General Grant Information

Applicant:	Country Coordinating Mechanism - India
Country:	India
Round:	2
Component:	Tuberculosis
Grant Title:	Expansion of the Revised National Tuberculosis Control Program to the "uncovered" 110 million population of Bihar and Uttar Pradesh and strengthening of DOTS in four urban areas
Grant Number:	IDA-202-G03-T-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)	29,110,000
2-Year Budget: (USD)	7,080,000
Disbursed to Date: (USD)	3,731,000
Signature Date:	12-Feb-04
Program Start Date:	01-Apr-2004

A. SECRETARIAT PHASE 2 RECOMMENDATION

Phase 2 Recommendation Category: Conditional Go

Incremental Phase 2 Amount Recommended for Board Approval (USD): * 22,020,000

Euro Equivalency :

Rationale for Recommendations:

The Secretariat classifies this renewal Request as a “Conditional Go”.

Program performance:
This grant is part of a well performing national Program, but has significant weaknesses. Despite building significant capacity, the Program has only achieved 36% of the DOTS detection target and has demonstrated further weakness in failing to involving NGOs and private practitioners in the national program, achieving only 9% of the set target for such involvement. However, there has been a recent acceleration of capacity building activities that should facilitate improved programmatic delivery in Phase 2. For example:
• 1,144 microscopy centres have been established and supported (114% of target);
• 2,967 medical professionals have been trained in (117% of target);
• 222 health facilities have been established and supported (111% of target); and
• 1,198 private practitioners have been trained through workshops and seminars (142% of target).

Treatment activities have demonstrated mixed performance. For example, treatment indicators in slum areas have met all the planned targets whereas people reached with treatment in other reported districts achieved only 35% of the set target. Efforts should therefore be made early in Phase 2 to harmonize the success of both treatment service delivery areas (SDAs) in all geographic regions covered under the Program. Further to this, the Secretariat shall require, as a condition to continued funding beyond the first two quarters of Phase 2, that the Principal Recipient (PR) demonstrate that it has caught-up with all higher-level DOTS coverage and detection targets within the first 6 months of Phase 2.

Program management and governance:
Overall, the PR, the Department of Economic Affairs of the Government of India, has demonstrated satisfactory management of the grant to date. The grant activities are focused on two of the most underdeveloped states in India, Bihar and Uttar Pradesh. Both states lack infrastructure and human resource capacity in their districts, have poor communication networks and have suffered flooding problems in several districts during the Phase 1 period. Added to this, democratic elections in the state of Bihar have impacted on the effective implementation of RNTCP. Nevertheless, despite these adverse ground conditions, programmatic achievement has improved significantly, particularly in the last 6 months and management structures continue to strengthen.

The PR has an effective system in place to disburse funds to sub-recipients (SRs) that has ensured the smooth implementation of most activities. Data quality has been satisfactory with WHO field support in all districts. However, marginal gaps in terms of financial data collection have been identified.

The CCM has a strong and broad multi-sectoral representation and has been actively engaged in grant oversight since Program start.

The Secretariat classifies this Request as a “Conditional Go”. In Phase 2, the PR should prioritize efforts on catching up with DOTS coverage and detection targets.

*** 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:

The Secretariat is recommending that the Board approve funding for Phase 2 of this grant at an amount higher than the maximum Phase 2 amount available as determined by the Board in its general decisions on Phase 2 funding. The Board has previously set the maximum that could be requested in a CCM Request for Continued Funding to be the amount approved in the original proposal for the full proposal period, less any budget reductions arising from TRP clarifications or budget negotiations, less the amount disbursed by the Global Fund to the PR at the end of the Phase 1 term.

In this case, Phase 1 saw a substantial budget reduction for the Phase 1 term. The initial amount approved by the Board was US$12.76 million, though this was reduced to US$7.08 million in the Phase 1 grant agreement. Under the Board policy of capping maximum amount available for Phase 2 funding at the Proposal amount less any budget reductions realized through TRP clarifications or negotiations, the US$5.68 million is not available for Phase 2 of the program. Under this rule, the maximum amount available for this grant would be US$16.34 million. However, the Secretariat believes that it is appropriate to take the exceptional step to request that the Board add the previously negotiated reduction amount back to the grant given (1) the PR's ability to effectively use the additional funds and (2) the PR's initial understanding that these funds would be available for Phase 2 of the program. This would increase the maximum available funds from US$16.34 million to US$22.02 million.

