Execution Version

Grant Confirmation

1. This **Grant Confirmation** is made and entered into by **the Global Fund to Fight AIDS, Tuberculosis and Malaria** (the "Global Fund") and **Solidarity and Action Against The HIV Infection in India** (the "Principal Recipient" or the "Grantee"), pursuant to the Framework Agreement, dated as of 21 July 2015, as amended and supplemented from time to time (the "Framework Agreement"), between the Global Fund and the Grantee, to implement the Program set forth herein. The Grant Confirmation is effective as of the earlier of the start date of the Implementation Period (as defined below) or the date of the Global Fund's signature below, and Program Activities shall not commence prior to the start date of the Implementation Period, unless otherwise agreed in writing by the Global Fund.

2. **Single Agreement**. This Grant Confirmation, together with the Integrated Grant Description attached hereto as Schedule I, sets forth the provisions (including, without limitation, policies, representations, covenants, Program Activities, Program budget, performance framework, and related implementation arrangements) applicable to the Program, and forms part of the Grant Agreement. Each capitalized term used but not defined in this Grant Confirmation shall have the meaning ascribed to such term in the Framework Agreement (including the Global Fund Grant Regulations (as amended from time to time), available at https://www.theglobalfund.org/media/5682/core_grant_regulations_en.pdf). In the event of any inconsistency between this Grant Confirmation and the Framework Agreement (including the Global Fund Grant Regulations (as amended from time to time)), the provisions of this Grant Confirmation shall govern unless expressly provided for otherwise in the Framework Agreement.

3. **Grant Information**. The Global Fund and the Grantee hereby confirm the following:

3.1	Host Country or Region:	Republic of India
3.2	Disease Component:	HIV/AIDS, Tuberculosis
3.3	Program Title:	Contribute to the national goals of ending AIDS by 2030, and TB elimination by 2025
3.4	Grant Name:	IND-C-SAATHII
3.5	GA Number:	3879
3.6	Grant Funds:	Up to the amount of USD 24,735,336 or its equivalent in other currencies
3.7	Implementation Period:	From 1 April 2024 to 31 March 2027 (inclusive)
3.8	Principal Recipient:	Solidarity and Action Against The HIV Infection in India

		1st Floor, C 1/3, Bhim Nagri Hauz Khas, Safdarjung Development Area 110016 New Delhi Republic of India Attention: Dr. Sai Subhasree Raghavan President Telephone: 911141007035 Email: subha@saathii.org
3.9	Fiscal Year:	1 April to 31 March
3.10	Local Fund Agent:	Price Waterhouse LLP Building 8, 8th Floor, Tower-B DLF Cyber City 122002 Gurgaon Republic of India Attention: Heman Sabharwal Team Leader Telephone: +911244620148 Facsimile: +91-124-462-0620 Email: heman.sabharwal@pwc.com
3.11	Global Fund contact:	The Global Fund to Fight AIDS, Tuberculosis and Malaria Global Health Campus, Chemin du Pommier 40 1218 Grand-Saconnex, Geneva, Switzerland Attention: Urban Weber Department Head Grant Management Division Telephone: +41-587911700 Facsimile: +41-445806820 Email: urban.weber@theglobalfund.org

4. **Policies**. The Grantee shall take all appropriate and necessary actions to comply with (1) the Global Fund Guidelines for Grant Budgeting (2023, as amended from time to time), (2) the Health Products Guide (2018, as amended from time to time), and (3) any other policies, procedures, regulations and guidelines, which the Global Fund may communicate in writing to the Grantee, from time to time.

5. **Covenants**. The Global Fund and the Grantee further agree that:

5.1 Personal Data

(1) Principles. The Principal Recipient, acknowledges that Program Activities are expected to respect the following principles and rights ("Data Protection Principles"):

(a) Information that could be used to identify a natural person ("Personal Data") will be: (i) processed lawfully, fairly and transparently; (ii) collected for specified, explicit and legitimate purposes and not further processed in a manner not compatible with

those purposes; (iii) adequate, relevant and limited to what is necessary for the purposes for which they are processed; (iv) accurate and, where necessary, kept up to date; (v) kept in a form which permits identification of the individuals for no longer than is necessary for the purposes for which the Personal Data is processed; and (vi) processed in a manner that ensures appropriate security of the Personal Data; and

(b) Natural persons are afforded, where relevant, the right to information about Personal Data that is processed; the right to access and rectify or erase Personal Data; the right to data portability; the right to confidentiality of electronic communications; and the right to object to processing.

(2) Limitations. Where collection and processing of Personal Data is required in order to implement Program Activities, whether by the Principal Recipient, a Sub-recipient, or Supplier, the Principal Recipient should respect the Data Protection Principles:

(a) to the extent that doing so does not violate or conflict with applicable law and/or policy; and

(b) subject to the Principal Recipient balancing the Data Protection Principles with other fundamental rights in accordance with the principle of proportionality, taking into account the risks to the rights and freedoms of natural persons.

5.2 With respect to Section 7.6 (Right of Access) of the Global Fund Grant Regulations (as amended from time to time), (1) the Global Fund may collect or seek to collect data, and it is possible that such data may contain Personal Data, and (2), prior to collection and at all times thereafter, the Principal Recipient shall take all necessary actions to ensure that the transfer of such information to the Global Fund does not violate any applicable law or regulation.

5.3 The Program budget may be funded in part by Grant Funds disbursed under a previous Grant Agreement, which the Global Fund has approved to be used for the Program under the current Grant Agreement ("Previously Disbursed Grant Funds"), as well as additional Grant Funds up to the amount set forth in Section 3.6. hereof. Accordingly, the Global Fund may reduce the amount of Grant Funds set forth in Section 3.6. hereof by the amount of any Previously Disbursed Grant Funds. Previously Disbursed Grant Funds shall be governed by the terms of this Grant Agreement.

5.4 External Auditor

1. Grant Funds may be used to pay for the services of an external auditor retained by the Global Fund for the annual independent audit of the Program (the "External Auditor") and the Global Fund may disburse such Grant Funds directly to the External Auditor;

2. The Principal Recipient consents, to the carrying out of audits of the Program by the External Auditor for the period covering fiscal years 2024-2025, 2025-2026 and 2026-2027 (and other such additional periods as the Global Fund may communicate to the Principal Recipient in writing), and to the terms of reference of the External Auditor and agrees that such terms of reference may be amended from time to time; and

3. Without limiting Section 7.5 of the Global Fund Grant Regulations (as amended from time to time), the Principal Recipient shall cooperate fully with the External Auditor to allow the External Auditor to perform its services, including by providing all information and documents requested by the External Auditor or the Global Fund.

5.5 The Global Fund and the Principal Recipient further agree that use of Grant Funds in Cost Input 13.2 of the Program Budget is conditional on the receipt of, by 30 September 2024: (a) written agreement by the National AIDS Control Organization ("NACO") and/or the Central TB Division ("CTD") for the activities listed in Cost Input 13.2; and (b) the submission and approval of a revised Performance Framework containing disbursement-linked indicators ("DLIs") or workplan tracking measures ("WPTM") for each of the activities listed in Cost Input 13.2. If the conditions in Section 5.5(a) and 5.5(b) are satisfied, any subsequent use of Grant Funds in Cost Input 13.2 must also satisfy the following additional requirements:

(1) The Grant Funds as set forth in Cost Input 13.2 include interventions under the payment for results modality ("PfR Modality"), and shall, unless otherwise decided by the Global Fund at its sole discretion, be made available to the Principal Recipient following receipt by the Global Fund of evidence confirming, to the Global Fund's satisfaction, that the results associated with DLIs or WPTMs described in the amended Performance Framework, have been achieved;

(2) Where funding relating to the PfR Modality is made available as an advance by the Global Fund, the Principal Recipient shall submit to the Global Fund's satisfaction, timely evidence confirming that the relevant DLI and/or WPTM has been achieved. Failure to meet this requirement will trigger the Global Fund's right to request for a refund pursuant to section 11.1 of the Global Fund Grant Regulations.

