

STRATEGIC TECHNICAL ALIGNMENT FOR RESULTS (STAR) PROCESS

PEPFAR India

Country Operational Plan

COP 2017

Strategic Direction Summary

March 27, 2017

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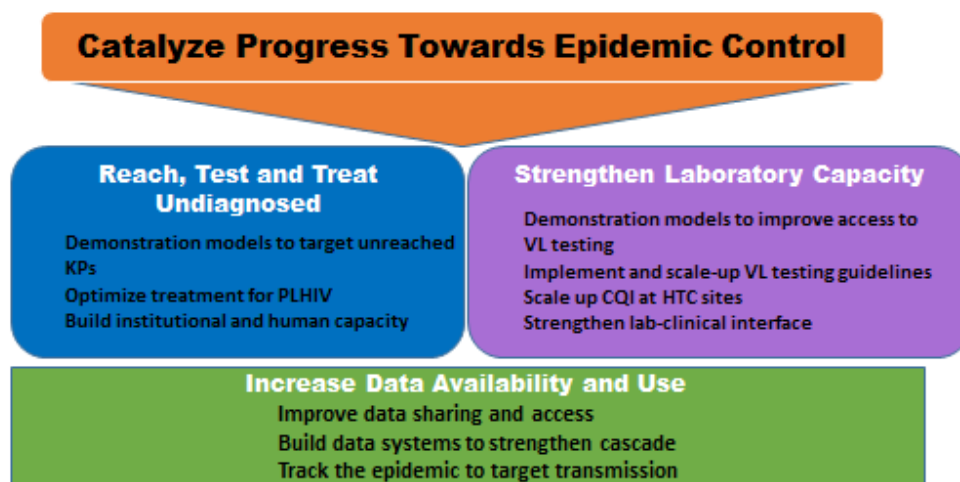
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INDIA - PEPFAR STRATEGY



1.0. Goal Statement

The goal of PEPFAR India's Country Operational Plan (COP 2017) is to catalyze progress towards epidemic control in India, through the demonstration of scalable models for an effective response. PEPFAR continues to partner with the Government of India (GOI) to achieve epidemic control through technical assistance (TA) to the GOI, particularly aimed at identifying and demonstrating high-impact interventions to reach, test, treat, and retain key populations (KPs), which include men who have sex with men (MSM), female sex workers (FSW), people who inject drugs (PWID) and transgender (TG) in geographic areas with the greatest burden of HIV, strengthening laboratory systems and processes, and improving the quality, availability, and use of strategic information. PEPFAR India will use a phased approach strategy to overcome bottlenecks to progress, enable use of lessons learned in early phases of implementation and contribute towards accelerating results prior to replication and scale-up by the GOI.

Based on the analysis of epidemiological and program performance data, PEPFAR India's COP 2017 will strengthen interventions across the HIV cascade with a focus on hidden and hard-to-reach KPs. PEPFAR India will target KPs with high-yield site level activities in three geographic clusters, using an epidemic control approach with demonstration programs to test and demonstrate innovative models for GOI to replicate and scale-up. COP 2017 will strengthen the lab-clinical interface and support the implementation of viral load management. PEPFAR India will work with the GOI to facilitate greater and timely dissemination and use of data, and will ensure that evidence and best practices from successful models will be documented and scaled-up.

In COP 2017, PEPFAR/India will support the GOI HIV/AIDS program through interventions in the three priority geographic areas and above-site investments. In consultation with the GOI, civil society, and development partners, COP 2017 aims to accelerate epidemic control through the following three strategic objectives (SO):

SO 1: Reach, test, and treat undiagnosed cases among KPs in high priority sub-national units

1. Implement, strengthen, and scale-up innovative approaches targeting unreached KPs to achieve 90-90-90
2. Demonstrate models to deliver optimal care and treatment services for people living with HIV

(PLHIV) with a focus on KPs, including Test and Start

3. Build institutional and human capacity to scale-up innovations on the prevention to care and treatment continuum

SO 2: Strengthen lab capacity

1. Demonstrate innovative approaches to improve access to viral load (VL) testing
2. Implement and scale-up VL testing
3. Demonstrate continuous quality improvement (CQI) at priority SNUs and facilitate scale-up at national level to all HIV testing and counseling (HTC) sites
4. Strengthen the lab-clinical interface to improve result uptake and clinical monitoring

SO 3: Increase data availability and use

1. Improve data sharing and access to promote transparency
2. Build quality data systems and strengthen surveillance to track HIV cases and trends, and strengthen the continuum of care cascade, including clinical management
3. Track the epidemic to identify specific high transmission areas in priority sub-national units (SNUs) to facilitate strategies to reach these populations

COP 2017 site level interventions in the three clusters (Andhra Pradesh, Maharashtra, and the North East) will continue with the strategy pivot implemented in COP 2015. PEPFAR India is proposing new ways to optimize models for greater impact, efficiency, and potential for scale-up. PEPFAR India will reduce leaks in the cascade for KPs in the cluster areas and will identify new ways to strengthen partner organizations in the community and build greater capacity among health providers.

At the above-site level, the program will operationalize new GOI initiatives such as Test and Start, including new testing models and VL testing. PEPFAR India will provide TA for the development and dissemination of guidelines, strengthening the lab-clinical interface, surveillance, population size estimates, and data systems to track HIV cases through the cascade. PEPFAR India will continue to work to protect human rights for all KPs, including supporting laws and policies to eliminate stigma, discrimination, and address violence faced by KPs.

In turn, site level interventions will inform above-site technical assistance and influence policy changes. PEPFAR will use these activities to demonstrate potential new practices considered for policies and to inform the policy-making process.

Lastly, PEPFAR India will continue to advocate for the transition of successful models and best practices to the GOI for replication and scale-up nationwide. PEPFAR will develop guidelines and provide skills training and targeted TA in transferring the successes and lessons learned.

While no major shifts are required to address PEPFAR India's COP 2017 objectives, the focus of the program has sharpened. In COP 2017, PEPFAR will have sustainably transitioned its previous work in the prevention of mother-to-child transmission and blood safety, and the PIPPSE project in Thane will end in August 2017.

COP 2017 will provide a platform for the continuation of the strong bilateral partnership between the USG and the GOI to accelerate epidemic control of HIV.

2.0 Epidemic, Response, and Program Content

2.1 Summary Statistics, Disease Burden and Epidemic Profile¹

India's current population is estimated at 1.2 billion.² As of 2015, an estimated 0.26% of the adult population (aged 15–49 years), or 2.12 million people are HIV-positive³, the third largest number of people living with HIV in the world. Just over two percent of all deaths, or 68,000 deaths per year, were attributed to AIDS,⁴ with TB causing approximately 54% of these deaths. India contributes 4% of new annual HIV infections globally.⁵ India is ranked by the World Bank as a lower middle-income country. The country has a gross national income (GNI) of \$1,515 per capita.⁶

India has achieved substantial progress in reducing the spread of HIV, with an overall reduction of 32% in new infections between 2007 and 2015.⁷ As a newly grouped STAR country, with PEPFAR in India providing a modest contribution to the national HIV control budget, the US government has a focused and critical role on providing TA to strengthen the GOI's response towards achieving 90-90-90 goals and on promoting and testing innovative approaches in case-finding to address India's HIV/AIDS service delivery equity and efficiency barriers.

Major barriers include reaching and testing hidden and hard-to-reach KPs, low yield of KP HIV positives, tracking positive KPs and PLHIV across the continuum of care, and low retention in care, support, and treatment. A key challenge is the inability to follow individuals through the entire cascade, due to the separate monitoring and reporting systems used at the community, integrated counselling and testing centers (ICTC), and antiretroviral therapy (ART) center levels.

At the national level, the focus on development of new policies in support of internationally recognized approaches is growing. In April 2017, the National AIDS Control Organization (NACO) will begin a phased roll out of Test and Start nationwide to include KPs and sero-discordant couples. Currently there are 10 VL testing sites in the country with other sites outsourced to the private sector under a national contract. From April 2017, NACO with the support of the Global Fund, will gradually phase out outsourced testing with up to 80 new VL testing sites strategically placed throughout India.

The national program is primarily responsible for adult and pediatric ART ICTCs across India and for approximately 1,550 KP programs (referred to as targeted interventions). Targeted Interventions (TIs) of NACO are preventive interventions working with KPs (MSM, FSW, TG, PWID) in a defined geographic area, where there is a concentration of one or more KP groups. TI projects provide a package of prevention, support, and linkage services to KPs through an outreach-based service delivery model. Members from KP communities are engaged to deliver services and act as agents of change for linkage to services. Since late 2016, community-based testing has been adopted nationally and introduced to community-based centers.

With substantial Global Fund investment and increase in the GOI budget to address the TB/HIV response in India, PEPFAR India will transition its interventions focused on building successful models to test and promptly refer TB patients to care and treatment services. PEPFAR India will leverage its membership in

¹ All NACO figures cited here are fully aligned with UNAIDS data; UNAIDS bases its data on NACO estimates

² NACO uses the figure of 1.2 billion, the population as determined in the 2011 Census

³ India HIV Estimations 2015, NACO

⁴ NACO Technical HIV Estimates, 2015

⁵ India HIV Estimations 2015, NACO

⁶ Central Statistical Organization, Ministry of Statistics and Program Implementation, Annual Report, 2016–2017

⁷ NACO Technical Estimates, 2015

the Global Fund Country Coordinating Mechanism (CCM) to advocate for GOI investment in HIV/TB testing, care, and treatment using lessons from PEPFAR demonstrated models. NACO has acknowledged the need to roll out new policies and guidelines, with technical support from PEPFAR, including a single window approach for joint dispensing of HIV and TB drugs from ART centers, the upfront use of CBNAAT (Xpert®) for faster and improved diagnosis of TB in PLHIV, TB Preventive Therapy (TPT) for PLHIV without active TB, and roll-out of airborne infection control (AIC) at ART centers.

PLHIV stigmatization is still high in India. Currently, an HIV/AIDS bill that supports the rights of PLHIV, focusing on stigma and discrimination, is being considered in Parliament. The Transgender Persons Protection of Rights Bill 2016 prohibits discrimination against transgender in areas such as education, health care, and employment, and was heralded by civil society organizations as a major step forward in the recognition of this key marginalized population in India. It directs the central and state governments to provide welfare schemes to this group in education, health care, and employment.

