United States Department of State

Washington, D.C. 20520

FY 2015 India Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for India.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

India

Country Operational Plan

COP 2015

Strategic Direction Summary

August 28, 2015

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Goal Statement

PEPFAR resources reinforce the effective deployment of India's national AIDS response, which is largely funded through domestic and other primary funding sources such as the Global Fund and World Bank. This support is implemented principally through the provision of above-site level technical assistance supplemented with time-limited site-level support to test new interventions or innovations to be scaled by the national program. Referring to the UNAIDS 90-90-90 framework and 2020 goals, the U. S. President's Emergency Plan for AIDS Relief (PEPFAR) India has developed a country operational plan that will contribute to accelerated epidemic control by increasing detection, linkage, treatment, and retention, towards 80% ART coverage by 2017 among PLHIV, especially key populations (KP). PEPFAR India will work towards achieving 80% ART coverage and retention in two high burden clusters of three districts each in Maharashtra (Mumbai, Pune and Thane) and Andhra Pradesh (East Godavari, Guntur and Krishna); and among people who inject drugs (PWID) in three North-Eastern states: a. Manipur (Churachandpur, Imphal East, Imphal West, and Thoubal), b. Mizoram (Aizwal, Champai, and Lunglei) and c. Nagaland (Dimapur, Kohima, Mokochung, Tuensung, and Wokha). The PEPFAR India program is focused on populations and locations where PEPFAR investments will have the greatest possible impact in the shortest time. PEPFAR India will scale up counseling and testing in the high priority districts, and aims to test and counsel 541,131 people (163,694 through direct service delivery and 377,437 through technical assistance for service delivery improvement) in FY 2016. PEPFAR India aims to achieve 80% coverage and retention by targeting 136,574 people currently on ART (135,391 through direct service delivery and 1,183 through technical assistance for service delivery improvement) and 17,660 newly enrolled on ART (through technical assistance for service delivery improvement) during FY 2016. PEPFAR India will support improving the national response by strengthening critical components at the central, state, and district levels to reach KPs and deliver and monitor the HIV care cascade. A sustained technical assistance approach will continue in other districts in the country, focused on prevention of parent to child transmission, strategic information, TB/HIV, and lab system strengthening.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

India has a total population of 1.2 billion and as of 2013, 0.27% of the population or 2.1 million people were living with HIV, 2.2% of all deaths were attributed to AIDS (WHO, 2012), and 4.7% of all deaths were attributed to tuberculosis (TB). TB causes approximately 25% of deaths of all HIV positive persons in India. India has the third largest number of people living with HIV in the world, and contributes to 6% of new HIV infections, 2% of pregnant women living with HIV, 9% of HIV deaths, and 10% of HIV-TB co-infected individuals.

HIV Disease Burden - Distribution of HIV by Population:

The HIV epidemic has substantial variance by district, state, and region, and is concentrated in key populations. Most recent prevalence estimates are 8.8% among transgendered individuals (TG), 7.1% among people who inject drugs (PWID), 4.4% among men who have sex with men (MSM), and 2.7% among female sex workers (FSWs). Sexual transmission is estimated to account for nearly 90% of new infections in India (88.7% heterosexual, 1.3% homosexual); however, stigma related to homosexuality encourages MSM to remain hidden, and data on this population is less reliable and/or underreported. 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.

HIV Disease Burden - Distribution of HIV by Geography:

Over 80% of people living with HIV (PLHIV) live in 10 states (out of the total 29 states): Andhra Pradesh, Bihar, Gujarat, Karnataka, Maharashtra, Odisha, Rajasthan, Tamil Nadu, Uttar Pradesh, and West Bengal. These states also represent 70% of total new infections and 89% of AIDS-related deaths. Of these, Andhra Pradesh and Maharashtra together represent 35% of the estimated PLHIV, 15% of new HIV infections in India, 37% of AIDS-related deaths, and 29% of ART provision needed to reach 80% coverage. Andhra Pradesh (0.75%) and Maharashtra (0.42%) are also among the ten highest in terms of HIV prevalence. Noticeably high prevalence rates exist within certain districts and states amongst key populations, some of which clearly align with high levels of overall state/district disease burden and ART needs. For example, in Maharashtra, there is a high volume of PLHIV in addition to FSW, MSM, TG, and migrants. However, of the 116,000 estimated new infections among adults in 2011, only 31% were from the six high-prevalence states (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland, Tamil Nadu), with Nagaland and Mizoram showing comparatively higher overall prevalence since 2010. States such as Chandigarh, Chhattisgarh, Delhi, Jharkhand, Odisha, and Uttarakhand have shown rising trends in HIV prevalence.

Progress towards epidemic control:

The Government of India (GOI) has achieved substantial progress in containing the spread of HIV, with an overall reduction of 57% in estimated annual new HIV infections among the adult population, from 274,000 in 2000 to 116,000 in 2011 (with a 76% decline in high-prevalence states). The National AIDS Control Organization (NACO) within the Ministry of Health and Family Welfare (MOHFW) is currently implementing its fourth national HIV/AIDS control plan (2012-2017). Over the past decade the national HIV program has made substantial progress in expanding HIV service delivery infrastructure, which currently consists of 1,870 combination prevention service delivery points for key populations (the combination prevention "Targeted Intervention" program, TI), 15,606 integrated HIV testing and counseling centers (ICTCs), 466 ART centers, 870 Link ART Centers (LACs), 228 Link ART Centers "plus", 264 CD4 testing sites, 224 care and support centers (CSCs), 10 Centers of Excellence, 7 Pediatric Centers of Excellence, and 9 viral load testing sites. The ART centers are established based on HIV prevalence, volume of PLHIV,

and capacity of the institution to provide comprehensive services to eligible PLHIV. ART centers have been organized so that LAC+ provide second line treatment to eligible PLHIV, and LACs provide follow-up for PLHIV closer to home after initiation at an ART center.

Major gaps in achieving epidemic control:

Data from the recent annual report show substantial progress but also gaps in the continuum of response cascade. For example, while India is reaching over 75-80% of the estimated key population groups it targets (except TGs) with combination prevention for each key population under India's "targeted intervention" program, only 51-64% are tested for HIV and the positivity rates of those tested within each target group is far below the estimated prevalence captured through surveillance activities. Referrals to care and treatment amongst key population individuals who test positive is above 90%, and currently India reports having 79% of its total PLHIV registered for care. A significant gap currently exists in the cascade from care to antiretroviral treatment (ART) as only 36% of total PLHIV are currently on ART (UNAIDS, 2013). However, if successful with the recently submitted Global Fund Concept Note, India aims to implement 2013 WHO treatment guidelines for treatment initiation from a CD4 count of 500. Current estimates show that 82% of all PLHIV are in need of treatment at CD4 500, and by April 2017, India aims to have 1.25 million on ART (80% coverage, CD4 500). Given the current figures of patients registered in care, which are currently being validated through a national ART assessment with support from PEPFAR, the revisions in the national guidelines should allow patients registered in care to quickly access treatment services with additional infrastructure and ARV drugs requested from the Global Fund. Results from the national ART assessment will serve as a foundation to create a sound implementation plan for roll-out of the revised guidelines. Additionally, the government is considering test and treat for key populations as part of its treatment strategy. Data gaps are the main challenge, in particular for monitoring of ART retention and adherence, for HIV counseling and testing, as well as a lack of ART coverage data among key populations and other vulnerable groups, low ART coverage among all populations with known data, and absence of data on viral load testing.

NACO is supporting the provision of opioid substitution therapy (OST) services through more than 150 OST centers and provides free substitution treatment to approximately 18,000 PWID. A national plan for expansion of OST services is currently being implemented across 32 states with a view to establish more than 300 OST centers, so as to cover at least 20% of the estimated PWID population with OST services, and to shift from buprenorphine to methadone as the treatment standard. As part of scale-up efforts, 45 new OST centers were established during 2013-2014, which resulted in doubling of the OST coverage in the country in one year.

A systematic review of existing research literature on AIDS stigma (30 publications) was published in the Journal of Social Aspects of HIV/AIDS Research Alliance. Involuntary disclosure of a person's HIV status in the health setting through health staff is reported to be the beginning of the stigmatization experience for most positive people in India. Potential loss of social status for

self and family, possible loss of job, and rejection from spouse, are reasons reported among men with HIV which influence their disclosure decisions and form the basis for felt and self-stigma. Similarly, the anticipated negative impact on children's school admission and likely rejection from spouses or in-laws, as reported among HIV positive women, affect their decisions to share information on HIV status with others. Health care settings are reported to be the most significant contexts for stigma and discrimination in India.

Data Availability and Limitations:

To prioritize populations and geography, the PEPFAR India team utilized national, state, and district level epidemiologic and programmatic data publicly available, including HIV sentinel surveillance which includes state-wise estimates of key populations and PLHIV, national and state level programmatic data published in the National AIDS Control Program (NACP) annual report, state HIV epidemic fact sheets, and district epidemiologic profiles. Limitations in data for decision making include old data, in particular size estimates and HIV prevalence for key populations, lack of published age and sex disaggregation for epidemiologic and programmatic data, lack of robust HIV incidence data, lack of data on ART coverage among key populations and other vulnerable populations, fewer data points publicly available at the district level, lack of data on viral load, and lack of real-time programmatic data. In the next year, India will publish updated HIV prevalence estimates and behavioral data from an integrated behavioral and biological survey (IBBS) for FSW, PWID, MSM, TG, migrants (destination states and districts), and migrant spouses (source states and districts) underway in 262 domains (districts or collection of districts). Additionally, a demographic health survey (DHS) will include regional general population HIV prevalence and behavior data. A PEPFAR-funded ART assessment will also be published and serve as the foundation for care and treatment technical assistance for the PEPFAR India program.

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	1,210,193,422		75,837,152	6%	82,952,136	7%	510,632,022	42%	540,772,113	45%	Source: National Commission on Population, Ministry of Health and Family Welfare: 2011 census data (http://populationcommission.nic.in/content/935_1_AgeStructureSexratios.aspx) Note: Age- and sex disaggregation available and provided are for age-groups 0-6 years and 7 + years
Prevalence (%)		0.27%		*No data*		*No data*		0.32%		0.22 %	State HIV Epidemic Factsheet, July 2014: 2011 data
AIDS Deaths (Yr)	147,729		*No data*		*No data*		*No data*		*No data*		State HIV Epidemic Factsheet, July 2014: 2011 data; Adults: 137,516; Children: 10,213
PLHIV	2,088,642		*No data*		*No data*		*No data*		*No data*		State HIV Epidemic Factsheet, July 2014: 2011 data; Age disaggregation: Adults: 1,943,197 and Children 145,455; Sex disaggregation is given as 1,272,663 males and 815,975 females
Incidence Rate (Yr)		*No data*		*No data*		*No data*		*No data*		*No data*	
New Infections (Yr)	130,978										State HIV Epidemic Factsheet, July 2014: 2011 data; Adults: 116,456; Children: 14,522
Annual births	25,595,000										The State of the World's Children, 2015, UNICEF: 2013 data; Sex ratio is 940:1000 (Female: Male).
# and % >= 1 ANC visit	20,671,240	75%	*No data*	*No data*			*No data*	*No data*			Source: Health and Family Welfare Statistics in India, 2014
Pregnant women needing ARVs	38,202	0.35%									State HIV Epidemic Factsheet, July 2014: 2011 data
Orphans (maternal, paternal, double)	*No data*		*No data*		*No data*		*No data*		*No data*		
TB cases (Yr)	2,600,000		*No data*		*No data*		*No data*		*No data*		TB India 2014, Annual Status Report, Ministry of Health and Family Welfare, 2014 (total patients registered for TB treatment) Note: TB prevalence is 2,600,000 (Source: Global Tuberculosis Report 2014; data provisional as not yet approved by Ministry)

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
TB/HIV Co-infection	120,000	5.95%	*No data*	*No data*	*No data*	*No data*	*No data*	*No data*	*No data*	*No data*	Global Tuberculosis Report 2014 Data is for HIV positive incident TB cases. Data provisional as not yet approved by Ministry.
Males Circumcised	*No data*	*No data*			*No data*	*No data*			*No data*	*No data*	
MSM	313,000	4.43%									NACO Annual Report, 2013-14; State HIV Epidemic Factsheet, July 2014: 2011 data
FSW	868,000	2.67%									NACO Annual Report, 2013-14; State HIV Epidemic Factsheet, July 2014: 2011 data
PWID	177,000	7.14%									NACO Annual Report, 2013-14; State HIV Epidemic Factsheet, July 2014 : 2011 data
TG	70,000	8.82%									NACO Annual Report, 2013-14; State HIV Epidemic Factsheet, July 2014 : 2011 data
Long Distance Truckers	*No data*	2.59%									NACO Annual Report, 2013-14; State HIV Epidemic Factsheet, July 2014 : 2011 data
Single Male Migrants	*No data*	0.99%									NACO Annual Report, 2013-14; State HIV Epidemic Factsheet, July 2014 : 2011 data

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)											
				HIV Care and Treatment					HIV Testing and Linkage to ART		
	Total Population Size Estimate	HIV Prevalence	Total PLHIV	In Care	On ART	Retained on ART 12 Months	Reached by prevention program	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)	(#)	(#)	12 Months	(#)	(#)	(#)
Total population	1,210,193,422	0.27%	2,088,642	1,700,000	810,339^	*No data*		*No data*	13,030,604***	228,226	No data
Population <15	No Data*	No data	145,455	106,824	44,592^	*No data*		*No data*	*No data*	*No data*	*No data*
Pregnant Women	29,000,000**	0.35%	38,000**	*No data*	*No data*	*No data*		*No data*	9,752,124***	12,008***	6,772**
TB/HIV Co-Infected	120,000	5.95%	120,000	*No data*	*No data*	*No data*		*No data*	887,903^^	45,599^^	33,299
FSW	868,000	2.67%	23,175	*No data*	*No data*	*No data*	718,998	*No data*	463,035	2,503	*No data*
MSM	313,000	4.43%	13,866	*No data*	*No data*	*No data*	258,660	*No data*	163,473	854	*No data*
PWID	177,000	7.14%	12,637	*No data*	*No data*	*No data*	13,200	*No data*	79,710	1,042	*No data*
TG	70,000	8.82%	6,174	*No data*	*No data*	*No data*	131752	*No data*	6,758	*No data*	*No data*
Long Distance Truckers	*No data*	2.59%	*No data*	*No data*	*No data*	*No data*	1,108,065	*No data*	*No data*	257	*No data*
Single Male Migrants	*No data*	0.99%	*No data*	*No data*	*No data*	*No data*	2,923,854	*No data*	*No data*	1,035	*No data*

Sources:
*: Age break-up available is 0-6 years (164,478,150); and 7 years & above (1,046,091,423). Source: Health and Family Welfare Statistics in India, 2013: 2011 data
**: PPTCT Assessment Report, NACO, August 2014
***: NACO Annual Report 2013-14 (results for 2013-14)
^: Source: wwww.naco.gov.in; Number of PLHIV alive and on ART at the end of September 2014

1.2 Investment Profile

India is a lower-middle income country with gross national income (GNI), PPP adjusted, of $5,350 USD per capita (World Bank, 2013). The major source of financing for India's $2.24 billion, five-year HIV response (2012-2017) is domestic resources (63%), a major increase from the previous five years, where international donors supported approximately 75% of overall costs. In the latter years of the five-year plan, domestic resources are expected to provide upwards of 80% of the total financing. The Global Fund for AIDS, Tuberculosis, and Malaria (GF) is estimated to support 14% of the five-year plan, the World Bank 10%, and other extra budgetary partners, including PEPFAR, 13%. The World Bank support is via a credit of $250 million to support prevention programs and GF continues to provide significant funding for PMTCT, HIV care and support, TB/HIV, and commodity procurement ($800 million New Funding Model 2014-2016).

