India

Operational Plan Report

FY 2012

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

CONTEXT

Epidemiology of the HIV Epidemic in India

India has the world's third largest HIV epidemic, with 2.4 million (2.1–2.8 million) people living with HIV (PLWH), 140,000 (110,000–160,000) new HIV infections, and 170,000 (150,000–200,000) AIDS-related deaths estimated in 2009. Women account for 39% of reported HIV cases.

India's epidemic is characterized by concentrated transmission and heterogeneous geographic spread. The relatively low overall HIV prevalence (0.31%) masks substantial variance by district, state, and region, including higher prevalence in some rural communities. India's epidemic is driven by infections among most-at-risk populations (MARPs), which in India include sex workers (SW) and their clients, men who have sex with men (MSM), transgender individuals (TG), and people who inject drugs (PWID). Recent evidence indicates elevated HIV prevalence among migrants and truckers, who also have been identified as bridge populations facilitating HIV transmission between MARPs and lower-risk, often rural populations. HIV prevalence in these groups is 10 to 30 times higher than in the general population at 4.9% among female SW, 7.3% among MSM, 9.2% among PWID, and 3.6% among migrants. However, survey data indicate substantial diversity of prevalence among MARPs, as is to be expected in a country of 1.2 billion citizens. Surveys in parts of southern India, for example, have reported 7% to 18% prevalence in MSM, while surveys of female SW in Maharashtra and Pune reported HIV prevalence far higher than the national average (18% and 41% respectively). National estimates indicate a MARP population of about 1.5 million including 868,000 female SW, 412,000 MSM and 177,000 PWID, in addition to an estimated 7.3 million migrants and 2 million truckers.

India is a priority country for the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (The Global Plan), and the Minister of Health and Family Welfare sits on the Plan's Global Steering Group. Of the 27 million pregnancies in India each year, an estimated 65,000 occur among HIV-infected women and result in an estimated 19,500 HIV-infected children born each year. India plans to introduce the World Health Organization expanded regimen for preventing mother-to-child transmission of HIV (PMTCT) 'Option B' in a phased manner beginning in 2012.

The geographic focus of new infections is shifting in India with some low-prevalence states showing

increases in new infections over the past two years. Of the 140,000 estimated new infections in 2009, only 39% were from the six states categorized at that time as high-prevalence (Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Manipur, and Nagaland). Seven low-prevalence states accounted for 41% of new infections, including Odisha, Bihar, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat. The limited public health capacity of some states has negatively impacted the quality of surveillance, services, and programming, leaving opportunities for HIV to spread. Some low-capacity states, which had not benefited from earlier Government of India (GOI) focus under the national program, are now learning to respond to this shifting epidemic.

Sexual transmission is estimated to account for nearly 90% of new infections in India (88.7% heterosexual, 1.3% homosexual). One in twenty (5.4%) new cases of HIV are acquired through perinatal transmission, 1.6% are related to injection drug use, and 1% through use of infected blood and blood products. Three percent of infections are of unknown source. Injecting drug use is the main mode of transmission in the northeastern states, but there are also large populations of PWID in four of India's largest cities – Chennai, Delhi, Mumbai and Chandigarh – and significant pockets in smaller cities.

India has the highest tuberculosis (TB) burden in the world, which accounts for 20 to 25% of deaths among PLWH. The estimated burden of HIV/TB co-infection is 900,000 cases, with HIV prevalence among TB patients at over 6%. In HIV high prevalence states and districts, positivity among TB patients is over 10% and may be as high as 40% in certain districts. Data on other opportunistic infections are not readily available.

Condom use (% reporting use of condoms at last sexual encounter) is reported to be high among female SW (83%), and transgender SW (93%). Only about half of male SW (50%) and MSM (58%) reported condom use at last sexual encounter. Among PWID, only 16% reported condom use, and 87% reported use of sterile injection equipment at last injection. Results from survey data from 2009 showed that internal male migrants in five states in India were much more likely to buy sex than were men in the general population (16%–88% of surveyed migrants, compared to 2.2%–15% of men in the general population).

Patterns of risk and risk behaviors are evolving. As one example, several studies and field reports have noted a shift in sex work practices away from brothel-based to locations and venues more difficult to reach with HIV interventions. These venues include home- and street-based sex work, but also sex work that is hidden in the guise of other trades, including among masseuses and bar workers.

India's National AIDS Control Program (NACP)

The GOI has documented substantial progress in containing the spread of HIV, with a more than 50%

decline in incidence over the last 10 years. The GOI's first five-year national strategic plan was launched in 1992, and since that time the GOI has implemented a series of increasingly strategic national programs. India is completing implementation of its third five-year program, the National AIDS Control Program, phase III (NACP-III), 2007-2012, with a goal of halting and reversing India's epidemic through four primary objectives: (1) Prevent infections through saturation of coverage of high-risk groups with targeted interventions, and scaled up interventions in the general population; (2) Provide greater care, support and treatment to larger numbers of PLWH; (3) Strengthen the infrastructure, systems and human resources in prevention, care, support and treatment programs at district, state and national levels; and (4) Strengthen the nationwide strategic information management system. This plan is implemented through the leadership of the National AIDS Control Organization (NACO), which has prioritized its focus on MARPs in 195 higher-prevalence districts (of 611 districts), and has adopted a phased approach to service scale up, prioritizing geographical areas with highest HIV burden. NACP-III goals included reducing new infections by 60% in high-prevalence states and 40% in low-prevalence states through targeted outreach to MARPs.

U.S. Government (USG) PEPFAR investments, described below, have supported objectives 1 (prevention, focusing on MARPs), 3 (strengthening systems, especially laboratories and management and training capacity) and 4 (strategic information, again focused on systems to improve targeting of MARPs), with specific contributions carefully negotiated with NACO by each USG agency.

NACP-III has been assessed twice each year through a Joint Implementation Review (JIR) with participation by Development Partners. The last JIR, conducted in December 2011, noted the steady progress in scaling up Integrated Counseling and Testing Centers (ICTCs), ART services and condom distribution, and coverage of targeted interventions for MARPs, the latter of which have reached 81% of female SW, 66% of MSM and 71% of PWID through October 2011. The national program has achieved or exceeded many of the targets set for NACP-III. Overall HIV prevalence is steadily declining in antenatal care attendees, sexually transmitted infections (STI) patients, and female SW. The trend is less clear for PWID, MSM and males who migrate for employment. The top line recommendations of the JIR include further attention to managerial and quality assurance; further refinement of use of epidemiologic data to target the most at risk and vulnerable; acceleration of testing for high risk groups while integrating testing into the GOI's larger National Rural Health Mission; rapid roll out of the new PMTCT guidelines on Option B; increased and intensified case finding of TB/HIV co-infected individuals; a strengthened national surveillance team; and finalization of transition plans for externally supported Technical Support Units. Eight USG staff participated in the JIR as members of all Field Assessment Teams.

The fourth phase of the NACP, NACP-IV, which covers a five-year period starting in April 2012, is currently in its final development. The USG and other partners have played a critical role in the design of this plan, through leadership and participation in working groups on thematic areas including MARPs, PMTCT, strategic information, laboratory strengthening, orphans and vulnerable children, integration, and

institutional strengthening. Prevention is expected to remain the focus of NACP-IV, which is in review by the GOI's Planning Commission, with accelerated coverage and improved quality of services for MARPs, and investments in innovations and technology to improve results. NACP-IV may be the final chapter of the GOI's targeted, vertical HIV/AIDS programming, as one of the GOI's objectives is to further integrate HIV/AIDS with other national health programs.

Development Partners

NACO works in close partnership with international donors and effectively coordinates their technical and financial inputs. Some large donors, such as the Bill and Melinda Gates Foundation (BMGF), the Clinton Health Access Initiative and United Kingdom's Department for International Development (DfID) are now phasing out their targeted HIV support in India, although BMGF and DfID are continuing to support integrated health responses and in particular the area of maternal, newborn, and child health. The Joint United Nations Program on HIV/AIDS (UNAIDS) remains focused on HIV in India, although with limited financial resources, and coordinates the work of all the UN partners (particularly the World Bank, World Health Organization, UNICEF, United Nations Development Program, United Nations Office on Drugs and Crime, and the International Labor Organization). The World Bank provided a credit of $250 million in support of NACP-III, and is currently evaluating a new request for financing for NACP-IV for an equivalent amount.

The USG is a member of the Development Partner Joint Review team that reviews the progress of NACP every six months, and has collaborated with other Development Partners in designing NACP-IV. The USG also fills one of three bilateral seats on the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) Country Coordinating Mechanism, and is a member of its Oversight Sub-Committee. Collaboration with these key Development Partners ensures that donor resources, particularly from GFATM, are leveraged by PEPFAR to optimize efforts in a range of program areas.

Private sector

The private sector provides an estimated 75% of health care in India, yet it is largely unregulated and directly contributes very little to national disease control programs. The USG has been a strong advocate for harnessing the contributions of the private sector, and has developed and tested innovative models for engaging the private sector, several of which have already been adopted and scaled up by the GOI or the private sector, including evidence-based prevention among MARPs, private sector PMTCT service delivery models, helplines, drop-in centers, insurance for PLWH, and workplace HIV programs. As part of the NACP-IV's Technical Working Group on Project Management and Organizational Restructuring, the USG played a key role in influencing NACO to establish a nodal coordinator to support private sector initiatives across different program areas.

In fiscal year (FY) 2012, the USG will continue its efforts to establish innovative model programs with the private sector, and also provide technical assistance to establish a national public-private partnership (PPP) coordination unit to strengthen the capacities of national, state and district level officials to foster, implement and monitor PPP initiatives. Additionally, the USG will provide technical assistance to establish a PPP innovation fund, linking industry/diaspora with NACO and the State AIDS Control Societies, and to pilot select private sector initiatives in prevention and treatment programs. The project will also support introduction of mobile and other information communication technologies in HIV programs to demonstrate efficiencies and support assessments and documentation of the value of engaging private sector actors in the national program.

PEPFAR/INDIA FOCUS FOR FY 2012

USG Priorities

Strategic choices about USG investments to support India's HIV response are the result of broad and sustained dialogue with a range of partners, framed by the PEPFAR/India Five-Year Strategy 2011-2015, and informed by continuing negotiations to ensure that investments best leverage current resources, capitalize on evolving opportunities, and optimize ultimate program sustainability. USG investments in FY 2012 are 'lean and mean', prioritized within strategic areas as a result of decreased funding.

India faces enormous and unique challenges on a scale unlike other countries, but it is also endowed with remarkable resources. All PEPFAR/India investments are designed to provide targeted and time-limited technical assistance that capacitates the GOI, private sector and civil society partners towards sustainable programming. All investments are selected based on their contributions to building sustainability, and particularly toward capacity strengthening at the organization and systems levels.

The GOI looks to the USG as an essential partner in meeting high-level technical collaboration requirements in priority areas linked to HIV prevention and system strengthening. As mentioned above, the USG has piloted and evaluated numerous innovations to improve service delivery subsequently adopted and scaled up by the GOI. District action plans, non-governmental organization (NGO) selection criteria, and behavior change communication tools and strategies have each emerged from USG programs. In recent years, USG staff and partners have collaborated with the GOI to develop and implement national policies on gender, migrants, children affected by HIV/AIDS, and greater involvement of PLWH. PEPFAR/India promotes local NGOs and private sector actors to support and assist in managing the response at the sub-national levels, while building capacity at these levels and in New Delhi to sustain the response.

In the PEPFAR/India Strategy, the agreed principles of USG/NACO collaboration in the next five years are to:

- Invest in technical collaboration and not direct implementation;
- Prioritize prevention and systems strengthening over care and treatment but support a continuum to care services with a focus on MARPs and migrants;
- Allow for flexibility in aligning with emerging NACP-IV priorities.

All FY 2012 investments will support these principles, while USG programmatic priorities will shape specific choices within these categories. USAID/India is in the process of developing a Country Development Cooperation Strategy for the Health Sector that will focus on further innovations in service delivery and achieving broad results. This process is ongoing and may result in adjustments to the Implementing Mechanisms proposed in the FY 2012 Country Operational Plan (COP). In addition, the overall projected USG investments in India over the next years will propel the USG to increase engagement with Development Partners, including GFATM mechanisms, to plan a rational and coordinated transition of funding and technical assistance over the five years of NACP-IV.

PEPFAR/India Contributions to GHI Principles

The USG/India overall health program, of which PEPFAR is a part, fully embraces and supports the principles of GHI, using a whole of government approach and integrated programming. This approach is supported by ongoing collaboration and monthly meetings of the USG 'Health Interest' group, that brings active participation from representatives of a range of USG agencies and sections that focus on health exclusively (National Institutes of Health, Food and Drug Agency, CDC, and USAID Health Office) or peripherally (Political, Economic, Agriculture, Public Affairs, and Science/Technology sections of the U.S. Mission in India).

The current framework for the USG/India health engagement with the GOI is the U.S.-India Bilateral Health Initiative under the U.S.-India Strategic Dialogue. The Health Initiative is led by the Secretary of Health and Human Services and the Minister of Health and Family Welfare, and coordinated in India by the USG Health Attaché. The Health Initiative is an inter-agency umbrella organizing mechanism for bilateral discussions on health collaborations and program implementation. The Initiative is composed of four U.S.-India Working Groups whose purpose is to share information, identify and address policy concerns, identify new technologies, share international best practices, and address implementation bottlenecks that might arise in the jointly prioritized areas of Non Communicable Diseases, Infectious Diseases, Maternal and Child Health, and Strengthening Health Systems and Services. These Working Groups include representatives from the USG and the GOI, as well as health leaders and area specialists from beyond the public sector.

Bilateral commitment to the Health Initiative was confirmed during the U.S.-India Strategic Dialogue

(Washington, June 2010) and during President Obama's visit to India in 2010 as a means of advancing public health and biomedical research collaborations by building on existing strong ties across academia and scientific communities. The Initiative is part of the U.S.-India Strategic Dialogue, launched by Secretary of State Clinton during her July 2009 visit to India.

PEPFAR/India fits in well to this overall strategic engagement with the GOI, and is the most integrated of the USG/India interagency collaborations, embodying 'one USG' in planning and implementation of programs on the basis of strengths of individual agencies. Major parts of the USG/India team have been structurally reorganized to support an integrated programming approach that leverages strong existing platforms for supporting maternal-child health, TB and reproductive health/family planning programs. Several new and continuing investments promote smart integration of activities that were previously vertical in these areas, including investments in behavior change communication, access to quality health services, private sector engagement, strategic information/policy and civil society. Some USG investments in HIV have already reaped benefits across other GHI-priority areas; for example, NACO's Technical Support Unit model, supported by the USG, is being replicated to provide improved support to the National Immunization Program.

FY 2012 COP investments are guided by PEPFAR/India's Five-Year Strategy, which prioritizes systems strengthening, capacity strengthening of local institutions, strong promotion of country ownership, and leveraging resources of the GOI and other partners to promote sustainability. The Five-Year Strategy prioritizes the GHI principles of: (1) Increase impact through strategic coordination and integration; (2) Strengthen and leverage key multilateral organization, global health partnership and private sector engagement; (3) Encourage country ownership and invest in country-led plans; (4) Build sustainability through health systems strengthening; and (5) Improve metrics, monitoring and evaluation (M&E). The remaining two GHI principles, implementing a woman/girl centered approach and promoting research and innovation, are respected and incorporated into programing with the GOI. For example, the USG supports NACO's draft policy guidelines to incorporate gender considerations into all HIV programs; and innovation has been a cornerstone of USG investments in HIV service delivery models in India, including through the private sector.

PEPFAR/India's USG team continues to work closely with the Indian public sector, and is building on existing programs that have developed innovative activities with the private sector, as well as with civil society partners, some of which have begun to assume strong roles in HIV program implementation in the country. In this way, PEPFAR/India's program bridges the three major sectors in the HIV response, using a targeted systems strengthening and resource leveraging approach at all levels to support program sustainability.

Monitoring Implementation of the PEPFAR/India Five-Year Strategy

In lieu of a Partnership Framework, PEPFAR/India developed a Five-Year Strategy for 2011-2015, described above. The FY 2012-FY 2016 COPs were envisioned as the implementation plans for this Strategy. Implementation monitoring will be conducted through Annual and Semi-Annual Program Reports, supplemented by the M&E framework established in the strategy.

PEPFAR/India recognizes the importance of measuring and quantifying the outputs, outcomes and impact of a program investing primarily in strengthening systems and capacity as a means of optimizing service delivery. In FY 2012, PEPFAR/India's direct service delivery targets are negligible; direct services are provided only in the context of implementation of pilot projects designed as learning sites for the development of service delivery models to be adopted and scaled up by the GOI. In this context, PEPFAR/India is committed to developing an additional framework to monitor progress in capacity strengthening, which is currently in draft form and will be finalized – and incorporated into the Strategy M&E Plan – in FY 2012. The framework will use routine program indicators, assessments and program evaluation to measure outputs and outcomes (short-term, intermediate and long-term).

In the interim, and after discussions with Office of the Global AIDS Coordinator (OGAC) Strategic Information staff, PEPFAR/India will monitor and report on the following indicators to demonstrate the program's progress:

1. Government of India budgetary resource allocation for HIV/AIDS (PEPFAR/India Five Year Strategy M&E Plan)

2. Domestic and International AIDS Spending by Categories and Financing Sources (H3.1.N and UNGASS #1)

COUNTRY OWNERSHIP ASSESSMENT

PEPFAR Engagement with Government of India

The GOI leads the scale-up and sustained implementation of the national and state level response to HIV/AIDS and efficiently manages its partnerships with all donors to ensure that resources are fully aligned with and contribute effectively to the achievement of the NACP goals and targets. Development Partners provide significant formal input to the development of the NACP through participation in the Technical Working Groups that inform the programmatic areas of the plan. Development Partners also contribute formally to the assessments of NACP implementation through participation in the Joint Implementation Reviews conducted every six months. Both the NACP development and the joint review processes are

important mechanisms for USG involvement. The USG also meets regularly – at least weekly – with GOI technical and bureaucratic leadership in NACO to provide input less formally on both specific projects and the overall NACP implementation. USG staff also meet with state government counterparts and implementing partners and others in focus states at least monthly, with routine communication occurring more frequently through emails and telephone contacts. The USG is a valued partner upon which NACO relies for a broad range of technical and strategic input.

Each NACP is for a period of five years, and the financial and technical inputs of all Development Partners are negotiated during the costing of the plan. For the USG, these inputs are negotiated based on the Partnership Agreements signed in 2010 (further described below), which define clear areas of technical input from USG agencies, and on the expected PEPFAR financial inputs during the period of the NACP. The annual planning for COP ensures through a process of continuous collaboration that all proposed activities remain aligned with the national plan and with the agreed areas of technical inputs. This clear and transparent process has worked well for several planning years, and optimizes the use of PEPFAR resources to leverage resources from the GOI, GFATM and Development Partners.

In addition to this strong NACO-led coordination of Development Partners, the USG meets regularly, both formally through coordination meetings and Technical Working Groups, and informally with other Development Partners, to ensure synergies in our collective efforts to support the GOI in the achievement of NACP goals and targets, and to work towards full alignment of NACP with international standards of service delivery for HIV prevention, care and treatment. In just one illustration, USG staff serve on the Technical Advisory Panel for the BMGF's implementation of the second phase of Avahan, its major HIV/AIDS program.

GOI Endorsement of the FY 2012 COP Proposal

All PEPFAR-funded activities are explicitly approved and endorsed by the GOI through the continuing process of dialogue, planning and negotiation described above. Although all proposed FY 2012 COP activities have been agreed to in principle, PEPFAR/India expects that some details of activities may be modified in the coming months to ensure alignment with NACP-IV, which is expected to be launched in April or May 2012. In addition, USAID's process of developing its Country Development Cooperation Strategy may result in modifications to specific Implementing Mechanisms proposed in the FY 2012 COP. All PEPFAR-funded activities will remain well-aligned and embedded in the NACP, will support the PEPFAR/India Five Year Strategy, and will be consistent with OGAC technical guidance. Any future modifications will be discussed with NACO and with OGAC to clarify whether they are substantial enough to submit through a formal COP Update process.

Challenges and Opportunities in Country Ownership

The sheer size of the country and its population, and the breadth of India's decentralized health system challenge full ownership of the country program at all levels. However, through strong national leadership and coordinated management of prioritized state and district programs, India has done remarkably well in rolling out its program and policies throughout the country.

Political ownership/stewardship: India is recognized as a model of country ownership, and has achieved the goals of "The Three Ones", with one HIV/AIDS action framework, the NACP; one national AIDS coordinating authority, NACO; and one national M&E plan. The GOI has led the country's HIV response for many years, planning and implementing a series of strategic and well-articulated national programs that have effectively reduced HIV transmission in the country, despite early predictions of massive growth in the epidemic. This success could not have been accomplished without the strong stewardship of the GOI through NACO, and its engagement with partners to fill gaps and strengthen capacities. The GOI continues to effectively coordinate the input of its partners, including the USG, to make strategic use of available resources. The GOI also funds research and evaluation and is willing to make mid-course corrections as new lessons are learned.

The GOI has also aptly managed the finances for this massive response, both from government sources and from the World Bank and GFATM, for which India is slated to be the largest recipient of HIV funding ($1.2 billion). Over the years, the resources for HIV have increased significantly in India, from US$ 99.6 million during NACP I (1992–1999) to US$ 2.5 billion during NACP III (2007–2012). The domestic contribution increased to 25% in 2011, and the GOI has committed to substantially increase financial support for the next five-year plan. The GOI investment in overall health programs has been relatively low, at approximately 1.2% of Gross Domestic Product (GDP). However, GOI commitment to health programs is expected to increase to over 3% of GDP over the next five years, substantially increasing the domestic resources potentially available for NACP-IV. The GOI financial commitment to NACP is expected to increase as GFATM and other donor support decreases.

One area of great opportunity is in India's private health care sector. The private sector provides over 75% of the country's health care services. Private sector health services are often unregulated and are provided outside of national standards and programs, making limited direct contributions to achievement of NACP goals. The GOI's stewardship capacity for this sector is limited, but the USG through PEPFAR and other programs is seeking to increase this crucial engagement.

Institutional Ownership: The GOI has full ownership of the country program at each stage of program development, and has institutionalized its commitment to HIV by establishing a Department of AIDS

Control, led by a Secretary to the GOI (the senior-most ranking government bureaucrat in the Indian Administrative Service). To support implementation of the national plan, a structure to provide technical assistance and oversight to GOI initiatives has been developed at the national (Technical Support Unit), state (State AIDS Control Society) and district (District AIDS Prevention and Control Unit) levels.

At the local level, the GOI has relied on NGOs and community-based organizations (CBOs) to implement targeted interventions to MARPs, and supports this implementation with technical and managerial oversight by GOI institutions at state and district levels. By design and in an effort to scale up these interventions and capacitate organizations to deliver them, the targeted interventions have been prescriptive. Some organizations are now capable of taking more ownership for program decisions based on local needs.

Capabilities: At the national level, there is technical and managerial capacity to plan and oversee the national program. NACO does continue to rely on external funding, however, to provide expert technical consultants, both through the National Technical Support Unit and other consultancies. In general, strategic information is used well and often to make program adjustments to improve results. Twice-yearly Joint Implementation Reviews of the national program provide an excellent opportunity for learning from the field at all levels. As the GOI has decentralized its implementation structure to district level under NACP-III, these reviews have identified specific gaps in capacity at the state and district levels. The capacity of local NGOs and CBOs to effectively implement targeted interventions is uneven, and many NGOs and CBOs require targeted capacity strengthening to function optimally.

Accountability: NACO supports input from Development Partners and academic institutions through their participation on Technical Working Groups and Joint Implementation Reviews, and by soliciting ad hoc input as needed. While the GOI engaged effectively with civil society in the development of the NACP, there are opportunities to better leverage the input and resources of the range of civil society organizations in India to improve planning and implementation of national plans.

USG Support for Country Ownership (Sustainability and Transition)

USG investments support the comprehensive NACP strategy and NACO leadership. PEPFAR programs are highly targeted to areas prioritized by the GOI to strengthen the capacity of individuals, organizations and institutions at all levels to improve quality of planning, management, implementation and measurement of results of the national program. PEPFAR/India also promotes local NGOs and private sector actors to support and assist in managing the response at the sub-national levels, while building capacity at these levels and in New Delhi to sustain the response.

Investments in individuals are designed to strengthen their managerial and technical capacity through mentoring, supportive supervision and in-service training. Increasingly USG investments in India are

focused on strengthening organizational and institutional capacities, including of local governments, civil society, and the private sector, to design and implement effective interventions. These investments support the establishment of enduring systems, for example in laboratory accreditation and training methodologies. USG investments in strategic information strengthen the systems that report, collect, analyze and use strategic information to plan and improve implementation of the national and state programs. As a valued and trusted partner to the GOI, USG investments also provide technical and strategic input on areas crucial to the national program, including input on new policies and technical guidance; assessments of achievements towards national goals; and input on prioritization of programs for maximum impact on the epidemic. These inputs are provided collaboratively through participation on Technical Working Groups and Joint Implementation Reviews.

The GOI has consistently and strategically reached out to partners best able to build specific capacity at national, state and district levels to address identified gaps. PEPFAR/India's contributions to building country capacity are aligned with the NACP and are developed through assessment, planning and negotiation with NACO and State AIDS Control Societies. Both CDC and USAID have formal bilateral agreements with the GOI that clarify the inputs and expectations of both parties and ensure that agency efforts are optimally leveraged based on identified needs and agency strategic advantage. CDC/GAP signed an agreement with NACO/Ministry of Health and Family Welfare on May 13, 2010 to expand and deepen technical assistance to the GOI in laboratory systems, strategic information, and human capacity development. USAID signed the GOI five-year Health Partnership Program Agreement on September 30, 2010 to provide technical assistance to strengthen the health system to address needs of vulnerable populations across a range of health areas including HIV.

One area in which the USG can provide valuable support to the GOI is in private sector partnerships. The USG in collaboration with the GOI has already demonstrated some successful models for coordinating support of private sector providers in delivering PMTCT and STI services. The USG and NACO are further working together to harness this extraordinary health resource by establishing a National PPP coordination unit to maximize partnership opportunities and impact at the national and state levels.

The GOI has demonstrated its capability to learn from USG-supported programs and transition them to the GOI. The USG and its partners will also continue to collaborate with the GOI to provide support to develop and implement national policies and national guidelines on a range of HIV prevention, care and treatment issues, and in particular on the GOI's new policy on PMTCT.

UPDATE ON CENTRAL INITIATIVES

PEPFAR/India's program has been bolstered by support from two Central Initiatives to support new and innovative work in gender and with GFATM mechanisms in country.

Gender Challenge: In February 2012 PEPFAR/India received approval for a Gender Challenge proposal in which it will invest $150,000 of FY 2012 COP funds, and will receive an additional $300,000 through central funding. The planned activities for this proposal are reported in the COP as part of the DAKSH Implementing Mechanism, with Gender Challenge activities submitted under HVSI and OHSS budget codes. The project is expected to begin in late 2012, once funding is received.

Global Fund Liaison Position: PEPFAR/India's request for funding for a Global Fund Liaison position was approved in 2009 ($300,000 over two years). However, this position has not yet been filled due to delays in finalization of the Scope of Work. The USG is now negotiating this position with new leadership in the GOI, and hopes to fill the position by mid-2012. The position description will benefit from recent changes in the GFATM strategy supporting increased partner participation in country implementation and oversight, as described in Secretary of State Clinton's January 13th 2012 cable.

NACP-IV: A CRUCIAL PERIOD FOR PEPFAR/INDIA

With a modest investment, USG strategic technical contributions to India's HIV response deliver a significant return. PEPFAR investments support the GOI's success in responding to the third largest HIV epidemic globally, and leverage the significant USG investments in India made through GFATM, of which India is the largest recipient of HIV funding. Furthermore, many elements of the GOI HIV response provide lessons for other national programs in the region and around the world.

The GOI publicly acknowledges and thanks USG agencies for their innovative and creative approaches to supporting India's programmatic response, and bridging gaps requiring technical assistance. The GOI looks to the USG as an essential partner in priority areas linked to HIV prevention and system strengthening.

