THE GLOBAL FUND
to Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM

FOURTH CALL FOR PROPOSALS

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Fourth Call for Proposals for grant funding. This Proposal Form should be used to submit proposals to the Global Fund. Please read the accompanying Guidelines for Proposals carefully before starting to fill out the Proposal Form.

Timetable: Fourth Round

Deadline for submission of proposals	April 5, 2004
Board consideration of recommended proposals	June 28 – 30, 2004

Resources available: Fourth Round

As of the date of the Fourth Call for Proposals, US$604 million is available for commitment for the Fourth Call for Proposals (pending any appeals to Third Round decisions). It is likely that more resources will become available before the Board consideration of proposals. The amount available will be updated regularly on the Global Fund's website.

Geneva, 10 January 2004

Notes:

How to use this form:

1. Please read ALL questions carefully. Specific instructions for answering the questions are provided.

2. Where appropriate, indications are given as to the approximate length of the answer to be provided. Please try, as much as possible, to respect these indications.

3. To avoid duplication of efforts, we urge you to make maximum use of existing information (e.g., from program documents written for other donors/funding agencies).

4. Proposals may be posted on the Global Fund web site and/or otherwise made public.

Proposal Title	**Accelerating HIV/AIDS, Tuberculosis and Malaria Prevention and Treatment**
Country/Countries	**India**

Type of Application:

- ☒ Country Coordinating Mechanism
- ☐ Sub-Country Coordinating Mechanism
- ☐ Regional Coordinating Mechanism (including Small Island States)
- ☐ Regional Organization
- ☐ Non-Country Coordinating Mechanism

[Please check one of the boxes, which will categorize your application type. For explanations of categories refer to Guidelines for Proposals section II paragraphs B1 to B4. Please note that Regional CM applications include also proposals from Small Island States.]

Proposal Components:

- ☒ HIV/AIDS
- ☒ Tuberculosis
- ☒ Malaria
- ☐ HIV/TB
- ☐ Integrated

[Please check the box or all boxes your proposal targets; for explanations of components refer to Guidelines for Proposals section III paragraph A.]

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1 Eligibility

Country / Countries	

☒ Low Income
☐ Lower-Middle Income
☐ Upper-Middle Income
☐ High Income

[See the Guidelines for Proposals, Annex 1. For proposals from multiple countries, complete separately for each country.]

1.1 Lower-Middle Income and Upper-Middle Income Country

[Countries classified as "Lower-Middle Income" or "Upper-Middle Income" by the World Bank are eligible to apply only if they meet additional requirements (see the Guidelines for Proposals section II.A.). Sections 1.1.1 and 1.1.2 are required for this proposal and without them this proposal will not be considered for financing.]

1.1.1 Co-financing and greater reliance on domestic resources

[This proposal is eligible only if it demonstrates that it is significantly co-financed from domestic resources. As a guide, for proposals from Lower-Middle Income countries, this co-financing should cover approximately 20% of the total cost of the program, whereas for proposals from Upper-Middle Income countries, this co-financing should cover approximately 50% of the total cost of the program. Loans should be considered as domestic resources for the purposes of quantifying co-financing. This proposal must also demonstrate that domestic resources are increasingly being relied upon over the five years of the proposal. Please complete the following table to fulfill both of these eligibility requirements. The field "Total requested from the Global Fund" should match the request in Table 5.2.]

Table 1.1 – Co-financing and greater reliance on domestic resources

Financing Sources	**In USD**				
	Year 1[2]	**Year 2**	**Year 3 Estimate**	**Year 4 Estimate[3]**	**Year 5 Estimate[3]**
Domestic resources that will be used to co-finance the proposal					
(a) Government[1]	89,480,000	97,480,000	105,950,000	115,180,000	124,680,000
(b) Other domestic					
Total requested from the Global Fund	27,918,387	44,696,043	55,161,502	60,602,109	72,720,998
Domestic co-financing percentage	76	69	66	66	63
Reliance on domestic resources (ratio of domestic resources to Global Fund financing)	3.18	2.23	1.94	1.94	1.70

Note:1. These figures represent budgetary allocations for these diseases in the Central Plan. There is substantial commitment of resources for State government, and the private sector which is difficult to quantify.
2. Year 1 refers to financial year 2004-5.
3. Year 4 and 5 extends into the eleventh five Year Plan, outlays for which have not yet been finalized.

1.1.2 Poor or vulnerable populations

[This proposal is eligible only if it demonstrates that it focuses on poor or vulnerable populations. Describe the poor or vulnerable populations targeted by this proposal (2–3 paragraphs).]

[Describe how these populations have been identified, and how they will be involved in planning and implementing the proposal (2–3 paragraphs).]

Several national social indicators such as level of education and access to health care are reflective of discrepancies in the country between men and women, rural and urban. An estimated 29% of the population lives below the national poverty line. Populations in many rural areas of India and in certain states such as in the North-Eastern are often lacking access to information, education and comprehensive health care.

Poverty and social and economic inequalities increase vulnerability to HIV/AIDS, TB and malaria which in turn increase poverty unless controlled. Therefore, addressing the three diseases will contribute to further reducing health and economic inequalities.

The malaria component targets mainly tribal populations in the states of Orissa, Jharkhand and in the North-Eastern States. Tribal populations in these states have often limited access to services including treatment for malaria, distribution and impregnation of bednets, indoor residual spray and health education.

In Andhra Pradesh and Orissa TB efforts will be expanded to provide TB treatment (DOTS) which will benefit mostly populations from low income segments of the population and underserved populations in rural areas of the two states. These population groups often live in crowded places, have a poor health status including malnutrition and have limited access to health services.

The HIV/AIDS proposal targets vulnerable populations, especially women in rural areas, and populations at high risk of infection in 14 states of India. It also aims at providing HIV care and support, including ART to people living with HIV/AIDS in six high prevalence states and Delhi. Many PLHAs come from low income and marginalized groups (MSM, sex workers, IDUs, out of school youth, migrants). They often suffer heavy economic and social consequences of due to their HIV infection, including loss of daily wages and other income from sale of assets. Families, especially children of PLHA are particularly vulnerable. By providing treatment to PLHA and family counseling , PLHA and their families will be benefited.

2 Executive Summary

[Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of The Global Fund.

NOTE: THIS SECTION TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED IN]

2.1 Component and Funding Summary

Table 2.1 – Total Funding Summary

	Total funds requested in USD					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
HIV/AIDS	13,956,726	21,583,923	31,924,420	43,407,212	54,541,857	165,414,139
Tuberculosis	500,000	6,406,000	6,319,000	6,548,000	6,859,000	26,632,000
Malaria	13,461,661	16,706,120	16,918,082	10,646,897	11,320,141	69,052,902
HIV/TB	0	0	0	0	0	0
Integrated	0	0	0	0	0	0
Total	**27,918,387**	**44,696,043**	**55,161,502**	**60,602,109**	**72,720,998**	**261,099,041**

2.2 Proposal Evaluation

[Please specify how you would like your proposal to be evaluated:]

☐ The Proposal should be evaluated as a whole
☒ The Proposal should be evaluated as separate components

2.3 Proposal Summary

[Please include quantitative information where possible (4-6 paragraphs total):

1. *Describe the goals, objectives and key service delivery areas per component, including expected results and timeframe for achieving these results. Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them (including target populations and their estimated number).*

HIV/AIDS SUMMARY

Introduction

In recent years India has made considerable progress in building capacity that has enabled a holistic and comprehensive response to HIV/AIDS. The major thrust of the national response to HIV/AIDS has thus far been on increasing awareness among the general population and implementing programs for prevention of HIV among vulnerable and high-risk groups—motivating them to seek HIV testing and diagnosis while enhancing services for People Living with HIV/AIDS (PLHA), including drugs and medicines for treatment of opportunistic infections (OIs) in PLHAs and prevention of parent to child transmission of HIV (PPTCT).

With an estimated 600,000 new HIV infections in 2002 and already high prevalence of HIV among injecting drug users (IDU), commercial sex workers (CSW), men having sex with men (MSM), migrants and other mobile groups, e.g. truck drivers, there is a high potential for a rapidly worsening and generalized epidemic.

In the six high HIV prevalence states and Delhi where the epidemic is maturing, the demand for treatment, care and support is increasing. The National Capital Territory (NCT), Delhi draws mobile and migrant people from across the country, and particularly from the low prevalence neighboring states of Haryana, Uttar Pradesh, Punjab, Bihar and Himachal Pradesh in search of livelihood and for care and treatment. Additionally, nearly 40% of the migrant population live in slums and shanties with no regular access to primary health care. For these reasons, the demand for care and treatment in Delhi increases many times over. Some of these individuals can afford to cover the cost of their own treatment and care[1]. However the vast majority of PLHA are unable to afford care and treatment for HIV/AIDS. Resultantly, they continue to suffer a heavy burden of disease and most die prematurely.

Enhanced care with treatment, intensified prevention, and expanded support are required to curb the course of these epidemics and mitigate their impact on individuals, families, communities and the whole nation. This project aims at strengthening the capacity of both the public and private sectors to deliver, care and support services with simultaneous intensified prevention, through access to a comprehensive HIV/AIDS care inclusive of antiretroviral treatment (ART), improving and expanding high quality clinical training and follow-up, increasing access to quality voluntary counselling and testing (VCT), improving diagnostic capability, augmenting quality assurance systems, consolidating and renewing communications strategies, and ensuring more effective referral linkages across the prevention-to-care continuum. The introduction and scaling up of ART is an important, significant innovative component within the overall effort.

Every State/Union Territory in India includes many vulnerable groups/communities at high risk of acquiring and transmitting HIV infection. A macro-analysis of the ongoing epidemics demonstrates that:

[1] One estimate indicates that nearly 16,000 people in India are on intermittent ART, sourced through the private sector.

HIV/AIDS SUMMARY

- Six states, with a combined population of 291 million—four in the South where the predominant mode of HIV transmission is sexual (Tamil Nadu, Maharashtra, Karnataka and Andhra Pradesh) and two in the North-East (Nagaland and Manipur) where the epidemic is driven predominantly by injecting drug use—are experiencing a high intensity transmission of HIV and a significant and fast growing number of AIDS cases.
- The National Capital Territory (NCT) Delhi, with a population of 14 million draws mobile and migrant people from across the country, and particularly from the low prevalence neighboring states of Haryana, Uttar Pradesh, Punjab, Bihar and Himachal Pradesh in search of livelihood and for care and treatment. Additionally, nearly 40% of the migrant population lives in slums and shanties with no regular access to primary health care. For these reasons, the demand for care and treatment in Delhi increases many times over. Some of these individuals can afford to cover the cost of their own treatment and care. However the vast majority of PLHA are unable to afford care and treatment for HIV/AIDS. Resultantly, they continue to suffer a heavy burden of disease and most die prematurely
- Eight additional States (Bihar, Jharkhand, Chattisgarh, Madhya Pradesh, Orissa, Uttar Pradesh, Uttaranchal and Rajasthan) with a combined population of 458 million, are experiencing more moderate epidemics, characterized by a high vulnerability to HIV and the rising need for AIDS care and treatment. These States must enhance prevention activities and prepare better for the emerging demand for care and treatment.

Altogether, the above 15 States account for 89% of all reported AIDS cases and 70% of the 1.07 billion country population (Figure 1).

Goals and objectives

This component aims at improving the survival and quality of life of people living with HIV/AIDS and at reducing HIV transmission. It has two objectives:

Objective 1: To reduce morbidity and mortality associated with HIV/AIDS and the transmission of HIV in the six high prevalence states and Delhi by combining care, treatment (including ART), prevention and support.

Objective 2: To increase awareness, encourage behaviour change and promote health-seeking behaviours to reduce vulnerability to HIV in eight low prevalence States with a view of lowering the risk of HIV transmission and prepare for future introduction of ART in HIV/AIDS care and treatment.

Quality ART for PLHA will be provided initially through the public health system and additionally, in partnership with the private corporate and non-government sectors. Prevention and support interventions for PLHA will be integrated with ART services in the six high-prevalence states and Delhi with the active involvement of PLHA and NGOs.

Active information, education and communication towards behaviour change and risk reduction in the additional eight States will be achieved under the respective State

AIDS Control Societies (SACS) and local partners.

Key service delivery

Under Objective 1: To reduce morbidity and mortality associated with HIV/AIDS and the transmission of HIV in six high prevalence States and Delhi by combining care, treatment (including ART), prevention and support

Antiretroviral treatment for both adults and children in the public sector is the new intervention to be introduced with the GFATM support. This complements India's existing VCT programme and the PPTCT programme supported by UNICEF in 138 district and 50 major teaching government hospitals in the six high prevalence States (and approved by GFATM, Round Two, as a key intervention in the HIV-TB co-infection Programme). The current proposal builds upon these previously installed services and seeks to link ART services with prevention, care and support; strengthen diagnostic and clinical capabilities in the same teaching and district hospitals; and engage non-governmental organizations (NGOs) and networks of positive people to ensure referral, adherence to ART and support to those on treatment.

Innovative communication strategies will be implemented with emphasis on creating a supportive community and institutional environment, in which PLHA can access ART, adhere to treatment and adopt safer preventive behaviours. The two-way referral system for PLHA (from community to hospitals for initiating and monitoring ART, and from hospital to community where the person on treatment can participate in community life and economy) is at the foundation of the present alliance between public health services and NGOs/private sector. The new interventions included in this proposal builds on ongoing and already implemented or planned activities of the National AIDS Control Organization (NACO) and on the continuing involvement of PLHA in the programme.

The first point of entry for people needing HIV/AIDS care will be in government hospitals and institutes besides private health care facilities where HIV infection will have been evaluated on clinical or biomedical grounds. In the six high HIV prevalence states and the national capital territory Delhi, the wide network of tuberculosis (TB) diagnosis and treatment centres, the existing 242 VCT centres (out of the 631 now functioning in public facilities in the country), an unknown number of private laboratories with HIV testing capability, and antenatal clinics where HIV testing is performed will all contribute to the referral of women, men and children to care and treatment centres in tertiary and district government hospitals identified. In these government facilities, HIV status will be assessed and followed-up, prevention and treatment of opportunistic infections with essential drugs offered and ART prescribed when clinical or biomedical indications warrant it. Thus, the additional services proposed in this application include strengthening of VCT, prevention and treatment of opportunistic infections, provisioning for ART and psycho-social support services for HIV-positive people. It is anticipated that the expanded demand for VCT will result in a number of people being referred to diagnosis and treatment centres (initially teaching and district hospitals) for clinical and biomedical assessment. It is also anticipated that the increased proportion of the population being aware of their HIV status will result in higher numbers of people seeking prevention and care services.

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Health providers at ART centres will be trained to assess risk-taking behaviours among PLHA, communicate prevention messages, reinforce positive changes in behaviour, and refer clients to other relevant services and sources of support, for example substance use treatment centres or peer group in highly vulnerable communities (e.g. CSW and MSM, NGO and PLHA networks).

People who are found to be HIV infected, regardless of whether they are at the pre-clinical or clinical stage of HIV infection, will require information, counselling and support so that they can adopt lifestyles and practices that will minimize their risk of acquiring HIV-related illnesses or of transmitting HIV to their sexual partners or to those with whom they may be inclined to share injection equipment. Counselling support for those at the pre-clinical stage would be provided by the existing VCT centres and NGO networks that are implementing targeted interventions and care and support projects. Friends and family members identified by PLHA as their preferred source of support and to whom they have voluntarily disclosed their HIV status will also require education and skills building in protective behaviours and practices appropriate to sexually transmitted infections (STIs) and HIV prevention. Information, education, and communication (IEC) designed for PLHA and their regular sexual partner(s) will include sexual health in the context of HIV, condom promotion, informed reproductive choice.

Under objective 2: To increase awareness, encourage behaviour change and promote health seeking behaviours to reduce vulnerability to HIV in the eight low prevalence States with a view of lowering the risk of HIV transmission and prepare for future introduction of ART in HIV/AIDS care and treatment.

The eight States (Bihar, Jharkhand, Chattisgarh, Madhya Pradesh, Orissa, Uttar Pradesh, Uttaranchal and Rajasthan) have a total population of 458 million, nearly half of the country's population. In general, the health and development indicators of these States, particularly literacy level and status of women, are lower than national averages. Although the intensity of spread of HIV in these States has thus far been documented as low, there are several risk/vulnerability factors in these States which are predictors of more intense HIV spread and consequent rise in the need for care and treatment.

To decrease vulnerability to HIV infection, there is a need to step-up interventions at community levels with behaviour change communication, that will increase awareness and promote health care-seeking behaviours. There is also a need to build capacity of the health system for detection and management of STIs/reproductive tract infections (RTIs) and begin to plan and work towards the introduction of ART. Prevention services will be stepped up to increase awareness and promote behaviour change in the population through a campaign-based approach while simultaneously increasing capacity of the health system to provide good quality services for prevention, treatment and care of STIs. Given the low literacy and higher risk/vulnerability of women, IEC campaigns will be designed with due attention to gender issues. The IEC campaigns or "family health awareness campaigns" will be

done once a year in each Block covering 150,000 population. The specific activities included in each round of the campaign will include sensitization of the community through effective and innovative communication strategies. These will provide correct information about all modes of transmission of HIV/AIDS and also address the most common myths and misconceptions. Moreover, during the campaign individuals suspected to have STIs will be referred to community health centres for diagnosis, treatment and follow-up. In collaborative projects of SACS and NGOs, focused IEC and behavioural change projects will be carried out. These will address specific needs of highly vulnerable groups such as out-of-school youth, and mobile and tribal populations. Referral linkages will be created and the capacity of the health system will be developed to manage referred patients for detection and treatment of RTIs and STIs and HIV care services for those groups; this is likely to result in improved health care seeking, creating an environment on which access to ART may eventually be built. It is expected that a strengthened health system with effective referral linkages and adequate drugs will create a demand for prevention and treatment services throughout the year and stimulate greater preparedness for responding to emerging HIV/AIDS-related care and treatment needs.

New public-private sector partnerships

Essentially, there will be two kinds of public private partnerships. The first relates to partnering with the networks of private sector laboratories, blood banks, already in position, for augmenting geographic coverage in respect of screening, testing and monitoring of people living with HIV/AIDS who are placed on antiretroviral treatment.

The second relates partnering with a Consortium of NGOs to achieve sustained and extensive involvement of PLHA networks in the national prevention and treatment programme in India, to manage sub-grants to community-level NGOs, and to provide an entry point for sustainable, innovative participation of the corporate sector in partnerships with the public health system. This second, and simultaneous public private partnership is seen as fundamental to sustaining the increased access to treatment and support.