(3) Results reported and supporting evidence submitted by the Principal Recipient will be independently verified by the Local Fund Agent and/or other third party, as determined and/or designated by the Global Fund in its sole discretion;

(4) Unless otherwise notified by the Global Fund in writing: (a) financial reporting on expenditures for the PfR Modality interventions is not required; and (b) Grant Funds disbursed under the PfR modality shall be exclusively used for implementing community-based interventions for key populations listed in Schedule I hereto;

(5) Any amendments to the scope of eligible expenditures under the PfR Modality requires written agreement by the Global Fund; and

(6) In the event that the results reported by the Principal Recipient are deemed by the Global Fund at its sole discretion, to be unsatisfactory, the Global Fund may elect to apply any remedies established in the Global Fund Grant Regulations or may decide to disburse only a percentage of the achieved results.

(7) If the requirements in 5.5(a) and 5.5(b), above, are not satisfied by 30 September 2024, the Grant Funds in Cost Input 13.2 may be reprogrammed in accordance with the terms and conditions of this Grant Agreement.

[*Signature Page Follows.*]

IN WITNESS WHEREOF, the Global Fund and the Grantee have caused this Grant Confirmation to be executed and delivered by their respective duly authorized representatives on their respective date of signature below.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

By: _____

Name: Mark Eldon-Edington

Title: Head, Grant Management Division

Date: Mar 29, 2024

Solidarity and Action Against The HIV Infection in India

By: _____

Name: Sai Subhasree Raghavan

Title: President

Date: 21, MARCH, 2024

Acknowledged by

By: _____

Name: Apurva Chandra

Title: Chair, Country Coordinating Mechanism of Republic of India

Date:

By: _____

Name: Anandi Yuvaraj

Title: Civil Society Representative, Country Coordinating Mechanism of Republic of India

Date: 27/03/24

Schedule I
Integrated Grant Description

A. PROGRAM DESCRIPTION

HIV
1. Background and Rationale for the Program

As of 2021–2022, India has achieved 77%, 84%, and 85% of the UNAIDS 95-95-95 targets, with a significant coverage gap in PLHIV detection and linkage to treatment (300,000) and viral load testing of those on treatment (500,000). Despite significant progress made by the EVTHS program since its inception in 2001-2002, there are still critical coverage gaps, including a 19% shortfall in HIV testing and 29% in syphilis testing, and an 18% shortfall in the identification of HIV+ pregnant women and the initiation of treatment (Sankalak, 5th ed., 2023). In addition, prevention services do not reach a substantial proportion of hidden key populations or new at-risk populations.
To address these gaps, a concerted effort is needed to reduce new infections and improve early detection among invisible, hard-to-reach, and new population groups, including young people; close the gap between identification and treatment linkage; improve rates of viral suppression; and reduce stigma and discrimination. The proposed program aims to address the key challenges by breaking the silos and building synergies across the various components of the NACP and National Health Program. India's HIV proposal to the Global Fund aligns with the NACP Phase V and will serve as catalytic funding to address the identified gaps.

2. Goals, Strategies and Activities

The goal of the project is to contribute to the national goal of ending AIDS by 2030. The program will support NACO's expansion of its new model for a comprehensive continuum of care from prevention to treatment.

A. OBJECTIVE 1: Increase the proportion of people who know their HIV status (contributing to the first 95)

1. Ensure that 95% of the incarcerated population is screened for HIV, TB, STIs, syphilis, and viral hepatitis (VH) in prisons and other closed settings (P&OCS).
2. Ensure that 73% of other vulnerable populations in ten states and territories (spouses, family members, and partners of PLHIV) are aware of their HIV status.

B. OBJECTIVE 2: Increase the percentage of PLHIV initiated and maintaining ART (thereby contributing to the second and third 95 percentiles)

1. Ensure the rapid initiation and continuation of ART for all newly identified PLHIV, including inmates in P&OCS, pregnant women, and spouses and family members of index cases.
2. Ensure that all HIV-exposed infants (HEI) receive virological testing within two months.
3. Increase the proportion of LFU and MIS cases that are tracked back to more than 95%.

C. OBJECTIVE 3: Enhance the capacity of HIV service providers and augment the knowledge of the general public by:

1. Increasing HIV, tuberculosis, STI, and SRH awareness among semi-urban and rural populations through the Red Ribbon Bus campaign
2. Strengthen community systems to ensure meaningful participation of HIV-related community groups in design, implementation, and monitoring.
3. Improve the capacity of NACP service providers under the prevention component using the Kshamta Kendra institutional mechanism

STRATEGIC APPROACHES and PLANNED ACTIVITIES:

The overarching strategies of the project includes - (1) Oversight sight and collaborative partnerships; (2) Community engagement; (3) Capacity Building; and (4) Health systems strengthening.

Strategies:

A. P&OCS Intervention: (1) Peer led intervention; (2) Differentiated Health Service Delivery;

B. RRB Campaign: (1) Leveraging local resources (Mobile Medical Units, local influencers, community radio, youth volunteers from various organizations); and (2) Ensuring synergy with various government and community stakeholders, and other HIV interventions.

C. CSC 2.0: (1) Differentiated care for high-priority PLHIV sub-client groups; (2) Strengthening the system for providing sustainable care and support to PLHIV through rigorous planning and monitoring.

D. CSS: (1) Build community ownership of the program and strengthen the capacity of CBOs and Community Champions for advocacy, monitoring and implementation; (2) Strengthen and sustain an enabling environment through community-led monitoring, policy discussion, and advocacy.

Activities:

A. Contributing to the first 95: The Prison & OCS interventions and Red Ribbon Bus campaign will provide the following services - (1) Prevention Education; (2) Screening/Testing; (3) Harm reduction; (4) Mental health services; (5) Other health and non-health services; (6) Index testing.

B. Contributing to the 2nd & 3rd 95s: The CSC 2.0 intervention (CSC 2.0 and EVTHS) will provide the following services - (1) Early initiation of ART for all PLHIV clients; (2) Peer-based support and counselling; (3) Bringing LFU and MIS cases back to care; (4) Differentiated care; (5) Adherence monitoring; (6) Managing comorbidities; (7) Initiation and retention of PPW on ART; (8) Institutional delivery; (9) Link to family planning; (10) ARV, CPT prophylaxis for HEI; (11) EID at 2, 6, 12 and 18 months; (12) Link Syphilis positive women and exposed children to treatment.

C. Health and Community Systems Strengthening: Towards this the following activities will be implemented (1) Refresher training of Community Champions (CC); (2) Supporting CC in Community Led Monitoring (CLM); (3) Strengthening District Community Resource Groups (D-CRGs); (4) Formation and strengthening of State Level Networks (SLN) of Key Populations (KP) and PLHIV groups; (5) Strengthening of Kshamta Kendra (KK) for continued capacity building of prevention cadres; and (6) Linking key and affected population to social protection schemes and benefits

3. Target Group/Beneficiaries

A. Primary Target Group: (1) PLHIV: newly identified, on-ART, LFU, MIS; (2) HIV and Syphilis positive pregnant and lactating women, their spouses, and exposed infants; (3) Inmates of P&OCS, juvenile homes and de-addiction centers; (4) Spouses and partners of PLHIV; (5) Key and vulnerable Populations (MSM, TG, FSW, PWID, PWUD, Migrants, Truckers, and others; (6) Adolescents and young adults from semi-urban and rural areas

B. Secondary Target Group: (1) Representatives of Law Enforcement, Women and Child Welfare Department (WCD), Ministry of Home Affairs (MHA), Ministry of Social Justice; (2) Healthcare providers from public and private health facilities, professional medical associations, and the State Health Society (SHS); (3) Representatives of Maternal and Child Health and Reproductive health programs under the National Health Mission; (4) Members of KP and PLHIV state-level networks; (5) Technical experts and master trainers; (6) Staff of TI and Link Worker Schemes

TB

1. Background and Rationale for the Program

TB affects an estimated 356,000 children under 15 years in India annually, accounting for 12% of total incident cases in the country. However, only half of this number are notified to the National TB Elimination Program (NTEP), with the highest gap (~70%) in the under-five age group. The pediatric TB notification gap is largely due to missed diagnosis, especially under five, due to the clinical characteristics, lack of systematic screening among vulnerable children, health system challenges at sub-district level including insufficient provider awareness, inadequate skills for sample collection and limited diagnostic infrastructure. In the private sector, providers are heterogeneous, and children typically visit multiple providers before getting diagnosed, incurring out-of-pocket expenditure, prescription of unstandardized dosages, and insufficient coverage and engagement of member pediatricians from Indian Academy of Pediatrics (IAP).

