RENEWAL SCORECARD

India

Tuberculosis

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1. SCORECARD SUMMARY

GENERAL PROGRAM INFORMATION

Applicant	India CCM
Country and Income Level	LLMI
Component	TB
Renewal cut-off date	30/09/2012
Renewal Review date	01/04/2013
Implementation Period start date	01/04/2013
Implementation Period end date	31/03/2016

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-T-CTD	Department of Economic Affairs, Ministry of Finance, GoI (Central TB Division)	B1	Go	$ 170,592,422	99.8%	0.2%	No
IDA-T-IUALTD	International Union Against TB and Lung Disease (The Union)	A2	Go	$ 23,600,360	97.5%	2.5%	Yes
IDA-T-WVI	World Vision India	B1	Go	$ 4,200,848	93.3%	6.7%	No
Total Recommended Incremental Amount (all PRs)				**$198,393,630**			
Total Adjusted TRP clarified Amount (all PRs)				**$199,645,827**			

2. COMPONENT PORTFOLIO OVERVIEW

2.1 PROGRAM CONTEXT

Epidemiological Situation and Program Objectives

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

India has more new tuberculosis (TB) cases annually than any other country. In 2011, out of the estimated global annual incidence of 9 million TB cases, 2.3 million were estimated to have occurred in India. The World Health Organization (WHO) estimated TB incidence, including HIV/TB co-infections, for the year 2011 to be 181 per 100,000 population and prevalence to stand at 249 per 100,000 (Global TB Report 2012). Estimated mortality from TB in India was 300,000 (190,000–430,000) in 2011. Earlier data (WHO, 2004) showed that TB accounts for 17.6% of deaths from communicable disease and for 3.5% of all causes of mortality in the country. The problem of TB in India is compounded by overcrowding, poverty and malnutrition, as well as the emergence of drug-resistance and HIV co-infection.

Among 27 high MDR-TB burden countries, prevalence of multi drug-resistant TB (MDR-TB) in India is relatively low, with prevalence of 2.1% of MDR-TB in new and 15% in retreatment cases in India, compared to 4.3% and 21%, respectively, in all high MDR-TB burden countries. It however translates into large absolute numbers. In 2010, an estimated 64,000 of the notified cases of pulmonary TB were cases of MDR-TB (WHO 2011 Global TB Report). The estimated number of such cases emerging annually in the country is 99,000. Prevalence of extensively drug resistant (XDR) TB is less than 0.5% in re-treatment cases and not yet reported in new cases.

Although only 5% of TB patients are HIV infected, in absolute terms it ranks 2nd in the world and accounts for about 10% of the global burden of HIV associated TB. Pediatric TB is estimated to account for 10-15% of all TB cases. With more than 100,000 estimated deaths every year, it is one of the top 10 causes of childhood mortality in India (TB India 2012, RNTCP).

Tuberculosis imposes a high socio-economic cost on India. Almost 70% of its TB patients fall between 15 and 54 years of age. While two thirds of the cases are male, TB takes disproportionately larger toll among young females, with more than 50% of female cases occurring before the age of 34. The direct and indirect cost of TB to India amounts to an estimated US $23.7 billion annually. Studies suggest that on an average 3 to 4 months of work time is lost as result of TB, resulting in an average lost potential earning of 20- 30% of the annual household income (Socio-economic impact of TB on patients and family in India, International Journal of Tuberculosis and Lung Disease IJTLD 1999; 3: 869-877). This leads to increased debt burden, particularly for the poor and marginalized sections of the population. The vast majority (more than 90%) of the economic burden of TB in India is caused by the loss of life rather than by morbidity. (TB India 2012)

India's Revised National Tuberculosis Control Program (RNTCP) is the world's largest TB control program. Launched in 1997, RNTCP covered the entire country by March 2006 and succeeded in bringing down mortality from annual levels that exceeded 5 million. Since 2008, the program has consistently succeeded in detecting more than 70% of the estimated new sputum smear-positive cases of TB and cured more than 85% of these (these estimates may omit a significant population of urban poor without access to the public health system). RNTCP diagnoses and treats over 1.5 million TB patients each year. While the performance of the program varies widely across districts and states, by most measures RNTCP has largely achieved its targets. RNTCP has entered its third 5-year phase of implementation; currently focusing on early and complete detection of all cases of TB, including drug resistant TB and HIV-associated TB, with greater engagement of the private sector in improving care for all TB patients. Culture and DST laboratories have been accredited nationwide to provide quality diagnostic services for drug resistant TB cases. All 35 States and Union Territories have introduced Programmatic Management of Drug-resistant TB Services (PMDT) services in at least some of their districts.

The Consolidated SSF Grant finances the activities of three Principal Recipients working in support of RNTCP, (Central TB Division – CTD -- of the Ministry of Health and Family Welfare; the Southeast Asia Office of the International Union Against Tuberculosis and Lung Disease – IUATLD or "Union"; and World Vision India -- WVI) that were previously supported under the country's Round 2 RCC and Round 9 TB grants. Under the Round 2 RCC grant, RNTCP registered approximately 427,000 people for DOTS treatment annually and afforded up to 1,100 patients access to free second-line drugs (SLDs) at DOTS plus pilot sites. The Round 9 Grant addressed challenges such as insufficient laboratory capacity for detection and follow up of drug resistant cases and funding gaps for procurement of second line drugs for all MDR-TB cases.

In specific terms, the SSF program aims to:

1. Achieve and sustain universal access to high quality diagnosis and patient-friendly treatment under DOTS; including MDR-TB and HIV/TB;
2. Consolidate efforts towards achieving the goal of TB control through sustainable and effective public-private partnership to involve all health care providers;
3. Contribute to national efforts in measuring the impact of RNTCP in relation to the MDG TB targets;
4. Establish and enhance capacity for quality assured rapid diagnosis of DR-TB suspects in 43 Culture and drug susceptibility testing (DST) laboratories in India by 2015;
5. Scale-up care and management of DR-TB in 35 states/Union Territories of India resulting in the initiation of treatment of 55,350 additional cases of DR-TB over the project period;
6. Improve the reach, visibility and effectiveness of RNTCP through civil society support in 374 districts across 23 states by 2015;
7. Engage communities and community-based care providers in 374 districts across 23 states by 2015 to improve TB care and control, especially for marginalized and vulnerable populations including TB-HIV patients.

CTD (through state TB societies) covers RNTCP activities in 196 districts in 8 states, namely, Bihar, Jharkhand, Chhattisgarh, Andhra Pradesh, Orissa, Haryana, Uttarakhand and Karnataka. The Union with its 8 SRs and World Vision India (WVI) with its 6 SRs implement the programs to improve reach, visibility and effectiveness of RNTCP through civil society support while improving TB care and control by engaging communities and community-based care providers in 374 districts across 23 states. Overall, the Consolidated SSF TB grant permits RNTCP to cover a population of 362 million in 8 states of India. In addition, two of CTD's sub-recipients, the Catholic Bishops Conference of India (CBCI) and Indian Medical Association (IMA), reach private sector providers and their patients in 16 and 19 states, respectively.

Three epidemiological factors merit greater attention in the future implementation of the national TB control program:

1. Urban TB: India has been experiencing rapid urbanization and growth of massive slum areas encompassing millions of people living in squalid conditions. Studies indicate that treatment failure among many urban patients is disproportionately high and that this situation may be a direct result of the tendency of slum dwellers to approach unqualified private practitioners for TB treatment. These providers often misdiagnose and/or mistreat TB and patients can reach government facilities after having gone to multiple such practitioners, taken incomplete drug regimens and developed resistance to rifampicin and other first line TB medicines. The number of such patients may actually exceed the number of patients in the public health care system.

2. Gender: Past studies in India and internationally have thrown light on gender specific aspects of TB disease- both diagnosis and treatment. TB is the leading infectious cause of death in females and is also an important cause of morbidity in women. Studies have also revealed that women are more likely to experience patient delay and delay in treatment initiation. Studies also show that men have worse outcomes after treatment initiation while women are more likely to successfully complete treatment. Thus, there is a need for gender-sensitivity in provision of services.

3. Malnutrition in all age groups and genders: India's chronic challenge with food security heightens the risk of contracting TB and also the effects of the disease on the body. Diabetes has also emerged as a contributory risk factor for TB in the country.

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 (2013-14)	Year 2 (2014-15)	Year 3 (2015-16) **2 quarters**
Detection of new smear positive TB cases	183,852 (8 states)	188,160 (8 states)	194,040 (8 states)	109,956 (8 states)
Detection and registration of TB cases (All forms) for treatment under RNTCP DOTS	437,743 (8 states)	448,000 (8 states)	462,00 (8 states)	261,800 (8 states)
Successful treatment of new smear positive pulmonary TB cases registered in a specified period	87%	88%	88%	88%
Enrollment of lab-confirmed MDR-TB patients in second-line anti-TB treatment (DOTS Plus treatment)	26,814	25,500 (national target) (62% from the GF)	30,000 (national target) (62% from the GF)	17,050 (national target) (62% from the GF)
Provision of HIV testing for TB patients	195,425 (8 states)	268,800 (8 states)	323,400 (8 states)	209,440 (8 states)

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)**				
	2013-2014	**2014-2015**	**2015-2016**	**Total**	**% Share**
Overall Needs Costing	**262**	**272**	**258**	**792**	**100%**
Government Resources	36	103	185	324	41%

Private Sector Contribution					
Total Domestic Resources	**36**	**103**	**185**	**324**	**41%**
UNITAID	5	12	17	33	
Total External Resources (Non GF)	**5**	**12**	**17**	**33**	**4%**
Total Resources Available	**41**	**115**	**202**	**357**	**45%**
Funding Gap	**221**	**158**	**57**	**435**	**55%**
Global Fund Next Implementation Period Funding	**124**	**158**	**25**	**307**	**39%**

Financial Gap Analysis and Counterpart Financing Table
Currency = USD in million

Funding Sources Year (-1), corresponds to current fiscal year. Years (-2) and (-3) correspond to years preceding current fiscal year and Years 1-3 to the following years.	**FIRST IMPLEMENTATION PERIOD**			**SECOND IMPLEMENTATION PERIOD**			
	Actual		**Planned**	**Estimated**			**Data Source**
	Year (-3)	**Year (-2)**	**Year (-1)**	**Year 1**	**Year 2**	**Year 3**	
Specify fiscal years here	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	
Part One: National Program (USD in millions): Funding Needs and Resources.							
SECTION A: Funding needs for the full national program							
LINE A *Provide annual amounts*				148.15	207.58	201.71	
SECTIONS B, C and D: Current and anticipated resources to meet the funding needs of the full national program.							
Section B: Current and Anticipated Domestic Resources							
Domestic source **B1** Loans and debt relief	26.07	32.49	28.68	-	-	-	
Domestic source **B2** Government funding resources	11.89	14.26	15.03	16.53	80.56	151.30	
Domestic source **B3** Private sector contributions (national)							
LINE B: Total DOMESTIC resources *Total of Section B entries*	37.96	46.75	43.70	16.53	80.56	151.30	
Section C: Current and Anticipated External Resources (non-Global Fund) *Insert additional lines below if there are more than three external sources.*							
External source **C1** *DFID(drugs)*	7.41	8.34					
External source **C2** *UNITAID*			9.81	4.89	11.66	16.55	
External source **C3**							
LINE C: Total EXTERNAL (non-Global Fund) *Total of Section C entries*	7.41	8.34	9.81	4.89	11.66	16.55	
Section D: Current and Anticipated External Resources (Global Fund), excluding funding from current request							
Grant/SSF D1							

SSF Second Implementation Period							
IDA T CTD							
RCC	28.62	15.71					
IDA-202-G03-T-00							
R9	0.84	12.61					
IDA-910-G18-T							
SSF First Implementation Period		35.00	72.74				
IDA-T-CTD							
LINE D: Total EXTERNAL (Global Fund) resources	29	63	73				
LINE E : Total current and anticipated resources	75	118	126	21	92	168	
Calculation of gap in financial resources and summary of total funding requested in next Phase/Implementation Period							
LINE F: Total funding gap *Line F = Line A – Line E*				127	115	34	
LINE G: CCM funding request.				113.36	88.61	11.68	
LINE H: Total Global Fund contribution including all grants/SSFs for the disease if CCM funding request is approved.				113	89	12	
Part Two: Overall Health Sector: Overall Health Spending and Domestic Public Resources							
Total Health Sector current and planned spending *include Domestic public and External resources*	4,799.23	5,281.90	6,808.57	7,489.43	8,238.37	9,062.21	
Section I: Current and Anticipated Government health sector spending							
Domestic source **I1** Loans and debt relief							
Domestic source **I2** Government revenue resources							
LINE I: Total GOVERNMENT resources *Total of Section I entries*							
Counterpart Financing *Low Income = 5%, Lower Middle Income - Lower Tier = 20 %, Lower Middle Income - Upper Tier = 40 %, Upper Middle Income = 60%*							
LINE J: Total Government Resources for Current and Future Years. *Line J = B1 + B2 entries*	37.96	46.75	43.70	16.53	80.56	151.30	
LINE K: Total Government Resources for Current and Previous Years.	128.41						

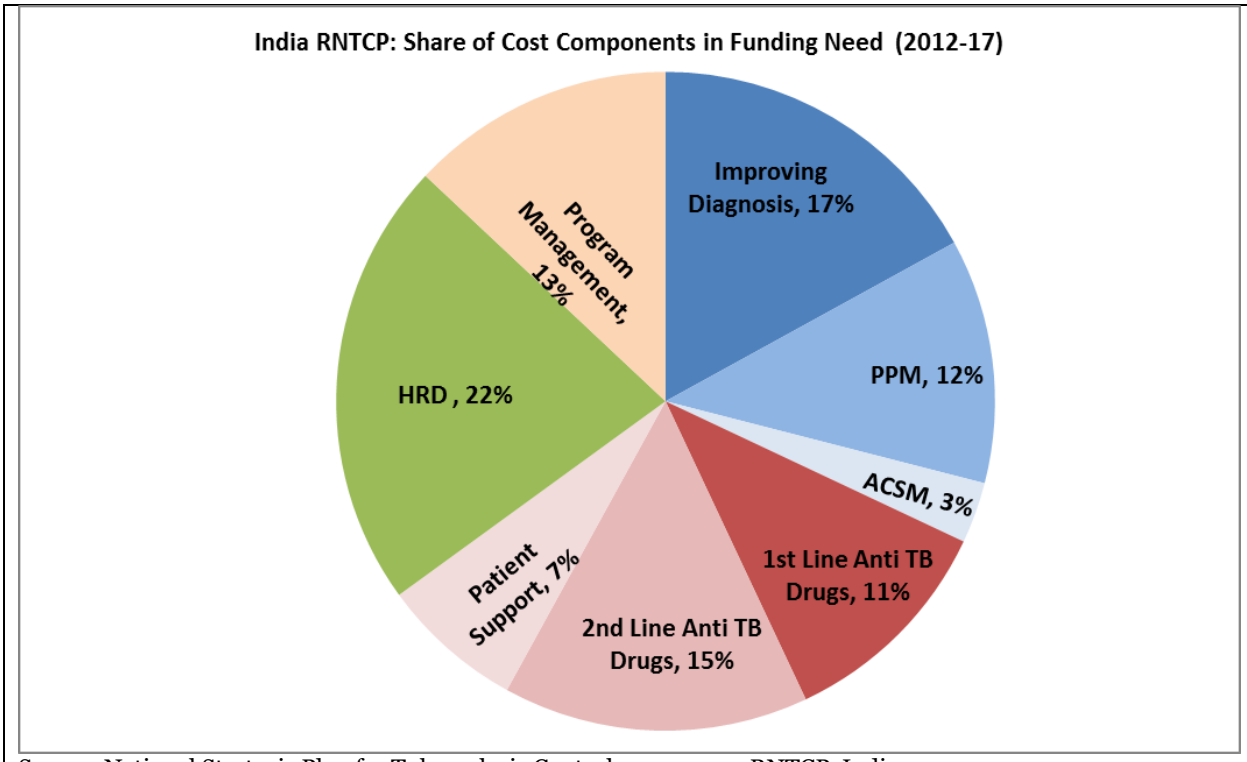
Line K = Sum of Line J entries for initial implementation period						
LINE L: Total Global Fund contribution during next Phase/Implementation Period (all grants/SSFs for the disease) *Line L = Sum of line H*				214		
Line M: Counterpart Financing = (calculation of government contribution)	***[Sum of Total Government Resources for Y(-3), Y(-2) and Y(-1) (Line K)]*** / ***[Total Global Fund Resources for Y1, Y2 and Y3 (Line L)] + [Sum of Total Government Resources for Y(-3), Y(-2) and Y(-1) (Line K)]***				***x 100***	**38%**

Comments:

The Revised National Tuberculosis Control Program of India (RNTCP) is a Centrally Sponsored Scheme (CSS) implemented by State governments with 100% central government assistance. The planning process for the RNTCP is aligned to the five year planning cycles of the Indian government. The funding need for the next implementation phase is derived from the costing of the 'National Strategic Plan for Tuberculosis Control' (NSP) for the 12th Five-Year Plan period (2012-17). The costing pertains only to activities implemented with funds allocated to RNTCP specific budget lines of the central Ministry of Health and Family Welfare. The substantive human resource, infrastructure and operational costs for TB service delivery that is primarily borne by the State governments (USD 93 million in 2013 as per WHO estimates)[1] is not included in the estimate of funding need. The costing also does not include central government spending on the National TB Training Institute, BCG Vaccine Laboratory and other TB institutes (around 15 million USD in 2012-13)[2] Further, funding requirements of the Global Fund supported Project Axshya, a civil society initiative to expand the reach of RNTCP among marginalized and vulnerable population is also not included in the NSP costing. To provide a full picture of Global Fund support in the next phase, the NSP cost estimate has been revised to incorporate the proposed funding for the two civil society Principal Recipients (The Union and World Vision India) that implement Project Axshya.

The estimated five year cost for the NSP for TB control (2012-17) is about 1.2 billion USD, two thirds of which is required for the next implementation phase of the current grant. About 32% of the funding is required for improving case finding through strengthening TB and MDR-TB diagnosis capacity (17%), PPM (12%) and ACSM (3%). Costs of first line anti-TB drugs (11%), second line anti-TB drugs (15%) and patient support including transport, counselling and honorarium for non-salaried DOTS providers (7%) for providing patient friendly treatment account for a third of the funding need. Human resource costs including salaries of contractual program staff and training constitute 22% of the funding need with operational expenses of program management accounting for the remainder (13%).

