# GRANT SCORE CARD (GSC)
# for RCC PHASE 2
# BOARD VERSION

| | |
|---|---|
| RCC Phase 1 currency: | USD |
| CCM Requested currency for RCC Phase 2: | USD |
| Secretariat recommended currency for RCC Phase 2: | USD |

**Panel date:** 15.Aug.2012

**Published on:** 07.Aug.2012

RCC Board version: 1.0.0

# Grant Scorecard for RCC Phase 2

**Grant Number: IDA-202-G19-H**

## EXECUTIVE SUMMARY

### GENERAL GRANT INFORMATION

| | |
|---|---|
| **Applicant** | Country Coordinating Mechanism - India |
| **Country** | India |
| **Component** | HIV/AIDS |
| **Round** | 2 |
| **Grant Title** | Scaling up of Integrated Counseling and Testing, PPTCT and Referral to Care, Support and Treatment Services for People Living with HIV in India |
| **Grant Number** | IDA-202-G19-H |
| **Principal Recipient** | IL&FS Education & Technology Services Ltd. |
| **Related Grants (all existing grants)** | |
| ***Same proposal*** | IDA-202-G02-H-00 |
| ***Same disease component*** | IDA-202-G02-H-00,IDA-405-G05-H,IDA-405-G06-H,IDA-607-G12-H,IDA-708-G13-H,IDA-708-G14-H,IDA-708-G15-H,IDA-910-G20-H,IDA-910-G21-H,IDA-910-G24-H |
| ***Other diseases (Same PR)*** | |

| | | | |
|---|---|---|---|
| **Proposal Lifetime (years)** | 4 | **Lifetime Budget** | $ 230,140,990 |
| **RCC Phase 1 Budget (1-3 year)** | $ 10,907,473 | **Original RCC Phase 2 Budget** | US $267,365,900 (combined RCC budget) |
| **Program Start Date** | 01.Jun.2010 | | |
| **Disbursed up to cut-off date** | $ 6,709,126 | **Disbursed funds as a % of the RCC Phase 1 budget** | 62 % |
| **Undisbursed up to cut-off date** | $ 4,198,347 | **Undisbursed funds as a % of the RCC Phase 1 budget** | 38 % |
| **Program End Date** | 30.Jan.2014 | | |

### SUMMARY CONCLUSIONS AND RECOMMENDATIONS

#### Secretariat RCC Phase 2 Recommendation Overview

| | |
|---|---|
| **RCC Phase 2 Rating** | A2 |
| **RCC Phase 2 Recommendation Category** | Go |
| **Incremental Phase 2 Amount Recommended for Board Approval (USD)** | $12,295,688 |

## Secretariat Assessment of Overall Grant Performance

### Programmatic Achievements

Although India is a country with low HIV prevalence, it has the third largest number of people living with HIV/AIDS (PLWHA) in the world. There are an estimated 2. 4 million PLWHA in India with an adult prevalence of 0.31% in 2009. Most infections occur through heterosexual transmission. However, in certain regions, injecting drug use (IDUs), men who have sex with men (MSM) and single male migrants are contributing for the spread of HIV epidemic. The heterogeneous spread of the HIV epidemic is evident in that some geographic areas show higher prevalence than others.

India's Round 2 HIV RCC program aims to prevent HIV transmission and mitigate the impact of HIV by expanding access to testing, counselling and prevention of parent to child transmission services (known under the acronym "PPTCT" in India and "PMTCT" elsewhere), strengthening inter-program linkages, especially HIV and TB collaboration, and integrating HIV services with the general health system. It is implemented by two PRs: the National AIDS Control Organisation (NACO) on the government side and Infrastructure Leasing & Financial Services, Limited, Education and Testing Service (IL&FS ETS – or simply IL&FS), which is the subsidiary of a private sector financial institution incorporated in 1997 as a social and health infrastructure initiative. These two grants are being reviewed for renewals in parallel.

The Government of India is compliant with the Global Fund's counterpart financing requirement of 20% for a lower lower-middle income country with a contribution that represents 79% of the HIV budget. Government financing for public health has been measurably increasing over the current grant period. The program is also compliant with the "focus of proposal" requirement with focus on reducing vertical transmission of HIV from positive pregnant women to their children and reducing of HIV/TB co-infection among vulnerable low income groups in rural areas.

Of the estimated 2. 4 million PLWHA, over 400,000 people (424,802 as of 2011 per WHO) have been put on antiretroviral treatment (ART) with Global Fund support, representing 100% of those on ART in the country. Global Fund grants have also financed HIV testing and counseling for over 25 million people.

Under the Round 2 RCC program, IL&FS is applying technological know-how and training expertise to prevent mother to child transmission (PMTCT) of HIV in high prevalence districts and complements NACO's efforts that have brought down the percentage of HIV positive infants born to HIV infected mothers from 30% in 2003 to 23% in 2011.

IL&FS focuses primarily on tracking and following up positive pregnant women from NACO- run "integrated care and treatment centers" (ICTCs). This area of service provision has lagged in India due to a host of reasons that include a general reluctance among rural patients to seek access to institutional public health care, difficulties in reaching health care facilities, belief in traditional child delivery and socio-religious influences.

The IL&FS grant program has enabled India to achieve measurable impact in reducing HIV prevalence among infants born to HIV positive mothers by:

- Organizing a network of roughly 180 NGO SRs at any given time to cover 220 districts in 23 states with PMTCT services;
- Expanding the "catchment area" for PMTCT services to non-high prevalence districts that have high numbers of women receiving antenatal care (ANC); and
- Developing a dedicated mobile-based technology for "real-time" reporting on PMTCT patients by outreach workers. Due to delays on the part of NACO in setting up the necessary ICTC-based computers (still in progress), this activity has yet to be completed.

The Joint Implementation Review (JIR) that took place on 7-17 December 2011 found that HIV prevalence among antenatal (ANC) clinic attendees declined to below 1% in all states. Hence, in the period leading up to the start of the fourth five-year National AIDS Control Program (NACP IV) in April 2012, NACO revised its estimates of HIV prevalence among pregnant women downward from 65,000 to 37,041 based on actual Quarter 7 data. In order to reflect this new situation, the targets for this indicator are being adjusted in the Round 2 RCC Performance Frameworks to account for the lower prevalence while continuing to provide PMTCT services to an increasing number of pregnant women.

This revision also prompted the CCM to propose the relocation of 700 ICTCs (out of 10,515) to districts, so more patients will have better access to services. In turn, NACO conducted a rationalization exercise to refine the ratio of outreach workers (ORWs) to pregnancies that has resulted in a concomitant reduction in the number of ORWs. For this reason, the number of positive pregnancies in the initial target districts has declined, but the number of districts, where the PMTCT program is being implemented, has increased. In the next phase, IL&FS will scale up program coverage in an increased number of districts for a larger number of patients, as captured in the Performance Framework.

As of the cut-off date (31 March 2012), the grant had an "A2" rating, with an average 98% achievement for the latest reporting period. The PR has competent staff and good financial and monitoring control mechanisms.

### Financial Performance

As of the cut-off date (31 March 2012), US $6,709,126 had been disbursed, representing 62% of the Phase 1 commitment and 93% of the budget for the period; however, the total verified expenditure was US $5,283,884. The PR's expenditure represents 48% of the total Phase 1 amount, 73% of the cumulative budget and 79% of the disbursed amount. The under-utilization of the budget is primarily due to the following:

- A change in the PR's Performance Framework, workplan and budget stemming from NACO's revision of HIV prevalence estimates among pregnant women and associated outreach worker (ORW) rationalization exercise, there was almost a year between the first and the second disbursement.
- Under expenditure in Human resources (US $524,651) due to late a start of the program and less than expected number of SR personnel hired.
- Underspending in training (US$ 934,298) due to a less than expected number of staff being trained. Two training manuals have not been fully utilized to date due to the late approval of a training plan in line with the PR's revised workplan and budget.
- The change in the workplan and budget also affected the Monitoring and Evaluation (M&E) budget, as well as delays in M&E activities (US $368,435).

PR and SR cash balance was US $1,316,838.

**Grant Management**

IL&FS has been compliant with grant specific conditions, except for areas where it is dependent on NACO. It has demonstrated flexibility in adjusting its own strategy, Performance Framework, workplan and budget to conform to NACO-led epidemiological and programmatic revisions in the national PMTCT program, as well as to Global Fund recommendations mandating corresponding changes in the Round 2 HIV RCC grant. However, due to the delays resulting from this process, the PR's 2011 audit planning and execution was delayed.

The Secretariat has observed certain non-material accounting weaknesses at the PR and SR levels, but these cash reconciliation issues will be address with a management action.

## Secretariat Assessment of External Factors and Governance specifically impacting on grant implementation

**External Factors specifically impacting on grant implementation**

The principal external factor that could have an effect on this grant's future is NACO policy vis-à-vis service provision to positive pregnant women. As seen in the CCM request, the Ministry of Health stresses on "convergence" of health services presupposes a phase out of outreach workers (ORWs) in favor of "accredited social health activists" (ASHAs) over a number of years. IL&FS is adjusting its Phase 2 implementation strategy to enlist ASHAs in patient follow up, taking advantage of the fact that these volunteers already engage in health-related volunteer work at the community level.

