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

PROPOSAL FORM – ROUND 9
(SINGLE COUNTRY APPLICANTS)

Applicant Name	INDIA - COUNTRY COORDINATING MECHANISM		
Country	INDIA		
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 9 Guidelines)*	Low Income		
Applicant Type	☒ CCM	☐ Sub-CCM	☐ Non-CCM

Round 9 Proposal Element(s):			
Disease	**Title**	**Does this disease include cross-cutting Health Systems Strengthening interventions in part 4B? *(include in one disease only)***	**Is this a 're-submit' of the same disease proposal not recommended in Round 8?**
HIV[1]	Priority Responses to Accelerate the National Programme with Difficult to Reach Key Populations in Underserved Areas.	No	**Yes**
Tuberculosis[1]	Providing Universal Access to DR TB Control Services and Strengthening Civil Society Involvement in TB Care and Control.	No	**Yes** *The TRP comments on the Round 8 TB Civil society proposal have been addressed and included. However, for Round 9 there are two additional objectives and a new PR.* *So being considered as a new submission.*
Malaria	Intensified Malaria Control Project II	No	**Yes**

[1] Different HIV and tuberculosis activities are recommended for different epidemiological situations. **For further information:** see the '*WHO Interim policy on collaborative TB/HIV activities*' available at: http://www.who.int/tb/publications/tbhiv_interim_policy/en/

If this is a Round 8 proposal being re-submitted, have the TRP Review Form comments been clearly addressed in s.4.5.2? **HIV/AIDS** The Round 8 HIV proposal of India CCM was rated Category 3 – "eligible for re-submission, following major revision". India is re-submitting Round 8 HIV proposal in Round 9, after comprehensively addressing the weaknesses identified by TRP and taking the opportunity to improve the proposal even further.	☒ Yes	☐ No
If this is a Round 8 proposal being re-submitted, have the TRP Review Form comments been clearly addressed in s.4.5.2? **Tuberculosis** The Round 8 Tuberculosis proposal of India CCM was rated Category 3 – "eligible for re-submission, following major revision". In the Country Proposal on Tuberculosis the Rd 8 proposal included only activities for strengthening civil society support to the RNTCP. The Rd 9 proposal includes the civil society component and the Revised National Tuberculosis Control Programme (RNTCP) component which is to strengthen drug resistance (DR) TB diagnosis and treatment activities. The TRP comments related to the Round 8 civil society component have been addressed. As there are considerable additions to the Round 8 proposal, the Country Proposal on Tuberculosis is to be considered as a new submission.	☒ Yes	☐ No
If this is a Round 8 proposal being re-submitted, have the TRP Review Form comments been clearly addressed in s.4.5.2? **Malaria** The Round 8 Malaria proposal of India CCM was rated Category 3 – "eligible for re-submission, following major revision". The TRP comments on the Round 8 Malaria proposal have been addressed and India is re-submitting Round 8 Malaria proposal in Round 9.	☒ Yes	☐ No

Are there major new objectives compared to the Round 8 proposal that is being re-submitted? If yes, please provide a summary of the changes in the box below by each disease re-submission and section number.	☒ Yes	☐ No

HIV/AIDS

Objectives of the Round 9 HIV/AIDS proposal is the same as in the Round 8 proposal

Tuberculosis

The Round 8 proposal included only activities for strengthening civil society support to the Programme while the current Round 9 proposal has civil society component and Programme (RNTCP) component to strengthen Drug Resistant TB diagnosis and treatment activities.

This Round 9 proposal clearly satisfies the Dual Track Financing mechanism. However, only the civil society component of this proposal can be considered resubmission of Rd 8 proposal.

The objectives of the proposal are:

1. Establish and enhance capacity for quality assured timely/ rapid diagnosis of DR-TB suspects in 43 Culture and DST laboratories in India by 2015
2. To scale-up management of MDR-TB in 35 states/Union Territories of India resulting in the initiation of treatment of 65,200 additional cases of Multi Drug Resistant TB (MDR-TB) by 2015
3. Empower people with TB and communities to participate in TB care and control in 374 districts by 2015 across 24 states and enhance political commitment
4. Improve access to quality TB care including DR-TB in 374 districts across 24 states, specifically for women, marginalised, vulnerable and hard-to-reach populations, by 2015
5. Improve care and support for TB-HIV co-infected cases by greater involvement of affected communities and training
6. Contribute to health system strengthening through civil society engagement

Out of these the first two objectives are new and pertain to scale-up of DR TB case diagnosis and management activities and are in line with National DOTS Plus plan. Considering the need for this important activity and existing gap in funding them, the objectives have been added to the proposal. Since activities pertaining to these objectives will be undertaken by the programme, Central TB Division would be the PR on behalf of the programme. The other two PRs from civil society remain the same.

Malaria

The Round 9 India Malaria proposal titled Intensified Malaria Control Project—II, is a re-submission of the Round 8 proposal. In the Round 9 proposal the NVBDCP is the Principal Recipient 1 (PR1) and Caritas India consortium comprising FBO/NGO/private sector is the Principal Recipient 2 (PR2), which is the same PR's as the Round 8 proposal. However, there are certain changes made in the scope and scale of the project. The key differences between the Round 8 and Round 9 India Malaria proposal are presented below.

The **Goal statement** has been re-worded to make it more specific and measurable.

Goal statement of Round 8 Proposal: To reduce malaria related mortality and morbidity in high burden areas.

Goal of statement Round 9 Proposal: To reduce malaria related mortality and morbidity by at least 30% by 2015 as compared to 2008.

The **Objectives** have been further broken down and re-worded to make it more specific, measurable, achievable, realistic and time-bound.

Objective 1 of Round 8 Proposal: To increase access to preventive, promotive and curative care through the public health system

The above objective 1 is being covered through the first two objectives of the Round 9 proposal:

Objective 1 of Round 9 Proposal: To achieve near universal coverage by 2015 by effective preventive intervention (LLIN) for population living in high risk project areas from 42% (2009-10).

Objective 2 of Round 9 Proposal: To achieve at least 80% coverage by parasitological diagnosis; and prompt, effective treatment of malaria through public and private health care delivery systems in project areas by 2015.

Objective 2 of Round 8 Proposal: To increase involvement and capacities of local communities to sustain malaria control efforts.

The above objective 2 has been re-worded and is addressed through the third objective of the Round 9 proposal which has been re-worded.

Objective 3 of Round 9 Proposal: To achieve at least 80% coverage of villages in project areas by appropriate BCC activities by 2015 to improve knowledge, awareness and responsive behavior with regard to effective preventive and curative malaria control interventions.

Objective 3 of Round 8 Proposal: To strengthen the management processes within the health system for improved outcomes

The above objective 3 is being covered through the last two objectives of the Round 9 proposal:

Objective 4 of Round 9 Proposal: To strengthen program planning and management, monitoring and evaluation, and coordination and partnership development to improve service delivery in project areas.

Objective 5 of Round 9 Proposal: To strengthen health systems through training, capacity building to improve service delivery in project areas.

The scale and coverage of the project has been reduced:

The Geographic Coverage of the Round 8 proposal included: 11 States (Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, Jharkhand, Orissa, Chhattisgarh and West Bengal), covering 126 districts and a total population of around 124.63 million

The Geographic Coverage of the Round 9 proposal is: 86 districts in 7 states in the northeastern region of the country, namely, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura covering a population of 42.53 million (2008).

The 12 districts in Jharkhand, 7 districts in West Bengal, 8 districts in Chhattisgarh, and 23 districts in Orissa that were part of the Round 8 proposal have not been included in the Round 9 proposal. These areas would be supported with World Bank/domestic funding.

The two PR's NVBDCP, GOI and Caritas India led NGO/FBO/private sector consortium are the same for both the Round 8 and Round 9 Malaria proposal. Due to reducing the geographic coverage and scale of the project five SR's ***(BCE, CRS, RCDC, CHAI, PSI)*** have not been included in the Round 9 proposal.

The key reasons for exclusion of five SRs in Round 9 proposal are presented below.

The process of preparation of the Round 9 proposal began in January-February 2009 and a number of meetings were held between NVBDCP and Caritas India (Principal Recipient 1 and Principal Recipient 2, respectively in both Round 8 and Round 9 proposals). Subsequently, the Caritas India leading the FBO/NGO/private sector consortium was also contacted the Round 8 sub recipients (SRs) electronically/by phone to apprise them about the Round 9 preparations. The various SRs contacted included: VHAI, CMAI, Futures, CHAI, CRS, BCE, RCDC, and PSI. Consultative meetings with various SRs were also held.

- In the time that elapsed between R8 and R9 proposal preparation, the NVBDCP had successfully obtained funding from the World Bank for malaria control in 93 districts in different states of the country (including 15 districts of Jharkhand, 14 districts of Orissa, and 16 districts of Chhattisgarh). Once the phase 1 of the World Bank review is over, there is a scope for including more districts from the state of Orissa under the ambit of World Bank funding.
- The India CCM recommended rationalization of the total budget being sought through the Round 9 proposal for the malaria component.
- In view of the above, it was proposed to exclude the states of Jharkhand, Chhattisgarh, Orissa, West Bengal originally proposed under GFATM Round 8 proposal; which would be supported with domestic and/or World Bank funding. It was proposed to focus interventions in high endemic northeastern states (7 NE states). Large parts of NE states are forested, remote and inaccessible with weak public health care system and predominantly inhabited by tribal population. In addition the NE region shares long international borders with neighbouring countries that are highly endemic for malaria. These factors together with problems of unrest in several parts of the NE region, presence of highly efficient and anthropophilic vector mosquitoes, warm/humid weather conditions, agricultural practices (shifting cultivation, etc) conducive for vector proliferation render this region highly vulnerable.
- As a result, the three SRs with the PR2 in the Round 8 proposal, namely, BCE, CRS, RCDC desiring to work in Jharkhand, Orissa were not included in the Round 9 proposal.

- Another SR--CHAI desiring to work in the NE region is a sister organization of the Caritas India. CHAI has since agreed to support the Round 9 proposal activities in selected NE region as part of the Caritas India (PR2).
- The PSI requested to opt out of the Round 9 proposal since they desired to focus on other areas.

Currency	☉ USD	Or	○ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Monday 1 June 2009**

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

'**+**' = A key attachment to the proposal. These documents **must** be submitted with the completed Proposal Form. Other documents may also be attached by an applicant to support their program strategy (*or strategies if more than one disease is applied for*) and funding requests. Applicants identify these in the 'Checklists' **at the end of** s.2 and s.5.

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

+ Attachment C: **Membership details of CCMs or Sub-CCMs**

Complete the following sections for each disease included in Round 9:

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

*** Only to be included in one disease in Round 9. Refer to the Round 9 Guidelines for detailed information.*

+ Attachment A: '**Performance Framework**' (Indicators and targets)

+ Attachment B: '**Preliminary List of Pharmaceutical and Health Products**'

+ Detailed Work Plan: Quarterly for years 1 - 2, and annual details for years 3, 4 and 5

+ Detailed Budget: Quarterly for years 1 - 2, and annual details for years 3, 4 and 5

IMPORTANT NOTE:

Applicants are strongly encouraged to read the Round 9 Guidelines fully before completing a Round 9 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 9 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Proposal Form. The *Round 9 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/documents/board/16/GF-BM16-Decisions_en.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Proposal Form. The Round 9 Guidelines therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

1. FUNDING SUMMARY AND CONTACT DETAILS

Clarified table: 1.1

1.1. Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	**69,41,647**	**1,40,58,559**	**1,99,55,622**	**1,90,89,412**	**1,86,67,400**	**7,87,12,640**
Tuberculosis	1,85,51,924	5,09,25,486	5,47,10,519	5,08,38,653	2,45,18,366	19,95,44,948
Malaria	1,61,90,073	2,19,15,532	3,37,09,129	1,82,89,081	2,35,76,364	11,36,80,179
HSS cross-cutting interventions section 4B and 5B within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*						
					Total Round 9 Funding Request ➔:	**39,19,37,767**

1.2. Contact details

	Primary contact	Secondary contact
Name	Mr. Naresh Dayal	Ms. K. Sujatha Rao
Title	Secretary	Secretary
Organization	Ministry of Health & Family Welfare (MoHFW)	Dept. of AIDS Control, National AIDS Control Organisation (NACO)
Mailing address	Ministry of Health & Family Welfare, 139-'A' Wing, Nirman Bhavan, New Delhi- 110011	Dept. of AIDS Control, National AIDS Control Organization (NACO), Ministry of Health and Family Welfare, 9th Floor, Chandralok Building, 36, Janpath, New Delhi- 110001
Telephone	+91-11-23061863	+91-11-23325331
Fax	+91-11-23061252	+91-11-23325331, 23351700
E-mail address	ndayal@nic.in	nacoasdg@gmail.com
Alternate e-mail address	secyfw@nb.nic.in	ksujatharao@hotmail.com

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
HIV/AIDS Proposal	
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti-retroviral therapy
ASHA	Accredited Social Health Activist
BCC	Behaviour Change Communication
BMGF	Bill and Melinda Gates Foundation
CBO	Community Based Organisation
CBWE	Central Board for Workers' Education
CCM	Country Coordination Mechanism
DAPCU	District AIDS Prevention and Control Unit
DFID	Department For International Development
DLN	District Level Networks
DWCD	Department of Women and Child Development
ESIC	Employees State Insurance Corporation
FRU	First Referral Unit
FSW	Female Sex Workers
GFATM	Global Fund for AIDS, TB & Malaria
GoI	Government of India
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HSS	Health Systems Strengthening
IBBA	Integrated Behaviour and Biological Assessment
I-CCM	India - Country Co-coordination Mechanism
ICTC	Integrated Counseling & Testing Centre
IDU	Injecting drug users
IEC	Information, Education, Communication
IHRN	Indian Harm Reduction Network
IMR	Infant Mortality Rate
INP+	Indian Network of Positive People
JMM	Joint Monitoring Mission
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MOHFW	Ministry of Health and Family Welfare
MOL&E	The Ministry of Labour and Employment
MoU	Memorandum of Understanding
MPW	Multi Purpose Workers
MSM	Men who have sex with men
NACO	National AIDS Control Organisation
NACP-III	National AIDS Control Programme phase III
NFHS	National Family Health Survey
NGO	Non Government Organisation
FBO	Faith Based Organisation
NHP	National Health Policy

NRHM	National Rural Health Mission
NRL	National Reference Laboratory
NSEP	Needle Syringe Exchange Programme
NSP	New Smear Positive (Pulmonary TB Case)
OI	Opportunistic Infection
OST	Opioid Substitution Therapy/Oral Substitution Therapy
PH&FWD	Public Health and Family Welfare Department
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PLHIV	People Living with HIV
PMTCT	Preventing Mother to Child Transmission
PMU	Project Management Unit
PPTCT	Prevention of Parent to child transmission
PR	Principal Recipient
SAATHII	Solidarity and Action Against The HIV Infection in India
SACS	State AIDS Control Society
SDA	Service Delivery Area
SHG	Self Help Group
SIAAP	South India AIDS Action Programme
SOP	Standard Operating Protocols
SR	Sub Recipients
SRH	Sexual Reproductive Health
SSR	Sub Sub Recipients
STAG	Strategic Technical Advisory Group
STI	Sexually Transmitted Infection
TI	Targeted Intervention (package for focused prevention, defined in NACP-III)
TRC	Technical Review Committee
TRG	Technical Resource Group
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VTCT	Voluntary Counseling & Testing Center
VVGNLI	V.V. Giri National Labour Institute
WHO	World Health Organisation
WPI	Work Place Intervention

Acronym/ Abbreviation	Meaning *(Those in **bold** are repeated often in the narrative – some of them are country/ Programme specific)*
Tuberculosis Proposal	
ACSM	**Advocacy, Communication and Social Mobilization**
AIDS	Acquired Immune Deficiency Syndrome
ADRA	Adventist Development and Relief Agency, India
AP	Andhra Pradesh
ART	Anti Retroviral Therapy
ARTI	Annual Risk of Tuberculosis Infection
ASHA	**Accredited Social Health Activist (Female volunteer worker)**
ATT	Anti-TB Treatment
BSL	Bio Safety Level
CARE	Cooperative for American Relief Everywhere, India
CBCI	Catholic Bishop's Conference of India
CBO	Community Based Organization
CDC	Center for Disease Control
CHAI	Catholic Health Association of India
CHC	Community Health Centre
CIDA	Canadian International Development Agency
CLRA	Centre for Legislative Research and Advocacy
CMAI	Christian Medical Association of India
CME	Continuing Medical Education
COILA	Collieries Outreach Intervention for Limiting HIV/AIDS
CP	Continuation Phase
CPT	Cotrimoxazole Preventive Therapy
CRS	Catholic Relief Services
Cs	Cycloserine
CTD	**Central TB Division (Central unit managing Tuberculosis control programme in India)**
DDG	Deputy Director General
DDS	District Drug Stores
DEO	Data Entry Operator
DFIT	Damien Foundation of India Trust
DLN	District Level Network
DMC	Designated Microscopy Centre
DNA	Deoxyribo Nucleic Acid
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment Short-course
DOTS Plus	**Programmatic management of MDR/XDR TB**
DRS	Drug Resistance Surveillance
DR-TB	**Drug Resistant Tuberculosis**
DST	Drug Susceptibility Testing
DTC	District Tuberculosis Centre
DTCS	District TB Control Society
DTO	District Tuberculosis Officer
E	Ethambutol
EC	European Commission
EHA	Emmanuel Hospital Association
EQA	External Quality Assessment
Eto	Ethionamide
FBO	Faith Based Organization
FHI	Family Health International
FICCI	Federation of Indian Chamber of Commerce and Industry

FIDELIS	Fund for Innovative DOTS Expansion through Local Initiative to Stop TB
FIND	**Foundation for Innovative New Diagnostics**
gfGDF	Global TB Drug Facility
GF	Global Fund
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIPT	Greater Involvement of People with TB
GLC	Green Light Committee
GLRA	German Leprosy and TB Relief Association
GMSD	Government Medical Store Depot
GoI	Government of India
HIPC	Highly-Indebted Poor Country
HIV	Human Immuno-deficiency Virus
HRD	Human Resource Development
I	Isoniazide
ICAT	India Coalition Against TB
ICTC	Integrated Counseling and Testing Centre
IEC	Information, Education and Communication
IMA	Indian Medical Association
IMPF	Indian Medical Parliamentarian Forum
IP	Intensive Phase
IRL	Intermediate Reference Laboratory
ISTC	International Standards for Tuberculosis Care
IUATLD	International Union Against Tuberculosis and Lung Disease
JALMA	Japanese Leprosy Mission for Asia
JATA	Japanese Anti TB Association
JMM	**Joint Monitoring Mission (External review of the Programme)**
K	Kanamycin
KAP	Knowledge, Attitude and Practices
LAMP	Loop-mediated isothermal amplification
LJ	Lowenstein Jenson
LPA	Line Probe Assay
LRS	Lala Ram Swarup Institute of Tuberculosis and Allied Sciences
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR-TB	**Multi Drug Resistant TB (resistance to at least rifampicin and isoniazid)**
MIS	Management Information System
MLA	Members of Legislative Assemblies
MMWR	Mortality and Morbidity Weekly Report
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
MSH	Management Sciences for Health
NAAT	Nucleic Acid Amplification Test
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NGO	Non Governmental Organization
NRHM	**National Rural Health Mission**
NRL	National Reference Laboratory
NSP	New Smear Positive (Pulmonary TB Case)
NTC	National Tuberculosis Consortium
NTI	National Tuberculosis Institute
NTP	National Tuberculosis Programme
Ofl	Ofloxacin
OR	Operational Research
PAS	Para-Amino Salicylic Acid
PCTC	Patients' Charter for Tuberculosis Care
PHC	Primary Health Centre
PHI	Peripheral Health Institute

PIP	Project Implementation Plan
PLHA	People living with HIV / AIDS
PMU	Project Management Unit
PP	Private Practitioner
PPM	Public-Private Mix
PR	Principal Recipient
PRI	Panchayati Raj Institutions
PSA	Public Service Advertisements
PSI	Population Services International
PSM	Procurement and Supply Chain Management
PWB	**Patient-wise Box (complete kit of medicines for a TB patient)**
QA	Quality Assurance
R	Rifampicin
RCC	Rolling Continuation Channel
REACH	Resource Group for Education and advocacy for Community Health
RNTCP	**Revised National Tuberculosis Control Programme (TB Control Programme in India)**
RTI	Right To Information
SACS	State AIDS Control Society
SDS	**State Drug Stores**
SEAR	South East Asia Region
SHG	Self Help Group
SHIS	Southern Health Improvement Samity
SIDA	Swedish International Development Agency
SLD	Second Line Drugs
SOP	Standard Operating Procedures
SR	Sub Recipient
STAG	Strategic Technical Advisory Group
STDC	State Tuberculosis Training & Demonstration Centre
STLS	Senior TB Laboratory Supervisor
STO	State TB Officer
STS	Senior Treatment Supervisor
TA	**Technical Assistance**
TB	Tuberculosis
TBCAP	Tuberculosis Control Assistance Program
TBCTA	Tuberculosis Coalition for Technical Assistance
The Union	International Union Against Tuberculosis and Lung Disease
ToR	Terms of Reference
TRC	Tuberculosis Research Centre
TU	Tuberculosis Unit
UP	Uttar Pradesh
USAID	United States Agency for International Development
USD	United States Dollar
USEA	Union South East Asia
UT	Union Territory
VHAI	Voluntary Health Association of India
WCC	World Care Council
WHO	World Health Organization
WPR	Western Pacific Region
WVI	World Vision India
XDR-TB	Extensively Drug Resistant TB
Z	Pyrazinamide

Acronym/ Abbreviation	Meaning
Malaria Proposal	
ABER	Annual Blood Examination Rate
ACD	Active Case Detection
ACT	Artemisinin based Combination Treatment
ANM	Auxiliary Nurse Midwife
API	Annual Parasite Incidence
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Unani, Siddha and Homeopathy
BCC	Behaviour Change Communication
BSC	Blood Smear Collection
BSE	Blood Smear Examination
CAG	Comptroller and Auditor General of India
CBO	Community Based Organizations
CHC	Community Health Centre
CIB	Central Insecticide Board
CSO	Civil Society Organization
DDT	Dichloro Diphenyl Trichloroethane
DMO	District Malaria Officer
EFC	Expenditure and Finance Committee
ETF	Early Treatment Failure
FBO	Faith Based Organization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS,Tuberculosis and malaria
GIS	Geographic Information System
GOI	Government of India
GP	General Practitioner
HH	Household
HR	Human Resources
HSS	Health System Strengthening
ICMR	Indian Council for Medical Research
IDA	International Development Association
IDR	In depth Review
IDSP	Integrated Disease Surveillance Project
IEC	Information Education and Communication
IMCP	Intensified Malaria Control Project
IPC	Inter Personal Communication
IRS	Indoor Residual Spray
ITN	Insecticide Treated Nets
IVC	Integrated Vector Control
IVM	Integrated Vector Management
JMM	Joint Monitoring Mission
LLIN	Long Lasting Insecticidal Nets
LMIS	Logistics Management Information System
LQAS	Lot Quality Assurance System
LT	Laboratory Technician
LTF	Late Treatment Failure
M&E	Monitoring & Evaluation
MDG	Millennium Development Goals

MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
MPO	Modified Plan of Operation
MPW	Multi Purpose Worker
MTS	Malaria Technical Supervisor
NAMMIS	National Anti Malaria Management Information System
NAMP	National Anti Malaria Program
NE	North East
NGO	Non Government Organization
NIMR	National Institute for Malaria Research
NMEP	National Malaria Eradication Program
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Diseases Control Program
OR	Operations Research
PCD	Passive Case Detection
Pf	Plasmodium falciparum
PHC	Primary Health Centre
PMU	Project Management Unit
PPP	Public Private Partnership
PR	Principal Recipient
PR1	Principal Recipient 1—National Vector Borne Diseases Control Program
PR2	Principal Recipient 2—Caritas India led FBO/NGO/private sector consortium
Pv	Plasmodium vivax
QA	Quality Assurance
RBM	Roll Back Malaria
RBM-MERG	Roll Back Malaria Monitoring and Evaluation Reference Group
RDT	Rapid Diagnostic Test
RRT	Rapid Response Team
RTI	Right to Information
SAP	Strategic Action Plan
SDA	Service Delivery Area
SEA	South East Asia
SfR	Slide falciparum rate
SHG	Self Help Group
SOP	Standard Operating Protocol
SP	Sulphadoxine Pyrimethamine
SP	Synthetic Pyrethroids
SPR	Slide Positivity Rate
SR	Sub Recipient
TOT	Training of Trainers
TRP	Technical Review Panel
UMS	Urban Malaria Scheme
UNICEF	United Nations International Children's Emergency Fund (now United Nations Children's Fund)
UNOPS	United Nations Organization for Procurement Support
VBD	Vector Borne Disease
VH&SC	Village Health & Sanitation Committee
VHAI	Voluntary Health Association of India
VPP	Voluntary Pooled Procurement
WHO	World Health Organization

2. APPLICANT SUMMARY (including eligibility)

CCM applicants: Only complete section 2.1. and 2.2. and DELETE sections 2.3. and 2.4.
Sub-CCM applicants: Complete sections 2.1. and 2.2. and 2.3. and DELETE section 2.4.
Non-CCM applicants: Only complete section 2.4. and DELETE sections 2.1. and 2.2. and 2.3.

IMPORTANT NOTE:
Different from Round 7, 'income level' eligibility is set out in s.4.5.1 (focus on poor and key affected populations depending on income level), and in s.5.1. (cost sharing).

2.1. Members and operations

2.1.1. Membership summary

Clarified table: 2.1.1

Sector Representation	Number of Members
☑ Academic/educational sector	5
☑ Government	13
☑ Non-government organizations (NGOs)/community-based organizations	4
☑ People living with the diseases	1
☑ People representing key affected populations[2]	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'[3])*	33[4]

[2] Please use the Round 9 Guidelines definition of *key affected populations*.

[3] **Attachment C** is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_AttachmentC_en.xls

[4] **During the Round 8 proposal submission India CCM constituted of 33 members. One CSO member resigned during the Proposal Development of Round 9, hence the current CCM has 32 members.**
As the term of the existing CCM is ending, the CCM re-constitution process has been initiated. The new CCM will assume responsibility from June-July 2009. The revised Terms of Reference includes 40 CCM positions. **(CCM Annexure 2 earlier ToR applicable upto 25 May 09 & 2 A- the revised TOR effective from 25 May 09)**

2.1.2. 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 To bring to the CCM a variety of stakeholders and increase the representation of different sub-sectors, it was decided in CCM meeting held on 9 January 2009 to increase the CCM membership from 33 members to 40 members. **CCM Annexure1.** The designated term of the current voting members on the India CCM was stipulated to end in 2009.Therefore the CCM re-constitution process has been initiated. Each of the different constituencies have initiated the process of transparently selecting their representatives by their own sector. The Non-government organizations (NGOs) and the People affected/ living with disease's constituencies have completed the open transparent CCM member's election process. **CCM Annexure1-A (Report on Re-constitution of India-CCM)** The remaining constituencies are in the process of selecting their representatives. It is expected that by mid-June 2009 the new CCM, will be in-place and latest by first week of July 2009 the re-constituted India CCM will assume responsibility.	☐ No	☒ Yes
(b) Is there continuing active membership of people living with and/or affected by the diseases.	☐ No	☒ Yes

2.1.3. 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 CCM or Sub-CCM.

(a) Describe the capacity and experience of the CCM (or Sub-CCM) to consider how health system issues impact programs and outcomes for the three diseases.

The India-CCM is a partnership of stakeholders from each of the GFATM defined constituencies – the government – at Union and State levels, the private sector, civil society, people living with the disease, bi-lateral agencies, multi-lateral agencies, and academic/research institutions. The India-CCM representatives 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, Health and Family Welfare Department from the Ministry of Health and Family Welfare; a ministry that is directly responsible for policy formulation and oversight of all national health programs including the Revised National Tuberculosis Control Programme (RNTCP),National Malaria Eradication Programme, National AIDS Control Programme, and National Rural Health Mission (NRHM). He functions as the chair of the India Health Sector Coordination Committee which is responsible to oversee health system strengthening activities in the country.

A total of 10 members from the public health sector at the national and state levels are members of the India-CCM and contribute significantly to the decision making process on health programs.

The state (provincial) representatives are the Secretaries of the health ministries of their respective state that represent five geographic regions (North, North-East, South, East and West) of the country. They bring with them in depth knowledge and expertise on public health systems, programmes and a broader vision of the needs of the country. They also bring with them regional knowledge and experience.

The India-CCM includes key decision makers of bi-lateral and multi-lateral agencies that have been engaged in supporting health system strengthening policy and programs across different states and have been at the forefront of several health reform initiatives. In addition, many of the India-CCM members from constituencies such as the private sector, civil society, people living with the disease, bi-lateral and multi-lateral agencies and academic/research institutions, have been, and continue to be closely involved with the design, implementation and monitoring of national and state level policies and programmes that directly effect health care systems.

The civil society representatives and the representatives of the people living with the disease bring to the table vast expertise and experience in health programs, specifically in these three diseases. Their contribution and participation in the India-CCM gives the planning processes a unique perspective of ground realities that may be different or complementary to both the government and donor agencies' approaches to health system strengthening.

Thus the India-CCM members from the different constituencies, through their capacities, experience, and the positions they hold within the health sector, represent a strong commitment to address health system strengthening, contributing significantly to the fight against the three diseases.

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 CCM (or Sub-CCM) in gender issues including the number of members with requisite knowledge and skills.

The members on the India-CCM have the required knowledge and skills to ensure that cross cutting issues concerning gender and equity are addressed in the overall framework of the comprehensive country proposal for Round 9. Drawing upon the important mandate for gender and equity as provided in the Global guidelines of the GFATM for the CCM, the ToR of the India-CCM provides substantive scope for inclusion and gender equity, as one of the guiding principles for improved outcomes for the diseases. There are 11 CCM members on the India CCM out of the 32 who are women.

A representative from UNIFEM participated in reviewing the initial proposals received from different NGO's against the call for concept notes for Round 8. Further the UNIFEM member was part of the writing team during preparation of the Round 8 proposal for the three disease components, to ascertain that gender and equity concerns were satisfactorily addressed by all principal recipients.

All the members in the India-CCM represent diverse constituencies, all of which have social inclusion, gender and equity enshrined in their organisational mandate. Practical and strategic gender interests are addressed through their policies, plans, programmes, institutional systems and knowledge management systems. Most of the organisations represented in the India-CCM state in their purpose and mission statements that women, girls and other marginalised sections of the society are priority target groups.

The India-CCM members are all senior level officials/directors/managers who have several years of experience of managing and guiding large scale programmes and policy directives in the area of public health, social and human development, which have strong gender components.

The India CCM has a Civil Society CCM position to represent the gender constituency. Solidarity and Action Against The HIV Infection in India (SAATHI) is the CSO that is currently representing the gender constituency.

For the re-constituted CCM, a gender CSO known as Society for Social Upliftment through Rural Action (SUTRA) has been elected by the civil society for the gender sub-sector. The CSO SUTRA has been working since 1977 addressing issues that affect Gender Equity.

Also, provision has been made to include a CSO to represent the sexual minorities sub-sector. Suraksha WRHCP was elected by the civil society to represent the sexual minorities sub-sector on the re-constituted India CCM. The new member's representing the gender and sexual minorities' constituency will assume responsibility from July 2009.

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 CCM (or Sub-CCM) in multi-sectoral program design.

The India-CCM is by itself a multi-sectoral partnership at the highest level, representing both the public and private sectors, including government agencies, civil society organisations, People living with and affected by HIV, bilateral development agencies, multilateral development agencies and academic institutions. The India-CCM comprises of representatives from:

- The Ministry of Health and Family Welfare
- The Ministry of Finance
- The Ministry of Defence
- The Dept. of Women and Child Welfare
- State Level representatives from their respective State Departments of Health
- People living/affected with the disease
- CSO representatives
- Private Sector representatives
- Academic or Education Sector representatives and
- Multi-lateral development agency representatives (DFID, USAID)
- Bi-lateral agency representatives. (WHO, World Bank, UNAIDS, UNFPA and UNICEF)

India has five-year national strategic planning processes for HIV and TB that involve a comprehensive consultation of stakeholders under the leadership of the programme divisions. The stakeholders include allied central ministries and the state level programme implementation departments, the academic and research institutions, technical agencies, UN agencies, the bilateral development partners, people affected by the diseases, the civil society sector as well as the private sector. Many of the India-CCM members have been an integral part of these strategic planning processes.

Coming from different sectors, the India-CCM representatives ensure a multi-sectoral approach in planning and decision making. 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.

The success in Round 4, Round 6 and Round 7 HIV component proposals, as well as the Round 6 Tuberculosis proposal gives enough evidence of the India-CCM stewardship in facilitating a multi-sector project design. The proposals for the current Round 8 for all the three disease components are clearly multi-sectoral in nature, with the HIV, Tuberculosis and Malaria Components exhibiting strong working partnerships between civil society, the private sector and different ministries within the government.

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 7 and/or Round 8 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
☐ Last time applied for funding was before Round 7 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' and complete.*** ➔ ***Then also complete sections 2.2.5 to 2.2.8 below*** *(Do not complete sections 2.2.2 to 2.2.4)*

2.2.2. Transparent proposal development processes

➔ *Refer to the document 'Clarifications on CCM Minimum Requirements' when completing these questions.*

➔ *Documents supporting the information provided below must be submitted with the proposal as clearly named and numbered annexes. Refer to the 'Checklist' after s.2.*

(a) Describe the process(es) used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, and at the national, sub-national and community levels. *(If a different process was used for each disease, explain each process.)*

The Round 9 India proposal to the Global Fund is a re-submission of the Round 8 India Country proposal for HIV and Malaria. For Tuberculosis the Round 8 proposal comprised of only the civil society component. A partnership of 16 NGOs organised under 2 civil society PRs (the International Union Against Tuberculosis and Lung Disease, or 'the Union', and World Vision India). The TRP comments on the Round 8 TB Civil society proposal have been addressed and included in the Round 9 proposal. However, for Round 9 there are two additional objectives that focus on strengthening the Country's response to drug resistance TB diagnosis and treatment activities and a new PR, which is the Central TB Division, the Government department that manages the Revised National Tuberculosis Control Program (RNTCP) in India. Hence the Tuberculosis proposal is to be considered as a new proposal.

The Round 8 India country proposal for HIV, Tuberculosis and Malaria secured a rating of Category 3 by the Technical Review Panel (TRP) which makes the country eligible for resubmission by addressing the gaps mentioned by the TRP **(CCM Annexure 3 – TRP comments on Round 8 India proposal)**

In the CCM meeting held on 17th October 2008, India CCM decided to re-submit the Round 8 proposal addressing the TRP comments received from GFATM, for Round 9. **CCM Annexure 4**

There were specific discussions on rationalization of the budget being requested from the Global Fund and the CCM requested the proposal preparation teams to reduce the overall budget being requested by around 20-30%. The Round 9 proposal being a re-submission of the Round-8 proposal, there was no separate invitation for new proposal submissions for possible integration into the India Country proposal for Round 9. **(CCM Annexure 5 – Announcement on I-CCM website)**.

The answer to the above question is the same as the one in the Round 8 proposal, on the processes followed for selection of priority focus areas under the three disease components and the open invitation for submissions of the Round 8.

Identification of focus areas of Round 8 in consultation with the programme divisions of three diseases

Formulation of the Round 8 Country Proposal was one of the agenda items deliberated upon at the 27th India-CCM meeting held on 17th December 2007 **(CCM Annexure 6)**. The three programme divisions were requested to present a gap analysis for the identification of focus areas for Round 8. In addition, the

India-CCM constituted a sub-committee of the CCM to organise preparatory work for the India proposal. The sub-committee of 9 CCM members had representatives from UNAIDS, USAID, UNICEF, DFID, INP+, SPYM (NGO), and three national programme divisions (HIV/AIDS, Malaria and Tuberculosis).

The sub-committee discussed the different thematic focus areas in a meeting organised on 8th February 2008 and shared their recommendations by e-mail with the National Programme Managers of the three disease components for their comments and feedback. **(CCM Annexure 7 Minutes of Sub-committee Meeting)**

At the 28th India-CCM meeting held on 18th February 2008 **(CCM Annexure 8)**, areas for Round 8 funding were discussed. At this meeting it was decided that the Ministry of Health and Family Welfare would submit a country proposal for Malaria for Round-8.

For Tuberculosis, Central Tuberculosis Division- the Government Department, which manages the Revised National Tuberculosis Control Program (RNTCP) indicated that it did not wish to submit a proposal for Round 8, but would welcome proposals from civil society, notably to increase outreach and coverage in specific areas of the country.

The recommendations of the sub-committee on the different thematic focus areas were shared with the CCM members. The CCM members discussed these and recommended few more areas for consideration. In the light of these discussions, the sub-committee was asked to develop and share their final recommendations by e-mail with the members.

HIV/AIDS
The Sub-committee in consultation with NACO identified the thematic focus areas for the Round-8 HIV/AIDS component as:

- Support to males who have sex with males for prevention of HIV transmission
- Prevention of injecting drug use (IDU) and harm reduction among IDU
- Prevention of HIV transmission among informal and migrant workers
- Strengthening health systems in Northern States to improve MCH and STI/HIV services

Tuberculosis
To expand the reach, coverage and success rate of the national programme, the focus areas for the Round-8 Tuberculosis component were identified as:

- Advocacy
- Mobilisation of decentralised authorities like PRI elected Representatives, District Magistrates,
- Member's of Legislative Assembly and others
- Social mobilisation
- Stigma reduction
- DOTS expansion in under-served states.

Malaria
To expand the reach of the malaria control programme in states/provinces with high malaria prevalence, the focus areas for the Round-8 Malaria component were identified as:

- Advocacy, social mobilisation, education and training
- Supply chain for insecticide impregnated bed nets, re-impregnation kits and social marketing of nets
- Diagnosis and care for malaria in the field
- Support for monitoring and evaluation
- Innovation in software and data handling

Regional Civil Society Consultations
In order to strengthen civil society participation, four Regional Consultations were organized. The civil society consultative meetings were largely organised for enhancing civil society participation to access the Global Fund Grants. The consultation was held in Delhi on 18th February, in Jaipur on 20 February, in Bhubaneswar on 21st February, in Bangalore on 29 February and in Bhopal on 8th March 2008. The meetings had a large number of participants from the civil society organizations of the four regions. In addition, CCM members, National and state program divisions (HIV, TB and Malaria) also participated. Nearly 100-125 participants attended each of the meetings held in different places.

