RENEWAL SCORECARD

India

Malaria

1. SCORECARD SUMMARY

GENERAL PROGRAM INFORMATION

Applicant	India CCM
Country and Income Level	India/LLMI
Component	Malaria
Renewal cut-off date	31 March 2012
Renewal Review date	28 September 2012
Implementation Period start date	01/10/2012
Implementation Period end date	30/09/2015

RENEWAL RECOMMENDATION SUMMARY

Please insert a table from Excel file, Financial Template-Program.

Grant number	PR name	Performance Rating	Recommendation Category	Recommended Incremental Amount	% of Adjusted TRP clarified amount	% saving	Within Investment Range?
IDA-911-G23-M	NVBDCP	B2	Go	$40,096,660	76%	24%	No, above
IDA-910-G22-M	Caritas India	C	Go	$6,827,588	94.5%	5.5%	No, above
Total Recommended Incremental Amount (all PRs)				**$46,924,248**			
Total Adjusted TRP clarified Amount (all PRs)				**$59,854,071**	**78%**	**22%**	**No**

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.

The epidemiology of malaria in India is complex because of geographic and ecological diversity, multi-ethnicity and wide distribution of nine anopheline mosquito vectors transmitting three plasmodial species: Plasmodium Falciparum (Pf), P. vivax, and P. malariae. During the country's eradication campaign in the late 1950s and early 1960s, malaria cases declined to 100,000 in 1964. However, malaria reemerged as a major public health threat, with incidence reaching 6.4 million new cases in 1976. Since then, malaria incidence has declined steadily. There were 1.53 million malaria cases in 2008 and 1.28 million in 2011. Similarly, Pf cases declined from 0.75 million to 0.64 million during the same period. This indicates declining overall endemicity of malaria in the country. Confirmed deaths due to malaria also declined from 935 in 2008 to 463 in 2011. The Annual Parasite Incidence (API) dropped from 1.36 per thousand in 2008 to 1.1 per thousand in 2011. While the Annual Blood Examination Rate has remained at approximately 9% during 2008-2011, the Slide Positivity Rate (SPR) fell from 1.57 to 1.23 during the same time period. Overall, 52% of malaria cases are due to *P. falciparum*.

Though approximately 82% of the country's population lives in malaria transmission risk areas, 80% of malaria occurs among 20% of the people classified as "high risk." These high risk populations are found in Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, seven northeastern states and Sikkim. In these states, some 200 districts contribute most to the burden of the disease. In its 2011 World Malaria Report, WHO categorized India as a country where malaria cases have fallen less than 25% compared to the previous year.

The Global Fund-supported "Intensified Malaria Control Project-II" (IMCP-II) was initiated in 2010 in the 7 northeastern highly malaria endemic states: Arunachal Pradesh, Assam, Meghalaya, Mizoram, Nagaland, Manipur and Tripura. Together, they have a population of some 45 million people in 86 districts. In 2011 there were 110,707 malaria cases in the 7 northeastern states covered by IMCP-II and 126 reported malaria deaths.

LESSONS LEARNED THROUGH IMCP-I:

IMCP-II is a refinement of a first five-year IMCP (2005-2010) that was funded through a Round 4 grant. IMCP-II focuses on providing health care for hard-to-reach people in remote areas though vector control, provision of rapid diagnostic kits and prompt treatment of malaria cases. The project features special interventions for people living below the poverty line, including provision of long lasting insecticide treated nets (LLINs) to people without fixed domiciles (e.g., slash and burn "Jhum" cultivators), as well as engagement of private community level service providers to reach remote communities that the public health care system does not cover. Two principal recipients manage the project: the National Vector Borne Disease Control Program (NVBDCP) of the Ministry of Health and Family Welfare (MoHFW); and Caritas India, which leads a civil society consortium that complements NVBDCP's efforts at the community level.

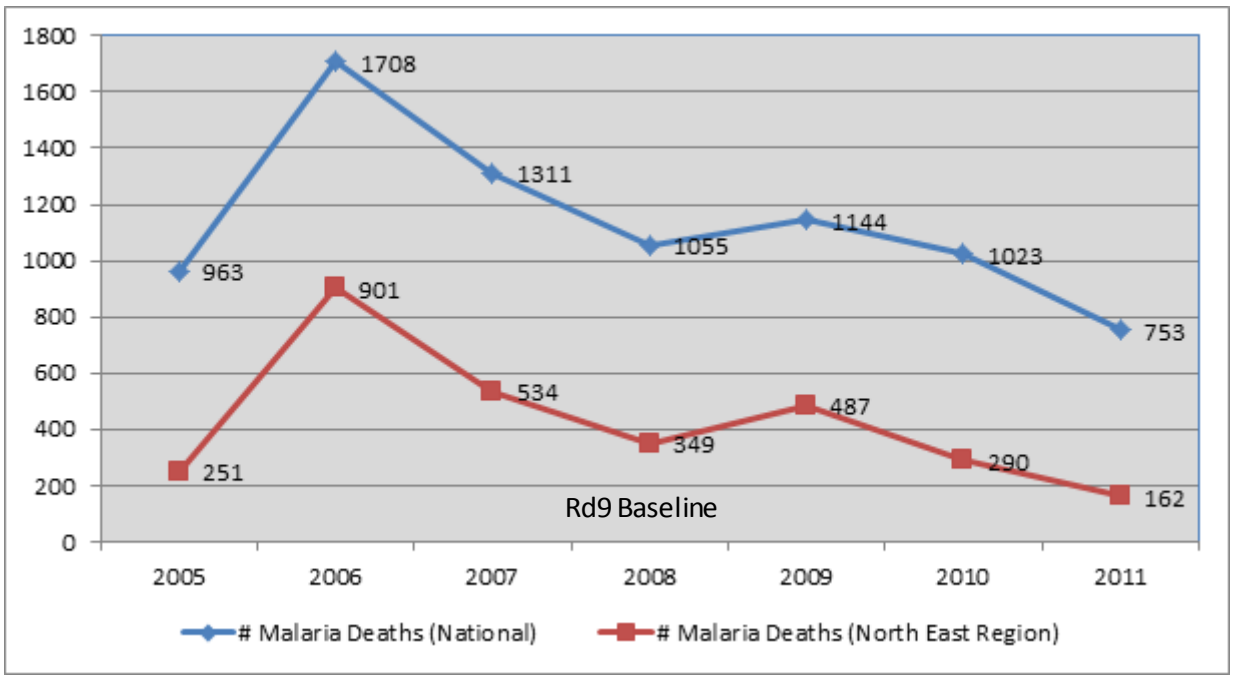
Through IMCP-I, the Global Fund Round 4 grant drove policy changes in malaria control. ITNs were substituted by LLINs, ACTs were introduced in place of chloroquine and rapid diagnostic testing was adopted, largely in response to international best practice examples initiated by NVBDCP. With the start of IMCP-II under Round 9, a civil society consortium led by Caritas India undertook essential efforts to complement the NVBDCP program at the community level in hard to reach areas in the 7 malaria endemic northeastern states.

The goal of IMCP is to reduce malaria related morbidity and mortality in project areas by at least 30% by 2015 as compared to 2008. The request for renewal aims at sustaining project gains by addressing the needs and gaps in those areas of the country where the intensity of transmission is the highest and the health care delivery system constraints are severe.

Since the start of IMCP-I in 2005, the project has pursued 5 objectives:

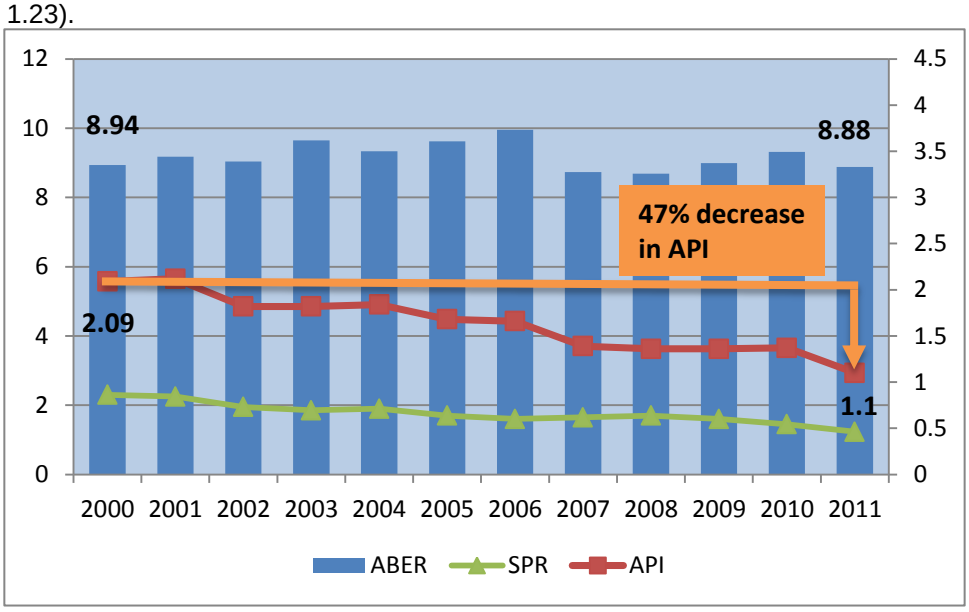
1) Universal coverage by 2015 by effective preventive intervention (LLIN) for population living in high risk project areas (up from 42% in 2009-10);
2) 80% coverage by parasitological diagnosis; and treatment of malaria in project areas by 2015;
3) 80% coverage of villages in project areas by appropriate BCC activities by 2015;
4) Strengthened program planning and management, monitoring and evaluation, and coordination and partnership development to improve service delivery in project areas; and
5) Strengthened health systems through training, capacity building to improve service delivery in project areas.

Malaria deaths are decreasing in the northeastern states, as they are at the national level.



The graph below also shows that while the relatively high annual blood examination rate (ABER) has not

been changing significantly, slide positivity rate (SPR), as well as annual parasite incidence (API), have been steadily decreasing. API has decreased by 47% between 2000 and 2011 (from 2.09 to 1.1). Available data from the northeastern region shows that API has also decreased by 47% between 2002 and 2011 (from 2.34 to 1.23).



While malaria morbidity and mortality have fallen by over 30% since 2008, this achievement is fragile, as was demonstrated in the mid-1960s. Further reductions towards pre-elimination and later elimination require sustained and more intensive efforts and resources.

The CCM is not proposing any change in program objectives. Rather, it seeks to focus existing successful interventions in the areas and on the groups most vulnerable to the disease. One major factor has determined this approach. The northeastern Round 9 project areas abut a large porous international border with Myanmar, which experiences frequent population migrations. Notably, the first case of chloroquine resistance to *P. falciparum* in the country occurred in Assam in 1973. Current artemisinin combination treatment (ACT) is at risk as well, especially in view of its relatively indiscriminate monotherapeutic use by private practitioners. ACT resistance began to appear in western Cambodia and Myanmar in 2003-04. Transmission of ACT-resistant malaria in the northeastern states and its eventual spread to other parts of the country pose a real threat. Vector behavior and density, insecticide resistance, shifting cultivation agriculture, climate, forestation, geographic accessibility, and uneven health seeking behavior of many ethnic groups can also exert a negative influence on the disease burden. Further, it should be noted that current surveillance data is largely from public sector. Hence, the real scenario may be more serious than the data suggest. Global Fund support of IMCP-II is intended to address the threat of (re-) emergence of malaria, particularly any ACT resistant strain in the most remote, underdeveloped part of India, thereby preventing a major resurgence of the disease not only in India, but throughout the region.

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
Vector control (API)	4.39	3.4	3.2	3
Treatment (mortality)	349	277	252	225

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.

Funding Source	Next Implementation Period (USD Million)					
	FY 2013		FY 2014		FY 2015	
	Amount	%	Amount	%	Amount	%
Overall Needs Costing	**$256.9**	**100%**	**$266.52**	**100%**	**$302.33**	**100%**
World Bank Loan	43.63					
Government Resources	83.16		121.5		150	
Total Domestic Resources	**$126.79**	**49%**	**$121.5**	**46%**	**$150**	**50%**
Global Fund (excluding current request)						
Other Donors						
Total External Resources	**0**		**0**		**0**	
Total Resources Available	**126.79**	**49%**	**121.5**	**46%**	**150**	**50%**
Unmet Need Gap	**$130.1**	**51%**	**$145.0**	**54%**	**$152.3**	**50%**
CCM Funding Request	**$30.37**	**23%**	**$19.96**	**14%**	**$20.97**	**14%**

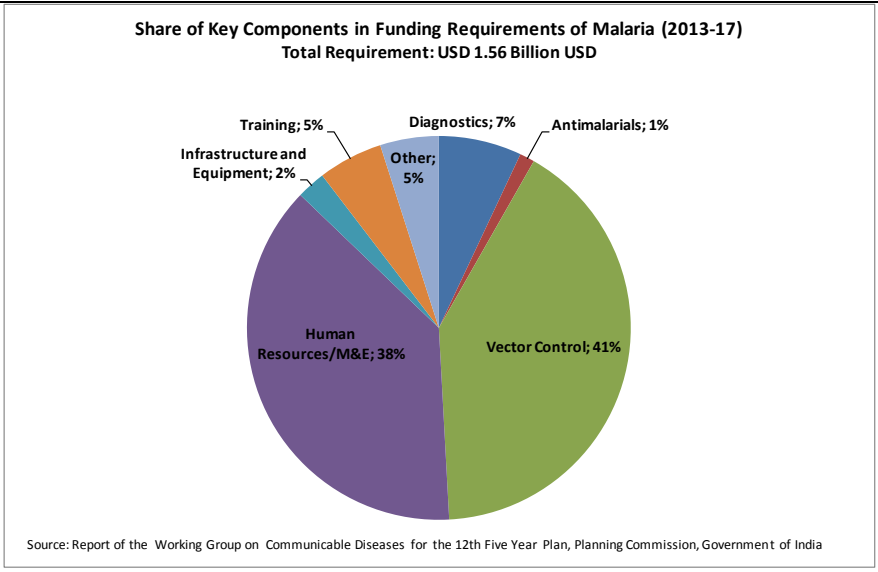
Comments:

The national malaria program is a centrally sponsored scheme implemented by state governments with 50% central government assistance (except the north-eastern states which receive 100% central assistance). Funding for the program is made available through 'Plan' and 'Non-Plan' allocations of the central, as well as state, governments. 'Plan' allocations are development expenditures approved by the Planning Commission under the national 'Five Year Plans' and are financed by government revenues, loans and external aid. The Malaria National Strategic Plan for the 11th five-year plan period (2007-12) incorporated a detailed costing of requirements. The plan also included estimates of funding required for 2012 to 2017 to meet the MDG malaria goals. The estimates for vector control, human resources and M&E were upwardly revised to meet the ambitious target of moving towards pre-elimination stage of malaria in the 12th plan period (2012-17). The funding requirements indicated in the table are derived from the costing of malaria program by the Planning Commission's 'Working Group on Communicable Diseases' constituted for formulating the '12th Five Year Plan'. Approximately 41% of the funding requirement of around US $1.5 billion for the next five years is for vector control. Human resources, including M&E, account for about 38% of the funding need. Non-Plan allocations typically support recurrent expenditure such as salaries of regular government staff, administration and maintenance of assets. These are significant, especially at the state level, but are not included in the funding requirement estimates.

