Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM
ROLLING CONTINUATION CHANNEL
(CCM AND SUB-CCM APPLICANTS)

Applicant Name	**India CCM**		
Country	**India**		
Applicant Type	**National Country Coordinating Mechanism**		
Income Level	**Low-income level**		
Disease	**Tuberculosis**		
Expiring Grant Number	**IDA-202-G03-T**	**Round**	**2**
Other same disease grants that have links to this proposal:	**IDA-405-G08-T (Round 4)** **IDA-607-G09-T (Round 6)**		

Currency	☐ USD	or	☒ EURO

Deadline for submission of proposal: **30 July 2008,**
12 noon, local Geneva time

RCC Wave 4 - Tuberculosis

INDEX OF SECTIONS AND KEY ATTACHMENTS FOR PROPOSALS **Page**

+ Attachment A: Performance Framework (Indicators and targets)

+ Attachment B: Preliminary List of Pharmaceutical and other Health Products

+ Detailed Proposal Budget: Quarterly for years 1 and 2 and annual details for years 3 to 6

+ Detailed Work plan: Quarterly for years 1 and 2 and annual details for years 3 to 6

IMPORTANT NOTE:

A number of recent Global Fund Board decisions have been reflected in the Proposal Form for the Rolling Continuation Channel. Information on these decisions is available at: http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf.

The ***Guidelines for Proposals*** *for the Rolling Continuation Channel (the 'Guidelines for Proposals')* contain the **majority of instructions** and examples to assist applicants to complete the Proposal Form. **Applicants are therefore strongly encouraged to read these *Guidelines for Proposals* fully before completing a proposal and continue to refer to them whilst completing this form.**

A checklist of all annexes to be attached to the Proposal Form is provided at the end of section 5 of this Proposal Form.

RCC Wave 4 - Tuberculosis

1.1 Proposal title

"Consolidating and scaling up of RNTCP interventions in order to move towards TB related MDGs"

1.2 Funding summary

Clarified Section 1.2

Disease	Years 1 to 2	Years 3 to 6	Total
Tuberculosis	Euro 31,897,140	Euro 116,092,650	Euro 147,989,790
HSS cross-cutting interventions **			

** *Only if this proposal requests support for health systems strengthening cross-cutting interventions in s.4B (**read the Guidelines for Proposals**). However, if the HSS support that is requested is easily included as part of the disease program strategy in s.4.6.4, do not include s.4B in this proposal.*

1.3 Contact details

	Primary contact	Secondary contact
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Title	Deputy Director General TB	Chief Medical Oficer (TB)
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1.4 List of Abbreviations and Acronyms used by the Applicant

ACSM	Advocacy, Communication and Social Mobilisation
AIDS	Acquired Immune Defi ciency Syndrome
AIIMS	All India Institute of Medical Sciences
ANSV	Annual Negative Slide Volume
ART	Anti Retroviral Therapy
ARTI	Annual Risk of Tuberculosis Infection
ASHA	Accredited Social Health Activist
CDC	Centres for Disease Control and Prevention
CGHS	Central Government Health Scheme
CHAI	Catholic Health Association of India
CHC	Community Health Centre
CII	Confederation of Indian Industries
CMAI	Christian Medical Association of India

CTD	Central TB Division
DALYs	Disability Adjusted Life Years
DANIDA	Danish International Development Assistance
DDG	Deputy Director General
DFID	Department for International Development
DGHS	Director General of Health Services
DMC	Designated Microscopy Centre
DOTS	Directly Observed Treatment Short-course
DRS	Drug Resistance Surveillance
DST	Drug Susceptibility Testing
DTC	District Tuberculosis Centre
DTCS	District TB Control Society
DTO	District Tuberculosis Offi cer
E	Ethambutol
EQA	External Quality Assessment
GMSD	Government Medical Store Depot
GoI	Government of India
HBCs	High Burden Countries
HRD	Human Resource Development
ICB	International Competitive Bidding
ICMR	Indian Council of Medical Research
ICTC	Integrated Counselling and Testing Centre
IEC	Information, Education and Communication
IMA	Indian Medical Association
IRL	Intermediate Reference Laboratories
ISTC	International Standards for Tuberculosis Care
KAP	Knowledge, Attitude and Practices
LT	Laboratory Technician
MDGs	Millennium Development Goals
MDR-TB	Multi Drug Resistant TB (resistance to at least rifampicin and isoniazid)
MIFA	Management of Information for Action
MIS	Management Information System
MMWR	Mortality and Morbidity Weekly Report
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MOTC	Medical Offi cer-Tuberculosis Control
MoU	Memorandum of Understanding
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non Governmental Organisation
NRHM	National Rural Health Mission
NRL	National Reference Laboratories
NTF	National Task Force
NTI	National Tuberculosis Institute
NTP	National Tuberculosis Programme
NUHM	National Urban Health Mission
OR	Operational Research
OSE	On-site Evaluation

PHC	Primary Health Centre
PP	Private Practitioner
PPM	Public-Private Mix
PSU	Public Sector Units
PTB	Pulmonary Tuberculosis
PWB	Patient-wise Box
QA	Quality Assurance
R	Rifampicin
RBRC	Random Blinded Re-Checking
RNTCP	Revised National Tuberculosis Control Programme
SCC	Short Course Chemotherapy
SDS	State Drug Stores
SPR	Slide Positivity Rate
STC	State TB Cell
STDC	State Tuberculosis Training & Demonstration Centre
STF	State Task Force
STLS	Senior TB Laboratory Supervisor
STO	State TB Offi cer
STS	Senior Treatment Supervisor
TB	Tuberculosis
TBCTA	Tuberculosis Coalition for Technical Assistance
TRC	Tuberculosis Research Centre
TU	Tuberculosis Unit
UHC	Urban Health Centre
USAID	United States Agency for International Development
USHA	Urban Social Health Activist
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant TB
Z	Pyrazinamide
ZTF	Zonal Task Force

Note to applicants:
CCM applicants: Complete sections 2.1 and 2.2 and DELETE section 2.3.
Sub-CCM applicants: Complete all of sections 2.1 to 2.3.

2.1 Members and operations

2.1.1 Membership summary

	Sector Representation	Number of members
☒	Academic/educational sector	5
☒	Government	13
☒	Non-government organizations (NGOs)/community-based organizations	5
☒	People living with the diseases	1
☐	People representing key affected populations ** [1]	
☒	Private sector	2
☐	Faith-based organizations	
☒	Multilateral and bilateral development partners in country	7
☐	Other *(please specify):*	
	Total Number of Members: *(Number must equal number of members in 'Attachment C')*	33

2.1.2 Member knowledge and experience in cross-cutting issues

Health Systems Strengthening	
The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the applicant.	
(a)	Describe the capacity and experience of the applicant to consider how health system issues impact programs and outcomes for the three diseases.
The India-CCM includes representation from each of the GFATM defined constituencies - the Government, non-governmental organisation (NGO)s, academia and research organisations, the private sector, people living with the disease, as well as multilateral and bilateral agencies. All the members hold senior management positions, representing their constituencies with the appropriate expertise, experience and authority to manage directly, or influence decisions on health systems. The Chair of the India-CCM is the Secretary, Ministry of Health and Family Welfare of the Government of India, a ministry that is directly responsible for policy formulation and oversight of all national health	

[1] The recommendation to include representation of ***key affected populations*** arose from changes introduced at the 16th Board meeting. The Global Fund adopts the UNAIDS definition as follows: *women and girls, youth, men who have sex with men, injecting drug users, sex workers, people living in poverty, prisoners, migrants and migrant laborers, people in conflict and post-conflict situations, refugees and displaced persons.*

programmes in the country, including the National AIDS Control Programme (NACP).

The members' diverse experience in public health as well as in other sub-sectors such as health systems financing, health administration, health economics, tuberculosis, leprosy, and malaria, etc., operational experience with government and non-government systems at the grassroots, design and implementation levels and representation from the private sector bring valuable understanding to address constraints in the health system and know-how of public and private 'system linkages' respectively. This experience has been brought to bear upon this proposal.

Gender awareness

The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in:

- methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and
- the factors that make women and girls and sexual minorities vulnerable.

(b) Describe the capacity and experience of the applicant in gender issues including the number of members with requisite knowledge and skills.

Members of the CCM, all of whom are senior level officials/directors/managers with extensive experience of managing and guiding large-scale programmes and policy directives in the area of public health, social and human development have years of accumulated experience in working with monitoring and evaluation frameworks that describe and analyse gender differentials. Drawing upon the important mandate for gender and equity as provided in the global guideline of the GFATM for the CCMs, all the 33 members of the India-CCM represent diverse constituencies, all of which have social inclusion, gender and equity enshrined in their organizational mandate. Most of the organizations represented in the India-CCM state in their purpose and mission statements that women, girls and other marginalized sections of the society are priority target groups. They possess the requisite knowledge and skills to ensure that cross-cutting issues concerning gender and equality are addressed in the overall framework of the RCC proposal.

Within the public sector, the Ministry of Women and Child Development is one of the India-CCM members. In addition, the private sector member is a keen observer of gender differentials and inequities. Recently, a strong pan India HV network (Solidarity and Action Against The HIV Infection in India, SAATHI) is a designated member of the India-CCM. Keeping in mind that this RCC application proposes strengthening of prevention of HIV among women, and from mothers to their children, and with the pooling of the tremendous individual and institutional expertise of all the India-CCM members as policy makers, programme managers, civil society leaders and technical experts, it is ensured that gender issues and concerns have been squarely addressed.

Multi-sectoral planning

The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.

(c) Describe the capacity and experience of the applicant in multi-sectoral program design.

The applicant has excellent demonstrated capacity and experience in multi-sectoral programme design. The India-CCM is a multi-sectoral partnership at the highest level, representing both the public and the private sectors, including government agencies, NGOs, people living with and affected by HIV, bilateral and multilateral development agencies and academic institutions. The India-CCM comprises of representatives from:

a. The Ministry of Health and Family Welfare
b. The Ministry of Finance
c. The Ministry of Defence
d. The Department of Women and Child Welfare
e. State level representatives from their respective State Departments of Health

f. Person living with the disease
g. NGO representatives
h. Private sector representatives
i. Academic/ education sector representatives
j. Multilateral and bilateral representatives

India has five-year national strategic planning processes for all three disesases, that involves a multitude of stakeholders under the leadership of the programme divisions. The stakeholders include central ministries and state level programme implementation departments, academic and research institutions, technical agencies, UN agencies, bilateral development partners, people affected by the disease, civil society sector as well as the private sector. Many of the India-CCM members have been an integral part of the strategic planning processes. In particular, several members are not only participants in the National AIDS Council (a multi-sectoral advisory body headed by the Prime Minister) but have been architects of the development planning in the country through their contributions to the Five Year Plans.

The India-CCM representatives from these different organizations ensure a multi-sectoral approach in enshrining the cross-cutting topics of gender and planning in the India-CCM working modalities. These members also bring to the India-CCM their specific agenda of addressing the thematic gaps and weaknesses within their sectors and ensure an effective liaison between the various sectors in the country context.

2.2 Eligibility

2.2.1 Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.	
☒ Applied for funding in Round 6 and/or Round 7 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of s.2.2.2 to s.2.2.8 below***
☐ Last time applied for funding was before Round 6 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***Complete 2.2.3-2.2.8 below and also complete 'Annex 1' to this Proposal Form.***

2.2.2 Broad and inclusive membership

Since the last time you applied to the Global Fund and were determined compliant with the minimum requirements:			
(a)	Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and	☐ No	☒ Yes
(b)	Is there continuing active membership of people living with and/or affected by the diseases.	☐ No	☒ Yes
If there are significant changes to these processes, or 'no' applies to either situation, the CCM (or Sub-CCM) should complete all of the questions in Annex 1 to this Proposal Form in addition to sections 2.2.3 to 2.2.8 below.			

2.2.3 Processes to select Principal Recipients for program implementation during the Rolling Continuation Channel term

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation.

➔ *Refer to the **Guidelines for Proposals** for further explanation of this recommendation.*

(a)	Describe the process used to transparently select each of the Principal Recipient(s) nominated in this proposal.	
	Central TB Division, Ministry of Health and Family Welfare was invited by GFTAM to submit a proposal following the successful implementation of the TB Round 2 proposal. In order to continue with the similar arrangements of Round 2, the Department of Economic Affairs, Government of India (represented by the CTD), was accordingly proposed as the PR by CCM, to submit a proposal to expand the scale of the proposal, in continuation with the objectives of Round 2.	
(b)	**Attach** the signed and dated minutes of the meeting(s) at which the CCM (or Sub-CCM) decided on the Principal Recipient(s) for this proposal.	***Annex 2.I— Minutes of the 28th CCM meeting***

2.2.4 Principal Recipients

Name	Sector **
Department of Economic Affairs(DEA) of the Ministry of Finance, GOI	Government
(Use "Tab" button on key board to add extra rows if required)	

*** Identify the 'sector' from the list of sectors that are provided in the table in section 2.1.1 above.*

2.2.5 Non implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for program implementation in this proposal. *(Note: if the same Princpal Recipient is selected as the expiring grant, provide a detailed explanation of the country's own assessment of performance, and critieria for that selection [that is, not relying only on Global Fund 'Grant Performance Report' materials]).*

The request for RCC proposal for supporting TB control activities in India, is against the expiring Global Fund proposal (Rd 2) covering 56 districts in the states of Bihar and Uttar Pradesh. It is also proposed to consolidate other existing GFATM TB grants in India (under Rd 4 and Rd 6) and expand RNTCP services in the state of Haryana. For the current RCC proposal, it is submitted to continue with the similar arrangements of the Government of India as the single PR, and the implementing States (Govt) as SRs. In addition, the Indian Medical Association (IMA) under Rd 6 and Catholic Bishop Conference of India (CBCI) under Rd 4, are being proposed to continue as SRs under the RCC project.

Respecting the Global Fund policy of dual track financing, due consideration was given to the nomination of additional PRs under the project. However, after wide-ranging deliberations, the existing arrangement under earlier rounds is being recommended for the following reasons:

- The invitation for RCC proposal partly overlapped the period of preperation of the Rd 8 proposal submission. Over the last 12-18 months, a civil society movement had gathered pace to support the public health efforts towards the fight against TB, Malaria and HIV/AIDS. Realizing the potential of concerted efforts, the varying strengths and capacities of civil society organisations, and their significant regional presence, these organizations have successfully formed a coalition/consortium with the broader objective of supporting the national programme in realizing the MDGs related to TB

control. The Round 8 application, which has been submitted by the civil society partners only, has been approved by CCM and submitted to the Global Fund.

- The NGO partners from earlier TB projects have also joined the coalition movement, and have submitted a combined proposal under the Global Fund Rd 8 announcement. The national programme strongly supports and encourages such initiatives, as it pulls in resources and also provides greater geographical coverage.
- Given the fact that the Rd 8 application process (call for proposals) was initiated before the RCC invitation was received, and civil society partners were already putting up a detailed proposal under Rd 8, no additional request for proposals (to nominate additional PRs) was made for the RCC project. However the Sub recipients in Round 6 (IMA) and Round 4 (CBCI) were persuaded to submit a proposal as PR, but they decided to participate as SRs for the RCC proposal. Since the CCM had just undertaken the entire process of selecting two civil society PRs for submission of the Round 8 proposal for TB, it was decided to submit the RCC proposal with the existing PR and SRs.

2.2.6 Transparent proposal development processes

Scale up *and* ***scope change*** *are desribed in the Guidelines for Proposals in detail. Applicants are encouraged to refer to this material before making decisions about the proposal development process.*

A	**If this proposal <u>continues/scales-up the interventions</u> from the expiring grant, describe in detail the transparent process used by the CCM (or Sub-CCM) to ensure that:**	
(a)	a broad group of stakeholders (including CCM, or Sub-CCM, members and non-members) were involved in evaluating the appropriateness of continuing the interventions; and	
(b)	the decision to continue relevant interventions was made after discussion among the stakeholders consulted.	
The India CCM reviewed the invitation from Global Fund to submit a proposal to extend the expiring Round 2 TB grant through the Rolling Continuation Channel (RCC) and a presentation was made by CTD to substantiate the basis of the request. Based on the performance of the Round 2 grant in the previous quarters and keeping in mind the observations included in the feedback given by the Global fund, the CCM agreed that CTD should develop a proposal to scale up the interventions of Round 2 and ensure alignment with other GFATM grants. The design of the RCC proposal was developed through an iterative consultative process (May 08 – July 08) with the basic services and care and support divisions of NACO, Tuberculosis (TB) and Reproductive and Child Health (RCH) programme of the National Rural Health Mission, and technical experts from NGO, academia and the WHO. The process of proposed implementation and the expected coverage was also discussed with the State TB programme personnel as well as the civil society Sub Recipients of the PPM projects in Round 4 and 6. Thus, a proposal was developed for the RCC application which was discussed with all stake holders and then shared with the CCM members . The proposal was then presented before the CCM on 18th July 2008, and after detailed deliberations, the CCM recommended the proposal for submission to the Global Fund with the recommendation to continue the similar arrangements of Round 2, ie the Government of India as the single PR, and the implementing States (Govt) as SRs. In addition, the Indian Medical Association (IMA) under Rd 6 and Catholic Bishop Conference of India (CBCI) under Rd 4, would continue as SRs under the RCC project.		
(c)	**Attach** documents that show the transparent, broadly inclusive proceses used to decide whether to continue (and if so, most probably, scale-up) some or all of the interventions from the expiring grant.	***[Insert Annex Number]***

And/or:

B	**If this proposal proposes a scope change/<u>new interventions</u>** (or does not continue some of the existing interventions), describe the transparent processes that the CCM or Sub-CCM followed to ensure that:	
(a)	a broad group of stakeholders (including CCM, or Sub-CCM members and non-members) were involved in an open and inclusive process to solicit submissions and review these for possible integration into this proposal; and	
(b)	the decision of whether to include new interventions was made after these submissions were received, transparently evaluated and discussed by the CCM (or Sub-CCM).	
The proposal is being submitted with scaling up on existing interventions with suitable modifications based on internationally accepted recommendations , and revised national policies. No scope change or new interventions are being proposed.		
(c)	**Attach** documents that show the transparent, broadly inclusive proceses used to decide which new interventions to include in the proposal to expand the activities of the expiring grant (or replace some of them).	***Not applicable***

2.2.7 Managing conflicts of interest

(a)	Are the Chair **and/or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as <u>any</u> of the nominated Principal Recipient(s) in this proposal?	☐ Yes ☒ No ➔*go to section 2.2.8*
(b)	**If yes, attach** the plan for the management of actual and potential conflicts of interest.	***[Insert Annex Number]***

2.2.8 Proposal endorsement by members

Attachment C – Membership information and Signatures	**Has '<u>Attachment C</u>'** been completed with the numbers of all members of the CCM (or Sub-CCM)	☒ Yes

2.3 Sub-CCMs

2.3.1 CCM Endorsement

(a)	**Attach** the signed and dated minutes of the **CCM meeting** at which the CCM agreed to endorse the Sub-CCM proposal.	***[Insert Annex Number]***
(b)	**Attach** a letter from the CCM Chair or Vice-Chair with the minutes.	***[Insert Annex Number]***

3.1 Duration of proposal

Please fill in the proposal term start date based on the former grant's expected expiration date.

	Planned start date	**To**
Month and year: *(up to 6 years)*	1 April 2009	31 March 2015

3.2 Consolidation of grants

(a)	Does the CCM (or Sub-CCM) wish to consolidate any existing same disease Global Fund grant(s) with part or all of this Rolling Continuation Channel proposal?	☒ Yes *(go first to (b) below)* ☐ No *(go to 3.3 below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the RCC proposal.*

(b)	If yes, which grants? *(List the relevant grant number(s))*	GFATM Rd 2 – IDA-202-G03-T-00 GFATM Rd 4 – IDA-405-G08-T GFATM Rd 6 – IDA-607-609-T

3.3 Alignment of planning and fiscal cycles

Describe how the start date:

(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or

(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.

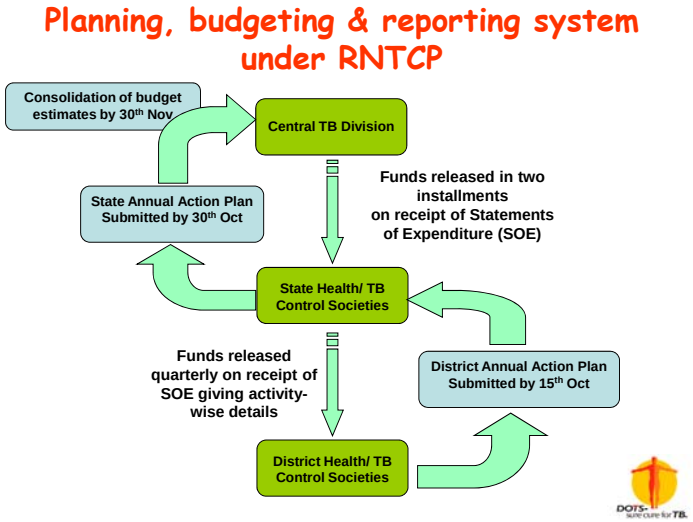
The fiscal year (financial year/ budget year) used for calculating annual ("yearly") financial statements by the Central and State governments in India is for the twelve month period from 1st April to 31st March. All national/state planning and budgeting is aligned with the above defined budgeting/fiscal year.

Health planning in India is an integral part of the national socio-economic planning through its five-year plans, developed, executed and monitored by the Planning Commission (11th five year plan – 2007-12). The National TB Programme Office (Central TB Division) undertakes strategic planning and budgeting for TB control activities in the country in consultation with the States. Based on the approved plan, the Government of India (GoI) makes allocations for TB Control under five-year plans. These amounts allocated for each year are made available to the Central TB Division through the Demand for Grants of the Ministry of Health and Family Welfare.

The Revised National TB Control Programme (RNTCP), based on the internationally recommended STOP-TB Strategy, is implemented in all states and union territories of India as a Centrally Sponsored

Scheme (CSS). The Central Government, through policy guidelines as well as through the provision of funds under centrally supported schemes (CSS), plays a catalytic role in aligning the States' health programmes to meet certain national health goals. These additional funds provided under CSS are a useful supplement to the state government resources and enable them to pursue the implementation of the various programmes and schemes which are key to the attainment of national health goals and also the Milleneum Development Goals.

The planning and budgeting system has been decentralized to the state and district level under the programme guidelines. The States submit their annual action plan for (which in turn is based on the consolidation of district action plans) in the month of October to the Central TB Division (CTD), wherein the State plans and seeks funding for all the activities for TB control planned for the next financial year (next April to March period). These annual action plans form part of the NRHM State Action Plan and are approved by the Ministry of Health. Based on the annual action plan, the previous trends in expenditure and the unutilized funds available with the state as a whole, the Finance Division of the Ministry of Health and Family Welfare makes bi-annual fund disbursements (April-May & Oct-Nov) to each State, after the approval of the Department of Health and Integrated Finance Division of the Ministry.



Thus, the proposed start date (on 1st April 2009) is in line with the national planning and budgeting cycle. This alignment, further facilitates timely administrative approval for release of grants to the states (sub-recepients) and other sub-recepients. In addition, the expiring grant against which the current RCC proposal is being submitted (GFATM Rd 2 – IDA-202-G03-T-00) is due for March 09, and ensures continuity of committed funding in the project states/districts. The other existing grants (Rd 4 – IDA-405-G08-T: 1 Aprl 05 – March 2010 & Rd 6 – IDA-607-609-T: 1 Aprl 07 – March 12) which are being proposed for grant consolidation under the current RCC are also in line with the national planning and fiscal cycle.

The process of consolidation besides aligning the planning and budgeting cycle, would also substantially reduce the duplication of efforts towards preparation of project performance and financial reports for the different grant proposals.

3.4 Program-based approach?

3.4.1	Does planning and funding for the country's response to the disease occur through a program-based approach?	☒ Yes ➔ Answer s.3.4.2 ☐ No ➔ Go to s.3.5
3.4.2	If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that	☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism AND provide information at the level of the common funding mechanism in s.4 as appropriate.***

approach?	☒ No ➔ Go to s.3.5

3.5 Summary of Rolling Continuation Channel proposal

Provide a summary of the proposal described in detail in section 4.

Prepare after competing s.4.

"Consolidating and scaling up of RNTCP interventions in order to move towards TB related MDGs"

India is the largest TB burden country in the world accounting for nearly one-fifth of the global incidence. With an estimated 1.8 million new TB cases occurring annually, and over 325,000 TB death occurring annually, TB control continues to be a major public health challenge in the country. Although the prevalence of MDR-TB (3% in new cases and 13-17% in retreatment cases) and TB/HIV co-infections (0.36% of adult population) are low, when translated into numbers they are significant and pose a serious challenge to TB epidemiology unless effectively managed.