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				Source (Year)
			Women		Men		Women		Men		
	N	%	N	%	N	%	N	%	N	%	
Total Population	1,210,854,977		78,745,680 (0-6 yrs)	6.5%	85,732,470 (0-6 yrs)	7.1%	508,702,050 (7+yrs)	42.2%	537,389,373 (7+yrs)	44.5%	Census of India 2011; Health and Family Welfare Statistics 2016 Projections, 2013 64% population is 15-59 years
HIV Prevalence (%)		0.26%						0.22%		0.30%	India HIV Estimations (2015) NACO Annual Report 2015-16
AIDS Deaths (per year)	67,612		7,526			11.1%	60,086			88.9%	India HIV Estimations (2015)
# PLHIV	2,116,581		138,456			6.5%	1,978,125			93.5%	India HIV Estimations (2015)
Incidence Rate (Yr)		N/A		N/A		N/A		N/A		N/A	
New Infections (Yr)	86,309		10,361			12%	75,948			88%	India HIV Estimations (2015)
Annual births (Total deliveries)	25,794,000	100%									SOWC, UNICEF 2016
% of Pregnant Women with at least one ANC visit (data is for % of Pregnant Women with at least three ANC checkups to total ANC registered)	22,053,687	77.2%	N/A	N/A			22,053,687	77.2%			SOWC, UNICEF 2016
Pregnant women needing ARVs	35,255	0.35%									India HIV Estimations (2015)
Orphans (maternal, paternal, double)	530,000		No data		No data		No data		No data		Estimated Children orphaned by HIV/AIDS (2014), SOWC, UNICEF 2016
Notified TB cases (Yr)	1,683,915		117,874			7%	1,566,041			93%	Global Tuberculosis Report 2015
% of TB cases that are HIV-Positive	113,000	4%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	WHO Global Tuberculosis Report 2016 Data is for HIV + incident TB cases
Estimated Population Size of MSM*	352,000										Mid-Term Appraisal Report, NACO, 2016
MSM HIV Prevalence		4.4%									India National Integrated Biological and Behavioural Surveillance (IBBS) (2014-15)
Estimated Population Size of FSW	868,000										Mid-Term Appraisal Report, NACO, 2016; State HIV Epidemic Factsheet, July 2014: 2011 data
FSW HIV Prevalence		2.2%									India National Integrated Biological and

											Behavioural Surveillance (IBBS) (2014-15)
Estimated Population Size of PWID	177,000										Mid-Term Appraisal Report, NACO, 2016
PWID HIV Prevalence		9.9%									India National Integrated Biological and Behavioural Surveillance (IBBS) (2014-15)
Estimated Population Size of TG	75,000										Mid-Term Appraisal Report, NACO, 2016; State HIV Epidemic Factsheet, July 2014: 2011 data
TG HIV Prevalence		8.8%									NACO Annual Report, 2014-15
*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.											

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)

	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	HIV Treatment and Viral Suppression				HIV Testing and Linkage to ART		
				PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total Population	1,210,854,977	0.26%	2,116,581	1,420,000***	990,286****	49	No data	29,310,492^	200,463^	114,000^
Population less than 15 years	449,480,430	3.5%*	138,456	126,827***	44,592	No data	No data	No data	No data	No data
15-24 years	17.99%**	****		587,118***	354,632***	60.4%***	No data			
25+ year-olds	54%**	****		34,112,562***	2,380,610***	-	No data			
Pregnant Women	29,339,000****	0.35%****	38,000***	95,799***	64,404***	67.2%***	No data	9,752,124****	12,008****	10,085****
FSW	868,000	2.2%*****	19,096	29,389***	18,934***	64.4%***	No data	463,035	2,503	No data
MSM	352,000	4.3%*****	15,351	17,405***	11,017***	63.2%***	No data	163,473	854	No data
PWID	177,000	9.9%*****	12,637	24,299***	12,551***	51.6%***	No data	79,710	1,042	No data
TG	75,000	8.82% Δ	6,174	9,341***	4,686***	50.1%***	No data	6,758	No data	No data

*HIV/ AIDS in India- World Bank 10 July 2012.

**India Demographic Profile 2016 at Index mundi

***NACO Annual Report 2015-16 and Mid-term Appraisal (MTA) presentation

****India HIV estimates 2015, HIV prevalence in 15-49 years is 0.32

^Program Report, March 2016

2.2 Investment Profile

India's commitment to addressing HIV/AIDS was confirmed by Prime Minister Modi's support to achieving the Sustainable Development Goals (SDG), including the SDG 3 target of ending the AIDS epidemic by 2030. In the 2017–2018 GOI national budget, the amount for the National AIDS and STD Program represents a 26% increase from the previous year.⁸

Table 2.2.1 Investment Profile by Program Area

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support					
Community-based care, treatment, and support					
PMTCT					
HTS					
Priority population prevention		<i>No disaggregated data available</i>			
Key population prevention					
OVC					
Laboratory					
SI, Surveys and Surveillance					
HSS					
Total⁹	\$330 million	7% (\$23M)		93% (\$307M)	

Table 2.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs		0%	50%	50%	
Rapid test kits		0%			
Other drugs		0%			
Lab reagents		0%			
Condoms		0%			
Viral Load commodities		0%			
MAT		0%			
Other commodities		0%			
Total		0%			0%

Expectation is that GOI is procuring 50% of ARVs, and Global Fund is procuring the remaining 50% per previous arrangements. Global Fund was also expected to procure 100% of test kits, condoms, and other commodities, but proportion and total expenditures are unpublished.

NACO is currently implementing the fourth National AIDS Control Program (NACP IV, 2012–2017, extended to 2018) and is preparing NACP V. Over the past five years, the GOI has become the primary funder for HIV/AIDS. India's health sector is, however, highly decentralized. Although annual budget disbursements for HIV/AIDS come from NACO, the authority for budget allocation and implementation of the national health policies is the responsibility of the states. The main source of financing for NACP IV was GOI resources (63%), a major increase from earlier years when international donors supported 75% of overall costs. However, domestic resources continue to be amplified by external donors, including the World Bank, Global Fund grants and extra-budgetary sources, including PEPFAR. The allocation of annual resources in the five-year NACP IV HIV budget was 63% of funding for prevention, 30% for care, support and treatment services, 4% for institutional strengthening, and 3% for strategic information management systems. The 2017–2018 NACO

⁸ GOI Union Budget document “Outlay on Major Schemes,” p. 17; February 2017

⁹ The GOI budget includes funding from the World Bank and the Global Fund.

annual budget was increased by approximately 26% from the 2015–16 budget, which may reflect changes in program policy, particularly the expansion of Test and Start planned for April 2017.

However, the outside resources available to the GOI will lessen. The Bill and Melinda Gates Foundation has closed their site level interventions and is phasing out of HIV/AIDS, and the Clinton Health Access Initiative is also closing. The World Bank loan, planned to end in March 2017, has been extended by one year to March 2018. It focuses on TIs, information, education, and communication (IEC), and institutional strengthening, together with supply chain management.

The Global Fund continues to be one of the largest external funders with a \$238 million HIV/AIDS grant from 2015–2017. A new grant of \$155 million for January 2018–December 2020 is under discussion. A significant portion of the current Global Fund grant is for ARV procurement, which is planned to be transitioned to GOI in a phased manner. This planned reduction in funding takes into account the GOI assuming responsibility for 70% of ARV commodities. These new Global Fund resources will complement PEPFAR’s support in the roll-out and implementation of Test and Start for all PLHIV, with a special focus on KPs. Other Global Fund activities will include the scale-up of VL testing services and the increased retention of patients on ART. Specifically, the Global Fund resources will be utilized for procurement of ARVs and VL testing machines. The PEPFAR program complements the Global Fund program by demonstrating implementation modalities for rolling out Test and Start for KPs, expansion of VL testing services in high burden locations, and providing TA for national level scale-up. GOI has initiated discussions to develop a costed National Strategic Plan for seven years and to identify the programmatic gaps for the Global Fund allocation period 2018–2020 given the decline in funding for the next project period

Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$6,000,000	\$0	\$0	\$0	
USAID TB	\$9,500,000	\$0	\$0	\$0	
USAID Malaria	\$0	\$0	\$0	\$0	
Family Planning	\$10,000,000	\$0	\$0	\$0	
CDC (Global Health Security)	\$4,732,287	\$0	\$0	\$0	
Total	\$40,100,000	\$1,800,000	3	\$1,294,167	

A major vulnerability in the HIV/AIDS budget is the supply of antiretroviral (ARV) drugs, test kits and other HIV commodities, which have experienced shortfalls in procurement and distribution. Currently, the Global Fund covers the majority of the cost. PEPFAR does not support the supply chain, but PEPFAR programs are vulnerable to shortfalls.

2.3 Sustainability Profile

PEPFAR India's 2017–2018 program proposal is aimed at sustaining efforts that address weaknesses which threaten sustainability. These include overcoming the increased difficulty in reaching KPs outside of the TIs, strengthening the capacity of health workers, working to promote and sustain VL and other lab procedures, facilitating the tracking of patients across different health services to strengthen cascade data, and assisting with the development of permanent, strengthened strategic information (SI) systems. The USG is also working to train and mentor health staff and community organizations to better detect and treat HIV-positive individuals. Another critical element that affects sustainability, though this is not in the PEPFAR India mandate, is the procurement and management of ART commodities. Historically jointly supported by the Global Fund and the GOI, the responsibility will now be primarily met through GOI funding. With plans to roll

out Test and Treat, it is critical that availability of ARVs is secured. PEPFAR India will provide TA to forecast and advocate for continued funding of ARV procurement.

NACO's leadership and funding of the HIV response in India are existing strengths that foster sustainability. The increased 2017–2018 budget for NACO demonstrates the GOI's commitment to a sustainable process. The policies developed and disseminated nationally by NACO also create a strong public health program. NACO funds the majority of HIV/AIDS service delivery and plans to fund a greater proportion of commodity procurement in the future.

PEPFAR India's seat on the Global Fund CCM ensures USG funding is complementary and not duplicative. Ongoing collaboration with civil society organizations is also essential to achieving sustainability. Interventions with KPs and other vulnerable groups will be carried out in partnership with civil society, and implemented through community-based organizations, health workers, and peer monitors.

Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$6,000,000	\$0	\$0	\$0	
USAID TB	\$9,500,000	\$0	\$0	\$0	
USAID Malaria	\$0	\$0	\$0	\$0	
Family Planning	\$10,000,000	\$0	\$0	\$0	
CDC (Global Health Security)	\$4,732,287	\$0	\$0	\$0	
Total	\$40,100,000	\$1,800,000	3	\$1,294,167	

2.4 Alignment of PEPFAR Investments Geographically to Burden of Disease

In COP 2015, based on a priority analysis, PEPFAR India selected three clusters geographically aligned to the burden of disease to focus our efforts. COP 2017 will continue to focus on these clusters, which are three districts in Andhra Pradesh (AP) state (East Godavari, Guntur, and Krishna), three districts in Maharashtra (MH) state (Mumbai, Pune, and Thane), and twelve districts in the North East region (Chandel, Churachandpur, Imphal East, West Imphal and Ukhrul in Manipur, Aizawl and Champhai in Mizoram, and Dimapur, Kohima, Mokokchung, Tuensang, and Phek in Nagaland, hereafter referred to as the North East) The program in the North East focuses specifically on people who inject drugs (PWID). In addition to the 12 high burden districts, above-site activities take place in other high burden districts in the NE region.

The first two states (AP and MH) and the districts within them were chosen because they have the highest absolute number, as well as the highest proportion, of PLHIV. The North East was selected because, although the population is smaller, the proportion of PLHIV in the regional population is high. The state of Andhra Pradesh (AP) has the greatest number of PLHIV in the country, with 395,000 (prevalence 0.66%), which comprises 19% of the PLHIV burden in India. Maharashtra (MH) has 301,000 PLHIV, the second largest number in India (prevalence 0.37%), which represents 14% of the PLHIV in India. More than one-third of estimated national ART need is in AP and MH. In the North East, there is a continuing epidemic of HIV/AIDS, with infection in PWID recognized as the key driver of the epidemic there.