[1] Global Tuberculosis Report 2012; World Health Organization
[2] Budget Estimates of the Ministry of Health and Family Welfare (Demand for Grants, 46)

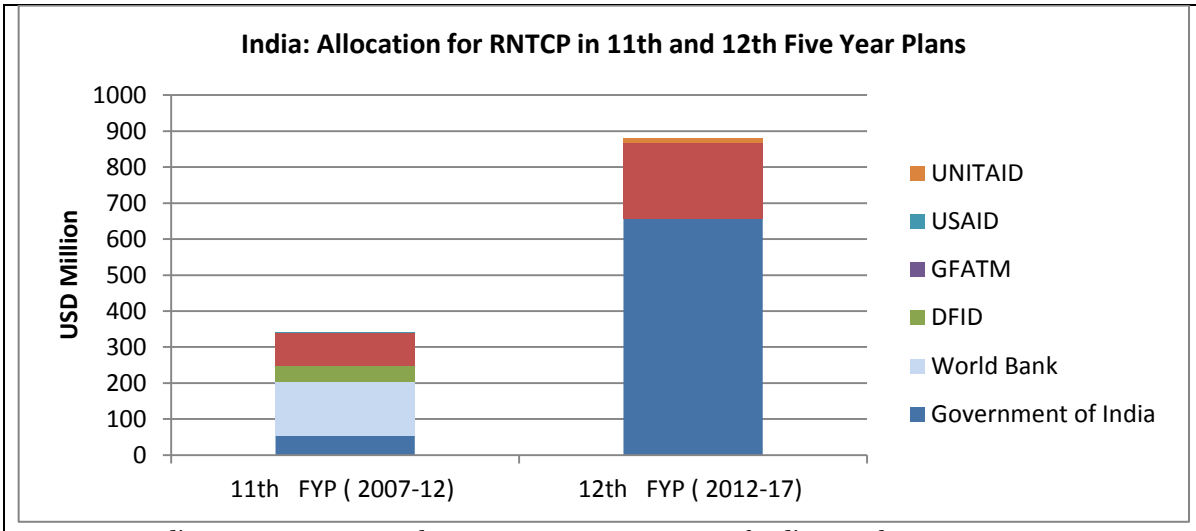


Source: National Strategic Plan for Tuberculosis Control 2012–2017, RNTCP, India
Note: Excludes Project Axshya, TB service delivery and institutional costs

Funding for the RNTCP is made available primarily through the 'Plan' allocations of the Central government. 'Plan' allocations are development expenditures approved by the Planning Commission of India under the national 'Five Year Plans' and is financed by government revenues, loans and external aid. In line with significant increase in government health spending envisaged in the 12th Plan period, the NSP 2012-17 anticipated that the increasing contribution from Government of India as well as the Global Fund would meet the total funding requirement of the NSP. However, the Planning Commission taking into account the programmatic and financial performance during the 11th Five Year Plan has approved an allocation of US $880 million for the RNTCP with US $650 million provided by the Government of India[3].

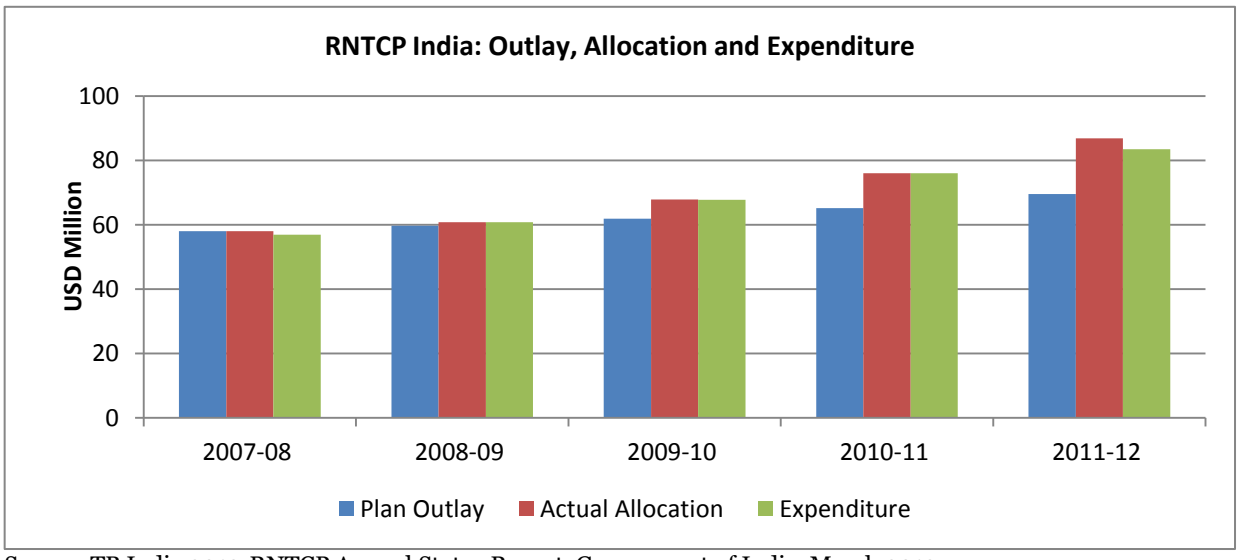
While the 12th Plan allocation is significantly higher than the 11th Plan allocation of US $358 million (see figure below), it is nevertheless short of the estimated requirement of US $1.2 billion. The funding gap is especially acute in the first two years of the 12th Plan period given the delay in finalization of the Plan and that additional government resources are expected to increase significantly only starting in the 2014-15 fiscal year. A funding gap of US $128 million (leading to the high estimate of expected Global Fund inputs by the CCM) in the next implementation period is primarily due to the lower than anticipated budget allocation 2013-14. Conversely, in subsequent years, the anticipated gap is significantly lower due to availability of higher than expected funding from the Global Fund and UNITAID. At the time of approval of the RNTCP allocation, US $210 million and US $11 million was anticipated from the Global Fund and UNITAID, respectively[4]. According to this scenario, savings from the first implementation period yield an additional US $60 million from the Global Fund in the next phase. Similarly, increased UNITAID support of US $40 million is now anticipated for the TB program in the 12th Plan period for strengthening MDR-TB diagnostic capacity (US $33 million in the next implementation period of the current grant).

[3] TB India 2013-RNTCP Annual Status Report, Government of India, March 2013
[4] TB India 2013-RNTCP Annual Status Report, Government of India, March 2013



Source: TB India 2013-RNTCP Annual Status Report, Government of India, March 2013

Given recent trends in actual allocation of funds and spending (see figure below) and government commitments, planned resources for the RNTCP are likely to materialize – at least to some extent. In previous years the RNTCP was primarily financed through World Bank loans with significant contribution from the Global Fund and other partners such as DFID and USAID. In the next phase, funding from the World Bank, DFID and USAID will not be available (excepting a TA package valued at some US $13 million in the current US fiscal year). Moreover, compared to incremental funding increases of previous years, the ambitious 12th five year plan goal of "Universal Access for quality diagnosis and treatment for all TB patients in the community" requires a significantly higher scale of funding. Commitment of substantial government investment notwithstanding, Global Fund support is critical to ensure scale up of the program in line with the NSP targets.



Source: TB India 2013-RNTCP Annual Status Report, Government of India, March 2013

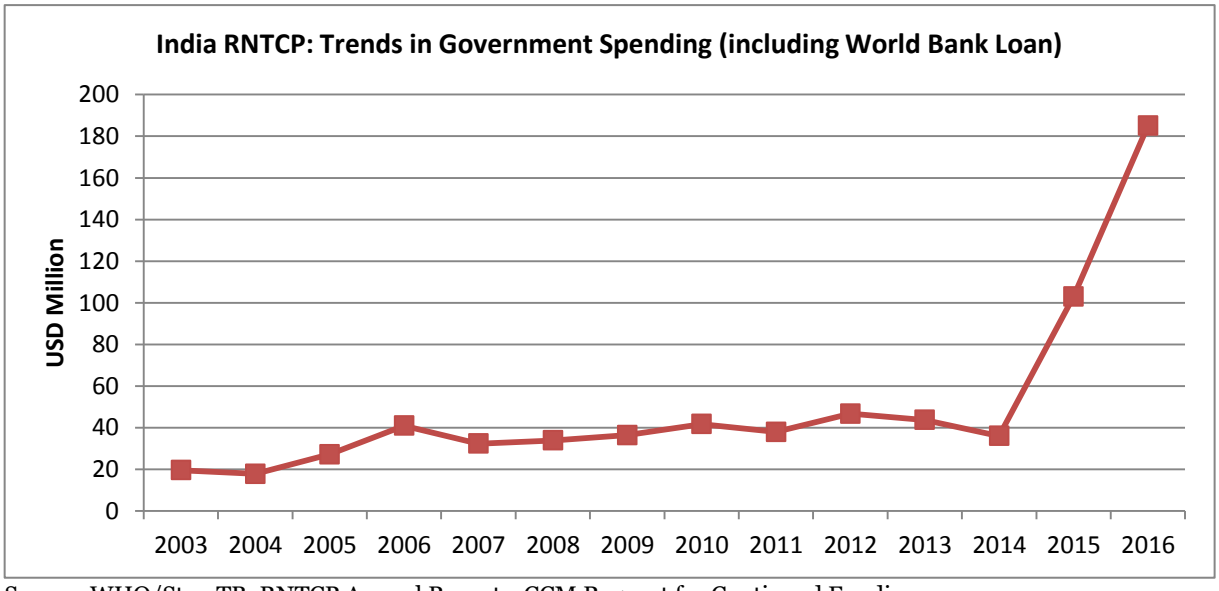
Counterpart Financing Compliance

Does the country currently comply with the counterpart financing requirements based on the income classification for the country[5]	**Yes**

(1) Availability of reliable data to assess compliance
As a centrally sponsored scheme, data on allocation of government resources to RNTCP and their expenditure is available from detailed demand for grants and financial accounts of the Ministry of Health and Family Welfare (MoHFW). The RNTCP is implemented through the National Rural Health Mission (NRHM) and funds are released by the Central TB Division (CTD) through the MoHFW to the NRHM State Health Societies (SHS). From the SHS, funds are subsequently released to District Health Societies for program implementation in districts. The State and District Health Societies have a separate sub-account for TB Control Activities. The accounts of State/District Health Societies are audited by empaneled auditors and at central level by CAGI, a division of Department of Economic Affairs (DEA), Ministry of Finance, Government of India. The country also routinely reports TB spending data as part of its annual reporting to WHO. Since, India is one of the high TB burden countries; program financing data is annually published in WHO's Global TB Reports. 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 TB specific expenditures across different States. As a result, actual government spending on TB is grossly 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 government spending earmarked for RNTCP in FY2010-11 to FY 2012-13, the counterpart-financing share is 29% and meets the minimum threshold requirement of 20%for Lower LMI countries. In the next implementation phase, the counterpart financing share will increase to 51%.

(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 fairly stable in recent years with incremental increases over time (see figure below). In the next implementation period, this trend is likely to accelerate given the ambitious targets proposed for the 12th Five Year Plan. Of the approved allocation of US $880 million, about US $650 million is anticipated from government resources.



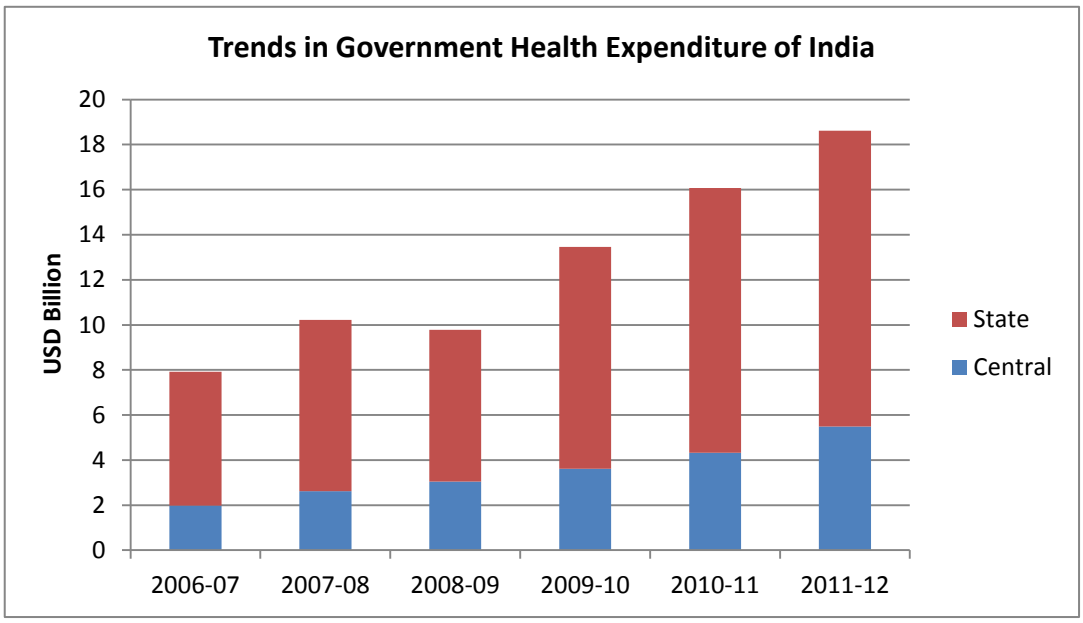
Source: WHO/Stop TB, RNTCP Annual Reports, CCM Request for Continued Funding

(4) Stable or increasing government contribution to health sector

Between FY 2006-07 and FY2011-12, government health spending has increased at an average annual rate

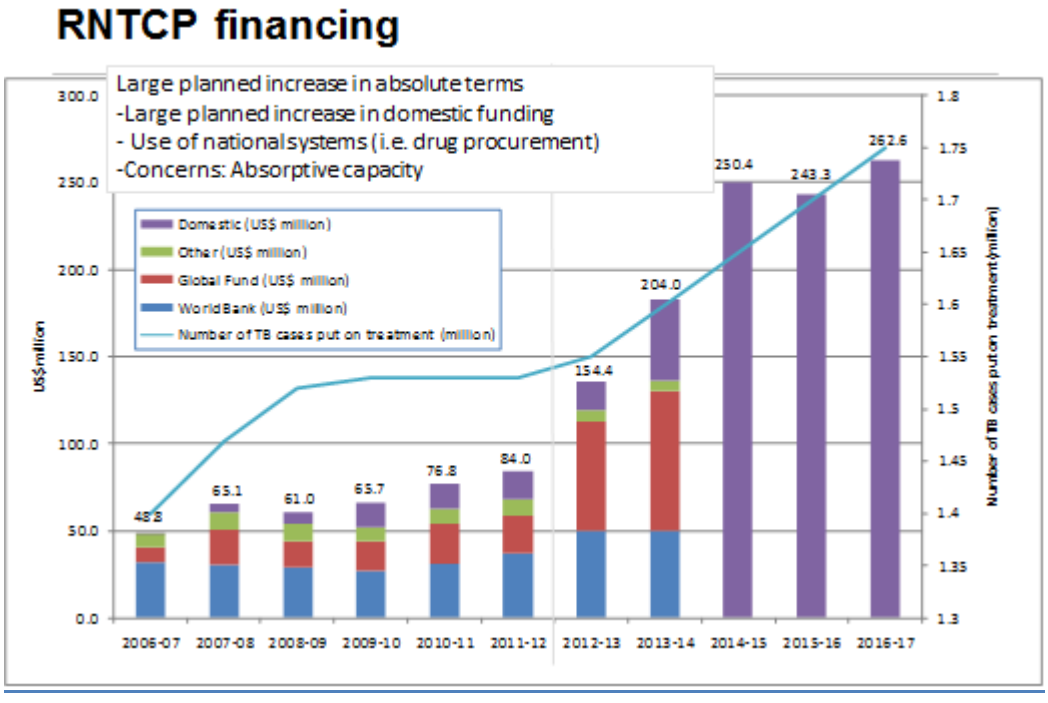
[5] http://www.theglobalfund.org/en/application/applying/ecfp/eligibility/

of around 19.5%. While there has been a significant infusion of government resources to health sector in recent years, public spending on health at around 1.04% of the GDP, is among the lowest in the region. There is high burden of out of pocket expenditure on health, which accounts for more than 65% of the total health spending. There appears to be a strong political will to address the issue of low public health spending. The 12th Plan Five Year Plan has tripled its allocation to health aiming to increase government spending on health to around 2% of the GDP by the end of the 12th Plan period (2012-17).



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

MoHFW projections for RNTCP funding take the current form:



Over the past year, this optimistic picture has been modified by the cancellation of the US $100 million World Bank loan and significant reduction in the anticipated RNTCP budget level for 2013 and 2014, the years immediately preceding the planned "take-over" of RNTCP funding by the government. The Indian Union Budget for 2012–13 allocated 373.3 billion rupees (ca. US $7.2 billion) for health and family welfare, an 8% increase over the previous year's budget. This marginal increase, after adjusting for inflation, amounts to a decline in real rupee terms. The ministry's corresponding request for RNTCP was approximately INR 936 crore (ca. US $180 million) for 2012-13. It actually received about INR 710 crore (ca.

US $136 million). The combined effect of these two shortfalls amounts to roughly US $150 million, which has the potential to "snowball" into future budgets. The bottom line is that India reports over two million new TB cases every year and has almost same TB control budget as the US, which reports just 10,000 cases.

Partnerships

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

The key technical, financial, and implementation partners providing support in implementation of India's national TB program in India include donors: World Bank, USAID/CDC, Bill and Melinda Gates Foundation, and DFID (until recently) and technical agencies: CDC, PATH (both funded through USAID), WHO (with US and Global Fund support) and a range of grant sub-recipients. The latter include the Catholic Bishops Council of India (CBCI), Emmanuel Hospital Association (EHA). Indian Medical Association (IMA), LRS Institute of Tuberculosis & Respiratory Diseases, All India Institute of Medical Sciences (AIIMS), over 300 medical colleges, and a number of corporate hospitals.

With the perceived economic growth in India, most funders are decreasing their assistance; World Bank and DFID-support for TB control ended in 2012; USAID support in 2013 is pegged at US $13 million, channeled through CDC, WHO, PATH and the Union. Peter Small of BMGF is returning to the US in 2013 following an 18 month stay in the country. Puneet Dewan will continue to lead the Gates Foundation technical assistance effort in support of RNTCP.

The Secretariat is actively engaged with grant implementers, national stakeholders and development partners on a range of issues. These include governance concerns, financial and audit issues, data gaps, health product stock-outs and budget allocations.

Most recently, the team has engaged with the Mumbai Municipal Corporation (city government) which will forward its forthcoming draft program for urban TB control through the CCM for Global Fund consideration under the New Funding Model. This will help address the key policy challenge facing RNTCP: how to cover millions of urban slum dwellers with effective TB services in a setting where most TB sufferers do not go to public health service providers.