The Revised National TB Control Programme (RNTCP) based on the internationally recommended DOTS strategy, has been implemented in a phased manner across the country since 1997 and complete nation wide covered was achieved in March 2006, with allocations from the national health budget, includit credit from World Bank, and support from Global Fund (Rd 1, 2, 4 and 6), DFID, USAID and DANIDA. Over the years, the programme has evolved, and currently implementing most of the components of the new Stop TB strategy, including services for the management of MDR-TB, TB-HIV co-infection and innovative schemes for the involvement of all care providers. In the year 2007, over 1.45 million TB patients were initiated on treatment and the programme achieved the global bench mark of 70% case detection rate and treatment success rate was over 85%. Sub-district level epidemiological surveys have indicated a decline in incidence rates by 6-11% annually.

However, wide inter-state and inter-district variations have been observed, due to challenges within the health system (infrastructure and human resource gap, sub-optimal programmatic capacity, etc) and the relative dominance of the private sector (80% of national health expenditure is out of pocket expenditure - 4.2% GDP) in such settings. It is crticial to address these challenges to be able to realize the national goal of TB control and the project goal "***To reduce the burden (morbidity and mortality) of TB in India by 2015, in line with the Millennium Development Goals, and eliminate TB as a public health problem in the country by 2050***".

The current RCC project proposal seeks to extend GFATM support till 2014-15 to the 125 million population (projected 2008) of Bihar and Uttar Pradesh (expiring Rd 2 – IDA-202-G03-T grant proposal) It is also proposed to scale up RNTCP services to cover 52 million additional population and consolidate other global fund grants (Rd 4 and Rd 6 covering 185 million population) under the current project. The proposed scale up to 8 remaining districts of Bihar (28 million) is to streamline funding at state level and simplify programme management and reporting; and to extend support to the state of Haryana (24 million), subsequent to the gap created due to reprogramming of USAID funds from DOTS implementation in Haryana to increased technical assistance to RNTCP. Thus, this RCC proposal will cover a population of 362 million in 8 states of India. In addition, the Catholic Bishops Conference of India's PPM project (continuation of Rd 4 project) and the Indian Medical Assocaition project (continuation of Rd 6 project) under the RCC proposal will target up to 19 states.

The main objectives of the project are

1. To achieve and sustain universal access to high quality diagnosis and patient friendly treatment under DOTS.
2. Expand and increase the reach of RNTCP to ensure equitable access to diagnostic and treatment services for TB/HIV and drug resistant TB.
3. To consolidate TB control efforts towards achieving the goal of TB control through sustainable and effective public-private partnership to involve all health care
4. To contribute towards national efforts in measuring the impact of RNTCP in relation to the MDG TB targets.

The project over the period of 6 years, envisages to detect and treat 2.36 million TB patients, including 1.03 million new smear positive cases, and successfully treat ≥85% of them. This would help in improving the case detection rates in Rd 2 project states from 53% to 70% by the end of the project, and save over 400,000 additional lives. The project would continue to support and invest in human resource and train/retrain 15,000 key programme staff, to meet the gap in key positions, facilitate supervision and montoring and strengthen programme management. The project also envisages to treat 12,000 MDR-TB patients over the project period, and help in establishing 31 DOTS Plus sites. To support the laboratory network for undertaking culture and DST, 4 National Reference Laboratories and 8 Intermediate Reference laboratories would be strengthened

and the network expanded by involving the accreditated medical college laboratories and labs in other sectors under the various PPM schemes under the programme. As part of the project, over 296,000 TB patients would be offered VCT services, and it is envisaged to test over 75% of the TB patients in high HIV prevalence state of AP, and offer ART service linkages to at least 50% of the co-infected.

The IMA PPM project would reach out to 202,000 private allopathic practitioners through CMEs, train over 37,500 of them, and successfully involve nearly 50% of those trained (18,750). In addition, over 145,000 of the its professional members would be reached out through TB specific newsletters and articles in journals. The CBCI sub-project seeks to expand services from 11 to 19 states, and involve additional 750 hospitals, senstise 12,000 health staff and train 7100 medical and paramedical staff under RNTCP. Through this involvement, it is estimated that over 648,000 additional TB suspects would be referred for diagnosis, and many more would be supported through their 2000 plus community outreach facilities. The PPM component of the project is estimated to increase the contribution of the private ector from under 10% to 20% by the end of the project.

All these efforts towards realizing the TB related MDGs would be measures by undertaking impact assessment surveys (TB prevalence surveys and Drugs resistance surveys). In addition, to assess the progress of the project and understand health systems challenges in the project states, a comprehensive health systems assessment with reference to TB control would be commissioned in year 3 of the project, for facilitating mid-term review and correction.

The combined (RNTCP, CBCI and IMA sub-components) proposed budget for 6 yrs is Euro 147.99 million .

4.1. Key changes in the stage or dynamics of the disease

Summarize the main changes in the **stage or dynamics** of the disease, including any changes in the most **affected population group(s)** between when the original proposal for the expiring grant was submitted, and now.

Applicants are requested to specifically comment on current trends in mortality and morbidity impact indicators within the populations targeted in this proposal, and the assessed contribution of the expiring grant towards more favorable trends in those indicators.

The Global Fund Rd 2 proposal (expiring grant) was submitted (in 2004-05) to expand the RNTCP DOTS services to the uncovered 110 million population (2001 projected, Census 1991) in 56 districts of Bihar and Uttar Pradesh and establish 4 model 'Urban TB control projects' through public-private collaboration. The global fund project supported the national efforts in achieving nation-wide DOTS coverage by March 2006. Since then, the programme is being consolidated to realize the goal of TB control, in line with the TB related Millennium development Goals (MDGs).

The programme performance has significantly improved since the time of the submission of the proposal. The new smear-positive case detection in 2004 which was 55% of the estimated cases in the country, has improved to 70% in 2007. The treatment success rate has been consistently maintained at over 85%.

India is the highest TB burden country in the world, accounting for nearly one-fifth of the global incidence. Every year, there are about 1.9 million new TB cases in the country, of which nearly 800,000 are infectious smear positive pulmonary cases. The prevalence of TB for the year 2000, has been estimated at 3.8 million bacillary positive cases. 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, i.e. 2 deaths every 3 minutes. 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. This burden is compounded by the existence of drug-resistent forms of TB and TB-HIV co-infection in the community.

Although the prevalence of MDR-TB in the population has been relatively low and stable (3% among new cases and 12-17% in retreatment cases), when translated into absolute numbers they are significant, with an estimated annual incidence of 110,000 cases of MDR TB in the country. Unless well managed by ensuring standardized treatment under observation of drug sensitive TB (to prevent emergence of MDR-TB) and effective management of prevalent MDR-TB cases (to prevent extensively drug resistant TB--XDR-TB), the disease can significantly increase morbidity and mortality due to TB.

Regarding TB-HIV co-infection in India, it must be noted that although the TB epidemic in the country is pre-dominantly driven by the non-HIV positive TB cases and the prevalence of HIV infection among TB patients is highly variable across the states. With an estimated 2.46 million (0.36% of adult population in the country) people living with HIV/AIDS (PLHAs) in 2006 (estimates revised from the earlier 5.2 million PLHAs in the country, based on the findings of the comprehensive National Family Health Survey – NFHS 3), this is an enormous challenge . The Joint TB-HIV action plan being implemented in the country

since 2001, has been scaled up from 6 high prevalent states in 2001 to 8 additional states in 2004, and subsequently to the entire country. These co-ordinated efforts have resulted in a quantum jump (300%) in the number of cross-referrals between the programmes, and continued efforts are being made to improve access to DOTS to people living with HIV/AIDS (PLHAs). The newly finalized framework document of 2008 includes plans for ICF. *(See Annexure 4.VII – National Framework for Joint TB/HIV collaborative activities. Feb 2008)*

The large scale expansion of DOTS, and gradual improvement in programme performance has resulted in the decline in the Annual Risk of TB infection (ARTI) in the country. As per the national survey conducted between 2002-04, the ARTI has declined from an estimated 1.7% (which translates into 85 new smear-positive cases per 100,000 population) in 2000 to 1.5% (which translates into 75 new smear-positive cases per 100,000) in 2004. The mortality rate due to TB has also declined from an estimated 37 per 100,000 population in 2002, to 28 per 100,000 in 2006, i.e. by nearly 25% (WHO Global TB Report-2008). In the last 4 years of the programme, nearly 5.4 million TB cases have been initiated on treatment, thereby saving nearly 100,000 additional lives.

To measure the impact of DOTS on TB burden, the programme has been undertaking detailed analysis of the notification data, and by conducting surveys. Sequential surveys undertaken by TB Research Centre, Chennai in the Model DOTS project between 1999-2006, has shown an annual decline in prevalence of infection by 6%. The programme is undertaking a repeat national ARTI survey in 2008-10, and TB prevalence surveys in 6 sites (2008-10). These would provide valuable information on the impact of DOTS on the TB burden in the community and India's progress towards the TB related MDGs.

(***Reference**: TB Epidemiology in India. Joint TB Programme Review 2006; WHO Global TB Report 2008; TB India 2008*)

4.2. National prevention, treatment, care, and support strategies

Describe how the country's disease specific planning frameworks have evolved since submission of the original proposal for the expiring grant to:

- Respond to changes in the stage and dynamics of the disease described in 4.1 above; and
- Focus on ensuring a scale-up in the reach of services to key affected populations beyond early estimates that may not have represented the full range of people needing prevention, treatment, care and/or support services.

Where such plans exist and they are directly relevant to the interventions in this proposal, they should be attached to the proposal (with clear references in the text of this proposal and in the 'Checklist' at the end of s.5) to assist proposal review

Although there have been significant gains due to the large scale expansion of DOTS in the entire country, as indicated in section 4.1, the burden of TB continues to be a major public health challenge. With an estimated 40% of the population infected, and a life-time risk of 10% to breakdown to active disease among those infected, the fight against TB is a long drawn out battle. In spite of impressive programme performance results at the national level, and evidence of epidemiological impact in a sub-district level study, TB control is an achievable goal, provided an equitable distribution of quality services are assured to the entire population irrespective of place of residence, gender or socio-economic status.

At the time of submission of the expiring grant proposal (GFATM Rd 2), the primary objective of the programme was to establish a network of decentralized quality assured (designated) laboratory network @1 per 100,000 population, and ensure uninterrupted supply of quality assured drugs using standardized treatment regimen (intermittent) for all TB cases. To guarantee treatment compliance, a vast network of DOT providers (>400,000) drawn from health staff, nutrition workers (Anganwadi workers), and community volunteers were enrolled, who were accessible, acceptable and accountable to the system to provide treatment under direct observation.

Being aware of the challenges posed by the large private sector, the programme initiated several innovative pilot projects to establish models for public-private-mix (PPM) approaches. It started with engaging with other public sector health establishments (medical colleges, railways, defence services, Steel & Mines, Coal, etc) to advocate for DOTS, and simultaneously working with the private sector directly or through interface NGOs and professional bodies like the Indian Medical Association (IMA), or Confederation of Indian Industries (CII). These efforts have resulted in nearly 8500 NGOs, 260 Medical Colleges, 18,000 private providers and 150 corporate houses being involved in the programme.

The Indian Revised National TB control programme (RNTCP) has been recognized as the fastest expanding DOTS programme, for contributing the maximum number of cases to the global TB control

efforts and for having achieved the global targets of time bound expansion, treatment success rates and case detection rates as well as for the programme's innovative approaches, quality of implementation and partnerships with other health and non health sectors. The strategic vision of the Centre gave due emphasis on establishing best practices and processes and strengthening systems in order to ensure sustainable TB control efforts. The needs of the poor, vulnerable, hard to reach and marginalized sections of the population have been prioritized. Systems for monitoring and evaluating the programme by surveys, studies and operational research are part of the programme vision and early indicators show a steady progress towards achieving the TB related Millennium Development Goals (MDGs) by 2015.

Simultaneously at the global level, there have been significant developments in the global strategy which include plans to address the challenges of drug-resistant TB and TB-HIV co-infection. Keeping in line with the Global Plan, the country has already begun implementing most of the components of the new WHO 'STOP-TB Strategy'.*(See Annexure 4.I RNTCP Strategic vision document for India upto 2015)*

The emphasis of the Phase II of the programme (2006-07 to 2011-12) has been on consolidation of services, with special attention to quality (for diagnosis and treatment), expansion of services to further enhance TB/HIV, PPM and ACSM initiatives, and build systems for implementing DOTS Plus services. The programme has also recharged its operational research agenda to not only measure the impact of DOTS programme but also to support research which will lead to evidence based policies.

The programme has strengthened itsTB-HIV collaborative activities from 6 states in 2001 to 14 in 2004, and now plans to scale up to cover the entire country in 2007-08. Strategic steps include advocacy for improved collaboration (at all levels) between the two programmes for policy and implementation, policy initiative for strengthening service delivery coordination across the country and an intensified TB/HIV package of services in high HIV prevalent settings.

Based on two large scale representative drug resistance survey findings and inputs of the national DOTS-Plus committee, the programme has developed a standardized diagnostic and treatment guidelines for MDR-TB in 2006. The national plan is built on the premise of first establishing a network of accreditated reference laboratories(at least 1 in each large state) capable of undertaking culture and drug sensitivity testing, and gradually building on the DOTS-Plus treatment services, to gain both technical and programmatic experience in implementing community based DOTS Plus services. However, with the early experience from the 2 implementing states (Gujarat and Maharshtra) and recognition of the scale of the problem, the programme is considering a scale up of services to ensure complete geographical coverage of DOTS Plus services by 2015, based on a continuum of expansion of screening services (for MDR TB) from Category II treatment failures (current policy) to screening of all Category II cases at entry as well as treatment failures of all categories.*(See Annexure 4.V RNTCP DOTS Plus Guidelines)*

4.3. Population and Epidemiological Background to proposal

4.3.1 Geographic reach of this proposal

Will activities be implemented: (*'check' one box only*)

☐ across the whole country	☒ in specific Region(s) *If so, insert a map immediately below this table to show where*	☐ with a focus on specific population groups but not country wide *If so, insert a map immediately belowto show where these groups are if they are in a specific area of the country*

Map showing proposed geographical coverage under the GFATM RCC (excluded the reach of under PPM initiative)

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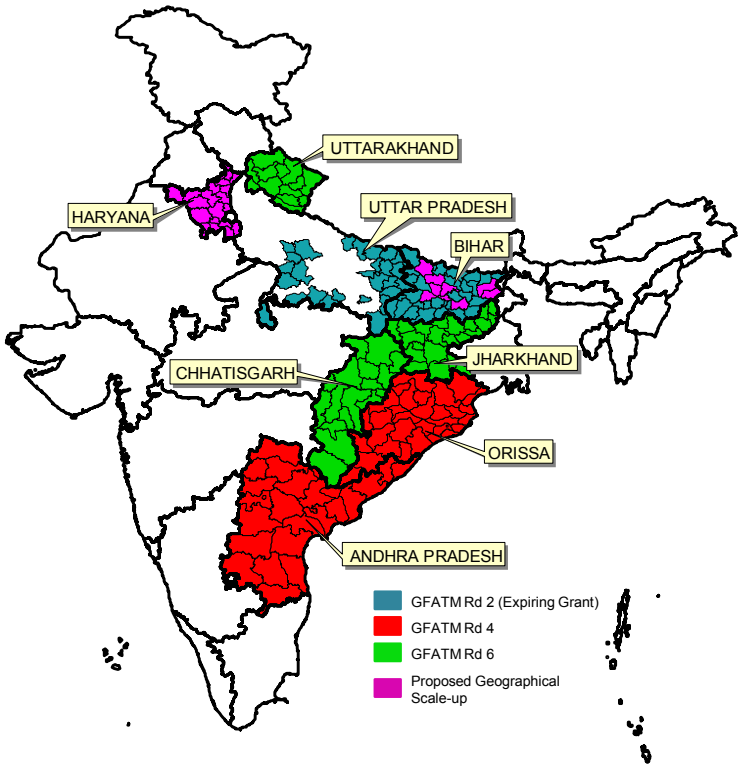

4.3.2 Size of population group(s) covered by this proposal*			
Population Groups *(if different age groups apply for your country, change the age groupings below.)*	**Population Size**	**Source of Data**	**Year of Estimate**
Total population (all ages)	362.1 Million	Projected Population, Census India 2001	2008
Women > 25 years	80 Million	National Family Health Survey III (NFHS)	2005-06
Women 19 – 24 years	34.9 Million	NFHS III	2005-06
Women 15 – 18 years	17.9 Million	NFHS III	2005-06
Men > 25 years	92.3 Million	NFHS III	2005-06
Men 19 – 24 years	40.8 Million	NFHS III	2005-06
Men 15 – 18 years	21.7 Million	NFHS III	2005-06
Girls 0 – 14 years *(HIV and Tuberculosis proposals. For malaria proposals, divide age groupings < 5 years, and 6 – 14 years)*	55.9 Million	NFHS III	2005-06
Boys 0 – 14 years **(same note as above)**	70.8 Million	NFHS III	2005-06
Other : Population living in poor & backward districts	25.5 Million	RNTCP Programme Performance Report	2008
Other : Population living in districts identified as predominantly Tribal	26.6 Million	RNTCP Programme Performance Report	2008
Other : Population living in Urban slum in the project states	10.8 Million	Census India 2001	2001

* Tuberculosis is prevalent in the population in all age groups. The prevalence of infection and disease increases with increasing age and is higher in men than women. National ARTI Survey 2002, results indicate the prevalence of infection is higher in urban areas than in rural areas.

4.3.3 Epidemiology of population group(s) covered by this proposal			
Population Groups	**Estimated Number**	**Source of Data**	**Year of Estimate**
Estimated number of total TB cases *(all ages) in the project states (362.1 Million)*	798,000	Based on National ARTI survey 2002, estimates	2008
Estimated number of new smear positive cases in the project states	295,240	Based on National ARTI survey 2002, estimates	2008

4.3.3 Epidemiology of population group(s) covered by this proposal

Population Groups	Estimated Number	Source of Data	Year of Estimate
TB related deaths in the population in the project states	101,383	Based on WHO Global TB report 2008, estimates	2006
Prevalence of multi-drug resistant TB cases	3% among new cases & 12-17% in retreatment cases	TB India 2008	2007
People notified for new smear positive cases	170,000	TB India 2008	2007
New smear positive case detection rate in the project states (%)	47 per 100,000 population (58%)	TB India 2008	2007
Treatment Success rate among registered new smear positive cases	85%	TB India 2008	2007
Proportion of Paediatric cases (0-14 yrs) out of all new notified cases	6%	TB India 2008	2007

4.4. Major ongoing weaknesses and gaps that affect outcomes

4.4.1 National disease program

Describe:

- the main weaknesses of the current disease program and how these weaknesses affect achievement of planned national program outcomes;
- existing gaps in the delivery of services to target populations; and
- main weaknesses of and/or gaps in the health system that affect disease program outcomes.

The TB control Strategy in India was revised in 1992 (hence called the Revised National TB Control Programme), to address issues related to inadequate funding of TB control activities, managerial weaknesses, non-standardized diagnostic (over-reliance on x-rays) and treatment guidelines, low rates of treatment completion, and lack of systematic information on treatment outcomes. Following the successful pilot projects between 1993-97, the DOTS Strategy was adopted and large scale phased expansion to cover the entire country was initiated in 1997. The expansion of DOTS services was taken up in a phased manner to ensure that adequate systems were in place (infrastructure, trained human resource, drug and logistic supply chain, and management information system) prior to the launch of the programme. To facilitate decentralized programme planning and financial management, district and state level Health/TB control societies were created. These efforts resulted in geographical expansion to entire country in March 2006, and the Indian DOTS programme being hailed as the fastest DOTS expansion in the world.

The Global Fund Rd 2 grant (expiring grant), supported the programme efforts to cover the 110 million population across 56 districts in the states of Bihar and Uttar Pradesh. These states were considered programmatically difficult due to their large size and population base, weak general health infrastructure (through which all the programme components are delivered) and varying levels of political and administrative commitment. This was compounded by political fluidity and natural calamities (floods) at the time of the original project proposal. However, with continued efforts from the national level and with the support of the States, the programme was extended to the entire population. Nevertheless, due to the existing weakness within the general health system, the programme performance in these two states has been sub-optimal, though there have been definite indications of improvement in performance (Bihar

improved it's case detection rate from 25% after complete expansion in March 06 to 40% in 4th quarter 2007).

In the second phase of the programme, the strategic vision is to consolidate the earlier achievements in every aspect of the programme. This will be achieved by focusing on strengthening state and district programme units through re-training and update training on new initiatives and financial management; implementation of quality assurance systems for sputum smear microscopy (EQA); strengthening of monitoring and evaluation through rigourous implementation of the national 'Supervision & Monitoring Strategy'; expansion of successful public-private partnership models through involvement of NGOs and other professional bodies; renewed advocacy and communication strategy; and phased implementation of DOTS Plus services for MDR-TB through strengthening the network of Intermediate Reference Laboratories which are capable of undertaking culture and drug sensitivity testing.

The programme is aware of the challenges and the gaps within the programme and in the health system, which are potential barriers towards ensuring high quality equitable distribution of diagnostic and treatment services to its population, including that for drug resistant TB and TB-HIV co-infection. Some of the key challenges are as under:

- Large variations in programme performance across states and within states across districts – due to diferences in health infrastructure and outreach; human resource capacity (vacancies and absenteeism); morale and commitment of programme/ administrative staff.
- Insufficient capacity at the state and district level to manage, supervise and monitor the expanded range of activities, including those needed for lab quality assurance (EQA), TB-HIV collaborative activities, PPM activities and DOTS Plus services (in the near future).
- Sub-optimal progress in strengthening of state level reference laboratories (IRLs), due to insufficient human resource capacity at the state level, and limited resources with the National Reference Laboratories to provide technical support and guidance to IRLs.
- The large and diverse group of private health care providers who are the first point of contact in nearly 60-70% of TB patients. The programme has successfully enrolled nearly 3000 NGOs, 18,000 private practitioners and 150 corporate houses. However, less than 50% have joined any of the signed schemes and a large proportion of allopathic practitioners (~70-80%) remain outside the RNTCP network, primarily due to the diverse nature of providers (no common platform), lack of faith from the private sector in the public sector services, and limited capacity and motivation within public sector in the field to forge alliances.
- Sub-optimal state and district level capacity to undertake strategic planning and implement need based advocacy and communication activties.

4.4.2 Health system

(a) Describe the main weaknesses of and/or gaps in the health system that affect outcomes for the disease.

The description should, in addition to explaining health system issues that impact outcomes for this disease, also include a discussion of issues that impact outcomes for other diseases where the weaknesses/gaps are common.

Over and above the weakness within the existing general health infrastructure highlighted above, India also has multiple sectors of health care providers who vary widely in their size, nature of service delivery and the socio-economic groups they serve. India's private spending on health is amongst the highest (4.2% of GDP) in the world and its proportion of government health spending (1.2% of GDP) amongst the lowest.

Since independence, the country has envisaged delivering universal health care to its population through a vast network of publicly managed health infrastructure (primary, secondary and tertiary health facilities). The primary health centres which provides the initial point of contact, have basic medical services including for TB, and have referral linkages for specialized care with the secondary and tertiary levels. To tide over variations in individual state's capacity (health being a state subject), priority health issues including maternal and child health interventions,TB treatment etc are being supported as Centrally Sponsored Schemes (national health programmes), and delivered through the public health care delivery system.

The non-public sector, includes the private sector, non-governmental organizations (NGO) and the corporate sector. The relative distribution of various medical and para-medical health staff in the non-public sector is given below.

	Allopathic doctors*	Dental surgeons	AYUSH practitioners	Nurses**	Pharmacist	Non-formal providers
Registered providers	643,520	55,000	717,860	560,000	530,000	~ 2 million
% in private sector	88%	96%	96%	64%	94%	100%

** ~24,000 are within public health delivery system and ~43,000 in other government services*
*** Only 40% of the 1.4 million registered nurses are in active service*

Given the complex nature of the multitude of players and the dominance of private providers (first point of contact for nearly 60-70% of TB patients), it is a major challenge attempting to reach out to all providers and patients. Qualitiative surveys have suggested that the preference for private sector by the community is due to the easy accessibility (usually in the neighborhood and flexible timings) and personalized attention in contrast to the perceived poor quality of services within the public health system.

