INDIA

INTEGRATED DISEASE SURVEILLANCE PROJECT (Credit 3952-IN)

JOINT IMPLEMENTATION REVIEW

AIDE MEMOIRE

July 1- 10, 2009

1. A joint implementation review of the Integrated Disease Surveillance Project (IDSP) was conducted by a World Bank team with technical support from the World Health Organization (WHO) during July 1-10, 2009[1]. The members of the review team discussed the implementation progress of IDSP and Human Health sub-component of Avian Influenza during the past 6 months with the Ministry of Health & Family Welfare (MOHFW) and IDSP Central Surveillance Unit (CSU) officials in Delhi and met with the representatives of 7 priority states identified for the implementation of a comprehensive disease surveillance package. The implementation plans for the proposed restructuring of the project prepared by CSU and the priority states were discussed and specific actions were agreed to complete the restructuring. Conjointly another Bank team working with Food and Agricultural Organization reviewed the implementation progress of the Animal Health sub-component of Avian Influenza and also discussed the proposed implementation plan for restructuring of this component. A separate Aide Memoire is being issued for the Animal Health sub-component summarizing the implementation progress and agreements reached for project restructuring so that the proposed restructuring could be done conjointly. Prior to the review, a joint team consisting of the CSU, WHO and the Bank visited the state of Karnataka to discuss and finalize the state draft implementation plan including laboratory networking which was subsequently discussed in a consultation organized for all priority states at Delhi in June 2009. Visits were also made to the states of Maharashtra and Karnataka to discuss and finalize the implementation arrangements for the community surveillance pilots during June 2009.

2. The Bank team would like to thank Mr. Naresh Dayal, Secretary, Health & Family Welfare, Government of India (GOI), Dr. Shiv Lal [Special Director General, Public Health and Director, National Institute of Communicable Diseases (NICD) and Project Director – IDSP] and Dr. R.S. Shukla (Joint Secretary) for sustaining strong political commitment for IDSP and encouraging frank and open discussions on project restructuring in the light of implementation experiences so far. The Bank team would like to specially thank Dr. A.C. Dhariwal, Additional Director (Public Health) and the National Project Officer (NPO) for the IDSP for his leadership to get project restructuring proposals prepared despite several demands on his time, especially during the recent outbreak of H1N1 influenza. Dr. R. L. Ichhpujani and Dr. Lata Kapoor have followed up with states to develop new approaches to improve laboratory surveillance. The contributions made by Dr. Shashi Khare in establishing the influenza laboratory network involving NICD and 9 laboratories located at different states under the IDSP is highly appreciated. The Bank team gratefully acknowledges the constant technical support being provided by WHO to IDSP.

3. Through an extensive consultative process involving all key stakeholders including the priority states and experts from NICD and CSU, IDSP the review team has successfully achieved its objective of undertaking a comprehensive review of the scope and implementation arrangements for the proposed project restructuring. It was agreed that the Bank support would be limited to CSU and 7 priority states while the GOI funds will be used to sustain basic surveillance preparedness in the remaining states. This

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will enable the project to demonstrate a viable model of disease surveillance for India which can be incrementally scaled-up to other states subsequently. In line with this strategic shift in the scope of the project, a new project development objective and results framework with clearly defined and measurable indicators were discussed and a timeframe was agreed to for completing specific actions by GOI and the Bank to complete the project restructuring. The team reported its findings at a wrap-up meeting, chaired by the Additional Secretary, Health and Family Welfare, on July 10, 2009. This Aide Memoire summarizes the findings of the review along with component-wise implementation ratings and agreed key actions. The detailed implementation progress is annexed.

4. **Key Project Data**

Project Data	**Project Performance Ratings**		
Board Approval: July 8, 2004	*Summary Ratings*:	*Last*	*Now*
Effectiveness Date: October 28, 2004	Achievement of PDO	MU	MU
Original Closing Date: March 31, 2010	Implementation Progress	MU	MS
Revised Closing Date (if relevant):	Financial Management:	MU	MU
MTR Date (Actual if completed): June, 2008			
Original Ln./Cr. Amt: US$ 68 Million			
Revised Ln./Cr. Amt:			
Amount Disbursed: US$ 19.5 Million			

Ratings: **HS**=Highly Satisfactory; **S**=Satisfactory; **MS**= Moderately Satisfactory; **MU**= Moderately Unsatisfactory; **U**=Unsatisfactory; **HU**=Highly Unsatisfactory; **NA**=Not Applicable; **NR**=Not Rated

Summary

5. The review team is pleased to note the significant contributions made by IDSP to contain the recent H1N1 pandemic in India. With IDSP infrastructure in place, India could put in place a highly effective tracking system which ensured prompt identification of all contacts of confirmed primary cases and ensured administration of prophylaxis with Tamiflu. The impact is visible with only 9 first generation cases among the contacts reported in India so far. The IDSP toll free call center also played an effective role in providing information to general community and also guiding them to facilities where suspects can be screened. The network of ten laboratories strengthened under Human Health sub-component of the Avian Influenza have been activated to undertake real time PCR (Polymerase Chain Reaction) testing for H1N1 and 3 of these labs have started testing the samples and all labs will be made fully functional by end July 2009.

6. The IDSP has institutionalized weekly review of the surveillance data and provided feedback to the states. Outbreak reporting has shown improvement as 418 outbreaks have been reported till June 2009 compared to 553 total outbreaks reported in 2008. The weekly outbreak report is shared with all key stakeholders including the Prime Minister's Office. As agreed, the CSU has started monitoring the quality of outbreak investigations using a standardized tool which identified an urgent need for improving the quality. A compilation of common disease patterns and IDSP activities among tribal populations was undertaken. Detailed implementation plans for project restructuring were shared by the CSU and 7 priority states during the mission. There has been progress in induction training for the new cadre of contractual staff being recruited under the IDSP. Two faculty sensitization sessions in epidemiology were held for 47 faculty members from training institutions belonging to 15 states and one meeting was held for faculty of 3 institutions identified for training microbiologists. Draft training modules have been prepared for induction training. A comprehensive procurement plan covering IDSP and human health components of IDSP has been finalized and shared with the Bank during the mission. Based on the

progress made in establishment of the core surveillance infrastructure in the country and notable contributions the project has started to make for detecting the outbreaks and containment of pandemics, the implementation progress is now rated “moderately satisfactory”.

7. Notwithstanding these developments, the project is facing serious implementation challenges and is currently rated as a “problem project”. Specific actions were agreed during the portfolio review held by the Department of Economic Affairs to upgrade the project. While there has been progress in some actions, few of the critical agreed actions to improve the ratings for financial management and procurement are still pending while the restructuring proposal which will address the disbursement flag has been shared during the mission. Frequent changes of state surveillance officers, turn-over of finance and procurement consultants due to low compensation package, challenges faced by the CSU to constantly follow-up with all states and Union Territories, and competing demands on health department seemed to have adversely affected the ownership at state and district levels for strengthening surveillance systems.

8. While the reporting has improved, participation of public hospitals and private sector continues to be low. Further, analysis and use of data for local response remains weak, especially at the district level and laboratory confirmation is still low. Thus, the project development objective of establishing an integrated and decentralized disease surveillance system that improves on the ground response to diseases and risk factors is not possible to achieve by the current closing date of the project and hence progress continues to be rated Moderately Unsatisfactory.

