2016 Sustainability Index and Dashboard Summary: India

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed periodically by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 90 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with other contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Dark Green Score (8.50-10 points) **(Sustainable and requires no additional investment at this time)**
Light Green Score (7.00-8.49 points) **(Approaching sustainability and requires little or no investment)**
Yellow Score (3.50-6.99 points) **(Emerging sustainability and needs some investment)**
Red Score (<3.50 points) **(Unsustainable and requires significant investment)**

India Overview: India has made solid progress in reducing HIV prevalence, with a 32% decline in new infections since 2007. During this time, the country has experienced significant economic growth, but the health budgets have been modest in the face of reducing national debt. Through the National AIDS Control Organisation (NACO), the Government of India has demonstrated strong leadership in crafting a national HIV/AIDS strategy and coordinating the response, and domestic funds support 63% of the National AIDS Control Programme-IV, the current five-year HIV strategy in the country. Overall, the sustainability of the response to the epidemic is promising, though targeted investments can be made to support the country's efforts. With a need to increase the number of PLHIV on treatment and a youth bulge looming, improving the reach, quality, and capacity of HIV services will be integral to sustainably controlling the epidemic.

SID Process: PEPFAR India completed a multi-step process for completion of the SID. Initial input was collected from the broader PEPFAR India team, the Department of State, the HIV/AIDS Alliance, and UNAIDS to develop a template for further action and comment by broader stakeholders (step 1). After sharing the template in advance, a meeting was convened to discuss any questions requiring further clarification. All inputs were compiled, and a completely drafted tool was developed for sharing more broadly. The completed tool was shared in advance of an in-person meeting with civil society participants, collaboratively determined by PEPFAR India, UNAIDS, and the HIV/AIDS Alliance (step 2). During the meeting, participants discussed the SID in small, domain-specific groups, and then in a large group session. Meeting participants included individuals from PEPFAR India and UNAIDS as facilitators, and representatives from FSW, MSM, TG, IDU, Trucker networks, PLHIV networks, an OVC network, the Lawyers Collective, and the Family Planning Association of India. PEPFAR India shared the tool with civil society inputs with NACO, and convened a meeting to discuss areas of strengths and vulnerability. After the meeting, the tool was shared more broadly across the NACO leadership for review.

Sustainability Strengths: One of GOI's strengths, as determined by the SID, is that NACO leads the HIV response in India. The 2015-6 domestic budget comprises more than 90% of the funds used to address the HIV response in India, as described above (**Domestic Resource Mobilization, 8.06, light green**). NACO has also been proactive about its **technical and allocative efficiency** (**7.34, light green**), using evidence to drive the allocation of funds across the country. NACO also funds and provides the overwhelming proportion of **service delivery** (**8.24, light green**), and has guided very structured approaches to community-based services.

An additional area of sustainability strength is that NACO is largely transparent in its planning and information. NACO consistently develops five-year strategies, in conjunction with all stakeholders, including donors and civil society (**Planning and Coordination, 9.03, dark green**). Further, under the NACP-III, NACO developed the structural elements that support civil society engagement. These channels allow civil society input not only to the development of strategic plans, but also to the Technical Resource Groups (TRGs). Finally, in terms of **public access to information** (**9.00, dark green**), NACO posts surveillance reports in a timely fashion, and produces an Annual Report documenting progress against the NACP and current expenditures.

Sustainability Weaknesses: Despite having channels to allow civil society input, it is important to note that the perception of civil society is that while these channels exist, their usage and impact have been decreasing (**Civil Society Engagement, 6.69, yellow**).

Though the overall SID category had strong reporting, as a subcategory, key identified weaknesses relate to health worker capacity. Pre- and in-service curricula need continuous review and assurance of HIV components (**Human Resources for Health, 7.67, light green**), as well as components on quality management and improvement (**Quality Management, 5.81, yellow**).

Further, the capacity of the lab workforce to perform point of care services was identified as a need for expansion **(Laboratory, 7.41, light green)**.

India also needs a rapid scale up of viral load capacity to support additional patients on treatment **(Laboratory, 7.41, light green; Epidemiological and Health Data, 6.55, yellow)**. This capacity will be built gradually, but in the meantime the GOI has recently decided to outsource these services to the private sector concurrently to meet the burgeoning need. Since the country is not yet implementing national rollout of Test and START, the current need will be based on the number of patients receiving treatment under CD4<500 guidelines.

A final area of weakness is **private sector engagement (3.82, yellow)**. NACO has done well in engaging large sections of industry under the Employer-Led Model (ELM), which works directly with employers and employer networks to reduce stigma and discrimination, as well as to provide prevention information, and has the ultimate goal of the integration of prevention-to-care linkage within industry systems. However, this could not be adequately captured under the framework of the SID. Beyond the ELM, engagement of the private sector, even under the auspices of the 2013 Companies Act, has generally been difficult and unclear. Also, the private healthcare sector is largely unmonitored and the percentage of people accessing services and the quality of the services provided is unclear.

Additional Observations: Although the Commodity and Supply Chain element scored in the yellow (6.75), it is not listed above as a PEPFAR priority because NACO receives support from both Global Fund and World Bank targeting this area, as well as some support from Clinton HIV/AIDS Initiatives and UNAIDS, and had requested in 2015 that PEPFAR focus on other priorities. Also, in the area of Policies and Governance (6.62, yellow), many of these policies are in flux, and are beyond the purview of the National HIV program.

Contact: For questions or further information about PEPFAR's efforts to support sustainability of the HIV response in India, please contact Laura Chittenden at ChittendenL2@state.gov.

Sustainability Analysis for Epidemic Control: India

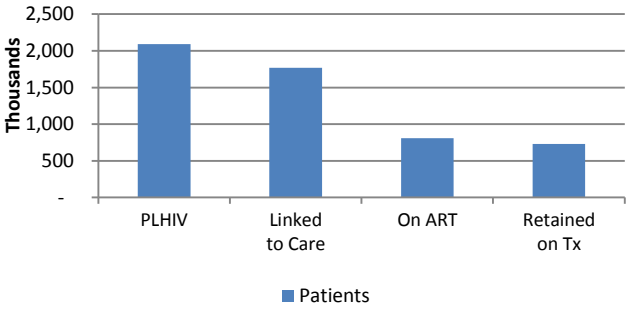
Epidemic Type: Concentrated
Income Level: Lower-middle income
PEPFAR Categorization: Technical Collaboration
PEPFAR COP 16 Planning Level: 25,000,000 (USD Millions)

SUSTAINABILITY DOMAINS and ELEMENTS

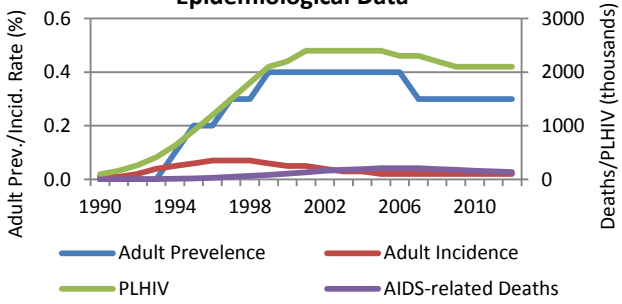
	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.03			
2. Policies and Governance	6.62			
3. Civil Society Engagement	8.02			
4. Private Sector Engagement	3.82			
5. Public Access to Information	8.00			
National Health System and Service Delivery				
6. Service Delivery	7.87			
7. Human Resources for Health	7.33			
8. Commodity Security and Supply Chain	6.75			
9. Quality Management	5.81			
10. Laboratory	7.41			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	8.06			
12. Technical and Allocative Efficiencies	7.82			
Strategic Information				
13. Epidemiological and Health Data	7.02			
14. Financial/Expenditure Data	6.25			
15. Performance Data	6.63			

