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

PROPOSAL FORM – ROUND 8
(SINGLE COUNTRY APPLICANTS)

Applicant Name	INDIA - COUNTRY COORDINATING MECHANISM		
Country	INDIA		
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)*	Low Income		
Applicant Type	☒ CCM	☐ Sub-CCM	☐ Non-CCM

Round 8 Proposal Element(s)		
Disease	**Title**	**HSS cross-cutting interventions section** ***(include in one disease only)***
☑ HIV[1]	Priority Responses to Accelerate the National Programme with Difficult to Reach Key Populations in Underserved Areas	☐
☑ Tuberculosis[1]	Enhancing India's TB Care and Control Efforts through Civil Society Participation	☐
☑ Malaria	Intensive Malaria Control Program	☐

Currency	☐ USD	or	☒ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Tuesday 1 July 2008**

[1] In contexts where HIV is driving the tuberculosis epidemic, applicants should include relevant HIV/TB collaborative interventions in the HIV and/or tuberculosis proposals. Different HIV and tuberculosis activities are recommended for different epidemiological situations. **For further information:** see the '*WHO Interim policy on collaborative TB/HIV activities*' available at: http://www.who.int/tb/publications/tbhiv_interim_policy/en/

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

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

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

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

Complete the following sections for each disease included in Round 8:

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

** *Only to be included in one disease in Round 8. Refer to the Round 8 Guidelines for detailed information.*

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

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

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

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

IMPORTANT NOTE:

Applicants are strongly encouraged to read the *Round 8 Guidelines* fully before completing a Round 8 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 8 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Round 8 Proposal Form. The *Round 8 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at: http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Round 8 Proposal Form. The *Round 8 Guidelines* therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

ROUND 8 – Tuberculosis

1. FUNDING SUMMARY AND CONTACT DETAILS

Clarified Table 1.1

1.1. Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	7,298,589	13,964,892	13,505,004	20,746,669	19,697,342	75,212,496
Tuberculosis	15,026,201	17,393,954	16,520,688	15,981,664	14,993,447	79,915,954
Malaria	17,493,227	22,389,953	20,969,449	18,471,269	20,986, 428	100,310,325
					Total Round 8 Funding Request ➔:	**255,438,775**

1.2. Contact details

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

1.3. List of Abbreviations and Acronyms used by the Applicant

HIV/AIDS Proposal

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ART	Anti-retroviral therapy
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BMGF	Bill and Melinda Gates Foundation
CBIS	Community Based Information System
CBO	Community Based Organisation
CBWE	Central Board for Workers' Education
CCM	Country Coordination Mechanism
CHC	Community Health Centre
CLSI	Community-led structural intervention
CME	Continuing Medical Education
DANIDA	Danish International Development Agency
DAPCU	District AIDS Prevention and Control Unit
DFID	Department For International Development
DLN	District Level Networks
DWCD	Department of Women and Child Development
ESIC	Employees State Insurance Corporation
FP	Family Planning
FRU	First Referral Unit
FSW	Female Sex Workers
GFATM	Global Fund for AIDS, TB & Malaria
GOI	Government of India
GP	Gram Panchayat
GUD	Genital Ulcer Disease
HIPC	Highly Indebted Poor Countries
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HSS	Health Systems Strengthening
IBBA	Integrated Behaviour and Biological Assessment
I-CCM	India Country Co-coordination Mechanism
ICRW	International Centre for Research on Women
ICTC	Integrated Counseling & Testing Centre
IDU	Injection drug users
IEC	Information, Education, Communication
IHRN	Indian Harm Reduction Network
IMR	Infant Mortality Rate
INP+	Indian Network of Positive People
IPC	Inter Personal Communication

IRL	Intermediate Reference Laboratory
JMM	Joint Monitoring Mission
Km	Kilo Meter
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MOHFW	Ministry of Health and Family Welfare
MOL&E	The Ministry of Labour and Employment
MoU	Memorandum of Understanding
MPW	Multi Purpose Workers
MSM	Men who have sex with men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Program
NACP-III	National AIDS Control Programme phase III
NFHS	National Family Health Survey
NGO	Non Government Organisation
FBO	Faith Based Organisation
NHP	National Health Policy
NMEP	National Malaria Eradication Program
NRHM	National Rural Health Mission
NRL	National Reference Laboratory
NSEP	Needle Syringe Exchange Programme
NSP	New Smear Positive (Pulmonary TB Case)
OI	Opportunistic Infection
OST	Opioid Substitution Therapy/Oral Substitution Therapy
PH&FWD	Public Health and Family Welfare Department
PHC	Primary Health Centre
PHI	Peripheral Health Institutions
PIP	Programme Implementation Plan
PLHIV	People Living with HIV
PMTCT	Preventing Mother to Child Transmission
PMU	Project Management Unit
PPTCT	Prevention of Parent to child transmission
PR	Principal Recipient
PRI	Panchayati Raj Institutions
SAATHII	Solidarity and Action Against The HIV Infection in India
SACS	State AIDS Control Society
SDA	Service Delivery Area
SHG	Self Help Group
SIAAP	South India AIDS Action Programme
SLD	Second Line Drugs
SOP	Standard Operating Protocols
SR	Sub Recipients
SRH	Sexual Reproductive Health
SSR	Sub Sub Recipients
STAG	Strategic Technical Advisory Group
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TI	Targeted Intervention (package for focused prevention, defined in NACP-III)
TRC	Technical Review Committee

TRG	Technical Resource Group
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VTCT	Voluntary Counseling & Testing Center
VVGNLI	V.V. Giri National Labour Institute
WAC	World AIDS Campaign
WHO	World Health Organisation
WPI	Work Place Intervention

Tuberculosis Proposal

Acronym/ Abbreviation	Meaning
ACSM	Advocacy Communication Social Mobilisation
ASHA	Accredited Social Health Activist
CME	Continuing Medical Education
CTD	Central TB Division (Central unit managing Tuberculosis control programme In India)
DOTS PLUS	Programmatic management of MDR/XDR TB
DTO	District Tuberculosis Officer
GDF	Global TB Drug Facility
GIPT	Greater Involvement of People with TB
ICAT	India Coalition Against Tuberculosis
IEC	Information, Education, Communication
IMPF	Indian Medical Parliamentarian Forum
IRL	Intermediate Reference Laboratory
IUATLD	International Union Against Tuberculosis and Lung Disease (The Union)
ISTC	International Standards for Tuberculosis Care
JMM	Joint Monitoring Mission
MLA	Member of Legislative Assembly
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MP	Member of Parliament
MDR-TB	Multi Drug Resistant Tuberculosis
NACP	National AIDS Control Programme
NGO/FBO/CBO	Non Governmental / Faith Based / Community Based Organisations
NRHM	National Rural Health Mission
NRL	National Reference Laboratory
NSP	New Smear Positive (Pulmonary TB Case)
NTC	NGO Tuberculosis Consortium
RNTCP	Revised National Tuberculosis Control Program (TB control Programme in India)
PCTC	Patients' Charter for Tuberculosis Care
PIP	Programme Implementation Plan
PHI	Peripheral Health Institutions
PMU	Project Management Unit
PP	Private Practitioner (providing health services)
PPM	Private Public Mix
PSA	Public Service Advertisement
SACS	State AIDS Control Society

SHG	Self Help Group
SLD	Second Line Drugs
STAG	Strategic Technical Advisory Group
STO	State Tuberculosis Officer
XDR-TB	Extensively Drug Resistant TB

Malaria Proposal

ACT	Artemisinin-based combination therapy
API	Annual Parasite Incidence
ASHA	Accredited Social Health Activist
BCE	Bethesda Charitable Endeavours
CBO	Community Based Organisation
CHAI	Catholic Health Association of India
CHCs	Community Health Centres
CMAI	Christian Medical Association of India
CRS	Catholic Relief Services
EDP	Electronic Data Processing
FBO	Faith Based Organisation
FTDs	Fever treatment depots
GMSD	Government Medical Store depots
HIPC	Highly-Indebted Poor Country
HMIS	Health Management Information System
ICMR	Indian Council of Medical research
IEC	Information, Education, Communication
IPC	Inter-Personal Communication
IRS	Indoor residual spraying
ITN	insecticide-treated mosquito nets
IVM	Integrated Vector Management
JBIC	Japan Bank for International Cooperation
JMM	Joint Monitoring Mission
LLIN	Long-lasting Insecticide treated nets
M & E	Monitoring and Evaluation
MIS	Management Information System
MIs	Member Institutions
MIST	Malaria Implementation Support Team
MPO	Modified Plan of Operation
MPWs	Multi Purpose Worker
MTS	Malaria Technical Supervisors
NAMMIS	National Anti-Malaria Management Information System
NGO	Non-Governmental Organisation
NHP	National Health Policy
NIMR	National Institute for Malaria Research
NMCP	National Malaria Control Programme
NMEP	National Malaria Eradication Programme
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OR	Operations Research
P.falciparum	Plasmodium Falciparum
PHC	Primary Health Centre
PMU	Project Management Unit
PQ	Program Quality

PR	Principle Recipient
QA	Quality Assurance
RBM	Roll Back Malaria
RCDC	Roman Catholic Diocesan Corporation
RDK	Rapid Diagnostic Kits
RDT	Rapid Diagnostic Test
ROH & FW	Regional Offices for Health and Family Welfare
SAN	Stop AIDS Now
SDA	Service Delivery Area
SHGs	Self Help Groups
SP Liquid	Synthetic Pyrethroid liquid
SP Tablets	Synthetic Pyrethroid Tablets
SUFI	Scale Up For Impact
UNOPS	United Nations Office for Project Services
VBD	Vector Borne Disease
VHAI	Voluntary Health association of India
VHSC	Village Health and Sanitation Committees
WHO	World Health Organisation

2. APPLICANT SUMMARY (including eligibility)

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

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

2.1. Members and operations

2.1.1. Membership summary

	Sector Representation	Number of members
☑	Academic/educational sector	5
☑	Government	13
☑	Non-government organizations (NGOs)/community-based organizations	4
☑	People living with the diseases	1
☑	People representing key affected populations[2]	1
☑	Private sector	2
☐	Faith-based organizations	
☑	Multilateral and bilateral development partners in country	7
☐	Other *(please specify):*	
	Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	**33**

[2] Please use the *Round 8 Guidelines* definition of *key affected populations*.
[3] **Attachment C** is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/8/AttachmentC_en.xls

2.1.2. Broad and inclusive membership

Since the last time you applied to the Global Fund (and were determined compliant with the minimum requirements):		
(a) Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; **(CCM Annexure 1)** and	No	☒Yes
(b) Is there continuing active membership of people living with and/or affected by the diseases.	No	☒Yes

2.1.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the CCM or Sub-CCM.

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

The India-CCM is a partnership of stakeholders from each of the GFATM defined constituencies – the government – at Union and State levels, the private sector, civil society, people living with the disease, multi/bi-lateral agencies and academic/research institutions. The India-CCM representatives hold senior management positions, representing their constituencies with the appropriate expertise, experience and authority to manage directly, or influence decisions on health systems.

The Chair of the India-CCM is the Secretary, Health and Family Welfare Department from the Ministry of Health and Family Welfare; a ministry that is directly responsible for policy formulation and oversight of all national health programs including the Revised National Tuberculosis Control Programme (RNTCP), National Malaria Eradication Programme, National AIDS Control Programme, and National Rural Health Mission (NRHM). A total of 10 members from the public health sector at the national and state levels are members of the India-CCM and contribute significantly to the decision making process. The state representatives are the Secretaries of the health ministries of their respective state that represent five geographic regions (North, North-East, South, East and West) of the country. In India, health is under the jurisdiction of the state and the state health departments play an important role in policy formulation, financing and implementation of health care delivery services.

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

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

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

Gender awareness

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

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

(b) Describe the capacity and experience of the CCM (or Sub-CCM) in gender issues including the

number of members with requisite knowledge and skills.

The India-CCM has the requisite knowledge and skills to ensure that cross cutting issues concerning gender and equity are addressed in the overall framework of the country comprehensive proposal for Round 8. Drawing upon the important mandate for gender and equity as provided in the Global guidelines of the GFATM for the CCM, the ToR of the India-CCM provides substantive scope for inclusion and gender equity as one of the guiding principles for improved outcomes for the diseases. **(CCM Annexure 1 A - TOR)**

All the 33 members in the India-CCM represent diverse constituencies, all of which have social inclusion, gender and equity enshrined in their organisational mandate. Practical and strategic gender interests are addressed through their policies, plans, programmes, institutional systems and knowledge management systems. Most of the organisations represented in the India-CCM state in their purpose and mission statements that women, girls and other marginalised sections of the society are priority target groups.

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

Within the Public Sector the Ministry of Women and Child Development is one of the India-CCM members. Another CCM-member represents civil society organizations working on gender issues.

With the pooling of individual and institutional expertise of all the India-CCM members as policy makers, programme managers, civil society leaders, technical experts, their skills and capacities include expertise and a permanent concern for gender, equity and rights based in-country efforts to prevent and control the three diseases. In addition, UNIFEM has participated in the writing of all disease proposals for Round 8 to ascertain that gender and equity concerns were satisfactorily addressed by all principal recipients.

Multi-sectoral planning

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

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

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

- The Ministry of Health and Family Welfare,
- The Ministry of Finance,
- The Ministry of Defence,
- The Dept. of Women and Child Welfare,
- State Level representatives from their respective State Departments of Health,
- Person living with the disease,
- NGO representatives,
- Private Sector representatives,
- Academic or Education Sector representatives and
- Multi or bi-lateral representatives

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

Coming from different sectors, the India-CCM representatives ensure a multi-sectoral approach in enshrining the cross-cutting topics of gender and planning in the India-CCM working modalities. These

members also bring to the India-CCM their specific agenda of addressing the thematic gaps and weaknesses within their sectors and ensure an effective liaison between the various sectors in the country context.

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

2.2. Eligibility

2.2.1. Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.	
☒ Applied for funding in Round 6 and/or Round 7 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
☐ Last time applied for funding was before Round 6 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' to and complete.*** *(Do not complete sections 2.2.2 to 2.2.4)* ➔ ***Then also complete sections 2.2.5 to 2.2.8 below.***

2.2.2. Transparent proposal development processes

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

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

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

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

Formulation of the Round 8 Country Proposal was one of the agenda items deliberated upon at the 27th India-CCM meeting held on 17th December 2007 **(CCM Annexure 1B)**. The three programme divisions were requested to present a gap analysis for the identification of focus areas for Round 8. In addition, the India-CCM constituted a sub-committee of the CCM to organise preparatory work for the India proposal. The sub-committee of 9 CCM members had representatives from UNAIDS, USAID, UNICEF, DFID, INP+, SPYM (NGO), and three national programme divisions (HIV/AIDS, Malaria and Tuberculosis).

The sub-committee discussed the different thematic focus areas in a meeting organised on 8th February 2008 and shared their recommendations by e-mail with the National Programme Managers of the three disease components for their comments and feedback. **(CCM Annexure 2- Minutes of Sub-committee Meeting)**

At the 28th India-CCM meeting held on 18th February 2008 **(CCM Annexure 1C)**, areas for Round 8 funding were discussed. At this meeting it was decided that the Ministry of Health and Family Welfare would submit a country proposal for Malaria for Round-8.

For Tuberculosis, NTCP indicated that it did not wish to submit a proposal for Round 8, but would welcome proposals from civil society, notably to increase outreach and coverage in specific areas of the country.

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

HIV/AIDS

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

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

Tuberculosis

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

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

Malaria

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

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

Regional Civil Society Consultations

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

The objectives of the meeting were:

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

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

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

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

It was also widely published in English Newspapers (both National and Regional issues) including the Hindustan Times, the Times of India, The Hindu and The Statesman. Samples of few news paper announcements are annexed. **(CCM Annexure 3)**.

A copy of the screen shot of the India-CCM website in which the call for proposals was placed along with the announcement, disease specific concept notes and application formats is enclosed as **(CCM Annexure 3 A)**

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

After the deadline for submission of proposals, the India-CCM Secretariat tabulated and documented the details of concept notes that were received in time for the three disease components. A total of 258 concept notes were received, of which 191 were for the HIV/AIDS component; 38 for Malaria and 29 for Tuberculosis. **(CCM Annexure 4)**

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

As per the procedure followed for Round 7, the India-CCM constituted a Screening Committee and Technical Review Committee to screen, review, rate and recommend the proposals. The Secretariat identified the members for these committees with inputs from the National Programme Divisions. List of Screening Committee and Technical Review Committee members **(CCM Annexure 5)**

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

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

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

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

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

The Technical Review Committee comprising of experts on the three disease components and on gender met at the UNAIDS office on 28th and 29th of April 2008. All 71 concept notes cleared by the Screening Committee were found to be valid on the three different disease components and were taken up for Technical Review. **(CCM Annexure 6)**

The concept notes were reviewed based on criteria formulated by the Technical Review Committee. The comments of the Technical Review Committee are annexed **(CCM Annexure 7)** .The comments of the

Screening and Technical Committees on each concept note were shared with the applicants by e-mail.

A member from the TRC from the three disease components presented the process and results of the review and the recommendation of the committees on the submissions received to the India-CCM at its 29th meeting held on 6th May 2008 **(CCM Annexure 8)**.

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

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

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

On the thematic focus area Prevention of HIV transmission among informal and migrant workers the concept note submitted by the Ministry of Labour and Employment (MoLE) was endorsed by the India-CCM. Five concept notes on the same thematic area from NGO's – Action Aid, Voluntary Health Services, Humana People to People, Hope Foundation and Catholic Health Association of India (CHAI) – were recommended for further discussion with NACO. The meeting was organized on 22 May 2008. It was discussed that the NGO's should put up a joint proposal along with MoLE to avoid duplication of efforts.

The meeting was closed with the following decisions:

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

The NGO's had taken a decision that Voluntary Health Services would be the PR. Based on this decision they prepared a proposal, which was submitted to the I-CCM Secretariat. The proposal was then reviewed by the CCM sub-committee on 16 June 2008 and the review comments were presented to the CCM in the meeting held on 24th June 2008.

Tuberculosis

Of the 5 concept notes that were kept for technical review by the screening committee, two were recommended as PR. The proposals were from the TB Coalition (ICAT) of IUATLD; and NGO Consortium for tuberculosis led by World Vision. The TRC suggested that the Southern Health Improvement Samity (SHIS) should join the NGO Consortium proposal as a SR and Manipur Voluntary Health Association join the TB Coalition via the VHAI, which is already a partner in the ICAT. Rejecting the BASS proposal, TRC requested the organization to explore possible collaborations with local RNTCP and NRHM authorities.

Malaria

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

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

The short-listed proposals on Tuberculosis and Malaria were endorsed, in principle, with additional comments to strengthen the proposals by the India-CCM.

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

At the India-CCM meeting held on 6th May 2008 the technical review committee recommendations were shared and endorsed, in principle, by the CCM. The CCM provided further recommendations to strengthen the concepts for the three disease components. Formal consultations were held with potential PR to discuss the recommendations of the CCM.

UNAIDS, Swasti and UNIFEM provided inputs and support during the proposal development process. UNAIDS represented the India-CCM and guided the process; the Swasti team was involved in writing the proposal; and UNIFEM provided the gender perspective and inputs.

HIV/AIDS

On 8th and 9th May 2008 the potential PR were invited for a consultation, organised in the UNODC conference hall. At this consultation comments of the TRC and recommendations of the India-CCM were shared. The potential PR worked in groups, based on the thematic focus area they had applied for, towards development of the country proposal.

On 9th May a meeting of the sub-groups was organised where they presented their draft conceptual framework. Detailed discussions followed each of the group presentations. Representatives from UNAIDS, UNIFEM and Swasti provided inputs to each of the groups.

Following the consultation the organisations continued working in their sub-groups and sought regular inputs from NACO and UNAIDS.

Malaria

The proposal submitted by the NVBDCP was developed using participative processes involving a broad range of stakeholders including technical agencies such as WHO, NVBDCP, and implementing state and district level agencies.

The civil society proposal submitted by CARITAS seeks to complement the activities proposed to be undertaken by the NVBDCP

On 12th May 2008 a meeting was organised by the India-CCM Secretariat at the UNAIDS conference hall for PR of the Malaria component. Representatives from WHO, NVBDCP, Swasti and CARITAS (and its consortium partners) participated in this meeting. The India-CCM recommendations were shared with the participants, following which the NGO discussed the architecture of the proposal.

Later that day the participants met once again in the Constella Futures office to discuss operational issues, technical support and other modalities between the NVBDCP and the Civil Society Proposal. The Swasti team, the consultants from the NGO consortium and WHO representatives participated in these discussions.

Following the 12th May meetings the writing teams of the NVBDCP and CARITAS consortium prepared separate proposals. However, the interactions between the NVBDCP, WHO and the CARITAS consortium continued for strengthening the country proposal.

