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Review on National AIDS Control Programme

Aditi[1], Harshit Sharma[2], Priya Darshini[3]
Student, Rao Birender Singh State Institute of Engineering and Technology Zainabad, Rewari (Haryana)
[1,2] Department of Computer Science and Engineering

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ABSTRACT: India's AIDS Control Programme has built up universal recognition for its smash. In 1992, the National AIDS Control Programme(NACP) was introduced to prevent and control HIV/ AIDS as a comprehensive approach in India. Over time, the program's focus has changed, shifting from raising mindfulness to promoting geste revision. also, it has transmuted from a civil approach to a more decentralized one, involving non-governmental associations(NGOs) and networks of People Living with HIV(PLHIV). The NACP Phase- V, completely financed by the Indian government with a budget of Rs15471.94 crore, operates as a Central Sector Scheme. Its ideal is to attain United Nations' Sustainable Development Goals3.3 by 2030, specifically to annihilate the HIV/ AIDS epidemic as a public health concern. This will be fulfilled through a comprehensive range of forestallment, discovery, and treatment services. Building upon the achievements of former phases, similar to the HIV/ AIDS Prevention and Control Act(2017), Test and Treat Policy, Universal Viral cargo Testing, Mission Sampark, Community-Grounded Webbing, and the transition to a Dolutegravir- grounded Treatment authority, Phase-V introduces fresh strategies to solidify and enhance progress. Among these strategies is the establishment of Sampoorna Suraksha Kendras SSK), which offers a comprehensive set of services through an intertwined approach, feeding individualities at threat of HIV and STIs. These services are customized to meet the individual requirements of guests and include strong liaisons and referrals within and outside of the health system. The NACP Phase-V is anticipated to continue until the Financial Year 2025- 26.

I. INTRODUCTION

1.1 Background

The HIV/ AIDS epidemic presents a meaningful obstruction to development and societal advancement, with far-reaching consequences. It intensifies poverty and inequality, placing a heavier burden on society's most vulnerable groups, including seniors, women, children, and the impoverished. Failure to respond instantly to this extremity imposes substantial costs on both public and private sector realities. These costs manifest as dropped productivity, loss of professed and educated labor, and increased charges associated with hand treatment and related services, as the demand for public coffers escalates. The impacts of the epidemic extend across colorful sectors, as apparent in oppressively affected regions like sub-Saharan Africa, where public husbandry has felt its impact in nearly every aspect of society.

1.2 Situation in India

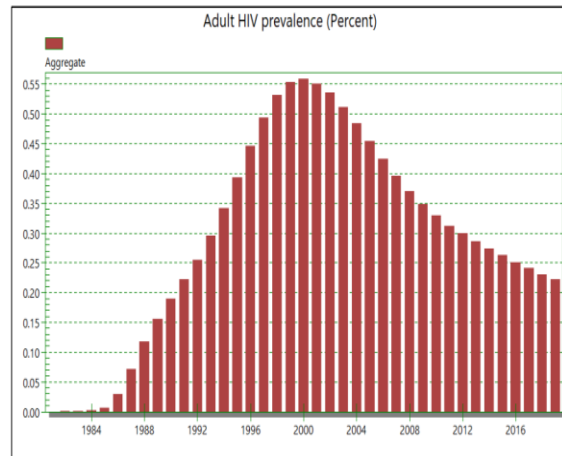
In India, the frequency of HIV within the population stands at around 0.3, surpassing the global normal of 0.2. (UNAIDS 2014) The epidemic in the country is uneven with the loftiest estimated frequency of 1.15 in the north-eastern state of Manipur. Mizoram, Nagaland, Andhra Pradesh, Telangana, and Karnataka are five countries in India that have displayed a frequency of HIV/ AIDS that is further than twice the public normal. The rising situations in adult HIV frequency have been noticed in some fairly low-frequency countries/ UTs like Assam, Chandigarh, Delhi, Jharkhand, Punjab, Tripura and Uttarakhand. The public AIDS response in India has yielded remarkable results, demonstrating a significant impact. New HIV infections have witnessed a decline of 48 annually, surpassing the global average reduction of 31(grounded on the 2010 birth time). AIDS-related deaths have also shown a substantial drop of 82, surpassing the global average reduction of 47(grounded on the 2010 birth time). It's worth noting that the HIV frequency in India remains comparatively low, with an adult HIV frequency rate of 0.22. Despite the significant achievements and impact, there are veritably lower chances for the country to fulfill the commitment of barring HIV as a public trouble by the time 2030. HIV is a public health precedence with new HIV