CONTEXTUAL DATA

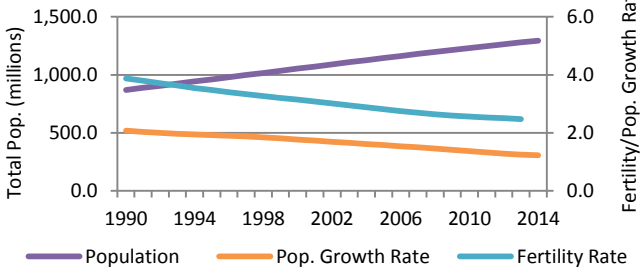
National Clinical Cascade



Epidemiological Data

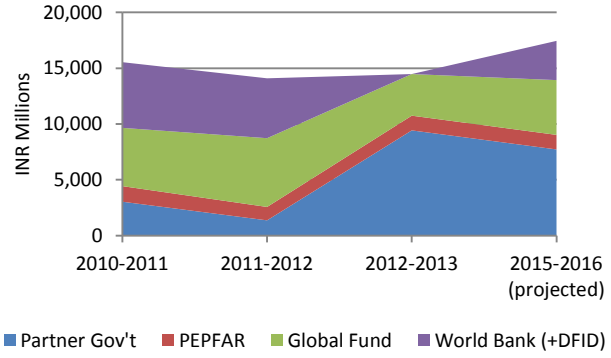


Population and Fertility

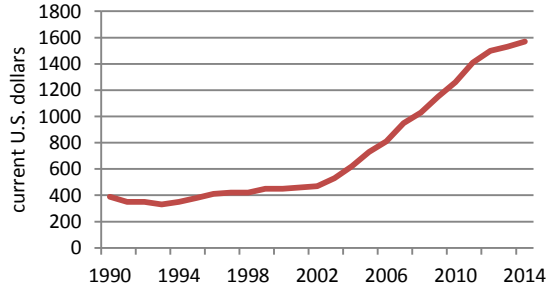


CONTEXTUAL DATA

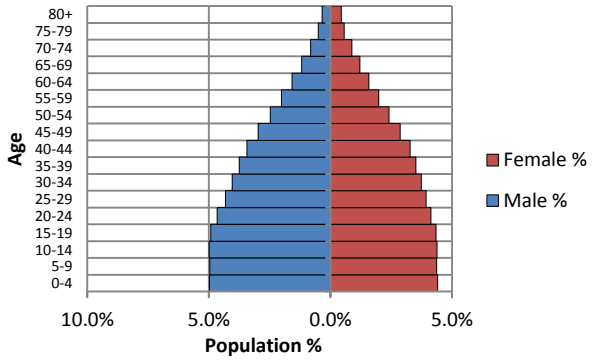
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2015)



Domain A. Governance, Leadership, and Accountability

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ◉ B. There is a multiyear national strategy. Check all ☑ It is costed ☑ It is updated at least every five years ☑ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics) ☑ Strategy includes explicit plans and activities to address the needs of key populations. ☐ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children	1.1 Score: 2.20	National AIDS Control Program Phase-IV (2012-2017) NACP IV targets, NACP IV components, Goals and objectives, safeguard documents (NACP social assessment report, infection control and waste) and National AIDS Control Support Project (http://www.naco.gov.in/NACO/NACP-IV2/)	The NACP IV strategic document outlines priorities, strategies and resource needs for programme components. Certain recednt policy decisions taken (e.g. test and treat for PMTCT) are not reflected in the NACP IV document.
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country ☑ Civil society actively participated in the development of the strategy ☑ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☐ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 2.00	National AIDS Control Program-IV, http://naco.gov.in/NACO/NACP-IV/National_AIDS_Control_Programme_Phase_-IV/NACP_-IV_Planning_process/	Representatives of civil society groups, key populations, PLHIV networks etc. participated in NACP IV planning. There is opportunity for strengthening their engagement and contribution/ role in planning/programming, implementation, community monitoring, etc. Corporate sector does not actively participate, but some influence is provided through the CSOs.

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS implemented activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Check all that apply: ☑ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☑ The host country government routinely tracks and maps HIV/AIDS activities of: ☑ civil society organizations ☐ private sector ☑ donors ☑ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☑ Joint operational plans are developed that include key activities of implementing organizations. ☑ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 2.33	NACP-IV NACO Annual Report 2014-15 Website: http://naco.gov.in/NACO/Quick_Links/Publication/Annual_Report/NACO_Annual_Report/Annual_Report_NACO_2014-15_English/ NACO Technical Resource Groups list Website:	Technical Resource Group meetings are convened for planning, monitoring and overview key initatives, etc. by programme component. Some TRGs are convened more regularly in comparison to others. Regular coordination meetings convened between Government and community representatives on commodity security and other issues in 2014-15, though most meetings are ad hoc. Coordination with NACO, particularly with/through Global Fund PRs, has improved, and they have active involvement in a multi-takeholder identification of gaps, and in addressing gaps and participating in the development of joint operational plans. There is also coordination through the CCM. Private sector has been involved, but via truckers, through organizaitons such as Apollo and TCI, though the reporting to NACO through these channels this is unclear.
1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for B and C)	○ A. There is no formal link between the national plan ◉ B. Sub-national units have performance targets that contribute to aggregate national goals or targets. ○ C. The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	State Annual Action Plans Website: http://naco.gov.in/NACO/Divisions/Finance_Division/Annual_Action_Plan_2013-14/	
	Planning and Coordination Score: 9.03			

2. Policies and Governance: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Data Source**	**Notes/Comments**
2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current or recent WHO guidelines for initiation of ART?	For each category below, check no more than one box that reflects current national policy for ART initiation: A. Adults (>19 years) ☐ Test and START (current WHO Guideline) ☑ CD4 <500 B. Pregnant and Breastfeeding Mothers ☑ Test and START/Option B+ (current WHO Guideline) ☐ Option B C. Adolescents (10-19 years) ☐ Test and START (current WHO Guideline) ☑ CD4<500 D. Children (<10 years) ☑ Test and START (current WHO Guideline) ☐ CD4<500 or clinical eligibility	2.1 Score: 1.07	Minister of Health announcement on WAD 2015 (website: http://pib.nic.in/newsite/PrintRelease.aspx) National strategic plan on PMTCT and updated treatment guidelines for PMTCT (website: http://naco.gov.in/NACO/Quick_Links/Publication/Basic_Services/National_Guidelines_for_PPTCT/National_Strategic_Plan_on_PPTCT/ ANDhttp://naco.gov.in/NACO/Quick_Links/Publication/Basic_Services/National_Guidelines_for_PPTCT/National_Guidelines_for_Prevention_of_Parent_to_Child_Transmission_PPTCT_of_HIV2/) Journey of ART programme in India website: http://naco.gov.in/NACO/Quick_Links/Publication/Treatment_Care__Support/Journey_of_ART_Programme_in_India_/Journey_of_ART_Programme_in_India_/	Treatment threshold for general population has been @ CD4 350 from 2012-15. Key announcement by Minister of Health on WAD 2015 included treatment initiation @ CD4 500 and third-line treatment- and announced that actual delivery would follow. Test and treat for PMTCT (Option B+) launched pan India in 2014. Test and treat for HIV-TB co-infected in 2012. Test and treat for discordant couples and children aslo in place.
2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?	Check all that apply: ☑ A national public health services act that includes the control of HIV ☐ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☐ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☐ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months)	2.2 Score: 0.41	National AIDS Prevention and Control Policy (NAPCP) 2002; (http://www.naco.gov.in/upload/Policies%20&%20Guidelines/NationalAIDSControl&PreventionPolicy2002.pdf); Juvenile Justice Act 2000 (http://www.childlineindia.org.in/CP-CR-Downloads/JJAct2006.pdf); Policy Framework for Children 2007	