The objectives of the meeting were:

(i) To improve civil society understanding of Global Fund processes especially dual track financing.
(ii) To enhance civil society participation in Global Fund Round 8 proposals.
(iii) To understand the India Country Coordinating Mechanism roles and responsibilities.
(iv) To plan for Round 8 proposal preparation.

The key areas covered during the meeting were: an overview of the Global Fund, call for proposals Round-8 & dual track financing, India CCM roles and responsibilities, indicative areas of interests of Program Divisions, experiences of NGO Principal Recipients and Sub Recipients, proposal preparation plan and timelines for civil society participation in Round-8 call for proposal

Communication of call for proposals through websites, list servers and newspapers

The concept notes and proposal submission formats were drafted and placed for viewing and downloading at the web sites of the India-CCM, One World South Asia, NGO Gateway and NACO. The Call for Proposals was published in widely read e-groups AIDS India Forum and Solution Exchange for the AIDS Community, AIDS Beyond Borders, Global Fund Observer (GFO)-Issue 86 and One World South Asia, which were further sent to more than 3,000 NGO's in India.

It was also widely published in English Newspapers (both National and Regional issues) including the Hindustan Times, the Times of India, The Hindu and The Statesman. Samples of few news paper announcements are annexed in the folder. **(CCM Annexure 9)**.

A copy of the screen shot of the India-CCM website in which the call for proposals was placed along with the announcement, disease specific concept notes and application formats is enclosed as **(CCM Annexure 10)**

Development of support mechanisms for enquiries
The last date for submission of concept notes was 21st April 2008. Provisions were made to communicate and handle enquiries related to the proposal by email or telephone, and for submission of completed proposals through email.

After the deadline for submission of proposals, the India-CCM Secretariat tabulated and documented the details of concept notes that were received in time for the three disease components. A total of 258 concept notes were received, of which 191 were for the HIV/AIDS component; 38 for Malaria and 29 for Tuberculosis. **(CCM Annexure 11)**

For the Round 9: The HIV and Malaria proposals and the CSO component of the TB proposal being a re-submission of the Round 8 there was no separate invite for submissions for possible integration into the proposal. This was announced on the India CCM website. **(CCM Annexure 5 – Announcement on I-CCM website)**.

The only addition for this Round are the activities related to strengthening the Country's response to drug resistance TB diagnosis and treatment. For which the Central TB Division which manages the Revised National Tuberculosis Control Program (RNTCP) put up a request to the CCM, for consideration to include this component. This was one of the agenda items deliberated upon at the 35th India-CCM meeting held on 12th February 2009 **(CCM Annexure 12.)** and the technical sub-committee meeting was held on 18 February 2009 (**CCM Annexure 12 A.)** The CCM agreed on this decision. As the activities related to diagnosis and treatment of MDR-TB is a key component under the national RNTCP the CCM endorsed that the Central TB Division be the PR to implement this component, in the CCM meeting held on 25 May 2009 **(CCM Annexure 20).**

(b) Describe the process(es) used to transparently review the submissions received for possible integration into this proposal. *(If a different process was used for each disease, explain each process.)*

The Round 8 India country proposal for HIV, Tuberculosis and Malaria secured a rating of Category 3 by the Technical Review Panel (TRP) which makes the country eligible for resubmission by addressing the gaps mentioned by the TRP. Hence, the Round 9 India proposal to the Global Fund is a re-submission of the Round 8 India Country proposal for HIV and Malaria. For Tuberculosis the Round 8 proposal comprised of only the civil society component. The TRP comments on the Round 8 TB Civil society proposal have been addressed and included in the Round 9 proposal. However, for Round 9 there are

two additional objectives that focus on strengthening the Country's response to drug resistance TB diagnosis and treatment activities and a new PR, which is the Central TB Division, the Government department that manages the Revised National Tuberculosis Control Program (RNTCP) in India. Hence the Tuberculosis proposal is to be considered as a new proposal.

Round 8 Review of Submissions

Similar to the procedure followed for Round 7 proposal development process. The India-CCM constituted a Screening Committee and Technical Review Committee to screen, review, rate and recommend the proposals. The Secretariat identified the members for these committees with inputs from the National Programme Divisions. List of Screening Committee and Technical Review Committee members **(CCM Annexure 13)**

Members were selected for the screening and review committee members based on their level of understanding of the National Disease Control Programs and Global Fund requirements, understanding of public health issues related to the different disease components, and their technical knowledge. In addition care was taken to ensure that there was no potential conflict of interest such as members having linkages with any organisation which had responded to the call for proposal.

The Screening and Technical Review Committee members represented different organisations including WHO, UNAIDS, UNIFEM, World Bank, USAID, and DFID; two National Programme Divisions (Malaria Programme Division was not involved as they were submitting a proposal); and the civil society.

On 23rd and 24th April 2008, the Screening Committee met at the UNAIDS office and all the 258 concept notes were screened for eligibility. This included their correspondence to the focus areas, conceptual clarity, and the capacity of the applicant to implement and manage the budget requested. The screening committee recorded their comments and recommendation's on each concept note which was screened.

The following table gives details of the status of concept notes following review by the Screening Committee:

	Total number of concept notes received	Number of concept notes accepted	Number of concept notes rejected
HIV/AIDS	191	52	139
Malaria	38	14	24
Tuberculosis	29	5	24
Total	**258**	**71**	**187**

Following the first Round of screening all short-listed the proposals were put for review by a Technical Review Committee (TRC). The Technical Review Committee comprising of experts on the three disease components and on gender met at the UNAIDS office on 28th and 29th of April 2008. All 71 concept notes cleared by the Screening Committee were found to be valid on the three different disease components and were taken up for Technical Review. **(CCM Annexure 14)**.

Concept notes on HIV/AIDS that were reviewed:

The 52 concept notes reviewed by the TRC on HIV/AIDS belonged to the following sub-categories:

Sub-category	Number of concept notes
Support to males who have sex with males for prevention of HIV transmission	5
Prevention of injecting drug use (IDU) and harm reduction among IDU	7
Prevention of HIV transmission among informal and migrant workers (the concept note from "Reliance" was moved from Health Systems Strengthening to this category)	28
Strengthening Health Systems in Northern States to improve MCH and STI/HIV services	12
Total	52

The concept notes were reviewed based on criteria formulated by the Technical Review Committee. The comments of the Technical Review Committee are annexed **(CCM Annexure 15)**.

The TRC reviewed the five concept notes received under the sub-category support to MSM and found that only one concept note was strong enough to build the proposal component. This was the concept note submitted by India HIV/AIDS Alliance, which includes several of the major civil society organizations working on issues of MSM and Transgender issues.

The TRC reviewed the seven concept notes received under the sub-category Prevention of IDU and harm reduction among IDU. The concept notes submitted by the Ministry of Social Justice and Empowerment (MoSJE) (with several NGOs and UNODC) and Emmanuel Hospital Association (EHA, in association with several NGOs and INP+) were found to have the potential to build the proposal component. Other good concept notes were received, with proposed activities in specific states. The technical review committee recommended a merger of the two main concept notes submitted by the EHA and MoSJE and the inclusion as (SSR's) of possible partners whose concept note were found of acceptable quality they include Community Development Programme Centre (Thoubal, Manipur), West Bengal Scheduled Castes tribes & Minority Welfare Association (Midnapore, West Bengal).

The TRC reviewed the 28 concept notes received under the sub-category prevention of HIV transmission among informal and migrant workers. One concept note submitted by the Ministry of Labour on the and Employment (MoLE) on informal labour and five concept notes submitted by the NGO's Action Aid, Voluntary Health Services, Humana People to People, Hope Foundation and Catholic Health Association of India (CHAI) on migration were found to have potential. As the National AIDS Control Program (NACP-III) was then in the process of finalising its migrant intervention strategy it was recommended that more clarity be sought from NACO on the approach to migrant interventions.

The TRC reviewed the 12 concept notes received under the sub-category Strengthening Health Systems in Northern States to improve MCH and STI/HIV services. The proposal submitted by PATH and other members of the consortium from (Bihar, Jharkhand, Orissa and Rajasthan); Mahila Chetna Manch (Madhya Pradesh and Chhattisgarh); Sanjay Gandhi Memorial Trust (Uttar Pradesh); SWARG (Uttar Pradesh) and Himalaya Hospital Institute Hospital (Uttarakhand) were found to have the potential. The TRC recommended that as CARE India a consortium partner of PATH had the potential to be the PR, CARE India should develop the proposal in association with 5 SR:

A TRC member representing each of the three disease components presented the process and results of the review and the recommendation of the committees on the submissions received and also recommended the names of potential PR's, to the India-CCM at its 29th meeting held on 6th May 2008 **(CCM Annexure 16)**.

The CCM recommended that the concept notes on the thematic areas of support to MSM, Prevention of injecting drug use (IDU) and harm reduction among IDU, and Strengthening Health Systems in Northern States be further discussed for conceptual strengthening and negotiation by the programme divisions with the applicants.

On the thematic focus area Prevention of HIV transmission among informal and migrant workers the concept note submitted by the Ministry of Labour and Employment (MoLE) was endorsed by the India-CCM.

The five concept notes on the 'informal and migrant workers' thematic area from NGO's – Action Aid, Voluntary Health Services, Humana People to People, Hope Foundation and Catholic Health Association of India (CHAI) were recommended by the CCM for further discussion with NACO. The meeting with NACO was organized on 22 May 2008. It was discussed that the NGO's should put up a joint proposal along with MOLE to avoid duplication of efforts.

The meeting was closed with the following decisions:

- Ideally a single PR approach would help in developing a coherent proposal; however the idea of one or two PRs in this category is acceptable.
- It was clear that the proposal should be coherent and not overlapping, either in terms of functionality or geography.
- The date of June 5th 2008 was mentioned for coming up with clear plan that could be written up by proposal writers.

Following the discussions, the NGO's decided to develop a proposal as a consortium which would be led by the proposed PR Voluntary Health Services (VHS). Based on this decision the NGO consortium prepared a proposal, which was submitted to the I-CCM Secretariat. The proposal submitted by the Voluntary Health Services (VHS) was reviewed by the sub-committee of the CCM on 16 June 2008 **(CCM Annexure 17)**. The sub-committee's comments on the proposal were as follows: the proposal was general, not focused and too broad geographically. Hence, VHS (and the consortium) has been encouraged to apply for Round 9, with a far stronger proposal. The review comments were presented to the CCM at the CCM meeting held on 24th June 2008**(CCM Annexure 18)**.

Based on the TRC comments and CCM's in principle approval the Health System Strengthening component consortium members along with the proposal writing team worked on the proposal. The proposal submitted by the CARE India was reviewed by the sub-committee following which the members[5] of the sub-committee for proposal preparation met with DG, NACO on 16 June 2008. Concerns raised by the sub-committee over the selection of the districts. The districts proposed for intervention were recognized to have weak health systems but they did not show high disease burden of HIV, TB or Malaria. Also, the budget being proposed was not cost effective. Other comments were: the links with NRHM are not strong enough and the effect of such a large component on HIV (and/or malaria and TB) is insufficiently developed, the component needs full endorsement of NRHM and a clear link with disease programmes (NACP, RNTCP and malaria control) to be part of the proposal. It was suggested that these recommendations need to be addressed at the earliest as it was close to the proposal submission date.

On 24 June 2008 in the I-CCM meeting the proposals submitted for the four thematic focus areas were presented. The CCM members expressed concern that the rationale of the Health Systems Strengthening (HSS) proposal needs to be further strengthened and as the proposal requires a minimum ten working days to turn it around which at this stage it was too late. Hence it was decided that the HSS proposal can be submitted in Round 9, depending on the thematic focus areas for Round 9.

Based on the TRC comments and CCM's in principle approval the MSJE initially took the lead on the IDU proposal component, but during the proposal preparation process there were concerns on the MSJE's capacity to be PR. Hence, on the IDU component there was a change proposed in the PR and the MSJE preferred to stay out of this Round. The Indian Harm Reduction Network (IHRN) took the lead and proposed that their partner the Emmanuel Hospital Association (EHA) be the PR as the EHA had the capacity to take on this role. The CCM agreed with the proposed recommendations and changes and endorsed the PR's that include:

	PR	**Component**
1.	Ministry of Labour and Employment	Informal Labour
2.	India HIV/AIDS Alliance	MSM
3.	Emmanuel Hospital Association (EHA)	IDU

The Round 9 India proposal for HIV to the Global Fund is a re-submission of the Round 8 India Country proposal. Hence, it is the same PR's who are leading the processes and have worked along with the proposal writing teams on addressing the TRC comments.

The Voluntary Health Services (VHS) proposal and the Health System Strengthening proposal, as recommended by the TRC and CCM, could not be included in the Round 9 submission as the Round 9 proposal is only a re-submission of the Round 8 and the CCM recommendation regarding budget reduction on the Round 8 proposal, would have not been possible by adding in newer components.

Tuberculosis

The technical review committee reviewed the five concept notes recommended by the screening committee. The proposals were from the TB Coalition (ICAT) of IUATLD; and NGO Consortium for tuberculosis led by World Vision was found to be having the potential to play a lead on the proposal. Both the proposals were recommended as proposed PR's by the TRC. It was further suggested that the Southern Health Improvement Samity (SHIS) should join the NGO Consortium proposal as a SR and Manipur Voluntary Health Association join the TB Coalition via the VHAI, which is already a partner in the

[5] Denis Broun, Country Co-ordinator, UNAIDS, Vidhya Ganesh, UNICEF and Janet Hayman, USAID

ICAT. The proposal submitted by BASS was rejected by the TRC, with a recommendation that the organization explore possible collaborations with local RNTCP and NRHM authorities.

The CCM agreed with the TRC recommendations and endorsed, in principle the TRC recommendation's regarding the PR's. The PR's on the TB proposal initially for Round 8 were:

1.	India Coalition Against Tuberculosis (ICAT)
2.	World Vision led consortium NGO Tuberculosis Consortium (NTC)

A TRC member representing the tuberculosis disease component presented the process and results of the review and the recommendation of the committee on the submissions received and also recommended the names of potential PR's, to the India-CCM at its 29th meeting held on 6th May 2008 **(CCM Annexure 16)**. The CCM recommended in the CCM meeting that these could be either merged into one single PR for TB or two civil society organizations as two separate PR. The two organizations proposed to work as independent PR's. The CCM endorsed the decision on the PR's for the Round 8 and the proposal was submitted to the GFATM.

For the Round 9 TB proposal, the TRP comments on the Round 8 proposal have been addressed and are being re-submitted with the same PR's as in the Round 8 proposal to lead the civil society component of the proposal.

However, for Round 9 there are two additional objectives that focus on strengthening the Country's response to drug resistance TB diagnosis and treatment activities and a new PR, which is the Central TB Division, the Government department that manages the Revised National Tuberculosis Control Program (RNTCP) in India. This inclusion is formally endorsed by the India CCM.

Malaria

Of the 14 concept notes on Malaria that were recommended for technical review by the screening committee, two strong concept notes were recommended by the Malaria technical review committee as PR, i.e. the national program on Malaria (NVBDCP) as Government's PR and a Consortium led by CARITAS as the civil society PR.

In addition, there were three interesting concept notes from the Roman Catholic Diocesan Corporation (Orissa), Human Resource Development Foundation (Assam) and Bethesda Charitable Endeavors (Jharkhand) that were recommended to be SR's of the CARITAS consortium. The Roman Catholic Diocesan Corporation (Orissa) and Bethesda Charitable Endeavors (Jharkhand) agreed to partner on the CARITAS proposal. The Human Resource Development Foundation (Assam) was informed through email but their response came in late and hence could not be processed as an SR.

The short-listed proposals on Malaria were endorsed, in principle, with additional comments to strengthen the proposals by the India-CCM. The TRC recommendation's regarding the PR's were also agreed upon by the CCM. The PR's on the Round 8 Malaria proposal include:

1.	Non Vector Borne Disease Control Programme (NVBDCP)
2.	CARITAS.

The Round 9 India proposal for Malaria is a re-submission of the Round 8 proposal that has addressed the TRP comments. For the Round 9 Malaria proposal the same organisations as in the Round 8 proposal are the PR's.

(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*

Processes to ensure input of people and stakeholders other than CCM members included a wide range of consultations including key stakeholders like potential PRs, sub-recipients, technical support providers, national disease control programmes, key UN agencies like UNAIDS, UNIFEM (gender component) and UNODC, civil society and experts in specific domain areas. The three disease components had different consultations and meetings; Key consultations are briefly described below.

At the India-CCM meeting held on 6th May 2008 the technical review committee recommendations were shared and endorsed, in principle, by the CCM. The CCM provided further recommendations to strengthen the concepts for the three disease components. Formal consultations were held with potential PR to discuss the recommendations of the CCM. UNAIDS, Swasti (A Health Resource Center who were commissioned by UNAIDS as technical writers for the HIV and Malaria components) and UNIFEM provided inputs and support during the proposal development process. UNAIDS represented the India-CCM and guided the process; the Swasti team was involved in writing the proposal; and UNIFEM provided the gender perspective and inputs.

HIV/AIDS
On 8th and 9th May 2008 the shortlisted and potential PR's were invited for a consultation, organised in the UNODC conference hall. At this consultation comments of the TRC and recommendations of the India-CCM were shared. The potential PR worked in groups, based on the thematic focus area they had applied for, towards development of the country proposal. On 9th May a meeting of the sub-groups was organised where they presented their draft conceptual framework. Detailed discussions followed each of the group presentations. Representatives from UNAIDS, UNIFEM and Swasti provided inputs to each of the groups. Following the consultation the organisations continued working in their sub-groups and sought regular inputs from NACO and UNAIDS.

The Round 9 HIV proposal submission process for India involved revising the Round 8 proposal in line with the TRP comments. UNAIDS facilitated the proposal preparation process and commissioned the services of Swasti, as the technical writers for the HIV component of the proposal. UNAIDS further facilitated the coordination amongst the three PR's and also provided the office space for the proposal preparation.

Swasti worked alongside the proposed PRs and assisted in writing the main proposal, clearly addressing TRP comments specifically focusing on bringing out strong linkages amongst the three components. Based on the overall revised framework for the three areas, revised the components of the proposal. Series of meetings were held among the key stakeholder's which includes the proposed PR's, Swasti, UNAIDS, and NACO. **(Minutes of the Round 9 related HIV proposal related meetings is annexed in folder CCM Annexure 19A)**

Malaria
The proposal submitted by the Non Vector Borne Disease Control Programme (NVBDCP) was developed through participation of a broad range of stakeholders including technical agencies such as WHO, NVBDCP, and implementing state and district level agencies. The civil society proposal submitted by CARITAS seeks to complement the activities proposed to be undertaken by the NVBDCP. On 12th May 2008 a meeting was organised by the India-CCM Secretariat at the UNAIDS conference hall for PR of the Malaria component. Representatives from WHO, NVBDCP, Swasti and CARITAS (and its consortium partners) participated in this meeting. The India-CCM recommendations were shared with the participants, following which the NGO discussed the architecture of the proposal Following the 12th May meetings the writing teams of the NVBDCP and CARITAS consortium prepared separate proposals. However, the interactions between the NVBDCP, WHO and the CARITAS consortium continued for strengthening the country proposal.

The Round 9 proposal has been developed in consultation with a broad range of stakeholders including NVBDCP (GOI), the WHO, FBO/NGO/private sector consortium led by Caritas India and state/district level implementing entities in public and private sector, besides national and international consultants who provided technical inputs. For the proposal preparation the NVBDCP and CARITAS proposal writing teams worked together. A series of joint meetings between the two proposed PR's were conducted and also meetings with the partners were organised in Delhi, Kolkota and Guwahati **(Minutes of the Round 9 related Malaria proposal related meetings is annexed in folder CCM Annexure 19B)**

Tuberculosis
The proposals submitted by the World Vision led National Tuberculosis Consortium and the ICAT were drafted with inputs from the District and State TB societies. These bodies are part of the RNTCP division beyond the India-CCM.

The members from the TRC that reviewed the proposals played a supportive role in the proposal preparation process by participating in the meetings between the two consortiums and also reviewing the proposals.

On 12th May 2008 a meeting was organised by the India-CCM Secretariat for the PR of the Tuberculosis component. Also present at this meeting were representatives from WHO, RNTCP, and the NGO consortium partners. The TRC comments and CCM recommendations were shared, followed by discussions on these recommendations. The proposal development process was discussed.

On the morning of 13th May 2008, ICAT Core Committee met with partners of the NGO TB Consortium (NTC) and agreed to develop and submit a single unified proposal to the India-CCM. The proposal was initially developed individually over a 3 week period from 23rd May to 6th June 2008. During this period, representatives from the two groups met at weekly intervals to coordinate and ensure synergy throughout the development stage.

On 6th June 2008, both the consortiums organised a meeting in the Care –India office to share the second draft of the full proposal developed by each consortium. At this meeting technical input from the national programme was sought to ensure that the proposals were in line with the national policy guidelines and requirements.

On 9th June 2008, the two groups met to synthesise the two proposals into a single unified proposal, with two PR and to include recommendations from the national programme. On 13th June the TB proposal was sent to the India-CCM Secretariat. On 16th June 2008 the draft comprehensive country proposal was uploaded for the CCM members to provide comments and inputs.

For the Round 9 TB proposal WHO supported the proposal preparation process by providing regular TA and contracting the Core writing team comprising of a lead Technical Consultant, a supporting Technical Consultant and a Finance Consultant. The Civil Society PR's also put together a writing team with a Lead proposal writer. There have been high levels of interaction between the three PR's along with selected SR's and the proposal preparation teams. The different stakeholders organised proposal discussion meetings which happened atleast once in two-weeks on a regular basis. **(Minutes of the Round 9 related TB proposal related meetings is annexed in folder CCM Annexure 19C)**

(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***CCM Annexure 4*** ***India-CCM Meeting held on 17 October 2008***

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.

One of the key governance roles of the CCM is to provide oversight of the different Global fund grants received by the country. Oversight requires the CCM to play a monitoring role to gauge the effectiveness of grant implementation, track progress, locate challenges, and make recommendations to the PR on strategies for improving performance. Oversight ensures that monitoring is being conducted by PR, results and impacts are being reported, and programs are meeting agreed targets. The revised ToR of the India CCM specifically mentions the oversight roles of the CCM.

An annual two-day workshop is organized to provide opportunities for all members to discuss outstanding issues, and to find ways of improving CCM performance. The review of the status of implementation of GFATM grants is a key agenda item in all regular meetings of the India-CCM. Quarterly reports on the implementation of each grant with respect to both financial and service-delivery targets are prepared by the PR and circulated to all the CCM members and invitees prior to each CCM meeting by the India-CCM Secretariat (and posted on the India-CCM website). In addition, the representative of the PR makes a brief presentation of progress during the meeting and respond to the queries of the members and

invitees. The views expressed by the members and invitees, the responses of the PR and the recommendations of the CCM for improving or accelerating performance, where relevant, are recorded in the Proceedings of the Meeting by the India-CCM Secretariat and circulated to all the members and the invitees. The India-CCM Secretariat also responds to queries from any interested stakeholders on the performance of the grant.

For GFATM grants, which have more than one PR (Round 4 and Round 6 HIV/AIDS grants), an advisory committee and a task force has been constituted, co-chaired by the non-governmental PR and the Head of the national disease control programme division (NACO, in this instance). Meetings of these bodies take place at regular intervals- every quarter - and performance of the grant is discussed and recommendations for improvement of coordination are made. The India-CCM Secretariat is invited to these meetings.

Starting with Round 9 grants, an oversight sub-committee will be formed for each of the three respective disease components. The tenure of each sub-committee will be for one year. The composition of the sub-committee will include one member each from the Government, Civil Society/Private Sector, Multi/Bi Lateral and the Academic/ Educational and PLWD Constituency.

Members of India-CCM representing PR who are receiving funds from GFATM will not be involved in oversight of that specific grant.

The functions of the sub-committees will include:

- Support PR in proposal development processes and grant negotiations
- Review progress reports on a quarterly bases, analyze data submitted by PR and provide feedback to CCM members
- Providing strategic direction for effective program implementation
- Informally interact with LFA on performance of processes related to financial management and grant disbursement.
- For HIV/AIDS grants, bi-annual site will be conducted in the process of the Joint Implementation Review, including World Bank, Global Fund, DFID, USAID and UN system.
- Review of close-out plan and close-out budget, and eventual RCC submission.

The oversight sub-committees will pay particular attention to the quality of reporting and monitoring, feeding of grant results into national M&E systems and appropriate communication about achievements attributable to the Grant.

Bi-Annual Site Visits

The oversight sub-committees will select specific grants for conducting site visits on a bi-annual basis. The selection of the grants will be done through purposive sampling covering a minimum of 40% of the disease specific grants.

Each of the disease specific sub-committees will develop a site visit form to capture aspects of program implementation and financial management and the challenges therein. A few indicators in each of the disease specific grant site visit forms will be standardized.

The sub-committee will closely work with donor coordination units, the national program divisions and other review teams to integrate their visits with that of the donor-funded joint review missions. In the case of HIV/AIDS grants, all visits will be integrated in the Joint Implementation Review Missions.
Each field visit will result in a detailed report, provided both to the PR and India-CCM through the Secretariat.
The oversight process outlined above comes in addition to the detailed evaluation of grant performance undertaken by the CCM as part of the request for continuation of funding into the Phase 2 of the grant and the regular monitoring of performance that is undertaken internally by the PR and/or the Ministry of Health & Family Welfare.

Joint Missions

Members would also be involved in Joint Review Missions of GF states and also participate in common review missions under NRHM.

(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.

All grants are submitted to regular visits and evaluation by services of the Government at the Union and State level. Other donors associated with programmes pertaining to the three diseases conduct reviews, studies, evaluations and missions. Their reports are shared with the PR and India-CCM members, as and when needed. In addition:

- A dedicated online feedback mechanism will be developed where stakeholders can post comments on the different grants on the CCM website. The important comments will be forwarded to the India-CCM members for their information and follow-up action.
- A consultation with external stakeholders will be organized within the scope of the India-CCM annual retreat.

Empanelment of Agencies

If needed, agencies with expertise in the areas of public health, project management and financial management will be empanelled to undertake external oversight in program and finance and provide inputs with an independent perspective.

Evaluation of Grants and of Grant Utilization

In addition to monitoring, India-CCM will evaluate grants during the final year of implementation and involve the participation of external stakeholders, notably beneficiaries and patients.

Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 9 Guidelines for further explanation of the principles. .*

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*

In India, for Government sector agencies, Department of Economic Affairs, Ministry of Finance is the authorized government entity to receive and disburse funding from external sources. Consequently, this entity is the automatic Principal Recipient (PR) for all GFATM grants to India. Nevertheless, this entity only services as the legal channel for funds; it delegates and designates the respective National Disease Control Programme Divisions (NACO / CTD / Directorate of National Vector Borne Diseases Control Programme - NVBDCP) of the Ministry of Health & Family Welfare or other interested Ministries as the Operational PR – to manage the programmatic aspects of the grant as well as the disbursement and audit of funds to the sub recipients of the grant.

The India-CCM decides on and nominates PR's that are non-governmental entities through the following process detailed in Section 53 of the Terms of Reference of the CCM.

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

Taking into consideration the above criteria, the technical review committee recommended potential PR's to the India-CCM. The CCM agreed with the recommendations and nominated the PR's (list of PR's provided in table 2.2.5) for the Round 9 India proposal.

The process followed by the India-CCM for the nomination of the PR for the three disease component of the proposal is captured in the proceedings of the 29th India-CCM meeting held on 6th May 2008 **CCM Annexure 16.**

Selection of PR's for the HIV/AIDS Component

For the Round 8 proposal initially it was envisaged that there would be four different thematic focus areas, that includes: informal labour, IDU, MSM and Health System Strengthening. Hence four PR's were short listed by the Technical Review Committee- and endorsed in principle by the CCM for further proposal development. The short-listed PR's were as under:

PR	Component
Ministry of Labour and Employment	Informal Labour
India HIV/AIDS Alliance	MSM
Ministry of Social Justice & Empowerment (MoSJE)	IDU
CARE India	Health System Strengthening

However, as the Round 8 proposal development progressed the CCM decided that the health system strengthening component of the proposal needed further inputs and cannot be included in the Round 8 country proposal.

Ministry of Social Justice & Empowerment (MoSJE) conveyed that it preferred to stay out of this Round, and the Indian Harm Reduction Network (IHRN) took the lead. The IHRN proposed that their partner the Emmanuel Hospital Association (EHA) be the PR as the EHA had the capacity to take on this role. The Ministry of Social Justice and Empowerment formally announced their decision to withdraw as a PR.

The decisions on selection the PR for Round 8 was shared at 30th India-CCM Meeting held on 24th June 2008 **CCM Annexure 18**

PR	Component
Ministry of Labour and Employment	Informal Labour
India HIV/AIDS Alliance	MSM
Emmanuel Hospital Association	IDU

The CCM endorsed the decision on the PR's for the Round 8 and the proposal was submitted to the GFATM.

Selection of PR's for the Round 9

HIV/AIDS
For the Round 9 HIV/AIDS proposal, following the CCM decision to re-submit the revised Round 8 proposal the PR's were invited to participate in the CCM meeting held on 9 January 2009 **CCM Annexure 1** to discuss the action plan for re-submission of Round 8 proposal for Round 9. It was further decided that a Technical Sub-committee be formed to oversee and guide the Round 9 proposal preparation. A technical sub-committee meeting was held on 18 February 2009 **CCM Annexure 12 A** The decision on the PR's and the Round 9 HIV/AIDS proposal was endorsed in principle with additional comments to strengthen the proposal by the India CCM, in the CCM meeting held on 25 May 2009. **CCM Annexure 21**

Tuberculosis
The technical review committee reviewed the five concept notes recommended by the screening committee. The proposals were from the TB Coalition (ICAT) of IUATLD; and NGO Consortium for tuberculosis led by World Vision was found to be having the potential to play a lead on the proposal. Both the proposals were recommended and proposed PR's by the TRC. It was further suggested that the Southern Health Improvement Samity (SHIS) should join the NGO Consortium proposal as a SR and Manipur Voluntary Health Association join the TB Coalition via the VHAI, which is already a partner in the ICAT.

A TRC member representing the tuberculosis disease component presented the process and results of the review and the recommendation of the committee on the submissions received and also recommended the names of potential PR's, to the India-CCM at its 29th meeting held on 6th May 2008 **(CCM Annexure 16)**. The two proposals from namely, the India Coalition Against Tuberculosis (ICAT) and World Vision led consortium NGO Tuberculosis Consortium (NTC) were endorsed in principle with additional comments to strengthen the proposals by the India-CCM. The CCM also recommended that that if possible both the proposals could be merged into one single PR for TB. This decision was left to the PR's. The two organizations proposed to work as independent PR's. The CCM endorsed the decision on the PR's and the final TB proposal for the Round 8, which was submitted to the GFATM.

For the Round 9 proposal submission the CCM decided that a revised Round 8 proposal will be re-submitted for the Round 9 for tuberculosis. Hence both the PR's were invited to the CCM meeting held on 9 January 2009 **CCM Annexure 1** to discuss the action plan for re-submission of Round 8 proposal for Round 9.

In the CCM meeting held on 12th February 2009 the Central TB Division which manages the Revised National Tuberculosis Control Program (RNTCP) indicated its interest to the CCM to include a component, notably to strengthen the Country's response to drug resistance TB diagnosis and treatment activities. This was deliberated upon at the CCM meeting and by the Technical sub-committee and it was

decided that DR TB diagnosis and treatment be included as part of the Round 9 proposal.

As the activities related to diagnosis and treatment of MDR-TB is a key component under the national RNTCP the CCM endorsed that the Central TB Division be the Operational PR to implement this component. The Department of Economic Affairs, Ministry of Finance is included as a PR on the Tuberculosis Proposal. Hence, for the Round 9 TB India proposal, the PR's are:

	Proposed PR's for Tuberculosis	
1	India Coalition Against Tuberculosis (ICAT)	Civil Society PR
2	World Vision led consortium NGO Tuberculosis Consortium (NTC)	Civil Society PR
3	Department of Economic Affairs, Ministry of Finance (PR) *Central Tuberculosis Division (CTD) Operational PR*	Government. PR

Malaria

For the Malaria proposal based on the Technical Review Committee's recommendations, it was endorsed in the CCM meeting that there be two PR, NVBDCP and CARITAS. Hence, for the Malaria India proposal for Round 8, the PR were: 1) NVBDCP and 2) CARITAS.

The Round 9 Malaria proposal being a re-submission the same PR's are the lead on the proposal.

(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	***CCM meeting minutes of meetings held on*** ***24th June 2008*** ***(CCM Annexure 18)*** ***&*** ***25th May 2009*** ***(CCM Annexure 20)***

2.2.4. Principal Recipient(s)

Name	Disease	Sector**
Ministry of Labour and Employment	HIV/AIDS	Government
India HIV/AIDS Alliance	HIV/AIDS	NGO's and Community Based Organization
Emmanuel Hospital Association	HIV/AIDS	NGO's and Community Based Organization
International Union Against Tuberculosis and Lung Disease (The Union) –	Tuberculosis	NGO's and Community Based Organization
World Vision of India	Tuberculosis	Faith Based Organization
Department of Economic Affairs, Ministry of Finance (PR) Central Tuberculosis Division (CTD) Operational PR	Tuberculosis	Government
Department of Economic Affairs, Ministry of Finance (PR) National Vector Borne Disease Control Programme (NVBDCP) Operational PR	Malaria	Government
CARITAS India	Malaria	Faith Based Organization

*** Choose a 'sector' from the possible options that are included in this Proposal Form at s.2.1.1.*

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 each disease in this proposal.
In compliance with the dual track financing, all the three disease components for the Round 9, proposal from India have PR's from the Civil Society Sector. The Government Sector PR's are the Directorate of National Vector Borne Diseases Control Programme - NVBDCP) for Malaria; The Central Tuberculosis Division (CTD) for Tuberculosis and Ministry of Labour and Employment (MoLE) for the HIV disease components.

2.2.6. 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) for any of the diseases in this proposal?	☐ Yes ***provide details below***
		No ✓ ➔ *go to s.2.2.8.*
(b)	**If yes, attach** the plan for the management of actual and potential conflicts of interest. **The India CCM follows the conflict of interest policy.** ***(CCM Annexure 22)***	☐ **Yes** ***[Insert Annex Number]***

2.2.7. Proposal endorsement by members

Attachment C – Membership information and Signatures	**Has '<u>Attachment C</u>'** been completed with the signatures of all members of the CCM (or Sub-CCM)?	☑ Yes
Yes, the attachement C has been completed with the signatures of all members of the CCM		

2.3.3. CCM Endorsement	
(a) **Attach** the signed and dated minutes of the **CCM meeting** at which the CCM agreed to endorse the CCM proposal.	***25th May 2009*** ***CCM Meeting Minutes*** ***(CCM Annexure 20)***
(b) **Attach** a letter from the CCM Chair or Vice-Chair with the minutes.	**CCM Annexure 21**

Proposal checklist - Section 1 and 2

Section 2: Eligibility		List Annex Name and Number
CCM and Sub-CCM applicants		
2.2.2(a)	Comprehensive documentation on **processes** used to invite submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	**CCM Annexure 6** Minutes of the CCM meeting held on 17 December 07 **CCM Annexure 7** Minutes of sub-committee meeting **CCM Annexure 8** Minutes of the CCM meeting held on 18 February 08 **CCM Annexure 9** Copies of published News paper advertisement's regarding Round 8 announcement. Copies of published online advertisement's for Round 8 **CCM Annexure 10** Announcement of focus areas and template for proposal submission. **CCM Annexure 3** TRP Comments on the Round 8 India Proposal. **CCM Annexure 4** CCM Meeting held on 17 October 2008. **CCM Annexure 5** Announcement made on India CCM website mentioning that Round 9 is a re-submisson of the revised Round 8 proposal

Proposal checklist - Section 1 and 2

2.2.2(b)	Comprehensive documentation on **processes** used to review submissions for possible integration into the proposal (if different processes used for each disease, attach as separate annexes).	**CCM Annexure 13** List of Screening Committee and Technical Review Committee members **CCM Annexure 11** Total Number of concept notes received with screening committee's comments. **CCM Annexure 15** Technical Review Committee's Comments on the concept notes reviewed. **CCM Annexure 16** TRC shared their recommendations with the CCM at the CCM 6th May 2008. **CCM Annexure 17** Minutes of the sub-committee meeting held on 16 June **CCM Annexure 18** CCM Meeting held on 24 June
2.2.2(c)	Comprehensive documentation on **processes** used to ensure the input of a broad range of stakeholders in the proposal development process	**CCM Annexure 19 A** **HIV proposal related meetings** **CCM Annexure 19 B** **HIV proposal related meetings** **CCM Annexure 19 C**
2.2.3(a)	Comprehensive documentation on processes to oversee grant implementation by the CCM (or Sub-	**CCM Annexure 2A**

Proposal checklist - Section 1 and 2

	CCM).	
2.2.3(b)	Comprehensive documentation on processes used to ensure the input of a broad range of stakeholders in grant oversight process.	
2.2.4(a)	Comprehensive documentation on processes used to select and nominate the Principal Recipient (such as the minutes of the CCM meeting at which the PR(s) was/were nominated). If different processes used for each disease, then explain.	Minutes of the India-CCM meeting held on 6th May 2008 **CCM Annexure 16.**
2.2.7	Documented procedures for the management of potential Conflicts of Interest between the Principal Recipient(s) and the Chair or Vice Chair of the Coordinating Mechanism	Conflict of interest policy. *(CCM Annexure 22)*
2.2.8	Minutes of the meeting at which the proposal was developed and CCM (or Sub-CCM) endorsed.	*CCM Meeting Minutes of CCM Meeting held on 25th May 2009* *(CCM Annexure 20)*
2.2.8	Endorsement of the proposal by all CCM (or Sub-CCM) members.	Attachment C

Other documents relevant to sections 1 and 2 attached by applicant:
(add extra rows to this section of the table as required to ensure that documents directly relevant are attached)

ROUND 9 – Tuberculosis

3 PROPOSAL SUMMARY

3.1 Duration of Proposal	Planned Start Date	To
Month and year: *(up to 5 years)*	April 2010	March 2015

3.2 Consolidation of grants	
(a) Does the CCM (or Sub-CCM) wish to consolidate any existing tuberculosis Global Fund grant(s) with the Round 9 tuberculosis proposal?	☐ Yes *(go first to (b) below)* ☒ No *(go to s.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 Round 9 proposal.*	
(b) If yes, which grants are planned to be consolidated with the Round 9 proposal after Board approval?	N/A

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.