Tuberculosis

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

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

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

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

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

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

(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***[Insert Annex Number]***

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.
I-CCM recognizes the importance of good governance for good grant performance. One of the key governance roles of the CCM is to provide oversight of the different Global fund grants received by the country. Oversight requires the CCM to play a monitoring role to gauge the effectiveness of grant implementation, track progress, locate challenges, and make recommendations to the PR on strategies for improving performance. Oversight ensures that monitoring is being conducted by PR, results and impacts are being reported, and programs are meeting agreed targets. In this context, oversight includes the role of the CCM in focusing on the “bigger picture” and ensuring that performance is on track. However, the oversight role does not necessarily address issues of day-to-day implementation and does not translate into micromanagement. Since all CCM members should understand their roles and responsibilities within the CCM and the basic principles of the Global Fund, an annual two-day workshop is organized to provide opportunities for all members to discuss outstanding issues, and to find ways of improving CCM performance. The review of the status of implementation of GFATM grants is a key agenda item in all regular meetings of the India-CCM.

Quarterly reports on the implementation of each grant with respect to both financial and service-delivery targets are prepared by the PR and circulated to all the CCM members and invitees prior to each CCM meeting by the India-CCM Secretariat (and posted on the India-CCM website). It is the responsibility of the India-CCM members to share this information with the constituency they represent. In addition, the representative of the PR will make a brief presentation of progress during the meeting and respond to the queries of the members and invitees. The views expressed by the members and invitees, the responses of the PR and the recommendations of the CCM for improving or accelerating performance, where relevant, are recorded in the Proceedings of the Meeting by the India-CCM Secretariat and circulated to all the members and the invitees. The India-CCM Secretariat also responds to queries from any interested stakeholders on the performance of the grant.

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

Starting with Round 8 grants, an oversight sub-committee will be formed for each of the three respective disease components. The tenure of each sub-committee will be for one year. The composition of the sub-committee will include one member each from the Government, Civil Society/Private Sector, Multi/Bi Lateral and the Academic/ Educational and PLWD Constituency.

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

The functions of the sub-committees will include:

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

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

Bi-Annual Site Visits

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

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

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

(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.
All grants are submitted to regular visits and evaluation by services of the Government at the Union and State level. Other donors associated with programmes pertaining to the three diseases conduct reviews, studies, evaluations and missions. Their reports are shared with the PR and India-CCM members, as and when needed. In addition: • A dedicated online feedback mechanism will be developed where stakeholders can post comments on the different grants on the CCM website. The important comments will be forwarded to the India-CCM members for their information and follow-up action. • A consultation with external stakeholders will be organized within the scope of the India-CCM annual retreat. **Empanelment of Agencies** If needed, agencies with expertise in the areas of public health, project management and financial management will be empanelled to undertake external oversight in program and finance and provide inputs with an independent perspective. **Evaluation of Grants and of Grant Utilization** In addition to monitoring, India-CCM will evaluate grants during the final year of implementation and involve the participation of external stakeholders, notably beneficiaries and patients.

2.2.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 8 Guidelines for further explanation of the principles.* .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*
In India, certain guidelines are followed with regard to the selection of PR's. For Government sector agencies, as per the rules and regulations of the Government of India, only the Department of Economic Affairs, Ministry of Finance is the authorized government entity to receive and disburse funding from external sources. Consequently, this entity is the automatic Principal Recipient (PR) for all GFATM grants to India. Nevertheless, this entity only serves as the legal channel for receiving and disbursing funds; it delegates and designates the respective National Disease Control Programme Divisions (NACO / CTD / Directorate of National Vector Borne Diseases Control Programme - NVBDCP) of the Ministry of Health & Family Welfare or other interested Ministries as the Operational PR – to manage the programmatic aspects of the grant as well as the further disbursement and audit of funds to the sub recipients of the grant. The India-CCM decides on and nominates PR that are non-governmental entities through the following process detailed in Section 53 of the Terms of Reference of the CCM (Annexure CCM- 1A) : 1. The non-governmental entity should have submitted a proposal for a disease component that was recommended by the relevant CCM Screening Committee to be included in the country proposal for that disease component and approved by the India-CCM. 2. It should be a domestic entity possessing the legal status to enter into a grant agreement with a non-domestic / external entity as per the rules and regulations stipulated by the Government of India and not in breach of any central or state specific legal provisions governing the functioning of such entities in the country. 3. The relevant national disease control programme division should present the merits of the concerned non-governmental entity for eligibility to be a functional PR based on: a. the technical expertise of the entity that would add value to the implementation of the grant and

the objectives of the national programme;

b. the organisational, leadership, managerial and financial expertise to utilise the grant efficiently and cost-effectively to achieve the desired service delivery and outcome targets; and

c. the adequacy of infrastructure and information system facilities in order to implement the grant, manage and support sub-recipients and monitor performance with reasonable additional overheads.

Taking into consideration the above criteria, the technical review committee recommended potential PR's to the India-CCM. The CCM agreed with the recommendations and nominated the PR's (list of PR's provided in table 2.2.5) for the Round 8 India proposal.

The process followed by the India-CCM for the nomination of the PR for the three disease component of the proposal is captured in the proceedings of the 29th India-CCM meeting held on 6th May 2008 CCM Annexure 8.

It is important to note that the selection of all PR in the three disease components was based on the recommendation of the disease-specific technical review committees.

For the Tuberculosis disease component, two proposals were endorsed in principle with additional comments to strengthen the proposals by the India-CCM. Both these proposals were from civil society organizations, namely, the India Coalition Against Tuberculosis (ICAT) and World Vision led consortium NGO Tuberculosis Consortium (NTC).

It was recommended in the CCM meeting that there could be either merged into one single PR for TB or two civil society organizations as two separate PR. The two organizations proposed to work as independent PR. Hence, for the TB India proposal, the PR are:

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

For the Malaria proposal, it was endorsed in the CCM meeting that there be two PR, NVBDCP and CARITAS. Hence, for the Malaria India proposal, the PR are:

1. NVBDCP
2. CARITAS

For the HIV/AIDS disease component, initially four PR were short listed by the Technical Review Committee- for the different thematic focus areas, and endorsed by the CCM for further proposal development. The short-listed PR's were as under:

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

In addition, five concept notes on the same thematic area "informal labour" from NGO's were recommended for further discussion with the NACO. The organizations that submitted the concept notes were not recommended for PR by India-CCM:

- Action Aid
- Voluntary Health Services,
- Humana People to People
- Hope Foundation and
- Catholic Health Association of India (CHAI)

The meeting was organized on 22 May 2008 (see 2.2.2)

On 16 June 2008, a meeting of the CCM Sub-committee was held with DG/NACO to review the proposal

development process, outputs and recommendations of the Sub-committee for proposal development of the CCM. **(Minutes of the meeting: Annexure 9)**

The proposal submitted by the Voluntary Health Services (VHS) was reviewed by the sub-Committee of the CCM on 16 June 2008. It was found that the proposal was general, not focused and too board geographically. Hence, VHS (and the consortium) has been encouraged to apply for Round 9, with a far stronger proposal. This was also shared in the CCM Meeting held on 24 June 2008.

There were concerns on the Health System Strengthening component over the selection of the districts. The districts proposed for intervention were recognized to have weak health systems but they did not show high disease burden of HIV, TB or Malaria. It was decided that the proposal be further be reviewed by NACO and a decision be made on whether this component be included in the Round 8, or further strengthened and re-submitted for Round 9.

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

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

The selected PR's for the Round 8 proposal is provided in the table given below:

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

The decisions on selection the PR was shared at 30th India-CCM Meeting held on 24th June 2008 CCM **Annexure 10** and this was endorsed by the I-CCM.

(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	***Insert Annex Number***

2.2.5. Principal Recipient(s)

Name	Disease	Sector**
Ministry of Labour and Employment	HIV/AIDS	Government
India HIV/AIDS Alliance	HIV/AIDS	NGO's and Community Based Organization
Emmanuel Hospital Association ***for** Indian Harm Reduction Network*	HIV/AIDS	Government
International Union Against Tuberculosis and Lung Disease (The Union) – ***for** India Coalition Against Tuberculosis*	Tuberculosis	NGO's and Community Based Organization
World Vision of India ***for** National Tuberculosis Consortium*	Tuberculosis	Faith Based Organization
National Vector Borne Disease Control Programme (NVBDCP)	Malaria	Government
CARITAS India	Malaria	Faith Based Organization

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

2.2.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.

In compliance with the dual track financing, all the three disease components for the Round 8, proposal from India have PR's from the Civil Society Sector.

The Government Sector PR's are the Directorate of National Vector Borne Diseases Control Programme - NVBDCP) for Malaria and Ministry of Labour and Employment (MoLE) for the HIV disease components.

The Central Tuberculosis Division (CTD) opted for not submitting a proposal which was shared in the 27th India-CCM meeting held on 17th December 2007 **(CCM Annexure 1B)**.

The RNTCP has consistently achieved a high treatment success rate since the inception of the programme. In the year 2006, more than 1.4 million patients were put on treatment and the programme has been able to put more than 1.2 lakh patients on treatment every month. Treatment success rate of 86% has been consistently achieved and death rates under RNTCP have reduced 7 fold from 29% to around 4%. In addition to implementing a technically sound TB control programme and maintaining quality services, the programme has taken initiatives to address newer concerns in TB control, eg, TB-HIV coordination and establishment of Intermediate Reference Laboratories for diagnosis and follow-up

of MDR-TB patients

Currently, the entire country is covered under RNTCP and adequate funding has been arranged for all the states from various donors. However, the Global Fund has approved the submission of the RCC (rolling continuation channel) mechanism for Round 2. Approval for submitting an RCC proposal is based on the performance of the Round 2 grant which is ending in March 2009. Since the RCC application has the scope for consolidation of all GFATM funding rounds, the government is in the process of preparing a consolidated RCC application for the next 6 years. The TB programme, therefore, will not be submitting any proposals for the GFATM Eighth round of grant funding.

However, it was agreed that to strengthen implementation of RNTCP CSO proposals would be invited from civil society and private sector.

2.2.7. Managing conflicts of interest

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

2.2.8. Proposal endorsement by members

Attachment C – Membership information and Signatures	**Has 'Attachment C'** been completed with the signatures of all members of the CCM (or Sub-CCM)?	√ ☐ Yes
The India-CCM has unanimously endorsed in the 26th I-CCM Meeting held on 29 June 2007 the decision that a quorum of two thirds of the members of India-CCM endorsing the proposal by signing would be sufficient to make it valid. **(Minutes of the 26th CCM meeting: Annexure 11)**		

Section	Document description	Annex Number
1 & 2	Proposal Sections 1& 2 CCM requirements	
	CCM Related Annexure	
3 to 5	**Round 8 HIV/AIDS India Country Proposal** HIV/AIDS Proposal Workplan, summaries by SDA and cost category	
	Annexures National Health Policy 2002	1
	National HIV Control Strategy or Plan	Submitted in Round 7
	Technical Report: India HIV Estimates: 2006	2
	Core Indicators for Monitoring & Evaluation, National AIDS Control Programme, Phase III	3
	Operational Manual for Strategic Information Management Unit	4
	Oral Substitution Therapy for Injecting Drug Users: A note	5
	Targeted Intervention under NACP III, Volume II, Migrants and	6

	Truckers	
	Targeted Intervention under NACP III, Volume I, Core High Risk Group	7
	Towards Faster and more Inclusive Growth : An Approach to the Eleventh Five : An Approach to the Eleventh Five Year Plan, December 2006	8
	MSM intervention sites	9
3 to 5	**Round 8 Tuberculosis India Country Proposal** Malaria Proposal Workplan, summaries by SDA and cost category	
	Planning Commission XI Plan TB	1
	Project Implementation Plan (PIP) Phase II	2
	DOTS Plus Guidelines	3
	NRHM Summary	4
	JMM 2006	5 a
	TB in India 2008	5 b
	DRS WHO IUALTD	5 c
	Monitoring Strategy	6
	ICAT Partners	7
	Media Plan ICAT	8
	PMU roles and its job description ICAT	9
	ISTC	10
	Patients Charter	11
	Community Care Guidelines	12
	Glossary	13
	PR2 Capacities NTC	14
	Sub-recipients and SDAs- PR2 NTC	15
	Partner Letters PR2 NTC	16
	HR Structure and Description NTC	17
	Distribution of Project Area PR2 NTC	18

3 to 5	**Round 8 Malaria India Country proposal** Malaria Proposal Workplan, summaries by SDA and cost category	
	Workplan	
	Combined Attachment A	Attachment A & B
	Attachment A India – NVBDCP	
	Attachment A India – Caritas	
	Attachment B	
	Detailed Budget	
	Annexures National Health Policy	1
	Report of the Working Group, XI Five Year Plan	2
	Operational Manual	3
	Joint Monitoring Mission Report 2007	4
	Monitoring and Evaluation Framework	5
	Epidemiological Report of Districts	6
	Drug efficacy 2003 onwards	7
	Insecticide resistance map – India	8
	Vector susceptibility tests	9
	Revised formats	10
	Procurement policy	11
	RDT use guidelines	12
	Drug Policy 2007	13
	ACT use guidelines	14
	Bednet treatment and distribution guidelines	15
	TORs of staff	16
	MTS module	17
	Model District Action Plan	18
	Public Private Partnership	19

	LLIN current status	20
	Sub-recipients	21
	Budget reference	22

3. PROPOSAL SUMMARY

3.1. Duration of Proposal	Planned Start Date	To
Month and year: *(up to 5 years)*	1st April 2009	31st March 2013

3.2. Consolidation of grants	
(a) Does the CCM (or Sub-CCM) wish to consolidate any existing tuberculosis Global Fund grant(s) with the Round 8 tuberculosis proposal?	☐ Yes *(go first to (b) below)* ☐ X No *(go to s.3.3. below)*
***'Consolidation'** refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 8 proposal.* ➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at: http://www.theglobalfund.org/en/apply/call8/other/#5*	
(b) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval? *(List the relevant grant number(s))*	

3.3. Alignment of planning and fiscal cycles

Describe how the start date:

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

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

This proposal from Indian Civil Society, facilitated by the Dual Track Financing Mechanism, will support the National Programme. Finance and budget cycles as well as data recording and reporting systems will synchronize with the Government's established finance and data reporting cycles (Financial year April to March and data reporting quarterly basis from January to March).

Taking into account the expected date of proposal approval and first possible disbursement from the Global Fund, the start date of this Global Fund supported interventions has been set for April 2009 coinciding with the start of national fiscal year from April to March. This will allow all partner organisations to account for the funds within the existing budget cycles and ease the audit requirements.

The month of April is start of the second quarter and hence the technical reports will get generated from the programme reports as per the existing cycles. Thus aligning the period of this proposal with the national fiscal year and reporting period will also assist better financial recording and reporting, and will avoid any duplication of reporting and prevent possible recording errors.

3.4. Program-based approach for Tuberculosis

3.4.1. Does planning and funding for the country's response to tuberculosis occur through a program-	☒ Yes. Answer s.3.4.2

based approach?	☐ No. ➔ *Go to s.3.5.*
3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?	☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***
	☒ No. Do not complete s.5.5

3.5. Summary of Round 8 Tuberculosis Proposal

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

India bears the world's highest TB burden and is also the world's largest democracy highlighted by the greatest number civil society organisations, such as NGOs, FBOs, and CBOs. It is the convergence of these two facts that has brought together civil society organisations, technical agencies and the National Tuberculosis Control Programme to strive in 'partnership' to turn back the burdens of a disease that caused a third of a million deaths last year in India. Although India's Revised National Tuberculosis Control Programme (RNTCP) has made great strides and achieved global targets for case detection (70%) and treatment success (85%), as stated in the Millennium Development Goals (MDGs) and related Stop TB Partnership's Global Plan 2006-2015, much work still remains to be done. Meeting these targets requires responses that not only consolidates and sustains current achievements uniformly across states and districts in the country, but also expands and increases access to quality TB Care for all.

Performance variation amongst districts is evident from the RNTCP 4th quarter performance report 2007 - NSP case detection rates varied from 29% to over 70%. The external joint review of the Programme in 2006- Joint Monitoring Mission (JMM) has also identified programmatic challenges that include limited community awareness, lack of community participation and sense of ownership, emerging challenges of TB-HIV co-infection and MDR-TB management requiring accelerated health system response , and limitations in access to quality TB care for the hard to reach, marginalized and vulnerable populations.

Two groups from Indian civil society, the India Coalition Against Tuberculosis (ICAT), a partnership of 15 national and international organisations, and the NGO Tuberculosis Consortium (NTC) consisting of 9 national and international organisations, together propose to support the RNTCP in achieving these objectives. These 24 NGOs, FBOs and CBOs, will collectively drive forward and galvanise other civil society groups in a coherent and synergistic manner, mobilising to Stop TB in close coordination with the RNTCP. The partners will increase awareness amongst various public and private stakeholders for engagement in the national strategy, and catalyse community based efforts to promote and implement Patient Centred Care enshrined in the International Standards for Tuberculosis Care (ISTC) and the Patients' Charter for Tuberculosis Care (PCTC). ACSM activities will focus on elected representatives, policy makers, media and the academia utilising the strengths of partners, other stakeholders, as well as hiring of experts where required.

The main objectives of the proposal are:

- Engaging and empowering patients and their communities for greater participation in TB care through increasing awareness, establishing peer support groups and community forums and by promoting the adoption of the Patients' Charter for Tuberculosis Care in all project districts, by 2013
- Improving access to quality TB Care services in the project areas and specifically for marginalized and vulnerable groups, affected communities and hard to reach populations.
- Improving care and support for people with MDR-TB and/or co-infected with TB-HIV in both the private and non-governmental health systems
- Enhancing political and administrative commitment at national, state and district level for increased and sustained priority to TB Control
- Strengthening the health system capacity to effectively implement various Programme components through technical assistance and trainings

The overarching objective of this initiative is to bring together and synergise civil society contribution to TB care in the country, and progress towards achieving the goals of the Global Plan to Stop TB 2006-2015 and the relevant MDGs. ICAT/NTC will support under-performing states and districts to uniformly achieve the global targets of at least 85% treatment success and 70% detection rates, reduce delays in diagnosis and treatment initiation, and strive for the implementation of Patient Centred Care for all TB patients, including those with MDR-TB and TB-HIV.

One of the long term objectives of the proposal is to broad base involvement of civil society and other sectors in the fight against TB at national and sub-national level, through an enduring national Partnership. Close coordination with the programme and other stakeholders will be ensured through coordination committees at national and state level. The combined proposed budget for 5 yrs is Euro 79.9 million

4. PROGRAM DESCRIPTION

4.1. National programme and strategy

(a) Briefly summarize:

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

The Indian TB Control Programme has successfully completed the largest and most rapid expansion of DOTS in history to cover the entire country. Since March 2006, The Revised National TB Control Programme is being implemented in all the districts of the country covering the entire 1114 million population. RNTCP Phase II (2006-2011) will further strengthen the quality of DOTS through implementation of the RNTCP quality assurance protocol for sputum microscopy; decentralised and patient friendly DOT services by trained health workers and volunteers; pro-active Public-Private Mix (PPM) activities to standardize early referral, diagnosis and DOT services; rational use of standardised first and second line anti-TB drugs; and need based advocacy, communication and social mobilisation to generate awareness and demand for quality services. The national programme is addressing newer challenges, such as TB/HIV collaborative activities, building partnerships with other sectors, and strengthening Advocacy, Communication, Social Mobilisation (ACSM) activities in order to achieve the MDGs. TB/HIV collaborative activities implemented jointly by the RNTCP and National AIDS Control Programme (NACP) have been scaled up to cover 14/35 states, and are being extended to the entire country. ACSM activities are being conducted aimed at informing people about TB, combating stigma and discrimination, and engaging and empowering people to take action for early self referral to seek treatment, improving case detection, and treatment adherence and completion. New activities in Phase II will also include initiatives for care and management for MDR-TB cases throughout the country in a phased manner. This will include a network of RNTCP accredited quality assured state level Intermediate Reference Laboratories (IRLs), one in each large state, providing culture and Drug Sensitivity Testing (DST) services and increase access to the diagnosis and management of drug resistant TB. In 2007, the national programme initiated DOTS Plus services for the management of MDR-TB in two states of Gujarat and Maharashtra. These services will be introduced in other states across the country in a phased manner in subsequent years.

