

SECTION I: Executive summary of Proposal

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

General information:

Table I.a

Proposal title (Title should reflect scope of proposal):	Expansion of Effective Public and Private Sector Interventions in HIV, Tuberculosis, and Malaria Prevention and Treatment in India			
Country or region covered:	INDIA			
Name of applicant:				
Constituencies represented in CCM (write the number of members from each Category):	8	Government – Health Ministry	4	UN/Multilateral agency
		Government – Other Ministries	2	Bilateral agency
	4	NGO/Community-based organizations	1	Academic/Educational Organizations
	3	Private Sector		Religious/Faith groups
	1	People living with HIV/TB/Malaria		Other (please specify):
If the proposal is NOT submitted through a CCM, briefly state why:	Submitted through CCM			

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund¹:

Table I.b

			Amount requested from the GF (USD Millions)					
			Year 1	Year 2	Year 3	Year 4	Year 5	Total
Component(s)	X	HIV/AIDS	9.02	17.09	25.12	24.10	24.74	100.08
(mark with X):	X	Tuberculosis	7.43	5.33	5.53	5.38	5.43	29.10
	X	Malaria	18.30	13.72	12.47	12.65	13.07	70.22
	X	HIV/TB	1.25	4.64	10.10	13.20	17.10	46.27
		Total	36.00	40.78	53.22	55.33	60.34	245.67
Total funds from other sources for activities related to proposal ^{1,2}			80.11	83.23	89.48	97.48	—	

¹ Year 5 extends into the 11th 5 year plan, outlays for which have not yet been finalized

² Refer to Question 31 for explanation by component

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

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

According to national epidemiological profile/characteristics

If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.

^{***} This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

Brief proposal summary

HIV/AIDS Component

HIV prevention and care for mothers, their families and PLWHA through scaling up PMTCT services and public private sector antiretroviral treatment

Goal

The goal is to reduce the spread of HIV infection in women, their partners and infants, and to provide HIV/AIDS care including anti-retroviral treatment.

Objectives

1. To scale up prevention and care interventions among women of child-bearing age and their families through providing a package of primary prevention, family planning, voluntary counseling and testing, anti-retroviral prophylaxis, and counselling on infant feeding.
2. To implement a comprehensive HIV/AIDS care package including anti-retroviral treatment for HIV-infected mothers, their infants and partners.
3. To enhance access to anti-retroviral treatment through public-private partnerships.

Broad areas of activities

- Training health care providers from public and private institutions on HIV prevention, PMTCT and HIV/AIDS care including provision of anti-retroviral treatment.
- Training laboratory technicians and counsellors on voluntary HIV testing and confidential counselling
- Strengthening antenatal clinics to provide HIV prevention counselling and PMTCT
- Providing anti-retroviral treatment for eligible HIV+ mothers and their families through the national program and for PLWHA through a public private partnership with 4 pharmaceutical companies. Establishing quality control programs in laboratories for monitoring of anti-retroviral treatment.
- Establishing linkages to medicine departments and NGOs for continuity of care in the community
- Developing a communication strategy to ensure effective and regionally appropriate messages for HIV/AIDS prevention and care.

Expected results

- PMTCT program is being implemented in 444 public and private sector institutions.
- More than 80% of HIV+ pregnant women have an opportunity to receive anti-retroviral prophylaxis
- By 2008, the percentage of HIV+ infants born to HIV-infected women decreases to less than 10%. Potentially 70,000 infant infections are averted
- Public and private sector health care providers provide appropriate care and anti-retroviral treatment to PLWHA
- HIV positive mothers, their children and their partners receive anti-retroviral treatment through the national programme.
- PLWHA receive appropriately prescribed and monitored anti-retroviral treatment in the private sector.
- Continuity of care is established between the health facilities and community through links between national programmes and NGOs. Stigma and discrimination are reduced. Information is available so that the program can be further scaled up in the public and private sectors.

Direct beneficiaries

- More than 7 million pregnant women and their families will receive HIV prevention counseling and be offered HIV testing every year
- 350,000 HIV+ pregnant women will be offered anti-retroviral prophylaxis and they and their families will be linked to HIV/AIDS care.
- 4,500 HIV+ women and families will be offered anti-retroviral treatment
- 15,000 PLWHA will receive quality anti-retroviral treatment and care in the private sector
- 2,220 Health care providers in public and private sectors and 1,300 NGOs will receive HIV/AIDS training especially in AIDS care.

Indirect beneficiaries

Communities and families of people living with HIV/AIDS, through the reduction of the adverse economic and social impact.

Brief proposal summary

TB Component

Expansion of the Revised National Tuberculosis Control Programme to the “uncovered” 110 million population of the states of Bihar and Uttar Pradesh and strengthening of DOTS in the urban slums in 4 major cities of India.

Goal

The goal is to achieve by 2005, nationwide coverage under RNCTP with DOTS strategy, which focuses on establishing sustainable technical, managerial and organizational infrastructure. The programme will continue to seek to achieve at least 85% treatment success and at least 70% detection of new smear positive cases in order to reduce morbidity, mortality and disability due to tuberculosis (TB), so that TB ceases to be a significant public health problem.

Objectives

1. To expand RNTCP to the “uncovered” population of 110 million in 56 districts of the States of Bihar and Uttar Pradesh, so as to ensure nationwide coverage by 2005.
2. To achieve at least 85% successful outcome of treatment amongst registered new smear positive pulmonary TB cases by 2005
3. To achieve a case detection rate of at least 70% of the estimated new smear positive pulmonary TB cases existing in the population by 2005
4. To establish model “Urban TB Control Projects” in 4 major cities of India by improving the quality and reach of RNTCP to special groups like slum dwellers and migrants, through more “patient-friendly” treatment observation, involvement of private and NGO sectors and IEC.

Broad areas of activities

- Expansion of the RNTCP to the “uncovered areas of Bihar and Uttar Pradesh (110 million), including both preparatory activities prior to starting of service delivery and implementation and maintenance of quality TB services activities thereafter
- Improvement of quality and reach of RNTCP through availability of free and uninterrupted high quality TB diagnostic and curative services, more “patient-friendly” treatment observation, greater involvement of other government, private and NGO sectors in the RNTCP, and enhanced IEC.

Expected results

- Achievement of nationwide RNTCP coverage by 2005
- Achievement of global targets of TB control of at least 85% treatment success rate and at least 70% case detection rate of new smear positive pulmonary TB cases
- Increase reach of RNTCP by making DOTS more accessible and acceptable among disadvantaged urban poor population, thereby supplementing the effort of the GOI in achieving global targets of TB control

Direct beneficiaries

- Additional 110 million population in 56 districts having access to DOTS
- >600,000 patients initiated on treatment
- >108,000 lives saved
- >1,200,000 individuals spared from becoming infected with TB

Indirect beneficiaries

- Thousands of families will be prevented from falling into the cycle of debt and poverty caused by a family member having TB.
- The community at large will have access to free and uninterrupted high quality diagnostic and curative TB services
- Returns of cured TB patients to productive employment will significantly improve the economy of the 2 States

Brief proposal summary

Malaria Component

Malaria control by supplementing and upscaling community based interventions

It is proposed to undertake comprehensive malaria control efforts covering 49 highly endemic districts spanning 5 states in India, which would cover about 85 million population. Following are the goal and objectives:

Goal

The goal is to reduce the burden of malaria and associated deaths in forty-nine endemic districts in India, and thereby improving the socio-economic status of the community

Objectives

1. To enhance access to malaria diagnosis and treatment through community based actions
2. Integrated vector control through partnership
3. To strengthen epidemic preparedness and rapid response
4. To build capacity & improve programme management.

Broad areas of activities

- Expanding the outreach services through community malaria volunteers/ community link volunteers
- Social Marketing of insecticide treated bed nets
- Developing and operationalizing of an action plan to control an outbreak / epidemic through a designated rapid response team
- Enhancing training activities for all programme functionaries; community volunteers; NGOs, private partners in related field etc.

Expected results at the end of five years

- 22 million additional people would have access to Early Diagnosis Preventive Treatment (EDPT)
- 7.5 million people would be protected through use of insecticide treated bed nets (ITN)
- 951 Primary Health Centers would be equipped to effectively handle cases of severe and complicated malaria.
- A cumulative reduction of malaria morbidity by 85 % would be achieved by the end of five years. This would translate into prevention of 374000 cases in five years.

Direct beneficiaries

The main beneficiaries would be the 85 million population of the project area.

Indirect beneficiaries

Additionally the neighboring populations will indirectly benefit by prevention of entry of new parasite strains. These districts are primarily rural and malaria control would benefit the poor farming populations, labor for agriculture / industry and the high-risk groups (pregnant women, children and migrants). Malaria control will increase household income and bring prosperity in the neglected and backward areas.

Brief proposal summary

HIV TB Component

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

Goal

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

Objectives

1. To promote utilisation of TB diagnostic and treatment services by HIV-TB co-infected persons at the sub-district level
2. To prevent further spread of HIV in the community by providing counselling, testing services, condom promotion, treatment of STI and treatment of Opportunistic infections for people living with HIV/AIDS
3. To develop partnerships with NGOs / CBOs / Private Practitioners for prevention and control of HIV and HIV/TB at the community level.

Broad areas of activities

- Establishing VCTCs at the sub-district level in a phased manner where RNTCP infrastructure in the form of TB diagnostic and treatment units already exist and establishing referral linkages with the TB control programme in all districts of the six high burden States by the year 2008.
- Improving the quality and reach of NACP through training of medical and paramedical workers, counselling, condom promotion, providing basic drugs for treatment of opportunistic infections and sexually transmitted infections, and developing referral linkages with care: Governmental and non-Governmental
- Mobilizing Communities for optimum utilisation of VCT services with the help of political leaders, NGOs, CBOs, private practitioners and faith-based organizations.

Expected results

- Early detection of TB in people living with HIV/AIDS and early initiation of therapy leading to a decrease in TB related morbidity, mortality and improvement in quality of life
- Prevention of further spread of HIV in the community by counselling, STI treatment, and condom promotion of HIV positive and HIV negative individuals
- Integration of HIV/AIDS programme activities within the health care system
- Improved case detection by the TB control programme as a result of referral linkages with the VCTCs.

Beneficiaries

People living with HIV/AIDS. There were an estimated 460,000 adults who were living with HIV in the rural communities of the six high burden States in 2001 who will be provided access to services under this component. Promotion of early diagnosis and treatment of TB, provision of treatment services for other opportunistic infections and sexually transmitted infections will lead to a decrease in morbidity and improvement in the quality of their lives.

People with risk behaviour, by provision of counseling services, condom promotion and treatment of sexually transmitted infections. In the six high HIV burden States, an estimated 3.88 million with risk behaviour will be provided access to these services out of which 60% i.e. 2.32 million will be targeted by the end of the project period.

Synergies expected from the combination of the components:

Although the HIV/AIDS, Tuberculosis, and Malaria components will be carried out in different areas of India, their implementation will lead to improved quality of life for millions of Indians living in rural and urban poor communities which have traditionally been under served. The reduced disease burden will contribute to improved community health and provide opportunities for individuals and families to lead productive lives thereby contributing to the Government of India's overall goal of reducing poverty nationwide.

Each component will strengthen health service delivery systems. Health and diagnostic facilities will be improved and local skills such as laboratory techniques, patient care and counseling will be strengthened through training and capacity building.

Linkages between programmes on a local and national level will be further strengthened. The TB/HIV component will link the National AIDS Control Programme and The Revised National TB Control Programme at the community level for the first time. Linkages to RNTCP DOTS will be strengthened in the HIV/AIDS component through the continuum of care for HIV-infected pregnant women and their families.

Strategies for involving communities, NGOs and the private sector in meaningful ways for awareness raising, community mobilization and service delivery will be implemented in all four components. Through the CCM, lessons learned from the individual components will be shared. This will improve the activities in each component during the project period and will help inform development of new activities in the future.

SECTION II: Information about the applicant

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

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

Table IIa

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

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

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

Table IIb

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	Yes
b). Has the composition of the CCM changed since the last submission?	No
c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives):	No

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

The Country Coordinating Mechanism for the Global Fund – India.

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

28th December 2001

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

The CCM, established in December 2001, is a new mechanism in India. However, it draws upon membership of different committees that have been set up to coordinate and monitor the national response to HIV/AIDS, tuberculosis and malaria. It provides a forum for strengthening efforts in controlling these diseases. In addition to Government of India representatives, the CCM includes representation from the apex medical research organisation in India i.e. the Indian Council for Medical Research. This is an autonomous body setup under a statute, and the head of the Council is a member of the CCM. There are 4 NGO representatives on the CCM, each of whom brings diverse experience to this body. They have been active in the area of public health for a considerable period of time. The 4 NGOs also represent the 4 different regions of the country – an important consideration in a country of India's size and diversity. The YRG Care focuses on evidence-based research, and care and support for people living with HIV and AIDS (PLWHA). The Sewadham Trust is an NGO which is active in the areas of public health, education and women's development; it also runs hospitals and operates mobile clinics in rural areas. The Vivekanand Education Society works in a number of areas related to prevention and treatment of drug abuse, STD and HIV / AIDS control, and also carries out programmes for women and children. The Voluntary Health Association of India is one of the largest health and development networks in the world and excels at involving communities in the health activities it supports. The private sector is represented on the CCM by the three major industry associations of the country. The Indian Network of Positive People, represented on the CCM is the coordinating body for HIV positive networks in different states of India. The UN and bilateral agencies have been chosen on the basis of their involvement in the 3 disease control programmes in India.

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

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

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

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

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

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

The CCM is to meet as often as required, and has actually held 4 meetings so far. Its functions and responsibilities are included in the order attached. The minutes of the previous meeting are also attached.

The CCM has set up a Task Force to assist in scrutinizing proposals received for inclusion in the CCP, and in drawing up the comprehensive proposal. The Task Force has had two meetings so far and minutes of these meetings are also attached.

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

This submission responds to the immediate requirements of the CCM to address the unmet need for specific components of service delivery in the 3 disease areas that have been previously identified and need additional resources.

In the months ahead the CCM will develop a focused set of strategic priorities for the three diseases for which GFATM funds will be sought in subsequent Rounds. These strategic priorities, and the modalities through which they will be implemented and monitored, will be identified through the following steps. First, a facilitated national consultation will be held in each disease "area". These consultations will include a review of the programme and will yield a series of recommendations in each disease area. The recommendations will then be reviewed by a working group of the CCM (this will include all constituents of the CCM), synthesized, and placed within a format that can be submitted for ratification by the full CCM. The recommendations will identify areas of comparative advantage for different service providers (public, private and NGO) in achieving these strategic priorities. Once the priorities have been identified, formulation of candidate proposals will pursue an identified process route.

This will result in a more comprehensive submission to the GFATM, for funding. It will also involve the CCM more directly in monitoring and evaluating both existing and future approved proposals. It is anticipated that this process will start in October 2002 and be completed before the Third Round.

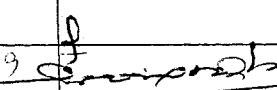
7. **Members of the CCM (Guidelines para. II.16 – 22):**

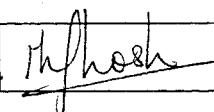
Please note: All representatives of organizations included in the CCM must sign this page to be included in the original, hard-copy proposal sent to the Secretariat. The signatures must reach the Secretariat before the deadline for submitting proposals.

Please print additional pages if necessary, including the following statement:

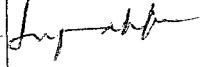
"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the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

Table II.7

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Ministry of Health & Family Welfare (Gov Sector)	Shri S K Naik	Secretary (Health)	24/9/2002	
Main role in CCM				
Heads the CCM and coordinates the work of managers of the various disease control programmes				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
National AIDS Control Organization (Gov Sector)	Smt. Meenakshi Datta Ghosh	Additional Secretary & Project Director	20/9/2002	
Main role in CCM				
Programme Manager of the National AIDS Control Program				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
DIRECTORATE GENERAL OF HEALTH SERVICES (GOVT SECTOR)	DR S P AGGARWAL	DIRECTOR GENERAL OF HEALTH SERVICES	23-9-02	
Main role in CCM				
Heads the technical wing of the CCM integrating inputs of technical managers of the HIV, Malaria and TB programmes				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Ministry of Health and Family Welfare (Gov Sector)	SHRI DEEPAK GUPTA	JOINT SECRETARY	23/9/2002	
Main role in CCM				
Programme manager of the Tuberculosis Control Programme				

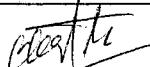
Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Ministry of Health and Family Welfare (Gov Sector)	SMT. BHAWANI THAYAGARAJAN	JOINT SECRETARY	20/9/02	
Main role in CCM				
Programme manager of the Malaria Control Programme				

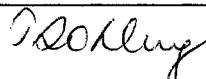
* E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

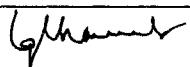
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Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Ministry of Health and Family Welfare (Gov Sector)	Shri Rakesh Behari	Joint Secretary and Financial Advisor	23/3	
Main role in CCM				
Manager of the finances of the CCM				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Indian Council of Medical Research (Research Organisation)	Dr N K Ganguly	Director General	24/3	
Main role in CCM				
Review proposals, and provide recommendations for improvement; identify links to ongoing research				

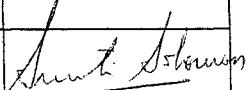
Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Directorate General of Health Services (Gov Sector)	Dr L S Chauhan	Deputy Director General (TB)	20/5 Sept	
Main role in CCM				
Technical manager of the Tuberculosis Control Programme				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Directorate of National Anti Malaria Programme (Gov Sector)	Dr Jotna Sokhey	Director	20/3	
Main role in CCM				
Technical manager of the National Anti-Malaria Programme				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Vivekananda Education Society (NGO)	Shri C G Chandra	Secretary	20 Sept 2002	
Main role in CCM				
Brings NGO perspective of NGOs working with women and children, IDUs. Represents eastern part of country				

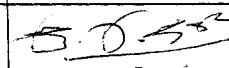
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Agency /Organization (including type*)	Name of representative	Title	Date	Signature
Y R G Care (NGO)	Dr Sunithi Solomon	Director	20/9	

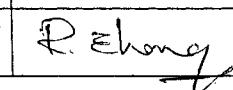
Main role in CCM

Helps evaluate the functioning of the CCM based on experience in epidemiologic surveillance, clinical care and support of people living with HIV/AIDS and PMTCT. Represents southern part of country

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Sevadham Trust (NGO)	Dr S V Gore	Managing Trustee	20/9	

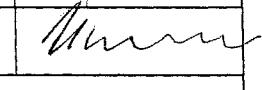
Main role in CCM

Brings NGO perspective of NGOs working with vulnerable including tribal populations. Representative of central India.

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Indian Network for People Living with HIV / AIDS	Shri Illango Ranchander	Treasurer	20/9	

Main role in CCM

Represents the concerns and interests of people living with HIV/AIDS in India

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Voluntary Health Association of India (NGO)	Shri Alok Mukhopadhyay	Chief Executive	20/9	

Main role in CCM

Represents activist umbrella organizations of NGOs working at the grass-roots in different parts of India. VHAI will help monitor the sustainability, cost effectiveness of the projects and good governance of the CCM

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Federation of Indian Chambers of Commerce and Industry (FICCI) (Private Sector)	Mr. Vivek Bharti	Advisor	20/9	

Main role in CCM

Represents the private sector on the CCM

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
Confederation of Indian Industries (CII) (Private Sector)	Dr. Sandhya Bhalia	Programme Director India Business Trust for HIV/AIDS	20/9	

Main role in CCM

To foster collaboration between the CCM and private sector industries

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The Associated Chambers of Commerce and Industry of India (ASSOCHAM) (Private Sector)	Shri Sanjay Bechan	Adviser, Projects	23/09/02	<i>Sanjay Bechan</i>
Main role in CCM				
To foster collaboration between the CCM and private sector industries				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
UNAIDS	Dr David Miller	Senior Country Program Advisor	23.09.02	<i>David Miller</i>
Main role in CCM				
Provide technical support for proposal development, review and monitoring				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
DFID (Bilateral)	Mr Tim Martineau	Senior Advisor, Health	23.09.02	<i>Tim Martineau</i>
Main role in CCM				
Provide technical inputs and represent DFID on CCM, to help identify gaps and areas of synergy				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
USAID (Bilateral)	Dr Victor Barbiero	Director- Population, Health and Nutrition, India	9/23/02	<i>Victor Barbiero</i>
Main role in CCM				
Provide technical inputs and represent USAID on CCM, to help identify gaps and areas of synergy				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
World Bank	Dr K Sudhakar	Senior Public Health Specialist	23/09/02	<i>Sudhakar</i>
Main role in CCM				
Provide technical inputs, monitoring and represent World Bank on the CCM, to help identify gaps and areas of synergy				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
WHO	Dr T Walia	Acting WR (India)	23/09/02	<i>T. Walia</i>
Main role in CCM				
Provide technical input to proposal development and monitoring and to help identify gaps and areas of synergy for projects				

Agency/Organization (including type*)	Name of representative	Title	Date	Signature
UNICEF	Dr Maria Calivis	Country Representative	23/09/02	<i>Maria Calivis</i>
Main role in CCM				
Provide technical input to proposal development and monitoring, in particular women and children and to integrate CCM activities with UNICEF supported projects in India				

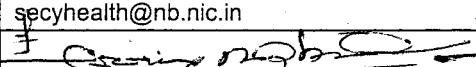
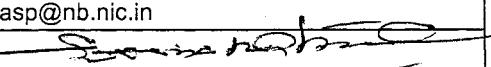
7.1 Provide as attachment the following documentation for private sector and civil society CCM members:

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

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

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

Table II.8

	Chair of CCM	Alternate Chair/Vice-Chair
Name	Shri S K Naik	Shri G R Patwardhan
Title	Secretary (Health)	Special Secretary (Health)
Address	Nirman Bhavan, Maulana Azad Road New Delhi	Nirman Bhavan, Maulana Azad Road New Delhi
Telephone	91 11 3018863	91 11 301 7451
Fax	91 11 3014252	91 11 301 7975
E-mail	secyhealth@nb.nic.in	asp@nb.nic.in
Signature		

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

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

Table II.9

	Primary contact	Second contact
Name	Shri Deepak Gupta	Shri N S Kang
Title	Joint Secretary, Ministry of Health	Director (Finance), NACO
Address	Nirman Bhavan, Maulana Azad Road New Delhi	9 th Floor, Chandralok Building 36, Janpath, New Delhi
Telephone	91 11 3019195	91 11 3731780
Fax	91 11 3018842	91 11 3731746
E-mail	jsd@nb.nic.in	nskang@vsnl.net

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

Not Applicable.

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

Not Applicable.

11. Sub-national Proposal from Large Countries

Not Applicable.

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

Not Applicable.

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

Not Applicable.

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

Not Applicable.

Non-CCM applicant

12. Name of applicant:

13. Representative of organization applying:

Table II.13

Representative	Alternate
Name	
Title	
Address	
Telephone	
Fax	
E-mail	

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

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

Table II.14

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

15. Description of applying organization

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

Table II.15.1

<input type="checkbox"/> Non-Governmental Organization (NGO) or network of NGOs
<input type="checkbox"/> Community based Organization (CBO) or network of CBOs
<input type="checkbox"/> Private Sector
<input type="checkbox"/> Academic/ Educational Sector
<input type="checkbox"/> Faith-based Organization
<input type="checkbox"/> Regional Organization
<input type="checkbox"/> Other (please specify):

15.2. Provide as attachment the following documentation:

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

16. Justification for applying outside the CCM

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

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

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

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

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

SECTION III: General information about the country setting

Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country.

For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.

18. **Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria:** (Describe current epidemiological data on prevalence, incidence or magnitude of the epidemics; its current status or stage of the epidemics; major trends of the epidemics disaggregated by geographical locations and population groups, where this data is available and/or relevant; *Guidelines para. III.37 – 38*), (1 – 2 paragraphs per disease covered in proposal):

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

HIV/AIDS

With an estimated 3.97 million people infected with HIV (0.8% of the adult population, age 15-49), India has the second highest number of people living with HIV in the world after South Africa and the highest number in South Asia. HIV/AIDS in India accounts for nearly 10% of the global HIV/AIDS burden and 68% of the total burden for South Asia. Given India's large population, a mere 1 percent increase in HIV prevalence increases the number of people infected with HIV by around 5 million.

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

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

One in four reported AIDS cases is among women. The National AIDS Control Organisation (NACO) estimated that in 2001, of the 27 million annual pregnancies in India, at least 100,000 occurred in HIV positive women. This leads to an estimated annual cohort of 30,000 infected babies and 70,000 future uninfected orphans. UNAIDS estimates that approximately 170,000 children in India under age 15 were living with HIV/AIDS at the end of 2001 [UNAIDS 2002].

TUBERCULOSIS

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

On an average, a TB patient loses three to four months of wages, equivalent to 20-30% of annual household income thereby making the poor poorer.⁵ Each year more than 300,000 children are estimated to leave school because of their parents' TB, and more than 100,000 women with TB are rejected by their families.⁴

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

Unless urgent and effective action is taken, approximately 10 million people will die of TB in India over the next 20 years. The rate at which Revised National TB Control Program (RNTCP) expands over the next few years will markedly change the number of new TB cases at any level of HIV prevalence⁷.

MALARIA

India contributes to almost three-fourths of all cases of malaria in the South-East Asia Region, with 2 to 2.5 million new cases and 1,000 deaths yearly. Annual lost income due to malaria was estimated at 0.5 to 1.0 billion USD in 1993. After a significant decline in the 1960s, malaria reemerged as a major health problem in the late 1970s and still poses a major health challenge. Growing industrialization, urbanization, de-forestation and natural disasters such as earthquakes, floods and cyclones provide an environment for continued spread. Efforts to control malaria through spraying of insecticides have not been successful due to limited coverage.

Tribal and marginalized populations, women and children are particularly vulnerable to infection. First reported in the North-Eastern state of Assam in 1973, drug resistance has become a problem throughout India, further complicating control efforts.

49 districts in five states represent 22% of the reported cases of malaria in 2001 and are among the most affected areas in the country. Forty percent of the cases are due to *P. falciparum* resulting in high mortality.

- 19. Describe the current economic and poverty situation** (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases; *Guidelines para. III.39*, (1–2 paragraphs):

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

Table III 19.1

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

* 64.6(RGI) in NHP 2002

1: *HDR 2002: Human Development Report, UNDP, 2002*

2: *WDR 2001/02: World Development Report, 2002*

3: *HP 2002: National Health Policy 2002*

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

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

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

The National Health Policy gives strong importance to ensure equitable access to health services to foster equitable development and growth and alleviate the impact of the high burden communicable diseases including TB, HIV/AIDS and malaria. To respond more effectively separate programmes and agencies were formed within the Health Ministry.

HIV / AIDS

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

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

Several Chief ministers from high HIV prevalence States are regularly monitoring the epidemic and efforts made to combat it. A Government – Business Partnership on HIV/AIDS spearheaded by the Prime Minister was initiated in December 2000. A Parliamentarians Forum that reaches out to all Members of Parliament, State legislators and elected representatives at the grass roots has been established.

TUBERCULOSIS:

From a limited coverage of 18 million people in 1997, today more than 495 million people are covered under the Revised National TB Control Program (RNTCP). Budgetary allocations for TB Control have increased from \$ 10.8 million in 1996 -1997 to \$ 28.3 million in 2001- 2002. With assistance from DANIDA, DFID, GFATM and the World Bank, the RNTCP plans to expand to 85% of the country by 2004.

Recognizing the need for the entire country to be brought under RNTCP, in order to effectively control TB, the Government of India is taking steps for 100% coverage by 2005. There is commitment to the tuberculosis control at all levels in India as evidenced by the Prime Minister A.B.Vajpayee who stated that "India has taken great strides towards control of tuberculosis. The Revised National Tuberculosis Control Programme has expanded rapidly and with good quality".

MALARIA:

The National Malaria Control and Eradication Programme was launched in 1953. Today, the National Anti Malaria Programme (NAMP) is one of the largest health programmes of the government. The Government of India (Centre and State) contributes about 37 million USD annually towards malaria control which is about 35% of the central and state health budgets.

Additional support of USD 184 million has been obtained from the World Bank for the Enhanced Malaria Control Project (EMCP) to protect 67 million tribal people living in 8 states (100 districts/1045 primary health centers). EMCP has been in operation since September 1997.

The Prime Minister of India has identified malaria for the mission mode project to be monitored from the office of the Prime Minister. Malaria control is a component of sanitation in the national development plan and appropriate legislative measures are in place in urban areas for malaria control. Municipal bylaws have been amended for controlling malaria.

21. Financial context

21.1. Indicate the percentage of the total government budget allocated to health*:

Central Government	1.3%
State Governments	5.5%

In the aggregate, spending on health exceeds 6% of the total government budget. Under the Indian Constitution, health is a State subject and largely within the jurisdiction of State governments.

21.2. Indicate national health spending for 2001, or latest year available, in the

Table III.21.2¹

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

¹Source: Derived from the National Health Policy 2000

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

21.3. Specify in Table III.21.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors):**

Table III.21.3

Total earmarked expenditures from government, external donors, etc. Specify Year:2002-2003 (current budgetary outlay)	In US dollars:
HIV/AIDS	47 million
Tuberculosis	24 million
Malaria	49 million
Total	120 million*

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

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

HIV/AIDS

In 1999 India initiated Phase II of the National AIDS Control Program based on lessons learnt from Phase I. The World Bank supports the implementation of the National AIDS Control Programme in India by providing a loan of US \$191 million. Bilateral donors such as USAID, DFID, CIDA are supporting AIDS prevention programmes in the States of Tamil Nadu, Maharashtra, Andhra Pradesh, Gujarat, Kerala, Orissa, Karnataka and Rajasthan. These programmes strengthen central and state responses particularly for IEC, targeted interventions and care for people living with HIV / AIDS through treatment of opportunistic infections.

TUBERCULOSIS

Though the National TB Control Programme started in India in 1962, it had limited success. A review in 1992 concluded that the problems associated with the programme related to shortages and irregular supply of drugs, absence of supervision for completion of treatment, poor diagnosis, shortage of resources and emphasis on detecting cases rather than completion of treatment. The Revised National TB Control Programme through the implementation of the DOTS strategy was adopted to remove these problems.

