PRIORITY AREAS FOR HIV PROGRAMME (April 2021- March 2024)

1. **Elimination of Mother to Child Transmission:**
   Govt. of India is committed to eliminate mother to child transmission of HIV. EMTCT continues to be a priority area which requires focus so as to scale up screening all the pregnancies for HIV at all levels of health care. In order to achieve targets of 95-95-95 of EMTCT, every HIV positive pregnant woman is to be identified and put on ART in partnership with private sectors and health systems. To reach out to positive pregnant women and estimated HIV positive infants, the universe of annual pregnancies has to be screened. The program will utilise innovative approaches to reach out to cover all pregnancies including those in the private sector. This support can remain with non NACO PR.

2. **Prevention of new infections among HRGs including those on virtual platforms:**
   i) The World Bank support for prevention programme under NACP comes to an end in June 2020. With the earlier mapping and population size estimations of 2009 likely to be rendered redundant, the interventions along the revamped TI strategy will require to be scaled up in both number of interventions and size/ coverage of existing interventions through NACO as PR.

   ii) The recently completed HIV Sentinel Surveillance among prison populations has revealed a provisional positivity of nearly 3% among prison inmates, likening this population to High Risk Group category for HIV. Interventions among prison and closed settings are ongoing with the help of Elton John Foundation, AIDS Fond, CDC through Project Sunrise, in Project mode and integrated package of services for prison inmates including OST, ART, Viral Hepatitis and HIV counselling/ testing/ STIs are required to be mainstreamed under the programme. This support can remain with non NACO PR.

   iii) Evidence is increasingly indicating that high risk behaviour is not confined only to the self identified population calling themselves HRG, but such risk behaviour is often negotiated by means of virtual platforms, who are out of the present reach of the TI programme under NACP IV. OR and pilot interventions through project support reveals that a separate modality for service delivery to such populations through dating sites, social media and internet is the need to reach the most difficult to reach, and often unorganized sector of people at risk and vulnerable to HIV infection. Reaching out to these populations is required to bridge the first 90 gap as well as curb the new infections. This support is required with the support of non NACO PR.

   iv) Under NACP, communities have been engaged for HIV prevention and linkage to services, and this mechanism is lauded as being an exemplary model of social contracting. With increasing needs of HRGs, like Drug users having mental health and de-addiction needs, transgenders and MSMs requiring linkage to general health systems for gender dysphoria, sex workers needing preventive measures for cervical cancer, as also for migrants and truckers, the programme needs comprehensive and integrated service delivery models through the existing social contracting modality.

3. **Community System Strengthening:** The community, civil society and key population have been the key reason whereby the programme has been able to reach out to the last mile and sustain efforts. In order to ensure the sustainability of the initiatives, it becomes imperative that the community is strengthened through planned and structured capacity building initiatives and is actively engaged across the continuum of HIV diagnosis, treatment and care.

4. 95-95-95 by 2024*:*

a) ***Testing***- Innovative approach to reach the unreached would be promoted. Efforts would be made to reduce the linkages loss from ICTC and tracing the lost to follow up cases would be focussed to achieve the target of people who know their HIV status. More intensive efforts are required to reach them. Strengthening of cold chain management systems is needed to provide the services close to home.

b) ***ARV drugs***- The program would continue with the procurement of second line and third line drugs, including TLD and DTG as per the recommendation of Technical resource group for adult treatment. Drugs would also be procured to cater to the needs of advance HIV disease.

c) ***CSC***-There is need of quality ART care and treatment services to all PLHIV. Provision should be made for differentiated care through innovative models like Care and Support centres and its transition.

d) ***Refurbishment of ART centres***– Need assessment exercise would be carried out based on which allocation of resources would be made for refurbishment of ART centers in order to provide differentiated care services.

e) ***Scale up of viral load testing***- Existing public sector labs would be strengthened along with use of outsourced component as per the needs of the program to scale of viral load testing from priority testing to general population.

5. **Private sector engagement***:* The private sector can be engaged to reach targets of **95-95-95**. Scope of PPP- ART centre can also be explored and there is a need to develop systems for private Sector Engagement across HIV care continuum and to scale up services and build sustainability.

6. **Development of robust IT systems**: IT systems can be used to develop a tracking mechanism of individuals/ unique identifiers from the level of prevention to care and support to prevent linkage loss. It will also help in effectively sustaining supply chain management systems. AI needs to be explored for the predictors of MIS and LFU patients. New innovations like machine learning, IOT etc would be explored across the continuum of HIV care. There is need for maintenance of the electronic integrated management system created and further enhancement of the same (SOCH project).

7. **Supply Chain Management**: Last mile solutions for supply chain of all commodities centrally procured by NACO is needed. Efforts to be made to ensure transition of existing initiatives. Convergence of Supply Chain Management System for HIV & syphilis kits and consumables below Stand Alone ICTC is needed
   Operational research of HIV/AIDS supply chain management for segmentation and integration of all commodities. Strengthening of warehouses by allocation of resources for procurement of equipment including cold chain equipments and refurbishing.