9. The GOI has demonstrated a very strong commitment to firmly establish disease surveillance program in India by creating positions of epidemiologists, microbiologists and entomologists under the National Rural Health Mission. The planned recruitment of epidemiologists (491), microbiologists (85) and entomologists (23) was notably delayed due to the general elections, shortage of trained human resources in the market and inherent complexities involved in undertaking such large scale nation-wide recruitment. As such, 142 epidemiologists, 15 microbiologists and 8 entomologists joined. With the remaining selected candidates expected to join by August 2009, the induction training requires priority attention to ensure meaningful and effective participation of new staff in the IDSP. With the planned training completed in the Phase I and II states, the emphasis of capacity building should now be on improving the reporting of clinician confirmed cases from hospitals using the P forms through sensitization of the doctors, pharmacists and staff nurses working in the outpatient departments of these facilities. The 2-week field epidemiology training has shown a strong positive impact on improving abilities of district surveillance officers in decentralized data analysis and initiating appropriate local actions. So far, 228 officers received this training and this needs to be further expanded.

10. Rapid and reliable etiological confirmation of outbreak prone diseases is critical for disease surveillance. Initially IDSP aimed to support laboratories at 5 different levels starting from the Primary Health Center. However, implementation experiences showed that due to limitations in availability and capacity of human resources, it is not possible to expand the laboratory strengthening component as envisaged. Many revisions in laboratory strengthening plan happened since then which resulted in confusion and incorrect comprehension at state levels. Over the past few months the laboratory cell of CSU has been very pro-active in engaging the states for the final revision of the laboratory component, concentrating on basic and feasible actions. This was translated in a new vision which is now included in the revised Project Implementation Plan. The laboratory component will focus on a two-pronged approach consisting of reinforcing the capacity of 50 priority public health labs at district level in the country and demonstrating success in seven good performing states by building up a referral network through partnering with existing and functioning laboratories. Both strategic orientations will integrate a competency based strengthening of human capacities and reinforce quality assurance standards at all levels. A detailed action plan with clear timelines was developed, taking into consideration some of the

major implementation challenges. To ensure success of the implementation, it will be crucial that the project reinforces capacity at central, state and district level, seeks active collaboration with WHO to define guidelines, obtains laboratory test results useful for surveillance (e.g. outbreak confirmation, diagnosis of key IDSP diseases difficult to diagnose on clinical grounds), and assures continuous handholding at state and district level.

11. 82.8% of the 606 districts are now generating weekly surveillance reports, mainly from the public primary health care facilities. The involvement of private sector continues to be poor as only 119 (20%) of these districts are reporting data from private sector. Despite notable progress in establishing the IDSP portal and broadband connectivity, only a third of the districts (220) are entering the data on-line. Since January 2009, 194 video conferencing sessions were held with states, but only 6 of them were used for training purposes. The validation of the SMS initiative by Andhra Pradesh is still to be undertaken and state level hands on training for the Data Managers needs to be accelerated to ensure on-line data entry and use of the portal tools for data analysis. There is also need for an efficient mechanism for promptly addressing the software glitches identified by the states. The review team was informed that due to steeply increased demands on the toll free call center with H1N1 pandemic, the language options were limited to Hindi and English. This needs to be revisited again to ensure the nation-wide use of the call center. The IDSP needs to clearly articulate the future role of the National Informatics Center (NIC) to ensure that the core skills required for software updates and data warehousing are available with the CSU.

Project Restructuring

12. Disease Surveillance is a core public health function and the recent H1N1 pandemic has amply demonstrated the need for such a system. India needs to be commended for taking lead in initiating the integrated disease surveillance program. The Bank operation is supporting the first phase of this long term vision. Based on the implementation experiences, the criticality of an incremental approach by demonstrating successful implementation of IDSP in few states is clearly evident. Also, meeting stringent Bank fiduciary requirements by all states for the small quantum of financing provided by the project became a constant irritant diluting the Bank's technical dialogue. Finally, the need for constant and strategic technical assistance for country capacity building and creating an understanding that surveillance data are needed to drive public health action has only become more evident during the first 4 years of implementation.

13. State Implementation Plans: The joint review team commends all seven priority states for preparing high quality State Implementation Plans (SIP). These reflect a shared understanding of the overall vision for the restructured project to have a high quality and dependable disease surveillance program compliant with the International Health Regulations (IHR-2005). Each SIP has outlined a prioritized set of activities to enhance surveillance preparedness, outbreak investigation and response, and data analysis and use. Each state plan identified the challenges of IDSP implementation and proposed specific actions to address them while building on the existing strengths. Examples of key activities include: creating a critical pool of dedicated human resources for disease surveillance; improving the participation of public and private hospitals in IDSP by sensitizing the medical officers about the IDSP and reporting requirements, training pharmacists and staff nurses in data compilation and reporting; enhancing PHC and district level capacity for data analysis, more meaningful engagement of medical colleges in disease surveillance, outbreak investigations and laboratory support; FETP training; seeking involvement of the private sector using innovative and proactive approaches; developing and testing a variety of innovative models building on strengths of community based organizations in respective states to involve communities in surveillance; and forging strategic coordination with NRHM, department of Medical Education, Private health provider networks, ID hospitals.

14. Scope: Taking the above in to consideration, it was agreed that the restructured project would have strategic focus on building the technical capacities of the CSU for effective oversight of disease surveillance activities in accordance with the International Health Regulations (2005) and the state level support under the Bank operation will cover only 7 states identified based on their performance during the first 4 years of the project. The remaining states will be supported by GOI domestic funding as they will take some more time to establish basic surveillance infrastructure learning from the experiences of the 7 states. It was agreed that the urban surveillance pilots would be integrated with the proposed Urban Health Mission and no further surveys for Non Communicable Disease Risk factors will be undertaken under the project. With the new country financing parameters agreed with GOI, the IDA credit could reimburse 100% of the expenditure for the activities financed by the Bank.

15. Enhancing state ownership: Implementation experiences of IDSP clearly suggest that the ownership of the states for IDSP remains quite varied. Where the state health mission and senior officers are fully seized with the benefits of IDSP, there is full ownership for the program and the data was effectively used for local actions. It was therefore agreed that some specific actions will be required to further enhance integration of IDSP with the NRHM as under:

- First, the revised implementation plans prepared by the states should be reviewed and forwarded through the state Mission Director.
- Second, the weekly surveillance updates will be shared with the Directors of Health Services, Medical Services and Medical Education, other senior policy makers and other key stakeholders as is being done by the CSU[2].
- Third, the importance of timely sharing of quality data needs will be emphasized through structuring of part of the salaries of the ICT staff (e.g. timely entry, completeness and analysis) and epidemiologists (e.g. for achieving over 50% score in outbreak investigations) in the form of performance incentives.

16. Involving Medical Colleges: It was agreed that the restructuring would ensure specific strategies for pro-active engagement of Medical Colleges. The specific activities discussed include: (1) IDSP case reporting (P and L forms) by medical colleges; (2) Making Edusat connectivity operational and using medical colleges as IDSP training hubs; (3) Using medical college faculty as mentors for the newly recruited epidemiologists; (4) Providing Referral Lab services; and (5) Sentinel lab based surveillance, such as laboratory testing of pediatric meningitis cases, or encephalitis cases. It was agreed that one coordinator will be identified by each medical college for these actions, as IDSP success requires active collaboration across many Medical College departments, and with state laboratory and surveillance personnel (and potentially CSU to provide access to specialized national reference laboratories and , national training efforts).

