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

Grant Scorecard

Grant Number: IDA-607-G10-H

GENERAL GRANT INFORMATION

Applicant:	Country Coordinating Mechanism
Country:	India
Round:	6
Component:	HIV/AIDS
Grant Title:	Promoting Access to Care and Treatment
Grant Number:	IDA-607-G10-H
Principal Recipient:	The Population Foundation of India
Related Grants (same proposal):	IDA-607-G11-H (implemented by National AIDS Control Organization); IDA-607-G12-H (implemented by India HIV Alliance)
Proposal Lifetime:	5 years
Lifetime Budget:	USD 259,211,571
2-Year Budget:	USD 7,918,367
Disbursed to Date:	USD 7,050,390
Signature Date:	15-May-2007
Program Start Date:	01-Jun-2007

A. SECRETARIAT PHASE 2 RECOMMENDATION

Phase 2 Recommendation Category:	Go
Incremental Phase 2 Amount Recommended for Board Approval(USD):*	$20,390,449
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:
Along with the grant managed by the Department of Economic Affairs of the Government of India (IDA-607-G11-H), this grant is being implemented under a “dual-track” financing arrangement, and the two programs are being effectively implemented in a coordinated manner

This Round 6 HIV grant seeks to reduce HIV related morbidity and mortality in adults and children in India, as well mitigate the impact of HIV on households headed by children and women. The Principal Recipient (PR), the Population Foundation of India, has achieved excellent results to date, meeting or exceeding most of its targets:

• 10,731 People Living with HIV/AIDS (PLWHA) received care at Community Care Centers (120% of target)
• 4,617 PLWHA were enrolled by district level networks for care and support (120% of target)
• 3 state networks were strengthened (100% of target)
• 427 people were sensitized at advocacy workshops/meetings (120% of target)
• 50 Community Care Centers were set up (120% of target)

Program management and governance:
The PR has demonstrated a strong capacity to manage this grant during Phase 1, disbursing funds to Sub-Recipients (SRs) in a timely and efficient manner to ensure uninterrupted program implementation. This PR, an NGO in India, has a history of excellent performance and management capacity, and has not experienced any major problems in the areas of financial management systems, procurement and supply management and M & E systems.

However, an M&E system assessment identified weaknesses that need to be addressed by the PR during Phase 2. In addition, there is an M & E budget for Phase 2 but no details of activities, and an M & E action plan is needed.

Furthermore, India had a major revision of the estimated disease burden, from .91% estimated HIV prevalence in 2005 to .34% in 2007. The CCM has not discussed any impact on the services being set up, and there has not been any mention of a change in strategy in the national plan. The PR has increased some targets but has not provided clear assumptions for how it has arrived at the revised targets, and there appear to be inconsistencies between the increased targets, the reduced HIV prevalence, and the National AIDS Control Organization (NACO) grant targets decrease relating to the number of adults on ARV treatment.

Rationale for Phase 2 Recommended Amount :

In light of good performance in Phase 1, the Secretariat concludes that an incremental amount of $20,390,449 (90% of original Phase 2 budget) is appropriate for continued funding.

SUGGESTED TIME-BOUND ACTIONS	
ISSUES	**DESCRIPTION OF TIME-BOUND ACTIONS**
1. The PR has not provided a list of the medicines to be procured for this program to treat opportunistic infections (Annex 1a to the Procurement and Supply Management (PSM) Plan template).	1. Prior to signing the Phase 2 extension, the PR shall provide to the Global Fund a list of the medicines to be procured for the treatment of opportunistic infections (Annex 1a to the PSM Plan template) including quantities, unit pack, unit costs and total cost. The PR shall include all assumptions used to determine quantities and unit costs and should clearly show the link to targets where appropriate. The PR shall also provide to the Global Fund written confirmation that that the procurement of medicines for opportunistic infections will be done through the Framework Contracting Procedure.
2. The level of carry over of PR and SR cash at the end of Phase 1 may exceed the projected levels include in the Phase 1 disbursements.	2. Prior to signing the Phase 2 extension, the PR and SRs cash balance at the end of Phase 1 (31 May 2009) shall be verified and any excess funds will be deducted from the Phase 2 incremental amount.

