

Approved



India

Country Operational Plan

FY 2014

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



Operating Unit Overview

OU Executive Summary

I. THE CONTEXT OF THE HIV RESPONSE IN INDIA

Epidemiology of the HIV Epidemic in India

India has the world's third largest HIV epidemic in terms of number of people infected. In 2011, there were an estimated 2.1 million people living with HIV (PLHIV), and annually there are 116,000 new infections among adults, 14,500 new infections among children, and 148,000 AIDS-related deaths. Women account for 39% of reported cases.

India's epidemic is characterized by concentrated transmission, primarily through Key Populations (KPs), and heterogeneous geographic spread. The 2012-2013 HIV Sentinel Surveillance (HSS) recorded an overall prevalence of less than 1% among Antenatal Clinic (ANC) attendees, considered a proxy for the general population, with a national average of 0.35%. This relatively low prevalence masks the actual magnitude, given a population of over 1.2 billion, as well as substantial variance by district, state, and region, including higher prevalence in some rural communities.

Sexual transmission is estimated to account for nearly 90% of new infections (88.5% heterosexual, 1.5% homosexual). Transmission through injecting drugs drives the epidemic in northeastern states, but there are also large numbers of people who inject drugs (PWID) in four of India's largest cities, and significant pockets in smaller cities. India's epidemic is driven by infections among key populations (KPs), which in India include men who have sex with men (MSM), female sex workers (FSW), transgendered individuals, and PWID. Single male migrants and truckers have been identified as behaviorally vulnerable to HIV, and also serve as bridge populations facilitating HIV transmission between KPs and lower-risk populations. HIV prevalence is 2.7% among FSWs, 4.4% among MSM, 7.1% among PWID, and 8.8% among transgendered individuals. Size estimates of KPs in India indicate that there are about 868,000 FSW, 412,000 high-risk MSM, and 177,000 PWID.

Of the 116,000 estimated new infections among adults in 2011, 31% were from the six high-prevalence states (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland, Tamil Nadu), with Nagaland and Mizoram showing comparatively higher overall prevalence since 2010. Over 100 ANC sites in these states have recorded an HIV prevalence of one percent or higher in at least three of the last six sentinel surveillance rounds. The geographic focus of new infections continues to shift, however, with some



low-prevalence states showing troubling increases in new infections during recent years. Eleven traditionally low and moderate prevalence states have demonstrated increasing trends, with Bihar recording a higher prevalence every year since 2010. The limited public health programming capacity of some states has negatively impacted the quality of surveillance, services, and programming, and may have contributed to these increases in those areas.

Status of the National Response: India's National AIDS Control Program (NACP)

The Government of India (GOI) has achieved substantial progress in containing the spread of HIV, with an overall reduction of 57% in estimated annual new HIV infections among the adult population, from 274,000 in 2000 to 116,000 in 2011 (with a 76% decline in high-prevalence states). The NACP, currently in its fourth phase (NACP IV, 2012-2017), is implemented through the leadership of the Department of AIDS Control (DAC), which supports prevention activities at the lowest administrative level and provides targeted interventions (TIs) to KPs in one-third of India's 640 districts that have been epidemiologically identified as geographic areas in the country with high HIV prevalence. HIV care and treatment is also being scaled up across the board to accelerate reversal of the epidemic by ensuring that all people living with HIV (PLHIV) eligible for antiretroviral therapy (ART) are initiated on treatment. DAC is also committed to mediating the epidemic's impact on migrant communities, based on study data indicating increasing prevalence at antenatal clinics in source communities for spouses of male migrants.