**Governance issues specifically impacting on grant implementation**

The basic governance issue affecting this grant is NACO's control of the CCM Secretariat. The Global Fund has asked the CCM Chair to resolve this issue as expeditiously as possible.

## Secretariat Rationale for Recommendation Category

In light of the program's "A2" performance rating and demonstrated impact, the Secretariat supports a "Go" Recommendation Category.

Average achievement of IL&FS on the following key output indicators was 98%:

- Number and percentage of HIV infected pregnant women and their babies (mother-baby pairs) receiving a complete course of ARV prophylaxis to reduce the risk of MTCT;
- Number of HIV positive pregnant women regularly followed by ORWs through home visits;
- Number and percentage of HIV positive pregnant women, regularly followed by ORW, who go for institutional delivery; and
- Number of network meetings held between health worker and ORW.

However, there is a need for the PR, in consultation with Global Fund, to ensure that the targets set for Phase 2 are feasible in light of the current programmatic achievements and trends. For IL&FS, there is a need to better describe the components of "PPTCT services" and to determine how the objective of providing PPTCT services to 80% of estimated HIV positive pregnant women will be measured. There are also certain challenges with regard to proposed convergence with the National Rural Health Mission (NRHM) and certain inconsistencies in the Performance Framework, budget and PSM plan will need to be addressed prior to grant signing and/or through appropriate management actions.

## Secretariat Rationale for Recommended RCC Phase 2 Amount

In view of the PR's solid performance and plan to expand PMTCT coverage to under-served populations, the Secretariat recommends an incremental amount of US $12,295,688 and a budget of US $14,123,961 for the next implementation period.

This amount corresponds to a workplan and budget that should enable the PR to contribute to the national program's goal of measurably reducing vertical transmission of HIV in India by 2015.

**Proposed Secretariat Board Conditions for "Conditional Go" Category**

| Issue | Board Conditions | Deadline |
|---|---|---|

**Proposed Secretariat Conditions**

| Issue | Conditions | Deadline |
|---|---|---|
| External PR and SR audits | The Principal Recipient will deliver to the Global Fund, in form and substance satisfactory to the Global Fund, the external audit reports relating to the Principal Recipient and Sub-recipients, including an action plan to address significant issues (if any) rose in the audit reports. | Prior to signing |

**Proposed Secretariat Management Actions**

| Issue | Management Actions | Deadline |
|---|---|---|
| Account reconciliation | 1. The Principal Recipient should prepare regular reconciliations to ensure that financial information on PUDR-EFR matches the information in the accounting system (chart of accounts).<br><br>2. The Principal Recipient should prepare and validate the monthly bank reconciliations to ensure proper reconciliation of cash book and bank statements at the end of each reporting period. | During implementation |
| M&E (mobile reporting system) | The Principal Recipient should draw up a time-bound plan of action for implementation of the mobile reporting system. The action plan should be used as a tool/guide to track the implementation of the application across all states where the program is being implemented. | Prior to the first disbursement |
| M&E (updating M&E plan) | The Principal Recipient has provided its M&E plan which is well linked to the national M&E plan. A revised plan is expected to be provided aligned to the new national M&E plan based on the NACP IV. | By March 2013 |

# COUNTRY AND PORTFOLIO ANALYSIS

## COUNTRY ANALYSIS

### Contextual Information

**Please describe the situation of the below issues with particular emphasize on key changes and the effect of these on grant implementation. Elaborate on mitigation strategies and material changes adversely affecting grant performance.**

**Political environment**

India has made major strides in providing support to the fight against HIV/AIDS. The National AIDS Council is headed by the Prime Minister and a separate department under the Ministry of Health and Family Welfare (NACO) manages the national response with a multimillion-dollar budget funded increasingly from domestic sources.

Government decisions in the public health field are slow in coming and marked by instances of policy indecision. Although the periods for the National Rural Health Mission (NHRM) and NACP IV programs have ended, extensions have not been formalized. Unless these programs are reactivated, this could negatively affect service delivery.

**Economic situation**

Many donors have ceased their support for HIV programs in India as a result of the global economic crisis. In response, the government intended to take over most of the activities supported by non-governmental donor into NACP IV. Budgets are unclear on whether this new government mandate will actually be funded. If it is not, this will have a negative impact on the national HIV program.

Also, government funded programs in India are not flexible instruments and this affects the ability of implementers to modify their approaches in light of changing epidemiological circumstances.

**Social situation**

Social acceptance of HIV programming continues to grow in India. As demonstrated in a 2009 BSS study, the level of stigma and discrimination has decreased - despite of continued high levels of societal stigma towards men who have sex with men (MSM), transgender individuals and other sexual minorities. Reaching these vulnerable stigmatized groups remains a major challenge. NACO is expanding services to high risk groups during Phase 2 by targeting MSMs, FSWs and IDUs in low prevalence states.

NACO's recently conducted social assessment provides a valuable advocacy tool for public health leaders, advocates and program managers.

**Legal context**

The national program has put into effect many good policies, such as a legal protection scheme for women, people living with HIV/AIDS (PLWHA), linkage to self-help groups, and an insurance plan for PLWHA, but implementation at the state, district and local levels remains minimal.

The case for decriminalizing homosexuality is underway in the Supreme Court of India. Currently, homosexual acts constitute a criminal offence under the Indian Law.

**Epidemiological situation**

Estimated adult HIV prevalence in India was 0.32% (0.26%–0.41%) in 2008 and 0.31% (0.25%–0.39%) in 2009. The adult prevalence is 0.26% among women and 0.38% among men in 2008, and 0.25% among women and 0.36% among men in 2009. Among the states, Manipur has highest estimated adult HIV prevalence (1.40%), followed by Andhra Pradesh (0.90%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%). Besides these states, Goa, Chandigarh, Gujarat, Punjab and Tamil Nadu have shown estimated adult HIV prevalence greater than national prevalence (0.31%), while Delhi, Orissa, West Bengal, Chhattisgarh and Puducherry have shown estimated adult HIV prevalence of 0.28-0.30%. All other states/Union Territories have lower levels of HIV. This data demonstrates the impact of the various interventions under the National AIDS Control Program.

Adult HIV prevalence has continued its steady decline from estimated level of 0.41% in 2000 to 0.36% in 2006 to 0.31% in 2009, reflecting a 50% decline in the number of new cases annually from about 270,000 in 2000 to about 120,000 in 2009. The six high prevalence states listed above show a clear declining trend in adult HIV prevalence. However, the low prevalence states of Chandigarh, Orissa, Kerala, Jharkhand, Uttarakhand, Jammu & Kashmir, Arunachal Pradesh and Meghalaya show rising trends in adult HIV prevalence in the last four years. The six high prevalence states account for only 39% of new patients, while the states of Orissa, Bihar, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat account for 41% of new infections.

The primary drivers of HIV epidemic in India are unprotected FSWs, MSM and IDUs. It is estimated that there are 126,300 FSWs, 350,000 "high risk" MSMs with high risk behavior and 186,000 IDUs in India. While FSWs account for 0.5% of adult female population, they account for 7% of HIV-infected females. Sex work continues to be the most important source of HIV infection and then serves as a "bridge" to infect other low risk populations, like wives and partners.

In India, the estimated number of HIV positive mothers requiring PMTCT services per 2009 data is 43,257 (95% CI 22,494–69,572). While this is a low prevalence group, it is directly vulnerable to the effects of high risk behavior by members of the "bridge" populations.

Summary of impact of HIV/AIDS programming in India:

| | |
|---|---|
| Prevalence | Adult prevalence among general population declined from 0.41% in 2000 to 0.31% in 2009 (NACO) |
| | Nationally, HIV prevalence among FSWs declined by 50% between 2003 and 2008 (UNAIDS) |
| | In Karnataka state, HIV prevalence among sex workers declined from 19.6% to 16.4%, high-titer syphilis from 5.9% to 3.4% and chlamydia and/or gonorrhea from 8.9% to 7.0% between 2004 and 2009 (Ramesh et al.) |
| Incidence | Estimated new infections reduced by >50% between 2000 (270,000) and 2009 (120,000) (NACO) |
| | Incidence trends in antenatal clinics (using prevalence among young women as proxy) declined by 54% between 2000 and 2007 in south India (Arora et al.) |
| Behavioral outcomes | In Karnataka state, reported condom use among FSWs at last sex increased significantly for repeat clients from 66% to 84% between 2004 and 2009 (Ramesh et al.) |
| | Consistent condom use by male clients with FSWs increased from 64% to 87% in the four southern high prevalence states between 2006 and 2008 (Lipovsek et al.) |
| Impact analyses | Over a 20-year period, prevention programs with FSWs in India reduced the prevalence of HIV infections by 47% (Prinja et al.) |
| | In districts with intensive prevention programs for sex workers in Karnataka, HIV prevalence among young ANC clinic attendees declined from 1.4% to 0.77%. The decline in standardized HIV prevalence in intensive districts was 56%, compared to 5% in the districts with non-intensive prevention programs (Moses et al.) |
| Cost-effectiveness analyses | Prevention programs with FSWs are a cost-effective strategy for HIV prevention. Each DALY averted has an incremental cost of US$ 10.7 (Prinja et al.) |

**Based on the available information, please comment whether the compliance with counterpart financing requirements has been met per the threshold based on the income classification for the country. If no, please provide the necessary justifications for non-compliance as well as the actions planned during the next Implementation Period to move towards reaching compliance.**

India is compliant with the Global Fund's counterpart financing requirement of 20% for a lower lower-middle income country with a counterpart financing level of 79%. Government financing for public health has been measurably increasing over the current grant period.

