

OVERSIGHT COMMITTEE

FIELD VISIT REPORT
TAMIL NADU

Chennai | Kancheepuram | Madurai | Dindigul



Oversight Committee team during the Tamil Nadu field visit, August 2026

17–21 August 2026

Oversight Committee, India Country Coordinating Mechanism (ICCM)

Table of Contents

1. Site Visit Details
 - 1.1 Objectives of the Field Visit
 - 1.2 Team Composition
 - 1.3 Facilities Visited – Team 1 (Chennai / Kancheepuram)
 - 1.4 Facilities Visited – Team 2 (Madurai / Dindigul)
 - 1.5 Overall Reflection of the Oversight Committee
 - 1.6 Debrief Meeting and Sharing of Findings
2. Executive Summary
 - 2.1 Key Findings – HIV
 - 2.2 Key Findings – TB
 - 2.3 Priority Recommendations
3. Tuberculosis (TB) Programme — Findings and Recommendations
 - 3.1 GHTM Tambaram — Centre of Excellence for DR-TB, ART Centre & ICTC
 - 3.2 Kanchipuram — District TB Programme
 - 3.3 General TB-Related Observations (Chennai / Kancheepuram)
 - 3.4 GTHTM, Chennai
 - 3.5 Technical Assistance for DBT & Finance (KHPT)
 - 3.6 Madurai Central Prison — TB Screening Cascade
 - 3.7 Dindigul — NTEP (TB Programme)
4. HIV/AIDS Programme — Findings and Recommendations
 - 4.1 Progress of activities in the state regarding the GC7
 - 4.1.1 Facilities status
 - 4.1.2 Current status of 95-95-99
 - 4.1.3 EMTCT programme
 - 4.1.4 Prison and other closed setting progress
 - 4.1.5 Community System Strengthening
 - 4.1.6 Global fund other activities progress
 - 4.1.7 Budget utilization by SAATHI NGPR
 - 4.2 Capacity Building (SAATHI / Kshamta Kendra)
 - 4.3 GHTM Tambaram — ART Centre & ICTC (HIV)
 - 4.4 Treatment Interruption, LFU Tracking & Viral Load Testing
 - 4.5 Index Testing — Programme-wide Gaps

- 4.6 Tamil Nadu SACS Snapshot – Madurai/Dindigul Facility Network
- 4.7 Prison and other settings
- 4.8 CSC (Bro Siga Social Service Guild) — Madurai
- 4.9 One Stop Centre (TG) — Madurai
- 4.10 Dindigul ART Centre / SSK — HIV Programme Snapshot
- 4.11 Kshamata Kendra, Gandhigram — Capacity Building
- 4.12 ART Plus Centre & Viral Load Lab — Govt. Rajaji Hospital, Madurai
- 4.13 ART center at Madras Medical College
- 4.14 Community system strengthening and CLM
- 5. Debriefing
 - 5.1 Overall reflection of Oversight Committee
- 6. Acknowledgement

The Oversight Committee of the India Country Coordinating Mechanism (ICCM) provides independent supportive supervision of Global Fund-supported HIV/AIDS and Tuberculosis programme implementation across states.

This report presents the findings, observations and recommendations of the Committee's field visit to Tamil Nadu from 17–21 August 2026.

1.1 Objectives of the Field Visit

- To review the implementation and performance of ongoing HIV/AIDS and Tuberculosis programmes in Tamil Nadu.
- To provide supportive supervision and assess opportunities to improve the coverage, quality, equity, efficiency and effectiveness of the programmes.
- To assess the qualitative and quantitative performance of programme activities, including implementation progress, results achieved and challenges faced by programme managers at the field level.
- To identify and document best practices adopted within Tamil Nadu and other States/Union Territories, with a view to their replication across relevant implementation geographies.
- To provide practical, time-bound recommendations for addressing identified gaps and improving overall programme performance.

The field visit took place during the third year of Grant Cycle 7 implementation. The oversight requirement at this stage is therefore increasingly focused on sustainability, quality, performance recovery, equity and demonstrable use of information for decision-making rather than only on establishment of programme structures.

1.2 Team Composition

The Oversight Committee visit comprised the following members, who divided into two field teams covering Chennai/Kancheepuram and Madurai/Dindigul respectively:

- Dr. Ravi Kumar
- Dr. Naresh Goel
- Dr. Rita Prasad
- Mr. Ramesh Babu
- Mr. Roshan Ningthoujam
- Mr. B. L. Parihar
- Mr. Amit Mittal
- Ms. Vera Sapu, Program Officer, India CCM Secretariat

1.3 Facilities Visited – Team 1 (Chennai / Kancheepuram)

Date	Component	Site	District
17 Aug 2026	—	Arrival in Chennai	Chennai
17 Aug 2026	HIV+TB	Briefing with State TB Officer & SACS; briefing by STC, SACS, KHPT, SAATHII & PLAN	Chennai
18 Aug 2026	HIV+TB	GHTM Visit – Centre of Excellence for DR-TB, ART Centre, ICTC	Chengalpet (Tambaram)
19 Aug 2026	HIV+TB	Prison visit – Kanchipuram Sub Jail	Kanchipuram
19 Aug 2026	HIV	CSC – South India Positive Network (SIP+)	Kanchipuram/Chengalpet
19 Aug 2026	TB	OTTERI DR-TB Centre	Chennai
20 Aug 2026	HIV	ICMR–NIRT, VL Lab	Chennai
20 Aug 2026	HIV	CSC/CSS, ART Centre – South India Positive Network (SIP+)	Chennai

1.4 Facilities Visited – Team 2 (Madurai / Dindigul)

Date	Component	Site	District
17 Aug 2026	HIV+TB	Arrival in Chennai; briefing with TNSACS, STC, KHPT, SAATHII, PLAN; travel to Madurai	Chennai
18 Aug 2026	HIV+TB	Prison & OCS visit – Madurai Central Jail	Madurai
18 Aug 2026	HIV	CSC – Bro Siga Social Service Guild (BSSSG)	Madurai
18 Aug 2026	HIV	One Stop Centre (TG)	Madurai
19 Aug 2026	HIV	SSK / ART / ICTC, Govt. Medical College Dindigul	Dindigul
19 Aug 2026	HIV	Kshamta Kendra, Gandhigram Institute of Rural Health & Family Welfare Trust	Dindigul
20 Aug 2026	HIV	Madurai Govt. Medical College – Viral Load Lab, ART Centre, airborne infection control measures	Madurai
21 Aug 2026	—	Debriefing meeting with Secretary (H&FW), MD (NHM), PD SACS, STO	Chennai

2. Executive Summary

Two Oversight Committee field teams undertook a joint supportive-supervision visit to Tamil Nadu from 17–21 August 2026, covering Chennai, Kancheepuram, Madurai and Dindigul. The visit reviewed the implementation and performance of ongoing HIV/AIDS and Tuberculosis programme activities in the state, assessed progress against previous recommendations, identified good practices for replication, and developed practical, time-bound recommendations to address the gaps observed in the field.