Targeted prevention interventions, including HIV testing and counseling (HTC), have reached 81% of FSWs, 64% of MSM and transgendered individuals, and 80% of PWID, as of December 2011. Of the 1.1 million adults and children estimated to be in need of ART in 2011, approximately 52% of adults and 34% of children were on treatment. These numbers are expected to grow given revisions in the national guidelines on ART eligibility from a CD4 count of 350 to 500. In 2011, the ratio of new infections to new patients on ART was around 0.6, with an estimated 130,500 new HIV adult and pediatric infections, and over 200,000 adults and children initiated on ART. Prevention of parent-to-child transmission of HIV (PPTCT) coverage is still low; it was estimated at 32% in 2011, up from 18% in 2007. In 2012, India began phasing in the World Health Organization (WHO) guidelines for the prevention of mother to child transmission (PMTCT) multi-drug regimen, "Option B", with its introduction in two high-prevalence states (Andhra Pradesh and Karnataka). As of February 2014, Option B+ is official national policy and will be scaled up across the country in a phased manner.

Notably, under NACP IV, domestic resources will fund an estimated 80% of the U.S. \$2.5 billion HIV response in India, a major increase from the previous five years, where international donors -- including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Bill and Melinda Gates Foundation (BMGF), the World Bank, United Kingdom's Department for International Development (DfID)



and PEPFAR, supported approximately 75% of overall costs. The World Bank recently provided a credit of \$250 million to support prevention programs under NACP IV, and the GFATM continues to provide significant funding for PPTCT, HIV care and support, and ART drug procurement (over \$700 million dispersed since 2004).

Final approval of NACP IV was delayed in part because of lengthy GOI discussions on priorities and budgeting for India's 12th Five-Year Plan. NACP IV was formally launched on Wednesday, February 12, 2014, with a continued focus on prevention, including accelerated coverage and improved quality of services for Key Populations, and investments in innovation and technology to increase impact. NACP IV will also work toward phased integration of most HIV services into the National Rural Health Mission (soon to be renamed the National Health Mission), with DAC continuing to manage Targeted Interventions (TIs) for key populations. Leadership transitions within DAC remain a possibility, particularly as India gears up for its general election in May 2014.

USG Role in the National Response, and Coordination with Stakeholders

DAC works in close partnership with international donors and effectively coordinates their technical and financial inputs. Both CDC and USAID have bilateral agreements with the GOI that identify specific areas of focus based on prioritized needs of the national program. CDC's agreement (signed May 2010) is to expand and deepen technical assistance (TA) to GOI laboratory systems, strategic information (SI), and human capacity development. Since the formalization of this agreement in 2010, CDC TA to the GOI has been requested for PMTCT (particularly the rollout of Option B+), blood safety, HIV/tuberculosis (TB), and targeted approaches to strengthen PWID programming in the areas of mapping, prevention, HTC, care-support-treatment, quality of services in opioid substitution therapy centers, and adherence. USAID's agreement (signed September 2010) is to provide TA to improve quality and coverage of services to key and vulnerable populations, enhance private sector engagement to complement GOI's prevention-to-care continuum efforts, strengthen supply chain management (SCM) systems, national capacity on behavior change communication programming, strategic information, quality of and access to services, support for global transfer of best practices, and support for high-impact innovations.

All PEPFAR/India investments are identified and developed through an ongoing consultative process with the GOI, in close coordination with other development partners, particularly the GFATM, to ensure that donor resources are leveraged to optimize efforts in a range of program areas. The USG is a member of the Development Partner Joint Review Team that examines the progress of NACP every six months, and which supported the design of NACP IV. USG is one of three representatives of the bilateral constituency on the GFATM Country Coordinating Mechanism (CCM), overseeing India's large GFATM programs, and serves on its Oversight Committee. India is among the countries to be included in the New Funding



Model, with GFATM Geneva encouraging the country to present an HIV-TB concept note. Most large donors, however, including BMGF and DfID, have phased out much of their targeted HIV support in India, or are in the process of doing so within the next few years.