17. Strengthening CSU oversight: The CSU staff and consultants need to undertake regular field visits and provide constant feedback. Constant monitoring of quality of data in P and L forms through regular data analysis, and outbreak investigations using the scoring tool, and providing feedback to states needs to be sustained. Appropriate checklists need to be developed for the epidemiologist to report findings of their field visits every week and report key actions every month. The CSU requires dedicated support in project management including the possibility of the Deputy Secretary visiting project at regular intervals. The FM cell requires strengthening by recruiting two accounts professionals and the procurement consultant requires training in Bank procedures. With the recent decision taken by MOHFW

[2] The CSU shares the weekly updates with the Cabinet Secretariat, Senior Officers of the MOHFW, NRHM and Disease Control Program Officers and other stakeholders.

to enhance and ensure uniform compensation to all consultants the frequent turnover of project fiduciary staff is expected to reduce. Regular state visits by the CSU fiduciary staff are required to ensure timely follow-up on pending fiduciary issues and a system of weekly reviews at the Project Director and Joint Secretary levels was agreed upon to promptly identify and resolve any implementation bottlenecks.

18. Technical Assistance for IDSP: WHO has been constantly supporting disease surveillance initiatives in India and has been closely associated with the IDSP. WHO has agreed to provide technical assistance through a full time n microbiologist and 50% support from two epidemiologists, one information technology specialist and one microbiologist. The Centers for Disease Control (CDC), USA has also been closely associated with the IDSP from the design phase. The MOHFW duly recognizing the expertise CDC could bring for country capacity building has proposed to seek technical assistance from them through the project as has been done by Brazil and Argentina under Bank supported operations. MOHFW had several rounds of discussion on the scope of TA from CDC and finalized a draft outline for the TA support. It was agreed that the TA support from CDC would be financed under the restructured project and MOHFW will enter in to a formal contract with the CDC foundation following agreed Bank procedures.

Avian Flu Human Health

19. India till date has reported 33 outbreaks of Avian Flu among the bird population and so far no human case has been reported. All the recent outbreaks reported are from Eastern and North Eastern India highlighting the need for heightened surveillance in this part of the country. The review team is pleased to note cross border discussions with Bangladesh on containment. The most recent outbreak has been reported from the Uttar Dinajpur district of West Bengal in May 2009. All the 10 labs included in network for the human health sub-component have entered in to MOU with the NICD and received most of the critical equipment. The Empowered Procurement Wing has finally resolved some operational problems in the transport of BSL 3 lab to Mumbai and used services on an independent agent for pre and post dispatch inspections. Two rounds of training programs have been held for the nodal officers and the lab technicians from these labs with the second training covering the H1N1 identification using real time PCR.

20. The review team strongly endorses the use of the AI lab network for H1N1 surveillance and the project funds could be used for procurement of consumables required. It was agreed that the project would include the requirement of consumables for H1N1 in the procurement plan and depending on urgency may use emergency procurement after obtaining Bank's no objection.

21. The surveillance of Influenza like Illness has started at 2 sites (Delhi and Ahmadabad). Based on the implementation experiences at these sites, it was agreed that each site will have a dedicated technician for specimen collection from the identified sentinel sites and s/he will be provided adequate transport allowance to use her/his vehicle for transportation. Training will be required for the doctors and nurses working at the selected sentinel sites and each identified site will be given a fixed sum every month to cover operational costs from the lab to which the site is attached.

Disbursement and Savings

22. As of July 8, 2009 the project disbursed USD 19.5 million equivalent including the special advance of USD 6.8 million and USD 3.9 million disbursed for the Avian Influenza Animal Health Component. This represents 27% of the total Credit. A net balance reimbursement claim of about USD 1.6 million for FY 2008-09 is in pipeline. Based on the available data, the IDSP still has around USD 23 million equivalent and the Human Health Avian Influenza has around USD 3.86 million to be disbursed.

Annex 1

Agreed Key Actions

For Project Upgrading

Area	Actions	Completion date
Procurement	• Share the reply/action taken on the last procurement review covering contracts issued during April 2006 to June 2007 • Issue RFP for E-learning	15 August, 2009 31 August, 2009
Financial Management	• Share the FMRs for 2008-09 from states in new formats along with list of contracts issued at central and state levels for post procurement review. • Respond to Bank's letter sent in February 2009 and June 2009 requesting for certain clarifications regarding 2007-08 audit observations for the states of Maharashtra, Karnataka, Chhattisgarh, Rajasthan, Sikkim and Uttaranchal • Share the Pending Audit report for 2007-08 for the state of Jammu & Kashmir	31 August 2009 31 August 2009 Immediate
Disbursement	• Agree the scope and timelines for restructuring of the project	31 July, 2009

For improving project implementation

Component	**Rating**	**Actions**	**By When**
Component 1. Establish and Operate Central Level Disease Surveillance Unit	**MS**	• Sustain the use of tool to assess quality and timeliness of outbreak investigations and provide monthly feedback to states. • Support the ID hospitals in data analysis and establish a mechanism for weekly feedback to states.	31 July, 2009 31, Dec 2009
Strengthen data quality analysis and links to action (Information Technology)	**MU**	• Communicate the decision to decentralize appointment of data managers and data entry operators, and pay operational costs for Broadband to States • Complete feasibility assessment of SMS reporting of S forms in AP	Aug 31, 2009 30 Nov, 2009

Technology)		in AP • Determine the future role of NIC in IDSP especially in the areas of data warehousing and software updating amend the TORs. • Based on the feedback provided by states address the software glitches in IDSP portal and update the IDSP webpage; put in place mechanism for feedback and continuous improvement of IDSP software • Review the toll free call centre functioning and agree actions for providing nation-wide multi-language option.	31 Aug, 2009 30 Nov, 2009 31 Dec 2009
NCD Risk factor surveys	**MS**	• IDSP will share the report and data of the first round surveys with the NCD cell for further analysis and dissemination	August 31, 2009
Component 2. **Integrate and strengthen disease surveillance at the state and district levels**	**MS**	• CSU will provide feedback on the proposals shared by the 7 priority states • Priority states to share revised proposals after obtaining approval of the State Mission Director, NRHM • States to complete appointment of all staff selected by National Health Systems Resource center • CSU to finalize arrangements to fill-up vacant posts in consultation with NHSRC	July 31, 2009 August 31, 2009 August 31, 2009 July 31, 2009
Component 3. **Improve Laboratory Support**	**MS**	• Complete induction training for the first batch of microbiologists • Undertake on the site assessment of at least 15 district labs in the 7 priority states with technical support from WHO • Start implementing the referral lab networking plans in all 7 priority states; document test results from the referral lab network reported to IDSP in the form of monthly reports.	October 2009 January 2010 December 2009
Component 4. **Training for Disease Surveillance and Action**	**S**	• Prepare revised training plan • Start induction training for the newly recruited epidemiologists and entomologists • Develop training modules for medical officers and data compilers (Pharmacists and Staff Nurses in OPD) with the help of WHO and share with the States	31 July, 2009 August 31, 2009 30 September, 2009
Avian Influenza Human Health	**S**	• Finalize the specimen transportation arrangements and start implementation of Seasonal Influenza surveillance plan	August 31, 2009