The GOI overall budget for 2015-16 has identified addressing India's fiscal deficit as one of its top priorities. The GOI seeks to reduce the current deficit of 4.1% of Gross Domestic Product (GDP) (2014-15) stepwise down to 3.0% of GDP in 2017-18. One of the consequences of this measure has been the reduction in allocation of resources to several sectors, including public health, down 5.7% overall. This comes on the heels of a 20% cut in 2014-2015 that prompted significant public outcry. Though federal public health spending has been cut, the new budget includes the key recommendation of the Fourteenth Finance Commission to transfer 42% of federal taxes to the states, an increase from the current level of 32%. The impact of significantly higher devolution to states will depend on the extent to which states prioritize health and their capacity to efficiently allocate and utilize additional resources. The reduced federal allocation for health care is likely to have some impact on health service provision, including the national HIV program, although the magnitude of impact on key national health programs is somewhat uncertain.

The five-year HIV budget is allocated primarily toward prevention (63%), an additional 30% towards care, support and treatment services, 4% for institutional strengthening, and 3% for strategic information management systems. However, the costing of the five-year strategy has not been updated to reflect changes in program policy, such as the 2013 WHO guidelines, updated partner contributions, nor changes in the domestic budget allocations. Adoption of revised WHO treatment guidelines adds to the overall financing needs as estimated in the five-year strategy. As a result, the majority of HIV financing requested from the Global Fund through 2017 focuses on care and treatment support. As reported in the Global Fund Concept Note, out of the total budget of $769 million required for treatment, care, and support from 2015-2017, 62% is expected to be financed by domestic funds, and the remainder is being requested to be financed by the Global Fund (11% in the above-allocation request).

Analyzing commodity specific expenditures, India and the Global Fund are the only financers. During India's 2013-2014 fiscal year, all ARV drugs were funded by the Global Fund. The GOI intends to expand its domestic budgetary support for ARV drugs, contributing 20%, 50%, and 70% of the total requirements over the next three GOI fiscal years.

Regarding expenditures, the historical spend has been around 80% of the approved health budget. The last HIV expenditure data published for India was in 2010. However utilizing the 2014 NACO annual report, which reported the total expenditures by source for the first year of the fourth HIV plan (2012-2013), domestic resources funded 72% of the national response, with the Global Fund financing 28%. However, PEPFAR and other partner expenditures were not reported in the annual report, when they did contribute to the national response.

Table 1.2.1 Investment Profile by Program Area (2012-2013, NACO Annual Report, 2014)

Program Area	Total Expenditure	% GOI	% GF	% PEPFAR	% Other
Clinical care, treatment and support					
Community-based care					
PMTCT					
HTC					
Priority population prevention		*No disaggregated data available*			
Key population prevention					
OVC					
Laboratory					
SI, Surveys and Surveillance					
HSS					
Total	**219,350,000**	**72%**	**28%**		

Table 1.2.2 Procurement Profile for Key Commodities (2014-2015 GOI FY)

Program Area	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
ARVs		0%	80%	0%	0%
Rapid test kits		0%	100%	0%	0%
Other drugs	*Data not published*	0%	100%	0%	0%
Lab reagents		0%	100%	0%	0%
Condoms		0%	100%	0%	0%
Other commodities		0%	100%	0%	0%

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives					
Funding Source	**Total Non-COP Resources**	**Non-COP Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	$16,500,000	$0	0	$0	
USAID TB	$10,500,000	$0	1	$250,000	CHALLENGE TB: improve case detection and treatment adherence in TB/HIV co-infected in private sector of Mumbai: co-funded by BMGF
USAID Family Planning	$19,000,000	$0	0	$0	
CDC Global Disease Detection/EIS	$3,800,000	$0	0	$0	
PEPFAR Central Initiatives	$1,800,000	$1,800,000	2	$300,000	Lab: leverage HIV lab infrastructure to strengthen public health lab system LCI: Strengthen capacity of civil society orgs in the HIV/AIDS country response
Total	**$51,600,000**	**$7,000,000**	**3**	**$800,000**	

1.3 National Sustainability Profile

Results from the Sustainability Index demonstrate that India has a sustainable HIV program and is likely to make considerable progress through 2017. However, the index highlights four broad areas which could improve toward a more sustained response: 1) Institutionalized Data Availability; 2) Health Financing and Strategic Investments; 3) Service Delivery; and 4) Enabling Environment.

Institutionalized Data Availability:

While expenditure data are reported in NACO Annual Reports, the information is not disaggregated by sub-national unit or program area. In terms of epidemiologic data, India does not currently collect incidence data although incidence data is modeled. Additionally, the country does not collect data on viral load, although viral load testing occurs in nine testing facilities for monitoring of treatment adherence.

Health Financing and Strategic Investments:

India's health expenditure is 1.3% of GDP and domestic revenue as a percentage of GDP is 12.3%. However, other indicators such as India's increased allocation of funding for the HIV program, including ARV drug costs previously fully financed by the Global Fund and its domestic financing of key population services, indicate significant commitment.

Service Delivery:

While the national program has greatly expanded its HIV service delivery infrastructure, including its services specifically for key populations, the national HIV program is still in the process of rolling out 2013 WHO treatment guidelines for pregnant women (Option B+), is soon to adopt treatment policies for all PLHIV (CD4 500), and is considering test and treat for key populations if the Global Fund Concept note proposal is successful. While non-discriminatory laws are not yet on the books, India's HIV/AIDS Bill, which will address most of the issues related to stigma and discrimination against PLHIV, is currently undergoing extensive review and discussions within the Indian Parliament.

Enabling Environment:

India retains Penal Code 377, an anti-homosexuality law, on its books although efforts are underway to remove the law from the Constitution.

The national government and civil society were consulted and provided inputs to the sustainability index. Both acknowledged the strengths of the India program given its long vibrant history. Areas of improvement were also acknowledged and it was agreed that India is likely to progress in the coming years in areas of HIV service delivery, commodity security, and laws and rights for PLHIV and key populations. However, civil society raised some concerns regarding a weakening civil society engagement with government that would not be reflected in the tool. More details can be found in the civil society consultation report.

Based on the findings for the Sustainability Index, PEPFAR support outlined in this COP will largely assist the India program to progress in the domain of epidemiologic data availability and service delivery. Areas where PEFPAR does not have a comparative advantage to impact include health financing and strategic investments. In terms of the enabling environment, PEPFAR will support specific activities to increase access to HIV services for key populations.

1.4 Alignment of PEPFAR investments geographically to disease burden

Given the technical collaboration approach of the PEPFAR India program, few resources were reported being expended in FY 2014 at the point of service delivery or site-level (15%), whereas above-site programming represented 85% of all expenditures. The majority of above-site expenditures were on Health System Strengthening (HSS) activities (62%), Strategic Information and Surveillance (15%), and Program Management (8%). The majority of HSS expenditures were within institutional capacity development for government (38%) and civil society (20%). Expenditures for supply chain management represented 16%, followed by technical areas specific guidelines and policies (6%), Training of Trainers (6%), lab strengthening (4%), health information systems (3%), human resource management and retention (2%), and curriculum development (2%).

Site-level expenditures consisted of a one-time purchase of GeneXpert machines in high volume ART centers and an innovative pilot on the continuum of care for key populations in Maharashtra (largely site-level personnel). In-service training (laboratory and care and treatment) comprised a nominal 1.77% of the total expenditure despite the vast outputs of trainings conducted with

PEPFAR India support. This is because the PEPFAR India model provides technical assistance to regional Training of Trainers (ToT), as evident in above-site HSS expenditures, while the national program covers the recurrent expenditures to conduct the trainings. Looking at program areas, the majority of PEPFAR resources were spent on prevention (31%) and strategic information and surveillance (31%), followed by Facility Based Care and Treatment (17%) largely due to the one-time expenditure of GeneXpert machines. Within prevention programming, 37% was expended on general population, 2% on other vulnerable populations such as migrants, 21% on FSW programming, 8% on MSM/TG, 7% on PWID. Overall, PEPFAR expenditures were not well aligned with identified core populations and thus changes are anticipated in FY 2016 reporting, such as a decrease in general population prevention expenditures and an increase in FSW, MSM/TG, and PWID.

Figures 1.4.1 and 1.4.2 compare PEPFAR expenditures in 2014 to burden of disease by state. Spend per PLHIV by PEFPAR ($10.26) is extremely low, which is expected given its technical collaboration (TC) role. Thus, overall expenditures do not show a correlation between PEPFAR spend and PLHIV, despite the fact that 80% of the sub-national PEPFAR India expenditures occurred in the 10 highest burden states. Outliers in Figure 1.4.1 are present for two reasons: First, modest in-service training investments of less than $10,000 in the areas of lab and care and treatment greatly impacted states and territories with low volume of PLHIV (less than 15,000). Secondly, Chandigarh, Goa, Haryana, Kerala, Meghalaya, Puducherry, and Uttarakhand are outliers due to support for Technical Support Units (TSUs) which oversee combination prevention programs for key populations (TIs) and technical support for supply chain management in Haryana, Himachal Pradesh, Jharkhand, Punjab, and Uttarakhand. Other higher priority states are currently receiving TSU support from other donors. PEPFAR support to the supply chain will not continue in FY 2016 (COP15 implementation) as NACO has indicated support is being provided by another partner.

Figure 1.4.1 2014 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU

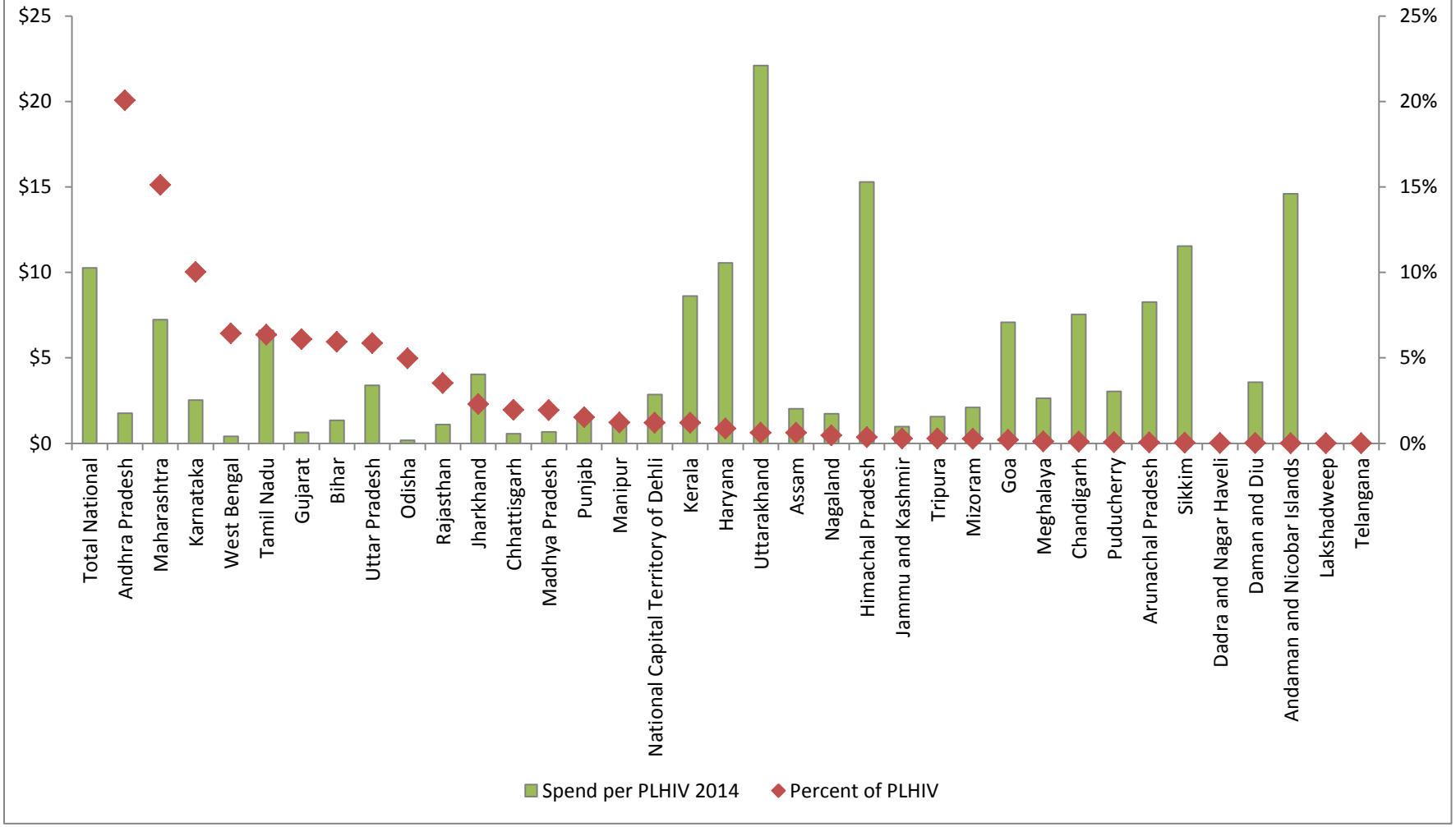

Figure 1.4.2 Total Expenditure, PLHIV, and ART Coverage by SNU

SNU	Total PLHIV	HIV Prevalence	ART Coverage	Total FY14 PEPFAR Expenditure
Andhra Pradesh	419,180	0.75	179,633	$736,340
Maharashtra	315,849	0.42	176,770	$2,286,959
Karnataka	209,368	0.52	112,677	$528,384
West Bengal	134,286	0.22	20,300	$54,506
Tamil Nadu	132,590	0.28	83,135	$875,726
Gujarat	127,092	0.33	41,715	$82,218
Bihar	123,875	0.2	21,967	$167,016
Uttar Pradesh	122,522	0.1	36,217	$416,117
Odisha	103,862	0.4	9,539	$19,128
Rajasthan	73,545	0.17	21,908	$80,947
Jharkhand	47,976	0.25	5,187	$193,967
Chhattisgarh	40,942	0.27	6,368	$22,852
Madhya Pradesh	40,451	0.09	12,240	$26,917
Punjab	31,961	0.18	14,399	$48,295
Manipur	25,369	1.22	9,729	$27,976
National Capital Territory of Delhi	25,161	0.22	17,588	$71,829
Kerala	25,090	0.12	9,286	$216,368
Haryana	17,876	0.11	5,740	$188,818
Uttarakhand	12,862	0.22	2,133	$284,317
Assam	12,804	0.07	3,085	$25,933
Nagaland	9,716	0.73	4,999	$16,871
Himachal Pradesh	7,346	0.17	2,839	$112,281
Jammu and Kashmir	5,812	0.08	1,478	$5,696
Tripura	5,684	0.24	545	$8,874
Mizoram	5,346	0.74	3,296	$11,250
Goa	4,126	0.43	2,125	$29,238
Meghalaya	2,381	0.13	571	$6,266
Chandigarh	1,814	0.28	3,697	$13,681
Puducherry	1,254	0.15	1,020	$3,805
Arunachal Pradesh	1,156	0.013	49	$9,553
Sikkim	593	0.15	104	$6,846
Dadra and Nagar Haveli	289	0.14		$0
Daman and Diu	268	0.18		$957
Andaman and Nicobar Islands	195	0.08		$2,848
Lakshadweep				$0
Telangana				$10,427
Total	**2,088,641**	**0.27**	**810,339**	**$6,593,206**

1.5 Stakeholder Engagement

NACO within the Ministry of Health and Family Welfare (MOHFW), the Global Fund Country Coordinating Mechanism (CCM) and Country Team, and civil society have been consulted on PEPFAR's (1) required data analysis for resource allocation for COP15 and reporting requirements; (2) investment approach to address barriers to saturation of combination prevention in areas with high HIV burden to reach epidemic control; and (3) PEPFAR India's proposed activities, including the transition of some activities no longer to be supported by PEPFAR. New leadership at NACO has acknowledged the need for timely and quality data for program management.

The PEPFAR India team will continue to engage all stakeholders through routine coordination mechanisms that exist, including biannual work plan meetings with NACO and quarterly donor partner meetings conducted by UNAIDS. Based upon recommendations from consultations with civil society organizations, PEPFAR India and civil society will establish regular meetings.