**Based on your analysis, please comment whether the focus of proposal requirement has been met per the threshold based on the income classification for the country. If no, please provide the necessary justifications.**

The program is also compliant with the "focus of proposal" requirement, centering on the reduction of vertical transmission of HIV from positive pregnant women to their children and HIV/TB co-infection among vulnerable low income groups in rural areas.

## PORTFOLIO ANALYSIS *(PROVIDED INFORMATION DEPENDING ON DISEASE COMPONENT)*

### Number of grants by disease and PR

| | HIV/AIDS | HIV/TB | Malaria | Tuberculosis | Total |
|---|---|---|---|---|---|
| **Civil Society/Private Sector: Non-Governmental Organization** | 5 | | 1 | 1 | **7** |
| **Civil Society/Private Sector: Other** | 1 | | | | **1** |

| | | | | | |
|---|---|---|---|---|---|
| **Civil Society/Private Sector: Private Sector** | 1 | | | | **1** |
| **Government: Ministry of Finance** | 1 | | 2 | | **3** |
| **Government: Ministry of Health** | 1 | | | | **1** |
| **Government: Other** | 4 | 1 | | 5 | **10** |
| **Multilateral Organization: Other** | | | | 1 | **1** |
| **Total** | **13** | **1** | **3** | **7** | **24** |

## Overview of Portfolio Financing

| | HIV/AIDS | HIV/TB | Malaria | Tuberculosis | Total |
|---|---|---|---|---|---|
| **Approved Maximum** | $ 721,439,210 | $ 14,819,772 | $ 91,592,971 | $ 219,707,807 | **$ 1,047,559,760** |
| **Total Funds Disbursed** | N/A | $ 14,819,772 | N/A | $ 151,923,507 | **$ 166,743,279** |

## Committed funds by Round and disease

| | HIV/AIDS | HIV/TB | Malaria | Tuberculosis | Total |
|---|---|---|---|---|---|
| **Round 1** | | | | $ 8,250,421 | **$ 8,250,421** |
| **Round 2** | $ 245,675,725 | | | $ 107,685,429 | **$ 353,361,154** |
| **Round 3** | | $ 14,819,772 | | | **$ 14,819,772** |
| **Round 4** | $ 290,396,779 | | $ 56,224,799 | $ 19,113,943 | **$ 365,735,521** |
| **Round 6** | $ 107,023,750 | | | $ 8,579,594 | **$ 115,603,344** |
| **Round 7** | $ 59,558,812 | | | | **$ 59,558,812** |
| **Round 9** | $ 16,877,490 | | $ 28,564,645 | $ 62,903,041 | **$ 108,345,176** |
| **Total** | **$ 719,532,556** | **$ 14,819,772** | **$ 84,789,444** | **$ 206,532,428** | **$ 1,025,674,200** |

## Grants in detail

| Component | Round | Grant No. | PR | Grant age (months) | Financial performance | | | | Latest performance rating |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Total grant amount | Disbursed to date | Percent disbursed | Time elapsed | |
| Tuberculosis | 1 | IDA-102-G01-T-00 | Department of Economic Affairs, Ministry of Finance of India | 115 | $8,250,421 | $8,250,421 | 100 % | 100 % | A1 |
| HIV/AIDS | 2 | IDA-202-G02-H-00 | Department of Economic Affairs, Ministry of Finance of India | 102 | $234,768,252 | $190,363,835 | 81 % | 92 % | x |
| Tuberculosis | 2 | IDA-202-G03-T-00 | Department of Economic Affairs, Ministry of Finance of India | 102 | $107,685,429 | $85,704,608 | 80 % | 88 % | B1 |
| HIV/TB | 3 | IDA-304-G04-C | Department of Economic Affairs, Ministry of Finance of India | 94 | $14,819,772 | $14,819,772 | 100 % | 100 % | A1 |
| HIV/AIDS | 4 | IDA-405-G05-H | Population Foundation of India | 89 | $34,088,843 | $28,766,717 | 84 % | 81 % | B1 |
| HIV/AIDS | 4 | IDA-405-G06-H | Department of Economic Affairs, Ministry of Finance of India | 86 | $256,307,936 | $197,964,601 | 77 % | 79 % | A2 |
| Malaria | 4 | IDA-405-G07-M | Department of Economic Affairs, Ministry of Finance of India | 86 | $56,224,799 | $56,224,799 | 100 % | 100 % | x |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Tuberculosis | 4 | IDA-405-G08-T | Department of Economic Affairs, Ministry of Finance of India | 90 | $19,113,943 | $19,113,943 | 100 % | 100 % | A1 |
| Tuberculosis | 6 | IDA-607-G09-T | Department of Economic Affairs, Ministry of Finance of India | 62 | $8,579,594 | $8,579,594 | 100 % | 100 % | A2 |
| HIV/AIDS | 6 | IDA-607-G12-H | India HIV/AIDS Alliance | 61 | $13,904,010 | $13,231,732 | 95 % | 93 % | A2 |
| HIV/AIDS | 6 | IDA-607-G10-H | Population Foundation of India | 63 | $14,472,382 | $14,472,382 | 100 % | 100 % | x |
| HIV/AIDS | 6 | IDA-607-G11-H | Department of Economic Affairs, Ministry of Finance of India | 60 | $78,647,358 | $78,647,358 | 100 % | 55 % | A2 |
| HIV/AIDS | 7 | IDA-708-G13-H | Department of Economic Affairs, Ministry of Finance of India | 49 | $22,885,155 | $15,194,426 | 66 % | 52 % | B1 |
| HIV/AIDS | 7 | IDA-708-G14-H | Indian Nursing Council | 48 | $23,924,839 | $18,972,482 | 79 % | 57 % | A2 |
| HIV/AIDS | 7 | IDA-708-G15-H | Tata Institute of Social Sciences | 48 | $12,748,818 | $11,784,517 | 92 % | 62 % | x |
| Tuberculosis | 9 | IDA-910-G16-T | International Union Against Tuberculosis and Lung Disease | 27 | $13,979,465 | $13,885,815 | 99 % | 75 % | A1 |
| Tuberculosis | 9 | IDA-910-G17-T | World Vision India | 27 | $3,736,045 | $3,508,744 | 94 % | 75 % | A2 |
| HIV/AIDS | 2 | IDA-202-G19-H | IL&FS Education & Technology Services Ltd. | 25 | $10,907,473 | $6,709,126 | 62 % | 73 % | B1 |
| HIV/AIDS | 9 | IDA-910-G20-H | India HIV/AIDS Alliance | 23 | $5,500,938 | $4,563,853 | 83 % | 50 % | A1 |
| HIV/AIDS | 9 | IDA-910-G21-H | Emmanuel Hospital Association | 23 | $4,700,873 | $3,749,189 | 80 % | 50 % | C |
| Tuberculosis | 9 | IDA-910-G18-T | Department of Economic Affairs, Ministry of Finance of India | 21 | $45,187,531 | $12,880,382 | 29 % | 0 % | |
| Malaria | 9 | IDA-910-G22-M | Caritas India | 20 | $5,156,680 | $3,260,689 | 63 % | 50 % | x |
| HIV/AIDS | 9 | IDA-910-G24-H | Department of Economic Affairs, Ministry of Finance of India | 18 | $6,675,679 | N/A | | | x |
| Malaria | 9 | IDA-911-G23-M | Department of Economic Affairs, Ministry of Finance of India | 18 | $23,407,965 | N/A | | | B2 |

| Legend | A1 (> 100) | A2 (90% - 100%) | B1 (60% - 89%) | B2 (30% - 59%) | C (< 30%) |
|---|---|---|---|---|---|

**Please provide a summary of the objectives of each of the grants in the portfolio and describe the linkages.**

India has made major advances in improving public health in spite of the many political and economic hurdles since independence. Public spending on health has never exceeded 2% of GDP and yet significant gains have been made in reducing infant mortality and increasing life expectancy. Nevertheless, India continues to battle acute morbidity stemming from poverty and malnutrition. Health problems in the country are intensified by socio-cultural factors such as discrimination against women and low levels of educational attainment. Health needs in India need to be addressed in the context of the country's diverse socio-political, cultural, religious and ethnic milieu. HIV/AIDS, TB and malaria continue to pose challenging threats given the sheer number of such cases.

The Global Fund's current portfolio of grants in India comprises nine active HIV grants, three active TB grants and two active malaria grants. In addition, there is one inactive HIV grant and two other grants – HIV and malaria -- in close out. All of the country's active grants are structured to support the three respective national programs to combat the diseases, developed by the Ministry of Health and Family Welfare (MoHFW), namely:

1. National AIDS Control Program (NACP-IV, now in its fourth five-year phase beginning in April 2012);
2. Revised National Tuberculosis Control Program (RNTCP, now implementing India's strategic plan for 2012-2017); and
3. National Vector Borne Disease Control Program (NVBDCP), the central agency for the prevention and control of

vector borne diseases, including malaria, dengue, lymphatic filariasis, visceral leishmaniasis (kala-azar), Japanese encephalitis and chikungunya.