Successful large scale implementation of RNTCP DOTS strategy, collaborations with health care providers within other Ministries, partnerships with NGOs and private-for-profit practitioners under different PMM schemes and ACSM initiatives have resulted in larger number of patients being diagnosed and treated under DOTS, as well as many providers adopting DOTS strategy.

In spite of these gains, the programme is well aware of the fact that a sizeable number of TB patients continue to seek treatment outside the programme. With non-standardized diagnostic and treatment practices and without systems to ensure compliance (nearly 30-40% of patients interrupt treatment), the low cure rates have the potential to increase the risk of MDR-TB in TB patients.

To summarize, for an effective TB control strategy which will realize the goal of TB control, a concerted effort is required at all levels. This should include strengthening of basic public health care delivery system, improving access to diagnosis (e.g. sputum collection centers) and treatment – (e.g. flexi-DOTS - workplace/flexi-time/neighborhood DOT) and involving all healthcare providers within the public and private health systems so that diagnosis and treatment of all TB patients confirms to standardized protocols and is given under observation. This will reduce the morbidity and mortality due to TB and reduce its socio-economic consequences on patients, their families, and communities.

(b) Describe what is already being done, and by whom [not what is planned in this proposal], to respond to health system weaknesses and gaps that affect outcomes for this disease.

Over the last few years, there has been a strategic shift in focus in the public health approach of the country. The National Health Policy 2002 envisages to increase public health spending from 0.9% of GDP (in 2000) to 2% by 2010, increase the share of central grants for total health spending from 15% to at least 25% by 2010, and also increase the state sector health spending from 5.5% of budget to 8% by 2010. These additional resources are vital to improve the public health infrastructure and increase reach, and is expected to improve the utilization of public health facilities from under 20% to >75% by 2010 (National Health Policy 2002).

Starting in April 2005, the National Rural Health Mission (NRHM) has been launched with special focus on 18 identfied states with poor health indices. The primary goal of the NRHM is to improve the availability of and access to quality health care by people, especially those residing in rural areas, and the poor and vulnerable groups. NRHM aims to carry out the necessary architectural correction in the basic health care delivery system of the country by increasing public expenditure on health, reducing regional imbalances in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, and the induction of management and financial personnel into district health system. As part of the Mission, Indian Public Health (IPH) Standards have been defined for the minimum level of infrastructure, human resource, equipment and drugs/consumables needed for effective functioning of the health institution (primary, secondary and tertiary units). This large scale investment into the health system would have positive ripple effects on the overall functioning of the health system and the disease specific interventions, including TB.

However, to meet the existing gap in infrastructure (for laboratory and drug store) and key human resource (laboratory technician/ Medical officers/ IEC officer etc), the TB programme has been supplemented by provision of funds for improving infrastructure (upgradation of microscopy centres and drug stores) and additional staff (20% of lab technicians/ 15% of Medical officers). In addition, to support the critical components of field supervision and monitoring and maintainence of TB records for monitoring and accounting every TB patient notified under DOTS inputs, the programme has provided dedicated paramedical TB staff (Senior Treatment Supervisor and Senior TB Laboratory Supervisor) at the field level for every 500,000 population (TB Unit level). However, in some states, like Bihar, there is an apparent skewed distribution of services, with most health care services concentrated at block level (i.e. for 100,000 population) against the recommended level of 1 primary health institution for every 30,000 population. This is due to a wide-spread gap in infrastructure or human resource which is difficult to cover with programme resources. In such situations, with consultation with state and district officials, treatment services are being facilitated by promoting systems for sputum collection and transport, and involving local NGOs and private providers in the programme.

These inputs are proposed to be continued under the current project till the public health system has been strengthened enough to absorb the critical requirements of the programme for diagnosis, treatment and monitoring of TB patients. It is also submitted that TB related services (microscopy centres and drug stores) and personnel (LTs, STS/STLS) have been included under the Public Health Standards.

The initiative undertaken by the national government and TB programme in particular to involve all health care providers has been highly successful. It can be confidently said that all public health care facilities (including those under different Ministries) have adopted the RNTCP DOTS strategy.The Confederation of Indian Industries (CII) has endorsed RNTCP guidelines.The largest professional body of practitioners, the Indian Medical association, has endorsed DOTS and is actively promoting the strategy among its members. These PPM acitives have led to the creation of civil society partnerships willing to take the onus and responsibility of promoting DOTS, and thus support the national endevour to control TB. The civil society coalition has drafted and submitted a proposal under Rd 8 to undertake comprehensive ACSM and community mobilization activities which will result in increasing awareness and generating demand for DOTS services across all groups. In addition, this initiative also includes a component to assist in strengthening the laboratory capacity, through an incremental process of testing and adopting newer diagnostic tools.

This transition from a programme led and public health system driven TB control programme to a civil society and industry supported initiative, will go a long way in establishing sustainable and cost-effective systems in place for TB control and hasten India’s progress towards the TB related MDGs.

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4.5. Main program areas of this proposal

4.5.1 Continuing interventions (including expanding and scaling-up program coverage)

Complete the tables below for three to six areas identified as the main program priorities for this proposal. Ensure that the choice of priorities is consistent with the current epidemiology and identified program gaps. ***Note****: activities that target health systems weaknesses that are specific only to this disease should be included as disease specific program areas (and described in s.4.6.4). However, if the activities respond to health systems weaknesses on a cross-disease basis (e.g., HIV, tuberculosis and malaria), and are not easily included in the disease specific description, they can be included in the optional s.4B for HSS cross-cutting interventions (and are not therefore also listed in the tables below).*

➔ Refer to the **Guidelines for Proposals** for more detailed information on the choice between including interventions as 'disease specific responses' and 'cross-cutting responses'.

Clarified Section 4.5.1

Priority No. 1 – continuing	**Actual**		**Targeted***						
Indicator name *Consolidate and maintain RNTCP DOTS services in the entire country* (Population covered in millions)*	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
A: Country target *(from annual plans where these exist)*	1114,199,978 (100%)	1131,041,999 (100%)	1147,677,000 (100%)	1164,127,000 (100%)	1180,409,000 (100%)	1196,554,000 (100%)	1212,579,000 (100%)	1228,494,000 (100%)	1244,220,000 (100%)
B: Extent of need already planned to be met through existing or known future funding *(This figure* ***must include*** *all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*			112,400,000	984,300,000	873,200,000	885,400,000	0	0	0
C: Expected annual gap in achieving plans	0	0	23,772,000	179,751,836	307,173,270	311,215,289	381,990,930+ 830,588,070**	386,815,122 + 841,678,878**	391,560,486 + 852,659,514**
D: Extent of total need covered by this proposal	*(i.e., can be equal to or less than full gap)*			179,751,836	307,173,270	311,215,289	381,990,930	386,815,122	391,560,486

***** *Source: Projected population Census India 2001*

**** Note:** The national TB control strategy - RNTCP Phase II, has been approved for the period Oct 2006 to Sept 2011 with committed funding from domestic resources, and World Bank Credit. The USAID supported project covering the state of Haryana (23.4 million), expired in March 08. The Global Fund Rd 4 project covering states of Andhra Pradesh & Orissa (120.8 million) is due for expiry in March 2010; and the Rd 6 project in the states of Chhattisgarh, Jharkhand and Uttarakhand (62.2 million) is due for expiry in March 2012. The government of India is commited to support TB control efforts, till it ceases to be a major public health problem. However, as on date there is no approved funding from other sources beyond 2012. In view of the commitment from Govt of India, the extent of need planned to be met for the period 2013 and 2014 has been indicated in the table above and funds would be raised from domestic resources.

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Priority No. 2 – continuing	**Actual**		**Targeted***						
Indicator name *Number of new smear positive cases detected under the programme, among the estimated cases in the country*	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
A: Country target *(from annual plans where these exist)*	553,660 (66%)	592,635 (70%)	602,530 (70%)	611,167 (70%)	619,715 (70%)	628,191 (70%)	636,604 (70%)	644, 959 (70%)	653, 216 (70%)
B: Extent of need already planned to be met through existing or known future funding *(This figure **must include** all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*			593,170	468,086	429,519	469,498	0	0	0
C: Expected annual gap in achieving plans	0	0	13116	143,081	151,615	158,693	203,389 + 433215*	211,925 + 433034*	223,062 + 430154*
D: Extent of total need covered by this proposal	*(i.e., can be equal to or less than full gap)*			143,081	151,615	158693	203,389	211,925	223,062

* To be met from domestic funding/other resources

Priority No. 3 – continuing	**Actual**		**Targeted**						
Indicator name: *New smear-positive TB cases that have successfully completed treatment, among the new smear-positive cases registered during the specified time period (%)*	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
A: Country target *(from annual, plans where these exist)*	86%	86%	512,151 (≥ 85%)	519492 (≥ 85%)	526758 (≥ 85%)	533962 (≥ 85%)	541113 (≥ 85%)	548215 (≥ 85%)	555234 (≥ 85%)
B: Extent of need already planned to be met through existing or known future funding			504195	397872	365091	399,073	0	0	0
C: Expected annual gap in achieving plans	0	0	11,149	121,689	128,873	134,889	172,881 + 368,232*	180,136 + 368,079*	189,603 + 365,631*
D: Extent of need covered by this proposal	*(i.e., can be equal to or less than full gap)*			121619	128873	134889	172881	180136	189,603

Note: The treatment outcomes would be reported 13-15 mths after registration. * To be met from domestic funding/other resources

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4.5.2 New interventions/scope change of the expiring grant – that are in line with the broader package of interventions to which the expiring grant was contributing.

Priority No. 1 – new/scope change	**Actual**		**Targeted**						
Indicator name: *Number of new MDR-TB cases diagnosed and initiated on DOTS-Plus treatment*	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
A: Country target *(from annual plans where these exist)*	100	450	1250	2350	3550	6500	8900	12400	15600
B: Extent of need already planned to be met through existing or known future funding *(This figure **must include** all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*	100	450	1200	2250	2600	4850	0	0	0
C: Expected annual gap in achieving plans	0	0	50	100	950	1650	1550 + 7350*	3500 + 8900*	4,200 + 11,400*
D: Extent of need covered by this proposal	*(i.e., can be equal to or less than full gap)*		100	950	1650	1550	3500	4200	

. * To be met from domestic funding/other resources

Priority No. 2 – new/scope change	**Actual**		**Targeted**						
Indicator name: *Cross referrals between Counselling and Testing centres (HIV) and RNTCP (TB) facilities*	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
A: Country target *(from annual plans where these exist)**			↑ trend	↑ trend	↑ trend	↑ trend	↑ trend	↑ trend	↑ trend
B: Extent of need already planned to be met through existing or known future funding *(This figure **must include** all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*									
C: Expected annual gap in achieving plans									
D: Extent of need covered by this proposal	*(i.e., can be equal to or less than full gap)*			87,000	100,000	110,000	120,000	130,000	140,000

* No specific targets have been fixed; but with nation wide expansion of TB/HIV collaborative activities, and expansion of HIV services across states, it is expected that the cross-referrals for diagnosis and management (DOTS/ART/CPT) would show an increasing trend.

Priority No. 3 – new/scope change	Actual		Targeted						
Indicator name: *Number of private providers and NGOs reached and involved in RNTCP through innovative Public Private Collaborative activties* *	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
A: Country target *(from annual plans where these exist)*	16937	20638	↑ trend	↑ trend	↑ trend	↑ trend	↑ trend	↑ trend	↑ trend
B: Extent of need already planned to be met through existing or known future funding *(This figure **must include** all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*									
C: Expected annual gap in achieving plans	0	0							
D: Extent of need covered by this proposal**	*(i.e., can be equal to or less than full gap)*		4000	6600	9300	14200	18650	24250	

* The national strategy and plan is towards an increasing trend to involve NGOs/PPs, hence no specific targets have been set.
** The targets indicated above includes the 17,500 PPs to be involved as a result of the IMA PPM component of the proposal; and the 700 Catholic Health Institutions proposed to be involved under the CBCI PPM project.

Priority No. 4 – new/scope change	Actual		Targeted						
Indicator name: *Number of surveys planned to measure impact of DOTS programme on the TB burden in the population, and progress towards Millennium Development Goals* *	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
A: Country target *(from annual plans where these exist)*	2		3	2			4 (DRS)		2 (ARTI and Prevalence)
B: Extent of need already planned to be met through existing or known future funding *(This figure **must include** all planned resources, domestic and external, including support from all years of Global Fund grants for the same disease – Phase 1 and Phase 2 support not yet approved nor disbursed)*	2		3	2			0		0
C: Expected annual gap in achieving plans	0		0	0			4		2
D: Extent of need covered by this proposal	*(i.e., can be equal to or less than full gap)*			0			2		1

* The programme proposes to undertake Annual Risk of TB infection (ARTI) surveys to meaure incidence, TB prevalence surveys and Drug Resistance surveys every 3-5 years to measure impact of DOTS programme and progress towards TB related MDGs. ARTI and TB prevalence surveys planned in 2009-10 and 2014-15; and repeat DRS surveys planned in 2012-13 (earlier rounds in 2005-06 and 2008-09).

Note to applicants:
The tables in s.4.5.1 (continuing interventions/scale-up) and s.4.5.2 (new interventions/scope change) highlight the main priorities. These priorities and all other activities should be very clearly described in the questions in s.4.6 below to ensure that the Technical Review Panel has a clear understanding of the planned work, and outcomes, over the proposal term.
➔ ***Read the Guidelines for Proposals for more assistance.***

4.6 Analysis of priorities for Rolling Continuation Channel proposal

Scope and Scale Considerations

4.6.1	**Continuation of Expiring Grant's strategy**	
(a)	Does this proposal continue the same objectives, same service delivery areas, and same focus and range of interventions as the expiring grant without any changes to program **scale** (i.e., no substantial increase in coverage) or **scope** (e.g., increasing the population groups covered, or the range of services offered?	☐ Yes ➔ *answer (b) below and then go to section 4.6.4* ☒ No ➔ *go to section 4.6.2*
(b)	If yes: • Describe the **strengths** of the expiring grant that have facilitated successful implementation and strong grant performance to date. Summarize how the strategy of this proposal continues and builds upon these key strengths; and • Explain why continuation of the original proposal's implementation strategy and scale of activities is the most effective approach to achieve sustained disease specific health outcomes and impact consistent with the national plan.	
Not Applicable		

4.6.2	**Program scale adjustments in this proposal**	
(a)	Does this proposal include a significant planned scale adjustment (whether a scale up by substantially increasing coverage for existing interventions, or, if relevant to the current disease profile, a reduction in interventions) compared to the expiring grant's planned focus and outcomes?	☒ Yes ➔ *answer question (b) below* ☐ No ➔ *go to section 4.6.3*
(b)	**If yes to (a)**, summarize the planned **scale** adjustments, and why this change will create more effective and sustained strategies for greater health outcomes and impact.	

The strategy and interventions implemented under the RNTCP are consistent with international guidelines. Initial estimates and evidence from the study area of TB research Centre, in Tamil Nadu, shows that RNTCP has started to make an impact on the prevalence of TB, risk of infection and the cause-specific mortality. In 2007, the global benchmark of 70% case detection and 85% treatment success was met at the national level, but the performance of states and districts varied greatly. Good quality RNTCP services for TB, including for drug resistant TB and HIV-associated TB, needs to be provided across the country with mechanisms to provide greater access to the high risk and vulnerable populations. This is crucial for achieving the TB targets under the MDGs in India. It is therefore necessary to scale-up all components of RNTCP services to achieve universal coverage and maintain them at least up to 2015.

The current proposal intends to achieve the following:

- **Extension of the time period** of the project under the expiring Round-2 grant. In order to achieve the TB-related MDGs in India it is necessary to maintain good quality RNTCP services in the two most challenging states of India (Bihar and Uttar Pradesh).
- **Increase in the geographical coverage**. The Round-2 proposal covered 30 out of the total of 38 districts in the State of Bihar. Under the RCC proposal the entire state of Bihar (38 districts) is proposed to be covered. This is expected to streamline funding at state level, simplify programme

management and reporting, and improve the overall efficiency of the programme. In addition, the state of Haryana (23.7 million population), which was supported under the USAID project till March 2008, is now being proposed for inclusion under the current RCC proposal. This was necessitated following the reprogramming of USAID funds from DOTS implementation in Haryana to increased technical assistance to RNTCP. Thus, this RCC proposal will cover a population of 362 million in 8 states of India. In addition, the CBCI and IMA projects under the RCC proposal will target up to 19 states.

- **Consolidation of states under different Global Fund grants proposals.** RNTCP services in the states of Andhra Pradesh and Orissa under Round-4, and Chhattisgarh, Jharkhand and Uttarakhand under Round-6, need to be continued at least till 2015 to have the desired impact on disease burden in these populations. These states are now being consolidated into the RCC proposal. This will bring in efficiency in programme management, funding and reporting, and will extend the committed funding of RNTCP services in these states till 2015.
- **Scaling up of other initiatives included under the 2006 Stop TB Strategy.** The revised TB/HIV framework (2008) is currently being rolled out across the country. Under RCC proposal, these TB/HIV activities will be scaled up and intensified. Using the national DOTS-Plus guidelines, MDR-TB management will be scaled up in the states proposed for coverage under the RCC proposal. Over the past several years, RNTCP has developed strategies to provide greater access of services to the tribal population, poor and marginalized population, urban slum populations, and prison inmates. These strategies have been implemented in many areas across the country in the form of 'tribal action plan', customized micro-planning for urban slums, flexi-time DOT, etc. Additionally, increased access has been provided to patients of pediatric age groups by developing pediatric TB guidelines and pediatric drug formulations. All these special initiatives will be further intensified and scaled-up under the RCC proposal. The newly developed schemes for collaborations with NGOs and Private Practitioners will be used to further scale-up Public-Private-Mix DOTS under RNTCP in the proposed states. In addition, under the RCC it is proposed to substantially scale-up the interventions of the CBCI (Round-4) from 11 to 19 states and that of IMA (Round-6) from 6 to 15 states.
- **Repeat surveys for epidemiological impact assessment**. After a series of discussions between national experts, and consultations with international experts,the RNTCP has developed a plan for repeat surveys for estimating incidence, prevalence and mortality. These surveys will establish the trend of the TB morbidity and mortality, the progress towards the TB targets under the MDGs, and the impact of RNTCP on the epidemiology of TB in India. The current project proposes to support the repeat TB prevalence surveys at 7 sites during 2014-15 and repeat drug resistance surveys in Andhra Pradesh and Orissa in 2013-14.

4.6.3	**Program <u>scope</u> change planned in this proposal**	
(a)	Does this proposal include a proposed change in **scope** as compared to the expiring grant's scope? (e.g., by adding new population groups, or incorporating, as a hypothetical example, treatment to complement prevention services under the expiring grant)	☐ Yes ➔ *answer question (b) below* ☒ No ➔ *go to section 4.6.4*
(b)	**If yes to (a)**, summarize the planned scope change and why this change will improve the national response to the disease, for greater health outcomes and impact.	

4.6.4 Detailed description of activities relevant to scale and scope changes

Explain: (i) who will be undertaking each area of activity (which Principal Recipient, which Sub-Recipient or other implementer); and (ii) the targeted population(s). *Ensure that the explanation follows the order of each objective, service delivery area (SDA) and indicator in the 'Performance Framework' and work plan, and budget.*

Where there are planned activities that benefit the health system, yet predominantly contribute to outcomes for the disease that is the subject of this proposal, these activities should be included in this description (and not in the optional additional s.4B that applies to cross-cutting health systems strengthening interventions).

Under the RCC-TB proposal, it is proposed to implement DOTS services as part of the overall RNTCP programme in India, in the states of Bihar & Uttar Pradesh (expiring grant), Andhra Pradesh and Orissa (Rd 4), and Chaatisgarh, Jharkhand and Uttarakhand (Rd 6) as part of grant consolidation, and Haryana (geographical expansion) and cover a population of 362 million (~35% of population). The proposal also contains a sub-component with the IMA (an NGO representing professionals from the modern allopathic system of medicine) and CBCI (a faith based organization) wherein geographical expansion of these projects is proposed to cover 19 and 16 states of India respectively.

The goal of this project is in line with the national TB control goal and is '***To reduce the burden (morbidity and mortality) of TB in India by 2015, in line with the Millennium Development Goals, and eliminate TB as a public health problem in the country by 2050'***.

The objectives of the project are as follows:

1. To achieve and sustain universal access to high quality diagnosis and patient friendly treatment under DOTS.
2. Expand and increase the reach of RNTCP to ensure equitable access to diagnostic and treatment services for TB/HIV and drug resistant TB.
3. To consolidate efforts towards achieving the goal of TB control through sustainable and effective public-private partnership to involve all health care providers
4. To contribute towards national efforts in measuring the impact of RNTCP in relation to the MDG TB targets.

The project envisages to detect and register a total of 2.75 million TB patients on treatment under DOTS. This would save an additional 495,000 lives. As part of the project, over 13,200 MDR-TB patients would be enrolled under DOTS-Plus.

To have an impact on the TB burden in the country and realize the goal of TB elimination by 2050, the national targets for TB control have to be achieved and then maintained for 2-3 decades. In 2007, the RNTCP reported 70% annual new smear case detection rate and 86% success rate in line with the global targets. This level of performance has to be achieved nation-wide so as to initially reduce the prevalent cases and then decrease the incident cases, thus achieving, in the long run, the TB related MDGs and control of the disease.

As explained earlier, the RNTCP had been implemented in the country in a phased manner since 1997, and nation wide coverage had been achieved in March 2006. As per the TB Control guidelines of the Government of India (GoI) which are followed throughout the country, a wide range of activities would need to be continued under the project by the State Health/TB Control Society and the District Health/TB Control Societies along with newer initiatives viz. MDR TB management, TB HIV collaborative activities etc. **The Objectives and SDAs are detailed in the RCC_Attachment A** and the **TB Component Work Plan** . The description of the activities undertaken in the RNTCP placed below, should be read in context of the broad objectives and SDAs stated in attachment A and the workplan.

Objective 1: To be undertaken by the PR (National TB programme office) and SRs (State Health/TB control Societies)

- Each district in the project states has formed a District Health/TB Control Society to plan, manage, implement, supervise and monitor TB control activities with funds routed through the central government and State Health/TB Control Societies which would be the Sub-Recipients of GFATM support.
- District TB Centre is the nodal agency which implements the programme under guidance from the District Health society. The District TB Officer is the nodal person and is responsible for all TB control activity in the district. The State Health Society is overall responsible for all TB control activity in the state. The Central TB Division at the central level would continue providing the leadership and policy

directives for TB control activities, and would supervise and monitor the state and districts.

- Under the RNTCP, TB Units (TU) have been established (for a population of 500,000 and in hilly/tribal and difficult areas for 250,000 population) at the sub-district level to supervise and monitor the programme. RNTCP Designated Microscopy Centres (DMCs) have been established for every 100,000 population, and in hilly/tribal and difficult areas for 50,000 population. Sputum Collection centres would be set up in hard to reach areas. DOTS centres are identified in a way so that DOT can be provided to the TB patient closest to their home and most conveniently by a person acceptable to the patient.
- Identification, recruitment and training of health personnel is undertaken by the respective Districts as per their Annual Action Plan and under the overall leadership of the State. Training is a key component of the RNTCP and all health personnel involved in the implementation of RNTCP are trained through specially prepared modules as per the current policy of GOI. *A total of 15,000 staff, including State and District TB Officers, supervisory staff and Laboratory Technicians are planned to be trained (induction, refresher and update training) over the project period.*
- Most of the civil works at the local, sub-district and district levels (for DMCs and TU drug stores) have been completed under the current proposal, and only essential maintenance and up-gradation of new facilities required for catering to additional populations, would be undertaken in the new proposal. *The project proposal intends to provide additional one time support to all the State Drug Stores, and to the District Drug Stores to increase and improve the storage capacity for the additional component of 2nd line drugs for MDR-TB.* This would also facilitate improving the storage conditions in centres which have not attained/maintained facilities as per guidelines and as per Global Funds observations and recommendations. National drug stores – GMSDs, are being supported under existing Global Fund grants for improving storage conditions and for introducing unique bar coding for drug boxes.
- To ensure high quality sputum microscopy under the programme, the External Quality Assurance protocol has been developed and will be implemented in all the proposal sites.
- Detailed diagnostic algorithms for diagnosis of sputum positive, sputum negative, extrapulmonary TB cases and for diagnosis of TB in pediatric patients have been developed. Facilities available under the general public health system in the secondary and tertiaty health care facilities would provide services for diagnosing extrapulmonary/ HIV infected/ pediatric TB cases. In order to move towards universal access and early case detection, the programme is considering revising the definitions for TB suspects and smear positive cases, as recommended by WHO - STAG 2007 and 08.
- The treatment regimen used under the RNTCP is based on the WHO recommended DOTS regimens adapted to the country context and needs, and is detailed in tabular form below:

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

In the column on Regimens: the number before the letters refers to the number of months of treatment. The subscript after the letters refers to the number of doses per week. H: Isoniazid (600 mg), R: Rifampicin (450 mg), Z: Pyrazinamide (1500 mg), E: Ethambutol (1200 mg), S: Streptomycin (750 mg). Patients who weigh 60 kg or more receive additional rifampicin 150 mg. Patients more than 50 years old receive streptomycin 500 mg. Patients who weigh less than 30 kg, receive drugs as per body weight. Patients in categories I and II who have positive sputum smear at the end of the initial intensive phase receive an additional month of intensive phase treatment. From 2007, paediatric patient wise boxes in two weight bands has been introduced and and would be used along with additional loose drugs.