Although the current HIV prevalence in India is 0.26%, in reality there are many different overlapping epidemics between states, regions, and risk groups. Overall, recent data¹⁰ shows higher prevalence for several KPs: 2.2% in female sex workers (FSW), 4.3% in men who have sex with men (MSM), 8.8% in transgender (TG),

¹⁰ Integrated Biological and Behavioral Survey (IBBS); 2014–2015 and for TG, HHS Sentinel Surveillance, 2011

and 9.9% in PWID. The HIV prevalence among KPs in the three clusters was higher than the national level. Prevalence among FSW was 7.4% in Maharashtra and 6.3% in Andhra Pradesh. Similarly, HIV prevalence was also high among MSM Andhra Pradesh (10.1%) and Maharashtra (4.9%). In the North East the prevalence of HIV among PWIDs was 12.1% in Manipur, 10% in Mizoram, and 3.2% in Nagaland.¹⁰

PEPFAR program data from family-based testing methods of PLHIV from 2015–2016 have demonstrated new HIV positivity rates of 30% in adults and 5% in children. Results from PEPFAR's index-based testing approach have shown a 4% HIV positivity in partners of KPs. In all three geographic areas, PEPFAR is working closely with the State AIDS Control Societies (SACS) and District AIDS Prevention and Control Units (DAPCUS), holding regular meetings with updates on activities, and involving NACO and SACS staff in the progress, monitoring and evaluation of the demonstration projects. Working at an above-site level, methodologies and best practices from new approaches can be transitioned nationally or to other areas to strengthen programming. The effect of capacity-building of health providers and the frequency of consultation with both communities and health staff will also be closely monitored.

2.5 Stakeholder engagement

COP 2017 was developed by engaging with a wide range of national stakeholders. This reflects PEPFAR India's long-standing collaboration with NACO, the SACS, the Global Fund, the World Bank, development partners and civil society, particularly organizations representing KPs. In addition to ongoing collaboration with government and community partners, a day-long meeting was held with senior members from NACO and other stakeholders to discuss current gaps and challenges related to the HIV/AIDS epidemic and solutions to those challenges. Separately, a consultation was held with male and female PWID community members from the North East to discuss gaps and elicit inputs to address the barriers and further strengthen PEPFAR India's response.

At the site level, quarterly meetings with implementing partners, and regular SIMS visits to demonstration sites, followed by discussions of findings, will contribute to a joint understanding of results. At the national and state level, PEPFAR will continue to share current results and information with the SACS and NACO. USG technical and management staff meet almost daily with various technical groups at NACO to review project activities and results, discuss concerns, and provide input on policy and health systems strengthening issues.

3.0 Program Activities for Epidemic Control

3.1 Description of Strategic Outcomes

COP 2017's strategic outcomes address finding, linking, treating and retaining KPs. Activities planned are listed in the Focused Outcome Impact Table (FOIT). These activities have been discussed with NACO and with the SACS in priority states. The overall goal is to build upon recent gains to catalyze further progress towards epidemic control.

PEPFAR India has a strong track record of close collaboration with NACO and the SACS. Over the past few years, PEPFAR has introduced new methodologies through demonstration interventions, and has provided TA to HIV/AIDS services and systems throughout the health sector. For example, PEPFAR's interventions and TA have included, as best practices acknowledged by and transitioned to NACO, community-based models and guidelines, a KP-specific M&E tool developed and scaled up by NACO, a secondary needle and syringe distribution program to reach PWID, index-based testing to increase the HIV positivity yield among KPs, and the transition of the State Technical Support Units – previously supported in priority states by PEPFAR India – to NACO management. It is expected that 75% of all interventions and TA proposed in this COP will in turn be transitioned to NACO or SACS management.

SO1: Reach, Test, and Treat Undiagnosed Cases Among KPs in High Priority SNUs

SO1 focuses on reaching, testing, and treating undiagnosed PLHIV among KPs in high priority SNUs.

SO1.1: Implement, strengthen, and scale-up innovative demonstration interventions targeting unreached KPs to achieve 90-90-90

GOI has supported expansive physical hotspot-based prevention and testing programs among KPs since 1997. KPs access these hotspots for the regular package of preventive services and routine testing, and are individually tracked. However, significant weaknesses have been identified in PEPFAR India cluster areas. These include suboptimal KP reach and testing, weak linkages, and low ART coverage among KPs. According to program data collected by a PEPFAR partner in five PEPFAR districts, major gaps were revealed in the HIV cascade for KPs: 54% of FSWs and 35% of MSMs were tested, and the proportion of new positives was low (0.53% of FSW and 0.51% of MSM), as was the total retained in ART. In context of the 90-90-90 goals, India has an estimated 2.1 million people infected with HIV, 1.5 million of whom are diagnosed (29% not diagnosed), and 1 million of whom are on treatment (35% not initiated).¹¹ VL data is not available at this time. There is a treatment gap of 42%. PEPFAR India will demonstrate new innovative strategies to increase reach and yield and to link KPs to HIV services at the site level. These strategies, aimed at finding the missing KPs, will include but are not limited to: hotspot analysis, peer navigation, snowballing, contact tracing, social networking, and use of technology to reach mobile KPs and their networks. To increase reach to KPs, PEPFAR India will introduce and evaluate new HIV testing models (e.g. Assisted Self-Testing) among hard-to-reach KPs. Alternative social-media based models will also be implemented for providing HIV services to KPs who are not covered under the TI programs and are often unreached for essential HIV services. Additionally, PEPFAR India will identify and address priority gaps and barriers in the national response for the hardest to reach KPs (TGs and MSMs). Best practices will be identified through innovative demonstration projects, leading to increased access of TGs and MSMs to services across the continuum of care, from prevention services to linkage and retention in care. Technical assistance will also be provided to NACO to promote policy changes, which will address structural barriers to accessing care for hardest to reach KPs and linkage to other healthcare services and social benefits.

PEPFAR will continue to strengthen existing social network testing strategies among hidden and non-venue based KPs. The Enhanced Peer Mobilization model will continue to increase HIV prevention and testing, and improve enrollment in care for those who test positive through an informal network of incentivized peer mobilizers who recruit clients from within their social and sexual networks. The index-based testing approach will continue to reach and test sexual partners (spouse, live-in and casual) of PLHIV KPs active in the TI. Peer Navigators will facilitate and track referrals to improve enrollment and retention in HIV care.

In the North East, PEPFAR has been successful in identifying 2,664 unreached PWID and 12,000 underserved PWIDs between April to September 2016, and they will be linked to services. Through the COP 2017 strategy, PEPFAR India will strengthen the community networking project and link the unreached and hard-to-reach PWID, including young PWID, to the Test and Start program initiated by the government. To further cut the transmission, the project will scale-up the demonstration interventions on secondary needle and syringe distribution and innovative medication-assisted treatment (MAT) approaches. In addition to sustaining the response, the project will build institutional capacity, including that of community-led organizations. PEPFAR will work with NACO to transfer the lessons learned from the demonstration projects implemented in the North East to other KPs in North East and other high burden PWID states by developing guidelines, providing skills training, and targeting TA.

In AP and MH, PEPFAR will scale-up the family-based testing model across the cluster districts to increase

¹¹ National Care and Treatment Review 2016 (unpublished)

reach and testing yield among children, spouses, and partners of KPs. This intervention has proven successful in reaching adults and children that had not been tested in the past and linking them to care, support, and treatment in early stages of disease progression. Guidelines and SOPs for the testing model will be disseminated for adoption by the national program.

PEPFAR India will increase access to social protection schemes for KPs and orphans and vulnerable children (OVC) with particular focus on children of PWIDs. Key strategies include economic strengthening and an increased focus on linkages to the schemes. Emphasis will also be given to increasing access to HIV testing for OVC and their families. The project will particularly target the children of KPs, especially FSW and PWIDs, affected and infected by HIV/AIDS and will create linkages between social service and health care providers. These activities will be carried out in the cluster areas of AP, MH and the North East, with a transition plan for above-site TA to support the utilization of this system at a national level. PEPFAR India will also focus on adolescent PWIDs and sex workers under eighteen years of age to assess the needs of these vulnerable groups and to link them to social protection and welfare schemes and services.

The overall objective is to facilitate access to and institutionalize the provision of essential health and social services for KPs and OVC. While social protection schemes provide education, nutrition, economic, livelihood and other benefits to the applicants, many are often unaware of these benefits and encounter great challenges in accessing them. At the site level, OVC activities will work with the DAPCUs to implement a “single window” approach for accessing social protection schemes within the ART Centers. KPs and OVC visiting the ART Center will be provided with the information needed to apply for social protection benefits. At the above-site level the project team will build the capacity of the DAPCU's M&E staff to compile a monthly report on the usage of the system, will develop guidelines for social protection schemes, and will advocate for the adoption of this combination of medical and social services by other states and at national level.

SO1.2. Demonstrate models to deliver optimal care and treatment services for PLHIV, with a focus on KP, including Test and Start

Identified HIV positives are referred to ART centers where care, support, and treatment services are provided along with baseline laboratory investigations, management of select co-infections, and management of various opportunistic infections. To improve quality of care and treatment services and ensure retention in care (both first-line and second-line treatment), center-specific gaps have been identified on the basis of a desk review of ART assessment reports, the early warning indicator for HIV drug resistance, quality of care indicator reports and site visits; focused work is being undertaken in identified centers. To complement the work being done and the lessons learned in the North East, focused work will be done at high-load PWID ART centers across the cluster to ensure access to optimal treatment services and improve retention in care. Simultaneously, work on the development of models to decentralize and ensure access to treatment in a stigma free, patient-friendly environment has already started. To strengthen the existing decentralized treatment units (LACs) and implement the model service concept of differentiated care in AP and MH clusters, existing LACs will be set up as model demonstration sites, to increase the quality and uptake of services in these units, and facilitate later scale-up to other states.

In the AP and MH clusters, PEPFAR will support the development of a demonstration model for implementation of TB preventive therapy (TPT) in PLHIV as a part of standard package of HIV care, establish systems for monitoring the uptake of TPT and follow-up, ensuring adherence. PEPFAR will facilitate the transitioning of the model to the national program in year 2 for scale-up.

SO1.3: Building institutional and human capacity to scale-up innovations on the prevention-to-care continuum

Above-site TA will include sharing the knowledge gained from these aforementioned interventions, providing TA to NACO and the states to develop various clinical and operational guidelines and enhance implementation

systems, conducting periodic assessments, ensuring documentation of best practices, and providing assistance to the GOI to scale-up proven approaches.

SO2: Strengthen Lab Capacity

SO2 focuses on strengthening lab capacity in the public sector, with an emphasis on accelerating and ensuring 100% access to VL testing in priority SNUs through demonstration models and approaches for national uptake within the next two years.

GOI is working to scale-up VL testing to meet the target of one million tests through 80 new public sector labs. Access to HIV testing has been scaled up to 29 million tests per annum through more than 5,000 HTC sites. However, weaknesses in the GOI program include lack of VL testing capacity and coverage, sub-optimal quality of HIV testing, and weak lab-clinical interface.

SO2.1: Demonstrate state-of-the-art approaches to improve access to VL testing

PEPFAR will focus on establishing and strengthening patient referral systems for KP PLHIV to increase access to VL testing. Training will also be provided to community and front line health workers to increase awareness and generate greater demand for VL testing.

To accelerate the accessibility to viral load testing, PEPFAR will demonstrate new laboratory interventions in the area of specimen collection (DBS) and transportation as well as point-of-care testing (POCT) to reach out to PLHIV and to assist in providing services in difficult geographic terrain such as the North East.

SO2.2: Implement VL testing at priority SNUs and facilitate scale-up at national level.

