# RENEWAL SCORECARD

## India

## HIV/AIDS

# 1. SCORECARD SUMMARY

## GENERAL PROGRAM INFORMATION

| | |
|---|---|
| **Applicant** | India Country Coordination Mechanism |
| **Country and Income Level** | Lower-Lower Middle Income Country |
| **Component** | HIV/AIDS |
| **Renewal cut-off date** | 31/03/2012 |
| **Renewal Review date** | 31/10/2012 |
| **Implementation Period start date** | 01/10/2010 |
| **Implementation Period end date** | 30/09/2015 |

## RENEWAL RECOMMENDATION SUMMARY

| Grant number | PR name | Performance Rating | Recommendation Category | Recommended Incremental Amount | % of Adjusted TRP clarified amount | % saving | Within Investment Range? |
|---|---|---|---|---|---|---|---|
| IDA-910-G20-H | PR 1 | A1 | Go | $16,892,697 | 90% | 10% | Yes |
| IDA-910-G21-H | PR 2 | B1 | Go | $7,367,237 | 83% | 17% | Yes |
| IDA-910-G24-H | PR 3 | No rating | Conditional Go | $ 0 | 0% | 100% | Yes |
| **Total Recommended Incremental Amount (all PRs)** | | | | **$24,259,934** | | | |
| **Total Adjusted TRP clarified Amount (all PRs)** | | | | **$51,941,191** | **47%** | **53%** | **No, below** |

# 2. COMPONENT PORTFOLIO OVERVIEW

## 2.1 PROGRAM CONTEXT

### Epidemiological Situation and Program Objectives

**Please describe the goals and objectives of the program and how these correspond to the epidemiological context.**

India has made major strides in providing support to the fight against HIV/AIDS. A National AIDS Council is headed by the Prime Minister. There is also a separate department, under the Ministry of Health and Family Welfare (MoHFW), India's National AIDS Control Organization (NACO) that manages the national response with a multimillion-dollar budget funded increasingly from domestic sources. NACO is supported by a range of civil society and private sector organizations, including six co-PRs for the Round 2 RCC, Round 4 RCC, Round 7 and Round 9 programs. The co-PRs for Round 9 are the India HIV/AIDS Alliance (IHAA) and Emmanuel Hospital Association (EHA).

HIV Sentinel Surveillance (HSS) conducted by NACO in 2008-2009 provided a national estimate of 2.39 million people infected with HIV, of which 39% were female and 3.5% were children. Among the states, Manipur had highest estimated adult HIV prevalence (1.40%), followed by Andhra Pradesh (0.90%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%). Besides these states, Goa, Chandigarh, Gujarat, Punjab and Tamil Nadu have shown estimated adult HIV prevalence greater than national prevalence (0.31%), while Delhi, Orissa, West Bengal, Chhattisgarh and Puducherry have shown estimated adult HIV prevalence of 0.28-0.30%. All other states/Union Territories have lower levels of HIV. These data reflect the impact of the various interventions under the National AIDS Control Program (NACP).

Although the estimates highlight an overall reduction in HIV incidence in India (adult HIV prevalence declined from 0.41% in 2000 to 0.31% in 2009), the epidemic remains concentrated in the High Risk Groups (HRGs) such as injecting drug users (IDUs), men who have sex with men (MSM), transgender (TG) individuals and hijras (men who adopt female gender identity) (collectively known as "MTH"), female sex workers (FSWs) and migrant workers. HIV prevalence among HRGs is 10-30 times higher than the general population. Estimates of an HIV Sentinel Surveillance (HSS) exercise for 2010-2011 indicate that prevalence among FSW, MSM, TG and IDUs are 2.6%, 4.43%, 8.8%, and 7.17%, respectively. Unprotected

sex is the major route of HIV transmission in this high risk group. Although the number of MTH in India is greater than sex workers, this group has proved particularly difficult to reach and has experienced a continuous increase in prevalence. For similar reasons, HIV/STI transmission among MTH populations is difficult to estimate.

The grant managed by India HIV/AIDS Alliance focuses on HIV prevention among MSM, TG and hijras, and in addition to service provision to the beneficiaries, the grant aimed at strengthening and building the capacity of community-based organizations (CBOs) to provide HIV prevention programming for MSM, TG and hijras (MTH) in 17 Indian states.

The grant managed by Emmanuel Hospital Association (EHA) mainly focuses on strengthening harm reduction interventions through institutional capacity building, individual training, quality assurance, as well as provision of reintegration and after-care services for IDUs.

## Programmatic and Funding Gap Analysis

Please summarize the programmatic needs in terms of planned targets/coverage for key services.

| | Targets/coverage | | | |
|---|---|---|---|---|
| Key services | End previous implementation period | Year 1 | Year 2 | Year 3 |
| IDU Harm reduction services | IDUs using sterile syringes = 50%<br>IDUs using condom = 48% | 60%<br>58% | 70%<br>68% | 80%<br>78% |
| Prevention and Care Services to MTH | Men using condom the last time they had anal sex with a male partner = 64%<br><br>MTH receiving at least 2 services = 11864 (targets pertain to the indicator, "Number of beneficiaries among MSM, Hijra and transgender communities reached by SSR CBOs with at least two new services" in Alliance's Performance Framework) | <br><br>54,129 | 70%<br><br>60,768 | 80%<br><br>To be negotiated |

Please summarize financial needs, current and planned sources of funding and financial gap for the fight against this disease by all domestic and external sources.

**India HIV: Program Financing and Counterpart Financing Compliance**

| Funding Source | 2013 USD million | 2014 USD million | 2015 USD million | Total USD million | % Share of Need |
|---|---|---|---|---|---|
| **Overall Needs Costing** | **591.05** | **651.95** | **673.24** | **1916.24** | **100%** |
| GOI Domestic Resources | 281.65 | 309.81 | 340.79 | 932.25 | |
| World Bank Loan | 50 | 50 | 50 | 150 | |
| **Total Government Resources** | **331.65** | **359.81** | **390.79** | **1082.25** | **56%** |
| Global Fund (excluding current request) | | | | | |
| **IDA-708-G13-H** | 5.01 | | | 5.01 | |
| **IDA-708-G15-H** | 1.29 | | | 1.29 | |
| **IDA-202-G19-H** | 5.66 | 4.93 | 3.54 | 14.12 | |
| **IDA-202-G02-H** | 27.81 | 30.12 | 30.69 | 88.62 | |
| **R4 RCC Grants** | 40.41 | 91.46 | 76.63 | 208.50 | |
| **Total Global Fund (excl. current request)** | **80.17** | **126.51** | **110.86** | **317.54** | **17%** |
| USAID | 22 | 22 | 22 | 66 | |
| CDC | 7.5 | 7.5 | 7.5 | 22.5 | |
| BMGF | 19 | 19 | | 38 | |
| **Total External Resources (non Global** | **48.5** | **48.5** | **29.5** | **126.5** | **7%** |

| | | | | | |
|---|---|---|---|---|---|
| **Fund)** | | | | | |
| **Total Resources Available** | **460.32** | **534.82** | **531.15** | **1526.28** | **80%** |
| Unmet Need Gap | 130.73 | 117.13 | 142.09 | 389.96 | 20% |
| **CCM Request** | **17.30** | **18.14** | **16.50** | **51.95** | **3%** |

**Comments:**

The National AIDS Control Program (NACP) is a 100% centrally sponsored scheme (CSS) implemented at the national level by the National AIDS Control Organization (NACO), a division of the Ministry of Health and Family Welfare. At the regional level, the NACP is implemented by the State AIDS Control Societies (SACS) through governmental and non-governmental agencies. The funding need and the allocation for the NACP is determined through a multi-stakeholder planning process as part of the national five year planning cycle. The Phase-III (2007-2012) of the NACP has been completed and the Program Implementation Plan (PIP) of Phase-IV is in the process of being finalized. The funding requirements for the next implementation period indicated in the table are derived from the budget proposed under the NACP IV, which is currently pending approval. NACP IV is expected to have an annual budget of roughly US $560 million per annum for a total of some US $2.8 billion over the five-year period of the program. This constitutes a 33% increase compared to previous phase.

To avoid fragmentation and duplication, both donor and government commitments to the NACP are incorporated in the PIP, irrespective of whether funding is routed through government budgets or as off-budget support. While the government of India budget allocation is centralized through NACO, donors provide off-budget support directly to implementing agencies. Donors that provided budgetary support in NACP-III included the World Bank, Global Fund (for government PRs), UK Department for International Development (DFID), USAID and UNDP. DFID contributed to a “Pool Fund” along with the World Bank loans. Off-budget support in NACP-III was provided by the Global Fund (for civil society PRs), the Bill and Melinda Gates Foundation, USG, DFID, UN agencies, CHAI and AusAid, directly to implementing agencies.

The allocation of government and donor resources, provided through the government of India budget to the States, is done by NACO based on annual plans submitted by the SACS. Grants to SACS are provided by NACO from the government of India resources, pooled fund, Global Fund and UNDP allocations under four major heads: (1) prevention of new infections; (2) care, treatment and support; (3) institutional strengthening; and (4) strategic management information systems. Additionally, NACO budget allocation is used for centralized procurement of drugs, commodities and equipment; national level education and communication (IEC) and direct support to Blood Transfusion Councils and Blood Banks. Financing of the NACO budget by different sources is given in the table below.

**Financing of AIDS Control through Government of India Budget**

| **Funding Source** | **2011-12** | | **2012-13** | |
|---|---|---|---|---|
| | Actual Expenditure USD million | % Share | Budget Allocation USD million | % Share |
| UNDP | 0.76 | 0.3% | | |
| Global Fund | 120.87 | 48% | 77.93 | 23% |
| USAID | 2.26 | 1% | | |
| DFID | 42.17 | 17% | | |
| World Bank | 58.48 | 23% | | |
| Government of India | 29.03 | 11% | 255.41 | 77% |
| Total | 253.56 | 100% | 333.33 | 100% |

Source: 2011-12-Expenditure Statement, Chief Controller of Accounts, MoHFW, GoI: 2012-2013 Demand for Grants, Ministry of Finance, GoI

Note: Excludes off-budget donor support and state government contributions

In 2011-2012, government resources (including World Bank loan) financed about a third of the government of India budget spending and about 30% of total program spending. The government of India allocation to NACP from its own resources has increased eight fold in 2012-2013. The projection of government spending in the next implementation period is based on the assumption that there will be an annual 10% increase over the 2012-13 allocation. Approximately half of the funding need in the next implementation period is expected to be met from the government of India revenues. State governments also support the NACP through (1) grants provided to SACS and (2) health system costs such as human resources,

development and maintenance of infrastructure for HIV service delivery. However, state government contributions are not included in reported government spending or the projections for the next implementation period.

In NACP-III, the pooled fund, contributed by the World Bank and DFID, along with the government of India resources, supported targeted interventions for prevention among high risk/vulnerable groups, as well as prevention programs for general population; strengthening services for care, support and treatment; mainstreaming of HIV/AIDS in key sectors; and strengthening program and strategic information management.

In Phase-IV, the World Bank loan contribution is expected to be the same as the one provided in Phase-III (US $250 million). The World Bank support in Phase-IV has two components (1) scaling up targeted prevention interventions (US $240 million) and strengthening institutional capacity and program management (US $10 million) (WB, Report No. ISDSA721).

DFID provided £102 million (approximately U $163 million) in support of NACP III. DFID's program of support consisted of two main components (1) contribution to pooled fund (around US $152 million) and (2) technical assistance (US $11 million). The DFID has announced that it will not be supporting the NACP in the next phase.

With withdrawal of donors, such as DFID, BMGF (from 2014), CHAI and AusAid from NACP IV, non Global Fund external resources will account for less than 7% of total funding need. Non-Global Fund external resources anticipated in the next implementation period is primarily from the US Government. The US Government (USG) provided both direct budget support and off-budget funding for NACP-III. Average annual USG disbursement to the NACP was about US $37 million between 2009 and 2011 (PEPFAR data provided to Global Fund Secretariat). USG support was primarily through USAID and the Global AIDS Program (CDC), with a small component routed through the Department of Defence to develop a strategic partnership with the Indian Armed Forces. USAID supported a number of projects in NACP-III, including:

a) Project connect for developing scalable Public-Private Partnerships models for prevention, private-sector health insurance for PLWHA and resource mobilization;
b) Samastha, a comprehensive HIV/AIDS prevention, care, support and treatment project in two high prevalence states, Karnataka and Andhra Pradesh; and
c) The Avert Project in Maharashtra and the APAC project in Tamil Nadu for scaling up targeted interventions for the most at-risk populations

USAID and CDC funding also supported technical assistance and capacity building at the national, state, and district levels. Some of the projects funded by USAID in NACP-III have already been handed over to the government for implementation in the next phase. As per the CCM request, support of around US $110 million through USAID and US $37.5 million through CDC is anticipated for NACP-IV. However, details of the available funding are not known.

The other likely source of funding in the first two years of NACO IV, the Bill and Melinda Gates Foundation supported the NACP-III, through financing of the Avahan Program – a targeted prevention program in selected districts (83 out of 130) of six high prevalence states (Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Nagaland, and Manipur). Until date, the Gates Foundation has provided over US $300 million for the Avahan Program. The Gates Foundation has announced its withdrawal from the Avahan project, but will provide funding of about US $38 million until 2014 to provide technical assistance and support transition of the project.

