Proceedings of the Orientation Workshop
organized for the
India-Country Coordinating Mechanism (India-CCM) Members
of
The Global Fund to Fight against AIDS, Tuberculosis and Malaria

July 23-24, 2009

India Habitat Centre, New Delhi, India

Background

The "India Country Coordinating Mechanism" (India CCM) is established in response to requirements and recommendations of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). The India CCM has been in existence since December 2001 and has been successful in obtaining grants from the Global Fund. The India CCM has been playing the role of an in-country 'Board' that facilitates and oversees The Global Fund grants on AIDS, TB and Malaria.

Over the course of its existence, The India CCM has become a truly multi-stakeholder partnership, with representation from all the sectors. The sectors being represented include government, private sector, civil society, People Living With Diseases (PLWD), academic and research institutions, and multi-lateral and bi-lateral agencies. In June 2009, The India CCM was re-constituted following a transparent selection and election process. The re-constituted CCM has grown and now comprises of 40 members from the earlier number of 33 members.

The objectives of the orientation workshop were to:

- Provide an overview of the Global Fund grants in the Indian context.
- Gain a perspective on the concept of CCM and of the expectations of GFATM from the CCM.
- Provide clarity on the roles and responsibilities of CCM members vis-à-vis the CCM and each of the constituencies being represented by them.
- Gain an understanding of GFATM/CCM processes and procedures.

The workshop provided an excellent platform for learning and exchange of ideas amongst the CCM members who represent different constituencies on the India CCM.

Day I: 23 July 2009

Inaugural Session

Welcome Note

Ms. Aradhana Johri, (Joint Secretary, NACO and CCM member) welcomed the participants. Ms. Johri pointed out that the orientation workshop was an opportunity for the new CCM members to interact and know each other to learn about the GFATM and CCM processes. She expressed her happiness that all the invitees from long distances have been able to make it possible to attend the orientation and she looked forward to fruitful deliberations and concrete outcomes for further action.
Ms. Aradhana Johri welcomed Ms. Sujatha Rao, Secretary and DG NACO to present the key note address.

Key note address

Ms. Sujatha Rao, (Secretary, Dept of AIDS Control and DG NACO, (CCM member and member of the portfolio committee of GFATM Board), delivered the keynote address. The keynote address reflected Ms. Sujatha Rao's long years of experience in interacting with the Global Fund and of being actively engaged on the India CCM.

In the keynote address, she captured the Global Fund grant support to India and the expectations from the CCM. She emphasised that the GFATM is becoming more stringent on the programme results being achieved under each grant. With the economic slow-down, it is becoming more difficult for technically weak proposals being selected by the Technical Review Panel (TRP) of the GFATM. Hence, the CCM has a major role in providing guidance and approving winnable proposals.

Ms. Sujatha Rao also emphasized that the CCM is a leveled ground where each CCM member has an individual and collective responsibility to the CCM and to the constituency they represent. She encouraged the people living with disease and (Civil Society Organisations (CSOs) to be actively involved in the CCM decision-making

process by being on top of the issues. She cited an example of the CSO representation on the GFATM Board where the representatives understand the issues, are well read on the issues, and support the decisions with evidence.

Following this session, the workshop was inaugurated by the lamp lighting ceremony.

Workshop Overview: Ice breaking and capturing expectations

Dr. Mala Srikant, National Project Consultant, CBCI conducted the ice-breaking session and capturing expectations of the participants.

Activity: Participants were asked to pair themselves into groups of two and provided with three questions. The questions to be answered were: What are your expectations from the workshop? What is the favorite book you have read? What is the best dish you like? Each partner was asked to fill in the answers being provided by the respondent. The intention was that participants get to know one another and to review whether the workshop objectives that were set, meets with the expectations of the participants.

After collecting the slips from the participants, Dr. Mala then read-out information from the slips which provided an opportunity for the larger audience to know more about the participants and understand their expectations from the workshop.

Dr. Mala then shared the objectives and agenda of the workshop and coordinated the proceedings of the workshop, focusing the discussions at every stage towards achieving the objectives of the workshop.

Session I: Introduction to the GFATM

Ms. Kamilla Nurbaeva, (Program Officer South and West Asia, The Global Fund) presented the session - 'Introduction to the GFATM'. She mentioned that India is a large portfolio country for the GFATM, as India has been successful in receiving many rounds of grant funds.

Ms. Kamilla's presentation covered the following areas:

- Mission and Principles of GFATM
- Key Actors and Structures
- Grant Management Processes and
- India Grants Portfolio.

She explained the basic philosophy of the GFATM, which is a global level independent, public-private partnership mandated to raise and disburse substantial new additional funds, operate transparently and accountably, and achieve sustained impact on AIDS, TB, and Malaria.

Ms. Kamilla shared the guiding principles of the GFATM which includes:

- Operate as a financial instrument, not an implementing entity;
- Make available and leverage additional financial resources;
- Support programs that reflect national ownership;
- Operate in a balanced manner in terms of different regions, diseases and interventions;
- Pursue an integrated and balanced approach to prevention and treatment;
- Evaluate proposals through independent review processes;
- Establish a simplified, rapid and innovative grant-making process, and
- Operate transparently, with accountability.

The GFATM currently implements 600 programs in 140 Countries. The GFATM achievements till June 2009 include 2,300,000 People availing Anti RetroViral (ARV) drugs; 5,400,000 people availing DOTS; and 88,000,000 insecticide treated nets for malaria control distributed.

Ms. Kamilla then elaborated the key actors on the Global fund. The CCM - a multi-stakeholder group that guides the in-country global fund processes, is responsible in guiding the proposal preparation and submission processes. It selects Principal Recipients (PRs), provides governance and oversight during implementation and monitors impact. The PRs are the grant managers and Sub Recipients (SRs) the program implementers.

The Local Fund Agent's (LFA) role is to provide independent and objective advice to the Global Fund. It is not the role of the LFA to act as Global Fund representative or to purport to represent the views of the Global Fund. The LFA has an obligation to preserve its fiduciary obligation to the Global Fund. In performing its role, the LFA will be required to interact with PRs, CCM and other stakeholders. This must be done within the parameters established and in such a way as to preserve the independence of the LFA which is critical to the oversight role.

Ms. Kamilla also shared the grant processes. A grant application process determines funding. Applications approved by the Country Coordination Mechanism (CCM) are submitted to the Global Fund. These applications are then approved or rejected by the Global Fund's Technical Review Panel. For the approved proposals, the PRs negotiate an agreement with the Global Fund, which identifies specific, measurable results to be tracked using a set of key indicators. LFAs are assigned to each grant as independent auditors, to monitor and verify information submitted by grantees.

The GFATM follows a performance based funding process which is guided by the following parameters: whether the projects are reaching the stated targets, effectiveness in disbursements and utilization of funds, timely procurement and activities, sub-recipient performance, timely reporting and reliability of data.

Ms. Kamilla then explained the grant life cycle which comprises:
Board Approval ⟶ Grant Signing ⟶ Grant Start ⟶ Grant renewal after two years of grant start ⟶ Grant end up-to five year's ⟶ Rolling Continuation Channel (RCC) for another six years (provided this is a well performing grant).

The presentation was followed by discussions. The topics discussed by the participants include:

Query: How long does each grant round continue with and without the RCC mechanism?

Ms. Kamilla clarified that a round of funding continues generally for five years and if the same grant is invited and approved for RCC, the grant would continue for another six years. Hence, the total project life cycle would be 11 years.

Query: What is the ratio of additional funds that can be sought from the GFATM, in comparison to the national program budget?

The presenter clarified that there is no such ratio specified. However, for the RCC, the budget can be upto 140% of the Phase II amount of the grant.

Query: Have there been changes in the selection of thematic focus areas for the proposals?

The guiding principle is that the proposal should be country driven and outcome focused, hence the thematic focus area is to be decided by the CCM, following a process of consulting a variety of stakeholders. However, the GFATM Board has been laying special emphasis to specific areas such as health system strengthening and gender.

