FUNDING REQUEST

Tailored to National Strategy-based Pilots

SUMMARY INFORMATION			
Applicant	**CCM INDIA**		
Component(s)	**Tuberculosis**		
Principal Recipient(s)	1. **Department of Economic** Affairs, Ministry of Finance, implementing through **Central TB Division**, Ministry of Health & Family Welfare, Government of India **2. William J Clinton Foundation** 3. **The Union** 4. **Department of Economic Affairs**, Ministry of Finance, implementing through **Indian Council for Medical Research**, Ministry of Health & Family Welfare, Government of India		
Envisioned grant start date	**01st January 2018**	**Envisioned grant end date**	**31st December 2020**
Allocation funding request	**US$ 279,929,924**	**Prioritized above allocation request**	**US$ 180.53 million** (includes US$ 40 million loan buy down)

SECTION 1: CONTEXT

1.1 Key reference documents on country context			
Key area	**Applicable reference document(s)**	**Relevant section(s) & page no.**	**N/A**
Resilient and Sustainable Systems for Health (RSSH)			
Health system overview	NHM Framework for Implementation 2012-2017 (Annexure-1)	Chapter 3 Pg. 7&8	☐
Health system strategy	National Health Policy 2017 (Annexure-2)	Section 3 Pg. 6-10	☐
Human rights and gender considerations (cross-cutting)	National Health Policy 2017 (Annexure-2)	Section 27 Pg. 27-28 Section 2.2 & 5 Pg. 2 & 14	☐
Disease-specific			
Epidemiological profile (including interventions for key and vulnerable populations, as relevant)	National Strategic Plan 2017-2025 (Annexure-3) WHO Global TB Report 2016 (Annexure-4) TB India 2017 (Annexure-5) Report of the Joint Monitoring Mission 2015 (Annexure-6)	Chapter 1 Pg. 14 & 15 India Country Profile Pg. 146 Chapter 2 Pg. 9 Chapter4 Pg. 30-33 Section 2.2 Pg. 14 - 18	☐
Disease strategy (including interventions for key and vulnerable populations, as relevant)	National Strategic Plan 2017-2025 (Annexure-3)	Section on Detect, Treat and Prevent Pg. 23 - 71	☐
Operational plan, including budgetary framework	National Strategic Plan 2017-2025 (Annexure-3)	Complete Documents	☐

	Technical and Operational Guideline 2016 (Annexure-7) National PMDT Guidelines 2017 (Annexure-8) SOPs for State and District Drug Stores (Annexure-9A,9B,9C) Tribal Action Plan (Annexure-10) Guideline for management of TB and HIV (Annexure-11) Guideline on Adverse Drug Reaction Management (Annexure-12) Handbook of Health Worker Surveillance for TB (Annexure-13)		
Program reviews and/or evaluations	Report of the Joint Monitoring Mission 2015 (Annexure-6) Concurrent Assessment of UATBC 2016 (Universal Access to TB Care Project) (Annexure-14) Rapid Assessment of the WHO TSN for RNTCP by USAID 2016 (Annexure-15) Common Review Mission of NHM 2016 (Annexure-16) National and State level evaluations (Annexure-17) STO and Consultant Review Meeting (Annexure-18) Regional PMDT Review Meetings (Annexure-19)		☐

Human rights and gender considerations (disease-specific)	NSP 2017-2025 (Annexure-3)	Chapter 13 Pg. 86	☐

1.2 Other contextual information

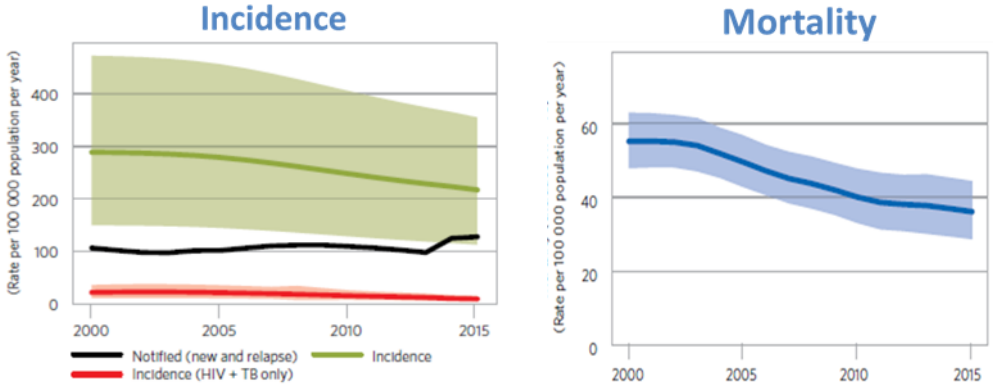
India with a population of 1.32 billion is the second most populated country in the world and is projected to be the **world's** most populous country by 2022. More than 50% of India's population is below the age of 25 and more than 65% below the age of 35. Poverty in India is an important issue. A significant proportion of the population**1** is undernourished due to poverty, which leads to weakened immunity and manifestation of TB. A considerable population also suffers from conditions weakening immunity, including smoking, diabetes and indoor air pollution from cook stoves, that increase the likelihood for progression to active TB. Poverty is associated with increased risk of TB and TB leads to high out-of-pocket expenditure thereby contributing to poverty and becomes a vicious circle. Thus, any sustained initiative to bring down this epidemic will also greatly accelerate poverty reduction and improve human development efforts not only within the country but in the region and globally as well

The TB Disease Burden in India:

Tuberculosis remains a major public health challenge despite of positive impact of many factors including established DOTS strategy in the country for about two decades.

India has revised its TB incidence and mortality estimates in 2016 based on updated availability of data from state level prevalence surveys, data from private sector TB notification, estimation of TB cases under-notified to national programme from private sector using drug sale data and mortality data from million death survey and verbal autopsy studies. With revised WHO estimates of TB burden in India, the incidence rate continues to be high with 217 per 1,00,000 population (CI: 112 to 355). The estimated incidence (new TB cases per year) is 2.8 million cases in 2015 (CI:1.47 to 4.65 million) and thus contributing to 27% of world's TB burden. The estimated mortality due to TB is 480,000 (CI: 380000-590,000). Against 18% of total global population, India's estimated burden is 27% in terms of incidence, while the mortality is 34%. Mortality due to TB is the third leading cause of years of life lost (YLLs), in the country. TB alone contributes to 3.3% of Disability adjusted life years (DALYs) attributable to all-cause premature mortality and morbidity in the country.

The trend in incidence and mortality rates is depicted below:



With backward calculations, both tuberculosis incidence and mortality rates are decreasing from 2000 to 2015. Though the available data suggests that the TB epidemic may be on the decline, India continues to be the highest TB burden country in the world in terms of the absolute numbers of incidence cases each year. With the estimated 40% of the population of the country infected with MTB, and with 10% life time risk of this population breaking down

into active tuberculosis, there is a need for substantial investment in resources and innovations to have a visible impact towards ending TB in India.

Approximately 5% of the incident TB cases have co-morbidity with HIV, though this proportion varies depending on the HIV prevalence of the population. Estimated incidence of TB and HIV co-infected patients is 113,000 (CI-58,000 – 186,000) and mortality from HIV+TB is 37,000 (CI 21,000-57, 000).

India is also the highest burden country for MDR/RR TB, with an estimated 0.13 million (CI: 0.08 – 0.18) incident cases annually. Nearly 2.5% (2.1% - 3.1%) of the notified new pulmonary cases and 16% (14% – 18%) of the notified previously treated pulmonary cases have MDR TB (WHO Global TB Report 2016). Cases of extensively drug resistant TB (XDR-TB) have also been reported from most states of India. National Drug Resistance Survey (NDRS) data shows the proportion of MDR-TB among new cases as 2.84% (2.28-3.49) and 11.67% (10.26-13.21) for previously treated case (unpublished). NDRS data shows high proportion of any INH resistance (New cases 11.06 (9.97-12.22) previously treated 25.09 (23.15-27.11) which needs urgent attention.

The programme has registered more than 33000 drug resistant TB patients in 2016. In addition, at the six sites implementing Bedaquiline containing regimen, mono INH and poly resistant TB patients are being diagnosed and put on treatment.

Diversity of epidemiology:
India has a wide spectrum of TB epidemiology. Data from the seven subnational prevalence surveys, sub national and district level prevalence of infection surveys and analysis of programme notification data on TB, MDR TB and TB HIV reveals that the country has varied epidemiology from very high TB prevalence to very low TB prevalence, high and low TB/HIV co infection and DR-TB depending on state/regions. There is general epidemiological difference between urban and rural areas, urban areas are typically characterized by lower prevalence with higher Annual Risk of TB infection (ARTI), while rural areas are characterized by higher prevalence and lower ARTI.

The diversity of TB epidemiology in the country necessitates different approaches to be adopted for addressing the problem. The programme has identified 184 priority districts based on the burden of DRTB, HIV/TB, high case notifications and weak health systems. These districts are being prioritized for focused interventions and monitoring.

Recent evidences from drug sales data (Annexure 20), sub national prevalence surveys, notification of TB patients from private sector suggest higher prevalence of TB in the country. The programme has also recently revised its incidence and mortality estimates. This makes a case for conduction of a nationwide TB prevalence survey. Ministry of Health & Family Welfare, GOI has initiated processes to conduct a **Nationwide TB Prevalence Survey** with State wise estimates. This will also form the baseline for monitoring progress against the SDGs related to Tuberculosis.

The procurements for initiating the TB Prevalence Survey are undergoing currently with the support of the Global Fund NFM Grant.

Monitoring of drug resistance in the country would be continued through sentinel surveillance of drug resistant TB.

Key Affected Population (KAP): The programme has identified populations for targeted interventions in the National Strategic Plan (NSP Chapter No.8, P.No.53). These key affected population groups are vulnerable, face barriers in accessing care and deserve more attention for reasons of equity, social justice and human rights.

The **pediatric TB patient's** coverage is another challenge. The proportion of children among new TB patients reported was 6% in 2016 as per program data.

Gender inequality and Human Rights considerations:

In India, the Directive Principle of State Policy under the Article 47 of the Constitution of India considers that it is the primary duty of the State to improve public health, securing of justice, human condition of works, extension of sickness, old age, disablement and maternity benefits. Under this Article, the State is expected to raise the level of nutrition and standard of living of its people and improvement of public health among its primary duties. Providing adequate medical facilities for the people is an obligation undertaken by the government in a welfare state. The government discharges this obligation by providing medical care to the persons seeking care.

The policies and strategic plan of the Revised National TB Programme of India are fundamentally based on a patient-centric and rights-based approach and equity. Access to TB services is provided to all irrespective of gender, caste, creed, domicile or other externalities.

The Programme along with its implementing civil society partners continues to disseminate the 'Patients Charter' which outlines the rights and responsibilities of people with Tuberculosis and empowers people with the disease and their communities.