To date, the Global Fund has disbursed US$3,731,000 (53% of funds available for Phase 1) to the PR. Of these funds, the PR has spent US$1,743,511 and disbursed US$1,643,267 to SRs. The overall expenditure rate at month 19 was approximately 55% in 79% of the time elapsed, putting the Program behind schedule. However, previous implementation delays have been overcome and expenditure rates have increased significantly over the past 6 months. This indicates that the Program has the potential to absorb the full Phase 1 amount within the two-year period. However, if any Phase 1 funds remain undisbursed, these funds will not be made available for use during Phase 2 and will subsequently be reduced from the maximum Phase 2 amount available.

In light of accelerated implementation over the last 2 quarters and the subsequent improvements in programmatic delivery, the Secretariat concludes that a Phase 2 amount of US$22,020,000 is appropriate for continued funding. As there are no surplus Phase 1 funds available to partially fund this amount, the Secretariat recommends to the Board to commit the amount of US$22,020,000 for this Program.

Suggested Remedial Actions

Issues	Description of Suggested Remedial Actions
1. Strengthen M&E at CTD (Central TB Department) and in the two states improve quality monitoring and timely data collection.	1a. By Q10, recruit a full time M&E officer and strengthen M&E training at the state level with district TB officials; develop training plan to ensure intensive training on M&E and annual action plan development. 1b. Provide an M&E budget breakdown on grant signing
2. The PR needs to improve partnership with the NGOs and the private sector.	2a. By Q10, the PR needs to organize training for state-level officials about the importance of private sector participation and include in its monitoring a plan to track state-level performance. 2b. Provide a strategy and workplan to catch-up on NGO and private health providers on grant signing and provide evidence of results achieved within 6 months.
3. PR needs to improve District-level capacity building for accelerated implementation.	3. By Q10, the PR needs to develop a system of quality assurance about SR capacity building and performance monitoring, and also ensure timely recruitment of staff.
4. Strengthen financial management at the SR level - Uttar Pradesh and Bihar.	4. By Q10, initiate intensive training for the newly recruited finance staff and ensure proper financial management including timely recording and reporting, standard fixed asset maintenance and verification, and timely preparation of Statement of Expenditures (SOE).
5. DOTS coverage and detection results behind schedule.	5. Catch-up on DOTS coverage and detection targets by 2nd Phase 2 disbursement (6 months).
6. DOTS detection targets should be increased in Phase 2.	6. Prior to Phase 2 grant signing, increase the targets for DOTS detection rates.
7. CCM compliance as per 9th Board decision.	7. Prior to Phase 2 grant signature, the CCM shall provide 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.
8. Undisbursed Phase 1 funds.	8. Any undisbursed Phase 1 funds as of the Program End Date will not be made available for use during Phase 2, and the amount of funds approved for Phase 2 will be correspondingly reduced.

B. PHASE 2 BUDGET AND IMPLEMENTATION ARRANGEMENTS

1. Estimated funds available for Phase 2

	Total	Year 3	Year 4	Year 5
Original Phase 2 Adjusted Proposal Amount (*)	16,340,000	5,530,000	5,370,000	5,440,000
Expected undisbursed amount at the end of Phase 1	0			
Estimated Maximum Phase 2 Amount	16,340,000			

(*) 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 (**)	6,265,403	7,773,611	7,983,917	22,022,931	135%	22,022,931	135%
Global Fund Recommendation (**)	6,265,403	7,773,611	7,980,986	22,020,000	135%	22,020,000	135%

(**) 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).

2. Is the budget within the permitted maximum?

☐ Yes ☒ No

See Rationale for Recommended Amount on page 3 above.

3. Is the budget in line with:

3.1 Usage of funds in Phase 1? ☒ Yes ☐ No

The actual expenditure of the PR has exceeded the budgeted amount as the preparatory activities in the districts covered under the program were completed ahead of schedule as compared to the original plan.

