



**PREVENTION SUMMIT**

---

# **Innovating HIV Prevention**

## **Programmes in India**

**5 & 6 October, 2017**  
**New Delhi**



# **PREVENTION SUMMIT**

## **Innovating HIV Prevention Programmes in India**

5 & 6 OCTOBER, 2017, NEW DELHI





# PREFACE



Twenty five years of sustained efforts to respond to the AIDS epidemic under the leadership of the National AIDS Control Organization (NACO) with the support of its partners and the communities of people living with HIV and the key populations resulted in an international public health best practice that should be used by other health programmes in India and around the world.

Indeed, the number of new HIV infections declined consistently since 2000 by 68% and the number of AIDS related deaths by 57% since 2007 when treatment was introduced at larger scale. Today 1.1 million people living with HIV have access to lifesaving medicines.

Despite that progress, we all recognise that there is no room for complacency because the number of new HIV infections has declined by only 20% during the period 2011-16; adding on average 80,000 new people living with HIV annually. Therefore there is a need to rethink the actual prevention strategies and urgently scale up our efforts to reduce the number of new HIV infections. With already 2.1 million people living with HIV, an annual increase of 80,000 new HIV infections will seriously compromise the national efforts to end AIDS by 2030.

Reducing the number of new HIV infections by 75% by 2020 is the target set to be achieved making the focus on primary HIV prevention paramount to that success. It is with that very clear understanding that NACO organised a National HIV Prevention Summit on October 5-6, 2017 in close collaboration with UNAIDS and PEPFAR with the objective to get the input of all key stakeholders in the rethinking and redesigning of a future generation of HIV prevention strategies and targeted interventions to address the new challenges.

The Summit has developed important recommendations to scale up efforts to reduce new HIV infections at a much faster rate, thus making HIV primary prevention a centre piece of the National Strategic Plan 2017-2024. These recommendations include adoption of new locally innovative approaches corresponding to the new life style of the key populations, to design more effective targeted interventions with maximum yield and impact to stop HIV transmission and develop outreach HIV prevention programmes models for the most-at-risk groups including the key populations and the young people.

Because of the changing practices among the key populations, the appropriate and adapted use of modern technology especially the social media to reach out to the “unreachable” and the “invisible” with HIV prevention messages and knowledge has become essential for our collective effort to reduce new HIV infections. This has to be strengthened by community-led HIV prevention programmes and availability of HIV commodities at the community and the health facilities levels to increase access to these commodities. These are the major recommendations from the HIV Prevention Summit which need to be pursued with greater determination so that India will achieve the Zero New HIV Infections and end AIDS by 2030.



**Dr Bilali Camara)**

# ABBREVIATIONS & ACRONYMS

---

AAP	:	Annual Action Plan
ART	:	Anti Retroviral Therapy
BCC	:	Behaviour Change Communication
BMGF	:	Bill & Melinda Gates Foundation
CBHT	:	Community Based HIV Testing
CBO	:	Community Based Organization
CDC	:	Centers for Disease Control and Prevention
CHCN	:	Community Health Care Navigators
CSR	:	Corporate Social Responsibility
DAPCU	:	District AIDS Prevention and Control Units
DIC	:	Drop-in Centre
ELM	:	Employer Led Model
EOI	:	Expressions of Interest
EPOA	:	Enhanced Peer Outreach Approach
FICTC	:	Facility Integrated Counselling and Testing Centres
FSW	:	Female Sex Worker
HRG	:	High-Risk Group
IBBS	:	Integrated Biological Behavioural Survey
ICC	:	Integrated Care Centre
ICTC	:	Integrated Counselling and Testing Centres
IDU	:	Injecting Drug Users
IEC	:	Information Education and Communication
IT	:	Information Technology
JIRM	:	Joint Implementation Review Mission
KP	:	Key Population
LAC	:	Link ART Centre
LDSS	:	Low Dead-Space Syringes
LWS	:	Link Worker Scheme
MoU	:	Memorandum of Understanding
MSM	:	Men who have Sex with Men
MTA	:	Mid-Term Appraisal

NACO	:	National AIDS Control Organization
NACP	:	National AIDS Control Program
NALSA	:	National Legal Services Authority
NHM	:	National Health Mission
NGO	:	Non-governmental organization
NSACS	:	Nagaland State AIDS Control Society
NSP	:	National Strategic Plan
NTSU	:	National Technical Support Unit
NUHM	:	National Urban Health Mission
ORW	:	Out-Reach Worker
OST	:	Opioid Substitution Therapy
PE	:	Peer Educator
PEPFAR	:	President's Emergency Plan for AIDS Relief
PLHIV	:	People Living with HIV
PrEP	:	Pre-Exposure Prophylaxis
PUD	:	People who Use Drugs
PWID	:	People Who Inject Drugs
SACS	:	State AIDS Control Society
STI	:	Sexually Transmitted Infections
TG	:	Transgender
TI	:	Targeted Intervention
TRG	:	Technical Resource Group
TSU	:	Technical Support Unit
TL	:	Team Leader
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children's Fund
UNODC	:	United Nations Office on Drugs and Crime
UPHC	:	Urban Primary Health Centre
USAID	:	United States Agency for International Development
WHO	:	World Health Organization

# CONTENTS

.....

Executive Summary .....	1
Background .....	3
Inaugural session .....	4
<b>Session 1:</b> Thematic address.....	7
<b>Session 2:</b> Group work .....	7
<b>Session 3:</b> Plenary .....	8
<b>Session 4:</b> Achievements, Successes and innovations.....	11
<b>Session 5:</b> Panel Discussion.....	16
<b>Session 6:</b> Developing prevention models and setting targets.....	18
<b>Session 7:</b> Group work .....	22
<b>Session 8:</b> Plenary .....	22
<b>Session 9:</b> Valedictory .....	26
Annexes.....	27



# Executive Summary

A Prevention Summit was held under the Chairpersonship of Mr. Sanjeeva Kumar, the Additional Secretary and Director General, National AIDS Control Organization (NACO) in New Delhi on the 5th and 6th of October 2017. This summit primarily took stock of HIV prevention programmes in India, identified emerging drivers of the epidemic, reviewed lessons learnt, discussed challenges and barriers to access and examined key targets and strategies to fast-track the programme.

Deliberations were held against the backdrop of perspectives from the community, government, donor agencies and technical partner agencies on current issues confronting the prevention programme in India. Recommendations of the Mid-Term Appraisal (MTA), the Joint Mid-Term Review Mission, the Technical Working Groups on Targeted Interventions (TIs) and Sub-group Meetings conducted earlier were taken forward. Participants worked on developing strategies for smart city interventions, addressing changing trends of sexual networks and unreached key populations, and formulation of differential approaches for prevention among core and bridge populations. Local innovations that have been implemented in response to emerging needs were also presented.

A panel discussed emerging challenges, strategies being proposed post- MTA and the National Strategic Plan (2017-2024), and how they needed to be implemented in the national programme. Participants developed strategies to enhance prevention, focusing on gaps in retention and building linkages to care; defined a monitoring framework to reduce the stigma and discrimination in healthcare settings; framed approaches for effective implementation of HIV programmes in prisons, engaging law enforcement agencies; and devised systems to strengthen data management. Focusing on target setting for key populations, the existing templates were reviewed and baselines for each indicator as well as interim and final targets were established.

## **Key recommendations that emerged from the deliberations at the Summit:**

- Redefine key populations to include hard to reach populations, taking into account evolving trends, dissolving typologies and changing geographies
- Adopt differential approach for TIs
- Include young people and partners of key populations in prevention programmes
- Scale up Prison HIV Interventions; expand services to women living in other correctional settings; and set up surveillance sites in prisons
- Enhance meaningful involvement of the community at all levels

- Ensure capacity building of the community to enable able management and ownership of programmes
- Revitalize partnerships with other non-health ministries and departments to enable a multi-sectoral approach to HIV prevention
- Enable use of technology-based approaches such as app-based communication devices and social media for real time monitoring, communication and outreach
- Identify champions from the community and supportive service providers by providing positive reinforcement; so that they can act as catalysts for enhancing access to HIV prevention and treatment services.

# Background

The Prevention Summit was held as a collaborative initiative of the National AIDS Control Organization (NACO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA) and the World Bank with the support of the Centers for Disease Control and Prevention (CDC), the United States Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR). It aimed to take stock of the existing HIV prevention programmes in India, examine innovations in HIV prevention and build data-driven programmes that would set realistic targets to reduce new infections.