Procurement	**U**	• Disclose procurement relation information (procurement plans and contract award) on IDSP and MOHFW websites	Immediate
Financial Management	**MU**	• Share consolidated statement of audited expenditure for CSUs and SSUs, summary of audit observations for 2008-09 • Strengthen FM cell at CSU with two full time finance staff with accounting background	30 September, 2009
Community Surveillance		• The CSU will closely monitor the implementation of the Tribal Action plan in the 6 Blocks and provide quarterly updates to the Bank • Under the project restructuring, a communications consultant will be engaged by the CSU to compile IDSP achievements and existing communication material on communicable diseases to develop advocacy plan for IDSP and provide repository of communication material for outbreak prone diseases for different agencies.	30, October onwards 31, December 2009

Annex 2

Status of Key Performance Indicators

Table 1. Status of agreed outcomes indicators

Indicators	Measurement					
	Baseline Value		Progress To Date		End-of-Project Target Value	
	Number or text	Date	Number or text	Date	Number or text	Date
1. Number and % of districts providing monthly surveillance reports on time	93 districts included in National Surveillance Program for Communicable Diseases	10/26/2004	82.8% of all districts (502 out of 606) generated weekly surveillance reports for the week ending 21 June 2009 mainly from primary health care facilities. Phase I: 82% (174/212) Phase II: 95% (178/189) Phase III: 73% (150/205)	06//21/2009	>50% of the districts providing monthly surveillance reports on time	03/31/2010
2. Number and % of districts in which private providers are contributing to disease information	None	10/26/2004	142 districts out of 401 districts covered in Phase I and II (35%) have identified reporting units in private sector and 114 (80%) of them reported from private sector in the week ending June 21, 2008	06/21/2009	at least 50% of reporting districts	03/31/2010
3. Number and % of laboratories providing adequate quality of information	None	04/04/2006	Around 74% of the districts covered in Phase I and II states are reporting data from laboratories	06/21/2009	>75%	03/31/2010
4. Number and % responses to disease-specific triggers assessed to be adequate	Not existing	10/26/2004	Weekly outbreak reporting started from September 2007 and 31 states reported 418 outbreaks in 26 weeks compared to 553 outbreaks reported during 2008 and most of the outbreaks were investigated by District RRTs. The laboratory confirmation is around 23%	06/21/2009	>75%	03/31/2010

Table 2. Status of agreed Intermediate Outcomes Indicators						
Indicators	**Measurement**					
	Baseline Value		Progress To Date		End-of-Project Target Value	
	Number or text	Date	Number or text	Date	Number or text	Date
1. IT software developed and operating through the national network established for the project	No software and networking	10/26/2004	The new software is now available on the IDSP portal and on-line data entry being done by over 200 districts in 17 states IT hardware supplied to 800 locations and installed in 760 Connectivity established at 676 locations through Broadband and 332 through and satellite.	06/21/2009	National IT network established for Integrated Disease Surveillance	03/31/2010
2. Number of state surveillance units established with adequate staff, IT hardware, linked to national network	Not applicable	10/26/2004	All 23 phase I and II states have established state surveillance units. 544 data managers have been appointed at state and district levels. 445 district/state surveillance units fully functional with human resources, ICT tools and Broadband connectivity.	06/21/2009	All major states of India will have state surveillance units	03/31/2010
3. Number of staff trained in disease surveillance epidemiology and outbreak investigation	Not applicable	10/26/2004	2,033 members of district and state surveillance teams, 26,065 medical officers, 138,772 health workers and 8,315 lab technicians received training in disease surveillance. 228 district surveillance officers were trained in the new two week field epidemiology program.	06/21/2009	2500	03/31/2010

Annex 3

Detailed Implementation Progress and Restructuring of IDSP

Component 1: Establish and Operate a Central-level Disease Surveillance Unit (CSU):

Assuring Surveillance preparedness

1. The CSU located at the NICD continues to provide strategic technical leadership for the IDSP. In addition to the National Program Officer, four senior staff from NICD with expertise in the areas of Epidemiology, Training, Microbiology and Entomology are working full time under the project. In addition, several NICD staff are providing regular inputs to the project to improve laboratory services, data analysis and community surveillance. The CSU now has 7 consultant epidemiologists; consultants for IT services and finance, data manager and training manager in position, and the vacant post of procurement consultant has recently been filled. As envisaged in the project design, the CSU has played a crucial role in the containment of H1N1 pandemic though coordinating with the states to trace the contacts of confirmed cases using IDSP network. The toll free call center was effectively used to inform medical personnel and general public about H1N1 including the location of nearest diagnostic centers. Finally, the laboratory network for Avian Influenza is now being used for the diagnosis of H1N1.

Improving outbreak investigation and response

2. Outbreak reporting has shown improvement. A total of 418 outbreaks were reported till June 2009 compared to 553 total outbreaks reported in entire 2008. The weekly outbreak report is shared with all key stakeholders including the Prime Minister's Office. As agreed, the CSU has started monitoring the quality of outbreak investigations using a standardized tool which identified an urgent need for improving the quality. The standard Competency Assessment Tool for outbreak investigations and management takes into consideration defined criteria[3]. The use of the tool to analyze 20 randomly selected outbreaks reported by June 2009 was discussed during the review and further improvements were agreed. The restructured project will emphasize sustained improvements in quality of outbreak investigation by regular video-conferencing and field visits by CSU epidemiologists.

Agreed Actions: *By August 31, 2009 the CSU will further update the tool based on agreements reached and will continue ongoing monitoring the quality of the outbreak investigations.*

Strengthening data quality, analysis and use

3. The data entry on IDSP portal is improving. In the recent weeks (25 &26), in the priority states, over 50% of the districts in Tamil Nadu, Uttarakhand, Karnataka, and Gujarat were entering data on-line, whereas in the states of West Bengal, Maharashtra and Punjab less than 20% of the districts are doing so. Amongst the other states, more than 50% districts of Chhattisgarh, Rajasthan, UP and MP are reporting on the portal. The proportion of reporting units in the state/district is much lower. The laboratory data on the portal is generally poor except in Gujarat.

[3] The criteria are: 1) a documented, real increase of incidence compared to the baseline; 2) availability of laboratory diagnosis; 3) use of a standard case definition; 4) use of explicit, uniform strategy to look for all cases and line listing them; 5) generation of hypothesis using time, place and person (e.g., incidence by age and sex) distribution of cases; 6) the testing of hypotheses through an analytical study (e.g., case control, cohort); 7) conclusions regarding the source of the outbreak; 8) any additional investigations conducted/asked for on the basis of the results of the analytical study; 9) a final report containing evidence-based recommendations; and 10) implementation of the recommendations

4. The review team was pleased to note that the revised P and L forms are now made available on the IDSP portal to enable on-line data entry. A committee consisting of IDSP epidemiologists and experts from NICD is now monitoring the status of receipt of weekly surveillance data, analyzing data on a sample basis, and sharing their analysis with state surveillance units to promote similar analysis at the state and district levels. Further, the CSU is undertaking regular video conferencing to discuss reporting issues and seek clarifications on discrepancies in data such as sudden increase in the number of reported cases including actions taken. The restructured project will ensure sustained and regular weekly data analysis and feedback to states including tracking of actions taken, and desegregated analysis of P& L forms from major hospitals.