2.2 CURRENT IMPLEMENTATION PERIOD PERFORMANCE

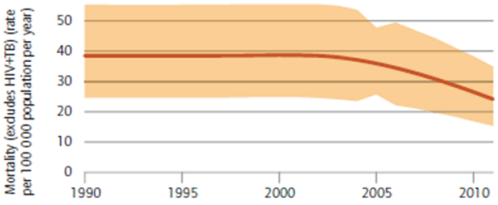
Progress Towards Impact / Outcome

Proposal Goal : To reduce significantly the burden, socio-economic impact, and transmission of TB in India

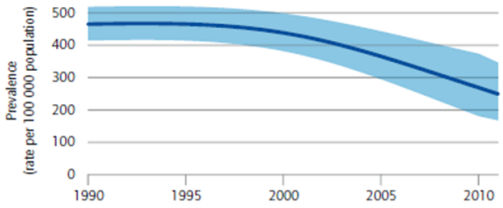
			Year 1 (2010 data)		Year 2 (2011 data)	
Impact and Outcome Indicator	Baseline Year	Baseline Value	Target	Result	Target	Result
TB incidence rate (NSP) (ARTI)	67/100,1000	2009	67/100,1000	75/100,1000	65/100,000	75/100,1000
TB incidence rate (All) (including HIV) (WHO)	190 (171-210)/ 100,000	2009	Same as baseline	185 (167-204)/ 100,000	3% decrease	181 (163-199)/ 100,000
TB prevalence rate (including HIV) (WHO)	289/100,000	2009	Same as baseline	269/100,000	6% decrease	249/100,000
TB mortality rate (including HIV) (WHO)	29 (18–41) /100,000	2009	Same as baseline	27 (17–38) /100,000	Same as baseline	24 (15–35) /100,000
Notification rate: new smear positive TB cases (WHO)	52/100,000	2009	≥51/100,000	51/100,000	≥51/100,000	52/100,000
Treatment success rat : new smear positive TB cases	87%	2008 (cohort)	≥85%	87% (2009 cohort)	≥85%	88% (2010 cohort)
Treatment success rate: laboratory confirmed MDR-TB	42%	2008 (cohort)	52%	52.9% (2009 cohort)	-	-

Comments:

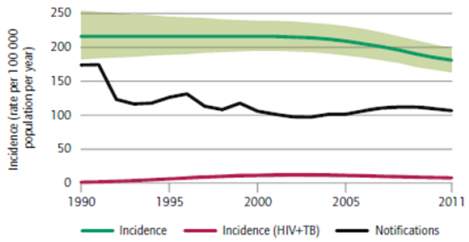
India has made significant progress in TB control both in terms of achieving the targets of its national strategic plan as well as the impact indicators agreed under the Global Fund grants. According to its Annual report for 2012, RNTCP achieved the National Strategic Plan (NSP) case detection rate target of more than 70% and a treatment success rate of greater than 85% in 2007 and has persistently maintained these global targets for TB control since. We note that these figures omit millions of urban poor without ready access to the public health system. Nevertheless, a comparative snapshot of the trends in TB burden, Prevalence Rate, Case Detection and Treatment success rates is depicted in the figures below:



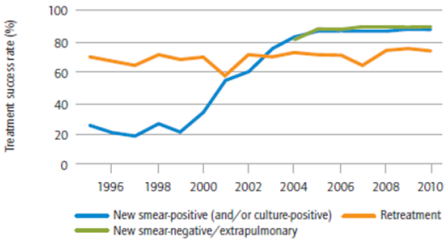
Mortality rate per 100,000 in 2011	India: 24
	SEARO: 26
	High Burden Countries: 19
	Global: 14



Prevalence per 100,000 in 2011	India: 249
	SEARO: 271
	High Burden Countries: 222
	Global: 170



Incidence per 100,000 in 2011	India: 181
	SEARO: 189
	High Burden Countries: 163
	Global: 125



Treatment success rate (2010 cohort)	India: 88
	SEARO: 88
	High Burden Countries: 88
	Global: 87

The WHO Global Tuberculosis Report 2012 indicates significant progress in terms of TB burden in India, especially between 2005 and 2011. The Report estimates that while 2,200,000 incident cases should have contracted the disease in India in 2011, the trend of incident rate is decreasing significantly between 2005 and 2011 (209 and 181 per 100,000 populations respectively).The report shows similar trends for estimated prevalence of TB and estimated mortality due to TB (excluding HIV); while the burden of disease is still very high, India is believed to have brought down the TB prevalence and mortality as estimated figures show that against population growth, the prevalent cases have decreased from 4,200,000 in 2005 to 3,100,000 estimated cases in 2011 (26% reduction). Estimated number of deaths due to TB (excluding HIV) also dropped between 2005 and 2011 (from 410,000 to 300,000 annually) (27% reduction).

The Global Tuberculosis Report however shows that in 2011 the contribution of public–private and public–public mix (PPM) to notifications of TB cases in India is the lowest among twenty one listed countries; as only 13 991 new TB cases notified in 2011 accounting only 2.1% of total notifications of new TB cases in 2011 are reported from through PPM in India. The Joint Monitoring Mission in 2012 also encourages India for greater focus on care providers in the private sector, and use the system to notify cases, provide treatment support and report treatment outcomes for all cases managed by them, irrespective of the treatment regimen and source of drugs, as long as the diagnostic practices and regimen are consistent with Indian/international standards of TB care.

The Global Report also indicates that in general progress in responding to multidrug-resistant TB (MDR-TB) remains slow; while the number of cases of MDR-TB notified in the 27 high MDR-TB burden countries is increasing and reached almost 60,000 worldwide in 2011, this is only one in five (19%) of the notified TB patients estimated to have MDR-TB. In the two countries with the largest number of cases, India and China, the figure is less than one in ten; scale-up is expected in these countries in the next three years.

With Global Fund support, India has recorded the following specific achievements:

- 95% of new smear patients diagnosed and started on treatment in the project districts;
- 337,637 patients of all types of TB were put on treatment with a success rate of 89%. Treatment success rate among New Smear Positive (NSP) patients living in tribal areas in the 8 project states was 79%;
- In 89% of the districts at least 30% of the TB patients received DOT through community volunteers;
- Against a target of 13,438 for the period October 2011 to September 2012, a total of 11,019 MDR-TB patients were put on treatment, reflecting an achievement rate of 82%;
- The program has scaled up diagnostic service for drug resistant TB by establishing molecular labs with Line Probe Assay (LPA) based DST diagnosis and BSL level 3 MDR TB laboratories in 35 states. It has provided the required infrastructure, additional lab staff and logistical support for 43 MDR TB laboratories;
- Through the Indian Medical Association (IMA), the program has reached out to 25,407 private practitioners and has signed 2,853 MOUs with IMA members in the RNTCP in project areas;
- The program has raised promoted behavior change communication, advocacy, and public awareness in 374 districts through community outreach, public media (such as radio and TV), and community engagement.

These successes have contributed to the successful achievement of the national targets on case detection, treatment success, and universal access to diagnosis and treatment.

PROGRAM IMPACT RATING	Demonstrated Impact

Financial Performance and Programmatic Achievements

Financial Performance at Program Level: Please refer to section 5 Current Phase/Implementation period performance in the CCM RFR

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)
GOV	1	$62,816,902	$62,816,900	$13,315,541	$37,382,247
ML/BL	1	$15,287,931	$15,287,930	$9,462,141	$7,901,281
PS	1	$2,202,090	$4,404,182	$609,126	$2,690,075
Grand Total	**3**	**$80,306,923**	**$82,509,012**	**$23,386,808**	**$47,973,603**

Disbursed vs Adjusted Budget at cut-off date	**28%**
Expenditure vs Adjusted Budget at cut-off date	**58%**
Current Implementation period % time elapsed	**67%**

Programmatic Achievements versus Finance Performance: Finance

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
TB Treatment	ACSM (Advocacy, communication and social mobilization)	$2,148,302	$1,239,001	58%	**97%**
	Community TB care	$618,389	$308,906	50%	

	High quality DOTS	$450,124	$239,716	53%	104%
	High-risk groups	$138,599	$80,279	58%	
	Human Resource Development	$2,513,120	$1,394,876	56%	97%
	M&E	$1,969,717	$1,119,387	57%	41%
	MDR-TB	$14,770,440	$10,392,909	70%	87%
	PPM / ISTC (Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	$208,806	$90,261	43%	
	Procurement and Supply management	$6,676,488	$4,749,313	71%	100%
Supportive Environment	ACSM (Advocacy, communication and social mobilization)	$7,449,619	$3,915,023	53%	94%
	All Care Providers	$3,565,791	$2,090,422	59%	
	Community TB care	$591,936	$76,818	13%	
	Human Resources Development	$1,375,751	$542,456	39%	
	M&E	$675,229	$418,105	62%	
	Other - Overheads	$1,129,431	$628,328	56%	
	Overheads	$412,286	$245,134	59%	
	Political Commitment	$15,586	$10,062	65%	
	PPM / ISTC (Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	$493,704	$189,585	38%	
	Program Management and Administration	$19,712,623	$11,935,906	61%	
	Programme-based operational research	$141,413	$65,465	46%	
	Supportive Environment: Health systems strengthening	$132,401	$51,836	39%	
	Supportive Environment: Sufficient Drug and Laboratory Supplies	$2,873,701	$1,293,555	45%	
	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)				81%
	TB/HIV				99%
TB Detection	Community System Strengthening	$67,694	$12,171	18%	
	Improving diagnosis	$12,828,044	$6,129,833	48%	102%
	M&E	$985,561	$525,907	53%	
Health System Strengthening (HSS)	HSS (beyond TB)	$249,916	$138,424	55%	
	Other - Political Commitment	$53,208	$2,368	4%	
TB/HIV Collaborative Activities	TB/HIV	$261,134	$87,558	34%	
Grand Total.		**$82,509,012**	**$47,973,604**	**58%**	

Average Performance on Top 10	**93%**
Average Performance All Indicators	**92%**

OVERALL PROGRAM RATING	**B1**[6]

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

[6] Adjusted for management issues.

The Global Fund supports three active consolidated SSF TB grants in India implemented by Central TB Division (MoH&FW), The Union and World Vision India in support of the Revised National TB Control Program (RNTCP). Begun in 1998, RNTCP is the largest such government program in the world, aimed at providing the Indian population access to WHO-recommended "Directly Observed Treatment, Short Course (DOTS) regimens. Under the Round 2 RCC grant, RNTCP registered approximately 427,000 people for DOTS treatment annually and afforded up to 1,100 patients access to free second-line drugs (SLDs) at DOTS-Plus pilot sites. The Round 9 Grant addressed MDR-related challenges such as insufficient laboratory capacity for detection and follow up of drug resistant cases and funding gaps for procurement of second line drugs. It also included a private sector component managed by the Indian Medical Association (IMA) and introduced 2 civil society PRs in support of the RNTCP. This was done in order to engage more community based care providers to improve care and control, especially for marginalized groups in 374 districts across 23 states. The current SSF grants finance the expansion of activities that were previously financed under Round 2 RCC and Round 9 grants.

2.3 NEXT IMPLEMENTATION PERIOD REQUEST

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

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

In India, TB predominantly affects people with poor socio-economic backgrounds, including urban slum dwellers, tribal populations, HIV-positive and other immune-compromised people, women and children. The Global Fund-supported grants focus specifically on these populations. For instance, the TB SSF grant to be implemented by IUATLD and WVI targets nearly 170 million women, 150 million children, 250 million poor, 50 million tribal and 40 million slum dwellers. The two TB SSF grants implemented by the civil society partners made effective efforts to develop local inventories of vulnerable groups (mapping of at-risk, socially vulnerable and marginalized groups) in the project districts. In the next implementation period these programs will deploy innovative-targeted case finding activities interventions to expand RNTCP services among the most vulnerable and at-risk populations. The program has plans to further intensify the efforts of the Axshya volunteers in retracing defaulters or those with missed doses in the identified MARPs areas of the target districts. In addition, TB Forums have and will continue to serve as a "Voice" for the TB patients and help to overcome district level challenges faced by them. The Project will continue to conduct TB awareness campaigns on globally identified health days and conduct suspect screening camps in "mass gatherings" especially during the festival seasons.

The second implementation period of the program will address gender mainstreaming by setting a minimum proportion of the overall sputum samples collected to be from women. Thus the achievements of the first implementation period will be replicated and the implementation gaps will be addressed accordingly in order to make the next implementation phase of the grant more responsive to the specific needs of women.

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

The CCM indicates that RNTCP is committed to ensuring and promoting the highest attainable standard of health for all, through services that are available, accessible, affordable, and of good quality, particularly for those who are the most marginalized, vulnerable or at highest risk. A tribal action plan for the marginalized is in place to address challenges faced by such populations. RNTCP also has revised norms and special schemes for NGOs to provide services for marginalized and vulnerable populations in urban slums.

Socio cultural barriers among marginalized and vulnerable population are being addressed through involvement of civil society involvement in behavior change communication at the community level. Likewise, the program will further gender mainstreaming by setting a minimum proportion of overall sputum samples collected to be from women.

The project's goal in achieving universal access ensures a move towards equity. RNTCP's existing strategy already provides for free, decentralized and patient-friendly services, quality-assured sputum microscopy

and use of standard first and second line TB drugs across the country. In addition to its own mechanisms for covering marginalized populations and difficult areas, RNTCP incorporates a strong commitment to make quality TB services locally available at the community-level by extending their reach to all segments of the population in the country in collaboration with civil society, community providers and other private providers.

Please describe the activities proposed for the next implementation period.

Continuing activities under RNCTP, CTD and its SSF Co-PRs intend to address identified challenges in TB control, among them, inadequate coverage of vulnerable and marginalized populations such as the urban poor, uneven quality of service provision by private and public providers, insufficient laboratory capacity for diagnosis and follow-up of requisite drug resistance cases in the country and funding gaps for procurement of second line drugs for all MDR-TB cases. Improved access to quality TB care through strengthening of public private partnership and civil society engagement will be a key aspect of this effort.

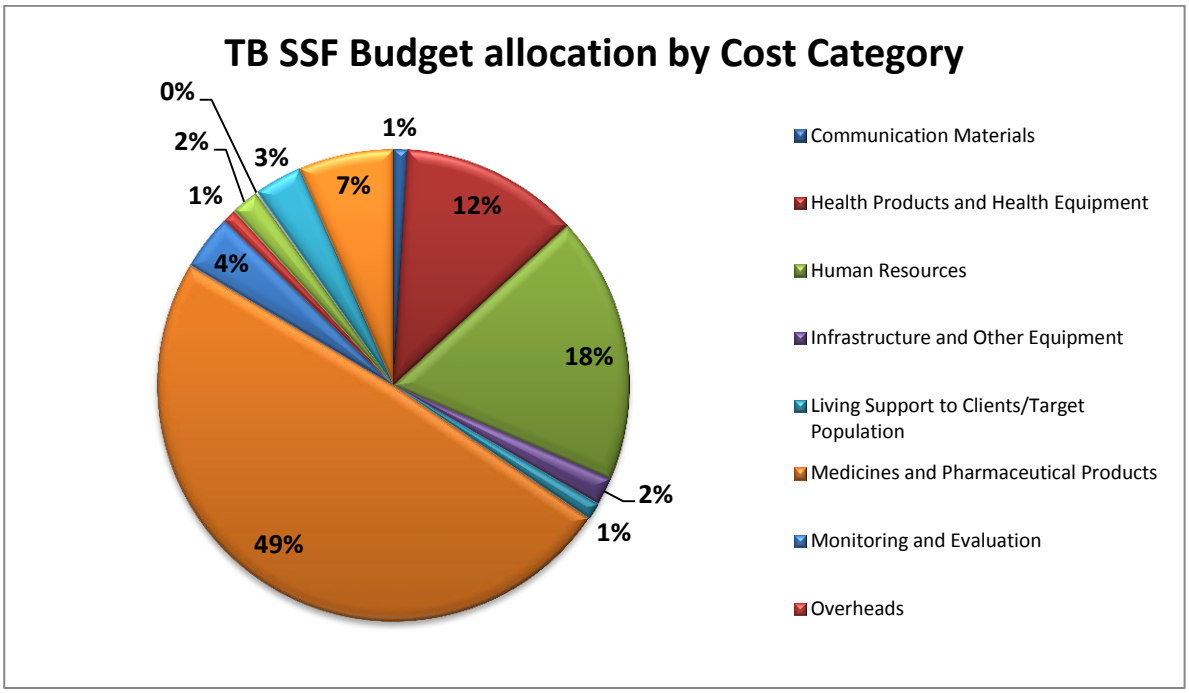
The SSF grant is part of RNTCP's plan for 2012-2017. The "National Strategic Plan" seeks to move towards a "TB-free India" by providing universal access to quality TB diagnosis and treatment for all TB patients in the country. This implies sustaining the program's to date, finding unreached TB cases before they can transmit infection, and treating all of them more effectively, thereby preventing the emergence of MDR-TB.