- *The programme is aware that research is being undertaken with newer drug molecules, diagnostic protocols and treatment regimens, and would consider adopting and implementing newer tools/regimens as found appropriate.*
- Supervision and monitoring is given highest priority under the Programme to ensure high quality of sputum microscopy and DOT services. A robust system of recording and reporting (electronic) has been established from the most peripheral level to the district, state and central levels. The programme has recently developed a user friendly Windows based Epi-Centre (upgraded from DOS based aversion and formulated a national data management training plan, to build the capacity of

district and state programme managers.

- To further improve case detection and increase reach of RNTCP, health facilities under private and other sectors, including NGOs, are being involved under the RNTCP. *The existing PPM schemes have been revised to increase the flexibility for involvement of NGOs/PPs for various programme activities, and also to make them financially viable and attractive for the partners to deliver high quality services.*
- Advocacy, Communication and Social Mobilisation (ACSM) activities play an important role in case detection, case holding and successful treatment of TB cases. ACSM would follow a holistic approach by providing relevant information to each target group of policy makers, key stake holders, patients, health care providers and the community. An appropriate and effective communication strategy will be employed. To facilitate ACSM activities, in addition to the IEC officer at the State level, '*Communication facilitators' @ 1 per 4-5 districts have been appointed to strengthen field level activities.*

Objective 2: To be undertaken by the PR (National TB programme office) and SRs (State Health/TB control Societies)

Management of Drug resistant TB

- Under the existing grant proposals, efforts have been made to establish state level quality assured mycobacterial culture and drug sensitivity testing (DST) facilities in each of the project states. The laboratories will be further strengthened and their capacity developed so that they can undertake routine DST for their respective states.
- Guided by the Strategy Paper developed for five years by the RNTCP, DOTS-Plus sites would be established in all the project states and thereafter MDR-TB patient management services would be scaled up. **A total of 13,200 MDR cases are proposed to be registered for treatment under the project**
  - The programme has developed national DOTS Plus guidelines, outlining the standardized diagnostic, treatment, follow-up and operational guidelines.
  - All patients failing a Cat II regimen would be screened for MDR-TB, and those found positive would be initiated on a 18-24 mth standardized treatment regimen at identified DOTS Plus sites, and supported through community DOT.
- The expansion of DOTS Plus services necessaties strengthening of programmatic capacity to supervise and monitor DOTS Plus activities, without compromising routine DOTS implementation. To facilitate this, a **DOTS Plus site Medical officer**, supported by a statistical assistant is being proposed to coordinate treatment, follow-up and recording/reporting activities at the site and with the implementing districts. To support community DOTS Plus activities, and referral and follow-up of cases, a '**DOTS Plus and TB/HIV supervisor'** @ 1 per district is proposed. Given the quantum of work, this supervisor is also expected to support ART/CPT service linkages
- Given the recent developments in new technologies for rapid diagnosis of drug resistant TB, the programme is piloting new technologies, and will adopt appropriate tools under programme conditions, as and when they are available. Any additional MDR TB patients diagnosed using these new diagnostics, would be provided treatment.
- At current levels of capacity of the existing laboratories, each IRL can perform upto 6000 cultures annually. Given the scale of burden the programme would, in a phased manner, move towards screening of all Cat II patients at entry to treatment as well as failures of 1st line therapy for MDR-TB management. This expansion would be facilitated by further strengthening the capacity of existing IRL network (by additional human resource and infrastructure inputs), and accrediting additional labs in medical colleges and other laboratories in public and private sector. In the private sector labs, RNTCP would seek to procure culture and DST services under the newly approved PPM schemes. Since these scale up plans are in the initial stages of deliberation for technical and administrative feasibility, no special funds have been requested under the existing RCC project.
- A one time grant of Rs 1,000,000 would be provided to each DOTS Plus Site hospital, to upgrade indoor facilities, and undertake minimal infrastructure modifications to facilitate infection control measures. In addition, a national plan for '**Air-borne infection Control Strategy**' is being developed and would be implemented by undertaking training of key staff at all DOTS Plus sites and other TB facilities.

TB/HIV Collaborative activities

- TB-HIV collaborative activities were started initially in the year 2001, in the six states with high

prevalence of HIV/AIDS i.e. ***Andhra Pradesh***, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu. The collaborative activities were extended to eight additional States of Delhi, Gujarat, Himachal Pradesh, Kerala, ***Orissa***, Punjab, Rajasthan and West Bengal in the year 2004. In 2007-08, TB-HIV collaborative activities were extended to the entire country and have been included as an integral part of NACP III and RNTCP II. (Most of the RCC project states have very low prevalence of HIV, except Andhra Pradesh)

- The goal of the Revised National framework (2008) of joint TB/HIV collaborative activities is to further enhance collaboration between RNTCP and NACP, and reduce the burden of TB and HIV in India.*(See Annexure No. 4.VII-National Framework for Joint TB/HIV collaborative activities.Feb 2008)* The framework has the following objectives:
  - To strengthen mechanisms of coordination between RNTCP and NACP at National, State and District levels.
  - To decrease morbidity and mortality due to tuberculosis among persons living with HIV/AIDS.
  - To decrease the impact of HIV in tuberculosis patients and provide access to HIV related care and support to HIV-infected TB patients.
- The key activities include:
  - Establishment of coordination committees at national, state and district level to strengthen collaboration. In addition, a full time TB/HIV coordinator has been sanctioned by RNTCP to facilitate successful implementation of TB/HIV collaborative activities in most of the states.
  - Strengthening of linkages between service delivery sites of NACP (ART centres, ICTCs, care and support centres) and RNTCP diagnostic and treatment services. This will be achieved by improving service delivery coordination and cross-referrals.
    - The periodic HIV survey in TB patients for the year 2006-07 demonstrated a wide and variable distribution of HIV prevalence among TB patients across the country. Central TB Division (CTD) & National AIDS Control Organization (NACO) have adopted the policy of providing a basic package of services in all settings and “Intensified TB/HIV package” for the nine States with highest estimated seroprevalence of HIV infection.
    - The activities undertaken in all settings include: a) Training of programme officials and field staff on TB/HIV; b) Intensified TB Case Finding at ICTCs, ART Centres, and Care and Support Centres; c) Risk-based referral of TB patients for voluntary HIV counselling and testing; and d) Referral of HIV-infected TB patients to NACP for additional care and support, including antiretroviral treatment
    - The 9 high HIV-seroprevalence states taken for implementation of the “Intensified TB/HIV Package” are Andhra Pradesh, Goa, Karnataka, Maharashtra, Manipur, Mizoram, Nagaland, Pondicherry and Tamil Nadu. The expansion of the Intensified TB/HIV package to additional States would be undertaken in a phased manner, jointly determined by the National Programmes. Intensified TB/HIV package of services includes: a) Routine referral of all TB patients for HIV counselling and testing; b) Decentralized cotrimoxazole preventative therapy (CPT) to HIV-infected TB patients; c) Expanded recording and reporting. Andhra Pradesh is the only high HIV-seroprevalence state which is included in this RCC proposal.
    - To facilitate delivery of intensified TB/HIV package, a senior ‘DOTS Plus & TB/HIV supervisor’ would be provided under the project
  - Involvement of NGOs working in NACP and RNTCP in TB/HIV collaborative activities.
  - Operational research, including ongoing operational research on IPT, to improve TB/HIV collaborative activities and inform future programme policy decisions.
  - Implementation of feasible and effective infection control measures

Objective 3: To be undertaken by the SRs – Indian Medical Association (IMA) and Catholic Bishops Conference of India (CBCI)

In addition to the two sub recipients mentioned, all the States covered under the proposal will implement RNTCP PPM activities to engage with private practitioners and NGOs, using the recently approved NGO/PP schemes for collaboration. *(See Annexure No 4.VIII – RNTCP Revised Public Private Mix Guidelines)*

3a. The IMA has been collaborating with the RNTCP for several years. This collaboration was formalised at the national level in 2004 when the National IMA formally announced it’s support to RNTCP. Following the experiences of implementing state and district level pilot projects, IMA is currently implementing the

Round 6 project for the training and involvement of private practitioners in 6 states/ union territory (Andhra Pradesh, Chandigarh, Haryana, Maharashtra, Punjab and Uttar Pradesh with a total population of over 401 Million). Based on the initial feedback from the implementing sites and acknowledging the need and request *from other States*, the IMA project under the RCC proposes to expand the coverage to 16 States/UTs, by reaching out to over 145,000 members across two-thirds of the districts in the country. *(See Annexure No.4.XIII IMA concept note for GFATM RCC TB component).*

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

i. Advocating DOTS to private medical practitioners through:
   - Periodical newsletters and medical journals and IEC/advocacy material **(to reach out to 145,000 practitioners, leaders and opinion makers)**
   - Sensitisation of key practitioners and motivators **(240,000 PPs to be sensitized)**
   - CME Programmes and workshops
   - Training of private providers **(35,000 PPs to be trained)**

ii. Conducting workshops where Public-Private dialogue and interaction would be made effective **(115 National and State level workshops planned)**

iii. Linking the private sector with the RNTCP at national, state and district levels **(17500 PPs to be involved in RNTCP)**

iv. Coordinating with the public sector in training of private providers

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

3b: First IMPACT (First Innovative Mobilization of Private Actors & Church against TB) – Health Commission of the Catholic Bishops' Conference of India (CBCI) project *(See Annexure No 4.XII CBCI concept note for GFATM RCC TB component).*

The Health Commission of the CBCI is a permanent association of the Catholic Hierarchy of India. The Church in India has been known for it's strengths in three main areas – education, health care and social development. The Church has an extensive health care network in the country. This includes a variety of health facilities ranging from tertiary care hospitals to one room dispensaries, and includes 6 medical colleges, 763 hospitals, 2575 dispensaries, 62 centres for TB, 75 Care & Support centres, over 100 medical training, and multitude of outreach programmes. Nearly 85% of the Catholic health care facilities are in remote villages providing access to millions of people.

CBCI seeks to build on the existing partnership of the Catholic Church network with RNTCP under Round 4 of the Global Fund by expanding activities from 11 to 19 states in the country. This project for the involvement of the Church network in RNTCP by the CBCI was the first time when such a large network of the Church had come together to work against TB and was hence called First IMPACT (Innovative Mobilization of Private Actors & Church against TB). While the project aims to bring under one 'umbrella', public and private providers who would work together in combating the scourge of tuberculosis in India, the structure of the CBCI model proposes a strong central control that regulates the policies of the project while implementation is simultaneously carried out in all states by the state cells which controls, oversees and reports its activities and those of its partners – the Catholic Health Association of India (CHAI), and the Catholic Relief Services (CRS), India program.

Key activities under the project include:

i. Advocating DOTS to partners in the network through periodical newsletters and medical journals

ii. Sensitization of key players and motivators **(12,000 health institution staff and leaders to be sensitized)**

iii. Training of health care personnel at these centers **(7500 medical and paramedical staff to be trained)**

iv. Implementation of RNTCP services in all Catholic Health Care facilities **(750 large hospitals to be involved)**

v. Establish, support and monitor RNTCP activities in the facilities and in the community served by them through outreach staff **(18 State level consultants** facilitate development of linkages with district/state programme units) and it would result **in over 648,000 TB suspects being identified and referred for diagnosis)**

vi. Support district and state programme in supervision and monitoring of RNTCP activities in the area served by the health institutions **(120 National and State level review workshops planned)**

vii. Establish RNTCP recording and reporting systems in all health facilities (PHI monthly report)

The ongoing "intensified PPM –DOTS activities" in 14 cities captures the contribution and impact of PPM DOTS to the RNTP case finding. In these sites, special recording and reporting systems have been put in place, without disturbing the national reporting mechanism, in order to document referral of TB suspects by PPs to DMCs and number of TB patients being provided DOT by PPs, along with other parameters. The modified surveillance system in these sites, would be used to monitor the contribution of PPs/NGOs in terms of case finding and case holding.

Objective 4: To be undertaken by the PR (National TB programme office)

- Measure impact of RNTCP DOTS: The project plans to measure the impact on RNTCP on TB burden in the country. The current national estimate of 3.8 million bacillary cases has been calculated from surveys undertaken by TRC in a subdistrict population of Tamil Nadu and national ARTI surveys. Since a national sample survey is resource intensive and operationally not feasible, the national expert committee, in 2004 , recommended conducting TB prevalence surveys at 1-2 select sentinel sites in each of the 4 zones of the country, to obtain a precise estimate of the TB prevalence at these sites. Repeat surveys at these sites over the next decade would demonstrate trends and the impact of RNTCP and progress towards TB related Millennium Development Goals. The current project proposes to ***support the initial round of the TB prevalence surveys at 4 such sites*** in the country and the **repeat surveys at 6 sites** (2 sites currently being supported by WHO) in 2014-15. TB mortality surveys had been undertaken in the states of Andhra Pradesh (south) and Orissa (East) under the GFATM Rd 4 project. However, due to limitations in the study methodology, the technical advisory group recommended not to undertake specific TB mortality surveys in the future, and to collaborate with the Registrar General of India's office as part of the comprehensive all cause mortality surveys undertaken by RGI. In view of the above, the programme would not be undertaking TB mortality surveys, and would refer to the WHO estimates and RGI data to measure trends in mortality. **Repeat Drug Resistance surveys** in Andhra Pradesh and Orissa have been planned in 2013-14.

To demonstrate the impact of RNTCP on the prevalence of infection and incidence of disease,the second and third national ARTI surveys have been planned before 2015 utilising other funding sources. Currently, the second survey is ongoing and is expected to be completed by the end of 2010.

Summary: Changes in scope and scale of the project

- Strengthening of National and State level capacity to support programme management by provision of additional human resource (Ex. Administrative officer at national level/ Epidemiologist at State level)
- Expansion of DOTS Plus and TB/HIV services in all project states
  - Strengthening National Reference laboratories and Intermediate Reference laboratories (human resource – Microbiologist and Lab Technicians) to support implementation and monitoring of quality assurance systems for sputum microscopy and accreditation of culture and drug sensitivity testing at IRLs
  - Expansion of TB/HIV and DOTS plus services across the project states. In order to ensure these additional activities, do not compromise routine DOTS implementation, and also given the fact that these require co-ordination and follow-up of patients and different centres (DOTS Plus sites or ART centres) for continued care, and developing community based support structures for patients and their families, a DOTS Plus and TB/HIV supervisor is being proposed at district level.
- Introduction of revised PPM schemes which will provide flexibility to address specific programmatic needs and strengths of the private/NGO sector; and with revisions in incentives to make the schemes attractive.
- Expansion of the PPM projects with strategic partnership with IMA and CBCI
- Strengthening and improving storage capacity and conditions at state drug stores and district drug stores to accommodate 2nd line anti TB drugs of State and district drug stores with introduction of Bar Code readers for improved logistic management

4.6.5 Incorporation of lessons learned into this proposal

Describe below:

(a) how this proposal **addresses and resolves weaknesses or bottlenecks** encountered during implementation of the expiring grant (including through the selection of additional PR(s) from appropriate sectors); and

(b) how this proposal has taken into account weaknesses identified by the TRP in a recent review of a same disease proposal from the country.

Applicants are encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants *(including 'Phase 2' amounts anticipated to become available).*

The expiring grant proposal was intended to expand the coverage of RNTCP DOTS services to the uncovered 110 million population in Bihar and Uttar Pradesh. As highlighted previously, both these states were programmatically challenging due to the poor socio-economic status of its population, poor health infrastructure and sub-optimal politico-administrative commitment seen in the initial phase of the programme implementation.

In its feedback on the expiring grant proposal, the Global Fund (in its invitation for the RCC proposal) has rated the overall performance of the project as good. It has also taken cognizance of the challenges faced in the state of Bihar, and has suggested increased private partnership to substantially improve the performance in the state. *(See Annexure No 2.II Global Fund Notification Letter OPS/ASIA 1/1281/PAS/TR/ldc).*

Currently both the States, especially Bihar, have undertaken significant steps under NRHM, to strengthen the public health care delivery system. Realizing the huge gap in infrastructure and human resource, the delivery units have been centralized to the block Primary Health Centre level (100,000 population) , to ensure 24x7 treatment facilities. The state has also initiated several innovative PPM approaches to improve out-reach of MCH and basic health care services, which would also benefit the TB programme. Against this backdrop of dynamic changes occurring within the system, the programme is collaborating closely with NRHM to make the best use of all available opportunities to strengthen DOTS services.

To facilitate these services, the states have been given incremental human resource to meet the gap in Lab Technicians (LTs sanctioned under the programme has been increased from 20% (for the entire country) to 50% in UP and 40% in Bihar). In addition, Bihar has been included in the proposal for expanding the reach to private practitioners under the IMA-PPM sub project, under the current RCC project proposal . Similarly, the CBCI would be targeting their network of health facilities in both the states.

In addition, the programme has requested the NGO led TB coalition/ consortiums (applying under Rd 8), to focus and emphasize on community level advocacy and communication and build a strong political and administrative commitment for TB control at all levels. The programme has urged the civil society to take the initiative and utilise their strong linkages and reach at the grass-root level. This multipronged approach would support the state and district programme management units by building their capacity and also by bring in expertise and additional resources for a coordinated effort to control TB.

In order to incorporate flexibility and innovations in public private collaborations, the newly revised NGO/PP schemes were developed in close collaboration with NGOs and civil society partners. It is expected that this will lead to a better uptake of these schemes, particularly in states like Bihar and Uttar Pradesh. To complement this activity, the programme is undertaking several initiatives to strengthen the capacity at the state and district level for improved implementation, supervision and monitoring of PPM activities.

4.6.6 Risks arising from disease specific responses to health systems weaknesses and gaps

If the activities described in s.4.6.4 include responses to health systems weaknesses and gaps through a disease-specific program approach, describe how the programming for this support has sought to mitigate any risks or unintended consequences of that support (compared responses that are undertaken on a cross-disease basis).

One of the most important requirements for the effective and efficient delivery of DOTS services in any setting is the availability of decentralized diagnostic and treatment service units. These service delivery points should be patient centric and be as close to the community as feasible, and can be in either the public sector or the private sector.

Risk identified: Weak public health system – infrastructure & human resource

India has a vast network of public health infrastructure, with establishment of primary health care centres for every 25-30,000 population, community health centres (1st referral units) for every 100,000 population, and the sub-district and district level hospitals at the secondary level, and medical colleges and large hospitals at tertiaty level. In addition, there are community outreach units through sub-centres (for every 5000 population) and their health workers; and the village level community volunteers – Anganwadi workers – from the nutritional supplementation programme under department of Women & Child development. The community outreach workers and the Anganwadi workers form the major strength of all the health interventions, including TB (DOT provision and health education), as they are from the community and trusted by its members. However, there is a human resource gap (staff vacancies) at all levels, especially for key staff like the medical officers and laboratory technicians. A skewed distribution of this key staff ,especially in rural areas as compared to urban areas, has been noticed in all the states.

Response: As TB services are human resource intensive, and need critical human resource for supporting diagnostic and treatment services as well as for programme management and monitoring, the programme has supported upgrading the infrastructure of laboratories and TU/District drug stores, within the existing general health facilities. In addition, additional human resources have been provided (Lab technicians and Medical Officers) to meet the critical gap, and dedicated supervisors (STS/STLS) to support supervision and monitoring and systematic reporting of all cases diagnosed and initiated on treatment, and their treatment outcomes. This model of providing additional support has been very successful and, has led to large scale nation wide coverage of DOTS services, and the fastest DOTS expansion in the world. Besides supporting the programmatic efforts, this has also led to strengthening of the general health system. The RNTCP programme, has been acknowledged as a flagship programme of the Ministry of Health, and its M&E systems and Financial Mangaement systems for recording and reporting are being taken up as case studies for overall improvement of the health system. Besides the specific TB programme response, there has been a much wider government response under the NRHM, which includes additional human resources, infrastructure development of health facilities to meet the public health standards, training and capacity building and strengthening programme management. To facilitate enhanced community outreach NRHM has engaged ASHA (Accredited Social Health Activists) workers. The TB programme, being a part of NRHM, will utilize these resources to strengthen TB care and control activities.

Risk identified: Sustainability of programmatic support

Recognizing the fact that to achieve TB control, activities will need to be maintained and sustained over several decades, continued strong commitment and sustained funding from the Government of India and the international donor community will be required.

Response: With reference to sustainability, it may be mentioned that the National Health Policy 2002, envisages to increase public health spending from 0.9% of GDP to 2% by 2010, increase the share of central grants for total health spending from 15% to at least 25% by 2010, and also increase the state sector health spending from 5.5% of budget to 8% by 2010. In response to the national policy, the National Rural Health Mission, launched in 2005, aims to achieve the goal of the National Health Policy (and the National Population Policy) through improved access to affordable, accountable and reliable Primary Health Services. With the additional resources being pooled in the structural and human resource deficits are expected to met, as TB control strategy with its critical components (like laboratories, drug stores, LTs, STS, STLS) have been incorporated as part of the Public Health Standards established for each level of health institution. In addition, ASHA workers would also facilitate enhanced outreach activities.Thus, it is presumed that over the years, with improvements in the health system as envisaged under the National Health Policy, these additional components are more likely to be integrated and supported from the domestic resources, than by disease specific response. The Govt of India will continue to advocate on the global stage for long term financial and technical commitment to TB control

activities in India, from international partners.

In addition, it is further reiterated that the government is committed to support TB as a 100% centrally sponsored scheme to the states, till TB ceases to be a major public health problem.

Risk identified: unregulated and dominant private sector

The third and crucial limitation of the public health system, is the large ,dominant, and unregulated private sector, which accounts for over 70-80% of allopathic practitioners, and 70% of the health spending in the country (out-of-pocket expenditure). As studies indicate, diagnosis and treatment within this sector is usually non-standardized. With no systems to ensure drug quality and treatment adherence, the treatment outcomes are poor with increased risk of developing drug resistant disease, and significantly increased financial burden to the patients and families,

Response: The programme has initiated its innovative PPM projects from 1999 onwards, and these efforts have resulted in nearly all (261) medical colleges involved under the programme, 2500 NGOs and 18,000 private practitioners and 150 corporate houses being involved in the programme. The programme recognizes that efforts of the programme officers have to be complemented with support of interface organizations like NGOs/ professional bodies, and in the current proposal has included CBCI and IMA as SRs. The approach adopted is education,advocacy and engagement with professional medical associations to impact on individual medical practioners . Adoption of TB management practices is encouraged , in order to make treatment practices consistant with International Standards of TB care. The newly revised NGO/PP schemes have been developed in close collaboration with NGOs and civil society partners, keeping in mind earlier financial and technical constraints faced in the field. Now that these constraints have been addressed, it is expected that there will be a better uptake of these schemes, particularly in states like Bihar and Uttar Pradesh.

Program linkages

4.6.7 Links to other grants or programs

(a) Describe:

- any program or operational links between the focus of this proposal and the activities or interventions supported through: (i) an existing Global Fund grant (including new proposals recently approved) or (ii)
- Whether this proposal is asking for support for the same program areas or interventions as another existing same disease Global Fund grant, and if so, why this is not a request for duplicative funding.

The present proposal is a continuation of the expiring Round 2, consolidation of Round 4 and 6 including scaling up of the IMA and CBCI sub projects as well as the addition of Haryana and 8 districts of Bihar. Activities proposed for support under this project are not financed by any other Global Fund project (or any other existing funding mechanism) other than Round 2, 4 and 6 as mentioned above. Details from 4.6.2

The Central TB Division is the nodal agency under the Ministry of Health & Family Welfare, Govt. of India, implementing the TB control programme in the country. This Division prepares policies and guidelines for implementation of the programme and coordinates activities undertaken by the States and districts with funding from domestic and external funding agencies. This Global Fund project is part of the overall RNTCP being implemented in the country.