The other major development partner that supported the NACP-III was UNDP. Between 2009 and 2011, UNDP contributed about US $10 million to NACP (Outcome Evaluation of UNDP India's HIV and Development Program). A critical role of UNDP was to coordinate assistance to the NACP under the United Nations Development Assistance Framework (UNDAF), support mainstreaming of HIV/AIDS programs and provide technical support to NACO for strategy and policy development to create an enabling environment for HIV prevention. At the state level, UNDP provided technical assistance for four states of the North East, namely, Manipur, Meghalaya, Mizoram and Nagaland as part of the Joint United Nations Technical Assistance (JUNTA). At field level, UNDP has been responsible for designing and piloting intervention prototypes that were subsequently incorporated into the national program for large-scale implementation. These include Project Sashakt that developed community systems for sexual minorities in Maharastra, Tamil Nadu, Manipur, Uttar Pradesh and Orissa, a forerunner of the Global Fund supported Pehchan project; legal aid clinics in Tamil Nadu and Andhra Pradesh; and the link worker scheme to reach rural populations. Currently, there is no indication that UNDP support will continue in NACP-IV.

The Global Fund was the single largest source of funding for NACP-III. In 2011-2012, the Global Fund supported 48% of the NACO budget and 55% of total NACP expenditure. With a projected increase in government spending, relative share of Global Fund support to the national program in the next implementation period will decline. Existing grants and expected funding for the Round 9 grants will meet about 8% of the funding need in the next implementation period. Existing grants and expected funding for the Round 4 RCC grants will meet about 17% of the funding need in the next implementation period. The current CCM request for Phase 2 funding of Round 9, accounts for about 3% of the funding need. The Round 9 grants finance well performing targeted intervention programs for MSMs and IDUs. Continued funding from the Global Fund is critical given the proposed scale up of TI programs and non-availability of TI funding from key donors such as Gates Foundation, DFID and UNDP in the next implementation period.

The focused or targeted interventions being implemented by IHAA and EHA should be increasingly emphasized as India seeks to lower HIV prevalence in HRGs during NACP-IV. These two well-performing programs are relatively small with modest performance targets. They incorporate international best practice interventions that formed the basis of previously Indian successes in HIV prevention, most notably the BMGF-funded Avahan Program. The two civil society PRs under the Round 9 program are lead Avahan implementers.

## Counterpart Financing Compliance

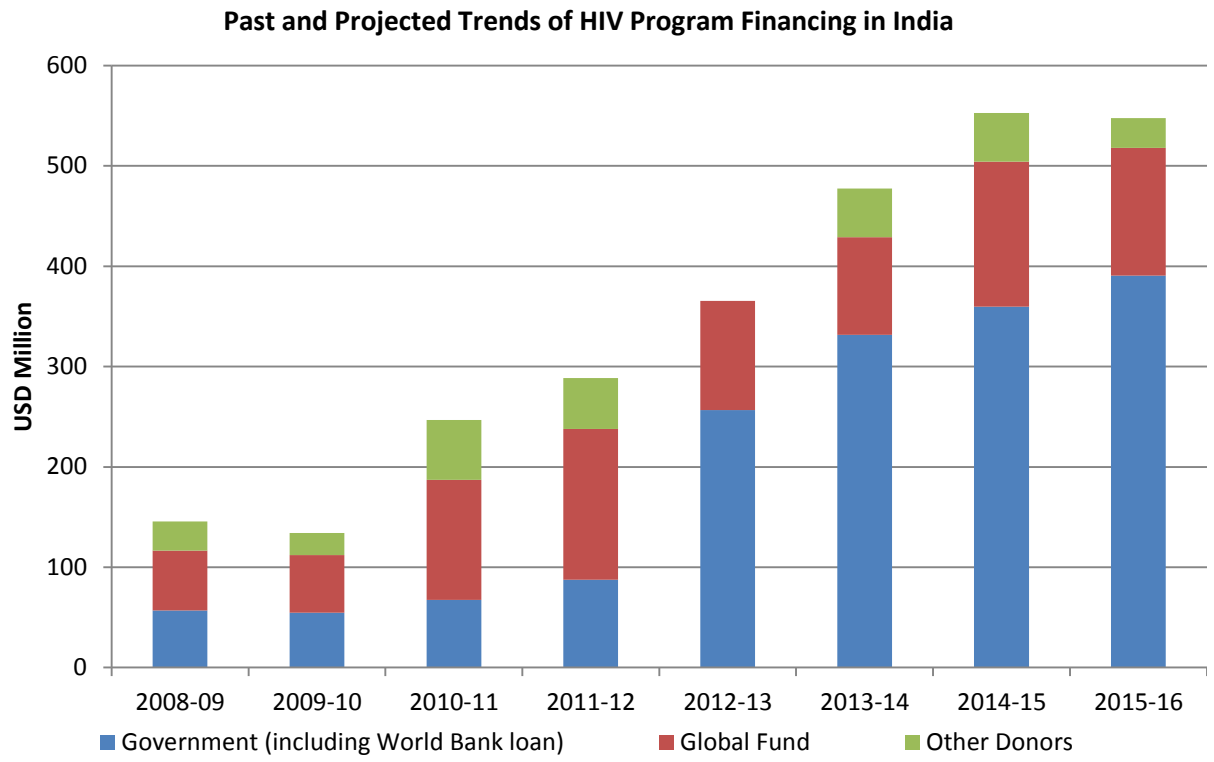
| **Does the country currently comply with the counterpart financing requirements based on the income classification for the country**[1] | Yes |
|---|---|

*(1) Availability of reliable data to assess compliance*
NACP has earmarked budget line items at both central and state government levels. Data on allocations to the HIV program and their expenditure by source of funding is available from the detailed demand for grants of central and state budgets and financial accounts of the government. The NACP is implementing a Computerized Project Financial Management System (CPFMS) to capture program accounts of funding disbursed through NACO. Detailed line items of each activity are available on CPFMS for capturing expenditure in each component. Available data is sufficient to assess compliance with counterpart financing requirements.

*(2) Minimum threshold government contribution to disease program*
Based on actual spending for the financial year 2010 and 2011, and budget estimate for 2012 of government spending through the Ministry of Health, the counterpart-financing share is over 52%, meeting the minimum threshold requirement of 20% for lower-lower middle income countries. In the next implementation period, the counterpart-financing share will increase to 75%.

*(3) Stable or increasing government contribution to disease program*
Government contribution to the national program (through its own revenue resources and World Bank loans) has been steadily increasing over time. In 2012-2013, the allocation of government resources has significantly increased to offset loss of donor funding and to meet the ambitious targets proposed for the NACP IV. While, World Bank loan resources accounted for a major share of government contribution in NACP III, government revenue resources will contribute the major share in NACP IV.

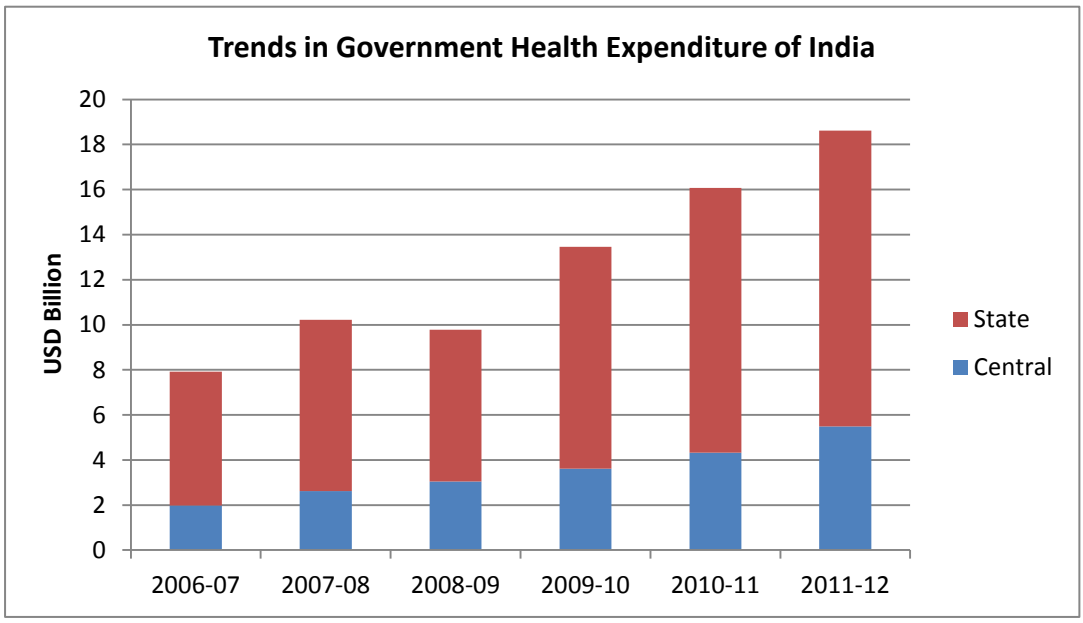
[1] http://www.theglobalfund.org/en/application/applying/ecfp/eligibility/




Source: 2008-10 (UNAIDS), 2010-11 onwards CCM Request

*(4) Stable or increasing government contribution to health sector*

Between the financial year 2006 and 2011, government health spending has increased at an average annual rate of around 19.5%. While there has been a significant infusion of government resources to health sector in recent years, public spending on health at around 1.3% of the GDP, is among the lowest in the region. There is high burden of out of pocket expenditure on health, which accounts for more than 65% of the total health spending. There appears to be a strong political will to address the issue of low public health spending. The draft approach paper for the 12th Plan Five Year Plan approved by the Union cabinet, aims to increase government spending on health to around 2.5% of the GDP by the end of the 12th Plan period (2012-2017).




Source: Comptroller and Auditor General, India; Reserve Bank of India, Ministry of Finance, GoI

## Partnerships

**Please briefly summarize key partners and their role in supporting the program implementation.**

The strategy and implementation plans for both NACP III (2007-2012) and NACP IV (20121-2017) were developed based on the synthesis of evidence with wide range of consultations with government departments, civil society, public and private sector partners, NGOs, and PLWHA networks. These include six co-PRs under Rounds 2 and 4 RCC, Round 7 and Round 9.

The key technical, financial, and implementation partners providing support in implementation of the national program in India include the World Bank, USAID, UNAIDS, Gates Foundation, European Community, civil society organizations and faith based organizations. Two of the HIV/AIDS PRs (Infrastructure Leasing and Financial Services Limited Education and Technology Services (IL&FS) and Tata Institute of Social Sciences (TISS), under different Global Fund rounds, are private sector PRs whereas the Emmanuel Hospital Association (EHA) is a faith based organization. While the donor contribution to the program is declining as a result of the global financial meltdown, increase in domestic funding to fill the gap, especially in critical areas such as treatment, is not clear. In addition, availability of technical experts to meet the technical assistance (TA) needs of the program is increasingly becoming a challenge.

# 2.2 CURRENT IMPLEMENTATION PERIOD PERFORMANCE

## Progress Towards Impact / Outcome

**Proposal Goal: to halt and reverse the epidemic in India over the next 5 years by integrating programmes for prevention, care, support and treatment**

| | | | Year 1 | | Year 2 | |
|---|---|---|---|---|---|---|
| Impact and Outcome Indicator | Baseline Year | Baseline Value | Target | Result | Target | Result |
| % of most-at-risk population(s) - migrants, men who have sex with men, injecting drug users who are HIV infected | 2006 | 7.41 (MSM)<br>7.2 (IDUs)<br>3.6 (migrants) | 7.41 (MSM)<br>7.2 (IDUs)<br>3.6 (migrants) | | 7.41 (MSM)<br>7.2 (IDUs)<br>3.6 (migrants) | 2010-11 data<br><br>4.43% (MSM)<br>7.17% (IDU)<br>0.98%(Migrant) |
| % of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse | 2006 | 58% | 58% | - | 60% | - |
| Percentage of men reporting the use of condom the last time they had anal sex with a male partner | 2006 | 13-87% | TBD | - | TBD | - |
| Percentage of MSM reporting cases of violence by law enforcement authorities/police | TBD | | TBD | - | TBD | - |
| % of women and men aged 15-49 expressing accepting attitudes towards people with HIV | 2006 | 31.3% | 41% | - | 51% | - |
| % of injecting drug users reporting the use of sterile injecting equipment the last time they injected | 2006 and 2009 | '29% - 88% and 73% - 87% | 40% | - | 50% | - |
| % of injecting drug users reporting the use of a condom the last time they had sexual intercourse with a non-regular partner | 2009 | '38% to 83% | 38% | - | 48% | - |

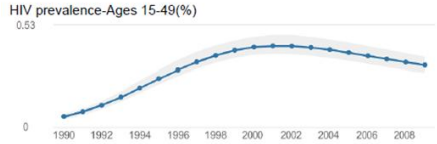
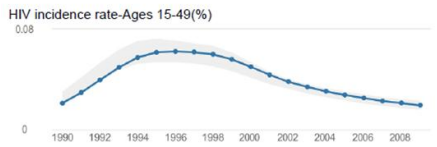
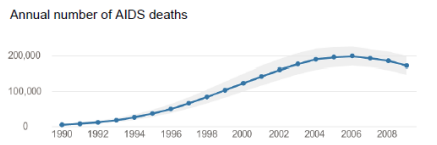
**Comments:**

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

• Focused prevention programs, known under NACP as "Targeted interventions" (TIs), started to be implemented as a national strategy in India since 1998 among high risk groups (HRGs) -- FSW, IDUs, MSM, TG and Hijras, as well as and bridge groups (truckers and migrants), by engaging community based organizations. Intervention services include behavioral change communication, condom promotion, STI care and referrals for HIV testing and ART. As of 2011, 1,385 TIs provide prevention services to an overall population of 3,132,000, covering: 78% of the estimated number of FSW, 76% of IDUs, 69% of MSMs, 32% of migrants and 33% of truckers.