The Revised National TB Control Programme (RNTCP) is being supported with a soft loan of US \$142.4 million from World Bank since 1997. In addition DANIDA and DFID are supporting the programme in the States of Andhra Pradesh and Orissa respectively.

By June 2002, India has made DOTS accessible to 480 million people, making it the second largest DOTS programme in the world. A total of 800 million people will be covered by DOTS under the RNTCP by 2004 and the whole of country is likely to be covered by 2005.

The RNTCP has achieved cure and treatment success rates consistently above 80% compared with fewer than 4 out of 10 in the previous programme. Every month, more than 50,000 patients are now being placed on treatment saving more than 9,000 lives and there has been a 7-fold reduction in TB death under RNTCP. Since its inception, RNTCP has initiated over 1.2 million patients on treatment, saved more than 200,000 lives and prevented 2.4 million infections.

MALARIA

The malaria programme has received external support for many years. Malaria control has been supported from 1977-1988 by the Swedish International Development Assistance and from 1994-1999 by the ODA/DFID project on malaria control in Surat City, Gujarat.

Currently (1997-2003), the Enhanced Malaria Control Project is partially supported by a World Bank loan to control malaria in 67 million people living in predominantly tribal areas. These projects have provided important information on the epidemiology and control of malaria and

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

have helped build capacity to reduce the incidence and mortality of malaria, delayed the spread of *P. falciparum* and the onset and dissemination of drug resistant parasites. These projects also supported operations research which demonstrated the useful role of insecticide treated nets in malaria control.

22. National programmatic context

- 22.1. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.), (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

Human resources and health infrastructure

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

HIV/AIDS

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

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

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

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

Mechanism to Channel Funds

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

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

TUBERCULOSIS

At the central level, the RNTCP is managed by the Directorate General for Health Services (DGHS), the Technical Arm of the Ministry of Health and Family Welfare (MOHFW). The program is supported such as the National Tuberculosis Institute (NTI), Bangalore, the Tuberculosis Research Center (TRC) and the Lala Ram Swarup Institute of TB and Allied Diseases (LRS).

Central activities focus on capacity enhancement of States and Districts, including training in managerial and financial matters, provision of technical advice, monitoring of trends, quality assurance, evaluation of programme performance, identification and dissemination of lessons learned.

State Tuberculosis Control Societies (STCS) and District Tuberculosis Control Societies (DTCS) have been formed to implement and monitor activities locally. Subdistrict TB Units (TUs) have been established for every 500,000 population to serve as a link between the district level and the periphery. At the TUs, a Senior Treatment Supervisor and Senior Tuberculosis laboratory Supervisor carry out supervisory work. To further decentralize diagnostic and treatment services, Microscopy Centres (MCs) have been established for every 100,000 population or 250,000 and 50,000 populations respectively in hilly/ difficult areas and for tribal population. All supervisory staff has access to vehicles.

At the state level implementation responsibility lies with the State TB Officer. In all major States, the NTP is supported by State TB Demonstration and Training Centers (STDC) for training and research to supplement the work of the Central Training Institutions. The Director of Medical Services and the Director of National Programs are responsible for overseeing implementation. At the District level, the District Tuberculosis Officer (DTO), under the direction of the District Medical Officer, is responsible for implementation through the General Health Care System.

More than 500 Non Governmental Organisations (NGOs) have been actively involved in program activities from awareness generation to forming model DOTS centers. They are encouraged to take up areas, especially where there is poor governmental health infrastructure. Private practitioners are being encouraged to participate in referral services and for DOT provision.

Mechanisms to channel funds

State Tuberculosis Control Societies maintain separate bank accounts for TB project funds. Financial accounts are computerized and a panel of chartered accountants conduct audits at state and district societies.

MALARIA

Malaria control has been decentralized to the state health departments. Program implementation is carried out with technical assistance of the National Anti Malaria Program (NAMP) consisting of the programme director and 17 Regional Directors.

At the state level the program is supported by a program officer and at the district level, Malaria Offices have been established for planning and monitoring of the programme. At present, 565 District Malaria Units are functioning.

Programme interventions include early case detection and prompt treatment (EDPT), containment of epidemics, selective Vector Control, promotion of personal protection methods, IEC (Information, Education and Communication) for personal prevention, community participation, institutional and management capacity building, trained manpower development and efficient Management Information System (MIS).

Primary Health Centres are the basic units in rural area for programme implementation in an integrated manner. Passive surveillance is carried out at all levels where patients may be seen for care including Primary Health Centres (PHCs), Malaria Clinics, Community Health Centres (CHC) and secondary and tertiary level Health institutions.

Mechanisms to channel funds:

Both the central and state governments contribute to the budget for malaria control. The central government meets logistic requirement and procures material and equipment and the state governments meet the operational cost. Under the World Bank assisted project, the funds are channeled through state / district malaria societies. The societies are autonomous institutions chaired by district collectors / deputy commissioners.

22.2. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes :
HIV/AIDS

Table III. 22.2

Name of Agency	Type of Agency (e.g., Government, NGO, private, bilateral, multilateral, etc.)	Main programs (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	Budget (Specify time period)
NACO: -Govt. of India -IDA Credit	Government	Comprehensive HIV/AIDS prevention	\$38.8 million \$191 million (1999-2004)
USAID	Bilateral	Comprehensive HIV / AIDS Control in States of Tamil Nadu, Maharashtra (APAC & AVERT projects)	\$51.5 million (1999-2004)
DFID	Bilateral	Prevention and control of HIV/AIDS and other sexually transmitted infections in States of Andhra Pradesh, Gujarat, Kerala, Orissa (PSH project)	\$21.67 million (1999-2004)
CIDA	Bilateral	Comprehensive HIV / AIDS control in Rajasthan and Karnataka	\$7.7 million (2001 – 2006)
UNDP	Multilateral	Strengthening effective responses to HIV/AIDS in 6 states	\$1.5 million (2002-2004)

** For NGOs, specify here your own partner organizations

TUBERCULOSIS

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

* Decision regarding disbursement mechanism pending

MALARIA

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

Note: For all 3 disease programmes, HIV/AIDS, Tuberculosis and Malaria, existing resources of the respective State governments, e.g. infrastructure and personnel, are being utilized. These have not been costed.

- 22.3 Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

HIV/AIDS

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

Several programmatic gaps remain including the need for:

1. Scaling up targeted interventions to increase coverage among high risk groups.
2. Expanding VCTCs in high prevalence areas and rural communities.
3. Building capacity for use of ARVs in the public and private sector. Although there are 11 anti-retroviral drugs available in the country, most people living with HIV/AIDS cannot afford them and none are available through the national program.
4. Strengthening capacity in the public and private sector for HIV/AIDS care and support including prompt treatment of RTIs, STIs.
5. Scaling up PMTCT in high prevalence areas and building capacity for PMTCT in low prevalence areas.
6. Integrating TB and HIV programmes.
7. Promoting behavior change beyond high risk groups in the general population.

Funding gaps

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

TUBERCULOSIS

The RNTCP is achieving remarkable success. However, certain gaps in the existing programme need to be filled in order to further strengthen the TB control programme.

Programmatic intervention gaps

1. Ensuring DOTS expansion to the entire country as fast as possible, while maintaining the quality and technical excellence. At present 50% of the country still needs to be covered.
2. Building capacity at State level to ensure long term sustainability of the programme.
3. Increasing the reach of RNTCP services, especially to disadvantaged groups, including the growing urban slum population.
4. Involving other government sectors (ESI, Railways, etc.) and the private sector.
5. Improving treatment observation by involvement of community level DOT providers and IEC.

Funding gaps:

At present, nearly 50% of the country is covered by the RNTCP, with funds obligated to expand to 85% by 2004 with DANIDA, DFID, GFATM and World Bank assistance. The entire country is to be brought under RNTCP as fast as possible in order to control TB and meet the global targets⁹.

MALARIA

India has a large public health infrastructure, which includes Primary, Secondary and Tertiary level health care facilities spread all across the country. Primary Health Centres (PHCs) form the backbone of public health service delivery in India. An ideal PHC is to cover around 30,000 population for the delivery of all Primary Health Care services. These centres act as first referral centres for the community. They are supposed to have provision of basic health services like immunization, antenatal checkup, provision of Blood Smear Examination (BSE) for malaria and provision of treatment. The Government of India spends about 35% of the health budget on malaria control alone. Despite the presence of such a huge infrastructure and major share of budget for malaria, there are major funding gaps in the country's response to malaria control.

Funding gaps:

Due to limited funds, the majority of malaria control staff has not received formal training and small hospitals in malaria endemic areas are not fully equipped. These gaps could be filled by expanding training programmes and strengthening infrastructure.

The stratification of the country based on receptivity of malaria and level of intervention is presented in table 3 below. 80% of the population live in areas either free of malaria transmission or where the malaria situation is manageable with national program inputs (category A). The remaining 20 % live in areas of high malaria transmission. Funding is available to support malaria control efforts for 11 % (category B and C). For the remaining 9 % (category D) there is no funding available.

Receptivity of malaria and level of intervention in India

Table 22.3

Category	Areas in the country	Population Million	Current Strategy	Gaps	Remarks
A	Hilly areas	50	Surveillance	-	No transmission
A	Towns	250	Sanitation and mosquito control	Planning, Health Impact Assessment and larval control	Urban malaria control strategy is partially effective
A	Low endemic areas	150	Surveillance, Focal spray	Nil	Strategy is effective
A	Moderately endemic areas	165	Surveillance, DDT spray		Strategy is effective
B	North Eastern states	50	Surveillance/ DDT spray	Nil	100% centrally sponsored scheme
C	Predominantly tribal areas	70 (100 districts)	Surveillance/ DDT spray	Nil	EMCP through WB loan
D	Rural areas	85 (49 districts)	IRS/ITN	Insecticide Treated nets EDPT (see notes below)	Highly receptive areas without any additional external sources

SECTION IV – Scope of proposal

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

Table IV.23

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

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

Rationale

HIV prevalence exceeds 1% and is as high as 5% in some areas in 6 states which have a combined population of 291 million. Almost 90% of all PLWHA in India live in these states. The impact of the epidemic is now being seen in children due to vertical transmission of HIV, with increasing under-5 mortality rates. Every year, more than 92,000 HIV infected women give birth. UNAIDS has estimated that there are already 170,000 HIV infected infants in India, and that many more (340,000) are, or will soon be orphans. Although prevention of mother to child transmission (PMTCT) was not a strategic priority in the Phase II National AIDS Control Program, the Government of India (GOI) in collaboration with UNICEF, carried out feasibility studies which demonstrated it is possible to implement PMTCT in the public sector. Significantly, these studies also found that PMTCT programs provided opportunities for HIV prevention counseling and STI diagnosis and treatment for the 98-99% of pregnant women who were uninfected.

More than 7 million women, including 92,000 HIV infected women, give birth every year in the 6 high prevalence states. The PMTCT feasibility program, which was initiated in 11 Centres urgently needs to be scaled up in order to prevent primary HIV in women and to provide HIV-infected women access to PMTCT in order to prevent vertical transmission of HIV. The program which is being proposed for implementation in this component was developed by WHO, UNICEF, UNFPA, and UNAIDS and includes the following 4 elements:

First, primary prevention of HIV infection especially in women. **Second**, prevention of unintended pregnancies. Reproductive health services, including family planning, are extended to all women, including women infected with HIV. The **third** component is directed at the many women whose HIV infection is identified only when they are already pregnant and for whom specific interventions are available to prevent ongoing transmission to their infants, including use of anti-retroviral (ARV) drugs, safer delivery practices, counselling for infant feeding and support. **Finally**, it is now accepted that there is an ethical imperative to provide HIV-infected women who enter these programmes and their families HIV/AIDS care and support services.

As the epidemic is maturing in India there are a growing number of people living with HIV who require care and anti-retroviral treatment (ART). Of the approximately 4 million HIV infected persons in India, 0.6 million are estimated to be eligible for ART (CD4 count <200) (*Hira et al, The Natural History of HIV in Mumbai, 2001*). It is estimated that half (0.3 million) know their HIV status but that only 1,500 are currently receiving ART in keeping with established guidelines. An additional 8 -10 thousand are transient users or poorly adherent, according to a leader of the Indian pharmaceutical industry. For this project, four drug manufacturers have agreed to participate in a graduated cost recovery programme. Importantly, this will facilitate PLWHA being followed in the private sector access to ART at reduced cost, in an environment where standard guidelines are followed. This innovative partnership will enable at least 15,000 PLWHA to gain access to ART. There is danger however, that expanded availability of ART may lead to increased risk-taking, setbacks in prevention programmes, and potentially an acceleration of the HIV epidemic as has occurred in other settings. Therefore, links with NGOs to reinforce prevention messages will be developed.

GOAL

To reduce the spread of HIV infection in women, their partners and infants, and to provide care including antiretroviral treatment.

OBJECTIVES

- 1:** To scale up prevention and care interventions among women of child-bearing age and their families through providing a package of primary prevention, family planning, voluntary counseling and confidential testing (VCT), ARV prophylaxis, and counseling on infant feeding. The activities that will be carried out to achieve this objective are: (a) to scale up implementation of the PMTCT interventions from 81 public sector hospitals to 444 public and private, tertiary and secondary health institutions; (b) to train Maternal Child Health (MCH) personnel in PMTCT in order to integrate activities into the Reproductive and Child Health (RCH) Programme; (c) to establish linkages to HIV/AIDS care in communities and institutions (d) to design a communication strategy to improve women's access to MCH services, including PMTCT; and (e) to document successful strategies and lessons learned from the scale up through ongoing monitoring and evaluation and operations research studies.

Expected results are: (i) more than 7 million pregnant women/year will become aware of strategies that they can take to remain uninfected and have access to condoms and STI diagnosis and treatment; (ii) a network of 444 institutions providing HIV prevention counselling and PMTCT interventions is established; (iii) 2,220 public and private sector MCH health care workers will have been trained in communication, counseling, HIV testing, administration of Nevirapine to mother and baby pairs, and in providing care and support for HIV/AIDS; (iv) reduction in the number of infants with maternally acquired HIV infection through ARV prophylaxis is reduced to less than 10,000/year

- 2:** To implement a comprehensive HIV/AIDS care package, including antiretroviral treatment for HIV-infected mothers, their infants and partners.

The activities that will be carried out to achieve this objective are: (a) to build the capacity of 11 PMTCT Training and Resource Centers to provide treatment, including ART to HIV positive mothers and families; (b) to strengthen follow up and referral services for improved management of HIV positive mothers, their infants and families; (c) to strengthen laboratory facilities for monitoring the response to ART; (d) to establish linkages between the PMTCT Training and Resource centers, PLWHA networks and NGOs for follow-up, counseling and continuum of care and support in the community for mothers, children and their families. (e) to scale up the program to other institutions in the 6 high prevalence states

Expected results are: (i) Strengthened capacity of health care workers to manage HIV positive women, their infants and families; (ii) Access to ART without stigma and discrimination for HIV positive mothers, children and families; (iii) Improved follow up and acceptance of ART for HIV infected mothers and their families (total 10,000); (iv) Continuum of care in the community for HIV infected mothers and their families; and (v) evidence-based strategy for scaling up developed

- 3:** To enhance access to anti-retroviral therapy through public / private partnership.

The activities that will be carried to achieve this objective are: (a) to set up a graduated cost recovery scheme in 4 private sector institutions for ART in collaboration with 4 Indian pharmaceutical companies; (b) to monitor adherence and viral resistance in patients receiving ART; (c) to establish public private partnership for monitoring response to ART by CD4 counts for PLWHA receiving care in the private sector; (d) to scale up the program

Expected results are: (i) ongoing partnerships between government, NGOs, private sector and pharmaceutical companies. (ii) 15,000 HIV-infected individuals receiving structured ART. (iii) a feasible and sustainable program in which PLWHA with low and moderate incomes will be able to afford quality HIV/AIDS care, including ART, in the private sector.

Implementation strategies & partners involved

A multi-sectoral, decentralized, phased and incremental approach has been adopted for this programme. The PMTCT programme activities will complement and reinforce those of the National AIDS Control Programme Phase II (NACP II) and be integrated with RCH. Primary health clinics which are the peripheral units of district hospitals will also be involved. Private

hospitals which have at least 100 beds and 1,000 deliveries per year with the necessary infrastructure and staff will be invited to participate in the program. Partnerships with NGOs will extend the outreach to the community. Beginning with 125 institutions in 2003, 444 institutions, from all 35 States and Union Territories will participate in the project by 2008. The 81 medical colleges in high prevalence states will be upgraded to participate in the programme to expand access to ART for mothers and their families.

Institution	Number=444
Medical Colleges in high prevalence states	81
District hospitals in high prevalence states	155
Maternity and private hospitals in high prevalence states	129
Medical Colleges in remaining states	79

Maximum use will be made of the existing health service infrastructure, key institutional strength and capacity for implementing the programme. The eleven medical colleges involved in the PMTCT Feasibility Study have been upgraded and will operate as PMTCT Training and Resource Centers. They have a key role in providing ongoing technical supervision, and monitoring and evaluation and will take the lead for developing locally appropriate models for more complex and high cost interventions, such as ART.

In terms of technical sustainability, the design is built around evidence-based PMTCT interventions and lessons learned during India's PMTCT Feasibility Study. Many of the priority interventions are already elements of the design for a comprehensive RCH programme. The NACP and State AIDS Control Societies (SACSs) will be responsible for coordination, monitoring and evaluation.

Beginning with 4 NGOs and 1000 PLWHA receiving ART in 2003, the cost-recovery program will be scaled up to include more private sector partners and 15,000 PLWHA by 2008. The NGOs have a long history of providing quality HIV/AIDS care and are already providing ART to PLWHA who can afford to pay the full cost. Their experience in working with communities and in providing quality ART will be the basis for programme implementation. The lessons they learn in the first 2 years of the program will inform further scale up. The AIDS Resource and Control Centre (ARCON), Mumbai will be responsible for monitoring and evaluation.

Partnerships

India has the capacity and existing partnerships to channel resources to significantly reduce MTCT within the next three to five years. India's National AIDS Control Programme (NACP II) is well - established, with a decentralised structure and strong partnerships with private and civil society. Part of the cost of the PMTCT programme, including health care personnel and medical supplies, will be funded by NACO. Coordinating meetings will be held on a regular basis between NACO and the Department of Family Welfare (the nodal department for Reproductive and Child Health Programme), in order to ensure smooth integration between programmes.

The State AIDS Control Societies (SACSs), will have responsibility for coordination, monitoring and evaluation, and for channeling funds to local institutions and NGOs. Local technical support for the programme will be provided by UNICEF funded PMTCT Consultants housed in the State 'AIDS Societies in the 6 high prevalence states. Other technical partners include UNICEF, ARCON, the National AIDS Research Institute (NARI) and centrally mandated Technical Resource Groups.

The cost recovery programme for ART in the private sector is an example of a innovative approach to make ART more available, accessible and affordable to PLWHA at all income levels without depending totally on the public health system for resources. This project will involve establishing partnerships in all sectors, public, private and corporate. Ultimately, it's success will depend on the relationships that are established with community groups and PLWHA who will be the end - users of the system.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	April 2003	To (month/year):	March, 2008
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26. Detailed description of the component for its FULL LIFE-CYCLE:

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

The goal of the proposed component is to reduce the spread of HIV infection in women, their partners and their infants and to provide HIV/AIDS care, including antiretroviral treatment.

We propose: (i) to scale up prevention of mother-to-child transmission of HIV programmes in a network of tertiary and secondary level health institutions in high prevalence states and in key medical colleges in low prevalence areas; (ii) to introduce ART in 5 PMTCT Training and Resource Centres and scale up the program to an additional 81 centers in high prevalence states and (iii) to implement a private-public model of HIV/AIDS care and ART beginning with 4 private sector sites and by 2008 reaching 15,000 PLWHA and build capacity for ART in more than 200 institutions by the end of the project.

Table IV 26.1

Goal :	To reduce the spread of HIV infection in women, their partners and Infants, and to provide care including antiretroviral treatment		
Impact indicators (Refer to Annex II)	Baseline	Target (last year of proposal)	
	Year : 2003	Year : 2008	
Prevalence of HIV infection in pregnant women	1.4%*	< 1.0%	
Mother to child transmission rate	30 %**	10%	
% of mothers in programme districts who utilise AIDS care.	NA	70%	
No. of hospitals that are able to provide quality Anti retroviral therapy	8	80	

*HIV seroprevalence among antenatal women in 6 high prevalence states, 2001

**T Jacob John, Indian Pediatrics 2001; 38: 680-683.

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

Specific objective 1:

To scale up prevention and care interventions among women of child-bearing age and their families through providing a package including primary prevention, family planning, VCT, ARV prophylaxis, counseling on infant feeding

Beginning with 125 institutions, the programme will be scaled up to more than 444 public and private institutions by 2008. Most of the institutions will be in the 6 high prevalence states. Through partnerships with private sector and NGOs, 80% of the annual deliveries to HIV infected women in India will be covered, consistent with UNGASS. MCH staff and counsellors in public and private hospitals, and NGOs/CBOs will be skilled in primary prevention and PMTCT. Besides, the quality, accessibility and utilisation of MTCT primary prevention services will be improved.

Table IV.27

Objective 1	To scale up prevention and care interventions among women of child-bearing age and their families through providing a package including primary prevention, family planning, VCT, ARV prophylaxis, counseling on infant feeding, and HIV/AIDS care.					
Outcome/coverage indicators (Refer to Annex II)	Baseline* 2003	Targets				
	Year 1	Year 2	Year 3	Year 4	Year 5	
No. of health facilities providing HIV prevention services which include STI, condom services etc.	125	331	400	420	444	
No. of hospitals providing VCT services to pregnant women and their partners.	125	331	400	420	444	
No. of hospitals providing MTCT prevention to pregnant women	125	331	400	420	444	
% of HIV+ pregnant women receiving nevirapine	70%	75%	80%	90%	95%	

*Feasibility Study of administering short term AZT intervention among HIV infected mothers to prevent MTCT of HIV-India, 2001

- 27.1 Broad activities related to each specific objective and expected output** (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Specific Objective 1:

To scale up prevention and care interventions among women of child-bearing age and their families through providing a package including primary prevention, family planning, VCT, ARV prophylaxis, and counseling on infant feeding Activities:

- (i) **Identification and training PMTCT teams:** Core teams from each of the identified medical colleges, will be trained at one of the 11 Resource and Training Centres on PMTCT. The team will include health care providers from Obstetrics and Gynaecology, Pediatrics, Microbiology, Medicine, Health Education, Counseling and Nursing. A five-day training manual has been prepared and field-tested for this purpose. A core PMTCT team will in turn be responsible for training of PMTCT core teams at district hospitals and maternity hospitals, linked to the Medical College. Prior to initiation of the programme, a full site orientation all staff at participating facilities will be conducted in order to sensitize them about the programme. Emphasis will be placed on confidentiality and non-discrimination.
- (ii) **Training and posting of counselors and laboratory technicians:** One laboratory technician and one counselor will be added to the existing VCT staff at each participating hospital. They will receive a standardized 5 day training course at one of the 11 PMTCT Training and Resource Centers . Particular emphasis will be paid to counseling for infant feeding. Technical supervision and support for MTCT counselors will be set up in Medical Centers.
- (iii) **Strengthening the existing infrastructure:** Antenatal clinics will be strengthened to facilitate group education and to ensure confidentiality during one-to-one counseling sessions. Laboratory facilities will be up-graded to provide quality HIV testing. Linkages and referrals to medicine departments will be established for management of HIV and opportunistic infections as per the National HIV/AIDS Clinical Management Guidelines.
- (iv) **Obtaining supplies:** Procurement of HIV testing kits, nevirapine, and medical supplies will be coordinated through the NACP following existing GOI guidelines for procurement. Drugs for treatment of opportunistic infections, sexually transmitted infections, and post-exposure prophylaxis will be provided as part of the NACP. Regular monitoring of the programme will be carried out to ensure stock outs do not occur.
- (v) **Involving NGOs:** 129 NGOs in the high prevalence states will be given grants to implement PMTCT in privately run hospitals. Projects will include a referral network of follow-up, care and support services for HIV infected women and their families.

- (vi) **Developing an effective communication strategy:** A strategy for communication based on existing information and formative research, supported by UNICEF, will be developed by 2004. It will aim at: (i) raising awareness about PMTCT as a component of MCH services to increase uptake of services by women and their partners; (ii) addressing staff concerns and fears about HIV in order to decrease stigma and discrimination; and (iii) developing innovative approaches to address stigma and discrimination in the broader community.

Table IV.27.a

Objective 1	To scale up prevention and care interventions among women of child-bearing age and their families through providing a package including primary prevention, family planning, VCT, ARV prophylaxis, counseling on infant feeding				
	Broad Activities	Process/Output indicators (indicate one per activity) (Refer to Annex II)	Baseline	Targets	
			(Specify year 2003)	Year 1	Year 2
MTCT prevention education & counselling skills training: MCH staff, private hospital staff & NGOs/CBOs	% of staff trained in HIV prevention/reproductive health/life skills	25%	70%	85%	National AIDS Control Organization; Dept. of Family Welfare; State AIDS Control Societies; NGO partners
Expanding and improving VCT facilities	% of med colleges/district hospitals with VCT facility	30%	50%	90%	-do-
Training laboratory technicians for HIV testing	% of lab staff trained	30%	85%	100%	-do-
Strengthening existing infrastructure Improving RCH services (antenatal, natal, post natal and child health)	% hospitals with improved MCH services	30%	70%	100%	-do-
Obtaining supplies	% of hospitals with nevirapine stockouts	N/A	NIL	Nil	-do-
Increasing participation of NGOs	% of NGOs actively involved in PMTCT	5%	30%	50%	-do-
Developing a communication strategy	Communication strategy ready	N/A	Formative research done	Strategy in place	NACO/UNICEF

27. Objectives and expected outcomes

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

Specific objective 2:

To implement a comprehensive HIV/AIDS care package including antiretroviral treatment for HIV-infected mothers, their infants and partners.

Beginning at 5 of the Resource and Training Centers in 2003, a program to expand PMTCT services to include provision of ART to HIV infected women and their families will be expanded to 81 institutions in the 6 high prevalence states by 2008. More than 4000 HIV infected women and their children and partners (total 10,000) will be placed on ART by 2008. Through establishing linkages with NGOs there will be improved quality, accessibility and utilization of HIV/AIDS care and support services, and information will be available to expand the project to other areas.

Table IV.27.2

Objective: 2	To implement a comprehensive HIV/AIDS care package including antiretroviral treatment for HIV-infected mothers, their infants and partners.				
Outcome/coverage indicators (Refer to Annex II)	Baseline	Targets			
	Year 1	Year 2	Year 3	Year 4	Year 5
Number of facilities with linkages for Treatment of OI.	125	331	400	420	444
No. of health facilities providing the Comprehensive package PMTCT, Care and ART.	5	11	11	45	81
Number of HIV+ mothers receiving ART	220*	650	1300	2800	4000

- 10% of total HIV positive, cumulative/year (feasibility study, 2001)
- Mothers used as indicator of couples and families receiving ART, with family members total estimated to be 10,000).

27. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Specific Objective 2:

To implement a comprehensive HIV/AIDS care package including antiretroviral treatment for HIV-infected mothers, their infants and partners.

Activities:

- i). **Training health care staff and NGOs:** A set of training modules for medical, paramedical and NGOs has already been developed and evaluated. 2200 obstetricians, general practitioners, pediatricians and nursing staff as well as NGOs/CBOs will receive training on management of HIV/AIDS infected women & their families, including rationale use of ART.
- ii). **Strengthening laboratory services:** Existing laboratories will be strengthened to support diagnosis of opportunistic infections and monitoring ART.
- iii). **Improving procurement systems and logistics for drugs and medical supplies.** Procurement of HIV testing kits, nevirapine, ARVs, and medical supplies will be coordinated through the NACP following existing guidelines for procurement. Drugs for treatment of opportunistic infections, sexually transmitted infections and post-exposure prophylaxis will be provided as part of the NACP. Regular monitoring of the programme will be carried out to ensure stock outs do not occur.
- iv). **Strengthening counseling services:** The counseling manual will be revised to include modules for follow up, recognition of symptoms, and adherence to ART in order to provide women and their families with the required information and skills that will enable them to seek appropriate care and support.
- v). **Involving NGOs and PLWHAs:** 162 NGOs in the program will be key to continuity of care in the community. They will develop innovative approaches for follow up, linking with RNTCP DOTS programme, treatment adherence and default tracing and will develop locally appropriate models to improve community-based care, and support for HIV positive women and their families. The networks of PLWHA will be actively involved in program design, work as counsellors, and assist in providing linkages to the community.
- vi). **Supervising and monitoring:** The SACS in the 6 high prevalence states will be responsible for overall implementation, monitoring and supervision of the program. Advisory boards with representation from PLWHA and the public and private sector will be established at each Training & Resource Center. The Board will meet at least quarterly to review the progress of the program.

Table IV.27.2a

Objective 2	To implement a comprehensive HIV/AIDS care package including antiretroviral treatment for HIV-infected mothers, their infants and partners.				
	Broad Activities	Process/Output Indicators (indicate One per activity)	Baseline	Targets	Responsible / Implementing agency or agencies
			(Specify year 2002)	Year 1	Year 2
Training of medical and para-medical staff in HIV/AIDS case management	No. of staff trained in HIV/AIDS Management	750	1300	425	National AIDS Control Organisation; State AIDS Control Societies; Dept. of Family Welfare, NGO partners and Medical Superintendents of respective Medical Colleges
Strengthening laboratory services with QC for CD4	# of laboratories improved	5	11	11	-do-
Improve procurement systems and logistics for drugs and medical supplies	% of hospitals with stock outs of ART drugs	N/A	Nil	Nil	-do-
Improving PMTCT psychosocial and nutritional counseling	% of HIV positive mothers provided psychosocial and nutritional support	80%	85%	90%	-do-
Establishing referral linkages with NGOs	No. of health facilities that have established referral linkages with NGOs.	N/A	125	331	-do-
ART Treatment adherence	% of women under treatment who adhered to more 95% doses the last week	N/A	70%	80%	-do-

Source: Feasibility Study Phase 1 and 2 monitoring report

27. Objectives and expected outcomes

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

Specific Objective 3:

To enhance access to anti-retroviral therapy through public / private partnership.