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 7,216,918	USD 7,769,285	USD 7,752,021

(*) 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 Adjusted Proposal Amount (table above)	USD 22,738,224
Expected undisbursed amount at the end of Phase 1	USD 867,977
Estimated Maximum Phase 2 Amount	USD 23,606,201

2.Phase 2 Budget and Recommended Amount

	Year 3	Year 4	Year 5	Total Phase 2 Amount	% of maximum Phase 2 Amount	Incremental Phase 2 Amount	% of original Phase 2 Proposal Amount
CCM Request(**)	USD 7,503,897	USD 8,077,148	USD 7,148,032	USD 22,729,077	96%	USD 21,861,100	96%
Global Fund Recommendation(**)	USD 7,008,458	USD 7,530,605	USD 6,719,363	USD 21,258,426	90%	USD 20,390,449	90%

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

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

m Yes l 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 increasesin program costs, etc.)

Non applicable

2. Is the budget within the permitted maximum?

l Yes m No

The revised CCM endorsed Phase 2 Budget Request is for USD 21,423,133, which is within the upper limit for Phase 2.

3. Is the budget in line with:

3.1 Usage of funds in Phase 1?

l Yes m No

The activities in Phase 1 were primarily undertaken as per the Work Plan and most of the targets have been achieved by the PR by end of Period 6. The PR was able to achieve certain savings/economies in Phase 1, which appear to have been built into the Phase 2 budget, as there has been an overall reduction in the Phase 2 budget from the original proposal, partly offset by certain new activities in the phase 2 budget. The actvities envisaged in Phase 2 are primarily the same as were there in Phase 1 i.e. establishing the DLNs and CCCs, expanding the create networks and their services to PLHA and providing care and support to PLHA. The PR has the absorptive capacity to utilise the budget, based on experience in Phase 1.

3.2 Anticipated program realities for Phase 2?

l Yes m No

Non applicable

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

l Yes m No

In general the assumptions used in the budget are reasonable and show sufficient level of detail. However, the LFA raised certain reservations on the following (please see LFA report for more details): (1) In case of certain costs in the budgets, the assumptions did not appear to be reasonable and accordingly, adjustments have been recommended by the LFA and accepted by the PR. (2) Costs of certain items have been budgeted as lump sum costs and were based on best estimates (e.g. management cost (8% of direct expenditure). The issue is currently being discussed with the PR.

5. Are there any other comments on the budget?

l Yes m No

The PR already revised the original budget submitted in the CCM Request for Continued Finding on the basis of the discussions with the LFA.

C. PROGRAM DESCRIPTION AND GOALS

1. Program Description Summary

There are three grants being implemented under Round 6 India HIV Proposal: IDA-607-G10-H by Population Foundation of India (PFI); IDA-607-G11-H by National AIDS Control Organization (NACO); and IDA-607-G12-H by India HIV Alliance. All three are part of National AIDS Control Program (NACP-III). Activities under IDA-607-G10-H and IDA-607-G11-H focus on scaling up access to antiretroviral treatment (ART) and care & support services in the highly vulnerable states, namely Uttar Pradesh, Madhya Pradesh, Rajasthan, Gujarat, Bihar, Chhattisgarh, West Bengal and Orissa. This is similar to the activities of Round 4 grants IDA-405-G05-H implemented by PFI and IDA-405-G06-H implemented by NACO.

While NACO scales up the ART services by increasing the number of ART centers and related activities such as Integrated Counseling and Testing Centers ("ICTC") for expanding access to treatment and prophylaxis of Opportunistic Infections (OI); PFI focuses on the care & support component of HIV/AIDS program.

