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National AIDS Control Organisation
India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
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Ministry of Health & Family Welfare
Government of India

Azadi Ka Amrit Mahotsav

Strategy Document

# National AIDS and STD Control Programme Phase-V

# (2021-2026)

Anchoring the national response towards ending the AIDS epidemic

National AIDS Control Organization
Ministry of Health & Family Welfare
Government of India

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Strategy Document

# National AIDS and STD Control Programme Phase-V

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सत्यमेव जयते

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## FOREWORD

Since the detection of first case of HIV in April 1986 in India, the national AIDS response has come a long way. The initial national response started with sero-surveillance, awareness generation and screening of blood units for HIV infection. In the last thirty-five years, the National AIDS Control Programme (NACP) in India has evolved as one of the world's largest programmes across the prevention-detection-treatment continuum. Globally recognised as one of the success stories, the programme is keeping millions of 'at-risk' people as HIV negative, while simultaneously providing high quality life-long free Anti-retroviral treatment (ART) to around 1.5 million people living with HIV (PLHIV).

Each phase of NACP has contributed to a successful AIDS response. NACP Phase-I (1992-1999) focussed on awareness generation and blood safety component, while Phase-II (1999-2007) included various new interventions for testing and treatment services. The third phase (2007-2012) was a story of programme scale-up, and the fourth phase (2012-2017) was a period of consolidation and enhanced Government funding.

The period of NACP Phase-IV Extension (2017-2021), was the era of gamechanger initiatives that included enactment of HIV and AIDS (Prevention and Control) Act, launch of 'Test & Treat' policy, universal viral load testing and introduction of safer and more potent Dolutegravir-based ART regimens under the programme. This phase coincided with the COVID-19 pandemic in the country. As the SARS-CoV-2 virus showed doggedness through mutation and capability to strike when least expected, therefore continuous vigil was warranted for ensuring uninterrupted service delivery through the national AIDS control programme.

NACP Phase-V (2021-2026) is evidence-driven. As per evidence gathered through various programmatic indicators, HIV incidence in certain geographic areas is rising. Therefore, the Phase-V has an ambitious agenda to achieve 80% reduction in new infections and AIDS-related deaths. NACP in the next Phase also must concentrate more efforts for dual elimination of HIV and Syphilis, and to target the interruption of vertical transmission from mother to child. Newer risk behaviours, like soliciting partners on virtual platform, etc. have emerged for which programmatic focus is essential.

NACP Phase-V is fully funded by the Government of India with an outlay of Rs.15471.94 crore for the period 2021-26. 'Break the Silos and Bring Synergy' is the mantra of the Phase-V, wherein resource optimisation and rationalisation would be worked out. The Programme has taken a gigantic shift in the provision of integrated beneficiary-centric services, which would be customised and tailored to the target population and priority geographic location.

I am confident that the NACP Phase-V, driven by this high-impact Strategy Document, would be a landmark phase as we make concrete progress to achieve ending of the AIDS epidemic as a public health threat by 2030.

(ALOK SAXENA)

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# Abbreviations

| | |
|---|---|
| **AEP** | Adolescence education programme |
| **AFHC** | Adolescent friendly health clinics |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ANC** | Antenatal care |
| **ART** | Antiretroviral treatment |
| **ARV** | Antiretroviral |
| **BPG** | Benzathine penicillin G |
| **CBO** | Community-based organization |
| **CBS** | Community-based screening |
| **CD4** | Clusters of differentiation 4 |
| **CLHIV** | Children living with HIV |
| **CLM** | Community-led monitoring |
| **CoE** | Center of Excellence |
| **COVID-19** | Coronavirus disease 2019 |
| **CS** | Congenital syphilis |
| **CSS** | Community system strengthening |
| **CST** | Care support and treatment |
| **DAPCU** | District AIDS Prevention and Control Units |
| **DISHA** | District Integrated Strategy for HIV/AIDS |
| **DSDM** | Differentiated Service Delivery Model |
| **DSRC** | Designated STI/RTI Center |
| **EID** | Early infant diagnosis |
| **ELM** | Employer-led model |
| **EQAS** | External quality assurance system |
| **FI-ICTC** | Facility-integrated counselling and testing center |
| **FSW** | Female sex worker |
| **GHSS** | Global Health Sector Strategy |
| **HIV** | Human Immunodeficiency Virus |

| | |
|---|---|
| **HMIS** | Health management information system |
| **HRG** | High-risk group |
| **HCTS** | HIV counselling and testing services |
| **HSS** | HIV Sentinel Surveillance |
| **H/TG** | Hijra/transgender people |
| **ICTC** | Integrated Counselling and Testing Center |
| **IDU** | Injecting drug user |
| **IT** | Information technology |
| **LWS** | Link worker scheme |
| **MoHFW** | Ministry of Health and Family Welfare |
| **MoSJE** | Ministry of Social Justice and Empowerment |
| **MSM** | Men who have sex with men |
| **MTCT** | Mother-to-child transmission |
| **MTP** | Mid-term plan |
| **NAC** | National AIDS Committee |
| **NACB** | National AIDS Control Board |
| **NACO** | National AIDS Control Organisation |
| **NACP** | National AIDS and STD Control Programme |
| **NERO** | Northeast regional office |
| **NGO** | Non-government organization |
| **NHM** | National Health Mission |
| **NRL** | National Reference Laboratory |
| **NTEP** | National TB Elimination Programme |
| **NVHCP** | National Viral Hepatitis Control Programme |
| **NVHSP** | National Viral Hepatitis Surveillance Programme |
| **OST** | Opioid substitution therapy |
| **p-MPSE** | Programmatic mapping and population size estimation |

| | |
|---|---|
| **PEP** | Post-exposure prophylaxis |
| **PLHIV** | People Living with HIV |
| **PMR** | Programme management and review |
| **PMU** | Project management unit |
| **PPTCT** | Prevention of parent-to-child transmission |
| **PSU** | Project support unit |
| **RCH** | Reproductive and child health |
| **RDT** | Rapid diagnostic test |
| **RKSK** | Rashtriya Kishor Swasthya Karyakram |
| **RMNCH+A** | Reproductive, Maternal, Newborn Child plus Adolescent Health |
| **RPR** | Rapid Plasma Reagin |
| **RRC** | Red ribbon club |
| **RTI** | Reproductive tract infection |
| **SACS** | State AIDS Control Society |
| **SI** | Strategic information |
| **SRC** | State Reference Center |
| **STD** | Sexually transmitted disease |
| **STI** | Sexually transmitted infection |
| **STRC** | State training resource center |
| **SRL** | State Reference Laboratory |
| **SSS** | Sampoorna Suraksha Strategy |
| **RSTRRL** | Regional STI Training, Research, and Reference Laboratories |
| **TI** | Targeted Intervention |
| **TRG** | Technical Resource Group |
| **TWG** | Technical Working Group |
| **WLHIV** | Women living with HIV |

# Executive Summary

**Genesis and Growth**

India's response to the HIV/AIDS epidemic was initiated in the form of sero-surveillance in 1985. While initial responses (1985-1991) focused on search of HIV in different population groups and locations, screening of blood before transfusion, and targeted awareness generation; the launch of National AIDS and STD Control Programme (NACP) in 1992 institutionalized beginning of a comprehensive response to the HIV/AIDS epidemic in India. Thirty-five years since then, NACP has evolved as one of the world's largest programmes through five-distinct phases.

The first phase of NACP (1992-1999) focussed on awareness generation and blood safety. The second phase witnessed launch of direct interventions across the prevention-detection-treatment continuum with capacity building of States on programme management. The third phase (2007-2012) was story of scale-up with programme management decentralised up to the district level. The fourth phase (2012-2017) was a period of consolidation and enhanced Government funding.

**The NACP Phase-IV (Extension)**

The NACP Phase-IV (Extension) was first approved for the period of 2017-2020 and then further extended for one more year i.e., 2020-21. Several gamechanger initiative were taken during NACP Phase-IV (Extension). The Phase started with the passing of the HIV and AIDS (Prevention and Control) Bill, 2017 and the launch of the 'Test and Treat' policy for HIV patients in April 2017. The Bill ensured equal rights for the people infected with HIV and AIDS in getting treatment and prevent discrimination of any kind. The Act came into force in September 2018. As the 'Test and Treat' policy was being scaled-up, the Programme implemented "Mission Sampark" in 2017 to bring back People Living with HIV (PLHIV) who have left treatment after starting ART. 'Test and Treat' was complemented by the launch of universal viral load testing for on-ART PLHIV in February 2018.

The year 2020-21 witnessed the onset of the COVID-19 pandemic. The national AIDS response was challenged in the initial months like any other aspect of life. However, the Programme soon took many initiatives turning challenges into opportunities. IT systems were leveraged to enhance programme review and capacity building. This resulted in improved inter and Intra-State coordination. Initiatives like multi-month dispensation and community-based ART refill ensured continuity in service provisions.

**Context and formulation of NACP Phase-V**

The impact of the national AIDS response has been significant. The annual new HIV infections in India have declined by 48% against the global average of 31% (the baseline year of 2010). The annual AIDS-related mortalities have declined by 82% against the global average of 47% (the baseline year of 2010). The HIV prevalence in India continues to be low with an adult HIV prevalence of 0.22%. Despite the significant achievements and impact, there is no place for complacency given the country's commitment to ending the AIDS epidemic as a public health threat by 2030. HIV remains a national public health priority with new HIV infections happening at a rate highethan the desired level. The annual number of new infections among adults has declined by 48% since 2010, but still has a long way to go to achieve a 90% decline by 2030. The progress on targets of 90-90-90 to be achieved by 2020 has gauzed the country's progress on ending the epidemic. The full realization of 90-90-90 by 2020 would have meant that at least 73% of PLHIV have suppressed viral loads in 2020 cutting down the transmission significantly. At the end of 2020, 78% of PLHIV knew their HIV status, 83% of PLHIV who knew their HIV status were on ART, and 85% of PLHIV on ART were virally suppressed.

The formulation of NACP Phase-V was necessitated by the need for continuous action and the vigil in context of the country commitment on ending of the AIDS epidemic as a public health threat by 2030. It was initiated in alignment with Fifteenth Finance Commission for 2021-26 of the Government of India. The formulation of NACP Phase-V coincided with formulation of UNAIDS Global AIDS Strategy 2021-2026, WHO Global Health Sector Strategies (GHSS) on HIV, viral hepatitis, and sexually transmitted infections for the period 2022-2030 and The Global Fund cycle of 2021-24. NACP Phase-V takes into account the global contexts, targets and strategies.

**Overview of NACP Phase-V (2021-26)**

NACP Phase-V is a Central Sector Scheme, fully funded by the Government of India, with an outlay of Rs 15471.94 crore. The NACP Phase-V aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline value of 2010. The NACP Phase-V also aims to attain dual elimination of vertical transmission, elimination of HIV/AIDS related stigma while promoting universal access to quality STI/RTI services to at-risk and vulnerable populations.

The specific objectives of the NACP Phase-V are as below:

**a. HIV/AIDS prevention and control**

**i.** 95% of people who are most at risk of acquiring HIV infection use comprehensive prevention
**ii.** 95% of HIV positive know their status, 95% of those who know their status are on treatment and 95% of those who are on treatment have suppressed viral load
**iii.** 95% of pregnant and breastfeeding women living with HIV have suppressed viral load towards attainment of elimination of vertical transmission of HIV
**iv.** Less than 10% of people living with HIV and key populations experience stigma and discrimination

**b. STI/RTI prevention and control**

**i.** Universal access to quality STI/RTI services to at-risk and vulnerable populations
**ii.** Attainment of elimination of vertical transmission of syphilis

Under NACP Phase-V, while the existing interventions will be sustained, optimized, and augmented; newer strategies will be adopted, piloted, and scaled-up under the programme to respond to the geographic and community specific needs and priorities. The HIV and AIDS (Prevention and Control) Act, 2017 will continue to be the cornerstone of the national response to HIV and STI epidemic in NACP Phase-V. The Act will be the enabling framework to break down barriers driving delivery of a comprehensive package of services in an ecosystem free of stigma and discrimination.

**Guiding Principles of NACP Phase-V (2021-26)**

Eight guiding principles will be central to strategies and activities to attain the specific targets.

1. Keep beneficiary and community in center
2. Break the silos, build synergies
3. Augment strategic information-driven planning, implementation, monitoring, and mid-course corrections
4. Prioritize and optimize through high-impact programme management and review
5. Leverage technology and innovation as critical enablers
6. Enhance and harness partnership
7. Integrate gender-sensitive response
8. Continue fostering technical arrangements and institutions

**Collaboration with public and private sectors**

NACP Phase-V will build upon the systematized convergence with the existing schemes of Central Government including synergy with National health programme, related line Ministries as well as State Governments through mainstreaming and partnership extending the reach of various HIV related services in a cost-neutral way. The collaboration framework of NACP Phase-V includes continued strategic engagement with private sector.

**Goal 1: Reduce annual new HIV infections by 80%**

NACP Phase-V will accelerate reduction in new annual HIV infections through a basket of strategies tailored to the high-risk, at-risk, and low-risk population groups.

1. Continue and evolve the existing peer-led targeted interventions (TI) and Link Worker Schemes (LWS) strategies for integrated services
2. Promote evidence-backed comprehensive prevention packages tailored to location and population
3. Strengthen the population size estimation and field epidemiological intelligence for coverage expansion and saturation
4. Expand and intensify the coverage of NACP interventions including OST among Injecting Drug Users (IDU)
5. Universalize the NACP interventions in prisons and other closed settings through a mix of service delivery models
6. Pilot and scale models for community-based integrated service delivery models
7. Redefine and expand coverage among the bridge population
8. Develop and roll-out new generation communication strategy suitable to current context
9. Cover 'at-risk' HIV negative through comprehensive prevention packages to keep them negatives
10. Develop and scale-up sustainable models for 'at-risk' Virtual Population
11. Maintain and augment the behavior change communications for general population
12. Sustain focus on adolescent and youth population

**Goal 2: Reduce AIDS-related mortalities by 80%**

NACP Phase-V will build upon the strong momentum from previous phases and further accelerate the reductions on AIDS-related mortalities through strategies directed across care continuum.

1. Maintain the existing models of HIV counselling and testing services (HCTS) and expand through strategic scale-up
2. Develop and roll-out tailored communication campaigns focusing on risk perception and HCTS uptake
3. Augment the existing HCTS models with efficient approaches for active case findings promoting early detections
4. Appropriately adapt evidence-backed newer technologies to supplement existing models
5. Maintain existing care, support, and treatment (CST) services models and expand further through sustainable manner
6. Continue provisions of high-quality ARVs through differentiated service delivery models improving through sustainable manner
7. Focus on rapid ART initiation and advanced HIV disease management augmenting quality of care
8. Suitably update the treatment guidelines periodically
9. Address linkage loss at all levels
10. Optimize the uses of public sector laboratories for viral load measurements
11. Offer integrated service delivery packages to 'at-risk' people and PLHIV
12. Prioritize sexual and reproductive health services for women at increased risk of HIV infection and women living with HIV
13. Bring efficiencies and improve linkages through single window service delivery models
14. Maintain and expand laboratory quality assurance system

**Goal 3: Eliminate vertical transmission of HIV and Syphilis**

The NACP Phase-V takes into the account the global guidance towards elimination of vertical transmission of HIV and Syphilis.