II. PEPFAR Focus in FY 2014

USG Role in the National Response, and Coordination with Stakeholders

Given India's vast size, huge population, and substantial domestic resources, PEPFAR/India maintains a highly focused portfolio that engages in technical collaboration with the GOI and its partners, to facilitate implementation of the NACP. PEPFAR/India makes strategic choices about USG investments based on broad and sustained dialogue with a range of partners, including government, civil society, the private sector, foundations and multilateral institutions. These discussions are framed by PEPFAR/India's Five-Year Strategy for 2011-2015, and informed by continuing negotiations to ensure that investments leverage additional resources, capitalize on evolving opportunities, and optimize program sustainability. All PEPFAR/India investments are designed to provide targeted TA that maximizes impact on the HIV epidemic in India, by strengthening capacity in critical program areas within GOI, the private sector, and with civil society partners. This partnership approach to programming continues to result in strategic, scientifically-sound investments that maximize program results.

India continues to be in a dynamic stage of its HIV response. The country's nationally mandated, phased transition to service integration with the NRHM is an excellent opportunity for the USG to achieve our own transition goals, including linkages with other ministries, such as Women and Child Development (MWCD). USG priorities for FY 2014 include: (1) Continue to enhance core systems through high-level TA to support the NACP IV roll out, capitalizing on USG strategic advantages in the key areas of laboratories, SCM, capacity strengthening, strategic information, behavior change communications (BCC), private sector engagement, and comprehensive HIV services for KPs and migrants; (2) Support GOI to identify, assess, prioritize, and implement "smart integration" with other GOI programs, appropriate to India's context; and (3) remain flexible to meet emerging needs identified by the national program, thus aiding its continued success at reversing the epidemic.

PEPFAR/India FY 2014 Funding Level Priorities

A focused investment approach in the FY 2014 Country Operational Plan (COP) has emerged as a result of discussions with the GOI during the past year, particularly given ongoing development of NACP IV. The COP includes proposed investments in eight new and 25 continuing mechanisms. All new Implementing Mechanisms address emerging NACP priorities, and take advantage of new opportunities to leverage



USG funds through partnerships with key GOI institutions, foundations and the private sector. CDC has proposed three new Implementing Mechanisms: the People Who Inject Drugs Collaborative Project; Care, Support and Treatment – HIV/TB Project; Laboratory Strengthening (a follow-on project); and are continuing two centrally managed cooperative agreements with the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF). USAID has also proposed three new Implementing Mechanisms: LINKAGES, a new KP field support activity; Urban HIV/TB Control; and Evaluation II, a follow-on to the current evaluation activity which is ending. The COP reinforces GOI capacity to both meet emerging needs and maintain a sustainable response to the epidemic. All proposed investments support high-quality TA and collaboration with GOI, the private sector, and civil society. The COP was developed through a coordinated interagency process to ensure that proposed investments are complementary and promote synergy, and that the overall portfolio is well-aligned with NACP goals.

PEPFAR/India’s planned funding level for FY 2014 was \$28 million. This allocation, though level for the last two fiscal years, reflects a 15% reduction since FY 2011, from \$33 million to \$28 million. After completing a program review, PEPFAR/India has determined that the full \$28 million is needed to fund required activities in FY 2014 given pipeline reductions that occurred this year. Although a large pipeline resulted in a correction of funds for USAID in FY 2013, pipeline has now dropped significantly from 3.5 to 2.5 years. The pipeline was due in part to delays resulting from the prolonged transition period between the third and fourth phases of NACP. Based on projected outlays and burn rates, PEPFAR/India expects to achieve an acceptable pipeline range of 12-18 months by the end of FY 2014. The PEPFAR/India interagency team has carefully projected mechanism-specific expenditures over the next 24 months, justifying this proposed budget level.

III. PROGRESS AND FUTURE PLANS

Monitoring Implementation of the Five-Year Strategy

In lieu of a Partnership Framework, PEPFAR/India developed a Five-Year Strategy (2011-2015). Annual COPs serve as the implementation plans, and monitoring is conducted through Annual and Semi-Annual Progress Reports, supplemented by a Monitoring and Evaluation (M&E) framework established in the strategy. PEPFAR/India has recently updated the M&E framework based on a detailed analysis of capacity strengthening activities, and its evolving technical partnership with GOI.