Under the grants to be implemented by the two civil society partners (World Vision and IUATLD), the CCM aims at improving the reach, visibility and effectiveness of RNTCP through civil society support in 374 districts across 23 states by 2015 in order to improve TB care and control, especially for marginalized and vulnerable populations including TB-HIV patients. Besides continuing with the activities successfully implemented in the first implementation period, the two civil society grants will implement the following interventions and strategies which will provide a critical support to the National Program in achieving its intended targets and goals:

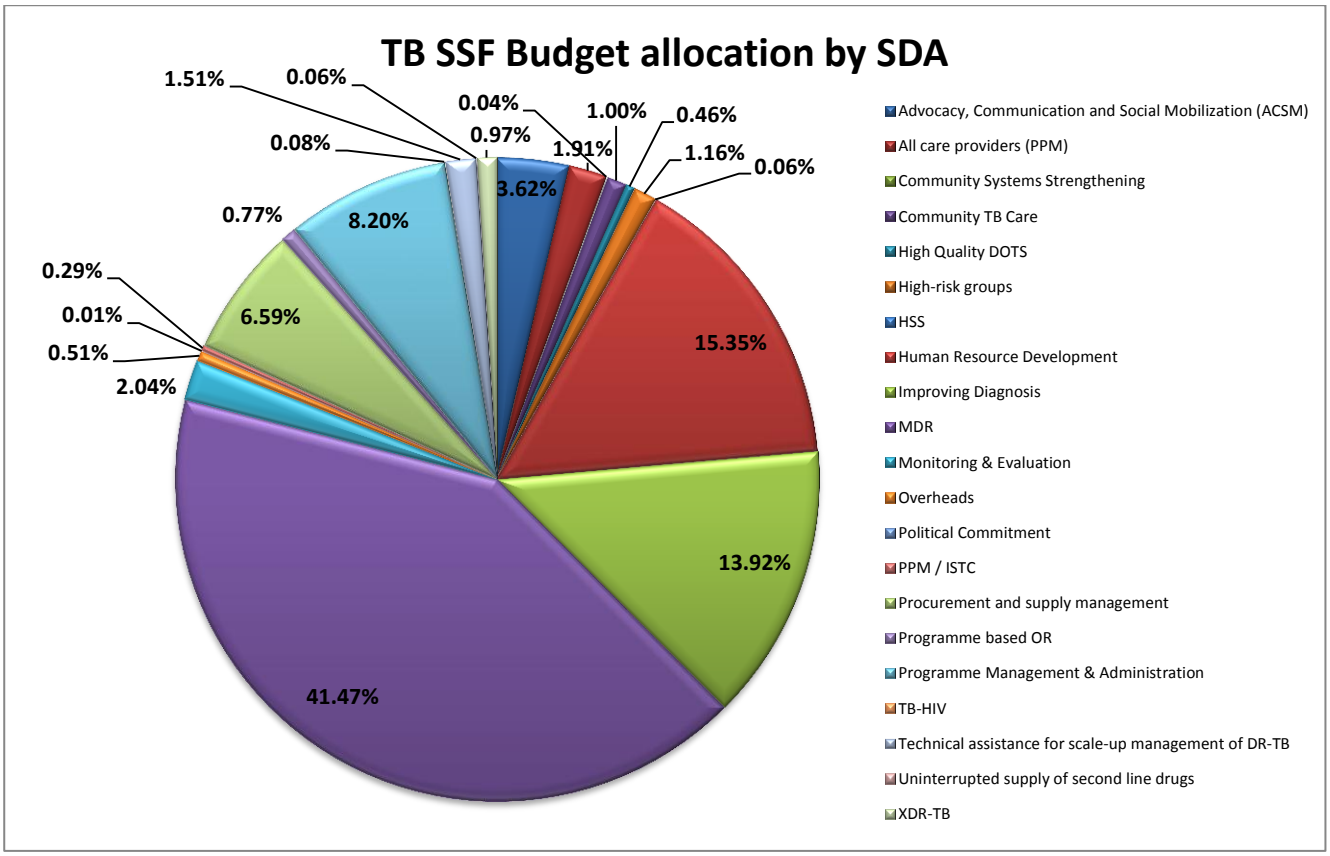
1. Enhancing case notification and improving treatment initiation in the 374 target districts;
2. Supervision of registered TB patients through community volunteers;
3. Developing new partnerships for TB control and enhancing awareness of people with correct knowledge about TB systems and treatment;
4. Sensitizing TB patients on their "Rights and Responsibilities" as per Patient Charter and the formation of "Axshya villages" which are the model villages demonstrating community ownership of TB control;
5. Sensitising NGOs on RNTCP schemes and ensuring that the target districts have an active TB officer;
6. Training rural healthcare providers and Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) providers who have been successfully engaged with RNTCP;
7. Sensitizing Medical laboratories on the ban on TB serological tests for diagnosis of TB and mandatory notification of TB and referring symptomatic chest patients who successfully undergo smear examination at DMC; and
8. Engaging and sensitizing members from DLNs on TB and targeted interventions for TB control.

While reducing the average default rate of smear positive re-treatment patients in the 374 target districts, the above interventions are expected to increase the annual new smear positive case notification and treatment success rates.

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

There is no change to either fund allocation between PRs or change in the institutional arrangements.

However, in case of PR1 (CTD), it is proposed to replace the 27 districts of Uttar Pradesh (UP -- which were funded under the grant in the first implementation period) with Karnataka. This has been done because only 27 out of 80 districts of UP were funded under the Global Fund grant (the remainder being funded through the domestic budget), which caused administrative difficulties. As a result, 8 states will be funded in their entirety under the SSF supported program.

With regard to the budget, modifications have been noted to certain proposed activities as compared to the TRP approved budget. The reasons for variance between the original TRP approved budget for Years 3-5 and proposed budget for Years 3-5 has been provided in Annexure to the Budget Review Checklist for the 3 PRs (CTD, Union and World Vision India). Most notably, drug costs now account for 67% of the adjusted budget request for the next 2.5 years of SSF-II.

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

The grant is managed as a reimbursement scheme by India's government and the Global Fund so shifts in budget allocations can be agreed, with the understanding that no changes in RNTCP are anticipated at this time within the current budget envelope.

The Union aims to adopt a robust approach towards active case finding through community engagement in the next phase of project implementation. There has been also concern regarding the effectiveness and value for money of the media campaign activities. Accordingly, the project has reprogrammed activities so that the media campaign activities are being replaced with community based activities and strengthening involvement of healthcare providers in the second implementation period. In addition emphasis will be given to community based case finding strategy amongst 'Most At Risk Populations' (MARPs, or vulnerable groups). During the second implementation period of the project, there are no changes in the goals and objectives of the project as these align with the RNTCP's National Strategic Plan (NSP) for 2012-17. The experience from the first implementation period has been translated into revised strategy of the project activities for higher impact and value for money. There are a revisions proposed in the service delivery area related indicators based on the experience from the first implementation period and to align the project with National Strategic Plan 2012-2017 (NSP) and focusing on vulnerable groups.

3. RECOMMENDATION BY PRINCIPAL RECIPIENT

3.1 PRINCIPAL RECIPIENT 1

Grant Number	IDA-T-CTD
Principal Recipient	Department of Economic Affairs (DEA) of the Ministry of Finance, Government of India
Grant Start date	01/10/2011
Grant End date	31/03/2013

a. SECRETARIAT PERFORMANCE RATING	**B1**

Secretariat rationale for the Recommended Performance Rating

The grant rating tool generated an 'A2' rating for the grant based on the programmatic performance. However, the overall grant rating has been downgraded from 'A2' to 'B1' due the following issues noted during the first implementation period:

1. Data quality issues with respect to two indicators examined during a recent OSDV;
2. Inadequate monitoring of the performance of the SRs;
3. Incomplete compliance with the conditions precedent and special conditions of the grant agreement, particularly those related to drug forecasting, quality assurance and PQR updating; and
4. Lack of dedicated staff for managing the Global Fund grant, causing delays in submission of

PU/DRs.

b. SECRETARIAT RECOMMENDATION CATEGORY	Go

Secretariat rationale for the Recommendation Category

The quantitative rating of the program over during the first period of implementation to the cut off period is 'A2'. The Secretariat recommends a rating downgrade to 'B1' in light of the issues described in the preceding section.

The PR has taken/planned to take some measures to address the above issues.

- In March 2013, the PR met 8 conditions precedent (CPs)/special conditions (SCs) and made progress on 5 CPs/SCs (out of the 14 total conditions).
- The PR is planning to procure drugs through GDF to ensure the Global Fund quality assurance policy compliance and reduce administrative bottlenecks.
- The PR also budgeted for 3 staff (M&E, finance and grant management) to oversee the Global Fund grant in the next phase.

The Secretariat further asked the PR to:

- Follow up and closely monitor the MDR TB program to ensure adequate infrastructure is in place to timely diagnose and put patients on treatment and closely follow up on cases to improve the success rate. PR also needs to keep track of drug stocks to ensure no wastage or expiry and non-interruption of drug supplies.
- Improve HIV/TB collaborative activities, especially in states where the collaborative activities have not been fully implemented.
- Closely monitor, supervise and review reported results at field levels to ensure the availability of programmatic records and data accuracy.
- Improve the quality of microscopy services.
- Ensure full compliance with the quality assurance policies of Global Fund and try to expedite the process of procurement (either through GDF or in-country through Procurement Agent) of 1st line drugs would be expiring in the coming months.
- Submit, as soon as possible, a revised PSM plan, Performance Framework and budget for the grant by taking into account the comments provided by the Secretariat. This was done on 22 April 2013.

Given the epidemiological situation and the country's objective need for additional resources, there are no contextual / programmatic / data integrity issues which should delay grant renewal. The PR has been successfully implementing the SSF grant (following the implementation of Round 2 RCC & Round 9 grants) The renewal request represents a continuation of the first implementation period activities. Most outstanding issues can be addressed during grant negotiations and/or through appropriate conditions in the Grant Agreement. Accordingly, the CT recommends a 'Go' decision for the next phase of the grant, in accordance with requirements of the OPN on grant renewals.

c. RECOMMENDED INCREMENTAL AMOUNT	US $170,592,422

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

The CCM/PR submitted a total budget of USD 258,566,446 for 2.5 years, 80% of the total budget allocated to procurement of drugs. This was in line with the objective of the grant. The total budget included the budget for the unreleased first implementation period commitment of USD 44,922,950. Based on the LFA detailed budget review feedback, the Secretariat made the following adjustments reducing the total budget by US$10,560,902 as detailed below:

Cost Category	CCM/ CTD Budget	GF Adjustments	Adjusted Budget
Human Resources	23,877,469	-254,241	23,623,228
Technical Assistance	7,137,930	-25,068	7,112,862
Training	2,851,238	0	2,851,238
Health Products & Health	27,930,386	772,222	28,702,608

Equipment			
Medicines & Pharmaceutical Products	141,573,180	9,259,454	150,832,634
Procurement & Supply Mgnt. Costs	703,730	632,448	1,336,178
Infrastructure & Other Equipment	2,566,630	-477,778	2,088,852
Communication Materials	793,676	972	794,648
Monitoring & Evaluation	4,005,672	-34,968	3,970,704
Living Support to Clients	0	0	0
Planning & Administration	1,559,689	0	1,559,689
Overheads	643,896	687,861	1,331,757
Other	0	0	
TOTAL	**213,643,496**	**10,560,902**	**224,204,398**

The Secretariat recommends a budget of US$ 244,339,432 for the next Implementation Period (inclusive of US$20,135,034 budget after cut-off). An **incremental amount of US$ 170,592,422** is recommended after deducting undisbursed funds and cash balance as of the cut-off date. This represents **99.8%** of the TRP adjusted amount which is above the investment range for a grant with B1 performance rating downgraded from A2 due to management issues.

Grant Performance rating	Adjusted TRP clarified amount for next implementation period	=	Indicative investment range % of adjusted TRP clarified amount	
			High	Low
B1	**$170,942,668**		**89%**	**60%**

3.2 PRINCIPAL RECIPIENT 2

Grant Number	IDA-T-IUATLD
Principal Recipient	International Union Against TB and Lung Diseases
Grant Start date	01/10/2010
Grant End date	31/03/2013

a. SECRETARIAT PERFORMANCE RATING	A2

Secretariat rationale for the Recommended Performance Rating

The Global Fund's grant rating tool generated a quantitative A2 rating for the grant's period ending 30 September 2012. Overall performance of this grant merits an "A2" rating based on the following:

1. The PR has demonstrated very good technical performance in achieving the intended targets on most of the indicators. The PR achieved over 100% of its targets on 3 out of 10 coverage indicators. The PR's performance on the remaining indicators was over 80%;
2. No major programmatic, management, or data quality issues were noted in the first implementation period of this grant. The PR is in a good standing to implement the next phase of the grant in a timely and effective manner;
3. The PR has met all the applicable conditions precedents and have completed most of the Global Fund's management recommendations;
4. The grant's cumulative expenditure rate as of the cut-off date was approximately 39%;
5. The LFA has identified some minor challenges which we believe will be adequately addressed by the PR during implementation of the next phase of this grant. These issues mainly include lack of documented M&E procedures for data aggregation and analysis, lack of proper supervision at the SR level, staff attrition at the district level, and delayed implementation of the MIS software.

b. SECRETARIAT RECOMMENDATION CATEGORY	Go

Secretariat rationale for the Recommendation Category

The TB SSF grant implemented by IUATLD (called Project "Axshya" in India which means "free from TB"), helps RNTCP expand its reach, visibility, and effectiveness, engage community based providers to improve TB services for women, children, marginalized, and vulnerable population such as TB-HIV co-infected individuals. A component of RNTCP's ACSM, training and research strategy, Axshya is implemented by IUATLD jointly with its co-PR WVI. The Project reaches people in 374 districts of India (IUATLD implements the program in 300 whereas WVI implements the program in the remaining 74 districts).

This grant plays an important role in preventing TB among the urban and rural population of India living in the target districts. Project Axshya reaches nearly 570 million people in the 374 districts, which include 170 million women, 150 million children, 250 million tribal and 40 million people living in urban slums. The project provides trainings to RNTCP staff on key subjects such as MDR-TB, epidemiology, program management, and operation research. In addition, the project conducts KAP surveys and communication needs assessment.

The recommendation category for the IUATLD rant is based on the following factors:

1. The PR's performance in achieving its targets in the first implementation period was very good. The grant has merited a quantitative grant rating of A2 which accurately reflects the PR's performance as of the cut-off date. The grant has played a vital role in reaching out to the marginalized groups of Indian society, such as tribal populations, slum dwellers, women, children and TB-HIV co-infected people. TB prevention and access to TB services in these vulnerable populations is of critical importance in achieving the objectives of the 12th national plan for TB control in India.
2. The PR has met all the applicable grant conditions and has demonstrated very good program management capacity. No major issues in data quality were noted in the first implementation period.
3. In response to Global Fund concerns, the Union has changed the focus of one its major SRs, PSI, from mass media campaigns to community-based behavior change in order to achieve greater value for money.

c. RECOMMENDED INCREMENTAL AMOUNT	US$ 23,600,360

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

The CCM submitted a request of US $ 37,352,507 for the next Implementation Period (inclusive of budget after cut-off date), which represents 100% of the ceiling amount available for this PR (Union) after the 90% Board mandated reduction on the original TRP amount.

The LFA recommended a number of adjustments resulting in a lower budget amount of US $ 36,816,631 for the next Implementation Period. The Secretariat agrees with the LFA recommendation and can accept an additional negative adjustment of US$ 64,740 on the budget for US$ 36,751,890.

Adjustments in detail:

Cost category	CCM request	GF recommended	Variance
Human Resources	8,875,215	8,344,135	- 531,080
Technical Assistance	871,277	863,113	- 8,164
Training	11,334,256	11,440,076	105,820
Health Products and Health Equipment	-	-	-
Medicines and Pharmaceutical Products	-	-	-
Procurement and Supply Management Costs	-	-	-
Infrastructure and Other Equipment	162,188	128,993	- 33,195
Communication Materials	1,238,674	1,138,674	- 100,000
Monitoring and Evaluation	3,751,579	3,751,579	-

Living Support to Clients/Target Population	-	-	-
Planning and Administration	3,436,152	2,934,117	- 502,035
Overheads	1,780,161	2,248,199	468,038
Other	-	-	-
TOTAL	**31,449,504**	**30,848,887**	**- 600,616**

The CCM submitted the budget with no details or breakdown on the overhead cost and with non-compliance with the ICR policy. The overhead cost will be discussed and negotiated prior to grant signing.

There are several potential savings in the CCM submitted budget, such as lump sums where the reasonableness could not be assessed and therefore these costs will be further negotiated.

In total, the Secretariat recommends a budget of US$ 36,751,890 for the next Implementation Period (inclusive of budget after cut-off). Less cash and the undisbursed amount from the current Implementation Period, this produces an **incremental amount of US$ 23,600,360**. This represents **97.5%** of the TRP adjusted amount which is within the investment range for a grant with A2 rating.

Grant Performance rating	Adjusted TRP clarified amount for next implementation period	=	Indicative investment range % of adjusted TRP clarified amount	
			High	Low
A2	**US$ 24,201,875**		**100%**	**90%**

3.3 PRINCIPAL RECIPIENT 3

Grant Number	IDA-T-WVI
Principal Recipient	World Vision India
Grant Start date	01/10/2011
Grant End date	31/03/2013

a. SECRETARIAT PERFORMANCE RATING	B1

Secretariat rationale for the Recommended Performance Rating

The Global Fund's grant rating tool generated a quantitative B1 rating for the grant's period ending 30 September 2012. The PR achieved more than 80% of its targets on 7 out of 10 indicators with an average performance of 85%. The PR met all the applicable condition precedents and special conditions in the Grant Agreement. However, number of issues were noted in the course of the program implementation such as:

1. Lack of a clarity at the level of the PR on engaging stakeholders after conducting the planned trainings;
2. Lack of a proper system for mapping out hard-to-reach areas and the vulnerable population;
3. Lack of documented M&E procedures such as data aggregation and analysis; and
4. Need for improving financial management capacity at the level of the PR to address issues such as lack of proper budget monitoring and placing qualified finance staff.
5. The PR has planned to take concrete steps to address these issues going forward:
6. The PR has included indicators for engagement of the stakeholders in their Performance Framework for the second implementation period;
7. The PR plans to strengthen its monitoring and supervision system by including monitoring of data reported across all the levels and linking the expenditure and program details in the software used for the program;
8. The PR has proposed additional M&E positions at the SR level and has plans to ensure that all the budgeted staff is in place;
9. The PR plans to provide regular orientation through meetings, reviews, and on-site supervision to strengthen the existing M&E systems and to reduce any data quality errors to an acceptable level; and

10. The PR plans to strengthen its Finance capacity by hiring a Finance Manager and training the related staff on important issues of Global Fund grant management.

b. SECRETARIAT RECOMMENDATION CATEGORY	Go

Secretariat rationale for the Recommendation Category

The TB SSF grant, implemented by IUATLD and WVI (also called Project "Axshya" in India which means "free from TB"), helps RNTCP expand its reach, visibility, and effectiveness, engage community based providers to improve TB services especially for women, children, marginalized, and vulnerable population such as TB-HIV co-infected population. The Project reaches people in 374 districts of India. Out of the 374 districts where the Axshya project is implemented, World Vision India implements the project in 74 districts.

This grant plays an important role in preventing TB among the urban and rural population of India living in the target districts. The project provides trainings to RNTCP staff on key subjects such as MDR-TB, epidemiology, and program management.

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

1. The PR's performance in achieving its targets in the first implementation period was very good. The grant has merited an overall B1 rating which accurately reflects the PR's performance as of the cut-off date. The grant has played a vital role in reaching out to the marginalized groups of Indian society, such as tribal populations, slum dwellers, women, children and TB-HIV co-infected people in 74 districts of India. TB prevention and access to TB services in these vulnerable populations is of critical importance in achieving the objectives of the 12th national plan for TB control in India.
2. Although some management issues were noted during the first implementation period of the grant, the PR has planned to take concrete steps to address the identified issues. These issues and the PR's plan to address these issues are described in the previous section.
3. This grant is by far the smallest of the three grants under the SSF, with an incremental funding recommendation of US $4.2 million.

c. RECOMMENDED INCREMENTAL AMOUNT	US $4,200,848

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

The CCM submitted a request of US $ 6,489,055 for the next Implementation Period (inclusive of budget after cut-off date), which represents slightly more than 100% of the ceiling amount available for this PR (World Vision) after the 90% Board mandated reduction on the original TRP amount.