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.

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 and other stakeholders. 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. As of now 11th five year plan is underway (2007-12). The ongoing World Bank (WB) funded project (RNTCP Phase II) as well as the GF supported projects are within 11th five-year plan. The WB project is till September 2011 while the approved GF RCC is till March 2015. Thus the GF RCC project as well as the scope of this proposal goes much beyond 11th five year plan, which subsequently will be part of the 12th five-year plan.

The start of 12th five year plan will coincide with Phase II of the GF RCC and Rd 9 proposal. Lessons learned in GF RCC project and Phase I of this project with regard to plan and budget will be incorporated into Phase II of the projects as well as strengthen TB programme component of 12th five year plan.

The fiscal year (financial year/ budget year) used for calculating annual 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 this budgeting/fiscal year.

Taking into account the expected date of proposal approval and first possible disbursement from the Global Fund, the start date of this Global Fund supported interventions has been set for April 2010 coinciding with the start of national fiscal year from April to March. This will allow all Principle Recipients – both in Govt and non-Govt sector to account for the funds within the existing budget/ fiscal cycles and ease the audit requirements.

The month of April is also the start of the second quarter for technical reporting and thus start date of this proposal will assist better financial and technical recording and reporting, and avoid any duplication or recording errors.

3.4 Program-based approach for Tuberculosis

3.4.1. Does planning and funding for the country's response to tuberculosis 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 approach?	☐	Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***
	☒	No. Do not complete s.5.5

3.5 Summary of Round 9 Tuberculosis Proposal

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

India bears 21% of the global burden of incident TB cases and has the highest estimated incidence of Multi Drug Resistant-TB cases (MDR-TB) (131,000 out of global incidence of about 500,000 in 2007). Extensively Drug Resistant TB (XDR-TB) has also been reported from India. HIV prevalence among TB patients is reported to be 4.85%. India's Revised National Tuberculosis Control Programme (RNTCP), based on DOTS strategy, is being implemented through general health system of the states under the umbrella of National Rural Health mission (NRHM). The Programme is implementing all components of WHO Stop TB Strategy 2006 and has made great strides in achieving global targets for new smear positive case detection (NSP CDR) (70%) and treatment success (85%), as per the Millennium Development Goals (MDGs) and the related Stop TB Partnership's Global Plan (2006-2015). The programme needs to now consolidate and sustain current achievements uniformly across all states and districts in the country, and to increase access to quality TB care for all, including DR-TB. However to achieve these goals, the programme faces certain challenges.

This proposal intends to address the identified challenges like insufficient laboratory capacity for detecting and follow up of requisite drug resistance cases in the country and funding gaps for procurement of second line drugs for all MDR-TB cases planned to be initiated on treatment. Though the programme is achieving targets of NSP CDR and treatment success at national level, wide variation in performance is observed across districts in form of low case notification rates, high treatment default rates, and areas with vulnerable populations or health systems access challenges. Further, the programme has a well defined ACSM strategy and continuous efforts are being made in building the capacity of the states for need based planning of ACSM activities. There are also approved schemes for the involvement of NGOs and Private Practitioners. However there is sub-optimal capacity in state and districts to execute and monitor such activities leading to poor community involvement and limited engagement of all health care providers including NGOs, corporate sector and private practitioners in the TB programme.

Addressing these challenges requires a concerted response from the government and civil society, this being the overall strategy of the GF Rd 9 proposal having three Principal Recipients *viz* Central TB Division (CTD) (Government of India - GoI), and a partnership of 16 NGOs organised under 2 civil society PRs (the International Union Against Tuberculosis and Lung Disease, or 'the Union', and World Vision India). In addition to being aligned with the national strategy and the WHO Stop TB Strategy, the proposal addresses several recommendations from the Joint Monitoring Mission (JMM) 2009, review by World Bank experts, and other stakeholders in TB Care and Control in India.

The present proposal intends to scale-up DR-TB diagnosis and management capacity under programme conditions and prevent emergence of drug resistance through improved access to quality TB care through strengthened civil society engagement.

The objectives of the proposal are:

1. Establish and enhance capacity for quality assured rapid diagnosis of DR-TB in 43 Culture and DST laboratories in India by 2015
2. Scale-up care and management of DR-TB in 35 states/Union Territories of India resulting in the initiation of treatment of 55,350 additional cases of Drug Resistant TB (DR-TB) by 2015
3. Improve the reach, visibility and effectiveness of RNTCP through civil society support in 374 districts across 23 states by 2015
4. Engage communities and community-based care providers in 374 districts across 23 states by 2015 to improve TB care and control, especially for marginalized and vulnerable populations including TB-HIV patients

Objective 1 will lead to establishment of capacity to perform at least 160,000 diagnostic culture/DSTs and 330,000 follow up cultures annually through Line Probe Assay (LPA) and liquid culture. The laboratory capacity will be strengthened through FIND (as sub-recipient to Central Unit of Programme – Central TB Division/CTD) under the overall guidance of National Laboratory Committee.

As per **objective 2**, second line drugs for 55,350 additional MDR-TB cases will be procured by the Programme through GLC/ GDF mechanism. Technical assistance for DOTS plus expansion and logistics management will be provided through WHO.

Civil society support to RNTCP in 744 million population of the country in 374 selected districts, through **objective 3 & 4**, will improve access to quality DOTS services and prevent emergence of drug resistance. The selected districts include more than 200 underperforming districts (with case notification rates of 50/100,000 or less), 82 'poor and backward' districts, difficult areas (like the north-east and Jammu & Kashmir), and 44 predominantly tribal districts where civil society will complement RNTCP's DOTS services by extending its reach, engaging communities and private providers, and improving access to quality TB services. The activities will address the identified gaps in DOTS implementation and important measure of contribution to RNTCP would be an increase in number of districts with NSP CDR of ≥ 70% from 143 to 300 and at least 5% reduction in annual default rate among smear positive re-treatment patients in project districts. In addition civil society involvement will also promote the adoption and implementation of Patient Centred Care for all TB patients including those with MDR-TB and HIV co-infection. The project will broad base civil society involvement in TB services through an enduring national Partnership to link RNTCP to other stakeholders through national and state coordination committees.The civil society partners will undertake intensified Advocacy Communication and Social Mobilisation (ACSM), community based support and care, increasing participation of traditional healers, and sensitisation of private practitioners and Non-Government Organisations (NGOs) for involvement in RNTCP schemes. Advocacy by civil society is expected to strengthen political commitment and increased allocation of resources for TB programme specifically at state level.

The total project budget for these activities is USD 199.54 million, out of which 48.4% is for procurement of second line drugs (SLDs). Trainings account for 12% while Human Resource component is 11.8% of the budget.

ROUND 9 – Tuberculosis

India's Round 9 TB proposal to GFATM - Strategic Framework & Summary

Goal	Decrease morbidity and mortality due to drug resistant TB (DR-TB) in India and improve access to quality TB care and control services through enhanced civil society participation			
Purpose	Providing universal access to DR-TB control services and to reduce TB related morbidity and mortality and accelerate progress towards achieving the Global Plan to Stop TB 2006-2015 targets and the relevant MDGs			
Key constraints/ challenges	• Insufficient state level culture and DST capacity for detecting and follow-up of drug resistant cases • Complete funding of second-line anti-TB drugs for MDR-TB patients yet to be secured • Under-performing districts with low case notification rates, high treatment default rates, and areas with vulnerable populations or health systems access challenges. • Limited community involvement in TB control • Sub-optimal capacity of the state and district to execute and monitor ACSM strategy including media campaigns • Variable state and district level capacity in need-based programme planning and financial management • Limited engagement of all health providers in TB programme			
Objectives	Objective-1: Establish and enhance capacity for quality assured rapid diagnosis of DR-TB in 43 Culture and DST laboratories in India by 2015	Objective 2: Scale-up care and management of DR-TB in 35 states/Union Territories of India resulting in the initiation of treatment of 55,350 additional cases of Drug Resistant TB (DR-TB) by 2015	Objective 3: Improve the reach, visibility and effectiveness of RNTCP through civil society support in 374 districts across 23 states by 2015	Objective 4: Engage communities and community-based care providers in 374 districts across 23 states by 2015 to improve TB care and control, especially for marginalized and vulnerable populations including TB-HIV patients
Service Delivery Area	1.1: Improving diagnosis	2.1: Uninterrupted supply of second line drugs	3.1:Advocacy, Communication and Social Mobilization	4.1 Community Systems Strengthening
	1.2: Monitoring & Evaluation	2.2: TA for scale-up management of DR-TB	3.2: Political Commitment	4.2: Community TB Care
	1.3: HRD		3.3: Improving diagnosis	4.3: All Care Providers
	1.4:Programme based Operational Research		3.4: HRD	4.4: TB-HIV
				4.5: Project Management and Administration
PRs	CTD/ Govt of India	CTD/ Govt of India	The Union and World Vision India	The Union and World Vision India
Coverage	Nation wide scale up of DR TB diagnosis and management of MDR-TB using second line anti-TB drugs. Civil society participation in 374 districts - 744 million population.			
Budget	USD $ 199.54 million			
Key outcomes	• Laboratory capacity to perform at least 160,000 diagnostic culture and DST tests and 330,000 follow-up tests annually • Treatment of more than 30,000 MDR-TB cases annually • Increase in number of districts with NSP CDR of ≥ 70% from 143 to 300 in 374 districts • Decrease in default rate amongst retreatment cases by 5% in 374 districts • Enhanced civil society participation in TB Care and Control at all levels			
Key guiding principles	The project will be guided by overall national strategy for TB control and WHO Stop TB Strategy. The guiding principles of the project will be: • Universal access to quality TB care and control services including DR-TB • Community participation and ownership • Sustainability of interventions • Equitable distribution with social and gender sensitivity			

4 PROGRAM DESCRIPTION

4.1 National program and strategy

(a) Briefly summarize:

- the current tuberculosis national program or strategy;
- how the strategy responds comprehensively to current epidemiological situation in the country; and
- the improved tuberculosis outcomes expected from implementation of these programs or strategy.

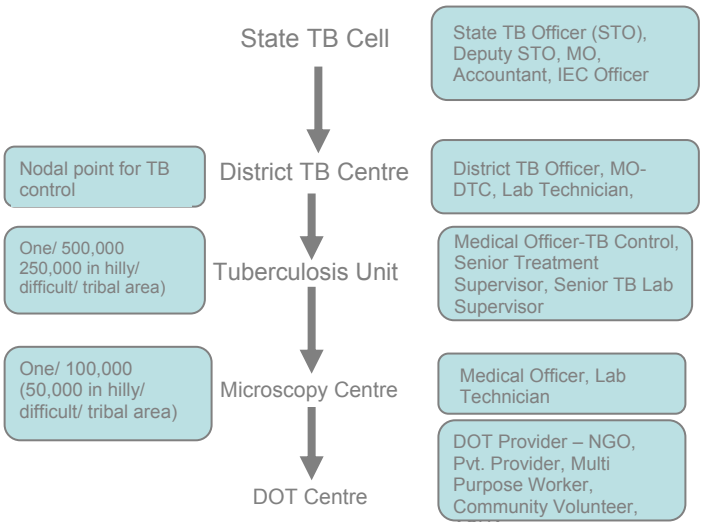
The Revised National TB Control Programme (RNTCP) is being implemented in all states and union territories of India as a **Centrally Sponsored Scheme** (CSS). The Central Government, through policy guidelines as well as through the provision of funds plays a catalytic role in aligning the states' health 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 Millennium Development Goals.

Since March 2006, the Revised National TB Control Programme (RNTCP) is being implemented in all the districts of the country. RNTCP Phase II (2006-2011) aligns with WHO Stop TB Strategy and **covers all the activities** proposed to address the current epidemiological situation in the country.

Diagnosis and treatment of TB under RNTCP is **integrated into the general health-care system** and is largely carried out by multipurpose, general health staff. RNTCP contributes to the organization of services, provides technical and operational guidelines and training materials, ensures supply of drugs and quality control (mainly of drugs and microscopy services), and monitors operational results and epidemiological impact. Program supervision is partly carried out by TB-specific contractual staff, but also relies on the supervision and governance functions of the general health system at the state, district, and sub-district levels.

At the national level, the **Central TB Division (CTD)** is responsible for policy, strategy, and centralized funding. It has five units: supervision, monitoring and epidemiology, human resource development, procurement, supply and logistics, finance, and advocacy and IEC. State RNTCP Cells are responsible for all aspects of the programme within their states. **State TB Office** oversees **District TB Centers (DTC)** and provides technical, financial, and logistical support. WHO technical consultants positioned at the Central TB Division and in each State Cell work closely with the program staff at the respective levels. Each DTC administers ~4-5 sub-district operational units called **Tuberculosis Units (TUs)**, and includes 5 to 6 **Designated Microscopy Centers (DMCs)**. **DOT Centers**, which are sites for free treatment of TB, include dispensaries, Primary Health Centers (PHCs), Community Health Cntres (CHCs), referral hospitals, major hospitals, specialty clinics/hospitals, TB hospitals, and medical colleges and places from where community volunteers operate DOT activities. Health facilities in the private/NGO sector participating in RNTCP are considered PHIs.

Structure of RNTCP at State level



Till date ~10 million TB patients have been initiated on treatment saving 1.8m additional lives. In 2008 alone, 1.51 million cases were registered for treatment. Detection rates amongst NSP cases for 2008 were **72%**. In 2007 cohort, **87%** NSP cases and 71% retreatment cases were successfully treated. Keeping in view the wide variation of performance across states and districts within states, the programme target is to uniformly achieve ≥85% success rate amongst new smear positives and ≥70% new smear positive detection rates in *at least 430* out of the 639 districts in the country by 2011.

The Programme aims to further strengthen the quality and reach of DOTS through - quality assurance protocol for sputum microscopy; decentralised and patient friendly DOT services; pro-active Public-Private Mix (PPM) activities for early referral, diagnosis and DOT services; rational use of first and second line anti-TB drugs; and need based Advocacy, Communication and Social Mobilisation (ACSM) to generate awareness and demand for services.

The National Programme has a well conceived **ACSM strategy** which aims to support TB control efforts by (i) improving case detection and treatment adherence; (ii) combating stigma and discrimination by creating patient friendly reassuring environment, and also informing communities about availability of quality services; (iii) empowering people affected by TB, (iv) and mobilizing political commitment and resources for TB. ACSM strategy endeavours to inform people and communities, sensitize care providers, gather political and administrative support to increase visibility and ensure provision of standardized TB diagnosis and treatment facilities to all TB patients in a patient-friendly environment, in all health care facilities. The activities facilitate administration of treatment under direct observation, reduce default, address side effects, promote community DOT provision, and ensure treatment completion and cure. In addition, ACSM aims widening the reach of services by bringing in larger number of health care providers/ NGOs and other stake holders so that patient get standardized good quality services.

RNTCP has identified **community participation** as one of the key strategies to achieve the TB-related Millennium Development Goals. This participation includes DOT and treatment support by community members, community education, and advocacy for support from local administrative organizations. India has several robust community-based institutional structures (e.g. "Panchayat"[1] "Gaon Kalyan Samitis"[2], and "Mahila Mandals"[3]), and a rich tapestry of community-based organizations (CBOs), operating even in the most difficult areas of the country. Till date, these organizations are rarely utilized in the fight against TB, and represent a tremendously under-utilized resource to strengthen programme implementation.

Community leaders and members can raise awareness, provide treatment support to patients, promote adherence and successful retrieval of treatment interrupters, which may reduce stigma, improve treatment outcomes, and promote earlier and more effective case finding. Local ownership and interest in TB control activities may yield better oversight of the quality and reach of programme implementation. Vulnerable populations, who are unable or unwilling to utilize existing programme infrastructure, can be provided community-based services, further reducing the economic and health burden to disadvantaged patients. Advocacy with and involvement of local institutional structures can contribute to sustainability of community level health interventions, as these entities have budgets that can be used to support TB control activities.

Community involvement is critical to achievement of national TB control targets – particularly in underperforming areas where RNTCP implementation through the health system has not been enough to achieve TB control targets. Community involvement may be increased by capacity building of institutional structures and Community Based Organisations (CBOs), through local advocacy, involvement of community-based volunteers from most-affected populations, developing patient support groups, building health systems capacity for interpersonal communication, and raising TB awareness in the community by mass media and social mobilization.

Public private mix (PPM) is an important component in the RNTCP strategy. RNTCP recognizes contribution of private health sector in the country as an important source of care. The NGOs and private providers are often available and better accessible to patients and perform an active role in health promotion in the community. The aim of PPM efforts is to effectively link the RNTCP and all public and private health-care providers presently out of realms of RNTCP efforts, so as to provide standardized treatment to all TB patients in the country. The Government of India has recently revised schemes for

[1] Local village council government structures, empowered to engage with district authorities.
[2] Village-level committees formed under the National Rural Health Mission (NRHM), entrusted with community-level planning and implementation of health and sanitation, with representation from the local government (*Panchayat)*, local health centre and community.
[3] Community-level federations of women, sometimes encompassing several women SHGs

NGO and private sector involvement in TB control. New schemes have been approved keeping in view newer initiatives like DOTS plus, TB- HIV collaboration and to improve access of DOTS for the TB patients. DOTS services require involvement of private and NGO sectors to reach to special groups like migrants and slum dwellers.

The Programme is addressing newer challenges, such as **TB/HIV co-infection** through collaborative activities. The National Framework for TB/HIV collaborative activities established that essential TB/HIV interventions were to be implemented nationwide. Areas with higher HIV burdens are implementing "Intensified TB/HIV Package" of services which includes routine referral of all TB patients for VCT, decentralised provision of co-trimoxazole preventive therapy, and care and support for HIV positive TB patients with expanded recording and reporting of TB/HIV activities. Presently 11 states are implementing this package. RNTCP plans to implement the intensified TB/HIV package nationwide by the end of 2012.

- For HIV infected TB patients requiring 2nd line ART, NACP will be providing 2nd line ART in selected ART centres, which are upgraded as centres of excellence.
- For all those HIV positive TB patients who receive 2nd-line ART, Rifabutin would be used in place of Rifampicin. Currently, as the quantity of Rifabutin required would be small, States/districts would be authorized to locally procure the required quantity of Rifabutin.
- All the DR-TB patients would be referred for voluntary counseling and testing for HIV. In addition to the standard Cat IV regimen for the management of MDR-TB, HIV positive cases will receive HIV care and support.

It is estimated that about 131,000 MDR-TB cases emerge in India annually, representing over 20% of the global incidence of MDR-TB. RNTCP realizes the urgent need to address the problem that has implications on TB control not only in India but globally. RNTCP views access to **DR-TB diagnosis and treatment** as a basic 'standard of care' in India and has developed a Response Plan for M/XDR-TB [Annex 1] , which includes prevention by quality DOTS expansion, laboratory strengthening for diagnosis and management of DR-TB under the programme, and rational use of second line anti-TB drugs. The approved GF RCC proposal spells out the specific core activities under the national MDR TB response plan; the Reponse Plan for M/XDR TB proposes acceleration of those activities in the RCC areas, and expansion nationwide.

Vision of the national TB programme under the National DOTS Plus plan for DR-TB management is:

- By 2010 DOTS-Plus services available in all states, with free and quality assured treatment to all MDR-TB cases diagnosed under RNTCP
- By 2012, universal access to quality-assured MDR-TB diagnosis and treatment under RNTCP for all smear-positive re-treatment TB cases and new cases who have failed first-line treatment
- *By 2015, universal access to MDR diagnosis and treatment for all smear-positive TB cases under RNTCP early in diagnosis*

National guidelines and plans for scaling up management of DR-TB have been developed under RNTCP. Diagnosis of DR-TB is undertaken in laboratories that are accredited by National Reference Laboratory. To lay the foundation of laboratory scale up for DR-TB diagnosis, the national programme has already invested in some renovation of infrastructure, trained human resources for solid (LJ media) culture and DST, core laboratory equipment, reagents and consumables for solid culture and DST in 4 national reference laboratories (NRLs) and 27 state level intermediate reference laboratories (IRLs). A cost of over USD$110,000 per laboratory for 27 IRLs has been provided for infrastructure development for culture and DST. Additional funds for physical infrastructure upgrades, including generators for uninterrupted power, have been made available by the government for state IRLs. Cost of space and human resource provided for the laboratory by states is additional to the inputs mentioned here. However it is very difficult to quantify the state costs.

To meet the dramatically expanded laboratory requirements posed by the national Response Plan to M/XDR TB, the **laboratory strategy for culture and DST services** is articulated in the 2009 National Laboratory Scale-up Plan [Annex 2]. The Laboratory Scale-up Plan establishes the projected laboratory capacity needs to provide MDR TB diagnosis to all smear-positive re-treatment patients by 2012, and all smear-positive patient by 2015, and lays down the road map towards implementation. The Scale-up plan dramatically expands previous laboratory plans in terms of number of facilities, human resources required, and the use of high-throughput rapid-diagnostic technologies like line-probe assay and liquid culture systems. To guide & review the progress of laboratory activities of RNTCP, **National Laboratory Committee** was **c**onstituted in the year 2004 to work as a national task force, mainly for (a) Developing

national policies, guidelines, manuals and Standard operating procedures (SOPs) for sputum microscopy labs as well as Culture & Drug Susceptibility testing labs (b) Status of External Quality Assurance (EQA) for sputum microscopy in states (c) EQA- On-site evaluation findings of the NRLs (d) Status of infrastructure, performance, and RNTCP accreditation process of Culture & DST Laboratories (e) Policies on evaluation, demonstration and introduction of newer/rapid technologies for TB diagnosis. The committee is comprised of the National TB Programme manager, directors and senior microbiologists of the National Reference Laboratories, members from the Central TB Division (CTD), WHO India, FIND and other laboratory partners, and meets quarterly

At the end of 1 Q 2009 the DOTS Plus services are available in 8 states. Gujarat has been the first state to initiate DOTS Plus services in August 2007 followed by Maharashtra, Andhra Pradesh, Haryana Delhi, Kerala, West Bengal and Tamil Nadu. It is planned to make available DOTS Plus services in all states by 2010 with complete geographical coverage by 2012.

Status of DOTS Plus activities at the end of 1Q, 2009

State	Date of Initiation	No. of MDR patients on treatment
Gujarat	August 2007	159
Maharashtra	September 2007	103
Haryana	December 2008	10
Andhra Pradesh	October 2008	50
Delhi	December 2008	52
West Bengal	December 2008	11
Kerala	December 2008	16
Tamil Nadu	January 2009	3

RNTCP is also taking steps to promote **rational use of anti TB drugs**. “Chennai Consensus Statement on the Management of MDR-TB outside of RNTCP” has been developed and disseminated. IMA is interacting with MCI for guidelines to all healthcare providers on rational use of anti TB drugs aligned to International Standards of TB Care (ISTC). Interactions are on with the Drug Controller General of India to draft guidelines for the regulation of ATT drugs, especially SLDs, and for the encouragement of additional pre-qualified drug manufacturers.

(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this proposal *(or, *identify the specific Annex number from a Round 7or Round 8 proposal when the document was last submitted, and the Global Fund will obtain this document from our files).*

Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

Document	Proposal Annex Number	Page References
☑ National Health Sector Development/Strategic Plan	Annex 3 (Planning commission report)	Entire document
☑ National Tuberculosis Control Mid Term Strategy or Plan	Annex 4 (RNTCP PIP phase II)	Entire document
☑ National Tuberculosis Guidelines (medical and laboratory)	Annex 5 (DOTS Plus guidelines)	Entire document
☑ Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	Annex 6 (Executive summary of the NRHM)	Entire document
☑ Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal	Annex 7 (JMM 2006*, JMM2009, India TB report 2009, DRS 2008)	Entire document
☑ National Monitoring and Evaluation Plan (health sector, disease specific or other)	Annex 8 (Monitoring strategy document 2005)	Entire document
☑ National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services	Annex 4 (RNTCP PIP phase II)	Relevant section

*Joint Monitoring Mission (JMM) 2009 was just completed at the time of preparation of the proposal. Some inputs from JMM 2009 executive summary have been incorporated into the proposal but a full report is expected only by July 2009

4.2 Epidemiological Background

4.2.1. Geographic reach of this proposal		
(a) Do the activities target:		
☒ Whole country*	☐ Specific Region(s) ***If so, insert a map to show where*	☐ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

* DR-TB services (Objective 1 and 2) cover the **entire country** while civil society component (Objective 3-4) covers **374 (out of 639) districts** in the country. Map for civil society coverage is provided in **Annex 9**

(b) **Size of population group(s)**
(If national data is disaggregated differently then type over the categories proposed)

Population Groups	Population Size (millions)	Source of Data	Year of Estimate
Total country population (all ages)	1147.7	Projected from Census 2001	2008
Women > 25 years	244.0	Population as of 2008; distribution as per National Family health Survey III - 2003	2008
Women 19 – 24 years	51.3	Population as of 2008; distribution as per National Family health Survey III	2008
Women 15 – 18 years	56.6	Population as of 2008; distribution as per National Family health Survey III	2008
Men > 25 years	266.5	Population as of 2008; distribution as per National Family health Survey III	2008
Men 19 – 24 years	56.9	Population as of 2008; distribution as per National Family health Survey III	2008
Men 15 – 18 years	70.5	Population as of 2008; distribution as per National Family health Survey III	2008
Girls 0 – 14 years	177.3	Population as of 2008; distribution as per National Family health Survey III	2008
Boys 0 – 14 years	224.5	Population as of 2008; distribution as per National Family health Survey III	2008
Population living in poor & backward districts	260.5	Projected as per Census India 2001	2008
Population living in districts identified as predominantly Tribal	51.8	Projected as per Census India 2001	2008
Population living in Urban slums	42.6	Projected as per Census India 2001	2008

4.2.2. Tuberculosis epidemiology of target population(s)				
	Indicators (see the footnote under this table for the references)		**Number or rate or percentage**	**[Calculation] or (reference)**
TB estimates, 2007				
a	Estimated number of new TB cases (all forms)		1,961,825	(1)
		Male 0-14 (5.4% of total number)	105,939	
		Female 0-14 (6.5% of total number)	127,519	
b	Estimated number of new TB cases (all forms) per 100 000 population		168	[a/population*100 000]
c	Estimated number of new smear-positive cases		872,514	(1)
d	Estimated number of new smear-positive cases per 100 000 population		75	[c/population*100 000]
e	Estimated prevalence of TB cases (all forms)		3,304,976	(1)
f	Estimated prevalence of TB cases (all forms) per 100 000 population		283	[e/population*100 000]
g	Estimated number of deaths due to TB (all forms)		331,268	(1)
h	Estimated number of deaths due to TB (all forms) per 100 000 population		28	[g/population*100 000]
i	Estimated number of HIV-positive new TB cases (all forms)		103,068	(1)
j	Estimated number of HIV-positive new TB cases (all forms) per 100 000 population		9	[i/population*100 000]
k	Estimated number of multi-drug resistant patients of TB (new and re-treatment cases combined)		130,526	(1)
ka	Estimated % of TB cases (new and re-treatment combined) that are multi-drug resistant		5	(1)
TB notifications, 2007				
l	Number of new TB cases (all forms) notified		1,199,087	(1)
		Male 0-14	4,305	
		Male , 15 and more	763,462	
		Female 0-14	7,575	
		Female, 15 and more	422,947	
m	Number of new TB cases (all forms) notified per 100 000 population		103	[l/population*100 000]
n	% of estimated new TB cases (all forms) notified		61	[l/a*100]
o	Number of new smear-positive TB cases notified		592,587	(1)
		Male 0-14	4,305	
		Male, 15-44	245,842	
		Male, 45 and more	161,744	
		Female 0-14	7,575	
		Female 15-44	132,215	
		Female, 45 and more	40,906	
p	Number of new smear-positive TB cases notified per 100 000 population		51	[o/population*100 000]
q	% of estimated new smear-positive TB cases notified - Case detection rate of new smear positive TB		68	[o/c*100]

s	Number of TB cases all forms (new and retreatment) that were tested for HIV	80,425	(1)
t	% of TB cases all forms (new and retreatment) that were tested for HIV	5	[s/l*100]
u	Number of notified TB cases all forms (new and retreatment cases) that were found or known to be HIV-positive	9,324	(1)
v	% of all estimated HIV-positive TB cases that were found or known to be HIV-positive - case detection of HIV+ TB	9	[u/i*100]
w	Number of notified HIV-positive TB cases (new and retreatment) started or continued on CPT	724	(1)
x	% of all notified HIV-positive TB cases (new and retreatment) started or continued on CPT	8	[w/u*100]
y	Number of notified HIV-positive TB cases new and retreatment) started or continued on ART	162	(1)
z	% of all notified HIV-positive TB cases (new and retreatment) started or continued on ART	2	[y/u*100]
aa	Number of TB cases (new and retreatment) received diagnostic DST	414	(1)
ac	Number of multi-drug resistant TB (MDR-TB) cases notified among new and re-treatment cases	146	(1)
ad	% of all estimated MDR-TB cases that were found or known as MDR-TB - case detection MDR-TB	0	[ac/k*100]
Treatment outcome, 2006			
ae	Number of new smear-positive cases registered for treatment	553,302	(1)
af	% of all notified new smear-positive TB cases that were registered for treatment	100	[ae/o*100]
ag	Number of new smear-positive TB cases that were successfully treated (2005 cohort)	475,276	(1)
ah	% of all new smear-positive TB cases registered for treatment that were successfully treated (2005 cohort)	86	[ag/ae*100]
ai	Number of new smear positive TB cases that failed their treatment	12,505	(1)
aj	% of all new smear-positive TB cases registered for treatment who failed their treatment (2005 cohort)	2	[ai/ae*100]
ak	Number of new smear positive TB cases who died while on TB treatment	25,470	(1)
al	% of all new smear-positive TB cases registered for treatment who died while on TB treatment (2005 cohort)	5	[ak/ae*100]
am	Number of new smear positive TB cases who defaulted	35,365	(1)
an	% of all new smear-positive TB cases registered for treatment who defaulted (2005 cohort)	6	[am/ae*100]

Source

1. Global tuberculosis control: surveillance, planning, financing: WHO report 2009. "WHO/HTM/TB/2009.411".

4.3. Major constraints and gaps

4.3.1. Tuberculosis program

Describe:

- the main weaknesses in the implementation of current tuberculosis program or strategy;
- how these weaknesses affect achievement of planned national tuberculosis outcomes; and
- existing gaps in the delivery of services to target populations.

Through the Revised National TB Control Programme, India has scaled-up nationwide implementation of the Global Strategy to Stop TB, with basic DOTS expansion as the first priority. Despite the national-level achievement of the basic programme indicators of >70% case detection and >85% cure for new smear-positive TB cases, some implementation challenges exist in further improving access to quality care including Drug Resistant TB, as placed below

- **Existing laboratory capacity is highly insufficient** to offer the planned services of MDR-TB evaluation to this large patient population.

Table: Diagnostic laboratory capacity need estimates 2010–2014, expressed as number of drug susceptibility tests. (Source: National Laboratory Plan, 2009)

	2010	2011	2012	2013	2014
Diagnostic laboratory capacity required to achieve planned patient coverage for MDR –TB diagnosis	32,000	80,000	144,000	156,000	160,000
Diagnostic laboratory capacity available under currently-funded plans *	14,000	27,000	42,000	53,000	56,000
Diagnostic laboratory capacity **gap**	**18,000**	**53,000**	**102,000**	**103,000**	**104,000**

*27 culture and DST laboratories, conducting solid culture and DST only
Sufficient laboratory capacity is also needed for follow-up culture monitoring of diagnosed MDR-TB patients (estimated to be 330,000 cultures per year by 2014)

- To meet this need for diagnostic testing, as well as the follow-up culture monitoring of diagnosed MDR-TB patients on treatment, the National Laboratory Committee has estimated a total of 43 culture and DST laboratories will be required, implementing high-throughput rapid diagnostic technology for MDR-TB. The projected number of laboratories needed is based on existing full capacity of individual culture and DST laboratories, which is estimated at 2100 diagnostic tests per lab per annum. To accomplish national targets, the capacity would need to be increased to at least 3720 diagnostics per annum for 43 laboratories. As of March 2009, only 10 laboratories (including 2 private) were accredited for solid media culture and DST for diagnosing MDR TB cases

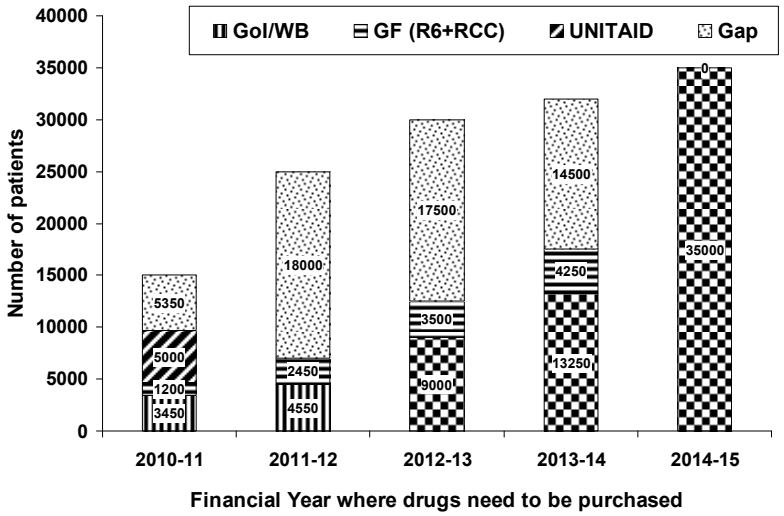
Table: Comparing conventional case finding for MDR-TB with new diagnostic technologies proposed to be implemented with assistance of FIND:

	Diagnostic testing				**Follow-up testing**	
	Number of days for sputum specimen to reach lab	Number of days to obtain test result (additional)	Turn around time from sputum collection (approx)	Cost per DST (INH & Rmp only)#	Number of days for sputum specimen to reach lab	Number of days for providing follow-up result
Conventional solid culture & DST	1 to 4	28 to 62 days	29-66 days	25 USD	1 to 4	14 to 40 days
Liquid culture & DST	1 to 4	12 to 20 days	15 -24 days	27 USD	1 to 4	7-16 days
Line probe assay	1 to 4	2 days	3-6 days	10 USD	N/A	N/A

Assuming that only two drugs are tested and excluding establishment costs
The table demonstrates that by using Line probe assay, the diagnosis of DR-TB can be had in 6 days, sometimes in three days, as compared to 66 days for the existing technology used in RNTCP labs. There

is considerable cost advantage to be had by switching to Line Probe Assay and liquid culture, in terms of faster turn-around time, lesser morbidity for patients and comparable or lesser cost for the actual test materials.

- To safely and effectively implement these new technologies, current and future laboratory facilities the laboratories would require
  - Upgradation in accordance with **biosafety requirements** (WHO BSL3).
  - Additional trained **human resources** for the implementation of new technologies
  - **Expanded technical assistance** for supply chain management, equipment maintenance, and development of information systems.
  - Reliable and time-bound **sputum transportation services**. Evaluation of the initial DOTS plus implementation have demonstrated large delays between identification of patients as MDR-TB suspect and diagnosis, contributing to an observed 30% patient loss due to death or non-initiation of MDR-TB treatment.
- Against 131,000 MDR TB cases estimated to have emerged in 2007 alone approximately 400 patients have been detected and placed on second line treatment (Category IV regimen) under the DOTS-Plus guidelines at 8 DOTS-Plus sites **till March 2009**. In line with the 2009 Response Plan for MDR TB, massive scale up of category IV treatment availability is envisioned. However, complete **funding of second-line anti-TB drugs** for MDR-TB patients has yet to be secured (figure).



WB project ends in Sep 2011. Funding availability beyond that period is anticipated from WB or GoI as part of its commitment.

- **Under-performing districts** where the standard implementation package through the health system has been unable to achieve effective TB control, with a) low case notification rates, (b) high treatment default rates, (c) areas with vulnerable populations or health systems access challenges. For new-smear-positive TB cases, at least 100 districts had an annual case detection rate of 50% or less (national average 72%), 50 districts reported treatment success rate <80%, (national average 87%), indicating special population and access challenges. (ref: 'TB India 2009 – Annual performance report' at Annex 7 c).

- In some difficult and remote areas, the Joint Monitoring Mission (**JMM**) 2009 found that RNTCP guidelines for sputum collection and transportation were not being used. Default rates are particularly high among retreatment patients (15% amongst 2007 cohort). Treatment observation is often not convenient for patients living in remote areas or for labourers in urban areas.

- **Limited community involvement in TB control** has contributed to underlying weaknesses in programme implementation and utilization. Most patients initially access private sector providers, posing health and financial burden for patients as they search for diagnosis and treatment.

- **Sub-optimal capacity of the state and district to execute and monitor ACSM strategy including media campaigns.** Low levels of awareness of services have been documented among those who need TB services the most. National level communication strategies and mass media campaigns

have been implemented with limited intensity, reach, and effectiveness evaluation. While the national ACSM strategy is comprehensive and encompasses all the necessary elements, its execution at state and district level has been variable. CTD has further identified three areas which require strengthening: i) high-level advocacy for political and administrative support; ii) implementation of the stated strategy at state and district levels; and iii) social mobilization. State and district level capacity to undertake strategic and need based advocacy and communication is sub-optimal. Such challenges related to ACSM implementation have been identified in the IEC Baseline (2007) document[4] (Annex 10). Many of the State TB Cells have a low level of confidence in planning and implementing Information Education and Communication (IEC) programmes.

- **Variable state and district level capacity in need-based programme planning and financial management**. This has challenged efforts to effectively implement all aspects of RNTCP, especially efforts to engage communities and all health providers. Without local need-based planning, financial expenditures for activities outside basic DOTS remains low, and available funds to engage other partners are underutilized. Furthermore, there are capacity constraints at state and district level to manage, supervise and monitor the expanded range of activities including PPM initiatives, TB-HIV collaboration, and DOTS Plus services.