The National Strategic Plan for TB Elimination 2017-2025 clearly recognizes that some key affected population groups are vulnerable and may face barriers in accessing care and deserve more attention for reasons of equity, social justice and human rights. The programme in spite of its efforts has reported the M:F ratio of 1.7 (1.07-2.25) in 2016. Male to Female ratio among notified TB patients has been declining steadily. RNTCP services are made available to the population irrespective of the gender.

The National Strategic Plan commits to make all efforts to support a comprehensive TB bill to be placed before Parliament of the country which will further promote TB care as a human rights issue and hasten the control of TB in the country (NSP Pg.no. 79-80).

India is a signatory to key international treaties and movements advocating for, and protecting human rights (The International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1979, the UN Convention on the Rights of Children in 1992 and the Convention on the Elimination of All Forms of Discrimination against Women in 1993, and the Convention on the Rights of the Disabled in 2007). Engaging representatives from various sectors and constituencies (including key affected populations) in the India Country Coordinating Mechanism ensures that voices of all groups are heard including, in respect of gender and human right issues in developing and implementing disease control strategic plans.

The Health Systems and Community Systems context in the country:

The Revised National TB Control Program (RNTCP) has helped India to make significant strides in addressing the requirements of TB, and also built coordination with HIV to address cross cutting issues. Although sizeable domestic funding is available, however, additional resources are still required to leverage and sustain the gains in reach and quality of services, as well as to integrate the program and reach the the goal of "TB elimination by 2025" as reflection of highest level commitment. (NSP Chapter No.13).

The programme is fully integrated and is being implemented through the general health services. The states are contributing significantly for implementation of the Revised National TB Control Programme. The Senior, Mid and Lower level administrators, Specialist Doctors like Chest Specialists, Medicine and other specialty experts, Microbiologists, Medical

Officers, Laboratory Technicians, health workers at different levels are all contributing towards implementation of the TB programme. The programme is being implemented through the state health infrastructure, state level human resources for Health and involvement of community structures. In addition, varied involvement of Public - Public and Public Private interventions are being implemented by different states.

The community level involvement of ASHA (Accredited Social Health Activists) voluntary workers (one ASHA per 1,000 population) selected from the community itself is happening through a large cadre of such workers who are directly involved for community mobilization. In addition, monthly Village Nutrition Health & Sanitation Committee (VNHSC) meetings organized by the ASHA workers at the village level also provide support in the area of community mobilization. The programme also envisages to involve Self Help Groups (SHGs) which will be a platform for a large scale community mobilization.

Under private sector engagement, the programme has registered more than 117,000 private sector establishments in Nikshay. This initiative can be leveraged by other programmes too, to deliver their services through the private sector.

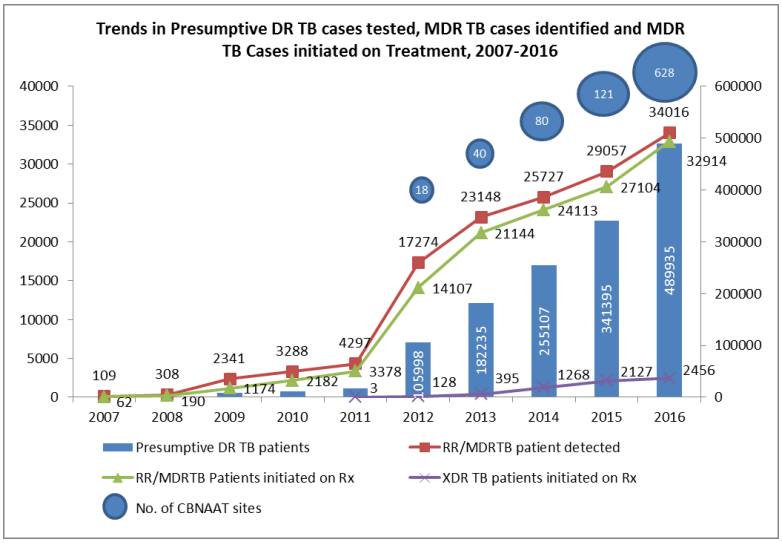
The implementation of TB activities is conducted based on the disease specific National Strategic Plan strategies and guidelines.

National Strategic Plan 2012-2017: Achievements & Lessons learnt

India's ambitious National Strategic Plan (NSP) to achieve universal access to quality TB diagnosis and treatment has guided activities and created accountability against results.

NSP achievements and lessons learnt are available in the document at Pg. no. 13-16.

However, it is important to mention here, that the scale up of MDR-TB was a major achievement of last NSP primarily supported by the Global Fund Grant as depicted below:



Lessons learnt during implementation of NFM grant:

- Inadequate oversight of non-Government PRs and SRs by national programme.
- Delay in implementation of the grant activities because of necessary Government approvals.

- Financial reporting of grant expenditures by the states in the quarterly Statement of Expenditure is not yet streamlined
- Supply chain management for first and second line drugs gets affected due to space constraints and inadequate observation of quality storage practices

SECTION 2: FUNDING REQUEST (Within Allocation)

2.1 NHP/NSP reference			
Reference document	**Relevant section(s) / page no.**	**Corresponding modules / interventions**	**Associated cost to be covered by this funding request**
NSP 2017-2025	Chapter 6 Chapter 4 & 5 Chapter 8 Chapter 16 Chapter 9 Annexure B Chapter 17	**Module1:** TB Care and Prevention **Interventions:** Engaging all care providers Case detection and diagnosis ACF in KAPs Research ICT tools for treatment adherence & patient support system Technical Assistance	US$ 94.96m (34%)
NSP 2017-2025	Chapter 4&5 Pg:26-30 Chapter 6 Pg:45-50 Chapter 9 Pg: 61-65	**Module 2**: MDR-TB **Interventions**: Case detection and Diagnostics Treatment Patient support systems	US$ 154.34m (55%)
NSP 2017-2025	Chapter 8 Pg. 54	**Module 3**: TBHIV **Intervention**: Procurement of IPT	US$ 2.64m (1%)

NSP 2017-2025	Chapter 19 Pg. 108 Chapter 18 Pg. 102-103	**Module 4**: RSSH **Interventions:** Streamlining use of PFMS for financial reporting of NTP Strengthening the Supply Chain Management system with infrastructure development/maintenance at central, state and district drug ware houses	US$ 5.72m (2%)
NSP 2017-2025	Chapter 13 Pg:82-83 Chapter 15 Pg. 93-94	**Module 5:** Program management **Interventions:** Grant management Other PA costs	US$ 22.26 (8%)
TOTAL			**US$ 279.93 million**

2.2 Funding request

The program is committed to achieve the targets set forth in the NSP 2017-2025 and expects domestic financing and other resources, including possible loan from the World Bank, will fill in the financial gap. Though such resources are not officially committed yet, and cannot be reflected in the financial gap table, current political commitment, and Tuberculosis being one of the priorities of Prime Minister of India, provide reasonable assurance that resources needed to finance the key areas of NSP will be made available to maintain and achieve NSP targets.

In order to inform a strategically focused funding request, the program has prioritized the areas of interventions for maximum impact which are expected to be supported through the Global Fund Grant. These have been detailed below:

Drivers of the Funding Request 2018-2020:

- Highest Level of Political Commitment to achieve TB elimination by 2025
- Plan of expanded resource envelope of US$ 1.86 billion over three years
- Priority areas identified in the NSP based on lessons learnt from previously implemented NSP.
- Implementation gaps identified from the current Global Fund NFM Grant.

In order to inform a strategically focused funding request, the program has prioritized the areas of interventions for maximum impact which are expected to be supported through the Global Fund Grant. These have been detailed below:

Module1- TB Care and Prevention

Programmatic Gap: The total estimated TB cases during the year 2018 is 3.9 million with an annual decline of 1.5% resulting into 11.5 million TB cases estimated to occur between 2018-2020 cumulatively, as per the calculations for the NSP 2017-2025 (Annexure- 3). As planned in NSP, the country, targets to achieve a total case notification of 9.95 million by 2020. Out of these targets, 6.18 million TB cases (61%) are to be detected through domestic resource investment and around 2.9 million TB cases (29%) through Global Fund Grant support. The domestic support also includes interventions for addressing the challenges of TB/HIV, TB-Diabetes and Smoking through programmatic collaborations As a result, around 0.57 million TB cases would remain missing against the estimated 3.6 million cases in the year 2020. The country plans to cover the gap through other external resources like CSR funds, Corpus Fund to be raised through program effort and engagement of the voluntary sector.

Rationale for prioritization:

1. **Engaging all care providers:**

The private sector is massive, heterogeneous and growing, accounting for roughly 80% of the first contact of patients with health-care providers in the country. Studies conducted since the 1990s have documented more than half of TB is diagnosed and treated in the private sector. The recent evidence on drug sales in private market suggests that an estimated 2.2 million TB patients are in private sector. In spite of the mandatory notification advisory, a significant number of patients are still not notified to the programme. Two decades of attempts to improve collaboration between the public and private sectors, have yielded limited results, except pilots in Mumbai Patna and Mehsana under Universal Access to TB Care project. Reaching to TB patients in private sector, ensuring quality of care and

reductions in cost incurred are important to address the issues in holistic manner (NSP pg. 31-33).

The proposed strategy is to have a constructive partnership with the private providers by establishing linkages to enhance notification as well as successful completion of treatment with efforts from the partners both in government and private sector and find the missing cases as a shared responsibility.

One such new approach to engage private sector providers has been tried in the project Universal Access to TB care. The intervention was aimed at improving TB notifications by using ICT support, free TB drug for notified TB patients, and to extend adherence support to patients diagnosed and treated in the private sector. In the urban areas (i.e. Patna and Mumbai), a 'Private provider interface agency' (PPIA) was used to enroll and extend public health services for a large number of private providers to ensure efficient service delivery.

Outcome of the pilot project:- In UATBC areas, TB case notification had increased rapidly and substantially relative to baseline, and this increase was directly attributable to private practitioners. (UATBC Report – Annexure 14)

Interventions Proposed with the support of Global Fund Grant:

The proposal for private sector engagement is designed to enhance the partnership management capacity by establishing Public Private Support Agency (PPSA) in 92 RNTCP districts covering more than One million population in 33 cities/urban agglomerations/corporations and state level management units by Consortium Organizations supported under the Grant. These 33 cities/urban agglomerations/corporations cover 92 RNTCP districts (for example Mumbai & Delhi cover 24 district each). The intervention would focus in the urban population of the districts. Most of the selected cities/urban agglomerations/corporations would be fully covered. Implementation arrangement will include countrywide mapping of the providers and capacity building through training of RNTCP staff. In the 142 RNTCP districts (including 92), intensified activities will be carried out which will include close coordination with private practitioners, linkages for free diagnostics and drugs and treatment support to ensure treatment outcome of TB patients seeking care in private sector. The civil society partner would establish State Programme Management Units to support the programme in the major states of the country. In the remaining districts of the country, the programme will implement these interventions through domestic budget.