1. Augment comprehensive synergy with NHM for testing of pregnant women for HIV and syphilis
2. Strengthen the primary prevention through coordinated actions
3. Introduce and scale-up dual test kits (HIV & Syphilis) to fast-track progress on the dual elimination
4. Strengthen linkage from screening facilities to confirmatory centers and subsequently to the treatment centers
5. Strengthen retention and on-ART adherence among eligible WLHIV
6. Prioritize family planning services for eligible PLHIV
7. Strengthen the early diagnosis of infants and all children living with HIV (CLHIV)
8. Engage with private sector augmenting their role in attainment of dual elimination
9. Strengthen the strategic information in the context of HIV positive pregnant women/mother
10. Prepare strategic roadmap to guide actions towards attainment of validation of elimination of vertical transmission

**Goal 4: Promote universal access to quality STI/RTI services to at-risk and vulnerable populations**

NACP Phase-V will reinforce the STI/RTI component not only in terms of elimination of vertical transmission of HIV and syphilis but also to augment access to quality STI/RTI services through maximizing its system and opportunities for shared delivery models.

1. Strengthen the strategic information on STIs
2. Maintain the existing model of Designated STI/RTI Clinics (DSRCs) augmenting the role
3. Develop and implement integrated communication strategies
4. Dovetail dual testing at HCTS centers
5. Promote active case findings facilitating early detections
6. Improve collaboration with NHM on STI/RTI services provisions and reporting
7. Strengthen and streamline private sector engagement on STI/RTI management
8. Suitably update the STI/RTI management guidelines periodically
9. Augment the laboratory capacities
10. Strengthen the supply chain management

**Goal 5: Eliminate HIV/AIDS related stigma and discrimination**

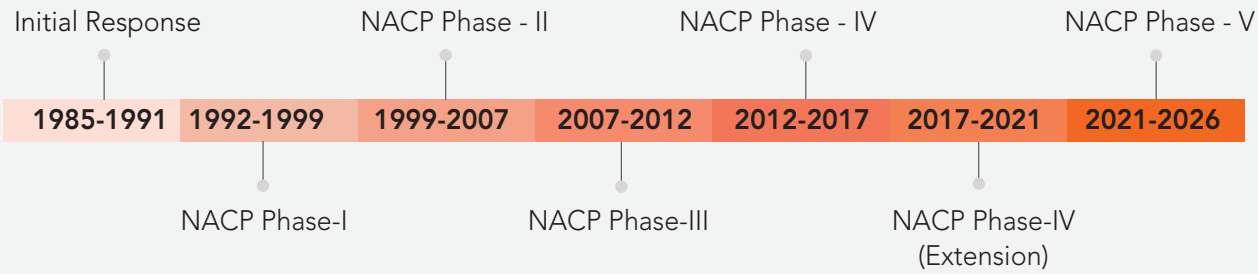
NACP Phase-V will build upon the gamechanger initiatives of NACP-Phase IV (Extension) to accelerate the progress on elimination of HIV/AIDS related stigma and discrimination.

1. Undertake bottom-up institutionalized community system strengthening
2. Accelerate the notification of State rules and appointment of Ombudsman in the context of the HIV and AIDS (Prevention and Control) Act, 2017
3. Undertake sensitization of related stakeholders on HIV/AIDS related stigma and discrimination
4. Design and implement communication strategy on elimination of HIV/AIDS related stigma and discrimination
5. Enhance strategic information on HIV/AIDS related stigma and discrimination
6. Engage with State governments promoting launch and scale-up of social protection schemes

# 1. National AIDS Response: Genesis and growth

In 1981, rare forms of unexplained pneumonia and cancer were reported among gay men in the United States of America in weekly surveillance reports [1,2]. Further research into these illnesses led to the discovery of a virus, later named Human Immunodeficiency Virus (HIV), which was causing acquired immunodeficiency among the infected [3]. Recognizing the threat posed by a new emerging global pandemic, the Indian Council of Medical Research (ICMR) initiated sero-surveillance in October 1985; an outcome of which was detection of the first case of HIV in Chennai in April 1986 [4,5]. Since then, the national AIDS response has travelled a long way (Figure 1, Table 1-6).

**Figure 1. Evolution of the National HIV/AIDS response**




## 1.1 Initial Interventions (1985-1991)

With reporting of HIV/AIDS cases in India, the Ministry of Health and Family Welfare (MoHFW) constituted a high-powered National AIDS Committee (NAC) in 1986 [6]. A mid-term plan was developed that focused on four States (Tamil Nadu, Maharashtra, West Bengal, and Manipur) and four metropolitan cities (Chennai, Kolkata, Mumbai, and Delhi) in view of identified vulnerabilities. The initial responses focused mainly on surveillance in perceived high-risk areas and population groups, screening of blood before transfusion, and targeted awareness generation (Table 1) [7].

**Table 1. Key highlights of initial National HIV/AIDS responses (1985-1991)**

| | Key Highlights |
|---|---|
| 1. | Launch and expansion of HIV Sero-Surveillance |
| 2. | Constitution of National AIDS Committee |
| 3. | Focus on blood screening and awareness generation |
| 4. | Mid-term plan for identified vulnerable areas |

## 1.2 National AIDS and STD Control Programme (NACP) Phase-I (1992-1999)

As the HIV epidemic in India seemed to be expanding (through rounds of sero-surveillance), the first phase of the National AIDS and STD Control Programme (NACP) was launched in 1992 [5,6,8,9]. The objective was to slow down the spread of HIV infections, and decrease the morbidity, mortality, and impact of HIV/AIDS in the country. The phase-I of NACP constituted the institutional structures of the National AIDS Control Board (NACB), the AIDS Control Organisation (NACO) as well as State-level programme management unit calleds State AIDS Control Societies (SACS) in the then 25 States and 7 Union Territories (UT). NACP Phase-1 undertook large-scale awareness generation campaigns. As initially blood transfusion was the major source of HIV transmission, licensing of the blood banks and banning of professional donors was a major priority under NACP Phase-I. Expansion of surveillance network and collaboration with non-government organizations (NGO)/ community-based organizations (CBO) for preventive interventions were also focused.

**Table 2. Key highlights of NACP Phase-I (1992-1999)**

| | Key Highlights |
|---|---|
| 1. | Establishment of NACB, NACO and SACS |
| 2. | Implementation of large-scale awareness generation campaigns |
| 3. | Licensing of blood banks and banning of professional donors |
| 4. | Collaboration with NGO/CBO for prevention interventions among high-risk groups (HRG) |
| 5. | Expansion of surveillance networks |

## 1.3 NACP Phase-II (1999-2007)

The Government of India launched the NACP Phase-II in 1999 with two objectives: (i) to reduce the spread of HIV infection in India, and (ii) to increase India's capacity to respond to HIV/AIDS on a long-term basis. NACP Phase- II was critical as some international organizations stated that the HIV epidemic in India was 'on African trajectory' with the world's largest number of HIV-infected people [10]. While the assessment was far-fetched, NACP Phase-II transitioned the national AIDS response through a sincere, intensive, and long-term commitment.

The awareness generation activities were backed by tailored and comprehensive service delivery packages [11]. Peer-led targeted interventions (TI) through NGO/CBO offered a package of preventive services to the key population [a]. Facilities for voluntary counselling and testing, (VCT), interventions for prevention of parent to child transmission (PPTCT), antiretroviral (ARV) medicines were introduced, and antiretroviral treatment (ART) centers were established and eventually scaled up. The Constitution of the National Parliamentarian Forum generated strong political support that culminated in the setting-up of the National Council on AIDS, chaired by the Prime Minister of India. Systematic interventions like the adoption of the National AIDS Prevention and Control Policy (2002) and the National Blood Policy (2003) reinforced the national AIDS response. Programme management was strengthened with the capacity building of SACS and the establishment of Project Support Units/Project Management Units (PSU/PMU) providing technical and managerial support for quality interventions for high-risk groups (HRG).

[a]Includes Female Sex Workers, Men who have Sex with Men, Hijra/Transgender People, Injecting Drug Users, Migrants and Truckers

**Table 3. Key highlights of NACP Phase-II (1999-2007)**

| | Key Highlights |
|---|---|
| 1. | Launch and expansion of peer-led targeted interventions (TI) through NGO/CBO |
| 2. | Establishment of facilities for VCT and PPTCT |
| 3. | Introduction of ARV and establishment of ART centers |
| 4. | Constitution of the National Parliamentarian Forum and National Council on AIDS |
| 5. | Adoption of the National AIDS Prevention & Control Policy and National Blood Policy |
| 6. | Capacity building of SACS and establishment of PSU/PMU |

## 1.4 NACP Phase-III (2007-2012)

The third phase of the NACP was launched in 2007 to halt and reverse the epidemic in India during the eleventh five-year plan (2007-12) of the Government of India. Rapid scale-up of the service delivery facilities aiming for saturation across the prevention-detection-treatment spectrum was the key highlight of the third phase [12]. The VCT services evolved into integrated counselling and testing centers (ICTC). The Programme adopted the offering of HIV counselling and testing services to pregnant women as an essential component of antenatal care (ANC) services [13]. Donor funded interventions for the key population were transitioned [14]. Mapping and population size estimation of HRGs were undertaken systematically.

Programme management was decentralized up to the district level with the establishment of the District AIDS and Prevention Control Unit (DAPCU) in 188 high-priority districts based-on rich epidemiological evidence generated under the Programme [15]. Institutional strengthening also included the establishment of Strategic Information Management Unit (SIMU) at NACO and SACS, a dedicated North-East Regional Office (NERO) for focused attention to the northeastern states, and state training resource centers (STRC) to help in capacity building of the state-level implementation units and functionaries [16]. By the end of NACP Phase-III, it was established that though there was significant progress under the national AIDS response in India, yet there was no scope for complacency [17,18].

**Table 4. Key highlights of NACP Phase-III (2007-2012)**

| | Key Highlights |
|---|---|
| 1. | Rapid scale-up of the service delivery facilities pan India |
| 2. | Offering of HIV counselling and testing services to pregnant women as an essential component of ANC services |
| 3. | Transition of donor-funded interventions for the key population |
| 4. | Establishment of SIMU at NACO and SACS |
| 5. | Programme management decentralized up to the district level with the establishment of DAPCU |

## 1.5 NACP Phase-IV (2012-2017)

The fourth phase of NACP was planned for the period 2012-17 in alignment with the duration of the twelfth five-year plan of the Government of India. Intending to accelerate reversal and integrate response, the Programme aimed to reduce new infections by 50% (2007 Baseline of NACP Phase-III) and provide comprehensive care and support to all persons living with HIV/AIDS and treatment services for all those who require it [19].

NACP phase-IV consolidated the gains made in previous phases. The National HIV/AIDS toll free helpline – 1097 was launched on 1st December 2014 on the occasion of World AIDS Day by Hon'ble HFM. The northeastern States become a key priority for the country in view of the sustained level of high epidemic and emerging new pockets [20]. The resolve to attain dual elimination of vertical transmission of HIV and syphilis got adopted and rooted in programme guidelines [13,14,21]. Comprehensive HIV prevention, care and support interventions in prisons and other closed settings were launched. The commitment was backed-up by expanding the reach of HIV screening services through strategies of facility-integrated HIV counselling and testing centers (FI-ICTC) under the national health mission as well as in the private sector and the launch of community-based screening (CBS) [22]. The CD4 cut-off level for initiation of ART was raised from 350 to 500 cells/mm3[23]. The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (Prevention and Control) Bill was introduced in the Rajya Sabha [24]. Mainstreaming & partnerships were focused to strengthen the multi-sectoral response [25]. A mid-term review of NACP Phase-IV was undertaken which informed the formulation of the seven-year National Strategic Plan [13]. Many of these initiatives primed the Programme for the next generation of AIDS response.

**Table 5. Key highlights of NACP Phase-IV (2012-2017)**

| | Key Highlights |
|---|---|
| 1. | Momentous change in funding landscape with Government of India providing 73% of the total budget for NACP |
| 2. | Launch of National HIV/AIDS toll free helpline – 1097 |
| 3. | Adoption of dual elimination of vertical transmission (of HIV & Syphilis) in NACP guidelines |
| 4. | Launch of NACP interventions in prisons and other closed settings |
| 5. | Strategic expansion of the reach of HIV screening services with FI-ICTC and CBS |
| 6. | CD4 cut-off level for initiation of ART was shifted to 500 cells/mm3 |
| 7. | The HIV and AIDS (Prevention and Control) Bill introduced in the Rajya Sabha |
| 8. | Mid-term review of NACP Phase-IV |

The NACP Phase-IV witnessed a momentous change in the funding landscape of national AIDS response with the Government of India (GoI) providing 73% of the total budget in comparison to 15 per cent domestic financing under NACP Phase-I [17]. The phase also witnessed the Government's decision to continue funding the Programme as a Central Sector Scheme demonstrating the political ownership of the national HIV/AIDS response [22].

## 1.6 NACP Phase-IV Extension (2017-2021)

The 12th five-year plan of the Government of India ended in 2017. A decision was taken that government schemes would be aligned with Finance Commission cycles improving the quality of the Government expenditure. The decision necessitated that the ongoing scheme would be aligned with the remaining Fourteenth Finance Commission period ending March 2020 after an outcome review [26]. Accordingly, the NACP Phase-IV (Extension) was formulated for the period April 2017 to March 2020. Later, the Programme was extended for one more year as the final report of the 15th Finance Commission was still awaited [27].

NACP Phase-IV Extension (2017-2021) was the phase of the gamechanger initiatives. The Phase started with the passing of the HIV and AIDS (Prevention and Control) Bill, 2017 and the launch of the 'Test and Treat' policy for HIV patients in April 2017 [28,29]. The Bill ensured equal rights for the people infected with HIV and AIDS in getting treatment and prevent discrimination of any kind. The Act came into force in September 2018. As the 'Test and Treat' policy was being scaled-up, the Programme implemented "Mission Sampark" in 2017 to bring back People Living with HIV (PLHIV) who have left treatment after starting ART [30]. 'Test and Treat' was complemented by the launch of universal viral load testing for on-ART PLHIV in February 2018 [31]. Differentiated Service Delivery Model (DSDM) to strengthen follow up, adherence and retention were initiated. Transitioning of PLHIV on Dolutegravir-based regimen was initiated [32].

The Extension phase witnessed revamped TI interventions to focus on hard-to-reach populations [33]. Differentiated prevention, peer-navigator and index testing were introduced under revamped strategies. Interventions to cover high-risk and at-risk populations seeking a partner through virtual populations were tested through demonstration projects [34]. The number of regional languages under the National HIV/AIDS toll free helpline – 1097 increased to 12 and referral and online grievance redressal mechanism was introduced.

NACP continued to be primarily responsible for provision of safe blood in NACP-Phase IV Extension. A network of 3311 licensed blood banks across all States and sectors, including 1131 NACO supported blood banks, were operational in 2019-20 under Blood Transfusion Services of NACP. External quality assurance for blood banks were undertaken through three proficiency testing providers. The success of NACP on provision of safe blood was evident with HIV sero-positivity of as low as 0.12% and a negligible proportion of PLHIV reporting to acquire HIV infections through blood and blood products in 2020-21.

Strategic information expanded into newer programmatic areas (Pre-Exposure Prophylaxis, HIV Self Testing etc.), newer population groups (prisoners, 'at-risk' people on virtual platform) and additional biomarkers (Hepatitis B and Hepatitis C) along with size estimations up to the district-level [35,36,37,38,39,40]. Beneficiary - centric, information technology (IT)-enabled monitoring, evaluation and surveillance system with embedded supply chain management was developed and rolled out for seamless management of information systems across various service delivery points [41]. Third-party evaluation of NACP Phase-IV and Extension was undertaken [42].