- The large and diverse groups of private health care providers are the first point of contact in nearly 60-70% of TB patients. **Engagement of all health providers in India holds massive potential, yet involvement has been limited**. The presence of an ever-growing and unregulated private sector and over-the counter access to TB drugs at private pharmacies suggests an environment conducive to the development of drug resistance. The widespread availability and irrational use of second line drugs in non-standardized regimen is a serious threat that could compromise programme achievements. Till date, the uptake of the 2008 PPM schemes formulated by RNTCP for involvement of private providers has been limited; only a small fraction of nearly 3000 NGOs, 18,000 private practitioners and 150 corporate houses enrolled under the Programme have signed for one of the schemes. This weakness was tied by the 2009 Joint Monitoring Mission to the reliance on the traditional public health system and programme managers to disseminate and promote the PPM schemes. Furthermore, efforts to engage with private providers have had limited reach into other groups of providers, as— particularly in underserved areas—a large proportion of the population primarily utilizes traditional, non-allopathic, or paramedical providers with limited qualifications.

- Significant proportion of the population is poor, or “Below Poverty Line” as designated by the Government of India. Poverty affects care seeking behavior. Though DOTS services are free, these segments of the population do not enjoy protective social nets. The loss of a day’s wages is often untenable for daily wage labourers, leading to **delayed care-seeking/ interrupted treatment**.

[4] IEC baseline document, August 2007, CTD, MOHFW

4.3.2. Health System

Describe the main weaknesses of and/or gaps in the health system that affect tuberculosis outcomes.

The description can include discussion of:

- *issues that are common to HIV, tuberculosis and malaria programming and service delivery; and*
- *issues that are relevant to the health system and tuberculosis outcomes (e.g.: PAL services), but perhaps not also malaria and tuberculosis programming and service delivery.*

The TB control programme in India, is being implemented through the general health system with the primary activity of identifying TB suspects, referral for diagnosis, smear microscopy, initiation and monitoring of directly observed treatment being conducted by the general public health staff. The RNTCP contributes to the organization of services, provides technical and operational guidelines and training materials, ensures resources (drugs, microscopes and lab consumables) and quality control (drugs and microscopy services), and monitors operational results and epidemiological impact. Programme supervision relies on the supervision and governance functions of the general health system at the state, district and sub-district levels supported by TB-specific contractual staff.

Being an integrated programme, the RNTCP depends on a functioning health system with sufficient infrastructure, outreach and access, and adequate, well trained and motivated staff at all levels. It also depends on functioning referral, transfer and information-sharing mechanisms between various public and private health-care providers. **Deficiencies in the general health-care system** constitute a major barrier to further improvements in programme performance, especially in a number of large states with high TB burdens and weak health systems.

- **Limited state resources** for health lead to a weak public health-care infrastructure and non-availability of services specifically in hard to reach/ difficult areas.
- Many health positions, specifically in rural areas are **vacant** due to the poor working and living conditions for staff. There is also skewed distribution of available staff. Particularly in rural areas the number of DOT providers is insufficient to meet ground-level needs.
- **Frequent transfer** of staff at all levels disrupts services, increases training load and reduces quality.
- **Staff absenteeism** and practice in private clinics to augment income are other problems.
- Delays between symptom onset and patients reaching RNTCP services in the general health system is a common phenomenon, suggesting that patients spend a lot of time and money shopping for care in a complex and poorly coordinated health system of private and public providers.
- **Limited capacity** at state and district levels for programme and financial management.
- Some of the key health system challenges identified for **managing TB-HIV co-infection** are
  - Expanding HIV testing services. The mismatch between Integrated Counseling and Testing Centres (for HIV) and Microscopy Centres (for TB) is quite large in most districts.
  - Training of all health staff on the Intensified TB/HIV package.
  - Development of human resources at the district level to supervise TB/HIV activities.
  - Linking HIV-infected TB patients to ART, and streamlining systems for recording ART status on TB patients records.

Inadequacies in staffing at all levels, human resource development, over-reliance on TB dedicated staff and limited engagement of non-programme provider and community have also been hhighlighted by the recently concluded JMM. (executive summary, JMM 2009 Annex 7 b)

4.3.3. Efforts to resolve health system weaknesses and gaps

Describe what is being done, and by whom, to respond to health system weaknesses and gaps that affect tuberculosis outcomes.

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 identified 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, the poor, women and children. The NRHM presents an opportunity to strengthen the public health services to improve quality and access to TB services. The NRHM is an effort at integrating resources and optimizing the delivery of health services through an omni-bus approach, wherein the MoH&FW seeks to adopts a sector-wide approach (rather than a programme-specific approach) and subsumes key national programmes such as the Reproductive and Child Health programme (RCH II), the National Disease Control Programmes (NDCP) and the Integrated Disease Surveillance Programme (IDSP).
As part of the Mission, Indian Public health Standards have been defined for the minimum level of infrastructure, human resource, equipment and drugs/consumables needed for effective functioning of the health institution. A key feature of the NRHM is the community ownership of public health, with important decision making powers, being progressively devolved to the community through the local government at village level. 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.
RNTCP, as other national disease control programmes is an integral part of the NRHM and would continue to deliver its services under the umbrella State/District Health society created under NRHM. As RNTCP is being implemented through the general health system, NRHM would further help in strengthening delivery of DOTS services and increasing accountability of general health system.

The appointment of the **ASHA (Accredited Social Health Activist)**, a voluntary female peripheral health worker, for every 1000 population provides another enormous opportunity to mobilise the community for better TB control and care. ASHA workers recruited under NRHM, are being trained for DOT provision and support to decentralize DOT services to the doorstep of the patients, thereby increasing patient convenience and thus treatment adherence.

Several steps have been undertaken by the programme to meet the gap in infrastructure (for laboratory and drug store) and key human resource (laboratory technician/ Medical officers/ IEC officer etc) for programme specific purpose. The Programme has supplemented resources 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). To support the critical components of field supervision and monitoring and maintenance of TB records, the Programme has provided Senior Treatment Supervisor and Senior TB Laboratory Supervisor at the field level for every 500,000 population (in normal area and for every 250,000 for tribal/hilly/difficult area) . However in some of the states there is a huge gap in infrastructure or human resource which cannot be bridged by the limited support from the Programme. In such situations, systems for sputum collection and transport, involvement of local NGOs and private providers to facilitate treatment services are being promoted.

It has also been recommended to the Programme by JMM 2009 to utilize financing and service delivery mechanisms such as NRHM flexible pool funds, social welfare schemes, Indian Public Health Standards, health insurance initiatives and other financing innovations. In particular, maintaining **priority for TB within NRHM** through regular advocacy can help address staffing, innovations, equipment and infrastructure needs.

Several health system gaps are also being addressed through **pro-active NGO/ Private sector involvement**. The programme has recently developed revised schemes for involvement of NGOs and Private Practitioners (PPs). These schemes are based on the felt-needs of the programmes and areas where the NGO/private sector could contribute to the Programme (Annex 11).

4.4. Round 9 Priorities

Complete the tables below on a program coverage basis (*and not financial data*) for **three to six areas** identified by the applicant as priority interventions for this proposal. Ensure that the choice of priorities is consistent with the current tuberculosis epidemiology and identified weaknesses and gaps from s.4.2.2 and 4.3.

Note: All health systems strengthening needs that are most effectively responded to on a tuberculosis disease program basis, and which are important areas of work in this proposal, should also be included here.

Clarified table: Priority No. 1

Priority No: 1	To strengthen culture and DST laboratories	Historical		Current		Country targets			
Indicator name	*Number of Laboratories strengthened to induct Rapid diagnosis (Line Probe Assay)*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		0	0	**5**	**12**	**25**	**43**	**43**	**43**
B: Extent of need already planned to be met under other programs		0	0	0	0	0	0	0	0
C: Expected annual gap in achieving plans		0	0	0	**12**	**25**	**43**	**43**	**43**
D: Round 9 proposal contribution to total need*		*(e.g., can be equal to or less than full gap)*			**12**	**25**	**43**	**43**	**43**

* Support from the Global Fund is sought for programmatic activities related to this gap and additionally UNITAID shall support commodity assistance for rapid diagnostics for these labs for year 2010-13.

Clarified table: Priority No. 2

Priority No: 2	To detect and treat DR-TB cases	Historical		Current		Country targets			
Indicator name	*MDR-TB cases registered for treatment*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		0	400	1500	8,000	15,000	25,000	30,000	32,000
B: Extent of need already planned to be met under other programs		0	400	1500	8,000	9,650	7,000	**12,500**	17,500
C: Expected annual gap in achieving plans		0	0	0	0	5,350	18,000	17,500	14,500
D: Round 9 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			0	5,350	18,000	17,500	14,500

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Priority No: 3	To attain a new smear positive case detection rate of ≥70%	Historical		Current		Country targets			
Indicator name	*Number of districts with new smear positive case detection rate ⩾ 70% in 374 districts selected for civil society objectives (3&4)*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		374	374	374	374	374	374	374	374
B: Extent of need already planned to be met under other programs. *As of now 143/ 374 districts have a CDR of 70%. It is assumed that there will be little change in these districts without additional inputs.*		140	143	143	143	143	143	143	143
C: Expected annual gap in achieving plans		234	231	231	231	231	231	231	231
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			7	37	82	117	157

Clarified table: Priority No. 4

Priority No: 4	To increase the number of smear positive retreatment patients successfully completing treatment	Historical		Current		Country targets			
Indicator name	*Average default rate of smear positive retreatment patients in the 374 districts covered by civil society objectives (3&4)*	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target *(from annual plans where these exist)*		**<8% (10225)**	**<8% (10430)**	**<8% (10638)**	**<8% (10851)**	**<8% (11068)**	**<8%(11289)**	**<8% (11515)**	**<8% (11745)**
B: Extent of need already planned to be met under other programs *Existing average default rate for smear positive retreatment patients in 374 districts. It is assumed that there will be little change without additional inputs.*		**17894 (14%)**	**18252 (14%)**	**18617 (14%)**	**18989 (14%)**	**19369 (14%)**	**19756 (14%)**	**20152 (14%)**	**20555 (14%)**
C: Expected annual gap in achieving plans		**7669 (6%)**	**7822 (6%)**	**7979 (6%)**	**8138 (6%)**	**8301 (6%)**	**8467 (6%)**	**8637 (6%)**	**8809 (6%)**
D: Round 9 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			**1356 (1%)**	**2767(2%)**	**4234(3%)**	**5758(4%)**	**7341(5%)**

4.5. Implementation strategy

4.5.1. Round 9 interventions

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, program work area (or, "service delivery area (SDA)"), activities and indicator in the 'Performance Framework' (Attachment A). The Global Fund recommends that the work plan and budget follow this same order.*
Where there are planned activities that benefit the health system that can easily be included in the tuberculosis program description (because they predominantly contribute to tuberculosis outcomes), include them in this section only of the Round 9 proposal.

The proposal built on the Global Fund principle of Dual Track Financing envisages bridging one of the most challenging gaps in Tuberculosis control - diagnosis and treatment of DR-TB through programmatic activities and to strengthen quality of basic DOTS services through civil society participation in a country that bears 21% of global burden of TB. With an aim to provide universal access to diagnosis and treatment for MDR-TB cases that would put >30,000 MDR-TB cases annually (**annual targets include funding from all sources**) and a total of 55,350 additional cases on treatment by 2015 in India, this GF supported project will be a major contributor to global efforts for controlling MDR-TB. The present proposal intends to fill the gaps in MDR-TB scale up plan already highlighted in section 4.1 and 4.3.1 of this proposal. The project activities related to diagnosis and treatment of MDR-TB under the Programme will be undertaken by the **Central TB Division as one of the PRs**.

The civil society component endeavors to address challenges in programme implementation and access to quality TB care enlisted in section 4.3.1 and 4.3.2. The project specifically addresses three areas in ACSM identified by the Central TB Division (CTD) for strengthening, viz. high-level advocacy for political and administrative support, implementation of the ACSM strategy at the state and district levels, and social mobilisation. Civil society involvement aims at strengthening engagement of non-programme providers and communities, complement programme efforts in human resource development, supervision and monitoring, and access to diagnostics, increased commitment to DR-TB and TB-HIV from all levels, enhancing engagement of community-based ASHAs (Accredited Social Health Activists), engage more providers in RNTCP's revised schemes, and some exemplary awareness raising efforts.

The civil society component will be implemented by 16 civil society sub-recipients (SRs) (annex 9) that have been implementing community based interventions in the proposed districts, supported and managed by **two civil society Principal Recipients (PRs), the Union (PR2) and World Vision India (PR3).** Two civil society PRs have been identified by partners based on several factors including management and leadership capacity, financial and reporting systems, geographical reach, and credibility. Civil society partners unanimously agree that two PRs identified by them in this project are essential to adequately address the complexity and intensity of interventions in a country of India's size and diversity.

The objectives of the proposal are:

1. Establish and enhance capacity for quality assured rapid diagnosis of DR-TB in 43 Culture and DST laboratories in India by 2015
2. Scale-up care and management of DR-TB in 35 states/Union Territories of India resulting in the initiation of treatment of 55,350 additional cases of Drug Resistant TB (DR-TB) by 2015
3. Improve the reach, visibility and effectiveness of RNTCP through civil society support in 374 districts across 23 states by 2015
4. Engage communities and community-based care providers in 374 districts across 23 states by 2015 to improve TB care and control, especially for marginalized and vulnerable populations including TB-HIV patients

Objective-1: Establish and enhance capacity for quality assured rapid diagnosis of DR-TB in 43 Culture and DST laboratories in India by 2015
The existing RNTCP laboratory network consists of the four designated National Reference Laboratories (NRLs) at national level (Tuberculosis Research Centre TRC, Chennai; National Tuberculosis Institute

NTI, Bangalore; Lala Ram Sarup Institute of Tuberculosis and Allied Sciences LRS, Delhi; and JALMA Institute, Agra), 27 state level Culture & DST labs, and 12,705 RNTCP designated microscopy centers (DMCs) at the periphery.

By 2015, RNTCP aims to treat 32,000 MDR-TB patients annually. To achieve target, laboratory network need to have capacity to perform *160,000 diagnostics tests and 330,000 follow up cultures examinations each year* under the programme. The estimate of tests to be performed is based on - transition in definition of MDR-TB suspect (DOTS Plus vision in section 4.1) and offer of tests; and accounting for operational losses as observed during pilots. The requirement of tests necessities upgradation of existing conventional TB laboratories to utilize rapid diagnostic technologies. In total, **43** laboratories are proposed to be upgraded to have Line Probe Assay facilities. In addition to LPA, automated liquid culture systems will be established in **33** of these labs. The laboratories to be upgraded include the existing 27 Intermediate Reference Laboratories (IRL) of RNTCP, and 4 National Reference laboratories (NRLs). In addition, two NRLs and 10 labs in medical schools (public/private) would be upgraded. This is in accordance with the "Laboratory Scale-up plan to address the problem of MDR/ XDR-TB for 2009-2014" of the RNTCP (Annex 2). All laboratories are being referred to as *culture and DST Laboratories* in section below.

FIND, an SR under this project (receiving funds directly as split disbursement), will undertake laboratory strengthening activities enlisted below under the overall guidance of Central TB Division (CTD) and National Laboratory Committee.

SDA 1.1: Improving diagnosis

Infrastructure upgradation (Civil works & Equipment):

1.1.1 **Laboratory layout modification**: Upgradation of TB culture laboratories to **BSL -3 (Containment Biosafety Level 3, WHO)** will take place in 39 out of 43 identified laboratories, 4 labs have been upgraded by GoI. Works include establishment of negative air pressure room facilities for TB culture manipulation and clean rooms for molecular diagnostics, in each of the centres. The main intent of modifications in laboratory layout is to (a) comply the requirements of the WHO biosafety level 3, to achieve uni-directional HEPA air flow (b) avoid inadvertent DNA amplicon cross-contamination in the molecular diagnosis facilities.

Equipment and consumables required for 43 laboratories: The procurements proposed under this objective are additional to the support from UNITAID for Line Probe Assay (LPA) in 40 (out of 43) laboratories and liquid culture equipment in 31 (out of 33 where liquid culture facility would be established) laboratories; and consumables for these labs coinciding with first four years of the GF project (except of the last quarter of 4th year and 5th year).

1.1.2 **Sputum processing**: All technologies require sputum processing before the test can be used. The throughput of laboratories is closely linked to their capacity for sputum processing. Under the proposal, it is envisaged to provide refrigerated centrifuges and bio-safety cabinets to 39 laboratories whereby their throughput is increased. Others have already been provided these equipment by the Programme

1.1.3 **Line Probe assay equipment:** Molecular Line Probe Assay equipment for detecting Rifampicin and INH resistance would be *procured for 3 laboratories* under this project in year 3.

1.1.4 **Liquid culture equipment:** Automated liquid culture system would be procured *for 2 laboratories* in year 3 of this project.

1.1.5 **Non-health equipment for office, data management:** Computer and broadband access would be provided in 43 laboratories for data management, logistics, and electronic data transmission to patients and providers.

1.1.6 **Solid culture equipment:** Solid culture equipment will be procured for 6 laboratories in year-1. Out of remaining, 8 laboratories have been provided these equipment under other GF grants and the rest have been provided these equipment by GoI/ WB/ state government.

1.1.7 **Consumables supply**: Consumables supply for rapid diagnostics under UNITAID project would cater to the needs of labs during the first four years of the proposal GF proposal (end of 2013). Subsequently support for these consumables is sought under GF Rd 9

1.1.7.1 Consumables for liquid culture *from the last quarter of 4th year till the end of project*.

1.1.7.2 Consumables for Line Probe Assay *from the last quarter of 4th year till the end of project*

1.1.7.3 Speciation by lateral flow *from the last quarter of 4th year till the end of project*
1.1.7.4 Consumables for DNA sequencing will be for *all 5 years*
1.1.7.5 Those for solid culture shall be purchased *from 3rd year till the end of the project and*
1.1.7.6 General laboratory supplies such as disinfectants, chemicals, diesel for generators, Personal Protective Equipment and stains (running costs) *for all 5 years* from GF grant.
1.1.7.7 Procurement and supply management costs are expected at 5% of the health products costs

The procurements will be undertaken as per the international best practices. In case of certain consumables such as liquid culture and line probe assay, where a single source is available, FIND negotiated price will be used.

1.1.8 **Sputum transportation**: Rapid diagnostics require transportation under cold chain within 72 hours, and therefore budget provisions need to include cost of time-bound transportation under special conditions. As per the guidelines, sputum sample from DR-TB suspect will be collected at microscopy centre by laboratory technician. Sputum will then be transported to the identified TB culture and DST laboratories. This activity will be undertaken by the Culture and DST Laboratories in coordination with District Health Societies. Based on reports of number of samples received from each district at the TB culture lab, payments will be made to the identified transport mechanism like a courier agency, by FIND.

1.1.9 Preparation and dissemination of **Lab SOPs and Manuals:** For new technologies, FIND will provide assistance to the RNTCP to design *2 manuals* and SOPs for use in the country under this project. The SOPs would be printed and disseminated to all laboratories in a phased manner

1.1.10 **Laboratory Quality Assurance**: All laboratories need to undergo RNTCP accreditation process for culture and DST, as per guidelines, coordinated by Central TB Division and National Reference Laboratories. Expenditure for on-site assessment visits for accreditation and for proficiency testing panel preparation would be supported under existing fund of RNTCP. FIND will support the programme in preparing state level culture and DST laboratories for accreditation specifically for newer diagnostics.

1.1.11 Outsourced **consultancies**: Procurement of the following consultancies would assist the SR (FIND) in implementation of the project: *Lab design & layout expertise*; *Bio-safety Verification* (Third party) for laboratories; *Equipment Maintenance* agency; and *Lab MIS maintenance*. The laboratory module of the MIS will be maintained with necessary updation, trouble shooting etc under this proposal as a "Helpdesk" service. (*A MIS for DOTS Plus, incorporating the lab activities is being put into place under the GF RCC grant*)

SDA 1.2: Monitoring & Evaluation

Overall monitoring of the culture and DST laboratories and their performance will be assessed by Central TB Division through National Laboratory Committee. FIND will assist this process specifically during the period of start-up and establishing the rapid diagnostics capacity.

1.2.1 Two microbiologists, a Finance Consultant, a logistics officer and other support staff will be appointed at FIND office to manage issues related to monitoring, supervision and evaluation of the Grant. Travel costs for these supervisory staff to states/ districts would be met out of the grant.

1.2.2 To facilitate information sharing and standardisation of procedures across the country and to monitor progress towards common goals, annual **National Lab network meetings** under the leadership of Central TB Division would be held with NRLs playing a facilitator role. Approximately 130 participants would participate including STDC Directors, two microbiologists each from each of the labs, faculty from NRLs, FIND and CTD. It would be a 2 day review meeting-cum-workshop and would assist the programme in disseminating policy changes and good practices

1.2.3 **Regional/ state level lab staff meetings**: *Quarterly review meetings* will be held at state level for large states and at regional level for smaller states. One meeting in one of the four zones of the country will be held in a quarter and the purpose of the meeting is to assist the lab staff in information sharing, ensure adherence to national guidelines for laboratories and enhancement of quality of laboratory work.

SDA 1.3: Human Resource Development (HRD)

Availability of qualified, trained manpower is critical and has impact on laboratory activities. Since states are not able to commit adequate resources towards appointment of suitably qualified staff, progress in activities towards lab accreditation has not been optimal.

1.3.1 **Hiring of staff:** It is proposed to have a team at each lab with complementary skill sets, with

appropriate qualifications. Under this project *one additional microbiologist and two technologists, two lab technicians and one lab assistant* will be hired per laboratory identified for strengthening. *43 data entry operators* are also proposed to be recruited to operationalize Lab MIS and electronic reporting mechanisms. The 43 labs are situated in states all over the country and ensuring availability of trained manpower in all labs is a challenge. An HR Management agency will be hired by FIND to facilitate the process of appointment of appropriate staff. The agency will help identify candidates as per RNTCP ToRs for various positions.

1.3.2 **Training and Capacity Building**: Standard training methodology would be used for training of staff at laboratories and at TB programme sites on the following technologies: *liquid culture*, *LPA*, and *Lab MIS*. A *four day on-site training course* on liquid culture will be provided for 5 to 6 lab staff at each of the lab sites and a *five day hands on training on LPA* in the lab will be provided for 5 to 6 lab staff in each lab. A small number of *re-trainings* are also included under training (in case of staff turn-over, etc). Besides structured training a component of technical assistance is also proposed and this includes higher level expertise for building capacity of the microbiologists and bacteriology technicians at the laboratories sites. The Data Entry Operators recruited under the project would be *trained in year 1 and 2* on the Lab MIS in a centralised training for two days.

SDA 1.4: Programme based Operational Research

1.4.1 Demonstration of new technology in programmatic setting post WHO STAG recommendations is ongoing. Two such Operational Research studies are budgeted under this proposal for 2nd and 4th year of the project. The studies would assess operational issues related to uptake of new technologies *such as fully automated NAAT, LAMP assay,* etc. The studies would consist of uptake of the said technology in 2 to 3 labs under RNTCP and assessing the impact of using that technology in programme settings.

Infection Control: Infection control and bio-safety in laboratories will receive due attention under proposal activities. Actions for Infection control would be organised as:

- **Administrative controls**: This would include - a laboratory infection control committee in each lab; written procedures for infection control and lab bio-safety; training of staff on bio-safety; bio-safety documentation and periodic review.
- **Environmental controls**: The entry and exit restrictions; Negative air pressure containment rooms for maintaining inward air flow into the culture and DST facilities; Certified Bio-safety cabinets and Bio-safe centrifuges; Hand-wash sink in the culture & DST room with effective disinfectant.
- **Personal protection**: Personal protective measures and universal precautions. Procedures for tackling spills and bio-safety emergencies.
- **Disinfection and bio-safe waste disposal**: Disposal of infected/ bio-hazardous waste as per guidelines through autoclaving at 121 degrees centigrade for 30 min (steam sterilization).

The administrative components of infection control activities in laboratories do not require additional funding support. Lab layout modification for BSL 3 at 1.1.1 and consumables as at 1.1.7 above have been budgeted.

Objective 2: Scale-up care and management of DR-TB in 35 states/Union Territories of India resulting in the initiation of treatment of 55,350 additional cases of Drug Resistant TB (DR-TB) by 2015

RNTCP has developed DOTS-Plus guidelines (Annex 5), in line with international recommendations for standardized 2nd line drug treatment of MDR-TB. Before the introduction of Cat IV treatment, some preparatory activities are required to be undertaken as per National DOTS plus guidelines. These include

Identification of DOTS-Plus sites and Up-gradation to meet infection control standards: A suitable and accessible DOTS Plus site, preferably in a tertiary care institute with facilities for pretreatment evaluation and referral services and a 30 bedded well ventilated ward and with appropriate infection control measures will be identified. 122 DOTS Plus Sites will be upgraded in phased manner by 2015 as per the national plan *with financial support from GoI/ WB and GF RCC project*. Training of the concerned ward and department staff and a pre-appraisal visit of the DOTS Plus Site for compliance to infection control guidelines, State and District Drug Stores are part of preparatory activities.

State and site DOTS-Plus committees: A State DOTS Plus Committee will be formed at each of the 35 states / UTs in the country to develop action plan for implementation, expansion, and maintenance of DOTS-Plus in the respective state; periodically review the implementation status of DOTS-Plus in the

respective state. Similarly, a DOTS Plus Site Committee comprising of experts from various concerned medical departments will be formed at each of the DOTS Plus Site to develop action plan for implementation, expansion, and maintenance of DOTS-Plus in the respective state. The committee would meet weekly or fortnightly for initiating the laboratory confirmed MDR patients on treatment, follow up and emergency services on an ongoing basis and once in a quarter to review the progress in preparation and implementation of DOTS Plus strategy in the state. *The activity has no financial implication for the proposal.*

SDA 2.1: Uninterrupted supply of second line drugs

To achieve the goal of universal access to patients with MDR-TB management services within programmatic conditions, funds for 122,950 Category IV patient courses are estimated to be required by 2014-15. This scale-up plan of DR-TB services will be supported by funds from the Government of India (via direct taxation and World Bank credit), the Global Fund (GF) (via the RCC of Rounds 2, 4 & 6), and UNITAID for 67,600 courses. For the anticipated gap of **55,350 courses** funds are being requested through the GF Rd 9 proposal. Description of RNTCP's Category IV regimen is placed at Annex 5 and calculation of requirements/ costs at Annex 12.

2.1.1 **Procurement and Supply of Second Line Drugs (SLD)**: The procurement of quality assured SLDs will be through the existing GLC / GDF mechanism. Individual drugs will be procured in tranches and supplied to the State Drug Store (SDS). The SDS will re-pack the drugs into patient wise boxes (PWB) of Intensive phase and Continuation phase and supply these to the District Drug Store (DDS) with adequate buffer. *Funds for placing drug purchase order are required one year ahead of initiation of treatment to ensure availability of drugs when the case is registered. Hence the course gap is calculated for expected patients to be registered in subsequent year. Funds requested in this proposal are till 4th year of the project, 2013-14 as these patients will be put on treatment in 2014-15. For funding requirement corresponding to last year of the project (cases to be initiated on treatment in subsequent year) GoI/ WB support is anticipated.*

2.1.2 **Green Light Committee Approval and fee**: The medical and operational guidelines (regimen, dosages & calculations) constituting the present request are in line with previous proposals submitted to the GLC committee. As per standard procedures, the Government of India will submit an expansion proposal to the Green Light Committee (GLC) for its approval to expand the currently approved patient treatment targets. This will be done as early as possible after intimation of GF approval of this request. Annual GLC fee has been budgeted under the proposal.

2.1.3 **Strengthening of existing drug management system**: Based on the observations and recommendations of the in-country systems assessment undertaken by the Global Fund, additional one-time resource allocation has already been given to the 6 Government Medical Stores and Depots (GMSDs/ equivalent to central drug store) for up gradation of storage facilities for TB drugs and in anticipation of increased storage space required for second line drugs. Additional human resource in form of additional Store Assistant has also been provided. Further details are provided in section 4.10.4 and 4.10.5. Technical assistance would be provided through WHO for development and periodic updating of the training modules in drug stock management, and strengthening logistics management for second line drugs. *Technical Assistance from WHO for strengthening existing drugs logistics management and for coordination with partners for procurement of second line anti-TB drugs and laboratory equipment is budgeted under the GF R9 proposal*.

Pre-treatment investigations, follow up investigations (other than sputum culture) and drugs for adverse events: These activities would be undertaken by *health system of respective state governments* and hence not budgeted under GF R9 proposal.

SDA 2.2: Technical assistance for scale-up management of DR-TB

2.2.1 WHO Technical Assistance for DR-TB scale-up is being proposed in the form of one consultant per large state (50 million population) through this GF proposal as per the national plan. Currently RNTCP is supported by a network of 100 medical consultants of which 10 are located at Central TB Division (CTD) while 90 are field consultants. It is proposed to dedicate 28 of this network to DR-TB scale up activities along with 2 consultants placed at CTD. *This TA with necessary support functions is budgeted under this proposal. Under this project funds will be released to WHO through split disbursement mechanism*

*All activities listed below for objective 2 are **not budgeted** for Rd 9 proposal as funding from other sources like GoI/WB and GF RCC project is available. These are included just to highlight the comprehensive scope of national DOTS Plus expansion plan*

Human Resource Development (HRD):

Provision of additional staff: The following staff would be provided to support state and district level activities:

- Medical officer and a Statistical Assistant per DOTS plus site to coordinate treatment, follow-up and recording/reporting activities.
- 'DOTS Plus and TB/HIV supervisor' to support community DOTS Plus activities in the district.
- Store Assistant to assist in re-packing of category IV drugs into 3 monthly PWB and supporting overall drug store management.

Training: As per RNTCP Human Resource Development plan, *three types of trainings* have been planned: the *initial training* for all newly placed staff; *Re-training* for all cadres of health staff, based on training needs of individuals assessed by supervisors. *Update training* would involve training of key staff on new initiatives. The Induction, Update and Refresher training action plan would be aligned with the annual national DOTS Plus expansion plan. Technical assistance would be provided through WHO for development and periodic updating of the training modules.

Initial RNTCP training on DOTS Plus

Category	Duration (days)	Batch Size	Training Material	Venue/ Level
State and District programme manager & state staff	5	25	DOTS Plus guidelines/ module	Central
Medical officers in district	3	20	Module for MOs on DOTS Plus	State
Sub-district supervisory and paramedical staff	3	10	Module for Paramedical workers on DOTS Plus	District
DOT Provider	1	30	Module for DOT Providers on DOTS Plus	Sub-district facility

Update/ Retraining on DOTS Plus

Category	Duration (days)	Venue
State level programme manager and staff	2	Central level
District level managers and medical officers	1	State level
Sub-district supervisory & paramedical staff	1	District

Workshops and Meetings: DOTS Plus guidelines will be percolated to all faculty and honorary specialist doctors of medical colleges and all other sectors practitioners through sensitization workshops and CMEs for the existing mechanisms of MoU for various GOI revised NGO PP schemes; National, Zonal and State Task Force for Medical Colleges.

Monitoring & Evaluation

Routine reporting mechanisms: The information system for RNCTP DOTS-Plus is based upon, and is an extension of, the basic RNTCP information system. The forms are therefore made as similar as possible to the existing forms in the RNTCP with the specific characteristics of a DOTS-Plus programme incorporated in the existing drug management and reporting system. All the standardized records and reports will be available in both paper and electronic versions. To facilitate better quality of the information as well as data analysis, development of an electronic format for the Category IV drug stock management will also be undertaken along with referral forms and DOTS Plus treatment card. Technical assistance will be provided through WHO for development and periodic updating of the drug stock management guidelines, records/reports and training modules on drug MIS. To ensure rigorous monitoring of activities proposed under this project for preparation, implementation, monitoring and evaluation of DOTS Plus services for management of MDR TB, **a Core Team** would be formed at Central TB Division.

Review meetings: National DOTS-Plus Committee will routinely review implementation status of DOTS-Plus activities, and provide recommendations for improvement and/or change. Preparatory activities and performance of DOTS Plus activities would be reviewed by Central TB Division for each of the states during the bi-annual national level review meetings with State TB Officers. Similarly, State DOTS Plus Committee would periodically review the implementation status of DOTS-Plus in the respective state. DOTS-Plus site committee would review the implementation status of DOTS-Plus in the respective site to ensure that RNTCP DOTS-Plus policies and guidelines are being followed; Clinical decisions pertaining to management of each and every case; Patients reporting adverse drug reactions are managed appropriately; All patients are registered in the DOTS Plus TB Register, monitored and periodically reported in the quarterly cohort reports on case finding, 6 & 12 months interim reports, culture conversion reports and treatment outcome reports.

Mobility/ transport for supervisory staff - Since supervision for MDR-TB activities would be part of regular DOTS supervisory activities, no additional costs are envisaged for this activity. However the existing monitoring activities will be strengthened for MDR-TB through available fundings by placing additional staff as at 2.4.1 above.

Survey/ surveillance: The programme has successfully conducted state wide population representative DRS survey in Gujarat and Maharashtra while DRS survey is ongoing in the state of AP, UP and Orissa. Repeat DRS surveys at 5 yearly intervals would be conducted in Gujarat, Maharashtra in the year 2011 and in Western UP in 2014.

Infection control:

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. A national infection control committee has been established for the purpose, consisting of senior chest physicians, representatives from National Reference Laboratory, and Central TB Division. The committee will review international guidelines and best practices for airborne infection control in health care facilities, and current infection control practices in health care facilities; Develop technical and operational guidelines for airborne infection control; Support the programme in implementing the guidelines, and serve as resources for evaluation, training, and capacity building efforts; Coordinate with patient safety initiatives, and seek the inclusion of airborne infection control measures in universal precautions, patient safety initiatives; Develop and disseminate tools for health care facilities to assess risk, identify simple solutions, and monitor effectiveness of interventions to reduce risk of airborne disease transmission; Revise and update guidance. Technical assistance will be provided through WHO.

Patient support to be provided by the programme includes: Drugs under DOTS plus are administered under direct observation on ambulatory basis. Patient support for treatment adherence include:

- Reimbursement of travel expenses to patient and attendant for visits to DTC and DOTS-Plus site
- Emotional support and counseling to the patient and family members through counseling
- Early and effective management of adverse drug reactions;
- Honorarium to the non salaried DOT provider

Linking patients to social scheme: The Programme would engage with NGOs and Self Help Groups to link up the laboratory confirmed MDR TB patient to the local available state level social welfare schemes. The civil society PRs (*objective 3-4*) and their implementing partners will also be undertaking community sensitization. This will also strengthen patient support systems in the Programme

Contact tracing: Prompt treatment of MDR-TB is the most effective way of preventing the spread of infection to close contacts and others. The measures to be taken to prevent spread of MDR-TB infection include early diagnosis and appropriate treatment of MDR-TB cases and screening of contacts as per RNTCP guidelines using sputum smear microscopy. The National DOTS Plus Committee is considering the decision of offering routine culture and DST services to the contacts of these MDR TB cases and treatment initiation with Category IV regimen under DOTS Plus.

Community TB care and default retrieval/ prevention system: The DOT Providers observing MDR-TB treatment are expected to monitor treatment for nearly 24-27 months. To facilitate DOT, trained DOT providers would be paid an honorarium for patient support. ASHA workers and other volunteers involved

would be eligible for the honorarium. This will encourage a system of community DOT for ambulatory DOTS plus treatment and help reduce default. Further the programme has recently revised NGO/ PP scheme (Annex11) for involvement of NGOs and PPs in various TB care and control activities including MDR-TB diagnosis and treatment.

Objectives 3 and 4 of the proposal stated below pertain to civil society engagement in RNTCP and seek to unify the response of civil society to improve TB care and control in 744.3 million people in 374 districts across 23 states of India (districts in Annex 9) by supporting RNTCP to expand its reach, visibility and effectiveness, and engaging community-based providers to improve TB services, especially for women and children, marginalized, vulnerable and TB-HIV co-infected populations.

The 374 districts covered by civil society in the proposal have been selected considering:

- **Presence** of civil society PRs and SRs in the districts and the level of need for civil society engagement expressed by State TB Officers during **mutual discussions**
- The **performance** of the districts compared to national averages – the 374 districts include 206 districts (out of 274 such districts in the country) with a new smear positive case notification rate of 50/100000 or less and 32 districts in the project areas have a new smear positive case notification rate of 30/100000 or less. The combined new sputum smear positive case notification rate for 374 districts is 50.3/100000 in 2008 (against a national average of 54/100000). 283 out of the 374 target districts had default rates of 10% or above for smear positive retreatment patients, and 33 districts where a quarter of these patients had defaulted.
- Each target district poses **key challenges** to improving the quality and reach of TB services, and significant marginalized and vulnerable populations. 82 of the 374 districts (population 102.4 million) are designated 'poor and backward' and 44 of the 374 districts with 15.8 million tribal and indigenous populations.[5] The 374 districts also have 'below poverty line' population segments and hence among those having high prevalence, incidence and mortality due to TB.

Out of the 374 districts where civil society will support RNTCP under this proposal, only 143 districts have a new smear positive case detection rate (NSP CDR) of ≥ 70%. These 374 districts recorded an average default rate of 14% among smear positive re-treatment patients.[6] Through civil society and community engagement, **the project aims to increase the number of districts with ≥ 70% NSP CDR to 300 and reduce the annual default rate among smear positive re-treatment patients by at least 5%, (from 14% to 9%),** in the 374 districts by 2015.

This project will scale up existing models with proven approaches of community interventions that have already contributed to RNTCP in different parts of India – these models are summarized in section 4.5.3. The project also includes pilots to test new interventions. **Since October 2008, USAID/India has supported a modest scale up of some of the model interventions in 80 of the 374 districts** through civil society partners, under a cooperative agreement with World Vision (WV). This meant the engagement of CBO/FBO networks, local self governments (*Panchayats)* and rural healthcare providers in RNTCP, leading to referrals of symptomatic persons to diagnostic centres. A needs assessment study identified the communication needs of vulnerable communities in 4 states, their perceptions, belief systems and care seeking behaviour. Efforts have begun to identify priorities for an intervention study for an effective ACSM model for TB services focusing on social and behavioural aspects. USAID grant also supported the establishment of a '**Partnership**' of civil society organizations with a Secretariat housed in the South-East Asia regional office of the International Union Against Tuberculosis and Lung Disease (the Union) in Delhi, to unify the civil society response on TB care and control.

