

INDIA
COUNTRY COORDINATING MECHANISM (CCM) for
The Global Fund - To Fight AIDS, Tuberculosis and Malaria

**Minutes of the India Country Coordinating Mechanism (CCM) Meeting
held on 24 June 2008 in New Delhi**

The 30th meeting of the India Country Coordinating Mechanism (I-CCM) for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) was held at 3 pm on 24th June 2008 at the Nirman Bhawan, New Delhi. The list of participating CCM members and invitees present at the meeting is attached in annexure 1.

The Chair of the India-CCM, Shri Naresh Dayal, Secretary, Health and Family Welfare, Government of India, presided over the meeting. The Chair welcomed the participants to the meeting and mentioned that he would have to leave by 4.30 pm after which the meeting would continue with the Vice Chair presiding over.

Agenda Item No. 1

Headlines of Global Fund Audit

The Chair introduced the first agenda item and invited the Inspector General, Mr. John Parsons of the Global Fund to give a brief presentation on the Global Fund independent audit that was recently undertaken.

Mr. Parsons, who directly reports to the Global Fund Board mentioned that a team had visited the India grants for the past five days as a part of the audit of GF grant funds.

The office of the Inspector General was in place in 2005 and the role is to conduct in-depth audits of country programs. The audit team has a mixed skill set comprising of a public health specialist, procurement specialist and the traditional financial auditors. He mentioned that India as a country is significant to the Global Fund for it has received the largest amount of funds. The final audit report will be ready by mid-September and the published report will be available on the Global Fund website for public access.

The main focus of the audit was on procurement and supply chain management and the program management of the three diseases as implemented by PRs, NACO, and Malaria and TB organizations. The major headlines from the findings so far were:

- There is a centralized procurement procedure in the three diseases
- There are a few issues as expected around delay in procurement but nothing troublesome
- Orissa, Andhra Pradesh and Karnataka are following NACO guidelines for procurement within HIV/AIDS program
- The performance of NGOs has been reassuring
- Critical issues have been located in the supply chain management. The shortcomings are in storage arrangement. There is a need for standardized technical specifications for storage facilities

The implementation is linked to the civil society. The highlights of the findings from the program management of the three disease components include:

- **HIV/AIDS:** The implementation systems are in place with strategic direction and comprehensive guidelines. There is a clear monitoring and evaluation strategy. The operational challenges are seen in the areas of increased engagement of private sector; integration with NRHM; and testing of HIV among TB patients which needs scaling-up.
- **Tuberculosis:** The programs follow high standards and reports back on a quarterly basis. This could be an example for other programs.
- **Malaria:** There is a need for a long term strategic plan for providing clear direction for India. The program seems to be disjointed and lacks policy support and guidelines. There is a visible deficiency at capacity and managerial levels. The malaria program could draw from the lessons of the Tuberculosis and HIV program of developing national guidelines.

There is a scope to strengthen the role of oversight within the CCM. Better oversight roles will in turn provide greater assurance to the LFA and also to the Global Fund on outcomes of grant implementation.

The audit report will be released by mid-September and the team welcomed feedback.

The Chair expressed gratitude to the audit team for their efforts that pointed out systemic gaps, which needs to be addressed.

The Chair mentioned that the suggestion to strengthen supply chain was a good complement to NRHM as the government has come across this gap in the NHRM as well. Another key gap was in the area of human system strengthening. Some of these gaps can be addressed through the HSS window which has not been undertaken so far. He reiterated that the remedy for providing capacity in the supply chain management and addressing storage issues can be done through a separate HSS proposal to the Global Fund.

In response to the audit comments on the Malaria Program, the Chair stated that an important aspect of the malaria component is capacity building.

Agenda Item No. 2

Endorsement of minutes of the India CCM Meeting held on 6 May 2008

The Chair called for comments by the CCM members on the minutes of the meeting held on 6th May 2008. With no comments provided, the Chair moved to confirm and endorse the minutes of the proceedings of the 29th I-CCM meeting held on 6th May 2008.

