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Department of AIDS Control

Ministry of Health & Family Welfare

Annual Report

2011-12

Department of AIDS Control
National AIDS Control Organisation
Ministry of Health & Family Welfare
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ACRONYMS

AEP	Adolescence Education Programme
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Clinic
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral therapy
ASHA	Accredited Social Health Activist
BCC	Behaviour Change Communication
BCSU	Blood Component Separation Units
BFPNI	Breast Feeding Promotion Network of India
BMGF	Bill & Melinda Gates Foundation
BSC	Blood Storage Centre
BSS	Behaviour Surveillance Survey
CBO	Community- Based Organisation
CCC	Community Care Centre
CD4	Cluster of Differentiation 4
CDC	Centers for Disease Control and Prevention
CHC	Community Health Centre
CLHIV	Children Living with HIV
CMIS	Computerised Management Information System
CoE	Centre of Excellence
CPFMS	Computerised Project Financial Management System
CPGRAMS	Computerised Public Grievance Redress & Monitoring System
CSMP	Condom Social Marketing Programme
CST	Care, Support and Treatment
CVM	Condom Vending Machine
DAPCU	District AIDS Prevention & Control Unit
DCGI	Drugs Controller General of India
DFID	Department for International Development, UK
DHR	Department of Health Research
DIC	Drop In Centres
DTC	Delhi Transport Corporation
DWCD	Department of Women & Child Development
EID	Early Infant Diagnosis
EQAS	External Quality Assessment Scheme

ESCM	Enhanced Syndromic Case Management
FC	Female Condom
FHI	Family Health International
FICTC	Facility Integrated Counseling & Testing Centre
FPA	Forum of Parliamentarians on HIV & AIDS
FRU	First Referral Unit
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People with HIV/AIDS
GIS	Geographic Information System
HIV/TB	Human Immunodeficiency Virus/ Tuberculosis
HMIS	Health Management Information System
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
IAP	Indian Academy of Pediatrics
IAVI	International AIDS Vaccine Initiative
IBBS	Integrated Biological and Behavioural Surveillance
ICF	Intensified TB Case Finding
ICMR	Indian Council of Medical Research
ICRW	International Centre for Research on Women
ICTC	Integrated Counseling and Testing Centre
IDU	Injecting Drug User
IEC	Information, Education and Communication
IHBAS	Institute of Human Behaviour & Allied Sciences
IL&FS	Infrastructure Leasing & Financial Services Limited
INC	Indian Nursing Council
IRDA	Insurance Regulatory Development Authority
JAT	Joint Appraisal Team
KHPT	Karnataka Health Promotion Trust
LAC	Link ART Centre
LFU	Lost to Follow-up cases
LWS	Link Worker Scheme
M & E	Monitoring & Evaluation
MARP	Most at Risk Population
MCD	Municipal Corporation of Delhi
MoHFW	Ministry of Health and Family Welfare

MoU	Memorandum of Understanding
MSM	Men who have Sex with Men
NABH	National Accreditation Board of Hospitals & Healthcare Providers
NABL	National Accreditation Board for Laboratories
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NARI	National AIDS Research Institute
NBTA	National Blood Transfusion Authority
NDMC	New Delhi Municipal Corporation
NEQAS	National External Quality Assessment Scheme
NERO	North Eastern Regional Office
NGO	Non-Government Organisation
NRHM	National Rural Health Mission
NRL	National Referral Centre
NTSU	National Technical Support Unit
NYKS	Nehru Yuva Kendra Sangathan
OI	Opportunistic Infections
ORT	Oral Substitution Therapy
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Centre
PLHIV	People Living with HIV
PPP	Public Private Partnership
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institution
RBTC	Regional Blood Transfusion Centre
RCH	Reproductive Child Health
RFD	Result Framework Document
RI	Regional Institute
RNTCP	Revised National Tuberculosis Control Programme
RRC	Red Ribbon Club
RRE	Red Ribbon Express
RSBY	Rashtriya Swasthya Bima Yojna
RTI	Reproductive Tract Infection
SAARC	South Asian Association for Regional Cooperation
SACS	State AIDS Control Society

SBTC	State Blood Transfusion Council
SIMS	Strategic Information Management System
SIMU	Strategic Information Management Unit
SMO	Social Marketing Organisation
SRL	State Reference Laboratory
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STRC	State Training & Resource Centre
TAC	Technical Advisory Committee
TB	Tuberculosis
TG	Transgender
THP	Truckers' Halting Point
TI	Targeted Interventions
TRG	Technical Resource Group
TSG	Technical Support Group
TSU	Technical Support Unit
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UT	Union Territory
VBD	Voluntary Blood Donation
VCTC	Voluntary Counseling and Testing Centre
WG	Working Group
WHO	World Health Organisation

OVERVIEW

The first National AIDS Control Programme (NACP) was launched in 1992 for prevention and control of HIV/AIDS in India. This was followed by NACP II in 1999 and NACP III in 2007. During different phases of the programme, the focus shifted from raising HIV/AIDS awareness to behaviour change, from a national response to a more decentralised response and to increasing involvement of NGOs and networks of people living with HIV/AIDS (PLHIV). Based on the lessons from NACP I and II, the government designed and implemented NACP III.

NACP Phase-III (2007-2012) has the overall goal of halting and reversing the epidemic in India. This phase has, therefore, placed the highest priority on preventive efforts by integrating prevention with care, support and treatment through a four-pronged strategy:

1. Preventing new infections in high risk groups and general population through saturation of coverage of high risk groups with targeted interventions and scaled up interventions in the general population,
2. Providing greater care, support and treatment to larger number of PLHIV,
3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national levels, and
4. Strengthening the nationwide Strategic Information Management System.

The HIV surveillance highlights an overall reduction in adult HIV prevalence. The analysis of epidemic projections has revealed that the estimated annual HIV incidence (new infections) has declined by about 56 percent over the last decade (2000-2009). Wider access to ART has resulted in decline of the number of people dying due to AIDS-related causes. This is one of the most important evidences of the impact of various interventions and scaled-up prevention strategies under the National AIDS Control Programme (NACP).

While declining HIV trends are evident at national level as well as in most of the States, some low prevalence and vulnerable states have shown rising trends in HIV epidemic, warranting focused prevention efforts in these States. HIV prevalence is showing declining trends among Female Sex Workers both at national level and in most of the states. However, other High Risk Groups such as 'Men who have Sex with Men', 'Injecting Drug Users' and Bridge Population such as 'Single Male Migrants' are emerging as important risk groups in many states.

Key Achievements during 2011-12

Targeted Interventions for High Risk Behaviour Group: Targeted Interventions main objective is to improve health seeking behavior of high risk behavior groups and reducing their vulnerability and risk to acquire STIs and HIV infections. TI provides services such as behaviour change communication, condom promotion and safe needle and syringe for people who inject drugs, STI care, referrals for HIV and Syphilis testing and Anti-Retroviral Treatment.

Targeted Interventions are implemented through non-government organisations and community-based organizations. Currently, there are 1,785 TIs providing prevention services covering 81 percent Female Sex Workers, 80 percent Injecting Drug Users, 64 percent Men having sex with Men, 40 percent Migrants and 57 percent Truckers. A revised migrant strategy was launched to provide HIV prevention services to migrants in source districts and transit districts, besides TI projects implemented in destination districts. Other initiatives include contracting 62 Opioid Substitution Therapy (OST) centres after accreditation by the National Accreditation Board of Laboratories (NABL) and piloting OST provision in public health care settings in Punjab.

Link Workers Scheme: This community-based intervention addresses HIV prevention and care needs of the high risk and vulnerable groups in rural areas by providing information on HIV, condom promotion and distribution and referrals to counseling, testing and STI services through Link workers. The scheme has been expanded to cover 209 districts across 20 states during 2011-12 in partnership with various Development Partners.

Blood Safety: Access to safe blood has been ensured through a network of around 1,149 NACO supported Blood Banks including 171 Blood Component Separation Units and 28 Model Blood Banks. During 2011-12, 72.7 lakh blood units were collected till January 2012, of which 83.1 percent was through voluntary donation in NACO-supported blood banks. Other initiatives include setting up of four Metro Blood Banks as Centres of Excellence in Transfusion Medicine, and one Plasma Fractionation Centre with processing capacity of more than 1, 50,000 litres of plasma.

Management of Sexually Transmitted nfections: The Sexually Transmitted Infections (STI)/ Reproductive Tract Infection (RTI) services based on the Syndromic Case Management are being provided through 1,112 designated STI/RTI clinics, including 79 new clinics established during 2011-12. Around 3,942 private preferred providers were identified for providing STI services to high risk behaviour groups. Overall, 74.57 lakh STI episodes were treated during 2011-12 (till December 2011). Seven regional STI training, reference and research centres have been strengthened. NACO has branded the STI/RTI service centres as "Suraksha Clinics" and has developed a communication strategy for generating demand for these services. Preferred Private Provider approach has been rolled out to scale up STI/RTI services to HRG population under TI Projects.

Information, Education & Communication: The focus of IEC activities is on promoting safe behaviours, reduction of HIV stigma and discrimination, on demand generation for HIV/AIDS services and condom promotion. As a follow-up to encouraging evaluation results emerging from the second phase of Red Ribbon Express project of 2009-10, the third phase of the project has been launched on 12 January 2012.

Mainstreaming: As a part of the initiative to mainstream HIV/AIDS response over 5.61 lakh frontline workers and personnel from various Government departments, Civil Society Organisations and corporate sector were trained. Initiatives are being taken for strengthening convergence of NACP with National Rural Health Mission (NRHM). NACO supported the Forum of Parliamentarians on HIV/AIDS, in organising a National Convention of Parliamentarians, Legislators, Zila Parishad Chairpersons and Mayors on HIV & AIDS in July 2011.

Condom Promotion: NACO launched the fourth phase of the Condom Social Marketing Programme in July 2011 in 13 States/UTs through 7 Social Marketing Organizations (SMO). SMO distributed 21.9 crore pieces of condoms till December 2011. Special focus was given to establish rural outlets, non-traditional outlets, outlets in TI project areas and at truck halt-points. NACO dispatched 32 crore free condoms to SACS till December 2011.

Other initiatives include implementation of Female Condom scale-up Programme and condom promotion extensively through enhanced mid-media contacts.

HIV Counseling and Testing Services: The ICTC programme offering Counseling and Testing services for HIV includes three main components – Integrated Counseling and Testing Centres (ICTC), Prevention of Parent to Child Transmission (PPTCT) and HIV-TB collaborative activities. The ICTC services are provided through 4,486 stand-alone ICTCs, 4,071 Facility integrated Counseling and Testing Centres at 24x7 PHCs and 902 ICTCs under Public Private Partnership model. During 2011-12, 161.39 lakh clients including 70.87 lakh pregnant women were counseled and tested till January 2012. Out of 13,213 pregnant women who tested HIV positive, 11,074 mother-baby pairs were provided Nevirapine prophylaxis to prevent the mother to child transmission of HIV. Under the HIV-TB coordination programme, during January to December 2011, around 12 lakh cross-referrals were made between NACP and Revised National Tuberculosis Control Programme (RNTCP), and 44,686 patients with HIV-TB co-infection were identified at ICTC and linked to care, support and treatment.

Care, Support and Treatment (CST) for PLHIV: CST programme provides prevention and treatment of opportunistic infections, Anti-Retroviral Therapy (ART), psychosocial support, home-based care, positive prevention and impact mitigation. Around 4.86 lakh PLHIV including 28,225 children are receiving free ART through 342 ART Centres and 685 Link ART Centres. Ten Centres of Excellence and seven Pediatric Centres of Excellence provide tertiary level specialist care and treatment, Second line and Alternate First Line ART, management of complicated Opportunistic Infections and specialized laboratory services to children. Currently, 4,208 persons are receiving free second line ART. 253 Community Care Centres provide psycho-social support, ensure drug adherence, treat opportunistic infections and trace lost to follow-up cases. The other new initiatives include universal access of second line ART for adults and adolescents; ART Plus Scheme to provide second line ART; setting up of Comprehensive Care & Support Centres (CCSC) as referral or mentoring centres to other CCCs; and LAC Plus Scheme.

Laboratory Services: Capacity of laboratories for CD4 testing has been strengthened with 213 CD4 machines functioning The assurance of quality in kit evaluation and assessment of HIV testing services through implementation of External Quality Assessment Scheme (EQAS) are given focus. Seven laboratories conduct viral load testing to support clinical decision making for starting second line ART. The Early Infant Diagnosis programme has been rolled out through 1088 ICTCs and 217 ART Centres across 26 states. During 2011-12, 6,927 HIV exposed infants and children less than 18 months of age have been tested by HIV-1DNA PCR test under this programme till January 2012.

Strategic Information Management: Strategic Information Management System (SIMS) has been established since August 2010 and nation-wide roll-out is under way with about 12,000 reporting units across the country to enable the programme to collect, analyze and utilize data for planning and implementation. HIV estimates for 2008 and 2009 were widely disseminated. HIV Sentinel Surveillance has been expanded to 1,361 sites across the country. Research in HIV/AIDS including capacity building in operational research and ethics have been strengthened. Thirteen research scholars were awarded the NACO research fellowship in 2012.

Finance: For FY 2011-12, against the revised estimate of Rs. 1,500 crore, an expenditure of Rs. 1,199.88 crore (80%) was incurred (as on 12 March 2012). Special efforts were taken to build in systems both at NACO and SACS levels for effectively managing resource mobilisation and fund utilisation. E-transfer facility to avoid transit delays in transfer of funds to states has been implemented last year. Payment of salary to staff in district and peripheral units is made totally through e-transfer.

Results Framework Document: For the performance of various activities in the Results Framework Document 2010-11, the Department of AIDS Control scored 91.27 percent with "Excellent" rating from the Performance Management Division of the Cabinet Secretariat.

An elaborate and extensive process to develop the strategy and implementation plan for the next phase of the programme (**NACP IV**) has been initiated with the goal of accelerating the reversal of epidemic through an integrated response

by providing care, support and treatment to all eligible population along with focused prevention services for the high-risk groups and vulnerable, marginalised and hard–to-reach populations. NACP IV planning has adopted an inclusive, participatory and widely consultative approach and is further building on the globally acclaimed and successful planning and implementation efforts of NACP III.

While consolidating the progress achieved, the Department of AIDS Control is committed to developing and implementing effective evidence based strategies with active involvement of all stakeholders towards reducing AIDS related morbidity and mortality.

SAYAN CHATTERJEE

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Ministry of Health & Family Welfare,

Government of India

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Date: 23 March 2012

New Delhi

CHAPTER 1

INTRODUCTION

The national response to HIV/AIDS in India over the last decade has yielded encouraging outcomes in terms of prevention and control of HIV.

India has the third largest number of people living with HIV/AIDS. As per the 2008-09 HIV estimates, there are an estimated 23.9 lakh people currently living with HIV/AIDS in India with an adult prevalence of 0.31 percent in 2009.

Spread of HIV in India is heterogeneous. Though India is a low HIV prevalence country, certain states and districts show higher HIV prevalence among high risk groups and general population. Most infections occur through heterosexual transmission. However, in certain regions, other risk groups like 'injecting drug users', 'men who have sex with men' and 'single male migrants' are contributing significantly to the spread of HIV epidemic.

The first AIDS case in India was detected in 1986 and since then HIV infection has been reported in all states and union territories. India had responded promptly to the HIV/AIDS challenge at the initial stage itself by setting up an AIDS Task Force under the Indian Council of Medical Research and a National AIDS Committee headed by the Secretary, Ministry of Health & Family Welfare. In 1990, a Medium Term Plan (1990-1992) was launched in four States - Tamil Nadu, Maharashtra, West Bengal and Manipur, and four metropolitan cities - Chennai, Kolkata, Mumbai and Delhi. The plan facilitated targeted IEC campaigns, establishment of surveillance system and safe blood supply.

In 1992, the Government of India demonstrated its commitment to combat the disease with the launch of the first National AIDS Control Programme (NACP-I) as a comprehensive programme for prevention and control of HIV/AIDS in India. The programme, implemented during 1992-1999 with an IDA Credit of USD 84 million, had the objective to slow down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country. To strengthen the management capacity, a National AIDS Control Board (NACB) was constituted and an autonomous National AIDS Control Organisation (NACO) set up for project implementation.

In November 1999, the second National AIDS Control Programme (NACP-II) was launched with World Bank credit support of USD 191 million. Based on the experience gained in Tamil Nadu and a few

other states, along with the evolving trends of the HIV/AIDS epidemic, the focus shifted from raising awareness to changing behaviour, decentralization of programme implementation to the state level and greater involvement of NGOs.

The third phase of National AIDS Control Programme (NACP-III), implemented during 2007-2012, is a scientifically well-evolved programme, grounded on a strong structure of policies, programmes, schemes, operational guidelines, rules and norms. Overtime, the focus has shifted from raising awareness to behaviour change, from a national response to a more decentralized response and to increasing involvement of NGOs and networks of PLHA. NACP-III aims at halting and reversing HIV epidemic in India over the five-year period by scaling up prevention efforts among High Risk Groups (HRG) and General Population and integrating them with Care, Support & Treatment services. Thus, Prevention and Care, Support & Treatment (CST) form the two key pillars of all the AIDS control efforts in India. Strategic Information Management and institutional strengthening activities provide the required technical, managerial and administrative support for implementing the core activities under NACP-III at national, state and district levels.

Package of services provided under NACP-III include:

Prevention Services

Targeted Interventions for High Risk Groups and Bridge Population [Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders, Injecting Drug Users (IDU), Truckers & Migrants]

Needle-Syringe Exchange Programme (NSEP) and Opioid Substitution Therapy (OST) for IDUs

Prevention Interventions for Migrant population at source, transit and destinations

Link Worker Scheme (LWS) for vulnerable population in rural areas

Prevention & Control of Sexually Transmitted Infections/Reproductive Tract Infections (STI/RTI)

Blood safety

HIV Counseling & Testing Services

Prevention of Parent to Child Transmission

Condom promotion

Information, Education & Communication (IEC) & Behaviour Change Communication (BCC) – Mass Media Campaigns through Radio & TV, Mid-media campaigns through Folk Media, display panels, banners, wall writings etc; Special campaigns through music and sports; Flagship programmes such as Red Ribbon Express.

Social Mobilization, Youth Interventions and Adolescence Education Programme

Mainstreaming HIV/AIDS response

Workplace Interventions

Care, Support & Treatment Services

Laboratory services for CD4 Testing and other investigations

Free first line & second line Anti-Retroviral Treatment (ART) through ART centres and Link ART Centres (LACs), Centers of excellence (COE) & ART plus centres.

Pediatric ART for children

Early Infant Diagnosis for HIV exposed infants and children below 18 months

Nutritional and Psychological support through Community Care Centres (CCC)

HIV-TB Coordination

Treatment of Opportunistic Infections

Drop-in Centres for PLHIV networks

Key functions of the Department of AIDS Control are as follows:

Policy Formulation with respect to prevention and control of HIV/AIDS

Development of standards, guidelines and norms for programme implementation

Development of strategy and finalization of state action plans

Financial planning & management, budgeting, release of funds and monitoring expenditures at national and state levels

Strategic Information Management including programme monitoring, HIV Surveillance and Research on HIV/AIDS

Institutional Strengthening and Human Resource Management

Capacity Building

Technical and Administrative Support and guidance to State AIDS Control Societies in programme implementation

Table 1.1 - Progress in Achievement of Physical Targets listed in Outcome Budget of the Department of AIDS Control for 2010-11 and 2011-12

Indicator	2010-11		2011-12	
	Target	Achievement	Target	Achievement up to January 2012
New Targeted Interventions established	140	188	170	208
STI/RTI patients managed as per national protocol	100 lakh	100.1 lakh	120 lakh	74.57 lakh*
New Blood Component Separation Units established	12	26	7	4
New District Level Blood Banks set up	6	7	22	8
Districts covered under Link Worker Scheme	186	179	219	209
Clients tested for HIV	111.71 lakh	95.45 lakh	120 lakh	90.52 lakh
Pregnant Women tested for HIV	86.49 lakh	66.38 lakh	90 lakh	70.87 lakh
HIV+ Pregnant Women & Babies receiving ARV prophylaxis	11,350	11,962	17,500	11,074
HIV-TB Cross Referrals	8.5 lakh	10.48 lakh	9.5 lakh	9.97 lakhs*
ART Centres established (Cumulative)	332	300	340	342
PLHIV on ART	4,04,815	4,07,361	4,50,000	4,86,173
Opportunistic Infections treated	2.7 lakh	4.97 lakh	3.1 lakh	5,41,997
Campaigns released on Mass Media - TV/Radio	6	6	9	6
New Red Ribbon Clubs formed in Colleges	1,200	5,190	1,000	585
Persons trained under Mainstreaming training programmes	2,50,000	5,22,337	1,50,000	5,61,734
Proportion of blood units collected through Voluntary blood donation in NACO supported Blood Banks	80%	79.5%	90%	83.1%
Social Marketing of condom by NACO contracted Social Marketing Organisations	22.46 crore pieces	44.72 crore pieces	34.9 crore pieces	42.9 crore pieces

* Up to December, 2011

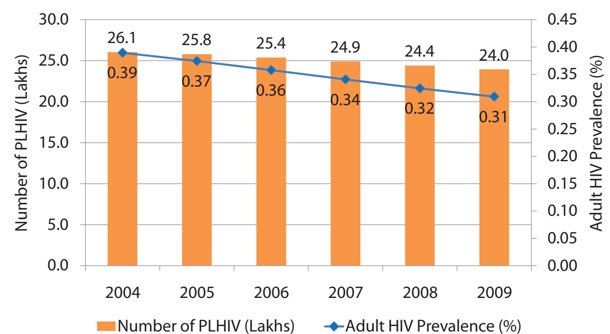
CHAPTER 2

CURRENT EPIDEMIOLOGICAL SITUATION OF HIV/AIDS

The estimated number of new annual HIV infections has declined by 56% over the past decade. But, some low prevalence states have shown a slight increase in the number of new infections over the past two years; this underscores the need for the programme to focus more on these states with low prevalence, but high vulnerability.

HIV epidemic in India is concentrated in nature. The HIV prevalence among the High Risk Groups, i.e., Female Sex Workers, Injecting Drug Users, Men who have Sex with Men and Transgender is higher than the general population. Based on HIV Sentinel Surveillance 2008-09, it is estimated that 23.9 lakh people are infected with HIV in India, of whom 39% are female and 4.4% are children. The estimates highlight an overall reduction in adult HIV prevalence and HIV incidence (new infections) in India. Adult HIV prevalence at national level has declined from 0.41% in 2000 to 0.31% in 2009. The estimated number of new annual HIV infections has declined by 56% over the past decade from 2.7 lakh new infections in 2000 to 1.2 lakh in 2009.

Fig 2.1: Trends in Estimated Adult HIV Prevalence and Number of PLHIVs in India, 2004- 2009



Source: Technical Report on HIV Estimations 2010

HIV Incidence: One of the key characteristics of this round of estimations is that it allowed for generating estimates of the HIV incidence (number of new HIV infections per year). Analysis of epidemic projections revealed that the number of new annual HIV infections has declined by around 56% during the last decade (2000-2009). This is one of the most important evidence on the impact of the various interventions under National AIDS Control Programme and scaled-up prevention strategies. It is estimated that India had approximately 1.2 lakh new HIV infections in 2009, as against 2.7 lakh in 2000.

While this trend is evident in most states, some low prevalence states have shown a slight increase in the number of new infections over the past two years; this underscores the need for the programme to focus more on these states with low prevalence, but high vulnerability.

Of the 1.2 lakh estimated new infections in 2009, the six high prevalence states account for only 39% of the cases, while the states of Odisha, Bihar, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat account for 41% of new infections.

Adult HIV prevalence: The estimated adult HIV prevalence in India was 0.32% (0.26% – 0.41%) in 2008 and 0.31% (0.25% – 0.39%) in 2009. The adult HIV prevalence was 0.26% among women and 0.38% among men in 2008, and 0.25% among women and 0.36% among men in 2009.

Among the states, Manipur has shown the highest estimated adult HIV prevalence (1.40%), followed by Andhra Pradesh (0.90%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%). Besides these states, Goa, Chandigarh, Gujarat, Punjab and Tamil Nadu have shown estimated adult HIV prevalence greater than national prevalence (0.31%), while Delhi, Odisha, West Bengal, Chhattisgarh and Puducherry have shown estimated adult HIV prevalence of 0.28-0.30%. All other states/UTs have lower levels of HIV.

Declining Trends of Adult HIV Prevalence

The adult HIV prevalence at national level has continued its steady decline from estimated level of 0.41% in 2000 through 0.36% in 2006 to 0.31% in 2009. All the high prevalence states show a clear declining trend in adult HIV prevalence. HIV has declined notably in Tamil Nadu to reach 0.33% in 2009. However, the low prevalence states of Chandigarh, Odisha, Kerala, Jharkhand, Uttarakhand, Jammu & Kashmir, Arunachal Pradesh and Meghalaya show rising trends in adult HIV prevalence between 2006 and 2009.

A clear decline is also evident in HIV prevalence among the young population (15-24 years) at national level, both among men and women. Stable to declining trends in HIV prevalence among the young population (15-24 years) are also noted in most of the states. However, rising trends are noted in some states including Odisha, Assam, Chandigarh, Kerala, Jharkhand and Meghalaya.

People Living with HIV (PLHIV)

The total number of people living with HIV (PLHIV) in India is estimated at 24 lakh (19.3 – 30.4 lakh) in 2009. Children under 15 years account for 4.4% of all infections, while 83% of PLHIV are the in age group 15-49 years. Of all HIV infections, 39% (9.3 lakhs) are among women. The four high prevalence states of South India (Andhra Pradesh – 5 lakhs, Maharashtra – 4.2 lakhs, Karnataka – 2.5 lakhs, Tamil Nadu – 1.5 lakhs) account for 55% of all estimated PLHIV in the country. West Bengal, Gujarat, Bihar and Uttar Pradesh are estimated to have more than 1 lakh PLHIV each and together account for another 22% of the estimated PLHIV in India. The states of Punjab, Odisha, Rajasthan & Madhya Pradesh have an estimated 50,000 – 1 lakh PLHIV each and together account for another 12% of PLHIV. These states, in spite of low HIV prevalence, have large number of PLHIV due to the large population size.

HIV concentrated amongst Injecting Drug Users and Men who have Sex with Men: This round of estimates has confirmed the clear decline of HIV prevalence among Female Sex Workers at national levels and in most states. However, the evidence shows that Injecting Drug Users and Men who have Sex with Men are more and more vulnerable to HIV with increasing trends in many states.

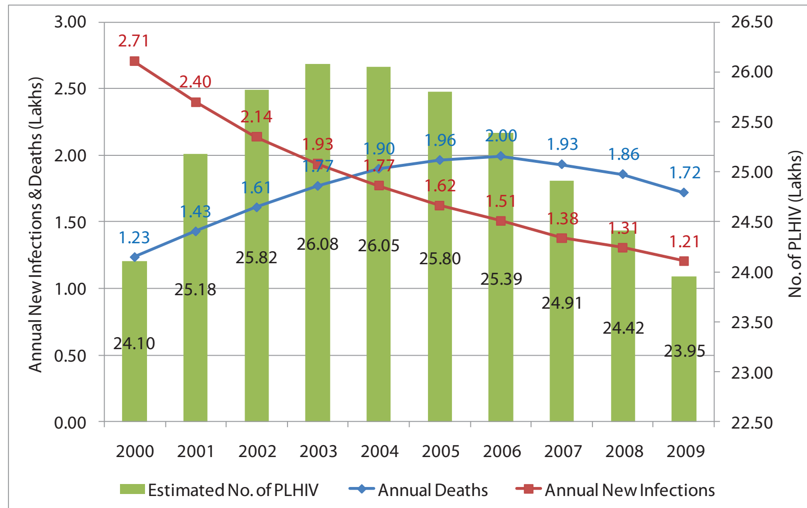
AIDS deaths: Using globally accepted methodologies and updated evidence on survival to HIV with and without treatment, it is estimated that about 1.72 lakh people died of AIDS related causes in 2009 in India. Wider access to ART has resulted in a decline of the number of people dying due to AIDS related causes. The trend of annual AIDS deaths is showing a steady decline since the roll out of free ART programme in India in 2004.

The primary drivers of HIV epidemic in India are unprotected paid sex/ commercial female sex work, unprotected sex between men who have sex with men, and injecting drug use. Sex work continues to act as the most important source of HIV infection in India due to the large size of clients who get infected from sex workers. These men, then, transmit the infection to their wives affecting several low risk women in the society. Long-distance Truckers and Single Male Migrants constitute a significant proportion of clients of sex workers.

Routes of Transmission: While heterosexual mode of HIV transmission accounts for 88.2% of HIV positive cases detected, mother to child transmission accounts for 5.0%, Infected Syringe and Needle 1.7%, Homosexual 1.5% and contaminated blood and blood products account for 1.0% of HIV infections detected during 2011-12.

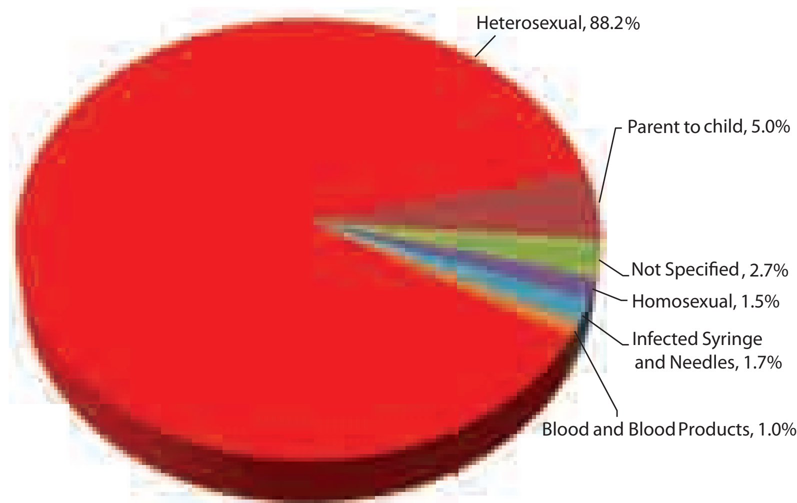
Concentrated Epidemic: The overall HIV prevalence among different population groups in 2008-09 (Fig 2.4) continues to portray the concentrated epidemic in India, with a very high prevalence among High Risk Groups – IDU (9.19%), MSM (7.3%), FSW (4.94%) and STI clinic attendees (2.46%), and low prevalence among ANC attendees (0.48%).

Fig.2.2: Decline in number of PLHIV as a result of greater decline in new infections, despite increased survival of PLHIV due to ART



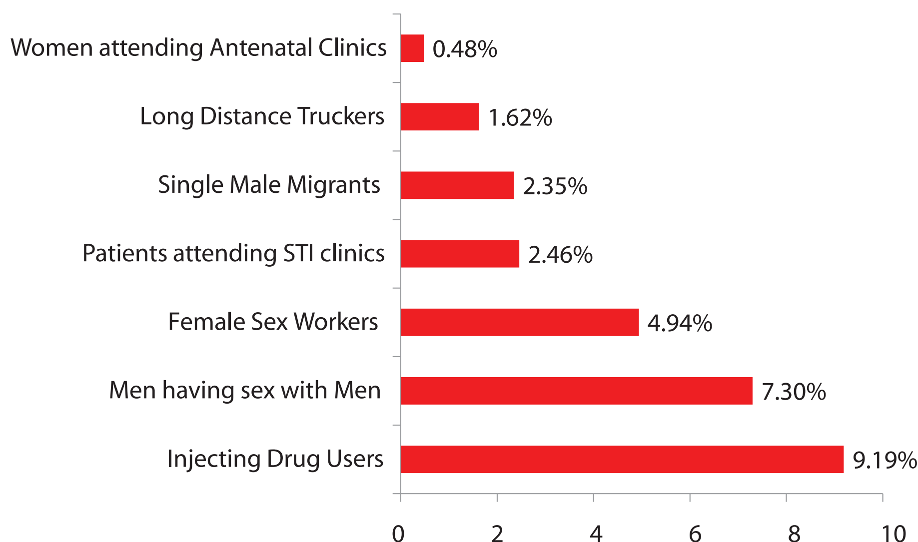
Source: Technical Report on HIV Estimations 2010

Figure 2.3: Routes of Transmission of HIV, India, 2011-12 (till January 2012)



Source: CMIS, NACO

Fig.2.4: HIV Prevalence: India, 2008-09



Source: HIV Sentinel Surveillance, 2008-09

CHAPTER 3

TARGETED INTERVENTIONS

As per Programme guidelines, all sexual encounters of HRG are to be protected by ensuring supply of condoms as per their demand (sexual encounters).

India's epidemic is similar to other Asian HIV epidemics as it is driven by groups with high risk behaviours. Currently, the epidemic remains concentrated in specific high risk populations (HRG - high risk groups or MARPS – Most at risk populations) and their sexual partners. Therefore, prevention through focused interventions amongst these groups is of extreme importance for controlling HIV epidemic.

HIV infection is transmitted from HRGs to General population through Bridge population who constitute major proportion of the clients of sex workers, such as truckers and male migrants. Given this model of epidemic transmission, it is most effective and efficient to target prevention efforts towards HRGs to keep their HIV prevalence as low as possible and to reduce transmission from them to the bridge population. Therefore, there is a need to have Targeted Interventions (TI) projects among HRGs as well as the bridge populations.

The key risk groups covered through Targeted Intervention (TI) programme include

- High Risk Groups (HRG)
  - Female Sex Workers (FSW)
  - Men who have Sex with Men (MSM)
  - Transgender (TG)
  - Injecting Drug Users (IDU)
- Bridge Populations
  - Truckers
  - Migrants

Targeted Interventions are preventive interventions focused at High Risk Groups and Bridge populations in a defined geographic area. The TI Projects are peer-led interventions implemented through NGOs/Community Based Organisations (CBOs). These projects are mentored, monitored and supported by the State AIDS Control Societies (SACS), Technical Support Units (TSUs), State Training and Resource Centres (STRC) and NACO. The NGOs/CBOs implementing the TI projects collect field level data based on the reporting formats developed by NACO which form a part of national Monitoring & Evaluation framework.

Core group interventions under NACP III

- **TI for Female Sex Workers (FSW)**

During the formulation of NACP III, it was estimated that there are 12.63 lakh Female Sex Workers in the country, scattered in different states. Size estimation exercises have shown the number of FSW as 8.68 lakh. Out of that, 6.78 lakh FSW are being covered through TI projects. TI projects cover different typologies of sex workers namely, brothel based, street based, home-based, lodge-based, dhaba-based, bar-girls etc. with specific intervention strategies. There are 28 TI projects implemented by Community Based Organizations.

- **TI for Men who have Sex with Men (MSM) and Transgenders (TG)**

NACO has given significant thrust to the interventions for MSM and TGs as the prevalence among these groups is considerably high. The country level estimation of High risk MSMs and Transgender population is 4.27 lakh. Through TI projects, 2. 74 lakh (64%) MSM and TGs/Hijras are being covered with services. 37 such Targeted Intervention projects in the country are implemented by CBOs which are managed by the community. Under Global Fund Round-9, India HIV/AIDS Alliance and Naz Foundation International (NFI) strengthening community institutions and systems for MSM, *Hijra*s and transgender interventions so that the outreach and quality of services are improved.

- **TIs for Injecting Drug Users**

The number of IDUs estimated during NACP-III formulation was 1.86 lakhs. Based on the revised mapping, estimation of IDU population in the country is 1.77 lakhs of which 1.42 lakh (80%) are currently being covered through 281 exclusive IDU Targeted Intervention projects.

NACO has undertaken several initiatives to improve the quality of services including a situational analysis of harm reduction interventions with support from DFID-TAST. Under Global Fund Round-9, the principal recipient, Emmanuel Hospital Association (EHA) is supporting NACO to strengthen the IDU interventions and building capacity at the national, state and district levels to deliver harm reduction services for IDUs and their partners. Opioid Substitution Therapy (OST) was incorporated into the harm reduction programme for IDUs in 2007-08 and since then NACO has been supporting more than 50 OST centres in NGO-settings covering about 4800 IDUs. At present, 52 NGO Centres have been contracted by the concerned SACS to implement OST after an independent accreditation by the National Accreditation Board for Hospital and Healthcare Providers (NABH). In addition, NACO launched OST centres in government health facilities as a pilot project in 5 districts of Punjab. Based on the encouraging response received by the pilot project, a national OST scale-up plan was developed and is currently being implemented across 23 states of the country. In all, NACO is presently implementing OST through 62 OST centres across 16 states/UTs of the country and provides free substitution treatment to approximately 5,800 IDUs.

TIs for Bridge populations in NACP III

- **Migrant Interventions**

NACO has revised the migrant intervention strategy with specific reference to linking migrants with services and information on HIV prevention, care and support at source (at their villages), at transit (places like rail or bus stations where large number of migrants board train or bus to travel to their places of work) and at destination (the places of work).

NACO has identified 122 districts with high out-migration (based on Census 2001) across 11 States which are on priority for starting up community level migrant interventions.

Health camps were organised at the block level during festivals when migrants return to their villages. These camps promoted health seeking behaviour as well as HIV testing and counseling services. 212 health camps were organised in the States of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and West Bengal during Dussehra, Diwali and Eid festivals. These camps were organised in close collaboration with NRHM and DAPCU of these districts. About 11.43 lakh migrants, their spouses and family members were treated for STIs and general ailments. A total of 24,291 had tested for HIV and 96 were found positive. The HIV positive clients were linked up with ART centres in respective States. These health camps provided a platform for condom campaigns by Social Marketing Agencies and folk media campaigns by trained folk artists.