***Agreed Actions**: By September 30, 2009, i) formalize weekly analysis and feedback system; ii) ensure all districts in focus states report on portal; iii) Desegregated analysis of P form data from major hospitals; iv) train all state level data managers in data analysis.*

Enhancing the quality, frequency and use of communication network for surveillance:

5. As described earlier, the IDSP communication network was effectively used to contain the spread of H1N1. Training of Data Managers and Data Entry Operators has been completed in 8 states (including 4 priority states). The portal re-design is in progress and several software updates have been undertaken such as provision of tools for better data analysis, provision of the new P and S forms on the portal for on-line data entry. The toll free number (1075) is now increasingly being used. Up to June 30, 2009 a total of 47,348 calls were received, leading to detection of 95 Health Alerts and nine outbreaks. . However, several actions agreed to during the previous review are yet to be completed. Despite good progress in phase I and II states, installation of IT hardware and connectivity is lagging behind (Status: Broadband - 676/796; Data Centers - 760/796; Training Centre (Broad band) - 331/396; Training Centre (EDUSAT) - 332/400). Only 220 districts (36%) have begun reporting data on-line. As expected, a number of software problems are faced by states and are being resolved by the NICD-NIC IT teams. To better manage the very high call load during the H1N1 pandemic, the languages used by the toll free call center were limited to only English and Hindi. This decision needs to be revisited to ensure nationwide access with all 14 languages as implemented earlier.

6. Building on the implementation experiences, specific actions for improving ICT services were proposed for restructuring. These include:

- *IDSP portal:* i) Upgrading the portal design and features to enhance data use and analysis, including integration of data from ID hospitals; ii) decentralizing the broad-band connections state and district levels to ensure 24X7 connectivity of the requisite speed; iii) directly contracting high quality services for server, hardware and software maintenance.
- *Videoconferencing***:** i) Enhancing the EDUSAT bandwidth capacity; ii) making all planned video-conferencing facilities functional; and iii) institutionalizing regular periodic videoconferencing.
- *Media Scanning and Verification System***:** Establishing a systematic media scanning system in each of the priority states.
- *SMS reporting***:** Scaling-up the AP SMS syndromic reporting model based on the findings of the independent assessment of the model and operational feasibility.
- *Toll-free number***:** Resolving technical issues and ensuring universal access (from all parts of the country and from all provider networks).
- *IT Human Resources***:** i) Complementing the ICT team with a senior consultant with expertise in IT and Disease Surveillance (WHO will support the position); ii) decentralizing recruitment and management of IT human resources (DMs and DEOs) to the state level; iii) revising DM and DEO remuneration package at par with other national projects/programs and performance based incentives

for regularity and completeness of reporting ; iv) training Data Managers and Data Entry Operators to improve their competencies.

Agreed Actions: *NICD will ensure that: i) Equipment installation and connectivity (broadband and Edusat) are in place in all target locations by November, 2009; ii) The redesigned portal is rolled out by August 31; iii) Training for the other three priority states and for all other states to be completed by August 15 and December 31, 2009 respectively; iv) A list of software problems are collected from the states and issues resolved by NIC by August 31, 2009; v) The data flow diagram, including Standard Operating Procedures (SOP), in consultation with the CDC IT expert and the states will be completed by September 30, 2009; vi) A comprehensive review and feasibility assessment of the AP model is completed by September 2009.*

New Initiatives

7. *Involving Medical Colleges:* The restructured project would seek to pro-actively engage Medical colleges by: i) strengthening reporting (P and L forms) by medical colleges; ii) making Edusat connectivity operational and using medical colleges as IDSP training hubs; iii) using medical college faculty as mentors for the newly recruited epidemiologists; iv) providing Referral Lab services; and v) encouraging sentinel lab-based surveillance (laboratory testing of pediatric meningitis or encephalitis).

8. *Infectious Diseases Hospitals (IDH) Networking:* Following two consultations IDHs in Chennai, Delhi, Mumbai, Ahmedabad, Kolkata, Bangaluru and Hyderabad are participating in IDSP, 3 of which IDHs have started sharing surveillance data since June 2009. Realizing the important contributions IDH data will make to the disease surveillance , it was agreed that this component would be continued under the restructured project.

9. *Urban Surveillance:* Urban surveillance in IDSP was introduced in 2007. Surveillance activities and funds flow systems were streamlined in the cities of Mumbai, Kolkata and Chennai. All three cities have completed the basic training of doctors and health staff. The restructured project will hand over this initiative to Urban Health Mission while the IDSP CSU will continue to extend technical support.

Component 2: Integrate and Strengthen Disease Surveillance at State and District levels

10. *State Implementation Plans:* Implementation of IDSP in the seven priority states has demonstrated many successes, and presented some challenges as well. There is significant recognition but varied ownership of IDSP at the highest levels in most states and a strong commitment to improved disease surveillance as a part of the NRHM. All priority states have designated Surveillance Officers at each district and at the state level. A number of states are generating weekly state alerts and sharing these with NRHM, and other departments; efforts to generate similar reports at the district level have been initiated. An increasing number of outbreaks are being investigated with improved efforts for laboratory confirmation and local response. Media scanning has been initiated in some states, as well as efforts to coordinate with the media including regular press briefings during outbreaks or for public information and awareness creation. During the recent H1N1 pandemic, many states could effectively use the IDSP structure and system for contact tracing, sample collection and ensuring supplies of pharmaceuticals.

11. Issues such as non-availability of dedicated, trained epidemiologists, lack of formal public health/epidemiology training, inadequate availability and capacity of a public health laboratory network for etiological confirmation of outbreaks, lack of interest from specialists to participate as members of multi-disciplinary investigation and rapid response teams, capacity limitations of IT human resources at the state and district levels, frequent turnover of state/district surveillance officers and project directors,

limited participation of communities, private health providers and medical colleges (public sector and private) in surveillance activities, problems of IDSP portal accessibility, connectivity and software, quality and infrastructure readiness for video-conferencing with districts are some of the challenges experienced by states. Weak coordination between the Departments of Medical Services (in charge of district and sub-district hospitals), Medical Education (in-charge of medical colleges & hospitals) and Health and Family Welfare (responsible for primary health care, public health including surveillance), controlled by different directorates/ministries has constrained the participation of teaching hospitals, major non-teaching hospitals, local urban bodies, ID hospitals in surveillance.

12. Restructuring plans of the seven priority states reflect a shared understanding of the vision of the restructured project to have a high quality and dependable disease surveillance program compliant with the International Health Regulations (IHR-2005). The following activities were proposed:

To enhance surveillance preparedness

- Positioning and training the newly recruited epidemiologists, microbiologists and entomologists to support disease surveillance; sensitizing physicians and pediatricians at district and sub-district hospitals to improve reporting of probable cases; encourage ASHAs/Anganwadi Workers to report unusual health events by providing incentives.
- Training the medical officers and support staff (Pharmacists, nurses and medical record technicians) at public hospitals including medical college hospitals and setting up formal coordination mechanism with the medical education and medical services directorates to improve coordination; identifying a limited number of private practitioners/labs and proactively seeking information from them over telephone rather than a written report;
- Ensuring fully functional IT systems supported by competent IT human resources (trained Data Managers and Data Entry Operators, including those in medical colleges) for on-line data entry and analysis.

