The International AIDS Society

Educational Fund meeting:
Outcome report
4 December 2019
Mumbai, India

Global to local: Science and community in the response to HIV in India
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This report was developed in collaboration with the Family Planning Association of India (FPA India). The views expressed in the report do not necessarily reflect the views of the International AIDS Society.
1. List of abbreviations and acronyms

<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ARV/ART</td>
<td>Antiretroviral Treatment</td>
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<td>ASI</td>
<td>AIDS Society of India</td>
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<td>CAB</td>
<td>Citizenship Amendment Bill</td>
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<td>CSR</td>
<td>Corporate Social Responsibility</td>
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<td>DSD</td>
<td>Differentiated Service Delivery</td>
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<td>FPA India</td>
<td>Family Planning Association of India</td>
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<td>HBV</td>
<td>Hepatitis B Virus</td>
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<td>HCV</td>
<td>Hepatitis C Virus</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>IWG</td>
<td>India Working Group</td>
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<td>LGBTI</td>
<td>Lesbian Gay Bisexual Transgender Intersex</td>
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<td>MDACS</td>
<td>Mumbai District AIDS Control Society</td>
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<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MTCT</td>
<td>Mother-to-child transmission</td>
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<td>NACO</td>
<td>National AIDS Control Organization</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<td>NALSA</td>
<td>National Legal Service Authority</td>
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<td>NCPI+</td>
<td>National Coalition of People Living with HIV</td>
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<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
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<td>SACS</td>
<td>State AIDS Control Society</td>
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<td>SOCH</td>
<td>Strengthening Overall Care for HIV patients</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>TB</td>
<td>Tuberculosis</td>
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2. Introduction

The International AIDS Society (IAS), in collaboration with the Family Planning Association of India (FPA India) and with the full endorsement of the AIDS Society of India (ASI), coordinated a scientific symposium in Mumbai, India, on 4 December 2019. The symposium, organized as part of the IAS Educational Fund, aimed at reducing the gap between HIV science and implementation by discussing the development and implementation of new strategies in prevention, treatment and care of HIV and co-infections within the Indian setting. With a focus to accelerate the vision to end AIDS by 2030, the scientific community, government representatives, healthcare providers, civil society representatives, activists, people living with HIV and representatives of key and vulnerable populations were brought together to discuss the strategies to reduce the gap between HIV science and implementation. The symposium resonated well with the theme of World AIDS Day 2019: Communities make the difference.

Over 115 HIV professionals and community representatives were gathered to share knowledge on HIV science, national policies and programmes. Welcoming remarks were delivered at the start of the meeting by the three chairs of the day: Dr Anton Pozniak, IAS President; Dr Ishwar Gilada, IAS Governing Council member representing the Asia and the Pacific Islands region and President of ASI; and Dr Kalpana Apte, Secretary General of FPA India. The IAS Educational Fund symposium objective was to present advances in topics
related to HIV and AIDS, ARVs and challenges to treatment access, HIV and co-infections, chemsex and HIV in Asia, PrEP and other prevention methods, as well as Differentiated Service Delivery. The aim of the meeting was to ensure that participants benefitted from a better understanding of HIV science and new developments and that they had the opportunity to come up with ideas and solutions for challenges that they face in their day-to-day work. In addition, the goal of the discussions was to have participants apply what they learned at the meeting to local issues. Participants were also provided with the opportunity to propose strategies on how to improve HIV policy and programmes regarding local and national implementation in question and answer sessions with panelists. Lastly, networking opportunities offered the time for attendees to create new contacts in their field of work and to have them collaborate to improve local and regional HIV policies and programmes.
3. Background and context

India is the third highest HIV burden country in the world. In 2017, the national adult (15-49 years) HIV prevalence was estimated at 0.22%\(^1\) with nearly 2.1 million people living with HIV.\(^2\) India continues to portray a concentrated epidemic,\(^3\) with high prevalence among key and vulnerable populations, moderate prevalence among bridge populations and low prevalence amongst the general population. The drivers of the epidemic include:

- Unprotected paid sex with female sex workers;
- Unprotected anal sex between men who have sex with men;
- Unprotected sex amongst Hijra (intersex and transgender people in the Indian sub-continent); and
- Intravenous needle sharing between people who inject drugs.