The objectives of this meeting were to achieve:

- a. An understanding of the drivers of the HIV epidemic in the country
- b. A review of what are the lessons learnt and the success stories
- c. An understanding of the challenges facing the Targeted Interventions (TIs) and the main barriers to access to prevention services
- d. A selection of key targets and best strategies and interventions to fast track the prevention programmes in India and achieve these targets.

The Summit was attended by representatives from affected communities, civil society organizations, non-governmental organizations (NGOs) involved with the TIs, PEPFAR, CDC, USAID, NACO, State AIDS Control Society (SACS), UNAIDS, UNFPA, World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), United Nations Children's Fund (UNICEF), World Bank, UN Women, United Nations Development Programme (UNDP) and Bill & Melinda Gates Foundation (BMGF).

The outcomes and targets set during this meeting as India's commitment to fast-track HIV prevention will be presented by national authorities at the upcoming high-level summit in Nairobi, Kenya.

# Inaugural Session

In his inaugural address, **Shri Sanjeeva Kumar**, the Additional Secretary and Director General, NACO, stated that prevention efforts should be strengthened while we talk about 'treatment as prevention' strategies. Recent landmarks in India include the development of the National Strategic Plan (NSP) (2017-2024), the enactment of the HIV (Prevention and Control Act), and increase in robust domestic funding – but new areas of concern have also emerged, thereby giving rise to the need to rethink previous strategies. Most TIs suffer from “participation fatigue” as they have been functioning for many years having limited innovations or new strategies to address emerging issues. He said that the guidelines for prevention would therefore be reviewed and changed as needed.

He outlined some of the initiatives being taken up such as review and reactivation of the existing Memorandum of Understandings (MoUs) with other ministries and departments, on-going efforts to rope in private sector agencies working on health, and HIV programmes in prisons that will extend to other correctional settings. Prevention strategies should ensure that children and adolescent groups including young people out of school are not left out. Research studies need to focus on prevention rather than being purely academic in nature. He stated that the community should be taken into confidence more closely through partnerships with the community.

**Dr Bilali Camara, Country Director, UNAIDS**, welcomed participants and underlined the need to rethink actions, strategies and directions against the backdrop of the recent trends indicating new infections in nine states, as well as the slow decline of new infections among children and adolescents. Stating that communities have suffered enough, he emphasized on the urgent need to reduce new infections and to explore more effective ways to address what is no longer working. He looked forward to the deliberations and outcome of the meeting that would help look at ways to find solutions and new ways to address problems in order to ensure an end to human suffering.

**Shri Alok Saxena, Joint Secretary, NACO**, outlined the objectives and proposed methodology of the meeting against the backdrop of the Mid-term Appraisal (MTA) of the fourth phase of the National AIDS Control Programme (NACP-IV), the Test and Treat strategy launched in April 2017, as well as the passing of the HIV (Prevention and Control) Act. He stressed on the need to cover physical groups that have moved to virtual spaces in order to turn the tide of the epidemic. Strategies have to be devised to reach the set of people indulging in very high-risk behaviour but not belonging to traditional High-Risk Groups (HRGs), for instance the population of young people below 18 years. With the extension of the NACP-IV up to 2020, he stated that it is the right time to discuss how to achieve goals in the light of the existing dynamics; and looked forward to result-oriented deliberations.

Deputy Directors General, Dr S. Venkatesh, Dr Naresh Goel, Dr R.S. Gupta and Dr K.S. Sachdeva and Assistant Director General, Dr Shobini Rajan from NACO were present at the summit.

**Mr. Abou Mere, community representative TI-NGO, KRIPA Foundation**, stated that abstinence programmes should be included in HIV prevention strategy as there is a pressing need to focus on primary prevention for young oral users who may also become Injection Drug Users (IDUs). Therefore, oral/non-injecting drug users should be included in the definition of bridge populations, along with migrants and truckers. For effective scale up of the Opioid Substitution Therapy (OST) programme, the national programme should include demand generation programmes and roll out of take-away doses. He requested the NACO to bring out a written policy that clearly spells out how communities can help assist the government in its response to HIV

**Mx. Laxmi Tripathi, community representative, Trustee Founder & Chairperson, Astitva**, underscored the urgent need to prioritize uninterrupted funding for TIs, empower Community Based Organizations (CBOs) to manage interventions meant for them rather than by NGOs, SACS and DAPCUs. This should help to create an enabling environment by bringing police/law enforcement agencies to the same table and protect the dignity of groups criminalized by the judiciary.

The leadership in NACO and UNAIDS has ensured that community voices are heard; similarly DAPCUs need to work more closely with communities. Communities in turn need to respond to opportunities to work together with the government and agencies and approach them in the right way. The MoUs signed by NACO with 23 ministries need to be followed up for providing various services for the community. She requested that NACO should consider involving communities in their research initiatives.

**Ms. Marietou Satin, Deputy Director, Health Office, USAID**, commended the achievements that India has made, for most part due to the remarkable leadership of the government. While new infections have been drastically reduced; still much remains to be done. The epidemic is controlled in some but rising in other states, thus requiring different ways of doing business and out-of-the-box thinking. There is need to revise estimates of Key Populations (KPs) to get realistic numbers, develop ways to address difficult to identify populations, adopt differential approach to address the epidemic and ensure access to HIV services in non-stigmatizing environment. All this calls for a strong partnership between civil society, academia, government and the corporate sector in order to achieve an AIDS-free generation in India.

**Mr. Ryan McGee, Deputy Director, CDC India**, stressed on the need to work together to reduce new infections by 75%, taking into account technical and financial imperatives. The changing landscape of KPs both in India and globally, necessitates acceleration in epidemic control. He stated that this was the time for bold leadership, in-depth deliberations and emphasis on areas where we are falling short. It is critical to focus on challenges of populations left behind and to tailor strategies specific to the needs of these groups; reduce stigma and discrimination; and focus on law and policy reforms for us to achieve the 90-90-90 targets. Therefore concluding session on next steps remains crucial.

**Mr. John D. Blomquist, Program Leader, World Bank**, stated that prevention is the essence to the HIV response as it involves communities at the front and centre. Granular work at community level makes a significant difference to developing effective programmes. Developing strategies to leverage communities in scale up and progress is the challenging task ahead.

**Dr Henk Bekedam, WHO Representative** in his address stated that while the MTA report has been cause for celebration for many reasons, he cautioned against complacency, stating that awareness among the general population must continue, particularly among young people. He also stressed on the importance of sustaining condom use promotion, focus on KPs and ensure that all groups are reached, especially those that not legally recognized. Other areas needing attention include clinical issues, particularly safe blood and the need not just for clean needles, but also for re-use of prevention needles, stigma, focus on treatment as prevention, looking at other diseases such as hepatitis, and exploring ways to use communication devices, social media and technology. Continuing to engage, involve and connect with communities remains vital and efforts need to be directed to ensure that every young and adult understands AIDS and how it can be prevented.

# Session 1: Thematic Address

*Chairs: Shri Alok Saxena, Joint Secretary, NACO & Dr Bilali Camara, Country Director, UNAIDS*

**Dr S. Venkatesh, Deputy Director General, NACO** presented the challenges in TIs and outlined ways in which the findings of the MTA were being taken forward in the context of current goals and targets. The challenges include: concentrated nature of the epidemic, dynamic epidemic with emergence of new locations, different drivers in every state, complex drivers in select states, migrants as drivers in select states, less than optimal coverage of high risk and bridge populations, declining coverage of TIs, need for progress on first two 90s, late detection of HIV positives and 'at risk' populations beyond traditional HRGs and bridge populations.

He shared the recommendations of the MTA and the technical strategy plan; highlighted current HIV interventions in prisons and other correctional institutions, setting up surveillance sites in prisons and described the action taken on some key recommendations.

He also expressed NACO's expectations from this summit, focusing on the need for broad operational strategies to implement key approaches at scale, considering differential HIV positivity among KP groups in different geographical settings, rates of positivity and challenges in coverage. Expectations also include description of alternate ways of TI performance tracking and identification of the next steps with timelines for rolling out the activity.