PPSA (Structure and Scope of work):

The PPSA will have a project office with a Director, an Operations Manager, an account assistant, an admin assistant and an MIS assistant. Two distinct streams, one for private sector engagement and other of patient services will be managed. Field Officer and Lab field officer will be responsible for engagement of private providers/facilities in the programme
The other team comprising of personnel responsible for sample collection and transport, recording and reporting support to the high burden facilities, treatment adherence support and social welfare linkages and other public health actions will have a population based norm for number of personnel

The **scope of work for PPSA will define the following objectives:**

- Networking with and sensitization of the private sector facilities (providers from both modern and Indian system of medicine, pharmacist/chemist, laboratories, hospitals, etc.)

- Engagement of the private sector under the programme. Once engaged, continued interaction and coordination with providers to sustain the rapport. A 'customer service' approach and procedures for that like feedback system, grievance redressal system, and recognition system for following good clinical practices will be established
- Continuing Medical Education for the private providers
- Service delivery linkages
    - Sample collection and transportation
    - Recording and reporting support to the private sector
    - Logistic support for free FDCs provision in private sector
    - Treatment initiation and adherence support patients treated with FDCs in private sector
    - TB notification and treatment outcome reporting of the privately notified TB patients
    - Capacity building of public sector to engage with private sector and extend public health action to private sector patients

The program would continue and strengthen implementation of activities under PPM- NGO involvement Guidelines which itself would contribute to the notification of TB patients from the private and voluntary health care providers. The drugs, diagnostics and incentives as envisaged in the NSP will be provided by the programme.

Effective ICT support will be the cornerstone for facilitating engagement, user-friendly patient reporting, patient centric adherence monitoring, and for smooth financial transactions. The eNikshay platform, supported with efficient call centre and provision of sufficient digital tools to field staff and providers, will be key to reaching patients in private sector. [NSP pg. 38, point 5]. A 250 seater call centre is proposed under the grant for countrywide coverage of providers and patients. A Call Centre, through toll free phone number is the centre of data exchange with patients, private practitioners, RNTCP staff, chemists, and laboratories. The Call Centre will perform activities for both public and private health sector for all forms of TB. The Programme has a case based web based MIS system – NIKSHAY. The public health staff are using the MIS since its inception for patient registration, follow up and updating treatment outcomes for both TB and drug resistant TB patients. The enhanced version (eNIKSHAY) would be on mobile platform to put more impetus on real time information interchange. This will be boosted by the availability of call centre which will be useful to do patient registration and updation of patient details more real time. The Call centre will be of more helpful for establishing a robust TB surveillance system in private sector. Here, the Call Centre will serve the purpose for TB notification, linkage of diagnostic and treatment services, adherence support and to report outcome of TB patients in private sector. The Programme has already an experience of successful use of call centre for smooth coordination with private sector at UATBC Project sites (Annexure 14). It was the key and worked as force multiplier in making the TB notification provider friendly and patient centric care possible.

In addition, ICT based adherence support system (99 DOT) has been proposed under the Grant is expected to cover 1.55 million TB patients over the three years.

Outcome: It is expected that this intervention would notify 1.7 million TB cases over the three years grant period from the private sector.

The Grant support of US$ 40 million is expected to cover the private sector engagement interventions (to be supported through civil society PR) and US$ 17.2 million includes the establishment and functioning of 250 seater call centre (US$ 8.78 million) to cover all TB patients notified both from public and private sector and support treatment adherence , (US$ 8.41 million) using ICT based interventions noted above.

2. Active case finding (ACF) in Key Affected Populations (KAP):

Passive case finding alone leads to missed cases or delayed diagnosis. Enhanced outreach activities to detect more TB cases are critical to universal access. ACF in vulnerable groups is a focus of the NSP with considerable efforts required to reach these populations. (NSP pg. 27). Vulnerable and marginalized target population (essential includes PLHIV, urban slums, Diabetes Mellitus, Tobacco use, undernourished etc.) have been well defined by the RNTCP. Program has gained some early experience of reaching such population in a campaign mode. The first round of Active TB case finding (ACF) activity was conducted across 50 districts and the 4 metros of the country in January 2017. During the campaign, more than 4,852,062 persons were screened for Tuberculosis following which 70,348 were tested for TB and additional 2,725 TB cases were diagnosed and initiated on treatment. The second phase is planned for 100 districts in the month of June, 2017.
Systematic active TB screening in key populations through house-to-house visits is the key strategy for active case finding. Community and institutional screening to be followed by appropriate linkages to the diagnostic facilities. This activity is resource intensive, needs to be demonstrated in program settings. Community engagement augmented with effective engagement of all care providers can bring the necessary impact**.** The programme has issued Surveillance guidelines for Health Care workers. Using the domestic resources, this activity would be strengthened further

During the current NFM Grant, active case finding is being implemented in 19 districts of 5 states to increase case detection amongst tribal population and 17 exile settlements of the Tibetan refugee population. The outcomes reported for the period April 2016 to March 2017, shows that in a Tibetan population of about 0.035 million, the total cases notified are 95 (271 cases per 100,000 population per year) and they have been initiated on treatment.

The NFM Grant supported the procurement of 35 mobile vans equipped with digital X-rays and microscopes to make ACF in tribal population a success. This intervention is likely to result in detection of additional 12,000 cases in a population 17 million over a period of 9 months ending December 2017. In addition, 45 mobile vans equipped with CBNAAT machines are being procured to support active case finding in all the states.

Interventions Proposed with the support of Global Fund Grant:

The program proposes to continue the current implementation arrangements and extend the Active Case Finding efforts further to 125 districts (which include high priority districts as identified by the programme) across country with support of Global Fund Grant in the funding request.

The strategy for Systematic Active TB Screening will be the same as defined under the National Strategic Plan and Active TB Case Finding Guidance Document of RNTCP (Annexure 21)

This intervention would be supported through civil society partners. In 14 states, the civil society partner will also provide technical assistance for planning and implementation of activities.

In 125 districts, the activities for active case finding under the grant request include identification and mapping of key affected population, community awareness, systematic active TB screening in both community and institutional settings, linkages for diagnostic evaluation of presumptive TB patients, treatment initiation of diagnosed TB patients. These

interventions will be carried out through local community volunteer who will be paid honorarium based on activities. The diagnostics (smear microscopy, chest X-ray and CBNAAT) and drugs will be provided by the programme. Besides, the project is also providing technical assistance for supporting the planning and implementation of the active case finding interventions in additional 350 districts. This will build the capacity of the states and districts for active case finding and ensure sustainability.

In addition to the above, Central TB Division has planned to conduct the Active Case finding using the grant funds. Depending upon the availability of Technical and managerial capacity, the activity may be carried out by CTD or may be outsourced to a third party at the time of grant implementation to meet the CTD targets defined in the performance framework.

Effectiveness of active TB case finding activity will depend upon the screening and diagnostic tools used. This can be achieved by using Chest X-Ray as a screening tool and CBNAAT as a diagnostic tool to improve sensitivity of active case finding screening. Under the Grant Proposal, 123 digital chest x-ray equipment are proposed to enhance existing capacity of digital radiology and increase access support to ACF activities. Out of the total capacity of the CBNAAT machines approximately 30% will be utilized for the diagnosis of TB by up-front testing with this test. Hence, 75 CBNAAT machines and 0.79 million cartridges are proposed under the grant for diagnosis of TB among key affected population and supporting private sector engagement.

The active TB case finding activities which will be implemented by the programme through domestic budget would include use of the 80 mobile vans in difficult reached population already supported through the current NFM grant. The consumables for radiology will also be procured through domestic budget.

Outcome: With the interventions supported through grant, the programme is aiming at covering **0.23 million TB patients** under the Grant Proposal

In addition, the programme through its efforts using global fund grant supported call centre, CBNAAT machines, Xray, Mobile vans would cover 1.17 million TB notifications over the grant period.

The Grant support for direct interventions would be nearly US$ 15 million besides the procurement of 75 CBNAAT machines and cartridges. The nature of the civil society's engagement under this grant is beyond project implementation and also focuses on capacity building, technical assistance and close coordination with all stakeholders and this will require the proposed HR structure. This is critical for the success of the project and to reach the 19 million KAP and enhance their access to TB services

3. **Research**:

The programme requires additional knowledge and evidence on the effectiveness of interventions aimed at TB care and management and a more proactive approach to promote and conduct operational research to optimize policies, improve service quality and increase operational efficiency. Furthermore, the programme seeks to better leverage the enormous technical expertise and resources existing within India both within the Programme, and across the many medical colleges, institutions and agencies

Interventions Proposed with the support of Global Fund Grant:

ICMR is the premier health research Institute in the country. It is proposed to conduct Operational/ Implementation Research studies through Indian Council of Medical Research in the priority areas

identified by the program with a grant support of nearly US$ 5 million

4. **Treatment adherence using ICT tools:**

ICT interventions:

Effective ICT enablement is the cornerstone for continued engagement with patients throughout their treatment life cycle. A patient centric and user friendly ICT solution accessible to programme staff over a tablet enabling near real-time patient information capture, would largely simplify patient tracking and monitoring. About 4,000 Tablets are being procured through domestic budget and 20,000 through reprogramming under GF Grant of 2015-17.

Interventions Proposed with the support of Global Fund Grant:

a) **Call Centre for integrated ICT support to services:** Under the Grant Proposal, 250 seater call centre is proposed. A call centre available through toll free phone number is the centre of data exchange with patients, private practitioners, RNTCP staff, chemists, and laboratories. A wide range of services will be provided through these call centre for both public and private sector TB and drug resistant TB patients including patient and provider feedback and support.
b) **ICT based treatment adherence monitoring and support:** As RNTCP shifts to daily regimen treatment for drug sensitive TB patients, direct observation of treatment becomes challenging. Adherence remains a critical aspect of patient treatment to ensure patient recovery and prevent drug-resistance. To provide adherence monitoring mechanisms that allow patients to take and report their medications independently and remotely, to use that information to encourage patients to adhere and to enable differentiated care by helping staff prioritize those patients who are becoming non-adherent, is possible through ICT based tools. One such solution is 99 DOTS. It uses basic mobile phones and augmented blister packaging to provide real-time medication monitoring. The programme has experience of use of 99 DOTS for HIV-TB patients across the country (~45,000 patients per year). Currently, with support of BMGF and USAID, the programme has planned to support 99 DOTS adherence support to drug sensitive TB patients in 5 states where daily regimen is being implemented (0.25 million TB patients per year). Under the Grant Proposal, it is proposed to expand for 1.5 million drug sensitive TB patients over 3 years. This will include supply of augmented blister packaging, ICT support and training materials**.**

5. **Technical Assistance for Quality Implementation:**

The programme proposes grant support for placement of 60 Technical consultants at National and State level in year 1 of grant implementation with a transition to 40 Consultants in year 2 and 3. This consultants' network will focus on providing the necessary technical assistance to the programme at various levels in planning, implementation, monitoring and evaluation with special emphasis on the newer activities envisaged in the NSP such as, private sector engagement, active case finding, preventive strategies, social support, digital health, drug resistant TB management, TB surveillance system etc. Technical assistance includes support for evidence for policy development, development of programme guidelines; capacity building with appropriate tools, facilitating implementation of newer initiatives proposed in NSP and trainings at various levels.
A Grant support of US$ 8 million approximately has been requested to utilize the Technical network.