2.0 Core, Near-Core and Non-Core Activities

PEPFAR India considered the activities required to accelerate sustained epidemic control in a concentrated epidemic, the current country investment portfolio in which PEPFAR India is not the primary funder of the national response, and the gaps/bottlenecks impacting leakage of patients in the care continuum cascade to define core, near-core, and non-core activities for program implementation in FY 2016. As a result, **core** activities will focus on 1) strengthening the cascade of care between community and facility with special focus on FSWs, PWID, MSM and transgender, with a focus on improving monitoring and evaluation in priority geographic clusters; 2) accelerated and focused technical assistance for PWID and their partners mentoring health care workers for increasing enrollment of PWID, medication-assisted therapy, real time monitoring system, and scale-up of partner/family based counseling and testing in priority districts of three North-Eastern states (Manipur, Mizoram, and Nagaland); 3) treatment coverage and retention for adults and children in priority geographic clusters, including TB/HIV identification and treatment and potential support for test and treat for key populations; 4) laboratory capacity for HIV testing, CD4, STI, EID, and viral load testing facilities with focus on priority geographic clusters, and; 5) surveillance, data quality and use, and national health information systems to collect, analyze and use priority epidemiological and program data. **Near-core** activities include: 1) operations research; 2) national and sub-national blood safety activities; 3) salary support for non-technical positions; 4) time-limited activities where PEPFAR anticipates building capacity or transitioning support within three years; and 5) migrants and truckers, currently part of the time-bound Thane District Network Model. **Non-core** activities include: 1) information, education, and communications (IEC) for general population, 2) global transfer programming to Africa and Asia which does not impact India's HIV epidemic, 3) FP/HIV integration, 5) supply chain, 6) Global Fund CCM support, and 7) commodity, procurement, and equipment support.

PEPFAR India will provide support to India's national HIV program through two methods: 1) accelerated epidemic control by increasing detection, linkage, treatment, and retention, towards 80% ART coverage among PLHIV, especially KPs in two high burden clusters of three districts each in Maharashtra (Pune, Mumbai and Thane) and Andhra Pradesh (East Godavari, Guntur and Krishna); and among people who inject drugs (PWID) in three North-Eastern states (Manipur, Mizoram and Nagaland); and 2) provision of sustained technical assistance in other districts based upon gaps/bottlenecks and service delivery targets. Given the need to scale combination prevention activities and improve HIV testing uptake for key populations, pilots of innovative models of service delivery in low yield sites will be discontinued with a shift toward community-based testing as a new strategy. Technical assistance which is not currently allocated at the most appropriate level (e.g. national vs. state) is being adjusted accordingly in this COP submission. Technical assistance which is not targeted to priority populations or is not addressing gaps/bottlenecks within the continuum of response cascade is classified as non-core and will end in 2016. An exception is the inclusion of truckers which are currently part of the time-bound Thane District Network Model. Unless IBBS results indicate much higher prevalence than previously suspected in this population, truckers will be considered near-core. Global transfer programming was determined to be non-core due to its focus on epidemics outside of India. A limited number of activities will be phased out by March 2016, with remaining activities focusing on bringing best practices to India to accelerate epidemic control for KPs, HSS, ART, and PWID aspects of programming. See Appendix A for full list of core, near-core, and non-core activities and transition plans.

3.0 Geographic and Population Prioritization

Data Availability and Limitations:

To prioritize populations and geography, the PEPFAR India team utilized national, state, and district level epidemiologic and programmatic data publicly available including HIV sentinel surveillance which includes: state-wise key populations and PLHIV, national and state level programmatic data published in the National AIDS Control Program (NACP) annual report; state HIV epidemic fact sheets; and district epidemiologic profiles. PEPFAR India team conducted a series of enhanced data analysis and interpretation steps to ensure that the program is focused on the populations and locations where PEPFAR investments will have the greatest possible impact in the shortest time.

Limitations in data for decision making include: old data, in particular size estimates and HIV prevalence for key populations; lack of published age and sex disaggregation for epidemiologic and programmatic data; lack of robust HIV incidence data; lack of ART coverage data for key populations and other vulnerable populations; fewer data points publicly available at the district level; lack of data on viral load; and lack of real-time programmatic data. In the next year, India will publish updated HIV prevalence estimates and behavioral data from an IBBS for FSW, PWID, MSM, TG, migrants (destination), and migrant spouses (source) underway in 262 domains (districts or collections of districts). Additionally, a demographic health survey (DHS) will include

regional general population HIV prevalence and behavior data. A PEPFAR-funded ART assessment will also be published and serve as the foundation for care and treatment technical assistance for the PEPFAR program.

Population Prioritization:

Based upon available population estimates, HIV burden and prevalence, service delivery coverage, and current technical assistance needs identified by the GOI based upon other donor support, PEPFAR India has prioritized technical assistance activities focused on PWID, FSWs, MSM, TG, HIV-infected adults and children, pregnant women, and TB/HIV co-infected individuals.. , Migrants will be covered as a near-core population unless the upcoming IBBS results reflect higher prevalence than expected. Population prioritization was triangulated with geographic epidemiologic and program information to focus PEPFAR India's COP 2015 activities.

Geographic Prioritization:

The PEPFAR India team conducted a series of enhanced data analysis and interpretation steps to ensure that the program is focused on the highest-burden populations and locations. Two states, Andhra Pradesh and Maharashtra, were selected because they have the highest burden of PLHIV (20% and 15%, respectively, of the national PLHIV burden). Based on district epidemiologic data, PEPFAR India has prioritized two high burden clusters of three districts each in Maharashtra (Mumbai, Pune and Thane -- these selected three districts comprise of 38% of the state's burden of PLHIV) and Andhra Pradesh (East Godavari, Guntur and Krishna -- these selected three districts comprise of 31% of the state's burden of PLHIV). In these selected districts, PEPFAR India will support the GOI in increased detection among KPs, partner testing, pregnant women, and children; increased linkage to and retention in care; and increased initiation and retention on ART.

TB/HIV Geographic Focus: Based upon the geographic overlap of the TB and HIV epidemic, focused PEPFAR India HIV/TB activities will be sustained in the highest burden districts of Andhra Pradesh and Maharashtra, as well as eight Northern States (Bihar, Chhattisgarh, Jharkhand, Odisha, Madhya Pradesh, Rajasthan, Uttar Pradesh, and Uttarakhand) which have a high burden of TB, low TB/HIV screening and show trends of rising HIV infections.

PWID: Injection Drug Use (IDU) has been identified to be the major vulnerability fuelling the epidemic in the North-Eastern States. PEPFAR India has also focused its efforts among people who inject drugs (PWID) in three North-Eastern states (Manipur, Mizoram and Nagaland). Analysis shows that a special focus is needed for the PWID population within these states to scale up combination prevention services and medication assisted therapy (MAT), and to increase ART coverage among PWID, which currently ranges from 37% to 51%.

Pregnant women and exposed infants: The states of Chhattisgarh, Haryana and Punjab were identified by NACO as focus states for PMTCT-Private Sector intervention as the number of new HIV infections is rising in these states, and the private sector provides ANC services to a large proportion of women in these states. To avoid duplication, only those states with high HIV burden and which are not covered under the GFATM were selected by NACO. Importantly, the

estimated number of HIV positive pregnant women is also high with 308 in Punjab, 195 in Chhattisgarh and 168 in Haryana (2013-14), and concentrated in four high prevalence districts across these states with a combined population of around 16 million. According to National Health Mission data 2013-14, a high proportion of pregnant women sought antenatal care from private health institutions (Punjab 57.8%, Haryana 45% and Chhattisgarh 25%). Institutional deliveries in private sector institutions were also high (Punjab 41.3%, Haryana 32% and Chhattisgarh 15%). Of the 1,720,000 estimated pregnant women in the three states, the estimated number of pregnant women who will be reached through sustained PEPFAR-supported PMTCT services in the private sector will be approximately 749,136 (43% of estimated pregnant women).

National level technical support, including support for laboratory and blood safety, will also be sustained to complement and maximize GOI investments.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

PEPFAR India has set service delivery targets in the states of Andhra Pradesh, Maharashtra, Manipur, Mizoram, and Nagaland. PEPFAR India provides direct support for targeted interventions and implementation of the District Network Model to increase coverage of prevention to care continuum services by reaching 18,249 KPs and 220,290 priority populations in Thane District, Maharashtra State. PEPFAR India is supporting three care and support centers that provide care and support services outside health facilities, and 28,338 HIV-infected adults and children will receive care and support services outside of the health facility. The package of services includes psychosocial counseling, treatment adherence counseling, referral and linkages to social welfare and protection schemes. Community-based testing among KPs will be piloted in Andhra Pradesh, Maharashtra, Manipur and Mizoram. Low threshold programs such as needle syringe program delivery models, take home dosing and task shifting in the OST program will be implemented in high burden districts of Manipur, Mizoram, and Nagaland. In the three North East priority districts, PEPFAR/India has planned to enroll 6,106 IDUs on methadone treatment, and will ensure PWIDs requiring ART are linked to service delivery sites and initiated on treatment. Further, PEPFAR/India will optimize the quality of services for PWID in these priority districts.

PEPFAR India's technical assistance activities will contribute to India's national program reaching 80% coverage of ART (CD4 500) by April 2017, estimating targets for the number of patients currently on ART from an expected increase over previous baselines derived from targeting implementation in the priority districts (Table 4.1.1). India will pursue focused technical assistance on priority states and districts, with aggressive scale up in the districts of Guntur and Krishna, scale up to saturation in the districts of East Godavari, Mumbai, and Pune, and will

Table 4.1.1 ART Targets in Priority Sub-national Units for Epidemic Control

	SNU	Total PLHIV	Expected current on ART (2015)*	Additional patients required for 80% ART coverage*	80% of PLHIV	FY16 Target Current on Care CARE_CURR	FY16 Target New on Care CARE_NEW	Est. ART Coverage by APR16 ALL PLHIV as Denom	Est. ART Coverage by APR16 80% PLHIV as Denom	FY16 Target Current on ART TX_CURR	FY16 Target New on ART TX_NEW
Andhra Pradesh	East Godavari	42575	16683	17377	34060	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Guntur	49074	14740	24520	39260	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Krishna	37145	12155	17561	29716	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Maharashtra	Mumbai	61113	24182	24709	48891	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Pune	39111	16510	14779	31289	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Thane	18448	10080	4679	14759	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Manipur	Churachandpur	3934	1532	1616	3148	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Imphal East	8971	3171	4006	7177	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Imphal West	8290	2830	3802	6632	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Thoubal	1184	467	481	948	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Mizoram	Aizwal	3799	2798	242	3040	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Champai	532	390	36	426	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Lunglei	311	268	-20	249	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Nagaland	Dimapur	5148	2884	1235	4119	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Kohima	2053	905	738	1643	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Mokokchung	747	269	329	598	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Tuensang	1519	583	633	1216	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Wokha	NA	NA	NA	NA	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Total	283,954	110447	116723		[REDACTED]	[REDACTED]			[REDACTED]	[REDACTED]

***Figures from the District Epidemiological Profiles, January 2014/12**

sustain coverage in Thane. The remaining 12 districts in the Northeastern corridor of Manipur (Churachandpur, Imphal East, Imphal West, and Thoubal), Mizoram (Aizwal, Champai, and Lunglei) and Nagaland (Dimapur, Kohima, Mokochung, Tuensung, and Wokha) will aim for aggressive scale up within the key population of PWID[1]. It is expected that during the coming year, PEPFAR India will work with NACO and partners on improving PLHIV estimations at the district-level based on new/updated data and improved methodologies, as currently, district-based estimates are limited in India.

4.2Priority population prevention

India's epidemic is driven by infections among KPs, which in India include FSWs and their clients, MSM, TG, and PWID. Some recent evidence indicates elevated HIV prevalence among migrants and truckers, who also have been identified as bridge populations facilitating HIV transmission between KPs and lower-risk, often rural populations, and activities for these populations are currently kept as 'near-core' as a part of the time-bound Thane District Network Model. PEPFAR India will review the forthcoming IBBS to determine if the populations still reflect significant prevalence, and program will be modified accordingly. It is proposed that this be reviewed at the POART calls after the IBBS results are released.

India is a model country with an extensive combination prevention program called "Targeted Interventions" which is currently reaching over 75-80% of the estimated key population groups it targets (except TGs). However, major gaps exist including: lack of robust systems to measure the quality and effectiveness of the interventions in a way that will improve intervention performance and quality, lack of systems to share knowledge between NGOs on best practices for KPs in India, underutilization of these community-based organizations to track and assist with linking KPs to appropriate care and treatment across the cascade of care, and lack of coordination between PLHIV organizations which limits their ability to effectively advocate for changes that will address barriers to care and treatment, particularly in the realms of stigma and discrimination.

PEPFAR India proposes to invest in the following combination prevention interventions in the coming cycle to accelerate epidemic control: time-limited service delivery innovation pilots and targeted technical assistance to: 1) increase availability, accessibility, and quality of combination prevention services for key populations and linkages to HIV testing, care, and treatment including community-based approaches to reach female sex workers and other key populations; 2) expand quality medically assisted therapy for PWID populations in defined high priority states and districts; 3) establish real time monitoring systems to improve tracking of KPs along the continuum of care cascade; 4) assess program gaps and barriers to care continuum in high burden districts, and; 5) exchange best practices on key population prevention to care continuum. This includes capacity building at the Technical Support Unit (TSU) level, and implementation of a quality improvement monitoring system. The estimated number of people targeted for prevention interventions is grounded in the state annual action plan estimates (2015-16), deconstructed to the

[1] Test and treat will be piloted among PWID in the prioritized Northeastern districts.

district level. Per these estimates, prevention coverage of the KPs is targeted at 33-37% per KP, and 50% of the priority populations[2] (Table 4.1.4).

PEPFAR India expects that the patients enrolled on ART in FY16 will be coming from pre-ART, TB-HIV infected individuals, HIV+ pregnant women, PWID, and other priority/key populations. Currently, national guidelines support test and treat for HIV+ pregnant women and children and TB-HIV co-infected individuals. PEPFAR India will rely on national systems to report data on PEPFAR care and treatment indicators; the national system does not currently track those on ART by population and thus it is hard to quantify targets by sub-population. During the course of FY15, PEPFAR India will aim to improve the reporting and tracking tools to monitor enrollment on ART by sub-population.

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

	Target Populations	Population Size Estimate (priority SNUs)	Coverage Goal (in FY16)	FY16 Target
	Indicator Codes include PP_PREV and KP_PREV.			
Key population	**FSW**	**182533**	**35%**	**63011**
	MSM	**111243**	**33%**	**36394**
	PWID	**3896**	**37%**	**1444**
	Total	**297672**	**34%**	**100849**
Priority population		**440581**	**50%**	**220290**
	Total	**738253**	**43%**	**321139**

PEPFAR India will work at the strategic level with the GOI, strengthening capacity in the above-mentioned targeted areas of identified need where the USG agencies have core strengths, supporting technical collaborations, strategic information and innovative service delivery models, and informing policy decisions and public health processes.

PEPFAR India has conducted a review of the ongoing activities focusing on priority populations and geographic focus and realigned activities with the core/near core/non-core framework. FP/HIV Integration activities that have been ongoing for the past year focused on referrals to FP services have been identified as non-core and will be transitioned out before September 30, 2015. See Appendix C for key deliverables.

[2] Note that the figures for PWID do not include the PWID in the methadone programs in the Northeastern states, as the focus of the program there is testing, methadone, and linkage to care and treatment, and not prevention.

See Appendix A for details on the core prevention package for each priority population. See Appendix C for key deliverables.

4.3 Preventing mother-to-child transmission (PMTCT)

Based on the 2013 WHO Guidelines, NACO initiated lifelong ART (using the triple drug regimen) for all pregnant and breastfeeding women living with HIV, regardless of CD4 count or WHO clinical stage. Currently, the updated guidelines are implemented across India with programmatic data from three states showing tremendous progress: more than 90% of HIV-infected pregnant women were enrolled on lifelong ART, 89% of HIV-exposed infants born alive received nevirapine, and 86% of HIV exposed infants eligible for six weeks received EID. As part of this effort, NACO is strengthening the early infant diagnosis program to ensure that all exposed children complete all tests including the confirmatory test. This is quite a challenging task of building the capacity of providers at all levels, ensuring a good information system to facilitate retention, and ensuring adherence.

