Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Grant Scorecard

GENERAL GRANT INFORMATION

Applicant:	Country Coordinating Mechanism
Country:	India
Round:	3
Component:	HIV/TB
Grant Title:	Expansion of effective public and private sector interventions in HIV and TB prevention and treatment in India
Grant Number:	IDA-304-G04-C
Principal Recipient:	The Department of Economic Affairs of the Government of India
Related Grants (same proposal):	
Proposal Lifetime:	5 Years
Lifetime Budget:	14,819,773.00
2-Year Budget:	2,667,346.00
Disbursed to Date:	1,583,561.00
Signature Date:	Oct/15/2004
Program Start Date:	Jan/01/2005

A. SECRETARIAT PHASE 2 RECOMMENDATION

Phase 2 Recommendation Category:	Go
Incremental Phase 2 Amount Recommended for Board Approval (USD):*	$ 12,152,426.00
Euro Equivalency:	€ 0.00

*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 Recommendations:

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

Program performance:
Overall performance of the program has been satisfactory with some very good absolute numbers reached with key services. For example:

- 4,040 people with advanced HIV receiving antiretroviral (ARV) combination therapy after successful completion of TB treatment (230% of target);
- 33,208 STI cases treated at sub-district level (265% of target);
- 78,179 people have received HIV tests (781% of target);
- 4,358 HIV positive and HIV/TB co-infected people on treatment for opportunistic infection (OI) at sub district level (316% of target); and
- 208 health facilities offering both voluntary counseling and testing (VCT) and TB diagnosis and treatment services (208% of target).

However, performance in coordination and partnership development has been poor with less than 50% achieved in both indicators. Therefore, the Principal Recipient (PR) must focus efforts on strengthening this service delivery area (SDA) early in Phase 2.

Additionally, as this program is part of the national program, the Secretariat would like to fully ascertain the Global Fund's contribution to the program in relation to other donors for Phase 2. Accordingly, greater transparency on this issue is to be reflected in the Phase 2 Budget and Work plans.

Program management and governance:
Overall, the implementing agent (under the PR, the Government's Department of Economic Affairs) the National AIDS Control Organization (NACO) has demonstrated satisfactory management of the program to date. Despite a slow start-up, implementation gathered pace particularly during Year 2, and the program is now demonstrating some solid programmatic achievement. Financial management has been adequate; however, training of all state level finance managers is required early in Phase 2 to ensure that the complex financial mechanisms of the program run smoothly in Phase 2. Training is also required at district level to strengthen monitoring and evaluation (M&E) systems. A number of concerns have been raised regarding data quality and the often cumbersome data collection system, which have prompted moves to improve M&E through training and strengthening the M&E team with additional staff for Phase 2.

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

The Secretariat classifies this Request as a "Go". In Phase 2, NACO should focus efforts on improving the performance of the coordination and partnership development SDA.

Rationale for Phase 2 Recommended Amount :

At the time of Phase 2 review, the Global Fund had disbursed US$2,185,472 (82% of funds available for Phase 1) to the PR. Of these funds, the PR has spent US$17,000 and disbursed US$1,579,000 to sub-recipients.

The latest verified PR cash balance stood at US$589,472 on 31 August 2006. These funds along with additional Phase 1 disbursements of US$481,874 will finance all remaining Phase 1 activities. Full utilization of the Phase 1 amount is anticipated.

In light of good overall performance and satisfactory grant management, the Secretariat concludes that the maximum Phase 2 amount of US$12,152,426 is appropriate for continued funding. As there are no surplus Phase 1 funds to partially fund this amount, the Secretariat recommends to the Board to commit the full US$12,152,426 for this program.