Besides, there are 75 important transit locations that have been identified across these 122 districts from where migrants usually board long distance trains/ buses to reach their destinations (usually work places). Transit interventions are established at 60 locations across 8 states covering migrants at railway stations and bus stops where inter-state migration occurs. At transit locations, the part time

outreach workers, placed with existing interventions, conduct one to group sessions on HIV prevention before the arrival of the train/ bus . Besides this, they distribute migration kits containing information booklet on services available in major destinations (as identified for specific source- destination corridor), condoms, daily utility materials like small notebook, ball pen, comb, etc. This strategy is to reinforce the HIV prevention messages and encourage out going migrants to seek services at destination. A total of 13,416 migrants and their spouses were reached through the transit migrant interventions.

Currently, there are 236 SACS-funded migrant interventions covering 28 lakh migrants in 32 States. The sectors mainly include industries, agriculture and transport. This includes 30 interventions funded by USAID in Maharashtra and Tamil Nadu.

- **Truckers' Interventions**

76 Truckers interventions are presently reaching out to 11.33 lakh truckers, providing STI health care services, risk reduction counseling and condoms. Clinics at Trans-Shipment Locations have been co-branded as *Khushi-Suraksha clinics*. IEC materials addressing issues such as self esteem, risk perception and services are made available. Besides this, there are 51 locations where condom social marketing initiatives have been implemented to promote risk reduction.

The Truckers Technical Support Group (TSG) monitors the quality of interventions in all 76 sites. The Behaviour Change Communication (BCC) materials, training kits and micro-plan have been adapted for each site to suit the local needs and maximize the impact of interventions.

Services under Targeted Intervention Projects in NACP-III

The primary focus of NACP–III is to halt and reverse the spread of the HIV epidemic in India by 2012. The programme plans to cover 80% of HRGs with primary prevention services, including:

- Treatment for Sexually Transmitted Infections (STIs)
- Condom provision – male and female condoms
- Provision of clean needles and syringes
- Behavior change communication (BCC)
- Creating an enabling environment with community involvement and participation
- Linkages to testing, care and support services
- Opioid Substitution Therapy (OST) for IDUs

Two important structural interventions have been added to NACP-III:

- Strengthening enabling environment for TIs, and
- Community organisation and ownership building

NACP III's goal is to scale up interventions for high-risk groups (HRGs) – both in terms of sheer numbers (coverage, number of targeted interventions) and in terms of quality of interventions.

Support mechanisms to ensure quality of interventions

The main focus in the initial two years of NACP-III was on ensuring that the systems of contracting, fund release, and evaluation are followed by the SACS. In the last two years, there is an increasing emphasis on ensuring that the quality of the TI implementation is improved. In this regard, a number of steps have been taken:

- **Standardisation of the tools for collection of data:** Tools for collecting data regarding provision of services and referrals have been developed. The field level data of HRG feeds into the Computerised Management Information System (CMIS).
- **Developing a quality guide for TIs:** To ensure a standard process, a guide has been developed which covers how the data flows from outreach to reporting level at TI and finally into Computerised Management Information System (CMIS). In addition, methods to check factuality of information, timelines and defining the roles and responsibilities of staff in collecting data, is also covered in the guide.
- **Monthly tracking of CMIS report** from TIs is being done at NACO; regular feedback to the SACS is provided on how many TIs are reporting. The SACS are encouraged to examine the data collected from CMIS and provide feedback to the TI. The number of units reporting has increased which shows that there has been a consistent improvement in the uptake of services in the TI.
- **Technical Support Unit (TSU):** A National Technical Support Unit (NTSU) at NACO

as well as Technical Support Units (TSUs) in fifteen states provide technical support on key aspects of the TI programme. TSU support the SACS in implementation of TI in respective states. They follow the NACP III guidelines and then facilitate its implementation. TSUs also facilitate the designing, planning, implementation and monitoring of TIs in the states and provide management and technical support to the SACS.

- **Supportive Supervision and Monitoring:** NACO has a strengthened organisational structure for TI supervision and monitoring. For the same, Project Officers (PO) are placed for handholding TIs. On an average, one PO covers 10 TIs and acts as an effective support mechanism which mentors and monitors the TI on a routine basis. The supportive supervision includes one day visits and intensive visits to ensure the quality of TIs.
- **Quality Assurance (QA) in OST programme:** With the implementation of OST services in government health settings, NACO has established a mechanism of on-site mentoring and capacity building of staff through field visits by experts on OST on a periodic basis. The experts follow a standard protocol to observe the procedures at the OST centre and provide feedback to the staff in order to improve the programme for the community's benefit.
- **Technical Support Group (TSG)** – Technical Support Groups on condom programme and Truckers interventions work closely with NACO and SACS. TSG on condoms ensures the accessibility and availability of condoms with all TI projects.

OST Accreditation: In addition to the external evaluation, the TI projects running OST services are also evaluated by National Accreditation Board of Hospitals and Healthcare Providers (NABH) on an annual basis for accreditation. NACO, with support from technical experts and NABH, has developed a specific tool for the purpose. The evaluations are conducted by external experts contracted by NABH and the findings are reviewed by committee of technical experts on OST before finalization. The OST accreditation has served as a useful strategy to ensure minimum standards of care at the NACO supported OST centres.

Capacity Building activities for TIs: This work is being carried out by State Training & Resource Centres (STRCs), which are designed to provide training and develop the capacity of TI projects staff to ensure the quality of interventions. There are 17 STRCs have been established. They work closely with the State AIDS Control Societies and TSUs to build the capacity of TI staff. While the new staffs are trained on the standardized modules, the old staff are imparted customized trainings based on needs assessment carried out by STRCs.

Thus, STRCs have built local resources to ensure that overall capacity of States improves.

Under the GFATM Round 9 project for IDU, modules for specific staff have been developed which include programme management, outreach workers, peer educators and clinical staff (doctors and nurses). In addition, a training module on counselling for IDUs, reaching out to Female Partners of IDUs, and Standard Operating Procedures (SOP) on waste disposal have been developed with support of various partners. NACO has also developed a National Training Manual on OST for training of staff of OST centres with support from AIIMS and DFID-TAST.

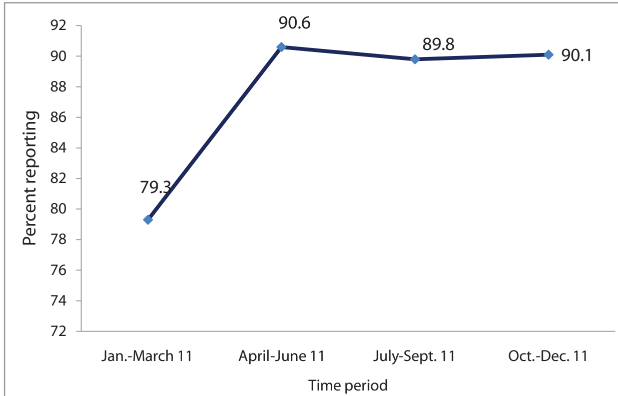
The trainings conducted for TI staff in states during 2011-12 are shown in Table 3.1.

Table 3.1: Details of trainings conducted for TI staff, 2011-12

Area of Training	Category of Participants	Number
Programme Management	Programme Manager of TIs	803
Out-reach Planning	Out-reach Workers	3184
Counseling	Counselor	1083
Peer Education	Peer Educators	7670
Financial Management	Accountants	978

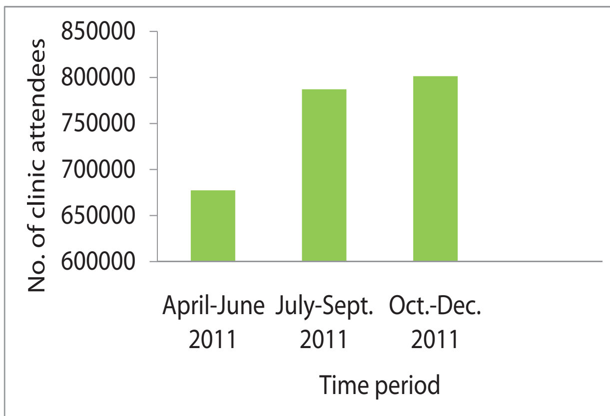
The key performance of the TIs for the period January 2011 to December 2011. The data presented is based on CMIS reports.

Fig 3.1: TI monthly reporting by TI NGOs



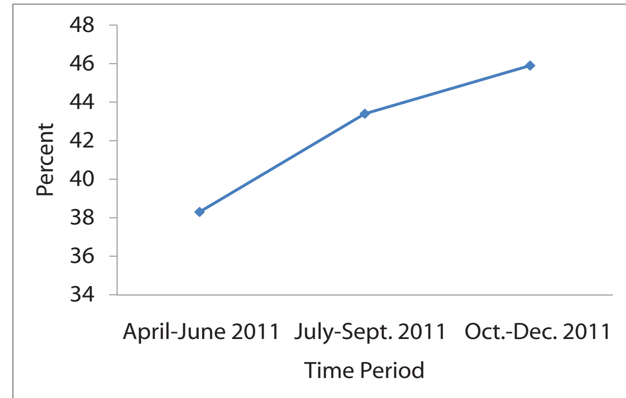
Consistent monthly reporting in CMIS by TI NGOs has considerably improved Nearly 90 per cent of TI NGOs reported consistently during the first three quarter of 2011-12.

Fig 3.2: STI clinic attendees



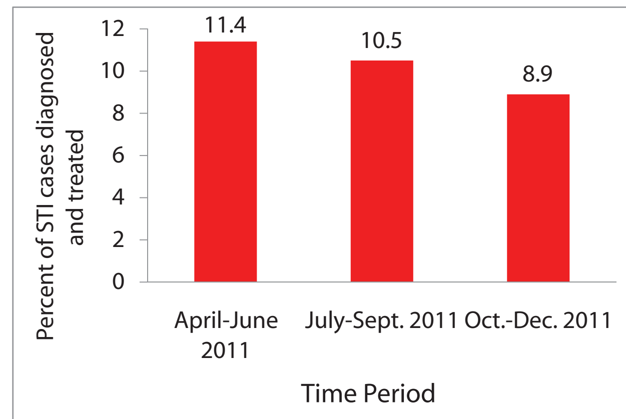
Clinical service is one of the core components of TI project services. Fig 3.2 reveals that clinic visit of HRG has improved over the quarters. During quarter first to third, no. of HRG availing clinic services has increased by 18%.

Fig 3.3: Regular Medical Check-up (RMC) of FSW and MSM



NACO guideline suggests that HRGs from core group, specially MSM and FSW, should visit STI clinic every quarter, i.e. 4 times in a year for regular medical check-up for STI/RTI. During April-June 2011, 38.5 percent of HRG had availed the RMC services whereas during Oct.-Dec. 2011 45.9 percent of HRG. Fig 3.3 clearly indicates that health seeking behavior among HRG has increased over the quarters.

Fig 3.4: Diagnosis and treatment of STI cases



It is evident from programme data that approximately 30 per cent of HRG might suffer from some sort of reproductive morbidity (RTS/STI) in a given year. Fig 3.4 shows that the number of STI/RTI cases has declined from first to third quarter of 2011-12 by 2.5 percent though the clinic attendance has gone-up.

As per NACO guideline, all HRG of core group, i.e. FSW, MSM and IDU, should be screened for syphilis biannually. Though Syphilis testing has improved by 6.5 percent during subsequent six months in the year but still it is below 40 percent against the target.

Fig 3.5: Syphilis Testing of HRG

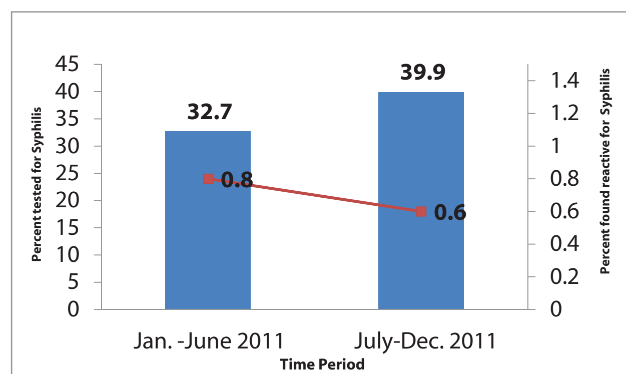
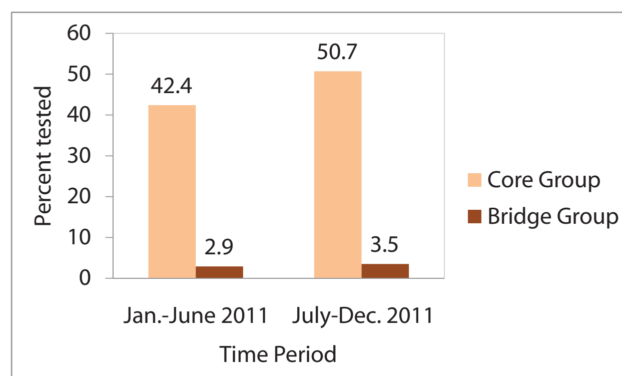
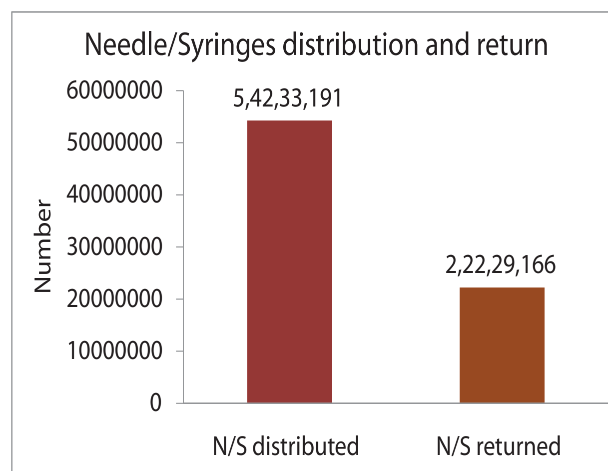


Fig 3.6: HIV Testing of HRG



TI guidelines specify that all core group HRG should be tested for HIV once in every six months. Fig. 3.6 indicates that HIV testing, with respect to the target, has increased between January 2011 and December 2011.

Fig 3.7: Needle and Syringe distribution and return (Jan. –Dec. 2011)



Reaching out to the unreached: The population-wise distribution of TI projects and their coverage are shown in Table 3.2 and the distribution of TI projects by typology in the various states and UTs in Table 3.3.

Table 3.2 -Population-wise distribution of TI projects and the coverage (As on 31st December, 2011)

Typology	Population Size Estimation	Current Coverage in TIs	No. of TIs	TI Coverage (%)
Female Sex Workers (FSW)	8.68	7	490	80.6%
Men-who-have-sex-with-Men (MSM) & Transgenders (TG)	4.27	2.74	183	64 %
Injecting Drug Users (IDU)	1.77	1.42	281	80%
Migrants	72.0	28.8	241	40.0%
Truckers	20.0	11.33	76	56.65%
Core Composite#			324	
Total			**1,595**	
Donor funded			**190**	
TOTAL TIs functioning			**1,785**	

 # Mix of FSW, IDU and MSM, or FSW with MSM, or FSW with IDU, or MSM with IDU.

Transition of interventions from Other Donors: As a part of consolidating efforts made by other Development Partners during NACP-III, NACO has developed a common strategic approach for transitioning of interventions implemented by other Development Partners based on "Three Ones Principles". Apart from NACO-supported TIs, develop-

ment partners, including the USAID and the Bill and Melinda Gates Foundation (BMGF), were implementing more than 200 HRG and bridge population TIs in the country during the NACP-III period (2007-2012). These interventions were primarily implemented in six high prevalence states (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu)

30% of the interventions have been transferred to the SACS according to their location (in Andhra Pradesh, Mumbai, Karnataka and Tamil Nadu) in 2009 and in 2011. Before the transfer, each TI was assessed by an external group of experts to grade the status of the programmes. This also provides a baseline for monitoring further progress. The Development Partner funded TIs identified for transition have been aligned to follow the costing and programme guidelines laid down by NACO.

Table 3.3: Distribution of Targeted Interventions by state and typology (as on December-2011)

Targeted Interventions								
State /UT	FSW	MSM	TG/Hijras	IDU	Core Composite	Truckers	Migrants	Total TIs
Ahmedabad	3	4	1	1	0	2	9	20
Andhra Pradesh	41	7	0	6	38	5	18	115
Arunachal Pradesh	4	0	0	3	8	0	6	21
Assam	38	5	0	8	2	1	6	60
Bihar	8	3	0	14	19	1	6	51
Chandigarh	4	2	0	2	1	0	3	12
Chhattisgarh	14	2	0	6	12	2	11	47
D&N Haveli	0	0	0	0	0	1	2	3
Daman & Diu	0	0	0	0	2	1	4	7
Delhi	40	17	2	19	0	4	8	89
Goa	6	3	0	2	1	2	2	16
Gujarat	13	14	1	1	42	6	19	96
Haryana	13	7	0	16	8	0	9	53
Himachal Pradesh	14	0	0	2	3	0	4	23
Jammu and Kashmir	3	1	0	1	0	0	1	6
Jharkhand	27	4	0	4	0	3	5	43
Karnataka	27	18	0	4	4	4	11	68
Kerala	20	14	0	8	0	2	8	52
Madhya Pradesh	17	10	0	8	22	4	3	63
Maharashtra	26	7	0	1	2	7	20	63
Manipur	6	3	0	40	1	0	2	52
Meghalaya	3	0	0	3	1	0	1	8
Mizoram	2	1	0	22	8	0	2	35
Mumbai	14	7	0	4	0	2	14	41
Nagaland	0	2	0	25	12	1	1	41
Odisha	19	4	0	9	26	1	12	71
Pondicherry	1	1	0	0	2	0	1	5
Punjab	12	2	0	23	19	3	3	62
Rajasthan	23	5	0	7	11	3	15	64
Sikkim	2	0	0	4	0	0	2	8
Tamil Nadu	17	14	0	2	27	5	6	71
Tripura	9	1	0	2	1	0	2	15
Uttar Pradesh (migrant transit)	11	5	0	16	48	8	12	100
Uttarakhand	11	3	0	7	5	0	6	32
West Bengal	42	13	0	11	1	8	7	82
Sub Total	490	179	4	281	326	76	241	1,595
Donor Supported TIs								190
TOTAL								1,785

CHAPTER 4

LINK WORKER SCHEME

The Link Worker Scheme (LWS) is a rural outreach programme established during NACP-III to reach out to rural HRGs, their partners and other vulnerable groups and to link them with HIV/AIDS services. In addition, the Scheme will also cover young people. It is being implemented in identified priority districts of the country.

Under NACP-III, the Link Worker Scheme (LWS) was launched to saturate the reach of the HIV- related services to the high risk groups and vulnerable population based in the rural areas. The need to strengthen the fight against HIV/AIDS—particularly in rural areas—becomes more pronounced in view of the stigma and discrimination surrounding the disease. Rural interventions continue to be a challenge owing to the inadequate infrastructures, weak health systems and poor outreach initiatives.

The Link Worker Scheme (LWS) is a rural outreach programme established during NACP-III to reach out to rural HRGs, their partners and other vulnerable groups and to link them with HIV/AIDS services. In addition, the Scheme will also cover young people. It is being implemented in identified priority districts of the country.

The objective of the Scheme is to "Reach out to HRGs and vulnerable men and women in rural areas with information, knowledge, skills on STI/HIV prevention and risk reduction."

Population covered under the scheme:

1. High–risk groups (HRG)
   - a Female Sex Workers (FSW)
   - b Men having sex with men (MSM)
   - c Injecting Drug Users (IDUs)
2. Vulnerable groups
   - a Women having casual partners
   - b Partners / Spouses of high risk and vulnerable groups
   - c Women in women-headed households
   - d Youth
3. Bridge Population
   - a Migrant (Male and Female)
   - b Truckers
4. People Living with HIV (PLHIV)

Further its **community-based model** (epitomised by the setting-up of youth-driven Red Ribbon Clubs in target villages, networking with PRI and

existing health systems, and developing a cadre of community-level volunteers) ensures sustainability while at the same time making members of its target populations stakeholders in the programme.

Folk media activity under Link Worker Scheme in Tamil Nadu

Progress under NACP III in the year 2011-12

The mandate under the Link Worker Scheme is to cover 209 Districts across 20 States in partnership with various Developement Partner (GFATM Rd-VII: 163 Districts; UNDP: 14 Districts; UNICEF: 26 Districts; USAID: 16 Districts).

During 2011-12, the Link Worker Scheme was implemented in 209 districts of 219 planned. This includes 163 high prevalence and highly vulnerable districts including 42 new districts in which the LWS was initiated in 2011-12 under GFATM Rd- VII. The selection of these Districts was based on the fact that these Districts were "Source Migrant" Districts where the vulnerability of HIV is increasing.

Capacity Building under LWS

Under the original Operational Guidelines, there were three training modules each for different cadres of staff at District and field level under the Scheme -District Resource Persons and Supervisors at the District level and Link Workers at the field. The training modules were revised condensing the set of four modules, which spanned 28 days earlier, to two modules of 5 days each. The number of staff trained using the revised modules (as on January, 2012) is as under:

Cadre of Staff	Module	Staff Trained
District Resource Persons, Training Officer & M&E cum Accounts	1. Induction and Mapping	351
	2. Outreach & Advocacy, Supportive Supervision	294
Supervisors	1. Induction , Mapping & SNA	468
	2. Outreach, Advocacy& Communication	392
Link Workers	1. Induction and Situation Needs Assessment	4,600
	2. Outreach , Advocacy & Micro planning	3,320

- **Coverage and Service Delivery:**

Keeping in mind the objective of reaching to the target population with the services available for HIV/AIDS, coverage of the target population and service delivery uptake by them define the key indicators under the Scheme. An estimated 1, 90,036 HRGs (FSWs, MSMs and IDUs), 17,72,676 Bridge population (truckers and male and female migrants), 13,92,662 Vulnerable Population (including, but not limited to, at risk women, spouses of HRGs, and out-of-school youth) and 52,348 PLHIVs have been mapped under the Scheme. In terms of coverage, the Scheme covers about 67% of the HRGs, 25% of Bridge Population, 87% of Vulnerable Population and 33% of PLHIVs.

Nearly 41% HRGs have been tested at ICTC and 23% HRGs have sought treatment for STI symptoms under this intervention. This has been done by establishing linkages with existing services.

Effective communication and easy availability of condoms is an integral part for correct dissemination of information and prevention from HIV/AIDS. In order to create a sense of ownership in the community and involve the youth in fighting against HIV, **Condom Depots**, **Red Ribbon Clubs (RRC)** and **Information Centres** have been established at the Village level. In 2011-12, a total of 10,996 and 11,542 Red Ribbon Clubs and Village Information Centres were functioning. A total of 21,170 Condom Depots were functioning leading

to easy accessibility of condom to the target population at the grassroots level.

- **IEC under Link Worker Scheme**:

Mid-Media plays a pivotal role under the Scheme for providing information on HIV and thereby promoting service uptake, IEC programmes were conducted in rural areas. The mid-media programmes include wall writings, wall paintings, folk performances and hoardings. These programmes were organised at the village level with support of Panchayati Raj Initiatives (PRI), line departments and RRCs. Locale-specific and culture-specific IEC programmes were selected to reach out to the rural people, especially the vulnerable and high risk population.

In FY 2011-12, under mid-media campaign special focus was on the Folk media in programme intervention villages. Folk shows were done in all the LWS villages. For this the troupes were selected and trained by respective SACS. The messages and scripts were approved by NACO.

Canopy exhibition of mid-media material, Gujarat

Folk performance on World AIDS day in Karnataka

Operational Research: During 2011-12, two research studies were conducted under the programme to assess the feasibility of increasing uptake and delivery of HIV/AIDS services through the capacitated front-line health workers (ASHAs).

CHAPTER 5

MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS (STI)/ REPRODUCTIVE TRACT INFECTIONS (RTI)

In order to improve the service utilization, local private health service providers preferred by HRG were selected. Under this scheme, all the HRG receives free STI/RTI treatment and the providers receive a token fee of Rs. 50 per consultation.

Provision of Sexually Transmitted Infections (STI) /Reproductive Tract Infections (RTI) services is aimed at preventing HIV transmission under the NACP III and Reproductive and Child Health (RCH II) programme of the National Rural Health Mission (NRHM). Enhanced Syndromic Case Management (ESCM), with minimal laboratory tests, is the cornerstone of STI/RTI management under NACP III.

An estimated 3 crore episodes of STI/RTI occur every year in the country. Against the annual target of 1 crore episodes of STI/RTI, for FY 2008-09, 2009-10 and 2010-11, 66. 7 lakh, 82.4 lakh, and 100.2 lakh STI/RTI patients respectively were managed across the country. Against the annual target of 1.2 crore episodes of STI/RTI to be managed for FY 2011-12, 74.57 lakh STI/RTI patients were managed till the end of December 2011. The details of the physical targets and achievements from 2008-09 to 2011-12 are shown in Table 5.1.

Progress of STI/RTI services under NACP III

Expansion of Service Provision in Public Sector: Under NACP III, it is a mandate to strengthen all public health facilities at and above district level as designated STI/RTI clinics, with the aim to have at least one NACO supported clinic per district. There are 34 Deputy Directors and Assistant Directors (STI) in various SACS to monitor and facilitate the programme implementation at state level and 14 programme officers (STI) in the technical support units.

Presently, NACO is supporting 1,112 designated STI/RTI clinics which are providing STI/RTI services based on the enhanced syndromic case management. 79 new clinics have been set up in 2011 - 12

NACO has strengthened seven regional STI training, reference and research centres. The role of these centres is to provide etiologic diagnosis to the STI/RTI cases, validation of syndromic diagnosis, monitoring of drug résistance to gonococci and implementation of quality control for Syphilis testing. These centres also provide training to various state reference laboratories to carry out etiologic diagnosis. Safdarjung Hospital, New Delhi acts as the Apex Centre in the country.

Table 5.1: Yearwise Targets vs Achievements of STI/RTI case management

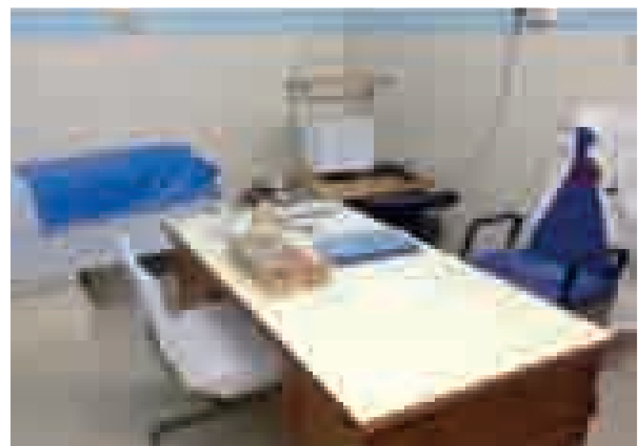
No of STI/RTI episodes treated	2008 - 09	2009 – 10	2010-11	2011-12
Target	100 lakh	100 lakh	100 lakh	120 lakh
Achievement	66.7 lakh	82.4 lakh	100.2 lakh	74.57 lakh*
Percentage achieved	66.7%	82.4 %	100 %	62.1%*

* till January 2012

Infrastructure strengthening of designated STI clinics

The infrastructure and facilities in designated STI/RTI clinics have been strengthened by ensuring audiovisual privacy for consultation and examination and one computer is provided to each of these clinics for data management.

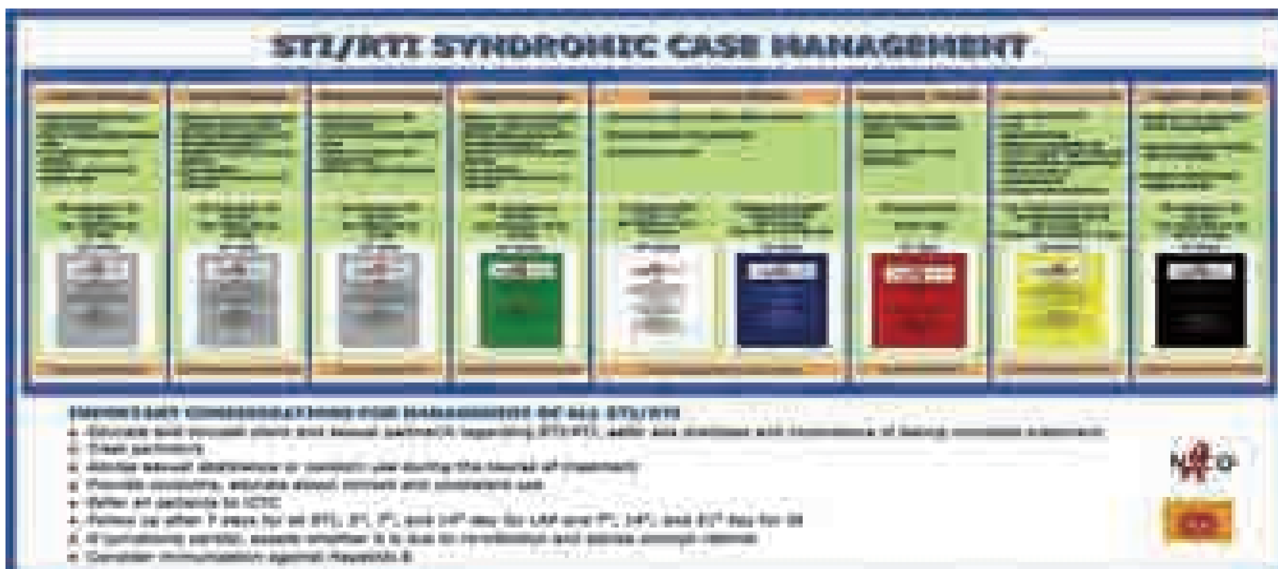
Fig 5.1: View of designated STI/RTI clinic



Appointment of Counselors at Designated STI Clinics

Counseling of STI/RTI patients forms an integral part of the service. To strengthen the counseling and behavior change amongst the STI/RTI patients, one counselor is provided in each of these designated clinics. 955 STI counselors are currently in position. Training material, curriculum and job aids, including posters, flip book and a film on counseling have been developed by NACO. Training for STI counselors has been conducted through 18 identified institutes. Different job aids have been developed to facilitate quality STI/RTI counseling and service delivery (Fig 5.2).

Fig 5.2: STI/RTI Job Aids (flip charts and posters)



Branding of STI clinics & National Communication Strategy on STI/RTI Service Delivery: NACO has branded the STI/RTI services as "***Suraksha* Clinic**" (Fig 5.3) and developed a communication strategy for generating demand for these services. STI/RTI services are being promoted through specially designed TV and radio campaigns to address issues of fear and reluctance in seeking treatment.

Fig 5.3: Brand logo of STI clinics/ Suraksha clinics

Capacity Building of STI/RTI service providers: NACO has trained a cadre of national and state resource faculties across all states in STI/RTI service delivery. All faculty members were trained using the same training material, following adult learning methods, using cascade approach. The state resource faculties in turn conducted training of STI/RTI clinic staff in the public sector. The state and regional resource faculties have trained a total of 7,511 persons in 2009–10 and 5,224 persons in 2010-11 (Table 5.2).

Table5.2: Status of training of Health care providers

Category of Health Care Providers	No. of persons Trained		
	2009 - 10	2010 – 11	2011-12*
STI Clinic Doctors	1,779	1,447	2,771
STI Clinic Paramedical staff	1,263	1,102	1,223
Preferred Private Providers	3,809	2,450	2,069
STI Counselors	660	225	433
Total	**7,511**	**5,224**	**6,496**

* till January 2012

Training of doctors working at NRHM health facilities is also being carried out using a common curriculum, by involving state and regional resource faculty trained by NACO (Fig 5.5).

Fig 5.5: Trainings related activities of health care providers on STI/RTI services,

Besides this, training institutes have been identified in every state to institutionalize STI/RTI related training for various cadres of staff.

Collaboration with NRHM: The physical targets of treating STI/RTI are distributed between NACO supported designated clinics and NRHM supported sub-district health facilities. Convergence has been strengthened through constitution of a joint working group at national level. National technical guidelines and training modules for medical officers and paramedical staff for STI/RTI services have been developed jointly and a joint operational framework has been developed. Colour coded drug kits have now been made available at all CHC and PHC. A Joint training plan has been developed. For training the service providers in CHC and PHC, a resource of 245 faculty was developed through six regional training of trainers workshops. Trained resources at state, regional and district levels provide quality training to medical and paramedical staff at all service sites. A total of 2,275 doctors and 4,296 paramedical staffs (Staff Nurse and laboratory Technician) from PHC and CHC facilities are trained on STI management till December 2011. Data on STI/RTI from designated and sub district health facilities is being collated at NACO from CMIS and HMIS and monitored periodically.

Pre-packed STI/RTI colour-coded Kits: Pre-packed color coded STI/RTI kits have been provided for free supply at all government STI/RTI clinics, CHC/ PHC and TI NGOs (Fig 5.6). These kits have been procured centrally by NACO and dispatched to all SACS and district level consignees, and are being distributed to facilities for use.

Fig 5.6: STI/RTI Colour-coded drug kits

Preferred Private Provider approach has been rolled out to scale up STI/RTI services to HRG population under TI Projects

The provision of a standardized package of STI/RTI services to High Risk Group (HRG) population is an important component of the Targeted Intervention projects. All the HRG population receives packages of services which includes

1. Free consultation and treatment for their symptomatic STI complaints

2. Quarterly medical check-up

3. Asymptomatic treatment (presumptive treatment)

4. Bi-annual syphilis screening

In order to improve the service utilization, local private health service providers preferred by HRG were selected. Under this scheme, all the HRG receives free STI/RTI treatment and the providers receive a token fee of Rs. 50 per consultation.

All NGO staff have been oriented and trained on the approach. Based on the workshop inputs, 3,942 Preferred Private Providers have been identified for the delivery of services. Majority of them have been trained using a standardized curriculum on syndromic case management. Colour coded STI/RTI drug kits have also been made available to these providers for free treatment of sex workers, MSM and IDU, and data collection tools are also provided to them. Service delivery has started in all states and a total of about 1 million HRG have accessed services in 2011 - 12. So far, about 22.6 lakh clinic visits have been made by HRG and 14.3 lakh regular medical checkups have been conducted.

The International Union against STI (IUSTI)'s 12th Global Congress and the Indian Association of STD & AIDS's 35th National Congress were held in Vigyan Bhavan, New Delhi, from 2-5 November, 2011. The theme was 'Promoting Sexual Health: Basic Science to Best Practices' and the event was attended by more than 600 medical experts, researchers, dignitaries and professionals from partner organisations who came together to discuss different aspects of sexual and reproductive health. During the satellite session NACO gave an overview of the STI/RTI prevention and control programme during NACP-III. NACO programme and efforts were lauded by the international audience and experts.

CHAPTER 6

INFORMATION, EDUCATION & COMMUNICATION AND MAINSTREAMING

The main purpose of mainstreaming is to ensure that all stakeholders and agencies, state and non-state, adapt their programmes and policies to address direct and indirect aspects of HIV/AIDS within the context of normal functions of their organisations.

Information, Education and Communication (IEC) activities continued to deal with all programme components of NACP-III. There has also been a shift in the strategy during NACP-III. The focus has shifted to Behavioural Change Communication (BCC) from that of general awareness creation. Such emphasis continued during this last year of NACP-III through intensive folk campaign. The key priorities of communication strategy continued to be:

- Motivate a behavioural change in a cross-section of identified populations at risk, including the High Risk Groups and Bridge Populations;

- To raise awareness levels about risk and the need for behavioural change among the vulnerable and general population, especially among youth and women;

- To generate demand and increase utilisation of HIV/AIDS related health services like usage of condoms, ICTC/PPTCT facilities; and

- To create an enabling environment that encourages HIV related prevention, care and support activities and to reduce stigma and discrimination at individual, community and institutional levels

Red Ribbon Express Project

As a follow-up to encouraging evaluation results emerging from the second phase of Red Ribbon Express (RRE) project of 2009-10, the third phase of the project has been launched on 12 January 2012.

Fig 6.1: RRE inaugural

The evaluation of the Red Ribbon Express–II, showed that 74% of those exposed to RRE knew at least two ways of preventing HIV compared to 45% of those who were not exposed to RRE. Use of cultural programmes and folk dances increased and sustained interest of the audience during outreach activities conducted in conjunction with RRE.

Fig 6.2: Flagging of RRE on National Youth Day

During the third phase, the special exhibition train with messages on HIV/ AIDS and other health issues and a training coach for providing Counseling, testing and other health services will traverse through 23 states halting at 162 stations. Outreach activities are a part of the project - conducted through mobile exhibition vans and folk troupes in areas around the halt stations. Mobile Health Units are also put in operation to cover rural areas with HIV/ AIDS and for providing information on health along with provision for treatment services. Trainings are also undertaken on the train.

Multi-media Campaign: State AIDS control Societies are carrying forward the NACO initiated special multi-media campaigns in all North-eastern states to increase awareness, educate youth on HIV/ AIDS issues and to promote safe behavioural practices. During the campaign, the HIV/ AIDS messages are disseminated through a series of music and sports events in view of popularity of music and sports among the youth of the North-East. To maximize the engagement of communities, a calendar of events and traditional festivals was developed for each state, and IEC activities based on this calendar were undertaken throughout the year. Special effort is made to reach out to the out-of-school youth in the states through youth clubs at district, block and village levels.

Many interesting and culturally appealing activities are undertaken during the Campaign. For example boxing matches in Mizoram and *Shumang Leela*, a traditional theatre, in Manipur are used to disseminate the messages on HIV/AIDS. The campaigns focused on increasing awareness of the routes of transmission and prevention, and reducing stigma and discrimination associated with HIV/AIDS. The music competitions and sports events organized initially at district level, culminated in the state level mega events, which saw huge youth participation. The winners of the music competitions are projected as "youth icons", and they further reach out to people in villages and far flung areas through road shows with messages on HIV/AIDS.