The LFA recommended a number of adjustments resulting in a lower budget amount of US $ 6,239,091 for the next Implementation Period. The Secretariat agrees with the LFA recommendation and proposes an additional negative adjustment of US$ 60,270 on the budget for US$ 6,178,821.

Adjustments in detail:

Cost category	CCM request	GF recommended	Variance
Human Resources	1,928,344	1,788,483	- 139,861
Technical Assistance	-	-	-
Training	877,730	772,325	- 105,405
Health Products and Health Equipment	-	-	-
Medicines and Pharmaceutical Products	-	-	-
Procurement and Supply Management Costs	-	-	-
Infrastructure and Other Equipment	40,333	40,333	-
Communication Materials	102,894	102,894	-
Monitoring and Evaluation	1,159,069	1,118,059	- 41,010

Living Support to Clients/Target Population	-	-	-
Planning and Administration	660,086	667,279	7,193
Overheads	530,721	499,570	- 31,151
Other	-	-	-
TOTAL	**5,299,178**	**4,988,944**	**- 310,234**

There are several potential savings in the CCM submitted budget, such as lump sums where the reasonableness could not be assessed and therefore these costs will be further negotiated.

In total, the Secretariat recommends a budget of US$ 6,178,821 for the next Implementation Period (inclusive of budget after cut-off). Less cash and the undisbursed amount from the current Implementation Period, this produces an **incremental amount of US$ 4,200,848**. This represents **93.3%** of the TRP adjusted amount which is above the investment range for a grant with a B1 rating.

Grant Performance rating	Adjusted TRP clarified amount for next implementation period	=	Indicative investment range % of adjusted TRP clarified amount	
			High	Low
B1	**$ 4,501,284**		**89%**	**60%**

4. DETAILED REVIEW BY PRINCIPAL RECIPIENT

4.1 PRINCIPAL RECIPIENT 1

Grant Number	IDA-T-CTD
Principal Recipient	Department of Economic Affairs (DEA) of the Ministry of Finance, Government of India
Grant Start date	01/10/2011
Grant End date	31/03/2013

STEP 1: Programmatic Achievements

Overall Performance Rating to cut-off date:

PR : Department of Economic Affairs, Ministry of Finance of India

Oct 1 2011 - Mar 31 2012	Apr 1 2012 - Sep 30 2012
B1	**B1**

Cumulative Indicator Rating at cut-off date:

IDA-T-CTD

Service Delivery Area	Indicator Number	Is Top 10	Is Training	Indicator	Rated Target	Rated Result	Percentage
Improving diagnosis	1.1			Number of functional Designated Microscopy Centres supported under RNTCP in the project states	3756	4368	116%
	1.2			Number and percentage of laboratories showing adequate performance among those that received external quality assurance for smear microscopy			
	1.3			Number of laboratories performing Line Probe Assay	19	26	120%
	1.4			Number of laboratories with enhanced sputum processing capacity	22	18	82%
	1.5	Yes		Number of DR TB suspects examined for MDR TB	50000	77117	120%
Procurement and Supply management	1.10			Number of reporting units (districts) reporting no stock out of first line anti TB drugs	N: 194 D: 194 P: 100 %	N: 196 D: 196 P: 100 %	100%
M&E	1.11			Number of districts evaluated (as per RNTCP guidelines) by the State and central level evaluation teams	32	13	41%
ACSM (Advocacy, communication and social mobilization)	1.12			Number of project districts where at least 30% of all forms of TB cases registered during the quarter are receiving DOT through community volunteers	N: 176 D: 194 P: 90.7 %	N: 174 D: 196 P: 88.8 %	98%
	1.13			Number and percentage of identified predominantly tribal and poor districts in the 8 project states achieving 85% treatment success rate among NSP cases	N: 6 D: 85 P: 80 %	N: 65 D: 85 P: 76.5 %	96%
TB/HIV	1.14			Number and percentage of TB patients who had an HIV test result recorded (positive and negative) in the TB register (among all registered patients in 8 project states)	N: 74,144 D: 106,682 P: 69.5 %	N: 136,106 D: 210,050 P: 64.8 %	93%
	1.15			Number and percentage of HIV positive TB	N: 9,743	N:	104%

				patients who receive at least one dose of cotrimoxazole preventive therapy during or at the end of TB treatment (among all HIV positive TB patients registered over a given period of time in 8 project states)	D: 10,947 P: 89 %	10,300 D: 11,088 P: 92.9 %	
Human Resource Development	1.16	Yes	Yes	Laboratory staff trained on line probe assay	119	115	**97%**
High Quality DOTS	1.6	Yes		Number of new smear positive cases reported to the national authorities and registered for treatment under RNTCP DOTS (non-cumulative)	195778	186018	**95%**
	1.7	Yes		Number of TB cases (All forms) registered for treatment under RNTCP DOTS	436561	413984	**95%**
	1.8	Yes		Number and percentage of new smear positive pulmonary TB cases registered in a specified period that are successfully treated	N: 149,797 D: 182,284 P: 82.2 %	N: 166,690 D: 190,306 P: 87.6 %	**107%**
	1.9	Yes	Yes	Number of key RNTCP staff (DTOs, MO-DTC, MO, STS, STLS and Lab Techs) retrained/trained in RNTCP	11750	20234	**120%**
MDR-TB	2.1	Yes		Number of lab-confirmed MDR-TB patients enrolled in second-line anti-TB treatment (DOTS Plus treatment)	13438	11019	**82%**
	2.2	Yes		Number and percentage of lab confirmed MDR-TB patients successfully treated among those enrolled in second line anti-TB treatment (according to program guidelines) during a specified period of time	N: 932 D: 1,759 P: 53 %	N: 707 D: 1,466 P: 48.2 %	**91%**
All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	3.1			Number of NGOs and Private Practitioners involved and supported (undersigned MoUs) under RNTCP-DOTS Programme	966	810	**84%**
	3.2			Number of IMA members from the 15+1 project states/UTs who have signed an MoU under one of the RNTCP PPM schemes	2817	5052	**120%**
	3.3			Number of Private Practitioners sensitized on RNTCP through CMEs conducted by the IMA-PPM project	65472	41511	**63%**
	3.4			"Number of Church health facilities (medical colleges, hospitals, dispensaries and TB centres) supported under signed schemes (diagnosis, treatment and DOT supervision) and involved under RNTCP"	350	147	**42%**
	3.5			Number of TB suspects referred for sputum smear examination from the Church Health facilities to RNTCP DMCs	104060	112697	**108%**

Training Indicator Rating	109%
Average Performance on Top 10	99%
Top 10 Indicator Rating	**A2**
Average Performance All Indicators	94%
All indicators Rating	**A2**
Number of TOP TEN Indicators with B2 or C Rating	0
Renewals Indicator Rating	**A2**

How has the grant performed in the current implementation period?

The overall performance of the program, including the implementation of activities, completion of conditions and management actions, as well as program management until the cut-off date merits a B1 rating.

While the Global Fund Grant Rating Tool generated an A2 Quantitative Indicator rating during the first implementation period, the Secretariat has downgraded this rating to B1 because of unmet Conditions Precedent /Special Conditions and Management Actions described in this GSC and other issues.

Out of the 22 indicators, the PR significantly achieved or over-achieved its targets by more than 120%:
For the following 6 indicators: Number of Laboratories performing LPA; number of laboratories with enhanced sputum processing capacity; number of DR TB suspects examined for MDR TB; number of key RNTCP staff retrained/ trained in RNTCP (DTOs/MO-DTC / STS/ STLS /MO and Lab techs); number of laboratories staff trained on line probe assay; and number of IMA members from 15+1 project states/UT who have signed a MOU in any of RNTCP schemes.

The PR also exceeded or reached its targets on the following:
Number of functional Designated Microscopy Centers (DMCs) and supported under the revised National TB Control Program (RNTCP) in the project states by 116%.

Number and percentage of new smear positive pulmonary TB cases registered in a specified that are successfully treated by 103%.

Number and percentage of HIV+ TB patients who has received at least one doze of CTZ during or at the end of TB treatment (8 state- out of HIV+), with an achievement rate of 103%.

Number of reporting units (districts) reporting no stock-out of 1st line TB drugs with an achievement rate of 100%.

On the other hand, the PR:

Slightly under-achieved on the on number of new smear positive cases reported to the national authorities and registered for treatment under RNTCP DOTS by 96% and number of TB cases (All forms) registered for treatment under RNTCP DOTS by 93% because of delay in the approval of the National Strategic Plan (2012 -2017); lack of advocacy, communication and social mobilization (ACSM) strategies; non- involvement of other sectors including public and private sectors in the program; and weak monitoring mechanisms at the grass - root level.

Under-achieved or significantly under-achieved its targets for:

Number and percentage of lab confirmed MDR- TB patients successfully treated among those enrolled in second line anti-TB treatment (according to program guidelines) during a specified period of time by 84% of the enrollment of chronic patients who had been previously treated on CAT II and high death/default propensity of these patients. *Based on the data analysis by the program, it is noted that around 53% of the MDR TB patients do not complete their treatment due to death or discontinuation of therapy due to various reasons. During discussions with the PR in-country, we were informed that this was a result of the fact that most of the initial cohort of patients enrolled were chronic patients (diagnosed late) who had been previously treated on CAT II. Also propensity of death/default on these initial cohorts was high due to earlier set of criteria for treatment. The PR has indicated that the attrition rate is expected to decline with the new diagnostic capabilities and as the program matures with lessons learned.*

Number of NGOs and Private Practitioners involved and supported (undersigned MoUs) under RNTCP-DOTS program by 84% due to delays/slow release of funds at the state level.

Number of lab-confirmed MDR-TB patients enrolled in second-line anti-TB treatment (DOTS Plus treatment) by 78% due to the non-coverage of many districts.

Number of Private Practitioners sensitized on RNTCP through CMEs conducted by the IMA-PPM project by 63% due to non-release of funds by MoHFW to IMA during the reporting period.

Number of districts evaluated (as per RNTCP guidelines) by the State and central level evaluation teams by 62% due to lack of funds at the states level.

Number of Church health facilities (medical colleges, hospitals, dispensaries and TB centers) supported under signed schemes (diagnosis, treatment and DOT supervision) and involved under RNTCP by 42% due to delay in release of funds by MoHFW to CBCI.

Revised Indicator Rating	B1

STEP 2: Quality of Data and Services

Date of most recent OSDV: 29/01/2013

Indicator Text	Overall Verification Factor	Data Quality Rating
Number of new smear positive cases (NSP) reported to the national authorities and registered for treatment under RNTCP DOTS	95.97%	No Risks
Number of key RNTCP staff (DTOs, MO-DTC, MO, STS, STLS and Lab Techs) retrained/trained in RNTCP	41.25%	Major Data Quality Issues
Number and percentage of new smear positive pulmonary TB cases registered in a specified period that are successfully treated	66.36%	Major Data Quality Issues

* In some settings, the source document was not available for verification of the numbers reported for this indicator, and no alternate records could be shown to us to verify the results reported against this indicator for the review period.
**It should be noted that in some settings, the results could not be verified because the TB register pertaining to patients registered during the verification period was not there, and in some others, the TB register did not update all the outcomes for the NSP registered.

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.

OSDV:
An OSDV conducted in Chhattisgarh state during January 2013 indicated that two out of the three indicators (Number of key RNTCP staff retrained/trained in RNTCP) and indicator 3 (Number and percentage of new smear positive pulmonary TB cases registered in a specified period that are successfully treated) had "major" data quality issues with verification factors 41.2% and 66.4% respectively. In addition, the PR has been slow in implementing the recommendations from the previous M&E system strengthening recommendations. Accordingly, the poor quality of data pose a risk for management of this grant as well as to the results reported. Poor quality of data recorded in the OSDV is considered as one among other management issues for downgrading the overall rating of this grant.

It was also noted that there is no practice of review of reports at lower levels and providing feedback on the quality of reporting at most of the locations visited. The quality of programmatic supervision was found to be weak at all levels. The system of record-keeping in both districts visited was found to be poor. Accordingly, it is highly likely that the quality of data pose a risk for management of this grant as well as to the results reported.

Data Quality Audit (DQA):
In December 2012, an audit was conducted on quality of data collected by states and reported to Central TB Division (CTD) on three indicators related to the number of new smear positive cases reported to the national authorities, number and percentage of new smear positive pulmonary TB cases registered in a specified period that are successfully treated, and number of lab-confirmed MDR-TB patients enrolled in second-line anti-TB treatment. The three states chosen for the program indicators were Uttarakhand, Bihar, and Andhra Pradesh (plus all the sites in the National Capital territory of Delhi only for PMDT).

The weighted final audit performance score was assessed at 84% (good) for the Case Detection indicator, at 79% (fair) for the Treatment Success indicator, and at 91% (excellent) for the DR TB indicator. Data accuracy was measured at 100% for the Case Detection indicator, at 87% for the Treatment Success indicator, and at 97% for the DR TB indicator. Availability of reports was 93% for both DOTS indicators and at 100% for the DR TB indicator. Timeliness of reports could not be assessed for the DOTS indicators and was 76% for the DR TB indicator. Completeness of reports was 39% for the DOTS indicators and 87% for the DR TB indicator. The System Assessment Protocol measured minor gaps in the data management and reporting system.

Whereas the data quality was judged as good to excellent on both the qualitative and quantitative aspects of

the DQA, some weaknesses were identified in the M&E system for the TB program funded by the Global Fund in India. There is no documentation on procedures to address late, incomplete, inaccurate and missing reports; including following-up with sub-reporting levels on data quality issues. While issues with availability, timeliness, and completeness of reports are addressed, there is no systematic process to track these aspects of data quality. Treatment registers were not always updated, especially in relation to treatment outcome. Supervisory activities are not systematically documented.

Rapid Service Quality Assessment (RSQA):

An RSQA was conducted by the LFA in Chhattisgarh state in November 2012. While the RSQA overall did not find major issues in several areas assessed by the team, it revealed that EQA was not being conducted in eight service delivery points visited in Chhattisgarh state. There was no On Site Evaluation (OSE) or Random Blinded Rechecking (RBRC) conducted at the Designated Microscopy Centers (DMCs) during the recent past. In addition, the report indicates that at all SDPs visited, that there was no method of systematically recording these reactions and altered regimens in the treatment cards. Poor quality of laboratory services also included improper storage and maintenance of microscopes and slides. Additionally, improper storage conditions for drugs were observed at SDP along with occasional stock outs of drugs at state, district as well as SDP levels. At all service delivery points visited, it was noted that there was no method of systematically recording adverse reactions and altered regimens in the treatment cards.

STEP 3: Grant Management and Compliance

Grant management assessment		Rating
Monitoring and evaluation	Reported results by the PR for several of the indicators did not match with back-up data provided during PUDR reviews, which reflects lack of quality in the results reported. The PR has been asked to rectify the reported data and incorporate the correct figures in the next PUDR.	Moderate issues
Program management	Out of 14 Conditions Precedent/Special Conditions applicable during the first implementation period, 1 SC is still not met and 1 CPs and 4 SCs are still in progress. The Global Fund recommendations in Management Letters of previous PUDRs are partially or not yet implemented (or implementation was in progress); some of these recommendations go back to Round 2 RCC and Round 9 grants; indicating inadequate follow up on the Global Fund recommendations. Lack of dedicated staff to manage Global Fund grant activities, causing delays in submission of PUDRs and provision of information for PU/DR reviews. The staff at CTD has been assigned various functional areas (such as MDR-TB, lab services, PPM etc.) and is responsible for looking after their respective functional areas for the entire country. There is no person currently in place to dedicatedly work on Global Fund grant management aspects such as financial management, data collection and reporting etc. This results in delay in submission of PUDRs, delay in response time to Global Fund/LFA queries and requests and non-compliance with CPs and recommended management actions, which causes delays in disbursement process. Considering the scale of operations and the different components of the grant (DOTS, DOTS plus, HIV/TB, PPM, Lab scale up activities, etc.), it is important to have dedicated persons working on the Global Fund grant to manage the grant implementation and comply with the reporting and other	Moderate Issues

	requirements, without disturbing other routine activities of CTD.	
Financial management and systems	Due to issues related to procurement of 1st line Anti-TB drugs: • PQR entries for invoices charged in the current PUDR have not been made by the PR. The PR has been recommended to make the entries as soon as possible. • PR also charged the cost of non-QA compliant medicines (Streptomycin Inj. 0.075g) [the same was adjusted by the CT in the PUDR for April-Sept 2012]. In the last PUDR, the PR expenditure included US $18,399 for human resources & technical assistance US $1309 for training cost and US $33,346 for Overheads for which no records of expenditure were provided. This expenditure could not be validated and were therefore reduced from expenditure reported in the last PUDR. The PR was asked to include the expenditure in the next PUDR with supporting documentation for the LFA review. The PR being a Government department, its annual audit is conducted by the Comptroller and Auditor General of India (CAG), which is the Supreme Audit Institution in the Country. The audit is conducted as per the auditing standards promulgated by the CAG. As a result, no change to the mechanism of audit can be made as the audit by CAG being a mandatory requirement in the Country Context. The PR audit report for financial year 2011-12 was shared with the LFA (financial year 2012-13 has recently ended and the audit report is not yet due). The audit report only includes details of Statement of Expenditure [SOE] and has no financial statement and notes to accounts. Adjustments based on the CAG audit report for 2011-12, were made by the LFA in the PU/DR for October 2011 to March 2012. We note that CTD does not submit SR audit reports. Audits of government institutions at the state level are handled by state governments, not the Union Ministry. For this reason, mandating submission of such reports at the Central level is not practical. The 2012 OIG program audit report is due to be released at the end of April 2013. No analysis (programmatic or financial) is sought from the SRs for justification of variance with budget/ targets.	Moderate Issues
Pharmaceutical and Health Products Management	**Procurement Process** - Drug procurement is characterized by frequent delays, which appear to be primarily due to the requirement for multiple approvals from the Ministry of Health at different stages of the tendering process. This hinders the provision of drugs to consignees and results in periodic shortages and/or stock outs. **MIS –** The LFA report informs us that while CTD has robust logistics information system (implemented by SAMS) and that stock on hand at various levels are adequately captured along with consumption data, the forecasting methodology may be slightly flawed. The stock on hand information is not considered in	Moderate issues