Counterpart Financing Compliance

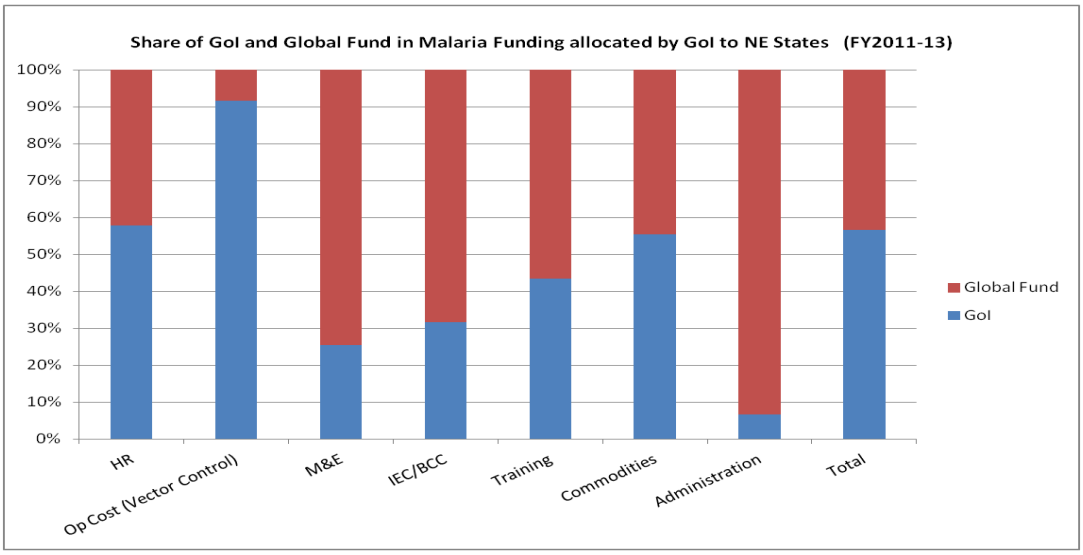
Does the country currently comply with the counterpart financing requirements based on the income classification for the country[1]	Yes

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



Currently, the government, through its revenues and a World Bank loan, finances over 85% of the malaria program. Central government assistance to the state includes commodity grants as well as cash grants that support wages for contractual staff, operational costs for vector control, IEC/BCC, M&E and training activities. State governments contribute to salary of regular staff, spray wages, decentralized drugs and other incidental expenses. One component of the World Bank project (2009-13) supports scaling up of the malaria program in about 100 districts of five high burden states (US $119.5 million). Another component supports strategy development, capacity building and monitoring and evaluation of the national program (US $52.1 million). In addition to the project components, approximately US $36.5 million has been included in the project as unallocated funds. These resources will be available to support more rapid scale-up of project interventions such as LLINs. The Global Fund is the only other source of funding for the malaria program and supports scaling up of the program in seven high-burden northeastern states. In these states, the Global Fund provides close to half of the malaria program funding and supports a significant share of human resources, commodities, M&E, training, program management and BCC costs.

While not making a funding contribution to the national malaria control budget, DFID is supporting India's program by providing technical assistance in Orissa and Madhya Pradesh. The Orissa malaria control program, formerly supported by the Global Fund during Round 4, is a successful programmatic model that benefits from complementary support from the national and state governments, as well as the World Bank.



Source: Approved allocations as per NRHM ROP and NVBDCP

The 12th five-year plan is awaiting approval therefore actual government commitments in the next implementation period are not available. Government contribution is expected to increase significantly in the Phase 2 period to support the scale up envisaged under the 12th five-year plan. While substantial, state

government contribution to the malaria program is not included in the table as these costs have not been captured in the funding requirements. Based on current projections, there is a gap of around 50% of the funding need. About 20% of the gap is sought to be addressed through the current request to the Global Fund.

(1) Availability of reliable data to assess compliance

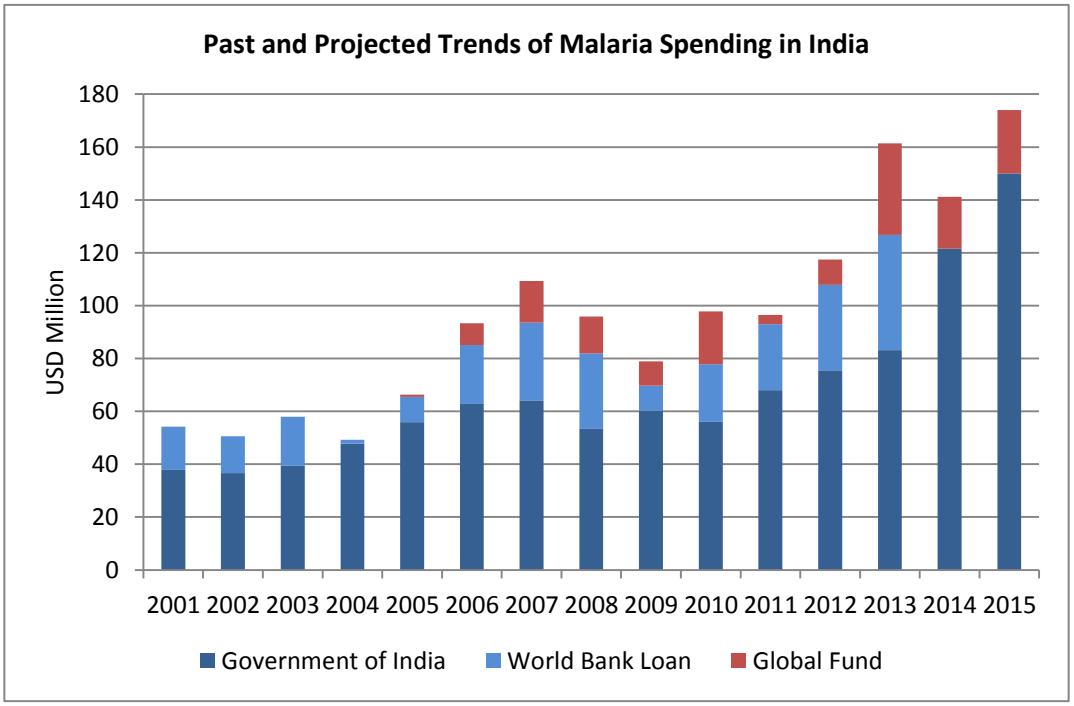
The malaria program has earmarked budget line items at both central and state government levels. Data on allocations to the malaria program and their expenditure by source of funding is available from the detailed demand for grants of central and state budgets and financial accounts of the government. Recent data is available online for Ministry of Health and many state governments. The country also routinely reports malaria spending data as part of annual reporting to WHO. However, what is routinely reported to WHO and Global Fund as well as in annual administrative reporting includes only the central government contribution to the national program. Currently there is no mechanism for consolidating malaria specific expenditures across different states. As a result, actual government spending on malaria is significantly underreported. This limitation notwithstanding, available data is sufficient to assess compliance with counterpart financing requirements.

(2) Minimum threshold government contribution to disease program

Based on actual spending for FY2010 and FY2011 and the budget estimate for FY 2012 of government spending through the Ministry of Health, the counterpart-financing share is over 75%. This meets the minimum threshold requirement of 20% for Lower LMI countries. If state government spending on malaria is included, the counterpart financing share will be even higher.

(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 the next implementation period, this trend is likely to accelerate given the ambitious targets proposed for the 12th five-year plan. The Planning Commission's 'Working Group on Communicable Diseases' has recommended a three-fold increase in allocations for the NVBDCP in the 12th five-year plan period (2012-17), compared to the previous one.

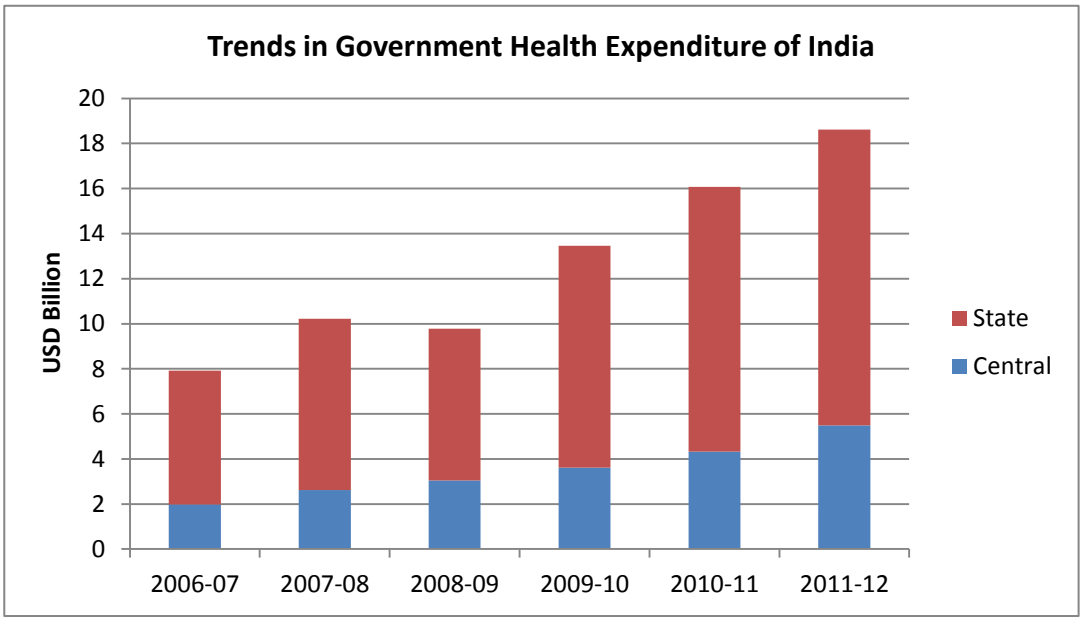


Source: 2001-2009 World Malaria Report, CCM Phase-2 Report, Global Fund EFR

(4) Stable or increasing government contribution to health sector

Between FY2006 and FY2011, 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 the 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 a 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 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 five-year plan period (2012-17).



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.

While the World Bank, DFID, USAID and other donors have offered critical support to the national malaria control program at key points since independence, partners other than the World Bank have withdrawn their funding over the past decade. The World Bank loan supporting NVBDCP has encountered challenges with procurement and tendering, which are reflected in underutilization of funds and implementation delays. Its program is set to conclude at the end of 2013.

2.2 CURRENT IMPLEMENTATION PERIOD PERFORMANCE

Progress Towards Impact / Outcome

Proposal Goal : To reduce malaria related mortality and morbidity in project areas by at least 30% by 2015 as compared to 2008

			Year 1 (for 2011)		Year 2 (for 2012)	
Impact and Outcome Indicator	Baseline Year	Baseline Value	Target	Result	Target	Result
Annual Parasitic Incidence (API)	2008	4.39	4.0	2.49	3.7	-
No of deaths due to malaria (confirmed malaria diagnosis)	2008	348	312	162	297	-
Percentage of households in high risk areas (API >2) with at least two LLINs	2008	42%	-	66% (in 2010)	77%	-
Percentage of household residents who slept under LLIN the previous night	2008	57.6%	-	82.4% (in 2010)	50	-

The reporting due date for outcome indicators is 15 November 2013, however, the above intermediary figures have been generated from the external evaluation done under the previous project in 2010.

Comments:

In 2010, India ranked 5th (out of 106 malaria-endemic countries) in terms of national number of malaria deaths (accounting for 3.6% of global malaria deaths) and 53rd in terms of deaths per 100 person-years. By the end of 2011, India had received 1.3% (US $59 million) of the Global Fund's portfolio-aggregate malaria disbursements and ranked 25th and 80th among 84 Global Fund-supported countries in terms of malaria disbursement received in absolute and per capita amounts, respectively.

Malaria control efforts in India have shown solid progress towards impact at national level, as well as in northeastern states, where Global Fund support accounts for more than half of the malaria control program's costs. Annual Parasitic Incidence (API) has reduced by 47% (from 2.09 to 1.1) between 2000 and 2011 at the national level. Available data from the northeast also indicate that API has decreased significantly (by 46% from 4.59 to 2.49) between 2002 and 2011. The number of deaths due to malaria, another key impact indicator, has also decreased over time Compared to the Round 9 baseline in 2008, the number of deaths decreased by 29% (from 1055 to 753) in 2011. Disaggregated data from the north-eastern states show an even greater reduction of 53% (from 348 to 162) in 2011 compared to the baseline.

