

|  |
| --- |
| Funding Request Form |
| Full Review |
| Allocation Period 2023-2025 |

A picture containing text, clipart

Description automatically generated

**Summary Information**

|  |  |
| --- | --- |
| Country(s) | India |
| Component(s) | Tuberculosis |
| Planned grant start date(s) | 01 April 2024 |
| Planned grant end date(s) | 31 March 2027 |
| 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. Karnataka Health Promotion Trust (KHPT) 3. Solidarity and Action Against the HIV Infection in India (SAATHII) 4. Doctors For You (DFY) 5. Tata Institute of Social Sciences (TISS) 6. Hindustan Latex Family Planning Promotion Trust (HLFPPT) |
| Currency | US$ |
| Allocation Funding Request Amount | 280,000,000 |
| Prioritized Above Allocation Request (PAAR) Amount | 115,983,339 |
| Matching Funds Request Amount  (if applicable) | 4,000,000 |

Refer to the [Full Review Instructions](https://www.theglobalfund.org/media/5743/fundingrequest_fullreview_instructions_en.pdf) for detailed elements related to each question which should be addressed for a response to be considered complete. The Instructions also include information, resources, and a description of necessary documents to be submitted along with this form.

Section 1. Funding Request and Rationale

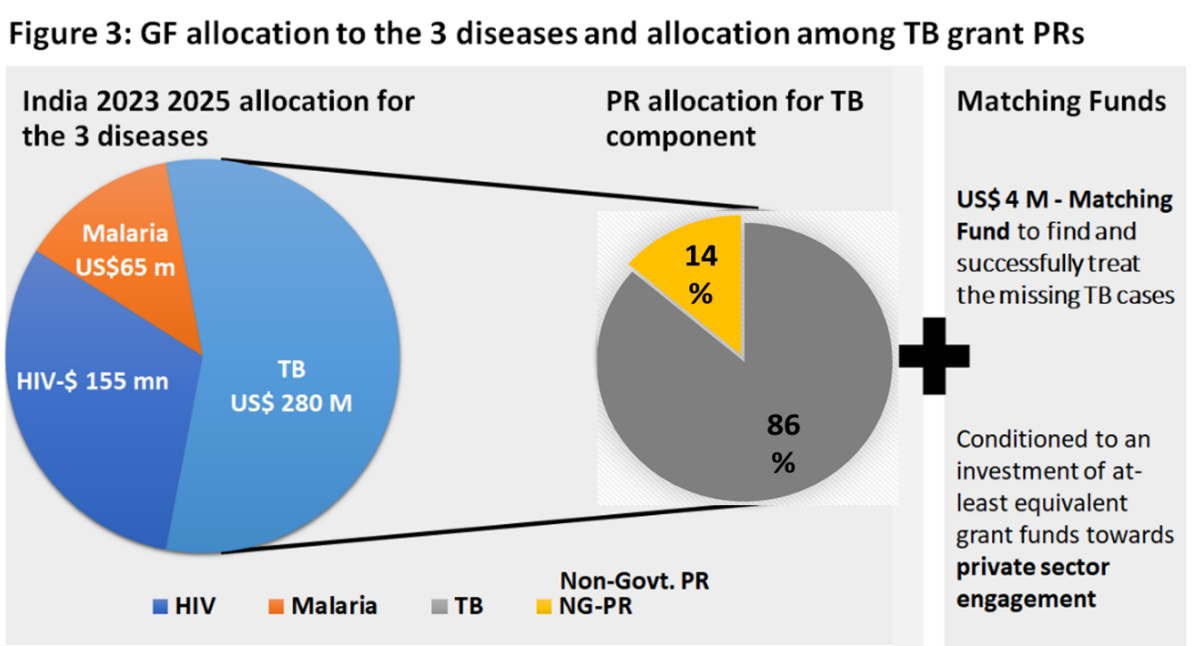
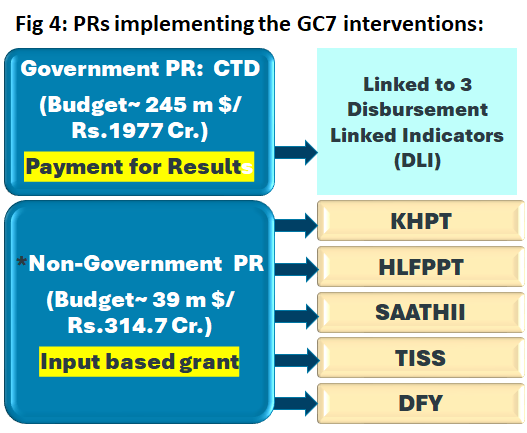
1. India, with its population nearing 1.4 billion, shoulders a significant burden in the global fight against Tuberculosis (TB). The nation accounts for more than a quarter (28% in 2021) of worldwide TB cases and 36% of TB-related deaths. Nevertheless, India's battle against TB has witnessed commendable strides over the past two decades. This progress is attributed to resolute political commitment, a fourfold increase in domestic funding for the National TB Elimination Program (NTEP), extensive deployment of rapid molecular diagnostics (mWRD), introduction of innovative strategies including scaled engagement with private healthcare providers, extensive use of digital technology for surveillance and reaching all TB patients and their providers from diverse sectors, and increased procurement of anti-TB medications.
2. Illustrating India's unyielding resolve, the government aims to eliminate TB as a public health problem by 2025 – a bold objective set five years ahead of the UN's Sustainable Development Goal (SDG) 3 target. This audacious goal stands on a foundation of steady accomplishments: Treatment coverage has soared by 58% since 2015, while new TB cases and fatalities have respectively plummeted by 13% and 15% since the same year. Despite a temporary dip in TB notifications during 2020 and 2021 due to the COVID-19 pandemic, the NTEP has surged back to pre-pandemic levels, marking a record-high notification of 2.42 million TB patients in 2022. This marks a notable 13% increase from 2021. Translating to a case notification rate of approximately 172 TB patients per 100,000 individuals, this year also witnessed the highest-ever private sector case notifications, totaling 0.73 million. The presumptive TB examination rate (PTBER) surged to 1281 per 100,000 population, marking a remarkable 68% increase from 2021. A notable 64,411 patients with multi-drug resistant or rifampicin-resistant TB were diagnosed during the year.



1. **Notwithstanding the consistent progress against TB,** the burden of incidence and mortality remains formidable. Drug-resistant TB (DR TB) is still a major public health threat. Challenges persist in improving access to care and extending preventive services to marginalized, vulnerable, and economically disadvantaged communities. The weight of the disease's burden, its socioeconomic repercussions, and its impact on the productive population segments impede India's development progress. In 2016 alone, TB inflicted an estimated economic loss of US$23.7 billion on India, roughly equating to 1% of the nation's GDP that year. Patients often grapple with substantial out-of-pocket expenses. However, paradoxically, this very breadth of impact underscores TB elimination as one of the most economically efficient health interventions available. Scaling up TB control is projected to avert 180,000 deaths in India by 2025, at an additional annual cost of approximately US$430 million.
2. **The Ongoing 2021–2024 Grant:** In the funding cycle spanning from April 2021 to March 2024, the Global Fund allocated US$280 million to combat TB in India. This grant operates through a dual-track funding mechanism, with the Central TB Division (CTD) acting as the government's principal recipient for US$200 million, and four non-governmental principal recipients (William J Clinton Foundation, FIND India, The Union, PLAN India) overseeing US$80 million. The Central TB Division's US$200 million grant operates under the Payment for Results (PfR) modality, tying disbursements directly to Disbursement Linked Indicators (DLIs).

**Table 1: Payment for results indicators for CTD grant (2021–2024)**

|  |  |
| --- | --- |
| **Disbursement Linked Indicators (DLI)** | **Allocation tied to DLIs for 3 years** |
| **DLI1:** Number of patients with RR-TB and/or MDR-TB that began second-line treatment. | US$79.6 million |
| **DLI 2:** A Treatment success rate of RR TB and/or MDR-TB: Percentage of cases with RR and/or MDR-TB successfully treated | US$39.9 million |
| **DLI 3:** Number of presumptive TB patients who received a molecular diagnostic test upfront | US$80.4 million |
| **Total Grant** | **US$ 200 million** |

1. **The Lessons Learned:** The review of the first year of implementing the **payment for results (PfR)** grant from April 2021 to March 2022 reflects impressive progress. **DLI1 reached 78% achievement, DLI2 achieved 102%, and DLI3 reached 63%.** DLI1 and DLI3 were affected by the challenges posed by the COVID-19 pandemic. The evaluation of data quality by the Local Fund Agent (LFA) revealed minor errors in the three indicators. The disbursement process has become streamlined and reporting efficiency has improved. This approach offers the government flexibility in resource utilization to address emerging program needs within the agreed boundaries. **Challenges experienced in the protocol and verification mechanisms** during the initial year were addressed by the second year.
2. **The Upcoming 2024–2027 Grant:** India has been allocated US$500 million to combat TB, HIV, and malaria for the 2023–2025 period. The **TB component's share of the Global Fund grant is US$280** million. The government's **Central TB Division and five non-government partners will implement these interventions.** An **additional US$4 million in catalytic matching funds** is provided to accelerate innovative private sector engagement models.
3. For the allocation period of April 2024 to March 2027, the ICCM (India Coordinating Mechanism) recommends adding **new Principal Recipients**. The newer NGOs that have been recommended include **1) Karnataka Health Promotion Trust, 2) Solidarity and Action Against the HIV Infection (SAATHII), 3) Hindustan Latex Family Planning Promotion Trust (HLFPPT), 4) Doctors for You (DFY), and 5) Tata Institute for Social Sciences (TISS)** (refer section 3A Implementation arrangements for greater details)**.** The inclusion of new Principal Recipients is necessitated by their intimate understanding of local contexts, effective community engagement, cost-effectiveness, and sustainable impact. By leveraging their local knowledge, expertise, and relationships, these PRs are expected to contribute significantly to the success of TB elimination initiatives. The new PRs have a proven track record of implementing large and complex programmes in TB, DRTB, HIV, RMNCAH, nutrition, non-communicable diseases, and communicable diseases, with a strong community/grassroots connection which brings a fresh 3600 perspective and holistic approach to addressing the TB problem in the country.
4. **Investment highlights in the** **April 2024 – March 2027 allocation utilization period:** The allocation of US$ 280M for April 2024 – March 2027 is the same as the last two grant cycles (GC5 and GC6). Overall, the Government of India implements a strategically, and technically sound and focused programme, with a strong track record of achieving results and significant implementation capacity built to date. The programme interventions proposed in this funding request will continue to sustain the gains made and build on the well-known strengths of the programmes, including the strong national commitment from the Prime Minister and the government, multi-sectoral collaboration with other ministries, corporates and professional associations, extensive private sector engagement, cutting-edge technological and programmatic innovations, community-led responses, and enhancing the focus on social determinants of TB. (Figure 5)

**Figure 5: Comparison of the current grant and the funding request allocation; the prioritized interventions (new interventions in red font) in this funding request**

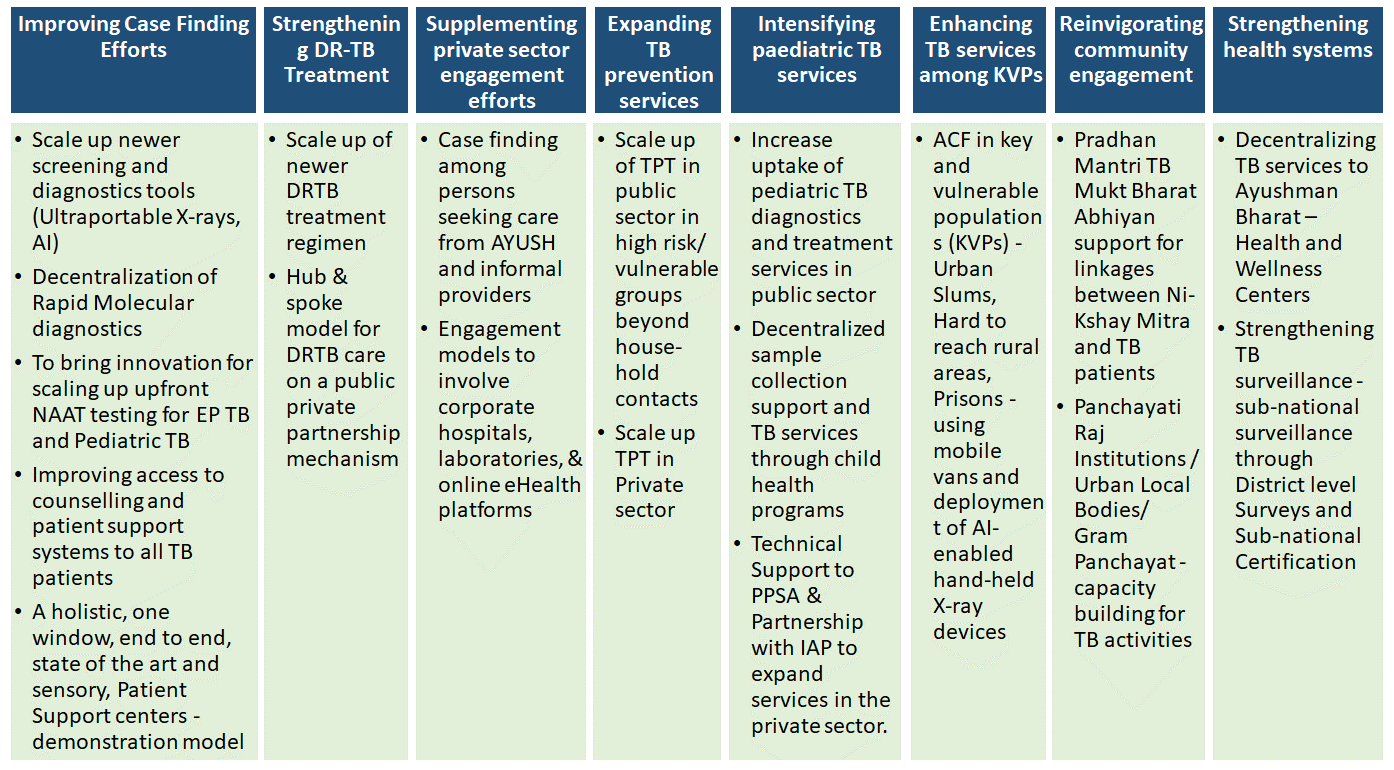
A blue and white chart with text and numbers

Description automatically generated with medium confidence

Simultaneously, considering the urgency of achieving the TB-related SDGs within a two-year timeframe, by 2025, well in advance of the 2030 target, the program intends to utilize the investment from the Global Fund strategically. This investment will work in tandem with and accelerate the impact of the programmatic interventions outlined below. (Figure 6)

1. **Bringing screening and diagnostic services closer to the communities through the continued scale-up of chest x-ray and rapid molecular diagnostic equipment**. Given the diverse geography of India, context-appropriate equipment (i.e., handheld/ultra-portable digital x-rays with CAD/AI and near point-of-care machines, e.g. TrueNat) will be increasingly made available for outreach use and at sub-district levels to increase access, and improve the quality of and aid in early diagnosis.
2. Efforts will be intensified for **scale-up of DR-TB diagnosis/DST and treatment and improved outcomes**. This will include the continued roll-out and strengthening of DST (including using XDR cartridges, LPA). This will be coupled with enhancing medical staff’s capacities in DR-TB treatment, including aDSM and scaling up the 6-month regimens (BPaL/BPaLM) for RR/MDR and Pre-XDR TB. (Innovative models of creating DRTB care centers in private sector)
3. Continuing the **scale-up of TB preventive therapy among eligible risk groups and PLHIV**. Going beyond household contacts of index cases to reach out to vulnerable populations in the community (including prisoners, miners, slums, tribals, migrant labourers), health care workers, those with clinical risk factor, and also to contacts of patients seeking care in the private sector. The intervention design is based on lessons learned from the current cycle. In specific, the programme will ensure that roles and responsibilities related to TPT are well understood by all Front Line Workers and that sufficient activities are planned for service delivery, capacity development and demand creation.
4. Expanding the coverage of **the private sector** with **focus on expanding TB preventive treatment amongst contacts of those who are seeking care in the private sector**, instituting **demonstration models for case finding among persons seeking care with AYUSH[[1]](#footnote-2) and informal providers,**  finding people with TB early, and programmes addressing TB co-morbidities (e.g. diabetes), and the social determinants of TB (e.g. undernutrition). To this end, the India **allocation includes US$ 4,000,000 in matching funds, which will be utilized to accelerate and expand the implementation of innovative private sector engagement models to include corporate hospitals, laboratories, online eHealth platforms and expanding DR -TB & Paediatric TB care in private sector.**
5. Besides **finding missing children with TB,** a more **systematic approach to improving childhood TB diagnosis** will be undertaken in the private and public sectors. The programme has prioritized the collection of specimens through gastric aspirate, induced sputum and stool and other extra-pulmonary sites and testing using GeneXpert Ultra, using x-ray to support diagnosis (including as part of contact investigation), and enhancing the capacity of medical professionals in the diagnosis and management of childhood TB. It will **engage the Indian Paediatric Association (IAP) at the national level and its state chapters** to reach out to its paediatrician members in the whole country. It will strengthen the capacity of the public health sector to diagnose paediatric TB at the sub-district level and strengthen case finding at the community level. Models will be demonstrated in identified districts which can be scaled up by the programme. TA will be provided to remaining districts in the state.

**Figure 6: Key interventions proposed in this funding request 2024 - 2027.**



1. **Community system strengthening** is one of the key strategies in the TB NSP 2020 – 2025 to develop a resilient and agile programme. The significance of communities in boosting the effectiveness of program strategies has gained substantial support, notably through the Prime Minister’s prominent initiative called the **Pradhan Mantri TB Mukt Bharat Abhiyaan. To enhance the program's impact, the initiative plans to utilize over 150,000 Health and Wellness centers (HWC),** which form the grassroots foundation of the public health infrastructure**.** These centers will play a role in providing **decentralized TB diagnosis, treatment, and prevention services, integrated into the comprehensive primary health care** they offer. Communities, especially TB survivors, possess a distinct advantage due to their proximity to their peers. They understand the challenges on a personal level and are well-versed in the practical realities of the field. Their ability to understand and articulate the needs of the patient also makes them important partners of the programme. This makes their involvement and active participation, alongside community leaders, elected representatives, and TB champions, absolutely crucial. Together, they will **act as a catalyst** in propelling the country towards its goal of eliminating TB by 2025.
2. **TB Surveillance will continue to be strengthened -** District Level Annual TB Survey (DLAS) and District Level Sentinel Surveys (DLSS) to feed in to the TB surveillance systems for precise estimation of disease burden at state and district levels and monitor epidemiological impact of the interventions. Also to support close monitoring of the trend in incidence at subnational levels. Proposal has also prioritized systems strengthening by upscaling capacities of NTEP staff in counselling skills of using patient centric -empathetic approach.
3. **Commodities (second-line drugs, drugs, and diagnostics for TPT, ultra-portable x-rays, and lab consumables)** to support the scale-up of the national response will be supported by the upcoming grant.

**Table 2: Payment for results indicators for CTD grant (2024–2027)**

|  |  |  |
| --- | --- | --- |
|  | **Disbursement Linked Indicators (DLI)** | **Allocation tied to DLIs for 3 years** |
| **DLI1** | Number of patients with RR-TB and/or MDR-TB that began second-line treatment | **US$ 72.09 million** |
| **DLI 2** | A treatment success rate of RR TB and/or MDR-TB: Percentage of cases with RR and/or MDR-TB successfully treated | **US$ 40.52 million** |
| **DLI 3** | Number of persons who received a molecular diagnostic test | **US$ 34.74 million** |
| **DLI 4** | Number of persons initiated on TB Preventive Treatment | **US$ 97.65 million** |
|  | **TOTAL GRANT** | **US$ 245 million** |

**Budgetary highlights:** The budget presented in the table outlines the strategic allocation of funds across various modules and interventions, underscoring a comprehensive approach to addressing the challenges posed by TB. The narrative below delves into the distribution of resources, providing insights into the percentage allocations and the PRs responsible for each module.

**Figure 7: Module and intervention wise distribution of the FR budget:**

A pie chart with text and numbers

Description automatically generated

**Module 1** focuses on **TB diagnosis, treatment, and care.** A total of $3,55,52,074 has been earmarked for TB screening and diagnosis (Intervention 1A), representing 12.52% of the overall budget. The Central TB Division (CTD), Hindustan Latex Family Planning Promotion Trust (HLFPPT), and Doctors for you (DFY) are the PRs for this intervention. Additionally, $42,40,410, constituting 1.49% of the total budget, is allocated for TB treatment, care, and support (Intervention 1B), with Tata Institute for Social Sciences being the designated PR.

**Module 2** is dedicated to addressing **drug-resistant TB (DR-TB) diagnosis, treatment, and care** which is a major concern for the NTP.A **substantial allocation of $7,20,96,425, accounting for 25.39% of the budget,** is designated for DR-TB diagnosis/drug susceptibility testing (DST) (Intervention 2A). Similarly, $4,05,18,898, representing 14.27% of the budget, is set aside for DR-TB treatment, care, and support (Intervention 2B). The CTD is PR responsible for these interventions.

**Module 3** places a strong emphasis on **TB prevention through** screening/testing for TB infection for which a budget of $2,84,74,241, accounting for 10.03% of the total funds is allocated. Additionally, $5,88,80,233, representing 20.73% of the budget, is assigned for preventive treatment. The CTD is the PR for both prevention interventions.

**Module 4 with private providers and other programs/sectors.** An allocation of $17,03,340 (0.60%) is designated for private provider engagement. Furthermore, $2,51,272 (0.09%) is allocated for collaboration with other programs and sectors. Additional 14,351,379 for patients referred for testing and treatment of patients referred from private sector has been budgeted in the respective module 1 and module 2.

**Key and vulnerable populations (Module 5),** encompassing children and adolescents (Intervention 5A), people in prisons/jails/detention centers (Intervention 5B), and urban poor/slum dwellers (Intervention 5C) are a focus of the FR. The budget allocates 1.73% for children and adolescents 0.01% for people in prisons, and 1.62% for urban poor/slum dwellers. Principal Recipients (PRs) responsible for these interventions include SAATHI, HLFPPT, and DFY**.**

**Module 6** addressesthe crucial aspect of **eliminating TB-related stigma and discrimination (Intervention 6A).** While the budget allocation is modest at $12,385, the significance of this intervention in ensuring equitable access to TB services cannot be understated. **Strengthening community systems (Module 7)** is through capacity building and leadership development (Intervention 7A) and community engagement, linkages, and coordination (Intervention 7B) for which the budget allocated is $12,92,013 (0.45%) and $88,66,597 (3.12%) respectively. KHPPT is PR for these interventions**.** Intervention 8A is for **PFMS.** An allocation of $8,90,934 (0.31%) is made to enhance financial management within the health sector. PR KHPPT is responsible for the implementation of **Module 8**. **Module 9** is dedicated to **Monitoring and Evaluation systems, involving Surveillance of TB** to be undertaken by conducting surveys (Intervention 9A). Around 3.62% of the total funds, is allocated for conducting surveys to be undertaken by CTD. **Module 10** Intervention 10A encompasses **program management,** specifically **grant management** with 4.02% of the budget to ensure efficient program coordination and oversight**.**

**Overall, the total budget** presented in this FRof **$284,000,000,** reflects a comprehensive and coordinated effort to combat TB and DR-TB through strategic allocation across diverse interventions and activities. This underscores the commitment to mitigating the impact of TB and advancing the national health outcomes.