Update on Country Ownership

The sheer size of the country and its population of over 1.2 billion, as well as the decentralized structure of India’s health system, preclude full “ownership” by DAC at all levels. With support from its strong



national leadership and coordinated management of prioritized state and district programs, India has done remarkably well in decentralizing its program and policies throughout the country. In particular, DAC continues to effectively manage contributions of development partners to ensure optimal support for priority programs.

Through a consultative process with prominent USG engagement, DAC has developed a prioritized HIV/AIDS research agenda to support implementation of NACP IV, reflecting a continued commitment to use data to make programmatic adjustments and improve results. Most important is the increase of domestic funding for NACP IV, continued expansion of services and offsetting of decreases in DP funding. PEPFAR/India recommends continued USG funding through the five years of NACP IV at the FY 2014 level, and will conduct transition planning and expenditure analysis exercises in the coming months in preparation for its Sustainability Plan due November 15, 2014. PEPFAR/India's funding trajectory is based on assessed needs in the context of expected GOI, GFATM and World Bank investments in India's HIV response.

PEPFAR/India Trajectory for FY 2015 and Beyond

PEPFAR/India anticipates continuing an important supportive role to the national program throughout NACP IV. To optimize sustainability prospects for the national response, the USG's role will focus on continued targeted policy and strategic inputs, including support to: (1) systems strengthening in SI, laboratory quality, SCM, human resources for health, and "smart integration" of HIV services; (2) development and assessment of model programs that improve service demand, uptake and quality, particularly for KPs and Orphans and Vulnerable Children (OVC); (3) increasing capacity of national and state-level institutions to roll out NACP IV prevention priorities and facilitate transfer of Indian best practices and innovations globally; and (4) increasing GOI engagement with the private sector. The USG will also support transition of activities covered under current GFATM grants to the GOI, private sector and other funding sources, and will strengthen capacity of Indian institutions providing TA to the national program.

IV. PROGRAM OVERVIEW

All PEPFAR/India investments are designed to promote technical collaboration that further increases the capacity of the GOI, and of private sector and civil society partners, to plan, implement, monitor, and evaluate the national program. The USG supports direct services only in the context of demonstration projects, designed to test interventions and service delivery models for adoption and scale up by GOI. Technical collaboration at the national level also continues to support development of evidence-based policies and guidelines.



As described in the March 3, 2014 letter from Ambassador Powell to Acting Global AIDS Coordinator Deborah von Zinkernagel, PEPFAR/India's proposed program reflects a strong commitment to the priorities laid out in the PEPFAR Blueprint: Creating an AIDS-Free Generation. PEPFAR/India's country strategy framework focuses on four major areas, in alignment with PEPFAR guidance for collaborative investments in the context of a concentrated epidemic: (A) improved access to the continuum of quality care among KPs, OVC and PLHIV; (B) stronger health systems; (C) strengthened capacity; and (D) country ownership and sustainability.

A. Improved Access to the Continuum of Quality Care among KPs, OVC, and PLHIV

The USG targets KPs, PLHIV, and other vulnerable populations through investments that strengthen national and state programs to: (1) effectively use data and evidence to plan and assess well-targeted, high-impact interventions; (2) identify, pilot, and assess service delivery innovations that contribute to the effectiveness and efficiency of prevention programs, and their linkages to a quality continuum of care; and (3) strengthen systems at national and state levels to improve the quality of planning, implementation, monitoring and evaluation of prevention-to-care continuum programs.

USG contributions to quality care begin at the policy level, through investments in evidence generation and technical collaboration, and continue with support for expert training and capacity strengthening for a range of clinical and public health service providers. Service access is improved through targeted efforts to create partnership models with the private sector, and programmatic interventions that strengthen clinical services for PLHIV (particularly through TA to HIV Centers of Excellence), and increasing HIV service delivery competencies to provide care and support to Children Affected by AIDS (CABA), women, and sexual minorities. While GOI should be commended for its continued focus on KPs, civil society organizations committed to this work recently experienced a major setback when the Supreme Court of India failed to overturn Section 377 of the penal code, therefore continuing criminalization of same-gender sex acts.