	☐ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☐ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☑ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS			
2.3 Non-discrimination Protections: Does the country have non-discrimination laws or policies that specify protections (not specific to HIV) for specific populations? Are these fully implemented? (Full score possible without checking all boxes.)	Check all that apply: Adults living with HIV (women): ☑ Law/policy exists ☐ Law/policy is fully implemented Adults living with HIV (men): ☑ Law/policy exists ☐ Law/policy is fully implemented Children living with HIV: ☑ Law/policy exists ☐ Law/policy is fully implemented Gay men and other men who have sex with men (MSM): ☐ Law/policy exists ☐ Law/policy is fully implemented Migrants: ☑ Law/policy exists ☐ Law/policy is fully implemented People who inject drugs (PWID): ☑ Law/policy exists	2.3 Score: 0.63	This question aligns with the revised UNAIDS NCPI (2015). NCPI B India - 2015 Supreme Court judgement on TG (Website: http://supremecourtofindia.nic.in/outtoday/wc40012.pdf) Juvenile Justice (Care and Protection of Children) Bill 2014 (Website:	General laws: Constitution of India guarantees Fundamental Rights to all citizens under Articles 14 (Equality before law), 15 (Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth…), 16 (Equality of opportunity in matters of public employment), 21 (Protection of life and personal liberty), and 21A (Right to Education) particularly. **It is important to note that the laws covers only public sector not private sector.** Children: Juvenile Justice (Care and Protection of Children) Act 2000, and Right to Education 2010. PWID: The national policy on NDPS, 2012 specify protections for PWID accessing OST and NSEP in the context of Harm Reduction. However, there are other laws that run counter to HIV/AIDS program policies. Transgender: India Supreme Court passed a landmark judgement in April 2014 granting Transgender the status of third gender Legislations for women: There are specific legislations for women such as under the Dowry Prohibition Act (Sections 498A, 304B of the Indian Penal Code), Hindu succession (Amendment) act 2005. However none of these provisions were considered satisfactory by women representatives. They were regarded as insufficient in adequately empowering them to seek 'system-supported' recourse to address grievances on account of discrimination

	☐ Law/policy is fully implemented People with disabilities: ☑ Law/policy exists ☐ Law/policy is fully Prisoners: ☐ Law/policy exists ☐ Law/policy is fully implemented Sex workers: ☐ Law/policy exists ☐ Law/policy is fully implemented Transgender people: ☑ Law/policy exists ☐ Law/policy is fully implemented Women and girls: ☑ Law/policy exists ☐ Law/policy is fully implemented			in the private and public sectors due to their sero-status. Further, the law is not specific to HIV. Legislations for PLHIV: Specific provisions to protect PLHIV, including against S&D, are proposed in the 2014 HIV Bill. The Bill is to be passed by the Parliament. <u>HIV+ children:</u> There is dicrimination in public schools -news reports from Kerala, UP are examples. There is a law but implementation is of great concern.

2.4 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services? Are these laws/policies enforced? (Enforced means any instances of enforcement even if periodic)	Check all that apply: Criminalization of sexual orientation and gender identity: ☑ Law/policy exists ☐ Law/policy is enforced Criminalization of cross-dressing: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of drug use: ☑ Law/policy exists ☑ Law/policy is enforced Criminalization of sex work: ☑ Law/policy exists ☐ Law/policy is enforced Ban or limits on needle and syringe programs for people who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on opioid substitution therapy for people who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on needle and syringe programs in prison settings: ☑ Law/policy exists ☐ Law/policy is enforced Ban or limits on opioid substitution therapy in prison settings:	2.4 Score: 0.93	This question aligns with the revised UNAIDS NCPI (2015). NCPI B India - 2015 Section 269 and section 270 of IPC. NDPS 2014 (http://www.unodc.org/documents/southasia/webstories/NationalPolicyonNDPS_FINAL.pdf). ITPA 1956, 1986 (http://www.keralawomen.gov.in/images/immoral_traffic-prevention_act_1986.pdf)	MSM and TG: Section 377 of Indian Penal Code PWID: NDPS 2014 lays out a framework for drug control in India. NDPS is banned and enforced. AIDS policy contradicts the law.The good policies are not enforced, like section 39 and 64 A, which are meant for offering treatment - these should be enforced. OST is piloted only in Tihar jail (Delhi) not elsewhere. Implementation is an issue. Sex Workers: ITPA 1986 Services available in prisons: *Condoms* and *needle/syringes* are not generally provided in prisons. In some prisons, *OST* programme is initatied as part of medical services provided to prisoners. For e.g. provision of OST in *Tihar* Prison. *HIV testing and counselling* is usually included as part of the medical screening process in prisons. There is referral to *ART centres* as well. *HIV and SRH services for adolescents/young people* : Parental consent is required in order for minors to access services. Banning is for only transmission (not for non-disclousure, exposure).Sex education is banned in four states. There are programs like ARSH of NHM and HIV information is banned.

	☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on the distribution of condoms in prison settings: ☑ Law/policy exists ☐ Law/policy is enforced Ban or limits on accessing HIV and SRH services for adolescents and young people: ☑ Law/policy exists ☐ Law/policy is enforced Criminalization of HIV non-disclosure, exposure or transmission: ☑ Law/policy exists ☑ Law/policy is enforced Travel and/or residence restrictions: ☐ Law/policy exists ☐ Law/policy is enforced Restrictions on employment for people living with HIV: ☐ Law/policy exists ☐ Law/policy is enforced			

2.5 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	There are host country government efforts in place as follows (check all that apply): ☑ To educate PLHIV about their legal rights in terms of access to HIV services ☑ To educate key populations about their legal rights in terms of access to HIV services ☑ National law exists regarding health care privacy and confidentiality protections ☑ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	2.5 Score: 1.43	UNAIDS NCPI	National, State and District Legal Services Authorities provide access to free legal aid for marginalized sections of society List of social protection schemes compiled and available at a dedicated portal that was launched on 2015 World AIDS Day
2.6 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?	○ A. No audit is conducted of the National HIV/AIDS ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ◉ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.6 Score: 1.43	NACO Statutory Audit Report 2012-2013; http://naco.gov.in/NACO/Divisions/Finance_Division/ Comptroller and Auditor General's report	Annual audits were held, though the last one publicly available was in 2013.
2.7 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?	○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ◉ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ○ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.	2.7 Score: 0.71	NACO Annual Report 2012-3	
	Policies and Governance Score:	**6.62**		

3. Civil Society Engagement: Local civil Society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			**Data Source**	**Notes/Comments**
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the ◉ B. There are no laws that restrict civil society playing a role in providing oversight of the ○ C. There are no laws or policies that prevent civil society from providing an oversight of the	3.1 Score: 0.83	-NACO Annual Report 2014-15 -NACP IV planning process *(http://naco.gov.in/NACO/NACO_Action_New/News_on_HIVAIDS/National_Aids_Control_Programme_IV/)* -List of NACO Technical Resource Groups (TRG) with members list - available at NACO website *(http://naco.gov.in/NACO/NACO_Action/TRG_List/)*	Civil society (including KP and PLHIV) support the AIDS response particularly from the implementation (prevention interventions) and care and support service sides. Representatives contributed to the NACP IV planning process.There is no oversight by CSOs, however. There is opportunity to civil society engage to play an oversight role, and more actively from the HIV programme/ planning perspectives, through monitoring etc.
3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ○ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ◉ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☑ In joint annual program reviews ☑ For policy development ☑ As members of technical working groups ☐ Involvement on government HIV/AIDS program ☑ Involvement in surveys/studies ☐ Collecting and reporting on client feedback	3.2 Score: 1.19	UNAIDS NCPI Assessment NACO Annual Report 2014-15	In terms of level and scope of civil society engagement, there is variation across states and programmatci areas. It was noted that there are formal channels, through the TRGs, through DAPCUs, SACS, etc., but (a) meetings are infrequent and often ad hoc, (b) many meetings are more administrative and not pertaining to programmatic issues of interest to the CSOs, and (c) the routine level of engagement has declined since NACP-III. It was also noticed that variation occurs not just by geographic context, but also by strength of the network or NGO.

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy and budget decisions (check all that apply): ☑ In advocacy ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☐ In HIV/AIDS basket or national health financing decisions	3.3 Score: 1.33	NACP-III	Civil society (including KP and PLHIV) conduct advocacy, service delivery and to an extent, engage in technical decision making (through Technical Resource Group meetings). However, their overall **impact** on HIV/AIDS policy and budget decisions is difficult to ascertain and there is scope to engage them further. It was noted that some engagement does provide impact, eg the recommendations for ORW salary increases under NACP-III was eventually enacted. It was noted that some recommendations experience a significant lag before enactment. The hope is that communication will flow from civil society, to the TRGs, to policy, but as noted previosly, the TRGs do not meet regularly, and there may be long time gaps between meetings. Several suggestions regarding budget were discussed - for xample, flexibility in allocaitons to the TIs, as currently all TIs across a state are given the same amount of funding. Across most policy and budget decisions, apart from service delivery, CS engagement is not as impactful.
3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments	○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund ○ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).	3.4 Score: 3.33	NACO Annual Report 2014-2015	The majority of the funding for key populations is provided by World Bank - Domestic Funding. However, Global Fund is also considered domestic funding.

column)	◉ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants).		