This next five years, as India rolls out its fourth NACP, will be a crucial period of transitioning funding and technical assistance elements of the national and state-level programs to the GOI. This transition must be a rational process, well-coordinated with the GOI and other partners to ensure continuation of the strong technical collaborations that have contributed to dramatic successes in India's HIV response. PEPFAR/India looks forward to continuing to strengthen its relationship with the GOI and other partners to meet the challenges of this transition period.

Population and HIV Statistics

Population and HIV		Additional Sources

Statistics	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	2,300,000	2009	UNAIDS Report on the global AIDS Epidemic 2010	2,306,350	2009	Annual Report 2010-11, National AIDS Control Organization, Department of AIDS Control (Page 4)
Adults 15-49 HIV Prevalence Rate	00	2009	UNAIDS Report on the global AIDS Epidemic 2010	00	2009	Annual Report 2010-11, National AIDS Control Organization, Department of AIDS Control (Based on HIV Sentinel Surveillance 2008-09, Page 4)
Children 0-14 living with HIV					2009	Annual Report 2010-11, National AIDS Control Organization, Department of AIDS Control (Page 4)
Deaths due to HIV/AIDS	170,000	2009	UNAIDS Report on the global AIDS Epidemic 2010	172,000	2009	Annual Report 2010-11, National AIDS Control Organization, Department of AIDS Control (Page 6)
Estimated new HIV infections among adults	120,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV	140,000	2009	UNAIDS Report			

infections among adults and children			on the global AIDS Epidemic 2010			
Estimated number of pregnant women in the last 12 months	26,787,000	2009	State of the World's Children 2011, UNICEF.	4,790,802	April-December 2010	Annual Report 2010-11, National AIDS Control Organization, Department of AIDS Control (Page 51)
Estimated number of pregnant women living with HIV needing ART for PMTCT					April-Dec.2010	Annual Report 2010-11, National AIDS Control Organization, Department of AIDS Control (Page 51)
Number of people living with HIV/AIDS	2,400,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV	880,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

In what way does the USG participate in the CCM?

Voting Member

What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

7+ times

What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

1-3 times

Has the USG or is the USG planning to provide support for Round 11 proposal development? Support could include staff time, a financial contribution, or technical assistance through USG-funded project.

Yes

In any or all of the following diseases?

Round 11 HIV, Round 11 TB, Round 11 Malaria

Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months?

No

In your country, what are the 2-3 primary challenges facing the Global Fund grant implementation and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc)? Are you planning to address those challenges through any activities listed in this COP?

Redacted

Did you receive funds for the Country Collaboration Initiative this year?
No

Is there currently any joint planning with the Global Fund?
No

Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, , or any other activity to prevent treatment or service disruption.

Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
2012 COP	Private Sector Partnerships for Health (PSP4H)	14841:The HIV/AIDS Partnership: Impact through Prevention, Private Sector and Evidence-based Programming (PIPPSE)				PEPFAR/India has invested in many PPPs, demonstrating innovative models that contributed to achieving HIV-related goals in India, and that informed national dialogue on private sector engagement in the NACP. In FY12, PEPFAR/India builds on these successes through a new

						mechanism – PIPPSE* - to strengthen the GOI's capacity to identify, attract and manage PPPs. The objectives of this project, launched June 2012, are to: (1) strengthen the stewardship role of NACO and SACS to foster and monitor PPPs; (2) strengthen evidence of PPP impact on HIV outcomes; and (3) demonstrate scalable PPP models to improve access to quality and affordable HIV services. PIPPSE will also support the GOI to establish a platform within NACO for enabling, identifying and managing future PPPs that support achievement of

						NACP goals. *Private sector activities under PIPPSE were originally approved in the FY11 COP under the IM PSP4H, and subsequently consolidated under the IM PIPPSE in the FY12 COP submission

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
N/A	Adult and Pediatric Case Reporting - not PEPFAR funded	AIDS/HIV Case Surveillance	Pregnant Women	Other	N/A
N/A	ANC Sentinel Surveillance/PMTCT	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Implementation	N/A
N/A	Behavioral Surveillance	Behavioral Surveillance among MARPS	Drug Users, Female Commercial Sex Workers, Injecting Drug Users, Male Commercial Sex Workers, Migrant	Planning	N/A

			Workers, Men who have Sex with Men		
N/A	HIV Drug Resistance Surveillance - not PEPFAR funded	HIV Drug Resistance	Other	Planning	N/A
N/A	HIV Incidence	Other	Injecting Drug Users, Migrant Workers, Men who have Sex with Men, Pregnant Women	Planning	N/A
N/A	India Demographic and Health Survey	Population-based Behavioral Surveys	General Population	Planning	N/A
N/A	Laboratory Support	Other	Other	Implementation	N/A
N/A	National Prevalence Estimates	Other	Other	Planning	N/A
N/A	Pediatric Surveillance - not PEPFAR funded	Other	Other	Implementation	N/A
N/A	Population size estimation	Population size estimates	Injecting Drug Users, Migrant Workers, Mobile Populations, Men who have Sex with Men, Other	Other	N/A
N/A	Surveillance Evaluation	Evaluation	Other	Other	N/A
N/A	TB/HIV Surveillance - not PEPFAR funded	TB/HIV Co-Surveillance	Other	Implementation	N/A
N/A	Vital Registration Sample	HIV-mortality	General	Other	N/A

	Registration Survey	surveillance	Population		

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHP-State	GAP	GHP-State	GHP-USAID	
DOD			0		**0**
DOL			150,000		**150,000**
HHS/CDC		3,000,000	3,740,638		**6,740,638**
HHS/HRSA			750,000		**750,000**
USAID			2,359,362	18,000,000	**20,359,362**
Total	**0**	**3,000,000**	**7,000,000**	**18,000,000**	**28,000,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency						Total
	DOD	HHS/CDC	HHS/HRSA	DOL	USAID	AllOther	
HBHC		40,000			219,628		**259,628**
HKID					216,775		**216,775**
HLAB		962,900					**962,900**
HTXS	0	374,522	575,000		258,444		**1,207,966**
HVAB					27,959		**27,959**
HVCT		45,000			513,979		**558,979**
HVMS		1,475,206			589,349		**2,064,555**
HVOP				18,000	5,327,792		**5,345,792**
HVSI		2,241,583			1,834,548		**4,076,131**
HVTB					66,775		**66,775**
IDUP					50,000		**50,000**
MTCT					2,592,053		**2,592,053**
OHSS		1,601,427	175,000	132,000	8,662,060		**10,570,487**
	0	**6,740,638**	**750,000**	**150,000**	**20,359,362**	**0**	**28,000,000**

Budgetary Requirements Worksheet

Program Area	Budget Code	Total Funding	Percent of Prevention, Treatment & Care	Budgetary / Reporting Requirement	Requirement Percentage	Does percentage meet the budgetary requirement/ recommendation?
Prevention	HVAB	27,959	0.3 %	AB	0.5 %	No
Prevention	HVCT	558,979	5.4 %			
Prevention	HVOP	5,345,792	51.8 %			
Prevention	IDUP	50,000	0.5 %			
Prevention	MTCT	2,592,053	25.1 %			
Care	HBHC	259,628	2.5 %	Care & Treatment	29.7 %	No
Care	HKID	216,775	2.1 %	OVC	2.1 %	No
Care	HVTB	66,775	0.6 %			
Treatment	HTXS	1,207,966	11.7 %			
Subtotal: Prevention, Treatment and Care		10,325,927	100.0 %			
Management and Operations	HVMS	2,064,555				
Governance and Systems	HLAB	962,900				
Governance and Systems	HVSI	4,076,131				
Governance and Systems	OHSS	10,570,487				
Total: All Program Areas		28,000,000				

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

Policy Area: Gender						
Policy: Mainstreaming HIV/AIDS for Women Empowerment						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						
Narrative	The purpose of these policy guidelines is to facilitate increased and improved action on the intersecting issues of HIV/AIDS and women by NACO, SACS,DAPCUs and all development partners.	The guidelines have been developed and framed in consultation with policy and programme personnel from the government, civil society including PLWH, women's organizations and the UN system. The policy may be periodically reviewed by a Committee comprising representatives from the	The guidelines were peer reviewed in 2007 and validated in April 2008 by experts on gender and HIV (Officials from NACO and SACS, senior government bureaucrats, civil society partners, PLWH networks, and donor and UN agencies)			

		government, development partners and civil society.				
Completion Date		2007	2008			
Narrative						

Policy Area: Most at Risk Populations (MARP)						
Policy: National Migrant Intervention Strategy: Operational Guideline						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	2007-08	2007-08	2007-08		2010	
Narrative	The purpose of these guidelines is to ensure the delivery of quality HIV prevention interventions to highrisk populations. Migrants are at higher risk for HIV due to their high-risk behaviours. Over 30% of the migrants at	An important source of HIV-related vulnerability is mobility and migration. Migrant populations have higher levels of HIV infection than those who don't move. India, home to the 3rd highest number of HIV positive people in	NACO has prepared these Operational Guidelines after a series of consultations with Technical Resource Groups (MARPs), representatives of civil society, Government, core groups, donors and other stakeholder		NACO has rolled out the guidelines to scale up and improve the quality of HIV/AIDS migrant interventions.	

	destination sites reported having sex with FSWs.	the world, is characterized by widespread migration. Male migrants in India often migrate alone, leaving their wives and families behind, usually to work in the informal sector, which is unorganised, unprotected and unregulated and accounts for 93% of total workforce in India.	s.A USAID partner led the development of the National Migrant Guidelines.			
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: Policy Framework for Children and AIDS						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion					2012-13	

Date						
Narrative	The Government of India is committed to preventing HIV infection and mitigating the medical impact of the virus on the lives of those already infected. There is a need for a simple yet comprehensive policy covering a broader agenda, spanning both the medical and socioeconomic dimensions of the epidemic as it affects children.	The Policy Framework adopts a rights based approach. It takes into account recent changes in the global understanding of the adverse impacts of HIV/AIDS on children, and of the best ways to address them. It is cognisant of advances in medical science.	The first priority of this Policy is to prevent HIV infection, in order to ensure an AIDS-free generation. In addition to prompt diagnosis, the focus will also be to ensure access to treatment to prolong life.	USG led the task force on Children affected by AIDS (CABA) in designing national operational guidelines. Following the launch of the Policy Framework for Children and AIDS further discussions with NACO and the Task Force Agencies for CABA led to consideration of the multi-sectoral mainstreaming approach for implementation of the operational guidelines for CABA.	Implementation of CABA pilot scheme in ten districts of six states	

Completion Date			2010			
Narrative						

Policy Area: Other Policy						
Policy: GIPA Policy Guidelines for HIV Programs						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			2013-14			
Narrative	In the late 1990s the first national network of people living with HIV/AIDS (PLWH) was formed. The network has since grown to have many state level and district level branches. However, the involvement of PLWH and those directly affected needs further strengtheni	The application of the principle of GIPA is an organic and ongoing process that demands different levels of readiness. This policy aims to effectively harness the meaningful involvement of PLWH in order to reduce the spread of HIV and mitigate its impact in India.	NACO has put in place an institutional arrangemen t at the district, state and national level to ensure that the GIPA policy guidelines will be implemente d effectively and with full integrity. USG supported the developeme nt of National GIPA policies and			

	ng to make it meaningful, consistent and systemic, thereby accelerating the national HIV response to HIV/AIDS.		guidelines, and is a member of the GIPA Technical Resource Group (TRG), which will function as a monitoring and advisory group to support the roll-out of the GIPA program in the country. NACO will publicize the monitoring report on its website.			
Completion Date						
Narrative						

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	259,628	0
HKID	216,775	0
HVTB	66,775	0
Total Technical Area Planned Funding:	**543,178**	**0**

Summary:

OVERVIEW OF INDIA'S NATIONAL HIV CARE AND SUPPORT RESPONSE

The Government of India (GOI) leads the scale-up and sustained implementation of national, state, district and community level HIV care and support programs and funds these efforts through the National AIDS Control Program (NACP). There are an estimated 2.4 million people living with HIV (PLWH) in India of which 39% are females and 3.5% are children. Among the 1.25 million PLWH registered across 320 functional Antiretroviral Treatment (ART) centers in India, over 420,000 are on ART and 700,000 are in pre-ART care.

The National AIDS Control Organization (NACO) envisions an India where every person living with HIV has equal access to quality care and is treated with dignity, where human rights are respected and where those infected or affected by HIV live without stigma and discrimination. NACO recognizes the fundamental synergy between prevention, care, treatment, and support and the need for a continuum of care, and supports these through policies and programs. NACO also works to improve service access through a number of service delivery mechanisms targeting marginalized and hard to reach populations.

In the third phase of the National AIDS Control Program (NACP-III, 2007-2012), the GOI focused on family and community care through a network of Community Care Centers (CCCs) and Drop-in Centers (DICs) in community-based settings. The establishment of CCCs was supported under the Global Fund for AIDS, TB and Malaria (GFATM) Rolling Continuation Channel for Rounds 4 and 6, implemented in 10 high-prevalence states (Karnataka, Maharashtra, Uttar Pradesh, Madhya Pradesh, Bihar, West Bengal, Odisha, Rajasthan, Chattisgarh and Gujarat). CCCs provide a comprehensive package of services including adherence counseling and treatment support, nutritional support, positive prevention, social support, outreach services for follow-up, referrals for higher level medical care and advice for economic, vocational and legal services targeted particularly to marginalized women and children affected by the epidemic. Since 2001, NACO in partnership with PLWH in high and moderate prevalence districts have established 255 of 350 planned CCCs linked to nearby ART centers to bridge the gap between tertiary care and home-based care. In 2007, NACO with technical support from the USG developed the National Operational Guidelines for CCCs with an increased focus on ensuring adherence to ART. More than 150,000 PLWH were treated for opportunistic infections in 2010 in public sector clinics.

Based on the 2009-2010 NACO-led assessment of existing CCCs, and subsequent deliberations in the

Technical Resource Group, NACO revised the Care and Support Scheme in 2010, creating two levels of CCCs. The first provides basic services and the second (renamed Comprehensive Care and Support Centers) provides expanded services, including treatment of serious opportunistic infections such as pneumonia and meningitis.

To complement the CCCs, NACO established and currently supports a network of over 200 DICs in high-prevalence districts. Managed by district level networks of PLWH, DICs serve as the first referral point for information and services related to positive prevention, care, support and treatment, and address individual and community needs of PLWH at the district and state levels. NACO with technical support from the USG is finalizing the National Operational Guidelines for DICs. Additional related networks in the continuum of care are described in the Treatment narrative, including Link ART Centers.

Finally, to increase coverage of HIV care and support services in rural areas, NACO launched the Link Worker Scheme (LWS), a community-based intervention providing information on HIV, condom promotion and distribution, referrals to counseling, testing and sexually transmitted infections (STI) services for most at risk populations (MARPs), vulnerable populations and PLWH. LWS expanded to 187 highly vulnerable districts across 20 states during 2010-11.

Tuberculosis (TB)

India has the highest TB burden in the world, where it accounts for 20-25% of deaths among PLWH. The estimated burden of HIV/TB co-infection is 900,000 cases, with HIV prevalence among TB patients over 6%. In HIV high prevalence states and districts positivity among TB patients is over 10% and may be as high as 40% in certain districts. GOI TB/HIV integration activities began in 2001 to address high co-infection rates in six states with high prevalence of HIV (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu). NACO and the Central TB Division adopted TB/HIV program level collaboration as a key strategy governed by the National Policy Framework for Joint TB/HIV Collaborative Activities developed in 2007 and revised in 2009. In October 2008, the intensified TB-HIV package of services was rolled out in 156 districts in nine high HIV prevalence states with a combined population of more than 320 million. This resulted in a seven fold increase in the detection of TB cases at Integrated Counseling and Testing Centers (ICTCs). The GOI is now scaling up this important initiative to over 200 high HIV burden districts throughout the country.

TB/HIV collaboration coordination committees and working groups have been formed at state and district levels, and coordination activities are closely monitored by NACP and the Revised National TB Control Program (RNTCP) both at state and national levels. TB intensified case finding was first implemented at ICTCs in 2008-09 and at ART centers in 2009. The Intensified Package of HIV/TB Collaborative Activities offers HIV testing to all TB patients registered under RNTCP, decentralized provision of Cotrimoxazole prophylactic therapy to all HIV infected TB patients detected, and linkage of all HIV infected TB patients to HIV care, support and ART. The activities are well rooted in all high prevalence states where the proportion of TB patients with known HIV status has now exceeded 80 percent. In the period 2009 to 2011, cross-referrals increased from 0.78 million to 1.05 million and over 42,500 HIV infected TB cases were identified and put on treatment.

NACO set a goal of diagnosing and treating 85% of the HIV/TB co-infected people through provider-initiated testing and counseling for TB clients and building capacity of HIV Testing and Counseling and RNTCP providers on HIV/TB co-infection and systems for cross-referrals and early detection of HIV/TB. NACO aims to increase the number of TB patients tested for HIV from 490,000 in 2008 to over 1.2 million by 2015. Previous challenges to co-location of HIV and TB services have been largely overcome.

NACO is contemplating the use of Whole Blood HIV tests for screening of TB among antenatal clinic patients in areas with poor coverage of HIV testing facilities, especially in large states in north India. The GOI is planning to introduce GeneXpert MTB/RIF to simultaneously detect both Mycobacterium

tuberculosis and resistance to rifampicin.

Orphans and Vulnerable Children (OVC)

India has over 3 million children affected by HIV (CABA) of which 115,000 are living with HIV. Although the onus for HIV programming lies with NACO, the success in ensuring access to services for these children can only be achieved with collaboration and coordination with the Ministries of Women and Child Development (MoWCD), Social Justice and Empowerment, and Human Resource and Development. MoWCD launched the 'Integrated Child Protection Scheme (ICPS)' in 2009 to establish Child Protection Societies at state and district level. ICPS links with MoWCD's on-going 'Integrated Child Development Scheme' providing supplementary nutrition and early childhood development services to all children less than six years of age, including CABA.

OVC programing has remained a low priority for NACO and this area is still evolving. During the planning for the fourth phase of NACP (NACP-IV, 2012-2017), the Care, Support and Treatment technical working group discussions highlighted the need to address OVC. NACO launched the national pilot scheme for CABA in May 2010. This scheme prioritized the provision of essential services for children of MARPs through coordination and establishment of linkages with existing government schemes and service providers at all levels. It is being implemented in ten districts across six states (Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur and Delhi). The baseline survey of this scheme was conducted in June 2010 and the scheme is currently being evaluated for its efficacy and scale up at the national level.

Quality Assurance

NACO has established programs to ensure quality of services through a number of mechanisms. For example, an effective system of follow-up by CCC outreach workers, PLWH networks and counselors at ICTC in some places halved the cumulative loss to follow-up from 15% in 2006 to 7% in 2010. Pre-ART and ART patients are tracked regularly where the ART center lab technician maintains a daily "due list" of the patients due for six-monthly CD4 testing from the CD4 laboratory register. HIV-infected pregnant women who do not undergo CD4 testing within one week of their due date are followed up by a lab technician to ensure the CD4 test is done on the next visit.

Greater Involvement of PLWH (GIPA)

PLWH play a central role in the response to the epidemic in India, particularly at the service delivery level. In 2011, the USG worked in technical collaboration with NACO to finalize India's policy on GIPA. Funding from the GFATM Round 4 (Rolling Continuation Channel) supported establishment and strengthening of 22 state level and 221 district level networks of PLWH to engage the community and ensure its access to HIV services.

PEPFAR/INDIA ACCOMPLISHMENTS IN LAST TWO YEARS

In the last year, the USG has played a key role in planning for care and support in the fourth phase of the NACP, through participation in its technical working group on Care, Support and Treatment. This working group analyzed the strengths and weaknesses of the current care and support program and made recommendations to strengthen and improve the quality of comprehensive HIV service delivery of the national program.

The USG has played a key TA and policy advocacy role for improving the quality of care and treatment services at national, state and district levels through its active role on the NACO Technical Resource Group for Care and Support and in care and support program assessments. For the 2010 assessment, the USG supported NACO in developing the tools that were utilized for assessing 206 CCCs and 10 Centers of Excellence and participated in assessment field visits. The USG also participated in the Joint

Implementation Reviews of NACP-III and provided technical input for improving care and support services at national and state levels.

The USG facilitated NACO adoption of the “continuum of care” model that addresses the needs of individuals at risk of, vulnerable to or infected with HIV, along with their families and communities. The components of continuum of care include home-based care training for PLWH network members and front line workers (Link Workers), to provide referrals and facilitate government social entitlements.

Orphans and Vulnerable Children

As a key member of the National Task Force Committee on CABA, the USG advocated for a policy and guidelines for this population. USG collaboration with UNICEF has successfully resulted in the launch of a National Policy Framework for Children and AIDS, followed by USG-supported development of national OVC guidelines. These national guidelines for implementing OVC programs outline steps for ensuring access to care, support, treatment, and protection services for children affected by HIV and define the minimum package of services for such children. These are: health/medical care, psychosocial support, nutrition support, education support, and special services such as social protection, economic strengthening, legal support and shelter/alternative care. The USG supported the development of the NACO pilot scheme and provided TA in the roll out of the new initiative, conducting the baseline survey of the scheme. The USG has developed a range of toolkits on OVC programing which are currently being used in NACO pilot districts. USG partners in the states of Tamil Nadu and Karnataka have successfully mobilized financial resources from the respective state governments to address the needs of OVC. The USG has been generating an India-specific evidence base that includes strategic inputs for national OVC programming, scientific documentation of USG OVC projects, and a greater understanding of the GOI’s OVC policy framework and pathways for the future. New evidence generated is informing development of NACP- IV.

The USG also supported six studies on OVC and one activity to build capacity of child health and welfare specialists at Pediatric Centers of Excellence in OVC research techniques and tools. These studies focus on OVC program issues such as the effectiveness of DICs in improving access to services and health outcomes among OVC, NGO programs for OVC, disclosure of HIV status to children, assessment of the Karnataka cash transfer program, organizational network analysis of the CABA scheme, and residential care for children of sex workers. The findings from these studies are providing important information for NACP-IV program strategies related to OVC.

Prevention for Positives (Positive Health, Dignity and Prevention)

The USG has supported district level networks to strengthen involvement of PLWH in positive prevention counseling. The USG developed a Positive Prevention Tool Kit (PPTK) focusing on advanced counseling. The PPTK facilitates positive living by providing accurate, realistic, and science-based information and counseling that addresses the comprehensive needs of PLWH by reinforcing preventive behaviors, consistent messages to facilitate a productive and healthy life, behavior change, improved quality of life (mental & physical), and planning for family health and happiness. The PPTK training was rolled out in Tamil Nadu, Andhra Pradesh and Karnataka. The USG provided TA in training counselors at ART centers, peer counselors of positive networks, ICTC counselors, counselors at CCCs in close collaboration with State AIDS Control Societies (SACS) and positive networks. The USG trained counseling faculty of NACO-designated training institutions as PPTK master trainers for future training rollout. The USG plans to conduct a formal evaluation of the PPTK tool kit in Fiscal Year (FY) 2012.

Tuberculosis

The USG has supported TB control activities in India for more than ten years, and continues to do so using non-PEPFAR funding. These efforts have focused on enhancing Directly Observed Therapy-Short Course

(DOTS) services, improving lab capacity to diagnose drug resistant TB, operations research, TB-HIV collaboration, and health systems strengthening. Current USG support focuses on high-level input on policy through USG participation in working groups and national planning mechanisms such as the NACP-IV.

The USG has supported a World Health Organization-based technical advisor who has provided critical policy and technical inputs on TB-HIV issues at the national level. This advisor worked closely with the GOI on policy development and program implementation, especially in the areas of TB/HIV surveillance, provider-initiated testing and counseling, and TB/HIV coordination. The USG also provided TA to revise the TB-HIV providers' curriculum to improve treatment in both RNTCP and NACP.

At the state level, all USG-supported HIV care and treatment programs in Karnataka implemented systems to screen for TB and refer patients for DOTS treatment. The USG provided TA to the Karnataka SACS to implement the intensified package of HIV/TB collaborative activities that included offering HIV testing to all TB patients registered under RNTCP and linking all HIV infected TB patients to care and support services.

Private Sector Engagement

The USG developed innovative and sustainable models for involvement of the private sector in care and support services. In 2009 for the first time in India, the USG piloted an HIV group insurance scheme for PLWH in collaboration with Star Insurance to determine feasibility for scale-up. Within two years, the number of PLWH enrolled under the Star Insurance scheme reached over 7,000 in the states of Karnataka, Tamil Nadu, Andhra Pradesh and Maharashtra. This model has been accepted by NACO and has expanded health insurance coverage to PLWH.

The USG initiated a unique consortium of private medical colleges in the state of Andhra Pradesh to strengthen HIV services catering to rural populations. NACO provided the funding and the USG provided TA for the establishment of counseling and testing centers and CCCs at consortium member private medical colleges. The consortium also provides subsidized CD4 testing facilities. The private medical colleges now are part of the State resource team for STI supportive supervision and its activities are self-sustaining.

Capacity Strengthening

Through a range of mechanisms and activities, the USG has provided significant TA in capacity building of health care providers in care and support, including prevention with positives. The USG has also demonstrated successful models for national scale-up of private sector engagement and strengthening HIV services in the private sector; for improving ART adherence through home and community-based approaches; and for implementing the CCC guidelines for care and support services.

To build human capacity in care and support, the USG supported NACO trainings for HIV specialists at ART Centers and Link ART Centers, CCC Medical Officers, and a one year HIV Fellowship Program for physicians in the Government Hospital for Thoracic Medicine (GHTM) in Tamil Nadu. The Fellowship Program is in its sixth year. Following training, Fellows continue to support the GHTM staff in providing clinical care and management of HIV patients. The USG provides TA in capacity building for 189 District AIDS Prevention and Control Units all over India to strengthen referrals and linkages between various facilities with CCCs, to integrate care and support with maternal and child health services and to support the implementation of CCC guidelines.

Policy Advances and the Evidence Base

As described above, the USG has provided technical advice and input on several national policies through its participation in technical and strategic working groups, including HIV/TB, GIPA, Care and Treatment and

Children Affected by HIV/AIDS. In addition, the USG develops evidence and advocates for shifts in policy or implementation strategy when warranted. All program and service implementation scale-up is supported financially by the GOI.

As described more fully in the Governance and Systems Technical Area Narrative, the USG is the GOI's lead technical partner on strategic information, and works closely with the Strategic Information Management Unit at NACO whose portfolio includes monitoring and evaluation, surveillance, and operations research. These efforts support the GOI to make strategic information and evidence at the center of program planning and decision-making.

Partnerships, Collaboration and Efficiencies

As described in the Governance and Systems Technical Area Narrative, and in the Executive Summary, NACO effectively coordinates the financial and technical contributions of Development Partners to ensure complementary inputs and non-duplication. All USG investments are aligned with NACP-III and directly support national and state priorities, and are the result of careful planning, coordination and negotiation. The USG also works with the UN agencies, the United Kingdom's Department for International Development (DfID), the World Bank, the Clinton Health Access Initiative and others to support development and implementation of the national plans. The USG also sits on the Country Coordinating Mechanism for the GFATM grants, several of which have important care and support components.

Building on these partnerships, the PEPFAR/India program builds efficiencies into all its investments. It strategically invests in value-added activities that leverage the considerable investments of the GOI, World Bank, GFATM and other partners. PEPFAR/India provides a model cost-effective TA program. The USG has a seat at the table as NACO develops the next national HIV response plan, while USG-supported programs increase the quality of the GOI response through evidence-based approaches. The India PEPFAR program leverages other efforts by building the capacity of local government, civil society, and the private sector to design and implement effective interventions.

PEPFAR/INDIA PRIORITIES FOR THE NEXT TWO YEARS

As in all intervention areas, PEPFAR/India works at the policy and technical levels to strengthen India's capacity to plan, implement, and evaluate its HIV care program at the national, state and district levels. The USG will continue to build on its strong record of providing high-level TA to strengthen sustainability in the area of care and support, and support adoption of a range of approaches that improve the quality of comprehensive services. The USG does not contribute funds to procure HIV-related drugs or commodities, nor does it support direct provision of care and support services.