## **Discussions:**

- *The national programme needs to address the first 90 and re-emphasise Information Education and Communication (IEC) activities*
- *If engagements are happening via technology, interventions also need to be happening in this medium; expenditure should make impact on outcomes within the narrow confines of epidemic control*
- *The JS, NACO shared the Director General's plan for NACO and the People Living with HIV (PLHIV) community to take part in the Airtel half-marathon to be held on 19th November, as an initiative to serve the dual purpose of visibility and education*

# Session 2: Group Work

1. **Group 1:** Develop a road map on district level/smart city intervention
2. **Group 2:** Develop a concept paper on changing trends of sexual networks among different typologies and to reach out to hidden and unreached population
3. **Group 3 (A):** Differential approach for HIV prevention among the KPs intervention, district yielding high HIV positive with alternate way of performance tracking
4. **Group 3 (B):** Differential approach for HIV prevention among the bridge population of migrants and truckers interventions, district yielding high HIV positive with alternate way of performance tracking.

## Session 3: Plenary

**Chairs:** Shri Alok Saxena, Joint Secretary, NACO & Dr Bilali Camara, Country Director, UNAIDS

**Group 1:** Develop a road map on smart city intervention

**Facilitators:** Mr. Amith Nagaraj, World Bank and Mr. G.S. Shreenivas, Consultant

**Presenter:** Dr Shrikala Acharya

The group focused on experiences from city interventions in Surat, Bengaluru, Mumbai, Vishakapatnam and Hyderabad; noting the key challenges such as high mobility, duplication, fragmentation of efforts and the possibility of reducing costs. Stakeholders such as municipal corporations, field based organizations, community groups, medical colleges, social institutions, industries and corporates were identified. Possible implementation arrangements included lesser contracts versus multiple contracts, formation of consortium models or having one large contract to reduce administrative costs. The enablers for setting up smart city interventions were listed as flexibility in guidelines, differential approach, leveraging private sectors, technology-based solutions and high-level coordination

**The following next steps were proposed:**

- Define criteria for selecting pilots – population, vulnerability, mobility – 15th November 2017
- Broad guidelines with flexibility – December 2017
- Encourage Expressions of Interest (Eoi) from SACS to come up with proposal – January 2018
- Pilot implementation for the interested states – April 2018

**Discussions:**

- *Taking the example of the Netherlands where confronting the HIV problem in Amsterdam and Rotterdam addressed 90% of the country's HIV problem, two cities in India that have signed off on the Paris declaration: New Delhi and Mumbai could be taken up*
- *It is critical to ask ourselves what we want to achieve; undertake situation analysis; decide on human and financial resources required and set clear targets. Besides decision makers in states and centre, the private sector, particularly multinationals need to be convinced that their resources are being effectively used towards measurable achievements and outcomes*
- *In India, efforts to set up smart cities necessitates advocacy for supportive laws and legislations to decriminalize drug users in order to effectively implement harm reduction programmes.*

**Group 2:** Develop a concept paper on changing trend of sexual network among different typologies and to reach out to the hidden and unreached population

**Facilitators:** Dr Rajesh Rana, NACO, Ms. Sophia Khumukcham, NACO and Mr. Aditya Singh, FHI 360.

**Presenter:** Shri Ashok Row Kavi

The concept note developed by the group defined changing trends in sexual networks over the past five years, as well as the specifics of 'hidden' and 'unreached' populations. These include: dissolving

typologies and geographies, not hotspot based sex work, rental homes, mobile networks, change in profiles of sex workers, part-time and seasonal sex work, students and minors, virtual soliciting, upper-class gay men who use drugs and buy sex, homeless populations, use of neuro-stimulants, intimate partner violence, HSV and viral STI co-infections.

It listed the current status of efforts to address these concerns and innovations currently being implemented by agencies such as Humsafar Trust, India HIV/AIDS Alliance, FHI 360, Astitva, National Legal Services Authority (NALSA), SACS and NACO. These innovations have to be documented and scaled-up. The group suggested strategies and proposed activities on the basis of practicability and sustainability; and proposed implementation modalities.

### **Specific recommendations:**

Redefinition of key populations, increase intake into TIs, interventions for viral Sexually Transmitted Infections (STIs), customized approaches to Behaviour Change Communication (BCC), interventions for young populations, web-based IEC modules, network enrolment approach, community engagement and collectivization, inclusion of pleasure and entertainment in IEC, add menu of services in Female Sex Worker (FSW) and Transgender (TG) sites, provision of packaged lubricants, online self-risk assessment tools, address violations and human rights, decongestion of Drop-in Centres (DICs) and OST centers by introducing satellites and take-away doses, differential TI strategies and segmented approaches, secondary distribution of commodities, community based monitoring systems, district prioritization and larger catchment areas to decrease management costs.

### **Discussions:**

- *29 years into TIs, there are still complaints about insensitivity of police and healthcare providers. Continued advocacy initiatives with law enforcement agencies at state level are therefore to be ensured in this regard*
- *At the centre, proactive steps should be geared up in working with relevant ministries to address cross-cutting violence faced by communities*
- *Incarceration of HRGs is not a solution as people coming out of prisons as hard-core criminals means a further loss to society. Careful consideration should be given while implementing prison HIV interventions to ensure promotion of overall health through a comprehensive package so that people can go back to the general community as healthy citizens*
- *Upper class drug-using gay men do not fall into any defined HRG. It is high time to altogether remove risk component and look at vulnerability.*
- *There is a need to explore what brings communities together in the present context. The concept of DICs does not make sense anymore; and we need to look at what is most attractive service that we should be offering as the central pivot*
- *If 40-50% of the KP is “non-self-identified” we need to rethink how to re-define the very concept of KPs. The terminology that we have been using needs to change.*

**Group 3-A:** Differential approaches for prevention among key populations

**Facilitators:** Mr. Kannan M, Consultant and Dr Govind Bansal, NACO

**Presenter:** Ms. Shama Karkal

The group identified the need to transform TIs into 'empowering' interventions; and suggested conducting regional consultations with the community to develop new models for prevention, besides revitalizing SACS, TSUs and DAPCUs.

Transforming TIs would require revised estimation of KPs, regular update of line-lists, quality assessment using revamped indicators and evaluation systems, modification of guidelines and definitions to cover non-injecting drug users, risk and vulnerability categorization, combination prevention, use of technology for real time monitoring, communication and outreach, creating enabling environment through linkage with other government departments and missions, introduction of Pre-Exposure Prophylaxis (PrEP), better compensation packages for peer educators (PE) and exploring options of non-traditional TI models that could either be physical or virtual.

Institutional capacities need to be strengthened by revitalizing SACS, TSU and DAPCU; integrating TSUs within SACS, meaningful participation of communities in Technical Resource Groups TRGs and other committees, handholding and supportive supervision, community monitoring with a focus on quality of services and support for NGO and CBO governance systems

**Discussions:**

- *The term IDU may be changed to 'people who use drugs' (PUD) to expand the reach of TIs*
- *'Traditional' TGs as well as the new, younger generation of TGs still fall outside the structure and reach of the current programme. There is a need to look beyond typologies*
- *Urgent need to address partners of all HRGs through the TI programme.*

**Group 3-B:** Differential approach for HIV prevention among the bridge population: migrants and truckers

**Presenter:** Mr. Sudhakar

Migrants and truckers remain a neglected group despite reflecting significantly high sero-reactivity (2.59%) as compared to other groups. Common areas of program management and strategic importance were identified. Emerging challenges were outlined and operational strategies recommended in order to meet the needs of these bridge populations.

Emerging challenges for migrants were identified as: access to services, service delivery mechanisms and support of employers, management. Operational strategies proposed included improved access to services through CBHT, self-testing, free condoms, increased use of radio, re-design of the Link Workers Scheme (LWS), involvement of the National Health Mission (NHM) in service delivery, work place interventions, engagement of associations, trade-unions, labour department, and employer led models (ELM)

For truckers, the emerging challenges were also access to services and support of employers and management. Suggested operational strategies in terms of service access include Anti Retroviral Therapy (ART) registration and continuation through automated reminders, smart card, smart linkage across ART centres; flexible ART protocol and regimen, Community Based HIV Testing (CBHT) and self-testing; free condoms at different locations, increased use of radio messaging through partnership with large corporates that employ large fleets of truckers; involvement of employers,

RTO, Transport associations, labour department; and workplace Interventions, engagement of associations, trade-unions and ELMs.

Other vulnerable groups that need to be addressed in the ambit of bridge populations include youth, adolescents, spouses of People Who Inject Drugs (PWID) and MSM, local transport workers, transit workers, short distance taxi drivers and persons with substance abuse issues other than PWID.

