General Grant Information

Applicant:	Country Coordinating Mechanism - India
Country:	India
Round:	2
Component:	HIV/AIDS
Grant Title:	HIV prevention and care for mothers, their families and PLWHA through scaling up PMTCT services and public private sector antiretroviral treatment
Grant Number:	IDA-202-G02-H-00
Principal Recipient:	The Department of Economic Affairs of the Government of India
Other Grants (From the same Proposal)	N/A
Proposal Lifetime: (Years)	5
Lifetime Budget: (USD)	100,081,000
2-Year Budget: (USD)	26,116,000
Disbursed to Date: (USD)	8,301,000
Signature Date:	10-Feb-2004
Program Start Date:	01-May-2004

A. SECRETARIAT PHASE 2 RECOMMENDATION

Phase 2 Recommendation Category: Conditional Go

Incremental Phase 2 Amount Recommended for Board Approval (USD): * 66,586,000

Euro Equivalency :

Rationale for Recommendations:

The Secretariat classifies this renewal Request as a "Conditional Go".

Program performance:
Overall performance has been satisfactory to date with targets met or exceeded for 8 of the 13 performance indicators. There are good results in the majority of the important people reached indicators as well as in key capacity building indicators. These include:
• 3,783 HIV positive mothers, their partners and children are now receiving antiretroviral therapy (ART) (946% of target);
• 5,807 HIV infected pregnant women are now receiving antiretroviral (ARV) prophylaxis to reduce the risk of mother to child transmission (MTCT) (110% of target);
• 29 project sites are now providing quality voluntary counseling and testing (VCT) services (161% of target); and
• 57 nongovernmental organizations (NGOs) are now involved in providing quality HIV/AIDS care and support services to people living with HIV/AIDS (PLWHA) (127% of target).

One important area with weak reporting is ARV training. This should to be accelerated early in Phase 2. The other area of weak performance is ARV treatment through the private sector. The number of people to be put on treatment in this indicator needs to be improved substantially in Phase 2. Additionally, the IEC/BCC component of Phase 1 started very late, i.e., mid 2005, and still needs to improve its implementation rate. There were no reports on the number of people tested for VCT in Phase 1, only for people trained. We therefore require this reporting in Phase 2.

It is important that more coverage and service delivery is achieved in Phase 2, taking into consideration the magnitude of the burden of disease in the country and the funds in this grant.

The most serious concerns with this Program have been the conservative target setting considering the relatively high rate of HIV infection in the targeted populations and the significant under-utilization of grant funds. Programmatic achievement has been strong to date with a very significant budget under-spend (at month 17, 24% of Phase 1 funds had been spent in 71% of the time elapsed). This means the results to date have been achieved with approximately one third of the funds available for Phase 1. This indicates that the grant should have and could have achieved far greater programmatic delivery in Phase 1. Therefore, as a condition to continued funding, a substantial upward revision of the targets in line with the Phase 2 budget is required prior to Phase 2 grant signing.

Program management and governance:
The Principal Recipient's (PR's) implementing agency, the National AIDS Control Organization (NACO), has demonstrated satisfactory management of the grant to date. Overall capacities have been strengthened during the Phase 1 period and significantly increased resources are allocated to PR capacity building in Phase 2 in order to manage a higher and expanded level of implementation. Most of the responsibilities for Phase 2 have been delegated to the sub-recipients (SRs), i.e., State AIDS Control Societies (SACS) and NGOs.

Monitoring and Evaluation (M&E) systems have not been functioning well to date, with many capacity gaps identified during the Phase 1 period. However, the planned capacity building activities for M&E should be completed by Quarter 8, which should see a marked improvement in the reporting framework, particularly at the state level. All SACS, four NGOs, and NACO will have M&E officers who will receive yearly training during years 3, 4, and 5.

Some areas of financial management also require strengthening. To achieve this, all finance officers will receive yearly training funded by this grant during Phase 2.

Further efforts are planned to strengthen the capacity at the state and district level under close supervision by NACO and the Ministry of Health's senior officials. The Computerised Management Information System will also be strengthened with financial support from the World Bank and the Government.

The CCM is functioning well and the national commitment to scale up treatment and prevention services is strong, supported by technical assistance from WHO, UNAIDS, Clinton Foundation, UNICEF, and CDC.

The Secretariat classifies this Request as a "Conditional Go". In Phase 2, NACO should focus efforts on fulfilling the extensive suggested remedial actions as stated on page 3 of this Grant Score card.

*** The maximum funding amount available for Phase 2 of each proposal shall be the sum of the incremental amount approved by the Board and the amount of any funds approved for Phase 1 that have not been disbursed by the Global Fund at the end of the Phase 1 period.**

Rationale for Phase 2 Recommended Amount:

To date, the Global Fund has disbursed US$8,301,000 (32% of funds available for Phase 1) to the PR. All of these funds have been disbursed to the SRs. The overall expenditure rate on this grant is very low at 24.5% at 17 months (71% of the grant term elapsed). Significant cost savings have contributed to this large under-spend.