2.1 Key Findings – HIV

- Tamil Nadu's HIV 95-95-95 cascade (92.0% – 93.1% – 95.9%) is ahead of the national average (87.4% – 90.0% – >95.0%), reflecting a mature and generally well-managed epidemic response, though 19 indicators are flagged red in the Sankalak 7th Edition report and warrant closer review.
- Loss-to-follow-up (LFU) tracking and viral-load (VL) overdue follow-up have improved steadily across districts (e.g., LFU tracking at Community & Support Centres rose from 72% in FY 2024–25 to 93% in Q1 FY 2026–27), but facility-level gaps persist in SOCH data updation, PLHIV tracking sheets and visibility of VL results, especially in prison settings.
- Index testing is a consistent weak link across ART Centres and CSCs — incomplete contact elicitation and documentation, no displayed client information, absent IPV screening and referral pathways, and inadequate staff training were observed at multiple sites.
- Good linkage outcomes were seen among key/vulnerable populations: The Madurai One Stop Centre (TG) has achieved 100% ART linkage for all newly diagnosed clients, and ART–CSC–TB coordination is functioning well at most ART Plus Centres.
- Cumulative mortality among ART registrants remains high at several centres (e.g., 3,899 of 26,903 at GHTM Tambaram; 4,545 of 22,790 at Madurai GRH; 896+2,878 of 8,991 at Dindigul), indicating a need for systematic root-cause review through death audits.
- Retention among newly initiated ART clients (~85% in Madurai) is markedly lower than overall tracking/testing performance, pointing to an early-retention gap needing focused adherence counselling.

2.2 Key Findings – TB

- Airborne Infection Control (AIC) and Infection Prevention & Control (IPC) civil-work recommendations from CTD /FIND inspection report (sputum collection shed, exhaust fan in the Bronchoscopy suite, Tamil-language signage, BMW segregation) have largely been completed and verified at GHTM Tambaram; however, healthcare-worker TB surveillance and regular Hospital Infection Control Committee meetings remain inconsistent across facilities.
- TB screening in closed settings is constrained by capacity: at Madurai Central Prison, weekly Handheld X-ray (HHXR) camps and a single radiographer cannot keep pace with a static population of ~2,100 and average monthly admissions of 380, and undertrial inmates are often transferred, produced in court or released before screening.

- Private-sector engagement is a bright spot in Kanchipuram, with 360 private doctors granted NIKSHAY access; however, screening coverage of vulnerable populations (including PLHIV) needs improvement, and 85 of 135 supplied Handheld X-ray machines are non-functional.
- In Dindigul, diagnostic turnaround for drug-resistant TB remains long (FL-LPA: 25 days; SL-LPA: 48 days), NAAT/CBNAAT coverage stands at 12 of 14 blocks, and TPT initiation among under-5 household contacts (46%) trails both eligibility and the over-5 contact rate (60%).
- TB-HIV coordination is a consistent good practice — regular joint review meetings, bi-directional screening and weekly handheld X-ray screening at ART Centres were observed across Chennai, Kancheepuram, Madurai and Dindigul sites.
- Rising TB-diabetes co-prevalence (18% in 2023 to 22% in 2026, Dindigul) signals a growing need for structured TB-DM co-management and referral pathways.

2.3 Priority Recommendations

- Institutionalize systematic, documented root-cause review (death audits) for ART and TB mortality across high-caseload centers, and feed findings into adherence and retention strategy.
- Strengthen Index Testing programme-wide through refresher training, standardized documentation, IPV screening and referral protocols, and routine supervisory review of the testing cascade.
- Close SOCH data-entry and VL-visibility gaps — particularly at Link ART Centers serving prisons — through SOPs for sample-referral entry and weekly reconciliation between laboratories and ART centers.
- Augment TB screening capacity in high-turnover closed settings (prisons) with dedicated radiographers, more frequent HHXR camps (ideally at intake), and separate tracking of undertrial-inmate coverage.
- Address the shortage of dedicated radiographers at high-turnover TB screening sites such as Madurai Central Prison — adequate handheld X-ray machines are available, but limited radiographer availability is causing inadequate screening coverage; explore mechanisms to fill these posts on a contractual basis or through Non-Governmental Programme Recipients (NGPRs).
- Address diagnostic and treatment-support bottlenecks for drug-resistant TB (LPA turnaround, NAAT/CBNAAT expansion) and intensify TPT initiation among under-5 household contacts.
- Strengthen TB Preventive Treatment (TPT) among PLHIV and improve TPT completion, drawing on site-level data from the visit — e.g., Dindigul's 76% TPT completion against 94% eligibility, and TPT initiation among under-5 household contacts (46%) trailing over-5 contacts (60%).
- Many TB treatment facilities in selected medical college hospitals in the state were inspected by the central team in 2023 for Airborne Infection Control Prevention activities under C19 RM and report was submitted identifying the actions to be taken up at different levels.

Current assessment should be conducted in all these facilities to find out the status of implementation.

- Document and formally replicate identified good practices — differentiated ART care models, Community ART Refill Groups, the 7-day ART Plus Centre service model, and CSC-led adherence/support-group models — across other facilities in the state.
- Strengthen early-retention support for newly initiated ART clients and continue to scale LFU track-back and VL-overdue follow-up systems that have shown measurable improvement.
- Fill critical staff vacancies (staff nurse, data manager, care coordinator, dedicated radiographers) and resolve NPY payment delays affecting contractual programme staff.

3. Tuberculosis (TB) Programme — Findings and Recommendations

As per the checklist provided by CTD, a brief review of the programmatic aspects of NTEP was undertaken. The performance of different indicators is as follows:

A. TB Notification, Public Health Action & Care

Q1. Number and % of TB cases notified against target, by Public and Private facilities

Location	Sector	Current Year (Jan to June 2026)			Previous Year (Jan to Dec 2025)		
		Male	Female	Total	Male	Female	Total
Tamil Nadu (State)	Public	26,402	11,226	37,628	54,877	22,513	77,390
	Private	4872	3168	8040	10,916	7,299	18,215
Kancheepuram District	Public	2038	809	2847	3,711	1,716	5,427
	Private	34	24	58	93	66	159
Madurai District	Public	1666	672	2338	3,537	1,340	4,877
	Private	593	354	947	1,135	772	1,907

Q1a. Number of patients with RR-TB and/or MDR-TB that began second-line treatment

Location	Current Year (Jan to June 2026)			Previous Year (Jan to Dec 2025)			
	Male	Female	Total	Male	Female	Total	
Tamil Nadu (State)	398	138	536	939	382	1,321	
Kancheepuram District	30	15	45	82	26	108	
Madurai District	33	11	44	81	25	106	

Q1b. What mechanism of treatment adherence is being used for TB patients?

Ni-kshay Adherence, Telemonitoring, home visits, collection of empty blisters during replacement

Q2. Number and % of people with confirmed RR-TB and/or MDR-TB notified, by Public and Private facilities (current & previous year).

Location	Sector	Current Year (Jan to June 2026)			Previous Year (Jan to Dec 2025)		
		Male	Female	Total	Male	Female	Total
Tamil Nadu (State)	Public	392	133	525	919	372	1,291
	Private	6	5	11	20	10	30
Kancheepuram District	Public	30	15	45	81	26	107
	Private	0	0	0	1	0	1
Madurai District	Public	33	10	43	79	25	104
	Private	0	1	1	2	0	2

Q2c. Whether newer drugs/regimens are being offered to all eligible patients, including private sector patients

Location	Yes / No	Remarks
Tamil Nadu (State)	Yes	
Kancheepuram District	Yes	It was crosschecked with a few patient records
Madurai District	Yes	It was crosschecked with a few patient records

Q3. Treatment success rate for ALL forms of TB, Public vs Private facilities

Location	Sector	Current Year (Jan to June 2025)			Previous Year (Jan to Dec 2024)		
		Male	Female	Total	Male	Female	Total
Tamil Nadu (State)	Public	91%	93%		91%	94%	
	Private	91%	90%		94%	95%	
Kancheepuram District	Public	91%	95%		89%	93%	

	Private	91%	95%		94%	95%	
Madurai District	Public	91%	96%		92%	95%	
	Private	98%	99%		95%	97%	