While the reporting due date for outcome and coverage indicators is the end of 2013, intermediary figures generated from the external evaluation under IMCP-I in 2010 indicate that the percentage of households in high risk areas (API >2) with at least two LLINs has increased from 42% to 77% between 2008 and 2010.

The 2011 WHO Global Malaria Report indicates that the data completeness score for India is modest at 58%, which is low among countries in the WHO South East Asia region. Following the observation and recommendations made during the last OSDV (conducted in 2012), NVBDCP is strengthening its Management Information Systems (MIS).While India has progressed significantly in terms of malaria mortality and morbidity, additional control and treatment efforts are needed for the country to reach its MDG target.

Indoor residual spraying (IRS) has historically been the focus for vector control, covering about 67 million people at risk in 2009. The Global Fund support led the government to introduce long lasting insecticide-treated nets (LLIN) to supplement regular insecticide treated nets (ITN) in 16 high endemic states, with 2.2 million, 2.6 million and 6.6 million LLINs distributed in 2009, 2010 and 2011 respectively. As a result of these interventions, annual parasite incidence (API), as well as malaria incidence and, mortality have decreased markedly over the past decade.

India's National Institute of Malaria Research (NIMR) conducted three case studies of district primary health care responses to the disease in order to measure the effectiveness of the Global Fund-supported program. A draft report released in August 2012 reveals the following impact since the start of IMCP-I in 2005:

- Program and intervention changes decreased both morbidity and mortality in the context of stable surveillance
- In Tablung PHC, Mizoram
    - Malaria cases decreased by 18% in 2007-2011 compared to 2005-2006
    - Malaria deaths decreased by 46% in 2007-2011 compared to 2005-2006
- In Sonapur PHC, Assam
    - Malaria cases decreased by 59% in 2007-2011 compared to 2005-2006
    - Malaria cases decreased by 71% in 2007-2011 compared to 2005-2006 accounting for increased treatment seeking behavior by patients
- In Kuarmunda PHC, Odisha (Orissa)
    - Malaria cases decreased by 66% in 2007-2011 compared to 2005-2006 with a small increase (69%) in the estimate due to changes in treatment seeking behavior

However, urbanization, drought, migration of workers, and lax control efforts all contribute to ongoing malaria endemicity in India.

PROGRAM IMPACT RATING	Demonstrated Impact

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)
MoH	1	$22,185,943	$22,185,943	$0	$6,079,865
NGO	1	$4,384,786	$4,384,786	$3,260,689	$1,953,636
Grand Total	**2**	**$26,570,729**	**$26,570,729**	$3,260,689	**$8,033,501**

Disbursed vs Adjusted Budget at cut-off date	**12%**
Expenditure vs Adjusted Budget at cut-off date	**30%**
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
	ITNs	10,371,389	3,044,474	29%	**77%**
	Diagnosis	2,627,295	366	0%	**25%**
	Treatment	1,536,406	0	0%	**42%**
	BCC	2,039,101	555,283	27%	**120%**
	HSS Workforce	8,628,987	3,373,079	39%	**51%**
	HSS Information System	1,219,791	1,110,993	91%	**120%**
	Service delivery	140,260	0	0%	
	Supportive environment: Coordination and partnership development (national, community, public-private)	7,500	0	0%	
Total (USD)		**26,570,729**	**8,084,195**	**31%**	

Average Performance on Top 10	**49% (B2)**
Average Performance All Indicators	**72% (B1)**

OVERALL PROGRAM RATING	B2

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

The two grants in this “dual track” program support the country’s second “Intensified Malaria Control Program” (IMCP-II) that is being implemented in 7 malaria endemic states (Arunachal Pradesh, Assam,

Meghalaya, Mizoram, Nagaland, Manipur, Tripura), covering a population of 45 million people in 86 districts in the northeastern region of the country. The program is managed by the National Vector Borne Disease Control Program (NVBDCP) of the Ministry of Health and Family Welfare (MoHFW) and Caritas India, a Catholic relief charity that leads a civil society and private sector consortium. Caritas complements NVBDCP's efforts at the community level in hard to reach areas. Both grants build on the experience of the first IMCP from 2005 to 2010 under Round 4 and are aligned with the Country Strategic Plan for Malaria Control (2007-2012).

The respective roles of each organization are as follows:

NVBDCP: IMCP-II stewardship; detection, diagnosis, treatment and follow-up; pharmaceutical and health product procurement and supply chain management; and integration of malaria control into the national rural primary health care system ("National Rural Health Mission").

Caritas: Service provider training for government, civil and private sectors, focusing on Accredited Social Heath Activists (ASHAs) and community health volunteers (CHVs); health promotion among vulnerable groups; logistics and supply chain management; staff support for the NVBDCP PMU; and monitoring and evaluation.

When looking at the program as a whole, both successes and areas in need of improvement stand out:

What has worked: Vector control with increased LLIN use; Shift to ACTs; Focus on remote, vulnerable populations; Differentiation of procurement priorities between Global Fund and World Bank; Agreement to provide NVBDCP staff support through Caritas.

What hasn't worked: Converting geographic risk and prevalence data into health product forecasts and distribution schemes; Quality Assurance Policy compliance for ACTs; WHO laboratory accreditation for the National Institute for Malaria Research (NIMR); Audit compliance; Staff support arrangements through WHO. We note that delays in the selection of villages for program coverage led to late community health worker selection and training, which in turn limited service provision during Phase 1. Under-spending for both grants is linked to initial programmatic delays and the quality assurance policy compliance issues involving both ACTs and RDTs.

For NVBDCP (PR1), a qualified audit finding by the Controller and Auditor General (CAG) of India hindered disbursements by the Global Fund Secretariat. The CAG was not offered much of the supporting documentation for grant related expenditures procurement that the Global Fund saw in the context of its PU/DR reviews, leading to the qualified findings. The PR has agreed to submit the supporting documentation to the CAG in order to reconciling these findings with the verified expenditure reports to the Global Fund.

Expenditure for the program at month 18 (31-Mar-12) amounted to US $8.1 million, representing 31% of the budget to date. The under-spending was mostly due to HR vacancies at the PR and SR level, delays in the procurement of health products and postponement of training activities until recruitment of staff is complete.

The variance of US $18.5 million between the budget and the actual expenditures was due to under spending across all SDAs, with most significant deviations noted in the area of HR and procurement of health products.

The discrepancy between programmatic achievement (72% average performance on all indicators) and spending (31%) at the cut-off date can be explained by the availability of government funding for health products and pharmaceuticals as well as BCC interventions, which have ensured achievement of programmatic targets with lower budgeted costs for the grant.

For Caritas, under-spending was primarily due to NVBDCP-dependent delays in site selection, health product distribution and associated training. Grant activities began in earnest started in P3/P4. P5 and P6 witnessed a measurable acceleration of activities, reflected in a jump of indicator target results to an average level of 30.2%, up from a 3.3% average at of the end of P4. A corresponding improvement in fund absorption over the last semester, reflected in a 94% burn rate, compares favorably with the 4.3% burn rate from the previous reporting period.

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.

The focus of the program is on people living in the northeast part of the country, where the intensity of malaria transmission is the highest and the health care delivery system constraints are the most severe. Continued efforts and investments are much needed to sustain the gains and save lives in endemic northeastern states and to address the specific local needs. The bottlenecks experienced during the implementation of the first phase of the Round 9 program, particularly in view of the possible rise of artemisinin resistance, are due to the relatively indiscriminate use of monotherapy by private providers.

The scale up of evidence-based high impact interventions, including rapid diagnostic testing, LLIN provision, IRS and treatment with ACTs are part of the continued proposal. The Global Fund is being asked to support RDT and LLIN procurement, associated health promotion and training activities aimed at addressing local barriers preventing access to malaria services.

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 malaria control interventions are delivered at the household level and therefore cover the total target populations at risk.

Please describe the activities proposed for the next implementation period.

The grant's objectives remain unchanged from Phase 1, namely to achieve the following goals:

- Near universal coverage of populations living in high risk project areas by effective preventive interventions (LLIN distribution) from a baseline of 42% in 2009-10;
- At least 80% coverage by parasitological diagnosis and prompt, effective treatment of malaria through public and private health care delivery systems in project areas by 2015 (by means of RDT and ACT); and
- At least 80% coverage of villages in project areas by appropriate BCC activities (both mass media and community outreach) by 2015 to improve knowledge, awareness and responsive behavior with regard to effective preventive and curative malaria control interventions.

And to strengthen:

- Program planning and management, monitoring and evaluation, and coordination of partnership development to improve service delivery in project areas; and
- Health systems through training and capacity building to improve service delivery in project areas.

Grant-supported (or related) activities focus on:

i. Rapid Diagnostic Testing (RDT);
ii. Long Lasting Insecticide Net (LLIN) distribution;
iii. Artesunate Combination Therapy (ACT) (currently not supported by the Global Fund due to lack of WHO prequalified combinations used, therefore, NVBDCP procures artemisinin combinations under its World Bank-supported program;
iv. Human resource development at the state, district and sub-district levels, through corresponding PMUs and malaria technical supervisors (MTS); and
v. Strengthening sentinel surveillance, microscopy services and M&E.

The Global Fund addresses funding gaps in the state budget, and provides support for critical civil society support among hard to reach populations in the most malaria endemic regions of India. It also drives critical

changes in public health policy, including: improvements in program planning including drug forecasting and site selection; use of quality ACTs; scale up of RDT and LLIN distribution; engagement of civil society organizations; and leveraging World Bank resources.

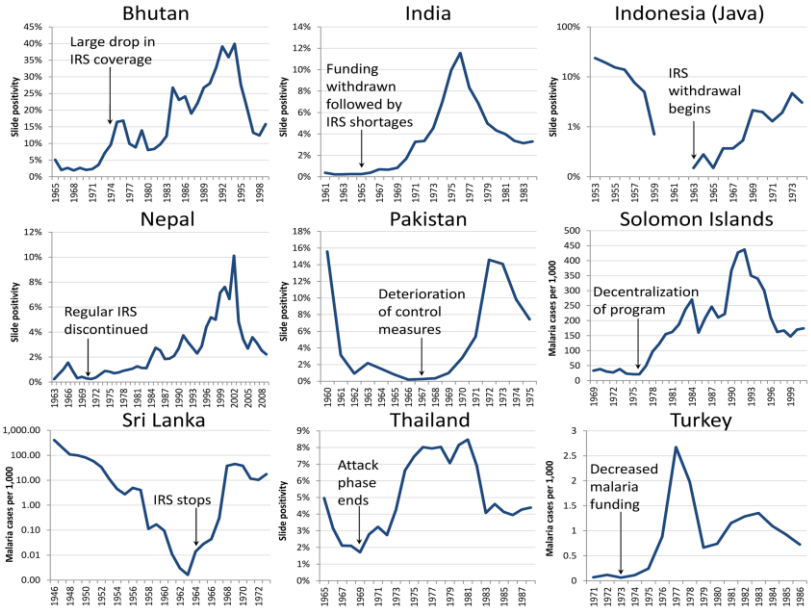
From an impact perspective, an incremental commitment of US $46 million over three years will accomplish the following:

1. It will enable India to differentially measure risk and scale up corresponding interventions in its most at risk regions to enable the country to move towards pre-elimination of malaria by 2017, replicating a success not seen since the early 1960s;

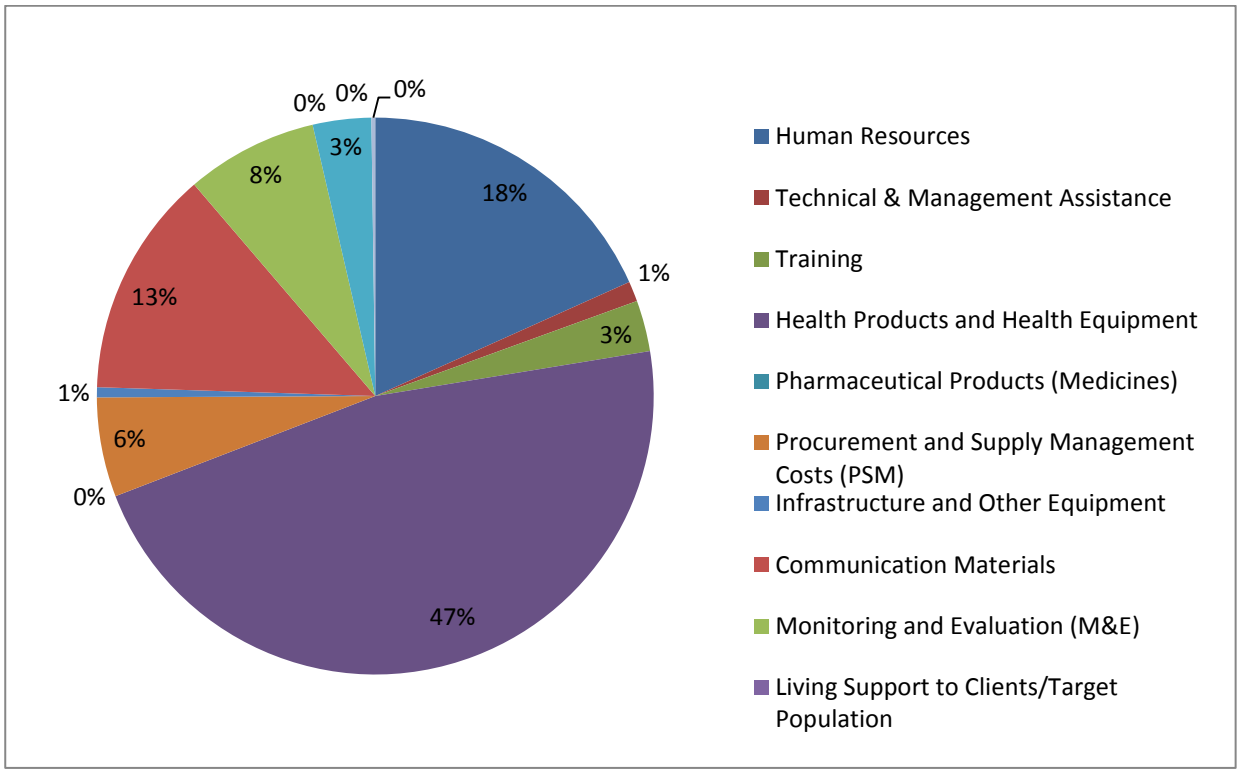
2. By covering not only settlements, but temporary workers living in the fields and forests of the northeast, it will enable the PRs to drive malaria transmission down along its actual pathways, not just in distinct localities; and

3. It will enable engagement of private sector providers in malaria control where public health services are minimal, thereby addressing one of the largest gaps in the current disease strategy.

