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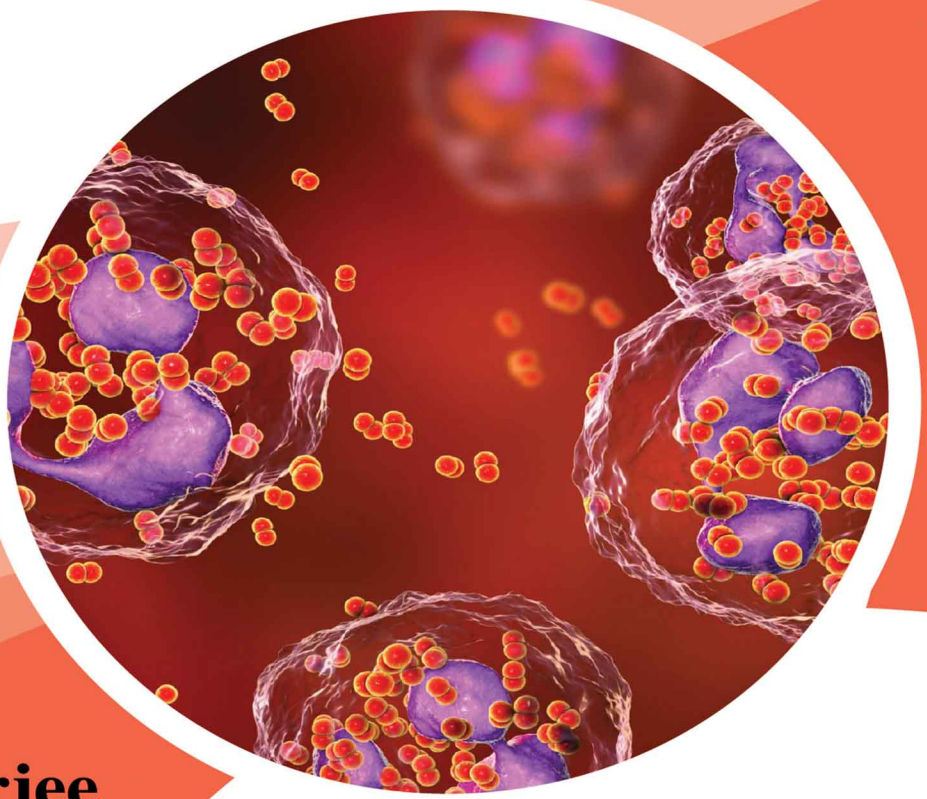
Clinical Focus on Dermatology

Sexually Transmitted Infections



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CHAPTER

8 Sexually Transmitted Infection Control Programs

Abheek Sil, Indrashis Podder

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INTRODUCTION

Sexually transmitted infections and reproductive tract infections (RTIs) remain major public health concerns, significantly affecting sexual and reproductive well-being. They contribute to a heightened risk of HIV transmission and are linked to serious complications such as infertility, adverse pregnancy outcomes, and certain cancers. Effective prevention, timely diagnosis, and comprehensive management of STIs/RTIs are thus pivotal in curbing HIV transmission and promoting overall sexual and reproductive health. This chapter emphasizes recent initiatives rolled out under phase V of the National AIDS Control Programme (NACP).

BACKGROUND EVOLUTION OVER THE DECADES

India initiated its formal response to the HIV/AIDS epidemic in 1985 through serosurveillance activities, emphasizing safe blood transfusions and public awareness. A structured approach took shape in 1992 with the inception of the National AIDS and STD Control Programme (NACP).[1] Over five progressive phases, the program has evolved into one of the largest globally **(Fig. 1)**.

- *Phase I (1992–1999)*: Primarily focused on raising awareness and ensuring blood safety
- *Phase II (1999–2006)*: Broadened its scope to include prevention, early detection, and treatment services
- *Phase III (2007–2012)*: Expanded services and introduced decentralized management structures
- *Phase IV (2012–2017)*: Consolidated earlier efforts with increased domestic funding support

An extension of phase IV (2017–2021) brought pivotal reforms, including the enactment of the HIV and AIDS

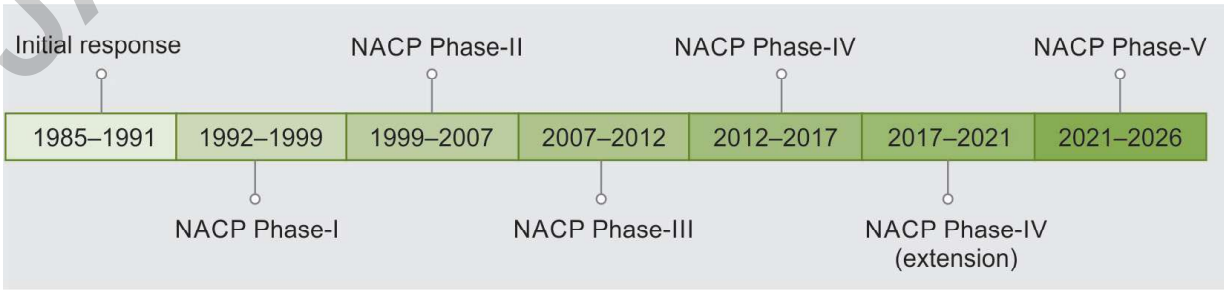

FIG. 1: National AIDS and STD Control Programme (NACP) phases.

(Prevention and Control) Act, 2017, which safeguarded the rights of people living with HIV (PLHIV). That period also marked the introduction of the "Test and Treat" policy, universal viral load monitoring, and "Mission Sampark"—a campaign aimed at re-engaging individuals who had dropped out of treatment.[2]

Need for NACP Phase-V

The formulation of phase V of the National AIDS Control Programme was driven by the necessity for sustained, strategic action to meet India's commitment to ending AIDS as a public health threat by 2030. This phase aligns with key national and global frameworks, including the Fifteenth Finance Commission (2021–26), UNAIDS Global AIDS Strategy 2021–2026, the WHO Global Health Sector Strategies for 2022–2030, and the 2021–24 funding cycle of The Global Fund.[1] The integration of these frameworks ensures that the program remains globally relevant and nationally effective.

The HIV and AIDS (Prevention and Control) Act, 2017

The HIV and AIDS (Prevention and Control) Act, 2017, is a landmark law that safeguards the rights of people affected by HIV **(Table 1)**. It remains important to India's HIV response under NACP Phase-V, serving as a key framework to ensure stigma-free access to comprehensive services.

TABLE 1: Various fields under the scope of the HIV and AIDS Act, 2017.