Long format Radio & TV programmes: The State AIDS Control Societies have been conducting various long format programmes like phone-ins and panel discussions on regional networks of All India Radio and Doordarshan.

Mass Media campaigns: During 2011-12, NACO released campaigns on Voluntary Blood Donation, condom promotion, sexually transmitted infections and on stigma and discrimination on AIR, Doordarshan, Cable and Satellite channels and FM radio networks. An annual media calendar was prepared to streamline these campaigns. Evaluation of some of these campaigns had also been conducted. To amplify the reach of mass media campaigns, innovative technologies like dissemination of advertisements in cinema theatres through digital media were also used.

The evaluation of STI mass media campaign indicates higher awareness of STIs among those exposed (93%) compared to those not exposed (82%). Those exposed (93%) said that they will seek STI treatment without embarrassment compared to those not exposed (86%).

The evaluation of Blood Donation campaign indicated that the reach was highest through TV (94.4 %) compared to radio (20.9%) newspaper (12.9 %) and outdoor (2.9 %).

Mid-Media:

Outdoor (Hoardings, Bus Panels, Kiosks): Outdoor is an important activity to increase visibility. Hoardings, bus panels, pole kiosks, information panels, wall writings, panels in trains and in metro trains, etc, are done by the State AIDS Control Societies, Condom Social Marketing Organisations (SMOs) of NACO, TCIF and under Link Workers Scheme. NACO has developed a well coordinated plan involving different agencies to avoid duplication of activities.

A rapid audience appraisal of panels in metro trains indicated the following:

- **Reach**: 90% of the respondents spontaneously mentioned seeing the panel.
- **Benefits of condom use:** 69% respondents said condoms are used for preventing unwanted pregnancy and HIV. 46% were able to recall triple benefit.
- 96% respondents said that they do not feel embarrassed seeing communication/ messages on condom use in public places.

Folk Media and IEC vans: Folk media is a powerful medium of communication to disseminate difficult social messages in rural areas. Integration of messages with local culture helps rural people to relate and respond easily. NACO has been conducting "*Zindagi Zindabaad*" campaign using folk troupes for information dissemination at village level. To strengthen the folk media component, NACO continued the practice of conducting national workshops before rolling out the campaign. 298 participants representing 45 different folk forms from 22 states participated in these workshops. During the workshops, the artistes were trained as master trainers and 144 standardized scripts were developed to ensure uniformity and correctness of the messages in the field. The resource persons and the folk artistes trained at the national workshops facilitated the State level trainings to create a larger pool of the master trainers and trained troupes in the States for further rollout of the programme.

Subsequently, operational guidelines and planning & management protocols were developed to facilitate implementation in the states. District Support Teams (DST), comprising of the organizations and entities working in the field of HIV AIDS, were formed at the district level for effective implementation of the campaign, which encompassed pre-publicity for crowd mobilisation, ground level support and monitoring of performances.

During the first phase of the campaign, a total of 10,692 performances were done across 18 states which reached out to 28 lakh people. The key messages included safe sex, migration, stigma & discrimination, counseling & testing, PPTCT & women issues, blood safety and vulnerability of youth. The national review on phase-I was conducted in October 2011 to discuss the way forward for the subsequent phase of the folk campaign. During phase – II of the campaign another 21,674 folk performances are being implemented.

Materials for interpersonal communication: NACO developed materials for migrants, truckers, STI clinics and Early Infant diagnosis during NACP-III and the soft copies were sent to State AIDS Control Societies for replication. Flip charts, General information booklet, brochures, folders and short films were printed/ prepared by SACS for use at service centers, fairs, exhibitions and for outreach activities such as Red Ribbon Express and in IEC Vans. The materials specially targeting high risk groups have been replicated and disseminated by most of the State AIDS Control Societies. Materials specific to population groups such as truckers, migrants, for OST and STI clinics and on themes like stigma & discrimination etc were also replicated in large quantity by SACS to reach out different population groups.

Special Events: The State AIDS Control Societies organised special events to reach out to the people with messages on HIV prevention, treatment, care and support, on the occasion of the World AIDS Day, the World Blood Donor Day, the National Voluntary Blood Donation Day, the International Women's Day, the International Day against Drug Abuse and Illicit Trafficking and on the National Youth Day.

International Congress on AIDS in the Asia and the Pacific, Busan: At the 10th International Congress on AIDS in the Asia and the Pacific (ICAAP) held in Busan, Republic of Korea, from August 26-30, 2011, an India satellite session was organized on "Accelerating reversal, integrating response: looking ahead". The Indian delegation shared India's Response to HIV/AIDS, on how the India HIV programme managed to contain adult prevalence of HIV at 0.31% and effected decline of 56% in annual estimated new infections. India emphasized the importance of continuing to work towards bringing down infections to zero level.

Fig 6.3: Indian delegation at the ICAAP

SAARC Regional Consultation Meeting on Universal Access for Women & Girls: It was organized by the SAARC Secretariat in Kathmandu Nepal during 17-18 May 2011. NACO contributed to the preparation of SAARC Regional Strategy on HIV and AIDS to provide PLHIV with access to affordable treatment and care, and also the opportunity to lead a normal life—a life of dignity.

Adolescence Education Programme (AEP): This programme runs in secondary and senior secondary schools to build up life skills of adolescents to cope with the physical and psychological changes associated with growing up. Under the programme, sixteen (16) hours sessions are scheduled during the academic sessions in classes IX and XI. The SACS have further adapted the modules after state consultations with stakeholders, such as NGOs, Academicians, psychologists and parent-teacher bodies. The programme is being implemented in 23 states. During 2011-12, about 50,000 schools were covered under the prograrmme. As the follow-up to the suspension of AEP in some states a toolkit was devised and disseminated to these States for training of trainers. Efforts are also on for resumption of the programme in some of these states where it was suspended.

Red Ribbon Clubs (RRCs): The purpose of Red Ribbon Club formation in colleges is to encourage peer to peer messaging on HIV prevention and to provide a safe space for young people to seek clarification to their doubts and on myths surrounding HIV/AIDS. The RRCs also promote voluntary blood donation among youth. Over 13,187 clubs are already functional and are being supported for these activities; this includes 585 RRCs started during 2011-12 (till January 2012).

MAINSTREAMING ACTIVITIES

The main purpose of mainstreaming is to ensure that all stakeholders and agencies, state and non-state, adapt their programmes and policies to address direct and indirect aspects of HIV/AIDS within the context of normal functions of their organisations. It aims to create an enabling environment through policies, programmes and communication. Mainstreaming facilitates the expansion of key HIV/AIDS services through integration with health systems of various stakeholders and design policies, programmes and schemes to support social protection needs of PLHIV and HRG. During the year 2011-12, following efforts were made for mainstreaming HIV/AIDS.

1. NACO supported the Forum of Parliamentarians on HIV/AIDS (FPA), in organising the **National Convention of Parliamentarians, Legislators, Zila Parishad Chairpersons & Mayors on HIV/AIDS** during 4 – 5 July 2011 at New Delhi. More than 800 elected representatives comprising of Parliamentarians, Legislators, Zila Parishad Presidents, Mayors, senior officials from government and international organisation, civil society & community representatives attended the convention. The convention emphasized the role of elected representatives in the effective implementation of the national AIDS response.

Fig 6.4: National Convention of Parliamentarians, Legislators, Zila Parishad Chairpersons & Mayors on HIV/AIDS inauguration by the Hon'ble Prime Minister of India and Hon'ble Chairperson, United Progressive Alliance

Fig 6.5: Lighting of the Lamp at the National Convention of Parliamentarians, Legislators, Zila Parishad Chairpersons & Mayors on HIV/AIDS

1. The convention provided a common platform to Members of Parliament, State Legislators, Zila Parishad Presidents and Mayors for discussions on emerging HIV prevention and policy issues in both rural and urban India.

   The Hon'ble Prime Minister recognised that the response to HIV/AIDS requires a multi-sectoral approach and there should be greater integration of resources in dealing with this problem. He stated that there is no room for complacency, despite the recent successes of the country's AIDS programme. The Hon'ble Chairperson of UPA called for a sustained focus of the AIDS response in providing universal access to medicines and health across the country. "AIDS is not a health issue alone rather it involves all aspects of social, economic and developmental facets".

   The Hon'ble Union Minister for Health & Family Welfare drew attention to the growing need for increasing domestic investments for the AIDS response in the wake of reduced international funding towards AIDS related programmes and reassured the world about India's continuing leadership role in providing high quality ARTs at reasonable cost.

2. **Training of Frontline Workers and other government officials:** As part of the strategy to enhance multi-sectoral responses which ensure meaningful involvement of major stakeholders at grassroots level; trainings with information of HIV prevention, treatment, care & support are prioritised by NACO. About 5.61 lakh frontline workers (AWW, ANM, ASHA), SHG workers, PRI members and personnel from various government departments, representatives of civil society organization and member of public and privates sectors have been trained through State AIDS Control Societies.

3. **Convergence with NRHM**: Strengthening convergence of NACP with the NRHM has been approved by Ministry of Health and Family Welfare and shared with the states for implementation. It emphasizes optimal utilization of existing NRHM resources for strengthening NACP services and vice versa. Key areas of convergence include:

- Counseling of non HIV pregnant women on nutrition, birth spacing and family planning by ICTC counselors
- Training of ASHA on module "Shaping Our Lives"
- Inclusion of HIV screening in routine ANC check up
- Expansion of ICTC and PPTCT services to all 24x7 health facilities
- Incentives to Health Care Providers for conducting deliveries of HIV positive pregnant women in public health facilities
- Training of Family Planning counselors on PPTCT, ANC, STI & nutrition.
- For National STI programme, NACO will continue to monitor & supervise the programme through technical support in training, quality supervision and monitoring access of STI services at facility level and procurement of colour-coded drug kits.
- Establishing district level blood banks with NACO support in equipment and recurring cost for blood collection, testing, matching and transportation and NRHM support for provision of infrastructure & essential manpower
- Strengthening of Health facilities for OST(Opioid Substitution Therapy)

States have started incorporating convergence mechanism in their respective NRHM / NACP Annual Project Implementation Plans.

4. **Tribal action Plan -** Under the first phase of National Folk campaign, tribal districts were covered on priority basis and in five states of Tamil Nadu, Karnataka, Maharashtra, Gujarat and Odisha more than 2000 folk performances have been done in 23 tribal districts of these states. NACO and SACS are working closely with tribal welfare departments of various states as a part of a Tribal Action Plan to implement an HIV/AIDS strategy specifically address vulnerable tribal population.

5. **Greater Involvement of People living with HIV/AIDS (GIPA)** - NACO is committed to promote greater involvement of People living with HIV. With this objective, a GIPA policy and operational guidelines which were approved in principle by the National AIDS Control Board. NACO in all its efforts and in all its campaigns has been advocating zero discrimination. NACO with the support of UNDP also initiated study to assess scope and possibilities of NGO/CSO/PLHIVNetwork led models of livelihoods promotion and suggest a strategy for livelihoods promotion will best suited for PLHIV and those directly affected.

6. **Insurance for PLHIV –** Following the International conference on Mainstreaming HIV/AIDS: Role of Insurance sector organised in February 2011, the matter for inclusion of PLHIV under the insurance has been followed up with Insurance Regulatory Development Authority (IRDA). It had resulted in IRDA issuing a draft exposure draft for providing insurance to PLHIV and to people vulnerable for infection for both life and non-life insurance coverage. The issue is under consideration.

7. **Drop-in-Centres:** NACO continued to support all the existing and efficiently working Drop-in Centres even while a participatory review of the functioning of those DICs, supported for last two consecutive years, was conducted to make recommendations for addressing gaps and redesigning strategies. NACO played major role in finalizing the Research tools, ensuring the participatory nature of review and facilitating coordination.

Fig 6.6: RRE on the run-it goes on

CHAPTER 7

CONDOM PROMOTION

During the initial period, condoms were promoted under the National Family Planning Programme. With the emergence of HIV as a serious health concern, promotion of condom for preventing HIV/AIDS was taken up under National AIDS Control Programme (NACP). With high number of HIV infections transmitted through unprotected sex, significant efforts have been made by NACO to increase the awareness and usage of condoms to prevent the transmission of HIV/AIDS.

Condom Demonstration in UP

Through rigorous efforts under NACP-I & II, significant achievements have been made, in terms of availability of condoms, increasing awareness and promoting condoms use in HIV/AIDS prevention. However, this did not have a significant impact on its use. Given the significant role of condoms in the prevention of STI/HIV infections, the Department of AIDS Control is faced with the challenge of promoting their use for controlling the epidemic. In view of the stagnant growth in condom use, a well focussed national level condom social marketing programme was devised under NACP III.

Condom Promotion through IPC session in MP

NACO-targeted CSMP focuses on ensuring easy accessibility by making it available with non-conventional shops like petrol pumps, barber-shops, wine-shops, PDS shops, *dhaba*, hotel, etc.

The thrust areas under the programme would be to expand the social marketing programmes to saturate coverage in districts characterized by high HIV prevalence and / or high family planning need and to increase the demand for condoms among high risk, bridge and general population. It also works toward minimizing the wastage in free supply of condoms and maximizing its access among the most vulnerable groups.

The desired behavioral outcomes of the programme are to increase consistent use of condoms among men with the non-regular sexual partners and during commercial sex encounters, and among married couples for preventing unwanted pregnancies.

Condom Promotion Activity for Truckers community at Truckers' Halting Point

The supply objectives of the social marketing programme are to:

Increase the retail off take of social marketed condom to 200 crores by 2012;

Increase the number of condom outlets to 30 lakh by 2012;

Increase the accessibility of condoms to make it available within 15 minutes of walking distance from any location; and

Optimise free supply of condoms to reduce wastage.

Targeted Condom Social Marketing programme (CSMP): NACO has successfully implemented 3 phases of Condom Social Marketing Programme. Presently, NACO is implementing the 4th phase of the programme with the assistance of the Technical Support Group on Condom Promotion, comprising experts at national and state level.

Phase I of CSMP was implemented by 4 Social Marketing Organisations (SMOs) in 2008 across 194 high prevalence and high fertility districts of 15 states. The rural coverage was the main focus of the programme.

Phase II of CSMP had been implemented across 294 high prevalence and high fertility districts of 25 states by 6 SMOs. The main focus of the programme was to cover all TI sites and to ensure accessibility of condoms in rural areas.

Phase III of CSMP was implemented in 370 high prevalence and high fertility districts of 26 states by eight SMOs. The programme covered all TI sites and enhanced condoms accessibility by focussing on non-traditional outlets specially falling within hotspots and in rural areas.

Phase IV of CSMP launched by NACO on 1 July 2011, is being implemented in 13 states/UTs by seven SMOs.

Road Show to spread Condom's Triple Protection Benefits

The condom market which had been stagnating for quite some time had shown significant growth. The overall condom usage which was 160 crores in 2006-07 has reached 270 crores in 2010-11, against the NACP III target of 350 crores condom usage per annum by 2012. The number of condoms stocking outlets has also increased from 6 lakhs in 2006-07 to 13 lakhs in 2010-11.

Under the Phase III of CSMP, the total condom sales achieved during July 2010- June 2011 was 52.45 crore pieces against the target of 47.83 crore pieces. It serviced 8.22 lakhs outlets against the target of 7.60 lakhs outlets.

Under the Phase IV of CSMP, the total condom sales target for the SMO is envisaged at 43.8 crores pieces during July 2011 – June 2012. SMOs have already distributed 21.9 crores pieces till Dec 2011. Figures 7.1 and 7.2 show the targets and achievements in various phases of CSMP (the achievements for Phase IV is till December 2011):

Fig.7.1: Achievement in Condom Sales and Outlet Coverage during four phases of CSMP

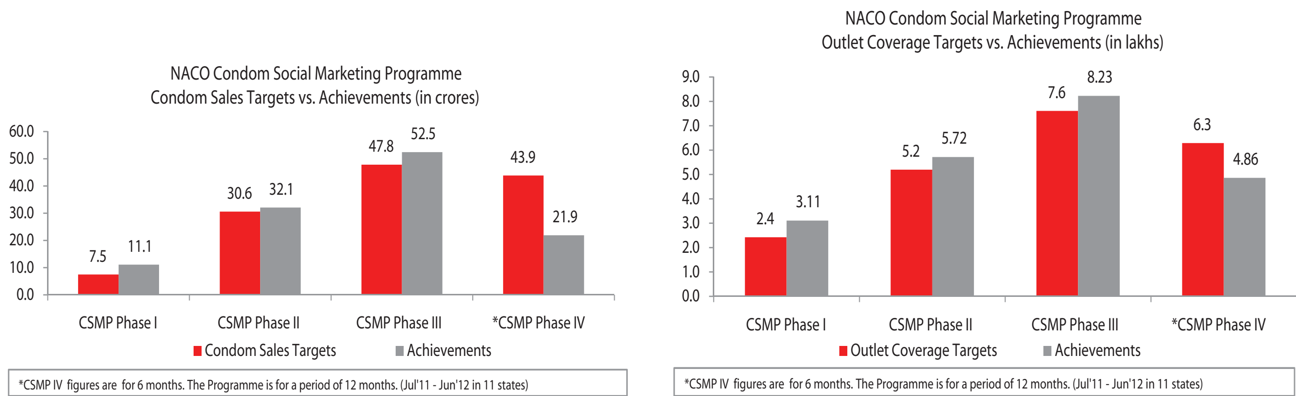
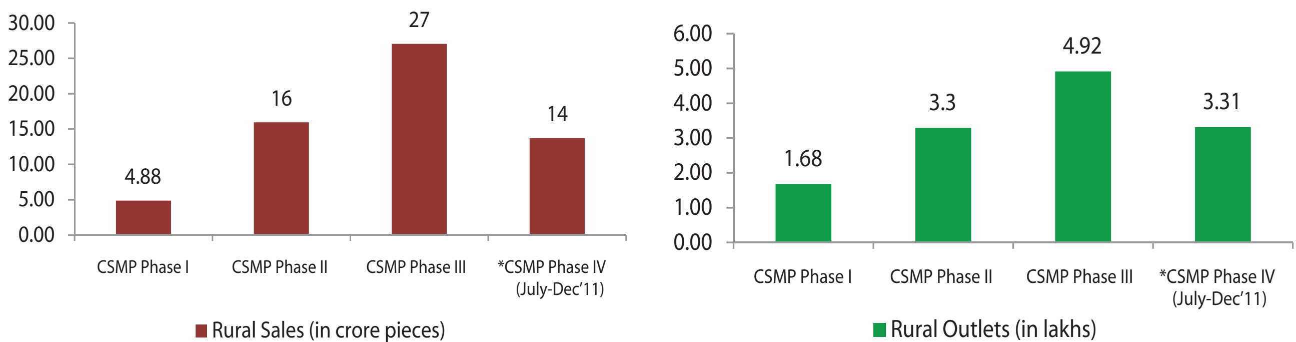
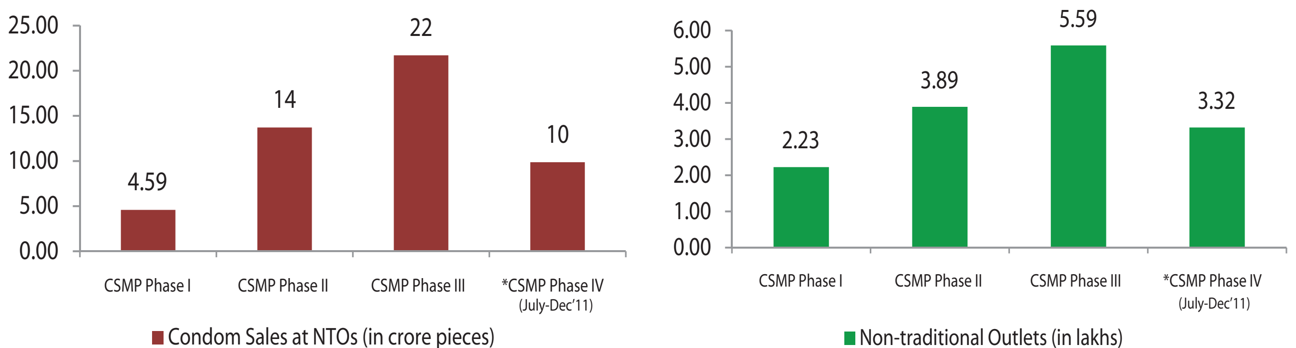


Fig.7.2: Enhancing Condom Use through Condom Social Marketing Programme

Enhancing condom access in Rural India through NACO Condom Social Marketing Programme



Enhancing condom access at Non-traditional Outlet through NACO Condom Social Marketing Programme

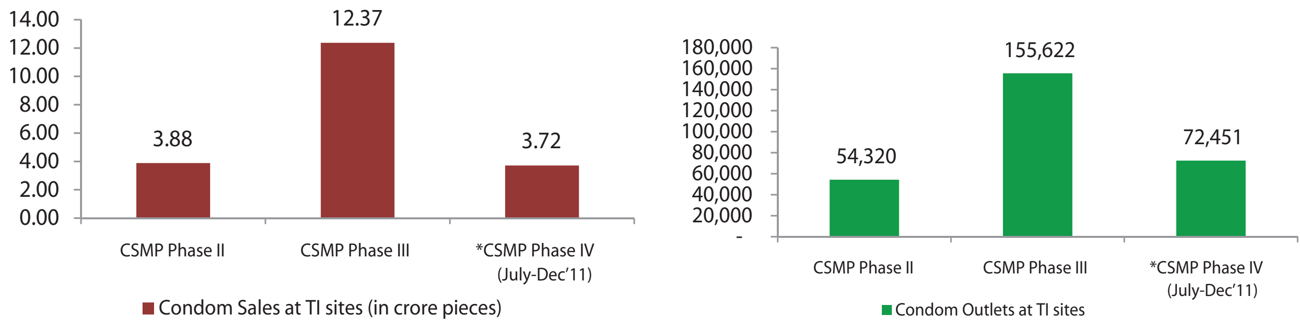


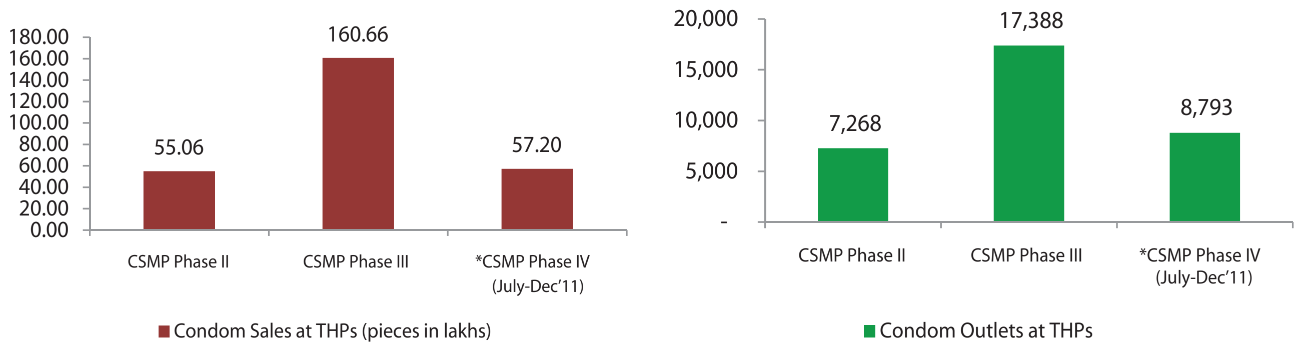
Source: MIS, TSG, NACO

NACO-targeted CSMP focuses on ensuring easy accessibility and hence has gone a step ahead to ensure easy accessibility of condoms in all situations by making it available with non-conventional shops like petrol pumps, barber-shops, wine-shops, PDS shops, *dhaba*, hotel, etc. The coverage and sustainability of non-traditional outlets is increasingly enhanced as they facilitate easy accessibility of condoms in rural and far flung areas.

The programme focuses on saturation of all the high risk areas, i.e., truckers halt points and TI areas (Fig. 7.3). All kinds of condom selling outlets located around these high risk areas are also covered in systematic approach under CSMP phase IV.

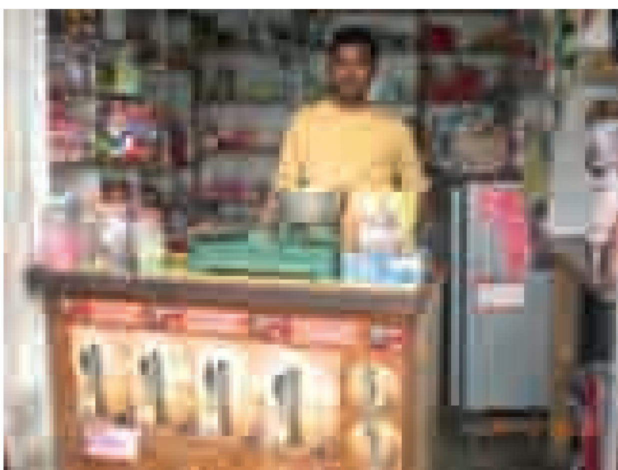
Fig.7.3: Progress in various phases of CSMP in enhancing Condom access at TI sites and Truckers' Halt Points





NACO promoted consistent condom usage by mass media campaign to increase demand. This campaign was based on theme of enhancing risk perceptions and the same theme was used in all forms of condom promotion communications including mid-media activities organized by Social Marketing Organisations.

Non-traditional outlet stocking condom



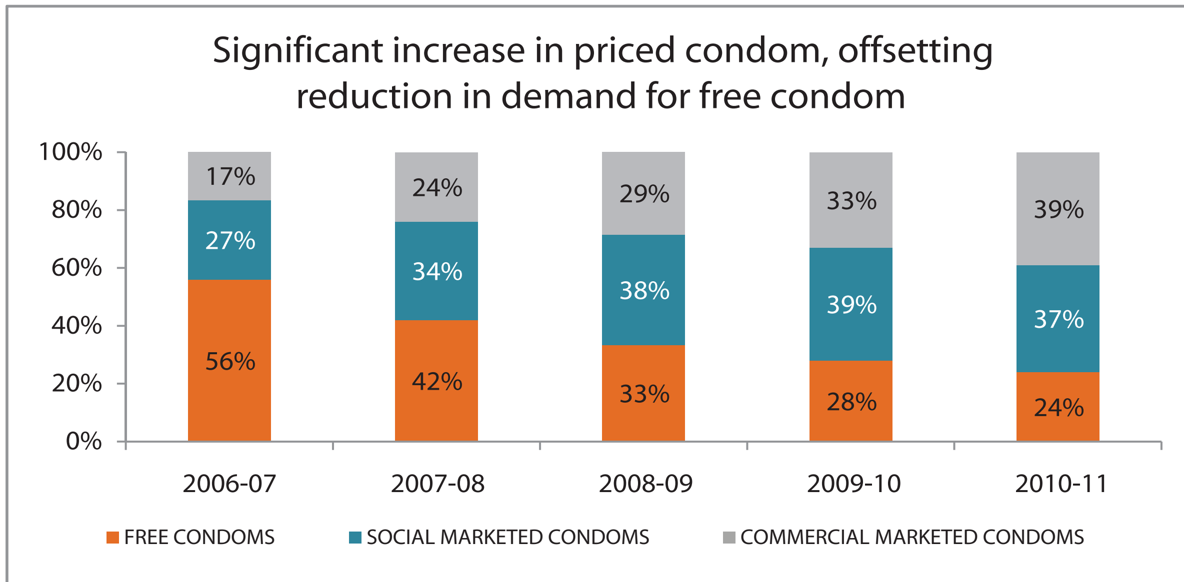
Optimization of Free Supply of Condoms

Another key objective of the NACO condom programme is to optimize the supply of free condoms to ensure availability to the vulnerable population and minimizing the wastage of free condom supply.

The State Marketing Managers under TSG assist respective SACS in calculating annual condom demand based on the coverage of HRGs, past condoms usage trends and the review of the existing inventory of the free condoms at the SACS and all the TI NGOs covered by the SACS. It has led to a significant reduction in the earlier projected estimates of free supply of condom requirements as received from the respective SACS.

Intensive social marketing efforts by NACO supported SMOs also led to the increased availability of socially marketed condoms at outlets situated in and around TI sites which appears to have reduced the demand of free condoms. (Figure 7.4)

Fig. 7.4: Distribution of Condom Promotion by Free, Social Marketing and Commercial Channel, 2006-11 (Source: NACO & MoHFW for free condoms and AC Nielsen for commercial & socially marketed condoms)



This disciplined approach led to the achievement of optimum coverage of free supply of condoms at all the TI sites without any major incidence of stock out positions at SACS and TI NGO sites. Against an annual target of 40.55 crores free condoms distribution, SACS have distributed 28.8 crores free condoms till December 2011.

As in the past, procurement and supply of condoms to SACS under free supply and to SMOs under social marketing continued to be made by Department of Health & Family welfare.

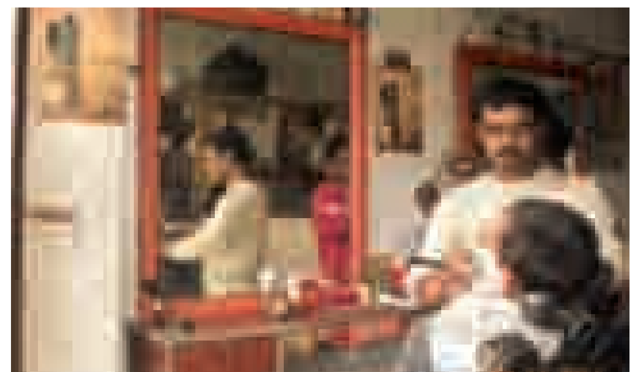
NACO, with the assistance of Condom TSG, has adopted multi pronged strategy to increase the efficiency of distribution system at various stages in distribution chain which includes

Regular tracking of free condom supply received from MoHFW to SACS every month to avoid any stock out situation at SACS.

Free condom supply analysis from SACS to TI NGOs and subsequent distribution of free condoms from various TI NGOs to TG population

Free condom annual demand estimation as done at TI NGO and SACS level based on previous data analysis.

Non-conventional outlets like Barber shop stocking and promoting Condom



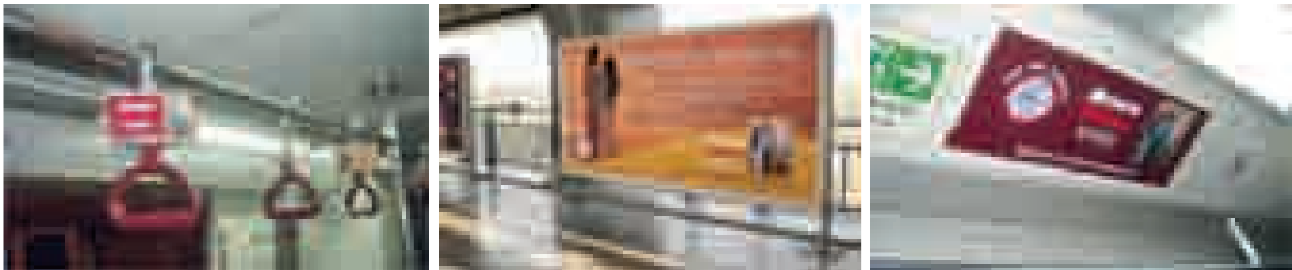
Other Innovative Programmes to Enhance the Accessibility of Condoms

Female Condom (FC) Scale Up Programme: NACO has successfully completed the implementation of phase II of the FC programme in four states Andhra Pradesh, Tamil Nadu, West Bengal and Maharashtra in December 2011. It has reached around two lakh FSWs ensuring 100 percent TI NGOs coverage. The programme focuses on capacity building, training and BCC activities for increasing use of female condoms. In the current phase of FC programme, 22.5 lakh pieces of FC were sold from July 2010 to December 2011.

NACO has also scaled up the FC Programme in nine other states – Delhi, Haryana, Punjab, UP, MP, Assam, Karnataka, Gujarat & Chhattisgarh. This scaled up programme is being implemented in two districts in each of these nine states through HLFPPT.

Communication Activities: Following the NACP-III communication strategy shift from creating awareness to motivating behaviour change, all condom promotion communication activities are developed to focus on to bring in positive behaviour change towards condom use. Various midmedia activities were organized to promote consistent condom use targeting identified key population like High Risk Groups, Bridge Population as well as general population especially in rural areas. These activities are designed to promote condom for its triple protection benefits against HIV/AIDS, STI and unwanted pregnancy. The primary objectives of these activities are to normalize the condom use and create an enabling environment that encouraged consistent condom use.

Display panels in Delhi Metro Rail & Stations promoting Condom



NACO ensured that in all mid-media activities organised by Social Marketing Organisations (SMO), condom as a generic product or Deluxe Nirodh brand is promoted under CSMP phase IV. In continuation with the previous phase policy, all SMO were given preset mid media contacts/ targets. This target was set for each state to ensure that SMO reach out to stipulated numbers of audience with the help of mid-media and communication activities promoting condom use. These condom promotion activities are organized in various forms viz. street plays, road shows, IPC and condom demonstrations etc. to make contacts with the target populations, motivate them to change behaviour for adopting condom use and thereby generate demand.

Condom Promotion through Folk Troupe performance and Condom Demand Generation Activity at Rural Mela Stall

Various trade promotional activities and schemes are also conducted to motivate retailers and suppliers to stock condoms. They are guided and encouraged to help normalize condom purchase by the consumer. Training sessions and discussions are also organized to understand their issues and concerns related to condom supply and distribution.

Promoting condom use by enhancing risk perceptions:

In phase-IV, NACO continued with condom promotion campaigns that were aimed at enhancing risk perceptions among target consumers. In this direction, a campaign was launched that was aired on television (Doordarshan and leading Cable & Satellite channels) as well as radio (All India Radio and private FM channels). This campaigns of 4-week duration was released in January 2012 on national scale in Hindi and other regional languages.

Street Play performance among Rural Audience

Programme Monitoring

Over last four years, the Technical Support Group has evolved a strong system to monitor the national condom social marketing programme using the following:

Central web based online monitoring system

Continuously tracking condom market dynamics

Periodic reviews of Social Marketing Organizations

Central Web Based Online CSM Programme Monitoring System: The web-based online reporting system introduced during the CSMP Phase-III, helps to monitor the progress of field level activities using a excel file based system to compile the monthly reports.

Continuously Tracking Condom Market Dynamics: The data on volume, outlet coverage and store coverage from the AC Nielsen's condom retail off take data is analyzed for universe of condom stocking outlets, brand penetration, market share and trends to further inform implementing partners to streamline supply related strategies.

Periodic reviews of performance of CSMP implementing SMOs: Periodic reviews of SMOs were organized to review the performance of the SMOs against the deliverables, resolve issues impacting programmme and promote replication of good practices among SMOs. The reviews help in building greater coordination/synergy between TSG and SMOs.

Condom Promotion through Road Show

Condom Promotion Slogan at TI Site in Maharashtra

'Condom Man' during Red Ribbon Express launch in Delhi

Table 7.1: NACO CSMP Performance of Social Marketing Organisations in Phase-IV (July 2011 - December 2011)

SMO	State	Total Condom Sales			Total Outlet Coverage			Communication		
		Annual Target	Achievement		Annual Target	Achievement		Annual Target	Mid Media contacts achievements	
			No.	%age		No.	%age		No.	%age
PSI	Andhra Pradesh	1,69,00,000	69,90,355	41%	36,400	22,696	62%	34,05,350	9,92,368	29%
	Delhi	1,54,80,140	89,17,782	58%	13,650	10,623	78%	4,87,500	1,51,346	31%
	Madhya Pradesh	4,36,67,000	2,17,37,454	50%	47,190	33,766	72%	19,63,260	7,10,044	36%
	Rajasthan	2,85,40,070	1,46,17,765	51%	44,720	31,346	70%	16,56,694	4,75,333	29%
JA-NANI	Bihar	3,83,50,000	1,82,41,713	48%	77,350	68,569	89%	31,13,224	19,47,520	63%
HLL	Punjab, Haryana & Chandigarh	3,40,66,500	1,32,96,554	39%	20,205	18,686	92%	8,67,100	4,38,613	51%
PCPL	Chhattisgarh	1,18,92,192	53,64,815	45%	17,722	7,418	42%	5,63,060	1,88,243	33%
HLFPPT	Uttar Pradesh	17,68,08,190	9,97,49,096	56%	2,40,500	1,89,901	79%	63,51,280	32,83,751	52%
PSS	West Bengal	3,80,98,970	83,26,347	22%	70,876	36,397	51%	27,67,700	19,59,053	71%
PHSI	Goa	25,35,000	621,177	25%	1,690	1,005	59%	67,340	40,973	61%
	Jharkhand	1,33,70,500	44,98,861	34%	13,130	7,601	58%	9,10,000	3,66,615	40%
	Total	**41,97,08,562**	**20,23,61,919**	**48%**	**5,83,432**	**4,28,008**	**73%**	**2,21,52,508**	**1,05,53,859**	**48%**

Table 7.2: NACO CSMP Performance of Social Marketing Organisations in Phase-IV (July 2011 - September 2011)

SMO	State	Total Condom Sales				Total Outlet				Mid-media			
		Annual Target	3 Months Target	Achievement		Annual Target	3 Months Target	Achievement		Annual Target	3 Months Target	Mid Media contacts achievements	
				No.	%age			No.	%age			No.	%age
PSI	Karnataka	2,29,19,520	57,29,880	61,32,107	107%	41,860	10,465	14,959	143%	24,05,000	6,01,250	1,87,153	31%
	Odisha	1,55,61,520	38,90,380	40,62,620	104%	31,504	7,876	16,333	207%	11,73,250	2,93,313	-	0%
	Tamil Nadu & Puducherry	1,82,27,560	45,56,890	41,05,497	90%	58,435	14,609	16,326	112%	28,05,628	7,01,407	3,05,652	44%
PHSI	Kerala	1,13,41,070	28,35,268	9,01,669	32%	17,875	4,469	1,870	42%	11,16,050	2,79,013	93,632	34%
	North East	71,63,000	17,90,751	14,26,774	80%	31,753	7,938	8,941	113%	6,65,470	1,66,368	69,718	42%
	Total	**7,52,12,670**	**1,88,03,168**	**1,66,28,667**	**88%**	**1,81,427**	**45,356**	**58,429**	**129%**	**81,65,398**	**20,41,350**	**6,56,155**	32%

CHAPTER 8

BLOOD SAFETY

Ensuring that the regular (repeat) voluntary non-remunerated blood donors constitute as the main source of blood supply through increase in donor recruitment and their retention is a generalised goal.