The program goal is to reduce HIV related morbidity and mortality in adults and children; and mitigate the impact of HIV on children and women headed households. The program target group/beneficiaries include women, children, and men from the eight highly vulnerable states. The program strategies include the following:
1. creating and strengthening networks of PLWHA for providing care and support, treatment education, prevention and building effective linkages for ART, PPTCT and other care services in three states of UP, MP and Rajasthan;
2. mapping and strengthening private / non-government/ faith based health care institutions to provide institution based care for PLWHA along with other reproductive health services in 8 states – UP, MP, Rajasthan, Gujarat, Bihar, West Bengal, Orissa and Chhattisgarh; and
3. creating an enabling environment for multi-sector convergence to mainstream convergence and integrate gender, RH and HIV/AIDS.

During the course of the project, PFI will promote and include other partnerships in the program such as:
• Indian Network of People Living with HIV/AIDS (INP+), which is responsible for setting up state and district level networks in UP, MP and Rajasthan.
• Hindustan Latex Family Planning Promotion Trust (HLFPPT), which manages & monitor community care centers from UP, MP and Rajasthan.
• Catholic Bishops' Conference of India (CBCI), which CBCI is envisioned to be responsible for managing & monitoring community care centers from Bihar, West Bengal, Orissa, Chhattisgarh and Gujarat.

The PFI carries the program activities in coordination with NACO and its State AIDS Control Society (SACS).

Planned Activities for Phase I (Year 1 & 2) under the grant include the following:
• setting up State Level Networks (SLN);
• establishing and strengthening District Level Networks (DLNs) for care & support services. DLNs are being established in 100 districts of 3 larger states: Uttar Pradesh (UP), Madhya Pradesh (MP) and Rajasthan. These networks mobilize PLWHA for accessing treatment, Prevention of Parent to Child Transmission (PPTCT), and for treatment adherence.
• identifying and strengthening Community Care Centres (CCC), which provide services to People living with HIV/AIDS (PLWHA) requiring a short period of institutional care. The CCC services include providing treatment education, treatment of OIs, and counseling as well as establishing linkages with positive networks for other care and support services.
• training service providers such as counselors, social workers doctors, nurses, paramedical and outreach workers, etc.;
• conducting advocacy workshop/meetings;
• conducting Operations Research/special studies; and
• conducting external annual evaluations.

PROGRAM GOALS AND IMPACT INDICATORS

Goal	To reduce HIV related morbidity and mortality in adults and children; and mitigate the impact of HIV on children and women headed households.	Baseline		Target				
		Value	Date	Year 1	Year 2	Year 3	Year 4	Year 5
Impact indicator	% of adults aged 15-49 who are HIV infected	0.36%	2007	NULLOR EMPTY	NULLOR EMPTY	0.36%	0.36%	0.36%
Impact indicator	% of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy (extend to 2, 3, 5 years as program matures)	n/a	2007	N: D: P: 75%	N: D: P: 80%	N: D: P: 85%	N: D: P: 85%	N: D: P: 85%
Impact indicator	% of adults and children who are still on treatment after 6 months, 1, 2, 3, 5 years from the initiation of treatment	80%	2006	N: D: P: 85%	N: D: P: 90%	N: D: P: 95%	N: D: P: 95%	N: D: P: 95%

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 program 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 infectionin 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 (numberes for easy referenceand for linkingwith the SDAs). The "Goal Number" column indicates which goal objective is linked to.

Objective Number	Objective Description	Goal Number
1	Ensure access to OI treatment and improve drug adherence by establishing Community Care Centers (CCC)	

2. Service Delivery Area (SDA) Ratings

As stated.Service Delivery Areas (SDA) 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 indicatiors 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: Strengthening of civil society and institutional capacity building	1	2	1	X	The performance of the indicators under this SDA is excellent. 4,617 PLHAs are enrolled by district level networks for care and support against the target of 3,500 (132%). This is due to the increased number PLHAs as well as the new strategies adopted to increase enrolment and access to services.
1	Care and Support: Care and support for the chronically ill	1	1	1	X	The performance of the indicators under this SDA is excellent. 10,731 PLHA were provided care at Community Care Centers (CCC) against the target of 1,830. This is primarily due to the efforts made at all levels, national, state and district to strengthen the referral and linkages between the ART centres and the CCCs.
1	Supportive environment: Stigma reduction in all settings	0	0	1	X	The performance of the indicators under this SDA is excellent. Targets for both indicators are over-achieved. Automatically generated rating is B1 due the the lack of Level 3 indicators under the SDA.