Query: On the India Grant Portfolio shared, till June 2009, total requested is USD 1,253,837,119 of which the approved maximum is USD 862,292,971 and total disbursed is USD 375,610,329, why is there a huge variance between the requested and approved figure and between the approved and total disbursed figure?

The difference between the requested and approved figure would have been affected by the grant negotiation process wherein a realistic budgeting exercise is undertaken prior to singing of the grant. The difference between the approved grants and disbursed grants are because many of the grant rounds are in different stages of implementation. The Round 7 grant has just started. In addition, some of the grants may have been slow in financial disbursement.

Session II: Presentations on AIDS, TB, and Malaria National Programs

Dr. D. Bachani, (DDG-NACO) was the facilitator of the session.

Dr. L.S. Chauhan, (DDG-RNTCP) presented the national tuberculosis program**.**
He shared that India is the highest TB burden country accounting for one fifth of the global TB incidence. India has had an on-going National TB Control Program (NTCP) since 1962. In 1992, the Government of India (GoI), together with the World Health Organization (WHO) and Swedish International Development Agency (SIDA), reviewed the National TB Program. Based on the findings and recommendations of the review, the GOI evolved a revised strategy and launched the Revised National TB Control Programme (RNTCP) in 1992. This started as a pilot project in 1993, and the strategy proved both its technical and operational feasibility. It was launched as a national program in 1997. Rapid RNTCP expansion began in late 1998 and by the end of 2000, 30% of the country's population was covered; by the end of 2002, 50% of the country's population was covered and by March 2006, the entire country was covered under DOTS. Since implementation, more than 40 million TB suspects have been examined of whom, more than 9 million patients were placed on treatment and more than 1.6 million lives saved (deaths averted).

The Directly Observed Treatment, Short-course (DOTS) strategy along with the other ingredients of the Stop TB Partnership are implemented as a comprehensive package for TB control. The five principal components of DOTS are:

1. Political and administrative commitment;
2. Case detection by Sputum Smear Microscopy;
3. Uninterrupted supply of good quality anti-TB drugs;
4. Standardized treatment regimens with directly observed treatment for at least the first two months; and
5. Systematic monitoring and accountability.

Diagnosis is primarily based on Sputum Smear Examination. X-ray plays a secondary role in the standard diagnostic algorithm for pulmonary tuberculosis.

In the first phase of RNTCP (1998-2005), the programme's focus was on ensuring expansion of quality DOTS services to the entire country. The future holds a different set of challenges including Multi-Drug Resistant TB (MDR-TB) and HIV - TB co-infection. The RNTCP has now entered its second phase in which the programme aims to firstly consolidate the gains made to date, to widen services both in terms of activities and access, and to sustain the achievements. These need to be done in order to achieve the TB-related targets set by the Millennium Development Goals (MDG) for 2015 and to achieve TB control in the longer term. The TB targets set by the MDG *Indicator 24* is to detect 70% of new infectious cases and to successfully treat 85% of detected sputum positive patients. The global New Smear Positive (NSP) case detection rate is 61% (2006) and treatment success rate is 85%. The RNTCP has been consistently achieving global benchmark of 85% treatment success rate for NSP; and case detection rate of 70% (2007).

In India, a sizeable proportion of the people with symptoms suggestive of Pulmonary Tuberculosis, approach the private sector for their immediate health care needs. There is need for regularizing the varied Anti-Tubercular Treatment (ATT) regimens used by General Practitioners and other private sector players.

Dr. Chauhan shared that the RNTCP has obtained GFATM funding in Rounds 1, 2, 4 and 6. Round 1 grant closed in Sep 2006 and the Round 2, 4 and 6 are consolidated in the RCC proposal. Under Round 1 during the period 2003 to 2006, a population of 56 million in the states of Chattisgarh, Jharkhand and Uttaranchal and areas around Chennai were reached. The approved budget was USD 8.6 million. The Round 2 from 2004 to 2009, covered 57 districts in the states of Bihar and Uttar Pradesh and the Urban DOTS project in four cities. The budget approved for Round 2 was USD 29 million and through this project, a population of 110 million was reached. The Round 4 grant covers the states of Andhra Pradesh and Orissa CBCI Public Private Mix (PPM) project. The approved project budget was USD 28.5 million for the period 2005 to 2010. The Round 4 grant project is to cover a population of 120 million. The Round 6 grants for the period 2006 to 2011 was to cover the states of Chattisgarh, Jharkhand, and Uttaranchal and also includes the IMA PPM project. The overall approved budget for Round 6 is USD 26.24 million and is expected to cover a population of 62.3 million. The RCC proposal which was approved recently for a

budget of USD 216 million for the period 2009 to 2015 is focused on continuation and scale-up of Round 2 activities with consolidation of Round 4 and Round 6 and inclusion of Haryana and 8 districts of Bihar and in addition scale-up of CBCI and IMA PPM projects. Through the RCC, a population of 382 million is expected to be reached. Dr. Chauhan shared that on the four key indicators almost all the targets have been achieved.

Application for Round 9 has been submitted to the GFATM. The civil society PRs - the International Union Against Tuberculosis and Lung Disease (IUALTD) and the World Vision addresses Advocacy, Communication and Social Mobilization (ACSM); while the National Tuberculosis Division - the government PR will address MDR-TB, which is an additional component of the RNTCP.

Dr. G.P.S. Dhillon, (Director – National Vector Borne Disease Control Programme, NVBDCP). Dr. Dhillon presented the national malaria control program. He shared that the NVBDCP is the central nodal agency for the prevention and control of vector borne diseases like Malaria, Dengue, Lymphatic Filariasis, Kala-azar, Japanese Encephalitis and Chikungunya in India. It is one of the Technical Departments of the Directorate General of Health Services, Government of India. Malaria has been a major public health problem in India and a potentially life threatening parasitic disease. There are two types of parasites of human malaria, Plasmodium vivax and Plasmodium falciparum, which are commonly reported from India. Infection with P.falciparum is the most deadly form of malaria. It is transmitted by the infective bite of Anopheles mosquito. Human beings develop disease after 10 to 14 days of being bitten by an infective mosquito.

Dr. Dhillon mentioned that the malaria programme has been largely supported with domestic funding and loans from the World Bank and it is only for Round 4, the malaria programme received GFATM grant funding. The title of the project is Intensified Malaria Control Project (IMCP). The goal of the Round 4 grant is to reduce malaria morbidity in 100 million population in 10 states by 30% in 5 years from 461,083 cases to 322,758 cases and mortality by 50% from 478 to 232. The Round 4 malaria grant covers 106 districts reaching out to a population of 100 million in the states of Jharkhand, Orissa, West Bengal and the seven North Eastern States.

The start date of the project is July 2005 (Phase I) and Phase II is from July 2007. These states were included in the project for several reasons:

- Poor and vulnerable groups settled in the poorest parts of the country in 10 states and 106 districts (erstwhile 94 districts);
- High disease burden of 9.76% of population contributing to 25% morbidity and 47% mortality due to malaria in the country; and
- About 24 million population under the project are living along the international borders with Bhutan, Bangladesh Myanmar and Nepal.

Salient features of the IMCP are:

- Improving access to early treatment and prompt diagnosis through RDT in difficult/remote inaccessible areas;
- Artesunate combination therapy instead of Sulpha-Pyremethamine for drug resistant areas;
- Distribution of bed nets in high risk inaccessible areas;
- Annual treatment of bed nets with insecticide for those distributed under the project and owned by the community;
- Capacity building for implementation of malaria control strategies; Involvement of CBO/NGOs/PRIs/FBOs in programme implementation;
- Awareness generation on malaria control aspects.

The additional support during Phase II are: Technical assistance for Directorate and State Head quarters; Strengthen Monitoring and Evaluation (M&E) at sub-district level through Malaria Technical Supervisors (MTS) (150); Increased provision of Lab technicians (100) to improve access to diagnosis; and Provision of ITN / LLINs

As part of the Round 9 grant application, a proposal has been submitted to the GFATM, which includes a civil society PR. The proposal envisages covering the 7 NE states for further five years from July 2010 to June 2015. The total budget requested is US$ 113.68 million.