**Discussions:**

- *There are still existing myths and misconceptions among the bridge population on anal/rectal sexual transmission of HIV; and it is imperative to address the risks of engaging in unprotected anal sex*
- *Sexual partner interventions must be emphasized across all HRGs*
- *Particularly for truckers, ART medication should be adjusted considering the nature of their work – Efavirenz affects concentration and should therefore be replaced by Tenofovir+ZTC+ boosted Atazavir; the nomenclatures ‘first line’ and ‘second line’ of ART may be re-visited*
- *Workplace policy in NACO needs to be adapted and applied to these groups*
- *Interventions for migrants merit serious thought on what can be done with limited resources to generate more evidence and empower them to access services.*

## Session 4: Achievements, Successes and Innovations

**Chairs:** Dr Salil Panakadan, UNAIDS and Dr Gangakhedkar, Director, NARI

In this session, speakers shared examples of how local innovations have responded to emerging needs in India

### 1. Community responses: Experience sharing

Mx Simran Shaikh, India HIV/AIDS Alliance

Innovative community responses introduced by the India HIV/AIDS Alliance were presented. These included projects such as Pehchan, a Global Fund supported programme for 200 organizations of MSM and TG; Samarth, reaching seven MSM/TG clinics for population who are not classically covered in TI such as hijra gharanas, joggapas, spas and clubs; and Wajood, a trans-specific response to violence, social protection and sexual health. It was underlined that solidarity and visibility events that promote acceptance and confidence building of the TG community in turn raises the demand for HIV related services

Recommendations from community include the need for KP size estimation, investment in community-led interventions, context specific approaches, expanding focus from static one-way messaging to interactive internet-based approaches and supporting CBOs.

**Discussions:**

- *Besides granting legal status to the TG community, it is important to provide strategic support for services such as sexual assignment surgery and counselling for PrEP*
- *Socially excluded populations have specific needs that are not necessarily health related, but can be pathways to increased access to health and HIV services.*

## **2. i-Astitva - A Community Recognizable Initiative Application**

Mx Atharva, Astitva

i-Astitva is a free app developed by Astitva with support from UNAIDS, Bangkok. Its features based on TI model are instant alerts, real time monitoring and increased access to social protection benefits. The app enables members to communicate instantly on mobile/tablet apps, email, social media and web forms, can capture information for any service area that needs real time monitoring and response mechanism and has the ability to report, map and assess quality of services by health facilities and programmes. i-Astitva offers GIS-based graphic analysis and facilitates interventions by identifying focus areas, hotspots and providing detailed analysis and trends. It allows users to access information on social protection schemes and benefits and offers parallel tracking of information used by programmes, service providers, civil society, government bodies and international community for triangulation and different actions.

### **Discussions:**

- *A question was raised on the challenges of managing this app in the context of studies indicating that practically 80% of the TG populations is non-literate, it was clarified that the pictorial details available are adequate for users to navigate the app*
- *On the issue of compatibility and capability of the technology used for this app to track mobility, it was agreed that the huge size of data collected would need to be analysed with external help*
- *The app is available for the use of grassroots NGOs or CBOs within the country, while access to agencies outside India could be granted after requisite clearances.*

## **3. Community driven innovation - for sustaining solutions**

Ms. Pratima, Ashodaya Samithi

Ashodaya Samithi, a sex workers' organization comprising female, male and transgender sex workers has implemented several innovations in their programme including the introduction of Community Health Care Navigators (CHCN); addressing PrEP and improving RMC and Cervical Cancer. The CHCNs are placed at Integrated Counselling and Testing Centres (ICTCs) and ART centres to promote access to and utilization of health services by sex workers in public hospitals. A feasibility study on PrEP was initiated in response to the need for additional HIV prevention tools, leading to the demonstration project which is showing encouraging results with high adherence (more than 90%) to PrEP. Cervical cancer screening was included in the spectrum of reproductive health services, leading to early treatment and improved community response.

#### 4. Holistic Outreach Model

Shri Ashok Row Kavi, Humsafar Trust

This model has NACO's TI at the centre of it, providing the traditional service package. This is invigorated through the implementation of enhanced peer outreach strategy and uses seeds in TI to reach out into the community through community mobilizers using respondent driven sampling technique. In addition, a wider population is reached through the internet through ISHKconnect and CHALO, besides engaging with online cruising sites such as Planet Romeo and Grindr, as well as Facebook groups for gay men. Humsafar puts up messages on HIV related services on these sites. This model is incentivized but cost-effective and gives valuable insights into the life of unreached populations

##### **Discussions:**

- *Besides granting legal status to TG, strategic support and services should be provided on areas such as sexual assignment surgery, and counselling for PrEP. Socially excluded populations have specific needs that are not necessarily HIV related*
- *In Humsafar's context, DICs are no longer used as conventional meeting places - DIC space is allocated on different days of the week for events, general health services such as issue of health cards, exclusive TG meetings, etc. to address needs of different service requirements. Single women have started visiting DIC to access services related to ICTC as they feel safer in the non-threatening environment.*

#### 5. Nagaland Experience

Dr Bernice Dzuvichu, Nagaland SACS

Some of the state-level initiatives taken up by Nagaland SACS (NSACS) to effectively address evolving trends among the KPs include: strategies to reach spouses and significant partners of PWID (programme data indicates 2.29% positivity in this population), developing local reporting systems to capture relevant programme data, up-scaling Clinic Service in FSW TI and ensuring community representation in all committees under NSACS.

Some key achievements towards a sustainable intervention include strengthening outreach by reducing HRG-Peer Educator ratio; initiating the individual service tracking system at local level; providing technical support for initiating community-initiated and state government supported OST for oral drug users in sites along the Indo-Myanmar border. NSACS has also facilitated drafting of the Nagaland State Substance Abuse and Prevention Policy that has received the approval of the State Cabinet. A training module for law enforcement agencies has been developed for inclusion in the state police-training curriculum.

## 5. Innovations in HIV service delivery for KPs under LINKAGES and Project Sunrise

Dr Bitra George, FHI 360

The presentation outlined the geographical priorities of the two projects: three districts each in Andhra Pradesh and Maharashtra for LINKAGES and eight states in Northeast India for Project Sunrise. It described the differential strategies employed to reach the KP that are registered in TIs, those that are not registered and unreached or unidentified individuals. These include piloting differential package of services based on revised risk and vulnerability index, provision of additional human resources where services are not available, mapping of new hotspots, virtual media mapping, secondary distribution of needles and syringes, providing low threshold OST services, and employing Field Mentors' Network models.

Project Sunrise also provides HIV services in prison settings in five states by placing staff on part-time basis within the prisons, providing risk and vulnerability counseling, linkage to services in collaboration with the state health systems and prison departments.

The LINKAGES project employs the Enhanced Peer Outreach Approach (EPOA) in Men who have Sex with Men (MSM) and TG populations through virtual and physical networks; encourages CBHT through community events; and uses Peer Navigation approach to link key populations to care and treatment services.

### **Discussions:**

- *Responding to a question on how the project reached people who did not come for physical testing from out of those contacted virtually through the 600 coupons distributed, the presenter explained that constant Whatsapp messages were sent to encourage them to access services*
- *New generation IEC messaging needs to be employed to reach partners of KPs through social media*
- *At present staff for the prison interventions are provided from the project and linked to SACS to ensure continuum of care, but the project aims to move towards setting up Facility Integrated Counselling and Testing Centres(FICTCs) – staff placed; but supposed to use existing staff and/or set up FICTCs*
- *The use of low dead-space syringes (LDSS) for PWID were proposed earlier, but was dismissed by TRG for IDUs as being not relevant to the Indian context. However, evidence for LDSS or non-reuse syringes may be considered*
- *The draft guideline for OST take-away doses is awaiting approval and NACO is considering buprenorphine-naloxone combination tablets for this purpose. The community representatives strongly recommended that the guidelines should reflect trust for the PWID community, flexibility and should be implemented at the earliest*
- *At present treatment centres are available only in urban areas and so people in rural areas are only tested while treatment is not available locally. The solution could lie in looking at differentiated care models to decongest ARTCs and provide refills at local level, although distances are still an area of concern as initiation of ART can only be done in hospitals.*

## 6. Integrated HIV Prevention and Treatment Services for PWID and MSM in India: A one-stop shop model

Dr A. K. Srikrishnan, YRG Care

The Integrated Care Centre (ICC) model is a research initiative that aims to improve HIV awareness, prevention, and treatment in PWID and MSM by providing a menu of integrated services such as HIV testing and treatment, OST, treatment for STI and tuberculosis (TB), condoms, counseling and general medical care in an environment tailored to the needs of the community.