3. Indicator level Performance

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

The numbers to the left of the indicators refer to the coverage level: Level 3, people reached; Levael 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 than 80% of their targets are green and others red.

Ensure access to OI treatment and improve drug adherence by establishing Community Care Centers (CCC)					
SDA	**Supportive environment: Strengthening of civil society and institutional capacity building**				
Level	**Indicator**	**Charted Period**	**Target**	**Actual**	**0% 50% 100% 150%**
Level 2-Service Points supported	Indicator 1.1 - Number of State networks strengthened	6	3	3	100%
Level 2-Service Points supported	Indicator 1.2 - Number of district level networks strengthened	6	55	56	102%
Level 1-People trained	Indicator 1.3 - Number of Counselors, Social workers, Treatment Education Coordinator and other project staff trained at DLNs	6	175	195	111%
Level 3-People reached	Indicator 1.4 - Number of PLHAs enrolled by district level networks for care & support	6	3,500	4,617	120%

SDA	**Care and Support: Care and support for the chronically ill**				
Level	**Indicator**	**Charted Period**	**Target**	**Actual**	**0% 50% 100% 150%**
Level 2-Service Points supported	Indicator 1.5 - Number of Community Care Centers set up	6	50	50	100%
Level 3-People reached	Indicator 1.6 - Number of PLHAs provided care at Community Care Centers	6	1,830	10,731	120%
Level 1-People trained	Indicator 1.7 - Number of staff at Community Care Centres trained (including Doctors, Nurses, Outreach workers and project support staff)	6	500	458	92%

SDA	**Supportive environment: Stigma reduction in all settings**				
Level	**Indicator**	**Charted Period**	**Target**	**Actual**	**0% 50% 100% 150%**
Level 0-Process/Activity Indicator	Indicator 1.8 - Number of advocacy workshops/meetings conducted for multi-sectoral convergence	6	4	6	120%
Level 1-People trained	Indicator 1.9 - Number of people sensitized at the advocacy workshops/meetings.	6	350	427	120%