Since April 2005, the Govt. of India has launched the National Rural Health Mission which integrates the various National Disease Control Programme and the Family welfare Programmes at the executive level while maintaining individual identity at technical and financial level. The RNTCP has also been subsumed under this Mission. This would lead to enhanced coordination within the Ministry of Health and Family Welfare, GOI resulting in effective implementation of health activities in the country. In addition, state governments would benefit in terms of concerted strengthening of health management systems at state and district levels as well as increase fund flow from the federal govt.

The current proposal is for implementation of RNTCP in the 8 states of Andhra Pradesh, Bihar, Chhattisgarh, Haryana, Jharkhand, Orissa, Uttarakhand and 27 districts of Uttar Pradesh covering a population 362 million across 191 districts. The RCC proposal is integral to the National TB control efforts which are being supported by the World Bank, GFATM and DFID. However, there is no duplicity of funding as all programme fundings are based on geographical demarcations with no dual funding in any district/state.

The PPM intervention, led by IMA and CBCI, extends beyond the 8 states proposed under the RCC proposal. Under the earlier approved proposals, IMA was supporting PPM activities in 6 States/UTs and CBCI in 11 states. It is proposed to expand the geographical coverage to 16 states/UTs by IMA, and 19 states by CBCI. Their activities are beyond the routine RNTCP services, and are specifically target the private providers and network of health care institutions by a process of advocacy, sensitization and training, and liasoning to seek their involvement under the existing RNTCP schemes. These additional collaborative activities are critical to reach out to all health care providers, and have not been budgeted under routine RNTCP programmatic activities. Urban PPM projects being undertaken in 14 urban sites would be used to provide critical sentinel information on contribution of PPM efforts especially in the areas of referral of TB suspects, case detection and DOT provision. This information would be utilized in the IMA sub-project to measure effectiveness of the PPM efforts and its contribution to the national initiative and particularly to the GFATM project. The participating centres under CBCI project would submit a monthly/quarterly report, which would be collated and used to provide information on the outcome of the initiatives

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

Similarly, for drug store at the GMSDs at the national level and transportation to the State Drug Stores, the existing mechanism of provision of support from the World Bank project and domestic respources

would be continued, for all states, including the RCC project states. Like-wise, funds have been provided to the GMSDs under the current Global Fund projects, to upgrade their facilities to improve their storage capcity and conditions in line with the GFATM review and recommendations, and improve logistic management. This Global Fund grant would translate in overall improvement of drug storage and logistic management at the national level, benefitting the entire project.

The flexibility and support provided under the Global Fund projects supports national efforts in adopting and expanding innovative PPM projects. The IMA and CBCI schemes would be supporting TB control efforts beyond the proposed 8 RCC states, and contribute to overall improvement in case detection and treatment provision across the country, increase in enrolled of private providers under RNTCP PPM schmes, and thus help in achieving the programme objective of involving all care providers.

Similarly, impact measurement surveys would be supported both under the WB project (ARTI, DRS and Social Assessment/IEC impact surveys) and GFATM project (TB prevalence surveys and DRS surveys).

These operational linkages are the key to the overall programme success, and hasten the national effort to realize TB related MDGs.

(b) **Only if relevant**, indicate whether any part of the request for funding in this proposal arises from the discontinuation of support from another source? If so, explain the reason why that source of funding is no longer available.

There is no discontinuation of funding from any source, but funds have been reprogrammed for optimal utilization of available financial resources, .

The state of Haryana (23.7 million population), which was supported under the USAID project till March 2008, is now being proposed for inclusion under the current RCC proposal. This was necessitated following the reprogramming of USAID funds from DOTS implementation in Haryana to increased technical assistance to RNTCP.

The Round-2 proposal covered 30 out of the total of 38 districts in the State of Bihar. Under the RCC proposal the entire state of Bihar (38 districts) is proposed to be covered. This is expected to streamline funding at state level, simplify programme management and reporting, and improve the overall efficiency of the programme.

4.7 Enhancing in-country capacity and equality

4.7.1. Partnerships with the private sector to support increased coverage and services

(a) The private sector may be co-investing in the activities in this proposal, or participating in a way that contributes to outcomes (even if not a specific activity). If so, summarize the main contributions anticipated over the proposal term, and how these contributions are important to the achievement of the planned outcomes and outputs.

*(Refer to the Guidelines for Proposals for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

Private sector will contribute towards the outcome of this project by participating in revised PPM schemes and via the sub projects of CBCI and IMA.

IMA will be contributing honorary project assistance in the form of 443 IMA functionaries, 2000 member doctors and office space at National and State level.

Similarly, the CBCI will be contributing human resources and office space at the National and State level. In addition, over 750 large hospitals and over 2000 other health facilities and their healthcare staff will contribute to RNTCP services.

This contribution of human resources and donation of office space by the IMA and CBCI is difficult to quantify in monetary values.

Clarified Section 4.7.1. Applicant was asked to give monetary estimates of the Private Sector contribution. Following is the answer received: The private sector will be participating in different activities in this project and contribute to the overall outcomes. The main areas of contribution are listed below, along with the rationale for not being able to assign a monetary value to these contributions.

- Participating in the revised PPM Schemes of RNTCP.
  In order to incorporate flexibility and innovations in public private collaborations, newly revised NGO/PP schemes have been developed in close collaboration with NGOs and civil society partners. PPs and other partners involved in these schemes will be contributing their time, attention and efforts towards different programme activities. The RNTCP schemes do not contribute towards payment of the salaries of all these NGO or PP staff. The efforts and the time contributed by the staff cannot be be assigned a monetary value. In addition, the premises are utilized for advocacy, social mobilization, diagnostic and treatment activities, the value of which is hard to quantify.
- IMA will be contributing honorary project assistance in the form of participation of more than 443 IMA functionaries and 2000 member doctors. The functionaries will be contributing their time and expertise to spread the message of DOTs among their members. In addition, the entire administration and planning of project activities is being done by the National Working Group of the IMA, whose members are contributing their time and efforts voluntarily. This is difficult to compute in financial terms.
- Office space is being provided at the National and State level, within the premises of the already functional offices of the IMA. Monetary value for these premises, their upkeep and maintenance is difficult to quantify and assign a financial value.
- CBCI will be contributing human resources and office space at National and State level. Human resources include technical and administrative staff, as well as the opinion leaders and religious heads, who will be providing their expertise and efforts, over and above their normal duties as implementing RNTCP activities is not their only responsibility. Assigning a financial value to these efforts is complex and hard to undertake.
- Staff, including technical, managerial and other healthcare staff, of more than 750 large hospitals and 2000 health facilities will be involved in the project. They will be providing diagnostic and treatment facilities, including field visits and defaulter retrieval activities. Once again, it is hard to provide a realistic monetary estimate for such activities of the healthcare staff.

(b) Identify in the table below the annual amount of the anticipated contribution from this private sector partnership. *(For non-financial contributions, please attempt to provide a monetary value if possible, and at a minimum, a description of that contribution.)*

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?*) ➔	

Contribution Value (in USD or EURO)

Refer to the Round 8 Guidelines for examples

Organization Name	Contribution Description (*in words*)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total

Use "Tab" key to add extra rows if needed]								

4.7.2 Enhancing social and gender equality

Explain how the overall strategy of this proposal will contribute to achieving equality in your country in respect of the provision of access to high quality, affordable and locally available prevention, treatment, care and/or support services.

*(If certain population groups face barriers to access, **such as women and girls, adolescents, sexual minorities and other key affected populations**, ensure that your explanation disaggregates the response between men and women, and girls and boys).*

A constant feature of the RNTCP pulmonary TB case notifications is that more male patients are detected than female patients, with the ratio being 1.8 : 1. A number of community based epidemiological studies have consistently demonstrated that in all age groups, pulmonary TB is predominantly a male disease. Operational research studies have also shown that among the cases existing in the community, a significantly higher proportion of male cases, especially elderly males, are "missed" from the case notifications, suggesting that generally males may have poorer access to TB services than females. RNTCP data consistently also shows 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.

The complexity and the cost of getting a TB diagnosis can be high for both poor women and men. Repeated visits, travel costs, rigid service timings, and delays in test reports reduce poor women and men's ability to access services. 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 addressing this issue. In relation to the states in the proposal, geographical coverage is already 100%. However, the need to increase accessibility to services is a recognized fact. A vital component of this step is increased inter-sectoral collaboration with sectors outside of the public health services. RNTCP has made efforts to increase access to services for socially disadvantaged groups through community outreach services (ASHA workers and community DOT providers) and provision of DOT service providers of acceptable gender, caste and religion. A range of innovative and creative provisions for DOT treatment at the community level has been evolved. 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 other gender-based issues. One such area 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 has provided data on the proportions of males and females being registered under the programme and their treatment outcomes.

Another area of programme activity that will address some of the gender-based issues the RNTCP ACSM strategy. The strategy encompasses efforts to encourage both men and women to report to health facilities if ill with symptoms of TB, and once diagnosed, to raise awareness amongst patients about the importance of completing treatment. Through intensified ACSM activities and greater accessibility of quality free TB services, community members with symptoms of TB will be encouraged to report to the health facilities for examination and treatment if required. Through the provision of quality decentralized free TB services, which will increase the number of cured TB patients present in the community, it is hoped that the stigma related to TB in the community will decrease. Cured patients can be DOT providers to future patients and also be advocates for the programme. They will be potent symbols in the community about the fact that TB is a curable disease and should that it should be seen as just another infection that needs antibiotic treatment for cure.

To ensure equitable access to services, RNTCP services will be made available to all cases diagnosed as TB under the health system and associated sectors, and will include all sections of the population. It has been mentioned above that the norms for the establishment of Designated Microscopy Centres and TB Units have been relaxed for communities living in hilly, tribal and difficult areas. Considering the

geographical barriers in such areas, establishment of sputum collection and transportation systems has been encouraged, and convenient DOT is to be ensured through community volunteers. Mobility in such areas is costly due to larger distances and non-availability of local transport. Therefore under the Tribal section of the respective District RNTCP Action Plans, staff working in such areas would be given additional funds for mobility and provisions have been made to suitably compensate the patients and reduce out of pocket expenditure. The RNTCP has also initiated routine monitoring of programme performance in identified tribal and poor/ backward districts, which is reported in the published quarterly RNTCP performance report.

Urban areas and urban slums in particular are other challenging areas. The public health care system is not well established in such areas, though tertiary care services are more readily available. To improve access of communities living in such slums and in the urban areas in general, on-going increased efforts are being made to involve civil society, NGOs, and the private sector, and additional support staff (Urban TB Co-ordinators and TB Health Visitors) are being provided.

For poor women and men, dependent on low income earning livelihood strategies, RNTCP is pro-actively working to link such patients to existing social welfare schemes of State and Central Government, by creating awareness among patients, regarding availability of such schemes for their utilization.

4.8 Planning for Sustainability and Impact

For more detailed information on the requirements of this section, see the Guidelines for Proposals s.4.8.

4.8.1 Potential for sustainability

(a) **Strengthening national capacity and processes**

Describe how this proposal makes an important contribution to the strengthening and/or further development of national systems and institutional capacity (including the capacity of the public, private and NGO sectors, and communities affected by the disease). Refer to country evaluation reviews, if available.

RNTCP has already been contributing to the human resource and infrastructure component of the general health system, by providing key contractual technical and supervisory staff at different levels. By providing computers and internet facility for electronic transmission of data at the district level, there is a significant contribution to improved institutional capacity for monitoring and supervision. This proposal will continue to support and sustain the existing infrastructure developed (eg peripheral laboratories, drug stores ,TB units etc) for the implementation of RNTCP in the project states. In addition, under the RNTCP DOTS Plus activities for treating MDR-TB patients, the proposal will strengthen the infrastructure and staffing at treatment sites, including capacity building of health care workers, and the use of ASHA workers as a link between the community and the health system.

The National level capacity to plan, monitor and supervise the activities will be further strengthened through this proposal by the provision of technical expertise in the form of microbiologists,administrative officer etc.The Revised NGO and PP schemes will contribute towards improving involvement of the civil society and private sector at the grass root level, and will have a positive effect on communitisation of DOTS strategy in the country. One of the NGO schemes is related to ACSM and is targeted at empowering and increasing community ownership of TB care and control activities.

The IMA and CBCI sub-project is expected to result in the required behavioural change among the private practitioners in the project areas through intensified behaviour change approaches and communication. Lessons learned would be replicated in different areas of the country in coordination with the RNTCP and other partners.

(b) **Alignment with Broader Developmental Frameworks**

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative and the Millennium Development Goals.

Also include an overview of any links to international initiatives, e.g. as the WHO/UNAIDS 'Universal Access Initiative' or the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities, or the 'Roll Back Malaria Global Strategic Plan').

India is not a Highly-Indebted Poor Country and does not have a PRSP. However, India's most compelling and globally significant challenge is the reduction of poverty. According to World Bank figures (World Development Indicators 2000), India has 433 million people living on less than US$1 a day,

making up 36% of the poor in the world. As per a 2003 report on Selected World Development Indicators, India spends 0.9% of its GDP on public health care. An additional 4% is spent in the private sector. The average annual health expenditure per capita is US$19.

India has developed elaborate consultative and consensus- building processes for the formulation of economic and social policies. The Planning Commission and the Five Year Plans have a special role in articulating the country's poverty reduction strategy. Tuberculosis causes huge economic losses with about 70% of cases occurring in the economically productive age group, resulting in an annual loss of 170 million workdays and an estimated economic loss of US$3 billion to the country. It is estimated that on the average, a TB patient loses 20 to 30% of his annual household income. Control of TB has the potential to significantly contribute to the reduction of poverty at both the individual and national levels. By reducing absenteeism, preventing incapacity from ill health, and by averting TB deaths among these workers, RNTCP will add to the productive capacity of the economy. The proposed project will contribute significantly to the RNTCP's efforts to impact the country's economy, by focusing on states and districts which have high numbers of people with TB.

The national strategy for control of TB is in line with the Global Plan to Stop TB 2006-2015, and the country is already implementing all the components of the WHO Stop TB Strategy 2006, including TB-HIV collaborative activites. This proposal envisages further scaling up and strengthening of activities to further advance progress towards achieving TB related MDGs.

4.8.2 Evidence of impact/potential for impact

For the questions below, the concept of 'impact' refers to whether there is clear evidence of impact on the relevant disease epidemic or influence of planned interventions on disease prevalence, incidence, mortality and/or averted infections.

(a) **Potential for demonstrating impact**

How will the additional support provided by this proposal increase the capacity of the country to demonstrate that its national disease strategy will have, or has the potential to have, a measurable impact on the burden of the disease (whether expressed in terms of overall morbidity and/or mortality and/or averted infections).

The impact of the programme on the TB epidemiology in the community will determine the progress made by RNTCP towards achieving its goal of controlling TB in India. Impact related to TB control activities, however, can only be seen after many years of activities. Further, the observed outcomes and impact may also be affected by other contributing factors such as improved socio-economic conditions, severity of the HIV epidemic, etc. The impact indicators link directly with the targets laid out in the TB related Millennium Development Goal.

TB-related Millennium Development Goal

Goal 6 – to combat HIV/AIDS, malaria and other diseases

Target 8 – to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases, including tuberculosis.

Indicator 23: Between 1990 and 2015, to halve the prevalence and death rates associated with tuberculosis; and

Indicator 24: by 2005, to detect 70% of new smear positive TB cases arising annually, and to successfully treat 85% of these cases

The RNTCP surveillance system collects routine information on notified cases to measure treatment success and case detection. For evaluating the impact of RNTCP in the community, the programme has developed a strategy to monitor the trends in TB incidence, prevalence, and mortality.

Incidence of TB: The Annual Risk of Tuberculous Infection (ARTI) was selected as the study parameter to obtain the most reliable index of TB situation in the country. The first nation wide ARTI survey was conducted from 2000-03. The programme has planned for repeat national Annual Rate of Tuberculosis Infection survey (ARTI) every 3-6 years, with the next round planned for in 2008-10, and followed up in 2014-15. These surveys are being supported under the World Bank project.

Prevalence of TB: Using available data, the prevalence of bacillary positive TB disease was estimated at 3.8 million in the Year 2000. This estimation provides a baseline for comparison against data in future years to measure the long term impact of TB control activities in India.

To obtain a representative estimate and study the trend in prevalence,a Govt of India expert committee in 2004 adviced undertaking TB prevalence surveys in 6-7 select sentinel sites/districts in different zones of the country. Surveys are currently being undertaken in 7 sites, starting in 2007. These would be repeated in 2014-15 to measure progress towards MDG. Out of the 7 sites, 4 are being supported under

the approved Global Fund Rd 6 project and rest by WHO.It is proposed to support 6 sites under the RCC for the repeat survey in 2014-15.

Mortality due to TB: Community based TB specific mortality surveys have been conducted by the programme with the technical support of TRC, Chennai. The GOI technical advisory group met in 2007 and reviewed the methodology. The group recommended for discontinuation of such programme sponsored surveys and suggested relying on Registrar General of India (RGI) verbal autopsy surveys and WHO estimates, in future. Implementing RNTCP activities through this proposal is expected to reduce the TB specific mortality. As per the WHO report 2008, mortality rate has reduced from 42/ 100,000 in 1990 to 28/100,000 in 2006.

Drug resistance surveys: State representative Drug resistance surveys (DRS) have already been conducted by RNTCP in the states of Gujarat and Maharashtra in 2005-06. Currently, DRS surveys are being undertaken in the states of Andhra Pradesh and Orissa (using GFATM Rd 4 funds) and in Uttar Pradesh. The programme has planned to undertake periodic state-representative DRS surveys every 3-5 years, and repeat surveys in Andhra Pradesh and Orissa are proposed in 2013-14 under the RCC project.

(b) **Impact Measurement Systems (IMS)**

Describe the strengths and weaknesses of in-country systems and organization(s)/team(s) that evaluate potential for health impact, determine country impact measurement indicators, and track/monitor achievements towards national goals.

Note ➔ **If there has been a recent national/external evaluation of the IMS, describe the main findings.**

Impact measurement will be done by conducting ARTI surveys, sentinel disease prevalence surveys and drug resistance surveillance.

Since the programme's notification system does not capture all TB cases in India (cases treated outside the programme are not notified), impact will have to be measured through periodic surveys in the community. The programme will use ARTI surveys to estimate trends in prevalence of infection and incidence of disease.

It is not feasible to conduct nationwide prevalence surveys in India due to enormous requirement of trained manpower, operational constraints and high cost. Therefore, RNTCP will conduct periodic prevalence surveys in 7 sites as recommended by Govt of India expert committee in 2004.

The vital registration system is weak and the cause of death statistics from this system is extremely unreliable. Additionally, TB specific mortality surveys have not been recommended by the GOI technical advisory group in 2007. The programme will therefore use Registrar General of India (RGI) verbal autopsy surveys and WHO estimates.

Community based surveys will be coordinated by TB Research Centre -Chennai, National TB Institute - Bangalore, LRS Institute-Delhi and several medical colleges across the country.

(c) **Strengthening monitoring and evaluation systems**

What improvements to the M&E systems in the country (including those of the Principal Recipients and Sub-Recipients) are included in this proposal to overcome gaps and/or strengthen reporting into the national impact measurement systems framework?

➔ *The Global Fund recommends that 5% to 10% of a proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.*

Monitoring and evaluation are crucial for the successful implementation of all programmes, including RNTCP. Supervision and monitoring are complimentary to each other, with the single objective of ensuring that the programme is implemented in a stipulated manner and achieves the predetermined programme objectives.

To facilitate the same, a robust recording and reporting system has been established, to support routine collection of the required data in a simple and standardized manner, which gives the required information for estimating the indicators. To facilitate the process, electronic connectivity has been established from district level upwards, using specially designed data management software *'Epicentre'. This software is being upgraded to windows based version* to facilitate user interface. Nearly 100% of the reports were received electronically in 2007 and 100% of the reporting units at TU/district had reported for all the implementing quarters. The reports are received quarterly and the programme publishes a quarterly 'RNTCP Performance report'. Standardized formats have also been developed for capturing patient information on *DOTS Plus* regimens, and an electronic web based database system is being developed.

A new *'Data management Training'* module has been developed with the support of WHO and a national

training plan has been devised to train all programme staff in this module. This will build the capacity of the states to analyze programme reports, provide technical feedback and initiate corrective actions for improvement of programme performance. To further strengthen the state capacity, the *post of Epidemiologist and Statistical Assistant at the State TB Cell* has been proposed to support programme monitoring and supervision.

The programme has also developed the *'RNTCP Supervision and Monitoring strategy'* as a tool for objective review of the programme at all levels, starting from the peripheral health institution level to the district, state and national level. *(See Annexure No 4.VI-Strategy Document on Supervision and Monitoring)*.The strategy lists out detailed protocols for conducting supervisory visits and checklists have been developed to facilitate the same. Under the RNTCP, transport is made available to the STO/DTO/MO-TC either by the provision of a vehicle directly (STO and DTO) or through the provision of programme finances to hire vehicles (MO-TC). The STS have been provided two-wheelers for conducting field visits. To support field level supervision of DOTS Plus and TB/HIV activities without compromising the routine DOTS, a new position for *'DOTS Plus and TB/HIV Supervisor'* of the rank of STS has been proposed.

Besides supervisory visits, the document also identifies *monitoring indicators* to review the quality of performance – which includes indicators to review political and administrative commitment, human resource availability and training, diagnosis and treatment, drugs and logistics management, TB-HIV collaborative activities, PPM activities, IEC and financial management. Guidelines for frequency of review and the officer to chair such meetings have been developed. Programme review checklists for the Chief District Health officer, District Magistrate and Secretary Health of the state have been provided to facilitate review. All activities identified above are routinely monitored.

The programme has developed a system of *'internal evaluations'* to review the performance in the districts from time to time. The states conduct 'Internal evaluations' in atleast 2 districts every quarter. A detailed format to capture information on all parameters related to programme implementation has been developed and is used by all the states. The centre also conducts comprehensive 'Central Level Internal Evaluation' of atleast 1 state every month. Besides these, the programme also undertakes external evaluations conducted by international and national experts, development partners and other stake holders. These *Joint Monitoring Missions* provide the programme an opportunity to review the technical and programmatic challenges, and also to advocate and build support for RNTCP. The previous reviews (Joint Monitoring Mission) were undertaken in 2000, 2003 and 2006. *(See Annexure No 4.III - Joint TB Programme review, India, 2006)*

Though the budget allocation appears to be about 6.8%, the core activities performed by key staff like the Senior Treatment Supervisor (STS) and Senior TB lab supervisor (STLS), Epidemiologist and Statistical assistant and the programme staff (including part of planning/administrative costs) are also part of the M&E activities.

4.9 Implementation capacity

4.9.1 Principal Recipient capacities

Describe the respective technical, managerial and financial capacities of each PR in this proposal (continuing and new) to manage and oversee implementation of the program (or their proportion) having regard to the proposed changes in scale and/or scope identified in section 4.6.

What plan(s) exist to strengthen the PR(s)' capacity to absorb these changes into their implementation management framework, and ensure strong performance? *Also discuss any anticipated barriers to strong performance, and how they will be addressed, referring to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).*

In this project, only one PR is being proposed (please refer to Section 2.2.4). The CCM India has nominated the Central TB Division, headed by a Deputy Director General (TB), as the Principal Recipient for the purposes of implementation of this TB control project.

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

India is a federation of states, which are further divided into administrative districts. States prepare their own annual plans for implementing the programme, based on the national guidelines and norms adopted in concurrence with key stakeholders. States monitor the programme at the district level and sub-district tuberculosis unit level. In order to strengthen the implementation capacity of the States, State TB officers undergo training in management ,finance and various technical issues. State TB Societies have been strengthened with the provision of necessary office equipment and appointment of contractual accountants, IEC officers and data entry operators.

The PR has been assessed at various times with regard to earlier rounds of Global Fund grants as well as during review missions conducted by the World Bank and other partners. The PR is currently receiving grants from Global Fund in rounds 2, 4 & 6 . Assessments have been conducted by the Global Fund through its nominated LFAs on areas of Institutional arrangements, Monitoring & Evaluation Systems, Procurement Systems, and Financial Systems etc at both the PR as well as different SR level. These assessments have been to the satisfaction of the Global Fund. Based on such assessments, the Phase II for the earlier grants (Round 1, 2 and 4) have been approved by GFATM. Therefore, it can be confidently stated that the PR has the relevant technical, managerial and financial capacity to implement this present proposal.