**Table 6. Key highlights of NACP Phase-IV Extension (2017-21)**

| | Key Highlights |
|---|---|
| 1. | Enactment of the HIV and AIDS (Prevention and Control) Act, 2017 |
| 2. | Launch and scale-up of the 'Test and Treat' policy for HIV patients |
| 3. | 'Mission Sampark' to bring back lost-to-follow-up PLHIV on ART |
| 4. | Launch and scale-up up universal viral load testing for on-ART PLHIV |
| 5. | Launch of DSDM for PLHIV to strengthen follow up, adherence and retention |
| 6. | Scale-up of NACP interventions in prisons and other closed settings |
| 7. | Revamped TI programme with differentiated prevention, peer-navigator, and index testing strategies to focus on hard-to-reach populations |
| 8. | Initiation of transitioning of PLHIV on Dolutegravir-based regimen |
| 9. | Strategic information expansion into newer areas like Pre-Exposure Prophylaxis, HIV Self Testing etc. through demonstration projects; newer and hidden population groups (prisoners, 'at-risk' people on virtual platform etc.) and additional biomarkers (Hepatitis B and Hepatitis C) |
| 10. | Population size estimation (PLHIV and HRGs) up to the district level |
| 11. | Development and roll-out of Client-centric, IT-enabled monitoring, evaluation, and surveillance system with embedded supply chain management |
| 12. | Third-party evaluation of NACP Phase-IV and Extension |
| 13. | Successful mitigation of COVID-19 pandemic ensuring uninterrupted service delivery to targeted beneficiaries |

## 1.7 Coronavirus disease (COVID-19) mitigation and preparation for NACP Phase-V

The year 2020-21 witnessed the onset of the COVID-19 pandemic. The national AIDS response was challenged in the initial months like any other aspect of life. However, the Programme soon took many initiatives turning challenges into opportunities [43]. IT systems were leveraged to enhance programme review and capacity building. This resulted in improved inter and Intra State coordination. Initiatives like multi-month dispensation and community-based ART refill ensured continuity in service provisions.

NACP Phase-IV extension was expected to be co-terminus on 31.03.2020 with the 14th Finance Commission cycle. However, as the final report of the 15th Finance Commission was awaited, all ongoing schemes were given an interim extension till 31.03.2021 or till the date of recommendations of 15th Finance Commission come into effect (whichever is earlier). As the 15th Finance Commission submitted its report in November 2020 for the period 2021-22 to 2025-26, the process of formulation of NACP Phase-V (2021-22 to 2025-26) was initiated following directives from the Ministry of Finance [44,45]. Subsequently, the Union Cabinet approved NACP Phase-V with an outlay of Rs 15471.94 crore [33].

The formulation of NACP Phase-V coincided with formulation of UNAIDS Global AIDS Strategy 2021-2026, WHO Global Health Sector Strategies (GHSS) on HIV, viral hepatitis, and sexually transmitted infections for the period 2022-2030 and The Global Fund cycle of 2021-24. National programme managers, communities and other related stakeholders from India participated extensively in development of Global AIDS Strategy, GHSS and proposal development for the Global Fund 2021-24. NACP Phase-V takes into account the global contexts, targets and strategies and takes forward the country commitment on ending of the AIDS epidemic as a public health threat by 2030.

# 2. The Context of NACP Phase-V: Current Status of the epidemic and the response

## 2.1 Current status of the Epidemic

### 2.1.1 The HIV/AIDS epidemic

Since the detection of the first case of HIV in Chennai (Tamil Nadu) in April 1986, considerable progress has been made under NACP to halt and reverse the epidemic. As a result, the HIV epidemic in India continues to be low (Table 7) [46]. The continued low prevalence may give an exaggerated sense of achievements leading to complacency. In fact, HIV prevalence and incidence among key population remains at much higher level than the general population [47]. Hence the need for continuous action and the vigil.

As a result of more and more PLHIV being initiated and retained on high-quality antiretrovirals (ARV) medicines, PLHIV cohort is living longer and growing older. It is estimated that almost two-fifth of the PLHIV would be aged 50 years or older in 2025[48]. This aging is anticipated to lead to more non-AIDS morbidities, and thus an inevitable need for multidisciplinary health-care services to ensure continued high-quality survival.

The HIV/AIDS epidemic continues to be heterogenic in terms of location, population, and route of transmission [47,49,50,51]. Almost 84% of the PLHIV are estimated to be in 299 districts of the country (Figure 2). The prevalence and incidence rate in the northeastern States of Manipur, Mizoram and Nagaland is much higher than the national averages. Twenty-five districts in the whole of country have estimated adult HIV prevalence of 1% or more; all are in the northeastern States.

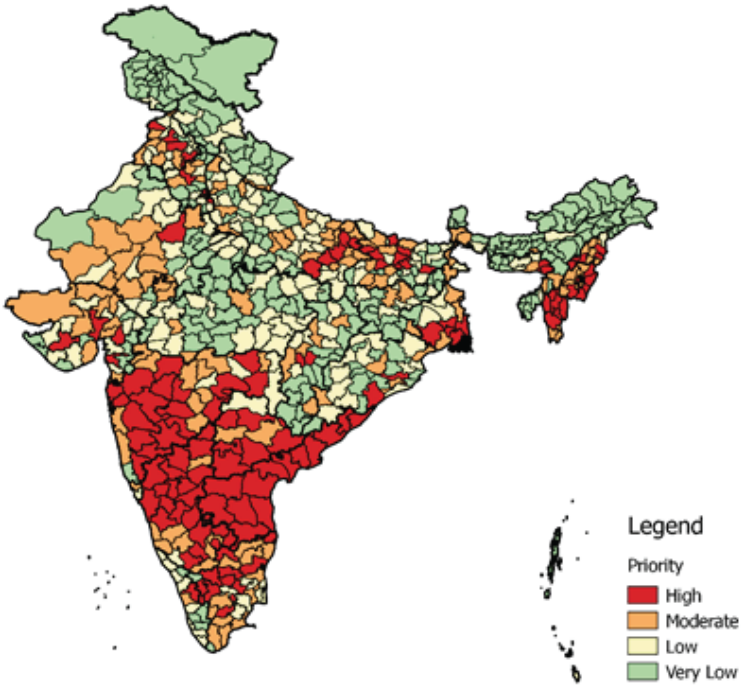
The prevalence rate among the HRG population of female sex workers (FSW), prisoners, men who have sex with men (MSM), hijra/transgender (H/TG) people and injecting drug users (IDU) is 7-28 times of adult population. While almost 90% of infections are through the sexual route nationally, at-least 25% are through infected syringes and needles in the States of Manipur, Mizoram, Tripura, and Punjab [52,53]. Higher prevalence of Hepatitis, especially of Hepatitis C Virus among IDUs, has been noted [54].

In a concentrated HIV epidemic, the size of HRG is a significant epidemiological indicator. The programme has launched the programmatic mapping and population size estimation (p-MPSE) to periodically update the HRG size estimates in India. While p-MPSE is being undertaken under the programme to do a local area mapping for launching and scaling up services, recent evidence has suggested a much bigger size of HRGs than being currently covered under the programme [55,56]. Further, the dynamics of seeking a sexual partner is changing with more and more use of online platforms fueled by widespread internet access [57,58,59].

**Table 7. Overview of HIV/AIDS Epidemic in 2020**

| Indicator | Disaggregation | Value |
|---|---|---|
| Adult (15-19 yrs.) Prevalence (In %) | **Total** | 0.22 [0.17-0.29] |
| | Male | 0.23 [0.18-0.31] |
| | Female | 0.20 [0.15-0.26] |
| Number of people living with HIV (In lakh) | **Total** | 23.18 [18.33-29.78] |
| | Adults (15+ years) | 22.37 [17.74-28.69] |
| | Women (15+ years) | 9.88 [7.82-12.68] |
| | Children (<15 years) | 0.81 [0.59-1.09] |
| HIV incidence per 1000 uninfected population | **Total** | 0.04 [0.02-0.09] |
| | Male | 0.05 [0.02-0.09] |
| | Female | 0.04 [0.02-0.08] |
| New HIV Infections (In lakh) | **Total** | 0.58 [0.29- 1.14] |
| | Adults (15+ years) | 0.52 [0.25-1.04] |
| | Women (15+ years) | 0.22 [0.11-0.45] |
| Change in new HIV infections since 2010 (In %) | **Total** | -47.89 |
| | Adults (15+ years) | -46.96 |
| | Female (15+ years) | -45.72 |
| | Children (<15 years) | -55.02 |
| AIDS-related mortalities (In lakh) | **Total** | 0.32 [0.20-0.52] |
| | Adults (15+ years) | 0.28 [0.18-0.46] |
| | Women (15+ years) | 0.07 [0.04-0.13] |
| Change in AIDS-related mortalities since 2010 (In %) | **Total** | -82.24 |
| | Adults (15+ years) | -83.19 |
| | Female (15+ years) | -89.17 |
| | Children (<15 years) | -68.09 |

**Figure 2. District Prioritization (District-level HIV burden estimations, 2019)**




| Priority level | Description | Number of Districts | Epidemic Burden |
|---|---|---|---|
| High | Adult prevalence of >=1% or PLHIV size of >=5000 | 144 | 63% of PLHIV, 49% of new infections and 55% of PMTCT need |
| Moderate | Adult prevalence of 0.4% - <1% or PLHIV size of 2500 - <5000 | 155 | 21% of PLHIV, 27% of new infections and 25% of PMTCT need |
| Low | Adult prevalence of 0.20%-<0.40% or PLHIV size of 1000 - <2500 | 180 | 12% of PLHIV, 16% of new infections and 14% of PMTCT need |
| Very Low | Adult prevalence of <0.20% or PLHIV size of <1000 | 256 | 4% of PLHIV, 8% of new infections and 6% of PMTCT need |

## 2.1.2 The STI epidemic

There is limited recent evidence on the burden of the STI epidemic in India. Except for syphilis, large scale prevalence data is usually not available for other STIs. However, based on a community-based study of 2002-03, it was noted that the STIs burden in India continues to be high with an estimated 33 million STI episodes in India in 2015-16[60]

The serum samples collected in HIV Sentinel Surveillance (HSS) under NACP are tested for syphilis using non-treponemal Rapid Plasma Reagin (RPR) test. Overall, the syphilis seropositivity in India appears to be low and stable to declining [48, 61].

In 2019, the syphilis seropositivity among pregnant women was at 0.10% (95% CI: 0.08–0.11) though some of the states in the northeastern part of the country had a much higher level. A study on the disease burden of maternal syphilis and associated adverse pregnancy outcomes estimated around 1.04 lakh pregnant women with probable active syphilis infections and around 16,300 cases of congenital syphilis (CS) in 2012 in India [62, 63]. This will translate into a case rate of CS of around 60 lakh per live birth in 2012.

The syphilis seropositivity appears to be low in other population groups also. Syphilis seropositivity was 0.40% (95% CI: 0.3%-0.5%) among the inmates in central jails in 2019 [49]. Among FSW and MSM, syphilis sero-positivity ranged from 0.20% to 0.40% in 2017[64].

## 2.2 Current achievements, impact, and challenges

### 2.2.1 Achievements

Evidence-driven AIDS response of India, following a three-pronged strategy of prevention-detection-treatment while keeping the community and gender in the center, has been a global success story [65]. As of March 2021, there were 1,472 targeted interventions, 232 opioid substitution therapy (OST) centers, 33,862 ICTC, 619 ART centers, 478 CD4 testing sites and 64 Viral load laboratories offering prevention, HIV counselling and testing, ART treatment, CD4 testing and viral load monitoring services. Rural areas in 138 districts were directly being covered through the link worker scheme (LWS) while 868 employer-led models (ELM) interventions were covering its worker in formal and informal sectors. The Programme covered 1059 prisons reaching out to 40% of the total admitted inmates in 2020-21. The service uptake at these facilities has increased significantly during NACP Phase-IV and Extension with more than 6 crore population being directly reached under the programme through these service delivery structures (Table 8) [51].

**Table 8. Progress on key performance indicators (2014-15 to 2020-21)**

| Indicator | Achievement (In lakh) | | | | | | |
|---|---|---|---|---|---|---|---|
| | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
| HRG, bridge and other vulnerable population covered | 59.51 | 55.63 | 49.3 | 74.72 | 87.65 | 103.16 | 81.80 |
| No. of STI/RTI patients managed | 75.46 | 88.39 | 85 | 86 | 88.35 | 95.38 | 68 .0 |
| General clients tested for HIV | 142.64 | 164 | 184.8 | 206.9 | 250.73 | 288.7 | 179.8 |
| Pregnant women tested for HIV | 106.10 | 125 | 161.2 | 203.2 | 223.4 | 265.3 | 222.2 |
| PLHIV on ART (Cumulative) | 8.51 | 9.4 | 10.5 | 12.03 | 13.98* | 14.86* | 14.94* |
| Viral load test conducted | - | - | - | 0.06 | 2.13 | 5.77 | 8.90 |

* Inclusive of 1.06 lakh PLHIV on ART in private sector

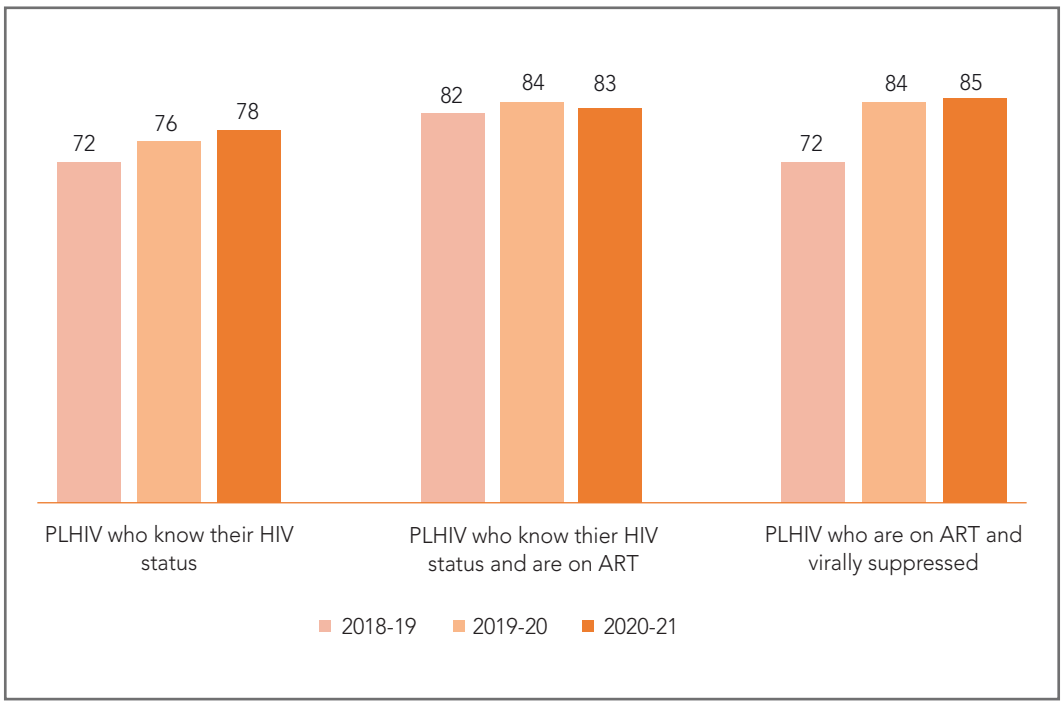
## 2.2.2 Impact

The impact of the national AIDS response has been significant. The annual new HIV infections in India have declined by 48% against the global average of 31% (the baseline year of 2010) [47]. The annual AIDS-related mortalities have declined by 82% against the global average of 47% (the baseline year of 2010). The HIV prevalence in India continues to be low with an adult HIV prevalence of 0.22%.