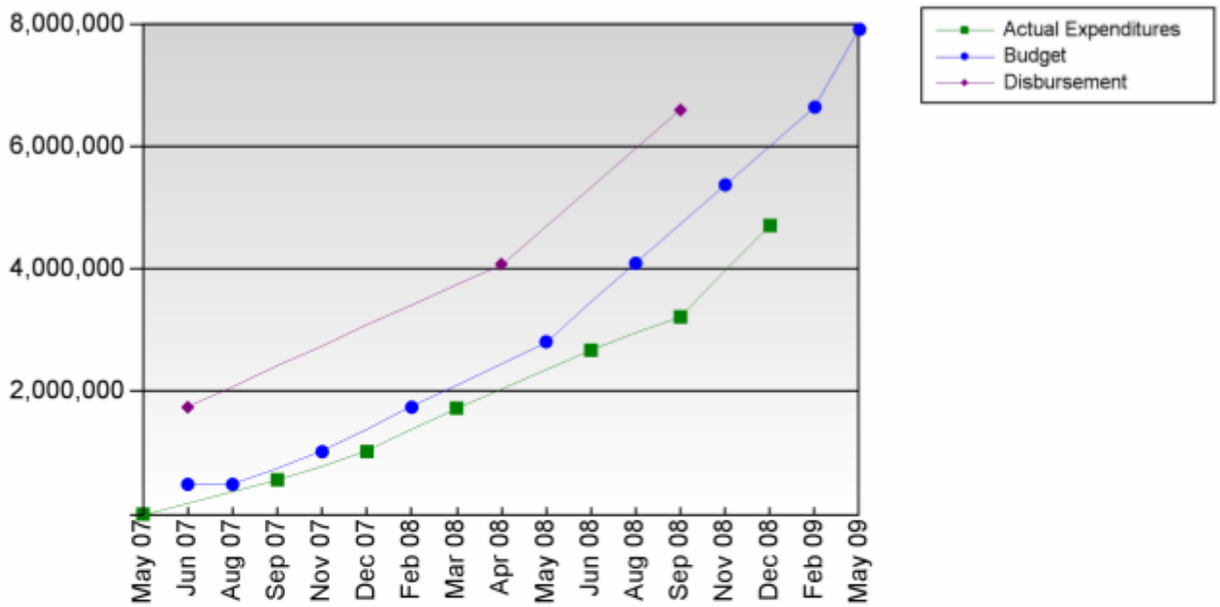
4. Disbursement History

*Note: In the absence of previous agreements, and noting in the future we will have agreed amounts and dates or 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

Expected vs. Actual Disbursements



5. Estimated under -disbursement in phase 1

Estimated under -disbursement in phase 1	Amount	Amount (in %)
Phase 1 grant agreement amount	USD 7,918,367	0%
Less:actual disbursed to date	USD 7,050,390	89%
Less:expected additional disbursement until the end of Phase 1 grant agreement	USD 0	0%
Expected undisbursed amount at the end of Phase 1	USD 867,977	11%

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

24 **Months**

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

If yes, please comment:

m Yes l No

Non applicable

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:

m Yes l No

Non applicable

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:

l Yes m No

USD 867,977 (11% of the Phase 1 budget) remains undisbursed at the end of Phase 1. The undisbursed funds are explained primarily by PR' introduction of cost cutting measures, especially on travel, meetings, and communication costs in order to offset loss due to exchange fluctuation.

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 7,050,390	100%	31-Dec-2008
Less: Direct payments for PR Expenditures	USD 587,749	8%	31-Dec-2008
Less: PR disbursements to sub-recipients	USD 4,058,707	58%	31-Dec-2008
PR cash-balance	USD 2,403,934	34%	31-Dec-2008

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:

m Yes l No

Non applicable

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)

l Yes m No

Cumulative budget of PR till December 31, 2008 amounted to USD 1,083,027, against which USD 655,128 had been expended, indicating utilization of approximately 60%. The lower utilization is primarily due to following two factors: (a) cost cutting measures initiated by the PR, especially on travel and meeting expenditure and telephone/electricity expenditure, thus reducing the utilization rate in planning & administration activity. This was done to offset loss due to exchange fluctuation. (b) Carry forward of certain activities to the next quarter. This includes advocacy, M&E training, SACS training, Reporting of IEC Material, etc. It is to be noted that though the utilization rate at the PR is low, the targets up to December 31, 2008 have been achieved. Taking into consideration the carry forward of certain activities to the next quarter, the PR expenditure rate is expected to increase.

F. CONTEXTUAL CONSIDERATION

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

m Yes | No

Non applicable

1.1 If yes can they be alleviated?

m Yes | No

Non applicable

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

m Yes | No

Non applicable

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

m Yes | No

There are no major weaknesses in either Programmatic and Financial Management. At the PR level, the programmatic and financial management capacity is adequate with all key positions occupied. The programme (including M&E) and finance staff is capable of handling the programme implementation in Phase 2; and there are no capacity gaps in Institutional and Programmatic arrangements.There are clear programmatic arrangements between the SRs and the PR.

4. Are there any systemic weakness in:

4.1. Monitoring and evaluation?

m Yes | No

The PR has systems in place that can adequately capture the quantitative and qualitative data. The LFA believes that the system of analysis of the data received from the SRs and providing related feedback to the SRs can be strengthened. This LFA recommendation is being discussed with the PR. LFA also recommended reporting of the qualitative data. This LFA recommendation is already being addressed by the PR.