3.5 Civil Society Enabling Environment: Is the legislative and regulatory framework conducive to Civil Society Organizations (CSOs) or not-for-profit organizations to engage in HIV service provision or health advocacy?	○ A. The legislative and regulatory framework is not conducive for engagement in HIV service provision or health advocacy ◉ B. The legislative and regulatory framework is conducive for engagement in HIV service delivery and health advocacy as follows (check all that ☐ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☑ Significant tax exemptions for not-for-profit CSOs ☑ Open competition among CSOs to provide government-funded ☑ Freedom for CSOs to advocate for policy, legal and programmatic change ☐ There is a national public private partnership (PPP) technical working group or desk officer within the government (ministry of health, finance, or president's office) in which CSOs or non-profit organizations participate/engage.	3.5 Score: 1.33	Companies Act 2013, Corporate Social Responsibilities Requirement	On paper, and in legislation for health, there are provisions that provide some freedoms for service delivery. However, there is some additional, and conflicting, legislation (eg Article 377) that is inhibitory to service access due to fear (esp. for MSM). There were also competing schemes for FSW, in terms of the economic empowerment schemes developed by the Ministry of Women and Child Development; participation in this scheme had affected women who were serviced in the FSW TIs. In terms of the broader enabling environment and guidelines/policies, there are constraints within the operaitonal guidelines for TIs that could be revised to provide better service delivery. For example: (1) expanding the number of TIs per CSO, given the volume of outreach; (2) including pimps as peers; (3) eliminating / changing the upper age cut off for the peer designation.
		Civil Society Engagement Score:	**8.02**	

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.			**Data Source**	**Notes/Comments**
4.1 Government Channels and Opportunities for Private Sector Engagement: Does host country government have formal channels and opportunities for diverse private sector entities to engage and provide feedback on its HIV/AIDS policies, programs, and services?	○ A. There are no formal channels or opportunities ◉ B. There are formal channels or opportunities, but private sector is called upon in an ad hoc manner to provide inputs and feedback ○ C. There are functional formal channels and opportunities for private sector engagement and feedback. Check all that apply: ☐ Corporate contributions, private philanthropy and giving ☐ Joint (i.e. public-private) supervision and quality oversight of private facilities ☐ Collection of service delivery and client satisfaction data from private providers ☐ Tracking of private training institution HRH graduates and placements ☐ Contributing to develop innovative solutions, both technology and systems innovation ☐ For technical advisory on best practices and delivery solutions	4.1 Score: 0.83	Companies Act 2013; http://www.naco.gov.in/NACO/Mainstreaming_and_Partnerships/Corporate_Sector_or_Private_Sector/	Although there are examples of private sector engagement, there is substantial potential to increase private sector engagement (such as through corporate contributions/philanthropy, joint supervision of private facilities, data, developing innovative solutions, etc.) Some private sector companies provide ad-hoc support to specific AIDS response components.

4.2 Private Sector Partnership: Do private sector partnerships with government result in stronger policy and budget decisions for HIV/AIDS programs?	◉ A. Private sector does not actively engage, or private sector engagement does not influence policy and budget decisions in HIV/AIDS. ○ B. Private sector engagement influences HIV/AIDS policy and budget decisions in the following areas (check all that apply): ☐ In patient advocacy and human rights ☐ In programmatic decision making ☐ In technical decision making ☐ In service delivery for both public and private providers ☐ In HIV/AIDS basket or national health financing decisions ☐ In advancing innovative sustainable financing models ☐ In HRH development, placement, and retention strategies ☐ In building capacity of private training institutions ☐ In supply chain management of essential supplies and drugs	4.2 Score: 0.00		

4.3 Legal Framework for Private Health Sector: Does the legislative and regulatory framework make provisions for the needs of the private health sector (including hospitals, networks, and insurers)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☐ Systems are in place for service provision and/or research reporting by private sector facilities to the government. ☑ Mechanisms exist to ensure that private providers receive, understand and adhere to national guidelines/protocols for ART. ☐ Tax deductions for private health providers. ☐ Tax deductions for private training institutions training health workers. ☑ Open competition for private health providers to compete for government services. ☑ General or HIV/AIDS-specific service agreement frameworks exist between local government authorities/municipalities and private providers at the sub-national unit (e.g. district) levels. ☑ Freedom of private providers to advocate for policy, legal, and regulatory frameworks. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between public and private providers.	4.3 Score: 1.04	http://naco.gov.in/NACO/Divisions/NGO__Targeted_Interventions2/CapacityBuilding/Employer_Led_Model_ELM_Training_Manuals/ http://khn.org/morning-breakout/dr00041929/ NACO Annual Report 2014-5	

4.4 Legal Framework for Private Businesses: Does the legislative and regulatory framework make provisions for the needs of private businesses (local or multinational corporations)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☐ Tax deductions for health-related private businesses (i.e. pharmacists, supply chain, etc.). ☑ Systematic and timely process for private company registration and/or testing of new health products; drugs, diagnostics kits, medical devices. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between local government and private business. ☑ Corporate Social Responsibility (CSR) tax policies (compulsory or optional) contributing private corporate resources to the HIV/AIDS response. ☑ Workplace policies support HIV-related services and/or benefits for employees. ☐ Existing forums between business community and government to engage in dialogue to support HIV/AIDS and public health programs.	4.4 Score: 1.11	http://naco.gov.in/NACO/Divisions/NGO__Targeted_Interventions2/CapacityBuilding/Employer_Led_Model_ELM_Training_Manuals/ http://khn.org/morning-breakout/dr00041929/ NACO Annual Report 2014-5	Workplace policies are minimal; very few exist.

4.5 Private Health Sector Supply: Does the host country government enable private health service provision for lower and middle-income HIV patients?	○ A. There are no enablers for private health service provision for lower and middle-income HIV patients. ◉ B. The host country government enables private health service provision for lower and middle-income patients in the following ☑ Private for-profit providers are eligible to procure HIV and/or ART commodities via public sector procurement channels and/or ☐ The private sector scope of practice for physicians, nurses and midwives serving low and middle-income patients currently includes HIV and/or ART service provision.	4.5 Score: 0.83	Companies Act 2013; http://www.naco.gov.in/NACO/Mainstreaming_and_Partnerships/Corporate_Sector_or_Private_Sector/	
4.6 Private Health Sector Demand: Is the percentage of people accessing HIV treatment services through the private sector similar to (or approaching) the percentage of those seeking other curative services through the private sector?	◉ A. The percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services through the private sector. ○ B. The percentage of people accessing HIV treatment services through the private sector is similar to (or approaching) the percentage seeking other curative services through the private sector due to the following factors (check all that apply): ☐ HIV-related services/products are covered by national health insurance. ☐ HIV-related services/products are covered by private or other health insurance. ☐ Adequate risk pooling exists for HIV services. ☐ Models currently exist for cost-recovery for ART. ☐ HIV drugs are not subject to higher pharmaceutical mark-ups than other drugs in the market.	4.6 Score: 0.00	Reference to the India GARPR report 2015: Number of people (adults+children) receiving ART in 2014-15: around 830,000 from public sector and 30,000 from private sector.	
		Private Sector Engagement Score: 3.82		