A cluster randomized trial on integrated HIV prevention and treatment services showed high utilization and service uptake but limited engagement in HIV care. The number of people with suppressed viral load was lower than expected. However, client satisfaction across all sites was high, as was the reported satisfaction level with HIV testing services.

### Discussions:

- Responding to a question on whether the study looked at areas such as reduction in unsafe injecting behaviour, retention in OST or reduction in HIV rates, the presenter explained that over 40% of the participants were not from the TI line-listing although a log of needle syringe tracking is maintained and active counselling on safe injecting is provided. He also said that the retention rate for OST was lower than desired
- Measures to address low retention rates for ART are being examined and tracking mechanism is being strengthened. There is also a move to ensure that in almost all ICCs, ART refill will happen onsite after initiation in ARTCs. This will cut down on retention issues
- The issue of ART side effects affecting adherence has been reported in the northeast and south India. Although no specific studies have been done yet, cases are being managed by changing medication. The key is to communicate better with patients. UNAIDS is working with PEPFAR and the government to explore options of medications that can be better tolerated.

## 7. Mumbai: Response to HIV

Dr Padmaja Keskar, Project Director, Mumbai DACS

Describing the fast track city response in Mumbai, the presenter explained the process of geoprioritization of HIV in Mumbai as the first step. Following this, advocacy and screening camps were conducted and community outreach testing camps were held in high transmission areas in the city. Other steps included convergence with the Urban Primary Health Centres (UPHCs) under the National Urban Health Mission (NUHM) for HIV screening services, family screening services at ART Centres, co-location of HIV and TB testing facilities, interventions among young people, engagement with public and private sector for advocacy and testing among informal workers, and setting up of FICTC / ICTC at public sector units. Newer collaborative initiatives include a pilot for differentiated preventive services among different HRG sub-population, EPOA for FSWs and TGs, engagement with NGOs working with street children, meeting Women and Child Department (WCD) officials for social benefits to PLHIV and Corporate Social Responsibility (CSR) consultations.

The initiative hopes to achieve 90% linkage to treatment through strategies such as CD4 sample transportation system through courier, tracking of pregnant women till 18 months through outreach workers (ORWs), validation of PLHIV across TI NGO/CBOs and ART Centres and address verification of newly registered PLHIV. Similar targets for treatment adherence are aimed for through identification of suspect failure patients, enhanced linkage to social benefit schemes, real-time treatment adherence monitoring (IVRS) and promoting yoga interventions.

The response looks forward to conducting advocacy campaigns among adolescents, BCC campaigns for general public, innovative use of social media, employing strategies to reduce linkage loss from ICTC-ART centres, transfers from ART centres, implementing flexible models for PPP-ART services and non-institutional antiretroviral delivery services, and integrated IT systems for monitoring continuum of care for PLHIV.

#### **Discussions:**

- *The initiative to scale up viral load testing started with Test and Treat methods*
- *The HIV programme earlier had strong workplace interventions with the corporate sector and media earlier, but lately there has been a step-back in engagement with these sectors and the general assumption is that the HIV issue has been resolved. It is imperative to therefore sustain engagement with non-health sectors for a comprehensive response.*

## **Session 5: Panel Discussion**

### **Reaching the last mile to achieve 90-90-90**

**Moderators:** Dr S. Venkatesh, DDG-TI, NACO and Dr Parimal Singh, PD Maharashtra SACS

**Panellists:** Ms. Meena Sheshu, Sangram; Dr Samiran Panda, Scientist, NICED, Kolkata; Mr. Shiv Kumar, SWASTI, Bengaluru; Mr. N.R. Manilal, India HIV/AIDS Alliance, New Delhi.

The panel discussed the emerging challenges, the strategies being proposed after the MTA, the development of the NSP (2017-2024), and how they need to be implemented in the national programme.

Specific questions were directed at the panellists, this was followed by comments and queries from the audience. Consolidated discussion points emerging from the panel discussion are as follows:

#### **Rights:**

- The matter of human rights should be taken more seriously. Engagement with the police and legislators needs to be an on-going process in order to ensure that communities are not criminalized. Human rights are not limited only to addressing incidents of stigma and discrimination but also include the need to educate and empower communities in the process of developing a better human rights paradigm.
- Identification of KPs according to occupations should be avoided as it causes further stigmatisation.

### **Approaches to prevention:**

- New approaches for reaching the KPs have to address three gaps: gaps in data, response and gaps in reaching the unreached.
- TIs generate an immense amount of data, which needs to be put to best use. Capacity building is needed at the local and programme levels to analyse this data and provide evidence that can inform the programme. This also implies the need to institute a mechanism for community feedback.
- While talking about 90-90-90, the elimination of new infections among children, combination prevention and reduction in stigma also need equal attention.

### **Focus on communities:**

- Champions from the community need to emerge, particularly IDUs who are better retained on ART and receiving OST. Similarly, locally generated data needs champions at the local level to better understand factors affecting issues such as vulnerability and intersections between key populations.
- For programmes to be effective, there needs to be analysis of reasons for people dropping out of the programme, whether the KPs receiving services for many years require reinforced services and how new populations can be reached.

### **Implementation issues:**

- Prevention challenges identified by the MTA and recommendations to resolve these challenges should be followed through at the earliest.
- In terms of ART side-effects, particularly for IDUs, it is important to note that while Buprenorphine does not have much interaction with ART, heroin and methadone do. It is preferable to provide buprenorphine to IDUs on ART.
- The national guidelines tend to be interpreted as rigid rules at implementation level needs to be viewed with flexibility specific to state-specific concerns. TI guidelines have to be re-examined and offer a menu of options offered along options for innovations.
- Capacity building must be provided at state and district levels to ensure relevance of programmes.

### **Discussions:**

- *The program needs to be people-centric, breaking down distances with services; the rigidity of the TI structure needs to be looked at to ensure that it meets the needs of the KPs they serve*
- *Flexibility is critical for scale up, reaching out to the unreached groups, improving coverage and increasing retention*
- *When analysing local level data, it is important to note that data speaks even in absence. For instance if the number of female IDUs is not known, the absence of these numbers calls for action. Heterogeneity of KPs can also be confirmed by analysing site-specific data*

- *Operational research can help identify the most effective approaches to adopt. FHI 360 and NACO will soon be launching a grand challenge grant to look at fund studies that propose to offer solutions to some problem statements*
- *The definition of KPs must be broadened in order to provide services to people who may require services that are not provided through typology-based TIs. For instance, truckers who also use drugs in Punjab are being prescribed OST medication by private practitioners at exorbitant costs. There is also a need to re-examine the division of TIs so that they encompass interactions between KPs*
- *The core competence of TI is outreach, not data; and so a note of caution was sounded on over-emphasis of data collection as it could affect the quality of outreach work*
- *Issues with consistent care and support mechanisms and side effects of ART adversely affect treatment retention. The national programme's Care, Support and Treatment (CST) division is also considering differential approaches such as dispensing ART medication through TIs, direct registration and shorter wait-time at ART centres and strengthening of supply-chain management*
- *It is important for the programme to understand that expectations from the programme are often not in alignment with those of the community. For example, OST should not be seen as a medicine to get a person out of drugs as that decision lies with the individual's choice*
- *The key to find solutions is to be able to apply innovations to the program, and allowing a menu of options for SACS, DAPCUs and NGOs to implement them*
- *A technical support system is required to address evolving needs. It is necessary to strengthen the mechanism through which current discussions may percolate to the community at the grass roots.*

## Session 6: Developing Prevention Models and Setting Targets

Participants worked in two groups on the following areas:

- **Group 1:** Consolidating Day 1 discussions on models of prevention
- **Group 2:** Setting targets for key populations P5 Working Groups

### 1. Differential approaches for prevention (building on Day 1)

**Chairs:** Dr Salil Panakadan; Dr Ashok Roy

**Facilitator:** Ms. Shama Karkal

**Presenter:** Ms. Sonalini Mirchandani

The group agreed on the need to address changes in dynamics without completely overturning existing systems. However, some of the 'non-negotiable' factors were that the programme should be community centric as it continues to be, flexible, accountable, and ensure saturation with services for all at-risk and vulnerable populations.