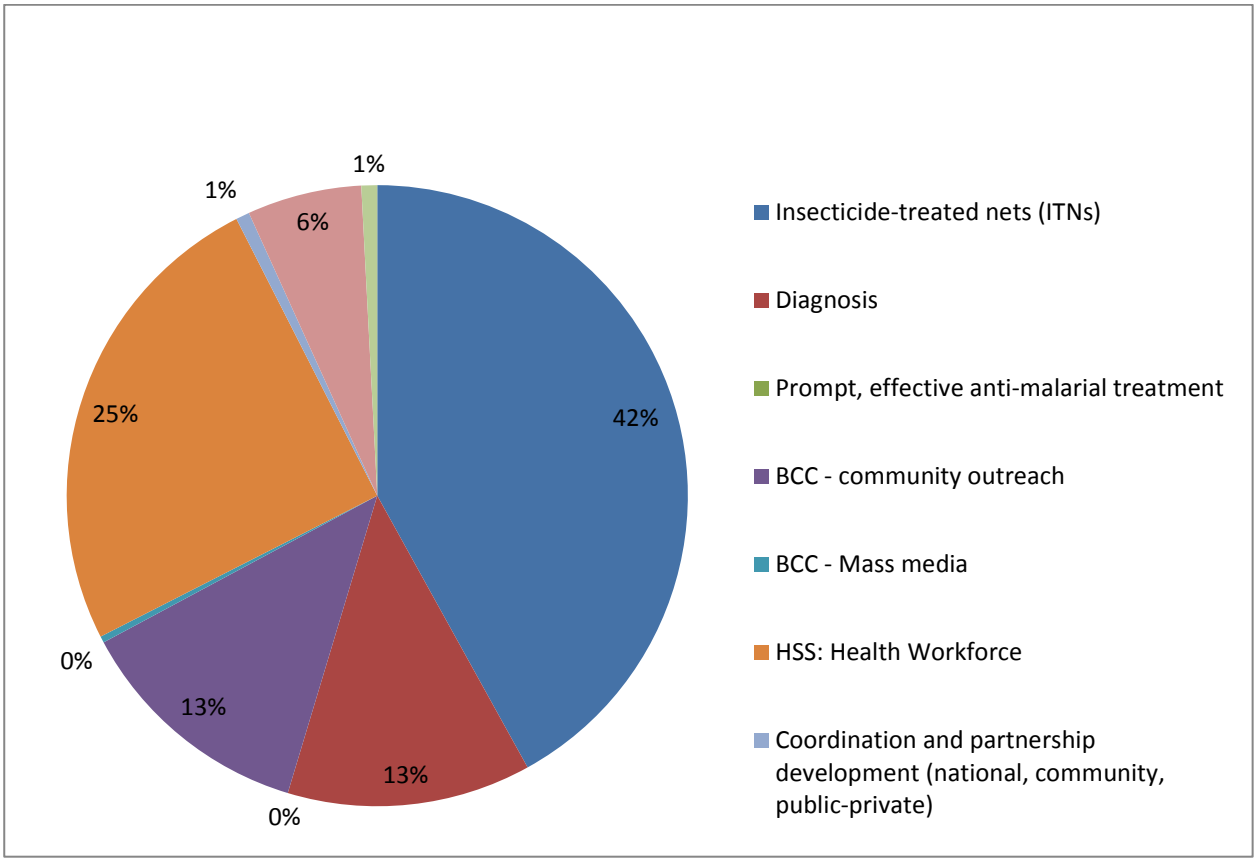
With continued Global Fund support, NVBDCP should be able to drive malaria incidence below 1 million, and malaria deaths further down from their current levels. Moreover, it may be able to prevent artemisinin resistance from appearing in the northeastern states. In continuing support for India's malaria control program, the Global Fund can help prevent malaria resurgence similar to one that occurred in the late 1960s and early 1970s. Simply put, IMCP-II continues to be a good insurance policy for an area of the world that has, and will likely continue, to experience malaria outbreaks when funding shortages arise, as shown in the slide below:



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

No material reprogramming is planned for Phase 2; however, NVBCDP proposes to provide LLINs to temporary workers (slash and burn "Jhum" cultivators) in the northeast through their employers. This will complement household distribution of LLINs and ensure higher coverage of vulnerable workers temporarily residing in the mountainous regions.

Additionally, both PRs plan on accelerating implementation in order to meet (and for LLIN coverage, exceed) their original grant targets. This includes training private sector service providers in the northeast in malaria prevention, diagnosis and treatment, which will address one of the major gaps in population coverage in the 7 states under the Integrated Malaria Control Program.

IMCP-II employs evidence-based interventions that are intended to move the country to pre-elimination. Over the course of Phase 1, the Global Fund worked with the PRs, World Bank and WHO to ensure adequate health product coverage for the program. This was in line with India treatment guidelines, World Bank procurement guidelines, WHO recommendations and Global Fund quality assurance policies for pharmaceutical and diagnostic products. This is reflected in NVBDCP's revised PSM plan.

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

No material changes are proposed. After comprehensive discussions with both Round 9 malaria PRs, WHO, World Bank and other partners, on 10 May 2012, the Global Fund approved a PSM plan for NVBDCP, which specifically excluded the non-QAP compliant SP-ACTs, injectable arteether doses and rapid diagnostic tests that the Global Fund cannot support currently. These products, approved for use by the national program and funded in part by the World Bank, will continue to be used, but outside of the scope of the grant's procurement and distribution arrangements. The revised PSM plan includes over 500,000 additional QA Policy-compliant LLINs, which will also be added to the targets in the Performance Framework. The revised NVBDCP Performance Framework will reflect a change in linkage of two ACT-treatment indicators (2.2a and 2.2b); they will now be tied to "national program" rather than "current grant".

3. RECOMMENDATION BY PRINCIPAL RECIPIENT

3.1 PRINCIPAL RECIPIENT 1

Grant Number	IDA-911-G23-M
Principal Recipient	National Vector-Borne Disease Control Program (NVBDCP)
Grant Start date	01/10/2010
Grant End date	30/09/2012

a. SECRETARIAT PERFORMANCE RATING	B2

Secretariat rationale for the Recommended Performance Rating

During Phase 1, NVBDCP's Round 9 malaria program was generally plagued by quality assurance policy compliance issues and inadequate financial reporting. These issues resulted in "B2" and "C" ratings for NVBDCP and Caritas, its co-PR, during the first 18 month period of Phase 1.

Due to the government's forward funding of NVBDCP, the program was able to generate a quantitative indicator rating of "B1" for the reporting period covering 1 July 2011 through 31 March 2012, with a 61% achievement on the Top Ten indicators and a 76% achievement on all indicators. The Global Fund considers that financial management issues, M&E weaknesses, and procurement shortcomings merit a downgrade of the quantitative rating to "B2." However, given the objective epidemiological achievements of the national program and near-term resolution of the major accounting and quality assurance issues affecting grant implementation, the PR's performance is expected to improve.

b. SECRETARIAT RECOMMENDATION CATEGORY	Go

Secretariat rationale for the Recommendation Category

Following discussions with NVBDCP aimed at overcoming the salient PSM and financial issues impeding implementation, the Global Fund was able to approve a revised PSM plan on 10 May 2012 that specifically excluded coverage on QAP noncompliant drugs and test kits and agree on modifications to the performance framework, including:

1. ACT-treatment indicators (2.2a and 2.2b) to be tied to "national program" rather than "current grant"; and
2. Adding 390,000 LLINs nets to the non-cumulative indicator for the second year of the grant, taking into account that 2.57 million LLINs were procured during Phase 1.

The Global Fund will adjust the baseline in the Phase 2 performance framework to include these changes, as well as the expansion of LLIN distribution described in the Section 3.a.

Moreover, it was agreed that NVBDCP would arrange for a re-audit (whether by the Controller and Auditor General of India or another outside auditor) of its prior Round 4 grant prior to its formal close-out, with the aim of reconciling its cumulative expenses through Phase 1 of Round 9. The PR agreed to a conservative Round 4 cash balance estimate of US $3,807,411 (in lieu of a final reconciliation of expenditures that is expected to yield a lower amount) to be attributed to the Round 9 grant total (adjusted accordingly), and thereby providing it with an opening cash balance as of 1 October 2010.

Taken together, these steps permit ongoing support of a sound epidemiological control effort.

c. RECOMMENDED INCREMENTAL AMOUNT	$40,096,660

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

The CCM submitted a request of US $60,082,568 for the next Implementation Period, which represents 114% of the ceiling amount available for this PR (NVBDCP) after the 90% Board mandated reduction on the original TRP amount. A number of adjustments resulting in a lower amount of US $59,146,248 were recommended for the next implementation period.

The Global Fund proposed an additional negative adjustment of US $1,426,827 on the budget for HR and communication materials. This is in view of requested significant increase for PR and SR salaries, as well as over-ambitious coverage for BCC outreach. The Global Fund also proposes to adjust the FX rate from 1US $ = 50.74 INR to 1US $ = 52.62 INR, which is in line with the recent exchange rate movement and produces additional savings of US $2,062,190. These adjustments bring the budget amount to US $55,657,231 for the next implementation period, which represents 106% of the Adjusted TRP Amount. The budget provision above the proposal amount (6%) is mostly due to the additional allocation for procurement and distribution of LLINs for forest workers, the carry-over of some delayed Phase 1 trainings and the increase in unit cost for some of the BCC interventions.

As procurement quantifications have not been finalized at the time of submitting these comments, the PSM-related budget will be further revisited during grant negotiations in line with the approval of the PSM plan, which is scheduled to take place no later than 31 March 201313. Any additional cost-savings will be de-committed at that time.

In addition, recognizing that the grant carries some major management issues, which have persisted since 2005 (Round 4 implementation) despite consistent improvement dialogue and strengthening efforts, the Global Fund proposes to condition the commitment of funding for Year 4 and Year 5 to: 1) submission by the PR of unqualified audit report for the full duration of the Round 4 grant confirming the total grant expenditure and 2) the PR demonstrating a significant improvement on the financial management, M&E and procurement issues detailed in Step 3 (Grant Management and Compliance) and Step 5 (ORM) below.

In total, the Global Fund recommends a budget of US $55,657,231 for the next implementation period, recognizing that it provides for 106% of the Adjusted TRP Reallocated Amount. Considering the programmatic achievement demonstrated at the cut-off date (B1), and the anticipation for improved results and increased spending following the PSM plan approval, the Global Fund sees this recommendation as

reasonable.

Less cash and undisbursed amount from the current implementation period, produces an incremental amount of US $40,096,660**.** This represents 76% of the TRP adjusted amount, which is within the range for a grant with B1 indicator rating.

Note: the grant is downgraded to B2 on account of management issues, which do not have an impact on the implementation forecast driven by the programmatic achievement.

Grant Performance rating	Adjusted TRP clarified amount for next implementation period	=	Indicative investment range % of adjusted TRP clarified amount	
			High	Low
B2	US $52,631,476		59%	30%

3.2 PRINCIPAL RECIPIENT 2

Grant Number	IDA-910-G22-M
Principal Recipient	Caritas India
Grant Start date	01/10/2010
Grant End date	30/09/2012

a. SECRETARIAT PERFORMANCE RATING	C

Secretariat rationale for the Recommended Performance Rating

Caritas is an organization capable of meeting its grant targets. Its grant's quantitative "C" rating directly reflects the PR's dependence on its co-PR, the National Vector Borne Disease Control Program (NVBDCP), for results for 8 of 12 coverage indicators. Due to its dependence on the national program for health products and site selection, Caritas' performance suffered while the Global Fund and NVBDCP resolved major issues related to account reconciliation across the latter's Round 4 and Round 9 grants and quality assurance of ACTs and rapid diagnostic tests.

The Global Fund and NVBDCP were able to move forward on account reconciliation through a forthcoming "re-audit" of the Round 4 grant program and to revise the national program's PSM plan to ensure QAP compliance of LLINs and RDTs to be covered by the Global Fund (ACTs would be covered by World Bank and domestic resources). The Global Fund has also asked Caritas to support key NVBDCP staff positions in lieu of WHO, in part to address programmatic and financial reporting deficiencies evinced by PR 1.

The grant's quantitative "C" rating reflects GMS-captured cumulative performance between P1 and P6. However, a comparison of P1-P4 data with results for P5-P6 shows a significant improvement between those periods; the average of all indicators rating increased from 21% to 51% between P1-P4 and P5-P6. The same is also seen for the Top Ten indicators, the average rating for which improved from 3% in P1-4 to 36% in P5-6 (please see table below). The grant's performance framework also lacks sufficient sensitivity to capture changes for training activities in that it sets cumulative targets for training, something the Global Fund no longer recommends and that is not found in the new Performance Framework.