Based on these transmission dynamics, India’s HIV epidemic pattern is monitored among key and vulnerable populations, bridge populations as well as the general population.\(^4\) The observed HIV prevalence was 0.28% among antenatal clinic attendees, 0.51% among single male migrants, 0.86% among long distance truckers, 1.56% among female sex workers, 2.69% among men who have sex with men, 3.14% among Hijra and transgender people and 6.26% among people who inject drugs.\(^5\)

India is estimated to have had around 87,580 new HIV infections in 2017, showing a new HIV infection decline by 85% since the peak of 1995, and by 27% between 2010-2017. The total number of people living with HIV in India is estimated at 21.40 lakh (unit in the Indian numbering system equal to one hundred thousand), or 2.14 million. Since 2005, when the number of AIDS-related deaths started to show a declining trend, this number has declined by almost 71%. In 2017, an estimated 69,110 people died of AIDS-related causes nationally.\(^6\)

By the end of 2017, the data for the 90-90-90 strategy in India indicated that 79% of people living with HIV knew their status, 56% of people living with HIV were on treatment and, of all adults aged 15 years and over living with HIV, 56% were on treatment.\(^7\)

**HIV and co-infections**

Tuberculosis (TB) is a leading cause of morbidity and mortality among HIV-infected patients while HIV remains a key risk factor for the development of active TB infection.\(^8\) People living with HIV are 21 times at higher risk of developing TB. TB and HIV co-infection results in higher mortality rates. Nearly 25% of all deaths among people living with HIV are estimated to be due to TB.\(^9\) HIV co-infection rates among incident TB patients is estimated to be 3%. Around 86,000 HIV-associated TB patients are emerging annually. In terms of numbers, India ranks second in the world and accounts for about 9% of the global burden of HIV-

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\(^3\) NACO Annual Report 2016-17.
\(^6\) National AIDS Control Organization (NACO): India HIV Estimation Report, 2017. / UNAIDS, India
\(^9\) India TB Report 2019, Central TB Division, Ministry of Health & Family Welfare.
associated TB. The mortality in this group is very high and every year 11,000 people die from co-morbid conditions.\textsuperscript{10}

HIV and hepatitis C (HCV) infections are major global public health problems, with overlapping modes of transmission and affected populations.\textsuperscript{11} All key and bridge population groups under the National AIDS Control Programme (NACP) for HIV infections are especially vulnerable to viral hepatitis infections, too.\textsuperscript{12} A study published in the \textit{Indian Journal of Medicine} (2018) reported that hepatitis B (HBV) and HCV cause acute and chronic hepatitis, and infections with HBV and HCV are common in HIV-infected patients. It also stated that HBV infection (11\%) was found to be less prevalent in contrast to HCV (13\%) amongst the HIV seropositive population. The age group between 21 and 40 was significantly associated with HBV and HCV infection. Heterosexual contact was the leading mode of acquiring HBV and HCV infection.\textsuperscript{13} Studies have shown that the HIV and HBV, as well as HIV and HCV co-infections can have grave effects and can hamper the fight against HIV.

Mental health and substance abuse

Another area of concern in India is the mental health of at-risk populations and people living with HIV. Substance abuse, alcohol abuse, depression and recreational drug use are seen amongst some key and vulnerable populations such as men who have sex with men. There is a three-way interaction between alcohol, depression and substance use amongst men who have sex with men in India.\textsuperscript{14} There have been reports of increase in use of substances/chemicals (non-injectable psychoactive drugs) for recreation and that often result in risky sexual activities (high fun and chemsex). Chemsex inhibits risk perception, promotes high-risk behaviour and puts users at risk of HIV, sexually transmitted infections (STIs) and serious mental health issues which are often overlooked.\textsuperscript{15}

Treatment response antiretroviral therapy (ART)

The introduction of antiretrovirals (ARVs) in 1996 was a turning point for a significant number of people who had access to healthcare systems. There were issues related to large numbers of pills, astronomically high costs and side effects of the drugs that are part of the treatment offered. Although ARVs cannot cure HIV or AIDS, they have the potential to dramatically reduce mortality and morbidity, prolong lives and improve the quality of life of many people living with HIV and AIDS.