SUGGESTED REMEDIAL ACTIONS	
ISSUES	**DESCRIPTION OF SUGGESTED REMEDIAL ACTIONS**
1. Data quality needs improvement. 2. Financial management issues. 3. NGO participation needs strengthening. 4. Targets and coverage to be negotiated to a reasonable increase over the Phase 2 period. 5. Global Fund contribution to this national program is not clear. 6. Audit Report not yet submitted.	1(a) By Q10 (July 2007) an additional M&E officer to be recruited in NACO. (b) The M&E system review is to include a systematic review and quality assurance of all data. This review of the M&E system is to be completed by NACO by Q10 (July 2007) so that recommended revisions to the system are in place by Q12. (c) M&E training to be organized for district level nodal officers and completed by Q12 December 2007. This to be done in consultation with World Bank - co-funders of the National AIDS Program. 2(a) Prior to Phase 2 grant signing, a plan shall be submitted on how to improve the current financial management capabilities by NACO and the SACS to ensure accurate expenditures. (b) During the first two Quarters of Phase 2, additional training on financial management is to be carried out for all state level finance managers. 3. NACO to hire an NGO Officer to coordinate national level efforts to increase civil society partnership in program implementation. This position should be filled by Q11 (September 2007). 4. Prior to Phase 2 grant signing, the attachment should be revised to indicate increased targets where appropriate. 5. Prior to Phase 2 grant signing, the Global Fund's contribution to the National HIV budget for at least Year 3 of the grant should be demonstrated through a high level review of the National Budget and planned contributions thereto. 6. Prior to Phase 2 grant signing, the Audit Report is to be submitted, and any issues cleared to the satisfaction of the Global Fund.

B. PHASE 2 BUDGET AND IMPLEMENTATION ARRANGEMENTS

1. Estimated funds available for Phase 2

	Year 3	Year 4	Year 5
Original Phase 2 Adjusted Proposal Amount (*)	4,058,282.00	3,952,899.00	4,141,246.00

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

Particulars	Total
Original Phase 2 Ajusted Proposal Amount (table above)	12,152,427.00
Expected undisbursed amount at the end of Phase 1	0.00
Estimated Maximum Phase 2 Amount	12,152,427.00

2. Phase 2 Budget and Recommended Amount

	Year 3	Year 4	Year 5	Total Phase 2 Amount	% of maximum Phase2 Amount	Incremental Phase 2 Amount	% of original Phase 2 Proposal Amount
CCM Request(**)	4,058,282.00	3,952,899.00	4,141,246.00	12,152,427.00	100.00 %	12,152,427.00	100.00 %
Global Fund Recommendation (**)	4,058,282.00	3,952,898.00	4,141,246.00	12,152,426.00	100.00 %	12,152,426.00	100.00 %

(**) 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

3. Is the budget in line with:

3.1. Usage of funds in Phase 1?

○ Yes ○ No

The Phase 2 budget is reasonable considering the usage of funds (actual and projected) during Phase 1. The total expenditure under Phase 1 (till March 31, 2006) is 75% of the budgeted amount.

The factors contributing to less expenditure have been stated below:

The PR indicated that there have been delays in the implementation of the project by the SACS and selection of NGOs for supporting GFATM Round 3 Implementation. The SOEs received from the States for Year 1 reveal that the expenses under the various activities are in line with the budget allocated to them. The major activity which depicts less expenditure is the NGO component.

Utilization of the budget amount for Year 1 is approximately 65%, which has increased in the first quarter of Year 2 to 91%. Expenses were slightly low in Year 1 as administrative and operational implementation were slow in the first 3 quarters of Year 1 at the SR level.

In addition, the estimated quantity of the ART drugs and test kits to be procured was on the higher side compared to its utilization. Also, the cost of the ART drugs and test kits has reduced which has resulted in savings. Some of the expenses incurred by the states were booked to accounts other than GFATM. Considering the work plan for the Phase 2 which entails the enhanced activities planned for Phase2, the PR is well equipped to utilize the funds.

3.2. Anticipated program realities for Phase 2?

(•) Yes ( ) No

The Phase 2 budget is reasonable considering anticipated program realities for Phase 2. Phase 2 of the program envisages to increase the training of CHC staff, training of the health care providers of ART, training of counselors and lab technicians. A baseline assessment (mapping) will be carried out by SACS with information from State TB Cell and District Co-ordination committees (DCC). In addition, the program intends to strengthen the project centers with additional facilities like space for the counselors for counseling clients in privacy. More staff are planned to be trained in ongoing monitoring and supervision. Under Phase I, most of the states indicated that the budget allocation under the NGO component was inadequate to carry out the required activities. In view of this, the PR has made adjustments to the component-wise budget so as to ensure a larger amount under the NGO activity.