Agenda Item No. 3

Presentations on the Disease Components of the Country Proposal

HIV/AIDS Component

The first presentation was given by Mr. N. Shiv Kumar, Consultant from SWASTI- the proposal writing team. In his presentation he covered the proposal development process that was followed for Round 8 and described the four thematic areas being covered in HIV/AIDS proposal.

The **Ministry of Labour and Employment** proposal to 'Strengthen Policy, Prevention and Care Services among Select Informal Labour Sectors' focused on reaching 27 million informal workers in four sectors, i.e construction, textiles/garments, manufacturing and mining across the different levels within the supply chain. The formal sector workers in these sectors will also be addressed through the companies, at no extra costs. Where companies have unions, the unions would be the focal engagement point; elsewhere NGOs would implement the program.

The Ministry of Labour and Employment was stated to be best placed to implement the program and reach out to the workers as the Ministry has the regulatory powers and the mandate of protection of workers rights. The research skills and training infrastructure of the National Labour Institute and Central Board for Workers Education would be an added strength to the project. The health services will be offered through the ESI and Labour Welfare Hospitals. Trade unions, corporate companies, employers' associations and NGO's are potential partners on the project.

The project has an in-built operations research component which will be completed by the second year and based on the findings the program would be re-strategized and up-scaled, if found necessary. The proposed budget was of US\$ 64 Million.

The highlights of the discussion on the MOLE proposal are as follows:

Ms Vidhya Ganesh UNICEF raised a concern about the employers associations being implementing partners as previous experiences of working with Employers Associations have not shown expected results.

AS& DG NACO mentioned that the budget would need to be streamlined, this could be achieved by focusing on the five priority states including Gujarat. Later, MOLE can expand the interventions to the other states.

The Chair mentioned that there was an opportunity of integrating the project with the National Rural Employment Guarantee Scheme (NREGA). The bio-metric smart cards to be issued under NREGA could possibly include the HIV status of the individual which would help in follow-up and treatment provision.

Mr Shiv Kumar cited a caution that, if there are lapses confidentiality could be at stake, leading to increased possibilities of stigma and discrimination.

Ms Janet Heyman, USAID requested clarification on the contribution from the private sector. Mr Shiv Kumar clarified that the proposal factors in the financial contribution from the corporations which is almost 50% from the companies. It has not shown up in the presentation but is an imputed value.

The CCM was also informed that all the HIV/AIDS proposals were reviewed by the CCM sub-committee on 16th June 2008; sub-committee members included representatives from UNAIDS, NACO, UNICEF and USAID. As the proposal submitted by Voluntary Health Services (VHS) NGO PR on informal labour was weak and not focused the sub-committee agreed that it should be dropped from this round. The Sub-committee felt that this proposal is not tenable for the following reasons:

- The proposal does not articulate clearly what kind of informal labour it seeks to reach
- It tries to do too many things, in too many places - no clear sectors have been identified within the labour market. A variety of interventions is proposed in 30 states
- Linkages with NACO, SACS and Round 7 efforts are unclear
- The budget requested, 74 million USD is far too high
- There is clear duplication of activities and approaches between the MOLE and VHS proposal, no common strategy could be evolved
- Overall the proposal is weak and not focussed

It was appreciated that the MOLE proposal looks at peer education and livelihood options.

Following the MoLE proposal discussion, there was a presentation of the proposal related to **interventions among MSM** titled 'strengthen community systems that benefit MSM, Hijra and trans-gender communities'. The proposal is built on the premise that this effort would ready the ground for expansion and strengthening the targeted interventions among the MSM.

India HIV/AIDS Alliance is the PR. The key service delivery areas include: policy development; strengthening of civil society and institutional capacity building; community outreach and HSS Service delivery. The proposed outcomes include: improved coordination with 17 SACS; 150 CBOs providing at least two new services to members of MSM, hijra and transgender communities; 27,000,000 lubricants for existing condoms distributed to MSM,

hijra and transgender clients of CBOs; 316,000 beneficiaries newly reached by CBOs among MSM, hijra and transgender communities; 6,600 health care and other service deliverers trained in providing population-friendly services; and 105 CBOs with active referral and tracking systems linked to local service providers. The overall budget requested was 51 Million USD.