The free ART initiative of the Government of India was launched in April 2004. The second-line ART treatment for patients that fail the first-line treatment was rolled out under the National ART Programme in January 2008.\textsuperscript{16} In April 2018, the Government of India announced a new test-and-treat policy that committed to providing access to HIV treatment for everyone living with HIV in the country.\textsuperscript{17} India’s ART programme is the second largest globally and has been acclaimed as one of the best public health programmes providing HIV care services.\textsuperscript{18}

\textsuperscript{10} India TB Report 2019, Central TB Division, Ministry of Health & Family Welfare.
\textsuperscript{11} https://www.who.int/hiv/mediacentre/news/hep-hiv-coinfected/en/
\textsuperscript{12} Technical and Operational Guidelines for Diagnosis and Management of Hepatitis B, Ministry of Health & Family Welfare, 2019
\textsuperscript{13} Sharma V, Ramachandran V G, Mogha NS, Bharadwaj M. Hepatitis B & C virus infection in HIV seropositive individuals & their association with risk factors: A hospital-based study. Indian J Med Res 2018; 147:588-93
\textsuperscript{14} Prabhu S et al; Clinical Infectious Disease, 2019.
\textsuperscript{15} https://sti.bmj.com/content/93/Suppl_1/A81.1
\textsuperscript{16} Journey of ART Program in India, NACO, 2014
\textsuperscript{17} https://www.unaids.org/en/resources/presscentre/featurestories/2017/may/20170501_veena
\textsuperscript{18} NACO, National Technical Guidelines on ART, October 2018.
The impact of the programme is evident. India’s gains are one of the major contributors to the global success. The adult HIV prevalence at the national level has continued its steady decline from an estimated peak of 0.38% in 2001-2003 through 0.34% in 2007, and 0.28% in 2012 to 0.22% in 2017. Annual new HIV infections have declined by more than 60% since 2000. The lifesaving ART has improved millions of lives. AIDS-related deaths have gone down by almost 71% since its peak in 2005, against a global average of 48%.

There have been substantial advances made by the scientific community in developing and using improved and effective formulations in the antiretroviral therapy domain. In the last couple of decades, ARVs have come a long way from a 20-pill-a-day dosage to a single-pill-a-day dosage. Rapid start or initiating ART on the same day that HIV is diagnosed is an emerging strategy that is proposed as a replacement to the ‘wait and watch’ strategy.

Pre-Exposure Prophylaxis (PrEP)

Prevention of new HIV infections continues to be the mainstay of India’s national AIDS response and has resulted in significant reductions in HIV incidence. HIV incidence per 1,000 of the population that is not living with HIV is estimated to have declined from 0.64 in 1995 to 0.07 in 2017. However, the pace of decline in HIV incidence has been a slow decrease, dropping from 0.10 in 2010 to 0.07 in 2017. Prevention strategy is no longer only condom-focused, but has now seen the introduction of Pre-Exposure Prophylaxis (PrEP). Studies have shown willingness and acceptability of PrEP uptake amongst female sex workers, men who have sex with men and transgender populations in India. However, there is a risk of PrEP being considered as an alternative for condom use. Studies have also shown that when taken consistently and correctly, PrEP reduces the chances of HIV infection to near-zero. Nonetheless, PrEP does not protect against STIs and blood borne diseases such as HCV, syphilis, and gonorrhoea. Therefore, while PrEP is especially beneficial to those with high-risk behaviours, it can also indirectly promote at-risk behaviour because users sometimes do not feel the need to use condoms.

Way forward: National AIDS Control Organization (NACO) National Strategic Plan (2017-2024)

The approach has been articulated in the National Health Policy and the implementation framework adopted in 2017, and will be implemented by NACO through a seven-year National Strategic Plan on HIV and AIDS and other STIs through 2017 to 2024. This National Strategic Plan will herald the country to the midpoint of the 2030 goals. The next seven years are, therefore, critical, and investments made now will result in substantive gains towards the ‘Ending of AIDS’. The vision of NACO is that of, ‘Paving the way for an AIDS free India’ through ‘attaining universal coverage of HIV prevention, treatment to care continuum of services that are effective, inclusive, equitable and adapted to needs’. The goals remain those of the ‘Three Zeros’, meaning zero new infections, zero AIDS-related deaths and zero discrimination that form the basis of this strategic plan.