To improve outbreak investigation and response

- Developing a public health laboratory network (either a district PH lab or identified functional referral lab network) meeting the external quality assurance standards (EQAS) of IDSP; establishing service standards for investigation of outbreaks; establishing a samples collection, transportation system, testing and laboratory confirmation from every outbreak reported
- Re-energizing multi-specialty district RRTs, including participation of medical colleges, for investigation and local response in real time, providing mobility support for outbreak investigation;
- Conducting Field Epidemiology Training in 2009-2010 for medical college staff (faculty from the departments of community Medicine, Microbiology, General Medicine and Pediatrics); and RRT training using WHO's standard 5-day module

To strengthen data analysis and use

- Introducing simple printed charts for weekly analysis of syndromic surveillance of selected diseases at the PHC level; training all district and sub-district Medical Officers and district Data Managers in IDSP data analysis
- Establishing a system of data analysis, and providing feedback at monthly meetings; ranking districts based on the timeliness, completeness and analysis of the P & L forms.
- Preparing weekly state surveillance reports and share these with the Secretary/Principal Secretary and NRHM Mission Director

13. State-specific activities and innovations proposed by the states are as follows:

- Community based surveillance pilots involving strong community based organizations already existing in states like Milk Cooperatives in Gujarat, NGOs and ICDS functionaries in Karnataka and Maharashtra, village health and sanitation committees in Punjab and Self Help Groups in Tamil Nadu, Swajal volunteers in Uttarakhand and Panchayati Raj Institutions in West Bengal.
- Piloting SMS reporting from remote/tribal sub centers will be done by the states of Karnataka and Punjab
- Tamil Nadu will establish DSUs in the 13 Health Districts not presently covered and proposes shifting the focus of disease surveillance to 'P' reporting from the routine 'S' reporting since the NRHM work schedule allows the worker to be in the field only 1-2 days per week.

Agreed Actions: *i) Based on discussions with states during the Mission, NICD will send comments to states by July 31, 2009; ii) States will send back revised restructuring proposals through the Project Director, NRHM by August 31, 2009.*

14. *Surveys for Risk Factors for Non-Communicable Diseases (NCD)*: It was agreed that the final report of the phase- I NCD surveys along with the data will be handed over by NICD to the NCD division in the Ministry of Health and Family Welfare. Further action in respect of the NCD surveys including dissemination of phase I report and future surveys will be taken over by the NCD division.

Component 3: Strengthening of Lab Network

15. To enable rapid and reliable laboratory confirmation of causative agent, as well as to improve the quality of laboratory data, IDSP initially aimed to support a five level laboratory network[4], providing normative financial support to upgrade the existing facilities. Implementation experience during the first two years revealed that this approach had added value in a very limited way. Thus, in the restructured project, IDSP decided not to support any further inputs for peripheral laboratories and microscopy centers as these are being strengthened by disease specific programs. Considering the operational feasibility and management challenge of the large number of district public health laboratories, it was decided to limit the number to 50 district labs in the initial years (2 district labs for large states and 1 for smaller states). In addition, in the 7 priority states, referral laboratory networks have been initiated. This two-pronged approach will complement the strengthening of surveillance in the priority states, while in other states, it will first focus on the strengthening of the district priority labs.

16. Under the revised approach, the State ownership will be demonstrated by mobilizing adequate samples and making provision for appropriate consumables and supplies, supplementing support provided by IDSP. The referral laboratory network concept envisages that linking the districts to existing functional laboratories will improve their access to quality public health laboratory services. An output based arrangement will be used for involving these labs in disease surveillance. Realizing the challenges of finding laboratories performing the whole set of tests required under IDSP, the project will support the process of enabling these labs to carry out all required tests gradually. CSU/SSU will ensure maintenance of competencies to perform complicated tests by the lab staff and after one year re-assess ways for supporting competency retention of referral lab staff. IDSP will also monitor closely the possible financial burden of increased routine testing by medical colleges.

[4] This network includes: Peripheral Laboratories and Microscopic Centers (L1 labs); District Public Health Laboratories (L2 Labs); Disease Specific State Laboratory (L3 Labs); Regional Laboratories (L4 Labs) and National Reference Laboratories (L5 Labs).

17. To ensure quality of activities, both of the above strategic orientations will integrate i) competency based strengthening of human capacities, ii) quality assurance activities. Nationwide, 50 district level microbiologists, as well as 35 state microbiologists hired will be trained. Currently, quality assurance systems are established mainly within national, specialized, reference laboratories and some tertiary care level institutions. Therefore the Quality assurance for public health laboratory testing will be supported by developing standard operation procedures, the external quality assessment system, bio-medical waste management, development of guidelines for quality of kits as well as sample transportation and handling.

***Agreed Actions**: With respect to the District Priority Lab, the CSU will by August 31, 200: i) prepare and distribute SOP manuals for the district priority labs; provide guidelines for procurement of quality kits and oversee procurement; ii) organize EQAS once the district priority labs become functional by early 2010; and iii) provide ongoing super version and monitoring of the functioning of district priority laboratories. With respect to the Referral laboratory Network in 7 priority States, the CSU will, by September 30, 20 09: i) support the states to establish a system of sample collection and transportation; ii) provide guidelines for procurement of quality kits and supervise procurement; iii) train SSUs for supportive supervision of the referral network; iv) by 31 December 2009, identify specialized laboratories for rare but contagious diseases; v) in early 2010, establish a system of EQAS; vi) on an ongoing basis, undertake supervision and assessment of the functioning of the lab network and adapt according to the local and national needs, as well as identify and share best practices of networking.*

For the 50 Priority Labs, the state surveillance units will by August 31, 2009: i) procure equipments; ii) develop a specimen collection and transportation system within the district; iii) position newly selected microbiologists at district/state labs; and iv) organize training for new microbiologists. For the Laboratory Network, the priority states will by August 31: i) map the functional laboratories to the districts; ii) establish a system of regular sample collection and transportation; iii) on an ongoing basis, ensure regular supervision, coordination with CSU and monitoring internal Quality Assurance.

Component 4: Training for Disease surveillance and Action

18. As a key input to the integrated diseases surveillance, the project since inception has trained 2035 trainers all over the country, who in turn have trained different categories of health staff for undertaking basic surveillance tasks. The training of doctors, health workers and laboratory technicians training for surveillance activities is completed in phase I (all 7 focus) states and is around 70% in phase II states and that in phase III states still remains around 10%.

Table-1: Training Status

Categories trained	Phase I states	Phase II states	Phase III states	Total
1. State/District trainers	924	773	308	2035
2. Medical officers	14051/10874	10203/7053	1811/8292	26065/64370
3. Health Workers	71740/66158	64320/45184	2712/48811	138772/160153
4. Laboratory Technicians	4500/2242	3652/464	163/1534	8315/4938

19. The four year IDSP implementation experience has highlighted the need for expanding the scope of training in the areas of (a) outbreak investigation skills, (b) laboratory confirmation especially during outbreaks, (c) analysis of routinely collated weekly data and identifying outbreak alerts and (d) improving the participation of hospitals in disease surveillance. It was agreed that under the restructured project, the focus would be on these areas in the priority states.