The Global Fund grants provide retrospective budget support to four components of NACP-IV, two aspects of RNTCP, and LLIN and malaria diagnosis under NVBDCP. In turn, all three programs contribute to the National Rural Health Mission (NHRM), India's program for improving health care delivery across rural areas. The Global Fund has designated the Department of Economic Affairs (DEA) of the Ministry of Finance as the de-jure PR for government grants; the de-facto PRs/implementing agencies are the National AIDS Control Organization (NACO), Central TB Division (CTD) and NVBDCP of MoHFW (the latter two agencies fall under the Directorate General of health Services - DHS). These implementers are forward funded.

The Global Fund also supports one private sector and six civil society PRs, which work with the respective government agencies on discrete elements of the national responses to the epidemics.

**HIV/AIDS:**

Starting in 2004, India's original Round 2 (PR: NACO) and Round 4 (PRs: NACO and Population Foundation of India -- PFI) grants supported treatment care and support programs in six high prevalence states. A further Round 3 grant (PR: NACO) was aimed at reducing TB-related morbidity in PLHA of high HIV-burden states while preventing further spread of HIV and TB. The country's Round 6 grants, now consolidated with extant programs, covered states referred to as Focus Geographic Areas, with certain components covering the entire country.

The country's nine active HIV/AIDS grants support distinct components of NACP IV. Its Round 7 program (PRs: Indian Nursing Council – INC; Tata Institute of Social Sciences –TISS; and NACO) started in 2008 and focuses on HIV-related health systems strengthening. Its three component grants aim at enhancing the institutional capacities of 55 nurse training institutes and institutional capacities of 40 counselors training institutes, as well as building a rural community outreach model (the so-called "link workers scheme") to address the needs of rural prevention, care and support requirements.

India's Round 2 RCC grants, signed in 2009, consolidate the testing and counseling component of the Round 2, Round 3 and Round 6 grants. The Round 2 RCC program permits scale-up of PPTCT services through the establishment of thousands of new counseling and testing centers in high prevalence districts throughout the country. The Round 2 RCC introduces, for the first time in a Global Fund supported grant in India, a PR from the private sector, IL&FS, in addition to NACO. IL&FS manages the outreach worker component of the program.

India's Round 4 HIV RCC program that started in 2010 consolidated the treatment component of the Round 4 and Round 6 grants of both NACO and PFI. The RCC is aimed at facilitating universal access to ART services. While NACO's focus remains on ART provision, the PFI component focuses on care and support interventions among HIV+ individuals and communities.

India's Round 9 program (PRs: India HIV/AIDS Alliance – Alliance; and Emmanuel Hospital Association – EHA) also started in 2010. The two constituent grants strengthen community systems that benefit MSM and strengthen the capacity, reach and quality of harm reduction services to IDUs. A third grant was intended for implementation by the Ministry of Labor and Employment (MoLE) to address prevention and care services among informal workers. However, lack of agreement on implementation arrangements between NACO and MoLE have not permitted this program to go forward. NACO is currently implementing interventions among informal workers with World Bank support.

According to recent verified reports, over 400,000 people have been put on ARV treatment with Global Fund support. Global Fund funding has also made it possible for over 25 million people to receive testing and counseling for HIV.

**TB:**

TB is perpetuated in India by poverty and limited healthcare. It is estimated that there are 1.9 million new TB cases in India every year, accounting for a fifth of all such cases worldwide or 30% of the global TB burden. It comes as no surprise that the strategy of DOTS was based largely on longitudinal research done on TB patients in India. A massive government program, known as the Revised National TB Control Program (RNTCP), was launched in recent years in order to provide the Indian population access to the DOTS program. Multi-drug resistance (MDR) TB is one of the biggest impediments to the fight against TB in India.

All Global Fund TB grants in India support RNTCP. The program provides DOTS and MDR treatment and strengthens public/private partnership. By the end of 2009, 534,100 people were placed on DOTS and 319,300 TB cases were successfully treated with Global Fund support.

The Global Fund supports three active SSF TB grants in India. The three previously on-going TB grants, implemented by the Ministry of Health and Family Welfare Central TB Division (CTD), were consolidated under the Board approved RCC proposal in May of 2009. A further government Round 9 proposal, approved in November 2009, aims to significantly enhance the quality and scale up of diagnosis, care, treatment and management of MDR-TB and engage more community-based care providers to improve care and control especially for marginalized groups. The Round 9 grant has an important private sector component and introduces two civil society PRs for TB for the first time: the International Union against TB and Lung Disease (Union) and World Vision India.

CTD's SSF grant agreement, consolidating Round 2 RCC and Round 9 grants, has been finalized. In August 2012, the Global Fund received signed copies from the country following government approvals. The current implementation period of all three grants ends 31 March 2013 and will undergo Periodic Review in the first quarter of next year.

**Malaria:**

Malaria is a major public health challenge in India. Of the 3.3 billion people at risk of malaria in the world, 800 million (24%) live in India. About 80% of malaria cases are confined to about 20% of the population residing in the high endemic areas, the eastern and north eastern parts of the country (Round 4 and Round 9 program areas). The current National Vector Borne Disease Control Program (NVBDCP) came into operation in 2003 as an umbrella program to cover prevention and control of malaria and other vector borne diseases. National malaria prevention and control strategies have been formulated to provide a comprehensive response to the current epidemiological challenge. The overall aim is to achieve universal coverage with effective interventions in endemic areas. Implementation is being phased so as to provide high burden areas with initial coverage.

NVBDCP's Round 4 malaria grant, in close out as of 30 June 2010, covered malaria diagnostic, prevention and care activities in north-east India. The National Program started the country's current Round 9 grant in 2010 in order to address gaps and scale up effective malaria control interventions in remote areas. NVBDCP is essentially continuing Round 4 activities with a recently re-worked procurement and supply management (PSM) plan that focuses on quality assured LLINs and RDTs instead of non-WHO prequalified ACT dosages that the program is procuring with World Bank support. The Round 9 grant continues with the same SDAs in seven out of the ten north-eastern states covered under Round 4. This region accounts for roughly 50% of malaria deaths in the country. Future interventions in the three states that are not part of Round 9 will be covered with World Bank support. Overall, the decline in malaria in the Round 4 project areas has been significantly higher than in the country as a whole with 18% decline in death against 4% overall in India.

Caritas India is implementing a dual track Round 9 grant aimed at involving community structures and civil society organizations in complementing the efforts of the government's malaria control program, especially in remote areas. It is being implemented in the seven North-Eastern Indian states. Caritas leads a consortium of civil and private sector organizations in providing services in areas with poor access to public sector health care services, organizing LLIN delivery, developing locally appropriate BCC and training of community health volunteers and private service providers to improve acceptance and use of preventive interventions, access to early diagnosis and prompt treatment.

## PROGRAM DESCRIPTION AND GOALS

### Program Description Summary

Despite low HIV prevalence of 0.34 percent, India is home to the third largest number of people living with HIV in the world. The HIV epidemic in India continues to be concentrated, with six high prevalence states -- Andhra Pradesh, Maharashtra, Karnataka, Tamil Nadu, Manipur and Nagaland -- which contribute to 68 percent of the national HIV burden. There is evidence to suggest a stabilization of the epidemic in these states, but pockets of infection have begun to emerge in a number of other states. In addition, HIV prevalence among key populations, specifically women who sell sex, men who have sex with men, and people who inject drugs, continues to be much higher than among the general population. The program supported by this Rolling Continuation Channel grant continues and builds on the work of implementing the prevention of parent-to-child transmission of HIV and voluntary testing and counseling services carried out under the expiring program supported by a Round 2 Global Fund grant in high prevalence states. The grant has been consolidated with a Round 3 grant that finances HIV/TB collaborative programs in high prevalence states and integrates components of a Round 6 grant, which focuses on low prevalence states.