Prevention among KPs

GOI's Targeted Interventions (TIs) for KPs include: 1) HIV testing and counseling, 2) condom provision, 3) other evidence-based targeted behavioral prevention activities, 4) screening for reproductive tract infections (RTIs), sexually transmitted infections (STIs), and opportunistic infections (OIs) including TB; and 5) and effective linkages and referrals to additional care and treatment services. The USG will continue to provide TA supporting GOI's comprehensive KP strategy, and to states with emerging epidemics. The USG will also continue to invest in developing prevention-to-care continuum network



models, as well as in capacity strengthening of national and state systems that oversee implementation of TIs. A USG commitment to support expanded access to services for KPs is reflected in projects across the entire PEPFAR India platform, including engagement with the private sector, targeted TA to increase prevention to care continuum services for PWID, innovative uses of technology to serve hard-to-reach and migrant populations, as well as by demand-generation activities through communications strategies. Migrants are a priority group for DAC; however, insufficient epidemiologic evidence about this diverse population limits strategic targeting to address the HIV prevention needs of this group. USG investments will support DAC to generate evidence on HIV risk and prevention opportunities in migrant communities, including their spouses and partners, as well as KPs within the migrant community, both at source and destination, and will inform the government's future strategy and investments among these bridge populations.

Continuum of Quality Services for KPs, PLHIV, and OVC

USG staff and partners provide technical expertise that informs national policies and guidelines, through participation in DAC Technical Resource Groups, including Prevention of Parent-to-Child Transmission of HIV (PPTCT), Care and Support, Treatment, KPs, SI, Laboratory, Prevention, and Mainstreaming. USG input supports policy development consistent with international standards that increase the quality of HIV services in India. USG also supports policy implementation through several Implementing Mechanisms, including: (1) continued investments in the expanding network of HIV COEs and State Nursing Councils, which strengthen the HIV skills of trained health care professionals through a range of model in-service training programs; (2) targeted TA to DAC and the Revised National Tuberculosis Control Program (RNTCP) to further consolidate HIV-TB collaborative activities and scale up successful models for integrated services; (3) support for quality services for OVC in higher-prevalence districts; and (4) prevention strategies for KPs including discordant couples, FSWs, MSM, and PWID. The USG will also support NACP IV efforts to test innovations in technology, products, and business models, as well as innovative approaches to smart service integration, quality assurance (QA), coverage saturation, and partnerships. Innovations are supported in most Implementing Mechanisms, and are a particular focus of the HIV/AIDS Partnership: Impact through Prevention, Private Sector and Evidence-based Programming (PIPPSE) Project, and the RMNCH and TB Alliances. With respect to PPTCT, USG will continue to prioritize demand creation and community mobilization, strengthen PPTCT data systems, and provide TA for the roll out of new PPTCT guidelines with a focus on retention in care, ART drug adherence and Early Infant Diagnosis (EID).

TB/HIV: Four implementing mechanisms are currently dedicated to TB/HIV activities. At the request of DAC, PEPFAR/India has prioritized amplification and uptake of HIV/TB targeted interventions, ranging from technical support for Isoniazid Preventive Therapy (IPT) for all HIV positive people, to improving



cross referrals between HIV and TB service facilities, to the scale up of airborne infection control programs at ART centers.

Gender: Given their role in both high-risk behaviors and service quality/access, gender considerations -- women's and girls' equality, male norms, behavior, and involvement, as well as violence and coercion -- are programmatically incorporated as part of strengthening competencies in service delivery through both facilities and TIs. Additional USG investments include support for training modules and models to reduce service barriers to women and KPs, and strategic partnerships (including with law enforcement) to reduce risks for gender-based violence (GBV).