Unless otherwise specified, all activities below will be implemented by all SRs of the two civil society PRs, and will cover 374 districts across 23 states.

Objective 3: Improve the reach, visibility and effectiveness of RNTCP through civil society support in 374 districts across 23 states by 2015

SDA 3.1: Advocacy, Communication and Social Mobilization (ACSM)
Empower communities to become active participants in RNTCP, able to demand and access its services
Unify the response of civil society to TB care and control through the civil society Partnership

[5] TB India 2009, Central TB Division, Ministry of Health and Family Welfare, Government of India.
[6] RNTCP Quarterly Recording & Reporting System, Annual Data, 2008. There is significant variation in these rates across districts.

The Partnership of civil society formed under the USAID grant will be strengthened to coordinate TB related activities of partners, increase community-level visibility and ownership of the national TB programme, facilitate need-based technical and financial support for partners and interface with donors. The Partnership will be a key link between RNTCP and the community, including the 'difficult' areas like the north-east and Jammu & Kashmir, through civil society partners. The activities include:

3.1.1 Sustain the **Secretariat** of the Partnership to provide *administrative support*, ensure regular communication among members through *quarterly newsletters* and *website*, and expand the membership base through *half-yearly national and regional meetings* – Union

3.1.2 **Coordinate and advocate with the Central TB Division and State TB Societies** in 23 states and appraise them of the needs and expectations of civil society from RNTCP through *annual meeting* and organizing *World TB Day at national level* - Union

Conduct media campaigns to increase public awareness and address gaps

These campaigns will be sensitive to gender and equity and address persisting misconceptions and myths on TB and its treatment, and the resulting stigma towards affected persons and families. Messages will be tested and toolkits piloted in 30 districts in 6 states.

3.1.3 **Produce Public Service Advertisements** (PSAs) as per a comprehensive, needs-based, RNTCP-aligned and gender-sensitive strategy in consultation with districts and states, *pre-test messages* for comprehension and cultural appropriateness to the regions, and broadcast on radio *(9850 over 5 years) and video (10,280 over 5 years) in 6 states*. All messages will be rigorously evaluated for recall and reach and RNTCP PSAs will be used with adaptations where feasible. *Technical assistance* will be provided from the headquarters to states. Mass media campaigns will include *media conferences (programme related meetings)* to maximise reach, and regular *monitoring* – PSI (SR to the Union)

3.1.4 Conduct **qualitative studies**(*baseline, annual tracking and end line*), and *simulated patient surveys* to inform media planning and strategy development studies – PSI (SR to the Union)

3.1.5 Consultatively *develop, pre-test and pilot* ***toolkits for mid media campaigns*** in 30 districts across 6 states (PSI), for subsequent dissemination to all the 374 target districts. These toolkits and IEC materials are intended to amplify and reinforce the messages of the PSAs above (toolkit details in annex 13). *Orientation training of community volunteers* on behaviour change communication on these materials will be held in all 374 districts by all SRs

3.1.6 Pilot the use of new **media like mobile telephony** (regional language text and voice messaging) and community radio to inform communities, increase awareness on services and network grassroots advocates, community influencers, RNTCP personnel and local administration. *Software and contents will be developed* for the purpose. – REACH (SR to the Union)

Social mobilisation for greater participation in RNTCP

Social mobilisation interventions will be carried out through local NGO networks in all 374 districts aimed at improving community participation in improving care seeking of symptomatic persons, while also continuing to complement the efforts made through campaigns to address locally prevalent myths and misconceptions.

3.1.7 Select and **train** networks of at least *15 local NGOs per district* in consultation with RNTCP, to serve as a mechanism to reach CBOs and communities for all community-based activities described subsequently. All NGOs will be encouraged to join the NGO schemes available with RNTCP. – all civil society SRs excluding PSI.

3.1.8 **Mobilise, sensitise and advocate with** existing Village Development Committees (Gaon Kalyan Samitis[7]), schools, women groups (Mahila Mandals[8]), SHGs (self-help groups), and other CBOs through *10 monthly meetings* per district to address myths and misconceptions, and help symptomatic persons seek timely appropriate care. Quarterly meetings will also be organized with district and sub-district health staff to identify and address gaps in service delivery – all civil society SRs excluding PSI.

3.1.9 Conduct **community wide awareness** programs through *rallies, village announcements, articles in local dailies and road shows* on World TB Day (local level) and International Women's day in consultation with district program officers, to reinforce messages on TB and address misconceptions identified through community meetings– all civil society SRs excluding PSI.

3.1.10 Sensitise, disseminate and promote adoption of the **Patients' Charter for TB Care** (annex 14) among all stakeholders in the 374 districts, by *translating in 11 major languages, printing 500 copies*

[7] Village-level committees formed under the National Rural Health Mission (NRHM), entrusted with community-level planning and implementation of health and sanitation, with representation from the local government (*Panchayat)*, local health centre and community.
[8] Community-level federations of women, sometimes encompassing several women SHGs

per district, and displaying them in prominent places across the districts through the meetings described in 3.1.8 – all civil society SRs excluding PSI

Conduct research and training to strengthen ACSM activities

3.1.11 Conduct **surveys of Knowledge, Attitudes and Practices** of target populations at *baseline, and at the end of 2nd and 5th years, across 374 districts* to ascertain baseline levels and to assess progress over the project's life. Research questions, survey design and protocol will be developed consultatively with RNTCP – The Union

3.1.12 Implement an **Operational Research study** *to determine an effective ACSM model* to improve TB care and control, focusing on social and behavioral aspects and using the design protocol developed in the USAID TB project in specific area covering 2-4 districts. The study will focus on additional programmatic outcomes on behaviour (beyond KAP). Findings from this study will be used to make mid-course corrections in the implementation strategy. Details on the study are in annex 15 – WV India

3.1.13 **Enhance state and district capacity in ACSM planning, implementation and M & E** in *3 states*, identified by the Central TB Division, through technical assistance and training based on the ongoing pilot in Orissa out of the GF Round 4 grant to the state. This pilot has helped increase the priority given to ACSM by RNTCP and the Orissa State TB Society (details in annex 16). *Two persons per state will coordinate with state and district TB programme managers to develop state and district level ACSM action plans. Sensitisation meetings/ trainings* will be held with local village government (Panchayti Raj Instititutes), Self-Help Groups and local associations*, Public and private sector health care providers, NGOs.* These will be monitored through *quarterly meetings* – The Union

SDA 3.2: Political Commitment

Advocate for enhanced political and administrative commitment to RNTCP at the national and state levels

3.2.1 Conduct *2 advocacy meetings* at the national level every year through the Parliamentarians' Group for TB, Parliamentarians' Group for MDGs and other parliamentary sub-committees, and publish *quarterly newsletters* for parliamentarians and administrators. – The Union

3.2.2 Establish corresponding state-level forums of MLAs (Members of Legislative Assemblies) in all 23 target states and conduct *one state-level advocacy meeting every year* to mobilise greater commitment, financial and human resources, especially for underperforming states and districts. – the Union & WV India

SDA 3.3: All Care Providers (PPM)

Support and expand RNTCP diagnostic and microscopy services, and help link patients with DOT services

3.3.1 Expand the network of **quality-assured routine laboratory services** in 374 districts by encouraging and sensitising NGOs and private hospitals to register under RNTCP's scheme for sputum collection/ transport and microscopy centres – all civil society SRs excluding PSI.

3.3.2 Pilot the feasibility of assisting CTD in obtaining **Annual Maintenance Contracts (AMCs)** for microscopes through public-private partnership in designated microscopy centres for *5 years in 3 states* identified by the CTD, through a contracted agency. States will be selected based on challenges faced in getting AMCs and the feasibility of implementing this intervention– The Union

SDA 3.4: Human Resource Development

Strengthen technical capacity of public and private healthcare professionals

3.4.1 **Strengthen state and district capacity in ACSM, PPM and M&E**, specifically in 'difficult' areas like the North-East states and Jammu & Kashmir by *hiring 3 national level experts* working under the guidance of CTD and *regularly visit to these areas*. These posts are additional to existing WHO support which is constrained to travel to such areas. RNTCP will pilot this arrangement in these thematic and geographical areas, and expand it to other areas depending on its success – Union

3.4.2 Adapt and conduct the *Union's training programmes* on *DR-TB* aligned with the national DOTS Plus guidelines (for specialist physicians, mostly private), *epidemiology, programme management* (including finance and logistics) and *operations research* with local and international faculty. One training will be provided on each thematic area per year at the national level to create a core group of trainers (25 participants per training). Technical support will be provided to cascade trainings to the state level. Courses will be adapted to the local context in consultation with RNTCP (annex 17). – Union

Strengthen the district level capacity of RNTCP and healthcare professionals

3.4.3 Provide opportunities to district/state RNTCP managers for **cross-learning** (*20 site visits across states*) and participation at regional and international conferences (*2 per year, 10 participants* each) – Union

3.4.4 Train *50 health staff per district per year in the 374 districts* in **interpersonal counseling and other 'soft' skills**, using *a three-level*, need-based training plan, carried out by a pool of trainers at state and district levels and drawn from a range of services/departments. This target is intended to address staff turnover and refreshers. These health personnel will be *followed up through six-monthly reviews* to establish their skills. (Overview and illustrative curriculum in annex 18) – All civil society SRs except PSI

Objective 4: Engage communities and community-based care providers in 374 districts across 23 states by 2015 to improve TB care and control, especially for marginalized and vulnerable populations including TB-HIV patients

SDA 4.1 Community Systems Strengthening

Establish and strengthen community-level capacities and mechanisms to interface with RNTCP

4.1.1 **Build capacity** of at least *10 CBOs in each district* to strengthen systems and improve partnerships for overall organizational effectiveness, by providing training in leadership, organizational and management skills, and basic one-time infrastructure. This will include identification of a total of 150 grassroots advocates from patient communities across the project period.

4.1.2 Facilitate *quarterly meetings* of the above **CBOs with District TB Officers through TB forums** described in 4.2.3 below and help them participate in all community-level mobilization activities. Prioritize indigenous and women's organizations for this and facilitate their integration with the mainstream.

SDA 4.2: Community TB Care

Improve community involvement in caring for TB patients, including DR-TB patients, reducing initial default and supporting treatment adherence, especially those on re-treatment

4.2.1 Support **collection and transportation of sputum** to diagnostic services and link those who test positive to DOT providers, in geographically hard-to-reach areas. It is estimated that *3,300 samples* will be handled *per district per year* through this mechanism (assuming 140 trips/ district/ month) – all civil society SRs excluding PSI.

4.2.2 Facilitate support to those on treatment and **link them with social support schemes**, especially women who have been ostracized due to past/present TB infection, and promote dialogue among patients, public health staff and community organizations through the community-level meetings described in activity 3.1.8. These activities aim to keep patients, especially migrant workers, from interrupting treatment and to *reduce initial defaulters*, including those on re-treatment.

4.2.3 Develop and orient **a forum for TB care** *in each district* with the participation of women, cured patients, tribal populations and aged persons. The forums will facilitate quarterly meetings of community organizations with district health services and TB program officers for better service delivery and 'community monitoring' of RNTCP – all civil society SRs excluding PSI.

4.2.4 Pilot the feasibility of **community based support for DR TB patients** *using local networks in 7 districts of Andhra Pradesh* to ensure that patients benefit from micro credit and social welfare schemes. The networks will also mobilize support for administration of injections in DOTS Plus. The pilot will be done by TB Alert (WV).

SDA 4.3: All Care Providers (PPM)

This SDA will emphasise rural healthcare providers and private providers that serve poor urban communities

Rural healthcare providers in India, including private providers and NGO health facilities, often have strong local/community links so that CBO/NGO networks can be used to increase their participation, especially in rural areas, and align them with RNTCP. A phased approach will be used, starting with areas with strong RNTCP performance and some foundation of PPM initiatives.

4.3.1 Profile **rural healthcare providers and institutions** not covered by the GF R6 IMA project (other than IMA members/ practitioners of other systems of medicine) and sensitize *at least 10 providers per district per year* to facilitate accessing of RNTCP schemes in the 374 districts – all civil society SRs excluding PSI

4.3.2 Facilitate *quarterly **review meetings** of enrolled providers with district programme staff* for joint problem solving on referral/treatment, ensure compliance with International Standards of TB Care (ISTC) (Annex 19) – including its recommendation on notification of TB cases by all care providers – and communicate key MDR-TB messages to clients in 374 districts. Include, where possible, NGOs, health professional associations, non-allopathic doctors, chemists, HIV-focused institutions and affected communities. In addition PSI will support *trainings of non-allopathic health care providers* in 30 districts in 6 states where it is conducting mass media and mid-media activities

4.3.3 **Advocate with medical colleges and NGO hospitals** *for adoption of DOTS plus guidelines* developed by RNTCP through annual meetings with senior administrators and Heads of Depts. – Union & WV

4.3.4 Pilot a dialogue with the State TB Officer and employers of small & medium enterprises for better care of workers with TB (help rewrite workplace policy if needed) and *sensitise and enroll local providers for* **'flexi-time' DOTS** to suit employee work hours in 7 districts of Andhra Pradesh – TB Alert(WV)

SDA 4.4: TB-HIV

Strengthen linkages between TB and HIV diagnostic and treatment services at district / sub-district levels

The existing programme efforts and collaborative TB-HIV activities have been explained in section 4.1. Civil society will additionally undertake following activities

4.4.1 Facilitate establishment of **cross linkages between ICTCs and DMCs**, through *quarterly joint meetings in each district* to review challenges and gaps, and mobilize PLHIV networks in districts and states to support early referrals and adherence to treatment.

4.4.2 **Build capacity** *(training)* **of DLN** (District Level Network) teams of PLHAs on TB diagnosis, treatment and cross-referral, advocate for TB to become an integral part of PLHA support group meetings, and motivate PLHAs to involve themselves in early diagnosis, DOT and follow-up of co-infected patients using DLNs set up in districts through the National AIDS Control Organisation (NACO) with funding from Global Fund Rd 4 and 6 HIV grants. This will be *piloted in 9 DLNs* currently functional in Manipur and expanded to 8 states' DLNs across project districts from year 2. Emphasise the link with the national expansion of the intensified TB/HIV package by CTD and (NACO) and the need to put TB/HIV on the agenda at the state-level.

SDA 4.5: Project Management and Administration

Project Management

4.5.1 Form **Project Management Units** (PMUs) for the Union and World Vision India to support and supervise operations in project districts, ensure fiscal compliance and monitor progress through quarterly/annual reviews and site visits. PRs will enter into written agreements with each SR with clearly spelt out objectives and scope of deliverables. Hire a core PMU team consisting of Project Director and staff for M&E, finance, grant compliance, book-keeping and administrative support – the Union & WV India (structure of PMU and roles of staff placed at Annex 22)

4.5.2 Provide one **training** in year 1 and one refresher in year 3 to state-level project staff on technical, implementation and financial aspects to ensure smooth and timely implementation of proposed activities.

4.5.3 Each SR will enter into agreements with their respective state/district TB societies and with local NGO networks. The PMU will include systems for rigorous monitoring and evaluation of project performance, data management, contracts and logistics management.

4.5.4 Support implementation by SRs by hiring 15 project managers and 15 finance officers (one each per civil society SR except PSI, which has a separate staff pattern), 17 assistant project managers (one per 20 districts), 9 finance assistants (one per 25 districts) and 187 district coordinators (one for 2 districts) to oversee community based interventions.

Monitoring and Evaluation

4.5.5 Carry out **site visits from PR** for monitoring program activities and financial compliance – please refer to the budget assumptions for details of the monitoring plan

4.5.6 **Support visits of SR staff** to the target districts and within the target communities to oversee implementation and support NGOs and CBOs in their day to day activities.

4.5.7 Conduct **annual and quarterly reviews with SRs** and with state and national programme staff to review progress of the project and make course corrections.

4.5.2. Re-submission of Round 8 (or Round 7) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 8 (or, Round 7, if that was the last application applied for and not recommended for funding).

The Rd 8 proposal included only activities for strengthening civil society support to the Programme while the current Rd 9 proposal includes civil society component and Programme (RNTCP) component to strengthen DR TB diagnosis and treatment activities. This Rd 9 proposal satisfies the Dual Track Financing mechanism, and **only the civil society component of this proposal can be considered resubmission of Rd 8 proposal**. The strengths and weaknesses identified by TRP, in the civil society component submitted under Rd 8 are given below, along with the steps that have been taken in this proposal to address the weaknesses. The process for addressing the weaknesses identified by the TRP included a meeting coordinated by the Stop TB Partnership to discuss and elaborate the strengthening of the proposal in Rd 9.

Strengths:

1. The proposal seeks to engage the impressive capacity of civil society organizations in India to work in synergy with the national program.
2. The proposal seeks to bring together numerous civil society organizations to move towards national coverage.
3. The requested funding is not excessive given the population covered.
4. The proposal is built around the recommendations of the Joint Partner Review of the National Tuberculosis Program in 2006 in regards to “limited community awareness, lack of community participation and sense of ownership, emergency challenges of TB/HIV and MDR-TB management, limitations in access to hard to reach marginalized and vulnerable populations”.

Weakness

1. The proposal does not demonstrate how it will contribute to overall improvement of India’s Tuberculosis program in terms of case finding and treatment outcome.

    - Section 4.4 and Attachment A prioritize and measure civil society contribution in terms of case finding (**targeting an increase in number of districts with ≥ 70% new smear positive case detection rate from 143 to 300**) and treatment outcomes (**targeting an annual decrease by 5% in default rates among smear positive retreatment patients**) in the 374 districts targeted by civil society interventions. As these districts constitute 64% of the country’s population and represent regions with significant proportion of poor, backward and tribal communities as well as districts with ‘poor’ program performance, improvements in these 374 districts will have a significant impact on the overall performance of India’s TB control program.
    - This proposal envisages a comprehensive multi-sector approach to TB care and control and complements and increases the national TB control programme (RNTCP) reach through civil society and private sector efforts.
    - The project proposes to improve both quality of care and uniformly improve access to quality care of TB services to the community

2. The proposal endeavours to achieve a harmonized, coordinated programme of civil society organizations; however there are two separate coalitions of civil society organizations and their “components” are presented separately with distinct objectives. It is not demonstrated that there is value added in nominating two separate Principal Recipients (civil society coalitions).
    - Considering the proposed coverage, the country’s variable socio-demographic situation and the fact that **18 large NGOs** will be involved (2 PRs and 16 SRs), two civil society PRs for the civil society component are essential to manage the intensity and complexity of the proposed community level interventions. This funding from GF will strengthen and expand RNTCP into the community that it serves. India is a large and diverse country and includes a multitude of nongovernmental organizations. The two PRs identified in this proposal represent important groups of NGOs with diverse skills and representation in the community across impressive geographic area in the country – this includes diversity in language, region and ethnicity. This proposal submission under Rd 8 has already paved the way for a larger Partnership of civil

society that has come together and is currently funded through a USAID/India grant to World Vision. SRs to respective civil society PRs will be working in different districts to avoid any overlap and yet within same state to promote synergies.

3. The proposal seeks to build synergies between civil society and the National Program. However, it is not demonstrated that a strong partnership exists between civil society and the national program. An example of this appears in the financial gap analysis (5.1) where it is stated "Section 5.1.2 and section 5.1.3 do not apply as the information sought in these sections are not available to civil society."
   - The Rd 9 proposal is a **single proposal with synthesized activities** for both programme and civil society. Civil society intends to supplement programme efforts on DOTS and DOTS plus activities
   - The programme has been involved **at all stages of developing** the civil society component of the proposal. The proposal development team consisted of members from the Programme and from civil society, and this team had regular interface with the Programme and participated in the mock TRP review organized by WHO SEARO. Civil society representatives have also had discussions with programme managers at the national and sub-national levels in identifying interventions that could be supported through this civil society initiative.
   - Programme and civil society representatives at the national and sub-national level would be part of the **coordinating committee** at all levels for monitoring performance
   - There will be **cross-learning opportunities** and conference attendance for public health staff
   - The National Programme has recognized the Partnership of civil society and extended its support to this Partnership

4. The proposal cites that the approaches will be based on model programs; however these model programs are not described.
   - Civil society interventions proposed here represent a scale up of existing interventions and models in various parts of the country, all of which are described in detail in **Section 4.5.3** below. These models have already been taken to a modest scale through the grant from USAID/India since October 2008, in 80 of the 374 districts targeted by civil society.

5. Technically the proposal does not sufficiently build on experiences of previous Global Fund grants (Public Private Mix (PPM) approach, Tuberculosis/HIV co-infection).
   - Current SRs include **CRS, REACH and Inter-Aide** who have implemented other GF projects.
   - The proposal will also link up with the **IMA project**, who are SRs to GF RCC

6. The monitoring and evaluation section describes the system of the National Program, but does not discuss how the SDAs of the Principal Recipients will be monitored and evaluated to ascertain their overall contributions and value-added
   - The SDAs of the civil society PRs will be monitored through **Project Management Information System** through which data will be collected from the CBO/Community level and collated and consolidated at district and state levels for reporting to the Global Fund. Data from this information system will be used to report against the four SDA level indicators provided in Attachment A.
   - In addition to this data system, **KAP surveys** will be carried out by the Union across the 374 targeted districts at baseline, midterm and end line, to track progress in population level attitudes and behavior related to TB.

4.5.3. Lessons learned from implementation experience

How do the implementation plans and activities described in 4.5.1 above draw on lessons learned from program implementation (whether Global Fund grants or otherwise)?

Implementation plans and activities described in section 4.5.1 address emerging challenges like DR TB within national programme and also focus on core programme areas like ACSM, DOTS expansion, TB-HIV and PPM through strengthened civil society engagement.

Response to DR-TB: This is a major component of the proposal for which the interventions have been taken up in a phased manner and builds on experience gained by the Programme till now. The steps involved so far have been, first to **gather information** on burden, **build on the evidence and experience** on interventions, and plan **scale up** to enhance capacity to address the challenges without compromising on the basic DOTS services.

Drug resistance surveys conducted between 2005-06, with support from World Bank have estimated the prevalence of MDR TB at about 3% in new cases and 17.2% in retreatment cases. Other DR surveys have been conducted in Andhra under GF **Rd 4** assistance while for UP under the World bank assistance. The national DOTS Plus committee recommended a community based treatment using standardized treatment regimen of 18-24 months for all such cases (also endorsed by the National Medical College Task Force). Given the experience from the first two sites in Gujarat (urban) and Maharashtra (rural), established under funding support from **World Bank**, the current policy is directed towards achieving geographical coverage of DOTS Plus services to the entire population, by a scaled increment in definition of DR suspects from the current policy of screening of all Cat II treatment failures for DR-TB to screening of all patients in entry into a retreatment Cat II regimen. The **projections for requirement of diagnostic tests and MDR-TB patients** to be put on treatment are based on experience in pilots.

At the end of 1 Q 2009 the DOTS Plus services are available in 8 states. Gujarat has been the first state to initiate DOTS Plus services in August 2007 followed by Maharashtra, Andhra Pradesh, Haryana Delhi, Kerala, West Bengal and Tamil Nadu. Around 400 MDR-TB patients have been initiated on treatment which is planned to be scaled up to 1500 in 2009 and **further expansion as in section 4.4**. It is also planned to make available DOTS Plus services in all states by 2010 with complete geographical coverage by 2012.

Civil society involvement: Learnings from several small to medium scale projects has built in the confidence of the public system and the private/civil society providers in one another for a long term partnership to reduce burden of TB in the country. These include

- Urban DOTS projects focusing on Urban providers and marginalized slum population, the REACH project under **Rd 1** using NGOs as instruments to change in community and private-for-profit provider perceptions on DOTS,
- Involvement of professional bodies like Indian Medical Association (IMA) under **Rd 6** grant and now **GF RCC**.
- Catholic Bishops Conference of India (CBCI – sub recipient under **Rd 4**), who have a network of rural and tribal health care institutions and community outreach staff providing health care to the rural population, especially in the hard to reach areas.

This has resulted in several of the NGOs and professional bodies coming together to form a partnership against TB, to complement each other strengths and supplement gaps within the public system in its programme management capacity and outreach efforts. The programme has encouraged and is supporting proposals by the NGO partners under this Rd 9 call for proposals in response to the demand from the State TB programme officers to include their states, which in itself is an exemplary example of improved collaboration between the public and private sector.

Civil society partners have been working with several GF and other source funded projects. Relevant national and international experience will be channelled for the success of this project.

National experience

1. The Union is the sub recipient of the GF **Rd 4**, for technical assistance to the Government of India in the management of the national TB programmes in Orissa for a period of two and a half years starting from October 2007. The model has been endorsed by the programme and would be replicated in 3 states in this project.
2. Projects in urban slums in Kolkata have had significant improvements in case holding and defaulter retrieval because of their community based approach and the employing of women DOT providers.

The latter approach greatly improved continuation rates among women. This proposed project has taken this lesson to feed into its strategic principle of deploying women in the community level workforce of its NGO partners.

3. Partnership between a private firm and local government in Greater Mumbai has demonstrated an effective and feasible way to share technical and infrastructure resources to make a positive impact on the employees. A critical success factor has been the location of TB services within the industry premises, a factor that will be considered in this project's dialogue with employers and STOs
4. A study of DOT provision through a medical college hospital in northern India has found this approach to be excellent for not only reaching program standards in care and in reaching outcomes but also an effective way of training graduate and undergraduate students on MDR TB and TB HIV

International experience will be used to manage grants under GF R 9 project

5. Since 2003 the Union was managing 52 projects in 18 countries under its project 'Fund for Innovative DOTS Expansion through Local Initiative to Stop TB' (**FIDELIS**) through USEA, India. Grants under this project were negotiated with govt and non-govt partners and subsequently technical and financial monitoring of projects undertaken.
6. The Union is also managing grants for tobacco control projects under the Bloomberg Initiative to reduce tobacco use.
7. PSI is also serving as **PR of 8 grants** in 5 countries and **SR on 52 grants** in 39 countries and the experience will be used to implement this project as well.

Existing models of community interventions that this project proposes to scale up include:

- **Improving access to diagnostic services** by decentralizing sputum collection beyond Designated Microscopy Centers (DMCs) in areas farther than 10 km from the DMCs by collecting and transporting sputum samples from symptomatics through a network of volunteers. Civil society partners established such mechanisms in 180 hard to reach locations in 4 predominantly tribal districts of Orissa and Andhra Pradesh since 1997. They complemented this effort with focused Information, Education, Communication (IEC) activities that, in addition to basic information on symptoms, diagnosis and treatment, also provide information on the location and functioning of the sputum collection mechanisms; taking results of sputum tests back to patients, and if found to have TB, link them with community DOT providers. This led to an increase in case detection and in the proportion of patients returning for follow up examinations of sputum.
- **Engaging rural, unqualified health care providers and druggists (PPM)** to refer care seekers with suggestive symptoms to the DMCs and also to function as DOT providers by accessing the schemes available within RNTCP. Complementary activities include focused IEC on TB and directing symptomatic persons to the nearest diagnostic centers. These efforts undertaken by civil society partners in 39 TB units across the 19 districts of West Bengal, with funding from the state TB office, has resulted in about 4000 rural healthcare providers engaged in referral / follow up of symptomatics, about a 100 providers and 3 private labs having accessed the DOT provider and lab schemes of RNTCP, increased case detection by 5 to 39% in 36 of the 39 TB units in the state since 2007, and contributed to the international learning through the PPM working group of the Stop TB Partnership.
- **Large scale, intensive IEC (public awareness)** using a wide range of methods has improved knowledge and awareness of TB, its symptoms, diagnosis and curability. Carried out through sub district networks of local CBOs and FBOs, these programs use folk performances and community meetings to reach areas that are difficult to access and communities that have had little prior exposure to public health services.
- **Improved collaboration (TB-HIV)** between Integrated HIV Counseling and Testing Centers (ICTCs) and DMCs through training, joint meetings and follow up by outreach workers, in 207 ICTCs and over 1000 DMCs in the catchment areas of these ICTCs in 2 districts of Andhra Pradesh by 2 NGOs. Counselors of ICTCs screen care seekers for TB symptoms, as part of pretest counseling, and link those with symptoms to outreach workers who provide continuity of services at the closest DMC and, then, to a DOT provider if the person tests positive for TB. Outreach workers also link symptomatics from ART and care & support centers run by NGOs/CBOs in the same localities to the nearest DMCs. These interventions led to about 10000 referrals to DMCs since 2006, of which about 2000 are HIV+.
- **Supporting states to implement the national ACSM strategy through technical assistance** and community interventions has seen increased community participation and ownership of TB care within the state and has repositioned and prioritised ACSM in the state's TB programme. A Round 4 Global Fund grant to the Union has tested this model in Orissa state since 2007.
- **Implementing RNTCP NGO schemes** on TB Unit (TU) adoption in 7 TUs in the Sunderbans of

South 24 Parganas in West Bengal since 2001 by a civil society partner has led to improvements in case detection and case holding between 2001 and 2007. The entire management of these TUs and the 253 DMCs in the TU areas have been taken over by civil society partners and TU teams report to the District TB officer.

- **Patient Support Groups (Community TB Care)** set up in 1225 villages in 8 districts of Andhra Pradesh have contributed to vast improvements in case detection and treatment adherence for the state in the past 7 years. The groups bring together cured patients, opinion leaders, outreach workers from the public health system (like ASHA and Anganwadi workers) and other community members to discuss, problem–solve and improve care seeking and treatment adherence. Many groups have also successfully linked patients, including TB-HIV co-infected, to social schemes and local businesses.

4.5.4. 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 tuberculosis diagnosis treatment and care and support services.

Overall, the ambitious targets of the project and its contributions to achieving **universal access** are by themselves a move towards ensuring equity. RNTCP's existing strategy already provides for **free, decentralized and patient-friendly services**, quality-assured sputum microscopy and use of standard first and second line TB drugs across the country. In addition to its own mechanisms for covering marginalized populations and difficult areas, RNTCP incorporates a strong commitment to make quality TB services locally available at the community-level by extending their reach to all segments of the population in the country in collaboration with civil society, community providers and other private providers. This is a key element of this proposal. While RNTCP mechanisms will continue to be used both for on-going TB care and control as well as for the DR-TB interventions under objectives 1 and 2 of this proposal, the civil society objectives 3 and 4 will emphasise underperforming and hard-to-access districts, marginalized and vulnerable populations (including 'poor and backward' districts, tribal areas, urban slums and migrant workers), and gender-disaggregated approaches where feasible (especially for community-level interventions in objective 4).

The proposal gives special attention to the following activities to ensure equitable service delivery:

- The existing national guidelines that the Programme for delivery of DR-TB services will follow in this project encompass **special provisions for Tribal/ difficult areas, focus on gender specific issues and strengthening services for populations in urban slums**. No additional financial resources are requested for implementation under the proposal as funds from other sources will be utilized.
- It is envisaged that for consolidation of the TB control efforts and specifically DR-TB control, marginalized sections / special groups will need more attention. Special mechanisms to make services accessible, acceptable to the **'difficult to reach' sections of the society** are already available under RNTCP. These include communication approaches specific to geographic areas or cultural/ social contexts and involvement of civil society in several districts. Special provisions, have already been made in the earlier projects to make services affordable and accessible to the special groups under the '***RNTCP Tribal Action Plan'***. In addition, specific support for diagnosis and treatment of DR-TB patients is also available where the indirect costs to the patient are high. Rs 2500/- (~USD 53) to the individual volunteer for each Cat-4 patient treatment completed to be disbursed in two installments
- **Expansion of diagnostic services** to 43 labs and introduction of rapid diagnostic techniques will ensure equitable access and wider availability
- The Programme 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.

Civil society while implementing the project will ensure equity through

- Targeting a significant proportion **of "underperforming" districts** (the 374 districts selected for civil society interventions include 206 districts with case notification rates of 50/100,000 or less and 283 districts with default rates of 10% or above among smear positive re-treatment cases)
- An **emphasis on marginalized and vulnerable populations**, including designated 'poor and backward' districts (82 of the 374 districts, with a population of 102.4 million), tribal areas (over 50%

population of 44 of the 374 districts are tribal, totaling 15,8 million), urban slums and migrant labourers

- The 374 districts also have **BPL (below poverty line) population** segments and hence among those known to have high prevalence and incidence of TB and mortality due to TB – several of the activities under the civil society component of the project will include a significant attention to these segments, including ACSM (SDA 3.1) and the engagement of rural healthcare providers and private providers for poor urban populations (SDA 4.3)
- Regions in the **north-east** part of the country (4 states), **Jammu & Kashmir**, and **other 'difficult' areas** are a focus for specific civil society interventions like sputum collection and transportation (4.2.1) and strengthening national capacity in ACSM, PPM and M & E (3.4.1), and the civil society Partnership will be a key link between RNTCP and these areas
- A focus on stigmatized women is built into community TB care in linking women with past or present TB to **social support schemes** and ensuring dialogue between patients, health staff and CBOs (4.2.2)
- Several of the community-based activities in the project prioritize women as an agency for those interventions – mobilizing and **sensitizing Mahila Mandals (women SHGs)** in all 374 districts to address myths and misconceptions and help symptomatic persons seek care (3.1.8), conducting **community-wide TB awareness programs** on International Women's Day and World TB Day (3.1.9), **building capacity of CBOs** and linking them to District TB officers for participation in community-level TB care (4.1.1 and 4.1.2) and developing a forum for TB care in each of the 374 districts with the participation of women, tribal populations, cured patients and aged persons (4.2.3)

In addition**, existing RNTCP mechanisms** to reach marginalized, difficult-to-reach and vulnerable segments include:

- The existing national **ACSM 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 ACSM activities and greater accessibility of quality free TB services, community members with symptoms of TB are encouraged to report to the health facilities for examination and treatment if required. Communication approaches specific to geographic areas or cultural/social contexts, as part of RNTCP's ACSM strategy mentioned earlier, and including the involvement of civil society.
- The **Tribal Action Plan** with special provisions for tribal groups, under which financial and programmatic norms have been relaxed to improve access to quality services. The plan has special incentives for patients and DOT providers in identified tribal TUs/districts. These incentives have contributed significantly to case finding and holding in these districts, and include: additional Rs1000 (~USD 21) remuneration to contractual supervisory staff posted at TUs with the tribal area DMC; Rs 100 (~USD 2.1) to Rs 200 (~USD 4.2) per month per volunteer for costs for sputum collection and transport, including for NGOs/PPs/ individuals under the revised NGO & PP schemes; an aggregate of Rs. 250 (~USD 5.3) on completion of treatment to cover travel costs for patients and one attendant towards travel for follow-up and treatment; additional tribal area allowance of Rs 1,000 (~USD 21) per month for lab technicians, training of community-based DOT providers; and production and distribution of locally appropriate IEC material for patients and communities.
- Augmented TB services for **urban slums** through the appointment of Urban TB Coordinators in 6 cities with more than a million slum dwellers. To improve services, baseline mapping of health facilities and services in urban slums of 25 major cities of India was undertaken and the information utilised to plan sputum collection centres, treatment centres and default retrieval activities with NGO participation and other facilities. The revised PP/NGO collaboration schemes include specific ones for improving urban slum TB services in conjunction with local service providers and NGOs.
- Addressing **prisons,** though these are not a specific focus of the current proposal. India has some 1200 prisons with a total capacity of 233,543 inmates, including 107 central, 268 district, 678 sub-district, 14 women and 73 other prisons. Since RNTCP has been implemented by all health systems in the public sector, including prison hospitals and dispensaries, inmates are diagnosed and treated as per DOTS strategy. Sputum microscopy facilities/DMCs have been set up in select prison hospitals depending on availability of lab services and size of inmate populations. In other prisons, sputum collection centres have been linked to nearby DMCs, or TB suspects are referred to the nearest DMC in general health facilities for diagnosis. All prison health staff, including Medical Officers posted in jail hospitals, are trained in DOTS. A prison staff/health worker is identified as a DOT provider and treatment given as per DOT guidelines. If inmates are released prior to completion of treatment, arrangements to continue treatment are made using RNTCP's 'transfer-out' mechanism.

- **Gender:** 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. This is consistent with the global picture reported in WHO report on Global TB Control 2008 (pg 22). 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 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. However, there is greater stigma attached to TB in female patients than males. RNTCP has made efforts to increase access through community outreach services like ASHA workers (females) and community DOT providers and provision of DOT service through providers of acceptable gender, caste and religion. CTD has already taken steps to address some of the other gender-based issues by redesigning the recording/reporting system to collect stratified data by sex on the proportions of males and females being registered under RNTCP and their treatment outcomes. Another area of programme activity that addresses gender-based issues is the RNTCP ACSM strategy, which encourages both men and women to report to health facilities if ill with symptoms of TB, and once diagnosed, to raise awareness about the importance of completing treatment.

For this proposal, the **use of local medical practitioners for referral, sputum collection and transport, involvement of NGOs, and awareness generation on DOTS through culture-specific local media** are some of the initiatives that complement the RNTCP strategy. Since DR-TB services will ride on the ongoing DOTS programme in the country, efforts to increase access to DOTS amongst specific groups will also improve access to DOTS plus services. In addition, specific support for diagnosis and treatment of DR-TB patients is available where indirect costs to the patient are high. Stakeholder groups, wherever possible, will be constituted to ensure participation of marginalized groups. The project will strive to recruit women, particularly ex-TB patients, for a significant proportion of staff positions and also encourage local NGOs to deploy women for community mobilization and supervision..

4.5.5 Strategy to mitigate initial unintended consequences

If this proposal (in s.4.5.1.) includes activities that provide a disease-specific response to health system weaknesses that have an impact on outcomes for the disease, explain:

- the factors considered when deciding to proceed with the request on a disease specific basis; and
- the country's proposed strategy for mitigating any potentially disruptive consequences from a disease-specific approach.

