

INDIA COUNTRY COORDINATING MECHANISM (CCM)
for
The Global Fund - To Fight AIDS, Tuberculosis and Malaria

Minutes of the 47th India Country Coordinating Mechanism (CCM) Meeting held on 16th Aug 2011

The 47th meeting of the India Country Coordinating Mechanism (India CCM) was held at 3.00 p.m. on 16th Aug 2011 at Ministry of Health & Family Welfare, Nirman Bhawan, and New Delhi. A list of India CCM members and invitees present at the meeting is annexed (Annexure-I). The meeting was chaired by Mr. K. Chandramouli, Chair CCM and Secretary, Health & Family Welfare. Ms. Aradhana Johri, AS NACO & Member Secretary CCM briefed the members on the agenda items and welcomed them.

Agenda No. 2: Discussion and decision on India's application for Round 11. Ms. Komal Khanna, India CCM Coordinator presented the highlights of the GFTAM Round 11 launch.

The GFTAM Board at its 23rd meeting in May 2011, approved the new eligibility, prioritisation and counterpart financing criteria that determine the countries eligibility to apply for The Global Fund. The eligibility criteria takes into account the country income level, the national disease burden, the focus of proposals and the history of recent funding of the applicant. The first criteria is Income level. The Global Fund makes the determination of income classification based on the World Bank (Atlas Method) Income Classifications. For purposes of eligibility, countries that fall into the income classifications Low income countries, Lower middle income countries, Upper middle income countries are eligible for Global Fund funding. Second criteria is Disease burden- For each disease in the country, a score is given according to the magnitude of the disease burden i.e. high, Extreme or Severe as a % of the total population. All low income and lower middle income countries, regardless of the magnitude of their disease burden, are eligible to apply under General Pool or the Targeted Pool. There is also a recent funding history rule when an applicant has a Global Fund grant for a particular disease that started implementation in the last 12 months (i.e. on or after 15 December 2010) or a recently approved proposal that has not yet been signed into a grant, that applicant is not eligible to submit a new proposal for that same disease (or HSS). Another criteria is the focus of proposals. In the General Pool, proposals from low income countries do not have to meet any focus criteria. Proposals from lower middle income countries must focus at least 50 percent of the budget on underserved and most-at-risk populations and/or highest-impact interventions within a defined epidemiological context. Proposals from upper middle income countries must focus 100 percent of the budget on these populations and/or interventions. In the Targeted Pool, all proposals regardless of the applicant's country income level must focus 100 percent of their budgets on most-at-risk

populations and/or highest-impact interventions. In the fourth criteria of Counterpart Financing, the governments are required to make minimum contributions to the national disease program budget. The counterpart financing requirement for India is 20% for lower LMICs. For India, as per the prioritization funding pool, the scores for disease burden are 'high' for HIV- score: 4, 'severe' for TB- score: 6, 'extreme' for Malaria -score: 8. The income level score for lower LMIC is 3 hence the TRP prioritization score would be HIV- 7, TB-9 and Malaria-11. Along with these, there are New CCM guidelines with 6 minimum requirements that are mandatory for Round 11 application. There is a requirement of mandatory grant consolidation in Round 11, per disease program. The proposal format was also mentioned briefly.

Discussion:

Ms. Aradhana Johri, AS NACO clarified that the Round 11 eligibility criteria stipulated by The Global Fund is quite complicated and funding for India programme is likely to be more difficult especially for HIV because of the new prioritization criteria. Hence careful analysis has to be made to understand the criteria employed by GFTAM. Counterpart financing and increased expenditure and tracking of expenditure could also be problematic. Hence there is greater need for planning and coordination.

Secretary H and Chair CCM stated that it will not be possible to have proposals with small gaps as the proposals would need to mesh with the larger national program.

Dr. Subhashree Raghavan, President SATHHI mentioned that the NACP IV consultations had brought up new knowledge gaps in the national program and that data could be considered for Round 11 gap identification and focused priority areas.