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.			**Source of Data**	**Notes/Comments**
5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data, or at least a summary report of data, and analyses are made available to stakeholders and general public in a timely way?	○ A. The host country government does not make HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public, or they are made available 3 or more years after the date of collection. ◉ B. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within 1-3 years. ○ C. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within the same year.	5.1 Score: 1.00	http://naco.gov.in/NACO/Quick_Links/Directory_of_HIV_Data/	NACO takes two years between surveillance reports in order to complete data collection and conduct thorough analyses of the data. However, other forms of data are provided on an annual basis, for example, in the Annual Report and State Fact Sheets.
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data, or at a minimum at least a summary of it, available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS expenditure summary reports available to stakeholders and the general public or they are ○ B. The host country government makes HIV/AIDS expenditure summary reports available to ◉ C. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public within 1 year	5.2 Score: 2.00	NACO Annual Report 2014-2015; State Epi fact Sheets July 2014 (subnational data); UNAIDS GARPR	Expenditure data reported in NACO Annual Reports is not disaggregated by SNU or by program area, however, it is reported in UNAIDS GARPR. Challenges are that the report only reports funds which flow through the government system. Funding flows out of the government system are not accounted for or tracked.
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data (or at a minimum of summary of it) available to	○ A. The host country government does not make HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of programming. ○ B. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1-3 years after date of programming.	5.3 Score: 2.00	E.g. NACO Results Framework Document (http://www.naco.gov.in/upload/Results%20Framework%20Document/RFD%202013-14.pdf) TI performance reports, TSU performance reports (http://naco.gov.in/NACO/Quick_Links/R	

stakeholders and the public in a timely way?	◉ C. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1 year after date of programming .		(http://naco.gov.in/NACO/Quick_Links/Publication/NGO__Targeted_Interventions/)	

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. Host country government does not make any HIV/AIDS procurements ○ B. Host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ◉ C. Host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ○ D. Host Country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 1.00	http://www.naco.gov.in/NACO/Divisions/Procurement/ Invitation of Bids by RITES (procurement agent) for ARV, pre-bid meeting minutes, etc. available on NACO website (http://naco.gov.in/NACO/About_NACO/Procurement/)	Award details are not provided
5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for educating the public about HIV?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score: 2.00	http://naco.gov.in/NACO/Divisions/IEC/	NACO develops IEC materials and provides HIV education to the general public. It has also established MOUs across many Ministries and Departments in its mainstreaming efforts, which supports HIV education and information to those employed under these institutions.
	Public Access to Information Score:	**8.00**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving prevention, treatment, and care services and interventions. There is a high demand for HIV/AIDS services, which are accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and/or are affected by the HIV/AIDS epidemic.

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☑ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☐ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 0.74	- NACO Annual Reports - NACO HIV Sentinel Surveillance Report, HIV Estimates Report, State Annual Reports *(http://www.naco.gov.in/NACO/Quick_Links/Directory_of_HIV_Data/)* - NACO district categorisation for priority attention (http://naco.gov.in/upload/NACO%20PDF/District%20Categorisation%20for%20Priority%20Attention.pdf	There are standard operational guidelines and protocols that are required to be followed while implementing interventions. However, there is some adaptation of service delivery at state and district level.
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services?	The host country has standardized the following design and implementation components of community-based HIV services through (check all that apply): ☑ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☑ National guidelines detailing how to operationalize HIV services in communities ☑ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities ☑ Providing financial support for community-based services ☑ Providing supply chain support for community-based services ☑ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to	6.2 Score: 1.11	-NACO operational guidelines for CBOs/NGOs implementing TIs *(http://www.naco.gov.in/NACO/Quick_Links/Publication/NGO__Targeted_Interventions/)* - NACO Operational guidelines for care and support centers *(http://naco.gov.in/NACO/Quick_Links/Publication/Treatment_Care__Support/)*	NACP III had CSO representaions CCCs also do no have CSC rep Design process of NACP IV. All KP groups were involved for the designing process. KPs were involved in the consultations. CSO not involved in implementation and review of NACP OIV. CSO rep in NACP TRG February 22. TCI was the TRG for truckers. After 2012, TCI/CSO not involved for any consultation. CSOs/Implementing organizations need to be involved in the annual review. There is no offcial recognition by the governement. NGOs give the recognition. Official recognition in terms identifying ORWs and PE as trainers Timely release of funds need to be ensured to NGOs. There is stock out of condoms
6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services in high burden areas (i.e. excluding any external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services in high burden areas ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services in high burden areas ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services in high burden areas ◉ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services in high burden areas ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services in high burden areas	6.3 Score: 1.25	NACO Annual Report 2014-2015	

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services in high burden areas are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services in high burden areas but with substantial external technical assistance. ◉ C. Host country institutions deliver HIV/AIDS services in high burden areas with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services in high burden areas with minimal or no external technical assistance.	6.4 Score: 0.74	NACO Annual Report 2014-2015	CSO not fully aware of the external technical assistance to host country. The group relies on the NACO Annual report findings. CSOs not involved in budget planning for technical assistance.
6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations in high burden areas (i.e. without external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ◉ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations in high burden areas.	6.5 Score: 1.25	NACO Annual Report 2014-2015	World Bank and Government of India (IDA) - HIV prevention interventions
6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ○ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ◉ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.74	NACO Annual Report 2014-2015	
	The national MOH (check all that apply): ☑ Translates national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Uses epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assesses current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develops sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engages with civil society in program planning and evaluation of services .	6.7 Score: 1.11	Source State Annual Action Plans 2013-14 *(http://naco.gov.in/NACO/Divisions/Finance_Division/Annual_Action_Plan_2013-14/)* State physical and fiancial monitoring status (e.g. Punjab *http://www.punjabsacs.org/Mont.aspx* HIV Estimates report *(http://naco.gov.in/NACO/Quick_Links/*	Comment on devolved responsibilities (vs national) NACO provides leadership to the AIDS Programme in India. State AIDS Prevention and Control Societies (SACS) implement NACO programme at state level and their functions include administration, planning, coordination, M&E, finance and etc. District AIDS Prevention and Control Units (DAPCUs) have been set up in prirority districts for supporting programme implementation at the district level. Technical Support Units (TSUs) were established at National and State level to assist in the programme monitoring and technical areas. It is translated to some extent, with operational issues and

6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services in high HIV burden areas?	☑ Designs a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.		*Publication/ME_and_Research_Surveillance/)*	lack of CSO participation. Lack of funding affects implementation. Gaps in coverage with no scale up in new emerging areas. Annual review of the effectiveness of the program is needed. Validity of data to measure coverage and sharing data. Need to be transparent and accountable for the funding and planning including timelines for the states. Greater engagement of CSOs in programs would render more effective program planning and evaluation services. Though there is strategy and a system for training and mentoring, there are concerns of quality. Training for trucker TIs is not held regularly. There is high turnover of staff due to non release of funds. New staff such as counselors are not provided training. In the last column, the TSUs are primarily supporting prevention (TIs)

6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan ☐ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training	6.8 Score: 0.93	State Annual Action Plans NACO Annual Report 2014-15	The capacities to plan and manage HIV services do exist, however, there is considerable variation in capacities across states. In addition, a high turn-over and attrition of personnel at managerial and programme levels in the states is noted particularly during 2014-15. SACS Project Directors who have additional charge do not focus enough attention affecting decision making. The scaling of TG and IDU intervention is limited.
	Service Delivery Score	**7.87**		

7. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Data Source**	**Notes/Comments**
7.1 HRH Supply: To what extent is the health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or comm site level?	Check all that apply: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of health care providers ☐ The country's health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☑ The country has developed retention schemes that address health worker vacancy or attrition in high HIV burden areas ☑ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.67	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3413963/; http://www.atmph.org/article.asp?issn=1755-6783;year=2013;volume=6;issue=1;spage=30;epage=41;aulast=Sharma http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61474-4/fulltext?rss=yes https://books.google.com/books?id=8tDTtOjzl7wC&pg=PA231&lpg=PA231&dq=India+NACO+human+resource+volume&source=bl&ots=lObpKyUeiV&sig=dtJAJFMXNbvlYMF2IEX33-y6B4g&hl=en&sa=X&ved=0ahUKEwiyv4P9_erLAhXDPB4KHfrwBlQQ6AEIIzAC#v=onepage&q=India%20NACO%20human%20resource%20volume&f=false	The longer-term issue is not about supply of health workers to enable HIV services, but rather is the issue of HIV integration in curriculum, work conditions and retention strategies, and whether where will they be positioned within the health systems. In the more immediate term, there has been a turn-over and attrition in number of personnel/staff. In terms of in-service training, HIV modules are included to training curriculum, induction training - e.g. ICTC, ART, STI counsellors ; nurses, doctors
7.2 HRH transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	○ A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ◉ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	7.2 Score: 1.00	COP15, COP16 salary support	There was a transition of funding support for human resources from BMGF and other externally supprted programmes to government. As far as USG funding is concerned, HR is increasingly limited to consultants providing support to government on a need basis, and not directly to government employees.