Top 10 (Y/N)	Indicator	Cumulative results against PF targets P1-P6		Cumulative results against PF targets P1-P4		Cumulative results against PF targets P5-P6	
Y	Number of LLIN distributed in LLIN eligible areas (API≥2) by functionaries of PR2	120,345/150,000	80%	0 / 75,000	0%	120,345 / 75,000	120%
N	Number of people reached through infotainment performance	201/823/339,660	59%	50,671 / 169,830	30%	151,152 / 169,830	89 %
N	Number of supervisory visits to community level (village) in a quarter by District Project Officer and report submitted to the Regional Project Manager	269/198	120%	114 / 66	120%	155 / 132	117%
Y	Number of ASHAs/community health volunteers trained	10,136/18,000	56%	2,927 / 15,000	19.5%	7,209 / 3,000	120%
Y	Number of private health care providers (village level) trained in diagnosis and treatment of malaria	0/2000	0%	-	-	0/ 2,000	0%
Y	Number of fever cases tested with RDT by non-government community health volunteers (CHVs) of SR2	5,659/287,294	2%	0 / 223,408	0.0%	5,659 / 63,886	9%
Y	Number of fever cases tested with RDT at non-government health facilities (dispensaries, clinics, etc. of SR2)	0/71,824	0%	0 / 55,852	0.0%	0 / 15,972	0.0%
Y	Number of Pf cases treated with ACT by non-government community health volunteers (CHVs) of PR2	164/13,392	1%	0 / 11,136	0.0%	164 / 2,256	7%
Y	Number of Pf cases treated with ACT at non-government health facilities (dispensaries, clinics etc. of SR2)	0/3,348	0%	0 / 2,784	0.0%	0 / 564	0%
Average Top 10 indicator rating		**18%**		**3.3%**		**36.6%**	
Average all indicator rating		**35%**		**21.2%**		**51.4%**	

The Global Fund believes that the PR will continue show measurable improvement on its subpar performance as of the cut-off date, given the changes already effected in onward implementation with both PRs.

b. SECRETARIAT RECOMMENDATION CATEGORY	Go

Secretariat rationale for the Recommendation Category

Although Caritas demonstrated slow progress during the first six quarters of grant implementation, a full two thirds of its coverage indicators reflect activities dependent on the performance of PR 1, NVBDCP. There have been delays in selection of the areas of operations, as well as in the delivery of needed health products, the distribution schemes for which were also contingent of Global Fund approval of NVBDCP's PSM plan. Caritas has been able to scale up activities in Q5-Q6, which is evident in the 94% burn rate for the current period, up from 37% as of Q4 and 5% in the first semester.

The resolution of the major issues impeding PR 1's performance should enable Caritas to successfully implement its supporting activities in Phase 2, therefore, meriting a "Go" recommendation. It should also be noted that Caritas is slated to provide critical staff support to NVBDCP during Phase 2, ensuring adequate programmatic and financial management capacity of the national PMU.

c. RECOMMENDED INCREMENTAL AMOUNT	$6,827,588

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

The CCM submitted a request of US $11,224,552 for the next implementation period, which represents 160% of the ceiling amount available for this PR (Caritas) after the 90% Board mandated reduction on the original TRP amount. There were a number of adjustments resulting in a lower amount of US $9,691,598 for the next implementation period.

The Secretariat agrees with the recommendations and proposes an additional negative adjustment of US $551,366 on the budget for HR, technical assistance, communication materials, procurement and supply management, and monitoring and evaluation. This is in view of requested significant increase for PR and SR salaries, as well as over-ambitious coverage for BCC outreach. 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 $326,611. These adjustments bring the budget amount to US $8,813,621 for the next implementation period, which represents 122% of the Adjusted TRP Amount.

The budget provision above the proposal amount (22%) is due mostly to two sets of increased costs:

- US $485,178 in the human resource budget due to the rectification in the classification of certain employees and the creation of new posts not found in the original budget.
- US $754,079 in the technical assistance budget due to the addition of 5 staff positions provided by Caritas to NVBDCP as well as short term expert positions for M&E, strategic advisor, MIS and technical experts. As an India government agency, PR 1 is administratively unable to hire dedicated PMU staff for the grant and is reliant on outside TA. Because the Global Fund did not fund staff support for NVBDCP through P6 and the government grant continues to need appropriate PMU staffing, it was decided that Caritas would provide the necessary positions through its grant. This arrangement should ensure both programs' improved overall performance.

The Global Fund recommends disbursing significantly above the disbursement range for a C-rated grant because of the strong performance demonstrated by the PR during the last two quarters of Phase 1. With the major issues in Phase 1 having been addressed and continuing to be addressed with close oversight from the Secretariat, there is strong reason to believe that grant performance will improve even further in the coming periods.

In addition, recognizing that Caritas' performance as of the cut-off date was very low, the Secretariat proposes a condition that will allow the Secretariat to take certain steps if Caritas fails to make significant improvements in its programmatic performance (i.e., minimum B1 or higher rating).

In total, the Global Fund recommends a budget of US $10,600,537 for the next implementation period. Less cash and undisbursed amount from the current implementation period, this produces an incremental amount of US $6,827,588. This represents 94.53% of the TRP adjusted amount.

Grant Performance rating	Adjusted TRP clarified amount for next implementation period	=	Indicative investment range % of adjusted TRP clarified amount	
			High	Low
C	US $7,222,595		29%	0%

4. DETAILED REVIEW BY PRINCIPAL RECIPIENT[2]

4.1 PRINCIPAL RECIPIENT 1

Grant Number	IDA-911-G23-M
Principal Recipient	National Vector Borne Disease Control Program (NVBDCP)
Grant Start date	01/10/2010
Grant End date	30/09/2012

STEP 1: Programmatic Achievements

Overall Performance Rating to cut-off date:

PR : National Vector Borne Disease Control Program (NVBDCP)

Oct 1 2010 - Jun 30 2011	Jul 1 2011 - Mar 31 2012
B2	**B1**

Cumulative Indicator Rating at cut-off date:

Service Delivery Area	Indicator Number	Is Top 10	Is Training	Indicator	Rated Target	Rated Result	Percentage
Prevention: Insecticide-treated nets (ITNs)	1.1			Number of LLIN distributed in LLIN eligible areas (API ≥ 2) by functionaries of PR1	1050000	809434	**77%**
Treatment: Diagnosis	2.1	Yes		Number of fever cases tested with RDT by ASHA	3097362	247048	**8%**
	2.2	Yes		Number of fever cases tested with RDT at public sector health facilities (Sub-center, PHC, CHC, etc.)	774342	800388	**103%**
Treatment: Prompt, effective antimalarial treatment	2.3	Yes		Number of Pf cases treated with ACT by ASHA	144378	14811	**10%**
	2.4	Yes		Number of Pf cases treated with ACT at public sector health facilities (Sub-center, PHC, CHC, etc.)	36094	67357	**120%**
	2.5			Percentage of ASHAs with no reported stock outs of nationally recommended antimalarial drugs lasting more than one week at any time during the past 1 month			
	2.6			Percentage of public sector facilities with no reported stock outs of nationally recommended antimalarial drugs lasting more than one week at any time during the past 1 month			
Prevention: Behavioral Change Communication - Community Outreach	3.1			Number of people reached through infotainment performance	2168160	3996357	**120%**
HSS: Service delivery	4.1			Number of supervisory visits to district periphery in a quarter by District VBDCP (Malaria) Officer (program/project) and report submitted to state program officer/district chief medical officer	691	2321	**120%**

[2] This section needs to be repeated for each PR in the portfolio.

HSS: Information System	4.2			Percentage of people in target areas who know the cause of, symptoms of, treatment for or preventive measures for malaria			
HSS: Health Workforce	5.1	Yes	Yes	Number of Malaria Technical Supervisor (MTS) trained	200	100	**50%**

Training Indicator Rating	50%
Average Performance on Top 10	61%
Top 10 Indicator Rating	**B1**
Average Performance All Indicators	76%
All indicators Rating	**B1**
Number of TOP TEN Indicators with B2 or C Rating	3
Renewals Indicator Rating	**B1**

How has the grant performed in the current implementation period?

Key Achievements of IMCP:

- Malaria cases in the seven northeastern states have declined from 191,742 in 2008 to 110,707 in 2011. Pf cases have declined from 133,595 to 85,531 cases during the same period.
- API in program areas declined by 56%: from 4.39 per thousand in 2008 to 2.44 per thousand in 2011.
- Confirmed deaths due to malaria have also declined by 36% from 349 in 2008 to 126 in 2011.

Main gaps in performance:

- NVBDCP is unable to procure ACTS compliant with the Global Fund's Quality Assurance Policy for finished pharmaceutical products. India's malaria program currently procures the following 4 ACT products and 1 injectable product:

  1. Infant <1 year — As 75mg+SP (125mg+6.25mg)
  2. 1-4 years — As 150mg+SP (500mg+25mg)
  3. 5-8 Years — As 300mg+SP (750mg + 37.5mg)
  4. 9-14 Years — As 450mg+SP (1000mg+50mg)
  5. Arteether Injection — 150mg/2ml

  Unfortunately, none of these products are QAP-compliant. To date, the Global Fund has been unable to identify any sources that provide the ACTs in the dosages utilized by India's national malaria program that are considered to be QAP compliant. The manufacturers of the same dosage forms have been consistently encouraged since 2010 to submit dossiers for review either for WHO prequalification or SRA authorization and/or ERP review following which, if a positive outcome is reached, would enable the Global Fund to fund procurement of quality assured medicines for use with the targeted populations. To this end, we continue to urge WHO, in its current role as provider of technical assistance to NVBDCP, to engage with the relevant authorities in India to move this issue forward, and specifically to ensure that the manufacturers of these health commodities comply with the requirement for prequalification. We are also working with WHO and the India's National Institute of Malaria Research to ensure smooth and efficient transition to WHO-prequalification and/or relevant ISO certification (assessed according to the requirements of Global Harmonization Task Force member authorities) to enable quality assurance activities including random sampling and testing.

With the latest Global Fund-approved revision of the PR's PSM plan, the national program has effectively swapped additional LLINs for non-compliant ACT combinations, the latter to be funded through the World Bank.

- NVBDCP needs to secure a CAG or other independent "re-audit" of its Round 4 grant prior to its formal close-out. This will enable it to reconcile its expenditure vis-a-vis both Round 4 and Round 9 grant budgets.

Reasons for under/over performance of top-10 or equivalent indicators:

- State and district level VBDCPs have successfully scaled up malaria control efforts, as reflected in overachievement of targets for ACT treatment of Pf cases in public sector health facilities.
- Incomplete integration with the National Rural Health Mission (NRHM – India's rural health care program) reflected in underperformance relative to fever cases tested and Pf cases treated by Accredited Social Health Activists (ASHA), in public sector health facilities.

Relevant interdependencies between PRs:

- NVBDCP relies on Caritas for health product (particularly LLIN and RDT) distribution, ASHA and private sector provider training and community based health promotion.
- Caritas provides staff support to the NVBDCP PMU in the form of consultants with expertise in finance, M&E and PSM.
- Caritas depends on NVBDCP for health product procurement, provision of treatment, technical supervision and M&E.

Contextual information:

QAP and finance/audit-related issues hampered grant performance in Phase 1. Their resolution in May 2012 should permit successful implementation in Phase 2.

Revised Indicator Rating	B2

STEP 2: Quality of Data and Services

Date of most recent OSDV: 21 February 2012

Indicator Text	Overall Verification Factor	Data Quality Rating
Indicator 1: Number of LLIN distributed in LLIN eligible area (API>2) by functionaries of PR1	130	Minor issue
Indicator 2: Number of fever cases tested with RDT at public sector health facilities (Sub center PHC, CHC etc.)	Some could not be verified	Major issue

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.

The OSDV identified systemic reporting issues at the state and district levels in the northeast states. While LLIN distribution was captured with relative accuracy, the same could not be said of RDT use. There were challenges in verifying some of the reported fever cases tested with RDT at several public sector health facilities, mainly because of poor record keeping. The Secretariat does not recommend further downgrading of overall grant rating based on the OSDV findings but will ask the PR (NVBDCP) to adopt an effective Management Information System (MIS) for all levels of data collection, collation and reporting channels in the form of an M&E Special Condition.

Two other issues identified by the OSDV bear note:

Limited monitoring visits/review meetings: The PR needs to strengthen its supportive monitoring and supervisory visits at various levels in the northeast, including the data reporting and quality of services provided by “Accredited Social Health Activists” (community based health volunteers -- ASHA).

National Strategic Plan: The current Strategic Action Plan for malaria control in India ends in 2012 and NVBDCP needs to update this National Plan for the next 5 year period. The PR has requested a budget line to conducting a national program review - a necessary step in this process.