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

(•) Yes ( ) No

The key assumptions used in building up the budget are primarily based on current existing rates, ground realities and on the past experiences of PR.

5. Are there any other comments on the budget?

(•) Yes ( ) No

As per the CCM request, the Year 4 budget amounts to US $ 395,899. This is an obvious error. The LFA has discussed with the PR and the corrected figure is indicated above which is US $ 3,952,898.

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

No changes proposed. NGO participation will need to be expanded to ensure community support and effective refferals. NACO and CTD have decided to be much more careful to select NGOs who have an interest and experience to support the national program. The role of INP+ and other NGO networks are expected to be increased.

C. PROGRAM DESCRIPTION AND GOALS

1. Program Description Summary

The overall goal of this component is reduction in TB related morbidity in people living with HIV/AIDS while preventing further spread of HIV and TB in the rural population of six high HIV burden states.

Objectives:
(i) To strengthen AIDS-TB programme collaborations at all levels (national, state, district and sub-district); (ii) To promote early diagnosis and treatment of TB in HIV infected persons at the sub-district level; (iii) To increase coverage of HIV prevention and care interventions; (iv) To increase demand for prevention, care and support for HIV and TB through community mobilization and capacity building at community level.

Broad areas of activities:
(i) Establishing joint HIV/TB co-ordination committees and HIV/TB units at the National and State levels for close co-ordination, implementation and monitoring; (ii) Establishing strong referrals and linkages on sub district level between existing RNTCP infrastructure and the newly established sub-district level VCT which increases the reach of the NACP; (iii) Increasing capacity through infrastructure measures, recruitment, training of health care workers, provision of services in counseling, testing, condom promotion, treatment of opportunistic and sexually transmitted infections, establishing referral linkages with care, including home based and community care, and developing strategies for ART delivery at district level; (iv) Increasing demand for health services through awareness raising and mobilization of political leaders, NGOs, CBOs, private practitioners, women's organizations, PLWHAs and faith-based organizations and increasing capacities of communities to provide care

Expected results: (i) Improved monitoring and surveillance of the HIV/TB dual epidemic. (ii) Decreased TB related morbidity and mortality in people living with HIV/AIDS. (iii) Increased access to health services including voluntary counseling and testing, HIV prevention and care. (iv) Reduced social stigma and discrimination in rural communities. (v) Increased involvement and capacities of communities and civil society including PLWHA groups in health including TB and HIV prevention, treatment, care and support.

The immediate beneficiaries of the component are people with HIV/AIDS, people with TB and their families in rural areas of six high HIV prevalence states. There were an estimated 460,000 adults who were living with HIV in the rural communities of the six high burden States in 2001 who will be provided access to services under this component. Overall an estimated 80 million rural adult population will be targeted during the project period with IEC services and provided access to voluntary counseling and testing facilities.
People living with HIV and especially those co infected with M. tuberculosis, will have early access to TB diagnosis treatment, HIV counseling and testing, treatment of sexually transmitted infections and opportunistic infections, and care and support.
Beneficiaries will be involved in planning & coordination, service delivery, in IEC and community mobilization. Beneficiaries will be members of the coordination committees at the National, State and District levels will be responsible for planning and implementation of the component and for influencing policy decisions. Cured TB patients and PLWA will further be involved as outreach workers for home or community based care programs and in providing treatment support for TB and HIV and will help in strengthening the links between the health centers and the community.

PROGRAM GOALS AND IMPACT INDICATORS

		Baseline		Target				
Goal	The overall goal of this component is reduction in TB related morbidity in people living with HIV/AIDS while preventing further spread of HIV and TB in the rural population of six high HIV burden states.	Value	Date	Year 1	Year 2	Year 3	Year 4	Year 5
Impact indicator	Reduction in TB related morbidity among people living with HIV/AIDS in the rural community of high HIV prevalence States	50%	Mar-04					37%
Impact indicator	Reduction in annual rate of increase of HIV infection among 15-24 year olds in the rural community of high HIV prevalence States							by 25%

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.