The highlights of the discussion on the MSM proposal are as follows:

AS&DG raised a concern on proposing the purchase of condoms and lubricants with GFATM funds as this would duplicate the NACO efforts of providing condoms. It was also pointed out by DG NACO that the MSM project must focus only on developing capacity of CBO's to avail of the NACO funding but not fund districts as this would result in duplication and not supplementation. It was clarified that this was the case.

The next presentation was on the **Harm Reduction component**, it was stated that the Ministry of Social Justice and Empowerment (MoSJE) was initially the proposed PR but as they were not keen to be the PR, the Indian Harm Reduction Network proposed Emmanuel Hospital Association (EHA) as the PR. The proposal focused on addressing the gaps in the system for effective harm reduction scale up as planned in NACP III that include: inadequate trained medical and non-medical staff at service delivery sites for effective implementation of harm reduction; absence of a reintegration package for IDUs so as to reduce relapse; and potentially poor outcomes in the absence of a system for establishing and delivering quality OST programme. The key objective is to capacitate service providers to deliver quality and comprehensive harm reduction services through NACP III. The strategies being proposed include strengthening institutional and technical capacity of civil society and other support structures to deliver harm reduction programmes including OST; reintegration package for male and female IDUs and their sexual partners; strengthening quality control system for quality delivery of OST programme; and enhancing technical and management support through supportive supervision system (Project Management Unit). The key outcomes are: system for quality control of harm reduction services including OST in place; improved capacity of the CSO's to deliver quality harm reduction services including OST; improved outreach services through capacitated peer educators; improved environment for reintegration of IDUs and sexual partners; and improved adherence for ARV's and DOTS. The total cost of the harm reduction proposal was 35.27 million USD.

The highlights of the discussion on the Harm Reduction proposal are as follows:

The Chair stated that the proposal should look at rehabilitation of IDU's especially focusing on follow-up to ensure weaning off people from drug addiction.

The AS&DG NACO stated that the IDU proposal similar to the MSM proposal should ready the ground for expansion and strengthening of the NACP.

Ms Vidhya Ganesh, UNICEF suggested that the proposal can explore the relationship, if any, with the MoSJE so as to build their capacity over-time.

Dr. Shubha Raghvan, SAATHI, mentioned that the integration with the government programs (NRHM) and advocacy has to come out strongly. There has to be a mention of the percentage increase in outcomes and processes moving forward.

Dr. Denis Broun, UNAIDS mentioned that it is important that OST programs have a strong control system in place. Supervision of tablet distribution is crucial. He also pointed out that there were three days to complete the proposal in light of the recommendations.

The next presentation was on **the Health System Strengthening (HSS) proposal** submitted by CARE that covers thirty underserved districts with worst health outcomes in the two northern states of Madhya Pradesh and Uttar Pradesh. The circulated draft included Bihar as a state but it was clarified that Bihar has been dropped. The 30 districts in the States of UP and MP were chosen due to: high levels of poverty, large SC and ST population, highly vulnerable states; high migration rates. UP has the highest net migration (2.6 million); large under-served areas; poor health indicators; weak health delivery systems, poor health seeking behavior; low awareness about SRH and AIDS , low literacy level; gender discrimination, stigma towards PLHIV and others. The purpose is to mobilize and strengthen health systems to effectively deliver equitable and quality SRH and HIV services in the most underserved areas of northern India. The key strategies proposed include: expanding access to health services through expansion of private sector services; demand generation; improved systems for better accountability and responsiveness (monitoring and reporting); advocacy for sustainability; and strengthen systems and capacity for ensuring quality and safety of services. The outcomes include:100,000 HIV+ people linked to support, care and treatment; 50,000 women referred for PPTCT;2,000,000 voluntary testing undertaken; 600,000 STI treatment done; 500,000 un reached /underserved population able to access SRH services and PLHIV stigma index reduced to 70%. The overall budget requested was 68 million USD.