Partnerships will be forged between the public sector providers of ART, PLHAs, NGOs and the corporate sector, with the common purpose of installing robust mechanisms that will ensure smooth referrals of people eligible for ART, together with psycho-social support, and peer counselling. The consortium of NGOs will have as their primary responsibility the maintenance of high rates of adherence and compliance among those on ART seeking to mitigate the effects of HIV/AIDS on these infected and affected (family and friends) of the PLHAs.

The Consortium of NGOs will expand its membership and sub-contract to NGOs and private entities. The establishment of a synergy amongst these partners and between them and public services will be an important feature of this programme.

At the national level, a joint Programme Committee consisting of senior representatives of the NACO, the Consortium of NGOs and co-opted experts, as

needed, will ensure harmonization of the efforts undertaken by partners. The Country Coordinating Mechanism (CCM) will provide oversight to the Programme Committee. These mechanisms will be central to the strengthening and monitoring of partnerships in a spirit of mutual and public accountability and transparency. Likewise, the State ART Programme Implementation Committee, under the auspices of SACS, will coordinate activities at the State level, whether they are funded through SACS or through the Consortium. This collaboration will be further expanded through the district AIDS committees for better coordination at the community level.

In response to a public call for proposals issued by the CCM, 105 proposals were received from NGOs. Of these, 48 were shortlisted as potential implementing partners. Upon further strengthening and resubmission, these proposals may find their place under the Consortium's effort in the six high prevalence States and Delhi or under the SACS in the eight low HIV prevalence States.

Expected impact of this project

During the five-year lifetime of the project, over 180,000 PLHA, both adults and children, will have been put on ART. Due to the attrition of this population as a consequence of treatment failure or non-adherence, an estimated 137,400 PLHA will be on ART received from public services by the end of 2009. It is projected that, by the end of 2009, an equal number of PLHA will be receiving ART through the private sector with costs covered by personal resources. In addition, by the end of the five years, over 2.8 million new HIV tests will have been carried out and 200,000 PLHA not needing ART will be provided care and support through the public sector.

Reduction of HIV transmission from mother to child undertaken nationwide (including the six high prevalence States and Delhi) under the PPTCT programme, will be closely linked to this programme component. Together, these efforts will contribute to decrease the rates of newly acquired HIV infection among highly vulnerable individuals, including those engaging in risk-taking behaviours and discordant couples (where only one of the partners is HIV-infected). They will reduce morbidity due to better management of opportunistic infections and the provision of ART. They will mitigate the impact of HIV in infected and affected individuals, improving their quality of life and enabling them to contribute more actively to social and economic development.

The programme will also contribute to building greater national capacity through infrastructure and human resources development, provision of such services as VCT through NGOs provided assistance by NACO (when these have, until now largely been managed by public health systems), establishing stronger linkages between people and entities that have until now been engaged in either care or prevention work, and explore avenues for effective home and community based care.

Funding

The total request for this application is US$ 165.4 million for five years, including US$ 35.5 million for the first two years. The five-year figure includes US$ 122.7 million for enhanced prevention care and support in the six high prevalence States&

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Delhi and US$ 77.1 million solely for the purchase of ARV drugs made available to States through public health services. An additional US$ 18.2 million have been budgeted for community-based care, prevention and support services implemented by NGOs in the six high prevalence States & Delhi and US$ 24.5 million for prevention and antiretroviral preparedness to be made available to local partners through SACS in the eight States with currently lower rate of HIV transmission, but with high vulnerability.

Innovative aspects of this proposal

There are four main innovative aspects to the proposal: (i) the launching of a large scale, phased ART access initiative closely linked to expanded prevention and support efforts; (ii) engagement of the private corporate sector for increasing access to diagnosis, screening, monitoring and support for people on antiretroviral treatment (iii) the extensive involvement of PLHA in the prevention and treatment programme in India; and (iv) the formation of a new and open national NGO Consortium to manage sub-grants to community NGOs, and to provide a joint platform for networks of positive people and the private corporate sector to work in coordination with the local NGOs. This will also facilitate a collective voice for all these constituents in respect of all issues surrounding care, prevention, treatment and support.

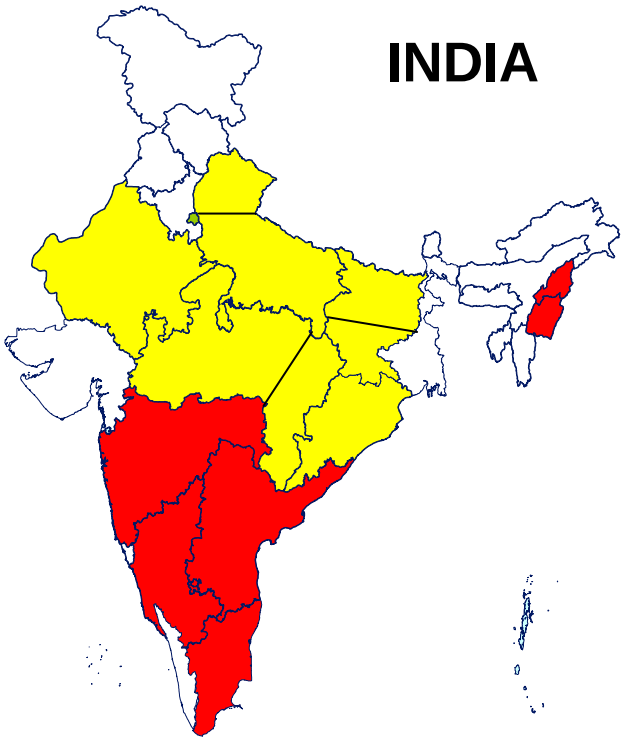
Links to previous grants from the GFATM

This proposal complements a number of activities currently being implemented with earlier grants from the Global Fund. India was granted US$ 26.1 million over two years from the second round of GFATM funding as a result of an application for support to introduce and scale up PPTCT. This programme is presently providing services in 250 institutions, predominantly in medical college hospitals in low prevalence States and both in medical college hospitals and district hospitals in high prevalence States. Provision has been made for nearly 4,500 women (and their partners and children) to receive ART through a Global Fund grant in Round Two. These institutions form the focus of the expanded ART programme for which support is being sought. The PPTCT programme implements a comprehensive care package for HIV-infected mothers, their infants and partners, and enhances access to ART through public-private partnerships. Funds due from Round Two are now being used to provide VCT to 7 million pregnant women and their families every year and offer ARV prophylaxis to pregnant women found infected with HIV. To date, more than 3,000 women and their children have benefited from this service, with more than 95% acceptance rate of PPTCT service following counselling.

In Round Three, India received approval for US$ 14.8 million over five years from an application to address HIV/TB co-infection. This will facilitate a series of activities to reduce TB related morbidity in PLHAs while preventing further spread of HIV and TB in the rural population of six high HIV burden States. Joint HIV/TB coordination committees and HIV/TB units are being established at the national and State levels for close coordination, implementation, monitoring, referrals and linkages at the sub-district level. Linkages between the existing Revised National Tuberculosis Control Programme (RNTCP) infrastructure and the newly established sub-district level VCT are being forged to increase the reach of the National AIDS Control Programme (NACP). Funds granted by the GFATM in support of the above have not yet been

received by India.

AIDS SUMMARY



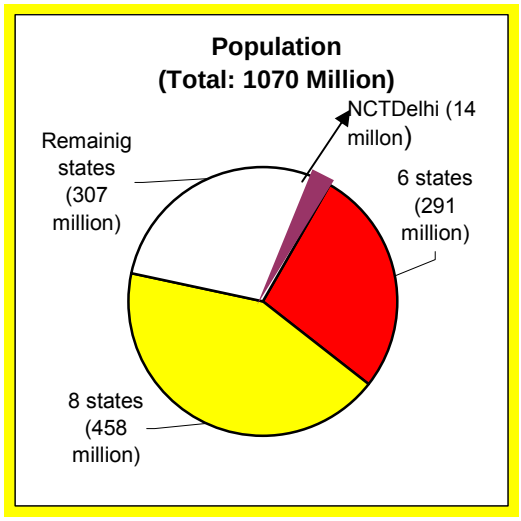


Fig. 1. States/Population of India, States/population planned for increased access to ART (7 States) and population with enhanced access to prevention (8 States)

TB SUMMARY

Background

Over the past five years, the RNTCP has expanded rapidly from covering 18 million people in 1998 to more than 800 million population by March 2004. Despite this rapid expansion, quality of services has been maintained and the national results (with treatment success rate > 87% & case detection rate of >69%) have reached internationally set targets. It is planned to cover the entire country under the RNTCP by the year 2005 and to achieve the global targets for TB control. TB control is a long-term battle and will require long term political support. To have an impact on the TB burden in a population, the targets of case detection and treatment success must first be reached and then maintained for several years. It has been documented in several countries, that initial success in the control of TB may lead to complacency and a subsequent resurgence of cases and the emergence and spread of drug resistance. The success of the RNTCP in India has been acknowledged worldwide. However it will take 10-15 years before the success makes a significant epidemiological impact on the problem of TB. Considering the existing caseload, and some continuous addition to this pool of patients, TB control services would be required for at least another 40-50 years in India. Though efforts have been made for decentralization of the programme, it may not be possible for the States to fund the logistics and technical support required for implementing the programme at this stage. It is essential that Central assistance to the States for implementation of RNTCP should continue for at least another 5-10 years.

Concurrently, consistent effort is necessary to fill the gaps in the strategies, and to improve the existing TB control services. This proposal is intended to address two gaps in the programme with assistance from GFATM:

1. To **sustain and strengthen services** in the 119 million population under RNTCP in 2 States namely, **Andhra Pradesh** and **Orissa** from **2004 to 2009**. Funding in these states will end in Oct/ Dec 2004.
2. **Improve accessibility of the programme** and case finding in the states of **Andhra Pradesh and Orissa by inter-sectoral collaboration** with other sectors outside of public health facilities such as private sector, NGO sector, etc. More involvement of other sectors in RNTCP in all activities like DOT, recording& reporting and monitoring and evaluation is envisaged.

Expected results

- Sustain the achieved global targets of TB control of at least 85% treatment success rate and at least 70% case detection rate of new smear positive pulmonary TB cases and thereafter maintain these targets for 4 to 5 years so that the programme is able to cause a reduction in the Annual Risk of TB Infection and a decrease in the mortality due to TB.
- Increase reach of RNTCP by making DOTS more accessible and acceptable among all sections of society, especially, those sections which approach facilities outside public health sector.

TB SUMMARY

TB SUMMARY

Beneficiaries

- >666,400 patients initiated on treatment, about 85% of them will complete treatment successfully. These patients would be from all sections of society. But as TB is predisposed to occur in people living in crowded conditions and in malnourished individuals, most of these patients are expected to be from economically weaker sections of society.
- >119,950 lives saved.
- >1,332,800 individuals spared from becoming infected with TB.
- Thousands of families prevented from falling into the cycle of debt and poverty caused by a family member having TB.
- The community at large having access to free and uninterrupted high quality diagnostic and curative TB services.
- Return of cured TB patients to productive employment will significantly improve the economy of the 2 States.
- Increase in case detection by involvement of other sectors. Based on previous experience under the programme, it is expected that inter-sectoral involvement will contribute to an increase of 10 to 20% in case detection in the districts over 3 to 4 years.
- Ensure use of DOT and RNTCP regimens by facilities of other sectors and to enhance their level of involvement in RNTCP (providing support through DOT, recording and reporting and monitoring) by ensuring treatment success of patients treated by them.
- State specific ARTI data, TB mortality data and data on Drug resistance levels in the two states will be available after the studies are conducted, thereby contributing to more scientific approach to TB control in these states.
- About 600 patients at DOTS plus pilot sites will have access to free second line drugs for tuberculosis.

Implementing partners

The expansion of the RNTCP envisaged within this proposal will, as in the ongoing programme, be implemented as a Centrally sponsored scheme. The 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) which will plan, monitor and supervise all RNTCP activities at the State level. At the District level, District TB Control Societies will implement the RNTCP. 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. NGOs and private sector will be involved as per the guidelines already developed.

Implementation strategies:

A. Maintenance and strengthening of programme activities in 119 million population in Andhra Pradesh and Orissa:

1. Under the programme Microscopy centres have been established in all districts, one

per every 100,000 population and in tribal and hilly areas per every 50,000 population. A full time laboratory technician, trained under RNTCP, is working in each microscopy centre;

2. At the 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 already exist. The STS and STLS have been appointed on a contractual basis and are responsible for assisting the District TB Officer (DTO) and Medical Officer–TB Unit (MO-TC) in supervision and monitoring of the various programme activities. The services of contractual STS and STLS will be continued under the proposal;
3. Different categories of health workers and community volunteers who will be new turnover staff in the districts will be continue to be given modular training under RNTCP as per the existing guidelines;
4. A 4-wheeler would be made available for all DTOs 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 established and strengthened;
7. 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.
8. Provision for contractual hiring of one TB Health Visitor per every 150,000 urban population for effective outreach to urban slum populations will continue under the proposal;
9. To facilitate the process of decentralisation, capacity building and strengthening of the State (STCS) and District TB Control Society (DTCS) will be undertaken. The State TB cell would continue to be authorised full complement of contractual staff including 2nd Medical officer, IEC officer, Accountant, data entry operator, Secretarial assistant, driver, etc.
10. Due to the existing situation in these States (as per the present policy), up to 20% of laboratory technicians will continue to be permitted for hiring on contractual basis, to be decided by State to enable services to reach under-served areas. However in exceptional circumstances up to 50% hiring can be supported under the programme.
11. Similarly, up to 15% of the second medical officers at the District TB Centre can continue to be hired by the State on contractual basis.
12. 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.
13. 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.
14. Within District and State Action Plans, special relaxed norms will be included to facilitate effective service provision for tribal and under-served populations.

B. Enhancement of quality of programme in 119 million population in Andhra

TB SUMMARY

Pradesh and Orissa- new initiatives under the proposal:

1. Capacity building of the State TB Training & Demonstration Centres (STDC) will be undertaken. The state will post epidemiologist, microbiologist, training co-ordinator, statistician and lab technicians as specified under the 'STDC guidelines' of RNTCP and conduct activities related to training, monitoring and evaluation, operational research, sputum microscopy external quality assurance, drug resistance surveillance and operational research;
2. The following studies would be conducted under the proposal:
   a. State level mortality surveys, one as a baseline study at the beginning of the project and another at the end of the project to assess the reduction in mortality due to TB in the state of Andhra Pradesh and Orissa.
   b. State specific Annual Risk of TB Infection Survey, -Baseline surveys and impact surveys to study reduction in risk of TB infection in the community in both the states.
3. The STDCs would implement sputum microscopy external quality assurance as per the new guidelines of Central TB Division and the same would be reported to CTD.
4. State specific drug resistance surveillance based on 100% sampling at microscopy centres would be conducted in both the states. There would be capacity building of the STDC in both the states to conduct these DRS studies and also develop facilities for culture and sensitivity testing. In the third year of the project there would be one site each of DOTS plus pilots. These would pave the way for implementation of DOTS plus in these states in future.

C. Increase the accessibility of RNTCP by involvement of sectors other than public sector in the states of Andhra Pradesh and Orissa:

1. Under the proposal there would be initiatives to increase the participation in schemes under RNTCP for NGO and PP involvement. Similarly efforts to increase participation of other sectors like Employee State Insurance Scheme, Corporate sector health facilities, Railway health facilities would be strengthened.
2. The districts will undertake line listing of NGO and PP facilities and facilities other than public health sector in the districts. Thereafter advocacy, sensitisation and dialogue would be undertaken for their involvement under the programme. The districts will conduct regular sensitisations meetings and trainings to enhance their involvement. For increasing the reach of RNTCP within the community, the districts will also conduct co-ordination meetings with SHGs, Community based organisations and PRIs.
3. Patient -friendly DOT centres will be established at as many NGO/ PP centres as possible. The approach would be to have flexi-timing at these centres and place them at locations convenient to the patients. The other sectors will be encouraged to provide DOTS to their patients at their DOTS centres.
4. Regular monitoring of patients on DOTS at other than public health centres would be reinforced. Under the proposal there would be stratification of case reporting and outcome reporting from other than public health sector to ensure achievement of the indicators under this objective.

MALARIA SUMMARY

Goal: To reduce malaria morbidity and mortality in 100 million population in 10 states by 30% in 5 years from 461,083 cases to 322,758 cases and deaths by 50% from 464 to 232.

Objective 1: Increase access to diagnosis and treatment in high endemic areas, with particular focus on remote and inaccessible areas through community participation, upgradation of peripheral health facilities and small hospitals in the diagnosis and treatment of severe malaria and use of second line artemisinin based combination drugs in the drug resistant areas.

Service delivery areas:

i. Training or re-training of existing laboratory technicians in the public, private and voluntary sectors to improve access to diagnosis and improve quality. Rapid Diagnostic Test (RDT) will be used in remote inaccessible or sparsely populated areas where access to laboratory services would not be practically feasible. **RDT** are in use in remote inaccessible areas under EMCP. 2,85,000 tests were supplied after training of the village volunteers.

ii. Training of personnel of peripheral health facilities in the public and private sectors for the treatment of severe malaria and supply of anti-malarial drugs.

iii. Use of artemisinine combination therapy in drug resistant area.

iv. Establishment of a community based drug distributor in each village or within 3 km walking distance by training village volunteers and supply of anti malarial drugs. The selection would be in consultation with the village representatives and work will be done on a voluntary basis. Extension or field level personnel of other government departments such as social welfare, tribal affairs, armed forces and local NGOs will also be involved. All the villages would be covered to ensure access to the anti-malarials.

Objective 2. Malaria Transmission Risk Reduction through integrated vector control

Service delivery areas:

i. Promotion of use of mosquito nets through awareness generation and advocacy workshops. Supply of mosquito nets to the most vulnerable sections with focus on the remote inaccessible areas, drug resistant pockets and from where deaths have been reported. The identification and distribution of the nets will be through the representatives of the civil society and local NGOs. About 12.01 million mosquito nets will be supplied to 30% of population and about 30000 persons (at the rate of one per village/1000 population) will be trained in the treatment of nets, including local NGOs and personnel from the private sector. The insecticide for the treatment of bednets will be supplied under the project and the NGOs will be provided funds for mobilization of the community and organization of insecticide treatment camps. The nets will be procured centrally through a professional procurement agency following World Bank guidelines.

ii. Treatment of community owned mosquito nets will be taken up by organizing mosquito net treatment camps in collaboration with the private sector, civil society and local NGOs. The Government will supply the insecticide for bed nets for the treatment of community owned nets for 3 years at the targeted coverage of 20%, 30% and 50% in first 3 years. The treatment would be

organized on cash recovery basis and the cost recovered would be used by the agencies involved including NGOs/CBOs etc. for sustaining this activity from 4th year onwards. The NGOs will be provided funds for mobilization of the community and organization of insecticide treatment camps.

iii. Suitable water bodies will be seeded with larvivorous fish, which is an environmental friendly and cost effective vector control measure. The community, NGOs, school children will be actively involved. The effort would be supported through domestic resources.

iv. Indoor residual spray would be carried out selectively as per the national norms (high API, high SPR, reported deaths and drug resistance). About 33 million population (33%) is proposed to be covered annually. However, this component will be funded through the domestic budget.

