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

Grant Scorecard

Grant Number: IDA-405-G06-H

GENERAL GRANT INFORMATION

Applicant:	Country Coordinating Mechanism
Country:	India
Round:	4
Component:	HIV/AIDS
Grant Title:	Accessing the Antiretroviral treatment to HIV/AIDS infected persons in six high prevalence States and NCT Delhi
Grant Number:	IDA-405-G06-H
Principal Recipient:	The Department of Economic Affairs of the Government of India
Related Grants (same proposal):	IDA-405-G05-H
Proposal Lifetime:	5 years
Lifetime Budget:	USD 140,878,119
2-Year Budget:	USD 21,672,559
Disbursed to Date:	USD 19,984,500
Signature Date:	27-Jun-2005
Program Start Date:	01-Sep-2005

A. SECRETARIAT PHASE 2 RECOMMENDATION

Phase 2 Recommendation Category:	Go
Incremental Phase 2 Amount Recommended for Board Approval (USD):*	$ 100,996,078
Euro Equivalency:	€ 0

*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:

Program performance:
This grant Program shows good performance throughout its Phase 1, reaching, or nearly achieving, the targeted numbers of people with key services. These include:

- 50,469 people living with HIV/AIDS (PLWHA) receiving antiretroviral therapy (ART) in the public sector (126% of target);
- 89,509 PLWHA receiving prophylaxis for opportunistic infections (74% of target);
- 87% of patients have reported that they take 95% of their required dosage each month (100% of target); and
- 2,247,529 people have undergone counseling and testing (499% of target).

Capacity building activities have also progressed well with satisfactory numbers of health facilities providing ART services and CD4 testing services. Further to this, the training activity has exceeded its target with good absolute numbers trained (result 864, target 800). In light of this strong performance, the Principal Recipient (PR) has planned to increase targets for Phase 2; most significantly, an increase of the ARV treatment target from 137,000 PLWHA's on ART in the original proposal to 180,000 by the end of Year 5 of the Program.

Program management and governance:
The PR, the Department of Economic Affairs of the Government of India, has demonstrated its ability to manage successfully this large Program. A significant number of programmatic achievements of targets have been made and the PR has made continuous efforts to strengthen the capacity of its implementing partners, particularly the main implementing agency, the National AIDS Control Organisation (NACO). Additionally, NACO has recently adopted the third national strategy NACPIII in consultation with over 30 partners including donors, national, and international partners. NACPIII has been operational since 1 July, 2007 and is a five year $2.5 billion national AIDS program. This Global Fund Program is part of the NACPIII.

Another key Sub-recipient, the Population Foundation of India is performing well and the coordination at the state level between NGOs and the State AIDS Control Societies (SACS) is reportedly very good. Regular coordination meetings are organized between NACO and other partners active in HIV/AIDS initiatives and regular Program review meetings with SACS Project Directors and Sub-recipients have showed to be effective in ensuring proper follow-up and coordination. This ensures a regular review of performance. Partners such as the Clinton Foundation have set up a national ARV training center for doctors in Chennai, and the US CDC (Center for Disease Control) is providing specific technical assistance at the state level. WHO has expanded its support to the Program with USAID and other donors. The US Government and EU have developed a technical assistance matrix for the CCM to strengthen its role, thereby focusing more specifically on CCM oversight development. Challenges continue in difficult states such as Manipur where insurgency and political instability create difficult conditions for implementation. NACO is closely monitoring the two north eastern states to improve their performance.

Additional capacity building is planned under NACPIII in Phase 2, most notably in financial management and monitoring and evaluation (M&E). This should further enhance the rate and quality of implementation.

The Secretariat classifies this Request as a "Go". In Phase 2, the PR should focus efforts on fulfilling the recommended time bound actions as stated on page 3 of this Grant Score Card.

Rationale for Phase 2 Recommended Amount :

In light of very good performance and sound grant management to date, the Secretariat concludes that the maximum Phase 2 amount of US$100,996,078 is appropriate for continued funding. As there are no undisbursed Phase 1 funds available to partially fund this amount, the Secretariat recommends to the Board to commit the full US$100,996,078 for this Program.