Q4. Treatment success rate for RR-TB/MDR-TB, Public vs Private facilities							
Location	Sector	Current Year (Jan to June 2025)			Previous Year (Jan to Dec 2024)		
		Male	Female	Total	Male	Female	Total
Tamil Nadu (State)	Public	54%	61%		65%	76%	
	Private	56%	43%		52%	77%	
Kancheepuram District	Public	63%	75%		76%	70%	
	Private	100%	Nil		0%	100%	
Madurai District	Public	38%	57%		53%	46%	
	Private	Nil	Nil		20%	0%	

Q5. % (number) of notified TB cases tested for DM, Public vs Private sector							
Location	Sector	Current Year (Jan to June 2026)			Previous Year (Jan to Dec 2025)		
		Male	Female	Total	Male	Female	Total
Tamil Nadu (State)	Public	95%	95%		98%	98%	
	Private	88%	87%		92%	91%	
Kancheepuram District	Public	96%	96%		96%	97%	
	Private	91%	96%		75%	73%	
Madurai District	Public	95%	98%		97%	98%	
	Private	98%	99%		97%	98%	
Q5. % (number) of notified TB cases tested for HIV, Public vs Private sector							

Location	Sector	Current Year (Jan to June 2026)			Previous Year (Jan to Dec 2025)		
		Male	Female	Total	Male	Female	Total
Tamil Nadu (State)	Public	98%	97%		99%	99%	
	Private	87%	82%		88%	84%	
Kancheepuram District	Public	98%	98%		98%	99%	
	Private	97%	100%		81%	80%	
Madurai District	Public	97%	98%		98%	99%	
	Private	99%	99%		97%	98%	

Q6. Has intensified case finding started at all high-risk OPDs (NCD clinic, Tobacco Cessation Clinic, ART clinics, OST clinics, RCH Clinics, NRC, etc.)?							
Location	Yes / No	Remarks					
Tamil Nadu (State)	Yes						
Kancheepuram District	Yes	It was observed that there is good amount of co-ordination and cross referral at the HQ hospital					
Madurai District	Yes						

Q7. How is data shared by various Health Programmes validated, reviewed and utilised at State/District level?	
Response / Notes:	Data of NCD patients shared by the public health department at the district levels for screening during community based campaigns.

B. Availability and Access to TB Laboratory Services

TB testing facilities/tests have been made available at all the blocks for presumptive TB cases and TB patients (Sputum microscopy / NAAT / X-ray / FL-SL LPA / CDST). Upfront Molecular Diagnostics are being offered to about 84 % in the state as a whole and 81% and 86 % in Kanchipuram and Madurai districts respectively. % of TB notified patients offered rifampicin testing is more than 95 %; of these, % offered within 15 days of notification is 100. Average Turn-Around-Time (days) between TB notification and result is minimum and is satisfactory. The challenge of irregular availability of CBNAAT cartridges was mentioned in few areas.

C. TB Drugs Availability:

The state has sufficient stock of FLD stock at all levels. However, the SLD stock is insufficient. In any case, the state has a clear plan for procuring drugs locally.

D. TB Preventive Treatment (TPT):

TPT is being implemented well. The limitation is said to be the dependence on CTD supply of TBI testing consumables. The current status of TPT is as follows:

Location	Category	Current Year		Previous Year	
		Under 5 yrs	More than 5 yrs	Under 5 yrs	More than 5 yrs
Tamil Nadu (State)	Contacts identified (A)	2006	42535	3365	103021
	Diagnosed with TB (B)	13	418	59	1969
	Eligible for TPT (C=A-B)	1993	42117	3306	101052
	Initiated on TPT (D)	1603	30941	2189	22740
Kancheepuram District	Contacts identified (A)	144	2621	172	3812
	Diagnosed with TB (B)	0	20	0	76
	Eligible for TPT (C=A-B)	144	2601	172	3736
	Initiated on TPT (D)	111	1858	141	1537
Madurai District	Contacts identified (A)	122	2592	233	5469
	Diagnosed with TB (B)	0	12	0	60
	Eligible for TPT (C=A-B)	122	2580	233	5409
	Initiated on TPT (D)	101	2107	159	1096

Regarding the status of availability of TBI tests, it is noted that CyTB is available in very limited quantity with no stock at DDS and TU/ two vials available in PHIs.

E. Other issues: 179 out of 1965 posts are vacant concerning NTEP. The training status of all categories of staff is adequate. No gender and access issues have been reported.

3.1 GHTM Tambaram — Centre of Excellence for DR-TB, ART Centre & ICTC (Chengalpattu District)

Team 1 | 18 August 2026

Observations

- The overall activities at the center are going on very well and need to be complimented. There is good leadership. The staff are very committed.
- The Hospital Infection Control Committee is functional and holds regular quarterly meetings, with detailed reports being prepared.
- The hospital has 280 regular staff and 240 outsourced staff. All the staff undergo yearly general health checkup along with chest X-ray and sputum examination. The record show that three contractual employees and one regular employee have contacted Pulmonary tuberculosis in the last two years.
- Passive TB surveillance is functioning appropriately at GTHTM Chennai for 2026, though the hospital's infection-control committee, while existing, does not hold regular meetings.
- The hospital was visited by the central team in 2023 for Airborne Infection Control Prevention activities under C19 RM and report was submitted identifying the actions to be taken up at different levels. Current assessment shows that significant recommendations were implemented. All civil-work recommendations — the ventilated sputum collection/deposit shed and the exhaust fan in the Bronchoscopy suite — have been completed and are functional; Tamil-language IPC/BMW signage, the 3-bucket floor-cleaning system and fast-tracking of symptomatic are confirmed as implemented. A Vanemometer and Anemometer supplied to the Institute are not in use, on the (incorrect) assumption that ward ventilation is already adequate. 5% phenol in individual spittoons is being provided to DR-TB in-patients, with regular counsellor-led training on spittoon use and cough etiquette, per on-site verification.
- All NDRTB staff require re-orientation on updated BMW, PPE, IPC and AIC guidelines; baseline training registers (2021–2022) are on record.

Recommendations

- Institute periodic (at minimum annual) healthcare-worker TB surveillance covering all staff categories, not a one-time screening exercise.
- Ensure the Hospital Infection Control Committee meets regularly at all facilities and that minutes/reports are maintained and shared with the Director of Medical Education & Research.
- Put the supplied Vanemometer and Anemometer into active use for routine ventilation/Air Changes per Hour (ACH) monitoring rather than assuming adequacy.
- Continue re-orientation of NDRTB staff on updated BMW, PPE, IPC and AIC guidelines through State- and site-level trainings, with periodic health monitoring of staff.

3.2 Kanchipuram — District TB Programme

Team 1 | 19 August 2026

Observations

- The headquarters hospital has a daily outpatient load of about 1,000; the proportion screened for TB (target: at least 2%) is somewhat below expectation.

- The combined Kanchipuram and Chengalpattu districts have a population of 34.7 lakhs. In this population, the vulnerable population is estimated to be 5,40,000 of which 1,45,271 have been screened from July 25 during the hundred-day campaign. 91,687 x-ray have been done of which 954 have been found to be abnormal out of the 91,687 cases for which x-ray was done, 47,964 (52%) asymptomatic total Truenat tests done during 2026 are 11,691. During year 2026 out of the 34.7,00,000 population, 37,102 chest x-rays and 26,440 NAT tests have been performed showing a total of 62,749. Out of the 68,749 test the vulnerable population tests are 48,780. Positivity among the vulnerable population and the general population have to be separately calculated.
- The District TB Officer has established good interaction with the private sector — regular WhatsApp/email communication, and 360 private doctors have been granted NIKSHAY access for data entry.
- TB Preventive Treatment (TPT) is progressing well: of 291 registered TB cases, 985 contacts were given TPT, with 10 confirmed cases identified among contacts.
- Screening of vulnerable populations needs improvement — beneficiaries such as HIV patients have not been adequately covered.