The following points highlight the discussion on the HSS proposal:

- At the outset it was felt that the proposal was well written but was conceptually weak, particularly in establishing its linkage with the goal of reversing the HIV/AIDS epidemic and focused more on strengthening health systems.
- The cost of 68 million USD for 30 districts though it has been reduced is still huge and the service delivery models are new to put to implementation.
- The demand generation is questionable since the proposal does not aim to work in high-risk districts. Additionally there is a lack of mapping of private sector engagement in the same districts.
- Ms. Vidhya Ganesh, UNICEF pointed out that the package of services has not been defined and without a proper mapping or identifying the service providers, it will be difficult to implement the program.
- The members suggested that the proposal needs direction and clear priority areas arriving at finer details through a consultation. It can be proposed Global Fund Round 9.

It was unanimously decided by the CCM members that the HSS proposal be dropped from this round but reiterated that work should be started soon to come up with a coherent and well articulated proposal for Round 9

The AS&DG NACO stated that NGOs should take the comments being provided in the right spirit and look at ways to strengthen the capacity of civil society. More consultations with NGOs are required and there should be an inclusion of more effective performing NGOs.

Dr. Broun mentioned that the theme areas for Round 9 should have elements of HSS for all three disease components. He appreciated that the HIV proposal has two PRs from the civil society organizations.

The total cost of the overall HIV proposal for Round 8 was 219 million.

It was decided that a sub-group be formed to review the proposals for the above recommendations. The sub-group members included Dr. Sai Subhasree Raghavan, SAATHI , Ms. Janet Hayman-USAID, Ms. Sabina Bindra Barnes- DFID and Dr. Denis Broun- UNAIDS.

Decision: The HIV/AIDS component of the proposal, barring the HSS proposal by CARE, was unanimously endorsed by the India CCM with MOLE, India HIV/AIDS Alliance and Emmanuel Hospital Association as the PRs for the Migrant Worker scheme, MSM and harm reduction.

Tuberculosis Component

Dr. Vineet Bhatia from the International Union Against Tuberculosis and Lung Disease (The Union) presented the TB proposal prepared and jointly prepared by two PRs – The Union and World Vision. A handout on the presentation was also given out to the members.

The project is titled 'Enhancing India's TB Care and Control efforts through Augmented Civil Society Participation'. The project intends to address gaps and complement the RNTCP Phase II (2006 - 2011) that is aligned with WHO Stop TB strategy. The overarching objective is to bring together and synergise civil society contribution to TB Care and Control

The gap areas that the project has identified and will address include: advocacy, communication and social mobilization, community system strengthening, community TB Care, involvement of all care providers not yet linked; private public mix (PPM), increase accessibility to ICTC services and TB-HIV care; address issues related to diagnosis and treatment of MDR-TB, and undertaking workplace intervention to raise concern about TB in their workplaces.

The Union led consortium known as India Coalition Against TB (ICAT), proposal would reach 630 million population in 350 districts in 22 States. The budget requested is of 69.2 million Euro with a contribution of 3.5 million organisational contributions. The World Vision led consortium known as The NGO Tuberculosis Consortium (NTC) proposes working with nine NGO Partners across 74 districts across Bihar, Orissa, Madhya Pradesh, West Bengal, Chhattisgarh, Jharkhand and Andhra Pradesh and reaching out to a population of 168.7 million. The budget requested is 13.02 million Euros, and an additional 152,000 Euros as cash match contribution.

The discussion highlights on the TB proposal included:

- There was a concern that the proposal covered a large geographical area and that it was ambitious considering that this was the first Civil Society proposal for the TB component as PR. It was clarified that the partners have been working with the programme in selected areas, and the proposal was an opportunity to come together and make a significant contribution.
- The legal status and registration of the ICAT entity was unknown. It was clarified that the PR was not NTC or ICAT but World Vision and International Union Against Tuberculosis and Lung Disease (The Union) respectively, who are registered entities and have the legal authority to receive Global Fund funding.
- A word of caution was pointed out by Dr. Broun to use the same terms for referring to the PRs, as used in the previous CCM meeting. This would avoid confusion.
- It was stated that proposal should project the magnitude of the scale-up, in terms of expected increase in detection and treatment of TB cases, since RNTCP is already reporting good achievements in case detection and treatment. It was clarified that although the programme has consistently shown results in line with the global targets still there are many districts which are unable to achieve the 70% NSP case detection rate and 85% cure rate. The interventions planned in this proposal will support the TB program to improve the performance in such districts and therefore make a significant improvement in the the national case detection and cure rates thereafter.
- A concern was raised whether the programme has a plan to establish and expand the laboratory network. It was clarified that the programme already has a plan to establish a network of 26 Intermediate Reference Laboratories (IRLs) utilizing the currently available technologies. The national plan also includes the strengthening of the four National Reference Laboratories (NRLs). The plan also includes the evaluation and demonstration of the newer diagnostics and their inclusion in the programme. As a first step in this direction, the programme has initiated the evaluation of newer rapid diagnostics including liquid culture and molecular tests, the results of which will be available in 6-9 months time. This proposal, if accepted by Global Fund, will serve to augment the capacity of IRLs through establishment of the rapid diagnostics in a phased manner.
- Regarding the molecular diagnostic technology, it was explained that these systems were currently being evaluated internationally, following the recommendation of the STOP –TB working group on Newer Diagnostics. India has also initiated evaluation and demonstration studies in 5 sites, results of which would be available by next year. Based on these results, lab strengthening would be taken up in a phased manner across the country, as proposed in the Civil Society proposal.
- The country programme has planned to initiate treatment of at least 5000 MDR TB patients annually by 2011 . Since enhancing the capacity of labs through the conventional and newer diagnostics will result in more patients being diagnosed and requiring treatment, additional requirement of drugs will be assessed periodically and procured accordingly to ensure that free treatment is made available to all MDR patients diagnosed in the programme.
- One of the concerns raised was collaboration of HIV and TB programmes and the mutual efforts made earlier to improve this process. It was stated that the HIV and TB

collaboration in India has already been established and is showing good results and both programmes are constantly working together to further strengthen this collaboration.

- The Chair stated that it is good to have an ambitious proposal and adequate avenues exist for efficiently utilising the grant amount to make a long lasting and significant impact on tuberculosis control in the country. He added that the civil society and NGOs must be encouraged to build their capacity to utilize funds for reaching out to the community and assisting the programme in its aim to control the disease.
- It was decided that the PRs would make a 10 percent reduction in the management costs of the proposal.

The AS&DG, NACO mentioned that the NGOs working in the three disease components are found to be the same groups. There should be an attempt to locate and encourage new and smaller organizations to participate in receiving GF funding. The Chair mentioned that organizations working on the disease component overlap will only strengthen their collaboration and partnership. There are several gains in the oversight area. It is important to chart out ways to engage more NGOs. The TB program already has schemes for NGO collaboration at the district levels and these schemes are being revised with the view of engaging NGOs in a wider field of activity.

Decision: The TB component of the proposal was unanimously endorsed by the India CCM with The Union and World Vision as the civil society PRs.

Malaria Component

Mr. Mahesh Srinivas, Consultant, SWASTI presented the proposal on Malaria, jointly proposed by National Vector Borne Disease Control Programme (NVBDCP) the Government PR and CARITAS the Civil Society PR. The proposal looked at, covering equity in participation and community involvement with a geographical coverage of 126 districts in 11 states in hard to reach areas addressing malaria control. The guiding principle followed for Round 8 were that the proposal: complements existing National efforts; ensures equity in service provision; promotes community involvement; and build partnership with civil society and private sector.

The key service delivery areas in the proposal include: scaling up access to early diagnosis through RDTs and improved laboratory microscopy; scaling up availability of effective anti-malarial treatment through ACT provision; referral and management of severe cases; provision of LLINs and reimpregnation of ITNs, behaviour change communication and community mobilization through ASHAs and CSOs; capacity building of personnel at village, PHC, district, state and national levels; strengthening monitoring and evaluation through improved supportive supervision; operational research for evidence based planning; and community-based planning and programme monitoring as a pilot in select villages.

The key outcomes include: increased availability of RDTs at village level, from existing 20,000 to 40,000 malaria high risk villages; More than 95% of *P. falciparum* cases treated with ACT; 30 million population protected with LLINs; 60,000 ASHAs trained in diagnosis and treatment

of malaria; at least 90% of the villages covered for BCC annually by 3rd year; improved capacities of communities for local production of bed-nets; and increased capacities of communities to manage malaria control efforts. The budget requested is US\$ 179,518,142.