STEP 3: Grant Management and Compliance

Grant management assessment		Rating
Monitoring and evaluation	There is lack of clarity at all levels of data collection, collation and reporting channels to ensure coverage and data quality.	Major Issues
Program management	Due to its inability to pay its own staff at competitive salary rates, NVBDCP relied on WHO for technical staff support through the first three semesters of Phase 1. Since that point, it has relied on Caritas to provide specialists with sufficient capacity in finance, M&E and PSM to manage its program in line with the terms of the Grant Agreement.	Major Issues
Financial management and systems	NVBDCP does not fund its SRs, the VDCPs at the state and district levels, directly; the latter are funded by the states themselves and limit their normal interaction with the national PMU to technical reporting. This makes PU/DR completion and audits challenging for the PMU because there is no process in place to review the expenditure reports received from SRs to ensure that all the expenditure reported by them is line with the Global Fund approved budget. Further, there is no mechanism for providing formal approval for SR expenditures incurred in excess of the available budget. Essentially, the Global Fund provides budget support for the national program, the grant-related expenses of which are reconciled with the aid of the LFA at the time of PU/DR review. This has led to a range of structural issues with financial reporting and audit compliance: **Audit –** significant issues have been observed in the audit arrangements of PR and SRs under the Round 4 grant. The major concern arises from the fact that the CAG audit for Round 4 grant has confirmed expenditure which is US$ 27 million less than the LFA verified expenditure reported through the PU/DRs. According to the PR and LFA, the difference is mostly resulting from un-presented supporting documents to the CAG. The PR has now agreed to engage with the CAG for re-audit of the entire Round 4 grant, which shall aim at confirming the total grant expenditure and shall allow formal closure of the grant. The Round 9 audit report for the first 18 months of implementation was due 30 September 2012; the PR reports that it expects to receive this document from the CAG shortly. **Expenditure reporting –** The quality of expenditure reporting has been below expectations, which is partially related to the maintenance of manual systems of accounting. Cases of incorrect and/or unsupported reporting of expenses and taxes charged have been observed in the PU/DRs, which have subsequently been adjusted. **Audit –** significant issues have been observed in the audit arrangements of PR and SRs under the Round 4 grant. The re-audit of the entire Round 4 grant is pending. The Round 9 audit for the first 18 months of implementation is due by 30 September 12. **Fixed assets** - The PR/ SRs have not maintained any ready information with regards to the assets procured with grant funds **SR oversight** – financial monitoring of Sub-recipients has been relatively weak, which has resulted in delayed and poor expenditure reporting from	Major Issues

	the states level. Most of the above constraints have been addressed as special conditions in the Phase 1 grant agreement and repeated in the proposed conditions and management actions for Phase 2, below.	
Pharmaceutical and Health Products Management	**Management Capacity** - During Phase 1, there were significant delays in approval of the PSM Plan due to quality assurance policy issues. After extensive deliberations, it was agreed that Global Fund resources would not be used to procure non-compliant anti-malarials. The PR also faced RDT and LLIN procurement delays which affected supply and distribution. For procurement of RDTs (2010), specifications were not in line with QA policies and therefore had to be re-tendered. It may be noted that procurements for Year 2 of the grant have not been carried out to date for any health products. The PR lacks adequately skilled and qualified procurement staff and has identified need for various procurement related activities in the PSM Plan for Phase 2. The PR has also hired an external agency during Phase 1, "Strategic Alliance Management Services" (SAMS), funded by the World Bank, to provide support in development of SOPs, monitoring and oversight. It is unclear at this time how the new recruitments are proposed to work in parallel without duplication or fragmentation of efforts. **Inventory Management** - OSDV (2010-2011) and OIG reports highlight deficiencies in inventory control including for distribution. For example, distribution of kits to district and sub-district levels is performed without proper forecasting (including lack of buffer stock). Distribution appears to be on the basis of expected consumption and availability of stock at the Central level. **Storage** – Inadequacy in storage capacity and condition (insufficient space for health products, lack of shelves/pallets, lack of pest control and fire control and inadequate recording and reporting. **Quality Assurance** – The PSM Plan does not highlight how it will comply with the QA policies for diagnostics (malaria RDTs). **Drug Management Information System (MIS)** – Incomplete and/or improperly completed reports point to inconsistencies in reporting mechanisms between the districts. During Phase 1, LLINs were inadequately quantified based on consumption data. During recent OSDV, several instances of shortages were noted for medicines and RDTs which may be attributed to the same not being procured at the central level.	Major Issues
Other Management Issues		Major /Minor /No Issues
Additional Safeguards	The fiscal 2011 (April 2011-March 2012) audit Report by the Controller and Auditor General of India is due for release by the end of 2012. An OIG team is currently in country to conduct the Global Fund's own 2012 program audit.	Minor issues

RECOMMENDED PERFORMANCE RATING	B2

STEP 4: Progress towards Impact /Outcome

IMPACT RATING	Demonstrated Impact

STEP 5: Operational Risk Management

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

None

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

This grant was not reviewed by the Operational risk Committee. However, the Global Fund would like to note the following issues in addition to those described in Step 3, above:

There is risk of treatment disruption and substandard quality of health products given the contextual information of Phase 1 grant implementation.

Management Capacity – Adequate management capacity is lacking at NVBDCP. Strengthening measures i.e. recruitment of appropriately skilled staff and training of existing staff are critical for successful implementation and delivery of health products to end users. The PR also needs to provide evidence of strengthening measures in supply chain as a result of activities being performed by "Strategic Alliance Management Services" (SAMS), evaluation of the said activities and any measures taken to address identified gaps and mitigate risk for further bottlenecks.

Inventory Management – The PR has included budget lines for 'Renting of storage space for LLIN at state/district level' in the budget documents (but not in the PSM Plan). The assumptions state that the same will be used for RDTs (and medicines). The PR should be reminded that RDTs may require a different set of minimum standards for storage than LLINs which can impact on quality of the health product. While the PR (in the PSM Plan) is proposing change in distribution model whereby regional warehouses/distribution centers may be established under the consignees to address needs of districts, it is not clear when and how this will be implemented. Little information has been provided on the current plan for distribution which is not only helpful in validating short and long term storage requirements but also indicates which states and districts need storage capacity.

The PR was asked to provide additional information on renting of storage space as well as distribution plan, number of centers planned, the value added by this model and timelines to achieve the same. Information on training of staff on inventory management (as above) with subsequent monitoring of its implementation is also sought to ensure quality of health products is maintained and there is no loss to damage.

Quality Assurance – The PR's consistent lack of attention to details on procurement of health products in line with QA policies of The Global Fund and acceptance of this requirement raises concerns on compliance with the same. The PR has been reminded during in-country discussion and subsequently via email and IL, to ensure compliance with QA policies particularly as it relates to ACTs, RDT and LLINs. In addition, the PR has been advised to remove all information in the PSM Plan related to procurement of anti-malarials.

The PR has not made any entries to date into the PQR database and has been asked to do so at the earliest possible in order to comply with the terms and conditions of the Grant Agreement for Phase 1.

MIS – While the PSM plan describes a well-organized paper based MIS and an online computerized software – NAMMIS (National Anti-malarial management Information System) for capturing inventory related data, the latter is not fully operationalized and the paper based system requires strengthening. The PR is proposing, in addition, to incorporate the current Health MIS into the NRHM-HMIS (National Rural Health Mission) system to capture both patient and inventory related data. However, there are no timelines for the same and weaknesses continue to prevail in recording and reporting data. The PR should provide realistic timelines, including training of relevant staff for implementation of this activity. In the interim, the PR should ensure strengthened oversight by SAMS for tracking consumption and stock levels at regular intervals and follow-up measures taken should be appropriately documented and verified.

Rational Use of Drugs – The PR indicates that it will make the transition to bivalent RDTs in the third year of the program. It is important for the PR to indicate training on bivalent RDT use and how the transition period will be handled (in terms of procurement and monitoring of trained personnel).

Additional information is currently being sought from the PR with regards to cost and quantities of health products planned for procurement in order to assess their reasonableness.

Risk mitigating measures

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

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)
Finance, Procurement, M&E	Recognizing that the grant carries some major management issues, which have persisted since 2005 despite consistent improvement dialogue and strengthening efforts, the Global Fund proposes to condition the commitment of funding for Year 4 and Year 5 to 1) submission by the PR of unqualified audit report for the full duration of the Round 4 grant confirming the total grant expenditure and 2) the PR demonstrating a significant improvement on the financial management, M&E and procurement issues detailed in the sections below.	Condition	If, by 15 November 2013, the PR does not deliver to the Global Fund, the following, in form and substance satisfactory to the Global Fund: a) unqualified audit report for the full duration of the Round 4 grant confirming the total grant expenditure; and b) evidence of significant improvement on the financial management, M&E and procurement issues (as detailed in the sections below), then the Global Fund, in its sole discretion, may undertake any one or more of the following actions: (i) Determine not to release or postpone the release of either or both the Second Commitment and Third Commitment; (ii) Require the PR to reprogram Program activities and de-commit Grant funds from the Grant; and (iii) Implement any other measures considered appropriate by the Global Fund (including without limitation, changing the Principal Recipient, transferring program assets and closing the Grant).	15 November 2013
Programmatic and Performance Risks	M&E Data Quality	Condition	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has strengthened its Management Information Systems (MIS) with clarity at all levels of data collection, collation and reporting channels to ensure coverage and data quality. The PR shall specifically take the following steps for the same:	Within 6 months of Phase 2 grant signature

			- Ensure maintenance of standardized registers and reports as prescribed by the Program at all levels. Duplication of reporting at various levels should be stopped immediately. - Ensure clarity on reporting time lines from lower level entities to higher level entities. - Ensure there is a system in place to include the achievements of the previous periods in the subsequent reporting period, if the same are not captured in the reporting for relevant months. - Ensure there is a system of reviews/checks for validation at each level to ensure data quality, coverage and timely availability of the reports sent to higher levels/received from lower levels. - Ensure that all the entities in the State (including State office itself) are given instructions to keep back ups of data reported to higher levels.	
Financial and Fiduciary Risks	**External audits –** significant weaknesses have been observed in the audit mechanism of the PR for PR/SR level audits based on the experience of Round 4 grant. The major concern arises from the fact that the CAG audit for R4 grant has confirmed expenditure which is $27 million less than the verified expenditure reported through the PU/DRs. According to the PR, the difference is mostly resulting from un-presented supporting documents to the CAG. The Round 9 audit report for the first 18 months of implementation is due by 30-Sep-12. <u>PR Level</u> The PR is a department under Ministry of Health and family welfare and the audit of PR is carried out by Comptroller and Auditor General of India (CAG) as per government rules and the TOR of 'CAG" is not available. Hence, it cannot be determined whether, the "Audit" is being conducted as per Global Fund guidelines.	Management Action (to follow up on the first condition, above)	The Global Fund has engaged with the PR to request from the CAG a re-audit of the entire Round 4 grant. This is expected to resolve the outstanding issues and allow closure of the Round 4 grant. Moving forward with the Round 9 grant, the Global Fund will follow up with the PR and CAG to better understand the scope of their audit and see whether there is room for improving the ToR and quality of audits. With respect to SRs, the Global Fund will engage with the PR to prepare a clearly defined ToR with audit plan for the audit of SR expenditure under the grant. Finally, the Global Fund will follow up on the timely submission of the Round 9 audit report for the first 18 months of implementation. The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, the following: (a) TORs and plan for the audit of the Round 9 grant, and (b) TORs and plan for audit of Sub-recipients. (c) Unqualified audit report from CAG for the first 18 months of the Round 9 grant	By 31 March 2013

	Also, the financial statements on the basis of which the audit is being conducted is not attached to the report issued by CAG, hence it is difficult to ascertain the audited expenses under each head for reporting purposes. Further, for the audit report of the Round 4 grant, it was observed that details of all the expenditures charged in the PU/DR were not made available to the auditor for audit. <u>SR Level</u> There is no standard audit ToR that the different states should follow. Since the scope is not available for review, it is not clear whether the audit is being conducted as per Global Fund guidelines. Further, significant discrepancies and shortcomings were noted in the SR audits provided for the Round 4 grant.			
	Accounting system - The PR follows manual system of accounting, which is based on the government systems and all the compilation of information is done through excel sheets for reporting, which increases the scope of human error. Significant errors have been observed in the expenses reported to date in PU/DRs. Further, there is no mechanism for taking regular backups of the financial information available in excel sheets.	Condition	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has (a) installed accounting software for separate accounting of the grant expenditure and (b) developed mechanisms for separate accounting of the grant expenditure, regular data backups and adequate data storage. This has been included as a special condition under Phase 1; however its implementation is pending.	By 31 March 2013
	Fixed assets register – The PR/ SRs have not maintained any ready information with regards to the assets procured with grant funds	Condition	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has developed a system of tracking of assets procured at PR/SR level under the grant and that it has established a control mechanism to reconcile the same with expenses reported under the infrastructure and equipment cost category. This has been included as a special condition under Phase 1; however its implementation is pending.	By 31 March 2013

	SR oversight – there is no system for conducting financial monitoring visits and for reconciling expenditures reported by the SRs. There is no clear practice at SR level of preparation of budget variance analyses, and the review of expenditure at PR level also does not appear adequate. Overall, the weak financial monitoring of SRs increases the risk of reporting unjustified expenditures.	Management Action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, an SR oversight plan and evidence that it has provided training to all finance staff appointed under the project in order to improve the quality of reporting. The Global Fund will engage with the PR and LFA to ensure that in line with the SR oversight plan financial monitoring visits are conducted on a regular basis and expenditure is verified against approved budgets.	By 31 March 2013
Health Services and Health Products Quality Risks (including Equity and Human Rights)	Treatment disruption and substandard quality of products	Condition	The PR shall deliver to the Global Fund a revised PSM Plan, in form and substance satisfactory to the Global Fund, supported by a finalized forecast for the Health Products to be financed under the grant for Phase 2. The PR shall ensure that the Plan is consistent with the Work-Plan and Budget and were applicable, linked to the targets in the Performance Framework.	Prior to disbursement of funds for Health Products
	Treatment disruption and substandard quality of products	Management Action	a. The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that the PR has hired, under terms of reference which are acceptable to the Global Fund, appropriately qualified and experienced individuals for inventory management at State headquarters. b. The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence of strengthening measures in supply chain as a result of activities being performed by the Strategic Alliance Management Services, evaluation of the said activities and any measures taken to address identified gaps and mitigate risk for further bottlenecks. This shall include but not limited to: i) Evidence that a fully functional system for recording and reporting on patient and inventory related data that can be validated, has been implemented to support forecasting and other procurement and M&E functions; and ii) Measures taken to address gaps in reporting	Prior to second disbursement