Recommendations

- Strengthen outpatient TB screening to close the gap against the 2% target.
- Extend structured TB screening to vulnerable populations, particularly PLHIV, in coordination with ART Centres and ICTCs.
- Continue and formalise the private-sector NIKSHAY engagement model as a good practice for replication in other districts.
- The TB case records showed that the date of onset of symptoms, health care facilities visited by the patient etc. are not being recorded. There is need to record these properly so that any delay in seeking treatment can be measured and investigated.



Oversight Committee team in discussion with the District TB Team, Kanchipuram, 19 August 2026

3.3 General TB-Related Observations (Chennai / Kancheepuram)

- CSR funding support for various capital expenditure requirements was observed.
- A considerable number of private health facilities are covered under the Clinical Establishment Act and are reporting on NIKSHAY.

- Sufficient Truenat chips are available and have been provided to private medical colleges for upfront NAAT screening.
- 85 of 135 supplied Handheld X-ray machines are currently non-functional.
- 10-Symptom (10S) IEC material is not available at several sites, including GHTM Tambaram and the DTO Centre, Kanchipuram (4S IEC material seen). It was seen in Otteri DRTB center though.
- NPY payments to contractual staff have been pending since January 2026 due to a shortfall of funds from State NHM; remuneration up to July 2026 has since been paid.
- Many TB treatment facilities in selected medical college hospitals in the state were inspected by the central team in 2023 for Airborne Infection Control Prevention activities under C19 RM and report was submitted identifying the actions to be taken up at different levels. Current assessment should be conducted in all these facilities to find out the status of implementation.
- The State TB Officer should formulate SOPs for preventive activities to be undertaken by DR-TB centres and all TB-treating health facilities, including periodic staff health monitoring.

3.4 GTHTM Chennai:

- The overall activities at the center are going on very well and need to be complimented. There is good leadership. The staff are very committed.
- Healthcare-worker TB surveillance is limited — staff have been screened only once in last many years (50 staff screened, no TB positives detected).
- The Hospital Infection Control Committee is barely functional and regular quarterly meetings not being done.



Oversight Committee team visit to GTHTM, DR-TB Centre, Otteri, 19 August 2026

3.5 Technical Assistance for DBT & Finance (KHPT)

Objective: to establish efficient systems for timely Direct Benefit Transfer (DBT) delivery through technical assistance.

- Technical assistance to state/districts on DBT implementation and scheme management within the NTEP programme.

- Monitoring and analysis of state DBT performance, with feedback shared with the State TB Officer.
- Financial technical assistance covering planning, budgeting and expenditure tracking through PFMS.
- Training and capacity building for state and district staff on DBT processes.
- Operational support for resolving DBT/PFMS system issues and grievances.
- Cross-learning and documentation of best practices across states.

Observations

- Adequate interaction exists between the State TB office and Non-Governmental Principal Recipients (NGPRs), but formal quarterly review meetings with recorded progress are not yet institutionalised.
- Communication with Superintendents of DR-TB facilities is required to hasten civil and other works flagged in AIC assessment reports of FIND/CTD, and to monitor progress of this work.

Recommendations

- Formalize quarterly review meetings between the State TB office and NGPRs, with documented progress tracking.

3.6 Madurai Central Prison — TB Screening Cascade

Team 2 | 18 August 2026 | Static population ~2,100; average 380 admissions/month | Source: SAATHII (Apr 2024–Jun 2026)

Indicator	Value
10-Symptom screening — Target	14,198
10-Symptom screening — Screened	10,785 (76%)
10-Symptom — Presumptive / Tested / Positive (on ATT)	1,500 / 1,507 / 30
HHXR screening — Screened / Presumptive / Tested / Positive (on ATT)	329 / 275 / 330 / 3

Observations

- The prison carries a high, dynamic caseload; a weekly HHXR camp, run by a single (non-dedicated) radiographer, cannot keep pace with inmate turnover.
- Many undertrial inmates are produced in court, transferred or released before the next weekly screening round and are consequently missed.
- Between April 2024 and June 2026, HHXR screening — the more sensitive modality — reached only 329 inmates, a small fraction of 10-symptom screening reach (10,785).

Recommendations

- Seek State permission to hire a dedicated radiographer for Madurai Central Prison, with mobility/travel cost support for flexible camp scheduling.

- Increase HHXR screening frequency beyond the current weekly camp — ideally screening all new admissions at intake — so fast-moving undertrial inmates are not missed.
- Track and report screening coverage separately for undertrial inmates given their high turnover.
- Close the gap between the 10-symptom screening target and achievement through intensified screening drives, particularly at admission and court-production points.
- Scale up HHXR throughput to bring case-finding closer to parity with 10-symptom screening.

3.7 Dindigul — NTEP (TB Programme)

Team 2 | 19 August 2026 | Govt. Medical College Dindigul | Annual trend 2023–2026 (Jan–Jun)

Year	Target	Notified	% Achieved	Tx. Success	Death Rate	DR-TB Notified
2023	3,750	2,762	74%	91%	4.0%	–
2024	3,338	2,531	76%	91%	4.0%	–
2025	3,220	2,558	79%	92%	4.4%	3.7%
2026 (Jan–Jun)	1,500	1,288	86%	96%	2.0%	3.8%

Observations

- NAAT/CBNAAT coverage stands at 12 of 14 blocks (86%); the remaining blocks rely on referral linkages for molecular testing.
- Laboratory turnaround for FL-LPA (25 days) and especially SL-LPA (48 days) is long, delaying second-line treatment decisions for drug-resistant TB.
- Diabetes co-prevalence among notified TB patients has risen from 18% (2023) to 22% (2026 Q1–Q2), warranting closer TB-DM co-management.
- TPT initiation trails eligibility among household contacts, particularly under-5 contacts (46%, 31 of 67 eligible) versus over-5 contacts (60%, 922 of 1,544); private-sector TPT uptake is also limited due to resistance concerns among practitioners.
- Treatment success has improved year-on-year to 96% in H1 2026; mortality fell from 4.4% (2025) to 2.0% (H1 2026); nearly 100% of notified patients have a known HIV and diabetes status.
- Weekly handheld X-ray screening at the ART Centre and regular TB-HIV coordination meetings are established good practices.

Recommendations

- Engage private-sector practitioners through structured sensitization on TPT safety and resistance evidence to close the private-sector TPT gap.

- Expand NAAT/CBNAAT coverage to the remaining uncovered blocks to reduce testing turnaround and referral burden.
- Address FL-LPA and SL-LPA turnaround times through capacity strengthening and sample-referral/logistics optimization.
- Intensify TPT initiation among household contacts, especially under-5 contacts, through active contact tracing and follow-up.
- Strengthen TB-DM co-management given rising diabetes co-prevalence, including referral pathways to NCD services.
- Continue and formalize TB-HIV coordination meetings to monitor bi-directional screening, TPT completion and referral outcomes.
- Address NAAT machine, cartridge and trained-manpower shortages, including dedicated staffing so Lab Technicians are not carrying multiple duties.
- Sustain and scale the weekly handheld X-ray screening practice at the ART Centre as a model for other high-risk OPDs.

4. HIV/AIDS Programme — Findings and Recommendations

4.1 Progress of activities in the state regarding the GC7

4.1.1 Facilities' Status:

Global Fund Grant Cycle 7 in Tamil Nadu is being implemented within a broad HIV service and community-system architecture. The state platform includes the following:

Name of facility	No.
Sampoorna Suraksha Kendra	4
Integrated Counselling and Testing Center (ICTC)	314
ART Centers	86 (58 + 28)
Care & Support Centers (Vihaan Supported)	16
Viral Load Labs	7
Prison & Other Close Setting	Prison- 124 OCS- 54
There is an adequate platform for prevention and key-population services. There is a large HIV testing network as well as a strong treatment and retention backbone with community based treatment support.	