By 2020, the focus of the national programme will be on achieving the following fast-track targets:

1. 75% reduction in new HIV infections;

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19 NACO, National Technical Guidelines on ART, October 2018.
23 NACO, National Strategic Plan for HIV/AIDS and STI, 2017 – 2024
2. 90-90-90: 90% of those who are HIV positive in the country know their status, 90% of those who know their status are on treatment and 90% of those who are on treatment experience effective viral load suppression;
3. Elimination of mother-to-child transmission of HIV and Syphilis; and
4. Elimination of stigma and discrimination.

By 2024, achievements envisaged are:
1. 80% reduction in new HIV infections; and
2. Ensuring that 95% of those who are HIV positive in the country know their status, 95% of those who know their status are on treatment and 95% of those who are on treatment experience effective viral load suppression.

To this effect, two key achievements in early 2017 to ‘Ending of AIDS by 2030’ include the enactment of the ‘HIV and AIDS Bill’ as a law protecting the rights of people living with and affected by HIV, as well as the announcement and implementation of the ‘Test and Treat’ policy in line with global guidelines.
4. Meeting report

4.1. Executive summary

The symposium aimed at reducing the gap between HIV science and implementation by discussing the development and implementation of new strategies in prevention, treatment and care of HIV and co-infections in India. The symposium began with opening remarks from Dr Anton Pozniak (IAS), Dr Kalpana Apte (FPA India) and Dr Ishwar Gilada (IAS and ASI).

The presentations and panel discussions included topics such as: the changing management of HIV, ARV rollout in India, ARVs and challenges to treatment access, HIV and co-infections, chemsex and HIV in India, PrEP and other prevention methods and Differentiated Service Delivery. Participants were given time for questions and answers after each set of presentations and during the panel discussions. Participants included representatives from the scientific community, the government (National and State), as well as healthcare providers, civil society partners, activists, people living with HIV and
representatives from key and vulnerable populations (female sex workers, men who have sex with men, Hijra and transgender people and people who inject drugs).

Gaps around each aspect of the HIV and AIDS implementation in the Indian context were discussed and deliberated. Recommendations were received from the participants, speakers and panelists in light of best practices and experiences. Some of the key recommendations of the scientific symposium included:

**Policy level (for government agencies)**
1. The government should look into the use of technology to resolve the issues around supply chain management and operational rollout of the ART service delivery. There needs to be a working group constituted for paediatric ARV.
2. A mechanism of data-sharing between governmental (public sector) and non-governmental actors (including private sector players) needs to be looked into (rollout and scale-up of project Strengthening Overall Care for HIV patients – project SOCH, an IT-enabled integrated monitoring and evaluation system). The State AIDS Control Society (SACS) needs to re-initiate the state committee meetings.
3. Human resource issues in the government-run HIV and AIDS service delivery programme need to be addressed, and best practices from other countries can be adopted and used as guiding principles. Sensitivity and empathy towards the needs of HIV-positive patients will result in good adherence.
4. Convergence and synergy in the HIV and co-infection programmes are necessary. A single-window approach to address HIV, co-infections and co-morbidities must be implemented.
5. The government needs to study differentiated service delivery models implemented by various agencies and assist these agencies in scaling up the effective models.

**Implementation level (for implementers and the community)**
6. Awareness and education should be enhanced and supported regarding newer co-infections, such as hepatitis B and hepatitis C in people living with HIV, as well as for key and vulnerable populations. This includes integrated testing and vaccination amongst most at-risk groups.
7. Awareness and education should be provided on PrEP, condoms and other prevention methods to key and vulnerable populations.
8. Community-led and peer-supported models (safe-spaces) and other mechanisms to address mental health issues and substance abuse need to be developed to address these populations' needs and be implemented. Awareness and education need to be raised around chemsex and its lethal effects.

**For both policy makers and community representatives:**
9. Study the PrEP model of rollout and implement strategies and ideas to adapt these models to the Indian context.
10. Generate evidence-based, local and region-specific data around HIV and co-infections (especially HBV and HCV) to feed into better-designed policies and implementation models.

The scientific symposium ended on a note of caution and hope, with the understanding that all gains against the HIV epidemic have come thanks to collaborative efforts of all
stakeholders. Networking and collaboration are crucial for the program to continue and meet the 100-100-100 target of 2030.

Participants were asked to provide their feedback on the symposium and share their personal goals by looking through a political, legal, economic, social, scientific, training and education, logistical and technical perspective, which they will achieve in the weeks and months following the meeting.

