Priority Areas for Malaria Application

1. LLIN procurement and distribution.
2. To study storage practices, distribution, utilization, impact and community behaviour/knowledge about the use of LLINs under IMCP-3 (through an experienced agency)
3. Surveillance & response for malaria prevention & control; Cross- border control of Malaria with neighbouring countries esp. Nepal, Bhutan, Myanmar and Bangladesh
4. Treatment seeking behaviour and provision of treatment in Tribal predominant areas.
5. Involvement of Private sector (formal, non-formal) for malaria treatment and control
6. Management Information System: epidemiological data, logistic supply, HR management for malaria prevention & control with special focus in hard to reach areas.

Priority Areas for Tuberculosis Applications

1. **Private Sector Engagement (US$ 40 million)** : Enhanced **notification of missing cases**, specifically through enhancing the **private sector response including private laboratories**, including follow up on treatment outcomes
    - Private provider mapping
    - Notification of TB cases from private sector
    - Collaboration with private sector laboratories for notification and for ensuring treatment initiation of all diagnosed drug sensitive and drug resistant TB cases
    - Monitoring and reporting of treatment outcomes of all patients notified by the private sector

2. **Active Case Finding in Key Affected Populations (US$ 15 million**) : TB care and prevention for key affected populations including ACF in urban slums, tribal populations, miners, prisoners, etc
    - Mapping of vulnerable and key affected populations.
    - Screening and diagnosis of TB through ACF in KAPs
    - Treatment initiation, Monitoring and reporting of treatment outcomes of all patients notified from the KAPs

3. **Research (US$ 5 million): Implementation and Operational Research**

– Preferably, in priority areas defined by the program as available on CTD website www.tbcindia.nic.in

Priority Areas for HIV Applications

1. **Reaching towards Targets of 90:90:90 -**India is committed to work towards achieving targets of 90-90-90, in line with global recommendation. Currently Out of estimated 2.1 million PLHIV it is estimated that 71% are aware of their status, out of which 66% are on ART (based on programmatic data) and since routine viral load is not available estimating achievement against third 90 is not possible yet. Based on this scenario there are three sets of sub priorities under this goal:

    a. Testing (to reach the first 90 of global 90:90:90 target) with following key focus areas:
        i. Capacity building of service providers (among general health system and community) to diagnose HIV early with special focus on key populations
        ii. Innovative testing models such as Community Based Testing, multi center Provider Initiated Testing and Self Testing
        iii. Community System Strengthening

    b. Treatment (to reach the second 90 of global 90:90:90 target)- key focus areas are:
        i. Linking all- between prevention - testing - treatment facilities by establishing strong linkages, communication and follow up activities between various facilities
        ii. Treating all – Currently India is following 500 CD4 cut off, in line to achieve second 90, one of the strategy will be to treat all as per recent WHO guidelines. This involves procurement of ARVs.
        iii. Retaining all – Retaining PLHIV under lifelong care, maintaining adherence and thereby suppressing viral load is one of the key necessity for ending AIDS as epidemic. Provision of adequate care and support is required. A strong and an effective mechanism is needed for constant patient education, adherence support and follow up of those lost from the cascade. Involvement of PLHIV and Key population communities in these intervention is required to be improved. Also, analysis and intervention to reduce AIDS related deaths must be established.

    c. Viral Load Suppression: (to reach the third 90 of global 90:90:90 target) –
        i. Scale up Routine Viral load testing for all PLHIVs
        ii. Adherence support, monitoring and interventions

2. **Elimination of Mother to Child Transmission:**

Government of India is committed to eliminate mother to child transmission of HIV by 2020. It is essential that every pregnant woman is tested for HIV. Currently only 45% of pregnant women is being test for HIV.

a. Reaching to pregnant women and outreach activity further continuum of care
    i. In Public Sector
    ii. In Private Sector: 30-40% of pregnant women accessing private sector
b. Early infant diagnosis:
    Currently, >90% of the pregnant women detected HIV are initiated on ART but there are challenges in implementing EID services for HIV exposed baby
c. Unmet need for family planning
d. Addressing adolescent population to prevent HIV in young reproductive age population

3. **Monitoring & Evaluation :**
    a. Tracking of PLHIV or key population between facilities is a challenge as different IT mechanisms are used for prevention, testing and treatment component. Hence it is essential to link all existing software and create one M & E comprehensive system.
    b. Digital records at facilities including all facilities providing prevention-testing-treatment
    c. Case based surveillance.

4. Evidence generation for policy changes: **Operation research proposals t**o guide the national programme on evidence based policy changes.

5. Last mile solutions for supply chain management of all commodities: Country has already rolled out a web based Inventory Management System for streamlining supply chain mechanism from suppliers till end user for ARV drugs. This needs to be further strengthened and expanded for regular and real time monitoring of the consumption, accurate forecasting, facilitating necessary relocations, timely procurement, and ensuring buffer stock for at least 3 months for all commodities in the facilities to avoid stock outs.

6. Mentoring and monitoring: It is critical to adequately and regularly train, monitor and build capacity of all healthcare staff to ensure provision of quality services for the patients under NACO's care. Timely dissemination of guideline changes is also critical to ensure standardized, high quality of care for all PLHIV. Additionally, innovative and sustainable service delivery models need to be implemented to ensure optimal

utilization of existing human resources under NACO and customization of services for PLHIV with differing needs.