Objective 3. Enhance awareness about malaria control and promote community, NGO and private sector participation

Service delivery areas:

i. Develop and implement strategy for enhancing awareness about various strategies of malaria control with particular emphasis on treatment of mosquito nets through public private partnership.

ii. Encourage local NGOs, CBOs, WSHGs, local self government etc. to participate in malaria control through training, sharing of technical guidelines and by providing funds. These agencies will be encouraged to participate in providing access to treatment, mosquito net distribution and in the insecticide treatment of community owned mosquito nets.

iii. Organized private sector, such as tea garden associations, large industries etc will be encouraged to have work-place policy guidelines for malaria control including insecticide treatment of community owned mosquito nets among their employees and to ensure access to appropriate treatment.

Prompt treatment with appropriate drugs will interrupt transmission. The risk of disease transmission will be further reduced through reductions in vector densities by applying locally suited vector control measures. Awareness generation and advocacy will promote intersectoral collaboration and better utilization of the available resources and tools.

The proposal is to scale up and improve the quality of services using the strategies that have been effective in the tribal areas under the World Bank assisted EMCP where the morbidity has dropped by 30% in 5 years. The lessons learnt, capacities built and experience gained under EMCP will be utilized. The capacities for planning, effective implementation and monitoring and supervision are now in place at the national level and in Jharkhand and Orissa. Procurement of all items is carried out through a professional procurement agency following World Bank guidelines. Funding is through the state malaria control societies and the accounts are audited annually. The quality of the services under EMCP has improved significantly due to carrying out more than 3500 training programmes and training nearly 84,000 personnel of various categories. Under EMCP, more than 2.4 million mosquito nets have been distributed and supply of another 1.8 million is proposed in 2004-05 selectively in remote highly vulnerable areas. Projects have been taken up for the

treatment of community owned mosquito nets with NGO and private sector collaboration. Special attention was given to the selection of areas and improving the quality of indoor residual spray by training spray men and field supervision. As a result of the decline in incidence and careful selection of areas, the use of insecticides for spray was reduced by 17%. Training/ re-training 1100 laboratory technicians and supply of rapid diagnostic tests to remote inaccessible areas significantly improved access to diagnosis and treatment. A drug distribution centre was established in each village by training volunteers and ensuring adequate supply of drugs. Blister packs of chloroquine and primaquine in chloroquine sensitive areas were introduced to improve compliance of radical treatment (4 tablets over a three day period instead of 16 tablets used earlier). Therapeutic efficacy studies using standard WHO protocols were used. Capacity for other specialized areas such as communication strategies and operational social sciences research have been contracted out to private sector institutions using World Bank guidelines for their selection.

The best practices included close interaction with the state and district health officials and development of microplans with process and performance indicators, involvement of the civil society, building up linkages with NGOs and the private sector through the Confederation of Indian Industries (CII) and the Associated Chambers of Commerce and Industry of India (ASSOCHAM), involvement of medical professional bodies, identification of nodal officers of each state at the national headquarters and frequent field visits for efficient monitoring and coordination; training/retraining of all concerned personnel, involvement of other government departments and use of integrated vector control measures suitable to local needs. Therapeutic efficacy studies using standard WHO protocols were carried out annually. Funding was routed through the state malaria control societies and the district malaria control societies. Audit was ensured regularly on an annual basis through the office of the Comptroller and Auditor General of India and Charted Accountants. Other national level institutions such as the National Institute of Communicable Diseases and the institutions under the Indian Council of Medical Research were actively involved for operational studies and for field monitoring and evaluation of new initiatives.

A software has been developed in collaboration with the Tata Consultancy Services, a private sector organization, for effective computerized management information system (MIS). The computerized MIS is being operationalized in the districts under EMCP and will be extended to all the districts in the country by March 2005. Inputs for MIS includes training, supply of computers and other hardware as well as contingency expenditure.

Further innovations include the introduction of Artemisinine and SP Combination Therapy (ACT) in the drug resistant pockets.

Non-Government Organizations (NGOs), Community Based Organizations (CBOs), Women Self Help Groups (WSHGs), local self government etc. will be involved as partners in the implementation of the strategies. Brief note on TRP comments is at Annexure-VI..

2. *If there are several components, describe any synergies expected from the combination of different components (By synergies, we mean the added value the different components bring to each other, or how the combination of these components may have broader impact).*

There are two major synergies that are envisioned this proposal. First, there will be improved access to and use of existing public health infrastructure through enhanced community mobilization. Grassroot NGOs, who will take the lead in mobilizing communities in all three components frequently address broad health and development issues, including malaria, HIV and TB.

Second, the proposals build capacity for diagnosis, care and treatment of HIV and TB and strengthen linkages between programs In India, many PLHA are first detected when they become ill, frequently with active tuberculosis, an entry point for ART. In addition, tuberculosis is the most common opportunistic infection among people living with HIV. Therefore, by strengthening the linkages and enhancing referral between the two programs there will be increased detection of TB among PLHA and improved survival of PLHA who have TB by increased opportunities for ART. This will be especially visible in Andhra Pradesh where HIV prevalence is >1% among pregnant women.

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

The proposal is to scale up existing efforts and initiate new activities. These include: scaling up antiretroviral programme in the public sector (Karnataka, Tamil Nadu, Andhra Pradesh, Maharashtra, Manipur, and Nagaland and Delhi), enhancing HIV prevention services in eight low prevalence States, preparing the groundwork for offering treatment to multi-drug resistant TB (MDR-TB) cases under DOTS Plus pilot projects, scaling up joint TB-HIV activities up in Andhra Pradesh and Orissa. The Malaria component proposes to scale up and improve the quality of services using the strategies that have been effective in the tribal areas under the World Bank assisted EMCP where the morbidity has dropped by 30% in 5 years.

Guidelines from WHO for establishing ART and DOTS plus services have provided the technical back-up for the design of this proposal. Further, important lessons about procurement, inventory control, quality assurance and capacity building will be applied from national programmes such RNTCP, PPTCT, Polio to the components of this proposal.

3 Type of Application:

Table 3 – Type of Application

Type of Application:

- ☒ Country Coordinating Mechanism (to National CCM section, 3.1)
- ☐ Sub-Country Coordinating Mechanism (to Sub-National CCM section, 3.2)
- ☐ Regional Coordinating Mechanism (including Small Island States) (to Regional CM section, 3.3)
- ☐ Regional (to Regional Organizations section, 3.4)
- ☐ Non-Country Coordinating Mechanism (to Non-CCM section, 3.5)

3.1 National CCM Section

Table 3.1 – National CCM Basic Information

Name of National CCM	Date of Composition
Country Coordinating Mechanism for the Global Fund, India	12/28/2001

3.1.1 Has the National CCM applied previously to the Global Fund? ☒ Yes ☐ No

[If yes, go to 3.1.2. If no, go to 3.1.3.]

3.1.2 Has the National CCM composition changed since the last submission? ☐ Yes ☒ No

[If yes, describe the changes (1-2 paragraphs).]

3.1.3 Did the National CCM build upon an existing body or is it a new mechanism? ☒ Existing ☐ New

[If existing CCM, briefly describe the work previously done, programs implemented and results achieved (1 paragraph).]

[If new CCM, briefly describe how the CCM coordinates its activities with existing structures (e.g., National AIDS Councils) (2 paragraphs).]

The CCM was created in 2001 by an executive order and is headed by the Secretary (Health) of the Government of India. From its inception, the CCM draws upon various committees already set up to coordinate the responses to HIV/AIDS, tuberculosis (TB) and malaria. It includes representation from the Government, non-governmental organizations (NGOs), private sector, United Nations and international development agencies. The CCM draws upon the membership of different committees that have been set up to coordinate and monitor the national response to HIV/AIDS, TB and malaria. In addition to the Government of India (GOI) representatives, the CCM includes representation from the Indian Council for Medical Research. Each of the four NGO representatives on the CCM brings diverse public health experience: The Indian Network of Positive People which coordinates networks of PLHA; the Voluntary Health Society, Chennai, managing the USAID funded AIDS Prevention

and Control Project (APAC) project; the Sewadham Trust that runs hospitals and operates mobile clinics in rural areas; and the Vivekananda Education Society working on the prevention and treatment of drug abuse, sexually transmitted disease (STD) and HIV/AIDS. The private sector is represented on the CCM by the three major industry associations of the country. United Nations and bilateral agencies have been chosen on the basis of their involvement in the three disease control programmes in India.

The CCM is tasked with the dissemination of information received from the GFATM on opportunities for grant applications. It defines priority areas for which GFATM support would be desirable. It oversees the processing of individual applications and their consolidation in a comprehensive proposal. It updates stakeholders on the outcome of individual and comprehensive applications. The terms of reference of the CCM also include assignment of responsibilities for programme implementation under GFATM funding, the monitoring and evaluation thereof, and accountability for the above towards the Board of the GFATM. The CCM has successfully overseen the preparation of GFATM applications for Rounds Two and Three. It meets as often as required, and has held ten meetings since its creation.

3.1.4 Describe how the National CCM operates.

[e.g., decision-making mechanisms, constituency consultation processes, structure of sub-committees, frequency of meetings, implementation oversight, etc. (2 paragraphs).
Provide statutes of the organization, organizational diagram, and terms of reference as attachments.]

The Secretariat of the CCM is located within the Ministry of Health and Family Welfare. No formal rules have been prescribed, and the CCM is free to devise and finalize its operating procedures and formalities. A copy of the order constituting the CCM and laying down its Terms of Reference is attached. The Committee has established several sub-committees, one of which, chaired by the Joint Secretary, Ministry of Health, has been tasked to screen grant applications received from NGOs, State AIDS Control Society (SACS) and the private sector prior to their consolidation and inclusion in the overall proposal. The members of this subcommittee/Core Group of Experts included WHO, UNICEF, USAID, the Voluntary Health Association of India (also members of the CCM), and a representative of the US Centers for Disease Control.

Since the last round of funding, in 2003, this subcommittee/Core Group of Experts has met on five occasions to consider individual applications, and has made suitable recommendations to the CCM. Other sub-groups of the CCM have also met on the following issues: proposal development, programme implementation, and monitoring and evaluation. Outside experts assist the CCM and its sub-committees in their work. To address the concerns of NGOs and CBOs, a series of consultations have been held since the submission of India's application for the last round of funding assistance.

3.1.5 Do you have plans to enhance the role and function of the National CCM?

☐ Yes
☒ No

[If yes please describe plans and ongoing activities, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required (1 paragraph).]

3.1.6 National CCM Membership Section

Table 3.1. 6A – National CCM Leadership Information

	National CCM leadership details	
	Chairperson	**Vice Chairperson**
Name	Shri J.V.R Prasada Rao	Mrs. Meenakshi Datta Ghosh
Title	Secretary (Health)	Additional Secretary & Project Director
Mailing address	Ministry of Health and Family Welfare , A- Wing Nirman Bhawan, New Delhi	National AIDS Control Organization, 36, Jan Path, Chandra Lok Building, New Delhi 110001
Telephone	91-11-3018863	91-11-23325331
Fax	91-11-3014252	91-11-23731746
Email address	secyhlth@nb.nic.in	mdg@nacoindia.org

[One of the tables below must be completed for each National CCM member.]

Table 3.1.6B – National CCM Member Information

National CCM member details	
Member 1	
Agency/Organization	Ministry of Health & Family Welfare
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government
Name of representative	Shri J.V.R Prasada Rao
Title	Secretary (Health)
Email Address	Secyhlth@nb.nic.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Heads the CCM and coordinates the work of managers of the various diseases control programmes

Member 2	
Agency/Organization	National AIDS Control Organisation
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government
Name of representative	Mrs. Meenakshi Datta Ghosh
Title	Additional Secretary & Project Director
Email Address	mdg@nacoindia.org
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Programme Manager of the National AIDS Control Programme
Member 3…	
Agency/Organization	Director General of Health Services
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government
Name of representative	Dr.S.P.Aggarwal
Title	Director General
Email Address	dghs@mohfw.delhi.nic.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Heads the technical wing of the CCM, and responsible for integrating inputs of technical managers of the HIV. Malaria and TB Programmes
Member 4…	
Agency/Organization	Ministry of Health & Family Welfare
Name of representative	Smt. Rita Teaotia
Title	Joint Secretary
Email Address	jsrt@nb.nic.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Programme Manager of the Malaria and Tuberculosis Control Programmes

Member 5	
Agency/Organization	Ministry of Health & Family Welfare
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government.
Name of representative	Shri. Arun Sharma
Title	Joint Secretary and Financial Advisor
Email Address	jsfa@nb.nic.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Manager of the finances of the CCM
Member 6	
Agency/Organization	Ministry of Finance, Department of Economic Affairs
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government.
Name of representative	Shri Ajay Seth
Title	Director
Email Address	ajayseth@finance.nic.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Representative of the Ministry of Finance on the CCM

Member 7	
Agency/Organization	Indian Council Medical Research & Ministry of Health & Family Welfare
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government
Name of representative	Dr.N.K.Ganguly
Title	Director General
Email Address	gangulynk@icmr.delhi.nic.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Review proposals, and provide recommendations for improvement; identify links to ongoing research
Member 8	
Agency/Organization	Director General of Health Services
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government
Name of representative	Dr. L.S.Chauhan
Title	Deputy Director General (TB)
Email Address	ddgtb@nb.nic.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical Manager of the Tuberculosis Control Programme

Member 9	
Agency/Organization	Directorate of National Anti Malaria Programme
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Government
Name of representative	Dr. Jotna Sokhey
Title	Director
Email Address	namp@ndc.vsnl.net.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Technical Manager of the National Anti-Malaria Programme
Member 10	
Agency/Organization	UNAIDS
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Bilateral development partners
Name of representative	Dr. Kenneth Wind Andersen
Title	Country Coordinator
Email Address	windandersenk@unaids.org
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Provide technical support for proposal development, review and monitoring

Member 11	
Agency/Organization	DFID (Bilateral)
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Bilateral development partners
Name of representative	Ms. Charlotte Seymour
Title	Senior Advisor (Health)
Email Address	C-Seymour-Smith@dfid.gov.uk
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Provide technical inputs and represent DFID on CCM, to help identify gaps and areas of synergy
Member 12	
Agency/Organization	USAID (Bilateral)
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Bilateral development partners
Name of representative	Dr. Walter E. North Mission
Title	Director
Email Address	wnorth@usaid.gov
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Provide technical inputs and represent USAID on CCM, to help identify gaps and areas of synergy

Member 13	
Agency/Organization	World Bank
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Bilateral development partners
Name of representative	Dr. K. Sudhakar
Title	Senior Public Health Specialist
Email Address	ksudhakar@worldbank.org
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Provide technical inputs, monitoring and represent World bank on the CCM, to help identify gaps and areas of synergy
Member 14	
Agency/Organization	WHO
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Bilateral development partners
Name of representative	Dr. Salim J. Habayeb
Title	WHO Representative (India)
Email Address	wrindia@whoindia.org
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Provide technical input to proposal development and monitoring and to help identify gaps and areas of synergy for projects

Member 15	
Agency/Organization	UNICEF
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Bilateral development partners
Name of representative	Ms.Erma Manancourt
Title	Officer- in- charge
Email Address	emanoncourt@unicef.org
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Provide technical input to proposal development and monitoring, in particular women and children and to integrate CCM activities with UNICEF supported projects in India
Member 16	
Agency/Organization	UNFPA
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Bilateral development partners
Name of representative	Mr. Francois M. Farah
Title	Representative
Email Address	India@unfpa.org.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Provide technical input to proposal development and monitoring and to integrate CCM activities with UNFPA supported projects in India

Member 17	
Agency/Organization	APAC
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	NGO
Name of representative	Dr. Bimal Charles
Title	Director
Email Address	apac@vsnl.net
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Helps evaluate the functioning of the CCM based on experience in epidemiologic surveillance, clinical care and support of people living with HIV/AIDS and PMTCT, represents southern part of country.
Member 18	
Agency/Organization	Sevadham Trust
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	NGO
Name of representative	Dr. S.V.Gore
Title	Managing Trustee
Email Address	
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Brings NGO perspective of NGOs working with vulnerable including tribal populations, Representative of central India

Member 19	
Agency/Organization	SAHARA – Centre for Residential Care and Rehabilitation
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	NGO
Name of representative	Mr. Neville Selhore
Title	Director
Email Address	sahara@nde.vsnl.net.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Represents activist umbrella organization of NGOs working at the grass-roots in different parts of India. SHARA will help monitor the sustainability, cost effectiveness of the projects and good governance of the CCM.
Member 20	
Agency/Organization	Vivekananda Education Society
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	NGO
Name of representative	Shri. C.G.Chandra
Title	Secretary
Email Address	Chandra@cal.vsnl.net.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Brings NGO perspective of NGOs working with women and children, IDUs, Represents eastern part of country

Member 21	
Agency/Organization	Indian Network for People Living with HIV/AIDS
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	PLHA
Name of representative	Shri. K.K. Abraham
Title	President
Email Address	inpplus@vsnl.com
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Represents the concerns and interests of people living with HIV/AIDS in India
Member 22	
Agency/Organization	Federation of Indian Chambers of Commerce and Industry
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Private Sector
Name of representative	Shri. Y.K.Modi
Title	President
Email Address	ficcisg@bol.net.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	Represents the private sector on the CCM

Member 23	
Agency/Organization	Confederation of Indian Industries (CII)
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Private Sector
Name of representative	Shri Anand Mahendra
Title	President
Email Address	Dilip.chenoy@ciionline.org
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	To foster collaboration between the CCM and private sector industries
Member 24	
Agency/Organization	The Associated Chambers of Commerce and Industry of India (ASSOCHAM)
Type (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Private Sector
Name of representative	Shri Mahendra Sanghvi
Title	President
Email Address	assocham@sansad.nic.in
Main role in National CCM and Proposal Development (Proposal Preparation, Technical Input, Component Coordinator, Financial Input, Review, other)	To foster collaboration between the CCM and private sector industries