The objective of the Blood Safety Programme under NACP-III is to ensure provision of safe and quality blood even to far-flung remote areas of the country in the shortest possible time, by a well-coordinated National Blood Transfusion Service. The specific objective is to ensure reduction in the transfusion associated HIV transmission to less than 0.5 per cent.

This is proposed to be achieved through the following four-pronged strategy:

- Ensuring that the regular (repeat) voluntary non-remunerated blood donors constitute the main source of blood supply through phased increase in donor recruitment and retention.
- Establishing blood storage centres in the primary health care system for availability of blood in far-flung remote areas.
- Promoting appropriate use of blood, blood components and blood products among the clinicians.
- Capacity building of staff involved in Blood Transfusion Service through an organised training programme for various categories of staff.

Current Scenario

Access to safe blood is the primary responsibility of NACO. As on January, 2012, it is supported by a network of 1,149 blood banks, including 171 Blood Component Separation Units (BCSU) and 28 Model Blood Banks. NACO has supported the installation of BCSU and also funded modernisation of all major blood banks at state and district levels. Besides enhancing awareness about the need to access safe blood and blood products, NACO has supported the procurement of equipment, test kits and reagents as well as the recurring expenditure of government blood banks and those run by voluntary/charitable organisations, which were modernized.

During 2011-12 (till January 2012), 72.7 lakh blood units were collected across the country. NACO supported Blood banks collected 40.12 lakh units; 83.1 % of this was through voluntary blood donation.

Practice of appropriate clinical use of blood amongst the clinicians has seen a definite rise due to the dengue epidemic, and training of clinicians on the rational use of blood. The proportion of blood components prepared by the BCSU was 20%in 2007-08, which rose to 41.1% in 2009-10 and 45.2% in 2010-11. At present it is 47.3% across the country.

In order to streamline blood transfusion services in the country, National and State Blood Transfusion Councils (SBTC) were established as registered societies. These councils are provided with necessary funds through NACP. While the National Blood Transfusion Council provides policy direction on all issues concerning to blood and related areas, its decisions are implemented by the State Blood Transfusion Councils.

Collection

Voluntary Blood Donation Programme

It has been recognised worldover that collection of blood from regular (repeat) voluntary non-remunerated blood donors should constitute the main source of blood supply. Accordingly, activities for augmentation of voluntary blood donation have been taken up as per "Operational Guidelines on voluntary blood donation".

In the year 2006-07, voluntary blood donation (VBD) was 54.4% which was the baseline for NACP-III. It increased to 59.1% in 2007-08, 61.7 % in 2008-09 and further to 74.1% in 2009-10 against the NACP-III target of 90%. During the year 2010-11, the percentage of Voluntary blood donation was 79.4% against the target of 80%. In the present scenario it has improved to 83.4%. Several activities to promote public awareness of the need for voluntary blood donation have been undertaken in collaboration with Red Cross and various Blood Donor Organisations. District-wise training programmes are running in the states to train the motivators and sensitize them. To augment VBD in the country, specific strategies were formulated for the entire country. These activities are carried out, through collaboration with these organizations, voluntary blood donation camps and other activities are regularly undertaken to increase blood collection in the country. TRG meeting was held in the month of January 2012 to target the issues related to the VBD programme. Ministry of Youth affairs, Ministry of Higher Education, and Ministry of Defence, Ministry of sports, NYKS, NSS, NCC, NGOs and others participated in the meeting. Donor motivation training modules have been developed and approved by the TRG and training of trainers have been done. The States of West Bengal, Maharashtra, Tamil Nadu, Gujarat, Tripura, Mizoram, Chandigarh Chhattisgarh, Haryana, J&K, Jharkhand, Kerala, Madhya Pradesh, Nagaland Puducherry, Sikkim, and Himachal Pradesh have crossed the national target of over 80% and are Good Performing States in voluntary blood donation. The states of Assam, Bihar, Delhi, Manipur, and Meghalaya are low performing states with voluntary blood collection much below the desired target. Steps are being taken to augment the donation in these states through the involvement of various stakeholders like Indian Red Cross Society, *Nehru Yuva Kendra Sanghatan* (NYKS), National Service Scheme (NSS), National Cadet Corps (NCC) and NGOs. New improved Trainings modules for VBD were developed by NACO and approved by TRG.

Scheme for modernisation of blood banks: NACP is implementing a scheme for modernization of blood banks by providing one time equipment grant for testing and storage, as well as annual recurrent grant for support of manpower, kits and consumables.

District level Blood Banks: During NACP-I and NACP-II, blood banks in all districts of the country were taken up under the scheme for modernization of blood banks, except those in the newly created districts. During NACP-III, 39 newly created districts were identified which did not have blood banks. NACO has taken the initiative with the concerned State Health department for setting up a blood bank in these districts. In these newly created districts, 25 blood banks have been made operational. In 6 districts construction of the building for blood banks is complete and steps are being taken to meet the requirements for a licence. In eight districts, blood bank buildings are under construction. Instructions have been issued by NACO to the respective SACS to set up a Blood Storage Centre in these districts till the new blood banks become operational.

Blood Component Separation Units: In order to promote rational use of blood, 82 BCSU have been established during NACP-I & II.

Installation of essential equipment procured for 80 BCSU has been completed. 77 Blood Banks have got the licence for operating as component separation units. The remaining blood banks have applied for a licence and are liaisoning with their respective State Drug Authorities for obtaining it.

Model Blood Banks

Under the NACP-II, 10 Model Blood Banks were developed in 8 under-served States, to improve upon the standards of blood transfusion services. These Model Blood Banks are expected to function as demonstration centres for the State in which they are being set-up.

The NACP-III target is to upgrade the existing 22 blood banks in the remaining States/UTs to Model Blood Banks, preferably in the State Capital. Identification of the blood banks was done by SACS and approval for the same has been obtained from the NACB. An MoU has been signed between the concerned State Government and NACO for the terms of reference in establishing these Model Blood Banks. NACO has deputed a team of technical experts to visit these banks for making a pre-assessment of the facilities available for upgrading them to a Model Blood Bank.

In 2009-10, 16 blood banks have been upgraded to Model Blood Banks, with all infrastructure facilities manpower and licenced for preparation of blood components. NACO has initiated the procurement of essential equipment earmarked for these 16 blood banks. Upgradation of the remaining blood banks was initiated in 2010-11. As on January 2012, 28 Model blood banks are functioning. A state of art blood mobile has been issued to each model blood bank to improve Voluntary collection in the states.

DISTRIBUTION

Blood Storage Centres: In order to make safe and quality blood available in these First Referral Unit (FRU) where setting up a licensed blood bank is not feasible, Government has taken the initiative of setting up blood storage units. NRHM and NACO have started a joint programme to have Blood Storage Units in the FRU. NRHM will provide the requisite infrastructure, manpower and procure the necessary equipment for storage and issue of blood. NACO was providing an annual recurring grant of Rs. 10,000 for procurement of consumables to link the centre to the nearest Regional Blood Transfusion Centre (RBTC) for supply of screened blood on a regular basis, and to train the staff attached to the storage centres in NACP III.

It has been proposed to establish 3,222 blood storage centres in the identified FRU during NACP-III. A target of 512 storage units was planned to be made operational by the end of 2009-10, of which 440 were made operational during 2009-10. During 2010-11, 245 and during 2011-12, 77 more blood storage centres were established. Thus presently 752 Blood storage centres are functional.

Blood Transportation Vans: Blood needs to be transported under proper cold chain maintenance from the linked RBTC to the Blood Storage Centre (BSC). Each RBTC will be linked to 6-8 BSCs. In order to supply blood units under proper conditions and storage, NACO has taken the initiative to provide 500 refrigerated Blood Transportation Vans to the RBTC/District Blood banks during NACP-III. These vans transfer blood units to the BSC on a regular basis and also on demand/emergency situations. During 2009-10, procurement of 250 Blood Transportation Vans and 1,000 Blood Transportation Boxes (four Blood Transportation Boxes and one Blood Transportation Van is considered One Unit) was initiated. The delivery of the Vans with Boxes has already commenced. The blood transportation vans are functioning well. Blood is collected from VBD camps in these vans and brought to mother blood bank for processing; after processing blood is being transported in these vans from mother blood bank to storage centre's in FRUs so that the blood is available in the far flung areas.

CAPACITY BUILDING

Blood Safety Training Programme: Education and training is fundamental to every aspect of blood safety. Many of the factors threatening safety of the national blood supply can be attributed, in part, to inadequate training.

The blood safety training programme aims to:

- Strengthening national capacity in education and training in all aspects of blood transfusion; and voluntary blood donation.
- Support the establishment of sustainable national education and training programmes in blood transfusion;
- Strengthen inter- and intra-regional collaboration in training in blood transfusion between NACO and its Collaborating Centres, national blood

transfusion services, education and training institutions and NGOs.

NACO has developed a uniform training curriculum for all aspects of blood transfusion. 17 centres have been identified across the country to impart training on all aspects of blood safety involving Blood Bank Medical Officers, Technicians, Counselors, Nurses, Clinicians, Donor Motivators and Programme Officers of SACS. During the year 2011-12 668 Medical officers, 1000 lab technicians, 261 nurses and 7397 donor motivators were trained till Jan 2012.

Quality management training module was developed at NACO and the trainings for quality management have been started in the month of Jan 2012. Till now, 5 regional trainings have been completed successfully.

Training of Trainers was conducted for the newly developed Voluntary Blood Donation training module.

PROGRAMME MANAGEMENT

Quality practices in blood bank activities can be improved by strengthening the monitoring and evaluation system. With a large network of blood banks and Blood Component Separation Facilities in the country, it is essential to supervise various activities undertaken, both, in blood banks as well as voluntary blood donations at different levels.

Supervisory Visits to NACO supported Blood Banks: A core team has been constituted in every state to carry out the inspection of all blood banks and voluntary blood donation camps. This core team comprises four members, which includes one Blood Safety Official of SACS, Director of State Blood Transfusion Council (SBTC), and one nominated expert in the field of Transfusion Medicine and a member of State Drug control. The team makes periodic supervisory visits to the blood banks in their state, to assess the functional status and prepares reports identifying various constraints and the methods to rectify them. Officials of NACO also undertake supervisory visits to blood banks to each State to inspect the quality checks, functional efficiency, identify crisis, and to verify the facts as reported (checking of the maintained records).

During the assessment of these blood banks, the following short-comings and deficiencies were identified:

- Lack of proper infra-structure and facilities
- Lack of manpower
- Frequent transfer of trained manpower to other departments
- Accessibility, adequacy, safety and quality not satisfactory
- Absence of Quality Management System
- Lack of standardization. Proper inventory of equipment, kits and consumables, not maintained
- Improper Record keeping and documentation

These issues have been taken up with PD and JD (BS) at SACS level.

NEW INITIATIVES

Setting up of Metro Blood Banks as Centre of Excellence in Transfusion Medicine

To improve the blood transfusion services in the country, a proposal to set up four Metro Blood Banks as Centres of Excellence in transfusion medicine in the cities of New Delhi, Mumbai, Kolkata and Chennai, has been approved. These banks will have State of the Art facilities with 100% Voluntary Blood Donation, 100% blood components preparation, and a capacity to process more than 100,000 units of blood annually. State Governments of Delhi, Maharashtra, Tamil Nadu and West Bengal have identified land for the construction of these centres. Design DPR Consultants for these sites have been identified to initiate work. Lay out plans and detailed Project report have been received for all four sites. Equipment requirement plans, bilateral agreement drafts are prepared and document for municipal approval are being obtained. DPR-1&2 has been approved by the Steering Committee for all sites except Delhi.

Plasma Fractionation Centre: Under NACP-III, one Plasma Fractionation Centre with a processing capacity of more than 1,50,000 litres of plasma, which can fulfill the country's demand has been proposed. A large volume of excess plasma in the country is being discarded, as there is no such centre in the public sector in the country. The Government of India has approved the project in 2008. The State Government of Tamil Nadu has provided land to NACO for the purpose.

CHAPTER 9

LABORATORY SERVICES

Laboratory services are not confined to HIV testing, but are overarching and have an impact on other interventions included under prevention, care, support and treatment, STI management, blood safety, procurement and supply chain management

Laboratory services function at the cross cutting interface of all other divisions. It is recognized that work related to laboratory services are not confined to HIV testing, but are overarching and have an impact on other interventions included under prevention, care, support and treatment, STI management, blood safety, procurement and supply chain management. Emphasis on quality assured laboratory service delivery is important to the success of the programme. Universal availability and routine access to quality assured HIV related laboratory services is ensured in all service delivery points through this division.

The assurance of quality in kit evaluation, assessment of HIV testing services through implementation of External Quality Assessment Scheme (EQAS), CD4 testing has been addressed in NACP-III with focus. NACO launched "National External Quality Assessment Scheme" (NEQAS) in year 2000 to assure standard quality of the HIV tests being performed in the programme. The scheme aims to:

- Monitor laboratory performance and evaluate quality control measures
- Establish intra laboratory comparability and ensure creditability of laboratory
- Promote high standards of good laboratory practices
- Encourage use of standard reagents/ methodology and trained personnel
- Stimulate performance improvement
- Influence reliability of future testing
- Identify common errors
- Facilitate information exchange
- Support accreditation
- Educate through exercises, reports and meetings.
- Assess the performance of various laboratories engaged in testing of HIV which will be used for finalising the India specific protocols.

Technical Resource Group and Standardization of Services

To ensure the above, a Technical Resource Group (TRG) was formed for Laboratory Services in December 2006. A revised pattern of assistance was suggested by the experts and action plan for 2007-08 was formulated. At its first meeting in June 2007, the critical areas for quality and relevant laboratory issues for the Programme were discussed. The TRG was reconstituted in 2010 and has discussed issues in laboratory services like quality of testing, Early Infant Diagnosis (EID) guidelines, HIV viral load testing platforms, sharing of reports of National Reference Laboratory (NRL) and State Reference Laboratory (SRL) assessments, review and discuss strategy of testing and formulate interim guidelines for HIV-2 testing till formal guidelines can be made looking at the results of planned operational research.

Capacity Building: Thirteen regional training workshops have been conducted to impart training on equipment management, calibration and waste management to the technical officers from SRLs and faculty from Microbiology departments with PCI/CDC support. 25 laboratories were provided calibration equipment through CDC.

The laboratory services division has conducted TO training workshops and addressed quality issues, details of Standard Operative Procedures (SOPs) and preparation of quality manual as a step towards National Accreditation Board for Testing and Calibration Laboratories (NABL) accreditation. As a result of the same, 7 NRLs and 2 SRLs have got accreditation for HIV testing by the NABL. 3 NRLs and 8 SRLs are in the cycle of accreditation.

ICTC/CD4 Training: The division is involved in on site supervision of trainings of Laboratory Technicians as per NACO norms and monitors modules for the same.

CD4 Testing: There are 213 CD4 machines installed at present serving 324 ART Centres. These include 112 FACS Count machines, 29 Calibur machines, 67 Partec machines and 5 Guava machines. All machines procured by NACO are under warranty or maintenance. At present 50 new machines have been procured and nearly 25 have been installed and training completed. During 2011-12, about 8,99,756 CD4 tests have been performed till December 2011.

CD4 training institutions were identified in 2009 to systematize the training of Laboratory Technicians in ART centres. A training of trainers (TOT) was held in May and June 2009 for CD4 machine technicians and in-charges. A regional capacity building of four institutions for Calibur machines (GHTM Tambaram, STM Kolkata, NARI Pune, and PGI Chandigarh), five institutions for Count machines (Vishakapatnam,NARI, MAMC, RIMS, CMC) and six institutions for Partec machines (Surat, Trichy, Kakinada, Davangere, Lucknow, Medinapur) has been done. Faculty of these institutions has been trained and is imparting further training. All technicians at ART centres are retrained at these institutions every year. Training plan has been developed in consultation with the respective manufacturer and NARI, Pune which provides technical expertise along with the resource persons for the same. Training of trainers was held for five days regionally and the regional training is ongoing for three days for FACS Calibur & Partec and two days for FACS Count. About 230 ART Laboratory Technicians operating these machines have been trained from April to December 2011.

CD4 EQAS: NACO with support from Clinton Foundation decided to initiate the development of National CD4 EQAS for Indian CD4 testing laboratories in 2005. National CD4 estimation guidelines were prepared in 2005. NARI functions as an apex laboratory for conducting the EQAS. QASI (an international programme for quality assessment and standardization for immunological measures) relevant to HIV/AIDS, is a performance assessment Programme for T lymphocyte subset enumeration. The technology transfer workshop was conducted for four regional centres at NARI in Sep 2009. Subsequently, an Indian database, *India. qasi-lymphosite* was developed and piloted in the proficiency round (Sep-Oct 2009) for data entry, online submission analysis and report preparation. Presently, 175 CD4 testing Centres are enrolled for EQAS.

Quality Assurance: The programme has emphasized on quality practices in the regional workshops and documentation of EQAS. A reporting format has been developed in consultation with the M&E division.

Internal Quality Control Procedures: The Programme is supporting the workshops of NRLs and SRLs for ensuring accurate record maintenance and optimal use of controls both positive and negative on a day to day basis. Instructions for preparation of QC sample have also been reiterated to all concerned laboratories. NRLS are preparing

the sample as per guidelines and sending to SRLs which will be further aliquoting for use at the peripheral testing sites.

External Quality Assessment Scheme (EQAS):

- NEQAS categorised the laboratories into four tiers, as follows:
    - Apex laboratory (**first tier**) - National AIDS Research Institute, Pune
    - Thirteen National Reference Laboratories (NRLs) located in all parts of India undertake EQAS in their respective geographical areas including apex (**second tier**).
    - State level: 118 State Reference Laboratories (SRLs) (**third tier**)
    - Districts level, i.e., all ICTC & Blood banks.
- Thus, a complete network of laboratories has been established throughout the country.
- Training of Apex and NRLs was completed in the first phase, followed by SRLs in the second phase and now ICTCs and blood banks in the ongoing third phase.
- Annually, two workshops are to be held at each level up to the SRLs.
- At present financial support under NEQAS program, to Apex laboratory is Rs 24.48 lakhs per year inclusive of NRL grant. The other 12 NRLs, excluding Apex Laboratories, have been provided Rs. 6.54 lakhs per year and each SRL has been given a grant of Rs. 4.44 lakhs this year.

Each NRL has been allotted designated states which are monitored by it and in turn each NRL has SRLs for which it has the responsibility to train and supervise. Each SRL, in turn, has ICTC and blood banks which it monitors. EQAS calendar for the year 2011-12 was prepared and shared with the concerned labs. One Technical Officer at each SRL is supported by funds from NACO to facilitate supervision, training and continual quality improvement in all SRLs and linked ICTCs.

Apart from the above financial assistance, NCDC Delhi; NICED Kolkata and NIMHANS Bangalore, which have been identified for panel preparation and quality assessment of HIV, HCV and HBV kits along with the Apex lab, have been provided an additional funding of Rs.9 lakhs for the above activity in addition to the NRL grant. These laboratories form a part of the consortium developed by NACO for kit evaluation.

Assessment of Standards: A level-2 check list was prepared based on the checklist prepared by CDC/WHO/CF which was used for assessment of all 118 SRL after modification suited to the programme. This activity was done to look at the quality of the laboratories. The first cycle of such an assessment took place in 2009 with support from CDC and other development partners The results of the assessment were disseminated to the concerned laboratories and follow up activities to improve their standards have being undertaken. A further assessment was done of the National Reference labs from May to July 2010 as per NABL standards and labs are being reviewed accordingly. A complete reassessment of all 118 laboratories initiated in December 2011, is expected to be completed in March 2012 following which a gap analysis will be done.

Rolling Out Viral Load Testing to Support Second Line ART – 2008: The Viral load (VL) assays are provided for patients failing first line anti-retroviral therapy. NACO piloted VL testing at two centres for 10 months from January 2008. Currently there are nine viral load labs, supporting clinical decision-making at 10 second line centres and ART plus centres for patients estimated to transit to second line therapy. Existing equipped testing laboratories were identified for viral load testing and consent of the labs for participation in the national programme was taken. Viral load laboratory experience training was done at Bangkok in December 2007. During 2011-12, about 2,305 PLHIV underwent viral load testing till December 2011.

National Programme on Early Infant/Child under 18 Months Diagnosis:

Addressing HIV/AIDS in children especially infants below 18 months is a significant global challenge. HIV-infected children are the most vulnerable and frequently present with clinical symptoms in the first year of life. Where diagnostics, care and treatment are not available, studies suggest that 35% of infected children die in the first year of life, 50% by the age of two and 60% by the age of three. A critical priority in caring for HIV-infected infants is accurate and early diagnosis of HIV. With the tremendous expansion in HIV programme in PPTCT, ICTC, ART (for adults and children) including access to Early Infant Diagnosis (EID) for HIV testing of infants less than 12 months old – it is now possible to ensure that HIV-exposed and infected infants

and children get the required essential package of care.

Objectives of providing care for HIV exposed infant and children are:

1. To closely monitor HIV-exposed infants and children for symptoms of HIV infection;
2. To prevent opportunistic infections by providing Co-trimoxazole prophylaxis to all HIV-exposed infants from 6 weeks of age;
3. To identify HIV status early through early diagnosis of infant/child and final confirmation of HIV status at 18 months by HIV antibody test;
4. To provide appropriate treatment including ART as early as possible; and
5. To reduce HIV related morbidity and mortality and improve survival.

These objectives are proposed to be achieved through following strategies:

- Integration of early infant diagnosis by HIV-1DNA PCR testing into the Care, Support and Treatment Services.
- Availability and accessibility for the HIV testing by DNA PCR test for the children below 18 months at all the ICTC centres (by Dried Blood Spot) and at the all ART Centres by Whole Blood Sample. Nationwide coverage will be done in phased manner.
- Infant HIV testing algorithm to be universally followed and implemented on every HIV exposed infant to ensure equal and routine access
- Linkage of the Exposed and infected infants to appropriate referral and care and treatment services to ensure timely intervention to reduce infant morbidity and mortality due to HIV infection.

Training on dried blood spot (DBS) and Whole blood (WB) sample collection, storage; transportation and packaging for the National Early Infant Diagnosis (EID) roll out by HIV DNA PCR testing was completed during June-September 2009, using training materials developed by NACO. NACO with Clinton Foundation has trained 1,088 ICTC and 217 ART Centres, i.e., approximately 3,000 doctors, nurses, and lab technicians across 26 states. NACO designed a vast sample transport network that would ensure timely specimen pick up, testing and report delivery between the 949 specimen collection centres and seven testing labs (already equipped with basic PCR facilities) and have been trained for the above. NACO developed ICTC-ART centre linkages for child referral for whole blood collection. Retraining was completed in all these centres. The same has been in operation in 1088 ICTCs & 217 ART Centres across 26 states. During 2011-12, 6,927 HIV exposed infants and children less than 18 months of age have been tested under this programme till January 2012.

Development of Systems for Reporting and Investigating 'exceptions': A system of reporting the panel results has been developed where the SRLs report the discordant test results along with the name of the testing centre which is giving discordant results for corrective action and the same is conveyed to the respective NRLs. The same is done at the NRL level where the SRLs are assessed and the final report is compiled at the Apex lab which is shared with NACO annually. In case there are exceptions where a batch of kit is found to be performing suboptimally, the in-charge of the ICTC is to look into the matter and prepare a detailed report which is communicated to the respective SACs. The manufacturer along with NACO and the licensing authorities are informed for further necessary actions and, if required, after enquiry the batch is withdrawn; detailed enquiry at the central level is done, if required.

CHAPTER 10

BASIC SERVICES

Quality HIV Counseling and testing is critical for achievement of prevention, care and treatment objectives

Integrated Counseling and Testing Services

Quality HIV Counseling and testing is critical for achievement of prevention, care and treatment objectives of NACP-III. As symptoms of HIV /AIDS appear late, it is imperative to encourage regular HIV testing among high risk groups for early detection and timely linkage to HIV care and treatment services. This helps prevent further HIV transmission. Besides efforts for increasing the number of people who seek HIV testing, NACP also ensures comprehensive pre-test and post-test counseling with HIV test reporting. HIV testing services are provided to clients who present voluntarily for Counseling and testing, pregnant women for prevention of parent to child transmission, TB patients and provider initiated counseling and testing (PITC) among other symptomatic patients. Overall the Integrated Counseling and Testing Centres (ICTCs) act like a hub, facilitating linkages between testing services with broader continuum of care and support services for those who need.

Types of facilities

Stand-alone Integrated Counseling and Testing Centres (SA-ICTC): These are HIV Counseling and testing facilities supported by NACP in the form of staff and all the necessary logistic support**.** The numbers of SA-ICTC were scaled up largely during NACP III (Fig. 10.1). Health facilities upto Block levels were saturated in states and districts with high HIV prevalence. In some of these districts SA-ICTC facilities are established even below the block level.

Facility Integrated Counseling and Testing Centres (F-ICTC): Considering a need for rapid scale up and sustainability of HIV Counseling and testing services below block level in high prevalent states and below sub-districts level in low prevalent areas, NACP promoted establishment of Facility Integrated Counseling and Testing Centres. Under this model, staff from exiting health facilities are trained in Counseling and testing, and service delivery is ensured with logistic support from NACP. Overall 4,071 F-ICTCs were established during NACP III. High prevalence states were encouraged to transition SA-ICTC into F-ICTC model in collaboration with NRHM. During 2011-12, 753 stand-alone ICTCs were

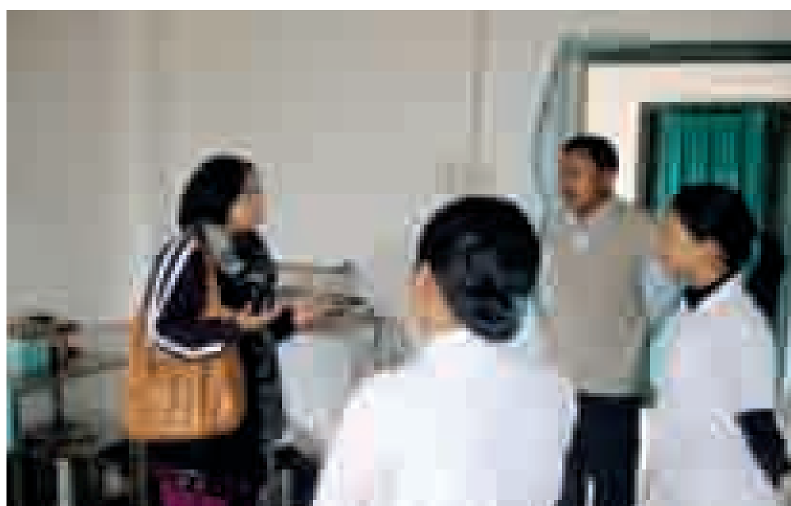
transitioned to F-ICTC/ NRHM supported facilities. Andhra Pradesh has the largest number of 24x7 PHC Facility Integrated ICTCs.

Public Private Partnership - Integrated Counseling and Testing Centres (PPP-ICTCs): Similar to F-ICTC in public health facilities, 902 PPP ICTCs were established in private health facilities in a Public Private Partnership (PPP) model during NACP III.

Mobile ICTCs: The high-risk or vulnerable populations are less likely to access fixed-facility ICTC due to several impediments most important being distance and timing. Mobile ICTCs are a way of taking the package of health services to the community. A mobile ICTC consists of a van with a room to conduct a general examination and counseling, and a space for the collection and processing of blood samples. A total of 105 mobile ICTC are functional in the country.

Fig:-10.1: Scale up of ICTCs during NACP-III

SACS officer interacting with staff of 24x7 PHC F-ICTC



Counseling and Testing of General Clients: During 2011-12, against the annual target of 1,26,86,044 clients to be counseled and tested, 90,52,015 (71%) received counseling and tesing services till January 2012. This yielded detection of 2,30,880 HIV-seropositive cases with a positivity of 2.5%. Mumbai shows the highest sero-positivity (5.6%) among General Clients, followed by Manipur (4.3%) and Andhra Pradesh (4.2%). The High prevalent states still contribute largely to total HIV case detection with Andhra Pradesh contributing 23%, Maharashtra 22%, Karnataka 14% and Tamil

Nadu 7%. The vulnerable states pose an emerging challenge for NACP with States like Uttar Pradesh, Bihar and Punjab which contribute 5%, 2.8% and 1.9% of the total detection with a positivity of 2.74%, 3.85% and 3.16% respectively among general clients. Figure 10.2 shows the trend of achievements in coverage among general clients over past five years.

Table10.1:- State wise number of General Clients counseled and tested for HIV and sero-positivity detected during 2011-12 (till January 2012)

	Number of general clients tested for HIV	No. of clients testing sero-positive for HIV (%age)
All India	**90,52,015**	**2, 30,880 (2.6%)**
Andaman & Nicobar Islands	9,987	56 (0.6%)
Andhra Pradesh	12,50,574	52,856 (4.2%)
Arunachal Pradesh	14,273	15 (0.1%)
Assam	1,01,103	922 (0.9%)
Bihar	1,90,755	6,958 (3.6%)
Chandigarh	23,994	735 (3.1%)
Chhattisgarh	78,072	2,252 (2.9%)
Dadra & Nagar Haveli	4,725	77 (1.6%)
Daman & Diu	2,484	49 (2%)
Delhi	2,07,117	6,028 (2.9%)
Goa	22,414	490 (2.2%)
Gujarat	6,41,192	10,902 (1.7%)
Haryana	1,66,427	3,064 (1.8%)
Himachal Pradesh	74,031	698 (0.9%)
Jammu & Kashmir	24,473	331 (1.4%)
Jharkhand	91,630	1,653 (1.8%)
Karnataka	9,81,622	33,153 (3.4%)
Kerala	2,27,440	1,621 (0.7%)
Madhya Pradesh	2,23,829	3,854 (1.7%)
Maharashtra	13,44,043	40,965 (3%)
Manipur	40,302	1,731 (4.3%)
Meghalaya	9,446	270 (2.9%)
Mizoram	39,681	1,091 (2.7%)
Mumbai MACS	1,90,670	10,624 (5.6%)
Nagaland	56,356	1,347 (2.4%)
Odisha	2,12,806	3,029 (1.4%)
Puducherry	29,567	557 (1.9%)
Punjab	1,37,269	4,228 (3.1%)
Rajasthan	2,73,411	5,785 (2.1%)
Sikkim	13,858	26 (0.2%)
Tamil Nadu	16,13,642	16,988 (1.1%)
Tripura	27,753	151 (0.5%)
Uttar Pradesh	4,44,482	11,789 (2.7%)
Uttarakhand	55,826	600 (1.1%)
West Bengal	2,26,761	5,985 (2.6%)

Programme for Prevention of Parent to Child Transmission of HIV (PPTCT)

The PPTCT programme involves counseling and testing of pregnant women, detection of positive pregnant women and the administration of ARV prophylaxis to HIV positive pregnant women and their infants, to prevent the mother to child transmission of HIV. Against the annual target of 1,02,71,183 in 2011-12, about 70,87,186 (69%) pregnant women were counseled and tested by January 2012, yielding detection of 13,213 HIV sero-positives (positivity being 0.19%). The state of Nagaland shows highest sero-positivity (0.89%) among pregnant women, followed by Mizoram with 0.62%. Figure 10.2 show the trend of achievement in coverage of pregnant women over the past five years.

The High prevalent states contributed largely to the detection of HIV positive pregnant women in the country, with Andhra Pradesh detecting 24%, Maharashtra 19%, Karnataka 16% and Tamil Nadu 7%.

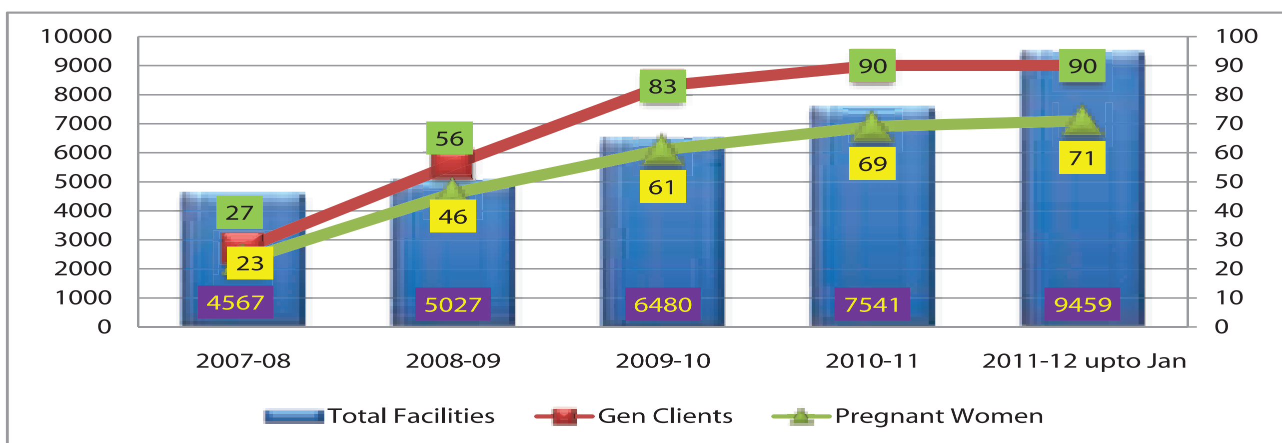
Mother Baby pair Coverage: - Pregnant women found HIV positive are administered ARV prophylaxis so as to prevent mother to child transmission of HIV. Between April 2011 to January 2012, out of 13,213 HIV positive pregnant women detected, 11,074 (84%) Mother Baby (MB) pairs received Nevirapine (NVP) prophylaxis for prevention of transmission of HIV from mother to child.