Module 2: MDR –TB Diagnosis and Treatment

Programmatic Gap:
As per NSP targets for 2018-2020, 236975 MDR/RR TB cases are expected to be notified for MDR/RR TB by end of 2020. The country plans to support the notification of i.e. 142185 (60%) MDR/RR TB cases through domestic resources and 94790 (40%) MDR/RRTB Cases through Global Fund Grant support.

The gap of 54% in year 2020 in diagnosis of RR/MDRTB cases is due to phased implementation of Universal DST to cover entire public sector by 2020 and coverage of drug resistant TB in the private sector would not be similar to the public sector (it is targeted to expand Universal DST for private sector in a proportion of 20%, 30% and 40% in three consecutive years)

The program is expected to initiate 90% of the total notified MDR/RR TB cases during the grant implementation period i.e. 213278 patients are estimated to be initiated on treatment. Out of these, 127967(60%) patients are expected to be covered through domestic resources and 85311 (40%) through grant support.

Rationale for prioritization:
Investments in the management of the DRTB is high impact and cost effective intervention.

With the roll out of shorter regimen, use of newer drugs for DRTB treatment and scale up of Universal DST, the program is requesting support of the Global Fund Grant for laboratory scale up and procurement of second line drugs complementary to domestic budgetary support.

During the current NFM grant, the country was able to procure additional 500 CBNAAT machines, establish 15 new C-DST labs and procured second line drug courses (31965 MDR-TB and 3500 XDR TB drug courses), The rapid scale up in RRTB diagnosis has been depicted in Fig. 1 Section 1.2

The DRTB Counsellor project was rolled out from July 2016 in 4 states for ensuring treatment adherence of DRTB patients and also developing patient support systems by SR TISS. The results have been encouraging- Till December 2016, 83 Saksham Pravaah counsellors have registered a total of 3602 DR-TB patients for counselling services. Presently out of the registered DR TB patients, 3348 are continuing with their treatment, 45 patients were lost to follow-up, 90 patients died during treatment, 64 patients stopped treatment due to ADR, and 55 patients transferred out (The programme experiences an attrition rate of 26% and 37% at 6 months and 12 months respectively). The project achieved its full strength by fourth quarter of 2016, since then there were only 5 lost to follow-up reported due to financial & family issues. Saksham Pravaah counsellors counselled 110 patients with treatment interruption instances out of which 88 patients were retrieved back to their regular treatment. 149 patients have been successfully linked for social protection out of which 13 were linked to GoI schemes, 58 patients were linked to nutritional support, 70 patients were linked to other health services, 4 patients were linked to insurance schemes and 4 patients were linked to income generation schemes.

Interventions Proposed with the support of Global Fund Grant:

1. **Scale up of diagnostic capacity of laboratories to have access to Universal DST**

The programme is aiming to achieve universal DST and DST guided treatment for all DR TB cases. This would require to build upon the capacity of the existing C-DST laboratories as well as establishing new labs including CBNAAT.

The Grant support is expected to cover establishment of 20 new Liquid Culture laboratories, 175 CBNAAT machines and sustenance of existing 63 laboratories including procurement lab consumables for all C-DST labs including existing genome sequencing labs.

2. Procurement of Second Line Drugs

Programme is also pursuing improvement in treatment success rate up to 65% by 2020.
The short course MDR-TB regimen is being introduced pan India under the programme as per the WHO guidelines (NSP page 46). Patients who do not meet the criteria for the short course regimen will be offered DST-guided treatment including regimens containing newer drugs such as Bedaquiline or Delamanid (whenever Delamanid would be available under programme). The Programme already has introduced Bedaquiline (BDQ) at six sites under the BDQ Conditional Access Program (CAP) and country-wide implementation of Bedaquiline is underway with the support of USAID donation programme.

During the grant implementation period, 85311 (40%) drug courses (including shorter regimen and DST guided regimen) and 4000 Bedaquline courses are planned to be procured through grant.

3. Patient Support systems to improve treatment adherence:

Patient counselling before initiation and during treatment is an essential support which requires for improving treatment success rate of DR TB patient. With the support of TISS would continue to implement the counselling project in 4 states and simultaneously linking these patients to social welfare schemes.

Outcome: Establishment of 20 new C-DST labs, 175 CBNAAT machines and 85311 RR/MDR TB patients would be initiated on second line treatment and lost to follow-up in the 4 states implementing the counselling project to be below 5% at end of 12 months treatment (currently 14%).

The Grant support requested includes about US$ 53 million for enhancing diagnostic capacity, US$ 96 million approx. for Second line drugs and US$ 5 million approx.for DRTB patient support

Module 3: TB-HIV

As per the policy adopted by the programme CBNNAT will be offered to all presumptive TB cases among PLHIV for early diagnosis of TB in settings such as ART centres, Link ART Plus centre (LAC+), Link ART centre (LAC), Integrated Counselling with testing centres (ICTC) and Targeted Intervention Projects. These interventions are being supported through domestic budgetary sources.

Under the grant support, the programme is proposing to procure Isoniazid and Pyridoxine for prevention of TB among PLHIV across country. The expected number of PLHIV to be covered is 1.41 million.

Module 4: Resilient and Sustainable Systems of Health:

Rationale for prioritization:

Use of Public Financial Management System for Financial reporting:
The current NFM grant supported the customization of the Public Financial Management System for strengthening financial reporting (expenditures) of NTP. This included the capacity building of RNTCP staff at both state and district level to help the program in shifting from an excel based reporting of expenditures to real time online expenditure reporting.

Strengthening Supply Chain Management System:
The NSP 2018-2020 focuses on Strengthen supply chain components to ensure the uninterrupted supply of TB drugs, including creating a supportive environment for a sustainable supply chain (Pg no. 75). it also identifies the certain weaknesses/ requirements for strengthening the supply chain management structures under NTP which includes: Inadequate infrastructure at state and district level stores, space being a major concern; inadequate basic infrastructure like racks, temperature and humidity monitoring systems, firefighting equipment, computers with internet facility, communications and mechanism for transportation of commodities; Lack of a uniform mechanism for Packaging / repackaging of 2nd line drug boxes across States; lack of adequately trained manpower to handle PSM activities at all levels.

Interventions proposed for Health System Strengthening through Global Fund Grant support:

1. **Streamlining the use of PFMS by all NTP health facilities**

It is proposed to continue capacity building of the staff to effectively use the PFMS software for financial reporting.

Outcome: It is expected that by the end of the grant, 100% districts would be efficiently reporting through PFMS by end of the grant period.

2. **Strengthening Supply Chain Management System:**

The program proposes to use the Grant funds for filling the gaps in infrastructure and capacity of HR to manage drugs and consumables.

The program proposes to strengthen the supply chain management system by shifting real time date reporting on stock status by implementation of CDAC (E-Aushadhi software) currently supported by the Global Fund NFM Grant. This would also include capacity building of the health staff at state drug ware houses and district drug ware houses to promote uninterrupted supply of drugs & logistics. The proposed infrastructure and capacity building exercise for all the regional, state and district level human resources is an activity which entails support from experts of PSCM who would support and mentor the different levels throughout the grant period.

In line with the NSP framework, this proposal aims to strengthen storage and management capacity for drugs and consumables within the National TB Control Programme.

Outcome: Gap analysis of existing infrastructure to assess the programmatic needs for building the infrastructure as well as HR capacity would be completed. This would end in streamlining the SCMS throughout country with real time data reporting of stock status in 100% districts by end of 2020.

Module 5: Program Management

The program division has an existing National Program Management Unit which has been established for management and oversight of the grants through its 10 staff positions. Similarly, other PRs have also planned to establish similar headquarter level system of

management for the purpose of M&E and oversight of the grant implementation. The details of the structures have been explained in Section 3.2 as proposed implementation arrangements.

The program management module also includes other interventions related to project implementation such as office related cost, program administration cost etc

Impact of Global Fund Investment

Investments in the approach of Prevent, Detect, Treat & Build has the potential to prevent transmission of disease to move towards the path of "End TB" efforts of India. These investments will bring 50% reduction in the annual missing cases by end of the third year, would enable management of the 85311 RR/MDRTB patients with quality assured WHO pre-qualified drugs and improve treatment outcome by at least 50% among DRTB patients (currently 46% increased to 75%).

The grant would support the scale up of laboratory services by establishing additional 20 C-DST laboratories to cater to the increased diagnostics expected due to roll out of Universal DST and shorter drug regimen. Investments will further institutionalized additional rapid molecular diagnostics in 250 facilities which will continue to provide the services beyond project period.

In addition, the programme would also address the issue of missing cases and improve the notifications from private sector and hard to reach areas through PPM and ACF interventions and improve quality of diagnosis and treatment for the patients being managed in private sector.

Treatment adherence for Drug sensitive TB would be improved using IT tools whereas in MDR TB patients the counselling project will improve treatment outcomes in view of decrease in the lost to follow-up, in four targeted states.

All districts would be trained in PFMS and CDAC and would move to real time data reporting on financial expenditures and drug stock status respectively by the end of the grant period. Infrastructure and capacity of HR for SCM would be adequately enhanced.

2.3 Focus of application requirement [2].	
For LMI countries: - Does the funding request focus at least 50% of the budget on: disease-specific interventions for key and vulnerable populations; programs that address human rights and gender-related barriers and vulnerabilities; and/or highest impact interventions?	☒ Yes ☐ No
- For RSSH, does the funding request primarily focus on improving overall program outcomes for key and vulnerable populations in two or more of the diseases, and is it targeted to support scale-up, efficiency and alignment of interventions?	☒ Yes ☐ No

The focus of application aims to ensure that the allocation is strategically invested towards key and vulnerable populations and towards addressing human rights and gender- related barriers, so as to achieve highest impact. This has been deliberated while presenting the funding request in Sections 2.1 and 2.2, by ensuring that the modules selected meet the focus of application requirement. The proportion of the funding request for KAPs and high impact interventions is about 56% of the total requested amount.