4.2. Procurement and supply management?

m Yes l No

The portion on procurement of drugs is only a small portion of the total budget (8.9%). The procurement component comprises purchase of certain OI drugs as well as certain general drugs at the Community Care Centers (CCCs) run by CBCI and HLFPPT. Considering the small proportion of the pharmaceuticals budget and also considering that procurements are usually specific to the CCCs, elaborate Procurement and Supply Management (PSM) arrangements are not required and no major risks to Phase 2 grant implementation have been identified.

4.3. Any other areas?

m Yes l No

Non applicable

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

m Yes l No

There are no major issues with the quality and validity of data.

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?)

m Yes l No

Non applicable

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

l Yes m No

The program implementation has been steadily good throughout the project implementation period. However, the performance particularly improved over the last 6 months due to the efforts made at all levels, national, state and district to strengthen the referral and linkages between the ART centres and new strategies adopted to increase enrolment and access to services.

8. Have there been any changes in disease trends?

m Yes l No

It should be noted that although there are no major changes in disease trends as such, the most recent data represents a significant reduction in the estimates submitted in the original Round 6 proposal. The latest methodology reveals reduction of adult prevalence rate from 0.91% (i.e. 5.206 million in 2005) to 0.34% (i.e. 2.31 million people with HIV/AIDS) in 2007. The data is based on the National Behavioral Sentinel Surveillance conducted by the Government of India (NACO) in 2006 and then in 2007 by UNAIDS.

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?

m Yes l No

India is one of the countries which have encouraged non-governmental agencies to be the Principal Recipient (PR) for the Global Fund grants. The current program is implemented through a non-government PR and involves non-government SRs and SSRs. All these work in close collaboration with the government infrastructure to help meet national goals. There are 3 SRs i.e. Hindustan Latex Family Planning Promotion Trust (HLFPPT), a leading NGO in the health development field; Catholic Bishops Conference of India (CBCI), a major Faith based organization; and The Indian Network for People living with HIV/AIDS (INP+), the largest national network of PLWHA. The number of smaller NGOs involved as SSRs is about 200 of which about 100 organization would have been newly created. The NACP – III works closely with and through over 1000 community organisations reaching difficult to access groups like Female Sex Workers (FSWs), Men having Sex with Men (MSMs), Injecting drug user (IDUs) etc. as well as with positive networks and NGO partners for care and support activities.All the above are indicative of the Public-Private Partnerships that have been established for the HIV Control efforts.

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

m Yes l No

The program is part of the National AIDS Control Program (NACP). NACP synergizes all its services with the National Rural Health Missions (NRHM), especially with the Reproductive and Child Health (RCH) programme and the Revised National TB Control Programme (RNTCP). Action Plans prepared by the State Health Society set up under NRHM and the State AIDS Control Society and their Monitoring & Evaluation (M&E) systems are dovetailed for more effective implementation. NRHM is involved in delivery of services in rural areas through Primary Health Centers (PHCs), Community Health Centers (CHCs) & rural hospitals. Reproductive and Child Health (RCH) program is involved in Delivery of Prevention of Parent to Child Transmission (PPTCT) program & Sexually Transmitted Infection / Reproductive Tracked Infection (STI/RTI) services while Revised National TB Control Programme (RNTCP) is involved in testing & treatment of HIV/TB co-infected patients.

9.3. Provide additional resources?

m Yes l No

The Global Fund grant funds are a portion of the total sources of funds for NACP III. The earlier allocations to Care, Support & Treatment, as a part of the National Programme, were not substantial. With the availability of funds from the Global Fund, this component has been expanded. The government of India uses its own funds for the base health programme in the country. Other donors for HIV/AIDS include the World Bank, Department for International Development (DFID), United States Agency for International Development (USAID), UN agencies, Bill & Melinda Gates Foundation, and Clinton Foundation.

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.)?

l Yes m No

The grant is part of the R6 India CCM Proposal "Scaling up care, support and treatment for HIV India" implemented jointly by HIV Alliance India, National AIDS Control Organization (NACO) of the Government of India and Population Foundation India (PFI). The current PR also manages IDA-405-G05-H, which has been just qualified for RCC.