Table 10.2:- State wise performance of the PPTCT programme during 2011-12 (till January 2012)

	Number of pregnant women tested for HIV	Total no. of pregnant women testing sero-positive	Number of MB pair receiving NVP
All India	**70,87,186**	**13,213 (0.19%)**	**11,074 (84%)**
Andaman & Nicobar Islands	4,617	0 (0%)	0 (0%)
Andhra Pradesh	10,01,430	3,180 (0.32%)	2,870 (90%)
Arunachal Pradesh	8,130	0 (0%)	0 (0%)
Assam	1,61,018	93 (0.06%)	64 (69%)
Bihar	1,61,546	262 (0.16%)	190 (73%)
Chandigarh	18,508	44 (0.24%)	36 (82%)
Chhattisgarh	68,164	211 (0.31%)	71 (34%)
Dadra & Nagar Haveli	4,778	7 (0.15%)	3 (43%)
Daman & Diu	2,038	3 (0.15%)	1 (33%)
Delhi	1,64,571	284 (0.17%)	190 (67%)
Goa	12,500	32 (0.26%)	14 (44%)
Gujarat	5,05,422	737 (0.15%)	560 (76%)
Haryana	1,24,960	175 (0.14%)	74 (42%)
Himachal Pradesh	35,900	28 (0.08%)	11 (39%)
Jammu & Kashmir	35,066	21 (0.06%)	8 (38%)
Jharkhand	55,573	62 (0.11%)	32 (52%)
Karnataka	8,56,921	2,090 (0.24%)	1,870 (89%)
Kerala	1,15,016	67 (0.06%)	55 (82%)
Madhya Pradesh	2,17,795	221 (0.1%)	184 (83%)
Maharashtra	10,23,000	2,072 (0.2%)	1,781 (86%)
Manipur	38,891	142 (0.37%)	178 (125%)
Meghalaya	14,155	41 (0.29%)	13 (32%)
Mizoram	19,878	124 (0.62%)	113 (91%)
Mumbai MACS	1,01,284	401 (0.4%)	344 (86%)

Nagaland	14,291	127 (0.89%)	100 (79%)
Odisha	1,96,710	250 (0.13%)	149 (60%)
Puducherry	28,225	37 (0.13%)	39 (105%)
Punjab	1,37,860	244 (0.18%)	177 (73%)
Rajasthan	2,93,410	317 (0.11%)	253 (80%)
Sikkim	6,273	3 (0.05%)	3 (100%)
Tamil Nadu	8,61,399	975 (0.11%)	1,131 (116%)
Tripura	15,071	13 (0.09%)	3 (23%)
Uttar Pradesh	3,88,128	465 (0.12%)	294 (63%)
Uttarakhand	46,528	45 (0.1%)	23 (51%)
West Bengal	3,48,130	440 (0.13%)	240 (55%)

Fig 10.2: Scale up of Counseling and Testing Services during last five years with numbers tested (in Lakhs)



Counseling and Testing of HRGs and STI Clinic Attendees: HRGs and STI Clinic attendees form a priority group of clients who would be at risk of being infected and hence ICTC programme focuses on establishing strong linkages with the TI projects and STI clinics. Special efforts like outreach activities are made by the ICTC team to enhance the uptake of ICTC services by these key populations. This has resulted in consistent improvement in coverage of services for HRGs and STI clinic attendees as evident from Fig 10.3

External Quality Assessment Scheme: SA-ICTCs participate in an external quality assessment scheme (EQAS) to maintain high standards of laboratory services through identified State Reference Laboratories (SRL). EQAS involves sending of "coded' samples from the SRL to ICTC twice a year for testing. In addition, ICTC sends samples for cross checking to the SRL once every quarter, which includes 20% of all positive and 5% of all negative samples collected in first week of every quarter. Table 10.4 illustrates achievement under EQAS during 2011-12

Fig 10.3: Scale up of In Referral of HRG and clinic attendees from TIs and STI Clinics during last five years

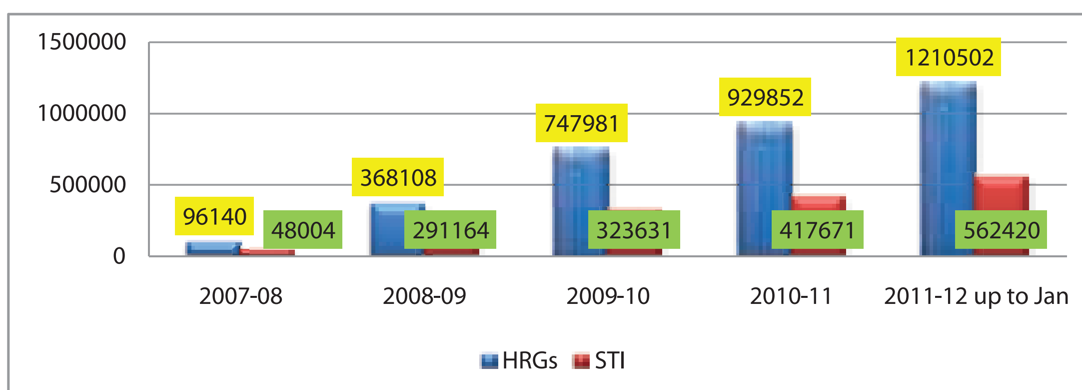


Table10.4: State wise participation of ICTCs in EQAS 2011-12

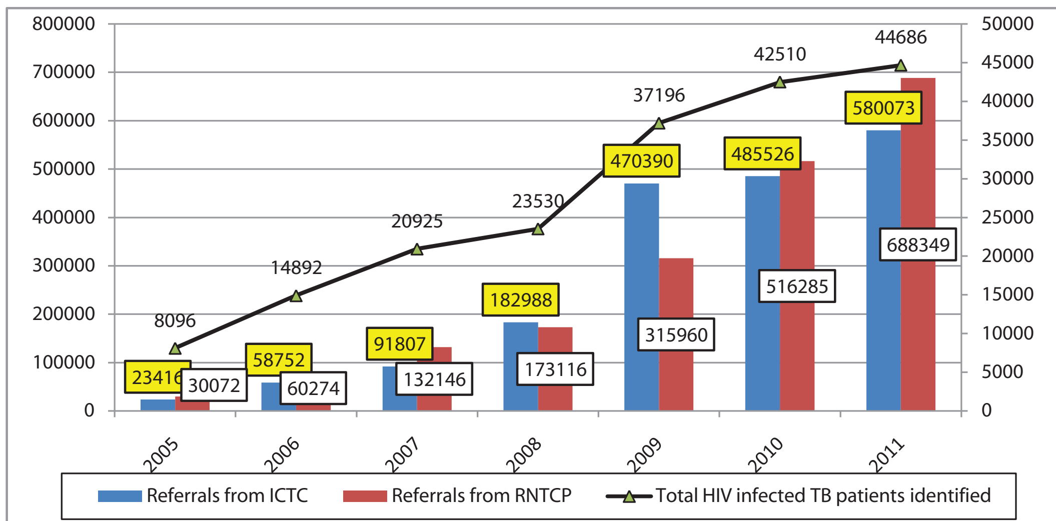
State	Number of SRLs in the state	Number of stand-alone ICTCs	Number of ICTCs which have sent EQAS samples to SRL (Oct,2011)	Number of ICTCs received report from SRL (Oct,2011)	Number of ICTCs reported discordant samples
Andaman & Nicobar	1	13	13	13	0
Andhra Pradesh	10	411	411	411	0
Arunachal Pradesh	1	35	10	10	0
Assam	3	83	78	78	0
Bihar	2	207	120	120	0
Chandigarh	1	11	11	11	0
Chhattisgarh	1	101	62	62	0
Dadra Nagar Haveli	0	1	0	0	0
Daman & Diu	0	4	0	0	0
Delhi	4	87	85	85	0
Goa	1	14	10	10	0
Gujarat+ Ahmedabad	5	305	299	299	9
Haryana	1	88	57	57	0
Himachal Pradesh	1	47	NA	NA	NA
J & K	2	35	22	22	0
Jharkhand	3	64	51	51	0
Karnataka	10	478	478	478	1
Kerala	5	162	162	162	1
Lakshadweep	0	0	0	0	
Madhya Pradesh	4	143	133	133	2
Maharashtra	12	578	550	550	4
Manipur	1	54	38	38	0
Meghalaya	1	10	10	10	0
Mizoram	1	27	28	28	0
Mumbai	4	74	67	67	0
Nagaland	2	60	60	60	0
Odisha	3	184	124	124	0
Puducherry	1	12	11	11	0
Punjab	3	72	85	85	1
Rajasthan	6	182	170	170	1
Sikkim	1	12	13	13	0
Tamil Nadu	12	384	783	783	0
Tripura	1	18	18	18	0
Uttar Pradesh	9	217	212	212	1
Uttarakhand	1	47	46	46	0
West Bengal	5	255	203	203	1
Total	**118**	**4,475**	**4,420**	**4,420**	**21**

HIV -TB collaborative activities

Tuberculosis is commonest opportunistic infection among people living with HIV. The existence of HIV and TB together greatly amplifies harmful effects of each other at individual level and contribute substantially to mortality among PLHIV. TB is estimated to cause one in four deaths among PLHIV in India. Majority of these deaths can be averted if HIV associated TB is detected and treated early. To ensure timely detection National AIDS Control Programme (NACP) and Revised National Tuberculosis Control Programme (RNTCP) have established mechanisms for collaboration at different levels of health system. These activities are governed by National (policy) Framework for Joint TB/HIV collaborative activities. Implementation of HIV/TB activities effectively is of critical importance in states and districts with high HIV prevalence, since TB notifications and mortality due to HIV/TB is more in these areas. HIV/TB activities also gain importance in situations with higher levels of multi drug resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB), since together they are a fatal combination.

Scale up of HIV/TB activities: Figure 10.4 depicts the progress made in HIV/TB activities over last few years in terms of cross-referral between the two programmes. The referrals between NACP and RNTCP consistently show an increasing trend, with more than 12 lakhs cross-referrals and detection of about 45,000 HIV/TB cases in 2011.

Fig:-10.4. Scale of HIV/TB collaborative activities, 2005 - 2011

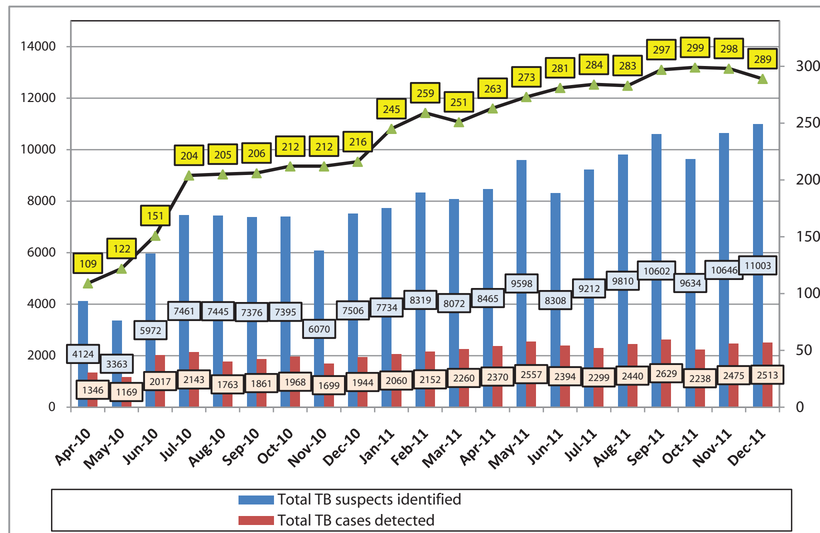


Overall the HIV/TB collaborative activities consist of: Measures for prevention of TB infection and disease among HIV infected individuals and Measures for early detection of HIV in TB patients and linkage to care and support services. **Activities for prevention of TB in PLHIV are grouped as 3 "I's" as follows**: Air borne **Infection control** (Measures to minimize spread of airborne infection in HIV care settings), **Isoniazid Preventive Treatment (IPT),** and **Intensified TB case** finding (ICF) at HIV care settings (early detection and treatment, which minimizes mortality and morbidity and also curtails further spread of infection).

Measures for airborne infection control are being implemented at all ART centres in India. These include "fast-tracking" of TB suspect for diagnosis and treatment, health education on cough hygiene supported with display of relevant IEC material etc. Further, NACP encourages adoption of administrative and environmental infection control measures by the hospital where ART centre is located. Regarding Isoniazid preventive treatment, a study is being conducted by National Institute of Research in Tuberculosis (NIRT/TRC) Chennai, on operational feasibility and efficacy of IPT in the Indian ART programme scenario at 12 ART centres. Findings from this study will guide the national programmes on the prospect of adoption of IPT as a programme strategy.

The Intensified TB case finding (ICF) activities are being implemented at all ICTC and ART centres in the country. While ICF at ICTC is implemented across the country since 2008, the same at ART centres is implemented since early 2010. ICF was implemented at all ART centres over 2011 and reporting on the same streamlined. The Figure 10.5 depicts trend of reporting on ICF by ART centres *vis a vis* trends in identification of TB suspects and detection of TB cases. ICF activities are further planned to be expanded to cover Link ART Plus and Link ART centres over 2012-13.

Fig:-10.5. Month-wise Intensified Case Finding at ART centres, April 2010 to December 2011



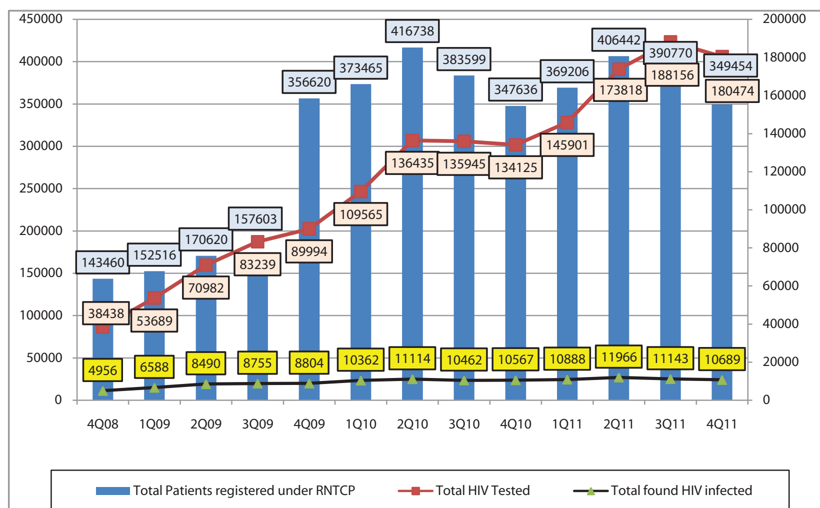
A total of 73,073 HIV infected TB cases were detected in 2011 through the HIV/TB cross referrals at ICTC and ART centres. This includes TB cases detected through ICF at ART centres. Overall ICF activities at ICTC and ART centres contributed about 8% of TB case notification in the country.

Table 10 5: Achievement of Intensified TB Case Finding at ICTC and ART centres, January - December 2011

Site of Implementation of Intensified TB case finding	*Number of clients / patients screened for TB diagnosis*	*Number of HIV Infected TB patients detected*
ICTC	*5,77,809*	*44,686*
ART centre	*1,11,403*	*28,387*
TOTAL	*6,89,212*	*73,073*

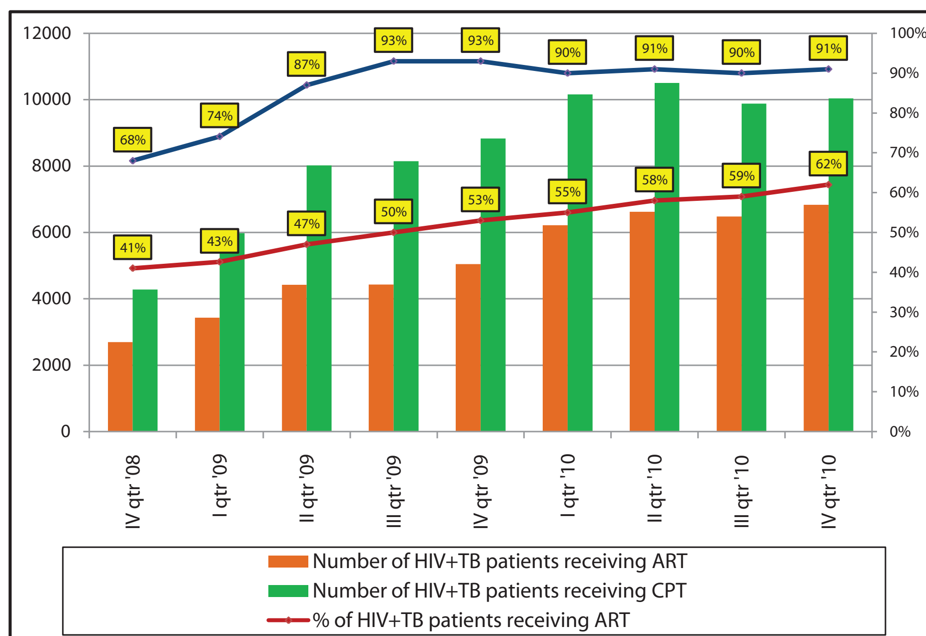
HIV testing of TB patients: HIV testing of TB patients has improved significantly over past 2-3 years, as intensified TB/HIV package implementation expanded to cover all states and union territories except Jammu and Kashmir in 2011. At the national level, the proportion of TB cases tested for HIV has increased to 62% in the fourth quarter of 2011. These proportions reached more than 80% in high prevalent states, e.g. Karnataka could achieve more than 90% testing. About 11,000 HIV positive individuals are detected every quarter through this activity.

Fig:-10.6. HIV testing of TB patients, 2008-2011 (Source RNTCP CMIS)



Linkage of HIV infected TB patients to Co-trimoxazole prophylaxis therapy (CPT) and the ART has also improved over the past year. In the fourth quarter of 2011 more than 90% HIV-TB cases received CPT and more than 60% were linked to ART. The linkage to ART has shown greater progress in high prevalent states (Karnataka leading with 71%). This remains a challenge in HIV-TB activities and needs further strengthening in 2012-13.

Fig:-10.7 Trend of linkage of HIV/TB cases to ART and CPT (Source-RNTCP CMIS), during 4th quarter 2008 to 4th quarter 2010.



Capacity Building:-

A large cadre of qualified & skilled counselors & technicians exists at NACO ICTCs. To build their capacity a set of comprehensive and standardized training modules with a combination of teaching techniques (lectures, hands-on demonstrations, role-plays etc.) are required. The NACO Basic Services Division provides these training to ICTC, FICTC & PPTCT staff aimed at developing and fine-tuning their skills, increasing their sensitivities, and enhancing their ability to reach out to the needs of their clients. Along with induction trainings, refresher training on HIV counseling & testing are also provided; In addition training material for HIV/TB activities, Whole blood HIV screening etc. are designed by NACO for different categories of staff including medical officers and counselors at ICTC,ART centre, RNTCP supervisors, ANM, labour room nurses, etc.; A separate curriculum is also designed for ICTC team to facilitate their functioning as a team involving ICTC counselor, Medical officer, technician & nurse. The status of different training facilitated by NACO are as follow:

Induction and Refresher Training for counselors and staff nurses: The Induction and refresher training to the counselors and Staff Nurses are provided through 36 institutes under the "Saksham GFATM Round-7". In 2011-12 total numbers of counselors trained in induction and refresher training are 323 and 1,801 respectively. In addition to counselors, 3,118 and 1,970 Staff Nurses from the F-ICTC have been trained in Induction and Refresher modules respectively by the Public Health Institutes.

Induction and Refresher Training for ICTC Laboratory Technicians: Training to Laboratory Technicians is imparted through the network of state and national reference laboratories (SRLs & NRL). In 2011-12, 4,322 Lab Technicians (2,832 from Stand Alone ICTCs and 1,490 from FICTCs) have been trained.

ICTC Full Site Sensitization: All the staff in a health facility having an ICTC need to be routinely updated on specific issues related to HIV/AIDS like importance of HIV counseling, confidentiality, PEP, universal precautions and maintaining a respectful and non- discriminatory attitude towards PLHIVs. NACO supports these activities through a team of trainers developed at the state level. In 2011-12, more than 8,000 personnel were sensitized through this activity across the country.

HIV-TB Training: The objective of the training is to make participants understand the burden of HIV/TB and programme guidelines concerning early

diagnosis and treatment of HIV/TB co-infection. Training also includes understanding of HIV-TB programme coordination activities. During 2011-12, more than 6,851 personnel have been trained in different modules.

Whole Blood Screening: NACO has initiated community based HIV screening using whole blood finger prick testing of pregnant women who do not come to health facilities for antenatal check-up through ANM to identify HIV positive cases, so as to further link with care, support and treatment services provided to PLHIV. Also unbooked ante-natal cases presenting to facilities directly in labour are also tested using the whole blood. NACO provides training to all concerned in these activities. During 2011-12, more than 4,000 personnel have been trained in this component.

ICTC Team Training: An ICTC team comprises a medical officer, one or two counselors, a lab technician and a nurse or an outreach worker. To ensure coordinated efforts, NACO provides for a team training package focusing on various aspects of working as a 'team'. The 'team' is trained in day-to-day activities of ICTC, specific procedures to be followed etc. Moreover, experience sharing in a group is also motivational & helpful. During 2011-12, more than 453 personnel have been trained, but this activity remains underreported.

Table10.6: Number of persons trained on different modules during 2011-12 (April 2011 – January 2012)

Training Type	No. of personnel Trained
SA ICTCs – Counselors – Induction	323
SA ICTCs – Counselors – Refresher	1,801
SA ICTCs – LTs – Induction	270
SA ICTCs – LTs – Refresher	2,562
FICTCs + PPP – Staff nurses – Induction	3,118
FICTCs + PPP – Staff nurses – Refresher	1,970
FICTCs + PPP –LTs – Induction	1,282
FICTCs + PPP – LTs – Refresher	208
Full Site – DH	3,877
Full Site – SDH	4,398
HIV-TB for Counselors, MOs, DISs, MO TC, ART MOs, HIV TB DSs (RNTCP)	6,851
Whole Blood screening for ANMs, Labour room nurses, RNTCP LTs, STS/STLS	4,186
Team training for Couselors, MOs, LTs, Nurses	453

Review Meetings and Workshop/Consultation Meetings:-

The following review meetings/consultations were conducted during 2011-12:

Two Review Meetings of the SACS Basic Service Divisions were conducted at NACO during September 2011 and January 2012, to assess the performance against the Annual Action Plan.

Review meeting of PPTCT programme was conducted with the PPTCT consultants.

Workshop for preparation of Operation Guideline on Whole Blood HIV screening.

Workshop for preparation of Recording and Reporting tools for FICTCs.

Technical Resource Group on PPTCT held in Nov 2011 for considering the more efficacious PPTCT Regimen

Basic services: Best field practices

1. Example of ICTC Counseling effort

Raju (name changed) a case of syphilis was under treatment at PGIMER Chandigarh. He was also diagnosed HIV infected and on history found to be a migrant from Uttar Pradesh. His wife was pregnant and at his native place. The ICTC team in their attempt to ensure spouse testing, communicated with UP-SACS to ensure coverage locally but she could not be tested. Due to further Counseling efforts the client got his wife to Chandigarh and her HIV test yielded positive results. She remains under regular follow up of the ICTC counselor and outreach worker and efforts are on to ensure hospital delivery. These efforts will help in provision of care and support to the HIV-positive couple as well as their unborn child. This is just one example of extraordinary efforts taken by ICTC team across the country contributing significantly in saving lives.

2. Use of technology to strengthen linkage of positive pregnant women to care and support:

A mobile based reporting system is implemented by the Infrastructure Leasing & Financial Services Limited (IL&FS), which partners NACP in provision of outreach services. It utilizes services of outreach workers who are from the community to strengthen linkages. To ensure timeliness and accuracy of reporting from Out-reach workers (ORW) a mobile based reporting system is developed through which ORWs can report directly from the community based on current line-listing as prescribed by NACO. The keyed in data gathered at a central server is easily accessible to all the stakeholders simultaneously. This ensures transparency and accountability within the system. The system not only captures data but also triggers alerts on the expected date of delivery (EDD) to the ORW and the concerned authorities. The system is presently operational in Tamil Nadu and Gujarat, and is being scaled up to other states.

3. Efforts for Integration of Basic Services of NACP-III with general health systems:

The coordination with NRHM improved greatly in 2011-12 both at national and state level. The basic services division in SACS developed good coordination with NRHM counterparts and advocated for transitioning of stand-alone facilities, establishment of F–ICTC, role of whole blood HIV screening etc. Majority of the SACS managed to take the coordination to next level. While Gujarat managed to convert all RNTCP DMC into F-ICTC, Andhra Pradesh, Karnataka and Tamil Nadu facilitated transitioning of SA-ICTC to NRHM to varying degree. AP, Karnataka, Maharashtra, Madhya Pradesh, Gujarat, Manipur, Haryana, etc. made significant strides in establishment of F-ICTC during 2011-12. States like Uttarakhand and Mizoram established F-ICTC in NRHM- MMU (mobile medical units), to ensure access to population in hard-to-reach areas.

CHAPTER 11

CARE, SUPPORT & TREATMENT

Care, Support and Treatment component of NACP-III aims to provide comprehensive management to PLHIV with respect to prevention and treatment of Opportunistic Infections

The Care, Support and Treatment component of NACP-III aims to provide comprehensive management to PLHIV with respect to prevention and treatment of Opportunistic Infections (OI) including TB, Antiretroviral therapy (ART), psychosocial support, home-based care, positive prevention and impact mitigation. For this, following targets were set.

- Provide free ART to 3,00,000 adult and 40,000 children through 250 ART Centres;
- Achieve and maintain a high level of drug adherence and minimize the number of patients lost to follow up, so that drugs are effective for a longer period of time; and
- Provide comprehensive care, support and treatment by establishing Community Care Centres (CCC).

The progress achieved in provision of Care, Support and Treatment services in NACP III is summarised in Table 11.1

Table 11.1: Infrastructure for Care, Support & Treatment Services in NACP III

Facility for CST	Baseline (March 2007)	Target (March 2012)	Achievement (Jan 2012)
ART Centres	107	250	342
Centres of Excellence	0	10	10
Link ART Centres	--	--	685
Community Care Centres	122	350	253
ART Plus Centres	--	--	20
Pediatric Centres of Excellence	0	7	7

Service Delivery Mechanism for Care Support & Treatment

A.1 ART Centres: Provision of free Antiretroviral Therapy (ART) for eligible persons living with HIV (PLHIV) was launched on 1 April, 2004 in eight government hospitals located in six high prevalence states. Since then, the programme has been scaled up significantly both in terms of facilities for treatment and number of beneficiaries

seeking ART. The ART centres are established in the medicine department of Medical Colleges and District Hospitals in the government sector. However, some ART centres are functioning in the sub-district and area hospitals as well mainly in high prevalence states. The ART centres are set up based on prevalence of HIV in the district/region, volume of PLHIV detected and capacity of the institution to deliver ART related services. Currently (as on January 2012), there are 342 fully functional ART centres against the target of 250 by March 2012.

A.2 Link ART Centres: Link ART centres (LACs) were originally not planned under NACP-III. A NACO study on "Assessment of ART centres: Clients' and Providers' Perspectives", revealed that distance, travel time and costs were the main reasons for patients not attending ART services regularly. In order to facilitate the delivery of ART services nearer to the beneficiaries, it was decided to set up Link ART Centres located mainly at ICTC in the district / sub-district level hospitals nearer to the patient's residence and linked to a Nodal ART centre within accessible distance. Presently, 685 Link ART Centres have been established and made functional. These centres are providing services to nearly 50,000 PLHIV.

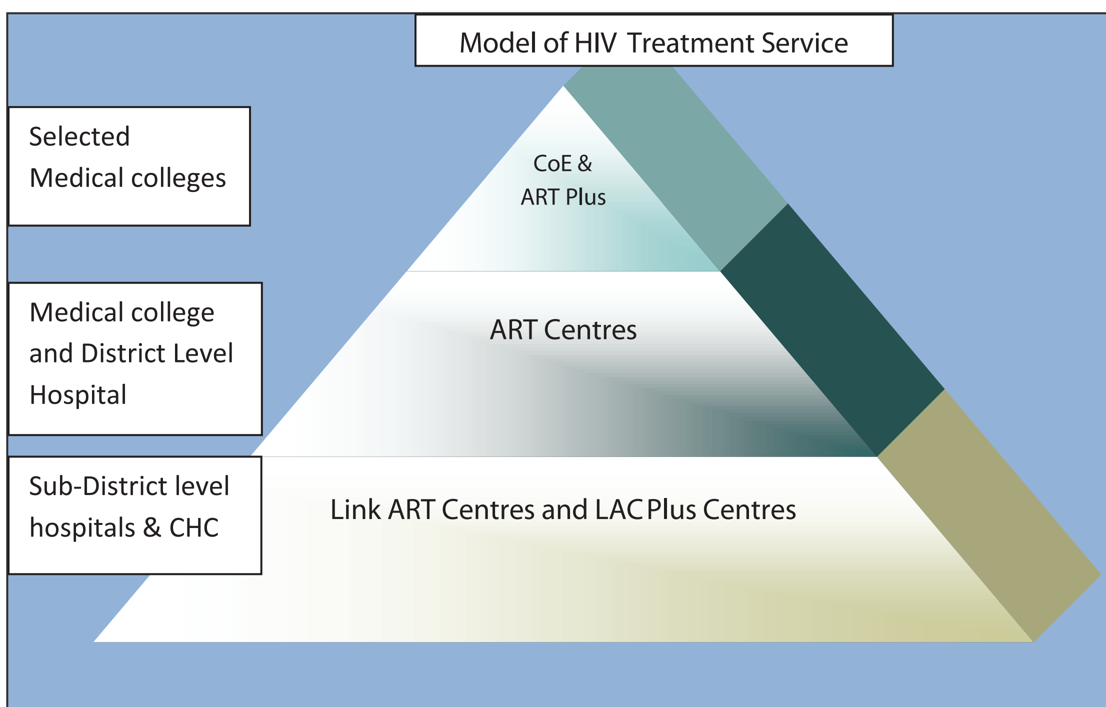
A.3 Link ART Plus Centres

It was observed that nearly 25-30% of persons detected HIV positive at ICTC are not linked to care, support & treatment services. Reasons for this included among others, persons being asymptomatic at the time of detection and long distances to reach the ART centre for registration and basic investigations which may lead them to postpone/delay their visit to ART Centres till they become symptomatic. It was also observed that nearly 20% patients reach ART Centres at a very late stage (CD4 count <50), when the risk of mortality is nearly 2-3 times higher.

In view of the above facts, the scope and functions of select Link ART Centres were expanded to include Pre-ART registration and HIV care at LAC itself. The LAC, which perform Pre-ART management also are designated as "LAC plus" This helps to bridge the gap between ICTC (Counseling & Testing services) and CST (Care, Support & Treatment) services and also reduces the travel cost and travel time of PLHIV in accessing ART services. These patients will be followed up at LAC plus till they become eligible for ART or are referred to ART Centre for any other reason.

A.4 Centres of Excellence (COE): The HIV/AIDS epidemic has, over the past decade, evolved into a more complex one necessitating operational research, effective health delivery system and a trained and motivated workforce. Complex treatment schedules and patient management require constant training and upgrading of skills among providers as well as planned research to guide programme planning and policy making. Centres of Excellence were envisaged under NACP-

Figure 11.1: Model of HIV Treatment Service



III to facilitate provision of tertiary level specialized care and treatment, second line and alternative first line ART, training and mentoring, and operational research. At present, 10 such centres are functioning in the country. They are located in Bowring & Lady Curzon Hospital, Bangalore; BJ Medical College, Ahmedabad; Gandhi Hospital, Secunderabad; PGIMER, Chandigarh; School of Tropical Medicine, Kolkata; Institute of Medical Sciences, BHU, Varanasi; Maulana Azad Medical College, New Delhi; Sir JJ Hospital, Mumbai; Regional Institute of Medical Sciences, Imphal; and GHTM, Tambaram, Chennai.

A.5 Pediatric Centres of Excellence (pCoE): The Regional Pediatric ART Centres (RPC) established under NACP III have been upgraded as Pediatric Centres of Excellence (pCOE) for Pediatric care including management of complicated OIs, training and research activities. These Centres have varying roles and responsibilities for delivery of care and support to infected children including specialized laboratory services, Early Infant Diagnosis, ART to children infected with HIV, counseling on adherence and nutrition, etc. These centres also provide technical support to the other ART centres in Pediatric care. Currently, seven pCoEs are functional in the country. They are located at Niloufer Hospital, Hyderabad; Indira Gandhi Institute of Child Health, Bangalore; LTMG Sion Hospital, Mumbai; JN Hospital, Imphal; Institute of Child Health, Chennai; Govt. MCH, Kolkata; and Kalawati Saran Children's Hospital, New Delhi.

A.6 ART Plus Scheme: It has been observed that patients need to travel long distance to access the second line treatment. This has resulted in low uptake of second line ART and also caused inconvenience to patients. In view of these, it was decided to expand the number of centres that provide second line ART. Accordingly, some good functioning ART centres were upgraded and labelled as 'ART Plus Centres'.

Criteria for selection of ART Plus Centres

The capacity of the institution to provide second line ART and linkage to lab for Viral Load testing

The availability of trained manpower in the institution

The geographical distribution of patients on second line ART

Accessibility and connectivity

Currently, ART Plus Centres have been approved at 28 sites covering all states except those with very low patient load.

A.7 Community Care Centres: With the mandate of providing a comprehensive package of CST services, the Community care Centres (CCC) have been set up in the non-government sector with the objective of providing psycho-social support, ensure drug adherence and provide home-based care. CCCs are linked with ART Centres and ensure that PLHIV are provided counseling for ARV treatment preparedness and drug adherence, nutrition and prevention, treatment of Opportunistic Infections, referral and outreach services for follow up, social support and tracing patients lost to follow-up (LFU) and those missing to get ARV drugs as per schedule. At present, 253 CCCs are fully functional.

B. Coverage of Services

- Main services provided to PLHIV under care, support & treatment include:
- Registration of PLHIV for ART and pre-ART services;
- Assessment of eligibility of ART based on clinical examination and CD4 count;
- Provision of first line ART to all eligible PLHIV and CLHIV
- Follow-up of patients on ART by assessing drug adherence, regularity of visits and periodic examination and CD4 count (every 6 months)
- Training for home-based care
- Treatment of opportunistic infections; and
- Provision of alternate first line and second-line ART to those experiencing drug toxicities and treatment failure, respectively
- Counseling on adherence, nutrition, positive prevention and positive living

Tables 11.2 and 11.3, and Figure 11.2 provide an overview of patients receiving services at different service delivery points under CST component.

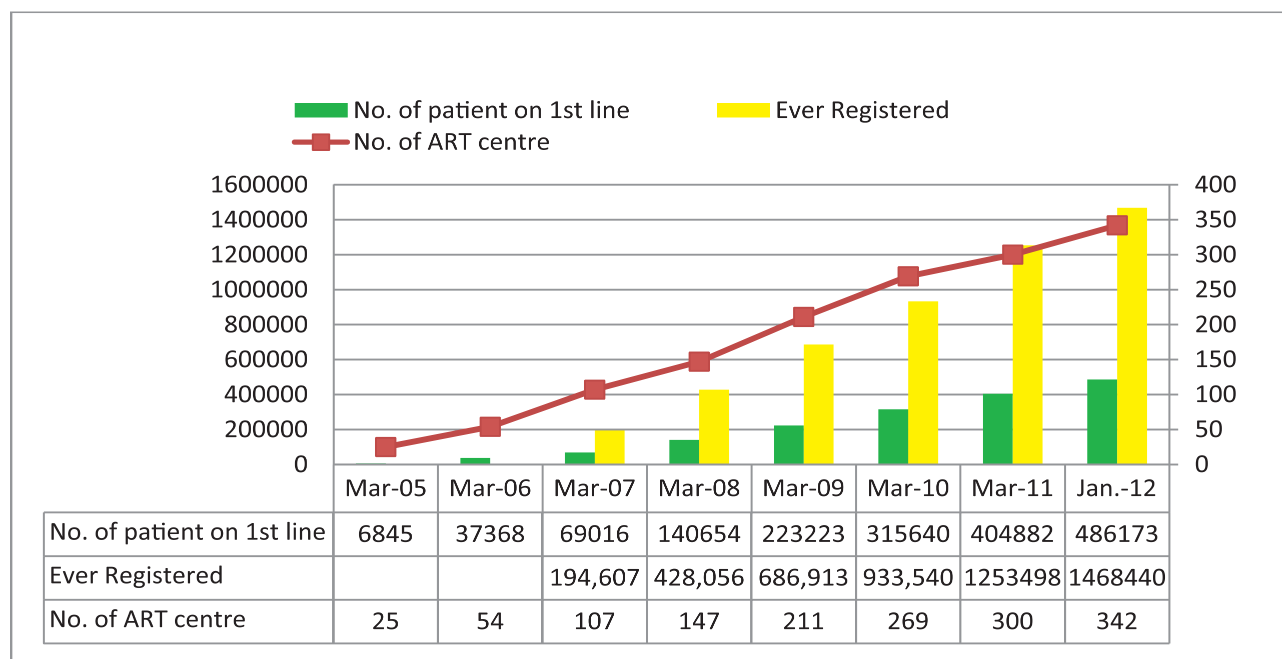
Table 11.2: No. of Persons Living with HIV/AIDS receiving Care, Support & Treatment services in NACP III

Services/Beneficiaries	Baseline (March 2007)	Target (March 2012)	Achievement (Jan 2012)
Adults registered for ART	1,85,953	-	13,71,232
Adults ever started on ART	80,355	-	7,61,488
Adults alive and on ART	59,673	3,00,000	4,57,948
Children registered for ART	14,409	-	97,208
Children ever Started ART	4,925	-	42,973
Children alive and on ART	4,107	40,000	28,225
Opportunistic Infections treated per year	70,099	3,00,000	5,41,997
Persons alive and on 2nd line ART	0	-	4,208

Table 11.3: State-wise list of ART Centres and patients on ART (as on Jan. 2012)

State	No. of ART centres	Total (Adult)	Total (Pediatric)	Total
Andhra Pradesh	45	98436	4960	103396
Arunachal Pradesh	1	25	1	26
Assam	3	1581	67	1648
Bihar	8	9650	471	10121
Chandigarh	1	1957	210	2167
Chhattisgarh	5	2515	212	2727
Delhi	9	9237	719	9956
Goa	1	1337	102	1439
Gujarat	24	24425	1460	25885
Haryana	1	2461	151	2612
Himachal Pradesh	3	1324	123	1447
Jammu & Kashmir	2	780	53	833
Jharkhand	4	2684	170	2854
Karnataka	46	66350	4669	71019
Kerala	8	6054	320	6374
Madhya Pradesh	10	6408	453	6861
Maharashtra	53	104496	7167	111663
Manipur	7	6654	504	7158
Meghalaya	1	207	5	212
Mizoram	3	1336	93	1429
Nagaland	6	3259	173	3432
Odisha	9	4042	182	4224
Puducherry	1	747	73	820
Punjab	6	7766	460	8226
Rajasthan	9	10121	640	10761
Sikkim	1	60	0	60
Tamil Nadu	43	55353	3179	58532
Tripura	1	211	5	216
Uttar Pradesh	20	17826	1019	18845
Uttarakhand	2	925	75	1000
West Bengal	9	9721	509	10230
Total	**342**	**457948**	**28225**	**486173**

Fig .11.2: ART Scale up in India



	Mar-05	Mar-06	Mar-07	Mar-08	Mar-09	Mar-10	Mar-11	Jan.-12
No. of patient on 1st line	6845	37368	69016	140654	223223	315640	404882	486173
Ever Registered			194,607	428,056	686,913	933,540	1253498	1468440
No. of ART centre	25	54	107	147	211	269	300	342

C. Care of Exposed Child and Early Infant Diagnosis

The National Programme on Early Infant Diagnosis (EID) for HIV ensures that the HIV-infected infants and children below 18 months get the required essential package of diagnostics, care and treatment (i.e. integration of early infant diagnosis by HIV-1 DNA PCR test into the Care, Support and Treatment services). The details regarding this programme are provided in the chapter on 'Laboratory Services'.

D. Capacity Building for CST

To ensure uniform standards of services, adherence to operational guidelines and treatment protocols, induction training is provided to various personnel using standard curriculum, training module and tools at identified institutions. Various training programmes organized under NACP-III include:

- Orientation of faculty of Medical Colleges/ District Hospital (4 days)
- Training of Medical Officers (SMO/MO) of ART Centres (12 days)
- Training of Medical Officer of CCC (4 days)
- Training of Medical Officer of Link ART Centres (3 days)
- Training of ART Counselors (12 days)
- Training of Data Managers of ART Centres (3 days)
- Training of Laboratory Technicians for CD4 count (2 days)
- Training of Pharmacists (3 days)
- Training of Nurses (6 days)

The curriculum for training of faculty /specialists of Medical Colleges and District Hospitals, ART, CCC and LAC Medical Officers has been revised. The Training of Master Trainers on revised curriculum has been carried out through 4 regional workshops at MAMC Delhi, STM Kolkata, PGIMER Chandigarh and GHTM Chennai.