Employment	Renting/Buying property
Educational institutes	Standing for office (public or private)
Healthcare setting	Insurance provision

Overview of NACP Phase-V

The NACP Phase-V is a centrally sponsored initiative, entirely funded by the Government of India, with a total budget allocation of ₹15,471.94 crore. The program aims to address the HIV and STI epidemics through comprehensive, integrated approaches and by aligning closely with other national health initiatives. The key targets of this phase include:[1]

- Achieving an 80% reduction in new annual HIV infections
- Decreasing AIDS-related mortality by 80%
- Eliminating vertical transmission of HIV and syphilis
- Ensuring universal access to high-quality STI/RTI services
- Eliminate stigma and discrimination related to HIV/AIDS

Objectives

To realize its overarching goals, NACP Phase V focuses on synergizing efforts with related national programs, especially those dealing with comorbidities such as tuberculosis and viral hepatitis.[1-3] The specific objectives include:

- Providing comprehensive prevention coverage for 95% of individuals at risk of HIV
- Ensuring that 95% of PLHIV are aware of their status
- Initiating treatment in 95% of those diagnosed
- Achieving viral suppression in 95% of those on treatment
- Reaching 95% viral suppression among pregnant and breastfeeding women with HIV to eliminate vertical transmission
- Reducing stigma and discrimination experiences to below 10% among PLHIV and key populations

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- Offering universal, high-quality STI/RTI services to vulnerable and high-risk populations

The specific objectives of the NACP Phase-V are tabulated in **Table 2**.

95-95-95 Targets (Fig. 2)

India has embraced the UNAIDS vision of ending AIDS as a public health threat by 2030, by adopting the 95-95-95 targets. This strategic goal aims to:

- Ensure that 95% of PLHIV are aware of their HIV status.
- Of those diagnosed, 95% should be on antiretroviral therapy (ART).
- Among those receiving treatment, 95% should achieve viral load suppression.

This cascade underscores the importance of early diagnosis, universal access to treatment, and effective viral control to reduce transmission, improve quality of life, and prolong survival.

Guiding Principles of NACP Phase-V

The success of NACP Phase-V is underpinned by eight key principles that shape the program's design, implementation, and evaluation **(Box 1)**.[1]

Public and Private Sector Collaboration

The NACP Phase-V emphasizes a collaborative approach by building on the existing convergence between national health programs, various ministries, and state-level authorities **(Fig. 3)**. The aim is to enhance the outreach, efficiency, and sustainability of services by fostering synergy across public and private health systems. This involves coordinated planning, service delivery integration, and joint monitoring frameworks to ensure that interventions reach all intended populations effectively.[1]

TABLE 2: NACP Phase-V objectives.

HIV/AIDS prevention and control	STI/RTI prevention and control
• Comprehensive prevention for 95% of individuals at risk of acquiring HIV infection • To ensure that 95% of HIV positive know their sero-status, 95% of those who know their status should be on treatment, and 95% of those who are on treatment should have viral load suppressed • 95% of women (pregnant and breastfeeding) living with HIV should have a suppressed viral load to ensure achievement of elimination of HIV vertical transmission • Experience of stigma and discrimination to be limited to <10% among people living with HIV and key populations	• Universal access to quality STI/RTI services for at-risk and vulnerable populations • Attainment of elimination of vertical transmission of syphilis

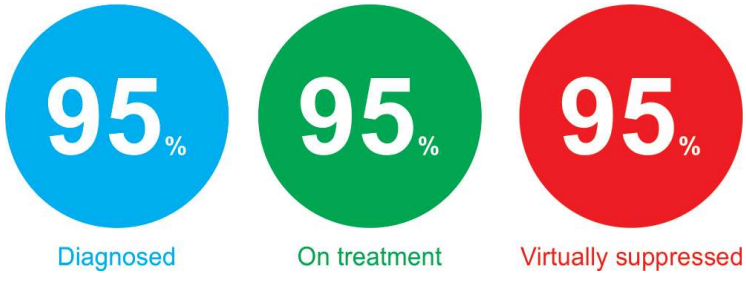

FIG. 2: Schematic representation of 95-95-95 targets.

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BOX 1: Guiding principles of NACP Phase-V.

- *Harnessing technology and innovation*: Utilize digital tools and medical advancements to improve outreach and service efficiency. Innovations will be tailored for local relevance and scalability
- *Promoting integration and synergy*: Enhance coordination among different sectors by adopting a single-window service delivery model and establishing robust referral and linkage systems with national health programs
- *Ensuring gender-responsive approaches*: Actively involve women, adolescents, and transgender persons in program design and implementation. Data analysis will be disaggregated by gender to support equitable interventions
- *Centering on community needs*: Deliver person-centered services by linking HIV-related interventions with broader healthcare services, including mental, reproductive, and noncommunicable disease care.
- *Evidence-based planning and monitoring*: Use real-time, granular, and cross-sectional data to guide planning, implementation, course correction, and performance evaluation
- *Decentralized high-impact program management*: Strengthen district-level management through strategies such as DISHA (district Integrated Strategy for HIV/AIDS), with a focus on effective supply chain and resource optimization
- *Partnership enhancement*: Foster collaboration across government departments, civil society organizations, private sector stakeholders, and international partners to expand the program's reach and impact
- *Institutional capacity building*: Strengthen technical infrastructure by empowering existing bodies such as technical resource groups (TRGs) and technical working groups (TWGs) to guide the program with scientific rigor

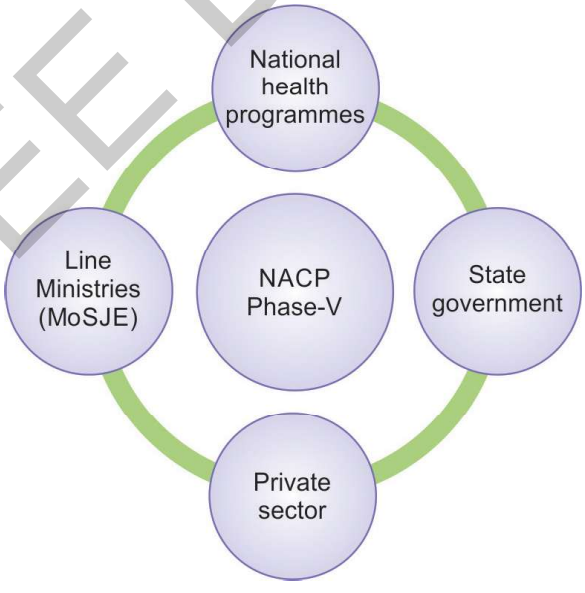

FIG. 3: Various collaborating agencies (public and private) under NACP Phase-V.