4.1.2 Current Status of 95-95-99

Source: TANSACS, as on July 2026

Indicator	India	Tamil Nadu	Interpretation
Estimated People Living with HIV (PLHIV)	25,61,161	1,67,856	
1st 95 — Know their status	87.4%	92.0% (1,54,459)	Strong progress; residual undiagnosed/unknown-status gap remains.
2nd 95 — Alive and on treatment	90.0%	93.1% (1,43,805)	High ART coverage among diagnosed PLHIV; continued retention and linkage are essential.

Indicator	India	Tamil Nadu	Interpretation
3rd 99 — Virally suppressed	>95.0%	95.9% (1,24,772)	Good reported suppression result but below the 99 ambitions; VL testing and clinical follow-up remain important.

3. EMTCT Programme:

Indicators	No.
No. of PW diagnosed HIV Positive	225 (51 New +174 known)
No. of PPW linked with ART Center	225
No. of PW referred to TB/STI/Hep.B & C	4076/300909/316910

4.1.4 Prison and Other Close Setting (OCS) Progress

Indicators	Prisons	Other Close Setting
Total facilities covered in the State under Prison and other closed setting intervention	124	54
Total Inmates	29,846	888
Total inmates tested for HIV	29,561	735
Total inmates found HIV positive (after three confirmatory test)	41	2
Total HIV positive inmates put on ART	41	2

4.1.5 Community System Strengthening (CSS)

Activities	Progress
Status of State Community Resource Group (SGRC)	Constituted; will be conducted during the last week of August
Release EOI for Identification of Community Champions	Yes, for 375 champions

Status of District Community Resource Group	Constituted in all 38 districts
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6. Global Fund other activities progress

Activities	Approved in	Procured / On-board
SSK	2024-2025- 3	14
	2025-2026- 1	
	<u>2026-2027- 10</u>	
	Total 14	
Mobile ICTC(state owned)	16	16
Mobile ICTC(hired)	16	16

7.

7. Saathi has utilized around 70% of the budget allocated to them under GC-7 as NGPR under NACO.

	Budget	Expenditure	% utilization
2024-25	2,94,92,676	2,94,92,676	100%
2025-26	6,73,54,187	4,87,24,040	72%
2026-27 (April-June 26)	1,70,11,321	1,08,96,416	64%
Total	11,38,58,184	8,91,13,132	78.26%

8.

Observations

- Tamil Nadu is ahead of national averages on all three 95s, reflecting a mature epidemic response.
- The Sankalak 7th Edition report flags 19 indicators red for the state, indicating specific areas of the cascade needing closer review.

Recommendations

- Identify and address leaky-cascade points through data cleaning and validation of existing data (e.g., permanent LFU lists).
- Re-emphasize death audits across ART Centres.
- Review existing HIV testing modalities against recommended guidance and protocols (e.g., index testing).
- Develop SOPs for systematic elicitation of partners of key populations living with HIV.
- The Global Fund Data Quality Improvement Framework states that data quality problems are systemic and should be addressed through integrated solutions, including clear indicator definitions, standardized tools, trained human resources, SOPs, digitization, routine validation and integration of data-quality assurance with supervision.

4.2 Capacity Building (SAATHII / Kshamta Kendra)

Reported by SAATHII / Kshamta Kendra, Gandhigram

Programme	Target	Trained (GC6)	Trained (Y1)	Trained (Y2)	Total Trained
TI Core Group	1,111	886	131	298	1,315 (118%)
Link Workers Scheme (LWS)	360	381	49	0*	430 (119%)
SMP / NWO / VI	444	0	0	287	287 (65%)**
TI Bridge Population	145	0	60	0	60 (41%)
Total	2,060	1,267	240	585	2,092 (102%)

Observations

- Training needs of field staff appear broadly aligned with staff capacity, though a formal training-needs assessment is recommended.
- Peer Leaders are yet to be trained.
- Kshamta Kendra, Gandhigram is functioning as an active capacity-building resource centre for HIV and allied community-health interventions, with training infrastructure and curriculum reviewed by the team (key contact: Mr. Shanmugapriyan, Training Coordinator).

Recommendations

- Undertake a formal training-needs assessment aligned to field-staff capacity, and prioritise completion of Peer Leader training.

4.3 GHTM Tambaram — ART Centre & ICTC (HIV)

Team 1 | 18 August 2026 | Chengalpet District

Observations

- Critical staff vacancies: 2 staff nurses, 1 Data Manager and 1 Care Coordinator posts are vacant.
- Cumulative PLHIV registered: 26,903; ever started on ART: 9,525; cumulative deaths: 3,899; alive on ART (Jul 2026): 3,293; only ~100 of those alive on ART are from Chengalpet district, with cases also reported from Andhra Pradesh.
- Good differentiated ART care practices observed — family-centric approaches, colour-coded case categorisation, prioritised-subpopulation support groups, and Community ART Refill Groups.
- Overall Tamil Nadu LFU cases remain a concern per Sankalak 2025 data; urgent, coordinated LFU-tracking and treatment-retention efforts are needed to support national and global fast-track goals.

Recommendations

- Fill critical vacant posts (staff nurse, Data Manager, Care Coordinator) with urgency.
- Review the Permanent LFU list in collaboration with the CSC to verify cases that could be re-contacted, and re-emphasise death audits and documentation.
- ARTC staff, in coordination with SAATHI, should document good-practice differentiated care models as knowledge products/SOPs for replication.
- Explore feasibility of Community ART Refill Groups (CARG) at additional sites in coordination with TANSACS.
- Institutionalise a State/district committee to review LFU-tracking process quality, data quality and documentation.



Oversight Committee team visit to ARTC ,GHTM Tambaram , 18 August 2026

4.4 Treatment Interruption, LFU Tracking & Viral Load Testing as observed in the three sites visited:

Addressing Tx interruption and LFU tracking (SAATHI CSC Progress Report)

District	2024-25 Target/Ach./%	2025-26 Target/Ach./%	Apr–Jun 26 Target/Ach./%
Chennai	932 / 605 / 65%	927 / 580 / 63%	302 / 108 / 60%
Kancheepuram	1,061 / 467 / 44%	702 / 454 / 65%	179 / 156 / 89%

District	2024-25 Target/Ach./%	2025-26 Target/Ach./%	Apr–Jun 26 Target/Ach./%
Madurai	2,760 / 1,981 / 72%	1,259 / 998 / 79%	760 / 708 / 93%

The state - level report shows that LFU outcome tracking improved substantially in the April - June 2026 period for the aggregate dataset, but the district pattern remains uneven. The data indicate that Chennai requires targeted management attention, while Kancheepuram and Madurai provide examples of improvement that can be examined for transferable practices. Viral load testing coverage among eligible/due beneficiaries shows similar gaps across districts, delaying identification of unsuppressed viral load and timely clinical/adherence intervention.

Observations

- A dedicated, due-list mechanism for tracking pending ART initiation was found inconsistent, with linkage to the ART Centre often dependent on individual follow-through after counselling/referral, rather than a structured track-back process.

Recommendations

- Introduce case-based LFU review with documented reason/outcome per case, and monitor track-back outcomes in real time.
- Strengthen counselling and psychosocial support where LFU relates to stigma, treatment fatigue or socioeconomic barriers, and strengthen migration/transfer linkage mechanisms.
- Generate and review VL due/overdue line lists regularly, with SAATHI coordinating with ART Centres for system-generated due lists.
- Integrate VL status checks into every ART visit, and document reasons for non-testing to enable corrective action.
- Maintain a dedicated due list capturing diagnosis date, testing facility, linkage status, ART registration, reasons for pending initiation and follow-up outcomes, and strengthen CSC caseload-management tools by risk category.