The following Institutions have been recognized for training of doctors:

Maulana Azad Medical College, New Delhi

J J Hospital, Mumbai

BJ Medical College, Ahmedabad

PGIMER, Chandigarh

Gandhi Hospital, Secunderabad

Bowring & Lady Curzon Hospital, Bangalore

School of Tropical Medicine, Kolkata

Regional Institute of Medical Sciences, Imphal

Government Hospital of Thoracic Medicine, Tambaram

Institute of Medical Sciences, BHU, Varanasi

Christian Medical College, Vellore

CSM Medical University, Lucknow

NARI & BJMC Consortium, Pune

E. Development of Operational Guidelines and Modules

The following guidelines have been developed for use by various centres and SACS:

- Guidelines for ART in adults & adolescents- March 2007 (Updated: April 2009)
- Guidelines for ART in children- November 2006 (Updated; September 2009)
- Guidelines for prevention and management of common Opportunistic infections and malignancies among adults and adolescents- March 2007
- Operational guidelines for ART centres- March 2007 (Updated: May 2008 & August 2009)
- Operational guidelines for Link ART centre/ LAC Plus - January 2012
- Post exposure Prophylaxis guidelines- January 2009
- Technical guidelines on second line ART in adults and adolescents- November 2008 (Updated in February 2012)
- Technical guidelines for alternate first line ART- October 2009 (Updated: February 2012)
- Technical Guidelines for Early infant diagnosis - January 2010
- Technical guidelines on second line ART for children- October 2009
- Training manual for ART Medical Officers May 2007, Updated: December 2010
- Training Manuals for specialists- May 2007, Updated: December 2010
- Training module for Link ART Centre doctors
- Guidelines for Community Care Centres: October 2010
- Draft guidelines for HIV care for prisoners: September 2009
- Guidelines for Air Borne infection control: September 2009
- Scheme for Centres of Excellence in HIV Care: January 2012
- Scheme for Pediatric Centres of Excellence in HIV Care: December 2011

These have been revised from time to time with the recommendations of the Technical Resource Groups and are available on NACO website.

F. Measures to provide high quality services

F.1. Technical Resource Groups on CST: Technical Resource Groups consisting of experts have been constituted on the following:

TRG on ART (Reconstituted)

TRG on Pediatric HIV (Reconstituted)

TRG on Community Care Centres (Reconstituted)

TRG on Laboratory services

National HIV Drug Resistance Committee

To review the progress and provide suggestion and recommendations on various technical and operational issues relating to the programme, these TRG groups meet periodically.

F.2. Strengthening the capacity of laboratories for CD4 testing: There are 213 CD4 machines installed at present serving 342 ART centres. Fifty more CD4 machines are in the process of installation.

F.3. Supervisory/Monitoring Mechanism: The Division is responsible for planning, financing, implementation; supply chain management, training, coordination, monitoring and evaluation of care support and treatment services in the country. The implementation and monitoring at State level is the responsibility of the concerned State AIDS Control Societies (SACS) consisting of Joint Director (CST), Deputy Director / Asst. Director (C&S), Assistant Director (Nursing) and Consultant (CST) based on volume of CST activities in the state.

For close monitoring, mentoring and supervision of ART Centres, various states have been grouped into regions and Regional Coordinators for CST have been appointed to supervise the programme in their regions. The Regional Coordinators and SACS officials visit each of the allotted ART Centres at least once in two months and they send regular reports to NACO. In addition, NACO officials also visit particularly the centres that are not performing satisfactorily or are facing problems in implementation of the programme.

Review meetings of all the CST officers from the state and all NACO Regional Coordinators are held on a regular basis. During these meetings, the state officers give an update on the various CST related activities in their state and wherever required remedial measures are taken.

At the state level, regular review meetings are conducted at SACS level. At these meetings, the representatives of NACO, CST officials of SACS, Regional Coordinators, medical officers and staff of ART centres and other facilities, review of the performance of individual centres. Participants are also given refresher/reorientation sessions during such meetings.

F.4. ART CCC coordination meeting: ART centre-CCC coordination meetings are also held in order to facilitate the induction of newly established Community Care Centres to facilitate the linkages and referral system with ICTCs, CCC, ART Centres. These meetings are attended by the Project Coordinators of the CCC and Medical Officers at the ART Centres. Members of the Governing Board of the NGO running CCC have also been encouraged to attend these meetings. These meetings provide a forum to address the local operational issues surrounding the ART Centres and the CCC, and facilitate better coordination.

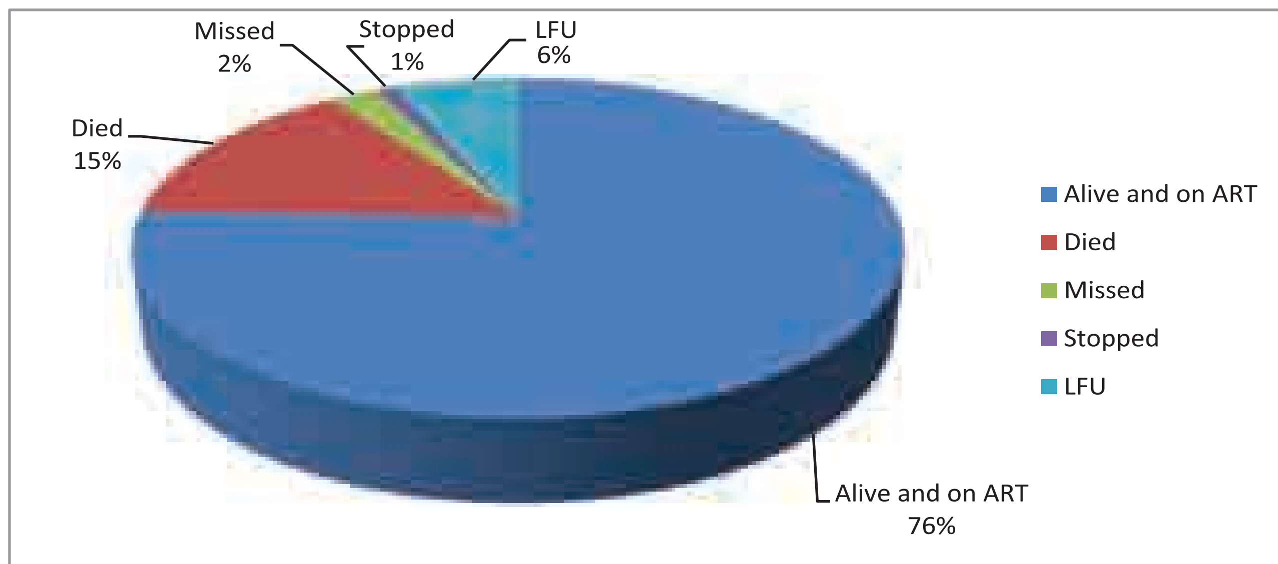
F.5. State Grievance Redressal Committee (SGRC): At the state level, Grievance Redressal Committee has been constituted to review the functioning of the ART Centres. The Committee is headed by the Health Secretary of the State and consists of Project Director of the SACS, Director of Medical Education, Director of Health Services, and the Nodal Officers of the ART Centres, representatives of Civil Society/ positive network and NACO. This mechanism ensures that issues pertaining to grievances on PLHIV are brought into notice of state authorities and SACS in a systematic manner for their timely response. So far, 106 meetings had been conducted in various states and over 500 cases taken up and necessary directives have been issued.

F.6. Missed/LFU Tracking Mechanism: The information on patients lost to follow up (LFU) is captured in the CMIS through the monthly reports from the ART Centres. This information is monitored very closely and centres with high rates of LFU are visited by senior officers of NACO. Presently the cumulative LFU has been reduced to nearly 6%. The responsibility of tracking and providing home-based counseling for LFU patients is shared with CCC through outreach workers, PLHIV networks and Counselors of ICTC in some places.

F.7: Follow up of Pre-ART LFU: All patients registered in Pre-ART and on ART undergo a CD4 test every six months. The ART centre lab technician maintains a daily "due list" of the patients who are due for CD4 testing. This list is prepared from CD4 laboratory register. This list is made available with SMO/MO and patients visiting in that particular month for ART are subjected to a CD4 test. Those who do not undergo CD4 test within one week of their due date are followed up by phone call to ensure that CD4 test is done on the next visit.

F.8. Smart Card System: This concept has been introduced to develop a computerized data storage and retrieval of patient records resulting in the development of the Health Smart Cards for PLHIV on ART. This card is a chip-based one providing restricted access in order to maintain confidentiality. The Smart Card System, apart from capturing details as required in the ART PLHIV record, also captures the photograph and fingerprint of PLHIV. After the preliminary data capture, the PLHIV is uniquely identified using biometric de-duplication process at the central database. Once the PLHIV has been identified, a unique ID is generated for each PLHIV to register in the system.

Fig. 11.3: Cumulative outcome of PLHIV on ART



- Much of the affected population is mobile. This card will help in accessing care and support in all parts of the country.
- Monitoring of treatment to ensure adherence to the treatment plan is essential to prevent the patient from becoming drug resistant.
- The patient's information can be kept confidential given the prejudices against the disease.
- Acts as a portable medical record.
- Linking the PLHIV for treatment of Opportunistic Infections.
- Linking with other social and health schemes.
- Plays a crucial role in time-sensitive emergency situations.
- Gives a cheaper alternative for storing data using the latest technology.
- Generates a set of important MIS reports that are immune to human errors; can act as early warning signals; help in decentralized decision making; can help in setting regional priorities.
- Prevents misuse of health subsidies.

Application Software for the Smart Card system has been developed. An expert committee has been constituted to oversee the project implementation.

G. Evaluation & Operational Research

Various studies conducted in relation to CST during NACP-III include the following:

G.1 Studies Completed

- Assessment of ART Centres in India: Clients' and providers' perspectives
- Baseline CD4 count of PLHIV enrolled for ART in India
- Assessment of Link ART Centres in India
- Assessment of the Centres of Excellence (COE) in India
- Assessment of Regional Pediatric Centres
- Assessment of Community Care Centres in India
- Factors affecting enrolment of PLHIV in ART centres
- Baseline CD4 count of healthy adult population
- Study of prevalence and types of baseline HIV drug resistance in the ART naive and previously treated HIV infected Northern Indian population.
- Determination of reference ranges for CD4+T cell count and percentages for Adult Indian Population.
- Determining factors associated with ART drug adherence among HIV positive patients in India –A Multi centric Study
- Psychosocial need and stresses in people infected with HIV/AIDS.

G.2 Ongoing Studies

- COHORT analysis for outcome of first line and second line ART initiated at 10 COEs
- Analysis of SACEP at 10 COEs
- Multicentre study on 'Integrating HIV prevention in NACO ART clinics"
- A study of early vs delayed initiation of ART for HIV infected patients with tuberculosis on Antituberculosis chemotherapy in Indian subjects.
- Nevirapine versus Efavirenz-based highly active antiretroviral therapy regimens in antiretroviral-naïve patients with HIV and Tuberculosis infection in India
- Efficacy of thrice weekly intermittent short course antituberculosis chemotherapy in tuberculosis patients with and without HIV infection.
- A Multicenter Study of Mental Health Morbidity and Psychosocial needs of Persons living with HIV/AIDS.

H. New Initiatives in Care, Support and Treatment

H.1 Decentralization of Supply Chain Management of ARV drugs

Through its directive dated 18 May 2011, NACO introduced a change in the way ARV drugs are distributed to ART Centres. Starting with the procurement cycle of Financial Year 2011-12, ARV distribution now follows a hub and spoke model where the suppliers deliver the entire quantity required by a state to the SACS which act as the hub for further distribution of the required quantity of drugs to ART Centres. Of the total stock of drugs received, 80% is moved to ART Centres immediately upon receipt and the rest 20% is kept as buffer stock at SACS.

H.2 Revision of the Scheme of Centres of Excellence (COE)

An assessment of 10 Centres of Excellence in HIV Care (COE) was conducted during July – August 2010 with the following objectives:

To carry out a situational assessment of COEs and their functioning with regard to stated rationale and guidelines.

To assess provider's perspectives regarding their roles and responsibilities, job satisfaction and constraints.

To understand the PLHIV's views about COEs and their satisfaction to the services offered.

To provide specific recommendations with critical observations for the overall improvement in the functioning of the COEs.

The assessments were completed between July and August 2010. Subsequently, a dissemination workshop was organized at NACO on 31st August-1st September, 2010 to discuss the COE Needs Assessment findings and prepare action plans for each COE. The teams involved in the assessment presented their findings in the meeting. The gaps identified were discussed at length and remedial measures were suggested.

Subsequently, a small working group on COE was constituted which discussed the existing COE scheme at length in view of finding of assessments. The revised draft scheme was circulated in the working group and many rounds of discussions were held. Based on these discussions and subsequent recommendations, certain aspects in the existing COE Scheme have been revised with the approval of the NACB. The revised COE scheme document was released in January 2012.

H.3 Revision of the Scheme of Link ART Centres/ Link ART Plus Centres

It has been observed that nearly 25-30% of persons detected HIV positive at ICTC are not accessing care, support & treatment services. Reasons for this could be many including persons being asymptomatic at the time of detection and long distances to reach the ART centre for registration and basic investigations which may lead them to postpone/ delay their visit to ART Centres till they become symptomatic. It has also been observed that nearly 20% patients reach ART Centres at a very late stage (CD4 count <50), when the risk of mortality is nearly 2-3 times higher.

In view of the above facts, the scope and functions of select Link ART Centre have been expanded to include Pre-ART registration and HIV care at LAC itself. The LAC, which shall perform Pre-ART management also, shall be designated as "LAC plus" This shall help to bridge the gap between ICTC (Counseling & Testing services) and CST (Care, Support & Treatment) services and also reduce the travel cost and travel time of PLHIV in accessing ART services. These patients shall be followed up at LAC plus till they become eligible for ART or referred to ART Centre for any other reason.

1. To reduce the travel cost and travel time in accessing ART services
2. To increase the access to HIV care for the PLHIV.
3. To improve the drug adherence of patients on ART
4. To bridge the gap between counseling & testing services and Care, Support & Treatment services
5. To integrate HIV Care, Support & Treatment services with the Primary / Secondary Health Care system (NRHM).
6. To build the capacity of the health care providers at the Primary/secondary Health Care Level for Care, Support

A revised guideline for the functioning of LAC/LAC Plus was published in January 2012.

H.4 Scheme for Pediatric Centres of Excellence in HIV care (pCoE): The National AIDS Control Organization launched National Pediatric Initiative was launched by NACO in November 2006 to rapidly scale up access to care, support, and treatment for Pediatric patients across the country. Currently, 97,208 HIV infected children have been registered at ART Centres of whom 28,225 are on treatment (NACO CMIS Report, January 2012).

Apart from a few Pediatric Centres, the majority of ART centres are not staffed by Pediatricians and often rely on a general Pediatric department to provide Pediatric expertise when needed. This referral system is dependent on the recognition that such expertise is required. Due to the relatively low burden of Pediatric HIV in India, many general Pediatricians have not developed competency in dealing with HIV specific complications including recognition of HIV symptoms and the need for early testing and enrolment. Hence, the need was felt to have "Pediatric Centres of Excellence (pCoE) in HIV

care" that are model treatment and referral centres and at the same time impart quality training to other personnel involved in caring for Pediatric HIV patients. These centres should be the primary sites for undertaking research, including operational research on a large scale. pCoEs are expected to conduct high quality research relating to different aspects of Pediatric HIV care and treatment. In view of the above, NACO has upgraded the 7 Regional Pediatric Centres as Pediatric Centres of Excellence (PCoE).

By equipping these centres for training and research, it is expected that the faculty from these PCoEs will carry out periodic site visits to the different ART centres to assess quality of care; monitor quality of care through a commonly agreed set of quality of care indicators for Pediatric HIV; encourage operational research on Pediatric HIV and related issues; support publication of research papers in reputed journals and present papers at research conferences and disseminate research findings to the different teaching medical institutions etc.

It is believed that by providing incentives such as a good work environment, capacity and scope for research etc., the programmes can attract some of the most talented to work in the programme. In establishing such Pediatric Centres of Excellence the stigma and discrimination that exists among the medical faculty in both the public and private sector is also expected to be broken down as well as increase in the recognition that Pediatric HIV patients require specialized care, support and follow up.

It is expected that, in these institutions, all the services that are essential for the package of comprehensive care of CLHIV are available under one roof, without the patient having to go from one place to the other.

H.5 Revision of M & E Modules: Continuous supervision of activities carried out at ART centres is essential for monitoring effectiveness and quality of services provided under the programme. To facilitate a uniform and systematic monitoring, systems and tools have been developed. The M & E tools for ART Centres, Centres of Excellence and Link ART Centres have been recently revised by NACO.

H.6 Phasing out of Stavudine: The 2010 guidelines WHO guidelines on ART recommended phase-out of Stavudine from ART regimen. It also recommend that "It is critical that national ART programme and public health leaders consider these recommendations in the context of countries' HIV epidemics, the strengths and weaknesses of health systems, and the availability of financial, human and other essential resources. WHO recommended a phased implementation of new guidelines. To discuss this, two meetings of Technical Resource Group (TRG) on ART were held in August 2010 and December 2011. It has now been decided that Stavudine would be phased out from the national ART programme. This phase out will be done during procurement cycle of 2012-13.

H.7 Post Graduate Diploma in HIV Medicine (PGDHIV): NACO, in collaboration with IGNOU, has rolled out a one-year PG Diploma programme in HIV Medicine. This programme is expected to bridge the gap in trained manpower for ART centre.

Programme Objectives

- To imbibe comprehensive knowledge on basics of HIV as related to details of management of HIV/AIDS in tertiary care set up;
- To manage all complications as well as opportunistic infections due to HIV/AIDS at the time of need; and
- To recognize and handle emergencies related to HIV/AIDS and its complication and take bedside decision for management whenever required.

The programme is implemented through a network of programme study centres (PSC) all over the country. The PSCs are located in select Centres of Excellence.

H.8 Expansion of the scheme of ART Plus Centres: The Scheme of ART Plus Centre launched in 2010-11 was expanded during the current year. A total of 28 ART centres have been upgraded and being capacitated to provide alternative first line / second line ART. Most of the states, except those having less patient load, are now covered under this scheme.

H.9 Finalization of the training curriculum for ART pharmacists: NACO, in collaboration with Delhi Society for Promotion of Rational Use of Drugs (DSPRUD), finalized the training curriculum for ART pharmacists. Thirteen training programmes have been completed so far covering the pharmacists working in all ART centres across the country.

H.10 Revision of the training curriculum for ART staff nurses: To ensure uniform standards of services, adherence to operational guidelines and treatment protocols, induction training is provided to nurses working at ART/CCC/LAC centres using

revised 6 day standard curriculum. 14 training institutions have been identified by Indian Nursing Council in coordination with NACO for the training of the nurses.The revised 6 day curriculum has been strengthened to include the areas on Nutrition Care & Support, HIV-TB, M & E and Pre-ART Management. Also, NACO National Master Trainers and INC trainers have been identified as the trainers for the training programmes. This training programme will equip the nurses working at various centres to provide standardised and quality care and support services to the people infected with HIV.

H.11 Nutrition Guidelines for CLHIV (Children Living with HIV): HIV and opportunistic infections not only depress the immune system, but also increase the need for energy, protein and other nutritional components. Malnutrition may result, and contribute to further weakening of the immune system. Nutrition care is to be integrated in care of all people and children living with HIV, especially for the most vulnerable groups which are the infants, young children under 5 years, pregnant and lactating women. To provide technical and operational details so as to enable integration of nutrition care of children living with HIV into everyday practice for health care providers the guidelines for feeding, care and management of malnutrition among HIV-affected infants and children have been developed. These guidelines are based on the 2010 WHO updated recommendations on nutrition for children living with HIV and a series of consultations convened by NACO involving expert Pediatricians, public health experts, obstetricians and gynaecologists, physicians and partners such as BPNI, Clinton Foundation, MOHFW, IAP, UNICEF and WHO. These guidelines have been developed for the use by doctors, nurses, counselors, community workers and volunteers working in nutritional care for mothers and children affected with HIV/AIDS.

H.12 Nutrition Guidelines for PLHIV (Adults): To provide common, consistent and sound recommendations and to build information and skills to guide quality nutritional care and support for PLHIV, NACO had been working for bringing the National Nutritional guidelines for the Adult PLHIVs. These guidelines provide the practical recommendations for institutionalizing nutritional support within health facilities. Moreover, these guidelines present the actions that service providers need to take in order to address nutritional requirements of PLHIVs as part of their care, support and management at various contact points. These will contribute to orient the service providers to the nutritional requirements of the PLHIVs at different stages of infection and various strategies which can be used to address the nutritional requirements of PLHIVs.

H.13 Addressing HIV Care and Support Needs of Children Affected by HIV/AIDS (CABA): The "National Scheme on Children Affected by HIV and AIDS (CABA)" was started to enable children living with and affected by HIV to gain access to a minimum package of services that would address their overall developmental needs. The package of services for CABA included Psychosocial counseling, food security interventions, linkages with social protection schemes, nutritional assessments and growth monitoring, linkage with formal and non–formal education, HIV testing, pre ART screening, OI prophylaxis and treatment.

NACO supported the piloting of this scheme in 10 select districts across six high HIV prevalence states in India. As part of piloting of the national pilot scheme, the orientation and capacity building of district government functionaries were conducted in coordination with non-government organizations (NGOs).

I. CST representation in international forum/ conferences

The CST division was represented in the following international conferences during the year 2011-12:

- 42nd Union World Conference on Lung Health, Lille, France
- Core Group meeting of HIV-TB of Stop TB Department, WHO
- High level meeting of UN General Assembly Special Session on HIV/AIDS (UNGASS), New York
- ESCAP, Bangkok
- ICCAP 10 Conference, Busan, South Korea

CHAPTER 12

STRENGTHENING OF DISTRICT AIDS PREVENTION AND CONTROL UNITS

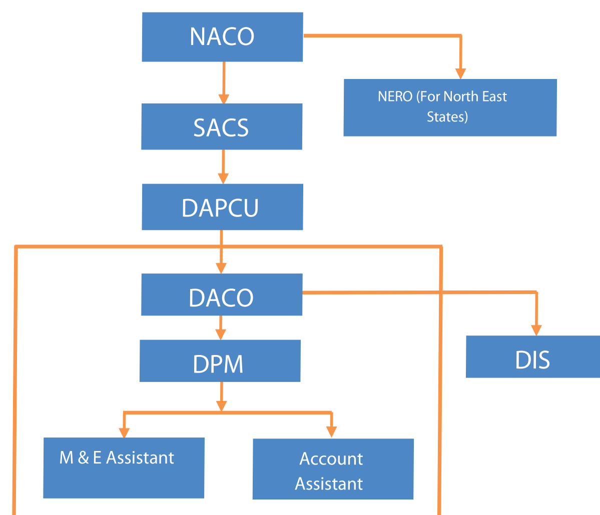
Under NACP III, District AIDS Prevention and Control Units (DAPCUs) have been established in 189 priority (A and B Category) districts. The main objective of DAPCUs is overall coordination and monitoring of NACP at district level, to take district specific initiatives and activities to integrate with formal health infrastructure and do mainstreaming with the other departments in the district.

NACO developed the capacity of DAPCUs through a National level training for all DAPCU staff. Based on the training, DAPCUs submit monthly reports to SACS and NACO, which includes critical indicators of coordination, Programme progress and convergence. NACO provides continuous feedback to the DAPCUS on their monthly report through written feedback, teleconference and field visits. The mentoring support is continued through DAPCU Blog and sharing case studies from various DAPCUs across states.

The DAPCUs have been involved on a regular basis in strengthening the Programme implementation at the district and facility level by identifying and addressing the issues relating to human resources, equipment, stocks and supplies, reporting and liquidating advances. The DAPCUs conduct field visits to facilities and have regular meetings with the staff of facilities and different departments in the district.

> The main objective of DAPCUs is overall coordination and monitoring of NACP at district level, to take district specific initiatives and activities to integrate with formal health infrastructure and do mainstreaming with the other departments in the district DAPCUs disseminate information on extended benefits of various social welfare schemes to HRGs and PLHIVs. They also play a pivotal role in facilitating their access to these schemes

STRUCTURE OF DAPCU



Note: DACO - District AIDS Control Officer; DIS - District ICTC Supervisor DPM - District Programme Manager

Services provided by DAPCU include:

i. **Supportive Supervision visits:** A total of 1,15,861 Supportive supervision visits (DACO 16,926; DPM 20,470; DIS 37,552; M&E Assistant 17,669; Account Assistant 14,280; Programme Assistant 8,964) were made by DAPCU staff from 189 DAPCUs to around 9500 HIV/AIDS related facilities in their districts from April 2011 to Dec 2011.

ii. **Human Resources:** DAPCUs play a pivotal role in identifying the status of Human Resources and the need for recruitment, training and capacity building of the staff at various HIV/AIDS facilities in the district

iii. **Stocks and Equipment:** DAPCUs monitor the stocks position, equipment functioning and coordinate with Facility Centres/ SACS to ensure regular supply of stocks, AMC of equipment procured and their calibration as required.

iv. **Referrals and Linkages:** DAPCUs conduct regular meetings with all the HIV Facility Centres and health system to facilitate stronger referrals and linkages to ensure health services.

v. **District Administration involvement:** DAPCUs coordinate and conduct quarterly District AIDS Prevention Control Committee meetings chaired by the District Collector with participation from health department, other line departments and various district level stakeholders. Consistent efforts are being made by DAPCUs, under the leadership of District Collectors for effective HIV awareness campaigns, condom promotion campaigns, dissemination and facilitation of social benefit schemes etc.

vi. **Coordination and integration with NRHM:** DAPCU play a key role in integration of NACP with NRHM and work closely with other line departments of the government to mainstream facilitate coordination of HIV/AIDS Programmes.

vii. **MIS:** DAPCUs submit monthly report to PD SACS and NACO on physical, financial, epidemiological progress of the programme maintain and update the District performance and regularly report to District Collector.

viii. **Schemes of other line departments for main streaming:** DAPCUs disseminate information on extended benefits of various social welfare schemes to HRGs and PLHIVs. They also play a pivotal role in facilitating their access to these schemes.

ix. **Finance management:** DAPCUs follow up with various facility centres for Submission of Statement of Expenditure, Utilisation certificates, audited statements and report the same to SACS. They also assist SACS in liquidation of advances pending from the district level facilities.

x. **District Action Planning:** Some DAPCUs have been capacitated and involved in the process of district level action planning exercise which eventually feeds into the state annual action plan. DAPCUs of Andhra Pradesh (23), Nagaland (10) and Karnataka (4) have already embarked on this process.

xi. **Other initiatives:**

- Spatial Maps: Information about the geographical distribution of the vulnerability and HIV/AIDS service facilities in the district has become important for planning and Programme implementation. 179 DAPCUs have prepared first draft of the spatial maps showing the geographical distribution of the burden (in terms of HRGs, PLHIVs, etc.) of the disease, to understand epidemic at district/ sub district level to inform District Collector/ District administration and People's representatives. This initiative helps them in prioritising specific areas (block/ villages) in the district for interventions.
- Human Resource data: 182 DAPCUs undertook an exercise to map all the human resource involved in NACP (both government and Development Partner level) in the DAPCU districts under NACP III.
- Storage facility details: DACPUs have collected and compiled information about the storage facilities (cold and non-cold) in their districts. This information is critical for national and state level supply chain management.

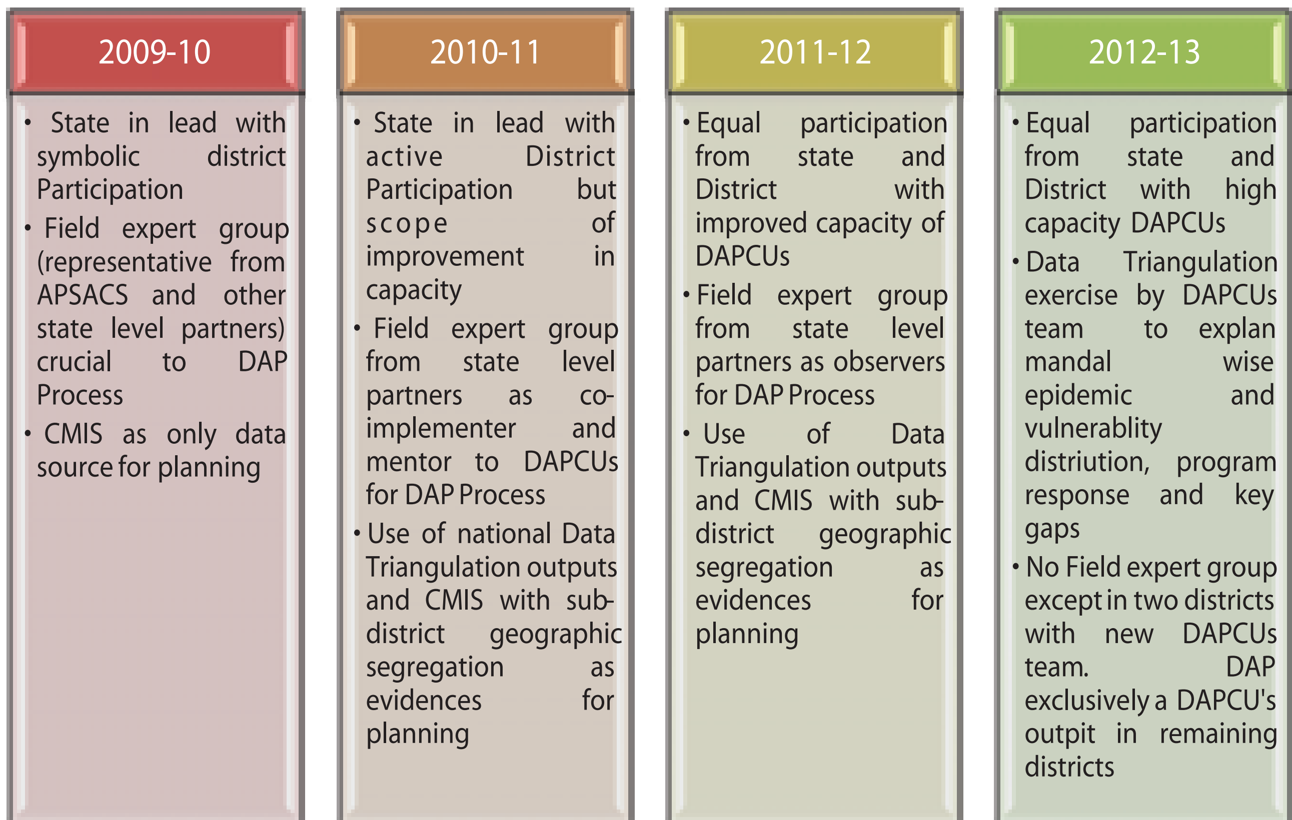
Decentralized Planning in Andhra Pradesh- A Case Study: Evidenced Based bottom up approach

Decentralized programme management through DAPCU has been crucial strategy under "Halting and Reversing the HIV epidemic" under NACP III. Accordingly, DAPCU has been established in each district in Andhra Pradesh since 2009 and APSACS has many "firsts" to its credit in strengthening implementation of National AIDS Control Programme (NACP) in state through DAPCUs.

Decentralize annual action planning has been

one of the key initiatives under decentralized programme management of NACP in Andhra Pradesh. The activity is coordinated by SIMU-APSACS with active support of TSU-APSACS. The process has started in 2009-10 and matured over the years in terms of ownership and involvement of DAPCU teams (Fig 12.1). When the DAP process was started for 2009-10, it was an exercise implemented by experts identified by SACS who went to districts and prepared the plan in consultation with the local stakeholders. Later the process was implemented for 2012-13 plan, it was completely prepared by DAPCUs following standard operating procedures without any support from external experts.

Fig 12.1. Evolution of District Action Plan process by DAPCUs in Andhra Pradesh



For 2012-13 plan process, a fresh data triangulation exercise was coordinated by SIMU where DAPCUs prepared a detailed sub-district level epidemiological profile, programme response as well as key gaps. The outputs of data triangulation exercise became the starting point for district level consultation meeting attended by representatives from various service delivery points, grass root level NGOs as well as personnel from NRHM and other line departments. A comprehensive situational analysis is followed by setting of the SMART objective with proper justification and pragmatic strategies. The plan was submitted to District Collector for perusal and approval. After preparing the plan, the districts presented their plan to state team in a dissemination workshop chaired by Project Director. Each district plan was discussed and debated in detail and feedback was given to concerned DAPCUs. The plan was further circulated to each component lead for in-depth review and incorporation of inputs from DAP into state's annual action plan.

CHAPTER 13

ACTIVITIES IN NORTH EASTERN STATES

National AIDS Control Programme is provided to the North Eastern states to address their special needs. State AIDS Control Societies have been strengthened in all North-Eastern States by providing them adequate financial and human resources for the effective implementation of programme components

In the North Eastern region, the dual HIV epidemic driven by unsafe sex and injecting drug use is highly concerning. Moreover, there are many new areas in the north-eastern states where HIV is increasing, particularly among injecting drug users. As such the strategy of Prevention & Control of HIV infection in these States is largely focusing on prevention of HIV infection in this sub population along with other components of the programme.

The HIV epidemic in the North Eastern region of the country is largely driven by use of HIV infected syringes and needles by Injecting Drug Users (IDUs) and increasing transmission of HIV through sexual mode in the region. This dual HIV epidemic in the northeast, driven by IDUs and sex workers, remains unabated.

According to HIV estimate of 2008-09, Adult HIV prevalence among ANC clinic attendees are Arunachal Pradesh (0.16%), Assam (0.08%), Manipur (1.4%), Meghalaya (0.08%), Mizoram (0.81%), Nagaland (0.78%) and Sikkim(0.06%) and Tripura(0.15%).

Progress of the programme and schemes in north-eastern states:

The comprehensive package of services under National AIDS Control Programme is provided to the North Eastern states to address their special needs. State AIDS Control Societies have been strengthened in all North-Eastern States by providing them adequate financial and human resources for the effective implementation of programme components. North East Regional Office, established by NACO, provides technical support to facilitate programme planning, implementation, capacity building and monitoring and reporting.

DAPCU has been operationlised in 25 districts with formation of Districts AIDS Prevention Control Committee. DAPCU have initiated and following up the process of convergence with NRHM at states and districts levels

Details of the Facilities and Services provided under National AIDS Control Programme in North-Eastern states have been summarized in Tables 1 & 2 respectively:

Table 13.1: Status of Facilities under National AIDS Control Programme (As of January 2012)

State	Stand alone ICTC	Facility Inte-grated	STI	Blood Banks	Targeted Interven-tion	Link Worker Scheme	Drop-in-cen-ters	ART Cen-tre*	Com-munity Care Centre	Total
Arunachal Pradesh	35	11	17	12	21	0	0	1	1	98
Assam	83	39	27	26	60	0	1	2	3	241
Manipur	54	15	10	3	69	9	4	6	9	179
Meghalaya	10	2	8	3	10	0	1	1	0	35
Mizoram	27	27	8	10	37	3	7	2	3	124
Nagaland	60	1	11	8	52	10	14	6	4	166
Sikkim	12	6	6	2	6	0	1	1	1	35
Tripura	18	38	14	6	14	2	1	1	2	96
Total	**299**	**139**	**101**	**70**	**269**	**24**	**29**	**20**	**23**	974

* 1 ART plus in Assam and Mizoram, 1 COE in Manipur, 1 PCOE in Manipur, 2 LAC plus in Assam and Nagaland (Data as on Jan 12)

Table 13.2: Services provided under National AIDS Control Programme (During 2011-12 till Jan. 2012)

State	Arunachal Pradesh	Assam	Mani-pur	Megha-laya	Mizoram	Naga-land	Sik-kim	Tripura	Total
Coverage (IDU)	1762	3470	27380	1506	15200	20448	1450	800	72016
Coverage (MSM)	150	2400	1950	200	600	1270	0	200	6770
Coverage (FSW)	3472	19560	6920	1839	1470	1850	902	8650	44663
Alive and on ART (Adult) #	25	1615	6948	209	1394	2972	61	226	13455
Alive and on ART (Pediat-ric) #	1	70	500	5	99	147	0	5	827
Total Blood Collec-tion	2849	154198	12037	7642	18509	7656	3060	18189	224140
Propor-tion of voluntary blood collection	63%	53%	45%	48%	91%	80%	78%	94%	61%
No. of general clients tested	15392	105958	40856	10501	43343	62655	15128	30666	324499

Number found positive (%)	15	979	1742	291	1188	1489	22	163	5889
No. of pregnant women tested	8854	171861	38696	15732	21812	15745	6757	16540	295997
Number found positive (%)	0	101	137	43	140	137	3	12	573
No of STI//RTI episodes treated (DSRC + TI STI)	11786	83094	10691	5729	20757	6497	1410	32002	171966

1. Preparation of Action Plans

A Strategic planning workshop for the NE states (except Sikkim) was organised in Guwahati on18-19 Jan 2011 by NERO with officials of NACO, NTSU, APAC and UNAIDS as resource. Best practices from different NE states as well as other parts of country were discussed to facilitate adapting them as required while formulating AAPs of 2011-12. Focus was given on relating trends of componentwise expenditures across NE states to identify successes and road blocks in implementation and prepare more realistic plans and strategies for AAP 2011-12. States were encouraged to build upon strategies of networking, engaging and leveraging existing Govt. systems to improve scale and impact of NACP III programme.