• Although HIV sentinel surveillance collected data on HIV prevalence by sentinel groups in recent years, available data covers the period only up to 2009. The available data on HIV prevalence and behaviors up to 2009 showed the progress towards impact in India. While the estimates highlight an overall reduction in HIV incidence in India (adult HIV prevalence declined from 0.41% in 2000 to 0.31% in 2009), the epidemic remains concentrated in the defined set of high risk groups.

Summary of impact of HIV/AIDS programming in India:

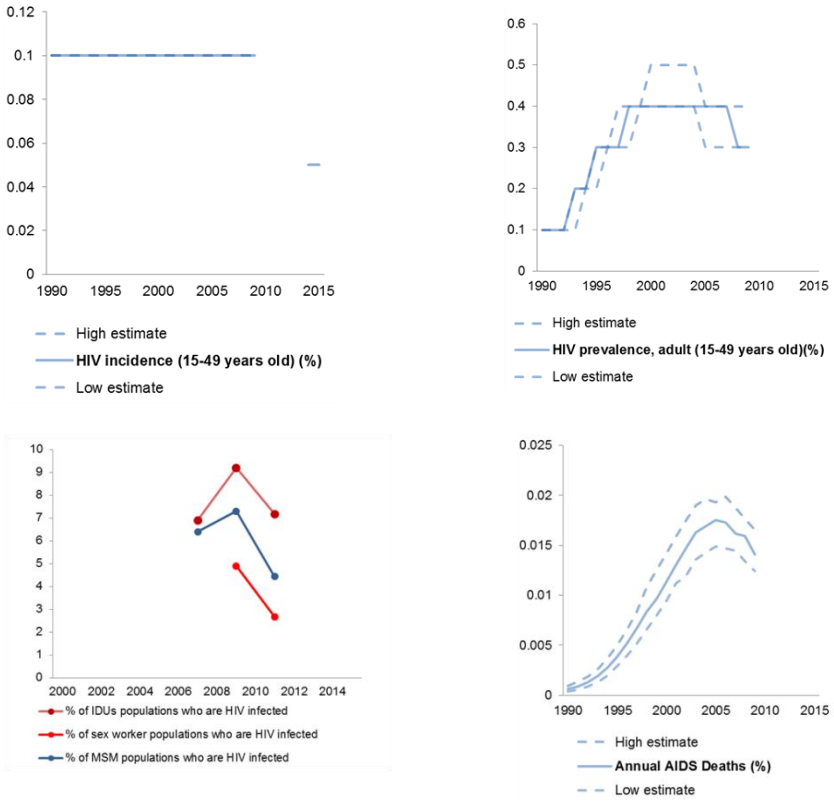
| | | |
|---|---|---|
| Prevalence | Adult prevalence among general population declined from 0.41% in 2000 to 0.31% in 2009 (NACO) |  |
| | Nationally, HIV prevalence among FSWs declined by 50% between 2003 and 2008 (UNAIDS) | |
| | In Karnataka state, HIV prevalence among sex workers declined from 19.6% to 16.4% (Ramesh et al.) | |
| Incidence | Estimated new infections reduced by >50% between 2000 (270,000) and 2009 (120,000) (NACO) |  |
| | Incidence trends in antenatal clinics (using prevalence among young women as proxy) declined by 54% between 2000 and 2007 in south India (Arora et al.) | |
| AIDS deaths | Number of deaths due to AIDS has constantly declined from 271,000 in 2000, to 196,000 in 2005 and lately 172,000 in 2009. |  |
| Impact analyses | Over a 20-year period, prevention programs with FSWs in India reduced the prevalence of HIV infections by 47% (Prinja et al.) | |
| | In districts with intensive prevention programs for sex workers in Karnataka, HIV prevalence among young ANC clinic attendees declined from 1.4% to 0.77%. The decline in standardized HIV prevalence in intensive districts was 56%, compared to 5% in the districts with non-intensive prevention programs (Moses et al.) | |
| Cost-effectiveness analyses | Prevention programs with FSWs are a cost-effective strategy for HIV prevention. Each DALY averted has an incremental cost of $10.7 (Prinja et al.) | |

Modeled incidence and mortality decreased from 2004 to 2009. Data for subsequent years (up to 2011) is due to be released at the end of 2012.

• The estimated adult HIV prevalence decreased from 0.41% in 2000 through 0.36% in 2006 to 0.31% in 2009 nationally. The decline is clear in six high prevalence states but an increase was found among the low prevalence states (Chandigarh, Orissa, Kerala, Jharkhand, Uttarakhand, Jammu and Kashmir, Arunachal Pradesh and Meghalaya) from 2006 to 2009.

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

Percentage of MSM who are HIV infected has come down from 7.41% (2006) to 4.43% (NACO estimates 2010) over a four-year period. Similarly, a significant reduction in percentage of IDUs has occurred reflected by a reduction in the percentage from 7.23% (in 2006) to 5.9% as per NACO's 2010 estimated figures. HIV positive migrants (from 3.61% in 2006 to 0.98% in 2010).




Impact Profile for HIV in India, original source of information NACO/UNAIDS

**India HIV/AIDS Alliance** (IHAA, IDA-910-G20-H)
The "Pehchan" ("Identity" in Hindi) grant has strengthened community systems by enhancing the capacity of 110 existing community based organizations (CBOs) and formation of 90 new CBOs, which has significantly contributed to the government's targeted intervention (TI) strategy. The program has improved the quality of outreach to MTH population, increased uptake of services, and has addressed issues such as discrimination, social stigma and violence which are the strong barriers to successful HIV prevention efforts in the MTH community.

The program has trained 1,378 SSR and CBO staff and has formed 44 new CBOS while strengthening 43 existing TIs to reach out to 11,864 MTH community members. While providing behavior change communication to MTH, the program registered 2,266 hijras and transgender individuals and referred over 7,000 MTH for HIV testing. The program refers HIV positive MTH to ART centers and provides treatment adherence support to HIV Positive MTH on treatment. It formed 178 MTH support groups, conducted 369 meetings sensitizing 4,481 individuals.

**Emanuel Hospital Association** (EHA, IDA-910-G21-H)
After initial programmatic delays, the "Hifazat" grant (HIV Intervention for Achieving Zero Addiction-related Transmission; hifazat also means "'protection" in Urdu) began to perform at a quantitative "A2" rating level as of the start of its second program year. The program trained 3,377 NGO staff, medical professionals and peer educators in harm reduction and provided counseling and reintegration services to 5,022 opioid substitution therapy (OST) clients as of the 31 March 2012. Two operational research studies were conducted on female IDUs and their partners and 2,593 female IDUs were reached during the Phase 1 period. In addition, this program has screened and referred 732 IDU clients to DOTs facilities. With its engagement of the Indian

Harm Reduction Network (IHRN) and UNODC as SRs, Hifazat stands at the forefront of India's harm reduction efforts.

**Ministry of Labor and Employment** (MoLE, IDA-910-G24-H)

The Ministry of Labor and Employment (MoLE) was proposed as the Phase 1 implementing agency for the grant related to migrants and informal workers. This PR was unable to start grant activities in Phase 1 due to NACO objection over its role. The CCM nominated NACO to assume management of this grant, ascribing activities being implemented under the agency's corresponding targeted intervention. Since no disbursements have been made for this grant, the Global Fund recommends reallocation of the undisbursed Phase 1 amount for this grant (US $7,417,421) to the two civil society PRs under this Round 9 program. This will permit an orderly scale up of successful focused prevention efforts among vulnerable MTH and IDU groups. Prevention work among migrants and informal workers continue to be supported by the India government.

| PROGRAM IMPACT RATING | Progress Towards Goals |
|---|---|

## Financial Performance and Programmatic Achievements

### Financial Performance at Program Level:

| PR Type | No. of SSFs / Grants | Cumulative Signed Budget to cut-off date (Grant Agreement) | Cumulative Adjusted Budget to cut-off date (EFR) | Disbursed to cut-off date (Finance) | Expenditures to cut-off date (EFR) |
|---|---|---|---|---|---|
| IHAA | IDA-910-G20-H | $ 3,332,239 | $ 3,332,239 | $ 4,563,853 | $2,850,111 |
| EHA | IDA-910-G21-H | $ 3,827,842 | $ 3,827,842 | $ 3,749,189 | $1,879,637 |
| MoLE | IDA-910-G24-H | $ 3,837,965 | $ 3,837,965 | $ 0 | $0 |
| **TOTAL** | | **$10,998,046** | **$10,998,046** | **$ 8,313,042** | **$4,729,748** |

| | |
|---|---|
| Disbursed vs Adjusted Budget at cut-off date | **76%** |
| Expenditure vs Adjusted Budget at cut-off date | **43%** |
| Current Implementation period % time elapsed | **75%** |

### Programmatic Achievements versus Finance Performance:

*Disclaimer: Please note that in many cases the expenditure categories in the EFR do not align with the SDAs in the Performance Framework that results in inconsistent data presented in the table below. This discrepancy will be resolved shortly.*

| Macro Category | Service Delivery Area | Total Adjusted Budget Amount to cut-off date (EFR) | Total Expenditure Amount to cut-off date (EFR) | Expenditure vs Budget at cut-off date | Programmatic Achievement |
|---|---|---|---|---|---|
| | CSS: Community activities and service delivery | | | | **87%** |
| | CSS: Community based activities and services – delivery, use and quality | | | | **93%** |
| | CSS: Human resources: skills building for service delivery, advocacy and leadership | | | | **83%** |
| | CSS: Monitoring & evaluation, evidence building | | | | **50%** |

| | | | | | |
|---|---|---|---|---|---|
| | Supportive Environment: Strengthening of Civil Society | | | | 112% |
| Health System Strengthening (HSS) (PR 2) | HSS: Community Systems Strengthening | $3,827,842 | $1,879,637 | 49% | |
| Supportive Environment (PR 1) | Supportive environment: Policy development including workplace policy | $226,735 | $84,588 | 37% | |
| | Supportive environment: Strengthening of civil society and institutional capacity building | $3,105,504 | $2,765,523 | 89% | |
| Care and Support (PR 3) | Prevention and Care services for informal workers | $1,614,733 | $0 | 0% | |
| | Mainstream HIV work place policy and interventions | $95,832 | $0 | 0% | |
| Supportive Environment (PR 3) | Capacity development | $1,775,558 | $0 | 0% | |
| | Research | $351,842 | $0 | 0% | |
| **Grand Total.** | | **$10,998,046** | **$4,729,748** | **543%** | |

| | |
|---|---|
| Average Performance on Top 10 | **107%** |
| Average Performance All Indicators | **92%** |

| **OVERALL PROGRAM RATING** | A2 |
|---|---|

**Please comment on the linkages between the grants in the program under review and the correlation or deviation between programmatic achievements and expenditures.**

While there are no direct links between the two ongoing civil society grants because they focus on separate high risk groups (EHA on IDUs and Alliance on MTH), the two PRs work as a part of the national strategy to enhance and scale up the government's "Targeted Interventions" for high risk groups. In addition, since MTH and IDUs are among the primary drivers of the epidemic, both grants contribute to the goal of reducing the incidence and prevalence of HIV in India.

IHAA met or exceeded its targets for all of its indicators except an indicator pertaining to HIV positive MTH referred to and registered at ART centers (36% achievement rate). This is because a portion of HIV positive MTH are reported as government-related TI results despite the fact that these MTH members are linked to the ART centers through CBOs working under the Global Fund-supported project. The PR is taking corrective measures together with NACO to ensure that these cases are reported under its grant.

With the selection of most of the SRs, which was not totally under the PR's control, EHA demonstrated excellent performance during the last two reporting periods. However, specialists from Good Practice Centers (GPC, now renamed "community care centers" -- CCCs) were unable to make the required number of supervisory visits to harm reduction sites.

Alliance**:** 1,378 SR and SSR staff trained on Program Management and Thematic Areas (137% achievement rate). There has been cost savings due to the SR selection process being delayed. Hence, all expenses, including the office establishment, training, M&E and all other related expenses were less.

EHA: 5,002 OST clients counseled on reintegration services (146% achievement rate) – The under spending in Supportive Environment SDA was due to delays in recruiting staff at SRR level as CBOs have come on board later than planned. Training module development and training of SR/SSR staff were delayed as well. Moreover, the budget Operations Research has not been utilized pending finalization of study topics in coordination with NACO and SR partners.