3.2 Anticipated program realities for Phase 2? ☒ Yes ☐ No

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 workplan. The key assumptions of the budget were disclosed to the LFA, although to strengthen the robustness of the assumptions it is recommended to periodically assess the validity of the assumptions since the current cost data used by the PR for estimating the expenditures refer to 2002 costing framework.

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

Over the past four years, the Revised National TB Control Program (RNTCP) has expanded rapidly in coverage, from 18 million people in 1997 to about 650 million by May 2003. The RNTCP is expected to cover the entire country by 2005. The proposed program will assist the national DOTS program expansion by covering an additional 110 million people in fifty six districts in two States, Bihar and Uttar Pradesh. It will also strengthen the urban TB control services in slum areas by establishing 'patient-friendly' TB control programs by NGOs, in 4 major cities in India- Mumbai, Hyderabad, Indore and Varanasi. The program will seek to achieve at least 85% treatment success and 70% detection of new smear positive cases. Approximately, 600,000 TB patients will receive treatment. Capacity building of District TB Control Cells and sub-district service centers will be key focus of the program. Lessons learned from existing TB programs in other states will be used to design interventions to ensure greater private practitioners participation. Binocular microscopes (BM) and anti-TB drugs will be procured by the Central TB Department and distributed to the states. RNTCP is implemented by Central TB Department.

Main objectives are:
1. To expand RNTCP to the "uncovered" population of 110 million in 56 districts of the States of Bihar and Uttar Pradesh to ensure nationwide coverage by 2005.
2. To achieve at least 85% successful outcome of treatment amongst registered new smear positive pulmonary TB cases.
3. To achieve a case detection rate of at least 70% of the estimated new smear positive pulmonary TB cases.
4. To establish model "Urban TB Control Projects" in 4 major cities of India by improving the quality and reach of RNTCP to special groups like slum dwellers and migrants, through "friendly" treatment observation, involvement of private and NGO sectors and IEC.

Expected Results for the five years:
-More than 600,000 TB patients provided DOTS treatment
-About 108,000 lives saved
-Over 1,200,000 individuals spared from becoming infected with TB
-The community at large having access to free and uninterrupted high quality diagnostic and curative TB services.

Program Goals and Impact Indicators

			Baseline		Target				
Goal 1	To achieve by 2005, nationwide coverage under RNCTP with DOTS strategy which focuses on establishing sustainable technical, managerial and organizational Infrastructure. The project will continue to seek to achieve at least 85% treatment success and at least 70% detection of new smear positive cases in order to reduce morbidity, mortality and disability due to tuberculosis, so that TB ceases to be a significant public health problem.		Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5
Impact Indicator	Population coverage under RNTCP in the entire country		600 million	2003					(>1,027 million)
Impact Indicator	Proportion of smear-positive TB cases registered under DOTS successfully treated		84%	2001					>85%
Impact Indicator	Proportion of all estimated new smear-positive TB cases (existing in the entire country) detected and put on under DOTS		35%	2001					>70%
Impact Indicator	Proportion of all treatment units implementing DOTS in line with standard criteria for effective implementation		60%	2003					100%

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 expand RNTCP to the uncovered population of 110 million in 56 districts of the states of Bihar and Uttar Pradesh and to achieve at least 85% successful outcome of treatment amongst the registered new smear positive pulmonary cases and detect at least 70% of such estimated cases.	1
2	To establish model 'urban TB control projects' in 4 major cities of India by improving the quality and reach of RNTCP to special groups like slum dwellers and migrants, through more patient-friendly treatment observation, involvement of private and NGO sectors and IEC	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	Prevention: Identification of Infectious Cases	1	1	1	B1	Late start up of activities but steadily increasing. Good performance on capacity building and facilities support.
1	Treatment: Timely detection and quality treatment of cases	2	2	0	B2	Late start, steady increase of enrolment in DOTS. No results yet for treatment success. Poor engagement of private sector and NGOs.
2	Supportive Environment: Coordination and partnership development (national, community, public-private)	0	1	2	B1	Identification of NGO partners took time due to lack of good NGOs. Implementation accelerated in Q6 and will continue in Q7 and Q8. Engagement of clinicians lagging behind.
2	Prevention: Behavioral Change Communication - Community Outreach	1	0	0	B1	Gross overachievement of target suggests weak target setting.
2	Treatment: Timely detection and quality treatment of cases	3	0	0	A	Strong result for this critically important SDA.

