Independent observer
of the Global Fund

The Global Fund's TRP praises India for ambitious plan to fast track the end of the HIV epidemic

When it reviewed India’s HIV funding request in 2017, the Technical Review Panel (TRP) commended the Government of India for its ambitious plan to fast track the end of the HIV epidemic. At the same time, however, the TRP raised concerns about what it viewed as the request’s failure to include a focus on human rights and gender.

This article provides a summary of the comments from the TRP and the Grant Approvals Committee (GAC) on the funding request. See separate article in this issue on the approval of India’s TB and TB/HIV grants. In addition, we plan to publish in the near future an article on the sustainability of India’s Global Fund grant portfolio.

Five HIV grants to India were recently approved by the Board.

The funding request was of the “tailored — national strategic plan” variety. (The existing HIV grants are part of a national strategy–based pilot.)

In 2015, according to India’s National Strategic Plan (NSP), HIV prevalence in the adult population was 0.26%; there were about 86,000 new HIV infections (including 10,400 among children); and there were an estimated 2.1 million people living with HIV (PLHIV). India has a concentrated HIV epidemic, with the national HIV prevalence being the highest among people who inject drugs (PWID) (9.9%), followed by men who have sex with men (MSM) (4.3%) and female sex workers (2.2%). Data for transgender persons was not yet available.

Overall, the TRP said that the national HIV strategy on which the funding request was based was “robust

and ambitious." The request included a comprehensive situational analysis with the most recent available data, which the TRP said clearly described the challenges and gaps for HIV programming in India. The TRP said that India's ambitious plan to fast track the end of the HIV epidemic included the following objectives:

- reducing new infections by 80%;
- linking 95% of estimated PLHIV to services;
- initiating treatment for 95% of PLHIV, and retaining them on treatment;
- eliminating mother-to-child transmission of HIV and syphilis; and
- eliminating HIV-related discrimination.

In its review of the funding request, the TRP highlighted the approvals of the Transgender Bill, the HIV and AIDS Prevention and Control Act, and revisions to the Narcotic Drugs and Psychotropic Substance Act. This is important for HIV programming, the TRP said, because it creates an enabling policy and regulatory environment for service delivery to transgender, PWID and other key populations living with HIV.

The total value of the HIV grants approved for India was $155.1 million. The HIV program will be implemented by the same four principal recipients (PRs) that are managing the current HIV grants — the National AIDS Control Organization (NACO), Plan International (India Chapter), Solidarity and Action Against the HIV infection in India, and the India HIV/AIDS Alliance — plus a new PR, the Christian Medical Association of India.

(Technically, the PR for the NACO grant is the Department of Economic Affairs in the Ministry of Finance. But the de facto PR is NACO.)

All five grants proposed a start date of 1 January 2018 and an end date of 31 March 2020. Adding an "extra" three months to the grants (39 vs. 36 months) will allow India to align its grant implementation periods to the country's fiscal cycle.

India submitted a prioritized above-allocation request (PAAR) of $96.8 million, of which $85.7 million was deemed "quality demand" by the TRP. During grant-making, $13.4 million in efficiencies was identified, all of which was used to fund interventions in the PAAR. Interventions totaling $72.3 million were added to the Unfunded Quality Demand (UQD) Register.

The TRP removed two activities from the within-allocation portion of the funding request. The TRP said that funding for 90 District AIDS Prevention and Control Units was inconsistent with India's goal to move towards sustainability. And it said that a proposed continuum-of-care demonstration project constituted poor value for money in that it would make a limited contribution to better understanding and responding to the HIV epidemic in India. To replace these activities in the within-allocation request, the TRP recommended that the following interventions be moved from the PAAR:

- key population–specific care and support interventions;
- development of a procurement strategy; and
- differentiated HIV testing services.

Strengths of the funding request

The TRP welcomed India's ambition to transition from Global Fund support to fully finance its national HIV

response with domestic resources by 2024. In addition, the TRP said that the HIV funding request made good use of India's Integrated Biological and Behavioral Survey (IBBS) on HIV prevalence for female sex workers, MSM and PWID to inform the geographical prioritization of interventions targeting these key populations.

The funding request clearly described the challenges and bottlenecks in the treatment cascade, the TRP said, which India will address using (a) complementary HIV testing approaches, such as community-based testing for key populations and the expansion of HIV self-testing; and (b) different HIV care models, such as multi-month drug dispensing, comprehensive care units and community-led drug distribution.