infections passing at a rate advanced than the normal position. From the records, it has been observed that the periodic number of new infections among grown-ups has declined by 48 since 2010, but still, there's a long way to go to achieve a decline of 90 by 2030. The progress on targets of 90-90-90 is to be achieved by 2020 has stopped the country's progress on terminating the epidemic. The full consummation 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 PLHIVs knew their HIV status, 83 of PLHIVs who knew their HIV status were on ART, and 85 of PLHIVs on ART were virally suppressed. Several transformative enterprises were introduced after 2014, similar to the enactment of the HIV/ AIDS Prevention and Control Act(2017), the perpetuation of the Test and Treat Policy, the preface of Universal Viral cargo Testing, the perpetration of Mission Sampark, the relinquishment of Community- Grounded Webbing, and the transition to a Dolutegravir- grounded Treatment authority, have significantly contributed in the name of National AIDS Control Program(NACP). As a result, roughly 14.20 lakh People Living with HIV(PLHIV) are entering lifelong, cost-free, and high-quality anti-retroviral treatment(ART) from the installations supported by the program. This achievement places India among the nations with one of the largest cohorts of PLHIV serving from government-funded treatment programs.

Overview of HIV/AIDS

Below are some figures to help understand HIV spread in India.

Figure 1 Estimated Adult HIV Prevalence in India during 1983 to 2019, HIV Estimations 2019



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

District Prioritization (District-level HIV burden estimations, 2019)

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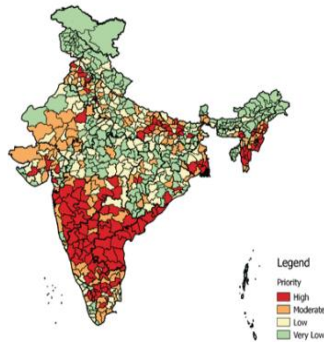

Priority level	Description	Number of Districts	Epidemic Burden
High	Adult prevalence of >=1% or PLHIV size of >=5000	144	63% of PLHIV, 49% of new infections and 55% of PMTCT need
Moderate	Adult prevalence of 0.4% - <1% or PLHIV size of 2500 - <5000	155	21% of PLHIV, 27% of new infections and 25% of PMTCT 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

1.3 Focus Area within the National AIDS Control Programme

NACP Phase- V can be defined as a Central Sector Scheme, which is completely funded by the Government of India, and has an disbursement of Rs15471.94 crore.

1.4 Foundations of the proposed national policy

Eight important principles will play a central part in our strategies and conditioning to achieve specific targets Putting the devisee and community at the heart of our sweats We'll prioritize the requirements and well-being of the people we aim to help and involve them laboriously in decision-making processes. Breaking down walls and fostering collaboration We'll work to overcome organizational walls and encourage collaboration between different stakeholders to maximize the effectiveness of our conduct. Using strategic information for planning and perpetration We'll use applicable and dependable data to inform our planning, perpetration, and monitoring, and make necessary adaptations along the way. Prioritizing high-impact program operation and review We'll fasten on optimizing our programs and enterprise

to achieve maximum impact and regularly review our progress to assure effectiveness. employing technology and invention We'll grasp technological advancements and innovative approaches as precious tools to support and enhance our sweat. Strengthening hookups We'll laboriously seek and nurture hookups with colorful stakeholders, feting that collaboration is essential for addressing complex challenges. Integrating a gender-sensitive response We will assure that our behavior and interventions hold into regarding the specific requirements, perspectives, and rights of all genders, promoting equivalency and inclusivity. Supporting specialized arrangements and institutions We'll continue to foster the development and strengthening of specialized arrangements and institutions that can effectively support our objectives and ease collaboration.