Although access to ART has expanded in India, only 10,000-12,000 of an estimated .6 million eligible HIV-infected individuals (CD4<200) are currently receiving ART. Most, > 85% are not receiving care in accordance with National Guidelines. Expanded availability of ART may also lead to setbacks in prevention, increased risk-taking, and potentially lead to an acceleration of the AIDS epidemic.

However, model ART programs have demonstrated that with good counseling and patient education, appropriate infrastructure, and attention to patient concerns, ART can be well adhered to in resource poor settings and may reduce HIV transmission. Through combining expanded ART access with ongoing prevention programs in specific locations, this project will aim to positively impact both HIV prevention as well as care and support in the project areas.

Rational use of ART and other HIV/AIDS care services will be established through active partnership with hospitals, civil society, the government, and the pharmaceutical industry. Government participation will catalyse the intended coalition of all partners. Through an innovative pricing collaboration between corporate pharmaceutical industry and private sector NGOs, 15,000 PLWHA will have access to ART and quality health services by 2008. 6000 PLWHA receiving care in the private health sector will be able to access ART monitoring (CD4 tests) at a subsidized rate (\$12) through this program. Viral resistance profiles will be monitored. If proved successful and feasible, replicating this program will provide thousands of other PLWHA in India similar benefits. Quality of life of will be improved, and with treatment more readily available, levels of stigma and discrimination may also be reduced.

This ART model intervention will be carried out in the 4 metropolitan areas of Mumbai, Chennai, Bangalore and Hyderabad. VCT facilities are available in all 4 cities and they are linked to community based health care programs. It is expected that this intervention, designed as a graduated cost-recovery program with the aim of making it financially self-sustainable, will establish benchmarks for best practices of ART in India. The implementing institutions in the 4 cities have a demonstrated capacity to institute, monitor, and follow patients receiving ART. Current characteristics of the 4 implementing institutions are provided in Table 27.3a.

Table 27. a

Implementing Institution	Type of Institution	ART since which year	Number of patients seen in last 6 months	Number currently being followed on ART	Number of new beneficiaries under GFATM
AIDS Research And Control Centre,(ARCON), Mumbai	Autonomous institution of Govt. of Maharashtra and the University of Texas	1996	4500	240	1000
YRG Care, Chennai	NGO	1997	2500	147	1000
Freedom Foundation, Bangalore	NGO	1998	1300	90	500
Freedom Foundation, Hyderabad	NGO	1999	1500	70	500

Until recently, patients at all these institutions have been required to pay the full cost of anti-retroviral treatment and monitoring CD4/CD8 tests. While these institutions have acquired experience in administering ART and obtained good adherence of their patients belonging to low socio-economic status (LSES) and those below poverty line (BPL) have not benefited. It is the latter groups that will constitute 40% of PLWHA who will be partially covered under the project.

The graduated cost-recovery for ARV drugs from the patients will be done by generic pharmaceutical companies at the time of dispensing these drugs. Hence, implementing institutions will not be involved with purchase or sale of ARV. Four Indian generic drug companies have agreed to the following scale: rich clients will pay the retail price of commodities (20% of total patients), middle-class clients (40%) will pay 75% of the retail price of ARV, low SES clients (20%) will pay half,, and the remaining who are below poverty line-BPL (20%) will be provided ART free by the companies (commitment letters attached). CD4/CD8 tests to monitor response to treatment will be carried out at the participating centers at no cost to these clients. As a result, there will be no additional monetary burden on rich clients, and others will receive care at a subsidized rate, which they will be able to afford. The retail price of basic ART (2NRTIs + 1NNRTI) for a high income client will be \$240 for 1 year of treatment and the cost of advanced ART (2NRTI + 1PI) will be \$1200 per year (ART guidelines published by NACO {2000} and WHO-SEARO {2002} will be followed).

Table IV 27.3

Objective 3:	To enhance access to anti-retroviral therapy through public / private partnerships					
Outcome / coverage indicators	Baseline*	Targets				
		Year 1	Year 2	Year 3	Year 4	Year 5
Number of patients receiving ART at project sites	0	1000	2500	3000	6000	15000
Additional Number of patients in private sector (outside project sites) being treated with rational ART through regular monitoring of CD4	0	500	2000	3000	4500	6000
Number of Institutions with capacity to provide ART	12	20	40	60	120	200
Expand CD4 testing capacity in the private health facilities	10	15	25	35	55	80

- 27.1. Broad activities related to each specific objective and expected output** (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Objective 3: To enhance access to anti-retroviral therapy through public / private partnership.

The intervention will be implemented at the 4 project sites. ARCON will be the umbrella organization for this project and will co-ordinate monitoring and evaluation activity of all centres. The project will have a Steering Committee comprising of representatives from NACO, State Governments, civil society, and PLWHA networks as well as leading technical experts. Prior to initiation of the project strict, eligibility criteria for selection of patients in all income categories will be developed. A communications strategy for recruitment and retention will be developed and will involve word of mouth, the PLWHA network, NGOs and the media.

Activities: Steps of Implementation.

1. **Establish hospital steering committees.** At each of the four implementing hospitals, a steering committee will be established comprising of government and hospital representatives, civil society, PLWHA, and technical experts.
2. **Training of health care professionals in structured use of ART.** Through structured modular training, physicians in four cities during the first two years will be trained in HIV/AIDS care and treatment including appropriate use of anti-retroviral drugs. Scale-up in years 4-5 will involve training for physicians at state levels, for NGOs and for the private sector.
3. **Quality VCT services.** These services are available in project sites. The quality of VCT counseling and adherence counseling will be strengthened to ensure that all clients receive quality services.
4. **Strengthening of laboratories.** Private sector laboratories will be encouraged to establish CD4 capabilities in project cities and to implement quality control and assurance procedures in their labs.
5. **Monitoring adherence and emergence of drug resistance.** In order to document the impact of the graduated cost recovery project, several studies will be conducted to explore determinants of adherence and to monitor emergence of ARV resistance.

6. **Linkages for continuum of care** Through discharge summaries and referrals, links will be established between institutions, the community and household levels. Efforts will be made to minimize losses in follow - up and poor adherence through ongoing counseling and networking with NGOs/CBOs, at the community level.
7. **Operational studies.** Operations Research studies will address determinants of widening access to ART in the project areas and scaling up access to ART in other high prevalence areas. Also, studies will be conducted to determine strategies to minimize loss associated with poor adherence and follow-up.
8. **Strengthen prevention and care programs in the vicinity of ART programs.** To prevent backsliding (increasing risky behavior) due to increased availability of ART in the four project cities, the technical staff of this project will contribute time to ongoing preventive activities in the area. For example, preventive projects in the vicinity may need assistance for designing monitoring and evaluation instruments. Private practitioners in the vicinity will be trained in the appropriate use of ART. To strengthen linkages with the private sector, subsidies will be provided for CD-4 counts for 6000 additional patients being treated with ART by private physicians practicing in the vicinities of the model project. This will result in improved prescribing and monitoring of their patients and improved patient compliance with prescriptions.
9. **Capacity building for scaling up.** During year 4 and 5, the implementing partners will conduct dissemination workshops for hospital administrators to share findings of this project, conduct training of physicians, mentor NGO and private sector hospitals in their respective states to build capacity for quality ART.
10. **Supervision and Monitoring.** Ongoing monitoring will be carried out to ensure the quality of care, laboratory testing, and impact of the project.

Table IV 27.3a

Objective 3	To enhance access to anti-retroviral therapy through public / private partnership.					
	Broad activities	Process/Output indicators (indicate one per activity)	Baseline	Targets		
				Year1	Year2	
Hospital Steering Committee	Functional Steering Committees		0	4	4	ARCON, YRG Care, Chennai, Freedom Foundation, Bangalore, Freedom foundation , Hyderabad and Hospitals
Training health care workers in rational use of ART	Number of health care workers trained in rational use of ART	80	200	400		ARCON, YRG Care, Chennai, Freedom Foundation, Bangalore, Freedom foundation , Hyderabad
VCT	Number of VCTs established	4	4	4		-Do-
Strengthening of labs and quality control / assurance	No. of labs participating in quality control programs for CD4	4	4	4		Implementing Institutions and Private Labs
Ensuring adherence	Number of studies completed	0	2	4		ARCON, YRG, Freedom Foundation
Operational studies	Determinants to wider access to ART, monitoring drug resistance,	0	2	4		-Do-
Linkages for continuum care	Number of partner NGOs	10	15	20		Implementing partners and NGOs/CBOs
Strengthen prevention in vicinity of ART programs: workshops by ART specialists	# of workshops by ART specialists	7	8	12		Implementing partners and NGOs managing targeted intervention projects in 4 cities

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner:

In the high prevalence states in India, HIV infection has spread to the general population, and there is increased frequency of mother to child transmission. The scaling up of the PMTCT program to district and private hospitals will provide increased opportunities for all antenatal clinic attendees to learn about HIV/AIDS and other sexually transmitted infections. Through counseling they will learn strategies they can take to protect themselves from such infections and facilitate early diagnosis and treatment for STIs. By linking to NGOs in the communities, ongoing prevention programs will be strengthened. Women already infected will be given information about maternal to child transmission of HIV and how risks can be reduced. Through this program the number of infants born with HIV will be substantially decreased.

Under the NACP, PLWHA are provided free treatment for opportunistic infections in public sector hospitals. Anti-retroviral treatment is not currently available in the public health system but is in use by those who can afford it in the private sector. This program will explore the feasibility of introducing ART in the public system as well as through the private sector. Generic pharmaceutical companies in India are producing a full range of ARVs, which are available in the market at much lower prices than those levied by the multi-national companies. However, resource constraints continue to prohibit their use in the public system. Even in the private sector, only the wealthy have been able to afford ART. The ART cost recovery programme in 4 cities in India will provide important information about the potential for increasing coverage of poor patients in the private sector through partnerships with corporations. Through strong linkages with NGOs and PLWHA networks, both programs will provide important information about how to optimize follow-up and adherence in these population groups.

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

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

This component addresses women, children and people living with HIV/AIDS. People living with HIV/AIDS will be involved in all phases of the program. PLWHA will be included in the national and local advisory committees that will develop, monitor and evaluate the activities. PLWHA and PLWHA networks will be actively recruited to directly participate in the programmes as peer educators and counselors. Individuals newly identified with HIV will be provided information about local PLWHA networks and encouraged to participate as appropriate.

29.2 Community participation:

Local communities will be involved in the program through NGOs and CBOs working in their communities. More than 500 NGOs will be involved in the PMTCT programs. These NGOs will facilitate implementation of PMTCT in maternity hospitals run by private sector. They will participate in public sector medical centers by providing linkages to prevention, counselling, care and follow-up of HIV+ individuals. The model ART delivery project will directly involve communities in linking treatment programs with prevention, and monitoring and evaluation.

29.3 Gender equality issues (Guidelines paragraph IV.53):

In India, gender inequality manifested by low social status, illiteracy, violence, sexual abuse and powerlessness puts girls and women at greater risk of HIV infection. Young girls in particular are vulnerable because of their inability to refuse unwanted or unsafe sex. Even women with a single partner are vulnerable to HIV infection. The findings of a recent study in India¹ show that 90% of women infected were married and had only one sex partner – their husbands. Many of the HIV positive women who become pregnant every year in India are rural and poor. All desire to have healthy children but almost a third of their infants are infected with HIV and will die young. By the time women become ill, resources from the family have been spent on health care services for their husbands. Invariably, their families cannot afford drugs, even simple ones to treat opportunistic infections. Up scaling the PMTCT program to rural areas and private hospitals in high prevalence states will provide opportunities for women in those communities to have healthy children. By strengthening linkages to health care systems, HIV infected women

¹ UNICEF, 2001, "South Asia. The HIV/AIDS Epidemic".

who become ill will have greater access to treatment so that they can live longer and have more productive lives. Women and families enrolled in the PMTCT – Plus and Model Cost recovery programs will be given opportunities to receive anti-retroviral treatment along with their husbands and children. Lessons learned from those projects will be critical for scaling up so that HIV-infected women all over India will have greater access to quality care for HIV/AIDS.

29.4 Social equality issues (*Guidelines paragraph IV.53*):

In India, only the rich can afford treatment with ART. This project, through innovative strategies in both the public and private sectors, will provide key information about how to increase access to ART for all who require them. According to UNAIDS / WHO², unequal access to affordable treatment and adequate health services is one of the main factors accounting for drastically different survival rates among those living with HIV/AIDS in rich and poor communities. National programmes have traditionally focused only on the public sector. By scaling up to include private sector institutions and actively involving NGOs in the program, pregnant women and families who utilize the private sector will become eligible for prevention counseling, PMTCT services, and HIV/AIDS treatment.

29.5. Human Resources development:

The capacity of public and private health care providers, laboratory technologists, counselors, NGOs, PLWHA and communities will be strengthened through training and active participation in the program. They will receive training on HIV/AIDS prevention, diagnosis, care and treatment of HIV/AIDS, PMTCT and use of anti-retroviral treatment.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), (*Guidelines para. IV.55*), (1–2 paragraphs):

The interventions proposed in the component will be using: (a) Nevirapine prophylaxis for prevention of mother to child transmission (b) treatment of opportunistic infections; and (c) antiretroviral treatment. National Guidelines will be followed throughout the program. The following protocols will be used in order to ensure rationale use of the drugs:

- 1) PMTCT: Nevirapine-200 mg at labour and 2 mg per kg/body weight for the baby within 72 hours of birth after exclusion of conditions contra indicated for use of Nevirapine. The drug will be administered in the presence of trained medical personal.
- 2) For comprehensive PMTCT care and the Model 4 city cost recovery programme, NACO and WHO SEARO guidelines for the use of Anti-retrovirals will be followed. Current guidelines are: Basic therapy comprises of 2NRTIs and 1NNRTI. The advanced therapy comprises of 2NRTIs and 1PI. Monitoring of ART will be done by CD4 count and clinical assessment as per WHO guidelines. Protocols for follow-up and adherence monitoring will be established in collaboration with NGOs, PLWHA networks and health care providers.
- 3) The National AIDS Research Institute, Pune; National Institute of Cholera and Enteric Diseases, Calcutta; MGM Medical College, Navi Mumbai and Dr. MGR Medical University, Chennai will be responsible for monitoring viral resistance in the project areas.

² UNAIDS/WHO 2001, AIDS Epidemic Update December 2001.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to Guidelines paragraph V.56 – 58):

Table V.30

Resources needed (USD)	Year 1 US\$(000)	Year 2 US\$(000)	Year 3 (Estimate) US\$(000)	Year 4 (Estimate) US\$(000)	Year 5 (Estimate) US\$(000)	Total US\$(000)
Human Resources	300	540	590	590	450	2470
Infrastructure/ Equipment	500	650	590	90	30	1860
Training/ Planning	1130	3395	2970	905	300	8700
Commodities/ Products/ NGO contracts	5512	10068	17700	19000	20000	72280
Drugs	53	315	675	875	1110	3028
Monitoring and Evaluation	743	1222	1500	1600	1800	6865
Administrative Costs	628	688	700	700	750	3466
Other (Please specify) Technical Assistance	156	216	400	340	300	1412
Total	9022	17094	25125	24100	24740	100081

The budget categories may include the following items:

Human Resources: Consultants, recruitment, salaries of front-line workers, etc.

Infrastructure/Equipment: Building infrastructure, cars, microscopes, etc.

Training/Planning: Training, workshops, meetings, etc.

Commodities/Products: Bednets, condoms, syringes, educational material, etc.

Drugs: ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.

Monitoring & Evaluation: Data collection, analysis, reporting, etc.

Administrative: Overhead, programme management, audit costs, etc

Other (please specify):

- 30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY: (ADD nevirapine)

Table V.30.1

Item/unit	Unit cost (USD)	Volume (specify measure)	Total cost (USD) (000)
Rapid HIV test	\$0.61	4million	2440
Antiretrovirals [3drugs & CD4 monitoring]	\$240	220	53
CD4/CD8 monoclonal antibodies	\$20.00	9000*	180
FBC-ESR, LFT, RFT	\$20.00	9000*	180
Education material, media for ART	\$10.00	9000	90
Educational material for prevention	\$0.05	6 million	300
			3243

*4,500 tests for project patients, 4,500 for community private sector

- 30.2 In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over

NOT APPLICABLE

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines para. V.62*):

Table V.31.1

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)		\$0.36m	\$2m	\$3.25m	\$3.15m	\$3.15m	\$3.15m
External [UNICEF]		\$0.035m	\$ 0.200m	\$ 0.80m	\$ 1.0m	\$ 1.0m	\$1.00m
Total*		\$0.395m	\$ 2.200m	\$ 4.05m	\$ 4.15m	\$ 4.15m	\$4.15m

*For PMTCT expansion only

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

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

Please see attached

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in percentage (*Refer to Guidelines para. V.63*):

Table V.33.a

Resource allocation To implementing partners* (%)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Government	20.5	23.4	12.0	9.5	8.0	14.7
NGOs / Community- Based Org	46.5	49.0	67.5	70.0	71.0	60.8
Private Sector	27.0	17.8	15.0	15.0	15.0	18.0
People living with HIV	1.0	6.1	4.0	4.0	4.0	3.8
Academic / Educational Organizations	5.0	3.7	1.5	1.5	2.0	2.7
Faith-based Organizations	0	0	0	0	0	0
Others	0	0	0	0	0	0
Total	100%	100%	100%	100%	100%	100%
Total in USD	9022	17094	25125	24100	24740	100081

SECTION VI – Programmatic and Financial Management Information.

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

- 34. Describe the proposed management arrangements** (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), (*Guidelines para. VI.64*),(1–2 paragraphs):

The following components will be implemented by the following partners:

- NACO, Government of India will coordinate with other stakeholders for implementation of the programme. NACO will provide managerial, technical and financial support to the implementing agencies. It will also monitor the progress of the project activities and submit report to the CCM. Regular coordinating meetings will be held with the Department of Reproductive and Child Health in order to ensure smooth integration between programmes
- PMTCT and PMTCT - Plus activities will be coordinated by the State AIDS Control Society. A steering committee at state level represented by public and private sectors, NGOs, PLWHA, and elected representatives and faith based organizations will be convened before initiation of the project. The State AIDS Control Society will oversee project implementation and report to the steering committee on quarterly basis. Funds will be released through the State AIDS Control Society and the SACS will be responsible for submission of expenditure statements, and progress reports to NACO. The state level steering committee will be headed by the Secretary (Health) of the concerned state.
- The Model ART program will be administered and monitored by ARCON. The advisory committee will meet at least quarterly to evaluate progress.

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

State AIDS Control Societies (SACS) are functional in all states in the country and have adequate managerial, technical and financial support. The society model has been found to be efficient in management of the programme as well as release of funds to NGOs as well as for maintaining transparency in financial management. The Executive Committee includes both government and civil society, including NGOs and PLWHA.

- 35. Identify your first and second suggestions for the Principal Recipient(s)**
(Refer to *Guidelines para. VI.65–67*):

Table VI.35

	First suggestion	Second suggestion
Name of PR	NACO	
Name of Contact	Project Director, NACO	
Address	Chandralok Building 9 th Floor 36, Janpath New Delhi 110001	
Telephone	3325331	
Fax	3731746	
E-mail	nacodel@vsni.com	

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

- 35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), (Guidelines para. VI.66–67), (1–2 paragraphs):**

The National AIDS Control Organization is the Apex agency at the national level to manage the National AIDS Control Programme. It has been in existence since 1992, and has seen through the National AIDS Control Programme Phase 1, and is coordinating the implementation and management of the NACP, Phase 11. It has developed competence and expertise in several aspects, such as having dedicated units for programme finance management staffed by trained, experienced persons with long experience in disbursement of funds, maintaining accounts and audit, surveillance, training, and monitoring and evaluation.

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

The Principal Recipient is one of the members of the CCM and responsible for implementing the programme in the entire country. The PR is directly linked to the State AIDS Control Societies for day to day monitoring of the programme.

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

Financial Management System is an effective tool to assist project managers to: (i) ensure efficient use of resources; (ii) achieve better project management by providing timely information on financial aspects; (iii) promote accountability at various levels and enhance transparency; (iv) establish satisfactory internal checks and controls; and (v) meet the financial reporting requirements of the Global Fund.

User friendly and simple statements of expenditure formats would be developed in consultation with the Global Fund Secretariat in order that user friendly information is regularly formatted and forwarded to the National AIDS Control Organisation (NACO). NACO would thereafter consolidate the information and prepare SOEs to be mailed to the Global Fund.

Budgeting and Flow of Funds

The funds, would be given to the NACO for implementing the activities through the budgetary process. NACO, in turn, would provide the funding to the SACS (Objective 1,2) and Coordinating Institution (ARCON) (Objective 3)

Disbursement

The disbursements of the funds will be based on the Statement of Expenditure (SOE). These reports would include information on financial accounting i.e. sources and uses of funds as per expenditure categories and project costing.

Accounting and Transaction Information Flow

Books of accounts for the project at implementing agency levels would be maintained. Standard books of accounts would be maintained by the implementing agencies.

NACO, and implementing agencies will generate and maintain the transaction vouchers for the various receipts and expenditures made at NACO, and implementing agency levels respectively. The accounting for NGOs will be done similarly. The statement of account and audit certificates received from NGOs will be accounted for at implementing agency levels. Consolidation of project accounts would be done at the NACO level, by consolidation of accounts of NACO and the implementing agencies.

Internal Checks and Control

Existing standard internal checks and control mechanisms would be enforced for the project funded by the Global Fund, and broadly include the following:

The establishment of appropriate budgeting systems, and regular monitoring of actual financial performance with budgets and targets;

Development and adoption of simple, clear and transparent financial and accounting policies, which would govern financial management and accounting for the project.

Financial Reporting

Statement of expenditure and other financial statements as prescribed by global funds would be prepared according to the project accounting system.

Auditing Arrangements

The purpose of the audit would be to provide an independent confirmation to project management and to the Global Fund on the accuracy of financial statements, the working of internal checks and controls. The duly appointed firms of Chartered Accountants will carryout audits on regular intervals.

Briefly indicate links between the overall implementation arrangements described above and other existing arrangements:

Implementation Arrangements:

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

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

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

Reporting deadlines:

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

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

Additional resources:

Additional resources would be required to strengthen the effectiveness and technical, managerial and financial sustainability of the programme at the national, state and municipal levels, and to develop a computerized financial management system to meet reporting requirements of project specific needs in respect of the project funded by the Global Fund.

SECTION VII – Monitoring and evaluation information

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

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines para. VII.76*):

For the routine management and monitoring of the National AIDS Control Programme, information systems are already in place. The report/data generated at the implementation and cutting edge level are forwarded to state levels for onward transmission to NACO. For tracking the geographic spread and trends in the spread of the HIV infection, an annual round of sentinel surveillance is conducted covering both high risk groups and the general population. Currently 384 sentinel sites have been established for this purpose. A nation-wide baseline behavioural surveillance survey was conducted in the year 2001 covering both general population and high risk groups. It will be repeated in alternate years. Community-based surveys on STI prevalence have been conducted in some of the states. Nation-wide community based survey of STI prevalence has recently been undertaken.

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.):

- Demographic data for the States and districts from the Census, using 2001 as the baseline.
- Data on prevalence rates (to assess impacts relating to the overall goal of the component).
- State AIDS Control Societies (SACS) monthly reports to NACO on reported AIDS cases and reported STIs.
- The existing system of sentinel surveillance of women attending covering both high risk (STI clinics) and general population (pregnant women).
- Reports on HIV test results.
- The existing system of birth and death notifications for mortality and morbidity.
- Ongoing monthly reporting system. There will be monthly reporting by each institution [12 indicators] to State AIDS Control societies [SACSs], and from SACSs to NACO/CCM.
- Existing system of Behavioural Surveillance Survey.

37.3. Timeline:

Monitoring, Evaluation and Supervision as parts of the managerial process will be conducted on a regular basis, i.e. to assess the progress at all levels and, or identify the constraints and the causes impeding the progress on a yearly basis.

37.4. Roles and responsibilities for collecting and analyzing data and information:

- The CCM will have overall responsibility;
- The PCC, reporting to the CCM, will have overall technical responsibility for M & E system planning and review;
- NACO at the national level and the SACS at state level will have operational responsibility (each SACS has an M & E officer);
- Reporting formats will be provided to the partner NGOs/CBOs & submissions monitored at the level of State AIDS Control Societies;
- UNICEF will have specific M & E and quality assurance responsibilities relating to the PMTCT scaling up process, and operations research while providing comprehensive PMTCT plus intervention in the 11 PMTCT Training and Resource centers;
- ARCON will be responsible for the M & E of the graduated cost recovery project;
- Independent evaluations of the programme will be conducted by relevant agencies used for this purpose by the NACP II. A participative approach will be used for evaluation studies.

37.5 Plan for involving target population in the process:

- Encouraging youth to form self help groups and their involvement in peer education and information dissemination.
- Encouraging HIV positive women to form self help groups and involve such groups in lay counseling, dissemination of information and referral services.

37.6. Strategy for quality control and validation of data:

- Results of qualitative studies and operational/formative research undertaken under the national programme and the NACP II
- Quality assurance: data on counseling and training from the national programme quality system with support from UNICEF
- Data collected through annual sentinel surveillance rounds
- Pre and post training evaluation results
- Supervision reports by consultants and programme officers from Central and State level
- Feedback from NGOs and PLWHA networks
- Data from National Quality Assurance Scheme for HIV laboratories

37.7 Proposed use of M&E data:

The Suggested monitoring and evaluation framework is as follows:

- Conduction of a participatory mid term programme review, coinciding with the independent mid-term evaluation;
- Submission of routine progress reports to the PCC, CCM and Global Fund (programme progress and measurement data and analysis against agreed indicators);
- Involving target populations and programme participants in evaluations (using NACP II mechanisms for community participation, and possibly the Panchayat Raj system);
- Timely use of evaluation data and findings and lessons learned to inform programme improvement and policy development.

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	Partner(s) (which may help in strengthening M&E capacities)	Resources Required (USD) (000)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
TA for PMTCT	UNICEF	36	24	48	44	24	176
TA for ART	University of Texas-Houston Brown University Johns Hopkins	90	120	180	150	120	660
TA for epi studies	CDC	12	24	48	48	48	180
TA for socio-economic impact	CDC	6	12	52	42	42	154
TA for M & E	CDC, UNICEF	12	36	72	56	66	242
Total requested from Global Fund		156	216	400	340	300	1412
Total other resources available	TA from CDC, Univ of Texas						

SECTION VIII – Procurement and supply-chain management information

- 39.** **Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to Guidelines paragraph VIII.86).**

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	National competitive process is followed as per World Bank guidelines for the selection of Procurement agency and subsequent procedure
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	Bid documents are prepared, bids invited and Scrutinized as per World Bank guidelines. Evaluation process is scrutinized by, Government Of India [Finance], and World Bank.
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	Specification for HIV test kits and, equipment is Finalized by a technical committee headed by Additional DGHS and approval obtained from World bank.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	Distribution from suppliers to consignees in the States is done at the request of National AIDS Control Organization directly by the suppliers.

- 40. Describe the existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs):**

Procurement of services e.g. hiring of Counselors and Lab technicians will be done through advertisement in Newspapers as well through the Employment exchanges

- 41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):**

NOT APPLICABLE

- 42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (Guidelines para. VIII.88):**

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Time frame and duration of request or grant

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

Concerted efforts are being made to scale up the existing interventions. However, India is a large and diverse nation with a proportionately large epidemic; hence, its needs in terms of prevention and control are equally large. The Government of India is therefore, pooling all the available resources to combat the epidemic.

The interventions described in the component are primarily focused to reduce the spread of HIV infection in women, their partners and Infants, and to mitigate its effects by providing care, including antiretroviral treatment. PMTCT is a relatively new initiative in India and is being scaled up after the conduct of successful feasibility studies.

The intervention will be scaled up in all the districts of the six high prevalence states (total population:292 million). Piloting of anti-retroviral therapy in the PMTCT programme at selected large centres, and innovative graduated cost recovery model with public-private partnership will provide insight into the introduction and administration of ART in resource poor settings. The lessons learnt will be further utilised for scaling up PMTCT and ART through public and private health facilities. The Government of India will require additional resources for all of these activities.

SECTION IV – Scope of proposal

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

Table IV.23

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

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

Rationale

Over the past four years, the RNTCP has expanded rapidly from covering 18 million people in 1998 to 495 million by mid-August 2002. Despite this rapid expansion, quality of services has been maintained and the national results (with treatment success rate > 82% & case detection rate of >65%) are nearing internationally set targets. This momentum needs to be maintained if the entire country is to be covered under the RNTCP by the year 2005 and to achieve the global targets for TB control. Concurrently, consistent effort is necessary to fill the gaps in the strategies, and to improve the existing TB control services. This proposal is intended to address two of the major gaps in the programme with assistance from GFATM;

1. To cover an additional 110 million population under RNTCP in 2 States namely, Bihar and Uttar Pradesh, thereby expediting achieving country-wide RNTCP coverage by 2005.
2. To strengthen the urban TB control services in slum areas by establishing Urban TB Control models in 4 major cities in India, which if proved to be successful can be replicated in other cities.

Goal

The goal is to achieve by 2005, nationwide coverage under RNCTP with DOTS strategy, which focuses on establishing sustainable technical, managerial and organizational infrastructure. The programme will continue to seek to achieve at least 85% treatment success and at least 70% detection of new smear positive cases in order to reduce morbidity, mortality and disability due to tuberculosis (TB), so that TB ceases to be a significant public health problem.