8. **Capacity Building**: Capacity Building of service providers and the community (among general is a focal area which may be expanded to other cadres of personnel both medical, non-medical, technicians, administrators etc.Inclusion of training modules such as program management, monitoring and evaluation, reporting. Integration of Learning Management system (LMS) to offer need-based training with innovative IT solutions and develop a mechanism to update

LMS.Inclusion of Distance Learning methodologies such as webinar, live classes and hosting theme based discussion forums (moderated by technical experts) in LMS to make it more dynamic.

9. **Communication**: Efforts may be made to develop a robust communication intervention to cater to the emergent need of different divisions with focus on pregnant mother, adolescents, and vulnerable youth through new age media to reach population on virtual platform. Focus on reducing new infections may be indicated asa priority achieved through digital interventions or new innovations focussing on the youth population. Interventions would include mass campaign to address different issues of HIV diagnosis treatment and care. Effective use of helplines and online counselling is required to enhance the reach of the correct information to all those who do not always visit facilities, so that they can assess and perceive their risk and access suitable preventive services.

10. **Research/ Evidence Generation:** Various research topics have been suggested by the committee such as:
    - Integrated models (single window models) of service delivery
    - Combination prevention as service delivery
    - Virtual models of service delivery
    - Strategies to reach out to at-risk groups
    - HIV and ageing
    - HIV and NCDs
    - Awareness of NACO guidelines in private practitioners
    - Impact of Gender Based violence on HIV services etc.

HIV programme is working towards the goal of 95-95-95 by 2024 based on the robust health system and infrastructure which exists in the public health system and supplementing it with efforts of the community to provide last mile linkage. NACO would focus on interventions on scale across the country and non government organisations would be encouraged to work on community led models like:

- Elimination of Mother to Child Transmission
- Care and Support Centres
- Community system strengthening
- Private sector engagement
- Development of robust IT systems
- Supply Chain Management
- Capacity building

This list is indicative and not exhaustive and the program would encourage innovative models of intervention.

Priority area of Tuberculosis Programme- (April 2021- March 2024)

1. Tuberculosis(TB) Prevention: India has the highest burden of Latent TB Infection (LTBI) globally and scaling up Latent TB Infection management would be key to hasten the decline in TB incidence from 2.5% at present to 10% required annually for achieving the SDG targets (2030) by the year 2025. In India, 40% of adult population is estimated to be infected with TB (Latent TB) with 10% life-time risk of developing TB. It further increases in presence of Malnutrition, HIV and other risk factors. Specific challenges include contact tracing of all beneficiaries, rolling out new LTBI diagnostics, adoption of shorter treatment regimens, counseling of patients, ensuring treatment initiation, adherence and completion. More research and in country evidence for LTBI is also needed.

2. Increasing access to high sensitivity Diagnostics: Microscopy is the primary tool used to diagnose TB with inherent limitations in sensitivity and specificity. Highly sensitive rapid molecular technologies are mostly centralized at district level, resulting in sub-optimal access to diagnostics in the periphery and TB cases being missed to be diagnosed.

3. Strengthening Surveillance Systems: India has diverse tuberculosis epidemiology as well as implementation coverage in terms of proportion of patients provided care under the programme. The country doesn't have a robust and comprehensive surveillance system to measure overall estimation of actual burden of tuberculosis in the country, sub-national and district levels on a frequent basis to assess the progress in efforts to eliminate tuberculosis. There is no established sentinel surveillance system under programme.

4. **Community Engagement, Advocacy and Communication**: TB patients are affected by social and political factors as well as economic barriers. Minimal community-led response exists in the programme to address the above issues, reduce stigma, promote person-centered approaches, reach the un-reached, support TB patients through their illness and therefore improve the quality of care by enhanced responsiveness to patients. Moreover, awareness about TB is low, incomplete or incorrect, especially about its symptoms among the general population. An issue-based, target group specific and integrated ACSM strategy to bring TB to the centre of public discourse, to generate demand for TB care services, facilitate early diagnosis, timely treatment initiation and treatment completion, is lacking.

5.Institutional Strengthening & Capacity Building: With expansion and further decentralization of TB program services for rapid decline of incident TB cases, NTEP requires robust capacity building of program officers and staff at each level for understanding changes, rapid adoption and implementation of new policy decision and its monitoring on ground coupled with patient centric care. It demands health system strengthening for capacity building through digital solutions like telemedicine, teleradiology, e- training platform etc. Specialized centers for linkages of complicated DRTB/TB patients for curative and palliative careare also needed.

6. Quality Assurance: TB diagnostic labs across country need robust quality assurance to strengthen the surveillance. There is a need for aligning TB laboratories with international standards for quality assurance and further reduction of discordances between the test results. Sensitive diagnostic tools will assist in high end monitoring when incident TB cases start declining in the country. Considering half of the estimated TB patients still approach private health facilities for diagnostic and therapeutic services, quality assurance mechanism

for private laboratories is also needed. Lab based surveillance with hotspot mapping and understanding transmission dynamics also remain a challenge.