2. Argument:

I. The National Council on AIDS, chaired by the Prime Minister of India, compacts the highest precedence to the safeguard of the force regarding HIV/ AIDS.

II. The workplace is the only spot where multiple diverse people approach simultaneously, and is traced as a conceptual spot that gives access to forestallment, treatment, heed, and support for entities who are dwelling with and experiencing HIV/ AIDS. It can also aid in degrading the negative conclusion of the contagion.

III. The negative goods and demarcation that are allied to HIV/ AIDS awake multiple meaningful demurrals during our conflict against the contagion. The chromatic negative stations and actions are challenged to be conquered for effectual HIV/ AIDS forestallment and endorse its different programs.

IV. Indian government has concurred and exhibited its full support to the International Labour Organization ILO) convention No. 111 on demarcation rested on exercise and employment The prior composition shows that the government is confined to battling demarcation in the workroom, carrying demarcation and racism that are hung on

HIV/ AIDS, and also it promotes attractiveness and equal chances for all commodities.
V. India's growth will bring about 14 million posts per cycle in the succeeding 10- 12 times.
VI. Universal case to quality STI/ RTI services to at-threat and endangered populations to achieve elimination of the succeeding.

3. Policy Framework:

The Policy architecture works hung on some of the information that are –

1) The most usual route to the transmission of HIV/ AIDS are

• unguarded sexual connection with an infected person;
• Transfusion of infected blood or blood products;
• participating of infected syringes hypes
• From infected mama to child during gestation, parturition or breastfeeding)

2) There's no trace that HIV can be transfused through any habitual connection(speaking to or touching the person, using the equal service outfit, tools, implements or restroom as a person infected with HIV). In solitary statuses where there's an implicit threat of liability, like healthcare employees who may approach into contact with blood or blood products, it's compulsory to follow special and applicable infection-control procedures called Universal preventives. These preventives help minimize the threat of transmission in similar circumstances.

3) Despite being infected with HIV, entities can stay well-conditioned and physically competent of working out for several periods. HIV infection doesn't inescapably suggest instantaneous sickness or disability. With befitting medical care, support, and treatment bonding, people with HIV can conserve their overall well-being and continue to laboriously share in the pool.

4) People dwelling with HIV can conduct a common and constructive life with the accessibility of Anti Retroviral Treatment(ART).

3.1 Aim:

This methodology, grounded on principles of mortal rights, aims to conduct the public response to HIV/ AIDS in reducing and managing the impact of the epidemic in India, especially the methodology aims to-
• avert transmission of HIV infection amongst individuals.
• guard the rights of those who are infected and furnish siege to accessible care, support and treatment.
• safeguard workers from smirch and demarcation allied to HIV/ AIDS by comforting them detachment and quality at the plant;
• ensure safe migration and mobility with access to information services on HIV/ AIDS.
• Attainment of elimination of perpendicular transmission of syphilis.

3.2 Factors:

3.2.1 Prevention: Targeted Interventions(TI) for towering-threat batches(Female Sex Workers FSW, Men who have sexual relations with Men- MSM, fitting medicine druggies- IDU, Transgenders Hijra-TGH) and Bridge population(settlers, truckers etc) is elemental to AIDS response and aims to keep these population mortal Immunodeficiency Contagion(HIV) free through mindfulness generation, safe geste creation, HIV testing etc. secure blood(independent of HIV, Malaria, Syphilis, Hep B and Hep C) is assured through a NACO-endorsed net of blood transfusion favors.