**Table 3: Module and Intervention wise budget across PRs**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Module (Number/Name)** | | **Intervention (Number/Name)** | | **Total (in US$)** | **%** | **Name of Principal Recipient (PR)** |
| **M 1** | TB diagnosis, treatment and care | **1A** | TB screening and diagnosis | 3,55,52,074 | 12.52% | **CTD, HLFPPT,DFY** |
| **1B** | TB treatment, care and support | 42,40,410 | 1.49% | **TISS** |
| **M2** | Drug-resistant (DR)-TB diagnosis, treatment and care | **2A** | DR-TB diagnosis/drug susceptibility testing (DST) | 7,20,96,425 | 25.39% | **CTD** |
| **2B** | DR-TB treatment, care and support | 4,05,18,898 | 14.27% | **CTD** |
| **M3** | TB/DR-TB Prevention | **3A** | Screening/testing for TB infection | 2,84,74,241 | 10.03% | **CTD** |
| **3B** | Preventive treatment | 5,88,80,233 | 20.73% | **CTD** |
| **M4** | Collaboration with other providers and sectors | **4A** | Private provider engagement in TB/DR-TB care | 17,03,340 | 0.60% | **HLLPPT, DFY, SAATHI** |
| **4B** | Collaboration with other programs/ sectors | 2,51,272 | 0.09% | **HLLPPT** |
| **M5** | Key and vulnerable populations (KVP) – TB/DR-TB | **5A** | KVP - Children and adolescents | 49,00,297 | 1.73% | **SAATHI** |
| **5B** | KVP - People in prisons/jails/detention centers | 14,862 | 0.01% | **HLFPPT** |
| **5C** | KVP - Urban poor/slum dwellers | 45,88,594 | 1.62% | **HLFPPT, DFY, SAATHI** |
| **M6** | Removing human rights and gender related barriers to TB services | **6A** | Eliminating TB-related stigma and discrimination | 12,385 | 0.00% | **KHPPT** |
| **M7** | RSSH: Community systems strengthening | **7A** | Capacity building and leadership development | 12,92,013 | 0.45% | **KHPPT** |
| **7B** | Community engagement, linkages and coordination | 88,66,597 | 3.12% | **KHPPT** |
| **M8** | RSSH: Health financing systems | **8A** | Public financial management (PFM) systems | 8,90,934 | 0.31% | **KHPPT** |
| **M9** | RSSH: Monitoring and evaluation systems | **9A** | Surveys | 1,02,92,346 | 3.62% | **CTD** |
| **M10** | Program management | **10A** | Grant management | 1,14,25,080 | 4.02% | **All PRs** |
| **Total** | | | | **284,000,000** |  |  |

The drive to eliminate TB as a public health problem in India has gathered significant momentum. This has been facilitated by several key actions, including the integration of primary healthcare facilities for advanced molecular tests, the implementation of newer treatment modalities, the establishment of interface agencies in 283 districts to involve the private sector (a success story from previous rounds of Global Fund investments), provision of patient support through direct benefit transfers, addressing population and social determinants through Memorandums of Understanding (MoUs) with prioritized ministries beyond health, and community engagement through digital tools such as the Ni-Kshay portal. The latter initiative, operating under the Prime Minister's flagship program "Pradhan Mantri TB Mukt Bharat Abhiyaan," has successfully drawn individuals, corporations, elected representatives, and organizations into the national effort to eliminate TB in India.

**In the upcoming grant utilization period 2024 -2027, the nation is aiming for remarkably ambitious targets. The US$ 284 million investment from the Global Fund is expected to play a catalytic role in achieving these targets.**

**To be noted:**

**It is to be noted that India is among the 30 countries with high TB HIV co-morbidity burden in the world**, but the TB HIV interventions are **NOT** budgeted under this funding request as these are **domestically funded,** and **hence the TB HIV module isn’t costed in this FR**. **However, it must be stressed that NTEP and National AIDS Control Programme (NACP) collaborate closely to implement integrated TB HIV services**. The prevention, diagnosis and treatment of TB and HIV-associated TB are key elements of the internationally endorsed comprehensive package of services which are given under a single-window delivery mechanism at the health facility level in the country. Nearly 95% of TB Detection Centres (TDCs) have co-located HIV testing facilities. TB services are also provided as a referral service to the most vulnerable populations, which include Female Sex Workers (FSW), Men having Sex with Men (MSM), Transgender (TG/TS), Eunuchs, People who inject drugs (PWID) and Bridge Populations such as migrants and truckers as part of harm reduction services. As per NACP, the total no. of TB HIV -co-infected patients in 2022 are 37,578. TPT is given to all eligible PLHIV after ruling out TB. Over 95% of PLHIV in active care have been provided with TPT until Mar 2022 through a single window delivery mechanism at the ART centres. In the year 2022, more than 2 lakh PLHIV on active care have been given INH preventive treatment at the ART centres. The management of these cases is being **jointly monitored** by the NTEP and NACP field staff.

Moreover, one of the Non-Government PR, HLFPPT is a HIV grant PR and will leverage it for TB elimination activities as well. The PR proposes to leverage the NACP project staff to strengthen TB screening and linkage among the presumptives identified during outreach activities for PMTCT, Care Support Treatment, Prison Intervention and Red Ribbon activities.

**1.1 Prioritized Request**

**A. For each module, provide information on the funding being requested from the Global Fund and what is expected to be achieved as a result of the Global Fund’s investment.**

|  |  |
| --- | --- |
| MODULE 1 | TB Diagnosis, Treatment and Care |
| Intervention 1A | **TB screening and diagnosis**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| CONTEXT AND RATIONALE | Over the past two decades, the National Tuberculosis Elimination Program (NTEP) in India has successfully developed an extensive TB diagnostic network that spans all tiers of the healthcare system. This network offers free laboratory services to patients in both public health facilities and those referred from the private sector. The program has evolved, expanding its reach within both sectors and integrating cutting-edge diagnostic technologies. By the conclusion of 2022, over 5000 health facilities were equipped with nucleic acid amplification tests (NAAT) capabilities. Within this well-connected and quality-assured laboratory network, an impressive 13.9 million sputum smear tests and 5.8 million NAAT were conducted in the same year. The current organization of laboratory services and the distribution of rapid molecular machines across the country are depicted in Figure 8.  **Figure 8: Lab infrastructure and distribution of rapid molecular diagnostics:**    However, as the laboratory network continues to grow, there arises a need to optimize its capacity further. This entails enhancing the utilization of existing facilities, scaling up the deployment of advanced diagnostics such as Truenat™, and establishing efficient systems for transporting samples.  **The National TB Prevalence Survey uncovered a critical issue:** 64% of symptomatic TB individuals did not seek care. This alarming trend is attributed to symptom ignorance and a lack of recognition regarding TB-associated symptoms. Furthermore, the absence of nearby molecular diagnostics and limited access to chest X-rays (CXR) present barriers to early diagnosis among those identified as presumptive TB cases. This underscores the urgent need to elevate community-level diagnosis through the early identification of symptomatic individuals, facilitated by innovative approaches such as ultra-portable/handheld AI-enabled digital CXR and NAAT on samples collected from symptomatic individuals.  While the NTEP has strategic plans to **decentralize NAAT** to sub-district health facilities and use newer ultraportable CXR devices, a substantial opportunity lies in leveraging these tools during ACF initiatives. This encompasses both targeted campaigns and non-campaign days, offering a means to achieve early diagnosis and amplify case detection. By optimizing the deployment of cutting-edge technologies and broadening their use, the potential for early identification within the community is vast. In doing so, ACF endeavours (Refer Module 5, intervention 5B also) stand poised to contribute significantly to addressing the gaps in TB case detection, thereby advancing the cause of TB elimination in India. |
| List of activities | Aligning with the TB elimination and universal DST goals, the NTEP will focus on **increasing the access to MTB/Rif testing through decentralizing the services and building robust sample transportation mechanisms.** The global fund investments will catalyze the utilization of domestic funds allocated for expansion of lab services and sample transportation. The activity will support the state NTEP to plan, implement and scale-up optimal sample referral and transportation systems that focus on improving access to testing. The various steps involved are below.   1. **Strengthening sample collection & transportation at service delivery level:** Efficient and accurate sample collection and transportation are essential components of a robust diagnostic system, especially for diseases like TB. The adoption of a barcode system can significantly enhance the traceability, tracking, and quality of samples throughout the testing process. **Building on the learnings from the ongoing USAID supported TIFA project implemented by PATH in Mumbai, this proposal aims to provide technical support to strengthen sample collection and transportation using a barcode system to streamline the diagnostic process, reduce errors, and improve the overall quality of TB diagnosis and treatment.** The project aims to provide technical assistance to the states by planning with the District TB Officers areas which need sample transportation mechanism and build systems for effective tracking and monitoring the system. These would be used to strengthen the system and provide innovative solutions using barcode system for sample transportation mechanism.    1. **System Implementation and Training:**        1. **Barcode System Integration:** A barcode system will be implemented for sample collection and transportation, enabling unique identification of each sample, and linking it to patient information.       2. **Technology Adoption:** Mobile applications or handheld devices equipped with barcode scanners under Nikshay reporting system will be used for easy sample tracking and data management.       3. **Training and Capacity Building:** Training sessions will be conducted for healthcare workers on the proper use of the barcode system, including sample labelling, scanning, and data entry.    2. **Sample Collection and Labelling:**        1. **Unique Barcoding:** A unique barcode will be assigned to each sample at the point of labelling: Barcode labels will be placed on sample containers, request forms, and patient records to establish a clear and consistent link between samples and patient data.    3. **Data Capture and Transmission:**       1. **Barcode Scanning:** Healthcare workers will scan the barcodes of samples, capturing essential information such as patient details, sample type, and collection date.       2. **Data Entry:** Barcode system will be integrated with electronic health records (Nikshay) or laboratory information systems to automatically input scanned data for accurate record-keeping.       3. **Real-time Transmission:** Real-time data transmission will be enabled from the point of collection to the testing laboratory, enhancing sample tracking and reducing delays.    4. **Sample Transportation:**       1. **Barcode Verification:** Barcode scanning will be implemented at various transportation points to verify sample integrity and prevent misplacement or contamination.       2. **Electronic Tracking:** GPS-enabled systems will be used to track the movement of samples during transportation, ensuring transparency and accountability.    5. **Quality Assurance and Feedback:**       1. **Quality Checks:** Quality control checks will be introduced at different stages of the process, such as sample collection, labelling, and transportation, to identify and rectify errors promptly.       2. **Feedback Mechanism:** A feedback loop will be established between healthcare workers, laboratory staff, and transportation teams to address issues and continuously improve the system. 2. **Strategies for Scaling up of UPFRONT NAAT testing for EP TB Specimen with focus on private sector.**     1. **Step 1. Mapping of resources and needs.**   **a) Existing NAAT labs, with possibility of upgradation, as described in Step 2, and**  **b) Providers and facilities catering to EP-TB & Paediatric TB cases**  It is suggested that in any given State may consider **assigning few of the established NAAT labs for upgradation for testing EP-TB and non-sputum Paediatric specimen**. The selection of the labs will be based on the availability of: 1) Adequate space for placing a BSC, Centrifuge, Tissue homogenizer, and a vortex mixer, 2) Uninterrupted power supply and availability of power back-up, 3) Feasibility of optimally utilizing the lab for extended hours – \_ideally up to 12 hours per day, 4) Availability of adequate and qualified laboratory technicians as per NTEP guidelines, 5) Central location and feasibility of establishing rapid specimen transportation with link centers, and 6) NAAT equipment and Adequate supply of NAAT cartridges  Facilities already having availability of above requirements may be given priority for ensuring preparedness, based on local acceptability and feasibility. In parallel, health care facilities, both public and private, catering to EP-TB and Paediatric TB cases, and already having processes in place for collecting various non-sputum specimen, be mapped. These non-sputum specimen include, BAL, Gastric lavage, CSF, Lymph node and other tissues, Bone and Joint Specimens, Pus and other aspirates. The mapping exercise should lead to development of dynamically expanding line-list of providers, with the area of specialization, institutional affiliation, contact details and relevant information related the patient load. This parallel mapping will help the State micro-plan the specimen transportation linkages for establishing a hub and spoke model and also help in identifying most appropriate lab for upgradation. Further, this should give the State authorities idea about the work load the NAAT lab (hub) is expected to cater**.**   * 1. **Step 2. Laboratory Preparedness:** Laboratory preparedness & Building capacity of the existing NTEP labs for the processing of paediatric specimen types such as gastric lavage, BAL, induced sputum, lymph node aspirates, etc. for use in NAAT. Once these labs have been identified, the respective State authorities may undertake the deployment of below-mentioned logistics, in consultation with Lab team of CTD and NTEP guidance documents for laboratory infrastructure. A one-day hands-on training would be conducted for all the lab staff on the Standard Operating Procedures for NAAT testing for EP-TB & Non-Sputum Paediatric specimen.   2. **Step 3. Establishment of Hub & Spoke model.**   **Step 3.a.** Linking local facilities with the lab for testing: Once the lab preparedness has been established, the lab be linked with rapid specimen transport linkages with Local facilities in the vicinity which are currently collecting non-sputum specimen. Linkages be established in a manner that the time from specimen collection from the patient be kept to a minimum and not greater than 12 hours. The specimen be stored and transported maintaining cold chain, and as per NTEP guidance for collection and transportation of patient specimen. The Step 2.a. has been suggested in the plan envisaging that there might be some initial bottlenecks at the end of the laboratory, such workflow, testing methodologies, and rapid reporting of results, etc. which would initially need to be streamlined. Hence for initial 2-3 weeks the lab may be linked with few facilities and workload be maintained at low levels. Optimally, the workflow should be streamlined to achieve, ideally, at least 6 NAAT cycles per day, over a 12-hour working day and a initial capacity of testing 20 to 24 samples per day, to effectively work as Hub and efficiently cater to the work-load. Capacity subsequently be enhanced by adding additional NAAT equipment, as per need.  **Step 3.b.** Scale up of linkages using hub & Spoke model: Establishing rapid specimen transport linkage (within 12-24 hours) with facilities, from both public and private sector, currently collecting non-sputum specimen in adjacent districts to saturate the utilization of lab. All health facilities and collaborating providers would be linked to the Xpert labs by means of rapid specimen transportation mechanisms. Site-specific specimen transportation planning would be done based on distribution of providers and distance from the lab ensuring specimens reach the lab within 12-24 hours of collection. This is a very pertinent aspect, as several times the collected EP-TB & Paediatric-TB patient specimen are precious specimen and delays in testing on account of transportation time might adversely impact the feasibility of testing the specimen with alternate methodology such as histopathology. Further, needless to mention patients with severe clinical conditions such as cerebral symptoms essentially require early test results for prompt clinical decision making**.**   * 1. **Step 4. Provider engagement – Public & Private**   Currently most of the EP-TB & Paediatric TB management, both in public and private sector, is undertaken without microbiological confirmation & their notification from private sector to NTEP is suboptimal. Further, in the private sector most of these clinically diagnosed cases do not get access to standardized TB care, including free & quality assured drugs being provided under NTEP.  As such it is imperative that efforts are made by State and District NTEP officials to ensure all these cases are notified to NTEP & have optimal access to free of cost high sensitivity molecular diagnostics, free Anti-TB drugs, and a benefited from various DBT incentives routinely provided by NTEP.  Local NTEP authorities are expected to implement a simplified provider engagement strategy - Educate and Engage as described below:  a. Educate: Educate providers from both private and public sector on NTEP guidance on diagnostic & treatment protocol for EP-TB & Paediatric TB  b. Engage: Effectively engage them under NTEP.  **Several complementary approaches may be undertaken to achieve effective communication among the mapped providers in public and private sector:**   * **CMEs** - organize a series of sensitization workshops for public and private providers for their effective engagement and optimal uptake of lab services. These workshops organize either physically or virtually, need to sensitize the specific providers already catering to Paediatric populations and EP-TB cases, and collecting patient specimen for TB diagnosis. In prominent tertiary care institutions, both in public and private sector, which cater to large number of TB cases, these CMEs can be organized in the respective institutions, there minimizing logistical delays and maximizing uptake. This should also help in kick starting large number of notifications as these institutions cater to significant volumes. * **Flyers/ Pamphlets** – Providing NTEP Diagnostic & Treatment algorithm, referral slips, contact details of Local Nodal person & NAAT lab * **One-on-One meeting** by the field staff & telephonic follow-up   1. **Step 5. Capacity building for specimen collection for providers:** * Series of hand-on workshops be organized for qualified providers, where required for building capacity and mobilizing collection of EP-TB specimen and non-sputum paediatric specimen such as gastric lavage and other types of specimen. * The local authorities should initially link facilities where such specimen is being collected, routinely. Subsequently, additional facilities where such services are not being provided, be identified for capacity building. Systematic capacity building workshops, and on-going mentoring would be undertaken in a phased manner. The trainings would be organized by the State with guidance from CTD. Trainers for the training would be identified by CTD.   1. **Step 6. Scale-up of lab network** * Once the capacity of existing labs is optimally utilized, scale-up the lab capacity by providing additional NAAT equipment to existing labs or establishing additional such labs.  1. **Activation of mobile medical units (MMUs):** There are around 73 Mobile medical units (MMU) functional across the selected geographies. These MMUs will be assessed and in coordination with the states coordinated for provision of TB services in high load settings. 20 out of these will undergo repairs and refurbishment. Efforts in coordination with the states will be made to upgrade MMUs along with Ultra-Portable X-ray. MMUs upgraded with TB screening and diagnostic tools will be utilized for coverage of key population to improve access to TB screening and on-site testing. The project implemented by the NGPR HLFPPT envisages to demonstrate upgradation and operationalization of available MMUs for expanding services for TB for scale-up in other states across the country. 2. The consumables for rapid molecular tests (machine/Chips/consumable) described above will be procured by CTD and are budgeted in this FR along with support for Ultra-portable X Rays (62 Ultra-Portable X Rays). In addition, consumables for 20% of the NSP targets for rapid molecular diagnostics is budgeted in PAAR. 3. The GF investments will be contributing to improve the access for chest X-ray by leveraging on the ultraportable/handheld Xray machines being made available through C19RM grant and the network will be further expanded through the GC7 grant support. |
|  | **1. Sample transportation** will be undertaken by **HLFPPT** in 6 states (Uttar Pradesh, Maharashtra, Orissa, Chhattisgarh, Gujarat, Rajasthan) in 58 districts and **DFY** in 18 districts of 3 states (UP, Bihar and Maharashtra) where they are implementing the ACF activities for KVP populations.  **2. DFY will implement the strategies for Scaling up of UPFRONT NAAT testing for EP TB Specimen with focus on private sector** will be implemented **in 18 districts across 5 states** (Rajasthan, Uttar Pradesh, Maharashtra, Bihar, Assam) creating 50 hubs.  3. Intervention on **Activation of mobile medical units (MMUs) will be implemented by HLFPPT pan India.**  **4. Intervention 4 will be done by CTD for entire country.** |
| Amount requested | **US$ 35.55 Million (CTD – 34.74 M; HLFPPT – 0.29 M; DFY – 0.52 M)** |
| Expected outcome | 1. **Strengthening Sample transportation:** The proposed activities will benefit patients undergoing TB diagnosis and other diagnostic tests in various healthcare settings, including:  * Primary health centers, district hospitals, and referral hospitals, * Geographical locations with limited healthcare infrastructure and resources, and * Areas facing challenges in accurate sample tracking, leading to delays and errors in diagnosis.   The initiative addresses barriers such as manual and error-prone sample tracking, delays in transportation while improving turn-around-time (TAT), and lack of transparency in the diagnostic process.   1. **No of EPTB and Paediatric samples tested**: 9000 (Y1), 13,500 (Y2) and 18,000 (Y3) over the three years. 2. **DLI 3: Number of persons who received a molecular diagnostic test:** From the baseline of 5.8 million, country has expanded its rapid molecular diagnostic sites to >6000 and thus expects to cover 6.5, 7 and 7.5 million persons over the project period. |
| Intervention 1B | **TB treatment, care and support**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| CONTEXT AND RATIONALE | **The proposed investments in this FR will address TB treatment by tackling two critical aspects. First, ensuring second line anti TB drugs covered in the module 2, and second, provide comprehensive psychosocial support to TB patients (Both DS TB and DR TB) for improving treatment outcomes. These interventions complement the actions under interventions 1A and 2A which are the gateway to additional testing and appropriate treatment.**  **This intervention will be implemented by NGPR TISS.**  The alarming increase of Drug Resistant (DR) TB in India and understanding of the social drivers of TB called for a paradigm shift in the programmatic response for DR-TB treatment. Since 2015, the CTD SR, Tata Institute of Social Sciences led “**Saksham**” project has demonstrated the need to move beyond the bio-medical approach and focus on psychosocial aspects of TB. Saksham in collaboration with the CTD introduced professional counselling for DRTB patients in Maharashtra, Gujarat, Karnataka and Rajasthan. Counselling is an important link in the TB care cascade because not only does it contribute to treatment adherence but also because it provides psychosocial support for undergoing the treatment and addressing issues of stigma, gender and mental health. Counselling is also important for early treatment initiation and will become absolutely essential for TB Preventive Treatment (TPT). Saksham developed a patient centric approach for counselling and strategies to address social determinants of TB in three phases of project implementation.  **Counselling is now included as a strategy in all treatment regimens by CTD**. However, there has been **limited to no investment** in building capacities of NTEP staff on counselling. Owing to the counselling acumen and demonstrated capacities for counselling, CTD entrusted Saksham to develop a **national strategy for building capacities of front-line TB staff on Counselling Soft Skills** in the current implementation phase. For the first time a systematic, in-depth and national strategy for Capacity Building on Counselling Soft Skills was undertaken and training programmes were conducted for front line TB staff.  Saksham has developed a three-day capacity building programme for counselling training. The training programmes are experiential and participatory in nature and focus on “un-learning” as much as on learning and are entirely power points presentation free. The trainings are designed for reflection, introspection and developing a patient centric, empathetic approach and practicing skills.  Saksham builds on the resources developed during the current grant intervention and engaged five university partners for undertaking the cascade training programmes. It has trained 409 master trainers from these universities and 672 NTEP front line staff. Saksham has also trained all the DRTB Counsellors (83) across the country on counselling soft skills. The training programmes are underway in the country and by current project completion in March 2024, Saksham will train 75% of front line NTEP staff in India.  In the current grant apart from conducting capacity building for front line TB staff, Saksham was approached for training of ICMR project staff and other development partners like Union for the Centre of Excellence staff (iDEFEAT TB). In the proposed intervention as well, Saksham will be available to conduct Training programmes on counselling and patient support for other partners, Community-Based Organisations, TB Champions, CHOs, Integrated Counsellors etc. |
| List of activities | In the next grant period, NGPR TISS through its ongoing SAKSHAM project will undertake two activities. One to build capacities of NTEP staff on patient centric outlook, empathetic approach, and counselling soft skills; and two to develop a holistic, one window, end to end, state of the art and sensory Patient Support model.   1. **Building Capacities of NTEP staff on Patient Centric and Empathetic approach and Counselling Soft Skills across India.** The project will create a **one window capacity building package on counselling and patient support aspects.** Going ahead, Saksham will consolidate all the learnings and serve as the centralized Counselling Capacity Building partner for which the following activities are proposed:    1. In the current phase, owing to their direct interaction with the patients, Saksham prioritized on capacity building of front-line TB staff viz Senior Treatment Supervisors and TB Health Visitors. The training programmes are well received and there have been requests to expand the same to all NTEP staff. In the proposed phase, Saksham plans to expand the training programmes to other cadres viz DTOs, MODTC, DPS, DPC and STLS.    2. Capacity Building focuses on three strategies of un-learn, learn and re-learn and hence Saksham will undertake Annual Refresher Training Programmes for Master Trainers, DR TB Counsellors as well as Front line TB staff who have been trained in the current implementation cycle.    3. Saksham proposes to undertake ongoing handholding and mentoring on ECHO platforms with a Saksham Counselling expert on various counselling issues/ discussing challenging cases.    4. Saksham also propose to develop a e-Repository for Strengthening Counselling and Patient Support which will be hosted on Ni-kshay. The following will be available on the e-Repository:       1. Geo tagged Master Trainers Database.       2. FAQs for Master Trainers.       3. All Training manuals developed by Saksham.       4. Self-study Material (Saksham is the process of development of these in the current phase).       5. Technology Aided Counselling tools (Saksham is the process of development of these in the current phase)       6. FAQs for Frontline Staff on Counselling Aspect.       7. First respondent chatbot for counselling/patient support queries – “Ask Saksham”. 2. **Demonstration model for holistic Patient Support Centre to address Social Determinants of TB**     1. Saksham proposes to expand the counselling experiences in the **4 implementation states** to develop a **sustainable and scalable model for a holistic, one window, end to end, state of the art and hands on** **Patient Support Centre (PSC) demonstration model**.    2. These **Patient Support Centre (PSC)** will be termed as **“Saksham (against TB) Swasthya Kendra” {Capable (Against TB) Health Centers}** and will be housed in the STDC. Saksham **recognizes the entire family as the unit of care.** Saksham also understands that family constitutes of anyone who supports the treatment and could be the roommates of migrant laborers. This center will be a **“one stop” for the entire family for navigating from diagnosis to treatment completion and beyond for all forms of TB**. Not stopping at treatment completion alone, the centers will also focus on preparing the patient and the family to a life without TB and staying TB free. These centers will have a strong element of regular and on-going care and support and will be seeped in patient centric and empathetic approach, moving beyond treatment education and will have established pathways for addressing social determinants of TB ranging from stigma and discrimination, mental health, gender issues, legal aid and deaddiction services.    3. The **PSC** will provide an inclusive and friendly space for all key populations. The staff will conduct regular outreach with Community Based Organizations (CBOs) to create awareness about TB and the availability of an affirmative and non-discriminatory space for TB treatment to increase notifications from the key populations. The PSCs will focus on demystifying the TB treatment and empowering as well as engaging the patient in their treatment journey, clarifying concerns about TB treatment and answering all the “why’s”. These centers will go beyond counselling (words) and will have sensory spaces/ corners (in a gallery walk format) for various aspects viz treatment education, home based care, social protection linkages, TPT focusing on all senses (sight, hearing, touch, smell, and taste). These corners will have pertinent IEC material, equipped with latest technology for virtual reality and 3600 immersive experiences with wireless audio (in local language) facility for personalized experiences. For instance, there will be a treatment corner which will have actual models of the medicines, where the patient and their caregivers can touch and feel and understand the regimes. These corners will also audio visuals for treatment information and patient testimonials on treatment adherence and becoming TB free.    4. There will also be a corner for **Home Based Care**, which will have all information about Home Based Care and regular demonstration for home-based care at various treatment phases will be undertaken by the staff nurses on the designated days (support group meetings). For example, there might be a need for demonstration on basic hygiene, changing bed sheets for bed ridden patients, basic physiotherapy etc. and sputum disposal, Air Borne Infection Control (AIC) for stable patients. These centers will also provide a basic home-based kit of mask, sputum disposal kit, disinfectant, sanitizer and nutrition kit (through the Nikshay Mitra) for all patients and bed pan/ wheelchair if required (on temporary basis) for ailing patients. These kits will be sourced from the regular supplies of the health facility and if required from donors. There will also be a **Mental Health corner** where the family members will be trained to identify early symptoms of depression, suicidal ideation and the pathways for reporting these for quick mitigation. Regular sessions will be conducted by the **Psychiatric or Psychologist** available at the health facility on designated days or during the **support group meetings**. Identifying and addressing with stigma and linkages to take action against discrimination will also be part of the home-based care corner. A de-addiction corner and linkages to de-addiction centers will also be available. A corner for Yoga, meditation and positive living will also be developed and regular sessions will be conducted for yoga, affirmations during the specified day or support group meetings.    5. Similarly, after undertaking **nutrition counselling** (part of the home-based care corner), **nutrition day** will be organized where the caregivers will be asked to actually cook nutritious, protein rich dishes with available and local ingredients and bring to the center in the “Master Chef” format where a nutritionist will be invited to give feedback and demonstrate a nutritious and protein rich dish with modest, every day and local ingredients.    6. A similar **corner will be available for TPT, TB prevention counselling and ADR management.** Priority based home visits will also be conducted at regular intervals for follow up counselling. **Small e-AV clips** re-iterating all the above aspects will be developed which will be shared with the patient and their family for retention and quick reference.    7. Saksham has demonstrated capacity for **linking not just the patient but the entire family with available social protection schemes**. A corner for information about available schemes, the documents required, forms for applying to the schemes will be available. The staff will guide the patient through all the steps to avail these schemes. For sustainable empowerment the centers will also link patients and their family members to livelihood options, self-help groups. Saksham also envisages a **youth corner for young patients, TB Champions, and young children of the patients** for overall development and more importantly **linkages** for skill building scholarships and vocational courses. In the current intervention, Saksham has demonstrated effective strategies for **migrant patients**, the same will be applied in these centers to reduce LFU due to migration within states and in the neighbouring border states.    8. A **tiny tots corner** i.e., play area with toys, drawing, moulding clay etc. will be available **for paediatric patients and to engage children of patients while the parents are otherwise occupied.**    9. The PSCs will also have a facility for anonymous recordings which will be directly sent to a high-ranking officer at CTD for grievance re-addressal.    10. Saksham envisions these PSCs removed from the negative association of stress, smell and taste of medicines and the overpowering smell of disinfectants associated with a hospital visit and give an affirmative and positive spin to the TB treatment journey without compromising on the importance of treatment adherence. Patient and their caregivers should look forward to these visits. These spaces will be available for fun activities, leisure, celebrating festivals, will have a selfie point, and a place just to “drop in” and spend some peaceful, fun moments and “me time” if required. Books, magazines, games like chess will be made available at these centers and soothing, relaxing music will always be played in the background.   This will be a need based and participatory space and patients themselves, family members and TB champions will be involved in all aspects of the center, including the name of the Centre. They will form and manage committees for various corners/days/celebrations.   * 1. Apart from the available NTEP staff at the existing centers at the STDC (for all forms of TB), Saksham proposes to appoint a **Patient Support Co-ordinator (PSC) at Centre**. The PSC will have a background in social sciences and will have experience of working in TB/HIV. Saksham in the current implementation phase, developed a model for Mumbai NTEP to meaningfully engage TB champions (moving beyond self-testimonials) as “Peer Counsellors” called “Saksham Saathis” (selected by the TB Champions themselves). The Saksham Saathi’s are paid a modest honorarium and were very effective in LFU retrieval (40% retrieval rate) and patients could identify with them. The model showed encouraging results and was scaled up to all 24 wards of Mumbai. As was done in Mumbai, Saksham will engage a TB Champion on a modest honorarium in these centers as well. The PSC will anchor all the activities but will predominantly play a mentoring role for the frontline NTEP staff and TB Champion.   2. Saksham proposes to have an **outreach centre of each demonstration site at the STDC (Hub) at the nodal DR TB centers (Spoke) to expand the patient support model to cover the entire the state and consolidate the current counselling services offered**. Only Patient Support Coordinator will be appointed at these outreach centers who will demonstrate similar strategies at the nodal centers will be undertaken in coordination with the DRTB Counsellors.   Saksham plans to **constitute a Project Advisory Committee (representation from TB survivors, key population, mental health expert, AIC expert, nutritionists, CTD) chaired by the State TB Officer to undertake needs assessment and guide and lead the development and maintenance process of the Patient Support Centers.** The project will also undertake external evaluation as well as documentation, dissemination, and publicity of these centers for wider reach. |
| Population, geographies and/or barriers addressed | * The primary target group is people living with TB and their family members. * The secondary target group is NTEP staff. * The **demonstration model for holistic TB care centres** have been proposed in the **4 implementation states (Gujarat, Bihar, Delhi and Andhra Pradesh)** as a pilot. However, they can be revised per CTD guidance and availability of funds. * **The selection of states for the implementation of the proposed initiatives** is grounded in a analysis of the treatment outcomes of TB patients notified in 2021, as reported in the India TB Report 2023.   + **The first initiative aimed at building capacities of NTEP staff** through induction and refresher trainings on patient-centric outlook, empathetic approach, and counselling soft skill, is implemented pan India.   + **The second initiative, focused on developing a holistic, one-window, end-to-end, state-of-the-art, and sensory Patient Support model,** considers states that have rates of treatment success, cure, death, and lost-to-follow-up that do not compare favourably with the activities undertaken. By including states like Maharashtra and Karnataka, which demonstrate moderate success rates but differ in their distribution of treatment outcomes, the initiative can be tailor-fitted to address the specific challenges faced by patients in these regions. |
| Amount requested | **US$ 4.24 Million (TISS)** |
| Expected outcome | 1. Patient support centers established in all STDCs of the country with facilities like home based corners, tiny tot corners, youth corner, as described in the narrative above, are established. 2. Capacities of all NTEP staff on Patient Centric and Empathetic approach and Counselling Soft Skills built. It will involve training 80% of the NTEP staff (13054 -DTO, MODTCS, DPS, STS, STLS, HV , DR TB Counsellors ) i.e 10440 are to be trained newly, while 2700 staff (STS and TBHV) trained in current grant will be provided refresher training. 3. e-Repository for Strengthening Counselling and Patient Support developed and hosted on Ni-kshay. 4. Mental health support provided for TB patients and families. |