## 2.3 NEXT IMPLEMENTATION PERIOD REQUEST

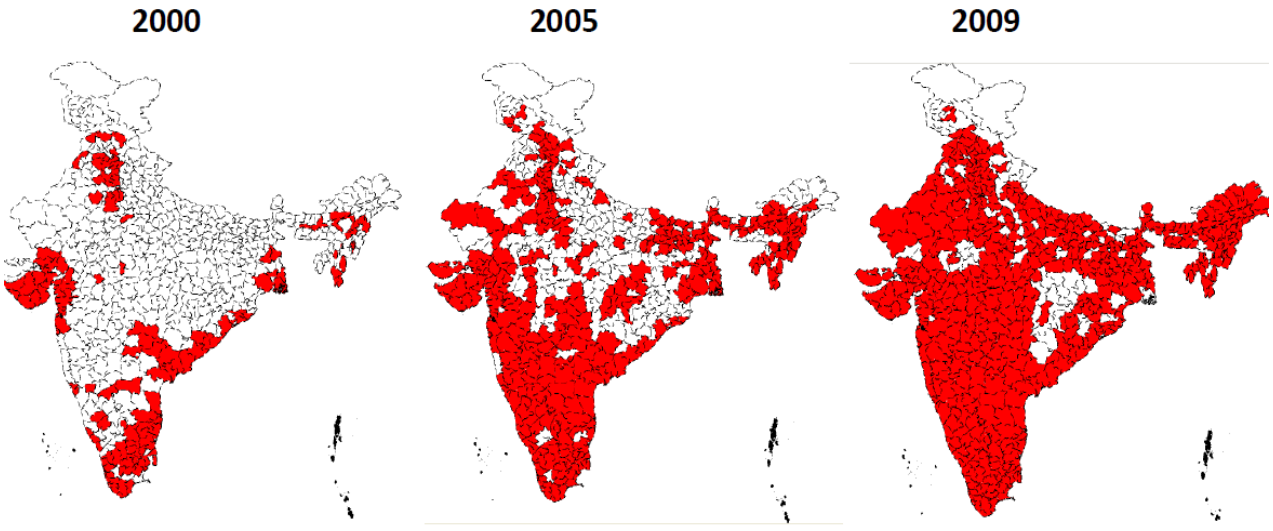
**Has the CCM Request met the Focus of Proposal requirements per the threshold based on the income classification for the country?** Yes

**Please describe how the CCM Request is focused on underserved and most-at-risk populations and/ or high-impact interventions.**

In India, the populations most at risk of HIV transmission are FSW, MSM, IDUs and MTH collectively constitute what is termed High Rrisk Groups (HRGs). Much of the HIV transmission in India occurs within groups or networks of individuals who have higher levels of risk due to a higher number of sexual partners or the sharing of injection drug equipment. It is estimated that HIV prevalence among HRGs is 10-30 times higher than the general population. As the primary drivers of HIV epidemic in India, HRGs have attracted specific focus and attention in India's national response reflected by a significant scale up of TI for HRGs.

According to NACO's annual reports 2010-2011 and 2011-2012, prevention through focused interventions among these groups is the key to controlling the country's HIV epidemic. Targeted Interventions are preventive interventions focused at High Risk Groups and Bridge populations in a defined geographic area. These are generally peer-led interventions implemented through NGOs/CBOs and monitored by the State AIDS Control Societies (SACS), Technical Support Units (TSUs), State Training and Resource Centers (STRC) and NACO.

**Targeted Interventions by district 200, 2005 and 2009**




The interventions implemented during the first phase of the Round 9 prevention program have provided critical support in containing the transmission of the epidemic in India through the TI strategy of NACP III. IHAA has contributed to the reach and quality of services for MSM, transgender and hijra communities. The PR engaged 87 CBOs to provide services to MTH, supported 44 new CBOs in enhancing interventions under the TI strategy, and promoted an enabling environment for MTH. The program reached 11,864 community members and referred 7,025 MTH for testing. The CBOs working under this program distributed more than 700,000 condoms and counseled 13,520 MTH on personal risk assessment, risk reduction, mental health, family counseling, and ART adherence. Similarly, the EHA's Hifazat project the reach and quality of IDU harm reduction services in target districts.

The interventions proposed by the CCM for Phase 2 are broadly in line with goal and objectives of the Round 9 proposal and are aimed at strengthening the TI strategy of the NACP-IV.

The program is also compliant with the focus of proposal requirement with at least 50% focused prevention

among HRGs. Focused prevention programs, known under NACP as TIs, started to be implemented as a national strategy in India since 1998 among high risk groups (HRGs -- FSW, IDUs, MSM, TG (individuals and hijras), as well as and bridge groups (truckers and migrants), by engaging community based organizations. Intervention services include behavioral change communication, condom promotion, STI care and referrals for HIV testing and ART. As of 2011, 1,385 TIs provide prevention services to an overall population of 3,132,000, covering: 78% of the estimated number of FSW, 76% of IDUs, 69% of MSMs, 32% of migrants and 33% of truckers.

**Has the CCM Request considered issues of human rights and gender equality?** Yes

The CCM proposal reflects the principle of equity as part of the larger national health program that emphasizes universal access for free or highly subsidized rates and quality health care for all citizens irrespective of gender and age. Key interventions are delivered to positive individuals at the household and community levels and therefore cover the at-risk populations irrespective of gender.

While the Global Fund has not noted any major gender or human rights related issues directly related to the program implemented by EHA and IHAA, the CCM addresses gender-related and human rights issues as part of the larger national health and social development effort, as well as its request for continued funding.

Social acceptance of HIV programming continues to grow in India. As demonstrated in a 2009 BSS study, the level of stigma and discrimination has come down despite continued high levels of societal stigma towards MSM, transgender individuals and other sexual minorities. Reaching these vulnerable stigmatized groups remains a major challenge.

As part of its overall social strategy under NACP-III and IV, NACO has established various social measures for women living with HIV, including free legal aid, state-level widow pension schemes, women's networks at national, state, and district levels, advocacy for access and utilization of HIV related services for women, grievance redress systems at the state levels to fight stigma and discrimination, and referral systems for women and children living with HIV to shelters and care facilities.

A case for decriminalizing homosexuality is underway in the Supreme Court of India. One of the outcome indicators proposed by the CCM for Phase 2 (Percentage of MSM reporting cases of violence by law enforcement authorities/police) will help address the issue of MSM-related human rights violations.

**Please describe the activities proposed for the next implementation period.**

The goal of NACP IV is to reverse the HIV epidemic in India through an integrated national response. NACP IV is expected to reduce new infections by 60% and provide comprehensive care, support and treatment to all persons living with HIV/AIDS. The country plans to achieve these objectives through the following key strategies, including TIs among High Risk Groups.

The overall goal of the Round 9 CCM proposal is in line with the goals, objectives, and strategies of NACP IV. The program's expected impact over Phase 2 is reflected by projected annual reductions in HIV incidence among MSM by 0.2% and among IDUs by 0.3%. In the program's second phase, the civil society PRs will scale up proven interventions in line with the intent of the original proposal:

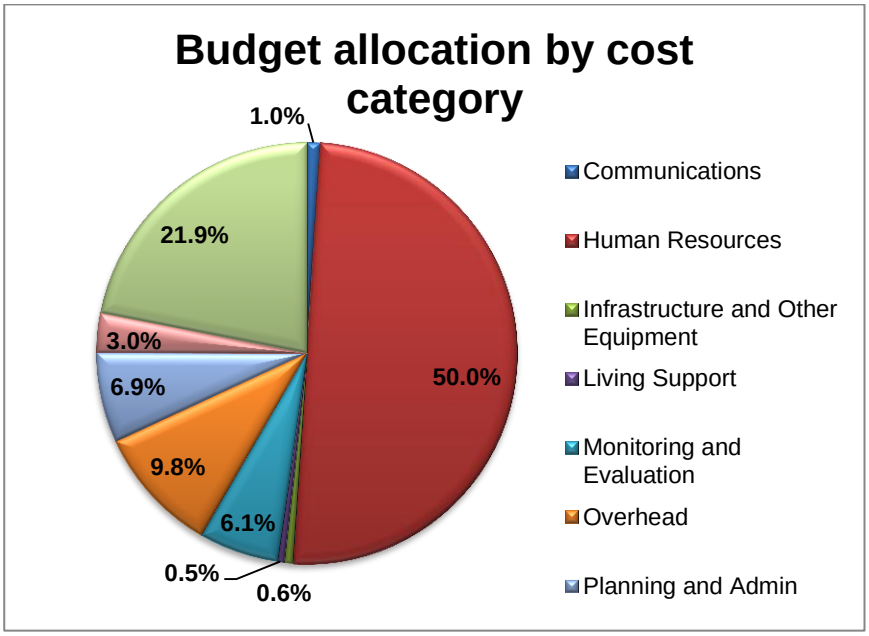
**IHAA** (IDA-910-G20-H)
The objective of the grant managed by IHAA is to strengthen community institutions and systems for MSM, Hijra and transgender communities to increase reach and quality of services. The grant targets an increase of up to 80% MSM using condoms and a reduction from 12% to 10% of MSM reporting cases of violence by law enforcement authorities.

The PR will provide services to MTH community members, referring approximately 1,800 registered MTH clients for HIV testing and counseling on an average each quarter, referring around 900 (on the average) MTH living with HIV to ART centers for registration and treatment every quarter, providing adherence support to MTH on ART, providing SRH services to the female partners of MTH, and addressing incidents of violence and harassment.

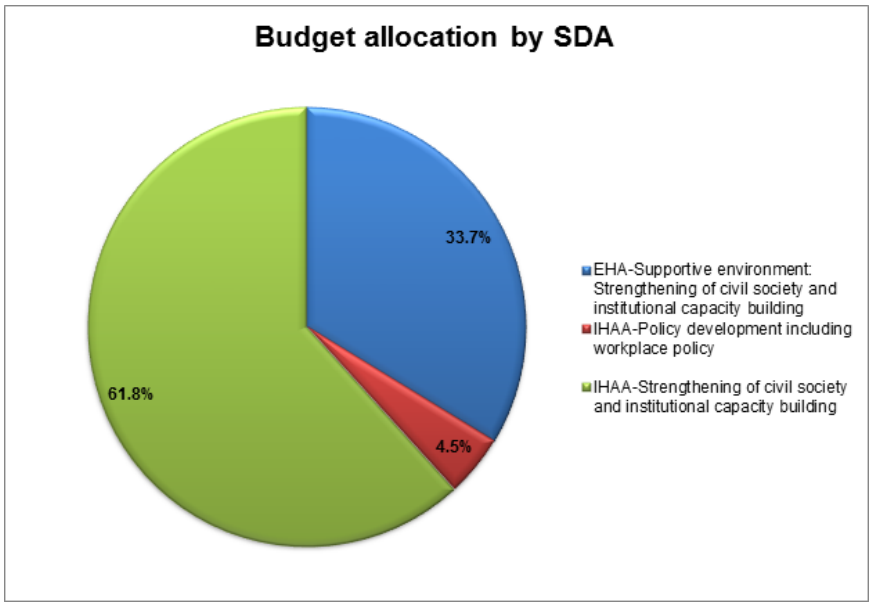
**EHA** (IDA-910-G21-H)
EHA's objective is to strengthen the reach and quality of harm reduction services for IDUs. By 2015, the PR intends to achieve a target of 80% IDUs who report using a sterile needle and syringe the last time they injected and 78% IDUs reporting the use of a condom the last time they had sexual intercourse.

Capacity-building training activities represent 48% of the grant's budget. EHA and its partners intend to train 29,070 program management, health care provider, and outreach staff needed to support NACP TI scale up over the next three years. EHA will also support the scale up of the national harm reduction program through operational research, counseling and reintegrating OST clients, improving harm reduction service quality, and strengthening supervision. The grant program will focus attention on female IDUs and female sexual partners of male IDUs.

**Budget allocation for the next implementation period by cost category:**




**Budget allocation for the next implementation period by SDA:**




**Are the activities to be funded in the next implementation period appropriate given the specific country and disease context?** Yes

The CCM has proposed no material programmatic changes in the IHAA and EHA grants. However, both PRs have presented scale-up options of proven outreach interventions should additional resources become available. This was done in recognition of the need to scale up focused prevention among India's HRGs and the heretofore modest resources that have been allocated for this purpose with the impending close-out of the Avahan Program in 2014.

**IHAA (IDA-910-G20-H)**
The CCM has proposed to revise the outreach approach in order to ensure service quality and effectiveness. Community Volunteers will also serve as primary contacts and community mobilizers at sites not covered by TIs. The CCM also suggests staff support for improved coordination at the state and district levels. Finally, the CCM proposes certain changes in indicator formulation in the Phase 2 Performance Framework (PF), to be negotiated with the Global Fund.

**EHA (IDA-910-G21-H)**
The CCM has proposed improvements to the training and capacity building activities managed by EHA. These changes would be reflected in modifications to most of the indicators in the Performance Framework in order to measure the actual work done under the program.

**MoLE (IDA-911-G24-H)**
The CCM proposed NACO as lead implementer for Phase 2, requesting that the Global Fund support the ongoing TI for migrants and informal workers. In view of the proposed change in implementation arrangements, the Global Fund recommends reallocation of the undisbursed Phase 1 amount for this grant (US $7,417,421) to the two civil society PRs under this Round 9 program -- US $4,270,391 for IHAA and US $3,147,030 for EHA. This will permit an orderly expansion and acceleration of successful focused prevention efforts among vulnerable MTH and IDU groups, thereby achieving greater impact and value for money. These changes are not expected to imply a significant departure from the key service delivery areas, goals and objectives of the relevant approved proposals. Prevention work among migrants and informal workers continue to be supported by the India government.

**Are the proposed changes, if any, considered material?** No

The discontinuation of the MoLE grant due to non-performance is a significant change. However, because the grant was never started, no material change between phases can be noted. The relatively modest reallocation of available Global Fund resources for NACP among "targeted interventions" should improve the overall performance of the Global Fund -supported program.

# 3. RECOMMENDATION BY PRINCIPAL RECIPIENT

## 3.1 PRINCIPAL RECIPIENT 1

| | |
|---|---|
| **Grant Number** | IDA-910-G20-H |
| **Principal Recipient** | India HIV/AIDS Alliance |
| **Grant Start date** | 01/10/2010 |
| **Grant End date** | 31/12/2012 |

| a. SECRETARIAT PERFORMANCE RATING | A1 |
|---|---|

**Secretariat rationale for the Recommended Performance Rating**

The PR's programmatic performance, as of 31 March 2012, was excellent. The PR met or exceeded its targets for six out of eight indicators. The PR achieved 94% of its target on the indicator, Number and percentage of registered MTH referred to HIV testing and counseling and who know their results". The PR could not fully achieve the targets on the indicator Number of MTH in the project living with HIV referred to and registered at ART Center (34% of the target) because of reasons not totally in the PR's control. There were no Major Data quality or service delivery issues were noted in the recent OSDV. The grant rating up to the cut-off date was an A1 and the Top Ten indicator rating was also A1.