3.2.2 Information, Education and Communication(IEC): Mindfulness generation services were rolled out 25 times ago with a focus on mindfulness generation on the modes of transmission of HIV/ AIDS and the services available for testing and treatment and continue to be the dependence of NACP through vibrant multimedia approach comprising Mass media, medial media and on-ground rallying & Interpersonal Dispatches across the country.

3.2.3 Testing: NACP provides freestanding HIV comforting and testing services(HCTS) for the primitive spotting of HIV infections.
3.2.4 Treatment: Treatment services offer free Antiretroviral Treatment(ART) as well as comprehensive operation of HIV- infected people concerning treatment and forestallment of opportunistic infections. The ' Test and Treat ' policy has been embraced to enhance the uptake of treatment services by all irrespective of CD4 counts. Single-window delivery of TB and HIV services has also been initiated across all ART centers.

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3.2.5 Laboratory favors: Quality of sampling under NACP is assured through laboratory favors through the State reference laboratory. 6. Mainstreaming & Partnership and Social Protection Mainstreaming & cooperation are the critical arrangements in NACP to harden the multisectoral response to HIV and AIDS.

3.3 Another enterprise by NACO:

3.3.1 Sunrise: The NACO's sweats are supported by this Project Sunrise to control the epidemic through an accelerated response of forestallment to watch and treatment continuum services among critical populations(KP)/ HRG, with a focus on PWID/ IDU. Project Sunrise has subsisted in enforcing data-punched and creative passages in cooperation with NACO, SACS and TI NGOs to fast-track the HIV/ AIDS reaction to attain epidemic control.

3.3.2 Linkages: ' Linkages across the continuum of HIV Services for KPs Affected by HIV LINKAGES Project) is to deliver Specialized backing(TA) for advancing the HIV waterfall of services. In India, this LINKAGES program is existing administered in six PEPFAR cluster quarters in the countries of Andhra Pradesh(Krishna, Guntur and East Godavari) and Maharashtra(Mumbai, Pune and Thane); and furnishing mount to NACO to harden special fields of services for KP through innovational strategies.

3.3.3. Cluster Strategy: USAID and CDC in collaboration with NACO jointly developed a cluster strategy and implemented various activities to enhance HIV/AIDS Care Prevention and Treatment services at selected districts. (USAID/CDC through FHI360 and other development partners).

3.3.4. Hridaya: Hridaya is implemented by India HIV/AIDS Alliance, as a part of the Alliance Integrated Harm Reduction Programme (AIHRP) of the International HIV/AIDS Alliance Brighton. Project Hridaya aims to address capacity-building needs and bridge implementation gaps in the states of Uttarakhand, Uttar Pradesh, and Bihar. The project has been specifically designed to target these areas and focus on improving the necessary skills and capabilities, as well as addressing any challenges in effectively implementing various initiatives and programs. Targeting these specific regions, Project Hridaya aims to bring about positive changes and enhance development in Uttarakhand, Uttar Pradesh, and Bihar. During this reporting period, more than 2,700 individuals who inject drugs (IDUs) and 700 of their female sex partners have received vital harm reduction services.

3.3.5. Nirantar: Project Nirantar is a civil society capacity building for advocacy and response to the HIV/AIDS epidemic among KPs (FSW, MSM, H/TG and IDU) 465 CHAPTER-24 in Chhattisgarh, Madhya Pradesh and Odisha are the primary focus areas for building local capacity initiatives of targeted intervention (TI) non-governmental organizations (NGOs) and State AIDS Control Societies (SACS). The aim is to strengthen the capabilities and resources of these organizations in both states. The project has built the capacity of more than 128 TIs through a mentorship program; enabled KPs to avail of social protection schemes; sensitized healthcare providers across facilities at the district level; and obtained community feedback by deploying community scorecard approaches to ensure quality service delivery.

