Global to local:
Science and community in the response to HIV in India

SCIENTIFIC SYMPOSIUM

India, 4 December 2019
ART Roll Out in India

Dr. Ishwar Gilada

HIV/AIDS Physician- Unison Medicare and Research Centre
President- AIDS Society of India
Governing Council Member- International AIDS Society
Sept. 1985: India’s first AIDS Awareness Campaign

THE SUNDAY OBSERVER, SEPTEMBER 29, 1985

‘AIDS danger not recognised in India’

Sunday Observer Correspondent

BOMBAY, Sept 28: There is every danger of the dreaded AIDS (Acquired Immune Deficiency Syndrome) spreading to India, feels Dr IS Gillada, honorary secretary of the Indian Health Organisation, and to meet the danger, the IHO is planning an awareness campaign from next month.

“When AIDS arrives in India, it will spread like plague,” says Dr Gillada, “because we don’t know its organisms and treatment. Many of the doctors who treat sexual disorders don’t even know what the letters AIDS stand for. Besides, an AIDS patient may not be treated as a venereal patient—he may be taken as a general patient, because the symptoms are not only sexual.”

Dr Gilada cites a number of reasons why AIDS might come here, although so far Asia is the only continent which has not recorded any victim of the disease. “There is no special immunity that Asians enjoy,” he says. Besides, some of the European victims have claimed to have had homosexual contacts with Indians. The percentage of homosexual population in India hasn’t been recorded, but he feels there are enough of them to cause concern. Jails, remand homes, hotels, are known homosexual breeding centres, and the Arab influx into India has increased this, he says.

Dr Gilada points out that India has the largest number of VD patients in the world, despite full AIDS-contaminated, but we are still dependent on its import. Reports of AIDS victims have come in from Lucknow, Delhi and Bombay, reveals Dr Gillada, but they remain unconfirmed.

“By the time we diagnose the first case, it would spread like anything,” he says, hence the awareness campaign. Symposia and workshops for doctors will form part of it, and the IHO will also pressure the government to make the study of the disease part of the medical curriculum. Apart from that, the IHO will stress the strengthening of traditional Indian moral and social values.

“Abroad, they are trying to emulate Indian culture, to cut down on promiscuity, but here we’re blindly aping the West and getting all the diseases. We must emphasise that pre and extra-galinda sex is harmful. At least in the West there exists the basic infrastructure—health and social consciousness—to go with these. Here no such infrastructure exists.”
India will top AIDS list this decade: Gilada

By The Daily Staff

BOMBAY, Dec. 26

AIDS cases in India will out-number those in any other country by 2000 A.D., Indian Health Organisation (IHO) honorary secretary Dr. I.S. Gilada said here today.

Gilada said the World Health organisation (WHO) estimated 50 million Indians suffered from sexually transmitted diseases (STD) out of 200 million cases worldwide.

In a joint press statement, Dr. Gilada and microbiology research associate in the US Dr. Bhaskar Rao said the chances of contracting AIDS increased if a person already suffered from sexually transmitted diseases, and stressed the vulnerability of genital ulcer sufferers.

He said if steps were taken to control and prevent AIDS, other STDs, which were at an all-time high in the country, would also be controlled. Besides, this would prevent unwanted pregnancies.

Dr. Gilada said political will was necessary in India, because nothing significant could be achieved without it.

In other countries, he said publicity focused, after a politician died of the disease.

Saying women and children were more susceptible to the disease, Gilada urged women’s organisations to concentrate on prostitution. He also offered technical guidance by the IHO and the newly-founded Indian...
India’s 90-90-90 targets: Status 2018

- Estimated: 2.1
- Knowing Status: 1.7 (80%)
- On ART: 1.2 (58%)
- Viral suppression: 1.5

To be Achieved by 2020
Achieved as on Mar-2018

Role of Industry

Slide Credit: NACO
### Current Status: India’s 90-90-90 targets

<table>
<thead>
<tr>
<th>Estimated HIV +ve people</th>
<th>Diagnosed positive</th>
<th>On ART</th>
<th>Viral suppression</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Million</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7 Million (79.4%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 Million (82.3%)*</td>
<td></td>
<td></td>
<td>74% among tested</td>
</tr>
</tbody>
</table>

*Second 90 includes 1.05 lakh from private sector*

Slide Credit:  
Dr. Naresh Goel, NACO
End **AIDS** by 2030 (targets of UN SDGs + India’s NHP2017) **warrant**