7.3 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ○ D. Host country institutions provide most (approx. 50-89%) health worker salaries ◉ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.3 Score: 3.33	NACO Annual Report 2014-2015; NACP-IV	
7.4 Pre-service: Do current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	○ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years) ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☑ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☐ Institutions maintain process for continuously updating content, including HIV/AIDS content ☐ Updated curricula contain training related to stigma & discrimination of PLWHA ☐ Institutions track student employment after graduation to inform planning	7.4 Score: 0.83	http://182.73.176.174/chc/nursing/e-learning.pdf	On Nov 18, 2014, the Indian Nursing Council provided a letter regarding GFATM training, stating that only faculty were trained, but curriculum is not updated based on new guidelines. An e-learning module was subsequently created, though the content, and if this provides the necessary updates, is unclear. It is now a mandatory module for all MscN students. However, it is not certain whether other health workers receive such pre-service training.
7.5 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☐ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☐ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☑ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☑ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS ☐ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☐ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden	7.5 Score: 0.67	NACO Annual Report 2014-2015; NACP-IV	

7.6 HR Data Collection and Use: Does the country systematically collect health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☑ The HRIS is primarily financed and managed by host country institutions ☐ There is a national strategy or approach to interoperability for HRIS ☐ The government produces HR data from the system at least annually ☐ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.6 Score: 0.83	**Human Resources Information System (HRIS): A review Across the States of India 2014**	According to HRIS review, there is no national repository. According to the recent report, only 14 states have HRIS data available. PEPFAR supported a nursing HRIS in one state, and the system has been shared with the Indian Nursing Council for scale up.
	Human Resources for Health Score	**7.33**		
8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Data Source**	**Notes/Comments**
8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known. ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ◉ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50 – 89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.42	Global Fund Concept Note 2015	During India's 2013-2014, all ARVs were funded by GF. The GoI will expand domestic budgetary support for ARV drugs, contributing 20% (2015-2016), 50% (2016-2017), and 70% (2017-2018) of the total requirements.
8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ◉ F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.83	Global Fund Concept Note 2015	No external resources are sought for HIV rapid test kits

8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ○ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ◉ F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.83	Global Fund Concept Note 2015	No external resources are sought for condoms
8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	○ A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ◉ B. There is a plan/SOP that includes the following components (check all that apply): ☑ Human resources ☐ Training ☑ Warehousing ☑ Distribution ☐ Reverse Logistics ☑ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☑ Supply planning and supervision ☑ Site supervision	8.4 Score: 1.82	World Bank JIRM Aide Memoire December 2015; http://www.naco.gov.in/upload/Divisions/TI/DAPCU%20Operational%20Guidelines%20(2012).pdf; additional details are providid within program guides/manuals	NACO has a working group currently developing a supply chain strategy that will combine these elements more succinctly.
8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)? (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not available. ○ B. No (0%) funding from domestic sources. ○ C. Minimal (approx. 1-9%) funding from domestic sources. ○ D. Some (approx. 10-49%) funding from domestic sources. ◉ E. Most (approx. 50-89%) funding from domestic sources. ○ F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score: 0.63	Global Fund Concept Note, 2015 World Bank JIRM Aide Memoir, December 2015	The budget in the current PSM plan is funded by government, world bank and global fund.

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock levels?	Check all that apply: ☑ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☑ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☑ Team that conducts analysis of facility data is at least 50% host government	8.6 Score: 2.22	NACO Annual Report NACO Weekly updated on commodities/stock *(http://www.naco.gov.in/NACO/Weekly_Stock_Register/)*	In terms of processes and systems for appropriate ARV stocks, the decision making and monitoring have been streamlined and strengthened following difficulties in maintaining and distributing adequate ARV stocks experienced in 2014-15.
8.7 Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years? (if exact or approximate percentage known, please note in Comments column)	◉ A. A comprehensive assessment has not been done ○ B. A comprehensive assessment has been done but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments ○ C. A comprehensive assessment has been done and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 0.00	NACO Weekly Stock Registers:http://www.naco.gov.in/NACO/Weekly_Stock_Register/	
Commodity Security and Supply Chain Score:		**6.75**		

9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			**Data Source**	**Notes/Comments**
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☑ Has a budget line item for the QM program ☐ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 1.33	http://naco.gov.in/upload/2015%20MSLNS/QMS_Guidelines.pdf NACO Operational guidelines for various programme areas (e.g. ICTC, SIMU, financial management, etc.) *(http://www.naco.gov.in/NACO/Quick_Links/Publication/Treatment_Care__Support/Operational__Technical_guidelines_and_policies/Operational_Guidelines_for_Care__Support_Centres_December_2013/)* NACO quality management system in HIV testing labs *(http://www.naco.gov.in/NACO/Quick_Links/Publication/Lab_Services2/)*	As part of quality management, NACO has organisational management and oversight structures across various programme areas (e.g. ICTC, financial management , SI etc.) - set-up at national and sub-national level with clarification on roles and responsibilities.
9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	○ A. There is no HIV/AIDS-related QM/QI strategy ○ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not current (updated within the last 2 years) ○ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements ◉ D. There is a current HIV/AIDS program specific QM/QI strategy	9.2 Score: 2.00	http://naco.gov.in/upload/2015%20MSLNS/QMS_Guidelines.pdf	In addition to the QMS Guidelines, the TI program also has 31 performance indicators to track the quality of the services, and a quality and tracking tool for all Tis.

9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. ◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): ☑ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement ☐ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities ☑ There is documentation of results of QI activities and demonstration of national HIV program improvement	9.3 Score: 1.33	NACP-IV http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3505438/	
9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	◉ A. There is no training or recognition offered to build health workforce competency in QI. ○ B. There is health workforce competency-building in QI, including: ☐ Pre-service institutions incorporate modern quality improvement methods in curricula ☐ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 0.00	http://naco.gov.in/NACO/Divisions/Blood_Safety/Blood_Safety_More/ http://www.indiahivinfo.naco.gov.in/naco/resource/national-guidelines-quality-management-systems-hiv-testing-laboratories	
9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☑ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convenes meetings that includes health services consumers ☑ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convene meetings that includes health services consumers ☑ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☐ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 1.14	http://www.indiahivinfo.naco.gov.in/naco/resource/national-guidelines-quality-management-systems-hiv-testing-laboratories naco.gov.in/NACO/Divisions/Blood_Safety/Blood_Safety_More/	
	Quality Management Score:	**5.81**		

10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			**Data Source**	**Notes/Comments**
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	○ A. There is no national laboratory strategic plan ○ B. National laboratory strategic plan is under development ○ C. National laboratory strategic plan has been developed, but not approved ○ D. National laboratory strategic plan has been developed and approved ◉ E. National laboratory plan has been developed, approved, and costed	10.1 Score: 1.67	NACP-IV	
10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	○ A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○ B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ○ C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○ D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ○ E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ◉ F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	10.2 Score: 1.67	NACO Point of Care Technical specifications (http://www.naco.gov.in/NACO/Quick_Links/Publication/Lab_Services2/Technical_Specifications/Point_of_Care_Technical_Specification/) NACO quality management systems in HIV testing labs (http://www.naco.gov.in/NACO/Quick_Links/Publication/Lab_Services2/11045/Quality_Management_Systems_in_HIV_testing_laboratories/) NACO Annual Report	
10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?	○ A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ◉ B. There are adequate qualified laboratory personnel to perform the following key functions: ☐ HIV diagnosis in laboratories and point-of-care settings ☑ TB diagnosis in laboratories and point-of-care settings ☐ CD4 testing in laboratories and point-of-care settings ☐ Viral load testing in laboratories and point-of-care settings ☑ Early Infant Diagnosis in laboratories ☑ Malaria infections in laboratories and point-of-care settings ☐ Microbiology in laboratories and point-of-care settings ☑ Blood banking in laboratories and point-of-care settings ☐ Opportunistic infections including Cryptococcal antigen in laboratories and point-of-care settings	10.3 Score: 0.74	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3413963/; http://www.atmph.org/article.asp?issn=1755-6783;year=2013;volume=6;issue=1;spage=30;epage=41;aulast=Sharma http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61474-4/fulltext?rss=yes https://books.google.com/books?id=8tDTtOjzl7wC&pg=PA231&lpg=PA231&dq=India+NACO+human+resource+volume&source=bl&ots=lObpKyUeiV&sig=dtJAJFMXNbvlYMF2IEX33-y6B4g&hl=en&sa=X&ved=0ahUKEwiyv4P9_erLAhXDPB4KHfrwBlQQ6AEIIzAC#v=onepage&q=India%20NACO%20human%20resource%20volume&f=false	