India's funding request included plans to integrate data systems and move to an electronic reporting system. Better data will mean that planning and monitoring is based on evidence rather than estimates, the TRP said.

The TRP commended India for its plans to integrate HIV testing and treatment services into the general health system by 2024, which will result in a more efficient use of resources such as healthcare workers, infrastructure, and supply-chain and information systems.

Issues and concerns

The TRP raised several issues, some of which were addressed during grant making, while others will be addressed during grant implementation. Some of these issues are described below:

Human rights– and gender-responsive programming: As mentioned above, the TRP expressed concern that the funding request was weak in integrating human rights– and gender-related issues into its HIV program interventions. The barriers to accessing HIV services due to punitive laws and sociocultural issues in India were not well described. Furthermore, the TRP said, gender issues with respect to women and girls were not mentioned at all in the funding request, which the TRP found surprising because women and girls in India face even greater issues (compared to boys and men) related to consent and agency, and — if they test HIV positive — stigma, discrimination, violence and exclusion. The lack of focused gender- and human rights–related interventions could impede access to, and uptake of, services for these populations, said the TRP.

The issue was cleared by the TRP during grant-making after NACO provided a brief document describing how it will include human rights and gender at all stages of HIV program planning and implementation. However, the TRP requested that NACO submit further information to the Secretariat by June 2018, including a matrix which lists the key intervention areas under the program and specifies for each of them what measures will be taken to ensure that they are gender-responsive and rights-based. The TRP said that the matrix should include specific actions that NACO will take to ensure that the scaling-up of community-based HIV testing adequately considers gender and human rights issues.

Capacity to outsource key enabling systems for the HIV response: The TRP noted that a social contracting process for health management information systems (HMIS) in the previous HIV grant could not be completed by NACO. In the funding request, the CCM proposed having NACO outsource key enabling systems for data management, procurement and supply chain management, as well as capacity development for healthcare workers and communities. However, the TRP said, the application didn't include a description of authorization processes, timelines, contract management or quality assurance. The TRP strongly recommended that NACO develop an organizational plan with timelines for outsourcing these key enabling systems, including alternative approaches to manage contracting delays as they can undermine the HIV program. The issue was reported to have been fully addressed during grant making; however, how it was resolved was not explained in the grant documents.

Rapid increase in treatment enrolment: India recently announced its National Test and Treat Policy, which allows PLHIV to receive treatment regardless of CD4 cell count. Of the estimated 2.1 million PLHIV in India, approximately 72% know their HIV status. Treatment enrolment stands at 1.1 million, which leaves about 462,000 people living with HIV who know their status but are not yet enrolled on treatment. The TRP said that the funding request did not include a plan to reach PLHIV who have been initiated on treatment but have defaulted; nor does it include activities targeting people who have tested HIV-positive but are not yet on treatment. The TRP requested that by 30 June 2018, NACO provide an implementation plan for treatment initiation and improved retention on treatment. It said that the implementation plan should include (a) methods to reach PLHIV who are not yet on treatment; (b) a detailed description of the approaches to increase treatment retention; and (c) details on the scaling-up of the adherence initiatives currently being implemented by the India HIV/AIDS Alliance.

Viral suppression and viral loads. The TRP raised a concern that the funding request did not include a strategy for the rapid scale-up of viral load testing, or an indication of how many people on treatment receive regular viral load tests. The CCM reported that, currently, about 10,000 viral load tests are conducted each year. The target set by the CCM in the funding request for the end of the next implementation period is to conduct 2.3 million viral load tests. The TRP was concerned that this number is not feasible. It requested that a viral load testing plan be developed within the first six months of grant implementation and that it include sections on (a) demand creation; (b) prioritized geographic locations for roll-out; (c) standard operating procedures; (d) materials that will be required; (e) reporting; and (f) sustainability.

HIV co-financing

In order for India to meet its co-financing requirements for the 2018–2020 implementation period of its HIV grants, the government needs to invest $31.0 million more than the $282.0 million it committed in 2015–2017. The government has gone well beyond that, committing to invest $1.33 billion in HIV programming during 2018–2020 (see the table for details).

Table: Domestic resources for the national HIV program 2018–2020

Program area	Investment ($ million)
Treatment, care and support	457.0 m
Targeted key population interventions	302.0 m
HIV testing and PMTCT	223.0 m
Blood safety	116.0 m
STI management	20.0 m
RSSH and program management	210.0 m
Total	1,328.0 m

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