3.1.7 National CCM Endorsement of Proposal

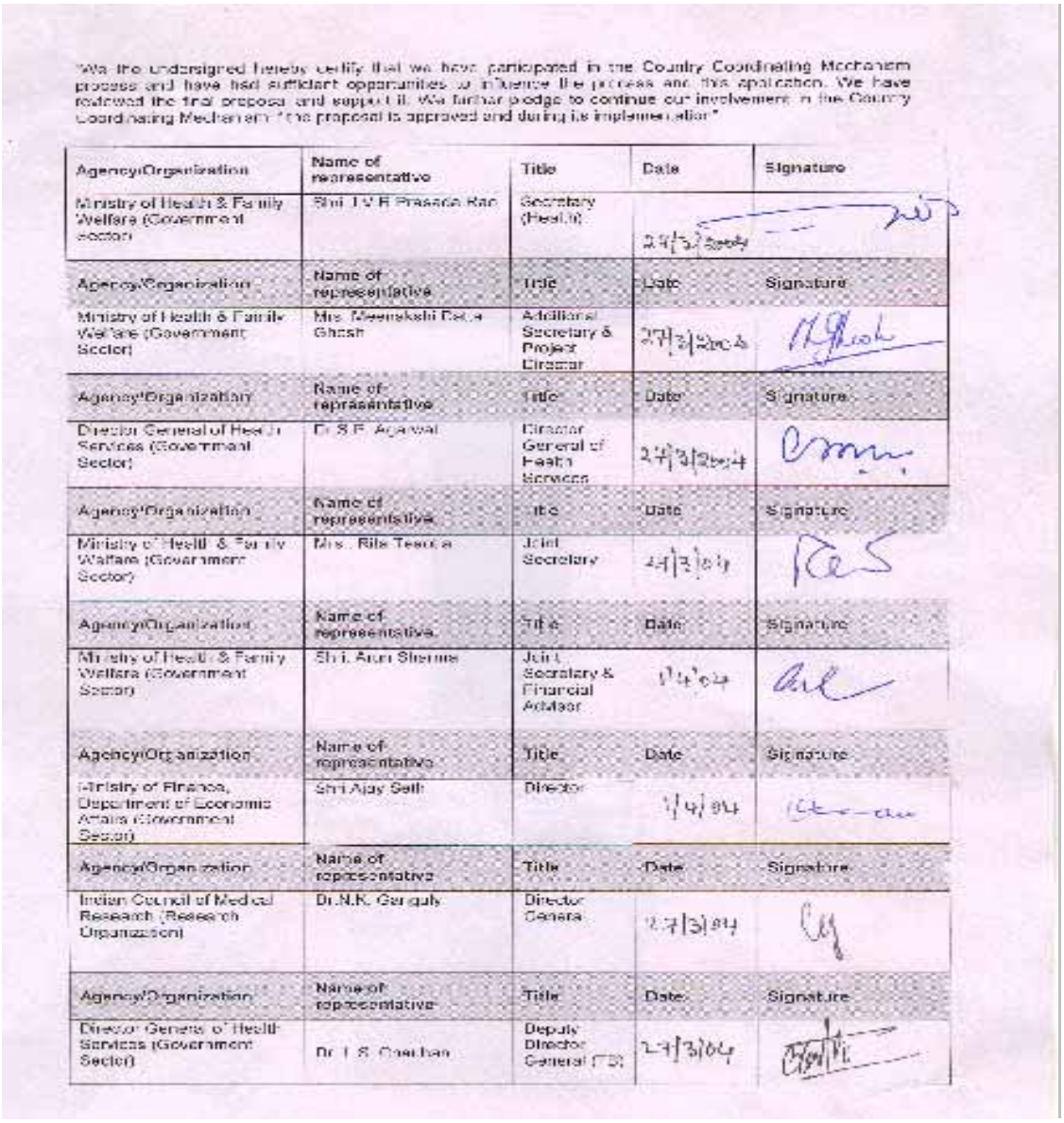
[Please note: When the proposal is complete, please print out the entire proposal form. A signature page will print, and CCM members must sign this page. The entire proposal, including the signature page, must be sent to the Global Fund Secretariat, arriving before the deadline for submitting proposals.
If insufficient consultation has occurred in the course of preparing a proposal, CCM members who have not been involved should not sign the proposal.
The minutes of the CCM meeting at which the proposal was endorsed must be attached as an Annex to this proposal. Please print additional pages if necessary, and including the following statement on each page:

PROPOSAL TITLE:

"We the undersigned hereby certify that we have participated in the Country Coordinating Mechanism process and have had sufficient opportunities to influence the process and this

application. We have reviewed the final proposal and support it. We further pledge to continue our involvement in the Country Coordinating Mechanism if the proposal is approved and during its implementation"

Table 3.1.8 – National CCM Endorsement

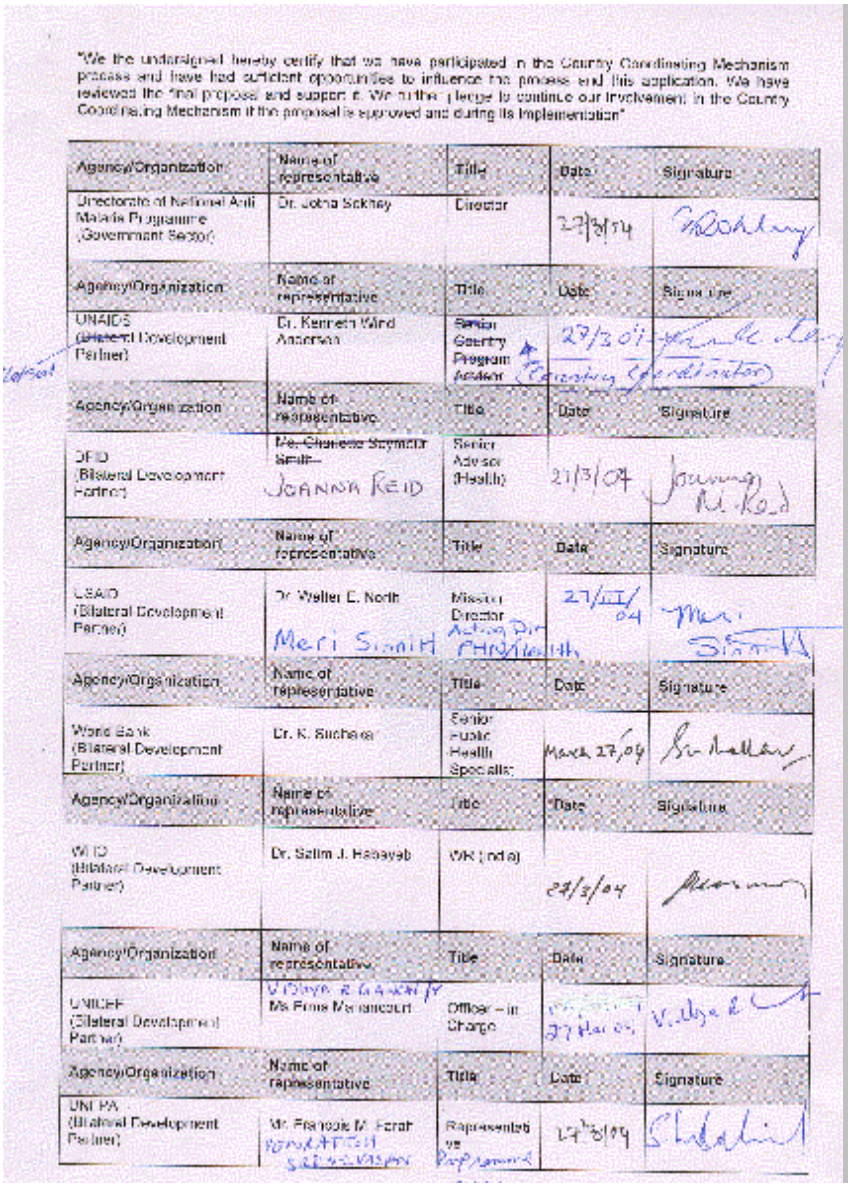


We the undersigned hereby certify that we have participated in the Country Coordinating Mechanism process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and support it. We further pledge to continue our involvement in the Country Coordinating Mechanism if the proposal is approved and during its implementation"

Agency/Organization	Name of representative	Title	Date	Signature
Ministry of Health & Family Welfare (Government Sector)	Shri T V R Prasada Rao	Secretary (Health)	24/3/2004	
Agency/Organization	Name of representative	Title	Date	Signature
Ministry of Health & Family Welfare (Government Sector)	Mrs. Meenakshi Datta Ghosh	Additional Secretary & Project Director	24/3/2004	
Agency/Organization	Name of representative	Title	Date	Signature
Director General of Health Services (Government Sector)	Dr. S.P. Agarwal	Director General of Health Services	24/3/2004	
Agency/Organization	Name of representative	Title	Date	Signature
Ministry of Health & Family Welfare (Government Sector)	Mrs. Rita Teaotia	Joint Secretary	24/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
Ministry of Health & Family Welfare (Government Sector)	Shri. Arun Sharma	Joint Secretary & Financial Advisor	24/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
Ministry of Finance, Department of Economic Affairs (Government Sector)	Shri Ajay Seth	Director	24/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
Indian Council of Medical Research (Research Organization)	Dr.N.K. Ganguly	Director General	27/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
Director General of Health Services (Government Sector)	Dr. L.S. Chauhan	Deputy Director General (TB)	27/3/04	

"We the Undersigned hereby certify that we have participated in the Country Coordinating Mechanism process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and support it. We further pledge to continue our involvement in the Country Coordinating Mechanism if the proposal is approved and during its implementation"

Agency/Organization	Name of representative	Title	Date	Signature
Voluntary Health Society, Chennai (NGO)	Dr. Simal Charles	Director	27th March 2004	
Agency/Organization	Name of representative	Title	Date	Signature
Sevadham Trust, Pune (NGO)	Dr. S.V.Gore	Managing Trustee	27th March 2004	
Agency/Organization	Name of representative	Title	Date	Signature
SAHARA – Center for Residential Care Nee Rehabilitation (NGO)	Mr. Navin Sahore	Director	27/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
Vivekananda Education Society, Kolkata (NGO)	Shri. C.G.Chandra	Secretary		
Agency/Organization	Name of representative	Title	Date	Signature
Indian Network for People Living HIV/AIDS (PLWHA)	Shri. K.K. Abraham	President	24/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
FICCI (Private Sector)	Shri. Y.K.Modi	President	27/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
Confederation of Indian Industry (Private Sector)	Shri Anand Mahendra	President	24/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
ASSOCHAM (Private Sector)	Shri Mahendra Sanghvi	President	29/3/04	



"We the undersigned hereby certify that we have participated in the Country Coordinating Mechanism process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and support it. We further pledge to continue our involvement in the Country Coordinating Mechanism if the proposal is approved and during its implementation"

Agency/Organization	Name of representative	Title	Date	Signature
Directorate of National Anti Malaria Programme (Government Sector)	Dr. John Sokney	Director	27/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
UNAIDS (Bilateral Development Partner)	Dr. Kenneth Ward Anderson	Senior Country Program Advisor (Planning Coordinator)	27/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
DFID (Bilateral Development Partner)	Ms. Charlotte Seymour Smith JOANNA REID	Senior Advisor (Health)	27/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
USAID (Bilateral Development Partner)	Dr. Walter E. North Meri Smith	Mission Director Acting Dir (HNP/Health)	27/III/04	
Agency/Organization	Name of representative	Title	Date	Signature
World Bank (Bilateral Development Partner)	Dr. K. Sucheras	Senior Public Health Specialist	March 27, 04	
Agency/Organization	Name of representative	Title	Date	Signature
WHO (Bilateral Development Partner)	Dr. Salim J. Habayeb	WR (India)	29/3/04	
Agency/Organization	Name of representative	Title	Date	Signature
UNICEF (Bilateral Development Partner)	V Divya R Gandhi Ms Rima Mansour	Officer – in Charge	27 Mar 04	
Agency/Organization	Name of representative	Title	Date	Signature
UNFPA (Bilateral Development Partner)	Mr. Francois M. Farah	Representative	29/3/04	

4 Components Section

[PLEASE NOTE THAT THIS SECTION AND THE NEXT SECTION NEED TO BE COMPLETED BY COMPONENT, so, for example, if the proposal targets three components sections 4 and 5 must be completed three times. The system will automatically generate separate sections for each component.]

4.1 Identify the component addressed in this section

☐ HIV/AIDS
☒ Tuberculosis
☐ Malaria
☐ HIV/TB
☐ Integrated

4.1.1 Indicate the estimated start time and duration of the component

[Please take note of the timing of proposal approval by Board of the Global Fund (listed on the cover of the Proposal Form), as well as the fact that funds typically will not be released for a minimum of 2 months after Board approval]

Table 4.1.1 – Proposal start time and duration

	From	To
Month and Year:	October 2004	September 2009

4.2 Contact persons for questions regarding this component

[Please provide full contact details for two persons – this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes.]

Table 4.2 – Component Contact Persons

	Primary contact	Secondary contact
Name	Dr L S Chauhan	
Title	Deputy Director General (TB)	
Organization	Ministry of Health & Family Welfare, Directorate General of Health Services, Government of India	
Mailing address	533, C Wing Central TB Division, Directorate General of Health Services, Nirman Bhawan, New Delhi – 110 011	
Telephone	+91 11 2301 8126	
Fax	+91 11 2301 8126	
Email address	ddgtb@tbcindia.org	

4.3 National context for this Component

4.3.1 Disease burden

[Please provide 1-2 paragraphs on each of the following]:

4.3.1.1 Latest data on prevalence, incidence and other disease measurements, including data sources used

India accounts for nearly 1/3 of the global burden of tuberculosis (TB).[1] Every year there are about 1.8 million new TB cases in the country, of

which nearly 800,000 are infectious smear positive pulmonary cases.[2] The burden of TB in India is indeed staggering by any measure.

Every day more than 20,000 people get infected with the tuberculosis bacillus, more than 5,000 people develop TB disease, and more than 1,000 people die of TB. In 2003, over 900,000 TB cases were reported by the Revised National Tuberculosis Control Programme (RNTCP).[3] The direct and indirect cost of TB to India amounts to an estimated $3 billion annually.[4] Studies suggest that on an average 3 to 4 months of work time is lost as result of TB, resulting in an average lost potential earning of 20-30% of the annual household income. This leads to increased debt burden, particularly for the poor and marginalized sections of the population.

The TB problem is further compounded by an estimated 4.58 million people in India infected with the human immunodeficiency virus (HIV), TB being the commonest opportunistic infection among HIV-infected individuals.[5] It is estimated that that up to 50% of the adult population of India is already infected with TB. A 3-year national annual risk of TB infection (ARTI) survey has recently been completed, and has found that the national ARTI is 1.5% i.e. 75 new smear positive pulmonary TB cases are expected annually per 100,000 population.[6] Regardless of the extent of the HIV epidemic, unless continued urgent and effective action is taken, over 4 million will die of TB in India over the next 10 years. The rate at which the RNTCP expands over the next few years and is able to maintain the existing quality TB services provided over the next few years, will markedly change the number of new TB cases at any level of HIV prevalence.[7]

4.3.1.2 Stage and type of epidemic, and most affected population groups

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

Increasing urbanization is a feature of India in the 21st century. The conditions found in the peri-urban slums found in many cities, are creating the ideal environment for the transmission of TB infection. From the recently completed national ARTI survey, infection rates and ARTI were found to be 50-100% higher in the urban areas compared with the rural areas. This will result in future years in comparatively higher disease rates in the urban areas.

[1] World Health Organization (WHO). Report on the Tuberculosis epidemic, 1998. WHO/TB/98.237. Geneva: WHO, 1998.
[2] WHO. WHO Report 2004. Global Tuberculosis Control. Surveillance, Planning, Financing. WHO/HTM/ TB/2004.331.
[3] Central TB Division (CTD), Directorate General of Health (DGHS), Ministry of Health & Family Welfare, Government of India (GoI). TB India 2004. RNTCP annual status report. New Delhi: CTD, 2004.
[4] TB Research Centre, Chennai. Socio-economic impact of TB on patients and family in India. *Int J Tub Lung Dis* 1999; **3**: 869-877
[5] NACO 2003 report
[6] DGHS, GoI. Annual risk of tuberculous infection in different zones of India. A national sample survey, 2000-2003. Bangalore: National TB Institute, 2004.
[7] Regional Office for South-East Asia, WHO. Joint Tuberculosis Programme Review, India, February 2000. SEA-TB 24. New Delhi: SEARO WHO, 2000, p12.

4.3.2 Describe the political commitment in responding to the disease, including by reference to internationally agreed-to targets (e.g., the commitment by African Heads

of State to increase health sector spending to 15% of public expenditure) (1–2 paragraphs)

TB control is a priority activity of Government of India. In the year 2000, there was a Ministerial Summit of the high burden countries, sponsored by the World Bank and WHO in Amsterdam. From India this Summit was attended by Union Health Minister and Member Planning Commission. It was resolved that every country would try to cover the entire country with this strategy by 2005 in order to reach global targets for TB control. Therefore the direction towards greater coverage under RNTCP is clear as a major policy objective of GOI, with a commitment to cover the entire country under the DOTS strategy by 2005. Further, the budgetary allocation for the TB Control programme in India has increased from INR 52 crores in 1996-97 to INR 125 crores in 2004-05.

4.3.3 List the national disease control strategies consulted in the preparation of the proposal, and describe how lessons learned from the implementation of these strategies have been incorporated in this proposal (2–3 paragraphs)

In India, the RNTCP is an adaptation of the internationally recommended Directly Observed Treatment, Short Course (DOTS) strategy to control TB, with the objective of curing at least 85% of new sputum positive TB patients and detecting at least 70% of such patients. The RNTCP has progressed in a phased manner as below:

Phase I: Five pilot sites launched in 1993 to test and demonstrate the technical feasibility of RNTCP in India.

Phase II: This phase which began in 1995, was designed to test the technical and managerial feasibility of implementing the revised strategy on a larger scale, including the institutional capacity of the central, state and district authorities to carry out the RNTCP with the necessary rigor to ensure efficient and effective programme implementation.

Phase III: Based on the findings of Phases I and II, the non-implementing areas began to be strengthened and preparation for coverage under the DOTS strategy.

Phase IV: Coverage of the entire country under RNTCP with assistance from various funding/donor agencies, still as a centrally funded programme whilst promoting State-based strengthening of RNTCP, leading to ownership of the programme by the States.

To date the programme has covered 466 districts covering a population of 829 million. After complete coverage of the country under RNTCP in 2005, the country will move into the next phase which entails sustaining the RNTCP in the entire country, whilst still maintaining the quality of the programme. Initial experience with other sectors indicates that case detection could be scaled up with further improving inter-sectoral collaboration. Inter-sectoral collaboration is important to widen access of RNTCP. The current proposal will contribute to this aim by providing assistance for sustaining the RNTCP in the States of Andhra Pradesh and Orissa.

4.3.4 List any broader development initiatives (e.g., Poverty Reduction Strategy Papers, Highly-Indebted Poor Countries initiative) ongoing in << pull country name >>, and describe the links between this proposal and these initiatives (2–3 paragraphs)

This proposal would ensure continued implementation of RNTCP in the states of Andhra and Orissa. RNTCP will be implemented as a Centrally sponsored scheme. This is an ongoing programme in these states, however financial assistance is only available upto October 2005. Further financial commitment is required to

sustain the programme in these two states. The programme is expected to contribute towards the broader development goals of the country.