PEPFAR will continue to support the GOI at the national level in further building the VL lab capacity of 10 VL facilities which will be upgraded to Centres for Quality Assurance (CQA) for VL labs and fast tracked to achieve ISO accreditation by replicating the lab accreditation demonstration model. Further, PEPFAR will support GOI in identifying and setting up systems to build the capacity of 80 new public sector VL facilities, mentored by CQA and establish a network to meet the VL demand of over a million tests annually. PEPFAR will continue to support national technical working groups and committees for implementation of guidelines as well as conduct training of trainers (TOT) to create a pool of trainers for national VL roll-out.

At the priority SNUs, PEPFAR will support implementation of the VL guidelines, Quality Assurance (QA) procedures and tools/training material to accelerate routine VL testing.

SO2.3: Demonstrate continuous quality improvement (CQI) at priority SNUs and facilitate scale-up at national level to all the HIV testing and counseling (HTC) sites.

To enhance access to HIV testing and counselling, HTC sites have been decentralized to the district, sub district, and community levels.

Based on the successful lessons learned from the PEPFAR lab accreditation program, PEPFAR India will set up a demonstration model for CQI. This model will work to achieve certification at HTC sites and improve proficiency testing performance in priority SNUs, leading to better quality testing services.

Using the demonstration model from the priority SNUs, PEPFAR will facilitate scale-up at the national level at all the HTC sites (>5000 HTCs).

SO2.4: Strengthen the lab-clinical interface to improve result uptake and clinical monitoring

Members of civil society organizations made a strong request for improved laboratory services for PLHIV, including single window services, in district level laboratories during our recent stakeholder planning meeting.

According to NACO (2014), only 63% of PLHIV on ART received basic lab services (diagnosis of adverse drug reaction, baseline work-up, and investigations for opportunistic infections for comprehensive management of PLHIV). PEPFAR India will support implementation of a sustainable integrated district model of laboratory services for comprehensive clinical management of PLHIV.

SO3: Increase Data Availability and Use

GOI supports the National Strategic Information System and 16 other data systems to track the program response. GOI also tracks bio-behavioral markers among KPs and other populations through surveillance, and conducts a HIV estimation every other year. They also support 189 DAPCUs that support decentralized coordination for effective program response. PEPFAR India will work to strengthen the data systems by addressing the following weaknesses: lack of integrated quality data systems which limit the availability and use of data; the lack of mechanisms for case-based reporting; the lack of district HIV and KP size estimates; and inadequately trained staff to monitor the epidemic.

SO3.1: Improve data sharing and access to promote transparency

There is a need for greater access, analysis, and utilization of data. PEPFAR India will support integration across national information systems, strengthen guidelines and capacities on M&E and surveillance, and support generation of new evidence to inform improved local decision-making and for refining program strategies- all of which will impact data access, sharing, and transparency in the analysis of data for epidemic monitoring. Key components are the production, analysis, and use of data in the clusters and at the national level to characterize the epidemic and the effectiveness of PEPFAR support to the government's response to the epidemic.

SO3.2: Build quality data systems and strengthen surveillance to track HIV cases and trends as well as strengthen the prevention to care and treatment continuum cascade, including clinical management.

Integration of the national individual and aggregate systems will address the challenges associated with tracking beneficiaries and patients through the continuum of HIV diagnosis to care and treatment, resulting from the lack of a unique patient identifier and the different monitoring and reporting systems used to track patients at various facilities. PEPFAR India will also work to strengthen the existing recording and reporting system for NACO and SACS to optimize program data quality and usage. Further, PEPFAR will provide TA for demonstration district dashboards-based epidemiology monitoring and support case-based reporting for KPs. In strengthening the cascade, facility-level data systems will also be a key system quality focus (e.g. QI of ART centers reporting systems).

SO3.3: Track the epidemic to identify areas of uninterrupted transmission to target strategies for these populations in priority SNU

PEPFAR India will continue to support high-quality scientific evidence with data generation and dissemination through regular technical support to national and state surveillance studies. This includes NACO's integrated bio-behavioral KP surveys (IBBS) as well as the generation of new evidence to guide strategies to reach hard to reach populations, such as guiding active case finding among KPs and their sexual and social networks. Regular data reviews will be held to monitor movement in the cascades and identify successes and areas for improvement. Fundamental to this initiative will be strengthening the capacity of district level M&E staff who will be critical to tracking and identifying local epidemics for control.

3.2 Site Level (rationale, geographic and population prioritization)

Site-level approaches will focus strongly on community involvement. This includes more support to guide and monitor KPs through the continuum of care, strengthening social network and community-based testing, and

continuing index-based and family-based testing to reach KPs, KP partners, and their children and family members. In the North East, PEPFAR will address the barriers PWID face through innovative community level intervention models including interventions in prisons, churches, and with the police.

New approaches, such as digital media, e-learning modules, and videos will be structured to focus on new KPs. PEPFAR India will collaborate with civil society organizations (CSOs) to reach KPs needing HIV testing and will promote a Peer Mobilizer model to identify and monitor take-up and retention of treatment for HIV-positive clients. Supporting facilities at the community level will strengthen demonstration interventions with KPs and PLHIV: NACO is currently discussing the introduction of community-based ART centers as a means to minimize PLHIV loss to follow-up. Building the capacity of health workers, outreach workers, and new community-level staff will be an essential component of site level interventions. Access to treatment services will be improved, especially for PWIDs and FSWs; satellite ART dispensation centers within the public health facilities will be introduced in the North East as well as the AP and MH cluster.

The family-based testing approach has proven to increase the yield of previously undiagnosed HIV cases, who are then guided through the continuum of care. Results in 2016 found that, of 2,606 children tested for HIV, 5% (121) were undiagnosed HIV-positives, while of 857 adults tested, 30% were positive. 77% of adults testing positive and 75% of children testing positive were linked to care and treatment services. The interventions were initiated either when PLHIV reached the ART center, or through community outreach focused on clusters with high numbers of PLHIV. The project will continue to implement the successful interventions in six cluster districts, with the aim of transitioning them to NACO and the SACS in 2019. A transition plan is built into the design of this project, as indicated by the associated benchmarks. In year 1, the family-based testing approach will be documented, and problems overcome and lessons learned will be shared with the SACS in AP and MH. The guidelines and SOP for family-based testing will be developed and shared with NACO. In year 2, technical assistance will be provided to NACO for the national scale-up of family-based testing.

Under the index-based testing method, the TI non-government organization (NGO) counselor plays a key role by contacting and motivating the sexual partners of KPs to be tested for HIV. Once the sexual partner of the KP PLHIV is identified, the TI outreach worker accompanies the partner to the nearest government HIV testing center. Partners testing positive are subsequently assisted in linking to the ART center for treatment. The HIV positivity yield for this group was 4%, compared to only 0.09% (88/93,905) HIV positivity obtained through the conventional TI approach during the same period. The highest positivity, which is 9%, was found among spouses, followed by 2% among live-in and casual sexual partners. Additionally, 90% of all identified positive KP cases were linked to treatment. This is an effective approach for early identification and treatment of new KP PLHIV.

Since April 2016, a program with PWID has been implemented in the North East which has rolled out a demonstration project on community mentoring for identifying unreached PWID populations and reducing barriers along the prevention to care and treatment continuum of services. Gains have been achieved in the project in the North East, laying the groundwork to catalyze further progress. By adopting community networking strategies, the project identified 2,664 hard-to-reach PWID. In the priority districts, retention in Medication Assisted Treatment (MAT) was high with 74% as compared to 53% in non-priority districts. Similarly, an increase in HIV testing coverage was observed in priority districts where 97 new infections were identified, versus 54 in non-priority districts. More importantly, prior low CD4 coverage, signifying that many PWID had failed to access ART, was reversed in the priority districts through mentors who interact with the facilities and the PWID.

PEPFAR India's program in the North East will strengthen existing and implement new demonstration projects to reach highly vulnerable unreached male and female PWID with the core package of harm reduction services. The demonstration projects include a community mentoring program focused on this group, including young PWID, and linking this unreached population to Test and Start. PEPFAR will also introduce a

young PWID volunteers program for improving access to services, expand secondary needle and syringe distribution outlets in hard-to reach-areas, and scale-up flexi-time, task shifting, and take home dosing. Demonstration projects will also include satellite MAT centers for female PWID to increase coverage and retention in MAT centers, expanding the helpline on overdose management, and addressing structural barriers such as incarcerations by police and stigma and discrimination by church and community gate keepers. The prison interventions to ensure that inmates can receive HIV services, currently implemented in three central jails reaching over 1,300 inmates, will be further enhanced by the addition of mobile HIV testing, the introduction of MAP dispensaries for OSD, and a stronger ART program. A real-time monitoring system is being introduced and assessed to track individual PWID across the cascade to reduce loss to follow-up and ensure retention. The project is also implementing structural interventions to address barriers faced by the PWIDs, including human rights issues. The project will transfer the lessons to other KPs in the North East.

PEPFAR India will implement innovative patient referral models to ensure that KPs are linked to treatment services and are retained in care, working in collaboration with the community. Innovative models for delivery of treatment services are being planned to improve access to quality treatment and the efficiency of the ART centers. To improve access to quality treatment, projects to demonstrate differentiated care, task shifting, and ART dispensation models for KPs and other PLHIV will be implemented.

PEPFAR will also support capacity building of public sector labs, targeted laboratory staff training, and other technical assistance to address issues in scaling up services for HIV rapid test (RT), VL, and related lab services. A system of CQI will be scaled up in priority SNU to ensure that high quality services will be strengthened and monitored at all sites. Building upon PEPFAR India's strong lab system strengthening and accreditation program, lessons learned will be replicated in HTC sites and scaled up to priority SNU. PEPFAR will introduce and test new interventions, including dried blood spots (DBS) as a specimen type for VL testing, to increase accessibility for specific populations, such as KPs and populations in difficult geographic terrain. PEPFAR will strengthen the lab-clinical interface for VL by providing tools and clinician and lab staff trainings in priority SNU. Additionally, PEPFAR will work with the treatment centers to strengthen the lab-based clinical monitoring of patients, emphasizing regular review of patient treatment records. Key activities at all facilities will include baseline assessment, onsite mentoring and supportive supervision, e-learning programs, and proficiency testing (PT) coverage and accreditation.

At the cluster level, data use for action, including triangulation, as well as basic and advanced data analysis are essential requirements for district M&E staff since they provide an overall view of the entire HIV program and cascade. USG will invest efforts into supporting districts to analyze their data in a way that generates evidence for guiding strategies to find unreached KPs and their partners. Consolidated guidelines and trainings on basic and advanced data analysis for all district M&E staff will aim to develop skills needed to generate data to guide decision-making. In close collaboration with NACO, the PLHIV ART Linkage Systems will be implemented for tracking PLHIVs (including KPs) and their families to develop continuum of care/cascades in AP and MH on a demonstration basis which will then be scaled up to the national level. USG will support SACS and DAPCUs in the clusters to undertake indicator rationalization to identify priority indicators for epidemic monitoring, develop district data dashboards for district level epidemiological analysis around KP and other high-yield populations, develop automation tools for information systems that check data quality and reduce manual errors, build the capacity of staff to carry out regular analysis of data for local decision-making, and fill critical human resource gaps. Standardized methods and operational guidelines for producing HIV estimations at the district level and for conducting rolling population size estimates for KPs will be developed in collaboration with relevant stakeholders and implemented in the 6 districts to gather lessons and inform national scale-up.