## 2.2.3 Challenges

Despite the significant achievements and impact, there is no place for complacency given the country's commitment to ending the AIDS epidemic as a public health threat by 2030. HIV remains a national public health priority with new HIV infections happening at a rate higher than the desired level. The annual number of new infections among adults has declined by 48% since 2010, but still has a long way to go to achieve a 90% decline by 2030 [47]. The progress on targets of 90-90-90 to be achieved by 2020 has gauzed the country's progress on ending the epidemic. The full realization of 90-90-90 by 2020 would have meant that at least 73% of PLHIV have suppressed viral loads in 2020 cutting down the transmission significantly. At the end of 2020, 78% of PLHIV knew their HIV status, 83% of PLHIV who knew their HIV status were on ART, and 85% of PLHIV on ART were virally suppressed (Figure 3) [b] [51].

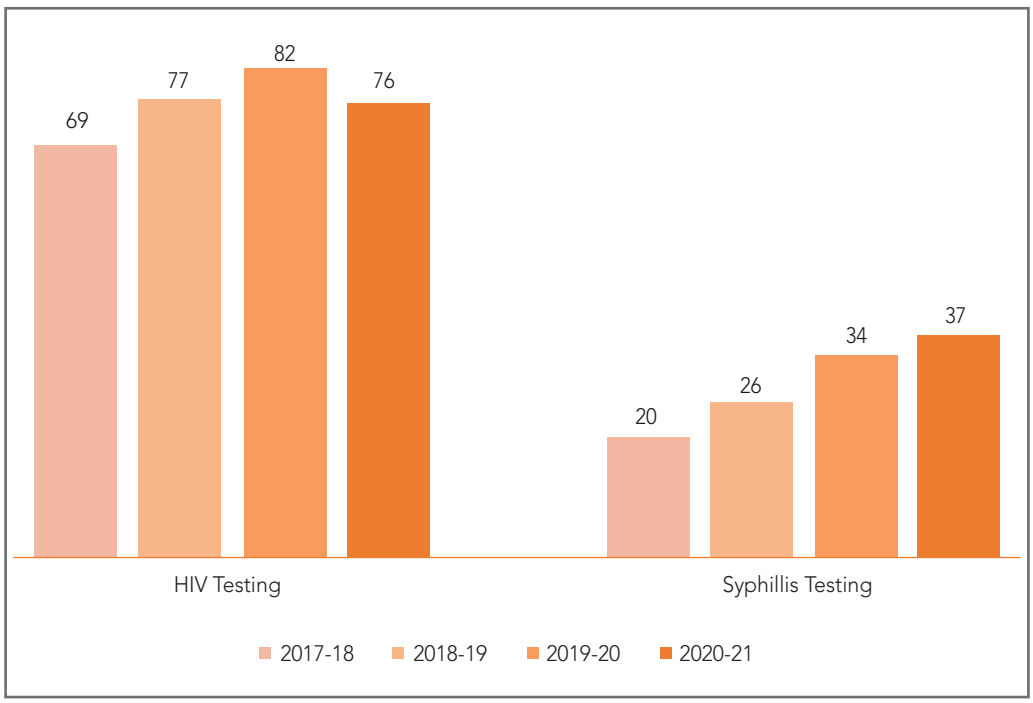
**Figure 3. Progress (in %) on 90-90-90 (2018-19, 2019-20 and 2020-21)**




[b]The denominator for first 90 informed by HIV Estimations 2020.

The country aimed to achieve the dual elimination of vertical transmission of HIV and syphilis by 2020. One of the key process targets for dual elimination was to test 95% of pregnant women for HIV and syphilis. There has been significant progress in testing pregnant women for HIV and syphilis. The testing coverage of pregnant women for HIV increased from 69% in 2017-18 to 82% in 2019-20. However, the strong momentum was adversely impacted by the COVID-19 pandemic as the testing coverage among pregnant women declined to 76% in 2020-21. The progress in syphilis testing among pregnant women, although improving, is far from the envisioned target. In 2020-21, around 37% of the pregnant women were tested for syphilis, almost twice the level in 2017 but still missing the target of 95% coverage by a huge margin (Figure 4).

**Figure 4. HIV and Syphilis testing coverage (in %) among pregnant women (2018-19, 2019-20 and 2020-21)**




In the spirit of the provisions of the HIV and AIDS (Prevention and Control) Act, 2017 and recognizing the HIV/AIDS-related stigma and discrimination as a significant barrier to uptake of HIV/AIDS-related services, the national AIDS response is committed to eliminate HIV/AIDS related stigma. In 2005-06, 60-63% of women and men were willing to buy fresh vegetables from a shopkeeper who has HIV/AIDS [66]. In comparison, 69-73% of women and men in 2015-16 were willing to buy fresh vegetables from a shopkeeper who has HIV/AIDS [67]. Despite the progress, the levels are still of concern and far from elimination targets.

## 2.3 Key recommendations from the endline evaluation of NACP Phase-IV and Extension

NACP Phase-IV and Extension Period were independently evaluated by the Indian Institute of Public Administration. Recognizing the unfinished agenda as well as the uniqueness of HIV/AIDS on one end as a manageable chronic disease requiring life-long medication and on the other end, the stigma and discrimination attached with the infection and those infected, the independent evaluation of NACP Phase-IV and Extension Phase recommended NACP as a vertical programme meeting the service requirement of marginalized communities and PLHIV [68]. The key recommendations have been summarized below (Table 9).

**Table 9. Key recommendations of the evaluation of NACP Phase-IV and Extension Period**

| Key recommendations from the evaluation of NACP Phase-IV and Extension Period | |
|---|---|
| Programme Management | |
| 1. | Scale-up efforts through prioritization, reorganization, resource optimization, building capacities and leveraging partnerships |
| 2. | Continue NACP as a vertical programme to do more justice to meeting the service requirement of marginalized communities and people living with HIV/AIDS |
| 3. | Leverage synergy and resource optimization with related schemes and programmes under the health systems and ensure smooth convergence |
| 4. | Develop network partners within and outside health system like the ministry of skill development entrepreneurship, Fit India Initiatives, Ministry of Social Justice etc |
| 5. | Establish a 'Strategic Unit' at NACO to focus on programme management |
| 6. | Review and update policies, guidelines, and strategies to ensure the reduction in implementation time, cost and fast response for integration |
| 7. | Leverage the presence of District AIDS Prevention and Control Units (DAPCU) to monitor the HIV programme across priority districts |
| 8. | Continue and emphasize building State leadership with design and implementation tailored to changing programme needs to ensure quality and desired outcomes |
| 9. | Build capacity of programme management and service delivery staff continuously to keep them always updated |
| 10. | Rework policy towards matching staff requirements and salary/remunerations to attract and retain talent better |
| 11. | Ensure filing of vacancies with appropriate measures and proactive follow up as well as competitive compensation packages as well as other incentives, perks and benefits |

Continued Table 9.

| Service Delivery | |
|---|---|
| 1. | Expand reach of NACP to the virtual platform through dedicated web-based and App-based interventions involving communities and 'at-risk' populations |
| 2. | HIV testing continues to be linked to mandatory counselling, confidentiality, informed consent, and an individualized linkage of those tested positive to treatment services. This needs a dedicated, trained and skilled workforce to be recruited and retained in the programme |
| 3. | Interventions on differentiated service delivery models, advanced disease management, death audit, verbal autopsy need to be adopted for better patient management and improving service delivery |
| 4. | The focus on STI/RTI programme needs to be strengthened |
| **Strategic Information** | |
| 1. | Evidence driven planning and implementation under NACP with a complementary and robust Strategic Information system shall be further enhanced and expanded to generate, analyse and disseminate high-quality action-oriented evidence |
| 2. | The IT-enabled client-centric management system to be made operational to improve programme management, monitoring and surveillance,ensuring tailored service delivery and avoiding data duplication |

# 3. NACP Phase-V (2021-26): An Overview

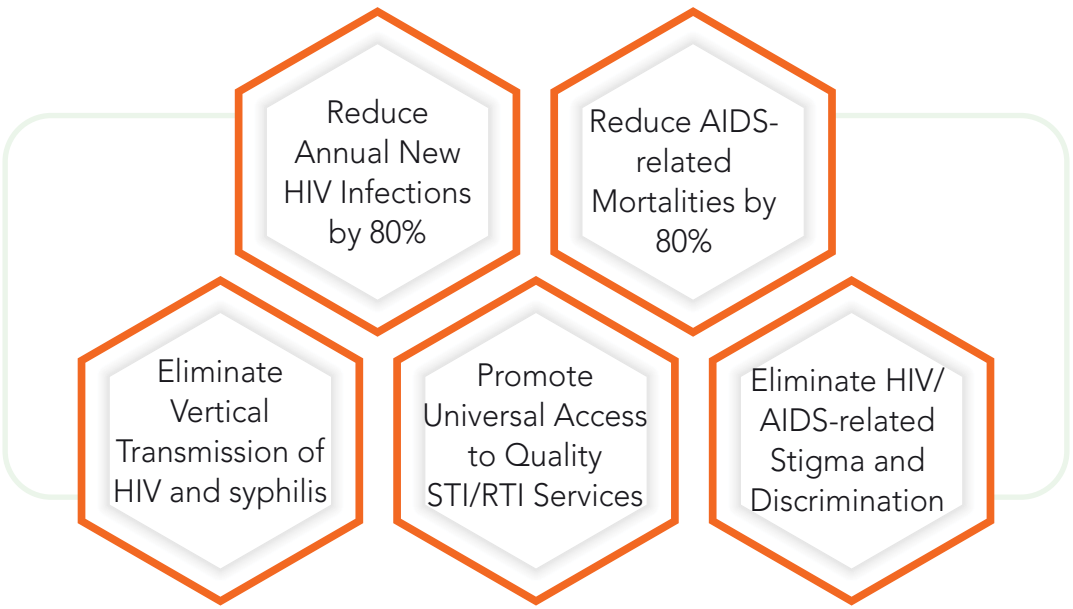
National AIDS and STD Control Programme (2021-26) (NACP Phase-V) is a Central Sector Scheme, fully funded by the Government of India, from 1st April 2021 to 31st March 2026 with an outlay of Rs 15471.94 crore. Recognizing the epidemiological and contextual shifts of recent years, the NACP Phase-V will anchor the national AIDS and STD response till 2025-26 towards the attainment of ending of the AIDS epidemic as a public health threat by 2030.

The NACP Phase-V consolidates the evidence and learnings from previous phases recognizing the significant progress yet the unfinished agenda. The NACP Phase-V builds on the gamechanger initiatives of the HIV and AIDS (Prevention and Control) Act, 2017 and rules thereof, Test and Treat policy, Universal Viral Load Testing, Mission Sampark, Community-Based Screening, transition to Dolutegravir-based Treatment Regimen etc. with an integral vibrant community engagement.

## 3.1 Goals and objectives

The NACP Phase-V aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline value of 2010 (Figure 5). The NACP Phase-V also aims to attain dual elimination of vertical transmission, elimination of HIV/AIDS related stigma while promoting universal access to quality STI/RTI services to at-risk and vulnerable populations.

**Figure 5. NACP Phase-V Goals**




To achieve the stated goals, the Programme will focus on the epidemics of HIV and STIs while augmenting the synergies with national programme on related co-morbidities like TB and viral hepatitis. The specific objectives of the NACP Phase-V are as below:

| a. HIV/AIDS prevention and control | |
|---|---|
| i. | 95% of people who are most at risk of acquiring HIV infection use comprehensive prevention |
| ii. | 95% of HIV positive know their status, 95% of those who know their status are on treatment and 95% of those who are on treatment have suppressed viral load |
| iii. | 95% of pregnant and breastfeeding women living with HIV have suppressed viral load towards attainment of elimination of vertical transmission of HIV |
| iv. | Less than 10% of people living with HIV and key populations experience stigma and discrimination |
| **b. STI/RTI prevention and control** | |
| i. | Universal access to quality STI/RTI services to at-risk and vulnerable populations |
| ii. | Attainment of elimination of vertical transmission of syphilis |

## 3.2 The HIV and AIDS (Prevention and Control) Act, 2017

The HIV and AIDS (Prevention and Control) Act, 2017 is a landmark legislation to provide for the prevention and control of the spread of HIV and AIDS and for the protection of human rights of persons affected by the HIV/AIDS. The Act aims to address stigma and discrimination so that people infected with and affected by HIV and AIDS are not discriminated in household settings, establishment settings and healthcare settings (Figure 6). The Act also reinstates constitutional, statutory, and human rights of people infected with and affected by HIV and AIDS. It also provides for a robust grievance redressal mechanism in form of Complaints Officer at establishments and Ombudsman at state level.

The HIV and AIDS (Prevention and Control) Act, 2017 will continue to be the cornerstone of the national response to HIV and STI epidemic in NACP Phase-V. The Act will be the enabling framework to break down barriers, driving delivery of a comprehensive package of services in an ecosystem free of stigma and discrimination.

**Figure 6. Salient features of the HIV & AIDS (Prevention & Control) Act, 2017**

## 3.3 Guiding Principles

The NACP Phase-V has specific outputs, outcomes, and impact targets. Eight guiding principles will be central to strategies and activities to attain the specific targets (Figure 7).

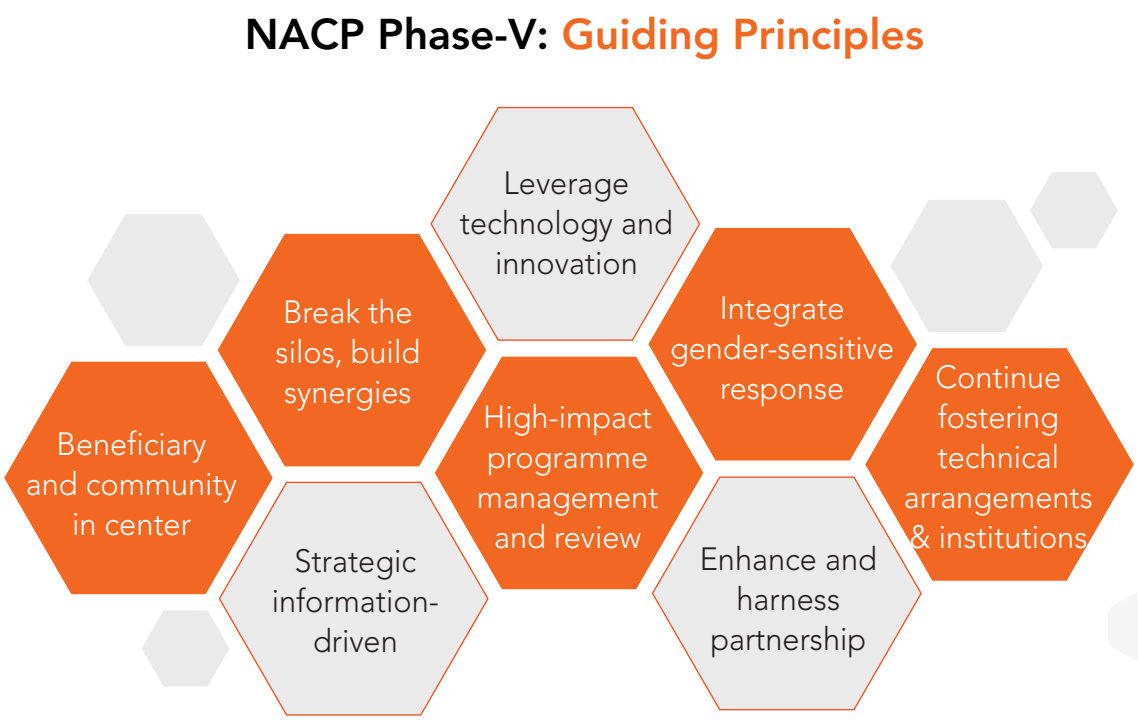
### 3.3.1 Keep beneficiary and community in center

The NACP Phase-V strategies and activities will be implemented with an aim to maximize the benefits to its diverse target population in a friendly ecosystem offering a basket of tailored integrated services across prevention-detection-treatment spectrum. This mean offering of services for relevant communicable diseases, non-communicable diseases, sexual & reproductive health, and mental health through a coordinated systems of referral and linkages. The service delivery will be done protecting and securing the human rights of people infected and affected by HIV in line with the provisions of the HIV and AIDS (Prevention and Control) Act, 2017.