India is currently only conducting HIV testing of 34% of the estimated 29 million pregnant women annually with only 18% on lifelong ART as the program rolls out Option B+. In India, 80% of outpatient services and 40% of inpatient services are provided by the private sector and obstetric and gynecologic services are one of the largest utilized services in the private sector. Considerable contributing factors to low HIV testing among pregnant women include limited HIV testing services in private sector, non-adherence to the National guidelines on HIV testing protocols including questionable quality of HIV testing services as many of the labs do not participate in government HIV External Quality Assurance Systems (EQAS) program, and lack of data flow from the private sector to the national system.

Based upon current epidemiological and program data, PEPFAR India will focus PMTCT resources on technical assistance at the national level to complete program management reviews of the Option B+ program, to improve the monitoring capacity of the PMTCT program and cohort analysis, and assisting in integrating PMTCT data with the National Health Mission's Mother and Child Tracking system, and NACOs Strategic Information Management System (SIMS). PEPFAR India will focus on the PMTCT cascade and linkage of affected infants with care and support services alongside convergence with National Health Mission services and strengthening the capacity of government service providers to facilitate quality improvement and service integration in priority geographic clusters. PEPFAR technical assistance will support the increase in number of private sector hospitals performing HIV testing per national protocol and contributing to 190,872 pregnant mothers in the six priority districts in Maharashtra and Andhra Pradesh knowing their status. Additionally, PEPFAR India will be implementing models of PMTCT and OVC integration in six districts of Andhra Pradesh and Maharashtra with emphasis on joint mother-infant pair follow up to support retention on ART, follow up of infants and access to care and support services. See Appendix C for key deliverables.

4.4 HIV testing and counseling (HTC)

While India is reaching over 75-80% of the estimated key population groups it targets (except TGs), only 51-64% are tested for HIV and the positivity rates of those tested within each target group are far below the estimated prevalence captured through the most recent surveillance. The bi-annual testing rate for KPs in India is less than 50%. Multiple factors identified as barriers for KPs and migrants to access testing include: repercussions of being seen accessing HIV services, previous experiences of discrimination at healthcare providers, and long waiting times (Beattie et al., 2012). The limited availability and accessibility of testing services also served as barriers. A rapid assessment done by a PEPFAR-supported project identified that distance from testing facility played a major barrier in testing of KPs. In order to increase testing rates among KPs and migrants, community-based testing is one of the best options.

Limited efforts have been directed towards increasing the testing of partners of HIV positive individuals; several reports in published in India over the last several years reported that the HIV positivity rate among spouses of HIV positive individuals was as high as 45%, therefore, increasing the coverage of partner HIV testing is vitally important for achieving the first 90 goal. However, reaching this population faces multiple implementation challenges. Tracing and testing the partners of HIV infected people is hindered by stigma and the fear of violence and/or separation upon disclosure. In addition, expansion of track and trace has been difficult due to both the lack of specific guidance and tools on partner notification, and high patient loads that constrain the amount of time a counselor can spend with the client. PEPFAR/India will augment the efforts of the government in the cluster districts through pilots of community-based counseling approaches, and by adapting existing modules to train counselors and community care volunteers on counseling and navigation strategies, to better reach partners of HIV infected people and navigating them to HIV testing and counseling services.

In 2014-15, 1.16 million pregnant and general clients were tested in the Andhra Pradesh and Maharashtra priority districts. Out of these, 30,230 tested positive. As it is a challenge to reach partners, PEPFAR will reach 30% of the partners (Table A) in the FY16 pilot and will scale up in subsequent years based on lessons learned.

At the site level, PEPFAR will support the piloting of community-based testing for key populations in Maharashtra and Andhra Pradesh with a focus on FSW, MSM, TG, PWID, and migrants to increase uptake of HTC, HTC yield, and linking to care services, and will be further rolled out by the national program if proven successful. Community-based testing will be accompanied by a standardized set of counseling resources for outreach workers and is linked to an IT system that will assist with tracking KPs tested and linked to care. PEPFAR India also conducted a site yield analysis, in Thane district, Maharashtra state, that resulted in support for three mobile testing low yield sites concluding with the aim to transition resources toward community-based testing. The time-limited service delivery innovation pilots will also focus on improving linkages to care and treatment and tracking linkages across the care continuum. This will be part of information communication technology and enhanced data tracking systems under

development. PEPFAR India will also work with civil society organizations to crowd source new approaches to improve testing in KPs, with a focus on female sex workers.

Table A: Partner testing by district

District	Pregnant women with known status	HIV+ pregnant women	Partners to be tested (30% of infected pregnant women)	General clients tested	General clients diagnosed HIV+	Partners to be tested (30% of the infected general clients)	Total tested	Total infected	Partners to be tested (30% of total infected)
East Godavar	23050	191	58	64569	3570	1071	87619	3761	1129
Gunthur	22880	190	57	81504	4687	1407	104384	4877	1464
Krishna	25649	85	26	102959	3982	1195	128608	4067	1221
Mumbai	71896	453	136	273499	9192	2758	345395	9645	2894
Pune	25084	168	51	124385	4070	1221	149469	4238	1272
Thane	22314	112	34	157822	2977	894	180136	3089	928
Total	**190873**	**1199**	**362**	**804738**	**28478**	**8546**	**995611**	**29677**	**8908**

National and state level technical assistance to NACO will focus on quality improvement of stand-alone HIV testing and counseling centers and to strengthen linkage to care. A 2012 assessment on the quality of National and State Reference Laboratories (NRLs and SRLs) indicated that a majority (69%) of labs performed inadequately (less than 80%) on quality parameters. These SRLs are responsible for oversight of quality of testing at ICTCs. India has an external quality assurance (EQA) and proficiency testing (PT) program for the HIV testing labs reference as well as the ICTCs. The coverage of the PT program is 90-95% for the stand-alone ICTCs, however, the performance EQAS/PT is poor. In the year 2013-14, out of the 4,818 standalone ICTCs, 4207 participated, of which 3,571 produced satisfactory results. The major sources of unsatisfactory results (> 50%) are two states; Andhra Pradesh and Tamil Nadu.

PEPFAR India will provide this technical assistance to NACO in support of 29 states and six Union Territories, with priority focus on the following states, given their population, burden or disease, and ICTC infrastructure (See Table B).

Table B: Focus states for support to ICTCs

Region	**State**
North	Punjab, Uttar Pradesh, Uttarakhand
South	Andhra Pradesh, Karnataka, Tamil Nadu
West	Gujarat, Rajasthan
Central	Maharashtra
Northeast	Manipur, Mizoram, Nagaland
East	Bihar, Chhattisgarh, Jharkhand, West Bengal

These focus states are considered based on: 1) Total estimated PLHIV burden, 2) HIV prevalence, and 3) Total new infections. PEPFAR activities will target estimated PLHIV at the ICTCs and link them to ART centres as indicated in Table C.

Table C: State-wise ICTC Figures

State/UT	Est. # PLHIV	Children (<15)	Adults (15-49)	Clients tested at ICTC	% Adult Prevalence	Total New infections	Total Registered at ART (March 2014)
Andhra Pradesh	419,180	27,499	363,115	1,570,885	0.75	18,615	4,35,795
Maharashtra	315,849	28,982	263,692	2,049,867	0.42	7,274	3,49,785
Karnataka	209,368	14,195	180,491	1,661,004	0.52	9,986	2,43,564
West Bengal	134,286	9,761	116,886	392,005	0.22	8,162	40,516
Tamil Nadu	132,590	6,504	113,911	2,063,807	0.28	3,148	1,99,238
Gujarat	127,092	8,598	110,516	939,669	0.33	7,560	79,132
Bihar	123,875	9,791	107,224	353,035	0.20	9,457	47,021
Uttar Pradesh	122,522	12,365	102,854	642,211	0.10	9,154	74,094
Odisha	103,862	4,815	94,060	40,454	0.40	13,733	21,943
Rajasthan	73,545	5,711	63,325	506,677	0.17	5,122	43,181
Jharkhand	47,976	1,931	43,831	128,573	0.25	9,670	5,187
Chhattisgarh	40,942	2,523	36,393	162,394	0.27	5,031	6,368
Uttarakhand	12,862	365	11,915	83,526	0.22	3,194	2,133
Nagaland	9,716	547	8,445	76,998	0.73	616	4,999
Mizoram	5,346	251	4,751	37,856	0.74	407	3,296
Manipur	25,369	1,552	19,464	51,583	1.22	1,493	9,729

The quality improvement exercise at ICTCs is expected to benefit all individuals who are tested at the ICTCs. The activity also focuses on strengthening ART and ICTC linkages and PLHIV diagnosed at ICTCs will be reached through this PEPFAR support. See Appendix C for key deliverables.

4.5 Facility and community-based care and support

NACO has developed the operational guidelines for implementation of the care and support interventions through Care and Support Centers (CSC). The CSCs are being implemented by civil society partners including District Level Networks (DLN) and non-government organizations (NGOs). As of March 2014, 1.7 million PLHIV have ever registered for care. The current network of CD4 testing lacks adequate external quality assurance (EQA) coverage, implementation, corrective action support, and reporting, analysis and use of EQA data for program improvement.

At the site level, PEPFAR will support CSCs in Maharashtra as part of time-limited service delivery innovation pilots to improve the continuum of care for key populations. Three CSCs are being supported in the Thane District Network model, with the prime objective of linking HIV positive KPs with care and support services, with special emphasis on treatment adherence. National level technical assistance will focus on developing the competencies of CSCs to improve coverage and retention of key populations and PLHIV. Technical assistance will also be provided to enhance the capacity of the national CD4 network with a focus on quality management and in-service training. Furthermore, a successful Global Fund Concept Note could expand the scope of technical assistance to support the growth of the CD4 network with point of care technology.

PEPFAR India will also build the capacity of networks of PLHIV to work together to advocate for key issues and influence policy at national, state and district level. Emphasis will be given to improve linkages of HIV testing at the ICTCs, ART centers, and CSCs in the states of Andhra Pradesh and Maharashtra.

See Appendix C for key deliverables.

4.6 TB/HIV

An analysis of the cascade of services for TB/HIV patients has shown that TB/HIV coordination is increasing from 19% of all TB patients having a known HIV status in 2009 to 58% in 2013. Among TB/HIV co-infected patients identified, 84% are currently on ART according to most recent GOI reports, but TB treatment success was less than 80% amongst TB-HIV co-infected patients. These data demonstrate a considerable gap in early diagnosis of TB among PLHIV, which, if resolved, would help increase TB treatment success rates and reduce mortality among co-infected individuals (13% in 2013).

PEPFAR India will invest in the following TB/HIV interventions to accelerate epidemic control: 1) testing of innovative models to improve TB treatment adherence, leveraging other sources of USG TB funding and Bill & Melinda Gates Foundation funding, and to scale up intensified case finding among key populations in TI programs, ART and Link ART centers, for ultimate scale-up by the national program; 2) provision of technical assistance package on airborne infection control in high volume ART centers including fast-tracking of pulmonary TB patients and persons with respiratory infection; 3) scaling up of HIV/TB coordination mechanisms in priority states; and 4) operations research.

PEPFAR India provided GeneXpert machines to 30 high-burden ART centers in five states to enable early diagnosis of TB, initiation of daily anti-TB drug regimens, provision of isoniazid preventive therapy for those testing negative, and implemented basic airborne infection control measures at these facilities. These activities are now transitioning to the GOI, which has pledged to procure 950 GeneXpert machines and begin piloting daily isoniazid preventive therapy.

Activities have been defined as 'core' if they address the diagnosis and treatment of TB among PLHIV, and prevent TB co-infection and mortality.

See Appendix C for key deliverables.

4.7 Adult treatment

As of September 2014, 810,339 PLHIV were receiving ART at 466 ART Centres. In addition to the ART network, ten Centres of Excellence (CoEs) provide tertiary-level specialist care and treatment including second-line and alternative first-line ART, management of complicated opportunistic infections and specialised laboratory services.

As part of national technical support, PEPFAR India will improve the mentoring and monitoring network of ART service delivery for continuous quality improvement through TA to the Centers of Excellence that support training for ART center staff, and provide direct services for advanced and complicated cases of HIV. Based upon the national ART assessment findings, specific technical assistance will be prioritized to assist India to reach its treatment targets. Furthermore, if successful with the Global Fund Concept Note application, PEPFAR technical assistance will help to support the roll out of 2013 WHO treatment guidelines. Based upon the success of the national ART assessment, PEPFAR India will support the assessment of Link ART centers and their cost-effectiveness as compared to ART centers. Lastly, PEPFAR India will support studies to assess factors associated with loss to follow up for PLHIV and existing models to reduce the loss to follow up for transfer to other priority districts and technical assistance for test and treat interventions for key populations. Pilot interventions amongst key populations in particular will focus on measuring and increasing the yield of care, treatment, retention, and adherence and demonstrate effective measures for the cascade.

PEPFAR will also provide technical assistance to nine viral load testing facilities to increase coverage of second line ART and improve detection of drug resistance through monitoring of indicators for drug resistance, monitoring of VL suppression and early initiation of second line ART. PEPFAR will also provide assistance for the expansion of the VL network to 39 testing facilities if the Global Fund Concept Note application is successful. See Appendix C for key deliverables.

4.8 Pediatric Treatment

Currently, almost 100,000 children living with HIV/AIDS (CLHIV) are registered for HIV treatment and care services at ART centres across India, and 44,592 (42%) of them are on ART. Barriers include the lack of comprehensive pack of services for CLHIV and a limited number of early infant diagnosis (EID) collection centers and delays in returning test results, due to limited EID testing capacity. Furthermore, there are barriers with the service delivery model in that mother-baby pairs and CLHIV do not receive complete care at a single site, resulting in poorer outcomes.

PEPFAR India resources for pediatric treatment will provide comprehensive technical assistance to the existing 7 Pediatric Centers of Excellence (pCoEs) and any newly opened CoEs during the cycle to facilitate comprehensive service delivery for CLHIV at ART centers. Interventions will

include cadre-wise training of ART staff on implementation of national guidelines and CLHIV care.

PEPFAR India proposes focused technical assistance to enhance the capacity of molecular labs performing EID testing, conducting a baseline assessment to identify gaps and training needs. Preliminary areas of focus are likely to be updating training modules, in-service training, and improvement of sample collection and transportation methods and strengthening reporting systems. See Appendix C for key deliverables.

4.9 OVC

India lacks robust data on orphans and vulnerable children (OVC). Data available through UNICEF (2010) estimated that India has 7 million children with at least one parent living with HIV, and 1.5 million children orphaned by HIV/AIDS. NACO launched the National Pilot Scheme for Children Affected by HIV/AIDS OVC (CABA) in May 2010. The purpose of this national scheme was to ensure access to all essential services through coordination and establishment of linkages with various existing government schemes and service providers at all levels. The CABA pilot scheme was implemented in ten districts across six states of Andhra Pradesh, Delhi, Karnataka, Maharashtra, Manipur and Tamil Nadu. PEPFAR India provided technical assistance to NACO in the development of this pilot scheme and its guidelines, and in the implementation at the district level.

PEPFAR India will support the six priority districts of Andhra Pradesh and Maharashtra (Table 4.1.5) in identifying and profiling children living with and affected by HIV, and will provide linkages to testing, care and treatment, increase access and utilization of priority health, educational, social protection and welfare schemes for CABA and their families, strengthen multi-sectorial collaboration between various government departments to ensure that OVC are provided all essential services, and increase private sector investment in CABA programs. Emphasis will be placed on meeting the needs of OVC (including health and nutrition, psychosocial support, household economic strengthening, social protection and legal support) in order to address deterrents to children accessing HIV services. PEPFAR India will demonstrate a scalable multi-sectorial model that identifies and reaches every child affected by HIV/AIDS in the project area, including children orphaned due to HIV/AIDS, children of key populations, and children infected with HIV, and linking them and their families to services. Data collected on OVC from these activities will help to improve geographic and programmatic targeting of activities. See Appendix C for key deliverables. Activities in districts outside these six districts will be responsibly transitioned, factoring in the sensitivities surrounding support for children.

Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment

		Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target)	Target # of children tested (FY16 Target)	Target # of children on ART
			OVC_SERV	OVC_ACC		
Andhra Pradesh	East Godavari			3892		
	Guntur			2487		
	Krishna			2000		
Maharashtra	Mumbai			7064		
	Pune			4364		
	Thane			3506		
	Sangli			500		
	Sholapur			500		
	Kolhapur			500		
	Yavatamal			500		
	Dhule			500		
	Ahmadnagar			500		
Karnataka	Belgaum			500		
	Bagalkot			500		
	Bijapur			500		
	Dharwad			500		
	Bellary			500		
Tamil Nadu	Salem			200		
	Erode			200		
	Coimbatore			200		
	Trichy			200		
	TOTAL			29,613		

5.0 Program Activities to Sustain Support for Other Locations and Populations

5.1 Sustained package of services in other locations and populations

PEPFAR received confirmation from NACO and the Maharashtra State AIDS Control Society (SACS) that based upon low yield they wish to shift from a mobile testing model in Thane District to a community-based testing model to increase testing among key populations. This request is in line with the results of the HTC yield analysis in the Thane District Network Model service delivery pilot project focused on linkages across the continuum of response amongst key populations. As a result, PEPFAR support for three mobile testing low yield sites will conclude, with the aim to transition resources toward community-based testing to reach populations with poor access to ICTCs.

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

Over the next year, PEPFAR support for global transfer programming to Africa and Asia will be discontinued as the agreement reaches its end date. Remaining funds which are unable to be reprogrammed will focus on global transfer programming of benefit to the India program. The PEPFAR India program will continue to encourage the utilization of the global transfer program platform, which exists and will serve as an interlocutor for countries interested in learning from India's best practices. However, the PEPFAR India program will request those activities be funded by the benefiting country. General population IEC activities have been concluded with the end of an agreement. Global Fund Country Coordinating Mechanism support will utilize its remaining funds by the first quarter of FY 2016. Discussions have taken place with NACO at all relevant levels to ensure there will be no service delivery interruption based upon non-core activity decisions.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

Quality of HIV and EID diagnostic and CD4 testing and viral load testing to assess treatment failure, adherence and effectiveness of ART have been identified as key bottlenecks in the continuum of response. As part of its support to increase ART coverage, PEPFAR India will focus its core laboratory activities on:

1) Quality assurance programs for HIV rapid testing, CD4 testing, EID and VL
2) In-service training for laboratory technicians conducting HIV rapid testing, CD4 testing, EID, and VL
3) Need-based supervision to laboratories
4) Technical assistance for roll-out of point of care testing/community-based testing
5) Technical assistance support for sample collection and transport network

PEPFAR India currently supports basic laboratory infrastructure for 117 state reference labs and 13 national reference labs and will enhance focus on 254 CD4 laboratories, 9 VL and 8 EID molecular laboratories. If India is successful with its Global Fund Concept Note application, it is possible technical assistance across these laboratory networks would also be expanded.

Blood Safety: There has been an evolution of blood transfusion services in India. In 1992 the Drug Controller General of India (DCGI) was given the responsibility of licensing blood banks in the country. In 1996, the Supreme Court of India ordered HIV transmission through blood transfusions to be reduced from 10% to less than 8%. NACO was then mandated to ensure safety of blood across the country, and access to safe blood was enacted into law. While a mandate, blood safety was not sufficiently addressed over the four phases of the National AIDS Control Program due to various reasons including the various stakeholders outside of NACO (including DCGI), lack of a national blood policy, lack of coordination between district and state levels (blood banks and blood storage centers) and the Central coordinating body, and poor quality of systems. Currently transmission of HIV through blood or blood products accounts for 1% of all HIV transmission. In some districts, transfusion transmitted infections (TTIs) account for as many as 5-10% of total HIV infections. Two hundred districts of the just over 600 districts in India report more than .5% HIV transmission through blood. In addition, 25% of maternal deaths in the country are due to lack of blood. In support of NACO's enhanced focus to reduce TTIs, and to strengthen the blood safety system in India, PEPFAR seeks to leverage its expertise in the provision of technical assistance in 14 states identified based on three criteria: percent HIV transmission through blood, HIV seropositivity, and ANC prevalence. The 14 states are Andhra Pradesh, Bihar, Chhattisgarh, Delhi, Gujarat, Haryana, Madhya Pradesh, Maharashtra, Meghalaya, Odisha, Punjab, Rajasthan, Uttar Pradesh, and West Bengal. Specific activities are outlined in the table below.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Provide TA for Quality improvement of ~ 5000 HIV stand-alone testing and counselling sites and strengthen linkage to care (ART centers)	Guidelines, tools, Training modules to implement minimal quality standards	Measurable increased adherence to minimal quality standards at 20% of HTC sites, Increase coverage of PT by 80% of HTCs	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Quality Management Q1 (4)	X	X			
Develop capacity of HIV referral lab network through QMS training of lab workforce at 13 National Reference Labs (NRLs) and 117 State Reference Labs (SRLs) as per ISO 15189, and through on-site visits to provide TA to strengthen laboratory capacity in the HIV referral lab network	Guidelines and Tools	Improved quality in HIV testing	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Quality Management Q1 (4)	X	X			
Strengthen STI laboratory network and improve uptake of lab and STI care services for prevention of HIV	Guidelines, tools	Improve STI referrals to regional labs for confirmatory diagnosis, Improved STI referrals to ICTC sites	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Quality Management Q1 (4)	X			X	

Implement QA in regional STI Labs, based on International Standards-ISO 15189 through QMS training of lab workforce at 10 regional STI labs	Guidelines and tools	Implement quality standards in STI regional labs	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Quality Management Q1 (4)				X	
Establish & strengthen EQAS network between 10 regional STI labs and 45 state STI labs	Guidelines, Tools	Strengthen STI Lab network	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Quality Management Q1 (4)				X	
Facilitate increase in ART coverage through strengthening referrals from 466 ART centers to 254 CD4 testing sites	Guidelines, Tools	Increase in annual CD4 testing , improved CD4 services at ART centers	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		X
Enhance capacity of CD4 testing facilities with a focus on implementing a Quality Management System, including training the workforce at these 254 CD4 laboratories to implement QMS	Guidelines and tools	Measurable increased adherence to minimal quality standards of CD4 testing sites	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)			X		X
Facilitate improved coverage of second line ART through strengthening linkages of 9 viral load testing facilities	Guidelines and tools to strengthen sample collection and transportation to testing sites	Annual increase in VL testing , improved VL services at COEs and ART plus centers	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		X
Baseline assessment to identify gaps and training needs of molecular lab	Assessment Tools and training of assessors	Assessment report	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery,					

workforce						Quality Management Q1 (4)					
Develop training modules and conduct training of molecular lab staff for EID and Viral Load testing	Guidelines and Training modules for EID and VL staff	Improve quality of Viral load and EID testing	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services (2)			X		X
Strengthen laboratory human resources for health through in-service training and strengthen laboratory referrals and linkages (OGAC Central Initiative; MOU between PEPFAR/CDC/BD)	Guidelines, Tools, training modules, standardized curriculum, GIS mapping of lab referral network	Trained lab workforce, Improve sample referrals and linkages	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Quality Management Q1 (4)	X	X			
Support integrated laboratory services that can be leveraged across co-morbidities of persons living with HIV/AIDS (PLHIV) for both communicable and non-communicable diseases (OGAC Initiative MOU between PEPFAR/CDC/BD)	Support QA programs	Implementation of quality systems compliant with national standards	HLAB	HLAB	Lab Strengthening	Domestic Program and Service Delivery, Quality Management Q1 (4)	X				

Quality improvement in Blood Transfusion Services through implementing quality standards and External Quality Assurance program for Transfusion Transmitted Infections (TTIs) including HIV	Develop/review Guidelines/policies Training modules	Build capacity of 18 regional training centers, Training of Trainers, and the implementation of Quality Management Systems in 300 NACO-supported blood banks through technical support activities	HMBL	HMBL	Blood Safety	Domestic Program and Service Delivery, Quality Management Q1 (4)	X	X			
Strengthen Blood Service Information Centre (MIS): mapping of blood banks and monitoring key indicators at national/state level, to ensure HIV-free blood stored in blood banks for utilization by PLHIV and non-PLHIV	National Consultations TA for the selection/implementation of an electronic blood management data system	Periodic progress report at National and state level	HMBL	HMBL	Blood Safety	Domestic Program and Service Delivery, Quality Management Q1 (4)					
National estimation of blood requirement: including estimation of blood used by PLHIV and patients on ART	National consultations, Develop protocol, Secondary data review/site visits	Study report	HMBL	HMBL	Blood Safety	Domestic Program and Service Delivery, Quality Management Q1 (4)		X			
Assist in development/review of five year strategic plan with Blood Transfusion Services, NACO and review the legal framework to establish a nationally coordinated Blood Transfusion Service	Work with MOH to draft strategy/review BTS policies	Strategy adopted by MOH	HMBL	HMBL	Blood Safety	Domestic Program and Service Delivery, Quality Management Q1 (4)		X			

Ensure safe transfusion practices through quality screening for TTIs, including HIV	Support QA programs, EQAS, Guidelines, Tools	Implement quality standards for TTI screening, EQAS coverage for TTIs	HMBL	HMBL	Blood Safety	Domestic Program and Service Delivery, Quality Management Q1 (4)	X	X			
Strengthen Blood Bank laboratory workforce through in-service training	Training packages, standardized curriculum	Number of Lab workforce trained	HMBL	HMBL	Blood Safety	Domestic Program and Service Delivery, Quality Management Q1 (4)	X	X			
PPP initiatives to improve access to blood and components, leverage Corporate Social Responsibility (CSR) resources for technological innovations in Blood Transfusion Services	National consultations to explore potential collaboration on electronic blood bank data management system and improve accessibility of blood	Strengthen blood bank network and improve accessibility to safe blood down to district level	HMBL	HMBL	Blood Safety	Domestic Program and Service Delivery, Quality Management Q1 (4)		X			

6.2 Strategic information (SI)

Quality data to inform decision making for India's national HIV program is a core priority for PEPFAR. As part of the assessment of the continuum of service cascade, PEPFAR India will focus its core SI technical assistance activities on:

1) Surveillance for priority key populations, pregnant women, and the general population demographic health survey (DHS)
2) Technical assistance to improve data availability for reporting on all key indicators in the continuum of response and data use for strategic planning and program planning
3) Assessment of key populations currently in care and treatment to improve access to services
4) Development and implementation of the national health information system (HIS) given that current HIV information systems and data are fragmented and inhibit effective strategic and programmatic planning
5) Research studies to gain information on critical gaps in the HIV/AIDS prevention program and on program performance

The USG support to Integrated Biological and Behavioral Surveillance (IBBS) will enable the quantification of HIV prevalence among key population groups across the country for the first time. It collects HIV prevalence and key knowledge, attitude and behavior indicators for key population groups, including female sex workers, men who have sex with men, transgender injecting drug users, migrants and currently married women as proxy for spouses of migrants. The effort was led by NACO and will be institutionalized, so that it will be repeated every three years to track the epidemic.

The National Family Health Survey-4 (NFHS-4), a nation-wide population based survey, will provide HIV prevalence for the general population for the second time. It will be critical to make adjustments in the periodic HIV estimation for key population and general population collected through the HIV Sentinel Surveillance Survey. NFHS-4 is being led by the Ministry of Health and Family Welfare, Government of India and PEPFAR provides technical support and covers a portion of the fieldwork cost.

PEPFAR will provide technical and financial support to government agencies to undertake research studies that aim at filling critical knowledge gaps in HIV/AIDS prevention programs, such as researching the shifting trends in sex work which is moving away from traditional FSW structures and systems, as a result of increased penetration of cell phones and other technologies within society. Assessment of the changing networking dynamics of injecting drug users and a vulnerability assessment of female migrants will provide valuable insights to reach the hard to reach populations among these targeted groups. A proposed study to be supported by PEPFAR will assess prevalence of STIs/RTIs among PLHIV and key population groups, and will fill the critical gap in existing information on STIs and RTIs.

All of these activities supported at the national and sub-national level will provide vital information on the spread of the epidemic and therefore help focus interventions. It will provide

an important basis for potential geographic shifts to better match trends in the epidemic with the goal of achieving epidemic control.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Surveillance											
IBBS Evaluation: from this first round of IBBS in India, a robust baseline of HIV prevalence in KPs will be derived. To improve and enhance the methodology and quality of future rounds, this evaluation will provide crucial lessons for the national program.	Key areas for evaluation and methodology agreed upon with NACO, Protocol developed	Protocol approved and evaluation initiated	HVSI	HVSI	Strategic Assessment for Strategic Action (SASA)	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5)	X	X	X	X	
IBBS: Support continuation of IBBS roll out to achieve national coverage for core HRGs, migrants, and currently married women in high out-migration districts	Monitoring and supervision of sites conducted ensuring quality of implementation. Corrective actions proposed and followed up on, documented feedback loop.	Report for IBBS topline findings developed and reviewed	HVSI	HVSI	WHO	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5)	X	X	X		
IBBS: Provide technical support to NACO to provide HIV prevalence and gather HIV knowledge, attitude and behavior indicators among key populations, including female sex workers, men who have sex with men, people who inject drugs, migrants, and currently married women through IBBS and other research studies.	IBBS conducted for key population groups and reports available	Research studies completed and disseminated, 1 research study underway	HVSI	HVSI	PIPPSE	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5)	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
ANC: Technical assistance to implement 2014-2015 round of HIV sentinel surveillance among ANC population	National Operational guidelines, training manuals and facilitator guide reviewed and finalized. Monitoring support for surveillance provided	Assistance provided in preparation of National ANC HSS Report	HVSI	HVSI	WHO	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5)	X	X	X		
ANC: Provide technical assistance to NACO in ANC Data Analysis from HIV Sentinel Surveillance, and Report Preparation and Dissemination	Plan for ANC National Level Report prepared, Site level data analyzed from all HSS ANC sites, Data shells and report outline prepared, Report prepared and reviewed by NACO	National ANC HSS report disseminated	HVSI	HVSI	Strategic Assessment for Strategic Action (SASA)	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5)	X	X	X	X	
DHS: TA to International Institution for Population Sciences on HIV module and sample sizes for National Family Health Survey-4 (NFHS-4) (aka DHS) to estimate HIV prevalence and gather information about HIV knowledge, attitudes, and practices among general population.	Data collection completed for 19 states and Union Territories on HIV prevalence and HIV knowledge attitudes and practices among general population	Data collection for all of the remaining 16 states and Union Territories completed and HIV prevalence data available along with report.	HVSI		DHS	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5)	X		X		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
DHS: TA to International Institution for Population Sciences on biological component of HIV testing of the NFHS-4, including blood collection and laboratory assessment. A sub-sample will be tested for HIV, adopting anonymous unlinked method; those interested in receiving their test results will be referred to the nearest ICTC for testing	Data collection completed for 19 states and Union Territories for biological component of HIV testing	Data collection for all of the remaining 16 states and Union Territories completed and HIV testing data available along with report.	HVSI		DHS	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5)	X		X		
DHS: TA to International Institution for Population Sciences to ensure quality throughout the NFHS-4 process and alignment with international standards		Quality report available	HVSI		DHS	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5)	X		X		
HIV Drug Resistance Surveillance: Strengthen national capacity in HIV drug resistance surveillance including improved routine monitoring of ART, and other program indicators	NACO sensitized on importance of HIV DR and roadmap developed on conducting HIV DR surveillance. Protocol Developed	Protocol approved, steps undertaken to lay ground for conduct of survey including sampling and trainings. Surveillance initiated on a pilot basis.	HVSI	HVSI	WHO	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)			X		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Case Reporting: establish mechanisms for tracking individuals in the diagnosis, care and treatment continuum, including mortality resulting from HIV/AIDS	Concept note developed and approved, preparatory site visits conducted, proposed roadmap for implementation of Case Reporting prepared, presented and reviewed, pilot sites identified	Pilot of Case Reporting in identified districts initiated and completed. Draft Report Prepared	HVSI	HVSI	WHO	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X		
National and sub-national level HIV Estimates for HIV	National Level Working Group on estimates trained, Estimates completed for all states, National Technical Estimates Report Prepared	Sub-national level analysis of data - training for identified states completed, estimates completed	HVSI	HVSI	UNAIDS	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5)	X	X	X	X	
Data Availability, Quality, and Use											
National Data Analysis Plan	Assigned topics for secondary data analysis completed	Paper on secondary analysis topic prepared and submitted to peer reviewed journal	HVSI	HVSI	WHO	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Determining key population characteristics and locations to guide targeted interventions to bring KPs in for treatment (IBBS, HSS)	Target districts identified, coordination mechanisms with states and districts established, datasets identified, program questions developed and analysis frame developed. Generation of evidence for directing decisions for KPs.	Data analysis report and recommendations prepared	HVSI	HVSI	WHO	Institutionalized Data Availability, Epi and Health Data, Q3 Prevalence and Incidence Data (2.5); Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X		
Use of Strategic Information Management System (SIMS) data to direct interventions at state and district level to improve the care cascade	Target districts identified, coordination mechanisms with state and district established, datasets identified and analysis frame developed	Data analysis report and recommendations prepared	HVSI	HVSI	Strategic Assessment for Strategic Action (SASA)	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X	X	
Training in data use, data analysis and problem solving at state and district levels for HIV program functionaries, to utilize currently collected site level data for improving services to KP and PLHIV	Training target audience and district(s) identified, training modules developed and vetted	Training(s) conducted and component wise data analysis plan submitted, component wise analysis report submitted (Basic Services, TI, IEC)	HVSI	HVSI	Strategic Assessment for Strategic Action (SASA)	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Guide the implementation of the National Health Research Plan and support new science that informs better targeting of services for PLHIV and key populations	Technical protocols reviewed and feedback provided	Oversight in the implementation of studies provided	HVSI	HVSI	WHO	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)	X	X	X		
Support the development of HIV epidemiological data sheets for select districts (high burden) in India, to assist State AIDS Control Societies to enhance/target prevention, care and treatment activities in high burden districts	DEP database updated with latest epidemiological data for all districts, Advocacy with NACO on handover of DEP Database to states, plan for handover finalized	DEP Database handed over to the districts, training/orientation associated with handover completed	HVSI	HVSI	Strategic Assessment for Strategic Action (SASA)	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X		
Improve program data quality through the development and implementation of a comprehensive Data Quality Management System which utilizes internal processes and capacities to enhance data use for decision making	Data quality improvement plan reviewed and finalized. Outline for pilot in representative districts developed and approved.	Data Quality Management guidelines developed and finalized. Roll out initiated.	HVSI	HVSI	WHO	Access and Demand, Quality Management Q4 QI Data Use (4)	X	X	X	X	
Strengthen HIV Centers of Excellence (COEs) for monitoring patterns and emerging trends of indicators related to ART service delivery (10 Adult COEs, 7 Pediatric COEs)	Improve reporting, Data quality and data usage	Improve reporting, Data quality and data usage	HVSI	HVSI	ITECH	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)		X	X		X