RNTCP Phase II (2006-11) aligns with the new WHO Stop TB Strategy for TB control and covers all the activities proposed under the strategy to address the current epidemiological situation in the country. The focus of the programme will be to maintain the quality of programme implementation throughout the country. As of now there is significant variation in performance within various states and within districts in states. Proactive involvement of other sectors in planning, policy-making and implementation of the RNTCP, and wider partnerships with all health care providers including the civil society, private sector, corporate houses and medical colleges in the programme will not only ensure uniform quality of services but also ensure sustainability through shared responsibilities. (*Source: India TB Report 2008)*

This proposal seeks to support and strengthen the national programme at central, state, district and community level through the active participation of civil society. The special focus will be on increasing awareness about TB and its curable nature and resultant reduction in stigma related to the diseases. The proposal also focuses on increasing access to quality TB diagnosis and treatment by increasing the involvement of patients, traditional healers, private and NGO sector health care providers, and community volunteers. A team of experts will advocate with elected representatives, policy makers, media and professionals in medical colleges, large hospitals and community health facilities for adoption of the national and international guidelines on MDR-TB management, while a team of ex-patients will be trained to become experts in social mobilisation and advocacy. These two teams will jointly endeavour to reach out to the widest possible populations on local, state and national levels, galvanising the 'top' and the 'bottom' into a broad based movement to confront the disease.

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

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

	Document	Proposal Annex Number	Page References
☑	National Health Sector Development/Strategic Plan	Annex 1 (Planning commission report)	Entire document
☑	National Tuberculosis Control Mid Term Strategy or Plan	Annex 2 (RNTCP PIP phase II)	Entire document
☑	National Tuberculosis Guidelines (medical and laboratory)	Annex 3 (DOTS Plus guidelines)	Entire document
☑	Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	Annex 4 (Executive summary of the NRHM)	Entire document
☑	Most recent annual reports, monitoring mission reports or reviews, including any epidemiology report directly relevant to the proposal	Annex 5 (JMM 2006, India TB report 2008, DRS 2008)	Entire document
☑	National Monitoring and Evaluation Plan (health sector, disease specific or other)	Monitoring strategy document 2005	Entire document
☑	National policies to achieve gender equality in regard to the provision of tuberculosis diagnosis, treatment, and care and support services to all people in need of services	Annex 2 (RNTCP PIP phase II)	Relevant section

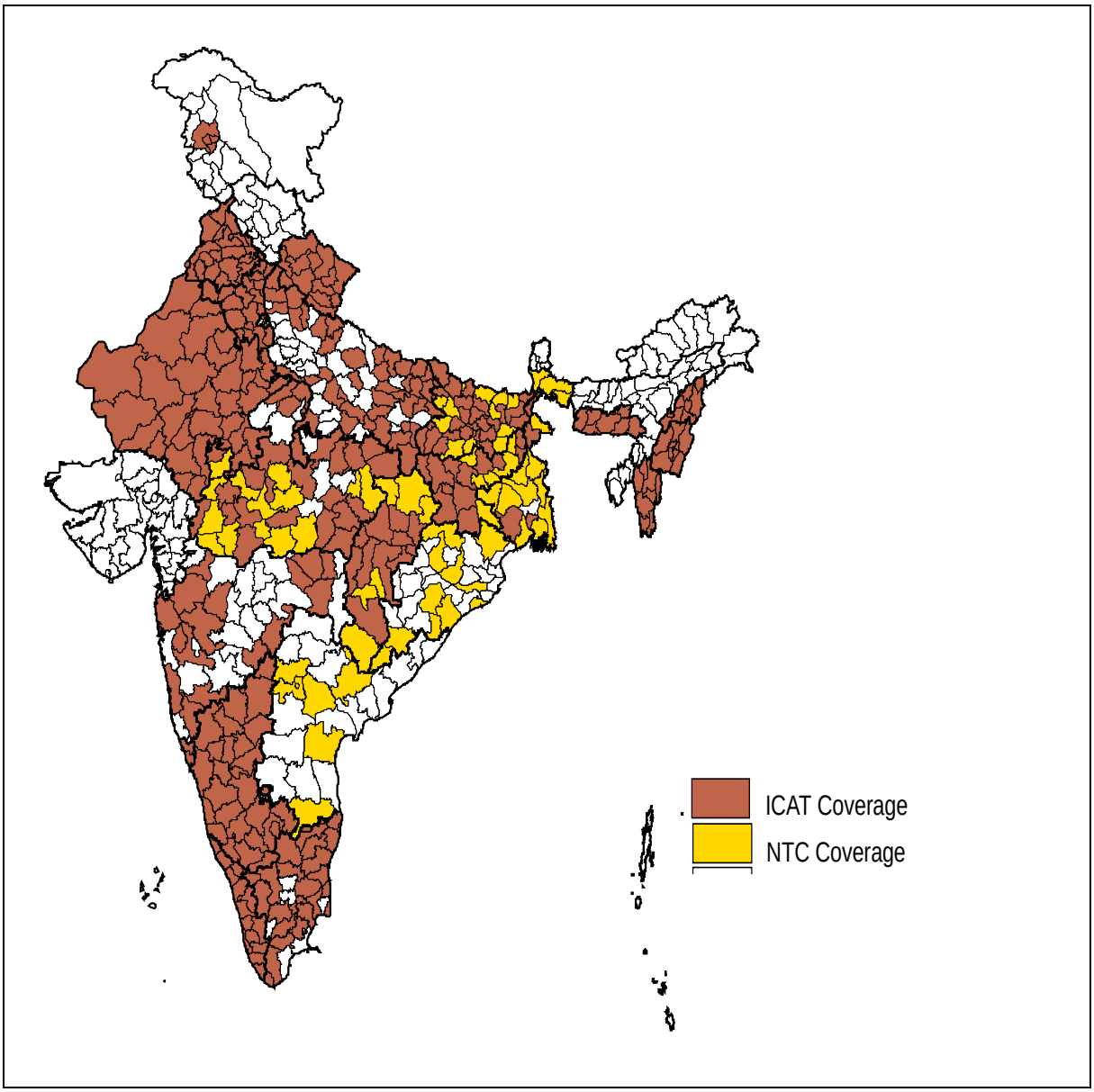
4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal

(a) Do the activities target:

☐ Whole country	☒ Specific Region(s) ***If so, insert a map to show where*	☐ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

ROUND 8 – Tuberculosis



(b) Size of population group(s) targeted in Round 8			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
Total country population (all ages)	801 million target population out of 1147 million country population	Projected from Census 2001	2008
Women > 25 years	173.2 million	Population as per first row; distribution as per National Family health Survey III (2005-06)	2008
Women 19 – 24 years	35.5 million	Population as per first row; distribution as per National Family health Survey III (2005-06)	2008
Women 15 – 18 years	39.0 million	Population as per first row; distribution as per National Family health Survey III (2005-06)	2008
Men > 25 years	187.7 million	Population as per first row; distribution as per National Family health Survey III (2005-06)	2008
Men 19 – 24 years	38.6 million	Population as per first row; distribution as per National Family health Survey III (2005-06)	2008
Men 15 – 18 years	46.9 million	Population as per first row; distribution as per National Family health Survey III (2005-06)	2008
Girls 0 – 14 years	124.7 million	Population as per first row; distribution as per National Family health Survey III (2005-06)	2008
Boys 0 – 14 years	155.5 million	Population as per first row; distribution as per National Family health Survey III (2005-06)	2008
Population living in poor & backward districts	203.1 million	RNTCP Programme Performance Report	2008
Population living in districts identified as predominantly Tribal	237.2 million	RNTCP Programme Performance Report	2008
Population living in Urban slum in the project states	46.7 million	Projected as per Census India 2001	2008

4.2.1. Tuberculosis epidemiology of target population(s)			
Population Groups	**Number**	**Source of Data**	**Year of Estimate**
Estimated tuberculosis patients - shown as number per 100,000 population (*all ages)*	Avg 203/100,000 for the country and Avg 181/100,000 for target population.	National ARTI Survey 2002 Regional variation as per survey and being used by National Programme has been taken into account for target states	2002
Female tuberculosis patients > 25 years	NA		
Female tuberculosis patients 19 – 24 years	NA		
Female tuberculosis patients 15 – 18 years	NA		
Male tuberculosis patients > 25 years	NA		
Male tuberculosis patients 19 – 24 years	NA		
Male tuberculosis patients 15 – 18 years	NA		
Estimated total tuberculosis cases in target population	1,521,261	National ARTI Survey 2002	2002
Notified Tuberculosis patients all forms (shown as number per 100,000 population)	124	RNTCP Perf report	2007
Estimated number new smear-positive tuberculosis patients (rate per 100,000 habitants)	Avg 75/ 100,000 for the country and Avg 72/ 100,000 for target population taking into account regional variation	National ARTI Survey 2002	2002
Estimated NSP cases in target population	572,264	RNTCP Perf report	2007
Notified new smear-positive tuberculosis patients (rate per 100,000 habitants)	49	RNTCP Perf report	2007

Case detection rate of new smear-positive cases	68%	RNTCP Perf report	2007
Estimated number of multi-drug resistant cases of tuberculosis	3% among new cases & 12-17% in retreatment cases	TB India 2008	2007
Notified number of multi-drug resistant cases bacteriologically confirmed	NA		
Treatment success rate of new smear-positive cases	85%	RNTCP Perf report	2007
Defaulter and transfer rate of new smear-positive cases	~6%	RNTCP Perf report	2007
Estimated number of girl (0 – 14 years) tuberculosis patients all forms	NA		
Notified number of girl (0 – 14 years) tuberculosis patients all forms	NA		
Estimated number of boy (0-14 years) tuberculosis patients all forms	NA		
Notified number of boy (0 – 14 years) tuberculosis patients all forms	NA		

Clarified Table 4.2.2

4.2.2. Tuberculosis epidemiology of target population(s)			
Population Groups	**Number**	**Source of Data**	**Year of Estimate**
Estimated tuberculosis patients - shown as number per 100,000 population (*all ages)*	Avg 203/100,000 for the country and Avg 181/100,000 for target population.	National ARTI Survey 2002 Regional variation as per survey and being used by National Programme has been taken into account for target states	2002
Female tuberculosis patients > 25 years	NA		
Female tuberculosis patients 19 – 24 years	NA		

Female tuberculosis patients 15 – 18 years	NA		
Male tuberculosis patients > 25 years	NA		
Male tuberculosis patients 19 – 24 years	NA		
Male tuberculosis patients 15 – 18 years	NA		
Estimated total tuberculosis cases in target population	1,521,261	National ARTI Survey 2002	2002
Notified Tuberculosis patients all forms (shown as number per 100,000 population)	124	RNTCP Perf report	2007
Estimated number new smear-positive tuberculosis patients (rate per 100,000 habitants)	Avg 75/ 100,000 for the country and Avg 72/ 100,000 for target population taking into account regional variation	National ARTI Survey 2002	2002
Estimated NSP cases in target population	572,264	RNTCP Perf report	2007
Notified new smear-positive tuberculosis patients (rate per 100,000 habitants)	49	RNTCP Perf report	2007
Case detection rate of new smear-positive cases	49/100,000	RNTCP Perf report	2007
Estimated number of multi-drug resistant cases of tuberculosis	3% among new cases & 12-17% in retreatment cases ***	TB India 2008	2007
Notified number of multi-drug resistant cases bacteriologically confirmed	NA		
Treatment success rate of new smear-positive cases	265417 (85%)	RNTCP Perf report	2007
Defaulter and transfer rate of new smear-positive cases	~2/100,000	RNTCP Perf report	2007

Estimated number of girl (0 – 14 years) tuberculosis patients all forms	NA		
Notified number of girl (0 – 14 years) tuberculosis patients all forms	NA		
Estimated number of boy (0-14 years) tuberculosis patients all forms	NA		
Notified number of boy (0 – 14 years) tuberculosis patients all forms	NA		

***** These are the data provided by the NTP and these figures are based on small studies conducted in different pockets of India.**

4.3. Major constraints and gaps

4.3.1. Tuberculosis program

Describe:

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

The sources of information used to identify challenges are Joint Monitoring Mission (JMM) 2006, IEC baseline document 2007 of the programme, Annual TB report 2008 and the WHO/ International Union Against Tuberculosis and Lung Disease report on *Anti-TB drug resistance in the world* 2008.The description of the challenges includes a discussion on how this will affect programme achievement and identifies gaps in service delivery to target populations that this proposal effectively addresses.

1. The JMM report underlines the enormous scope for improvement in IEC / ACSM because of current low priority by state and district managers and administrative delays in execution of activities. There were inconsistencies between action plans, proposed activities and actual verified activities. The activities focussed on producing materials and providing information rather than incorporating more persuasive, behaviour-centred ACSM approaches. Stigma continues to lead to the isolation of patients, and impair effective referral, treatment and care. The problems of stigma are more acute with specific groups such as young rural women who live in fear of being rejected by partners and potential spouses. Further, evidence that specific efforts have been made to promote awareness about the location of new services or increase service demand by promoting these services through IEC/ACSM activities was lacking. Similar challenges have been identified in the IEC Baseline (2007) document[4]. State and district level capacity needs to be strengthened and many of the State TB Cells had expressed lack of or a low level of confidence in planning and implementing IEC programmes.

2. Although the RNTCP reported an increase in cases detected since its implementation, the NSP case notification rates have been variable across states and districts within states. In difficult and remote areas, the RNTCP guidelines provide for sputum collection and transportation, but the JMM observed that this system was not used. Default rates are particularly high among retreatment patients. The JMM team noted that among the visited districts, **the district with the highest proportion of community DOT (Chikmagalur, 45%) had the lowest default rates**. Treatment observation is often not convenient for patients living in remote areas and for labourers in urban areas.

3. The JMM mission identified a large, untapped potential for further action to involve providers not yet linked to the Programme. In many districts, PPM activities receive insufficient attention, and staff responsible for implementing the RNTCP is often not sufficiently equipped to efficiently scale up PPM.

4. Although drug resistance is reportedly moderate (from 0.5% to 3% in new cases and around 12% in previously treated patients), the large numbers of total TB cases makes the actual burden of resistant cases very high. The presence of an ever-growing and unregulated private sector and over-the counter access to a wide range of TB drugs suggests an environment conducive to the development of drug resistance. The plan to address MDR-TB has been prepared; the pace of implementation needs to be accelerated. Most states have designated a state-level IRL but challenges exist with respect to staffing and training of staff in undertaking quality culture and DST. In private sector, MDR-TB diagnosis is often based on clinical and radiological parameters, and smear microscopy alone. Culture and DST are being done in laboratories (at some medical colleges and in the private sector) which are not accredited and lack quality control by an NRL. The widespread availability, and use, of second line drugs is a serious threat that could compromise programme achievements.

5. Although good-quality binocular microscopes are generally available, and “annual maintenance contracts” are in place in a few states, there remain many challenges to the maintenance of binocular microscopes.

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

6. Although a concerted effort has been made to decentralize Integrated Counselling and Testing Centres (ICTCs), accessibility to such services is still suboptimal for TB patients. MOs and ICTC counsellors have been sensitized regarding TB/HIV activities and the cross-referral process but referral and feedback are sub-optimal. High rates of patient loss were observed between referral of TB suspects from ICTCs and evaluation by the RNTCP.

7. The World Economic Forum reports that managers around the world are more ill informed and concerned about tuberculosis (TB) in their workplaces than HIV and AIDS. Sixty three percent of firms in low income countries expect some impact from TB in the next five years compared to 46% of all firms expecting some impact from HIV. The current misinformation on TB resulting in mismanagement results in two interrelated problems that contribute its spread in the workplace. Firstly, employers who are not willing to provide sick leave to employees that have TB. Secondly, when employers directly or indirectly terminate employees with TB, access and monitoring of these employees will not be possible. These factors underscore the need for focused dialogue between the employers/managers and the program to facilitate the development of work place policies and provision of employee friendly services.

4.3.2. Health System

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

The description can include discussion of:

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

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

Being an integrated programme, the RNTCP depends on a functioning health system with sufficient infrastructure, outreach and access, and adequate, well trained and motivated staff at all levels. It also depends on functioning referral, transfer and information-sharing mechanisms between various public and private health-care providers. Deficiencies in the general health-care system constitute a major barrier to further improvements in programme performance, especially in a number of large states with high TB burdens and weak health systems. Limited public resources for health have contributed to a weak public health-care infrastructure. It has also translated into low salaries for health staff, with consequences for recruitment, staff turnover and staff morale. Many health positions in rural areas are vacant due to the poor working and living conditions for staff. Frequent transfer of staff at all levels increases training load and reduces quality. Staff absenteeism and practice in private clinics to augment income are other problems. Complex bureaucracies also contribute to low morale and inefficient management and supervision. A recent analysis showed that TB case notification and rate of TB suspect investigation is associated with outpatient visits to general health facilities which, in turn, may be associated with the general state of the health system. The JMM teams made similar observations in the six states visited. Long delays between symptom onset and patients reaching RNTCP services in the general health system is a common phenomenon, suggesting that patients waste time and money shopping for care in a complex and poorly coordinated health system of private and public providers. There is very limited capacity at state and district levels for human resource, programme and financial management.

Public health services are perceived as inconvenient in terms of timing and location, and the providers unsympathetic, hurried and authoritative (Pathania V, Almeida and Kochi A, WHO, 1997, p145). Thus the community practice of having the private providers as the first point of contact has a spill over effect on a

significant proportion of patients with tuberculosis. There is an opportunity to reduce diagnostic delay, with a concurrent reduction in transmission through involvement of this sector. This will improve patient access and acceptance and thereby treatment outcomes; avoid unnecessary diagnostic delay, and encourage all health care providers to uniformly adopt standardized diagnostic and treatment regimens under RNTCP.

Present training methodologies and curricula present a huge opportunity and scope for building in the development of counseling, interpersonal and other "soft" skills of health service providers. This training component will assist public health staff broaden their repertoire of a range of people skills and their execution capacity. These skills refer to the cluster of personality traits, social graces, facility with language, personal habits, friendliness, and optimism that mark people to varying degrees. Soft skills complement hard skills, which are the technical requirements of a job and are critical to performance and include interpersonal skills, handling confrontation, building rapport, listening and questioning skills.

4.3.3. Efforts to resolve health system weaknesses and gaps

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

The National Rural Health Mission (NRHM) is an ongoing reform, within the general health system in India, aimed to address several of the health system weaknesses. The primary goal of the NRHM is to improve the availability of and access to quality health care by people, especially those residing in rural areas, the poor, women and children. The NRHM presents an opportunity to strengthen the public health services to improve quality and access to TB services. A key feature of the NRHM is the community ownership of public health, with important decision making powers, including those that could challenge the core areas specific to RNTCP described earlier, being progressively devolved to the community through the local government at village level. The appointment of the ASHA (Accredited Social Health Activist), who is a voluntary female peripheral health worker for every 1000 population provides another enormous opportunity to mobilise the community for better TB control and care.

As part of the Mission, the government has formulated - 'Indian Public Health Standards', which will ensure a minimum acceptable levels of infrastructure, human resource, facilities and services at all levels of the public health system. All national health programmes with their respective verticality has been subsumed under the NRHM to provide a convergent and synergistic platform to address weakness of the health care delivery system in the country. The resultant improvement of the health system supports improved service delivery under the NTP. This Health System Strengthening (HSS) initiative will form the base from which high quality care, including TB care, will be made available to communities in rural areas.

The RNTCP has developed strategic plans to address health system gaps in the Strategic Vision Document 2005-2015 which can be best supported through civil society partnerships. The activities as per this strategic plan has been detailed in the WHO Global TB Control report for 2008 and are as under:

<u>System strengthening , including human resource development</u>

- Planning for TB control involved sector-wide and intersectoral collaboration, including close involvement of the NTP in planning the ongoing primary health-care reform by the National Rural Health Mission (NRHM)
- Continue active engagement with NRHM to support its elements for health system strengthening,
- To provide human resources to fill critical gaps in the health system (e.g. laboratory technicians)
- Develop training plans that will endeavour to minimize delay in the training of newly placed staff while making allowances for the existing and on-going turnover of staff and for training in newer intervention.
- Periodic programme assessment and review at all levels

<u>Engaging all care providers</u>

- Adopt ISTC in order to improve the standards of TB management across all sectors
- Continue scale up of PPM activities
- Plans to develop guidelines for further involvement of other public sectors in TB control

- Work with the Professional Association to increase participation of private practitioners

Diagnosis and treatment of multidrug-resistant TB

- Develop capacity at the Intermediate level Reference Laboratories in mycobacterial culture to facilitate management of MDR-TB cases.

Empowering people with TB and communities through ACSM

- Involved communities in TB control activities in all districts, and self-help groups, cured TB patients, folk media and traditional healers in TB care and control activities
- Strengthened capacity of NTP staff in states and districts to plan and implement locally relevant ACSM activities,
- Needs-based ACSM activities for patients and communities, health-care providers and decision-makers
- Encourage states and districts to develop ACSM activities focusing on tribal and other hard-to-reach populations

Community participation in TB care

- Enhance community involvement through community meetings, and collaboration with groups such as self-help groups, youth organizations, schoolchildren, local NGOs, faith-based organizations and Panchayati Raj Institutions
- Involve community volunteers and cured TB patients to provide motivation and support for TB patients
- Undertake mass media activities in collaboration with national telecast network
- Initiate TB care in the community

This proposal will contribute to leveraging community support across the country to build on each of the health systems strengthening plan enlisted above.