It was proposed that the prevention model could include a menu of modalities and indicators that offer options such as flexibility in deciding staff ratio, budgets, dynamic line-list, segmentation of community, focus on qualitative outcomes and not just numbers, service delivery linked to technology-based communication, positive prevention and services for partners. The rating mechanism and overall indicators of the TIs should be revised and flexibility should be linked to the rating.

**Next steps:**

- NACO to allow states to innovate and prioritize modalities specific to contexts
- Capture all innovations; study cost effectiveness and replicability
- Study NHM Community Based Monitoring Tool for use
- Current innovators to work with SACS to include into next AAP
- Provide guidance on how to work with minors
- Flesh out the guidelines and options for finalization with NACO and UNAIDS.

**Discussions:**

- *Detailed costing of the new model will need to be worked out before the next AAPs are finalized, looking at room for innovation and flexibility within existing guidelines. Technical partners should be nominated for states that don't have adequate capacity to develop innovations*
- *Presently innovations are mostly funded by donors, but it would be worthwhile for NACO to allow proposals for TI models to be submitted to respective SACS with clear specification of costing modalities*
- *Missing enablers such as female condoms and social marketing are a challenge*
- *With the National Technical Support Unit (NTSU) no longer in existence, there is need to strengthen the TI division within NACO*
- *There should be at least six months funding for TIs in the pipeline in order to ensure zero-stock out and zero cash-out.*

## 2. Setting targets

Chairs: Dr Bilali Camara, Dr S. Venkatesh

**Facilitators:** Dr Pradeep Kumar, NACO Dr Savina Ammasari, UNAIDS and Mr. Manish Kumar, TL-TSU, Punjab

**Presenter:** Ms. Deepika Srivastava

The group reviewed the target templates provided to determine appropriateness of each indicator, identify data sources and feasibility of collecting data, establish baselines for each indicator and establish interim and final targets using NSP targets where available. For reference, NSP, Integrated Biological Behavioural Survey (IBBS), and programme data were used.

The group also deliberated on the need for incidence for impact measurement, considerations about data sources for measurement, modeling and projections, cohort-based surveillance in TIs and lab-based incidence, need to have a consistent tracking mechanism to gauge trends over time and the need for more granular data for younger age groups (15-19 years) and other age disaggregation.

## Group Work: Template Review: example

INDICATORS	Data Source/ Available (Y/N)	Baseline	Target	Target	Target	Target
		2016	2017	2018	2019	2020
<b>IMPACT</b>						
% HIV incidence in FSW per 1000 uninfected FSW						
% prevalence among young FSW (15-24)						
<b>OUTCOME</b>						
% condom use on last sex among FSW						
% condom use at last sex with non-regular partner						
% condom use at last sex with spouse/regular partner						
1st 90 - % of HIV positive FSW who know their status						
2nd - % of FSW who know their status receiving ART						
3rd 90 - % of FSW on treatment who have suppressed VL						
<b>OUTPUT</b>						
# of condoms distributed/sold (by free/social marketing) per person						
# lubricant distributed/sold per person						
% FSW reached by prevention interventions						
# of FSW contacted through outreach (by physical/virtual)						

### Outputs:

INDICATORS: IDU	Baseline	Baseline	Target	Target	Target	Target
	2010	2016	2017	2018	2019	2020
<b>IMPACT</b>						
% HIV incidence in PWID per 1000 uninfected PWID						
% incidence among young PWID (15-24) by M/F						
<b>OUTCOME</b>						
% of PWID with comprehensive knowledge of HIV	42.6% IBBS		40	60	80	90
% condom use on last sex among male PWID						
% condom use at last sex with non-regular partner			80	85	90	95
% condom use at last sex with spouse/regular partner			20	40	60	80
% use of safe injecting equipment during last injection	14.5% IBBS		80	85	90	95
<b>OUTPUT</b>						
1st 90 - % of HIV positive PWID who know their status	Check			70	80	90
2nd - % of PWID who know their status receiving ART						
3rd 90 - % of PWID on treatment who have suppressed VL						
# of needles and syringes received by person – 20 NS per month		33% received 30 NS per month, IBBS	30	60	70	90
% PWID reached by prevention interventions (ART + 1 of the other 2: NSEP or OST)			15	30	60	90
- NSEP look at other indicators			15	30	60	90
- ART						
- OST			50	55	60	65
# of PWID put on OST against active coverage of PWID in TI						
# of PWID contacted through outreach (one of any services)	73		65	75	85	90

INDICATORS: FSW	Baseline	Baseline	Target	Target	Target	Target
	2010	2016	2017	2018	2019	2020
<b>IMPACT</b>						
Comprehensive knowledge pf HOV		42.5 (2014-15)			60%	70%
% HIV incidence in FSW per 1000 uninfected FSW	Estimations					
<b>OUTCOME</b>						
% condom use on last sex among FSW						
% condom use at last sex with non-regular client	IBBS	94%- non-regular client Regular client – 90.7			94%	80% 96% 94%
% condom use at last sex with spouse/regular partner	IBBS	54.9%			60%	70%
1st 90 - % of HIV positive FSW who know their status	IBBS	85.8% of HIV positive FSWs (IBBS)				90%
2nd - % of FSW who know their status receiving ART	IBBS	51% (awareness of ART- IBBS)				90%
3rd 90 - % of FSW on treatment who have suppressed VL		No data				90%
<b>OUTPUT</b>						
# of condoms distributed/sold (by free/social marketing) per person	Program Data	TBD			85%	90%
% of condoms distributed against demand (by quarter)						
# lubricant distributed/sold per person	NA	NA	NA	NA	NA	NA
% FSW reached by prevention interventions	Program Data	TBD				90%
# of FSW contacted through outreach (by physical/virtual)	need discussion on methodology virtual	TBD			85%	90% (physical)

INDICATORS: MSM	BL					Source	Comments
	2010	2017	2018	2019	2020		
<b>IMPACT</b>							
% HIV incidence in MSM per 1,000 uninfected MSM						- National HIV estimates (modelling) - TI cohort data (correction factor to be used for unaccounted population) - IBBS (inclusion of an antibody test to detect new infections)	-
% incidence among young MSM (15-24) by M/F							
<b>OUTCOME</b>							
% of MSM with comprehensive knowledge of HIV						IBBS / survey data	Need to define 'comprehensive knowledge'
% MSM reporting consistent condom use in last 1 month							
- With paying partners						TBC(90)	
- With casual partners						TBC	
- With regular partners						TBC	
1st 90 - % of MSM living with HIV who know their status					90	Denominator (MSM living with HIV): HIV estimated (modelling) / calculating no. considering prevalence Numerator : ICTC data	- Potential under-reporting - For cohort data - May take a little time for smoothening IT systems

2nd - % of PLHIV who know their status receiving ART (by GP and KPs)					90	Numerator: ART data	- Potential under-reporting - For cohort data - May take a little time for smoothening IT systems
3rd 90 - % of PLHIV on treatment who have suppressed VL (by GP and KPs )					90	Numerator: (currently data not available – to be captured with expansion of VL testing)	
<b>Output</b>							
# No. of condoms (30?) distributed/sold (by free/social marketing) per MSM in last 1 month [Note: indicator slightly reworded]						- IBBS / survey data - TI data	- These are more output indicators – there was discussion on whether to keep these indicators
# lubricants/distributed sold							
% MSM reached by prevention interventions						TBC - Program data	- Need to define 'reached' and ideally this should be reached by comprehensive package of services (e.g. tested for HIV twice a year, at least 2 RMS, etc.) – need to check global guidance on exact definition etc for consistency

### **Conclusion:**

The outputs of the group work still needs to be brought together into a cohesive framework, taking into account the need to resolve issues around denominators and methodology for measurement. There is still a need to strike a balance between aspirational and realistic targets, and to involve all stakeholders to enrich the perspective.

### **Discussions:**

- The current framework explains 15% of new infections. For the general population, proxy indicators like HIV among young people (15-19/15-24 years) will be taken
- It will be important to understand how this new tool will affect the overall programme and service delivery indicators; and to have a detailed understanding
- This is a simplified tool and can be made more outcome-oriented to meet all the programme needs and also align interventions from input-oriented to outcome-oriented
- Alignment of indicators across different methods (IBBS, HSSS and programme data) is needed. Unique identifier for treatment cascade (prevention to treatment) is required as is a common definition of KP across delivery points
- The discussions need to be followed up with regard to the general population component.