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Health Information Systems											
Technical support to identify and resolve challenges developing Strategic Information Management System (SIMS) analytic modules, including GIS for decision making and program implementation	Activate SIMS database - rationalization of all 25,000 reporting units. Validation of input data completed. Validation of input data completed.	GIS based analytics module launched on the SIMS. (Once SIMS is functional)	HVSI	HVSI	WHO	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X		
Information management experts' support for completing the national information system that is the repository for all site-level data that drives programming for key populations and PLHIV	TORs for identified experts developed, information management experts on board and providing support, SIMS transition handover plan completed	TORs developed for new vendor for national information systems	HVSI	HVSI	UNAIDS	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X		

6.3 Health System Strengthening (HSS)

PEPFAR's TA strategy is specifically targeted to fill gaps in the HIV response that are preventing the achievement of epidemic control. PEPFAR's support in India builds on existing government systems by addressing specific weaknesses to ensure that results achieved will be sustained in the future. Based on health system bottlenecks to delivery of HIV services, India's core systems strengthening activities will focus on providing technical assistance at national, state and facility level in the following:

1) Service Delivery – Key Population and Care and Treatment: PEPFAR India technical assistance will increase the capacity of institutions at the national, state, and district levels to deliver HIV services for key populations, pregnant women, TB/HIV co-infected, and HIV-positive adults and children.
2) District management and planning: PEPFAR India technical assistance will focus on strengthening the capacity of District AIDS Prevention and Control Units (DAPCUs) in high burden districts to effectively implement prevention, care, and treatment continuum of services.
3) Service Delivery - Integration of HIV services: An aim of the five-year national HIV plan is to look toward integration of the HIV program within the Division of General Health Services, National Health Mission within the Ministry of Health. PEPFAR India will support the conduct of assessments and provide technical assistance on integration of HIV within the national primary health service delivery system to ensure that shifts in policies, implementation of integration, and decentralization of services happen smoothly without an interruption to services or quality.

Civil society continues to report a weak supply chain and shortages of critical commodities such as HIV drugs and test kits as major challenges, with increased reports over the past nine months. NACO has requested that HIV/AIDS related supply chain strengthening be supported by only one donor partner (CHAI), who has developed an inventory management system to track ARV drugs along with individual dispensation to patients that is linked to biometrics and CD_4 count, enabling a cross-matching of supply chain and programmatic data. Using prior COP resources, PEPFAR India supported CHAI in the roll out and training of staff in the use of the system. World Bank is supporting logistics managers for each state. Based upon this information, PEPFAR India is not funding any technical assistance for the HIV supply chain.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Service Delivery - Key Populations											
Enhance the current monitoring and evaluation system by providing TA and mentoring on use of programmatic data for timely programmatic improvement, and building skills at all levels to improve quality of services	Guidelines, Tools	Training Report, Progress Report	OHSS	OHSS	PWID Collaborative Project	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X	X	
Linkages with other health and local social welfare institutions (government and private) to facilitate access to health, welfare and social protection services for PWID populations	Guidelines, Tools	Training Report, Progress Report	OHSS	OHSS	PWID Collaborative Project	Domestic Program and Service Delivery, Access and Demand, Rights to Access Services Q6 (2.4)				X	
Provide TA to NACO, IRDA, and private sector stakeholders on social protection measures for key populations and PLHIV	Social protection services accessed by 30% of KPs.	Social protection services accessed by 50% of KPs.	OHSS	OHSS	PIPPSE	Domestic Program and Service Delivery, Access and Demand, Rights to Access Services Q6 (2.4)		X	X		
Develop and ensure implementation of written policy on stigma and discrimination reduction at the community level, with specific focus on MSM and transgender population.	Written policy on Stigma and discrimination in 60% of NGOs in 8 states.	Written policy on Stigma and discrimination in 100% of NGOs in 8 states.	OHSS	OHSS	Linkages	Domestic Program and Service Delivery, Access and Demand, Rights to Access Services Q6 (2.4)	X	X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Service Delivery - Care and Treatment											
Provide knowledge exchanges to Government of India staff and other HIV/AIDS stakeholders in country to benefit from global best practices in leveraging innovative/alternative financing options and innovations in integrating HIV into health systems	Countries identified where knowledge exchanges will occur and selection of appropriate decision-makers for knowledge exchanges made.	Global best practices on leveraging innovative and alternative health financing prioritized and a roadmap to introduce health insurance programs for OI and ARV treatment for PLHIV and key populations developed.	OHSS		SHARE UNAIDS	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)		X	X		
Develop competencies of ART and Care and Support Centers (CSCs) to improve coverage and retention of PLHIV in treatment		Activity Report	OHSS	OHSS	CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		
Develop a Technical Support Program to improve ART coverage based on ART center assessment findings		Strategic plan, periodic progress reports	OHSS	OHSS	CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Establish a technical support program for Airborne Infection Control (AIC) in ART Centers to ensure implementation and monitoring of AIC policies and procedures in high volume ART centers to reduce the transmission of TB to PLHIV attending ART centers	Tools and manual	Training Report	OHSS	OHSS	CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X			
Train ART staff on Universal Workplace Precautions, Waste Segregation and Disposal, and Airborne Infection Control Practices, including general and cough hygiene	Training module	Training Report	OHSS	OHSS	CS HIV TB			X			
Provide TA to NACO for policy, guideline, curriculum development and review of CST activities; provide high level clinical TA to NACEP (National AIDS Clinical Experts Panel) and selected State AIDS Clinical Experts Panel (SACEP)	Guidelines, Training curricula, reports	Guidelines, Training curricula, reports	OHSS	OHSS	ITECH	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		
State/District Management and Planning											
Strengthen capacity of high burden districts to effectively implement the prevention, care and treatment continuum of services through District AIDS Prevention and Control Units (DAPCUs), which currently are present in 189	Progress Reports	Progress Reports	OHSS	OHSS	TA to NACP	Enabling Environment, Planning and Coordination, Coordination of national response Q4 (6)	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
high burden districts in India.											
Strengthen capacity of government service providers, counsellors, Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs) for facilitating quality improvement and horizontal convergence of HIV with Andhra Pradesh and Telangana States' health program (will use this model to scale up to other states)	Training Manual, report, demonstration of integration model - integrating PMTCT with General Health Services	Training Manual, report, Demonstration of integration model - integrating PMTCT with General Health Services	OHSS	OHSS	UNICEF	Domestic Program and Service Delivery, Access and Demand, Access to PMTCT Q2 (2)	X	X			
Technical support for strengthening the capacity of program managers, state epidemiologists, M&E officers and other relevant staff involved in data generation, quality management and data analysis for program decision making	Training target audience and district(s) identified, training modules developed and vetted	Training(s) conducted and component wise data analysis plan submitted, component wise analysis report submitted (ART, Basic Services, TB/HIV, STI)	OHSS	OHSS	WHO	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Develop capacity of Andhra Pradesh state government partners on scale programs to ensure access to comprehensive services for PMTCT, as part of routine antenatal and post-natal care (as per new PMTCT regimen Option B+ initiated in India)	Strengthen PMTCT services (based on updated guidelines)	Strengthen PMTCT services (based on updated guidelines)	OHSS	OHSS	UNICEF	Domestic Program and Service Delivery, Access and Demand, Access to PMTCT Q2 (2)	X	X			
Quality assessment and outcome evaluation of NACO training program for clinical staff of ART centers	Assessment/ Evaluation report, revised training curricula	Assessment/ Evaluation report, revised training curricula	OHSS	OHSS	ITECH	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		
Service Delivery: Integration of HIV Services											
Support integration and decentralization by reviewing service integration and quality across programmatic components	Analysis of opportunities for service integration completed. Program areas where integration is feasible, is identified and vetted. Report on recommendations for mechanisms for integration developed.	Monitoring support for integration in identified districts conducted	OHSS	OHSS	WHO	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X		
Global Fund											

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Provide TA to selected Principal Recipients (PRs) in the implementation of ongoing GFATM HIV/AIDS grants to resolve bottlenecks, improve the quality of processes, and increase efficiency and effectiveness. Provide TA to the Country Coordinating Mechanism (CCM) members and Secretariat staff to manage the overall portfolio of GFATM grants.	TA provided to PRs and CCMs		OHSS		Grants Management Solutions	Enabling Environment, Planning and Coordination, CCM criteria Q3 (2)	X	X	X	X	

7.0 Staffing Plan

The PEPFAR India team conducted an initial analysis and assessment of 1) programmatic alignment of staff towards sustained epidemic control and 2) the ability to successfully implement the new PEPFAR business model. As a result of this initial assessment, Centers for Disease Control and Prevention (CDC) will add two new LES positions to support the enhanced focus on the clinical cascade for COP 15. *[REDACTED]*. Enhanced emphasis of staff time will be placed in the priority geographic areas identified for PEPFAR activities. COP 14 expenditures were reviewed in detail to estimate impact on the overall cost of doing business (CODB). Overall, we anticipate an increase in CODB of 55% as compared to FY 2014 outlays (CDC 10%; USAID 280%), with the primary drivers being increased travel for SIMS visits and new projects, LE staff raises, ICASS increases, new staff hired, and corrected charges to PEPFAR for USAID funded costs. Due to no funds for M&O being received by USAID in COP13, a significant portion of the USAID funded M&O costs were funded by funding sources other than PEPFAR in FY 2014 outlays. This will be corrected in FY 2015 with the receipt of COP14 M&O funds.

Given a more focused technical assistance approach in COP 15 and an increase in the number of innovative service delivery projects, the total number of sites requiring visits is expected to increase slightly based upon current activity and target proposals. Thus, travel costs have increased to match this need. Staff will be adequately proportionate to meet quarterly SIMS requirements, and as such, staff will be expected to increase their travel for site monitoring and support.

APPENDIX A REQUIRED

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Core	Near-core	Non-core
Clusters: Strengthening the cascade of care between community and facility with special focus on FSW, PWID, MSM, and TG	Other Vulnerable Populations: Migrants, spouses and partners in Thane; examine forthcoming IBBS to determine if other key pops reflect significant prevalence	Information, Education, Communications (IEC) for General Population
Accelerated and focused TA for impact with PWID and their partners: mentoring HCW for increasing enrollment of PWID; MAT; real time monitoring system; scale up partner/family based counseling and testing;	Operations research	Blood Safety - national and SNU that are non- priority
Technical Assistance (TA) for Adult & Pediatric Treatment in priority geographic areas 10 COEs and 7PCOEs	Salary support for non-technical positions (NACO admin and financial, social protection, and mainstreaming staff)	Other Priority Populations: Truckers**
HIV/TB—Airborne ICT (TA); strengthening TB and HIV in 8 northern states; HIV/TB in private sector in Thane		
Lab—Referral lab network trainings to the site level (ICTCs) in clusters, CQI troubleshooting, STI, VL, EID, CD_4 at national and state level	Blood safety—QA in the system in the 6 districts	Global Transfer Programming to Africa and Asia* (excluding regional TA to Sri Lanka and Bangladesh)
CQI to combat stigma and discrimination and to improve KP's access to services		FP/ HIV integration
SI—TA Strategic Information Management System (SIMS), surveillance, IBBS, SOP for DQAs, Epi indicator working group, outcomes monitoring for PPCTC and ART; focused site visits, data quality		
PMTCT—technical guidelines and training		
District AIDS Prevention and Control Units (DAPCUs)— in focus cluster districts, regularly monitor sites and provide capacity development	DAPCUs—189-195, in high burden districts, provide light touch capacity building of district AIDS prevention control units to improve reporting	
PMTCT in priority geographic areas		Commodity procurement and equipment
Lab TA: diagnostic and ART biological monitoring - HIV testing, CD 4, Vial Load, EID,	TA for DHS	Supply Chain***

STI with focus on priority geographic areas		
Blood Safety - HIV screening and quality assurance in priority geographic areas		Global Fund CCM Support****
Data Quality and Use	TSU Support	HIV/AIDS Helpline
Health Information Systems		Employee-led model Activities

**Exception due to obligated pipeline to UNAIDS mechanism; remaining funds will focus on exchange activities to benefit India program*
***Exception for truckers as part of the Thane District Network Model.*
****National HIV supply chain technical assistance lead designated by NACO is CHAI. Progress will be discussed during PEPFAR quarterly reviews.*
*****Exception for one month of funding for the last TA visit from GSM for activities requested in COP14 that will carry over.*

