improvement in Health & Development scenario of those pockets through its KHOJ projects, integrated Health & Development Projects. While most programmes face the challenge of reaching the unreached, VHAI has succeeded not only in reaching out to the vulnerable but has also worked with them. However due to paucity of resources, issues of TB, Malaria and HIV/AIDS have not received adequate attention. Therefore, the present project is to initiate comprehensive activities for prevention and control of TB, Malaria and HIV AIDS in 6-selected pockets through existing projects as well as the government primary health infrastructure by taking over the Primary Health Centres in these areas where the KHOJ projects are already operating.

Goal

To improve the health status of the community in select areas.

Geographical area

The project will be implemented in 6 different pockets. These pockets represent different geographical and socio-cultural diversity of the country. For e.g. Seppa Subdivision in East-Kameng district of Arunachal is a hilly tribal area while Osian block in Jodhpur is in the heart of *Thar* Desert.

Profiles of the proposed operational areas

Sr. No	Name of collaborating NGO	Location of operational area		
		State	District	Block
1.	Gramin Vikas Vigyan Samiti	Rajasthan	Jodhpur	Osian (tehsil)
2.	Manipur Voluntary Health Association of India	Manipur	Imphal District	
3.	Tarun Sanskar	Madhya	Jabalpur	Majholi

		Pradesh		
4.	Arunachal Pradesh Voluntary Health Association	Arunachal Pradesh	East Kameng	Chayang Tajo
5.	Centre for Regional Education, Forest and Tourism Development Agency (CREFTDA)	Orissa	Mayurbhanj	Jashipur
6.	Manav Sewa Kendra	Uttar Pradesh	Varanasi	Naugarh

* Implementation would be done in 6 blocks in the 6 districts mentioned above; each covering an approximate population of 100 000.

Direct Beneficiaries

Population at large of the Block, approximately 100 000 population per block; 6 blocks

Key implementation strategy

The emphasis will be primarily on enhancing response and participation of the community and strengthening of the general public health infrastructure and delivery systems with special emphasis on Malaria, TB and HIV/ AIDS. A multipronged strategy is proposed to address the variation in prevalence of the diseases in the proposed remote areas where the basic public health infrastructure is inadequate and inaccessible.

To address the issue of inadequate and inaccessible public health infrastructure, VHAI proposes to take over one Primary Health Centre in each block of the intended operational area. Financial resources from the government at the existing level of funding are proposed to be utilized to strengthen them & develop a model of effective primary health care for difficult areas with major focus on control of communicable diseases particularly TB, Malaria and HIV/ AIDS.

In the first year VHAI will work through its implementing partners, build linkages and initiate negotiations with the government to take over the PHC so as to begin work on them from the second year. The strategy proposed by VHAI is to :

- Integrate its efforts in the fight against Malaria, TB and HIV/ AIDS with ongoing interventions and existing systems; to address the socio-economic dimensions of these diseases;
- To work through its partnership with grass root level implementing member organizations and their existing infrastructure and to promote sustainable systems from the point of view of finances and human resources;
- To take over a Primary Health Centres in each block to help develop and strengthen simple, accountable and effective service delivery systems with close monitoring mechanisms; to establish a coordinating mechanism with all concerned partners and to ensure adequate and regular quality services including drug supply by better collaborations and interactions with the government;
- To begin negotiations with the State governments to take over a Primary Health Centre in each block in the first year and by second year to actually take over the PHCs

- Involvement and enhancement of community participation and strengthening of community leadership; attempts to encourage their participation in the micro planning processes; promote community based care and support patients in completing their treatment;

- To involve Self Help Groups, Women's groups and other special common interests groups in the process to ensure that the marginalized sections, especially women are organized and have their interests adequately represented;

- To promote the participation of Panchayat representatives to play an important part in facilitating collaboration with the Government to encourage community to launch and support people's initiatives;

- Quality preventive, promotive and curative services to be provided on an interim basis; emphasis on adherence to the guidelines specified under the National Health Programmes with creation of innovative mechanisms and processes;

- To enhance the understanding of the Private service providers on essentials of the National Health Programmes and to enable them to implement the different components of the Malaria, TB and HIV/ AIDS Control Programmes;

- To enable the community to become better aware of their own situation and to understand existing structures and processes as the basis for community participation; to create community awareness by a steady flow of information on how to access services, prevent ill- health by facilitating timely health action.