3.4 Achievements:

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

4. Guidinig Principle:

5. Goals of NACP Phase-V:

5.1 Reduce annual new HIV infections by 80%

More than 99.5% of the 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, new HIV infections declined by 48%, yet there is a long way to go to achieve a 90% decline by 2030.

5.1.1 The interventions have progressed and now provide a comprehensive range of services across the prevention-testing-treatment spectrum through a revised model. The Phase-V will build on this the proven strategy of peer-led interventions, providing services tailored to the needs of individuals and communities. To overcome service uptake barriers, new technology, such as dual test kits for HIV and Syphilis will be implemented in TI and LWS settings. The interventions will continue to develop by providing an integrated package of services through referrals and linkages for co-morbidities supported by evidence, including viral hepatitis, tuberculosis, sexual and reproductive health, mental health, and non-communicable diseases.

5.1.2 The NACP Phase-V aims to enhance population size estimation and field epidemiological intelligence to expand and saturate coverage. Phase V will continue to improve the periodic, community-led, cross-sectional programmatic mapping system and population size estimation at the most detailed level to guide the initiation, shift, and expansion of location and population-based interventions. Capacity building, community engagement and institutional networking will be crucial in strengthening these activities. Furthermore, the Phase-V will enhance the reporting and utilization of field epidemiological intelligence to facilitate the early initiation, expansion, and modification of interventions

5.1.3 The NACP Phase-V aims to extend its interventions in prisons and other closed settings through a combination of service delivery models. In some settings, the prevalence of HIV among inmates are higher than that of other HRGs and bridge population groups. Additionally, amonginmates, the prevalence is significantly higher among under-trials than among convicts. Furthermore, prisons with high HIV prevalence among IDUs have observed a higher prevalence of the Hepatitis-C virus among prisoners. To address this issue, Phase V will cover every prison in the

country using a combination of facility-based and outreach-based services. In facility settings, counseling, testing, and treatment services will focus on an integrated package of HIV, TB, and Hepatitis when inmates are inside the prisons. To the greatest extent possible, facility-based services will be provided through the mainstream health systems of the prisons. The outreach arm will offer services directly or through referrals/linkages for inmates who have been released.

5.1.4 The HIV epidemic in India is still concentrated in certain populations, and migrants and truckers are included as a bridge population group under the NACP through TI, Employer Led Models, and LWS. However, there may be other population groups included under the broad definition of bridge population. In Phase V of the NACP, evidence will be gathered to gain a better understanding of the bridge population and its networks to provide a tailored package of services through suitable intervention models

5.1.5 Phase-V of the NACP aims to provide a comprehensive and integrated service delivery package to both urban and rural populations. However, many of the target population may not perceive themselves as being at risk and having poor awareness of the risks involved. To expand the reach and impact of NACP services, a new generation communication strategy will be developed and rolled out, leveraging the internet and mobile-based applications. This communication the strategy will be tailored to young people and at-risk populations, with a focus on improving risk perception and encouraging service uptake.

5.1.6 Less than 5% of HIV detections at NACP's Integrated Counselling and Testing Centers (ICTC) were among HRG, indicating that other population groups are at risk of acquiring HIV or STIs due to risky behavior of themselves or their partners. NACP Phase-V will implement the Sampoorna Suraksha Strategy (SSS) to cover the "at-risk" HIV negative but non-TI population through a comprehensive package of services tailored to their needs. The strategy will primarily target direct walk in clients at ICTCs who perceive themselves at risk of HIV infection due to past/current HIV/AIDS related risk behaviors. Additionally, the SSS will cater to the needs of the "at-risk" HIV-negative but the non-TI population identified through risk screening at ICTCs, STI/RTI clinics, virtual outreach, and the National HIV/AIDS toll-free helpline