The key activity proposed for the health system is hiring of specialized contractual staff and training of the programme staff. This generic activity has the potential to improve the overall performance of health and programme staff and local planning for this activity will ensure that there is proportionate participation. The following activities will have direct The fact that the involvement of public health staff in RNTCP varies significantly between states and districts has been key factor that led to the decision to categorize this activity as a disease specific one

- **Potential Unintended consequence**: New posts within the project may attract personnel from other sectors/ programmes to migrate to the project.
  Mitigation: The salaries/ remuneration/ honorarium of staff under the project has been kept a standard level keeping in mind payments being made in other sectors for staff at similar positions
- **Potential Unintended consequence** Communication materials generated by civil society do not convey the intended message to target audience.
  Mitigation: The content of the messages will be developed in close consultation with the Programme and technical experts, and pretested before being used for dissemination and evaluated. Wherever available, the existing messages developed by the Programme will be used
- **Potential Unintended consequence**: CMEs on MDR-TB conducted by civil society, outside of the Programme may tend to deviate from national strategy.
  Mitigation The content of CMEs will be based on consensus statement available with the programme on rational use of 2nd line drugs and also discussed with the programme. The CMEs will be conducted in close coordination with state and district level programme managers.

- **Potential Unintended consequence**: Project may create parallel monitoring structures
  Mitigation The project staff will only monitor project related activities. Outcome will be measured through regular RNTCP mechanism. Monitoring meetings at all levels will be done in close coordination with programme staff.
- **Potential Unintended consequence**: TB patients may go for shopping between Govt and non-Govt facilities
  Mitigation: As per the policy of RNTCP, DOT services will be provided through the nearest convenient DOT centre for the patient and this will be coordinated with the programme.
- **Potential Unintended consequence** Utilizing existing infrastructure like Anganwadi centers and primary schools for TB activities like community DOT centers can disrupt the mainstream activities of these centers, especially in urban localities.
  Mitigation: This will be avoided by facilitating discussions between communities and municipal authorities and ensuring adequate space and privacy for both sets of activities before making the proposals.
- **Potential Unintended consequence** Frequent community meetings for discussing TB advocacy issues, support for DOTS plus and folk performances in TB can be disruptive to the work and life culture of communities especially in tribal areas.
  Mitigation: The project trainings for staff and partners will emphasize sensitivity to local cultural issues and the pre existing priorities of families and communities to minimize disruption.
- **Potential Unintended consequence** Large scale detection of MDR-TB cases may create panic amongst general public and stigma.
  Mitigation: Appropriate communication messages and public information activities will help give clear and correct picture of the situation and counter stigma

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

Describe any link between the focus of this proposal and the activities under any existing Global Fund grant. *(e.g., this proposal requests support for a scale up of ARV treatment and an existing grant provides support for service delivery initiatives to ensure that the treatment can be delivered).*

(***A table showing linkages with various GF and non-GF grants is provided after this section***)
The Global Fund grants have supported DOTS expansion in India under different rounds. DOTS expansion in the 3 States of Chhattisgarh, Jharkhand, and Uttarakhand (56 million populations) was supported by grants for USD 8.78 million under Round 1 of GFATM from April 2003-September 2006. Round 2 of GFATM supported DOTS expansion in 56 districts of Bihar and Uttar Pradesh with a population of 110 million for USD 29.10 million (April 2004 to March 2009). Round 4 of GFATM supported strengthening of RNTCP implementation in the states of Andhra Pradesh and Orissa from November 05 and January 2006 respectively for USD 26.63 million till March 2010. The programme has successfully obtained GFATM Rd 6 grant proposal for USD 24.3 million to continue support for strengthening RNTCP services in the 3 Round 1 project states (Chhattisgarh, Jharkhand, and Uttarakhand). Starting 2009 various GF grants have been consolidated under RCC Rd 2 grant. The project covers a total of 362 million population across 191 districts in 8 states of India. In addition, the Catholic Bishops Conference of India's (CBCI) public-private mix (PPM) project - continuation of Round 4 project) and the Indian Medical Association (IMA) project (continuation of Round 6 project) under the RCC proposal target 19 states.

The RCC project over the period of 6 years, envisages screening around 11 million TB suspects, detecting and registering for treatment at least 2.75 million tuberculosis patients, including 1.25 million new smear positive cases, and successfully treating ≥85 percent of them. This would help in improving the case detection rates in Rd 2 project states from 53 percent to 70 percent 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 at least 18,000 key program staff, to meet the gap in key positions, facilitate supervision and monitoring and strengthen program management.

Key DR-TB control related activities in GF RCC project include

- Treating at least 12,600 MDR-TB patients over the project period – corresponding drug costs
- Establishing at least 31 DOTS-Plus sites.
- Support the laboratory network for undertaking solid culture and drug susceptibility testing (DST), 4 National Reference Laboratories and 8 Intermediate Reference laboratories and the network expanded by involving the accredited medical college laboratories and laboratories in other sectors under the various public-private mix (PPM) schemes under the program. However this support is only for solid culture technique.
- Establishing Lab MIS

Thus GF RCC project has limited scope and the activities proposed in Rd 9 proposal are over and above those covered under the RCC project

TB/HIV co-infection – National strategy for TB-HIV coinfection is explained in section 4.1. The **Rd 9 HIV proposal** from India under submission also links up with TB activities by promoting prevention and care services among informal workers. The Behaviour Change Communication activities proposed under Rd 9 HIV proposal aim at identification of TB care for diagnosis and treatment and strengthen linkages. Civil society component of this proposal will also strengthen linkages through capacity building of District Level Networks of PLHAs

Civil society component under the RCC proposal: Through the RCC proposal, the Indian Medical Association PPM project would reach out to 202,000 private allopathic practitioners through CMEs, train over 37,500 of them, and successfully involve nearly 50 percent of those trained (18,750). In addition, over 145,000 of its professional members would be reached out through tuberculosis specific newsletters and articles in journals. The CBCI sub-project seeks to expand services from 11 to 19 states, and involve additional 750 hospitals, sensitize 12,000 health staff and train 7,100 medical and paramedical staff under RNTCP.

Civil society component in the GF R 9 proposal will link up with these organizations to prevent duplication and promote synergies. The IMA project is planning to involve allopathic practitioners while activities under this proposal are directed towards non-allopathic practitioners and traditional healers. Cross referrals will be facilitated amongst CBCI project hospitals and other NGO hospitals under this project allowing patients to have convenient access to quality services. This will also collectively help to address issues related to TB treatment in migrant populations and other marginalized groups.

The Union, which is one of the PRs is already implementing a project to support ACSM in the state of Orissa under **GF Rd 4**. The RNTCP has recommended replication of this model in other states of the country which would be accomplished through this grant. The activities planned under this project in Orissa will complement the existing funding support through Rd 4. *While the round 4 activities are mainly focussed in providing the state and district technical assistance on ACSM, the proposed activities in this project will implement the ACSM on ground.*
Catholic Relief Services (CRS) is also a sub-sub recipient to the Catholic Bishops Conference of India under **GF Rd 4**. The objective of this project is to improve access to the diagnostic and treatment services provided by the RNTCP within the Catholic Church health care facilities and thereby improve the quality of care for patients suffering from Tuberculosis in India. Under Rd 4 TB program CRS proposes to engage Church health care facilities into the RNTCP program. But under Round 9 CRS has proposed to carry out ACSM activities which are community based and that will again help in strengthening RNTCP program in the community. *Thus Rd 4 program of CRS is institution based while Rd 9 will be community based.*

The grant from **Rd 6** supports sensitization of private providers to participate in DOTS plus action plans of the state of Andhra Pradesh and is expected to be rolled out before this proposed grant is signed. The proposed project will ensure coordination at all levels with this intervention of Rd 6 and ensure that the activities of both projects complement and strengthen each other.

ROUND 9 – Tuberculosis

	The Global Fund grants					Other grants	
	GF R2	**GF R4**	**GF R6**	**GF RCC** (all earlier grants consolidate into RCC from April 2009)	**GF R9 proposal**	**UNITAID**	**GOI / WB / USAID**
Key activities under objective 1 of Rd 9 proposal							
Establishment of Line Probe Assay and consumables (Total 43 labs)	**No**	**No**	**No**	**No**	**Yes** 3 labs; Consumables for 4th qtr of Y4 and Y5 for 43 labs	**Yes** 40 labs; Consumables for Y1-3 till 3rdqtr of Y4	**No**
Establishment of Liquid Culture and consumables (Total 33 labs)	**No**	**No**	**No**	**No**	**Yes** For 2 labs; Consumables for 4th qtr of Y4 and Y5 for 33 labs	**Yes** For 31 labs; Consumables for Y1 till 3rdqtr of Y4	**No**
Support for Up-gradation of Solid Culture Labs and consumables (Total 43 labs)	**Yes** 2 labs for upgradation (UP & Bihar)	**Yes** 2 labs for upgradation (AP & Orissa)	**Yes** 3 labs for upgradation (Chhatisgarh, Jharkhand, Uttaranchal)	**Yes** 8 labs for consumable only. Expand to private labs	**Yes** 6 labs for upgradation. Consumables support to all 43 labs as per targets. increased annually (Y3-5)	**No**	**Yes** 30 labs (19 WB, 7 GOI, 4 USAID)
HR for Lab strengthening	**No**	**No**	**No**	**No**	Additional Microbiologist and 3 LTs for performing rapid diagnostics for all 43 labs	**No**	**No**
Key activities under objective 2 of Rd 9 proposal							
Second Line Drug (CAT IV) courses purchase	**No**	**No**	**No**	**Yes** 12,200 CAT IV courses	**Yes** 55,350 CAT IV courses	**Yes** 9,850 CAT IV courses	**Yes** 67,600 CAT IV courses

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TA for scale-up of DOTS	**No**	**No**	**No**	**No**	**Yes**	**No**	**No**
HR, Training, M&E, Patient support, Infection control	**No**	**No**	**No**	**Yes**	**No**	**No**	**Yes**
Key activities under objective 3 & 4 of Rd 9 proposal							
Civil society undertaking ACSM activities*	**No**	**Yes** TA for ACSM in Orissa - Union	**No**	**No**	**Yes** Implement ACSM in 374 districts in 23 states	**No**	**No**
Public Private Mix	**No**	**Yes** Engage Allopathic practitioners in States/UTs 11 - CBCI, 06 - IMA; Engage Church health care facilities – CRS	**Yes** Sensitize of private providers to participate in DOTS Plus action plans of AP	**Yes** Cover Allopathic practitioners in 19 States/UT - CBCI and 16 States/UT – IMA	**Yes** For non-allopathic practitioners and traditional healers; Involve private providers in RNTCP for microscopy and sputum transport	**No**	**No**
Community Systems strengthening	**No**	**No**	**No**	**No**	**Yes**	**No**	**No**
Strengthening TB HIV linkage through civil society engagement	**No**	**No**	**No**	**Yes** 1 state (AP)	**Yes** Strengthen TB HIV interventions in 374 districts in 23 states	**No**	**No**

* Funds for ACSM in other GF proposals/ through WB funding are only for programme based activities

4.6.2. Links to non-Global Fund sourced support

Describe any link between this proposal and the activities that are supported through non-Global Fund sources (*summarizing the main achievements planned from that funding over the same term as this proposal*).

Substantial resource gaps exist relative to existing funding for laboratory scale-up under the programme. To meet these funding gaps, several sources of support are being pursued. Expanded government resources are being made available, particularly for the establishment of laboratory sites, civil works, and infrastructure. Supporting the domestic contribution are funds sourced from the World Bank credit agreement. Additional support to augment sputum processing capacity and technical assistance has been provided by USAID and WHO. UNITAID support shall be available for critical start-up costs and initial laboratory consumables for State and National Reference Laboratories. The UNITAID grant would only support equipment, consumables and some technical assistance needs. Since it is purely commodity assistance, various laboratory support activities such as infrastructure upgradation, manpower and training needs to be covered by other grants. This round-9 proposal to GFATM is expected to be the main source of funding for the Laboratory support and preparedness activities required under RNTCP for uptake of equipment and consumables of the UNITAID grant. The Government of India would provide the main laboratory infrastructure, administrative set-up, manpower and institutional systems required to sustain these laboratories, which is a considerable proportion of the funding corpus.

WHO Country Office in India, through USAID funding, is providing additional equipment required in all laboratories for supporting sputum processing capacity increase during 2009. The national programme also plans to seek additional skilled human resources under the World Bank project, which will be proposed and discussed during the mid-term review scheduled for April 2009. Also, NGOs (e.g. DFIT, PATH) may provide additional human resources and technical support for 2-3 laboratories
Successful implementation of laboratory enhancements will require technical assistance for assessments, capacity building, training, monitoring and evaluation. This would include on-site mentoring by laboratory experts. This support would be available from GLI, FIND, and other project partners. GLI/FIND support would be available to set up and facilitate monitoring and evaluation of the public health impact

The following key activities mentioned in 4.5.1 related to DR-TB scale-up would be funded through other sources like GoI/ WB project:

- Identification of DOTS-Plus sites and Up-gradation to meet infection control standards
- Formation of state and site DOTS-Plus committees
- Strengthening of existing drug management system – (only TA is budgeted in this proposal)
- Drugs for adverse events
- Contact tracing activities
- Provision of additional staff like
    - Medical officer and a Statistical Assistant per site to coordinate treatment, follow-up and recording/reporting activities.
    - 'DOTS Plus and TB/HIV supervisor' to support community DOTS Plus activities.
    - Store Assistant to assist in re-packing of category IV drugs into 3 monthly PWB and supporting overall drug store management.
    - A counselor to promote treatment adherence and support
- Training of staff in DOTS Plus and related Workshops and Meetings.
- Patient support like transportation of patients and attendant to DTC/ DOTS-Plus sites; emotional support and counseling; Honorarium to the non salaried DOT provider and Linking patients to social scheme:
- M& E activities like: Routine reporting; Review meetings of National DOTS-Plus Committee, State DOTS Plus Committee and DOTS-Plus site committee Mobility/ transport for supervisory staff - Since supervision for MDR-TB activities would be part of regular DOTS supervisory activities, no additional costs are envisaged for this activity.
- Repeat DRS surveys.
- Infection control including development of a national plan for 'Air-borne infection Control Strategy' and its implementation.
- Community TB care and default retrieval system

UNITAID shall support the technology establishment costs and consumable costs for first four years (2010 to 2013) with ***commodity assistance*** in the form of equipment and consumables, whereas GF would support the programmatic costs (HRD, maintenance, M&E, etc) for all the five years and consumable costs for a quarter and a year (as would be applicable based on timing of project cycles for the two projects). The UNITAID assistance by itself cannot ensure complete implementation of lab network strengthening. *UNITAID support includes*

- LPA equipment for 40 (out of 43 planned) laboratories and Liquid culture for 31 laboratories (out of 33 planned)
- Laboratory supplies/ consumables for first four years for 256,000 diagnostics and 337,000 follow ups
- Drug costs for 9850 patients

Prospective funding sources	Patients to be treated in the year	
	2009-10	2010-11
Government of India (World Bank)	2,350	3,450
Global Fund RCC	800	1,200
UNITAID	4,850	5,000

Amongst the civil society implementers, **PSI** has state and project offices in all the proposed states and would leverage resources from other projects for implementing the proposed project, such as Public Private Partnership for STI/RTI control in four states through NACO funding under NACP-III (2008 onwards) and Avahan Initiative (2003-2008), led by the Bill & Melinda Gates Foundation, in partnership with NACO, SACS and RNTCP; Project Connect for catalyzing Public-Private Partnerships to Mitigate HIV/AIDS and TB in partnership with USAID, NACO, FICCI, RNTCP and SACS (2006-2011); Recently, PSI has been awarded a £32,000 grant for one year from Jharkhand State AIDS Control Society for implementation of the COILA (Collieries Outreach Intervention for Limiting HIV/AIDS) project in 5 coal mining districts of Jharkhand state.
Mamta plans to scale-up the involvement of affected communities (existing and former DOTS Clients as well as PLHA), which is an experience from ongoing project with support from STOP TB Initiative of WHO Geneva. The said project is being implemented in one block each in 6 districts of UP. The proposed project will be linked to ongoing health programmes of MAMTA which are largely based on community mobilisation and system strengthening strategies. It is mainly to draw upon the ground work that has already been done towards community mobilisation on health and HIV/AIDS related issues.
GLRA India, will identify and address operational issues related to synergy and linkages in West Bengal through its own resources.
SHIS, in West Bengal is working in seven TB Units in hard to reach district, through a memorandum of understanding with the state TB office. The interventions that this proposed project brings in will complement the operations of these TU s and expand their reach into the remotest segments of this district. There are privately funded initiatives that strengthen TB diagnosis and treatment infrastructure and other resources in private health facilities in the proposed target districts in Bihar and Jharkhand states. These activities are complementary and will help bring the two ends of the supply – demand chain closer and more efficient.
DFIT, has been working in TB care and control in 28 districts of Bihar for nearly 30 years. A memorandum of agreement with the state government has enabled DFIT to provide technical training in TB to health personnel and diagnostic and HR resources and infrastructure to peripheral health institutions, along with LEPRA Society. Community mobilization components of the proposed project will complement the infrastructure related inputs of DFIT.
LEPRA Society is currently involved in research on the incidence of MDR TB through the research wing of its Blue Peter Research Center in Andhra Pradesh and the proposed NTC component in that state will inform the research process. In the same state, LEPRA Society also has HIV TB coordination activities along with Andhra Pradesh State AIDS Control Society at the state level, which will give the needed head start to the TB HIV coordination activities planned in this proposed project at district levels.

4.6.3. Partnerships with the private sector

(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 Round 9 Guidelines 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.)*

There is no direct co-investment envisaged from private sector under this project. However the private physicians will be involved in several ways to support the activities.

The newly developed schemes for collaborations with NGOs and Private Practitioners will be used to further scale-up ***Public-Private-Mix DOTS*** under RNTCP. The Programme has piloted, implemented and scaled up several novel PPM (Public-Private Mix) projects to involve all other health care providers under the programme. Successful large scale implementation of RNTCP DOTS strategy in collaboration 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 over 19,000 private practitioners, 2600 NGOs, 150 corporate houses, and 263 Medical colleges being involved till date under the programme. PPM schemes under earlier GFATM grants include the REACH Project under Rd 1, PPM sub-projects in 4 urban sites under Rd 2, CBCI and IUATLD projects under Rd 4 and IMA project under Rd6.

The project proposes to sensitize and enroll private providers and 'for profit' health facilities in RNTCP schemes and facilitate their continued involvement in the program in all project districts through civil society advocacy and communication activities. This activity is expected to re position TB as a priority in the policies and strategies of these private institutions and this is significant given the evidence that exists for private sector being the provider of choice for a major proportion of health care seekers. Though private sector is not direct recipient of financial support through this project, the intervention is expected to contribute to the outcomes of the project including improving case detection and treatment success.

The lab strengthening component of the project proposes to contribute to uptake of new diagnostic methods for TB and implementation of Good Lab Practices in Medical Colleges and recognized Private Laboratories involved under RNTCP schemes for diagnosis. It has been envisaged to have participation form such stakeholders in the 'Annual RNTCP Lab Network' meetings under this proposal, so as to bring about partnership and a sense of ownership for the process amongst all stakeholders. By advocating for use of standardized laboratory techniques, and conducting laboratory audits the proposal would help in stream-lining lab services for TB amongst laboratories of all stake-holders. Private Laboratories which would participate in Lab strengthening activities for RNTCP would be co-investors. However it is not possible to quantify this contribution in financial terms.

(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)?)* ➔	N/A

Contribution Value (in USD or EURO)

Refer to the Round 9 Guidelines for examples

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

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved tuberculosis outcomes

The Global Fund recognizes that the relative capacity of government and non-government sector organizations (including community-based organizations), can be a significant constraint on the ability to reach and provide services to people (e.g., home-based care, outreach contact, orphan care, etc.).

Describe how this proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved tuberculosis service delivery and outcomes. ➔ *Refer to country evaluation reviews, if available*.

The GF Rd 9 proposal has both the Programme and two civil society PRs. While DR-TB activities will be strengthened within the programme setup, civil society PRs will support the programme activities through community based activities, NGO/FBO networks and technical assistance. This proposal, over a five year period, will build capacity in institutions and individuals to contribute to health and development in the country in capacities within or outside a similar project.

Programmatic activities supported through this proposal would help in rapid scale-up of lab capacity and introduce newer diagnostic techniques that is critical to address the DR-TB problem.

The civil society component essentially seeks to supplement the national TB control programme through time bound interventions – activities and infrastructure and human resource to support these activities. Community ownership of TB care, increased public awareness about TB and availability of free diagnosis and treatment will contribute to reduce both TB and HIV related stigma, increase patient friendly accessibility of TB services and will enhance early referral, diagnosis and treatment, which are outcomes of this proposal, will in the long term contribute to sustainability of TB control in the broader context of responsible public health care.

TB case finding and case holding education programmes for the private physicians, paramedics including traditional healers about the need to maintain a high index of suspicion of tuberculosis and rapidly performing appropriate tests (priority is given to sputum microscopy) or immediately referring to DOTS centres will contribute to reduce health system delay and prevent MDR TB.

Strengthening the capacity of private health care providers and community health workers in TB-HIV management particularly screening of symptomatic cases, referring them for HIV testing, and putting them into appropriate treatment will help to integrate TB-HIV services at community level.

The development of soft skills in health personnel will go a long way in impacting client provider interactions that will not be limited to TB–specific outcomes nor to the project's term. These assume significance given the prevailing perceptions in communities about public health services, and also given the ongoing integration of all disease components, including TB, into the public health mainstream through the National Rural Health Mission.

4.7.2. 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, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities.

Though India does not have a PRSP and is not an HIPC, reduction of poverty is indeed India's most compelling challenge, one of global significance. According to World Bank figures[9] (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. According to 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.

[9] World Bank Indicators, 2000

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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, leading to 170 million workdays lost annually due to the disease and an estimated loss of US$3 billion to the country's economy. It is estimated that on average, a TB patient loses 20 to 30% of his annual household income[10]. Control of TB has the potential to significantly contribute to the reduction of poverty at both the individual and national levels. Improved productivity of workers by reducing absenteeism, preventing incapacity from ill health, and by averting TB deaths among these workers, the Program will add to the productive capacities of the economy.

Addressing the issues of **DR-TB are now integral to TB control** and essential for attainment of Millennium Development Goals (MDG 6, Target 8, and Indicator 23-24). The marginalized groups tend to have poor outcome to TB treatment because of various factors including accessibility and indirect costs involved, thus leading to higher possibility of DR-TB. Through the project it is aimed to provide universal access for DR-TB diagnosis and treatment. The civil society component will contribute significantly to the RNTCP's efforts to impact the country's economy, by focusing on states and districts which have the highest numbers of people with TB, both undetected and on treatment and improving access and quality of care. Improved access to both DOTS and DOTS plus services will reduce direct and indirect costs for patients who might have already lost substantial bit of earnings if affected in productive age.

Objectives set out in the proposal cater to **component 1, 2, 4, 5 and 6 of the WHO Stop TB Strategy**. Global Plan 2006-2015 calls for «Empowering People with TB and Communities», and contains three components: Advocacy, Communication, Social Mobilization (ACSM); Community Care; and the Patients' Charter for Tuberculosis Care (Annex 14). These components are closely related, and are an essential arm in the fight against TB, TB-HIV and MDR/XDR-TB. The Patients' Charter for Tuberculosis Care (PCTC) was developed by the World Care Council through an open-drafting process that allowed over 850 patients in high burden communities to be contributors and stakeholders.

Created in tandem with the **International Standards for Tuberculosis Care** (ISTC - Strategy Element 4) as a framework of recommendations, rights and responsibilities for building mutually beneficial partnerships in health on local, district, state and national levels. Evidence shows conclusively that mobilization 'on the ground' to improve the well-being of the community is best led by the people most affected, patients and their families, local providers and partners, and that 'consumer' driven demand stimulates performance to achieve goals.

[10] TB Research Centre, Chennai. Socio-economic impact of TB on patients and family in India. Int J Tub Lung Dis 1999; 3: 869-877

4.8. Measuring impact

4.8.1. Impact Measurement Systems

Describe the strengths and weaknesses of in-country systems used to track or monitor achievements towards national tuberculosis outcomes and measuring impact.

Where one exists, refer to a recent national or external evaluation of the IMS in your description.

RNTCP has a systematic monitoring mechanism which accounts for the outcome of every patient put on treatment. There is a standardised recording and reporting structure in place. The cure rate and other key indicators are monitored regularly at every level of the health system and supervision is intensified if an area is not meeting the desired expectations. The uniqueness of RNTCP is that it shifts the responsibility for cure from the patient to the health system. An important feature of the RNTCP HMIS is the quarterly reporting on cohorts of patients. Each cohort is followed up, and reported on, in relation to smear conversion and treatment outcomes as a unique group of patients. The cohort reporting mechanism enables the programme managers to monitor progress against these two objectives on a quarterly and annual basis at the district, state and national levels. Routine reporting in the RNTCP is generated from the peripheral health institution (PHI) level upwards. In the RNTCP, a Tuberculosis Unit (TU) has been created at the sub-district level covering a population of 5,00,000 (2,50,000 in tribal and mountainous areas).

At the national level, after a round of cross-checking of the submitted reports with the respective DTOs, a quarterly and an annual progamme performance report is compiled which presents district-, state- and national-level data and information. The quarterly performance report is a published document, as a printed version and an electronic version on the RNTCP website, which ensures wide dissemination not only to programme officers but also in the public domain. Annual programme results are published in the yearly “TB India. RNTCP Status Report”, which is also available both as a printed and an electronic version. The RNTCP annual national data is reported yearly to WHO for inclusion in the WHO Annual Global TB Surveillance Report.

Increasingly, the RNTCP is moving to a state of electronic submission of reports. E-mail facilities have been provided to the staff at the CTD, all 35 STOs, 548 DTOs, 15 State TB Training and Demonstration Centres, and over 117 WHO-RNTCP consultants. At present, as an alternative method to paper copies, the districts have the option to submit their quarterly reports electronically, either in MS Word or in an “EPI-INFO” based custom-designed software called “EpiCentre”.

Estimates of TB prevalence, incidence and mortality in the country are based on an analytical and consultative process that takes into account all information available on case notifications, prevalence of infection and disease, tuberculin surveys, duration of illness, proportion of smear positive cases, number of cases treated and untreated, HIV prevalence, mortality and demography.

It is estimated that two of every five Indians are infected with the TB bacillus. ARTI surveys are conducted regularly.

National estimates of Annual Risk of Tuberculosis Infection (ARTI) prior to 2000 were 1.7% and estimates based on National ARTI survey in 2001-03 are 1.5%. Repeat ARTI survey has been initiated in 2007. Repeat disease prevalence surveys conducted by TRC in its field research area indicate an annual decline in prevalence of disease by 12%. Disease prevalence surveys have been initiated at 6 other sites across the country this year.

The external monitoring missions (Annex 7 a) found that the recording and reporting system is extremely strong, with complete and generally electronic submission of quarterly reports. For the most part, the review team found the reports to accurately reflect reality, with some exceptions. However, in many places, treatment that is not directly observed continues to be recorded as observed in the treatment card. In some districts, smears that had not been taken were recorded in laboratory registers, treatment cards, TB registers and quarterly reports. While the team was informed that these patterns were known to the CTD through the internal evaluation process, inaccurate recording and reporting continued.

4.8.2. Avoiding parallel reporting

To what extent do the monitoring and evaluation ('M&E') arrangements in this proposal *(at the PR, Sub-Recipient, and community implementation levels)* use existing reporting frameworks and systems (including reporting channels and cycles, and/or indicator selection)?

The existing national reporting formats captures data including case finding, smear conversion rates, treatment outcomes and other programme interventions including ACSM and trainings. The RNTCP also monitors status on key staff positions and training; involvement of medical colleges, partners and stakeholders. The RNTCP also has a well established system of quarterly programme review at district and state level where available data on programme performance are reviewed from higher level.

This GF supported project will utilize the existing RNTCP mechanism of recording and reporting available at district and state level to report outcomes on case finding, case holding and treatment outcomes. The information system for RNCTP DOTS-Plus is based upon, and is an extension of, the basic RNTCP information system. The forms are therefore made as similar as possible to the existing forms in the RNTCP with the specific characteristics of a DOTS-Plus programme incorporated in the existing drug management and reporting system. All the standardized records and reports will be available in both paper and electronic versions. To facilitate better quality of the information as well as data analysis, development of an electronic format for the Category IV drug stock management will also be undertaken along with referral forms and DOTS Plus treatment card.

As there would be co-implementation of activities in each of the project districts by both the RNTCP and civil society partners in this project, it will not be possible to attribute any incremental increase to one party. However, as all efforts in this project are towards supporting the national strategy it would be appropriate to attribute all improvement to the national programme. This mechanism will ensure that we do not have any parallel reporting on TB outcome indicators.

The activities and processes under the civil society component are unique and will be implemented by two PRs and several SRs. To ensure achievement of planned activities under this project a detailed system of monitoring including recording, reporting, feedback, and review will be put in place by the respective PRs and their SRs. This M&E system will focus on input, process and output indicators to facilitate effective implementation of the project. The project activities will be jointly reviewed at regular agreed intervals with the RNTCP at central, state and district level. Reports on key output indicators will be prepare and shared with the donor and the RNTCP.

4.8.3. 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.*

The current proposal will strengthen M&E activities through:

1) Providing computer and broad band access to 43 laboratories
2) Providing a Data Entry Operator to 43 laboratories and their training for lab MIS
3) Civil society PRs will constitute a Project Management Unit to oversee and monitor project activities
4) Coordination committees will be formed at national, state and district level between programme managers and civil society implementing agencies to jointly monitor the programme activities.
5) The project also has component of M&E through regular quarterly meetings of civil society implementing staff and supervisory visits at all levels. Quarterly monitoring of the project will be done at national, state and district level along with programme managers at these levels while for evaluation of the project the GF performance framework will form the benchmark. Quality and consistency of data will be ensured through internal consistency checking of data, periodic on-site visits and comparison with programme data.

There are also ongoing programme activities under GoI/WB and GF RCC funding to strengthen the M&E system that will complement M&E for the Rd 9 project.

To facilitate better quality of the information as well as data analysis, development of an **electronic format for the Category IV drug stock management** will be undertaken by RNTCP. To ensure rigorous monitoring of activities proposed under this project for preparation, implementation, monitoring and evaluation of DOTS Plus services for management of MDR TB, **a Core Team** would be formed at Central TB Division.
National DOTS-Plus Committee would routinely review implementation status of DOTS-Plus activities, and provide recommendations to CTD for improvement and/or change. Preparatory activities and performance of DOTS Plus activities would be reviewed by Central TB Division for each of the states during the bi-annual national level review meetings with all State TB Officers. Similarly, State DOTS Plus Committee would periodically review the implementation status of DOTS-Plus in the respective state. DOTS-Plus site committee would review the implementation status of DOTS-Plus in the respective DOTS-Plus site to ensure - RNTCP DOTS-Plus policies and guidelines are being followed; Clinical decisions pertaining to management of each and every case; Patients reporting adverse drug reactions are managed appropriately; All patients are registered in the DOTS Plus TB Register, monitored and periodically reported in the quarterly cohort reports on case finding, 6 & 12 months interim reports, culture conversion reports and treatment outcome reports.

For monitoring of treatment and drug dosages of individual patient under DR-TB, the Programme will continue to use patient wise boxes. However, unlike the first line anti-TB drugs which come in Patient wise drug boxes, the 2nd line MDR-TB drugs need to be aggregated into patient boxes/pouches at the State Drug Stores. This is further explained in section 4.10.5 (c)

The programme, with the support of WHO, has developed a 'Data Management Training Module' to build the capacity of State and District programme managers to analyze and evaluate programme performance data to initiate time action and undertake evidence based planning and programme implementation. For undertaking large scale training Master Trainers from the states would be trained at the national level, who would further train the district managers. The programme has also 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. The strategy lists out detailed protocols for conducting supervisory visits and tools for objective review.

Existing RNTCP reporting format are comprehensive and collect wide array of information. The outcome data like NSP case detection, treatment outcome and quality related data like treatment initiation interval will be collected from the RNTCP formats while project specific data not included within RNTCP formats and specifically process indicators will be collected through specific RNTCP reporting formats. Data from poor and backward districts, and tribal areas will specifically be analysed for improvement in services and outcomes. Innovative indicators like number of TB related questions raised in parliament will be a useful indicator fo outome of political advocacy component.

- The SDAs of the civil society PRs will be monitored through a Project Management Information System through which data will be collected from the CBO/community level and collated and consolidated at district and state levels by the SRs for reporting on a quarterly basis by the PRs to the Global Fund. Data from this information system will be used to report against the 4 SDA level indicators in Attachment A. The PRs will provide feedback on the quarterly reports to the SRs and thence to the state and district levels.
- PR will coordinate regular joint review of the project activities along with RNTCP and other key stakeholder. PR will also hold an initial sensitisation training of SRs on recording and reporting specifically for the project.
- The SRs of this project are well established organsiations and have an internal review and evaluations mechanisms. These mechanisms and process will form the basis of the evaluation that will be conducted jointly by the PR along with respective SRs, RNTCP, donor, national experts and other key stakeholders.
- In addition to this data system, KAP surveys will be carried out by the Union across the 374 targeted districts at baseline, midterm and end line, to track progress in population level attitudes and behavior related to TB

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

Describe the respective technical, managerial and financial capacities of each Principal Recipient to manage and oversee implementation of the program (or their proportion, as relevant).

*In the description, discuss any anticipated barriers to strong performance, referring to any pre-existing assessments of the Principal Recipient(s) **other than 'Global Fund Grant Performance Reports'**. Plans to address capacity needs should be described in s.4.9.6 below, and included (as relevant) in the work plan and budget.*

PR 1	Central TB Division/ Ministry of Health and Family Welfare, Govt of India
Address	Nirman Bhavan, Delhi – 110011, India

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

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

The PR has been assessed at various times with regard to earlier rounds of Global Fund grants as well as other agencies notably the WHO, the World Bank, DFID and GDF. The PR is receiving grants from Global Fund in rounds 1, 2, 4, 6 and now RCC. 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.

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

Therefore, it can be confidently stated that the PR has the relevant technical, managerial and financial capacity to implement this present proposal.

PR 2	The Union
Address	C-6, Qutab Institutional Area, New Delhi – 110016; HQ: 68 boulevard Saint Michel, 75006 Paris Email : NWilson@theunion.org www.theunion.org

The Union is an international scientific organization headquartered in Paris, since 1920. A leader in the field of TB, it works closely with leading international, regional and local TB control agencies, including the World Health Organization (WHO). It has 17 organisational members, 93 constituent members (national lung associations / TB programmes) and over 10,000 individual members (physicians, microbiologists, researchers, epidemiologists, veterinarians, nurses and allied health professionals, activists, etc). Its annual turnover for 2007 was Euro 25.38 million. It undertakes projects across the globe in middle and low income countries.

The Union's regional office for South East Asia (USEA), located in New Delhi, will manage this project as one of the two civil society PRs. Other than the Union's globally recognized TB expertise and experience that will be used on this project, its technical, managerial and financial capacities within India to oversee project implementation and support RNTCP is well established. The Union is the convener of the India Coalition Against TB (ICAT), 10 of whose member organizations will be the Union's sub-recipients in this project. These are among the most widely respected and managerially sound organizations working on TB care and control in India, with enormous experience and trust in the districts and communities in which they work. Between them they cover 300 of the 374 civil society districts proposed to be covered. Details on these are given later.

Internationally, the Union's scientists developed the DOTS strategy, adopted by WHO in 1993 for global control of TB and implemented by 184 countries, covering 93% of the world's population. The Union prioritises the needs of low-and-middle income countries. It is a pathfinder organization that develops, promotes and evaluates cost-effective strategies for TB control in collaboration with national Ministries of Health and national and international partners. Its technical work focuses on three main pillars: (1) technical support to public health programs, (2) training, and (3) operations research, and its core values are the ***quality*** of its technical work, ***independence*** with an emphasis on critical evaluation and ***solidarity*** with countries with limited resources. It provides direct technical assistance to 75 countries, conducts clinical trials, organizes international conferences and training courses, manages the grant program for the Bloomberg Global Initiative to Reduce Tobacco Use, manages the Fund for Innovative DOTS Expansion through Local Initiatives to Stop TB (FIDELIS), and publishes the peer reviewed *International Journal of Tuberculosis and Lung Disease*. The Union was the first non-governmental agency accredited with WHO after being founded and has, as part of its official constitution, an obligation to work in close collaboration with it. Accordingly, technical experts of The Union are members of almost every global and regional coordinating body of the WHO. The Union and the WHO were founding members of the Stop TB partnership which engages over 640 other organizations.

The head of The Union's Laboratory Strengthening Division is based at Prince Leopold Institute for Tropical Medicine (ITM), in Antwerp, Belgium. The Union is a founding partner in establishing the Global Drug Facility (GDF) for TB that brought access to quality-controlled anti-TB medications to all countries in need of it. The GDF has provided treatment for more than 4.5 million patients and catalyzed a worldwide improvement in the quality of TB drugs and a reduction in their cost. A Union consultant is also a member of the Green Light Committee (GLC), which promotes access to, and rational use of, second-line drugs with activity against MDR-TB. The Union was also a key partner in elaborating the International Standards of Tuberculosis Care, which serves to raise the global standard of TB care (TB Coalition for Technical Assistance, 2006). It has long-standing experience in conducting multi-center trials in several countries. Its financial management system and internal controls are compliant with OMB Circular A-122, Cost Principles for not-for-profit organizations.

In India, the Union has played a significant role in TB care and control. Projects handled by the Union's regional office for South East Asia (**USEA**) in New Delhi India include:

1. **Fund for Innovative DOTS Expansion through Local Initiative to Stop TB (FIDELIS)**: Since 2003, The Union manages a Euro 17.13 million grant for 52 projects in 18 countries. All these grants were negotiated through USEA, which also undertook technical and financial monitoring of the projects in 7 countries.
2. **BI project**: USEA was managing a grant of US$ 8.59 million in 7 countries (including India) in round 1 and was involved in negotiating a grant of US$ 5.10 million in 8 countries in round 2. It was involved in negotiating a grant of US$ 2.60 million across 8 countries in round 3 and a grant of US$2.31 million across 7 countries in Round 4. Technical and Financial monitoring was undertaken for 35 grants in 8 countries.
3. **Orissa TB control programme**: The Union is the sub recipient to CTD of a US$ 810,933 grant for two and a half years starting October 2007 for technical assistance to RNTCP in the state of Orissa under the GFATM Round 4, Phase II.
4. **World Bank project**: USEA negotiated the World Bank project in China for promotion of Lung health
5. **GFATM:** USEA consultants provided Technical Assistance to DPR Korea in developing a proposal for GF Rd 8 for TB and providing Technical Assistant to Myanmar in developing proposal for GF Rd 9 for HIV.
6. **USAID Project**: The Union was the sub recipient for World Vision of a USAID project for a grant of

US$ 600,000 for a period of one year from October 2007.