Recently submitted information indicates that expenditure rates are expected to accelerate considerably over Quarters 7 & 8 of Phase 1 and in Phase 2 with an ambitious scaling up of activities planned. The scale up involves the reallocation of forecast savings of US$18m from drugs and commodities towards increased numbers of PPTCT centers, covering rural as well as urban areas.

It is expected that approximately US$7.3m will remain undisbursed at the end of Phase 1. As a result of poor expenditure rates to date, these funds will not be made available to increase the maximum Phase 2 amount. Based on performance to date and conditional upon strong evidence being provided to the Global Fund Secretariat of a scaling up of activities early in Phase 2 (as set out on page 3 below, as well as a clear demonstration of the value for money achieved with this investment), the Secretariat concludes that an amount of US$73,965,000 (91% of maximum Phase 2 amount) is appropriate for continued funding. However, this amount is strictly conditional to an appropriate upward revision of all Phase 2 targets prior to Phase 2 grant signing and a clear reconciliation of the targets with the phase 2 budget. As US$7,379,000 of undisbursed Phase 1 funds are available to partially fund this amount, the Secretariat recommends to the Board to commit an incremental Phase 2 funding amount of US$66,586,000 for this Program.

Suggested Remedial Actions

Issues	Description of Suggested Remedial Actions
1. M&E capacity needs to be improved at NACO and at the six states and the respective districts.	1. NACO will organize regular training as per the workplan on M&E for state and district level professionals, to be completed by Q11 for all six states and by Q14 for the districts officials.
2. A system of independent data validation through external agencies for monitoring the program.	2. The GF grant is part of the national strategy NACPIII. As part of overall evaluation, annual external reviews of NACPIII will be organized by the World Bank and the reports will form a core part of GF internal program review process.
3. Improvement in the financial systems to book payments made through the grant.	3. NACO to complete training of finance staff on financial management in all six states by Q 12.
4. Target and budget review required.	4. Prior to Phase 2 signature, the PR shall submit to the Global Fund Secretariat a revised Attachment 3 (with indicative targets for years 4 and 5) that reflects an appropriate upward revision of all targets for Phase 2 and the scaling up of activities in line with the Phase 2 budget The PR must also provide to the Global Fund Secretariat a revised work plan and budget for Phase 2 period. Phase 2 grant signature is conditional upon the Global Fund Secretariat's satisfaction with the revised Phase 2 targets and budget clarifications.
5 BCC strategy for Phase 2 is clear but the implementation strategy is not clear.	5. The work plan and budget for Phase 2 submitted prior to Phase 2 signature should also incorporate a clear plan for the accelerated implementation of the BCC/IEC component.
6. Wrong booking of GF expenditures to other donors.	6. NACO to streamline financial management so that wrong bookings do not occur during Phase 2. Also refer to action point # 3.
7. CCM compliance as per 9th Board decision.	7. Prior to Phase 2 grant signature, the CCM shall provide updated evidence that it has fully met all CCM requirements as set forth in the Decision taken by the Global Fund Board at the Ninth Board Meeting in November 2004.

B. PHASE 2 BUDGET AND IMPLEMENTATION ARRANGEMENTS

1. Estimated funds available for Phase 2

	Total
Original Phase 2 Adjusted Proposal Amount (*)	**73,965,000**
Expected undisbursed amount at the end of Phase 1	7,379,000
Estimated Maximum Phase 2 Amount	**81,344,000**

Year 3	Year 4	Year 5
25,125,000	24,100,000	24,740,000

(*) Adjustments to the original Board approved proposal amount may be a consequence of TRP review and grant negotiation before Phase 1.

2. Phase 2 Budget and Recommended Amount

	Year 3	Year 4	Year 5	Total Phase 2 Amount	% of maximum Phase 2 Amount	Incremental Phase 2 Amount	% of original Phase 2 Proposal Amount
CCM Request (**)	25,125,000	24,100,000	24,740,000	**73,965,000**	**91%**	**66,586,000**	**90%**
Global Fund Recommendation (**)	25,125,000	24,100,000	24,740,000	**73,965,000**	**91%**	**66,586,000**	**90%**

(**) Including any partial or total roll-over into Phase 2 of undisbursed Phase 1 amounts.

1. Does the Phase 2 budget include a material amount of un-disbursed Phase 1 funds?

☐ Yes ☒ No

If yes, please explain how the CCM anticipates that these extra funds will be absorbed in Phase 2 (e.g. increased scope of activities, increased targets, activities initially planned during Phase 1 to be undertaken in Phase 2, unanticipated increases in program costs, etc).

Undisbursed Phase 1 funds will not be made available for Phase 2.