4.3.5 Describe how the proposal will contribute to broader efforts to reach the Millennium Development Goals (www.un.org/millenniumgoals) (1–2 paragraphs)

It would help in alleviation of poverty and hunger. It is expected that on an average a TB patient loses 20 to 30 % of his annual household income. Control of TB is significantly contributing to reduction of poverty at both the individual and national level. More than 600,000 patients, who will be successfully treated during the project period, would return back to work. Improved productivity of workers by reducing absenteeism, preventing incapacity from ill health, and by averting TB deaths among these workers, add to the productivity capacities of the economy. India contributes 30% to the global case load of TB. By implementing the programme, significant numbers of patients will be treated and cured, thereby contributing to the reduction in mortality and morbidity due to TB.

The proposal will assist India in achieving the goals set out at the twenty-sixth G8 Summit in Okinawa, Japan, June 2000, to reduce TB deaths and TB prevalence by 50% by 2010 compared with levels in the year 2000. And also to achieve the Millennium Development Goals related to the "combat of HIV/AIDS, malaria and other diseases". More specifically, that the increase in tuberculosis is to be halted and that the incidence of TB be reversed by 2015.

4.3.6 Describe the links to international initiatives (e.g., the World Health Organization/UNAIDS "3-by-5" initiative to address the insufficient access to antiretroviral therapy, the Global Plan to Stop TB, and the Roll Back Malaria Partnership) (1–2 paragraphs)

The GoI is a major player in the Stop TB Partnership and RNTCP sits in the heart of the Global Plan to Stop TB. The second Global Stop TB Partners Forum was held in New Delhi, India from the 24th to the 25th March 2004.

4.3.7 Is there a sector-wide approach or other fund-pooling mechanism in place in the health sector?

☐ Yes
☒ No

[If yes, briefly describe how it operates and if you anticipate using it to administer part/all of the Global Fund grant (1–2 paragraphs)]

There is no sector-wide approach or other fund-pooling mechanism in place for the Health Sector, however, since the TB programme is a Centrally Sponsored Scheme, the funds provided by various funding agencies/donors are pooled together in such a manner that there is no over-lapping or duplication of activities.

[For HIV components only:]

4.3.8 Is there a World Bank Multi-Country HIV/AIDS Program?

☐ Yes
☐ No

[If yes, describe how interventions in this proposal complement those financed by the World Bank MAP (2–3 paragraphs)]

Describe how the financial management approach of this proposal relates to that being used by the World Bank MAP (1–2 paragraphs)

4.3.9 Indicate names and types of key agencies providing technical assistance to the national response

Table 4.3.9 - Technical Partners in National Response

Name of Agency	Type of Agency (academic/educational sector; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis, and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)	Main technical focus (e.g., prevention, care and support, treatment, etc.)
Government of India (Central Government)	Government	Diagnosis and Care/treatment, Monitoring and Evaluation
State Government	Government	Diagnosis and Care/treatment, , Monitoring and Evaluation
World Bank	Multilateral	Monitoring and Evaluation
World Health Organization	Multilateral	Monitoring and Evaluation
Danida *	Bilateral	Monitoring and Evaluation
DFID *	Bilateral	Monitoring and Evaluation
GFATM	Multilateral	Monitoring and Evaluation
USAID	Bilateral	Monitoring & Evaluation
GDF	Multilateral	Logistics, Monitoring and Evaluation

*Presently programme in AP and Orissa is being implemented with assistance from DFID and Danida with their commitment up to Oct 2005 and Dec 2005 respectively.

4.3.10 Earmarked financial contributions to the national response to this disease

[List the financial contributions dedicated to the fight against this disease by all domestic and external sources.]

Table 4.3.10- Financial Contributions to National Response

	Financial contributions in USD Million							
	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Domestic	25.93	21.98	17.53	16.04	21.27	22.34	23.46	23.92
External	3.96	3.29	7.75	11.43	6.73	1.52	1.60	0.00
Total resources available	**29.89**	**25.27**	**25.28**	**27.47**	**28.00**	**23.86**	**25.06**	**23.92**

4.3.11 Total resource needs

[Describe the total resources needed to combat this disease.]

Table 4.3.11- Total resource needs

	In USD Million				
	2004-05	2005-06	2006-07	2007-08	2008-09
Total resources available	27.47	28.00	23.86	25.06	23.92
Total need	27.97	34.29	36.00	37.80	38.56
Unmet need	**0.50**	**6.29**	**12.14**	**12.74**	**14.64**

[Describe the source of the resource needs (e.g., costed national strategies), or, if they were estimated for the proposal, how the estimates were developed (1 paragraph)}

The resource needs for 2004-05 have been taken from the annual budget outlay submitted by the National TB Control programme to the Government of India for the TB Programme. The remaining years have been estimated based on expected costs for running the programme.

4.3.12 Describe plans to ensure that any Global Fund resources received would be additional to the existing and planned resources (2–3 paragraphs)

[Global Fund financing should be additional to existing and planned resources in the fight against AIDS, tuberculosis and malaria, and so should not replace existing domestic or external resources]

The RNTCP is integrated with the general health services utilizing the available infrastructure. The health centres are staffed by the state governments and these centres are implementing the programme. The infrastructure and regular staff are paid for by the state governments and all investment costs for the basic services under the programme have already been taken care of. It is only recurrent costs like drugs and new activities that would be provided for by the proposal. Thereby contribution made by GFATM to the programme would be in addition to the ongoing efforts being made by the health system.

To provide quality TB services to the whole of India, with its population of over 1000 million, is in itself is a challenging task. As described earlier, with assistance from several external agencies, GOI is planning to control TB by expanding the RNTCP to cover the entire country by 2005, and then maintain quality services until such time that the desired epidemiological impact is attained. As indicated in Tables 4.3.10 and 4.3.11 the total annual requirement for the country is approximately $35 million, of which domestic contribution will be approximately $22 million. This proposal, along with other external resources, would provide assistance in meeting the total requirements of the country. As assistance to RNTCP from DFID and DANIDA in the States of Andhra Pradesh and Orissa respectively, is committed only up to Oct 2005 and Dec 2005, funding is sought from GFATM to maintain and improve the existing quality TB services to the population of over 119 million in these states, after the above period. Thus, the funding sought under this proposal is an additional resource requirement to meet the efforts being made by the GoI to provide quality DOTS services to the entire country and help in realising the MDG of halting and reversing TB. As the RNTCP services are fully integrated with the general health services, any contribution to RNTCP will lead to a strengthening of the general public health system in India.

4.3.13 Analysis of gaps in coverage of key service delivery areas

[Please list any key service delivery areas from Annex B that are included in national strategic plans but which are currently not available at all or not currently available at sufficiently wide scale]

The key service delivery areas which are part of the national strategic plans will be made available, which include:

	Service delivery areas
Prevention	Identification of infectious cases
	Prevention of transmission by treating infectious cases
Care and Support	Supporting patients through direct observation of treatment
Treatment	quality treatment of cases
	Control of drug resistance
	Systematic monitoring of performance in case management
Supportive environment and cross-cutting aspects	Coordination and partnership development (national, community, public-private)
	Health systems strengthening
	Monitoring, evaluation and operations research

4.3.14 Does this application focus primarily on scaling up existing interventions, introducing new interventions, or both?

☐ Scaling up
☐ New
☒ Both

4.3.14.1 If "scaling up" or "both", describe how the interventions addressed in the proposal build upon existing programs (2 – 3 paragraphs)

The programme is expected to cover the entire country by 2005, after which this proposal would ensure that the achievements of the current programme are consolidated by maintaining quality TB services in the areas proposed to be covered under this proposal. Continued implementation of DOTS is the main strategy for control of TB. Case finding and treatment activities will continue. Further, in addition to maintaining quality TB services this proposal will strive to increase the reach of RNTCP services to all sections of society. Various activities to improve the quality of the programme will be strengthened in the project areas.

Managerial and supervisory capabilities of states would be strengthened further. It has been noted that the budget line for dedicated staff under the programme is unusually high among the 22 high TB burden countries. However this dedicated allocation has resulted in the strict appraisal process prior to implementation and routine supervision after implementation to happen, and the success of the programme to date has been largely ascribed to this factor of staffing.[2] A recent Joint Monitoring Mission of the RNTCP highlighted the need for a strengthening of the human resource capacity of the programme and the risk of future decline in programme success if this recommendation is not followed through with[8.] Case finding activities will be scaled up by involvement of other sectors and by generating awareness through advocacy and IEC activities. Drug quality monitoring would be carried out as existing in the programme.

4.3.14.2 If "scaling up" or "both", describe how the interventions to be scaled up were identified from among other existing interventions (1–2 paragraphs)

The RNTCP is an application of the DOTS strategy which advocates case finding by sputum smear Microscopy and treatment under direct observation. The strategy has been found successful in the areas where it is being implemented. The treatment success rates have increased 3 times and the death among TB patients has decreased 7 fold as compared to the pervious programme. Learning from the past experience it is envisaged that by continuing to implement the programme in the 2 states with greater involvement of other sectors, strengthening of IEC, enhanced supervision and monitoring, the global targets of 85% success rate and 70% case detection rate of new sputum positives will be achieved.

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

[8] Regional Office for South-East Asia, WHO. Joint Tuberculosis Programme Review, India, September 2003. SEA-TB 265. New Delhi: SEARO WHO, 2004.

4.3.14.3 If "scaling up" or "both", indicate the major barriers to scaling up the interventions that have been identified as proven and effective have not previously been scaled up

[Check as many as apply, and then briefly (1–2 paragraphs) explain each barrier below.]

☐ Policies, standards and guidelines
☒ National capacity (health systems, human resources, etc.)
☐ Stigma, discrimination and human rights
☐ Gender-related issues
☐ Financing
☐ Other (please specify: _____)

Given the size of the country and huge population the provision of quality DOTS services to the entire country is a daunting task. At present the focus is on ensuring coverage of the entire country under DOTS strategy, therefore as of now there is no major barrier to scaling up, however, as envisaged the programme intends to scale up in 2005 at which time if adequate financial resources are not made available, that could prove to be a major barrier. The exact funds position is given in Table 4.3.11. Further, another aspect requiring continued support is maintenance, and in fact strengthening of, human resources provided under the programme especially supervisory at sub-district level and at state level. As highlighted by the recent Joint Monitoring Mission of the RNTCP if strengthening of the human resource capacity of the programme is not undertaken, the future success of the programme is at risk.[8] Inadequate staffing in Orissa is a major barrier to smooth and efficient implementation of this programme in the state.

4.3.14.4 If "scaling up" or "both", describe any innovative aspects to scaling up these interventions (2 – 3 paragraphs)s

In its efforts to scaling up the programme the government is resorting to innovative methods for involvement of other sectors. The other sectors to be involved include the NGOs, private practitioners, medical colleges, corporate sectors, Employees State Insurance Scheme, Armed Forces, etc. Innovations also include Improving health sector services in urban areas, co-ordination activities for the management of patients with TB-HIV co-infection.

4.3.14.5 If "new" or "both", describe how the new interventions addressed in the proposal complement and build upon existing programs (2 – 3 paragraphs)

Various new interventions would be adopted under this proposal in the two states. These would include preparing the groundwork for offering treatment to multi-drug resistant TB (MDR-TB) cases under DOTS Plus pilot projects, quality assurance of sputum microscopy and approaches for improving acceptability of DOTS amongst the medical community by facilitating adoption of DOTS regimens in Medical colleges. The TB-HIV co-ordination activities would be scaled up in Andhra Pradesh and would be an innovation in Orissa.

The proposal also would allow for the undertaking of crucial epidemiological surveys for assessing the impact of the project. A baseline State representative annual risk of TB infection (ARTI) survey would be undertaken in Andhra Pradesh in Year 1 of the project, and resurveys undertaken in both states at the end of the project. Mortality surveys would be performed in both states at the beginning and the end of the project. State

representative drug resistance surveillance (DRS) surveys will be conducted in both states during the project period as preparation for the DOTS Plus pilots. These studies will be conducted through the Central Institutes involved in RNTCP such as TRC Chennai and NTI Bangalore. A committee of experts will be set-up at national level to monitor these studies.

4.3.14.6 If “new” or “both”, describe how these interventions were identified (1–2 paragraphs)

The RNTCP in Andhra Pradesh was started with a pilot project in Hyderabad in 1995. Large scale expansion took place in 2001 and the entire state was covered under the DOTS strategy by January 2004. Similarly the state of Orissa started RNTCP implementation in August 1997 and completed full coverage in March 2004. Both these states have achieved treatment success and case detection rates close to the global targets during expansion. However the intersectoral linkages under the programme are still under-developed and now when the programme is moving from the expansion stage to the stage of maintenance of quality activities, the cross-cutting aspects and community participation at all levels need priority attention. The linkages are to be honed and participation of entire cross-section of the society is to be ensured. Therefore the inter-sectoral collaboration activities were identified as one of the objectives of this proposal. The second objective was identified based on the need to suatain and strengthen existing programme activities and to consolidate the gains of the programme in TB control so far.

This proposal adopts innovative ways of assessing impact of TB control activities under RNTCP in the two states by conducting baseline and follow-up surveys to determine the state-level Annual Risk of TB Infection (ARTI) and Mortality at the onset and at the conclusion of the project in the two states. Orissa will start TB-HIV co-ordination activities as part of the national TB-HIV co-ordination plan.

4.3.14.7 If “new” or “both”, describe why these interventions were not previously in widespread use (1– 2 paragraphs)

So far, the priority of activities in these states has been to ensure complete expansion of the DOTS strategy to all districts in these states. Now since the states have been completely covered under DOTS, the future direction is to ensure that the existing quality TB services provided are sustained and that the “reach” of the DOTS services are enhanced. The Government of India published innovative guidelines on the involvement of NGOs and Private Practitioners (PP) in 2001 and 2002 respectively. Both guidelines lay out how interested NGOs and PPs can be involved in RNTCP activities under a number of signed schemes. Basic requirements such as registration under the Societies Registration Act and experience with related activities, must be met by the respective NGO prior to be involved in RNTCP.

The state of Andhra Pradesh being a high prevalence state for HIV had already started implementing TB-HIV co-ordination activities, which are to be scaled up now on a priority basis. Orissa is being included in the next phase of expansion of TB-HIV co-ordination. The State TB Demonstration Centres (STDC) in both the states will be upgraded and made functional as per the requirements under the national STDC guidelines to conduct various activities like operational research, state level RNTCP training, M&E activities, Sputum microscopy EQA, DR surveillance etc. Under this proposal, the states would be facilitated to ensure these activities.

DOTS Plus pilots have not been initiated previously under RNTCP as the overarching national priority is to achieve 100% geographical coverage and global targets set for treatment success and case detection by 2005. However now that many states have achieved these targets, the Central TB Division has drawn up a strategy to address the issue of drug resistance under which there will be a phase roll out of state representative DRS surveys and subsequent initiation of DOTS Plus pilots. The proposal here fits into this national strategy and plan. Application to GLC will be made once the DRS studies from the two states and lab quality assurance reports of the states are available (Expected at the end of year 1/ beginning of year 2).

4.3.14.8 If "new" or "both", describe any innovative aspects to these interventions (2 – 3 paragraphs)

This proposal adopts proven ways of assessing impact of TB control activities under RNTCP in the two states by conducting baseline and follow-up surveys to determine the state-level Annual Risk of TB Infection (ARTI) and Mortality at the onset and at the conclusion of the project in the two states. Orissa will start TB-HIV co-ordination activities as part of the national TB-HIV co-ordination plan.

4.3.15 Does this application complement earlier grants from The Global Fund?

☐ Yes
☒ No

4.3.15.1 If yes, describe how this application complements earlier grants from the Global Fund (2 – 3 paragraphs)

4.4 Program Strategy

Guide to the Program Strategy Section

Goal, Objectives, Services to be delivered and Main Activities

In this section, the component strategy is described by completing Table 4.4, as well as the questions which follow.

Table 4.4 is designed to help applicants clearly summarize the strategy and logical rationale behind their proposal, and to show how expanded coverage of key services to be supported by the Global Fund relate to a broader national plan for the disease component. Applicants are asked to describe the program goal, objectives, services to be delivered and main activities, as well as key indicators to be used for measuring impact and coverage. See the Guidelines for Proposals, section V.B.2 for more information.

Applicants should also include a detailed action plan for the first 12 months and an indicative action plan for the second year. These should be attached as an annex to the proposal form.

Goal

Overall goal of the Revised National Tuberculosis Control Programme (RNTCP) is to reduce the mortality and morbidity due to tuberculosis (TB), and cut transmission of TB until TB ceases to be a significant public health problem in India. The project seeks to maintain and improve sustainable RNTCP technical, managerial and organizational infrastructure in the states of Andhra Pradesh and Orissa in order to maintain the achieved ≥85% treatment success and ≥70% detection of new smear positive pulmonary TB cases and thus contribute to the overall national goal of RNTCP.

Table 4.4A: Goals and impact indicators

No	Goal					
1	Overall goal of the Revised National Tuberculosis Control Programme (RNTCP) is to reduce the mortality and morbidity due to tuberculosis (TB), and cut transmission of TB until TB ceases to be a significant public health problem in India. The project seeks to maintain and improve sustainable RNTCP technical, managerial and organizational infrastructure in the states of Andhra Pradesh and Orissa in order to maintain the achieved ≥85% treatment success and ≥70% detection of new smear positive pulmonary TB cases and thus contribute to the overall national goal of RNTCP.					
	No	**Impact indicator**		**Baseline**	**5 year target**	**Year in which target will be reached**
	1	Annual Risk of Tuberculosis Infection (ARTI)	Andhra Orissa	NA [1]	6% annual decline from baseline	2009
	2	Mortality rate due to TB per 100,000 population	Andhra Orissa	NA [2]	25% ↓ from baseline rate	2009

[1] Based on the National ARTI survey, 2000 – 2003, the national ARTI is 1.5%. A State specific ARTI survey has just been completed in Orissa and the data should be available in the near future. However State specific ARTI data is not available. State specific baseline survey's to be conducted in Year 1 of proposal.

[2] Baseline data is not available. Baseline surveys to be conducted in Year 1 of proposal.

Objectives

1. Maintain and improve the quality of services delivered under the programme.
2. Increase the accessibility of RNTCP services in the states of Andhra Pradesh and Orissa by inter-sectoral collaboration with other sectors outside of public health facilities such as private sector, NGO sector, etc.