### Program Goals and Impact Indicators

| Goal Description | Indicator | Indicator Name |
|---|---|---|
| To prevent HIV transmission and mitigate the impact of HIV by expanding access to testing & counseling and PPTCT services, strengthening inter-program linkages, especially HIV/TB collaboration, and integrating HIV services with general health system. | Impact Indicators | HIV Prevalence |
| | | % of infants born to HIV infected mothers who are infected |

# Grant Scorecard for RCC Phase 2

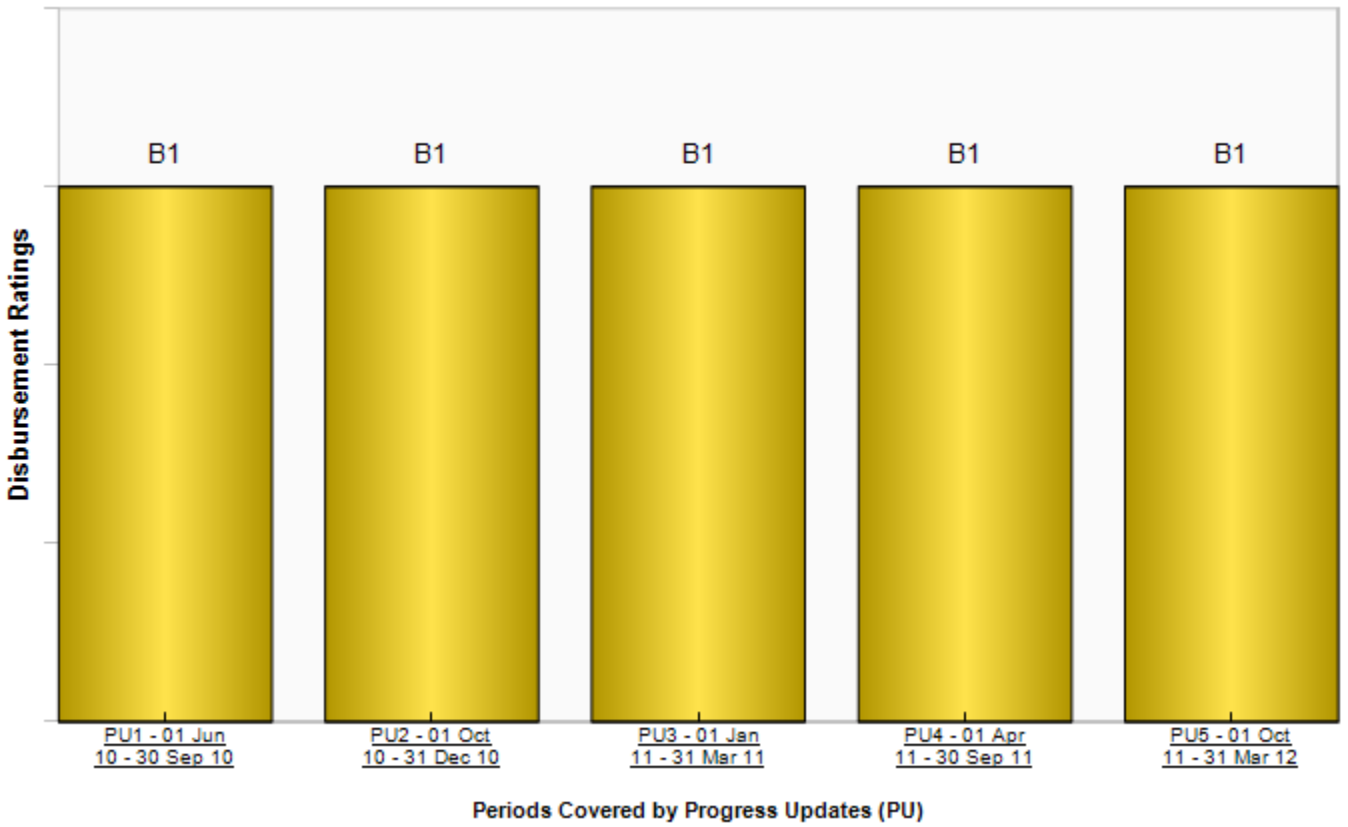
**Grant Number: IDA-202-G19-H**

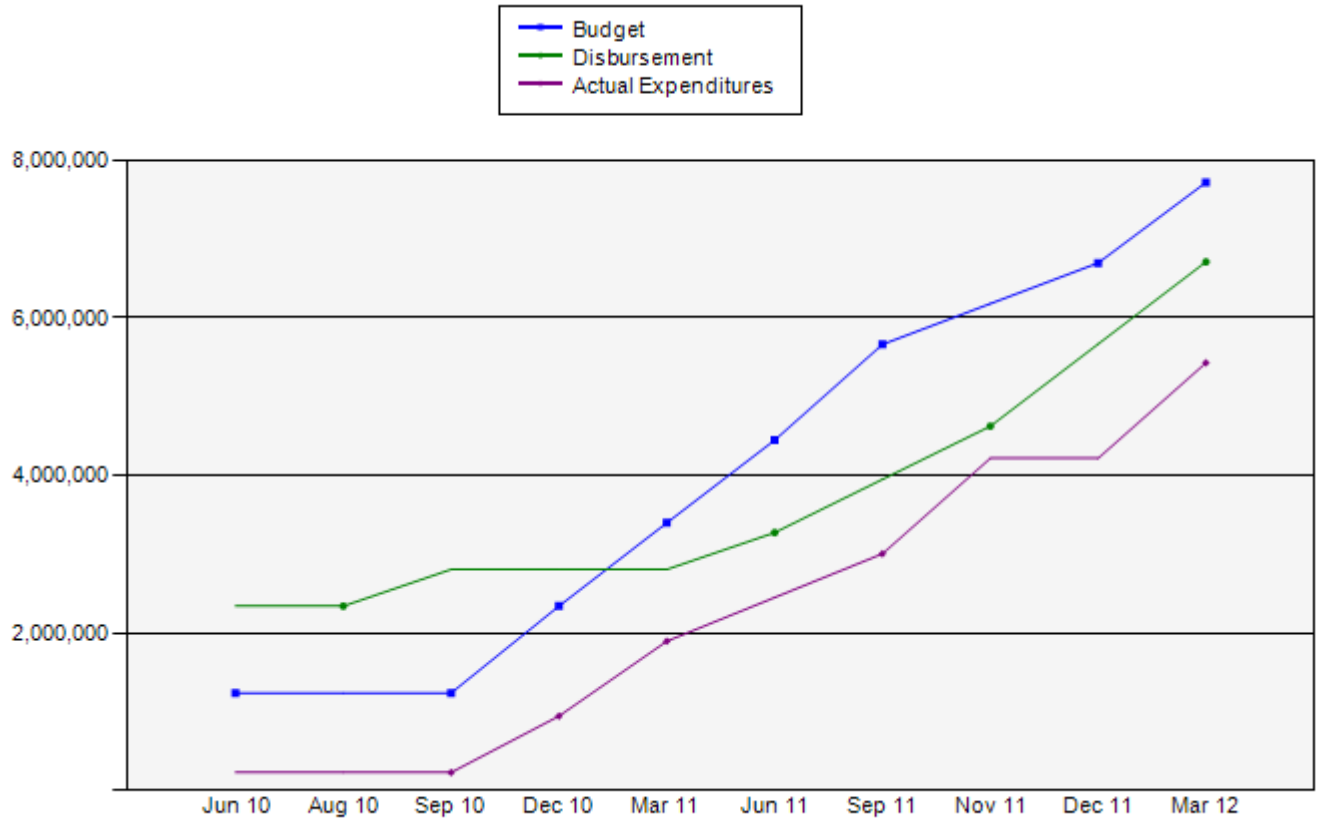
## RCC PHASE 1 PERFORMANCE

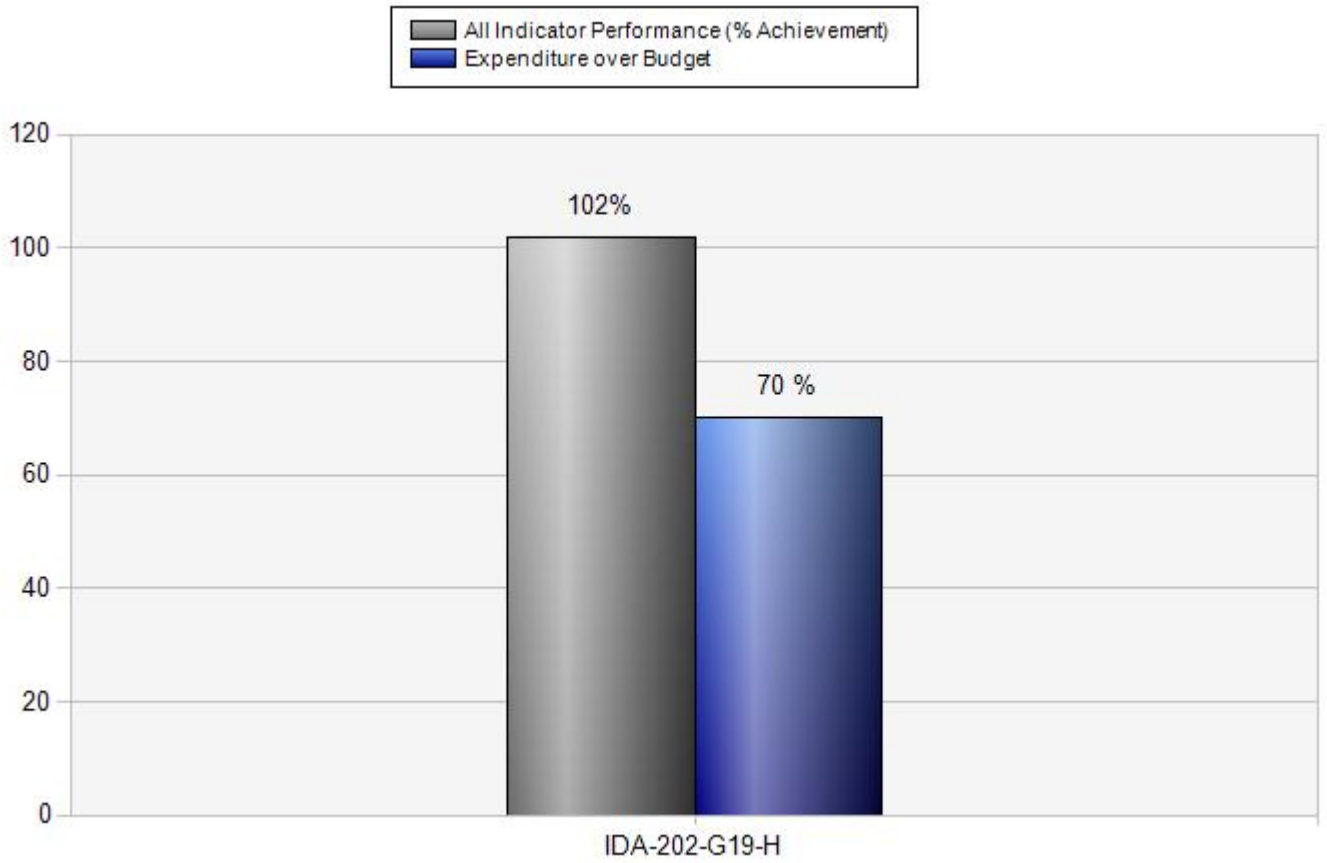
### GRANT PERFORMANCE OVERVIEW

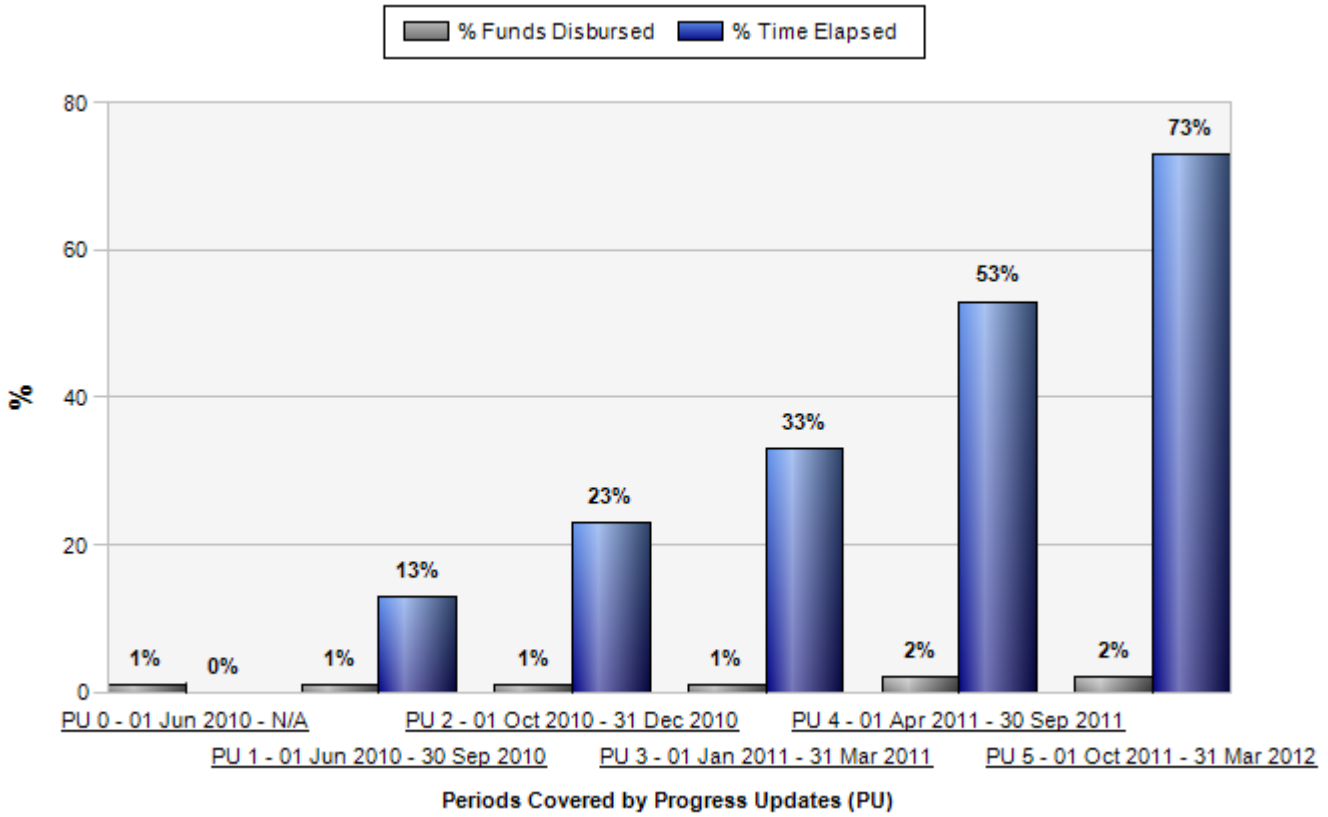
| Latest PU | Latest TGF Rating | All Indicator Perf. | Top 10 Indicator Perf. | RCC Time Elapsed | Disbursed to Date | Fulfilled CPs | Expenditure Rate | Latest Disbursement Date |
|---|---|---|---|---|---|---|---|---|
| 01.Oct.2011 - 31.Mar.2012 | B1 | 102% | 99% | 22 Months (50%) | $ 6,709,126 | 11/18 | 70 % | 12.Mar.2012 |

| Legend | A1 (> 100) | A2 (90% - 100%) | B1 (60% - 89%) | B2 (30% - 59%) | C (< 30%) |
|---|---|---|---|---|---|




Budget
Disbursement
Actual Expenditures
8,000,000
6,000,000
4,000,000
2,000,000
Jun 10
Aug 10
Sep 10
Dec 10
Mar 11
Jun 11
Sep 11
Nov 11
Dec 11
Mar 12


All Indicator Performance (% Achievement)
Expenditure over Budget
120
100
80
60
40
20
0
102%
70 %
IDA-202-G19-H




## FINANCIAL RCC PHASE 1 PERFORMANCE

**Are there any undisbursed funds or available cash from RCC Phase 1?** Yes

**If yes, please explain the reasons for it (activities not performed, savings realized,...)**

As of the cut-off date, the undisbursed amount was US$ 4,198,347, which will cover the remaining Phase 1 period after cut-off date (USD 3,710,593). A disbursement of US $2,369,909 has recently been processed. Expenditure incurred for SRs has been taken from the EFR, but has not yet been verified so these may change. The cash balance was US $1,316,838, which was corrected based on the lasts PUDR for October 2011 to March 2012.

**Was the RCC Phase 1 expenditure in line with targets achieved in RCC Phase 1?** Yes

**Please explain**

The EFR still needs to be verified; however, main variances are explained as follows:

- Human resources: Savings totalling US $524,651 occurred due to late start of the program and less than expected number of SR personnel hired.
- Training: There was under-spending in the amount of US$ 934,298 due to a less than expected number of staff trained. Lines related to development of both PHMMS and PPTCT training manuals have not been fully utilized due to the late approval of a training plan in line with the PR's revised workplan and budget.
- Monitoring and Evaluation: US $368,435 was not used due to the change in its workplan and budget, the PR delayed some M&E activities.

**Secretariat Conclusions and Recommendations - Financial Aspects of RCC Phase 1 Performance**

The grant tool generated an average performance of 98% for all indicators in the latest verified PUDR, whereas the cumulative utilization is 73%; thus, the average programmatic performance exceeds the grant's burn rate. This is primarily due to the fact that the PR has exceeded its targets for many indicators that are not directly tied to the budget.

# Grant Scorecard for RCC Phase 2

**Grant Number: IDA-202-G19-H**

## PROGRAMMATIC ACHIEVEMENTS AND MANAGEMENT PERFORMANCE

**Programmatic period index and dates:**

| 7 | 01.Jan.2012 | 31.Mar.2012 |
|---|---|---|

| Top 10 | Train. | # | Active Indicator Name | Target | | Result | | Percentage |
|---|---|---|---|---|---|---|---|---|
| | | | | Period | Value | Period | Value | |
| Top 10 | No | 2.1 | Number and percentage of HIV infected pregnant women and their babies (or: mother-baby pairs) receiving a complete course of ARV prophylaxis to reduce the risk of MTCT. | 7 | N: 5,800<br>D: 8,000<br>P: 72.5 % | 7 | N: 2,836<br>D: 3,422<br>P: 82.9 % | 114 % |
| Top 10 Equ. | No | 2.11 | Number of M&E System Strengthening measures implemented | 7 | 2 | 7 | 2 | 100 % |
| Top 10 | No | 2.2 | Number of Outreach Workers and DLN/CSO staff trained on PPTCT module. | 7 | 3,155 | 7 | 2,752 | 87 % |
| Top 10 | No | 2.5 | Number of HIV positive pregnant women regularly followed by ORWs through home visits. | 7 | 2,487 | 7 | 2,388 | 96 % |
| | No | 2.7 | Number of network meetings held between health worker and ORW. | 7 | 14,210 | 7 | 33,271 | 120 % * |
| | No | 2.8 | Number and percentage of ORWs submitting reports in time | 7 | N: 3,500<br>D: 3,500<br>P: 100 % | 7 | N: 2,333<br>D: 2,529<br>P: 92.2 % | 92 % |

* Individual indicators should have a maximum score of 120%, when calculating the mean.