Capacity Strengthening

The USG will prioritize support to existing national, state and district level structures to strengthen capacity and improve quality of comprehensive services. The USG will support the expanded role of NACO's Technical Support Units (TSUs) for increasing access to care and support services for MARPs; and provide TA and capacity building for an enhanced role of DICs in positive prevention counseling using the USG-supported Positive Prevention Toolkit. With FY 2012 investments, the USG will provide TA to SACS in identifying training institutions, developing training curricula and supporting CCC capacity building to improve access to care and support services for HIV+ MARPs.

Through participation in a range of NACO-led Technical Working Groups, and through membership in the GFATM Country Coordinating Mechanism, the USG will support NACO to build the capacity of SACS to implement the GIPA policy; and to implement the revised (2010) CCC Guidelines, including standardization and monitoring of the CCC. The USG will also provide technical support to capacitate District AIDS Prevention and Control Units to strengthen referral systems and linkages between various facilities and

CCCs, to integrate care and support with maternal and child health services, and to implement CCC guidelines.

To improve the quality of clinical care and support services, the USG will also invest in support for the Centers of Excellence to train HIV Specialists at ART and Link ART Centers, and CCC Medical Officers and nurses in these areas. The USG will also support the roll-out of a one-year HIV Fellowship Program for physicians. These efforts are described in the Governance and Systems Technical Area Narrative.

Finally, to support the Ministry of Defense Armed Forces Medical Service (AFMS) to establish training capacities in HIV prevention, diagnosis, care and treatment, USG will provide training for three AFMS HIV physicians at the four-week Military International HIV Training Program in San Diego, California. This course will be followed up through ongoing military to military collaboration with the USG Department of Defense HIV/AIDS Prevention Program (DHAPP).

HIV-TB

Through non-PEPFAR funds, the USG will continue to support the World Health Organization technical advisor at the national level for ensuring effective cross-referrals from ART centers to the RNTCP sites and better linkages with DOTS treatment.

Through participation in a range of NACO-led Technical Working Groups, and through membership in the GFATM Country Coordinating Mechanism, the USG will also continue to provide TA to NACO and RNTCP for further consolidation of HIV-TB collaborative services and scale-up of successful models for integrated services, including scaling up provider-initiated testing and counseling for TB patients in selected states. The USG will work with selected SACS to advocate for and facilitate placement of district level TB-HIV Coordination Committees to improve linkages between ICTCs and District Microscopy Centers in HIV high-prevalence states.

Orphans and Vulnerable Children

The USG will continue to provide TA to the national CABA pilot scheme for OVC to ensure provision of the basic services of health care, nutrition and food security, shelter and care, protection, psychosocial support, education and economic strengthening. The USG will also provide support to build capacity of the SACS and District AIDS Prevention and Control Units to implement OVC programs.

Gender

Through participation in Technical Working Groups and Advisory Committees, the USG will support the finalization and implementation of the National Gender Policy at national, state and district levels, and support NACP's cross-cutting policy of integrating gender across prevention, care and treatment programs. Specifically, the USG will assist NACO in the formation of a Gender Task Force. These efforts are described in the Governance and Systems Technical Area Narrative, and in the Executive Summary.

Laboratory

The USG will continue TA to NACO on lab quality systems improvement and expand the scope to include diagnosis of sexually transmitted and reproductive tract infections. The USG will continue support to other lab services including Early Infant Diagnosis, viral load and CD4. These efforts are described in the Governance and Systems Technical Area Narrative.

Strategic Information

The USG will increase the availability of quality data and evidence from special studies, operations

research, surveillance, program evaluation and population-based surveys to inform care and support programs. The USG will also provide TA for improved data quality generation and reporting from the point of data generation to improve program planning and advocacy. These efforts are described in the Governance and Systems Technical Area Narrative.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	962,900	0
HVSI	4,076,131	0
OHSS	10,570,487	0
Total Technical Area Planned Funding:	**15,609,518**	**0**

Summary:

OVERVIEW OF HIV GOVERNANCE AND SYSTEMS IN INDIA

India's health system is a vast network of public and private facilities providing services for the country's 1.2 billion people. The extensive public system supports the national health policy of universal access to health care, which is implemented by India's 35 states and union territories. This public system is complemented by a private health care system that provides an estimated 75% of India's health services and encompasses hugely varied quality of care. Overall there is low Government of India (GOI) investment in the health sector (1.2% of total Gross Domestic Product), and a wide variation in public health achievements and per capita health spending among the States. Quality health care for the majority of the population remains unaffordable and inaccessible.

At the central level, India's capacity for planning national campaigns has resulted in significant achievements in reducing disease burden. India has successfully eradicated Smallpox and Guinea Worm disease, has recently marked a Polio-free year, and is expected to eliminate Leprosy, Kala Azar, and Filariasis in addition to Polio in the foreseeable future. India has reduced its Total Fertility Rate, Infant Mortality Rate and Maternal Mortality Ratio.

The GOI has shown similar commitment and capacity to tackle the HIV epidemic, reducing new infections by more than 50% between 2000 and 2009. India's national HIV program is recognized as a model of country leadership and has achieved the goals of "The Three Ones". The National AIDS Control Organization (NACO), under the Ministry of Health and Family Welfare, manages the strategic National AIDS Control Program (NACP), currently finishing its third phase (NACP-III). NACO develops the standards for a uniform national program, implemented through annual state-led plans; the GOI has delegated implementation of many elements of the program to civil society and private sector partners. NACO is committed to evidence-based programming and uses a range of data sources to know its epidemic and plan appropriate responses, including data mapping to estimate the size of most at risk populations (MARPs), annual HIV Sentinel Surveillance Surveys, and periodic national Behavioral Surveillance Surveys in a sample of general and high-risk populations.

The national program has strategically targeted MARPs for many years. NACP-III has focused on MARPs through targeted interventions (TIs), while shifting from a state to a district-based response and prioritizing 195 of 640 districts based on HIV prevalence. Under NACP-III, Technical Support Units (TSUs) and District AIDS Prevention and Control Units were established to support service delivery to MARPs and other hard

to reach populations, with a focus on preventive services and information, and to initiate the process of integrating HIV services into blood safety, maternal-child health and family planning programs through the National Rural Health Mission. [National Rural Health Mission is an Indian health program launched in 2005 to improve health care delivery across rural India, and run by the Ministry of Health and Family Welfare.] Although the GOI allocates more than two-thirds of its HIV resources to prevention, the full range of HIV services was significantly scaled up and decentralized during NACP-III.

The fourth phase of the NACP (NACP-IV, 2012-2017), to be launched in April 2012, will focus on quality in implementation of the national program, and investments in innovations and technology to improve results. Developed in consultation with civil society and Development Partners, NACP-IV may be the final chapter of the GOI's targeted, vertical HIV/AIDS programming, as one of the GOI's objectives is to further integrate HIV/AIDS with other national health programs. Most importantly, the GOI has envisioned strengthening of program management structures at all levels to achieve the NACP-IV objectives. The current five-year plan has a US$2.5 billion budget supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the World Bank and other Development Partners who pool resources to leverage GOI funds. Domestic contributions increased to 25% in 2011, and the GOI has committed to substantially increase financial support for NACP-IV.

NACO has developed a strong policy environment supporting HIV programming and implementation of the NACP, described in the prevention, care and treatment Technical Area Narratives. With regard to sexuality and gender, the policy environment in India is improving. The Delhi High Court legalized consensual adult male homosexual sex in 2009, overturning Indian Penal Code Section 377, and the GOI recognizes three separate categories for sex (male, female, transgender) in GOI documents and surveys. The Ministry of Women and Child Development is mandated to ensure gender-inclusive programming across the health sector, and NACO is working to mainstream HIV into women's empowerment efforts of other ministries. NACO has also issued draft policy guidelines to incorporate gender considerations into HIV programs.

CHALLENGES IN IMPLEMENTING THE NACP

India has the world's third largest HIV epidemic. Though overall HIV prevalence is low (0.31%), prevalence varies substantially by district and state, with high prevalence concentrated among MARPs that are estimated to number 1.8 million, and bridge populations comprising an additional 11 million. Nearly 20,000 HIV-infected infants are estimated to be born each year, making India the country with the largest unmet need for preventing mother-to-child transmission of HIV (PMTCT).

Although India's program has shown remarkable successes in the last several years, full attainment of the country's ambitious HIV goals is hampered by systemic challenges, many due to the sheer size of the country and its population, and the breadth of its decentralized health system. Rolling out any change in policy or practice is an enormous undertaking. Significant challenges are described below.

Strategic Information (SI)

In a country of 1.2 billion people and an epidemic driven by behaviors, compiling adequate data to understand and plan for the national and state responses will always be challenging. Although the GOI is committed to expanding and better using SI, limited data and information systems in some states and districts hinder effective decision-making. There is a paucity of quality data for tailoring interventions to specific prevention needs and to the changing dynamics of the epidemic, including the dynamics of migrant populations and their risk behaviors. MARP practices and locations are constantly changing and targeted interventions must respond to shifting patterns and environments (for example brothel-based sex work giving way to home-based commercial sex). The GOI and partners have also identified poor quality of the data reported by non-governmental organizations (NGOs) implementing TIs; to date, there has not been a systematic effort to strengthen the SI capacity of these NGOs.

Quality in Policy implementation and Program Management

The GOI is recognized for its evidence-informed policy development processes, and one of the public sector's core strengths is policy achievements. However, policy implementation is frequently noted as a significant challenge and lack of sufficient quality control and quality improvement may limit the impact of well-planned programs. The national program lacks a robust quality assurance system, including adequate supportive supervision and a plan for creating quality assurance competency and culture in the NACP implementation structures. Insufficient management and oversight capacity weakens service quality in some higher-prevalence states and districts.

Human Resources for Health

There are important gaps in health workforce planning in India, and human resource data are limited, inconsistent or out-dated. Mobilization and retention of qualified human resources, particularly in remote and rural areas, remains a major challenge, and shortages of health care providers skilled in HIV service delivery decrease service quality in some higher-prevalence states and districts. In addition, NACO faces serious difficulties attracting and retaining qualified and technically competent professionals for key positions in the State AIDS Control Societies (SACS) due to increased competition from the private sector, low levels of remuneration in the public sector, and limiting hiring mechanisms. There continue to be frequent changes in leadership of the state agencies. NACO has used a combination of strategies, including personal service contracting and the use of expert consultants, to ensure a critical mass of qualified individuals to support the massive scale-up of activities.

NACP Financing

As described in the Executive Summary, there will be a reduction in external resources for NACP-IV, and the program will increasingly depend upon domestic funding. In the coming years, the management and drug costs of the universal antiretroviral treatment (ART) scale-up will be substantial. In addition to identifying and implementing more effective and efficient service delivery approaches, a challenge under NACP-IV will be to identify and explore innovative approaches of sustainable financing to address this burden. Finally, NACP-IV needs to explore the development of mechanisms to address risk pooling, social protection and insurance issues.

HIV Diagnostics

There is a four-tiered laboratory structure for HIV testing comprising more than 5,000 Integrated Counseling and Testing Centers at district level, 118 state reference laboratories, 13 national reference laboratories and one apex laboratory. These laboratories are responsible for the diagnosis of HIV infection by rapid test, enzyme immunoassay or molecular methods. A subset of reference laboratories carry out HIV/AIDS care and treatment monitoring with CD4 and HIV viral load testing. There are seven laboratories carrying out HIV-1 DNA testing for Early Infant Diagnosis, with a logistics network for timely sample collection. NACO has identified the inconsistent quality of HIV diagnostics as an impediment to scaling up HIV services, and has initiated steps to assess, strengthen and accredit public sector laboratories with United States Government (USG) assistance.

HIV and Gender, Stigma and Discrimination

Early marriage, societal reluctance to discuss sex, and male dominance in sexual decision making are continued barriers to HIV prevention for women, and women in general have poor access to health services, including lower rates of HIV testing. Men who have sex with men and transgender individuals also have poor access to appropriate health care and sexual health information and are at heightened risk for HIV, other sexually transmitted infections (STI), and gender-based violence. Stigma and discrimination continue to limit access to HIV services among those who may need it, including access to counseling and

testing.

Private Sector

At least partly due to gaps in the public health care system, the majority of the population turns to private health care which is largely unregulated and often provides a sub-optimum quality of care to India's poor while also incurring significant out-of-pocket expenses. There is currently no estimate of the proportion of HIV care provided by India's private sector, including through individual providers, and private clinics and hospitals, but it is certainly substantial. The GOI's stewardship capacity to address quality in the private sector, including regulatory enforcement, is limited; this has implications for the quality of HIV care including potential for antiretroviral (ARV) drug resistance as a result of poor prescribing practices. Most importantly, this massive health resource is not being leveraged to support the implementation of NACP and further reductions in the epidemic.

Health Care Costs

One survey on the health care financing system in India found that over one-third of reported ailments from the lowest income quintile of the population went untreated due to lack of funds. The impact of inequitable health care financing on households with PLWH due to high treatment costs, long periods of illness and the burden of care is five times greater than on non-HIV households.

Procurement and Supply Management

The Indian logistics system continues to face most of the classic issues of developing country systems: shortages or stock-outs of key commodities, poor or nonexistent inventory control systems, and inadequate storage systems. NACO's HIV Counseling and Testing and PMTCT working group identified stock-outs and supply shortages as major issues needing to be addressed in NACP-IV.

PEPFAR/INDIA PRIORITIES IN GOVERNANCE AND SYSTEMS IN NEXT TWO YEARS

Given India's geography and population size, its substantial domestic resources, and the relatively small PEPFAR budget, the USG maintains a highly focused programmatic portfolio developed through a productive and ongoing consultative process with the GOI and in close coordination with other Development Partners. PEPFAR/India's portfolio provides high-impact, high-level technical support to the GOI and its partners to facilitate implementation of the NACP. The USG carefully targets its resources in joint programming decisions with the GOI to address critical gaps -- in technical areas in which the USG has unique strengths, and with institutions with the greatest potential for impact on HIV in India. This approach to planning has resulted in strong program impact with a modest USG investment. The USG supports direct services only in the context of demonstration projects designed to test interventions and service delivery models for eventual adoption and scale-up by the GOI. The USG has already demonstrated strong program impact with modest investments in such areas as comprehensive prevention packages for MARPs, strategic information, laboratory strengthening, private sector engagement and leveraging, policy development and institutional strengthening at state and district levels.

All investments by PEPFAR/India build towards country ownership (sustainability and 'transition') by strengthening existing individual, organizational and systems capacities. All investments also support the PEPFAR/India Five-Year Strategy (2011-2015) and are in line with the guiding principles of the Global Health Initiative (GHI). The USG works as a country team, closely collaborating with NACO and the range of donors involved in HIV and health in India.

In FY 2012 and FY 2013, USG Governance and Systems investments prioritize high-impact work in capacity strengthening at all levels; leadership and governance; quality and innovation in policy implementation and service delivery; strategic information; laboratory strengthening; leveraging the private

sector; human resources for health; and small investments in health efficiency and financing, and supply chain management. GHI and gender-related efforts are cross-cutting throughout the program, and are discussed at the end of the section.

PEPFAR/India does not provide support to pre-service training of health professionals. India has a well-structured pre-service training infrastructure in government and private medical colleges, nursing institutes, and paramedical courses, overseen by regulatory agencies such as the Medical Council of India, the Nursing Council and the Quality Control Institute. In consultation with the GOI, the USG will continue to invest in strengthening the HIV-specific skills of trained health care professionals through a range of model in-service training programs. PEPFAR/India does not anticipate that pre-service training will become part of its increasingly streamlined portfolio.

Capacity Strengthening

As noted above, all PEPFAR/India investments have a substantial capacity development component to strengthen government, private sector and civil society capacity to plan, manage, monitor and evaluate HIV programs through in-service training and mentoring. All investments are designed to provide targeted and time-limited technical support and capacitate the GOI or other private sector and civil society partners to continue successfully after the USG transitions out. The USG will also continue to work closely with the GFATM programs in India to strengthen the India Country Coordinating Mechanism (CCM) Secretariat and build capacity to increase private sector and civil society engagement in GFATM programs, as described in the “Global Fund/Multilateral Engagement” section of the COP.

The USG will prioritize management training at state and district levels along with cutting edge technical capacity strengthening in strategic information, laboratory systems, human resource management, and prevention programming. The USG will help national and state programs strengthen: (1) evidence-based planning; (2) implementation, monitoring and evaluation (M&E); (3) institutional capacity of NGOs, community- based organizations (CBOs) and networks to manage and deliver quality HIV services; (4) management skills of health sector personnel; (5) integration of HIV into National Rural Health Mission primary health services, and; (6) HIV program efficiency. The range of support will include strategic communication planning, training of trainers and targeted support to designated Centers of Excellence.

Leadership, Governance and Policy Development

Through direct participation by USG staff and support for senior technical consultants, the USG will continue to work in collaboration with NACO and SACS to ensure policies meet global standards, to develop operational guidelines, to test and implement innovative approaches, and to establish quality improvement systems. Currently, the USG is fully engaged in a number of technical working groups led by NACO to provide input to the design of NACP-IV.

The USG has supported the GOI to strengthen HIV policies to create an enabling environment for effective implementation of NACP, from identification of HIV policy issues, through policy development, government endorsement, policy implementation and evaluation. This support has been described in the prevention, care and treatment Technical Area Narratives. This comprehensive approach maximizes the potential for PEPFAR interventions to support the GOI in achieving a truly enabling environment that allows for an effective continuum of response. As NACP-IV is rolled out and especially with increased HIV mainstreaming and integration with the National Rural Health Mission, the USG anticipates that NACO and its partners will identify new gaps in the policy framework that will need to be addressed, including for example additional guidelines related to human resources for health, stigma and discrimination, service quality improvement, laboratory standards, counseling and testing, and PMTCT. Through existing staff and technical support mechanisms, the USG will support NACO and the SACS to develop and implement policies and operational guidelines for services, supportive supervision, monitoring, laboratory systems, information management, and quality control and improvement.

Seven African delegations have visited India in the recent past to learn from India's successful HIV programming. There is continued interest in learning more from India on MARP targeted interventions, engagement of the private sector and civil society, and management and coordination of the national HIV program. New to COP 2012 is an activity that, in collaboration with other Development Partners, will promote South-to-South technical exchange between India and African countries, showcasing best practices, particularly for MARPs, and strengthening India's capacity to provide TA in HIV.

Quality in Policy Implementation

In FY 2012 the USG will continue its successful partnership with NACO to optimize roll-out of new policies and programs by strengthening capacity and oversight mechanisms and developing and testing innovative service delivery models.

To strengthen programming targeted at MARPs, the USG will support institutional strengthening at the national level and in poorer performing states. Existing structures charged with ensuring quality of policy implementation include a National TSU for guiding prevention efforts in the field, state TSUs to supervise and mentor local prevention intervention partners, and District AIDS Prevention and Control Units to oversee program coverage and quality at the district level. The USG will support TSUs in three new focus states to scale up and monitor the quality of TIs implemented by NGOs. The USG will also collaborate with SACS in focus states and districts to strengthen leadership and management skills of CBOs and PLWH networks implementing HIV services, and to identify effective strategies to increase MARP access to HIV testing, care and treatment. With COP 2012 funding, the USG in partnership with the International Labor Organization will strengthen the capacity of institutions including the Ministry of Labor and Employment, employers' and workers' organizations, NACO, SACS, and private companies to effectively implement the GOI's World of Work Policy.

The USG will also support NACO in rolling out the National Rural Health Mission/NACP integration guidelines at national, state and district levels, in particular the integration of PMTCT with maternal and child health and reproductive health under the National Rural Health Mission, and the engagement of the private medical sector in HIV services for pregnant women and MARPs. The USG also plans to support phased roll-out of the new PMTCT national policy incorporating the World Health Organization's Option B.

The GOI has an excellent track record of scaling up models that the USG has shown to be effective. For example, lessons learned in the successful NACO-USG collaboration on mobile STI/HIV testing services targeted at MARPs in Andhra Pradesh and Maharashtra is being integrated into NACO guidelines and scaled up to other states. Systems and staffing established for other USG-supported projects have also been successfully transitioned to GOI support.

Quality in Service Delivery

India has scaled up an extensive system to address the continuum of response, which has evolved step-wise to meet the identified needs of the national program. These mechanisms are described in the prevention, care and treatment Technical Area Narratives and include: Targeted Interventions for MARPs to ensure outreach and access to a comprehensive package of prevention and care services; Integrated Counseling and Testing Centers that register HIV-positive individuals into the care and treatment system; Community Care Centers that provide care for opportunistic infections, CD4 monitoring and now ART; Link ART Centers located at district and sub-district hospitals and Community Health Centers; nodal ART Centers that initiate patients on ART; and Link Worker programs that track patients to reduce loss to follow up between pre-ART care and ART.

The GOI continues to scale up this system using existing resources, including significant GFATM resources, and a major thrust under NACP-IV is on ensuring higher quality of services in the prevention to

care and treatment continuum while expanding service coverage. The USG will support the GOI to optimize the quality of these services through capacity strengthening in program management and implementation, including through improved integration and linkages.

The USG supports the GOI in all aspects of the continuum of response. Through its investments in systems and capacity strengthening, the USG works to improve the sustainability of existing service delivery systems, service coverage and service quality. To further improve access and an equitable distribution of services, the USG will build on past successes, including insurance for PLWH, quality improvement systems, and better use of management information and data for service improvements and client tracking.

Strategic Information (SI)

The USG is the GOI's lead technical partner on SI, and works closely with the Strategic Information Management Unit at NACO whose portfolio includes M&E, surveillance, and operations research. SI is a key NACP-III objective and accounts for 3% of the total budget. In NACP-III, NACO greatly scaled up its SI management capacity, with an emphasis on data collection and data use at national, state and districts levels. In NACP-IV planning, the GOI continues to place high importance on SI and evidence as the basis for program planning and decision-making.

In 2012, NACO's Strategic Information Management System (SIMS) will replace the national computerized management information system (CMIS), the primary reservoir of programmatic data and service statistics. The USG will support NACO in the roll-out of training and resources across the country for SIMS deployment, strengthening capacity for routine reporting, analysis and use of data from the SIMS, and exploring how to integrate existing public health data information systems into the SIMS core architecture. The USG will also continue to provide crucial provisional SI staff support at national and state levels, including epidemiologists, M&E officers, and program officers to ensure that the SIMS has the optimal human resources to manage the volume and complexity of data that the system generates.

To facilitate evidence-based planning, the USG will support the development of data quality tools and policies, indicator definitions and M&E toolkits, and assist NACO in broadening the sources of data used to classify a district's vulnerabilities and risk factors through epidemiological profiling. The USG will also support pilot HIV case reporting systems in two or three states.

Through mechanisms established in FY 2011, the USG will continue to work with UNAIDS on HIV prevalence estimates, projections and trend analysis and develop the capacity of states to generate estimations. In collaboration with WHO, the USG will support HIV drug resistance surveillance, monitoring of ART and PMTCT, HIV estimations and projections, state-based modeling, cohort analyses, and operations research. The USG will also assist in incidence analyses, identifying pockets of infection and estimating the burden of infection. USG support for prevention-related SI will include the Integrated Biological and Behavioral Assessment, formative studies and social science research on the dynamics of MARPs including factors affecting the utilization of testing and counseling and care and treatment services. The USG will also collaborate with the Ministry of Health and Family Welfare to integrate a robust HIV module in the integrated National Health Survey being planned for 2013.

The USG will continue to strengthen the SI capacity of the national and state level TSUs, and help develop a strong cadre of M&E officers across the various program components, by supporting in-service training at state and district levels and promoting post-training mentoring in qualitative evaluations, data triangulation, economic evaluations, and basic and advanced data analysis.

In collaboration with NACO, UNAIDS, and the Bill and Melinda Gates Foundation (BMGF), the USG will support the creation of an information warehouse to house evidence on the epidemic in India. The warehouse will enable efficient access to complete information to guide future HIV estimations, and support NACO's role in disseminating information to implementing partners and other stakeholders.

Laboratory Strengthening

The USG is the major donor providing TA in laboratory systems strengthening in coordination with the Laboratory Services Division at NACO, and has built a strong partnership with the network of 13 national and 117 state reference laboratories through its ongoing work on laboratory accreditation for HIV diagnostics. In FY 2012, the USG will build on these successes through continued work in laboratory assessment and support towards accreditation, expanding these efforts to include STI diagnostics. In addition, the USG will continue its support to policy development and implementation at the national and state levels through its strong role in the NACO-led laboratory services technical resource group. The following activities are planned to strengthen laboratory services for HIV at the individual, organization and institutional level.

Laboratory Accreditation and Quality Assurance: In 2012, the USG will conduct a re-assessment of all SRLs to identify International Organization for Standardization (ISO) 15189 compliance. USG-supported regional technical specialists will continue to provide monitoring, mentoring and routine TA on-site at NRLs and SRLs in support of quality assurance of HIV, Hepatitis A and Hepatitis B virus serology kits and for proficiency testing for all HIV serology and CD4 count laboratories. USG-supported TA will also expand to strengthen laboratory testing for STI and reproductive tract infections. In FY 2012 the USG also will leverage its international technical experience to provide training to senior level laboratory personnel on laboratory management, innovative techniques and technical and quality issues related to HIV testing and diagnosis. To enhance learning, the USG will support participation of government-nominated laboratory staff for national and international study tours, meetings, conferences, and short-term trainings.

Early Infant Diagnosis (EID): The USG provides TA for proficiency testing for HIV-1 DNA PCR at India's seven EID laboratories. The GOI is now conducting EID training for physicians, nurses, and laboratory technicians, previously led by the Clinton Foundation across 26 states on dried blood spot and whole blood sample collection and storage, as well as transportation of samples from clinic to testing laboratories.

Policy and strategic planning: With the lens of gradual integration with the National Rural Health Mission, the USG will continue to support TA and training to NACO in laboratory sciences and policy development. The USG will support targeted laboratory TA to NACO to improve quality standards through the Laboratory Accreditation Program, implement a Laboratory Information Management System for managing HIV laboratory data, and scale up innovative strategies for enhancing laboratory services.

Leveraging the Private Sector

The USG has played a significant role in engaging the private sector in broad health programs in India, working successfully to develop effective mechanisms to increase private sector involvement in HIV services, and to strengthen and institutionalize GOI engagement with the private sector, while leveraging substantial private sector resources. Notable initiatives include: a) a private provider network in Tamil Nadu to provide STI services to MARPs; b) private health care facility mapping and assessments; c) partnering with Tata Business Support Solutions on an HIV toll-free helpline; d) a white paper on private sector engagement in health, including HIV; e) a risk analysis matrix for prioritizing industries for work place interventions; and f) India's first private health insurance product for PLWH, which covered more than 7,000 PLWH. These initiatives have leveraged private sector resources and expertise and have influenced policy makers and program managers to partner with the private sector for HIV prevention and care programs.

The USG advocated for and provided TA during NACO's first national review of private sector initiatives in the recent Joint Implementation Review, which recommended the formation of a public-private partnership (PPP) coordination unit to provide strategic oversight and support states in rolling-out of PPPs. The USG has been actively engaged in the NACP-IV project management and organizational restructuring working group that recommended the creation of dedicated staff to support PPPs.

Through existing mechanisms, the USG continues to support TA to national and state governments to partner with private health facilities for Integrated Counseling and Testing Centers and PMTCT services. In FY 2012, to strengthen stewardship of national and state governments to engage the private sector in HIV programs, the USG will support NACO in establishing a dedicated national health PPP coordination unit that will manage PPPs and provide TA to NACO and the SACS to effectively marshal private sector for scaling-up STI, Integrated Counseling and Testing, and PMTCT services. The USG will build capacity of the PPP coordinating unit to provide strategic oversight of the private sector in HIV programs, review policies, identify and address capacity and structural gaps, facilitate innovative PPPs, and leverage resources from the Indian diaspora. The USG will initiate a number of new activities to support effective private sector engagement, including an assessment of key issues and capacity gaps for engaging the private sector in HIV, mentorship support for PPPs and dedicated learning sites through twinning between national and international institutions, systems for quality improvement in private health care facilities, and integrating private sector ART data into state management information systems. The USG will provide TA at national and state levels to generate evidence for private sector engagement and its influence on health outcomes.