10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	◉ A. There is not sufficient infrastructure to test for viral load. ○ B. There is sufficient infrastructure to test for viral load, including: ☐ Sufficient viral load instruments and reagents ☐ Appropriate maintenance agreements for instruments ☐ Adequate specimen transport system and timely return of results	10.4 Score: 0.00		Expansion for viral load testing is included under the Global Fund NFM 2015-17 grant for India, however this expansion would not be adequate to test viral load systematically to reach sustained epidemic control.
10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○ A. No (0%) laboratory services are financed by domestic resources. ○ B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ○ C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○ D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ◉ E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	10.5 Score: 3.33	NACP-III	
		Laboratory Score:	**7.41**	

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.			**Data Source**	**Notes/Comments**
11.1 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☐ The HIV/AIDS budget is program-based across ministries ☑ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☐ The budget includes specific HIV/AIDS service delivery targets ☑ National budget reflects all sources of funding for HIV, including from external donors	11.1 Score: 1.67	http://indiabudget.nic.in/ub2015-16/bag/bag8.pdf Ministry of Health, India finance outlays and outcome budget 2015-16 *(http://www.mohfw.nic.in/WriteReadData/l892s/6541236578963214.pdf)* *NACO Annual Report*	The total budget for NACP IV was estimated at INR 13,415 crore which comprises Government Budgetary Support, Externally Aided Budgetary Support from World Bank and The Global Fund - and Extra Budgetary Support from other Development Partners. (Reference to the NACP IV strategy document)
11.2 Annual Targets: Did the most recent budget as executed achieve stated annual HIV/AIDS goals? (if exact or approximate percentage known, please note in Comments column)	○ A. There are no HIV/AIDS goals/targets articulated in the national budget ○ B. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but none (0%) were attained. ○ C. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but very few (approx. 1-9%) were attained. ○ D. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and some (approx. 10-49%) were reached. ○ E. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and most (approx. 50-89%) were reached. ◉ F. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and all or almost all (approx. 90%+) were reached.	11.2 Score: 2.22	Ministry of Health, India finance outlays and outcome budget 2015-16 *(http://www.mohfw.nic.in/WriteReadData/l892s/6541236578963214.pdf)* India GARPR report 2015 NACO Annual Report	Ministry of Health finance outlays and outcome budget 2015-16 defines NACO's objectives and quantifiable deliverables for the period. Previously, targets set under various programme components are achieved or nearly achieved - according to annual targets set

11.3 Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	○ A. Information is not available ○ B. There is no national HIV/AIDS budget, or the execution rate was 0%. ○ C. 1-9% ○ D. 10-49% ◉ E. 50-89% ○ F. 90% or greater	11.3 Score: 1.67	http://indiabudget.nic.in/ub2015-16/eb/stat12.pdf NACO has published the expenditure against budget provision for 1999-2007. Expenditure inclurred from 2012-13 to 2014-15 (upto Nov 2014) is available in the NACO Annual Report 2014-15	Under Finance Balance sheets, available funds not disbursed Expenditure report State SACS Audit on NACO site Actual expenditure?
11.4 PLACEHOLDER for future indicator measuring country's financial ability to pay for its HIV response (will not be included in SID for COP 16)				
11.5 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding (excluding out-of-pocket and donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ○ B. Very little (approx. 1-9%) is financed with domestic funding. ○ C. Some (approx. 10-49%) is financed with domestic funding. ◉ D. Most (approx. 50-89%) is financed with domestic funding. ○ E. All or almost all (approx. 90%+) is financed with domestic funding.	11.6 Score: 2.50	NACO Annual Report 2014-2015 WB aide de memoire Dec 2015 Private sector HIV funding- no info (ORG Pharma Sector) - Pvt. Sector ART Sale for 14-15 is 86 Crores, of which 20 Crores (Mumbai) Highest 2nd Line and 3rd Line	
	Domestic Resource Mobilization Score:	**8.06**		

12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			**Data Source**	**Notes/Comments**
12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources? (note: full score achieved by selecting one checkbox)	○ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ◉ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☐ Optima ☑ Spectrum (including EPP and Goals) ☐ AIDS Epidemic Model (AEM) ☐ Modes of Transmission (MOT) Model ☑ Other recognized process or model (specify in notes column)	12.1 Score: 1.43	NACP-IV	Annual State Action Plans, and District Action Plans, are completed annually; the National Strategy is conducted every 5 years

12.2 High Impact Interventions: What percentage of site-level point of service HIV domestic public sector resources (excluding any donor funds) are being allocated to the following set of interventions: provision of ART, VMMC, PMTCT, HTC, condoms, and targeted prevention for key and priority populations? (if exact or approximate percentage known, please note in Comments column)	○ A. Information not available ○ B. No (0%) site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ C. Minimal (approx. 1-9%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ D. Some (approx. 10-49%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ◉ E. Most (approx. 50-89%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ F. All or almost all (approx. 90%+) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.	12.2 Score: 1.07	NACP-IV NACO Annual Report	WB aide de memoire
12.3 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)? (if exact or approximate percentage known, please note in Comments column)	○ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ◉ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ○ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.3 Score: 0.71	State Annual Action Plans; District Categorization (http://naco.gov.in/upload/NACO%20PDF/District%20Categorisation%20for%20Priority%20Attention.pdf), though a little outdated	State Action Plans, and District Action Plans, are completed annually; the National Strategy is conducted every 5 years New emerging data as incidences & categories A, B, C, D

12.4 Data-Driven Reprogramming: Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle?	○ A. There is no system for funding cycle reprogramming ○ B. There is a policy/system that allows for funding cycle reprogramming, but it is seldom used. ◉ C. There is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ○ D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 0.95	AAP Audit Report Consignee recd. Expenditure Data is not updated www.naco.gov.in/NACO/News-And-Update/Statutory-Audit-Reports-2012-13)	
12.5 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country government does not use recent expenditure data or cost analysis to estimate unit costs ◉ B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply): ☑ HIV Testing ☑ Care and Support ☑ ART ☑ PMTCT ☐ VMMC ☐ OVC Service Package ☑ Key population Interventions	12.5 Score: 1.43	Operational Guidelines for NGOs/CBOs (TI Program Costing), Operational Guidelines for Care Support and Treatment(p98-102). NACO study. Strategic Options for the NACP-IV AAP of States www.naco.gov.in/uploads/NACO %20-%20IV/NACP-IVO/O20Strategy%20Documents%20.pdf	Mostly expenditure data Not based on cost analysis Nor need based data

12.6 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☑ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☑ Reduced overhead costs by streamlining management ☑ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☐ Improved procurement competition ☐ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☐ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☑ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years) ☑ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years) ☐ Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)	12.6 Score: 0.79	Strategic Options for NACP-IV	Cost-effectiveness study done in 2009/2010 for mid-term review of NACP-III. In 2012, cost-effectiveness analysis for NACP-IV was conducted but not utilized. Scaling up of high impact interventions are happening for PPTCT Option B+ and implementaiton of WHO CD4<500 ART Guidelines was announced in December 2015, and community based testining, and test and start for key populations is being piloted. During the World Bank Joint Implementaiton Review Mission, data on the impact of interventions across the TIs was presented.