Dr. D. Bachani, (DDG-NACO) presented the National AIDS Control Programme, Phase III (NACP-III)**.**

Dr. Bachani narrated how the HIV epidemic has moved over the years from urban to rural India and from high risk to general population largely affecting youth. About 2.5

million people in India, aged between 15 and 49, are estimated to be living with HIV. HIV prevalence rate in the country is 0.36 percent. Most HIV infections in India occur through heterosexual transmission. In the north-eastern part of the country, however, injecting drug use is the major cause for the epidemic spread; sexual transmission comes next.

Given this prevalence scenario, the primary concern of NACP-III is to halt and reverse the epidemic in India over the next five years. The programme works to achieve this through a number of measures – saturation of coverage of high-risk groups with targeted interventions, scaled up interventions for the general population, and through integration and augmentation of systems and human resources in prevention, care and support and treatment at the district, state and national levels. It was in 2005, that the government initiated the provision of ART which is now scaled-up to all the States in the country and provision of second-line ART has also been initiated.

For effective outreach, NACP-III has decentralised its implementation structure to district level. Apart from this, Regional AIDS Control Unit in the North-East, a sub-group of NACO, will address special vulnerabilities of the region.

A nationwide Strategic information management system addresses issues of planning, monitoring, evaluation, surveillance and research to help track the epidemic, identify the pockets of infection and estimate the burden of infection. These measures can reduce new infections by 60 percent in high prevalence states and by 40 percent in the vulnerable states.

NACP-III also seeks to promote district-level network of people living with HIV. It seeks the active role of welfare organisations in providing nutritional support, opportunities for income generation and other welfare activities for HIV positive people.

This session was followed by a round of discussions seeking clarity from the presenters.

Query: It is known that high risk and marginalised groups such as sex workers, Men who have Sex with men (MSM) and Injecting Drug Users (IDU) are faced with challenges in accessing HIV-related treatment services. How does NACP-III plan to address these specific needs related to accessibility?

Each of the ART centres has a person living with HIV who is expected to play the role of the treatment coordinator, who guides the patients availing ART services. Having the treatment coordinator in-place alone may not address this barrier of marginalised groups not availing ART services comprehensively. For this a strategy would need to be developed.

Query: Can more information be provided on the Second line Anti-Retroviral Therapy (ART) being offered?

The second line ART drugs are presently being supported by the Clinton Foundation and are being provided by the 10 centers of excellence. The experience gained from this roll out shall be used to further expand the second line ART at other centres/States. As there is no third line ART available in the country, the roll out of second line has to be very controlled and strongly monitored for adherence so that patients can continue on these drugs for long time.

Session III: Presentations by the Principal Recipients (PRs) on each of the Grant Rounds 1 to 7 and how they support the National Programs

Dr. Suresh Mohammed, (National Program Officer, NACO) presented the different GFATM grants to NACO.

NACO is the operational PR for the Rounds 2, 3, 4, 6 and 7. Round 2 focused on Prevention of Parent To Child Transmission (PPTCT) of HIV in six high prevalence states i.e Andhra Pradesh, Maharashtra, Karnataka, Tamil Nadu, Nagaland and Manipur. As of April 2009, 2800 Integrated Counselling and Testing Centres (ICTCs) have been established with PPTCT services.

Round 3 focused on reduction in TB related morbidity in people living with HIV and preventing further spread of HIV and TB in the rural population of the six high HIV burden states. Until May 2009, 423 ICTCs have been established.

The Round 4 Grant focused on accessing ART to People Living with HIV (PLHIV) in six high prevalent states and National Capital Territory (NCT), Delhi. Population Foundation of India (PFI) is the other PR for Round 4. Round 6 grants focused on expanding access to ART and Counseling and testing facilities in focus geographic areas of India. The sub-recipients to NACO under Round 6 are Karnataka Health Promotion Trust (KHPT) for implementation of 55 community care centres in Karnataka and Maharashtra, Deepam Educational Society for Health (DESH) for training of 500 counselors, Infrastructure Leasing and Financial Services (ILFS) for creating Smart Cards for computerized patient records and State AIDS Control Societies (All States/UTs). The other two PRs along with NACO for Round 6 are PFI and India HIV AIDS Alliance.

The Round 7 grants to NACO focuses on the community outreach sub-component, the link workers scheme. The other two PRs for Round 7 are the Indian Nursing Council (INC) and the Tata Institute of Social Sciences (TISS).

The presentation covered the achievements and budget utilization under each of these grants. Following this presentation, the floor was open for discussions.

Query: Has any cost benefit analysis exercise been undertaken which shows that the programs being implemented are cost-effective?

Dr. Suresh Mohammed responded to this query by saying that there were no specific cost benefit analysis undertaken. However, external program reviews and mid-term and end-term reviews, recognize that the ICTC program being implemented in India is globally recognized as being most efficient.

Query: Is there scope for NACO to support research agencies to undertake qualitative research studies?

There is scope to support research studies by NACO. The process is that the proposal is presented to the research committee which will review the proposal and the proposal would also be screened by the ethics committee prior to approval.

Comment: For all proposal's the CCM should encourage PRs to include qualitative indicators which can help in assessing client satisfaction.

Ms. Sonal Mehta, (Program Director - HIV/AIDS Alliance)

Ms. Mehta presented that with the funding from GFATM Round 6 grants, The India HIV/AIDS Alliance as a civil society PR, and its consortium is implementing an expanded child-centered home and community-based care and support project, in line with the strategic priorities of the National AIDS Control Programme Phase III. Over the 5 years, the CHAHA project (meaning 'a wish' in Hindi) is extending care and support services to 64,000 children living with and/or affected by HIV, and their families (especially women-headed households). They work closely with different stakeholders and Government Ministries to find ways to help keep children with their parents or extended families.

Definitions of Children Affected and/or Living with HIV and AIDS: Any person between the age of 0-17+ years (A person ceases to be a child on her/his 18th birthday). An infected child is defined as a child living with HIV. An affected child is defined as a child who has not tested HIV positive but has one or both parents, or

another family member living with HIV, or lost one or both parents or significant others such as siblings, guardians or care providers due to an AIDS-related illness.

Activities under the project include: Home and community based care and support model, to provide a package of services which include improving access to health care prevention and treatment; providing supplementary nutrition and health information; facilitating access to formal and informal education and vocational skills-based training for older children; providing psycho-social support for children and family members affected by AIDS through counseling and mainstreaming in the community; providing economic support to families affected by AIDS, including access to credit especially for AIDS orphans directly or through foster homes; providing household support in the form of food, travel to hospital, funeral expenses and medicines.

CHAHA has its presence in 41 districts across four states (Andhra Pradesh, Manipur, Maharashtra and Tamil Nadu) with sub-recipient organisations who are engaged in implementing the project.

Ms. Brinelle Dsouza, (Director-Tata Institute of Social Sciences,TISS)

Ms. Dsouza presented that TISS has been nominated as the PR for Round-7 grant on the HIV counselling sub-component. The nature and extent of the scale-up planned under NACP-III requires that the infrastructure and human resources for counselling training be also enhanced. It is expected that NACO will provide PLHIV with ART, set up Community Care Centres and strengthen their linkages with Targeted Interventions (TI) as well as establish Integrated Counselling and Testing Centers (ICTC). In addition to this, private sector facilities will also be providing treatment and care to PLHIV. TISS will therefore be responsible for scaling up capacity in counseling and strengthen training institutes in various parts of the country. Many Centres of Higher Learning (CHL), which are usually specialized institutes or universities are involved in graduate teaching and research. Eighteen of these CHL are also recognized as Centres of Excellence for HIV counseling training by NACO. An improvement is desirable in both infrastructure and learning resources of the CHL to meet the varied needs. Therefore, the Program will aim to train counsellors and strengthen capacities of CHL at the state level.

The process for identification of the target CHL includes consultation with the State AIDS Control Societies (SACS) of the respective states to identify institutes which are currently part of the counseling training or recognized as centre of excellence for HIV and AIDS counseling. Other universities may be selected through the National Assessment and Accreditation Council (NAAC) Accreditation. In states where the university system is not well developed, the Preventive and Social Medicine department or Psychiatry departments within the government medical colleges are included.