** The Results reported earlier than expected are rewarded with a 120% achievement.

Value for Reporting Period missing. The nearest preceding value is taken if available

Value of the first valid Target, for an Early Reporting scenario.

| Performance Rating | All Indicator or Top Indicator Score |
|---|---|
| A1 | >100 |
| A2 | 90%-100% |
| B1 | 60% - 89% |
| B2 | 30% - 59% |
| C | < 30 % |

| Cannot Calculate Scenarios | |
|---|---|
| S1 | Target and Result are in different value types |
| S2 | Target and Result are entered as Text. % Achievement is missing. |
| S3 | Target is zero |
| S4 | Result is zero for indicator requiring reverse calculation. |
| S5 | Numerator/Denominator/% value incomplete |

| | |
|---|---|
| AVG performance on TRAINING Indicators | 0% |
| AVG performance on TOP TEN indicators (including TRAINING) | 99% |
| TOP TEN indicators rating | A2 |
| AVG performance ALL indicators | 102% |
| ALL indicators rating | A1 |
| Number of TOP TEN indicators with B2 or C Rating | 0 |
| Quantitative Indicator rating | A2 |

**How does the grant contribute to the achievement of national targets? Please indicate the contribution of specific indicators.**

The program made significant progress in achieving targets and achieving impact toward a reduction in MTCT, especially in providing ARV prophylaxis to 78% of mother-baby pairs for prevention of MTCT, following up on 77% of positive pregnant women through home visits, and following up 44% of positive pregnant women going for institutional delivery. These achievements coupled with successful implementation of other interventions, such as training field staff on PPTCT and holding regular network meetings with health workers at the district level has significantly contributed to decreasing the percentage of infants born to HIV positive mothers to below 23%. A reduction in percentage of infants born to HIV positive mothers contributes to the downward trend in the prevalence rates in India. Reduction in percentage of infants born to HIV positive mothers and HIV prevalence rates are the national targets to which this grant is contributing.

**Analysis of Indicator Performance to date** **(including reasons for important deviations between results and targets, if any)**

The PR's performance relative to the grant's coverage indicators is given below:

- Number and percentage of HIV infected pregnant women and their babies (mother-baby pairs) receiving a complete course of ARV prophylaxis to reduce the risk of MTCT: Against a target of 71% (45,940/65,000), the PR achieved a revised target of 78% (28,747/37,041) based on the actual number positive pregnant women diagnosed. The achievement rate was 96%.
- Number of Outreach Workers (ORW) and district Level network/civil society organization (DLN/CSO) staff trained on PPTCT module: Against a target of 87% of the target, the PR trained 2,752 ORWs and DLN/CSO staff against a target of 3,155.
- Number of HIV positive pregnant women regularly followed by ORWs through home visits: The target during the period under review was 80% of the positive pregnant positive women detected by the National Program. NACO could only detect 37,041 positive pregnant women during Phase 1 against a target of 65,000. Out of this number 28,449 pregnant women were followed up by the PR which indicates that 77% of the detected positive pregnant women were followed and reflects a 96% achievement rate under this indicator.
- Number and percentage of HIV positive pregnant women, regularly followed by ORW, who go for institutional delivery: A follow up of 44.7% of these women was the target set under this indicator. The PR followed 11,530 women under this indicator out of a total 26,061 women which reflects 44% of these women. Thus, the achievement rate on this indicator is 98.3%. The total achievement in terms of absolute numbers is less because of the lesser than expected number of positive pregnant women detected by the National Program.
- Number of network meetings held between health worker and ORW: The over-achievement (167% achievement rate) was mainly because the PR has considered individual meetings of ORWs with a health worker or meeting of an ORW with two to three health workers as one meeting. Initially, it was assumed that each ORW will meet five health workers. The CCM has increased targets under this indicator in their request for Phase 2 funding.
- Number and percentage of ORWs submitting reports in time: Out of a total of 2,529 ORWs 2,333 ORWs submitted reports in time which represents 92% achievement. This process indicator is not proposed in the Performance Framework for Phase 2.
- Number of M&E System strengthening measures implemented: The PR's achievement rate on this indicator was 100% inasmuch as the PR implemented two system strengthening measures, including a monthly reporting format and M&E Plan.

The PR's underachievement against coverage targets in the Performance Framework is generally attributable to the following main factors:

- While achievement on the indicators related to positive pregnant women depend on the number of these women detected by the National program, a lesser than expected number of these women were detected by NACO during the period of review;
- Delays in recruitment of field staff led to challenges in follow-up of HIV positive mothers;
- Delays in piloting and implementing the mobile based reporting system for ORWs – communication and data management charges left out of the original budget had to be included in a revised submission to the Global Fund. The activity is now underway.

No targets were set for the three following indicators as of the cut-off date; they are reported by PR 1, NACO :

- Number/percentage of infants born to HIV+ pregnant women followed by ORW that go for follow up visit at health facility at 18 months post-delivery;
- Number of infants born to HIV infected women who receive an HIV test within 2 months of birth (virological testing); and
- Number of infants born to HIV infected women who start on cotrimoxazole prophylaxis within two months of birth.

## Achievement against program impact goals

| | Baseline | | | Year1 | | Year 2 | | Year 3 | |
|---|---|---|---|---|---|---|---|---|---|
| | Source | Date | Baseline | Target | Result | Target | Result | Target | Result |
| HIV Prevalence | Specific surveys and research (Revised estimates based on Annual Sentinel Surveillance 2003 and National Family Health Survey III and Integrated Behavioral and Biological Assessment study of 2006) | 2003 | 0.43 | | | | | | |
| % of infants born to HIV infected mothers who are infected | HMIS | 2003 | 30 | | | | | | |

**Is there a recent national survey or national study on impact and outcome available?** Yes

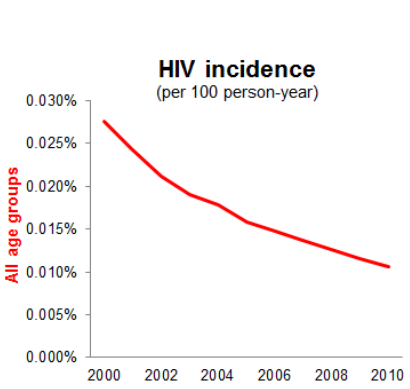
**If yes, when was it conducted?** 2010-2011

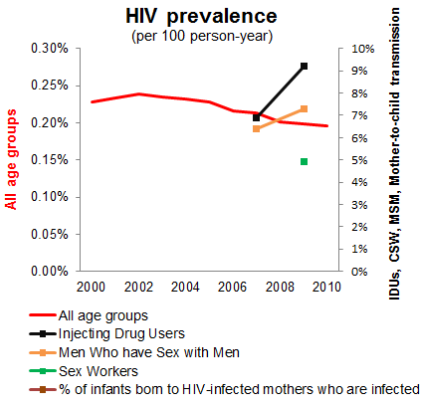
**Please provide your analysis of progress towards the goals of the proposal in the last commitment period, based on (1) trend analysis of results for key indicators; (2) findings of the Impact assessment study; (3) global and partners information.**

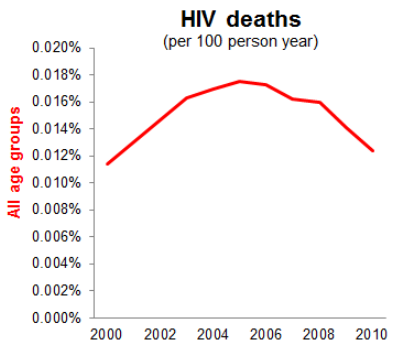
With the third largest number of PLWHA in the world, India has a concentrated epidemic nationally, but relatively high adult HIV prevalence in six states, namely Manipur (1.40%), Andhra Pradesh (0.90%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%) . The epidemic is predominantly driven by high risk heterosexual intercourse. Emerging and increasing incidence was found among IDUs, MSM and single male migrants while decreasing prevalence was found among FSW. With the scale-up of ART since 2004, AIDS mortality has been steadily declining, as reflected in the 2009 data, and the HIV incidence has decreased by 50% from 2000 to 2009.

Targeted interventions (TIs) started to be implemented as a national strategy in 1998 among high risk groups (FSWs, MSM and transgender, IDU) and bridge groups (truckers and migrants) by engaging community based organizations. Intervention services include BCC, condom promotion, STI care and referrals for HIV testing and ART. As of 2011, 1,385 TIs provided prevention services to an overall population of 3,132,000, covering 78% of the estimated number of FSW, 76% of IDUs, 69% of MSMs, 32% of migrants and 33% of truckers.

Although, the HIV sentinel surveillance collected data on HIV prevalence by sentinel groups in recent years, available data covers the period only up to 2009. The available data on HIV prevalence and behaviors up to 2009 showed the progress towards impact in India.




Source: UNAIDS unpublished estimates (Feb 2012)

Modeled incidence and mortality decreased from 2004 to 2009. Data for subsequent years (up to 2011) is due to be released at the end of 2012. The estimated adult HIV prevalence decreased from 0.41% in 2000 through 0.36% in 2006 to 0.31% in 2009 nationally. The decline is clear in six high prevalence states but an increase was found among the low prevalence states (Chandigarh, Orissa, Kerala, Jharkhand, Uttarakhand, Jammu & Kashmir, Arunachal Pradesh and Meghalaya) from 2006 to 2009.