The Secretariat has noted a few minor management issues related to the PR's financial management of the grant. These issues were shared with the PR in the most recent management letter. Regardless, the grant rating does not merit a downgrade because of the management issues.

| b. SECRETARIAT RECOMMENDATION CATEGORY | Go |
|---|---|

**Secretariat rationale for the Recommendation Category**

Like its counterpart grant, managed by EHA, IHAA's grant owes its genesis to the US $338 million Avahan HIV prevention initiative, funded by the Bill and Melinda Gates Foundation from 2003 through 2009. The program is in a "hand-over" phase to the government and is due to officially conclude in 2014. Both EHA and IHAA implemented components of Avahan that evolved into their own grant programs. An October 2011 study published in the Lancet concluded that between 2003 and 2008 the program lowered community rates of HIV acquisition with an increase in protection relative to increased funding per person in the six states where Avahan was active. As many as 100,000 new infections may have been prevented.

This grant plays an important role in containing and reversing the epidemic among HRGs by supporting the government's targeted intervention strategy. Pehchan has made a major contribution to the national TI strategy through interventions implemented during Phase 1, including capacity building of CBO and TI staff, referring MTH community members for HIV testing and counseling and treatment, distributing condoms, and providing treatment adherence support to MTH on ART, reflect best practice and lessons learned from the successful Avahan program.

The recommendation category for this grant is based on the following factors:

1. The PR's performance in achieving its targets in Phase 1 was excellent. The grant has merited a quantitative grant rating of A1 which accurately reflects the PR's performance as of the cut-off date. The grant has played a vital role in reaching out to one of the most marginalized and hidden group of Indian society, MTH. Addressing the HIV epidemic in this high risk group is of critical importance in achieving the objectives of NACP IV.
2. The PR has met all the applicable grant conditions and has demonstrated very good program management capacity.
3. Despite its relatively modest scope, the grant is making a significant contribution to the scale-up of focused prevention, or "targeted interventions," by the national program.

The Global Fund will seek to consolidate this grant with grant IDA-405-G05-H RCC, also being reviewed in this renewals wave.

| c. RECOMMENDED INCREMENTAL AMOUNT | US $16,892,697 |
|---|---|

**Please explain key differences between CCM and Secretariat Recommended Incremental Amount.**

The CCM submitted a request of US $18,023,871 for the next Implementation Period, which represents 96% of the ceiling amount available for this PR (Alliance) after the 90% Board mandated reduction on the original TRP amount.

The Secretariat recommends an adjustment of US $289,987 on the budget for Human Resource and M&E in view of over-ambitious human resource cost and monitoring activities. In addition, the Secretariat proposes to adjust the FX rate from US $1 = 50.74 INR to US $1 = 52.62 INR, which is in line with the recent exchange rate movement and produces additional savings of US $639,481. Finally, the Secretariat recommends support of a new outreach strategy aimed at increasing the quality and impact of Round 9 MTH coverage. In Phase 1, community-based SSRs found that employing part-time peer educators was not an effective outreach strategy for MSM, transgender and hijra populations. Consequently, in Phase 2, the Secretariat recommends phasing out peer educators in favor of dedicated field officers, each of whom would cover between 250 and 400 clients. This shift will result in a significant increase in service provision to vulnerable groups, which will be reflected in upwardly revised Performance Framework targets. The cost of this expansion comes to US $4,270,391, subject to CCM concurrence and finalization at the time of grant negotiations with the PR.
Therefore the proposed adjustments will bring the adjusted Phase 2 budget amount to US $21,239,600 for the next implementation period, which represents 114% of the adjusted TRP Amount.

In addition to the scale-up described above, the difference between the original proposal and the current budget is mostly due to:

- An increase of US $1,878,956 in human resource budget due to increase in the number of staff as well as the salaries at PR level, in line with the actual salaries. Also, the salary cost at SSRs has been increased mainly due to provision of PD's oversight cost, finance officer and Pehchan Field officers, which were not there in the original TRP approved budget.
- An increase of US $1,007,917 in training budget is mainly because of certain training activities provided in the current budget, which were not budgeted originally. The trainings mentioned above have been introduced in Phase 2 based on need of the program.
- An increase of US $3,002,942 in overheads is mainly because the office administration expenses, which were classified under planning and administration in the original budget, have been classified under overheads in the current budget.
- A decrease of US $5,340,066 in communication, mainly because many activities at CBO level such as mental health counseling, life skills training, priority issues of MSM, community awareness and CBO learning and advocacy are not included in the current budget.
- A decrease of US $2,533,661 in Planning and Administration is mainly because the office administration expenses, which were classified under 'P&A' in the original budget, have been classified under overheads in the current budget.

In total, the Secretariat recommends a budget of US $21,239,600 for the next Implementation Period which includes the budget reallocation of US $4,270,391. Less cash and the undisbursed amount from the current Implementation Period, this produces an incremental amount of US $16,892,697. This represents 90% of the TRP adjusted amount which is within the investment range for a grant with A1 rating. The Secretariat proposes to take any needed a savings for the Round 9 program from the un-started government grant, IDA-910-G24-H.

It should be noted that Quarter 9 costed extension was signed for this grant and an amount of US $1,427,087 has already been committed from the Phase 2 amount, leaving US $15,465,610 to now be approved as the rest of the incremental amount for the next implementation phase.

| Grant Performance rating | Adjusted TRP clarified amount for next implementation period | = | Indicative investment range % of adjusted TRP clarified amount | |
|---|---|---|---|---|
| | | | High | Low |
| A1 | $ 18,698,828 | | 100% | 90% |

## 3.2 PRINCIPAL RECIPIENT 2

| | |
|---|---|
| **Grant Number** | IDA-910-G21-H |
| **Principal Recipient** | Emanuel Hospital Association |
| **Grant Start date** | 01/10/2010 |
| **Grant End date** | 30/09/2012 |

| a. SECRETARIAT PERFORMANCE RATING | B1 |
|---|---|

**Secretariat rationale for the Recommended Performance Rating**

EHA significantly improved its performance over the last two reporting periods prior to the cut-off date, from a “C” to a quantitative "A2" rating. The PR’s initial difficulties stemmed from the need to secure NACO approval for SR selection and the delays resulting from this process. However, these difficulties were overcome and, as of the cut-off date (31 March 2012), the PR had met or exceeded its targets for its three major coverage indicators:

1. Number of FIDUs reached and provided services at GPCs (Good Practice Centers) through the project – 109% of target;
2. Number of OST (opioid substitution therapy) clients counseled on reintegration services – 147% the target; and
3. Number of harm reduction sites implementing quality assurance protocol – 102% of target;

Also, the PR reached 93% of its target for the indicator, “Number of RTTCs (Regional Technical Training Centers), STRCs (State Training Resource Centers), and GPCs selected and staff recruited”;

EHA was able to substantially meet its target for “Total number of people (NGO program staff, medical staff and peer educators) trained on harm reduction,” with an achievement rate of 72%.

No Data quality or service delivery issues were noted pertaining to the indicator, “Total number of people (NGO program staff, medical staff and peer educators) trained on harm reduction”. However for two indicators, namely, “Number of FIDUs reached and provided services at GPCs through the project” and “Number of OST clients counseled on reintegration services”, SRs had reported cumulative, not periodic coverage numbers, in the first instance, and instances of service provision, not clients, in the second. Although these issues stem from the PR’s late start in working with its SRs due to NACO-related delays, they are nevertheless of sufficient significance to downgrade the cumulative performance rating of the grant to B1 as of the cut-off date.

The Secretariat has noted a few minor management issues. Most of these issues were shared with the PR in the last management letter. The grant rating does not merit a downgrade because of the management issues.

| b. SECRETARIAT RECOMMENDATION CATEGORY | Go |
|---|---|

**Secretariat rationale for the Recommendation Category**

Like its counterpart grant managed by IHAA, EHA’s grant owes its genesis to the US $338 million “Avahan” HIV prevention initiative, funded by the Bill and Melinda Gates Foundation from 2003 through 2009 (the program is in a “hand-over” phase to the government and is due to officially conclude in 2014). Both EHA and IHAA implemented components of Avahan that evolved into their own grant programs. In October 2011

study published in the Lancet concluded that between 2003 and 2008 the program lowered community rates of HIV acquisition with an increase in protection relative to increased funding per person in the six states where Avahan was active. As many as 100,000 new infections may have been prevented.

The project has complemented and supplemented the national efforts through a series of interventions supporting the national scale up of TI interventions for IDUs including the development of SOPs and training modules, conducting operational research and diagnostic studies, building capacity of TI staff and other key stakeholders. These activities reflect best practice and lessons learned from the successful Avahan program.

The recommendation category for this grant is based on the following factors:

1. The PR's performance in achieving its targets in Phase 1 was very good. The grant has merited a quantitative grant rating of A2 which accurately reflects the PR's performance as of the cut-off date. The grant has played a vital role in reaching out to IDUs which is one of the three high risk groups driving the HIV epidemic in India. Addressing HIV epidemic in this high risk group is of critical importance in achieving the objectives of NACP IV. Now that implementation arrangements are set between the PR and its SRs, data quality issues should lessen.

2. The PR has met most of the applicable grant conditions and has demonstrated solid program management capacity.

3. Despite its relatively modest scope, the grant is making a significant contribution to the scale-up of focused prevention, or "targeted interventions," by the national program.

| c. RECOMMENDED INCREMENTAL AMOUNT | US $7,367,237 |
|---|---|

**Please explain key differences between CCM and Secretariat Recommended Incremental Amount.**

The CCM submitted a request of US $9,160,017 for the next Implementation Period, which represents 104% of the ceiling amount available for this PR (EHA) after the 90% Board mandated reduction on the original TRP amount.

The Secretariat has reduced the budget to US $9,116,043 and recommends adjustment of US $178,887 on the budget for trainings because the budget contains consultancy fees for full-time SR staff to conduct trainings. The Secretariat also proposes to adjust the FX rate from US $1 = 50.74 INR to US $1 = 52.62 INR, which is in line with the recent exchange rate movement and produces additional savings of US $319,305.

Finally, the Secretariat recommends support of the program to support an increase in the number of Regional Technical Training Centers from five to eight, State Training and Resource Centers from nine to 12 and Learning Centers from 13 to 18, in line with the new strategy under NACP IV. Moreover, the program is asked to support an increase in the number of IDU targeted intervention sites from the current 300 to 400 by the fourth quarter of 2014, as well as the number of female IDU TI sites from 10 to 30 in the same time frame. OST site are scheduled to increase from 100 to 300 by October 2014. In sum, the PR estimates that 1,184 training sessions will be needed train over 35,000 persons in order to operationalize these new facilities. As in the case with IHAA, this scale-up can be financed with US $3,147,030 in available Round 9 funds, subject to CCM concurrence and finalization at the time of grant negotiations with the PR.

Therefore the proposed adjustments will bring the adjusted Phase 2 budget to US $11,764,881 for the next Implementation Period, which represents 133% of the Adjusted TRP Amount

The PR calculated its portion of the CCM request for the remaining Phase 1 based on budget, not forecast, hence an additional amount of US $411,990 was added to the Phase 1 budget.

In addition to the scale-up described above, the difference between the original proposal and the current budget is mostly due to:

- An increase of US $323,703 in human resource budget is because the original proposal PR had proposed for 30 SRs. However, additional 11 have been proposed from April 2013 considering the increased work load.

- An increase of US $703,839 in technical assistance budget is mainly because in the original budget the amount required for the TMA (i.e. consultants' fees) was budgeted in other cost category.
- An increase of US $1,521,167 in trainings is mainly because in Phase 2 the number of sites is increasing.
- An increase of US$ 482,197 in Monitoring and Evaluation is mainly because the budget for Phase 2 takes into account the field visits cost for additional 11 SRs proposed in Phase 2.
- A decrease of US $2,026,959 in Planning and Administration and a decrease of US $490,742 in Overheads are based on actual Phase 1 expenditure under these cost categories which was lower than in the originally proposed budget.

In total, the Secretariat recommends a budget of US $11,764,881 for the next Implementation Period which includes the budget reallocation of US $3,147,030. Less cash and undisbursed amount from the current Implementation Period, this produces an incremental amount of US $7,367,237. This represents 83% of the TRP adjusted amount which is within the investment range for a grant with B1 rating. However, taking into consideration the significant improvement of the PR's performance in Quarter 5 and Quarter 6 and the fact that the data quality issues it encountered are directly attributable to a late start of SR activities, the Secretariat believes that the recommended incremental amount will enable the PR to maintain its current "A" level performance while scaling up essential harm reduction activities.