ROUND 8 – Tuberculosis

4.4. Round 8 Priorities

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

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

***(Some of the targets projected below will be achieved through combined efforts of existing programme activities and the activities proposed through this project. The achievement cannot be attributed to a single intervention. However for purpose of assumptions the current level of achievements of programme are being taken as baseline that is assumed to continue to remain at same level with available resources)*

Priority No: 1	NSP case detection rates of at least 70%**	**Historical**		**Current**		**Country targets**			
Intervention	Community engagement in TB control, Improved access for marginalized, vulnerable groups and hard to reach areas	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist) (for project districts) @70% of estimated NSP cases and 2% annual increase in population*			400,585	408,597	416,769	425,104	433,606	442,278	451,123
B: Extent of need already planned to be met under other programs			390,412	390,412	390,412	390,412	390,412	390,412	390,412
C: Expected annual gap in achieving plans			10,173	18,185	26,357	34,692	43,194	51,866	60,711
D: Round 8 proposal contribution to total need *(however the actual contribution is expected to be more than the country target i.e. exceeding 70% NSP CDR)*		*(e.g., can be equal to or less than full gap)*			26,357	34,692	43,194	51,866	60,711

ROUND 8 – Tuberculosis

Priority No: 2	Cat II treatment completion rate of at least 85%	Historical		Current		Country targets			
Intervention	Improving access to quality care	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)(85% of all Cat II cases initiated on treatment); 2% annual population increase*			126264	128789	131365	133992	136672	139405	142193
B: Extent of need already planned to be met under other programs			37106	37106	37106	37106	37106	37106	37106
C: Expected annual gap in achieving plans			89158	91683	94259	96886	99566	102299	105087
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			39409	46897	61502	83643	99535

Priority No: 3	Improving access to routine TB care and control services	Historical		Current		Country targets			
Intervention	PPs and NGOs involved in project districts (in addition to existing and the IMA project contribution)	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*			20641	***Increasing trend	***Increasing trend	***Increasing trend	***Increasing trend	***Increasing trend	***Increasing trend
B: Extent of need already planned to be met under other programs				NA	NA	NA	NA	NA	NA
C: Expected annual gap in achieving plans (figures are for health care providers not expected to be covered under IMA project and hence the gap)					14310	16395	17185	27185	32150
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			14310	16395	17185	27185	32150

Clarified priority No. 4.

Priority No: 4	Strengthening response to MDR TB care	Historical		Current		Country targets			
Intervention	Number of IRLs upgraded to undertake newer diagnostics	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)(These are for solid culture while the project proposes to upgrade labs for undertaking liquid culture in alignment with national programme requirements)*		15	21	24	24	24	24	24	24

ROUND 8 – Tuberculosis

Priority No: 4	Strengthening response to MDR TB care	Historical		Current		Country targets			
Intervention	Number of IRLs upgraded to undertake newer diagnostics	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
B: Extent of need already planned to be met under other programs (the programme has already upgraded 2 IRLs in 2007for undertaking DST and solid culture. Funding plan for liquid culture is not available as of now.		NA	NA	NA	NA	NA	NA	NA	NA
C: Expected annual gap in achieving plans (cumulative)					0	9	26		
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			0	9	26		

➔ *If there are six priority areas, copy the table above once more.*

4.5. Implementation strategy

4.5.1. Round 8 interventions

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

This proposal 'Enhancing India's TB Care and Control efforts through augmented civil society participation' is a historic effort from civil society comprising a wide array of partners including patients, affected communities, NGOs, CBOs, FBOs and technical agencies to come together and have a participatory role in TB Care and control efforts in India

The proposal is being submitted, in common cause, by two Principal Recipients (PRs) approved by the CCM for submission to GF R 8 – **PR 1 The International Union Against Tuberculosis and Lung Disease (The Union) for India Coalition Against TB (ICAT)** and **PR 2 World Vision India for The NGO TB Consortium (NTC)** which brings together 24 national and international partners to support the RNTCP in harnessing the strengths of civil society in a coherent and synergistic response to India's TB epidemic. The overarching goal of this proposal is to contribute to the Programme's effort to reduce TB related morbidity and mortality and accelerates progress towards achieving the Global Plan to Stop TB 2006-20015 targets and the relevant MDGs. Under-performing states and districts will be specifically supported to achieve 85% treatment success rate and 70% detection rates among new smear positive cases, reduce delays in diagnosis and treatment initiation, and promote the adoption and implementation of Patient Centred Care for all TB patients including those with MDR-TB and HIV co-infection.

The proposal will increase access to quality TB services in project districts with special focus on marginalised and vulnerable groups, and hard to reach populations through community empowerment, increased awareness, enhanced political and administrative engagement and systems strengthening through collaboration with National Rural Health Mission (NRHM).

A coordination committee involving the implementation agencies as well as all stakeholders will be formed at national, state and district level. The committee will meet at least 6 monthly and if needed quarterly for coordination and review of project implementation activities and guide further action. The committees will be formed under overall guidance of Central TB Division. At national level, the meetings will be organised by the secretariat being proposed by ICAT in coordination with NTC.

The ICAT partners in the proposal include Catholic Health Association of India (CHAI), Christian Medical Association of India (CMAI), Centre for Legislative Research and Advocacy (CLRA), Catholic Relief Services (CRS), Emmanuel Hospital Association (EHA), Foundation for Innovative New Diagnostics (FIND), InterAide, Mamta, Mamta Samajik Sanstha, Manavadhikar Samajik Manch, Population Services International (PSI), Resource Group for Education and advocacy for Community Health (REACH), International Union Against Tuberculosis and Lung Disease (The Union), Voluntary Health Association of India (VHAI) and the World Care Council. Several ICAT partners are umbrella organisations representing large networks of state and local grassroot units. These partners already support large scale public health interventions within states and represent an enormous human resource network which will now be systematically available for the RNTCP through ICAT. The ICAT proposes to support RNTCP in more than 630 million population in 350 districts of the country including geographically difficult areas of North-east, tribal populations of 224 million, poor and backward districts with population of 143 million and estimated slum population of 22 million. The members of ICAT have mandated the Union to lead the coalition (organisation details and coverage are provided in detail in Annexure 7).

The **NGO Tuberculosis Consortium (NTC)** is a civil society initiative of nine national and international NGOs born in March 2007 with World Vision India as its convener, to coordinate and consolidate efforts to complement RNTCP in reducing the burden of TB in India. Among its many strengths are its members' long standing experience in social mobilization through local community networks, also technical and programming capabilities related to TB. Since its inception NTC has drawn upon the strengths of its constituents to raise support for the cause of TB in state, national and international forums. NCT's partners in the proposal include LEPRA Society, TB Alert, German Leprosy and TB Relief Association (GLRA), PATH India, Adventist Development and Relief Agency (ADRA) India, CARE India and Southern Health Improvement Samity (SHIS) and World Vision India. Damien Foundation of India Trust (DFIT) and PATH India are members of NTC who will support the project as non SRs. The members of the NTC have mandated World Vision India to lead the project as the Principal Recipient. Details and coverage of the members are provided in Annex 7. The NTC component of the proposed project will be implemented in 74 districts across Bihar, Orissa, Madhya Pradesh, West Bengal, Chhattisgarh, Jharkhand and Andhra Pradesh, covering a total population of 168.7 million that of which 13.2 million are tribal and 24.7 million are urban poor. Target districts have been chosen on the basis of program outcomes being lower than

the state averages, the presence of challenges significant enough to warrant additional support and those with a high proportion of vulnerable populations.

The common objectives of the proposal for both PRs are:

1. Engaging and empowering patients and their communities for greater participation in TB care through increasing awareness, establishing peer support groups and community forums and by promoting the adoption of the Patients' Charter for Tuberculosis Care in all project districts by 2013
2. Improving access to quality TB Care services in the project areas and specifically for marginalised and vulnerable groups, affected communities and hard to reach populations.
3. Improving care and support for people with MDR-TB and/or co-infected with TB-HIV in both the private and non-governmental health systems

The additional objectives specific for ICAT component of the proposal are:

4. Enhancing political and administrative commitment at national, state and district level for increased and sustained priority to TB Control
5. Strengthening the health system capacity to effectively implement various Programme components through technical assistance and trainings.

PR1: The Union for India Coalition Against Tuberculosis (ICAT)

Objective 1: Engaging and empowering patients and their communities for greater participation in TB care through increasing awareness, establishing peer support groups and community forums and by promoting the adoption of the Patients' Charter for Tuberculosis Care in all project districts by 2013.

The proposal aims to translate Component 5 of the WHO Stop TB Strategy into beneficial realities, implemented on the ground. Through this component, the proposal will: empower people with TB, and communities: increase advocacy, communication and social mobilization; improve community participation in TB care • facilitate awareness and adoption of the Patients' Charter for Tuberculosis Care. Patients and members of the affected communities will be involved in designing the ACSM campaign and developing messages that are contextually appropriate

To achieve this objective the ICAT will work through following SDAs:

Objective 1: SDA 1 – ACSM

Increasing community awareness and participation through comprehensive and sustained media campaigns and community action that addresses four key challenges:

- Improving case detection and treatment adherence
- Combating stigma and discrimination
- Empowering people with TB and their communities
- Enhanced mobilization of political commitment and in turn financial and human resources for TB.

This will involve:

1.1 *Mass media campaign*:

1.1.1 Production and broadcasting of high quality mass media campaign outputs, including TV and radio Public Service Advertisements (PSAs) and outdoor and print media apt for local settings and culture. Messages will be rigorously pre tested and evaluated for recall.

1.1.2 Production and broadcasting of series of radio programmes to demystify issues related to TB.

1.1.3 Media broadcast plan to ensure cost effectiveness and high reach.

Existing material of the RNTCP, wherever available will also be used to minimise production costs and maximising the output.

The mass media campaign will be complemented through mid-media (like street plays) and interpersonal communication that will reinforce the messages at ground level and ensure sustained effect beyond the campaign itself.

1.2 Mid-media and interpersonal communication:

1.2.1 Development and dissemination of campaign toolkits.

1.2.2 Organization/ participation in specific events like street play, fair, road show

1.3 Impact research:

1.3.1 Baseline study

1.3.2 Simulated patient study

1.3.3 Annual trend line

1.3.4 End line study

Details of mass and mid media campaign, and campaign tool kits are available in annexure 8.

1.4 Orientation on campaign tool kit for field workers

1.4.1 A workshop/ training of community workers on BCC will be organized for effective utilization of toolkit in all project districts.

1.5 Innovative pilots for social mobilization for quality Community TB Care

1.5.1 The methodology for social mobilization, Community Gardening, developed by the same 'patient-powered NGO that produced the Patients' Charter for Tuberculosis Care, the World Care Council, will empower and mobilize people with TB and/or TB-HIV and their communities. With partnerships with a dynamic CBOs on the ground (Delhi Network of PLWHA DNP+, Kuknalim Foundation in Nagaland, Zindagi in Goa, Nalamdana in Tamil Nadu, and the Council of People living with HIV/AIDS in Kerala), national institutions, technical agencies, and other civil society organizations, an innovative approach will be rolled out in key states, and its impact studied through operational research. Around fifty 'activists' will be trained and equipped to spearhead the drive for Drugs, Diagnostics and Dignity, reaching out to empower patients and their communities. Social mobilization will generate the advocacy and communication needed to build a broad based movement to Stop TB, with a focus on improving care in the community.

1.5.2 TB Community Central Stations: Physical and virtual (telephone/ internet based) meeting points for people affected by TB, will be established to allow the wider TB community to interact, learn and find support. They will serve as a model 'welcoming' space, where all people who may have tuberculosis, or who are either on treatment or have been cured are embraced with dignity and respect - either in person, by telephone, or within an online social community. These Stations will be focal points for growing peer support groups while regular training workshops and events will be offered for future patient advocates on treatment literacy, case detection, community mobilization techniques and specific issues such as TB-HIV, MDR/XDR, and infection control. The main Community Central Station will house the TB Call Center – a multi-lingual telephone and online service with toll-free 24h SMS offering information, solidarity, and referral services to all those in need.

1.5.3 TB Community Mobile Units: A number of state-wide mobilization projects will be equipped with a mobile ACSM unit and support service. These mid-sized vehicles, with distinctive exterior signs, décor and sound systems with public address, will carry small teams of community mobilisers to where the targeted (often marginalized) public gathers, to deliver 'consumer information' about TB, and to document and amplify the voices of those suffering in silence. The Mobile Units will be able to offer social support, rapid referral service and a dynamic outreach platform to develop local peer support groups, advocacy and media-friendly actions in the community. The Mobile Units will visit and 'partner' with private and public clinics, health centres and DOTS providers, and conduct outreach at local marketplaces, schools, and cultural or sporting events. Adaptable to the targeted population, setting and services, they will move ACSM forward on the ground - raising awareness, raising smiles, and raising a movement to Stop TB.

1.5.4 Open Access for Universal Access: A number of key state projects will incorporate the use of very basic mesh-networked (interlinked) laptop computers, such as the accessible units produced by the One Laptop Per Child Foundation (www.olpc.org). These will be used as tools of interactive communication and to deliver health information designed for, and by, members of the targeted populations. Each TB Community Mobile Unit will be equipped to offer an internet connection for the mesh-network of laptops to allows peer group meetings, workshops and public

events to not only have relevant information in local languages, but to be linked to others in the state 'community' network. A number of children affected by TB in each community will be trained as 'tech-teachers', while the Mobile Unit staff can show people to how to apply the information that the technology makes available. This initiative brings the expertise of the Open Source community, a network of IT developers committed to increasing access to the internet through sharing and exchange, into a dynamic partnership to mobilise affected communities for increased access to quality TB Care.

1.6 Community support groups for TB care

1.6.1 Developing a forum with participation of cured patients, marginalized population, old age people, population living in slums and homeless, affected communities. These will act as peer educators, treatment facilitators and advocates with local administration.

1.6.2 Involving Village Health and Sanitation Committee with representation from PRIs, local SHGs, ASHA and other associations through regular meetings.

These two activities will result in developing a system of 'community monitoring' of the project where the patient groups will support the programme staff at health facility level in ensuring quality DOTS

1.7 *Adoption of Patients' Charter by non-govt health facilities*:

1.7.1 Patients' Charter will be translated into local language

1.7.2 Printed and distributed to all health facilities.

1.7.3 Specific events for Patients' Charter dissemination will also be organised.

1.8 *Strengthening civil society engagement in TB control*: Over the long term ICAT seeks to; draw up a combined strategic plan for civil society to support the fight against TB in India, coordinate TB related activities of partners, increase visibility and ownership of the national TB programme, facilitate need based technical and financial support for partners, interface with donors and expand its membership. This proposal also includes a component to establish a Secretariat to achieve these objectives. The Secretariat will:

1.8.1 Develop and execute Memorandum of Association amongst members

1.8.2 Organise an office for secretariat - Hire Technical Officer/s and one administrative assistant for the purpose

1.8.3 Ensure regular communication amongst all members – through e-mail and monthly newsletter

1.8.4 Organise meetings of members. Regional meetings will help to expand membership base and establish direct contact with NGOs and CBOs in various parts of the country.

1.8.5 Appraise Central TB Division with needs and expectations of civil society and maintaining constant working relation with RNTCP

Objective 2: **Improving access to quality TB Care services in the project areas and specifically for marginalised and vulnerable groups, affected communities and hard to reach populations**.

As part of social mobilisation campaign to build a sense of 'community' amongst those most affected by tuberculosis and to support their greater participation in all aspects of TB Care to help improve early referral of chest symptomatics, case detection, adherence and treatment outcomes. This will be done by forging sustainable networks of TB patients and members of their communities to support a social movement driving for access to drugs, diagnostics and dignity. This will also include mobilising community based organisations, local representatives like Panchayati Raj Institutions (local gov't), private providers, traditional healers and health system functionaries for increased participation in TB care.

Objective 2: SDA 1 – Community TB Care

2.1 *Community volunteers will be engaged in identification of TB suspects and their early referral to seek treatment (reduce patient delay); counselling the importance of three sputum tests (reduce diagnosis delay); counselling the importance of adherence to treatment (reduce treatment delay and improve treatment outcomes).* Community networks will function as treatment supporters and will be involved in

2.1.1 Sputum collection and transport

2.1.2 Retracing Initial Defaulters

2.1.3 Visits to patients and health facilities for which a nominal honorarium will be paid.

2.2 Involving traditional healers specially in slums

2.2.1 Sensitisation meetings in areas with significant slum population

Objective 2: SDA 2 – Improving diagnosis

2.3 Expanding the network of quality assured routine laboratory services

2.3.1 Through sensitisation and trainings the project will facilitate scheme IV (under NGO scheme as of now – Microscopy Centre) participation by partners and other NGOs

2.3.2 Maintenance of all microscopes in all designated microscopy centres for 5 years in 5 states through a contracted agency. Selection of states will be based on challenges being faced in having Annual Maintenance Contracts and feasibility. This would be extended to other states on need basis

Objective 2: SDA 3 – Involvement of all care providers (PPM)

Increase involvement of private and non-government health care providers in the programme to ensure early referral, diagnosis and treatment. This will focus on proactively increasing engagement and partnership with private, corporate, charitable and other partners for services and referrals.

2.4 *Wherever feasible PPs/ NGOs not covered under IMA project (other than IMA member and practitioners of other systems of medicine) will be encouraged to join the existing RNTCP schemes as per their capacity. This will be done through*:

2.4.1 Sensitization workshop/ trainings to RNTCP staff on PPM

2.4.2 Workshop/ trainings to Non-RNTCP staff including certification

2.4.3 Door to door visits by project staff

2.5 Work place intervention

2.5.1 Working with corporates to develop work place policy. The corporates will be provided TA wherever necessary to develop the policy

2.5.2 Increasing the number of work place programs to reduce stigma and increase treatment seeking and support for workers with TB

Objective 3: Improved care and support for MDR-TB cases and TB-HIV coinfected cases in private and non-government health system

Objective 3: SDA 1 - ACSM

3.1 *Advocacy for adoption of DOTS Plus guidelines*:

3.1.1 The project will advocate with Medical Colleges, Secondary and Tertiary non-government hospitals for adoption of WHO/STAG and RNTCP recommended DOTS Plus strategy. This will be done through a team of 5 members inclusive of 3 senior microbiologists and 2 chest physicians who will advocate with Medical Colleges and professional bodies.

Objective 3: SDA 2 – MDR-TB

3.2 Continuing Medical Education (CME) for specialist physicians on MDR TB management in close collaboration with national stakeholders.

Full fledged CMEs are in addition to advocacy activities. The CMEs are more extensive, for physicians dealing directly with patients while advocacy meetings will be with senior hospital/ medical college administrative staff (like Director and HODs of deptt). The CMEs will be done in close coordination with professional bodies like Indian Medical Association (IMA)

3.3 *For selected senior level physicians in non-government sector, trainings with international expertise will be organised*.

Objective 3: SDA 3 – Improving diagnosis

3.4 *Strengthening the network of quality assured referral laboratory services in alignment with the RNTCPs DOTS Plus strategic plan.* Technical capacity building of labs will be speeded up so as to enable them to deliver on the responsibility of diagnosing and managing all MDR TB cases in their states as per diagnostic criteria under RNTCP. Labs will be enabled to adopt new and approved lab technologies in a sustainable and long-term manner. Quality of diagnosis under RNTCP will be improved by reducing time to diagnosis, improved training methods, assured availability of lab staff, better lab techniques and technologies and provisions for equipment maintenance and stream-lined working of labs.This includes:

3.4.1 Introducing and supporting the adoption of new and improved diagnostics to address emerging programme needs. These include evidence based technologies as per recommendations of Stop-

TB partnership working group on newer diagnostics:

3.4.1.1 Infrastructure for negative pressure culture facilities in two National Reference Laboratories (NRL) and TB molecular diagnostics facilities in four NRLs and 26 Intermediate Reference Laboratories (IRL) of RNTCP

3.4.1.2 Infrastructure for upgradation of training facilities in identified 16 IRLs of RNTCP

3.4.1.3 Provision of fluorescence microscopy in identified 120 high workload DMCs

3.4.1.4 Consumables supply for new technologies so as to provide rapid diagnosis for all MDR-TB suspects as per RNTCP definitions in vogue (Category II failure cases).