4.5 Index Testing — Programme-wide Gaps

Observed across multiple ART Centres and CSCs visited by both teams

Observations

- All steps of Index testing as per the NACO guidelines need to be followed. Documentation of contacts in the client registration form is frequently inadequate — only the family member is often recorded, with no evidence of comprehensive assessment of all eligible contacts/partners.
- The contact elicitation process is not consistently followed or recorded; where information is incomplete, follow-up/re-interview is often not conducted.
- Required client-facing Index Testing information materials are not displayed at service delivery sites.

- The Index Testing cascade is not recorded systematically, with no clear documentation from identification through contact elicitation, notification, testing and outcomes.
- Contact elicitation is generally restricted to spouse or biological children, with other eligible contacts not systematically explored.
- HIV-negative contacts are not systematically offered or referred for HIV prevention services.

Recommendations

- Ensure contact elicitation is conducted systematically and documented using prescribed Index Testing tools/registers, maintaining confidentiality.
- Conduct documented contact elicitation for all eligible index clients, with follow-up/re-interview where information is incomplete.
- Display approved, confidentiality-sensitive client information materials at service delivery points.
- Maintain the Index Testing cascade routinely, with supervisory review and data-quality checks.
- Conduct comprehensive contact elicitation based on client circumstances and programme definitions, with routine supervisory record review.
- Document and follow the client's preferred notification method; make provider-assisted notification available where indicated.
- Conduct structured refresher training and on-site mentorship on Index Testing SOPs, notification, confidentiality, IPV screening and documentation.
- Incorporate IPV risk screening into the Index Testing process, and establish a formal, documented IPV referral pathway.
- Ensure HIV-negative contacts receive prevention counselling and are assessed for appropriate services, with referrals documented.

Additionally, of 375 Community Champions (CCs) engaged, only 127 are currently active, of whom 97 have been trained; further feedback collection is awaiting NACO portal access.

EMTCT/PPTCT and HIV-Exposed Infant Follow-Up:

Indicator	Chennai	Kancheepuram	Madurai	Interpretation
PPW due for VL at 32–36 weeks Apr–Jun 2026	62.5% (5/8)	100% (2/2)	88.9% (8/9)	Chennai requires immediate attention; small denominators should be interpreted cautiously.

HIV-exposed infant testing Apr–Jun 2026	86.1% (31/36)	83.3% (5/6)	97.6% (41/42)	Madurai strong; Chennai/Kancheepuram require targeted follow-up.
PPW VL 2025–26	93.3% Chennai; 71.4% Kancheepuram; 96.2% Madurai	See district figures	See district figures	Kancheepuram requires historical root-cause review.

- Track every PPW due for 32–36-week VL until result is documented.
- Review missed EID cases in monthly district meetings and document reasons.
- Ensure data fields distinguish not due, not tested, result pending and missing record.

Partner, Sexual-Partner and Biological-Child Testing:

District	2025–26 spouse testing	2025–26 sexual-partner testing	2025–26 biological-child testing	Priority
Chennai	94.7%	95.3%	100%	Maintain.
Kancheepuram	95.4%	95.3%	100%	Current-period biological-child testing fell to 33.3% (1/3); investigate.
Madurai	99.6%	99.6%	100%	Strong performance.

4.6 Tamil Nadu SACS Snapshot — Madurai/Dindigul Facility Network

District-level 95:95:99 (latest available): Madurai — 92% / 92% / 95%; Dindigul — 93% / 90% / 96%. EMTCT: 225 pregnant women diagnosed HIV-positive (51 new + 174 known), all 225 linked to ART Centres.

4.7 Prison and Other Close Settings :

State level, reports mention 88,056 inmates in April 2024–March 2025, 80,339 in April 2025–March 2026 and 22,888 in April–June 2026. HIV testing was reported for 84,759, 78,702 and 21,541 respectively.

District	2024–25 testing	2025–26 testing	Apr–Jun 2026 testing	Treatment linkage evidence
Chennai	1,305/1,350	1,132/1,132	205/205	9/9 HIV-positive on ART; 5/5 in 2025–26.
Kancheepuram	843/843	679/679	184/184	No positive cases reported in the periods.
Madurai	4,302/5,284	6,106/6,161	1,736/1,736	6/6 and 4/4 in earlier periods; current 2/2 linked.

Oversight recommendations

- Maintain high testing coverage but verify continuity after transfer or release.
- Ensure positive cases have documented confirmatory testing and ART linkage.
- Use a transfer/release referral mechanism connecting prison/OCS services with ART and community systems.
- Reconcile district and state denominators where facilities are added, removed or reporting periods differ.

Observations in Madurai Central Prison

- Daily HIV screening is conducted, linked to the prison ICTC, with IEC/IPC materials on display; HIV-TB coordination is well established.
- Positive Peer Volunteer (PPV) interventions have not been initiated at Madurai Prison; can be introduced.
- The Link ART Centre serving the prison lacks visibility of the complete treatment cascade — VL reports are shared only by phone, and no PLHIV tracking sheet is maintained at the prison.
- Syphilis test kits are available and linkage to treatment is technically possible, but no escort service exists to take inmates for treatment/hospital referral.

- Hepatitis B/C testing is ensured, though irregular supply/shortage of test kits has been observed at times; there is no regular nodal ART Centre follow-up visit, largely due to lack of escort services.
- IEC materials on HIV are not adequately displayed and inmate awareness remains low; a lady doctor is available and could be trained in basic HIV/STI/TB service delivery, but a dedicated Medical Officer is still required.
- White cards have not been issued for about 20 eligible under-trial inmates.

Recommendations

- Advocate with NACO for SOCH viewing rights for the Link ART Centre to access PLHIV viral load data directly.
- Maintain a PLHIV tracking sheet at the prison/LAC, and institute at least weekly cascade-data review by the nodal ART Centre.
- Ensure all inmates are screened for Hepatitis B/C with a regular, adequate test-kit supply, and strengthen escort services for off-site referral (syphilis, Hepatitis B/C, etc.).
- Ensure the nodal ART Centre conducts at least one follow-up visit to the prison every month.
- Prominently display IEC materials and strengthen inmate awareness sessions; train the available lady doctor in basic HIV/STI/TB service delivery and position a dedicated Medical Officer.
- Issue white cards to eligible under-trial inmates without delay.



Oversight Committee team with prison and DAPCU officials, Madurai Central Prison, 18 August 2026



Oversight Committee team with prison and DAPCU officials, Kanchipuram Sub-jail, 19 August 2026

4.8 CSC (Bro Siga Social Service Guild) — Madurai

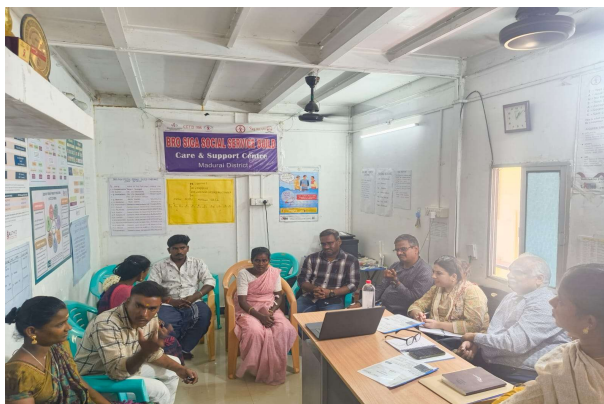
Team 2 | 18 August 2026 | SR: SAATHII

Observations

- Coordinated case management, ART adherence support and psychosocial support are delivered through Community Linkage Hubs (CLH) linked to the ART Centre/ICTC network.
- LFU tracking improved from 72% (FY 2024–25) to 93% (Q1 FY 2026–27); VL-overdue follow-up improved from 79% to 90–97% over the same period; index testing consistently achieves 96–100% against target.
- Multiple pregnancies were observed among PLHIV attending the centre; treatment literacy is limited, and CLH staff are not consistently aware of clients' current viral load status.
- Data capturing on client follow-up is not being done consistently by CSC/CLH staff, though CSC staffing is at full strength with completed capacity building.
- Retention cohort analysis for newly initiated ART clients found only ~85% retention, notably lower than the strong tracking/testing performance otherwise observed.