- Through this collaborative process and interphase between the community, project implementing agencies and the service providers, the project would attempt to promote community participation and develop linkages. VHAI perceives that the awareness in the community on rights and entitlements would grow and there would be a gradual improvement in utilization of public health services.

- VHAI does not propose to replace or duplicate Government efforts but it intends to make efforts to supplement and complement existing efforts and systems.

C.2 Objectives and indicators

Objectives

- To strengthen existing community health projects in selected locations so as to provide preventive, promotive and curative health care for control of TB, Malaria and HIV/AIDS.

- To enhance effectiveness of government primary health care services by improved management of available resources.

- To develop a replicable model to show how to effectively deliver primary health care services in difficult rural areas by strengthening existing infrastructure (of the Primary Health Centres)

- To establish linkages with government health system

- To increase the capacity of Panchayati Raj Institutions (PRIs), Self Help Groups (SHGs) and other community based groups in becoming

competent catalysts and mobilizers of the community to initiate and/ or actively participate in TB, Malaria & HIV/AIDS control programs.

- Promote safer practices adopted by community at large so as to facilitate prevention of Malaria, TB, HIV/AIDS

Process indicators:

- Training of project staff
- Establishment of diagnostic facilities
- Development of IEC strategy
- Development of IEC material

Performance indicators

- Case detection
- Treatment success rate
- No. / types of programmes conducted for PRIs, SHG members
- No. of persons contacted
- Participation of community in disease control activities.

In addition indicators to assess socio-economic dimensions of the diseases and the impact of the interventions will be developed.

C3. Programmatic Monitoring and evaluation plans

For monitoring the existing MIS will be augmented to include newer components like specific information about the project activities. Presently field supervisors maintain basic village level records in the form of village register. VHW provide monthly report to supervisors who compile it and send to the project office.

Pattern of reporting

- Village Health Worker ➡ Supervisor monthly
- Supervisory level ➡ Project office monthly
- Project office ➡ VHAI quarterly
- VHAI ➡ CCM half yearly.

Monitoring visit

VHAI will visit each project once in a quarter. During these visits not only the progress made will be assessed but opportunity will also be used to provide technical support to fill up identified gaps so that the monitoring visits do not become merely a fault-finding exercise.

Financial monitoring

Quarterly financial plan will be made and variance analysis done to monitor finances.

C4. Duration

3 years (May 2002-April 2005)

C.5 Implementation Plan

For Year 2002-2003
(USD million)

	Budget Categories (please fill in according to your plan)							
Implementing Partner	*Human Resources*	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or Products**	*Data & informa-tion systems*	*Other (explain)*	***TOTAL***
Government								
Civil Society	0	.0172	.0172	.0287	.0402	.0115		0.115
Private sector								
Donors								
Other								
TOTAL	0	.0172	.0172	.0287	.0402	.0115		0.115

**Including drugs*

Other (explain): civil works and office operation

Attachments : List of Supporting Documents

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

General documentation:	**Attachment #**
1. Approach paper to Tenth Five Year Plan	1
HIV/AIDS specific documentation:	**Attachment #**
2. Situation analysis (PMTCT)	1
3. Baseline data for tracking progress[6] (Feasibility study)	2
4. National strategic plan for HIV/AIDS, with budget estimates (Combating HIV in India)	3
TB specific documentation:	**Attachment #**
5. Multi-year DOTS expansion plan and budget to meet the global targets for TB control	1
6. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents	2
7. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form)	3
8. Most recent independent assessment/review of national TB control activities	4
Malaria specific documentation:	**Attachment**
9. Situation analysis (Country Report)	1
10. Country strategic plan to Roll Back Malaria, with budget estimates	2
11. Others	NAMP Drug Policy 3

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