Other than its technical capacity in TB, the Union's financial, administrative and monitoring systems are fully geared towards a project of this scope. It has expertise and experience of managing several, large projects funded by agencies such as CIDA, USAID, World Bank and the European Commission, and has well defined financial systems in place comprising ERP based accounting system, a monthly reporting system to headquarters in Paris, internal controls, a donor reporting system (monthly or quarterly), travel, recruitment, and procurement policies, regular donor audits for each project, and statutory audits in place for all offices**.**

Recent projects handled/being handled by The Union

Donor	Programme	Union's role	Period	Amount
FIDELIS Project - Canadian International Development Agency (CIDA)	DOTS strategy expansion initiatives at the local level with emphasis in serving populations with limited access to health care.	Lead partner with the National TB control programmes of each of the 13 countries in project implementation	Starting of project Oct. 2003 (closed)	EUR 17.13 million
USAID		Developing new methods and approaches to reduce the burden of global TB	Started in October 2003 (on-going)	EUR 11.2 million
Tuberculosis coalition for Technical Assistance (TBCTA)	Provide technical assistance of TB control and implementation of DOTS strategy in multiple countries	Partner with National TB Control programme in project implementation. Other partners – Damien foundation, WHO, USAID, FHI, and KNCV	Started January 2003 - 5 years (closed)	EUR 1.93 million
TBCTA	Provide technical assistance with funds from USAID	Partner with National TB control programme of Senegal and Norwegian Heart and Lung Association in project implementation.	Union started TA to Senegal in 1993 (closed)	EUR 2.34 million per year
TBCTA with funding from USAID	To conduct large scale clinical trial of tuberculosis treatment regiments	Lead partner with collaborating centres around the World	Launched in Nov. 1997. On-going via USAID Coop. Agreement Grant	EUR 677,067
TBCTA with funding from USAID	To conduct large scale clinical trials in different countries around the World	Lead partner with 11 collaborating centres around the world.	Launched in 2003 – 5 year project. On-going via USAID Coop. Agreement Grant	EUR 4.1 million
French Ministry of Foreign Affairs	Provide technical assistance and support to Cameroon, Congo republic, Ivory Coast, and other Francophone African countries	Lead partner with the National TB control programmes of Cameroon and other countries	Started in 2006 for 3 year period	EUR 3 million
Norwegian Association of Heart and Lung	Provide technical assistance for TB control and implementation of the	Partner with the National TB Control Programme of Myanmar in the project	2001-2005	EUR 1.6 million

Patients	DOTS strategy in Sudan	implementation		
Ligue Pulmonaire Suisse	Provide technical assistance for TB control and implementation of the DOTS strategy in Benin.	Partner with the National TB Control Programme of Benin in project implementation.	2005-2008	EUR 303,455
Global Alliance for TB Drug development	To develop and upgrade clinical trials capacity in low income countries	Lead partner with collaborating centres around the world.	Launched in 2002. 3 years project.	EUR 720,000
European commission (EC)	To develop and upgrade clinical trials capacity in low income countries	Lead partner with collaborating centres around the world.	Launched in 2002. 3 years project.	EUR 90,000 – one time allotment
European Commission (EC) (co-financing from USAID in DRC / Ligue Pulmonaire Suisse & Global Fund in Benin)	Development of Programme of integrated HIV care for Tuberculosis Patients Living with HIV/AIDS.	Lead partner with the National Tuberculosis programmes of Democratic Republic of Congo and Benin	Started Dec. 2004 – 4 years project	EUR 4.8 million
European Commission	Development of Programme of integrated HIV care for TB Patients Living with HIV/AIDS.	Lead partner with the National TB programmes of DR of Congo and Zimbabwe (Phase II)	Started in August 2007 for 5 years	EUR 5.4 million
Center for Diesase Control (CDC), Atlanta	Improving the Effectiveness of Tuberculosis Prevention and Control Programs in Resource-Limited Countries	Lead and implementation	2003/2003	US$180,000 a year
Agence Nationale de Recherche sur SIDA et les Hépatites Virales (French National Agency on AIDS and Hepatitis)	Clinical trials on use of TB drugs with ART	In South Africa and Vietnam	2007/2010	EUR 350,000
TOTAL	TB/HIV collaborative activities in Myanmar	Implementation in-country (with opening of one office in Mandalay)	2005/2010	$650,000 a year
Agence Française de Développement (French Agency for Development)	Provide technical assistance and support to Cameroon, Congo republic, Ivory Coast, and other Francophone African countries	Lead agency	2008/2010	EUR 3 million, in continuation of French Ministry of Foreign Affairs
TBCAP (a USAID funded project)	Technical assistance and reinforcement of DOTS in high burden countries	In continuation of the TBCTA project; co-operation with WHO, KNCV, JATA, FHI, MSH and CDC	2005/2010	Budget negotiated yearly; to-date US$9 million over 3 years
WHO APW	Technical assistance in target countries	Consultancy work based on request from the NTP	NA	Average of US$200,000 a year on

				multiple contracts
Bloomberg Foundation	Initiative to reduce Tobacco use	Coordinator of the initiative (with World Lung Foundation, WHO and Campaign for Tobacco-Free Kids)	Started in June 2007 for a minimum of 4 years (renewable)	US$ 70 million
USAID – ACSM Project through World Vision	Advocacy, communication and social mobilization Project	Implementing this project in India through 9 partners in 40 districts	October 2008 – September 2009	US$ 600,000

PR 3	World Vision, India
Address	16, VOC Main Road, Kodambakkam, Chennai, India. PIN 600 024

As a National Office within the global network of close to 98 locally incorporated and registered national bodies within the World Vision International (WVI) partnership, World Vision India (WV India) has the double advantage of being an Indian non profit organization with its own Board of Directors and local management leadership while adhering to the parent organization's commitments to rigorous professionalism, financial transparency and cost efficiency. WV India is also the convener of the **NGO TB Consortium** the member organizations of which include the most active, technically respected and financially stable stakeholders in TB programming in India. Their profiles are described in the section on SRs below.

World Vision is one of the most significant civil society partners of the Global Fund internationally. Four National Offices are Principal Recipients of GF grants and the total multilateral donor grant portfolio stands at more than $140 million (see table below). A total of seventeen World Vision National Offices have been involved in implementing eleven projects in TB, twelve projects in HIV and AIDS and four projects in malaria funded by the Global Fund. These projects are located in Africa, Asia and Pacific, Latin America and the Caribbean, and Middle East and Eastern Europe regions.

The relevant strengths of WV India that lend credibility to its nomination as PR include the following:

Technical: WV India has an extensive network of relief and development projects in the country – 134 Area Development Programs (ADP) in 24 states benefiting over 5,000 communities. It also has been implementing a TB project funded by the Canadian International Development Agency (CIDA) in eight districts of Andhra Pradesh state from 2002 to '07, and subsequently the India TB Follow up program in five districts of the same state and the TB Mainstreaming project in five ADPs across five states, both with private funding. These three programs focused on community TB care, private sector engagement and ACSM. A current grant from USAID/India is being used to implement ACSM interventions in 80 districts across the country, through 6 sub recipients. Community based "TB Care Groups" were formed and strengthened, leading to effective community participation in TB diagnosis, care and case holding. It has a health team with significant experience in the technical support and management of child survival, HIV and AIDS, and health in humanitarian emergencies, in addition to TB. World Vision India is well positioned to access technical assistance from other Global Fund projects of World Vision in other country offices.

Managerial: WV India has been managing projects in India for the last 50 years. It is locally registered as an Indian charity, led by an indigenous Board of Directors. All projects are run by a total of 2,000 Indian national staff, 1,600 of whom are regular staff. Within India, there is a growing support base of 242,000 local child sponsors, who together with corporate donors gave US$2.5 million in 2006. World Vision India also manages grants and cooperative agreements from a diverse funding base that includes ten countries in the World Vision International Partnership, as well as bilateral donors such as USAID, DFID, AusAID, CIDA, and the EU, as well as local funding sources like State Innovations in Family Planning Services Agency (SIFPSA).

Financial: WV India manages an average US$50 million a year for its projects and US$56 million for the fiscal year 2009, making it one of the largest international NGOs in the country in terms of budget. WV India also currently implements a total of US$ 4.4 million USAID grants in India. To ensure accountability,

compliance and efficiency, WV India undergoes annual statutory audits by Deloitte Haskins and Sells, annual internal audits by a team of 14 chartered accountants and a biennial Partnership audit by WV International. For the last round of audits that was completed in February 207, WV India received a clean bill of health for its financial systems, protocols and transactions.

WV India is well experienced in the disbursement of funds to partners to finance local activities. Each of the 134 ADPs is treated like a local partner. They are regularly visited for both financial monitoring and programmatic support-a-vision by the nine regional teams. Regular visits are done for the purposes of mentoring, technical assistance and problem solving.

Monitoring and Evaluation: The process of collecting, analyzing, and reporting on indicators and using the information for project management is led by a Monitoring and Evaluation Unit, which has several experts for this purpose. For many grant-funded projects, monitoring is a day-to-day part of project management. Evaluations are required at mid-term and at the end of projects to ensure lessons are captured and project refinements are done. For ADPs, World Vision India, collects transformational development indicators (TDI) within a framework called LEAP (Learning and Evaluation with Accountability and Planning), World Vision International's global management information system. The LEAP framework works to ensure that community input is incorporated into all aspects of the programming cycle, including assessment, project design, implementation, and monitoring & evaluation to achieve community and donor objectives and results. LEAP institutionalizes the reflection and transition processes into all project cycles to further achieve project success.

Procurement and Logistics: There will be no annual major procurements for medications and supplies; this role will be maintained by the RNTCP at the national and state levels. World Vision India, on this issue, will draw from a significant body of knowledge and experience in managing GF- supported projects from other World Vision national offices worldwide that have implemented GF and non-GF TB projects. WV Guatemala, for example, has set up a procurement and logistics model for countries in Latin America.

World Vision India will look to its partnership-wide technical and external assistance to fill the gaps as needed.

GF portfolio of World Vision International

Country	Focus of Grant	Amount	Status	WV PR
Asia and Pacific				
Philippines	TB	$4,600,000	Approved	No
Myanmar***	HIV, TB, Malaria	$2,700,000	Approved	No
Thailand	TB	$9,400,000	Just signed	Yes
Cambodia	OVC	$1,200,000	Round 7 – Approved	No (FHI)
Mongolia	TB	$499,500	Approved	No
PNG	TB	$5,400,000	Just signed	No
Vanuatu (Pacific)	HIV	$20,000	Round 7 approved	No
Latin American and Caribbean				
Guatemala	HIV	$40,921,918	Approved	Yes
	Malaria	$13,750,042	Approved	Yes
	TB	$3,728,437	Approved	Yes
Haiti	HIV	$149,164	Approved	
Middle East and Eastern Europe				
Armenia	HIV	$7,200,000	Approved, nearing completion	Yes
BIH	HIV	$117,000	Approved - first phase	No
Africa				
Somalia	TB	$8,866,079	Approved	Yes
	TB	$29,353,798	Approved	Yes
Southern Sudan	Malaria	$2,207,386	Approved	No
	HIV/AIDS	$1,233,994	Submitted	No
	TB	$1,044,305	Approved	No
	TB and HIV/AIDS	$768,428	Submitted	No
Malawi	HIV, OVC	$11,000,000	Approved	No

Lesotho	AIDS		Round 7 - Approved	No
Rwanda	TB, Malaria and HIV	$2,033,485	Round 7 - Approved	No
Total approved		**$141,491,114**		

4.9.2 Sub-Recipients	
(a) Will sub-recipients be involved in program implementation?	☑ Yes
	☐ No
(b) **If no**, why not?	
N/A	
(c) **If yes**, how many sub-recipients will be involved?	☐ 1 – 6
	☑ 7 – 20
	☐ 21 – 50
	☐ more than 50
(d) Are the sub-recipients already identified? *(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)*	☑ Yes **[Insert Annex Number for list]**
	☐ No **Answer s.4.9.4. to explain**
(e) **If yes**, comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program delivery at the sub-recipient level, please explain why.	

Fund for Innovative Newer Diagnostics (FIND) is an SR to the proposal and mainly responsible for objective 1 related to strengthening of laboratories and uptake of newer diagnostics. *FIND will receive funds through split disbursement mechanism i.e. directly from GF to their HQ*. FIND within a short span of time has demonstrated its expertise in Lab strengthening by working with partners and has established quality assured laboratories with all basic bio-safety practices in place.

The 16 civil society SRs are nationally and internationally reputed organizations with wide experience, expertise and trust in the communities they work with. Many of them are sub-grantees/sub-sub grantees under the USAID/India TB ACSM project implemented by WV India. ADRA India, CARE India CHAI, CMAI, CRS, EHA, GLRA India, Inter Aide, Mamta, MSS, LEPRA society, REACH, SHIS, TB-Alert India and VHAI will undertake the core set of civil society activities as given in the table below. PSI will undertake mass media and toolkit development activities in 30 districts in 6 states. TB-Alert India and REACH will undertake pilots as detailed below. The districts covered by these SRs and their activities envisaged under this project are given in the table below. Detailed districts/states/populations covered by the SRs are given in annex. 9. The implementation and coverage of the SRs has evolved through an interactive consultation process with the partners. The allocation was proportionate to the extent an SR scored on the following areas:

- Experience and expertise in TB programming
- Managerial and programming capacity of the SR
- Presence of community NGO/CBO networks and location of programmes for community activities
- Relationship with the state health and TB offices
- Preferences of the SRs themselves based on the strategic directions of their respective organizations

Other criteria included the ability to invest time and contribute to the project design process; local registration with the Government of India; and sufficient financial systems to track external funding. All members were amply supported with information and advice from WHO/New Delhi and senior staff of RNTCP. This project harnesses the technical strengths of the SRs by proposing a centrally located TA pool to which the SRs will contribute personnel, technology and skills, and this pool will provide technical support project wide.

Distribution of Project Districts and Interventions			
#	**Sub-Recipient**	**# districts**	**SDA / activity focus in the project**
PR1	**CTD/Govt. of India**	**National**	• Overall monitoring of project • Scale-up of diagnostic and management services for DR-TB patients
1	Fund for Innovative Newer Diagnostics (FIND)	**National**	Setting-up/upgrading laboratories for rapid diagnostics and their functioning - Objective 1
2	WHO	**National**	Technical assistance on drugs and logistics management and DOTS Plus scale-up – part of Objective 2
PR2	**The Union**	**300**	• Manage and monitor the implementation by 10 SRs • Sustain the national Partnership activities • Conduct KAP surveys • Strengthen state and district capacity • Increase political commitment • Pilot the use of private support to maintain microscopes • Strengthen national, state and district technical capacity of RNTCP • Advocate with the private health sector to adopt DOTS plus guidelines
1	Catholic Health Association of India (CHAI)	**85**	**Core Civil Society SDAs / Activities** • Communication & social mobilisation • Engaging private providers to access RNTCP laboratory schemes • Training peripheral health staff in soft skills • Community systems strengthening including building CBO capacity • Community TB care (including sputum collection and transportation, linking patients with social support, and developing TB care forums) • Engaging rural healthcare providers in RNTCP • Strengthening linkages between TB and HIV services
2	Catholic Relief Services (CRS)	**24**	
3	Christian Medical Association of India (CMAI)	**15**	
4	Emmanuel Hospital Association (EHA)	**25**	
5	Inter Aide	**11**	
6	MAMTA	**62**	
7	Mamta Samajik Sanstha	**18**	
8	Population Services International (PSI)	**30***	Media campaigns & toolkit developments through pilots (3.1.3–5) *** The 30 PSI districts overlap with those of other Union**

			SRs.
9	Resource Group for Education and Advocacy for Community Health (REACH)	**14**	• All **Core Civil Society SDAs / Activities** as above • Pilot the use of new media like mobile telephony, and community radio (3.1.6)
10	Voluntary Health Association of India (VHAI)	**46**	• All **Core Civil Society SDAs / Activities** as above
PR3	**World Vision India**	**74**	• Manage and monitor the implementation by 6 SRs • Implement the intervention study for the ACSM model • Increase political commitment • Advocate with the private health sector to adopt DOTS plus guidelines
1	Adventist Development and Relief Agency (ADRA) India	**13**	• All **Core Civil Society SDAs / Activities** as above
2	CARE India	**17**	
3	German Leprosy and TB Relief Association (GLRA) India	**8**	
4	LEPRA Society	**23**	
5	Southern Health Improvement Samity (SHIS)	**6**	
6	TB Alert India	**7**	• All **Core Civil Society SDAs / Activities** as above • Pilot feasibility of community-based support for DR-TB patients (4.2.4) and assist small & medium enterprises develop and implement workplace policy for TB (4.3.4)
Total		**374**	

4.9.3. Pre-identified sub-recipients

Describe the past **implementation experience** of key sub-recipients. Also identify any challenges for sub-recipients that could affect performance, and what is planned to mitigate these challenges.

Adventist Development and Relief Agency-India: ADRA India is implementing a 3-year TB control and prevention project in 3 districts, since 2006, with a target population of 176,000 people. The focus is on capacity building of health service providers for behavior change communication, support of community-based DOTS providers, and community awareness. The project has 17 full time project staff, and 2 part-time consultants. ADRA India provides technical support through its health team at the national office in New Delhi and through the Department of Community Medicine at the Pondicherry Institute of Medical Sciences. ADRA India has an annual budget of US$5 million for its relief and development projects in 7 states of India, and accesses additional technical and management support from a global network of national offices.

CARE India has been operational in India for over 57 years. CARE is presently implementing programs in the areas of health, nutrition, reproductive health, microfinance, education and economic empowerment. CARE India implemented a community DOTS program with its NGO partners in the state of West Bengal, and is currently operational in 12 states for implementing health, gender and development programs to bring lasting change in the well being and social position of vulnerable groups, with special emphasis on women and girls. It has offices and field staff at the state and district levels in the areas being covered. CARE also has extensive experience in implementing TB programs in countries like Haiti, Zambia, Indonesia and Uganda. Care India accesses foreign funds through the prior permission mechanism of the Government of India.

Catholic Health Association of India: CHAI was established in 1943 and is one of the world's largest NGO networks in the health sector with over 3200 member institutions, which provide curative and promotive care, and extend healthcare facilitates to the poor and marginalised. CHAI has extensive

experience in administering DOTS programmes through its hospitals and has been recognised for expanding the programme in hard-to-reach areas and among the marginalised.

Catholic Relief Services: CRS was founded in 1943 and globally provides health services to more than 80 million people in over 100 countries. Since 1946, CRS in India has worked on health and nutrition programmes. It has led the expansion of TB-HIV care for patients, provided nutrition and care support for such patients and created advocacy programmes to remove stigma in both HIV and TB patients and their families.

Christian Medical Association of India: CMAI was formed in 1905 and has done pioneering work in several areas, including leprosy, tuberculosis, malaria and HIV/AIDS. The focus of CMAI's work is to provide affordable, ethical, relevant and compassionate care, especially for the disadvantaged. CMAI has over 330 Christian health institutions and over 6500 health professionals.

Emmanuel Hospital Association: EHA is a network of 20 rural hospitals and administers 28 community health and HIV/AIDS projects across 13 states in North, North east and Central India. EHA cover nearly 20 million population, especially tribal communities, HIV/TB co-infections in IDUs and sex workers, and hard to reach communities. EHA manages 15 laboratories and has 4 MDR laboratories.

Fund for Innovative Newer Diagnostics: FIND works in close collaboration with government and WHO, in line with national TB control policies. FIND is closely associated with WHO-GLI and has experience on Laboratory support in a number of countries such as Ethiopia, Lesotho, Tanzania, Uganda etc. FIND within a short span of time has demonstrated its expertise in Lab strengthening by working with partners and has established quality assured laboratories with all basic bio-safety practices in place. FIND lays emphasis on sustaining such activities by training the local laboratory personal. FIND's method ensures transfer of ownership and responsibilities to the local lab personnel. In India FIND has established molecular diagnostics for TB in 5 laboratories and have assisted in liquid culture uptake in 3 laboratories.

German Leprosy and TB Relief Association-India: GLRA India is a member of GLRA worldwide that has 356 projects in 46 countries. GLRA-India was registered as a local trust in 1989, and currently supports 60 local NGOs involved in leprosy work, and 38 local NGOs involved in TB work in support of RNTCP's overall goals, including a PPM project in all 19 districts of West Bengal. It is currently accredited by RNTCP to work in 16 districts nationwide. Its staff includes 134 doctors, 298 technical staff, 249 field staff and 776 support and administrative staff. Its annual budget is US$3.5 million. GLRA is a founding member of ILEP (International Federation of Anti-Leprosy Associations).

Inter Aide: Founded in 1980, Inter Aide is a French NGO working in TB control in India since 1985. It partners local NGOs, state health departments and municipal corporations to manage health facilities and clinics whose services range from diagnosis to treatment and patient follow-up. It covers 1.5 million slum population of Mumbai and Greater Mumbai region. Since March 2005, Inter Aide has been the nodal NGO for the urban DOTS project funded by the GFATM Round II. Inter Aide accesses foreign funds through the prior permission mechanism of the Government of India.

LEPRA Society was registered in Hyderabad in 1988, while BELRA, its parent organization, is in the public health field since 1925. LEPRA is dedicated to restoring health, hope and dignity to those affected by leprosy, TB, malaria, HIV/AIDS and other diseases associated with disability, stigmata and discrimination. It has extensive TB programs and in-depth expertise in various aspects of ACSM and field research for the diseases of poverty in several states, including Andhra Pradesh, Bihar, Madhya Pradesh, and Orissa. LEPRA Society's Blue Peter Research Centre was accredited by RNTCP as an IRL. The focus of these programs is in 4 areas: direct participation in service delivery, capacity building, field research and ACSM. LEPRA also lobbies with other local NGOs and private medical practitioners to refer symptomatic persons to district medical centers for diagnosis and treatment, and to foster effective collaboration between health providers, reaching about 12 million people. It is the lead partner of the International HIV/AIDS Alliance.

Mamta – Health Institute for Mother and Child: MAMTA is a grassroots NGO that started work in urban slums of Delhi in 1990 by providing preventive, promotive and health education services to women and children with the mission to empower the underserved and marginalized individuals and communities. It is a leader in conducting grassroots research and documentation, and is a member of several committees within the Ministry of Health and Family Welfare that cover technical, policy and advocacy issues on public health.

Mamta Samajik Sanstha: MSS, founded in 1992, is a leading NGO that works on public health in Uttaranchal. It works in partnership with the state government and coordinates with other NGOs to advocate improving community access to DOTS services. It has been working specially on reduction of stigma in communities in Uttaranchal and western Uttar Pradesh.

Population Services International: PSI, since 1988, has harnessed the vitality of the private sector to

address the health problems of low-income and vulnerable populations. PSI works on safe water, nutrition, family planning and HIV/AIDS (including TB/HIV) and uses principles of social marketing to achieve positive behaviour change through the promotion of ideas, products and services supportive of better health. PSI is active in 22 states and covers the entire national highway system of India.

Resource Group for Education and Advocacy for Community Health: REACH works in the state of Tamil Nadu and has extensive experience in developing community-based networks and advocating on TB control. It has been an active communication vehicle for RNTCP in the state since 2003, and has sustained its efforts to work closely with district and state programme managers on communication and advocacy issues.

TB Alert-India: TBAI is the locally registered branch of TB Alert UK, the UK's National and International TB charity launched in London's Houses of Parliament on World TB Day in 1999. TBAI exists to work towards the control and ultimate eradication of TB by increasing access to effective treatment for all. It accesses a wealth of technical expertise through its network of projects in Andhra Pradesh, Delhi, Jharkhand, Bihar, Uttar Pradesh and Madhya Pradesh through funding from DFID and Andhra Pradesh State AIDS Control Society. TBAI's Chair of the Board runs the world's biggest TB hospital and the Vice-Chair is the ex-president of the Andhra Pradesh Voluntary Health Association with 250 health-oriented NGO members. Internationally, TB Alert UK's Chairman is also the Chair of the Stop TB Partnership Working Group on ACSM. TB Alert is an organizational partner of both the Stop TB Partnership and IUATLD.

The Southern Health Improvement Samity: SHIS has been working for more than 30 years in the area of TB control and care, pursuing high quality DOTS expansion and its enhancement, especially in underserved areas. To ensure sustainability each program is implemented and improved with the help of community members, including the poor and backward, tribal populations and women. The founder of SHIS was recently conferred the "Unsung Heroes of Compassion" award by His Highness the Dalai Lama. SHIS has been successfully working in partnership with the State Health and Family Welfare Department in 7 TB Units in the underserved and un-served areas of the Sunderbans Forest Reserve Area, where SHIS is a household name. SHIS has also established and maintains an effective cross referral mechanism between TB and HIV. In addition to health, it also implements community programs for economic development and leadership.

Voluntary Health Association of India: VHAI is a leading NGO working in public health since 1970. It is a federation of 27 State VHAs, linking together more than 4500 health institutions across the country. VHAI is one of the largest health and development networks in the world. VHAI advocates for policy change and effective health planning and programme management through active participation of the people. It also leads the Independent Commission on Development and Health in India set up by the Prime Minister in 1995.

Potential Challenges: This is a concerted effort by a large number of civil society partners to implement a major TB care and control project in unison with RNTCP across a sizeable part of India (for 744 million people in 374 districts). A key challenge for SRs that could affect performance is negotiating the allocation of work at state and district levels with the respective programme managers. However, all SRs have considerable experience working with health programme managers at these levels. The challenge will be addressed through dialogue with the state and district public health machinery, along with the TB programme managers. The National Rural Health Mission (NRHM) will itself be a vehicle to facilitate this dialogue.

4.9.4. Sub-recipients to be identified

Explain why some or all of the sub-recipients are not already identified. Also explain the transparent, time-bound process that the Principal Recipient(s) will use to select sub-recipients so as not to delay program performance.

N/A

4.9.5. Coordination between implementers

Describe how coordination will occur between multiple Principal Recipients, and then between the Principal Recipient(s) and key sub-recipients to ensure timely and transparent program performance.

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** *(e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems)*; and
- **The extent to which partners will support program implementation** *(e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant)*.

The Programme will be responsible for overall monitoring activities. While all the outcomes for the Programme and specifically this project will be monitored through routine channels, process indicators will be monitored by individual organisations responsible for implementation.

Civil society activities will be undertaken in full coordination with the Programme through the formation of a coordination committee involving all stakeholders will be formed at national, state and district level. The two civil society PRs in the proposal will work in different geographical areas – based on district distribution. District level coordination with programme will be done by individual SRs working in the district with relevant authorities. However there could be multiple SRs/ implementing agencies within one state. All these organisations working within the state will form a coordination committee with state programme manager/s. National level coordination will be achieved by a coordination committee comprising of Programme, Other stakeholders like WHO, civil society PRs, and SRs with large coverage/ presence. The committees will be formed under overall guidance of Central TB Division. The committee will meet quarterly for coordination and review of project implementation activities and guide further action.

To ensure coordination, regular review meetings will be held between various PRs as well as between PRs and respective SRs. The Govt and non-Govt PRs along with other stakeholders like WHO, will plan joint monitoring missions to project areas to assess and evaluate progress. The civil society activities intend to complement the programme and hence needs assessment would be done on a dynamic basis. Respective SRs will coordinate efforts along with the state program units.

To enhance coordination between PRs and SRs**, The Union** will establish a PMU for the management of the project and coordination with SRs. The PMU will consist of relevant experts for technical and operational management of the project. **World Vision India**, will also have a management team, including the Team Leader, M&E officer and finance officer The PRs will have a sub-grant agreement with all SRs inclusive of recording and reporting structures. PR will oversee management, coordination and oversight of SR programmes and set up financial procedures and manage donor agreements and timely disbursement to Sub recipients; manage procurement and supply chain where central procurements are required while oversee decentralised procurements to ensure best practices; financial management and audit; collate and analyse the reports received from SRs; facilitating communication, interactions and synergies with CCM and the among implementing partners to act as a common information point for all implementing partners and other stakeholders (WHO, GoI) and circulating meeting reports and agendas. Staff of the PR will regularly visit project sites, often along with the respective SRs, to support operations, problem solve, encourage and learn. Cross visits between project sites will help enrich the learning process.

At the state level SRs will work closely with and through the program structure, strengthening and supporting processes required to meet project targets. In two project states where there is more than one partner, all partners will participate and contribute to coordination and synergy at the state level.
Clear, standardized guidelines will be jointly developed for recruiting project staff, selecting local NGOs from their existing networks, for carrying out community activities, and quality standards for community events like folk performances and CBO capacity building. All project staff including those of the PR will undergo a standard initial orientation on the project as well as on the overall program, with technical and managerial input. Periodic refreshers will be organized to go along with sharing of lessons and promising

practices. Content and schedule for all field level training and sensitization events will be drawn up using existing program guidelines, informed by baseline studies and in consultation with the state TB officers. Each state coordination unit will identify and equip a pool of trainers for the different streams of training events.

4.9.6. Strengthening implementation capacity

The Global Fund encourages in-country efforts to strengthen government, non-government and community-based implementation capacity.

If this proposal is requesting funding for management and/ or technical assistance to ensure strong program performance, summarize:

(a) the assistance that is planned;
(b) the process used to identify needs within the various sectors;
(c) how the assistance will be obtained on competitive, transparent terms; and
(d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

Under the proposal, the following key areas have been identified requiring technical assistance and how this assistance will be obtained:

1. The Programme needs to rapidly scale up the laboratory capacity to perform culture and DST. This also includes introduction of newer and rapid diagnostic techniques like LPA and liquid culture. While there is sufficient capacity available for ongoing solid culture methodology with support from WHO-India, additional international TA would be required for newer techniques. This will be available through FIND, which is also a sub-recipient under this grant. FIND has been supporting introduction of new techniques internationally and has been instrumental in procuring these techniques at competitive prices. The ongoing TA will be assessed on the basis of output vis-à-vis the targets laid in this grant
2. FIND will hire technical assistance for Lab design & layout expert; Supply chain management agency; HR management agency and Equipment Maintenance agency. The hiring will be done on competitive basis amongst reputed/ established agencies. The work will be monitored through standard set of indicators and progress
3. For ensuring uninterrupted supply of second line drugs, TA will be available through WHO India in following areas:
    a. Logistics management, reporting and MIS
    b. DR TB scaleup in states
4. Procurement of second line drugs will be through GLC mechanism and therefore ongoing support from GLC will also be available for introduction and monitoring DOTS plus

Amongst the civil society interventions, additional TA (both national and international) will be obtained in-house or procured for the following areas:

- Conduct KAP surveys across 374 target districts (refer activity 3.1.11)
- Finalise and implement an intervention study on an ACSM programme model (refer activity 3.1.12)
- Enhance state and district capacity in ACSM (activity 3.1.13)
- Pilot the feasibility of private support for maintaining microscopes (activity 3.3.2)
- Union's training programmes on DR-TB, epidemiology, OR and programme management (refer activity 3.4.2)
- Developing a training package for soft skills (refer activity 3.4.4)

For external TA needs, standard competitive bidding processes will be employed. The PR and technical advisors from the SRs will provide a studied feedback to each step of the TA process beginning with the Terms of Reference, Scope of Work, to the tools used, timeliness of the processes and completeness in providing the deliverables. The TOR will be designed to allow for changes in every step based on feedback from the PR and from the SRs.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 9 proposal

Does this proposal seek funding for any pharmaceutical and/or health products?	☐ **No** ➔ ***Go to s.4B if relevant, or direct to s.5.***
	☉ **Yes** ➔ ***Continue on to answer s.4.10.2.***

4.10.2. Table of roles and responsibilities

Provide as complete details as possible. *(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?	In this proposal what is the role of the organization responsible for this function?	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	CTD/MOH&FW	In this proposal the drugs will be directly procured through *GDF / GLC mechanism* and lab consumables through *FIND*	☐ Yes ☉ No
Intellectual property rights	CTD/ MOH&FW	GDF/FIND will be responsible for IPR	☐ Yes ☉ No
Quality assurance and quality control	CTD/MOH&FW	GDF/FIND will be responsible for QA/QC with monitoring by CTD. Both organizations have an established QA/QC mechanism for procurements. The costs of QA are inbuilt into procurements	☐ Yes ☉ No
Management and coordination *More details required in s.4.10.3.*	CTD/MOH&FW	CTD through its established system for management of drugs and health products for the first line drugs will manage and coordinate PSM for second line drugs	☐ Yes ☉ No
Product selection	CTD/MOH&FW	Standardized drug regimen as per WHO recommendation are being procured for MDR-TB patients	☐ Yes ☉ No
Management Information Systems (MIS)	CTD/MOH&FW	The data on logistics will be collected on quarterly basis from reporting units by CTD. FIND will help set-up a help-desk for Lab MIS	☉ Yes ☐ No
Forecasting	CTD/MOH&FW	The consumption will be monitored through the programme MIS and forecasting of requirements will be done accordingly on annual basis. WHO will provide TA for this	☐ Yes ☉ No

Procurement and planning	CTD/MOH&FW	This will be based on calculated needs and will be done on annual basis through GDF for drugs and FIND for lab consumables	☉ Yes ☐ No
Storage and inventory management *More details required in s.4.10.4*	CTD/MOH&FW	The Programme has set up adequate distribution facilities which have now been upgraded to absorb SLD purchased under this project. TA on logistics management will be provided through WHO	☉ Yes ☐ No
Distribution to other stores and end-users *More details required in s.4.10.4*	CTD/MOH&FW	The consumption will be monitored through the programme MIS and forecasting of requirements will be done accordingly. WHO will provide TA for this	☐ Yes ☉ No
Ensuring rational use and patient safety (pharmacovigilance)	CTD/MOH&FW	The programme has already developed guidelines for SLD use which have been endorsed by medical professional bodies	☐ Yes ☉ No

4.10.3. Past management experience

What is the past experience of each organization that will manage the process of procuring, storing and overseeing distribution of pharmaceutical and health products?

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
CTD	PR	CTD has handled procurements worth more than USD 11.28 million in 2008-09 out of which almost equal amounts were under World Bank and GFATM funding. Around USD 10 million were for purchase of 1st line anti-TB drugs while USD 0.89 million was for 2nd line anti-TB drugs
FIND	SR	Procurements worth USD 1.68 million in last financial year

4.10.4. Alignment with existing systems

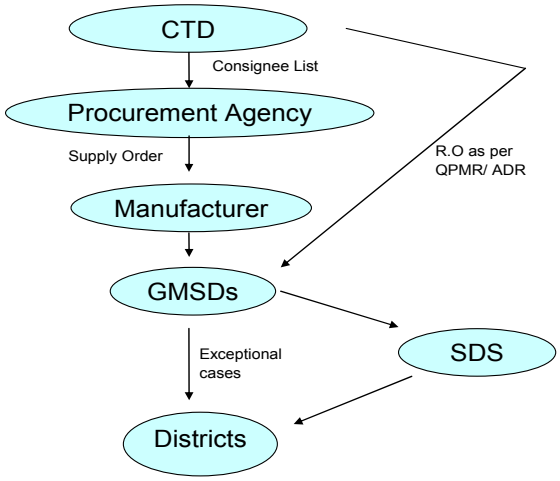
Describe the extent to which this proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacovigilance systems. If existing systems are not used, explain why.

The Programme, through its established system for management of drugs and health products for the first line drugs will manage and coordinate PSM for second line drugs

The area of drug logistics management has been decentralized to the states for which they are being imparted trainings on an on-going basis. The Drug Stores in states have shown a substantial improvement pursuant to these trainings resulting in better logistics management and ensuring no stock-outs of drugs in the country.

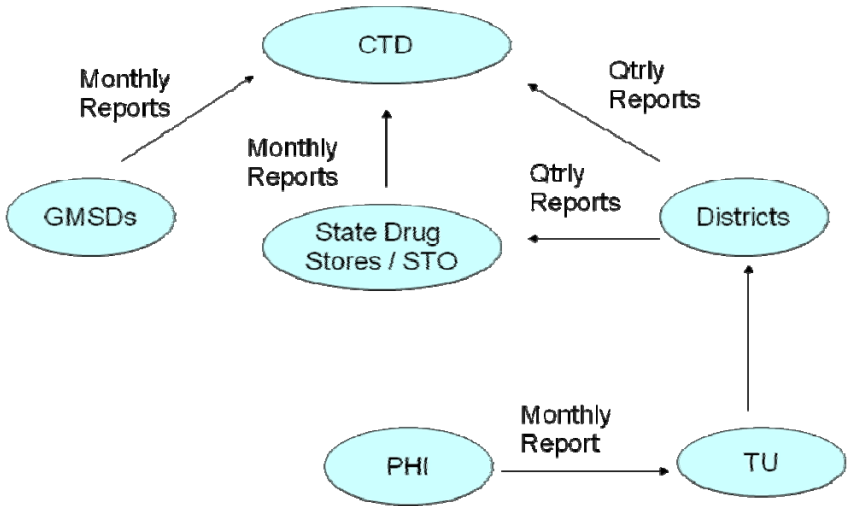
Anti-TB Drugs are procured centrally on an annual basis through a procurement agent. Distribution of drugs to the range of service delivery outlets under the programme is carefully monitored, so as to ensure

uninterrupted availability of quality drugs. Requirements at drug stocking points are worked out on the basis of current utilization patterns and expected stocks at the time of delivery. The drug distribution process of 1st line drug is depicted in Fig below:-



Monitoring of drug supplies with regard to requirement and consumption is done through a system of Quarterly Reports, tracking the drug stock position at each district by providing details of number of patients put on treatment, quantity of drugs utilized, closing stocks available & drugs received during the quarter.

The monitoring of drug stocks is done through an elaborate reporting mechanism originating from the PHIs through their monthly reports which are consolidated at the TU level. Further consolidation of TU reports is done at the district level. In addition, each of the State Drug Stores & the 6 GMSDs send monthly reports to Central TB Division which fulfils the drug data requirement for subsequent release of drugs for the next quarters to the States. The monitoring mechanism may be explained as below:



Drug requirements, consumption and stock positions, both at State and district levels are monitored at the Central TB Division through the Quarterly Programme Management Reports submitted by the districts /states. The drugs are issued to the States to replenish their stocks which includes the buffer stocks required to be maintained at various levels of Drug Stores under RNTCP.