	estimation of quantities and is basically assumed to be buffer stock which presents a risk of erroneous forecasting through over and under-estimation of buffer. **Quality Assurance –** While the PR has generally complied with the Global Fund's quality assurance policy for finished pharmaceutical products, it has often sought 'no objection' certificates for medicines that do not fully comply with the policy. Many of the drugs planned for procurement in the second implementation period are neither aligned with the QA policy, nor do they have valid ERP approval certificates. The PR continues to request funds to procure streptomycin 750mg along with patient kits for pediatric doses which do not meet the QA criteria for procurement and has not been granted exceptional approval exceptionally by the ERP to date. Due to the challenging procurement and quality assurance situation, no procurements of first and second line TB medicines have been conducted under the SSF to date, raising the real possibility of drug stock-outs in all 8 Global Fund-supported states. The situation is particularly acute for pediatric TB medicines used by the National Program. The Global Fund is currently working closely with the PR and the manufacturers to obtain the necessary dossiers and documentation for a swift review by ERP. Until such time that ERP provides a positive response, the PR is reminded that Global Fund resources may not be used to procure the same. The PR during discussions in-country has expressed its intent to procure both first- and second-line TB medicines through GDF/IDA, which can circumvent historical quality issues as well as procurement delays. Given the contextual knowledge of shortages in supply of second-line TB medicines, combined with the ambitious scale-up of treatment service, challenges in ensuring continuous availability of these pharmaceuticals may be foreseen. The PR is advised to confirm its decision to change its drug procurement arrangements with the Global Fund as soon as possible. **Inventory Management –** We note from the OSDV report and indicated in the QUART for this grant that various gaps were encountered in inventory management. These included issues related to indenting, receipt, distribution, storage and overall management. Details of the same are also highlighted in the LFA assessment report. The LFA however informs us in the assessment that the PR has submitted a situation analysis report for 26 out of 37 State Drug Stores (SDSs) to assess the storage arrangements (including infrastructure and Human resource) along with the checklist used for analysis (Feb 6, 2013). It is anticipated that an action plan would be prepared for each state and will be followed up by PR with the respective states. The recent RSQA additionally informs of poor quality of laboratory services including but not limited to improper storage and maintenance of microscopes and slides, Improper storage conditions for drugs at SDPs and stock out of drugs at State, District and SDP levels. **Forecasting of costs and quantities** – Several issues were identified related to costs and quantities for first- and second-line TB medicines which have been communicated to the PR. The PR has also been advised that the quantities for buffer (10 months stock as per National guidelines) be added onto the annual needs and concurrently adjust the quantities by the actual stock on hand	

	prior to placing the indent for the next procurement – for 2013-14. All recommendations and revisions are anticipated to be captured in the PSM Plan to be submitted by the PR to The Global Fund for review and approval. It is important to take note of the following related to quantification of medicines for TB. CTD determined that, instead of offering complete treatment courses for 8,775 MDR TB cases, it would frontload the procurement of 15,275 MDR TB regimen intensive phase drugs exclusively. In other words, CTD will procure 6 months' worth of drugs with a 2 month extension for roughly 50% of the cases, using the available GF-SSF first implementation period funds allotted for procurement of the 8,775 complete courses for this purpose. It will then adjust for continuation phase SLD needs in 2013 with SSF-II funds after April 2013. This will ensure non-interruption of treatment enrolment of MDR TB cases in 2013. Since the programme is experiencing attrition of MDR TB patients after treatment initiation to the level of ca. 16% at month 6, ca. 27% at month 12 and about 50% at month 24 in the initial patient cohorts, the un-utilized drugs of these patients lost to follow up will be effectively utilized (not wasted) by linking them to some of the IP courses being procured. **PQR** - The PR has not fully completed entries into the PQR database. The PR has been advised to do the required entries at the earliest possible in line with the requirements of the periodic review**.**	
Other Management Issues	Errors were noted in data reported by states/ SRs for certain indicators during the PUDR reviews, indicating lack of review of results reported by FIND. This reflects inadequate monitoring of the performance of the SRs.	Moderate issues
	The 2012 OIG program audit report is due to be released at the end of April 2013.	

RECOMMENDED PERFORMANCE RATING	B1

STEP 4: Progress towards Impact /Outcome

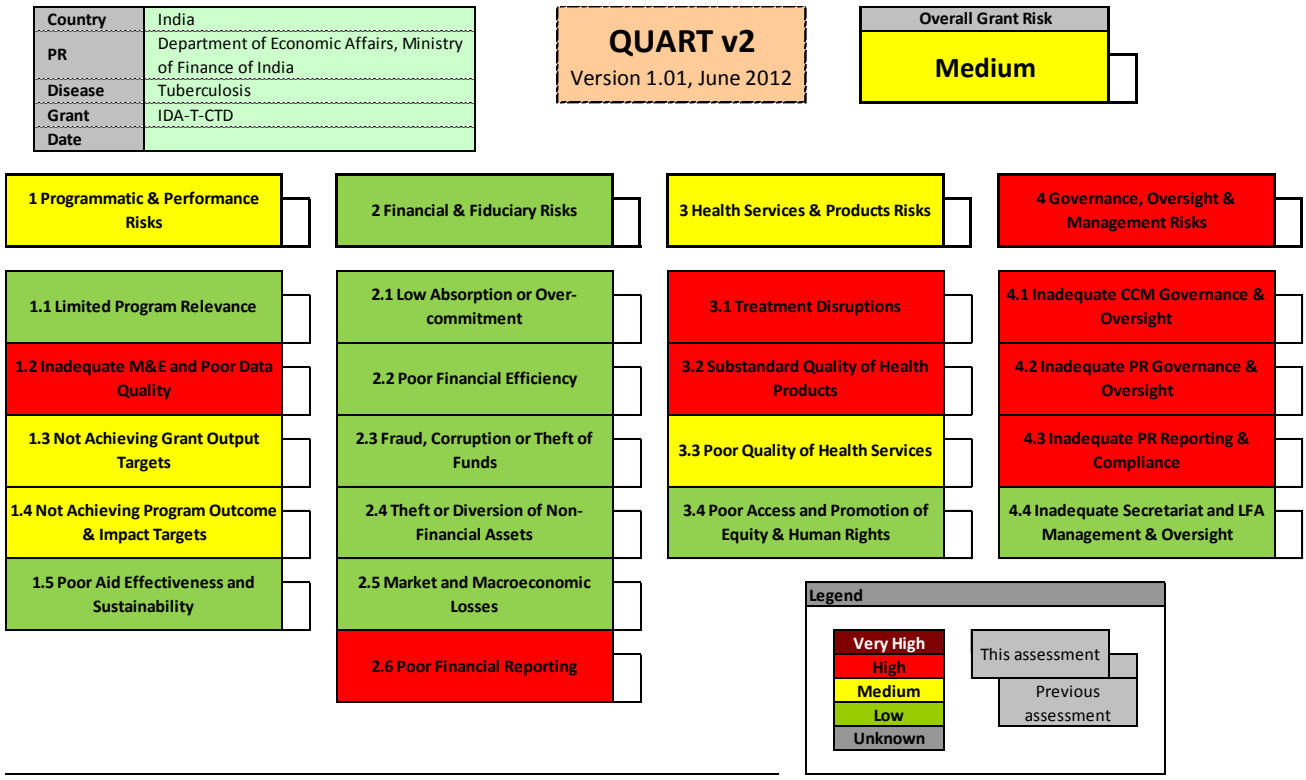
IMPACT RATING	Demonstrated Impact

STEP 5: Operational Risk Management

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

Qualitative Risk Assessment Tool (QUART)

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



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

<u>Key Issues Escalated to the Committee</u>

Engagement

The Global Fund needs to shape constructive engagement with one of the world's "emerging economies" in a context of budgetary uncertainty and continued high disease burdens. Despite its perceived wealth, India remains a lower-lower middle income country whose disease programs are "under-resourced' by up to 33%. The Global Fund's challenge is to leverage its relationship with India to facilitate efficient and effective application of increasing government and private sector health resources.

The SSF renewal request featured a budget forecast that exceeds the adjusted incremental amount by over US $100 million.

Governance

The over-concentration of programmatic decision-making authority in the office of the NACO Additional Secretary is problematic in light of the CCM's need to oversee not only the HIV/AIDS portfolio, but also the Global fund-supported TB and malaria programs. This has led to otherwise avoidable reductions in grant funding to the TB and malaria programs.

The TB and Malaria PIUs are woefully understaffed. This needs to be corrected on a priority basis. Civil service regulations necessitate "work-arounds" with civil society PRs.

Quality Assurance and Procurement of Health Products

Administrative bottlenecks resulting in procurement delays, prioritization of World Bank procurement and the global fund's quality assurance requirements (which requires the PR to submit request for ERP approved products) can significantly contribute towards stock-out of medicines.

Faulty DOTS implementation and lack of private sector involvement have resulted in 50% 2 year "attrition" rates for second line treatment.

WHO needs to adopt a coordinated (Geneva-SEARO-Country Office) position on these issues.

<u>Committee Decision Points</u>

Action for the escalated issues

Senior Global Fund management should meet with the India Planning Commission, Ministry of External Affairs, Ministry of Finance, and Ministry of Health and Family Welfare to gain greater certainty regarding the country's health budget and corresponding priorities over the next 3-5 years. An ongoing strategic dialogue will serve to clarify the scale and scope of future Global Fund investments in Indian government, civil society and private sector programs following the 2013 Replenishment.

Senior Global Fund management should engage with its counterparts at WHO on malaria and TB health product quality assurance and procurement issues.

Risk mitigating measures

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

Main Areas	Compliance Issue/Risk	Prevention or Mitigating measure type (Board Condition, Secretariat 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	Poor data reporting systems and monitoring and supervision of the SRs.	Management Action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that: (a) it has made the necessary modifications to its Epicenter software to improve data reporting from districts and states, including without limitation reporting of DOTS plus data; (b) regular supervisory visits of states and districts will be done throughout the term of the program with the goal of improving data reporting; and (c) it has provided written guidance to districts and states in connection with all key indicators tracked by the program, including their definition, data sources, means and formats for tracking and reporting at each level.	Within 6 months after grant signing
Financial and Fiduciary Risks	Poor financial reporting system and monitoring of the SRs	Management Action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has a system and procedures in place to carry out periodic financial monitoring visits to the SRs and an action plan, with timelines, for improving the financial reporting of SRs.	Within 6 months after grant signing
Health Services and Health Products Quality Risks	Treatment Disruption	Secretariat Condition	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, the PSM Plan for the second implementation period. The Plan shall include,	Prior to grant signing

(including Equity and Human Rights)			without limitation, all assumptions used for forecasting, ensure consistency with the budgets and alignment with targets in the Performance Framework, where appropriate.	
	Substandard Quality of Health Products	Management Action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, an action plan with specific implementation arrangements and associated timelines to address the issues identified in the situation analysis report for 26 out of 37 State drugstores.	Within 6 months after grant signing
Governance, Oversight and Management Risks	Inadequate capacity to manage grants	Secretariat Condition	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has recruited the following staff dedicated to Global Fund grants: a grants manager, a finance specialist and an M&E specialist.	Within 6 months after grant signing

RECOMMENDED PERFORMANCE CATEGORY	Go

STEP 6: Programmatic achievements and financial performance

Financial situation at cut-off date

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

Disbursements

Signed Budget for current implementation period	USD 107,739,848
less: disbursed to cut-off date	USD 13,315,541
Undisbursed amount at cut-off date	USD 77,515,865

Cash at cut-off date

	PR	SRs	Total
Disbursed to PR to cut-off date[7]	30,223,985	N/A	30,223,985
Less: Disbursed from PR to SRs	(16,639,563)	16,639,563	-
Less: Expenditure incurred to cut-off date	(16,249,008)	(16,639,563)	(32,888,571)
Add: Interest received/exchange loss			
Add: Other income please specify	(1,104,270)		(1,104,270)
Equals: Cash at cut-off date	(3,768,855)	-	(3,768,855)

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

This grant is forward funded by India. The Global Fund reimburses India's Ministry of Finance for allowable expenses under this grant agreement.

Undisbursed funds of US$77,515,865 as of the cut-off date resulted from the delays in PR's submission of the progress update and disbursement request report. There were also outstanding issues such as lack of drug quantification and pro-forma invoices, and non-fulfillment of disbursement related Conditions Precedent and Special Conditions stipulated in the grant agreement.

The cash balance disbursed to the PR as of the cut-off date includes the amount disbursed under the CTD SSF grant of US$13,315,541 and the opening cash balance of US$15,313,062 at the start of the SSF grant period coming from Round 2 RCC grant and US$1,595,382 coming from the Round 9 grant.

A disbursement of US$40 million ($22 million reimbursement of expenses to CTD and $18 million for commitments related to procurement of drugs to IDA Foundation) is being made by the Global Fund after grant end date, 31st of March 2013. Thus, a 3-month no-cost extension ending 30 June 2013 is being approved by the Global Fund to ensure continuity of the program implementation while the grant renewal is in process.

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

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

Programmatic achievements and financial performance

Percentage of funds budgeted at PR level	56%
Percentage of funds budgeted at SR/SSR level	44%

[7] Funds in-transit shown as disbursements received.

IDA-T-CTD

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
TB Treatment	ACSM (Advocacy, communication and social mobilization)	$2,148,302	$1,239,001	58%	97%
	High quality DOTS	$450,124	$239,716	53%	104%
	High-risk groups	$138,599	$80,279	58%	
	Human Resource Development	$2,513,120	$1,394,876	56%	97%
	M&E	$1,969,717	$1,119,387	57%	41%
	MDR-TB	$14,770,440	$10,392,909	70%	87%
	Procurement and Supply management	$6,676,488	$4,749,313	71%	100%
Supportive Environment	All Care Providers	$3,565,791	$2,090,422	59%	
	Program Management and Administration	$15,313,470	$8,773,490	57%	
	Programme-based operational research	$141,413	$65,465	46%	
	Supportive Environment: Sufficient Drug and Laboratory Supplies	$2,873,701	$1,293,555	45%	
	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)				83%
	TB/HIV				99%
TB Detection	Improving diagnosis	$12,255,735	$5,943,835	48%	110%
Grand Total		**$62,816,900**	**$37,382,247**	**60%**	94%

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

This grant is forward funded by India. The Global Fund reimburses India's Ministry of Finance for allowable expenses under this grant agreement.

The cumulative budget utilization as of the cut-off period is 60% as compared with the average programmatic performance of "All Indicators" of 94%. The main reason for the discrepancy is that more than half of the output indicators are not tied to the budget.

The under-spending of budget in all the cost categories is primarily due to the delay in signing of the grant agreement for TB SSF First Implementation Period (i.e. grant signed in July 2012 as compared to grant start date of 1st of Oct 2011), and delayed disbursement of funds from the Global Fund resulting to delayed fund transfer to SRs and unutilized funds (i.e. equipment not purchased, training not conducted, M& E visits did not happen as planned, technical assistance support was not released to WHO).

A disbursement of US$40 million ($22 million reimbursement and $18 million for commitments) is being made by the Global Fund after 31 of March 2013 during the no-cost extension period (April-June 2013) that will increase the absorption rate in the next reporting period.

STEP 7: Financial Recommendation

Resources available to finance program for next implementation period

	Year 1 (2013-2014)	Year 2 (2014-2015)	Year 3 (2015-2016)	Total
TRP clarified amount allocated to PR	$76,522,036	$ 76,509,227	$57,135,099	$210,166,362
Any Board mandated adjustments	(7,652,204)	(7,650,923)	(5,713,510)	(21,016,637)
Adjustment +/(-) for (borrowing) and/or staggered commitments not yet committed	(18,207,058)			(18,207,058)
Adjusted TRP clarified amount	$50,662,775	$68,858,304	$51,421,589	$170,942,668
CCM reallocations +/(-) (implementation arrangements)				
Adjusted reallocated amount	50,662,775	68,858,304	51,421,589	$170,942,668
+ Undisbursed amount at cut-off date				77,515,865
+ Cash at cut-off date				(3,768,855)
=Total Resources available (after cut-off date for the next Implementation Period)				$244,689,678

Summary Budget Recommendation and Incremental Amount

	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)*	$20,135,034	$113,344,371	$88,6190,922	$11,677,203	$233,778,530
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)*	$0	$11,397,840	($2,672,037)	($80,405)	$8,645,398
Total Budget Recommended by the Secretariat	$20,135,034	$125,503,810	$87,103,790	$11,596,798	$244,339,432
- Undisbursed amount at cut-off date					$77,515,865
- Cash at cut-off date					($3,765,855)
RECOMMENDED INCREMENTAL AMOUNT					**$170,592,422**
% of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)					**99.8%**

4.2 PRINCIPAL RECIPIENT 2

Grant Number	IDA-T-IUATLD
Principal Recipient	International Union Against TB and Lung Diseases
Grant Start date	01/10/2011
Grant End date	31/03/2013

STEP 1: Programmatic Achievements

Overall Performance Rating to cut-off date:

PR : International Union Against Tuberculosis and Lung Disease

Oct 1 2011 - Mar 31 2012	Apr 1 2012 - Sep 30 2012
A2	A2

Cumulative Indicator Rating at cut-off date:

IDA-T-IUATLD

Service Delivery Area	Indicator Number	Is Top 10	Is Training	Indicator	Rated Target	Rated Result	Percentage
ACSM (Advocacy, communication and social mobilization)	3.1			Number of districts with new smear positive case notification rate of ≥ 51 per lakh in 30 target districts	101	86	85%
	3.2	Yes		Percentage and number of target districts where at least 90% of all smear positive TB patients are started on treatment within 7 days of TB diagnosis	156	128	82%
	3.3	Yes		Percentage and number of target districts where at least 40% registered TB patients (all forms) are supervised through a community volunteer	171	184	108%
	3.4			Number of new partners signing a Letter of Commitment with the Partnership	39	44	113%
	3.5			Percentage of population with correct knowledge about TB (symptoms, treatment and curability)			
	3.6	Yes	Yes	Number of people trained at state level TOTs for NGOs/CBOs/PP training	479	414	86%
	3.7			Number of episodes broadcasted Radio Programme and TV/Video spots	9050	9931	110%
Improving diagnosis	3.10			Number of NGOs sensitised at state level to register under RNTCP schemes for sputum collection/transport/microscopy	1284	1174	91%
	3.9			Number and percentage of target districts which an active District TB officer	355	352	99%
All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	4.1			Number of rural healthcare providers sensitized on referral, DOT provision and eligible schemes	19490	16855	86%
	4.2			Number of people from District Level Networks sensitized on TB	735	654	89%

IDA-T-IUATLD

Training Indicator Rating	86%
Average Performance on Top 10	90%

Top 10 Indicator Rating	**A2**
Average Performance All Indicators	95%
All indicators Rating	**A2**
Number of TOP TEN Indicators with B2 or C Rating	0
Renewals Indicator Rating	**A2**

How has the grant performed in the current implementation period?