Table 4.4B: Objectives

Goal	Overall goal of the Revised National Tuberculosis Control Programme (RNTCP) is to reduce the mortality and morbidity due to tuberculosis (TB), and cut transmission of TB until TB ceases to be a significant public health problem in India. The project seeks to maintain and improve sustainable RNTCP technical, managerial and organizational infrastructure in the states of Andhra Pradesh and Orissa in order to maintain the achieved ≥85% treatment success and ≥70% detection of new smear positive pulmonary TB cases and thus contribute to the overall national goal of RNTCP.		
Number	**Objective**		
1	Maintain the quality of services delivered under the programme.		
	What percentage of the people reached by this objective will be women?		35%
	What percentage of the people reached by this objective will be youth?		21%
	What percentage of the people reached by this objective will be in:		
		Rural areas	73%
		Urban areas	27%
	What percentage of the services in this objective will be delivered by:		
		Government	80%
		Non-governmental partners	5-15%
		Private sector	10-15%
	What percentage of people trained will be:		
		Health personnel	-
		Non-health personnel	-
	What percentage of people trained will be:		
		Government	80%
		Non-governmental partners	5-15%
		Private sector	10-15%

Describe, for each objective, which target groups are important beneficiaries of this objective (check all that apply):

- ☒ Injecting drug users
- ☒ Men who have sex with men
- ☒ Mobile populations
- ☒ Orphans
- ☒ People living with HIV/AIDS
- ☒ Sex Workers
- ☒ Youth (in school)
- ☒ Youth (out of school)
- ☒ Other (please specify: Lowest socio-economic sections of the community; industrial workers

Goal	Overall goal of the Revised National Tuberculosis Control Programme (RNTCP) is to reduce the mortality and morbidity due to tuberculosis (TB), and cut

	transmission of TB until TB ceases to be a significant public health problem in India. The project seeks to maintain and improve sustainable RNTCP technical, managerial and organizational infrastructure in the states of Andhra Pradesh and Orissa in order to maintain the achieved ≥85% treatment success and ≥70% detection of new smear positive pulmonary TB cases and thus contribute to the overall national goal of RNTCP.		
Number	**Objective**		
2	Increase the accessibility of RNTCP services in the states of Andhra Pradesh and Orissa by inter-sectoral collaboration with other sectors outside of public health facilities such as private sector, NGO sector, etc.		
	What percentage of the people reached by this objective will be women?		35%
	What percentage of the people reached by this objective will be youth?		21% (15 to 24 yrs)
	What percentage of the people reached by this objective will be in:		
		Rural areas	50%
		Urban areas	50%
	What percentage of the services in this objective will be delivered by:		
		Government	80%
		Non-governmental partners	5-15%
		Private sector	10-15%
	What percentage of people trained will be:		
		Health personnel	-
		Non-health personnel	-
	What percentage of people trained will be:		
		Government	80%
		Non-governmental partners	5-15%
		Private sector	10-15%

Describe, for each objective, which target groups are important beneficiaries of this objective (check all that apply):

- ☒ Injecting drug users
- ☒ Men who have sex with men
- ☒ Mobile populations
- ☒ Orphans
- ☒ People living with HIV/AIDS
- ☒ Sex Workers
- ☒ Youth (in school)
- ☒ Youth (out of school)
- ☒ Other (please specify: Lowest socio-economic sections of the community; industrial workers

Services to be delivered, Coverage indicators and Main activities

Table 4.4Ci: Services to be delivered

Objective	Maintain the quality of services delivered under the programme						
Number	**Services to be delivered**						
1	**Category**	Identification of infectious cases					
	Description	Provision of sputum microscopy facilities for chest symptomatics reporting to health centres.					
	Coverage indicator	**Baseline (2003)**	**Year 1 target**	**Year 2 target**	**Year 3 target**	**Year 4 target**	**Year 5 target**

	1	% of designated microscopy centres (DMC) with RNTCP trained Laboratory Technician (LT) in post	90%	-	95% or above	100%	100%	100%
	2	% of estimated new smear-positive pulmonary TB (NSP) cases detected under DOTS *	Andrha Pradesh 66.4% Orissa 41.3%	-	≥72%	≥74%	≥76%	≥78%
	Main activity		**Indicator**			**Implementing partners**		
	1	Training of LT	Number of LT trained			*Central TB Division (CTD), State TB Control Society (STCS),District TB Control Society (DTCS)*		
	2	Sputum microscopy for suspected TB cases	Number of operational DMCs			*CTD, STCS, DTCS, NGOs, Private sector*		
	3	Initiating cases on treatment	Number of new smear-positive PTB cases registered under RNTCP			*CTD, STCS, DTCS, NGOs, Private sector*		
	4	Provision of laboratory materials	Expenditure per million population on laboratory consumables			*CTD, STCS, DTCS*		
	5	State representative ARTI survey (Year 1)	Survey completed and results published			*CTD, STCS, DTCS, National TB Institute (NTI), TB Research Centre (TRC), WHO*		
	6	State representative ARTI survey (Year 5)	Re-survey completed and results published			*CTD, STCS, DTCS, National TB Institute (NTI), TB Research Centre (TRC), WHO*		

Table 4.4Cii: Services to be delivered

Objective	Maintain the quality of services delivered under the programme						
Number	**Services to be delivered**						
1	**Category**	Prevention of transmission by treating infectious cases					
	Description	Provision of free drugs for all patients for the entire duration of treatment; treatment given under direct observation; follow-up sputum microscopy examination undertaken to assess response to treatment					
	Coverage indicator		**Baseline**	**Year 1 target**	**Year 2 target**	**Year 3 target**	**Year 4 target**	**Year 5 target**
	1	% of service deliverers in post who have been trained in RNTCP Medical Officer (MO), Primary Health Centre (PHC)	80%	-	85%	90%	90%	90%

	2	Percentage of new smear-positive cases registered under DOTS who smear-convert at end of intensive phase	85%	-	85%	85%	85-90%	85-90%
	3	% of patient-wise boxes stock-outs*	Nil	-	Nil	Nil	Nil	Nil

	Main activity	**Indicator**	**Implementing partners**
1	Training of MO PHC, DOT providers	Number of MO PHC, DOT providers trained	*CTD, STCS, DTCS*
2	Provision of treatment	Number of patients put on DOT	*CTD, STCS, DTCS*
3	Follow up of new smear-positive PTB cases	Percentage of new smear positive PTB cases, registered under DOTS, who have the follow-up smear examination performed at the end of the intensive phase treatment	*CTD, STCS, DTCS, NGOs, Private sector*

*Stock out is defined as the number of districts having less than one month's requirement as closing balance in their quarterly programme management report/ total number of districts reporting x 100.

Table 4.4Ciii: Services to be delivered

Objective	Maintain the quality of services delivered under the programme								
Number	**Services to be delivered**								
1	**Category**	Prevention of TB among people living with HIV/AIDS							
	Description	Training of RNTCP, NACO and NGO staff on TB/HIV; develop linkages and referral of patient mechanisms between RNTCP microscopy centres and NACO voluntary counseling and testing centres (VCTC).							
	Coverage indicator			**Baseline**	**Year 1**	**Year 2 target**	**Year 3 target**	**Year 4 target**	**Year 5 target**
	1	Number of patients registered under RNTCP following referral from VCTC to RNTCP services	Andhra Pradesh	Baseline as exists in 2005	-	5% increase over baseline	10% increase over baseline	10% increase over baseline	15% increase over baseline
			Orissa	Baseline as exists in 2005		5% increase over baseline	10% increase over baseline	10% increase over baseline	15% increase over baseline
	2	Percentage of smear-positive TB cases who are HIV	Andhra Pradesh	Baseline as exists in 2005	-	5% increase over	10% increase over	10% increase over	10% increase over

		infected registered under RNTCP successfully treated	Orissa	Baseline as exists in 2005		baseline	baseline	baseline	baseline
	Main activity		**Indicator**					**Implementing partners**		
	1	Training of RNTCP, NACO and NGO staff on TB/HIV	Number of RNTCP, NACO and NGO staff trained on TB/HIV					*CTD, NACO, STCS, State AIDS Control Society (SACS), DTCS, VCTC*		
	2	Referral of TB suspects from VCTC to RNTCP services	Number referred					*CTD, NACO, STCS, SACS, DTCS, VCTC*		
	3	Referral of TB patients from RNTCP services to VCTC	Number referred					*CTD, NACO, STCS, SACS, DTCS, VCTC*		

Table 4.4Civ: Services to be delivered

Objective	Maintain the quality of services delivered under the programme							
Number	**Services to be delivered**							
1	**Category**	Supporting patients through direct observation of treatment						
	Description	Treatment under DOT						
	Coverage indicator		**Baseline**	**Year 1 target**	**Year 2 target**	**Year 3 target**	**Year 4 target**	**Year 5 target**
	1	% of public health treatment facilities providing DOTS services	100%	-	100%	100%	100%	100%
	2	Percentage of patients diagnosed in the district who are placed on DOTS	90%	-	95%	95%	95%	95%
	3	% of NSP cases registered under DOTS successfully treated	85%	-	85%	85%	85%	85%
	Main activity		**Indicator**			**Implementing partners**		
	1	Provision of services through increased number of DOTS centres	Number of centres providing DOT services			*CTD, STCS, DTCS, NGOs, Private sector*		
	2	DMCs and TB Units operational in districts as per RNTCP guidelines	Number of treatment facilities implementing DOTS			*CTD, STCS, DTCS, NGOs, Private sector*		
	3	Provision of DOT for all cases	Number of patients diagnosed within the district that are put on DOT			*CTD, STCS, DTCS, NGOs, Private sector*		

Table 4.4Cv: Services to be delivered

Objective	Maintain the quality of services delivered under the programme	
Number	**Services to be delivered**	
1	**Category**	Control of drug resistance
	Description	Drug resistance surveillance; reporting of category I and II failure cases.

	Coverage indicator	Baseline	Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target
1	% of new smear-positive PTB cases registered under RNCTP fail treatment	Failure rate of 2004		<3%	<3%	<3%	<3%
2	% of new smear-positive PTB cases registered under RNCTP who default from treatment	Default rate of 2004		<5%	<5%	<5%	<5%
3	State representative drug resistance surveys	None	Surveys initiated/ completed (x2)	Surveys completed(x2)	-	-	-
4	DOTS Plus sites*	0	0	0	1 per state	1 per state	1 per state

	Main activity	Indicator	Implementing partners
1	Quarterly and Annual programme reporting	Quarterly and Annual programme reports published	*CTD, STCS, DTCS*
2	State representative drug resistance studies (Year 2-3)	Studies completed and results published	*CTD, STCS, DTCS, NTI, TRC*
3	DOTS Plus pilot sites initiated - 1 per state (Year 3-4)	Pilot sites initiated and patients being enrolled for treatment	*CTD, STCS, DTCS, NTI, TRC, WHO, GLC, GDF*

*Application to GLC will be made once the DRS studies and lab quality assurance reports are available (Expected at the end of year 1/ beginning of year 2)

Table 4.4Cvi: Services to be delivered

Objective	Maintain the quality of services delivered under the programme							
Number	**Services to be delivered**							
1	**Category**	Systematic monitoring of performance in case management						
	Description	Field visits by District TB Officers, State TB Officer, Medical Officer TB control; routine quarterly and annual RNTCP reporting on performance; quarterly internal evaluation of district level programmes; Regular reporting and feedback on TB control activities at all levels of programme implementation; 2-3 research studies per year per State.						
	Coverage indicator		**Baseline**	**Year 1 target**	**Year 2 target**	**Year 3 target**	**Year 4 target**	**Year 5 target**
	1	% of TB Units with staff in post as per RNTCP guidelines*:						
	1.a	STS	>90%	-	100%	100%	100%	100%
	1.b	STLS	>90%	-	100%	100%	100%	100%
	2	% of reporting units that submit reports on time	90%	-	100%	100%	100%	100%

	3	% of NSP patients registered under RNTCP who die whilst on treatment	National 4% AP 5% Orissa 6%	≤4%	≤4%	≤4%	≤4%	≤4%
	Main activity		**Indicator**			**Implementing partners**		
	1	Training of STS and STLS	Number of STS and STLS trained			*CTD, STCS, DTCS*		
	2	Printing of records and reports	Expenditure incurred per million population on printing			*CTD, STCS, DTCS*		
	3	Quarterly and Annual programme reporting	Quarterly and Annual programme reports published					
	4	Supervision of RNTCP service facilities by STS & STLS	Number of visits made to DMCs and DOT centres					
	5	Field visits by DTO	Field visits by DTO per quarter			*CTD, STCS, DTCS*		
	6	Field visits by MOTC	Field visits by MOTC per quarter			*CTD, STCS, DTCS*		
	7	State level quarterly RNTCP review meeting	Number of meetings held					
	8	Quarterly internal evaluation of district level programmes	Number of district level internal evaluations undertaken per quarter			*CTD, STCS, DTCS*		
	9	Mortality survey in 2 States (Year 1)	Survey completed and report published			*CTD, NTI, TRC, WHO*		
	10	Mortality re-survey in 2 States (Year 5)	Survey completed and report published			*CTD, NTI, TRC, WHO*		

* Whenever a contractual post falls vacant, new appointment will be done from the waiting list. For new recruitment process, it is expected that it will take an average of 40 days to complete new recruitment.

Table 4.4Cvii: Services to be delivered

Objective	Maintain the quality of services delivered under the programme.						
Number 1	**Services to be delivered**						
	Category	Health systems strengthening					
	Description	Adequate staffing at State and district level; enhanced technical capacity building of State TB and Demonstration Centres (STDC); training of all staff of states in TB control; Electronic connectivity of all districts with state level and central level; Provide feedback regularly on programme reports.					
	Coverage indicator	**Baseline**	**Year 1 target**	**Year 2 target**	**Year 3 target**	**Year 4 target**	**Year 5 target**
	1 % of State TB Cell staff in post as per RNTCP guidelines*	83%	-	100%	100%	100%	100%
	2 % of districts with all key RNTCP staff in place	90%	-	95%	100%	100%	100%
	3 % of districts reporting electronically to Centre	90%	-	95%	100%	100%	100%
	Main activity	**Indicator**			**Implementing partners**		

	1	Contractual staff posted at State TB Cell	Percentage of posts remaining vacant	*CTD, STCS, DTCS*
	2	Civil works at STDC	Budget spent on civil works at STDC	*CTD, STCS, DTCS*
	3	State level to provide feedback to all districts on their quarterly reports	Percentage of districts receiving feedback on quarterly reports	*CTD, STCS, DTCS*
	4	Electronic connectivity of all District TB offices	Percentage of District TB centres electronically connected	*CTD, STCS, DTCS*

* Whenever a contractual post falls vacant, new appointment will be done from the waiting list. For new recruitment process, it is expected that it will take an average of 40 days to complete new recruitment

Table 4.4Cviii: Services to be delivered

Objective	Increase the accessibility of RNTCP services in the states of Andhra Pradesh and Orissa by inter-sectoral collaboration with other sectors outside of public health facilities such as private sector, NGO sector, etc.						
Number 2	**Services to be delivered**						
	Category	Coordination and partnership development (national, community, public-private)					
	Description	NGO and PP training in RNTCP, participation in health fairs, CMEs for private practitioners and medical colleges. Involvement under approved RNTCP schemes, training/ sensitization of PRIs, self help groups and community based organizations.					
	Coverage indicator		**Baseline**	**Year 1 target**	**Year 2 target**	**Year 3 target**	**Year 4 target**	**Year 5 target**
	1	% of NGO or Private health facilities participating in RNTCP	Baseline will be developed	-	10% increase over baseline	15% increase over baseline	20% increase over baseline	25% increase over baseline
	2	% of total DOT providers from NGOs or Private sector	Baseline will be developed	-	5% increase over baseline	10% increase over baseline	15% increase over baseline	20% increase over baseline
	3	% contribution of non-public health facilities to case detection rate	CDR of the respective state in 2005	-	5% of cases detected are from other sectors	10% cases detected are from other sectors	15% cases detected are from other sectors	20% cases detected are from other sectors
	4	% of NSP cases registered under DOTS with non-public health facilities successfully treated	% success of NSP cases in the states in 2005	-	85%	85%	85%	85%
	Main activity		**Indicator**			**Implementing partners**		
	1	Training of NGO staff, PPs and staff of concerned sector	Number of staff of other sectors trained			*CTD, STCS, DTCS, NGOs, private sector*		

	2	Co-ordination meetings and CMEs	Number of meetings and CMEs held	*CTD, STCS, DTCS, medical colleges, NGOs, private sector*
	3	Establishing MCs in other sectors	Number of MCs established	*CTD, STCS, DTCS, medical colleges, NGOs, private sector*
	4	Sensitisation of PRIs, SHGs and CBOs.	No of members of PRIs, SHGs, CBOs trained	*CTD, STCS, DTCS, medical colleges, NGOs, private sector*
	5	Reporting of cases detected and treated at NGO / private / corporate sectors	Details of new smear positive PTB patients cases detected and treated under non-Govt health facilities routinely recorded and reported	*CTD, STCS, DTCS, medical colleges, NGOs, private sector*

4.4.1 Describe the quality and type of the training to be carried out (e.g., delivery of ART services according to national guidelines, or peer counseling in sexual and reproductive health, according to national youth mobilization guidelines).

Training under RNTCP is conducted as per standard guidelines. The training material have been prepared as modules and manuals centrally by Central TB Division and have been widely disseminated and reprinted by all states.

The details of training of various categories of staff are as under:

	Category of staff	**Number of days**	**Training material**
1.	Programme managers	14	Modules 1 to 10
2.	Medical Officers	5	Modules 1 to 4
3.	Supervisory staff	STS – 8; STLS- 15	Modules
4.	Laboratory technicians	10	Module, manual, practicals
5.	Peripheral workers	2/ 3 days	Modules

The key programme managerial staff receive training which imparts the skills required for management of the programme, including financial and logistical management. The basic training also includes a module on Inter-Personal Communication (IPC), which all health staff receive training on.Training is also imparted to the concerned health workers to upgrade skill required for performing sputum smear examination, monitoring and evaluation of the programme, for improved interpersonal communication with patients, record keeping etc. Selected staff e.g. STO, DTO, STS, STLS, LTs, will receive further training on external quality assessment of smear microscopy services (EQA) and drug resistance surveillance (DRS). Specialised training will be given to those staff involved in implementation of the proposed DOTS Plus projects.