Objectives

1. To expand RNTCP to the “uncovered” population of 110 million in 56 districts of the States of Bihar and Uttar Pradesh, so as to ensure nationwide coverage by 2005;
2. To achieve at least 85% successful outcome of treatment amongst registered new smear positive pulmonary TB cases by 2005; and
3. To achieve a case detection rate of at least 70% of the estimated new smear positive pulmonary TB cases existing in the population by 2005.
4. To establish model “Urban TB Control Projects” in 4 major cities of India by improving the quality and reach of RNTCP to special groups like slum dwellers and migrants, through more “patient-friendly” treatment observation, involvement of private and NGO sectors, and IEC.

Expected results

- Achievement of nationwide RNTCP coverage by 2005
- Achievement of global targets of TB control of at least 85% treatment success rate and at least 70% case detection rate of new smear positive pulmonary TB cases by 2005
- Increase reach of RNTCP by making DOTS more accessible and acceptable among disadvantaged urban poor population.

Beneficiaries

- Additional 110 million population having access to DOTS
- >600,000 patients initiated on treatment
- >108,000 lives saved
- >1,200,000 individuals spared from becoming infected with TB
- Thousands of families prevented from falling into the cycle of debt and poverty caused by a family member having TB.
- The community at large having access to free and uninterrupted high quality diagnostic and curative TB services
- Return of cured TB patients to productive employment will significantly improve the economy of the 2 States.
- Urban poor in 4 metropolitan cities of India having access to better quality TB control services

Two broad areas of activities

1. **Expansion** of the RNTCP to the “uncovered” areas of Bihar and Uttar Pradesh (110 million), including both **preparatory activities** prior to starting of service delivery and **implementation and maintenance of quality** TB services activities thereafter; and
2. **Improvement of quality and reach** of RNTCP through availability of free and uninterrupted high quality TB diagnostic and curative services; more “patient-friendly” treatment observation; greater involvement of other government, private and NGO sectors in the RNTCP; and enhanced IEC.

Implementing partners

The expansion of the RNTCP envisaged within this proposal will, as in the ongoing programme, be implemented as a Centrally sponsored scheme. The Deputy Director General (TB) in the Directorate General of Health Services will continue to implement the project under overall administrative supervision of the Ministry of Health & Family Welfare. RNTCP will be implemented in the States through the State TB Control Society (STCS) which will plan, monitor and supervise all RNTCP activities at the State level. At the District level, District TB Control Societies will implement the RNTCP. All existing RNTCP norms and protocols will be followed. Successful appraisal of each preparing district will continue to be a prerequisite for starting of RNTCP service delivery. NGOs and private sector will be involved as per the guidelines already developed.

Tuberculosis Association of India (TAI), the largest and oldest NGO in the field of Tuberculosis, will be responsible for implementation of the Urban TB Control Project in 4 metropolitan cities of India with supervisory input from the Central TB Division.

Implementation strategies:

A. DOTS expansion to 110 million population in Bihar and Uttar Pradesh:

1. For accessible and quality diagnosis, a microscopy centre will be established per every 100,000 population and in tribal and hilly areas per every 50,000 population. A full time laboratory technician, trained under RNTCP, is to be working in each microscopy centre;
2. Creation of a sub-district level, the “TB Unit”, staffed by a Senior Treatment Supervisor (STS) and Senior TB Laboratory Supervisor (STLS) per 500,000 population and in tribal/difficult areas per 250,000 population. The STS and STLS will be appointed on a contractual basis and be responsible for assisting the District TB Officer (DTO) and Medical Officer–TB Unit (MO-TC) in supervision and monitoring of the various programme activities;
3. Different categories of health workers and community volunteers will be given modular training under RNTCP as per the existing guidelines
4. A 4-wheeler would be made available for all DTOs and a 2-wheeler for both STS and STLS to ensure mobility. MO-TCs would have the option of hiring a 4-wheeler.
5. Drugs will be provided free of cost to all patients under the RNTCP;

6. In order to ensure efficient drug management, State Drug Stores will be established and strengthened;
7. Capacity building of the State TB Training & Demonstration Centres (STDC) will be undertaken;
8. To ensure quality diagnosis, proper storage of drugs and availability of essential service facilities, civil works will be supported at the State TB Training & Demonstration Centres, District TB Centres, TB Units and Microscopy Centres.
9. Wherever necessary provision will be made for contractual hiring of one TB Health Visitor per every 150,000 urban population for effective outreach to urban slum populations.
10. To facilitate the process of decentralisation, capacity building and strengthening of the State (STCS) and District TB Control Society (DTCS) will be undertaken.
11. Due to the existing situation in these States (as per the present policy), up to 20% of laboratory technicians will be permitted for hiring on contractual basis, to be decided by State to enable services to reach under-served areas. However in exceptional circumstances up to 50% hiring can be supported under the programme.
12. Similarly, up to 15% of the second medical officers at the District TB Centre can be hired by the State on contractual basis.
13. To aid information storage, quick retrieval and rapid communication, the TB reporting systems will be computerised at the State and District levels through an electronic connectivity programme. Submission, analysis and feedback of reports will be encouraged via e-mail and the Internet.
14. Involvement of NGOs and private sector in RNTCP under approved schemes.
15. Provision of patient-friendly services by decentralisation of DOT to peripheral health workers, anganwadi workers, panchayat leaders, and other community members.
16. Keeping in view the recommendation of the World Bank and GOI-WHO joint review of February 2000 there has been decentralization of programme in a phased manner which includes release of funds/drugs to the State Societies instead of District Societies, monitoring of technical performance of Districts by State and other activities.
17. Within District and State Action Plans, special relaxed norms will be included to facilitate effective service provision for tribal and under-served populations.

B. *Urban TB Control Project to improve quality and reach of RNTCP:*

1. Innovative approaches, centered around services to the patients, will be undertaken to improve case detection and treatment outcomes through effective involvement of NGOs, private sectors, and the community at large. DOTS will be made more accessible and acceptable by utilising among others former patients as DOT providers, establishing more DOT centers at convenient locations, etc.
2. Resource mapping of existing health facilities including private and non-government facilities in the slum areas of the project sites will be conducted. Health-seeking behaviour, KAP and barriers to access among the target population will be determined. This information will be used to develop specific targeted approaches and to monitor progress of the project.
3. Subsequently, an Urban Task Force (UTF) involving all stakeholders – State/District TB Officials, State/District AIDS Officials, State affiliates of TAI, local NGOs, Private Practitioners (PP), community leaders etc will be formed to assist in planning, implementing, monitoring and evaluation of the project.
4. Training will be given to interested partners who will also be encouraged and supported to participate in the programme via signed schemes as per RNTCP policy. The project will also coordinate with available health providers to utilize their services and establish where necessary, additional facilities to make the provision of DOT more convenient. This could be in the form of 'open clinics' operated by trained community volunteers with flexible timings and friendly services.
5. IEC materials and activities will be designed and developed to target specific segments for advocacy, awareness generation in the community, and improved interpersonal communication between patients and providers. Mass media (TV/radio/press), wall paintings, banners, films on success stories, newsletter, a new 'TB seal' focusing on urban TB control etc will be used to disseminate messages. Outreach activities including cultural performance like street plays, puppet shows, use peer educators, community meetings etc will be held periodically.
6. Urban TB programme report will be published indicating key indicators
7. National/International review of progress will be conducted at regular interval

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	April 2003	To (month/year):	March 2008
*From (month/year):	April 2003	To (month/year):	March 2006

* The TAI proposal for urban TB control project is proposed for 3 years duration

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

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

Indicators: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.

Baseline data: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.

Targets: Clear targets should be provided in absolute numbers (if possible) and percentage.

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

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

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

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

The overall project goal will be to achieve by 2005, nationwide coverage under RNCTP with DOTS strategy, which focuses on establishing sustainable technical, managerial and organizational infrastructure. The RNCTP will continue to seek to achieve at least 85% treatment success and at least 70% detection of new smear positive cases in order to reduce morbidity, mortality and disability due to tuberculosis (TB), so that TB ceases to be a significant public health problem. To achieve this, highest priority is given to the detection and successful treatment of those individuals who transmit the infection i.e. sputum smear positive pulmonary TB (PTB) cases. The global targets set for TB control under the internationally recommended DOTS strategy are ≥85% successful outcome of treatment in new smear positive PTB cases and ≥70% detection of the estimated new smear-positive PTB cases existing in the community.

To have an impact on the TB burden in a population, these targets must first be reached and then maintained for several years. If this is achieved, the impact on the TB burden has been demonstrated both in models and in the setting of a country-wide TB control programme. Just a few years after the implementation of a successful country-wide TB control programme, Peru reported a rapid decline in mortality and morbidity, firstly in prevalent and then in incident cases.¹⁰ In India under the RNCTP, successful outcome of treatment is consistently over 82%, and over time case detection rate has increased to about 56%¹¹. However, latest quarterly report (Q2 2002) shows an encouraging rise in case detection rate to above 65%.

Table IV.26.1

Goal:	To achieve by 2005, nationwide coverage under RNTCP with DOTS strategy which focuses on establishing sustainable technical, managerial and organizational Infrastructure. The Project will continue to seek to achieve at least 85% treatment success and at least 70% detection of new smear positive cases in order to reduce morbidity, mortality and disability due to tuberculosis, so that TB ceases to be a significant public health problem.		
Impact indicators <i>(Refer to Annex II)</i>	Baseline	Target (last year of proposal)	
	Year: March 2003	Year: March 2008	
Population coverage under RNTCP in the entire country	600 million	The entire country (>1,027 million)	
Proportion of smear-positive TB cases registered under DOTS successfully treated	84%*	≥85%	
Proportion of all estimated new smear-positive TB cases (existing in the entire country) detected and put on under DOTS	35% **	> 70%	
Proportion of all treatment units implementing DOTS in line with standard criteria for effective implementation	60%	100%	

* In the currently implementing RNTCP areas (results from latest cohort reported on, Q2 2001)

** Out of the estimated number of total new smear positive cases in India (includes both RNTCP and non RNTCP areas) as reported in the WHO report 2001 on global TB control.

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

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

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

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 1:

To expand RNTCP to the “uncovered” population of 110 million in 56 districts of the States of Bihar and Uttar Pradesh, so as to ensure nationwide coverage by 2005;

To date, about 50% of the country is covered by the RNTCP. Existing plans are to expand to cover about 85% by March 2004. With the GFATM assistance requested in this proposal, an additional 110 million in the States of Bihar and Uttar Pradesh will be covered under RNTCP, to expedite achievement of nationwide coverage under RNTCP by the target date of 2005.

Table IV.27

Objective: 1	To expand RNTCP to the "uncovered" population of 110 million in 56 districts of the States of Bihar and Uttar Pradesh, so as to ensure nationwide coverage by 2005;				
Outcome/coverage indicators (Refer to Annex II)	Baseline	Targets			
	Year: March 03	Year 2: March 05	Year 3: March 06	Year 4: March 07	Year 5: March 08
Coverage by RNTCP in The "uncovered" population of 110 million in Bihar and Uttar Pradesh in 56 districts*	0m (0 district)	110m (56 districts)	110m (56 districts)	110m (56 districts)	110m (56 districts)

- The districts will be covered in two phases, in first phase 29 districts and in the second phase remaining
- 27 districts, which are expected to start service delivery under RNTCP by October 2003 and April 2004 respectively.

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

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

Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

As per the existing norms and guidelines laid down by the Government of India (GoI), which are being followed in rest of the country, a wide range of preparatory activities will proceed prior to the initiation of service delivery under RNTCP.

- Each district will form a society and open a special bank account for fund flow under TB control programme
- Action plan will be prepared by each district outlining the detailed plan with a realistic timeframe for completion of each activity
- TB Units, Microscopy Centers, and DOTS centers will be identified as per the population norms
- Identification, recruitment and training of health personnel will be undertaken as per the respective District and State Action Plan. Training is key to success for RNTCP and all health personnel involved in the implementation of RNTCP will be trained through specially prepared modules as per the current policy of GoI. State and District TB Officers (STO & DTO) will be trained in central level institutes, while other staff at the appropriate facilities at their respective levels.
- Civil works will be undertaken at the local, sub-district and district levels depending upon the requirement. Laboratories will be upgraded in rural and urban peripheral health institutions to allow more efficient functioning of microscopic diagnosis of tuberculosis; drug storage areas will be upgraded at the sub-district and district levels.
- Procurement and distribution of drugs, required equipment, vehicles, laboratory consumables etc. will occur before starting of service delivery under RNTCP
- Successful appraisal by a team will continue to be a prerequisite for starting of RNTCP service delivery.

Table IV.27.1

Objective: 1	To expand RNTCP to the "uncovered" population of 110 million in 56 districts of the States of Bihar and Uttar Pradesh, so as to ensure nationwide coverage by 2005;					Responsible / Implementing agency or agencies
	Broad activities	Process/Output	Baseline	Targets		
Indicators (indicate one per activity) (Refer to Annex II)		Indicators (indicate one per activity) (Refer to Annex II)	March 2003	End Year 1: March 2004	End Year 2: March 2005	
Formation and registration of DTCS	DTCS formed and registered	0	29	56	Goi, GoB, GoUP and the respective district authorities	
Preparation of District Action Plans	District Action Plans available	0	29	56	Respective DTO, STO and DTCS	
Identification of TB Units	TB Units identified @ one per every 500,000/ 250,000 population	0	All identified 29 districts	All identified 56 districts	Respective DTO, STO and DTCS	
Identification of DOT Centres	DOT Centres identified	0	All identified 29 districts	All identified 56 districts	Respective DTO, STO and DTCS	
Identification of MO-TCs	MO-TCs identified one per each TU	0	All identified 29 districts	All identified 56 districts	Respective DTO, STO and DTCS	
Trained supervisory staff in district/ sub-district	All key staff of district/ subdistrict in place and trained	0	All identified 29 districts	All identified 56 districts	Respective DTO, STO and DTCS	
Civil work in District/ sub-district/ local level	Required civil work complete in MC/ TU and DTC	0	All identified 29 districts	All identified 56 districts	Respective DTO, STO and DTCS	
Training of Medical Officers and Laboratory Technicians	≥80% MOs and LTs trained prior to appraisal	0	Achieved in all identified 29 districts	Achieved in all identified 56 districts	Respective DTO, STO and DTCS	
Appraisal for service delivery	Appraisal done and successful outcome	0	29 districts	56 districts	CTD, respective DTO, STO and DTCS	
Service delivery under RNTCP	RNTCP service delivery started on planned date	0	29 districts	56 districts	Respective DTO, STO and DTCS	

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

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

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

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 2:

To achieve at least 85% successful outcome of treatment amongst registered new smear positive pulmonary TB cases.

The first priority of the RNTCP is the treatment, appropriate management and cure of TB patients, especially sputum positive cases, as this is the only way to break the chain of transmission. To ensure these, quality drugs will be provided for the entire duration of treatment under direct supervision of a DOT provider. Follow up sputum examinations will be undertaken periodically, as per the RNTCP guidelines, during treatment course and after completion of treatment to monitor progress and successful treatment outcome.

In terms of control of the disease i.e. to have an impact on the prevalence and incidence of TB, a global target of ≥85% successful outcome of treatment amongst new smear positive PTB cases has been set. Although successful outcome of treatment rates in India under RNTCP have to date been consistently ≥80%, the rates in those districts not yet covered by RNTCP are significantly worse. By utilising funds from GFATM to implement RNTCP in the population proposed in this component, it is planned to achieve the global target of at least 85% successful outcome of treatment in all 56 districts by 2005 and maintain it thereafter. To achieve this target, quality services for the treatment of TB, which are available and accessible throughout the 56 districts and to all sections of the population, are required. In addition, the population needs to be aware of the provision of such free treatment services and how they may avail themselves of these services.

Table IV.27

Outcome/coverage indicators (Refer to Annex II)	Baseline	Targets				
		March 03	Year 2: March 05	Year 3: March 06	Year 4: March 07	Year 5: March 08
Smear conversion rate of new smear positive cases at 3 months: In 1 st 29 districts In 2 nd 27 districts In all 56 districts	NA*		≥85% ≥85% ≥85%	≥90% ≥85% ≥85%	≥90% ≥90% ≥90%	≥90% ≥90% ≥90%
Treatment success rate in new smear positive cases: In 1 st 29 districts In 2 nd 27 districts** In all 56 districts**	40% ***		≥80%	≥85% ≥80% ≥80%	≥85% ≥85% ≥85%	≥85% ≥85% ≥85%
Default rate**** among new smear positive cases In all 56 districts	> 10%	< 7%		≤ 5%	≤ 5%	≤ 5%

* NA = Data not available under the earlier TB Control Programme

** Treatment outcome result may not be available for the remaining 27 districts by March 2005, as they are expected to start implementation during second quarter 2004.

*** Under the earlier non-DOTS/ non-RNTCP, successful outcome of new smear positive cases is not being reported systematically.

**** Proportion of new smear positive cases who, at any time after registration, has not taken anti-TB drugs for 2 months or more consecutively

27.1. 2 Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

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

Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

Once a patient is diagnosed as having TB, the concerned treating medical officer is responsible for deciding the appropriate regimen depending on the history of previous treatment and results of investigations. After the categorization of treatment is done for a patient, the treatment card and patient identity card is prepared. A field health worker verifies the address of the patient before initiation of treatment. Registration is done and the TB number is given during the supervisory visit of the STS. The MO of the Peripheral Health Institution (PHI) explains to the patient about the disease, informs about the dosage schedule, duration of treatment, examination of contacts and frequency of monitoring of progress towards cure whenever they have contact with the patient. The MO also determines the DOT centre most easily accessible to the patient after discussing with him/her and arranges for the treatment. The treatment card is maintained in the health facility, where the patient was diagnosed. If the treatment provider is a peripheral health worker/ community volunteer, the MO ensures the training of DOT provider. A duplicate card is prepared and given to the DOT provider to record DOT in that patient. The medicine box containing drugs for the entire duration of treatment is given to the treatment provider after being duly recorded in the register. During the intensive phase of treatment, each and every dose of the thrice weekly treatment regimen is to be taken under direct supervision of the treatment provider. Similarly, during continuation phase, the patient takes first dose of the thrice weekly drugs as directly observed therapy. Follow up sputum examinations is done during and at the end of the treatment course, as per guidelines, to ensure effective treatment. Either "Monday, Wednesday and Friday" or "Tuesday, Thursday and Saturday" are fixed as drug administration days for a particular patient for giving DOTS. In case the patient does not turn up on the specified day, s/he is contacted within a day of missing a dose during the intensive phase. Similarly, a patient must be contacted within a week of missing the weekly collection of drugs during the continuation phase.

To ensure the above services, trained staff needs to be in post and free drugs made available at all times. Supervision/monitoring system also needs to be in place to inform on the performance of RNTCP.

One aim of the DOTS strategy is to bring treatment as close to the patient as is practical. This requires decentralisation of DOT provision. All public sector facilities from tertiary centres to community clinics will provide DOT services. A further level of provision will be based in the community, involving both government workers and community volunteers. Involvement of the NGOs, village doctors and private practitioners will be pursued. To facilitate this involvement, the RNTCP has issued and disseminated two sets of guidelines for the respective involvement of NGOs and Private Practitioners (PPs) in RNTCP activities.

IEC activities will play an important role in ensuring successful treatment of TB cases. This would follow a holistic approach by providing relevant information and employing appropriate and effective communication especially through improved interpersonal communication.

Table IV.27.1

Objective: 2	to achieve at least 85% successful outcome of treatment amongst registered new smear positive PTB cases by 2005					Responsible/Implementing agency or agencies	
Broad activities	Process/Output Indicators (indicate one per activity) (Refer to Annex II)	Baseline	Targets				
		March 2003	End Year 1 Feb 2004	End Year 2 Feb 2005			
Establishment of DOT services	Establishing adequate number of functioning DOT Centers with trained DOT provider in place*	0	In all the 29 implementing districts	In all the 56 implementing districts	Respective DTO, MO-TCs and STSs		
Increased acceptance of DOT services by making DOT services more "patient friendly"	% of estimated TB patients residing within district put on DOTS	NA	≥90%	≥90%	Respective DTO, MO-TCs and STSs		
Uninterrupted supply of quality anti-TB drugs	Number of stock outs reported	NA	0	0	CTD, respective STO, DTO, MO-TCs & STSs		
Timely quarterly reporting	% of districts submitting quarterly report on time (i.e by 24 th of the following month of the quarter-end)	NA	>95%	>95%	Respective DTO, MO-TCs, and STSs		
Involvement of NGOs in RNTCP	Number of NGOs working in health sector involved in RNTCP	NA	20%	>40%	Respective DTO, MO-TCs, and STSs		
Involvement of private practitioners in RNTCP	Number of PPs involved in RNTCP	NA	20%	>40%	Respective DTO, MO-TCs, and STSs		

* As per the guidelines, DOT centers will be located at places convenient to the patients and providers and would generally be made available at least one per sub-center level (Sub-centers have been established @ one for every 5,000 population in plain areas and per every 3,000 population in hilly and difficult areas)

NA Not applicable

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

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

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

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 3

To achieve a case detection rate of at least 70% of the estimated new smear positive PTB cases existing in the population

To achieve the control of TB in a population, a sufficient number of individuals with infectious TB are required to be detected and successfully treated from amongst the respective population. The global target for case detection has been set at ≥70% detection of the estimated new smear positive PTB cases existing in a population in order to break the chain of transmission. At present, nationally about 30% of the estimated new smear positive cases in the country are being detected and put under DOTS. However, the 66% case detection achieved under RNTCP (Q2 2002 cohort report) represents a major improvement over the previous National TB Programme's (NTP) estimated case detection rate of <30%. By utilising funds from GFATM, it is planned to achieve the global target of >70% by 2005 in the identified population and maintain it thereafter.

Table IV.27

Objective: 3	To achieve a case detection rate of at least 70% of the estimated new smear positive PTB cases existing in the population by 2005					
	Outcome/coverage indicators (Refer to Annex II)	Baseline	Targets			
		March 03	Year 2: March 05	Year 3: March 06	Year 4: March 07	Year 5: March 08
Percentage of new adults OPD cases examined by sputum microscopy: In 1 st 27 districts In 2 nd 29 districts In all 56 districts	NA*		>1.8% >1.5% >1.5%	≥2% ≥1.8% ≥1.8%	≥2% ≥2% ≥2%	≥2% ≥2% ≥2%
Ratio of new smear negative cases to smear positive cases In 1 st 27 districts In 2 nd 29 districts In all 56 districts	NA		<1.2 <1.2 <1.2	<1.2 <1.2 <1.2	<1.2 <1.2 <1.2	<1.2 <1.2 <1.2
Case detection rate in percentage of estimated new smear positive cases: In 1 st 29 districts In 2 nd 27 districts In all 56 districts	<30%**		≥55% ≥55% ≥55%	≥60% ≥60% ≥60%	≥65% ≥65% ≥65%	≥70% ≥70% ≥70%

* NA = Not available under the earlier TB Control Programme

** The national average under the earlier programme (from data available only from the districts who submit their reports).

27.1.3 Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

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

Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

To achieve a case detection rate of at least 70% of the estimated new smear positive PTB cases existing in the population in 2005, not only do RNTCP services need to be available in the 56 "uncovered" districts included in this proposal, but that these services need to be of the highest quality possible and be readily accessible to the patients.

As the core of the DOTS strategy is bacteriological diagnosis and follow-up of cases, thus the RNTCP must ensure that the sputum smear microscopy services provided are of the highest quality. This requires that all MCs have the best available equipment and sufficient laboratory consumables to perform sputum smear microscopy examinations at all times.

To ensure quality smear microscopy services, requires the presence of trained laboratory staff in post at all MCs. Thus laboratory staff from the different partners and sectors require training on AFB microscopy. In addition, supervisory staff and external quality assurance assessors will need training in the quality assurance system and methods. Existing training material will be reviewed and revised if required, to meet the training needs.

A supervision / monitoring system to inform on the performance of RNTCP needs to be in place. This also requires a quality assurance (QA) system involving the checking of laboratory services by supervisory staff during field visits, and cross-checking of slides in all the MCs of the 56 districts covered by this proposal.

IEC activities will play an important role and is to be viewed in the context of RNTCP's long-term goal of detecting and curing TB patients so that TB ceases to be a major public health problem. Increased commitment at national and local levels through the involvement of the key opinion makers, NGOs and the private sector to keep TB control at the forefront of national priorities will be ensured. The IEC strategy would follow a holistic approach by providing relevant information, employing appropriate and effective communication for motivation, empowering people by supporting their ability to access services and fostering an enabling environment through improved interpersonal communication to achieve RNTCP's long term goals. Activities will include training of health providers in inter-personal communication and awareness raising amongst patients and general public, with enhanced advocacy around events (e.g. World TB day). Different media such as mass communication media, seminars, sensitization workshops, wall paintings, street plays, banners and hoardings would be used.

Table IV.27.1

Objective:3	To achieve a case detection rate of at least 70% of the estimated new smear positive PTB cases existing in the population by 2005					Responsible / Implementing agency or agencies
	Broad activities (indicate one per activity) (Refer to Annex II)	Process/Output Indicators	Baseline	Targets		
			March 2003	End Year 1 Feb 2004	End Year 2 Feb 2005	
Provision of laboratory diagnostic services of TB by sputum microscopy	Number of functioning MCs as per RNTCP norm (i.e one for every 100,000 population in plain areas and 50,000 population in hilly, difficult and tribal areas)	-	In all the 29 identified districts	In all the 56 identified districts	Respective STO, DTCS and DTO	
Provision of lab equipment	Functional binocular microscopes available in every MC	-	In all Identified 29 districts	In all the identified 56 districts	CTD, respective STO and DTO	,
Training of staff for sputum microscopy	Availability of RNTCP trained LTs in Microscopy Centers	0	At least 80% of the MCs in 29 districts	100% of the MCs in 56 districts	Respective STO, STDC and DTO	
Supervision to ensure quality laboratory services	Availability of trained STLS in post (one per every 500,000 population)	0	In all Identified 29 districts	In all the identified 56 districts	Respective STO, DTCS and DTO	

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

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

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

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 4:

To establish model “Urban TB Control Projects” in 4 major cities of India by improving the quality and reach of RNTCP to special groups like slum dwellers and migrants, through more “patient-friendly” treatment observation, involvement of private and NGO sectors and IEC.

Health care services available in urban areas are often lacking in primary health care infrastructure, primarily curative in nature, costly, and provided by divergent health establishments. Moreover, the rudimentary services that are available in the slums are mainly through PPs, many of whom are not qualified physicians, and NGOs working in the area¹¹. As a result, it is felt that a large number of TB patients in urban areas, especially in the slums do not have access to DOTS. This problem is more acute in the metropolitan cities, with the capital city of Delhi alone housing a slum population of more than 2 million.¹² Associations among tuberculosis, urbanization, and poverty have been noted in studies from many countries.¹³ A recent study conducted in two RNTCP implementing sites in New Delhi found that patients, largely those who were in absolute poverty, socially marginalized, itinerant laborers, poorly integrated in the city, were put on long course standard tuberculosis regimen without direct observation of treatment¹⁴.

Existing services in urban slum areas and health seeking behavior of these populations reveal the insufficiency of available services. In Bombay, most poor male and female tuberculosis patients either did nothing or took home remedies for the first two months of symptoms. When symptoms continued, private practitioners were the first source of allopathic treatment, they were generally unable to correctly diagnose the disease. Patients then went through the rounds of the municipal hospitals and NGO health services when private treatment became unaffordable or because of the poor quality of services. This adversely affects the wage-earning capacity of both men and women¹⁵.

It is felt that separate urban TB models are needed, in order to plan, pilot and implement an effective TB control programme in such area, especially for those who live in the slum areas.

Objective: 4	To establish model “Urban TB Control Projects” in 4 major cities of India (Bangalore, Delhi, Hyderabad, Kolkata) by improving the quality and reach of RNTCP to special groups like slum dwellers and migrants, through more patient-friendly treatment observation, involvement of private and NGO sectors and IEC.				
Outcome/coverage indicators <i>(Refer to Annex II)</i>	Baseline	Targets			
	March 03	Year 2: March 05	Year 3: March 06	Year 4:	Year 5:
New smear positive TB case detection rate in selected urban slum areas	To be determined	>60%	≥70%	NA*	NA
% of new smear positive PTB cases registered under the RNTCP with successful treatment outcome	To be determined	≥85%	≥85%	NA	NA
Default rate among new smear positive TB cases in selected urban slum areas	To be determined	<7%	≤5%	NA	NA

* NA- not applicable, as the project is for 3 years

27.1.4 Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

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

Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

Tuberculosis Association of India, in consultation with the Central TB Division, will formulate a Project Implementation Plan outlining the detailed activities. A core group will be formed for overall monitoring of the project, with representation from the Central TB Division.

To coordinate and build a partnership between the different sectors, an Urban Task Force (UTF) involving all stakeholders – State/District TB Officials, State/District AIDS Officials, State affiliates of TAI, local NGOs, PPs, community leaders etc will be formed to assist in planning, implementing, monitoring and evaluation of the project. Periodic interaction to review the status of the project will be held at the central as well as four project sites.

Resource mapping of existing health facilities including private and non-government facilities in the slum areas of the project sites will be conducted. Health-seeking behaviour, KAP and barriers to access among the target population, will be determined. This information will be used to develop specific targeted approaches and to monitor progress of the project.

The project will establish additional facilities to make the provision of DOT more convenient. Trained community volunteers, PPs and NGOs would be supported to operate 'open clinics' for providing DOTS at timings and location convenient to patients. NGOs and PPs will be involved as under the existing schemes.

Need based targeted IEC materials in local vernacular would be developed with the help of a professional agency. Through these IEC materials, messages would be disseminated to the community to generate awareness. Emphasis will be given to IPC and use of folk media considering cultural sensitivities.

Sensitization workshops for NGOs/PPs/Community volunteers and other stakeholders will be conducted at the local level. Training will be given to interested partners who will also be encouraged and supported to participate in the programme.

Monitoring:

Continuous monitoring and supervision would be built in the project to keep track of the progress and ensure timely completion of tasks. Resource mapping will be initiated within one month of commencement of the project and data collected and complied in the next three months. Data on case detection and management by the PPs & NGO involved in the project will be submitted to DTCS by the first week of next quarter. This information from project sites will also be compiled and collated by the project coordinator and reports submitted to the UTF in a similar time frame. Reports on training, sensitization and IEC activities along with report on outreach activities will be submitted within one month after end of each six month period to the UTF. Annual reports on all project activities will be submitted by UTF within one month of end of first year continued similarly till completion of project. A detailed report will be submitted within three months of conclusion of the project to GFATM through CCM.