SECTION 3: OPERATIONALIZATION AND RISK MITIGATION

3.1 Implementation arrangements summary	
Do you propose major changes from past implementation arrangements, e.g. in key implementers, flow of funds or commodities?	☒ Yes ☐ No

The TB allocation for India under the Global Fund Grant 2017-2019 was intimated to the India Country Coordinating Mechanism (ICCM) through the Global Fund Secretariat, Geneva, following which the ICCM followed a transparent bid process for selection of Principal Recipients.

The ICCM selected **two Government** and **two Civil Society organizations** to promote **Dual Track Financing** for implementation of TB interventions during the next Grant implementation period 2018-2020.

The Department of Economic Affairs (DEA), Ministry of Finance, GoI, would be the Principal Recipient for the Grant funds for two government implementing partners- The **Central TB Division** (CTD) and **Indian Council for Medical Research** (ICMR) both as entities functional under the Ministry of Health & Family Welfare, Government of India. The non government PRs –**The Union** and **William J Clinton Foundation** (WJCF) would receive direct funding from Global Fund.

The proposed areas of intervention for the three PRs – ICMR, WJCF and the Union are different as they would be implementing their projects in the area of Research, Private Sector engagement and Active Case Finding in Key Affected Populations respectively. However, the CTD and other PRs' interventions would be complementary for each other in the fields of active case finding and for reaching the private providers as a shared responsibility. Besides, CTD would be supporting the scale up of laboratory services as well as treatment of Drug resistant TB cases. The CTD Grant would also include the component of Health System Strengthening. The details of the interventions have been described in Section 2.2

PR 1- CTD: Implementation Arrangements

The CTD as the implementing PR for the current NFM grant, proposes some key changes in the implementation arrangements for the next grant based on the recent learnings. CTD would exercise diligence in ensuring that Global Fund Resources are used for their intended purposes and reach the intended beneficiaries.

These have been detailed below:

- **Allocation and Selection**:
  - A decision was taken in consultation with the Ministry of Health & Family Welfare (MoHFW), GoI, to increase allocations for other partners who would be performing the responsibility of implementation as PRs and SRs. This would help increasing access to the community and unreached and key affected populations population as well as in engagement of the private sector. Accordingly, the allocation increased from **25% to 45%** of the allocated amount to PRs and SRs for the next Grant.
  - The SRs to CTD have been selected through a transparent bid process, evaluated by a Screening Committee constituted with the approval of Directorate General Health Services and MoHFW, Govt.of India, based on

the priority areas identified during “Call for Proposals” by the program division
- Selected SRs include:
  1. Tibetan Voluntary Health institution (TVHA)
  2. FIND India (FIND)
  3. Tata Institute of Social Sciences. (TISS)
  4. Strategic Alliance Management Services Pvt. Ltd (SAMS)
  5. Southern Health Improvement Samity (SHIS)
  6. World Health Organization, Country Office for India
  7. Everwell Health Solutions Private Limited

- **Engagement of SRs**:
  - The PR plans to do the capacity assessment of the SR before signing the Memorandum of Understanding to ensure strong monitoring, financial management and program management systems as 3 out of the 7 selected SRs would be newly engaged
  - The MoU to include the interventions, targets and budgets linked to the performance of the SRs
- **Fund Flow Mechanism**:
  - The PR would do a direct disbursement to all the SRs Including WHO and FIND
  - The disbursements would be done on 6 monthly basis based on the performance except the first disbursement as an advance for 2 quarters.
  - The disbursement to GDF for second line drug procurement would be done directly by The Global Fund
- **Procurement Mechanism**:
  - The PR would conduct procurements of all First Line Drugs through Domestic Budgetary Support (DBS) through the Procurement Agent identified by the MoHFW which is CMSS (Central Medical Services Society)
  - The forecasting and quantification of drugs would be continued centrally through a Coordination Committee comprising of subject experts
  - The procurement of Second Line Drugs to be done using dual resources-DBS and GDF procurement (Section 2.2 may be referred for the same). The grant funded SLDs would be procured through GDF only.The Domestic procurement would be done through CMSS
  - Procurement of logistics for establishment of C-DST laboratories to be continued through SR FIND but procurement of molecular diagnostics (CBNAAT) and cartridges would be done by the PR (through its identified SRs or otherwise).
  - The procurement of Anti-TB drugs would happen at Central level, although, provision for emergency procurements would be made effective in the state action plans of states.
  - The distribution system would initiate from Central to State and further down to district and sub district level.

- **Monitoring & Evaluation**:
  - The Central TB Division, as part of its program management, has the responsibility to monitor the implementation of the Program by Sub-Recipients supported by Global Fund Resources, including compliance with the Code of Conduct and The Global Fund Grant Regulations (2014) provided to the sub-recipient.
  - All data reported to The Global Fund in next grant cycle would be through NIKSHAY. The PR would support LFA in conducting DQR visits, if

applicable for next grant.

- Management arrangements and coordination between SRs will be ensured through a comprehensive system for oversight (both technical and delivery-related) in keeping with the principles of supportive supervision. However, the oversight system would remain dependent upon the strengthening of NPMU by appointing the required staff for supervision and monitoring.
- The PR would revise it's Oversight Plan as per the Grant needs for next implementation period 2018-2020. (Annexure 26)
- The Oversight Plan of the PR would include mechanism of SR monitoring, PR-PR coordination and mechanism for Self assessment of the PR's performance
- Besides, desk reviews, the Grant performance would also be reviewed during National review meetings, Coordination meetings with PRs and quarterly reviews of States
- The PR plans to use the PR Dashboard for updating the CCM on grant implementation status on a quarterly basis as well as during reviews of the SRs.
-

The Revised **Implementation Arrangement Map** for PR CTD has been annexed as Annexure 23 detailing the program's design and process from receipt of funds to beneficiary-level activity

PR 2- The Union: Implementation Arrangements

International Union Against TB and Lung Disease (The Union) is implementing Project Axshya with Global Fund support since 2010. The Union is Principal Recipient (PR) of Global Fund grant along with 7 Sub-Recipients (SR's) partners as mentioned below:

1. Resource Group for Education and Advocacy for Community Health (REACH)
2. Population Service International (PSI)
3. Emmanuel Hospital Association (EHA)
4. MAMTA Health Institute for Mother and Child (MAMTA)
5. Voluntary Health Association of India (VHAI)
6. Catholic Health Association of India (CHAI)
7. Catholic Bishops' Conference of India-Coalition for AIDS and Related Diseases (CBCI-CARD)

In the EOI for the GFATM grant period 2018-20, the same SR partners who are currently engaged with The Union are proposed to be continued under the new grant.

- **Fund flow mechanism:**
  - The project is proposed to be implemented with Global Fund support. Fund flow would be established with The Union as Principal Recipient (PR) and 7 partner organisations as 7 Sub-Recipients (SR's) of Global Fund grant.

M&E system:

- Project activities are being reported to PMU by SRs on a quarterly basis. The performance of the project is reviewed with project managers of SRs on a quarterly basis apart from routine grants monitoring visits by the PMU. Robust monitoring and evaluation systems are established for data collection, transcription and transmission to all levels (district, state and PMU) for public health action with minimal errors. This system is ensured as per the Monitoring and Evaluation (M & E) framework with components at national and state/ district level .

- **Financial management system including internal controls**
    - The PR follows high standards in financial management at different levels. It ensures that Global Fund conditions are fulfilled at all levels. PR conducts periodic reviews of financial management systems of SRs and undertakes regular field visits to ensure that project goals are attained and guidelines are adhered to..
    - The Union has a robust internal control mechanism to prevent and detect misuse at various levels. This is ensured through benchmarks for the PR and SRs, and is detailed in the technical, financial and operational guidelines, and checked during regular monitoring of project activities.
- **Governance**
    - The Union South-East Asia (USEA) office is a branch office of The Union with its office in New Delhi, India. There are two Board of Directors of the branch office .Regional Director of USEA head the office with the support of three Deputy Regional Directors heading different departments

PR 3- WJCF: Implementation Arrangements

Project JEET (Joint Effort for Elimination of **TB)** will be implemented by a consortium comprising of **William J Clinton Foundation (WJCF), PATH and FIND** with WJCF acting as lead PR. Additional SRs/SSRs/implementation agencies will be added, as needed in distinct geographies, through a fair / transparent process in line with The Global Fund (TGF) requirements.

WJCF is a new PR for The Global Fund TB Grant but has an experience of working with the National TB program

- **Operational arrangements:**
    - The project proposes mapping of and engagement with private sector in urban agglomerates while working closely with RNTCP at all levels – national, state and district/cities/towns. The project proposes to work at a pan-country level with state level SPMUs coordinating closely with state TB teams. The project will also include intensified private sector engagement via the PPSA (Patient Provider Support Agency) mechanism. The areas for intensified activities have been prioritized based on population, estimated TB burden and existing private sector set up. All activities under the program will be monitored at state level by SPMU and roll up into the National PMU. The interventions under the project will cover 42% of India's urban population.
- **Fund flow mechanism:**
    - WJCF as lead PR will receive funds directly from TGF and disburse to respective SRs. Funds disbursed to SRs/SSRs/implementation agencies will take into account the scope of activities for the disbursement period and performance during prior period. Fund flow and financial management for SSRs will be the responsibility of the respective SRs.
- **M&E system:**
    - The project will be managed through the National Programme Management Unit (NPMU). NPMU will house a dedicated monitoring and evaluation team of 5 personnel for project supervision, evaluation and periodic reporting to TGF and Central TB Division, MoHFW. The management of this project via the NPMU will entail periodic evaluations and programmatic / financial audits of SPMUs, PPSA / non PPSA and

other private engagement sector activities undertaken by SPMUs. Additionally, at each State Programme Management Unit (SPMU) level, a data management personnel will enable data collation and reporting to NPMU and, eventually, TGF. The project will put in place an MIS system to track project activities and progress across all implementation geographies.

- **Financial management system including internal controls:**
  - WJCF has robust financial management systems in place which includes multi-tiered approval systems for expenses, dedicated team for financial accounting, access to licensed accounting software (Quickbooks), clearly defined policies governing all financial decisions, procurement policies and annual external statutory audit. Existing financial and management policies of WJCF will be tailored to fit the project needs and these policies will be applicable for SRs/SSRs/implementation agencies.
  - In addition to above, the "Finance and Administration team" in "National Programme Management Unit" (NPMU) will ensure compliance by SRs/SSRs/implementation agencies to project defined financial policies across the project activities. In addition to the NPMU and SPMU, each SR will be responsible for financial management as per project defined policies and their individual policies under their scope of work.
  - Yearly external audit will be carried out as defined under The Global Fund rules
- **Govern**ance:
  - WJCF, the lead PR, is a section 8 organization with a Board of Directors comprising of four Directors. The National Programme Management Unit (NPMU), housed by WJCF in its capacity as lead PR, will be the nodal body for managing all project activities and ensuring compliance to project management policies.
  - A Project Secretariat comprising of representatives from consortium partners will act as an advisory body to the project.