To strengthen adherence and retention in care among the beneficiaries availing services from ART and Link ART Centers, a cost-effective IT-based demonstration project will be implemented in the North East to track patients' ART pill count and institute a mechanism to send reminders to providers and patients for compliance using mobile technology. To improve the quality of services at the high patient load ART centers, a project will

be implemented to demonstrate process improvement using existing resources addressing sustainability. PEPFAR will continue to provide technical support to strengthen the DAPCUs of NACO at AP and MH cluster districts in increasing access across and decreasing the linkage losses in the prevention and care and treatment cascades.

PEPFAR India also provides technical support to NGOs, MAT and ART facilities to carry out local level analysis at the sub-national level and use the information to intensify interventions in locations with the highest burden. In the North East, for example, PEPFAR carried out an analysis of ART and ICTC data to understand the drivers of the epidemic and target interventions to affected age groups, such as young PWIDs and high burden districts.

All programs will include a transition plan to NACO or SACS management, with the timing of each transition depending on intervention results, gaps revealed by national and state data, progress in implementing needed change, and the availability of USG funding. Only successful activities will be transitioned, with success defined during planning and monitoring. All project elements may not be transitioned independently; for instance, training materials could be shared nationally before mainstreaming a project. The financial cost of each project, including the cost of monitoring and evaluation, the staff needed, and the time required to result in a benefit to epidemic control, will all be built into project design.

3.3 Critical Above-Site Systems Investments for Catalyzing Further Progress Toward Epidemic Control

Above-site investments are enhanced with regular interaction of PEPFAR India staff with NACO and the SACS. In COP 2017, PEPFAR's key above-site level investments will focus on three critical inputs: 1) facilitation of national data systems integration; 2) strengthening national dashboards to encourage data use and availability; and 3) development of methodology for KP size estimations and improving HIV surveillance methodologies. PEPFAR's TA is linked to site level data that is regularly collected and reviewed. This requires established structures such as state level committees and district level mechanisms that monitor the progress of site interventions through quarterly monitoring. Supportive supervision and monitoring is carried out at the field level. For example, in the North East, a full review of project activities at the facility and NGO level is carried out every quarter by a team comprised of the activity manager, NACO officials, SACS staff, and the project team.

PEPFAR provides TA in strategic development, advocates for policy adoption (such as the implementation of Test and Start), dissemination of policies to states, development of standard operating procedures and guidelines and advocates for streamlining procedures to facilitate data collection, such as harmonizing or further linking data systems, and facilitating access to and the timely distribution of data.

In the area of treatment, work at the national level involves providing direct support to NACO. As the program is scaled up, special efforts need to be put in to ensure treatment quality and implementation of Test and Start in accordance with national policy. Working closely with the treatment Centers of Excellence (COE), we aim to improve the quality of treatment (first-, second- and third-line), and improve the uptake of VL testing for PLHIV nationwide. Through collaboration with the COEs, we will share, discuss, and disseminate lessons learned from implementing KP-specific activities in the cluster districts across the country.

Further, to enhance access to HIV counselling and testing, ICTCs have been decentralized to the district, sub district, and community levels by the GOI. There is an 88% increase in number of HIV testing centers from 2011-12 (10,515) to 2015-16 (19,800 centers). There is a 58% increase in HIV testing from 2012-13, with the NACP IV target of 28 million tests exceeded, at 29 million tests. To assure quality in HIV testing, PEPFAR will promote the national uptake of lessons learned from India's Laboratory System Strengthening project to HTC sites. In addition, work at national and state level supports and validates state-level interventions. For example, PEPFAR provides TA for development of a strategic framework for VL and for the scale-up of VL testing guidelines. PEPFAR will develop training tools and support the roll-out of VL testing in priority SNU as a

proof of concept for national scale-up.

Other activities include TA to increase access to social protection schemes for KPs and OVCs in a stigma-free environment. This includes strengthening the evidence to support social protection interventions, providing TA to NACO and the states to develop operational guidelines and enhance implementation systems, conducting periodic assessments, ensuring the documentation of best practices, and providing assistance to the GOI to scale-up proven approaches. PEPFAR will also explore options of introducing sustainable financing approaches in HIV/AIDS program. Currently, there is no national policy on Pre-Exposure Prophylaxis (PrEP). PEPFAR India will generate evidence for the development of a PrEP national policy for the feasibility of introducing PrEP as part of the national program and its probable adherence rates among KPs. USG will also support the GOI in the implementation of the PrEP policy.

PEPFAR has provided technical assistance at the national level for strengthening the PWID program. This includes drafting guidelines on secondary needle and syringe distribution program, take-home dosing, flexi-timing, task shifting and prison intervention. TA will continue to be provided to NACO in developing guidelines and training modules for replication of the lessons learned from the project in the North East to other high burden states.

Strengthening data systems will be a key activity at the above-site level. PEPFAR's unique partnership with UNAIDS and WHO will continue to facilitate high quality data generation, data sharing, and data use to focus on using data locally for driving crucial decisions, rather than reporting numbers for target tracking. PEPFAR will also support the DAPCUs and SACS in cluster states to improve the collection, analysis, and use of data for decision making. This includes improving district level estimates of KPs for program use, as well as the ability to estimate KP population size and modes of transmission regularly in order to strategically target interventions to KPs. Data sharing will also be improved through integration of the national systems and their implementation at the subnational level to track the cascade response to the epidemic. Sharing this data through dashboards will encourage discussion and development of solutions that will assist in identifying KPs and linking them to care and treatment. Rapid situational assessments to guide the policy to implementation gap will be undertaken continually to provide an evidence base and fuel program strategies and implementation. Direct district level estimates of KPs, complemented by national level surveillance and estimates, will better characterize the epidemic in India and also clarify the need for a strong district level response to achieve epidemic control. The USG will support national and sub-national epidemiological analysis in the clusters to identify KPs, typologies, and geographies with consistently high positivity and high risk behavior. The USG will inform new program implementation modalities (across prevention, testing, and treatment), and advocate for integration of recommendations into implementation for improved results to help reach population level epidemic control.

PEPFAR India will support the national HIV estimation exercise to ensure that India continues to utilize high quality population estimates to track progress in controlling the HIV epidemic. TA for national sentinel surveillance will be provided to ensure high quality standards, with adherence to surveillance methodology and continual improvements in surveillance protocols.

Support to the National Technical Support Unit (NTSU) to provide national level TA for KP programming across the continuum of care will also be provided by expanding the NTSU's role from solely prevention. The NTSU will serve as a platform for scaling up successful demonstration projects from cluster districts across all USG interventions. At the national level, PEPFAR along with NACO, will review the existing TA by PEPFAR and transition that support in a phased manner at the national level.

3.4 Description of How PEPFAR Will Support Greater Sustainability

Sustainability is built into PEPFAR India's planned activities. It rests on several components, primarily that the program's country plans and specific activities are discussed with and authorized by NACO prior to

implementation. National support is essential as is the concurrence of the states and/or civil society organizations (CSO) in approval of each intervention and its eventual transition to other management and funding. PEPFAR India will continue to support active participation of CSOs in planning, implementation, and monitoring of PEPFAR-funded activities in India. In terms of policy, such as the national expansion of Test and Start, law enforcement issues, gender violence, or policy guidance on VL delivery, health diplomacy efforts can support advocacy with the Ministry of Health and Family Welfare (MOHFW) and other relevant ministries. In addition, all planned projects are required to have a transition plan with a clearly defined timeline to NACO, SACS, and/or community management once deemed successful.

PEPFAR India also invests time and resources into ensuring that materials to promote sustainability are produced and circulated. This includes guidelines, modules, training materials, and project reports and data. Systems for monitoring and reporting are essential to ensure that methodologies, challenges and gaps, and their solutions are clearly recorded. Support for economic and financial modelling will also strengthen the response to the HIV/AIDS epidemic.

Interaction with key bilateral partners is essential. PEPFAR has strong relationships with the Global Fund, the World Bank, UNAIDS, and other agencies. Finally, PEPFAR regularly interacts with a wide group of stakeholders; this broad-based support and input is one of the key factors affecting the long-term sustainability of the national program.

4.0 USG Management, Operations, and Staffing Plan to Achieve Stated Goals

COP 2017 represents a continuation and refinement of the strategy of COP 2016, and staffing will remain level. Staff vacancies are a concern, with two of four positions (2 LE Staff) in the PEPFAR unit vacant, four positions at CDC (1 DH, 3 LE Staff) vacant, and two positions at USAID (1 DH, 1 LE Staff) vacant. Recruiting and placing direct-hire staff has been difficult due to significant concerns about air pollution in Delhi and ongoing delays in obtaining diplomatic entry visas for staff. For example, CDC has attempted to fill its Care and Treatment Branch Chief position three times and has been unsuccessful. The current hiring freeze can only further delay filling vacancies.

CDC will move one LE Staff position from Hyderabad to Mumbai. When filled, the incumbent will provide additional coordination for CDC activities in Maharashtra.

A significant number of CDC staff members provide daily technical assistance at the district, state and national levels in the areas of prevention (1 staff), care and treatment (3 staff), lab (3 staff) and strategic information (3 staff). This level of effort is calculated at 66.7% of total staff time and excludes management staff who also spend a significant amount of time representing the program and influencing policy in meetings and events with the GOI. The Acting PEPFAR Coordinator has also been highly involved in policy and representational activities.

The cost of doing business is expected to show some marginal increases over time. Both Capitol Security Cost Sharing and ICASS costs have increased. In addition, it is expected that LE Staff salaries will increase later in FY17 in order to keep up with inflation. Since there was no LE Staff salary increase in FY 2016, this increase could range from 15-25%.

APPENDIX A

A.1 Planned Spending in 2017

Table A.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$US 5,292,351	\$US 17,707,649	\$US 23,000,000

Table A.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	--
HVAB	Abstinence/Be Faithful Prevention	--
HVOP	Other Sexual Prevention	\$ 2,038,132
IDUP	Injecting and Non-Injecting Drug Use	\$ 2,111,076
HMBL	Blood Safety	--
HMIN	Injection Safety	--
CIRC	Male Circumcision	--
HVCT	Counseling and Testing	\$ 1,587,328
HBHC	Adult Care and Support	\$ 705,406
PDCS	Pediatric Care and Support	--
HKID	Orphans and Vulnerable Children	\$ 290,391
HTXS	Adult Treatment	\$ 1,864,059
HTXD	ARV Drugs	--
PDTX	Pediatric Treatment	\$ 36,860
HVTB	TB/HIV Care	\$ 297,908
HLAB	Lab	\$ 494,065
HVSI	Strategic Information	\$ 3,058,213
OHSS	Health Systems Strengthening	\$ 2,533,350
HVMS	Management and Operations	\$ 2,690,861
TOTAL		\$ 17,707,649