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Strategies for Goal Implementation[1]

Goal 1: Reduce annual new HIV infections by 80%.	
Strengthening targeted interventions (TIs) and link worker schemes (LWS)	Existing peer-led outreach models such as TIs and LWS are being enhanced to provide integrated services to high-risk groups (HRGs) and other vulnerable groups at physical hotspots **(Table 3)**. This includes the introduction of *dual HIV-syphilis rapid diagnostic kits* to boost early detection and service uptake. The referral and linkage system will be further utilized to identify and record comorbidities in such patients **(Fig. 4)**
Customizing prevention packages by location and population	Evidence-driven and location-specific strategies are promoted to ensure contextual relevance. This includes improved data collection to inform targeted interventions based on local epidemiology
Enhancing population size estimates and intelligence	Efforts are underway to refine population size estimations and gather field-based intelligence using tools such as *programmatic mapping and population size estimation (p-MPSE)* for saturation of services
Expanding harm reduction initiatives for IDUs (injecting drug users)	Key harm reduction programs such as the *needle-syringe exchange program (NSEP)* and *opioid substitution therapy (OST)* are being scaled up in partnership with the Ministry of Social Justice and Empowerment, with linkages to hepatitis services under NVHCP to reduce comorbidity
Reaching incarcerated populations	HIV, TB, and hepatitis services are being integrated into correctional facilities. Additionally, referral systems are set up for inmates' postrelease to ensure continuity of care
Community-based integrated service models	Models like *one-stop centers (OSCs)* **(Box 2 and Flowcharts 1 and 2)** are being piloted and expanded. These community hubs provide bundled services including HIV testing, STI treatment, counseling, and social support, tailored to high-risk populations
Expanding coverage among bridge populations	Bridge populations such as *migrants* and *truckers* are targeted using employer-led models, LWS, and customized TIs. Research will also identify other subgroups under this category to develop specific intervention models
Innovating communication strategies	A fresh communication strategy is being rolled out, leveraging digital platforms (Internet and mobile apps) to engage populations that may not perceive themselves at risk but exhibit risk behaviors
Sampoorna Suraksha Strategy (SSS)	This initiative caters to HIV-negative but at-risk individuals who fall outside traditional TI categories. Using a cyclical and comprehensive service package, SSS ensures that they remain HIV free. Key entry points include *ICTCs, STI clinics, and virtual outreach platforms*
Virtual interventions for online populations	Given the growing use of virtual platforms **(Table 4)** by young people, MSM, and sex workers, new models will engage these groups with online education, risk assessment, and linkage to testing services. The *1097 Toll-Free AIDS Helpline* anchors these efforts
Behavior change campaigns for the general public	Mass media and interpersonal communication strategies are maintained to ensure sustained awareness among the general population. The National Toll-Free AIDS Helpline – 1097 is an important link for service access
Youth-focused programming	Adolescents and young adults are prioritized through peer-led initiatives that promote safe behaviors, STI/HIV education, and early testing

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TABLE 3: Classification of high-risk groups.

High-risk groups (HRGs)		
Core population: • Female sex workers (FSW) • Male having sex with men (MSM) • People who inject drugs (PWID) • *Hijra*/Transgenders (H/TGs)	*Bridge population*: • Truckers • Migrants	Prison and other closed settings



FIG. 4: Targeted interventions in high-risk groups (HRGs).

BOX 2: Overview of one-stop centers.

One-stop centers (OSCs)
- Integrated service delivery model at community settings
- Person-centered and resource-effective approach to deliver integrated HIV prevention services in settings with low-concentrated HIV epidemics
- Community-based centers which are designed to be a single umbrella approach to attract the key and bridge population

Objectives:
- Promote screening and linkage for HIV and other essential health services
- Promote screening and referral to requisite holistic care services
- Ensure completion of referrals/linkages among the different service providers
- Increase access to HIV, other essential health services, and social welfare services
- Increase awareness and reduce stigma and discrimination

Service benefits:
- Adequate infrastructure
- Recreational facilities
- Flexible timings
- Community preferred doctor
- Nonstigmatizing environment
- OSCs will improve general health and well-being by helping them reduce the harm associated with risk behaviors

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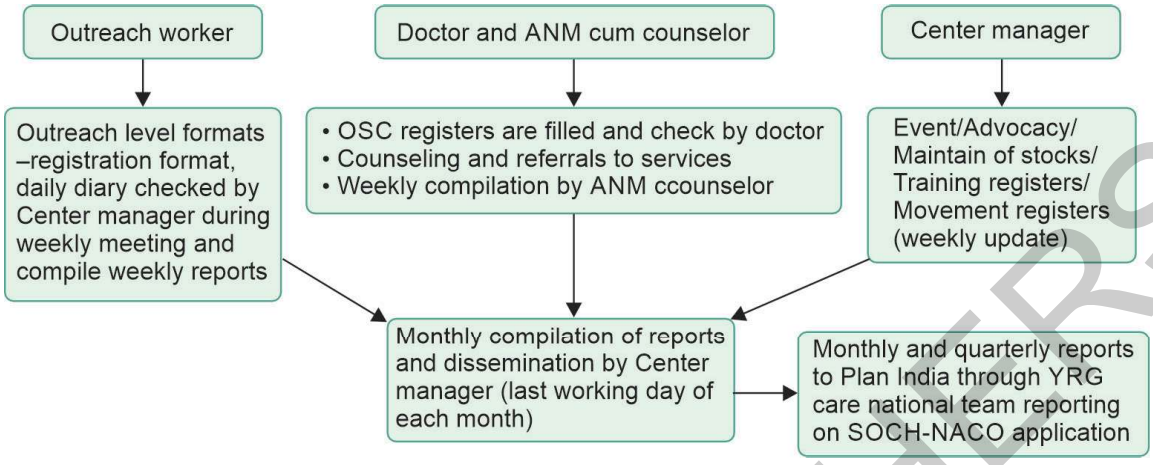
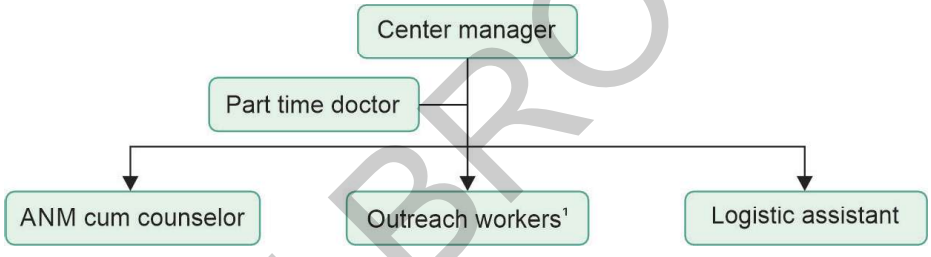


FLOWCHART 1: Flow of services at one-stop centers (OSCs).

(ANM: auxiliary nurse midwife; NACO: National AIDS Control Organization; SOCH: strengthening overall care for HIV beneficiaries)



FLOWCHART 2: Staff at one-stop centers (OSCs).

TABLE 4: Virtual interventions under NACP-V.