Since the inception of the DOTS programme, the PR has developed its capacity to provide leadership, plan and monitor this challenging programme which is being implemented through the states. Human resources have been added and the PR now has necessary expertise in policy formulation, supervision & monitoring, finance management and procurement. There are units within the Central TB Division with necessary experts and support staff that deal with specific areas of the programme like training, monitoring and evaluation, procurement, IEC and advocacy, and finance. With this organizational support the Central unit has been able to scale up DOTS implementation in the country and achieve the global targets.To further enhance the capacity of the CTD to undertake activities under the proposed project, an additional administrative human resource has been sought. The PR also receives technical assistance from WHO at the central and state level through a network of consultants. The PR is thus in a position to effectively absorb the additional work and funds generated under this proposal.

4.9.2 Sub-Recipient information

(a)	Are the majority of sub-recipients (SRs) **from the expiring grant,** continuing their roles and responsibilities in this proposal?	☒ **Yes** *➔ Go to s.4.9.3* ☐ **No** *➔ answer (b) before completing s.4.9.3*

(b) **If no**, explain why, and for new SRs who will either receive a substantial proportion of the funding for this proposal or will be involved in funding to sub-sub-recipients:

(i) describe the **transparent** process by which new SRs were identified **and the criteria** that were applied in the identification process.

(ii) summarize the past implementation experience of these new SRs

Not Applicable

4.9.3 Sub-Recipient capacities

What plans exists to strengthen the capacity of the major SR(s) to absorb the continuing and/or expanded responsibilities under this proposal, and ensure strong performance? Please also discuss any anticipated barriers to strong performance, and how they will be addressed, referring to any evaluations by the existing PR(s) of SR capacities (e.g., capacity-building needs, staffing and training requirements, etc.).

The proposed sub-receipients for the RCC project include the State TB/Health Societies, with the State TB Officer as the nodal person overall responsible for implementation and monitoring of all project activities. The SRs include the State TB offices of Bihar and Uttar Pradesh (expiring grant), Haryana (geographical expansion – and earlier under the USAID supported project), Andhra Pradesh and Orissa (GFATM Rd 4 states), and Chhattisgarh, Jharkhand and Uttarakhand (GFATM Rd 6 states). The NGO SRs of the PPM component of the project include the Indian Medical Association (GFATM Rd 6 project) and the Catholic Bishops Conference of India (GFATM Rd 4 project). In the current RCC project, their activities are being extended with increase in scale of activities. All the SRs have been assessesed in the previous rounds both by the PR and by the Global Fund/LFA.

The states have been supported with a medical officer at the state TB cell, to support programme activities. In addition, a full time accountant has been provided for financial management and timely submission of financial reports. The capacity of the state TB cell is further proposed to be enhanced by the RCC project through provision of additional contractual staff positions. All the states/SRs have been regularly submitting the programme performance reports and the financial management reports with no major objections/errors.

In an ongoing effort to build their capacities, regular trainings (update/refresher trainings) are planned and conducted to improve their skills on programme and financial management as per programme guidelines.

4.10 Management of pharmaceuticals and health products

4.10.1 Overview of changes to the management of pharmaceutical and health products

(a)	Does this proposal involve the management of pharmaceuticals and other health products?	☐ **No** ➔ ***Complete s.4B if relevant to this proposal*** *(see insbructions below this s.4.10)* ***and/or go directly to the budget section*** *(section 5)*
		☒ **Yes** ➔ *answer question (b)*
(b)	**If yes to (a)**, does this proposal give rise to **any change(s)** in the **roles and responsibilities** for management of pharmaceuticals and health products compared to the expiring grant?	☒ **No** ➔ ***Complete section 4.10.2 and then complete s.4B if relevant to this proposal,*** *and/or* ***go to section 5 and Attachment B*** *(detailing quantities and unit costs for health products)*
		☐ **Yes** ➔ ***Go to section 4.11 before completing s.4B (if relevant to this proposal)*** *and/or* ***section 5*** *and* ***Attachment B***

4.10.2 Management of pharmaceuticals and health products for continuing PR(s) involving a scale-up of ongoing activities

Describe:

(a) how implementation arrangements relevant to this proposal have been planned to ensure *(including, as relevant, plans to obtain necessary additional technical assistance, training or other capacity building assistance)* that continuing PR(s) have sufficient capacity to absorb the increased responsibilities in respect to the management of pharmaceuticals and health products for the planned scale-up; and

(b) the extent to which the ongoing management of pharmaceuticals and health products under this proposal will be coordinated with other procurement and supply management actions in support of the national disease prevention and control program to ensure greater impact on the disease.

The current RCC project is part of the overall RNTCP DOTS implementation in the country, and is an extension of the earlier GFATM projects. Central TB Division, the PR for implementation, has in the past undertaken all activities related to procurement of 1st line and 2nd line drugs (other than those provided by donors as grant via Global Drug Facility), including the strategic planning of procurement cycles, estimating the quantity of drug requirement; developing the technical specifications for their procurement and the process of procurement and the subsequent drug and logistic management.

To facilitate the procurement process, a procurement agency duly selected by the Ministry (in accordance with the World Bank guidelines and their compliance) has been hired and presently UNOPS is the procurement agency. The drug procurement at the central level is being done by International Competitive Bidding (ICB). The procurement under this project will be done using the procurement mechanism in place for RNTCP through UNOPS, which is the procurement agency hired by Ministry of Health and Family Welfare (MoHFW). In addition, the Empowered Procurement Wing (EPW) established in the MoHFW will continue to monitor the management of the procurement process of pharmaceuticals.

The 2nd line anti TB drugs for the management of MDR-TB under the Global Fund project (Rd 4) are being procured from the GLC, following the procedures as outlined in the GFATM and GLC procurement policies and the PR is committed to follow the same procedure under Rd 6 project. The proposed RCC project will also follow the same procedure.

The drug and logistic management is being facilitated by an agency (Strategic Alliance) with the support of WHO. In addition, for quality testing of drugs, an independent agency has been hired as per national procurement guidelines, for quality testing on a regular basis. All these activities are coordinated and monitored by the Chief Medical Officer of the division, and supported by the 'Procurement & supply Management' consultant hired under the project.

4.11 Management of pharmaceuticals and health products New PR(s) and/or newly introduced activities

4.11.1 Table of amended roles and responsibilities

Describe the amended roles and responsibilities for pharmaceutical and health products management under this proposal. *(e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner).*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principle Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc).*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	Central TB Division, Ministry of Health and Family Welfare	Principal Receipient	☒ Yes ☐ No
Intellectual property rights	Department of Science and Biotechnology	Regulatory authority for IPR	☐ Yes ☒ No
Quality assurance and quality control	Central TB Division and DCGI Ministry of Health and Family Welfare and	Predispatch QA is done by UNOPS, the procurement agency and post dispatch	☐ Yes ☒ No

	Supported by UNOPS	QA/QC is done by Central TB Division assisted by Anusandhan laboratory, Indore, Madhya Pradesh	
Management and coordination *More details required in s.4.11.3*	Central TB Division: Ministry of Health	Principal Recipient	☒ Yes ☐ No
Product selection	Central TB Division: Ministry of Health	Principal Recipient	☒ Yes ☐ No
Management Information Systems (MIS)	Central TB Division: Ministry of Health	Principal Recipient	☒ Yes ☐ No
Forecasting	Central TB Division: Ministry of Health	Principal Recipient	☒ Yes ☐ No
Procurement and planning	Central TB Division: Ministry of Health	Planning of requirement by Principal Recepient and procurement by UNOPS	☒ Yes ☐ No
Storage and inventory management *More details required in s.4.11.4*	Central TB Division: Ministry of Health	Principal Recipient assisted by Strategic Alliance	☒ Yes ☐ No
Distribution to other stores and end-users *More details required in s.4.11.4*	Central TB Division: Ministry of Health	Principal Recipient assisted by Strategic Alliance	☐ Yes ☒ No
Ensuring rational use and patient safety (pharmacovigilance)	Central TB Division: Ministry of Health	Principal Recipient and Sub Recepients	☒ Yes ☐ No

4.11.2	**Procurement capacity**	
(a)	Will management of pharmaceutical and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient(s) or will sub-recipients also procure these products?	☒ PR(s) only ☐ SRs only ☐ Both

(b) For each new organization planned to be involved in the procurement of pharmaceutical and health products, provide details of the current volume of products procured on an annual basis in the table below. *Use the "tab" button on your computer to add extra rows at the bottom of the table if more than four new organizations will be involved in **procurement**.*

Organization Name	**Total value of pharmaceuticals and other health products procured during last financial year** *(In same currency as on facesheet of this proposal)*
No new organistion planned to be involved	

4.11.3 Alignment with existing systems

Describe the extent to which ongoing management of pharmaceutical and health products under this proposal will be coordinated, to the extent possible and appropriate having regard to country contextual considerations, with other pharmaceutical and health product management actions undertaken in support of the national disease prevention and control program.

Organizational structure – Procurement of anti-TB drugs, binocular microscopes, culture and drug sensitivity testing equipment etc., for the RNTCP are done at the central level. The Procurement Unit within the CTD handles issues related to central level procurement, with the assistance of the procurement agency selected as per World Bank guidelines (presently it is UNOPS). This unit also handles issues related to logistics with the support of Strategic Alliance.

Procurement systems – Procurements for the RNTCP are done as per World Bank guidelines. Items to be procured are categorized based on the value of the procurement as for ICB, National Competitive Bidding (NCB) or for National Shopping. Anti TB drugs, binocular microscopes (BM) and PPD and culture and drug sensitivity testing equipment are procured at central level. Most anti TB drugs and BMs are procured through ICB. The procurement agency processes bid documents, floats tenders, evaluates tenders, takes approval of the MoHFW and issues purchase orders. *(See Annexure No 4.X --RNTCP Procurement Manual)*

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

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

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

DOTS Plus is planned to be expanded to the entire country in a phased manner after strengthening of the state level laboratories for culture and drug sensitivity testing. By 2015, the programme envisages to offer culture and DST services to all pulmonary TB patients being initiated on Cat-2 treatment including cat-1 and cat-3 failures. The GLC mechanism would be used for procurement of 2nd line TB drugs for this project. Detailed guidelines have been developed for roll out of DOTS plus for the management of MDR-TB which includes the details on technical and operational aspects *(See Annexure No 4.V….RNTCP DOTS Plus Guidelines)*

4.11.4	**Storage and distribution systems**	
(a)	Will the same organization as in the expiring grant provide the supply management (storage and distribution) functions for pharmaceutical and health products during the proposal term?	☒ Yes ☐ No

(b)	**Indicate** which types of organizations will be involved in the supply management of pharmaceutical and health products during the proposal term. If more than one of the adjacent boxes is checked, also briefly describe the inter-relationships between these entities when answering (c) and (d) below.	☒	National medical stores or equivalent
		☐	Sub-contracted national organization(s) *(specify)*
		☐	Sub-contracted international organization(s) *(specify)*
		☒	Other: *(specify)* State and district level Government drug stores

(c) Describe each organization's current **storage capacity** for pharmaceutical and health products, and indicate how a possible scaling up of interventions and increased requirements under this proposal will be transparently and effectively managed.

The 7 Government Medical Stores Depots (GMSDs) in the country have capacity to handle drug storage of all National Health Programmes and which is monitored and strengthened as per overall national needs. The drug requirement of the first line anti-TB drugs in the coming years would only be marginally higher than the current levels, and the current requirements for 2nd line drugs is comparatively smaller (given that only about 13,000 MDR cases are being planned to be treated under the project againt 2.75 million drug sensitive TB). It is assumed that the GMSDs would be able to manage the increased requirements of drug and logistics systems.

To ensure long term sustainability of the programme, drug and logistic management has been decentralized to states by establishing State Drug Stores (SDS) in all states of the country including those under this project. SDSs facilitate the distribution of drugs within the state by sharply reducing lead times for fulfilling drug requests, there by ensuring uninterrupted supply of drugs. All districts have a drug store to handle the requirements in the district. Adequate buffer stocks are maintained at all levels (A buffer stock of 4 months is maintained at district level).

However, the capacity within the State and District drug stores is limited, and a one time sanction of additional funds is being made to improve and expand the storage capacity in the State and district drug stores. To further strengthen 2nd line drug management, a store assistant (in addition to pharmacist) is being proposed at the state drug store in this proposal.

(d) Describe each organization's **current distribution capacity** for pharmaceutical and health products. In your response, indicate how any increased responsibility for distribution of pharmaceutical and health products under this proposal will be managed, and potential challenges addressed. In addition, provide an indicative estimate of the percentage of the country and/or population covered by pharmaceutical and health product management services under this proposal, and the relative percentage increase (if any) this represents on existing distribution arrangements for the nominated distribution partners.

Distribution and inventory management – The drugs are supplied to the states and districts by the GMSDs situated in various parts of the country. To decentralize drug and logistic management, each state has established its own State Drug Stores (SDS), with larger states having more than one such store. Presently, 40 SDSs are functional under the programme. All districts have TB drug stores. Monitoring of drug supplies with regard to the requirement and consumption is done through a two-tier monitoring system - a central system at Central TB Division (CTD) and a decentralised system by the State TB Officers (STOs) and the District TB Officers (DTOs). At central level, the drug logistics management is supported by Strategic Alliance, which reviews and ensures adequate drug stocking at GMSDs, SDS and district drug stores (DDS). The same processes are done by the STOs and DTOs to ensure adequate stocks till the level of the DOT Centre. CTD ensures adequate drug stocks at districts by analyzing the district Quarterly Programme Management Reports (QPMR) and issuing drugs as per norms. CTD continuously verifies these quarterly reports including the details of patients put on treatment during the quarter, quantities consumed, stock received during the quarter, closing stock and drug requirements of the district. *(See Annexure No 4.XI – RNTCP State Drug Stores Manual)*

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

To streamline and strengthen logistic management, the GMSDs have been provided additional funds (under existing GFATM project). Similar support is being extended to the state drug stores under the RCC

project to facilitate improved monitoring of drug stocks and flows.

The current project would be covering roughly 35% of the country's population.

4.11.5 Pharmaceutical and health products selection

- **Complete 'Attachment B' to this Proposal Form for the relevant disease**, to list all of the pharmaceutical and health products that are requested to be funded in this proposal. Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs').
- If the pharmaceutical products included in 'Attachment B' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

Not Applicable

4.11.6 Multi-drug-resistant tuberculosis (HIV and tuberculosis proposals only)

Is the provision of treatment of multi-drug-resistant tuberculosis included in this HIV proposal as part of HIV/TB collaborative activities?	☒ Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.*
	☐ No. *Do not include Green Light Committee costs in the budget.*

5. Funding request

Clarified Table 5.1

5.1 Financial gap analysis

➔ *Summary Information provided in the table below should be explained further in sections 5.1.1 – 5.1.3 below.*

Financial gap analysis in Euros million *(same currency as identified on cover page of Proposal Form)*

Note ➔ Adjust headings (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**

	Actual	Expected	Planned		Estimated			
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
HIV program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	**40,260,000**	**42,600,000**	**55,250,000**	**62,670,000**	**69,190,000**	**69,530,000**	**75,250,000**	**82,065,000**
Line A.1 ➔ Total need over length of RCC Funding Request *(combined total need over RCC proposal term)*								496,790,000
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*IDA World Bank Credit*)	**16,360,000**	**18,630,000**	**22,130,000**	**24,200,000**	**16,490,000***			
Domestic source **B2** National funding resources	**4,070,000**	**4,700,000**	**5,520,000**	**6,020,000**	**8,270,000**			
Domestic source **B3** Private Sector contributions (national)								
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	**20,440,000**	**14,620,000**	**27,640,000**	**30,210,000**	**24,820,000***	**37,610,000***	**40,750,000***	**43,880,000***
External source **C 1** (*USAID*)	**213,134**	0						
External source **C2** (*DFID*)	**5,830,000**	**5,830,000**	**5,770,000**	**6,580,000**				

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External source **C3** (*WHO Technical Assistance*)	**2,070,000**	**2,510,000**	**2,660,000**	**2,820,000**	**2,990,000****	**3,170,000****	**3,360,000****	**3,560,000****
External source **C4** Private Sector contributions (International)								
Total of Line C entries → Total current & planned EXTERNAL (non-Global Fund grant) resources:	**8,110,000**	**8,340,000**	**8,430,000**	**9,400,000**	**2,990,000****	**3,170,000****	**3,360,000****	**3,560,000****
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	**11,660,000**	**10,930,000**	**7,240,000**	**3,100,000**	**3,290,000**			
Line E → Total current and planned resources (i.e. Line E = Line B total+ Line C total + Line D Total)	**40,260,000**	**42,600,000**	**43,310,000**	**42,720,000**	**47,590,000**	**40,780,000**	**44,110,000**	**47,440,000**
Calculation of gap in financial resources and summary of total funding requested through RCC *(to be supported by detailed budget)*								
Line F → Total funding gap (i.e. Line F = Line A – Line E)	[redacted]		**12,230,000**	**20,250,000**	**21,620,000**	**28,770,000**	**31,170,000**	**34,625,000**
Line G = Rolling Continuation Channel funding request *(same amount as requested in table 5.3)*			**11,943,281**	**19,953,860**	**21,597,362**	**28,747,400**	**31,143,313**	**34,604,575**

* Commited funding for RNTCP Phase II project (from the existing World Bank credit and Domestic resources) is available till Sept 2011, ie 6 months of the financial year 2011-12. However, Govt. of India is committed to support TB control activities, by raising necessary funds either through continuation of the World bank credit or from domestic or other sources till TB ceases to be a major public health problem.
** Committed funding from WHO subject to continuation of on-going support from DFID and USAID

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants	
In this RCC proposal, the total maximum funding request for in Line G is: *(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and* *(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*	
Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund **Cost sharing = (Total of Line D entries over 2009-2013 period + Line G Total) X 100 / Line A.1**	**32.5 %**

5.1.1 Explanation of financial needs – LINE A in table 5.1

Explain how the annual amounts were:

- developed *(e.g., through costed national strategies, a Medium Term Expenditure Framework [MTEF], or other basis);* and
- budgeted in a way that ensues that government, non-government and community needs were included to ensure fully implementation of country's disease program strategies.

The national estimates of the annual amounts for the years 2009-12 are based on the approved national plan for expansion and consolidation of TB services in the country under the Phase II of RNTCP project and duly approved under the National 11th Five year Plan (2007-12).

The projected figures from 2012-15 have been calculated based on the requirements to consolidate all programme activities to realize the global TB bench marks of 70% new smear positive case detection rates, and 85% treatment success rates across all states by 2015. In addition, additional resources needed for expansion of TB/HIV, DOTS Plus and PPM activities have been incorporated in the national plan.

However, it is also submitted that the national requirements are not comprehensive and subject to change, due to the likely changes in programme guidelines with introduction of newer technologies and tools for diagnosis and treatment and increment in costs during the course of implementation (pharmaceutical product costs; implementation and human resource costs etc). The relative demand for implementing and strengthening the programme across other non-public sectors for PPM activities and ACSM acitivities cannot be estimated and foreseen, as they are challenging areas of service delivery and highly dependant on other partners coming forward to share the responsibility, and would serve as an additionality to expand the reach of the programme.

5.1.2 Domestic funding – 'LINE B' entries in table 5.1

Explain the processes used to:

- prioritize domestic financial contributions to the national disease program *(including HIPC [Heavily Indebted Poor Country] and other debt relief, and grant or loan funds that are contributed through the national budget)*; and
- ensure that domestic resources are utilized efficiently, transparently and equitably, to help implement treatment, prevention, care and support strategies at the national, sub-national and community levels.

The national government is committed to support TB for the coming years, till it ceases to be major public health problem, and with increased commitment for public health spending under the National Health Policy, there would be an incremental investment in TB care services also.

The approval of funding for individual national health priorities is given by the National Planning Commission for a period of five years (Five year Plans) and is by a consultative process of national experts and policy makers. To ensure domestic resources are efficiently and euitable managed, the plan ensures adequate distribution of resources based on need and disease burden; and specifically tagetting the poor, hard to reach, rural and tribal areas. The national Rural Health Mission and the National Urban Health Mission serve as a means to reduce inequity in health care distribution.

Currently the domestic resources are being raised from the World bank credit (80% contribution) and the Ministries health budget (20%). In addition, the states also contribute from their health budgets for the maintainance of public health system (including staff, infrastructure and equipments). The current RNTCP Phase II World Bank project is till Oct 2012; and the government would seek continued assistance under IDA to maintain TB control activities in the country atleast till 2015.

5.1.3 External funding *excluding Global Fund* – 'LINE C' entries in table 5.1

Explain any changes in contributions anticipated over the proposal term (*and the reason for any identified reductions in external resources over time)*. Any current delays in accessing the external funding identified in table 5.1 should

be explained (including the reason for the delay, and plans to resolve the issue(s)).
The RNTCPprogramme since its inception has been supported by external funding both by bilateral and multilateral agencies. Currently the programme is being supported by DFID grant for supplying drugs to 500 million population till 2010-11. DFID is also supporting the programme through WHO for supporting the WHO technical consultant network, and conducting TB research. USAID which had supported RNTCP implementation in the state of Haryana till 2008, is continuing its support through WHO for providing technical assistance through the WHO consultant network. This change in focus was an outcome of the programme request to support the network, after end of support from CIDA to the WHO network. The programme will seek continued support from these partners to supplement the national efforts towards realizing TB related MDGs.

5.2 Detailed Budget

Suggested steps in budget completion:

1. **Submit a detailed proposal budget *in Microsoft Excel format as a clearly numbered annex.*** Wherever possible, use the same numbering for budget line items as the program description.

2. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (section 5.3)

3. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (section 5.4); and

4. Ensure the detailed budget is consistent with the detailed workplan of program activities.

5. Do not include any CCM (or Sub-CCM or RCM) operating costs in this proposal. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available on the Global Fund's website.

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5.3 Summary of detailed budget by objective and service delivery area

Figures in Euros (Millions)

Clarified Table 5.3

Objective Number	Service delivery area (Use the same numbering as in program description in s. 4.6.4)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
1.1-1.3	Improving diagnosis	2,280,634	4,066,756	4,315,701	5,341,090	5,599,807	5,862,754	**27,466,741**
1.4-1.9	High Quality DOTS	2,845,354	5,180,254	5,568,801	6,951,213	7,114,651	6,997,723	**34,657,995**
1.10	Procurement and supply management (First Line Drugs)	1,354,933	2,381,140	2,604,258	3,376,562	3,677,157	3,908,516	**17,302,566**
1.11	M&E	1,463,652	2,168,504	2,434,203	2,968,842	3,080,396	3,351,086	**15,466,683**
1.12	ACSM	308,862	527,231	531,575	686,140	691,324	696,423	**3,441,554**
1.13	High-risk groups	164,002	242,530	272,247	332,041	344,549	374,792	**1,730,162**
2.1-2.4	TB/HIV	138,653	267,788	359,159	610,195	786,048	961,857	**3,123,699**
2.5-2.7	MDR-TB	613,744	1,409,481	1,677,248	3,255,132	4,211,385	5,134,187	**16,301,176**
3.1-3.13	All care providers (PPM/ISTC)	2,756,134	3,681,221	3,764,918	5,195,440	5,405,757	6,077,535	**26,881,005**
4.1	Operational Research / Impact assessment surveys	17,313	28,955	69,254	30,746	232,239	1,239,701	**1,618,209**
Total requested from the Global Fund:		**11,943,281**	**19,953,860**	**21,597,362**	**28,747,400**	**31,143,312**	**34,604,575**	**147,989,790**

Clarified Table 5.4

5.4 Summary of detailed budget by cost category ***(Summary information in this table should be further explained in sections 5.4.1-5.4.3 below)***

Avoid using the "other" category unless necessary – read the Guidelines.	*(same currency as indicated on cover sheet of this Proposal Form))*						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
Human resources	3,590,506	5,904,325	6,359,577	7,835,504	8,356,408	8,899,187	40,945,507
Technical and Management Assistance	600,471	897,954	958,953	1,192,470	1,269,582	1,384,537	6,303,967
Training	2,395,748	3,796,533	3,775,526	4,770,650	4,848,275	4,951,270	24,538,003
Health products and health equipment	502,435	866,670	877,573	1,091,855	1,104,825	1,117,763	5,561,122
Pharmaceutical products (i.e. medicines)	1,350,416	2,916,867	3,535,388	5,747,330	7,128,751	8,133,019	28,811,771
Procurement and supply management costs (for pharmaceutical and health products)	100,372	185,987	155,434	189,647	203,022	213,592	1,048,055
Infrastructure and other equipment	282,486	307,380	209,176	317,726	249,176	318,059	1,684,003
Communication materials	783,466	1,109,945	1,118,748	1,444,655	1,455,103	1,465,546	7,377,464
Monitoring & Evaluation	1,120,804	1,669,804	1,786,437	2,270,758	2,563,604	3,669,603	13,081,010
Living Support to clients/target populations	45,072	77,023	78,036	95,783	96,992	98,182	491,088
Planning and administration	412,746	558,168	573,613	646,622	664,580	683,604	3,539,333
Overheads	23,522	40,358	506,627	743,864	752,505	761,004	2,827,880
Other: *(Use to meet national budget planning categories, if required)*	735,235	1,622,846	1,662,273	2,400,534	2,450,489	2,909,208	11,780,586
Total funds requested from Global Fund *(Totals in tables 5.3 and 5.4 should be the same)*	**11,943,281**	**19,953,860**	**21,597,362**	**28,747,400**	**31,143,313**	**34,604,575**	**147,989,790**

Figures in Euros (Millions)

5.4.1 Overall budget context

Briefly explain any significant variations in cost categories by year, or significant six year totals for those categories.