3.4.2 Providing ongoing technical assistance for the upgradation, and management of TB lab systems and provision for implementation of RNTCP lab techniques:

3.4.2.1 Technical assistance from high level technical experts to provide hands-on training for short duration

3.4.2.2 Appointment of a team comprising of a mix of skill sets to manage TB culture services at each IRL and managed by a HR agency

3.4.2.3 Design and dissemination of lab manuals and SOPs for new techniques, lab management and lab bio-safety

3.4.2.4 Hands-on training on lab techniques for RNTCP labs

3.4.2.5 Establishing systems for data management at Labs

3.4.2.6 Conducting Annual National Lab co-ordination meeting by RNTCP

3.4.2.7 Provision for Annual maintenance for lab equipments

The programme will be assisted to fast-track the accreditation of IRLs through technical support

3.5 This will lead to increased access for patients to culture and DST for MDR-TB diagnosis
The increase in number of MDR-TB patients being diagnosed will be regularly reviewed with RNTCP to assess the drug requirements and ensure treatment availability for all patients

The procurements of equipment for IRLs will be undertaken through a procurement agency

Objective 3: SDA 4 – TB-HIV

3.6 *TB-HIV*: In high HIV prevalent states and specific districts under coverage, ICAT project will coordinate to increase access to HIV counselling and testing for all TB patients through:

3.6.1 Greater involvement of affected communities

3.6.2 Training of health staff in ICAT partner health institutions in counselling and testing

3.7 Increasing referral of TB patients from non-government sector

3.7.1 Establish a recording and reporting mechanism to track referrals

3.7.2 The referred patients are expected to receive free ARVs as per the Govt policy. The community support groups will facilitate this process

Objective 4: Enhancing political and administrative commitment at national, state and district level for increased and sustained priority to TB control

Objective 4: SDA 1 – ACSM

4.1 Political commitment

4.1.1 Advocacy meetings with Indian Medical Parliamentarian Forum (specifically through the Parliamentarian Group for TB created in 2006) at national level.

4.1.2 Formation and meeting with corresponding bodies of MLAs at state level

4.2 Administrative commitment

4.2.1 State level sensitisation meetings with administrators and health dep't personnel

4.2.2 Quarterly newsletter for administrators and programme staff

Objective 5: **Strengthening the health system capacity to effectively implement various programme components through technical assistance and trainings.**

The project envisages to enhance capacity of the states and districts to design and implement ACSM planning, implementation, monitoring and evaluation among programme staff through technical assistance and training. This will be done based on existing model of TA support being provided by the Union to Orissa RNTCP that has been acclaimed and endorsed by RNTCP. This main activities will be:

Objective 5: SDA 1 – HSS-health workforce

5.1 Technical assistance on ACSM

5.1.1 Supporting State TB Officer in 5 selected states through a lean structure of two local consultants who will work along with District TB Officers to develop state and district specific ACSM action plans

5.1.2 Need based expert international TA to support ACSM

5.1.3 Regular review and monitoring of the progress of ACSM activities

5.2 *Training programmes, for senior district and state level programme managers, focussing on thematic areas such as programme management (including finance and logistics), epidemiology, operations research, and MDR-TB.* The Union will adapt its international courses to local context,

5.3 *Facilitate participation of district, state and national level programme managers in international conferences and workshops*.

5.4 Provide opportunities for cross learning and study tours for district and state level programme managers

5.5 *Capacity of central level will be strengthened by hiring of four senior experts in ACSM, PPM, Microbiology and M&E* who will work in close coordination with Central TB Division (CTD) of RNTCP. This will strengthen national level capacity to oversee the programme in general and specifically the project activities.

Project Management and Supervision

A **Project Management Unit (PMU)** will be established to coordinate with partners, stakeholders and the RNTCP. The PMU will include systems and capacity for rigorous monitoring and supervision of project performance, fiscal control, data management, procurement, contracts and logistics management. Project Director will be the overall incharge and responsible for the project. The PMU will have a technical unit headed by Project Coordinator and operations unit headed by Chief Finance and Operations coordinator. They will be further supported by technical team, grant administrators and admin staff. The PMU will also ensure coordination and regular review of the project with national programme. The organogramme and TORs are in Annexure 9

The district and state level activities will be reviewed with programme managers and administrators at respective level by the implementing partners. The implementing partners will also facilitate regular supervision of the project activities by programme managers.

PR 2: World Vision India for NGO TB consortium

Objective 1: To engage and empower communities for a greater role in TB control and care through improved knowledge, changed attitudes and participation

This objective will be met through the following SDAs and Activities:

Objective 1, SDA 1: ACSM

1.1 Mobilize Communities through local NGO/FBO networks:

1.1.1 Profile NGOs/FBOs and sensitize at least 10 NGOs/FBOs on TB and RNTCP schemes per district in the first two years and 5 per district in the remaining years.

1.1.2 Sensitize community groups, CBOs, schools and decentralized authorities like PRIs, aiming at sustained increase in awareness on TB, reducing stigma, tracing and recovering defaulters, and promoting dialogue amongst patients, providers and communities. This will be carried out through the identified NGOs/FBOs with customized geographic and/or thematic divisions of the tasks, financed through micro-grants from the project in the first and second years, and resourced by RNTCP schemes in subsequent years. The stakeholder base will be wide, and include traditional

healers in tribal districts. These NGOs will complete at least 75 community, PRI and school sensitization and special annual events in each target district each year.

1.1.3 Ensure sourcing and utilization of IEC material from RNTCP by the above NGO/FBOs and their community networks. In addition, a range of locally adapted methods including folk art, TV and radio spots will be employed, including those for observing World TB and Health days

1.1.4 Facilitate regular meetings of enrolled NGOs with DTO for coordination and feedback to ensure their continued participation in the program.

1.1.5 Facilitate communities to lobby at state, district and local levels through legislative forums and health societies in a sustained and focused manner to reposition TB as top priority.

1.2 Support community mobilization through field based research:

1.2.1 Support sensitization efforts through district – specific formative research on communication needs and household survey on knowledge and attitudes related to TB.

Household Surveys for Knowledge of and Attitudes towards TB will provide the needed evidence base for tailoring key messages on TB and RNTCP to suit local needs and to power the advocacy efforts of the project. Indicators recommended by the ACSM framework, including those on stigma, will be included and all results will be triangulated with the qualitative social assessments to provide RNTCP with a well rounded and balanced overview of the knowledge and attitudes of communities. Rigorous and internationally accepted sampling techniques, tested questionnaires and standard software program packages will be used. The KAP surveys will be jointly designed with ICAT and jointly carried out in the states where both groups propose to be present.

Communication Needs Assessment will supplement quantitative data from household surveys and provide insights into risk perceptions, habits and opinions on TB, probe myths and misconceptions about TB, understand information and care seeking behaviors and what influences these preferences, identify the role of gatekeepers, opinion leaders and service providers in care seeking, assess barriers and facilitating factors for effective communication (including socio cultural, religious and gender barriers), and the nature, incidence and manifestation of stigma and discrimination. These assessments will use a range of survey methods, principally focus group discussions and in depth interviews using small, purposive samples, guided by clear research questions. The final analysis will employ the barrier analysis framework.

1.2.2 Design and conduct exploratory studies to identify *the more effective and feasible community level interventions to improve case holding/defaulter retrieval.* This perceived problem will be analyzed methodically using critical variables and the effects that program based action has on these variables.

Objective 1, SDA 2: Community Systems Strengthening

1.3 *Building capacity of Community Organizations:*

1.3.1 Build capacity of at least 50 community organizations in each target area through training in leadership and organizational skills, and provide basic, one time infrastructure like internet.

1.3.2 Ensure their membership and active participation in district health society and other working groups. In tribal areas in Orissa and MP, priority for these activities will be given to those CBOs formed of tribal populations to bring them to mainstream society.

1.3.3 Facilitate regular joint meetings of the community organizations with NRHM functionaries at the peripheral level, like ASHAs for better coordination and accountability.

1.3.4 Regular stakeholder meetings to share data to inform community led lobbying. Facilitate incorporation of Patient Charter on TB Care in community based monitoring systems.

Objective 2: To improve access to and utilization of TB diagnosis and treatment

This objective will be met through the following SDAs and activities:

Objective 2, SDA 3: PPM

2.1 Activities under PPM:

Findings of health seeking behavior in baseline formative research will help the project adapt its PPM to suit local needs, especially in involving traditional and unqualified providers.

2.1.1 Profile PPs and private healthcare institutions not covered under IMA project (other than IMA member and practitioners of other systems of medicine), sensitize them on RNTCP and ensure the enrolment of at least 50 PPs in each district each year in RNTCP schemes for the first two years, and 25 per year in the second and third years.

2.1.2 Facilitate regular review of the involvement of enrolled PPs with the DTO and take corrective actions by mobilizing district level steering committees and ensure compliance with International Standards of TB Care. Sensitize district level health staff on the need and best practices for continuous engagement of private providers.

Objective 2, SDA 4: Work place Interventions

2.2 Address TB in the Workplace:

These interventions will be carried out in those districts and sub districts that have a significant workforce in the skilled and unskilled sector. The strategy aims at supporting the state program teams and employers provide better access to the employees to TB diagnosis and treatment and support them in completing treatment.

2.2.1 Support the State TB Office establish regular interface with large employers – coal, steel, and software manufacturers among others – and with the unorganized sector, to identify needs related to TB. Support AP to interact with these industries to review and help re write workplace policies for employees on treatment, especially women.

2.2.2 Conduct sensitization workshops for employers, managers and supervisors to familiarize them on TB, RNTCP and the need for conducive work place policies and a tailored treatment program to suit their employees' needs.

2.2.3 Facilitate the development or re writing of workplace policies that are comprehensive and support not only timely diagnosis and treatment success and also other aspects such as:

- Non-discrimination of TB and HIV positive employees.
- Formal announcement of TB and HIV and AIDS policy to employees.
- Confidentiality procedures for TB infected and HIV positive employees.
- Reasonable assistance to TB affected employees.
- Provision of education and training on TB to employees.
- Community outreach activities relating to TB.

2.2.4 Conduct sensitization workshops in the work place, for employees.

2.2.5 Sensitize and enroll local PPs for "flexi time" DOTS, to suit employees' work hours. This model is being effectively carried out in a project that supports RNTCP efforts in urban slums of Mumbai where DOT providers tailor their time with individual patients, to suit the work hours of both client and provider.

Objective 2, SDA 5: HSS

2.3 Strengthen health staff performance

2.3.1 Train at least 100 health staff per district per year and at least 25 per urban slum in interpersonal, counseling and other "soft" skills, through a three level, need based training plan, carried out by a pool of trainers at state and district levels, drawn from a range of services/departments. The above target is intended to meet the need arising out of staff turnover as well as that for refreshers. Given below is an illustrative curriculum for soft skills training for health staff:

Module 1: Effective communication and Interpersonal Skills, Six hours. Illustrative Topics: The role of communication in health service delivery, Characteristics of effective communicators, Barriers to effective communication, Recognize/assess communication styles, Sharpening listening skills and Non verbal communication

Module 2: Team Building, Six hours. Illustrative Topics: Sources of conflict, Stages in Team development, Reaching consensus and Effect of communication styles on team work

Module 3: Time Management, Four hours. Illustrative Topics: Identifying time wasters, Structuring and organizing one's work day, Avoiding procrastination, Setting realistic goals and Delegating tasks

Total: 16 hours, including recaps

This four day training package will be customized based on the results of the social assessments and perceptions of communities, as well as through discussions with RNTCP staff and WHO on the details of the package, and will use an empowering and self assessment approach to the training. The modules will

be tested through their use in the project and advocated for further scale up. The training schedule will be spread over a period of time to keep the staff from being away from their work for long stretches of time.

Objective 3: To address emerging challenges like MDR TB and HIV TB co infection

This objective will be met through the following SDAs and activities:

Objective 3, SDA 6: MDR TB

3.1 Mobilizing communities for MDR TB and DOTS Plus:

The focus of ACSM activities under the additional package will be to prepare communities to understand and execute their role in those with treatment failure and/or relapse and for MDR TB. The project will identify areas for support in consultation with DOTS Plus committee and in alignment with the respective states' DOTS Plus action plans.

3.1.1 Profile available NGOs/FBOs and sensitize them in each target district in the first two years, on TB and RNTCP, with specific focus on DOTS plus and MDR TB.
3.1.2 The above NGOs will sensitize communities and facilitate the formation and regular meeting of patient support groups – at least 50 in each target district. The focus of these meetings will be the provision of psycho social support to those on DOTS plus and link them with available benefit schemes. Community meetings will also ensure that these patients are linked to self help groups and income generation activities that are available at the local level.
3.1.3 Facilitate (through the local RNTCP units) the specific training of DOT providers in DOTS plus including standard infection prevention procedures.
3.1.4 Work with the DTO and communities to customize arrangements for injections during the first six months.
3.1.5 Facilitate a multi layered support system including initial counseling during the initiation phase of treatment and linking patients with support groups within their native communities, even while they are in the hospital for the initiation of the treatment.
3.1.6 Coordinate between the STO and the Government General and Chest Hospital to strengthen the MDR component of Continuing Medical Education (CME) programmes in select government and private medical colleges specifically in the state of Andhra Pradesh.

Objective 3, SDA 7: TB/HIV

3.2 Improved TB HIV coordination
Activities will be detailed in consultation with TB HIV coordination committees at the state and district level and in alignment with the respective states' action plans.
3.2.1 Facilitate review of the functioning of TB HIV coordination committees.
3.2.2 Facilitate the establishment of cross linkages between ICTCs and the DMCs
3.2.3 Train DTO staff using a tailored TB HIV package that includes infection prevention within ICTC and DMC premises, and analysis and interpretation of data on referrals.
3.2.4 Follow up those with co infection, to link them with community support groups.

The above activities have been packaged into "core" and "additional". The core package consists of all activities described above excluding those related to work place interventions, MDR TB and TB HIV coordination, and the latter three constitute the additional package. The core interventions will be implemented in 67 target districts where key program outcomes have not kept pace with the overall progress at the national level, while the additional package will support efforts to address emerging challenges of MDR TB, TB HIV co infection and TB in the workplace, in 17 target districts, in a phased manner, as found in annexes 15 and 16.

SDA 8: Project Management

1.4 Project Management
1.4.1 Recruit, project staff to supervise the additional project activities and coordinate with STO and DTOs, in each target state: State Liaison (1), Zonal Coordinators (2 or 3), and District coordinators (2 or 3, for the most challenging districts in the state). Provide amenities for

workspace, travel and communication.

1.4.2 Technical advisors for specific technical areas of ACSM, PPM, WPI and MDR TB will be provided from individual SRs with that capability but service the entire project area.

1.4.3 Source technical support from within and outside the country for improving quality of project activities and bring in state of the art methodologies and approaches.

1.4.4 The PR team will coordinate with the national program staff and also supervise operations in project districts and assume responsibility for fiscal compliances, and coordinate with the national program for mid term and final reviews and workshops for disseminating lessons and experiences including quarterly project newsletter. Staff of the PR team as well as senior personnel from World Vision will visit project sites to support and monitor progress towards targets.

1.4.5 The PR will enter into written agreement with each SR with clearly spelt out objectives and scope of deliverables. Each SR will enter into agreements with their respective state TB units and with local NGO networks with whom they have pre established relationships, and carry out all community mobilization and communication activities through these networks. Supervisory visits by staff of the SRs will help support and supervise project activities and for joint problem solving with the state program units

Contribution from PR and SRs: A key strength of this proposal is the matching contribution by the PR of € 152380 (US$ 240,000) from the World Vision Partnership over the life of the project which will be utilized to purchase essential amenities like project four wheelers and motor cycles for the project to improve efficiency in field processes. Each SRs will contribute 100% staff time to function as project manager.

DFIT, an NTC partner, has been working in TB control and care in 28 of 34 districts of Bihar for nearly 30 years. A memorandum of agreement with the state government has enabled DFIT to provide technical training in TB to health personnel and diagnostic and HR resources and infrastructure to peripheral health institutions, along with LEPRA Society another NTC partner. DFIT will provide state coordination in the state of Bihar as matching staff time.

4.5.2. Re-submission of Round 7 (or Round 6) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 7 (or, Round 6, if that was the last application applied for and not recommended for funding).

TWO PAGES MAXIMUM – Not Applicable

4.5.3. Lessons learned from implementation experience

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

Implementation plans and activities described in section 4.5.1 focus on core programme areas that include ACSM, DOTS expansion, Public-Private Partnerships, lab strengthening and addressing emerging challenges to TB HIV co-infection and MDR TB. The description of activities is guided largely by the Stop TB Planning Framework documents that describe activities, models, case studies and include process and outcome indicators for all the core areas addressed in this proposal. Partners also bring their individual field experience both within India, and from other parts of the world.

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

1. The Union is the sub recipient of the Global fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for technical assistance to the Government of India in the management of the national TB programmes in Orissa for a period of two and a half years starting from October 2007. The model has been endorsed by the programme and would be replicated in 5 states in this project.
2. Since 2003 the Union was managing 52 projects in 18 countries under its project 'Fund for Innovative

DOTS Expansion through Local Initiative to Stop TB' (FIDELIS). Grants under this project were negotiated with govt and non-govt partners and subsequently technical and financial monitoring of projects undertaken.

3. The Union is also managing grants for tobacco control projects under the Bloomeberg Initiative to reduce tobacco use.
4. PSI is also serving as PR of 8 grants in 5 countries and SR on 52 grants in 39 countries and the experience will be used to implement this project as well .

The **NTC component of this proposal** has factored in several lessons from current and past programs:

Work Place Interventions: A partnership with a private firm and the local government in Greater Mumbai has demonstrated an effective and feasible way to share technical and infrastructure resources to make a positive impact on the employees. A critical success factor has been the location of TB services within the industry premises, a factor that will be considered in this project's dialogue with employers and STOs

A HIV and AIDS workplace intervention in Thailand funded by a grant from Global Fund round 1, has found that the initial coordination between the national program and the industries is critical and should be carried out by a team that has broad representation from civil society and local government.

Community DOT provision: Projects in urban slums in Kolkatta have had significant improvements in case holding and defaulter retrieval because of their community based approach and the employing of women DOT providers. The latter approach greatly improved continuation rates among women. This proposed project has taken this lesson to feed into its strategic principle of deploying women in the community level workforce of its NGO partners.

DOT Provision through Tertiary care facility: A study of DOT provision through a medical college hospital in northern India has found this approach to be excellent for not only reaching program standards in care and in reaching outcomes but also an effective way of training graduate and undergraduate students on MDR TB and TB HIV

4.5.4. Enhancing social and gender equality

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

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

ICAT and NTC partners already work with patients and affected communities from marginalised and vulnerable groups, including migrants, women and children, tribal populations, urban slums dwellers and the rural poor. Their grass root presence in these communities, long experience and local staffing underpin the design and implementations of all activities. Furthermore, these partners have a history of working to alleviate poverty, improve the health of the disadvantaged, bring dignity to the affected and to empower those disenfranchised from society.

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

- Participation and involvement of marginalised and vulnerable people and their community structures and groups from the design stage to reach underserved and hard to reach areas/groups
- Mobilisation of local civil society, and intersectoral collaboration to further reach underserved and hard to reach areas/groups
- Facilitating the establishment of patient-driven self help groups and nurturing community based organzations from these marginalzed communities.
- Community involvement to reduce stigma through locally appropriate, need based planning & implementation of IEC/ACSM activities

The project's strategy enables a deliberate focus on populations that have sub optimal access to TB as well as other health services: tribal populations, slum dwelling women and children, migrants, sex-workers, and fishing communities in various target districts of the proposal. Ensuring access to TB services to these specific populations is a significant contribution from this project.

The proposed interventions on communication and community mobilization will have a focus on stigma reduction, which is a significant deterrent for marginalised populations from accessing TB services. The project will ensure that the content of IEC/ACSM material and activities – both in products and practice, have a balanced gender representation as well as be adapted to specific sub populations. Stakeholder groups will be constituted in such a way as to ensure participation of marginalized groups.

The project will strive to recruit women, particularly those who have been through TB, for a significant proportion of staff positions and also encourage its local NGOs to deploy women for community mobilizing and supervision activities. Overall, the ambitious targets of the projects and its contributions to achieving universal program coverage are by themselves a move towards ensuring equity.