5.2 Reduce AIDS-related mortalities by 80%

The country has made significant progress in reducing AIDS-related mortality with an 82% decline between 2010 and 2020. This has been made possible with the 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, the 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 of AIDS-related mortalities through strategies directed across the care continuum. This will also contribute to the prevention of new HIV infections through the attainment of viral load suppression among PLHIV

5.2.1 The NACP currently provides HIV counselling and testing services (HCTS) through various models such as standalone facilities, mobile vans, facility-integrated facilities (in both government and private sectors), and community-based screening (CBS). This has greatly expanded the reach of HCTC services, with over 5 crore HIV screenings and tests conducted in 2019-20. In NACP Phase-V, there will be a continued emphasis on maintaining these existing models and strategically expanding them in the public and private sectors, based on the location and population context, through facility-integrated and CBS models.

5.2.2 NACP Phase-V will enhance the effectiveness of the existing HCTS models by incorporating efficient approaches such as social-network-based testing, index testing, and repeat screening/testing among discordant couples. The aim is to improve the detection of undiagnosed infections, promote early diagnosis and treatment, and bridge the gap in the first 95. These efficient approaches will be implemented within the framework of the HIV & AIDS (Prevention and Control) Act, 2017, which ensures the confidentiality, protection, and sharing of data

5.2.3 The NACP Phase-V will prioritize rapid ART initiation and advanced HIV disease management

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to improve the quality of care for PLHIV. A significant number of PLHIV are still being diagnosed with very low CD4 counts and advanced disease. Rapid ART initiation within seven days of HIV diagnosis can improve clinical outcomes, retention, adherence, and viral load suppression. In addition, same-day ART initiation will be offered to PLHIV who are ready to start. People with advanced HIV disease will be given priority for assessment to ensure they receive the care they need.

5.2.4 NACP Phase-V aims to address the issue of the loss of patients in the different stages of HIV screening, testing, and treatment. The linkage loss from screening to ART initiation, as well as retention on ART, is a significant obstacle in achieving the 95-95-95 targets. To mitigate this issue, NACP Phase-V will employ several strategies, such as technology-based interventions, outreach programs, and improved counselling services. Predictive analysis will be used to identify clients at risk of linkage loss, and customized counselling and follow-up services will be offered to them. Artificial intelligence will also be utilized to identify PLHIV requiring additional care and ensure timely attention. These interventions will promote retention and adherence to ART, leading to rapid viral load suppression

5.2.5 The provision of a full range of sexual and reproductive health services to women who are at high risk of HIV infection and women living with HIV/AIDS is considered essential for an integrated AIDS response. Under NACP Phase-V, a comprehensive package of sexual and reproductive health services will be provided to these women based on their age and population-specific needs. This will be achieved by enhancing the capacity of NACP service delivery points and improving collaboration with the National Health Mission.

5.2.6 NACP services are provided through various centers with their personnel, such as Designated STI/RTI Centers, Integrated Counselling and Testing Centers, and ART facilities. NACP Phase-V aims to improve service delivery through role upgradation, IT-enabled models, and upskilling in appropriate locations.

5.3 Eliminate vertical transmission of HIV and Syphilis

The program for the prevention of vertical transmission of HIV was launched under the second phase of the National AIDS and STD Control Program (NACP) of the Government of India in the year 2002. Since then, the elimination of vertical transmission of HIV and Syphilis remains one of the key objectives under NACP. However, in 2020-21, testing coverage for HIV and syphilis among pregnant women were 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 positive syphilis serology were treated adequately. This progress is far from global guidance on targets for the elimination of vertical transmission (Table 14). The global guidance also refers to foundational requirements of data, laboratory, program, human rights, gender, and community. The NACP Phase-V considers the global guidance towards the elimination of vertical transmission of HIV and Syphilis.