SUGGESTED TIME-BOUND ACTIONS		
ISSUES	**DESCRIPTION OF TIME-BOUND ACTIONS**	
1. Care and Support services for PLWHA were not conducted in Delhi NCT, as envisioned.	1. Prior to the signature of the Phase 2 extension, the PR shall put in place the Care and Support structures through the establishment of TCCs (Treatment Counseling Centers) and DLNs (District level networks) in Delhi NCT.	Delete
2. M&E strategy under NACPIII was developed but an operational plan is yet to be developed by NACO and key donors.	2. By 31 December 2007, the PR shall deliver to the Global Fund an operational plan for M&E of the Program, taking into account the national M&E operational plan of NACPIII.	Delete
3. Global Fund financial management and reporting requirements are not addressed by the national computerized accounting framework (CFMIS software).	3. By 31 December 2007, the PR shall integrate Global Fund financial management and recording needs in CFMIS.	Delete
4. Potential savings were identified by the Secretariat on ARV costs.	4. Prior to signature of the Phase 2 extension, the PR, in consultation with the Secretariat, shall explore using potential savings in the Program budget. Such saving should be reallocated to the Program with a corresponding increase in impact and outcome of the Program and/or to strengthen quality assurance activities for the Program (namely M&E, training, HR). If any such savings are not re-invested in such ways, and if a compelling case for reallocating them in other ways is absent, such funds shall be returned to the Global Fund.	Delete
5. Audit report.	5. Prior to first Phase 2 disbursement, the 2005-6 audit report shall be finalized. However, this deadline may be extended if the delay stems from the unavailability of the sector wide report.	Delete
		Add

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 (*)	USD 23,897,307	USD 33,522,566	USD 43,576,205

(*) 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)	USD 100,996,078
Expected undisbursed amount at the end of Phase 1	USD 0
Estimated Maximum Phase 2 Amount	USD 100,996,078

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(**)	USD 27,027,600	USD 35,054,026	USD 43,051,030	USD 105,132,656	104%	USD 105,132,656	104%
Global Fund Recommendation (**)	USD 27,027,600	USD 35,054,026	USD 38,914,452	USD 100,996,078	100%	USD 100,996,078	100%

(**) 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

PR has received disbursements amounting to US$ 19.985 million from GF for the entire Phase 1. The actual expenses till March 31, 2007 were US$ 19.472 million as compared to the budgeted amount of US$ 18.848 million, representing approximately 103% utilization.

PR shall be placing an additional DR for the remaining balance of Phase 1 which amounts to US$ 1.688m. In view of the past utilization rate, the PR shall be able to utilize the entire funds of phase 1.

With regard to the Phase 2 budget, cost efficiency has been factored in the preparation of the same.

Operational guidelines have been developed for ART centers which describe the functions of ART centers, facilities required in terms of infrastructure, medical equipment, human resources and linkages from and to the center.

The guideline clearly spells out the roles and responsibilities of each staff member. The mechanism for maintenance of drugs and patients records and M&E tools have also been detailed out.

Further, the guidelines also describe issues related to financial management including audit and expenditure.

Guidelines have been prepared on the past experience of PR gained from Phase 1 and other similar programs.

Budget is primarily based on NACPIII financials norms, current existing rates, ground realities and on the past experiences of PR.

3.2. Anticipated program realities for Phase 2?

jn Yes jn No

The overall performance has been consistent and the progress of the implementation targets has been met with efficiency, with clear deliverables and positive results.

At the end of Phase 1, PR expects entire Phase 1 budget shall be utilized and shall achieve all the targets.

PR has shown capacity to implement the project as per the approved plans. However, intensifying monitoring of program performance at PR and sub recipient level would help achieve targets for year 3 and 4 and overall expenditure would be in line with the plan.

The Phase 2 budget is based on the projected work plans for the 3 years. The work plan gives a detailed breakdown of activities based on targets which are achievable in the light of constraints, resources available.