The variations in proposed budgetary requirements across years are in line wth the planned scale up of the RNTCP activities in the 8 project states, as outlined in section 4.6.2.

The main expenditures by cost category include human resource which accounts for 27.6% of the budget, followed by drugs/pharmaceutical products (19.4%) and training (16.5%). The Monitoring and Evaluation costs for the entire project is 9.2%, and the planning and administration costs account for 2.3% of the overall budget.

5.4.2 Human resources

In cases where '*human resources*' represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial three years; (ii) the method of calculating the anticipated costs over years four to six; and (iii) to what extent human resources spending will strengthen service delivery.

Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

➔ *Attach supporting information as a clearly named and numbered annex*

As outlined in earlier sections, RNTCP is integrated and implemented through the general health services utilizing the available infrastructure. The infrastructure in the general health system are established and staffed by the local state governments and these facilities implement the programme. The infrastructure and regular staff are paid for by the state governments and all investment costs for the basic services under the programme have already been provided for by the state government.

However, due to variations in the human resource capacity across states, and to supplement critical gaps in key positions, the programme proposes to support 20% of Lab technicians and 15% of TB Medical Officers in the States covered under this project.

In addition, there is limited capacity of the existing human resource in the states for undertaking supervision, monitoring and quality assurance activities as desired under RNTCP. As TB Control acitivities are human resource intensive, the programme strengthens the states capacity by providing technical supervisory staff, such as STS, STLS, TBHVs, Accountants, DEOs, etc on contractual basis.

With expansion of DOTS Plus services and TB/HIV activities across the states, additional technical assistance is sought under the project to strengthen the National, state and district programme management units. Govt. of India and the state governments are committed for providing high quality,patient friendly DOTS services to its people, and would ensure adequate funding for continuation of provision of essential drugs and services under RNTCP from domestic and other sources.

As already stated above, the amount budgeted under human resources have taken into account additional technical assistance required to maintain the program till 2015 and to continue national efforts towards realizing TB related MDGs. . The budget calculation for human resource is based on the national guidelines for provision of staff as outlined in the 'Financial management Manual' with additional staff proposed for strengthening of DOTS Plus, TB/HIV and ACSM activties.

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

5.4.3 Other large expenditure items

If other 'cost categories' represent important amounts in the summary in the table above explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national disease program.

➔ *Attach supporting information as a clearly named and numbered annex*

Other important large expenditure items are as under:

Drugs/Pharmaceutical products: During the course of the project, over 2.7 million drug sensitive cases

of TB, and 11,950 multi-drug resistant cases of TB would be treated. In addition, adequate buffer stocks of drugs would be maintained at all levels, to ensure uninterrupted supply of quality assured drugs. The 2nd line drugs account for roughly 43% of entire drug cost.

Training: This accounts for roughly one-sixth of the total budget. RNTCP has developed a series of modular training courses, with printed material, for all levels of staff ranging from the State TB Officers to the community DOT providers. Over the last three years, all RNTCP training modules have been updated and newer guidelines, modules and training programmes have been added to the existing training packages. It is envisaged to train 15,000 key programme staff during the course of the project. Besides training activities, undertaken by the programme, the PPM initiative through the IMA and CBCI would further sensitize and train nearly 250,000 private providers.

5.5 Funding requests in the context of a common funding mechanism

In this section, **common funding mechanism** refers to situations where all funding is contributed into a common fund for distribution to implementing partners. ***Do not complete this section if the country pools, for example, procurement efforts, but all other funding is managed separately.***

5.5.1 Operational status of common funding mechanism

Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners.

➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*

Not Applicable

5.5.2 Measuring performance

How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.

Not Applicable

5.5.3 Additionality of Global Fund request

Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism.

If the focus of the common fund is broader than the disease program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on the disease outcomes during the proposal term.

The National TB Programme in India (RNTCP) is integrated with and implemented through the general health services utilizing the existing available infrastructure in the health system. This infrastructure in the general health system is established and maintained by the respective state governments, and the state health facilities implement the programme activities. All this infrastructure and governmental staff are paid for by the respective state governments and the initial investment as well as the recurring costs for maintaining the basic services under the programme are also provided for by the state government. RNTCP only funds the additionalities like the costs for essential anti-TB drugs and laboratory consumables, to ensure uninterrupted quality assured diagnosis and treatment. The funds are also utilized to support supervision and monitoring of all the programme activities, which would be provided for under this proposal. Thereby, any fund commitment by GFATM to the programme would be in addition to the ongoing efforts being made by the public health system and there would be no replacement of allocations of the state or central government.

The provision of services under RNTCP, with a renewed emphasis on quality TB control services, to the whole of India, with its population of over 1114 million, is in itself a challenging and is a resource-intensive task. As described earlier, several external agencies have supported the GOI in expansion of TB control activities in the whole country, and thereafter, having achieved national coverage, have are

also committed to contribute towards the maintenance of quality services until such time that the desired epidemiological impact is attained. The RNTCP has signed the credit agreement with the World Bank to implement the programme for five years from Oct 2006 to Sept 2012 to cover a population of 768 million. This proposal, along with other external resources, would provide assistance in meeting the costs for focused TB control initiatives of the country.

Thus, the funding sought under this proposal is an additional resource requirement to meet the efforts being made by the GoI to provide quality DOTS services to the entire country, and to cover the remaining 362 million population in the 8 project states, and to help realize the MDG of halting and reversing TB. Additional funding is sought to cover the state of Haryana, due to the funding gap created by expiry of the USAID grant in March 2008. With planned scale up of the DOTS Plus project and further strengthening of programme supervision, the commitment of domestic resources to support RNTCP in the rest of country will also be substantially increased over the next 6 years.

The IMA and CBCI project are over and above the routine RNTCP activities (and which have not been budgetinged in the national TB plan), and would facilitate in advocating, engaging, and training of providers outside the public health system to seek their involvement under DOTS.

COPY HERE AN OPTIONAL SECTION 5B THAT IS TO BE INSERTED INTO THIS PROPOSAL HERE IF THE PROPOSAL INCLUDES S.4B (HEALTH SYSTEMS STRENGTHENING CROSS-CUTTING INTERVENTIONS)

The table below provides a list of the various annexes that should be attached to the proposal after completing sections 4 and 5. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Section 2: Applicant Summary (including eligibility)		Annex Name and Number
CCM and Sub-CCM applicants		
2.2.3	Comprehensive documentation on processes used to select and nominate Principal Recipients(s) (such as the minutes of the CCM meeting at which the PR(s) was/were nominated).	Minutes of 28th CCM meeting on 18.02.08 (Annexure 2-I)
2.2.6	Documentation relevant to the minimum requirements for eligibility regarding the proposal's scale and/or scope from the expiring grant.	Global Fund notification letter OPS/ASIA1/1281/PAS/TR/ldc (Annexure 2-II)
2.2.7	Conflict of interest policy of the Coordinating Mechanism where the Chair and/or Vice Chair from the same entity as a nominated PR.	Not applicable
2.2.8	List of members of the Coordinating Mechanism as signed by those members to confirm endorsement of the proposal.	**Attachment C**
Sub-CCM applicants only		
2.3.1(a)	Signed and dated minutes of the **CCM meetings** at which the CCM reviewed and endorsed the Sub-CCM proposal.	Not applicable
2.3.1(b)	Letters from the CCM Chair of Vice-Chair endorsing the Sub-CCM proposal.	Not applicable
Section 4: Program Description		**Annex Name and Number**
4.2	National disease specific prevention and control plan (or equivalent), if one exists.	Vision Document: RNTCP Strategic vision document for India up to 2015 (Annexure 4.I)
4.3.1	Map if proposal targets specific region(s)/population group(s).	(within the proposal document)
4.4.1	Documentation relevant to the national disease program context.	TB India 2008 (Annexure 4.II) Joint TB Programme review, India, 2006 (Annexure 4.III) RNTCP Technical & Operational guidelines for TB control (Annexure 4.IV) RNTCP DOTS Plus Guidelines (Annexure 4.V) Strategy document on supervision and monitoring (Annexure 4.VI) National Framework for Joint TB/HIV collaborative activities. Feb 2008 (Annexure 4.VII) RNTCP Revised Public-Private Mix guidelines (Annexure 4. VIII) RNTCP Tribal Action Plan(Annexure 4.IX) RNTCP Procurement Manual (Annexure 4.X)

		RNTCP State Drug Stores Manual(Annexure 4. XI)
4.4.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	Same as Annex 4.III (Joint TB Programme review, India, 2006)
4.5	Document(s) that explain basis for coverage	CBCI concept note for GFATM RCC TB component (Annexure 4.XII) IMA concept note for GFATM RCC TB component (Annexure 4.XIII)
4.6.4	**A completed 'Targets and Indicators Table' Refer to the M&E Toolkit for help in completing this table**.	**RCC_Attachment A_TB component 2008**
4.6.4	**A detailed Work Plan** (quarterly information for the first two years, and annually for year 3 to 6).	TB Work Plan with Budget (Annexure 4.XIV)
4.6.5	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved recent proposal (if relevant)	Not Applicable
4.8.2	**A recent evaluation of the 'Impact Measurement Systems'** as relevant to the proposal (if one exists)	Same as Annex 4.III (Joint TB Programme review, India, 2006)
4.9.1	**A recent assessment of the Principal Recipient capacities** (other than Global Fund Grant Performance Report).	Report of Joint Donor review Mission May 2008 (Annexure 4.XV)
4.9.2	**List of sub-recipients already identified** (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)	As outlined in Attachment A and Annexures 4.XII and 4.XIII
4.11.5	**A completed 'List of Pharmaceutical and Health Products'** by disease (if applicable).	**RCC-Attachment B_TB component 2008**
Section 4B: HSS Cross-cutting (once only in whole country proposal)		**Annex Name and Number**
4B.2	**A completed separate HSS cross-cutting '*Performance Framework' (or add a separate "worksheet" to the disease 'Performance Framework' under which s. 4B is submitted)* Refer to the M&E Toolkit for help in completing this table**.	**Not applicable**
4B.2	**A detailed separate HSS cross-cutting Work Plan *(or add a separate "worksheet" to the disease Work Plan under which s. 4B is submitted)*** (quarterly information for the first two years and annual information for years 3 to 6).	**Not applicable**
Section 5: Funding Request		**Annex Name and Number**
5.2	**Detailed Proposal Budget** (quarterly information for the first two years and annual information for years 3 to 6).	**RCC_Consolidated Budget Sheet_TB component 2008 (Annexure 5.I)**
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	RNTCP GFATM RCC Budget _T B component (Annexure 5.II) CBCI GFATM RCC Budget (Annexure 5.III) IMA GFATM RCC Budget (Annexure 5.IV)
5.4.3	Information on basis of costing for 'large cost category' items	Included in the Annexes of the individual budget sheets

5.5.1 *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism	Not Applicable
5.5.2 *(if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism	Not Applicable
Section 5B: HSS Cross-cutting financial information		**Annex Name and Number**
5B.1	**A separate HSS cross-cutting 'detailed budget' *(or add a separate "worksheet" to the disease 'detailed budget' under which s. 4B is submitted).*** Quarterly information for the first two years and annual information for years 3 to 6.	**Not applicable**
5B.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	Not applicable
5B.4.3	Information on basis of costing for 'large cost category' items	Not applicable
Other relevant documents attached by Applicant (including for Annex 1 if applicable to the Applicant's CCM eligibility status/application history, s.2.2.1)**:**		**Annex Name and Number**

Please note that the following sections follow the order set out in the document entitled 'Clarifications on CCM Minimum Requirements' at
http://www.theglobalfund.org/en/files/apply/rcc/documents/Clarifications_on_CCM_requirements_RCC.pdf.

Principle of broad and inclusive membership

Requirement 1 ➔ Selection of non-governmental sector representatives

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

*Please indicate below (via the check-box below) which documents are relied on to support the Applicant's statement of compliance with this requirement **AND** attach as an annex the documents showing **each sector's transparent process** for Coordinating Mechanism representative selection, and **each sector's** meeting minutes or other documentation recording the selection of their current representative.*

Documentation relied on to support compliance with Requirement 1	Identify which annex to this proposal contains these documents
☒ Selection criteria for each sector developed by each respective sector	CCM Annex 1.I Selection criteria for non-governmental sector CCM Annex 1.II selection criteria on indiaccm website.pdf
☒ Minutes of meeting(s) at which the sector transparently determined its representative	CCM Annex 2.I Minutes of meeting for identification of the private business sector CCM Annex 2.II Minutes of meeting for identification of academic and professional sector CCM representatives CCM Annex 2.III Results of the Civil Society election process.doc CCM Annex2.IV bilateral partners.doc CCM Annex 1.II selection criteria on indiaccm website.pdf CCM Annex2.VI Proceedings_18th_India_CCM_Meeting.pdf
☒ Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member	CCM Annex 3.I Rules for selection of NGO CCM members CCM Annex 3.II Eligibility criteria for non-govt sectors_subcommittee recomendations
☒ Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process	CCM Annex 4.I letter for Results of the Civil Society election process.doc CCM Annexure 4.II letter for multilateral partners.doc
☒ Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the Coordinating Mechanism	CCM Annex 5.I Announcement for CSO election CCM Annex 5.II Scan of CSO Advertisement CCM Annex 5.III notice for online registration on indiaccm website.pdf
☒ Other: *(please specify):*	CCM Annex 6.I List and contact details of India

	CCM members CCM Annex 6.II Dates of CCM Meetings for RCC

(b) Please briefly summarize how the information provided within the annexes listed above satisfies Requirement 1.

A decision to restructure the India-CCM to ensure compliance to GFATM Board requirements and eligibility to apply for GFATM grants was taken at the 22nd meeting of the India-CCM.The current composition of the India-CCM satisfies the constituency wise breakup, stipulated by the Board requirements, the process of independent and transparent selection of the representatives of non-governmental constituencies at the CCM by the constituencies themselves,along with a formal documentation of this selection process being made available to the GFATM and all other stakeholders.

Detailed discussion ensued on all proposed elements of restructuring. The consensus decision on the modified composition of the India-CCM and the selection processes to be adopted for the various non-governmental constituencies are presented in the table below:

Constituency	Proposed		Selection Process
	Members	Nos.	
Government – Central (MoH&FW)	Status quo	5	Nomination by MoH&FW
Government – Central (Other Ministries)	Current members + Ministry of Women and Child Development and Ministry of Education by rotation	3	Nomination by respective ministry. Ministry of Women and Child Development to be requested to nominate member for the 1st term
Government. – States & Union Territories	Other states and Union Territories from each of the five regions by rotation	5	States and Union Territories from each region to decide on process of rotation and the selected state to nominate member
Communities – People Living with HIV/AIDS (PLHA)	One of the national PLHA networks by rotation	1	INP+ to consult with other networks of PLHA, if any and mutually decide on the rotation process and nominate member
Civil Society Organizations including Faith Based	1. Two organizations each working on HIV/AIDS, Malaria and TB respectively 2. One organization working on issues of Child Development & Rights 3. One organization working on issues of Gender	8	Eligibility Criteria and process of selection to be developed by the India-CCM Sub-Committee nominated for the purpose
Constituency	Proposed		Selection Process
	Members	Nos.	
Private Sector	1. One Business Association 2. One Foundation registered in India 3. One Association of Medical Professionals	3	Eligibility Criteria and process of selection to be developed by the India-CCM Sub-Committee nominated for the purpose. Principle of rotation to be developed by the sub-sector
Academic & Research Institutions	1. Two Bio-Medical Academic/Research Institutions 2. One Public Health Institution 3. Association of Management Institutions or Schools of Social Work by rotation	4	Search Committee consisting of Director General, ICMR and WHO Representative to India to finalize selection criteria and principle of rotation and subsequently invite nomination of institutions selected on behalf of the India-CCM
Development Partners – UN Agencies	WHO, UNAIDS, UNICEF, UNFPA & WB	5	Status Quo
Development	Two Bilateral Partners by	2	Bilateral Partners to mutually decide

Partners – Bilateral	rotation from among DFID, USAID, EC, GTZ & JICA		on principle of rotation and nominate representative
Total		36	

As per the decision of the CCM at its 18th meeting, the CCM endorsed a sub-committee to draft the eligibility criteria and selection process for representatives of the non-govenmental sector (civil society (including faith based orgaizations), private foundations), people living with the disease constituency, academic/research institutions, association of medical professionals, private business associations, and development partners-both multilateral and bilateral.

The decisions of the Sub-Committee were intimated to all members of the India-CCM and the process of selection of the new members commenced at the earliest.

An online announcement was posted regarding the enrolment process at the CCM website and at the websites of the MoH&FW, Revised National TB Control Program (RNTCP), NVBDCP and National AIDS Control Organization (NACO). A copy of the text of the announcement was also sent by email to all CCM members requesting them to communicate the same to their Civil Society and Private Foundation partners and associated networks and to post the announcement on their websites if possible with a link to the India-CCM website. A short version of the announcement was also issued through the Department of Audio Visual Publicity (DAVP), Government of India at the request of NACO in English in all the editions of the Hindustan Times and The Hindu and in Hindi in most of the editions of Dainik Baskar nationwide.

269 organizations enrolled through the online process which was opened from 31st August to 17th September 2006. The documentation, submitted by the enrolling organizations as proof of their meeting the eligibility criteria, was scrutinized by the India-CCM sub committee and both the eligible electorate and the candidates were electronically announced, after which the online polling commenced electronically through a web based interface, between 19th February to 23rd February 2007.

Of the 121 registered NGOs, 64 of them cast their votes in the time allotted, ensuring 52.8% turnout. The sector elected 2 organizations to represent the HIV/AIDS sub-sector and one each to represent the Tuberculosis and Child Development & Rights sub-sectors. The elected representatives were inducted in the 2nd reconstituted India-CCM on 9th March, 2007

A second round of CSO enrollment was initiated just prior to the call for proposals for the Round 8 to increase enrollment followed by self nomination of eligible enrolled CSO constituency members for election to fill the vacant CSO seats as mentioned above. The announcements were made on the CCM website, websites of stakeholder organizations and by advertising in the national newspapers .Also please refer to the link to view the advertisement placed on the NGO Gateway website http://www.ngogateway.org/ngo-news/the-india-country-coordinating-mechanism-india-ccm-for-gfatm.html.

This was followed by the electronic registration, self nomination, eligibility scrutiny and electronic voting.

80 nominations were received to fill the vacant seat for the gender sub-sector of the CSO constituency of the India CCM. The response to the Malaria and Tuberculosis sub-sectors was found to be insignificant and not taken up for the election process.

Out of the 80 nominations for the gender constituency, only one organization was found to be fulfilling all criteria and qualifications for filling up the seat for Gender Sector as laid down by the relevant sub-committee of the CCM. The name of the organization was SAATHII. An invitation was sent to the organization by the CCM Chair to represent the gender sub-sector in the CCM. (The result of the nomination and uncontested selection process was informed to the CCM through email). The organization (SAATHII) attended the CCM meeting held on 6th May 2008 for the first time as a CCM member representing the gender sub-sector.

The Private foundation sub-constituency representative was selected through its own constituency by an online electronic polling process, similar to that of CSOs. Population Foundation of India was selected as the representative of this sector in the India-CCM, as it was the only organization, of the 14 organizations in the sector that fulfilled the eligibility criteria.

Based on the eligibility criteria for representation of the People Living with the Disease Constituency, developed by the sub committee and endorsed by the India-CCM, INP+ was selected by its own constituency for representation in the India-CCM.

A Search committee, constituted and endorsed by the India-CCM, developed the eligibility criteria for selection of institutions for the academic/research sector and association of medical professionals sub sector. Based on the

endorsed eligibility criteria for selection of the institutions, 5 representatives were selected and approved by the India-CCM.

At the 18th India-CCM meeting, the recommendations of the CCM sub committee on eligibility and selection criteria for representation of the Private business sector, was endorsed. According to the endorsed recommendations of the India-CCM sub committee, it was decided that only one of the three members from the private industry associations namely, ASSOCHAM, CII and FICCI would be represented at the India-CCM. It was requested that a joint letter of endorsement / minutes of a joint meeting of the three associations, regarding the selection of a representative, on a consensus basis, along with the rotation policy decided mutually, would be required to be communicated, for representation to the India-CCM.
Following the recommendations of the 18th CCM Meeting, a decision was taken by the Bi-lateral partners constituency that it would be represented by USAID and DFID.

Principle of involvement of persons living with and/or affected by the disease(s)

Requirement 2 ➔ People living with and/or affected by the disease(s).

Describe the involvement of people living with and/or affected by the disease(s) in the Coordinating Mechanism. *(Importantly, Applicants submitting HIV/AIDS and/or tuberculosis components must clearly demonstrate representation of this important group. Please carefully review the Global Fund's 'Clarifications on CCM Minimum Requirements – Round 7' document before you complete this section.)*

The Indian Network of People Living with HIV/AIDS (INP+) is a network at the national level representing people with HIV/AIDS. INP+ has about 30 state-level networks affiliated to it. Each state level network has a large number of affiliated District Level Networks. The office bearers of the District Level Networks elect the office bearers of the State Level Networks who in turn elect the office bearers of INP+. The general body of INP+ meets annually to elect its representatives.

The President and/or Secretary of the INP+ represents the People Living with HIV at different forums both nationally and internationally. This network has played an active role in formulating the principles of Greater Involvement of People Living with AIDS (GIPA).

Based on the eligibility criteria for representation of the People Living with and/or affected by the Disease Constituency, developed by the sub committee, the India-CCM endorsed the continuation of representation of (INP+) for a second term in the reconstituted India-CCM. The decision was based on the supporting documentation, provided to the India-CCM, setting out the selection process of INP+ to represent its constituency

At the India-CCM, the President of INP+ represents the people living with the disease. He is also the Vice-Chairman of the India-CCM.

Principle of transparent and documented CCM, Sub-CCM and RCM grant oversight processes (Requirements 4 and 5).

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

Please describe and provide evidence of the applicant's documented, transparent and established processes to respond to each of the 'Requirements' set out below:

Requirement 4(b) ➔ Process to oversee/review program implementation by the Principal Recipient(s) during the proposal term.