4.2. ARVs and challenges to treatment access

**ART availability and accessibility:** India has been home to the manufacturing of many ARV drugs, however the same are not integrated and available in the National HIV and AIDS Control Programme. Accessibility has been scaled up in terms of the service delivery centres, but shortage of medicines are often reported. There was discussion around the service delivery mechanism of ART in public and private healthcare setups. Public healthcare setups provide free ART (and other allied services), but are over-burdened. The ART centres’ timings are often not suitable for the people who are accessing treatment from remote areas of the districts, thus resulting in adherence issues. Private healthcare setups involve a cost for the services, which greatly affects the variety of patients that are able to access and afford such services.

**Procurement and the supply chain management of ARVs:** There needs to be robust stock forecasting and more effective stock inventories and distribution systems that must be applied on a real-time basis. Treatment uptake patterns need to be well-documented and reported. Lastly, procurement is often held up, due to procedural delays.
Data sharing and voices from the community: There is an evident gap between the data sharing mechanism of public and private providers. In addition, the voices of the community were absent in the decision-making process of the SACS in national programmes.

Human resources in service delivery: One of the factors influencing poor rollout and management of services is the attrition rate of the staff involved in the service delivery. Inadequate capacity building of key personnel such as the medical officers at ART centres is an issue. Often, the attitude of the service provider and their apathy towards the HIV-positive patient is the reason for adherence issues.

Mother-to-child transmission (MTCT) and paediatric ART: India is one of the largest manufacturers of ARVs, but some of these advanced treatments are not included in the National Programme. The reason why the NACP does not include ARVs in policies is due to the programme needing a single-source procurement. Companies are not interested in providing small quantities of treatment and there is a lack of interest in financial support.

There were concerns and apprehensions raised from participants around discrimination faced by people living with HIV and AIDS. The participation of pharmaceutical companies in the ARV provision as part of their Corporate Social Responsibility (CSR) was of high concern to participants as well. In addition, demands in some ART centres to link adherence numbers and force patients to choose ART centres near their residential address was judged unreasonable by certain attendees. Finally, Red Ribbon Clubs (RRCs), which acted as key platforms to involve youth, were defunct in national colleges and need to be revived. It was also mentioned that training of counsellors to deal with key and vulnerable populations in a more sensitive manner was also needed for healthcare services. Lastly, the issue of loss of wages due to the time taken at the ART centres by patients was also raised.
Key recommendations on ARVs and challenges to treatment access:

1. Encourage Government to address the use of technology to resolve the issues around the supply chain management and operational rollout of the ART service delivery;
2. Share data between Government (public sector) and non-governmental actors (including private sector players) more frequently and transparently, including rollout and scale-up of the SOCH project, an IT monitoring and evaluation system. Reinitiate state redressal committee meetings at SACS;
3. Address Human Resources (HR) issues in the government-run HIV and AIDS service delivery setup and apply best practices from other countries that can be adopted and used as guiding principles. Implement sensitivity and empathy towards the needs of HIV-positive patients that will lead to good adherence;
4. Research on paediatric ARV needs, access and supply in India and create a working group at NACO for this purpose.

4.3. HIV and co-infections

India has traditionally seen co-infections such as TB and STIs with HIV. There has been a substantial increase in hepatitis B and hepatitis C co-infections globally and in the country. There is a dearth of data and operational research around these newer co-infections.

Dr Sunil Solomon (Johns Hopkins School of Medicine) presenting on HIV and co-infections in India, Mumbai, India, 4 December 2019

Although the Government of India has initiated a National Programme on hepatitis, there is still a long way for converging and synergizing HIV and hepatitis programmes. The viruses have the same route of transmission and, thus, a high probability of affecting key and vulnerable populations for co-infection cases. There is also a need to address co-morbidities such as diabetes, heart diseases and hypertension. The panel discussion on HIV and co-infections, followed by an open discussion with the audience, raised the clear lack of awareness and updated information on HIV and HBV or HCV. In addition, a proper linking of samples of HIV, HBV, HCV and syphilis to blood donors in banks was also raised as a
concern, and the awareness and accessibility of specific needs of the Hijra and transgender populations, such as hormonal therapy, were also discussed.