Mr. Dileep Kumar, (President-Indian Nursing Council, INC)

Mr. Kumar mentioned that INC is a PR under Round 7. The program focuses on strengthening institutional capacity for nursing training on HIV in India, which is a component under the Round 7 India proposal. The project aims to enhance the institutional capacities of 55 Nurses' Training Institutes and will provide training to 90,000 Nurses on AIDS and ART within a period of five years (2008-2013). INC is implementing this project with support of the management agency Futures Group International (India) Private Limited and 55 nursing institutions.

Following this presentation, the floor was open for discussions:

Query: As both TISS and INC work to build human capacities and nurses being the key point of contact for the person living with any disease and their caretakers, did any interactions on this happen between the two PRs? Building the counseling skills of nurses is an important area. As PR, TISS has a mandate of building capacity in the area of counseling.

It was acknowledged that the program has just been initiated and hence no such meeting has taken place until now but this is a valuable suggestion and will be followed through.

Query: As the methodology proposed is a ToT model for training, what are the quality assurance mechanisms put in place to ensure quality of training till the peripheral level?

The presenter responded that quality assurance has been ensured by making provisions for the lead trainers to participate in all the training programs. Moreover, check lists and evaluation forms would be used.

Comment: It will be effective if Family Planning Counseling is included as a topic under the Counselors training component.

Comment: TISS could consider expanding the scope of the program by training the multi-disciplinary care team on counseling instead of only focusing on the Counselors alone.

Dr. Mary Verghese, (Director- Population Foundation of India, PFI)

Dr. Verghese stated that PFI is the PR for Round 4 and Round 6 grants for AIDS. The Round 4 grant which started from April 2005 covers six states and the Round 6 grant which started from June 2007 covers eight states. Under Round 4, PFI was to establish 130 District Level Networks (DLNs) and 44 Treatment Counseling centers. The treatment counseling centers related work was re-strategised based on the ART scale-up plan. Under the private sector component, the Confederation of Indian Industries (CII) was involved in establishing 7 corporate ART centers. The Round six proposals focused on scaling up the activities proposed in Round 4 to the rest of the country. The PFI component fits within the objective 2 of the NACO Round 6 proposal and looks at addressing the care and support needs with specific focus on treatment adherence, working through the community care centers and district level networks.

Dr. Verghese shared that the Round 4 grant has been invited for the RCC and PFI is working to consolidate both the Round 4 and Round 6 under the RCC.

This session was followed by a round of discussions seeking clarity from the presenter.

Query : What are access issues faced by marginalised communities? Are they using the services of the ART centres and Community Care Centers (CCCs)?

> Dr. Mary Verghese responded that though there are challenges, the number of people from marginalised groups availing services from the CCCs are on the rise. It largely depends on the facilitative environment created by the CCCs, DLNs and the ART Centers.

Session IV: Presentation on the formulation of Country Coordinated proposals to the Global Fund.

Pre Grant application phase; the preparation of Grant proposals; Post Grant Application phase: Grant Approval and Negotiation process.

The post tea session focused on the GFATM grant application. Dr. G Balasubramanian, National Consultant was the key facilitator for this session.

Pre Grant application phase: Mr. Maju Mathew, Consultant, made a brief presentation on the pre-grant application process covering the different steps being followed by the CCM in preparing the country proposal from the time GFATM announces a particular Round. The India-CCM forms a sub-committee to organise preparatory work for the Country proposal. The CCM sub-committee then works with the three National program divisions and undertakes wider consultations. The sub-committee discusses the potential thematic focus area with the CCM which is endorsed by the CCM.A nation-wide communication of call for proposals is then launched through websites, list servers and National newspapers. The concept notes and proposal submission formats are drafted and placed for viewing and downloading on different web sites. Once the CCM Secretariat receives the concept notes, they are screened by a Screening Committee. The approved concept notes are then reviewed by The Technical review committee. The potential PRs are also initially identified by the Review Committee.The review process and the names of the potential PRs are shared with the CCM in the next CCM meeting. The CCM discusses and formally endorses the shortlisted concept notes and the proposed PRs. Thereafter begins the Technical writing process.

The preparation of Grant proposals: Dr. Suresh Mohammed made a presentation on grant proposal preparation. The guiding principles being: the proposal should be country-driven and outcome-focused; should be inclusive and collaborative; be in harmonization and alignment with in country systems; should focus on strengthening service delivery and program sustainability.; and improving outcomes for the three diseases through health systems strengthening. The five key steps to developing a strong proposal were shared. PR Selection process and the steps following the proposal were discussed in the presentation.

Post Grant Application phase, Grant Approval and Negotiation process: Dr. Mala Srikant introduced the technical aspects related to the GFATM proposal. She presented the post-grant application which includes grant approval and negotiation process. She mentioned from her experience that 'proposal submission is just the beginning'. The proposal document comprises of the following sub-sections: Completed proposal form, Budget, Attachment A- performance Framework, Attachment B-List of Pharmaceuticals, Health Products and Health Equipment and Work Plan with Budget.

She explained that the PR solicits India CCMs endorsement. Following this, India-CCM Secretariat submits the Country proposal to the GFATM Secretariat in Geneva by the closing date. The GFATM Secretariat reviews the proposal for CCM eligibility and completeness, following which the proposal is handed over to Technical Review Panel (TRP) for review of proposals. The TRP outlines main strengths and weaknesses of each proposal, with recommendations. TRP recommendations are then shared with the applicants. If the TRP clarifications are addressed, the proposal is shared with the Board for approval. The Board decision is then shared vide a written notification with the applicants. Following the Board Approval, the grant negotiation and signing process happens. The Local Fund Agent then conducts an independent assessment to assess whether the PR has, or is able to rapidly develop (including through outsourcing), certain minimum capacities in areas of financial management systems, institutional and programmatic arrangements, procurement and supply management and monitoring and evaluation arrangements. Dr. Mala presented the different documents to be completed for the grant negotiation process to reach the grant signature level.

Following these three presentations, the floor was open for discussions. The queries raised by the participants were as follows:

Query: What is the expected role of the CCM after a proposal is submitted?

Once the proposal is submitted, the CCM has a role in addressing queries related to the proposal which could arise from the GFATM Secretariat or the

TRP. Also playing the oversight role for the ongoing rounds is a regular role for the CCM.

Query: What is the CCM's role in the grant negotiation process?

The CCM has a role in helping the PR and facilitating a smooth grant negotiation process by ensuring that PR submits the entire set of related documents to the GFATM. The CCM should be fully aware of the grant as the final signature on the grant is of the CCM Chair.

Query: Do we have pre-set criteria against which the Technical Review Committee evaluates the concept notes for selection to be part of the Country Proposal ?

The process that was followed for the earlier rounds, includes putting together a panel of subject experts known as the 'Technical Review Committee' for each specific Round who then develops the concept note evaluation criteria. Based on the evaluation criteria the concept notes are selected. While evaluating, the panel also looks out for potential PR's to lead the proposal.

Query: How is the PR selected?

The process followed till date is that the 'Technical Review Committee' proposes the names of potential PRs to the CCM and following further deliberations, the CCM approves/rejects the proposed PRs.

Session V: Presentation on the role and responsibilities of the Local Fund Agent (LFA)

Ms. Anuradha Tuli, (Director, Price Waterhouse Coopers, PWC) chaired this session and the presentation was made by **Mr. Heman Sabharwal**, (Associate Director, PWC). The presentation covered the following areas: The role of LFAs in Performance Based Funding, LFA role in grant life-cycle and LFA Critical Success factors.

Discussions followed the presentation.

Query: If there is a situation of contradiction between how the CCM perceives an issue related to the PR and how the LFA perceives the same issue? What will be Global Fund's position on this?

Global Fund would be open to discussions with the CCM and the LFA and taking into consideration the inputs of the CCM and the LFA will take a decision related to the issue.

Query: Is the LFA expected to look at both the financial and programmatic aspects?