100% people know their HIV status

100% HIV+ people on ART

100% virally suppressed

**ZERO** new HIV transmission (prevention works)
HIV in India

2.14 million living with HIV

0.3% adult HIV prevalence

>90% infections - unsafe sex

83% of infections are in adults between 15-49

40% are in women

Only 65% are on treatment
Game Changers

Launch of Test and Treat: 28th April 2017
HIV/AIDS Act: 11th April 2017
Launch of Viral Load Testing: 26th February 2018

Slide Credit: NACO
ART Transitioned from Empty to ~20 tab/day to STR
1995-2015: India transitioned from beggary to donors

GILADA/UMRC/MUMBAI
Figure 1: Sample Country Highlights on Progress against HIV

>40% Decrease in annual new HIV infections since 2007
- DR Congo
- Eswatini
- Malawi
- Togo

>80% ART coverage of PLHIV, 2017
- Botswana
- Cambodia
- Namibia
- Rwanda

>80% Viral suppression rates of PLHIV on ART, 2017
- Laos
- Kenya
- Lesotho
- Vietnam

Lists are not intended to be exhaustive

GILADA/UMRC/MUMBAI
INDIA

Estimated new HIV infections in adults and children between 1998-2015

300,000

Children 0-14 years

200,000

Adults 15+ years

100,000

AVERT.org
Estimated new HIV infections in adults and children between 1998-2015

- Children 0-14 years: 200,000
- Adults 15+ years: 100,000

National AIDS Control Programme (NACP) evolution

NACP I (1992-1999)
Initial interventions

NACP II (1999-2006)
- Decentralization to states
- Limited coverage of services

NACP III (2007-2012)
- District Focus
- Massive scale up with quality assurance mechanisms

NACP IV (2012-2017)
- Consolidate gains
- Focus on emerging vulnerabilities,
- Balance with growing treatment needs,
- Integrate & Mainstream
- >65% reduction in new infections achieved since 2000

NACP-IV Extension (2017-20)
- Committed to make concrete progress towards “End of AIDS by 2030”
- Test and Treat; Mission Sampark
- Viral Load Monitoring
- HIV/AIDS Act
- Universalization of testing of HIV among pregnant women

Slide Credit: NACO
# NACP: Changing Focus

<table>
<thead>
<tr>
<th>NACP</th>
<th>Years</th>
<th>Major Focus</th>
</tr>
</thead>
</table>
| NACP-I | 1992-1999  | - Understanding trends of HIV  
                      - Raising public awareness                                                |
| NACP-II| 1999-2006  | - Raising public awareness  
                      - Blood-bank safety  
                      - Increase sentinel surveillance  
                      - Establishing targeted interventions  
                      - Conducting behavioural surveillance                                      |
| NACP-III| 2006-2012 | - Continued prevention, focus reduced  
                      - Targeted intervention, focus reduced  
                      - Care, support and management                                              |
| NACP-IV | 2012-2017  | - Targeted intervention, focus reduced  
                      - Care, support and management                                              |
| NACP-V | 2017-2024  | - Test and Treat  
                      - Viral Load testing                                                           |
FIRST 90

Opt-in Screening in India (in contrast to the opt-out screening in many other countries)

TESTING STRATEGIES

Voluntary
Based on clinical suspicion
Partner testing/testing for MTCT
ANC
Pre-operative/In-Patients
Blood bank
Self-testing

GILADA/UMRC/MUMBAI
Second
90
# ART Roll-out Public v/s Private

<table>
<thead>
<tr>
<th>Sr.No.</th>
<th>Parameter</th>
<th>NACO Centres</th>
<th>ART</th>
<th>ART in Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>When did ART start?</td>
<td>2004</td>
<td>1997, widely from 2000</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CD4 testing start widely</td>
<td>2004-5, more 2007</td>
<td>1994, widely from 1998</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>When did PMTCT start?</td>
<td>~ 2000</td>
<td>1993 onwards</td>
<td></td>
</tr>
<tr>
<td>4-a)</td>
<td>ARVs available for 1&lt;sup&gt;st&lt;/sup&gt; line ART?</td>
<td>Five</td>
<td>~15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) ART combinations for 1&lt;sup&gt;st&lt;/sup&gt; line</td>
<td>Four, now only one</td>
<td>~ 10</td>
<td></td>
</tr>
<tr>
<td>5-a)</td>
<td>Drugs available for 2&lt;sup&gt;nd&lt;/sup&gt; line ART</td>
<td>One PI</td>
<td>Three PIs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) ART combinations for 2&lt;sup&gt;nd&lt;/sup&gt; line</td>
<td>One</td>
<td>~ 10</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Adherence</td>
<td>~75%</td>
<td>~ 90%</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Continuity of ART officers</td>
<td>Poor, ~ 6-8 months</td>
<td>Excellent (nos stagnant)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Qualifications/Experience of ART Officers</td>
<td>MBBS, Poor</td>
<td>PGs, Excellent</td>
<td></td>
</tr>
</tbody>
</table>