The budget contains some lump sum estimation; hence, there are potential savings in the budget which can be identified during grant negotiation.

| Grant Performance rating | Adjusted TRP clarified amount for next implementation period | = | Indicative investment range % of adjusted TRP clarified amount | |
|---|---|---|---|---|
| | | | High | Low |
| B1 | $ 8,830,003 | | 89% | 60% |

## 3.3 PRINCIPAL RECIPIENT 3

| | |
|---|---|
| **Grant Number** | IDA-910-G24-H |
| **Principal Recipient** | Ministry of Labor and Employment |
| **Grant Start date** | 01/10/2010 |
| **Grant End date** | 30/09/2012 |

| a. SECRETARIAT PERFORMANCE RATING | C |
|---|---|

**Secretariat rationale for the Recommended Performance Rating**

Due to an internal dispute in the India government, the Ministry of Labor and Employment (MoLE) was unable to implement this grant. NACO's informal/migrant worker Targeted Intervention was insufficiently in line with the grant's Performance Framework, workplan and budget to permit a formal change in implementation arrangements, performance measurement and disbursement in Phase 1.

UNAIDS reports that of over 500,000 individuals tested for HIV under this TI, less than 200 positive individuals were detected, calling into question the possible impact of the requested investment.

| b. SECRETARIAT RECOMMENDATION CATEGORY | Conditional Go |
|---|---|

**Secretariat rationale for the Recommendation Category**

The Secretariat recommends that Phase 1 undisbursed funds are reallocated to the harm reduction and MTH-focused prevention activities of the Round 9 civil society co-PRs.

| c. RECOMMENDED INCREMENTAL AMOUNT | US $0 |
|---|---|

**Please explain key differences between CCM and Secretariat Recommended Incremental Amount.**

The CCM has requested funding for NACO's informal worker TI amounting to US $25,313,263 for the next Implementation Period. This represents 104% of the ceiling amount available for this PR (NACO) after the 90% Board mandated reduction on the original TRP amount.

Because there has been no implementation and disbursements under this grant during Phase 1, the Secretariat recommends no incremental funding and the reallocation of the grant's undisbursed Phase 1 amount (US $7,417,421) to the other two PRs under this Round 9 program to scale up activities pertaining to harm reduction and MTH-focused prevention activities. This reflects a saving of the adjusted TRP-approved amount for Phase 2 of US $24,412,360.

| Grant Performance rating | Adjusted TRP clarified amount for next implementation period | = | Indicative investment range % of adjusted TRP clarified amount | |
|---|---|---|---|---|
| | | | High | Low |
| No rating | $ 24,412,360 | | negotiable | <30% |

# 4. DETAILED REVIEW BY PRINCIPAL RECIPIENT

## 4.1 PRINCIPAL RECIPIENT 1

| | |
|---|---|
| **Grant Number** | IDA-910-G20-H |
| **Principal Recipient** | India HIV/AIDS Alliance |
| **Grant Start date** | 01/10/2010 |
| **Grant End date** | 30/09/2012 |

## STEP 1: Programmatic Achievements

### Overall Performance Rating to cut-off date:

**PR : India HIV/AIDS Alliance**

| 1 Oct 2010 – 31 Mar 2011 | 1 April 2011 – 30 Sep 2011 | 1 Oct 2011 – 31 Mar 2012 |
|---|---|---|
| **B1** | **A1** | **A1** |

### Cumulative Indicator Rating at cut-off date:

**IDA-910-G20-H**

| Service Delivery Area | Indicator Number | Is Top 10 | Is Training | Indicator | Rated Target | Rated Result | Percentage |
|---|---|---|---|---|---|---|---|
| Supportive Environment: Strengthening of Civil Society | 2.1 | Yes | Yes | SR & SSR staff trained on Program Management & Thematic Areas | 1003 | 1378 | 120% |
| | 2.2 | Yes | | No of MTH (MSM, Transgender and Hijra) reached through community mobilization meetings | 1200 | 1525 | 120% |
| | 2.3 | | | No of groups (Proto CBOs) formed by MTH | 60 | 64 | 107% |
| | 2.4 | | | Number of CBOs providing at least two new services to members of MSM, Hijra and transgender communities. | 87 | 87 | 100% |
| CSS: Community activities and service delivery | 2.5 | Yes | | Number of beneficiaries among MSM, Hijra and transgender communities reached by CBOs with at least 2 new services | 11622 | 11864 | 102% |
| | 2.6 | Yes | | No/% of registered MTH referred to HIV Testing & Counseling and who know their results | 7439 | 7025 | 94% |
| | 2.7 | | | No of MTH in the project living with HIV referred to and registered at ART Centre | 689 | 239 | 35% |
| | 2.8 | Yes | | No of MTH on ART receiving adherence support | 110 | 128 | 116% |
| | 2.9 | | | No of female partners of MTH seeking SRH services | | | Cannot Calculate |

| | |
|---|---|
| Training Indicator Rating | **120%** |
| Average Performance on Top 10 | 110% |

| | |
|---|---|
| Top 10 Indicator Rating | A1 |
| Average Performance All Indicators | 99% |
| All indicators Rating | A2 |
| Number of TOP TEN Indicators with B2 or C Rating | 0 |
| Renewals Indicator Rating | A1 |

**How has the grant performed in the current implementation period?**

IHAA continues to demonstrate excellent performance over most of the Periods in Phase 1 of the grant. The grant has met or exceeded its targets for most of the indicators as mentioned in the table above. The PR's quantitative rating was A1 for the last four quarters. These achievements indicate that the grant has reached the hidden and most at risk populations in the target districts which significantly contributes to the impact of the program in containing the epidemic among MTH.

The PR's performance on one indicator namely, Number of MTH in the project living with HIV referred to and registered at ART Center, lagged because some of HIV positive MTH are reported under government-related TI data despite that the fact that these MTH members are linked to the ART centers through CBOs working under the Global Fund grant. The PR working with NACO to ensure that these cases are reported under the Global Fund grant.

As noted above, IHAA's grant owes its genesis to the US $338 million Avahan HIV prevention initiative, funded by the Bill and Melinda Gates Foundation from 2003 through 2009 and currently in close-out. Both EHA and IHAA implemented components of Avahan that evolved into their own grant programs, working in close collaboration with NACO and state level government agencies. IHAA manages the "Pehchan" program as part of NACP-IV and in support of the national program's TI strategy.

Both IHAA and EHA are dependent on NACO to implement their programs successfully in the context of NACP-IV and the Round 9 program. Both grants recognize NACO's chairmanship of a Project Advisory Board PAB) that coordinates activities in support of the respective HR and MHT TIs. In Phase 1, this dependency materially delayed program activities and disbursements to EHA.

Despite a declining trend in stigma and discrimination against HIV positive people in India, the PR continues to operate in an environment of high levels of societal stigma towards MSM, TGs and Hijras. Social perceptions of these populations pose a challenge to the program in reaching out to the MTH individuals and community. Prohibitive policy frameworks contributing to stigma and discrimination against MTH, lack of the required social and political support to the MTH community, and legal barriers to overcome the criminalization of MTH pose contextual challenges to the program.

| **Revised Indicator Rating** | **NA** |
|---|---|

## STEP 2: Quality of Data and Services

**Date of most recent OSDV:** 2012

| Indicator Text | Overall Verification Factor | Data Quality Rating |
|---|---|---|
| Number of beneficiaries among MSM, Hijra and transgender communities reached by CBOs with at least 2 new services | 99.02% | No Data Quality Issues |
| No of registered MTH referred to HIV testing and counseling and who know their results | 99.41% | No Data Quality Issues |
| Number of MTH in the project living with HIV referred to and registered at ART Center | 100% | No Data Quality Issues |

**Summarize the findings from the most recent OSDV, DQA, RSQA or any other external data quality or quality of services assessments. Include a summary of the M&E systems issues and recommendations arising from these assessments.**

None.

## STEP 3: Grant Management and Compliance

| Grant management assessment | | Rating |
|---|---|---|
| Monitoring and evaluation | The PR conducted a data quality audit in 2011-2012. Although, the final report has not been issued yet, we understand the audit has identified data quality issues at the SR and SSR level. In conjunction with the findings of the OSDV, the Secretariat will follow-up with the PR in Phase 2 to ensure that the issues identified in the OSDV and the data quality audit conducted by the PR are addressed in a timely manner.<br><br>The PR has started reporting data from a computerized management information system (CMIS) as of Period 7. However, the PR has planned to upgrade the software in Phase 2. The PR is currently reconciling old data in the CMIS with past records. Until this process is complete, the CMIS may not be fully usable. | Minor Issues |
| Financial management and systems | 1. Several instances of improper accounting/ reporting of expenses noted during PUDR reviews which can be attributed to staff efficiency in performing this role. PR may need to assess if staff training will help improve the quality of financial reporting.<br>2. Some issues were identified related to the PR's inadequate monitoring of SRs resulting to ineligible expenses charged by SRs undetected by PR. PR needs to strengthen its SR monitoring capacity. As of the date of the latest PR response to the Global Fund management letter, IHAA has corrected majority of the issues identified in the assessment report of the CCM Request for Renewals.<br>3. The PR has recently received an order from the income tax department of the Government of India to pay income taxes because the PR has charged "management fees" to the Global Fund grant which, according to the income tax authorities, reflect income by the organization. IHAA has appealed against the Order and a final decision is awaited. | Minor Issues |
| Additional Safeguards | 4. A PR audit has recently completed and the audit report has been submitted, but not yet reviewed. The audit report for SRs for Year 1 of the grant has been completed and submitted by the PR. | |

| RECOMMENDED PERFORMANCE RATING | A1 |
|---|---|

## STEP 4: Progress towards Impact /Outcome

| IMPACT RATING | Progress Towards Proposal Goals |
|---|---|

## STEP 5: Operational Risk Management

**Please note what tool, if any, was used to support the assessment of operational risks and required actions**

**If available, please include the Calibrated (QUART) or Un-calibrated (ORAP Template) Operational Risk Heat Map.**

N/A

**If the grant was reviewed by the Operational Risk Committee, please include a summary of the recommendations here.**

N/A

## Risk mitigating measures

RECOMMENDED PERFORMANCE CATEGORY

| | | measure type (Board Condition, Condition, MA, other) | Description of Go mitigating measure | Timeframe (prior to signature, at signature, first disbursement, second disbursement, disbursement linked to specific action or category, date, on-going) |
|---|---|---|---|---|
| Program Management | Value for Money | Condition | The CCM shall provide to the Global Fund, in form and substance satisfactory to the Global Fund, a detailed description of the focused interventions to be funded using the incremental funding to be allocated by the Global Fund, which shall be taken into account in the budget and performance framework for the grant. The final amount of such incremental funding shall be subject to the grant renewals and grant negotiation process, including finalization of the grant documentation. | Prior to grant signing |
| Financial and Fiduciary Risks | Several instances of improper accounting/ reporting of expenses were noted during PUDR reviews | Management Action | The Principal Recipient shall, upon written request by the Global Fund, provide to the Global Fund evidence, in form and substance satisfactory to the Global Fund, that there is a system for the proper review and reconciliation of accounts to ensure accuracy in reporting financial information. | Prior to grant signing |
| | Inadequate monitoring of SRs resulting ineligible expenses not detected by PR | Management Action | The Principal Recipient shall, upon written request by the Global Fund, provide to the Global Fund evidence, in form and substance satisfactory to the Global Fund, a system for a more robust review of the periodic Statements of Expenditures from Sub-recipients is in place. | Prior to grant signing |

**Based on the identified issues/risks please complete a below table:**

## STEP 6: Programmatic achievements and financial performance

## Financial situation at cut-off date

**Disbursements**

| | |
|---|---|
| Signed Budget for current implementation period | $ 6,112,153 |
| less: disbursed to cut-off date | $ 4,563,853 |
| Undisbursed amount at cut-off date | $ 1,548,300 |

**Cash at cut-off date**

| | PR | SRs | Total |
|---|---|---|---|
| Disbursed to PR to cut-off date[2] | $ 4,563,853 | N/A | $4,563,853 |
| Less: Disbursed from PR to SRs | ($1,825,658) | $1,825,658 | 0 |
| Less: Expenditure incurred to cut-off date | ($1,408,694) | ($1,441,417) | ($2,850,111) |
| Add: Interest received | $8,145 | $3,484 | $11,629 |
| Add: Other income/ exchange gain/loss | ($277,825) | ($36,470) | ($314,295) |
| **Equals: Cash at cut-off date** | **$1,059,821** | **$351,256** | **$1,411,077** |

**Please explain the reasons for undisbursed funds and/or available cash (activities not performed, savings realized, etc.)**

At the cut-off date (31 March 2012) the total cash balance was US $1,411,077 and the undisbursed funds were US $1,548,300, which brings the total available funds to US $ 2,959,377. The forecast for the period April-September 2011 was US $ 2,882,861 which will absorb almost all of the available resources.

**Have all liabilities at cut-off date been taken into account in the post-cut-off date budget?** Yes

*If not, please ensure unaccounted liabilities are budgeted in the remaining current implementation period.*

## Programmatic achievements and financial performance

**Percentage of funds budgeted at PR level** 35%

**Percentage of funds budgeted at SR/SSR level** 65%

**IDA-910-G20-H**

| Macro Category | Service Delivery Area | Total Adjusted Budget Amount to cut-off date (EFR) | Total Expenditure Amount to cut-off date (EFR) | Expenditure vs Budget at cut-off date | Programmatic Achievement |
|---|---|---|---|---|---|
| | CSS: Community activities and service delivery | | | | **87%** |
| | Supportive Environment: Strengthening of Civil Society | | | | **112%** |
| Supportive Environment | Supportive environment: Policy development including workplace policy | $226,735 | $84,588 | 37% | |
| | Supportive environment: Strengthening of civil society and institutional capacity building | $3,105,504 | $2,765,523 | 89% | |
| **Grand Total** | | **$3,332,239** | **$2,850,111** | **86%** | **99%** |

[2] Funds in-transit should be shown as disbursements received.