2. Is the budget within the permitted maximum?

☒ Yes ☐ No

3. Is the budget in line with:

3.1 Usage of funds in Phase 1?

☐ Yes ☒ No

Fund utilization by the program was low in Phase 1. Low fund utilization was due to the problems in making estimations at the program planning stage. The initial estimations for the quantity of ART drugs and test kits to be procured for the program were found to be much higher than utilization of these products by the program. Another factor for the lower utilization of funds has been the reduction in the cost of ART drugs and test kits in India that has led to a prices that are 20 times lower than those used as estimates at the planning stage.
The targets for Phase 2 have been scaled up substantially with increase in the targets of numbers of PPTCT centres to be set up and the numbers of HIV positive women that would receive ARV prophylaxis. The increased targets and the reasonable budget assumptions make the projection of the usage of funds reasonable.

3.2 Anticipated program realities for Phase 2?

☒ Yes ☐ No

The program environment for the implementation of the grant has improved with the establishment of partnerships, technical partners involvement and with the linkages established in the public health system. Political commitment is strong and partners commitment under NACPIII is now well established which will contribute to overall coordinated implementation of the national program. UNAIDS, CDC, and WHO are working closely with NACO to monitor the implementation. CCM has a Secretariat which will also monitor performance and report back to the CCM on quarterly basis. The program has shown accelerated implementation in the last 9 months with an achievement of results of over 80% of the target in 9 of the 13 indicators. In only one of the 13 indicators has achievement been low. The budget reflects the acceleration the program is anticipated to make in the Phase 2 period. Detailed implementation plan at NACO and SACS level also indicate preparedness for major scale up of the PPTCT centers. NACO has also instituted a regular review of program performance which is chaired by the Director General and other senior staff.

4. Do the budget and workplan show sufficient detail (including key budget assumptions)?

☒ Yes ☐ No

The detailed budget for Year 3 covers all the activities planned in the work plan. Work plans and budgets for Year 4 and 5 cover the scale up of the activities. The LFA has reviewed the work plan and budget for reasonableness and all budget assumptions have been revealed to the LFA. The budget assumptions have been revised based on the prevailing circumstances - existing rates, ground realities and the plan for implementation and the experience gained during the Phase 1 budgeting and implementation. The assumptions are reasonable.

5. Are there any other comments on the budget?

☐ Yes ☒ No

6. Please comment on any changes or proposed changes in implementation arrangements?

C. PROGRAM DESCRIPTION AND GOALS

1. Program Description Summary

The proposed program will scale up care and prevention interventions among pregnant women in six states with high HIV/AIDS prevalence. The states are: Andhra Pradesh, Karnataka, Tamil Nadu, Maharastra, Nagaland, and Manipur. These states have a population of 291 million people and where more than 7 million women give birth every year. An innovative partnership between the National AIDS Council and four private sector pharmaceutical institutions will improve access to anti-retroviral therapy. NACO will have close collaboration with the SACS and will develop strong public private partnerships. The need, absorptive capacity, feasibility and deficiency have been highlighted in the feasibility studies. The implementation will be decentralized to the SACS in respect of the technical, managerial and organizational infrastructure at State and district levels in order to ensure long term sustainability of PMTCT. The objectives of the program are - (1) To scale up prevention and care interventions among women of child-bearing age and their families through providing a package of primary prevention, family planning, voluntary counseling and confidential testing (VCT), ARV prophylaxis, and counseling on infant feeding. (2) To implement a comprehensive HIV/AIDS care package, including antiretroviral treatment for HIV-infected mothers, their infants and partners.(3) To enhance access to anti-retroviral therapy through public/private partnership.

A multi-sectoral, decentralized, phased and incremental approach has been adopted for this program. The PMTCT program activities will complement and reinforce those of the National AIDS Control Program Phase II (NACP II) and be integrated with RCH. Primary health clinics which are the peripheral units of district hospitals will also be involved. Private hospitals which have at least 100 beds and 1000 deliveries per year with the necessary infrastructure and staff will be invited to participate in the program. Partnerships with NGOs will extend the outreach to the community. Beginning with 125 institutions in 2004, 444 institutions, from all 35 States and Union Territories will participate in the project by 2009. The 81 medical colleges in high prevalence states will be upgraded to participate in the program to expand access to ART for mothers and their families.