Prof. Gilks mentioned that funding gap analysis was important. There was a shift in The Global Fund approach towards grant consolidation hence a gap analysis of what has been done from NACP III to NACP IV could be undertaken. NSA mechanism could also be considered. Without any fall back mechanism for future funding, India might miss the cycle in the 11th five year plan.

Mr. Sayan Chatterjee, Secretary & DG NACO agreed that this was a valid point and given the current situation the logical way to proceed forward was to identify the gaps and priority areas and then check the availability of resources.

Ms. Aradhana Johri, AS NACO mentioned that GFTAM processes take a long time. There may be another funding window of NSA next year which could also be explored although it is dependent on the resources available at that time. There is a probability that the consolidated NSA application gets a higher TRP rating than a standalone Round 11 application. She cautioned that India should apply for funding under Round 11 only if it is a national priority.

Dr. Subhashree Raghavan, President SATHHI stated that at the NACP IV meeting there has been some ambitious thinking with a finite amount of money. Financial gaps should be understood well by the committee to move forward with Round 11 application. If we succeed, then it would be good if not, then there may be an issue with 2nd line therapy for India.

Prof. Gilks, UCC UNAIDS stated that the country priorities will be included in the next five year plan once the country identifies the priorities.

Father Varghese, Executive Director, CARITAS proposed that efforts should be made to identify the gap areas and position them strategically. It was suggested that three committees should be constituted to study the gaps in the three diseases.

Dr. Subhashree Raghavan, President SATHHI suggested that Govt. and CSO consultations could be organised for the three diseases and especially for Malaria.

Mr. John K. George, Executive Director Swiss Emmaus proposed that a consensus should be made to apply for the three diseases.

Secretary H and Chair CCM mentioned that it should be first checked whether the disease proposal stands a good chance of qualifying for Round 11.

Mr. Nirod Kumar Bhuyan, Program Officer, Lepa Society requested that regional workshops should be organised to identify the malaria burden in states.

Mr. Manohar Elavarthi, CCM Vice chair, Board member Suraksha enquired whether funds were available with CCM to conduct regional workshops.

Secretary H and Chair CCM stated that the focus should be first at the national level then state and then at district level. Out of 30 states, only 6 states constitute urban malaria in the country where 13 towns and districts are covered.

Decision:

It was decided that as soon as possible after the CCM meeting, three disease specific committees should be formed. These committees should comprise of people to scrutinize the gaps and the Round 11 guidelines from each of the constituencies by looking at the disease profile, identified gaps and priority areas, then bring them to CCM for CCMs approval and accordingly advertisements can be released inviting call for proposals.

The participants of the disease specific committees were proposed as follows-

HIVAIDS- NACO, representative of state Govt; Prof. Gilks, UNAIDS, Bi/Multilateral; Dr. Paranjape, NARI, Academic & Research; Mr. Manoj Pardesi, NMP+, PLHA; Mr. James Robertson, IHAA, CSO

TB- Mr. Ashok Kumar, RNTCP; Dr. Hemachandran, USAID Bi/Multilateral; Mr. John, Swiss Emmaus,CSO; Dr. Srinath, People affected by TB, Dr. Kuryan George, Academic & Research Institute, CMC Vellore

Malaria-Dr. Dhariwal, NVBDCP, Govt; Dr. Gunashekhar, WHO, Bilateral and multilateral; Dr. Dhiman, NIMR, Academic & Research, Mr. Nirod Kumar Bhuyan, Lepa Society; People affected by Malaria; Father Varghese, CARITAS, CSO.

Agenda No. 1: Discussion on INP+ issue, an update by Ms. Poonam Muttreja, Executive Director PFI

Ms. Poonam Muttreja briefed the CCM on the progress made in the financial management issue with INP+. She mentioned that after the KPMG report was released, OIG conducted an investigation but did not find any evidence against INP + board members on the mismanagement of GFTAM Grant money. OIG had rejected the KPMG report. But GFATM asked PFI to tell INP+ to transfer the GFATM money that was lying in the PSF account back to INP+. Accordingly, INR 1.6 crores was transferred back from PSF to INP+ in April 2011. This money is now lying in fixed deposits with INP+.