Active Case Finding (ACF) strategy, implemented in one or more cycles in a year, is one of the key strategies for increasing TB case detection among key and vulnerable population (KVP}. Studies recommended the need for improving the TB case detection among asymptomatic individuals, reducing the losses between screening and testing among KVP in urban, rural, and tribal areas, and improving data quality.

To address these gaps and achieve the National Strategic Plan (NSP) targets, SAATHII and its Sub-Recipient (SR) partners, with the support from CTD and respective State TB Offices, will provide technical support in increasing the pediatric TB case detection in public and private health sector through a health system strengthening approach, and improve the early TB case detection among KVP through deploying the portable handheld X-ray devices.

2. Goals, Strategies and Activities

Goal: To reduce the morbidity and mortality due to TB and contribute to achieving NTEP's goal of TB elimination by 2025

Objectives: Increasing access and uptake of pediatric TB diagnostics and treatment services through integrated pediatric TB services across all levels of public and private health sector and increasing TB case detection through innovative active case finding using AI-enabled handheld X-ray device.

1. Increase the number of Pediatric TB case notification from 55114 (2022) to 87417 (2026-27) across 7 states

2. Increase the pediatric TB treatment success rate from 90% (2021) to 92.5% (2027) across 7 states
3. Increase the annual TB case notification in 42 districts of 6 states through deployment of portable handheld X-ray device as part of TB case finding activities

Geography: The project will be implemented in seven high TB prevalence and burden states of Chhattisgarh, Haryana, Karnataka, Punjab, Rajasthan, Telangana, and Uttar Pradesh, through six SR partners.

The overarching strategies of the project includes - (1) Health Systems Strengthening, (2) Collaboration with other technical partners and private health sector partnerships, (3) Community engagement.

A. Pediatric TB Component: The pediatric TB project will be implemented in 267 districts of the 7 states through three models: (a) Intensive interventions in 20 districts (2-5 per state), (b) District-level technical assistance in 64 districts, and (c) Technical assistance to the state NTEP for the rest 183 districts The project will be implemented consultatively, engaging all levels of the NTEP functionaries and other TB and child health implementation partners.

The project will ensure that all children with TB are identified early through comprehensive evaluation, initiated on treatment as per the national guidelines, and followed up until successful treatment completion. The following are the key strategies and activities:

1. Increase the screening of vulnerable children and referrals of Pediatric Presumptive TB from entry points of Community, Primary Health Care and Child Health Programs
   a) Sensitization of child health program stakeholders through consultations
   b) District and block level Training of Trainers (ToT)
   c) Sensitization of Frontline workers
   d) Ensuring the screening of children in the community and primary health facilities and referrals to higher facilities for case evaluation and diagnosis
2. Enhance the provision of Comprehensive Pediatric TB Services at sub-district public hubs and private hubs across the district
   a) State level ToT
   b) Establishing public hubs in sub-district facilities (CHCs, SDH and DH) through provision of consumables and equipment and CXR/FNAC partnerships
   c) Establishing private hubs in each district
   d) Training and mentorship of health care providers from hub sites
   e) Strengthening sample collection and transportation
3. Increase the engagement of Tertiary Level Health Facilities in the district to improve the quality of pediatric TB care in the district, and improve the Extra-Pulmonary TB diagnosis and care
4. Engage the IAP and 13000+ member pediatricians to Increase private notification through
   a) Developing and designing partnership models
   b) Designating nodal persons by IAP from states and districts and engage them for progress reviews

c) Leveraging PPSA and STSU support for saturation of coverage of private pediatricians
d) Engaging informal and local practitioners who treat children

5. Engage Communities and TB Champions to Promote Community-led Advocacy for Efforts towards TB Elimination through trainings, and community mobilization activities
6. Increase Treatment Success and Patient Support through leveraging the follow-up of public sector pediatric TB families by NTEP, and private sector by PPSA

The project will increase in the number of pediatric TB case notification from 55114 (2022) to 87417 (2026-27) across 7 states and increase the pediatric TB treatment success rate from 90% (2021) to 92.5% (2027) across 7 states.

B. Active Case Finding (ACF) Component:

The project will undertake ACF activities in six out of the seven pediatric TB implementation states, except Uttar Pradesh. The project will strengthen the implementation of national ACF strategy by deploying the AI-enabled hand-held X-ray devices in selected 42 districts for systematic screening of key vulnerable populations during the community based active case finding and generate evidence on early identification of Presumptive TB and TB cases. The handheld AI-enabled X-ray devices will be available from second half of Year 1. The following are the key strategies and activities:

1. Development of Operational Guidelines using handheld X-ray device
2. Providing technical assistance to NTEP in the mapping of KVP and validation of mapping and secondary data, and development of micro-plans
3. Implementation of the ACF activities utilizing the hand-held Xray machine
4. Ensuring sputum sample collection and referrals of presumptive TB (pediatric, EP-TB and those in medical need) to health facilities:
5. Strengthening sample transportation and follow-up of test results
6. Engaging expert radiologists for X-ray interpretation when X-ray results are abnormal, but NAAT results are negative
7. Monitoring and strengthening ACF documentation, data availability and reporting

The project will increase the annual TB case notification to 3496 in Year 3 (2026-27) across 42 districts of 6 states.

3. Target Group/Beneficiaries

Primary Target Group: (1) **Children under 15 years of age and their caregivers** accessing health services in the community, public and private sector health facilities. Targeted approach with most at-risk for TB namely children under-five, malnourished children, and child contacts of TB patients. (2) **Key affected and vulnerable population in the general community**. The focus will be in geographies with high TB burden, and those who are clinically, socially, and occupationally vulnerable and marginalized populations.

Secondary Target Group: (1) **Health System and Health Care Providers**: a. Public health sector: All levels of health facilities - primary, secondary and tertiary, including Nutrition Rehabilitation Centres (NRCs) and the Pediatric Centre of Excellence (PCoEs), b. Community and frontline workers, school and adolescent health program staff, and community volunteers, c. Private health sector: All pediatric private health facilities and care providers, IAP and its members, pathology and radiology services, and informal practitioners, d. Child health program implementers under Departments of Health (Nutrition Rehabilitation Centres, Rashtriya Bala Swasthya Karyakram, Rashtriya Kishore Swasthya Karyakram) and Women and Child Welfare Department (WCD), key departments of Tribal Welfare, Panchayat and Rural Development, Urban Development. (2) **TB Champions** (adult and pediatric) and their families for community mobilization and engagement

B. PERFORMANCE FRAMEWORK

Please see attached.

C. SUMMARY BUDGET

Please see attached.

THE GLOBAL FUND

Performance Framework

Country	India
Grant Name	IND-C-SAATHII
Implementation Period	01-Apr-2024 - 31-Mar-2027
Principal Recipient	Solidarity and Action Against The HIV Infection in India

Reporting Periods	Start Date	01-Apr-2024	01-Oct-2024	01-Apr-2025	01-Oct-2025	01-Apr-2026	01-Oct-2026
	End Date	30-Sep-2024	31-Mar-2025	30-Sep-2025	31-Mar-2026	30-Sep-2026	31-Mar-2027
	PU includes DR?	No	Yes	No	Yes	No	No

Program Goals, Impact Indicators and targets

1	The goal of the project is to contribute to the national goal of ending AIDS by 2030. The program will support NACO's expansion of its new model for a comprehensive continuum of care from prevention to treatment.
2	To reduce morbidity and mortality due to TB and contribute to achieving National TB Program's goal of elimination by 2025