The highlights of the discussion on the Malaria proposal are as follows:

- There was a concern on the agency that will purchase the long lasting nets and it was clarified that the agency would be the Government of India through UNOPS. The procurement will be conducted through the existing procurement mechanism.
- It was mentioned by Dr. Shukla that the nets are brought through the central government but only one company has been registered. The CIB has been in touch with the manufacturers and will get back to them after the initial scrutiny by 30th June 2008. Thereafter another scrutiny will be conducted in July 2008 and the manufacturer will be informed by end of July 2008 and by early August 2008 may be given permission for commercialization of LLINs for a period of two years. It was further clarified that the procurement process will only commence in April 2009 and there is no possibility for retroactive financing to commence preparatory groundwork. It was suggested that the grants should ideally additionally cover and allow for a preparatory stage before the implementation roll-out period.
- It was clarified that the responsibility of the private bednets lies with the civil society organization who is the PR. There is a component looking at local bednet production as a pilot project wherein SHGs are involved with the stitching of bednets. If the strategy is successful, it can be scaled up.
- There was a concern that the private sector is not involved in the implementation of the Malaria proposal. It was clarified by the representative from NVBDCP that the private sector will be involved in training through the Indian Medical Association.
- It was clarified that the proposal will cover forty percent of the population in the most high-risk group. All BPL population of the covered states will be covered by bednets by the third year of the project implementation.
- It was stated that the budget of the proposal covers and is included in the total budget (government and externally aided) combating malaria in India.
- One of the concerns looked at the disbursement of funds and the implementation track record of the Malaria proposal to be dismal in the Round 4 proposal. However, it was clarified by the NVBDCP that the current proposal attempts to implement the global strategy of providing bednets to every country in India in a huge upscaling mode. Therefore, the ability to spend will be much greater in this round.
- It was stated that the proposal should cover and address guidelines as recommended by the audit team and it was clarified that appropriate measures will be taken to mainstream the implementation of guidelines.
- It was stated that the proposal should include regular and frequent monitoring mechanisms covering technical and financial aspects of the program. Monitoring needs to be a very robust part of the project and as top priority.
- It was iterated that the funding from the World Bank is not an add-on financing but the heart of the Malaria control program. A discussion on the competition of funding sources is irrelevant.

- The Malaria control program is a single project with a common monitoring system wherein donors do the monitoring together.
- It was stated that the proposal should aim at increasing civil society participation. It was clarified that the government system will be complemented for early diagnosis and treatment by involving community level structures (SHGs and CBOs) for enhancing control and treatment and bringing CSOs and community to work together in a major way.

The members decided to endorse and ratify this Malaria proposal to the GFTAM.

Decision: The Malaria component of the proposal was unanimously endorsed by the India CCM with NVBDCP as the Government PR and CARITAS as the civil society PR.

At 5.15pm, the Chair requested the Vice-Chair to convene the meeting further since he had to leave the meeting.

Agenda Item No. 4

Discussion and Decision on the Regional Proposals for Endorsement

The meeting moved to discuss the two regional proposals. The presentations were followed by discussions.

The CARE Consortium's Regional Proposal

CARE made a presentation on the proposal on amplifying the regional response to reduce vulnerability of mobile populations to HIV and AIDS across the borders of Bangladesh, India, and Nepal. The proposal aims to reduce the vulnerability to HIV of mobile populations across the across borders of Bangladesh, India and Nepal and mitigate its impact on communities, with a focus on empowering women and protecting children. The proposal has been resubmitted from Round 7.

The focus of the proposal is on migrants from Bangladesh, Nepal (source) and India (Destination) and the project period is from April 2009 to March 2014. It is expected that the proposal will cover 1.12 million migrants and cross country mobile populations (men, women, children and youth). In Nepal, twenty districts will be covered, in Bangladesh, sixteen districts and in India, twenty one transit sites and six destinations. The total budget in euros is 40.82 million for five years.