Featured virtual strategies for HIV care in India	
Virtual DIC, Delhi SACS, FSW/MSM/TG	Risk awareness, prevention, testing, and service linkage
MDACS/HST, ITECH-CDC, young MSM	Risk awareness, prevention, testing, and service linkage
Maharashtra SACS, HRGs (FSW)	Knowledge, awareness, feedback, and planning
Ujwala project—Alliance India, FSW	Prevention, testing, treatment, and care support
Yes4Me—USAID, general, and KPs	Risk assessment, prevention, testing, and service linkage
Safe Masti—Elton John AIDS Foundation, young MSM	Awareness, prevention, and stigma reduction
Virtual outreach, Nagaland, ITECH-CDC, MSM, and TG	Outreach, awareness, HIV testing and treatment services, distribution of commodities

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Goal 2: Reduce AIDS-related mortalities by 80%.	
Expanding HIV counseling and testing services (HCTS)	HIV testing will continue through a mix of service models—standalone centers, mobile units, and facilities integrated within both public and private healthcare settings. Community-based screening (CBS) models will also be strengthened to improve outreach in hard-to-reach areas
Focused communication to boost testing uptake	Special campaigns will be rolled out targeting adolescents and youth to improve awareness and increase uptake of HIV testing. Platforms such as *Red Ribbon Clubs* and the *Adolescence Education Programme (AEP)* will be actively leveraged
Active case finding and early diagnosis	To enhance the detection of undiagnosed cases, techniques such as *social network testing, index testing*, and *repeat testing for discordant couples* will be implemented. These approaches are expected to increase the efficiency of existing HCTS models
Integrating new testing technologies	The program will generate evidence on innovative testing options such as *HIV self-testing*, enabling informed decisions about scaling these models across diverse populations and regions
Sustaining and scaling up care, support, and treatment (CST) services	The established three-tier CST framework **(Fig. 5)** will continue to serve as the backbone of HIV care. Expansion of ART centers will be undertaken, particularly through public medical colleges and collaboration with private hospitals and laboratories
Improving access to high-quality ART	NACP Phase-V promotes *Dolutegravir-based regimens* as the preferred ART option, due to their superior outcomes in terms of viral suppression, adherence, and tolerability. These regimens will also be introduced for *Postexposure prophylaxis (PEP). Differentiated service delivery models*—such as community-based drug refills and multi-month dispensing—will improve retention and convenience for PLHIV
Rapid ART initiation and management of advanced HIV disease	Timely ART initiation is crucial. Ideally, treatment should begin within 7 days of diagnosis, and same-day initiation will be offered to those ready. Individuals presenting with advanced HIV disease will receive priority for immediate clinical management
Updating clinical guidelines regularly	Treatment protocols will be reviewed and revised based on emerging scientific evidence. Options such as *dual therapy, long-acting injectables*, and *implants* are being evaluated for simplified and more sustainable disease management
Minimizing linkage loss	To prevent drop-offs between diagnosis and treatment, predictive analytics using *machine learning* and centralized data systems will help identify and engage individuals at risk of discontinuation. Customized counseling and follow-up strategies will be applied
Enhancing viral load monitoring	The program will expand *dried blood spot (DBS)* sample collection to improve access to viral load testing. Selected public laboratories will be upgraded for *drug resistance monitoring*, ensuring timely and effective treatment adjustments. **(Fig. 6)**
Integrated service packages for PLHIV and at-risk groups	Holistic service packages—including HIV, TB, STI, hepatitis, and mental health services—will be delivered through integrated referral and linkage systems in collaboration with other health programs
Prioritizing women's health	Women living with HIV will receive focused support, including *reproductive health services, family planning*, and *early infant diagnosis*. Coordination with the *National Health Mission (NHM)* will support this comprehensive care approach

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Goal 2: Reduce AIDS-related mortalities by 80%.	
Enhancing service efficiency through single-window models	Service delivery will be reorganized in selected locations for efficiency. This includes better space utilization, task shifting, and the adoption of IT-enabled systems, backed by focused training and capacity-building of staff **(Flowchart 3)**
Strengthening laboratory quality systems	The quality assurance framework will now go beyond HIV testing to include STI/RTI diagnostics. This involves *proficiency testing, inter-laboratory comparisons*, and *laboratory accreditations*, ensuring high standards across the diagnostic chain

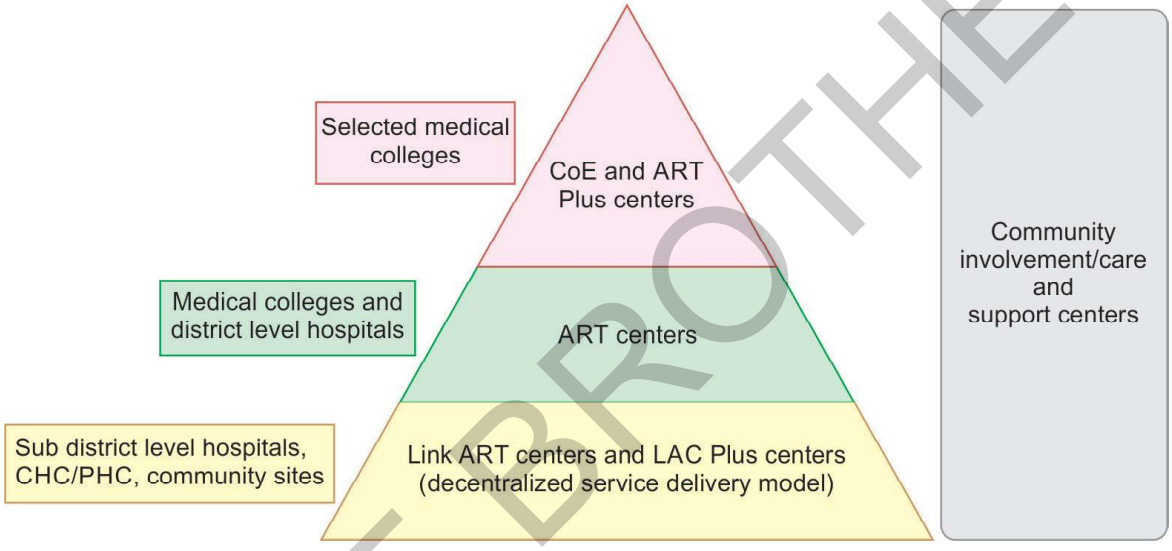

FIG. 5: HIV care, support, and treatment services.