Leveraging the Private Sector: Since approximately 80% of the population access outpatient services through the private sector, the USG continues to build on its significant role in (1) engaging the private sector in health programs in India, and (2) strengthening national and state government capacity to engage the private sector in HIV programs. USG support is facilitating establishment of a National Public Private Partnership (PPP) Core Unit that will manage partnerships (coordinating with World Bank efforts in this endeavor), and provide TA to DAC and the State AIDS Control Societies (SACS) to marshal private sector partnerships effectively for scaling up a range of HIV services. PEPFAR funding will build the capacity of GOI to provide strategic oversight of the private sector in HIV programs; review policies, identify and address capacity and structural gaps, facilitate innovative partnerships, and leverage resources from the Indian diaspora. National and state level efforts will generate evidence regarding the private sector's influence on health outcomes, and support its increased engagement in HIV programs. To further its engagement with the private sector, PEPFAR/India recently submitted two Round Three PPP Incentive Fund demonstration to scale applications, proposing to 1) develop market-based health insurance products for PLHIV and 2) enhance India's laboratory capacity in partnership with Becton, Dickinson and Company through the Labs for Life partnership. The former has been given a green light and the latter is under review for central funds as part of a larger global partnerships managed by OGAC's Private Sector Engagement team.

B. Stronger Health Systems

The USG continues to invest in critical cross-cutting systems strengthening interventions that enhance national program outcomes. Health systems priorities include investments in SI, laboratory strengthening, human resource planning, and logistics and SCM.

Strategic Information (SI)

The USG is GOI's lead technical partner on SI, and works closely with DAC's SI Management Unit,



whose portfolio includes M&E, surveillance, and operations research (OR). USG SI priorities focus on DAC's SI Management System (SIMS), on availability of quality data and evidence, and its use to inform program planning and research. USG investments will support NACO's prioritized research agenda for NACP IV, including TA and research collaboration for a range of prioritized and secondary data analyses, operational research, and surveys. An additional priority is the National Family Health Survey IV (NFHS IV), which will provide the second data point for national HIV prevalence.

SIMS: The USG continues to invest in development and roll-out of SIMS, as the primary reservoir for India's HIV programmatic and service data. This support includes planning and quality monitoring of SIMS training and deployment across the country, strengthening capacity for routine reporting, analysis and use of data from SIMS for over 12,000 health facilities, and integrating existing public health data information systems into SIMS core architecture. USG will also continue to provide crucial provisional SI staff support at national and state levels, including epidemiologists and M&E officers, to ensure the availability of optimal human resources to manage the volume and complexity of data that the system generates.

Data Quality and Use: USG investments facilitate evidence-based planning through support for development of data quality tools and policies, M&E toolkits, and processes and system tools to improve the quality of program data. USG investments will continue to strengthen the SI capacity of national and state-level Technical Support Units (TSUs), and will help develop a strong cadre of M&E officers across program components, by supporting in-service training at state and district levels, and promoting post-training mentoring in qualitative evaluations, data triangulation and economic evaluations.

The USG will continue to work with partners on HIV prevalence size estimation strategies, projections and trend analyses; HIV case reporting; ART and PPTCT monitoring; cohort and early warning indicator analyses; drug resistance monitoring; OR on care, support, and treatment decentralization and integration within general health system; ART service delivery data validation; district epidemiological profiling and, impact assessment of key population intervention programs. The USG will also assist in incidence analyses, and support Integrated Biological and Behavioral Surveillance (IBBS), formative studies, and social science research on KPs, including factors affecting the utilization of testing and counseling and care and treatment services. The NFHS IV will provide a wealth of national and state-level information on HIV prevalence and related behaviors.