5.3.1 The NACP Phase-V aims to work closely with the National Health Mission (NHM) to increase the coverage of HIV and syphilis testing for pregnant women. This will involve capacity building, supply chain management, and district prioritization to ensure the universalization of testing in all districts in a phased manner. To streamline the process, HIV testing data reported through NHM's health management information system (HMIS) and reproductive and child health (RCH) portal will be mainstreamed into NACP systems for immediate follow-up services. In addition, efforts will be made to develop a case-reporting system for exposed children to eliminate congenital syphilis.

5.3.2 NACP Phase-V will use the existing system of HIV testing of pregnant women to increase screening and testing for Syphilis. Dual test kits (HIV & Syphilis) will be introduced and scaled up to allow for early diagnosis of both infections. This will involve capacity building, supply chain management, and district prioritization to ensure the universalization of testing in all districts in a phased manner. To streamline the process, HIV testing data reported through NHM's health management information system (HMIS) and reproductive and child health (RCH) portal will be mainstreamed into NACP systems for immediate follow-up services. In addition, efforts will be made to develop a case-reporting system for exposed children to eliminate congenital syphilis.

5.3.3 Improve linkage from screening to treatment centres by enhancing outreach, capacity building,

technology utilization, and granular-level review under NACP Phase-V.

5.3.4 NACP Phase-V aims to strengthen the early diagnosis of children living with HIV (CLHIV) through early infant diagnosis (EID) and family testing. This will be further supported by the rapid initiation of ART for CLHIV. The program will also focus on generating evidence on technologies such as point-of-care early infant diagnosis platforms to promote early diagnosis and adopt suitable options under national frameworks through appropriate implementation modalities.

5.3.5 NACP Phase-V will engage with the private sector to promote their involvement in achieving the dual elimination goal. The current focus of the private sector is mainly on HIV testing, but NACP Phase-V will encourage them to offer testing for both HIV and Syphilis. Additionally, they will be educated about the use of benzathine penicillin G for treating pregnant women with Syphilis

5.3.6 NACP Phase-V will create a strategic roadmap to achieve validation of the elimination of vertical transmission of HIV, Syphilis, and Hepatitis B. This validation is measured through specific criteria and processes outlined by WHO. The roadmap will focus on the four thematic areas of program, laboratory, data, human rights, gender equality, and community engagement, and will include defined timelines for achieving elimination targets. Standardized tools will be used to assess progress toward elimination, and a series of national, regional, and global-level reviews will be conducted to validate the elimination process.

5.4 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 enhance 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.

5.4.1 NACP Phase-V will collaborate with NHM to improve the provision and reporting of STI/RTI services. This will involve scaling-up services to the sub-district level, leveraging the RMNCH+A framework, and facilitating STI/RTI services for adolescents through RKSK and AFHC. Training and capacity building of healthcare personnel, as well as data sharing, will be promoted. Additionally, NACP Phase-V will improve information on cervical cancer among WLHIV and FSWs and facilitate screening and management of cervical cancer through collaboration with NPCDCS.

5.4.2 NACP Phase-V will improve private sector engagement in STI/RTI management by strengthening partnerships and expanding services through tailored implementation models. This will involve training, capacity building, and data reporting in alignment with national frameworks.

5.4.3 NACP Phase-V will strengthen the supply chain management of STI/RTI drugs by improving forecasting and procurement through IT-enabled supply chain management information systems to ensure timely and accurate data on commodity needs and consumption.

5.4.4 Develop and implement integrated communication strategies HIV and STIs shares behavioural, 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 these adverse outcomes. NACP Phase-V will develop and implement tailored integrated communication strategies on the prevention, testing, and treatment of HIV and STIs.

5.4.5 NACP Phase-V will promote active case findings for early detection of STIs, including social-network-based testing and index testing. Partner management services will prioritize volunteerism and confidentiality.

5.4.6 In comparison to HIV, NACP currently lacks sufficient strategic information (SI) on STIs. NACP Phase-V aims to strengthen SI on STIs through program monitoring, surveillance, epidemiology, research, and evaluation. This will involve a beneficiary-focused approach that incorporates real-time, cross-sectional evidence and engages a range of stakeholders, including institutional networks.