Objective Number	Objective Description	Goal Number
1	To strengthen AIDS-TB program collaborations at all levels (national, state, district, and sub-district)	1
2	To promote early diagnosis and treatment of TB in HIV infected persons at the sub-district level	1
3	To increase the coverage of HIV prevention, treatment and care interventions	1
4	To increase demand for prevention, care and support for HIV and TB through community mobilization and capacity building at community level.	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	SDA	Level3	Level2	Level1	Rating	Evaluation of Performance (at the SDA level)
1	Supportive Environment: Health systems strengthening	0	0	1	B1	Number of hospital staff trained exceeded target while other indicators will be met by December 2006.
2	Treatment: HIV/TB treatment	1	1	1	A	Major acceleration in Year 2 has resulted in overachievement of all targets.
3	Prevention: HIV/TB prevention	5	1	2	A	Major acceleration toward the end of Year 1 and at the beginning of Year 2 resulted in very good performance.
4	Supportive Environment: Coordination and partnership development (national, community, public-private)	0	1	1	B2	The NGO component had a slow start. NACO has completed a planning meeting to accelerate implementation.

3. Indicator level Performance

PROGRAM OBJECTIVES, SERVICE DELIVERY AREAS, (SDAs), INDICATORS, TARGETS AND RESULTS.

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. Coverage indicators that have reached more that 80% of their targets are green and others red.

To strengthen AIDS-TB program collaborations at all levels (national, state, district, and sub-district)					
SDA	Supportive Environment: Health systems strengthening				
Level	Indicator	Charted Period	Target	Actual	0% 50% 100% 150%
Level 1- People trained	No. of national and state level HIV/TB unit staff trained in program planning and management and technical aspects of NACP and RNTCP and program supervision	5	143	255	178%

To promote early diagnosis and treatment of TB in HIV infected persons at the sub-district level					
SDA	Treatment: HIV/TB treatment				
Level	Indicator	Charted Period	Target	Actual	0% 50% 100% 150%
Level 1- People trained	No. of health center staff trained (2MOs, 1 lab technician and 1 counselor per health center)	5	400	887	221%
Level 2- Service Points supported	No. of health facilities offering both VCT and TB diagnosis and treatment services	5	100	208	208%
Level 3- People reached	No. of new cases of TB identified through TB screening in people attending VCT centers	5	1375	10523	765%

To increase the coverage of HIV prevention, treatment and care interventions					
SDA	Prevention: HIV/TB prevention				
Level	Indicator	Charted Period	Target	Actual	0% 50% 100% 150%
Level 3- People reached	No. of STI cases treated at sub-district level	5	12500	33208	265%
Level 3- People reached	No. of people receiving HIV testing	5	10000	78179	781%
Level 3- People reached	Number of TB patients receiving counseling at sub-district level	5	12500	35839	286%
Level 3- People reached	Number of HIV positive and HIV/TB co-infected people on treatment for OIs at the sub-district level	5	1375	4358	316%
Level 3- People reached	No. and percentage of people with advanced HIV infection receiving ARV combination therapy after successful completion of TB treatment	5	1750	4040	230%
Level 2- Service Points supported	No. of rural district hospitals providing ART	5	3	2	66%
Level 1- People trained	No. of hospitals staff trained at ART sites (2Mos, 2 counselors, 2 lab technicians, 1 pharmacist in each site)	5	21	41	195%
Level 1- People trained	No. of outreach workers trained in follow up of patients receiving ART	5	1250	903	72%

To increase demand for prevention, care and support for HIV and TB through community mobilization and capacity building at community level.					
SDA	Supportive Environment: Coordination and partnership development (national, community, public-private)				
Level	Indicator	Charted Period	Target	Actual	0% 50% 100% 150%
Level 1-People trained	Number of staff (NGOs, CBOs, private practitioners, women's group, PLWHA support groups, community and home based care programs) trained in providing care and support for people infected with HIV and/or TB.	5	75000	16200	21%
Level 2-Service Points supported	No. of networks/partnerships involved with NGOs working with RNTCP/NACP to raise awareness and mobilize communities to access sub-district level HIV/TB services	5	15	7	46%