	Impact Indicator	Country	Baseline Value	Baseline Year and Source	Required Dissagregation	2024	2025	2026
1	HIV I-4 Number of AIDS-related deaths per 100,000 population	India	N: 2.8900 D: P: %	2022 Global AIDS Monitoirng, 2022	Gender,Age,Gender | Age	N: D: P: % TBD Due Date:	N: D: P: % TBD Due Date:	N: D: P: % TBD Due Date:
	Comments							
	Baseline # N - 39624 Baseline # D - 1371733204 Value - 2.89 The indicator will be reported on annual basis. Source: Information as provided by NACO. The indicator will be reported on annual basis. Targets will be set as made available by the NACO and updated with the first reprogramming. This data will be reported by NACO							
2	HIV I-14 Number of new HIV infections per 1000 uninfected population	India	N: 0.0500 D: P: %	2022 Global AIDS Monitoirng, 2022	Gender,Gender | Age,Age	N: D: P: % TBD Due Date:	N: D: P: % TBD Due Date:	N: D: P: % TBD Due Date:
	Comments							
	Baseline # N - 66408 Baseline # D - 1369266204 Value - 0.05 The indicator will be reported on annual basis. Source: Information as provided by NACO. Targets will be set as made available by the NACO and updated with the first reprogramming. This data will be reported by NACO							
3	HIV I-6 Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	India	N: D: P: 19.91%	2022 Global AIDS Monitoirng, 2022		N: D: P: % TBD Due Date:	N: D: P: % TBD Due Date:	N: D: P: % TBD Due Date:
	Comments							
	Baseline # N - 4128 Baseline # D - 20735 Percentage (%) - 19.91 The indicator will be reported on annual basis. Source: Information as provided by NACO. Targets will be set as made available by the NACO and updated with the first reprogramming. This data will be reported by NACO							
4	TB I-2 TB incidence rate per 100,000 population	India	N: 196.0000 D: P: %	2022 Annual TB Report 2023 -India; in-country model		N: 180.6100 D: P: % Due Date: 30-Sep-2025	N: 162.5500 D: P: % Due Date: 30-Sep-2026	N: 138.0000 D: P: % Due Date: 30-Sep-2027
	Comments							
	Baseline incidence rate of 196 per 100,000 population in 2022 as reported in Annual India TB Report 2023, in-country model. Incidence will reduce to 180, 162 and 138 over 3 years 2024, 2025 and 2026, annual reporting Source: Information as provided by CTD							

5	TB I-3 TB mortality rate per 100,000 population	India	N: 23.0000 D: P: %	2022 Annual TB Report 2023 -India; in-country model		N: 22.0000 D: P: % Due Date: 30-Sep-2025	N: 21.0000 D: P: % Due Date: 30-Sep-2026	N: 20.0000 D: P: % Due Date: 30-Sep-2027
	Comments							
	Baseline mortality rate of 23 per 100,000 population in 2022 as reported in Annual India TB Report 2023, in-country model. This will be reduced to 22, 21 and 20 over 3 years 2024, 2025 and 2026, annual reporting Source: Information as provided by CTD							
6	TB I-4 RR-TB and/or MDR-TB prevalence among new TB patients: Proportion of new TB patients with RR-TB and/or MDR-TB	India	N: D: P: 2.50%	2021 Global TB Report 2022		N: D: P: 2.29% Due Date: 30-Sep-2025	N: D: P: 2.19% Due Date: 30-Sep-2026	N: D: P: 2.08% Due Date: 30-Sep-2027
	Comments							
	Baseline proportion of new TB patients with RR-TB/MDR-TB is 2.5 in 2021, as per Global TB report 2022 and assumed to remain same till 2023, and this will reduce to 2.08 by 2026, annual reporting Source: Information as provided by CTD							

Program Objectives, Outcome Indicators and targets

1	Increase the proportion of prison inmates and those at OCS who know their HIV status from 56% to 100% in 10 states/UTs
2	Increase the proportion of other vulnerable populations (spouses and family members, and partners of PLHIV) who know their HIV status from 43% to 73% in 10 states/UTs
3	Increase the proportion of HIV-exposed infants who received the virological test within 6 months of birth from 92% to 100% in 10 states/Uts
4	Increase the proportion of PLHIV LFU to ART Center tracked back with definite outcome from 50% to 98% in 10 states/UTs
5	Increase the proportion of PLHIV due for VL test that have been tested for VL from 60% to 95%
6	Increase the pediatric TB case notification in nine states from 59219 (2022) to 74170 (2026-27)
7	Increase the pediatric TB treatment success rate in nine states from 90% (2021) to 92% (2026-27)
8	Increase the annual TB case notification by 4564 in 60 districts of 8 states through deployment of portable handheld X-ray device as part of TB case finding activities
9	Increase the annual TB case notification among the prisoners from 18 to 142 in 10 states and UTs by March 2027

	Outcome Indicator	Country	Baseline Value	Baseline Year and Source	Required Dissagregation	2024	2025	2026
1	HIV O-11 Percentage of people living with HIV who know their HIV status at the end of the reporting period	India	N: 1948635.0000 D: 2467000 P: 78.99%	2023 Sankalak Fifth Edition, 2023 Pg # 153	Gender | Age,Age	N: D: P: 91.00% Due Date: 30-Mar-2025	N: D: P: 95.00% Due Date: 30-Mar-2026	N: D: P: 95.00% Due Date: 30-Mar-2027
	Comments							
	Baseline # N - 1948635 Baseline # D - 2467000 Value - 79% Periodicity: The indicator will be reported on annual basis. Target Assumption: The targets defined for these indicators are as per NACP V strategy document Pg#42. Numerator: Number of PLHIV who know their HIV Status (Post Test Counselling) Denominator: Estimated number of PLHIV Source: Information as provided by NACO. Targets will be set as made available by the NACO and updated in the first year. This data will be reported by NACO							
2	HIV O-12 Percentage of people living with HIV and on ART who are virologically suppressed	India	N: 1009262.0000 D: 1084218 P: 93.09%	2023 Sankalak Fifth Edition, 2023 Pg # 153	Gender | Age,Age	N: D: P: 93.00% Due Date: 30-Mar-2025	N: D: P: 94.00% Due Date: 30-Mar-2026	N: D: P: 95.00% Due Date: 30-Mar-2027
	Comments							
	Baseline # N - 1009262 Baseline # D - 1084218 Value - 93% Periodicity: The indicator will be reported on annual basis. Target Assumption: The targets defined for these indicators are as per targets for DLIs (mentioned in coverage indicators) for Payment for results grant. Numerator: Number of PLHIV on ART who are virally suppressed. Denominator: Number of PLHIV on ART who are tested for viral load. Source: Information as provided by NACO. Targets will be set as made available by the NACO and updated in the first year. This data will be reported by NACO							

3	TB O-5 TB treatment coverage: Percentage of patients with new and relapse TB that were notified and treated among the estimated number of incident TB in the same year (all forms of TB - bacteriologically confirmed plus clinically diagnosed	India	N: D: P: 79.00%	2022 Program data and in-country projections	Gender,Age	N: D: P: 90.00% Due Date: 30-Mar-2025	N: D: P: 92.00% Due Date: 30-Mar-2026	N: D: P: 94.00% Due Date: 30-Mar-2027
	Comments							
	Baseline: 79%, Treatment coverage of 90%, 92% and 94% during 2024,2025 and 2026 respectively Source: Information as provided by CTD. This will be reported by CTD							
4	TB O-2a Treatment success rate of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapse	India	N: D: P: 85.50%	2022 Annual TB Report 2023 - India		N: D: P: 87.00% Due Date: 30-Mar-2025	N: D: P: 88.00% Due Date: 30-Mar-2026	N: D: P: 90.00% Due Date: 30-Mar-2027
	Comments							
	@ equity lined to treatment succes rate among children.coverage indicator. Baseline: 85.5%, Treatment success rate of 87%,88% and 90% during 2024,2025 and 2026 respectively Source: Information as provided by CTD. This will be reported by CTD							
5	TB O-4 Treatment success rate of RR-TB and/or MDR-TB: Percentage of patients with RR and/or MDR-TB successfully treated	India	N: D: P: 68.00%	2022 Annual TB Report 2023 - India		N: D: P: 70.00% Due Date: 30-Mar-2025	N: D: P: 72.00% Due Date: 30-Mar-2026	N: D: P: 75.00% Due Date: 30-Mar-2027
	Comments							
	Baseline: 68%, Treatment success rate among RR/MDR-TB - 70%, 72% and 75% during 2024,2025 and 2026 respectively Source: Information as provided by CTD. This will be reported by CTD							