Human Resources for Health

The USG has a multipronged strategy to strengthen the different cadres of health care workers at all levels. The USG's contribution in this area focuses mainly on strengthening competencies and skills and empowering personnel to take ownership of the HIV response at national, state, district and community levels, within both the government and private sectors. For example, the USG continues to address the capacity strengthening needs of the District AIDS Prevention and Control Units in priority high burden states and supports their training in technical and management areas where a need has been identified. The USG supports TA to improve training for various service providers in the public sector, such as nurses, counselors, care givers, and STI and ART specialists. The USG works in close collaboration with academic institutions to strengthen their ability to provide direct training to clinical and program staff of NGOs, District AIDS Prevention and Control Units, SACS and NACO, and supports training programs that strengthen core skills (peer education, condom social marketing, communication, counseling and M&E) of NGOs implementing TIs. For example, in a partnership with the Indian Nursing Council, the USG will support phased in-service training in HIV clinical care for all ART Center and Link ART Center nurses in the country. NACO has already adopted and scaled up several USG-developed training modules.

The USG efforts promoting quality service delivery will address human capacity development in the traditional areas of grants management, communication, surveillance and data triangulation, and will include continuing areas of priority such as laboratory strengthening and service integration. The USG will support advance certificate training in HIV Epidemiology, and capacity strengthening in a range of SI areas to strengthen the cadre of individuals that can use data for program improvement. The USG will transition its clinical fellowship to the Tamil Nadu state government, but will continue to support the Government Hospital of Thoracic Medicine to facilitate its role as a learning site for clinical mentorship and quality of services for the 10 Centers of Excellence. The USG will provide TA in the development of training modules for different cadres of staff based on competency and gap analysis, to strengthen capacities of trainers, mentors and nurses linked to ART centers and to develop demonstration sites at ten Centers of Excellence for ART.

To address gaps in human resource planning, the USG will also support technical assistance to Nursing councils and the Ministry of Health and Family Welfare in developing a holistic Human Resource Health Management Information System that will be the interface between the data of health care councils (including nursing councils) and the Ministry's health care facility data provided through the Health Management Information System.

The USG supports a range of staff placed in strategic positions at national and state levels. These include four leadership positions at the national TSU (Team Leader, National Epidemiologist, IT specialist and M&E

Officer), 30 key technical specialists at NACO in HIV Counseling and Testing, PMTCT, ART, surveillance, laboratory and M&E, and staff in six TSUs. These USG-funded technical specialists help to strengthen the health systems in priority states.

The USG will approach its programmatic transition through continued strengthening of local institutions to take on the TA provider roles. USG support for technical specialists at NACO and SACS will be gradually reduced and transitioned to those offices, continuing support in the short term only for strategic positions critical for sustaining USG technical investments. The USG will continue to support the national TSU and state TSUs in three focus states (Uttar Pradesh, Odisha and Maharashtra) while tracking benchmarks for successful transition that measure improved capacity of SACS.

Health Efficiency and Financing

The USG will invest in a targeted health financing component focused on strengthening the health sector's ability to analyze and use health expenditure data to make sound program and budgetary decisions. These efforts will include support for development of a data system on PLWH morbidity and mortality (since lack of such data is a key barrier to the insurance industry's participation in health insurance coverage for PLWH); support for HIV subaccounts within the National Health Accounts framework to advocate for greater GOI budgetary support for HIV; and development of econometric techniques for estimating private health expenditures on HIV.

Supply Chain Management (SCM)

In India, a number of major donors support SCM improvements, including UNICEF, the World Bank, United Nations Population Fund and BMGF, particularly for supplies related to maternal, child and reproductive health. The USG collaborates with these partners, for example providing significant input into BMGF's planning for SCM efforts in Uttar Pradesh. As noted above, the USG has small investments in SCM, implemented as part of the collaborative development and implementation of an integrated service delivery model that can be scaled up by the GOI. In FY 2012, some support for supply chain management may also be provided for overall logistics system strengthening within the integrated programming approach to support implementation of NACP-IV; this will be carefully coordinated with the GOI and other donors to ensure that no duplication occurs, and that any support provided results in maximum impact.

Innovations

NACO has included a major focus on innovations under NACP-IV, as it feels that the next major advances in controlling the HIV epidemic can be achieved through developing models that improve service delivery, coverage and quality. The USG will support NACP-IV efforts to test various innovations that are in line with the aims and within the resource framework of the PEPFAR strategy. These will include innovative approaches to service integration, quality assurance, coverage saturation, partnerships, and data quality and use. In addition, innovations are also planned in the areas of risk assessments and risk pooling, to facilitate suitable financing options for insurance coverage and other social protection measures.

Gender

As noted above, gender is a cross-cutting area, supported by a range of integrated activities described below. Within the country team, PEPFAR/India established an interagency Gender Technical Working Group to identify and define strategic priorities for the program, and to promote the use of both PEPFAR and NACO gender guidelines. In 2010, USAID conducted a gender analysis of its programs, the results of which have informed development of the new USAID project designs. The Technical Working Group prepared a report of gender activities in 2011, highlighting the important progress and continued gaps in ensuring that new projects effectively address HIV-related gender issues, such as gender equality, male norms and behaviors, and violence and coercion.

USG efforts to integrate capacity strengthening around gender-relevant policies, challenges, and strategic information are reflected in a range of activities and products integrated into the USG portfolio. These include support for training modules and models to: strengthen women's capacity for negotiation of safe sex, and for sharing these skills as community change agents; support young men and women in colleges to challenge traditions and practices that increase vulnerability to HIV (Red Ribbon Clubs); promote more equitable gender norms among a range of adult target groups through self-help groups; and support safe disclosure for HIV-positive women who fear violence from their partners (Positive Prevention Counseling Toolkit). Through USG support to state and district-level implementation of TIs for MARPs, the USG continues to strengthen the capacity of civil society partners to assess and reduce barriers to services for women and sexual minorities, for example by working with law enforcement and brothel owners to create a more enabling environment for TIs.

At the strategic level, the USG is a member of NACO's Mainstreaming Task Force, which supports national gender policy and guidelines. The USG continues to collaborate with agencies of the United Nations (UNAIDS, UNIFEM, UNICEF, and UNDP) to support a resource pool of experts to review available gender data, assess current programs, and recommend actions to improve GOI health programs. The USG also supports efforts to better understand and document gender inequalities in service access by promoting analysis of gender-disaggregated data at the national, state and district levels.

The GOI in NACP-IV has articulated a clear strategy to address stigma and discrimination related to HIV and gender, by creating an overarching enabling environment that reinforces positive attitudes and practices at the societal level, and in various settings including homes, health care facilities, workplaces, and educational institutions. Reviewing existing and developing new policies as needed, along with related tools, are parts of the efforts to protect and promote the rights of PLWH, marginalized and vulnerable populations.

Global Health Initiative (GHI)

India does not have a stand-alone GHI strategy. The goals of GHI are integrated into the PEPFAR/India Five Year Strategy 2011-2015, developed in consultation with the Government of India, and into the planning for PEPFAR/India annual investments through the COP. The USG's strong commitment to integrated programming, particularly in the areas of primary health care, and women's, children's and reproductive health, is reflected in these investments, many of which are part of larger programs that address broad health issues through strengthening both human and organizational capacity and systems.

In India, the USG also supports the unique structure of the U.S.-India Health Initiative, launched in 2010 and part of the broader U.S.-India Strategic Dialogue. Led by the U.S. Secretary of Health and Human Services and India's Minister of Health and Family Welfare, and coordinated in India by the USG Health Attaché, the Health Initiative is an inter-agency umbrella organizing mechanism for bilateral discussions between the United States and India on public health collaborations and program implementation. Four Working Groups comprised of high-level representation from the U.S. and India are developing plans to leverage each country's strengths in areas of (1) Non Communicable Diseases, (2) Infectious Diseases, (3) Maternal and Child Health and (4) Strengthening Health Systems and Services. The purpose of the Working Groups is to share information, identify and address policy concerns, identify new technologies, share international best practices and address implementation bottlenecks that might arise in each of these areas, many of which support the broad agenda and specific principles of the GHI. PEPFAR/India's support for GHI principles is further discussed in the Executive Summary.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount

HVMS	2,064,555	
Total Technical Area Planned Funding:	**2,064,555**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	27,959	
HVCT	558,979	0
HVOP	5,345,792	500,000
IDUP	50,000	0
MTCT	2,592,053	0
Total Technical Area Planned Funding:	**8,574,783**	**500,000**

Summary:

OVERVIEW OF THE EPIDEMIC

India has the world's third largest HIV epidemic, characterized by concentrated transmission and heterogeneous geographic spread. The relatively low overall HIV prevalence (0.31%) masks substantial variance by district, state, and region, including higher prevalence in some rural communities. India's epidemic is driven by infections among most-at-risk populations (MARPs), which in India include sex workers (SW) and their clients, men who have sex with men (MSM), transgender individuals (TG), and people who inject drugs (PWID). Recent evidence indicates elevated HIV prevalence among migrants and truckers, who also have been identified as bridge populations facilitating HIV transmission between MARPs and lower-risk, often rural populations. HIV prevalence in these groups is 10 to 30 times higher than in the general population at 4.9% among female SW, 7.3% among MSM, 9.2% among PWID, and 3.6% among migrants. Overall prevalence among antenatal clinic attendees is 0.48%. Data on prevalence of sexually transmitted infections (STI) in India is based on a limited number of studies conducted among MARPs and hospital-based populations, estimating that 5% of the adult population is STI-symptomatic. 2007 HIV prevalence studies among STI clinic attendees indicated low HIV rates in most states with the exception of Karnataka (8.4%), Maharashtra (11.6%), and Andhra Pradesh (17.2%).

National estimates indicate a MARP population of about 1.5 million including 868,000 female SW, 412,000 MSM and 177,000 PWID, in addition to an estimated 7.3 million migrants and 2 million truckers. Of the 27 million pregnancies in India each year, an estimated 65,000 occur among HIV-infected women and result in an estimated 19,500 HIV-infected children born each year.

Sexual transmission is estimated to account for nearly 90% of new infections in India (88.7% heterosexual, 1.3% homosexual). While injection drug use is the primary route of transmission in northeastern states, it accounts for only 1.6% of transmission nationally. Over 5% of new cases of HIV are acquired through perinatal transmission and 1% through receipt of infected blood and blood products. Three percent of infections are of unknown source.

The geographic focus of new infections is shifting in India with some states formerly designated as low-prevalence showing increases in new infections over the past two years. Of the 140,000 estimated new infections in 2009, 39% were from the six states designated as 'high-prevalence' (Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Manipur, and Nagaland). Seven states designated as 'low-prevalence' accounted for 41% of new infections, including Odisha, Bihar, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat. The limited public health capacity of some states has negatively impacted the quality of surveillance, services, and programming, leaving opportunities for HIV to spread. Injecting drug use is most concentrated in the northeastern states, but there are also large populations of PWID in four of India's biggest cities – Chennai, Delhi, Mumbai and Chandigarh.

India is a priority country for the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (The Global Plan), and the Minister of Health and Family Welfare sits on the Global Steering Group. Antiretroviral (ARV) prophylaxis is provided to HIV+ pregnant women with a CD4 count of =350 cells/mm3 and lifelong ARV treatment (ART) provided with a CD4 count <350 cells/mm3. India is currently providing single-dose nevirapine for preventing mother-to-child transmission of HIV (PMTCT); however a recent policy shift provides for World Health Organization Option B as the maternal component of this ARV prophylaxis strategy, with plans for a phased Option B roll-out in 2012 beginning in two states.

Despite these challenges, the GOI has made remarkable progress in containing the spread of HIV, with a more than 50% decline in estimated incidence over the last 10 years. India allocates two-thirds of its HIV resources for prevention to achieve its goal of reducing new infections by 60% in high-prevalence states and 40% in low-prevalence states in the next five years.

PROGRESS AND ACCOMPLISHMENTS IN THE LAST TWO YEARS

The GOI approaches its national prevention program as a data informed work in progress, with formal and ad hoc feedback loops, assessments and adjustments that consider innovation and new information. The 50% decline in HIV incidence between 2000 and 2009 was the result of the GOI's successful prevention programs targeted to high-prevalence states and supported by important policy shifts, including the historic 2009 decriminalization of same-sex behavior among consenting adults.

During the third phase of the National AIDS Control Program (NACP-III, 2007-2012) the National AIDS Control Organization (NACO) prioritized its focus on MARPs within 195 higher prevalence districts [of which 156 have =1% prevalence among antenatal care (ANC) attendees in the last three years, and 39 have <1% HIV prevalence among ANC attendees but =5% prevalence among MARPs at any site). GOI scaled up evidence-informed interventions based on its comprehensive 2007 guidance on targeted interventions (TIs) for core high risk groups (MARPs). The 2007 guidelines are consistent with the 2011 PEPFAR Technical Guidance on Combination HIV Prevention (for MSM programming) and with the 2010 PEPFAR Revised Guidance on Comprehensive HIV Prevention for People Who Inject Drugs. The NACO and PEPFAR/India approach and programming is also consistent with the "Four Knows" approach of the 2011 Guidance on Prevention of Sexual Transmission.

Targeted Interventions for MARPs

The GOI's primary prevention mechanisms are to intensively reach MARPs (focusing on those in high prevalence districts) through data-driven TIs. TIs are preventive interventions focused on MARPs and bridge populations in a defined geographic area. The TI projects are peer-led interventions implemented through non-governmental organizations (NGOs) and community-based organizations (CBOs), and mentored and monitored by State AIDS Control Societies (SACS), Technical Support Units, and State Training and Resource Centres. The national program's target is to reach at least 80% of MARPs with a package of quality prevention services outlined in the national program's TI guidelines. These

comprehensive services include behavior change communication, provision of commodities to ensure safe practices (male and female condoms, lubes for MSM populations, opioid substitution therapy drugs, and needles and syringes), linkages to HIV testing and counseling (HTC), regular medical checkups, presumptive treatment of STI, and syphilis screening. These interventions also include promoting an enabling environment through structural interventions and community support, and an enhanced focus on evidence based programming through intensive monitoring and evaluation. NACO's capacity building strategy for prevention programs is two pronged: a) Technical Support Units provide ongoing mentoring support to SACS to scale up and enhance the quality of TIs; and b) State Training and Resource Centres train NGO outreach staff and peer educators on core skills such as inter-personal communication, condom promotion, STI care, enabling environment, data management and financial management.

India rapidly scaled up TIs for MARPs, focusing on roll-out in high-prevalence districts. NACO and SACS now support 1,631 TIs that cover an estimated 3.1 million people, including 1.1 million or 70% of MARPs (81.7% of SW, 66.5% of MSM and 80.2% of PWID), and over 2 million or a third of bridge populations (truckers and migrants). To support these interventions, NACO has established Technical Support Units and State Training and Resource Centres throughout the country. NACO has defined training targets including quality standards, and holds quarterly reviews to assess performance of these training resources.

Policies and guidelines

The GOI has developed and issued a range of policies and guidelines that support an enabling environment for HIV prevention. For example, GOI has adopted the "National Policy on HIV/AIDS and the World of work" to promote safe migration and mobility with access to HIV information and services: issued policy guidelines to incorporate gender considerations into all HIV programs; and produced a protocol on management of biomedical waste.

HIV Testing and Counseling (HTC)

NACO provides HTC services primarily through Integrated Counseling and Testing Centers (ICTCs) located in government health facilities such as District Hospitals, and Community Health Centers at sub-district level. Under NACP-III, all stand-alone HTC and PMTCT Centers funded under Global Fund for AIDS, Tuberculosis and Malaria (GFATM) Rounds 2, 3, and 6 were redesigned as ICTCs. Each ICTC provides HTC and PMTCT services, TB screening and linkages to ART services. As a result, the number of individuals receiving HTC increased from 2.1 million in 2006 to over 9.5 million in 2011. To increase access to HTC for MARPs, NACO decentralized services to Community Health Centers and 24-hour Primary Health Centers in high prevalence districts, and with TA from PEPFAR/India instituted a community mobilization strategy that includes mobile HTC and outreach in rural areas through the Link Worker Program. The HTC service uptake among MARPs has seen a steady increase from 356,537 in 2008 to 852,439 in 2011.

PMTCT

India's PMTCT program is supported by GFATM Round 2 funding. The Round 2 (Wave 6) PMTCT scale-up activities are being implemented in high prevalence districts reaching across government and non-governmental health systems to provide HIV testing and single dose nevirapine to what the GOI estimates as 80% of HIV+ pregnant women. In September 2010, the GOI introduced a new policy for integration of HIV testing within the basic antenatal routine screening blood tests, as part of National Rural Health Mission (NRHM) and NACP integration. [NRHM is an Indian health program launched in 2005 to improve health care delivery across rural India, and run by the Ministry of Health and Family Welfare.] The objective is to ensure that HIV+ pregnant women (and their families) are linked to HIV services for their own health and to prevent perinatal transmission. There has been a significant scale up of HTC and PMTCT services over the last five years. Between 2004 and 2011, the number of pregnant women tested annually increased from 800,000 to 6.6 million (24.4% of all pregnancies) across 5,246 ICTCs with 16,954 pregnant

women testing HIV positive in 2011. PMTCT services include provision of quality antenatal and delivery services, ARV prophylaxis of single dose nevirapine, health education, nutrition and contraceptive counseling. In 2010, NACO estimated that 70.6% of the mother/baby pairs in need received the single dose nevirapine. NACO introduced Early Infant Diagnosis in 2009 and is using dried blood spot collection scaled up to over 900 ART centers and ICTCs.

Sexually transmitted infections

NACO and NRHM jointly issued national technical guidelines and training modules for medical officers and paramedical staff for STI services, an operational framework and training plan and implemented training of health care providers. NACO supports designated clinics and the NRHM supports sub-district health facilities in providing STI services. In addition, NACO centrally procures pre-packed color-coded STI drug kits and provides them to all government STI clinics, primary health care centers, and TI NGOs working with MARPs. The Preferred Private Provider approach has been rolled out to scale up STI services to MARPs under TI Projects and provides a standardized package of STI services to MARPs, including free consultation and treatment for STI complaints, quarterly medical check-ups, symptomatic treatment and syphilis screening. Nearly 4,000 private preferred providers were identified and are providing STI services to MARPs and more than 8.4 million STI episodes were treated during 2010. Enhanced Syndromic Case Management of STIs is currently provided through 1,038 designated STI clinics, including 90 new clinics established during 2010-11. NACO has branded these STI services as “Suraksha Clinic” and developed a communication strategy for generating demand for these services.

Condoms

NACO is implementing phase three of the Condom Social Marketing Program that focuses on increasing sales at TI sites with large concentrations of MARPs and vulnerable populations and on increasing both rural and urban condom market penetration. The market for commercial and socially marketed condoms increased from 1.6 billion in 2007 to 2.7 billion in 2011 with over 1.3 million condom outlets across the country. A Technical Support Group at the national level strengthens NACO’s capacity to manage the condom promotion program and provides TA in building condom sales, distribution and monitoring systems. NACO provides condoms with separate lube sachets to MSM and transgender populations through TI programs and introduced a female condom program for female SW in four high prevalence states.

PEPFAR/INDIA ACCOMPLISHMENTS IN THE LAST TWO YEARS

PEPFAR/India works primarily at the strategic level with the GOI, strengthening capacity in targeted areas of identified need where the United States Government (USG) agencies have core strengths, supporting strategic information and innovative service delivery models, and informing policy decisions and public health processes.

Unlike most other PEPFAR countries, PEPFAR/India’s success can be measured through a decrease rather than an increase in direct service provision indicators. Although the country program has directly reached many thousands of individuals through services provided in USG-funded demonstration or pilot projects, the value of these services is in their role in clarifying scalable best practices within a service model; the ultimate achievement related to the services is the adoption by the GOI of the program model, and its dissemination throughout the country through national policy.

In the last year, PEPFAR/India has continued to leverage its strong partnership with the GOI and other stakeholders to realize achievements in a range of prevention activities:

Innovative demonstration projects adopted and scaled up by NACO

The USG has piloted and evaluated numerous demonstration projects that subsequently have been adopted and scaled up by the GOI or the private sector, including evidence-based prevention among MARPs, private sector PMTCT service delivery models, behavior change communication tools and strategies, helplines, drop-in centers, service provider networks, and workplace HIV programs. The USG demonstrated a successful TI program in Tamil Nadu that generated several practices adapted by the state and nationally; these included NGO capacity building monitoring strategies and service delivery approaches that have now been incorporated into the national guidelines for TIs. In addition, the USG successfully demonstrated the value of community-based Link Workers and mobile HTC to improve access of HTC services among MARPs, the latter of which NACO has already adopted as a core approach in the national migrant HIV strategy. Two project final evaluations completed in 2011 provided important recommendations on a range of timely issues including integration of HIV services; rural outreach in high-prevalence districts; the value of placing technical specialists within SACS, and of strengthened quality assurance systems and operations research as integral parts of program design.

As a part of the public-private partnership (PPP) initiative in three states, the USG supported training of health and laboratory personnel while SACS provided test kits in private secondary hospitals and tertiary care medical college hospitals for scaling up PMTCT services. These private facilities now provide data to the government on PMTCT services and have begun to handle HIV positive deliveries at subsidized rates. Crucial information from this initiative will inform the evolving national guidelines on delivery of PMTCT, including lessons on community engagement, follow-up services and linkages to nutrition support subsidies; partner counseling and testing for all pregnant women; and implementation of an expanded ARV regimen consistent with international PMTCT standards.

Policy involvement and targeted technical collaboration

The USG serves on several technical working groups that guide national prevention policies and programs. The USG played a significant role in developing national guidelines on migrant interventions and leads the national capacity program on folk media campaigns targeted at MARPs and vulnerable populations. The USG also played a pivotal role in the evolution of the Condom Social Marketing Program. During the development of Phase Four of the National AIDS Control Program (NACP-IV), the USG served on sub-groups (SW, MSM, Migrants, and Capacity Building) that designed NACP-IV prevention strategies, and chaired the subgroup that developed migrant strategies and plans. The USG also participated in semi-annual Joint Implementation Reviews of the NACP with NACO and development partners assessing progress of TIs among MARPs. In December 2010, the USG led three state reviews.

In strong partnership with the GOI, development partners and the community, the USG invested in strengthening national and state capacity for scaling up evidence-based prevention interventions. Through both long- and short-term consultants, the USG placed technical resources in the HIV management structures at national (NACO and National Technical Support Unit), state (SACS, State Training and Resource Centres) and district (District AIDS Prevention and Control Units) levels that designed, implemented and monitored the priority interventions in India. For example, the USG supported six Technical Support Units in seven high prevalence states and built capacity of SACS to plan, implement, monitor and evaluate TIs for MARPs. These SACS attained 80-90% coverage of population estimates. USG-funded technical experts placed at the Karnataka SACS provided TA, monitoring and oversight which led to increased referrals to PMTCT and ART services by front-line community level Link Workers and Accredited Social Health Activists (village-level health workers under the NRHM). Many of these consultancies have already been transitioned into GOI positions.

The USG has also supported NGOs implementing targeted prevention interventions in several districts in high-prevalence states, helping to directly implement and evaluate new national policy as it was being rolled out. These investments gave the USG a strong voice in assessing the quality and feasibility of the national plans, and in guiding their continued evolution. Now well established, all USG-supported TI NGOs will transition to SACS in 2012.

CONTINUED CHALLENGES

Despite the GOI's impressive expansion of a range of services, there remain significant gaps in a number of priority interventions, including:

TIs for MARPs: Despite the rapid expansion of prevention services, coverage of the hardest to reach populations, including MSM and TG individuals, remains low and the changing landscape for sex work has moved female SW away from brothels and to home and street-based sex work that is more difficult to access with prevention interventions. MARP access to HTC is poor, and effective HIV prevention activities among positives, and interventions for migrants are still in the nascent stage. The quality of TIs varies by NGO implementer, and recent assessments identified a large number with a poor implementation record.

HTC: Only 20 to 25% of adult PLWH are estimated to be aware of their status and only 10-13% of their partners are estimated to have been tested. HTC coverage among MARPs remains low at 15-20%. Overall low uptake of HTC limits the pace of scale-up to HIV care and treatment and limits opportunities for positive prevention services that may help reduce risky behaviors. HTC services at ICTCs are hampered by the poor quality of counseling for partner notification and risk reduction, the lack of a supportive supervision system, and weak referral linkages between HTC and ART. Only 60% of those testing positive at ICTCs reach ART Centers.

STI services: Access to services for rural populations remains a gap, and there is in general low condom utilization in most populations. Challenges within the health system include lack of sufficient preparation among medical officers to provide STI services in all settings, a weak referral and follow-up system, and a low emphasis on partner notification.

Strategic Information: Collecting and analyzing adequate strategic information to tailor interventions to the specific needs and changing dynamics of the epidemic is a continued challenge in a country of over a billion population. Targeting interventions to the shifting geographic movements and demographic and behavioral characteristics of migrant populations, for example, requires accurate strategic information that is not always available.

PMTCT: Implementing the shift to Option B will be a major challenge in a country with almost 17 million institutional deliveries annually, a large proportion of which take place in private facilities where stigma remains a significant barrier to conducting deliveries of HIV-infected women and of which only a small minority provide PMTCT. In addition, nearly 4.5 million deliveries occur at home, and it is common for pregnant women to travel to their mother's home for delivery; both practices increase the challenges to appropriate ARV administration and follow-up for HIV+ women and exposed newborns.

Stigma and Discrimination: Stigma remains a significant reality in India, creating barriers to service access. There is continued discrimination, including in the health sector, against vulnerable populations including sexual minorities. Stigma and discrimination also remain a barrier to private sector provision of HIV prevention, care and support services, particularly maternity services, as many private facilities are reluctant to provide services for HIV-infected individuals. MSM and transgender groups continue to suffer gender-based violence in India.

PEPFAR/INDIA PRIORITIES FOR THE NEXT TWO YEARS

The GOI leads the scale-up and sustained implementation of national and state HIV prevention programs. Prevention will remain the focus of NACP-IV (2012-2017) with accelerated coverage and improved quality of services for MARPs, including northern vulnerable states where national HIV/AIDS program activities and capacity building will be expanded. PEPFAR prevention priorities and activities in India are aligned with the NACP and are based on dialogue, planning and negotiation with NACO and SACS. The USG provides

expert technical assistance for developing and piloting scientifically sound and innovative approaches to increase access to, and improve quality of prevention programs nationally and in priority states. In addition, PEPFAR/India's investments in strategic information promote the availability and use of quality data for decision making in prevention programs.

PEPFAR/India, together with NACO, coordinates its investments with those of other development partners to ensure complementarity and non-duplication. The main development partners supporting prevention are the United Kingdom's Department for International Development (DfID), The Joint United Nations Program on HIV/AIDS, the United National Children's Fund (UNICEF), the United Nations Development Program, the United Nations Office on Drugs and Crime, and the Bill and Melinda Gates Foundation.

As in all intervention areas, PEPFAR/India works at the strategic level to strengthen individual, organizational and institutional capacity to plan, implement, and evaluate the country's prevention program at the national, state and district levels. NACO also looks to the USG to demonstrate innovative service delivery models for the continuum of response for MARPs, from prevention to care and treatment, and advising on national scale-up of HTC for MARPs and vulnerable populations. USG efforts will support national and state prevention programs to strengthen capacity to: 1) effectively use data for decision-making; 2) plan, implement and evaluate programs that improve core skills of NGOs, CBOs and health care providers to expand coverage and deliver quality services to MARPs and vulnerable populations; 3) integrate selected HIV services into NRHM; and 4) identify, pilot, assess and scale up service delivery innovations that contribute to the effectiveness and efficiency of prevention programs. In addition, technical collaboration at the national level will continue to support development of evidence-informed policies and guidelines. PEPFAR/India will also collaborate with the GOI to share the best practices from these activities with other countries. Specific areas of investment are described below.

Prevention among MARPs

The USG will continue to invest in developing prevention to care continuum models and capacity-strengthening of the national and state systems that oversee implementation of the crucial TIs. The USG also invests in strengthening the capacity of Technical Support Units and State Training and Resource Centres to improve the quality of the technical support they provide. The latter will be informed by operations research, and rely on implementing innovations in curriculum development, training methods, training administration and training evaluation.