Yes the LFA review does look at both the financial and programmatic aspects. PWC being a financial institution draws on the technical expertise of subject experts, who are engaged as Consultants to support the programme review related work.

Participants sought more clarity on the working relationships between the PRs and the LFA. Similarly the working relationship between the LFA and the CCM and LFA and the Global Fund was discussed in detail. Also clarity was sought on whether the CCM can have access to the LFA reports sent to the Global Fund.

Comment: It would be good if the LFA participated in the CCM meetings. Ms. Tuli responded saying that it is of interest to the LFA to participate in the CCM meetings and if invites are received at least two weeks in advance, the LFA would plan its schedule and participate in the CCM meetings.

Day II: 24 July 2009

Recap of Day I and Agenda for Day II

Dr. Sai Subhashree Raghavan, (President, SAATHII) was the key facilitator for the day. She shared the objectives and Agenda for Day II sessions driving home the importance of the role and responsibilities of the India CCM.

Session I: Introducing the concept of Country Coordinating Mechanism as an innovation in the architecture of development.

Ms. Katherine Owen, (Senior CCM Support Officer, the Global Fund) shared that she has been using the India CCM as an example with other countries and hence is privileged to be here among the CCM members. She appreciated the well performing India CCM.

She then presented key aspects of the CCM guidelines which is one of the founding documents written to guide CCMs. A question to the participants was 'Why is it important to have broad-sectoral participation?'. Each of the constituency representatives were given an opportunity to share their perception.

Ms. Katherine emphasized that the guidelines are not a prescriptive document but provide opportunity for the CCM to decide in most situations. She shared some of the key decisions that a CCM would need to make. The CCM would first need to assess the national priority needs and understand the gaps based on the national disease strategies. Then take a decision on whether the country should apply for a Round of grants and if yes, for which of the disease components. Also within that disease component, the thematic focus area which is of priority to the country needs to be identified. Ms. Katherine suggested that a broad consultative process be followed to identify the priority areas for the round.

She shared that a common trend being noticed is that many applicants are successful in getting the proposal approved for funding but when it comes to actual implementation there are challenges related to fund disbursement and quality program implementation.

So it is the CCM, which needs to decide on whether the proposed PR has the capacity to manage the grant. The CCM should be transparent about announcing the call for proposals and in selecting the PRs and SRs. When the proposal is being developed, inputs from as many stakeholders beyond CCM and the key stakeholders need to be included. Transparent selection of the PR is another key responsibility of the CCM. Ms. Katherine's presentation covered the CCM related eligibility. Specific eligibility criteria need to be fulfilled, for the country application to be considered for TRP review.

Conflict of interest, Oversight role of the CCM and providing timely guidance and support to the PRs are some of the areas which were discussed in detail.

There were queries from the participants related to areas of conflict of interest especially when PRs are CCM members. Katherine shared examples of Jamaica where the CCM members filled out a conflict of interest questionnaire and identified areas where there could be potential conflict of interests and found redressal mechanisms to address the same. She encouraged the India CCM to undertake a similar exercise and develop an effective plan to address conflict of interest that could arise.

Query: If for a specific Round, the CCM nominates a PR. e.g. a national program division is nominated as the PR, would it need to be justified.

> Yes, as the PR selection is to be done in a transparent manner and if the CCM choses to select a particular PR, the reason for selecting this PR as against the other potential PRs and the decision making process should be documented in the proposal form. This could be supported by the minutes of the CCM meeting.

Discussions on the India CCM Terms of Reference (ToR)

Ms. Sabina Bindra Barnes's, (Human Development Advisor & Task Team Leader, DFID), presentation re-emphasized the role of the CCM in the light of the ToR. The ToR has been an evolving document and is largely based on The Global Fund guidelines. The India CCM now comprises of 40 members representing different constituencies. Each of the CCM members is representing specific constituencies and the members bring to the CCM, their constituency related interests. Hence managing the group dynamics is foreseen as a challenge. This could be overcome if the ToR is applied in the true spirit. One of the key responsibilities of the CCM is facilitating the development of quality proposals ensuring that a transparent process is followed. Another challenge which needs to be addressed by the CCM is to develop capacity of smaller grassroot level NGOs so as to help them participate in the proposal submission processes and be grant implementers. Linking the proposal within the national program framework is another challenge faced when CSOs are also PRs.

Making last minute changes to the country proposal to be submitted to the GFTAM is seen as another challenge. The CCM has a role in informing their respective constituencies with quality information on outputs, outcomes and impacts of the grants. Ms. Sabina also shared that attendance and participation of the CCM members in the CCM processes is key to the success of the CCM and this supports in ensuring quality. She requested that enough time be given to the members (atleast 15 days) to review documents. Another effective way to ensure CCM effectiveness is to conduct periodic external review of the CCM to assess the areas which need further strengthening.

Following this, **Ms. Komal Khanna**, India CCM Coordinator presented the CCM re-constitution process that was followed as per the Terms of Reference for the new CCM 2009-11 and shared how the selection/election of each of the 40 CCM positions was undertaken. This presentation by Ms. Komal Khanna helped all the CCM members to understand the transparent process followed to elect/select members from the different constituencies to be represented on the India CCM.

The presentations were followed by discussions on how to bring in the un-represented stakeholders who can play an active role on the CCM, especially groups such as media representatives, politicians and others. Participants shared their responses to this query. It was felt that if there are media representatives who are sensitized to the CCM issues, they could be invited as special invitees. It was also shared that instead of politicians, the parliamentarians be invited as special invitees to the CCM.

Participants sought clarification on the ToR related to the positons of the Chair and Vice-Chair selection.

Session II: Panel Discussions on the "Roles of the CCM"

Facilitator: Ms. Sabina Bindra Barnes Panel: Dr. R.S. Shukla, Joint Secretary MoHFW, Mr. K.K. Abraham, President- INP Plus, Dr. Malini Eden, Director- Search, Ms. Asa Anderson, Senior Program Officer, UNAIDS

Introducing this session of the workshop, the facilitator made the distinction between the "activities" that a CCM member was obligated to execute (attending meetings, voting on decisions, participating in any committee work of the CCM etc.) and a high level understanding of what the CCM existed for. Ms. Barnes facilitated the Panel Discussions on the "Roles of the CCM" by bringing forth the multiple roles that a CCM member has to play like Governance Role, Oversight Role, Business Role, Constituency Role, Technical Role and Coordination Role. Each of the panelists shared from their experience on the CCM about the roles of the CCM members.

Dr. R.S. Shukla, (Joint Secretary, MoHFW and CCM member) shared about the expected governance role of the CCM. He further sought suggestions on how to ensure participation of members, how to ensure mechanisms for communicating in a more structured manner among the CCM members and to the constituencies. **Ms. Asa Anderson**, (Senior Program Officer, UNAIDS) shared the role UNAIDS played in supporting the CCM functions and also sought suggestions on how to make the CCM processes open and transparent. **Mr. K.K Abraham,** (President, INP Plus) mentioned that the CCM should work to bring in participation from different stakeholders especially the hard to reach and marginalized groups. **Dr. Malini Eden**, (Director, Search) focused on how to get the messages across and bring in the involvement from different geographic areas. Considering the size of the country, she suggested creating regional level CSO forums.

The floor was open for further questions and discussion on this topic of roles of the CCM. Discussions were held on how to make the CCM more accountable and how to monitor the functionality of the CCM. Various issues came up for clarification like legal obligation on the CCM members as they are signing on the grants, expectation from CCM, how to know the grant related issues at the field level and and also how to have the macro picture.

Session III : Group Discussions on the various Roles of CCM members with regard to the constituencies being represented.

Mr Alexander Matheou, (Country Director, HIV/AIDS Alliance) facilitated this group work by requesting the participants to break into groups based on the constituencies they represent. He then provided the group members the task of discussing few questions provided by him. The first question to be discussed was to identify groups from larger constituency that is being represented on the CCM. The next question was to identify the key interests of one's constituency that members bring forth to the CCM and the third question was to point out the best way to consult with the larger constituency members and the challenges foreseen of being representative of that constituency.