Coverage indicators and targets

CI Number	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Cumulation Type	Reverse Indicator	01-Apr-2024 30-Sep-2024	01-Oct-2024 31-Mar-2025	01-Apr-2025 30-Sep-2025	01-Oct-2025 31-Mar-2026	01-Apr-2026 30-Sep-2026	01-Oct-2026 31-Mar-2027
Differentiated HIV Testing Services														
1	HTS-3f Number of people in prisons and other closed settings that have received an HIV test during the reporting period and know their results	Country: India; Coverage: Geographic Subnational, less than 100% national program target	N: 301644 D: P: %	2023 PSI 2021 and Sankalak Fifth Edition, 2023 Pg # 81&153	Gender	Yes	Non cumulative	No	N: 215518 D: P: %	N: 215518 D: P: %	N: 242458 D: P: %	N: 242458 D: P: %	N: 269398 D: P: %	N: 269398 D: P: %
	Comments													
	Target assumptions : The indicator will be reported as number. The overall targets for the number of inmates who received an HIV test are projected at 80% in Year 1, 90% in Year 2, and 100% in Year 3. The targets were projected based on current coverage and facilities. The current intervention progress as per Sankalak 5th edition shows 56% of HIV testing among incarcerated population for proposed 10 intervention states and the continued efforts resulted for this progress will be used to achieve the 100% and above by the end of the project period in 2027. Target Population: Current facilities: Subhiksha+ aims to cover 659 incarceration facilities, including 455 prisons and 204 other closed settings, housing a total annual turnover of 5,38,795 inmates in 10 states. There are 68 prison-based HIV testing centers, including 17 SA-ICTCs and 51 F-ICTCs, in these 10 states. However, 591 facilities do not have any such facilities. Definitions: Numerator: The number of inmates in prison and closed settings (from 10 states with interventions in place) who were tested for HIV and reported in SANKALAK 5th Edition, 2023 Baseline: The baseline calculation is based on SANKALAK 5th Edition, 2023. The baseline population for estimating inmates is 5,38,794 and the number of inmates tested for HIV is 301644. Proposed strategies for achieving the projected targets include but are not limited to: i) Establishing FICTCs in facilities with more than 500 inmates. ii) Extending service coverage by SA-ICTCs located within facilities on regular basis. iii) Organizing more screening camps within the facilities in coordination with the nearest SA-ICTCs. iv) Advocacy for fulfilling the vacant position of medical and paramedical staff inside the prison. Data Source- Project MIS													
3	HTS-3e Percentage of other vulnerable populations that have received an HIV test during the reporting period and know their results	Country: India; Coverage: Geographic Subnational, less than 100% national program target	N: 37333 D: 63674 P: 58.63%	2023 SANKALAK 2022-23		Yes	Non cumulative	No	N: 9551 D: 15919 P: 60.00%	N: 9551 D: 15919 P: 60.00%	N: 11143 D: 15919 P: 70.00%	N: 8319 D: 11885 P: 70.00%	N: 8605 D: 10757 P: 79.99%	N: 1590 D: 1988 P: 79.98%
	Comments													

THE GLOBAL FUND

Coverage indicators and targets

CI Number	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Cumulation Type	Reverse Indicator	01-Apr-2024 30-Sep-2024	01-Oct-2024 31-Mar-2025	01-Apr-2025 30-Sep-2025	01-Oct-2025 31-Mar-2026	01-Apr-2026 30-Sep-2026	01-Oct-2026 31-Mar-2027
3	Target Assumptions: The target calculation for achieving the set goals follows the CSC 2.0 transition model recommended by NACO. Denominators are determined based on the calculation of CSC transition per state in each PU and year. The baseline, derived from SANKALAK 222-23 data, was 459%, and the aim is to reach 80% by the end of the program period in 2027 with 10% increase in each year as per the national programme progress trend. Target Population: Spouses and Sexual Partners of PLHIV Definitions: Denominator -Number of found HIV positives during the reporting period with minimum 1 sexual partner or injecting partner. "The number of individuals testing positive for HIV during the specified reporting period will have had at least one sexual partner or injecting partner." First PU result for this indicator will be combined effort of NGPRs (Data of Q-1 will be shared among NGPRs of their respective components and geographies). Numerator - Number of spouses and sexual partners screened for HIV during the reporting period Monitoring will be against the percentage (actual denominator and actual numerator) Baseline (2022-23) - The baseline denominator and numerator has been taken from Sankalak 2022-23. 59% is the baseline numerator of this indicator. To reach these targets, several strategies will be implemented, including: a) Determining the HIV status of spouses and partners of people living with HIV (PLHIV). b) Establishing a system to track and monitor the testing status of spouses and partners. c) Conducting home visits to educate clients about the importance of spouse/partner testing and providing assistance in scheduling tests for those who may be hesitant. d) Educating couples where one partner is HIV-positive and the other is HIV-negative (discordant couples) about the benefits of disclosure. Source: Sankalak 2022-23 report/Project MIS													
Elimination of vertical transmission of HIV, syphilis and hepatitis B														
2	VT Other-1-Percentage of HIV-exposed infants tested for HIV at 6 months of birth	Country: India; Coverage: Geographic Subnational, less than 100% national program target	N: 4598 D: 4996 P: 92.03%	2023 BSD MPR/SOCH		No	Non cumulative	No	N: D: P: 92.00%	N: D: P: 92.00%	N: D: P: 95.00%	N: D: P: 95.00%	N: D: P: 100.00%	N: D: P: 100.00%
	Comments													
	Target Assumptions: As India has reached the target for tesitng at 2 months, a custom indicator has been proposed to monitor testing at 6month in line with the country policy. The target calculation for achieving the set goals follows the CSC 2.0 transition model recommended by NACO. Denominators are determined based on the calculation of CSC transition per state in each PU and year. Current achievement is 92% in SAATHII-allocated states. The target for all SAATHII states in Y1 is projected at 92%, 95% in Y2, and 100% in Year Y3. First PU result for this indicator will be combined effort of NGPRs (Data of Q-1 will be shared among NGPRs of their respective components and geographies). Target Population: Babies, who are alive at the age of 6 months. EID at 2 months will be reported as a dissagregated indicator in the comments each PU period. Numerator: No. of HEI tested at 6 months of birth under EID cascade during the reporting Period. Source: BSD MPR/SOCH/PMTCT Program Data Denominator: No. of HEI eligible for 6-months testing under EID cascade during the reporting Period Source: BSD MPR/SOCH/PMTCT Program Strategies that will be used for reaching the set targets will include: a) Strengthen coordination at the ART centre and ensure 100% of positive pregnant women list sharing b) Meticulous outreach strategies and plan for timely EID testing c) Weekly due list generation and intensive follow-up of the eligible mother-baby pairs d) Close coordination with ART / SAICTC to ensure uninterrupted supply of consumables and DBS cards e) Strengthen the coordination with SRL /NRL for timely testing and result-sharing f) Coordination with ART / ICTC counsellors for an appointment-based method for bringing the eligible mother-baby pairs to EID testing. g) Goal of 95-95-95 - In line with the national agenda including achieving EVTHS goals													
Treatment, care and support														
4	TCS Other-1 Percentage of PLHIV on ART who are Lost to follow up (LFU) tracked with definite outcome	Country: India; Coverage: Geographic Subnational, less than 100% national program target	N: 1699 D: 3388 P: 50.15%	2023 SOCH		No	Non cumulative – other	Yes	N: D: P: 70.00%	N: D: P: 70.00%	N: D: P: 85.00%	N: D: P: 85.00%	N: D: P: 98.00%	N: D: P: 98.00%
	Comments													
	Target Assumptions:The target to achieve 98% tracking of LFU cases with definite outcomes by March 2027 has been set based on the current performance and the gradually transition of the CSC from quarter 7. The target calculation for achieving the set goals follows the CSC 2.0 transition model recommended by NACO. Denominators are determined based on the calculation of CSC transition per state in each PU and year. First PU result for this indicator will be combined effort of NGPRs (Data of Q-1 will be shared among NGPRs of their respective components and geographies). Target Population: People Living with HIV (PLHIV) who have been lost to follow-up (LFU) to the ART Denominator: The Number of LFU cases reported in ART MPR/SOCH from two preceding years. Definitions -On ART lost to follow up (LFU): PLHIV on ART with no clinical contact or ARV pick-up for 90 days or more since last due date (missed appointment). Opted out: If a PLHIV is contacted through outreach (home visit) and expresses his/her unwillingness to continue ART services under national program (after adequate ounselling) and provides in writing about the same, outcome of the visit will be reported as 'opted out' in the tracker sheet. Once such information is received from outreach staff by ART centre, counsellor and medical officer will reach the patient through phone call and try to counsel to continue ART services. If not reachable, another visit through project coordinator/peer counsellor of CSC should be attempted. Such patients would be labelled as "Opted Out" in white card and IMS/MLL, at least after 3 documented attempts by CSC/ART centre to retrieve patient back and resolve the reason for not continuing ART services under national programme. Patients taking treatment from private or taking alternate medicines shall also be considered as "Opted Out" Stopped treatment: PLHIV on ART whose treatment is stopped on medical advice (in discussion with the clinical team). The reasons for stopping treatment should be documented in white card. Died: If death of a patient is confirmed by family members/relatives/loca authorities during outreach and valid documentation such as death certificate (or any other document, which can prove the death) is provided then upon submission of the same, it could be updated in white card/MLL/IMS as "death" by the data manager of ART centre. In case death certificate or a valid documentation is not available, documentation can be obtained by outreach workers/CSC staff in writing either from the village headman or close family members who are ready to give their contact details for verification by ART centre. If outreach is not possible and family member/relative, declare death over phone, medical officer of the ART centre shall take details of the same over phone and document on white card (e.g. date of death, probable reason of death). Transferred out: Transferred out refers to a situation when a patient seeks transfer from one ART centre under the national program to another. However, PLHIV will be labelled as 'transferred out' only when patient reaches recipient ART centre and transfer has been accepted in IMS by recipient ART. After confirmation of transfer by recipient ART centre, the parent ART centre will change status in their MLL/IMS as "transferred out" and the receiving ART centre will label this patient as "transferred in." Numerator: The total number of PLHIV in the target population or area for whom tracking and determining their definite outcome is being performed. The numerator represents the specific subset of PLHIV who are lost to follow up and have missed their appointments. *Definite Outcomes are - Definite outcomes will include opted out, stop treatment, death, transfer out, clients taking ART from Private sector, taking ART at other NACO ART centre , taking alternate medicine and brought back to ART center. Long untraceable (Incorrect / Incomplete address) should not be considered while measuring the achievement against PF. Monitoring will be against the percentage (actual denominator and actual numerator). Data Source: Project MIS													
5	TCS-8 Percentage of people living with HIV and on ART with viral load test result	Country: India; Coverage: Geographic Subnational, less than 100% national program target	N: 441673 D: 732255 P: 60.32%	2023 SOCH	Gender | Age,Age	Yes	Non cumulative – other	No	N: D: P: 75.00%	N: D: P: 75.00%	N: D: P: 85.00%	N: D: P: 85.00%	N: D: P: 95.00%	N: D: P: 95.00%
	Comments													