**Key recommendations on HIV and co-infections:**

1. Converge and synergize the HIV and co-infection programmes. A single-window approach to address HIV, co-infections and co-morbidities is needed;
2. Raise awareness and increase education on newer co-infections such as hepatitis B and hepatitis C in people living with HIV and key and vulnerable populations. Include integrated (screening) testing and vaccination amongst most at-risk groups;
3. Generate evidence-based, local and region-specific data around HIV and co-infections (especially HBV and HCV) to feed into a better-designed policy and implementation model.

4.4. **Chemsex and HIV in India: PrEP and other prevention methods**

The use of non-injectable psychoactive drugs has seen a considerable rise, especially amongst men who have sex with men. Studies have shown that this is attributed to multi-level stigma and mental health issues have been noticed within the community. Stigmatization associated with being queer and HIV-positive is coupled with mental health issues including self-loathing, loneliness, isolation, body shaming and peer pressure. Users are mostly well educated with high income, younger (less than 35 years of age), and from urban and semi-urban cities. There is a sense of normalcy also seen around the users and those practicing chemsex, with dating apps openly allowing profile users to express their desire in indulging in chemsex and the use of specific emoticons or ‘emojis’ designed to denote their interests. There is a lack of awareness on the after-effects of the use of these drugs, such as increased addictions, and the risk that they pose in the transmission of HIV, STIs and other infections. Safe-spaces and de-addiction centres to deal with users – in particular men who have sex with men – are not readily available, and those available are not equipped to deal with the reality of the situation.
The legal obligation of medical practitioners to report illegal drug use was also discussed with the audience, in addition to the need to address the stigma faced by drug or substance users. The perception that implementers of harm reduction programmes appear to be promoting soft drug-use was also discussed.
Implement PrEP as part of the National Programme: Currently, studies on PrEP are done in smaller isolated quarters. The efficacy and willingness to use PrEP at a larger level needs to be established. However, accessibility is a question, as PrEP is only available and accessible in private healthcare settings at a cost. PrEP needs to be piloted as part of the National Programme in certain districts. Proper and correct information around PrEP also needs to be available and disseminated to users. In addition PrEP should not be promoted as a standalone preventive method, but needs to be advocated with the use of condoms, thus effectively preventing HIV, STIs and other infections.

Key recommendations on chemsex and PrEP and other prevention methods:

1. Raise awareness on the use of PrEP and condoms, especially targeting key and vulnerable populations, and implement in educational systems;
2. Address mental health issues and substance abuse through community-led and peer-supported models (safe-spaces) and implement these models at national levels;
3. Raise awareness on chemsex, its lethal effects and implement educational systems if possible by including the topic in school curricula;
4. Study the PrEP rollout model (such as the New York, USA, model) and get strategies and ideas to normalize and implement the model in the Indian context.
4.5. Differentiated Service Delivery for key and vulnerable populations

The meeting ended with a panel discussion on Differentiated Service Delivery (DSD), where each of the speakers shared their personal experiences in implementing DSD models. This included the Vihaan & Ujwala model by the India HIV and AIDS Alliance, as well as the Sonagachi cooperative model and the 99-DOTS Programme, especially targeting key and vulnerable populations. Daxa Patel (India Working Group [IWG] and the National Coalition of People Living with HIV [NCPI+] (India Working Group [IWG] and the National Coalition of People Living with HIV [NCPI+]) moderated the discussion. Panelists included transgender representative Abhina Ahire (India HIV/AIDS Alliance), Dr Prashant Deshpande (I-TECH/CDC), Dr Jalpa Hasmukh Thakker (ACCELERATE and Johns Hopkins School of Medicine), renowned Indian HIV activist Jahnabi Goswami (Assam Network of Positive I) and sex worker representative Ms Kusum (All India Network of Sex Workers).

Many of these DSD models are client-centered and adopt HIV services across the cascade in ways that serve the needs of people living with HIV and reduce unnecessary burdens on the health system. Using technology (mobile phones) was one of the highlights of the models targeting hard-to-reach populations and invisible sub-groups within key and vulnerable populations. These models are community-specific and tailor-made to address their needs and have yielded desired results. There is a need to include more populations under the DSD umbrella, such as prisoners and women in shelter homes.