These investments in capacity include quality improvement (QI) mechanisms, which are a focus of most USG investments in the 2012 fiscal year (FY). In addition to supporting the GOI to develop a national QI strategy and establish QI systems for a range of interventions, the USG will also support specific quality-related assessments, including cost-effectiveness analyses of the Link Worker Program; assessments of barriers to service access for MARPs; and vulnerability assessments of migrant populations to improve targeting of interventions, including an assessment of Knowledge, Attitude, Perception and Practice among truckers and migrants.

The USG will also continue its successful strategy of working with NACO and SACS to develop, implement and evaluate model interventions that can be scaled up by the GOI. These interventions will serve a range of targeted populations including source, transit and destination migrants; rural and urban MARPs; sex workers; and PWID.

A USG commitment to support expanded access to services is reflected in projects through the private sector and through innovative use of technology to serve hard to reach populations; as well as by generating demand for services through communications strategies and campaigns targeting migrants

Through the National and State Technical Support Units, the USG will provide TA to the Technical Support Group (supporting condom programming) for increasing condom access to MARPs and vulnerable

populations. The USG will assist NACO to conduct a feasibility study of integrating the Technical Support Group with National and State Technical Support Units. The USG will also provide ongoing technical support to NACO in developing creative approaches to improve access of condoms/lubes for MSM and TG populations and in scaling up the female condoms throughout the country.

The USG and its partners will collaborate with a range of state and national actors, including trade unions for efforts with migrants, the NRHM, several GOI ministries (including Labor and Employment, Statistics and Program Implementation), private sector providers, and NGOs and CBOs implementing TIs.

PMTCT

NACO with USG active engagement is currently revising the national PMTCT guidelines. Through participation in Technical Work Groups, provision of strategic information, and by demonstrating effective models for PMTCT service delivery in both public and private sectors, the USG will continue to invest in technical collaboration at the national level to guide policy for Option B roll-out, strengthen the Country Coordinating Mechanism for effective scale up of the GFATM funded PMTCT activities, and facilitate integration of PMTCT with maternal and child health services. USG will contribute to the body of knowledge in this area and continue to help generate strategic information around barriers to the uptake of PMTCT services and other implementation challenges, through the conduct of and capacity building in operations research on PMTCT.

In FY 2012 PEPFAR/India will support four mechanisms that will improve both demand for and access to PMTCT services through a range of activities. The USG will support a demonstration project on supportive supervision to increase PMTCT coverage. Through a second mechanism, the USG will support TA to the national program to collaboratively develop, implement and monitor a media/communications campaign aimed at increasing demand for PMTCT. A third project supports NACO to increase access to PMTCT through the private sector through an innovative project providing technical assistance to four states. Finally, the USG will support technical assistance on training and development, implementation and monitoring of a demonstration project on PMTCT integration at the facility level. All projects are carried out in close collaboration with NACO and SACS, but also leverage the considerable efforts of a broad range of non-government partners, including NRHM, UNICEF, the Federation of Obstetricians and Gynecologists of India, and social franchising networks.

HIV Testing and Counseling (HTC)

To support the tremendous scale-up of HTC services throughout the country, the USG will invest in improving access for the hardest to reach populations, and supporting quality improvement for the range of HTC models, including development of a model for effective supportive supervision. The USG will continue to support mobile HTCs and further evaluate the effectiveness of that and other community mobilization approaches on increasing HTC coverage and linkages to care among MARPs nationally and in focus states. Using proven strategies to increase rates of repeat testing among MARPs, the USG will support increased uptake of HTC among MARPs, migrants and their partners in vulnerable districts. The USG will also provide technical experts to guide NACO in establishing a pilot program to implement quality improvement in HTC services and integration of HTC with other health services, including supportive supervision and staff training. Significant USG investments in laboratory-strengthening for HTC are described in the Governance and Systems narrative.

Strategic Information for Prevention

NACO uses a data-driven process of assessing its strategies for reaching the most at risk and vulnerable populations with prevention services. NACO has requested CDC to be the lead agency for strengthening NACP-III/IV's strategic information (SI) system. SI activities include supporting the implementation of the national strategic management information system, surveillance, HIV estimation, capacity strengthening on

data analysis and support for operations research. The USG will strengthen the capacity of NACO, and of SACS and District AIDS Prevention and Control Units in its focus states, on prevention-related strategic information to improve understanding of available data and promote relevant analysis and data use for program planning. In FY 2012, USG investments will: (a) support studies on barriers to utilization of prevention, HTC, care and treatment services by MARPs including migrant populations to track prevention indicators; (b) Support NACO to conduct the Integrated Behavioral and Biologic Assessment of MARPs and migrant populations; (c) Support capacity building of TI NGOs on data management; and (d) Support capacity strengthening of SACS and District AIDS Prevention and Control Units on data triangulation in focus states; and (d) Improve the quality of TI program data by creating processes and systems for routine data quality analysis for all TI data.

Promoting Gender Equity in Prevention Programs

The USG's FY 2012 gender-specific investments include: a) Design a curriculum and implement a training program to address gender concerns in TIs, including issues affecting women, MSM and TG; b) Pilot programs to address gender concerns of migrant women and partners of male migrants; and c) Design strategies to improve women's access to HTC, care and treatment services. The USG will also support NACP-III and NACP-IV's cross-cutting policy of integrating gender across prevention, care and treatment programs. Specifically, the USG will assist NACO in the formation of a Gender Task Force and strengthen its capacity to roll out gender integration activities. Additional discussion of PEPFAR/India's gender investments are included in the Governance and Systems Technical Area Narrative and in the Executive Summary.

Positive Health Dignity and Prevention (PHDP)

Positive prevention is part of a comprehensive care package provided by Community Care Centers and partner testing is included in ICTC services. USG continues to support quality improvements to GOI TIs for MARPs, including HIV+ MARPs, which emphasize the continuum of care for HIV+ individuals. In addition, the USG will pilot PHDP as a part of the prevention to care and treatment continuum intervention in one high prevalence district in Maharashtra. In a separate investment in Tamil Nadu, the USG will support TANSACS to implement and evaluate a program to strengthen PHDP counseling using materials developed in FY 2011, Living Positively with HIV: A Follow-up Counseling Toolkit.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXS	1,207,966	0
Total Technical Area Planned Funding:	**1,207,966**	**0**

Summary:

OVERVIEW OF THE INDIA ART PROGRAM

Free antiretroviral treatment (ART) services were introduced in India in April 2004 in eight government hospitals located in the six states categorized as high prevalence. Since then, the National AIDS Control Organization (NACO) has made great strides in scaling up and improving access to ART services throughout the country. There are now 320 ART centers that initiate ART in addition to 641 Link ART Centers that dispense antiretroviral (ARV) drugs and monitor ART patients initiated elsewhere. Similar to other countries in Asia, ART coverage is estimated at 23-28% based on an ART eligibility criteria of a CD4 count of 250 cells/mm3 or lower.

The Government of India (GOI) encourages all individuals testing HIV positive to register for pre-ART, which enters them into a system providing HIV care and support including 6-monthly CD4 testing to assess treatment eligibility. Of the 1.25 million people living with HIV (PLWH) who are registered, over 420,000 are currently on ART and an average of 7,000 PLWH newly initiate ART every month. NACO estimates that an additional 40,000 seek ART services from the private sector, though reliable data on private sector ART services are currently not available. An analysis of ART center data in 2009 found that 77% of ART patients were alive and on ART, 6% were lost to follow up, 1% had stopped treatment, 13% had died, and for 3% data were not available. In 2009, there were an estimated 172,000 AIDS related deaths (150,000-200,000).

Based on data indicating that poor geographic access and high transportation costs limited the use of services, in 2008 NACO set up Link ART Centers (LACs) in district and sub-district hospitals and in Community Health Centers that had Integrated Counseling and Testing Centers (ICTC). Initially, the main functions of LACs were to dispense ARV drugs and monitor ART patients, treat minor opportunistic infections, identify and manage side-effects, and provide adherence support. In 2010 NACO began a process of integrating ART services into the primary and secondary health care system by broadening the role of some LACs to deliver comprehensive ART support services (Link ART Plus Centers, LAC+); while these centers do not initiate patients on ART, they provide comprehensive pre-ART services, and full monitoring of patients on ART including ARV drug dispensing. Currently, there are 641 LACs that serve 26,023 PLWH. NACO plans to gradually scale up to 1,200 LACs by 2015-16 to achieve targets set in the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) Round 4 Rolling Continuation Channel grant.

National technical guidelines for ART in adults guide the national program, which provides first-line regimens of either Zidovudine/Lamuvidine/Nevirapine or Stavudine/Lamuvidine/Nevirapine. These drugs along with Efavirenz are available at all ART centers. The Government of India (GOI) selects the first-line regimens on the basis of a number of considerations including potency, profile of side effects, ability to keep future treatment options open, ease of adherence, cost, risk during pregnancy and potential for the development of resistant viral strains. Fixed-dose combinations are preferred because they are easy to use and have distribution advantages.

NACO revised its national guidelines for ART initiation in 2009 to increase eligibility to those with a CD4 count of 250 cells/mm3 (up from 200 cells/mm3), and to extend treatment to all HIV+ pregnant women and individuals with HIV/Tuberculosis (TB) coinfection with a CD4 count of 350 cells/mm3. In November 2011 NACO revised its ART initiation guidelines to expand ART to HIV+ individuals with a CD4 count <350 cells/mm3.

A rapid survey conducted by NACO in 2006 revealed a 2-3% failure rate with first-line ARV drugs. The roll out of second-line ARV drugs began from January 2008 at two sites and has expanded to ten government medical colleges designated by NACO as Centers of Excellence (CoEs). Over 2,000 patients have been enrolled on second-line ARV drugs. The alternate first-line drug Tenofovir and the second-line ART regimen drugs Tenofovir/Lamivudine/Atazanavir/Ritonavir are currently available only at the ten CoEs. CoEs provide comprehensive care for PLWH, train health care providers, and carry out operational and scientific clinical research for evidence-based programming and program management.

NACO has well-established internal and external quality assurance systems in place for CD4-testing laboratory facilities, and has provided CD4 machines to 211 ART centers. The GOI provides viral load testing at six laboratories in the country. Dried blood samples and blood/plasma samples are collected and couriered to these laboratories. Routine drug resistance testing is not part of national protocols but is being conducted at select centers.

The national ART program has a set of monitoring and evaluation tools and formats for standardized recording and reporting from ART centers. Information is collected through a range of formats from the centers including Pre-ART register, ART enrolment register, Patient ART record, Patient Identification card,

drug stock register, drug dispensing register, and alternate first-line and second-line monthly reports.

NACO has independently developed a Smart Card system for computerized data storage and retrieval of ART patient records and is in the process of conducting a user acceptance test. This card is chip-based providing restricted access to maintain confidentiality. For each PLWH, a unique identifier is generated by the central database system using a biometric de-duplication process.

Annual costs for treatment are currently USD 120/person for first-line ARV drugs. The GOI allocated 17% of the budget for the third phase of the National AIDS Control Program (NACP-III, 2007-2012) to Care, Support and Treatment. The majority of funding for ART comes from the GFATM Rounds 4 and 6. The Clinton Health Access Initiative has funded all second-line ART drugs in the public sector; however, it plans to transition out of India by March 2012. NACO has not made a final decision on a source of replacement funding for second-line ARV drugs.

To ensure continuity in the supply of ARV drugs, NACO has a Logistics Coordinator who centrally monitors all ARV drugs based on monthly consumption reported by districts. As per NACO guidelines, all ART centers must have at least a three-month supply of all adult and pediatric ARV drugs.

There has been limited emphasis on private sector engagement in ART service delivery at the national and state levels. NACO currently supports provision of ART at 15 corporate and non-governmental facilities. A recent Supreme Court decision has advised the GOI to provide free ART to people seeking care from private health care facilities.

India supports a system of passive surveillance of adverse events potentially related to ARV drugs. Pharmacovigilance reports from ART Centers are centrally reviewed, but reporting is not systematic and is likely to be incomplete. There is currently no contingency planning for uninterrupted ARV drug supplies in the event of natural disaster or other sociopolitical disruptions.

Pediatric Treatment

There are an estimated 115,000 children living with HIV in India of which approximately 92,000 are registered at 320 ART Centers. Currently 24,400 children are on ART out of which 100 children are on second-line drugs. Two age-appropriate pediatric ARV drug regimens are available at 320 ART centers: (1) Stavudine/Lamivudine/Nevirapine (for children more than 5 kg) and (2) Stavudine/Lamivudine/Efavirenz (for children more than 10 kg, older than 3 years). Second-line ARV drugs, (Lopinavir/Ritonavir syrups) are available at 17 sites in the country.

ART has been free for children since the launch of the national ART program in 2004. India's Pediatric AIDS Initiative launched by NACO and The Clinton Foundation in 2006 improved access and scaled up treatment for HIV infected children by making available simplified regimens of pediatric-formulated fixed-dose combination drugs.

NACO developed The National Pediatrics Care and Treatment Guidelines in 2006 based on WHO guidelines for ART in infants and children in resource limited setting. The main thrust areas of these guidelines cover the newborn component of preventing mother-to-child transmission of HIV (PMTCT), follow-up of the HIV-exposed infant, counseling mothers on infant feeding choices, pneumocystis prophylaxis, and appropriate diagnosis of infected children. In 2007, NACO and WHO/India developed a manual on pediatric ART counseling to improve drug adherence.

Early Infant Diagnosis was introduced in 2009 and is now available at 900 facilities across 27 states. NACO also launched the Strengthening Provider-Initiated Testing initiative to facilitate integration of HIV and Integrated Management of Newborn and Childhood Illnesses for early identification of children living with HIV at the facility level within medical colleges across seven states.

MAJOR CHALLENGES IN HIV TREATMENT

The broad challenges facing the national ART program relate primarily to quality of and access to services, human resources for health, and integrated care. Weaknesses in data systems limit the availability of strategic information to assess and address these issues.

ART Coverage and Quality

As noted above, despite increased access to services, ART coverage is estimated at 23-28% of those eligible for treatment. There continue to be weak referral systems from ICTCs to ART centers, with only 30% of HIV+ patients tested at ICTCs registering at public sector ART centers. There is also significant pre-ART loss to follow-up and late ART initiation; the median CD4 count at entry to GOI ART centers is 119 cells/mm3, and nearly 20% of PLWH that reach ART centers have CD4 counts <50cells/mm3. Although data are poor, it is likely that a significant number of children eligible for ART are not identified due to weak follow-up of HIV-exposed infants.

There are scant data on ART service utilization among eligible most at risk populations (MARPs) and marginalized populations, but it is widely understood to be low. The failure to access services is at least partly due to the stigma and discrimination faced by MARPs and marginalized populations at ICTCs and ART centers. NACO is considering a range of strategies to enhance the uptake of ART by MARPs, and to improve adherence for those on treatment.

Women living with HIV face special challenges in accessing treatment services. They often are constrained from leaving their homes and villages to seek treatment as they are responsible for managing their households, looking after children, and in many cases, caring for a sick husband. In addition, women living with HIV experience a high degree of stigma and discrimination which may involve forced estrangement from their marital homes, physical and psychological abuse, and loss of property and child custody rights.

There are few data on the quality of services provided to the estimated 40,000 PLWH provided ART in the private sector.

Human Resources for Health

As discussed in the Governance and Systems Technical Area Narrative, mobilization and retention of qualified human resources, particularly in remote and rural areas, remains a major challenge, and shortages of health care providers skilled in HIV service delivery weaken service quality in some high-prevalence states and districts. There is also inadequate capacity and knowledge among service providers in clinical management of pediatric HIV, and in the specific counseling needs for this population, including disclosure of HIV diagnosis to infected children, adherence support, and positive prevention.

Integration of HIV into Broader Health Services

Another challenge has been the legacy of verticality of the ART program which is not yet seen as a broader public health program. Ownership for the program among the district hospitals and medical colleges has been weak, resulting in a slowed process of integrating ART service delivery with the existing departments of Medicine, Pediatrics, Dermatology, Obstetrics, Tuberculosis and other specialties in the health system.

PEPFAR/INDIA ACCOMPLISHMENTS IN HIV TREATMENT IN THE LAST TWO YEARS

The USG has been actively engaged in national policy development through participation in a range of NACO-led technical working groups. These have included the working groups that developed technical guidelines on ART in adults, and on pediatric ART counseling to improve drug adherence, as well as

bi-annual Joint Implementation Reviews to identify the major gaps and challenges in the national program's Care and Treatment service delivery.

The USG is one of the key members of the Technical Working Group on Care, Support and Treatment that is guiding strategy development for ART as part of planning the fourth phase of the NACP (NACP-IV, 2012-2017). The USG focus has been to support planning for quality improvement of ART services, including developing overall quality standards and clinical care guidelines.

Through strategic and sustained technical assistance (TA) to the State AIDS Control Societies, the USG has significantly strengthened health systems and contributed to scaling up and improved quality of care, support and treatment services. TA has also included capacity strengthening of ICTCs, ART Centers, Integrated Positive Prevention and Care Centers, LACs, Community Care Centers, counseling services, and mentoring of district-level managers. The USG contributed to increased access to and utilization of services primarily by building the capacity of medical officers and specialists and by training, deploying and supporting essential cadres of field-based outreach workers (Link Workers, and MARP Peer Educators and Outreach Workers), who mobilized and supported community members to access HIV testing and ART services. Indicators of improvement include steady increases in service utilization, absence of drug stock-outs and low loss-to-follow-up rates in USG-supported districts. In high prevalence districts of Maharashtra, Karnataka, and Tamil Nadu USG-supported training of Link Workers in ART counseling resulted in better utilization of care and treatment services, especially for MARPs.

The USG's TA in strategic information to the National Program in data analysis and data management, described in the Governance and Systems narrative, has improved the GOI's use of information in policy making and program planning. The USG supported a patient information database at the Government Hospital for Thoracic Medicine (GHTM) that enables providers to track patient adherence and monitor clinical outcomes and treatment, resulting in improved patient retention and providing valuable strategic information for clinicians and program managers. The USG has supported NACO in training and strengthening the district level functionaries to monitor treatment adherence to improve HIV care and treatment. The USG also supported NACO in strengthening laboratory services in National and State Reference Laboratories contributing to improved diagnostics in HIV and opportunistic infections and in the care and treatment of PLWH (also described in the Governance and Systems Technical Area Narrative).

The USG has been instrumental in the development and strengthening of CoEs. The USG provided technical support for tool development and participated in field assessments for the NACO-led CoE needs assessment to identify gaps and challenges and recommend measures for improving the quality of services. Subsequently, the USG facilitated the revision of CoE guidelines. These guidelines established a State AIDS Clinical Expert Panel at each institution to confirm treatment failure cases and need for second-line ART. This panel system is now successful and institutionalized, and serves to rationalize use of second-line ARV drugs.

PEPFAR/INDIA PRIORITIES FOR THE NEXT TWO YEARS

In line with PEPFAR/India's Strategy and needs identified with NACO related to NACP-IV, the continued thrust of USG efforts in treatment will be to provide high quality policy and technical support and capacity building to improve access to and quality of ART services, in particular for MARPs and vulnerable populations including women. The USG will provide TA to NACO in implementing an effective continuum of care approach that links prevention, testing, care and treatment, and in integrating ART with TB and primary health care services. In addition, the USG will continue to support the strengthening of CoEs, reference laboratories and quality data for decision-making. During the next two years, the USG will work closely with GOI counterparts at all levels to implement NACP-IV goals and objectives related to ART. This support includes participation on strategic and technical advisory groups at the national and state level, and clinical and managerial capacity building to improve quality and oversight of antiretroviral treatment (ART) services. All investments are in line with the National AIDS Control Program (NACP) and the PEPFAR/India Strategic

Plan. The USG does not contribute funds to procure antiretroviral (ARV) drugs, nor does it support direct provision of ART services.

Quality of and Access to Services

Through participation in a range of NACO-led Technical Working Groups, and through membership in the GFATM Country Coordinating Mechanism, the USG will support NACO to improve the quality of and access to ART services. Activities will include performance assessments of all 320 ART centers, including barriers to access by MARPs; development of an accreditation process for publicly-funded ART to improve quality and standardize services; improvements to the operationalization of NACO guidelines on timely cotrimoxazole prophylaxis; strengthening of HIV service integration and linkages with the Revised National Tuberculosis Program and the National Rural Health Mission to ensure comprehensive HIV services for PLWH within the public health system; strengthening of linkages and referrals to the PMTCT program; and support for oversight of the GFATM Rounds 4 and 6 Rolling Continuation Channel to ensure effective implementation of ART service delivery for both first-line and second-line drugs.

The USG will provide TA to the national and state Technical Support Units (TSUs) for rolling out treatment literacy activities that will include accurate, simple information about the names and types of medicines, how they work, managing side effects, dispelling myths and misconceptions about HIV and ART as well as safer sex practices. In addition, the USG will provide capacity strengthening for TSUs on integrating and reinforcing HIV prevention messages when discussing treatment, including discussion of safer sex, reproductive options for people who want to conceive, and early detection and treatment of sexually transmitted and other infections. The USG will ensure that positive prevention will be a focus within treatment literacy for increasing self-esteem, confidence and ability of HIV positive people to protect their own health and to avoid passing on the infection to others.

Additional support to TSUs will include strengthening of Care and Treatment expertise at the state level TSUs, and expansion of their roles to ensure continuum of HIV care for MARPs.

Clinical Capacity Strengthening

The USG will invest in TA to strengthen capacity of NACO to support designated regional CoEs, which in turn strengthen human resources in ART centers, Community Care Centers and LACs. USG support will include capacity development in all designated CoEs, focusing on the introduction of various training models that can be taken to the periphery by the CoEs in improving care and treatment services and re-emphasizing the continuum of care concept especially for MARPs.

To support the Ministry of Defense Armed Forces Medical Service (AFMS) to establish training capacities in HIV prevention, diagnosis, care and treatment, USG will provide training for three AFMS HIV physicians at the four-week Military International HIV Training Program in San Diego, California. This course will be followed up through ongoing military to military collaboration with the USG Department of Defense HIV/AIDS Prevention Program (DHAPP).

The USG will also provide ongoing clinical continued medical and nursing education and updates through the Distance Learning Clinical Seminar Series and the Expert Physician Access Number. Emphasis will also be given to capacity building on research methods and scientific writing to improve the quality of research and increase the availability of publications on ART in India to advance evidence-based programming and planning across the CoEs and ART centers.

The USG will support task shifting to improve care and treatment provided at the ART centers by building the capacity of nurses, para-medical personnel, and support staff, and by contributing to revisions/additions to the national ART curriculum for these cadres.

Private Sector Engagement

The USG will provide TA to NACO and SACS to assess the quality of ART by private health care facilities and to establish systems that facilitate the flow of treatment data from the private sector to the state management information systems. Results of these assessments will inform policy and program management, including NACO strategies for increasing private sector participation in the NACP.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2012	Justification
IN.223	Number of local organizations provided with technical assistance for HIV-related policy development	261	Redacted
IN.224	Number of local organizations provided with technical assistance for HIV-related institutional capacity building	487	Redacted
IN.225	Number of individuals trained in HIV-related policy development	4,058	Redacted
IN.226	Number of individuals trained in HIV-related institutional capacity building	4,191	Redacted
IN.227	Number of individuals trained in HIV-related stigma and discrimination reduction	3,434	Redacted
IN.228	Number of local organizations provided with technical assistance for Strategic Information	604	Redacted
P1.1.D	P1.1.D Number of	n/a	Redacted

	pregnant women with known HIV status (includes women who were tested for HIV and received their results)		
	Number of pregnant women who were tested for HIV and know their results	0	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	n/a	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	0	
	Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)	0	
	Life-long ART (including Option B+)	0	
	Newly initiated on treatment during		

	current pregnancy (subset of life-long ART)		
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	0	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	0	
	Single-dose nevirapine (with or without tail)	0	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People	5,277	

	Living with HIV (PLHIV) interventions		
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	35,000	
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted

	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	3,000	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	214,065	
	By MARP Type: CSW	27,400	
	By MARP Type: IDU	500	
	By MARP Type: MSM	6,165	
	Other Vulnerable Populations	180,000	

P8.4.D	Number of targeted condom service outlets	4,984	Redacted
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	69,260	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	0	
	By Age/Sex: 15+ Female		
	By Age: 15+	69,260	
	By Age/Sex: 15+ Male		
	By Sex: Female	12,000	
	By Sex: Male	57,260	
	By Test Result: Negative		
	By Test Result: Positive		
P12.2.D	Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS	0	Redacted
	By Age: <15	0	
	By Age: 15-24	0	

	By Age: 25+	0	
	By Sex: Female	0	
	By Sex: Male	0	
C1.1.D	Number of adults and children provided with a minimum of one care service	7,844	Redacted
	By Age/Sex: <18 Female		
	By Age/Sex: <18 Male		
	By Age: <18	1,561	
	By Age/Sex: 18+ Female		
	By Age: 18+	6,283	
	By Age/Sex: 18+ Male		
	By Sex: Female	3,274	
	By Sex: Male	4,570	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	5,497	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	545	
	By Age/Sex: 15+ Female		
	By Age: 15+	4,952	
	By Age/Sex: 15+ Male		
	By Sex: Female	2,156	
	By Sex: Male	3,341	
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients	88 %	Redacted

	who were screened for TB in HIV care or treatment setting		
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	4,827	
	Number of HIV-positive individuals receiving a minimum of one clinical service	5,497	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	7 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	391	
	Number of HIV-positive individuals receiving a minimum of one clinical service	5,497	
C5.1.D	By Age: <18	416	Redacted
	By Age: 18+	925	
	Number of adults and children who received food and/or nutrition services during the reporting period	1,341	
	By: Pregnant Women	5	

	or Lactating Women		
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	132	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	31	Redacted
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	18,550	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	71,311	Redacted
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	140	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
9195	Tamil Nadu AIDS Control Society	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP	1,000
9196	University of Manitoba	University	U.S. Agency for International Development	GHP-USAID	0
9349	University of Washington	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	750,000
10085	SHARE India	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHP-State	1,300,000
10964	APAC	Private Contractor	U.S. Agency for International Development	GHP-USAID	0
10975	Avert Society	NGO	U.S. Agency for International Development	GHP-USAID	0
10982	U.S. Department	Other USG	U.S. Department	GHP-State	0

	of Defense (Defense)	Agency	of Defense		
13196	Project Concern International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, GAP	1,100,000
13387	FHI 360	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, GAP	1,100,000
13453	FHI 360	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHP-State	450,000
13527	TBD	TBD	Redacted	Redacted	Redacted
13573	FHI 360	NGO	U.S. Agency for International Development	GHP-USAID	2,500,000
13599	Social Impact	Private Contractor	U.S. Agency for International Development	GHP-USAID	759,000
13604	TBD	TBD	Redacted	Redacted	Redacted
13642	TBD	TBD	Redacted	Redacted	Redacted
13649	TBD	TBD	Redacted	Redacted	Redacted
13711	TBD	TBD	Redacted	Redacted	Redacted
13810	International Labor	Multi-lateral Agency	U.S. Department of Labor	GHP-State	150,000

	Organization				
13887	TBD	TBD	Redacted	Redacted	Redacted
14088	UNAIDS II	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	250,000
14089	World Health Organization	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	256,808
14838	TBD	TBD	Redacted	Redacted	Redacted
14839	TBD	TBD	Redacted	Redacted	Redacted
14840	TBD	TBD	Redacted	Redacted	Redacted
14841	TBD	TBD	Redacted	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 9195	**Mechanism Name: TANSACS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Tamil Nadu AIDS Control Society	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GAP	1,000

Sub Partner Name(s)

National Institute of Epidemiology		

Overview Narrative

The TANSACS/CDC collaborative program was initiated in 2001 at the Government Hospital for Thoracic Medicine (GHTM), one of India's largest HIV care centers, to strengthen comprehensive care and implement a range of SI and systems strengthening activities. GHTM is recognized as an HIV Center of Excellence.