|  |  |
| --- | --- |
| MODULE 2 | DR-TB Diagnosis, Treatment and Care |
| Intervention 2A | **DR-TB diagnosis/ drug susceptibility testing (DST)**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| List of activities | **Ensuring uninterrupted diagnostic service delivery through supplies of essential consumables and reagents:** NTEP has made significant efforts to transition procurement of consumables and reagents to domestic budgets. However, the consumables for rapid molecular tests (machine/chips/consumable) required for DRTB diagnosis will be procured by CTD. 70% of the total procurement is expected to be used for DR TB diagnosis and DST purposes and hence budgeted in this module on DR TB. |
| Population, geographies and/or barriers addressed | Pan India  The Government PR, CTD, will implement this intervention |
| Amount requested | **US$ 72.09 Million (CTD)** |
| Expected outcome | This intervention will contribute to achieving the DLI 3 of providing 21 million persons with molecular tests over the three years |
| Intervention 2B | **DR-TB treatment, care and support**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| CONTEXT AND RATIONALE | The management of drug-resistant TB (DR-TB) is complex and hence, rapid and universal drug-susceptibility testing (UDST) in all DS-TB cases is crucial for early identification of DR-TB to choose the most appropriate treatment for every patient and monitor treatment adherence to achieve the goals of TB treatment. There are **792 DR-TB treatment centres** in the country. Among these, **30 private DR-TB centres** were established under a MoU in accordance with the NTEP guidelines. Improving coverage of treatment for DR TB increases the chances of treatment success for the patients, hence, reducing primary transmission of DR TB in the community. In 2021, the **shorter oral Bdq-containing MDR/RR-TB regimen was introduced** to replace the shorter injection-containing MDR-TB regimen in a phased manner. The **programme completely transitioned to the shorter oral Bdq-containing MDR/RRTB regimen** in all States/ UTs in April 2022. |
| List of activities | With the roll out of shorter regimen (Bedaquiline containing all oral 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 procurement of second line drugs to complement the domestic budgetary support.  Out of the total investment from the country for DRTB treatment mechanism (drugs), approximately 50% has been planned to be contributed from the GF investments.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Regimen** | **2024** | **2025** | **2026** | **TOTAL** | **%** | | BPaLM/BPaL regimen | 55030 | 54193 | 47964 | 157187 | 82% | | Shorter oral Bdq containing regimen | 7732 | 7614 | 6739 | 22085 | 12% | | **Longer oral M/XDR-TB regimen** | | | | | | | With Lfx | 123 | 121 | 107 | 352 | 0% | | With high dose Mfx | 1609 | 1584 | 1402 | 4596 | 2% | | With DLM | 2687 | 2646 | 2342 | 7676 | 4% | | **TOTAL** | 67181 | 66159 | 58555 | 191895 | 100% |     The Rest of the second-line drugs comprising of the shorter and longer regimen will be procured through the domestic budget.  The drugs will be procured as per Government of India policy, which advocate to procure drugs, supplies and commodities like diagnostics, anti-TB drugs with a principal of ‘value for money” through the in-country procurement process at the most cost-effective market rates. If the commodity and anti-TB drugs are available at a rate lower than the tender rates or if procurement fails due to any reason, then the supplies will be explored for procurement through GDF.  The availability of these drugs will be ensured through the domestic resources (PIP, State Budgets) and the existing/routine supply chain of the State and Local governments. |
| Population, geographies and/or barriers addressed | Pan India  The Government PR, CTD, will implement this intervention |
| Amount requested | **US$ 40.52 Million (CTD)** |
| Expected outcome | * **DLI1-** Number of patients with RR-TB and/or MDR-TB that began second-line treatment – 191895 over three years. * **DLI 2-** A treatment success rate of RR TB and/or MDR-TB: Percentage of cases with RR and/or MDR-TB successfully treated form a baseline of 68% it will be improved to 70%, 72% and 75% over the three years of the grant period. |

|  |  |
| --- | --- |
| MODULE 3 | TB/DR-TB Prevention |
| CONTEXT AND RATIONALE | **The PMTPT interventions over the next grant period will focus on uptake of TPT by the expanded group of vulnerable and high risk groups other than household contacts and also rolling out TPT services in the private sector. Currently, 60% of the programmatic management of TPT in the country is funded by the domestic sources.**  National TB prevalence survey (2019-21), India estimated 31.3% crude prevalence of TB infection (TBI) among the population aged 15 years and above. In August 2021, the NTEP expanded the policy to offer TPT to all household contacts (HHC) of pulmonary TB patients (prioritized in pulmonary bacteriologically confirmed TB [PBCT]) and other high-risk groups beyond the existing policy of TPT for PLHIV (erstwhile isoniazid preventive therapy [IPT]) and HHC <5 years). By the end of 2022, 722 (94%) districts of India have expanded TPT as per the national guidelines and more than 1.39 million eligible household contacts, and PLHIV were put on TPT in 2022.  **Figure 9: Achievement in the programmatic achievement of TPT.**  Chart, line chart  Description automatically generated  However, despite significant progress in the scale-up of TPT services in the country, timely initiation and adherence to TPT among almost all high-TB-risk groups are sub-optimal. This is due to inadequate awareness about TPT among health care providers and the community, limited access to radiography (to exclude TB disease), non-availability of tests for TB infection, non-availability of new shorter TPT regimen, long duration of therapy, and sub-optimal programmatic planning and monitoring.  Going forward, NTEP has prioritized the following activities for the next 3 years, which form the basis for selection of activities to be supported by the GF investments:   * Institution-based mapping of other risk groups for TPT by districts. * Integration of TPT and ACF risk groups and updating of the national guidelines on both interventions. * Scale-up of 3HP shorter TPT regimen and introduction of newer skin test for detection of TB infection. * Scaling up community engagement for TPT. * TPT adherence monitoring through digital technology. * Mobilizing professional bodies, the national task force for medical colleges and the technical support unit’s workforce for private sector engagement to promote the implementation of TPT guidelines across all sectors.   To better appreciate the activities described below, it must be understood that PMTPT projects was introduced in limited geographies under the GF (21-24) grant to establish a model of implementation which was well demonstrated in 194 districts and is now being integrated within the general health system. The country has already expanded PMTPT, through the domestic resources leveraging NTEP staff in all 700+ NTEP districts since its launch in Aug 2021. The service delivery for TPT is being provided through the general health system. More than 60% of the TPT programme is resourced by domestic funding.   * Contact tracing is one of public health actions and being undertaken by health worker (STS, TBHV, ASHA) during home visit of the patient after notification. * The follow-up and adherence is being conducted at Health & Wellness Centres through CHO and Multi-purpose health workers. To ensure TPT adherence and follow-up, treatment support incentive scheme is now extended to the treatment supporter of TPT and being paid INR 250 per TPT completion under India's National Health Mission. |
| Intervention 3A | **Screening/testing for TB infection**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| List of activities | **Testing for TB infection:** The Government PR, CTD will expand the TPT coverage to cover all the 797 districts in the country, employing the "Test and Treat" and “Screen and Treat only” approach in line with the PMTPT guidelines, Aug 2021. Within these districts, HCWs/CHVs stationed at each block/village will screen close contacts of Pulmonary TB patients, evaluating them for TPT eligibility. During household visits, all contacts will be assessed for key TB symptoms. Those with symptoms will undergo sample collection and transport for rapid molecular tests from NTEP. Additionally, interventions will bolster universal drug susceptibility testing (UDST) through sample testing from index TB patients. Upon diagnosis, TB patients will be linked to treatment services, while negative cases will be considered for TPT eligibility. Contacts < 5 years and PLHIVs are routinely offered TPT. For those above 5 years the programme has introduced TPT since 2021 and will be continued in the upcoming grant. Eligible contacts over 5 years old will be tested for TB infection using Cy-TB/IGRA, with positive results leading to TPT linkage. The PR will extend "test and treat" and "screen and treat" approaches utilizing GF funds for TB infection tests in all districts of the country. The intervention will provide free chest X-rays for eligible individuals, fostering private sector involvement, and leveraging community platforms to overcome demand-side barriers. |
| Population, geographies and/or barriers addressed | The population prioritized for TPT includes **all household contacts/close contacts of pulmonary TB patients, PLHIV, individuals who are on immunosuppressive therapy, having silicosis, on anti-TNF treatment, on dialysis and preparing for organ or hematologic transplantation as high risk groups**. Apart from these high-risk groups, the intervention will also cover target groups in high TB transmission settings to include **healthcare workers, prisoners, miners, people living in slums, tribals, and migrant workers** guided by the state TPT expert groups if the extent of TB among them is greater than that of the general population. |
| Amount requested | **US$ 28.47 Million (CTD)** |
| Expected outcome | Will contribute to the achievement of DLI4. |
| Intervention 3B | **Preventive treatment**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| List of activities | **Currently, 1.3 million eligibles (Household contacts irrespective of age of bacteriologically confirmed pulmonary TB and other risk groups including PLHIVs) have been initiated on TPT since the initiation of the PMTPT programme in August 2021. Figure 8 above.**  **The upcoming grant will be leveraged to scale up coverage to household contacts (HHCs) and other high-risk groups (HRGs).** 3HP/6H/3HR (3HR from domestic budget in 3 states) will be administered for people > 6 years of age through project support, while 6H will be mobilized from NTEP supplies for children <6 years of age. 20% of drug requirement has been budgeted under the grant as emergency procurement. The TPT drugs will be provided by CTD.  Besides implementing the ongoing interventions, the following newer activities/initiatives have been added to address the programmatic gaps identified during the current implementation period.   1. **The NTP will implement activities to ensure coverage of TPT for all contacts including private sector patients contacts, engagement of Health Well Centers and address adverse drug reactions due to TPT.**     1. **Enhance TPT in both public and private sector with enhanced focus on u**ptake of TPT in the private sector, where it is still low.    2. **Engagement of Health and Wellness Centers:** This would include training of Community Health Officers (CHOs who are a part of the National Health Mission) and ASHA workers with the support of general health system and NTEP to ensure their active participation in PMTPT. Since ASHA workers have now been incentivised, they will be actively engaged for TPT. This intervention has been proposed keeping in mind the operational losses (25-40%) due to accessibility issues and non-adherence to treatment. There is no financial implication for this intervention as this is a program-driven activity.    3. **Adverse Drug Reaction** for household contact of PTB for 6H has been 15%-25% and for 3HP 30%-50%. And that has been a key reason for lost to follow up reported. Taking cue and in anticipation of higher burden of ADR for contacts of Drug Resistant TB, a well-designed counselling mechanism is need of the hour. The project proposes to set up a mental health counselling unit at district level to manage ADR and simultaneously support DRTB patients mental health issues like depression to improve adherence and treatment outcomes (see Module 1, Intervention 1B for greater details). |
| Population, geographies and/or barriers addressed | * The interventions covers Pan India * The major operational gaps experienced at various steps of cascade of care include 25-40% loss in reaching health facility for medical officer assessment, 20% loss in initiation of TPT due to accessibility issues and availability of drugs at the primary health care facilities, 20-30% loss in adherence and low TPT uptake in private sector (nearly 40-60%). * The TPT drugs will be procured by CTD. A proportion **(20%)** of the drugs are proposed under PAAR. |
| Amount requested | **Total US$ 58.88 million (CTD)** |
| Expected outcome | **DLI 4:** Number of people in contact with TB patients who began preventive therapy from a baseline of 1181396 in 2022 to 1,298,618 (Y1), 1,511,304 (Y2), and 1,706,238 (Y3). Over the three years the interventions aim to reach 4,516,160. The total number person initiated on TPT including HCC will be 2.5 Million (Y1), 3.6 Million (Y2) and 4.5 Million (Y3) so as to reach 10.6 Million during grant period. |