## **Session 7: Group Work**

This session required participants to work in four groups on the following areas:

- **Group 1:** Enhanced Prevention Strategy vis-a-vis the Treatment Cascade
- **Group 2:** Defining Monitoring Framework for Stigma and Discrimination in Health Care Settings
- **Group 3:** Law Enforcement Agencies and how HIV prevention can be enhanced in prisons and other correctional settings
- **Group 4:** Strengthen data management and data use at sub-national level.

The outcomes of the group work were presented in the following plenary session.

## **Session 8: Plenary**

Chairs: Dr Salil Panakadan, Dr Bilali Camara, Dr Swarup Sarkar, Dr S Venkatesh, Dr Pradeep Kumar

**Group 1:** Enhanced Prevention Strategy vis-a-vis the Treatment Cascade

**Facilitators:** Dr Asha Hegde, WHO and Dr Manish Bamrotiya, NACO

**Presenter:** Mr. Manoj Pardesi

The group worked on developing workable strategies on the following areas:

- Enhancing linkage between TI to testing
- Enhancing linkage between testing to treatment for HRG/KP
- Strategy for HRG ART retention
- Strengthening systems at SACS: TI-BSD-CST.

The strategy to enhance linkage between TIs to testing includes focus on KPs and their partners, both registered as well as not registered in TIs or Link Worker Scheme (LWS); community-based screening and confirmatory testing such as Testing through Targeted Intervention models while retaining traditional testing approaches.

To enhance linkage between testing to treatment for HRG/KP, the programme needs to develop and strengthen information (IEC, IPC, BCC) on treatment; decongest ART centres; employ differentiated care models; improve understanding of KP typologies at ART centres; train Medical Officers and staff on sensitive treatment of KP; improve quality of counseling; increase Peer Counselors in 'high-load' settings; improve coordination and information sharing between TI-ICTC-ART counselors and involve Peer Navigators to support/accompany KPs through CST services.

A workable strategy for HRG ART retention includes ensuring preparedness; follow up mechanism for non-reachable clients; involvement of Peer Navigators; decongestion; and differentiated care. The strategy also involves strengthening systems at TI, Blood Safety and Care, Support and Treatment divisions at the SACS level.

Operational strategies that were identified included the pilot differential care models in TI and OST settings (Project Sunrise and Linkages FHI360), link ART pilot in Aizwal Central Jail (Project Sunrise FHI360), provision of ART in 3 OST sites Delhi (Delhi SACS) and TI-ART models in selected sites (Alliance).

#### **Discussions:**

- *Include additional community counsellor at ART centres with a relaxation in requisite qualifications, taking into account years of experience instead*
- *Differential care models must be focused on making access easier for patients.*

#### **Group 2: Defining Monitoring Framework for Stigma and Discrimination in Health Care Settings**

**Facilitators:** Dr Venkatesan Chakrapani, Expert and Ms. Nandini Kapoor Dhingra, UNAIDS

**Presenter:** Mr. Yashwinder

The group identified steps to reduce discrimination in health care settings through training of healthcare providers on HIV and sexual health and cultural competency on KPs; incorporating unbiased information on KPs in medical/nursing/paramedical curriculum (MCI); developing PLHIV/KP-friendly checklist at hospitals; developing adaptable non-discrimination hospital policy; rating system for hospitals be based on non-discrimination; involving professional associations; recognizing champions among HCP/media; mass media campaigns; and appointing ombudsmen at the district and state levels.

Methods identified for monitoring of incidents of stigma and discrimination included periodic monitoring at hospitals; network/TI-based monitoring and real-time direct reporting by PLHIV and KPs through information technology (IT) (such as apps, government websites and helplines).

Surveillance mode monitoring at the national level to monitor the extent and trend in stigma/discrimination would necessitate incorporation of questions on stigma and discrimination in HCS that are part of a periodic national survey such as the PLHIV Stigma Index and KPs Stigma Index; as well as inclusion in IBBS.

**Discussions:**

- *The community has a role to play in addressing self-stigma through building capacities of positive speakers*
- *Celebration/recognition of champions who are KP-friendly needs to be done systematically using a grading/rating system*
- *A combination of strategies needs to be in place to address stigma and discrimination particularly among the PWID community as many do not have smartphones to use apps*
- *Learning from the IBBS experience, a more institutional structure like a community monitoring board could be set up to report adverse incidents.*

**Group 3:** Law Enforcement Agencies and how HIV prevention can be enhanced in prisons and other correctional settings

**Facilitators:** Mr. Abraham Lincoln, NACO, Dr Jyoti Mehra, UNODC and Dr Rajesh Kumar, SPYM

**Presenter:** Mr. Anupam Hazra

The group discussed scale up of HIV intervention in prison settings; expansion of services to women living in other correctional settings; and setting up surveillance sites in prisons; sStrategies to be planned for generating strategic evidence where programmes are currently being implemented; coverage of other correctional facilities to be expedited; setting up of ICTCs and Link ART Centre (LACs in prisons) to be focused upon; advocacy with state governments to update prison manuals; dedicated staff at SACS to be appointed for coordination of issues related to prison interventions, law enforcement and human rights; institutionalization of mechanisms for post-release follow-up; allocation of resources to expand prison HIV interventions; and identify and promote NGO/CBOS/ Networks/forums to support the national prison HIV intervention.

Working with law enforcement agencies necessitates institutionalization of mechanisms to sensitize the judiciary, police and prisons. A Memorandum of Understanding between NACO and the Ministry of Home Affairs would facilitate directives to state governments to bringing prison HIV interventions under state prison medical facilities. Funds for advocacy and Crisis Management should be reinstated in TI programmes. Coordination with the Home Ministry and police training academies is required to institutionalize HIV related sensitization for all law enforcement personnel for which the current LE manual developed by UNODC may be customized. Advocacy efforts may be initiated to align with other departments and ministries for providing HIV prevention and treatment services for children and juveniles.

**Discussions:**

- *Two LACs in central prisons have been initiated in Punjab, and medical officers are being trained. The positivity among prisoners who are IDUs is known to be high, although no specific studies have been conducted so far*
- *Prison interventions should ensure provision of an integrated health package as recommended by international agencies*
- *There should be focus on protecting rights and confidentiality of PLHIV in prisons.*

**Group 4:** Strengthen data management and data use at sub-national level

**Facilitators:** Dr Pradeep Kumar, Dr Pamela Ching, CDC and Mr. Shajan Matthew

**Presenter:** Mr. Shajan Matthew

The group identified the current status and challenges imposed by aggregated monthly data; too many indicators; burdensome and repetitive process; infrastructure and staff capacity; multiple and parallel systems with no interoperability; limited analyses and output generation and as being not up to date with current technological advancement.

SIMS+ was proposed as a strategy to move from aggregated numbers to individual focus, the salient features of which include workability across different devices; capability of uploading functionalities both online and offline; customized dashboards; GIS integration and analytics; Data Intelligence Assistant (DIA) integrated with Cortana; and incorporation of status update page to share best practices, key achievements and important useful information. The proposed integrated approach includes individualized data from all divisions; surveillance data; TSU's supportive supervision activities; partner reporting and updates and feedback from the community.

**Recommendations:**

- Rationalization of indicators; decision on periodicity depending on the indicators
- Establishment of an IT cell at NACO
- Constitution of a Technical Working Group
- Development of dashboards, visualization and reports using existing data base
- Data sharing, transparency and dissemination
- Development of an analytical lens.

**Discussions:**

- *Capacity building for a robust support system at TI level must be ensured to strengthen data management*
- *Community feedback should be generated in the system as an alert, and mechanism should indicate whether action has been taken or not*
- *Analysis of national data needs to be institutionalized to avoid delays*

- *An integrated Monitoring and Evaluation (M&E) framework is desirable, possibly tracking of individuals from TI/ICTC onwards using thumb impressions/biometrics as unique identifier. However, biometrics could pose challenges while taking the system to scale, besides apprehension of misuse related to confidentiality*
- *The option of using existing government-issued ID cards as identifier could be considered*
- *The dialogue between the community and NACO needs to continue to enable data to be used for the benefit of the community as well as to facilitate enhanced planning, budgeting and service provision.*

## Session 9: Valedictory

Dr Salil Panakadan, UNAIDS; Dr Bilali Camara, UNAIDS; Dr Swaroop Sarkar, Director (CDS) WHO/SEARO; Dr S Venkatesh, DDG NACO; Ms. Kaushalya Penasamy, PWM+; Ms. Sheena Chhabra, World Bank; Ms. Henita Kuntawala, PEPFAR Coordinator

The meeting concluded with closing remarks from speakers representing a cross-section of stakeholders.