Recommendations

- Given the ~85% retention finding for newly initiated clients, intensify adherence counselling with a sustained focus on clients in their first months on ART.
- Strengthen family planning counselling to address multiple-pregnancy observations, and strengthen treatment literacy so clients can monitor their own VL/CD4 status.
- Maintain a PLHIV tracking sheet at CSC/CLH level, regularly update CLH staff on clients' viral load status, and strengthen data-capturing practices with periodic monitoring.
- Ensure EID testing for all eligible infants at 32–36 weeks, targeting 100% coverage.
- Have CLH staff conduct 10-symptom TB screening during every client visit, with linkage of presumptive/symptomatic clients to TB services.
- Undertake more detailed outcome analysis at CSC/CLH level, with specific focus on virally unsuppressed clients, using the CSC app for closer monitoring.



Oversight Committee team in discussion with CSC (BSSSG) staff and PLHIV community members, Madurai, 18 August 2026

4.9 One Stop Centre (TG) — Madurai

Team 2 | OSC 2.0 | Direct implementation by PLAN India (PR) | 18 August 2026

The PLAN India OSC 2.0 does direct implementation for transgender persons, people who inject drugs and bridge populations such as transportation workers and allied populations. The stated objectives are to identify new and uncovered key/bridge populations, provide integrated health and non-health services, and create an enabling environment that reduces stigma and discrimination.

The prevention package includes awareness/counselling, STI and syphilis screening, TB screening, HIV testing, ART linkage, care/support counselling, condom/lubricant distribution, needle/syringe and OST-related services, partner testing and related services. The minimum package is defined as at least three services for TG/PWID clients and at least two for bridge-population clients.

OSC performance period	HIV screening	Prevention package	Reported outcome
Apr 2024 - Mar 2025	726/667 = 109%	876/667 = 131%	Both targets exceeded; 2 HIV-positive linked to ART.
Apr 2025 - Mar 2026	987/930 = 106%	1042/1110 = 94%	Testing exceeded target; prevention package below target.
Apr–Jul 2026	283/308 = 92%	322/308 = 105%	Testing below target; package exceeded target.

The presented report suggests cumulative unique registration of 550 through July 2026, 535 cumulative HIV-tested unique clients, 8 reactive results, 8 confirmatory tests, 7 newly HIV-positive clients and 7 ART initiations. HIV Testing yield extremely low, may need to review the testing modality and approach.

Madurai OSC service profile:

Service	Unique clients, Apr 2024–Jul 2026
Lubricants	548
IEC	545
BCC	544
Beauty management	514
Condoms	483
Blood pressure	429
STI check-up/syndromic management	333
Prevention/risk-reduction counselling	316
Welfare scheme linkage/referral	159
Blood sugar	158
Self-care counselling	110
Mental-health counselling	43
TG card linkage/referral	27
ART adherence	23
Care/support counselling for PLHIV	15
ART linkage	8
Livelihood linkage/referral	10
Legal aid/support	1

These figures show a strong reach and prevention platform. They also suggest a management question: the volume of prevention/commodity services is much greater than the number of documented downstream clinical and enabling-service referrals. This does not by itself prove a

service gap because clients may not require every service; however, the program should verify whether referral needs are systematically assessed and closed.

Equity, Key Populations and People-Centred Services:

The OSC 2.0 model is closely aligned with the Global Fund's equity and people-centred orientation because it combines HIV prevention/testing with psychosocial, legal, social-protection, livelihood and gender-affirming referrals. The programme targets populations that may face stigma, discrimination and barriers to conventional health services.

The strategic opportunity is to move from counting service contacts to measuring whether barriers are actually reduced. The programme should therefore add outcome-oriented measures such as: referral completion, time to ART after confirmation, retention, client-reported experience, successful social-protection linkage and community-generated quality issues.

Observations

- Established January 2023 as an anchor centre for the transgender (TG) community with linkages to ICTC, ART Centre, OST Centre, DSRC, TB Division, private hospitals and social welfare schemes.
- Since inception (to July 2026): 550 unique registrations, 535 tested, 8 HIV reactive, 8 confirmatory tests done, 7 newly HIV positive — all 7 initiated on ART (100% linkage).
- Screening and prevention-package coverage have consistently met or exceeded annual targets across FY 2024–25 and FY 2025–26.
- TG community representatives noted delay in the full rollout of the OSC 2.0 service model at the site.
- Good practices noted: TB screening camps using handheld X-ray in coordination with DAPCU/TB department, ABHA card generation, and PLHIV nutrition support in coordination with CBOs.

Recommendations

- Expedite full transition to the OSC 2.0 service model to address the implementation delays noted at the site.
- Sustain strong screening and prevention-package coverage through continued outreach into FY 2026–27.
- Continue linking all newly diagnosed TG clients to ART (100% since inception) and consider replicating this practice at other OSC sites.
- Institutionalize regular monitoring of OSC functionality, incorporating community/TG representative feedback into service design.

- Continue and scale good practices — HHXR TB screening camps, ABHA card generation and PLHIV nutrition support.

4.10 Dindigul ART Centre / ICTC-SSK — HIV Programme Snapshot

Team 2 | Govt. Medical College Dindigul | Cumulative & FY-wise data as on 17–18 August 2026

Year	New Reg.	ART Initiated	LFU	Deaths	Alive on ART	VL Suppression
FY 2024–25	177	174	4	13	157	93.6%
FY 2025–26	173	168	8	8	152	94.3%
Apr–Jul 2026	72	69	0	1	68	95.4%

Cumulative as on 17-08-2026: 8,991 total registrations | 4,579 alive on ART | 132 LFU | 3,774 cumulative deaths (896 pre-ART + 2,878 on-ART). Q1 FY26-27 scorecard: 98.9% retention, 97.1% VL suppression, 76% TPT completion.

Observations

- Cumulative mortality is substantial against total registrations, warranting a root-cause review; TPT completion (76%) trails eligibility (94%).
- Marital status is not being captured/displayed in SOCH, though other case-record fields are otherwise in order; the SSK model's operational concept, sustainability planning and enlarged testing scope remain open issues.
- No shortage of medicines, testing kits or staff was reported; ART, ICTC and SSK are co-located, supporting integrated service delivery.
- Retention is strong — cumulative LFU is low (132 of 8,991) and VL suppression has improved steadily to 95.4% (Apr–Jul 2026); opted-out cases have fallen sharply from 1,066 (Mar-26) to 447 (18-08-26).
- As a good practice the CSC runs support-group meetings for VL-unsuppressed clients, enhanced adherence counselling, and nutrition/local support for bed-ridden patients.

Recommendations

- Conduct a root-cause review of pre-ART and on-ART mortality to identify avoidable death drivers.
- Institutionalise LFU/opted-out data reconciliation and verify the declining opted-out trend reflects genuine tracing rather than reporting adjustment alone.
- Ensure the marital status field is consistently captured in SOCH.
- Document and scale the CSC-led support-group and enhanced adherence counselling model as good practice.
- Strengthen TPT completion monitoring through periodic cohort tracking, and clarify/disseminate a clear SOP for the SSK model.