THE GLOBAL FUND

Coverage indicators and targets

CI Number	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Cumulation Type	Reverse Indicator	01-Apr-2024 30-Sep-2024	01-Oct-2024 31-Mar-2025	01-Apr-2025 30-Sep-2025	01-Oct-2025 31-Mar-2026	01-Apr-2026 30-Sep-2026	01-Oct-2026 31-Mar-2027
5	Target Assumptions :The target calculation for achieving the set goals follows the CSC 2.0 transition model recommended by NACO. Denominators are determined based on the calculation of CSC transition per state in each PU and year. Current achievement is 60% in SAATHII-allocated states. The target for all SAATHII states in Y1 is projected at 75%, 85% in Y2, and 95% in Y3. Timely pick up of VL samples and delivery of VL test reports. First PU result for this indicator will be combined effort of NGPRs (Data of Q-1 will be shared among NGPRs of their respective components and geographies). Target Population: People Living with HIV (PLHIV) who are due for Viral Load testing. Denominator:Number of people on ART at the end of the reporting period. Source: SOCH Numerator: Number of people living with HIV on ART with at least one routine viral load test result during the reporting period. Source: SOCH The PR will provde the data for numerator and denomnator and percentage at the time of reporting As a disaggregation - the data will be reported for 1. Percentage of PPW at 32-36 weeks of pregnacy that have had a VL, 2. Number of PLHIV newly initiated on 3rd line ART eligible for VL test during reporting should be reported during PU/DR. Monitoring will be against the percentage (actual denominator and actual numerator) Strategies that will be used for reaching the set targets will include: a) Establish a robust monitoring system to track the percentage of PLHIV due for VL testing and their testing status. b) Meticulous outreach strategies and plan to prioritize outreach for timely VL testing. c) Increase awareness among the community on the importance of adherence and VL testing. d) Adherence monitoring through counselling and facilitating viral load testing (and ensured) between 32 and 36 weeks of pregnancy. e) Include discussions on the importance of adherence and VL testing in every SGM f) Analysis of TAT for VL test reports and sharing with SACS and NACO for appropriate actions. g) Align the date for sample collection of VL test with the date of ARV pickup for the monthly due cases. h) Training of CLH on communication messages for stress on adherence and VL testing. i) Immediate dissemination of any change in the VL algorithm to the facility level staff. In order to determine the ARV prophylaxis for the baby, plasma viral load testing will be facilitated (and ensured) to all HIV-positive pregnant women between 32 and 36 weeks of pregnancy. Data Source- SOCH / IIMS and Project MIS.													
6	TBDT Other-1 Number of pediatric patients with all forms of TB notified (i.e., bacteriologically confirmed + clinically diagnosed); *includes only those with new and relapse TB.	Country: India; Coverage: Geographic Subnational, less than 100% national program target	N: 55114 D: P: %	2022 India TB Report 2023		Yes	Non cumulative	No	N: 31449 D: P: %	N: 33307 D: P: %	N: 36448 D: P: %	N: 39412 D: P: %	N: 43709 D: P: %	N: 43709 D: P: %
	Comments													
	Baseline: At baseline, the total number of TB cases notified in 2022 is 55114 pediatric TB cases from all 267 districts of 7 states (Source: India TB Report 2023), and it is estimated that in Year 2023, the pediatric TB notification will be 61040. Indicator: The numerator for the target indicator is the total number of pediatric TB cases notified from all districts of seven states, Reference data source: The reference data source is Nikshay,as reported in India TB Report 2023. There is no denominator for this indicator Target:The targets is calculated as pediatric TB cases notified from all 267 districts of seven states. For target calculations, the pediatric TB estimated notification of 61040 is considered as baseline.The reference source for target reporting will be Nikshay. The TB targets include pediatric TB case detection (64755 in 2024-25, 75860 in 2025-26 and 87417 in 2026-27) in public and private health sector from all 267 districts of seven states. The targets are differentiated based on the baseline pediatric TB coverage in a state. The states of Chhattisgarh, Haryana, Karnataka,Punjab and Rajasthan with baseline pediatric TB between 4-6% coverage is targeted with 20% annual increase, while Uttar Pradesh with above 6% has target of 10% annual increase, and state of Telangana with <4% has target of 30% annual increase. Strategy: I. For pediatric TB, at baseline (2022), 55114 (5.43%) pediatric TB cases were notified out of a total 1015238 TB notifications in seven states. The project will increase the pediatric TB notification in seven states to 87417 in 2026-27 through three models - first model is direct implementation with intensive intervention in two-four districts per state with 3 dedicated staff per district (total of 20 districts), second is district level technical support to district NTEP with one dedicated staff in each distrcit covering 64 districts, and third model covering the rest of 183 districts of 7 states without any field/district staff. The three models implementation will be done through technical support to state and district NTEP units, in collaboration with WHO Technical Unit, and State Technical Support Units (TSU) in 3 states of Karnataka, Rajasthan and Uttar Pradesh, and mini-TSU in Telangana. The key strategies are to integrate pediatric TB with all levels of public and private health sector and strengthen health systems through establishing sample collection hubs in secondary level public facilities, sensitise the frontline workers at primary care level so as to identify and refer Presumptive pediatric TB to secondary and tertiary facilities, engage medical colleges for EP-TB and advanced case management at tertiary levels, and saturation of the private sector pediattricians through engagement of Patient Provider Support Agency (PPSAs), and collaboration with Indian Academy of Pediatrics (IAP). Altogether, 84 out of 267 districts in 7 states are covered through district based staff in the first two models, while the rest of183 districts dont have district based field staff. Hence, the implementation in 183 districts (third model) is planned in phased manner, where in one third (61) of 183 districts in third model will be covered in Year-1, and 100% of districts in third model will be covered in Years 2 and 3. While the field staff in 84 districts directly implement the pediatric TB activities, the actvities in the 183 districts under third model would be faciliitated by State headquarters based project staff through state level advocacy and integration of pediatric TB with child health programs, and will leverage the state health and NTEP budget.													
7	TBDT Other-2 Treatment success rate- all forms: Percentage of pediatric patients with all forms of TB, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among pediatric TB patients notified during a specified period; *includes only those with new and relapse TB.	Country: India; Coverage: Geographic Subnational, less than 100% national program target	N: 42039 D: 46759 P: 89.91%	2021 India TB Report 2023		Yes	Non cumulative	No	N: 27621 D: 30520 P: 90.50%	N: 27773 D: 30520 P: 91.00%	N: 28776 D: 31449 P: 91.50%	N: 30642 D: 33307 P: 92.00%	N: 33714 D: 36448 P: 92.50%	N: 36456 D: 39412 P: 92.50%
	Comments													
	@equity indicator linked to TB-02a Baseline: At baseline, treatment success rate for pediatric TB is 89.91% for those notified in 2021 and reported in 2022 (Source - Nikshay) as per India TB Report 2023. Indicator: Numerator is No. of pediatric patients with all forms of TB who are documented to be successfully treated (cured plus treatment completed), Denominator is No. of Pediatric TB patients notified (cohort) one year before the reporting period. • NTEP has estimated 61040 Pediatric TB notifications for 2023 (one year) and this data has been taken as reference for year 1 targets for fixing the denominator for treatment success rate. This 61040 is divided into two semi-annual denominator targets as 30520 for Apr 24-Sept 24, and Oct 24-Mar 2025 • The denominator for treatment success rates for Years 2 and 3 is the number of pediatric TB cases notified in Years 1 and 2 respectively Target and strategy: The project will increase the pediatric TB treatment success to 90.5% and 91% over two semi-annual periods of Year 1, 91.5% and 92%over two semi-annual periods of Year 2 and 92.5% in both semi-annual periods of Year 3 through leveraging the community home visits and follow-ups by NTEP, TB Champions, and Private Provider Support Agency (PPSA) mechanisms. As the project do not have direct outreach, existing mechanisms will be leveraged. Data source: The reference data source for reporting will be Nikshay. The data will be disaggregated for gender and age categories													
Key and vulnerable populations (KVP) – TB/DR-TB														
8	KVP-2 Number of people with TB (all forms) notified among key affected populations/high risk groups (other than prisoners); *includes only those with new and relapse	Country: India; Coverage: Geographic Subnational, less than 100% national program target	N: D: P: %			Yes	Non cumulative	No	N: D: P: %	N: 1665 D: P: %	N: 1665 D: P: %	N: 1665 D: P: %	N: 1748 D: P: %	N: 1748 D: P: %
	Comments													