PR 4-ICMR: Implementation Arrangements

ICMR is currently a Sub-Recipient to the CTD under the NFM Grant and would now implement as a PR for the next grant implementation period**.**

The overall coordination of the project will be done by the ICMR, while the primary implementing institute will be the National JALMA Institute for Leprosy and Other Mycobacterial Diseases, Agra.
he ICMR has 33 Institutes across the country. A few research topics will be identified for undertaking research under the Global Fund Grant. These studies will be planned to be multi-centric to ensure that each of the research topic has sufficient data with geographical representativeness so that the same can be used for influencing the policy of RNTCP. The country will be identified into 5 – 6 zones for executing the studies in parallel to the 'Task Force Mechanism for involvement of Medical Colleges' under RNTCP.

The Department of Health Research is establishing a network of Model Rural Health Research Units (MRHRU) across the country. These MRHRUs are adequately staffed to undertake research activities and have a modern laboratory wherein various investigations can be done. The MRHRUs are embedded in the community and are built in a CHC campus. As such, they are actively engaged in community based research projects. Each MRHRU has a linked Medical College which is responsible for the research activities. These mechanisms will be leveraged upon to undertake the research projects under this grant.

In each zone an ICMR Institute will be identified which will work actively with the medical colleges

within each zone. The ICMR institute will be responsible for ensuring identification of suitable faculty from the medical colleges for engaging for undertaking of research activities. The ICMR Institute will also undertake activities for capacity building for research such as workshops for the identified faculty of Medical Colleges.

An approximately 8 research projects will be undertaken based on the priority list of CTD. A standard protocol will be developed for each of the research projects. This will be done at the ICMR Headquarter by an Expert Committee constituted for the same. These experts will be drawn from the existing pool of resources with the ICMR. Participation of Medical College faculty, General Health System will also be ensured in the protocol development process.

Each of the developed research project will then be implemented in each of the zones by the identified medical colleges supported by the identified ICMR Institute. The whole process of effectively implementing the research project will be supported by the ICMR Institute. Capacity building exercises for the research staff will be undertaken by the ICMR Institute.

The ICMR has institutionalised mechanisms for effective monitoring of research projects. For research projects of The Global Fund Grant a Committee will be constituted at the ICMR Headquarter which will monitor the execution of the research projects with strict timelines. Quarterly meetings will be conducted at ICMR Headquarters to monitor the progress of the research project

PR- PR Coordination:

CTD is not only a Principal recipient of the project but also the apex body for the TB control program at national level . Therefore, the PR is also committed to coordinate with the other PRs of Global Fund so that all program works under the preview of nation guideline of RNTCP.

The following mechanisms has been proposed for effective coordination with other PRs:

1. PR Coordination Committee
2. National TB/HIV Coordination Committee
3. National Biannual Review meeting
4. Evaluation of PR activities during Central & State Internal evaluations
5. Participation of PR members in CIE & SIE

With a view to promote coordination with the other 3 PRs and all TB partners at national level, a Coordination Committee will be established.

PR Coordination Committee will be the mechanism that will be represented by PRs, Representatives from the CCM Oversight Committee, National TB/HIV Coordinating Committee(NTCC), beneficiary groups (PLHIV networks) etc. This will be a platform for coordination, technical discussion, trouble shooting on any ground level coordination issues, as well as serve as a learning and sharing platform for the PRs

National TB/HIV Coordination Committee (NTCC), which is currently established and operational at national level, will continue to play a key role in facilitating coordination among the PRs. The role of this committee at national level will be primarily for technical oversight and guidance. The National Technical Working Groups working under this committee will play a key role in ensuring technical quality of the program being implemented

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. Structure/ Composition of this committee

Chair: Representative of Government of India (Deputy Director General Health Services -

TB)

Members:

- The National Project leads from the two civil society PRs.
- ADDG-TB -CTD coordinating Partnerships
- ADDG-TB -CTD coordinating The Global Fund Grant
- 2 State TB Officers (STOs) of the states where the project is being implemented (in rotation based on recommendation from the Chair)
- Representative of the Secretariat of the Partnership for TB Care and Control
- Representative of India-CCM Secretariat
- Up to 2 SR representatives from each of the civil society PRs

Functions: The terms of reference/ functions of this committee include:

- Regular review of progress in implementation, discuss co-ordination and operational challenges and provide guidance addressing these challenges.
- Provide strategic leadership and direction to the successful implementation of the Global Fund NFM grant in alignment with the objectives of the RNTCP.
- To review and ensure provision of overall program support to the civil society PRs and SRs for the successful implementation of the annual project implementation plans at state and district level

Frequency of Meetings: This Coordination Committee will meet quarterly/biannually. Detailed minutes of the meetings of this committee will be prepared and made available to the various stakeholders.

Oversight by the ICCM:

The purpose of the Global Fund's Grant support is to invest as effectively as possible, so that partners can reach people affected by the three diseases HIV, TB and Malaria. The funding request has been designed to have predictable funding, to reward ambitious vision, to work on more flexible timings and with a smoother, shorter process that ensures a higher success rate of applications.

As the ICCM has one of it's major role to oversee the implementation of Program Activities, the program would support the ICCM by providing timely updates on the performance of the grant as well as inform the risks foreseen which may delay/affect the grant implementation.

The PR would support the ICCM Oversight Committee technically by providing all relevant data/information applicable to the grant implementation. This also includes the action taken reports on the findings and recommendations of the ICCM Oversight Committee

The ICCM includes representatives from key affected populations and people living with the disease which are actively involved during the ICCM quarterly meetings, oversight committee visits and also provide inputs to program divisions on findings of the field as well as on responses of the committee. The same mechanism is proposed to be continued for the next grant

Minimum Standards for Principal Recipients:

The four PRs selected for the TB Grant include Central TB Division (Government), Indian Council for medical research (Govt), The Union (Civil Society) and William J Clinton Foundation (Civil Society) as a consortium of three partners including PATH and FIND and WJCF as the leading PR

Out of the four selected PRs, CTD and The Union have an experience of managing the Global Fund Grants since 2002 and 2008 respectively. However, ICMR and WJCA are new PRs for the GF Grant which have been selected by ICCM after a review of their Management and Financial capacities. However, ICMR is currently working as an SR to CTD under the NFM grant

The existing PRs have effective management structures and planning capacity, systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients) internal control system to prevent misuse or fraud, effective and accurate financial management system, Data-collection capacity and tools to monitor program performance, functional routine reporting system with reasonable coverage to report program performance timely and accurately
The CTD also has Central and state level warehousing which are aligned with good storage practices to ensure adequate condition, integrity and distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions. CTD has the capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain

However, for the new selected PRs- ICMR and WJCA, the proposed arrangements for grant management have been assessed by the ICCM and found to be satisfactory and it is expected that further building of the strengths of the PRs would be an ongoing process during Grant implementation.

3.2 Key implementation risks			
Risk Category (Functional area)	**Key Risk**	**Mitigating actions**	**Timeline**
PR 1- CTD			
Programmatic/ M&E risk	1. The programme under NSP has planned to target 2000,000, 2062500 and 2125000 notification of all forms of TB using domestic budget. In addition, 39,600, 47,385 and 55,200 MDR cases are targeted to be detected and out of these 35,640, 42,647 and 49,680 cases are targeted to be treated in the three years of grant period, using domestic sources. These targets are considerably high compared to the current achievement on these targets. They can only be met if the domestic and/or other resources, including World Bank loan under loan buy down initiative, are made available. However the program is committed to achieve and maintain the ambitious NSP targets to advocate and generate additional funding from domestic and other resources.	The estimated targets under the within allocation request can be met when the above allocation funding request of USD 180.53 (including USD 40 Million for loan buy down) is approved with a World Bank Loan Buy Down of UDS 400 Million over the grant period. The World Bank Loan has been considered under the assumptions for increased finding allocation of USD 224, 246 and 270 Million over the grant period.	Throughout the Grant cycle.
	2. Achieving targets of NSP in context of annual budget allocation to the program	Plan to meet the targets through other funding sources like Corpus Fund, CSR, etc.,	Throughout the Grant cycle.

	3. The roll out of DST guided treatment and shorter regimen will modify the consumption patterns of the drugs. This may lead to risks of either drug shortage or excesses leading to expiry of drugs 4. Accounting of notification data from private sector and Active case Finding interventions reported through the civil society PRs as well as data notified by the program during project period.	The review of the requirement and consumption to be included during forecasting of drugs. ‘ Each civil society PR to maintain a back up of reported data The final data to be reported from Nikshay	Annually Quarterly
Procurement & Supply Chain Management risk	1. Delays in procurement processes 2. Changes required in the forecasted quantities for procurement depending upon scale up of activities like roll out of shorter regimen, etc 3. Variation in prices of drugs as quoted during grant making v/s actual procurements leading to major savings / additional requirements. 4. Delays in receipts of drugs/ logistics	-Pro active initiation of procurement process considering a timeline of 6 months. -States to be prepared for emergency procurement. -Shifting of procurement to any SR capable for the same with prior approval of GF and MoHFW Adjustments during placing of orders to be made. Program to proactively submit reprogramming request for optimal utilization of grants GDF would be requested to include a suitable clause for penalizing the delays in procurement beyond delivery schedule committed by the supplier(s)	-As per mitigation plan - 3 months prior to anticipate delay in procurement - As per requirement - At the time of submission of indent/procurement request form. As per requirement. -Before grant initiation.

	5. Storage capacity of drug ware houses	Planned to be increased during the current grant implementation	-Second year of the grant period.
Financial risks	1. Delays in release of funds to the SRs	Advance releases to the SRs to facilitate implementation	-As per mitigation plan
	2. Annual Budget allocation to program not as per proposed NSP	Raise funds from other sources like Corpus Fund, CSR, etc	- Throughout the Grant cycle.
	3. Financial efficiencies during implementation by SRs	The action to be taken by PR would be clearly stated in the MoUs of SRs	- At the time grant initiation.
Governance and Program implementation risk	1. Procedural delay in initiation of Grant implementation	CTD would proactively facilitate the timely signing of Grant Agreement and also MoUs with the SRs by keeping all concerned authorities prepared through initial dialogue.	- Before the time grant initiation.
	2. Vacant key positions at CTD including the NPMU	Program to ensure that all key positions, especially the NPMU is kept functional	- Before the time grant initiation within the NFM period.
	3. Non effective engagement of the private sector due to HR vacancies at state level	The civil society's PR proposal on private sector would also depend upon the HR available through the program at state and district level so filing of these positions will be monitored and pursued by CTD	- Throughout the grant period.
	4. Monitoring of SRs	The NPMU at CTD needs will be made functional to have effective supervision of SRs. In their absence, the key staff at CTD would to be responsible for M&E	- Before the time grant initiation within the NFM period.