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

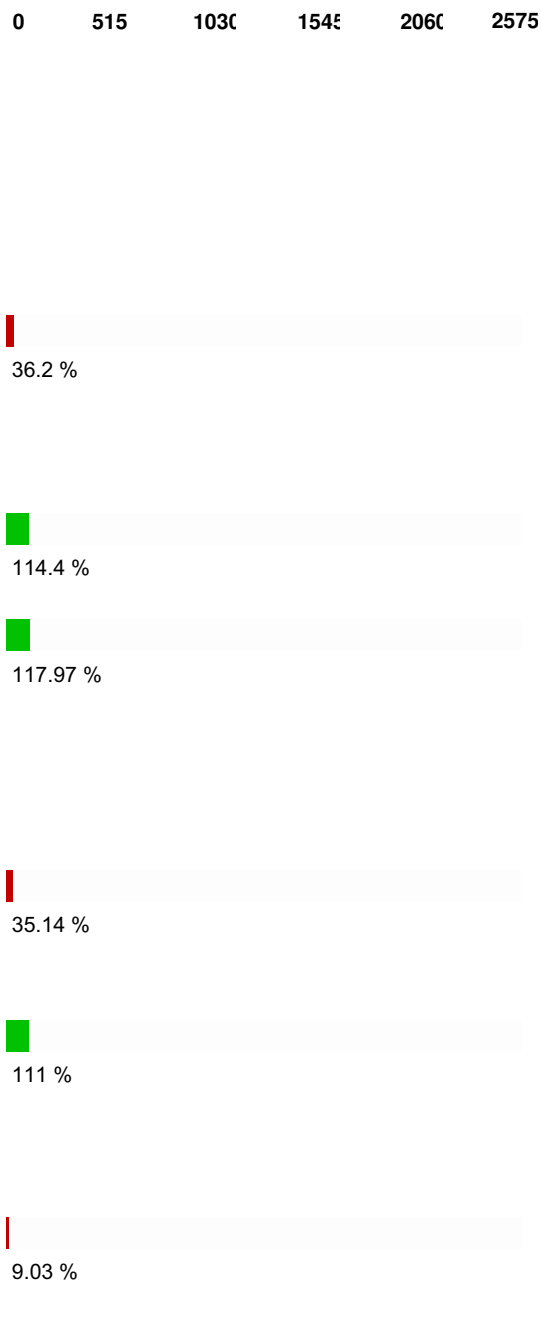
3. Indicator level Performance

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.

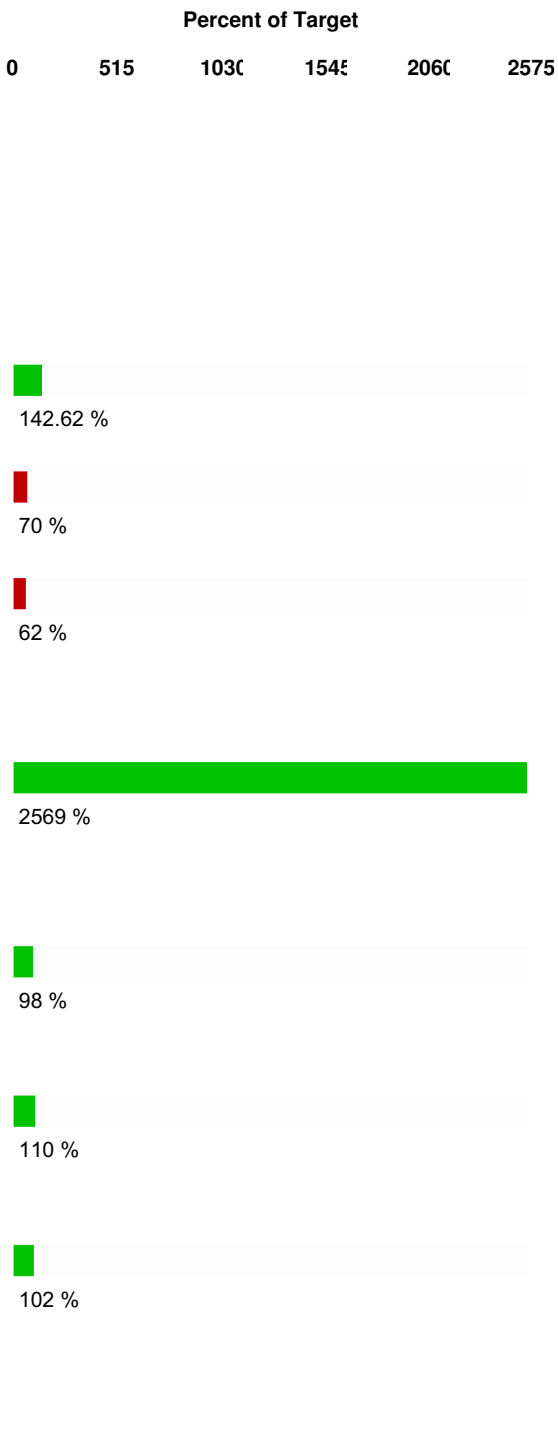
These early grants typically reported on a quarterly basis, so each period usually represents one quarter. Therefore, results reported in Period 6 are typically from month 18 of the grant term and are the most recent results available.