Objective 4 :		To establish model “Urban TB Control Projects” in 4 major cities of India (Bangalore, Delhi, , Hyderabad, Kolkata) by improving the quality and reach of RNTCP to special groups like slum dwellers and migrants, through more patient-friendly treatment observation, involvement of private and NGO sectors and IEC.				
Broad activities	Process/Output *	Baseline**	Targets **		Responsible/ Implementing agency or agencies	
		Indicators (indicate one per activity) (Refer to Annex II)	April 2003	Year 1	Year 2	
Establish infrastructure for project implementation	<ul style="list-style-type: none"> Preparation of detailed Project Implementation Plan (PIP), ensuring key project staff in position and procurement of office equipment 	-	PIP Prepared Staff in place and equipment procured			TAI in collaboration with CTD
Improved coordination between public, private, and other sectors	<ul style="list-style-type: none"> % of NGOs/PPs in the area involved under RNTCP 	-	> 20%	> 40%		TAI, UTF, Concerned STC/DTC
Making DOTS more patient friendly	<ul style="list-style-type: none"> % of TB patients diagnosed residing within project area put under DOTS 	NA	≥ 90%	>90%		TAI, UTF, concerned STC/DTC
Improving IEC activities	<ul style="list-style-type: none"> Proportion of planned IEC materials developed, outreach activities undertaken & of community meetings held 	NA	≥ 25%	>60%		TAI, UTF, concerned STC/DTC
Training, supervision and monitoring	<ul style="list-style-type: none"> Proportion of planned activities for training, supervision and monitoring that were actually conducted 	NA	≥ 25%	>60%		UTF, TAI, concerned STC/DTC

* Additional indicators will be worked out in the PIP

** Based on the baseline data, more realistic targets will be set

28. **Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner:** (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41 – 42*),(2–3 paragraphs):

India being the second largest country in the world in terms of population, and having nearly 1/3rd of global TB burden, to provide good quality TB treatment services to the entire country with >1000 million population itself is a challenging task. As described earlier, with assistance from several external agencies, GOI is planning to control TB by expanding RNTCP to the entire country by 2005. This proposal is an additionality to the current ongoing expansion of RNTCP in the country in order to fill the programmatic and financial gaps facilitating meeting of the global targets of TB control by the target date of 2005. The proposed additional 110 million population to be covered with the GFATM assistance is situated in two States of Bihar and Uttar Pradesh, which are among the underdeveloped States with low socio-economic development indicators. Similarly, the "Urban TB Control Projects" if proved to be effective, will be replicated in other urban areas as well.

Control of TB is significantly contributing to reduction of poverty at both the individual and national level. More than 600,000 patients, who will be successfully treated during the project period, would return back to work. Improved productivity of workers by reducing absenteeism, preventing incapacity from ill health, and by averting TB deaths among these workers, add to the productivity capacities of the economy.

In addition to the health sector, RNTCP activities link with other sectors such as the Integrated Child Development Services Scheme of the Department of Women and Child Development, via the Anganwadi Workers who act as DOT providers. Grass-root level elected representatives of the people (Panchayat leaders), cured TB patients, traditional birth attendants and people from the community at large such as teachers, tailors, grocers, shoemakers, etc.. also participate in the programme as DOT providers. Private sectors and NGOs are encouraged to participate in the programme. Schemes have been developed for the partnering of the public and private sectors in TB control activities.

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

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

By provision of available and accessible high quality diagnostic and curative TB services, the direct beneficiaries of the component will be the >600,000 individuals initiated on treatment and cured of TB. Cured patients will be involved in the programme as DOT providers for future patients and as potent advocates on behalf of the RNTCP.

29.2. Community participation:

Participation of the community will be encouraged under the programme at various levels. To ensure community involvement in the decision making, the local leader representatives (village Panchayat) will be included as members in the District and State TB control societies. Community volunteers are also involved as DOT providers wherever possible according to patients' convenience. Through IEC activities, every attempt will be made to involve community at large in order to address various issues like social stigma, access of RNTCP services to marginalized group of population etc.

29.3. Gender equality issues (Guidelines paragraph IV.53):

The provision of country-wide available and accessible TB services as close to the patients as possible, is an important first step in beginning to address this issue. Attempts to make available TB control services gender sensitive is ongoing. Recognition of gender equality issues is already reflected under the TB Control Programme activities. For example, the recording/reporting system collects stratified data by sex and provides readily obtainable data on the proportions of males and females being registered under and their treatment outcomes.

29.4. Social equality issues (Guidelines paragraph IV.53):

It is well recognized that TB is predominantly a disease of the poor. A sample study showed that on an average, a TB patient loses three to four months of wages, equivalent to 20-30% of the annual household income, thereby making the poor poorer¹⁶. The provision of country-wide quality TB services as close to the patient as possible and free of charge, will decrease the financial losses incurred by the patient and the number of families falling into the cycle of debt and poverty caused by a family member having TB disease.

29.5. Human Resources development:

The RNTCP is not a vertical programme, is fully integrated with the existing health care infrastructures, and is implemented through the General Health Service Delivery System. Regular government staff provides the majority of services required under the programme. As per the norms under the ongoing World Bank-assisted project, some staff are appointed on contractual basis as per requirement. These are mainly supervisory staff at the subdistrict level and microscopists. The District and Statelevel TB control services are also strengthened with adequate staff to support the District TB Officer/ State TB Officer. Prior to initiation of service delivery, a wide range of staff is trained in various fields, enhancing their skills and capacity to perform the assigned tasks. The key programme managerial staff will undertake training on skills required for management including financial management. Training is also imparted to the concerned health workers to upgraded skill required for performing sputum smear examination, monitoring and evaluation of the programme, for improved interpersonal communication (IPC) with patients, record keeping etc.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), (Guidelines para. IV.55), (1-2 paragraphs):

Under the RNTCP, intermittent short course chemotherapy (i.e. rifampicin containing) regimens are used for all patients, with Category I and III cases receiving 6-7 month regimens and Category II cases an 8-9 month regimen (see table below).

Category of Patient	Regimen
I	2H ₃ R ₃ Z ₃ E ₃ / H ₃ R ₃
II	2S ₃ H ₃ R ₃ Z ₃ E ₃ / 1H ₃ R ₃ Z ₃ E ₃ / 5H ₃ R ₃ E ₃
III	2H ₃ R ₃ Z ₃ / 4H ₃ R ₃

Drugs are procured as patient-wise boxes containing blister combi-packs, packed in separate pouches for intensive and continuation phase of treatment. All doses in the intensive phase and at least the first of the thrice-weekly doses in the continuation phase of treatment are given under direct observation of a trained DOT provider. Follow up sputum examinations will be done as per RNTCP guidelines to ensure effective treatment completion. There are well-defined methods for default retrieval under the programme. In case the patient does not turn up to take medicines on the specified day, the DOT provider will contact him/her within a day of missing a dose during the intensive phase. Similarly, a patient must be contacted within a week of missing the weekly collection of drugs during the continuation phase.

The districts will report category-wise utilization of drugs every quarter and the balance stock along with the expiry dates to the State and Central levels. Close monitoring of the drugs stock will continued to be done by District/ State/ Centre to avoid stock-outs and expiry.

SECTION V – Budget information

- 30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to Guidelines paragraph V.56 – 58):**

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Human Resources	1.53	1.97	1.98	1.98	1.99	9.44
Infrastructure/ Equipment	1.74	0.00	0.00	0.00	0.00	1.74
Training/ Planning	0.76	0.09	0.09	0.09	0.09	1.12
Commodities/ Products	0.92	0.23	0.23	0.23	0.23	1.84
Drugs	0.19	0.89	1.08	1.18	1.22	4.56
Monitoring and Evaluation	1.00	0.70	0.70	0.70	0.70	3.80
Administrative Costs	0.34	0.44	0.44	0.45	0.45	2.12
Other (Please specify)						
• IEC	0.11	0.17	0.17	0.17	0.18	0.80
• NGO*	0.84	0.84	0.84	0.58	0.58	3.68
Total	7.43	5.33	5.53	5.38	5.43	29.10

* Includes the budget earmarked for NGO involvement under RNTCP including the TAI activities

The budget categories may include the following items:

Human Resources: Consultants, recruitment, salaries of front-line workers, etc.

Infrastructure/Equipment: Building infrastructure, cars, microscopes, etc.

Training/Planning: Training, workshops, meetings, etc.

Commodities/Products: Bednets, condoms, syringes, educational material, etc.

Drugs: ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.

Monitoring & Evaluation: Data collection, analysis, reporting, etc.

Administrative: Overhead, programme management, audit costs, etc

Other (please specify):

- 30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:**

Table V.30.1

Item/unit	Unit cost (US D)	Volume (specify measure)	Total cost (USD)
Category I (patient-wise box)	5.75	127000 boxes	73,025
Category II (patient-wise box)	10.10	5100 boxes	51,531
Category III (patient-wise box)	5.08	9900 boxes	50,325
Prolongation Pouch (Box of 5)	8.75	400 boxes	3,500
Streptomycin 750 vial	0.06	122400 vials	7,854
Rifampicin 150mg (strips of 10)	0.13	14169 strips	1,771
Isoniazid 100mg (strips of 10)	0.04	35733 strips	1,489
Pyrazinamide 500mg (strips of 10)	0.23	3324 strips	762
Binocular Microscopes	625	1101 nos	688,250
Lab Materials per million population	2083	110 million population	229,417

- 30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

The majority of services required under the programme are provided by the regular government staff. As per the norms in the ongoing World-Bank assisted project, the following staff are appointed on contractual basis as per necessity:

- **Senior treatment supervisors (STS)** monitor all components of RNTCP (except laboratory services) including the effectiveness of treatment, assist in returning patients who have interrupted treatment to service, ensure accurate and timely admission of quarterly reports, and, in general ensure efficient and effective treatment services. The existing approved norm is for one STS for every 500,000 population and one for 250,000 population in tribal areas. This pattern is proposed to be continued.
- **Senior tuberculosis laboratory supervisor (STLS)** ensures the accuracy of laboratory diagnosis, which is the primary tool of diagnosis of tuberculosis in peripheral health centres. The population coverage, which applies to STS, also apply to STLS, and these are also proposed to be continued in the present proposal.
- Qualified and trained **Laboratory Technicians** are the key professionals to undertake the core responsibility of sputum smear microscopy diagnosis.. It has been observed that there are a large number of vacancies of LTs in the peripheral health infrastructure largely because of inability of States to fill up existing and emerging vacancies due to fiscal constraints. Therefore, provision has been kept for hiring of LTs at a rate of two per million population on contractual basis to reach out to marginalized urban and rural populations where the majority of vacancies exist. As a part of decentralization of services the microscopy services would be made available in PHIs at every 100,000 population.
- Urban areas have very little health infrastructure. Therefore, a special provision has been made for **Tuberculosis Health Visitors (TBHV)** exclusively for the urban areas, which make up about 25% of the total population. It has been found that because of the density of population and non-availability of Primary Health Care infrastructure, the existence of tuberculosis health visitor is crucial for successful programme implementation and particularly to implement the DOTS strategy in urban areas. Therefore, TBHVs are provided, on contractual basis, at the rate of one for every 150,000 of urban population.
- As in the ongoing project, **data entry operators and drivers** are provided at state and district levels. The provision of a full time **accountant** at State and a part-time accounting staff at the district level will be provided. Accountants are essential for accurate and timely submission of statements of expenditures, and have been provided for with a nominal monthly honorarium of Rs 1000.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines para. V.62*):

Table V.31.1

	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
Domestic* (public and private)	8.03	4.82	3.84	4.38	4.79	5.42	6.67
External	10.61	17.5	15.37	17.50	19.17	21.67	26.67
Total	18.64	22.3	19.21	21.88	23.96	27.08	33.33

*Central Government funds only – State spending in terms of infrastructure and personnel has not been costed

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.
33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in percentage (Refer to *Guidelines para. V.63*):

Table V.33

Resource allocation to implementing partners* (%)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Government	87%	81%	82%	86%	86%	85%
NGOs / Community-Based Org.	13%	19%	18%	14%	14%	15%
Private Sector						
People living with HIV/ TB/ malaria						
Academic / Educational Organizations						
Faith-based Organizations						
Others (please specify)						
Total	100%	100%	100%	100%	100%	100%
Total in USD	7.43	5.33	5.53	5.38	5.43	29.10

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

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

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

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

- 34. Describe the proposed management arrangements** (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), (*Guidelines para. VI.64*),(1–2 paragraphs):

The implementation and management of the project will occur as per the ongoing programme. At the central level, the RNTCP will continue to be managed by the Central TB Division, headed by the Deputy Director General for TB as the National Programme Director. The Joint Secretary from the administrative arm of MOHFW will oversee the financial and administrative control of the TB Control Programme. The programme is supported by selected National Institutions like National Tuberculosis Institute (NTI) in Bangalore, the Tuberculosis Research Center (TRC) in Chennai and the Lala Ram Swarup Institute of TB and Allied Diseases (LRS) in Delhi, for carrying out various activities.

At the State level, the Director of Medical Services and the Director of National Programmes is responsible for overseeing implementation. Implementation responsibility, however, lies primarily with the State TB Officer. At the State level, State TB Training and Demonstration Centers (STDC) will support the programme for training, research etc. At the District level, the District Tuberculosis Officer (DTO), under the direction of the District Medical Officer, will be responsible for implementing the programme through the existing General Health Care Delivery System.

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

As the RNTCP is an ongoing national programme, the existing management system will be best suited and therefore, no change has been proposed in the management structure in this proposal.

- 35. Identify your first and second suggestions for the Principal Recipient(s)** (Refer to *Guidelines para. VI.65–67*):

Table VI.35

	First suggestion	Second suggestion
Name of PR	Central TB Division	
Name of contact	Dr L S Chauhan, Deputy Director General (TB)	
Address	522, C wing, Nirman Bhawan	
Telephone	011 3018126	
Fax	011 3018126	
E-mail	Ddgvtb@nb.nic.in	

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

- 35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component** (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), (*Guidelines para. VI.66–67*), (1–2 paragraphs):

The Central TB Division, headed by the Deputy Director General for TB, has an established programme management system including financial management system in place. Central activities focuses on building capacity at the State and District levels, including training in managerial and financial matters, provision of technical advice, monitoring trends, quality assurance, evaluation of programme performance, identification and dissemination of lessons learned across States. Adequate trained staff is in post to look after various aspects of the programme. The financial system tracks the releases made from CTD to the State and District TB Control Societies (STCS and DTCS). Similarly, quarterly statements of expenditure (SOEs) are received by CTD from societies to which funds have been released. Therefore, it is strongly recommended that the same system continue for the proposed proposal.

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

The suggested PR is already a member of the CCM. Similarly, the already established fund flow mechanism will facilitate disbursement of funds to the sub-recipients. Funds will flow from CTD to STCS and from STCS to DTCS. Reporting will similarly flow from DTCS to STCS to CTD. Annual audits will be sent from DTCS to STCS. STCS will undertake a consolidated audit, which it shall send to GOI and GFATM. CTD will submit annual financial status reports based on reported expenditures.

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

As per the existing system, funds will be released through State TB Control Society to District TB Control Societies. For audit, the STCSs will maintain a panel of Chartered Accountants from which panelists will be assigned to audit accounts of District Societies, which will then be received by the STCS where they will be consolidated and sent to the Centre. The Centre will consolidate the country-wide audit reports and submit to the GFATM according to their requirements. There are already Terms of References developed stating the operating policies for audit of District and State TB Control Societies. In addition to above, a consolidated annual project financial statement will be submitted by CTD for the overall project reflecting both component wise and category wise expenditure within 6 months of the close of GOI's fiscal year.

SECTION VII – Monitoring and evaluation information

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

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (Guidelines para. VII.76):

The existing reporting system under RNTCP is a quarterly reporting system from Districts to State to Central levels. The reporting proforma have been developed based on experience of GOI/WHO. Reports submitted include case finding, smear conversion rates, treatment outcomes, logistics and programme management, and Financial Reports detailing statement of expenditure etc. Detailed feedback on programme activities and achievements to each District are given by the State level, supplemented by additional feedback from the central level, by a fixed date of each quarter. Via an on-going electronic connectivity project, it is foreseen that over the next few years, submission of, analysis and feedback on the quarterly reports from and to all levels (Central, State and District) will move into the electronic domain utilising the Internet.

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.):

Four types of reports will be prepared quarterly at the subdistrict (TU) level and submitted for onward transmission to the District / State / Centre.

- **Quarterly Report on Case Finding** will be filled at any unit maintaining a TB register (which may be at the sub-district/ chest clinic/ borough level) by a Senior Treatment Supervisor and sent to the District/ city headquarter level. This pertains to the patients registered during a quarter and gives case-finding data and relationship between new smear positive and new smear negative cases.
- **Quarterly Report on Sputum Conversion** will be filled at any unit maintaining a TB Register (which may be a sub-district/chest clinic/borough level) by the Senior Treatment Supervisor and sent to the District/city headquarters level. This report gives the proportion of smear-positive cases of the cohort registered in the previous quarter who became smear-negative at 2 and 3 months of treatment.
- **Quarterly Report on Treatment Outcome** of cases registered 12-15 months earlier will be filled at the sub-district/chest clinic/borough level by the Senior Treatment Supervisor and sent to the District/city headquarters level. This report shows the various treatment outcomes of all cases registered during the repetitive quarter.
- **Quarterly Report on Programme Management** filled at the sub-district/chest clinic/borough level by the Senior Treatment Supervisor and sent to the District/city headquarters level. This report indicates the status of the health units, its functionaries as well as the state of logistics in the District.

Involvement and performance of NGOs in the RNCTP, will be monitored by number of NGOs participating in the various schemes as well as by their performance by analysis and feedback on reports submitted by the participating NGO. Monitoring and evaluation of private practitioners will follow the approved mechanisms included in the respective policy document.

37.3. Timeline:

Reports are completed by the staff at the sub-district or chest clinic level on the first week of each quarter and sent to the District/city level. This information is compiled and analysed at the District level. Remedial actions will be initiated immediately at the District level where the technical and managerial indicators have not been achieved. This compiled and analyzed report is then sent to the State along with a copy to the Central TB Division in the next week, i.e., in the first fortnight of the next quarter. The reports from all the districts are compiled and analyzed at the State level within the first month of the next quarter. The shortfall in achievement of performance indicators should be noted by the State TB Officer for the initiation of immediate remedial measures. The completed report and the measures initiated to correct any deficiencies identified previously should be sent to the Central TB Division within 6 weeks of the next quarter.

37.4. Roles and responsibilities for collecting and analyzing data and information:

The Tuberculosis Unit (TU) is the most peripheral reporting unit under the programme. The MO-TC in assistance with STS is responsible for the submission of quarterly reports: on case finding and programme management for the same quarter, sputum conversion report for the cohort of previous quarter, and the results of chemotherapy of Smear positive cases registered 12-15 months earlier, for their respective TUs to the districts. The reports generated at TU are compiled and consolidated at the District level under overall supervision of District TB Control Officer for onward submission to the State / Centre.

37.5. Plan for involving target population in the process:

Involvement of the target population and the community at large is encouraged under the programme at various levels. To ensure target population involvement in the decision making, overall supervision and monitoring, the local leader representatives (village Panchayat) are included as members in the District and State TB control societies. Community volunteers are also involved as DOT providers wherever possible according to patients' convenience. Also through IEC activities, every attempt will be made to involve community at large, directly and indirectly, in the process of monitoring of the programme implementation.

37.6. Strategy for quality control and validation of data:

Quality control and validation of data is ensured by several means:

- The reporting system utilised by the RNTCP has been proven to be robust. Performance in relation to any one indicator is easily verifiable via cross-checking of records and registers. Indicators are inter-linked and the reporting of one indicator can be used to project accurately other performance indicators (e.g. smear conversion results to treatment outcomes) and needs (e.g. number of cases detected to usage of sputum containers and thereby logistic needs). Reporting of such indicators as smear negative to smear positive ratio gives a good indication of the quality of diagnostic services being provided. In addition, field visits will continue to be the norm to improve the field performance, and review meetings will be held at the State level and at Central level quarterly and six-monthly respectively.
- Quality control of sputum microscopy is ensured by cross-checking of certain slides by the STLS during supervisory visits. The supervisor indicates his readings in the lab register and will write the number of slides examined and discrepancies found in his diary.
- A network of WHO-RNTCP Medical consultants has been appointed all over the country to ensure quality implementation of the programme. At present one consultant looks after about 10-15 million population. They facilitate in preparation and submission of accurate reports as well as data validation.
- The Programme performance is periodically evaluated. A comprehensive and independent review done in 2000 by a team of national and international experts found that the RNTCP was being implemented successfully. Patients are being accurately diagnosed, drug supply is regular and uninterrupted, and there has been a striking increase in the proportion of patients cured. In addition, a countrywide internal evaluation of the RNTCP has been conducted to identify the programme's strengths and weaknesses, build capacity of staff in programme evaluation, and assess the accuracy of recording and reporting.

37.7. Proposed use of M&E data:

The data generated by compiling and analyzing of the reports will continue to be used for monitoring performance of the RNTCP. Feedback on the quarterly reports will be provided as is being done at present for those districts implementing RNTCP. Reasons for poor performance for the concerned areas will be identified and appropriate actions taken to rectify and improve performance. The information will also be used for advocacy and policy making regarding TB control. In addition, regular workshops/ meetings will be held at District/ State/ Central level with the District and State authorities to review performance in their areas.

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	Partner(s) (which may help in strengthening M&E capacities)	Resources Required (USD)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
	Not applicable						
Total requested from Global Fund							
Total other resources available							

SECTION VIII – Procurement and supply-chain management information

- 39. Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to Guidelines paragraph VIII.86).**

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	The procurement of drugs, binocular microscopes and other equipment is made through an independent procurement agency, M/s MECON, for the World Bank assisted RNTCP Project. Until the previous year, the procurement was being done by forwarding the requirements, delivery schedule, consignee details and technical specifications to M/s MECON, who in turn prepared the bid document and obtains 'No Objection' from the Ministry and World Bank. Subsequently the advertisement was given in to the national dailies and UNDP bulletin for procurement through International Competitive Bidding (ICB). From the current year the procurement is being made by pre-qualifying the manufacturers based upon their manufacturing experience, required quality assurance, experience of manufacturing particular products, experience on packaging, distribution and transportation, registration requirements, production capability, financial capability and manufacturer's full-filling the WHO GMP conditions etc. The procurement is being handled separately in the Central TB Division, and the procurement agency M/s MECON has its own compliment of various technical experts and supporting staff.
What procurement procedures are used to ensure open and competitive tenders, Expedited product Availability, and Consistency with national and international intellectual property laws and obligations?	The procurement is made through International Competitive Bidding which ensures timely product availability and consistency with national and international laws and obligations. To ensure the timely availability of products, the procurement process is initiated well in advance, based on the lead time.
What quality assurance Mechanisms are in place to assure that all products procured and used are safe and effective?	In the case of drugs, pre shipment inspection is done by the procurement agency for all batches, and all batches are tested for quality. These drugs are supplied to the six Government Medical Stores Depots (GMSDs). However, a proportion of the total drug shipment is supplied directly to the consignees to save transportation costs and to ensure timely delivery. The GMSDs do random checking of samples for ensuring quality. For the drugs supplied directly to the consignees, State Drug Inspectors and Central Drug Inspectors do the random sampling of drugs to ensure quality. These drug inspectors also get the samples tested based on complaints. Govt. of India is in the process of engaging a separate agency for undertaking independent quality assurance of drugs. In case of equipment including binocular microscopes, pre-shipment inspection is done by the technical experts of M/s MECON and representatives of the Ministry of Health & Family Welfare. Post delivery quality is ensured by having a warranty period of about 3 years or so.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	For drugs, the distribution is made through the following : 1. Six Central level Government Medical Store Depots (GMSDs). 2. Five State level stores. In the future, it is envisaged to establish State Drug Stores in all the States. 3. District level RNTCP stores. 4. TB Unit level stores. To ensure continuous availability of drugs, the following buffer stocks are maintained at the various levels: <ul style="list-style-type: none"> • GMSDs – 6 months • State Drug Stores – 3 months • District Drug Stores – 3 months • TB Unit Drug Stores – 3 month • Peripheral Health Unit – 1 month For equipment, the products are supplied directly from the manufacturer to the consignees. In case of international manufacturers, Central TB Division and the procurement agency takes the responsibility of clearance from the port of supply up to the delivery of the product to the consignee. HOW WILL SUPPLY OF DRUGS, LAB CONSUMABLES ETC HAPPEN IN THE URBAN TB PROJECT?

40. **Describe the existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs):**

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

Regular training programmes are arranged for training of key TB programme managers of States and Districts, at Central Institutes and at State level Institutes. Training of the other general health staff of the districts is arranged either at State/ District or Local level. Separate training modules have been developed for training of each category of health workers. Clear-cut guidelines are also available regarding batch size of various trainees, prescribed duration of training, norms for expenditure for a training session, etc.

41. **Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):**

M/s MECON, an independent agency is undertaking procurement of drugs and other equipment for GOI. The procurement would be made through the same independent agency and accordingly their consultancy fees will be paid.

42. **Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (Guidelines para. VIII.88):**

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant
	Not applicable		

- 42.1. **Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):**

Not applicable.

SECTION IV – Scope of proposal

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

Table IV.23

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

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

Malaria is a major public health problem in India, and in South East Asia Region. Annually, nearly 75% of new malaria cases in the region occur India. Malaria in India in the last decade has become a serious re-emerging infection due to the steady increase in *P. falciparum*, and the spread of mono and multi-drug resistant strains. The problem is acute in hard to reach areas where primary health care system is unable to cope with the malaria problem. Malaria in its present form is a growing worldwide threat to the health of the people due to population migration seeding new parasite strains in malaria receptive areas. Furthermore, major ecological changes like irrigation, deforestation, urbanization, industrialization, and large-scale population migration have been continuously enhancing malaria receptivity, resulting in focal outbreaks. Malaria epidemics and deaths due to malaria that had been completely eliminated have now become a regular feature of the country's malaria situation.

The Government of India has been taking many steps to combat malaria at a war footing. Central budgetary assistance for malaria control to all the seven highly endemic North Eastern states of the country has been enhanced from 50 % to 100%. Furthermore, highly vulnerable populations settled in remote and forest areas are covered under a World Bank funded project, which is providing malaria control to a population of 67 million people. However, additional support is needed for the 49 districts, which currently contribute to nearly 22% of the new malaria cases in India. (see Table 22.3a for details of stratification that led to the selection of these areas for GFATM support).

The goal of this project is to control malaria by up-scaling interventions in 49 highly endemic districts. This will be accomplished by improving access to early diagnosis and treatment of malaria by involving community volunteers, developing partnership with private providers, providing rapid diagnostic dipsticks for early diagnosis and strengthening planning and supply systems. Vector control will remain the back-bone of malaria control. In the project districts vector control will rely on selective insecticide residual spraying (IRS) and introduction of larvivorous fishes to reduce mosquito breeding. Spraying will be targeted and focal. Project areas outside those designated for spraying will receive insecticide treated bednets. This activity will be carried out in partnership with Population Services Internationally reputed NGO in social marketing. While these interventions will reduce malaria transmission significantly, there still may be small outbreaks of malaria. These areas will receive special attention and will be tackled by rapid response teams for which the expertise and resources will be generated at the district level. Malaria control staff will be trained in specialized institutions, and there will be advance planning and concurrent monitoring and evaluation. Successful implementation of the GFATM project will lead to a significant reduction in malaria-associated morbidity and mortality and the following results are expected to be achieved.

- 22 million additional people will have access to Early Diagnosis Preventive Treatment
- 7.5 million people will be protected through use of ITN
- 951 Primary Health Centres will be equipped to effectively handle cases of severe and complicated malaria.
- A cumulative reduction of malaria morbidity by 85 % will be achieved by the end of five years. This will translate into prevention of 374000 cases in five years.

Government-NGO-private sector partnership with a view to converge malaria control activities at the community level will be the cornerstone of the implementation strategy. Towards this end the existing public health infrastructure will be strengthened and optimally utilized to implement the project. The Directorate of NAMP will function as the nodal agency to coordinate with CCM, provide technical guidance, monitoring and evaluation of the Programme. The state and district authorities will be responsible for planning area specific activities, implementation, and supervision and monitoring. NGOs, CBOs, village-level local self-government (*the Panchayat*), and communities will be key partners to enhance and scale up the control activities in the project areas. This strategy will enable the development, strengthening and expansion of government/private/NGO partnership. The national NAMP Drug Policy, Insecticide Policy and approved Programme Guidelines will be adhered to in the execution of the project.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	April 2003	To (month/year):	March 2008
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26. Detailed description of the component for its FULL LIFE-CYCLE:

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

Indicators: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.

Baseline data: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.

Targets: Clear targets should be provided in absolute numbers (if possible) and percentage.

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

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

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

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

The goal of the project is to control malaria morbidity and mortality in a time bound manner (2003-2008) in partnership with the stakeholders and communities. A major component of the strategy of malaria control using the insecticide treated bed nets will be implemented in partnership with the Population Services International. Communities will be involved which will enhance the sustainability of malaria control in the country. The target population for this project are 85 million people living in 49 malaria prone districts in 6 states of India. These districts contribute disproportionately to the burden of malaria in India, approximately 22% of all cases.