|  |  |
| --- | --- |
| MODULE 4 | Collaboration with other providers and sectors |
| Intervention 4A | **Private provider engagement in TB/DR-TB care**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| CONTEXT AND RATIONALE | Based on the National Strategic Plan 2020–25, the Indian government aims to eliminate catastrophic costs for TB patients and to achieve 80% reduction in TB incidence and 90% reduction in deaths by 2025. To focus on TB elimination, India has increased funding from the domestic budget substantially in the last couple of years along with support of (23% of National TB Budget) from major multilaterals (World Bank, Global Fund for AIDS) and bilateral organizations (USAID, PEPFAR, BMGF etc) to accelerate efforts towards elimination of TB in India. In view of concerns of inconsistent and suboptimal management in the private sector, the National Strategic Plan 2020-25 prioritizes strengthening private sector engagement.  **The activities proposed aim towards covering and strengthening the private sector engagement including the corporate hospitals and laboratories, paediatricians, AYUSH practitioners, and informal private healthcare providers.**  **1.** The **investment taps into the private sector** which a major source of health care services, for **younger children up to 10 years who typically visit paediatricians**. Private providers are heterogeneous, and children typically visit multiple providers before getting diagnosed, incurring out-of-pocket expenditure. Suboptimal clinical practices stemming from inadequate provider knowledge of guidelines and perceptions of paediatric TB as a relatively rare condition delay diagnosis. There exists a **relatively low proportion of private sector paediatric TB notifications (37%) compared to the public sector despite care seeking behavior skewed toward the former** and indicates considerable scope for improving early identification and notification. Further, **treatment regimens often consist of unstandardized dosages, and incomplete drug combinations that could result in treatment failure**. While PPSAs have mapped most of the private facilities in their respective geographies, due to the very less proportion of paediatric TB cases, the formal engagement of paediatricians through partnership models, and targeted approach in following them for paediatric TB notification is limited.  **2. Evidence suggests DR-TB patients and more so ever among private ones are more likely to present with delay in treatment initiation**[[2]](#footnote-3)and complexity of treatment protocols, negatively impact patients’ adherence to those protocols and play a significant role in the emergence of DR-TB. India has a huge private sector market and faces the difficult task of keeping private care providers up-to-date in their practices given the frequently changing global discourse.[[3]](#footnote-4) Private TB patients are highly vulnerable to non-adherence.[[4]](#footnote-5) Barriers to treatment adherence found include drug side effects, a perceived lack of provider support, patient financial constraints, conflicts with the timing of treatment services, alcoholism and social stigma.[[5]](#footnote-6) Adverse events (AE) incidence are high among patients with DR-TB in the first three months of treatment and treatment seeking/reporting remains low.[[6]](#footnote-7) Programme mandates decentralization of the DRTB services till district level and also appeals medical colleges to set up Dedicated DRTB management centres to improve patient access, minimize patient trips and maximize patient satisfaction. Moreover, while the MDR regimen is free of costs in the public sector, patients in the private sector are subject to enormous out-of-pocket treatment expenditures. 3 states namely UP, Bihar, Maharashtra are top most contributor to the TB drug sales in the private sector. At the same time sales of newer drugs like bedaquiline are completely regulated and these are not accessible to the private sector patients. On one hand a large sum of the patients seek care from private sector while on the other hand there are only 30 DRTB center in the whole country running in the private set up thus pointing towards unmet need of DRTB patients**. The aim of the DRTB intervention in the private sector is** to strengthen the existing system of DRTB patient management and strengthen linkages to TB treatment services in the private sector, thus reducing the infectivity rate and burden of the disease. NGPR DFY will undertake these activities.  **3. Involving AYUSH** (Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homoeopathy) providers in the TB elimination programme in India is necessary to enhance the reach and effectiveness of the programme. AYUSH systems of medicine are often the first point of contact for patients seeking healthcare in rural and remote areas where the burden of TB is high, and access to allopathic healthcare may be limited. Their involvement offers chances of early detection and treatment of the disease. Moreover, AYUSH systems of medicine have a holistic approach to healthcare and emphasize the importance of lifestyle modifications, such as diet and exercise, to prevent and manage diseases. This can complement the existing TB elimination programme's efforts to promote healthy lifestyles and prevent the spread of TB. Their involvement is in line with the NSP, which recognizes the need for a multi-sectoral approach to achieve its goals. NGPR HLFPPT will undertake these activities.  **Three NG PRs (HLFPPT, DFY and SAATHII) will be working on expanding the private sector engagement through different activities.** |
| List of activities | 1. **(HLFPPT, DFY) Engagement with corporate hospitals, Labs, and eHealth platforms:** This intervention targets the corporate sector hospitals and labs engagement which will help build trust between the public and private sectors. Collaboration with the private hospitals will provide an option to TB patients to avail treatment as per their requirement thereby facilitating easier access. Corporate sector brings across National and International benchmarks for treatment and care which the project aims to tap to achieve standards of care for TB for patients accessing TB care. Public sector will gain from such collaboration and will also help in improving systems within the Public Sector. This engagement involving large corporate chain of hospitals which will eventually form role models for other smaller corporate hospitals to be engaged with NTEP. This engagement model will be achieved by additionally not burdening the existing over-stretched staff and so the project with via its PMU proposes to support the NTEP for this corporate sector collaboration and scaleup. The skill sets needed for such ambitious approach will need adequately capacitated staff so the project will contract professionals with the skills and capacity to engage with large number of Corporate sector hospitals and Labs. These skill sets will be shared as models with the NTEP which has been ever adapting to the newer changing scenarios and taking up the ambitious challenge towards TB elimination.   The project will engage corporate hospitals and lab chains with different models of engagement including reagent sharing, reagent rentals, equipment rentals etc. They will be offered free FDCs and also be asked to join for DR-TB management. The project plans to conduct a major meeting involving all large corporate hospital and Lab chains at the National level. Prior to the big corporate meeting initial meetings to understand their apprehensions and needs will be undertaken. These initial findings will be shared with NTEP and possible models with offers from NTEP and offers from corporate setup will be finalized and agreed with them. They will be encouraged to offer standardized packages of services for TB patients as ‘complete TB management under 1 roof’, which could help in reducing overall costs. As additional gain for NTEP, advertisements for such package of services for TB by corporate hospitals will help NTEP gain additional cases. Success of such models will encourage other smaller corporate hospitals to also get engaged with NTEP for better footfall from TB patients.   1. The project will map and engage with 150 large corporate hospitals and corporate labs and their network. An initial mapping of all the hospitals and Labs for services available would be undertaken. Which would include Digital X-Ray, sample collection and reporting for NAAT based testing and DST. Local level coordination with the STC and DTC would be undertaken to model these facilities and leverage the available resources for overall patient benefit. 2. Negotiate and leverage for subsidised costing of diagnostics and leverage scope of provisioning availability of NTEP drugs and diagnostics/ reagents. 3. These corporate hospitals and labs will be encouraged to provide a **One Stop NTEP umbrella** of services under one roof which will benefit both Private sector and Patients. 4. The project will assess each corporate hospital in the implementation area to understand the prevailing procedures and policies and which can then be supported for aligning to the Standards for TB Care in India. 5. Even though the public sector has been scaling up TPT across the country but the corporate sector has been slow towards the uptake of management of Latent TB infection (LTBI), so the project will look towards sensitizing towards the need for Immunocompromised patients specifically on cancer treatment, Dialysis, geriatric care etc to take up TB preventive treatment (TPT). 6. On similar lines sensitization on Airborne Infection control would be conducted and simple administrative Airborne Infection control measures would be suggested to eliminate TB along with other airborne infections. 7. Furthermore, this would form the basis for engagement with smaller corporate hospitals subsequently as **One Stop NTEP umbrella**. This implementation of end to end model for better outcomes of TB prevention and care services in corporate hospitals developed under the Project will strengthen overall TB outcomes including reducing OOPE for all TB patients in the corporate sector. 8. The project will help in preparing Job Aides targeted towards increasing outcomes for TB patients across private sector. Regular meetings and follow ups with these corporate will help build additional trust and could also look into leveraging some CSR activities for NTEP. 9. **Involvement of eHealth platforms:** Post COVID many private sector telemedicine agencies have come up like Practo, NetMeds, TATA1MG etc which offer services for TB under their teleconsultations. The project will engage with these different agencies and get them to notify their cases to NTEP and help set standards of TB care within their existing telemedicine practice. HLFPPT will undertake this activity. 10. **Involvement of Indian Academy of Paediatrics for expanding child TB services among its members. This activity will be implemented by the NG PR SAATHII.**     1. Conduct a meeting of National Indian Academy of Paediatrics (IAP) leadership, along with CTD and National Technical Support Unit, to discuss the current paediatric TB implementation status in public and private sector including presence of Patient Provider Support Agency (PPSA) across the country, and finalise the implementation arrangements for (a) engaging paediatricians across the country, (b) preparing partnership models including the costing for paediatric TB services, (c) partnerships on bundling of paediatric TB services, (d) preparing standard MoUs for such paediatric TB partnerships, (e) identifying and nominating one IAP nodal person at five multi-state regional level and one from each state level for spearheading the paediatric TB activities in each state across the country, and lastly, (f) deciding the paediatric TB targets for the private sector at national, state and districts     2. Organise national level consultation meeting with identified IAP nodal persons from each state and five regions of the country, and finalise the above-mentioned implementation arrangements.     3. Organise similar consultation meetings at state level in nine selected implementation states, while provide need based technical support to other states, to finalise the district level implementation arrangements and the targets     4. Establish active collaboration of NTEP with state IAP in the nine states, and gain support from state IAP in nomination of nodal persons at the district levels towards the following:        1. Conducting CMEs in all IAP chapters through joint NTEP-IAP initiatives (where resources available)        2. Forming paediatric TB expert committee in each district to support in ongoing capacity building of private paediatricians        3. Sharing of periodic technical updates with all members in each IAP chapter, and        4. Participation of nominated IAP representative in state and district level NTEP review meetings, and develop strategies for engaging more paediatricians     5. Provide technical support to PPSAs and NTEP staff (where PPSAs not there) of each state for collaboration with IAP Paediatric TB district representative, on the following:        1. Conduct Training of member paediatricians on the updated NTEP Paediatric TB Management Guidelines (2022) across IAP district chapters, where IAP has not conducted training previously        2. Sensitisation of all member paediatricians across IAP chapters on NTEP program services such as NAAT and FDC drugs in the public health sector, and lab partnerships for diagnostics such as free-of-cost CXR and fine needle aspiration cytology (FNAC) services to private sector patients        3. Assessment of paediatric TB services in the private sector in the district through Identifying the list of all private sector paediatrician and other paediatric practitioners in the district, and facility assessments of potential hub sites        4. Identifying and establishing three to five private paediatric facilities as hubs in the district, based on the availability of TB care services, with the support of the IAP and in consultation with the respective District TB Officer (DTO) in the district        5. Follow-up of all paediatric sites towards engaging them through provision of paediatric TB related IEC materials, ensuring real time notification of presumptive TB cases and their evaluation, ensuring the referral systems of presumptive paediatric TB cases from all paediatric sites to (i) existing CXR and FNAC-partner sites, by providing vouchers, and (ii) paediatric hub sites for sample collection and comprehensive paediatric TB cascade management        6. Leverage PPSA services for sample transportation from private sites to government free NAAT testing        7. Leverage PPSA services for care of children with TB through access to free FDC drugs for treatment initiation, provision of differentiated paediatric TB care, follow-up till treatment completion including reverse contact tracing, TPT initiation, Direct Benefit Transfer of Rs 500 for nutrition support, drug adherence, HIV and diabetes screening.        8. Targeted follow-up of paediatric hub sites for collection of vouchers and making monthly payments and ensuring the quality of services at hub sites        9. Gather ongoing patient feedback on quality of services, and use them for quality improvements at these hub sites and across all paediatric sites     6. Facilitate quarterly progress reviews, jointly organized by IAP and NTEP, at national, state and district levels        1. Support national and regional IAP paediatric TB nodal persons to monitor the state IAP nodal persons, who in turn do with the districts nodal persons for conducting reviews in their internal IAP monthly meetings        2. Conduct need-based field visits by IAP paediatric TB nodal persons at national to state levels and further state level persons to districts for active engagement of its members towards TB elimination, and address any operational bottlenecks, and strengthen the functioning of IAP expert committees at districts     7. Raise awareness about paediatric TB through sessions on paediatric TB organised at national and state IAP conference, and joint NTEP and IAP led communication campaigns at national, state and district level on important events like children’s day, pneumonia campaign days, and World TB days towards engaging all paediatricians, and parents visiting the private health facilities 11. **(DFY) Facilitating operationalization of hubs for the inpatient management of DRTB cases in concordance with standards of DRTB care:**      1. An expression of interest will be floated to select the facilities as hub and spoke. EOI will mention the checklist of functions, input mechanisms and required outputs from the service provider.     2. **Mapping of the potential facilities-** All the facilities – nursing homes, polyclinic, secondary/tertiary Hospitals which are already providing treatment to the TB patients will be mapped and informed about EOI     3. **Expression of Interest for DRTB Facilities –** An EOI will be floated to find out the interested facilities for running a DRTB center. Facilities which apply for EOI will be seen through the lens of capacity assessment results and their willingness to provide the DRTB care services at a subsidized rates to the patients.     4. **Capacity assessment of the facilities will be done on the basis of the following parameters-** AIC, human resource & Training, Infrastructure, record keeping, laboratory services, target beneficiary and records, stockkeeping of commodities like drugs etc, IEC patient protection rights, referral mechanism.     5. Extending **technical support to the Hubs and Spokes** for upgrading their facilities as per the need assessment in case there is a need to do so. Though the EOI will mention about the required inputs checklist, but some levy will be given to the facilities who are willing to develop such input mechanism through the handholding support specially in the states lacking any such facility in the private sector.     6. **Selection of the Hub and Spoke**: Hubs and spokes will be the private facilities either a nursing home/polyclinic/tertiary hospital and will offer following services as indicated in the table below. Services will be divided as non- negotiable and desirable. An effort will be made that facilities chosen to fulfil all the non-negotiable criteria’s and at least some of the desirable criteria’s.  |  |  |  | | --- | --- | --- | | **Type of facility** | **Non- negotiable services** | **Desirable services** | | **Hub** | * Separate ward for male and female with at least 2 beds in each * Daily OPDs * Specialist – Pulmonologist, Anaesthetist, Paediatrician, Pathologist * ADR management * Air borne Infection control mechanism * 24 hour –Ambulance * Radiology services - CT scan, X ray * Laboratory services * Institute a DRTB committee * Counsellor | * 10 bedded unit * 2 bedded ICU (oxygen, ventilator) * OT for TB surgery * Post operative care * NAAT and LPA test inhouse or outsource * Physiotherapy for palliation | | **Spoke** | * Air borne Infection control mechanism * Round the clock physician/pulmonologist * Institute a DRTB committee * Inhouse lab for Pretreatment evaluation * Counsellor | * Linked to Specialists * NAAT test * ADR management |  * 1. Program management team will provide technical and handholding support to Private Medical College which are potential candidates for developing such inpatient facilities.   2. Facilities which qualify the above criteria’s will be approached to Initiate a dialogue with them for Non-Financial Agreement   3. A consultative approach will be followed to curate inpatient and outpatient DRTB care Packages for the services mentioned under Hub and Spoke at a negotiated cost to leverage good quality care for Private sector patients within the purview of recent guidelines and by reducing out of pocket expenditure. While such an arrangement allows the private hospital to gain access to newer market in terms of DRTB care which is currently lacking in private sector at the same time it also urges them to utilize their CSR funding for service provision at a subsidized cost.   4. Since 80% of the DRTB patients can be managed through outpatient mode thus, 1 Hub for every 3-5 districts within a state will be chosen to provide Inpatient facilities while private provider with a polyclinic or nursing home with the abovementioned facilities with high case load for TB patients will be chosen as spoke.   5. Handholding and Mentorship of the Private clinicians/ specialists and junior & senior residents to sensitize them for Programmatic management for Drug Resistant TB cases through 2-3 days of the mentorship program which will be undertaken by the State to ensure standards of care are followed at each level.   6. Inpatient Facility will extend services to all kind of pulmonary, extrapulmonary DRTB, Difficult to treat TB, HIV DRTB, pregnant women DRTB, paediatric DRTB and other vulnerable groups like transgenders etc.   7. Patient wise boxes/drugs will be sent to the treating physician in the hubs and spokes. Since, Hubs will cater to a large number of the patients thus a buffer of 3 patient boxes will also given.   8. All the drugs obtained from NTEP will be replenished once their utilization/ consumption certificate is established to the DTO.   9. All the services including in patient stay till 5 days in hubs, diagnostics, treatment will be provided to all the patients in this facility at a negotiated cost during the project phase.   10. To ensure smooth functioning of this partnership by facilitating timely DRTB drug delivery, linking the patient with PPSA or NTEP for Public health action, contact tracing of the families and timely disbursal of drugs consumption report and demand generation for getting new indents.   11. Private Clinicians will be encouraged to prescribe TB preventive Therapy on the patient’s prescription for the family following their screening for Latent TB infection. This strategy will work in similar like treating the spouse in case of Sexually transmitted disease.   **Proposed Flow Mechanisms for DRTB patients in the proposed model:**       1. **DRTB, paediatric DRTB, patients seeking care in the private sector intervention by DFY will cover 5 states in which around 30 Nodal DRTB Hubs will be created in the private sector wherein each hub will serve 4-5 districts as spokes.** 2. **Engagement with the AYUSH and non-traditional health care providers:** AYUSH and informal providers are an important provider group in the care cascade and are among the first point of care in India for different ailments. These informal health care providers are often the first point of contact for a significant proportion of TB patients in rural areas/ semi-urban/ tribal settings due to factors related to accessibility and affordability. Care provided by these providers often comprises of suboptimal diagnostic and treatment elements and complicates TB patient pathway- contributing towards health system delays and morbidity and mortality among TB patients. Leveraging this network of providers, for symptom screening and suspect identification and referral system will be established to enable early diagnosis. A simplified approach is proposed to proactively reach out to patients catered by informal providers. This would enable patients catered by informal providers are benefited by NTEP package of services including access to free programmatic drugs, diagnostics and public health actions. The specific activities include:    1. An initial Line-Listing of Informal Providers by various field staffs    2. An initial mapping of all types of services provisioned by the AYUSH and non-traditional health care providers to understand the availability of services being offered by them    3. The project will sensitise them about NTEP and possible engagement points under the project.    4. They will be disseminated with uniform messages on NTEP engagement and share communication on TB with AYUSH and non-traditional health care providers as targeted audience.    5. The project will encourage these AYUSH and non-traditional health care providers to use the available tools to facilitate access of free services available through the Public Health System even to patients who seek care within their network for complete TB diagnosis and treatment.    6. Establishing referral linkages between informal providers and the nearest public/private health facility for accurate diagnosis and access to standardize TB treatment to the patients catered by them.    7. Coordination with the STC and DTC would be undertaken to model these facilities as NTEP- AYUSH and non-traditional health care providers linkage model.    8. The program provision for informant incentive and treatment supporter incentive which can be availed by any person who help in providing information about TB cases and helps in treatment adherence and support TB patient will be encouraged.    9. The project aims to engage with these informal providers largely for referral of presumptive TB cases and provision of treatment support as treatment supporters. In addition, they will be used for counselling TB patients about treatment adherence and follow up etc. They will also be used for contact tracing from index cases and Active Drug Safety Monitoring and Management (aDSM) as they are much closer to the patient’s reach.    10. All these activities would help in providing overall technical support to NTEP on private sector engagement and would form the basis for further incorporation of similar activities under the domestic budget of NTEP. |
| Population, geographies and/or barriers addressed | * HLFPPT will work on strengthening private sector engagement through chain of corporate hospital (approx. 150) and integrating online healthcare platforms across India . Activity 1 (targeting 150 major hospital) and activity 2 (involvement of E Health platforms) will be undertaken Pan India by HLFPPT * The NGPR SATHII will engage Indian Association of Paediatrics (IAP) which is a professional medical association and has 5 zones, 31 state branches, 329 city/district branches with 32000 paediatricians across the country. It has specific disease committees including TB that could be leveraged for forming paediatric TB expert committee at the districts. It has done trainings of its member paediatricians across around 150 chapters, while the engagement after the training has been a challenge. Hence, active engaging IAP chapters at districts, state, zonal and national levels into the NTEP activities will enable unform designing of models, costing of services, and increasing access to free NAAT and FDCs, and notifications, public health action including reverse contact tracing, and TPT initiation. IAP will be an active partner through a formal MoU for the roll-out of the activities in nine states and engaging paediatricians across the country.   Under the Paediatric TB project of SAATHI, activity 3 above, will be implemented in both public and private health sector in the nine states of Andhra Pradesh, Assam, Chhattisgarh, Haryana, Karnataka, Punjab, Rajasthan, Telangana, and Uttar Pradesh. These states have been prioritized based on criteria like higher TB prevalence and low proportion of Paediatric TB case notification (< 6.5%).   * The NGPR DFY’s intervention (Activity 3 and 4) will be implemented in 230 districts of 5 states (Rajasthan, Uttar Pradesh, Maharashtra, Bihar and Assam) and * Activity 6 -case finding and enabling early diagnosis by engaging AYUSH and informal providers in Uttar Pradesh. will be implemented in 18 districts of 3 states (Bihar, UP and Maharashtra) by DFY and by HLFPPT only in Uttar Pradesh |
| Amount requested | **US$ 1.70 million (HLFPPT – 0.58 M; DFY – 0.85 M; SAATHII – 0.27 M)** |
| Expected outcome | 1. For NGPR SAATHII interventions on Paediatric TB the outcomes are as follows:    1. Increase in the number of private paediatricians reporting paediatric TB through engagement of 16000 paediatricians across nine states (directly) and indirectly, reach 32000 paediatricians across the country through national level IAP partnerships.    2. 20% increase in the paediatric TB notification in private sector across nine states over three years.    3. 95% of children with TB, identified in private sector, have successfully completed treatment. 2. NG PR DFY: The DRTB private sector activities will cover 150 districts in the country through the hub and spoke model. Around 2150 people with confirmed RR/MDR TB will be notified from these centers. 3. 774 Ayush & informal providers to be engaged by DFY and 540 by HFLPPT. Around 15000 (in DFY geographies) and 12474 (in HLFPPT geographies ) presumptive TB cases are expected to be referred by AYUSH and informal service providers in three years |
| Intervention 4B | **Collaboration with other programs/sectors**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| CONTEXT AND RATIONALE | TB not only affects physical health but can also have a significant impact on individuals' and their families’ socio-economic well-being. Many individuals who have TB or have recovered from TB, including their families, face challenges in re-entering the workforce due to gaps in their skills and education. **Providing skill development opportunities can empower these beneficiaries and their families to regain their economic independence, enhance their employability, and contribute positively to society**. |
| List of activities | 1. **Skill development of TB survivors:** This proposal aims to address the skill gap among TB survivors as well as their family members in identified states, supporting their reintegration into the workforce, and ensuring long-term socio-economic stability. The project will aim to provision technical support to the states on linkage for Skill development. **State TB program will be provided support to link with the** **Skill development Council**.    1. **Beneficiary assessment for social support and financial empowerment of the TB affected Families:** Project will provide technical support to the State TB cells and help coordinate for nomination of TB survivor or their family member for Skill Development courses.    2. **Skill development of identified beneficiaries:** The identified beneficiaries will be screened for eligibility of various skill development programs, and help the individuals to select appropriate non Health skill course. Project staff will facilitate and organize for enrolment of residential / non-residential skill development program. The beneficiaries will be provided required support for enrolment, completion of course and post-course completion job placement services / entrepreneur program. 2. **Corporate sector engagement meetings:** The NGPR HLFPPT will conduct a major consultation involving all large major corporate hospital at the National level. Prior to the big corporate consultation initial key informant interviews to understand their business models, apprehensions, and challenges towards engagement with NTEP will be undertaken. These initial findings will be translated into development of long-term self-sustaining models of engagement leveraging provisions under NTEP. |
| Population, geographies and/or barriers addressed | * NG PR HLFPPT will undertake the skill development activities in 6 states and will conduct one national consultation workshop. |
| Amount requested | **Total: US$ 0.25Million (HLFPPT)** |
| Expected outcome | 1. 150 large corporate hospitals participate in the national consultations. (This outcome is in line with the outcome in intervention 4A) 2. NTEP will nominate TB survivors and/or their family members for Skill Development courses. |