20. *Field Epidemiology Training :* The training capacity to deliver the WHO-2 weeks Field Epidemiology Training Program (FETP) has been expanded to 8 key training institutes. A total of 337 district level surveillance officers across 228 districts in 20 states have been trained so far. An induction training package for district epidemiologists has been developed by including introduction to health system, national health programs and other basic information on IDSP to the existing FETP module. For career development, a Diploma in Epidemiology will be offered by Sri Chitra Institute of Medical Sciences, Trivandrum with mentoring from identified medical college faculty in each state. Through IDSP support four faculty development workshops are planned, of which 2 have been completed covering 47 faculty members in 13 states. The self-learning CD version of this FETP course developed earlier will be refined, distributed to the training institutes and also placed on the IDSP portal. iii) A 5-day FETP package, field tested in BJM College Ahmedabad by WHO in 2008, will be used to train medical college faculty to support the neighboring DSUs in quality outbreak investigations and data analysis.

21. *Microbiologist, Entomologist training:* Induction training of the 85 microbiologists recruited is planned through PGI Chandigarh, BJ Medical College Pune and CMC Vellore. Core content and methodology has been finalized and the training for the microbiologists recruited will be completed by September 2009. The entomologists will be trained by NICD in September 2009.

22. *Major Hospital staff training:* With the support of WHO, the project will develop: i) training materials for half a day's course to the doctors (introduction to IDSP, case definitions, recording provisional diagnosis in OPD register/slip and seeking laboratory diagnosis) and ; ii) a 1-day training package to train the health staff manning outpatient departments (pharmacists, medical record technicians or nurses) and for collating data.

Agreed Actions*: By August 31, 2009, prepare a revised Training plan; start Induction training of Newly recruited Epidemiologists, Microbiologists and Entomologists; update & load on IDSP Portal user friendly CD of FETP self learning material; with the help of WHO develop training modules of hospital doctors and staff; and by March 31, 2010, complete the TOT for phase III states.*

Annex 4

Procurement

Status of important Action Points from previous missions

1. Status of important actions from the previous mission is as follows:

Action Point	Status
Submit the filled-up check lists for the prior review contracts already awarded for WBR Number	Completed
Submit the proposal for setting up two studios, in case it is to be financed from IDSP	Bank's funding is not being sought for this
Provide the updated procurement plan for AI-HH and residual IDSP components (for both goods and services) for CSU/EPW level	Received during the current mission
Submit the proposal for directly contracting manpower agencies (which is currently through NICSI) for providing contractual staff	Hiring of contractual staff is being decentralized
Submit the procurement plan for state level procurement for strengthening of 50 Labs	Completed
Submit the action taken repot on suspected collusion/fabricated quotations (in Karnataka)	Received
Submit the reply/action taken on the findings of the last post review report	Pending
Submit the list of post review contracts issued by CSU and states (apart from those already shared) during July 2007-June 2008	Partly complied
Improve the disclosure of procurement related information on IDSP and MOHFW websites	To be improved

Progress on Procurement at CSU Level

2. The progress in agreed procurement actions continues to be slow. The slow decision-making process and pre-occupation of staff in recent H1N1 virus outbreak has greatly hampered the progress. The review team is pleased to note the specific actions proposed by MOHFW to accelerate the procurement process. These include: appropriate delegation of authority to the Project Director in-line with the current delegation as the head of the NICD; Joint Secretary providing all clearances except for the financial approval; and weekly review meetings will by the Joint Secretary to monitor the progress on the procurement.

3. The procurement plan for 2009-10 was shared during the mission. As per this plan consultancy services amounting to Rs.124.70 Million would be procured till the end of the year. In addition, goods totaling to Rs.61.30 Million are likely to be procured till December 2010.

Progress on Procurement at Decentralized Level

4. The Bank team was informed that the procurement of the items for strengthening 50 labs under residual IDSP is under progress at the state level. It was agreed that in view of the urgency and small value of the items being procured, the states may use direct contracting in the cases where National Shopping has not been successful and the items are not available under DGS&D rate contracts.

Procurement Staffing/Training

5. A new procurement consultant has recently joined the CSU, who will require undergoing suitable procurement training at the earliest possible. During the restructuring of the project, adding one more procurement consultant may be considered, particularly for monitoring the decentralized procurement under the project (including the district level procurement not being funded by the Bank), following up on PPR findings etc.

Procurement Post Review (PPR)

6. The Bank is yet to receive the response/action taken report on the findings of PPR of the contracts issued during April 2006 to June 2007. The Bank team was informed that the comments of CSU will be shared by August 15, 2009. The Bank team strongly emphasized that some of the findings are quite serious and in these cases, Bank may use remedial actions available under the legal agreements including declaration of misprocurement, if needed. Similar action may also be needed for the case of suspected collusion/ fabricated quotation (in Karnataka) which was observed during a previous mission.

7. The next PPR (covering the contracts issued during July 2007 to June 2008) has been completed and the report will be shared shortly with CSU. Despite rigorous follow-up, Bank could get the list of contracts issued by only two states (Punjab and Uttarakhand) before initiating the PPR. Bank may take suitable remedial actions like not reimbursing the expenditure incurred on procurement for the states that did not provide the list of contracts for the PPR. To address this constraint, it was agreed that effective from the year 2008-09, the states will attach the list of contracts (upon which the expenditure were incurred) with the fund utilization statement/ SOE /FMR shared with the CSU for onward transmission to the Bank.

Other matters

8. There is a need to disclose the procurement related information (invitation of bids, bid document, contract award notice, and request for EOI etc.) on IDSP website. While EPW is publishing the IFB and making available the bid documents on MOHFW website, it is still not disclosing the contract award information. CSU may also ask the states to increase the disclosure of procurement related information (e.g. to put the information pertaining to the award of contracts on website) to the extent possible. This was an agreed action for the last mission but no progress has been reported.

Performance Rating on Procurement

9. During the review meeting taken by DEA on May 26, 2009, it was agreed that the procurement rating for the project will upgraded if the following milestones are achieved:

Milestone	Deadline
Submit the filled-up check lists for the prior review contracts already awarded for WBR Number	June 30, 2009
Issuing the RFP for Census of equipment, E-learning and Media Scanning	June 30, 2009
Submit the reply/action taken on the findings of the last post review report (covering contract issued during April 2006 to June 2007)	June 30, 2009
Sharing the short-list with the Bank for National Nodal Agency, State Survey Agency and Quality Control Agency for NCD Risk factor survey	July 15, 2009

Out of these the first milestone has been achieved, while the second mile stone was partially achieved after some delay (RFP for Census of Equipment and Media Scanning recently issued). The third milestone has been partially achieved (report from Tamil Nadu and Uttarakhand received) while the fourth milestone is not yet due. During the mission the revised deadline for remaining milestones were again discussed and it was agreed that the current rating will be upgraded if all the remaining milestones are achieved latest by September 30, 2009.

Important Action Points for follow-up

10. Apart from achieving the above milestones, other important actions are to improve the disclosure of procurement related information on IDSP and MOHFW websites and follow-up with the states for submitting the list of contracts along with FMR.