4.4.2 Describe the broad approach for human resources development, including how adequate human resource capacity will be developed to support program scale up (2–3 paragraphs)

The RNTCP is fully integrated within the existing health care infrastructure and is implemented through the General Health Service Delivery System. Regular government staff provides the majority of the services under the programme. As per the norms under the ongoing World Bank-assisted project, some staff are appointed on contractual basis as per requirement. These are mainly the supervisory staff (STS & STLS) at the sub-district level (approximately covering 500,000 population) and a proportion of the laboratory technicians. As highlighted by the recent Joint Monitoring Mission of the RNTCP if strengthening of the human resource capacity of the programme is not undertaken, the future success of the programme is at risk.[8] The provision of trained staff as per the programme guidelines, is of crucial importance to the future, as is a plan for human resource development. The District and State level TB control services are also strengthened with adequate staff to support the District

TB Officer and State TB Officer. Prior to initiation of service delivery, a wide range of staff is trained in various fields, enhancing their skills and capacity to perform the assigned tasks. Before the programme is allowed to be implemented in a district, an appraisal by a central level team is undertaken. Strict criteria are laid down to which the district that is being appraised, must reach prior to approval to start implementing the programme is given.

Regular training needs assessments will be undertaken by the staff of the State TB Cell (STC) and STDC to identify staff who require either basic training or refresher training. During 2004-05, all basic training modules are to be updated. Also during 2004-05, the curriculum and training material for refresher training will be developed and field tested. This will be undertaken by the Central TB Division, with technical assistance from the National TB Institute (NTI) in Bangalore and WHO. Training modules for EQA and DRS are being developed by the Central TB Division, with technical assistance from NTI, the TB Research Centre (TRC) in Chennai, and WHO. Training material will be developed in regard to the implementation of DOTS Plus projects. Provision of adequate funding for all of these activities will have to be made.

To develop the technical capabilities at the state level, the programme will encourage skilled senior officers of the health services to move on deputation to the State TB Cell for the posts of Epidemiologist and TB control officer. The STDC will be supported to undertake operational research, conduct modular training and continuously monitor quality assurance of microscopy activities in the field.

4.4.3 Describe the key risks and assumptions made in preparing this proposal (3–4 paragraphs)

Assumption: All TB control services using the DOTS strategy are in place in the two states, and to create an epidemiological impact on TB, need to be continued for a period of at least 5-10 years. By sustaining and improving the TB control services in the two states over a period of the next 5 years, a decrease in mortality will be seen and subsequently a decrease in the incidence of TB.

Risk: If financial support to the programme is not available for the coming years, there is a significant risk of the gains made in the previous 5 years being lost, and the goal of controlling TB in India being lost for another generation.

4.4.4 Describe gender inequities regarding access to the services to be delivered (1–2 paragraphs)

A constant feature in the case notifications under the programme is that more male patients are detected than female patients, with the ratio of being 1.8: 1. A number of epidemiological studies have demonstrated that in all age groups pulmonary TB is predominantly a male disease. In fact, it is male cases that are not being detected. It is also seen that male patients are more likely to default from treatment and have slightly worse treatment outcomes than female patients. However there is greater stigma attached to the disease amongst female patients than males.

4.4.5 Describe how this proposal will contribute to minimizing these gender inequities (1–2 paragraphs)

From 4.4.4, it is seen that there are gender-based issues both for male and females in relation to TB control activities. The provision of country-wide available and accessible TB services as close to the patients as possible, is an important first step in beginning to address this issue. In relation to the two states in the proposal, geographical coverage is already 100%. However there is a recognition that accessibility to services needs to be increased. Important to this is increased inter-sectoral collaboration with sectors outside of the public health services. With increased accessibility to RNTCP services, some of the gender based issues will be addressed e.g. difficulty of working males to attend public health services for DOT due to inconvenient opening hours addressed by DOT provision via NGO or private sector health facilities, or by community volunteers.

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

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

4.4.6 Describe the populations that are particularly vulnerable to this disease (1–2 paragraphs)

TB can affect any person irrespective of gender and social class. However the poor sections of society are more vulnerable to tuberculosis. A sample study showed that on an average, a TB patient loses three to four months of wages, equivalent to 20-30% of the annual household income, thereby making the poor poorer[16]. The provision of country-wide quality TB services as close to the patient as possible and free of charge, will decrease the financial losses incurred by the patient and the number of families falling into the cycle of debt and poverty caused by a family member having TB disease.

4.4.7 Describe how these populations are involved in planning the program and how they will be involved in implementing and monitoring it (including, if appropriate, describe their role as service deliverers) (1–2 paragraphs)

This proposal is part of the ongoing effort of decentralizing TB control services from the district levels to the sub-district levels down to the smaller villages. RNTCP increasingly is using community volunteers as treatment providers (DOT providers). These DOT providers are generally selected from within the same locality and community as the patient to enable easy access to DOT for the patient. DOT providers come from a wide range of community members such as shopkeepers, teachers, people working in the home, and cured patients themselves.

Participation of the community will be encouraged under the programme in other ways. To ensure community involvement in the decision-making, the local leader representatives (village Panchayat) will be included as members in the District and State TB Control Societies. Through IEC activities, every attempt will be made to involve the community at large in order to address various issues such as stigma, access to RNTCP services by marginalized sections of the population.

4.4.8 Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs) (1–2 paragraphs)

RNTCP services will be available to all cases diagnosed as TB under the health system and associated sectors and will not exclude any section of the population.

4.4.9 Describe how this proposal will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis, and malaria, and other types of stigma and discrimination, including gender-based, that facilitate the spread of these diseases (1–2 paragraphs)

Through intensified IEC activities and greater accessibility of quality free TB services, community members with symptoms of TB will be encouraged to present to the health facilities for examination and treatment if necessary. Through the provision of quality decentralized free TB services resulting in the presence of increasing numbers of cured TB patients in the community, it is hoped that the stigma related to

TB in the community will decrease. Cured patients acting as DOT providers to future patients and advocates for the programme, will act as potent symbols to the community of the fact that TB is a curable disease and should be seen as just another infection that needs antibiotic treatment for cure

4.4.10 Describe how the beneficiaries of this proposal (e.g., people living with HIV/AIDS, tuberculosis, and/or malaria) and/or affected communities are involved in planning the program and how they will be involved in implementing it (including, if appropriate, describe their role as service deliverers) (1–2 paragraphs)

Cured TB patients are increasingly being used as DOT providers for future patients and as potent advocates on behalf of the programme. Through advocacy by patients to their local Panchayat, and subsequent representation of the community by the Panchayat members in the District and State TB Control Societies, beneficiaries can be involved in the planning of the programme.

4.4.11 Describe how the communities involved in this proposal are involved in planning the program, and how they will be involved in implementing it (including, if appropriate, describe their role as service deliverers) (1–2 paragraphs)

Through advocacy by the community to their local Panchayat, and representation of the community by the Panchayat members in the District and State TB Control Societies, the community can be involved in the planning of the programme. NGO and private sector members involved in TB control activities are also members of the DTCSs and thereby participate in planning and monitoring the programme.

4.4.12 For malaria components only: If the proposal contains anti-malarial drugs or insecticides, include data on drug resistance and/or resistance of vectors in the country or in the target population/area (1–2 paragraphs)

4.5 Program and Financial Management

[In this section, CCMs should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals, Section V.B.3 for more information.]

4.5.1 Will implementation be managed through a single Principal Recipient or multiple PRs?

☒ Single
☐ Multiple

[Every component of your proposal can have one or several Principal Recipients. In table 4.5.1 below, you must nominate the Principal Recipient(s).]

Table 4.5.1- Implementation Responsibility

Responsibility for Implementation			
Nominated Principal Recipient(s)	**Area of Responsibility**	**Contact Person**	**Address, Telephone & Fax, Email address**

4.5.2 Describe the process by which the CCM nominated the Principal Recipient(s).

[Minutes of the CCM meeting at which the Principal Recipient(s) was nominated should be included as an Annex to the proposal]

[If there are multiple PRs, questions 4.5.3 – 4.5.6 should be repeated for each one.]

4.5.3 Describe the relevant technical, managerial and financial capabilities for each nominated Principal Recipient.

[Please also discuss any anticipated shortcomings these arrangements might have and how they will be addressed (i.e. capacity building, staffing and training requirements, etc.).]

4.5.4 Has the nominated PR(s) previously administered a Global Fund grant?

☒ Yes
☐ No

4.5.5 If yes, describe the performance of the nominated PR in administering previous Global Fund grants (1–2 paragraphs)

4.5.6 Describe other relevant previous experience(s) that the nominated PR has had:

[Please describe in broad terms the relevant programs, and their objectives, key implementation challenges and results (2–3 paragraphs)]

4.5.7 Describe the proposed management approach.

[Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM (1–2 paragraphs).]

4.5.8 Explain the rationale behind the proposed arrangements

[For example, explain why you have opted for that particular management arrangement (1 paragraph)]

4.5.9 Are sub-recipients expected to play a role in the project?

☐ Yes
☐ No

[If yes, proceed to 4.5.10 and subsequent questions. If no, proceed to Section 4.6.]

4.5.10 Have the sub-recipients already been identified?

☐ Yes
☐ No

[If yes, please answer 4.5.11 and 4.5.12. If no, please answer 4.5.13 and 4.5.14.]

4.5.11 Describe the process by which sub-recipients were selected (e.g., open bid, restricted tender, etc.) (2–3 paragraphs)

4.5.12 Describe the relevant technical, managerial and financial capabilities of the sub-recipients.

[Describe anticipated shortcomings or challenges faced by sub-recipients and how they will be addressed (i.e. capacity building, staffing and training requirements, etc.).]

4.5.13 Describe why sub-recipients were not selected prior to submission of the proposal (1–2 paragraphs)

4.5.14 Describe the process that will be used to select sub-recipients if the proposal is approved (1–2 paragraphs)

4.6 Monitoring and Evaluation (M&E)

In this section of the proposal form, applicants should describe the main elements of the program's monitoring and evaluation plan. This is done primarily through completion of Table 4.6.

This table is closely linked to Table 4.4 above; fields marked "[4.4]" below should be copied from Table 4.4.

Complete Table 4.6A for all goals and impact indicators.

Table 4.6A- M&E Table

Behavioral and disease impact				
Goal	**Impact indicator**	**Technical partners involved in measurement**	**Data source**	**Frequency of data collection**
Overall goal of the RNTCP is to reduce the mortality and morbidity due to TB, and cut transmission of TB until TB ceases to be a significant public health problem in India. The project seeks to maintain and improve sustainable RNTCP technical, managerial and organizational infrastructure in the states of Andhra Pradesh and Orissa in order to maintain the achieved ≥85% treatment success and ≥70% detection of new smear positive pulmonary TB cases and thus contribute to the overall national goal of RNTCP.	Annual Risk of TB Infection (ARTI)	CTD, STCS, DTCS, NTI, TRC, WHO	Baseline State specific ARTI not available Baseline State specific ARTI survey State specific ARTI re-survey	Baseline State specific ARTI survey to be done in Year 1 State specific ARTI re-survey to be done in Year 4-5
Overall goal of the RNTCP is to reduce the mortality and morbidity due to TB, and cut transmission of TB until TB ceases to be a significant public health problem in India. The project seeks to maintain and improve sustainable RNTCP technical, managerial and organizational infrastructure in the states of Andhra Pradesh and Orissa in order to maintain the achieved ≥85% treatment success and ≥70% detection of new smear positive pulmonary TB cases and thus contribute to the overall national goal of RNTCP.	Mortality rate due to TB per 100,000 population	CTD, STCS, DTCS, NTI, TRC, WHO	Baseline mortality data not available Baseline State specific mortality survey Baseline State specific mortality re-survey	Baseline State specific mortality survey to be done in Year 1 State specific mortality re-survey to be done in Year 5

Complete Table 4.6B for each objective, adding additional service delivery areas to each table as appropriate.

Table 4.6B- M&E Table

Goal:	Overall goal of the RNTCP is to reduce the mortality and morbidity due to TB, and cut transmission of TB until TB ceases to be a significant public health problem in India. The project seeks to maintain and improve sustainable RNTCP technical, managerial and organizational infrastructure in the states of Andhra Pradesh and Orissa in order to maintain the achieved ≥85% treatment success and ≥70% detection of new smear positive pulmonary TB cases and thus contribute to the overall national goal of RNTCP.			
Objective 1:	Maintain the quality of services delivered under the programme			
	Service delivery area 1:	Identification of infectious cases		
			Data source	**Frequency of data collection**
	Coverage indicator 1:	% of designated microscopy centres (DMC) with RNTCP trained Laboratory Technician (LT) in post	RNTCP Quarterly Programme Management Report	Quarterly and Annually
	Coverage indicator 2:	Percentage of estimated NSP cases detected under DOTS	RNTCP Quarterly Programme Management Report State specific ARTI survey	Quarterly and Annually In Years 1 and 5
	Service delivery area 2:	Prevention of transmission by treating infectious cases		
			Data source	**Frequency of data collection**
	Coverage indicator 1:	% of service deliverers in post who have been trained in RNTCP 1.a Medical Officer, Primary Health Centre	RNTCP Quarterly Programme Management Report	Quarterly and Annually
	Coverage indicator 2:	Percentage of NSP cases registered under DOTS who smear convert at the end of the intensive phase of treatment	RNTCP Quarterly Smear Conversion Report	Quarterly and Annually
	Coverage indicator 3:	% of patient-wise boxes stock outs	RNTCP Quarterly Programme Management Report	Quarterly and Annually
	Service delivery area 3:	Prevention of TB among people living with HIV/AIDS		
			Data source	**Frequency of data collection**
	Coverage indicator 1:	Number of patients registered under RNTCP following referral from VCTC to RNTCP services	VCTC-DMC referral system register RNTCP Quarterly Case Finding Report	Monthly, quarterly and annually
	Coverage indicator 2:	Number of persons with HIV infection detected following referral from RNTCP services to VCTC	VCTC-DMC referral system register RNTCP Quarterly Case Finding Report	Monthly, quarterly and annually
	Coverage indicator 3:	Percentage of smear-positive TB cases who are HIV infected registered under	VCTC-DMC referral system register RNTCP Quarterly	Monthly, quarterly and annually

		RNTCP successfully treated	Treatment Outcome Report	
	Service delivery area 4:	Supporting patients through direct observation of treatment		
			Data source	**Frequency of data collection**
	Coverage indicator 1:	% of public health treatment facilities providing DOTS services	RNTCP Quarterly Programme Management Report	Quarterly and Annually
	Coverage indicator 2:	Percentage of patients diagnosed in the district who are placed on DOTS	RNTCP Quarterly Programme Management Report	Quarterly and Annually
	Coverage indicator 3:	% of NSP cases registered under DOTS successfully treated	RNTCP Quarterly Treatment Outcome Report	Quarterly and Annually
	Service delivery area 5:	Control of drug resistance		
			Data source	**Frequency of data collection**
	Coverage indicator 1:	% of new smear-positive PTB cases registered under RNCTP who fail treatment	RNTCP Quarterly Treatment Outcome Report	Quarterly and Annually
	Coverage indicator 2:	% of new smear-positive PTB cases registered under RNCTP who default from treatment	RNTCP Quarterly Treatment Outcome Report	Quarterly and Annually
	Coverage indicator 3:	State representative drug resistance surveys	Survey Report	Once during project period
	Coverage indicator 4:	DOTS Plus sites	Pilot site reports	Quarterly and Annual
	Service delivery area 6:	Systematic monitoring of performance in case management		
			Data source	**Frequency of data collection**
	Coverage indicator 1:	% of TB Units with staff in post as per RNTCP guidelines 1.a STS 1.b STLS	RNTCP Quarterly Programme Management Report	Quarterly and Annually
	Coverage indicator 2:	% of reporting units that submit reports on time	RNTCP Quarterly Reports	Quarterly and Annually
	Coverage indicator 3:	% of NSP patients registered under RNTCP who die whilst on treatment	RNTCP Quarterly Treatment Outcome Report	Quarterly and Annually
	Service delivery area 7:	Health systems strengthening		
			Data source	**Frequency of data collection**
	Coverage indicator 1:	% of State TB Cell staff in post as per RNTCP guidelines	RNTCP Quarterly Programme Management Report	Quarterly and Annually

	Coverage indicator 2:	% of districts with all key RNTCP staff in place	RNTCP Quarterly Programme Management Report	Quarterly and Annually
	Coverage indicator 3:	% expenditure from the State level of the released budget	RNTCP Quarterly Statement of Expenditure Report	Quarterly and Annually
	Coverage indicator 4:	% of districts reporting electronically to Centre	RNTCP Quarterly Reports	Quarterly and Annually

Table 4.6B- M&E Table

Goal:	Overall goal of the RNTCP is to reduce the mortality and morbidity due to TB, and cut transmission of TB until TB ceases to be a significant public health problem in India. The project seeks to maintain and improve sustainable RNTCP technical, managerial and organizational infrastructure in the states of Andhra Pradesh and Orissa in order to maintain the achieved ≥85% treatment success and ≥70% detection of new smear positive pulmonary TB cases and thus contribute to the overall national goal of RNTCP.			
Objective 2:	Increase the accessibility of RNTCP services in the states of Andhra Pradesh and Orissa by inter-sectoral collaboration with other sectors outside of public health facilities such as private sector, NGO sector, etc.			
	Service delivery area 1:	Co-ordination and partnership development (national, community, public-private)		
			Data source	**Frequency of data collection**
	Coverage indicator 1:	% of NGO or Private health facilities participating in RNTCP	RNTCP Quarterly Programme Management Report	Quarterly and Annually
	Coverage indicator 2:	% of total DOT providers from NGOs or Private sector	RNTCP Quarterly Programme Management Report	Quarterly and Annually
	Coverage indicator 3:	% contribution of non-public health facilities to case detection rate	RNTCP Quarterly Case Finding Report	Quarterly and Annually
	Coverage indicator 4:	% of NSP cases registered under DOTS with non-public health facilities successfully treated	RNTCP Quarterly Treatment Outcome Report	Quarterly and Annually

The Global Fund encourages the development of nationally owned monitoring and evaluation plans and M&E systems, and the use of these systems to report on grant program results. By answering the questions below, applicants should clarify how and in what way the M&E plan for the grant application relates to existing data collection efforts, and summarize any capacity development needs, to enable applicants to carry out the M&E plan described in Table 7.

4.6.1 Describe how the plan complements or contributes towards existing efforts to strengthen M&E plans and/or relevant health information systems.

The existing reporting system under RNTCP is a quarterly reporting system from TB Unit level (approximately covering 500,000 population) to District level to State and Central level. The reporting proformae have been developed based on experience of GoI. Reports submitted include case finding, smear conversion rates, treatment outcomes, logistics and programme management, and financial reports detailing statement of expenditure etc. Detailed feedback on programme activities

and achievements to each district are given by the State level, supplemented by additional feedback from the central level, by a fixed date of each quarter. A quarterly and annual programme performance report is published by the programme, and widely disseminated to programme officers and in the public domain.

Via an on-going electronic connectivity project, over 90% of districts are now reporting electronically which enhances the timely progress of data analyses, feedback and decision-making on achievements.