GILADA/UMRC/MUMBAI
# WHO ART GUIDELINES: WHEN TO START

<table>
<thead>
<tr>
<th>TARGET POPULATION (ARV-NAIVE)</th>
<th>2010 ART GUIDELINES</th>
<th>2013 ART GUIDELINES</th>
<th>2016 ART GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV+ ASYMPOTOMATIC</strong></td>
<td>CD4 ≤350 cells/mm³</td>
<td>CD4 ≤500 cells/mm³ (CD4 ≤ 350 cells/mm³ as a priority)</td>
<td>ALL</td>
</tr>
<tr>
<td><strong>HIV+ SYMPTOMATIC</strong></td>
<td>WHO clinical stage 3 or 4 regardless of CD4 cell count</td>
<td>No change</td>
<td>ALL</td>
</tr>
<tr>
<td><strong>PREGNANT AND BREASTFEEDING WOMEN WITH HIV</strong></td>
<td>CD4 ≤350 cells/mm³ or WHO clinical stage 3 or 4</td>
<td>Regardless of CD4 cell count or WHO clinical stage</td>
<td>ALL</td>
</tr>
<tr>
<td><strong>HIV/TB CO-INFECTION</strong></td>
<td>Presence of active TB disease, regardless of CD4 cell count</td>
<td>No change</td>
<td>ALL</td>
</tr>
<tr>
<td><strong>HIV/HBV CO-INFECTION</strong></td>
<td>Evidence of chronic active HBV disease, regardless of CD4 cell count</td>
<td>Evidence of severe chronic HBV liver disease, regardless of CD4 cell count</td>
<td>ALL</td>
</tr>
<tr>
<td><strong>HIV+ PARTNERS IN SD COUPLE</strong></td>
<td>No recommendation established</td>
<td>Regardless of CD4 cell count or WHO clinical stage</td>
<td>ALL</td>
</tr>
</tbody>
</table>
### WHO 2018 recommendations for first-line

<table>
<thead>
<tr>
<th>Population</th>
<th>Preferred</th>
<th>Alternatives</th>
<th>Special situations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult men, adolescent boys boys</td>
<td>TLD&lt;sup&gt;a&lt;/sup&gt; TDF/3TC/DTG</td>
<td>TLE600</td>
<td>AZT+3TC+ EFV600&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pregnant (from 8 weeks after conception) &amp; breastfeeding women and adolescent girls</td>
<td>TDF+3TC (or FTC)+PI/r&lt;sup&gt;c&lt;/sup&gt;</td>
<td>TLE400</td>
<td>TDF+3TC (or FTC)+PI/r&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Women and adolescent girls with effective contraception or not of childbearing potential</td>
<td>TLE600</td>
<td>TDF/3TC/EFV</td>
<td>AZT+3TC+ EFV600&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Women and adolescent girls of childbearing potential who want to be pregnant and have no effective contraception</td>
<td>TLE400</td>
<td>TDF+3TC (or FTC)+PI/r&lt;sup&gt;c&lt;/sup&gt;</td>
<td>AZT+3TC+ EFV600&lt;sup&gt;b&lt;/sup&gt; TDF+3TC (or FTC)+ RAL</td>
</tr>
</tbody>
</table>
## ARVs Global v/s Local