Focused Outcome and Impact Table (FOIT) Overview India

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Outcome 1: Strengthen Key Population pilot outcomes to achieve 50% coverage among KPs in year one and 70% coverage in year two, taking 75% of pilots to scale through Gol investment							
Demonstration site: key populations	Demonstrate model programs on secondary NSEP, MAT, Community based testing(CHBT) and Start, overdose management, prison intervention	<p>The feasibility of the implementation model for CHBT and Test and Start piloted in Manipur, Mizoram and Nagaland</p> <p>60 secondary NSEP will be established in the first year of the pilot</p> <p>Take home dosing implemented in 40%, Flexi-timing in 50% and Task shifting in 50% MAT facilities in the first year of the pilot</p> <p>Six OD Helplines established in the first year</p> <p>HIV testing and treatment program including MAT piloted in three prisons</p>	<p>The findings of the feasibility of the implementation model for CHBT and Test and Start disseminated and scale up plan developed</p> <p>Secondary NSEP scaled up to 90 outlets, evaluated and disseminated for scale up</p> <p>Pilot on Take home dosing, Flexi-timing and Task shifting evaluated and disseminated for scale up</p> <p>OD Helplines evaluated and disseminated for scale up</p> <p>HIV testing and treatment program including MAT pilot evaluated and disseminated</p>	KP_Prev, KP_MAT, HTX_TST, TX_New, TX_Curr, TX_Ret	Program Indicator	<p>1. Increased HIV testing coverage from 70% to 90% and increase in yield from 1% to 4% among PWID and other KPs</p> <p>2. 95% of the positive PWID linked to ART</p> <p>3. 80% of the positive PWID retained at 12 months</p> <p>4. Increased MAT coverage from 12.6% to 25% and 12 month retention from 40% to 80%</p> <p>5. 80% of the unreachable /hard to reach PWIDs are linked to Government needles and syringes program</p>	\$850,000
Demonstration site: key populations	Strengthen social network testing strategy based on sexual/social network analysis among hidden and non-venue based KPs through the Enhanced Peer Mobilization model/RDS/Social media	<p>1. Scale-up of EPM Model in newly identified hot spots/sites, based on KP mapping data, in all cluster districts to reach Hidden & Non venue based KPs (MSM,FSW,TG).</p> <p>2. Reach KPs through use of social media platforms at 2 sites in cluster districts through demonstration models</p> <p>3. 70% of Identified KPs linked to HIV testing & treatment</p>	<p>1. Adoption of EPM model by TIs across all districts</p> <p>2. Provide TA to NACO to scale-up of demonstration model for utilizing social media platforms as a strategy to reach KPs.</p> <p>3. 90% of identified KPs linked to HIV testing and treatment.</p>	KP_PREV, HTC_TST	Other	<p>1.No. of new KP's reached through EPM model</p> <p>1.No of new KP's tested through EPM</p> <p>2.No. of positives detected out of tested KP's through EPM</p>	\$400,000
Demonstration site: key populations	Increase HTS coverage by introducing & evaluating newer HIV testing models & strategies i.e. assisted self-testing among hard to reach younger KPs	<p>1. Identify appropriate new & untested HTC strategies for India context.</p> <p>2. In consultation with NACO, implement identified new testing strategies, i.e. assisted self-testing, for KPs (MSM,FSW,TG) at selected sites in AP & MH either through OR piloting, .</p> <p>3. Link 100% of identified KPs to HIV treatment</p> <p>4. Document and disseminate evidence generated through newer testing approaches for adoption by NACO</p>	<p>1.Develop guidelines and SOP for selected successful new testing model.</p> <p>2.Adoption of approved and successful new testing model at the national level</p>	KP_PREV, HTC_TST			\$600,000

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Demonstration site: key populations	Improve enrollment and retention in treatment for PLHIV KPs via Peer Navigators for facilitating & tracking referrals	<ol style="list-style-type: none"> 1. 80% of all newly identified HIV+ KPs are enrolled in treatment through Peer Navigator model 2. Track and link 60% of old HIV+ KPs who are lost to follow up from treatment. 3. Increase retention in treatment for HIV+ KPs by 20% from existing levels 	<ol style="list-style-type: none"> 1. Sustain improved enrollment & retention in treatment for new and existing HIV+ KPs. 2. Transition the model into existing NACO TI system for scale-up. 	NA	Program Indicator	No .of PLHIV successfully linked to Tx & initiated on ART	\$100,000
Demonstration site: key populations	Implement demonstration model for decentralizing ART services from ART centers to TI and/or NGOs	<ol style="list-style-type: none"> 1. Select 2 sites for decentralized ART services in high load PLHIV KP areas using updated Linkages KP mapping. 2. Develop model for community based ART services in consultation with NACO/SACS. 3. Demonstrate 1-2 sustainable models of community based ART services at 2 selected sites with NACO approval. 	<ol style="list-style-type: none"> 1. SOP & guidelines developed for adoption of KP friendly Community Based ART services. 2. Adoption & transition of Community-Based ART centers to NACO/SACS to ensure sustainability. 	NA	Program Indicator	No. of patients accessing treatment at the center	\$200,000
Demonstration site: key populations	Scale-up of Family Based & Index Based testing	<ol style="list-style-type: none"> 1. Increase testing yield for Index-based testing approach by 5% from current yield and sustain current testing yield for Family-Based testing for KS and OVCs in priority SNUs. 2. Guidelines & SOP developed for Family Based & Index Based testing strategy 3. Scale up Family based & Index based testing strategy to saturate cluster districts & other priority sites in AP & Maharashtra 4. Dissemination of guidelines & SOP for family based testing for adoption by National Program 	1. Provide TA to NACO for Scale up of family based & Index based testing strategy nationally .	OVC-HIVSTAT , HTC_TST		\$200,000	
Demonstration site: key populations	Increase awareness and knowledge of younger KPs through education to improve case identification and promotion of HIV services	<ol style="list-style-type: none"> 1-Develop updated communication tools targeting younger and non-venue based KPs 2-Dissemination and adoption of communication tools by NACO 3-Provide TA to NACO for roll out nationally. 		N/A			\$300,000

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Service delivery and quality improvement: key populations	Demonstrate Community level mentoring program to mobilize hard to reach PWID including young PWID and other KPs for improving access to HIV services	70% of new PWID pockets/new PWIDs including other KPs identified and linked to services 70% of the districts implement an young PWID peer volunteers program	80% of new PWID pockets/new PWIDs including other KPs identified and linked to services 90% of the districts implement an young PWID peer volunteers program	KP_Prev, KP_MAT, HTX_TST, TX_New, TX_Curr, TX_Ret	Program Indicator	80% of the unreached /hard to reach PWIDs are linked to Government needles and syringes program Increased HIV testing coverage from 70% to 90% and increase in yield from 1% to 4% among PWID and other KPs Increased ART coverage from 30% to 80% and retention from 60% to 80% among PWID and other KPs 70% of the young PWID tested and 80% of the positive young PWID put on ART	\$600,000
Service delivery and quality improvement: key populations	Demonstrate model for implementation of TPT as a part of standard HIV Care to reduce TB burden among PLHIV	Systems for monitoring uptake of TPT, follow up, ensuring adherence and recording will be established in cluster districts and then scaled up to national level so that high level of compliance to TPT can be maintained. Tools for mentoring and monitoring ART Centers for TPT are developed. 80% of the persons initiated on TPT complete their TPT course successfully	This activity will be transitioned to the program for scale up in other parts of the country	TB_PREV			\$300,000
Systems: Governance (including policy)	Support NE Technical Support unit to provide program management and technical support including trainings at state, district & facility level and NGOs	Annual Action Plans developed for NE SACS based on programmatic gaps and response Key program and implementation barriers identified and action plan developed to address coverage barriers Addressed coverage barriers on MAT, HIV testing and ART in 60% of the TI NGOs and facilities TOT and cascade training modules developed on Snowball/RDS techniques to identify new populations - counseling, overdose management,	Annual Action Plans developed for SACS of NE region based on programmatic gaps and response Addressed coverage barriers on MAT, HIV testing and ART in 80% of the TI NGOs and facilities Follow up trainings conducted at site level to address skills gap in 80% of the facilities		Program Indicator	80% of the unreached /hard to reach PWIDs are linked to Government needles and syringes program Increased HIV testing coverage from 70% to 90% and increase in yield from 1% to 4% among PWID and other KPs Increased ART coverage from 30% to 80% and retention from 60% to 80% among PWID and other KPs	\$450,000

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Systems: Governance (including policy)	Demonstrate structural intervention approaches among police, church and community gate keepers, linkage to social protection services	<p>PWID/KP friendly Sensitization module developed for police church and community gatekeepers</p> <p>60% of the police stations, church and community gatekeepers sensitized to provide an enabling environment for PWID and other KPs in accessing services</p> <p>Pilot Community Level Structural Interventions in local police stations, church pastorates and other community structures</p> <p>Community participation (all KPs) in NACO and SACS quarterly review meetings and provided a forum to voice their concerns</p>	<p>80% of the police stations church and community gatekeepers sensitized to provide an enabling environment for PWID and other KPs in accessing services</p> <p>Evaluate Community Level Structural Interventions and develop scale up plan</p> <p>Community participation (all KPs) in quarterly review meetings and provided a forum to voice their concerns</p>		Program Indicator	<p>60% decrease in police harassment</p> <p>70% decrease in stigma and discrimination by church and community</p> <p>40% of the PWID and other KP community accessed at least one social protection scheme</p>	\$300,000
Systems: Governance (including policy)	TA as Member of National Technical Working Groups, Review Committees, Master Trainer, developing National Guidelines, curriculum and training tools	<ul style="list-style-type: none"> - Concept note on improving efficiency of ART centers developed; - Develop a concept note to improve linkage between testing and treatment facilities and ensure retention in care (plug the leaky cascade); - Prepare a plan for developing patient friendly and paperless ART centers; - Finalize the 2017 ART treatment and ART Centre Operational guidelines; - Training cum orientation manual for community care coordinators finalized 	<ul style="list-style-type: none"> - Implementation of test and treat guidelines nationwide as per the national policy; - Develop a concept note to improve/monitor adherence to ART; - Implement efficiency improvement model in all the cluster districts - Develop curriculum for health providers, review reports to NACO on - EMTCT/PPTCT/ICTC 				\$0
Service delivery and quality improvement: key populations	Scale-up activities across KP continuum of care based on lessons learned for KPs in priority SNU's	1. Implementation of new design	<ol style="list-style-type: none"> 1. Improve linkage of KPs to HIV prevention, Testing & Treatment Services by 20% from baseline. 2. Demonstration Models for Integrated HIV Service Delivery for KP across the Continuum of Care 3. Community Strengthening for generating demand and increasing access to services 4. Improving data quality & use for improving KP coverage & access in 80% of the facilities. 	KP_PREV HTC_TST			\$2,000,000
Systems: Governance (including policy)	Enhancing access to testing at more accessible locations w/flexi-timing across all KP groups	1. TA to operationalize more accessible and flexible testing in cluster districts for KPs across different settings to increase access to HIV testing.	1. TA to improve yield of accessible and flexible testing in different settings by 1-3% by refining strategies.	NA			\$300,000