(ART: antiretroviral therapy; CHC: community health center; CoE: center of excellence; PHC: primary health care)

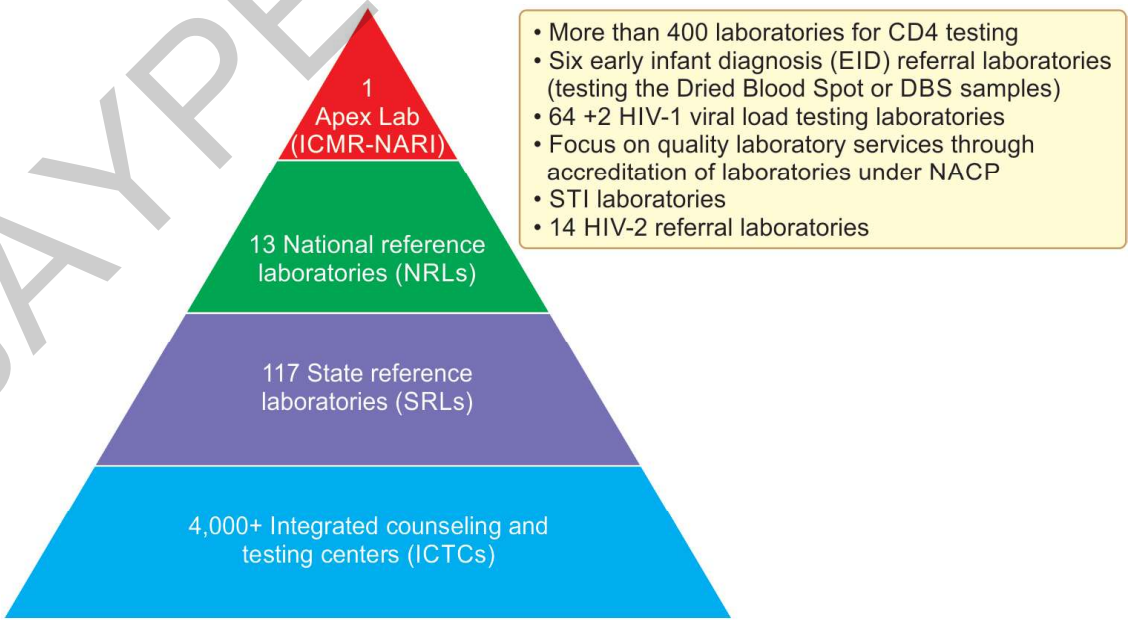

FIG. 6: HIV laboratory services.

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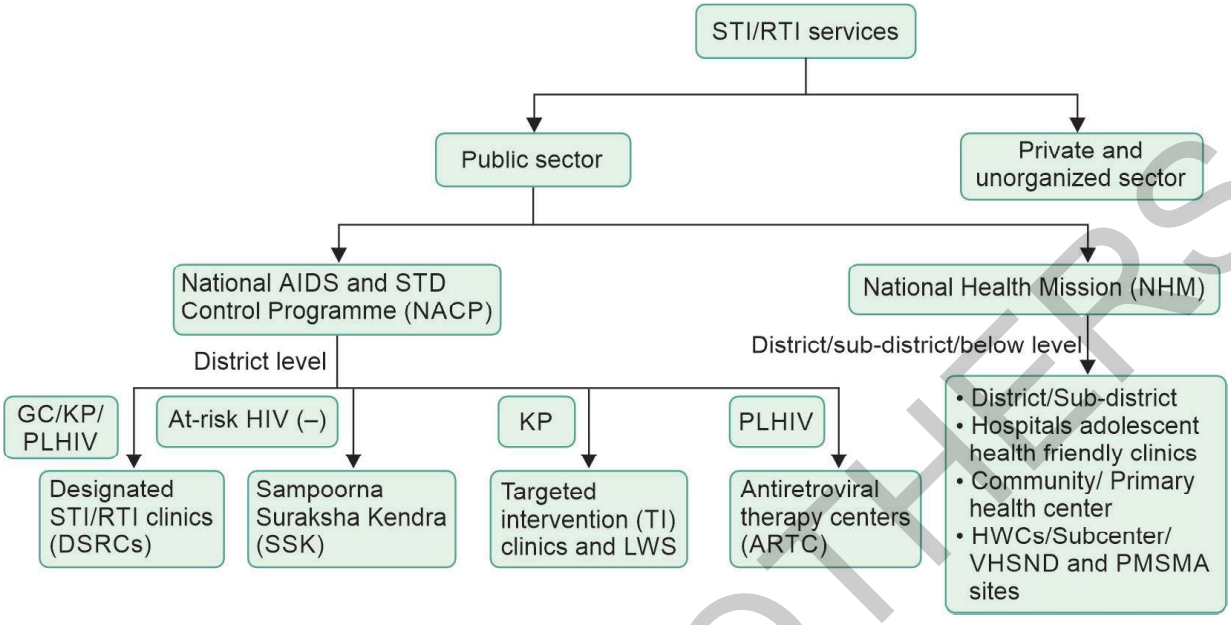

FLOWCHART 3: Sexually transmitted infection (STI) and reproductive tract infection (RTI) services delivery in India.

Goal 3: Eliminate vertical transmission of HIV and syphilis.	
Integrating with NHM for universal antenatal testing	A strategic collaboration with the *National Health Mission (NHM)* facilitates universal HIV and syphilis testing during pregnancy. Prioritized district-level interventions ensure complete coverage, with data from HMIS and RCH portals being integrated into NACP systems for immediate confirmatory testing and linkage to care
Strengthening primary prevention efforts	Awareness campaigns and behavior change interventions focused on safe sexual practices are being scaled up. Adolescents and young women are engaged through joint programs of NHM (e.g., *RKSK*) and NACP (e.g., *Red Ribbon Clubs* and *AEP*) to reduce new infections and associated risks
Rolling out dual test kits	Rapid diagnostic kits capable of simultaneously detecting HIV and syphilis are being deployed at antenatal clinics and labor rooms. This dual testing approach allows for early identification and immediate initiation of treatment, minimizing the window for vertical transmission **(Fig. 7 and Flowchart 4)**
Ensuring linkage to treatment	Not all women who test positive for HIV during antenatal screening reach confirmatory centers or begin ART. To address this gap, targeted outreach, use of digital tools, and structured review mechanisms will be employed to strengthen the continuum of care
Promoting ART adherence among WLHIV	Pregnant and breastfeeding women living with HIV (WLHIV) will receive ongoing counseling and support to achieve sustained viral suppression. Confidential, community-based service delivery models will be scaled up to reduce stigma and improve adherence

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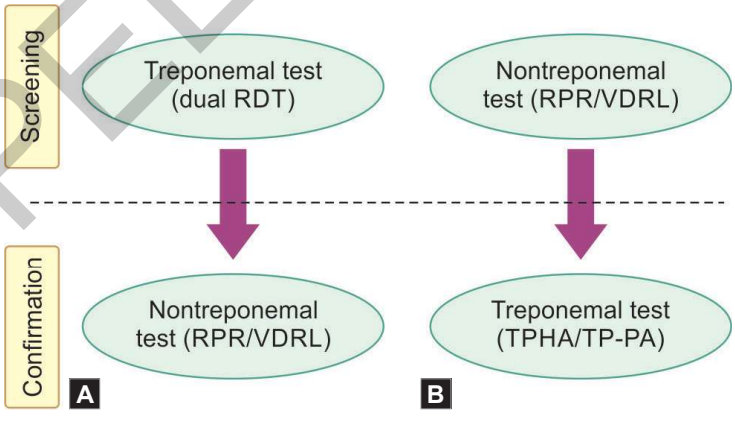
Goal 3: Eliminate vertical transmission of HIV and syphilis.	
Integrating family planning services	All PLHIV, especially women, will be assessed during their ART center visits for contraceptive needs and referred to family planning services, ensuring informed reproductive choices and preventing unintended pregnancies
Early diagnosis and management of infants	Emphasis will be placed on *early infant diagnosis (EID)* and HIV testing of family members. Identified *children living with HIV (CLHIV)* will be promptly linked to ART services to improve long-term outcomes
Engaging the private sector	Private healthcare providers will be sensitized and engaged in dual elimination efforts. They will be encouraged to offer routine antenatal testing and appropriate treatment (e.g., *benzathine penicillin G* for syphilis-positive pregnant women)
Improving strategic information	Efforts will be made to strengthen data systems for tracking fertility patterns among WLHIV, adherence to ART during and after pregnancy, and identification of HIV-exposed infants. Integrated monitoring using research, epidemiology, and surveillance data will guide program actions
Roadmap for validation of elimination	A structured action plan will be developed using WHO-recommended tools to assess progress and guide interventions toward validated elimination of vertical transmission. This roadmap will include clearly defined milestones and timelines
Enhancing behavior change communication	Social media campaigns and digital outreach will be leveraged for cost-effective dissemination of information. The *National Toll-Free AIDS Helpline (1097)* will support awareness efforts and facilitate service linkages
Sustained youth engagement	Adolescent-focused interventions will promote uptake of HIV-related services through age- and gender-appropriate messaging and delivery platforms, in alignment with national policies