<table>
<thead>
<tr>
<th>NRTIs</th>
<th>Integrase Inhibitors</th>
<th>PIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine (AZT) (future?)</td>
<td>Raltegravir (RAL)</td>
<td>Saquinavir (SQV)</td>
</tr>
<tr>
<td>Didanosine (ddl)</td>
<td>Elvitegravir (ELV)</td>
<td>Indinavir (IDV)</td>
</tr>
<tr>
<td>Stavudine (d4T)</td>
<td>Dolutegravir (DTG)</td>
<td>Ritonavir (RTV)</td>
</tr>
<tr>
<td>Lamivudine (3TC)</td>
<td>Bictegravir (BIC)</td>
<td>Nelfinavir (NFV)</td>
</tr>
<tr>
<td>Abacavir (ABC)</td>
<td></td>
<td>Lopinavir/ritonavir (LPV/r)</td>
</tr>
<tr>
<td>Emtricitabine (FTC)</td>
<td></td>
<td>Atazanavir (ATV/r)</td>
</tr>
</tbody>
</table>

### NNRTIs

<table>
<thead>
<tr>
<th>Nevirapine (NVP)</th>
<th>Efavirenz (EFV)</th>
<th>Rilpivirine (RLP)</th>
<th>Etravirine (ETV)</th>
</tr>
</thead>
</table>

### Nucleotide RTIs

<table>
<thead>
<tr>
<th>Tenofovir DF (TDF)</th>
<th>TAF</th>
</tr>
</thead>
</table>

### Entry Inhibitors

<table>
<thead>
<tr>
<th>Maraviroc (CCR5)</th>
<th>Enfuvirtide (ENF, T20)</th>
<th>Darunavir (DRV/r)</th>
</tr>
</thead>
</table>

### Post Attachment Inhibitor

<table>
<thead>
<tr>
<th>Ibalizumab</th>
</tr>
</thead>
</table>
### First Line Options Public v/s Private

<table>
<thead>
<tr>
<th>Single Pill/ day</th>
<th>Two Pills/day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tenofovir DF + Lamivudine + Efavirenz 600mg</strong></td>
<td></td>
</tr>
<tr>
<td><strong>In private sector</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TDF + Lamivudine+ Dolutegravir</strong></td>
<td>TDF + Lamivudine/Emtricitabine plus Boosted Atazanvir</td>
</tr>
<tr>
<td><strong>TDF + Lamivudine+ Efavirenz 400mg</strong></td>
<td>TDF/TAF + Emtricitabine plus Boosted Darunavir</td>
</tr>
<tr>
<td><strong>TDF + Emtricitabine + Efavirenz 600mg</strong></td>
<td>TDF/Emtricitabine + Dolutegravir</td>
</tr>
<tr>
<td><strong>Abacavir + Lamivudine + Dolutegravir</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TAF + Emtricitabine + Dolutegravir</strong></td>
<td></td>
</tr>
</tbody>
</table>

**GILADA/UMRC/MUMBAI**
Timeline of ART Roll-out

1992: NACO born
2004: Roll-out launched
2014: Transition to newer drugs
2016: EMTCT and EID
2017: HIV/AIDS Act, Test-and-Treat
2018: Viral load testing
2019: Differentiated Health Care
2020: DTG based regimens

SLN/ZLN
TLE
ATZ/r
LPV/r

3HP

GILADA/UMRC/MUMBAI
Strawberry-flavored HIV medicine could save thousands of children

Quadrimune is easy to take, easy to preserve and relatively affordable.

New York Times 30/11/2019
# ART Roll-Out: Current Status

<table>
<thead>
<tr>
<th>ART Center</th>
<th>CoE</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link ART Center</td>
<td>548</td>
<td></td>
</tr>
<tr>
<td>CSC (Care &amp; Support Center)</td>
<td>310</td>
<td></td>
</tr>
<tr>
<td>PLHIV on ART (Govt. sector)</td>
<td>13,45,215</td>
<td></td>
</tr>
<tr>
<td>PLHIV in preparedness</td>
<td>28,162</td>
<td></td>
</tr>
<tr>
<td>PLHIV on second line</td>
<td>57,298</td>
<td></td>
</tr>
<tr>
<td>PLHIV on third line</td>
<td>2,558</td>
<td></td>
</tr>
</tbody>
</table>

Slide Credit: NACO
Implementation Structure

- National AIDS Control Organization
  - State AIDS Control Society
    - District AIDS Prevention & Control Unit
      - District AIDS Control Officer (DACO)
      - District Programme Manager (DPM)
        - M&E Ass.
        - Account Ass.
        - Program Ass.
      - District ICTC Supervisor
    - Technical Resource Groups
    - Technical Support Units
    - Institutional Arrangements

188 districts with DAPCU

Heterogeneous Spread of HIV in India (District Categorisation based on HIV Prevalence)

Slide Credit: NACO
ART Coverage in Maharashtra

Over 94% of HIV+ on anti-retroviral therapy

Mumbai: Over 94% of the HIV-positive people in the state have been put on life-saving anti-retroviral therapy (ART) in the last few years, shows data released by the state AIDS control body on Saturday. The Maharashtra State Aids Control Society (MSACS) has put renewed focus on initiating more jail inmates on HIV treatment, an area that has remained a challenge over the years. Statistics suggest that only 40-60% of those who tested positive for the virus after entering a prison could be started on anti-retroviral therapy (ART).