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Systems governance	Demonstrate restructured Targeted Intervention models to address barriers to service provision for KPs	1. Pilot models for innovative restructuring of the current framework of TI NGO's of NACO at 2 sites in cluster districts.	1. Develop SOP & Guidelines for the models in consultation with NACO to be taken to scale.	KP_PREV			\$525,000
Systems: Governance (including policy)	Support the National Technical Support Unit to NACO for providing TA for KP programming across the continuum of care	1. Scale up current pilots of Single window systems for social protection schemes in all cluster districts in to link all KPs to social welfare schemes of the Government. 2. identify & pilot new strategies for effectively linking KPs & their families to social protection & welfare schemes in cluster districts.	1. Increase scope of work of NTSU to include care, treatment & retention in addition to prevention. 2. TA for NACP-V through NTSU to incorporate effective & newer models of TI & newer approaches for reaching KP's. 3. Use NTSU platform for scaling up innovations nationally for all USG pilots across all partners. 4. TA to NACO for increasing access of KPs to other general health services	KP_PREV			\$727,000
Systems: Governance (including policy)	Provide TA to Implement Single window models for increasing access to social protection schemes for KPs & their families	1. Scale up current pilots of Single window systems for social protection schemes in all cluster districts in to link all KPs to social welfare schemes of the Government. 2. Identify & pilot new strategies for effectively linking KPs & their families to social protection & welfare schemes in cluster districts.	1. Provide national level TA for developing SOP & guidelines for single window approach for Social welfare schemes nationally. 2. Advocate for scale up at State and National inter-departmental coordination.	OVC_SERV			\$200,000
Systems: Institutional Capacity Building	Strengthen CoEs to provide quality treatment to KP and linked PLHIV	* 20% reduction from the current baseline of new LFU among PLHIV initiated on ART; * 25% increase from current baseline in the number of patients identified for first line ART failure and initiated on second line treatment; * Non-compliance towards 2017 clinical guidelines noticed in less than 15% of all ART centers in the cluster districts; * Improvement in the documentation of ARV associated toxicities by 20% from current baseline. * 80% of key field data completed in IMS	* 50% reduction from the current baseline of levels of new LFU among PLHIV initiated on ART; * 40% increase from current baseline in the number of patients identified for first line ART failure and initiated on second line treatment; * Non-compliance towards 2017 clinical guidelines noticed in 0% of all ART centers in the cluster districts; * Improvement in the documentation of ARV associated toxicities by 50% from current baseline. * 100% of key field data completed in IMS	TX_NEW, TX_CURR, TX_RET			\$100,000

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Demonstration site: key populations	Implement models to improve access to HIV treatment for PWID, other PLHIV as per learning from Project Sunrise	Reduction in LFU by 25% of the baseline among PWID; Test and start among 70% of KPs coming to ART centers ; Rate of appointment keeping to improve by 25% of baseline;	Reduction in LFU by 50% of the baseline among PWID; Test and start among 90% of KPs coming to ART centers ; Rate of appointment keeping to improve by 50% of baseline;	TX_NEW, TX_RET			\$250,000
Systems: Institutional Capacity Building	Technical support to NACO and SACS of NE region to scale up lessons of Project Sunrise in high burden PWID states and districts	TOT on Project Sunrise knowledge transfer on local level analysis, secondary needle and syringe distribution program and mentoring strategies to increase yield conducted in four high burden states Mentoring of four state teams by NETSU on building their skills on conducting local level analysis, implementation of secondary needle and syringe distribution program and onsite mentoring program Four Experience Sharing workshops conducted for knowledge transfer in the areas listed above Four states implement secondary needle and syringe distribution program	TOT on Project Sunrise knowledge transfer on take home dosing, real time monitoring and overdose management conducted in four high burden states Mentoring of four state teams by NETSU on building their skills on take home dosing, real time monitoring and overdose management conducted in four high burden states Four Experience Sharing workshops conducted for knowledge transfer in the areas listed above Four states implement take home dosing and overdose management programs				\$300,000
Systems: Institutional Capacity Building	TA for adoption of the Stigma and Discrimination tool kits for the Indian context addressing KPs	1. Tool kits developed for the Indian context addressing stigma & discrimination among KPs in consultation with NACO & Stakeholders	1. Field testing & dissemination in AP, Maharashtra. 2. Roll out of the tool kit nationally by NACO.	NA			\$100,000
Demonstration site: key populations	Using priority SNUs to demonstrate differentiated care model at ART Centers to inform policy and scale up	Increase linkage to LAC by 25% from baseline; Implement model of differentiated care at 4 ART centers; Reduction in LFU by 15% from baseline; Increase in the SACEP referrals by 30% from baseline (confirmation of treatment failure)	Increase linkage to LAC by 50% from baseline; Implement model of differentiated care at 4 ART centers; Reduction in LFU by 25% from baseline; Increase in the SACEP referrals by 60% from baseline (confirmation of treatment failure)	TX_NEW, TX_RET			\$200,000
Other: specify in activity description	Grand Challenge Grant for funding group of Innovations to address challenges in KP programming in India	1. Engagement of shortlisted non-traditional solvers to address key issues in KP programming in India in round 1 in consultation with stakeholders & NACO. 2. Evaluate innovations and carry forward 4-5 most innovative approaches for KP programming in India	1. Final evaluation for acceptability, scale up, sustainability of the successful models. 2. National level scale up for successful innovation.	NA			\$500,000

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Systems: Institutional Capacity Building	TA to accelerate implementation of single window services at ART clinics to improve TB and HIV care among PLHIV	Systems are established coordination and; for data sharing and utilization between Lab, RNTCP functionaries and ART staff for better uptake and access to HIV/TB services Uptake of TPT is scaled up to 40% of the patients, without active TB disease. 80% of PLHIV are screened and referred for appropriate test for TB diagnosis. 92% of TB-coinfected PLHIV initiated on daily ATT and ART in a timely manner.	The activity will be transitioned to the national program for scale up	TB_ART, TB_PREV			\$500,000
Systems: Institutional Capacity Building	Enhancing & streamlining OVC programming for children of KPs and KPs under the age of 18 by improving access to HIV testing and treatment	1. Provide TA for OVC friendly services resulting in an increase of HIV testing & 70% linkage of positive OVCs to HIV treatment in cluster districts. 2. Improve retention in care of OVCs by 10% through linkage to formal & informal support systems (i.e. education & vocational training)	1. Provide TA for OVC friendly services resulting in an increase of HIV testing & 80% linkage of positive OVCs to HIV treatment in cluster districts. 2. Improve retention in care of OVCs by 20% through linkage to formal & informal support systems (i.e. education & vocational training)	NA			\$400,000
Other: specify in activity description	Strengthen civil society organizations including KP groups	1. Enhance leadership role of CBOs in promoting HIV services for KP 2. Rapid response system for addressing violence among KPs 3. Consultations with community leaders to share experiences of KP programs 4. Capacity building of identified KP representatives through a community leadership program for KPs by partnering with formal educational institutions 5. Address Gender Based Violence among KP's	1. Enhance leadership role of CBOs in promoting HIV services 2. Rapid response system for addressing violence 3. Consultations with community leaders to share experiences of KP programs 4. KPs trained through Capacity building initiative 5. Address Gender Based Violence among KP's	NA			\$748,343
Strategic Outcome 2: Strengthen laboratory capacity and ensure 100% of patients have access to viral load (VL) testing within 2 years.							
Systems: Laboratory	Replicate lab accreditation program to fast track accreditation of current VL Public sector testing facilities and support NACO to establish VL network	Accreditation of 10 Viral load facilities to serve as center of quality assurance	Identified 80 new viral load public sector labs and established a VL network	policy tracking table	National Indicator	NA	\$150,000
Systems: Laboratory	Implement VL guidelines to scale up VL testing in the priority SNU's with a focus on strengthening lab-clinical interface	50% of lab staff trained on VL guidelines and QA procedures, 50% of clinical staff trained on VL guidelines 50% of PLHIV have access to VL testing	80% of Lab staff trained on VL guidelines, 80% of clinical staff trained on VL guidelines 100% of PLHIV have access to VL testing	Lab_PTCQI	Program Indicator	VL cascade indicators (coverage of VL testing, percentage of PLHIV below viral cut-off and their outputs)	\$475,000

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Systems: Laboratory	Demonstration model for building sustainable diagnostic quality services through CQI at HTC sites to improve PT performance in priority SNUs	80% lab staff trained on CQI at HTC sites in priority SNUs 90% HTC sites in priority SNUs pass the PT 100% of HTC sites in priority SNUs which did not pass the PT will have a corrective action and preventive action in place	50% of the HTC sites in Priority SNUs received certification	Lab_PTCQI,	SIMS	no. of lab staff trained no. of HTC sites certified	\$275,000
Systems: Laboratory	Through phased in implementation approach support NACO to scale up CQI across > 5000 HTC sites (as demonstrated in priority SNUs, refer to FOIT 2.03	Developed a sustainable national model of HTC CQI certification i) A pool of master trainers at the national level ii) Built capacity of all HIV national reference labs (13) for implementation of CQI at linked HTC sites towards certification	10% of HTC sites outside priority SNUs receives CQI certification	Lab_PTCQI		NA	\$150,000
Systems: Laboratory	Demonstrate innovative approaches to increase access to VL testing e.g.. newer technologies like POCT and DBS will be introduced	Validate and demonstrate newer technologies in priority SNUs to increase accessibility to VL test	Facilitate scale-up of validated newer technologies (i.e. DBS/ POCT) to ensure 90% access to VL testing in difficult to reach places	Lab_PTCQI		NA	\$200,000
Systems: Laboratory	Implement a sustainable integrated district model of laboratory services for comprehensive clinical management of PLHIV e.g.. baseline work up, OI and ART management	100% of identified district labs in priority SNUs visited for baseline evaluation 50% district labs capacitated for provision of integrated lab services 50% of district lab staff trained on CQI	80% of district labs capacitated for provision of integrated lab services	Lab_PTCQI		NA	\$200,000
Systems: Health workforce (including CHWs)	Increase awareness for timely referral for viral load testing, patient awareness, and demand creation among CHWs/KHPT outreach workers	Train 90% CHWs in the priority SNUs on timely referral for viral load testing, patient awareness, and demand creation.	NACO to scale-up training of CHWs on timely referral for viral load testing, patient awareness, and demand creation.	NA			\$150,000

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Systems: Health workforce (including CHWs)	Establish & Strengthen the patient referral system from TIs to lab for KP PLHIV to increase uptake to viral load testing	1. Demonstrate patient referral mechanisms for Viral Load testing in 2 sites in priority SNU in coordination with USG partners working in facilities to strengthen viral load testing. 2. 70% of all eligible KP PLHIV receive a viral load test	1. 90% of all eligible KP PLHIV receive a viral load test 2. Provide TA for scale up of patient referral systems at other sites through SACS/NACO	NA			\$200,000
Systems: Governance (including policy)	TA as Member of National Technical Working Groups, Review Committees, Master Trainer, developing National Guidelines, curriculum and training tools	- Developed Strategic Framework and approved national VL guidelines, and tools and training materials for implementation. - Developed Strategic framework on scale up of good practices at HTC sites	- Train pool of master trainers for training lab and clinical staff on approved VL guidelines				\$0
Systems: Institutional Capacity Building	Accelerate utilization of district integrated laboratory services (refer FOIT 2.08) for comprehensive clinical monitoring of PLHIV	80% PLHIV on ART received initial and follow up investigations	90% PLHIV on ART received initial and follow up investigations		National Indicator	Percent patients undergone viral load test as per scale up plan	\$150,000
Systems: Institutional Capacity Building	Improve utilization of district model of integrated laboratory services (refer FOIT 2.08) for comprehensive clinical monitoring of PLHIV	80% PLHIV on ART received initial and follow up investigations;	90% PLHIV on ART received initial and follow up investigations;		National Indicator	Percent patients undergone baseline CD4 testing and viral load tests done as per scale up plan	\$150,000
Strategic Outcome 3: Improve data sharing, access and utilization to promote full transparency in working jointly towards epidemic control.							
Systems: Strategic information	NETSU team provide hands-on skills training to SACS staff, DAPCU, facilities/NGOs on data management and analysis	Training module on local level analysis developed and 90 % of TI NGOs and facilities trained State and district level program response analysis carried out every quarter 60% of the facilities and TI NGOs conduct quarterly analysis	State and district level program response analysis carried out every quarter 80% of the facilities and TI NGOs conduct quarterly analysis		Program Indicator	All SACS and high burden districts and 80% of the facilities conduct program response and gap analysis	\$200,000
Systems: Strategic information	Implement Real Time Monitoring Program to monitor individual PWID tracking across the prevention to care and treatment continuum cascade	RTM implemented in 6 districts	RTM implemented in 12 districts, evaluated and scaled up based on lessons learned				\$200,000
Systems: Strategic information	i) Pilot Implementation of PLHIV-ART Linkage System to track all PLHIVs ii) Capacity building and mentoring of DAPCUs in tracking 90-90-90	Tracking all KP and other PLHIV for continuum of care achieving 90-90-90	Scale up to other districts and States in India	NA			\$70,000
Systems: Strategic information	i) Develop/implement PLHIV ART Linkage System to track all the KP-PLHIV ii) Revised modules, mentoring, monitoring and review of 188 DAPCUs	i) PLHIV ART Linkage software implementation-KP Cascades ii) Develop technical modules, monitoring, mentoring tools for DAPCU and review addressing sustainability	i) Transition to government ii) Document lessons learnt and transition plan to government based on the review	NA			\$30,000