People living with disease constituency group

Ms. Daxa Patel, (President GNP Plus) presented the discussion points of the group. The PLWD constituency represented the infected and the affected groups that include people living/affected with the three diseases HIV, TB and Malaria, MSM, sex workers, migrant workers and IDU.

To take inputs from the constituency, the group discussed that different channels of communication should be used i.e. telephone and e-mails. Also visiting different projects would help in gathering first hand information.

The interest brought by the PLWD constituency to the CCM is to participate and provide inputs in the proposal preparation and quality assessment of services being delivered.

The challenge identified is the size of the country with state and regional specific issues and differences. A key challenge is how to ensure quality of services. The group discussed that the challenge related to quality can be addressed to some extent

by establishing in any proposal, a grievance redressal mechanism. Every indicator list should include few qualitative indicators that measure the quality of services being delivered. Qualitative research should be incorporated in the proposal. Review meetings and review missions should include PLWD constituency members.

Civil Society Constituency Group

Fr. Varghese Mattamana, (Director CARITAS) presented the CSO constituency discussion. The group recognized that the wider constituency that the CSO group represents on the CCM should include NGO, CBOs, FBOs, social activists, individuals and organizations that are participating in the CSO processes.

The interests the CSO representatives bring to the CCM includes: Information sharing and Technical assistance as many larger constituency members are not aware of the CCM and GFATM mechanisms. The first task will be to increase their awareness. Technical assistance should be provided so as to help smaller CSO organizations submit technically sound proposals in response to call for proposals. Ensuring access to quality services to socially excluded groups such as dalit women, primitive tribals and affected children. So that they take interest to identify and bring the interests of the unrepresented groups into the GFATM and CCM processes. This could be done through creation of a community forum for unrepresented groups so as to ensure their participation as an invitee or through prior consultations with the identified un-represented groups. Long term sustainability plan should be built into the five year project or RCC considering community participation as key to sustainability.

Access to data base for all the three diseases should be made available, if database is already available, otherwise access should be arranged and if not available, database should be generated. Another challenge is geographical distribution and allocation of the responsibility to generate information. This could be possible by organizing Multi-sectoral regional or national consultations which are led by the CCM members from that particular region. Wherever possible, electronic media could be used to transfer and gather information. The challenges identified are in terms of time, money and human resources and accessibility to data.

Multi-lateral and Bi-lateral Constituency

Ms. Kerry Pelzman, (Director, USAID) shared the discussion points from the multilateral and bilateral constituency group. The larger multi-lateral constituency includes 10 UN organizations and the World Bank and the bi-lateral constituency comprises of 40 countries that are in India. However there are seven bilaterals and the European Commision (EC) who are more active in the three diseases. The EC represents 27 countries.

Since many of the bi-lateral and multi-lateral organisations are involved in funding related activities in India, the key interest for the bi-lateral and multi-lateral organisations being represented on the CCM is to ensure coordination so as to avoid duplication. Another area of interest is to identify the potential needs for additional support in terms of Technical Assistance (TA) and assist with TA for the three diseases as well as with the Global Fund grant implementation. A unique interest for the bi-laterals is that many of the countries they represent are contributing resources to the Global Fund at the global level. Hence the bi-laterals need to be accountable to their Governments by reporting back on the Global Fund grants progress in India.

The bi-lateral constituency has developed and is guided by a formal Terms of Reference (ToR) which was jointly developed and is available on the website for reference. The ToR formalizes the process on how CCM members will further communicate with the larger constituency. The ToR states that at least two larger constituency meetings organized in a year to be used as a platform to share information and obtain feedback. Other methods to share information within the constituencies are to use the existing channels e.g. UNAIDS provides information through the UN Country team and the EC has a communication mechanism through the development council.

Challenges identified: Fewer donors are active in India in the area of Malaria disease control. There are many players in Tuberculosis sector but there are no formal fora to share information and take feedback from the multi-lateral perspective. These gaps need to be addressed.

Recommendations from the group include: Other members from organizations and constituency and subject experts should be drawn in to support activities of the CCM such as, review of proposals, conduct oversight, provide TA and other areas. Focal points on TB and Malaria should be identified and made responsible to increase focus on these two diseases. The multi-lateral and bi-lateral constituency to organize at least two meetings in a year to discuss and seek feedback from the larger constituency members.

Academic, Educational and Research Constituency group

Dr. R. C. Dhiman, (Director, National Institute of Malaria Research, NIMR) presented the Academic & Research Constituency discussion. The academic sector would be interested to add scientific content, help programs in development of proposals and support development of IEC materials. There is an existing network of ICMR with 29 institutes. NIMR, TISS and Lala Ram Sarup (LRS) institutes also have their own networks. Information can be gathered from these networked organizations. Challenges are related to the different languages in the country, the limited resources and maintaining timelines.

Private Sector Constituency group

Mr. Deval Sheth, (Manager, Accor Services) presented the Private Sector Constituency discussion. Private sector constituents include small, medium and large enterprises across various sectors, including private health care sector, industry foundations, professional bodies such as Doctors association and others.

Primary interest of the private sector is to promote health and consider the commercial issues related to enhancing productivity, mitigating risks and look for opportunities on how to participate in the process, undertake advocacy and share information, which could be achieved by using effective communication tools in a phased manner.

The challenges identified are that the private sector is not homogenous in nature and there is a large unorganized sector within the private sector. There is also lack of awareness on issues related to health and how to link health promotion and public health programs, taking the business needs into consideration.

A participant added that the real challenge to the Private Sector is to make services cost effective, affordable and accessible for the common man.

Government Constituency

Mr. Mathivathan, (Mission Director, National Rural Health Mission, NRHM, Orissa) presented the government CCM group discussion. The identified larger government constituency includes: the various government departments, the states and Union Territories (UTs) in the country. The states and UTs are being represented on the CCM by five Mission Directors of NRHM.

The main interest of the government on the CCM is to ensure that the needs of the people affected by the three diseases are met. This supplements the CSO constituency's interest. Other key interests include: an opportunity to disseminate information on GFATM, CCM, and the opportunities for program funding to the different departments.

And the CSOs who are closely engaged in implementing the government programs, should participate and good quality proposals should come from them. There is also an opportunity to align the GFATM program with the schemes of the national state programs which ensures that there is no duplication of services. This is possible because the government is largely aware of the different schemes being implemented in the state either through government funding, private donor or by corporates.

The challenges identified are the reach into other states in the region. However with more interaction and a formal mechanism to share information this could be overcome. The states in many situations are not in the loop and aware of the programs. The national program divisions are aware of the PRs implementing programs in the state. This should be shared with the state machinery, to involve more

stakeholders which would bring in more transparency. The village health committees, Panchayati Raj, Accredited Social Health Activists (ASHAs) could be encouraged to participate in the decision making and program implementation which would bring in more local ownership and accountability and involvement in the implementation process.

A key challenge identified within the system, is the unstable tenure of the government officials. Hence we need to develop systems to institutionalize the memory and also not lose the momentum which could be affected by the frequent transfers of Government representatives. This could be done by involving the associate members in the CCM processes.

Session IV: Oversight

Prof.Charles Gilks, Country Coordinator and Asa Anderson, Senior Program Officer, UNAIDS

Prof. Charles Gilks, (Country Coordinator, UNAIDS) chaired this session. **Ms. Asa Anderson,** (Senior Program Officer, UNAIDS) presented the oversight concept for India CCM. She shared that the page 9 of the ToR contains a paragraph on oversight. It states that the India CCM should have an oversight sub-committee for each of the 3 diseases with atleast three constituencies being represented on the oversight sub-committee, which then reports back to the larger CCM. The oversight committee could be part of the national joint reviews**.**

She also shared that the Round 9 proposal shared extensive ideas on how we propose to undertake oversight. The purpose of oversight is to monitor progress, performance and address challenges to improve the performance of grants. To ensure program meets targets and reports impacts, it is proposed that an annual two day workshop be organized to discuss outstanding issues and review grants. It is noticed that all the CCM meetings have an agenda item on discussions related to grants. This could be formalized as an oversight task and more focus given by bringing it on the top of the agenda items for each CCM meeting. Quarterly reports prepared by PRs could be posted on the CCM website and sent to CCM members. This should be taken up as an activity by the Secretariat.