4.5.5 Strategy to mitigate initial unintended consequences

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

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

The key activity proposed for the health system is the training of the program staff and those from the public health system interpersonal and soft skills. This generic activity has the potential to improve the overall performance of health and program staff and local planning for this activity will ensure that there is proportionate participation from both cadres. The fact that the involvement of public health staff in RNTCP varies significantly between states and districts has been key factor that led to the decision to categorize this activity as a disease specific one

- **Potential Unintended consequence**: New posts within the project may attract personnel from other sectors to migrate to the project.
  Mitigation: The salaries/ honorarium of staff under the project has been kept a standard level keeping in mind payments being made in other sectors for staff at similar positions
- **Potential Unintended consequence** Communication messages do not convey the intended message to target audience.
  Mitigation, the content of the messages will be developed in close consultation with the programme and technical experts and pretested before being used for dissemination and evaluated.
- **Potential Unintended consequence**: CMEs on MDR-TB may tend to deviate from national strategy.
  Mitigation The content of CMEs will be based on consensus statement available with the programme on rational use of 2nd line drugs and also discussed with the programme
- **Potential Unintended consequence**: Project may create parallel monitoring structures
  Mitigation The project staff will only monitor project related activities. Outcome will be measured through regular RNTCP mechanism. Monitoring meetings at all levels will be done in close coordination with programme staff.
- **Potential Unintended consequence**: TB patients may go for shopping between Govt and non-govt facilities
  Mitigation: As per the policy of RNTCP, DOT services will be provided through the nearest convenient DOT centre for the patient and this will be coordinated with the programme.
- **Potential Unintended consequence** Utilizing existing infrastructure like Anganwadi centers and primary schools for TB activities like community DOT centers can disrupt the mainstream activities of these centers, especially in urban localities.
  Mitigation: This will be avoided by facilitating discussions between communities and municipal authorities and ensuring adequate space and privacy for both sets of activities before making the proposals.
- **Potential Unintended consequence** Frequent community meetings for discussing TB advocacy issues, support for DOTS plus and folk performances in TB can be disruptive to the work and life culture of communities especially in tribal areas.
  Mitigation: The project trainings for staff and partners will emphasize sensitivity to local cultural issues and the pre existing priorities of families and communities to minimize disruption.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

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

Proposals should clearly explain if this proposal requests support for the same interventions that are already planned under an existing grant or approved Round 7 proposal, and how there is no duplication. Also, it is important to comment on the reason for implementation delays in existing Global Fund grants, and what is being done to resolve these issues so that they do not also affect implementation of this proposal.

RNTCP has been the main recipient of earlier GF grants where the major focus was provision of services through public health system. The current proposal is an entirely civil society initiative that would support RNTCP efforts and would be additional to ongoing activities and available resources under various GF and non-GF grants. The identified opportunities in this proposal are based on the information available in official documents of the programme/ WHO and hence fully align and link with other grants in the country. The approach and interventions will be innovative and will increase participation of all the stakeholders in the programme and improve TB Care services in un-served and un-reached pockets. The project will also linkup with Indian Medical Association (IMA) (recipient of grant under Rd 6) for approaching Private Providers and Medical Colleges.

The PR for **ICAT component** of proposal (The Union) is already implementing a project to support ACSM in the state of Orissa under Round 4 (MOHFW is PR). The RNTCP has recommended replication of this model in other states of the country.

PSI has state and project offices in all the proposed states and would leverage resources from other projects for implementing the proposed project, such as -

- Public Private Partnership for STI/RTI control in four states through NACO funding under NACP-III (2008 onwards) and Avahan Initiative (2003-2008), led by the Bill & Melinda Gates Foundation, in partnership with NACO, SACS and RNTCP.
- Project Connect for catalyzing Public-Private Partnerships to Mitigate HIV/AIDS and TB in partnership with USAID, NACO, FICCI, RNTCP and SACS (2006-2011).
- Recently, PSI has been awarded a £32,000 grant for one year from Jharkhand State AIDS Control Society for implementation of the COILA (Collieries Outreach Intervention for Limiting HIV/AIDS) project in 5 coal mining districts of Jharkhand state.

CRS is also a sub-sub recipient to the Catholic Bishops Conference of India under Global Fund Round 4 fund support for which the Central TB Division /GOI is the Principal Recipient. The objective of this project is to improve access to the diagnostic and treatment services provided by the RNTCP within the Catholic Church health care facilities and thereby improve the quality of care for patients suffering from Tuberculosis in India. Under R4 TB program CRS proposes to engage Church health care facilities into the RNTCP program.
But under Round 8 CRS has proposed to carry out ACSM activities which are community based and that will again help in strengthening RNTCP program in the community. Thus R program of CRS is institution based while R8 will be community based.

Other partners have also successfully implemented or are presently implementing projects funded by Global Fund and other donors. The proposal takes into consideration the ongoing activities of all partners to avoid duplication.

Two Global Fund grants are currently active in the proposed target areas of the **NTC component of this proposal –** ones from rounds four and six respectively. A review of the activities in these grants brings the following areas of overlap with the proposed project and with the potential for synergy and better outcomes:

1. The grant from Round four has been roping in private providers in RNTCP and intersectoral participation of health care providers for TB care in Orissa state and this grant is expected to come to a close by the year 2009 which will coincide with the start up of the proposed project.

The latter will factor in the earlier grant's outcomes in Orissa

2. The grant from Round six supports sensitization of private providers to participate in DOTS plus action plans of the state of Andhra Pradesh and is expected to be rolled out before this proposed grant is signed. The proposed project will ensure coordination at all levels with this intervention of Round 6 and ensure that the activities of both projects complement and strengthen each other.
3. The activities planned under this project in Orissa will complement the existing funding support through Round 4. While the round 4 activities are mainly focussed in providing the state and district technical assistance on ACSM, the proposed activities in this project will implement the ACSM on ground

4.6.2. Links to non-Global Fund sourced support

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

For ICAT component:
VHAI and its partners will be working mainly in the area of Advocacy Communication and Social Mobilization (ACSM) DOTS Expansion, and PPM activities for the current proposal. Organizations have sufficient experience of implementing these activities. However the area selected for GFTAM is largely new. VHAI is not directly implementing similar activities in these areas on such scale. Most of the interventions were implemented in a small geographical area. So there is no duplication with other sources of funding.

Mamta plans to scale-up the involvement of affected communities (existing and former DOTS Clients as well as PLHA), which is an experience from ongoing project with support from STOP TB Initiative of WHO Geneva. The said project is being implemented in one block each in 6 districts of UP.
2) The proposed project will be linked to ongoing health programmes of MAMTA which are largely based on community mobilisation and system strengthening strategies. It is mainly to draw upon the ground work that has already been done towards community mobilisation on health and HIV/AIDS related issues

The **NTC component of the proposed project** will work in coordination with the PPM activities already being implemented through private funding in selected districts of West Bengal. As both these initiatives will be coordinated by a single point of contact at the state TB office, thereby avoiding possible duplication of efforts and maximizing reach of PPM interventions in these districts. GLRA India, the NTC partner in West Bengal will identify and address operational issues related to synergy and linkages.

SHIS, another NTC partner in West Bengal has taken over operations of seven TU s in a proposed hard to reach target district, through a memorandum of understanding with the state TB office. The interventions that this proposed project brings in will complement the operations of these TU s and expand their reach into the remotest segments of this district.

There are privately funded initiatives that strengthen TB diagnosis and treatment infrastructure and other resources in private health facilities in the proposed target districts in Bihar and Jharkhand states. Though these activities are not similar to those of the proposed NTC component, are complementary and will help bring the two ends of the supply – demand chain closer and more efficient.

DFIT, an NTC partner, has been working in TB control and care in 28 districts of Bihar for nearly 30 years. A memorandum of agreement with the state government has enabled DFIT to provide technical training in TB to health personnel and diagnostic and HR resources and infrastructure to peripheral health institutions, along with LEPRA Society another NTC partner. The proposed NTC input of soft skills training through the Global Fund grant will complement the technical trainings already underway and provide for a well – rounded capacity building of health staff. Community mobilization components of the proposed project will complement the infrastructure related inputs of DFIT.

LEPRA Society is currently involved in research on the incidence of MDR TB through the research wing of its Blue Peter Research Center in Andhra Pradesh and the proposed NTC component in that state will inform the research process. In the same state, LEPRA Society also has HIV TB coordination activities along with Andhra Pradesh State AIDS Control Society at the state level, which will give the needed head start to the TB HIV coordination activities planned in this proposed project at district levels.

4.6.3. Partnerships with the private sector

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

*(Refer to the Round 8 Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

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

The lab strengthening component of the project proposes to contribute to uptake of new diagnostic methods for TB and implementation of Good Lab Practices in Medical Colleges and recognized Private Labs involved under RNTCP schemes for diagnosis. It has been envisaged to have participation form such stakeholders in the 'Annual RNTCP Lab Network' meetings under this proposal, so as to bring about partnership and a sense of ownership for the process amongst all stakeholders. By advocating for use of standardized lab techniques, and conducting lab audits and onsite-evaluations amongst both private and public labs the proposal would help in stream-lining lab services for TB amongst labs of all stake-holders. Private Labs which would participate in Lab strengthening activities for RNTCP would be co-investors.

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

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

Contribution Value (in USD or EURO)

Refer to the Round 8 Guidelines for examples

Organization Name	**Contribution Description** *(in words)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
[use "Tab" key to add extra rows if needed]							

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved tuberculosis outcomes

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

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

ONE PAGE MAXIMUM

Partners in **ICAT proposal** are recognised and established institutions with internal capacity for system sustainability. This proposal essentially seeks to supplement the national TB control programme through time bound interventions. Funding sought in this proposal is only for supporting these time bound interventions – activities and infrastructure and human resource to support these activities. This proposal, over a five year period, will build capacity in institutions and individuals to contribute to health and development in the country in capacities within or outside a similar project.

Community ownership of TB care and increased public awareness about TB and availability of free diagnosis and treatment will contribute to reduce both TB and HIV related stigma, will increase patient friendly accessibility of TB services and will enhance early referral, diagnosis and treatment, which are outcomes of this proposal, will in the long term contribute to sustainability of TB control in the broader context of responsible public health care.

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

The lab strengthening activities of the proposal will seamlessly merge into the efforts of national programme to establish quality assured routine and referral network across the country. It will enhance a policy partnership with provide health care providers to address the emerging challenge of MDR TB.

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

The **NTC component of the project** proposes to make significant contribution to improving capacity and capabilities of community based organizations and local NGOs. This is expected to increase public engagement in the national program and will not end with the project's lifetime, being a movement led by people for themselves. Such an approach brings the marginalized to the mainstream, enlarges their choices and opportunities, and provides for their participation in decisions affecting them. It can also be expected that this engagement will have ramifications into other health and development sectors that will in turn, improve demand for services, and not only reinforce TB outcomes, reduce stigma and also help society evolve as a whole.

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

Several community led projects across the globe have demonstrated that community led actions move in ever widening circles of impact as more and more communities catch on to the ongoing movement This

holds for both for civil society at large and the "community" of health staff, when the impact of external mobilizers, top down service providers and bottom up community movements meet. (Taylor Ide D and Taylor C E. Just and Lasting Change, Johns Hopkins University Press, 2002). The above two factors will serve to concomitantly improve demand, supply and utilization, in a virtuous spiral with ever widening circles of impact.

4.7.2. Alignment with broader developmental frameworks

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) initiative, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities.

Though India does not have a PRSP and is not an HIPC, reduction of poverty is indeed India's most compelling challenge, one of global significance. According to World Bank figures[5] (World Development Indicators 2000), India has 433 million people living on less than US$1 a day, making up 36% of the poor in the world. According to a 2003 report on Selected World Development Indicators, India spends 0.9% of its GDP on public health care. An additional 4% is spent in the private sector. The average annual health expenditure per capita is US$19.

India has developed elaborate consultative and consensus- building processes for the formulation of economic and social policies. The Planning Commission and the Five Year Plans have a special role in articulating the country's poverty reduction strategy. Tuberculosis causes huge economic losses with about 70% of cases occurring in the economically productive age group, leading to 170 million workdays lost annually due to the disease and an estimated loss of US$3 billion to the country's economy. It is estimated that on average, a TB patient loses 20 to 30% of his annual household income[6]. Control of TB has the potential to significantly contribute to the reduction of poverty at both the individual and national levels. Improved productivity of workers by reducing absenteeism, preventing incapacity from ill health, and by averting TB deaths among these workers, the Program will add to the productive capacities of the economy.

The proposed project will contribute significantly to the RNTCP's efforts to impact the country's economy, by focusing on states and districts which have the highest numbers of people with TB, both undetected and on treatment.
The project would also contribute to the achievement of Millennium Development Goals (MDG 6, Target 8, and Indicator 23-24)

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

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

Over a third of a million Indians from diverse communities die every year from tuberculosis. Many are wasting away in the barren emptiness of poverty, suffering in the dark shadows, mostly unheard and unseen by those 'on the top'. The Patients' Charter is the foundation for building the rights and responsibilities approach, which allows for the establishment of a partnership in health on local, district and state levels.

[5] World Bank Indicators, 2000
[6] TB Research Centre, Chennai. Socio-economic impact of TB on patients and family in India. Int J Tub Lung Dis 1999; 3: 869-877

After decades of a top-down approach to TB Control, a process is beginning, from the bottom-up, to increase access to quality care and contribute to the efforts to turn back the growing pandemic. Designed and driven by and for people with the disease and their communities, a dynamic new mobilization system is rolling out, in a convergence of the efforts of the RNTCP for better TB Control and needs of communities for quality TB Care.

The project strives to collaborate with national programs, health providers and civil society to raise the standards of care. Its partners are now driving for Drugs, Diagnostics and Dignity, and developing innovative projects towards scaling-up TB services in the community led by the people most affected. Committed to pressing forward on community systems strengthening.

The involvement of private practitioners, including traditional healers and private pharmacies, into the DOTS system of RNTCP would help to reduce the number of encounters of the patients in their health seeking journey which will significantly contribute to reduce patient direct and indirect expenditures at individual, household and population at large.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

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

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

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

At the national level, after a round of cross-checking of the submitted reports with the respective DTOs, a quarterly and an annual progamme performance report is compiled which presents district-, state- and national-level data and information. The quarterly performance report is a published document, as a printed version and an electronic version on the RNTCP website, which ensures wide dissemination not only to programme officers but also in the public domain. Annual programme results are published in the yearly “TB India. RNTCP Status Report”, which is also available both as a printed and an electronic version. The RNTCP annual national data is reported yearly to WHO for inclusion in the WHO Annual Global TB Surveillance Report8.

Increasingly, the RNTCP is moving to a state of electronic submission of reports. Since 2004, e-mail facilities had been provided to the staff at the CTD, all 35 STOs, 548 DTOs, 15 State TB Training and Demonstration Centres, and over 117 WHO-RNTCP consultants. At present, as an alternative method to paper copies, the districts have the option to submit their quarterly reports electronically, either in MS Word or in an “EPI-INFO” based custom-designed software called “EpiCentre”.

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

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

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

across the country this year.

The external Joint Monitoring Mission of 2006 found that te recording and reporting system is extremely strong, with complete and generally electronic submission of quarterly reports. For the most part, the review team found the reports to accurately reflect reality, with some exceptions. However, in many places, treatment that is not directly observed continues to be recorded as observed in the treatment card. In some districts, smears that had not been taken were recorded in laboratory registers, treatment cards, TB registers and quarterly reports. While the team was informed that these patterns were known to the CTD through the internal evaluation process, inaccurate recording and reporting continued.

4.8.2. Avoiding parallel reporting

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

The national reporting system under RNTCP is a quarterly reporting system from TB Unit level (approximately covering 500,000 population) to District level to State and Central level. The programme implementation and performance is monitored through analysis of routine surveillance data, supervisory visits, review meetings at various levels and periodic in-depth internal evaluations. Measurable indicators for quality control, programme outcomes and operational effectiveness are the basis for programme monitoring. The national reporting formats captures data including case finding, smear conversion rates, treatment outcomes and other programme interventions including ACSM and trainings. The NTP also monitors status on key staff positions and training; involvement of medical colleges, partners and stakeholders. The NTP publishes quarterly and annual programme performance report for wider dissemination. The NTP also has a well established system of quarterly programme review at district and state level where available data on programme performance are reviewed from higher level.

This GF supported project will utilize the existing NTP mechanism of recording and reporting available at district and state level to report outcomes on case finding, case holding and treatment outcomes. As there would be co-implementation of activities in each of the project districts by both the RNTCP and civil society partners in this project, it will not be possible to attribute any incremental increase to one party. However, as all efforts in this project are towards supporting the national strategy it would be appropriate to attribute all improvement to the national programme. This mechanism will ensure that we do not have any parallel reporting on TB outcome indicators.

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

4.8.3. Strengthening monitoring and evaluation systems

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

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

As stated in the above sections, the project will utilise the exiting M&E structures for evaluating the outcome. However the project also has strong component of self M&E through regular quarterly meetings of implementing staff and supervisory visits at all levels. There will be internal project related reporting that will be undertaken by the respective SRs on a quarterly basis. These reports received from peripheral levels will be firstly compiled and analysed at the SR level. The SRs will provide feedback through formal mechanism and also during the regular review meetings. At the PR level the reports from the SRs will be analysed and compiled into quarterly reports. The PRs will intensely supervise the M&E systems of the SRs to ensure quality and timeliness of project reporting. PR will coordinate regular joint

review of the project activities along with NTP and other key stakeholder.

An M&E plan will be developed in the initial weeks of the project that will detail process for effective monitoring, will have tools (including reporting formats and supervisory checklists) that will support monitoring and supervision. The PRs will be guided by the 'Three One' strategy when developing this M&E plan.

The SRs and PRs of this project are well established organsiations and have their own internal review and evaluations mechanisms. These mechanisms and process will form the basis of the evaluation that will be conducted jointly by the PR alongwith respective SRs, NTP, donor, national experts and other key stakeholders. .

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

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

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

PR 1	The Union
Address	C-6, Qutab Institutional Area, New Delhi – 110016; HQ: 68 boulevard Saint Michel, 75006 Paris Email : NWilson@iuatld.org www.iuatld.org

Existing in its present form since 1920, The Union is the oldest international non-governmental scientific organization in the field of TB and Lung health. It is headquartered in Paris, France. The India Resource Centre is the regional office of The Union, for the South Asian and Western Pacific regions, located in New Delhi India.

The mission of The Union is to improve lung health and decrease the impact of other diseases of public health importance in low-income countries; it has developed skills in tuberculosis, HIV, child lung health, asthma management and tobacco prevention. In order to reduce the burden of disease, it focuses on providing technical assistance to improve public health services, education and training to build capacity, research with an emphasis on developing innovative methods to promote actions for health, and advocacy to mobilize decision-makers and the public to improve the life and health of communities in low and middle income countries.

Main activities 2007 – 2012

- Stop TB strategy: Country support
  - TB/HIV: develop and consolidate new program models
  - MDR TB: assistance through lab strengthening and training in clinical management
  - Operational Research and Clinical Trials
  - Laboratory strengthening
- Asthma Drug Facility: improve access to asthma medicines for all
- Tobacco Control: grant programme and capacity building within the Bloomberg Global Initiative managing more than 18 countries
- Develop and implement TB and Tobacco joint program activities
- Expand network of training courses (technical and management)
- Improve quality and attendance of World and Regional Conference

Project management

The Union has experience of managing several, large, multi country projects funded by various agencies such as CIDA, USAID, World Bank EC and the Bloomberg Initiative tobacco control programme.

The India resource centre handled so far

5. Fund for Innovative DOTS Expansion through Local Initiative to Stop TB (FIDELIS)
   Since 2003 the Union was managing 52 projects in 18 countries for a grant of Euro 17.13 million and all these grants were negotiated through IRC.
6. Technical and financial monitoring of FIDELIS projects in 7 countries was undertaken by IRC
7. Tobacco control project: IRC negotiated a grant of US$ 8.59 million in round 1 in 7 Countries (including India) and involved in negotiating grant of US$ 5.10 million in spread across in 8 countries in round 2.

Technical and Financial monitoring undertaken for 14 grants in 7 countries

8. Orissa TB control programme: The Union is the sub recipient of the Global fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and has received a grant of **US$ 810,000** for a period of two and a half years starting from October 2007 for technical assistance to the Government of India in the management of the national TB programmes in Orissa.
9. World bank project
   IRC negotiated the World Bank project in China for promotion of Lung health
10. IRC consultants are providing Technical Assistance to DPR Korea in developing a proposal for GF round 8 projects

Financial and Admin systems

The Union has well defined financial systems in place consisting of

- ERP based accounting system
- Monthly reporting system
- Internal controls
- Donor reporting system
- Travel policy
- Recruitment policy
- Audits: The union has regular donor audits for each project and statutory audits in place for all offices.

Procurement and supply management

- The IRC's Procurement Unit undertook procurements valued at around USD 6 million since its inception in 2004.
- It also provided procurement assistance to Panama, Nicaragua and Chile for anti-TB drugs.
- Consultants facilitated the Procurement and Supply Chain Management sessions at the International Management, Finance and Logistics for TB control course of The Union held in India, Uganda and Afghanistan.
- The Global Drug Facility (GDF) missions have been undertaken for Philippines, Mongolia, Myanmar and Lao PDR.

The annual turn over of the Union for 2007 is EURO 30.14 million

(Annual turn over of 12 coalition partners (including the Union) out of 16 partners for the year 2006-07 EURO 60.49 million.)