PFI had organised a meeting with the INP+ Board in Chennai on 22nd July, 2011 and discussed the way forward on the roll out of RCC with effect from 1st October, 2011 with INP+ and SLNs. Some preconditions were laid down for the RCC implementation as laid out in the management letter of GFATM. The interim arrangements with DLNs were ending on 30th September, 2011. Following the management letter dated 27th June 2011, PFI had asked Abraham, Jhanabi and Renuka to recuse themselves from all decision making and fiduciary roles of GF grants. Accordingly, INP+ Board passed a resolution that Abraham, Jhanabi and Renuka would recuse from all decision making and identified three new decision makers with regard to GF Grant. INP+ is in the process of appointing an independent CA firm to conduct a special audit regarding how much overhead costs from R4 and R6 grants were received from PFI, its legitimate expenditure, transfers made to PSF attributable to GF resources, and whether the money was spent legitimately for program purposes. INP+ was asked to work out viable solutions in Uttar Pradesh and Maharashtra states so that simultaneous roll out RCC in these two states as well could be done.

Further to this, PFI organized a meeting with an advisory committee on 26th July to develop an action plan on the basis of the GFTAM management letter. Mr. Manohar Elavarthi, Prof. Charles Gilks, Mr. Subhash Mendhapurkar and Ms. Brinelle D'Souza attended this meeting. Ms. Kerry Pelzman could not attend the meeting due to a prior commitment. A roll out of RCC with INP+ on board along with SLNs was discussed at length at the meeting.

PFI wanted to take the concurrence of CCM to roll out the program with INP+ and SLNs from 1st October 2011, therefore PFI had requested for an agenda item in the CCM meeting.

Discussion:

Prof. Gilks, UCC UNAIDS stated that PFI was working directly with 200 DLNs and SLNs and the deadline on this interim arrangement was end Sep 2011. Hence it was a priority to get this issue resolved. The GFATM Fund Portfolio Manager, Mr Andreas Tamberg visited India to move this issue forward.

Secretary H and Chair CCM questioned the timeline for closure on this issue. It was clarified that CCM had no contribution to make in this particular issue at this stage. CCM had been working on this issue for over a year and half and instituted an investigation with KPMG. KPMG report was sent to GFTAM and OIG came into the country stating the KPMG report was not valid and started its own investigation, the report for which is still not released. Hence it was never clear who had the final authority on resolving this issue. Also the role of CCM needs to be defined when such issues come up in a country. PFI should sort out this issue with the GFTAM as soon as possible as there were already lot of misgivings on this account in the community.

Ms. Poonam Muttreja, Executive Director, PFI mentioned that the 1st Oct is the rollout of the RCC grant.

Swami Shantatmananda, Secretary Ramakrishnan Mission enquired about the system of accounting and transparency mechanism to ensure that the same problem does not get repeated in the future. The responsibility of the PR is to ensure that the grant is managed properly for which PFI was given 12% management fees. He wanted to know what was the value added by PFI.

Secretary H and Chair CCM mentioned that the same questions were being asked of the GFTAM but there have been no clear answers. PFI should sort out this issue and report back to CCM.

Mr. John K George, Executive Director Swiss Emmaus enquired whether there was a protection policy for the whistleblower.

Mr. Sayan Chatterjee, Secretary & DG NACO stated that there is no clear cut policy and that still needs to emerge. CCM should have a clear cut policy on how to proceed forward when such issues come up gain.

Mr. Nirod Kumar Bhuyan, Lepira Society enquired whether money is being returned with interest by INP+. It was suggested to wait for the report.

Father Varghese, Executive Director, CARITAS suggested that when INP+ starts working with SLNs under RCC, same criteria should be used for their approval/disapproval if all are at the same level of functionality.

Dr. Subhasree Raghavan, President SATHHI mentioned that this transition would be very time consuming and there was a clear requirement of concrete recommendations and guidance to improve the systems to be given from the PR to the SR.

Secretary H and Chair CCM clarified that CCM cannot give any guidance on the lessons learnt from this issue. In order to oversee any GFATM grant issues, CCM should be clearly told about the extent of its delegated authority.