Laboratory Strengthening

The USG will continue its strong partnership with DAC's Laboratory Services Division and its network of 13 national and 117 state reference labs (NRLs/SRLs) through ongoing work on laboratory accreditation and QA for HIV, STI, and Hepatitis A and B diagnostics. USG investments will include training and



mentoring of senior-level laboratory personnel on laboratory management systems, innovative techniques, and technical and quality issues related to testing and diagnosis. FY 2014 investments in biomedical blood safety prevention activities include capacity and QA in laboratories under the DAC-managed National Blood Transfusion Council, development of guidelines for transfers within blood transfusion networks, district-level needs assessments of annual blood requirements, standardization of blood testing protocols (particularly kits and reagents), strengthening national compliance standards, improving horizontal and vertical linkages of blood banks and storage centers at state and district levels, STI lab assessments and operational guideline revisions, and promotion of E-blood banking opportunities. Other priority activities include strengthening biomedical waste management and infection control measures at HIV service delivery facilities, and expansion of EID, viral load testing and lab networks.

Supply Chain Management (SCM)

Targeted TA will be provided to GOI's SCM systems for HIV, OI, and STI drugs and commodities, including condoms. This activity builds on prior support and will focus on collaborating with other DPs, particularly the Clinton Health Access Initiative (CHAI), supporting roll out of an Inventory Management System, recruitment and training of regional coordinators, and forecasting, logistics and distribution management. Efforts will support the main Ministry of Health and Family Welfare (MOHFW) logistics system, which handles STI and OI drugs and condoms, as well as all essential drugs and other health commodities, and the smaller DAC system supporting ARVs and test kits. Efforts will focus in nine states as well as nationally.

Human Resource Planning

USG investments in a Human Resource Health Management Information System (HRHMIS) address gaps in human resource planning for HIV in key states. Through TA to Nursing Councils and in partnership with the National Informatics Center, this successful system is currently under consideration for national scale up through the MOHFW.

C. Capacity Strengthening

As in all intervention areas, PEPFAR/India works through high-level policy and technical advice to strengthen GOI's capacity to plan, implement, and evaluate its HIV prevention, care, and treatment programs at national, state, and district levels. In addition to the investments described above, USG prioritizes investments in public health management and institutional strengthening, to increase the capacity of the public, private, and civil society sectors to manage the program efficiently.



Capacity Strengthening for Public Health Management

USG investments focus on strengthening competencies and skills in program management and implementation, including improved integration and linkages at national, state, district, and community levels, in both the public and private sector. The USG prioritizes management training at state and district levels, to help strengthen evidence-based planning, implementation, and M&E, effective resource management, smart integration of HIV with other services, and program efficiency.

Institutional Capacity Strengthening

The USG is continuing its programmatic transition with additional investments in strengthening local institutions to take on TA provider roles. The USG supports key government, civil society, and private sector technical institutions, including TSUs, reference labs, COEs, and several local prime partners, to provide leadership in India's HIV response. The USG will support a national prevention team to enhance DAC's capacity to achieve NACP IV prevention goals, and support TSUs in eight focus states demonstrating functional integration models with SACS and District AIDS Prevention and Control Units (DAPCUs). This integration will include tracking of benchmarks for the SACS' successful absorption of TSU operations, thus assisting DAC in expanding TSUs nationwide. PEPFAR will also continue its support to DAC's National HIV/AIDS Communications Resource Support Center (NHCRSC), finalizing the transition of the Center to DAC in FY 2014.

D. Country Ownership and Sustainability

The GOI already leads and substantially funds its national program. USG support for sustainability of India's program prioritizes continued collaboration with DAC and SACS, to ensure that policies and guidelines meet global standards; to test, implement, and share innovative approaches; and to establish quality improvement systems.

Policies and Guidelines: Through direct participation by USG staff and support for senior technical consultants, the USG continues to assist GOI to strengthen HIV policies that create an enabling environment for effective implementation of NACP IV. USG contributions include identification of HIV policy issues, evidence generation, and support for policy development, national level policy reviews and revisions, implementation and evaluation. As NACP IV rolls out, and especially as increased HIV mainstreaming and service integration with NRHM and MWCD occur, the USG anticipates that DAC and its partners will identify new gaps in the policy framework that will need to be addressed, including, for example, additional guidelines related to human resources for health, the role of the media in decreasing stigma and discrimination towards PLHIV, and service quality improvement. Through existing staff and TA



mechanisms, the USG will support the development and implementation of policies and operational guidelines to improve services including social protection, supportive supervision, monitoring, laboratory systems, SI, and SCM.