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

Priority Population Prevention (HVOP)	Core Activities	Near-core Activities	Non-core Activities
All KPs	Assessment of program gaps and barriers across prevention to care continuum with focus on PWID and FSWs in high priority geographic clusters	Assessment of the Quality of targeted intervention (TI) services and demonstrate strategies to improve quality of TI services.	Global Transfer Programming to Africa and Asia (excluding regional TA to Sri Lanka and Bangladesh)*
		TA and mentoring on use of programmatic data for timely programmatic improvement; Skills at all levels to improve quality of services	FP/HIV integrated services for key populations
		TA to 8 TSUs for quality improvement of targeted interventions and data quality enhancement	
		Social protection for key populations time bound based on PIPPSE project	
		Combatting stigma and discrimination in HIV/AIDS services for KPs	
		Inter-state transfer of best practices on key population prevention to care continuum programs	
PWID	Establish Real Time Monitoring System to capture local level data at service delivery points, represent it visually, and use the data on services for monitoring progress against targets and improving program delivery and quality	Implement lower threshold service strategy to increase availability, accessibility, acceptability, coverage, quality and increase efficiencies of combination PWID services - time bound	
	Provide targeted TA to scale up Methadone program	Linkages with other health and social welfare local institutions (government and private) for facilitating access to health, welfare and social protection services for PWID populations	
	Innovative approaches in providing gender sensitive services for Female PWID	Capacity Building of Harm Reduction Force on improving quality of PWID package of services and Sensitization workshop of law enforcement officials	
		Establish an Implementation Science agenda and plan to	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15			
		systematically test practical public health strategies to expand coverage and improve quality, efficiencies and effectiveness of PWID services	
FSWs		Supportive supervision tools for FSW programs	
Migrants		HIV prevention for migrants	
General Population			IEC strategy for prevention to care continuum for key populations
Preventing mother-to-child transmission (PMTCT)	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	Developing competencies of PMTCT centers to increase coverage of PMTCT services for pregnant women, lactating mothers and children	Program Management Review of the Option B Plus program	
	Scaling up Private Sector Engagement in PMTCT program to increase private sector hospitals performing HIV testing per national protocol thus increasing number of women tested	Strengthening PPTCT Data Management System for Program Improvement	
		Improving capacity in monitoring PPTCT program outcomes and Cohort Analysis	
		Strengthen capacity of government service providers, counselors, ANMs and ASHAs for facilitating quality improvement and horizontal convergence of HIV with AP's/TS health program	
HIV testing and counseling (HVCT)	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	TA to pilot and introduce community-based testing for key populations and strengthen linkages between TI sites and ICTCs	District Network Model for HIV testing, care and support in Thane	
	Linkages: Improving civil society approaches to improving continuum of care in KPs	Improving community approaches to improving testing in KPs	
		TA for Quality improvement of ~ 5000 HIV stand-alone testing and counselling sites and strengthen linkage to care (ART centers) -	
		TA for lab for introduction of community based testing and strengthen linkages between TI sites and ICTCs	
Facility and community-based care and support (HBHC)	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	Developing competencies of ART and Care	District Network Model support to Care and Support Centers	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15			
	and Support Centers (CSC) to improve coverage and retention of PLHIV in treatment		
	Facilitating increase in ART coverage through strengthening referrals from 425 ART centers to 254 CD_4 testing sites and strengthening quality of CD_4 testing Enhancing capacity of CD_4 testing and linkage to service delivery with focus on implementing QMS CD_4 testing sites; Train workforce at 254 CD_4 laboratories to implement QMS	Develop capacity of AP state governments partners on scale programs to ensure access to comprehensive services for PMTCT	
TB/HIV	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	Scale up of HIV-RNTCP coordination mechanisms in six other low prevalence northern states	Conduct operations research (OR) on Fast Tracking of known pulmonary TB patients and persons with respiratory infection as an effective airborne infection control practice	
	Establish a technical support program on Airborne Infection Control in ART Centers to ensure implementation and monitoring of airborne infection control policies and procedures in high volume ART centers. Train ART staff		
	Training of Nurses and Counselors of high volume ART centers on fast tracking of pulmonary TB patients and persons with respiratory infection.		
	Demonstrating innovative approaches to scale up ICF among KPs in targeted intervention (TI) programs and PLWH in ART and Link ART centers (LACS)		
	Crowd sourcing innovations in TB treatment adherence		
	Control of urban TB, with a focus on identifying and improving diagnosis and treatment for TB-HIV co-infections in urban areas of 1-3 or more cities in India (new THALI – Tuberculosis Health Action Learning Initiative project)		
Adult treatment (HTXS)	**Core Activities**	**Near-core Activities**	**Non-core Activities**
Adult	Strengthening ART CoEs for monitoring patterns and emerging trends of indicators related to ART service delivery	Training improvement. Quality assessment and outcome evaluation of DAC training program.	
	Develop a Technical Support Program to strengthen ART program to improve ART	CoE/PCoE Accreditation. Targeted assistance to CoEs/PCoEs in support of external accreditation for quality practice	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15			
	coverage based on Assessment findings		
	Provide TA to NACO for policy, guideline, curriculum development and for review of CST activities; provide high level clinical TA to NACEP (National AIDS Clinical Experts Panel) and selected SACEP	M&E activities: 1. CoE Assessments - Assist DAC in systematic assessment of all current and new CoEs and PCoEs; 2. Development of key national indicators, ART review meetings, National CST review meetings, CoE/pCoE review meetings	
	Enhancing capacity of Molecular Labs (Viral Load) to implement QMS; Baseline assessment to identify gaps & training needs of lab workforce; Develop training modules & conduct training; Improvement of sample collection, sample transportation methods & strengthening of reporting systems	Triangulation of ART assessment data with data quality/validation exercise	
	Evaluation of Link ART Centers and its cost effectiveness over the ART centers	Study to assess factors associated with Loss to Follow Up for PLHIV on ART, and study of existing models to reduce the LFUs	
Key Populations	Test and treat interventions for key populations	Improving cascade of care for KPs	
Pregnant Women		Develop capacity of AP state governments partners on scale programs to ensure access to comprehensive services for PMTCT, as part of routine antenatal and post-natal care (as per new PMTCT regimen Option B+ initiated in India	
Pediatric treatment (PDTX)	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	Strengthening Pediatric Centers of Excellence (pCoEs) for monitoring patterns and emerging trends of indicators related to ART service delivery		
	Expansion of support to pCoEs in HIV care, support and treatment - Expand support and TA (using selected activities) to existing 7 pediatric CoEs and any additional CoEs launched in program year		
	Enhancing capacity of Molecular Labs (EID) to implement QMS; Baseline assessment to identify gaps & training needs of lab workforce; Develop training modules & conduct training; Improvement of sample collection, sample transportation methods & strengthening of reporting systems		
OVC (HKID)	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	TA to strengthen integration of OVC and	Map and profile children affected by HIV/AIDS in each	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15			
	PMTCT services through training, supportive supervision, and consultation	district to generate data in the care and treatment cascade. Conduct district situational needs assessments and train high-volume facilities to identify sick children and refer to HIV counseling and testing	
		To strengthen multisectorial collaboration between various government departments to ensure that OVC are provided all essential services	
		To increase private sector investment in CABA programs	
Program/system support	**Core Activities**	**Near-core Activities**	**Non-core Activities**
Laboratory (HLAB)			
	Facilitating improved coverage of second line ART through strengthening linkages of 9 viral load testing facilities with 10 CoEs. Provide TA for Quality improvement and strengthening of specimen collection/transportation for Viral Load and Early Infant Diagnosis Enhancing capacity of Molecular Labs (EID & Viral Load (VL)) to implement QMS; Baseline assessment to identify gaps & training needs of lab workforce; Develop training modules & conduct training; Improvement of sample collection, sample transportation methods & strengthening of reporting systems	Scale up of good laboratory practices in peripheral HIV testing & counseling sites	
	Quality improvement of 10 STI regional referral laboratories. Strengthen STI laboratory network and improve uptake of lab and STI care services for prevention of HIV	Develop capacity of STI program - Improving lab Linkages and linkages to services delivery with focus on Implementing QA in regional STI Labs through Accreditation by International Standards-ISO 15189 through QMS training of lab workforce at 10 regional STI labs ; Establish & strengthen EQAs network between 10 regional STI labs & 45 state STI labs	
	Facilitating increase in ART coverage through strengthening referrals from 425 ART centers to 254 CD4 testing sites and strengthening quality of CD4 testing Enhancing capacity of CD4 testing and linkage to service delivery with focus on implementing QMS CD4 testing sites; Train workforce at 254 CD4 laboratories to implement QMS		
	Develop Capacity of HIV referral lab network: 1. QMS training of lab workforce at 13NRLs and 117 SRLs for Lab		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15			
	accreditation as per ISO 15189 2. Direct TA through onsite visits		
Blood Safety (HMBL)			
		Quality improvement in Blood transfusion services through implementing quality standards and External quality assurance program for Transfusion Transmitted Infections (TTIs) including HIV	
		Strengthen Blood service information center (MIS): mapping of blood banks and monitoring on key indicators at national/state level	
		National estimation of blood requirement: estimation of blood used by PLHIV and patients on ART	
		Assist in development/review of five year strategy plan with BTS, NACO and review the legal framework to establish a nationally coordinated blood transfusion services	
		Ensure safe transfusion practice through quality screening of TTIs including HIV	
		Strengthen Blood Bank laboratory workforce through in-service training	
		TA for Implementation of national Blood safety policy	
		PPP initiatives to improve access of blood and components, leverage CSR resources for technology innovations in Blood Transfusion Services	
		Improving quality management system in Blood banks under national AIDS Control Program	
Strategic Information (HVSI)			
IBBS	Determining key population characteristics and locations to guide targeted interventions to bring KPs in for treatment (IBBS, HSS)	IBBS Evaluation	
		National and sub-national level HIV Estimates for HIV	
ANC Surveillance	TA in preparation of ANC Data Analysis and Report Preparation and Dissemination	Technical assistance to implement 2014-2015 round of HIV sentinel surveillance among ANC population	
		Support continuation of IBBS roll out to achieve national coverage for core HRGs, migrants & currently married women in high out-migration districts	
DHS		Support for Demographic Health Survey (DHS) HIV module and sample sizes which will estimate HIV prevalence and gather information about HIV knowledge, attitudes, and practices among general population	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15			
HIV Drug Resistance Surveys		Strengthening national capacity in HIV drug resistance surveillance including improved routine monitoring of ART, & other program outcomes	
Case Reporting		Case Reporting (establishing mechanisms for tracking individuals in the diagnosis, care and treatment continuum , including mortality)	
Implementation Science and Research		Guide the implementation of the National Health Research Plan and support new science that informs better targeting of services for PLHIV and key populations	
Data Quality	Improve program data quality through the development and implementation of a comprehensive Data Quality Management Program which utilizes internal processes and capacities to enhance data use for decision making		
Data Use		Supporting the development of HIV epidemiological data sheets which triangulate epidemiologic and programmatic data for select districts in India	
		TA for National Data Analysis Plan	
		Support integration and decentralization by looking at service integration and quality across programmatic components.	
		Training in data use, data analysis and problem solving at state and district level for HIV functionaries, to utilize currently collected site level data for improvement of series to KP and PLHIV	
		Technical support for strengthening the capacity of program managers, state epidemiologists, M&E officers and other relevant staff involved in data generation, quality management and analysis for use	
National Health Information Systems		Technical support to identify and resolve challenges developing analytic Strategic Information Management System (SIMS) modules, including GIS for decision making and program implementation	
		Information management experts' support for completing the national information system (SIMS) that is the repository for all site level data that drives programming for key populations and PLHIV	
		TA for SIMS data to direct interventions at state and district level to improve the care cascade	
Capacity Building (OHSS)			
	Strengthening capacity of high burden districts to effectively implement the prevention, care and treatment continuum services through DAPCUs		

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Global Transfer Program	End of project	$0	$0	1	July, 2015	
Supply Chain Management	End of project	$0	$0	1	September 30,2015	
Global Fund CCM Support	End of project	$0	$0	1	November 30, 2015	
Totals		$0	$0	3		

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

	Applied Pipeline	New Funding	Total Spend
	$US	$US	$US
India	$6,045,454	$16,954,546	$23,000,000
Sri Lanka & Bangladesh	$0	$2,000,000	$2,000,000
Total	**$6,045,454**	**$18,954,546**	**$25,000,000**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$542,302
HVAB	Abstinence/Be Faithful Prevention	$0
HVOP	Other Sexual Prevention	$2,424,423
IDUP	Injecting and Non-Injecting Drug Use	$1,089,625
HMBL	Blood Safety	$829,595
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$444,168
HBHC	Adult Care and Support	$1,152,490
PDCS	Pediatric Care and Support	$132,729
HKID	Orphans and Vulnerable Children	$105,924
HTXS	Adult Treatment	$454,475
HTXD	ARV Drugs	$0
PDTX	Pediatric Treatment	$248,130
HVTB	TB/HIV Care	$1,204,995
HLAB	Lab	$3,001,435
HVSI	Strategic Information	$1,523,133
OHSS	Health Systems Strengthening	$2,229,110
HVMS	Management and Operations	$3,572,012
TOTAL		**$18,954,546**

B.2 Resource Projections

Each project was closely examined to determine the pattern of quarterly expenditures for the past year. After examination of the most recent quarters of spending, projected outlays for the remaining quarters of FY2015 were revised. This factored into an analysis of the projected pipeline as of September 30, 2015. Then, each mechanism was examined to determine the extent of implementation in FY 2016 (i.e. how many months would the project actually be in operation in FY2016) and whether there were any revisions to the core activities covered by the project. Any reduction in activities was reflected by a reduction in needed funding. For new activities, the Independent Government Cost Estimate was used to project the outlays for the first year of the project, taking into account the estimated date the project would be awarded and that most new projects have an initially low spend level compared to later in the project once implementation begins. New funding requests were adjusted based upon available pipeline to be applied to COP 2015 implementation.

APPENDIX C

Priority population prevention

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Assessment of the quality of targeted intervention (TI) services and demonstrate strategies to improve quality of TI services. TI projects in India are implemented among FSW, MSM, TG and PWID populations.	Protocol		HVOP	HVOP	TA to NACP	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	
Implement lower threshold service strategy to increase availability, accessibility, acceptability, coverage, quality and efficiencies of combination PWID services	Guidelines, Tools	Progress Report	IDUP	IDUP	PWID Collaborative Project	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Establish Real Time Monitoring system (RTM) to capture local level data at service delivery points, represent it visually, and use the data on services for monitoring progress against targets and improving program delivery and quality of services to PWID	RTM application, guidelines	RTM reports	IDUP	IDUP	PWID Collaborative Project	Institutionalized Data Availability, Performance Data, Service Delivery Data Q1 (7) and Q2 (5)	X	X	X	X	
Establish an Implementation Science (IS) agenda and plan to systematically test practical public health strategies to expand coverage and improve quality, efficiencies and effectiveness of PWID services	IS agenda and implementation plan		IDUP	IDUP	PWID Collaborative Project	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Provide targeted TA to scale up Methadone treatment program	Guidelines, Tools	Training Report, Progress Report	IDUP	IDUP	PWID Collaborative Project	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)				X	
Capacity building of Harm Reduction Force on improving quality of PWID package of services and sensitization workshop of law enforcement officials	Task Analysis report, Training module	Training Report	IDUP	IDUP	PWID Collaborative Project	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	
Evidence generation to assess programmatic gaps and barriers, and identify strategies to accelerate scale-up and improvement of the organization and delivery of quality harm reduction services	Evidence Generation plan and protocol	Report	IDUP	IDUP	PWID Collaborative Project	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Develop innovative approaches in the provision of gender-sensitive services for Female PWID	Guidelines, Tools	Progress Report	IDUP	IDUP	PWID Collaborative Project	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	
Provide TA to national institutions to introduce global best practices in improving access to prevention and treatment services for key populations.	Global best practices for KP test and treatment; OST, community testing, outreach to hard to reach groups and addressing gender based violence among KPs, mapped and related guidelines, tools and roadmap developed	Roll-out of test and treat and programs to address violence among key populations introduced in high prevalence states.	HVOP		SHARE UNAIDS	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)		X	X	X	X
Provide direct support for TIs and implementation of District Network Model in Thane.	Increase coverage of outreach services for KPs from 50% to 80%.	Increase coverage of outreach services for KPs from 80% to 90%.	HVOP	HVOP	PIPPSE	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	
Provide technical assistance for effective community	Strong community networks established in 2 states (5	Strong community networks; combat stigma * discrimination	HVOP	HVOP	Linkages	Domestic Program and Service Delivery, Access and Demand,	X	X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
mobilization and empowerment of KPs to raise awareness about their rights and provision of community based decentralized services.	districts).	in 2 states (5 districts).				Services to Key Populations Q4 (3)					
Provide TA to 6-8 TSUs for quality improvement of targeted interventions and data quality enhancement. Pilot TSU integration model in Gujarat in an effort to ensure long term sustainability of prevention program.	Technical Assistance provided to 600 targeted intervention (TI)NGOs; 1-2 TSUs transition to GOI support	Technical Assistance provided to additional 100 TI NGOs. Total 700 TI NGOs	HVOP HBHC	HVOP HBHC	PIPPSE	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	
Provide TA to NACO on establishment and support for NACO Migrant Unit, migrant component of IBBS, and migrant service delivery system.	IBBS data findings for migrant population available.	Increase coverage of outreach services for migrant population to 60%.	HVSI	HVSI	PIPPSE	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Provide knowledge exchanges to Government of India staff and other HIV/AIDS stakeholders in country to benefit from global best practices in KP real-time monitoring, city approaches to the epidemic, community based testing, innovative models to reach Key Populations engaged in new modalities of sex work, and harm reduction models for PWIDs.		Implementation or adaptation of new strategies for KP real time monitoring, community based testing and harm reduction models.	HVOP		SHARE UNAIDS	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	
Demonstrating new community based approaches to "plugging the leaky cascade" for KPs - addressing barriers for improving linkages, referrals and retention in	Develop plan with TIs (via TSU engagement) in 2 states (5 districts) and other community based organizations to monitor KPs access to ICTC, care and	Improved cascade of care for KPs in 2 states (5 districts) Develop plan with TIs (via TSU engagement) in another 5 states and other community based	HVOP HBHC	HVOP HBHC	Linkages	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	X