|  |  |
| --- | --- |
| MODULE 5 | Key and Vulnerable Populations (KVP) – TB/DR-TB |
| Intervention 5A | **KVP - Children and adolescents**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| CONTEXT AND RATIONALE | **TB affects an estimated 356,000 children under 15 years in India annually, accounting for 12% of total incident TB cases in the country.** However, **only half of this number are notified** to the NTEP, with the highest gap (~70%) in the under-five age group. **Underdiagnosis** is a key cause of the large gap and linked with both clinical characteristics and health system challenges.  In children, TB presents with **non-specific and variable symptoms** that may indicate other conditions, and is **paucibacillary**, which makes microbiological confirmation difficult. Further, in the public sector, **specialists are scarce, provider awareness of the NTEP diagnostic algorithm is poor, and diagnostic infrastructure such as X-ray facilities and NAAT are typically available only at the district-level**. Evaluating children for TB may require relatively **complex sample collection procedures such as gastric lavage, lymph node aspiration and spinal tapping, which non-specialists at sub-district level facilities lack skill and confidence to perform. In addition, sample transport facilities from such sites to district TB centres for NAAT are limited.**  Further, **private sector services for paediatric TB suffer from challenges** such as, poor adherence to the NTEP diagnostic algorithm and management guidelines, and weak linkages to the public sector TB program (discussed in Module 4).  Recognizing children as a vulnerable population, the government of India has implemented several initiatives. These include, recommending systematic screening at non-TB entry points, developing guidelines for paediatric TB diagnosis and management, and a framework for integrating TB screening with other child health programs, and making WHO-approved child-friendly drug formulations available nationally. Moreover, the NTEP has partnered with organizations such as SAATHII, NGPRs in this FR, to implement solutions for increasing access to NAAT and improving the quality of care available for paediatric TB patients. Despite such initiatives, paediatric TB case notification has remained at 6% of total TB notifications for several years.  The proposed interventions based on experiences from UNITAID funded “Catalyzing Paediatric TB Innovations (CaPTB) and USAID-JSI funded TB Implementation Framework Agreement projects” implemented by the PR will address these capacity gaps in public sector through ensuring the availability of expertise (trainers and experts) from national to state to districts levels in public and private health sector, building the capacity of public sector paediatricians and medical officers up to primary care level towards adhering to national guidelines there by address the challenges due to under-diagnosis and over-diagnosis, improving the access to paediatric TB services especially to NAAT and CXR at sub-district level, and improve the surveillance mechanisms through better tracking of pathways from primary to secondary to tertiary levels. |
| List of activities | The project will be implemented using a **differentiated approach in nine states through three models - (A) intensive interventions in 18 districts (two per state), (B) district-level technical assistance in 15% of the districts (42 districts), and (C) technical assistance to the state NTEP for the other districts (237 districts).** Districts for each intervention model will be finalized in consultation with the CTD and the respective State TB Offices. District-level activities will vary based on the model employed i.e., intensive, district-level and state-level technical support, and the resources deployed by the states and district NTEP units.   * **Model A (18 districts)** deploys both human resources and project activities in high-priority districts in a comprehensive manner to fast track paediatric TB detection, * **Model B (42 districts)** will have limited human resources and only essential project activities to catalyze the district NTEP and PPSA units of high to medium priority districts to increase the paediatric TB case detection, * **Model C (237 districts)** leverages the domestic budget and NTEP staffing of the medium to low priority districts for paediatric TB services through state-level technical support to State NTEP unit, in collaboration with State Technical Support Unit, and WHO Consultants.   All the activities will be done in close collaboration with District TB Office and their NTEP field staff (STS, TBHV and STLS) at district level. The project will be implemented consultatively, engaging the departments of Health, Women and Child Welfare (WCD), Tribal Welfare and Rural Development.  The following are activities aimed to address paediatric TB by improving detection, diagnosis, and treatment in the nine states.   1. **Decentralize Paediatric TB Services to Increase Access:** The project will **establish paediatric TB hubs at all the Community Health Centers (CHC), Sub District Hospitals (SDH) and the District Hospitals (DH), in addition to private hubs** across all districts in nine states by the end of Year 3. These hubs would provide comprehensive paediatric TB services, including screening, evaluation (especially pulmonary sample collection procedures),diagnosis and treatment. Toward this, public facilities in each district will be assessed to understand their capacity to provide paediatric TB services, and prioritize sites for hub establishment in each year of implementation. To establish the hubs, **SOPs and IEC** materials for **sample collection**, and necessary **consumables and equipment** will be provided. Where in-house CXR and fine needle aspiration cytology (FNAC) services are absent, partnerships will be leveraged or facilitated with private **radiology and pathology centres** for free-of-cost diagnostic (CXR and FNAC) services to patients through a **voucher system.** For sample transport from hubs to NAAT centres, **local community volunteers and TB champions** will be leveraged. In addition, where the hubs have Nutrition Rehabilitation Centres (**NRCs)**, TB services will be integrated at the NRCs. Moreover, the referral system between hubs and Medical College Hospitals (MCH) will be strengthened for extrapulmonary and severe paediatric TB case management. 2. **Strengthen Health Systems to Improve the Quality of Paediatric TB Care:** The project will build the capacities of health care providers through theoretical and skill-based training, using paediatric TB training material developed by NTEP and IAP. The skill training will employ demonstrations of pulmonary (gastric aspirate, induced sputum) and extra-pulmonary sample collection procedures. Job aids, IEC and SOPs on sample collection already developed will be leveraged for trainings. To enable on-going capacity building and sustainability, the PCoEs/one nodal State Medical College will be involved. These experts from PCoEs will conduct ToTs for paediatricians and staff nurses from each district, establishing a pool of master trainers who will further conduct district level cascade training on national guidelines for at least one doctor and nurse from each hub.   **Ongoing Capacity Building:** As a follow-up of training, the hub's capacities for sample collection (GA/IS) will be built through periodic **mentorship visits** by master trainers and project nurse mentors. In addition, the project team will visit the hubs periodically for **supportive supervision visits** to enable the timely detection of presumptive TB and evaluation with CXR and sample collection, and also identify and address any other operational challenges at facility, lab, and patient education. Further, district level master trainers will be engaged to conduct experience sharing sessions with hubs and also advise the hubs on the management of complex cases and CXR interpretation as and when needed. For ongoing technical capacity building of the district master trainers, **state level medical colleges/Paediatric Centre of Excellence (PCoE)** will be leveraged.   1. **Integrate Paediatric TB with Child Health Programs to Increase Screening and Referrals:** The project will facilitate inter-program coordination between TB and other child health programs (RBSK, RKSK, and ICDS) by operationalizing existing national guidelines and advocating with relevant stakeholders. The stakeholders from WCD and Health departments[[7]](#footnote-8) will be engaged through national, state and district level consultations to develop strategies and action plans for integration. Further, priority blocks with vulnerable populations will be identified through situational assessments of TB and child health service coverage in each district. Subsequently, the capacities of frontline workers will be built on screening and referring presumptive paediatric TB using the frontline workers handbook developed in the TIFA-paediatric TB project SAATHII and by disseminating standardised referral SOPs. Training will be organized in a phased manner, where community health workers in vulnerable blocks will be covered first, followed by the other blocks. District and block level ToTs will be followed by cascade training at monthly PHCs/block/ sectoral meetings to cover all community health workers (CHW), i.e., ASHA, ANM, AWW, CHO.   The training will be followed-up with periodic field visits by the project team to motivate CHWs and support Active Case Finding (ACF) and paediatric TB screening activities undertaken by them. Further, the project team will share progress on referrals at monthly sectoral/block level health meetings and enable the integration of paediatric TB in routine activities and at special health events (e.g., SAANS campaign) by CHWs. Further, the project will coordinate with TPT and NTEP outreach for referrals of presumptive TB children from contact tracing visits for evaluation.  In addition to provider capacity building, gaps in diagnostic infrastructure will be addressed through the deployment of new technology for TB evaluation. Hand-held X-ray machines (Annex E) will be used in hard-to-reach areas through health camps, community health activities, and at facilities without X-ray machines.  To enable real-time reporting and tracking of the paediatric presumptive TB referrals by CHWs, the project will establish a simple ICT-based system. Through these approaches, the Health, and Wellness Centres (HWC-PHC and HWC-HSC) and their respective frontline workers in 297 districts of nine states will be able to identify paediatric presumptive TB and refer them to facilities for presumptive TB evaluation.   1. **Engage Communities and TB Champions to Promote Community-led Advocacy for Efforts towards TB Elimination:** The project will work on enhancing community awareness on paediatric TB to improve health-seeking behaviour. Sensitization activities will include mass and mid-media and localised communication campaigns such as door-to-door visits, in collaboration with district health officials and CHWs. In addition, paediatric TB champions will be engaged to support improvements in the delivery of paediatric TB services in the health system. To advocate for improving quality of care the paediatric TB Champions will be encouraged to participate in state, district- and block-level forums such as paediatric TB training for public and private providers and IAP. Further, their participation would be facilitated at community health workers’ and village/local body meetings to highlight the support required by all stakeholders. Moreover, TB Champions in the districts will be trained to screen and refer presumptive paediatric TB cases (Annex I). The support of TB Champions and community volunteers will be leveraged for sample transportation to reduce the turnaround time for diagnosis. 2. **Increase Paediatric TB Treatment Initiation:** The project will track and follow-up with confirmed paediatric TB cases reported by the public and private health sectors. Caregivers of paediatric TB patients will be counselled to initiate TB treatment to reduce delays. Support will be provided to ensure that children with paediatric TB are initiated on child-friendly, WHO-approved fixed dose combination (FDC) drugs in the public sector by NTEP staff. The project team will ensure timely reporting in Nikshay for each paediatric TB case identified. Any child identified with drug-resistant TB (DR-TB) will be referred to the district DR-TB centre for treatment initiation as per national guidelines. 3. **Increase Treatment Success and Patient Support:**  The project will leverage NTEP outreach activities to track paediatric TB positives, and ensure public health action including, reverse contact tracing, TPT initiation, and HIV and diabetes screening. Follow-up for each paediatric TB patient will be undertaken through monthly home visits/telephonic counselling to ensure treatment adherence and drug refills, and timely referrals in case of adverse drug reactions. In the private sector, the project staff will coordinate with PPSA teams for tracking and follow-up of drug refills. Caregiver support groups will be created and adult/caregiver TB champions will be engaged to support treatment adherence and follow-up of paediatric TB patients, leveraging the existing treatment supporter incentive provision. The paediatric TB patients will be linked with NPY-DBT and Nikshay Mitra and social protection support, wherever needed. In coordination with NTEP and PPSA staff, all children with TB will be followed-up till the successful completion of treatment without any treatment interruptions.   Moreover, to generate evidence for policy and programmatic adaptations, paediatric TB surveillance will be undertaken. Care cascade data from each entry point of community referrals and health facility walk-ins will be tracked to capture the yield of paediatric TB cases, and help identify priority geographies and vulnerable sub-populations that need attention. Ensure paediatric TB cascade data matches with Nikshay, and facility level reports of health systems. Use project data to advocate for policy and implementation level changes, mid-course corrections, and new strategies development |
| Population, geographies and/or barriers addressed | The project will be implemented by SAATHI in 297 districts of 9 states of **Andhra Pradesh, Assam, Chhattisgarh, Haryana, Karnataka, Punjab, Rajasthan, Telangana, and Uttar Pradesh**. The states have been selected to ensure geographic representation across the country.  Districts will be selected in consultation with the Central TB Division and State TB Cell in each state, based on the district-wise TB burden/prevalence and the current coverage of total TB and paediatric TB notification.  The criteria for the selection of districts for the first two models (A & B) will be a higher TB burden with lower paediatric TB coverage. Based on the criteria, the districts will be prioritized, with Model A being in two top priority districts with high TB burden and lower paediatric TB notification, model B in the next 15% of high to medium priority districts, and the rest of districts covered through model C. |
| Amount requested | **US$ 4.90 Million (SAATHII)** |
| Expected outcome | 1. Scaled up capacities for paediatric TB at country level with Expert Trainers available at states and districts. 2. Paediatricians and Medical Officers from sub-district facilities are trained on paediatric TB cascade 3. Decentralised paediatric TB services in public facilities (5-10) at sub-district level 4. Paediatric TB integrated with child health programs (RBSK, Malnutrition, SAANS pneumonia) with increased referrals from primary and community health system 5. Streamlined referrals from primary to secondary/tertiary health system for EPTB and severe cases 6. Establish 90 sample collection centres in public health facilities across 18 districts of nine states 7. 20% increase in the paediatric TB notification from both public and private sector in nine states from 59219 ( 2022) to 70769 (2026-27) over three years 8. 90% of the notified paediatric TB cases are initiated on treatment 9. >90% of paediatric TB patient initiated on treatment who successfully completed treatment 10. Linking 80% of consented TB patients to Ni-Kshay Mitra for nutritional support. 11. Establishing TB community group at each State and high burden district for facilitating linkage of TB patients with Ni-Kshay Mitra. 12. Increase in the numbers of Ni-Kshay Mitras |
| Intervention 5B | **KVP – Urban population**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| CONTEXT AND RATIONALE | **Investing in active case finding (ACF)** emerges as a compelling imperative based on India's TB landscape. In 2022, the country reported 2.42 million TB notifications, reflecting a notification rate of 172 per 100,000 population. While this indicates progress, it still falls short of the estimated incidence of 196 per 100,000 and a prevalence of 312 per 100,000 individuals. A pivotal strategy to enhance case detection lies in ACF, particularly within key and vulnerable populations (KVPs). Last year, a staggering 221 million individuals were screened for presumptive TB, leading to the diagnosis of 48,329 TB cases (2.5%).  WHO and National TB Elimination Program (NTEP) reiterate that to End TB a multipronged approach is required which involves detecting missing cases through active and passive case finding, treatment and follow up of diagnosed cases. Active Case Finding (ACF) has shown to reduce the burden of TB in terms of both mortality and morbidity. It aims to diagnose TB either in those who do not recognise that they have symptoms, or those who do recognise symptoms but for whatever reason do not, or cannot, access services at health-care facilities. Individuals with symptoms are identified and often referred for testing during ACF activity. Though an effective approach but pre-treatment patient loss have been identified due to lack of willingness to travel long distances for health services and poor health seeking behaviour. Thus, tools like portable x ray services provide effective solutions to prevent pre-treatment loss to follow up. As per National Strategic Plan for TB Elimination 2017-25, in the urban areas ACF activity should be carried in the vulnerable groups particularly in people living in slums, night shelters, homeless, old age home, construction workers, homes for destitute etc  Currently only 15.6% of the country’s total population is screened through ACF, thus missing many cases. |
| List of activities | 1. To carry out active case finding among vulnerable population and streamlining linkages for their management 2. Vulnerable population such as those residing in slums, night shelters, old age home, construction workers, homes for destitute, homeless people, tribal people, prisons, drug addicts, sex workers, diabetic will be screened by ASHA workers & TBHV. 3. Sensitization training will be given to ASHAs and TBHVs for conducting Household level/ symptomatic screening of the TB cases by the District NTEP. 4. 1 ACF coordinator per state will work with DTOs to prepare monthly microplan for carrying out ACF. 5. Microplan will be prepared in a manner that at least 10 working days in a month are dedicated for conducting x rays where at least 40 x rays done each month. 6. As per the microplan, all the presumptive cases will be asked to collect at one of the identified sites like school/community hall/ PHC/ Sub health and wellness center etc. by the ASHA workers & TBHV. 7. Radiographer preferably (Lab Technician, TBHV, Nurse etc) trained for taking x rays through the portable x ray machine will take the chest x ray impressions of the presumptive cases and generate AI reports. 8. Since, the teams will work in the PPSA assigned districts thus, early morning sputum collection of all those who are x ray positive will be done by PPSA staff and same will be transported to the NAAT site for testing. 9. Line list of all x ray positives and of those whose sputum is collected will be shared with the DTO by the ACF coordinator. 10. All those diagnosed to have TB either through NAAT result or clinically diagnosed will be initiated on treatment by District NTEP team. 11. District NTEP team will follow up the patient and initiate public health action. 12. All the contacts will be given TPT as per the protocol |
| Population, geographies and/or barriers addressed | **ACF in KVPs:** The proposed interventions related to ACF will address the barriers of access to quality screening (an algorithm including symptomatic screening for TB presumptive together with Ultraportable CXR); community awareness and participation, breaking stigma, addressing inequities in access to screening and diagnostic services.  NGPRs SAATHII and HLFPPT will implement the **ACF activities** in the following geographies:   |  |  |  | | --- | --- | --- | | **PR** | **States (Number and Names)** | **Districts** | | SAATHII  Urban/ Slums/ Rural | 8 (Andhra Pradesh, Assam, Chhattisgarh, Haryana, Karnataka, Punjab, Rajasthan, and Telangana) | 60 | | HLFPPT  Urban/ Rural | 6 States (Uttar Pradesh, Maharashtra, Orissa, Chhattisgarh, Gujrat, Rajasthan) | 58 | | DFY  Urban/ Rural | 3 states (UP, Bihar, Maharashtra) | 18 |   The population targeted for ACF will include socio-economically and occupationally vulnerable and high-risk populations for TB, such as slums, industries, localised pockets with malnourished children, tribal hamlets, high TB load pockets, and in prisons. |
| Amount requested | **US$ 4.59 Million (HLFPPT – 1.69 M; DFY – 1.56 M; SAATHII – 1.34 M)** |
| Expected outcome | Out of the total population in selected states/districts, 5% will consist of Key Vulnerable Populations (KVP), who will undergo verbal screening as part of the ACF activities conducted by NTEP. Among this 5% KVP, 0.9% will be identified as chest symptomatic individuals, and they will undergo screening using CXRays, including Ultraportable X-rays when available, administered by the NGPRs. Furthermore, these chest symptomatic individuals will also undergo TB diagnostics through NTEP. Ultimately, 10% of the chest symptomatic individuals will be diagnosed as TB patients and initiated on treatment.  It is expected that DFY will notify 4578 TB cases, HFLPPT 16868 and SAATHI 11411 TB cases in three year through the ACF intervention. |
| Intervention 5C | **KVP - People in prisons/jails/detention centers;** Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| Context and rationale | Tuberculosis (TB) remains a significant public health concern, especially within vulnerable populations like prison inmates. Overcrowding, inadequate healthcare access, and high-risk behaviours in prison settings contribute to the spread of TB. Active case finding is a proactive strategy to identify and treat TB cases early, thereby preventing transmission and improving health outcomes. There are approximately 150 prisons and 250,000 inmates across the country. By implementing an active case finding program for TB among vulnerable prison inmates, we can mitigate the impact of TB in both the prison environment and the broader community. |
| List of activities | 1. The activity will be **leveraging the Prison intervention** being undertaken in 15 states under the National AIDS Control Program by PR. 2. **Coordination between health systems:** Project team will coordinate with the prison health system and district health authority for systematic TB screening on periodic basis in each prison. Hand-held X-ray on wheels will be prioritized for TB screening. Health and non-health staff working in prison will be oriented to identify presumptive TB, establish linkages for TB diagnostics and treatment. 3. **Screening Campaigns:** Regular (biannual) and systematic TB screening campaigns will be conducted using methods such as chest X-rays (using the ultra-portable Xray machines where available or linking with the district hospital), and symptom assessment. These campaigns will target all inmates, particularly focusing on vulnerable groups such as those with HIV, substance abuse issues, or compromised immune systems. 4. **Symptom Education:** Education will be provided to inmates and prison staff about TB symptoms, transmission, and the importance of early detection. This can empower individuals to seek help when experiencing symptoms and reduce the stigma associated with TB. 5. **Contact Tracing:** individuals who have been in close contact with confirmed TB cases will be identified and tested. This is crucial for identifying latent TB infections and preventing their progression to active disease. 6. **Infection Control Measures:** Implement infection control protocols within the prison to reduce the risk of TB transmission. This may involve improving ventilation, ensuring proper hygiene, and providing access to masks for symptomatic individuals. 7. **Collaboration with Healthcare Providers:** Strong collaboration between prison healthcare staff and NTEP staff will be established to ensure proper diagnosis, treatment, and follow-up for TB cases. 8. **Treatment and Monitoring:** Adequate treatment and monitoring will be provided for diagnosed TB cases within the prison. It will be ensured that medication regimens are followed and that patients receive appropriate medical care throughout their treatment journey. |
| Population, geographies and/or barriers addressed | **Population, geographies:** Total 150 prison with estimated 295000 inmates across 15 states covered under the HIV program covering 76 districts will be covered through this intervention. **Barriers addressed:** The intervention will address barriers such as limited healthcare infrastructure and access to quality TB care services within prisons, lack of awareness about TB, and challenges in accessing timely diagnosis and treatment of TB. |
| Amount requested | **US$ 0.01 Million (HLFPPT)** |
| Expected outcome | **a) Early Detection and Treatment:** Active case finding among prisons will be conducted using symptom screening of 118034 inmates, 165248 and 188854 inmates in year 1, year 2 and year 3 respectively. Intervention estimates to identify 5902, 8262 and 9443 symptomatics among screened in year 1, 2 and 3. These inmates will then undergo chest X-rays using ultra-portable X-rays or rapid molecular test, based on the availability of the X-ray machine. Through this intervention a total of 944 (236, 330 and 378) TB cases may be reported over the three years resulting in early detection of TB cases, while enabling timely treatment and reducing the risk of transmission within the prison and the community upon release.  **b) Reduced TB Transmission:** By identifying and isolating active cases promptly, the program will help curb the spread of TB within the prison environment, protecting both inmates and staff.  **c) Improved Inmate Health:** Vulnerable inmates with TB will receive proper medical attention and treatment, leading to improved health outcomes and quality of life.  **d) Community Protection:** By addressing TB within prisons, the initiative contributes to preventing the transmission of TB to the broader community once inmates are released.  **e) Enhanced Institutional Awareness:** Implementing active case finding will raise awareness about TB among both inmates and staff, promoting a culture of health and disease prevention within the prison.  f) **The intervention aims to detect 1000 (250 (Y1), 350 (Y2), and 400 (Y3))TB patients among the prisoners over the three years.** |

|  |  |
| --- | --- |
| MODULE 6 | Removing Human Rights and Gender-related Barriers to TB Services |
| Context and rationale | Central TB Division (CTD), developed the national strategy document, “Ending Stigma and discrimination associated with TB” in March 2021. A training module based on this strategy document is developed by the NG PR, KHPT through a USAID funded Breaking the Barriers project, in collaboration with CTD, State NTEP of Karnataka and Telangana and GCTA in 2022/2023. |
| Intervention  6A | **Eliminating TB-related stigma and discrimination**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| List of activities | 1. In the proposed intervention, **NGPR KHPT**, will develop **a field guide to mitigate stigma and discrimination against TB based on the National strategy**. This field guide will be developed through a **national consultation workshop** in Delhi, in the year one of the project period, with community leaders, CTD officials and civil society organisations. 2. The developed field guide to mitigate stigma and discrimination associated with TB will be used in all the intensive intervention districts for orienting the community stakeholders and elected representatives. The same will be scaled up in the 14 intervention states and later this will be scaled across all the states and UTs of the country. 3. **At the sub-national level, district level orientation** and implementation will be undertaken by **orientation of the community coordinators** (CC) on the usage of the field guide. Further, **block level orientation programs** for **local self-government** **representatives like the elected representatives in Gram Panchayats and Urban local bodies**, **community leaders, TB champions, leaders of Self-Help groups, ASHAs, ANMs, Community Health officers (CHOs) of Health and wellness centres (HWCs) (refer footnote 9 for more information)**, about the field guide on mitigating stigma and discrimination associated with TB. **Grassroot level oath taking** “to mitigate stigma and discrimination associated with TB” will be undertaken by all community stakeholders and elected representatives during important national days like Independence Day, Republic Day, World TB day, National Panchayati Raj day, Mahatma Gandhi birth anniversary day, World Health Day. |
| Population, geographies and/or barriers addressed | * 297 million population from 98 districts of 14 States & 1 UT (Karnataka, Assam, Bihar, Telangana, Haryana, Punjab, Chandigarh, Uttar Pradesh, Himachal Pradesh, Uttarakhand, Delhi, Rajasthan, Gujarat, Madhya Pradesh and West Bengal). * Intervention districts will be selected by the guidance of Central TB division and State governments. |
| Amount requested | **US$ 0.012 Million (KHPT)** |
| Expected outcome | 60% of community leaders, leaders of Self-Help groups, elected representatives in Gram Panchayats and Urban local bodies, ASHAs, ANMs, Community Health officers (CHOs) of Health and wellness centres of intervention districts will be oriented through the field guide on stigma and discrimination associated with TB. |