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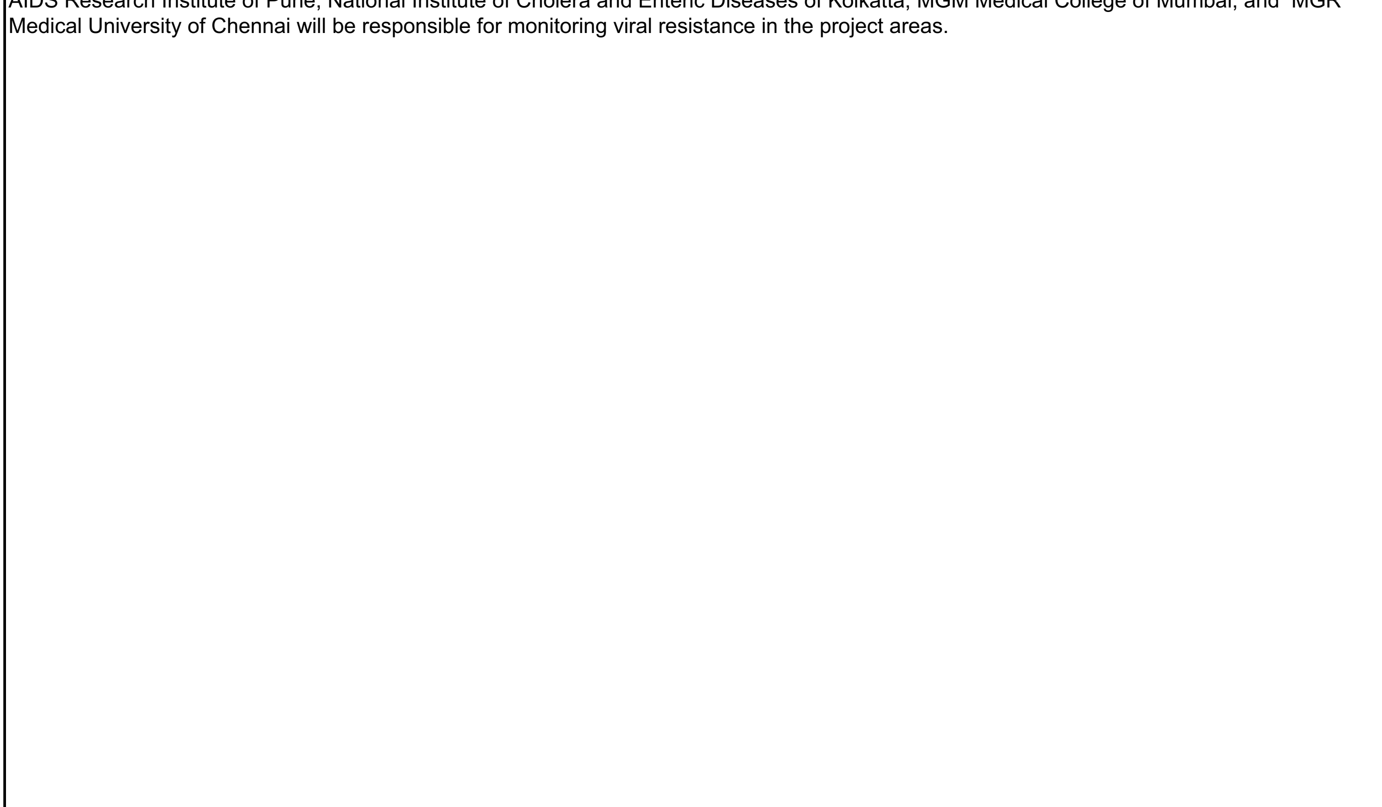
The AIDS Resource and Control Centre (ARCON), Mumbai, will be responsible for monitoring and evaluation of the NGO program. The National AIDS Research Institute of Pune, National Institute of Cholera and Enteric Diseases of Kolkatta, MGM Medical College of Mumbai, and MGR Medical University of Chennai will be responsible for monitoring viral resistance in the project areas.



Program Goals and Impact Indicators

Goal 1	To reduce the spread of HIV infection in women, their partners and infants, and to provide care including antiretroviral treatment	Baseline		Target				
		Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5
Impact Indicator	Prevalence of HIV infection in pregnant women	1.4%	2003					<1.0%
Impact Indicator	Mother to child transmission rate	30%	2003					10%

D. SUMMARY OF Y1-2 GRANT PERFORMANCE

1. Overall Grant Rating

B1. Adequate

This section contains the assessment of performance by service delivery area (SDA).

Each grant is structured into goals, objectives, and SDAs.

- Goals are broad and overarching and will typically reflect national disease program goals. The results achieved will usually be the result of collective action undertaken by a range of actors. Examples include “Reduced HIV-related mortality,” “Reduced burden of tuberculosis,” “Reduced transmission of malaria.”
- Objectives describe the intention of the programs for which funding is sought and provide a framework under which services are delivered. Examples linked to the goals listed above include “To improve survival rates in people with advanced HIV infection in four provinces,” “To reduce transmission of tuberculosis among prisoners in the ten largest prisons” or “To reduce malaria-related morbidity among pregnant women in seven rural districts.”
- SDAs describe the key services to be delivered to achieve objectives. The service delivery area is a defined service that is provided. Examples for the objectives listed above include “Antiretroviral treatment and monitoring for HIV/AIDS”, “Timely detection and quality treatment of cases for Tuberculosis,” or “Insecticide-treated nets for Malaria”. A standard list of service delivery areas agreed and used by international partners is contained in the Monitoring & Evaluation Toolkit.

The table below lists the objectives for this grant (numbered for easy reference and for linking with the SDAs). The “Goal Number” column indicates which goal each objective is linked to (goals are numbered on page 5).