MSACS data shows that the positivity rate in prisons hovers around half a percent. In 2017-18, for instance, out of 28,012 inmates screened, around 146 tested positive for the virus, out of which 81 were reportedly started on ART.

In the general population, the MSACS data shows that while ART coverage was available for 89% (total of 28,925) of the positive people in 2014-2015, the coverage has increased to 94% (total 10,743) in 2018-2019 so far. MSACS officials said that after working with prison officials, they have managed to increase that number to almost 80% since April this year. During this period, out of 98 inmates who tested positive, 81 were started on treatment. An official said the missing patients were mostly undertrials who could not be followed-up once they were out on bail.

“There are special counsellors now who would be following up with undertrials and link them with ART centres,” said an official. Of the 81 positive cases, highest detections were from Pune jail (27) followed by Thane (16). Officials said that the detections are made during routine tests carried out once they enter the prisons.

GILADA/UMRC/MUMBAI
Differentiated Care

Patient Fast Tracking

I can now collect my ARVs in less than 10 min. after coming to ARTC.

Multi-month dispensation

Patients can get 3 months of medicine if they are stable on ART.

Dispensation at CSCs, TIs

I can get my medicine from a centre close to my home!

Intensive Counselling and Follow-up

Doctors can spend more time with patients who require assistance.

Slide Credit: NACO
Rationale for integrated M&E

As ART models diversify and additional patients move to DSD models, ensure information is accessible to HCW.

Clinic-based ART

Fast-track

Community pick up

M&E - Monitoring & Evaluation
DSD - Differentiated Service Delivery
CAG - Community ART Group

GILADA/UMRC/MUMBAI
Lost-to-Follow-up: Mission SAMPARK

Mission “SAMPARK” was launched to reach out to all those “who are aware of their HIV positive Status” but are “Not on ART” and linking them back as much as possible to HIV Care

- 70% of backlog initiated on ART
- approx. 50,000 LFU linked back
## First line ART in Adults & Adolescents

<table>
<thead>
<tr>
<th>ART Regimen</th>
<th>Recommended For</th>
</tr>
</thead>
</table>
| Tenofovir + Lamivudine + Efavirenz | **First-line ART regimen for:**  
All ARV naive PLHIV with HIV-1 infection, age >10 years and body weight >30 kg                                                                 |
| Abacavir + Lamivudine + Efavirenz  | **First-line ART regimen for:**  
- All patients with abnormal serum creatinine values (Calculate Creatinine clearance)  
- All adults and adolescents with body weight ≤30 kg                                       |
| Tenofovir + Lamivudine + Lopinavir/ritonavir | **First line ART regimen for:**  
- All women with single dose Nevirapine exposure in a past pregnancy  
- All confirmed HIV-2 or HIV-1 & HIV-2 co-infection                                       |
Elimination of Mother to Child Transmission

- HIV transmission from HIV infected mother to child
  - during pregnancy
  - during delivery or
  - during breast-feeding

- Free counselling & testing for HIV to all pregnant women as a part of Antenatal care

- 2.30 Crore HIV testing among pregnant women
  - 91% of identified HIV positive pregnant women initiated on lifelong ART
  - 86% of exposed babies initiated on ARV prophylaxis

- Around three fourth of estimated pregnancies tested for HIV

Slide Credit: NACO
Prevention of MTCT

SIMPLIFYING PMTCT PROTOCOL

OPTION B+:
• Initiate immediate lifelong ART in pregnant/breastfeeding mother irrespective of CD4 counts
• HIV exposed infant receives 4-6 weeks of ART (Nevirapine or Zidovudine) regardless of feeding method
• Linkage to treatment and care for both mother and infant

GILADA/UMRC/MUMBAI
Third
90
Challenges ahead

1. Viral Load Facility – Procurement, technical know how, cost, up-scaling
2. DTG-based regimen
3. Expansion, sustainability with resource limits
4. Operational issues
5. Public-Private Partnership and collaboration
6. PrEP, PEPSE, Home-testing
7. Expanding focus to NCDs and including adult vaccination
8. Fighting Stigma and Discrimination
1. Where are we with viral load tests?