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Systems: Strategic information	Generation of new evidence and program data analysis for improved local decision-making and refined program strategies	<ol style="list-style-type: none"> 1. Indicator rationalization to identify priority indicators for epidemic monitoring, district cascades and data dashboards with priority indicators, developed for district-level epidemiological analysis 2. Collaborative data analysis and review with district (DAPCU) and state (SACS) staff to improve data quality, use of tools, and systems 3. Increased evidence to guide active case finding through analysis and GIS mapping of positives for modes of transmission, geographical and socio-demographic profiling in both clusters to identify key and priority populations with consistently high positivity and risk behaviors 4. Documentation of Cluster Project process, ongoing findings and interim results, through informational communications products 	<ol style="list-style-type: none"> 1. Routine use of priority indicators, as part of district-level quarterly reviews to focus improvement efforts on key and priority populations. Continuous update of district dashboards, and distribution/access to all decision-makers 2. Development and dissemination of district cascades by each administration unit in cluster district by key and priority populations 3. Finalize guidance on using program data to inform innovative testing strategies for NACO and SACS 4. Generate a knowledge base which compiles and summarizes the innovations, results and lessons learned from the PEPFAR Cluster Strategy 	No specific PEPFAR indicators are applicable, but progress under the IM will be monitored through periodic partner review	SIMS	Visits to the specific SACS and DAPCUs will help in assessment of progress towards these benchmarks	\$200,000
Systems: Strategic information	Strengthen strategic information systems at sub-national levels to foster insights into the prevention to care continuum cascade	<ol style="list-style-type: none"> 1. Plan at sub-national entities for linking data and data systems across the prevention to care and TX cascade developed for all cases, including KPs and priority populations 2. Demonstrate case reporting and channel learnings for national scale-up by preparation of technical and operational guidance documents 	<ol style="list-style-type: none"> 1. Pilot for all integrated, across-the-cascade information systems for linking and tracking all HIV positives completed 2. Lessons learned document to inform national scale-up, developed and shared with GOI (please see activity 3.05 below) 3. Data from case reporting used to understand impact of program interventions, characterize risk factors and measure disease burden <p>(Please note that this activity is linked to 3.09, since modality for case reporting will be integrated within the national systems, and not by creating parallel systems)</p>	No specific PEPFAR indicators are applicable, but progress under the IM will be monitored through periodic partner review	SIMS	Visits to the specific SACS, DAPCUs and service delivery facilities will help in assessment of progress towards these benchmarks	\$200,000

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Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Strategic information	Improve cluster-level PLHIV estimates	<ol style="list-style-type: none"> 1. Standardized methods and operational guidelines for producing HIV estimations at district level developed, and implemented in 6 districts, to construct typology-wise cascades 2. Standardized approach for conducting rolling population size estimates for KP developed and implemented in 6 districts+L50 	<ol style="list-style-type: none"> 1. Using experience from implementation of the guidelines at the sub-national level, cuts, to calculate the district level PLHIV estimates for all key and priority populations, with most recent data available from surveillance, program and research 2. Epidemiological analysis for both clusters completed and data shared and disseminated, for action 	No specific PEPFAR indicators are applicable, but progress under the IM will be monitored through periodic partner review			\$150,000
Systems: Strategic information	Strengthen National level Surveillance and Estimations to generate an evidence base for the GOI national response to the HIV epidemic	<ol style="list-style-type: none"> 1. National ANC and KP HIV sentinel surveillance conducted with high quality standards and adherence to surveillance methodology 2. National HIV Estimates process initiated with national government 3. Consultation conducted with stakeholders at national, state and district levels including NACO's targeted interventions division to use existing processes as the basis for continuous population size estimates for key populations. 3.1 National protocol (process and methodology) for PSE for KP developed, in consultation with concerned stakeholders and partners at the national level. 	<ol style="list-style-type: none"> 1. National ANC and KP HIV sentinel surveillance data analysis completed and report prepared 2. National HIV Estimations Report prepared 3. New methods to improve size estimations in collaboration with partners, piloted in selected districts to produce more accurate estimates on a regular basis. 3.1 Methods and operational guidelines for producing population size estimates for key populations, at a district level, developed 	No specific PEPFAR indicators are applicable, but progress under the IM will be monitored through periodic partner review			\$150,000
Systems: Strategic information	Support government information enterprise architecture to fully implement the M&E 'Three Ones' at national and sub-national levels	<ol style="list-style-type: none"> 1. National monitoring dashboards with key priority indicators developed 2. National data systems integrated to produce actionable strategic information across the prevention to care continuum 3. Capacity building for analysis and use of routine quality data at the national level 	<ol style="list-style-type: none"> 1. Access and regular review of national dashboards for program reviews, enabled 2. Routine program reviews, assisted by national dashboard, with ability to drill down to sub-populations and geographies, for an enhanced understanding of programmatic and operational issues 	No specific PEPFAR indicators are applicable, but progress under the IM will be monitored through periodic partner review			\$150,000
Systems: Strategic information	Standardizing/updating KP mapping for cluster districts to unveil total number of KPs	<ol style="list-style-type: none"> 1. Periodic assessments & validation of programmatic data for KPs in cluster districts 2. Support standardization of for KP estimation in coordination w/USG 	<ol style="list-style-type: none"> 1. Annual revalidation of KP mapping in cluster districts 2. Dissemination of KP mapping data and methodology through bi-annual meetings w/NACO & SACs 	NA			\$50,000
Systems: Strategic information	Strengthen Data systems at Targeted Intervention (TIs) level including Individual Tracking System, standardization & cascade data utilization	<ol style="list-style-type: none"> 1. Train 50% of all sites in cluster districts on risk segmentation & cascade analysis among KPs. 2. Data systems strengthened in 70% of all Targeted Intervention sites supported by PEPFAR in cluster districts of AP & Maharashtra 	<ol style="list-style-type: none"> 1. Train 100% of all sites in cluster districts on risk segmentation and cascade analysis among KPs. 2. Data systems strengthened in 100% of all TI sites supported by PEPFAR in cluster districts of AP & Maharashtra 	NA			\$50,000

Focused Outcome and Impact Table (FOIT) Overview India

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Strategic information	Technical Support to NACO for individual tracking systems to track KPs from TIs through continuum of care especially treatment & retention in care	1. TA to Strengthen NACO's available IT & paper based data systems 2. TA to strengthen real-time case based tracking system for KPs across the Continuum of care	1. TA to Strengthen NACO's available IT & paper based data systems 2. TA to strengthen real-time case based tracking system for KPs across the Continuum of care	NA			\$175,357
Systems: Strategic information	Generate evidence to identify & address changing network dynamics, enablers & barriers to testing & treatment for hidden & younger KPs	1. Generate evidence for implementation and feasibility of PrEP among all KP groups in India 2. Identify new & innovative approaches for reaching & testing KPs	1. Disseminate evidence gathered through studies to NACO & Stakeholders. 2. Advocate with NACO for changes in programming based on study findings.	NA			\$800,000
Systems: Strategic information	Generate evidence to assess risk of HIV transmission among children of KP	1. Assessment study conducted to assess risk of HIV transmission among children of KPs 2. Documentaion and dissemination of preliminary study findings to all stakeholders	Final Study report available for developing package of services for children of KS	NA			\$150,000
Systems: Strategic information	Stigma & Discrimination assessment for KPs in HIV facilities in cluster districts & sensitization to decrease S&D.	1. Stigma & Discrimination baseline assessment completed using the UNAIDS tool adopted for the Indian context at PEPFAR supported facilities in cluster districts 2. Dissemination of findings to key stakeholders.	1. Sensitization of health care staff in facilities with high stigma & discrimination to decrease S&D 2. Post intervention reassessment at facilities	NA			\$50,000
Systems: Strategic information	Development of knowledge products capturing best practices/lessons learned from programs targeting young vulnerable adolescents	Development and dissemination of best practices and lessons learned to USG partners and state and national level stakeholders	Development and dissemination of best practices and lessons learned to USG partners and state and national level stakeholders	NA			\$25,000
Systems: Strategic information	Improve data sharing among USG PEPFAR Implementing partners	Quarterly review meetings for PEPFAR Implementing partners to monitor progress against benchmarks and disseminate best practices	Quarterly review meetings for PEPFAR Implementing partners to monitor progress and disseminate best practices	NA			\$25,000
Systems: Institutional Capacity Building	Sustainable financing and improved fiscal efficiency of Key Population programs through digital payments, CSR and linking payments to results	Guidelines and tools developed on digital payments for KP programs and linking results to payments	States operationalize guidelines and tools on digital payments for KP programs and linking results to payments	NA			\$100,000

Focused Outcome and Impact Table (FOIT) Overview India

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Governance (including policy)	TA as Member of National Technical Working Groups, Review Committees, Master Trainer, developing National Guidelines, curriculum and training tools	- Guide efforts towards generating good quality estimations data, and improvement of surveillance - Guide NACO resources towards systems consolidation and improvement - Data pertaining to HIV-TB co-infection is integrated with NACP and RNTCP data systems for information sharing, access and utilization in a transparent manner so that the programs can jointly work towards epidemic control and for efficient management of co-infected patients.	- Systems are established for data sharing and utilization between Lab, RNTCP functionaries and ART staff for better uptake and access to CBNAAT. - Systems for recording & reporting TPT uptake, follow up, and adherence are established. Tools for mentoring and monitoring ART Centers for TPT and AIC practices developed.				\$0
Systems: Institutional Capacity Building	Improvement in real time data for better clinical monitoring and policy decision making	Completion of data in the IMS across all centers in the cluster districts; Strengthen the ART- LAC and ART-CSC data sharing mechanism	Demonstrate feasibility of paper free ART center at 4 sites	TX_NEW, TX_RET			\$150,000
Systems: Institutional Capacity Building	Improvement in real time data for better clinical monitoring and policy decision making	Completion of data in the IMS across all centers in the cluster districts; Improve the quality/ consistency of data reporting from ART centers ;	Automation of retention cascade from existing data recording and reporting tools;	TX_NEW, TX_RET			\$200,000
Systems: Strategic information	Pilot- IT based solution for monitoring ART adherence	Increase adherence and retention of patients on ART to 30% from the baseline	Increase adherence and retention of patients on ART to 90% and scale-up to other areas	TX-RET			\$50,000
Systems: Strategic information	Information systems management process improvement to complete and improve NACO HIV case management and tracking.	All independent data systems at NACO are able to exchange data and converge on one technical platform.	Every client is tracked from initial contact through viral load suppression in a system robust enough to handle the volume of 90 90 90 in India.				\$350,000