Objective Number	Objective Description	Goal Number
1	To scale up prevention and care interventions among women of child bearing age for their families through a package of primary prevention, family planning, voluntary counselling and testing (VCT), ARV prophylaxis and counselling on infant feeding	
2	To implement a comprehensive package including ARV treatment of HIV infected infants and partners in six states with high HIV prevalence	1
3	To enhance access to ARV therapy through public private partnerships in 4 metropolitan cities	1

2. Service Delivery Area (SDA) Ratings

As stated, Service Delivery Areas (SDAs) are linked to an Objective (the 1st column on the left contains the objective number). Some SDAs may appear under different Objectives.

SDAs are typically measured through coverage indicators, categorized into three levels: *Level 3, people reached*; *Level 2, service points supported;* and *Level 1, people trained* (the 3rd, 4th and 5th columns display the number of indicators per level that have been assessed for the SDA indicated).

Based on results achieved against targets for each indicator, SDAs are given a rating: A= *Expected or exceeding expectations; B1= Adequate; B2= Inadequate but potential demonstrated; C=Unacceptable* (the 6th column contains the SDA rating and the 7th contains the rating's justification).

Objective	Service Delivery Area	Level 3	Level 2	Level 1	Rating	Evaluation of Performance (at the SDA Level)
1	PMTCT	1	1	1	B1	Results are good compared to targets but as they were easily surpassed this suggests that there is a great need for more services and that the capacity to meet that need exists. Targets must be made more ambitious for the future.
1	VCT	0	0	1	B1	Target exceeded, indicating that capacity to do much more already exists and should be pushed forward.
2	Antiretroviral treatment and monitoring treatment	1	1	1	B1	Good results, but significant overachievement suggest that the need, the demand and the capacity is in place to set and achieve much more ambitious targets in the future.
3	Coordination and partnership development	2	3	1	B1	Performance in 4 of the 6 indicators is good. Training of the health workers was low due to initial problems with the NGO Consortium, these have been resolved and the Phase 1 targets will be met by the end of Phase 1. The number of PLWHA receiving ARV from the private sector was low because of delays in the procurement of the CD4 machines. Procurement is now underway and the targets are expected to be achieved by the end of Phase 1.

Level 1: No. of people trained indicators.
Level 2: No. of service points supported indicators.
Level 3: No. of people reached indicators.

3. Indicator level Performance

The numbers to the left of the indicators refer to their coverage level: Level 3, people reached; Level 2, service points supported; and Level 1, people trained.

These early grants typically reported on a quarterly basis, so each period usually represents one quarter. Therefore, results reported in Period 6 are typically from month 18 of the grant term and are the most recent results available.

Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results

		Period	Target	Actual	Percent of Target	Percent of Target (0 – 190 – 380 – 570 – 760 – 950)
Objective 1	**To scale up prevention and care interventions among women of child bearing age and for their families through a package of primary prevention, family planning, voluntary counseling and confidential testing (VCT), ARV prophylaxis and counseling on infant feeding.**					
Service Delivery Area 1	**PMTCT**					
1	No. of staff trained in MTCT prevention	Period 6	6000	3831	64	64 %
2	No. of health facilities offering minimum package of PMTCT (incl. HIV prevention services, VCT, ARV prophylaxis to pregnant mothers, STI treatment, condom distribution, linkages for treatment of OIs)	Period 6	225	306	136	136 %
3	No. and percentage of HIV infected pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	Period 6	5264	5807	110.32	110.32 %
Service Delivery Area 2	**VCT**					
1	No. of counselors and lab technicians trained on VCT	Period 6	450	612	136	136 %
Objective 2	**To implement a comprehensive HIV/AIDS care package including ARV treatment of HIV infected infants and partners in six states with high HIV prevalence.**					
Service Delivery Area 3	**Antiretroviral treatment and monitoring**					
1	No. of service providers trained in HIV/AIDS management	Period 6	1600	2321	145	145 %
2	No. of health facilities providing comprehensive package of PMTCT, care and Antiretroviral therapy and laboratories	Period 6	9	7	78	78 %
3	No. of HIV positive mothers, their partners and children on ART	Period 6	400	3783	946	946 %

Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results		Period	Target	Actual	Percent of Target	Percent of Target (0 – 190 – 380 – 570 – 760 – 950)
Objective 3	**To enhance access to ARV therapy through public private partnerships in 4 metropolitan cities**					
Service Delivery Area 4	**Coordination and partnership development**					
2	No. of partnerships established with pharmaceutical companies	Period 6	4	4	100	100 %
1	No. of health care workers trained in appropriate use of ARV therapy	Period 6	1300	560	43	43 %
2	No. of project sites providing quality VCT services	Period 6	18	29	161	161 %
2	No. of NGOs (linked to the health facilities providing ARTs) involved in providing quality HIV/AIDS care and support services to PLWHA	Period 6	45	57	127	127 %
3	No. of PLWHA receiving ART through the four selected private hospitals including regular CD 4 monitoring (incl. Number of patients	Period 6	4500	3937	87	87 %
3	Number of PLWHA receiving ARV from private sector being monitored at project sites through subsidized CD4 count machines.	Period 6	1000	4	0	0 %

4. Disbursement History

***Note: In the absence of previous agreements, and noting in the future we will have agreed amounts and dates for disbursement, we have created an expected amount.**
The Expected Amount is calculated by subtracting the first disbursement from the 2 year approved budget and spreading the remaining portion evenly over 6 additional disbursement. The Expected Date is calculated by assuming that quarterly updates and disbursement requests are due within 45 days after completion of each quarter.