The program's performance in achieving most of its targets in the first implementation period was very good. The grant's technical performance during the first implementation period merits a quantitative A2 rating. The PR's average performance on all indicators was approximately 95%. During the first implementation period, the PR has exhibited adequate capacity in program management, M&E, and financial management. No major data quality issues were noted in the most recent OSDV. Besides providing trainings to more than 9000 health staff in the target districts on various TB related subjects and soft skills, the program trained nearly 12,000 RHCPs and more than 500 DLN members on TB control. The program has sensitized members of village health committees on TB through more than 4000 meetings. The program has supported the establishment of TB forums in more than 200 target districts.

As the PR has a dedicated team with the required skills and experience to manage the grant in an effective manner, the program did not face any major management or implementation-related issues in the first implementation period. Given the capacity of the PR and the progress made in the first implementation period, we firmly believe that the PR will address the identified issues while successfully implementing the second phase of this grant.

CTD is the main government body coordinating the implementation of RNTCP in all the states and union territories of India. Since the Union supports RNTCP in 300 districts, the PR has to work in close coordination with CTD. In addition, IUATLD depends on CTD for reporting two indicators in its Performance Framework for the second implementation period. These indicators are as follows:

1. Number of chest symptomatics *[sic]* referred through Axshya who successfully undergo smear examination at DMC – the referred chest symptomatics *[sic]* are recorded in the TB laboratory register of the Designated Microscopy Center (DMC);
2. Percentage and number of target districts where at least 40% registered TB patients (all forms) are supervised through a community volunteer - the PR depends on the national R&R system for reporting this indicator.

Revised Indicator Rating	**A2**

STEP 2: Quality of Data and Services

Date of most recent OSDV: 4 January 2013

Indicator Text	Overall Verification Factor	Data Quality Rating
Number of NGOs sensitized at state level to register under RNTCP schemes for sputum collection/transport/microscopy	100%	No Risks
Number of rural health care providers sensitized on referral, DOT provision and eligible schemes	90.63%	No Risks
Number of people from District Level Networks sensitized on TB	100%	No Risks

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, completed on 4 January 2013, verified data quality on three indicators mentioned above. No major data quality issues were noted in the OSDV. However, the LFA noted the following issues related to M&E, Program Management, and Financial Management system:

1. There is no system in place through which the PR could follow-up of the participants who receive trainings from the PR. With a proper follow-up system in place, the PR can ensure the impact and effectiveness of the trainings provided to RNTCP staff;
2. In certain cases, the trainings given to the Rural Health Care Providers (RHCPs) were not in accordance with the M&E Plan, for instance trainings of a 6-hours duration were concluded in less than 3 hours;
3. There are either no or Irregular procedures for securing backup of program data;
4. Some of the SRs (for instance *Mamta*) did not follow the organization's policy on cash transfers. In most of the cases amount paid to the District Coordinators (DCs) for conducting trainings was 8 times above the limit. In addition, the SR paid amounts to the DCs without settling previous advances which is also against the policy of the organization.

STEP 3: Grant Management and Compliance

Grant management assessment		Rating
Monitoring and evaluation	The following issues in the PR's M&E system were noted in the first implementation period of the grant: 1. Lack of a proper system for mapping out hard-to-reach areas and vulnerable populations; 2. Lack of documented procedures for data aggregation and analysis.	Minor
Program management	N/A	No Issues
Financial management and systems	1. Need for improving financial management capacity at the level of the PR to address issues such as lack of proper budget monitoring and placing qualified finance staff; 2. Some of the SRs (for instance *Mamta*) did not follow the organization's policy on cash transfers. In most of the cases amount paid to the District Coordinators (DCs) for conducting trainings was 8 times above the limit. In addition, the SR paid amounts to the DCs without settling previous advances which is also against the policy of the organization. 3. The LFA disallowed PSI (SR) to recover their indirect costs because it is higher than it is determined in the ICR policy. For the second implementation period, the budget for overheads is a lump-sum, with no details and it represents 6% of the total budget. The PR (and SRs) will be requested to provide details on any overheads during grant negotiation and they will be guided to apply the ICR policy. 4. The SR audit reports for the year 2011-12 highlighted several issues in the management letters of the respective SRs which appear to be critical and/or have financial impact on the expenditure reported by SR to PR The latest PR audit report has been submitted. The 2012 OIG program audit report is due to be released at the end of April 2013.	Minor
Pharmaceutical and Health Products Management	N/A	No Issues

Other Management Issues	N/A	No Issues
Additional Safeguards	N/A	N/A

RECOMMENDED PERFORMANCE RATING	A2

STEP 4: Progress towards Impact /Outcome

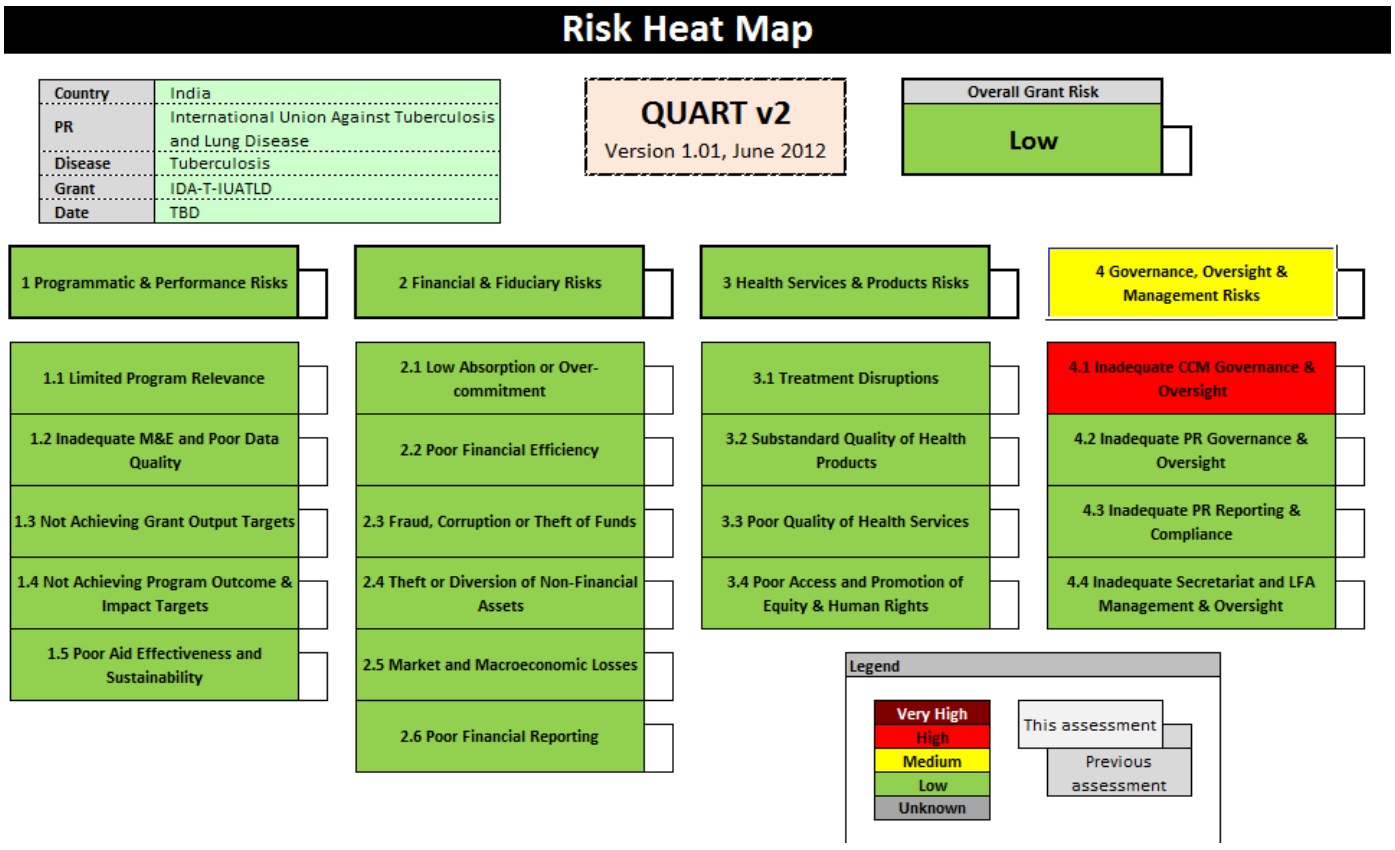
IMPACT RATING	Demonstrated Impact

STEP 5: Operational Risk Management

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

Qualitative Risk Assessment Tool (QUART)

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



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

This is a low risk grant. Besides the overarching issues related to a lack of CCM secretariat's independence and the resulting gaps in CCM's communication and its role in coordinated the national response with the other stakeholders, no issues reflecting any major or medium risk were identified. There were some minor issues pertaining to the effectiveness of mass media campaign. The CCM has not proposed this activity in its request for continued funding under this SSF grant. Relatively lower expenditure rate in 1the first implementation period (approximately 39%) was also noted in the QUART. However, this issue does not pose any significant financial risk to the grant.

Risk mitigating measures

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

Main Areas	Compliance Issue/Risk	Prevention or Mitigating measure type (Board Condition, Secretariat 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	N/A			
Financial and Fiduciary Risks	The budget for overheads is a lump-sum, with no details and it represents 6% of the total budget. The PR and SR do not apply the ICR policy to recover HS costs.	Secretariat condition	The PR shall deliver, and cause SR (PSI) to deliver, to the Global Fund, in form and substance satisfactory to the Global Fund, detailed assumptions with respect to its overhead costs, including HQ indirect costs, which should be consistent with the Global Fund's indirect cost recovery policy.	Prior to grant signing
	The SR audit reports for the year 2011-12 highlighted several issues in the management letters of the respective SRs which appear to be critical and/or have financial impact on the expenditure reported by SR to PR	Management action	With every program update, the PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, a progress report on its efforts to strengthen prevailing fiscal controls and enhancing financial monitoring / supervision at SR level (including without limitation follow-ups on audit observations with respect to SRs).	During implementation
Health Services and Health Products Quality Risks	N/A			

(including Equity and Human Rights)				
Governance, Oversight and Management Risks	N/A			

RECOMMENDED PERFORMANCE CATEGORY	Go

STEP 6: Programmatic achievements and financial performance

Financial situation at cut-off date

Disbursements

Signed Budget for current implementation period	$ 21,280,154
less: disbursed to cut-off date	$ 14,426,683
Undisbursed amount at cut-off date	$ 6,853,471

Cash at cut-off date

	PR	SRs	Total
Disbursed to PR to cut-off date[8]	$ 14,426,683	N/A	$ 14,426,683
Less: Disbursed from PR to SRs	$ (6,375,492)	$ 6,375,492	-
Less: Expenditure incurred to cut-off date	$ (1,455,913)	$ (6,445,259)	$ (7,901,172)
Add: Interest received/exchange loss	$ 113,591	$ 46,408	$ 159,999
Add: Other income please specify	$ (270,236)	$ (117,215)	$ (387,451)
Equals: Cash at cut-off date	**$ 6,438,633**	**$ (140,574)**	**$ 6,298,059**

*****_The cumulative disbursed amount of US $ 14,426,683 is inclusive of US $ 4,964,542opening cash balance at 1 Oct 2011, the start date of SSF grant._

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

The main reason is delay in signing of the grant agreement for SSF first implementation period (in June 2012 as compared to grant start in October 2011) and delay in receipt of funds from Global Fund.

The cumulative utilization rate until cut-off date was 52% for further details on the analysis of expenditure vs budget please refer to the section below.

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

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

Programmatic achievements and financial performance

Percentage of funds budgeted at PR level 20%

Percentage of funds budgeted at SR/SSR level 80%

IDA-T-IUATLD

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
Supportive Environment	ACSM (Advocacy, communication and social mobilization)	$6,741,449	$3,463,545	51%	**97%**
	Community TB care	$591,936	$76,818	13%	
	Human Resources Development	$1,375,751	$542,456	39%	
	Other - Overheads	$1,129,431	$628,328	56%	
	PPM / ISTC (Public-Public, Public-	$493,704	$189,585	38%	

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

	Private Mix (PPM) approaches and International standards for TB care)				
	Program Management and Administration	$3,006,141	$2,163,930	72%	
	Supportive Environment: Health systems strengthening	$132,401	$51,836	39%	
	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)				**88%**
TB Detection	Improving diagnosis	$572,308	$185,998	32%	**95%**
	M&E	$985,561	$525,907	53%	
Health System Strengthening (HSS)	Other - Political Commitment	$53,208	$2,368	4%	
TB/HIV Collaborative Activities	TB/HIV	$206,041	$70,509	34%	
Grand Total		**$15,287,930**	**$7,901,281**	**52%**	**95%**

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

Expenditure at the cut-off date (30-Sep-12) amounted to US $ 7,901,281representing 52% of the originally approved budget to date. The underspending of budget in all the cost categories primarily due the delay in signing of the grant agreement for the SSF (in June 2012 as compared to grant start in Oct 2011) and delay in receipt of funds from the Global Fund.

The key reasons for the underutilization are as below:

- delay in signing of the grant agreement for the first implementation phase of the SSF grant between the Global Fund and PR and PR and SRs;
- the signing delay forced delays in implementation of program activities such as recruitment of consultants, initiation of trainings, monitoring visits, printing of materials and other programmatic activities (sputum collection); and
- overhead costs had not been charged to the cut-off date because overhead policy for the PR and SRs had been recently submitted to Global Fund and are under review.

ACSM	51%	Activities could not be conducted due to shortage of funds
PPM / ISTC	38%	Trainings could not be conducted due to shortage of funds
Community Systems Strengthening	39%	Trainings could not be conducted due to shortage of funds
Community TB care	13%	Sputum transportation and retracing initial defaulters was delayed and not extended to entire districts due to late recruitment of staff at SR level and shortage of funds.
Human Resources Development	39%	District level health staff trainings could not be conducted due to non-availability of staff for trainings and state level ToT and health staff review meetings could not be conducted due to shortage of funds.
Improving diagnosis	32%	Trainings could not be conducted due to shortage of funds
M&E	53%	Due to delay in staff recruitment the expenditure is on lower side and due to shortage of funds travel expenditure for many SRs is not paid and will be accounted in next quarter periods.
Political Commitment	4%	Activities could not be conducted due to shortage of funds
Overheads	56%	Global Fund approval on overhead costs is awaited and hence the overhead cost is not charged in totality.
Program management and administration	72%	Activities could not be conducted due to shortage of funds
TB/HIV	34%	Activities could not be conducted due to shortage of funds

The cumulative budget utilization for the period from October 2011 to September 2012 has been 52% against average programmatic performance of "All Indicators" as 95%. The main reason for such a variation is that more than half of the output indicators are not tied to the budget. Also, as per the approved Performance Framework, the results achieved under Round 9 grant prior to the transition of that into SSF First Implementation Period grant (till 30 September 2011) became the baselines which were included in the proposed targets for the first implementation phase of the SSF 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	$ 14,396,108	$ 13,841,918	$ 11,813,159	$ 40,051,185
Any Board mandated adjustments	$ (1,439,611)	$ (1,384,192)	$ (1,181,316)	$ (4,005,119)
Adjustment +/(-) for (borrowing) and/or staggered commitments not yet committed	$ (11,844,192)			
Adjusted TRP clarified amount	$ 1,112,305	$ 12,457,726	$ 10,631,843	$ 24,201,875
CCM reallocations +/(-) (implementation arrangements)				
Adjusted reallocated amount	**$ 1,112,305**	**$ 12,457,726**	**$ 10,631,843**	**$ 24,201,875**
+ Undisbursed amount at cut-off date				$ 6,853,471
+ Cash at cut-off date				$ 6,298,059
=Total Resources available (after cut-off date for the next Implementation Period)				**$ 37,353,405**

Summary Budget Recommendation and Incremental Amount

	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)*	$ 5,903,003	$ 11,930,290	$ 12,582,623	$ 6,936,591	$ 37,352,507
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)*	$ -	$ (222,815)	$ (244,362)	$ (133,439)	$ (600,616)
Total Budget Recommended by the Secretariat	$ 5,903,003	$ 11,707,474	$ 12,338,261	$ 6,803,152	$ 36,751,890
- Undisbursed amount at cut-off date					$ 6,853,471
- Cash at cut-off date					$ 6,298,059
RECOMMENDED INCREMENTAL AMOUNT					**$ 23,600,360**
% of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)					97.5%

4.3 PRINCIPAL RECIPIENT 3

Grant Number	IDA-T-WVI
Principal Recipient	World Vision India
Grant Start date	01/10/2011
Grant End date	31/03/2013

STEP 1: Programmatic Achievements

Overall Performance Rating to cut-off date:

PR : World Vision India

Oct 1 2011 - Mar 31 2012	Apr 1 2012 - Sep 30 2012
B1	**B1**

Cumulative Indicator Rating at cut-off date:

IDA-T-WVI

Service Delivery Area	Indicator Number	Is Top 10	Is Training	Indicator	Rated Target	Rated Result	Percentage
ACSM (Advocacy, communication and social mobilization)	3.1	Yes		Number of districts with new smear positive case detection rate 70% in 74 target districts	37	23	**62%**
	3.2	Yes		Percentage and number of target districts where at least 90% of all smear positive TB patients are started on treatment within 7 days of TB diagnosis	N: 35 D: 72.9 P: 48 %	N: 24 D: 72.9 P: 32.9 %	**69%**
	3.3	Yes		Percentage and number of target districts where at least 40% registered TB patients (all forms) are supervised through a community volunteer	N: 40 D: 74.1 P: 54 %	N: 55 D: 74.1 P: 74.2 %	**120%**
	3.5	Yes	Yes	Number of people trained (TOT) at State level on NGO/CBO/PPRNTCP scheme	124	124	**100%**
	3.6			Number of NGOs sensitized at District level on community mobilization and RNTCP schemes	1006	1006	**100%**
	3.7	Yes	Yes	Number of people trained/retrained on interpersonal skills and soft skills (through State level TOT and district level health staff at district level)	14307	11655	**81%**
	3.8			Number and percentage of target districts with an active District TB officer	N: 74 D: 74 P: 100 %	N: 72 D: 74 P: 97.3 %	**97%**
All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	4.1			Number of rural health care providers sensitized on referrals, DOTS provision and eligible RNTCP schemes	10205	8363	**82%**
	4.2			Percentage of sputum positives initial defaulters successfully retraced and enrolled in DOTS	N: D: P: 5 %	N: D: P: 11 %	**120%**
	4.3			Number of district level TB forums functional	74	12	**16%**

Training Indicator Rating	91%
Average Performance on Top 10	85%
Top 10 Indicator Rating	**B1**
Average Performance All Indicators	85%
All indicators Rating	**B1**
Number of TOP TEN Indicators with B2 or C Rating	0
Renewals Indicator Rating	**B1**

How has the grant performed in the current implementation period?