- Routine VL Started in 2018. Sample Collection at all ART centers – Transported to central labs
- 24 in-house VL labs now functional, up from 10 in 2018, each doing ~10,000 tests/yr = 240,000 VL tests
- 1.4 out of 1.7 million PLHIV are on ART
- Recent decision to scale-up VL in a PPP model is praiseworthy, adds another 200,000 VL
- If every PLHIV needs VL once/yr, we need to scale up capacity by five times to do over 2 million tests
- Private sector has been doing viral loads since 1995

GILADA/UMRC/MUMBAI
2. Adoption of Newer Regimen

- Following global recommendations NACP decided to adopt DTG-based ART
- Procurement process initiated. Stocks are expected in Feb. 2020
- In first phase, new initiations will be done on TLD, then TLE will be switched to TLD
- Raltegravir (currently in 3rd line) will be substituted with DTG
3. Expansion: Gazette for ART services: ART centres at Medical Colleges - Private-198/Govt (new)-30

OFFICE MEMORANDUM

This is with reference to The Gazette of India issued by Board of Governors in super-sessioon of Medical Council of India dated 25th June, 2019 wherein amendment has been done on 'Minimum Standard Requirement for MBBS Admissions Annually Regulation, 1999'. As per the amendment, every Medical College should have an Anti Retroviral Therapy center at the time of 4th renewal for admission of 5th Batch of MBBS students.

To have an ART Centre in the college roles of National AIDS Control Programme (NACP) and Medical College shall be as following:

<table>
<thead>
<tr>
<th>National AIDS Control Programme</th>
<th>Medical College (Government or Non-Government)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide ARV drugs</td>
<td>Provide Infrastructure and Human resources for ART Center.</td>
</tr>
<tr>
<td>Provide CD4 testing and Viral load testing for people living with HIV through linkages with existing laboratories under NACP.</td>
<td>Shall follow the National Operational and Technical Guidelines for ART Services and M&amp;E Tools provided by NACP.</td>
</tr>
<tr>
<td>Provide trainings of staff of ART Centers</td>
<td>Shall provide all health services related to provision of ART and treatment of opportunistic infections, free of cost to patients who require treatment.</td>
</tr>
<tr>
<td>Provide regular updates on guidelines.</td>
<td>Shall report to NACO in prescribed formats at prescribed intervals.</td>
</tr>
<tr>
<td>Shall provide technical support through concerned State AIDS Control Society (SACS) for establishment as well as functioning of ART center.</td>
<td></td>
</tr>
</tbody>
</table>

Process for establishing ART centers shall be as following:

1. Proposal for establishing ART center shall be sent by Institute to respective State AIDS Control Society.
2. Representatives from State AIDS Control Society will visit the institute and provide technical support for establishing ART center and suggest improvement as required.
3. Provisional approval by NACO based on report.
4. Appointment of staff and arrangement of infrastructure as per operational guidelines for ART services.

5. Final approval of NACO.
6. Training of Staff by NACO/SACS.
7. Provision of drugs, recording tools and guidelines by NACO.

For Government Medical Colleges where ART Center is already functional with NACO support, Medical Colleges shall take over the HR and recurring cost component of ART Centers in phased manner.

(Alok Saxena)
Joint Secretary (NACO) 30.9.19

To:
Dean, All Medical Colleges (Government and Non-Government)

Copy to:-
- Principle Secretary (Medical Education), All States
- Principle Secretary (Health & Family Welfare), All States
- Project Director, All State AIDS Control Society
- Board of Governors in Super Session of MCI
- PPS to Secy. (Health and Family Welfare) Govt. of India
- PPS to SS & DG (NACO)
- PPS to DGHS, Dte. GHS, Govt. of India
- PS to JS (Medical Education), Govt. of India
- All DDG/ADG/DD/ NC (NACO)
- Regional Directors for H&FW, Govt. of India
4. Operational Issues

• Supply-Chain Management : Stock-outs
• Staff selection, retention, training
  - *Blending Clinical Training of master-trainers underway*
• ART Officers – remuneration, training, grooming
• Finances – when everything is free
• Where do we draw a line in FoCs?
What should be done?