Recent projects handled/handling by the Union

Donor	Programme	Union's role	Period	Total amount
FIDELIS PROJECT - Canadian International Development Agency (CIDA)	DOTS strategy expansion initiatives at the local level with emphasis in serving populations with limited access to health care.	Lead partner with the National TB control programmes of each of the 13 countries in implementation of project	Starting of project Oct. 2003	EUR 17.13 million

USAID		Developing new methods and approaches to reduce the burden of global tuberculosis.	started in October 2003	EUR 11.2 million
Tuberculosis coalition for Technical Assistance (TBCTA)	provide technical assistance of TB control and implementation of DOTS strategy in DRC	Partner with National TB Control programme in the implementation of the project. Other partners – Damien foundation, USAID, FHI and WHO	started January 2006 - 5 years expected for continuation of activities	EUR 1.93 million
TBCTA	Provide technical assistance with funds from USAID	Partner with National TB control programme of Senegal and Norwegian Heart and Lung Association in implementation of the project.	It is on going project. Union started TA to Senegal in 1993	EUR 2.34 million per year
TBCTA with funding from USAID	To conduct large scale clinical trial of tuberculosis treatment regiments	lead partner with collaborating centres around the World	Launched in Nov. 1997	EUR 677,067
TBCTA with funding from USAID	To conduct large scale clinical trials in different countries around the World	lead partner with 11 collaborating centres around the world.	launched in 2003 – 5 year project.	EUR 4.1 million
International Tuberculosis Foundation with support from BMGF	to implement The Union programme for the surveillance, diagnosis and treatment of respiratory diseases	The Union is sole partner with the Ministry of Health and population of Malawi in implementation of the Project		EUR 1,912,800 for 5 years
French Ministry of Foreign Affairs	provide technical assistance and support to Cameroon, Congo republic, Ivory Coast,	lead partner with the National TB control Programmes of Cameroon, and other countries	Started in 2003 for 3 year period	EUR 2.1 million
Norwegian Association of Heart and Lung Patients	provide technical assistance for TB control and implementation of the DOTS strategy in Sudan	Partner with the National TB Control Programme of Myanmar in the implementation of this project	2001-2005	EUR 1.6 million
Ligue Pulmonaire Suisse	provide technical assistance for TB control and implementation of the DOTS strategy in	Partner with the National TB Control Programme of Benin in the implementation of this project.	2001-2005	EUR 303,455

	Benin, West Africa.			
KNCV Tuberculosis foundation	provide technical assistance for TB control and implementation of the DOTS strategy in Benin, West Africa.	Partner with the National TB Control Programme of Benin in the implementation of this project.	- 2001-2004	EUR 180,504
Global Alliance for TB Drug development	To develop and upgrade clinical trials capacity in low income countries	lead partner with collaborating centres around the world.	launched in 2002 - 3 years project.	EUR 720,000
European commission (EC)	To develop and upgrade clinical trials capacity in low income countries	lead partner with collaborating centres around the world.	launched in 2002 - 3 years project.	EUR 90,000 – one time allotment
European Commission (EC) – (co-financing from USAID in DRC, Ligue Pulmonaire Suisse and Global Fund in Benin.	Development of Programme of integrated HIV care for Tuberculosis Patients Living with HIV/AIDS.	Lead partner with the National Tuberculosis programmes of Democratic Republic of Congo and Benin	started Dec. 2004. – 3 years project	EUR 4.3 million

PR 2	World Vision India
Address	16, VOC Main Road, Kodambakkam, Chennai, India. PIN 600 024

As a National Office within the global network of close to 70 locally incorporated and registered national bodies within the World Vision International (WVI) partnership, World Vision India has the double advantage of being an Indian charity with its own Board of Directors and local management leadership while adhering to the parent organization's commitments to rigorous professionalism, financial transparency and cost efficiency. World Vision India is also the convener of the NGO TB Consortium the member organizations of which include the most active, technically respected and financially stable stakeholders in TB programming in India. Their profiles are described in the section on SRs below.

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

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

Technical: World Vision India has an extensive network of relief and development projects in the country – 107 Area Development Programs (ADP) in 24 states benefiting over 5,000 communities.

It also has been implementing a TB project funded by the Canadian International Development Agency (CIDA) in eight districts of Andhra Pradesh state from 2002 to '07, and subsequently the India TB Follow up program in five districts of the same state and the TB Mainstreaming project in five ADPs across five states, both with private funding. These three programs focused on community TB care, private sector engagement and ACSM, with lessons and practices from each cycle of programming feeding into the next one. Community based "TB Care Groups" were formed and strengthened, leading to effective community participation in TB diagnosis, care and case holding. It has a health team with significant experience in the technical support and management of child survival, HIV and AIDS, and health in humanitarian emergencies, in addition to TB. World Vision India accesses technical assistance from the Asia Pacific Regional office and other national offices with TB experience, notably World Vision Development Foundation of the Philippines, Yayasan Wahana Visi Indonesia and World Vision Foundation of Thailand. Advocacy, Communication and Social Mobilization has been the distinguishing strength of WVI's GF and non GF funded proposals around the world, including the Shifa TB project in Andhra Pradesh which was implemented with CIDA funding in eight districts of Andhra Pradesh Managerial: World Vision has been managing projects in India for the last 50 years. It is locally registered as an Indian charity, led by an indigenous Board of Directors. All projects are run by a total of 2,300 Indian national staff, 1,300 of whom are regular staff. Within India, there is a growing support base of 40,000 local child sponsors, who together with corporate donors gave US$2.5 million in 2006. World Vision India also manages grants and cooperative agreements from a diverse funding base that includes ten countries in the World Vision International Partnership, as well as bilateral donors such as USAID, DFID, AusAID, CIDA, and the EU. A special funding source was the state of Uttar Pradesh through the State Innovations for Family Planning Services Agency (SIFPSA).

Financial: World Vision India manages an average US$50 million a year for its projects and US$57 million for the fiscal year '08, making it one of the largest international NGOs in the country in terms of budget. During the past three years, there were additional resources of US$ 67 million for Tsunami relief and rehabilitation. To ensure accountability, compliance and efficiency, World Vision India has a team of highly qualified finance staff including six qualified chartered accountants to ensure transparent transactions for both local and international donations – from receipt of funds, to disbursements, and finally to reporting on activities financed. Every two years, World Vision India undergoes a mandatory external audit to ensure good standing within the World Vision Partnership. For the last round of audits that was completed last November 2006, World Vision India received a clean bill of health for its financial systems, protocols and transactions.

World Vision India is well experienced in the disbursement of funds to partners to finance local activities. Each of the 107 ADPs is treated like a local partner. They are regularly visited for both financial monitoring and programmatic support-a-vision by the nine regional teams. Regular visits are done for the purposes of mentoring, technical assistance and problem solving.

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

Specific experience from the Shifa TB Project in Andhra Pradesh will be adapted by this project to ensure that the M&E system's architecture will be effective, verifiable and able to track progress in terms of processes and outputs, to the satisfaction of the Global Fund's quarterly reporting. For

outcome data the proposed project will utilize the R&R system of the national program and not set up a parallel reporting system. Evaluations will be completed after two years and at the end of the project.

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

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

Contribution to Project: The proposed project will be supported by a matching contribution of € 152,380 (US$ 240,000) from the World Vision international partnership over the life of the project which will be utilized to purchase essential amenities like project four wheelers and motor cycles for the project to improve efficiency in field processes.

GF portfolio of World Vision International:

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

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

PR 3	[Name]
Address	[street address]
[Description]	

➔ ***Copy and paste tables above if more than three Principal Recipients***

4.9.2 Sub-Recipients	
(a) Will sub-recipients be involved in program implementation?	☒ Yes ☐ No
(b) **If no**, why not?	
(c) **If yes**, how many sub-recipients will be involved?	☐ 1 – 6 ☐ 7 – 20 ☒ 21 – 50 ☐ more than 50
(d) Are the sub-recipients already identified? *(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)*	☒ Yes ***[Insert Annex Number for list]*** ☐ No **Answer s.4.9.4. to explain**
(e) **If yes**, comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program delivery at the sub-recipient level, please explain why.	
The geographical distribution amongst partners is provided in Annex 8 CHAI, CMAI, CRS, EHA, InterAide, Mamta, REACH, VHAI will undertake community mobilisiation activities. Organisations with hospital network will undertake lab strengthening. PSI will undertake mass media and PPM in 6 states.	

WCC will pilot and establish innovative models of community care involving patients and their communities

CLRA will undertake advocacy with elected representatives and FIND will do strengthening IRLs. State level advocacy depending on organisational will and strength

The Union will provide need based TA and replication of Orissa model in 5 states

The implementation and geographic coverage of the **NTC component of the proposal** were decided through an iterative consultation process with the partners in the consortium. The allocation was proportionate to the extent each SR scored on the following key areas:

- Experience in TB programming,
- Presence of community level NGO/CBO networks and location of present programs
- Relationship with the state health and TB offices and the
- Preferences of the SRs themselves based on the strategic directions and the vision of their respective organizations and
- Managerial and programming capacity of the SR

Other criteria included the ability to invest time and contribute to the project design process; local registration with the Government of India; and sufficient financial systems to track external funding. All members of the consortium were amply supported with information and advice from WHO/New Delhi and the senior staff of the RNTCP.

The numbers and distribution of districts to the six SRs are detailed in annex 15.

This project harnesses the technical strengths of the SRs by proposing a centrally located TA pool to which the SRs will contribute through personnel, technology and skills, and this pool will provide technical support interventions project wide.

Two partners of NTC, while not being SRs, will contribute to the project: Damien Foundation of India Trust (DFIT), a partner that has over 30 years' experience in TB programming in Bihar state, working in 28 out of its 34 districts, will provide, as its contribution, state level coordination and support to ADRA, the implementing SR in that state. PATH India office will provide technical support in operations research and content development for specific training packages. Another significant c

Civil Society Involvement: This is the cornerstone of the NTC proposal, as this is a consortium of civil society organizations, aiming to garner a focused civil society response and participation in achieving the project's outcomes. As detailed in the Implementation Strategy (s 4.5.1), the involvement of communities will be substantial. ACSM forms the mainstay and the largest SDA in terms of effort and budget, for the project. In addition, the NTC project proposes to build capacity of large numbers of community based organizations and facilitate their participation in the decision making processes at the district level. The project is founded on the ethos that outcomes are sustainable only when communities own their future.

4.9.3. Pre-identified sub-recipients

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

The proposed SRs for ICAT component are:

Catholic Health Association of India (CHAI)

CHAI was established in 1943 and is one of the world's largest NGO network in the health sector with more 3200 member institutions. The members provide curative and promotive care, and extending health care facilitates to the poor and marginalised. CHAI has extensive experience in administering the DOTS programmes through its hospitals and has been recognised for expansion of the programme in hard to reach areas and the marginalised.

Catholic Relief Services

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

Centre for Legislative Research and Advocacy (CLRA)

CLRA is a leading national policy advocacy group mandated to strengthen and promote institutions of governance in order to ensure transparent, accountable and participatory governance. It began its work in 2004 by engaging with the Members of Parliament and state legislatures. The Centre has gained reputation for its expertise in legislative advocacy and garnering political support across partylines for public health programmes.

Christian Medical Association of India

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

Foundation for Innovative New Diagnostics (FIND)

FIND is dedicated to the development of rapid, accurate and affordable diagnostic tests through public-private partnerships. Its mission is driven by the conviction that good health is central to winning the war against poverty and that correct diagnosis is a crucial first step towards establishing health and efficient use of resources.

Emmanuel Hospital Association

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

Inter Aide

Founded in 1980, Inter Aide is a French NGO that has been working in TB control in India since 1985. It partners with local NGO, state health department and municipal corporations to manage health facilities and clinics whose services range from diagnosis to treatment and patient follow-up. It covers 1.5 million slum population of Mumbai and Greater Mumbai region. Since March 2005, Inter Aide has been the nodal NGO for the urban DOTS project funded by the GFATM round II.

Manavadhikar Samajik Manch

MASM is a New Delhi based NGO and founded in 1997.It works towards enhancing protection of human rights and has been championing the cause of public health as basic human right in India.

Mamta – Health Institute for Mother and Child

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

Mamta Samajik Sanstha

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

Population Services International

Since 1988, PSI has harnessed the vitality of the private sector to address the health problems of low-income and vulnerable populations. PSI works on safe water, nutrition, family planning and HIV/AIDS

(including TB/HIV) and uses principles of social marketing to achieve positive behaviour change through the promotion of ideas, products and services supportive of better health. PSI's is active in 22 States and covers the entire national highway system of India.

Resource Group for Education and Advocacy for Community Health (REACH)

REACH works in five district of Tamil Nadu and has extensive experience in developing community based networks and advocating with the community on TB control. It has been an active communication vehicle for the RNTCP in the five districts since 2003, and has sustained its efforts to work closely with DTCs/STC on communication and advocacy issues.

Voluntary Health Association of India

VHAI is a leading NGO working in public health since 1970. It is a federation of 27 State VHAs, linking together more than 4500 health and institutions across the country. VHAI is one of the largest health and development networks in the world. VHAI advocates for policy change and effective health planning and programme management through active participation of the people.

World Care Council

WCC strives to raise the standards of care for people with Tuberculosis, HIV/AIDS, and Malaria. The TB control initiative is driving for drugs-diagnostics- and dignity and developing innovative projects towards scaling up TB services in the community led by the people who are most affected. In India, WCC brings the key resource of a network of TB-patient activists across India and has developed the Patients' charter for TB care and several guidelines and manuals for community-led advocacy initiatives.

The proposed SRs for **the NTC component of this project** are:

- **German Leprosy and TB Relief Association-India (GLRA India)** is a member of GLRA worldwide that has 356 projects in 46 countries. GLRA-India was registered as a local trust in 1989, and currently supports 60 local NGOs involved in leprosy work, and 38 local NGOs involved in TB work in support of the RNTCP's overall goals. It is currently accredited by the RNTCP to work in 16 districts nationwide. It has staff that includes 134 doctors, 298 technical staff, 249 field staff and 776 support and administrative staff. The annual budget of GLRA-India is ca. US$3.5 million. GLRA is a founding member of ILEP (International Federation of Anti-Leprosy Associations).
- **LEPRA Society** was registered in Hyderabad in 1988, while BELRA, its parent organization is in the public health field since 1925. LEPRA is dedicated to restoring health, hope and dignity to those affected by leprosy, TB, malaria, HIV/AIDS and other diseases associated with disability, stigmata and discrimination. It has extensive TB programs and in-depth expertise in various aspects of ACSM and field research for the diseases of poverty in several states, including Andhra Pradesh, Bihar, Madhya Pradesh, and Orissa. The focus of these programs is in four areas: direct participation in service delivery, capacity building, field research and ACSM. LEPRA also lobbies other local NGOs and private medical practitioners to refer symptomatics to district medical centers for diagnosis and treatment, and to foster more effective collaboration between health providers, reaching about 12 million people. LEPRA is the lead partner of the International HIV/AIDS Alliance.
- **TB Alert-India (TBAI)** is the locally registered branch of TB Alert UK, the UK's National and International TB charity – launched in London's Houses of Parliament on World TB Day in 1999. TBAI exists to work towards the control and ultimate eradication of TB by increasing access to effective treatment for all. TBAI accesses a wealth of technical expertise through its network of projects in Andhra Pradesh, Delhi, Jharkhand, Bihar, Uttar Pradesh, and Madhya Pradesh. TBAI's Chair of the Board runs the world's biggest TB hospital and the Vice-Chair is the ex-president of the Andhra Pradesh Voluntary Health Association with 250 health-oriented NGO members. Internationally, TB Alert UK's Chairman is also the Chair of the Stop TB Partnership Working Group on Advocacy, Communications and Social Mobilization (ACSM). TB Alert is an organizational partner of both the Stop TB Partnership and IUATLD.
- **The Southern Health Improvement Samity (SHIS)** is working for more than thirty years in the area of tuberculosis control and care, pursuing high quality DOTS expansion and its enhancement especially in the underserved areas. SHIS in its experience and expertise believes that each intervention has to address the present as well as the future. To ensure sustainability each program is implemented, improved and structured with the help of the community members including active and organized participation of strata of civil society, including and especially the poor and backward

and tribal populations and women.. SHIS has been successfully working in partnership with the State Health and Family Welfare Dept in the 7 Tuberculosis Units located in the underserved and the un served areas in the Sunderbans Forest Reserve Area of the state, where SHIS is a household name. In the area of National AIDS Control Program III ICTC Centre of SHIS has established and maintains an effective cross referral mechanism between TB and HIV. In addition to health, SHIS also implements community based programs for economic development and leadership.

- **CARE India** has been operational in India for more than 57 years. CARE is presently implementing programs in the area of health, nutrition, reproductive health, microfinance, education and economic empowerment. CARE India implemented a community DOTS program with its NGO partners in the state of West Bengal, and is currently operational in 12 states for implementing health, gender and development programs focused on bringing lasting change in the well being and social position of vulnerable groups with special emphasis on women and girls. CARE India has offices and field staff at the state and district level in the areas which are being covered. CARE has extensive experience in implementing TB programs in countries like Haiti, Zambia, Indonesia and Uganda.
- **Adventist Development and Relief Agency- India (ADRA India)** is implementing a three-year TB control and prevention project in 3 districts, since 2006, with a target population of 176,000 people. The focus is on capacity building of health service providers towards behavior change communication (BCC), support of community-based DOTS providers, and community awareness. The project has a total of 17 full time project staff, and two part-time consultants. ADRA India provides technical support through its health team at the national office in New Delhi and through the Department of Community Medicine at the Pondicherry Institute of Medical Sciences. ADRA India has an annual budget of US$5 million for its relief and development projects in seven states of India. ADRA India accesses additional technical and management support from a global network of national offices.

Potential Challenges:

Though the NTC has been in place for over a year now, this is the first concerted efforts by a majority of its partners, to bring together a project with common outcomes and a single donor. Many processes within the consortium have been standardized and the working relationship amongst partners has been exemplary. However, challenges are anticipated especially in those states where two SRs will operate with one of them leading the state level implementation.

The key strategy employed to overcome this challenge is to ensure regular coordination meetings at the state level along with the program officials, and joint supervisory visits by the SRs, for problem solving and continuous quality improvement. The PR emphasizes proactive and pre emptive measures, as well as delegating problem solving to the most peripheral level possible.

4.9.4. Sub-recipients to be identified

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

4.9.5. Coordination between implementers

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

Comment on factors such as:

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

The **PR for ICAT component** will establish a PMU for the management of the project and coordination with SRs. The PMU will consist of relevant experts for technical and operational management of the project. The PR will have an MOU with all SRs inclusive of recording and reporting structures. PR will oversee management, coordination and oversight of SR programmes and set up financial procedures and manage donor agreements and timely disbursement to Sub recipients; manage procurement and supply chain where central procurements are required while oversee decentralised procurements to ensure best practices; financial management and audit; collate and analyse the reports received from SRs; facilitating communication, interactions and synergies with CCM and the among implementing partners to act as a common information point for all implementing partners and other stakeholders (WHO, GoI) and circulating meeting reports and agendas.

The PRs of both ICAT and NTC will meet regularly with the national program units and WHO for reviewing progress against targets and to identify and sort out implementation bottlenecks. Respective SRs will coordinate efforts along with the state program units in those states where both the ICAT and NTC components of the project are being implemented.

The estimated contribution of ICAT partners for programme implementation will be Euro 3.5 million through existing infrastructure and human resources

The **PR of the NTC component of the proposal** will enter into sub grant agreements with its six SRs, which will include the negotiated financial arrangements and programmatic reporting. Staff of the PR management team, including the Team Leader, M&E officer and finance officer will regularly visit project sites, often along with the respective SRs, to support operations, problem solve, encourage and learn. The PR will meet with all SRs once a month for the first six months of the project and quarterly thereafter, to share experiences and lessons in implementation, bottlenecks and challenges and jointly search for solutions. Cross visits between project sites will help enrich the learning process.

At the state level SRs will work closely with and through the program structure, strengthening and supporting processes required to meet project targets. In two project states where there is more than one partner, all partners will participate and contribute to coordination and synergy at the state level.
Clear, standardized guidelines will be jointly developed for recruiting project staff, selecting local NGOs from their existing networks, for carrying out community activities, and quality standards for community events like folk performances and CBO capacity building. All project staff including those of the PR will undergo a standard initial orientation on the project as well as on the overall program, with technical and managerial input. Periodic refreshers will be organized to go along with sharing of lessons and promising practices. Content and schedule for all field level training and sensitization events will be drawn up using existing program guidelines, informed by baseline studies and in consultation with the state TB officers. Each state coordination unit will identify and equip a pool of trainers for the different streams of training events.