Annex 5

Financial Management

Issues

1. The project frequently experienced delayed submission of completed financial statements and audit reports during the last two years. Certain improvements have been noted during the last six months as the project completed reconciliation of audited expenditures with the amounts reimbursed by the bank until 2007-08 and also submitted financial report for 2008-09 during the mission. This financial report however does not include complete expenditure of 2008-09 for five states[5] and the list of contracts issued at the central and state levels. Non availability of such list of contracts issued by most of the states for 2007-08 had earlier rendered the related expenditures as ineligible. Lack of adequate follow up with the states by the CSU coupled with inclusion of all the 35 states under the project appears to be the primary reasons for under-performance of FM in the project.

Proposal for restructuring and impact on FM arrangements

Number of states and reporting

2. The mission is informed that the Bank financing during the extension phase effective April 1, 2010 will be limited to 7 priority states. The quarterly FMR to be submitted by the project from 2010-11 will henceforth include the expenditure incurred at the CSU and these 7 priority states.

Financial management cell

3. In order to ensure that adequate follow up is taken with the states and credible financial information for actual eligible expenditure incurred during a period is prepared by CSU, it has been agreed that CSU will strengthen the financial cell, which will include two full time financial staff/consultants with accounting background and experience in dealing with Bank projects. This is agreed to be a covenant in the Financial Agreement.

Auditing and disbursement arrangements

4. **For 2008-09**, the project will submit by September 30, 2009, a consolidated statement of audited expenditure for CSU and the SSUs, summary of audit observations along with details of follow up taken; and reconciliation of audited expenditure with the reimbursement claim submitted to the Bank for the year.

5. **Starting 2009-10**, the audit for CSU and the participating 7 states will be conducted as per the earlier agreed arrangements. However as an improvement from the existing procedure, the project shall furnish to the Association no later than six months after the end of each Fiscal year, a consolidated Report on audits containing consolidated expenditure statements and audit observations from audit reports along with actions taken; and the disbursement will be made on the basis of consolidated audited expenditures. The financing agreement will be amended to reflect such change.

6. **Immediate actions required to be undertaken:** The key actions that would be required to be completed by the project in order to upgrade the FM status from MU are to: (1) share complete FMR for 2008-09 with the Bank along with the list of contracts issued at central and state levels for post

[5] Maharashtra, J&K, Delhi, UP and Bihar

procurement review; (2) share the audit report for the state of Jammu and Kashmir for 2007-08 (further disbursements for the state have been suspended effective July 1, 2009); (3) respond to Bank's letters of February 2009 and June 2009 requesting clarifications regarding 2007-08 audit observations for the states of Maharashtra, Karnataka, Chhattisgarh, Rajasthan, Sikkim and Uttaranchal; and (4) strengthen the FM cell at the CSU with two full time finance staff/consultants with accounting background and knowledge on Bank procedures.

Avian Flu: Human Component

7. The mission was informed that in addition to the expenditure at the central level, 9 laboratories in different states will also be incurring operating expenditure (salaries for contractual staff and revenue expenditure) in this component of the project for necessary testing and research. These labs are from government institutions except for Kasturba Medical College in Manipal. To facilitate funds flow and timely reporting it was agreed that each institute will open a separate bank account to receive the project funds, maintain cash book as per the project requirements and send SOEs along with original vouchers, purchase orders and bills every quarter to the CSU. The reimbursement claims to be submitted to the bank will only include the actual expenditure incurred by these laboratories once the original and bills have been received by CSU. Audit of the expenditures incurred by the participating labs will be a part of the IDSP central audit carried out by the C&AG for which CSU will maintain the expenditure records.

Action Plan

	Action Point for CSU	Timeline
1	Submit pending audit reports for 2007-08 for the state of Jammu & Kashmir	July 31, 2009
2	Submit FMR for 2008-09 to the Bank including expenditure from all states along with list of contracts issues at central and state levels for post procurement reviews	Aug 31, 2009
3	Respond to Bank's letter sent in February 2009 and June 2009 requesting for certain clarifications regarding 2007-08 audit observations for the states of Maharashtra, Karnataka, Chhattisgarh, Rajasthan, Sikkim and Uttaranchal	Aug 31, 2009
4	Submit consolidated statement of audited expenditure for CSU and the SSUs, summary of audit observations for 2008-09 along with details of follow up taken; and reconciliation of audited expenditure with the reimbursement claim submitted to the Bank for the year	September 30, 2009
5	Strengthen the FM cell at the CSU with two full time finance staff/consultants with accounting background and knowledge on Bank procedures	September 30, 2009

Annex 6

Community Involvement in Disease Surveillance (CIDS)

1. It was proposed that as part of project restructuring, the strategy for promoting community involvement in disease surveillance will be reworked taking into consideration state-specific advantages available for innovative initiatives. The priority states have agreed to prepare CIDS strategies specific to their human resource, social capital and institutional advantages. Punjab will focus on the NRHM supported village heath and sanitation committees (VHSC) for promoting CIDS, whereas Uttarakhand will focus on NGOs and the Swajal groups. West Bengal has proposed to encourage the participation of local representatives (PRIs) in addition to strengthening the role of community level health and sanitation workers in CIDS. Gujarat propose to involve the milk and other cooperatives whereas Tamil Nadu will work with women's self help groups (SHGs). Orissa, Karnataka and Maharashtra will continue to promote CIDS by involving the community level workers and health volunteers including the ANMs, AWWs, ASHAs in two select blocks earlier identified as part of the **Tribal Action Plan (TAP)**. The CSU has documented common disease patterns among tribal populations from the existing studies and how IDSP activities have benefited tribal populations in the tribal districts as part the TAP.

2. Stakeholder consultations were held at Nadurbar (Maharashtra) district at Hangda PHC, on June 27, 2009, in Chamrajnagar Kagaladahundi PHC (Gundulpet Block) and at Kollegal Taluka Hospital on June 28 and 29, 2009 in which representatives from the NICD and the Bank participated. Orissa has made progress in planning and implementing its proposed activities following the stakeholder consultation during the January 2009 mission, and shall continue to implement CIDS as part of the TAP. WHO has agreed to provide Orissa, which is not a priority state, with required financial support to implement CIDS as part of the TAP. The Central Surveillance Unit (CSU) will integrate the CIDS strategy, activities, and budget proposed by the priority states in the final restructuring proposal.

3. The CSU needs to hire a communications expert who will assist in developing and implementing an IEC strategy in order to: (a) compile knowledge and information on disease surveillance from various sources including public health programs for community level dissemination; (b) promote visibility of IDSP through advocacy including documentation and dissemination of innovations, successes, and challenges; and (c) and build partnership and collaboration with other public health programs, important academic and media organizations, and corporate houses for advocacy and knowledge dissemination for strengthening disease surveillance. It was agreed during the last mission that the CSU will initiate early steps in this direction, which is pending. The CSU is advised to urgently finalize the ToR for hiring the communication expert. The priority states will prepare their specific IEC strategies for promoting CIDS, which needs to be integrated and reflected in the national IEC strategy for IDSP. As NRHM remains the key public health program in the country, the CSU will closely coordinate its efforts for implementing the IEC strategy through integration with NRHM. The CSU will also improve the IDSP portal as part of the IEC for dissemination of information for CIDS.

Agreed Actions

- CSU will hire a Communications Expert and prepare IEC strategy and action plan;
- CSU will reflect state specific IEC and CIDS strategies in the restructuring proposal.