Expected vs. Actual Disbursements

	Date		Amount		Cumulative	
	Expected	Actual	Expected *	Actual	Expected	Actual
1	26-Apr-2004	26-Apr-2004	2859000	2859000	2859000	2859000
2	15-Sep-2004	21-Dec-2004	3876167	1907000	6735167	4766000
3	16-Dec-2004	26-Aug-2005	3876167	3535000	10611334	8301000
4	18-Mar-2005	--	3876167	0	14487501	8301000
5	15-Jun-2005	--	3876167	0	18363668	8301000
6	15-Sep-2005	--	3876167	0	22239835	8301000
7	16-Dec-2005	--	3876167	0	26116002	8301000

Expected vs. Actual Disbursements

Millions

$50	
$45	
$40	
$35	
$30	
$25	
$20	
$15	
$10	
$5	
$0	

Apr 2004 | Jun 2004 | Aug 2004 | Oct 2004 | Dec 2004 | Feb 2005 | Apr 2005 | Jun 2005 | Aug 2005 | Oct 2005 | Dec 2005 | Feb 2006

Actual Cumulative
Expected Cumulative

5. Estimated under-disbursement in Phase 1

Estimated under-disbursement in Phase 1	Amount (in USD)	Amount (in %)
Phase 1 grant agreement amount	26,116,000	100 %
Less: actual disbursed to date	8,301,000	32 %
Less: expected additional disbursement until the end of Phase 1 grant agreement	10,436,000	40 %
Expected undisbursed amount at the end of Phase 1	7,379,000	28 %

1. How many months of the program lifetime are covered by the actual disbursements to date, including buffer period (e.g., 18 months, 21 months, 24 months, etc)?

18 months

2. Are actual disbursements to date significantly behind original disbursement schedules?

If yes, please comment:

☒ Yes ☐ No

Fund utilization by the program was 43.7% up to 31 March 2005. Low fund utilization was also due to the problems in making estimations at the program planning stage. The initial estimations for the quantity of ART drugs and test kits to be procured for the program were found to be much higher than utilization of these products by the program. Another factor for the lower utilization of funds has been the reduction in the cost of ART drugs and test kits in India that has led to a prices that are 20 times lower than those used as estimates at the planning stage.

3. Do the expected additional disbursements until the end of Phase 1 appear to be high compared to amounts previously disbursed?

If yes, please comment:

☒ Yes ☐ No

The expected additional disbursements are planned to cover procurement expenses of Q5-8 ($5m), reimburse the PR for the funds disbursed to SRs ($1.016m) and program expenses of Q6-8 ($4.5 m).

4. Is it anticipated that there will be undisbursed funds of a material amount at the end of the Phase 1 period?

If yes, please explain why and provide other relevant comments, inf any:

☒ Yes ☐ No

The undisbursed amount is mostly due to savings realized in Phase 1. These savings were to due a number of reasons, key among them were: (i) that some of the expenditures incurred by states were charged to other GOI or WB funded accounts and these could not be reversed because the national audit was completed; (ii) under utilization of funds by NGOs due lack of coordination; (iii) sufficient number of NGOs were not identified to be assigned to the PPTCT centers; (iv) competitive drug procurement resulted in lower prices; (v)actual number of patients receiving HIV rapid test was lower than budgeted number (vi) payment to trainers done at GOI rate as opposed to WHO rate; (vii) ART used from state budgets; and (viii) operations research were not conducted but now budgeted in Phase 2.

6. Expenditures and Cash Balance

Principal Recipient Cash Balance	Amount (in USD)	Amount (in %)	Date
Actual disbursed to date by the Global Fund (to PR)	8,301,000	100 %	30-Sep-05
Less: Direct payments for PR Expenditures	0	0 %	
Less: PR disbursements to sub-recipients	9,317,000	112 %	
PR cash-balance	-1,016,000	-12 %	30-Sep-05

1. Are there any significant PR commitments to date that will be expended during the current or the next reporting period?

If yes, please give detailed comments:

☐ Yes ☒ No

The existing cash balance is negative due to the fact that the program implementation was substantially accelerated in the past few months and the PR disbursed the Government of India funds to sustain the pace of implementation. This amount is expected to be compensated in the next disbursement to the PR.