The estimation in 2009 has confirmed that there is a clear decline of HIV prevalence among FSW at national levels and in most states. However, the evidence shows that IDUs and MSM are more and more vulnerable to HIV with increasing trends in many states.

The effectiveness of the Round 2 HIV RCC program in contributing to India's overall results is supported by the following achievements:

- ARV prophylaxis provided to 78% of mother-baby pairs for prevention of MTCT;
- Regular follow-up of 77% of positive pregnant women through home visits; and
- Follow-up of 44% of positive pregnant women going for institutional delivery.

**In cases of documented evidence of outcome and/or impact, please explain how the activities of the grant may have contributed**

The following main activities implemented by the PR have directly contributed to the reduction of infants born to HIV infected mothers who are infected:

- HIV infected pregnant women and their babies receiving a complete course of ARV prophylaxis to reduce the risk of MTCT;
- Outreach Workers trained on PPTCT module;
- District Level Networks (DLN) and Civil Society Organization (CSO) staff trained on PPTCT module;
- Tracking and reporting percentage of infants born to HIV infected women who receive an HIV test within 2 months of birth (virological testing);
- Tracking and reporting percentage of infants born to HIV infected women who start on cotrimoxazole prophylaxis within 2 months of birth; and
- HIV positive pregnant women regularly followed by ORW through home visits as well as following those HIV positive pregnant women who go for institutional delivery.

A reduction in HIV incidence in infants born to HIV positive mothers contributes to a reduction in the prevalence rates of HIV epidemic, so the grant has supported interventions that contributed to the reduction of HIV prevalence in India below 0.31%.

## Grant Management Issues

**ADDITIONAL Management issues identified by teams**
***identified in the LFA report or other sources (after the last disbursement)***

**Monitoring and Evaluation Systems Management -** *Please address issues related to data quality*

Some of the SRs in Bihar and Uttar Pradesh have reported a much higher than expected number of network meetings held between health workers and ORWs (Indicator 2.7), which may indicate data quality issues. The PR has been requested to check the accuracy of these results and provide us with their analysis.

Most of the district counselors do not have a proper supervisory and monitoring plan, and there are some data-quality issues on indicator performance resulting from the paper based recording systems, coupled with frequent changes in the reporting format. This issue is especially important due to the large number of SRs (up to 180 NGOs) and frequent turnover of staff. The PR will address these issues and closely monitor data quality issues and take corrective measures as appropriate.

Significant delays were observed in the implementation of the mobile based reporting system for ORWs due to delays on setting up the necessary ICTC-based computers, conducted by NACO. The PR plans to implement the mobile based reporting system throughout India in Phase 2, so the PR may face challenges arising from the lower literacy levels of ORWs and parallel reporting until the reliability of the mobile based reporting is assured. The Secretariat will be working with the PR to address these issues with both PRs.

**Program Management**

Some variances on indicators reported by NACO were identified and will need to be reviewed.

The Principal Recipient has met all applicable conditions, except for the one pertaining to ongoing assessment of SR capacity. Given the expansion of the program into new districts and turnover of SRs this condition will remain "in progress."

**Financial Management & Systems**

The expenditure reported by the PR does not agree with the books of account due to an error in compilation of expenditure for the purpose of reporting in PUDR; however, these non-material amounts were adjusted in the PUDR verification. The PR should prepare regular reconciliations to ensure that financial information on PUDR-EFR matches the information in the accounting system (chart of accounts).

Although there is a separate bank account for the grant, its balance does not agree with the closing balance as per the cash reconciliation. This is mainly attributed by the PR to the Global Fund-related transactions (such as salaries), which are effected through the PR's main bank account and not the Global Fund specific bank account. Again, these are non-material amounts that are adjusted in the course of the PUDR verification.

**Pharmaceutical and Health Product Management**

NA

**Other Management Issues (e.g. Quality of services etc).**

Some of the SRs use ORWs for a wide range of other activities ranging from data collection to maintaining records (such as daily diaries, minutes of the meeting, program registers, and monthly reporting forms) besides their routine work. This adds to the workload of the ORWs beyond their capacity and may negatively affect the quality of service delivery.

In certain cases, ORWs have to cover larger geographical areas in larger district which makes it difficult for the ORW to reach to the target population.

There is a need for the program to enhance interactions with accredited social health activists (ASHAs) and auxiliary nurse-midwives (ANMs) and work more closely with the national program at the district levels. This will help increase the number of positive pregnant women reached by the program.

These three operational issues will be addressed by the PR in the next implementation period.

## Recommended Secretariat RCC Phase 2 Rating

| | |
|---|---|
| **FINAL RECOMMENDED SECRETARIAT RCC PHASE 2 RATING** | A2 |

## OTHER RCC PHASE 1 PERFORMANCE ISSUES

### Aid Effectiveness

**Please elaborate on effectiveness issues identified in the Effectiveness Support Tool or other sources in the areas of a. ownership & accountability, b. alignment to country cycles and c. harmonization and coordination with other donor-funded activities.**

Over the last two decades, the Government of India has developed and gradually enhanced its response to the epidemic. The National AIDS Control Program (NACP) was established in 1986 with support from the World Bank. This sustained commitment has yielded benefits, including an effective blood safety program, increased number of sexually transmitted

disease clinics, voluntary counseling and testing centers, and an expansion of prevention of parent to child transmission services delivered through a quasi-autonomous NACO, supported by a strengthened state level implementation structure. With Global Fund support, NACP began providing free anti-retroviral therapy in high prevalence states in April 2004 and now have over 400,000 persons on treatment.

In 2005, GOI launched the National Rural Health Mission (NRHM) in order to reduce maternal and infant mortality, provide universal access to public health services, prevent and control communicable and non-communicable diseases, ensure population stabilization, maintain gender balance and revitalize local health traditions. NACP links closely with the operational framework provided for the Health sector by NRHM.

Significant financing is provided by the Global Fund and World Bank and other development partners - United States Government through USAID and PEPFAR and the UK Department for International Development (DFID – now withdrawing from India).

The current grant is a constituent part of NACP IV, takes account the convergence strategy with NRHM, and is aligned to the India government fiscal year of April –March.

## Gender Equality

**Is there evidence that women and/or sexual minorities are restricted from accessing care / receiving interventions?** No

**If yes, please explain**

NA

## PQR

**Was the PQR data entry up-to-date for all relevant health products procured during RCC Phase 1?** NA

**if not, please explain**

There is no procurement of health products and pharmaceuticals under this grant.

**Please assess compliance with the Global Fund QA policy for pharmaceuticals**

NA

## RCC PHASE 2 FINANCIAL REQUEST

### FINANCIAL ASPECTS OF RCC PHASE 2 REQUEST

#### Resources available to finance program after cut-off date

| Original RCC Phase 2 adjusted proposal Amount | Total | Year 4 | Year 5 | Year 6 |
|---|---|---|---|---|
| | $13,382,745 | $4,808,350 | $4,460,915 | $4,113,480 |

| Resources available to finance program after cut-off date | |
|---|---|
| Original RCC Phase 2 adjusted Proposal Amount | $13,382,745 |
| Undisbursed at cut-off date | $4,198,347 |
| Cash at cut-off date | $1,316,838 |
| Total Resources available (month 25-72) | $18,897,930 |

#### RCC Phase 2 Budget and Recommended Amount

| Recommendation | Year 4 | Year 5 | Year 6 | Total RCC Phase 2 Amount | % of maximum RCC Phase 2 Amount | Incremental RCC Phase 2 Amount | % of original RCC Phase 2 proposal Amount |
|---|---|---|---|---|---|---|---|
| **CCM Request** | $6,069,915 | $5,239,587 | $3,813,130 | $15,122,632 | 113% | $13,318,040 | 100% |
| **Secretariat Recommendation** | $5,656,003 | $4,927,647 | $3,540,311 | $14,123,961 | 105% | $12,295,688 | 92% |

**Comment on CCM analysis of RCC Phase 2 request versus original RCC Phase 2 budget**

Differences between original budget and CCM request:

- Human resources (US $3,427,606) - There is a decrease in HR costs mainly because there is a net reduction in the salary costs of outreach staff, as the number of such personnel has been reduced significantly from the originally proposed budget
- Training (US $926,891) - There is an increase in training costs is mainly because of the introduction of trainings which were not budgeted originally.
- Planning and Administration and Overheads (US $397,407) – There is an increase in management fees and audit costs and some decrease in administration cost regarding NGOs.
- Monitoring and Evaluation (US $2,356,224) - There is an increase in M&E costs is mainly a function of the following new items budgeted in the Phase 2 budget: Evaluation of NGOs, Communication & Data Management Charges (for mobile reporting application), Administrative costs paid to NGOs for M&E purposes.

**Secretariat Assessment of Financial Aspects of RCC Phase 2 Request**

The Secretariat recommends a total Phase 2 amount of US $14,123,961, US$ 3,686,912 for the remaining Phase 1 period after the cutoff date, and an increment of US $12,295,688 million, which represents 91.9% of the adjusted TRP approved RCC Phase 2 amount.