### 3.3.2 Break the silos, build synergies

NACP Phase-V recognizes opportunities available within the Programme as well as in other national health programmes to catalyze progress on stated goals. Break the silos, build synergies will promote coordinated actions, through single window delivery systems along with functional and measurable referral and linkages, within NACP and across national health programmes and related sectors, for an efficient service delivery. This will take into account the local contexts to ensure a suitable, functional and sustainable model.

**Figure 7. Guiding Principles of NACP Phase-V**



The designing, implementation, and monitoring of the beneficiary-centric services will meaningfully involve collaborators and leaders from the community concerned, including those from adolescent, youth and women living with HIV, ensuring beneficiary full ownership and participation in national AIDS response. Structural interventions like community system strengthening and community-led monitoring will navigate beneficiary and community centric approaches under NACP Phase-V.

### 3.3.3 Augment strategic information-driven planning, implementation, monitoring, and mid-course corrections

NACP Phase-V will continue to augment and harness its robust strategic information (SI) systems of programme monitoring, surveillance & epidemiology, and research & evaluation for evidence-led interventions improving the directions and results of a programme. The augmented complementary action-oriented SI systems, with in-built mechanisms of data protection-sharing-quality assurance-analysis-interpretation-dissemination, will be fundamental to all strategies and activities under NACP Phase-V. The augmented SI system will be vital to informed decision making at all levels. The system will be beneficiary centric encompassing granular, real-time, and cross-sectional evidence while engaging and expanding various stakeholders including institutional networks at district, State, regional and national level.

### 3.3.4 Prioritize and optimize through high-impact programme management and review

The strategies and activities of the NACP Phase-V will aim to achieve better return on the investments by augmenting decentralized programme management through District Integrated Strategy for HIV/AIDS (DISHA). The oxygen function of programme management and review (PMR) will rationalize and optimize the resources through synchronizing and bringing together different aspects of high-impact service delivery management with specific focus on robust supply chain management structure at national, State and periphery level. Location and population specific repurposing/integration of the existing service delivery models, backed with role upgradation, capacity building and upskilling, will be fundamental in the programme management under NACP Phase-V.

### 3.3.5 Leverage technology and innovation as critical enablers

Ever-evolving communication and medical technologies (across spectrum of prevention, diagnostics, and treatment) have proliferated every aspect of life. The NACP Phase-V will leverage technology and innovations as critical enablers not only to expand the reach but also for re- shaping of existing HIV interventions improving the efficiency. The Programme will promote local evidence generation on communication and medical innovations gaining the knowledge and experience required to scale novel interventions to entire populations in most cost-efficient manner.

### 3.3.6 Enhance and harness partnership

The NACP Phase-V will continue to foster and augment strategic partnerships to strengthen and support a comprehensive and integrated response at the most granular level. This will include working with government ministries and departments at national, state and district level, multilateral and bilateral agencies, civil society organizations and private sector.

### 3.3.7 Integrate gender-sensitive response

The NACP Phase-V will continue to integrate appropriate gender sensitive HIV/AIDS services improving programme responsiveness to the need of the women living with HIV (WLHIV), young and adolescent girls, vulnerable women, and transgender people. Greater engagement of WLHIV, young and adolescent girls, vulnerable women and transgender people in planning, implementation and monitoring along with gender-disaggregated analysis will be integral to all strategies and activities across the cascade of prevention, testing, treatment, and care.

### 3.3.8 Continue fostering technical arrangements and institutions

The technical rigors in policy formulation, development, and institutionalization under NACP is ensured through arrangements of Technical Resource Groups (TRG) and Technical Working Groups (TWG). The TRG/TWG, usually under chairpersonship/ co-chairpersonship of a subject expert/community (as appropriate), are multidisciplinary with representatives from related stakeholders like programme managers, clinicians, communities, strategic information etc. The TRGs/TWGs provides independent advise to NACP on the given mandate. The technical rigor in implementation at the most granular level is strengthened through technical support units. NACP Phase-V will continue fostering and harnessing of its robust technical arrangements and institutions network providing high quality policy formulation and programme implementation.

## 3.4 Key highlights

The HIV and STI epidemic response will be at a very crucial stage in the NACP Phase-V given the national commitment of achieving the end of the AIDS epidemic by 2030. While the tenets of Test and Treat, Viral Suppression, Prevention and Enabling Environment complying to the HIV/AIDS Act and Rules will remain the backbone of the programme, the recent initiatives of community systems strengthening and differentiated models of treatment and prevention will continue to be built upon.

The unprecedented momentum of the national AIDS response under NACP Phase-IV and Extension would be sustained to anchor the country progress as newer challenges emerge in the form of expanding epidemic in many States, very high level of HIV/AIDS epidemic in north-eastern States, more and more of HRG population using virtual platforms to solicit clients and rising prevalence of high-risk behaviors among the general population.

While the existing interventions will be sustained, optimized, and augmented, newer strategies will be adopted, piloted, and scaled-up under the programme to respond to the geographic and community specific needs and priorities (Figure 8). The need for newer approaches has been well reflected in epidemic heterogeneity, evolving programmatic context, community expectations and in the provisions of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017.

**Figure 8. Goals, objectives, and strategic interventions under NACP Phase-V**

| Goals |
|---|
| To reduce annual new HIV infections and AIDS-related death by 80% since the baseline value of 2010; Eliminate Vertical Transmission of HIV and Syphilis; Eliminate HIV/AIDS-related Stigma and Discrimination; Promote Universal Access to Quality STI/RTI Services |

| Objectives | | | |
|---|---|---|---|
| 95% of people who are most at risk of acquiring HIV infection use comprehensive prevention | 95% of HIV positive know their status, 95% of those who know their status are on treatment and 95% of those who are on treatment have suppressed viral load | 95% of pregnant and breastfeeding women living with HIV have suppressed viral load towards attainment of elimination of vertical transmission of HIV | Less than 10% of people living with HIV and key populations experience stigma and discrimination |
| Promote universal access to quality STI/RTI services to at-risk and vulnerable populations; Attainment of elimination of vertical transmission of Syphilis | | | |

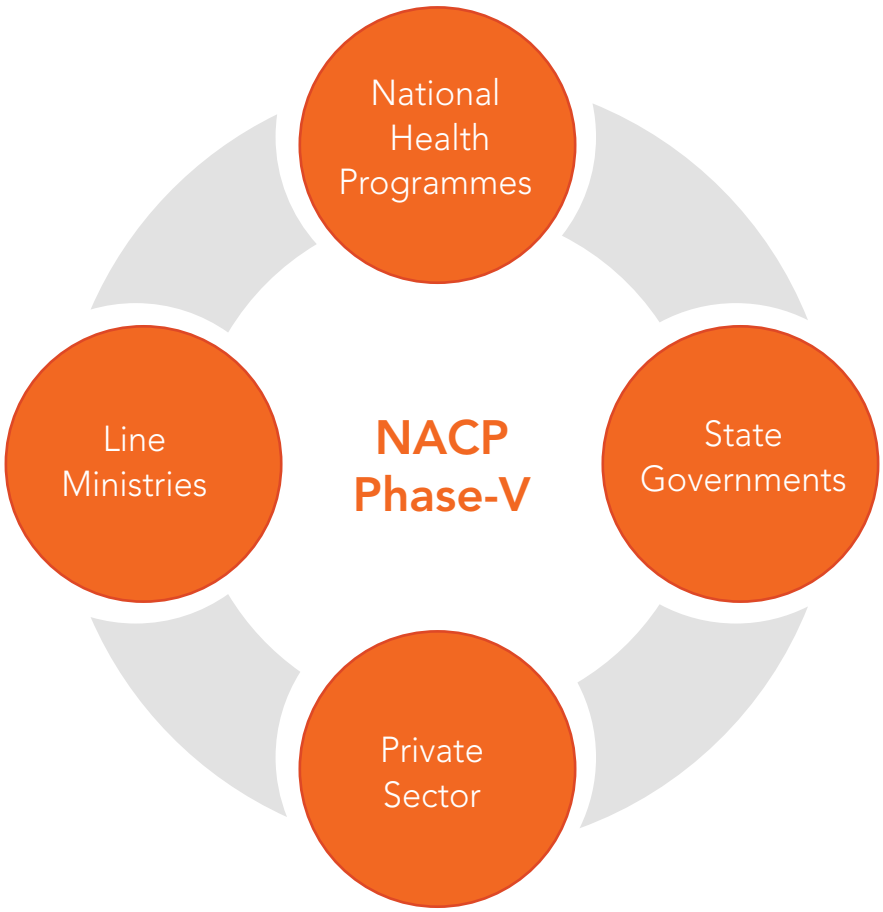
| Strategic Interventions | | | |
|---|---|---|---|
| New generation communication strategy | Reaching the Missing million - The virtual approach | Promoting integrated service delivery through one-stop centers | Provision of comprehensive package of services through "Sampoorna Suraksha" |
| Augmenting contact tracing and index testing promoting early detection of undiagnosed infections | Leveraging dual test kits (HIV & Syphilis) for dual elimination and integrated service package to the people who are at higher risk | Addressing linkage loss at all levels | Differentiated care model augmenting adherence |
| Prioritize sexual and reproductive health services for women at increased risk of HIV infection and women living with HIV | Adapting new approaches to expand the reach of viral load testing services | Enhancement of private sector engagement | I.T. enabled client centric integrated monitoring, evaluation, and surveillance system |
| Enhancement of community support through community system strengthening | Building and augmenting Synergies | Anchoring the response through focused programme management and review | Enhancing the strategic information systems to meet the evidence needs in ever evolving and dynamic epidemiological and programmatic context |
| Leveraging technology to bring efficiency and expand the reach of the services. | | | |
| Consolidation and expansion of existing interventions across prevention-testing-treatment continuum with critical enablers of IEC, laboratory services and strategic information management. | | | |

## 3.5 Collaboration with public and private sectors

NACP Phase-V will build upon the systematized convergence with the existing schemes of Central Government including synergy with National health programme, related line ministries like Ministry of Social Justice and Empowerment (MoSJE) as well as State Governments to increase the reach of the services while bringing efficiency to the programme (Figure 9). It will maintain and augment its convergence with National TB Elimination Programme (NTEP) through HIV-TB cross-referrals and single window delivery of TB and HIV services at all antiretroviral therapy centers.

Surveillance systems under the National AIDS Control Programme are also facilitating evidence generation for National Viral Hepatitis Surveillance Programme (NVHSP) with the integration of Hepatitis B and Hepatitis C as additional biomarker. The NACP Phase-V and National Viral Hepatitis Control Programme (NVHCP) will engage and explore designing and delivering of an integrated package of services, especially for key populations.

**Figure 9. Convergence architecture under NACP Phase-V**



North-eastern States of Mizoram, Nagaland and Manipur have been severely impacted by HIV/AIDS epidemic with a rising trend at a very high level. Then there are hot spots in States of Assam, Meghalaya, and Tripura. NACP will engage with National Health Mission, the Ministry of Development of Northeastern Region, the North Eastern Council and all other line departments to halt and reverse the epidemic curve in the region for community-led planning, implementation, and monitoring of integrated AIDS response in north-eastern States.

NACP Phase-V will continue to endeavor to link its clients to all other related national health programmes in a cost-efficient manner. It will include leveraging the existing NACP systems through technology-enabled approaches for linking the beneficiaries to respond to their mental health need. NACO will continue to work with MoSJE to extend the coverage of de-addiction centers and various social protection schemes of MoSJE to the eligible high-risk group, bridge population as well as PLHIV.

Mainstreaming & partnerships under NACP has impacted positively in vulnerability reduction through inclusion in programme & policy, awareness generation through training and sensitization, expansion of HIV related services in existing health services of non-health Ministries, Public Sector Undertakings and extending social protection benefits through active linkages of marginalized persons including people infected and affected by HIV and AIDS. As of now, NACO has formalized a partnership with 18 key Ministries & Departments of Government of India to strengthen the multi-sectoral response to HIV. NACP Phase-V will further mainstream and partnership extending the reach of various HIV related services in a cost-neutral way.

The collaboration framework of NACP Phase-V includes continued strategic engagement with private sector. India's private health sector is vast and heterogeneous, encompassing small clinics to large multi-specialty hospitals, laboratories and pharmacies. Despite legislation such as the Clinical Establishments Act, the private sector does not uniformly comply with programmatic testing and treatment protocols, or report diseases of public health relevance to the national health program. The NACP Phase-V will engage with corporates and professional medical associations to mainstream the HIV prevention-testing-treatment services under a given framework providing a high quality of prevention-testing-treatment services at private sector in accordance with national guidelines.

## 3.6 Budget

The NACP Phase-V will be implemented for a period of 5 years from 1st April 2021 to 31st March 2026 with a total outlay of Rs. 15,471.94 crore (Table 10). This outlay is almost 12 times of the expenditure incurred in FY 2014-15 and 1.63 times of the expenditure incurred during the whole of NACP Phase-IV Extension. The NACP Phase-V will be predominantly (~ 93%) supported through domestic budget. The outlay for NACP Phase-V includes Rs 705 crore from the current grant cycle (01.04.2021 to 31.03.2024) of The Global Fund.

## 3.7 Outputs and Outcomes

The NACP Phase-V will achieve the physical and output targets along with the outcome targets in line with the stated goals. Table 11 presents the year-wise target under the NACP Phase-V.