|  |  |
| --- | --- |
| MODULE 7 | RSSH: Community Systems Strengthening |
| Context and rationale | The NG PR KHPT will **support the achievement of the goals of** **Pradhan Mantri TB Mukt Bharat Abhiyaan (PMTBMBA)” [[8]](#footnote-9) (Prime Ministers TB Free India Mission)**. The initiative will extend human resources and technical assistance to governmental systems on both the national and state levels. At the state and district levels, the plan includes offering technical support to health administrations in order to **reinforce the connections between Ni-Kshay Mitra and patients, along with facilitating the delivery of nutrition packets through collaboration with NGOs and community engagement efforts**. The development of training materials and modules for community-driven training will be undertaken under the guidance of the Central TB Division (CTD).  Support will be channelled towards states and union territories (UTs) to **enhance the allocation and utilization of budgets for community engagement.** Additionally, efforts will be directed towards **strengthening the functionality of TB Forums and networks led by TB survivors at various tiers** to ensure that these meetings align with the overarching objectives of the TB program. The core aim of capacity-building and network reinforcement is to establish sustainable community structures that bridge the gap between the TB program and the affected communities.  On the national level, the initiative will involve orientation sessions regarding PMTBMBA for stakeholders, as well as workshops that combine review discussions and experience sharing. Similarly, at the state level, a series of 25 orientation workshops will be conducted. The project extends its support to states and districts in identifying Ni-Kshay Mitra and establishing connections with TB patients. Furthermore, assistance will be provided to state and district health departments in bolstering the data management, monitoring, and reporting systems aligned with PMTBMBA. This involves the measurement and monitoring of treatment outcomes, including parameters such as weight gain, mid-upper arm circumference, and body mass index, following the provision of nutrition support.  The proposed intervention outlines **Community Engagement interventions** that will involve interaction with Panchayat Raj Institutions (PRIs) in rural areas and urban local bodies (ULBs) in urban areas, adopting context-specific strategies that address unique barriers presented by these differing settings. PRIs and ULBs serve as formal structures that hold influence at the grassroots level while shouldering the responsibility for the welfare of communities within their regions. Thus, the project emphasizes empowering these statutory bodies to prioritize TB, facilitate coordinated efforts across programs, optimize resource utilization, and strategically approach the objective of achieving a healthy and TB-free panchayat/urban area.  The efforts undertaken in the previous year (2022) for building community engagement capacity under the National TB Elimination Program (NTEP) have shown significant progress, resulting in nationwide community engagement initiatives. The National TB program aims to **engage TB survivors as champions in the fight against TB, particularly at the level of Ayushman Bharat Health and Wellness Centers (AB-HWCs)[[9]](#footnote-10),** ensuring support from trained TB champions for all notified TB patients and assisting Gram Panchayats in becoming TB-free. This initiative seeks to train and mobilize a total of 300,000 TB champions as part of the “Jan Andolan” (peoples movement) to eliminate TB, with over 85,000 potential champions already identified by AB-HWCs. Collaboration with the Central TB Division and State NTEPs will facilitate the identification, training, and involvement of potential TB champions in District and State TB forums.  Aligned with the NTEP's vision of having two trained TB Champions linked to each Health and Wellness Centre across 11 states, the project aims to train 31,000 TB champions in the family caregiver model. These trained champions will play a vital role in providing personalized care to individuals with TB and actively participating in district and state TB forums, ultimately contributing to the comprehensive effort to combat TB effectively. |
| Intervention  7A | **Community engagement, linkages, and coordination**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| List of activities | 1. **KHPT** will support the achievement of the goals of **Pradhan Mantri TB Mukt Bharat Abhiyaan (PMTBMBA)”** [[10]](#footnote-11)(Prime Ministers TB Free India Mission). **Human resource and technical assistance** **will be provided to government systems at National and state level**. Technical assistance will be provided to state and district level health administration **to strengthen linkages between Ni-Kshay Mitra and patients and also nutrition packet delivery** through NGO and community engagement. Training packages and modules for **community-led training** will be developed under the guidance of the CTD. Support will be provided to states and UTs to **strengthen allocation and utilization of budgets for community engagement**. At the national level **orientation on PMTBMBA for stakeholders, and review meeting cum experience sharing workshop** will be conducted. Similarly, at the State level, orientation workshops will be conducted. The states and districts will also be supported for identification of Ni-Kshay Mitra and their linkage to the TB patients. 2. **KHPT** will also support the **community engagement efforts in TB elimination efforts by involving the Panchayati Raj Institutions (PRIs)** which are the local self-governments in rural areas and with **urban local bodies (ULBs)** with differential approaches that work best to address the barriers in these distinct scenarios, which also have a general epidemiological difference. Rural local self-governments and Urban local bodies are the formal structures, influential at the grassroots and, at the same time, responsible for the well-being of communities in their geographies. Therefore, the **intervention at the district, state and national levels will focus on equipping and empowering these statutory institutions to prioritize TB, effectively converge efforts between programs at functionaries for TB prevention, optimally utilize the resources available to them and strategically plan their approach to achieving a healthy and TB-free panchayat/urban area**.    1. **At the district (intensive intervention districts) level community-led mass awareness campaigns** will be organized **to dispel misconceptions about TB and address stigma,** led by NGS[[11]](#footnote-12), PRIs and ULBs. The intervention will reach representatives from 4846 Gram Panchayats and ULBs. **Community-led enhanced case finding and case holding** will be **intensified** by:       1. **Mapping of panchayat and ward areas** in the districts to ear mark (1) formal and informal community structures such as self-help groups, youth associations, labor associations etc. (ii) service delivery points such as health and wellness centres, PHIs etc. This mapping exercise will be done by PRI and ULBs in collaboration with CHOs of Health and Wellness centres. Tools for micro-planning exercise will be developed and CHOs/PRI representatives will be capacitated to develop micro plan for each GP/Ward. TB and comorbidities screening camps in coordination with Health and wellness centers/ Urban Health facilities will be organized to facilitate referrals for testing for TB or other comorbidities. Implementation of already developed behavior change tools for case find and case holding such as TB Shoochana (**mass awareness in the form of audio jingles and short messages**), Jaanch Coupon (**behaviour nudge for accessing health facility for TB testing**), and Treatment Completion Certificate (**adherence motivation and stigma mitigation**).       2. Graduating towards **TB Mukt GP/Wards (TB Free village/urban wards)** byorganizing District Panchayat meetings at the district for all Block Panchayats. (Jointly by District Tuberculosis Officer (DTO) and District Panchayati Raj Officer (DPRO). Facilitating the regular block and District TB Forums, with participation of TB champions, CHOs, PRI and ULB members. Quarterly monitoring of ULBs which is a pre-requisite for TB Mukt Ward status based on a checklist during JAS meetings. Importantly activities for TB free village/ward will be included in the Panchayat Development Plans (PDP) of the villages and urban local bodies. They Gram Panchayats/ULB will be supported to submit claim to district for TB Mukt Panchayat/TB Mukt Ward verification as well as in the assessment of Gram Panchayat and ULBs to be declared as TB Mukt. 3. **At the State level (in project states) technical support will be provided to States for strategizing and working towards achieving TB Mukt (free) GPs and TB Urban local bodies (ULBs) and effectively implement TB champion engagement.** Activities will be undertaken to **enhance convergence of actions** and aggressively push for TB free GPs and ULBs. This will include liaising with state programme and the **Department of Panchayat Raj Institutions and Department of Municipal administration** for better convergence in the state to scale up TB Mukt interventions in collaboration with the other line departments. **MoUs will be executed with different line departments** at the State level. TB Mukt activities will be incorporated in Panchayat Development plans and ULB development plans. For **communication and knowledge management,** annual state level learning and sharing workshops will be organized. Materials (Inter-personal Communication, Mid and Mass media, digital media) on TB and Health will be adapted for local use. 4. **At the National level a project management Unit (PMU) will be established.** The PMU will closely work with CTD in seeking support for the project and regularly cross-share the project experiences and learnings at the central level. This operating unit is proposed to streamline the decision-making process by making it consultative and transparent. Innovations will be developed and demonstrated. The activities in the PMU level will include supporting the states in **documentation and knowledge management which will include** mapping and identifying vulnerable population clusters in intervention districts and urban areas, enhance the quality of implementation by supportive supervision and monitoring of States/districts, adapting and developing the communication materials (Inter-personal communication, Mid and Mass media, digital media) on TB and Health, documentation of proven best practices and dissemination across the country and conceptualizing and implementing concurrent monitoring and implementation research activities in the intensive intervention districts. In addition, **convergence will be promoted** by liaising with NTEP and the department of Panchayat Raj Institutions, Urban Local Bodies other line departments for better convergence. National level platforms will be organized for sharing the experiences and technical support to scale the interventions across the country with the support of CTD. National level advocacy will be accelerated for including TB Mukt activities in Panchayat Development plans |
| Population, geographies and/or barriers addressed | * Activity 1 will be pan India. * Activity 2 will cover 98 districts of 14 States & 1 UT (Karnataka, Assam, Bihar, Telangana, Haryana, Punjab, Chandigarh, Uttar Pradesh, Himachal Pradesh, Uttarakhand, Delhi, Rajasthan, Gujarat, Madhya Pradesh and West Bengal). The intervention districts will be selected in discussion with Central TB division and State governments. |
| Amount requested | **Total: US$ 8.86 Million (KHPT)** |
| Expected outcome | **Activity 1 outcomes** include:   * Ensuring that 80% of TB patients who have consented to receive support will be receiving support from Ni-Kshay Mitra under PMTBMBA * Establishing TB community group at each State and high burden district for facilitating linkage of TB patients with Ni-Kshay Mitra. * Increase in the numbers of Ni-Kshay Mitras   **Activity 2 outcomes** include:   * 80% (Y3) of the GPs/ULBs included TB Mukt activities in their annual Panchayat development Plan / ULB plans in the 8 intervention districts across 8 States. * 60% of the GPs/ULBs will submit claim to district for TB Mukt Panchayat / TB Mukt Ward verification and certification, in the 13 intervention districts across 13 states. * 300000 TB patients will be linked to family care giver by 31000 trained TB Champions * 60% of the TB champions will actively participate in District and State TB forums |
| Intervention  7B | **Capacity building and leadership development**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| List of activities | **Training of TB champions, PRI and Urban local bodies: The** NG PR KHPT will support the involvement of PRI and Urban local body leader’s orientation programs on TB. Also, the CHOs in Health and wellness centres, TB Champions will be oriented in engaging family caregivers in supporting PWTB.   * 1. **District level activities** (in intensive intervention districts)      1. Conduct **trainings for GP members and ULB team** on health and TB and their roles and responsibilities. (**Representatives from 4846 GPs**)      2. Facilitate **joint review and reflection mechanisms** involving PRI/ULB/HWC/WCD/line Department representatives.      3. Organise **orientation trainings to CHOs, 31000 TB champions** in engagement of family caregivers in supporting PWTB, through self-learning modules or virtual platforms provided by CTD.      4. **Build the capacity of TB-affected communities in 98 districts across 14 states and one urban UT through a decentralised approach at the Health and Wellness Centre/village levels**,      5. **Identification and training of over 31000 TB survivors as TB Champions across 98 districts** through a decentralised approach at the district/sub-district level. In line with the NTEP’s vision, this will result in about two trained TB Champions linked per Health and Wellness Centre across 14 states and one UT.      6. **Strengthening District TB forums by including TBCs:** The project will strengthen the district TB forums in the 98 intervention districts through conducting periodic meeting.   2. **State level activities** (in project states) through **state level technical support to State level NTEP** to strategize and work towards achieving TB Mukt GPs and TB Urban local bodies.      1. **Adaptation of training materials** for capacitating Gram Panchayat and ULB representatives, Frontline workers and community structure leaders on Health, TB, and their roles and responsibilities.      2. Facilitate State level **ToTs for training of District Nodal officers**. These officers will be responsible for capacitating Gram Panchayat and ULB representatives and other informal community structures on Health, TB, and their roles and responsibilities.      3. Creation **master trainer’s pool at the District and State level** to facilitate training of frontline workers in the project area.      4. Supportive supervision and monitoring of district/s to enhance the quality of the implementation.      5. State specific innovations will be developed and demonstrated.   3. **National level activities** (collaborate with Central TB division and reach all states in the country)      1. Develop **training materials** for the project interventions in consultation with CTD.      2. Strategize and implement **capacity building interventions** under the project in consultation with National NTEP      3. Ensure **quality of trainings** carried out in the States.      4. Facilitate **scale up of training** in non-intervention States and UTs.      5. State specific innovations will be compiled and advocated |
| Population, geographies and/or barriers addressed | * **KHPT** will implement TBC training, PRI training & ULB training on Health, TB covering 297 million population from 98 districts of 14 States & 1 UT (Karnataka, Assam, Bihar, Telangana, Haryana, Punjab, Chandigarh, Uttar Pradesh, Himachal Pradesh, Uttarakhand, Delhi, Rajasthan, Gujarat, Madhya Pradesh, and West Bengal). |
| Amount requested | **US$ 1.29 Million (KHPT)** |
| Expected outcome | * 70% (3392) of the total Gram Panchayats (4846) in the interventions districts will initiate GPs Ni-kshay Gram Sabha (NGS) involving TB champions, and CHOs by the end of the project period. * 100% of GP members oriented on health and TB and their roles and responsibilities. (Minimum one representative- Nodal person from 4846 GPs). * 80% of the GPs/ULBs included TB Mukt activities in their annual Panchayat development Plan / ULB plans in the 13 intervention districts across 13 States. * 60% of the GPs/ULBs will submit claim to district for TB Mukt Panchayat / TB Mukt Ward verification and certification, in the 13 intervention districts across 13 states. * 60% of the TB champions will be involved in family care support. * 60% of the TB champions will actively participate in District and State TB forums. * Technical support will be provided for technical support to the states on linkage for Skill development.in the 6 states. |

|  |  |
| --- | --- |
| MODULE 8 | RSSH: Health Financing Systems |
| Intervention  8A | **Public financial management (PFM) systems**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| CONTEXT AND RATIONALE | Ni-Kshay Poshan Yojana (NPY) is a priority scheme for NTEP wherein rigorous efforts are put in to ensure timely direct benefit transfer (DBT) to all beneficiaries through the Government’s Public Financial Management system (PFMS). The Union is giving technical support to DBT in 17 states and 6 UTs through regional consultants. The Union has also supported Single Nodal Agency (SNA), introduced for fund monitoring at the state level and fund allocation throughout the districts which will be transitioned to the new PR KHPT. The PFMS team ensures the timely completion of this activity. However, certain gaps need to be addressed, like delays in payments due to administrative (lack of funds, lack of trained HR) or technical constraints at the bank level, PFMS structure, Ni-Kshay portal updating, etc. The PFMS technical consultants support the States in solving these day-to-day issues in strong coordination with the national team and monitor the issues until they are resolved. There is a strong felt need to continue this support with further expansion to all States for streamlining the DBT process. |
| List of activities | **Technical support for PFMS and DBT:** The interventionproposes to continue 1 National Consultant, and an additional 17 State consultants including regional consultants to extend technical support to States/UTs. |
| Population, geographies and/or barriers addressed | Pan India  NGPR KHPT is undertaking this activity. |
| Amount requested | **US$ 0.89 Million (KHPT)** |
| Expected outcome | Technical Assistance to all states for 100% implementation of PFMS |

|  |  |
| --- | --- |
| MODULE 9 | RSSH: Monitoring and Evaluation Systems |
| Intervention  9A | **Surveillance, Analyses, evaluations, reviews and data use**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| CONTEXT AND RATIONALE | **Sub-national surveillance** is an important path to elimination. CTD is implementing the **Sub-National Certification of Progress Towards TB Free Status** since FY 2020-21. Under this initiative, districts/States/UTs can claim for awards under various categories of reduction in TB incidence from 2015. **MoHFW awards these districts/States/UTs after verifying the claim through an independent agency.** The initiative promotes both district level TB burden estimation as well as incentives for good performance and a healthy competition among the districts and States. The protocol for verification of the SNC claim is same as that of DLAS. It is planned to be continued over the next grant period 2024 - 2027.  In 2021, A total of 10 States/UTs and 201 districts across the country submitted claims under various categories in 2021. Following the verification process by by a national team composed of personnel from ICMR National Institute of Epidemiology, ICMR- National Institute for Research in TB, WHO India and Indian Association of Preventive and Social Medicine., the States/UTs of Kerala, Dadra and Nagar Haveli and Daman and Diu, Puducherry were awarded “Silver” category award (achieving more than 40% reduction in TB incidence) and “Bronze” category-award (achieving more than 20% reduction in TB incidence) was awarded to Gujarat, Himachal Pradesh, Sikkim, Tripura and Ladakh. Also, 91 districts were awarded in various categories, Gold - 8, Silver-27 and Bronze-56, respectively |
| List of activities | **The CTD will undertake the following activities:**   1. **District Level Annual Survey (DLAS) -** To measure the prevalence of newly diagnosed bacteriologically positive pulmonary TB in the community to cover the districts which are submitting claims for Sub-National Certification of Progress Towards TB Free Status. 2. **District Level Sentinel Survey (DLSS) -** To measure the country level TB prevalence in general population and in key population |
| Amount requested | **US$ 10.29 Million (CTD through SR)** |
| Expected outcome | This burden estimation exercise will be made as an annual event **for re-calibrating the strategies of the states and districts.** In addition to the District Level Annual surveys, District Level Sentinel Surveys (DLSS) will be done to supplement the estimates. |

|  |  |
| --- | --- |
| MODULE 10 | Programme Management |
| Intervention  10 A | **Grant Management**  Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| List of activities | 1. **Quarterly monitoring meetings** by PRs and SRs at different levels to ensure the coordination and integration among all stakeholders. 2. To ensure the quality of the programme implementation, **regular/ periodic/ routine monitoring and supervision related travels** at different levels of healthcare by PRs will be performed. 3. Coordination meeting for **programme review** of all districts/states conducted by the STO/DTO and PR/SR representatives to assess the programme performance and provide resolution to the same. 4. As per the policy of The Global Fund, **external audit** is being performed annually which will also continue during the next grant cycle. 5. **Office expenditure** – communication, rent, utilities, 6. **HR recruitment costs** 7. **Programme Management Unit associated costs** |
| Population, geographies and/or barriers addressed | Pan India |
| Amount requested | **US$ 11.42 Million (HLFPPT – 2.17 M; DFY – 2.07 M; SAATHII – 2.48 M; KHPT – 3.94 ; TISS – 0.76 M)** |
| Expected outcome | This will ensure that the grant is managed efficiently from the beginning to end of the grant utilization period. All agreed upon deliverables including reports are of good quality, generated and sent timely to GF and MOH.  Improved coordination, and collaboration between all PR, SRs, NTEP at all levels for TB elimination and prevention in India. Collaborative approaches will promote strategic and operational planning at various levels e.g., governance, health systems management and service delivery and contribute to RSSH. |

**B. If you are using a Payment for Results modality, provide information on the performance indicators/milestones, targets and amounts that are proposed.**

***Note from the NTEP: Kindly note that the rationale for the selection of the indicator/milestone, and how the accuracy and reliability of the reported results will be ensured, has been provided in a separate table below thereby altering the original table configuration.***

| **Performance indicator or milestone** | **Target** | | | | **Amount requested** | **Expected outcome** |
| --- | --- | --- | --- | --- | --- | --- |
| **Baseline** | **Y1** | **Y2** | **Y3** |  |  |
| **DLI 1:** Number of patients with RR-TB and/or MDR-TB that began second-line treatment | 58918 | 67181 | 66159 | 58555 | **US$ 72.09 million** |  |
| **DLI 2:** A treatment success rate of RR TB and/or MDR-TB: Percentage of cases with RR and/or MDR-TB successfully treated | 66% | 70% | 72% | 75% | **US$ 40.51 million** | Improved Treatment success rate and reduction in proportion of RR/MDR among incident TB cases |
| **DLI 3:** Number of persons who received a molecular diagnostic test | 5,848,869 | 6,500,000 | 7,000,000 | 7,500,000 | **US$ 34.73 million** | Improved bacteriological confirmation of notified TB cases |
| **DLI 4:** Number of persons initiated on TB Preventive Treatment | 1,455,957 | 2,500,000 | 3,600,000 | 4,500,000 | **US$ 97.64 million** | Enhanced coverage of TPT and Reduction in the incidence rate of TB |
| ***Total*** | | | | | **US$ 245 million** |  |

**Rationale for selection of the indicator/milestone:**

**The overall rationale for selection of each indicator** is that these are in alignment with thepriority activities from National Strategic Plan 2020-2025 with direct measurable impact on TB epidemic. As a high level approach, we have considered the impact of reducing TB incidence and mortality at the required pace to achieve SDG targets by 2025 or reach close. The DLIs reflect critical issues for the NTEP, are quantitative in nature and hence easily measured. The programme collects the data of the indicators in its routine M&E activities though NIKSHAY. This makes its easily available and verifiable thereby making it cost effective to collect.

| **Performance indicator or milestone** | **Rationale for selection of the indicator/milestone** | **Specify how the accuracy and reliability of the reported results will be ensured.** |
| --- | --- | --- |
|
| DLI 1: Number of patients with RR-TB and/or MDR-TB that began second-line treatment | * In recent years, the country has made far-reaching progress in the management of TB, including DR-TB and scaling up shorter oral regimens across the country. However, it continues to be a high DR TB burden country. * Offering prompt rapid molecular tests and treatment with shorter and safer regimens will ensure the country can address the problem. | * Nikshay ensures internal data validation at the time of data entry by the user; using a number of protocols and algorithms. Reports are calculated automatically based on data entered into the system. Thus validation is required only at the data source. This gives the NTEP the opportunity to move into an era where data validation is primarily done with external data sources. * External data sources include direct interviews with patients and any records or registers maintained at the point of information generation such as investigation reports etc.In addition, all S,M&E activities are carried out using two methods, i.e. the patient visit and the health facility visit. The data verification components are also embedded in these two methods of SM&E. * The routine reports of the programme will be utilized and cross validated with the related standard indicators reported in Nikshay for concurrence. * NTEP will also strengthen the existing patient feedback mechanisms as well as establishing newer mechanisms, if needed, to capture patient feedback on quality of services. * Regular measurement of quality will also be undertaken through internal checks, indicators and reviews to ensure that quality of care is central to all efforts, strategies and course-corrections. Suitable grievance redressal mechanisms is also being developed. |
| DLI2: Percentage of cases with RR and/or MDR-TB successfully treated | * The scaling up of rapid molecular tests (DLI 3) along with newer, shorter treatment regimen for DR TB will enhance the effective programmatic management of DR TB in the country where DR TB is a major problem. |
| DLI 3: Number of TB patients who received a molecular diagnostic test upfront | * Quality-assured diagnostic services are the hallmark of NTEP. * Newer technologies for TB diagnosis diagnostic services and detection of drug resistance have been introduced and suitably placed in the recently revised diagnostic algorithm, to aid prompt initiation of appropriate treatment regimen. * Offering upfront NAAT for diagnosis of TB has been a programme policy, a standard of care, and also prioritized by the programme. * By 2022, NAAT facilities in the country were increased from 3760 in 2021 to 5090. Also, in the same year, 5.848 million NAAT tests were conducted, which are to be augmented to meet the PF targets of a total of **21 million NAAT tests** performed over the three years. * Owing to the programme policy, need, priority, updated diagnostic algorithm, this indicator has been selected as a DLI. |
| DLI 4: Number of persons initiated on TB Preventive Treatment | * ‘Prevent’ is one of the four critical pillars (Detect – Treat – Prevent – Build) of India’s NSP 2017-2025 that focuses on preventing the emergence of TB disease in a vulnerable population. The task of TB Prevention Treatment (TPT) scale-up has been taken up in 2022. By the end of 2022, 722 (94%) districts of India have expanded TPT as per the national guidelines. * All the modelling exercises for achieving the TB related SDG targets for 2030 stress the need for TB preventive treatment to be scaled up significantly for bending the incidence curve meaningfully, in the absence of a TB vaccine. * Additionally, 476 (62%) districts have expanded TPT in eligible house-hold contacts (HHC) after ruling out active TB while awaiting establishment of TBI testing services. The rest of the 41 (6%) districts have planned to expand TPT services by first quarter of 2023. TPT coverage increased considerably after the expansion of services by geography and high-risk groups. More than 1.392 million eligible household contacts and PLHIV were put on TPT in 2022. To continue the ambitious pace of expansion an additional 10.60 million persons will be initiated on TPT is being proposed as a DLI. |

*Countries should discuss with their country teams if they are considering the use of a Payment for Results modality as the basis of the funding request.*

1.2 Rationale

A**. Describe the overall approach to how you selected and prioritized the requested interventions (or indicator/milestone if using a Payments for Results modality).**

Much of the priority-setting process for this funding request application for the grant cycle 2023-2025 is built on the findings from the recent prevalence survey 2019, priority activities from National Strategic Plan 2020-2025 with direct measurable impact on TB epidemic, learnings from the national response to COVID 19 pandemic especially to those related to TB, situation analysis and population consultation phases, closely examining the evidence generated as well as those analysed during these processes. In addition, a TB-specific transmission-based compartmental mathematical model was adapted to the Indian context to understand the dynamics of coverage of different interventions and their impact on TB incidence. The model inputs are based on expert consultations and the overall country target achievements. The models demonstrate a range of projected future estimations, providing assumptions for target estimation in the PF.