Table IV.26.1

Goal:	To reduce the burden of malaria and associated deaths in forty nine endemic districts in India, and thereby improving the Socio-economic Status of the Community	
Impact indicators <i>(Refer to Annex II)</i>	Baseline	Target (last year of proposal)
	Year: 2001	Year: 2007
Annual Parasite Incidence (API)	5.2	1.04
Slide Positivity Rate (SPR)	7.0	1.4
Malaria Mortality	To be ascertained	90% reduction

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

(1) **Enhancing access to early malaria diagnosis and prompt treatment through community based action**

Information, education and communication (IEC) activities will be intensified to improve awareness about the disease, its control through community action, diagnosis of fever, presumptive treatment, diagnosing a case of severe malaria at the village level and referral to the nearest hospital/clinic for treatment. Existing laboratory services will be strengthened as per the NAMP norms. On an average half of the existing positions for multi-purpose worker (MPW) and laboratory technicians are vacant in these districts. As a result, slides from fever cases are not collected and those collected are not examined in places where there are acute staff shortages. Slide examination may take 6-8 weeks during the peak transmission season. Peripheral areas are the most neglected. In order to overcome this the GFATM supported project will strengthen early diagnosis and prompt treatment (EDPT) at the periphery by recruiting community malaria and community link volunteers. These volunteers have been successfully used in other parts of India for early diagnosis of malaria, giving the correct dosage of antimalarials, and in referring serious cases to the nearest hospitals. Rapid Diagnostic Dipstick tests (RDT) will be introduced for times and locations where laboratory technicians are not available and where *P. falciparum* is the predominant infection. A large number of patients go to the private providers for treatment. These providers will be trained in malaria microscopy and in the use of RDTs for quick and accurate diagnosis. They will also be trained in treating the patients as per the National Anti Malaria treatment Policy, so as to reduce the menace of drug resistance arising out of improper/inadequate treatment.

Table IV.27.1

Objective:	Enhancing Access to Early Malaria Diagnosis and Prompt Treatment through Community Based Actions				
Outcome/coverage indicators <i>(Refer to Annex II)</i>	Baseline	Targets			
	Year:	Year 2:	Year 3:	Year 4:	Year 5:
Percentage of patients with uncomplicated malaria getting correct treatment at health facility and community levels, according to national guidelines, within 24 hours of onset of symptoms	To be ascertained	30 %	35 %	50 %	75 %
Percentage of villages having at least one trained Community Malaria Volunteer	50 %	60 %	70 %	80 %	100%

Table IV.27.1a

Objective: I	Enhancing Access to Malaria Diagnosis and Treatment through Community Based Actions				
Broad activities	Process/Output indicators (indicate one per activity) (Refer to Annex II)	Baseline	Targets		Responsible / Implementing agency or agencies
		(Specify year)	Year 1	Year 2	
Expanding the outreach services through community malaria volunteers/ community link volunteers	Number of community malaria volunteers recruited	30000 (50%)	40000	50000	Panchayat / Community / Primary health Center
Activating malaria microscopy as per programme norms	Number of PHCs having microscopist	70 %	85%	100 %	State health department
Enhancing the capacity of peripheral health institutions for treatment of severe and complicated cases of malaria	Number of medical officers trained	To be ascertained	50 %	60 %	State health department
Encouraging private sectors participation in diagnosis (microscopy and RDT) and treatment of malaria	Number of private medical practitioners trained	To be ascertained	10 %	20 %	State health department / Indian Medical association / Christian Medical Association of India / Voluntary Health Association of India etc
Enhancing availability of rapid diagnostic facilities where microscopic facilities are not available	Percentage of Health facilities that do not have malaria microscopic facilities, having RDTs	Nil	>25%	>50%	Sate/ District Health authorities
Improved community awareness for the need of EDPT	Percentage of population aware of symptoms of malaria and the need for EDPT	To be ascertained	>50%	>75%	NAMP and Partners

(2) Integrated vector control through partnership

Effective vector control to interrupt malaria transmission will be carried out by integrated vector control methods, which will involve a mix of IRS, Insecticide treated Bednets and bio-environmental measures like use of larvivorous fishes. In the first year high transmission areas will receive IRS. Simultaneously fish hatcheries will be established in all 49 districts in partnership with the state fisheries department. Communities will participate in the introduction of larvivorous fish in water bodies in and around villages and in the maintenance of these hatcheries. In subsequent years, in sections with low transmission insecticide treated bednets (ITN) will be introduced and the remaining high transmission areas will be sprayed with. The ITN programme will be implemented in partnership with the Population Services International (PSI). PSI will work in close collaboration with the directorate of NAMP. PSI will carry out social marketing of insecticide treated nets. IEC campaign about the need for ITN as a means to prevent malaria will be done by PSI and NAMP. The ITNs will be introduced in a phased manner covering 6 million people by the end of 5 years. Insecticide spraying will be phased out with the expansion of ITNs and bio-environmental measures.

Intersectoral coordination meetings will be held at the district level under the chairmanship of the District Collector/Deputy Commissioner. In his capacity as the coordinator, he will identify main agencies to enhance the impact of interventions either by directly participating in malaria control or by incorporating malaria control in the ongoing and planned activities. These 4 or 5 agencies will work in partnership with the NAMP and help in accelerating the implementation of malaria control activities from their own resources. Suggested departments/agencies that may be considered for partnership in malaria control are the departments of: Social Welfare (women and child welfare, tribal development); Rural Development; Local Self Government; Department of Irrigation, Agriculture, Forestry, Fisheries, Education, Public Health, and Engineering; Non- Governmental Organizations; Community Based Organizations; Religious Groups; Professional bodies such as the Indian Medical Association; Christian Medical Association of India; Federation of Obstetrics and Gynecology Society of India, and Research Organizations such as the Indian Council of Medical Research.

Table IV.27.2

Objective: II		Integrated Vector Control through Partnership				
Outcome/coverage indicators (Refer to Annex II)	Baseline		Targets			
	Year:	Year 2:	Year 3:	Year 4:	Year 5:	
Proportion of households having at least one treated bed net	To be ascertained	5 %	10 %	15 %	20 %	
Per man hour vector density	To be ascertained	80 % reduction	80 % reduction	80 % reduction	80 % reduction	
Per man hour mosquito density	To be ascertained	80 % reduction	80 % reduction	80 % reduction	80 % reduction	

Table IV.27.2a

Objective:	Integrated Vector Control through Partnership					Responsible / Implementing Agency or agencies
	Broad activities	Process/Output Indicators (indicate one per activity) (Refer to Annex II)	Baseline	Targets		
			(Specify year)	Year 1	Year 2	
Social Marketing of insecticide treated bed nets (in a phased manner covering 6 million population by the end of 5 years) through partnering with Population Services International (PSI)	Number of bed nets distributed	0	5 % of target population	10 % of target population	PSI	
Indoor residual spray (SP) in highly malarious areas covering 12 million population (to be reduced gradually with the expansion of ITN and bio-environmental measures)	Percentage of rooms covered in each round of spray	So far 40 % with DDT	> 90 %	> 90 %	State and district health departments.	
Introduction of larvivorous fishes in partnership with department of fisheries and their maintenance with active community participation	% of districts/blocks having a functional hatchery.	< 5 %	25 %	50 %	State and district health departments.	
Increase awareness of community for the need of ITN for personal protection	Percentage of population aware about ITN and its advantages	To be ascertained	25%	>60%	PSI/Grass root NGOs and state health authorities.	

(3) Strengthening epidemic preparedness and rapid response

In regions of the country with unstable malaria, malaria epidemics occur frequently and with regularity. In 1995, a system that relied upon the rise in epidemiological indices for detection of epidemics was developed, but this mechanism did not work well because it depended on an effective surveillance system. Furthermore, a malaria information system was never fully developed so information about epidemic was delayed and response reached the site late during crisis situations. This will be remedied by this project by using a sudden rise in the fever cases as an indicator. The community malaria volunteers will routinely report fever cases to the primary health center (PHC) for investigation. Guidelines for the investigation will be provided to all PHCs and adequate stocks of antimalarial drugs will be made available. As soon as a sudden rise in the number of reported fever cases is detected and the cause established to be malaria appropriate action will be taken at all levels, beginning at the periphery. Antimalarial drugs will be given to all suspected of suffering from malaria as the first line of treatment. Hospitals will be alerted to diagnose early and treat malaria cases according to the treatment policy of the NAMP. In the affected area vector control teams will be deployed for appropriate interventions and intensified surveillance.

Table IV.27.3

Objective: III		Epidemic Preparedness and Rapid Response				
Outcome/coverage indicators <i>(Refer to Annex II)</i>	Baseline	Targets				
	Year:	Year 2:	Year 3:	Year 4:	Year 5:	
Districts with Epidemic Response Teams	10	25	40	49	49	

Table IV.27.3a

Objective:		Epidemic Preparedness and Rapid Response				
Objective:	Broad activities	Process/Output Indicators (indicate one per activity) <i>(Refer to Annex II)</i>	Baseline	Targets		Responsible / Implementing agency or agencies
			(Specify year)	Year 1	Year 2	
Early reporting of any sudden rise in number of fever cases in the community by the CMV	% fever outbreaks reported within two weeks of onset	To be ascertained	25%	50%	Dte. of NAMP / State/district health departments	
Investigation of the cause of sudden rise in fever cases at the PHC and appropriate response	% of malaria outbreaks confirmed within two weeks of onset and control measures initiated	To be ascertained	40%	70%	Dte. of NAMP / State/district health departments	
Development and operationlization of action plan to control an outbreak / epidemic through a designated rapid response team	% of malaria epidemic responded within two weeks of onset and properly controlled	To be ascertained	40%	70%	Dte. of NAMP / State/district health departments	

(4) Capacity building and improved program management

Training is a vital component of the NAMP. In the GFATM supported project, staff recruited against existing vacancies and those required for the new positions in NAMP and state health departments will be trained appropriately. Capacity of various functionaries like public and private health care providers, community volunteers, NGOs, partners at the district level will be built. Computers will be provided at the district level for better and more efficient management of data. All records related to malaria at the district level will be computerized for easy access and monitoring. Analyzed data will be forwarded to various levels for information and necessary action.

Table IV.27.4

Objective: IV		Capacity Building and Improved Programme Management				
Outcome/coverage indicators (Refer to Annex II)	Baseline	Targets				
	Year:	Year 2:	Year 3:	Year 4:	Year 5:	
% of Health Staff trained in various malaria control activities	50%	75%	>90%	100%*	100%*	

* New entrants

Table IV.27.4a

Objective:	Capacity Building and Improved Programme Management					
	Process/Output Indicators (indicate one per activity) (Refer to Annex II)	Baseline	Targets		Responsible / Implementing agency or agencies	
Broad activities		(Specify year)	Year 1	Year 2		
Appropriate training activities for all programme functionaries , community volunteers, NGOs , private partners in related field	% of health facilities able to confirm malaria diagnoses according to national policy (microscopy, rapid tests, etc)	70%	80%	>90%	NMCP/State Health Depts./ Local self government/ NGOS / Private Partners/Training institutes	
Strengthening and upgradation of the Management Information System	% of District Malaria Offices with computerized MIS	5%	30%	>80%	State Health Authority / Society	

- 28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (Guidelines para. III.41 – 42),(2-3 paragraphs):**

The National Anti Malaria Programme is being implemented in the peninsular India on a 50: 50 cost sharing basis with the state governments, and 100% central assistance to the north eastern states. In addition 67 million people in 100 districts in 8 states are covered under the Enhanced Malaria Control Programme funded by the World Bank. The remaining 85 million people living in high malaria transmission areas are not receiving any outside donor support and require additional resources for effective malaria control. The resource gaps have been identified for support from GFATM project. This component will build on and scale up the existing malaria activities in the 49 districts. The resources asked for in the proposal will be complementary to the existing anti-malaria programme activities.

Table 4 showing the various malaria control activities and sharing of expenditure between the Government and the GFATM

Sl. No.	Activity	Best estimates possible for the contributions (%) by the two funding partners		GFATM Support Requested in million USD
		Central and State Governments	GFATM (Malaria)	
1.	Human Resources	98	2	0.51
2.	Infrastructure / equipment	90	10	2.65
3.	Training / planning	60	40	0.45
4.	Commodities / products	25	75	31.85
5.	Drugs	65	35	0.46
6.	Monitoring and evaluation	35	65	2.01
7.	Administrative costs	77	23	0.44
8.	Others	2	98	21.12
	Total	100	100	59..49

The GFATM proposal is in fact a part of the over all national malaria control plan. The proposal reinforces the existing links with NGOs, partnership with stakeholders and brings them together bringing about malaria control as prescribed in the 5-year national development plan document.

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

29.1. The involvement of beneficiaries:

The health, economic and social consequences of malaria are worst felt among low-income populations, particularly the families of pregnant women and children under the age of five. Project activities, which will target low-income populations, will reach a large number of direct and indirect beneficiaries by promoting personal protection against malaria. Involvement of project beneficiaries will be essential for project success, particularly in design of appropriate communications materials. Women and men from low-income groups will participate fully and actively in the development of all project materials. Community Based Organizations, which consist mainly of women will be the vehicle for spreading key messages regarding malaria prevention and treatment.

29.2 Community participation:

The project involves building strong partnerships between government, non-governmental agencies and community. The partnership with local organizations will establish trust and gain access to communities. Local partners such as NGOs, CBOs and health providers will be critical in both spreading key messages for improved protection against malaria, and in providing credibility to these messages. In all spheres of development, it has been clearly demonstrated that those projects that enjoy the full involvement and support of the community leadership and civil society have the highest rates of success. For this project, community initiatives based on partnership and participation will be undertaken in collaboration with local partners with proven capacity in this area.

29.3. Gender equality issues (Guidelines paragraph IV.53):

Emphasis will be on the vulnerable groups of women and children. Health care workers will be trained to recognize and treat malaria in pregnancy. In selected high-risk areas chemoprophylaxis in antenatal period will be provided in collaboration with the Maternal and Child Health Division in the Department of Health & Family Welfare. ITNs present special gender-based challenges in many Indian sub-cultures. Women and young children are in the greatest need of the benefits of ITNs. Yet, in many instances, the purchase and use of the net must be negotiated with the male head of a household. A woman's power and ability to discuss the issue with her husband will determine whether a net is introduced into the household and properly used. To fully address this issue, men and women will be involved equally in the development and targeting of communications materials to promote a supportive environment for discussion about good health, especially malaria prevention in the household.

29.4. Social equality issues (Guidelines paragraph IV.53):

Malaria accentuates social inequalities by worsening poverty, while its prevention has tremendous implications for cost saving and poverty alleviation. The poor and the marginalized will receive unbiased protection, EDPT and referral services under this project. Social marketing as will be used for ITNs is a strong, cost-effective and sustainable tool for empowering low-income people to lead healthier lives, and thereby improve their economic condition. Social marketing of ITNs, will create well-informed demand and a widely accessible, affordable supply of high quality, affordable branded nets with a treatment kit for low-income populations that need affordable health products, but do not need to rely on free products from the government and yet cannot afford private sector prices. Operations research will examine the social structures and dynamics of target populations, and use this information to inform strategy development and refinement to reach underserved or marginalized populations and groups. Product distribution and communication activities will focus on reaching underserved populations such as those residing in urban slums or remote rural areas, and who are not covered by mass media or conventional distribution systems. This will ensure creation of sustainable access to products, services and information for malaria prevention.

29.5. Human Resources development:

Structured training programs for all categories of health personnel will be established. This program will draw on expertise from reputed institutions in India. These institutions will also be involved in training new and existing staff from the project.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), (Guidelines para. IV.55), (1–2 paragraphs):

A National Anti-Malaria Drug Policy and the National Insecticide Policy have been developed. These policies will be updated as needed after consultation with the Technical Advisory committee of the NAMP.

P. falciparum monitoring teams located in various regions of the India routinely carry out monitoring for drug resistance in the malaria parasite (s). These teams report to the Director NAMP for policy decisions. In addition, several research institutes of the ICMR also carry out drug resistance monitoring. The 72 zonal entomological units of the NAMP and the research institutes with entomological expertise also carry out insecticide resistance in malaria vectors.

Malaria treatment protocols are widely distributed to ensure the implementation of uniform treatment policy in all states.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to Guidelines paragraph V.56 – 58):

Table V 30

Resources needed (USD)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Human Resources	63,184	63,184	127,102	127,102	127,102	507,673
Infrastructure/ Equipment	530,612	530,612	530,612	530,612	530,612	2,653,061
Training/ Planning	20408	20408	177,041	127,347	107,857	453,061
Commodities/ Products	12,739,592	6,369,796	4,246,531	4,246,531	4,246,531	31,848,980
Drugs	91,837	91,837	91,837	91,837	91,837	459,184
Monitoring & Evaluation	528,796	406,347	508,388	365,531	447,163	2,256,224
Administrative Costs	72,531	72,531	96,898	96,898	96,898	435,755
Other (IEC/NGO / Panchayat – community / Pvt. treatment provider)	3,142,857	4,469,388	4,571,429	4,469,388	4,469,388	21,122,449
Total	17,189,816	12,024,102	10,349,837	10,055,245	10,117,388	59,736,388
PSI for ITN	1,112,387	1,699,729	2,123,358	2,593,418	2,951,084	10,479,976
Grand total	18,302,203	13,723,831	12,473,195	12,648,683	13,068,472	70,216,364

* Training funds available.

- 30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

Item/unit	Unit cost (USD)	Volume (specify measure)	Total cost (USD)
Vehicles on hire	2,449.00	55	134,695
Rapid diagnostic Kits	0.82	200,000	164,000
Synthetic Pyrethroids wp	17,694.00	720	12,739,680
Drugs (Inj. Artemisinine derivative etc)	3.06	30,000	91,800
Total			13,130,175

- 30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

The human resource component budget request amounts to only 0.7% of the total GFATM assistance requested.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (Guidelines para. V.62):

External assistance for the 49 district project area has not been received for the years specified in table v31.1. This table shows the extent of approximate government funding for the project area (49 districts) in US million dollars.

Table V.31.1

	1999	2000	2001	2002	2003	2004	2005
Domestic*	23.7	31.6	25.5	31.2	31.2	31.2	36.0
External	12.4	20.4	20.4	20.8	20.8	20.8	24.0
Total*	36.1	52.0	45.9	52.0	52.0	52.0	60.0

* NOTE: The budgetary figures shown above are based on plan allocations for central government expenditure of Malaria control and do not reflect amounts spent by state and local government bodies for infrastructure, personnel, etc. – estimated to be 3 times the central government's contribution. Private spending cannot be determined at this stage but is approximately 4 times the national spending.

The figures indicated in the executive summary are for 5 years which will commence from the date of funding, while Table V 31.1 shows expenditure from 1999-2005, thus the two do not totally overlap, however years 2003, 2004 and 2005 do correspond

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled. Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

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

Kindly see Attachment M4.

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in percentage (Refer to Guidelines para. V.63)

Table V.33

Resource allocation to implementing partners* (%)	Year 1 (% allocation)	Year 2 (% allocation)	Year 3 (% allocation)	Year 4 (% allocation)	Year 5 (% allocation)	Total (In USD)
Government	81.15	61.67	52.41	50.96	49.39	42,802,728
NGOs / Community-Based Org.	17.23	36.18	43.78	46.18	47.32	25,652,425
Private Sector	0.56	1.49	2.46	1.61	1.55	1,020,408
People living with HIV/ TB/ malaria						
Academic / Educational Organizations	0.95	0.52	1.39	0.4	1.01	602,041
Faith-based Organizations						
Others (procurement agency fees etc)	0.11	0.15	0.16	0.16	0.16	102041
Total	100	100	100	100	100	
Total in USD	18,302,203	13,723,831	12,473,195	12,648,683	13,068,472	70,216,384

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

If these arrangements are the same for all components, you do not need to answer these questions for each

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

34. **Describe the proposed management arrangements** (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), (*Guidelines para. VI.64),(1–2 paragraphs)*:

Implementation arrangement:

GFATM project will have an independent secretariat at Directorate of National Anti Malaria Programme comprising of the following staff:

- GFATM coordinator will be the Director, NAMP.
- Project consultants (2), one each for IEC and Finance
- Investigator / Programmer (2)
- Data entry operator (2)
- Secretarial assistant (4)

At the states, there will be,

- State GFATM coordinator (Malaria) in each state (5)
- Project consultants (2), one each for IEC and Finance (Total 10)
- Investigator / Programmer one in each state (Total 5)
- Supporting staff three in each state (Total 15)

Each state will have a malaria society at the state headquarters. Each district will have a malaria control society and the GFATM funds will be channeled through the society. The District Collector (Executive Head of the District) will chair the society with 5 to 6 members. The society will meet as often as necessary and execute the programme with the help of CMO/DMO and the partners. The society will ensure that the budget will be used for the purposes it was intended in a cost-effective manner.

Director NAMP will be over all in-charge of all activities related to GFATM project. The Project Coordinator at the HQs and his own staff will assist her. The project coordinator will be supported by the state level coordinators. Partners (e.g. PSI, MRC, IEC, Fisheries etc.) will report directly to their own coordinators. For supervision and training Regional Directors will participate in the GFATM project and report directly to the Director NAMP. Director will ensure that the progress of the project is smooth and will lead to meet the targets of each activity. Financial transactions will be transparent and monitored as per the GOI norms and procedures. Financial procedures to minimize transaction costs will be adapted at all points of decision-making.

At the district level, CMO/DMO will carry out the interventions, monitoring and other activities. The district infrastructure responsible for various malaria control activities will continue to work as before. Additional staff appointed for MIS or any other activity will also report to the CMO/DMO.

Partners-Role and Responsibilities:

The major partners in malaria control are the GOI at the National and State Level, PSI, Fisheries Department, and Community. All partners will work under the direction and supervision of the CMO/DMO and participate in the District Intersectoral Coordination meetings. They will be fully responsible for all the actions producing synergy as reflected in the process and outcome indicators. In return they will be provided with adequate resources and technical support in the execution of their specific activity.

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

NAMP has 5 decades of experience in malaria control. The infrastructure is huge with enormous capacity to deliver health interventions. As per the Indian constitution health is a state subject. Malaria control is the direct responsibility of the state health departments. State governments carry out interventions in consultation with the NAMP. The Central Government provides resources and technical guidance to the programme. In the past successful malaria control was carried out with the existing administrative and technical expertise. However, during a time when there was a resource crunch there was a resurgence of malaria and has required intensive efforts to control. The focused attack on malaria strategy in 49 districts in this component will improve service coverage in the neglected area. NAMP in partnership with sister organizations will demonstrate that it is possible to obtain a measurable impact on malaria transmission.

- 35. Identify your first and second suggestions for the Principal Recipient(s)** (Refer to Guidelines para. VI.65–67):

Table VI.35

	First suggestion	Second suggestion
Name of PR		
Name of contact		
Address		
Telephone		
Fax		
E-mail		

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

- 35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component** (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), (Guidelines para. VI.66–67), (1–2 paragraphs):
- 35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners** (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph):
- 36. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements** (including, for example, details on annual auditing and other related deadlines). If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity, (1–2 paragraphs).

SECTION VII – Monitoring and evaluation information

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

In addition to the identified monitoring indicators mentioned in section IV. 27 and routine epidemiological indicators in use by NAMP, an additional monitoring mechanism will be followed as described below.

GFATM project will have an independent monitoring and evaluation mechanism that will review the programme annually (total review), but certain activities will be reviewed at 6-monthly interval. The decision to review certain activities at 6-monthly interval will be taken by the chair in consultation with the other members of the review team. The proposed composition of the team with the terms of reference is given below.

Independent Monitoring and Evaluation Mechanism

Members:

1. Chair (non-governmental malaria expert)
2. Members from organizations like - Indian Institute of Health Management Research, Malaria Research Center, Vector Control Research Center, National Institute of Health and Family Welfare, Administrative Staff College of India, WHO etc.
3. Member Secretary NAMP, Delhi

Terms of Reference

1. To review the progress of project with reference to technical, administrative and financial aspects of the project against targets.
2. Role of implementing partners in project implementation.
3. Recommendations.

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys,

Demographic health surveys and living standard health surveys are done at fixed intervals by the Census department of the Government of India, Economic ministries in consultation with the Ministry of Health and Family Welfare. The data is analyzed and published for circulation to various interested parties/ministries. Ministry of health has disease control programmes and specific surveys are the responsibility of the programme e.g. HIV AIDS, TB, Blindness, Goiter Control, etc. NAMP is responsible for the control of vector borne diseases such as malaria, filariasis, dengue fever, Japanese encephalitis, kala-azar etc. NAMP carries out demographic surveys from the standpoint of disease vector control. Primary data is collected by the multipurpose worker (MPW) and the spray squads for collation at the PHC level. This data is transmitted to the district for further collation and analysis. At the district level Chief Medical Officer (CMO) is responsible for all disease control programmes, but for disease vector control District Malaria Officer (DMO) is responsible for all the activities related to the control of malaria and other vector borne diseases. Control of vector borne disease in urban areas is the responsibility of the local self-government and Medical Officer (MO) of the urban area/Town is responsible for pest control including the control of malaria and other vector borne diseases, and works in partnership with the DMO. NAMP is supported by highly specialized national research institutes for specialized activities related to malaria control such as the monitoring of entomological component in the country, insecticide resistance, vectorial capacity, mapping, monitoring of drug resistance, cross-checking of epidemiological indices, epidemic investigations and fighting emergencies.

With particular reference to malaria, NAMP collects primary data on the 17 forms at different level starting from sub-centre. These forms are received at the district level for information sharing with the state HQ and the NAMP HQ. This data is the basis of annual reports, planning of malaria control and evaluation by the NAMP and independent agencies. This procedure will continue uninterrupted in the GFATM districts. For speedy reporting and response Malaria Information System (MIS) has been developed but yet to be implemented in the districts, except on testing basis. As soon as the MIS become operational, data transmission and sharing will become a routine procedure in the country. Furthermore, the special committees appointed by the Government of India from time to time conduct independent appraisals, and this procedure will be followed in the future as well.

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.):

Malaria population surveys are conducted every year and included in the annual reporting. In addition to this various intervention and outcome data is collected at the fixed intervals as given below.

- Blood smear collection by the MPW at fortnightly intervals.
- Cross-checking of blood smear data at monthly intervals.
- Spray data at 6-monthly intervals
- Drug consumption/distribution data by the MPW, clinics, DDCs / FTDs/ special activity etc. at monthly intervals.
- Epidemic investigation data as soon as possible.
- Disaster management data at weekly intervals.
- Mosquito net monitoring at monthly intervals at sentinel points.
- Quality control data before the supplies are accepted for final payment.
- Impact assessment data at quarterly intervals and finalized annually.
- Financial audit at periodical intervals, but at least once a year.

37.3. Timeline:

- Base line data collection by December 2003.
- IRS two rounds (First Year) before the transmission season. In subsequent years selective and focal spraying each year depending on malaria situation. After each round of spray data will be collected regarding coverage and quality.
- Treated nets to replace IRS from the second year onwards. Six monthly surveys will be conducted to ascertain coverage.
- Epidemiological data collection to continue uninterrupted in all districts.
- Monitoring and evaluation teams to review the implementation of the project every 6-months and annual review.

37.4. Roles and responsibilities for collecting and analyzing data and information:

NAMP is one of the oldest programmes of the Ministry of Health and responsibilities for collecting; analyzing and collating data are very well defined and understood. The new elements of community participation, inter-sectoral coordination will require additional responsibility at various levels. This will be done through Malaria Information System (MIS) and by organizing meetings and workshops. However a brief description of malaria control activities and major responsibilities is given in the tabular form for brevity.

Table VII 37.4

S. No.	Activity	Agency	Responsibility
1.	Epidemiological data collection	Surveillance workers/village level volunteers (CMV/CMLV)	PHC doctor / DMO / CMO
2.	Indoor residual spraying	Spray supervisor	DMO/CMO
3.	Treated bed nets	PSI	DMO/PSI
4.	Fish introduction and maintenance	Fisheries department/ Malaria link worker, Panchayat/ communities	DMO/CMO and fisheries department at the district
5.	Information, education and communication	NAMP	Joint Director at the state HQs
6.	Entomological monitoring	Malaria Research Centre	Director/in-charge field stations
7.	Intersectoral coordination	District Administration	District collector
8.	Monitoring and evaluation	NAMP	Director
9.	Supervision	NAMP Centre and State	Director/ Regional Director/Joint Director Malaria (State)/CMO district.
10.	Financial audit	AGCR/Health Dept.	Financial adviser
11.	Administration	NAMP	Admin. Officer
12.	Reports	NAMP	Director

37.5. Plan for involving target population in the process:

- There will be a village level malaria link volunteer in all villages of the area. He will form the link between the governmental surveillance mechanism and the community thereby achieving early diagnosis and prompt treatment of malaria cases.
- Community will report fever to the health functionary and ensure administration of antimalarial drug.

37.6. Strategy for quality control and validation of data:

The following quality control checks will be introduced.

- Independent surveys by the Malaria Research Centre to check on the quality of data collection.
- 10% positive and 2.5% negative slides to be referred to Regional Director / Joint Director's laboratories for cross-checking.
- Independent surveys to monitor coverage with IRS/ITN and re-treatment of ITN.

37.7. Proposed use of M&E data:

M & E data will be used in the: procurement of supplies in time; planning of malaria control activities, re-organization of malaria control activities in the light of epidemiological picture of malaria, report writing, organizing IEC activities, and in directing independent assessment of any particular activity and supervision.

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	Partner(s) (which may help in strengthening M&E capacities)	Resources Required (USD)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
Review meetings	NAMP, Delhi and State Health Dept	16,326	16,326	16,326	16,326	16,326	81,633
Evaluation independent agency)	NAMP/MRC Drawn from various institutions	20,408	20,408	20,408	20,408	20,408	102,041
Entomological monitoring	NAMP, Delhi and State Health Depts	118,367	77,551	77,551	36,734	36,734	346,939
Collection of drug resistance data	NAMP, Medical Colleges, ICMR	28,061	28,061	28,061	28,061	28,061	140,306
Special studies (Baseline etc)	NAMP/MRC Drawn from various institutions	81,633	0	102,041	0	81,633	265,306
Total requested from Global Fund		264,795	142,346	244,387	101,529	183,162	936,225
Total other resources available							

SECTION VIII – Procurement and supply-chain management information

39. Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to *Guidelines paragraph VIII.86*).