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

		Period	Target	Actual	Percent of Target
Objective 1	**To expand RNTCP to the uncovered population of 110 million in 56 districts of the states of Bihar and Uttar Pradesh and to achieve at least 85% successful outcome of treatment amongst the registered new smear positive pulmonary cases and detect at least 70% of such estimated cases.**				
Service Delivery Area 1	**Prevention: Identification of Infectious Cases**				
3	Number of new smear positive cases detected and put on treatment among the total estimated number of new smear positive TB cases per year in the areas covered under DOTS	Period 6	28737	10404	36.2
2	Number of microscopy centers established and supported	Period 6	1000	1144	114.4
1	Number of District TB Officers, Medical Officer-TB Control, Senior Treatment Supervisors, Senior TB Lab Supervisor, lab technicians trained in RNTCP	Period 6	2515	2967	117.97
Service Delivery Area 2	**Treatment: Timely detection and quality treatment of cases**				
3	Total number of patients put on DOTS (in 42 and 56 districts in the first and second half of the year respectively)	Period 6	76600	26917	35.14
2	Number of health facilities (TU-Tuberculosis Unit stocking drugs and providing supervision for DOT services to a population of 250,000 to 500,000) established and supported.	Period 6	200	222	111
2	Number of NGOs and private health providers involved in Revised National Tuberculosis Control Program (RNTCP).	Period 6	775	70	9.03



Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results						
		Period	Target	Actual	Percent of Target	
Objective 2	**To establish model 'urban TB control projects' in 4 major cities of India by improving the quality and reach of RNTCP to special groups like slum dwellers and migrants, through more patient-friendly treatment observation, involvement of private and NGO sectors and IEC**					
Service Delivery Area 3	**Supportive Environment: Coordination and partnership development (national, community, public-private)**					
1	Number of private practitioners trained through workshops/ seminars	Period 6	840	1198	142.62	
1	Number of Laboratory technicians trained (Private Sector and NGO)	Period 6	86	60	70	
2	Number of private health facilities participating in the RNTCP as DOT Centres in the four cities.	Period 6	29	18	62	
Service Delivery Area 4	**Prevention: Behavioral Change Communication - Community Outreach**					
3	Number of people reached through community meetings	Period 6	400	10275	2569	
Service Delivery Area 5	**Treatment: Timely detection and quality treatment of cases**					
3	Number of new smear positive TB cases detected and put on treatment, in entire 4 districts where the NGOs are working in selected urban slum	Period 6	6576	6476	98	
3	Total number of TB patients put on treatment under DOTS in entire 4 districts where the NGOs are working in selected urban slum	Period 6	17766	19512	110	
3	Number and percentage of new smear-positive TB cases registered under DOTS who are successfully treated	Period 6	5446/6406 85%	87%	102	