	Treatment disruption and substandard quality of products	Management Action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has created jointly with PR 2 a coordination plan. This plan shall include but not limited to, actions for overseeing the implementation of PHPM-related activities for the Grant (e.g. ensuring the routine submission of patient- and inventory-related data, implementing regular supervision visits to sites responsible for the receipt and management of health products, ensuring that storage conditions meet the minimum requirements in terms of good storage practices) to ensure an uninterrupted supply of Health Products and to ensure that any gaps identified in the PSM system are addressed in a timely and coordinated manner.	Within 6 months of Phase 2 Grant signature
	Treatment disruption and substandard quality of products	Management Action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that measures to ensure quality of Malaria Diagnostics have been put into place in order to comply with The Global Fund's Quality Assurance Policy. This shall include but not limited to random sampling and testing along the supply chain as per the said policy requiring that lot-testing for the concerned commodities be conducted at centers assessed by WHO as meeting the relevant requirements for testing for the same commodities.	Within 6 months of Phase 2 Grant signature
Governance, Oversight and Management Risks	NVBDCP relies on technical assistance for core technical expertise	Management Action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, an action plan for hiring of NVBDCP staff who can/will take over the functions performed by the Caritas-provided consultants. The PR shall ensure that it has all the required technical support (in program management, financial management, monitoring and evaluation and PSM) at all times during the entire Phase 2 period.	Within 6 months of Phase 2 grant signature

RECOMMENDED PERFORMANCE CATEGORY	Go

STEP 6: Programmatic achievements and financial performance

Financial situation at cut-off date

Disbursements

Signed Budget for current implementation period	$26,008,849	
less: disbursed to cut-off date	$0	
Undisbursed amount at cut-off date	$26,008,849	

Cash at cut-off date

	PR	SRs	Total
Disbursed to PR to cut-off date[3]	$3,807,411*	N/A	$3,807,411
Less: Disbursed from PR to SRs	-$2,922,557	$2,922,557	0
Less: Expenditure incurred to cut-off date	-$2,956,183	-$3,123,682	-$6,079,865
Add: Interest received/exchange loss	-	$45,366	$45,366
Add: Other income please specify	-$551,834	-	-$551,834
Equals: Cash at cut-off date	**-$2,623,163**	**-$155,759**	**-$2,778,922**

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

**The amount of $3,807,411 represents the closing Round 4 cash balance as at 30-Jun-10. The Round 4 grant is currently under closure and the remaining cash balance was ascribed as opening cash balance for the Round 9 grant. The Global Fund and the PR have agreed to use this conservative estimate in lieu of a final reconciliation of expenditures that was expected to yield a lower amount. The Global Fund has requested the PR to subject the Round 4 grant to a re-audit, either by the Controller and Auditor General of India (CAG), or other external auditor, in order to facilitate the close out of the grant.*

- The first Round 9 disbursement to NVBDCP was made only in September 2012 following resolution of the QAP and accounting issues mentioned earlier. Hence, at the cut-off date (31 March 2012), undisbursed funds were $26,008,849 which represents the total Phase 1 signed budget amount.
- NVBDCP and IMCP-II are forward funded by the India government. The availability of government funding together with the remaining Round 4 cash balance have enabled the PR to proceed with program implementation, and report programmatic results and expenditure against the signed framework of the Round 9 grant.
- As of today, the first and last disbursement for the current implementation period has been processed for an amount of US$ 10.3 million, leaving undisbursed funds at the end of Phase 1 at US$ 15.6 million. This disbursement comprised of a reimbursement of reported grant expenditure to date and a US$ 7.7 million forecast for the period of month 19-24, most of which is supporting the procurement of LLINs and RDTs.
- With the approval of the PSM plan in May 2012, the spending over the last semester of the current implementation period is expected to increase as compared to the absorption rate during the first 18 months of the program. The cumulative disbursement rate at the end of Phase 1 will be at 40%.
- PR and SR cash balance at the cut-off date was negative US$ 2,778,922, representing government pre-financed expenditure, which was subsequently reimbursed by the Global Fund through the disbursement processed in September 2012.

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

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

budget?

Programmatic achievements and financial performance

Percentage of funds budgeted at PR level 74%

Percentage of funds budgeted at SR/SSR level 26%

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
	HSS: Health Workforce	$6,179,615	$1,886,148	31%	**50%**
	HSS: Information System	$697,846	$746,268	107%	
	HSS: Service delivery	$140,260	0	0%	**120%**
	Prevention: Behavioral Change Communication - Community Outreach	$813,567	$435,051	54%	**120%**
	Prevention: Insecticide-treated nets (ITNs)	$10,255,218	$3,012,364	29%	**77%**
	Treatment: Diagnosis	$2,563,031	0	0%	**56%**
	Treatment: Prompt, effective antimalarial treatment	$1,536,406	0	0%	**65%**
Grand Total		**$22,185,943**	**$6,079,831**	**27%**	**76%**

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 month 18 (31 March 12) amounted to US$ 6.1million representing 27% of the budget to date. The under spending was mostly due to HR vacancies at PR and SR level, delays in the procurement of health products as well as infrastructure/equipment, and postponement of training activities until recruitment of staff is complete.

The variance of $16.1 million between the budget and the actual expenditures was due to under-spending across all budget categories, with most significant deviations noted in the area of HR and procurement of health products. With the approval of the PSM plan in May 2012 and the completion of recruitment of program staff, the spending over the last semester of the current implementation period is expected to increase, bringing the cumulative expenditure rate at the end of Phase 1 to 53%.

The discrepancy between programmatic achievement (B1) and spending (27%) at the cut-off date could be explained mostly by the availability of government funding for health products and pharmaceuticals as well as for BCC interventions, which has ensured achievement of programmatic targets with lower than originally budgeted cost for the grant.

As far as it can be determined based on the analysis, the program activities have been implemented in an efficient and cost-effective manner. There are no material concerns that have impacted the value-for-money aspect of the grant.

STEP 7: Financial Recommendation

Resources available to finance program for next implementation period

	Year 3	Year 4	Year 5	Total
TRP clarified amount allocated to PR (in USD)	$26,349,856	$13,897,271	$18,232,291	$58,479,418
Any Board mandated adjustments	-$2,634,986	-$1,389,727	-$1,823,229	-$5,847,942
Adjustment +/(-) for (borrowing) and/or staggered commitments not yet committed	-	-	-	-
Adjusted TRP clarified amount	$23,714,870	$12,507,544	$16,409,062	$52,631,476
CCM reallocations +/(-) (implementation arrangements)	-$225,000	-$219,500	-$235,450	-$679,950
Adjusted reallocated amount	$23,489,870	$12,288,043	$16,173,612	$51,951,526
+ Undisbursed amount at cut-off date				$26,008,849
+ Cash at cut-off date				-$2,778,922
=Total Resources available (after cut-off date for the next Implementation Period)				$75,181,453

Summary Budget Recommendation and Incremental Amount

(In USD)	Year 2 after cut-off date	Year 3	Year 4	Year 5	Total
Total Budget requested by the CCM *(after cut-off date for the next Implementation Period)*	$17,279,615	$26,161,001	$16,737,362	$17,184,205	$77,362,183
Adjustment to budget if counterpart financing requirement is not met	0	0	0	0	0
Adjustments to CCM Funding	$(9,610,259)	$(413,146)	$(283,843)	$(239,330)	$(10,546,578)
Adjustments to CCM Funding Request by Secretariat	0	$(1,163,005)	$(1,163,006)	$(1,163,007)	$(3,489,018)
Total Budget Recommended by the Secretariat	$7,669,356	$24,584,850	$15,290,513	$15,781,868	**$63,326,587**
- Undisbursed amount at cut-off date					$26,008,849
- Cash at cut-off date					-$2,778,922
RECOMMENDED INCREMENTAL AMOUNT					**$40,096,660**
% of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)					**76%**

5. DETAILED REVIEW BY PRINCIPAL RECIPIENT[4]

4.1 PRINCIPAL RECIPIENT 2

Grant Number	IDA-910-G22-M
Principal Recipient	Caritas India
Grant Start date	01/10/2010
Grant End date	30/09/2012

STEP 1: Programmatic Achievements

Overall Performance Rating to cut-off date:

PR : Caritas India		
Oct 1 2010 - Mar 31 2011	**Apr 1 2011 - Sep 30 2011**	**Oct 1 2011 - Mar 31 2012**
B2	**C**	**B2**

Cumulative Indicator Rating at cut-off date:

Service Delivery Area	Indicator Number	Is Top 10	Is Training	Indicator	Rated Target	Rated Result	Percentage
Prevention: Insecticide-treated nets (ITNs)	1.1			Number of LLIN distributed in LLIN eligible areas (API ≥ 2) by functionaries of PR2	150000	120345	**80%**
Treatment: Diagnosis	2.1	Yes		Number of fever cases tested with RDT by non-government community health volunteers (CHVs) of PR2	287294	5659	**2%**
	2.2	Yes		Number of fever cases tested with RDT at non-government health facilities (dispensaries, clinics, etc. of PR2)	71824	0	**0%**
Treatment: Prompt, effective antimalarial treatment	2.3	Yes		Number of Pf cases treated with ACT by non-government community health volunteers (CHVs) of PR2	13392	164	**1%**
	2.4	Yes		Number of Pf cases treated with ACT at non-government health facilities (dispensaries, clinics etc. of PR2)	3348	0	**0%**
	2.5			Percentage of CHVs with no reported stock outs of nationally recommended antimalarial drugs lasting more than one week at any time during the past 1 month			
	2.6			Percentage of non-government health facilities (dispensaries, clinics, etc. of PR2) with no reported stock outs of nationally recommended antimalarial drugs lasting more than one week at any time during the past 1 month			
Prevention: Behavioral Change Communication -	3.1			Number of people reached through infotainment activity	339660	201823	**59%**

[4] This section needs to be repeated for each PR in the portfolio.

Community Outreach	3.2			Percentage of people (please specify target groups) who know the cause of, symptoms of, treatment for or preventive measures for malaria			
HSS: Information System	4.1			Number of supervisory visits to community level (village) in a quarter by District Project Officer and report submitted to the Regional Project Manager	198	269	120%
HSS: Service delivery	5.1	Yes	Yes	Number of ASHAs/community health volunteers trained	18000	10136	56%
HSS: Health Workforce	5.2	Yes	Yes	Number of private health care providers (village level) trained in diagnosis and treatment of malaria	2000	0	0%

Training Indicator Rating	28%
Average Performance on Top 10	19%
Top 10 Indicator Rating	C
Average Performance All Indicators	35%
All indicators Rating	B2
Number of TOP TEN Indicators with B2 or C Rating	6
Renewals Indicator Rating	C

How has the grant performed in the current implementation period?

Key achievements of Caritas:

- Over 120,000 LLIN distributed in eligible areas, exceeding the program target by 60%.
- Over 155 village-level supervisory visits conducted, 22 more than planned over the first 18 months of implementation.
- Significant scale-up of health promotion and community level health worker training as of 2012.

Main gaps in performance:

- Caritas was unable to register significant results for testing and treatment due to dependence on NVBDCP for RDTs and ACTs
- Caritas was unable to train sufficient numbers of private health care providers due to delays in site selection by NVBDCP

Reasons for under/over performance of top-10 or equivalent indicators:

- LLIN distribution exceeded the grant target due to a scale up of efforts in early 2012.
- RDT, ACT and training activities lagged due to Caritas' dependence on NVBDCP for procurement and site selection.

Relevant interdependencies between PRs:

- NVBDCP relies on Caritas for health product (particularly LLIN and RDT) distribution, ASHA and private sector provider training and community based health promotion.
- Caritas provides staff support to the NVBDCP PMU in the form of consultants with expertise in finance, M&E and PSM.
- Caritas depends on NVBDCP for health product procurement, provision of treatment, technical supervision and M&E.

Contextual information: QAP and finance/audit-related issues severely hampered grant performance in Phase 1. Their resolution in May 2012 should permit successful implementation in Phase 2.

Revised Indicator Rating	C

STEP 2: Quality of Data and Services

Date of most recent OSDV: 19 September 2012

Indicator Text	Overall Verification Factor	Data Quality Rating
Indicator 1: Number of LLIN distributed in LLIN eligible areas (API≥2) by functionaries of PR2.	100%	No Data Quality Issues
Indicator 2: Number of fever cases tested with RDT by non-government community health volunteers (CHVs) of PR2	82.45%	Minor Data Quality Issues
Indicator 3: Number of people reached through infotainment activity	91.13%	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.

The most recent OSDV in Nagaland found data quality to be generally reliable and encountered a range of minor reporting issues characterizing this in this far northeastern state on the Myanmar border.

The OSDV report also identified significant issues in the following areas:

1. Insufficient incentive payments to community health volunteers;
2. Data for testing and treatment done by the CHV's not integrated with the National MIS;
3. The number of fever cases tested with RDT at non-government health facilities was not being tracked;
4. LLIN distribution contrary to established guidelines;
5. Double reporting of LLIN coverage and infotainment activities by the 2 PRs;
6. Weaknesses in health product forecasting, procurement and supply chain management leading to:
   - Shortages of ACTs and RDTs
   - Excess stock and drug expiry issues
7. SR- level financial reporting and audit delays

The Global Fund will address these issues with the PR upon receipt of the final LFA OSDV report. By and large they mirror the larger challenges facing IMCP-II and the Round 9 grant, as documented in this scorecard.