In FY12, the project will strengthen human and institutional capacity in Tamil Nadu through capacity building programs in Epidemiology, Strategic Information and Data Management and build the capacity of key local institutions to monitor the quality of HIV programs. This project supports goals 2 and 4 of the PEPFAR/India Strategy (data for decision-making, health systems strengthening). Although focused on Tamil Nadu, programs developed through the project will have national benefit through close collaboration between TANSACS, CDC and the national program.

This project leverages resources from TANSACS, NACO, GHTM and USG. NACO and TANSACS partially

support implementation costs of mainstreamed projects, GHTM contributes staff and facilities and USG provides technical assistance (TA) through CDC staff based in Chennai and through other contracts. The collaboration with TANSACS has a successful track record of transitioning projects to GOI, particularly demonstration projects developed in collaboration with USG; a similar transition is planned for activities continuing in FY12.

Project monitoring will be completed by officers from TANSACS and District AIDS Prevention and Control Units, including CDC supported staff. CDC and the Project Director TANSACS will review project progress at regular intervals. Key programs will be periodically evaluated.

The funding request for FY12 is $1000; most proposed activities will be funded using FY11 pipeline.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,000

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	9195		
Mechanism Name:	TANSACS		
Prime Partner Name:	Tamil Nadu AIDS Control Society		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	1,000	0

Narrative:

In Tamil Nadu HIV prevalence among women in ANC has declined from 1.13% in 2001 to 0.25% in 2009. However, in many districts prevalence remains high or expected declines have not been observed. Despite its innovative programs, there are important gaps in the capacity of TANSACS and its partners to effectively use data to target, plan and manage effective programs in an evolving epidemic. USG collaborative programs will address these gaps by strengthening government staff, institutions and systems to collect, analyze and use program data. HIV Epidemiologist Training Program: In FY 11, the National Institute of Epidemiology (NIE) in partnership with TANSACS and USG developed a training program in HIV Epidemiology and Biostatistics. In FY12, this collaboration will train 6 state and national M&E staff to use statistical software to analyze field/program data; interpret surveillance data and prepare reports; undertake research studies; write scientific papers, publish in peer reviewed journals; and conduct HIV epidemiology and data management trainings. Strengthen TB/HIV Information System (T/HIS) at Government Hospital for Thoracic Medicine (GHTM): USG supported the development of the T/HIS at GHTM, an electronic health management information system which supports patient care and program management at the hospital and reports for the State and National program. In FY12, USG will continue to support the operation of T/HIS on data collection, data entry and data management while transitioning data entry to hospital laboratory technicians and counselors. As the revised NACO electronic data collection system is implemented, USG will assess mechanisms where the more robust T/HIS can interface with the NACO system required for national reporting. USG will work with TANSACS-GHTM to determine how to upgrade T/HIS and develop bridging software, as required. USG will provide TA to increase use of quality data for decision-making by strengthening capacity to obtain and analyze data using the latest information technology for data triangulation, operations research, surveillance, modeling, epidemiological profiling, costing, and evaluation. USG will continue to work with GHTM and its partners to carry out need-based

research and build the capacity of health care professionals in research activities. USG will provide TA to the Quality Improvement Committee, Research Committee and Institutional Review Board which provide support for carrying out operational and scientific research and use of the data for publications. Strengthen TANSACS Management Information System (MIS): USG supported the establishment of a robust information system at TANSACS and provided TA to generate and report quality information for guiding HIV services and activities. In FY12, USG will facilitate capacity building of staff to use program data effectively to review programs and to create a scientific body of evidence to assist in program planning. USG will collaborate with TANSACS/GHTM to conduct training programs that build the capacity of TANSACS and DAPCU staff, strengthen NGO partners and health care workers at Integrated Counseling and Testing Centers, ART centers and Community Care Centers. USG will facilitate increasing availability of scientific evidence from special studies, operations research, surveillance, program evaluation and population-based surveys to inform prevention, care and treatment programming.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

With USG technical and financial support, TANSACS has documented successful innovative programs and leveraged national funds to continue these activities. In FY12, USG will continue low levels of support to these activities and provide a model to strengthen the district units while mainstreaming the Red Ribbon Club program. Information-Sharing Workshops. In FY12, USG will support TANSACS to share best practices. USG will provide TA and GHTM will provide the facilities to conduct training programs, technical reviews, conferences and workshops. USG will facilitate information and expertise sharing opportunities between key institutes in the state such as the National Institute of Epidemiology (NIE), Tuberculosis Research Center, GHTM and SACS. USG will provide TA to TANSACS to organize collaborative workshops and seminars with health and development departments in the state to facilitate comprehensive care for PLWHs. Mainstream RRC and Self-Help Group (SHG) Intervention programs. RRC is an on-campus voluntary educational intervention among college students with the dual objectives of reducing HIV infection among youth by raising their risk perception and preparing them as peer educators. In FY12, RRC managers will work with Vice Chancellors of Universities, Department of Higher Education and Nodal officers at colleges to mainstream the program. Learning from the experience in 3 universities, USG and TANSACS will work with the remaining 11 universities to make the training a credit course within the curriculum. USG supported Red Ribbon Club (RRC) managers will be integrated into DAPCU as team members. Working within the DAPCU structure, RRC managers will support strengthening of the referral system for counseling and testing for youth/women and for comprehensive care to secondary and tertiary centers. RRC managers will facilitate capacity building programs for health care providers on risk reduction and prevention with positives. USG will work with the Tamil Nadu Women's Development Corporation (TNWDC) to facilitate scaling up of the SHG intervention program throughout the state. This program,

previously funded through USG, is now supported by the state with TA provided by USG for quality assurance. USG will work with TNWDC to develop a plan to monitor the program for effectiveness and quality. Strengthen counseling for prevention with positives. CDC, in partnership with India-CLEN, developed the Living Positively with HIV: A Follow-up Counseling Toolkit. In FY12, USG will work with TANSACS to strengthen the counseling program in the state. USG with TANSACS will evaluate the Toolkit for effectiveness and feasibility. USG will also work towards coordinating with the National Rural Health Mission to leverage funds and expertise in planning and implementing these programs. Support for Laboratory Services: With USG support, GHTM was accredited as a State Reference Laboratory and serves as a training center for India's laboratory personnel. In FY12, USG will provide TA to strengthen the capacity of GOI institutions such as SACS and National Reference Laboratories, and private sector and NGOs to plan, support, implement and monitor quality assurance/quality control at laboratories.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 9196	**Mechanism Name: Samastha**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Manitoba	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-USAID	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This Mechanism will close in 2012. All proposed activities are included in the FY 2012 COP with a $0 budget, funded with pipeline from previous fiscal years. A full description of approved activities for this Mechanism is provided in the FY 2010 COP. There have been no important adjustments to the planned

activities as described in detail in the FY10 COP, and as approved in the FY10 and FY11 COPs. In FY12, Samastha will complete its gradual phase-out in a considered transition process. Staff transitions are described in the HCW Salary section of this COP. FY12 activities will continue the process of documenting and disseminating project activities, results and lessons.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**9196**		
Mechanism Name:	**Samastha**		
Prime Partner Name:	**University of Manitoba**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	0	0
Narrative:			

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 9349	**Mechanism Name: I-TECH**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 750,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	750,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

I-TECH's goal is to strengthen health systems for improved, expanded, equitable and sustainable HIV service delivery through individual and institutional capacity building. This is an ongoing project that supports goal 4 (HSS) of PEPFAR/India's strategy.

I-TECH works at the national level with NACO, and with the 10 NACO-designated Centers of Excellence (COE) throughout India. This project also targets health care providers in these institutions.

Project efficiencies are maximized by using innovative and economical capacity building models including the National Distance Learning Clinical Series (NDLCS) using Adobe Connect Pro Platform, clinical and programmatic mentoring, Expert Physician Access Number (EPAN), E-Library, COE Network Website, Research Capacity Building Programs.

I-TECH's transition strategy is based on equipping COE staff to implement this range of programs in their

regions through a) continuous on-site capacity building and technical assistance, and b) creation of customized database management systems

To monitor and evaluate project activities, I-TECH plans a range of activity-specific and project-wide assessments including: baseline and final assessments of training and clinical mentoring; continuous monitoring of specific activities through periodic reporting, site visits and quarterly review meetings. I-TECH plans a program-wide expert external evaluation.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
OHSS	NACO	750000	Technical Assistance to the NACO designated Centers of Excellence through in-service trainings, CMEs, Clinical Mentoring, Expert Physician Access Number (E-PAN), Research Capacity Building

Cross-Cutting Budget Attribution(s)

Human Resources for Health	750,000

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	9349		
Mechanism Name:	I-TECH		
Prime Partner Name:	University of Washington		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	175,000	0

Narrative:

NACO supports designated regional Centers of Excellence (COEs) to strengthen human resources in ART centers, Community Care Centers (CCCs) and Link ART Centers (LACs). I-TECH will facilitate this process by supporting capacity development in all designated COEs. In the area of health system strengthening, I-TECH will support capacity-building for operations research, and roll-out of a NACO-COE website.

Research Capacity Building Training Programs:

The main goal of the Non-Clinical trainings is to improve the capacity for conducting operations research at the NACO designated COEs. As India scales up prevention, care, and treatment efforts, research activities also need to scale up to provide strategic information to guide the national program. Assessments of the 10 COEs in India documented the need for capacity development in the areas of Research Methods, Data Analysis and Technical Writing. I-TECH proposes to develop a series of short training workshops on these topics to support systems strengthening activities for the COEs.

I-TECH will help each COE strengthen its capacity to collect, analyze and publish scientific papers on prioritized HIV topics. In FY12 I-TECH will assist COEs in designing research protocols, forming research committees/IRBs and providing training and technical assistance.

National COE Network Website:

In FY11 I-TECH developed a robust website to link all training centers and HIV Care COEs in the country and presented it to NACO. In FY12 NACO will scale up this website and roll it out for use by the COEs. This site is an excellent resource for physicians, program managers, ART medical officers, and policy makers. The NACO-COE website will provide access to updated information on the background of each COE, their staff strength, facility infrastructure available, and location details. It will also feature resources at each centre such as details on the comprehensive HIV care services, training and mentoring services, research activities, and clinical expert panel activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	575,000	0

Narrative:

NACO supports designated regional Centers of Excellence (COEs) to strengthen human resources in ART centers, Community Care Centers (CCCs) and Link ART Centers (LACs). I-TECH will facilitate this process by supporting capacity development in all designated COEs; specifically, I-TECH will introduce various training models that can be taken to the periphery by the COEs in improving care and treatment services.

National Distance Learning Clinical Series (NDLCS):

NDLCS can be used to increase health care workers' knowledge and skills related to care, treatment, diagnosis, and comprehensive management of HIV and AIDS patients in resource-limited settings. It is a tool to increase collaboration and communication across NACO's ART Medical Officers, with an emphasis on sharing best practices and lessons learned from HIV and AIDS-related clinical issues; share information on cutting edge HIV and AIDS research and evidence-based case-management approaches; and identify complex issues related to managing HIV through case-specific clinical consultations. NDLCS also builds skill and experience in the use of the interactive webcasting distance learning technology that can be used to broaden its application for new audiences and purposes. In FY12, I-TECH-India will conduct 20 in-country NDLCS case-based instructional sessions on the clinical management of HIV via web cast to participants in all districts in India. Presenters for the series are national experts who have vast experience in the HIV field.

Clinical and Programmatic Mentoring:

One of the key components of I-TECH programs is mentoring. Clinical mentorship is a training and consultation system that fosters ongoing professional development and expertise to yield sustainable high quality clinical care outcomes. This practice supports decentralization of HIV care and standardizes antiretroviral therapy following national guidelines. In FY12, I-TECH will both mentor and provide mentoring training and other technical assistance to COE senior medical staff. Leveraging this supportive supervision

model maximizes the knowledge and expertise of COE/ART clinicians. One senior NACO National Consultant will be supported by I-TECH.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 10085	**Mechanism Name: SHARE**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: SHARE India	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,300,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GAP	200,000
GHP-State	1,100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

SHARE supports NACO to capacitate District AIDS Prevention and Control Units (DAPCUs) and State AIDS Control Societies (SACS) to lead state-level decentralization efforts and integration of the National AIDS Control Program (NACP) with the National Rural Health Mission (NRHM).

SHARE provides a range of Technical Assistance (TA), prioritized in consultation with CDC and NACO, to strengthen DAPCUs/SACS to plan, implement, support through training and supervision, and monitor HIV programs and integration. Based in Andhra Pradesh (AP), it provides focused TA to APSACS to further strengthen integration with NRHM, operations research and gender policy. SHARE supports Goals 2 and 4 (Data for Decision Making, Health Systems Strengthening) of the PEPFAR/India Strategy.

The project is implemented at the national level, reaching 22 SACS and 189 DAPCU districts, including 1134 DAPCU staff, 22 DAPCU Nodal Officers and key staff of NRHM and implementing NGOs. A SHARE staff serves as National DAPCU Coordinator in NACO's National Technical Support Unit (NTSU). A SHARE team at Hyderabad serves as DAPCU National Resource Team to support initiatives.

Cost-efficiency will be achieved by leveraging a small TA group to support activities that reach 22 States and 189 districts; in addition the project's focus on service integration will eventually improve broader cost-efficiencies. As part of its transition strategy the project will institutionalize systems for continuous capacity development around integration in SACS and Technical Support Units.

In addition to PEPFAR quarterly and annual reporting the project will continuously monitor DAPCU strengthening activities, including feedback on monthly reports, online and on site mentoring and APSACS related activities.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	50,000
Human Resources for Health	200,000

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	10085		
Mechanism Name:	SHARE		
Prime Partner Name:	SHARE India		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	400,000	0

Narrative:

SHARE's activities strengthen the institutional and staff capacities of NACO and related agencies to improve field level monitoring and reporting of facility-based HIV programs. SHARE will strengthen the capacity of DAPCUs and SACS to facilitate and provide ongoing supervision of compilation of district level strategic information and validation of the information systems. SHARE will help strengthen capacity of APSACS to understand programmatic issues through operational research. The following activities are proposed:

Activity 1: DAPCU online mentoring through feedback on analysis of DAPCU Monthly Reports (DMRs):
There are 189 DAPCUs in high-prevalence (Category A & B) districts spread across 22 states. SHARE along with CDC and the National Technical Support Unit (NTSU) of NACO conducted national training of DAPCU staff from July 2010 - February 2011 in a phased manner. One of the outputs of this training was establishment of a monthly reporting system (DAPCU Monthly Report i.e. DMR). NTSU receives the DMRs and with the support of SHARE analyzes their content and provides written feedback to DAPCUs. This feedback is used as a medium for continuous instruction to the DAPCUs to build their skills and capacities. All feedbacks are shared with SACS, and a compilation of the district findings is sent to the SACS as a state report for action on a quarterly basis. SHARE will continue to work with CDC and through NTSU/NACO to provide online mentoring through feedback and phone calls based on need.

Activity 2: DAPCU refresher training on DMRs and SI related to HIV facilities
SHARE along with CDC and NTSU/NACO provide TA to NACO and SACS across the country to train DAPCU staff on program management and coordination functions. Induction training of all the DAPCUs was completed by February 2011. In FY12, NACO/SACS will lead additional training for M&E Assistants at each of 189 DAPCUs, with support from SHARE. The training will focus on DMRs, including coordination of facility-level reporting, and review and validation of facility-level information, including data quality. M&E Assistants will be trained in groups of 20-25 to facilitate networking for sustainable support. The modules and content of the refresher trainings will be developed in consultation with CDC and NTSU/NACO.

Activity 3:

Technical assistance to Andhra Pradesh State AIDS Control Society (APSACS) to fill the knowledge gap through Operations Research:
During various interactions with APSACS with SHARE, CDC and APSACS partners for the last 3-4 years, it has emerged that the epidemic in the state of AP and the program response needs further clarity. APSACS recognizes the need for operations research to fill in this knowledge and information gap. The capacities of Centers of Excellence for ART, State Technical Resource Center for prevention programs and other medical and non-medical institutions who are or should be providing this support to APSACS, also need to be strengthened. SHARE proposes to provide this technical assistance by recruiting technically competent persons who would provide continuous support to these institutions and also set up a system within the state to organize these research initiatives including formation of a state level committee which would play the pivotal role connecting institutions with State and NACO.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	900,000	0

Narrative:

NACP initiated steps to systematically decentralize HIV services to district level with a focus on facilitation, coordination and integration of HIV programs within health systems. SACS and DAPCUs due to gaps in technical, managerial, coordination and training capacity are limited in their effectiveness to move this agenda forward. Emphasis on gender issues is limited. SHARE with support from CDC will address them through following activities.

Activity 1: DAPCU induction trainings for new staff and refresher training
In FY11, SHARE along with CDC and NTSU/NACO completed induction training for DAPCU staffs. In FY12, SHARE will mentor SACS to facilitate these trainings at regional or state level for new DAPCU staff, and to identify gaps and develop and implement refresher training as needed.

Activity 2: Short term training of DAPCUs and SACS on management development and instructional design and building expertise through ongoing mentoring

SHARE will identify key training needs of DAPCUs and SACS in the areas of management development and instructional design based on the national program strategy and its evaluation and mid-term review reports. Identified needs will be prioritized in consultation with CDC and NTSU/NACO. SHARE will conduct short term trainings to improve management and training skills in district and state institutions like DAPCU, SACS and implementing partners. SHARE will further build local expertise in NACP components at district and state levels by creating or strengthening identified resource persons from SACS, DAPCU and local partners. These resource persons will be mentored on a continuous basis and will be utilized for decentralized trainings.

Activity 3: Mentoring of SACS and DAPCUs
DAPCUs are new structures of NACP III, and the extent to which they have been integrated into district public health structures relies largely on individual staff capacities to gain acceptance. To ensure DAPCUs carry out their roles and responsibilities effectively, sustained quality TA is required. SHARE will continue providing this TA through online mentoring and hands on trainings/ mentoring during field visits with SACS personnel. With support and guidance of CDC and NTSU/NACO, SHARE will provide direct TA to SACS officials especially DAPCU Nodal Officers to build their capacities for supporting DAPCUs. TA will also be provided for preparing District Annual Action Plans, Epidemiological Profiling at district level, integration of NACP with NRHM, and other areas of identified need.

Activity 4: TA to SACS and NRHM department for NACP
State level TA will be provided in Andhra Pradesh to support integration of NACP with NRHM by placing 2 high level technical consultants in NRHM to work with local staff. SHARE will facilitate various inter-departmental workshops at district level for capacity building of district staff for NACP and NRHM integration and developing joint NACP-NRHM monitoring mechanism.

Activity 5: Expert technical input at state and national level
Expert staff in SHARE, in consultations with CDC and NTSU/NACO, will participate in technical groups on decentralization, counseling, supply chain and procurement for NACP at state and national levels.

Activity 6: Building a state level gender policy
Gender has less focus due to competing priorities in APSACS. SHARE proposes to provide TA to APSACS to build and implement state level gender policy based on national guidelines which can then form a basis fo

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 10964	**Mechanism Name: APAC**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: APAC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	

G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-USAID	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This Mechanism will close in 2012. All proposed activities are included in the FY 2012 COP with a $0 budget, funded with pipeline from previous fiscal years. A full description of approved activities for this Mechanism is provided in the FY 2010 COP. There have been no important adjustments to the planned activities as described in detail in the FY10 COP, and as approved in the FY10 and FY11 COPs. In FY12, APAC will complete its gradual phase-out in a considered transition process. Staff transitions are described in the HCW Salary section of this COP. FY12 activities will continue the process of documenting and disseminating project activities, results and lessons.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**10964**		
Mechanism Name:	**APAC**		
Prime Partner Name:	**APAC**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	0	0
Narrative:			

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 10975	**Mechanism Name: AVERT**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: Avert Society	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-USAID	0

Sub Partner Name(s)

Bharatiya Adim Jati Sevak Sangh, Nagpur	Committed Communities Development Trust	Dr. Babasaheb Ambedkar Vaidyakiya Prathisthan- Migrant-

		Aur'bad
Francois Xavier Bagnoud International	IRCS - Nagpur - FSW	Krishna Charitable Trust
M/s. Lad & Nagaral Associates	Manav Vikas Bahuuddeshiya Sanstha	Marathwada Gramin Vikas Sanstha, Vaijapur
Mook Nayak Swayamsevi Sanstha, Sangli	Nirmala Niketan College of Social Work	P.K. Chopra and Company Chartered Accountants
Prerana Samajik Sanstha	Setu Charitable Trust-FSW/MSM, Jalna	UDAAN, MSM
Vasai Region AIDS Control Society (VRACS)-Migrant-Thane	Young Mens Christian Association, India	

Overview Narrative

This Mechanism will close in 2012. All proposed activities are included in the FY 2012 COP with a $0 budget, funded with pipeline from previous fiscal years. A full description of approved activities for this Mechanism is provided in the FY 2010 COP. There have been no important adjustments to the planned activities as described in detail in the FY10 COP, and as approved in the FY10 and FY11 COPs. In FY12, Avert will complete its gradual phase-out in a considered transition process. Staff transitions are described in the HCW Salary section of this COP. FY12 activities will continue the process of documenting and disseminating project activities, results and lessons. Select activities related to interventions with migrant populations, support for the prevention to care continuum, and support for the Technical Support Unit, will be transitioned to a new mechanism, as described in the narratives for the HIV/AIDS Prevention Project (HAPP).

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID:	10975		
Mechanism Name:	AVERT		
Prime Partner Name:	Avert Society		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	0	0
Narrative:			

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 10982	**Mechanism Name: DoD**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: U.S. Department of Defense (Defense)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Indian Armed Forces personnel are an at-risk population as soldiers are generally young, mobile, separated from their families, and exposed to commercial sex workers. The Department of Defense (DOD) in collaboration with the US Pacific Command/Center of Excellence (PACOM/COE) has supported the Indian Armed Forces Medical Services (AFMS) since 2004 to build their capacity to provide HIV prevention, care and treatment services to military personnel and their families. These activities are a continuing collaboration to improve capacity to address HIV care and treatment at military medical facilities. The program targets the military population and their families in India.

The proposed training activities, along with support from DOD HIV/AIDS Prevention Program (DHAPP), will enable AFMS to establish its own military training capacities to provide HIV prevention, diagnosis, and treatment.

The USPACOM HIV/AIDS Strategy builds upon and leverages its established working relationships with military partners and civilian experts and its access to technical expertise in the field to prevent the transmission of HIV in the Asia Pacific/South Asia Region. In India, this strategy supports and augments the Indian military's evolving comprehensive HIV/AIDS prevention program by building and improving human resources. The goal of the DOD is to transition the DOD/AFMS partnership to a technical assistance model through which sustainable capacity will be developed or enhanced in the AFMS. Achievement of targets and success of activities will be monitored through post-training meetings and written communication.

All proposed activities are funded with available pipeline and are included in the FY12 COP with a $0 budget.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Military Population

Budget Code Information

Mechanism ID:	10982		
Mechanism Name:	DoD		
Prime Partner Name:	U.S. Department of Defense (Defense)		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	0	0

Narrative:

Activities under Adult Treatment have traditionally focused on strengthening the human resource capacity of the AFMS to provide a high quality of treatment to HIV-positive soldiers and to ensure that the AFMS has the critical medical supplies available when providing treatment and care services. Discussions with AFMS led to selection of training programs as activities in FY12. Ministry of Defense has approved AFMS participation in the training. This course will enhance AFMS capability in HIV prevention, diagnosis, and treatment, surveillance and M&E. Activity 1: DOD India will provide training for three Armed Forces Medical Services (AFMS) HIV physicians at the 4- week Military International HIV Training Program (MIHTP) in San Diego, California, USA. This course is a military to military training, offered by DOD HIV/AIDS Prevention Program (DHAPP). MIHTP is a collaboration of the Naval Medical Center, San Diego (NMCSD) and two San Diego universities - the University of California, San Diego and San Diego State University. The Naval Health Research Center provides operational support through the DHAPP. DHAPP has facilitated the establishment of this mini-residency in HIV/AIDS clinical management located in San Diego, California for foreign military medical personnel currently dealing with HIV/AIDS in their country. MIHTP is funded by the US Department of Defense as an international assistance program, and is designed to promote HIV prevention, care and treatment through training of military medical providers and country assistance in strengthening or development and implementation of HIV programs. An effective

response to the HIV/AIDS epidemic requires expertise, experience and training in the prevention and management of people infected with HIV. This program was established to use the HIV expertise in three closely associated San Diego institutions. The course provides training of medical military personnel actively caring for HIV-infected patients. The course provides clinical training in HIV-related patient management, epidemiology, and public health. Activity 2: DOD India will be sending 2 attendees from the Indian Military as a part of the country delegation to the 2012 International Military HIV/AIDS Conference (IMilHAC): Re-Energizing HIV Campaigns, which will be held 7-10, May 2012, in Maputo, Mozambique. The conference is being organized by The Forças Armadas de Defesa de Moçambique (FADM), and the U.S. DOD, and will be attended by approximately 400 participants from over 70 countries engaged in the military partnership against HIV/AIDS. The mission of the 2012 IMilHAC is to bring together international military leadership and HIV/AIDS specialists, multilateral organizations, U.S. DoD/PEPFAR Program Managers and Headquarters staff, non-governmental organizations, and academia to share best practices in leadership, HIV prevention and care and treatment. The objectives for the conference are: 1. Highlight the role of leadership in successful military HIV/AIDS programs 2. Emphasize the best military health system practices in HIV prevention, care, treatment, and strategic information. 3. Facilitate military to military technical assistance, networking and partnerships. 4. Consolidate advances in military medical HIV programs to support an agile, effective, and sustainable response to the epidemic.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 13196	**Mechanism Name: PRATIBHA**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Project Concern International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,100,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GAP	200,000
GHP-State	900,000

Sub Partner Name(s)

NACO		

Overview Narrative

PRATIBHA is an ongoing project to strengthen capacity of NACO and affiliated Indian organizations in lab management, with a focus on supporting lab accreditation, increased adoption of innovative technologies, and lab-related policy development and strategic planning. In FY12, CDC will continue and expand these lab capacity development activities. In addition, CDC proposes to leverage Project Concern International (PCI) expertise in additional areas, including community-based interventions to increase access to HIV services, particularly among women. The project will be implemented in districts where PCI has been supporting GOI agencies to integrate HIV with MCH services using existing community based platforms such as women's groups and NGO networks. PRATIBHA supports PEPFAR/India's Strategy goals 1 (improved access to quality services), and 4 (health systems strengthening).

Geographic focus for lab strengthening is both national and regional, covering all 13 National and 118 State Reference Labs (NRL, SRL), and targeting technical and managerial staff from NRLs, SRLs, NACO and SACS. Gender initiatives will focus in Maharashtra state and target grassroots level healthcare workers, community members and pregnant women.

PRATIBHA leverages GOI infrastructure at national, state and district level, where PRATIBHA staff provide the TA for GOI-funded activities (e.g. serving as faculty for GOI-organized trainings). Staff placed regionally maximize mentoring and TA time to improve outcomes. During the project life, these activities will all be transitioned to the national health programs.

The project's results framework and M&E plan guide project M&E; computer based reporting formats and regular qualitative feedback from trainees and lab feed continuous improvement.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	100,000
Human Resources for Health	400,000

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	13196		
Mechanism Name:	PRATIBHA		
Prime Partner Name:	Project Concern International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	900,000	0

Narrative:

Based on the outcome of nationwide HIV laboratory assessments, and subsequent prioritization discussions with NACO, PRATIBHA will continue to focus on providing TA to the laboratory services commissioned under phase 3 of the National AIDS Control Program (NACP-III) by building on previous accomplishments and lessons learned. The project is expected to extend its support to additional HIV-related services including viral load and incidence testing, EID, and testing of Sexually Transmitted Infections (STIs) and reproductive tract infections (RTIs).

1. Regional and State level Technical Training: PRATIBHA will hold trainings for NRLs, SRLs, NACO and SACS officials. In addition, the PRATIBHA team will participate as faculty in trainings organized by NACO, SACS and other institutes to train healthcare workers and Technical Officers in lab-related activities.

2. TA to laboratory services commissioned under NACP-III: To strengthen quality assurance in laboratory

services, PRATIBHA will conduct onsite visits and trainings. In addition, PRATIBHA will train program managers, laboratory-in-charges (Lab Directors) and medical officers through learning visits and TOTs.