Session V: The way forward

Dr. Sai Subhashree Raghavan, (President, SAATHII) presented the way forward session. She shared that it is a historic moment for the India CCM as more than one billion dollars have been committed to India by GFATM to fight the three diseases through the different grant rounds. It is the CCM which is elected by the respective constituencies which acts as the in-country Board to oversee that the money works.

She also emphasized that all of the CCM members are here because they wanted to be part of CCM processes and if the CCM works together we will become the model CCM. The CCM's tasks ahead would be to ensure that the money works and ensure quality services are being provided. This could be done by putting in place an oversight mechanism. Undertaking impact analyses, health system strengthening work and publishing materials related to specific technical, program and research areas are to be the CCM's priorities.

Conclusion

The workshop saw a unique coming together of around 70 participants comprising of all the new members, their alternates, some old members, PRs, consultants, supporters and The Global Fund team. This provided an opportune forum for the new CCM members to interact with multi-stakeholders and learn from their experiences.

There has been some level of thought on how to engage with the constituencies being represented. A sense of togetherness - it is not they and us but it is 'We' as CCM members - has been built to some extent. The issues of Oversight and Conflict of Interest were deliberated upon but due to the time constraints it was decided that there was a need for another session to formalize the oversight plan and the conflict of interest policy. It was recognized that the CCM needs to give equal focus to the Malaria and TB control programs. The CCM needs to engage with stakeholders beyond the members who could be stakeholders from different constituencies or subject experts, so as to bring in the needed support and technical assistance to the CCM work.

Before closing the workshop, the CCM Secretariat distributed a questionnaire asking for feedback on the workshop, and its methodology, from the participants. The participants were responsive on the feedback and were positive on the discussions that took place. The participants recognized the usefulness of an orientation workshop such as this, which allotted time for the CCM members to understand and question the processes involved within the existing CCM structures.

The links to the **Power Point Presentations of the workshop** are provided below:

http://72.14.181.81/iccm-rcc/23-July-2009.zip

http://72.14.181.81/iccm-rcc/24-July-2009.zip

The links to the photographs of the workshop are provided below:

http://72.14.181.81/iccm-rcc/images.zip

Annexure 1

AGENDA

Orientation Workshop of New CCM Members

Venue: Magnolia Hall, India Habitat Center, Delhi
Date: 23rd July and 24th July 2009

Workshop Objectives

- To provide an overview of the Global Fund Grants in the Indian context.
- To gain a perspective on the concept of CCM and of the expectations of GFATM from the CCM.
- To provide clarity on the roles and responsibilities of CCM members vis-à-vis the CCM and each of the constituencies being represented by the members.
- To gain an understanding GFATM/CCM processes' and procedures.
- To approve the RCC India HIV AIDS Round 4 Proposal IDA-405-G06-H & IDA-405-G06-H.

Participants: CCM Members & PRs

Purpose: Orientation for new members and as a forum for the reflection of older members on the journey so far.

Agenda

Day I- 23rd July 2009

Time	Session/Topic	Specific Objectives	Methodology	Speaker/ Facilitator
8:30- 9:00 AM	Registration			
9:00-9:05 AM	Welcome			Ms. Aradhana Johri, JS NACO
9.05-9.25 AM	Keynote Address			Ms. Sujatha Rao Secretary & DG NACO, Deptt of Aids Control
9.25-9.30 AM	Formal Inauguration			
9:30- 10:00 AM	Introduction by participants Ice breaking Capturing participants' expectations from the workshop Agenda	Setting the ground for the workshop	Facilitator	Dr. Mala Srikant, National Project Consultant, CBCI

Time	Session/Topic	Specific Objectives	Methodology	Speaker/ Facilitator
10:00-10:15 AM	Tea Break			
10:15-11:15 AM	Introduction to the GFATM Q & A	Core principles of the Fund. Grant Management India's Grants Role of the GFATM Secretariat		Ms. Kamilla Nurbaeva Program Officer South and West Asia, The Global Fund
11: 15- 12:00 PM 12.00-12.15 PM	Short presentations on National Programs (AIDS, TB and Malaria) by Program Heads Discussion		 Facilitator	Dr D. Bachani, DDG-NACO Dr. LS. Chauhan, DDG-RNTCP Dr. G.P.S. Dhillon, Director -NVBDCP Dr. D. Bachani
12:15-1:15 PM	Presentation on Global Fund Support in India		*Short Presentations by each of the Principle Recipients (PR's) on each of the Grants Rounds 1 to 7and how they support the National Programs*	Dr. L.S. Chauhan, DDG-RNTCP Dr. G.P.S. Dhillon, Director -NVBDCP Dr. Suresh Mohammed, NPO,-NACO Mr. Alexander Matheou, Country Director -HIV/AIDS Alliance
1:15- 2:15 PM	Lunch			
2:15- 2:45 PM	Presentation on Global Fund Support in India		*Short Presentations by each of the Principle Recipients (PR's) on each of the Grants Rounds 1 to 7and how they*	Ms. Brinelle Dsouza, Director-TISS Mr. Dileep Kumar, President-INC

Time	Session/Topic	Specific Objectives	Methodology	Speaker/ Facilitator
2.45 -3.00 PM	*support the National Programs* Q & A			Dr. Mary Verghese, Director- PFI
3.00- 3:30 PM	Introduction to the GFATM grant life-cycle		Presentation followed by discussions	Dr. Mary Verghese,Director-PFI
3:30- 3:45 PM	Tea Break			
3:45- 5:15 PM	The formulation of Country Coordinated proposals to the Global Fund. • Pre Grant application phase • The preparation of Grant proposals Introducing the technical aspects related to the GFATM proposal • Post Grant Application phase • Grant Approval and Negotiation process.		Facilitator	Dr. G. Balasubraniam, Consultant Mr. Maju Mathew, Consultant Dr. Suresh Mohammed, NPO, NACO Dr. Mala Srikant, National Project Consultant, CBCI
5.15 - 5.45 PM	Presentation on the role and responsibilities of the Local Fund Agent			Ms. Anuradha Tuli, Director, PWC Mr. Heman Sabharwal, Associate Direc tor, PWC
7:00- 9:00 PM	Dinner **Old, New CCM Members and PR's**			

Day II – 24th July 2009

Time	Session/Topic	Specific Objectives	Methodology	Facilitation
9:00- 9:15 AM	Re-cap of Day 1		Facilitator	Dr. Shubha Raghavan, President, SAATHII
9:15-10:15 AM	Introducing the concept of Country Coordinating Mechanism as an innovation in the architecture of development. India CCM ToR Q & A	 Presentation & Discussion		Ms. Katherine Owen, Senior CCM Support Officer, The Global Fund Ms. Sabina Bindra Barnes, Human Development Advisor-DFID Komal Khanna, India CCM Coordinator
10:30-10:45 AM	Tea Break			
10.45- 11:45 AM	Panel Discussions on the "Roles of the CCM" Governance Role Oversight Role Business Role Constituency Role Technical Role Coordination Role Q & A	Issues, Challenges, Learnings in each Role	Facilitator & Panel Panel	Ms. Sabina Bindra Barnes, Human Development Advisor-DFID Dr. R.S. Shukla, Joint Secretary MOHFW Mr. K.K. Abraham, President- INP Plus Dr. Malini Eden, Director- Search Ms. Asa Anderson, Senior Program Officer, UNAIDS
11.45- 12.45 PM	Group Discussions on the various Roles of CCM member's with regard to their constituencies. Plenary Session	Solutions to the identified issues and challenges & Key Actions to represent their constituencies.	Group Work Presentations from the working Groups	Mr. Alexander Matheou, Country Director -HIV/AIDS Alliance