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
care.	treatment services and assisting with follow-up and retention in care and for repeat testing	organizations to monitor KPs access to ICTC, care and treatment services and assisting with follow-up and retention in care and for repeat testing									
Strengthen capacities of TSUs and TIs to analyze program gaps and barriers across prevention to care continuum services. Focus will be on community based aspects of retaining PLHIV in care and treatment services beyond the first test.	6-8 TSUs with established plans to analyze program gaps and barriers	6 TSUs regularly analyze program gaps and barriers with TIs they provide support to	HVOP HBHC	HVOP HBHC	Linkages	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	

Preventing mother-to-child transmission (PMTCT)

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Strengthen PPTCT Data Management System for Program Improvement	Manual		MTCT	MTCT	TA to NACP	Domestic Program and Service Delivery, Access and Demand, Access to PMTCT Q2 (2)				X	
Scale up of Private Sector Engagement in the PMTCT program, as the largest proportion of deliveries occur in private facilities.	Guidelines, Tools, Training Report	Progress Reports	MTCT	MTCT	TA to NACP	Domestic Program and Service Delivery, Access and Demand, Access to PMTCT Q2 (2)				X	
Improve capacity in PPTCT program monitoring, including outcomes and analysis of cohorts	Reporting formats for Option B+ finalized, support for B+ implementation plan provided, identified states visited and corrective actions proposed and followed up on	Review of implementation conducted. Corrective action recommended and feedback documented	MTCT	MTCT	WHO	Domestic Program and Service Delivery, Access and Demand, Access to PMTCT Q2 (2)	X	X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Program Management Review of the Option B Plus program implementation in India.	Concept Note	Option B+ Program Management Review Report	MTCT	MTCT	TA to NACP	Domestic Program and Service Delivery, Access and Demand, Access to PMTCT Q2 (2)				X	
Single-window testing (for HIV and Syphilis) in all five High priority districts in Andhra Pradesh and Telangana states– Universal coverage of pregnant women	Government Order on implementation of Single window testing and implementation	Implementation of Single window testing and dissemination and scale-up to other states	MTCT	MTCT	UNICEF	Domestic Program and Service Delivery, Access and Demand, Access to PMTCT Q2 (2)	X	X			

HIV testing and counseling (HTC)

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Piloting community-based testing in select NGOs in Thane district and using ICT model, an	Increase coverage of HIV testing to 90% in selected pilot intervention points. ICT rolled out	Increase coverage of HIV testing in selected pilot intervention points to 100%.	HVCT	HVCT	PIPPSE/LINKAGES	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
android based system.	at TI ICTC in one district	ICT rolled out at TI ICTC, ART and program level in six districts				Q4 (3)					
Work with Civil Society Organizations to crowd source new approaches to improve testing in KPs, with a focus on female sex workers and other KPs including MSM and TG.	Announcement of crowd-source opportunity to improve testing in KPs	10 new approaches to improve testing in KPs undergo concept development stage. 3 selected to advance to next stage to demonstrate interventions	HVCT	HVCT	Linkages	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X			
Ensuring that KPs have access to HIV/AIDS testing, care and treatment services, including assisting networks of PLHIV to work together to advocate for key issues and influence policy at national, state and district levels. TA would be		Increase in HIV testing among KPs from 30% to 50% in intervention states	HVCT	HVCT	Linkages	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
provided to groups and networks together.											

Facility and community-based care, support, and treatment – Adults and Pediatric

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Improve care, support and treatment service delivery among CLHIV	Improve quality of clinical care, Retention in Pre-ART and ART care	Improve quality of clinical care, Retention in Pre-ART and ART care	PDCS PDTX	PDCS PDTX	ITECH	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		X
Strengthen Pediatric Centers of Excellence (PCOEs) for monitoring patterns and emerging trends of indicators related to ART service delivery	Improve reporting, Data quality and data usage	Improve reporting, Data quality and data usage	PDCS PDTX	PDCS PDTX	ITECH	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		X

Improve care, support and treatment service delivery to PLHIV through HIV Centers of Excellence (COEs)	Improve quality of clinical care, Retention in Pre-ART and ART care	Improve quality of clinical care, Retention in Pre-ART and ART care	HBHC HTXS	HBHC HTXS	ITECH	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		X
Continue to provide direct care and support services to PLHIV at community centers.	Increase access to care and support services for PLHIV from 10% to 30%.	Increase access to care and support services for PLHIV from 30% to 40%.	HBHC	HBHC	PIPPSE	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)	X	X	X		
Provide knowledge exchanges to Government of India staff and other HIV/AIDS stakeholders in country to learn from global best practices in treatment scale-up, monitoring systems, viral load testing, and community partnership integration from South African programs.		GOI adoption of new strategies for treatment scale-up and viral load testing	HVOP		SHARE UNAIDS	Domestic Program and Service Delivery, Access and Demand, Services to Key Populations Q4 (3)	X	X	X	X	X
Triangulation of ART assessment data with data quality/validation exercise	Report		OHSS		CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		
Review of Link ART Center (LAC) Program	Concept Note	Link ART Centers Program Management Review	HBHC HTXS	HBHC HTXS	TA to NACP	Domestic Program and Service Delivery, Access and		X	X		

		Report				Demand, Uptake of ART services Q5 (2)					
Evaluation of Link ART Centers and its cost effectiveness over ART centers (Under the National Health Research Plan)	Participation in TRG, Research agency selected, protocol developed, protocol approved, study personnel trained	Study initiated and completed	HTXS HBHC	HTXS HBHC	Strategic Assessment for Strategic Action (SASA)	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X	X		

TB/HIV

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Scale up of HIV and Revised National Tuberculosis Control Program (RNTCP) coordination mechanisms in six northern states with poor infrastructure and linkages for HIV and TB cross-referrals		Guidelines, Tools, Training Report	HV-TB	HV-TB	CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)	X	X	X		
Conduct operations research (OR) on Fast-Tracking of known pulmonary TB patients and persons with		OR Report	HV-TB	HV-TB	CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART		X			

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
respiratory infection as an effective airborne infection control practice, to reduce TB infections among PLHIV						services Q5 (2)					
Training of Nurses and Counsellors of high volume ART centers on fast-tracking of pulmonary TB patients and persons with respiratory infection to reduce TB transmission among PLHIV		Training Report	HV-TB	HV-TB	CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X			
Training of HIV-TB coordination teams in two Northern States with high burden for HIV and TB	Training Module and Report		HV-TB	HV-TB	CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)	X	X			
Demonstrate innovative approaches to scale up Intensive Case Finding (ICF) among KPs in targeted intervention (TI) programs and PLHIV in ART		Activity Report	HV-TB	HV-TB	CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X			

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
and Link ART Centers (LACS)											
Strengthen HIV-RNTCP coordination mechanisms in two northern states (identified based on TB and HIV burdens and poor health infrastructure) and scale up to other vulnerable states	Guidelines and Tools	Coordination Reports	HV-TB	HV-TB	CS HIV TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)	X	X			
Crowd-sourcing TB/HIV innovations for TB diagnostics, to improve treatment adherence for TB patients and case detection. Innovative ideas are given seed funding to prove the concept, and then winners of that round are selected for additional funding to prove impact at a larger scale and to demonstrate that they can be scaled up in India to	Selection of 15 innovators for Phase I – duration 6 months and Selection of 4 innovators (from 15) for Phase II – duration 12 months	4 innovations tested that will impact TB/HIV programs	HVTB	HVTB	IKP Knowledge Park	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)		X			

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
make an impact on TB and HIV/TB.											
Building coalitions in urban areas to align the public and private sectors involved in TB control. Focus on improving HIV-TB case detection, referral to appropriate care and management of treatment adherence, including leverage of private sector resources to identify and treat TB/HIV patients in urban areas of India		Case detection processes for TB-HIV co-infections in the private sector in Mumbai, building on BMGF private sector engagement	HVTB	HVTB	CHALLENGE TB	Domestic Program and Service Delivery, Access and Demand, Uptake of ART services Q5 (2)	X	X	X		

OVC

Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism	7. Relevant Sustainability Element and Score	Impact on epidemic control				
2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
DAPCU staff in 16 implementation districts trained in OVC programming.	DAPCU staff in 5 additional districts trained in OVC programming.	HKID		OVC-KHPT		X	X	X		
OVC and PMTCT integration operationalized in 5 districts.	OVC and PMTCT integration Improving services for OVC in 6 districts, transition in Tamil Nadu completed	HKID		OVC-KHPT	Domestic Program and Service Delivery, Access and Demand, Access to PMTCT Q2 (2)	X	X	X		
District level data on OVC available in 16 implementation districts.	District level data on OVC available in additional 5 districts.	HKID		OVC-KHPT		X	X	X		
Multisectorial linkages established in 70% of the implementation districts.	Multisectorial linkages established in 100% of the implementation districts.	HKID		OVC-KHPT		X	X	X	X	

India COP15 Targets by State: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
_Military India	-	-	-	-	-
Andaman and Nicobar Islands	-	-	-	-	-
Andhra Pradesh	107,328	11,609	88,100	7,496	57,470
Arunachal Pradesh	-	-	-	-	-
Assam	-	-	-	-	-
Bihar	-	-	-	-	-
Chandigarh	-	-	-	-	-
Chhattisgarh	-	-	-	-	-
Dadra and Nagar Haveli	-	-	-	-	-
Daman and Diu	-	-	-	-	-
Goa	-	-	-	-	-
Gujarat	-	-	-	-	-
Haryana	-	-	-	-	-
Himachal Pradesh	-	-	-	-	-
Jammu and Kashmir	-	-	-	-	-
Jharkhand	-	-	-	-	-
Jharkhand	-	-	-	-	-
Karnataka	-	-	-	-	-
Kerala	-	-	-	-	-
Lakshadweep	-	-	-	-	-
Madhya Pradesh	-	-	-	-	-
Maharashtra	296,384	20,922	108,982	10,163	77,920
Manipur	10,710	-	-	-	1,006
Meghalaya	-	-	-	-	-
Mizoram	6,387	-	-	-	714
Nagaland	9,865	-	-	-	151
National capital Territiory of Delhi	-	-	-	-	-
Odisha	-	-	-	-	-
Puducherry	-	-	-	-	-
Punjab	-	-	-	-	-
Rajasthan	-	-	-	-	-
Sikkim	-	-	-	-	-
Tamil Nadu	-	-	-	-	-
Telangana	-	-	-	-	-
Tripura	-	-	-	-	-
Uttar Pradesh	-	-	-	-	-
Uttarakhand	-	-	-	-	-
West Bengal	-	-	-	-	-
Total	**430,674**	**32,531**	**197,082**	**17,659**	**137,261**

India COP15 Targets by State: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
_Military India	-	-	-
Andaman and Nicobar Islands	-	-	-
Andhra Pradesh	-	51,069	8,379
Arunachal Pradesh	-	-	-
Assam	-	-	-
Bihar	-	-	-
Chandigarh	-	-	-
Chhattisgarh	-	-	-
Dadra and Nagar Haveli	-	-	-
Daman and Diu	-	-	-
Goa	-	-	-
Gujarat	-	-	-
Haryana	-	-	-
Himachal Pradesh	-	-	-
Jammu and Kashmir	-	-	-
Jharkhand	-	-	-
Jharkhand	-	-	-
Karnataka	-	-	2,500
Kerala	-	-	-
Lakshadweep	-	-	-
Madhya Pradesh	-	-	-
Maharashtra	220,290	49,780	17,934
Manipur	-	-	-
Meghalaya	-	-	-
Mizoram	-	-	-
Nagaland	-	-	-
National capital Territiory of Delhi	-	-	-
Odisha	-	-	-
Puducherry	-	-	-
Punjab	-	-	-
Rajasthan	-	-	-
Sikkim	-	-	-
Tamil Nadu	-	-	800
Telangana	-	-	-
Tripura	-	-	-
Uttar Pradesh	-	-	-
Uttarakhand	-	-	-
West Bengal	-	-	-
Total	**220,290**	**100,849**	**29,613**

India COP15 Targets by State: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
_Military India	-	-
Andaman and Nicobar Islands	-	-
Andhra Pradesh	-	633
Arunachal Pradesh	-	-
Assam	-	-
Bihar	-	-
Chandigarh	-	-
Chhattisgarh	-	-
Dadra and Nagar Haveli	-	-
Daman and Diu	-	-
Goa	-	-
Gujarat	-	-
Haryana	-	-
Himachal Pradesh	-	-
Jammu and Kashmir	-	-
Jharkhand	-	-
Jharkhand	-	-
Karnataka	-	-
Kerala	-	-
Lakshadweep	-	-
Madhya Pradesh	-	-
Maharashtra	-	1,053
Manipur	-	-
Meghalaya	-	-
Mizoram	-	-
Nagaland	-	-
National capital Territiory of Delhi	-	-
Odisha	-	-
Puducherry	-	-
Punjab	-	-
Rajasthan	-	-
Sikkim	-	-
Tamil Nadu	-	-
Telangana	-	-
Tripura	-	-
Uttar Pradesh	-	-
Uttarakhand	-	-
West Bengal	-	-
Total	**-**	**1,686**

India COP15 Targets by State: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Organisation units/Data	-	-
_Military India	-	-
Andaman and Nicobar Islands	17,595	2,774
Andhra Pradesh	-	-
Arunachal Pradesh	-	-
Assam	3,867	42
Bihar	-	-
Chandigarh	5,662	41
Chhattisgarh	-	-
Dadra and Nagar Haveli	-	-
Daman and Diu	-	-
Goa	-	-
Gujarat	-	-
Haryana	-	-
Himachal Pradesh	-	-
Jammu and Kashmir	-	-
Jharkhand	6,510	121
Jharkhand	-	-
Karnataka	-	-
Kerala	-	-
Lakshadweep	5,352	46
Madhya Pradesh	43,420	1,893
Maharashtra	-	-
Manipur	-	-
Meghalaya	-	-
Mizoram	-	-
Nagaland	-	-
National capital Territiory of Delhi	6,708	164
Odisha	-	-
Puducherry	-	-
Punjab	11,767	64
Rajasthan	-	-
Sikkim	-	-
Tamil Nadu	-	-
Telangana	-	-
Tripura	11,318	90
Uttar Pradesh	5,890	44
Uttarakhand	-	-
West Bengal	118,089	5,279
Total	**-**	**-**