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	Indian Standards Institution specification products will be short-listed. Team of experts will select the best quality product. Quality control through contractual arrangement with the govt. approved institutions.
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	Government of India guidelines on procurement procedures will be followed for open and competitive tenders. Financial officer/CCM of the GFATM project will be responsible for ensuring expedited product availability. International intellectual property laws and obligations will be respected.
<i>What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?</i>	There are government recognized /approved laboratories to check products e.g. drugs, insecticides, equipment etc. All products will be checked for quality assurance before final settlement. CCM will enter in to contractual arrangement for continuous product monitoring of quality.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	The system of direct dispatch to the district is already in place. The same system will be followed with provision of adequate funds for transport and distribution at the district level. District collector and CMO will be responsible to oversee the distribution arrangement, and ensure that the products are not diverted for any other purpose.

40. Describe the existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs):

There is a clear mechanism to advertise the requirement of services by calling applications from the prospective qualified persons / agency to take on the requisite services in the programme. Mostly these services are time-bound and performance based which is clearly indicated in the press notification and which forms the criteria for short-listing the prospective candidates. Based on their credit and merit vis-à-vis cost, the final selection takes place.

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

At the country level, in the GFATM cell, there is a provision for appointing two project officers. One of the project officers will be consultant (financial/procurement and logistics). He will be the coordinating person with the project authorities and the industry to supplement the activities of the project goal in procuring various goods and services. He will be assisted by two project assistants, one for purchases and the other for distribution.

The budget provision for salaries and allowances has been already done in the general budget.

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88*):

NIL

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant

- 42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

NAMP and the state governments are responsible for malaria control in the country on 50:50 cost sharing basis. Increasing the share of the central government from 50 to 100% has strengthened malaria control in the NE states. In the predominantly tribal population of 1,045 PHCs (100 districts and 8 states) malaria control has been strengthened by World Bank support. There is no other support to the remaining population. Stratification of the country revealed additional 85 million populations in 49 districts that contribute at least 22% malaria of the country. Malaria control in this population will eliminate a major source of infection in the country, but this requires urgent and accelerated interventions for which the resources are not available. In this population contribution of the central and state government will remain as before and additional support from the GFATM will be used for strengthening field operations. There will be no duplication or diversion of resources from the project areas targeted for additional GFATM support.

SECTION IV – Scope of proposal

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

Table IV.23

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

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

TB is the most common serious opportunistic infection among HIV positive persons in India and is a major cause of morbidity and mortality in people living with HIV/AIDS. Early diagnosis and effective treatment of TB disease can improve the quality of life of these patients and lead to a decrease in morbidity and mortality.

Collaboration between the National AIDS Control Programme and the Revised National TB Control Programme (which incorporates the DOTS Strategy) is an ongoing process in six high HIV burden States in India: Andhra Pradesh, Maharashtra, Tamil Nadu, Karnataka, Manipur and Nagaland. An Action Plan on the HIV-TB co-infection (attachment) was developed in November 2001 between the National AIDS Control Organization (responsible for implementation of the NACP) and the Central TB Division (responsible for implementation of RNTCP), and disseminated to the six high burden States for implementation. The initial focus of the action plan is on these six States.

Presently, district level linkages between the National AIDS and TB control programmes are being established. However, no VCT have been set up at the sub-district level by the Government of India, nor were resources allocated for sub-district VCT under the NACP -II. As the districts in India are large (average population 2 million), the outreach of the district level VCT is limited. Over 70% of people live in rural areas. There is also emerging evidence that the gap in the HIV prevalence rates in rural and urban areas is closing rapidly (*HIV Sentinel Surveillance, 2001, NACO*). Therefore, the number of HIV infected persons living in rural areas would also be high as compared to urban areas. There is a need for VCT services in rural areas in order to facilitate early diagnosis of the HIV status of individuals as well as early detection of any associated TB disease, for appropriate integrated management.

The existing HIV-TB co-ordination programme is confined in outreach and limited upto district-levels only. Since no VCT have been put in place at sub-district levels, there is a complete absence of any effective and meaningful HIV-TB co-ordination mechanism at the community level. However, infrastructure for the TB programme exists at the sub-district levels, within the capacity of the current health care system. If the National AIDS Control Programme establishes VCT at these sub-district level sites, this will ensure that they not only provide linkage and support for TB, but will also facilitate early diagnosis and initiation of anti-TB therapy for HIV/TB co-infected persons. In addition, as these sub-district level VCT will be closer to the rural community, they will play an extremely important role in linking with the community and play a role in awareness raising and prevention. These VCT will be more accessible to the community, act as an entry point for HIV/AIDS prevention, care and support and strengthen the existing National AIDS Control Programme in increasing its outreach in the rural population. This project will contribute to the Government of India's goal to achieve 0% level growth of HIV/AIDS by the year 2007.

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

Objectives: (i) To promote utilisation of TB diagnostic and treatment services by HIV-TB co-infected persons at the sub-district level; (ii) to prevent further spread of HIV in the community by providing counselling, testing services, condom promotion, treatment of sexually transmitted infections (STI) and treatment of opportunistic infections (OIs) for people living with HIV/AIDS; (iii) to develop partnerships with NGOs / CBOs/ Private Practitioners for prevention and control of HIV and HIV/TB at the community level

Broad areas of activities: (i) Establishing VCT at the sub-district level where RNTCP infrastructure in the form of TB diagnostic and treatment units already exist and establishing referral linkages with the TB control programme; (ii) Improvement of quality and reach of NACP through training of medical and paramedical workers, counseling, condom promotion, providing basic drugs for treatment of opportunistic infections and sexually transmitted infections, and developing referral linkages with care: Governmental and non-Governmental; (iii) Community mobilisation for optimum utilisation of VCT services with the help of political leaders, NGOs, CBOs, private practitioners and faith-based organizations.

Expected results:

- 1) Early detection of TB disease in people living with HIV/AIDS and early initiation of therapy leading to a decrease in TB related morbidity, mortality, and improvement in quality of life
- 2) Prevention of further spread of HIV in the community by counseling, STI treatment, and condom promotion of HIV positive and HIV negative individuals
- 3) Integration of HIV/AIDS programme activities within the health care system
- 4) Improved case detection by the TB control programme as a result of referral linkages with the VCT

Implementation strategies

HIV-TB collaborative activities will be set up at the sub-district level in all the districts of the six high HIV burden States. National AIDS Control Organization will have overall responsibility for the programme under the administrative supervision of the Ministry of Health & Family Welfare. VCT will be setup at the sub-district level at health centers where RNTCP microscopy centers already exist. One VCTC will be set up per 500,000 population. The existing district level HIV-TB collaboration will also be strengthened and will serve as an anchor to the programme at the district level. Establishment of sub-district VCT would be in a phased manner and will be co-ordinated with RNTCP expansion in the high prevalence States. Based on the experience gained, HIV-TB collaborative activities would be expanded to cover at least 40% of all such health care centers in these States in the 4th and 5th year of the project.

Setting up of sub-district level VCT would involve recruitment of additional staff; capacity building at the sub-district level by provision of training, provision of consumables, drugs for syndromic management of sexually transmitted infections and basic management of opportunistic infections; infrastructure development; developing referral linkages with care. Community mobilization for utilization of the sub-district level VCT would be achieved by sensitization of elected representatives, political leaders and opinion leaders; involvement of NGOs, CBOs, private practitioners and faith-based organizations.

For effective and smooth functioning of these sub-district VCT, strengthening of district level VCT will be undertaken and they will be responsible for providing technical and counseling support to the sub-district VCT.

Partners involved

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

State level: State AIDS Control Societies (SACS) in co-ordination with the State TB Control Society (STCS), HIV-TB Consultant (WHO), as well as professional counselling organizations.

District level: District Nodal Officers for AIDS, District TB Control Society, HIV-TB supervisor, NGOs, CBOs, faith-based organizations, private practitioners and people living with HIV/AIDS

Sub-district level: NGO, CBOs, faith-based organizations, panchayats, local governments, PLWAs

Co-ordination mechanisms will be set up between both the programmes at each level and are detailed in the proposal.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year):	March 2003	To (month/year):	Feb 2008
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26. Detailed description of the component for its FULL LIFE-CYCLE:

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

Indicators: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.

Baseline data: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.

Targets: Clear targets should be provided in absolute numbers (if possible) and percentage.

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

The National AIDS Control Organization (NACO) will have overall responsibility for programme co-ordination, monitoring and evaluation under the administrative supervision of the Ministry of Health & Family Welfare. It will work in close partnership with the Central TB Division, which is responsible for implementing the Revised National TB Control Programme. This programme will be implemented in the States through the State AIDS Control Society (SACS) which will plan, monitor and supervise all the activities at the State level in co-ordination with the State TB Control Society (STCS). **The State Programme Officer of TB will be a member of the executive committee of the State AIDS Control Society and vice versa for the effective co-ordination between the two programmes.** At the District level, District Co-ordination Committees will be formed for monitoring the progress of the collaborative activities. Chief Medical Officer (CMO), District Nodal Officer for AIDS, District TB Officer, district HIV/TB supervisor, District health education officer (DHEO) and representatives from NGOs, CBOs, faith-based organizations and people living with HIV/AIDS would be members of this committee.

1) Identification of sites:

VCT will be setup at the sub-district level at health centers where microscopy centers (MCs) exist under the RNTCP. One VCT would be set up per 500,000 population. Under the RNTCP, microscopy centers have been established limited at a maximum of one per 100,000 population. Hence on an average 20% of the MCs in a given district would be covered initially. The site for the sub-district VCT will be based on the following criteria:

- facilities for TB diagnosis and treatment under the RNTCP programme already exist;
- space for setting up VCT exists.

Establishment of sub-district VCT will be in a phased manner and will be co-ordinated with RNTCP expansion in the **high prevalence States**. The target of RNTCP is to cover 85% of the country by 2004 and the entire country by 2005. Hence, it is envisaged that HIV-TB collaborative activities would be set up in all the districts of the six States latest by 2006. Later, based on the experience gained, HIV-TB collaborative activities would be expanded to cover at least 40% of all the RNTCP microscopy centers in these States.

2) Phasing:

Presently, out of a combined total of 132 districts in these 6 high HIV burden States, 83 districts are already implementing RNTCP. It is envisaged that sub-district VCT will be set up in 20% of the MCs of these districts in the following manner and will serve a population of 500,000

1st year: 15 districts (45 sub-district units)

2nd year: 65 total districts (195 sub-district units)

3rd year: 132 total districts (396 sub-district units)

4th and 5th year: coverage of 40% of all health centres (i.e. a total of 792 sub-district units) with functional RNTCP microscopy sites in these districts

3) Capacity building:

Recruitment

- Counselors will be appointed and trained in HIV, TB and issues related to HIV/TB.
- Laboratory technician will be appointed and trained in HIV testing. He/she would also assist in other laboratory procedures at the health center including sputum microscopy and malaria detection
- An HIV-TB supervisor appointed at the district level will be responsible for monitoring and supervision of the collaborative activities in his/her district and for timely reporting to the State AIDS Control Societies.

Training of medical staff: Two medical officers from each selected sub-district unit will be trained in HIV/AIDS, issues related to HIV/TB, diagnostic and treatment issues related to HIV-TB, syndromic management of sexually transmitted infections, management of opportunistic infections (OIs), and early recognition of signs and symptoms of serious OIs. Algorithms will be developed for diagnosis and treatment of OIs at the sub-district level and the cutoff for timely referral to secondary or tertiary level hospitals. The other medical officers and paramedical staff of that health center will be sensitized on HIV/AIDS under the current training activities of the National AIDS Control Programme.

Establishing linkages with and orientation & strengthening of the district level VCT will be prioritized, as these will act as the nodal point at the district level for the sub-district units. There will also be strengthening of the existing referral linkages between district level VCT and the RNTCP sputum microscopy sites.

A two-way referral mechanism between the sub-district VCT and RNTCP microscopy centers will be established by imparting training of health functionaries and constant monitoring and supervision. Patients once referred to the RNTCP will be diagnosed and treated under that programme. Drugs for TB treatment will be provided by the RNTCP.

•Supervision:

The Medical Officer in charge of the health centre will be responsible for the collaborative activities at the health center, and the smooth functioning of the VCT. The district HIV-TB supervisor will supervise the HIV/TB activities in his/her district and will visit all the VCT in the district on a weekly basis. He/she will receive technical support from the HIV-TB Consultant based at the SACS.

4) Infrastructure development:

- To ensure confidentiality for counseling, quality diagnosis and proper storage of testing kits, civil works will be supported at these health centres.
- Strengthening of the laboratory facilities by provision of additional equipment: refrigerator (for storage of HIV testing kits), needle cutter, centrifuge, microscopes
- Supply of Rapid HIV testing kits to facilitate reporting on the same day.
- Supply of consumables - syringes & needles, condoms, gloves, hypochlorite solution.
- Supply of drugs: for syndromic management of STI and treatment of opportunistic infections.
- Supply of IEC material after translation into the locally acceptable regional language

5) Community mobilization:

Will be achieved by sensitisation of elected representatives, opinion leaders, functionaries of other departments and faith-based organizations, ongoing capacity building and involvement of NGOs, CBOs and private practitioners involved in either programme and outreach activities undertaken by the NGOs.

6) Monitoring and evaluation: Operational responsibility for M&E will be with NACO and SACS. Concurrent monitoring will be carried out by (i) the HIV/TB supervisor on a weekly basis, (ii) monthly reports to SACS and NACO in the Monitoring Information Systems (MIS) formats, and (iii) the district co-ordination committee on a quarterly basis by reviewing the programme activities. Annual evaluation will be undertaken by an external independent agency.

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

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

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

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

It is estimated that 40% of the Indian population is infected with *Mycobacterium tuberculosis*. HIV is the most important risk factor for development of active TB (disease). The rate of progression from TB infection to TB disease is 10 to 30 times higher among individuals infected by both TB and HIV than among those infected only with TB. The risk of development of TB disease in HIV infected persons in India is 6.9/100 person-years (*Swaminathan et al, Int J Tubercl Lung Dis 2000; 4(9): 839-844*). Moreover, due to low immunity, recent infection may rapidly lead to TB disease. This will further increase the TB burden by increasing transmission of TB in the community. TB is the most common serious opportunistic infection occurring among HIV positive persons in India. **Among the AIDS cases reported so far in India, 55-60% of them had been diagnosed as having TB (NACO India Country report 2001).** TB in turn may accelerate the progression of HIV to AIDS and has been implicated as the cause of death in one out of every three AIDS deaths globally. Effective treatment of TB can improve the quality of life of these patients and lead to a decrease in mortality and morbidity. Delays in diagnosis of TB disease have been associated with worse outcomes, so initiation of treatment as soon as TB disease is suspected is very important. Hence early diagnosis and effective treatment of TB disease

among HIV-infected patients are critical for curing TB, minimizing the negative effects of TB on the course of HIV, and interrupting the transmission of *M. tuberculosis* to other persons in the community.

Unlike HIV/AIDS, a low cost cure already exists for TB and is being provided in the context of the internationally accepted DOTS strategy. DOTS is the WHO-recommended technical and management package aimed at achieving the twin goals of more than 85% cure rate and 70% case-detection of new infectious cases. The Revised National TB Control Programme (RNTCP) uses the DOTS strategy. **Diagnosis and treatment of TB under the RNTCP is free for all patients.** Standard regimens of RNTCP, particularly if supervised properly, are as effective in HIV positive as in HIV negative patients (*Perriens et al, NEJM 1995; 332: 779-784*). Treatment of TB disease in HIV-infected patients using DOTS strategy has been shown to improve patient survival (*Alwood et al, AIDS 1994; 8:1103-8*)

The vast majority of people living with HIV infection are unaware of their HIV status and may continue their high-risk behaviour, thus contributing to the spread the infection in the general community. Provision of counselling, testing and treatment facilities close to their place of residence will improve accessibility, while community mobilization to increase uptake of these services provided will help in reducing stigma and discrimination and improve acceptability. Preventive, pre-and post-test counselling, condom promotion, treatment of sexually transmitted infections will prevent further spread of the epidemic in the rural population and will help in reduction in the annual rate of increase of HIV cases in that community, as measured by the annual rounds of sentinel surveillance.

Table IV.26.1

Goal	Reduction in TB related morbidity in people living with HIV/AIDS in the rural population of high HIV burden States, while preventing further spread of HIV in the community.	
Impact Indicators <i>(Refer to Annex II)</i>	Baseline	Target (last year of proposal)
	March 2003	Feb 2008
Reduction in TB related morbidity among people living with HIV/AIDS in the rural community of high HIV prevalence States *	50% ¹	37%
Reduction in annual rate of increase of HIV infection among 15-24 year olds in rural community of high HIV prevalence States**	N/A	By 25%

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

** The data generated in the annual sentinel surveillance round 2002 will be compared with the round 2001 and the annual rate of increase determined to be used as baseline. The data will be compared using the same assumptions and methodologies.

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

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

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

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

¹ AIDS case surveillance data, NACO , 2001-2002

Objective 1: To promote utilization of TB diagnostic and treatment services by HIV-TB co-infected persons at the sub-district level.

The prime focus of the activities in order to achieve this objective will be: establishing VCT at the sub-district level; intensified identification of VCT attendees with symptoms of TB; establishing referral linkages with TB diagnostic and treatment facilities located in the same premises; providing follow-up counselling to HIV-TB co-infected patients to ensure compliance with treatment; and counselling of asymptomatic HIV positive persons on symptoms of TB disease for early referral. This will promote early detection of TB disease and early initiation of therapy by the TB programme for HIV-infected persons with TB disease. Community mobilization to realize the stated objective will be achieved by involving NGOs/CBOs and private practitioners. Early diagnosis and effective treatment of TB disease among HIV-infected patients will contribute to a decrease in mortality, morbidity and improvement in their quality of life.

Table IV.27

Objective: 1	To promote utilization of TB diagnostic and treatment services by HIV-TB co-infected persons at the sub-district level.					
	Outcome/coverage indicators (Refer to Annex II)	Baseline	Targets			
		Mar-03	Year-2 Feb- 05	Year-3 Feb- 06	Year-4 Feb- 07	Year-5 Feb- 08
Total number of districts covered by sub-district VCT		0	65	132	132	132
Total number of sub-district level units established		0	195	396	594	792
Proportion of VCTC attendees counselled on HIV-TB		0	100%	100%	100%	100%
Proportion of VCTC attendees with symptoms of TB referred for sputum microscopy		0	100%	100%	100%	100%
Proportion of referred cases diagnosed as sputum smear positive TB disease		0	10-15%	10-15%	10-15%	10-15%
Treatment success rate		0	75%	80%	85%	>85%

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

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

Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

Objective 1: To promote utilization of TB diagnostic and treatment services by HIV-TB co-infected persons at the sub-district level.

Broad activities related to specific objective and expected output

A wide range of preparatory activities will proceed prior to the initiation of sub-district level HIV-TB collaborative activities. District co-ordination committees will be formed and will be involved from the planning phase. Identification of the health centers at the sub-district level where collaborative activities will be implemented. Civil works will be initiated in the counseling room and laboratory in order to ensure confidentiality and quality HIV testing.

Identification, recruitment and training of counselors, lab technicians, district HIV/TB supervisors. Counselors will be appointed by NGOs after imparting them the requisite training in TB and HIV/AIDS. PLWHAs will be appointed and trained as counselors if

possible. This will give a unique opportunity to involve PLWHAs and to help reduce stigma and discrimination in the medical setting as well as in the community. The existing health centers have one laboratory technician who does the entire routine laboratory work of the medical center, besides doing sputum microscopy and helping in peripheral smear examination for malaria detection. These laboratory technicians are already over-burdened, so it will be essential to appoint another laboratory technician who will be trained in HIV testing and will also assist in the other routine laboratory procedures.

Training of medical officers in HIV, TB and issues related to HIV/TB co-infection will be carried out and will include principles of infection control. All health personnel involved will be trained through specially prepared training manuals already prepared by GOI. Training will be conducted at district / state headquarters depending on the number of trainees.

Procurement and distribution of required equipment (refrigerators, centrifuges, microscopes, needle cutters etc), commodities (HIV testing kits, gloves, condoms, needles and syringes, etc) and drugs (for OIs and STI) would be the responsibility of the SACS. Assessment by a team comprising a representative of the State AIDS Control Society, State TB Control Society and the State HIV-TB consultant will be a prerequisite prior to starting VCT service delivery.

HIV/TB supervisors will be appointed in each district. They will be responsible for monitoring and supervision of the functioning of all the VCT in the district- the district-level VCT and the sub-district VCT. He/she will conduct supervisory visits to each VCT at least once a week and will compile the VCT reports on a monthly basis and forward them to the SACS and STCS.

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

Table IV.27.1

Objective : 1	To promote utilisation of TB diagnostic and treatment services by HIV-TB co-infected persons at the sub-district level.				
	Broad activities	Process / Output	Baseline	Targets	Responsible / Implementing agency or agencies
		Indicators (indicate one per activity) (Refer to Annex II)	March 2003	End Year 1: Feb 2004	End Year2: Feb 2005
Identification of health centers where sub-district VCT to be established	Health centres identified	0	45	195	NACO and respective SACS
Recruitment of contractual staff	Process initiated	0	Achieved in all 45 sites	Achieved in all 195 sites	SACS
Training of counselors	100% trained	0	Achieved in all 45 sites	Achieved in all 195 sites	NGOs, SACS, STCS
Training of laboratory technicians	100% trained	0	Achieved in all 45 sites	Achieved in all 195 sites	SACS, STCS
Training of medical officers of the selected health centers	≥90% health centers with at least 2 MOs trained	0	Achieved in all 45 sites	Achieved in all 195 sites	SACS, STCS
Assessment for start of service delivery of HIV-TB collaborative activities	Assessment done and successful outcome	0	Achieved in all 45 sites	Achieved in all 195 sites	SACS, STCS
Supervision	Proportion of trained HIV/TB supervisors in place	0	Achieved in all 15 identified districts	Achieved in all 65 identified districts	SACS, STCS
Review of HIV-TB collaborative activities	Number of district co-ordination committee meetings to review programme	0	4	4	District Collector, Chief Medical Officer (CMO)

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

Objective 2: To prevent further spread of HIV in the community by providing counselling, testing services, condom promotion, treatment of STI and treatment of opportunistic infections for people living with HIV/AIDS.

Establishing VCT at the sub-district level will have a significant and cumulative impact on the prevention and control of further spread of HIV in the community and will help in achieving the Government of India's goal of "Zero level growth of HIV/AIDS by the year 2007".

Counselling and testing will be carried out as per recommended National guidelines of pre-test and post-test counseling and maintenance of confidentiality. Pre-test counselling will focus on the links between risk behaviour, STI and HIV and methods of prevention. Post-test counseling will be imparted to all persons tested, irrespective of their HIV test result. Condom distribution will be an important activity of the VCT. An increase in condom usage by high-risk groups will limit further spread of STIs and HIV in the community. Syndromic management of STIs at the health center and behaviour modification to prevent recurrent episodes will decrease risk factors for HIV. Management of opportunistic infections and early recognition of signs and symptoms of serious OIs for early and timely referral to secondary and tertiary levels of care. Provision of treatment services at these health centers will further increase the uptake of these VCT. Continued follow-up counseling for people living with HIV/AIDS will provide ongoing psychological support, reinforce safe behaviour and ensure increased uptake of the services provided, thus contributing to limiting the spread of HIV in the community. There would be involvement of PLWHA networks for community mobilization as peer educators, counselors and community activists. Linkages with support groups in the community will ensure psychosocial support to HIV positive individuals.

Objective: 2	To prevent further spread of HIV in the community by providing counselling, testing services, condom promotion, treatment of STI and treatment of opportunistic infections for people living with HIV/AIDS.				
Outcome/coverage indicators	Baseline	Targets			
(Refer to Annex II)	Mar-03	Year-2 Feb- 05	Year-3 Feb- 06	Year-4 Feb- 07	Year-5 Feb- 08
Proportion of health center attendees accessing VCT services at sub-district level*	0	Increase by 10%	Increase by 15%	Increase by 20%	Increase by 25%
Proportion of VCTC attendees tested for HIV	0	50%	60%	70%	>70%
Proportion of tested patients given post-test counseling at sub-district level	0	80%	85%	90%	90%
Proportion of VCTC attendees with symptoms referred for treatment	0	90%	90%	90%	>90%
Proportion of VCTC attendees given condoms	0	60%	70%	80%	>80%

*1st year data to be used as baseline

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Objective 2: To prevent further spread of HIV in the community by providing counselling, testing services, condom promotion, treatment of STI and treatment of Opportunistic infections for people living with HIV/AIDS.

Establishing sub-district level VCT will increase the outreach of the National AIDS Control Programme in the community. The districts implementing RNTCP in the six high HIV burden State will be covered in a phased manner. In the first year 15 districts will be covered and by end of year 2, 65 districts will be covered.

HIV testing: Rapid HIV testing methodology will be used in order to provide the results to the patients the same day. This will in turn improve uptake of VCT services at the sub-district level and facilitate an increase in walk-in clients to the VCT. External quality assurance will be an important activity of these HIV testing centers in order to ensure reliability of test results. The third phase of EQAS in the country will be completed by end 2002, which will cover all the district VCT under the EQAS programme. These sub-district VCT can be covered in the fourth phase of EQAS to ensure >95% concordance in test results from these sites.

Adequate supply of condoms will be made available at the VCT for distribution to individuals with risk behaviour. This provision will be made from the National programme.

Two medical officers from each of these health centers will be trained in issues related to HIV/AIDS; syndromic management of sexually transmitted infections (STI) and essential principles of management of OIs. Diagnosis and treatment algorithms and flow charts will be developed in consultation with experts for treatment of OIs within the resource limitations of a sub-district level health center and the cutoff for timely referral to secondary or tertiary referral hospitals. Drugs for syndromic treatment of STIs and treatment of OIs will be supplied to the health center.

The IEC strategy would follow a holistic approach by providing relevant information, employing appropriate and effective communication for motivation, empowering people by supporting their ability to access services and fostering an enabling environment through improved interpersonal communication skills. Activities will be conducted in collaboration with NGOs and will include training of health providers in inter-personal communication and raising awareness amongst patients and general public, with enhanced advocacy around events (e.g. World AIDS day). Different media such as mass communication media, seminars, sensitization workshops, wall paintings, street plays, banners and hoardings would be used. Adequate amount of IEC material in the regional language should be available at these VCT and should be distributed to all persons accessing the VCT services. IEC material will be provided from the National programme.

Monthly reporting by these VCT in approved format to the district HIV/TB supervisor by the 3rd of the following month, who in turn will be responsible for compiling the reports from the district and submitting to the SACS by the 5th.

Table IV.27.1

Objective:2	To prevent further spread of HIV in the community by providing counselling, testing services, condom promotion, treatment of STI and basic treatment of Opportunistic infections for people living with HIV/AIDS.				
Broad Activities	Process/Output	Baseline	Targets		Responsible / Implementing Agency or agencies
	Indicators (indicate one per activity) (Refer to Annex II)	March 2003	End Year 1 Feb 2004	End Year 2 Feb 2005	
Counselling	Number of clients counseled at sub-district level	0	Baseline will be established	Increase by 10%	NGOs, SACS, District Nodal Officer-AIDS, HIV/TB Supervisor
HIV-testing	Number of stock outs of HIV testing kits reported	0	< 5 sites	< 10 sites	SACS, District Nodal Officer-AIDS, District HIV-TB supervisor
Condom distribution	Number of stock outs of condoms reported	0	< 5 sites	< 10 sites	SACS, District Nodal Officer-AIDS, District HIV-TB Supervisor
Treatment of STIs and OIs	Number of stock outs of drugs for treatment of STIs/OIs reported	0	< 5 sites	< 10 sites	SACS, District Nodal Officer-AIDS, District HIV-TB Supervisor
Distribution of IEC material	Number of stock outs of IEC material reported	0	< 5 sites	< 10 sites	SACS, District Nodal Officer-AIDS, District HIV-TB Supervisor
Timely monthly reporting	Proportion of sub-district VCTCs submitting monthly report on time	0	80%	>90%	Respective DNO-AIDS, HIV/TB Supervisor

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

Objective 3: To develop partnerships between NGOs / CBOs/ Private Practitioners for prevention and control of HIV and HIV/TB at the community level

For success of HIV/TB collaborative activities at the sub-district level, there should be optimum utilization of the VCT. Learning how to mobilize the community in a sensitive and non-discriminatory way and to sustain their involvement in a realistic manner will be essential to the success of this initiative. It is important to sensitize opinion leaders, elected representatives, religious leaders at the village levels since they play an important role in shaping popular opinion. NGOs often have the resources to catalyse community initiatives. Community based organizations exist and are increasingly being given power and authority by government and international donors like the World Bank. CBOs can help in achieving acceptability for VCT services, reducing stigma and discrimination, improving compliance to treatment and early case detection. Community involvement in collaboration with NGOs will be achieved by (i) focus group discussions with NGOs/CBOs for developing different methods and appropriate strategies for involving people of different communities; (ii)

spreading messages regarding the availability of VCT and TB treatment services; (iii) follow up of chest symptomatics to ensure completion of treatment; (iv) involvement of community members as DOT providers. Partner NGOs have been identified for training of NGOs/CBOs, providing trained counselors, establishing referral linkages with health care system and IEC activities. It can also catalyse the involvement of PLWAs, who can have an important influence on the acceptance of VCT. Proposals will be encouraged from CBOs on these aspects and resources provided. Women's groups like "Mahila Mandals" are particularly active in the southern States of Tamil Nadu and Maharashtra. Involvement of women's organizations and self-help groups will ensure that their needs and concerns are addressed. As a result of inadequate public health facilities, it has been estimated that less than 20 percent of the population, which seek OPD services, avail of such services in the public sector (NHS-2002). As the majority of the population access basic health care in the private sector, it is very important that the private practitioners are involved for the HIV-TB initiative to succeed. Besides Registered Medical Practitioners, efforts will be made to sensitize and involve the practitioners of the Indian Systems of Medicine and Homeopathy.