3. Re-assessment of non-accredited labs: PRATIBHA together with NACO will conduct reassessment exercises for select labs to monitor progress towards accreditation.

4. Mentoring towards accreditation: In FY12, PRATIBHA will continue to provide mentoring, monitoring and TA to the NRLs and SRLs to undergo and maintain the accreditation with the National Accreditation Board for Testing and Calibration Laboratories (NABL). PRATIBHA will place technical specialists in different regions of the country that will conduct site visits and provide support and training to the NRL and SRL staff in implementation of and adherence to good laboratory practices and quality management systems. To support these activities, PRATIBHA will continue to facilitate development of SOPs, distribute job aids, and ensure access to centralized or SRL-based e-resource libraries for quality improvement tools and materials.

5. Resources for Quality Improvement: PRATIBHA will initiate activities to set up an e-resource (portal cum digital library) center to facilitate laboratory quality improvement interventions. In FY 12, the project will also establish 10 laboratory quality assurance resource centers within the SRLs to facilitate continuous training and e-certification courses.

6. Strategic Planning: PRATIBHA will provide TA to NACO to support policy development and strategic planning related to lab services by participating in the Technical Resource Group (TRG) meetings and consultations related to NACP.

7. Building capacity in NACO: In FY12, PRATIBHA will continue to provide TA to NACO on strengthening the laboratory services component of NACP. The project will place consultants within NACO laboratory services division to provide technical and administrative assistance on laboratory quality assurance processes. PRATIBHA will also support NACO laboratory staff to participate in national and international study tours, meetings, conferences, and short-term trainings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	200,000	0

Narrative:

Studies conducted in India consistently report that women are less knowledgeable about HIV and less likely to be HIV tested compared to men. In a new activity in FY12, PRATIBHA will provide TA to NACO to address gender related disparities within HIV programs through a demonstration project designed to improve access to HIV information and services by women of reproductive age. Specifically, the project

through grassroots level interventions will address broader gender issues, cultural and societal norms that influence behaviors and outcomes of both males and females related to uptake of HIV services.

The project will address both demand and supply side issues. At the supply side (health systems), the project will implement training and sensitization programs for healthcare workers to equip them to decrease health system barriers to HIV service utilization by women. For example, Auxiliary Nurse Midwives (ANMs) will be trained to provide counseling about HIV testing for pregnant women. For cost effectiveness and sustainability, the project will complement and coordinate with activities being rolled out by NACO to integrate HIV with MCH and the National Rural Health Mission. Continued, detailed consultations with NACO and other ministries will further identify specific areas for synergy.

At the demand side (grassroots), PRATIBHA will address societal norms that shape community uptake of HIV testing. Specifically the project will address the norms that restrict women's access to HIV prevention, care and support services, including gender-based violence, which women often face with regard to HIV related issues. The project will collaborate with local NGOs to initiate grassroots level activities (community mobilization, dialogue among community members) to empower women's free and equitable access to quality HIV services.

The project will be implemented at Pune, Maharashtra, where the implementer (Project Concern International) has been supporting NACO to integrate HIV and MCH services through training ANMs in HIV rapid testing, and already has community based platforms such as women's groups and NGO network. PCI's community platforms and existing linkages with government and health infrastructure in Pune will support rapid roll-out of activities.

The full scope and scale of the activities will be defined following national level consultations with gender experts and the agencies implementing gender related HIV programming. PRATIBHA's final design will build on the lessons learned from ongoing work in other states, adapting resources and tools that have already been tested and implemented in other gender related projects. The project may be rolled out in an additional site, based on recommendations from the consultation workshops.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 13387	**Mechanism Name: DAKSH**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,100,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GAP	321,808
GHP-State	778,192

Sub Partner Name(s)

The Society for Welfare and Advancement of the Rural Generation	United Nations Development Programme	Zila Yuva Kalyan Samiti

Overview Narrative

USG has funded FHI 360 to provide technical assistance (TA) to National AIDS Control Organization (NACO) for Strategic Information (SI) since 2009. Core TA areas include: 1) M&E including project evaluation, data triangulation, operations research (OR) and qualitative and economic evaluations; 2) Surveillance including roll-out of Integrated Behavioral and Biological Assessment (IBBA); and 3) Data Use including support on SI Management System (SIMS). DAKSH supports PEPFAR/India strategy Goals 2 (Data for Decision making) and 4 (Capacity Building). In FY12, CDC will also leverage FHI 360 expertise in community-based interventions for enhancing access to HIV services, particularly among women with Gender Challenge funds. The project will be implemented in a district where FHI 360 has already been supporting GOI to integrate HIV with MCH services using existing community based mechanisms.

Project activities target M&E staff at national, state and district levels and NGOs implementing Targeted Interventions (TIs) for MARPs, Medical College faculty and program staff. The PEPFAR Gender project will target MARPs and their partners and wives of male migrants in Uttar Pradesh.

DAKSH maximizes cost-efficiency by leveraging GOI program investments through targeted TA that builds capacity for sustainability beyond project life. DAKSH ensures complementarity and coordination through regular partner meetings.

In-service training and TA provision to local organizations are measured through PEPFAR indicators. Other outputs and outcomes of the SI component will be tracked as per the indicators in the results framework and the 5 year strategy for PEPFAR/India. Gender project M&E systems at community and facility levels will be supplemented with case studies and success stories.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	50,000
Human Resources for Health	507,791

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**13387**

Mechanism Name:	DAKSH		
Prime Partner Name:	FHI 360		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	40,000	0

Narrative:

The gender project will work with wives of male migrants to improve their risk perception to HIV and improve their health seeking behavior including access to early HIV testing and treatment services. The project will work with existing Targeted Intervention being supported by the State AIDS Control Society (SACS) for a migrant intervention. Line lists of migrants whose spouses are living in the source district will be compiled and after following due process of informed consent, home visits will be made to improve access to HIV prevention, testing, care and treatment services.

ACTIVITY 1: Trainings to existing TIs and NGOs on Collectivization and addressing Gender-based violence

Trainings and other learning sessions will be conducted with the staff of 2 TIs to facilitate:

- Formation of Gats (groups) of female sex workers and MSM to address violence/crisis e.g. police raids, fights with pimps, brothel owners, clients etc.
- Establishment of a Rapid Response System for crisis intervention

ACTIVITY 2: Setting up a Rapid Response systems and formation of groups/Gats

DAKSH will introduce a 'Rapid Response System' for timely interventions by peers and key influencers during any instance of reported crisis or violence related to MARPs. The NGO partners in Allahabad will maintain a system of tracking instances of reported violence and response time to monitor effectiveness. Peers will be trained to respond to such calls for assistance at the earliest and adopt different response strategies depending on the intensity of the crisis/problem. To be able to introduce and implement this system effectively, MARPs will be collectivized into groups or Gats. MARPs once collectivized will be trained on how to rapidly report and respond to instances of violence or crisis and what recourse to take during different instances including police raids.

ACTIVITY 3: Engaging men and community

The NGOs will work to increase male engagement and their sense of responsibility to identify and address harmful gender attitudes and practices that increase women's vulnerability to HIV. The NGO partner will be trained on counseling men on enhancing male responsibility with respect to sero-discordant status and

positive prevention. This will include counseling men on early partner disclosure and notification, avoiding use of violence associated with HIV testing and disclosure towards partner, correct and consistent condom use, and STI treatment for self and partner. The NGO partner working with wives of male migrants will also conduct sensitization meetings with the community at large to create an enabling and supportive environment for increasing women's access to HIV service by reducing stigma and discrimination and for greater community participation to address gender based violence.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	985,000	0

Narrative:

SI is one of the three pillars of the National AIDS Control Program, but SI capacities are limited to a few individuals. DAKSH is a key SI partner to NACO and strengthens NACO's response to the epidemic by promoting evidence-based HIV prevention, care, support and treatment services.

ACTIVITY 1: TA on M&E

CDC provides TA in the roll-out of NACO's SI Management System (SIMS), which has capacity for advanced data capture, aggregation and analysis, and is a repository of all data related to India's HIV epidemic and response. DAKSH supports the process through capacity strengthening and quality control support. USG will also support finalization of 400 district epidemiological profile reports incorporating 2010 data, including analysis and dissemination. In FY11, DAKSH supported local institutions to develop an operations research protocol on PMTCT; TA to other Government Medical Colleges and Research Institutes will be provided in FY12. DAKSH will also design and conduct end-of-project evaluations for two CDC projects, including local institutions to build capacity throughout the process. Building on experience of conducting qualitative and economic evaluation of CDC-funded projects, DAKSH will provide TA on qualitative and economic evaluation to national and state government institutes. Finally, DAKSH will collaborate with NACO, WHO and UNAIDS on a national conference and regional workshops on program evaluation.

ACTIVITY 2: TA on Surveillance

NACO is planning an Integrated Biological and Behavioral Assessment (IBBA) at the national level. In FY11, DAKSH provided TA in design of the national IBBA and in FY12 will provide TA to plan the IBBA in collaboration with WHO. Also with WHO, DAKSH will support implementation of systems to routinely collect early warning indicators for HIV drug resistance and lay the ground for cohort analyses.

ACTIVITY 3: TA on Data Use

Over 11,000 government and non-government facilities deliver and report on HIV services. Maintaining quality of data generated by these reporting units, and ensuring their robust use at all levels is a significant challenge. In FY11, DAKSH in collaboration with National Technical Support Unit (NTSU) assessed skills building needed by M&E staff at all levels. In FY12 DAKSH will design a capacity and skills strengthening program including modules on data analysis, data presentation and data quality tools, and conduct trainings and provide mentoring support to government stakeholders. The project will provide TA in advanced data analysis to the National Data Analysis and Dissemination Unit to create skills in program data analysis and dissemination at the national level with a plan for transferring this capacity to the states. DAKSH will also continue its support to NACO to finalize and roll-out the NACP-IV implementation plan.

ACTIVITY 4: Gender and Vulnerability Analysis, M&E and Process Documentation

DAKSH will complete a Gender and Vulnerability Analysis related to HIV in the target community, including social constructs of male-female relationships and gender-based norms and practices governing risk perception, health seeking behavior and access to HIV testing, treatment, care and support services . The study will explore factors leading to vulnerability to GBV, stigma and discrimination. As part of establishing the project MIS, capacities of NGO will be built in collecting, collating and analyzing project data, and monitoring data quality.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	30,000	0

Narrative:

The gender project will work with the State AIDS Control Society (SACS) and the District AIDS Prevention and Control Unit (DAPCU) to integrate gender approaches within ongoing targeted interventions funded by SACS in Allahabad district. The focus will be on building capacities of local NGOs as well as government frontline workers including Accredited Social Health Activists (ASHAs), Ancillary Nurse Midwives (ANMs) and Anganwadi Workers (AWWs) and their supervisors, [AWWs are frontline workers under the government's Integrated Child Development Scheme (ICDS)]. The focus of capacity building efforts will be on adopting innovative strategies to improve early and repeat HIV testing among MARPs and their partners, addressing issues of violence among MARPs, and interventions with spouses of male migrants to improve risk perception and health seeking behavior.

ACTIVITY 1: Capacity building of frontline workers and government healthcare providers at facility level

The Project will conduct trainings for government health care providers and frontline workers (ASHAs, ANMs, AWWs and their ICDS Supervisors and DAPCU staff) focusing on sensitization about current

gender inequities that increase risk for HIV transmission and impede access to HIV services by MARPs as well as wives of migrants. Trainings will also cover the linkages between gender and health, particularly gender based violence (GBV) and HIV; risk perception for GBV; and referral mechanisms for women to link them to relevant services. The training will build basic skills in psychological counseling such as listening, assuring and not blaming women, and how to facilitate a process whereby women clients will visit and talk.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	45,000	0

Narrative:

The gender project aims to mobilize early and repeat HIV testing among MARPs and their partners. One of the strategies will be to introduce voluntary HIV testing campaigns within existing TIs that will include generating line lists of sex workers prioritized for HIV testing, generating demand for services and ensuring laboratory supplies and personnel to facilitate higher rates of repeat HIV testing among MARPs. The project will build upon FHI 360's experience from the BMGF-funded Aastha project in Mumbai and apply the learnings to DAKSH. It is expected that by the end of the project, at least 50% of the MARPs will have been repeat HIV tested at least once.

ACTIVITY 1: Trainings to existing Targeted Intervention (TI) NGOs and service providers

DAKSH will train the 3 existing NGOs implementing TIs; training includes counseling on risk perception, importance of early and repeat HIV testing and effective referrals for HIV testing. Accompanied referrals will be conducted by the community-based and government healthcare providers and frontline workers and TIs to the target populations under this project to facilitate their timely access to counseling, testing and treatment services. As part of training, project staff will conduct follow up visits to ensure proper referrals. The trainings will include the Vivek model, an intensive VCT campaign in outreach settings implemented by FHI 360 as part of the Gates-funded Aastha project.

ACTIVITY 2: Roll out of Vivek Model for repeat testing among MARPs

Learnings from FHI 360's Aastha project will be shared with the TI NGOs in Allahabad including sharing of tools and resources (IEC materials) that have been developed under Aastha as part of this effort. The TI NGOs will be supported to pilot Vivek-like interventions in Allahabad district and will be supported to track increase in repeat HIV testing rates among the registered MARPs. This model involves intensive planning including preparing line lists of sex workers who are due for HIV testing, consistent with NACO guidance. The intervention will include demand creation activities by the NGO partners. Finally, DAKSH and the NGOs will collaborate with the State AIDS Control Society to ensure a sufficient and continuous supply of HIV test kits, laboratory consumables, and necessary trained personnel to handle increased demand for

onsite HIV testing. ACTIVITY 3: Working with partners of MARPs DAKSH will support the two GOI-funded TI NGOs working with FSW and MSM in Allahabad to initiate interventions with partners of MARPs. The NGOs will be supported to generate line lists, consistent with NACO guidance, of FSW and MSM who are married or are living with regular partners. The NGOs will be trained on issues of partner notification and disclosure, safe sex including condom negotiation with regular partners, STI diagnosis and management, early HIV testing, and linkages to HIV care, support and treatment services. Training will include addressing issues of partner violence related to disclosure and HIV testing. The NGO partners will be supported to incorporate additional indicators for outreach and service delivery to monitor interventions with partners of MARPs.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 13453	**Mechanism Name: SNEH**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 450,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GAP	150,000
GHP-State	300,000

Sub Partner Name(s)

Catholic Health Association of	IGNOU	SHARE India

India		

Overview Narrative

SNEH is a continuing project that contributes to PEPFAR India's goals 2 and 4 (data for decision-making and HSS). The goal of SNEH is to increase capabilities of nurses to provide HIV clinical services in India as part of sector-wide efforts to strengthen human resources for health (HRH) systems. Project objectives are to 1) demonstrate an effective model to enhance HIV clinical capacities of nurses working on HIV ; 2) provide TA to nursing councils and Ministry of Health and Family Welfare (MoHFW) to strengthen human resource planning/management; and 3) provide need-based TA (models) in capacitating nursing councils and institutions.

The project targets nursing decision-makers at national level, and all nurses working in the area of HIV in India. SNEH will work with associations of nurses, nursing institutions, and academic institutions and build their overall institutional capacity in areas including information systems, continuing education, curriculum development, accreditation and policy review and development. Increasing gender equity in HIV services is addressed in all components of these in-service trainings.

To support cost-efficiency, SNEH's activities are limited to TA at the national and state level, with all implementation done by GOI. SNEH will ensure through regular partner meetings that efforts of USG funded agencies are complementary rather than duplicative. The project strategy is to build capacity of local government staff, so that effects will be sustainable beyond the project life.

M&E will be through project-specific process monitoring of activities and through Management Information Systems developed by FHI 360 and its sub partners. FHI will hold quarterly review meetings with donors and project partners.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	450,000

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	13453		
Mechanism Name:	SNEH		
Prime Partner Name:	FHI 360		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	177,690	0

Narrative:

SNEH will work with nursing councils, associations and academic institutions and build their overall institutional capacity in areas including information systems, continuing education, curriculum development, accreditation, policy review and development in close collaboration with the Ministry of Health and Family welfare.

Health workforce planning supports efficient recruitment, training and deployment of health workers. Managers and health planners need information about the size, composition, skill sets, training needs, and performance of the public health workforce in order to make informed, well-timed decisions. However, in India, human resources for health data are limited, inconsistent, out-dated, or unavailable. At present most use paper-based systems for health workforce information. Computerized human resources for health management information systems (HRHMIS) enable countries to collect, maintain, and analyze health workforce data. The development and use of HRHMIS is an attainable and cost-effective strategy to address workforce shortages and improve public health in India.

In FY10, SNEH facilitated formation of and mentored a core group for Human Resource for Health Management Information System (HRHMIS), which developed a project management Plan for designing, developing and implementing HRHMIS in India. SNEH is supporting this core group to pilot HRHMIS in

Andhra Pradesh in FY11. In FY12, SNEH will revise and replicate the HRHMIS in new states. SNEH will work closely with the HRHMIS core group which includes Andhra Pradesh State Project Management Unit (SPMU), Directorate of Medical Education (Government of Andhra Pradesh), National Health System Resource Centre (NHSRC), National Informatics Center, and Public Health Foundation of India (PHFI). Project sub-partners (CHAI and SHARE India) will continue to be involved in the project for HRHMIS and nursing council capacity building.

1: Strengthening human resource for health management within nursing councils
Based on the FY11 pilot HRHMIS (one state) and feedback from State Nursing Councils (SNCs), in FY12 SNEH will continue to work closely with the HRHMIS core group and provide technical assistance (TA) to replicate the HRHMIS in three states (to be decided). SNEH will also ensure registration and tracking through HRHMIS of all nurses undergoing the training program. USG and partners will provide TA to SNCs and state health departments to utilize HRHMIS data for strategic planning to optimally utilize available health care human resources in the state.

2: Capacity building for nursing councils and nursing institutions
In FY12, SNEH will continue to provide TA to three SNCs to implement their five-year strategic plans and budgeted annual action plans which were developed in FY11. In FY12 USG and partners will revisit the SNCs and review progress on implementing the annual action plan. USG and partners will provide TA to SNCs to address specific challenges to implementation. SNEH will also build on these experiences to provide TA to three additional states to develop similar strategic plans and annual action plans. SNEH will also provide need- based TA (develop models) to nursing associations and nursing institutions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	272,310	0

Narrative:

A 2007 CDC/I-TECH review of the technical capacities of nurses in ART centers and Community Care Centers showed that most nurses lacked satisfactory HIV knowledge, skills and formal training. It also found that the roles of these nurses were unclear. NACO ART operational guidelines recommend clinical triaging for nurses working in ART centers for better clinical care of patients. SNEH will introduce clinical triaging in HIV service centers through training and defining the task sharing roles of nurses.

1: Task-sharing for nurses working in HIV: Based on the FY11 review of workload of nurses in sample HIV service centers, in FY12 SNEH will provide TA
to i) State AIDS Control Societies (SACS) to redefine and expand roles for nurses (task sharing) in HIV clinical care in collaboration with NACO and MOHFW, ii) develop action plans in consultation with NACO

and SACS to raise the capacities of selected HIV service centers to function as demonstration sites for HIV nursing.

2: Specialized training for nurses working in HIV: SNEH facilitated development of 10-day in-service ART nurses training curriculum and framework with continuous mentoring in FY10 and trainings rolled out in FY11. This specialized training bridges the current NACO/Indian Nursing Council 5-day basic course for all nurses and the Yale University/Clinton Health Access Initiative advanced training (3-months) planned through the Indian Institute of Advanced Nursing (IIAN). In FY12 SNEH will continue roll-out of this 10-day training/mentoring support for the nurses; develop a 3-day refresher hands-on curriculum for nurses trained in FY10-11; develop need-based curriculum for the nurses to improve HIV clinical skills and develop print and audio-visual material. SNEH will review the capabilities of trained nurses 9 months post training. Increasing gender equity in HIV services is addressed in all components of these in-service trainings.

3: Continuing Nursing Education (CNE) on HIV clinical care via distance self-learning: In FY12 SNEH will continue to provide TA to Indira Gandhi National Open University (IGNOU) to strengthen India's first certified distance learning courses on HIV for nurses (begun in FY11). In FY12, SNEH/IGNOU will revise the pilot web-based and distance learning CNE based on FY11 assessments. SNEH will advocate with public (NACO, SACS, ART, LAC, CCC, CHCs, district hospitals and Medical Officers of ART centers and LACs) and private sector institutions (profit and not for profit, faith based organizations) to facilitate the use of self-learning modules in all clinical care services in India.

4: Quality Assurance (QA) program for monitoring nurse training: Through site visits, SNEH will develop and implement a QA system for monitoring quality of training provided to nurses. Quality standards including standard operating procedures and quality checklists will be administered to trainees and key elements of process, content and facilitation skills of the trainers will be assessed. SNEH will regularly monitor the quality of the mentorship program and the self-learning module through use of quality checklists and feedback from nurses/mentors on the use of knowledge and skills gained through the training. Results of QA assessments will be fed back into training modules, the mentorship program and self-learning modules.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 13527	**TBD: Yes**

REDACTED

Implementing Mechanism Details

Mechanism ID: 13573	**Mechanism Name: Improving Healthy Behaviors Program (IHBP)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,500,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-USAID	2,500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

IHBP is a 3-year $32m integrated health project launched in October 2010 with PEPFAR and non-PEFAR funding, and implemented at national level and in Uttar Pradesh (UP). IHBP strengthens capacity of national GOI agencies and their state counterparts to design, deliver and evaluate behavior change communication (BCC) programs on a range of health issues. For HIV, IHBP works with NACO and the UP State AIDS Control Society (UPSACS) to strengthen institutional capacity to promote behavior changes to prevent HIV transmission and reduce stigma and discrimination through mid-media and interpersonal communication (IPC). IHBP aligns with PEPFAR/India's Strategy goals 1 (improved access to quality services), 3 (building on country leadership and commitment), and 4 (health systems strengthening).

IHBP provides technical assistance (TA) to NACO and UPSACS via collaborative mentoring from project staff in planning, implementing and evaluating BCC campaigns, development of modules and materials, training of trainers, media planning and communications M&E. GOI will cover costs for all systems improvement actions, cascade training of health providers and field workers, mass production of communication materials, airing of media campaigns, and various campaign evaluations. Advocacy efforts will be undertaken to ensure that follow-up training and communication activities will be included in the

government's annual Project Implementation Plans.

In FY12, IHBP will conduct baseline and endpoint Knowledge-Attitudes-Practices studies in districts where BCC campaigns for truckers and migrants are implemented; process evaluation to determine changes in quality of GOI BCC planning; monitoring and evaluation; quality monitoring of cascade training and follow-up after-training.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	700,000

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Mobile Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13573**
Mechanism Name:	**Improving Healthy Behaviors Program (IHBP)**
Prime Partner Name:	**FHI 360**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	300,000	0

Narrative:

BCC activities are currently not monitored in existing M&E plans at the national and state level. In early 2012, IHBP will conduct a review of M&E related to BCC activities at the national level and in UP to assess adequacy of current M&E systems in measuring and monitoring coverage and quality of BCC activities, and to identify and prioritize gaps that can be addressed. In FY12 IHBP will support 3 additional activities to be developed based on the results of this review.

1.
Support for strengthening M&E system on BCC in NACO
IHBP will continue its support to NACO to strengthen its M&E system for BCC programs. While specific activities will be planned based on results of the BCC M&E review, they will include advocacy with NACO officials and program managers on incorporating BCC indicators in the existing M&E system, training of NACO M&E staff in collecting information from various levels, tracking and analyzing BCC indicators and incorporating them in M&E reports, and support implementation of the M&E system in pilot areas.

2.
Support for strengthening M&E system on BCC in UPSACS
IHBP will continue its support to strengthen the monitoring and evaluation system on BCC in UPSACS. While specific activities will be planned based on results of the BCC M&E review, they will include advocacy with UPSACS officials and program managers on incorporating BCC indicators in the M&E system, training of UPSACS M&E staff at the state and district levels in collecting information, tracking and analyzing BCC indicators, and support for implementation of the M&E system in pilot areas.

3.
Support research to assess effectiveness of comprehensive BCC strategic plan of UPSACS
In 2012, UPSACS will initiate implementation of a comprehensive BCC strategic plan based on evidence generated from a 2011 Communication Needs Assessment. IHBP will support qualitative program evaluations, conducted in targeted areas, for early tracking of (1) acceptability of messages, materials and communication approaches among specific population segments and (2) implementation by health providers and community-based workers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	1,000,000	0

Narrative:

Various government and donor-sponsored reviews reveal weak capacity of GOI institutions for planning and implementing communication programs. Among the problems cited are: plans are not based on evidence and do not target behavior change of specific audiences; focus is usually on mass media and production of materials which raise awareness but are not effective in changing health behaviors; there is insufficient emphasis on mid-media and interpersonal communication activities; human resource capacity for communications is weak; and the M&E system is inadequate to track effectiveness of communication campaigns. In FY12, IHBP will support 3 activities to address these systems gaps.

1. Support capacity building on strategic communication planning, implementation and evaluation in NACO and UPSACS

IHBP will continue TA to strengthen institutional and human resource capacity in NACO and UPSACS for strategic BCC planning, implementation and evaluation. Based on an organizational assessment in 2011-2012, IHBP will continue regular technical assistance from project staff and long-term BCC consultants who will provide on-the-job mentoring and support to NACO and UPSACS IEC staff in managing various aspects of BCC work including strategic campaign planning, writing creative briefs, reviewing ad or media agency proposals, coordinating with local government on BCC, and developing mid-media and IPC campaigns. IHBP will hire creative agencies to enhance capacity of GOI IEC staff in developing creative communication materials, and media agencies to help NACO design and monitor effective media plans. IHBP will collaborate with NACO and UPSACS in developing communication-related research proposals and in overseeing research by contracted research agencies. IHBP will also support: training of trainers to enhance communication skills of health care and community-based workers; experience sharing through workshops and study visits; dissemination of best practices; and a system to recognize staff who demonstrate exemplary skills and commitment in performance of communication-related tasks.

2. Support institutional strengthening of NACO and UPSACS through capacity building of local nodal institutions

Since NACO and UPSACS will not be able to perform all aspects of communication work (e.g. production of materials, media planning, communication-related research), IHBP will strengthen local nodal institutions (academic institutions like the Indian Institute of Mass Communication, parastatal organizations like the State Institute of Health and Family Welfare, NGOs and commercial agencies) to assist these government agencies with communication at the national and UP state.

3. Provide TA for training of trainers of health care and community-based workers in UP

Stigma and discrimination continue to impede high-risk populations and PLWH from seeking diagnosis and care. Qualitative studies reveal that stigma and discrimination exist not only among the general population at the community level but also among health providers and community-based workers. IHBP will support development of innovative, participatory modules and training of trainers to reduce stigma and discrimination among health care and community-based workers in the government system and private health sector networks. It will strengthen the capacity of district level supervisors to provide supportive supervision for communication on stigma and discrimination reduction.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	900,000	0

Narrative:

NACP-IV will consolidate the efforts of NACP-III to saturate coverage of MARPs and improve the quality of prevention services. In FY12 IHBP will support GOI at the national and state levels to update and improve prevention communication campaigns targeting migrants and long-distance truckers through 4 activities. The activities planned support targeted interventions carried out by NGOs and CBOs funded by UPSACS.

1. TA at national level for BCC second phase campaign targeting migrants including development of communication materials and media plan.

A main goal of NACP IV is to accelerate the prevention response among MARPs. There is growing evidence that inter-state migration is fueling India's HIV epidemic. To improve migrant access to services, in FY12 IHBP will build on the communication campaign already initiated in collaboration with NACO by strengthening campaign scale-up at transit points for migrants, and support intensive mid-media activities like song/magic shows, theater performances in trains and other education-entertainment activities. These will carry messages in line with the mass media component, including messages on stigma and discrimination.

2. TA to UPSACS to refine the communication plan to reach MARPs, update communication materials and retrain community health workers on campaign messages.

UPSACS has developed a BCC strategy targeting MARPs and vulnerable populations such as migrants and truckers in UP. IHBP will support UPSACS to refine its BCC strategy, update communication materials and messages as necessary, and provide retraining for community-based health staff on campaign messages. It will also provide technical support in monitoring and evaluating the MARPs communication

plan.