People living with HIV and other key and vulnerable populations (female sex workers, men who have sex with men, Hijra and transgender people and people who inject drugs) still face stigma and discrimination while accessing healthcare services. Measures need to be adopted by the stakeholders implementing programmes, especially in public healthcare settings to provide services with empathy and sensitivity towards key and vulnerable populations.

HIV programmes and healthcare services in communities need to go beyond the scope of HIV and AIDS. Inclusion of social welfare schemes, social entitlements and human rights are key points to ensure community ownership and partnership, leading to overall successful
national implementation. The mental health of these communities also needs to be addressed. Reproductive and sexual health also needs to be included in interventions, with a focus on women’s rights. The implementation of laws guaranteeing equality (such as the National Legal Service Authority (NALSA) judgement in the case of transgender people) needs to be translated appropriately to be applicable in the field.

The final point raised by the panel and the participants concerned the impact of the Citizen’s Amendment Act (CAA) and National Register of Citizenship (NRC) on HIV Programmes, as many key and vulnerable populations are deprived of social entitlements and do not process documentary evidence of their existence.

**Key recommendations on Differentiated Service Delivery (DSD):**

1. Implement DSD models at government level and encourage implementation of these models by other national agencies to help the scaling-up of these models;
2. Ensure DSD models implemented are client-centered and adopt HIV services across the cascade in ways that serve the needs of people living with HIV and reduce unnecessary burdens on the health system;
3. Address more DSD services that are applicable to groups that are hard-to-reach and most-at-risk, such as prisoners and women in shelter homes;
4. Ensure that health services address stigma and discrimination, human rights, mental health and the inclusion of social welfare schemes so that national HIV and AIDS programmes go beyond treatment and care.
5. Conclusion

The IAS Educational Fund scientific symposium in Mumbai, India, was one of the rare occasions to gather diverse stakeholders in the HIV and AIDS community in India, with representatives from the scientific community, government, healthcare providers, civil society, activists, people living with HIV and key and vulnerable populations (including female sex workers, men who have sex with men, Hijra and transgender people and people who inject drugs). The meeting provided a unique platform to share the latest developments in antiretroviral therapy, updates on HIV and co-infections, information on PrEP and other prevention methods, chemsex and differentiated service delivery.

The symposium highlighted the importance and need for all stakeholders to continue working together, network and collaborate to achieve the goal of ending the HIV epidemic by 2030.

Key concluding points of the scientific symposium:

1. There is a significant gap found between the current HIV Programme in India and the newer strategies, approaches and scientific advances existing in the global community. A special focus needs to be laid upon the provision of advanced formulations available in ARVs for people living with HIV in India under the National Programme. There is a need to develop a special focus on paediatric ART and effective MTCT prevention;
2. There is a need to design efficient systems in procurement of ARVs and the use of technology to address issues around the treatment supply chain;
3. The use of social media platforms in service delivery (in particular adherence) needs to be addressed and adopted;
4. The availability of safe spaces, enabling environments and stigma-and-discrimination-free services should be emphasized and implemented;
5. Binary gender approaches in the public healthcare system and in the private healthcare system must be addressed. Gender diversity and equal opportunities to seek care in a non-discriminatory manner needs to be advocated and ensured;
6. Service providers need to be adequately engaged and trained to be empathetic to communities and ensure the service users do not face any stigma and discrimination while accessing services;
7. The significant rise in co-infections (other than TB) such as HBV and HCV need to be addressed and mitigated through convergence and synergizing within programmes, especially around raising awareness, dissemination of correct information, screening, testing and treatment (both for communities and for caregivers);
8. There needs to be focus around co-morbidities and HIV, such as diabetes, hypertension and heart conditions. The mental health of people living with HIV and key and vulnerable populations need to be included in programmes’ implementation design;
9. Measures to ensure that every person living with HIV is part of the service delivery umbrella need to be treated with sensitivity, dignity and without any discrimination;
10. Prevention strategies such as PrEP and condoms need to be part of the continuum of services in the National HIV Prevention Programme;
11. Awareness needs to be created around the effects of chemsex and the risks involved. Safe spaces and de-addiction mechanisms need to be put in place;
12. Models implemented in various other countries can be studied and can be used as
guiding strategies and best practices for local implementation;
13. There is a need to understand and scale-up the Differentiated Service Delivery
models. These models are designed around specific community needs and have
yielded the desired results in the fight against the HIV epidemic;
14. Single-window services and services beyond HIV need to addressed. Inclusion of
social welfare schemes, social entitlements and human rights is crucial;
15. Community involvement and engagement in decision-making and policy development
need to be re-introduced by government bodies. This will ensure community ownership
and help minimize the bottlenecks faced in programme delivery and administrative
operations;
16. Data sharing between different stakeholders needs to be conducted transparently and
the data needs to be fed in the National Programme for effective decision-making and
strategic planning.
6. Acknowledgements