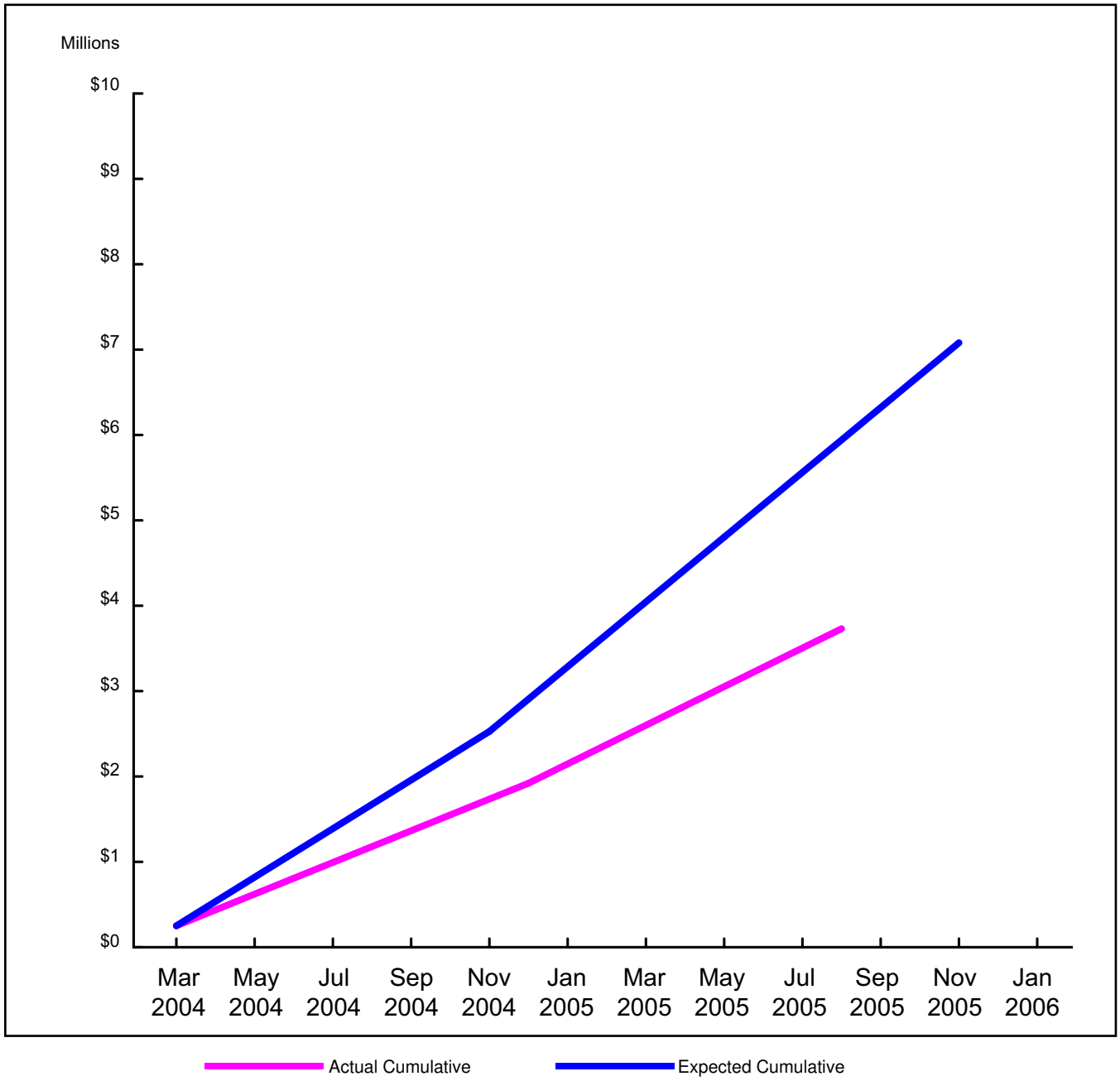
4. Disbursement History

***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-Mar-2004	26-Mar-2004	251000	251000	251000	251000
2	15-Nov-2004	17-Dec-2004	2276334	1670000	2527334	1921000
3	16-May-2005	31-Aug-2005	2276334	1810000	4803668	3731000
4	15-Nov-2005	--	2276332	0	7080000	3731000

Expected vs. Actual Disbursements



5. Estimated under-disbursement in Phase 1

Estimated under-disbursement in Phase 1	Amount (in USD)	Amount (in %)
Phase 1 grant agreement amount	7,080,000	100 %
Less: actual disbursed to date	3,731,000	53 %
Less: expected additional disbursement until the end of Phase 1 grant agreement	3,349,000	47 %
Expected undisbursed amount at the end of Phase 1	0	0 %