FIGS. 7A AND B: Reverse testing algorithm for syphilis. (A) Reverse algorithm—treponemal antibody testing (e.g., dual RDT); (B) Traditional algorithm—nontreponemal antibody testing (e.g., RPR)-traditional syphilis screening algorithm.

(RDT: rapid diagnostic test; RPR: rapid plasma reagin; TPHA: *Treponema pallidum* hemagglutination assay; TP-PA: *Treponema pallidum* particle agglutination; VDRL: venereal disease research laboratory)

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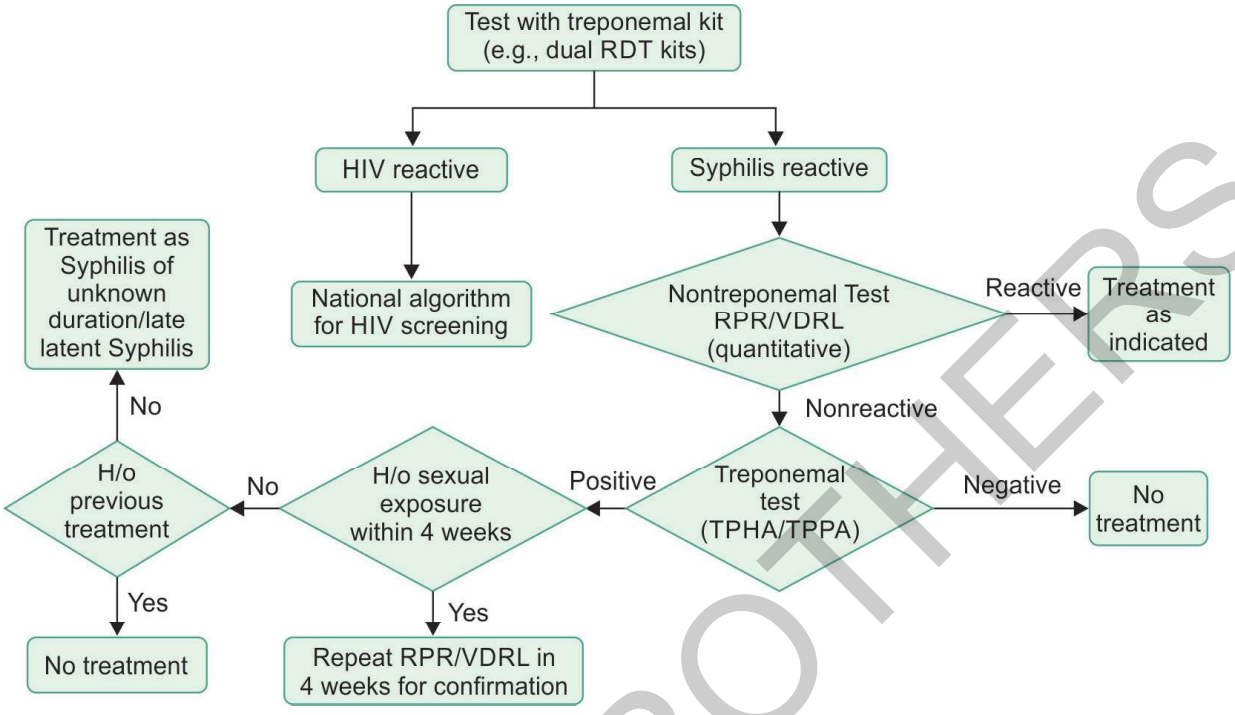

FLOWCHART 4: Reverse treatment algorithm for syphilis.

(TPHA: *Treponema pallidum* hemagglutination assay; TPPA: *Treponema pallidum* particle agglutination)

Goal 4: Promote universal access to quality STI/RTI services to at-risk and vulnerable populations.	
Enhancing strategic information on STIs	Improved data collection, monitoring, and analysis are central to informing STI interventions. The program promotes a multidimensional information ecosystem involving surveillance, research, and evaluation to track trends, identify gaps, and guide responses
Strengthening the designated STI/RTI clinics (DSRC) model	DSRCs will continue to anchor STI/RTI services using a dual setup under the departments of Obstetrics and Gynecology and Dermatology/Venereology. These clinics will also coordinate newer initiatives such as the *Sampoorna Suraksha Strategy (SSS)* and other integrated service models, adapted to local epidemiological contexts **(Flowchart 5)**
Developing integrated communication strategies	Recognizing the shared behavioral and structural determinants of HIV and STIs, NACP promotes unified communication campaigns. These will cover awareness, risk reduction, testing, and treatment, and will be tailored by age, gender, and risk profile
Scaling up dual testing at HCTS centers	Rapid diagnostic test kits for *simultaneous detection of HIV and syphilis* will be expanded across service delivery points. These efforts will include structured algorithms for confirmatory testing, case management, and follow-up. Syphilis screening through *RPR testing* will be targeted at populations and locations with high prevalence