THE GLOBAL FUND

Coverage indicators and targets

CI Number	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Cumulation Type	Reverse Indicator	01-Apr-2024 30-Sep-2024	01-Oct-2024 31-Mar-2025	01-Apr-2025 30-Sep-2025	01-Oct-2025 31-Mar-2026	01-Apr-2026 30-Sep-2026	01-Oct-2026 31-Mar-2027
8	Baseline: At baseline, the ACF districts are not yet finalised and will be decided in consultation with respective State TB Offices. So, the baseline data of ACF for intervention districts is not available. Total of 8137 TB cases notified from ACF intervention across192 districts of 6 ACF states (Source: India TB Report 2023). Indicator: The numerator for the target indicator is the number of total TB cases (both adult and children) from 42 selected districts of 6 states. Reference data source: The reference data source is Nikshay,as reported in India TB Report 2023. There is no denominator for this indicator. Target:The targets is calculated as total TB cases (both adults and children) from 42 selected districts of 6 states. Regarding ACF activitiy, the 42 districts selection will be done by the respective State TB Offices during grant initiation. The baseline data of 8137 TB cases available is given for the entire 192 districts of 6 ACF states while it is not available for selected districts. The target is calculated for the selected 42 intervention districts. The reference source for target reporting will be Nikshay. The TB targets stated include total case detection target of 1665, 3330, and 3496 TB positives for years 1,2 and 3 respectively through Active Case Finding in 42 selected districts of six states. Strategy: For ACF activities, the project will be implemented in 6 of 7 pediatric TB intervention states under Pediatric TB intervention, except Uttar Pradesh. The project will support the district NTEP units in active case finding, both camp and non-camp approaches, using portable AI-enabled handheld X-ray in 42 selected districts across 6 states among the estimated 5% key and vulnerable population (KVP). The KVP prioritised are population living in urban slums and population from difficult to reach villages, villages with population seeking care from traditional healers, and areas with high malnutrition in rural and tribal areas. The key approaches are: Providing technical assistance to NTEP in mapping of KVP and validation of secondary data and support in the microplanning of ACF activities, 2. Coordinate with health department in conducting door-to-door TB symptom screening and identifying the presumptive TB cases in urban slums tribal and rural areas, and inform TB program staff for arranging health and X-ray camps among vulnerable groups, 3. Utilizing the hand-held Xray machine under NTEP for TB screening. If availability of the handheld X-ray devices are delayed, the X-ray technician will not be hired and the budget will be used for X-ray at private X-ray centres through partnerships with private diagnostic facilities and for any other transportation arrangements, 4. Collecting samples (from presumptive cases) through Community frontline and NTEP workers and transporting them to DMC/NAAT sites. 5. Facilitating accompanied referral and TB testing for presumptive TB cases, 6. Ensuring TB testing for all presumptive cases using X-ray, NAAT, or microscopy (if NAAT is not available) and subsequent notification, 7. Engaging expert radiologists for X-ray interpretation when X-ray results are abnormal but NAAT results are negative. Wherever possible, the services of existing TB champions will be leveraged. It is estimated that 85% of KVP will be mapped, 90% of them willl be screened and 5% of them will be identified as presumptive TB (ref: National ACF 2022 data, India TB Report 2023), 95% of Presumptive TB will be offered handheld Chest X-ray investigation NAAT and diagnostic tests in the field, and will identify 3% of them as TB positive in a year. It is expected that handheld digital X-ray devices will be made available in 42 selected districts of 6 states by end of Quarter 2, Year 1 and hence the project activities are planned to start from Q3, Yr 1. All data will be disaggregated by gender, adult and children to ensure the health equity in service coverage.													
9	KVP-1 Number of people with TB (all forms) notified among prisoners; *includes only those with new and relapse TB	Country: India; Coverage: Geographic Subnational, less than 100% national program target	N: 18 D: P: %	2022 India TB Report 2023		Yes	Non cumulative	No	N: 32 D: P: %	N: 33 D: P: %	N: 49 D: P: %	N: 49 D: P: %	N: 71 D: P: %	N: 71 D: P: %
	Comments													
	Target Assumptions: The indicator will be reported as number. The overall targets for the number of people with TB notified among prisoners are projected at 65 in Year 1, 98 in Year 2, and 142 in Year 3. The target calculations follow the NTEP's Active Case Finding Guidelines that include prisoners as one of the Key and Vulnerable population, and are based on the prison TB data reported in Annual TB report 2023 (https://tbcindia.gov.in/showfile.php?lid=3680) and PSI 2022. The denominator is determined based on the number of prison inmates in the central and District prisons (static population) as reported in Prison Statistics India report 2022 (https://ncrb.gov.in/uploads/nationalcrimerecordsbureau/custom/psiyearwise2022/1701613297PSI2022ason01122023.pdf) Target Population: A total of 1,02,914 prison inmates in 10 states will be covered under the TB services, which include screening, referral, testing, and diagnosis services. Definitions: Numerator: The number of prison inmates in Central and District Prisons from 10 states/UTs who were diagnosed and notified. Denominator: The estimated number of prisoners (Static) in Central and District Prisons from 10 states/UTs Source: (Project MIS / Nikshay) Baseline: The Jan-Dec 2022 prison TB data, as reported in Nikshay, for 10 states/UTs (Source: Annual TB Report 2023) shows 88% of prison inmate population are screened for TB, 3.4% are identified as Presumptive TB and referred for TB testing, 84% of those referred were tested, and 1.35% of tested were diagnosed for TB. The annual TB notification target of 65 in Year 1, 98 in Year 2, and 142 in Year 3 are calculated based on the proportion of prisoners screened at 88% in Year 1, 90% in Years 2 and 3, those with Presumptive TB and referred for TB testing to 6% in Year 1, 8% in Year 2 and 10% in Year 3, those who got tested for TB at 85%, 88% and 90% for respective years 1, 2 and 3, and 1.4% in Year1, 1.5% in year 2 and 1.7% in year 3 of those tested are diagnosed as TB. Proposed strategies for achieving the projected targets include but are not limited to: i. Screening the prison inmates during the camps approach and through prison-based health facilities in collaboration with prison health officials. ii. Identifying those with presumptive TB and referring them for sample collection. iii. Ensure the transportation of samples to TB diagnostic centres through coordination with prison health officials and staff of project and NTEP. iv. Advocacy for fulfilling the vacant position of medical and paramedical staff inside the prison v. Conduct training/sensitisation of the Health Care Provider (HCP) on HIV, TB and other health aspects vi. Ensuring the test results from the TB diagnostic centres are shared with prison officials for treatment initiation of those diagnosed with TB vii. Ensure the establishment of a data-sharing mechanism among the Project, Prisons, and NTEP, encompassing Nikshay data reporting at both the state and district levels. viii. Linking up post release TB diagnosed inmates to the regular NTEP program and community champions.													