- Better pay to increase stability for ART officers
- May be, cost sharing, like Tata Hospital model
- Develop Generic VL, resistance tests
- Integrated care - 3H and TB convergence
- Optimise healthcare spending
- Introduce smart card
- Priority for MTCT adolescents PLHIV in education and jobs, including at ART centres
- Prioritisation on Sex Workers, MSM, IDUs
5. Public-Private Partnerships

- Approximately 100,000-200,000 PLHIV avail ART in private sector *(drug sales and survey in Private Practitioners)*
- To and fro movement of patients between private and public sector, without formal system
- Coordination on data sharing is need of the hour
- Requires strengthening private sector reporting
- NACO included ASI nominated Practitioners as Master-Trainees for downward training
6. PrEP, PEPSE and other prevention strategies

**DID YOU KNOW?**

There's more than 1 way to prevent HIV.

ONE PrEP PILL A DAY IS 99% EFFECTIVE AT PREVENTING HIV.

To learn more about PrEP, call Evergreen at 716.541.0676 or visit takeprep.com.
82% (n=909/1111) of people living with HIV surveyed had experienced some form of stigma related to their HIV within the past year.¹

¹ - Positive Perspectives Survey, 2017

GILADA/UMRC/MUMBAI
1. The Bill makes anti-retroviral therapy a legal right of HIV/AIDS patient and states that “every person in the care and custody of the state shall have right to HIV prevention, testing, treatment and counselling services.” It also asks the central and state governments to provide such treatment along with infection management. The Bill also asks the state and central governments to facilitate access for the HIV/AIDS community to welfare schemes.

2. The Bill defines what can count as discrimination against HIV positive people and people living with it. It lists that denial or discontinuation of employment, education, healthcare services, renting or residing property, standing for public or private office will count as discrimination along with unfair treatment in any of the above mentioned categories. The Bill also prohibits HIV testing being used as a pre-requisite for securing a job, accessing health care or education.

3. No person shall have to undergo HIV test or medical treatment without one’s informed consent. The informed consent for HIV test shall include pre-test and post-test counselling to the person being tested or such person’s representative in the manner as may be specified in the guidelines.

GILADA/UMRC/MUMBAI
One of the greatest achievements of ASI-NACO advocacy: Medical insurances to cover HIV related claims

Print Date: 11/11/2019
Dear Policyholder,

Greetings from Max Bupa.

Thank you for being a part of the ever growing Max Bupa family! We value your continued patronage which has made Max Bupa the health insurer of choice for more than three million customers.

We are pleased to announce that we will be introducing a refreshed version of your Heartbeat policy on 12th November 2019, providing you with more flexibility and enhanced coverage.

It is our constant endeavor to continuously improve our offerings based on customer feedback, to ensure we provide you with best in class coverage. In the refreshed version, we have introduced some key enhancements and modifications in the product features to better suit your needs. These include:

1. **Refill Benefit**: Enjoy additional sum insured (up to 100% of the base sum insured) for subsequent claims for both same & different illness, in the same policy year. (Available under individual & family floater variants)
2. You may now purchase medicines or avail diagnostic services from our service provider through our website or mobile application.
3. **HIV/AIDS**: Expenses incurred for hospitalization (including day care treatment) due to condition caused by or associated with HIV/AIDS are now covered under the policy subject to sub-limit as specified in the Policy.

GILADA/UMRC/MUMBAI
U=U: A opportunity to de-stigmatize HIV

UNDETECTABLE Equals UNTRANSMITTABLE

UNINFECTIONOUS

VIRAL LOAD <40-400 cpm

#UequalsU
Undetectable = Untransmittable

SCIENCE NOT STIGMA

U=U
#LOVE Positive
FAMILY FRIENDS, WELL-WISHERS & CARE-GIVERS on ONE PLATFORM
The least to be achieved:
Hepatitis-B
HPV
Typhoid
Pneumococcal
Sincere Thanks to

- Our patients for being a great source of learning and inspiration
- NACO, WHO, UNAIDS, MSF for data/graphics
- Several scientists, clinicians and colleagues
- IAS Educational Fund and IAS President Dr. Anton Pozniak for providing me this honour
- All of you for your presence and attention

Global to Local & Local to Global

Qs/Suggestions/Any Assistance

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