- Develop a structured sustainability and transition plan for SSK integration into routine district HIV services, and rationalise SSK testing targets against realistic yield.



Oversight Committee team with facility staff outside the Dindigul ART Centre, 19 August 2026

4.11 Kshamta Kendra, Gandhigram — Capacity Building

Team 2 | 19 August 2026 | SR: SAATHII |

Kshamta Kendra is a capacity-building and training resource centre supporting NGO and programme staff working on HIV and allied community health interventions in the district. The team reviewed the training infrastructure and curriculum used to build the capacity of outreach workers, peer volunteers and facility staff and was satisfied with the overall capacity building provided at the Kshamta Kendra to NACP TI and LWS staff. NACO and SACS need to institutionalize the capacity building mechanism beyond Global Fund period



Orientation training for Peer Workers under Scheme 2.0, Kshamta Kendra, Gandhigram, 17–19 August 2026

4.12 ART Plus Centre & Viral Load Lab — Govt. Rajaji Hospital, Madurai

Team 2 | 20 August 2026 | PR: NACO | Data as on 31 July 2026

Indicator	Cumulative	Apr–Jul '26
ART registrations	22,790	82
ART initiations	14,243	81
Alive on ART	4,850	4,850
VL testing (since 2019)	27,884	3,403
VL unsuppressed	418	184
Cumulative deaths	4,545	138
Index testing	3,181	688

Observations

- Strong ART Centre–CSC coordination supports continuity of care, adherence follow-up and psychosocial support for PLHIV and families; ART–TB bi-directional screening and referral linkages are functioning well.
- The hospital undertakes structured death audits for PLHIV mortality, supporting root-cause review; the ART Plus Centre operates 7 days a week — a longstanding good practice improving access and continuity.
- SOCH is not fully updated at the ART Plus Centre, delaying VL report visibility for referring ART centres — the same SOCH/VL-reporting gap flagged at Madurai Central Prison and Dindigul ART Centre, pointing to a recurring, cross-facility data-integration issue.
- Lab quality is a strength: no shortage of VL/CD4 reagents or consumables, and EQA participation for both VL and CD4 testing has been regular and concordant.
- Cumulative VL-unsuppressed rate is low (~1.5%), but the Apr–Jul 2026 period rate is notably higher (~5.4%) — worth tracking as a possible cohort or reporting-period effect.
- Of 135 HIV-TB co-infected cases notified in Madurai district in 2025, treatment success stands at 82% (111/135). Airborne Infection Control infrastructure (GUV fixtures, ACH monitoring, exhaust/ceiling fans) is now in place with FIND support.

Recommendations

- Institute an SOP requiring ART centres to complete the SOCH sample-referral entry at the time of sample collection/dispatch.
- Introduce weekly reconciliation between the lab's sample-testing log and ART centres' SOCH referral entries.
- Continue and formally document the lab's regular EQA participation as good practice; sustain current reagent/consumable supply planning.
- Review the Apr–Jul 2026 cohort with referring ART centres given the higher period VL-unsuppressed rate, and strengthen linkage of unsuppressed clients to Enhanced Adherence Counselling.

- Complete SOCH data entry at the ART Plus Centre given its criticality for VL/CD4 report visibility across referring facilities.
- Institutionalise and document the centre's existing good practices — ART–CSC coordination, ART–TB coordination, death audits and the 7-day service model — as a replicable model for other ART centres.
- Given cumulative mortality recorded, continue and strengthen the death-audit process to identify avoidable drivers.
- Sustain strong PEP, legal-aid and government/entitlement scheme linkage volumes through continued dedicated staffing.



Oversight Committee team in discussion with ART Plus Centre / CSC staff and PLHIV community members, Govt. Rajaji Hospital, Madurai, 20 August 2026

4.13 ART center at Madras Medical College;

The general activities of the center were seen to be excellent under the leadership of Dr. Shekhar. 3007 HIV cases are on hand with LFU of 124 cases. Drop-in center is being implemented by the state health department. DCRG has been constituted. One meeting has been held under the chairmanship of DC. District Legal aid clinic and a Transgender clinic are functional.

The CSC run by SAATHI was also seen to be doing very good work. The CSC has employed 10 staff. About 7000 HIV cases have been under care since inception. 300 new cases have been registered in the year 2025-26. Of them 40 have been given social benefit support. 177 LFU cases have been followed up by the NGO partner. Of them 17 cases have been brought back. 15 have died. 5 are duplicate. 5 are taking private treatment. 60 are untraceable. 2 are transferred to other CSC.

More trainings of the CLH are required.

4.14 Community System Strengthening and CLM:

Community-system indicator	Reported status	Oversight interpretation
State CRG meeting	1 meeting; balance of typology members available	Structural mechanism established.
District CRGs	38/38 formed; notification submitted for 37/38	Reconcile reporting inconsistency before next report.
Community Champions trained on CLM	97/127	Capacity-building underway.
Districts with CLM rolled out	0/38	Major implementation gap.
Strengthening of SLNs for key populations	1 progress	Continue documentation of outcome and use.

The Global Fund KPI framework considers community systems across policy, strategy, capacity and data integration. It also recognizes that community-provider data should feed health information systems.

The current evidence suggests that Tamil Nadu has established important community structures but has not yet translated them into operational CLM. This is the most significant gap in the community-system component.

CLM operationalization roadmap

Phase	Activity	Output	Suggested timeline
1	Finalize district CLM plan and tools	38 district implementation plans	30 days
2	Train/retrain community monitors	Functional district teams	45 days
3	Conduct baseline community monitoring	Service-access and quality findings	60 days
4	Triangulate with SACS/NGPR data	Validated priority issues	75 days

5	Closure of issues and dissemination	Documented response and closure	90 days
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5 Debrief Meeting and Sharing of Findings

- The team appreciates the overall administrative and technical guidance provided by TANSACS and the State TB Division.
- Human resource management, capacity building, procurement of commodities, supply chain and coordination with implementing partners are streamlined and working smoothly.
- A strong health system with highly committed staff was observed at ART Centres, ICTCs, DR-TB Centres and VL Labs, with good inter-departmental and institutional coordination.
- Good TB-HIV coordination was observed, with regular joint meetings and exchange of data between the two programmes.
- Local resources are being effectively leveraged for community services, including CSR support and nutritional assistance through CSCs.
- Good coordination between ART, ICTC and ART co-location was observed at most facilities, helping to prevent linkage losses.

5.1 Overall Reflection of the Oversight Committee

At the conclusion of the field visit, the Oversight Committee held a debrief meeting on 21 August 2026 in Chennai to share preliminary findings and observations from both field teams with State officials and implementing partners.

- The debrief was attended by the Project Director, TANSACS (PD SACS), the State TB Officer (STO) and other TANSACS/State TB Division officials.
- Representatives of Global Fund Non-Governmental Programme Recipients (NGO PRs) — including KHPT, SAATHII and PLAN India — participated in the debrief and discussion of findings.
- Key observations on HIV and TB programme performance, good practices identified, and preliminary recommendations were presented to State officials and implementing partners for validation and follow-up.
- Feedback and clarifications provided by State officials and NGO PR representatives on selected findings have been incorporated into the observations and recommendations presented in this report.



Oversight Committee team debriefing with TANSACS and State TB Division and NGPRS, 21 August 2026

6. Acknowledgement

The Oversight Committee places on record its appreciation for the cooperation, transparency and hospitality extended by TANSACS, the State TB Division, District officials, implementing partners (KHPT, SAATHI, PLAN India), facility staff and PLHIV/TG community representatives across all sites visited during this field visit.