CARE mentioned that the Nepal CCM might be soon receiving the endorsement of their proposal in Nepal. The Bangladesh CCM had already endorsed the regional proposal.

The AS&DG, NACO cautioned on the duplication of the proposal with NACO's efforts and urged that the proposal looks at the complementing aspects.

CARE emphasized that the proposal focuses on the male migrants from Bangladesh, Nepal and India and not the commercial sex workers from the same regions.

It was suggested that Assam also be covered in the proposal since there are large number of migrants from Bangladesh known to be residing in Assam.

Mr. Rajesh Kumar, Executive Director, SPYM mentioned that the apple farms in Himachal Pradesh and Jammu and Kashmir attract large number of migrant workers from Nepal especially during the harvest season. Hence, CARE could consider planning interventions in these states.

It was also mentioned that since Bangladeshi migrants are illegal, working with them would be challenging. CARE responded that they intend to intervene through NGOs.

Decision: The CCM members endorsed the CARE Consortium's proposal to GFTAM.

The SAARC TB and HIV/AIDS Centre, Kathmandu, Nepal Regional Proposal

The next presentation was on the regional proposal for supporting SAARC member countries that aims to implement the New Stop TB Strategy for effective programme implementation. The program elements include diagnosis of MDR-TB, TB/HIV collaboration, public private partnerships. STAC functions as a Regional Centre under the SAARC Secretariat.

The proposal covers strengthening laboratory infrastructure that has been recognized as a challenge by all SAARC countries and instating another supranational laboratory for the region, mentioned as a felt need and that has also recommended by Governing Board of STAC & WHO. The budget looks at procuring lab equipment and management assistance. The request for funding is USD \$205,445,247.

One of the concerns raised was about the absorptive capacity and management of funds within the SAARC mechanism since the number of personnel is minimal and the budget is minimal for the secretariat. DDG(TB) clarified that all activities would be handled by the country programmes, who are going to be the SRs. India, however, will not be accepting any funds as SR, since adequate budget has already been kept for these activities. However, all activities will be undertaken by the programme.

It was recommended that for the effective implementation, professionals should be hired, based on their technical qualifications, not on the system of nomination by member SAARC countries. As a concept, the idea of planning to make the STAC lab a Supranational Regional Laboratory, for the SAARC region, was appreciated.

Decision: The CCM members endorsed the SAARC TB, HIV/AIDS Centre proposal to GFTAM.

Since it was late, it was decided by the Vice-Chair that a meeting be held in early July 2008 to discuss the revised Terms of Reference and to review the progress of implementation of the Global Fund Programmes.

The meeting was concluded by the Vice-Chair.

ANNEXURE - I

List of CCM Members present in the meeting

1. Mr Naresh Dayal, Secretary, Health & Family Welfare, MoH&FW, Govt. of India, India-CCM Chair
2. Ms. K Sujatha Rao, AS & DG (NACO), MoH&FW, Govt. of India
3. Mr. R.K. Srivastava, Director General of Health Services, MoH&FW, Govt. of India
4. Mr Santosh Kumar on behalf of Mr Naved Masood, Additional Secretary & Financial Advisor, MoH&FW, Govt. of India
5. Mr. R.S. Shukla, Joint Secretary, MoH&FW, Govt. of India
6. Dr. Avinash Sharma of Haryana Health & Family Welfare on behalf of Ms. Navraj Sandhu, Secretary (Health & Family Welfare)
7. Dr. Denis Broun, Country Coordinator, UNAIDS
8. Dr Dinesh Agarwal, National Programme Officer (RH & HIV/AIDS), UNFPA on behalf of Dr. Marc Derveeuw, Representative, UNFPA
9. Dr. Vidya R. Ganesh, Chief HIV/AIDS Section, UNICEF on behalf of Mr. Cecilio Adorna
10. Dr. Salim J. Habayeb, WHO Representative to India, (WR India) WHO
11. Ms Janet Hayman on behalf of Mr Robert Clay, Director, USAID
12. Ms Sabina Bindra Barnes. Senior Health Advisor, DFID
13. Ms. Anne Bossuyt, Human Development Specialist, World Bank
14. Ms. Jhanbi Goswami on behalf of Mr K K Abraham, General Secretary, Indian Network of People Living with HIV/AIDS, India-CCM Vice Chair
15. Dr. Sai Subhasree Raghavan, President, Solidarity and Action Against the HIV Infection in India - SAATHI
16. A. Amalavalan on behalf of Dr. Ravi Raj William, Director, Christian Council for Rural Development and Research (CCOORR)
17. Ms. Malini B. Eden, Director Strategic Alliances - SEARCH on behalf of Mr F. Stephen, Executive Director
18. Dr. Rajesh Kumar, Executive Director, Society for Promotion of Youth & Masses on behalf of Dr. Zeenat N.