3. Grants to NGOs in UP for innovative community mobilization, mid-media and IPC campaigns to reach truckers and migrants.

IHBP will award grants to local NGOs to implement innovative community mobilization, mid-media and IPC campaigns to reach long-distance truckers and migrants in UP in both source and destination areas. The BCC activities for truckers include film shows, individual or group sessions using entertainment education to desensitize and increase skills in condom use and reduce stigma and discrimination, and distribution of leaflets and flyers in transportation hubs where truckers congregate. Use of mobile phones to transmit compelling prevention and condom reminder messages will be piloted. Activities will be undertaken in migrant. Some activities (film shows, group communication sessions which will include competitions, entertainment, Question and Answer sessions) in migrant source areas will be implemented to reach migrants' spouses and community influentials. These are aimed at creating an enabling social environment wherein HIV and safe sex will be openly discussed and stigma and discrimination will be reduced.

4. Quantitative research in UP to assess changes in knowledge, attitudes and prevention practices, including condom use, among truckers and migrants.

IHBP will develop a system to regularly monitor progress of NGO activities funded through the grants program. A research study will be conducted to evaluate results in terms of changes in correct knowledge, attitudes and prevention practices, including condom use among truckers and migrants. Capacity of the UPSACS network at district and block levels will be strengthened to coordinate and monitor NGO activities with support from IHBP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	300,000	0

Narrative:

NACO has dramatically scaled-up PMTCT services by establishing over 7,538 PMTCT centers throughout the country. Under NACP III, all stand-alone HTC and PMTCT Centers funded under GFATM Rounds 2, 3 and 6 were redesigned as integrated counseling and testing centers (ICTC). These centers provide HTC and PMTCT services, TB screening and linkages to ART service. NACO recognizes the need to ramp up demand generation activities to increase service uptake, and has been systematically carrying out campaigns based on the needs and gaps in the program. There is a continued need to scale-up demand generation activities as uptake of services remains below target, there is a high rate of loss to follow-up, and coverage is uneven. IHBP will support 3 independent but closely linked activities in FY12.

1. TA at national level for PMTCT campaign (based on new needs) including formative research, development of communication material prototypes and media plan.

IHBP will collaborate with NACO in designing, implementing and evaluating a demand generation campaign which will address barriers to uptake of services focusing on stigma and discrimination (thrust of NACP-IV IEC strategy). The campaign will have a unifying theme and strengthen national and state coordination regarding key messages and materials and train health providers on key messages and addressing stigma and discrimination issues. IHPB will hire creative agencies/consultants in designing the campaigns and proto-type materials. It will provide technical support for the roll-out and hire an agency to monitor and evaluate the campaigns. IHBP will also support NACO in strengthening the mid-media and IPC component of the campaign and in coordination with states.

2. Support capacity building for NGOs and civil society groups in UP to generate demand for PMTCT services.

Based on the National Family Health Survey -3, in UP women's knowledge of HIV is very low (40%), compared to that of men in UP (74%) and of women nationally (57%). Pregnant women are particularly vulnerable, especially spouses of truckers, migrants and high-risk groups. In coordination with UPSACS, IHBP will support NGOs and civil society groups to develop their capacity to promote messages regarding PMTCT at the community level. Small grants will be used for innovative community mobilization activities by these groups (e.g. use of entertainment education, local competitions, testimonials from women who accessed ICTC diagnostic services, film showings, community radio).

3. Support training of trainers of Accredited Social Health Activists (ASHAs) to communicate PMTCT messages.

IHBP will train trainers of GOI-supported community-based ASHAs, especially those operating in villages that are source areas for male migrants, to promote PMTCT messages among pregnant women and their spouses through group and individual communication sessions. ASHAs will incorporate PMTCT messages in their existing health communication functions, using existing community platforms. IHBP will support GOI to train ASHAs to organize one Village Health Nutrition Day (VHND) session on HIV and PMTCT for pregnant women, which will include reduction of stigma and discrimination. IHBP will develop a short film and prototype communication material (visual leaflet); GOI funds will be used to mass produce these materials.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 13599	**Mechanism Name: Evaluation Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Social Impact	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 759,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-USAID	759,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The five-year Evaluation Project was initiated in October 2010 to conduct mid-term and end of project assessments of USG funded projects. The objective of this project is to design and implement both quantitative and qualitative independent evaluation studies and assessments of bi-lateral development programs. In particular, the project will assess the impact of USAID's HIV-related projects in the context of overall development programs, identify lessons learned, and provide recommendations to address the evaluation findings.

Social Impact, in line with the PEPFAR/India Strategy monitoring and evaluation plans, will carry out performance and impact evaluations, evaluation case studies, meta analyses and other evaluations as appropriate to the stage and design of the HIV projects in the focus states of Maharashtra, Uttar Pradesh, Rajasthan, Odisha and at the national level. It will also conduct data quality assessment of the HIV projects at mid-term and provide guidance for establishing systems to improve data quality.

Social Impact will conduct evaluations that will provide an objective analysis of completed projects and address the areas of performance, sustainability and results management.

The Project will also assess whether gender concerns have been addressed by the projects in their HIV

prevention, care and treatment programs. The evaluation design will include questions on gender issues and appropriate tools will be developed to collect the information.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**13599**		
Mechanism Name:	**Evaluation Project**		
Prime Partner Name:	**Social Impact**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	759,000	0
Narrative:			
As part of broad efforts to assess and document results and lessons learned from USG-supported projects,			

Evaluation will support two strategic information activities in FY12.

1: Mid-term Review of the Behavior Change Communication for Improving Healthy Behaviors Program (IHBP).

The agency will carry out the independent mid-term review of the Behavior Change Communication for Improving Healthy Behaviors Program in India Project (IHBP). The $32 million IHBP Project is implemented by FHI 360. The overall goal and approach of IHBP is to improve adoption of healthy behaviors through institutional and human resource capacity building of national, state and district levels.

The scope of work for carrying out this review will be prepared in consultation within USG and the partner agencies. Based on the agreed scope of work, Social Impact will develop a mid-term evaluation protocol including the terms of reference. The review team will assess the log frame and the programs to choose appropriate designs and tools for carrying out the review. The findings/recommendations from this review will be used to refine project strategies and will be disseminated to various stakeholders including USG, National AIDS Control Organization (NACO), Uttar Pradesh State AIDS Control Society (UPSACS) and project partners. The evaluation will assess the following:

1. Project progress in developing capacity of NACO, UPSACS and local institutions on strategic communication planning, implementation and monitoring, and on evaluating campaigns
2. Project achievements at mid-term relative to planned outputs and outcomes
3. Quality of communication skills training, campaigns and products developed by the project.
4. Quality of technical assistance provided by the project to NACO and UPSACS.

2: Evaluation of effectiveness of linking most-at-risk populations (MARPs) to care and treatment services in one USG focus state

The National AIDS Control Program, Phase III (NACP-III), 2007-2012, has expanded services and continues to tailor interventions to the unique dynamics of the epidemic in India. NACP has made substantial efforts and adopted a variety of approaches to improve access to HIV services for MARPs such as mobile HIV testing and counseling, formation of MARPs self-help group networks, and capacity building and sensitization of the health care providers towards MARPs.

This activity will evaluate the effectiveness and efficiency of the systems established to link MARPs with care and treatment services in one USG focus state. Social Impact will develop a protocol that will include both quantitative and qualitative evaluation methods. Quantitative analyses will be conducted using data collected from public sector facilities and will include proportion of MARPs (disaggregated) who were tested and counseled and received test results, registered for pre-ART, and received ART and HIV care

and support services. Qualitative data will be collected from stakeholders, USG and its implementing partners using key informant interviews, focus group discussions, and other techniques, and analyzed using standard methods. This evaluation will be a collaborative effort of NACO and USG. The findings and recommendations from this evaluation will be used for making informed decisions for scaling-up services.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 13604	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 13642	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 13649	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 13711	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 13810	**Mechanism Name: Department of Labor**
Funding Agency: U.S. Department of Labor	Procurement Type: Cooperative Agreement
Prime Partner Name: International Labor Organization	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 150,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The project, funded in FY09 and FY10, supports the GOI "National Policy on HIV in the World of Work", launched by Ministry of Labour and Employment (MOLE) in 2009, and contributes to PEPFAR/India's goals 1, 3 and 4: access to quality services; country leadership and commitment; and health systems. The USDOL/ILO approach mobilizes and builds capacity of national stakeholders to address HIV prevention, stigma and discrimination in the workplace and enhance social protection for PLWH.

In FY12, ILO will:

1. Support development and implementation of a model intervention targeted at most at risk migrant/informal workers and increase access to HIV services in selected sectors.

2. Strengthen institutional capacity of MOLE; National AIDS Control Organization (NACO); State AIDS Control Societies (SACS); and employers', workers' and private sector organizations to implement the National Policy. Technical assistance to these institutions will have nation-wide impact.

This project will strengthen the collaborative mechanism among the SACS, state Labor Departments, trade unions, employers' organizations and the private corporate sector. This institutional capacity strengthening improves sustainability of the efforts and supports country ownership; the collaboration with MOLE and its institutions, and investment of GOI funds for activities, will ensure financial sustainability.

USDOL and ILO have a comprehensive monitoring and evaluation system to ensure continual improvement of activities. A Project Management Team, chaired by the Additional Secretary MOLE with membership from NACO, employers' and workers' organizations, UNAIDS and networks of PLWH, supervises and monitors progress.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
OHSS	Ministry of Labor and Employment (MOLE)	0	ILO has been providing TA to MOLE, the PR for one of the 3 approved Round 9 grants, in areas of project management, institutional capacity building of management units, and research. ILO is expected to be one of the three SRs, but there is no-sub-recipient agreement signed as yet with MOLE. ILO has also supported the grant preparatory work, including grant negotiation for Rd-9.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Mobile Population

Workplace Programs

Budget Code Information

Mechanism ID:	13810		
Mechanism Name:	Department of Labor		
Prime Partner Name:	International Labor Organization		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	132,000	0

Narrative:

With funding support from USDOL, the ILO started in 2001 a three-phase project aimed at establishing a sustainable national program to provide HIV prevention, care and support through the world of work in India. Working with government, employers' and workers' organizations, NACO, UNAIDS, and PLWH, the project contributed to strengthening the policy environment, and developing the capacities of employers and workers organizations/SACS and enterprises to implement HIV workplace interventions and PPP. Together with its partners, the ILO developed a five-year strategic framework for action on HIV (2010-2015) that builds on previous work and contributes to achievement of PEPFAR and GOI goals related to workplace interventions. Building on this solid ground, the PEPFAR funding for FY12 will be utilized for continuing technical assistance to the following activities:- Support MOLE to implement at least three state level workshops in collaboration with state Labor Departments, SACS, and employers' and workers' organizations to disseminate the National Policy on HIV in the World of Work and to develop a plan of action for its implementation; - Support MOLE in its coordination and advisory role as chair of the National Steering Committee on HIV and the World of Work, which is responsible for supervising and monitoring the implementation of the National Policy. - Support MOLE to institutionally mainstream HIV and to identify opportunities for integrating with schemes/institutions with large outreach such as National Rural Employment Guarantee Act (NREGA), Rashtriya Swasthya Bima Yojana (RSBY), Director General Labor Welfare (DGLW) and Employees State Insurance Corporation (ESIC), through training and technical support. - In partnership with MOLE, develop and conduct skills-building workshops for SACS/TSUs on HIV workplace programs and PPP for participants from at least 20 states, including the USG priority states. These activities will contribute to the NACP by intensifying the mainstreaming efforts with key ministries/departments and leveraging resources of multiple departments for implementation. In addition,

to increase engagement of the corporate sector in reducing stigma and discrimination and facilitating PPP, the USDOL/ILO project will work with employers' and workers' organizations to leverage partnerships by: (1) organizing and conducting workshops to strengthen capacity of HIV focal points from at least five employers' organizations/chambers and seven workers organizations to mobilize their members and affiliates to respond to HIV; and (2) providing technical assistance to NACO/SACS in developing and replicating models of PPP in the framework of NACP to reach most vulnerable workers. Additional contributions to NACP will be made by promoting the rights of PLWH, marginalized and vulnerable populations at workplaces by organizing and conducting capacity building workshops for PLWH networks using materials and tools developed by the USDOL/ILO project in collaboration with the PLWH networks. These workshops will equip the networks to advocate on HIV issues at the workplace. The individuals trained among the PLWH networks will be resource-persons for advocacy and sensitization programs aimed at protecting the rights of PLWH and addressing stigma and discrimination at the workplace.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	18,000	0

Narrative:

The National Policy on HIV and the World of Work, developed by MOLE with technical support from ILO, recognizes HIV as a threat to the Indian working population. Nearly 93% of the 400 million working population in India is in the informal economy. Many of these workers are also migrants who are largely unskilled, characterized by low literacy, negligible social protection benefits, difficult working conditions, poor health seeking behavior and limited access to health care services. According to NACO, prevalence of HIV among single migrants is 2.35%. Reaching out to migrants is a key focus of the National AIDS Control Program (NACP) Phases III and IV.

The USDOL/ILO partnership has demonstrated the important role that trade unions can play in reaching the vulnerable informal workers from the construction sector through three trade union led projects in Maharashtra, Andhra Pradesh and Delhi. With FY12 funds, the USDOL/ILO will work with workers' and employers' organizations and state Labor Departments in the Northern Indian States (USG priority states) to develop an intervention to reach migrant/informal workers from a key economic sector (such as construction, mining, textile sectors). This activity will support NACP by intensifying and consolidating quality prevention services to high risk and vulnerable populations.

Technical assistance will be provided to a trade union to support implementation of the intervention in collaboration with the SACS; an estimated 10,000 workers will be reached with HIV prevention, care and support services. The objective is to promote combination prevention by:

- Creating an enabling environment through sensitization of key stakeholders and mobilization of

community-based organizations/structures; - Involving key stakeholders (employers, contractors, workers, supervisors and enforcement authorities) in planning, implementation and monitoring; - Increasing knowledge and risk perception on STIs and HIV among the targeted workers through a combination of peer education and media campaigns; - Supporting the target workers in adopting preventive and safer behaviors with BCC strategies; - Promoting STI treatment seeking, condom use and uptake of counseling and testing services; - Creating a referral network to reach migrant/informal workers with government/ SACS supported facilities; - Facilitating access of workers to the welfare schemes of the health and labor departments; - Building partnership with the government and SACS services to ensure workers' access to treatment, counseling and ART; - Leveraging in-kind and financial contributions. The trade union will follow the SACS/NACO guideline for migrant/informal workers' interventions and will share progress on all key indicators. The ILO will develop additional indicators to capture access to government services by workers, and the inclusion of HIV in existing programs such as safety, health and insurance schemes. The ILO will document and share the results with NACO/SACS/USG for replication and scaling up. This will address the dual objectives of raising awareness on the need for HIV interventions targeting workers at risk as well as of sharing the lessons learned with the national program.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 13887	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14088	**Mechanism Name: UNAIDS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: UNAIDS II	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 250,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	250,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This project aims to strengthen capacity, systems and institutions -- at national level and across 35 states and Union Territories -- to generate and use strategic information for delivering HIV prevention, treatment and care programmes effectively. Interventions will be targeted for specific key stakeholders including SI/M&E staff and programmers of NACO and State AIDS Control Societies (SACS). The objectives are: 1) facilitating evidence informed decision making for effective HIV programming at decentralized implementation levels, by supporting generation of quality data; and 2) strengthening programmers' and implementers' capacities to generate, disseminate and utilize data and information under the third National AIDS Control Program/NACP III (and NACP IV).

The project shares a common vision with PEPFAR/India's Strategy for supporting availability of quality data and evidence, and data use in decision-making processes (Goal 2), and increasing human capacity to design, plan and monitor HIV services (Goal 4).

UNAIDS collaborates and seeks opportunities for cost-sharing with a range of SI partners to maximize technical collaboration and cost efficiency, including important investments of GOI.

The project will build core competencies of GOI staff to sustain these investments. Discussions are already underway with NACO to secure integration of the project's activities within NACP IV to ensure its sustainability.

Technical background documents and operational plans will be developed for all activities. Activity implementation will be closely monitored to ensure that deliverables/targets are achieved in terms of numbers, profiles, and geographical distribution of people trained.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**14088**		
Mechanism Name:	**UNAIDS**		
Prime Partner Name:	**UNAIDS II**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	250,000	0

Narrative:

In FY12 UNAIDS will strengthen identified gap areas in existing human capacities, data/information availability, and data collection/use for NACP through a series of activities.

National training workshop and ongoing mentoring (Health Economics): The aim is to develop capacities of a national core group of M&E officers/epidemiologists in health economics and cost effectiveness analysis to support NACP IV planning and effectively utilize resources. The core group will receive theoretical

training and mentoring by global experts.

Development of a National Capacity Building Plan for Operations Research (OR) and evaluation studies to support NACP IV: The aim is to develop a comprehensive plan to build OR capacity and implement OR networks at national/sub-national levels. UNAIDS and GOI partners will carry out a situational analysis of: Existing research capacities; lessons from past investments; and potential links with capacitated research institutes.

National workshop on evaluation studies; setting new priorities for evaluation and research for NACP IV: The aim is to develop a national evaluation and OR agenda and a roll-out plan. UNAIDS/NACO will convene a meeting of the Technical Resource Group (TRG) on Research and Evaluation to review catalogued HIV evaluation and OR material; explore possible regional/international cooperation; strengthen links between the Network of Indian Institutes on HIV/AIDS Research (NIIHAR) members and other institutes; and assess influence of OR on policy and programs.

National workshop on HIV estimation tools and the 2010/2011 HIV estimation process: UNAIDS together with the NACO TRG on Surveillance and Estimates will conduct a national training for a broader core group of epidemiologists/statisticians on tools/methods for 2010/11 HIV estimates. The training will be facilitated by members of the Global Reference Group on estimates and projections.

Regional workshops on 2010/11 national/state HIV estimates and support for sub-national level data analysis and program response formulation: Following national release of 2010/11 HIV estimates, UNAIDS with NACO/National Institute of Medical Statistics will roll out a series of regional workshops for state programmers. The aim is to disseminate national/state HIV estimates; clarify methods/tools used; interpret HIV estimates; discuss implications of estimates on program response and data needs.

Development of web based AIDSInfo data base and fact sheets: UNAIDS will support NACO to adapt the UNAIDS AIDSInfo database for generating HIV information at state and district levels. The aim is to facilitate regular data analysis and dissemination with updated data, including bubble charts for inter-state/inter-district comparisons.

Technical Assistance to the National AIDS Control Program in SI/M&E and Research: To implement SI/M&E and research activities planned under the CoAg and support NACO in NACP implementation, a portion of PEPFAR funding will be used to support staffing of UNAIDS' M&E team beginning in March 2012.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 14089	**Mechanism Name: WHO**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: World Health Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 256,808	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	256,808

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism provides technical assistance (TA) to the National AIDS Control Program (NACP) in strategic information (SI) policy, decision making and planning. Objectives are: 1) Strengthening national and sub-national capacity in SI including surveillance, estimations and projections, state-based modeling, district-level profiling by data triangulation, improving data management; and monitoring and evaluation (M&E); 2) Strengthening national capacity in HIV drug resistance surveillance and monitoring including improved routine monitoring of ART and PMTCT program outcomes; and 3) Strengthening operations research (OR) capacities. The objectives support Goal 2 (data for decision making) of the PEPFAR/India strategy.

USG funding supports 3 National Program Officers for the World Health Organization/India Country Office (WHO/India) to provide TA at the national level to build capacity at national, state and district level in SI and to institutionalize capacities in information management and evidence based policy making at state level. Capacity-building activities are expected to continue through 2017 to support full roll-out of improvements and newer methodologies for HIV surveillance (e.g. HIV case reporting and high risk group surveillance). The project provides TA, while all surveillance activities are funded by GOI. During this period, states will be capacitated to analyze and triangulate their own data, to enable improved policy and program

implementation, with technical support and leadership/guidance from the national level.

As project key achievements will be based on the outputs of the NACP in implementing the proposed activities, progress will be monitored through reports of relevant activities conducted by the national program.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	170,000

TBD Details

(No data provided.)

Construction/Renovation

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14089**
Mechanism Name:	**WHO**
Prime Partner Name:	**World Health Organization**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	256,808	0

Narrative:

In FY12, WHO/India will continue to support the national program to implement its SI workplan in phases

for routine surveillance, monitoring and evaluation. NACO and its partners identified several SI gaps during recent NACP-IV planning, and in detailed discussions within the technical program areas, including weaknesses at data generation points, poor use of data at service sites, insufficient management of data quality, lack of analysis for policy and program implementation, poor data on extent of HIV drug resistance (HIVDR) and an overall lack of human capacity in knowledge management and programme evaluation. At the national level, WHO will advocate for and support planning and preparation for implementation of newer elements such as the “rolling” Integrated Behavioral and Biologic Assessment (IBBA), HIV case reporting, HIV incidence and drug resistance studies, and improved methodologies for high risk group surveillance. This work will be done in close collaboration with other partners in HIV SI including CDC, UNAIDS and USAID. WHO will also strengthen core components of SI within the technical program areas including treatment, HIV testing and counseling, paediatric early infant diagnosis and prevention of mother to child transmission, and STI. The following activities will be prioritized for FY12:

1. Expansion of capacity building for cohort analysis and monitoring of HIVDR early warning indicators (EWI) for ART centers: WHO and partners will train Centers of Excellence (COE) to establish institutional capacity in this area, and then support COE to scale up nationally.
2. Support for implementation of two HIVDR surveys in support of India’s HIVDR plan (three surveys planned in 2013).
3. Support for continuation of the ‘rolling’ IBBA to achieve national coverage; 3 states undergo IBBA every year to cover the country in a phased manner.
4. Support for implementation of HIV case reporting in several states. During 2012 WHO will support NACO and its partners to prepare for implementation, which will begin in 2013 in 4 states with at least 2 districts in each.
5. Together with UNAIDS, provide ongoing technical support for estimations and projections of HIV burden for 2012 as well as to implement the annual/biannual sentinel surveillance rounds.
6. Review methods for high risk group surveillance and provide technical assistance to support improved implementation of high risk group surveillance for 2012.
7. Capacity building for operations research and program evaluation: WHO will provide technical support to prioritization of research questions, protocol-writing and formative evaluation of program areas. As there are major shifts in guidelines for pregnant women in 2012, WHO will provide intensified support for monitoring and ongoing assessment.
8. Provide technical support in data analysis and GIS for decision making and program implementation.
9. Provide technical support in strengthening capacities of program staff, state epidemiologists, M&E officers and other relevant staff involved in data generation, quality management and analysis.

WHO/India is currently developing its 5-year Country Cooperation Strategy with GOI, stakeholders, civil society and development partners. The WHO’s specific plan of work under this Implementing Mechanism will be finalized based on this Cooperation Strategy.

Implementing Mechanism Indicator Information

Redacted

Implementing Mechanism Details

Mechanism ID: 14838	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14839	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14840	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14841	**TBD: Yes**
REDACTED	

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services		20,000	110,000		130,000
ICASS		18,000	30,000		48,000
Management Meetings/Professional Developement		10,000	3,000		13,000
Non-ICASS Administrative Costs		55,000	19,000		74,000
Staff Program Travel		19,000	118,362		137,362
USG Staff Salaries and Benefits		128,000	470,000		598,000
Total	**0**	**250,000**	**750,362**	**0**	**1,000,362**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		20,000
Computers/IT		GHP-USAID		110,000

Services				
ICASS		GHP-State		18,000
ICASS		GHP-USAID		30,000
Management Meetings/Professional Developement		GHP-State		10,000
Management Meetings/Professional Developement		GHP-USAID		3,000
Non-ICASS Administrative Costs		GHP-State	USAID Non-ICASS Administration Costs include housing for PEPFAR Coordinator: lease ($40,000), guard services ($2,000), utilities ($4,000), supplies/maintenance ($3,000). Non-ICASS Administrative Costs also cover expenses of 14 staff: office supplies ($5,000), communications ($7,000), vehicle rental ($5,000), IT software/hardware expenses ($5,000), and miscellaneous operational expenses ($3,000, which cover unscheduled events, VIP visits, strategy development related meetings, etc.).	55,000

Non-ICASS Administrative Costs		GHP-USAID		19,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Capital Security Cost Sharing	270,000	36,000			306,000
Computers/IT Services	20,000				20,000
ICASS	210,000				210,000
Institutional Contractors	100,000				100,000
Non-ICASS Administrative Costs	255,200	55,000			310,200
Staff Program Travel	286,000	21,000			307,000
USG Staff Salaries and Benefits	985,992	43,638			1,029,630
Total	**2,127,192**	**155,638**	**0**	**0**	**2,282,830**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GAP		270,000
Capital Security Cost Sharing		GHP-State		36,000
Computers/IT Services		GAP		20,000
ICASS		GAP		210,000
Non-ICASS		GAP	Transportation of	255,200

Administrative Costs			things: $2000; Rent, communication and utilities: $221700; Printing & reproduction: $500; Contractual (maintenance office/vehicle): $20000; Material & supplies: $17000; Equipment: $49000 CDC has a vehicle which is now more than 9 years old. A vehicle requires a high level of maintenance and needs to be replaced with a new vehicle. A vehicle is needed in order to support the day to day activities of the program. CDC hopes to procure a less expensive version of similar vehicle.	
Non-ICASS Administrative Costs		GHP-State		55,000

Supporting Documents Library

Document Type	Name	Date of Upload
Ambassador Letter	Cover Letter from Ambassador Burleigh (COP 2012).pdf	3/1/2012
Budgetary Requirements Justifications	PEPFAR India Justification for OVC Investment under 10% (COP 2012).doc	3/1/2012
Functional Staffing Chart or Agency Management Chart	CDC India Management Chart (COP 2012).docx	3/1/2012
Functional Staffing Chart or Agency Management Chart	DOD India Management Chart (COP 2012).docx	3/1/2012
Functional Staffing Chart or Agency Management Chart	PEPFAR India Management Chart (COP 2012).docx	3/1/2012
Functional Staffing Chart or Agency Management Chart	USAID India Management Chart (COP 2012).docx	3/1/2012
Health Care Worker Salary Report	Consolidated HCW Statement.xlsx	6/7/2012
Health Care Worker Salary Report	PEPFAR India Health Care Worker Salary Support Table (COP 2012).xls	3/1/2012
Justification for Partner Funding	PEPFAR India Justification for Mechanisms Exceeding Single-Partner Funding Limit (COP 2012).doc	3/1/2012
Justification for Partner Funding	PEPFAR India Justification for Mechanisms Exceeding Single-Partner Funding Limit (COP 2012-June 2012-FINAL) (2).doc	7/6/2012
Obligation and Outlay Plan	CDC India - Projected Outlays for Continued Mechanisms (COP 2012).xlsx	3/1/2012
Obligation and Outlay Plan	DOL (India) - Projected Outlays for Continued Mechanisms (COP 2012).xls	3/1/2012
Obligation and Outlay Plan	HRSA India - Projected Outlays for Continued Mechanisms (COP 2012).xlsx	3/1/2012
Obligation and Outlay	USAID India - Projected Outlays for Continued	3/1/2012

Plan	Mechanisms (COP 2012).xlsx	
Obligation and Outlay Plan	USAID India - Projected Outlays for TBD Mechanisms (COP 2012).xlsx	3/1/2012
Obligation and Outlay Plan	USAID-Projected Outlays for Contd Mech (COP 2012)-June 12.xls	7/6/2012
Other	2011-05-10 India FY2011 COP Approval Memo.pdf	3/14/2012
Other	India FY 12 Vehicle Data.docx	3/21/2012
Other	Key HIV-related Government Structures in India (COP 2012).docx	3/1/2012
Other	National AIDS Control Program of India - Organogram (COP 2012).pptx	3/1/2012
Other	PEPFAR India Explanation for Delay in TBD Awards (COP 2012).docx	3/1/2012
Other	PEPFAR India list of Acronyms (COP 2012).docx	3/1/2012
Other	PIPPSE Narrative and Justification (2012-04-23 final).doc	7/6/2012