Technical Exchanges/Global Transfer: The USG continues to support efforts by the GOI and civil society to share best practices within and outside India. In collaboration with other DPs, the USG promotes South-to-South technical exchanges between India and African and Asian countries, facilitating bidirectional transfers and adoption of best practices, particularly for KPs, and strengthening India's capacity to provide HIV TA globally. Additional USG investments will support exchanges within India to share practices between states.

Global Fund: The USG is critically engaged in supporting GFATM processes in India, as these play a crucial role in key areas of the national program. Through participation and support to the India CCM and its Oversight Committee, TA provided to Principal Recipients, and strong linkages with the Secretariat in Geneva, the USG will continue to strengthen the CCM to provide effective leadership and oversight of the substantial GFATM investments in India, ensuring high-impact programs.

V. GHI, Program Integration, Central Initiatives, and other Considerations

India does not have a stand-alone GHI strategy. COP investments are guided by PEPFAR/India's Five-Year Strategy, which prioritizes GHI principles to increase impact through strategic coordination and integration, strengthen and leverage key multilateral and global health organization partnerships, as well as private sector engagement, encourage country ownership and invest in country-led plans, build sustainability through health systems strengthening, and improve metrics and M&E. The remaining two GHI principles, implementing a woman and girl-centered approach, and promoting research and innovation, are also incorporated across programs. Innovation has also been a cornerstone of USG investments in India, including through the private sector. Additionally, USG strongly supports DAC's recently-launched HIV research agenda.

PEPFAR/India is highly integrated, embodying a one USG approach in planning and implementation of programs. Some parts of the PEPFAR/India portfolio have been structured to support an integrated programming approach, which leverages strong existing platforms for TB and other disease programs. Several new and continuing investments promote smart integration of activities that were previously vertical in these areas, including investments in BCC, access to quality health services, TB, innovations in reproductive/maternal/newborn/child health, health systems strengthening (particularly SCM), and private sector engagement. Some USG investments in HIV have already reaped benefits across other GHI priority areas; one example is DAC's TSU model, first supported by the USG, which is being replicated to



provide improved support to the national immunization program. PEPFAR/India's program has also been bolstered by funding from central Initiatives to support new and innovative work in gender, to strengthen GFATM mechanisms in country, and to fund a local capacity initiative.

Staffing: Six PEPFAR/India positions are in various stages of being filled, including the PEPFAR Coordinator role which has been vacant since May 2013. A Global Fund Liaison, funding for which was secured in a prior COP, has been advertised. Given PEPFAR/India's increased lab strengthening role, a Public Health Lab specialist position was created, cleared, and filled in anticipation of reprogramming. A new SI position will work with DAC, implementing partners, and nongovernmental organizations as an expert in information technology, quality management systems, and data use. Additionally, an HIV Specialist providing critical expertise on KPs will be contracted to fill a recently-vacated position. Lastly, recruitment for an Epidemiologist has also commenced.

NACP IV: A Unique Opportunity for Investments by PEPFAR/INDIA

As India rolls out its fourth NACP (2012-2017), the USG, now as the largest bilateral technical and funding partner, has a unique opportunity to support the continued strong technical collaboration that has contributed to dramatic successes in India's HIV response. PEPFAR/India looks forward to continuing to strengthen its relationship with GOI and other partners, providing a model cost-effective technical cooperation program, building efficiencies into all its investments. The large number of high-profile USG visitors to India in the last few years, including President Obama (November 2010), USAID Administrator Shah (November 2010, December 2011, and February 2013), CDC Director Frieden (January 2012), Health and Human Services (HHS) Secretary Sebelius (June 2012), and Ambassador Goosby (May 2013), have served to reaffirm PEPFAR's commitment to expand and deepen USG technical collaboration with Indian stakeholders, in support of India's accelerated reversal of the HIV epidemic.