**Please provide a summary of the expenditures vs. budget analysis using EFR including for deviations between programmatic performance and expenditure rate, based on EFR.**

Expenditure at the cut-off date (31 March 12) amounted to US $2.8 million representing 86% of the budget to date. The under-spending of budget in all the cost categories primarily due to the following:

The variance of US $0.5 million between the budget and the actual expenditures was due to under-spending mainly in human resources, communication materials, living support and M&E costs.

The average performance of all indicators of 99%, whereas the cumulative utilization is 86% thus the average programmatic performance is higher than the cumulative utilization for the grant.

## STEP 7: Financial Recommendation

### Resources available to finance program for next implementation period

| | Year X | Year Y | Year Z | Total |
|---|---|---|---|---|
| **TRP clarified amount allocated to PR** | $ 7,184,024 | $ 6,872,188 | $ 6,720,264 | $ 20,776,476 |
| Any Board mandated adjustments | $ (718,402) | $ (687,219) | $ (672,026) | $ (2,077,648) |
| Adjustment +/(-) for (borrowing) and/or staggered commitments not yet committed | - | - | - | - |
| **Adjusted TRP clarified amount** | $ 6,465,622 | $ 6,148,969 | $ 6,048,238 | $ 18,698,828 |
| CCM reallocations +/(-) (implementation arrangements) | - | - | - | - |
| **Adjusted reallocated amount** | $ 6,465,622 | $ 6,148,969 | $ 6,048,238 | $ 18,698,828 |
| + Undisbursed amount at cut-off date | | | | $ 1,548,300 |
| + Cash at cut-off date | | | | $1,411,077 |
| **=Total Resources available** (after cut-off date for the next Implementation Period) | | | | **$ 21,658,205** |

### Summary Budget Recommendation and Incremental Amount

| | Year W after cut-off date | Year 1 | Year 2 | Year 3 | Total |
|---|---|---|---|---|---|
| **Total Budget requested by the CCM** *(after cut-off date for the next Implementation Period)* | $3,540,258 | $ 5,750,632 | $6,392,143 | $ 5,881,096 | $21,564,129 |
| Adjustment to budget if counterpart financing requirement is not met | 0 | 0 | 0 | 0 | 0 |
| Adjustments to CCM Funding Request by Secretariat *(add as many lines as required)* | $(657,394) | $ (586,446) | $(363,201) | $ (105,015) | $(1,712,056) |
| **Total Budget Recommended by the Secretariat** | $2,882,864 | $ 5,164,186 | $6,028,942 | $ 5,776,081 | $19,852,073 |
| - Undisbursed amount at cut-off date | | | | | $1,548,300 |
| - Cash at cut-off date | | | | | $1,411,077 |

| | Year W after cut-off date | Year 1 | Year 2 | Year 3 | Total |
|---|---|---|---|---|---|
| **RECOMMENDED INCREMENTAL AMOUNT** | | | | | $16,892,697 |
| % of adjusted TRP clarified amount | | | | | 90% |

## 4.2 PRINCIPAL RECIPIENT 2

| | |
|---|---|
| **Grant Number** | IDA-910-G21-H |
| **Principal Recipient** | Emmanuel Hospital Association |
| **Grant Start date** | 01/10/2010 |
| **Grant End date** | 30/09/2012 |

## STEP 1: Programmatic Achievements

### Overall Performance Rating to cut-off date:

**PR: Emmanuel Hospital Association (EHA)**

| 1 Oct 2010 – 31 Mar 2011 | 1 April 2011 – 30 Sep 2011 | 1 Oct 2011 – 31 Mar 2012 |
|---|---|---|
| C | C | A2 |

### Cumulative Indicator Rating at cut-off date:

| Service Delivery Area | Indicator Number | Is Top 10 | Is Training | Indicator | Rated Target | Rated Result | Percentage |
|---|---|---|---|---|---|---|---|
| CSS: Human resources: skills building for service delivery, advocacy and leadership | 3.1 | | | Number of RTTCs, STRCs and GPCs selected with staff recruited. | 28 | 26 | **93%** |
| | 3.2 | Yes | Yes | Total number of people (NGO program staff, medical staff & peer educators) trained on harm reduction. | 4680 | 3377 | **72%** |
| CSS: Monitoring & evaluation, evidence building | 3.3 | | | Number of operation research on female IDUs and their partners conducted, reports finalized & results disseminated. | 4 | 2 | **50%** |
| CSS: Community based activities and services – delivery, use and quality | 3.4 | Yes | | Number of FIDUs reached & provided services at GPCs through the project. | 2380 | 2593 | **109%** |
| | 3.5 | Yes | | Number of OST clients counseled on reintegration services. | 3413 | 5002 | **120%** |
| | 3.6 | | | Number of harm reduction sites implementing quality assurance protocol. | 125 | 128 | **102%** |
| | 3.7 | | | Number of supportive supervision visits made by GPC officials to harm reduction sites (Number of visits are based on the ranking of the site). | 546 | 221 | **40%** |
| | 3.8 | | | Number of IDU clients screened and referred by GPC DIC staff to DOTS government facilities | Not Found | Not Found | Cannot Calculate |

| | |
|---|---|
| Training Indicator Rating | 72% |

| | |
|---|---|
| Average Performance on Top 10 | 100% |
| Top 10 Indicator Rating | A2 |
| Average Performance All Indicators | 84% |
| All indicators Rating | B1 |
| Number of TOP TEN Indicators with B2 or C Rating | 0 |
| Renewals Indicator Rating | A2 |

**How has the grant performed in the current implementation period?**

EHA significantly improved its performance over the last two reporting periods from a “C” to a quantitative "A2" rating. The PR’s initial difficulties stemmed from the need to secure NACO approval for SR selection and the delays resulting from this process. However, these difficulties were overcome and as of the cut-off date (31 March 2012), the PR had met or exceeded its targets for its three major coverage indicators:

1. Number of FIDUs reached and provided services at GPCs (Good Practice Centers) through the project – 109% of target;
2. Number of OST (opioid substitution therapy) clients counseled on reintegration services – 147% the target; and
3. Number of harm reduction sites implementing quality assurance protocol – 102% of target;

Also, the PR reached 93% of its target for the indicator, “number of RTTCs (Regional Technical Training Centers), STRCs (State Training Resource Centers), and GPCs selected and staff recruited”;

EHA was able to substantially meet its target for “Total number of people (NGO program staff, medical staff and peer educators) trained on harm reduction,” with an achievement rate of 72%.

The PR’s performance on a final two indicators lagged due to late site selection and SR approvals by NACO: Number of operational research (studies) on female IDUs and their partners conducted, reports finalized and results disseminated” - 50% of the target (all four plans studies have been completed as of October 2012); and Number of supportive supervision visits made by GPC officials to harm reduction sites (number of visits are based on the ranking of the site) – 40% of the target.

Data quality issues discussed in the succeeding section merit a downgrade in the grant’s cumulative rating with reflecting on the PR’s recent success in overcoming its start-up difficulties.

As noted above, EHA’s grant owes its genesis to the US $338 million Avahan HIV prevention initiative, funded by the Bill and Melinda Gates Foundation from 2003 through 2009 and currently in close-out. Both EHA and IHAA implemented components of Avahan that evolved into their own grant programs, working in close collaboration with NACO and state level government agencies. EHA manages the “Hizafat” program as part of NACP-IV and in support of the national program’s TI strategy.

Both IHAA and EHA are dependent on NACO to implement their programs successfully in the context of NACP-IV and the Round 9 program. Both grants recognize NACO’s chairmanship of a Project Advisory Board PAB) that coordinates activities in support of the respective HR and MHT Targeted Interventions. In Phase 1, this dependency materially delayed program activities and disbursements to EHA.

Despite a declining trend in stigma and discrimination against HIV positive people in India, the PR continues to operate in an environment of high levels of societal stigma towards IDUs. Social perceptions of injection drug use pose a challenge to the program in reaching out to IDUs and their families. Prohibitive policy frameworks contributing to stigma among IDUs, lack of required social and political support to the IDU community, and legal barriers to overcome the criminalization of injection drug use pose contextual challenges to the program.

| **Revised Indicator Rating** | **NA** |
|---|---|

## STEP 2: Quality of Data and Services

**Date of most recent OSDV:** September 2012

| Indicator Text | Overall Verification Factor | Data Quality Rating |
|---|---|---|
| Total number of people (NGO program staff, medical staff & peer educators) trained on harm reduction | 97.55% | No data quality issues |
| Number of FIDUs reached & provided services at GPCs through the project | 21.06% | Major Issues |
| Number of OST clients counseled on reintegration services | 37.98% | Major Issues |

**Summarize the findings from the most recent OSDV, DQA, RSQA or any other external data quality or quality of services assessments. Include a summary of the M&E systems issues and recommendations arising from these assessments.**

Major data quality issues for two of the three indicators were identified in the OSDV. No data quality or service delivery issues were noted pertaining to the indicator Total number of people (NGO program staff, medical staff and peer educators) trained on harm reduction. However for two indicators, namely, Number of FIDUs reached and provided services at GPCs through the project and Number of OST clients counseled on reintegration services, SRs had reported cumulative, not periodic coverage numbers, in the first instance, and instances of service provision, not clients, in the second.

A brief summary of the data quality issues follows:

Number of FIDUs reached and provided services at GPCs through the project: The data collected under this indicator does not reflect the number of FIDUs reached through the project. While only one FIDU was reached through the project during the period October 2011 to March 2012, the numbers reported is the total number of FIDUs ever registered. The SR responsible for this indicator did not consolidate the data under this indicator. Multiple counting of the same numbers reported by the targeted interventions sites was also identified.

Number of OST clients counseled on reintegration services: Most of the data quality issues noted under this indicator are similar to the issues pertaining to the above indicator. No records for the OST clients selected for services were maintained, which makes it difficult to verify the reported results. While the targeted interventions (at the sites selected for OSDV) cover certain reintegration topics during counseling, these targeted interventions do not provide specific reintegration counseling. The targeted interventions sites report the total number of counseling sessions held instead of reporting the number of clients counseled. No separate records are maintained for the selected clients provided reintegration services under the project and the SR does not consolidate the reported results.

## STEP 3: Grant Management and Compliance

| Grant management assessment | | Rating |
|---|---|---|
| Monitoring and evaluation | 1. The PR could not provide the underlying compilation of results for its coverage indicators;<br>2, Results reported by the PR did not tally with the results in the SR reports for some of the indicators mainly because results on these indicators were either based on the field visits or were obtained on telephone;<br>3. As a result, analysis of the reported results remains incomplete.<br><br>The Secretariat recommended to the PR that it compile SR results for those results to be reported. In addition, the PR was asked to report SR results based on formal reports from the SRs. Moreover, the PR was advised to put in place a system whereby SR reports are properly | Major Issues |

| | | |
|---|---|---|
| | reviewed and have asked it to take the following corrective actions:<br>1. Provide feedback to SRs in case of errors in the reported results;<br>2. Following feedback to the SRs, receive the correct reports within a specified time frame; and<br>3. Provide all the required details in the PU/DR pertaining to variance in the targets achieved by the PR.<br><br>These issues are being resolved as of the date of this review. | |
| Financial management and systems | The current PR and SR audit systems have certain shortcomings, which were identified during the PU/DR review for the period October 2011 – March 2012. These findings led the PR to seek revised audit reports revised from the auditors. | Some Issues |
| Additional Safeguards | Audit report submitted and review submitted on 7 March 2012. | |

| RECOMMENDED PERFORMANCE RATING | B1 |
|---|---|

## STEP 4: Progress towards Impact /Outcome

| IMPACT RATING | Progress Towards Proposal Goals |
|---|---|

## STEP 5: Operational Risk Management

**Please note what tool, if any, was used to support the assessment of operational risks and required actions**

NA

**If available, please include the Calibrated (QUART) or Un-calibrated (ORAP Template) Operational Risk Heat Map.**

NA

**If the grant was reviewed by the Operational Risk Committee, please include a summary of the recommendations here.**

NA

## Risk mitigating measures

**Based on the identified issues/risks please complete a below table:**

| Main Areas | Compliance Issue/Risk | Prevention or Mitigating measure type (Board Condition, Condition, MA, other) | Description of mitigating measure | Timeframe (prior to signature, at signature, first disbursement, second disbursement, disbursement linked to specific action or category, date, on-going) |
|---|---|---|---|---|
| Program Management | Value for Money | Condition | The CCM shall provide to the Global Fund, in form and substance satisfactory to the Global Fund, a detailed description of the focused interventions to be funded using the incremental funding to be allocated by the Global Fund, which shall be taken into account in the budget and performance framework for the grant. The final amount of such incremental funding shall be subject to the grant renewals and grant negotiation process, including finalization of the grant documentation. | Prior to grant signing |
| M&E | Data quality | Condition | The Principal Recipient shall provide to the Global Fund evidence, in form and substance satisfactory to the Global Fund, of a comprehensive plan to strengthen its data reporting system, including MIS/Database system, as well as monitoring and supervision of the SRs/targeted interventions. | Within three months after signing of second implementation period documents |
| Financial and Fiduciary Risks | The year 1 Audit needs to be revisited in view of the shortcomings identified in the audit systems of the PR and SRs. | Management Action | The Principal Recipient shall provide to the Global Fund, evidence that the revised audit report for Year 1 of the grant has been completed, in form and substance satisfactory to the Global Fund, which shall be in accordance with the international standards of auditing and report as per the Global Fund approved terms of references. | 30 June 2013 |

| RECOMMENDED PERFORMANCE CATEGORY | Go |
|---|---|

## STEP 6: Programmatic achievements and financial performance

### Financial situation at cut-off date

**Disbursements**

| | |
|---|---|
| Signed Budget for current implementation period | $ 5,223,193 |
| less: disbursed to cut-off date | $ 3,749,189 |
| Undisbursed amount at cut-off date | $ 1,474,004 |

**Cash at cut-off date**

| | PR | SRs | Total |
|---|---|---|---|
| Disbursed to PR to cut-off date[3] | $ 3,749,189 | N/A | $ 3,749,189 |
| Less: Disbursed from PR to SRs | ($1,668,239) | $1,668,239 | 0 |
| Less: Expenditure incurred to cut-off date | ($452,007) | ($1,427,630) | ($1,879,637) |
| Add: Interest received/exchange loss | $41,083 | 0 | $41,083 |
| Add: Other income | ($298,881) | ($27,801) | ($326,682) |
| **Equals: Cash at cut-off date** | **$1,371,145** | **$212,808** | **$1,583,953** |

**Please explain the reasons for undisbursed funds and/or available cash (activities not performed, savings realized, etc.)**

Late site selection and sub-agreement arrangements, now resolved.