Based on the interplay of coverage of services, its impact on TB burden and resource requirements, strategic interventions that are best suited to decrease incidence at the available resources have been prioritized and will be implemented in the country. The interventions have also been prioritized based on recommendations of the Joint Monitoring Mission in 2019 (chapter 3 NSP), Central Internal Evaluations over the last three years, various donor missions, and programme evaluations conducted by the Central TB Division.

Having adopted a full review approach, this FR proposal has prioritized interventions that address the critical gaps in TB care related to ensuring Universal access to TB care services through the expansion of rapid molecular tests, treatment of DS and DR TB specifically increasing the coverage with second-line drugs, countrywide saturation with TPT services, and community engagement and empowerment.

Other key factors considered ensure that t**he** **prioritized interventions are directly linked to outcomes:**

* 1. Increase TB case notification with intensified case finding, community contact investigation, and decentralization of rapid molecular tests (TrueNat) to the Ayushman Health and Wellness Center level (AB-HWCs).
  2. Increase DRTB treatment outcomes by supporting treatment adherence, and safer, shorter regimens.
  3. Increase the coverage of TB preventive treatment among household contacts, PLHIV, and people with immunosuppressed condition.

1. **Priority interventions with financial gaps that have the potential to be transitioned and sustained by domestic resources** in the future:
   1. Demonstration models for PMTPT proposed under this grant are envisaged to be transitioned to the NTEP based on the outcomes and learnings from these models.
   2. DR-TB service and TB laboratory capacity expansion
2. **Intervention to strengthen community systems and processes** to reduce barriers to TB care, such as stigma and discrimination, and ensure the rights of TB patients. It will also innovate approaches that can be implemented by community actors to improve TB program effectiveness. To ensure the selected interventions produce the desired results, community empowerment and engagement mechanisms receive special attention in this FR. State and District level TB Forums have been formed to provide platform for TB champions to execute their role which ensures the “voice” of the community is heard, issues addressed timely, stigma addressed and community responses necessary for a rights-based and gender sensitive care for people with TB are undertaken.
3. **Interventions that have worked well in the past**, like the PPSA mechanism are being transitioned to domestic resources over a period of 6 to 9 months in the first year of proposed grant.
4. Considering the rapid scale-up of molecular diagnostics, the National programme will **move for TB Preventive Treatment for contacts of DR-TB patients based on drug susceptibility patterns of index cases**.
5. The other factors in the selection of performance indicators considered the indicator’s **ability to accurately measure programme performance in a time-bound manner** given the **availability on Ni-kShay**, **direct measure** of the programme’s proposed intervention, **usefulness in informing decision making at all relevant levels**, reflects **the interests of all stakeholders**, and an **agreement on the choice of indicators between NTEP partners**.

**B. Describe the decision process for interventions selected for allocation funding versus those included in the unfunded Prioritized Above Allocation Request.**

**The interventions selected for PAAR are the same as those in allocation funding. With the availability of additional funding from PAAR, the activities will be scaled up to cover newer geographies with vulnerable populations.**

1.3 Context

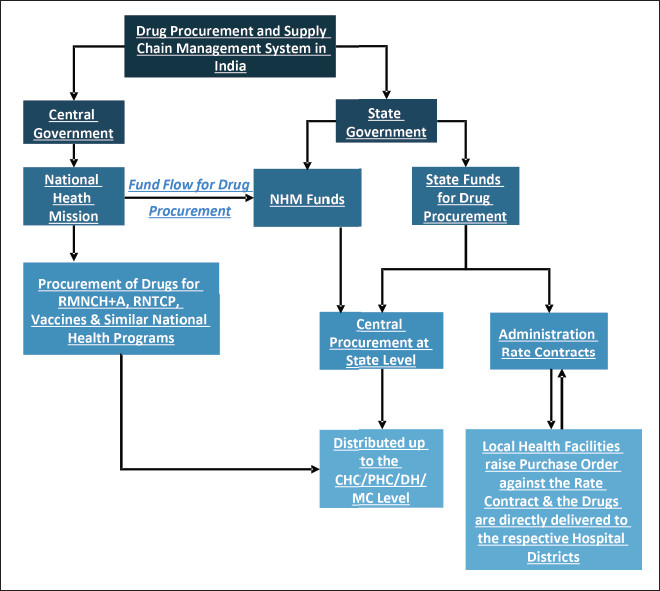
**Describe the main changes to the country context since the previous funding request submission to the Global Fund.**

Over the last three years the programme has worked on strengthening the systems and integrating it with other programmes for a multisectoral, holistic thrust on TB elimination as well as transforming NTEP into a resilient programme. The country has again demonstrated its global leadership on TB elimination efforts with events helmed by the Prime Minister himself. In September 2022, the president of the country launched the “Pradhan Mantri TB Mukt Bharat Abhiyan” - the Prime Ministers TB Free India Campaign” for community support to TB patients to provide people with TB and their families increased nutritional, diagnostic, and vocational support, delivered within the community. This effort at people centric TB care and attempt at a mass movement to eliminate TB are major changes in the context related to TB elimination in the country. The NTEP has also entered in an MOU with around 18 ministries/departments within the government for a holistic approach to addressing the determinants of TB that are outside the purview of the health sector.

The big changes that influenced this funding request are the National TB Prevalence Survey (NATBPS) 2019-2021 findings, the learnings from the COVID 19 response, and the performance of the programme with expansion of Ni-Kshay platform and e-enabled services for all sections of the society throughout the country. Moreover, the India CCM has selected 5 new PRs for implementing the GF grant activities as has been described in the Implementation arrangements (Section 3). This has necessitated the transition of some ongoing activities to the CTD and other PRs. The key among them are as follows:

In the current grant cycle, investments were made to strengthen the lab infrastructure and health product management systems, the progress and plan going forward are as follows:

1. **Lab refurbishment and upgradation:** 11 labs were identified for full renovation and 5 labs for partial renovation. As of now Guwahati (ongoing) and Kolkata (to be started in Dec 23 upon the request of CTD as the priority was to start the work in North East states, hence work at Guwahati has been started earlier) are to be completed. All the others are in final stages of completion (Agra, Siliguri – 100% works done; rest in final stages of completion – to be completed by Dec 2023).
2. **LIMS integration of NAAT testing with Nikshay** is ongoing and will be transitioned to CTD under the NIKSHAY umbrella.
3. The **EQA for NAAT** is being done by NTI, Bangalore which has already conducted EQA exercise and will lead the activity with the support of other 5 National Reference Labs.
4. The **certification for C&DST and LPA labs** has already been transitioned to CTD. The current PR FIND is only providing additional support.
5. **NABL accreditation and ISO 15189 accreditation of labs**: This activity will be transitioned under the programme budget through the PIP to ensure that labs currently accredited will maintain the quality standards and continue to mitigate biosafety risks.
6. And lastly, the **training and capacity building for lab staff** will be undertaken by NTI, which is already providing Lab training for all technologies at the National level. NRLs are also conducting need based training in the linked laboratories.
7. Another area of **importance has been the 3PL support for TB drugs and commodities supply chain** implemented by a PR PLAN India. This activity was historically undertaken by the existing mechanism of the health system. However, to build the capacity and streamline the processes 3PL support was solicited through GF investments. After 3 years of 3PL support, the programme now considers the capacity at the national and sub national levels adequate enough to revert back to the health system led supply chain management functions. TB drugs and commodities will be hitherto managed by CTD. The Nation has a comprehensive pharmaceutical supply chain in the public sector that is used by the various programmes at the National, and Sub national Levels. In India, the procurement of medicines and medical supplies takes place at various levels, including the national level (MoHFW), state health directorate, state-level autonomous government bodies and local government (Figure below). The central government has also enabled the establishment of a transparent IT-enabled system for procurement, supply chain management and quality assurance, to ensure highest levels of safety and quality of drugs.

Under NHM, financial and technical support is provided to the states for strengthening health systems, including provision of free essential drugs at public health facilities for the nationalized programmes, such as the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCHA+) Programme, NTEP, National AIDS Control Programme (NACP) and immunization programme.

The NTEP is integrated in the national health system and the TB stores are currently funded by domestic resources. The procurement of Anti TB drugs, equipment and diagnostics is planned, coordinated, and conducted centrally on an annual basis through a well-defined procurement mechanism.

The financial support for procurement is provided by Domestic Budgetary Source (DBS), World Bank (WB) and The Global Fund (TGF). While procurement of consumables is decentralized to the states, drugs may be procured by the states during emergencies subsequent to proper authorization from CTD. The procurement, supply chain and logistics activities at the central level are administered by the Additional Deputy Director General (TB) with support from procurement and supply chain consultants. A procurement agency M/s Central Medical Services Society (CMSS), an independent and autonomous body under MoHFW is responsible for ensuring all bidding procedures under the International Competitive Bidding (ICB) and supply of anti TB drugs to the consignees is completed in a timely manner. These Procurement Agents also ensure that drugs procured are compliant with the quality policy of the NTEP, WB and TGF. The SCM activities will be integrated in the NHM SCM mechanism as has been explained in the above note.

The COVID-19 pandemic has had a profound impact on India. The country faced multiple waves of infections, with the second wave being particularly severe in early 2021. The healthcare system faced immense pressure, and efforts were made to ramp up testing, treatment, and vaccination campaigns. The pandemic has had repercussions on various sectors, including healthcare, economy, education, and social dynamics. However the TB services despite a slow down in 2021 has recovered totally by 2023.

The pandemic highlighted the need to bolster health infrastructure in India. Efforts were made to enhance hospital capacities, set up COVID-19 treatment centers, and improve medical facilities in both urban and rural areas. Investments were directed toward upgrading healthcare infrastructure and ensuring access to quality healthcare services across the country. TB has taken advantage of the renewed consciousness about air borne communicable diseases and pushed for elimination efforts with the policy makers.

India witnessed a significant acceleration in digital transformation across sectors. Online platforms became essential for work, education, healthcare consultations, and retail services. The government launched various initiatives to promote digital literacy, connectivity, and digital governance, aiming to bridge the digital divide and ensure digital inclusion. NTEP has been a early adopter of digital technology and has leveraged it to reach greater number of TB patients every year with Direct Benefit Transfer. Recently the “Nikshya Mitra” programme was launched to involve the society in the fight against TB, Provide additional patient support to improve treatment outcome of TB patients, and leverage Corporate Social Responsibility (CSR) activities. A tremendous response has been seen for this initiative since its launch. As on 1st January 2023, more than 58,000 Ni-kshay Mitras (donors) have come forward and committed to support more than 0.9 million consented TB patients.

NTEP is at the forefront of supporting innovations and also adapting them. The country context especially the social, economic, and cultural dimensions are undergoing rapid changes and the NTEP will continue to adapt to the changing context to enhance its resilience and effectiveness in the fight against TB in India.

1.4 Lessons Learned

Describe the main lessons learned from current programs.

1. **Implementation of PMTPT**
2. Complete geographical and household contacts coverage for screening is a challenge and nearly 80% of the population can be covered through increased HR resources.
3. Procurement of IGRA services and Drugs is a challenge for the States.
4. Shortage of drugs impacts field operations as TPT initiation cannot be done.
5. Engagement of the general health system, including CHOs, ASHA workers is essential for the smooth implementation of PMTPT.
6. **Multisector engagement**
7. Multiple partners are working across different geographies and coordinating within different stakeholders, which has helped many new innovations in these areas for the benefit of TB patients.
8. States have a buyer for multisectoral engagement if proper guidance and an action plan is prepared for them.

**3. Community systems strengthening**

1. In Community engagement, it is crucial to expand the boundaries beyond TB champions. In larger community engagement, TB champions are in center, but engaging with (i) community leaders from the formal and informal community structures in the grassroots - SHGs, youth associations (ii) elected local self-government leader accelerates the TB elimination activities at grassroot levels. (THALI and BTB Programs in Karnataka, Bihar, Assam and Telangana)
2. Community engagement is a key approach to addressing stigma and discrimination attached with the disease TB. (THALI and BTB Programs)
3. Community led verbal screening and referrals for TB reduces the delay in case detection and disease transmission. (THALI, BTB and GPAAA Programs)
4. Devising practical solutions to address behavioural and structural barriers enhances the early detection and treatment adherence of TB (BTB program)
5. Engaging the local self-governments always ensured reaching all the unreached populations, such as migrants, rural vulnerable population (GPAAA program)
6. Addressing the population with a comprehensive health care approach has more acceptability among the grassroots than reaching out them only for TB. Equipping the local self-governments with a comprehensive health management program substantially yielding in the areas of TB case finding and case holding (GPAAA program)
7. Community leaders from formal, informal community structures like SHGs, Youth associations, elected local self-government leaders, becoming/mobilizing NI-KSHAY Mitras is accelerating Jan Andolan. (BTB Program)

**4. Health Products and supply chain management**

The activities that went well:

1. Sensitized the national and state leadership to understand the importance of supply chain management in achieving the NTEP objectives.
2. The project hired and implemented the outsourcing of distribution adapting the private sector models and increased the products availability at the facilities levels.
3. Reviewed, designed, and developed the standard operating procedures for SCM for NTEP.
4. Improved the data recording and reporting in eLMIS at the last mile.
5. The project conducted the maturity models of eLMIS considering the global health supply chain management and recommended improving the modules for end to end visibility.
6. The project developed digital platform to manage the distribution of drugs and diagnostics across the country.
7. The project has built capacity of NTEP systems and staff. To ensure sustainability the activities will be undertaken through domestic resources by states /districts.

The activities to be addressed:

1. The challenges with eLMIS to be addressed to customize for better data recording and reporting from last mile
2. Enhance the skills of human resources at various level on procurement and supply chain management.
3. Implementation of the best practices of storage and distribution for health products across the system.
4. Improve the forecasting of drugs and diagnostics adopting the scientific methods and assumption to minimize the errors demand and supply.

1.5 Focus of Application Requirements

**Describe how the funding request complies with the focus of application requirements specified in the Allocation Letter.**

The FR aligns with the focus of application requirements specified in the Allocation Letter by addressing the following areas:

**Engaging private sector providers for TB:** The request acknowledges the importance of involving private sector providers in TB elimination and outlines specific strategies and activities to engage them effectively. It proposes partnerships with private healthcare facilities, establishing training programs, and implementing mechanisms to ensure the participation of private providers in TB prevention, diagnosis, and treatment efforts.

**Scaling up the use of BPaL(M):** The FR recognizes the significance of expanding the use of the BPaL(M) regimen, which is a highly effective treatment for drug-resistant TB. It outlines plans to enhance the availability and accessibility of BPaL(M) through training programs for healthcare providers, and procurement of necessary drugs and equipment.

**Continuing the scaling up of preventive therapy for latent TB infection (LTBI):** The request demonstrates a commitment to sustaining the efforts in providing preventive therapy for individuals with latent TB infection. It proposes strategies to expand LTBI testing and treatment services, ensuring that individuals at risk receive appropriate preventive therapy to reduce the likelihood of developing active TB disease.

**Continuing lab capacity strengthening:** The FR emphasizes the importance of strengthening laboratory capacity for effective TB diagnosis and monitoring as has been outlined in the rationale and context at the beginning of this FR as well as in the module 1A. It outlines plans to invest in laboratory infrastructure, procure necessary equipment and reagents, and train laboratory personnel to improve diagnostic capabilities and ensure accurate and timely reporting of TB cases.

**Strengthening data quality:** The funding request acknowledges the importance of reliable and accurate data for evidence-based decision-making in TB elimination. It proposes initiatives to enhance data quality, including implementing standardized data collection tools, strengthening data management systems, and providing training to healthcare personnel on data collection, analysis, and reporting.

**Overall, the funding request demonstrates a clear alignment with the focus areas outlined in the Allocation Letter, addressing gaps in TB elimination and building on transition successes and lessons learned from existing models.**

1.6 Matching Funds (if applicable)

**If Matching Funds were designated for the 2023-2025 allocation period:**

1. **Describe how integrating the Matching Funds will increase the impact and improve the outcome of the allocation for the Matching Funds area.**

Private sector engagement in TB care and prevention has been a focus of the GF investment in India over the past cycles. In the GC7 also private sector engagement remains a priority given the scale and reach of the sector in India. Irrespective of the overall approach that has been used by the programme, the following measures are taken by the States to enhance the involvement of private healthcare providers in the programme and (some) will be scaled up in the upcoming grant:

* Involvement of professional bodies like Indian Medical Association (IMA), Indian Academy of Pediatrics, FOGSI etc. States have also gone one step ahead and engaged the chemist associations to ensure the local chemists selling the anti-TB drugs are involved as well.
* Provision of free diagnostics under NTEP either through linkages with the NAAT facilities under NTEP or engagement with private laboratories providing diagnostic facilities through a formal MoU with NTEP.
* Provision of government FDCs to the patients seeking care from private sector.
* Incentives for private providers for notification, treatment outcomes or referral (wherever applicable).
* Incentives to patients seeking care from private sector in the form of Nikshay Poshan Yojana.
* Access to all public health actions to patients either through an interface agency or existing NTEP staff or an assigned staff of the private health facility.

1. **Describe how programmatic and access conditions have been met.**

Private sector engagement investments using Global Fund matching funds have successfully met programmatic and access conditions through various strategies and approaches.

* 1. **The Programmatic Conditions have been met** by ensuring the **i**nvestments follow **results-based approaches,** ensuring that funds are allocated based on measurable outcomes and impact. Private sector engagement programs set specific targets and indicators, monitoring progress, and reporting on the achieved results. This approach ensures accountability and drives programmatic effectiveness. Moreover, the NTEP has used **innovations and best practices to involve the private sector**. The private sector brings expertise, technology, and business acumen, which can be leveraged to develop and implement innovative solutions. These investments encourage the adoption of proven strategies and interventions, enhancing programmatic outcomes.
  2. **The Access Conditions have been met by a total of more than 16 million investment in the scale up of private sector involvement with a focus on the hitherto uninvolved AYUSH practitioners and also the large private hospitals**. The investment in Ayush and Hospitals involvement (Module 4) is to the tune of 1.95 million USD. Another 14.7 million USD investments will be used for patients from the private sector who will undergo rapid molecular diagnostics and management of DRTB patients notified from the private sector. Costs of 14.7 Million is a part of the modules on Case finding (Module 1) and DRTB management (Module 2).

**The details of the investments in enhancing private sector engagement is as follows**:

|  |  |
| --- | --- |
| **Particulars (Module / Intervention / Activity)** | **Estimated investment** |
| Collaboration with other providers and sectors: Private provider engagement in TB/DR-TB care | 17,03,340 |
| Collaboration with other providers and sectors: Collaboration with other programs/sectors | 2,51,272 |
| Rapid Molecular Diagnostics, laboratory support - 924,000 rapid molecular diagnostic tests (10% of tests from GF investments) budgets allocated for the patients referred from private sector (Baseline 2023: ~283,000 tests) | 1,02,99,489 |
| DRTB patients initiated on treatment - Notified from private sector - 8177 RR/MDR TB patients (10% of estimated investments from GF ) (Baseline 2023: 4146 notifications from private sector) | 40,51,890 |
| **TOTAL** | **1,63,05,990** |

Through these programmatic and access conditions, private sector engagement investments using Global Fund matching funds contribute to the achievement of health outcomes, improved access to healthcare, and sustainable impact. These investments leverage the strengths of the private sector to complement public efforts, foster innovation, and address barriers that hinder access to essential health services.

Section 2. Maximizing Impact

[The 2023-2028 Global Fund Strategy[[12]](#footnote-13)](https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf) describes clear pathways for control and elimination of the three diseases at a global level. The [Review Criteria of the Technical Review Panel](https://www.theglobalfund.org/media/3048/trp_technicalreviewpanel_tor_en.pdf#page=15)1F1F[[13]](#footnote-14) will be used to help evaluate optimal program design.

2.1 Ending AIDS, TB and Malaria

* + 1. Describe how the Global Fund-supported program(s) advance the primary goal of ending AIDS, TB and malaria.

The GF support to NTEP contributes significantly to the primary goal of ending AIDS, TB, and malaria. It works in close collaboration with the GOI, CSOs, and other partners to ensure a coordinated and comprehensive response, ultimately leading to a significant reduction in the burden of these diseases and improved health outcomes for the population. The focus of the investments has been on prevention strategies to reduce new infections; strengthening diagnostic capabilities for HIV, TB, and malaria; strengthening the overall health system; targeting key populations and vulnerable groups who are disproportionately affected by these diseases; and a very robust monitoring and evaluation systems to collect accurate and timely data on disease prevalence, treatment outcomes, and program performance. The NTEP emphasizes the importance of data monitoring and evaluation to track progress, identify gaps, and inform evidence-based decision-making.

* + 1. Indicate if any of the Program Essentials are currently not fulfilled, explain why, and describe the proposed pathway to reach them in coming years.

All programme essentials are fulfilled.

2.2 Resilient and Sustainable Systems for Health

Describe how the Global Fund-supported program will maximize people-centered, integrated, systems for health to deliver impact, resilience and sustainability.

The GF investments supported program maximizes people-centered, integrated systems for health by prioritizing the needs of individuals and communities, integrating health services, delivering impactful results, building resilience, and promoting sustainability. The program focuses on delivering tangible and measurable impact in terms of health outcomes. It sets clear targets and indicators to track progress and ensure accountability through various mechanisms at the institutional and community levels. By investing in evidence-based interventions and innovative approaches, the program seeks to achieve significant results in reducing disease burden, improving health indicators, and saving lives. NTEP recognizes the importance of building resilient health systems that can effectively respond to existing and emerging health challenges, more so after the COVID 19 pandemic. The GF investments support efforts to strengthen health infrastructure, supply chains, workforce capacity, and information systems. By enhancing the resilience of health systems, the program aims to ensure continuity of care, even in the face of crises such as pandemics, natural disasters, or other disruptions.