Objective: 3	To develop partnerships between NGOs / CBOs/ Private Practitioners for prevention and control of HIV, TB and HIV/TB at the community level				
Outcome/coverage indicators (Refer to Annex II)	Baseline	Targets			
	Mar-03	Year-2 Feb- 05	Year-3 Feb- 06	Year-4 Feb- 07	Year-5 Feb- 08
Proportion of existing NGOs /CBOs referring patients	N/A	20%	40%	60%	>60%
Proportion of existing PPs referring patients	N/A	20%	40%	60%	>60%

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Objective 3: To develop partnerships between NGOs / CBOs/ Private Practitioners for prevention and control of HIV, TB and HIV/TB at the community level

The involvement of NGOs/CBOs and private practitioners will be actively sought, and will require a range of activities including sensitization meetings, workshops and distribution of IEC material. The new partners will act as educators, motivators and contribute to referral services. Referrals will be both ways: both to the VCT and from the VCT to these partners. Confidentiality will be an issue and ways to maintain confidentiality will differ in different settings and the various modalities will be discussed with focus group discussions with these partners.

Table IV.27.1-

Objective:3	To develop partnerships between NGOs / CBOs/ Private Practitioners for prevention and control of HIV, TB and HIV/TB at the community level				
Broad activities	Process/Output Indicators (indicate one per activity) (Refer to Annex II)	Baseline	Targets		Responsible / Implementing Agency Or agencies
		March 2003	End Year 1 Feb 2004	End Year 2 Feb 2005	
Sensitisation of elected representatives, opinion leaders, faith-based groups	Proportion of elected representatives, opinion leaders, faith-based groups sensitised at sub-district level	N/A	20%	40%	SACS, Respective DNO-AIDS, DTO, NGOs
Sensitisation and involvement of NGOs / CBOs	Proportion of NGOs/CBOs sensitized and involved at sub-district level	N/A	20%	40%	SACS, Respective DNO-AIDS, DTO, HIV/TB Supervisor, NGOs
Sensitisation and involvement of PPs	Proportion of private practitioners sensitised at sub-district level	N/A	20%	40%	Respective DNO-AIDS, DTO, HIV/TB Supervisor, NGOs

- 28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner:** (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

Collaboration between the National AIDS Control Programme and the Revised National TB Control Programme (which incorporates the DOTS Strategy) is an ongoing process in six high HIV burden States in India - Andhra Pradesh, Maharashtra, Tamil Nadu, Karnataka, Manipur and Nagaland. An action plan on HIV-TB co-infection was developed in November 2001 in consultation with the National AIDS Control Organization (responsible for implementation of NACP) and the Central TB Division (responsible for implementation of RNTCP); and disseminated to the six high burden States for implementation. The initial focus of the action plan is on these six States. Since then the following activities have been undertaken:

- a. Sensitisation workshops for key policy makers to address the importance of HIV-TB co-infection have been held in all these States.
 - To present the facts about morbidity, mortality and socio-economic consequences of HIV, TB, and the interaction between HIV and TB
 - To emphasize that HIV is preventable, TB is curable, DOTS prolongs life of HIV-infected persons and stops the spread of TB, and that HIV prevention is essential to the control of tuberculosis
- b. Supplementary training material on HIV-TB for different level of health functionaries of both programmes has been prepared at the Central level
- c. Training programmes for District Nodal Officers-AIDS and counsellors on HIV-TB related issues have been conducted.

- d. Referral linkages between VCT and sputum microscopy centres of the RNTCP are being established and reporting of HIV-TB cases at the level of VCT has already started in some States.
- e. NGOs participating in the NACP are being encouraged to open DOTS centres under the RNTCP.
- f. Four HIV-TB consultants had been appointed by WHO (out of these two are currently in place) to oversee the collaborative activities in these six States and more HIV-TB consultants will be appointed by the year-end with the aim of having one consultant in each high prevalence State.

Major programme intervention gap: Under the on-going National AIDS Control Programme, infrastructure for the implementation programme activities has been provided up to the district level. Presently as there are no VCT in the public sector (and very few, if any in the private sector) beyond the district level, there are no linkages and a lack of an effective co-ordination mechanism at the sub-district level. Over 70% of people live in rural areas and the gap in the HIV prevalence rates in rural and urban areas of the high HIV burden States is narrowing rapidly. Therefore, there is a need for VCT services in rural areas in order to facilitate early diagnosis of the HIV status of individuals as well as early detection of associated TB disease for proper management.

Involvement of NGOs, CBOs and the private sector will be actively sought for increasing the reach of the programme and for community mobilization.

Increasing the outreach of the National AIDS Control Programme to the sub-district level will improve access to information, leading to an increase in awareness in the rural community. Provision of drugs will ensure that there is access to treatment services for TB, basic Opportunistic infections and STIs. Counselling will facilitate behaviour change, leading to a reduction of transmission of HIV in the community; it will also facilitate compliance to treatment provided. As the HIV/AIDS epidemic matures, strengthening the capacity of the public and private health care systems will be the key to a sustainable response to care at the community level.

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

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

By provision of available and accessible quality diagnostic and treatment services for TB, treatment of opportunistic infections and treatment of STIs, besides providing psychological support by continued follow-up counseling, the direct beneficiaries of the component will be people living with HIV/AIDS. PLWHAs, in whom TB disease has been successfully treated, can act as peer educators and peer motivators for other clients in the community. Using them as counsellors after adequate training in these VCT will be a unique method of involving them and giving them a meaningful role in the programme. This will also help in strengthening the links between the VCT and the community. They can facilitate increased uptake of health care services, ensure treatment compliance and act as DOTS providers. They can be involved in care and support and rehabilitation of other infected and affected people. Formation of self-help groups by PLWAs will be encouraged and their active participation will be sought in all HIV/AIDS related activities. They will be effectively involved in IEC activities as they bring a face to the epidemic.

PLWHA representatives, as members of the district-coordination committees, will help influence policy. They will also assist in designing referral plans and patterns of follow-up for other PLWA in the community.

29.2. Community participation:

The component promotes social mobilization and community participation at every level for the success of the interventions. Participation of the community will be encouraged via sensitization of elected representatives, opinion leaders, Panchayati Raj system, local self government and faith-based groups, involvement of NGOs, CBOs, women's groups, youth groups and private practitioners. These efforts will be complemented by IEC activities in locally relevant and acceptable dialects. Resources would be provided and funds made available for actual activities carried out in the community.

29.3. Gender equality issues (Guidelines paragraph IV.53):

Women in rural areas are vulnerable to HIV due to increasing migration of men to urban areas where they get involved in high-risk behaviour patterns, leading to increased risk of STI and HIV. The men, in turn, often transmit infection to their wives/partners in the rural areas. This is exacerbated by lack of empowerment of women in the rural areas: high levels of illiteracy and social and biological vulnerability of the women. Involvement of women's self-help groups, women's organizations, health workers (female) and employees of other departments such as the Integrated Child Development Scheme (ICDS) will help ensure that their issues and concerns are addressed and will motivate more women to access VCT services.

29.4. Social equality issues (Guidelines paragraph IV.53):

Important issues of social equality will be addressed in this programme which is focused on rural communities who don't have easy access to HIV testing and counseling facilities. It is well recognized that TB is predominantly a disease of the poor. Focusing on promotion of early detection and provision of free treatment for TB disease in HIV infected individuals will promote access to these services by the poor and vulnerable sections of the rural community.

29.5. Human Resources development:

The component will strengthen the capacity of the functionaries of the primary health care system. Prior to initiation of service delivery, a wide range of staff, including medical officers, counselors and laboratory technicians will be trained in various aspects of HIV and TB, enhancing their skills and capacity to perform their assigned tasks. Counseling skills will be reinforced and upgraded on a yearly basis. Sensitisation of stakeholders in the community like elected representatives; opinion leaders, CBOs and private practitioners will ensure sustainability of the programme after the funding duration is over. Setting up of community care and support centers will be actively encouraged and supported by the government.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), (Guidelines para. IV.55), (1-2 paragraphs):

Treatment of TB disease in HIV infected patients will be as per then standard RNTCP protocol. At present, the RNTCP in India uses intermittent short course chemotherapy (i.e. rifampicin containing regimens for all patients). Treatment under RNTCP in India is free for all patients. Under the RNTCP, intermittent short course chemotherapy (i.e. rifampicin containing) regimens are used for all patients, with Category I and III cases receiving 6-7 month regimens and Category II cases an 8-9 month regimen (see table below).

Category of Patient	Regimen
I	2H ₃ R ₃ Z ₃ E ₃ / H ₃ R ₃
II	2S ₃ H ₃ R ₃ Z ₃ E ₃ / 1H ₃ R ₃ Z ₃ E ₃ / 5H ₃ R ₃ E ₃
III	2H ₃ R ₃ Z ₃ / 4H ₃ R ₃

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

Treatment of opportunistic infections: The following spectrum of OIs has been reported in AIDS patients in India between 1986-2001: tuberculosis (59%), candidiasis (51%), cryptosporidiosis (32%), pneumocystis carinii pneumonia (24%), herpes zoster (18%), toxoplasmosis (14%), bacterial pneumonia (13%), cryptococcal meningitis (9%), etc.(NACO India Country report 2001).

Essential principles of management of OIs will be imparted to the medical officers during their training. Algorithms will be developed in consultations with experts for diagnosis and treatment of OIs at the sub-district level and early identification of symptoms and signs of serious OIs for timely referral to secondary or tertiary level hospitals. This will be the responsibility of NACO.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to Guidelines paragraph V.56 – 58):

Table V.30

Resources needed (USD)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Human Resources	168,750	731,250	1,485,000	1,980,000	2,475,000	6.84 m
Infrastructure/Equipment	91,125	303,750	407,025	400,950	400,950	1.6 m
Training/Planning	36,255	143,350	259,439	352,704	451,704	1.24 m
Commodities/Products	27,450	132,700	314,800	556,300	858,300	1.89 m
Drugs	632,800	2,190,850	5,256,250	6,636,000	8,646,900	23.36 m
Monitoring and Evaluation*	39,600	112,500	206,700	217,100	227,500	0.8 m
Administrative Costs	113,900	423,250	917,800	1,201,100	1,554,700	4.2 m
Others NGO-outreach activities	140,625	609,375	1,237,500	1,856,250	2,475,000	6.3 m
Total (US \$)	1.25 m	4.64 m	10.1 m	13.2 m	17.1 m	46.27 m

- As the existing Monitoring Information Systems will be used the funds for M&E are being requested only for annual independent external evaluation and ongoing monitoring activities of the HIV-TB supervisors

The budget categories may include the following items:

Human Resources: Consultants, recruitment, salaries of front-line workers, etc.

Infrastructure/Equipment: Building infrastructure, cars, microscopes, etc.

Training/Planning: Training, workshops, meetings, etc.

Commodities/Products: Bednets, condoms, syringes, educational material, etc.

Drugs: ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.

Monitoring & Evaluation: Data collection, analysis, reporting, etc.

Administrative: Overhead, programme management, audit costs, etc

Other (please specify):

- 30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

Item/unit	Unit cost (USD)	Volume (specify measure)	Total cost (USD)
HIV tests	\$ 0.61 per patient	45,000 tests	\$ 27,450
STI drugs	\$2.08 per patient / course	270,000 courses	\$ 561,600
1. Metronidazole			
2. Doxycycline			
3. Azithromycin			
4. Cefexime			
5. Ciprofloxacin			
6. Fluconazole			
7. Acyclovir			
8. Tetracycline			
9. Benzathine Penicillin			
OI drugs	\$31.25 per patient / year	2250 patients	\$70,312
1. Trimethoprim+ Sulphamethoxazole			
2. Nystatin			
3. Fluconazole			
4. Doxycycline			
5. Benzathine Penicillin			
6. Erythromycin			
7. Acyclovir			
8. Spiramycin			

- 30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):**

Currently voluntary counseling and testing facilities are not available at the sub-district levels. Establishment of such facilities would enhance skills and capacity of health care functionaries as well as NGOs in the management of HIV/AIDS, HIV-TB as well as sexually transmitted infections. This would lead to a snowballing effect in education and motivation of frontline workers in dissemination of positive messages about these diseases.

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

- 31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollar (Guidelines para. V.62):**

Table V.31.1

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)							
External*			50,000	50,000	100,000	110,000	120,000
Total							

* for salaries of HIV/TB consultants

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

32. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.
33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in percentage (Refer to *Guidelines para. V.63*):

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

Resource allocation to implementing partners* (%)	Year 1	Year 2	Year 3 (Estimate)	Year 4 (Estimate)	Year 5 (Estimate)	Total
Government	80.6%	78.7%	80.3%	77.6%	76.9%	78.15%
NGOs / Community-Based Org.	17.8%	20.7%	19.3%	22%	22.7%	21.4%
Private Sector	1.6%	0.6%	0.4%	0.4%	0.4%	0.45%
People living with HIV/ TB/ malaria						
Academic / Educational Organizations						
Faith-based Organizations						
Others (please specify)						
Total	100%	100%	100%	100%	100%	100%
Total in USD						

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

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

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

- 34. Describe the proposed management arrangements** (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), (*Guidelines para. VI.64*), (1–2 paragraphs):

At the **National level**, a programme co-ordination committee (PCC) will be formed under the Chairpersonship of Additional Secretary and Project Director, NACO. There will be adequate representation from NACO, CTD, CCM, NGOs, SACS, State TB Control Societies, PLWHA and technical experts from premier AIDS and TB research institutes in India as well as international agencies such as WHO, World Bank, UNAIDS.

At the **State level**, a State co-ordination committee will be set up under the Chairpersonship of the secretary Health.

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

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

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

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

At the State level, the Secretary (Health) is the person in charge of both the programmes
At the District level, the District Collector is responsible for implementation of all the Government programmes and policies.

- 35. Identify your first and second suggestions for the Principal Recipient(s)** (Refer to *Guidelines para. VI.65–67*):

Table VI.35

	First suggestion	Second suggestion
Name of PR	NACO	
Name of contact	Project Director, NACO	
Address	NACO 9 th Floor, Chandralok Building 36 Janpath, New Delhi	
Telephone	3325331	
Fax	3731746	
E-mail	nacodel@vsnl.com	

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

- 35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component** (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), (*Guidelines para. VI.66–67*), (1–2 paragraphs):

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

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

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

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

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

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

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

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

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

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

SECTION VII – Monitoring and evaluation information

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

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines para. VII.76*):

Monitoring and Evaluation is an integral part of NACP-II. For effective monitoring and evaluation of implementation of the Phase-II of the National AIDS Control Project at National and State level, the following mechanism has been developed.

- a Establishment of a **Computerized Management Information System** (CMIS) at the National and State levels: All information is being transferred electronically to NACO from the States on a monthly basis since January 2002. M&E Officers based at SACS have complete responsibility for CMIS. The data from the districts is sent on a monthly basis to the SACS where it is compiled and forwarded to NACO in an electronic format. This is a powerful tool for the programme managers at the National and State levels for effective monitoring of the programme.
- b Conducting base line, mid term and final evaluation of the programme. Base line **Behavioural Surveillance Survey** has already been conducted in year 2001 through out the country. This base line survey covered both the general population (15-49 years age group) and as well as high risk groups of population like Female Sex Workers, Intravenous Drug users and Men having Sex with Men. The bridge groups of clients of female sex workers were also covered. In the general population Behavioural Sentinel Survey covered about 85,000 population while in the high-risk groups, 12,000 people were surveyed. The findings of the survey will act as a baseline for monitoring the effectiveness of National AIDS Control Programme activities over the next 5 years. These surveys will be repeated twice over the next five years and will be used to monitor impact of the interventions.
- c **National Sentinel Surveillance:** Every year from August to October, a round of survey is conducted at designated sites to assess trends of HIV prevalence rates in high-risk and general population. In 2002, the survey is planned in 384 sites.
- d Conducting the Annual Performance and Expenditure Review (APER); and
- e Conducting the National Performance Review (NPR), National AIDS Control Board.
- f **The RNTCP recording and reporting system.** The RNTCP has a well-established system of reporting that is used to monitor progress of the program. The existing reporting system under RNTCP is a quarterly reporting system from Districts to State to Central level. The reporting proformae have been developed based on experience of WHO-GOI. Reports submitted include case finding, smear conversion rates, treatment outcomes, logistics and programme management, and financial reports detailing statement of expenditure etc

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.):

Monthly reporting in approved format from sub-district units to the District HIV-TB Supervisor will be implemented. The existing AIDS case surveillance will be extended up to the sub-district level to the project sites for measuring the pre-designed indicators. Intensive technical monitoring of the sub-district and district VCT will be performed by the HIV-TB supervisor, who will visit each unit at least once in a week. HIV-TB supervisor, will in turn compile all the reports from the district and forward them to the State AIDS Control Society as a part of Management Information System (MIS). At the State level the data will be analyzed by the State HIV-TB Consultant based at the State AIDS Control Society, who will give feedback to the district and sub-district level. From the State, the data will be forwarded as a part of the current CMIS (computerized management information systems) to the

National AIDS Control Organization. The identified HIV/TB indicators will be included in the current NACP II Computerized Monitoring Information System (CMIS).

- Monthly review meetings will be held between the District Nodal Officer-AIDS, the District TB Officer, HIV/TB supervisor with the VCT staff and NGOs / CBOs.
- The District co-ordination committee will be responsible for monitoring, analyzing data and for providing positive inputs to the centers and will hold quarterly meetings at the District level.
- Quarterly review meetings will be held at the State level between the State AIDS Society, State TB Control Society under the chairmanship of the Director General Health Services (DGHS). District programme officers of the poorly performing districts may be called to attend these meetings. The State level is the prime responsible authority in monitoring the implementation of the programme.
- The Central level will provide ongoing technical assistance to States and on need basis to the districts. A programme coordinating committee (PCC) will be established and meet six-monthly at NACO. Membership will comprise: NACO representative; Central TB Division representative, representatives of the Country Coordinating Mechanism (CCM); the SACS project directors and the State TB Officers of the six States; representatives of partner NGOs/CBOs and a small number of other technical experts drawn from research or academic institutions. NACO will provide secretariat services.

37.3. Timeline:

Reports at the district level will be compiled by the HIV/TB supervisor and forwarded to the SACS, with a copy to the STCS by the 5th of the following month. At the SACS the State HIV/TB consultant will compile and analyze the data and forward the report to NACO by 15th of the month as a part of the CMIS, with a copy to CTD. The progress of the programme will be monitored and in the event of a shortfall, the reasons will be sought for initiation of immediate remedial measures.

37.4. Roles and responsibilities for collecting and analyzing data and information:

- The CCM will have the overall responsibility;
- The PCC, reporting to the CCM, will have overall technical responsibility for M & E system planning and review;
- NACO at the national level and the SACS at state level will have operational responsibility (each of these six SACS has an M & E officer and will have an HIV-TB consultant by the year-end);
- Reporting formats will be provided to the partner NGOs/CBOs & submissions monitored at the level of State AIDS Control Societies
- Independent evaluations of the programme will be conducted by external private agencies used for this purpose by the NACP II. These evaluations will be carried out on a yearly basis. A participatory approach will be used for evaluation studies.

37.5. Plan for involving target population in the process:

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

PLWA representatives are already members of the existing executive committee of the SACS and have a say in the policy decisions at the State level.

37.6. Strategy for quality control and validation of data:

- Quality control of HIV testing will be carried out under the current EQAS (External Quality Assurance System). Currently the third round of EQAS is underway for establishing quality HIV testing at the district levels. After that the district level VCT will be responsible for maintaining the quality of HIV testing at the sub-district level.
- District HIV/TB Supervisor to be responsible for validation of data prior to forwarding to the State level.
- SACS to have overall responsibility for cross-checking and validation of data from districts and will be assisted by the State HIV/TB Consultant appointed by WHO. Checklists will be developed for periodic cross verification.
- CMIS has inbuilt mechanisms for checking consistency of data.

37.7. Proposed use of M&E data:

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

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

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

The information generated from this programme will be disseminated and will be a useful resource for generating advocacy material to highlight the importance of HIV-TB co-infection

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

There is an existing system of annual external evaluation of NACP who will be entrusted the responsibility of evaluating the current programme and adequate resources provided.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	Partner(s) (which may help in strengthening M&E capacities)	Resources Required (USD)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
NOT APPLICABLE							
Total requested from Global Fund							
Total other resources available							

SECTION VIII – Procurement and supply-chain management information

39. **Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets** (Refer to Guidelines paragraph VIII.86).

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	Suppliers are awarded contracts after evaluation for technical and commercial parameters, and all procurement processes are in accordance with World Bank's Guidelines on Procurement.
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	Standard bidding documents of World Bank are used in procurement processes. In accordance with threshold limits bids are invited locally and at national levels. At times bids are invited globally. The supply managements are part of contract management by the Procurement agent specially selected for the Project. All suppliers contractually bound by the national and international property laws.
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	All products are procured in accordance with technical specifications stipulated by special standing Technical committees of NACO. Further the goods are subjected to pre-despatch material inspection plans and/or inspections. Wherever a drug license is required, it is insisted upon. For such goods Good Manufacturing Practice (GMP), or if WHO-GMP is available, the same is called for from all successful bidders (manufacturers).
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	The supplies are effected through AIDS Control societies. The goods are issued to authorised centres only, and as per their allocations fixed after a careful evaluation of their requirements. Inventories are maintained by these Societies, who resort to procurements locally, if there are any shortages in regular supplies, thus ensuring a continuous supplies of goods.

40. **Describe the existing arrangements for procurement of services (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs):**

Procurement services are hired through open competitive procedures. Personnel or contracts required are advertised in National newspapers and selection is made in a transparent manner by a selection committee especially constituted for this purpose. A suitable number of candidates in the panel are kept in the waiting list. In the appointment offer, it is specifically mentioned that the appointment will be purely on contractual basis. Initial appointment to all posts are usually for a period of one year and renewable on a yearly basis subject to satisfactory performance.

Regular training programmes are arranged for training of key program managers of States and Districts, at Central and at State level institutes. Training of general health staff is arranged in their respective institutes or arranged at the local level. Separate training manuals have been developed for training of different levels of health care staff. Clear cut guidelines are also available regarding batch size of various trainees, prescribed duration of training,etc.

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

Not applicable

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88*):

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant
	NOT APPLICABLE		

- 42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

There would not be any duplication, as the existing Revised National TB Control Programme will provide the drugs for TB free to HIV positive patients with TB.

Counseling and testing services at the sub-district level is an entirely new initiative being suggested as such facilities are almost nonexistent at present. These will complement the current activities of the National AIDS Control Programme.

LIST OF ATTACHMENTS

General documentation:	Attachment #
1. Poverty Reduction Strategy Paper (PRSP) 2. Medium Term Expenditure Framework 3. Sector strategic plans 4. Any reports on performance National Health Policy – 2002** Approach Paper to the 10th Five Year Plan (2002-2007)**	GD1 GD2
HIV/AIDS specific documentation :	Attachment #
5. Situation analysis 6. Baseline data for tracking progress ¹ a) Feasibility Study of Administering Short Term AZT Intervention Among HIV-infected Mothers* b) HIV Seroprevalence, ante-natal women High Prevalence States 7. National strategic plan for HIV/AIDS, with budget estimates National AIDS Prevention and Control Policy* 8. Results-oriented plan, with budget and resource gap indication (where available) Combating HIV/AIDS in India 2000-2001*	H1 H2 H3 H4 H5
TB specific documentation:	Attachment #
9.a) Multi-year DOTS expansion plan and budget to meet the global targets For TB control b) Operational Guidelines for TB Control* 10) Documentation of technical and operational policies for the National TB programme, in the form of national or similar documents Technical Guidelines for TB Control* 11) Most recent annual report on the status of DOTS implementation, Expansion, and financial planning (routine annual WHO TB data [and Finance] Collection Form) TB India 2002 RNTCP Status Report* 12) Most recent independent assessment/review of national TB control activities Joint TB Programme Review India February 2000*	TB1a TB1b TB2 TB3 TB4
Malaria specific documentation:	Attachment #
13) Situation analysis 14) Baseline data for the tracking of progress 15) Country strategic plan to Roll Back Malaria, with budget estimates 16) Result oriented plan, with budget and resource gap indication (where available)	M1 M2 M3 M4

* Attachment is a brochure accompanying the proposal

General documentation:	Attachment #
17) Documentation for Question Section II.4 (TOR of CCM)	GD3
18) Documentation for Question Section II.5 (CCM Minutes)	GD4
19) Documentation for Question Section II.5 (CCM Task Force)	GD5
20) Documentation for Question Section II.7.1 (Private Sector and Civil Society CCM Members)	GD6
HIV/AIDS specific documentation:	Attachment #
21. Detailed Budget Plan	H6
22. Letters of Collaboration from Pharmaceutical Companies	H7
23. National Guidelines on Clinical Management of HIV/AIDS*	H8
24. Guidelines for Rational use of Antiretroviral Drugs*	H9
25. Use of Antiretroviral Therapy: A Simplified Approach for Resource-Constrained Countries*	H10
26. Specialists Training and Resource Module*	H11
27. Manual on Quality Assurance Practices in HIV Testing Laboratories*	H12
28. National Baseline General Population Surveillance Survey*	H13
29. Sentinel Surveillance of India 2001	H14
30. Documentation for Question 29 HIV/AIDS Component	H15
TB specific documentation:	Attachment #
31. List of References	TB5
32. Detailed Budget Bihar and UP	TB6
33. Detailed Budget Plan Bihar	TB7
34. Detailed Budget Plan UP	TB8
35. Detailed Budget Plan TB Association of India	TB9
Malaria specific documentation:	Attachment #
36. List of References	M5
37. List of Acronyms	M6
38. Proposal for ITN, Population Services, International	M7
HIV Tuberculosis documentation	Attachment #
39. Situational Analysis	HTB1
40. Action Plan for HIV-TB Co-infection	HTB2
41. Detailed Budget	HTB3
42. List of NGOs in 6 Southern States	HTB4
43. <i>Treatment Guidelines for TB in HIV infected*</i>	HTB5
44. RNTCP Training Manual for Medical Officers on HIV-AIDS*	HTB6
45. HIV and TB a Guide for Counsellors*	HTB7
46. TB-HIV a Guide for Health Workers*	HTB8
47. Training Module on HIV/TB for District Nodal Officers and Medical Officers in Charge VCTC*	HTB9
48. National Baseline General Population Behavioural Surveillance Survey*	H13
49. Sentinel Surveillance – India 2001	H14

* Attachment is a brochure accompanying the proposal

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ARCON	AIDS Research and Control Center
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CMO	Chief Medical Officer
DOTS	Directly Observed Treatment, Short-course
DTO	District Tuberculosis Officer
EDPT	Early Diagnosis and Prompt Treatment of Malaria
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOI	Government of India
HIV	Human Immunodeficiency Virus
ICMR	Indian Council of Medical Research
IEC	Information Education Communication
ITN	Insecticide Treated Bed Nets
MCH	Maternal and Child Health
MIS	Malaria Information Systems
MPW	Multi Purpose Workers
MTCT	Maternal to Child Transmission
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NAMP	National Anti Malaria Project
NARI	National AIDS Research Institute
NGO	Non Governmental Organization
NTP	National Tuberculosis Programme
OI	Opportunistic Infections
PHC	Primary Health Centers
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PP	Private Practitioners
PSI	Population Services International
QA	Quality Assurance
RCH	Reproductive and Child Health
RDT	Rapid Diagnostic Dipstick Tests
RNTCP	Revised National Tuberculosis Control Programme
SACS	State AIDS Control Society
SEARO	South East Asia Regional Office, WHO
SES	Socio Economic Status
STCS	State Tuberculosis Control Society
STI	Sexually Transmitted Infection
TAI	Tuberculosis Association of India
TB	Tuberculosis
TBVH	Tuberculosis Health Visitors
TRG	Technical Resource Groups
TU	Tuberculosis Unit
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UTF	Urban Task Force
VCTC	Voluntary Counselling and Confidential Testing
WHO	World Health Organization

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<i>List of Attachments</i>		

Volume 2

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Section II	Attachments – HIV/AIDS
Section III	Attachments – Tuberculosis
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Received in Global Fund

26 SEP 2002

No.:
Signature:



DEEPAK GUPTA

Joint Secy. & CVD

Telefax : 3018842

Tel. : 3019195

भारत सरकार

स्वास्थ्य एवं परिवार कल्याण मंत्रालय

निर्माण भवन, नई दिल्ली-110011

GOVERNMENT OF INDIA

MINISTRY OF HEALTH & FAMILY WELFARE

NIRMAN BHAVAN, NEW DELHI - 110011

E-mail:jsd@nb.nic.in

- dgupta@bol.net.in

D.O. No. M-18016/4/2002-NACO

Dated the 24th September 2002

Dear Prof. Feachem,

On behalf of India's Country Coordinating Mechanism (CCM), we are pleased to forward the attached proposal for the Global Fund to fight HIV/AIDS, TB and Malaria (GFATM).

The proposal has been put together through a wide-ranging consultative and participatory process involving all stakeholders. It furthers the spirit of public-private partnership that informs the working of our CCM, and also the entire GFATM process. A number of NGOs have participated in the exercise to finalize the proposal, and some of their proposals have been included in the CCP. Moreover, all components of the CCP would have substantial NGO involvement in their actual implementation.

Among other highlights of the CCP is a component devoted exclusively for HIV-TB management, which would be taken up on such a substantial scale for the first time in the country. It is also proposed to strengthen the national programme for prevention of mother to child transmission. There is also a focus on expansion and up scaling of successful interventions in all three disease-control areas. Populations in urban slums and the under-served rural areas of the country are also being covered.

We are requesting a total of US\$ 245.67 million from the Fund over the next five years, with a first year budget US\$ 36.0 million. As would be apparent from the contents of the proposal, the government itself is also committed to provide substantial resources for combating these diseases, and has a budget of US\$ 120 million during the current financial year itself for this purpose. It may also be pointed out that the largest external assistance is in the form of loans from the World Bank, wherein expenditure is first incurred out of the government budget and reimbursement (which is about 80% of the loan component) is subsequently claimed from the World Bank.

The above figures are for interventions that would be implemented by the national programmes in association with NGOS and civil society. A separate proposal prepared by an NGO for HIV/AIDS prevention and control activities in

the new State of Chattisgarh, with a 5-year budget of about US\$ 6 million, has also been considered and endorsed by the CCM, and is also attached.

The proposed interventions are urgently required to boost the national response, and we hope for a positive response from the Fund.

With best regards

Yours sincerely,



(Deepak Gupta)

Professor Richard Feachem
Executive Director
Global Fund to Fight HIV/AIDS, TB & Malaria
Geneva.