In the proposal, PR had originally indicated total number of PLHAs to receive ART as 137,372. PR has now increased this coverage to 180,000 by the end of Phase 2, an increase of 31% which will have additional costs of drugs, care and support, counselling and testing,etc. Further, PR had estimated counseling and testing for 1 million people which PR expects to reach to 3 million.

Therefore, PR is able to meet a much larger coverage than originally planned for. The issue of the total financial resources sufficing for this additional effort was also gone into by LFA. It is concluded that additional expenditure was linked to usage of more drugs and testing kits cost. It is understood that economies of scale as well as reduction in procurement prices of drugs as well as testing kits should cover the enhanced targets.

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

jn Yes jn No

5. Are there any other comments on the budget?

jn Yes jn No

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

No change.

C. PROGRAM DESCRIPTION AND GOALS

1. Program Description Summary

The program is being implemented by the National AIDS Control Organization (NACO) in six high prevalence states and Delhi to reduce morbidity and mortality associated with HIV/AIDS. NACO works in partnership with the NGO consortium led by the Population Foundation of India. These six high prevalence states are: Tamil Nadu, Maharastra, Karnataka, Tamil Nadu, Nagaland and Manipur. Combined population of the six high prevalence states and Delhi is 305 million people. The National Capital Territory (NCT), Delhi draws mobile and migrant people from across the country, and particularly from the low prevalence neighboring states of Haryana, Uttar Pradesh, Punjab, Bihar and Himachal Pradesh in search of livelihood and for care and treatment. These migrant population is be part of the services covered under this program. This project aims at strengthening the capacity of both the public and private sectors to deliver, care and provide antiretroviral treatment (ART) by improving and expanding high quality clinical training and follow-up, increasing access to quality voluntary counseling and testing (VCT), improving diagnostic capability, augmenting quality assurance systems, consolidating and renewing communications strategies, and ensuring more effective referral linkages across the prevention-to-care continuum.

The intervention includes treatment (including ART), care, and support through the public and the private sectors. During the first two years, over 1200 health professionals should receive ART training and 50 CD4 machines should be procured to expand the capacity of ART centers.

Two kinds of public private sector partnerships are proposed. The first relates to public sector partnership with private sector networks of health centers, blood banks, and laboratories to increase access to screening, testing, and monitoring PLWHA. Second partnership is with NGO consortium to improve involvement of the PLWHAs, community-based care and support and expanded partnerships with grassroots level NGOs.

This is a major phased scale up of ARV treatment in India through an enhanced partnership with the NGO and the private sectors. Over a five year period, 137,000 PLWHAs will receive ART and over 2.8million people will be tested. The program will complement existing donor funded programs in 138 districts and 50 major teaching medical hospitals.

PROGRAM GOALS AND IMPACT INDICATORS									
Goal	To improve the survival and quality of life of people living with HIV/AIDS and reduce HIV transmission in the high prevalence states and Delhi	Baseline		Target					
		Value	Date	Year 1	Year 2	Year 3	Year 4	Year 5
Impact indicator	% of people still alive at 6,12, and 24 months after initiation of antiretroviral treatment	N/A	N/A	N/A	N/A	N/A	N/A	90% 85% 80%
Impact indicator	% of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner	25%	2005	N/A	N/A	N/A	N/A	50%

D. SUMMARY OF Y1-2 GRANT PERFORMANCE

1. Overall Grant Rating

A. Expected or exceeding expectations

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 reduce morbidity and mortality associated with HIV/AIDS and the transmission of HIV in 6 prevalence States & NCT Delhi by combining care, treatment (including ART), prevention and support.	

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	SDA - Treatment: Antiretroviral treatment and monitoring	3	2	1	A	Number of PLHAs on ART is 126% of target and other ART related targets have achieved high performance.
1	SDA - Supportive Environment: Monitoring and evaluation and operations research	0	0	0	X	N/A, as this is process indicator.
1	SDA - Prevention: Counseling and testing	1	0	0	A	High performance due to excellent expansion of VCCT services and NGO participation.

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 reduce morbidity and mortality associated with HIV/AIDS and the transmission of HIV in 6 prevalence States & NCT Delhi by combining care, treatment (including ART), prevention and support.