The International AIDS Society (IAS) in collaboration with the Family Planning Association of India (FPA India) who served as the local organizer, and endorsed by the AIDS Society of India (ASI), would like to acknowledge and thank all participants and stakeholders for their contribution to making the IAS Educational Fund symposium on 4 December 2019 the huge success that it was.

Special appreciation goes to the chairs, speakers and panelists for their participation and contribution during the meeting.

The IAS would also like to extend its appreciation to the Swiss Agency for Development and Cooperation, Gilead Sciences and Merck Sharpe & Dohme for their financial support for this meeting.
7. Appendices

7.1. IAS Educational Fund meeting detailed programme

Scientific Symposium

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

4 December 2019
Holiday Inn Mumbai International Airport, Mumbai, India

**Chairs:**
Dr Anton Pozniak, International AIDS Society (IAS) President
Dr Ishwar Gilada, GC regional representative, IAS
Dr Kalpana Apte, Secretary General, Family Planning Association of India (FPA India)

08:30-09:00 Registration

09:00-09:15 Welcoming remarks

09:15-11:05 ARVs and challenges to treatment access

*How is the management of HIV changing?*
Dr Anton Pozniak, International AIDS Society (IAS) President

*ARV rollout in India*
Dr Ishwar Gilada, GC regional representative, IAS

**Panel discussion**
Panel moderator: Dr Anton Pozniak, International AIDS Society (IAS) President
*Panelist 1: Dr Chinmoyee Das, Deputy Director, National AIDS Control Organisation*
*Panelist 2: Dr Amar Pazare, King Edward Memorial Hospital, Mumbai*
*Panelist 3: Ms Leena Menghaney, Médecins Sans Frontières (MSF)*
*Panelist 4: Sandeep Mane, The Humsafar Trust, Mumbai*

11:05-11:25 Tea Break

11:25-12:45 HIV and co-infections

**HIV and co-infections**
Dr Sunil Solomon, Assistant Professor of Medicine, Johns Hopkins School of Medicine

**Panel discussion**
Panel moderator: Dr Dilip Mathai, ID Specialist, Dean Apollo Medical
12:45-14:00  Lunch

14:00-15:00  Chemsex and HIV in Asia: PrEP and other prevention methods

**Project HERO**
Dr Carol Strong, National Cheng Kung University, Taiwan

**Youth perspective on chemsex**
Sadam Hanjabam, Founder, Ya-All

**Chemsex in India**
Dr Rajiv Jerajani, Senior Consultant Psychiatrist, Anatta Humanversity, Mumbai

**PrEP and HIV in India**
Dr Venkatesan Chakrapani, Chairperson/Director, Center for Sexuality and Health Research and Policy, Chennai, India, and Wellcome Trust/DBT Senior Fellow, India Alliance

**Q&A session**

15:00-15:20  Tea Break

15:20-16:35  Panel Discussion: Differentiated Service Delivery
Panel moderator: Daxa Patel, Founding Member, India Working Group (IWG), and President, National Coalition of People Living with HIV (NCP+), Surat-Gujrat

**Panelist 1:** Transgender HIV prevention services - Abhina Ahire, Associate Director, Gender sexuality and rights, India HIV/AIDS Alliance
**Panelist 2:** Differentiated HIV services for key and vulnerable populations - Dr Prashant Deshpande, Team Lead, I-TECH/CDC
**Panelist 3:** Differentiated services for people who inject drugs - Dr Jalpa Hasmukh Thakker, Program Director, ACCELERATE, Johns Hopkins School of Medicine
**Panelist 4:** Differentiated services for women, young women and girls - Ms Jahnabi Goswami, HIV activist, Assam Network of Positive I
**Panelist 5:** Ms Kusum, President, All India Network of Sex Workers

16:35-17:00  Closing remarks and networking