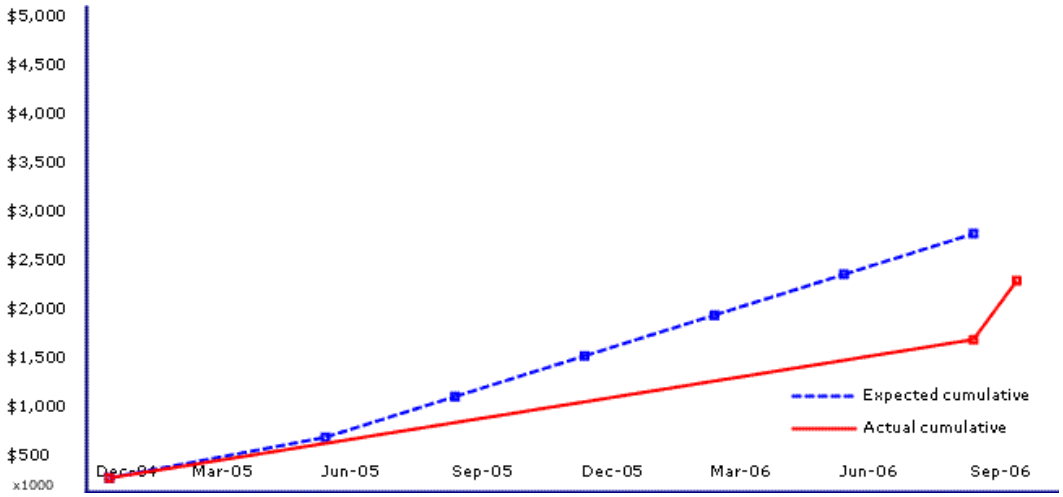
4. Disbursement History

*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

Disbursement Request	Expected Date	Actual Date	Expected Amount	Actual Amount	Expected cumulative	Actual Cumulative
1	22-Dec-2004	23-Dec-2004	165428	165428	165428	165428
2	14-May-2005		416986	0	582414	165428
3	14-Aug-2005		416986	0	999400	165428
4	14-Nov-2005		416986	0	1416386	165428
5	14-Feb-2006	07-Aug-2006	416986	1418132	1833372	1583560
6	14-May-2006	13-Sep-2006	416986	601912	2250358	2185472
7	14-Aug-2006		416988		2667346	2185472

EXPECTED VS. ACTUAL DISBURSEMENTS



5. Estimated under-disbursement in Phase1

Estimated under-disbursement in Phase 1	Amount	Amount (in %)
Phase 1 grant agreement amount	2,667,346.00	0 %
Less: actual disbursed to date	2,185,472.00	82 %
Less: expected additional disbursement until the end of Phase 1 grant agreement	481,874.00	18 %
Expected undisbursed amount at the end of Phase 1	0.00	0 %

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

21 Months

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

If yes, please comment:

Yes No

The program was experiencing significant reporting delays from the State AIDS Control Societies. The reporting has become more regular since the recruitment of 5 finance officers (1 per each State) for the program. The Director General is strengthening the finance team which now has seven professionals and a Director. The state level financial management is also strengthened through training and recruitment of additional finance officers.

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

If yes, please comment:

Yes No

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

If yes, please explain why and provide other relevant comments if 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)	2,185,472.00	100 %	Aug/31/2006
Less: Direct payments for PR Expenditures	17,000.00	1 %	
Less: PR disbursements to sub-recipients	1,579,000.00	72 %	
PR cash-balance	589,472.00	27 %	Aug/31/2006

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

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 any 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

E. CONTEXTUAL CONSIDERATION

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

○ Yes ● No

1.1. If yes can they be alleviated?

○ Yes ● No

2. Are there any unresolvable internal issues (e.g. , non-functioning CCM)?

○ Yes ● No

CCM complied with the Global Fund requirements. The compliance took much longer than anticipated but the CCM followed an extensive process to ensure that constituency selection is properly being followed.

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

● Yes ○ No

The PR is managing multiple projects and working with a large number of State AIDS Societies. The PR's capacity is being stretched in monitoring the sub-recipients. In addition, the PR has to gradually move from manual financial management to an automated one. Reporting delays have been predominant in the first few quarters of the program, however, the situation has improved dramatically since appointment of the finance officers at the state level. Five states have appointed finance officers and the sixth state will do this by September 2006.