Through GFATM support the existing M&E systems will be strengthened through training of staff, supervision of activities, and continuation and development of the existing programme MIS. As highlighted by the recent Joint Monitoring Mission of the RNTCP, it is crucial firstly that the present staffing at all levels be met as per the programme guidelines, and as recommended by the Monitoring Mission, increased at the Central and State levels. The Monitoring Mission highlighted that if strengthening of the human resource capacity of the programme is not undertaken, which would especially jeopardize the supervisory and monitoring activities of the programme, the future success of the RNTPC is at risk.[8] It is important also that the programme develops a plan for future human resource development.

4.6.2 Describe any capacity building that might be required to implement the M&E plan.

[2–3 paragraphs)]

Development of the existing HMIS will be needed to capture new areas of data such as contribution of other sectors to case detection, data on TB/HIV activities etc. Existing pilot projects which are on-going in other states of India at present will inform the developments required to capture the needed data. Refresher training of staff will be required on any future developments in the HMIS.

NTI and TRC have long experience in conducting ARTI, DRS and field level operational research.

Recruitment and training of field staff to undertake the ARTI study will be required. There will be a need for development of HMIS system for the proposed DOTS pilot projects, and training of staff involved will be required and production of required records and reports.

4.7 Procurement and Supply Management

[In this section, applicants should describe their arrangements for procurement and supply management of health products, integral to this component's proposed disease interventions, including pharmaceutical products, diagnostic technologies and other supplies related to the use of medicines, bednets, insecticides, aerial sprays against mosquitoes, other products for prevention (e.g., condoms), laboratory equipment and support products (e.g., microscopes and reagents).
When completing this section, applicants should refer to the Guidelines for Proposals section V.B.5.]

4.7.1 Will procurement and supply management of health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of health products?

☒ PR only
☐ Sub-recipients only
☐ Both

4.7.2 Approach to procurement of health products

[Which of the following types of organizations will be involved in the procurement of health products. Check all that apply:

☐ National medical stores, national tender board or equivalent
☒ Sub-contracted procurement organization(s) (national) (To be decided by competitive bidding)
☒ Sub-contracted procurement organization(s) (international) (specify which one[s])
☒ Other (State and Districts would be involved in procurements)
[If more than one of these is checked, describe the relationships between these entities (1 paragraph)]

There is no relationship between the above entities, as the sub-contracted procurement organization is contracted at the National level for procurement of good to be supplied at various levels, whereas the State and districts would be involved in procurement of procurement of goods for their own use.

4.7.3 Approach to supply management of health products

[Which of the following types of organizations will be involved in the supply management of health products:

☒ National medical stores or equivalent
☒ Sub-contracted procurement organization(s) (national) (to be decided by competitive bidding)
☐ Sub-contracted procurement organization(s) (international) (specify which one[s])
☐ Other (specify)
[If more than one of these is checked, describe the relationships between these entities (1 paragraph)]

4.7.4 Describe the capacity that exists to ensure compliance with the Global Fund's policies in each of the following areas, and any capacity building and/or technical assistance needs (1 paragraph per topic):

Procurement systems – Procurements are done as per World Bank guidelines. Items to be procured are categorized based on the value of the procurement as for ICB or for National Shopping. In general the procurement process is based on a two-bid system, which first involves a technical pre-qualification of the supplier followed by a financial analysis (compare product prices). An independent procurement agent is selected by ICB through a fair selection process conducted by the Ministry of Health and Family Welfare. ICB is carried out at central level and items procured through ICB are drugs and Microscopes. All other procurements are done

by National Shopping and include office equipment, vehicles, laboratory consumables, printing, IEC etc.

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

For hiring of personnel, terms of references, duly approved by the World Bank have been developed and used for recruitment of various staff. Initial appointment to all posts is usually for a maximum period of one year at a time and renewable for one year subject to satisfactory performance. The posts are advertised, by the State/ District society or the concerned agency, in at least two leading newspapers published in the state. Applications, if required, are short-listed on the basis of pre-determined criteria subject to fulfillment of eligibility criteria. A Selection committee is constituted for short-listing and interview of the candidates. A suitable number of candidates in the panel are kept on a waiting list. In the offer of appointment it is specifically mentioned that the appointment will be purely on contractual basis.

Quality assurance and quality control – The Director Controller General of India is the authority dealing with issues related to quality control of the country. A pre-delivery testing by the manufacturer of all drugs being procured is included in the terms of contract for procurement. Besides this, within the RNTCP, an independent testing lab has been contracted to carry out drug testing at the field level. Districts to be checked for quality are sampled and thereafter the drug samples are collected and sent to the laboratory. After testing the reports are sent by the lab to Central TB Division.

National laws and international agreements – All TB drugs being procured in India are free from patenting. They are also included in the national Essential Drugs List.

Distribution and inventory management – The drugs are supplied to the districts by the GMSDs (Government Medical Stores Depots) situated in various parts of the country. All districts have TB drug stores. Monitoring of drug supplies with regard to the requirement & consumption is done through a two-tier monitoring system - a central system at Central TB Division (CTD) and a decentralised system by the State TB Officers (STOs) & the District TB Officers (DTOs). CTD reviews and ensures State & district- level drug adequacy whereas the STOs & the DTOS do the same to the level of the DOT Centre. CTD ensures drug adequacy at districts by way of Quarterly Programme Management Reports (QPMR) received by the districts which is able to continuously monitor drug stock position including verification of Reports giving details of patients put on treatment during the quarter, quantities consumed, stock received during the quarter, closing stock and requirement of the district.

A buffer stock level of 3 months at each district is maintained on a national level which is achieved by a system of projections of future utilization and supply needs of the districts. Moreover, drug stock supplies at each GMSD & SDS is also monitored through a system of receipt of monthly statements from them giving details of quantities issued during the month, stock in hand and expiry details of the stocks.

Appropriate use – TB drugs in India are supplied in Patient-wise Boxes, wherein the required amount of drugs as per the regimen are provided in a single box for a patient. The patient-wise box facilitates ensuring proper intake of drugs in

adequate dosages by any given patient. In the TB drug stores principles of FIFO and FEFO are used to ensure proper utilization.

4.7.5 Drug donation programs

[Specify participation in any donation programs that are currently supplying health products (or which have been applied for) including the Global TB Drug Facility and drug donation programs by pharmaceutical companies, multilateral agencies, and NGOs relevant to this application (1 paragraph).]

The Global TB Drug Facility is providing grant assistance in the form of anti-TB drugs to RNTCP in Orissa. This assistance is committed up to Dec 2005.

[For tuberculosis and HIV/TB components only:]

4.7.6 Does the proposal request funding for the treatment of multi-drug resistant TB?

☒ Yes
☐ No

[If yes, be aware that all procurement of medicines to treat multi-drug resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee of the Stop TB Partnership. For a Green Light Committee application form see Annex C.]

5. Component Budget Section

[Please remember that this section is to be completed for each component. Throughout "year" refers to the year of proposal implementation. For example, if Table 4.1.1 indicates that the proposal starts in June, year 1 would cover the period from June to the following May.]

5.1 Full and detailed Budget as an attachment to the Proposal Form

[By way of supporting information for the Summary Budget in Table 5.2, a detailed budget should be provided as an attachment to the Proposal Form. It should reflect and be consistent with the broad budget categories mentioned in Table 5.2 and preferably also reflect the activities of the component. The detailed budget should include assumptions and formulas used to estimate major budget items. It should cover the first and second year of the Proposal and in respect of the first year may be broken down by quarters.]

[*Please note that a detailed one-year action plan and an indicative action plan for the second year need to be provided with the detailed budget.*]

5.2 Budget Summary

[In Table 5.2, summarize the funds requested from the Global Fund. The budget should be by year and budget category. The budget categories are explained below:]

Human Resources: *Salaries, wages and related costs (pensions, incentives and other employee benefits, etc.) relating to <u>all</u> staff (including field personnel), consultants (excluding short term consultants included under categories below) and staff recruitment costs*
Infrastructure and Equipment: *Information Technology (IT) and building infrastructure, office equipment, audio visual equipment, vehicles, and related maintenance and repair costs, etc.*
Training: *Workshops, meetings, training publications, training-related travel, etc. Do not include training-related human resources costs which should be included under the Human Resources category above.*
Commodities and Products: *Bednets, condoms, diagnostics, microscopes, syringes, etc.*
Drugs: *Antiretroviral therapy, drugs for opportunistic infections, TB drugs, anti-malarial drugs, etc.*
Planning and Administration: *This category includes;*

(a) *Short term technical consulting costs, travel, field visits and other costs relating to program planning, supervision and administration (including in respect of managing sub-recipient relationships, monitoring and evaluation, and procurement and supply management).*
(b) *Overhead costs such as office rent, utilities, internal communication costs, insurance, legal, accounting and auditing costs, etc*
(c) *Printed material and communication costs associated with program related campaigns, etc.*

In relation to (a), (b) and (c) do not include human resources costs which should be included under the Human Resources category above
Other: *Costs that do not fall within above categories – please specify*

Table 5.2a –Fund Request from the Global Fund

	Funds requested from The Global Fund (in USD Million)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human Resources	0.000	1.319	1.319	1.319	1.319	5.276
Infrastructure & Equipment	0.000	0.426	0.264	0.281	0.257	1.228
Training	0.000	0.223	0.188	0.188	0.188	0.787
Commodities & Products	0.075	0.347	0.282	0.282	0.266	1.252
Drugs	0.000	1.296	1.511	1.680	1.766	6.253
Planning & Administration	0.425	2.795	2.755	2.798	3.063	11.836
Total	**0.500**	**6.406**	**6.319**	**6.548**	**6.859**	**26.632**

As the two states are fully covered under RNTCP, all investment costs such as upgrading of health infrastructures, supply of binocular microscopes etc, have already been incurred. Also due to the international competitive bidding process used by the RNTCP, and the worldwide decrease in the cost of anti-TB drugs, overall costs of first-line drugs have fallen within the programme. Due to these two factors, high proportion of budget request falls under recurring costs for HR and Planning & Administration. The break-up of expenditure under Planning and Administration is as under:

- IEC (Publicity) US$ 0.649 million
- NGO/PP support US$ 2.580 million
- Printing US$ 1.257 million
- Research & studies US$ 0.926 million
- Vehicle hiring US$ 1.444 million
- Supervision & Monitoring US$ 3.432 million
- Office operation US$ 1.548 million

Total US$ 11.836 million

5.3 Funds requested for functional areas

[Provide the budgets for each of the following three functional areas. In each case, these costs should have already been included in Table 5.2, so the below tables should be subsets of the budget in Table 5.2, not additional to it. For example, the costs for monitoring and evaluation will be included in various of the line items above (e.g., Human Resources, Infrastructure and Equipment, Training, etc.).]

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

Table 5.3a – Costs for monitoring and evaluation

	Funds requested from the Global Fund for monitoring and evaluation (in USD Million)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Monitoring and evaluation	0.425	1.789	1.621	1.664	1.929	**7.428**

Includes cost of baseline and follow up surveys (ARTI and mortality), and DRS surveys. Also included are the routine supervisory and monitoring activity costs.

Procurement and supply management:
[This includes: consultant and human resources costs (including any technical assistance required for the development of the Procurement Plan), warehouse and office facilities, transportation and other logistics requirements, legal expertise, costs for quality assurance including laboratory testing of samples, and any other costs associated getting sufficient health products of assured quality, procured at the lowest price and in accordance with national laws and international agreements to the end user in a reliable and timely fashion; do not include drug costs].

Table 5.3b – Costs for procurement and supply management

	Funds requested from the Global Fund for procurement and supply management (in USD)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Procurement and supply management	**NOT APPLICABLE**					

All large procurements are handled from the centre, therefore the costs for procurement and supply management become negligible for the two States and have therefore been excluded.

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

Table 5.3c – Costs for technical assistance

	Funds requested from the Global Fund for technical assistance (in USD)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Technical assistance	**NOT APPLICABLE**					

No funds will be needed from the Global Fund for technical assistance as various partners/ Donors to the government provide technical assistance at their own costs.

5.4 Partner Allocations

[Indicate in table 5.4 below how the requested resources in Table 5.2a will, in percentage terms, be allocated amongst the implementing partners:

Table 5.4 – Partner Allocations

		Fund allocation to implementing partners (in %)				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Academic/educational sector						
Government	100%	90%	90%	90%	91%	**90%**
Non-governmental/ Community-Based Org.		10%	10%	10%	9%	**10%**
People living with HIV/AIDS, tuberculosis, and/or malaria						
Private sector						
Religious/faith-based organizations						
Multi-/bilateral development partners						
Others (please specify)						
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

[If there is only one partner, please explain why (1 paragraph).]

5.5 Key Budget Assumptions for Requests from the Global Fund

5.5.1 Specify in the tables below the Drugs and Commodities & Products unit costs, volumes and total costs, for the FIRST AND SECOND YEARS ONLY.

*[Use the treatment categories that follow the tables (organized by disease). Unit prices for pharmaceutical products should be the **lowest** of: prices currently available locally; public offers from manufacturers; or price information for public information sources. (For example:* Sources and Prices of Selected Drugs and Diagnostics for People Living With HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2003 (http://www.who.int/medicines/organization/par/ipc/sources-prices.pdf); Market News Service, Pharmaceutical starting materials and essential drugs, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); International Drug Price Indicator Guide on finished products of essential drugs, Management Sciences for Health in collaboration with WHO (published annually) (http://www.msh.org); First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (http://www.stoptb.org/GDF/drugsupply/drugs.available.html*)) If prices from sources other than those specified above are used, a rationale must be included.*

Table 5.5.1.A – Drugs, Year 2

Year 2			
Treatment category	**Average cost (based on delivery duty unpaid) per person-year or treatment course (in USD)***	**Number of person-years or treatment courses procured**	**Total cost (in USD)**
Category I	6.00	76300	457,800
Category II	10.54	30800	324,739
Category III	5.30	59100	313,487
DOTS Plus	2000	50	100,000

**Average cost per treatment course has been used*

[If prices from sources other than those specified above are used, provide a rationale for using these prices]

HIV/AIDS:

- Antiretroviral therapy (prevention of mother-to-child transmission)
- Antiretroviral therapy (first-line for adult treatment)
- Antiretroviral therapy (second-line for adult treatment)
- Antiretroviral therapy (other including post-exposure prophylaxis)
- Antiretroviral therapy (first-line for pediatric treatment)
- Antiretroviral therapy (first-line for pediatric treatment)
- Prophylaxis of opportunistic infections
- Treatment of opportunistic infections (including home-based and palliative care)
- Treatment of sexually transmitted infections
- Other (please specify)

Tuberculosis:

- Anti-tuberculosis therapy (first-line) **X**
- Anti-tuberculosis therapy (second-line) **X**
- Other (please specify)

Malaria:

- Monotherapy

- Artemisinin-based combination therapy: Artemether–lumefantrine (Coartem®)
- Artemisinin-based combination therapy: other
- Combination therapy: Non-artemisinin-based
- Parental and rectal antimalarials for severe malaria
- Prevention
- Other (please specify)

[Use the commodities and products categories that follow the tables (organized by disease)]

Table 5.5.1B –Commodities & Products Year 1

Year 1				
Commodities and products categories	**Unit (e.g., one mosquito net, one gross of condoms)**	**Unit cost (in USD)**	**Quantity**	**Total cost (in USD)**
Lab Equipment for Culture sensitivity	Set	75,000	1	75,000

Table 5.5.1B –Commodities & Products Year 2

Year 2				
Commodities and products categories	**Unit (e.g., one mosquito net, one gross of condoms)**	**Unit cost (in USD)**	**Quantity**	**Total cost (in USD)**
Binocular Microscopes	Nos	217	62	13,454
Lab materials	Million population	2174	119	258,061
Lab Equipment for Culture sensitivity	Set	75,000	1	75,000

HIV/AIDS
- Condoms
- Diagnostic tests for HIV infection (e.g., rapid tests, ELISAs, etc.)
- Diagnostics: CD4+ T cell
- Diagnostics: HIV RNA (viral load)
- Diagnostics: Other
- Sterile injection equipment (e.g., syringes, etc.)
- Universal precautions supplies (e.g., syringes, etc.)
- Other (please specify)

TB
- Laboratory equipment (durable products, such as microscopes, x-ray machines, etc.)
- Laboratory supplies (non-durable products, such as slides, reagents, sputum containers, x-ray films, etc.)
- Other (please specify)

Malaria
- Mosquito nets: Insecticide Treated Nets: Factory pretreated mosquito nets
- Mosquito nets: Insecticide Treated Nets: Untreated mosquito nets
- (Re)treatment supplies
- Long lasting insecticidal mosquito nets
- Insecticides for outdoor and/or indoor spraying
- Spraying equipment
- Diagnostics: Rapid Diagnostic Tests (RDTs)
- Diagnostics: Other
- Other (please specify)

5.5.2 Justification for Drugs and Commodities and Products

[Provide the rationale (e.g., assumptions or formulas used) for the volumes of drugs and commodity/products listed in Table 5.5.1. (2–3 paragraphs)]

The volumes for drugs have been based on the population to be covered by the programme in the two states of Andhra Pradesh and Orissa. It is expected that by the start date of the current proposal the two states would be fully covered and the annualized case detection rate would in around 120 per lakh population in year 1 and 135 per lakh population in year 2. Thus it is expected that there will be 148,300 patients put on treatment in year 1 and 162,200 patients put on treatment in year 2. Of all patients treated, 46% are Category I, 18% are Category II and 36% are Category III. Therefore, the estimation of drugs has taken into account the population as well the ratio in which patients will be treated in order to arrive at the total volume required. However funding of drugs from GFTAM assistance will only start from Year 2 of the proposal.

The volumes for the different types of commodity/products have been based on the following assumptions:

Binocular Microscopes – As the both the States will be fully covered by 2005, there will be no requirement of binocular microscopes, however, as the population is growing there will a need to increase the number of microscopy centres for which additional microscopes will be needed. Therefore, the number of binocular microscopes to be procured is based on the additional increase in population by 2005.

Lab Materials – The cost of lab materials has been estimated on the number of smears which will be tested in a year by a microscopy centre. One MC covers a one lakh (hundred thousand) population and it is estimated that 2000 smears will be examined. There are one time costs which are expected to be required once every five years and are estimated at $1/5^{th}$ of their costs. Therefore, based on the above assumption the cost per million population has been estimated for the purposes of budgeting.

5.5.3 Human Resources costs

[In cases where Human Resources is an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent Human Resources spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1–2 paragraph)]

As already stated above, both the states would be fully covered by 2005, therefore the amount budgeted under human resources have taken into account the full strength of staff required to maintain the program over the next five years of the project. In the first two years of the amount budgeted under human resources will be the same.

5.5.4 Other key expenditure items

[With respect to other expenditure categories (e.g., Infrastructure and equipment) which form an important share of the budget, explain how these amounts have been budgeted for the first two years (1–2 paragraph)]

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

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