Contribution: The proposed project will be supported by a matching contribution of € 152380 (US$ 240,000) from the World Vision international partnership over the life of the project which will be utilized to purchase essential amenities like project four wheelers and motor cycles for the project to improve efficiency in field processes. Two partners of NTC, while not being SRs, will contribute to the project: DFIT, a partner that has over 30 years' experience in TB programming in Bihar, in 28 out of its 34 states,

will provide, as its contribution, state level coordination and support to ADRA, the implementing SR in that state. PATH India office will provide technical support in operations research and content development for specific training packages.

4.9.6. Strengthening implementation capacity

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

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

(a) the assistance that is planned;**

(b) the process used to identify needs within the various sectors;

(c) how the assistance will be obtained on competitive, transparent terms; and

(d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

*** (e.g., where the applicant has nominated a second Principal Recipient which requires capacity development to fulfill its role; or where community systems strengthening is identified as a "gap" in achieving national targets, and organizational/management assistance is required to support increased service delivery.)*

The Union (PR for ICAT) is a recognized and credible technical agency providing expertise on Tuberculosis control - Technical Assistance for 98 projects in 46 low and middle income countries, Education activities in 36 countries and Research projects in 47 countries. Clinical trials are being undertaken in 12 countries. The strength will be utilized for supporting the existing project.

Technical assistance for ACSM to states is based on existing model of activities being undertaken under Rd4 project that have been found successful and already endorsed by RNTCP for expansion to other states.

For the **NTC component of the proposal,** two areas have been identified for possible contracting for technical assistance:

1. Design and conduct KAP surveys and formative research on communication needs.
2. Content development for training in soft skills.

For these and other TA needs, the common process used to identify and ensure timely delivery of services will include:

1. TA will be sourced from the national program to the extent possible. For external TA, the search will begin from within the program, from among the NTC partners and from within the country, in that order, before seeking the same from international sources.
2. Standard competitive bidding processes used by the World Vision International partnership will be employed for deciding the source of TA. These processes are compliant with the requirements of most bilateral donors like USAID, CIDA and AusAID.
3. The PR and technical advisors from the SRs will provide a studied feedback to each step of the TA process beginning with the Terms of Reference, Scope of Work, to the tools used, timeliness of the processes and completeness in providing the deliverables. The TOR will be designed to allow for changes in every step based on feedback from the PR and from the SRs.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 proposal	
Does this proposal seek funding for any pharmaceutical and/or health products?	☐ **No** ➔ *Go to s.4B if relevant, or direct to s.5.*
	☒ **Yes** ➔ *Continue on to answer s.4.10.2.*

4.10.2. Table of roles and responsibilities

Provide as complete details as possible. *(e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	NGO – FIND through a procurement agency. International best practices will be followed in all cases	SR	☐ Yes ☒ No
Intellectual property rights			☐ Yes ☐ X No
Quality assurance and quality control	NGO – FIND through a procurement agency. International best practices will be followed in all cases	SR	☐ Yes ☒ No
Management and coordination *More details required in s.4.10.3.*			☐ Yes ☒ No
Product selection	NGO – FIND through a procurement agency. International best practices will be followed in all cases	SR	☐ Yes ☒ No
Management Information Systems (MIS)			☐ Yes ☐ X No
Forecasting			☐ Yes

			☐ X No
Procurement and planning	NGO – FIND through a procurement agency. International best practices will be followed in all cases	SR	☐ Yes ☒ No
Storage and inventory management *More details required in s.4.10.4*			☐ Yes ☐ X No
Distribution to other stores and end-users *More details required in s.4.10.4*			☐ Yes ☐ X No
Ensuring rational use and patient safety (pharmacovigilance)			☐ Yes ☐ X No

4.10.3. Past management experience

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

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
Clarification: Foundation for Innovative New Diagnostics	**Sub-recipient**	**Approx Euro 812,000**
[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]		

4.10.4. Alignment with existing systems

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

Clarification: The health products planned to be procured under this proposal are Health products like specialised in-vitro diagnostics (IVDs), systems for laboratory Environment control (for ensuring Bio-safety levels) and consumables for laboratory procedures.

FIND's existing procurement mechanisms are currently used for specialised procurement, importation and quality assurance of limited amounts of IVDs for Reference Labs, academic Health Institutions, etc in different countries in the world. FIND's modus operandi is to enter into a Memorandum of Undertaking with the local government, Institution. For large scale programmatic procurement within the country, FIND would use either competitive bidding process at national level or shopping procedures, based on value of the procurement and using technical specifications agreed upon by LFA of the GFATM for IVDs available in India. In India, FIND has staff dealing with procurement and logistics management and also uses the services of a

Regulatory Affairs consultant and a customs clearing agent. The proposal plans to use the existing mechanisms in the country for distribution, supply and inventory management of Health products under this proposal. Information on utilisation and stock would be provided by the IRLs and labs covered under this proposal. A Procurement, Supply & Distribution Plan for IVDs, agreeable to the National TB programme would be prepared prior to project implementation.

Pharmaceutical products are not planned to be procured under this proposal.

4.10.5. Storage and distribution systems	
(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?	☐ National medical stores or equivalent
	☐ Sub-contracted national organization(s) *(specify)*
	☐ Sub-contracted international organization(s) *(specify)*
	X Other: *(specify)*
(b) For storage partners, what is each organization's current **storage capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.	
The volume of consumables and IVDs for recurrent use, planned to be procured, is not considered to be large enough to require procurement of storage points at national level by the PR or SR. What is procured can be stored at the Intermediate Reference Labs (IRLs) as it is for use by TB programme.	
(c) For distribution partners, what is each organization's **current distribution capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.	
Clarification: The IVDs mentioned in the proposal have private sector distributors and suppliers in India (except for line probe assay). The Procurement contracts will specify Point-to-point delivery at IRLs, participating labs and district HQ (in case of consumables for fluorescence microscopy), in tranches. Procurement contracts would be annual based on patient load at different IRLs. For Line-probe assays FIND has the capacity to undertake competitive bidding for this product and import it to the country. It is also expected that this product would be locally available in India by 2009 as it is now an approved technology. Information on utilisation and stock for consumables would be provided by the IRLs and labs covered under this proposal under a reporting mechanism agreed to with the National TB programme.	

4.10.6. Pharmaceutical and health products for initial two years

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

Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs'). **However**, if the pharmaceutical products included in 'Attachment B-Tuberculosis' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

Clarification: There are no pharmaceutical products planned to be procured. The Health products are In-vitro Diagnostics (IVDs), approved for use by WHO STAG in the diagnosis of tuberculosis. The environment controls required at the labs are also mentioned in these expert opinions. (http://www.who.int/tb/dots/laboratory/Use%20of%20Liquid%20TB%20Culture_Summary%20Report.pdf ; http://www.who.int/tb/features_archive/policy_statement.pdf)

There are 3 major categories of procurement that The Union (PR1) is involved in:

- **Supply: supply market covers the purchase of products and equipments. The delivery of products may in addition include set up, installation and maintenance depending of the nature of the product. Union typical procurements of supply are: drugs, lab material, microscopes, medical equipment, office stationeries, computer equipment .**

- **Works: works market covers either the execution, or both the execution and design of works or the realization, by whatever means, of a work corresponding to the requirements specified by the contracting authority.**

- **Services: service market covers all intellectual and non-intellectual services other than those covered by supply contracts, works contracts and property contracts. Service contracts equally comprise study and technical assistance contracts.**

The Union has a clear and documented procurement policy and is flexible enough to incorporate donor described terms and conditions.

Maintaining transparency and competitiveness in procurement of goods:

- **The Union has undertaken large procurements in past to the satisfaction of various donors**
- **Large volume procurements have been done through International Competitive Bidding (ICB) whereby advertisements are placed in international media and widely publicized.**
    - **The tender document is made available at The Union's website that is accessible to all potential participants. (www.iuatld.org/tenders)**
    - **Supplier submitting tenders are free to attend the tender opening session**
    - **Tender adjudication committee consists of members independent of procurement division and where possible, independent of The Union. The group consists of technical and procurement experts relevant to the procurement.**
    - **All tender adjudication members sign a statement of no conflict of interest and confidentiality statement.**

- **Procurements requiring three quotations are also widely publicised through direct mails. At least three quotations from reputed suppliers are invited to ensure quality.**
- **In all requests for quotations, technical specifications are well described – broad enough to encourage greater participation and yet specific enough for supplier to be clear on the requirements.**
- **Criteria for selection are specified in the request for quotations/ tenders.**

The Union's procurement services are designed to ensure uncompromising standards of quality at best possible prices and to comply with donor requirements. The procurement unit ensures an

uninterrupted supply of a variety of products, including drugs to laboratory equipment, vehicles and consumables.

Some of the recent activities include

- **Supported procurements for National Tuberculosis Programmes (NTPs) in Chile, India, Malawi, Panama, Nicaragua, Senegal, Sudan, Uganda as well as The Union's Integrated HIV Care (IHC) projects in Benin, DRC Myanmar Uganda and Zimbabwe.**
- **Assisted the Global Drug Facility (GDF) in monitoring supply chain management of TB drugs in Lao PDR, Mongolia, Myanmar and Philippines.**
- **Improving drug management capacity through Procurement and Supply Chain Management (PSM) sessions in The Union's courses.**

Over the recent 4 years, the procurement unit has provided services to the value of nearly 6.5 million USD

4.10.7. Multi-drug-resistant tuberculosis	
Is the provision of treatment of multi-drug-resistant tuberculosis included in this tuberculosis proposal?	☐ Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.*
	☐ No *Do not include these costs*

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 8 and only if:

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

Read the Round 8 Guidelines to consider including HSS cross-cutting interventions.

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

ROUND 8 – Tuberculosis

5. FUNDING REQUEST

5.1. Financial gap analysis – Tuberculosis

The National Programme reports no financial gaps (GTR 2008). Funds requested are additional to address civil society intervention to support the National Programme. The combined budgets of the two PRs are given in Line G.

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

Clarified Table 5.1

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
All figures in Euros and for financial year (April-March)	**Actual**		**Planned**		**Estimated**			
	2006-07	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**
Tuberculosis program funding needs to deliver comprehensive diagnosis, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	34,370,000	47,590,000	50,400,000	68,796,201	67,123,954	47,570,688	NA	NA
Line A.1 ➔ Total need over length of Round 8 Funding Request *(combined total need over Round 8 proposal term)*								
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*World Bank*)	22,380,000	19,740,000	20,650,000	25,130,000	27,020,000	19,250,000	NA	NA

ROUND 8 – Tuberculosis

Financial gap analysis *(same currency as identified on proposal coversheet)*

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

All figures in Euros and for financial year (April-March)	**Actual**		**Planned**		**Estimated**			
	2006-07	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**
Domestic source **B2** National funding resources (Govt of India)	10,000	8,120,000	8,470,000	4,120,000	4,060,000	1,680,000	NA	NA
Domestic source **B3** Private Sector contributions (national)	[redacted]							
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	22,390,000	27,860,000	29,120,000	29,250,000	31,080,000	20,930,000	NA	NA
External source **C 1** (*DFID*)	5,440,000	5,520,000	5,880,000	6,840,000	6,290,000	6,480,000	NA	NA
External source **C2** (*USAID*)	310,000	980,000	980,000	NA	NA	NA	NA	NA
External source **C3** Private Sector contributions (International)	[redacted]							
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	5,750,000	6,500,000	6,860,000	6,840,000	6,290,000	6,480,000	NA	NA

ROUND 8 – Tuberculosis

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
All figures in Euros and for financial year (April-March)	**Actual**		**Planned**		**Estimated**			
	2006-07	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	6,220,000	13,230,000	14,420,000	17,680,000	12,360,000	3,640,000	NA	NA
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	34,370,000	47,590,000	50,400,000	53,770,000	49,730,000	31,050,000	NA	NA
Calculation of gap in financial resources and summary of total funding requested in Round 8 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	0	0	0	**15.,026,201**	**17,393,954**	**16,520,688**	**15,981,664**	**14,993,447**
Line G = Round 8 tuberculosis funding request *(same amount as requested in table 5.3 for this disease)*				**15,026,201**	**17,393,954**	**16,520,688**	**15,981,664**	**14,993,447**

ROUND 8 – Tuberculosis

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants	
In Round 8, the total maximum funding request for tuberculosis in Line G is: *(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and* *(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*	
Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund **Cost sharing = (Total of Line D entries over 2009-2013 period + Line G Total) X 100 / Line A.1**	%

5.1.1. Explanation of financial needs – LINE A in table 5.1

Explain how the annual amounts were:

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

The annual amounts for the national programme are as provided by the Programme for the implementation of planned activities in the country by the Programme and the cost of proposed activities in the proposal have been added to the amounts provided.

The activities budgeted in this proposal are as per the national guidelines/ policy and have been developed under the guidance of national programme. They are civil society endeavour and represent costs that have not been included in existing national plan and budget. Therefore these costs are additional to the programme budget and translate to a funding gap.

Clarified Sections 5.1.2 and 5.1.3.

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

Explain the processes used in country to:

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

Clarification: This proposal is from the Civil Society submitted under the "dual track mechanism" of the Global Fund round 8 call. Section 5.1.2 and section 5.1.3 do not apply as the information sought in these sections are not available with Civil Society.

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

Explain any changes in contributions anticipated over the proposal term (*and the reason for any identified reductions in external resources over time)*. Any current delays in accessing the external funding identified in table 5.1 should be explained (including the reason for the delay, and plans to resolve the issue(s)).

Clarification: This proposal is from the Civil Society submitted under the "dual track mechanism" of the Global Fund round 8 call. Section 5.1.2 and section 5.1.3 do not apply as the information sought in these sections are not available with Civil Society.

5.2. Detailed Budget

Suggested steps in budget completion:

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

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/apply/call8/single/#budget

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

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

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

5. Do not include any CCM or Sub-CCM operating costs in Round 8. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/apply/mechanisms/guidelines/

ROUND 8 – Tuberculosis

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

Obj.No.	Service Delivery Area (SDA)	Year 1	Year 2	Year 3	Year 4	Year 5	Grand Total
	Summary by SDA for ICAT						
1,3,4	ACSM	2074941	3383451	4436684	4543148	2730358	17168582
2	Community TB care	695398	336799	370481	407527	438363	2248568
5	HSS-Health workforce	639962	638723	675250	733647	797654	3485236
2,3	Improving diagnosis	3138961	5125834	2935750	2080701	2670583	15951829
2	Involvement of all care providers (PPM)	815556	897111	986822	1085504	1194055	4979048
6	M&E-PR	47968	52765	22803	22803	22803	169142
7	M&E-SR	247604	272364	272364	272364	272364	1337060
3	MDR-TB	110870	362113	398324	438157	481972	1791436
8	Overheads	1075392	1371548	1285864	1243408	1150680	6126892
7	Project Management and Supervision - SR	1793932	1940740	1997482	2051621	2061138	9844913
6	Project Management and supervision - PR	732065	448600	472160	480920	489954	2623699
1	Strengthening Civil society engagement in TB control	87998	78071	93684	101196	109404	470353
3	TB-HIV	368699	178933	196827	216509	238160	1199128
	Total	11829346	15087052	14144495	13677505	12657488	67395886
	Summary by SDA for NTC						
1	ACSM (Advocacy, communication and social mobilization)	933021	464476	610388	403638	368869	2780392
1	Community Systems Strengthening	314941	113204	112091	118865	123581	782682
2	HSS	242465	27518	26836	27344	28712	352875
3	MDR-TB	16216	17672	21412	22482	23606	101388
1	Over heads	152232	109852	130917	112711	114353	620065
2	PPM	93421	87163	57823	112226	20406	371039
1	Project Management	1393001	1425897	1343476	1429983	1575672	7168029
3	TB/HIV	34891	43340	51660	54242	56957	241090
2	Work Place Intervention	16667	17780	21590	22668	23803	102508
	Total	3196855	2306902	2376193	2304159	2335959	12520068
Grand Total		**15026201**	**17393954**	**16520688**	**15981664**	**14993447**	**79915954**

ROUND 8 – Tuberculosis

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

Avoid using the "other" category unless necessary – read the Round 8 Guidelines.	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	3033320	3747472	3877831	4016147	4610791	19285561
Technical and Management Assistance	1381340	2545141	1784496	1367025	675818	7753820
Training	4165027	2722517	3707260	4094130	4340371	19029305
Health products and health equipment	390654	1230846	959714	996536	984714	4562464
Pharmaceutical products (medicines)	0	0	0	0	0	0
Procurement and supply management costs	17640	98840	98840	100590	100590	416500
Infrastructure and other equipment	2328452	1583422	656720	18828	20286	4607708
Communication Materials	541269	2102003	2182592	2126497	1070463	8022824
Monitoring & Evaluation	1250832	1069231	1034896	1064510	1085802	5505271
Living Support to Clients/Target Populations	224	448	704	739	776	2891
Planning and administration	689819	812634	800854	840543	838803	3982653
Overheads	1227624	1481400	1416781	1356119	1265033	6746957
Round 8 tuberculosis funding request (*Should be the same annual totals as table 5.2*)	**15026201**	**17393954**	**16520688**	**15981664**	**14993447**	**79915954**

5.4.1. Overall budget context

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

Yearly variations in cost category in the **NTC component of the budget** are in line with the planned activities and their phasing, with gradual increases over the years. Training, M&E and Planning and Administration each make up 15 to 22% of the total budget and are reasonable proportions, in keeping with the project's approach and strategy. The SDA Programme management comprises of cost categories – Planning and Administration, HR, M&E and Technical and managerial assistance.

5.4.2. Human resources

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

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

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

Costs for human resources represents 24.7% of the total budget of the ICAT component of the proposal. This includes human resources with a Project Management Unit (PMU) of PR, project management for 350 districts/ 22 states and national level of implementing partners. (TORs and organogramme for PMU are provided at Annex 9). Out of the budgeted amount, 9.23% is for human resources within PMU, 89.93% for SR to monitor implementation of the project in 350 districts across 22 states with a population of 634 million. 0.84% of the human resource cost will support staffing in the partnership secretariat.

The PMU and national level team of implementing partners will be involved in providing technical assistance and oversight to project implementation while the human resource at state and district level would be involved in direct implementation of activities. The secretariat staff will be involved in coordination with various civil society members, expanding membership, capacity building of civil society and organizing central level coordination meetings with central unit of national programme.

The basis for budget calculations for all five years is available in full detail in the budget. Unit rates have been calculated using salary review system for similar work positions within the country.

Staff costs comprise 21 % of the total budget of the **NTC component of the proposal** and reflect the proposed staff structure as found in annex 17 the timing of recruitment of these staff, and the planned technical assistance amongst SRs. The costs for the last three years of the project have been estimated based on the planned phasing in of additional interventions in select target districts, as outlined in the implementation strategy. The approach adopted by this project is one of working through the national program systems and structures at the state, district and peripheral levels. This empowerment approach has guided the choice of activities which are focused on supporting the program improve its reach and depth of coverage, rather than providing services through a parallel system. The staff pattern has also been guided by this principle

5.4.3. Other large expenditure items

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

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

HALF PAGE MAXIMUM

5.5. Funding requests in the context of a common funding mechanism

In this section, **common funding mechanism** refers to situations where all funding is contributed into a common fund for distribution to implementing partners.

Do not complete this section if the country pools, for example, procurement efforts, but all other funding is managed separately.

5.5.1. Operational status of common funding mechanism
Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners. ➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*
5.5.2. Measuring performance
How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.
5.5.3 Additionality of Global Fund request
Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the focus of the common fund is broader than the tuberculosis program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on tuberculosis outcomes during the proposal term.*

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS

Applying for funding for HSS cross-cutting interventions is optional in Round 8

*SECTION 5B CAN ONLY BE INCLUDED IN **ONE DISEASE** IN ROUND 8 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.*

Read the Round 8 Guidelines to consider including HSS cross-cutting interventions

Down load 'Section 5B' from the Global Fund website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions') ***in Round 8 and has completed section 4B and included that section in the Tuberculosis proposal sections.***

Proposal checklist

Section	Document description	Annex Number
	Planning Commission XI Plan TB	1
	Project Implementation Plan (PIP) Phase II	2
	DOTS Plus Guidelines	3
	NRHM- Summary	4
	JMM-2006	5 .a
	TB in India-2008	5.b
	DRS_WHO_IUATLD	5.c
	Monitoring Strategy	6
	ICAT partners	7
	Media Plan_ICAT	8
	PMU roles and its job description_ICAT	9
	ISTC	10
	Patients' Charter	11
	Community Care Guidelines	12
	Glossary	13
	PR2 capacities NTC	14
	Sub-recipients and SDAs – PR2 NTC	15
	Partner letters PR2 NTC	16
	HR structure and description – NTC	17
	Distribution of project area PR2 NTC	18