Dr Bilali Camara stressed on the need for collective action to ensure an end to the suffering that has gone on for too long. He lauded the community for giving voice to issues that require agencies to work together to achieve common goals.

Dr Swarup Sarkar underlined the importance of asking ourselves tough questions about what we can do to save people who are getting infected. He stated that addressing the issues of population prioritization, intervention prioritization, prevention financing, community involvement and sustaining the response to AIDS are of primary importance in formulating India's response to the world.

Ms. Kousalya Penasamy highlighted the necessity to prioritize primary prevention for women and the high-risk population.

Ms. Sheena Chhabra described the MTA as a watershed in terms of providing an opportunity to look at actions that need to be taken in terms of defining KPs, interventions or programme delivery; requiring a clear strategy to steer the programme going forward, incorporating flexibility, demonstration of innovative models and new approaches.

Ms. Henita Kuntawala commended the productive meeting, and emphasized on the need for a multi-faceted strategy that involved working closely with the community; reiterating PEPFAR's commitment to support India's goal to control the epidemic.

Dr S. Venkatesh, on behalf of NACO and the organizers, thanked the participants and partners for their support. He made a commitment to consolidate the recommendations and see how the deliberations and proposed actions could be taken forward.

## Annex 1: Agenda

### Prevention Summit Venue: Le Meridian 5th October 2017

**Registration:**

**0830 hrs**

**Inaugural**

**0930-1030 hrs**

**Welcome-**Dr Bilali Camara, UNAIDS Country Director

**Objectives & Methodology of the Summit-** Shri Alok Saxena, Joint Secretary, NACO

**Remarks-**

Mr. Abou Mere, Community Representative TI-NGO, KRIPA Foundation

Mx. Laxmi Tripathi, Community Representative, Trustee Founder & Chairperson, Astitva

Ms. Marietou Satin, Deputy Director, Health Office, USAID

Mr. Ryan McGee, Deputy Director, CDC India

Mr. John D. Blomquist, Program Leader, World Bank

**Address-**Dr Henk Bekedam, WHO Representative

**Inaugural Address by Chief Guest-** Shri Sanjeeva Kumar, Additional Secretary and Director General, NACO

**Vote of Thanks-**Mr. Rajeenald, NACO

*\*Group photo*

**Session 1**

**Thematic Address**

**1030-1100 hrs**

Challenges in Targeted Interventions & taking forward the findings from Mid-Term Appraisal and sub-group meeting held on Prevention

**- Dr S. Venkatesh, DDG, NACO**

**Session 2**

**Group Work**

**1100-1200 hrs**

Key recommendations of the Working Group on Next Generation TI, MTA and JIRM Aide Memoire

**Group 1:** Develop a road map on District level/ Smart City Intervention

**Facilitators:** Mr. Amith Nagaraj, World Bank and Mr. G.S. Shreenivas, Consultant

**Group 2:** Develop a concept paper on changing trend of sexual network among different typologies and to reach out to the hidden & unreached population

**Facilitators:** Dr Rajesh Rana, NACO, Ms. Sophia Khumukcham, NACO and Mr. Aditya Singh, FHI 360.

**Group 3-A:** Differential approach for HIV prevention amongst the Core population intervention

**Facilitators:** Mr. Kannan M, Consultant, and Dr Govind Bansal, NACO

**Group 3-B:** Differential approach for HIV prevention among the bridge population of migrants and truckers interventions district yielding high HIV positive with alternate way of performance tracking

- Each group to propose concrete model/s - operational, financial, programmatic and policy changes

**Session 3: Plenary**

**1200-1300 hrs**

**Chairs: Shri Alok Saxena, Joint Secretary, NACO & Dr Bilali Camara, Country Director, UNAIDS**

Presentations from the groups and discussion

**Lunch**

**1300-1400 hrs**

**Session 4**

**1400 –1830 hrs**

**Achievements, Successes and Innovations**

**Chairs:** Dr Salil Panakadan, UNAIDS & Dr Gangakhedkar, NARI

- Community Feedback tool, experience sharing- Mx. Atharva, Astiva and Mx. Simram, Alliance
- Community outreach models – Ms. Pratima, Ashodaya
- Outreach and use of social media – Mr. Ashok Row Kavi, Humsafar Trust
- State experience - Dr Bernice, Nagaland SACS

**6th October 2017**

**Welcome and Recap from Day One**

**0900-0915hrs**

**0915-1030 hrs**

- Innovative interventions under Project Sunrise and Linkages – Dr Bitra George, Country Director, FHI360
- Integrated Care Clinic: Single Window Approach – Dr A.K. Srikrishnan, YRG Care
- Fast Track City response – Dr Padmaja Keskar, Project Director-MDACS

**Session 5: Panel Discussion**

**1030-1200 hrs**

Emerging challenges, the strategies being proposed in after the Mid-Term Appraisal and the development of the NSP (2017-2024) and how they need to be implemented in the National Programme

**Moderators: Dr S. Venkatesh, DDG-TI, NACO & Dr Parimal Singh, PD Maharashtra SACS**

**Panellists**

- Ms. Meena Sheshu, Sangram
- Dr Samiran Panda, Scientist, NICED, Kolkata
- Mr. Shiv Kumar, SWASTI
- Mr. N.R. Manilal, India HIV/AIDS Alliance

**Session 6:**

**1200-1330hrs**

**Developing Prevention Models and Setting Targets**

**Facilitators: Dr Pradeep Kumar, NACO, Dr Savina Ammasari, UNAIDS and Mr. Manish Kumar, TL-TSU, Punjab**

**Introduction:** Size estimation and target setting for Key Populations at National, State and District levels: Dr Pradeep Kumar.

TG-MSM-FSW-PWID-Young Women

Setting targets for prevention among Key Populations

- Condom use at the last sexual encounter (TG, MSM, FSW)
- Use of needle and syringes (PWID)
- OST uptake (People who inject drugs)
- Testing for HIV (TG, MSM, FSW, and PWID)

**Lunch**

**1330-1430 hrs**

**Session 7: Group Work**

**1430-1530 hrs**

**Group 1:** Enhanced Prevention Strategy vis-a-vis the Treatment cascade- focus on gaps in retention cascade especially between detection and linking to care specifically for HRGs

**Facilitators:** Dr Asha Hegde, WHO and Dr Manish Bamrotiya, NACO

**Group 2:** Defining monitoring framework for Stigma & Discrimination in Health Care Settings

**Facilitators:** Dr Rajesh Rana, NACO and Ms. Nandini Kapoor Dhingra, UNAIDS

**Group 3:** Law Enforcement Agencies and how HIV prevention can be enhanced in prisons & other correctional settings

**Facilitators:** Mr. Abraham Lincoln, NACO, Dr Jyoti Mehra, UNODC and Dr Rajesh Kumar, SPYM

**Group 4:** Strengthen data management & data use at sub national level (for eg. real time monitoring, geo-prioritization, upgrading the IT architecture, leveraging institutional support etc.)

**Facilitators:** Dr Pradeep Kumar, Dr Pamela Chang, CDC and Mr. Shajan Matthew

**Session 8:** Plenary

1530-1630 hrs

**Chairs:** Dr Salil Panakadan, Dr Bilali Camara, Dr Swarup Sarkar, Dr S Venkatesh, Dr Pradeep Kumar

Presentations from the groups and discussion

**Session 9: Valedictory**

1630-1700 hrs

**Next Steps and Action**

- Dr Salil Panakadan, UNAIDS
- Dr Bilali Camara, UNAIDS
- Dr Swarup Sarkar, Director (CDS) WHO/ SEARO
- Dr S Venkatesh, DDG NACO
- Ms. Kaushalya Penasamy, PWM+
- Ms. Sheena Chhabra, World Bank
- Ms. Henita Kuntawala, PEPFAR Coordinator

**Vote of Thanks**

**Dr S. Venkatesh, DDG, NACO**

The two-day Prevention Summit organized by NACO in collaboration with UNAIDS and PEPFAR brought together key stakeholders of India's HIV prevention programme to deliberate upon building on the gains made so far, understand emerging challenges, examine targets and develop strategies to accelerate progress. Diverse perspectives from the community, the Government of India, donor agencies and technical partner agencies set the scene for participants to identify priority areas for strategy development.

This report describes the proceedings at the Prevention Summit and highlights the significant outcomes and recommendations that seek to contribute towards enhancing and streamlining the national strategy on HIV prevention.