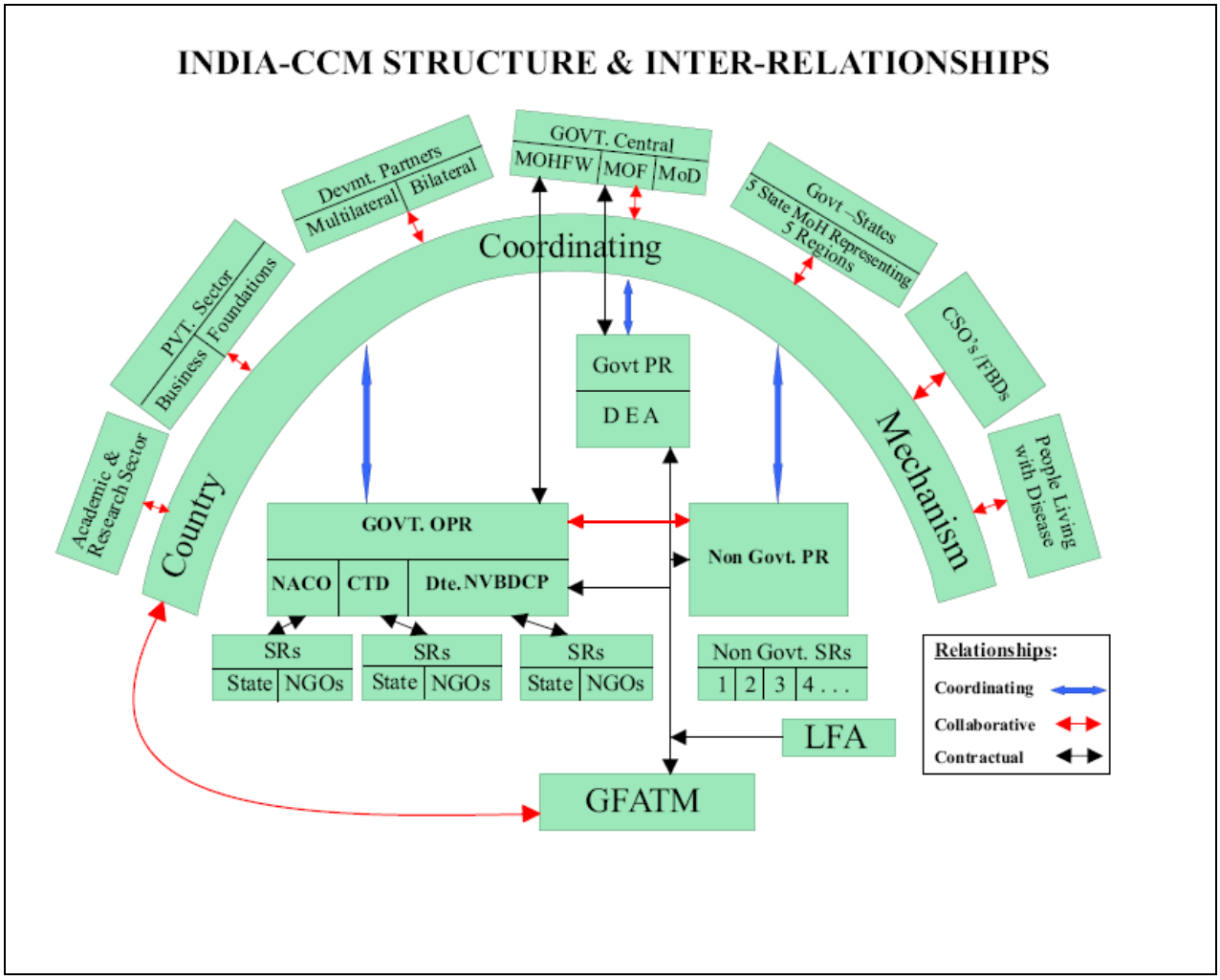
Quarterly reports received from districts and States are compiled into quarterly RNTCP performance report and an annual RNTCP status report. CTD analyses the performance of individual states and provides regular feedback to them.
The Central TB Division undertakes biannual national review meetings in which the individual state performance is reviewed and key issues resolved. These meetings are attended by all State TB officers , consultants and other health care providers who are involved in the programme. All States also conduct

regular quarterly review meetings of all districts, to review the program.
CTD undertakes regular visits to states to monitor the programme and to facilitate improvement in all the requisite areas which need attention. It conducts 'Central Level Internal Evaluation' of atleast 1-2 districts every month. States have also been directed to conduct indepth internal evaluations of 2 districts every quarter, reports of which are submitted to the Central TB Division for analysis and appropriate action. Besides these, the programme also undertakes external evaluations conducted by international and national experts, development partners and other stake holders.

The programme has developed a 'RNTCP Supervision and Monitoring strategy' as a tool for objective review of the programme at all level from the peripheral health institution level to the district, state and national level.

Requirement 5(b) ➔ **Process to ensure the input** of a broad range of stakeholders, including Coordinating Mechanism members **and non-CCM members**, in grant oversight processes.

. The members of the India-CCM are accountable to constituencies they represent and are mandated to convey the concerns and view points of these constituencies to the meetings of the India-CCM and provide feedback to the constituencies on the discussions and decisions of the India-CCM on all aspects of the GFATM grant cycle. The CCM-Secretariat facilitates this process by servicing the CCM and by disseminating the necessary information in a timely manner. In order to strengthen the information dissemination and participative oversight processes, the India-CCM at its 18th meeting held on 11th May 2006, approved the prototype of the website of the India-CCM (CCM Annex 2.VI). The website was subsequently launched in the beginning of June 2006. The address is www.indiaccm.org. The Agenda and Proceedings of the recent India-CCM meetings are hosted on the website. The India-CCM monitors the performance of the programme through reviews carried out every six months. The CCM requests for presentations from the Principal Recipients on the performance and the same is reviewed at the CCM meetings. The Principal Recipients also share a copy of the quarterly progress reports submitted to the Global Fund, with the India-CCM Secretariat. These reports are utilised for programme review. The programmes also conduct external evaluations, the reports of which are sent to the India-CCM Secretariat. The Principal Recipients submit disbursement requests every six months providing the progress against the performance indicators provided in Attachment A signed with the grant agreement. These documents are also shared with the CCM secretariat and members.


INDIA-CCM STRUCTURE & INTER-RELATIONSHIPS
Devmt. Partners
Multilateral
Bilateral
GOVT. Central
MOHFW
MOF
MoD
Govt –States
5 State MoH Representing 5 Regions
PVT. Sector
Business
Foundations
Coordinating
CSO's /FBDs
Academic & Research Sector
Country
Govt PR
D E A
Mechanism
People Living with Disease
GOVT. OPR
NACO
CTD
Dte. NVBDCP
Non Govt. PR
SRs
State
NGOs
SRs
State
NGOs
SRs
State
NGOs
Non Govt. SRs
1
2
3
4 . . .
Relationships:
Coordinating
Collaborative
Contractual
LFA
GFATM

Performance Framework 6-11/ RCC proposal: Indicators, Targets, and Periods Covered

Program Details

Country:	India
Disease:	Tuberculosis
Grant number:	
Principal Recipient:	India CCM

Program Goal, impact and ouctome indicators

Goals:	
1	To reduce the burden (morbidity and mortality) of TB in India by 2015, in line with the Millennium Development Goals, and eliminate TB as a public health problem in the country by 2050.

Impact / outcome Indicator	Indicator	Baseline[1]			Current status[2]			Targets						Comments*
		value	Year	Source	value	Year	Source	Year 6 (2009-10)	Year 7 (2010-11)	Year 8 (2011-	Year 9 (2012-13)	Year 10 (2013-14)	Year 11 (2014-15)	
Impact	Reduction in Incidence of TB disease in India	75 new smear positive (NSP) cases per	2002	National Annual Risk of TB Infection (ARTI)	75 NSP cases per 100,000 population	2008	National Annual Risk of TB Infection (ARTI)			67 NSP cases per 100,000 populatio n			60 NSP cases per 100,000 population	Last round of ARTI survey will be conducted in 2014-15 and report will be available in 2017
Impact	Reduction of prevalence of TB disease in the community	370 bacillary positive TB cases per 100,000 population	2000	Report of expert committee meeting on TB Burden based on prevalence survey data	370 bacillary positive TB cases per 100,000 population	2000	Report of expert committee meeting on TB Burden based on prevalenc e survey data			280 bacillary positive cases per 100,000 populatio n			200 bacillary positive cases per 100,000 population	TB prevalence survey at select sentinel sites to be repeated in 2014-15; and the report will be available in 2016
Impact	Reduction in mortality due to TB in India	29 deaths per 100,000 population	2005	WHO Global TB Report	28 deaths per 100,000 population	2006	WHO Global TB Report	27	26	25	24	23	22	
Outcome	New smear-positive TB cases detected (diagnosed and reported to the national health authority), among the new smear-positive TB cases estimated to occur countrywide each year per 100,000 population (number and percentage)	51 (70%)	2007	RNTCP Annual Report	51 (70%)	2007	RNTCP Annual Report	≥ 51 (70%)	≥ 51 (70%)	≥ 51 (70%)	≥ 51 (70%)	≥ 51 (70%)	≥ 51 (70%)	
Outcome	New smear-positive TB cases that have successfully completed treatment, among the new smear-positive cases registered during the specified time period (%)	86%	2007	RNTCP Annual	86%	2007	please select…	≥ 85%	≥ 85%	≥ 85%	≥ 85%	≥ 85%	≥ 85%	

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description
1	To achieve and sustain universal access to high quality diagnosis and patient friendly treatment under DOTS.
2	Expand and increase the reach of RNTCP to ensure equitable access to diagnostic and treatment services for TB/HIV and drug resistant TB.
3	To consolidate TB control efforts towards achieving the goal of TB control through sustainable and effective public-private partnership to involve all health care providers
4	To contribute towards national efforts in measuring the impact of RNTCP in relation to the MDG TB targets.

Objective / Indicator Number	Service Delivery Area	Indicator	Baseline (if applicable)[1]			Phase 2		Targets for years 6 - 8						Annual targets for years 9 - 11			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y - over program term / Y - cumulative annually / N - not	DTF: Name of PR responsible for implementation of corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	Targets	Results (Mar-08)	6 months	12 months	18 months	24 months	30 months	36 months	Year 9	Year 10	Year 11					
1.1	Improving diagnosis	Number of Designated Microscopy Centres supported under RNTCP in the project states	0	mars.05	R&R TB system, quarterly reports	1'157	1'016	1'484	1'499	2'968	3'008	3'028	3'048	3'864	3'913	3'962	Y	Y	Y - over program term	PR: Central TB Division	1469 Designated Microscopy Centres (DMCs) are currently being supported in the RCC project states of Bihar, Uttar Pradesh and Haryana. With planned increase in scale of the project, existing DMCs in the other project states would be supported, along with updradation of new DMCs with increase in population across years. In addition to the existing 3705 existing DMCs, 257 new DMCs will be upgraded and supported during the project period.
1.2	Improving diagnosis	Number and percentage of districts implementing RBRC component of External Quality Assurance for sputum smear microscopy	NA	mars.05	R&R TB system, quarterly reports	NA	NA	60/85 (70%)	80/85 (95%)	140/140 (100%)	140/140 (100%)	140/140 (100%)	140/140 (100%)	191 (100%)	191 (100%)	191 (100%)	Y	Y	Y - over program term	PR: Central TB Division	162/191 RCC project districts are currently implementing External Quality Assurance protocol for sputum smear microscopy. Out of the 29 non-implementing districts, majority are in the GFATM Rd2 project districts
1.3	Improving diagnosis	Number of TB suspects examined for sputum microscopy	NA	mars.05	R&R TB system, quarterly reports	NA	861,324 TB suspects examined from Apr 05 to Dec 07	374'058	719'352	1'428'912	2'083'896	########	3'512'133	5'342'634	########	9'257'472	Y	N	Y - over program term	PR: Central TB Division	Approx. 400,000 suspects are being examined every quarter in the 8 RCC project states
1.4	High Quality DOTS	Number of key RNTCP staff (DTOs, MO-DTC, MO, STS, STLS and Lab Techs) retrained/trained in new initiatives	0	mars.05	R&R TB system, quarterly reports	4'141	4'401	600	1'200	2'400	3'600	4'800	6'000	9'000	12'000	15'000	Y	N	Y - over program term	PR: Central TB Division	As per programme guidelines, 20% of staff will be retrained /trained in new initiatives every year.
1.5	High Quality DOTS	Number of new smear positive cases registered for treatment under RNTCP DOTS	0	mars.05	R&R TB system, quarterly reports	143'012	105'760	41'562	79'928	158'768	231'544	314'064	390'237	593'626	805'549	1'028'608	Y	N	Y - over program term	PR: Central TB Division	Approx. 40,000 new smear positive cases are being registered under DOTS every quarter in the 8 RCC project states
1.6	High Quality DOTS	Number of TB cases (All forms) registered for treatment under RNTCP DOTS	0	mars.05	R&R TB system, quarterly reports	321'073	280'778	95'593	183'834	365'166	532'550	722'346	897'542	1'365'339	#########	2'365'808	Y	N	Y - over program term	PR: Central TB Division	Approx. 95,000 TB cases (all forms) are being registered under DOTS every quarter in the RCC project states
1.7	High Quality DOTS	Number of new smear-positive cases started on DOTS within 7 days of diagnosis (Under the RNTCP this is one of the important indicators to assess the quality of DOTS treatment services)	NA	mars.05	R&R TB system, quarterly reports	NA	NA	36575 (90%)	70337 (90%)	139716 (90%)	203759 (90%)	276376 (90%)	343409 (90%)	522391 (90%)	708883 (90%)	905175 (90%)	Y	N	Y - over program term	PR: Central TB Division	Currently 86% of NSP cases are being started on DOTS within 7 days in the project states
1.8	High Quality DOTS	Number and percentage of new smear positive TB cases registered under DOTS who smear convert at the end of initial/intensive phase of treatment	NA	mars.05	R&R TB system, quarterly reports	NA	NA	13,802 (90%)	37,406 (90%)	71,935 (90%)	142,891 (90%)	208,390 (90%)	282,658 (90%)	351,213 (90%)	534,263 (90%)	724,994 (90%)	Y	N	Y - over program term	PR: Central TB Division	Smear conversion rates are reported for the patients registered 3-6 months earlier. Currently, the smear conversion rate among the registered new smear positive cases is 89% in the RCC project states. Approx. 15,000 NSP cases are registered every quarter in the 3 states of Bihar,
1.9	High Quality DOTS	Number and percentage of new smear positive pulmonary TB cases registered in a specified period that are successfully treated	(≥ 85%)	mars.05	R&R TB system, quarterly reports	≥ 85%	83.6%	29,515 (≥85%)	56,998 (≥85%)	121,572 (≥85%)	181,181 (≥85%)	248,196 (≥85%)	310,055 (≥85%)	474,759 (≥85%)	647,639 (≥85%)	827775 (≥85%)	Y	N	Y - over program term	PR: Central TB Division	Treatment success rates are reported 13-15 months after the NSP cases are registered.
1.10	Procurement and supply management (First line drugs)	Number of State, District and sub-district (TB Unit) drug stores supported	0	mars.05	R&R TB system, quarterly reports	235	231	334	338	626	632	636	643	820	831	842	Y	Y	Y - over program term	PR: Central TB Division	Currently 764 drug stores are being supported in the RCC project states
1.11	M&E	Number of districts evaluated (as per RNTCP guidelines) by the State and central level evaluation teams	NA	mars.05	R&R TB system, quarterly reports	NA	NA	10	22	38	54	70	86	140	200	260	Y	N	Y - over program term	PR: Central TB Division	
1.12	ACSM (Advocacy, communication and social mobilization)	Number and percentage of key ACSM Staff (IEC officer and Communication Facilitators) in place and trained	NA	mars.05	R&R TB system, quarterly reports	NA	NA	20 (100%)	33 (100%)	33 (100%)	33 (100%)	33 (100%)	33 (100%)	46 (100%)	46 (100%)	46 (100%)	Y	N	Y - over program term	PR: Central TB Division	Currently 30/46 (65%) of the sanctioned key ACSM staff are in place and trained in the 8 project RCC states
1.13	High-risk groups	Number and percentage of identified predominantly tribal and poor districts in the 8 project states achieving 70% case detection and 85% cure rate	NA	NA	R&R TB system, quarterly reports	NA	NA	0	4	7	10	15	20	40	50	55 (70%)	Y	Y	Y - over program term	PR: Central TB Division	16/77 (20%) identified tribal or poor & backward districts in the 8 RCC project states (and none from Bihar and UP) have achieved the bench mark of 70% CDR and 85% treatment success rate in 2007.
2.1	TB/HIV	Number of TB patients tested for HIV having been referred from RNTCP (TB) facilities	NA	NA	R&R TB system, quarterly reports	NA	NA	250	250	18'500	37'000	61'500	86'000	146'000	215'000	296'000	Y	N	Y - over program term	PR: Central TB Division	The number of referrals, is inclusive of the numbers indicated in Objective 2.3.
2.2	TB/HIV	Total Number of TB suspects (HIV Positive plus HIV Negative) referred from Counselling and Testing Centres to RNTCP (TB) facilities	NA	NA	R&R TB system, quarterly reports	NA	NA	250	250	25'000	50'000	75'000	100'000	150'000	200'000	250'000	Y	N	Y - over program term	PR: Central TB Division	Approx. 12000 TB suspects are being referred every quarter, from counselling and testing centres to RNTCP facilities.
2.3	TB/HIV	Proportion of TB patients with known HIV status (i.e. have been tested for HIV) in the intensified (TB/HIV) project state (Andhra Pradesh)	NA	NA	R&R TB system, quarterly reports	NA	NA	0	0	35% (17,500)	35% (35,000)	45% (58,000)	45% (81,000)	55% (137,000)	65% (203,000)	75% (281,000)	Y	N	Y - over program term	PR: Central TB Division	The number of referrals, have been included under objective 2.1
2.4	TB/HIV	Proportion of known HIV infected TB patients initiated on ART in the intensified (TB/HIV) project state (Andhra Pradesh)	NA	NA	R&R TB system, quarterly reports	NA	NA	0	0	440 (25%)	880 (25%)	1,680 (35%)	2,480 (35%)	4,980 (45%)	8,380 (50%)	12,280 (50%)	Y	N	Y - over program term	PR: Central TB Division	For high prevalent states (AP) only. It is estimated that ~10% of the TB patients will be HIV positive in the high prevalent setting
2.5	MDR-TB	Number of Intermediate Reference Laboratories accredited and supported for conducting Mycobacterial culture and drug sensitivity testing	0	0	please select…	0	0	3	3	5	5	5	5	8	8	8	Y	Y	Y - over program term	PR: Central TB Division	As on date, 8 IRLs in the project states are in the process of being established

Objective / Indicator Number	Service Delivery Area	Indicator	Baseline (if applicable)[1]			Phase 2		Targets for years 6 - 8						Annual targets for years 9 - 11			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y - over program term / Y - cumulative annually / N - not	DTF: Name of PR responsible for implementation of corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	Targets	Results (Mar-08)	6 months	12 months	18 months	24 months	30 months	36 months	Year 9	Year 10	Year 11					
2.6	MDR-TB	Number of new MDR-TB cases diagnosed and started on DOTS Plus treatment	0	0	please select…	0	0	50	100	400	750	1'250	1'800	4'250	7'750	12'000	Y	N	Y - over program term	PR: Central TB Division	
2.7	MDR-TB	Number of MDR-TB patients who have successfully completed DOTS Plus treatment (according to programme guidelines) among all the MDR-TB patients who were registered for DOTS Plus treatment during a specified time period	0	0	R&R TB system, yearly management report	0	0	Not Expected	Not Expected	Not Expected	Not Expected	35 (70%)	70 (70%)	525 (70%)	1260 (70%)	2975 (70%)	Y	N	Y - over program term	PR: Central TB Division	Treatment outcomes of MDR-TB cases registered would be reported 24-30 months later
3.1	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of NGOs and Private Practitioners involved and supported under RNTCP DOTS Programme	0	0	R&R TB system, quarterly reports	2'095	439	850	900	1'700	2'000	2'300	2'600	3'750	4'500	6'000	Y	Y	Y - over program term	PR: Central TB Division	2063 NGOs and PPs involved in RNTCP in the RCC project states
3.2	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of review cum workshops held at national and state levels	NA	NA	IMA quarterly Report	NA	NA	5	16	24	32	40	48	75	100	125	Y	N	Y - over program term	PR: Central TB Division	18 State/National Worshops conducted in Yr 1 of GFATM Rd 6 TB project
3.3	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of Private Medical Practitioners reached through CME	NA	NA	IMA quarterly Report	NA	NA	4'000	12'000	22'000	32'000	52'000	62'000	102'000	152'000	202'000	Y	N	Y - over program term	PR: Central TB Dvision; SR - Indian Medical Association	12,000 IMA Members sensitized in Yr 1 of GFATM Rd 6 TB project
3.4	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of private providers trained in DOTS using the RNTCP Module for Private Practitioners and International Standard of Care guidelines	NA	NA	IMA quarterly Report	NA	NA	200	4'500	6'500	8'500	13'500	16'500	23'500	30'500	37'500	Y	Y	Y - over program term	PR: Central TB Dvision; SR - Indian Medical Association	1,600 IMA Members trained in RNTCP in Yr 1 of GFATM Rd 6 TB project
3.5	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of issues of dedicated RNTCP - IMA newsletter and IMA journals published and distributed to all IMA members in the 15 project states and 1 UT	NA	NA	IMA quarterly Report	NA	NA	3	6	10	14	18	22	30	38	46	Y	N	Y - over program term	PR: Central TB Dvision; SR - Indian Medical Association	12 News letters produced in Yr 1 of GFATM Rd 6 TB project
3.6	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of IMA members from the 15+1 project states/UTs who have signed an MoU under one of the RNTCP PPM schemes	NA	NA	IMA quarterly Report	NA	NA	80	1'800	2'600	3'400	5'400	6'600	11'750	15'250	18'750	Y	N	Y - over program term	PR: Central TB Dvision; SR - Indian Medical Association	These targets are specific for the PPM project, and extend to states beyong the proposed 8 RCC states
3.7	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of Church health facilities (medical colleges, hospitals, dispensaries and TB centres) supported (diagnosis, treatment and DOT supervision) and involved under RNTCP	NA	NA	CBCI Quarterly Report	NA	NA	20	50	200	250	350	450	550	650	750	Y	Y	Y - over program term	PR: Central TB Division; SR - Catholic Bishops Conference of India	50 Health facilities involved under RNTCP in Yr 1 of GFATM Rd 4 TB project
3.8	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of Hospital and Health Centre staff from the Catholic Health Institutions sensitized in RNTCP	NA	NA	CBCI Quarterly Report	NA	NA	500	1'500	2'400	3'300	4'200	5'250	7'500	9'750	12'000	Y	N	Y - over program term	PR: Central TB Division; SR - Catholic Bishops Conference of India	500 key staff sensitized in Yr 1 of GFATM Rd 5 project
3.9	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of Medical and Paramedical staff, including Lab technicians (key staff) from Catholic Health Facilities trained in RNTCP	NA	NA	CBCI Quarterly Report	NA	NA	150	300	900	1'500	2'100	3'300	4'500	5'800	7'100	Y	N	Y - over program term	PR: Central TB Division; SR - Catholic Bishops Conference of India	500 key staff trained in RNTCP in Yr 1 of GFATM Rd 5 TB project
3.10	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of review cum workshops held at national and state levels	NA	NA	CBCI Quarterly Report	NA	NA	10	20	30	40	50	60	80	100	120	Y	N	Y - over program term	PR: Central TB Division; SR - Catholic Bishops Conference of India	10 State/National Worshops conducted in Yr 1 of GFATM Rd 4 TB project

Objective / Indicator Number	Service Delivery Area	Indicator	Baseline (if applicable)[1]			Phase 2		Targets for years 6 - 8						Annual targets for years 9 - 11			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y - over program term / Y - cumulative annually / N - not	DTF: Name of PR responsible for implementation of corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	Targets	Results (Mar-08)	6 months	12 months	18 months	24 months	30 months	36 months	Year 9	Year 10	Year 11					
3.11	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of TB suspects identified and referred for examination from the Church Health facilities	NA	NA	CBCI Quarterly Report	NA	NA	12'000	30'000	54'000	84'000	126'000	180'000	312'000	468'000	648'000	Y	N	Y - over program term	PR: Central TB Division; SR - Catholic Bishops Conference of India	All the Catholic Health Facilities involved in RNTCP would compile and submit a PHI monthly report. This data would be compiled by CBCI and submitted quarterly. Approx. 25,000 TB suspects were examined in Yr 1 of the GFATM Rd 4 TB project
3.12	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International	Percentage of pulmonary TB suspects examined in the 14 districts conducting sentinel PPM documentation, who have been referred by private practitioners/NGOs	NA	NA	R&R TB system, quarterly reports	NA	NA	11%	11%	13%	13%	15%	15%	17%	19%	20%	N	N	N - not cumulative	PR: Central TB Division	In 2007, date from 14 PPM sentinel sites indicates, 11% (i.e. 39,000/356,854) of TB suspects were referred by PPs/NGOs
3.13	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Percentage of diagnosed TB patients receiving DOT from PPs/NGOs in 14 districts conducting sentinel PPM documentation	NA	NA	R&R TB system, quarterly reports	NA	NA	20%	20%	22%	22%	24%	24%	25%	25%	25%	N	N	N - not cumulative	PR: Central TB Division	In 2007, date from 14 PPM sentinel sites indicates, 20% (i.e. 15,205/76,028) of diagnosed TB patients were receiving DOT from PPs/NGOs
4.1	Operational Research	Number of surveys undertaken to measure impact of DOTS on TB burden	NA	NA	Specify-Reports, Surveys, Questionnaires etc.	NA	NA	0	0	0	0	0	1	0	3	9	Y	N	Y - over program term	PR: Central TB Division	TB prevalence surveys is currently being undertaken in 4 sentinel sites under GFATM Rd 6 TB project and report is expected in 2010-11. Other surveys planned under RCC include Health Systems assessment between 20011-12, repeat Drug Resistance Surveys at 2 sites in 2013-14, and repeat TB prevalence survey at 6 sites in 2014-15. **Reports of the surveys will be submitted within 6 months of completion of survey.**