2. Priority District Action Plans

The District Action Plan Development workshops were organised in coordination with SACS and technical support from NTSU, NACO, CDC and PHMI (Hyderabad) for Dimapur in Nagaland and Aizawl in Mizoram in January & March, 2011. With participation from significant stakeholders, the respective district action plans were developed and later incorporated into the annual action plan preparation for 2011-12 by the respective SACS. The implementation of the plan has been followed up by NERO team through regular supportive supervisory visits to the districts. For the year 2012-13 DAP ahs been prepared for all 11 districts of Nagaland.

3. DAPCU Annual Work Plans

With an aim of ensuring effective implementation of approved annual action plan in the 25 A and B category districts where all DAPCU Teams are present, NERO facilitated SACS to disseminate the approved action plans to the DAPCU Teams. Annual Work Plans were developed for all DAPCUs. The DAPCU nodal Officer from SACS, with technical support from NERO, followed up the implementation. As result all, DAPCUs were enabled to submit the monthly report on time and accurately. These reports are analysed by the National DAPCU Resource Team and feedback provided to the concerned states with recommendations. NERO team followed it up and submits action taken reports to NACO and NTSU.

4. NE Regional Consultation on Formulation of NACP-IV Design

As per the recommendation of the 1st round of National Level consultation on NACP IV, the 1st regional consultation was held at Guwahati in June 2011 organized by NERO supported by UNAIDS and NACO. The consultation was for two day, the first day was attended by the communities and civil societies (73 participants comprising of HRG, PLHIV Communities, NGO reps, CSOs). The second day was attended by multi-stakeholders (104 participants comprising of various govt department, FBO, Development partners, SACS, DAPCU, selected CSO representatives and NERO).The documentations from the two consultations were circulated among the participants. All the feedbacks received through emails were consolidated and finalized on 29th June meeting. The final recommendations were submitted to NACO for incorporating it in the 2nd round of NACP-IV discussion at the national level.

5. Training and Capacity Building

NERO coordinated with SACS and various training institutes identified by NACO for conducting various training activities under different Programme components of NACP for the following activities and ensure completion of the training targets:Finalization of the annual training calendar,Release of fund by SACS to STRCs, Identification of Master Trainers for each of the states and approval from NACO,Roll out of training as per approved training calendar and Supervision of training quality assurance by observing the training conducted by training institutes Training report submission by training institutes to SACS, NERO and NACO for training staff of TI NGOs, there are 3 State Training Resource Centres (STRC) for 8 NE states identified by NACO. MSDRB STRC at Aizawl is for Mizoram and Arunachal Pradesh, Emanual Hospital Association (EHA), Dimapur-STRC for Manipur and Nagaland. Recently EHA, Guwahati has been identified as STRC by NACO Assam, Tripura and Meghalaya. Before establishing STRC at Guwahati, NERO in coordination with SACS priority trainings such as on Harm Reduction, Financial Guidelines, Effective outreach planning, Data collection tools were conducted.

- 2nd National TOT on new refresher module for ICTC counselors: NERO in coordination with Assam SACS had organized a 4 days TOT conducted by NACO and NERO resource team. 20 training institutes and 24 SACS participated in this TOT.NERO in consultation with Training institutes and SACS, refresher training plans were finalized and the orientation of master trainers on the new module have been completed by the training institutes. Following which

refresher training for the Counselors using the new module will be started by January 2012.

- TOT on ICTC Team Training: 27 participants comprising representatives from SIFW, RRTC and Health Departments from all NE states except Tripura attended the training. Training plan developed and the team training will be rolled out from January 2012. Learning site visit for all the state IEC and mainstreaming persons was organized by NERO
- SIMS Training: Training for SACS officials, DAPCUs and facility sites staff on SIMS completed in the entire NE states.

6. Scale up of Oral Substitution Therapy in NE Sates

Out of 16 NACO approved OST sites, feasibility assessment of 14 sites have completed; sensitization workshops for stakeholders have been completed in all assessed sites. 12 sites have been provided to set up OST in Govt Health set up (2 in Manipur, 3 in Nagaland, 3 in Mizoram, 2 in Sikkim and 2 in Assam). Staff recruitment completed in Nagaland and Sikkim

7. Folk Media Campaign 2011-12

National folk media campaign rolled out in four SACS (Assam, Manipur, Tripura and Sikkim). The strategy adopted for the campaign at each strategic venue was through the crowd mobilization and dissemination of HIV messages. This was the first phase of the state wide folk media campaign which was a great success where a series of performances were performed in different districts attracting thousands and thousands of people. As foreseen, the folk troupes could reach out to the public, and messages were correctly conveyed. Besides NGOs and other stakeholders, both print and electronic media supported the campaign by giving good coverage down to district level.

8. Multi-media Campaign

The multi-media campaign on HIV/AIDS, Red Ribbon Super Stars', targeted youth aged 15 - 29 has been successfully implemented in the north-eastern states (Arunachal, Assam, Meghalaya, Mizoram, Nagaland and Sikkim). The campaign used a combination of music competitions, dramas and football tournaments organised at district level culminating into the state level mega events. These were further amplified through the use of TV, radio, newspapers and outdoor media. Owing to the culture of North-east over 100 faith based organisations were sensitised and involved in the campaign. A special effort was made to reach out to the out-of-school youth in the states. BCC messages were developed and disseminated by RRCs and Colleges youth. The winners of the music competitions positioned as "youth icons or the super star" are further taking messages on HIV/AIDS to the community through road shows at villages and blocks of every district.

9. Legislative Forum on AIDS

Legislative Forums on AIDS are functioning in Assam, Nagaland, Manipur, Meghalaya, Mizoram, Sikkim and Tripura with support from the SACS. The Tripura Legislative Forum organised a Workshop with support from Tripura SACS on 20 Feb 2012 at Tripura Legislative Assembly Conference Hall, Agartala.

10. SACS-IEC Officials:

Educational Exchange Programme in Tamil Nadu facilitated 14 IEC Officials from SACS (Arunachal, Meghalaya and Nagaland) to visit Tamil Nadu to exchange and learn the HIV communication strategies as a cross cutting and integral intervention of all components of HIV and AIDS prevention, care, support and treatment programme. This activity was part of the annual action plan approved by NACO to undertake this activity. The exposure learning benefited not only to provoke and motivate the officials but also provide a roadmap towards designing more effective and efficient communication programmes, operations and service delivery in the states. Emphasis was given on mainstreaming, advocacy and social mobilization, on the importance of monitoring and evaluation, financial management and inter-sectoral-coordination issues were also discussed during the visit. The exposure learning's are being incorporated and adapted in the state.

CHAPTER 14

STRATEGIC INFORMATION MANAGEMENT

Strengthening the nationwide Strategic Information Management System is one of the four key strategies of NACP-III. Having a strong Strategic Information is a high priority agenda of NACP-III, towards building up an effective response to the HIV epidemic in the country.

NACP-III is based on the experiences and lessons learnt from NACP-I and II, and is built upon their strengths. The strategies and approaches of NACP-III are guided by the principle of unifying credo of Three Ones, i.e., one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National Monitoring and Evaluation System. This framework ensures effective use of information generated by government agencies, non-government organisations (NGO), civil society and development partners. NACP-III is a scientifically well-evolved programme grounded on a strong structure of policies, programmes, schemes, guidelines, rules and operational norms. Formulating each of them is a rigorous process of undertaking research, reviewing evidence, consolidating field observations and programme experiences, conducting detailed discussions and deliberations, piloting and periodic evaluations.

Strengthening the nationwide Strategic Information Management System is one of the four key strategies of NACP-III. Having a strong Strategic Information is a high priority agenda of NACP-III, towards building up an effective response to the HIV epidemic in the country. The effective utilisation all available information for evidence-based planning and implementation brought out the need for establishing the Strategic Information Management Unit (SIMU) under NACP-III. It has been set up at national level and at state level for tracking the epidemic and the effectiveness of the response. It helps in assessing how well NACO, SACS and all the partner organizations are fulfilling their commitment to meet the agreed objectives. SIMU comprises three divisions – Programme Monitoring Division, Research & Evaluation Division, and Surveillance and Epidemiology Division. They generate and manage crucial information on the entire spectrum of HIV epidemic and its control – vulnerabilities and risk behaviours pre-disposing HIV transmission, patterns of spread of the epidemic and factors contributing to it, disease progression, treatment requirements and regimens, planning and implementing interventions, monitoring service delivery and tracking beneficiaries, programme gaps and ways to overcome them, effectiveness and impact of interventions. Another key function

of SIMU is to promote data use for policy making, programme planning, implementation and review at national, state, district and reporting unit level. A Data Analysis and Dissemination Unit has been set up under SIMU at NACO to undertake technical and analytical work at national level, promote and mentor technical work at state and district levels and ensure effective data use at all levels of the programme.

Programme Monitoring:

For programme management and monitoring following key activities are undertaken:

- Managing Computerised Management Information System (CMIS)/Strategic Information Management System (SIMS) for routine reporting from programme units, including system development and maintenance, finalizing reporting formats, ensuring modifications/ improvements based on feedback, training programme personnel in its use, troubleshooting and mentoring.
- Monitoring programme performance across the country through CMIS/SIMS and providing feedback to concerned programme divisions and SACS
- Monitoring and ensuring data quality, timeliness and completeness of reporting from programme units
- Data Management, Analysis and Publications
- Data Sharing & Dissemination
- Maintenance of NACO Website
- Processing Data Requests
- Capacity Building in programme monitoring and data management
- Preparation of Programme Status Notes & Reports (Annual Report, Monthly Cabinet Note,
- Results Framework Document, UNGASS Report, Universal Access Report, etc.)
- Providing Data for National/International Documents

Computerized Management Information System:

Data collection under the programme is done through Computerized Management Information System. Currently, monthly reports are received from 35 SACS and 3 Municipal AIDS Control Societies, 9,459 Integrated Counselling and Testing Centres (Standalone ICTCs, Facility Integrated ICTCs and PPP sites), 1,785 Targeted Intervention facilities, 1,200 Blood Banks, 255 Community Care Centres and 1,112 Sexually Transmitted Infection Clinics.

Timeliness and completeness of reporting is monitored on monthly basis, and feedback is provided to SACS for improving them. Every state has to submit the monthly report to CMIS by 10th of every month. If the states lag behind, reminders are given. Visits to major non-reporting states resulted in rectifying problems of non-reporting. Percentage timeliness of reporting to CMIS has reached up to 97 percent.

Table 14.1: Dashboard Indicator for NACP-III (2010-11)

S.No.	Indicators	Target for NACP-III by 2012	April-June, 2011	July-Sept, 2011	Oct -Dec, 2011
1	Number of Targeted Intervention Projects (Total)	2,100	1,487	1,540	1,785*
	a. Female Sex Worker		482	489	490
	b. Men who have Sex with Men		179	186	183
	c. Injecting Drug Users		284	267	281
	d. Truckers		75	75	76
	e. Migrants		205	206	241
	f. Core Composite		262	317	326
2	Number of TI's reporting condom Stock-out in last month (%)	Nil	52(3.4%)	21(1.4%)	15(0.9%)
3	Number of ICTC Clients Tested (Non-Cumulative)	2.2 crore / year	44,79,358	46,52,844	44,34,563
	Number of ICTC Clients post test counselled and received result		43,16,896	47,36,596	42,33,004

S.No.	Indicators	Target for NACP-III by 2012	April-June, 2011	July-Sept, 2011	Oct -Dec, 2011
4	Number of HIV positive pregnant women (mother & baby) receiving complete course of ART prophylaxis (Non-cumulative)		2,775	3,496	3,688
5	Percentage of blood units provided by voluntary blood donors**	90%	81%	82.5%	83.7%
6	Number of ART Centres	250	316	320	330
7	Number of eligible persons with advance HIV infection receiving ART	3,00,000	3,50,294	3,77,391	4,74,461
	a. Male		1,91,244	2,06,087	2,52,057
	b. Female		1,38,808	1,50,171	1,93,978
	c. Children		19,038	21,133	27,597
	d. Transgender		1,204		829
8	Percentage of SACS with HRG representatives included in SACS decision making bodies	100	91%	91%	91%
9	Percentage of districts with at least one functional PLHIVNetwork	100	60%	60%	60%
10	Percentage of funds disbursed relative to target (Cumulative)	100	29%	50%	54%
11	Percentage of SACS having approved financial and administrative delegations	100	100%	100%	100%
12	Percentage of states where Donor Partnership forum met last quarter	100	74%	74%	62%
13	Percentage of SACS where JD(TI)/AD(TI)/ DD(TI) position in SACS filled	100	74.20%	82.40%	88.20%
14	Percentage of SACS where Project Director is sole in-charge of SACS for more than one year	100	82.30%	69%	75%
15	Percentage of SACS with at least 80% CMIS reporting	80	97%	97%	97%
16	Percentage of SACS which submit Dashboard to NACO regularly	100	97%	97%	97%
17	Percentage of due procurement contracts awarded during original validity period	100	80%	80%	80%
18	Number of ICTC's reporting test kits stock out during quarter	Nil	1,000	1,220	659
19	Number of ART Centres reporting drugs stock-out during quarter	Nil	32	9	10
20	Percentage of SACS where Governing body met during the reporting quarter	100	69%	24%	53%
21	Number of districts with District Unit (DAPCU) established	189	189	189	189

* includes 190 TIs supported by donor agency; ** Collection in NACO supported Blood Banks

Strategic Information Management System: In order to meet the objectives of NACP-III and to ensure robust reporting and monitoring, Strategic Information Management System (SIMS), a web-based integrated monitoring and evaluation system is being developed as a mechanism. SIMS is a centralised system that allows the users to capture the data at various levels like Reporting Unit, District Level, and State Level and enables them to view the data whenever required. It enhances the efficiency of computerised M&E system by having adequate data quality through centralised validated data. Data transfer mechanisms are improved by using the web-enabled application and efficient data management rights (Access Rights Control) from reporting unit to national level. This system provides

evidence to track the progression of epidemic with respect to demographic characteristics and geographical area including GIS support and enables individual level data collection for key programme areas (e.g., ICTC, ART) through built-in real-time analytic, triangulation and data validation capabilities. SIMS also provides tools for better decision making through data triangulation from different sources and thereby facilitates ease of evaluation, monitoring and taking policy decisions at strategic or tactical level. SIMS was launched by Secretary& DG, NACO in August 2010 and the roll out of SIMS is in progress in phased manner.

SIMS roll out: For successful implementation of SIMS, four phases of training was undertaken for national, state, district and reporting unit levels. A preparedness matrix was developed including the questions on the functionality of the system (availability of required configuration i.e. software, hardware and internet connectivity), user training requirements in each state. Many of the monthly formats and daily (patient wise) formats have been developed and rolled out in a phased manner. During the pilot phase, feedback was provided to the SIMS development agency. By December, 2011, most of the monthly formats were rolled out and data entry is in progress in all the states.

Table 14.2: SIMS Training organised from August 2010 to June, 2011

Phase	Category of personnel trained in SIMS	No. Trained
I	Monitoring & Evaluation Officers, M&E staff, TSU staff	37
II	SACS officers (Orientation)	262
III	DAPCU staff	282
IV	Reporting Unit Personnel	9,667
V	Regional institute teams (in Surveillance module)	18
Total		**10,266**

Table 14.3: Monthly formats rolled out

Blood Bank	Lab Services
TI- NGO	Integrated counseling & Testing Centre
Sexually Transmitted Infections-TI, RSTRL, NRHM-STI	Dashboard
Community Care Centre	Training
IEC/Mainstreaming	Adolescence Education Programme
Red Ribbon Club	Drop-in-Centre (DIC)
Surveillance (HSS Format) Anti Retroviral Treatment	

Fig14.1SIMS Login Screen

Fig. 14.2: Supervisory Visit at PPTCT centre in Puducherry

Table 14.4: Phases of roll out of National SIMS

1st August, 2011	15th September, 2011	1st December, 2011	1st December, 2011
Delhi	• Ahmadabad MACS	• Bihar	• Arunachal Pradesh
	• Andhra Pradesh	• Chandigarh	• Assam
	• Chennai MACS	• Haryana	• Dadra & Nagar Haveli
	• Gujarat	• Himachal Pradesh	• Daman & Diu
	• Karnataka	• Chhattisgarh	• Lakshadweep
	• Maharashtra	• Kerala	• Meghalaya
	• Mumbai MACS	• Jammu & Kashmir	• Mizoram
	• Puducherry	• Jharkhand	• Nagaland
	• Tamil Nadu	• Madhya Pradesh	• Sikkim
	• Goa	• Odisha	• Tripura
		• Punjab	• Manipur
		• Rajasthan	
		• Uttar Pradesh	
		• Uttarakhand	
		• West Bengal	

Capacity Building:

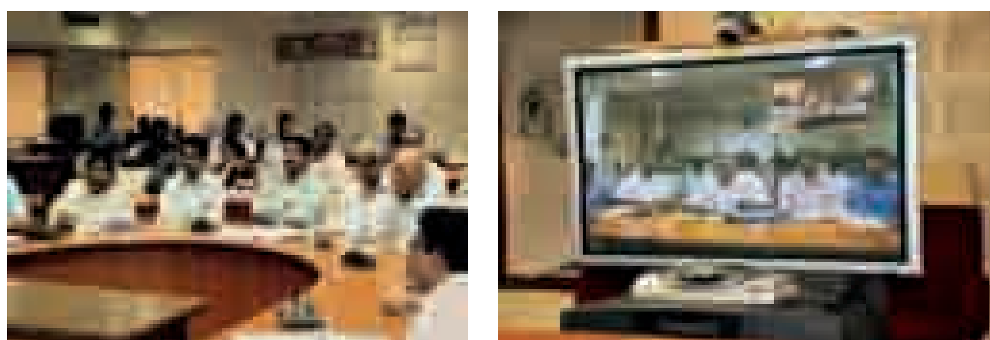
NACO is organising a series of Capacity Building Workshops on Ethics in HIV/AIDS research for young researchers. Following the first workshop conducted for Northern region at New Delhi in November, 2010, two more workshops were organised, with support from UNICEF, for Western and Southern regions at the National AIDS Research Institute, Pune (13-15 September, 2011) and the Government Hospital of Thoracic Medicine, Tambaram (14-16 November, 2011) respectively. At these workshops, 55 young researchers from NIIHAR institutions and Medical Colleges, and State Epidemiologists were trained during 2011-12.

Fig.14.3: Review–Cum-Continuing Education Programme for State M&E officers

Programme Monitoring through Video Conference; a Case Study of Andhra Pradesh

Andhra Pradesh has piloted use of videoconference for regular monthly project reviews with DAPCUs. The review, conducted by the Project Director on the third Monday of every month, is attended by various stakeholders like state lead partners, NRHM functionaries and grass root personnel from LWS, ART, CCCs, TI's, etc. An indicator review matrix, prepared by SIMU-APSACS, is shared with DAPCU's prior to the review to ensure that state and district teams are on same page on critical performance indicators. The review provides opportunity for instant problem solving and decision making in many cases. This sustainable time and cost effective mechanism of project monitoring ensures that each cadre of programme implementors receives the same message with immediate, unambiguous communication. The approach has strengthened evidence-based programme monitoring and decision making in the state.

Fig 14.4: Programme Monitoring through Video Conference in Andhra Pradesh



Processing data requests: NACO's Data Sharing Guidelines specify the formats for receiving data requests from researchers or institutions and process them for providing the data. A committee has been formed which meets every month and processes the data as per the guidelines.

Preparation of documents and reports: Programme monitoring personnel prepare various planning documents and reports. Strategic Plan Document of the Department of AIDS Control for next five years and the Outcome Budget Document 2012-13 for the Department of AIDS Control were prepared during February 2011. State fact sheets, Bulletins and reports are prepared on regular basis for dissemination of the programme data.

Data Analysis and Dissemination Unit: The National AIDS Control Board has approved the establishment of 'Data Analysis & Dissemination Unit' to focus exclusively on data analysis and data use at national, state and district levels and disseminate key findings.

Providing data for National/International Documents: The Department of AIDS Control provides information for national and international documents such as Economic Survey, National Health Profile, India Report, Plan Documents, Joint Implementation Review Mission Reports, Results Framework Document, UNGASS report, Universal Access report and SAARC report.

Website NACO: The website (www.nacoonline.org) provides access to information relating to policy, strategy and operational guidelines under the programme, and the status of the facilities and programme interventions.

HIV SENTINEL SURVEILLANCE (2010-2011)

The 12th round of HIV Sentinel Surveillance (HSS) was conducted during 2010-11 & 2011-12. While HSS among pregnant women attending antenatal clinics (ANC) and patients attending Sexually Transmitted Diseases, Clinics (STD) was conducted during 2010-11, that among Female Sex Workers (FSW), Men who have Sex with Men (MSM), Injecting Drug Users (IDU), Transgenders, Single Male Migrants (SMM) and Long distance Truckers (LDT) was conducted during 2011-12. Overall, sample collection was done from 1,361 sentinel sites across the country. The scale up of sentinel sites in India since 1998 is shown in table below.

Table 14.5: Scale-up of Sentinel Sites in India, 1998-2010

Site Type	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2010
STD	76	75	98	133	166	163	171	175	251	248	217	184
ANC	92	93	111	172	200	266	268	267	470	484	498	503
ANC (Rural)	-	-	-	-	-	210	122	124	158	162	162	182
ANC (Youth)	-	-	-	-	-	-	-	-	8	8	8	8
IDU	5	6	10	10	13	18	24	30	51	52	61	79
MSM	-	-	3	3	3	9	15	18	31	40	67	98
FSW	1	1	2	2	2	32	42	83	138	137	194	267
Migrant	-	-	-	-	-	-	-	1	6	3	8	20
Transgenders	-	-	-	-	-	-	-	1	1	1	1	3
Truckers	-	-	-	-	-	-	-	-	15	7	7	17
TB	2	2	-	-	-	-	7	4	-	-	-	-
Fisher-Folk/ Seamen	-	-	-	-	-	1	-	-	1	-	-	-
Total	**176**	**177**	**224**	**320**	**384**	**699**	**649**	**703**	**1122**	**1134**	**1215**	**1361**

Fig 14.5: Training on Collection of Dried Blood Spot Specimen under HIV Sentinel Surveillance

Key Strategies

1. Expansion of High Risk Group (HRG)& Bridge Population sites
2. Introduction of rural composite ANC sites (at PHC level) to capture effect of migration in heavy out-migration districts
3. Random Sampling at select HRG sites with validated line lists in 8 states
4. Dried Blood Spot (DBS) method & Informed consent continued at HRG sites (Fig. 14.5)
5. DBS Method introduced at select ANC/STD sites in remote places
6. Renewed focus on quality of data collection, specimen collection & processing

Key Initiatives

1. User-specific Operational Manuals and Site-specific Wall Charts developed & distributed
2. Supervision of all state level trainings of sentinel site personnel by officers from Regional Institutes (RIs)
3. Mop-up trainings & on-site training for sentinel site personnel who missed the trainings
4. Introduction of Bi-lingual data forms with instructions for the first time; Data forms translated into Hindi & 7 regional languages
5. Unique site codes and lab codes developed for error-free compilation of data ; Elimination of errors in coding of site information through pre-printed stamps/ stickers provided to sentinel sites
6. Composite site mechanisms specified with pre-allotted sub-site number and sample size
7. Development of SIMS Application for HSS with separate modules for Data entry, Data monitoring, Lab monitoring & Field monitoring
8. Specialised data entry module with in-built validation reports, matching reports & reports to monitor data entry status & positivity rates
9. Double data entry at RIs under close supervision and quality checks
10. Enhanced quality of specimen processing by limiting testing to SRLs & NRLs; 17 best labs designated for testing of DBS specimens
11. Streamlined External Quality Assurance mechanisms through online reporting
12. Special focus on strengthening Field Supervision –100% sites covered through supervisory visits in most of the states

Key Activities undertaken

1. Completed sample collection at 484 High Risk Groups sentinel sites (including 163 new sites).
2. Completed testing of dried blood spot specimens at 17 designated testing laboratories.
3. Completed double entry of data from all risk groups completed at six Regional Institutes using SIMS Application for HSS.
4. Undertaken data cleaning and validation of data; Provisional findings were generated and reviewed.
5. Conducted a workshop of data management teams from Regional Institutes for finalization of HIV Sentinel Surveillance data at NIHFW, New Delhi.
6. Conducted regional and national post-surveillance review meetings at the six regional institutes and National Institute of Health and Family Welfare, New Delhi to review the issues during implementation of HSS and identify corrective measures.
7. Organised meetings for dissemination of HIV Estimations to SACS officers and state epidemiologists in phased manner.
8. The national dissemination of HIV estimations to national stakeholders as well as North and North eastern states was conducted on 2nd March 2012 at PGIMER, Dr. RML Hospital, New Delhi. The technical report on HIV estimations was formally released during the meeting by the Secretary & DG, NACO, Secretary, Ministry of Statistics & Programme Implementation and Chief Statistician of India and Country Coordinator, UNAIDS India. Separate regional meetings for southern and western regions were held subsequently. (Fig. 14.7).

Other activities undertaken during 2011-12 include:

1. Coordination of editing and finalization of district reports and fact sheets from District Epidemiological Profiling (Phase-II) by identified epidemiologists

2. Updation of framework for district re-categorisation with data up to 2011.
3. Coordination of study of cost-effectiveness of intervention scenarios for NACP-IV planning
4. Development of study protocol and operational plan for implementation of national Integrated Biological & Behavioural Surveillance among High Risk Groups

Fig. 14.6: Implementation Structure of HSS & Key Functions of Implementing Agencies

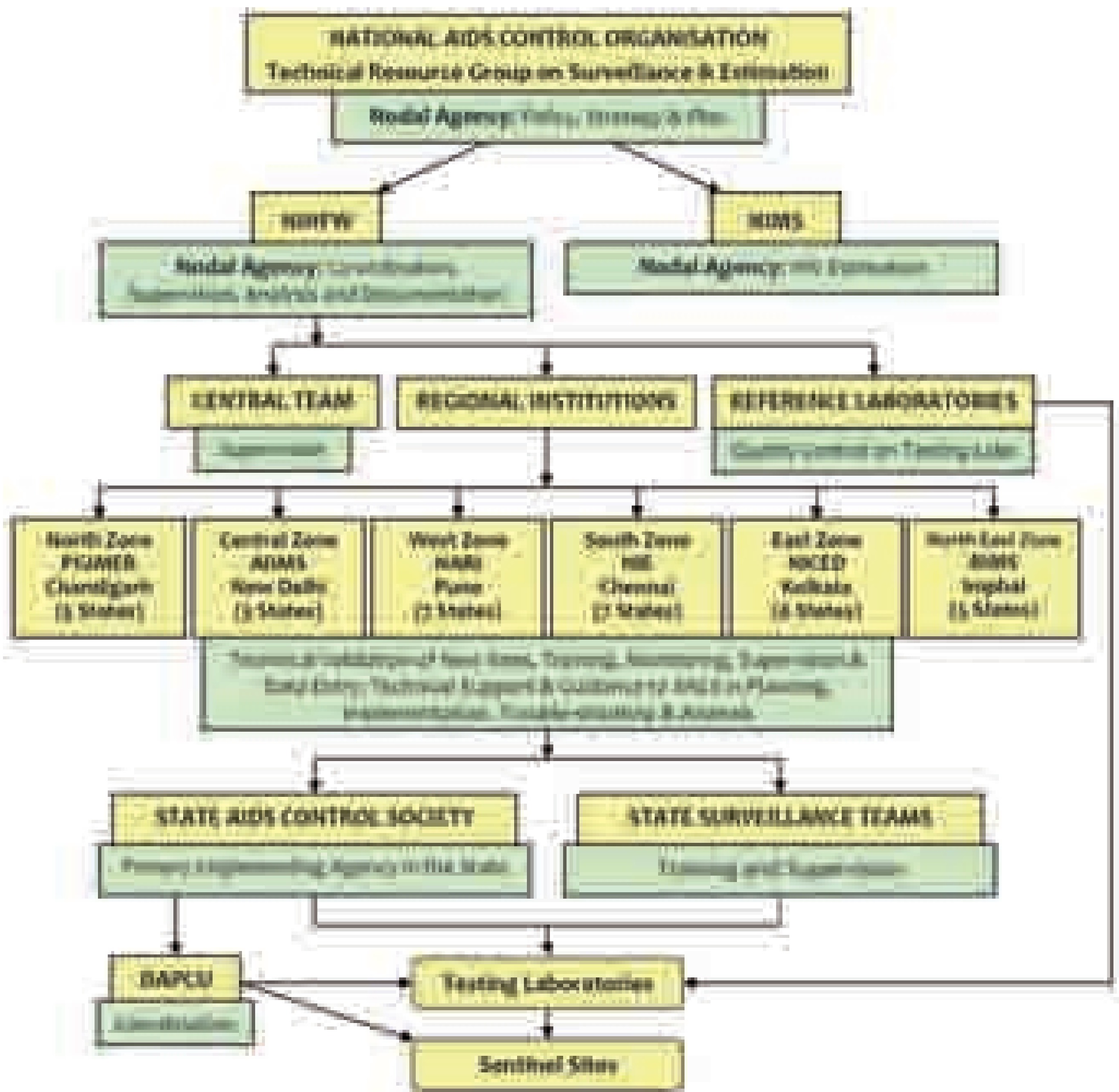


Fig. 14.7: National Dissemination of HIV Estimations 2010

RESEARCH

The main objective of the research agenda under NACP-III is to position NACO as the leading national body, promoting and coordinating research on HIV/AIDS nationally and in the South Asia region through;

- Developing guidelines, norms and standards for undertaking HIV/AIDS research;
- Partnerships and networking with multiple stakeholders and established national academic and other research institutions;
- Supporting capacity building in research related to HIV/AIDS;
- Functioning as the central repository of all relevant resources, research documents and data base on HIV/AIDS in the country;
- Ensuring translation of research outputs into programmatic action and policy formulation.

The Department of AIDS Control had organised the National Conference on HIV/AIDS Research with the theme "Towards Evidence- Policy linkages in HIV/AIDS Research" and Continuing Education Workshop on "HIV/AIDS Research: Challenges & Perspectives", in January 2011 at New Delhi.

The main activities of the Research Division are as follows:

- *Technical Resource Group on R&D*

The Technical Resource Group (TRG) on Research & Development consists of experts in diverse disciplines such as epidemiological, clinical, behavioural and social sciences. TRG on R&D was reconstituted with Dr. Prema Ramachandran, Former Advisor (Health), Planning Commission and Director, Nutrition Foundation of India, as the Chairperson. The TRG-R&D held meetings thrice during 2011-12.

The key roles and responsibilities of the TRG include:

- Discuss and identify critical gaps in existing knowledge on HIV epidemic through a commissioned comprehensive research review in relevant disciplines (bio-medical, clinical, epidemiological, behavioral and social) to develop an appropriate research agenda for filling gaps at various levels.
- Support ongoing applied research programmes for better understanding of the epidemic – its spread and impact.
- Strengthen operations research and evaluation studies on the design, strategies, implementation and testing of HIV intervention programmes and measure

their impact related to risk/vulnerability reduction, behaviour change, stigma reduction, HIV prevalence rate etc.

- Facilitate capacity building of researchers in the country for undertaking HIV research including inter-disciplinary, multi-site, action, Intervention and operations research, and to increase skills in communicating research findings for impacting policy and programme.

The following NACO supported research proposals were recommended by the TRG-R&D through its meetings held in 2011-12:

- Once daily dose of Nevirapine (400 mg.) vs. Twice daily dose (200 mg.) of Nevirapine based highly active antiretroviral therapy regimens in antiretroviral-naive patients with HIV and Tuberculosis infection in India.
- Uptake of Prevention of Parent to Child Transmission (PPTCT) services in North-East India
- Observational feasibility study of efficacy and safety of Isoniazide Preventive Therapy (IPT) in HIV seropositive patients with latent tuberculosis infection.
- Randomised Controlled Trial of efficacy and safety of daily, part-daily and thrice weekly intermittent anti-tuberculosis drug regimen in HIV sero-positive patients with pulmonary tuberculosis.
- Integrating HIV prevention with HIV care in NACO ART Clinics.

Review of Indo-foreign proposals

As decided by the Health Ministry's Screening Committee in March 2010 all research projects in the area of HIV/AIDS, specifically related to therapeutics, operational research and patient care, are referred to NACO for review by the Technical Research Group on R&D. So far, 36 Indo-foreign proposals have been reviewed by the TRG.

The following criteria have been formulated by the TRG for examining the foreign collaborative research proposals:

1. Research should make significant contribution to the advancement of knowledge in the field of HIV/AIDS.
2. Research proposal should have scientific merit.
3. Significant input should be provided by the foreign collaborator.

NACO Ethics Committee (NACO – EC)

NACO Ethics Committee for Research was constituted with the chief responsibility of ensuring that the ethical implications of any research activity are afforded serious consideration prior to the commencement of the project and that such research is consistent with legislative and statutory requirements. Its main function is to consider and provide ethical clearance for those research proposals and projects that involve participation and experimentation on human participants, where their mental, physical, social and emotional health and well-being may be affected by the proposed research.

The Committee is chaired by Prof. Gouri Devi, Consultant Neuro-physician and former Director Vice-Chancellor, NIMHANS, Bengaluru and consists of experts in epidemiological, behavioral and social sciences disciplines, a legal expert and a representative from the PLHIV community.

The committee met twice in 2011-12. The amendments to the "National Guidelines on Ethics for Research on HIV/AIDS" were discussed in the meeting. Total 7 research proposals were granted ethical clearance.

- *Network of Indian Institution for HIV/AIDS Research (NIIHAR)*

NACO has constituted the 'Network of Indian Institutions/Organizations for HIV/AIDS Research (NIIHAR)' to facilitate and undertake operational research and evaluation studies in epidemiological, behavioural, social and bio-medical disciplines. This consortium will pool resources and expertise to conduct high quality, collaborative, multi-centric research that will help evidence based decision making on policy, management and evaluation of interventions.

The functions of NIIHAR are:

1. Participation in various studies including multi-centric funded by NACO.
2. Participation in training and capacity building programs of individuals and Institutions.
3. Organizing Annual Conference on HIV/AIDS Research.
4. Deputation of experts to NACO as short-term consultants based on specific requirements.

42 Indian Institutions are members of the NIIHAR Consortium. List of NIIHAR members is at Annexure - 4

- *NACO Research Fellowship Scheme (NRFS)*

This Scheme was conceptualized to facilitate capacity building of young researchers in the country for undertaking HIV/AIDS research and to communicate research findings for impacting policy and programme. NACO Research Fellowships provide opportunities in the form of financial assistance to pursue research, ultimately leading to attainment of MPhil/MD/PhD degrees under experienced academi-cians and researchers. These fellowships serve as an incentive for them to take up quality and need-based research in the field of HIV/AIDS.

Any young scientist, below 35 years of age at the time of applying and enrolled in full-time MD/MPhil/PhD degree program in relevant disciplines from any recognized Indian University/Institute, can apply for the fellowship to carry out research relevant to HIV/AIDS in bio-medical/clinical, epi-demiological and social disciplines.

The maximum grant for each fellowship is Rs. 1.5 lakh. During 2011-2012, fellowships were awarded to 13 students.

Capacity Building Workshop on Ethics in HIV/AIDS Research

NACO is organising a series of Capacity Building Workshops on Ethics in HIV/AIDS research for young researchers. Following the first workshop conducted for Northern region at New Delhi in November, 2010, two more workshops were organised, with support from UNICEF, for Western and Southern regions at the National AIDS Research Institute, Pune (13-15 September, 2011) and the Government Hospital of Thoracic Medicine, Tambaram (14-16 November, 2011) respectively. At these workshops, 55 young researchers from NIIHAR institutions and Medical Colleges, and State Epidemiologists were trained during 2011-12.

Fig 14.8: Capacity Building Workshop on Ethics in HIV/AIDS Research for held at GHTM, Tambaram, Chennai from 14-16 November, 2011.

CHAPTER 15

CAPACITY BUILDING

NACO has been giving utmost importance to the fact that quality and trained human resource is very important for effective Programme implementation and delivery of services. Capacity building has been made an integral part of NACP to enhance technical and managerial capacities of all functionaries. The divisions in NACO have developed standardized curriculum, modules and tool kits for all the functionaries. They have developed capacities of the training institutions in Government, Quasi Government and Social Development Agencies and engaged such agencies for conducting training.

The respective departments in NACO and SACS have taken innovative approaches to use information technology by developing E-learning, Video conferencing, E-groups and Blogs etc. The divisions also developed learning site and peer learning approach and engage the peers for imparting training in institution settings as well as at site. The training is planned and executed in cascade model by developing master trainers at National and State level and they are engaged for imparting training at district and facility level. The training details are given in Table. 15.1

NACO has been giving utmost importance to the fact that quality and trained human resource is very important for effective Programme implementation and delivery of services.