STEP 3: Grant Management and Compliance

Grant management assessment		Rating
Monitoring and evaluation	Please describe what issues, if any, where encountered in these functional areas in the current implementation period.	Major /Minor /No Issues
Program management	Also include what was done to address the issues during the current implementation period.	Major /Minor /No Issues
Financial management and systems	**Expenditure reporting:** The PR has yet to put into place a process in place to review expenditure reports received from SRs to ensure that all the expenditure reported by them is line with the Global Fund approved budget. Further, there is no	Some Issues

	mechanism for providing formal approval for SR expenditures incurred in excess of the available budget. Such expenses have been disallowed at the time of PU/DR review. **Cash management**: There is no written policy for cash transaction.PR policy states that single cash payments above INR 5,000 (< US $10) at regional PMUs and INR 1,000 (< US $2) at district PMUs are not acceptable. However, payments above those limits have been recorded. Further, there is no system of documenting physical verification of cash appearing in the cash book. **Capacity:** Currently, the position of Manager – Finance and Grants is vacant due to the health related retirement of the previous Finance Manager. **Fixed asset register:** The PR has maintained a fixed asset register; however no physical verification has been conducted. **Internal audit**: With regards to the special condition, the PR had submitted the ToR for internal audit and the same was approved by Global Fund. However, due to funding limitations per its approved budget, the PR has planned to get only statutory audit done for the program.	
Pharmaceutical and Health Products Management	Inventory Management – While no issues were highlighted during discussions with the PR, it is important to note that the storage and distribution arrangements of PR 2 (Caritas India) have not been assessed during the current phase. An OSDV is planned to be carried out before the year end. Implementation of activities - PR2 is dependent on PR1 (NVBDCP) for the health commodities (LLINS and RDTs) for its procurement and is responsible for the distribution of the same to program areas. Due to delays in procurement encountered during Phase 1, stock out of certain pharmaceuticals and RDTs have been experienced. In addition, when products were received, some medicines were near expiry. MIS – There appears to be no structured periodic reporting by the PR and information is shared on an ad-hoc basis. The PR has been advised to develop and implement a formal reporting mechanism to ensure flow of timely and accurate data systematically form all levels of the supply chain. This may be facilitated by the development of a coordination plan in collaboration with PR 1.	Minor Issues
Additional Safeguards	Caritas is planning to submit an 18 month audit for the period October 2010 – March 2012. An OIG team is currently in India to complete the Global Fund's 2012 program audit of India grants.	Minor Issues

RECOMMENDED PERFORMANCE RATING	C

STEP 4: Progress towards Impact /Outcome

IMPACT RATING	Demonstrated Impact

STEP 5: Operational Risk Management

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

None

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

N/A; however, the Global Fund notes the following pharmaceutical and health product management risks:

- With the understanding that PR 2 will not be involved with procurement of any health products and will only be responsible for the storage and distribution of the same, the PR has been requested to submit a PSM Plan which may only reflect information on implementation arrangements for this activity. The PSM Plan submission is still pending.

- As indicated in Step 3, storage sites used by PR during distribution of health products will be assessed during the next OSDV.

- Key challenges for the PR may relate to distribution in difficult to reach areas. Once details on arrangements have been received, we may be in a position to recommend some actions to mitigate this risk.

- Lack of a standardized reporting mechanism may result in the PR not availing quality information for program implementation and monitoring. The PR is recommended to coordinate with PR1 to receive data on stock from the periphery and share information gathered from oversight and monitoring visits that can inform program planning and implementation.

- It has been agreed that there is a need to review the grant in one year through the Operational Risk Management Committee. The Global Fund recommends a Condition that will allow certain steps to be taken if Caritas fails to make significant improvements in its programmatic performance (i.e., minimum B1 or higher rating).

Risk mitigating measures

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 and Performance Risks				
Financial and Fiduciary Risks	**Low programmatic Performance**	Condition	If, by 15 November 2013, the PR does not deliver to the Global Fund, evidence in form and substance satisfactory to the Global Fund, that there has been a significant improvement in the programmatic performance of the Program (i.e. minimum B1 or higher performance rating), then the Global Fund in its sole discretion, may undertake any one or more of the following actions: (a) Determine not to release or postpone the release of either or both the Second Commitment and Third Commitment; (b) Require the PR to reprogram Program activities and de-commit Grant funds from the Grant; and (c) Implement any other measures considered appropriate by the Global Fund (including without limitation, changing the Principal Recipient, transferring Program Assets and closing the Grant).	15 November 2013
	Cash management: There is no written policy for cash transaction. As explained by the PR as per understanding there should be no single cash payment above INR 5,000 at RUMP and INR 10000 at DPMU but there were number of transactions above those limits.	Management action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that (a) the financial guideline for the project has been prepared which have the required details for the cash controls and (b) it has issued instructions to SRs to have a system of the physical verification of cash at RUMP/DPMU and have documentation of the same.	Prior to Grant Signing

	Capacity: Currently position of Manager – Finance and Grants at PR is vacant due to previous Finance Manager having left the job	Management action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has filled the position of Manager – Finance and Grants.	Prior to Grant Signing
	Expenditure reporting: There is no process in place to review the expenditure reports received from SRs to ensure that all the expenditure reported by them is line with the Global Fund approved budget. Further, there is no mechanism for providing formal approval for SR expenditures incurred in excess of the available budget.	Management action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has reviewed the SR reported expenditure in line with the Global Fund approved budget and has followed a mechanism of providing formal approval, wherever necessary, for expenditure incurred in excess of the available budget.	Prior to Grant Signing
	Fixed asset register: The PR has maintained a fixed asset register; however no physical verification has been conducted.	Management action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has conducted physical verification of fixed assets.	Prior to Grant Signing
	Internal audit: With regards to the special condition, the PR had submitted the ToR for internal audit and the same was approved by Global Fund. However, the PR has planned to get only statutory audit done for the program.	Condition	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that the Principal Recipient has instituted a system for the conduct of an annual internal audit of the use of Grant funds under the Program. The annual internal audit shall include, but will not be limited to, an assessment of the Principal Recipient and recommendations for addressing any programmatic, managerial and financial capacity gaps. The condition is carried over from Phase 1.	Within 6 months of Phase 2 Grant signature
	External Audit: The external Audit of the first 18 months of the	Management Action	Upon request from the Global Fund from time to time, the PR shall deliver to the Global Fund, in form and substance satisfactory to the Global	Follow-up during implementation

	implementation will be due on 30 September 2012.		Fund, evidence of progress of the external audit for the first 18 months of program implementation due on 30 September 2012.	
Health Services and Health Products Quality Risks (including Equity and Human Rights)	Treatment disruption	Management Action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has created jointly with PR 1 a coordination plan including formation of coordination committee made up of key stakeholders involved in the PHPM activities. This working group or committee shall be tasked with, but not limited to, overseeing the implementation of PHPM-related activities for the Grant (e.g. ensuring the routine submission of patient- and inventory-related data, implementing regular supervision visits to sites responsible for the receipt and management of health products, ensuring that storage conditions meet the minimum requirements in terms of good storage practices) to ensure an uninterrupted supply of health products and to ensure that any gaps identified in the system are addressed in a timely and coordinated manner.	Within 6 months of Phase 2 Grant signature
	Inadequate case detection QAP compliance Artemisinin resistance	Condition	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, a PSM plan detailing the distribution arrangements for health products in line with PR1's procurement schedule and spatial roll-out plan.	Within 6 months of Phase 2 Grant signature.
Governance, Oversight and Management Risks				

RECOMMENDED PERFORMANCE CATEGORY	Go

STEP 6: Programmatic achievements and financial performance

Financial situation at cut-off date

Disbursements

Signed Budget for current implementation period	$5,729,644
less: disbursed to cut-off date	$3,260,689
Undisbursed amount at cut-off date	$2,468,955

Cash at cut-off date

	PR	SRs	Total
Disbursed to PR to cut-off date[5]	$3,260,689	N/A	$3,260,689
Less: Disbursed from PR to SRs	-$1,985,015	$1,985,015	0
Less: Expenditure incurred to cut-off date	-$318,220	-$1,635,415	-$1,953,635
Add: Interest received/exchange loss	$31,812	$17,263	$49,075
Add: Other income	-$52,135	0	-$52,135
Equals: Cash at cut-off date	$937,131	$366,863	$1,303,994

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

Following a first disbursement in February 2011, with an agreed grant start date of 1 October 2010, the PR experienced programmatic delays related to the first PR's difficulties in site (village) selection and procurement of ACTs and RDTs. These delays snowballed until Q6, at which point we have observed an acceleration of implementation and funds utilization. Notably, during the latest reporting period from 1 October 2011 to 31 March 2012, the PR had a burn-rate of 94% of the period budget (budget was US $1,135,117 and reported expenditure was US $1,069,995). The burn rates for the previous periods were 16.7% and 37%, for P1-2 and P3-4, respectively.

The under-spending was mainly due to delay in the start of the program and the activities could commence only in Quarter 3, hence the budget for almost all budget lines were not fully utilized. For details, please refer to the section below.

The grant has undisbursed monies totaling US $1,895,991 out of US $5,156,680 grant budget (36.8%) until the cut-off date of 31 March 2012. However, in September 2012, the Global Fund processed a disbursement of US $1,164,547 million, which will cover the period 1 April to 31 December 2012, with a Type 1 no-cost extension.

The PR's adjusted cash balance stood at US $937,130 as of 31 March 2012 with an SR-level cash balance of US $366,863.

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

Programmatic achievements and financial performance

Percentage of funds budgeted at PR level	51%
Percentage of funds budgeted at SR/SSR level	49%

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

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
	Prevention: Insecticide-treated nets (ITNs)	116,171	32,109	28%	80%
	Prevention: BCC - community outreach	1,225,534	120,232	10%	**59%**
	Treatment: Diagnosis	64,264	366	1%	**1%**
	HSS: Human resources (HR, TMA, etc.)	1,545,678	1,082,639	70%	
	HSS: Information system & Operational research (M&E/ MIS)	521,945	364,725	70%	120%
	HSS: Human resources (training/ capacity building)	903,694	404,292	45%	51%
	Supportive environment: Coordination and partnership development (national, community, public-private)	7,500	0	0%	**0%**
Grand Total		4,384,786	2,004,363	46%	35%

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 reported in EFR and presented in above table has not been revised by the LFA. The total amount of EFR reported expenditure of $2,004,363 exceeds the verified expenditure of $1,953,636 as of month 18. In the absence of adjusted EFR data, the above has been used for comparative percentage analysis – expenditure versus programmatic achievement acknowledging that there may be some misrepresentation of the data. However, for deriving the month 18 cash balance, the verified expenditure of $1,953,636 has been considered.*

Expenditure vs Budget:

The Global Fund disbursed US $3,260,689 as of 31 March 2012 (i.e., for an 18 month period of performance) representing 60% of the Phase 1 commitment and 74% of the budget for the period.

The total expenditure under this grant as of 31 March 2012 is US $1,953,635. The PR's expenditure represents 34% of the total Phase 1 amount, 45% of the cumulative budget and 60% of the disbursed amount. The under-utilization of the budget is primarily due to the following:

- There was delay in the start of the program and the activities could commence only in Quarter 3 and Quarter 4 and hence the budget for almost all budget lines were not fully utilized
- There were also staff turnover during the reporting period.
- The expenditure on printing of BCC material (like leaflets/ caps/flip book/information card etc.) has not been undertaken.
- All the activities budgeted under TA could not be undertaken
- Training of private health care providers could not be undertaken and the numbers of ASHA

workers trained were less than the budget.

- There was less expenditure on distribution of LLINs as all the cost incurred is not paid and shall be paid in future periods.

The variance of US $2.4 million between the budget and the actual expenditures was due to under-spending the following budget categories:

- Human Resources: (US $268,192) (72% - Reason: delay in the start of the program and staff turnover)
- TA: (US $80,930) (59% - Reason: delay in the start of the project)
- Training: (US $505,087) (44% - Reason: trainings rolled-over from previous periods)
- Procurement and Supply Management Cost: (US $144,935) – (17% - Reason: delay in the start of the project and dependence on PR 1)
- Infrastructure and Other Equipment: (US $20,165) (89% - Reason: misclassification of cost category)
- M&E: US $156,236 (61% - Reason: activities rolled-over from previous periods)
- Communication Materials: (US $1,112,803) (10% - Reason: delay in the start of the project)
- Planning and Administration: (US $142,802) (58% - Reason: delay in the start of the project and local socio-political situation in project area has affected activities)

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Performance vs Expenditure:

The grant rating tool has generated a 35% average performance of all indicators, whereas the cumulative utilization is 45% thus the average programmatic performance is less than the cumulative utilization for the grant. This is primarily because of the following:

- As PR-2 has established new sets up at each level, there were significant costs of infrastructure and human resources the benefits of the same shall be realized in whole of the grant period, the impact of which is not reflected in the current achievements.
- PR-2 is dependent on PR-1 for supply of LLIN's/RD Kits and SP-ACT which were not provided as targeted. Hence, despite setting up the whole mechanism PR was not able to report achievements against these indicators.
- Some of the activities budgeted and carried out by the PR were not linked to the PF (e.g., local school activity for dissemination of messages and community message dissemination).

STEP 7: Financial Recommendation

Resources available to finance program for next implementation period

	Year 3	Year 4	Year 5	Total
TRP clarified amount allocated to PR (in USD)	3,615,979	1,907,116	2,502,010	8,025,105
Any Board mandated adjustments	-361,598	-190,712	-250,201	-802,510
Adjustment +/(-) for (borrowing) and/or staggered commitments not yet committed				
Adjusted TRP clarified amount	3,254,381	1,716,405	2,251,809	7,222,595
CCM reallocations +/(-) (implementation arrangements)	225,000	219,500	235,450	679,950
Adjusted reallocated amount	**3,479,381**	**1,935,905**	**2,487,259**	**7,902,545**
+ Undisbursed amount at cut-off date				2,468,955
+ Cash at cut-off date				1,303,994
=Total Resources available (after cut-off date for the next Implementation Period)				**$11,675,494**

Summary Budget Recommendation and Incremental Amount

(in USD)	Year 2 after cut-off date	Year 3	Year 4	Year 5	Total
Total Budget requested by the CCM *(after cut-off date for the next Implementation Period)*	2,507,129	4,210,003	3,225,160	3,789,389	**13,731,681**
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)*	(720,213)	(1,410,434)	(514,671)	(485,826)	(3,131,144)
Total Budget Recommended by the Secretariat	1,786,916	2,799,569	2,710,489	3,303,563	**10,600,537**
- Undisbursed amount at cut-off date					2,468,955
- Cash at cut-off date					1,303,994
RECOMMENDED INCREMENTAL AMOUNT					**$6,827,588**
% of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)					94.53%