7. **Digital Interventions:** Despite NTEP having a digital case-based web based surveillance system for identification and monitoring TB patient care cascade, the surveillance is fragmented between NIKSHAY, NIKSHAY Aushadi, Lab as well as logistic management information system. IDSP and other programs are also yet to be lined to digital surveillance system of NTEP requiring excel based transfer of information. There is no provision of LTBI management, Lab surveillance module, schedule H1 drug implementation module, adverse drug reaction module which need to be built for expansion of data collection, analytic based information for action at each level and for policy decision. At present TB patient transfer to other countries, information of test results to TB patients and provider, grievance addressals are being undertaken with time consuming difficult mechanism. Use of Artificial intelligence for prediction of epidemic in specific population and TB hotspot identification, identification of silent zones of TB epidemic, transfer of results of newer tests for epidemiological purpose like pyrosequencing and whole genome sequencing , TB patient prevalence survey are yet to become integral part of single digital platform. Supply chain management and case based surveillance are yet to integrate completely posting challenges in both components. Data from NTEP is not directly linked to monitoring units like NITI Ayog, IDSP, NUHM and other portals of national importance.

8. Supply Chain Management Strengthening: Currently NTEP is unable to reach out to all notified TB patients for provision of free diagnostic and free drugs especially in private sector. Supply chain monitoring poses serious challenges in terms of real time monitoring and review of release, transfer, delivery and receiving of drugs as well as lab consumables. Center, State, district and peripheral public and private health facilities are unable to forecast correct drug requirement based on consumption and the future requirement due to lack of system. There is weak mechanism for 'supply of drugs to private providers and notified private TB patients which can be monitored by private provider or private patients' due to which patient incurs significant out of pocket expenditure. Program faces issues like less utilization of free drugs and diagnostics, drug supplies delay, stock out, expiry and at times non-availability of essential commodities which affect treatment coverage, patient compliance and overall success rates. There is lack of robust supply chain mechanism with the aim of knowing overall consumption, system-enabled forecast of drugs and logistic, prevention of expiry and TB patient as well as provider friendly interface for day to day management of supply chain management till end user.

9. Drug Resistant TB: NTEP faces specific challenges in achieving universal drug susceptibility testing (UDST) for all notified TB patients (including private notified TB patients) and subsequent attrition of patients in DRTB patient cascade resulting in DRTB case detection gap with specific challenge for Drug Susceptibility Guided Treatment for all DRTB patients. There are challenges in monitoring the completion rates among DRTB patients, ensuring treatment adherence among patients, long term follow up monitoring, monitoring of adverse drug reaction by medical officer and procurement of second line drugs (including newer drugs), logistics management and other consumables. Some patient need repeated hospitalization and palliative care which is currently not available on ground.

10. Patient Support Systems-To achieve more than 90% success rates among all notified TB patients, strong patient support system is needed in the form of nutritional support,

counselling, peer support groups, digital adherence monitoring mechanism with instant retrieval mechanism, Direct Beneficiary Transfer (DBT) for various schemes and travel support. Patient linkage with various other national programs like PDS, ICDS centers and Nutritional Rehabilitation centers to address malnutrition associated TB. Psycho-social support for family, vocational rehabilitation and palliative care for the TB patients are other core areas to be addressed.

11. Workplace Intervention and Multi Sectoral Engagement:

India's national strategic plan is ambitious to link TB patient services into various PSU's service delivery system like CGHS, Railway, AYUSH workers, miners, migrants, tribal population, women and children etc. There is lack of knowledge about TB in the people working in these big sectors as health service delivery is isolated from the public health system and it needs linkage with NTEP for creation of awareness, establishment of diagnosis and treatment linkage and monitoring till the end of the treatment. It will enhance TB surveillance in workplaces and reduce diagnosis and treatment delays which have direct impact in disease transmission. Program needs strong workplace policy intervention cutting across all sectors and through multisectoral engagement coupled with community engagement, the program will be able to reach TB vulnerable populations by leverage existing government programs & schemes.

PRIORITY AREAS FOR MALARIA PROGRAMME (April 2021- March 2024)

1. **Strengthening of surveillance** - State, district, block and at community level and support for software and hardware for HMIS for Malaria.

2. **Technical Human Resource Support**- at National (Malaria Elimination Cell), State & District level.

3. **Capacity Building**-Training of HR (implementation of anti-malaria interventions) – various Categories.

4. **Community awareness, involvement & participation**

5. **LLINs Support**- replacement supplied in earlier GF supported projects.

6. **Strengthen Diagnosis & management** - ASHA incentives, good quality microscopes.

7. **Miscellaneous**-- Mobility Support (vehicles at state/ district level, support of POL and Motor bikes),VC facility at Dte., Performance awards, ASHA kit, etc.