4. Are there any systemic weaknesses in:

4.1. Monitoring and evaluation?

● Yes ○ No

There are significant delays in data transmission from district offices to state offices. Similarly, there are delays in transmitting reports from State level to the national Office. Monitoring and Evaluation capacity at the national level needs to be strengthened to ensure that consistent and suitable M&E practices are employed at the field level. NACO now has a M&E team of six people under the supervision of a Joint Director. An additional M&E officer is proposed under Phase 2 so that further strengthening of the data analysis and collection can be done.

4.2. Procurement and suppy management?

○ Yes ● No

NACO and the Ministry of Health have decided that all procurement will be managed by the procurement division of the MOH. Crown Agent has been tasked to improve overall procuremnet and supply management syststems of the procurement division. In addition, MOH has had several discussions with the international procurement agents and is now following a competitive process to recruit international procurement agents for various MOH procurement.

4.3. Any other areas?

Yes No

5. Are there any material issues concerning the quality or validity of data?

Yes No

The LFA confirmed that the PR has considerably improved their monitoring systems, however, the appointment of an M&E officer at the national level can help ensure more coordinated and consistent reporting. The new M&E officer will join the current M&E team which has six professional staff. UNAIDS provides technical support to NACO on M&E. NACPIII has a major component to improve national M&E systems.

6. Have there been any major changes in the program-supporting environment? (e.g., recent initiation of capacity strengthening, support of implementation by technical partners, changes in the intervention context or political commitment?)

Yes No

1.National AIDS Council has been constituted under the chairmanship of the Prime Minister of India to regularly review the progress of the program. Teams for NACP III have been set up to prepare the road map. Fourteen (14) Strategic Groups have been constituted to further discuss the various areas of the program, making recommendations to the NACP-III Planning teams. These teams are working to have the NACP-III in place at the earliest. The National Rural Health Mission (NRHM), launched in April 2005, by the Prime Minister, envisages to further strengthen the entire public health system including HIV/AIDS. TB continues to be a major priority area for the Gov't.

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

Yes No

The program implementation has significantly accelerated since January 2006. During this period the program has consistently increased the coverage of number of integrated counselling and testing centers (ICTCs), accelerated training of people to provide care and support, strengthened referral linkages from the sub-district to state and national levels. Based on revised national strategy and the importance of improving access, NACO has scaled up setting up ICTCs in district and sub district level and has exceeded the target set for Phase 1.

8. Have there been any changes in disease trends?

Yes No

At the time of proposal submission the epidemic was confined to urban localities and high risk groups. Today the epidemic is spreading from high risk groups to general population, from urban to rural areas, from high prevalence states to all states increasingly affecting female and youth population. The Government has now initiated a major focus on increasing access to services in both urban and rural areas. There is strong political commitment to ensure that both TB and HIV+ patients receive timely counselling and treatment. The government is committed to accelerating scaling up implementation of HIV/AIDS prevention and treatment programs.

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

9.1. Promote broad and inclusive partnerships?

Yes No

The TB/HIV unit at NACO should ensure that states better understand the program structure and have better access to the epidemiologist and technical officers at the central level. In addition, the role of the private sector needs to be strengthened by providing more training to private practitioners. It may be noted that the national HIV+ peoples network INP+ is an integral part of the program and is providing community level support to the programs in six states. The partnership between INP+ network NGOs and the state government is strong.

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

○ Yes ● No

The program implementation is based on national strategy, national systems including M&E. the Global Fund has accepted the national M&E system and is working closely with other donors and the government. There is strong coordination between State AIDS Societies and the TB program (RNTCP).

9.3. Provide additional resources?

○ Yes ● No

World Bank, DFID, and other donors will provide additional resources under NACPIII which is costed at $2.5 billion. Current funding provides support to twelve states on HIV/TB through the Central TB Division.

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

● Yes ○ No

Current grant is implemented in six high prevalence states which are also covered by HIV/AIDS grants of rounds 2 and 4. NACO implements the program through same management arrangement i.e., through State AIDS Control Societies.