SDA	SDA - Treatment: Antiretroviral treatment and monitoring				
Level	Indicator	Charted Period	Target	Actual	0% 50% 100% 150%
Level 2-Service Points supported	Indicator 1.1 - No of public health facilities providing ART services with adequate supply of ARVs and drugs for OI management and voluntary counseling and testing facilities.	6	90	88	98%
Level 3-People reached	Indicator 1.2 - No of PLHAs receiving ART in the public sector	6	40,000	50,469	126%
Level 3-People reached	Indicator 1.3 - No of PLHAs receiving prophylaxis for OIs	6	120,000	89,509	74%
Level 3-People reached	Indicator 1.4 - Percentage of patients reporting that they took 95 % doses each month	6	87%	87%	100%
Level 1-People trained	Indicator 1.5 - No of required staff trained at ART center level	6	800	864	108%
Level 2-Service Points supported	Indicator 1.6 - No and proportion of diagnostic facilities providing quality CD4 testing as per required norms	6	50	42	84%

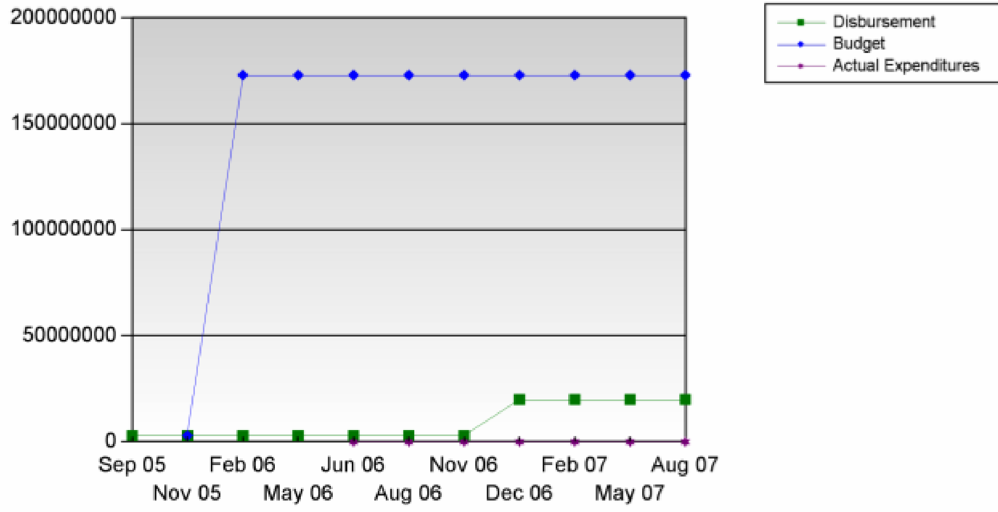
SDA	SDA - Supportive Environment: Monitoring and evaluation and operations research				
Level	Indicator	Charted Period	Target	Actual	0% 50% 100% 150%
Level 0-Process/Activity Indicator	Indicator 1.7 - No of operation research studies completed	6	2	0	0%

SDA	SDA - Prevention: Counseling and testing				
Level	Indicator	Charted Period	Target	Actual	0% 50% 100% 150%
Level 3-People reached	Indicator 1.8 - No of people undergone HIV counseling and testing	6	450,000	2,247,529	499%

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



5. Estimated under-disbursement in Phase1

Estimated under-disbursement in Phase 1	Amount	Amount (in %)
Phase 1 grant agreement amount	USD 21,672,559	0%
Less: actual disbursed to date	USD 19,984,500	92%
Less: expected additional disbursement until the end of Phase 1 grant agreement	USD 1,688,059	8%
Expected undisbursed amount at the end of Phase 1	USD 0	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.) ?

16 Months

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

If yes, please comment:

Yes No

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

Against the Phase 1 budget of US$ 21.673 million, PR has received US$ 19.985 million. PR has advised that it shall be placing an additional DR for the ensuing period of Phase 1. Keeping in view the past utilization rate (i.e., 103%) PR shall be able to utilize the entire Phase 1 funds. Hence, PR will not have any undisbursed funds at the end of Phase 1.