NTEP promotes sustainable health interventions by strengthening local ownership, capacity building, and health system governance. It supports countries in developing long-term financing strategies, mobilizing domestic resources, and improving the efficiency of health expenditure. By fostering sustainability, the program aims to ensure that health gains are maintained beyond the lifespan of external funding, thus enabling countries to take ownership of their health programs.

By adopting this comprehensive approach, the program aims to achieve sustained improvements in health outcomes and contribute to the overall well-being of the country’s population.

2.3 Engagement and Leadership of Most Affected Communities

Describe how the design for the Global Fund-supported program(s) will maximize the engagement and leadership of most affected communities.

The community engagement proposed through the local self-governments (LSGs) will ensure engagement of formal and informal community structure leaders in the grassroots (SHG, Faith Based Organizations, Community Based Organizations, labour associations/unions, youth clubs etc.) from the vulnerable communities and mandated committees in the LSGs such as MAS, VHSNC, School Development Committee etc. A substantial number of elected representatives are also from the vulnerable communities.

The leaders from above explained structures will undergo perspective building training on TB and health. The elected members of LSGs will also be trained for health, TB and their roles and responsibilities. The trained leaders will be continuously provided hand holding support through trained frontline workers and TB Champions.

The capacity building and engagement is in view of addressing health in general and TB in particular. Both the case finding and case holding for TB will be prioritized over the project period to ensure TB Mukt GPs and Urban Wards, which will be contributing the to TB elimination plan of the country.

2.4 Health Equity, Gender Equality and Human Rights

**Describe how the Global Fund-supported program(s) will maximize:**

1. **Health Equity.**

Differential strategies are used to ensure all affected seek and are provided with TB care at a place, and time of their choice ensuring respectful, confidential, non-judgemental and non-discriminatory TB care. Mental health remains a neglected area in TB care and hence as a project it is being addressed for DR-TB patients.

1. **Gender Equality.**

The programs prioritize the collection of sex-disaggregated data to better understand and address gender disparities in health outcomes and addressed them accordingly. The NTEP has also ensured that the facilities are safe and non-discriminatory environments for all genders. The ongoing GF investments in the community based activities for enhancing community engagement and participation: has also borne fruit. These programs actively engage with communities, including marginalized and vulnerable groups, to ensure their meaningful participation in program design, implementation, and monitoring. This engagement helps to identify and address gender-specific barriers and social determinants of health, fostering community ownership and sustainable outcomes.

1. **Human Rights.**

The GF investments since the earlier rounds have worked towards activities to reduce the stigma and discrimination associated with TB and TB HIV. The programme has put in place promote inclusive policies, community-based initiatives, and awareness campaigns to challenge discriminatory practices and create an enabling environment where individuals can seek and receive appropriate care without fear of stigma or discrimination.

2.5 Sustainability, Domestic Financing and Resource Mobilization

1. **Describe the major challenges to the sustainability of the national response and efforts to address these challenges.**

Increasing investments for the TB program from the domestic funding with the highest level of political commitment has been demonstrated over the last eight years and will be further enhanced. The overall funding gap is **30%** for the grant period which is expected to be covered with additional resources from state and other domestic partners, corporate and private sector (CSR funds) and increased allocation from central level as the trend of expenditure increases after Covid-19 pandemic. Program will continue its efforts to leverage on the other ministries, program and corporate and private sector to bring in efficiencies to close the gap. Program has been already an integral part of the National Health Mission and integration of the various components of the program are getting merged with the respective budget heads of the health system strengthening.

Moreover, the investments in the interventions related to community systems strengthening will be sustainable as they are configured into the project by its very approach of involving existing locally mandated self-governing structures such as the PRI in rural areas and urban local bodies in urban areas. Strengthening these bodies through capacity building and institutionalization of approaches and of review and monitoring tools will ensure that the TB agenda is embedded into their community health and welfare mandate. Moreover, facilitating the inclusion of the core project activities into the annual plans of the local PRI and urban bodies to ensure allocation of funding and regular review which plays a key role in sustainability. Also, the project will offer technical support to the local state governments in the light touch districts to adopt the project approaches and track progress through the M&E and evaluation study. This will build preparedness and perspectives on involving PRI and ULBs for TB elimination. The CSS interventions leverages the strengths of an already existing robust network of community groups which will build community ownership of this project and hence its sustainability.

The human resource for the program is being slowly shifted to the human resource head of the National Programme through the common fund, removing the dependency on the program allocated funds.

Procurement of first line TB drugs are totally under the domestic budget whereas increasing trends for 2nd line drug courses from domestic budget is moving ahead. Around 50% of DRTB management is going to be supported from GF investments in this cycle. .

Procurement of diagnostics and outsourced services e.g. X-ray test is also being offered through the common pool of free diagnostics initiative of NHM which covers all the programs.

Country’s ambitious target of ending TB will bring down the funding needs drastically by end of this NSP and domestic funding will continue to implement the program in sustainable way.

1. **Describe how co-financing commitments for the 2020-2022 allocation period have been realized.**
2. Describe how co-financing will **increase** over the 2023-2025 allocation period, how these co-financing commitments will be tracked and reported, and planned actions to address remaining funding gaps.
3. If applicable, describe **specific** arrangements and modalities related to innovative financing approaches linked to this funding request and/or the national response.

2.6 Pandemic Preparedness

**Describe how the Global Fund-supported program(s) build capacities that are most critical to prevent, detect and respond to infectious disease outbreaks.**

The Global Fund-supported program/projects in India for TB have played a crucial role in building capacities, strengthening systems, and fostering innovations that are vital for preventing, detecting, and responding to this major public health problem in India. The GF supported grants have also helped establish robust disease surveillance systems. Enhancing laboratory capacities has been a significant investment and has been fundamental for accurate diagnosis, monitoring, and research on TB. It support has strengthened laboratory capacities, including infrastructure development, procurement of essential equipment and supplies, and training of laboratory personnel. This has ensured the availability of high-quality rapid molecular diagnostic services that was also used during the COVID pandemic.

Adequate numbers of skilled healthcare workers are essential for responding to the TB epidemic effectively. The Global Fund-supported programs invest in training and capacity building for healthcare personnel. This includes training on disease surveillance, outbreak investigation, infection prevention and control, and case management. By strengthening the knowledge and skills of healthcare workers, the country is better equipped to respond to TB, other outbreaks and provide quality care.

An efficient and robust supply chain is crucial for the timely procurement, distribution, and management of essential medicines, diagnostic tools, and other healthcare commodities. The GF support is vital in strengthening the supply chain systems, ensuring the availability of necessary commodities during outbreaks. This has involved improving forecasting and procurement processes, enhancing storage and distribution systems, and building capacities in supply chain management.

Strong community engagement is essential for effective outbreak response. The GF programs are significantly vested in community mobilization, awareness raising, and empowerment. They support activities such as community education, social mobilization, and behavior change communication to enhance community understanding of TB, promote preventive measures, and encourage early care-seeking behaviors.

By investing in these critical capacities, the GF supported programs strengthen the overall resilience of health systems, enabling NTEP to prevent, detect, and respond to TB more effectively. These efforts contribute to saving lives, reducing the burden of disease, and promoting national health security.

Section 3. Implementation

Implementation Arrangements

1. **Describe changes to implementation arrangements which will maximize implementation effectiveness and optimize efficiency. (Individual PR and their implementation arrangement sent as a separate file)**

* NTEP is thoroughly and systematically integrated with the general health system. As health care is a state subject, state governments implement NTEP through their health care network with active engagement of the private health care providers. Budgetary provisions is through the National Health Mission (NHM). Additional human resource (HR) provided by NHM for NTEP, is to supplement and reinforce the state health system HR, not to substitute it. This additional HR is meant for coordination, monitoring, logistic management, private sector engagement and Advocacy, Communication and Social Mobilization (ACSM).
* The TB allocation for India under the Global Fund Grant 2023-2025 was intimated to the India Country Coordinating Mechanism (ICCM) through the Global Fund Secretariat, Geneva, in Dec 2022 following which the ICCM followed a transparent bid process for selection of Principal Recipients.
* The ICCM selected **one Government and five Civil Society organizations to promote Dual Track Financing** for implementation of TB interventions during the next Grant implementation period 2024-2026.
  + **Government PR:** The **Department of Economic Affairs (DEA), Ministry of Finance, GoI**, would be the Principal Recipient for the Grant funds the government implementing partners- The Central TB Division (CTD) functional under the Ministry of Health & Family Welfare, Government of India.
  + **Non-Government PRs (NGPRs) TISS, KHPT, SAATHII, HLFPPT and DFY** would receive direct funding from Global Fund.
* The proposed areas of intervention for the PRs would be complementary to each other in the area of scaling TB preventive Treatment, expanding the involvement of private providers, and addressing TB in KVPs as a shared responsibility. The non-Government PRs are implementing their projects in separate geographies and no overlap or duplication of efforts is possible. Besides, CTD would be supporting the scale up of laboratory services, TB preventive treatment, as well as treatment of Drug-resistant TB cases.

**PR’s experience of working in TB elimination:**

1. **Tata Institute of Social Sciences (TISS),** founded in 1936 and funded by UGC, is Asia's oldest institution for professional social work education in Mumbai, India. TISS collaborates with NTEP on the "Saksham" project, which focuses on psychosocial aspects of DR-TB treatment since 2015 and is a sub recipient in both the HIV and TB grants. This project includes professional counseling, home-based counseling for over 65% of DR-TB patients, and linkage to social protection services for patients and families. Saksham has also engaged TB survivors in Mumbai and trained over 40% of frontline NTEP staff on counseling soft skills. Additionally, they initiated community engagement activities in Govandi, Mumbai, from January 2017 to March 2018.
2. **Karnataka Health Promotion Trust (KHPT**), a 20-year-old organization, emphasizes evidence-based, community-oriented projects with government partnerships. Notable TB projects include "Breaking the Barriers" (2020-2024) supported by USAID, which targets vulnerable populations across 15 districts. KHPT also led initiatives like Tuberculosis Health Action Learning Initiative (2016-2020), "JEET 2.0" (July 2021-March 2024), and "Catalysing TB Elimination in Private Health Sector" (December 2019-April 2023), supported by various organizations including GF, expanding TB prevention and care efforts.
3. **Doctors For You (DFY)** operates in 63 districts and 5 states in India, focusing on TB detection and treatment through the PPSA. They have experience in active case finding, health system strengthening, and capacity building for DRTB programs. DFY also engages in training programs and nutrition support for TB patients across four states.
4. **Solidarity and Action Against The HIV Infection in India (SAATHII)** partners with UN agencies and the Indian government to support HIV programs. It is a GF PR in the HIV grant. Their work includes eliminating mother-to-child transmission, scaling up diagnosis and treatment for incarcerated individuals, and training National AIDS Control Programme providers. They also implemented the CaP TB project (2017-2021), which significantly expanded pediatric TB services and engaged private sector pediatric providers.
5. **Hindustan Latex Family Planning Promotion Trust (HLFPPT)** collaborates with Central TB Division (CTD) and various state NHMs to accelerate TB case detection in private health facilities across 5 states as a **PPSA**. They have capacitated healthcare providers, labs, and pharmacists, promoting private sector engagement in NTEP services. HLFPPT also supports TB elimination interventions in Bihar, Karnataka, and Madhya Pradesh through State Technical Support Units (STSU) and multi-sectoral collaboration.

**A brief of the implementation arrangement is described below:**

**PR- PR Coordination:**

CTD is a Principal recipient of the GF grant and also the apex body for the TB elimination program at national level to coordinate with other PRs of Global Fund so that all program works under the preview of national guidelines of NTEP.

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 PRs and all TB partners at national level, **a Coordination Committee will be established**.

**The 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.

* **Structure/ Composition of this committee:**

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

**Members:** 1) The National Project leads from the five civil society PRs, 2) ADDG-TB -CTD coordinating Partnerships, 3) ADDG-TB, CTD coordinating The Global Fund Grant, 4) Two State TB Officers (STOs) of the states where the project is being implemented (in rotation based on recommendation from the Chair), 5) Representative of the Secretariat of the Partnership for TB Care and prevention, 6) Representative of India-CCM Secretariat, 7) 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 its major roles 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.

1. **Describe the role that community-based and community-led organizations will have in implementing programs supported by the Global Fund.**

Community-based and community-led organizations will have an important role in improving TB related service coverage and deliver accessible and people centered integrated care. They will ensure an increase in health service coverage and find the missing people with TB, while ensuring that delivered care is safe, effective, efficient, equitable, and people centered. Under the NSP 2017-2025, a community led response for TB has been incorporated as one of the key strategies to reach the unreached and to support persons affected with TB through their care cascade. In the current and earlier grant, investments were made under the NTEP to actively engage various stakeholders including civil society and community in programme planning and design, service delivery, monitoring and in advocacy. These include elected representatives and local self-governments, Civil Society Organizations, industries, etc. and TB affected communities.

* TB Forums have been established at National, State and District levels for ensuring a patient centric and community led response to TB. These Forums have been constituted with representatives from various stakeholders including cured TB patients, civil society etc. 36 State TB Forums and 711 District TB forums have been established in the country.
* TB Survivors can play an important role in creating awareness about TB and motivating individuals to seek and adhere to TB care, as they have the unique advantage of having defeated TB in their own personal lives. A national level standardized training curriculum has been developed for building the capacity of TB Survivors to facilitate their participation in the mission to end TB as TB champions. .
* More than 3000 TB survivors were trained as TB Champions using the standardized training curriculum on empowering TB survivors to TB champions till date. In order to fast track the engagement of TB survivors in the mission to end TB, a self-learning module for TB survivors as TB champions has been launched by the programme through digital platforms of iGOT, TB Champion Vani and Swastha-e-Gurukul. 28,000 unique registrations were reported to access the course.

In this FR, community engagement will be further mainstreamed for ensuring that communities are equal partners in the nation’s collective response to ending TB.

Key Risks and Mitigation Measures

**Describe up to three risks and mitigating measures for each of the following risk areas:**

1. **Procurement of health products, management of health products and laboratory related activities.**
2. **Flow of data from service delivery points.**
3. **Financial and fiduciary concerns.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Key Risk Area** | **Identified risks** | **Mitigation Measures** |
|  | Procurement of health products, management of health products and laboratory related activities. | Quality Assurance Issues in Laboratory Activities in private sector laboratories (needs to be elaborated to be specific) | Policy of NTEP is to provide quality assured diagnostics both in public as well as private sector through an in-built routine quality assurance system for all diagnostic tests offered.  The NTEP is actively working towards accreditation to maintain uniform quality standards. It's also in the process of expanding the quality management systems for all labs to enhance precision and dependability. Furthermore, EQA initiatives, are being expanded to cover all NAAT facilities. |
| Changes required in the forecasted quantities for procurement depending upon scale up of activities like roll out of shorter regimen, etc. | Adjustments during placing of orders to be made at the time of submission of indent/procurement request form. |
| Variation in prices of drugs as quoted during grant making v/s actual procurements leading to major savings / additional requirements | Savings are expected and will be used to fill funding gaps as per identified priorities. |
| Delays in procurement processes | * Proactive 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 * Leveraging on free drugs and diagnostic scheme of National Health Mission at state level |
| Risk of stock out at state levels districts and TU level especially due to the transportation distribution and storage of goods, and monitoring implementation | * States will work closely with SDS and DDS to ensure the timely placement of transportation and delivery of free drugs to stores. Ensure the appropriate budget for distribution and establish the long term contract to avoid delay in delivery. * Also, Emergency procurement can be managed through GDF procurement * Advanced planning and indenting for procurement of drugs is n=being practiced * 25% of states annual drug requirements has been allowed to be budgeted under pip for local procurement |
|  |  | Non-availability of NAAT consumables and/or NAAT centres are overloaded with specimens with resultant inability to process paediatric samples | Prioritise the paediatric samples whenever possible. In exceptional situations, private CBNAAT services under PPM could be utilised. |
|  |  | Sample collection (GA/IS) service access is refused by the beneficiaries due to belief of complicated procedure in the public and cost factor in the private sector | To address this issue and ensure clear understanding of the necessity of sample collection procedures, the parents and caregivers will be counselled on procedures by both public and private health care providers, and sharing the information on the availability of free-of-cost services at select private hub sites. Involvement of mothers/caregivers as TB champions will further provide peer support, wherever needed |
|  | Flow of data from service delivery points. | Ensuring the entry of all “Presumptive TB testing” across the health facilities in Ni-kshay, irrespective of methodology of testing. |  |
| Accounting of notification data from private sector interventions reported through the civil society PRs as well as data notified by the program during project period. | Each civil society PR to maintain a backup of reported data. The final data to be reported from Nikshay. Data quality assurance mechanisms will be put in place to ensure robust valid data is being reported. |
|  | Financial and fiduciary concerns. | Achieving targets of NSP in context of annual budget allocation to the program | Plan to meet the targets through other funding sources like contribution by states, National Health Mission, Corpus Fund, CSR, etc. |
| Availability of domestic funds for NTEP capacity building activities (Specific for Project Saksham) | Project Saksham will draw on synergy developed with NTEP in the current implementation phase and facilitate involvement of capacity building in the Annual PIP and call on CTD for support to meet deadlines. |

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.

This checklist only applies to applicants requested to apply using the Full Review application approach.

Refer to the [Full Review Instructions](https://www.theglobalfund.org/media/5743/fundingrequest_fullreview_instructions_en.pdf)[[14]](#footnote-15) for details, applicability and resources.

Documents Reviewed by the Technical Review Panel

|  |  |
| --- | --- |
|  | Funding Request Form |
|  | Performance Framework |
|  | Detailed Budget |
|  | Programmatic Gap Table(s) |
|  | Funding Landscape Table(s) |
|  | Prioritized Above Allocation Request (PAAR) |
|  | Health Product Management Template |
|  | Implementation Arrangement Map(s) |
|  | RSSH Gaps and Priorities Annex |
|  | Gender Assessment (if available) |
|  | Assessment of Human Rights-Related Barriers (if available) |
|  | Essential Data Table(s) |
|  | National Strategic Plans |
|  | Innovative Financing Documentation (if applicable) |
|  | Supporting Documentation Related to Sustainability and Transition (if available) |
|  | List of Abbreviations and Annexes |

Documents Assessed by the Global Fund Secretariat

|  |  |
| --- | --- |
|  | Funding Priorities from Civil Society and Communities Annex |
|  | Country Dialogue Narrative |
|  | CCM Endorsement of Funding Request |
|  | CCM Statement of Compliance |
|  | Additional documentation to support co-financing requirements |
|  | Sexual Exploitation, Abuse and Harassment (SEAH) Risk Assessment (optional) |

1. AYUSH is an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy and are the six Indian systems of medicine prevalent and practiced in India and some of the neighbouring Asian countries with very few exceptions in some of the developed countries. [↑](#footnote-ref-2)
2. Yasobant S, Shah H, Bhavsar P, Patel J, Saha S, Sinha A, Puwar T, Patel Y and Saxena D (2023) Why and where?—Delay in Tuberculosis care cascade: A cross-sectional assessment in twoIndian states, Jharkhand, Gujarat. Front. Public Health 11:1015024. [↑](#footnote-ref-3)
3. Husain AA, Kupz A, Kashyap RS. Controlling the drug-resistant tuberculosis epidemic in India: challenges and implications. Epidemiol Health. 2021;43:e2021022. doi: 10.4178/epih.e2021022. Epub 2021 Apr 7 [↑](#footnote-ref-4)
4. Treatment adherence status of the TB patients notified from private sector and its associated factors: Findings of a secondary data analysis from West Bengal, India, Indian Journal of Tuberculosis, Volume 69, Issue 3, 2022,Pages 334-340 [↑](#footnote-ref-5)
5. Deshmukh RD, Dhande DJ, Sachdeva KS, Sreenivas A, Kumar AMV, Satyanarayana S, et al. (2015) Patient and Provider Reported Reasons for Lost to Follow Up in MDRTB Treatment: A Qualitative Study from a Drug Resistant TB Centre in India. PLoS ONE 10(8): e0135802. [↑](#footnote-ref-6)
6. Akasania, A., Shringarpure, K., Kapadia, D. *et al.* “Side effects--part of the package”: a mixed methods approach to study adverse events among patients being programmatically treated for DR-TB in Gujarat, India. *BMC Infect Dis* **20**, 918 (2020) [↑](#footnote-ref-7)
7. CDPOs, BMOs, ASHA Mentors, RBSK and RKSK nodal persons and the District TB Cell, *Anganwadi* Supervisors, CHOs, ASHA Facilitators, PHC Medical Officers, ASHAs and AWWs [↑](#footnote-ref-8)
8. In addition to the NTEP’s provision of free diagnostics, free drugs and NPY benefits to all TB patients notified from both public and private sectors, The Government of India has launched “The Pradhan Mantri TB Mukt Bharat Abhiyaan” envisioned to bring together all community stakeholders to support those on TB treatment and accelerate the country’s progress towards TB elimination. By augmenting community involvement and leveraging Corporate Social Responsibility (CSR) in meeting India’s commitment to end TB by 2025, the Abhiyaan aims to provide additional patient support to improve the treatment outcomes of TB patients. Page 167 – 176, CHAPTER 17 – India TB Report 2023 [↑](#footnote-ref-9)
9. Ayushman Bharat - Health and Wellness Centers (AB-HWC) is a last mile functional health facility and expected to provide the expanded range of services including TB services to address the primary health care needs of the entire population in their area, expanding access, universality and equity close to the community. Integrating TB care and prevention activities within the platform of HWC is a critical move for ensuring the availability of TB services closer to the communities. Central TB Division and India’s National Health Mission released the operational guidelines for TB services at AB-HWC. The specific roles and responsibilities of team members including ASHA, Community volunteer, Community Health Officer, MPHW in TB prevention and care at HWC is mentioned in this operational guideline. The remuneration for community volunteer, TB Champion and ASHA is incentive based and also mentioned in the chapter 8 of this guidelines. The guidelines available from <https://tbcindia.gov.in/showfile.php?lid=3575>. [↑](#footnote-ref-10)
10. In addition to the NTEP’s provision of free diagnostics, free drugs and NPY benefits to all TB patients notified from both public and private sectors, The Government of India has launched “The Pradhan Mantri TB Mukt Bharat Abhiyaan” envisioned to bring together all community stakeholders to support those on TB treatment and accelerate the country’s progress towards TB elimination. By augmenting community involvement and leveraging Corporate Social Responsibility (CSR) in meeting India’s commitment to end TB by 2025, the Abhiyaan aims to provide additional patient support to improve the treatment outcomes of TB patients. Page 167 – 176, CHAPTER 17 – India TB Report 2023 [↑](#footnote-ref-11)
11. NGS is Ni-Kshay Gram Sabha - a periodic Gram Sabha meeting will be organized through project. This Gram Panchayat meeting will be exclusively for deliberating TB activities in Panchayat level. NGS will be conducted once in 6 months. TB champions, TB Ambassadors, Community Health officers will participate in NGS. [↑](#footnote-ref-12)
12. 2023-2028 Global Fund Strategy - <https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf> [↑](#footnote-ref-13)
13. Review Criteria of the Technical Review Panel - <https://www.theglobalfund.org/media/3048/trp_technicalreviewpanel_tor_en.pdf#page=15> [↑](#footnote-ref-14)
14. Full Review Instructions - <https://www.theglobalfund.org/media/5743/fundingrequest_fullreview_instructions_en.pdf> [↑](#footnote-ref-15)