Table 15.1 NACO Training Achievements during April-December, 2011

Category of Participants	Number trained
BLOOD SAFETY	**9,218**
Doctors	642
Nurses	251
Lab Technicians	1003
Donor Motivators & Organizers	7,322
COUNSELING	**4,678**
STI Counselors	77
ART Counselors	115
CCC Counselors	57
ICTC Counselors	1,530
ICTC Nurses	973
ICTC Lab Technicians	1,926
CARE, SUPPORT & TREATMENT	**703**
ART Medical Officer	158
ART Team Members (Medical Officers)	265
LAC Medical Officers	243
CCC Medical Officers	37
MONITORING & EVALUATION	**3,459**
State M&E Officers	35
Counselors (Lab)	111
Counselors (Blood Safety)	613
STI Counselors	381
CCC Counselors	39
ICTC Counselors	1,374
IEC	23
M&E Officers/M&E Asst (TI)	883
STI	**19,964**
Doctors	2,653
Staff Nurses	1,069
Lab Technicians	1,012
PPP Doctors	3,882
STI Regional Centre staff (microbiologist, lab technician)	52
NRHM Doctors	4,104
NRHM Paramedical Staff	7,192
LINK WORKER SCHEME	**9425**
District Resource Persons	430
District M&E Officers	215
Supervisors	860
Link Workers	7920
TARGETED INTERVENTION	**20,105**

Category of Participants		Number trained
Project Directors	Induction	153
	Programme Management	111
	Revised Migrant strategy	14
	Financial Management	36
	Outreach Planning	22
Programme Managers	Induction	300
	Programme Management	803
	Revised Migrant strategy	105
	Harm reduction module	130
	Financial Management	398
	Community mobilization, networking	63
	Condom Social Marketing	34
	MIS	343
	Outreach Planning	153
Counselors/ ANMs	Induction	260
	STI	260
	Counseling	1083
	MIS	77
	Revised Migrant strategy	23
	Community mobilization, networking	38
	Truckers programme orientation	2
	Outreach Planning	95
	Harm reduction module	172
Accountants	Induction	142
	MIS	191
	Outreach Planning	35
	Revised Migrant strategy	4
	Harm reduction module	6
	Financial Management	978

Category of Participants		Number trained
M&E Officers	Induction	152
	MIS	242
	Revised Migrant strategy	9
	Outreach Planning	68
ORWs	Induction	941
	Outreach Planning	3,184
	Harm reduction module	544
	Community mobiliza-tion, networking	258
	MIS	16
	Revised Migrant strategy	103
	Truckers programme orientation	4
	Peer Education	414
Peer Educa-tors	Peer Education	7,670
	Truckers programme orientation	20
	Harm reduction module	20
PPP	STI Management	305
TSU POs		86
TSU Personnel		5
SACS/NERO Personnel		22
STRC Training Coordinators/ Training Officers		11
DAPCU		**30**
DACO		8
DPMs/ DPOs		2
M&E Assistant		1
ICTC Supervisors (DIS)		7
Accounts Assistants		2
Office/Programme Assistants		10
MAINSTREAMING		**4,86,595**
Panchayat members/ PRI		8911
SHG members		2,35,022
ASHA		92,364
ANMs/LHVs/ Nurses		7,153
Youth groups		13,685
Police/ Jail personnel		44,036
Government Officials		43,642
Prisoners & Jail inmates		4,408
Tourism professionals		851
Members of faith-based organizations		326
Industrial workers		9,354
Transport workers		1,756
Cooperative members		149
Others		24,938
TOTAL		**5,54,177**

CHAPTER 16

RESULTS FRAMEWORK DOCUMENT

The Department of AIDS Control scored 92.89% and 91.27% as the overall composite score for RFD 2009-10 and 2010-11 respectively with "Excellent" rating.

The "Performance, Monitoring and Evaluation System" is an important initiative of the government towards creating a vision-driven government that is focused on results. The Results Framework Document (RFD) for individual departments is the cornerstone of this initiative.

Dr. S. Venkatesh, DDG has been designated as departmental coordinator for RFD in the Department of AIDS Control. The Department of AIDS Control scored 92.89% and 91.27% as the overall composite score for RFD 2009-10 and 2010-11 respectively with "Excellent" rating.

RFD for the period of 2011-2012 has been submitted to Performance Management Division by the Department of AIDS Control on 7 March, 2011.

Officers of the Department of AIDS Control were oriented on ISO-9001 certification and on Citizens/Clients Charter by experts from the Bureau of Indian Standards and the Department of Administrative Reforms and Public Grievances respectively.

Officers from the Department of AIDS Control attended the following workshops:

- Workshop on Capability Building for Sevottam organized by the Department of Administrative Reforms and Public Grievances on 21-22 September, 2011 at New Delhi
- Workshop on Citizens'/Clients' Charter organised by the Department of Performance Management Division, Cabinet Secretariat on 15-16 March, 2012 at New Delhi.

Sevottam Compliant Citizen's Charter of Department of AIDS Control was finalized and submitted to Performance Management Division, Cabinet Secretariat in January 2012.

Section-6 of the RFD on Outcome/Impact Indicators was finalized at a meeting chaired by Secretary (Performance Management) at Cabinet Secretariat on 5 January, 2012.

RFD 2012-13 was finalised at a meeting of The Adhoc Task Force on 22 March, 2012.

CHAPTER 17

ADMINISTRATION

Department of AIDS Control has been created as a new Department in December 2008 under the Ministry of Health & Family Welfare.

Department of AIDS Control has been created as a new Department in December 2008 under the Ministry of Health & Family Welfare. The Ministry is headed by the Union Minister of Health & Family Welfare, Shri Ghulam Nabi Azad and is assisted by Ministers of State for Health & Family Welfare - Shri S. Gandhiselvan and Shri Sudip Bandyopadhyay.

The Department of AIDS Control is headed by the Secretary to the Government of India who is assisted by Addl. Secretary, four Deputy Directors General, three Assistant Directors General, two Directors, and a Joint Director. Organizational Chart is at 'Annexure I'. The total sanctioned strength of regular staff of the Department in Group 'A', 'B', 'C' and 'D' is 64 which include secretarial and technical posts. Besides, there are contractual staffs to assist the Department in discharging its assigned functions.

The work allocated to the Department of AIDS Control as per the existing Allocation of Business Rules, is as under:

- Inter-Sectoral, Inter-Organisational and Inter-Institutional Coordination, both, under the Central and State Governments in areas related to HIV/AIDS control and prevention.
- Providing institutional framework for high end research for control, prevention, cure and management of HIV/AIDS and all coordination in this regard.
- Dissemination of accurate, complete and timely information about HIV/AIDS to motivate, equip and empower the people and promotion of measures for effective protection against the spread of the disease.
- National AIDS Control Organisation (NACO).
- International co-operation, exchange programmes and advanced training in HIV/AIDS Management and Research.
- Promoting research studies in the field of HIV/AIDS prevention.

The information on the Department and its

various activities are provided in the website of the Department http:// www.nacoonline.org and it is updated from time to time. The website is linked to the Centralised Public Grievance Redress and Monitoring System (CPGRAMS) of Department of Administrative Reforms and Public Grievances, Ministry of Personnel, Public Grievances and Pensions.

Implementation of RTI Act, 2005

The Right to Information Act, 2005 enacted with a view to promote transparency and accountability in the functioning of the Government by securing to the citizen's the right to access the information under the control of public authorities has already come into force w.e.f. 12.10.2005. Under the Act, for different subjects, three Central Public Information Officers (CPIOs) and seven Appellate Authorities have been appointed in the Department of AIDS Control. During 2011-12, 140 applications and 18 appeals have been received till 31st December 2011 and replies sent.

CHAPTER 18

PROCUREMENT

Hand-holding support to State AIDS Control Societies (SACS) has been provided by the procurement division at NACO for smooth and efficient procurement at State level.

Procurements are done using pool fund (World Bank and DFID), Global Fund for AIDS, Tuberculosis and Malaria (GFATM) through a procurement agent. During the year 2011-12, M/s Rites Ltd. Continued to provide services to Department of AIDS Control as Procurement Agent in terms of contract concluded between National Aids Control Organizations, Department of AIDS Control & M/s Rites Ltd. on 16th Feb 2010.

As in the past, all the main items required for the National AIDS Control Programme, including test kits viz. HIV (Rapid), HIV (ELISA), HBs Ag (Rapid), HBs Ag (ELISA), HCV (Rapid), HCV (ELISA), RPR kits, and other items such as ARV drugs, STI drug kits, blood bags and equipment (CD4 Machines and Blood Bank equipment), etc., are centrally procured and supplied to peripheral units and SACS. Expenditure incurred on procurement at central level till 29.02.2012 is shown in the table below.

Table 18.1: Expenditure Incurred on procurement at Central Level

	(Rs. in Cr.)
Budget Estimate (2011-12)	388.01
Revised Estimate (2011-12)	492.43
Expenditure Incurred (As on 29.02.2012)	332.52

To ensure transparency in the procurement of goods Bid Documents, Minutes of pre-bid Meeting and Bid Opening Minutes are uploaded on the websites of M/s Rites Ltd. (www.rites.com) and NACO (www.nacoonline.org).

Procurement at state level remained an area of importance for NACO. Hand-holding support to State AIDS Control Societies (SACS) has been provided by the procurement division at NACO for smooth and efficient procurement at State level.

With increasing number of facilities (ICTCs, ART Centres, Blood Banks, STI clinics) being catered in the National Programme, the issue of Supply Chain Management (SCM) has gained importance. Efforts made to streamline the Supply Chain Management of various supplies to consuming units include providing training on SCM to the procurement officials of SACS, placing Procurement & Logistics Coordinators for group of SACS.

CHAPTER 19

FINANCIAL MANAGEMENT

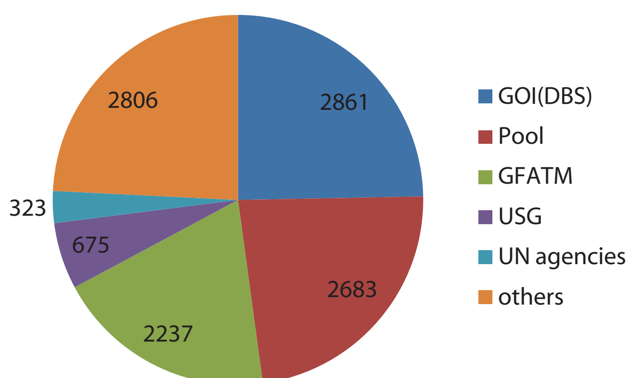
The programme is implemented through State AIDS Control Societies in all States and Union Territories.

Financial Management is an integral and important component under NACP III programme architecture.

Sources of Funds

NACP-III (2007-2012) requires an investment of Rs. 11,585 crores to implement a wide range of Interventions. A resource envelope was identified with external funding from Development Partners, (both budgetary as well as extra budgetary support), bilateral and multi lateral agencies and UN. Their resources are supplemented by domestic contribution by Government of India. Distribution of resource envelope by funding sources shown in Fig 19.1

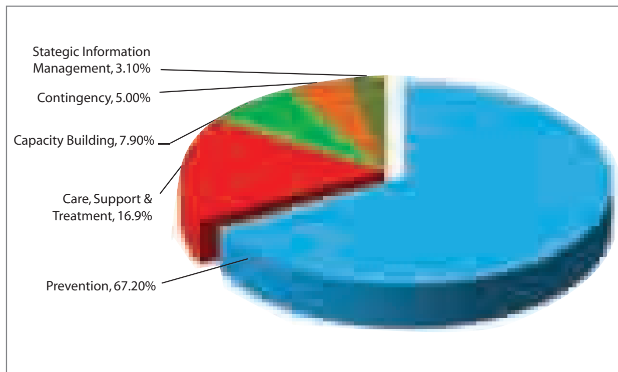
Fig. 19.1: Distribution of resource envelope by funding sources



Out of Rs. 11,585 crores, Rs. 8023 crores is provided through the budget, the balance being extra budgetary funding.

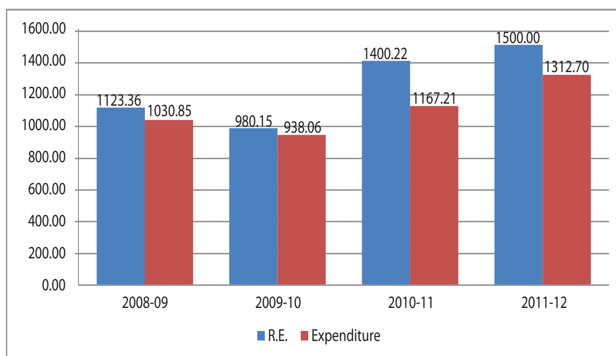
Resource allocation: Of this budget, 67.2 percent is earmarked for prevention activities among high risk groups and general population, 17 percent for Care, Support and Treatment of PLHA, 8% for Programme Management, three percent for Strategic Information Management, and five percent for contingency (Fig. 19.2).

Fig. 19.2: Resources allocation for NACP-III



Utilization of Funds: Details of fund allocation and utilization (budgetary amount) during NACP-III year-wise are shown in figure below.

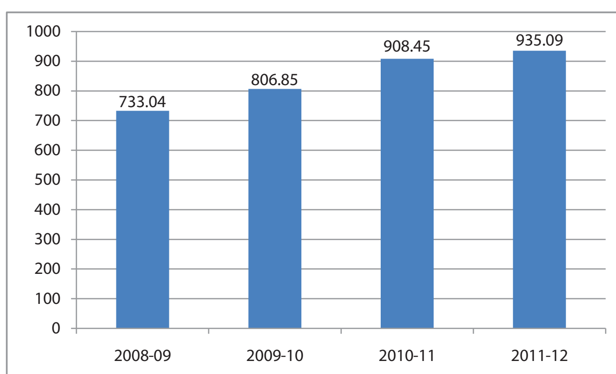
Fig. 19.3: Utilisation of Funds under NACP-III (Rs. in Crore)



Note: Expenditure of 2011-12 is as on 31.01.2012.

Utilization through State Structures: The programme is implemented through State AIDS Control Societies in all States and Union Territories. The details of approved plans for the states across the years are furnished below. There had been significant increase in the state plans as up-scaling of planned activities have been getting stabilized. The graphical presentation of the scaling up of resource support is given in Fig. 19.4:

Fig. 19.4: Annual Action Plan Figures for States NACP-III (Rs. in crore)



In addition to this commodity and equipment support to the service Centres are facilitated by NACO following central procurement method.

Steps for improving the financial systems-some highlights

Improved approval systems

- Belated approval of Action Plan had been identified as one of the main reasons for delay in implementation. Action has been taken over the last four years to convey the Administrative approvals before the close of the previous financial year to enable the states to plan the activities properly and execute from the start of the implementing period. This has paved a long way in the planning and implementation of activities with adhering to the time frame.
- Systems have been established to release the amount in phases closely monitoring the cash flow to peripheral units so that the states are at no point face shortage of resources. This is monitored through the on line systems by devising a snap shot of resource position at any given time.

Expanded workforce in Finance Units

- NACP III emphasized the need for strengthening the workforce in the accounts and finance units at the centre level for close monitoring and state and district level for prompt utilization of resources. From a skeleton staff structure at various levels it has enlarged to a group of professionals, with a good mix of both regular and contractual staff.
- Recruitment norms have been suitably modified by retaining the head of Finance division to be regular cadre for accountability reasons while allowing the states and districts to have qualified contractual staff.
- District structures (DAPCU) has been established and a qualified finance personnel is posted in the district to handhold the financial aspects of the implementing agencies, NGOs, service delivery institutions. On a analysis of the utilization of the expenses and obtaining of UCs, adjustment of advances, this step has contributed much compared to the earlier years of implementation.

- Strategies have been evolved and implemented to retain the skilled human resources by incorporating non cash incentives like specialized periodic training in collaboration with premier institutions like NIFM, IIM etc. This would be a value addition for the career development of the staff.

Better monitoring Systems

- Computerized Project Financial Management System (CPFMS) has been developed and rolled out to have better financial management. The system is working in all SACS for tracking expenditure management, capturing financial data, and utilization and monitoring of advance. States are being linked to Central level at NACO through VPN with the technical support of NIC to have on line transfer of financial data.
- E-Transfer facility to avoid transit delays in transfer of funds to states has been implemented last year. This has stabilized in all states now and the steps taken for onward transfer of money from state to district and other implementing agencies at peripheral unit level.
- Payment of salary to staff at district and peripheral units have been totally made through e-transfer and this has brought down accumulation of funds at implementing agencies thereby minimizing advances.
- Copy of sanctions orders and guidelines, instructions are put on the website of NACO and updated periodically so that wider dissemination of information is ensured.
- The most recent and important audit observations are given in Annex -5

CHAPTER 20

WAY FORWARD- NATIONAL AIDS CONTROL PROGRAMME PHASE IV (NACP-IV)

An elaborate and extensive process to develop the strategy and implementation plan for the next phase of the programme (NACP IV) has been initiated early last year.

Preparation Process

The National AIDS Control Programme Phase III (NACP III) was launched in July 2007 with the goal of halting and reversing the epidemic by the end of project period in mid 2012. The National AIDS Control Organization (NACO) has initiated the process to start the next phase of the programme. National AIDS Control Programme Phase IV (NACP IV). NACP IV will build on the successes of the robust NACP III and ensure completion of the reversal of the epidemic through enhanced prevention efforts linked with care support and treatment of PLHA.

The NACP III strategy and implementation plan was developed based on the synthesis of evidence with wide range of consultations with government departments, civil society, public and private sector partners, NGOs, PLHIVnetworks. The entire process was a home grown yet world class Programme that was appreciated by the global community.

Programme reviews indicate that most of the targets set for NACP III are likely to be achieved by mid 2012 in terms of scale-up of coverage of HRG, safe blood supply, testing services, scale-up of ART and various interventions with community ownership and following principles such as GIPA. However, consolidating the gains and ensuring quality and coverage will require attention in the next few years.

An elaborate and extensive process to develop the strategy and implementation plan for the next phase of the programme (NACP IV) has been initiated early last year, as was done for previous programmes. NACP has explored various approaches towards this. NACP IV will continue to provide care, support and treatment to all eligible population along with focused prevention services for the high-risk groups and vulnerable, marginalised and hard–to-reach populations.

The 12th Five Year Plan is scheduled to begin on the 1st April 2012 and the next phase of the NACP formulation is also in synchronisation with the 12th Five Year Plan timeline. Hence, the process has been initiated with a sense of urgency and expediency to ensure that the NACP IV preparation process also

feeds into the national 12th plan planning processes.

The NACP IV planning has adopted the inclusive, participatory and widely consultative approach similar to that of NACP III and is also further building on the globally acclaimed and successful planning efforts of NACP III. The process will essentially involve a wide range of consultations with a large number of partners including government departments, development partners, non-governmental organizations, civil society, representatives of people living with HIV, positive networks and experts in various subjects. NACP IV development will use specific mechanisms and follow a structured process.Several working groups have been formed and some of them have participant affiliations.

The working groups are listed below (details of working groups are provided in Table 20.1):

a. Programme Implementation and Organisational Restructuring
b. Finance Management / Innovative Financing
c. Procurement
d. Laboratory Services
e. Sexually Transmitted Infections (STI)/ Reproductive Tract Infections (RTI)
f. Condom Programming
g. Communication Advocacy and Community Mobilization
h. Greater Involvement of People Living with HIV/AIDS (GIPA), Stigma, Discrimination and Ethical issues
i. Mainstreaming and Partnerships
j. Blood Safety
k. Integrated Counseling and Testing Centres (ICTC)/ Prevention of Parent to Child Transmission (PPTCT)
l. Care, Support and Treatment
m. Strategic Information Management (SIMS)
   - Surveillance
   - Research and Knowledge Management
   - Monitoring and Evaluation
n. Gender, Youth and Adolescence
o. Targeted Interventions (TI)
   - Female Sex Workers (FSW)
   - Men having Sex with Men (MSM)
   - Injecting Drug Users (IDU)
   - Capacity Building
   - Migrants
   - Link Workers
   - Transgenders
   - Truckers

Table 20.1: List of Working Groups and their Group Representations.

Name of the Group	Group Representation								
	Civil Society	Network	Experts	Development Partners	NACO	SACS	NRHM	Other Govt. Departments	Total
Programme Implementation	1		6	8	5	7	1	1	29
Finance Management/Innovative Financing	6		7	6	8	11	1	3	42
Procurement			4	2	6	3	1	1	17
Laboratory Services			8	1	1	3	1	1	15
STI/RTI	4	1	7	2	7	3	1	1	25
Condom Programming	2		6	2	6	3	1	2	22
IEC	2		18	3	6	0	1	1	31

GIPA, Stigma, Discrimination	3	3	2	3	6	4	1	2	24
Mainstreaming and Partnership	3	1	1	4	5	3	1	10	28
Blood safety	3		6	1	4				14
ICTC/PPTCT	4	1	9	6	4	6	1	4	35
CST	9	1	11	12	4	8	1	2	48
SIMS	8		24	13	7	11	2	8	73
Gender Youth and Adolescence	11	1	2	6	3	3	2	4	32
Targeted Interventions	74	8	20	26	22	29	1	8	188
Total	**130**	**15**	**131**	**95**	**94**	**94**	**16**	**48**	**623**

Each of the abovementioned working groups met twice during May-August 2011 and in each round of working group meetings, 623 members participated in this elaborate exercise. They discussed the current status and achievements under NACP III, identified gaps, emerging priorities, potential strategic options and national, state and district level operational aspects.All working group members have provided excellent inputs and covered geographical, thematic and operational issues thoroughly.In doing so,they have contributed to the future programmatic directions, priorities, capacity building needs and monitoring and evaluation requirements.The working groups have also addressed policy level and implementation options.

After two rounds of deliberations the working groups prepared reports based on thematic areas. These reports and consultations provided invaluable insights and the groups have identified a wide range of suggestions and recommendations. These inputs will be taken into consideration and fine-tuned while developing the overall strategy and implementation plan for NACP IV. Based on the reports, a list of the recommendations suggested by the working groups have been incorporated under each strategy. Consultations are continuing with different divisions at NACO and the final NACP IV document is in the process of being finalized.

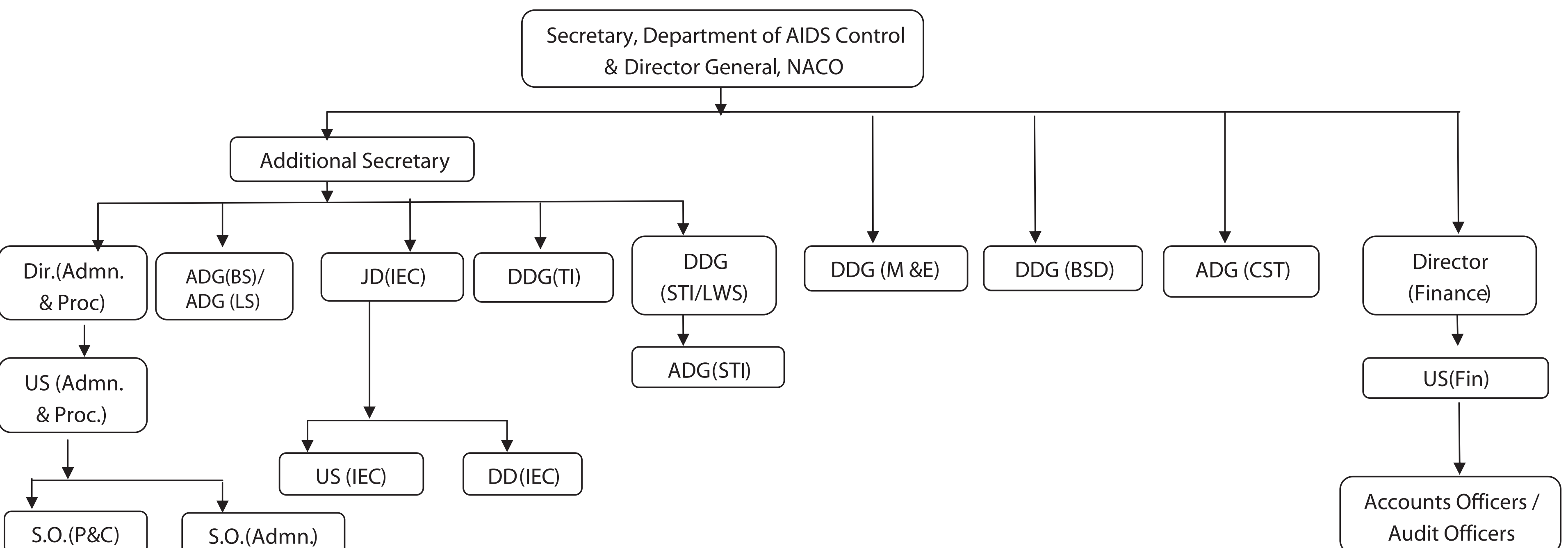
The key steps in the NACP IV preparation process include:

- Collating inputs from more than 15 Working Groups with sub-groups (about 20 -25 representatives from central and state levels, people living with HIV/AIDS, civil society, subject experts, development partners and other stakeholders in each group)
- Consultations with civil society
- Consultations at the state level with SACS and partners
- Regional consultations with PLHAs, public-sector, private sector and other key stakeholders
- E-consultations / discussions on specific topics to enrich the project development process and strategic approaches.
- Commissioning of assessments
- Collaboration with development partners
- Preparation of draft strategic plan
- Reviews, clearances and approvals
- Launch of NACP IV

ANNEX-1

Organisation Chart of Department of AIDS Control

Position as on 31.1.2012 (Designation-wise)



ADG-Assistant Director General, BS-Blood Safety, BSD-Basic Services Division, CST-Care, Support & Treatment, DD-Deputy Director, DDG-Deputy Director General ,Fin.-Finance, IEC-Information Education & Communication, JD- Joint Director, LS-Lab Services, LWS-Link Worker Scheme,P&C-Planning & Coordination, S.O.-Section Officer, STI-Sexually Transmitted Infections, TI-Targeted Intervention, US-Under Secretary.

ANNEX-2

Categorisation of Districts (Based on HIV Sentinel Surveillance 2004-06)

Category A and B Districts based on HIV Sentinel Surveillance 2004 - 2006			
Catetory A (156)			Catetory B (39)
ANDHRA PRADESH (23/23)	Kodagu	**MIZORAM (2/8)**	**ASSAM (1/23)**
Adilabad	Kolar	Aizawl	Sonitpur
Anantapur	Koppal	Champhai	**BIHAR (1/38)**
Chittoor	Mandya	**NAGALAND (10/11)**	Katihar
Cuddapah	Mysore	Dimapur	**CHANDIGARH (1/1)**
East_Godavari	Raichur	Kohima	Chandigarh
Guntur	Shimoga	Mokokchung	**DELHI (4/9)**
Hyderabad	Tumkur	Mon	Delhi_Central
Karimnagar	Udupi	Phek	Delhi_East
Khammam	Uttara_Kannada	Tuensang	Delhi_North
Krishna	**MADHYA PRADESH (5/48)**	Wokha	Delhi_North_East
Kurnool	Balaghat	Kiphera	**GOA (1/2)**
Mahabubnagar	Dewas	Peren	South_Goa
Medak	Harda	Zunheboto	**GUJARAT (4/25)**
Nalgonda	Panna	**ORISSA (4/30)**	Ahmadabad
Nellore	Rewa	Anugul	Bhavnagar
Nizamabad	**MAHARASHTRA (32/35)**	Bolangir	Rajkot
Prakasam	Ahmadnagar	Bhadrak	Boroda (Varodara)
Rangareddi	Akola	Ganjam	**KERALA (2/14)**
Srikakulam	Amravati_Rural	**PUNJAB (1/17)**	Ernakulam
Visakhapatnam	Aurangabad_MH	Ludhiana	Kozhikode
Vizianagaram	Bhandara	**RAJASTHAN (1/32)**	**MADHYA PRADESH (3/48)**
Warangal	Beed	Ganganagar	Indore
West_Godavari	Buldana	**TAMIL NADU (22/30)**	Mandsaur
ARUNACHAL PRADESH (1/16)	Chandrapur	Coimbatore	Bhopal
Lohit	Dhule	Cuddalore	**MIZORAM (1/8)**
BIHAR (2/38)	Gadchiroli	Dharmapuri	Kolasib
Araria	Hingoli	Erode	**ORISSA (3/30)**
Lakhisarai	Jalgaon	Kanniyakumari	Baleswar
CHHATTISGARH (1/16)	Jalna	Karur	Khordha
Durg	Kolhapur	Krishnagiri	Koraput
GOA (1/2)	Latur	Madurai	**PONDICHERRY (1/4)**
North_Goa	Mumbai	Namakkal	Pondicherry
GUJARAT (6/25)	Mumbai (Suburban)	Perambalur	**PUNJAB (1/17)**
Banas_Kantha	Nagpur_Rural	Pudukkottai	Bhatinda
Dahod	Nanded	Ramanathapuram	**RAJASTHAN (6/32)**
Mahesana	Nandurbar	Salem	Ajmer
Navsari	Nashik	Sivaganga	Alwar
Surat	Osmanabad	Theni	Barmer
Surendranagar	Parbhani	The_Nilgiris	Jaipur
HARYANA (1/20)	Pune	Thiruvallur	Udaipur
Bhiwani	Raigarh_MH	Tiruchirappalli	Tonk
KARNATAKA (26/27)	Ratnagiri	Tiruvanamalai	**TAMIL NADU (5/30)**
Bagalkot	Sangli	Toothukudi	Chennai
Bangalore_City	Satara	Vellore	Kancheepuram
Bangalore_Rural	Solapur	Viruddhnagar	Tirunelveli
Belgaum	Thane	**UTTAR PRADESH (5/70)**	Thanjavur
Bellary	Wardha	Allahabad	Villupuram
Bidar	Yavatmal	Banda	**TRIPURA (1/4)**
Bijapur	**MANIPUR (9/9)**	Deoria	North Tripura
Chamarajanagar	Bishnupur	Etawah	**WEST BENGAL (4/19)**
Chikmagalur	Chandel	Mau	Darjeeling
Dakshina_Kannada	Churachandpur	**WEST BENGAL (4/19)**	Jalpaiguri
Davanagere	Imphal East	Kolkata	Medinipur_East
Dharwad	Senapati	Puruliya	Murshidabad
Gadag	Tamenglong	Barddhaman	
Gulbarga	Thoubal	Uttar_Dinajpur	
Hassan	Ukhrul		
Haveri	Imphal West		

ANNEX-3

Contact details of State/Municipal AIDS Control Societies

Andhra Pradesh AIDS Control Society, Directorate of Medical and Health Services, Sultan Bazar, Hyderabad - 500059.	Andaman & Nicobar AIDS Control Society, G.B. Pant Hospital Complex, Port Blair - 744104	Arunachal Pradesh State AIDS Control Society, Directorate of Health Services, Naharlagun, Arunachal Pradesh -791110
Assam State AIDS Control Society, Khanapara, Guwahati-781022	Ahmedabad Municipal corporation AIDS Controls Society, Old Municipal Dispensary, C.G.Road, Ahmedabad-380006	Bihar State AIDS Control Society, State Institute of Health & Family Welfare, Sheikhpura, Patna – 800014
Chennai Municipal Corporation AIDS Control Society, 82 Thiru Vi-Ka Salai, Mylapore, Chennai-600004	Chandigarh State AIDS Control Society, SCO No. 14-15, 1st Floor, Sector - 8C, Chandigarh - 160018	Chhatisgarh State AIDS Control Society, Directorate of Health Services, State health Training Centre, Near Kalibari Chowk, Raipur.
Dadra & Nagar Haveli State AIDS Control Society, Shri Vinobha Bhave Civil Hospital Campus, Silvassa – 396230	Daman & Diu State AIDS Control Society, Community Health Centre, Moti Daman, Daman – 396220	Delhi State AIDS Control Society, Dr. Baba Saheb Ambedkar Hospital, Dharmshala Block, Sector-6, Rohini, Delhi - 110 085
Goa State AIDS Control Society, First Floor, Dayanand Smriti Building, Swamy Vivekanand Road, Panaji – 403001	Gujarat State AIDS Control Society, 0/1 Block, New Mental Hospital, Complex, Menghani Nagar, Ahmedabad – 380016	Haryana State AIDS Control Plot No. C-15, Awas Bhawan, Sector-6, Panchkula, Haryana
Himachal Pradesh AIDS Control Society, Block No. 38, Ground Floor, SDA Complex, Kasumppti, Shimla – 171009	Jammu & Kashmir AIDS Control Society, 48, Samandar Bagh, Exchange Road, Srinagar	Jharkhand AIDS Control Society, Sadar Hospital Campus, Purulia Road, Ranchi - 834001
Karnataka AIDS Control Society, No.4/13-1, Crescent Road, High Grounds, Bengaluru-560001	Kerala State AIDS Control Society, IPP Building, Red Cross Road, Thiruvananthapuram, Kerala – 695035	Lakshadweep State AIDS Control Society, Directorate of Medical and Health Services, UT of Lakshadweep, Kavaratti – 682555
Madhya Pradesh State AIDS Control Society, 1, Arera Hills, Second Floor, Oilfed Building, Bhopal – 462011	Maharashtra State AIDS Control Society, Ackworth Leprosy Hospital Compund, R.A. Kidwai Marg, Wadala (West), Mumbai- 400031	Manipur State AIDS Control Society, New Secretariat, Annexe Building, Western Block Imphal, Manipur-795001
Meghalaya State AIDS Control Society, Ideal Lodge, Oakland, Shillong - 793001.	Mizoram State AIDS Control Society, MV-124, Mission Veng South, Aizwal – 796005,	Mumbai Districts State AIDS Control Society, Municipal Corporation of Greater Mumbai, R.A. Kidwai Marg, Acworth Complex, Wadala, Mumbai-400031
Nagaland State AIDS Control Society, Medical Directorate, Kohima – 797001	Odisha State AIDS Control Society, Oil Odisha Building, Nayapalli, Bhubaneshwar	Puducherry State AIDS Control Society, No : 93, Perumal Koil Street Puducherry-605001
Punjab State AIDS Control Society, SCO – 481-82, 1st Floor, Sector 35-C, Chandigarh	Rajasthan State AIDS Control Society, Medical & Health Directorate, Swasthya Bhawan, Tilak Marg, Jaipur - 302005.	Sikkim State AIDS Control Society, STNM Hospital, Gangtok, 737101.
Tamilnadu State AIDS Control Society, 417 Pantheon Road, Egmore, Chennai-600008	Tripura State AIDS Control Society, Akhaura Road, Opposite to I.G M Hospital, Agartala- 799001	Uttar Pradesh State AIDS Control Society, A-Block, 4th Floor, PICUP Bhawan, Vibhuti Khand, Gomti Nagar, Lucknow-226010
Uttarakhand State AIDS Control Society, Chandar Nagar, Dehradun	West Bengal State AIDS Control Society, Swasthya Bhavan, GN - 29, Sector - V, Salt Lake, Kolkatta – 700091	North East Regional Office Banphool Naga Path, Near Housefed Bus Stop, Beltola Road, Guwahati, Dist-Kamrup - 781006, Assam

ANNEX-4

Members of the Network of Indian Institutions/Organisations for HIV/AIDS Research (NIIHAR)

1. All India Institute for Medical Sciences, New Delhi
2. National Institute of Mental Health and Neuro Sciences, Bangalore
3. Institute of Health and Management Research, Jaipur
4. International Institute for Population Sciences, Mumbai
5. Institute for Economic Growth, New Delhi
6. National Institute of Health & Family Welfare, New Delhi
7. Family Health International, New Delhi
8. National AIDS Research Institute, Pune
9. Institute of Health Systems, Hyderabad
10. National Institute of Medical Statistics, New Delhi
11. National Centre for Disease Control, Delhi
12. National Institute for Research in Reproductive Health, Mumbai
13. National Institute of Epidemiology, Chennai
14. National Institute of Cholera and Enteric Diseases, Kolkata
15. International Centre for Research in Women, New Delhi
16. Population Council of India, New Delhi
17. School of Public Health, Post Graduate Institute of Medical Education & Research, Chandigarh
18. Tata Institute for Social Sciences, Mumbai
19. National Institute for Research in Tuberculosis, Chennai
20. Government Hospital of Thoracic Medicine, Tambaram
21. Government Gandhi General Hospital, Hyderabad
22. Maulana Azad Medical College, New Delhi
23. Bairamji Jijibhai Medical College, Ahmedabad
24. Bowring and Lady Curzon Hospital, Bangalore
25. Sir J.J. Hospital, Mumbai
26. Centre for Advanced Development Research, Bhopal
27. Regional Institute of Medical Sciences, Imphal
28. Calcutta School of Tropical Medicine, Kolkata
29. Institute of Medical Sciences, Banaras Hindu University, Varanasi
30. India Clinical Epidemiological Network, Chennai
31. Nagaland University, Kohima
32. The Tamil Nadu Dr MGR Medical University, Chennai
33. Lala Ram Swarup Institute of Tuberculosis and Respiratory Diseases, New Delhi
34. Rajendra Institute of Medical Sciences, Ranchi
35. Maulana Azad Institute of Dental Sciences, New Delhi
36. Department of Humanities, IIT, Chennai
37. Manipal Academy of Higher Education, Karnataka
38. JIPMER, Puducherry
39. Public Health Foundation of India, New Delhi
40. Government Medical College & Hospital, Chandigarh
41. Chhatrapati Shahuji Maharaj Medical University, Lucknow
42. Indian Statistical Institute, Delhi

ANNEX-5

Most Recent and Important Audit Observations

Sl. No.	Year	No. of paras/PA reports on which ATNs have been submitted to PAC after vetting by Audit	Details of the Paras/PA report on which ATNs are pending		
			No. of ANTs not sent by the Ministry even for the first time	No. of ATNs sent but returned with observations and Audit is awaiting their resubmission by the Ministry	No. of ATNs which have been finally vetted by Audit but have not been submitted by the Ministry of PAC
1.	2004-05 Report No. 3 of 2004 entire report on National AIDS Control Programme	Report is under examination of Public Accounts Committee. Recommendations of PAC [19th Report of PAC 2005-06]. Further recommendations [vide 63rd Report of PAC 2007-08 on ATN of 19th Report]. ATN on recommendations made in 63rd Report sent to PAC on 29.6.09.			
2.	2010-11	Report No. 16 of 2011-12 para 8.3	ATN vetted by Audit has been forwarded to Ministry of Finance (Monitoring Cell) for submission before PAC		Reply of UNOPS has been received and action taken note is being finalized.