Time	Session/Topic	Specific Objectives	Methodology	Facilitation
12:45-1:45 PM	Lunch			
1.45- 2.45 PM	Discussions on Oversight Role of the CCM Discussion on the Conflict of interest policy			Prof. Charles Gilks UCC-UNAIDS Ms. Asa Anderson, Senior Program Officer, UNAIDS
2.45 PM -3.00 PM	The way forward Closing			Dr. Shubha Raghavan, President, SAATHII
3.00 -4.00 PM	**39th India CCM Meeting**	Discussion and Endorsement for RCC India HIV AIDS Round 4 Draft Proposal IDA-405-G05-H & IDA-405-G06-H		India CCM

Annexure 2

List of Participants

Day I- 23rd July 2009

S.No	Title	First Name	Last Name	Organisation
1	Ms.	K.	Sujatha Rao	Deptt of AIDS Control, NACO
2	Ms.	Aradhana	Johri	Deptt of AIDS Control, NACO
3	Dr.	Damodar	Bachani	Deptt of AIDS Control, NACO
4	Mr.	Suresh	Mohammed	Deptt of AIDS Control, NACO
5	Ms.	K. S.	Bharti	India Nursing Counsil
6	H.E.	Jérôme	Bonnafont	French Embassy
7	Dr.	Ivonne	Camaroni	Unicef
8	Dr.	Panna	Choudhury	IAP
9	Ms.	L. S.	Chauhan	RNTCP
10	Dr.	G. P. S.	Dhillon	NVBDCP
11	Ms.	Brinelle	D'Souza	TISS
12	Mr.	Nicolas	Ferrari	French Embassy
13	Mr.	G.	George	CST
14	Ms.	Indrani	Gupta	Ministry of Labour and Employment
15	Mr.	Vikram	Gupta	Sir Ratan Tata Trust
16	Ms.	Yashashree	Gurjar	Ballarpur Industries Ltd.
17	Ms.	Karin	Hulshof	Unicef
18	Mr.	R.R.	Jannu	NRHM, Karnataka
19	Ms.	Asa	Andersson	UNAIDS
20	Dr.	Sangeeta	Kaul	USAID
21	Mr.	P. N.	Kaul	India Nursing Counsil
22	Ms.	Anuradha	Tuli	PWC
23	Mr.	Nirod	Kumar Bhuyan	LEPRA Society

S.No	Title	First Name	Last Name	Organisation
24	Dr.	Vandana	Mahajan	UNIFEM
25	Ms.	Tara	Manchin	EHA
26	Mr.	Maju	Mathew	Consultant
27	Mr.	G.	Mathivathan	NRHM, Orissa
28	Ms.	Sonal	Mehta	India HIV/AIDS Alliance
29	Mr.	Subash	Mendhapurkar	SUTRA
30	Ms.	Sabina	Barnes	DFID
31	Mr.	Heman	Sabharwal	PWC
32	Ms.	Vimla	Nadkarni	TISS
33	Ms	Kamilla	Nurbaeva	The Global Fund
34	Ms	Katherine	Owen	The Global Fund
35	Ms.	Harshita	Pande	Apollo Tyres
36	Mr.	Arun	Pandhi	Sir Ratan Tata Trust
37	Dr.	S.	Paranjape	National AIDS Research Institute
38	Ms.	Daxa	Patel	GSNP+
39	Ms.	G.	Rashmi	Vasavya Mahila Mandali
40	Mrs.	Urvashi	Sadhwani	Ministry of Tribal Affairs
41	Dr.	Rohit	Sarin	LRS
42	Mr	Deval	Sheth	Accor Services
43	Ms.	Scherazade	Siganporia	GTZ
44	Mr.	Vikas	Singh	Ministry of Labour and Employment
45	Dr.	Mala	Srikanth	CBCI
46	Mr.	S.	Srinath	Person affected by TB
47	Mr.	Jerome	Adam	French embassy
48	Capt	Rajesh	Vaidya	Ministry of Defence
49	Ms.	Sarah	Victor	EHA

S.No	Title	First Name	Last Name	Organisation
50	Dr.	D	Behera	LRS
51	Dr.	R.C.	Dhiman	NIMR
52	Dr.	Jyaprakash	Muliyil	Christian Medical College
53	Mr.	Alexander	Matheou	India HIV/AIDS Alliance
54	Dr.		Ramakrishnan	SAATHII
55	Mr.	John	K. George	Swiss Emmaus Leprosy Relief Work
56		Swami	Shantatmananda	Ramakrishna Mission
57	Father	Varghese	Mattamana	Caritas India
58	Mr.	Elavarti	Manohar	Suraksha WRHCP
59	Ms.	Sabina	Barnes	DFID
60	Ms.	Kerry	Pelzman	USAID
61	Mr.	Nevin C	Wilson	International Union Against TB & Lung Disease
62	Dr.	H. G.	Thakor	
63	Mr.	Sandeep	Bannerjee	Accor Services
64	Mr.	Shadab		FICCI
65	Ms.	Polin	Chan	WHO
66	Dr.	G.	Balasubramaniam	Consultant
67	Mr.	Nicolas	Ferrari	French embassy
68	Ms.	Komal	Khanna	India CCM Secretariat
69	Ms.	Ashima	Mohan	India CCM Secretariat

Day II- 24th July 2009

S.No	Title	First Name	Last Name	Organisation
1	Dr.	R.S.	Shukla	MoHFW
2	Mrs.	Urvashi	Sadhwani	Ministry of Tribal Affairs
3	Ms.	Sabina	Barnes	DFID
4	Dr.	Ivonne	Camaroni	Unicef
5	Dr.	Panna	Choudhury	IAP
6	Ms.	Brinelle	D'Souza	TISS
7	Mr.	Nicolas	Ferrari	French Embassy
8	Ms.	Indrani	Gupta	Ministry of Labour and Employment
9	Mr.	Vikram	Gupta	Sir Ratan Tata Trust
10	Ms.	Yashashree	Gurjar	Ballarpur Industries Ltd.
11	Mr.	R.R.	Jannu	NRHM, Karnataka
12	Dr.	Sangeeta	Kaul	USAID
13	H.E.	Jérôme	Bonnafont	French Embassy
14	Mr.	Nirod	Kumar Bhuyan	LEPRA Society
15	Ms.	Tara	Manchin	EHA
16	Prof.	Charles	Gilks	UNAIDS
17	Mr.	G.	Mathivathan	NRHM, Orissa
18	Ms.	Sonal	Mehta	India HIV/AIDS Alliance
19	Mr.	Subash	Mendhapurkar	SUTRA
20	Dr.	Sai Subhashree	Raghavan	SAATHHI
21	Ms.	Vimla	Nadkarni	TISS
22	Ms	Kamilla	Nurbaeva	The Global Fund
23	Ms	Katherine	Owen	The Global Fund
24	Ms.	Harshita	Pande	Apollo Tyres

S.No	Title	First Name	Last Name	Organisation
25	Ms.	Daxa	Patel	GSNP+
26	Ms.	G.	Rashmi	Vasavya Mahila Mandali
27	Dr.	Rohit	Sarin	LRS
28	Mr	Deval	Sheth	Accor Services
29	Mr.	Scherazade	Siganporia	GTZ
30	Mr.	S.	Srinath	Person affected by TB
31	Dr.	D	Behera	LRS
32	Dr.	R.C.	Dhiman	NIMR
33	Dr.	Jayaprakash	Muliyil	Christian Medical College
34	Mr.	Alexander	Matheou	India HIV/AIDS Alliance
35	Dr.		Ramakrishnan	SAATHII
36	Mr.	John	K. George	Swiss Emmaus Leprosy Relief Work
37		Swami	Shantatmananda	Ramakrishna Mission
38	Father	Varghese	Mattamana	Caritas India
39	Mr.	Elavarti	Manohar	Suraksha WRHCP
40	Ms.	Sabina	Barnes	DFID
41	Ms.	Kerry	Pelzman	USAID
42	Ms.	Asa	Andersson	UNAIDS
43	Mr.	Maju	Mathew	Consultant
44	Mr.	Sandeep	Banerjee	Accor Services
45	Mr.	Shadab		FICCI
46	Ms.	Polin	Chan	WHO
47	Ms.	Komal	Khanna	India CCM Secretariat
48	Ms.	Ashima	Mohan	India CCM Secretariat