**Table 10. Component-wise and year-wise outlay under NACP Phase-V***

| S. No | Programme Components | Budget by years (INR in crore) 2021-22 | 2022-23 | 2023-24 | 2024-25 | 2025-26 | Total |
|---|---|---|---|---|---|---|---|
| **A. State Grant in Aid (GIA)** | | | | | | | |
| 1 | Targeted Interventions including Link worker Scheme | 421.11 | 433.75 | 446.76 | 460.16 | 484.92 | 2246.69 |
| 2 | Blood safety | 82.95 | 85.43 | 88.00 | 90.64 | 95.51 | 442.53 |
| 3 | Sexually transmitted infections | 29.17 | 30.04 | 30.94 | 31.87 | 33.59 | 155.61 |
| 4 | Information, Education & Communication (IEC) & Mainstreaming | 74.74 | 76.98 | 79.29 | 81.67 | 86.07 | 398.76 |
| 5 | Lab Services | 21.88 | 22.53 | 23.21 | 23.90 | 25.19 | 116.71 |
| 6 | Care, Support & Treatment | 241.55 | 248.79 | 256.26 | 263.95 | 278.15 | 1288.68 |
| 7 | Integrated Counselling and Testing Centers (ICTC)/Basic Services Division (BSD) | 337.25 | 347.37 | 357.79 | 368.52 | 388.35 | 1799.30 |
| 8 | Institutional Strengthening and Programme Management | 160.42 | 165.24 | 170.19 | 175.30 | 184.73 | 855.88 |
| 9 | Strategic Information | 10.93 | 11.27 | 11.60 | 11.95 | 12.60 | 58.35 |
| 10 | Sub-total (State GIA) | 1380.00 | 1421.40 | 1464.04 | 1507.96 | 1589.11 | 7362.51 |
| **B. Central Level Expenditure** | | | | | | | |
| 11 | Antiretroviral (ARV) Drugs | 883.43 | 909.93 | 937.23 | 965.35 | 1017.30 | 4713.24 |
| 12 | ICTC Kits and Prevention of Parent to Child Transmission of HIV/AIDS (PPTCT) Medicine & HIV Test Kits | 77.14 | 79.45 | 81.84 | 84.29 | 88.84 | 411.56 |
| 13 | Opioid substitution therapy (OST) Drugs | 34.39 | 35.43 | 36.49 | 37.59 | 39.60 | 183.50 |
| 14 | Blood Bags & Testing Kits | 68.79 | 70.85 | 72.98 | 75.17 | 79.21 | 367.00 |
| 15 | Sexually Transmitted Infections / Reproductive Tract Infections Kits | 14.74 | 15.18 | 15.64 | 16.11 | 16.97 | 78.64 |
| 16 | Viral Load, EID & CD4 Test Kits | 230.93 | 237.86 | 244.99 | 252.35 | 265.93 | 1232.06 |
| 17 | IEC | 62.89 | 64.78 | 66.72 | 68.72 | 72.42 | 335.53 |
| 18 | Human Resource | 2.95 | 3.04 | 3.13 | 3.22 | 3.39 | 15.73 |
| 19 | Supply Chain Function | 29.48 | 30.36 | 31.28 | 32.21 | 33.95 | 157.28 |
| 20 | Allied professional services/Institutional Strengthening at Central Level including Surveillance, Research, and TSU | 94.13 | 96.96 | 99.86 | 102.86 | 108.39 | 502.20 |
| 21 | Capital | 21.13 | 21.76 | 22.41 | 23.08 | 24.31 | 112.69 |
| 22 | Sub-total (Central Level Expenditure) | 1520.00 | 1565.60 | 1612.57 | 1660.95 | 1750.31 | 8109.43 |
| **C. Grand Total** | | | | | | | |
| 23 | Grand Total | **2900.00** | **2987.00** | **3076.61** | **3168.91** | **3339.42** | **15471.94** |

* Blood transfusions services and NBTC transitioned to Directorate General of Health Services, MoHFW in the beginning of NACP Phase-V.

**Table 11. Year-wise output/outcome target under NACP Phase-V**

| S No | Indicator | Year-wise targets | | | | |
|---|---|---|---|---|---|---|
| | | 2021-22 | 2022-23 | 2023-24 | 2024-25 | 2025-26 |
| **A.** | **Physical and output targets** | | | | | |
| 1 | No. of calls received at AIDS Helpline (1097) (In lakh) | 5.5 | 6.1 | 6.7 | 7.3 | 8.1 |
| 2 | No. of Targeted Interventions (TI) | 1663 | 1735 | 1808 | 1880 | 1927 |
| 3 | No of districts with the Link Worker Scheme (LWS) | 165 | 175 | 185 | 195 | 200 |
| 4 | No. of HRG, bridge and vulnerable population covered through TI/LWS (In lakh) | 102.4 | 105.92 | 109.12 | 111.81 | 113.91 |
| 5 | No. of OST Centers | 400 | 450 | 500 | 550 | 600 |
| 6 | No. of IDU on OST (In lakh) | 0.38 | 0.42 | 0.48 | 0.54 | 0.63 |
| 7 | No. of 'Sampoorna Suraksha' Centers | 25 | 75 | 150 | 250 | 400 |
| 8 | No. of contacts with 'at-risk' population through 'Sampoorna Suraksha' Centers (In lakh) | 0.22 | 0.65 | 1.31 | 2.18 | 3.48 |
| 9 | No. of STI/RTI patients managed (In lakh) | 100.16 | 106.7 | 112.1 | 117.7 | 123.5 |
| 10 | No. of 'at-risk' population (excluding pregnant women) tested for HIV (In lakh) | 252 | 265 | 278 | 292 | 306 |
| 11 | No. of pregnant women tested for HIV (In lakh) | 252 | 265 | 278 | 292 | 295 |
| 12 | No. of pregnant women tested for Syphilis (In lakh) | 176.4 | 190.8 | 205.72 | 221.92 | 230.1 |
| 13 | No of ART Centers | 597 | 627 | 657 | 683 | 703 |
| 14 | No of Link ART Centers | 1294 | 1324 | 1354 | 1380 | 1400 |
| 15 | No of Care Support Centers | 100 | 200 | 300 | 350 | 400 |
| 16 | No. of PLHIV on ART (Cumulative)* (in lakh) | 15.30 | 16.77 | 18.25 | 19.72 | 21.20 |
| 17 | No. of viral load test conducted among PLHIV on ART (in lakh) | 11.00 | 13.50 | 16.00 | 18.50 | 21.00 |
| **B.** | **Outcome targets** | | | | | |
| 1 | Percent of estimated PLHIV who know their HIV status | 79 | 82 | 86 | 91 | >=95 |
| 2 | Percent of PLHIV who know their HIV status and are on ART | 84 | 87 | 90 | 93 | >=95 |
| 3 | Percent of PLHIV who are on ART and are virally suppressed | 84 | 87 | 90 | 93 | >=95 |
| 4 | Percent of estimated pregnant women tested for HIV | 84 | 88 | 93 | >=95 | >=95 |
| 5 | Percent of PLHIV reporting experiencing stigma and discrimination in healthcare and community settings# | - | - | - | - | <10% |
| 6 | % HRGs reporting use at least one of comprehension prevention methods during last high-risk behavior act# | - | - | - | - | >=95% |

* Including PLHIV on ART in private sector, # baseline and intermediate targets to be developed for these indicators

# 4. Goal 1: Reduce annual new HIV infections by 80%

More than 99.5% of adult population in India is HIV free. Still, the incidence rate is high in certain States and among high-risk groups. Between 2010 and 2020, the new HIV infections declined by 48%, yet there is a long way to go to achieve 90% decline by 2030. NACP Phase-V will accelerate reduction in new annual HIV infections through a basket of strategies tailored to the high-risk, at-risk and low-risk population groups.

## 4.1 Continue and evolve the existing peer-led targeted interventions (TI) and Link Worker Schemes (LWS) strategies for integrated services

The peer-led TI and LWS have been extremely successful reaching out to HRGs (FSW, MSM, IDU, H/TG people), bridge population (migrants, and truckers) and other vulnerable groups at physical locations year after year. The interventions have evolved offering a comprehensive package of services across prevention-testing-treatment spectrum through a revamped model. NACP Phase-V will build upon the time-tested strategy of peer-led interventions offering differentiated services meeting the needs of people and communities. Newer technology like dual test kits for HIV and Syphilis, will be introduced in the TI and LWS settings to break-down barriers in service uptake. The interventions would continue to evolve to offer integrated package of services through referral and linkages for evidence-backed relevant co-morbidities such as viral hepatitis, tuberculosis, sexual and reproductive health, mental health, and noncommunicable diseases.

## 4.2 Promote evidence-backed comprehensive prevention packages tailored to location and population

The toolbox for HIV prevention is ever growing with more and more options being made available. With growing evidence, the dichotomy between treatment and prevention is becoming more and more artificial. NACP Phase-V will continue to facilitate evidence generation in diverse location and population settings on newer prevention models in Indian setting. The evidence-backed models will be promoted under basket of prevention models through context-specific differentiated approaches.

**Table 12. Reducing New HIV Infections: Strategies at a glance**

| S. No. | Strategy |
|---|---|
| 1 | Continue and evolve the existing peer-led targeted interventions (TI) and Link Worker Schemes (LWS) strategies for integrated services |
| 2 | Promote evidence-backed comprehensive prevention packages tailored to location and population |
| 3 | Strengthen the population size estimation and field epidemiological intelligence for coverage expansion and saturation |
| 4 | Expand and intensify the coverage of NACP interventions including OST among Injecting Drug Users (IDU) |
| 5 | Universalize the NACP interventions in prisons and other closed settings through a mix of service delivery models |
| 6 | Pilot and scale-up models for community-based integrated service delivery models |
| 7 | Redefine and expand coverage among the bridge population |
| 8 | Develop and roll-out new generation communication strategy suitable to current context |
| 9 | Cover 'at-risk' HIV negative through comprehensive prevention packages to keep them negatives |
| 10 | Develop and scale-up sustainable models for 'at-risk' Virtual Population |
| 11 | Maintain and augment the behavior change communications for general population |
| 12 | Sustain focus on adolescent and youth population |

## 4.3 Strengthen the population size estimation and field epidemiological intelligence for coverage expansion and saturation

NACP Phase-V will continue to strengthen the system of periodic, community-led, cross- sectional programmatic mapping, and population size estimation at the most granular level to inform the location and population-based interventions initiation, shifting and scale-up. Capacity building, community engagements and institutional networking will be fundamental to the strengthening of p-MPSE activities. NACP Phase-V will further strengthen the reporting and use of field epidemiological intelligence to inform the initiation, scale-up and modifications in the implementations as early as possible.

## 4.4 Expand and intensify the coverage of NACP interventions including OST among Injecting Drug Users (IDU)

HIV prevalence among IDUs continue to be unacceptably high. NACP Phase-V will respond to the IDU epidemic by expanding the coverage based on the p-MPSE and local epidemiological intelligence. This will include expansion of comprehensive harm reduction services of needle-syringe exchange programme (NSEP) and opioid substitution therapy (OST) through direct offering and convergence with the MoSJE adopting evidence-backed implementation modalities. The linkages and referrals with NVHCP will be specifically developed and harnessed to reduce morbidity from viral hepatitis among IDUs.

## 4.5 Universalize the NACP interventions in prisons and other closed settings through a mix of service delivery models

HIV prevalence among inmates in some settings is higher than that among other HRGs and bridge population groups. Even among the inmates, the prevalence is much higher among the under-trials than that of convicts. In the settings with high HIV prevalence among IDUs, higher prevalence of Hepatitis-C virus among prisoners has been noted. NACP Phase-V will cover every prison in the country through a mix of facility and outreach-based services. In the facility settings, counselling, testing, and treatment services will be focused for integrated package of HIV, TB, and Hepatitis when inmates are inside the prisons. To the extent possible, the facility-based services will be offered through the mainstreamed health systems of the prisons. The outreach arm will offer the services, directly or through the referral/linkages, for the released inmates.

## 4.6 Pilot and scale-up models for community-based integrated service delivery models

HRGs continue to face substantial structural and interpersonal barriers to access NACP services, increasing their risk of HIV acquisition. Integrated or combination approaches to HIV prevention service provision may reduce stigma or logistical barriers. The NACP Phase-V will pilot and scale the community-based models like 'One-Stop Centre' among HRGs offering integrated services to meet a wide range of healthcare needs of the population group including mental health, drug deaddiction, social protection, etc.

## 4.7 Redefine and expand coverage among the bridge population

The HIV epidemic continues to be concentrated in nature in India. Migrants and truckers are covered as bridge population group under NACP through TI, Employer Led Models, and LWS. However, there may be other population groups under the broader umbrella of bridge population. NACP Phase-V will generate evidence to understand the bridge population and its network better to inform offering of the tailored package of services through suitable intervention models.

## 4.8 Develop and roll-out new generation communication strategy suitable to current context

NACP Phase-V interventions for the population in the urban and rural locations will work towards offering of a comprehensive and integrated service delivery package. Many of the target population may not identify themselves as being at risk and have poor risk perception. The communication strategy would be suitably developed and rolled out, leveraging the internet and mobile-based applications, to expand the reach and impact of NACP services. The communication messages would be specifically tailored to young people and 'at-risk' people focusing on risk perceptions and service uptake.

## 4.9 Cover 'at-risk' HIV negative through comprehensive prevention packages to keep them negative

The prevention under NACP has traditionally directly covered HRG people (female sex workers, men who have sex with men, IDU, hijra/ tansgender people, migrants, and truckers) through TI and LWS. However, new infections are happening among other population groups also. In 2015-16,

less than 5% of the total detections at NACP's Integrated Counselling and Testing Centers (ICTC) were HRG. The National Family Health Survey-IV (2015-16) reported around 7% of men and 1% of women in 15-49 yrs. age group, who were sexually active in last 12 months, engaged in higher-risk sexual intercourse. As evident, there are other population groups also who are 'at-risk' of acquiring HIV or STIs due to risky behavior of self or partner.

NACP Phase-V will implement the Sampoorna Suraksha Strategy (SSS) to cover 'at-risk' HIV negative but non-TI population through a cyclical and comprehensive package of services as per their needs to keep them HIV free, thus boosting the country's progress on prevention of new HIV infections. The direct-walk in clients at ICTCs, who perceives them at the risk of HIV infection because of their past/current HIV/AIDS related risk behaviors are the primary targets for SSS. Besides, the SSS will also cater to the need of 'at-risk' HIV negative but non-TI population identified through risk-screening at ICTC, STI/RTI clinics, virtual outreach and National HIV/AIDS toll free helpline.

## 4.10 Develop and scale-up sustainable models for 'at-risk' Virtual Population

In the last decade, India has experienced massive growth in internet access and therefore social media usage. There are over 280 million Facebook users and an estimated 2.7 billion WhatsApp users in India, making it the leading country in terms of Facebook and WhatsApp audience. India ranked second in the world with 88 million Instagram users[69].

The massive internet access in India has not left the key and vulnerable populations untouched. Increasingly MSM, sex workers, as well as many young persons are using internet-based platforms and communication technologies to socialize, seek sexual partners, and find a sense of community. These persons do not perceive risk and are misinformed regarding HIV/STI and its spread. The NACP Phase-V will develop and scale sustainable models to initiate and strengthen the HIV prevention efforts, including access to HIV testing among key and vulnerable populations (High-risk groups and at-risk adolescents and youth, men, and women with high-risk behaviors) seeking partners on virtual platforms. National Toll-Free AIDS Helpline – 1097 would be anchoring the linkage between the virtual platforms and NACP service delivery points.

## 4.11 Maintain and augment the behavior change communications for general population

With more than 99.5% of adult population free of HIV, NACP Phase-V will maintain and augment the behavior change communications for general population through a mix of multimedia campaigns and outdoor activities. Continuous leveraging of social media would be fundamental to NACP Phase-V efforts to increase the reach in a most cost-efficient manner. National Toll-Free AIDS Helpline – 1097 would be anchoring not only the information dissemination but would also actively link the target population for access to services.