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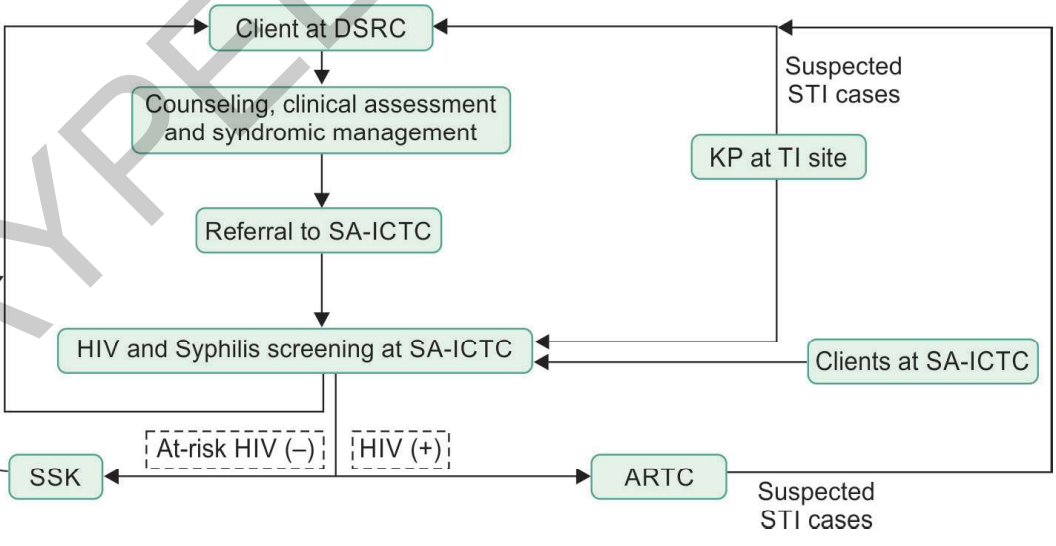
Goal 4: Promote universal access to quality STI/RTI services to at-risk and vulnerable populations.	
Promoting active case finding	To detect STIs early, the program will intensify outreach using *social network-based testing, index case tracing*, and proactive risk screening in key populations
Collaborating with NHM on service provision and reporting	NACP will work closely with the National Health Mission to scale up STI prevention and management services across all levels of the health system. Emphasis will be placed on integrating diagnostics and linking clients to quality-assured care pathways **(Fig. 8)**
Engaging the private sector	Private healthcare providers, including those in the unorganized sector, will be brought into the national response through capacity building, standardized protocols, and reporting frameworks aligned with national guidelines
Regularizing the update of the STI/RTI management guidelines periodically	Advances in diagnostics—especially point-of-care multiplex tests for HIV, STIs, and Hepatitis—will inform the transition from syndromic to etiological treatment models **(Table 5)**. Emerging service delivery options such as telemedicine and self-care strategies are being piloted for broader implementation
Enhancing laboratory capacity	The existing three-tier STI laboratory network **(Fig. 9)** will be reviewed, restructured, and strengthened. Focus areas include diagnostic upgrades, antimicrobial resistance surveillance, and informed updates to national treatment policies
Strengthening supply chain systems	IT-enabled systems will be implemented to track supply and usage of STI diagnostic and treatment commodities, ensuring availability and reducing stock-outs across service delivery sites



Note: There are in-referrals to DSRCs from other departments (including OBGY and DVD) of District Hospital/Medical Colleges.

FLOWCHART 5: Service delivery framework at designated STI/RTI clinics (DSRC).

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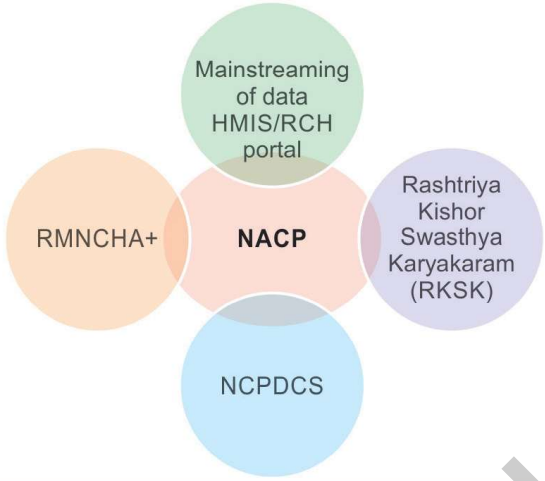

- Mainstreaming of HIV testing data reported through NHM portal, i.e., health management information system (HMIS) and reproductive and child health (RCH) portal
- Screening and management of STI/RTI services among adolescents through RKSK
- Screening and management of cervical cancer among WLHIV and FSWs through NCPDCS
- Case reporting system for syphilis among pregnant women and exposed children

FIG. 8: Collaboration with National Health Mission (NHM).

TABLE 5: Color-coded kits under NACP.

Kit	Composition	Targeted syndrome
Kit 1 (gray)	Tablet azithromycin 1,000 mg and cefixime 8,000 mg single-dose tablet	• Urethral discharge syndrome • Vaginal discharge syndrome (for cervicitis) • Painful scrotal swelling • Presumptive treatment (PT)
Kit 2 (green)	Tablet secnidazole 2,000 mg and tablet fluconazole 150 mg single dose	Vaginal discharge syndrome (for vaginitis)
Kit 3 (white)	• Injection benzathine penicillin G 2.4 MU • Azithromycin 1,000 mg single dose and tablet • Disposable syringe 10 mL with 21-gauge needle and sterile water 10 mL	Genital ulcer disease syndrome (for syphilis and chancroid)
Kit 4 (blue)	Tablet doxycycline 100 mg (28 capsules as twice/day dose for 14 days) and tablet azithromycin 1 g single dose	Genital ulcer disease syndrome (for syphilis and chancroid when unavailability or history of allergy to BPG)
Kit 5 (red)	Tablet acyclovir 400 mg (21 tablets as three times/day dose for 7 days)	Genital ulcer disease syndrome (for herpetic ulcers)
Kit 6 (yellow)	Tablet cefixime 800 mg single dose and tablet metronidazole 400 mg (28 tablets as twice/day dose for 14 days) and capsule doxycycline 100 mg (28 capsules as twice/day dose for 14 days)	Lower abdomen pain PID
Kit 7 (black)	Tablet doxycycline 100 mg (42 capsules as twice/day dose for 21 days)	• Inguinal bubo under genital ulcer disease syndrome • LGV proctitis under anorectal discharge syndrome
Kit 8 (brown)	Tablet cefixime 800 mg STAT dose and tablet doxycycline 100 mg (14 capsules as twice/day dose for 7 days)	Anorectal discharge syndrome