RNTCP is also taking steps to promote **rational use of anti TB drugs**. "Chennai Consensus Statement on the Management of MDR-TB outside of RNTCP" has been developed and disseminated (Annex 20). IMA on behalf of RNTCP is interacting with MCI for guidelines to all healthcare providers on rational use of anti TB drugs aligned to ISTC. Interactions are on with the Drug Controller General of India (DCGI) to draft guidelines for the regulation of ATT drugs, especially SLDs, and for the encouragement of additional pre-qualified drug manufacturers.

GMSD – Govt Medical Stores Depot (equivalent to national store)
SDS – State Drug store
DDS – District Drug Store
TU – TB-unit (sub-district supervisory unit
PHI – Peripheral health Institution

4.10.5. Storage and distribution systems		
(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?	☒	National medical stores or equivalent
	☐	Sub-contracted national organization(s) *(specify)*
	☐	Sub-contracted international organization(s) *(specify)*
	☐	Other: *(specify)*

(b) For storage partners, what is each organization's current **storage capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

The 6 **Government Medical Stores Depots** (GMSDs) in the country have adequate capacity to handle drug storage of all National Health Programmes including the MDR-TB drugs intended to be purchased under this project. Further, as the uptake of patients over coming years is expected to increase in a graded manner, the GMSDs would be able to take up the management of increased requirements of drug and logistics systems. Based on the observations and recommendations of the in-country PSM systems assessment undertaken by the Global Fund, **additional one-time resource allocation** has been given to the GMSDs for up gradation of storage facilities for TB drugs. In addition to the **Pharmacist/storekeeper** provided at the State Drug Stores under RNTCP, the programme is now support an additional Store Assistant at the SDS to handle second-line TB drugs. The programme is also supporting introduction of **newer technology**, in the form of introduction of 'Bar Codes' to track flow of drugs from GMSDs to State Drug Stores (SDS) and then to Districts. The GMSDs are in the process of acquiring Bar Coding systems, and under the project Bar Code Readers would be provided at all the State Drug Stores. Introduction of the available technology would facilitate tracking of drugs and significantly reduce the risk of expiry of drugs on shelves.

To ensure long term sustainability of the programme, drug and logistic management has been decentralize to states by establishing at least one SDS in all major states of the country. SDSs facilitate the distribution of drugs within the state and sharply reduce lead times for fulfilling drug requests, thereby ensuring uninterrupted supply of drugs. Under the GF supported RCC project, one time allocation for increasing and improving drug storage facilities at the State Drug Store (~USD 3200) and District/sub-district Drug store (~USD 640) has been made for managing the additional stocks of 2nd line anti-TB drugs that these stores would have to handle for implementation of DOTS Plus.

Lab materials specifically for rapid diagnosis need cold chain and quick delivery. These will be directly supplied to the laboratories thereby eliminating the of intermediate storage space

(c) For distribution partners, what is each organization's **current distribution capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

Current distribution capacity: RNTCP is coordinating supply of first line anti-TB for around 1.5 million patients annually. For several years no user-level drug stock-out has been reported. This has also been validated by independent monitoring missions. Good quality drugs are being supplied and districts are now ensuring correct distribution and storage practices.

The vision of the programme is to have at all times, sufficient quality assured anti-TB drugs available at the appropriate levels to ensure that no patient has to delay initiation of their treatment, or interrupt treatment, due to the lack of drugs. To ensure and monitor quality of drugs in this vast country and to ensure timely availability, the programme undertakes centralized procurement of anti-TB drugs, as per the World Bank approved mechanisms. Internal and external quality assurance of drugs are as per the existing protocol. The bottom-up reporting and ordering of drug needs, based on available stocks within the respective district will be continued. The programme will continue to support the states to further

strengthen drug store management and drug distribution via State Drug Stores, until the drug distribution system is entirely managed by the states, with adequate stock of anti-TB drugs maintained at all levels. The sub-district drug storage at the TB Unit will be maintained, to ensure adequate stocks and prevent any delays in treatment initiation.

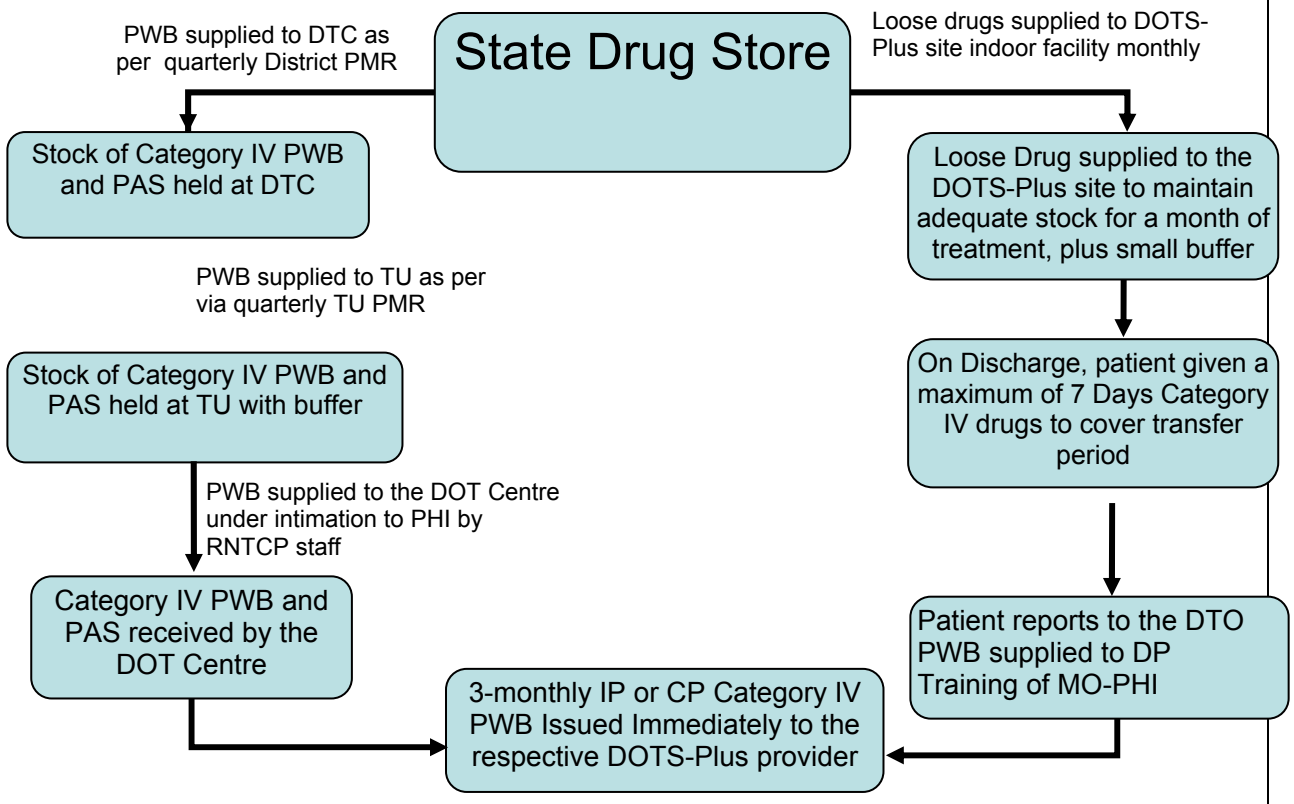
Drug distribution plan for MDR-TB drugs

a. Loose drugs, being procured by Central TB Division (CTD) through GDF, shall be dispatched to the State Drug Stores (SDS) directly by the suppliers. The States need to ensure that drugs are as per Technical Specifications with special regard to their date of manufacture & expiry.
b. The first time, SDS shall send some Intensive Phase (IP) boxes to the implementing District Tuberculosis Centre (DTC). Subsequently, the flow of IP boxes shall be monitored through the District Quarterly PMR. DTC shall send the IP boxes to its implementing TB Unit (TU) in a similar manner & then monitor through the TU Quarterly PMR
c. Continuation Phase (CP) boxes shall be issued from the SDS to the DTC at the end of the treatment of first three months of IP (1st Quarter), information of which shall be received through the Quarterly PMR. These boxes will then be issued to the TU by the DTC accordingly.
d. Buffer stocks of IP & CP boxes will be held only at DTC & the concerned TU, equivalent to one IP/CP box for each patient undergoing IP/CP

Packaging Instructions

a. Loose drugs to be packaged into 3-monthly drug boxes for both IP & CP at the SDS only
b. Packaging of IP/CP boxes to be done under guidance of the STO/Medical Officer/Drug logistics In-charge at the State level
c. One 3 monthly IP/CP box to have 3 divisions with 1 monthly box/pouch – similar to Prolongation Pouches
d. Durable cardboard boxes to be used for IP & CP 3 monthly drug boxes. Inj Km to fit into IP boxes
e. Label on IP/CP boxes should clearly mention the following:
   i. Item-wise name of drugs with Quantity in the box
   ii. Batch No. & DOE of individual drugs
   iii. DOE of the IP/CP box – DOE should be the expiry date of the drug containing shortest expiry

Proposed Movement of drugs



Stock Registers: To be maintained at SDS, DOTS Plus Site, DTC & TU levels

f. SDS – Stock Register to have stock details of both loose drugs & 3 monthly IP & CP boxes
DOTS Plus Site – Stock Register to have stock details of only loose drugs

g. DTC – Stock register to have stock details of only 3 monthly IP & CP boxes

h. TU - Stock register to have stock details of only 3 monthly IP & CP boxes

i. Recording of stock details of individual drugs

j. Recording of stock details of IP & CP boxes

Repackaging / use of incomplete IP/CP boxes

a. In case of default/death/transferred out/treatment stopped cases, the unconsumed boxes to be brought back from DOT Centre to TU to DTC to SDS within shortest possible time

b. All loose drugs of the boxes received back to be accounted for in the Stock Register at the SDS

c. Loose drugs from IP/CP boxes may be used at DOTS Plus site

Reporting of Stocks/Indenting

a. SDS level – Monthly Stock Report for stocks to be submitted to CTD

b. DOTS-Plus site – Monthly Stock Report for stocks & indenting of Cat IV drugs to be submitted to STO /SDS

c. DTC level – Quarterly PMR for stocking & indenting of Cat IV drugs to be submitted to STO/SDS and CTD

d. TU level - Quarterly PMR for stocking & indenting of Cat IV drugs to be submitted to respective DTC

GMSD – Govt Medical Stores Depot (equivalent to national store)
SDS – State Drug store
DDS – District Drug Store
TU – TB-unit (sub-district supervisory unit
PHI – Peripheral health Institution
DTC – District TB Centre

4.10.6. Pharmaceutical and health products for initial two years

Complete 'Attachment B-Tuberculosis' to this Proposal Form, to list all of the pharmaceutical and health products that are requested to be funded through this proposal.

Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs'). **However**, if the pharmaceutical products included in 'Attachment B-Tuberculosis' 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.

Attachment B is filled and included. The unit costs of drugs are calculated based on:

- The last procurement of CAT IV drugs from GDF
- As approved in recent UNITAID proposal
- Anticipated increase in costs over the project period

Further details are available at 5.4.3.

However attachment B does not permit for an yearly increase in unit cost. This has been taken care of in the budget only.

The drugs are as per STGs and explained in national DOTS Plus guidelines. DOTS Plus guidelines and Cat IV regimen are available at Annex 5

4.10.7. Multi-drug-resistant tuberculosis	
Is the provision of treatment of multi-drug-resistant tuberculosis included in this tuberculosis proposal?	☉ 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 these costs*

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 9 and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases (and perhaps also benefit other health outcomes); and*
- *Section 4B is not also included in the HIV or malaria proposal*

Read the Round 9 Guidelines to consider including HSS cross-cutting interventions.

'Section 4B' can be downloaded from the Global Fund's website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions').

5. FUNDING REQUEST

5.1. Financial gap analysis - Tuberculosis

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

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007-08	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
Tuberculosis program funding needs to deliver comprehensive diagnosis, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	**60,147,000** (@USD 1:42)	**55,199,000*** (@USD 1:47)	**94,884,000**	122,821,520	159,380,760	193,490,045	208,891,386	223,487,284
Line A.1 ➔ Total need over length of Round 9 Funding Request	*(combined total need over Round 9 proposal term)*							
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*) (World Bank Credit)	25,316,800	26,120,000	41,024,000	47,820,800	60,919,200			
Domestic source **B2** National funding resources (Govt of India)*	6,329,200	6,53,000	10,256,000	11,955,200	15,229,800	92,204,000**	112,180,800**	149,463,000**
Domestic source **B3** Private Sector contributions (national)								
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	**31,646,000**	**32,650,000**	**51,280,000**	**59,776,000**	**76,149,000**	92,204,000	112,180,800	149,463,000
External source **C 1** (*DFID- drugs*)	9,723,000	9,796,000	8,163,000	8,516,000	0	0	0	0

ROUND 9 – Tuberculosis

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007-08	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
External source **C2** (*USAID – Haryana)*)	867,000	0	0	0	0	0	0	0
External source **C2** (*UNITAID)*) (expected support)	0	0	0	10,600,000	2,700,000	4,500,000	0	0
External source **C3** Private Sector contributions (International)								
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	**10,590,000**	**9,796,000**	**8,163,000**	**19,116,000**	**2,700,000**	**4,500,000**	**0**	**0**
In line D below, insert additional separate lines for each separate Global Fund grant. This will ensure that you show information on different Global Fund grants.								
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years								
Global Fund Round 2	5,675,000	4,992,000						
Global Fund Rd 4	8,162,000	5,006,000						
Global Fund Rd 6	4,075,000	2,755,000						
Global Fund RCC	0	0	15,170,000	24,450,000	27,060,000	39,340,000	43,330,000	48,280,000
Total Global Funds	**17,912,000**	**12,753,000***	**15,170,000**	**24,450,000**	**27,060,000**	**39,340,000**	**43,330,000**	**48,280,000**
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	**60,148,000**	**55,199,000***	**74,613,000**	**103,342,000**	**105,909,000**	**136,044,000**	**155,510,800**	**197,743,000**

ROUND 9 – Tuberculosis

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2008 etc.) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2007-08	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
Calculation of gap in financial resources and summary of total funding requested in Round 9 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	0	0	0	19,479,520	53,471,760	57,446,045	53,380,586	25,744,284
Line G = Round 9 tuberculosis funding request *(same amount as requested in table 5.3 for this disease)*				**18,551,924**	**50,925,486**	**54,710,519**	**50,838,653**	**24,518,366**

*The expenditure in 2008-09 appears less than 2007-08 because of exchange rate fluctuation, though expenditure in INR is higher in 2008-09. Exchange rate used is as per actuals. For subsequent years' projection, conversion rate is 1:47.5, as decided by India CCM and used for the entire proposal.
** Committed funding for RNTCP Phase II project (from the existing World Bank credit and Domestic resources) is available till Sept 2011. 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.

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants

In Round 9, the total maximum funding request for tuberculosis 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

$$\text{Cost sharing} = \frac{(\text{Total of Line D entries over 2010-2014 period} + \text{Line G Total}) \times 100}{\text{Line A.1}}$$

%

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 ensures that government, non-government and community needs were included to ensure fully implementation of country's tuberculosis program and strategy.

Line A includes

- Running costs of ongoing DOTS Programme activities. These costs are based on the budget as prepared by the Programme and included in the planning cycle of the country. These include programme costs of civil society participation in DOTS through RNTCP schemes and patient support activities like reimbursement of transport costs and DOT honorarium to community volunteers. Budget projections are part of regular planning exercise and have earlier been submitted to Planning Commission, GoI. However the current projections are available only till 2012, when the 11th five-year plan ends. The process of budget preparation beyond this term is expected to begin soon and in the absence of existing plan, the projections are based on assumptions.
- Additional funding required for DOTS plus activities is calculated as per the national plan and included into the projections. Expansion for universal access to DOTS plus is newer initiative and hence the costs are additional to the earlier budget for DOTS activities. The costs include mainly the additional DR-TB suspects to be investigated, procurement of drugs for MDR-TB cases to be put on treatment and the follow up sputum/ culture tests for these cases on treatment. Part of the funding is available from GoI/ WB, GF RCC round, UNITAID and USAID which are part of the RNTCP budget. Additional costs for diagnosis and management have been added on to the DOTS budget
- The GF RCC proposal further consolidates the national efforts and spells out the strategies under the national MDR TB scale up plan up to 2015 that has been approved. However, the GF RCC project has limited scope as the decision of Nation wide scale up of MDR TB services using Rapid diagnostics to minimize the turnaround time was taken recently and the national MDR TB scale up plan was presented at the Beijing Ministerial Meeting. The UNITAID proposal complements the GF RCC in establishing capacity of the nation to conduct rapid diagnosis of MDR TB using LPA and liquid culture as well as further supplement the management of MDR TB cases. The activities proposed in Rd 9 proposal are a large top-up as a response plan to global upsurge of MDR TB over and above those covered under the RCC and UNITAID project. These strategies under RCC and UNITAID would be incorporated in the 12th five year plan as well as the next National Strategic Programme Implementation Plan. The Government of India is committed to implement RNTCP as centrally sponsored programme till TB ceases to be a public health problem.
- The civil society would be participating in the proposal to complement Programme activities on a large scale. Funding requirements of civil society for enhanced participation in supporting patient access to quality DOTS services has also been incorporated. These are mainly based on activities that would be carried out by civil society partners in the implementation area

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

Explain the processes used in country to:

- prioritize domestic financial contributions to the national tuberculosis 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, diagnosis, care and support strategy at the national, sub-national and community levels.

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 (www.planningcommission.nic.in). Planning Commission plays an integrative role in the development of a holistic approach to the policy formulation in critical areas of human and economic development. Emphasis of the Commission is on maximising the output by using the limited available resources optimally. The key to efficient utilisation of resources lies in the creation of appropriate self-managed organisations at all levels. In this area, Planning Commission attempts to play a systems change role and provide consultancy within the Government for developing better systems.

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

The Programme has well laid technical, financial and operational guidelines that are documented. The technical guidelines are as per the internationally recommended strategy. These guidelines ensure that funds are utilized efficiently and in a transparent manner.

TB programme is covered under the audit of the Comptroller and Auditor General (CAG) of India. CAG is the supreme audit institution of India that annually audits public accounts as per the constitution of India and international best practices. Offices of the Principal Directors of Audit are responsible for audit of the activities of the Federal Government, including Civil Ministries and Departments. Auditing standards have been published and give overall direction for auditing (available at www.cag.gov.in). The audit enhances accountability of the Programme to the public representatives.

Further, the Programme has been assessed at various times with regard to earlier rounds of Global Fund grants as well as other agencies notably the WHO, the World Bank, DFID and GDF. The Programme is receiving grants from Global Fund in rounds 1, 2, 4, 6 and now RCC. 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 GF.

The 'Right To Information' (RTI) act (www.rti.gov.in) incorporated in June, 2005 by Govt of India is an Act to provide for setting out the practical regime of right to information for citizens to secure access to information under the control of public authorities, in order to promote transparency and accountability in the working of every public authority, the constitution of a Central Information Commission and State Information Commissions and for matters connected therewith or incidental thereto. The act has introduced transparency into the systems

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 external resources like the UNITAID support are time bound (2010-2013) and anticipated changes to contribution have been accounted for in this proposal budget. Similarly DFID support would end in 2011. The World Bank Project ends in September 2011. However Govt of India is committed to support TB control activities by raising necessary funds either through World Bank Credit or domestic funding or other sources. As of now there are no delays in accessing the external resources.

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.

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/rounds/9/single/#budget

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

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

4. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (s.5.4.)

5. Do not include any CCM or Sub-CCM operating costs in Round 9. 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 at: http://www.theglobalfund.org/en/ccm/

5.3. Summary of detailed budget by objective and service delivery area

Objective Number	Service delivery area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
3	Advocacy, Communication and Social Mobilization (ACSM)	1,700,711	5,636,002	6,321,555	5,810,310	3,530,707	22,999,285
3&4	All care providers (PPM)	217,386	596,617	747,883	785,278	803,430	3,150,594
4	Community Systems Strengthening	145,355	176,268	365,457	13,673	402,916	1,103,669
4	Community TB Care	98,620	675,586	844,727	886,963	931,312	3,437,208
1&3	Human Resource Development	1,642,915	2,904,297	3,664,854	3,880,523	3,796,073	15,888,662
1	Improving Diagnosis	1,855,009	2,539,152	3,189,825	3,496,090	6,047,404	17,127,480
1	Monitoring & Evaluation	842,140	1,225,886	1,264,766	1,316,367	1,382,183	6,031,342
3	Political Commitment	13,768	40,581	42,610	44,739	46,976	188,674
1	Programme based OR	0	105,000	0	115,763	0	220,763
4	Programme Management & Administration	2,308,754	3,362,581	3,729,157	3,915,618	3,917,293	17,233,403
4	TB-HIV	44,832	195,156	238,335	250,252	262,764	991,339
2	Technical assistance for scale-up management of DR-TB	411,463	1,728,143	1,814,550	1,905,277	2,000,541	7,859,974
2	Uninterrupted supply of second line drugs	8,635,000	30,395,000	30,947,563	26,935,841	80,388	96,993,792
	Overheads	635,971	1,345,217	1,539,237	1,481,959	1,316,379	6,318,763
Round 9 tuberculosis funding request:		18,551,924	50,925,486	54,710,519	50,838,653	24,518,366	199,544,948

ROUND 9 – Tuberculosis

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 Round 9 Guidelines	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	2,524,326	4,458,274	5,272,983	5,524,997	5,668,268	**23,448,848**
Technical and Management Assistance	872,938	3,176,911	3,318,483	3,511,600	2,651,498	**13,531,430**
Training	2,507,943	4,883,893	5,676,827	5,313,536	5,654,546	**24,036,745**
Health products and health equipment	488,720	361,940	898,380	1,232,280	3,239,880	**6,221,200**
Pharmaceutical products (medicines)	8,560,000	30,240,000	30,870,000	26,856,900	0	**96,526,900**
Procurement and supply management costs	24,436	18,097	179,676	246,456	647,976	**1,116,641**
Infrastructure and other equipment	1,122,592	1,234,092	634,576	8,287	8,700	**3,008,247**
Communication Materials	270,528	1,982,583	2,246,411	1,966,323	444,307	**6,910,152**
Monitoring & Evaluation	815,729	1,319,439	1,525,099	1,598,649	1,646,770	**6,905,686**
Living Support to Clients/Target Populations	0	0	0	0	0	**0**
Planning and administration	678,528	1,694,147	2,327,410	2,865,157	2,995,908	**10,561,150**
Overheads	686,184	1,556,110	1,760,674	1,714,468	1,560,513	**7,277,949**
Other: *(Use to meet national budget planning categories, if required)*	0	0	0	0	0	**0**
Round 9 tuberculosis funding request	**18,551,924**	**50,925,486**	**54,710,519**	**50,838,653**	**24,518,366**	**199,544,948**

5.4.1. Overall budget context

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

The total budget requested in the proposal is USD 199.54 million out of which

- 48.4% is requested for second line drugs. The cost of drugs is based on the previous purchase experience. Changes in number of patients to be put on treatment in various years vis-à-vis available funds for second line drugs is major reason for yearly cost variations observed in the cost category and the total budget.
- Another cost increase observed over 4th and 5th year is in health products and equipment. This is because equipment for rapid diagnostics will be purchased in 3rd year and laboratory consumables for diagnostics will be required from 4th quarter of 4th year. Funding for other years having been secured from UNITAID. There is also corresponsing change in Procurement and Supply management costs
- Since costs under Infrastructure and Equipment, most of the purchases being completed within first two years
- The other two major cost categories are Human Resource and training, constituting ~12% each
- Annual increase for recurring costs has been kept at 5% to account for cost escalations and any currency exchange rate fluctuations

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 two years; (ii) the method of calculating the anticipated costs over years three to five; 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.

The budget for HR is 11.8% and has been calculated based on:

- Anticipated number of staff to be hired for the activities to be undertaken under each objective in addition to already available staff at various levels through domestic/ WB funding and through other GF supported projects. Most of the funding requirement for HR under objective 2 is being met from other sources.
- National and international rates depending on the placement of staff.
- A 5% increment per year from year 1 base upto the 5th year of the project

Justification:
Inadequacy in staff at all levels has been identified as a constraint by Joint Monitoring Mission (JMM) 2009. Additional human resources are being hired under the project for Objective 1 – Availability of qualified, trained manpower is critical and has impact on laboratory activities. Since states are not able to commit adequate resources towards appointment of suitably qualified staff, progress in activities towards lab accreditation has not been optimal. Only essential staff required for the increased workload at the laboratories would be hired. Under this project one additional microbiologist and two technologists, two lab technicians and one lab assistant would be hired per laboratory identified for strengthening. About 37 data entry operators are also proposed to be recruited to operationalize Lab MIS and electronic reporting mechanisms.

Technical staff, a Finance Consultant, a logistics officer and other support staff will be appointed at FIND office to manage issues related to monitoring, supervision and evaluation of the Grant.

For objectives 3 and 4, additional staff is being hired for:

- Strengthening RNTCP technical capacity at the central level – 3 senior experts for ACSM, PPM

and M&E
- Project Management Units of the PRs and for the state and district levels for the SRs

Senior experts are required specifically for capacity building of difficult states like thos e in North-East and Jammu & Kashmir where the current WHO staff is constrained to travel.

Civil society staff hiring would be essential in strengthening the programme and management at various levels and ensure successful implementation of the project. The staff roles at PMU have been explained in detail at Annex 22. PMU will be responsible for overall coordination and monitoring of project and grant management. Peripheral staff hired by SRs would collect process specific indicators and liaise with district level programme staff to ensure coordination. Link between civil society activities and programme at all levels is essential and hence this staff requirement.

5.4.3. Other large expenditure items

If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national tuberculosis program.

Major cost category is purchase of Second Line Drugs for the treatment of MDR-TB patients. The costs are based on:

- The last procurement of CAT IV drugs from GDF as the basis as well as cost calculations for UNITAID proposal.
- Possible increase in cost of drugs when the orders are placed (2010) with annual cost increase of 5%.

In addition

For second line drugs (CS, Eto, Kn, Ofx/Levo, PAS):
- PSI and quality control charges: QC costs are built in the unit prices of the drugs (QA is performed by IDA through Vimta). Additional 450 USD for Pre-shipment Inspection (not mandatory for SLDs)
- Insurance: 0.6% of total order value
- Agent fee: 7% agent fee is included in the drug prices.
- Transport: All products were procured from India with the exemption of Inj. Kanamycin. According to previous examples, freight charges were approx. 1.5% of total order value including international freight for Kn.

For first line drugs (E, Z, X):
- PSI and quality control charges: varies depending on products and no. of batches being tested, but average cost is approx. 6% of drug price
- Insurance: Included in drug prices
- Agent fee: 2.95 % of drug prices + QC fees
- Transport: Included in drug prices since specific DDU prices have been negotiated for the products included in India ’s CAT-IV regimen

Taking into account the proportion of ‘FLDs & SLDs’ value in the treatment regimen, a 5% was used for the UNITAID proposal to be on the safe side, to which a 10% product price and a 4.4% freight fluctuation costs were added in accordance to UNITAID practice.

As mentioned in Section 3.5 and Section 4.4, there is a gap in meeting the demand for SLDs in the country. Funding support from GF is essential to meet this gap and achieve the aim of universal access to care for DR-TB patients.

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.*

N/A

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.

N/A

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 tuberculosis program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on tuberculosis outcomes during the proposal term.

N/A

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

Applying for funding for HSS cross-cutting interventions is optional in Round 9

SECTION 5B CAN ONLY BE INCLUDED IN ***ONE DISEASE*** *IN ROUND 9 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.*

Read the Round 9 Guidelines to consider including HSS cross-cutting interventions

Download 'Section 5B' from the Global Fund website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions') ***in Round 9 and has completed section 4B and included that section in the Tuberculosis proposal sections.***

Proposal checklist – Section 3 to 5 Tuberculosis

Section 3 and 4: Program Description		List Annex Name and Number
4.1	Supporting documentation for National Strategy	Annex 3 Planning_Commission_ XIPlan_TB
4.2.1	Map if proposal targets specific region/population group	Annex 9 ICAT NTC coverage with map (for civil society coverage)
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists).	Annex 7 (a) JMM-2006_Report; Annex 7 (b) Executive summary-JMM 2009
4.4	Document(s) that explain basis for coverage targets	Annex 1 RNTCP response plan to MDR XDR; Annex 2 Laboratory Scale up Plan
4.5.1	**A completed '*Performance Framework*' by disease** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**
4.5.1	**A detailed component Work Plan** (quarterly information for the first two years and annual information for years 3, 4 and 5) by disease.	**Work plan**
4.5.2	**A copy of the Technical Review Panel (TRP) Review Form** for unapproved Round 7 or Round 8 proposals (only if relevant).	Annex 21_TRP Review Rd 8 TB_India
4.8.1	**A recent evaluation of the 'Impact Measurement Systems'** as relevant to the proposal (if one exists)	Annex 7 (a) JMM-2006_Report; Annex 7 (b) Executive summary-JMM 2009
4.9.1	**A recent assessment of the Principal Recipient capacities** (other than Global Fund Grant Performance Report).	Annex 7 (b) Executive summary- JMM 2009; Annex 23 (a) report The Union and 23 (b) report World Vision
4.9.1 *(for non-CCM applicants)*	**Document describing the organization such as: official registration papers, summary of recent history of organization, management team information**	NA
4.9.2	**List of sub-recipients already identified** (including name, sector they represent, and SDA(s) most relevant to their	Annex 9 ICAT NTC coverage with map

Proposal checklist – Section 3 to 5
Tuberculosis

	activities during the proposal term)	
4.10.6	**A completed 'List of Pharmaceutical and Health Products'** by disease (if applicable).	**Attachment B**
Section 4B: HSS Cross-cutting (once only in whole country proposal)		**List 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**.	**Attachment A**
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, 4 and 5).	**Work plan**
Section 5: Financial Information		**List Annex Name and Number**
5.2	**A 'detailed budget' (quarterly information for the first two years, and annual information for years 3, 4 and 5)**	**Detailed Budget**
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)	List included in detailed budget
5.4.3	Information on basis of costing for 'large cost category' items	Annex 12 Budget R9 Drug procurement
5.5.1 *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism	NA
5.5.2 *(if common funding mechanism)*	Most recent assessment of the performance of the common funding mechanism	NA
Section 5B: HSS Cross-cutting financial information		**List 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, 4 and 5).**	**Detailed Budget**
5B.4.2	Information on basis for budget calculation and diagram	NA

Proposal checklist – Section 3 to 5 Tuberculosis

	and/or list of planned human resources funded by proposal (only if relevant)	
5B.4.3	Information on basis of costing for 'large cost category' items	NA
Other documents relevant to sections 3, 4 and 5 attached by Applicant:		**List Annex Name and Number**
4.1	RNTCP response plan for MDR/XDR TB	Annex 1 RNTCP response plan to MDR XDR
4.1	Laboratory scale up plan	Annex 2 Laboratory Scale up Plan
4.3.1	Programme performance	Annex 7 (c) TB India 2009
4.3.1	Baseline study on Information Education Communication	Annex 10 IEC Baseline Document
4.3.3	NGO and PP schemes of the Programme	Annex 11 Revised schemes for NGOs & PPs
4.5.1	DOTS Plus guidelines	Annex 5 DOTS Plus Guidelines
4.5.1	Geographical coverage by civil society	Annex 9 ICAT NTC coverage with map
4.5.1	Medial plan and PSA toolkits	Annex 13 (a) Media plan; Annex 13 (b) PSA tool kit
4.5.1	Patient's Charter	Annex 14 patients_charter
4.5.1	ACSM study design	Annex 15 ACSM Intervention Study Proposal Brief
4.5.1	Orissa Model for TA on ACSM	Annex 16 Union Orissa project
4.5.1	International courses of The Union	Annex 17 Union International courses
4.5.1	Overview and curriculum of soft skills training	Annex 18 Soft skill training curriculum
4.5.1	International Standards of TB care	Annex 19 ISTC
4.5.1	Project Management Unit of civil society PRs	Annex 22 PMU Organizational Chart and roles
4.10.4	Chennai Consensus statement	Annex 20 Consensus statement on MDR XDR TB

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	India
Disease:	TB
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
1	Decrease morbidity and mortality due to drug resistant TB (DR-TB) in India and improve access to quality TB care and control services through enhanced civil society participation.
2	
3	
4	
5	

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	TB incidence rate	75 new smear positive (NSP) cases per 100,000 population	2002	National Annual Risk of TB Infection (ARTI) survey		67 NSP cases per 100,000 population			60 NSP cases per 100,000 population	Next round of ARTI survey will be conducted in 2014-15
impact	TB prevalence rate	370 bacillary positive TB cases per 100,000 population	2000	Report of expert committee meeting on TB Burden based on prevalence survey data		280 bacillary positive cases per 100,000 population			200 bacillary positive cases per 100,000 population	TB prevalence survey at select sentinel sites to be repeated in 2014-15
impact	TB mortality rate	28 deaths per 100,000 population	2006	WHO Global TB Report	26	25	24	23	21	
outcome	Number of districts with new smear positive case detection rate ≥ 70% in 374 districts selected for civil society objectives (3&4)	143	2008	R&R TB system, yearly management report	150	180	225	260	300	This will also contribute to the programme target of uniformly achieving ≥70% NSP CDR in at least 430 districts across the country
outcome	Average default rate of smear positive re treatment patients in 374 districts selected for civil society objectives (3&4)	14% (17, 894 cases)	2008	R&R TB system, yearly management report	13%	12%	11%	10%	9%	Annual numbers have not been provided as these would change with the case notification rates and population increase. Total decrease in annual default rate is expected to be 5%
outcome	MDR TB cases registered	400	2008	R&R TB system, quarterly reports	8,000	15,000	25,000	30,000	32,000	Figures for MDR-TB patients to be initiated on treatment irrespective of funding sources. GF specific figures are availble in proposal narrative - section 4.4
outcome	MDR TB cases successfully treated	NA		R&R TB system, quarterly reports	≥ 70%	≥ 70%	≥ 70%	≥ 70%	≥ 70%	
impact	Proportion of new TB cases that have MDR-TB	≤ 3%	2006	Specify- Reports, Surveys, Questionnaires etc.					≤ 3%	The proportion of MDR-TB cases would remain stable because of the project inteventions. Since DRS studies would be done in 2014, the results are expected to be available in early 2015 - by the close of the project
please select…	Please Select…			please select…						
please select…	Please Select…			please select…						

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	Establish and enhance capacity for quality assured rapid diagnosis of DR-TB suspects in 43 Culture and DST laboratories in India by 2015	
2	Scale-up care and management of DR-TB in 35 states/Union Territories of India resulting in the initiation of treatment of 65,200 additional cases of Drug Resistant TB (DR-TB) by 2015	
3	Improve the reach, visibility and effectiveness of RNTCP through civil society support in 374 districts across 23 states by 2015	
4	Engage communities and community-based care providers in 374 districts across 23 states by 2015 to improve TB care and control, especially for marginalized and vulnerable populations and including TB-HIV patients	
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Attachment A - Tuberculosis Performance Framework

Program Details

Country:	India
Disease:	TB
Proposal ID:	

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4 and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	Improving diagnosis	Number of laboratories performing Line Probe Assay	5	2009	R&R TB system, yearly management report	5	12	15	25	43	43	43	N	Y	Y - over program term	CTD/ SR-FIND	The data would be collected and verified based on reports of monitoring visits and pre-accreditition visits
1.2	Improving diagnosis	Additional lab staff trained on rapid diagnostics	5	2009	R&R TB system, yearly management report	30	40	30	35	10	0	0	Y	N	N - not cumulative	CTD/ SR-FIND	Based on training records and attendance
1.3	Improving diagnosis	DR TB suspects examined	8000	2009	R&R TB system, quarterly reports	10,000	22,000	30,000	50,000	144,000	156,000	160,000	N	N	Y - over program term	CTD/ SR-FIND	Quarterly reports collected by the Programme. The targets for suspects examination is based on the scaled up lab capacity; tranistion in case definition and accounting for operational loss in number of suspects
2.1	MDR-TB	Number of MDR-TB cases initiated on treatement	300	2008	R&R TB system, quarterly reports	3000	5000	7000	8000	25,000	30,000	32,000	N	N	N - not cumulative	CTD	Quarterly reports collected by the Programme. The targets are inclusive of all MDR-TB patients to be registered, irrespective of funding source.
3.1	ACSM (Advocacy, communication and social mobilization)	Proportion of women and men aged 15 to 49 years who know that cough over 2 weeks could be TB, that TB is curable, and that TB treatment is free AND agree with the statement that they will share a meal with and live in the same house as a person with TB	NA		KAP survey	NA	NA	NA	NA	20% increase from baseline levels	NA	40% increase from baseline levels	Y	N	Y - over program term	The Union and World Vision India	KAP surveys will be done across the 374 districts at baseline, at the end of year 3 and 5. This is a composite indicator, combining gender disaggregated data from indicators on knowledge and attitudes
3.2	ACSM (Advocacy, communication and social mobilization)	Number of target districts where at least 60% of Village Development Committees (Gaon Kalyan Samiti) had a TB related agenda in a meeting in the past quarter	NA		Records of GaonKalyan Samiti	0	50	100	150	200	250	300	Y	N	Y - over program term	The Union and World Vision India	These targets are for a total of 374 districts.
3.3	All care providers (PPM / ISTC)	Number of additional quality-assured routine labs in private and NGO health facilities registered under RNTCP's DMC/ sputum collection/ transport scheme	NA		R&R TB system, quarterly reports	0	0	25	110	220	330	440	Y	N	N - not cumulative	The Union and World Vision India	Assuming 5 labs per target state per year access DMC Scheme
4.1	Community Systems strengthening	Number of target districts where at least 2 CBOs were represented in district-level health/TB meetings in the past quarter	NA		District records	0	50	100	150	200	250	300	Y	N	Y - over program term	The Union and World Vision India	These targets are for a total of 374 districts.
4.2	All care providers (PPM / ISTC)	Number of additional rural healthcare providers collaborating with the RNTCP on TB referral/treatment in selected districts	NA		Management reports of the PR	0	0	748	1496	2244	2992	3740	Y	N	Y - over program term	The Union and World Vision India	For a total of 374 districts, assuming 10 rural healthcare providers per district successfully access RNTCP schemes.