Workplan Tracking Measures

Intervention	Key Activity	Milestones	Criteria for Completion	Country	01-Apr-2025 30-Sep-2025	01-Oct-2025 31-Mar-2026	01-Apr-2026 30-Sep-2026	01-Oct-2026 31-Mar-2027
RSSH: Community systems strengthening								
Community engagement, linkages and coordination	9 SLNs formation at the end of 3 years Coordination with CBOs to nominate the SLN members. Electing the SLN board members based Developing on vison mission and MoA of the respective SLNs. Applying for registration of SLN. Quarterly meeting with SLN (2 meeting per SLN each PU)	3 SLNs established and certified	o= not started 1=started= Ony 1 SLN formed 2 = advanced= 2 SLN formed 3= completed= 3 SLN formed	India		X		
		6 SLNs established and certified	o= not started 1=started= Ony 3 SLN formed 2 = advanced= 4 SLN formed 3= completed= 6 SLN establihed and certified and quartelry review meetings implemented	India			X	
		9 SLNs established and certified	o= not started 1=started= Ony 3 SLN formed 2 = advanced= 6 SLN formed 3= completed= 9 SLN establihed and certified and quartelry review meetings implemented	India				X
		Development of the process for SLN Coordination with CBOs to nominate the SLN members	o= not started 1=started= Process drafted and developed 2 = advanced=Process agreed and ratified by stakeholders 3= completed= SLN creation process published	India	X			
Comments								
Criteria for completion is cumulative- SLN establishment will start from 2nd Year onwards, 2nd Year 6 SLN will established and at the end of 3rd all 9 will be esatablished certified. Coordination with CBOs to nominate the SLN members. Electing the SLN board members based Developing on vison mission and MoA of the respective SLNs. Applying for registration of SLN. Quarterly meeting with SLN (2 meeting per SLN each PU)								

THE GLOBAL FUND

Summary Budget

Country	India
Grant Name	IND-C-SAATHII
Implementation Period	01-Apr-2024 - 31-Mar-2027
Principal Recipient	Solidarity and Action Against The HIV Infection in India

By Module	Total Y1 - 2025	Total Y2 - 2026	Total Y3 - 2027	Grand Total	% of Grand Total
Collaboration with other providers and sectors	**$69,433**	**$55,090**	**$33,417**	**$157,940**	**0.6 %**
Key and vulnerable populations (KVP) – TB/DR-TB	**$2,122,688**	**$2,340,522**	**$1,892,992**	**$6,356,203**	**25.7 %**
Prevention package for other vulnerable populations (OVP)	**$587**	**$1,098**	**$350,014**	**$351,700**	**1.4 %**
Prevention package for people in prisons and other closed settings	**$656,420**	**$666,537**	**$584,382**	**$1,907,339**	**7.7 %**
Program management	**$2,567,942**	**$2,300,124**	**$1,893,543**	**$6,761,609**	**27.3 %**
RSSH/PP: Human resources for health (HRH) and quality of care	**$756,953**	**$204,841**		**$961,794**	**3.9 %**
RSSH: Community systems strengthening	**$122,252**	**$265,084**	**$106,774**	**$494,109**	**2.0 %**
Treatment, care and support	**$2,635,564**	**$2,935,409**	**$2,173,669**	**$7,744,642**	**31.3 %**
Grand Total	**$8,931,839**	**$8,768,704**	**$7,034,792**	**$24,735,336**	**100.0 %**

By Cost Grouping	Total Y1 - 2025	Total Y2 - 2026	Total Y3 - 2027	Grand Total	% of Grand Total
1.Human Resources (HR)	**$4,708,202**	**$5,079,580**	**$4,835,047**	**$14,622,828**	**59.1 %**
2.Travel related costs (TRC)	**$3,261,540**	**$3,055,533**	**$1,325,661**	**$7,642,734**	**30.9 %**
3.External Professional services (EPS)	**$59,538**	**$76,064**	**$473,918**	**$609,520**	**2.5 %**
8.Infrastructure (INF)	**$13,470**			**$13,470**	**0.1 %**
9.Non-health equipment (NHP)	**$526,481**	**$115,965**	**$71,730**	**$714,176**	**2.9 %**
10.Communication Material and Publications (CMP)	**$140,333**	**$16,624**	**$6,648**	**$163,605**	**0.7 %**
11.Indirect and Overhead Costs	**$168,815**	**$252,850**	**$179,057**	**$600,722**	**2.4 %**
13.Payment for Results	**$53,461**	**$172,089**	**$142,731**	**$368,281**	**1.5 %**
GrandTotal	**$8,931,839**	**$8,768,704**	**$7,034,792**	**$24,735,336**	**100.0 %**

By Recipients	Total Y1 - 2025	Total Y2 - 2026	Total Y3 - 2027	Grand Total	% of Grand Total
PR	**$2,263,900**	**$2,286,064**	**$3,462,895**	**$8,012,858**	**32.4 %**
Solidarity and Action Against The HIV Infection in India	$2,263,900	$2,286,064	$3,462,895	$8,012,858	32.4 %
SR	**$6,667,940**	**$6,482,641**	**$3,571,897**	**$16,722,478**	**67.6 %**
SAATHII_KK_1_to_20	$702,045	$131,674	$365	$834,084	3.4 %
SAATHII_SR1	$656,755	$724,480	$387,419	$1,768,653	7.2 %
SAATHII_SR2	$767,876	$651,402	$250,839	$1,670,117	6.8 %
SAATHII_SR3	$788,287	$823,824	$398,464	$2,010,576	8.1 %
SAATHII_SR4	$1,012,445	$1,152,697	$780,811	$2,945,953	11.9 %
SAATHII_SR5	$422,645	$461,539	$206,887	$1,091,071	4.4 %
SR1 TB	$326,453	$387,900	$231,854	$946,207	3.8 %
SR2 TB	$499,159	$484,322	$310,144	$1,293,625	5.2 %
SR3 TB	$283,967	$323,244	$194,946	$802,157	3.2 %

THE GLOBAL FUND

By Recipients	Total Y1 - 2025	Total Y2 - 2026	Total Y3 - 2027	Grand Total	% of Grand Total
SR4 TB	$369,305	$421,064	$255,453	$1,045,822	4.2 %
SR5 TB	$378,842	$395,331	$245,283	$1,019,457	4.1 %
SR6 TB	$460,160	$525,164	$309,432	$1,294,756	5.2 %
Grand Total	**$8,931,839**	**$8,768,704**	**$7,034,792**	**$24,735,336**	**100.0 %**

Source Of Funding	Total Y1 - 2025	Total Y2 - 2026	Total Y3 - 2027	Grand Total	% of Grand Total
Approved Funding	$8,931,839	$8,768,704	$7,034,792	$24,735,336	100.0 %
GrandTotal	**$8,931,839**	**$8,768,704**	**$7,034,792**	**$24,735,336**	**100.0 %**