12.7 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	○ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ○ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. ○ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. ○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. ◉ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.	12.7 Score:	1.43	http://apps.who.int/hiv/amds/price/hdd/	$36.83
Technical and Allocative Efficiencies Score:			**7.82**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

What Success Looks Like: Using local and national systems, the host country government collects, analyzes and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

13.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.			**Data Source**	**Notes/Comments**
13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ◉ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies	13.1 Score: 0.71	National AIDS Control Programme Phase-IV (2012-2017) Strategy Document HIV Sentinel Surveillance: A technical brief and HIV Estimates report *(http://www.naco.gov.in/NACO/Quick_Links/Publication/ME_and_Research_Surveillance/)*	
13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external ◉ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external	13.2 Score: 0.71	District Epidemiological profiling Factsheets, 2012-2014, NACO HIV Sentinel Surveillance: A Technical Brief *(http://www.naco.gov.in/NACO/Quick_Links/Publication/ME_and_Research_Surveillance/)* : This publication provides latest available HSS KP data. National IBBS is planned for release in Feb 2016 NACO Annual Report	

13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ◉ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	13.3 Score: 1.25	NACO Annual Report, 2014-2015; Global AIDS Response Progress Reporting (GARPR) 2014	
13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ◉ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (approx. 90% +) is provided by the host country government	13.4 Score: 1.25	IBBS, HSS, NACP-IV	

13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age ☑ Sex ☑ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☑ Sub-national units ☐ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☐ Age ☐ Sex ☐ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☐ Sub-national units	13.5 Score: 0.48	State HIV epi sheets, NACO, July 2014: 2011 data for sex-wise prevalence in state NACO Annual Report, 2014-2015: 2011 data for the key population	Incidence data not collected India generates estimates of HIV incidence using modelling (Spectrum tool) for national level and all states/union territories. Reference: India HIVEstimates Technical Report *http://naco.gov.in/upload/2015%20MSLNS/HSS/India%20HIV%20Estimations%202015.pdf*
13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage known, please note in Comments column)	◉ A. The host country government does not collect/report viral load data or does not conduct viral load monitoring ○ B. The host country government collects/reports viral load data (answer both subsections below): According to the following disaggregates (check ALL that apply): ☐ Age ☐ Sex ☐ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) For what proportion of PLHIV (select ONE of the following): ☐ Less than 25% ☐ 25-50% ☐ 50-75% ☐ More than 75%	13.6 Score: 0.00	No public source available	HCG does not collect data on viral load as a routine mechanism or for any analysis. This data is still at an individual level, available at labs that perform VL testing or in the white card of patients who undergo viral load testing. This is also entered in SACEP registers. the only information NACO asks of the labs and CoEs is how many tests were performed. *The GF country proposal includes a component on viral load detection but has not yet been implemented.*

13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM) or priority populations (Military, etc.). ◉ B. The host country government conducts (answer both subsections below): IBBS for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM)/transgender ☑ People who inject drugs (PWID) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM)/transgender ☑ People who inject drugs (PWID) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.)	13.7 Score: 0.95	IBBS NACO Annual Report 2011 (for estimates on key population size) *Website: http://naco.gov.in/upload/REPORTS/NACO%20Annual%20Report%202010-11.pdf*	In addition to FSW, MSM, and PWID, the IBBS collects data on the transgender, trucker, and migrant populations.
13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	○ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys ○ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups ◉ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups	13.8 Score: 0.95	NACP-IV http://www.naco.gov.in/NACO/National_AIDS_Control_Program/10711/	Annual plan for HIV surveillance and surveys are formulated by NACO. Open source document is not available. Though a strategy exists, timelines are not outlined and it is frequently not referenced.
13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☑ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☑ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection ☐ An in-country internal review board (IRB) exists and reviews reviews all protocols.	13.9 Score: 0.71	http://naco.gov.in/NACO/Divisions/ME/ IBBS protocol	TAB; mangement at state levels; not IRB, but technical research committee (TRC), then ent to HMSC & ICMR
	Epidemiological and Health Data Score:	**7.02**		

14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.			**Data Source**	**Notes/Comments**
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	◉ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○ B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ○ C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ○ D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some ○ E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 0.00	NACO Annual Report 2014-2015	Expenditures are tracked via the NACO Annual Report, but NHA and NASA have not been recently performed, nor according to our knowledge, is there a government-produced report published that reports expenditures by geography, program area, cost type, etc. in a manner standardized as in an NHA or NASA.
14.2 Who Finances Collection of Expenditure Data: To what extent does the host country government finance the collection of HIV/AIDS expenditure data (e.g., printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ◉ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	14.2 Score: 2.50	NACO	
14.3 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉ B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☑ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☑ Sub-nationally	14.3 Score: 1.67	NACO Annual Report 2014-2015	Breakdown not provided in 2014-2015; private?; expenditures by program area are tracked but are not public; and sub-nationally only to the state level

14.4 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○ A. No HIV/AIDS expenditure data are collected ○ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ○ C. HIV/AIDS expenditure data were collected at least once in the past 3 years ○ D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ◉ E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.4 Score: 1.67	NACO Annual Report 2014-2015	
14.5 Economic Studies: Does the host country government conduct health economic studies or analyses for HIV/AIDS?	○ A. The host country government does not conduct health economic studies or analyses for HIV/AIDS ◉ B. The host country government conducts (check all that apply): ☑ Costing ☐ Economic evaluation (e.g., cost-effectiveness analysis and cost-benefit analysis) ☐ Efficiency analysis (e.g., efficiency of service delivery by public and private sector, resource allocation) ☐ Market demand analysis	14.5 Score: 0.42	In country reports: GOALS modeling (UNAIDS); in budget outlay line items	
	Financial/Expenditure Data Score:	**6.25**		

15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.			**Data Source**	**Notes/Comments**
15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?	○ A. No system exists for routine collection of HIV/AIDS service delivery data ○ B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions ○ C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ◉ D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution ○ E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	15.1 Score: 1.00	NACO SIMS (http://www.naco.gov.in/NACO/Quick_Links/SIMS_Website/ NACO SIMS wall chart (http://www.naco.gov.in/upload/Divisions/MnE/SIMS%20Wall%20Chart.pdf) NACO Annual Report 2014-15	
15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No routine collection of HIV/AIDS service delivery data exists ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ◉ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	15.2 Score: 2.50		

15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☑ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☑ Orphans and Vulnerable Children ☐ Voluntary Medical Male Circumcision ☑ HIV Prevention ☑ AIDS-related mortality ☑ B. Service delivery data are being collected: ☑ By key population (FSW, PWID, MSM/transgender) ☑ By priority population (e.g., military, prisoners, young women & girls, etc.) ☑ By age & sex ☐ From all facility sites (public, private, faith-based, etc.) ☐ From all community sites (public, private, faith-based, etc.)	15.3 Score: 1.22	NACO Annual Report, 2014-2015; State Epi Fact Sheets; District Epidemiological Profiles 2014; NACO Strategic Information Management System (SIMS)	ARDs are not reported in the NACO Annual Report Data also collected on transgenders; priority populations include truckers and migrants
15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?	○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data ◉ B. The host country government collects & reports service delivery data annually ○ C. The host country government collects & reports service delivery data semi-annually ○ D. The host country government collects & reports service delivery data at least quarterly	15.4 Score: 0.44	http://naco.gov.in/NACO/Quick_Links/Directory_of_HIV_Data/ NACO Annual Report	

15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	○ A. The host country government does not routinely analyze service delivery data to measure program performance ◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☐ Continuum of care cascade for each identified priority population (e.g., military, prisoners, young women & girls, etc.), including HIV testing, linkage to care, treatment, adherence and retention ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM/transgender), including HIV testing, linkage to care, treatment, adherence and retention ☑ Results against targets ☑ Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☐ Site-specific yield for HIV testing (HTC and PMTCT) ☑ AIDS-related mortality rates ☑ Variations in performance by sub-national unit ☐ Creation of maps to facilitate geographic analysis	15.5 Score: 0.67	NACO Annual Report 2014-2015; National Data Analysis Plan; Joint Reviews on TIs, HTC, PPTCT, and ART; CST national review	Continuum of care cascade is only partially analyzed - for adherance and retention - not ICP wide; Coverage of treatment and prevention activities is not a true analysis, but it is an annual exercise for World AIDS Day. Coverage definition is unclear to the community.
15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☐ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☑ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☐ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☑ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	15.6 Score: 0.80	NACO Annual Report 2014-15 NACO Strategic Information Management Unit *http://www.naco.gov.in/NACO/Quick_Links/Publication/ME_and_Research_Surveillance/*	Only by service provider, not beneficiaries
		Performance Data Score: **6.63**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D