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)	USD 19,984,500	100%	31-Mar-2007
Less: Direct payments for PR Expenditures	USD 16,364,000	82%	31-Mar-2007
Less: PR disbursements to sub-recipients	USD 4,872,000	24%	31-Mar-2007
PR cash-balance	-USD 1,251,500	-6%	31-Mar-2007

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)?

jn Yes jn No

1.1. If yes can they be alleviated?

jn Yes jn No

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

jn Yes jn No

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

jn Yes jn No

Financial management needs to be further strengthened and this has been indentified as a capacity building initiative under NACPIII. NACPIII has developed a detailed plan for further computerisation and will include GF funded grants under computerised financial management used for World bank and other donors. Additional documentations have been provided by NACO to substantiate this claim. During phase1 period, there have been challenges with financial management and NACO has gradually increased capacity at NACO and state levels. Additional finance managers will be hired for NACO within next three to six months. Financial management training have been provided to state finance officers and additional training will be done with GF support in July 2007.

4. Are there any systemic weaknesses in:

4.1. Monitoring and evaluation?

jn Yes jn No

A number of M&E strengthening measures have been identified under NACPIII. This includes further computerisation of MIS and additional indicators to track performance. The national program will also support Joint Monitoring Mission but the details will have to be worked out in 2008. Some of the reporting problems are being corrected through regular review meetings. MIS review and upgrade is part of NACPIII. NACO has completed the self assessment M&E tool and has updated their M&E plan. However, M&E strategy under NACPIII needs to be operationalised and the partners are discussing timeline for an operaitonal plan for M&E. UNAIDS has recently completed a program review and will consider additional support to the national program.

4.2. Procurement and suppy management?

jn Yes jn No

An international procurement agent has been appointed. The Empowerment Procurement Wing of MOH will be strengthened with technical assistance from Crown Agents. Six international consultants are assisting MOH for additional capacity enhancement. PRM is now regularly updated. NACO will send procurement specialist to attend GF sponsored training on QA in August 2007.

4.3. Any other areas?

jn Yes jn No

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

jn Yes jn No

This is a fast moving program in very large states. Some reporting problems have been reported by LFA which has been discussed with NACO for further improvement. Reporting needs to be further strengthened to improve accuracy of data reporting and this will be taken up under NACPIII. The partners have agreed with NACO to develop better data quality and monitoring, an exercise similar to national TB program.

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?)

jn Yes jn No

1. National AIDS Council has been constituted under the chairmanship of the Hon'ble Prime Minister. The National Council reviews the progress of the program from time to time and suggest on the future course of action;
2. Mainstreaming of the 31 Ministries of the Government have come forward to take HIV/AIDS as a major agenda in their respective Ministries;
3. National AIDS Control Program –Phase III (NACP-III) Designing teams have prepared the roadmap for the NACP-III. Fourteen Strategic Groups were constituted to discuss the different areas of the program and make recommendations to the NACP-III Planning teams. NACP-III is likely to commence from 2007. NACP-III- emphasizes decentralized implementation, public-private partnership, comprehensive care, greater involvement of NGOs, CBOs and networking with various stakeholders and partners;
4. The National Rural Health Mission (NRHM), launched in April 2005, by the Hon'ble Prime Minister, envisages the further strengthening of the entire public health system including National AIDS Control Program;
5. Progressive scaling up of ART centers from initial 8 (April 2004) to 100 (October 2006);
6. Special initiative to identify & treat HIV/AIDS with children has been taken up. Paediatric formulation have been made available at 36 ART centers;
7. Partners such as WHO, CDC, Clinton Foundation, and UNAIDS are providing technical and other support; and
8. USG and EU have developed a technical assistance plan to strengthen CCM which will be funded by USG.

After successfully managing two phases of the National AIDS Control Program, India is in the process of Implementation of the Third National AIDS Control Program [NACP III] (2006-2011). The overall goal of NACP III is to halt and reverse the epidemic in India over the next 5 years by integrating programs for prevention, care, support and treatment. This will be achieved through four strategic objectives namely:

1) Prevention of new infections in high risk groups and general population through:

- Saturation of coverage of high risk groups with targeted interventions (TIs)
- Scaled up interventions in the general populationIncreasing the proportion of people living with HIV/AIDS who receive care, support and treatment.