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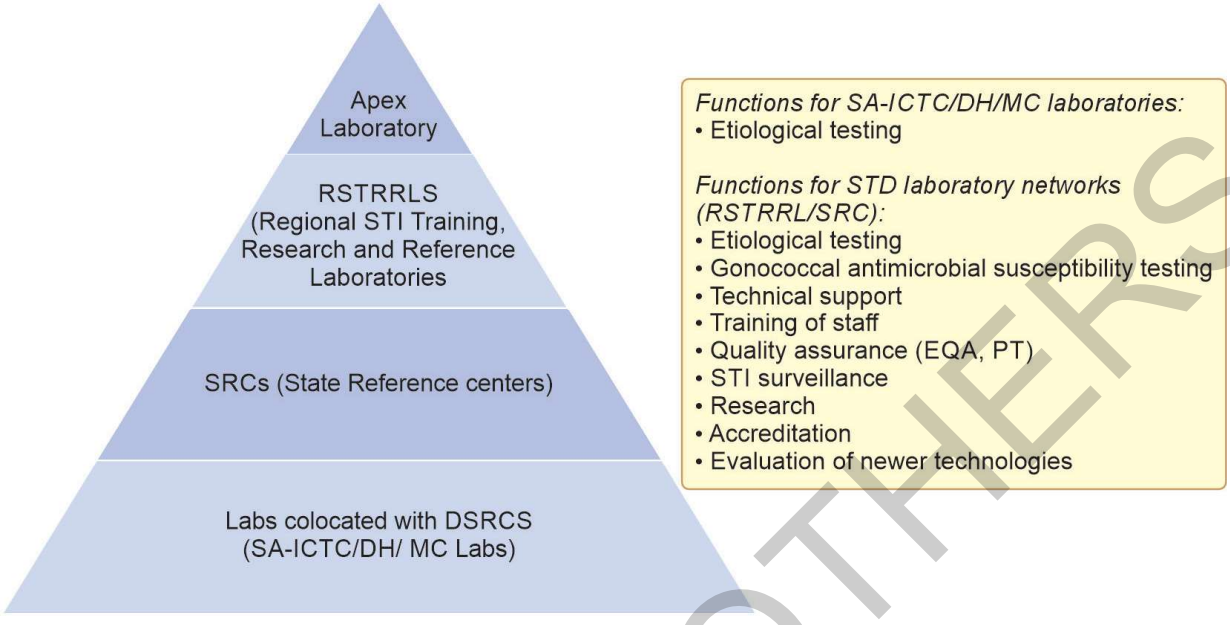

FIG. 9: STI laboratory network.

Goal 5: Eliminate HIV/AIDS-related stigma and discrimination.	
Institutionalizing community engagement	Community system strengthening (CSS) is being embedded into the program to ensure active participation of key populations (KPs) and PLHIV. These systems will support the design, delivery, and monitoring of services through grassroots-level leadership and feedback mechanisms **(Flowchart 6 and Boxes 3 and 4)**
Operationalizing legal provisions under the HIV Act, 2017	Efforts are underway to accelerate the notification of state-specific rules under the HIV and AIDS (Prevention and Control) Act, 2017. Each state will appoint an *ombudsman* and *complaints officers* at institutions to handle grievances related to discrimination and ensure enforcement of the Act
Stakeholder sensitization	Targeted capacity-building programs will be rolled out for key institutions—including workplaces, schools, and healthcare facilities—to raise awareness, reduce prejudice, and promote nondiscriminatory service delivery. These programs will educate stakeholders on legal provisions and build their ability to respond effectively
Strategic communication campaigns	Mass media, mid-media, and interpersonal communication approaches will be integrated into stigma-reduction campaigns **(Table 6)**. These campaigns will address misconceptions, promote empathy, and support behavior change. All communication efforts will include measurable indicators for tracking their effectiveness
Improving strategic information systems	New data collection tools will be introduced to assess stigma and discrimination across four key settings: Healthcare, community, workplace, and educational institutions. This evidence will guide targeted interventions and allow for regular impact evaluation
Promoting social protection schemes	Social welfare initiatives launched by state governments will be scaled up and aligned with the national HIV response. These schemes improve access to services and empower PLHIV and vulnerable populations by addressing barriers related to social exclusion, poverty, and marginalization

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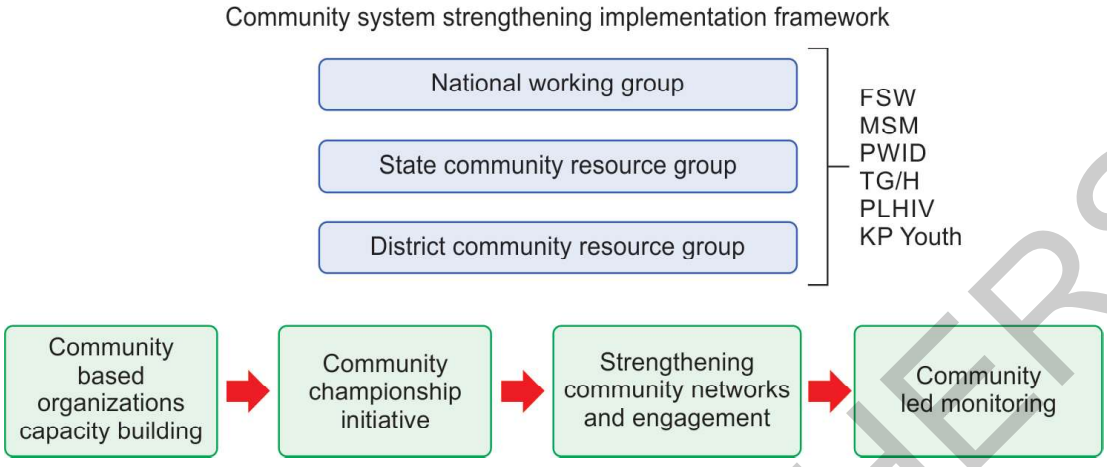

FLOWCHART 6: Implementation framework of community system strengthening.

BOX 3: Key aspects of community-led monitoring.

- CLM will play a central role in ensuring that program design and implementation reflect the needs of the community
- It involves routine feedback from people living with HIV (PLHIV) and key populations on the quality of services, challenges faced, and suggestions for improvement, especially around stigma, access, and retention in care

BOX 4: Key aspects of community champions.

- Influential individuals from within key population groups will be identified and trained as community champions
- These individuals will serve as advocates, educators, and mobilizers within their networks, helping to reduce stigma, encourage service uptake, and build community resilience

TABLE 6: Key aspects of information, education, and communication.

Information, education, and communication (IEC)	
Objectives of IEC: • Behavior change • Demand generation • Reduction of stigma and discrimination	*Flagship initiatives*: • National Toll-free AIDS Helpline (1097) • Red Ribbon Express campaigns • Digital media outreach (social media, mobile apps) • Community events and school-based activities • Resource hubs and repositories for knowledge sharing
A multimedia approach: • Mass media (TV, radio, etc.) • Mid media (posters and special events) • Interpersonal communication (IPC) • SBCC	

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CONCLUSION

- India has the second largest estimated number of PLHIV (24 lakhs) in the world of which 40% are in Maharashtra, Andhra Pradesh, and Karnataka.
- Injecting drug users have the highest prevalence of HIV (9%).
- NACO has adopted 95-95-95 targets set by UNAIDS "to end HIV/AIDS as a Public Health threat by 2030".
- Quality standardized sexual and reproductive health services provided at district, subdistrict, and medical college level, through designated STI/RTI clinics (DSRC) or "Suraksha Clinics".
- NACP Phase V will focus on newer initiatives such as Sampoorna Suraksha Strategy to cover "at-risk" HIV negative but non-TI population through a cyclical and comprehensive package of services.
- NACP phase-V focuses on STI/RTI through the inclusion of Goal 3 and 4.
- Laboratory support for STI/RTI has been strengthened through a network of 10 regional STI laboratories and 45 state reference centers.

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