2. Is the PR cash-balance of a material amount (relative to disbursements received from the Global Fund)?

If yes, please explain why and provide other relevant comments, if any: (e.g., if disbursements received from the Global Fund cover a period beyond the expenditure period, unpaid commitments, implementation delays, etc)

☐ Yes ☒ No

The cash balance is negative.

E. CONTEXTUAL CONSIDERATIONS

1. Have there been significant adverse external influences (force majeur)?

☐ Yes ☒ No

1.1. If yes, have they been (or are they being) alleviated?

☐ Yes ☐ No

2. Are there any unresolvable internal issues?

☐ Yes ☒ No

The CCM India consists of a cross section of stakeholders. The CCM reform process is in an advanced stage. WHO has funded a CCM Secretariat with two professional staff and two assistants. These two staff members also facilitate the work of the India Board members.

The Secretariat has worked to prepare guidelines to mitigate against conflict of interest, to seek better representation, on the organization of meetings and on communication with members and other stakeholders.

The CCM has created a new position of Vice Chairperson of the CCM and the President of the India Network of Positive People a NGO has been elected to this post. A detailed update from the CCM received on 29 November 2005 indicates that the CCM has met GF requirements and is fully functional.

3. Are there financial and program management issues (e.g., slow or incomplete disbursements to sub-recipients or issues with the PR)?

☐ Yes ☒ No

Financial management and fund flow mechanisms at the Principal Recipient is satisfactory and in accordance with approved financial norms, and the sub-recipients have received funds as soon as they were received from the Global Fund.
However the utilization of funds by the program was 43.7% up to 31 March 2005. There are reasons for the low fund utilization and include the lower cost of product procurement, incorrect estimations made at the program planning stage of the need for products, and the difficulties of identifying NGOs and PHLA groups to support each of the PPTC and ART centres. All these reasons have led to savings.
In addition the cost of products purchases by the Sate AIDS Control Societies (SACs) - HIV test kits, ART, reagents for the CD4 machines had been booked to the advanced funds placed by NACO with the SACs, for the program, but had not yet been reflected as program expenditure. The issue is being resolved by the concerned SACs and NACO.

4. Are there any systemic weaknesses in:

4.1. Monitoring and evaluation? ☒ Yes ☐ No

The indicators being used are relevant and appropriate for measuring program coverage, implementation and for measuring impact. Plans are in place for data collection. It is necessary to ensure that qualified M&E officers are recruited in the three states where the recruitment has not been completed. There is a need to carry out special studies and research details of patient profiles - their socio-economic background, etc to gain a better understanding o the disease prevalence and patterns for refining program implementation strategies. A system of independent data validation through external agencies would be useful for monitoring the program. District level data analysis will assist service delivery teams at the district level evaluate their performance against targets.
The CMIS was developed under NACPII. The CMIS is supplemented by the concurrent evaluation of the on going programs. A national level Monitoring and Evaluation Agency will be selected under NACPIII to conduct independent evaluation of project activities. The M&E agency will be responsible for collection of baseline data, annual evaluation, strengthening CMIS, and training state level officials. Each SACS will have one M&E officer, one statistical officer, and two statistical assistants in the M&E unit. Some of these staff are already in place. Behavioral Surveillance surveys(BSS) and Surveys of Health care providers on SYD case management(HCPS) will be carried out at the state level. Evaluation of the medium and long term effects of programs on beneficiaries will also be carried out under NACPIII. NACO and WHO have completed a national process for M&E for ART roll-out in India.

4.2. Procurement and Supply Chain Management? ☐ Yes ☒ No

Government of India procedures for procurement, indenting and stock management are being followed. World bank guidelines are followed to ensure compliance with international standards, quality and competitive process.
Specifications on all products, health and non health, are described in the NACO website. NACO follows GF quality assurance guidelines for procurement of health product and ensures a competitive selection process. Payments for GF funded health product procurement is as per GF guidelines and QA policy.

4.3. Any other areas? ☐ Yes ☒ No

There is a need for the program to place an emphasis on partner tracing, counselling and contact.

There is a need for district level health managers to be involved in validating data that is being reported, and for taking actions at the district level to achieve program targets.

Drop-in centres have been identified as a good support interventions in HIV/AIDS programs and it would be useful for this program to examine the usefulness of this intervention.

Confidentiality of patients accessing services need to be ensured; and linkages of referral systems need to be clearly established and documented.

5. Are there any material issues concerning quality or validity of data? ☒ Yes ☐ No

A system is in place for the flow of information. All data on program performance including on treatment, staff positions and drugs and equipment is compiled by NACO. A monthly report is published by the Central Information Management System (CMIS) at NACO. Technical assistance is provided by UNAIDS for validating data and data management.

However, quality of data should be upgraded and independent quality assurance teams should monitor quality. District Health Officers could be involved at the service delivery points to check the reliability of data that is reported. These recommendations are part of NACPIII and will be implemented as part of the national program.