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

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

If yes, please comment: ☒ Yes ☐ No

As per the original disbursement schedule for Phase 1, the expected dates were March 2004, October 2004, May 2005 and October 2005 for USD 251,000, 2,276,334, 2,276,333 and 2,276,333 respectively. However, the actual disbursements were made only in April 2004, January 2005 and September 2005 for USD 251,000, 1,670,000 and 1,810,000 respectively. The delay in the disbursement schedule was primarily on account of implementation delay. However, as per the activity planned for the next few months till completion of Phase I and the corresponding expenditure pattern, the disbursement request number 4 would bring the expected disbursement at par with the actual disbursement.

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

Additional disbursements comprise 47% of the total Phase 1 grant amount. However, reports indicate that this amount will be expensed by the end of Q6. The current cash balance will partially cover for PR's and SR's Q5 expenses. Thus the USD 3,349,000 is the amount to be expensed over quarters 6, 7 and 8. Considering the accelerated pace of implementation of the last 6 months, the Secretariat believes that the program has the potential to absorb this amount. It is worth to note that the expenditure incurred by the PR (including sub-recipients) at the end of year 1 was in excess of approximately 29% of the budgeted amount which indicates PR's strong absorptive and distributive capacity. However, if any Phase 1 funds remain undisbursed, these funds will not be made available for use during Phase 2 and will subsequently be reduced from the maximum Phase 2 amount available.

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

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)	3,731,000	100 %	02-Sep-05
Less: Direct payments for PR Expenditures	1,743,511	47 %	
Less: PR disbursements to sub-recipients	1,643,267	44 %	
PR cash-balance	344,222	9 %	09-Nov-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

Though the cash balance is US$ 344,000, the amount that is expected to be paid is US$ 500,000 as the release will be made from the PR's budget allocation to the RNTCP.

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 PR's cash balance as of November 9, 2005 amounts to US$ 344,222 which is about 9% of the actual disbursed amount to date by the Global Fund. GOI has a system of using its own funds and not wait for donor disbursement. This is a standard system for India. Since the national audit is strong, CTD has to ensure receipt of certified SOEs before any disbursement can take place. SOE from Bihar is late due to elections.

E. CONTEXTUAL CONSIDERATIONS

1. Have there been significant adverse external influences (force majeur)?	☐ Yes ☒ No	However, the election in Bihar considerably slowed down implementation and disrupted service delivery. Government doctors from the TB and other programs were deputed for election work, thus slowing down work in a number of districts. As a result only 11 districts in Bihar were brought under service delivery by September 2005. An accelerated implementation will now be pursued from December 2005 to bring more districts under DOTS program.
1.1. If yes, have they been (or are they being) alleviated?	☐ Yes ☐ No	The election was completed by November 2005 and the staff are now redeployed to health centers.
2. Are there any unresolvable internal issues?	☐ Yes ☒ No	The CCM reform process is in an advance stage. WHO has funded a CCM Secretariat with two professional staff and two assistants. These two staff members also facilitate India Board members work. However, the two staff are now preparing guidelines such as COI, seek better representation, organize meetings, communicate with members and other stakeholders. The CCM has also elected a Vice Chair from the HIV+ community and NGO. A detailed update from the CCM was received on November 29,2005 which 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	The challenge with India is that it is a large country with independent state level management structure. Each state is big and the reporting takes time because many of the districts are in remote areas and the communication is not good in poorer districts. Without complete reports from all districts, the state TB department can not send the report to the Central TB Department (CTD). This has been the major reason for delays in receiving reports. The CTD is very efficient with efficient management structure. Funds are being disbursed to the Sub-Recipients (SRs) which are the State TB Control Societies through 6 monthly releases from the Central level for onward disbursement to the District TB Control Societies (DTCS) as per GOI guidelines. Expenditure incurred by STCS and DTCS are as per existing guidelines for these societies. Quarterly statements of expenditure are being submitted by the DTCS to the STCS, and from the STCS onto the central level. The DTCS and STCS accounts were audited annually by independent chartered accountants. The Central TB Division has been activity monitoring the financial management systems in the state. Monitoring of expenditure, budget utilisation and reimbursement has been carried out at the State and Central levels every quarter. The SOEs of the districts were consolidated by the States (in standard approved format, as per guidelines) and forwarded to Central TB Division and reported on the agreed format. Fund flow formats were devised and shared with the states. Communication was sent to all STOs to maintain books as per STCS guidelines and to follow up with recommendations of audit.