**Have all liabilities at cut-off date been taken into account in the post-cut-off date budget?** Yes

*If not, please ensure unaccounted liabilities are budgeted in the remaining current implementation period.*

## Programmatic achievements and financial performance

**Percentage of funds budgeted at PR level** 20%

**Percentage of funds budgeted at SR/SSR level** 80%

| Macro Category | Service Delivery Area | Total Adjusted Budget Amount to cut-off date (EFR) | Total Expenditure Amount to cut-off date (EFR) | Expenditure vs Budget at cut-off date | Programmatic Achievement |
|---|---|---|---|---|---|
| | CSS: Community based activities and services – delivery, use and quality | | | | **93%** |
| | CSS: Human resources: skills building for service delivery, advocacy and leadership | | | | **83%** |
| | CSS: Monitoring & evaluation, evidence building | | | | **50%** |
| Health System Strengthening (HSS) | HSS: Community Systems Strengthening | $3,827,842 | $1,879,637 | 49% | |
| **Grand Total** | | **$3,827,482** | **$1,879637** | **49%** | **84%** |

**Please provide a summary of the expenditures vs. budget analysis using EFR including for deviations between programmatic performance and expenditure rate, based on EFR.**

Expenditure at the cut-off date (31 March 12) amounted to US $1.9 million representing 49% of the budget to date. The under-spending of budget in all the cost categories primarily due to the following:

PR expenditures:

- Less monitoring visits were carried out as the SRs have started implementation from August 2011 and there was not much progress to be monitored;

[3] Funds in-transit should be shown as disbursements received.

- Certain trainings could not be conducted as per the work plan;
- Fees negotiated with the auditors are less than the budgeted cost; and
- Administrative costs are less than originally budgeted.

SR expenditures:

- The under spending under HR and Planning and administration primarily is due to the delay in selection of SRs;
- Delay in Development of the SOPs and completion of OR studies; and
- Certain trainings could be conducted in Quarter 6 (i.e. January 2012 - March 2012) as per the work plan. Targeted intervention staff was busy with the preparation of Annual Action Plan, Annual Evaluations and De-briefing which is a requirement from NACO/SACS.

The average performance of all indicators of 75%, whereas the cumulative utilization is 49%; thus, the average programmatic performance is higher than the cumulative utilization for the grant. This is primarily because most of the indicators where the grant has exceeded the targets are not directly tied to the budget.

## STEP 7: Financial Recommendation

### Resources available to finance program for next implementation period

| | Year X | Year Y | Year Z | Total |
|---|---|---|---|---|
| **TRP clarified amount allocated to PR** | $ 3,392,456 | $ 3,245,200 | $ 3,173,458 | $ 9,811,114 |
| Any Board mandated adjustments | $ (339,246) | $ (324,520) | $ (317,346) | $ (981,111) |
| Adjustment +/(-) for (borrowing) and/or staggered commitments not yet committed | - | - | - | - |
| **Adjusted TRP clarified amount** | $ 3,053,210 | $ 2,920,680 | $ 2,856,112 | $ 8,830,003 |
| CCM reallocations +/(-) (implementation arrangements) | - | - | - | - |
| **Adjusted reallocated amount** | **$ 3,053,210** | **$ 2,920,680** | **$ 2,856,112** | **$ 8,830,003** |
| + Undisbursed amount at cut-off date | | | | $ 1,474,004 |
| + Cash at cut-off date | | | | $1,583,953 |
| **=Total Resources available** (after cut-off date for the next Implementation Period) | | | | **$ 11,887,960** |

### Summary Budget Recommendation and Incremental Amount

| | Year W after cut-off date | Year X | Year Y | Year Z | Total |
|---|---|---|---|---|---|
| **Total Budget requested by the CCM** *(after cut-off date for the next Implementation Period)* | $1,395,353 | $2,694,743 | $3,149,966 | $3,315,308 | $ 10,555,370 |
| Adjustment to budget if counterpart financing requirement is not met | 0 | 0 | 0 | 0 | 0 |
| Adjustments to CCM Funding Request by Secretariat *(add as many lines as required)* | $ 411,990 | $(174,157) | $(174,555) | $(193,454) | $ (130,176) |
| **Total Budget Recommended by the Secretariat** | $1,807,343 | $2,520,586 | $2,975,411 | $3,121,854 | $ 10,425,194 |
| - Undisbursed amount at cut-off date | | | | | $ 1,474,004 |
| - Cash at cut-off date | | | | | $1,583,953 |

| | Year W after cut-off date | Year X | Year Y | Year Z | Total |
|---|---|---|---|---|---|
| **RECOMMENDED INCREMENTAL AMOUNT** | | | | | **$ 7,367,237** |
| % of adjusted TRP clarified amount | | | | | 83% |

## 4.3 PRINCIPAL RECIPIENT 3

| | |
|---|---|
| **Grant Number** | IDA-911-G24-H |
| **Principal Recipient** | Ministry of Labor and Employment |
| **Grant Start date** | 01/10/2010 |
| **Grant End date** | 30/09/2012 |

## STEP 1: Programmatic Achievements

### Overall Performance Rating to cut-off date: C

**PR : Ministry of Labor and Employment (MoLE)**

### Cumulative Indicator Rating at cut-off date:

### No rating

**How has the grant performed in the current implementation period?**

**NA**

This Round 9 Grant was signed on 17 February 2011 on behalf of the Ministry of Labor and Employment. NACO's opposition to the CCM's nomination of MoLE did not permit the grant to start; subsequently NACO proposed to implement the program and secured a CCM endorsement for this course of action. However, inconsistencies in the revised budget and workplan did not permit consensus on restarting the grant.

NACO proposed to reach informal workers working in selected sectors of manufacturing, mining, construction, textiles and some agriculture related sectors like tobacco and food processing. It reported the results achieved for the period of review for migrants (from the CMIS), which might include formal and informal workers, as well as non-migrant workers. Therefore, it appears that both formal and informal workers, as well as other beneficiaries are being counted.

Currently, sector-wise data, can be compiled at TI level but is not being captured in the CMIS. UNAIDS reports that of over 500,000 individuals tested for HIV under this TI, less than 200 positive individuals were detected, calling into question the possible impact of the requested investment.

The results reported by NACO for three indicators (i.e. Indicator number 1(a) – "Number of informal workers reached through outreach services", 1.3 – Number of informal workers with suspected TB symptoms who are referred to and access DOTS center and 1.4 – Number of HIV positive informal workers referred to and registered at the ART centers) are based on assumptions, or do not correspond to the definitions of the indicators as provided in approved Performance Framework.

| **Revised Indicator Rating** | **No rating** |
|---|---|

## STEP 2: Quality of Data and Services

| | |
|---|---|
| **Date of most recent OSDV:** | **N/A** |

## STEP 3: Grant Management and Compliance

NA

| | |
|---|---|
| **RECOMMENDED PERFORMANCE RATING** | **No rating** |

## STEP 4: Progress towards Impact /Outcome

| | |
|---|---|
| **IMPACT RATING** | **No rating** |

## STEP 5: Operational Risk Management

| Main Areas | Compliance Issue/Risk | Prevention or Mitigating measure type (Board Condition, Condition, MA, other) | Description of mitigating measure | Timeframe (prior to signature, at signature, first disbursement, second disbursement, disbursement linked to specific action or category, date, on-going) |
|---|---|---|---|---|
| Programmatic | Reallocation/consolidation | Board Condition | The CCM shall provide to the Global Fund, in form and substance satisfactory to the Global Fund, evidence of concurrence for the reallocation of the undisbursed Phase 1 amount under this grant for the expanded and accelerated implementation of program activities under grants IDA-910-G20-H and IDA-910-G21-H. The final reallocation amounts shall be subject to the grant renewals and grant negotiation process, including finalization of the grant documentation. | Prior to grant signing |

## Risk mitigating measures

**Please note what tool, if any, was used to support the assessment of operational risks and required actions**

NA

**If available, please include the Calibrated (QUART) or Un-calibrated (ORAP Template) Operational Risk Heat Map.**

N/A

**If the grant was reviewed by the Operational Risk Committee, please include a summary of the recommendations here.**

N/A

# STEP 6: Programmatic achievements and financial performance

## Financial situation at cut-off date

***Please insert the tables from Excel file, Financial Template-PR.***

**Disbursements No disbursements have been made under this grant**

| | |
|---|---|
| Signed Budget for current implementation period | US $7,417,421 |
| less: disbursed to cut-off date | 0 |
| Undisbursed amount at cut-off date | US $7,417,421 |

**Cash at cut-off date**

| | PR | SRs | Total |
|---|---|---|---|
| Disbursed to PR to cut-off date[4] | x | N/A | x |
| Less: Disbursed from PR to SRs | x | x | x |
| Less: Expenditure incurred to cut-off date | x | x | x |
| Add: Interest received/exchange loss | x | x | x |
| Add: Other income please specify | x | x | x |
| **Equals: Cash at cut-off date** | | | |

**Please explain the reasons for undisbursed funds and/or available cash (activities not performed, savings realized, etc.)**

N/A – The program was not implemented and no disbursement was made to the PR for this grant.

**Have all liabilities at cut-off date been taken into account in the post-cut-off date budget?** N/A

*If not, please ensure unaccounted liabilities are budgeted in the remaining current implementation period.*

## Programmatic achievements and financial performance

**Percentage of funds budgeted at PR level** N/A

**Percentage of funds budgeted at SR/SSR level** N/A

| Macro Category | Service Delivery Area | Total Adjusted Budget Amount to cut-off date (EFR) | Total Expenditure Amount to cut-off date (EFR) | Expenditure vs Budget at cut-off date | Programmatic Achievement |
|---|---|---|---|---|---|

[4] Funds in-transit should be shown as disbursements received.

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | N/A |
| | | | | | N/A |
| | | | | | N/A |
| | | | | | N/A |
| | | | | | N/A |
| | | | | | N/A |
| | | | | | N/A |
| | | | | | N/A |
| | | | | | N/A |
| | | | | | N/A |
| **Grand Total** | | | | | N/A |

**Please provide a summary of the expenditures vs. budget analysis using EFR including for deviations between programmatic performance and expenditure rate, based on EFR.**

N/A – The program was not implemented and no disbursement was made to the PR for this grant.

## STEP 7: Financial Recommendation

### Resources available to finance program for next implementation period

| | Year 1 | Year 2 | Year 3 | Total |
|---|---|---|---|---|
| **TRP clarified amount allocated to PR** | $ 9,379,142 | $ 8,972,024 | $ 8,773,678 | $ 27,124,844 |
| Any Board mandated adjustments | $ (937,914) | $ (897,202) | $ (877,368) | $ (2,712,484) |
| Adjustment +/(-) for (borrowing) and/or staggered commitments not yet committed | | | | |
| **Adjusted TRP clarified amount** | $ 8,441,228 | $ 8,074,822 | $ 7,896,310 | $ 24,412,360 |
| CCM reallocations +/(-) (implementation arrangements) | | | | |
| **Adjusted reallocated amount** | $ 8,441,228 | $ 8,074,822 | $ 7,896,310 | $ 24,412,360 |
| + Undisbursed amount at cut-off date | | | | $ 7,417,421 |
| + Cash at cut-off date | | | | 0 |
| **=Total Resources available** (after cut-off date for the next Implementation Period) | | | | $ 31,829,781 |

### Summary Budget Recommendation and Incremental Amount

| | Year W after cut-off date | Year X | Year Y | Year Z | Total |
|---|---|---|---|---|---|
| **Total Budget requested by the CCM** *(after cut-off date for the next Implementation Period)* | $3,262,967 | $9,799,518 | $9,588,053 | $5,925,692 | $ 28,576,230 |
| Adjustment to budget if counterpart financing requirement is not met | 0 | 0 | 0 | 0 | 0 |
| Adjustments to CCM Funding Request by Secretariat *(add as many lines as required)* | (3,262,967) | (9,799,518) | (9,588,053) | (5,925,692) | (28,576,230) |
| **Total Budget Recommended by the Secretariat** | $ 7,417,421 | | | | $ 7,417,421 |

| | Year W after cut-off date | Year X | Year Y | Year Z | Total |
|---|---|---|---|---|---|
| - Undisbursed amount at cut-off date | | | | | $ 7,417,421 |
| - Cash at cut-off date | | | | | 0 |
| **RECOMMENDED INCREMENTAL AMOUNT** | | | | | **$0** |
| % of adjusted TRP clarified amount | | | | | 0 |