6. Are there major changes in the program-supporting environment (e.g., recent initiation of capacity strengthening, support of implementation by technical partners)? ☒ Yes ☐ No

The changes in the nature of the HIV/AIDS epidemic has seen a commitment from the Government of India that has been endorsed at the highest level. The National AIDS Council has been constituted under the chairmanship of the Prime Minister. Convergence with the Reproductive and Child Health Program (RCH) and the National Rural Health Mission (NRHM) has been established for the the program to the district and sub-district level and for increasing the coverage of services for women receiving antenatal care.

Several partnerships are established for the implementation of the HIV/AIDS programs in India especially for the provision of PPTCT. UNICEF is providing technical assistance for PPTCT implementation at the state level and providing consultants at the national level. UNICEF is also providing Neverapine free of cost to support this program. The WHO and UNAIDS also provide technical assistance at the national level. The World Bank, The Gates Foundation and AusAID are also providing financial assistance. The William J Clinton Foundation is collaborating in the development and implementation of a comprehensive plan for scaling up the prevention of HIV/AIDS and care, support and treatment for people living with AIDS in India.

Partnerships are also being established with private pharmaceutical companies for the HIV/AIDS program - Ranbaxy, Emcure and Cipla.

7. Has the program demonstrated significant improvements in implementation over the last 6 months?

☐ Yes ☒ No

The program has shown significant improvements in the last nine months.306 health facilities in six states offer PMTCT. 5807pregnant women have received ARV prophylaxis, 612 counselors and lab technicians have been trained on VCT and 2321 service providers have been trained in HIV/AIDS management. 560 health workers have been trained in the use of ARV therapy through the public private partnership. 3783 HIV positive mothers, their partners and children have been put on ART in addition 3937 PHLWA are receiving ART through the four private hospitals. partnerships have been established with 4 pharmaceutical companies. 29 project sites are providing VCT services. 57 NGO are involved in providing care and support.

8. Have there been any changes in disease trends?

☒ Yes ☐ No

At the time of the submission of the proposal, the HIV epidemic was confined to the urban areas and the high risk groups. There has been a change in the characteristics of the epidemic with HIV spreading to the general population, and from the urban to the rural populations, with women forming 29.24% of all reported AIDS cases and youth becoming increasing vulnerable to the disease.

India has an estimated 5.13 million HIV/AIDS cases and is the country with the second highest HIV/AIDS disease burden in the world. The estimated prevalence rate in the adult population is 0.92%.

9. Is there information that would indicate that the program was not advancing the Global Fund's operating principles to:

9.1. Promote broad and inclusive partnerships?

☐ Yes ☒ No

The program has established partnerships with the NGOs and the private sector.
The development partners of the HIV/AIDS program are detailed below (9.3). Other technical partners of the program include the National AIDS Research Institute (NARI) and the Technical Resource Groups. Partnerships are also being established with private pharmaceutical companies - Ranbaxy, Emcure and Cipla by the HIV/AIS program in India. The State AIDS Controls Societies (SACS) have broad representation from various government ministries, private sector and NGOs. At the state level, an empowerment committee has also been constituted by the states either under the chairmanship of chief secretary or additional chief secretary to make policy decisions for implementation of HIV/AIDS program. NACO collaborates with private sector organizations such as CII, FICCI and ASSOCHAM. It also partners with networks of positive people, NGOs, elected representatives, women's groups, self-help groups, and community-based organizations.

9.2. Promote sustainability and national ownership through use of existing systems and linkages with related strategies and programs?

☐ Yes ☒ No

The GF program is implemented by NACO that is the nodal agency for implementation of HIV/AIDS programs in India and by the States AIDS Control (SACS) organizations in the six states respectively in addition to the NGO Consortium.

The Government of India has put in place arrangements to integrate PPTCT interventions within its public health delivery system and will not develop a parallel infrastructure, linkages that have been established with other health programs, notably the National Rural Health Mission and the Reproductive and Child Health Program, that will allow the integration of HIV/AIDS services at the district and sub-district level.

The Government has also made efforts to decentralize services to the NGO and private-sector for long-term sustainability.

9.3. Provide additional resources?

☐ Yes ☒ No

UNICEF, WHO, UNAIDS, the World Bank, DfID, The Gates Foundation, USAID,AusAID and the William J Clinton Foundation provide technical and financial resources to the HIV/AIDS programs. Under NACPIII, World Bank and other donors are expected to provide approximately $350million over five years.

In view of the importance given to the control and treatment of HIV/AIDS, the Government of India treats GFATM assistance as an addition to the funds committed by the Government to HIV/AIDS control and treatment.

10. Are there any synergies between this grant and other Global Fund financed programs (e.g., grants to be signed, other on-going grants, etc)?

☐ Yes ☐ No

PPTCT program will establish a strong base for service delivery. Such capacity building and partnership will contribute to scaling up of ART proposed under round 4 grant. Round 3 grant will coordinate collaboration between SACS and State B Societies and facilitate referrals of HIV+ cases to treatment centers to be funded under round 4 grant.