19. Dr Rajbir Singh, Medical Coordinator (North), German Leprosy & TB Relief Association on behalf of Dr Jayaraj Devadas, Director
20. Dr Kumudha Aruldas, Additional Director, Population Foundation of India
21. Ms. Kavita Chandokh, MPH, Country Director, International Training and Education Centre on HIV (I-Tech)
22. Dr L.P Singh, Dean, Indian Institute of Health Management Research (IIHMR)

List of Members not present in the meeting

1. Mr Madhusudan Prasad, Joint Secretary (FB), Ministry of Finance, Department of Economic Affairs, Govt. of India
2. Ms. Manjula Krishan, Secretary, Department of Women and Child Development, Govt. of India
3. Lt General Yogender Singh, Director General, Armed Forces Medical Services, Ministry of Defence, Govt. of India
4. Mr. Anshu Prakash, Secretary, Health & Family Welfare, Govt. of Arunachal Pradesh
5. Mr. P. Ramesh Kumar, Secretary, Health & Family Welfare, Govt. of Chattisgarh
6. Mr. Anand Prakash, Development Commissioner & Secretary, Govt. of Goa
7. Mr Madan Gopal, Principal Secretary, Health & Family Welfare, Govt. of Karnataka
8. Dr. P. R. Narayanan, Director, Tuberculosis Research Centre (TRC)
9. Dr K. R. Thankappan, Professor, Achutha Menon Centre for Health Science Studies (AMCHSS)
10. Dr. Madhumita Dobe, Secretary General, Indian Public Health Association
11. Prof. A.P. Dash, Director, National Institute of Medical Research (NIMR)

Permanent Invitees present in the meeting

1. Dr. L.S. Chauhan, DDG (TB), Central TB Division, MoH&FW, Govt. of India
2. Dr G.P. S. Dhillon, Director, Directorate of National Vector Borne Diseases Control Programme (NVBDCP, MoH&FW, Govt. of India)
3. Mr. Ramesh Chandra, Country Coordinator, UNOPS

Permanent Invitees not present in the meeting

1. Dr. Jotna Sohkey, Additional Project Director, NACO, MoH&FW, Govt. of India

2. Ms Maxine Olson, UN Resident Coordinator, UNDP

Special Invitees present in the meeting

1. Mr. Deepak Gupta, Additional Secretary, MoH&FW, Govt. of India
2. Alexander Matheou, Director (Programmes), India HIV/AIDS Alliance

Special Invitees not present in the meeting

1. Mr. S. Suresh Kumar, Director Finance, NACO, MoH&FW, Govt. of India

Additional Participants

1. Dr Sonal Singh, Joint Director, NVBDCP
2. Dr Prabha Arora, Dy Director. NVBDCP
3. Dr Mala Shrikanth, CTD Consultant
4. Dr. A. Gunasekar, NPO (Malaria & Vector Borne Diseases) WHO
5. Ms Kendra Phillips, Dy, Director, Population & Nutrition, USAID
6. Mr Raleigh Watts, Director (Country Programmes), I-TECH

Country Proposal Presentations made by:

1. **HIV/AIDS Component** by Mr Shiv Kumar, Consultant, SWASTI
2. **Tuberculosis Component** by Dr Vineet Bhatia, International Union Against Tuberculosis and Lung Disease (The Union)
3. **Malaria Component** by Mr Mahesh Srinivas, Consultant, SWASTI

Regional Proposal presentations made by representatives of:

1. CARE
2. CTD