PR 2 – The Union			
Financial risk	The project would be dependent on timely disbursement of funds from the GFATM to PR and then disbursing funds to SRs. This will have an implication on subsequently timely release of incentives to CVs and enablers to patients.	The Union has developed systems at programme and finance level to effectively monitor the project activities (Grant Monitoring Visits (GMV) for financial and programmatic review etc.) and timely submission of reports to the donors. Efficient systems will be in place for timely disbursement of funds from PR to SRs, ensuring remittance of incentives to the CVs	During implementation
Programmatic Risk	1. Availability of diagnostic services like microscopy, CXR and CBNAAT from RNTCP/ public sector for appropriate linkages etc. 2. The project proposes to provide technical assistance in the remaining districts for preparation and implementation of ACF in KAP. This activity will also largely depend on availability of funds to districts from National Health Mission (NHM). 3. Commitment from the programme- CTD, states and districts is required for active case finding (ACF) in campaign mode both for direct implementation and technical assistance in identified districts.	The project will do adequate advocacy and coordinate closely with centre and state/ district officials for implementing all project activities in the field. Linkage will be established with available diagnostic services like microscopy, CXR and CBNAAT from RNTCP/ public sector wherever possible. The project will seek support from the Central TB Division for release of necessary communication to the states for exclusive direct implementation of the project from the identified KAP mapped areas in the project districts.	During implementation
M&E Risk	Success of ACF in KAP is dependent on implementation of ACF activities by CVs and their engagement levels with the project	Robust monitoring and evaluation systems will be further strengthened for data collection, transcription and transmission to all levels	During implementation within 6 months

		(district, state and PMU) for public health action with minimal errors.	
PR 3- WJCF			
Programmatic risk	Impact on project implementation due to dependence on the National program for free drugs and diagnostics to private sector, Availability of HR at state and district level	Coordination with state and CTD team to facilitate the filling of vacancies. The project staff would be used in the interim period to execute the critical SPMU work to the extent possible	Starting of the grant implementation period
Operational risk	Operational efficiency of the selected SRs to effectively set up SPMUs and carry out intensified PPM interventions in districts/cities/towns may be challenging	Periodic reviews will be conducted to ensure best operational practices are followed by all SRs/SSRs throughout the project activities. Additionally, disbursements to SRs will be based on performance during prior period. M&E team will further conduct periodic review of all SPMU**s.**	Quarterly
Financial risks	Ensuring best financial practices following all norms amongst all SRs as well as the PR as per CTD and TGF requirements would be challenging in the initial stages of the project roll out	Periodic evaluation and audits. Global Fund guidelines around internal and external audits would also be adhered to**.**	Internal Audit to be conducted **Six monthly**

SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY

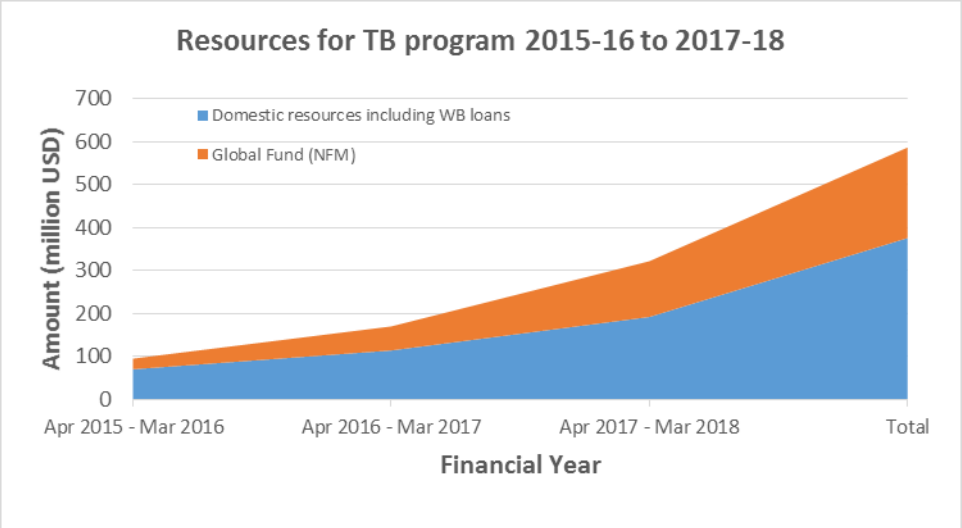
4.1 Funding Landscape and Co-financing		
a) Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? **If yes,** provide details below.	☒ Yes	☐ No
b) Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health-financing reforms? **If yes,** provide a brief description below.	☐ Yes	☒ No
c) Have previous government commitments for the 2014-16 allocation been realized? **If not**, provide reasons below.	☒ Yes	☐ No
d) Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy?[3] **If not**, provide reasons below.	☒ Yes	☐ No
e) Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, **specify** below how realization of co-financing commitments will be tracked and reported.	☒ Yes	☐ No

a) National Health Policy 2017 is aiming to increase health expenditure by Government as a percentage of GDP from the existing 1.15% to 2.5 % by 2025 and increase State sector health spending to > 8% of their budget by 2020. The policy of the prioritization of the local specific strategies and cost sharing by the states (sub-national) level will enable greater efficiency and effectiveness of health spending. Initiatives of shifting the disease specific program staff (e.g. laboratory technician of the DMCs) to the health system staff will enable efficient utilization of the human resources. Contractual staff is being planned to be shifted from disease flexi-pool to the health system strengthening (HSS) pool which is also expected to bring about more effectiveness and greater efficiencies. Leveraging the urban health component by including the disease specific component will further help to improve the support for the program. Introduction of the PFMS for reporting the expenditures will enable the strengthened monitoring of the investments for timely corrective actions for improving greater efficiency and effectiveness of the health spending.

b) NA

c) The allocations for last three years 2015-2017, which includes the NFM project period, the ratio of the allocations for domestic resources (~376 Million USD) including loans vs GF existing investments (~211 Million USD) is 64:36. US$ 376 million is the expenditure in the last Three years under domestic budget which includes World Bank loan component. The budget under domestic component for the last Three years is US$ 50 million ,70 million and 114 million respectively. With the proposed NSP 2017-2025, country is committed for massive investments to move forward towards “TB elimination” by 2025.

[3]



However, for the incentive funding component, the allocation commitment of the government of India is yet to be realized although a commitment from Ministry of Health has already been given to the GF.

d) The current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive.

e) The PFMS has been adapted to include the expenditure heads as per the disease specific program. Training of the staff has been completed in one state and is expected to be completed in all states by end of the year. Once the PFMS is institutionalized and operational by end of the year, the tracking mechanisms of expenditure on TB program will be in place. The realization of the co-financing commitments will be tracked and reported by PR from the government annual allocations (Budget estimates and Final estimates).

4.2 Sustainability

The proposed NSP for 2017-2025 has estimated the requirement of increasingly massive investments of 1.86 billion USD over next three years. The domestic allocations for 2017-18 has already been increased by 30% (149 M USD) as compared to 2016-17. Notional increase of annual increase of 10% has been shown in the funding landscape template, but based on the expenditure trends, the domestic allocations are expected to increase to match the requirement to meet the gap. NSP has also proposed enabling environment for mobilizing the resources from the local partners (e.g. CSR) to further fulfil the gap. The component wise estimated resource requirement for three years is as follows:

Component wise resource requirements for three years (2017-18 to 2019-20) *(# in million USD)*

Program Areas	2017-18	2018-19	2019-20	Total	%
Diagnostics	69.05	132.80	174.34	376.19	**20%**
Drugs	133.96	153.02	195.72	482.70	**26%**
PPM	42.42	57.86	67.44	167.73	**9%**
HR	80.17	84.18	88.39	252.73	**14%**
Patient enablers - social & nutritional support and honorarium	102.63	144.70	188.77	436.10	**23%**
Supervision & Monitoring	27.75	30.95	33.35	92.05	**5%**
Others (ACSM, Training, Printing, Research & Studies, program management etc.)	19.11	20.07	21.07	60.26	**3%**
TOTAL	**475.09**	**623.58**	**769.08**	**1867.76**	**100%**

The estimated investments for diagnosis of DSTB and DRTB is around 20% and is increasing over three years as moving towards the quality assured diagnostics, universal DST and massive extension of the free diagnostic services to private sector patients. The investments from the proposed funding request is including approximately 40% of the estimated requirement of the CBNAAT cartridges while remaining will be provided through domestic and other resources. Similarly, the laboratory consumables for the C&DST laboratories is proposed to be transitioned through the RNTCP domestic funding through the respective laboratories / state procurement mechanisms. The annual maintenance contract services for the C&DST laboratories supported by the existing GF grants are planned to be transitioned to respective laboratories / states through RNTCP domestic funding for estimated value of approximately 50% in year 2 and 70% in year 3 of the proposed project. The required capacity building and hand holding for smooth transition will be supported through the proposed project. Similarly, the human resource in the C&DST laboratories from the existing GF grant is proposed to be transitioned to the respective states / laboratories from the RNTCP domestic funding from January 2018 onwards. Need based support will be extended for the recruitment of these staff through the proposed GF grant for next three years for smooth transition and ensuring the uninterrupted continuity of the quality laboratory services. The proposed HR recruitment agency would also support recruitment of additional staff, if required, due to transition of HR from Global fund grant to domestic component.

The estimated investments required for the anti-tuberculosis drugs for management of DSTB and DRTB patients among public and private sector is around 26%. All the FLDs including paediatric drugs are already planned to be proposed from domestic budgetary resources including loans. The recent change from intermittent regimen to daily regimen with FDC is a

massive resource intensive activity. For ensuring the uninterrupted supplies of SLDs along with introduction of the shorter regimen and DST guided treatment, it is proposed to include 31% of the drugs from the GF grants while the remaining 60% to be supported from the domestic resources including loans. The newer drug - BDQ is being proposed for year 3 only from the proposal and would be taken up from domestic resources beyond the project period.

The estimated investments required for the Public Private Mix activities is 9%. The investments from this grant aims at institutionalizing the state (sub-national) structures at 24 states, PPIA structures at 33 cities/urban agglomerations and capacity building of additional 50 cities. The scaling up of these initiatives will build the capacity and linkages at district, state and national level which will continue with the program beyond the project period. The investments in the PPM initiatives for the remaining districts, PPM schemes for all districts, medical college involvement will continue from domestic resources. The active case finding activity initiated by the program last year, will be intensified through the investments from the grant for coverage of 18.7 million key population in 125 districts, however the remaining districts are proposed to be covered through the domestic resources. Capacity building of the state level units will enable to continue the activity beyond the project period.