## 4.12 Sustain focus on adolescent and youth population

NACP has always provided high priority to adolescent and youth population through specific interventions like adolescence education programme (AEP), red ribbon clubs (RRC) and out of school youths programme. NACP Phase-V will continue to sustain the focus on adolescent and youth population to promote safe behavior practices through peer designed and led programme. NACP Phase- V will further augment access to and uptake of prevention, testing, and treatment services in line with national laws, policies, and context through mainstreaming of tailored age and gender appropriate context at each service delivery points.

# 5. Goal 2: Reduce AIDS-related mortalities by 80%

The country has made significant progress on reducing AIDS-related mortality with 82% decline between 2010 and 2020. This has been made possible with rapid expansion of screening, testing, and treatment services along with the game changer initiatives of the HIV/AIDS (Prevention and Control) Act, Test and Treat, and Universal Viral Load Testing. By 2020-21, country has achieved 78–83–85 i.e., 78% of people living with HIV knew their status, 83% of people living with HIV who know their status were accessing antiretroviral therapy and 85% of people accessing treatment had suppressed viral loads. NACP Phase-V will build upon the strong momentum and further accelerate the reductions on AIDS-related mortalities through strategies directed across care continuum. This will also contribute to prevention of new HIV infections through attainment of viral load suppression among PLHIV.

## 5.1 Maintain the existing models of HIV counselling and testing services (HCTS) and expand through strategic scale-up

Under NACP, HIV counselling, and screening/ testing services are provided through a mix-model of standalone facilities, mobile vans, facility-integrated facilities (in both government and private sectors) and community-based screening (CBS). This has rapidly increased the reach of HCTC services tremendously with more than 5 crore of HIV screening and testing in 2019-20. NACP Phase-V will continue to maintain the existing models and focus on strategic scale-up in public as well as private sector, aligned with location and population context, through facility integrated and CBS models.

## 5.2 Develop and roll-out tailored communication campaigns focusing on risk perception and HCTS uptake

NACP Phase-V will complement the HCTS models with communication campaigns, tailored to epidemiological contexts of location and population, to augment self-risk perception and demand generation. This will include the focus on adolescent and youth while harnessing the platforms of adolescence education programme, red ribbon clubs and out of school youths.

## 5.3 Augment the existing HCTS models with efficient approaches for active case findings promoting early detections

The NACP Phase-V will improve the yield from existing models with focus on the efficient approaches like social-network based HIV testing, index testing and repeat screening/testing among discordant couples promoting early detection of undiagnosed infections. The efficient approaches to improve the case findings and bridge the gap in first 95 will be implemented within data confidentiality-protection-sharing framework of the HIV & AIDS (Prevention and Control) Act, 2017.

**Table 13. Reduce AIDS-related mortalities: Strategies at a glance**

| S No | Strategy |
|---|---|
| 1 | Maintain the existing models of HIV counselling and testing services (HCTS) and expand through strategic scale-up |
| 2 | Develop and roll-out tailored communication campaigns focusing on risk perception and HCTS uptake |
| 3 | Augment the existing HCTS models with efficient approaches for active case findings promoting early detections |
| 4 | Appropriately adapt evidence-backed newer technologies to supplement existing models |
| 5 | Maintain existing care, support, and treatment (CST) services models and expand further through sustainable manner |
| 6 | Continue provisions of high-quality ARV through differentiated service delivery models improving access and retention to care |
| 7 | Focus on rapid ART initiation and advanced HIV disease management augmenting quality of care |
| 8 | Suitably update the treatment guidelines periodically |
| 9 | Address linkage loss at all levels |
| 10 | Optimize the uses of public sector laboratories for viral load measurements |
| 11 | Offer integrated service delivery packages to 'at-risk' people and PLHIV |
| 12 | Prioritize sexual and reproductive health services for women at increased risk of HIV infection and women living with HIV |
| 13 | Bring efficiencies and improve linkages through single window service delivery models |
| 14 | Maintain and expand laboratory quality assurance system |

## 5.4 Appropriately adapt evidence-backed newer technologies to supplement existing models

NACP Phase-V will continue to adapt evidence-backed newer testing technologies and innovative strategy to reach UNAIDS targets to end HIV by 2030. This will include facilitation of evidence generation on newer testing technologies like HIV self-testing in diverse location and population settings for informed decision making and implementation modalities.

## 5.5 Maintain existing care, support, and treatment (CST) services models and expand further through sustainable manner

CST services under NACP is provided through three-tiered structures. PLHIV enter the CST service models through Anti-retroviral treatment (ART) centers. Subsequently, PLHIVs are linked with link ART centers and care & support centers for decentralized dispensation, counselling and follow-ups. PLHIVs are linked to Centers of Excellence (CoE) and ART Plus Centers for timely initiation of second and third-line ART. NACP Phase-V will maintain the three-tiered model. Further, NACP Phase-V will expand the CST service delivery points in a sustainable manner tapping the

public as well as private sector. This will include saturation of medical colleges by opening ART centers as per the clause in National Medical Commission Notification dated 28th October 2020. NACP Phase-V will also expand the CST service delivery models through suitable engagement with private sector comprising private physicians, private hospitals, and private laboratories within national frameworks.

## 5.6 Continue provisions of high-quality ARV through differentiated service delivery models improving access and retention to care

NACP adopted 'Test and Treat' policy in 2017 and then introduced Dolutegravir-based treatment regimen in 2020. NACP Phase-V will fast-track and complete transition of PLHIV on high-quality Dolutegravir-based treatment regimen ensuring fewer side effects, better retention, rapid viral load suppression and improved quality of life. Dolutegravir-based regimen will also be considered suitably for Post-Exposure Prophylaxis (PEP). The differentiated approaches like multi-month dispensation, community-based refill etc. for eligible PLHIV will be scaled-up not only to bring the services closer to the PLHIV but also to decongest ART centers. This will further improve the adherence thus facilitating the attainment of viral load suppression.

## 5.7 Focus on rapid ART initiation and advanced HIV disease management augmenting quality of care

A significant proportion of PLHIV continue to present with very low CD4 counts and advanced disease. Rapid ART initiation will improve clinical outcomes not only for those with late diagnosis but also among the rest promoting better retention, improved adherence, and rapid viral load suppression. NACP Phase-V will make all efforts to facilitate ART initiation within seven days from the day of HIV diagnosis. ART initiation would be offered on the same day to PLHIV who are ready to start. People with advanced HIV disease would be given priority for assessment.

## 5.8 Suitably update the treatment guidelines periodically

The science of high-quality anti-retroviral are ever emerging. Dual therapy options are in development that reduce the burden of drug classes. Long-acting formulations in the form of injectables, implants and once a month Injection has potential to simplify disease management, thus facilitating better retention and rapid viral load suppression. NACP Phase-V will facilitate evidence generation on more effective treatment technologies and adopt/advocate the suitable options under national treatment frameworks through appropriate implementation modalities.

## 5.9 Address linkage loss at all levels

In 2019-20, for every 100 people detected with HIV infection, only 65 are retained on ART at 12 months since detection. This linkage loss starts right from screening centers (facility integrated HIV counselling and testing centers) when those who are screen reactive do not reach to the confirmatory centers. There is further linkage loss from confirmatory centers to the antiretroviral treatment (ART) centers and finally, even after reaching ART centers, not all HIV positive individuals are initiated or retained on lifelong antiretroviral. This linkage loss adversely impacts the progress on all the three 95s.

NACP Phase-V will mitigate linkage loss across screening-confirmation-treatment-retention by leveraging technology, strengthening outreach, upskilling field resources, improving counselling and building synergy across service delivery points. Predictive analysis will apply statistical algorithms and machine learnings on the integrated database to generate alert and offer customized step-up counselling and follow-up services to clients at the risk of linkage loss. Adoption of clinical decision support systems using artificial intelligence will also help in identification of PLHIV requiring additional care and attend to the same timely. These initiatives, in turn, will promote retention and adherence towards rapid viral load suppression.

## 5.10 Optimize the uses of public sector laboratories for viral load measurements

Currently, there are 64 public sector viral load laboratories under NACP. The laboratories were initially testing samples from co-located ARTCs but in NACP Phase-V, the viral load testing at these laboratories will be optimized through systematic mapping and linkages complementing the public-private model of viral load testing. The programme will introduce and scale-up Dried Blood Spot method as a sample collection method for optimizing the use of public sector laboratories. Also, the capacity of select laboratories in public sector would be enhanced to initiate laboratory-based monitoring of HIV drug resistance.

## 5.11 Offer integrated service delivery packages to 'at-risk' people and PLHIV

NACP Phase-V recognizes the need for integrated service delivery approach to 'at-risk' people and PLHIV for their overall wellbeing. The need for the linking to services for communicable diseases (Tuberculosis, Viral Hepatitis etc.), non-communicable diseases, mental health etc. is well established. NACP Phase-V will offer integrated service delivery packages through establishing referrals and linkages in coordination with related national health programmes.

## 5.12 Prioritize sexual and reproductive health services for women at increased risk of HIV infection and women living with HIV

The offering of a comprehensive package of sexual and reproductive health services to women who are at increased risk of HIV infection as well as to the women living with HIV/AIDS is increasingly being recognized as fundamental to the integrated AIDS response. The NACP Phase-V will offer age and population appropriate need-based comprehensive package of sexual and reproductive health services to those who are at increased risk of HIV infection as well as to the women living with HIV/AIDS. This will be achieved through upskilling at NACP service delivery points as well as augmenting synergies through National Health Mission.

## 5.13 Bring efficiencies and improve linkages through single window service delivery models

In a healthcare set-up, NACP services are provided through different centers; each with its own dedicated personnel for a given mandate. There are Designated STI/RTI Centers (DSRCs) which focus on STI/RTIs. Then, there are Integrated Counselling and Testing Centers (ICTCs) offering HCTS. Many of the facilities also have ART, Link ART, CoE etc. for offering treatment services.

Medical colleges/district hospitals are provided with one or more of dedicated laboratory networks in the form of State Reference Centers (SRC), State Reference Laboratories (SRL), Regional STI Training, Research, and Reference Laboratories (RSTRRL), National Reference Laboratories (NRL), Early Infant Diagnosis (EID) Laboratories and Viral Load Laboratories. NACP Phase-V will undertake re-engineering of service delivery models in appropriate locations through role upgradation, space management, IT-enabled models etc. backed by suitable upskilling.

## 5.14 Maintain and expand laboratory quality assurance system

Delivering correct tests is fundamental to the success of any public health programmes. NACP Phase-V will continue to have three-tiered external quality assessment system as one of the key strategies under NACP Phase-V. The external quality assurance system (EQAS) will be expanded beyond HIV testing and will include other related components of the Programme like STI/RTI management, especially given the context of the laboratory quality assurance as one of the foundational requirements of dual elimination. This will include framing/ upgradation of proficiency testing, inter-lab comparisons, laboratory accreditations etc.

# 6. Goal 3: Eliminate vertical transmission of HIV and Syphilis

The programme for prevention of vertical transmission of HIV was launched under the second phase of the National AIDS and STD Control Programme (NACP) of the Government of India in the year 2002. Since then, elimination of vertical transmission of HIV and Syphilis remains as one of the key objectives under NACP. Initially, the aim was to attain elimination of vertical transmission of HIV by 2015 which was subsequently shifted to 2020.

However, in 2020-21, testing coverage for HIV and syphilis among pregnant women was at 76% and 37% respectively. Even among identified positives, not everyone was initiated or retained on ART. Similarly, only half of the ANC attendees with a positive syphilis serology were treated adequately. These progresses are far from global guidance on targets for elimination of vertical transmission (Table 14). The global guidance also refers to foundational requirements of data, laboratory, programme, human rights, gender, and community. The NACP Phase-V takes into account the global guidance towards elimination of vertical transmission of HIV and Syphilis.

**Table 14. Impact and process indicators and targets for elimination of vertical transmission of HIV and Syphilis**

| Infection | Indicator Type | Indicator | Target |
|---|---|---|---|
| HIV | Impact | HIV mother-to-child transmission (MTCT) rate, and | <5% (breastfeeding populations) OR <2% (non-breastfeeding populations) |
| | | Case rate of new paediatric HIV infections due to MTCT | ≤50 per 100,000 live births |
| | Process | ANC-1 coverage (at least one visit)<br>Coverage of HIV testing among pregnant women<br>ART coverage of pregnant women living with HIV | ≥95%<br>≥95%<br>≥95% |
| Syphilis | Impact | Case rate of Congenital Syphilis (CS) | ≤50 per 100,000 live births |
| | Process | ANC-1 coverage (at least one visit)<br>Coverage of syphilis testing among pregnant women<br>Adequate treatment coverage of syphilis-seropositive pregnant women[c] | ≥95%<br>≥95%<br>≥95% |

[c] Syphilis seropositive pregnant women received at least one dose of intramuscular benzathine penicillin G at least 30 days prior to delivery

## 6.1 Augment comprehensive synergy with National Health Mission (NHM) for testing of pregnant women for HIV and Syphilis

Screening of pregnant women for HIV and Syphilis was made an integral component of the routine ANC check-up in July 2010. NACP Phase-V will further build upon this guidance and work with NHM at the most granular level to increase the coverage of both, HIV and syphilis testing. This will be done through focus on various aspects such as capacity building, supply chain management and review at the most granular level. The universalization of HIV and Syphilis testing will be driven through district prioritization, as available under NACP, ensuring saturation across all districts in a phased manner.

Augmenting synergy will also include mainstreaming of HIV testing data reported through NHM portal i.e., health management information system (HMIS) and reproductive and child health (RCH) portal. Systems will be developed through which data about screened reactive are immediately transferred to NACP systems for immediate follow-up services of confirmatory testing and subsequent linkages to CST services. For the progress on elimination of congenital syphilis, this will also include working with NHM to develop a case reporting system for the exposed children.

## 6.2 Strengthen the primary prevention through coordinated actions

Primary prevention of HIV and Syphilis among women is the foundation for achievement and maintenance of dual elimination. NACP Phase-V will build upon the strategies for primary prevention among general population with focus on elimination of vertical transmission as one of the key thematic areas. Coordination and synergy with NHM will be leveraged for awareness generation along with promotion of behavior change for adoption of safe practices suitably. Adolescents and young population would be specifically focused by working through available opportunities including that of NHM (Rashtriya Kishor Swasthya Karyakram) and NACP (RRC, AEP etc.).

**Table 15. Eliminate vertical transmission of HIV and Syphilis: Strategies at a glance**

| S No | Strategy |
|---|---|
| 1. | Augment comprehensive synergy with NHM for testing of pregnant women for HIV and Syphilis |
| 2. | Strengthen the primary prevention through coordinated actions |
| 3. | Introduce and scale-up dual test kits (HIV & Syphilis) to fast-track progress on the dual elimination |
| 4. | Strengthen linkage from screening facilities to confirmatory centers and subsequently to the treatment centers |
| 5. | Strengthen retention and on-ART adherence among eligible WLHIV |
| 6. | Prioritize family planning services for eligible PLHIV |
| 7. | Strengthen the early diagnosis of infants and all children living with HIV (CLHIV) |
| 8. | Engage with private sector augmenting their role in attainment of dual elimination |
| 9. | Strengthen the strategic information in the context of HIV positive pregnant women/mother |
| 10. | Prepare strategic roadmap to guide actions towards attainment of validation of elimination of vertical transmission |

## 6.3 Introduce and scale-up dual test kits (HIV & Syphilis) to fast-track progress on the dual elimination

NACP Phase-V will use the extensive system of HIV testing of pregnant women to boost the screening and testing of ANC and direct-in-labor pregnant women for Syphilis. Rapid Diagnostic Test (RDT) Kits in the form of dual test kit (HIV & Syphilis), with specific framework on follow-up testing and treatment algorithms, will allow for early diagnosis for HIV and Syphilis by reducing testing barriers and increasing uptake of testing for both HIV and Syphilis. This will include orientation of associated service delivery health systems, on appropriate algorithms for referral, follow-up testing and/or confirmatory testing, and treatment and/or management of both HIV and Syphilis infection especially for co-infected or severely sick patients.