The Global Fund's grant rating tool generated a quantitative B1 rating for the grant's period ending 30 September 2012. The PR achieved more than 80% of its targets on 7 out of 10 indicators with an average performance of 85%. The PR has met all the applicable condition precedents and special conditions in the Grant Agreement. Besides sensitizing around 1000 district level NGOs on community mobilization and RNTCP schemes, the PR has trained more than 14000 people on soft skills and TB-related interpersonal skills. In addition, the PR has sensitized more than 10,000 rural health care providers on referrals, DOTS provision and eligible RNTCP schemes. The PR's under- achieved its targets on the three following indicators:

- Number of Districts level TB forums functional –the lower achievement rate (16%) is mainly attributed to delays in disbursement of funds partly because of delayed submission of backup documents to the LFA for verification;
- Percentage and number of target districts where at least 90% of all smear positive TB patients are started on treatment within 7 days of TB diagnosis – the PR attributes a relatively lower achievement (approximately 69%) under this indicator to systemic issues affecting service delivery such as vacant position of key program staff in the RNTCP in the target districts;
- Number of districts with new smear positive case detection rate of ≥70% in 74 target districts – the PR's achievement on this indicator is 62%. The lower achievement is attributed to issues pertaining to vacancies of key positions such as the Lab Technician (LT), Senior Treatment Supervisor (STS) and Senior TB Laboratory Supervisor (STLS).

The Global Fund's grant rating tool generated an "B1" quantitative rating for the PR's technical performance during 1the first implementation period of the grant, which, given the scale of the PR's program and its dependence on PR, CTD, is an accurate reflection of its overall performance.

A number of issues were noted in the course of the periodic review:

- Lack of a clarity at the level of the PR on engaging stakeholders after conducting the planned trainings;
- Lack of a proper system for mapping out Hard-to-Reach areas and the vulnerable population;
- Lack of documented M&E procedures such as data aggregation and analysis;
- Need for improving financial management capacity at the level of the PR to address issues such as lack of proper budget monitoring and placing qualified finance staff.

The PR has planned to take concrete steps to address these issues going forward. In addition to the above, we have noted issues in the PR's performance during the recent OSDV as well as during the on-going management of this grant. These issues are as follows:

- Although the Global Fund has recommended the PR to report the denominator for the indicator "Percentage of sputum positive initial defaulters successfully retraced and enrolled in DOTS". However, the PR was persistently not able to report the denominator for the above indicator since the start of the grant;
- We have noted capacity gaps at the level of the PR which has resulted in lack of an adequate process of monitoring the budget and expenditure at the levels of the SR as well as a lack of proper analysis of variance between the budget and actual expenditure. In addition, the position of finance manager for the project is empty for the last one year or so;
- There are inconsistencies in keeping backups of the reported expenditure and SR cash balance;

- The PR staff makes ad-hoc visits to the SRs without a standardized checklist to capture issues and provide recommendations to the SRs. In addition, the PR lacks a proper mechanism to follow up on the recommendations provided during the previous visits.

We also note the following issues related to the PR's M&E system:

- The PR does not have a defined set of policies and procedures regarding the frequency of monitoring visits, the type of feedbacks to be given to the SRs and actions recommended for correcting the identified issues;
- The PR does not have a system to do a follow-up of the outcomes of the trainings provided to RHCPs, NGOs, and CBOs through a follow-up of the activities the trained entities as the functioning of the RHCPs, NGOs, and CBOs play a key role in the proper function of the community based healthcare system for TB control;
- Some issues related to the PR's M&E system were noted in the most recent OSDV which are mentioned in the subsequent sections in detail.

Revised Indicator Rating	B1

STEP 2: Quality of Data and Services

Date of most recent OSDV: 15/12/2012

Indicator Text	Overall Verification Factor	Data Quality Rating
Number of people trained and retrained on interpersonal skills and soft skills (through State level TOT and District level health staff at District level)	100%	No Data Quality Issues
Number of Rural Health care providers sensitized on referrals, DOTS provision and eligible RNTCP schemes	100%	No Data Quality Issues
Percentage of sputum positive initial defaulters successfully retraced and enrolled in DOTS	100%	No Data Quality Issues

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

Although no major data quality issues pertaining to the three indicators above were noted in the recent OSDV conducted in December 2012, various issues relating to program and financial management were noted. These issues are as follows:

Program Management and M&E issues:

- Lack of follow-up and supportive supervision to track the involvement of trained participants in the program;
- Sub-optimal follow-up on the retrieved initial defaulters – certain SRs do not have the required clarification and understanding on how to derive the denominators for Initial Defaulters;
- Lack of understanding on the linkages between the Project activities and RNTCP which results in poor overall analysis of progress in TB control at the level of TB units;
- There is a need to put into place a formal system of backing up program data.

Financial Management Issues:

- Certain expenditures of some of the SRs reported in the PUDR did not match with the books of accounts and the FPMS mainly because the FPMS software was not updated;
- A proper system for financial monitoring visits by the SRs to the SSRs is not in place at most of the SRs – the SRs do not use a standard checklist and do not provide formal feedback to the SSRs on their visits to the SSRs.

STEP 3: Grant Management and Compliance

Grant management assessment		Rating
Monitoring and evaluation	3. There is a need to put into place a formal system of backing up program data; 4. The PR does not have a defined set of policies and procedures regarding the frequency of monitoring visits, the type of feedbacks to be given to the SRs and actions recommended for correcting the identified issues; 5. Lack of documented M&E procedures such as data aggregation and analysis.	Moderate Issues
Program management	1. Lack of follow-up and supportive supervision to track the involvement of trained participants in the program; 2. Sub-optimal follow-up on the retrieved initial defaulters – certain SRs do not have the required clarification and understanding on how to derive the denominators for Initial Defaulters; 3. Lack of understanding on the linkages between the Project activities and RNTCP which results in poor overall analysis of progress in TB control at the level of TB units; 4. Lack of a proper system for mapping out Hard-to-Reach areas and the vulnerable population;	Minor Issues
Financial management and systems	1. Need for improving financial management capacity at the level of the PR to address issues such as lack of proper budget monitoring and placing qualified finance staff. 2. There is a gap at the level of the PR which has resulted in lack of an adequate process of monitoring the budget and expenditure at the levels of the SR as well as a lack of proper analysis of variance between the budget and actual expenditure. In addition, the position of finance manager for the project is empty for the last one year or so 3. Certain expenditures of some of the SRs reported in the PUDR did not match with the books of accounts and the FPMS mainly because the FPMS software was not updated 4. There are inconsistencies in keeping backups of the reported expenditure and SR cash balance; 5. The PR staff makes ad hoc visits to the SRs without a standardized checklist to capture issues and provide recommendations to the SRs. In addition, the PR lacks a proper mechanism to follow up on the recommendations provided during the previous visits. 6. The PR's Head Office charges certain HR expenditure to the Global Fund grant for which debit advices are raised and sent to the PMU. 7. The recent audit report has noted instances of ineligible expenses (approximately US$ 1905), non-compliance with policies and procedures (approximately US$13,500) and inadequate procurement procedures (approximately US$ 9,000). The latest audit report has been submitted. The 2012 OIG program audit report was released on 06 May 2013.	Major Issues
Pharmaceutical and Health Products Management	N/A	No Issues
Other Management	N/A	No Issues

Issues		
Additional Safeguards	N/A	

RECOMMENDED PERFORMANCE RATING	B1

STEP 4: Progress towards Impact /Outcome

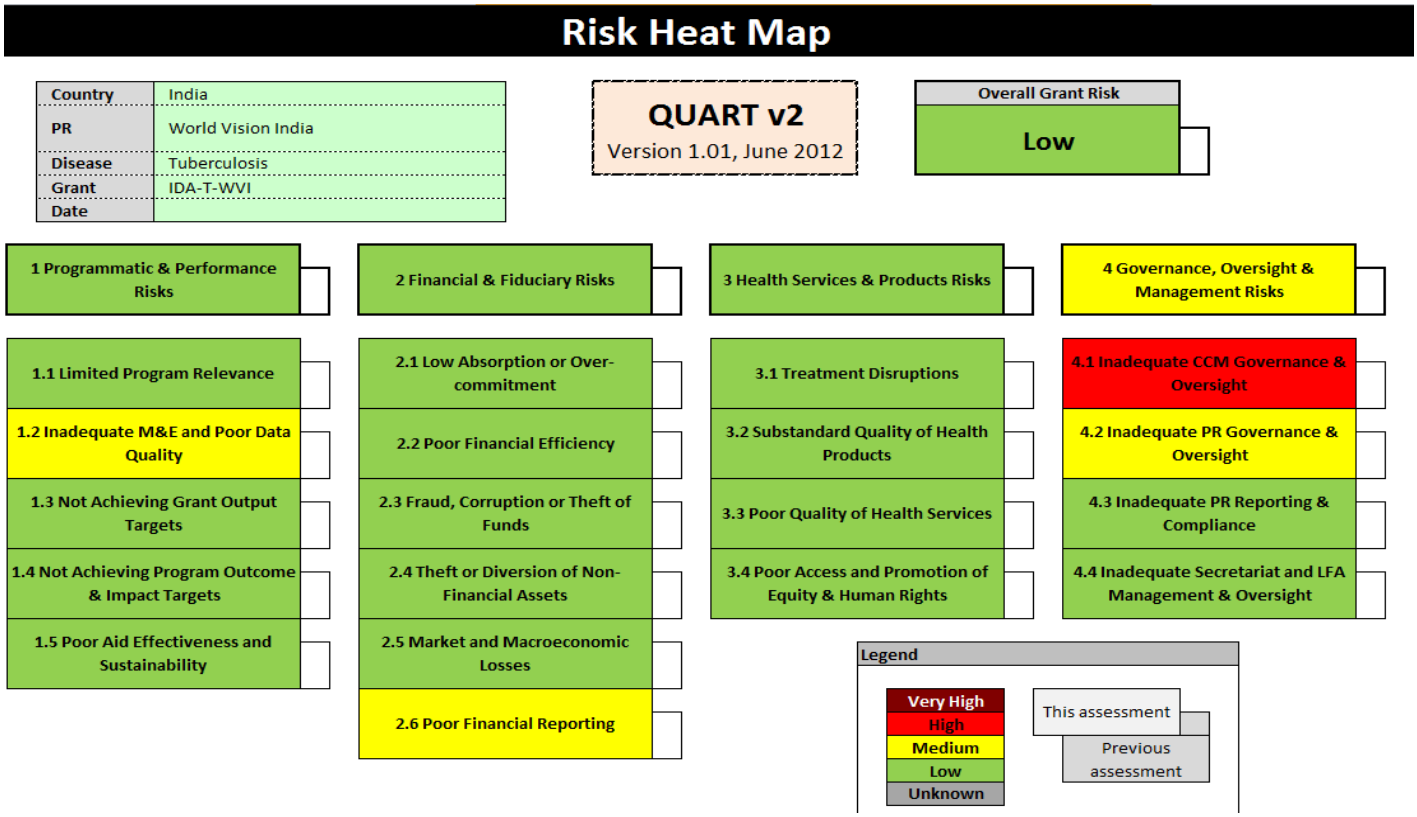
IMPACT RATING	Demonstrated Impact

STEP 5: Operational Risk Management

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

Qualitative Risk Assessment Tool (QUART)

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



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

This is a low risk grant. Besides the overarching issues related to a lack of CCM secretariat's independence and the resulting gaps in CCM's communication and its role in coordinated the national response with the other stakeholders, the following risks of medium level severity were identified.

1. Besides the lack of clarity at the level of the SRs on the indicator pertaining to the Percentage of sputum positive initial defaulters successfully retraced and enrolled in DOTS, the most recent OSDV (conducted in December 2012) has noted some M&E-related issues (most of which are already described in the sections above).

2. There is a need to improve the capacity of the finance staff to avoid issues in the PR's financial management and reporting under the Global Fund grant (please see details of these issues and actions taken in the table below).

These issues do not pose any significant financial risk to this small grant. The actions recommended for addressing these issues are described in the table below.

Risk mitigating measures

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

Main Areas	Compliance Issue/Risk	Prevention or Mitigating measure type (Board Condition, Secretariat 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	N/A			
Financial and Fiduciary Risks	Inadequate finance capacity	Management action	The PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, evidence that it has recruited a finance manager and has conducted training sessions to address gaps in the capacity of its finance staff on financial management and reporting issues.	Within 6 months after grant signing
	The recent audit report has noted instances of ineligible expenses (approximately US$ 1905), non-compliance with policies and procedures (approximately US$13,500) and inadequate procurement procedures (approximately US$ 9,000)	Management action	With each program update, the PR shall deliver to the Global Fund, in form and substance satisfactory to the Global Fund, a report on the progress made to address issues identified in audit reports, including with respect to SRs and SSRs.	During implementation
Health Services and Health Products Quality Risks (including Equity and Human Rights)	N/A			
Governance, Oversight and Management Risks	N/A			

RECOMMENDED PERFORMANCE CATEGORY	Go

STEP 6: Programmatic achievements and financial performance

Financial situation at cut-off date

Disbursements

Signed Budget for current implementation period	$ 3,433,683
less: disbursed to cut-off date	$ 2,132,595*
Undisbursed amount at cut-off date	$1,301,088

Cash at cut-off date

	PR	SRs	Total
Disbursed to PR to cut-off date[9]	$ 2,132,595*	N/A	$ 2,132,595
Less: Disbursed from PR to SRs	$ (1,050,073)	$ 1,050,073	-
Less: Expenditure incurred to cut-off date	$ (237,394)	$ (1,108,688)	$ (1,346,082)
Add: Interest received/exchange loss	$ 4,977	-	$ 4,977
Add: Other income please specify	$ (9,173)	$ (105,432)	$ (114,605)
Equals: Cash at cut-off date	**$ 840,932**	**$ (164,047)**	**$ 676,885**

***The cumulative disbursed amount of US $ 2,132,595 is inclusive of US $ 616,622 opening cash balance at 1 Oct 2011, the start date of SSF grant.*

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

The main reason is delay in signing of the grant agreement for SSF First Implementation Period (in July 2012 as compared to grant start in October 2011) and delay in receipt of funds from the Global Fund.

The cumulative utilization rate until cut-off date was 61% for further details on the analysis of expenditure vs budget please refer to the section below.

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

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

Programmatic achievements and financial performance

Percentage of funds budgeted at PR level 15%

Percentage of funds budgeted at SR/SSR level 85%

IDA-T-WVI

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
Supportive Environment	ACSM (Advocacy, communication and social mobilization)	$ 354,085	$ 225,739	64%	**90%**
	M&E	$ 337,614	$ 209,052	62%	
	Overheads	$ 206,143	$ 122,567	59%	
	Political Commitment	$ 7,793	$ 5,031	65%	
	Program Management and Administration	$ 696,506	$ 499,243	72%	
TB Detection	Community System Strengthening	$ 33,847	$ 6,086	18%	

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

	Improving diagnosis	$0	$0		
TB Treatment	Community TB care	$ 309,195	$ 154,453	50%	
	PPM / ISTC (Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	$ 104,403	$ 45,130	43%	
Health System Strengthening (HSS)	HSS (beyond TB)	$ 124,958	$ 69,212	55%	
TB/HIV Collaborative Activities	TB/HIV	$ 27,547	$ 8,524	31%	
Grand Total		**$4,404,182**	**$2,690,075**	**61%**	**85%**

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

Expenditure at the cut-off date (30-September-12) amounted to US $ 1,345,038 representing 61% of the originally approved budget to date. The underspending of budget in all the cost categories primarily due the delay in signing of the grant agreement for the SSF (in July 2012 as compared to grant start in October 2011) and delay in receipt of funds from the Global Fund.

SDA	Utilization	Comments
ACSM	64%	Targets could not been achieved due to late receipt of funds
HSS (beyond TB)	55%	Targets could not been achieved due to late receipt of funds
Community System Strengthening	18%	The work got temporarily hampered due to late receipt and disbursement of funds.
Community TB care	50%	Targets could not been achieved due to late receipt of funds
PPM / ISTC	43%	Targets could not been achieved due to late receipt of funds
TB/HIV	31%	These activities could not be under taken due to lack of funds.
Program management and administration	72%	The staff's salaries were not paid due to delay in receipt of funds.
M&E	62%	Expenses incurred but not paid due to lack of funds.
Political Commitment	65%	Activities were postpone due to late receipt of funds and will be conducted in the current implementation phase.
Overheads	59%	Expenses incurred but not paid due to shortage of funds.

The grant rating tool has generated an average performance of all indicators of 84%, thus it is higher than the cumulative utilizations for the grant. This is primarily because of the following reasons:

- Indicator "Number of people trained (TOT) at State level on NGO/CBO/PPRNTCP schemes" and "Number of NGOs sensitized at District level on community mobilization and RNTCP schemes" where achievement shown is 100% is not tied to the budget since the targets were met prior to the SSF period and no additional targets were planned in the first implementation period of the SSF.
- Indicators "Percentage and number of target districts where at least 40% registered TB patients (all forms) are supervised through a community volunteer" where the grant has exceeded the target is not directly tied to the budget.

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	$ 2,348,227	$ $ 2,336,621	$ 2,517,283	$ 7,202,131
Any Board mandated adjustments	$ (234,823)	$ (233,662)	$ (251,728)	$ (720,213)
Adjustment +/(-) for (borrowing) and/or staggered commitments not yet committed	$ (1,980,634)	-	-	-
Adjusted TRP clarified amount	$ 132,770	$ 2,102,959	$ 2,265,555	$ 4,501,284

CCM reallocations +/(-) (implementation arrangements)	-	-	-	-
Adjusted reallocated amount	**$ 132,770**	**$ 2,102,959**	**$ 2,265,555**	**$ 4,501,284**
+ Undisbursed amount at cut-off date				$ 1,301,088
+ Cash at cut-off date				$ 676,885
=Total Resources available (after cut-off date for the next Implementation Period)				**$ 6,479,257**

Summary Budget Recommendation and Incremental Amount

	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)*	$ 1,189,877	$2,086,408	$2,203,295	$ 1,009,474	$ 6,489,055
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)*	$ -	$(108,339)	$(110,572)	$ (91,323)	$ (310,234)
Total Budget Recommended by the Secretariat	$ 1,189,877	$1,978,069	$2,092,723	$ 918,151	$ 6,178,821
- Undisbursed amount at cut-off date					$ 1,301,088
- Cash at cut-off date					$ 676,885
RECOMMENDED INCREMENTAL AMOUNT					**$ 4,200,848**
% of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)					93.3%