4. Are there any systemic weaknesses in:

4.1. Monitoring and evaluation?	☐ Yes	☒ No	Regular review meetings are being held at all levels. The Peripheral Health Institutions (PHIs) and District Medical Centres (DMCs) are conducting weekly meetings with all staff involved in RNTCP. The MO-TC formally reviews the activities of Senior Treatment Supervisor (STS)/Senior Treatment Laboratory Supervisor (STLS) fortnightly. The District TB Officer (DTO) reviews the activity reports of all Medical Officer TB Centres (MOTCs), STS & STLS on a monthly basis. The Chief Medical Officer (CMO) and District Magistrate (DM) also review the program on a regular basis. State level review meetings are being held at the end of each quarter, chaired by the Secretary. The STO reviews the monthly activity reports of DTOs. The CTD holds review meetings of State TB Officers (STOs) twice in a year, chaired by the Union Secretary, Health. The states conduct an internal evaluation of two districts per quarter.
4.2. Procurement and Supply Chain Management?	☐ Yes	☒ No	The procurement is managed by the CTD through a nationally appointed procurement agent. World Bank guidelines are followed to ensure compliance with international standards, quality, and competitive processes. The following steps have been undertaken to ensure the quality of all anti-TB drugs used under the RNTCP. - Samples from each batch of anti-TB drugs are tested before being cleared for dispatch. - The GMSDs take random samples from their inventory for quality checks. - Central and state drug inspectors periodically test drug samples from the districts. - An independent laboratory has been selected for quality assurance testing of anti-TB drugs. Drug samples to be tested are collected by the program officials every quarter and sent to this laboratory via yet another independent channel.
4.3. Any other areas?	☐ Yes	☒ No	
5. Are there any material issues concerning quality or validity of data?	☐ Yes	☒ No	RNTCP follows a standard data collection and validation system which is applicable to World Bank and GOI funded programs. The M&E system receives extensive technical support from WHO consultants based in districts who continuously monitor data quality and reporting.
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	WHO continues to provide large scale technical support through national technical advisors at the state and district level, thus strengthening monitoring and evaluation, technical competencies of local teams, and ensuring good communication. The World Bank's new support to RNTCP will focus on improving overall capacity of the program both at the state level and CTD and ensure strengthening of procurement and financial management systems.

7. Has the program demonstrated significant improvements in implementation over the last 6 months?	☒ Yes ☐ No	By end of March 2005, compared to the planned 27.5 million population in 14 districts, 31 million population in 16 districts in the States of Bihar and by end September about 68 million population in 30 districts of Bihar and Uttar Pradesh are covered under DOTS. 20,664 patients have been put on treatment by quarter 6 i.e., September 2005, of these, 8078 were new smear positive cases.¨More than 771 laboratories have been supported/established which are functioning as Microscopy centers under RNTCP. 87% of the new smear-positive TB cases registered under DOTs are successfully treated. Over 10,000 people have been reached through community outreach.
8. Have there been any changes in disease trends?	☐ Yes ☒ No	

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	
9.2. Promote sustainability and national ownership through use of existing systems and linkages with related strategies and programs?	☐ Yes ☒ No	The GF funded program is part of the national program RNTCP and it all existing systems are used for the GF funded program.
9.3. Provide additional resources?	☐ Yes ☒ No	The World Bank is negotiating a continuation of their current support. DFID has agreed to fund drug procurement for the national program to cover over 400m people.
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	A recent meeting with CTD resulted in harmonization of reporting and disbursements among all three existing grants. The GF and the World Bank have agreed to harmonize review missions and acceptance of the national reports. The GFATM project is linked to the World Bank project. Procurement agent and Central level Mass Media agency cover is being provided for GFATM areas also with GoI funds. The Supply and distribution agency cover is provided by Central TB Division for all the three states.