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5.5 Eliminate HIV/AIDS-related stigma and discrimination

The strategies adopted under the NACP have always kept the HRG and PLHIV at the center of its response. With the notification of the HIV/AIDS (Prevention and Control) Act 2017 and the decriminalization of section 377 of the 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 game-changer initiatives to accelerate the progress on the elimination of HIV/AIDS-related stigma and discrimination.

5.5.1 NACP Phase-V plans to strengthen the engagement of communities through community system strengthening (CSS) at a granular level.This will improve health outcomes by strengthening targeted interventions, reducing stigma and discrimination, enhancing treatment literacy, involving communities in decision-making, and implementing community-led monitoring.

5.5.2 The HIV and AIDS (Prevention and Control) Act, 2017 is crucial legislation safeguarding the rights of people living with HIV. It takes a comprehensive approach and prohibits discrimination in various settings while also penalizing any acts of hate or physical violence against protected individuals. The Act also establishes a grievance redressal system through Ombudsmen at the state level and Complaints Officers at the establishment level to quickly resolve complaints related to violations of the Act. In NACP Phase-V, there will be an effort to speed up the notification of State rules and appointment of Ombudsmen under the HIV/AIDS (Prevention and Control) Act, 2017.

5.5.3 NACP identifies workplace, healthcare, and educational settings as crucial areas for addressing HIV/AIDS-related stigma and discrimination. To tackle this issue, NACP Phase-V will undertake sensitization initiatives aimed at educating stakeholders, enhancing their skills and raising awareness about the provisions of the HIV/AIDS (Prevention and Control) Act. These efforts will be targeted specifically at the three aforementioned settings to help reduce stigma and discrimination.

5.5.4 NACP currently employs various communication strategies to combat HIV/AIDS related stigma and discrimination, including mass media, mid-media, and interpersonal behavior change communication. In Phase V, NACP will develop and implement a new communication strategy specifically focused on the elimination of HIV/AIDS-related stigma and discrimination. This strategy will include mechanisms for measuring the effectiveness and reach of the campaign in terms of knowledge, attitudes, and behavior change.

5.5.5 Improving our understanding of the extent, patterns and underlying factors driving HIV/AIDS related stigma and discrimination are crucial for developing effective responses. NACP recognizes that such knowledge is particularly important in four key settings: community, workplace, education, and healthcare. In Phase V, NACP will work to enhance strategic information on HIV-related stigma and discrimination in these settings, enabling the development of targeted interventions to address this issue.

5.5.6 NACP recognizes the importance of social protection schemes in promoting inclusivity and reducing inequalities for people affected by HIV, especially the vulnerable population. Several state governments have already launched social protection schemes that have not only helped the target population access necessary services but also empowered them to overcome social exclusion. In Phase V, NACP will continue to work with state governments to promote the launch and expansion of social protection schemes as a key strategy to address HIV/AIDS-related stigma and discrimination

Conclusion:

Failure to adhere to antiretroviral therapy (ART) is a significant current challenge that, if left unaddressed, could result in the emergence of HIV strains that are resistant to treatment. To prevent the possibility of a secondary epidemic of drug-resistant viruses in India, it is essential to ensure that there are no shortages of ART and that services are brought closer to clients. Going forward, viral load testing and resistance testing for HIV should be a priority. HIV is a disease that presents numerous sociocultural issues and the stigma surrounding it has caused more deaths than the disease itself. Nevertheless, HIV is now a

manageable chronic disease. This year's World AIDS Day theme, "Getting to Zero," aims to achieve zero new infections, zero discrimination, and zero AIDS-related deaths. To attain this goal, we must work towards finding a cure for HIV or, better yet, developing a preventive vaccine

Keywords: Transfusion, AIDS, HIV, PLHIV.

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