Investments in enhancing the utilization of the ICT – interventions will create an enabling provisions for the project period and will continue from the program beyond the project period. Interventions introduced through the 99DOTS are being linked with the proposed call centres. The services will also get extended for the PPM providers which will augment the PPM initiatives. The data is being hosted at NIC servers which will be sustainable beyond the project areas.

Investments from the grant for innovative approach to improve access to difficult to reach population of Sundarban areas through the local NGO, will provide the learnings which will be appropriately scaled up through the domestic resources beyond the project period.

Investments in the ICMR lead researches would further help to expand the TB related researches in the centrally supported research institutes in various parts of the country. The available funding with these institutes for areas of research will support the TB related researches beyond the project period.

Investments in the DBT will help to support the patients to cover the out-of-pocket expenses for travel, diagnostic and treatment costs and nutritional support, nutritional support and enablers for the providers would help in creating an enabling environment. Enablers through DBT to the providers will help to capture all notifications. These are being institutionalized through the government systems for all other DBT to ensure sustainability beyond the project period. The enablers are proposed to be funded partly through through above allocation request (PAAR- 13%) whereas the remaining 87% is expected to be met through the domestic budgetary sources including GF supported loan buy down proposal.. .

During the NFM period 80 positions of WHO-Technical Support Network (TSN) are being funded through the Grant. Considering the massive scale-up of the activities, the technical support will be required to be continued in the upcoming grant for first year, however it is proposed to be transitioned. It is envisaged to have 60 positions in first and 40 positions in second and third year of the grant.

SECTION 5: PRIORITIZED ABOVE ALLOCATION REQUEST / UPDATE

Prioritized Above Allocation Request

[Tuberculosis]			
Module	**Interventions**	**Amount requested**	**Brief Rationale, including expected outcomes and impact** (how the request builds on the allocation)
MDR TB	Treatment: MDR-TB Provision of the second line drugs - shorter and DST guided regimen	US$ 29.85m	Management of DRTB patients - SLD: An above allocation grant with funding amounting to 29.85 Million USD is requested to initiate additional 20,000 MDR-TB patients on treatment.
TB Care & Prevention and MDR-TB	TB Care & Prevention-Case detection and diagnosis: & Case detection & diagnosis: MDR-TB Provision for the rapid molecular diagnostics - equipment and cartridges	US$ 10.86m	Diagnostics: Rapid molecular diagnostics scale up would require 1000 CBNAAT machines during project period; out of which 25% is proposed to be met from GF allocation, 25% from GF above allocation and 50% from domestic resources. This will assist the roll out of universal DST component and diagnosis of TB among the key population including TBHIV. Increasing the 250 machines from above allocation will increase the diagnostic test capacity by 1.5 million tests essentially resulting into 0.21 million TB patients (1 out of 7 tests would be TB) early diagnosis of TB including status of R-resistance. It would require additional 533400 cartridges and remaining coming from domestic resources. The total investments being proposed from the global Fund above allocation is UYS$ 10.86 million.
TB Care and Prevention	Other TB care and Prevention intervention (s) Payment of enablers to patients to cover nutritional supplementation and providers for notification, treatment support and reporting of treatment outcomes (Direct Beneficiary Transfers)	US$ 72.39m	NSP envisages the Direct Benefit transfers (DBT) for enablers to patients and providers to move towards the goal of reducing the catastrophic costs. The scheme includes Rs. Provision of Rs. 500 per month for the patient on completion of one month treatment as an enabler to cover out of pocket expense and nutritional support. This is to be provided to the patients through the normal banking channel / electronic transfers / non-cash mode as per other government schemes. This will be linked with the ICT platform to have accountability and transparency. The estimated investments required for the project period is 527 Million USD. This will reduce the catastrophic costs to the patients

			and would help in capturing notification of all TB cases especially from the private sector. It is being proposed to have 72.39 M (~13%) from above allocation to cover 9.55 million patient-months DBT and remaining 544.61 M USD (87%) would come from domestic resources including 190 M from domestic budgetary resources. (GF supported WB loan-buy-down proposal). This will translate provision to ~1.34 M tuberculosis patients to reduce catastrophic costs.
MDR TB	Treatement: MDR-TB Extension of the DRTB Counsellors project for remaining districts Hiring of 475 District DRTB Counsellors	US$ 8.5m	A counsellors' Project is being supported under the current NFM Grant in 4 states of the country by CTD through it's SR TISS to improve treatment outcomes in DRTB patients and also reduce the 6 months attrition rates. The project has shown encouraging results as detailed in section 2.2 and thus, has been proposed to continue in the next grant implementation cycle 2018-2020. The scale up of the intervention across country could not be suggested due to budget constraints. Thus, the additional 475 Counsellors to be placed across country are requested through above allocation. It is expected that this intervention would improve treatment success rates by 50%
MDR TB	Treatment: MDR-TB ICT enable monitoring of DR TB patients	US$ 0.91 m	ICT enabled monitoring of DR TB patients There is a better the chance of patient retrieval if the time taken for patient retrieval is less. To monitor DR TB patient adherence and disseminate real time information to concerned health worker, some supportive ICT tool is required. Few tested ICT technologies can be used for selected group of patients to monitoring of DR TB patient to improve its treatment outcome. • Drug will be provided to the patient in digital box which is enabled with chip which captures information. • Technology captures patient wise adherence information in real time through digital box. Box can disseminate information to server when it gets connected to server. • It has long battery backup and provided with charging cable also. • This intervention will be implemented to selected type of patients only where current monitoring system requires additional support. • Estimated number of patient enrolled during grant period is 10-20000 in selected states. Estimated investments 0.91 M USD from GF Grant (above allocation).

Programme Management	Policy, Planning, Coordination and management of National disease control programmes ICT support for NIKSHAY	US$ 0.43 m	ICT support for NIKSHAY: National Case Based web-based surveillance system (Nikshay) has been developed and deployed across the country with more than 7 million TB patients registered including 0.7 Million cases notified by private sector since 2012. The scope of NIKSHAY is being enhanced through a mobile-based solution which will enable real time TB notification at source along with features of adherence support, programme management, DBT support for providers, etc. This will need a national level ICT support unit for data base architecture, system security, development work, help desk,, website and server management. Under the grant the support structure is proposed in line with the NSP Investments being proposed by the Gf (above allocation) is US$ 0.43 m
Programme Management	Other Programme management intervention(s) Social marketing: Provision for social marketing program-provided daily FDCs for the patients in private sector	US$ 1. 59 m	Programme-provided daily FDC drugs will be available for treatment of TB patients in private sector. Effective and provider/patient friendly linkages to ensure accessibility to these daily FDC to meet the need of private health care providers will increase uptake of free services provided by the programme. The experience in large scale social marketing of health products can be leveraged to ensuring demand and supply of quality anti-TB dugs for patients who seek care from private sector. Introducing social marketing of anti-TB drugs in line with the RNTCP recommended regimen would provide an alternative for patients wishing to access treatment in the private sector, while discouraging the purchase of drugs outside the standard regimen, including mono therapy. The patients will not have to pay for these drugs as these would be procured and provided from the Programme. Strategies including creating aspirational brand will be owned by RNTCP, promotion, marketing, provision, incentives for distributors and pharmaceuticals to cover their cost of stocking, distributing and dispensing the FDCs and to ensure that patient gets it at an affordable cost from private retailers. Socially marketed drugs will be available at dispensing qualified private facilities. Social marketing organizations use supply chain, retailers and distributors for supplying the socially marketed TB drugs at the door step of chemists and PPs Investments required from Global fund grants (above allocation) is 1.59 million US$ to cover 5 urban cities/ agglomerations.

TB Care and Prevention	Key Populations (TB Care and prevention) - Others Active Case Finding	US$ 10 m	Scaling up the proposed interventions under Active case finding to another 100 districts covering additional 20 million KAP resulting in diagnosis and treatment of 100,000 cases over the project period.
TB Care and Prevention	Engaging all care providers (TB Care and prevention) Private Sector Involvement - PPIA: Project JEET will set up Patient Provider Support Agencies (PPSA) to ensure universal access to quality TB care in private sector by facilitating access to quality diagnostics and drugs provided by RNTCP. (additional 25 cities / urban agglomerates)	US$ 6m	PPIA initiative under JEET project has envisioned setting up of PPSA agencies across in 58 cities/towns in India with population greater than 1 Million. 33 of these prioritized cities/urban agglomerates is being proposed through GF allocation budget for private sector engagement. With the additional $6M requested here, PPSA is proposed to be established in additional 25 cities/urban agglomerates realizing additional 100,000 notifications with limited HR involvement as compared to the PPSAs in 33 prioritized cities/urban agglomerates under within allocation funding request.
TOTAL AMOUNT		**US$ 140.53m**	
TOTAL AMOUNT (including US$ 40 Million for Loan Buy Down)		**US$ 180.53m**	

Relevant Additional Information (optional)

In context of a possible Loan Buy Down from the World Bank, the above allocation request includes an amount of US$ 40 million for the costs of the Loan Buy Down for a total value of US$ 400 million to be funded out of the loan.

The funding gap for which a loan buy down is proposed has been tabulated below:

NSP Cost categories	**Funding Need**	**Domestic**	**Non Global Fund external resource**	**Global Fund (existing grant)**	**Global Fund (Funding Request)**	**Funding Gap**
	2017 – 2020	**2017 - 2020**	**2017 - 2020**	**2017 - 2020**	**2017 - 2020**	**2017 - 2020**
Diagnostics	567.96	178.28	0.00	75.16	59.37	255
Drugs	698.00	357.28	0.00	28.40	103.66	209
PPM	241.91	39.38	3.55	0.00	25.42	174

HR	349.95	189.65	0.00	16.50	43.99	100
Patient social & nutritional support and Honorarium	643.74	55.69	0.00	0.00	0.00	588
Supervision & Monitoring	128.74	46.41	3.55	5.94	3.44	69
Others (ACSM, Training, Printing, Research & Studies)	83.44	22.18	0.00	4.00	44.04	13
Total	2,714	889	7	130	280	1,408

Impact of Loan Buy Down:

As is evident from the table, there is a funding gap of US$ 1,408 million which is planned to be covered partially through a loan buy down of US$ 400 million from the World Bank. For the purpose, an amount of USD 40 million is expected to be provided through the above allocation request. This funding would be used to meet the programmatic gaps and would be linked to the prioritized activity indicators. The details of the same would be worked out at the time of formulation of World Bank Funding project. The program expects to prioritize the activities related to the missing 1 million cases, incentives to be provided to the patients and providers and to fill up the diagnostic and treatment gap for drug resistant TB cases. The expected impact of this investment would be to result in 60% reduction in the annual missing cases by end of the third year of the grant, and improve treatment outcome by at least 60% among DRTB patients