## 6.4 Strengthen linkage from screening facilities to confirmatory centers and subsequently to the treatment centers

Not every pregnant woman with a screened reactive result for HIV reaches to a confirmatory center. Not every woman with a confirmed HIV positive result is linked and initiated on ART. This is a missed opportunity. NACP Phase-V will strengthen the linkage from screening facilities to confirmatory and treatment centers through targeted outreach, capacity building, leveraging technology and institutionalized review at the granular level.

## 6.5 Strengthen retention and on-ART adherence among WLHIV

High retention and on-ART adherence among WLHIV during the pregnancy and breastfeeding will significantly reduce the vertical transmission risk for HIV. NACP Phase-V will offer intensified counseling and follow-up among all pregnant and breastfeeding WLHIV towards attainment of 95% viral suppression through differentiated and community-led services with full sensitivity and confidentiality avoiding any stigma and discrimination.

## 6.6 Prioritize family planning services for eligible PLHIV

Preventing unintended pregnancies is one of the key components of elimination of vertical transmission. NACP Phase-V will strengthen the coordinated referral and linking of PLHIV with family planning services. This will include assessment of all eligible PLHIV for their family planning needs at each visit to ART center followed by subsequent linkage to family planning services. Volunteerism will be fundamental to this strategy giving PLHIV the ability to make a full, free, and informed choice about his/her family planning needs, without any force, coercion or undue incentivization.

## 6.7 Strengthen the early diagnosis of infants (EID) and all children living with HIV (CLHIV)

NACP Phase-V will continue to focus on EID and family testing for the early diagnosis of CLHIV under NACP. This will be supported by rapid initiation of ART among CLHIV. NACP Phase-V will facilitate evidence generation on technology like point-of-care early infant diagnosis platform to promote early diagnosis of CLHIV and adopt/advocate the suitable options under national frameworks through appropriate implementation modalities.

## 6.8 Engage with private sector augmenting their role in attainment of dual elimination

Private healthcare sector is engaged under NACP through MoU for offering of HIV counselling and testing services. However, the focus of private sector till now is largely on the HIV testing. NACP Phase-V will engage with private sector to offer testing in the context of the dual elimination. This will further include the sensitization of the private sector about the uses of benzathine penicillin G (BPG) to treat identified pregnant women with Syphilis.

## 6.9 Strengthen the strategic information in the context of HIV positive pregnant women/mother

Attainment of elimination of dual transmission is a data driven process with integral role of strategic information for evidence-based policy formulations. NACP Phase-V will respond to the specific strategic information need of fertility rates among WLHIV, tracking of known on-ART WLHIV in the perinatal and post-natal period as well as tracking of WLHIV identified during post-natal period through complementary systems of programme monitoring, surveillance & epidemiology, and research.

## 6.10 Prepare strategic roadmap to guide actions towards attainment of validation of elimination of vertical transmission

The country progress towards attainment of elimination of the vertical transmission of HIV Syphilis, and Hepatitis B is measured through standard criteria and process for validation prescribed by WHO in its global guidance. While there are specific numeric targets for validation, countries must also demonstrate progress on foundational requirements across four thematic areas of programme, laboratory, data and human rights, gender equality and community engagement. The progress on criteria is assessed using standardized tools. The validation process consists of a series of national, regional, and global-level reviews on the standardized processes and criteria of validation. NACP Phase-V will undertake assessment of country progress on elimination using WHO recommended tools and prepare the roadmap on action points for the attainment of the elimination of the vertical transmission with defined timelines.

# 7. Goal 4: Promote universal access to quality STI/RTI services to at-risk and vulnerable populations

More than 30 different bacteria, viruses and parasites are known to be transmitted through sexual contact. Some of these pathogens are of public health importance not only due to their prevalence and sequelae but also due to the epidemiological synergy with HIV. As STI and RTI enhances chances of acquiring and transmitting HIV infection by 4-8 times; prevention and management of STI/RTI is a key strategy under NACP since its inception. NACP Phase-V will reinforce the STI/RTI component not only in terms of elimination of vertical transmission of HIV and syphilis but also to augment access to quality STI/RTI services through maximizing its system and opportunities for shared delivery models.

## 7.1 Strengthen the strategic information on STI

Overall, strategic information (SI) under NACP on STIs is less than that of HIV. NACP Phase-V will strengthen the strategic information on STIs through the complementary, action-oriented systems of programme monitoring, surveillance & epidemiology, and research & evaluation. The SI on STI will be beneficiary centric encompassing granular, real-time, and cross-sectional evidence while engaging and expanding various stakeholders including institutional networks.

## 7.2 Maintain the existing model of Designated STI/RTI Clinics (DSRC) augmenting the role

NACP provides quality standardized STI/RTI services at DSRC, branded as Suraksha Clinic. DSRC offers syndromic management of STI/RTI through its two arms i.e. obstetrics & gynecology OPD and STI OPD under dermato-venereology clinics. NACP Phase-V will maintain the DSRC model while augmenting its role to anchor newer initiatives like Sampoorna Suraksha Strategy and integrated service delivery tailored to the local contexts.

## 7.3 Develop and implement integrated communication strategies

HIV and STIs shares behavioral, social, and structural determinants. Untreated syphilis and HIV infections among pregnant and breastfeeding women may lead to adverse outcomes and share similar strategies to avoid the adverse outcomes. NACP Phase-V will develop and implement tailored integrated communication strategies on prevention, testing, and treatment of HIV and STIs.

## 7.4 Dovetail dual testing at HCTS centers

The extensive HCTS models (standalone, facility integrated and CBS) under NACP offer an opportunity to significantly increase the coverage of syphilis testing. NACP Phase- V will introduce and scale-up RDT dual test kit (HIV & Syphilis), with specific framework on follow-up testing and treatment algorithms, increasing testing uptake in a very cost-efficient manner. This will include orientation of associated service delivery health systems, on appropriate algorithms for referral, follow-up testing and/or confirmatory testing, and treatment and/or management. NACP Phase- V will continue to have the role of RPR for identification of active cases tailored to the location and population needs as per the provisions of national framework.

**Table 16. Promote universal access to quality STI/RTI services to at-risk and vulnerable populations: Strategies at a glance**

| S No | Strategy |
|---|---|
| 1 | Strengthen the strategic information on STI |
| 2 | Maintain the existing model of DSRC augmenting the role |
| 3 | Develop and implement integrated communication strategies |
| 4 | Dovetail dual testing at HCTS centers |
| 5 | Promote active case findings facilitating early detections |
| 6 | Improve collaboration with NHM on STI/RTI services provisions and reporting |
| 7 | Strengthen and streamline private sector engagement on STI/RTI management |
| 8 | Suitably update the STI/RTI management guidelines periodically |
| 9 | Augment the laboratory capacities |
| 10 | Strengthen the supply chain management |

## 7.5 Promote active case findings facilitating early detections

Identification and detection of sexual partners of a STI client helps early diagnosis and treatment averting further transmission and reinfection. The NACP Phase-V will promote active case findings through approaches like social-network based testing and index testing approaches. Volunteerism and confidentiality would be the vital component of partner management services.

## 7.6 Improve collaboration with NHM on STI/RTI services provisions and reporting

Under NACP, the healthcare facility for STI/RTI services are usually limited to district-level facilities while NHM has wider and more granular presence up to the sub-district level. NACP Phase-V will collaborate with NHM to scale-up the preventive and management services for STI and linkages to quality diagnostics services and quality assurance systems.

The care continuum framework of Reproductive, Maternal, Newborn Child plus Adolescent Health (RMNCH+A) would be leveraged. Information, screening, and management of STI/RTI servicesamong adolescents would be facilitated

through Rashtriya Kishor Swasthya Karyakram (RKSK) dovetailing Adolescent Friendly Health Clinics (AFHC). The collaboration will include the training and capacity building of healthcare personnel and coordination on health information systems promoting data sharing.

NACP Phase-V will strengthen strategic information on cervical cancer among WLHIV and FSWs. Screening and management of cervical cancer among WLHIV and FSWs in collaboration with National Programme for Prevention & Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS) through suitable implementation arrangements would be facilitated.

## 7.7 Strengthen and streamline private sector engagement on STI/RTI management

Healthcare providers in private sector have a significant share in STI/RTI management services. Recognizing the reach and acceptance of private sector in offering of STI/RTI services, NACP has meaningfully involved private sector in the form of preferred private providers to give services to the high-risk group population through TI projects. NACP Phase-V will strengthen and streamline the partnership with private sector to expand the reach of the STI/RTI services in alignment with the national frameworks. This will include the training, capacity building, and reporting of data through tailored implementation models.

## 7.8 Suitably update the STI/RTI management guidelines periodically

The science on diagnostics of STI/RTI is continuously growing with reliable and affordable new quality-assured diagnostic tests becoming available. Rapid point-of-care multiplex tests for HIV, STIs and Hepatitis allow multiple benefits. Based on improved diagnostics, transition from syndromic management to causative management is being recommended. New models for delivering STI/RTI services such as telehealth, self-care strategies are being piloted. NACP Phase-V will facilitate evidence generation on more effective STI/RTI management models and adopt/advocate the suitable options under national frameworks through appropriate implementation modalities.

## 7.9 Augment the laboratory capacities

The STI/RTI services under NACP are supported through a three-tier STI laboratory network of SRC, RSTRRL and apex laboratory. The system is supposed to strengthen the etiological diagnosis of routine and treatment failure cases of various syndromes diagnosed in their allotted geographies. NACP Phase-V will review, re-engineer/mainstream and strengthen this three-tier laboratory network for better outcome. This will include the strengthening of antimicrobial surveillance informing the periodic update of national treatment guidelines and policies.

## 7.10 Strengthen the supply chain management

Central supply of color-coded STI/RTI drug kits for syndromic management and RPR kits for Syphilis, are key component of STI/RTI services under NACP. NACP Phase-V will strengthen the supply chain management services through timely forecasting and procurement. This will be done through institutional structures supported through IT-enabled supply-chain management information systems ensuring ensure timely and accurate data regarding commodity needs and consumption.

# 8. Goal 5: Eliminate HIV/AIDS related stigma and discrimination

The strategies adopted under the NACP have always kept the HRG and PLHIV in center of its response. With notification of the HIV/AIDS (Prevention and Control) Act 2017 and decriminalization of section 377 of Indian Penal Code, the country has brought significant structural changes to eliminate HIV/AIDS related stigma and discrimination. NACP Phase-V will build upon these gamechanger initiatives to accelerate the progress on elimination of HIV/AIDS related stigma and discrimination.

## 8.1 Undertake bottom-up institutionalized community system strengthening

NACP recognizes the need for community - engaged responses as key to elimination of HIV/AIDS related stigma and discrimination.NACP Phase-V will institutionalize the community engagement and meaningful participation at the most granular level in the form of community system strengthening (CSS) (Figure 10). CSS will catalyze the improved health outcomes of NACP specifically through strengthening targeted interventions (TI) program, advocacy and rapid response reducing stigma and discrimination, enhancing treatment literacy, greater involvement of communities in decision making and finally developing structured systems of community-led monitoring (CLM).

**Figure 10. Implementation framework of Community System Strengthening**

## 8.2 Accelerate the notification of State rules and appointment of Ombudsman in the context of the HIV and AIDS (Prevention and Control) Act, 2017

The HIV and AIDS (Prevention and Control) Act, 2017 is the primary legislation protecting and promoting the rights of people infected and affected with HIV. The Act takes a multi-sectoral approach and prohibits discrimination in multiple settings. The Act also penalizes propagation of hate and physical violence against a protected person. The Act further provides for a grievance redressal mechanism by placing Ombudsman at State level and Complaints Officer at establishment level for a prompt resolution of complaints, related to violations of the provisions of the Act. NACP Phase-V will accelerate the notification of State rules and placement of Ombudsman in the context of the HIV/AIDS (Prevention and Control) Act, 2017.

## 8.3 Undertake sensitization of related stakeholders on HIV/AIDS related stigma and discrimination

NACP prioritizes workplace, healthcare, and educational as key settings to respond to the HIV/AIDS related stigma and discrimination. This will include educating the related stakeholders, their skill-building initiatives and awareness generation about the provisions of the HIV/AIDS (Prevention and Control) Act in these three settings as approaches for stigma and discrimination reductions.

**Table 17. Eliminate HIV/AIDS related stigma and discrimination: Strategies at a glance**

| S No | Strategy |
|---|---|
| 1 | Undertake bottom-up institutionalized community system strengthening |
| 2 | Accelerate the notification of State rules and appointment of Ombudsman in the context of the HIV and AIDS (Prevention and Control) Act, 2017 |
| 3 | Undertake sensitization of related stakeholders on HIV/AIDS-related stigma and discrimination |
| 4 | Design and implement communication strategy on elimination of HIV/AIDS related stigma and discrimination |
| 5 | Enhance strategic information on HIV/AIDS related stigma and discrimination |
| 6 | Engage with State governments promoting launch and scale-up of social protection schemes |

## 8.4 Design and implement communication strategy on elimination of HIV/AIDS-related stigma and discrimination

NACP undertakes HIV/AIDS related communication campaigns through a mix model of mass-media, mid-media, and interpersonal behavior change communication strategies. NACP Phase-V will build upon the previous campaigns to develop/implement communication strategy on elimination of HIV/AIDS related stigma and discrimination. The campaigns will have in-built mechanism to measure the reach of these communication campaigns in conjunction with contributions to knowledge, attitudes, and behavior change.

## 8.5 Enhance strategic information on HIV/AIDS related stigma and discrimination

Evidence on the level, trends and determinants of HIV/AIDS related stigma and discrimination in settings of community, workplace, education, and healthcare is an enabler for developing comprehensive responses. NACP Phase-V will enhance the strategic information on HIV-related stigma and discrimination in four settings to inform the magnitude, directions and why of stigma and discrimination to inform the designing and implementation of suitable interventions in each setting.

## 8.6 Engage with State governments promoting launch and scale-up of social protection schemes

Social protection schemes mainstreams people infected and affected with HIV, including the vulnerable population, through reducing inequalities and promoting inclusions. Many State governments has launched social protection schemes which have not only facilitated the services uptakes by target population but also empowered them to break the barriers on social exclusion. NACP Phase-V will continue to engage with State governments promoting launch and scale-up of social protection schemes as a critical enabler to respond to HIV/AIDS related stigma and discrimination.

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The NACP Phase-V will take the national AIDS and STD response till Financial Year 2025-26 towards the attainment of United Nations' Sustainable Development Goals 3.3 of ending the HIV/AIDS epidemic as a public health threat by 2030. The strategy document outlines the roadmap to attain the goals to be achieved under NACP Phase-V.