1. Strengthening the infrastructure, systems and human resources in prevention and treatment programs at the district, state and national levels.
2. Strengthening a nation-wide strategic information management system.

NACP III is designed to provide a range of preventive services i.e., behaviour change communication, treatment of STIs, condom promotion, Integrated Counselling and Testing, PPTCT, supply of safe blood and infection control. The focus of NACP II was on prevention along with low cost treatment for Opportunistic Infections. It was only in 2005 that the government initiated the provision of ART. While the emphasis on prevention will be retained, NACP III will also lay stress on care, support and treatment services integrated with prevention. This will include management of opportunistic infections; control of Tuberculosis in PLHA; clinical diagnosis, ART, community outreach for treatment adherence and psycho social support; safety measures; positive prevention; impact mitigation programs; and establishment and support of Community Care Centers etc. ART is now made available in 88 centers (till March 2007) and it is proposed to scale them up. 50469 persons have been placed on ART as on 31st March 2007.

Since the India – Country Coordinating Mechanism (India-CCM) for the GFATM at its meeting on 11th May 2006, had resolved to focus the entire Round-6 proposal on care, support and treatment, the effectiveness and importance of providing ARV treatment as is on going under Round 4 and further proposed to be extended during the Phase 2 of the program is going to be further enhanced. Besides the results of the Round 4 Phase 2 are expected to be achieved effectively as the support care and support and counselling activities will be also taken up by other PR's i.e. PFI and HIV Alliance as part of the Round 6.

The strategies that have been adopted and are proposed to be continued as part of Round 4 Phase 2 will be in line with the framework developed for NACP III. The NACPIII strategies include:

1. Prophylaxis and management of opportunistic infections;

2. Prevention of Parent to Child transmission;
3. Anti- Retroviral Therapy;
4. Diagnostics and resistance monitoring including supply and maintenance of CD4 and PCR machines;
5. Paediatric Anti-retroviral therapy;
6. Community outreach for treatment literacy and adherence;
7. Establishment and support of Community Care Centers;
8. Support and training to PLHA;
9. Palliative care; and
10. Impact mitigation.

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

Yes No

8. Have there been any changes in disease trends?

Yes No

A recent report indicates that the total number of HIV+ people may be less than 5.7 million. This report is yet to be made public. However, the national program claims the number of HIV+ people to be much higher in other states which are not part of the high prevalence six states.

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 institutional arrangements, capacity strengthening, technical support and monitoring and evaluation systems are being configured to support the interventions as part of NACPIII. These interventions will be delivered in collaboration with private sector, academic/research/training institutions, civil society organisations (CSO), and PLHA networks. NACP III envisages contracting to private providers and civil society organisations in the provision of services through public-private partnership.

NACO is partnering with private sector and NGOs to expand services rapidly. Innovative conmponents such as cost recovery scheme and introduction of computerised patient cards will be done under NACPIII. NGOs are part of state level implementation and NACO has successfully partnered with a number of local and international partners.

Under NACP III Community Care Centers are proposed to be set up. These will be managed by CSOs. Innovative mechanisms for treatment monitoring, community based approaches for care and support, models for successful integration of prevention in care and support, models for impact mitigation are some of the other areas where proposals from the private sector and civil society organisations will be welcome.

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

Yes No

The program is part of NACPIII and National Rural Health Mission Strategy.

9.3. Provide additional resources?

Yes No

NACPIII budget is $2.5 billion over five years, a large poriton is from the GOI. World Bank is the other large donor. DFID, USAID, and Gates Foundation also provides large funding.

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.)?

jn Yes jn No

This program focusses on six high prevalence states. Round 6 will focus on other states which are termed as highly vulnerable states. The strategy to scale up is the same as used under this program. The national program will scale up ART services while NGOs provide care and support through community based networks and referrals. Pregnant women attending VCCT centers under round 2 are referred to ART centers and TCC for treatement and counselling. Procurement of drugs are done by the national government and will be distributed using the same distribution channel.