



**Country
Progress
Report**

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UNGASS

INDIA

I. TABLE OF CONTENTS

List of Figures	iv
List of Tables	v
Foreword	vi
Acronyms	vii
II. STATUS AT A GLANCE	1
II. A. Involvement of stakeholders in the reporting process	1
II. B. The framework of the response	2
II. C. The epidemic in India	3
II. C. 1. HIV prevalence among various groups	3
II. C. 2. Behavioural tracking of the population	3
II. D. Prevention	4
II. D. 1. Prevention efforts among high risk groups	4
II. D. 2. The bridge populations	4
II. D. 3. Prevention interventions for the general population	5
II. E. Care, Support and Treatment	6
II. F. Enabling environment and impact alleviation	7
II. G. Best practices and challenges	8
II. H. Support from development partners	8
II. I. The M&E environment	9
II. J. Overview Table of UNGASS Indicators	10
III. OVERVIEW OF THE AIDS EPIDEMIC	14
III. A. The HIV and AIDS epidemic in India	14
III. A. 1. Pattern of the HIV epidemic at national level	14
III. A. 2. State wise estimated adult HIV prevalence	17
III. A. 3. HIV epidemic among high risk groups	18
III. B. Behavioural patterns among adult population and HRG	21
III. B. 1. Knowledge of HIV	22
III. B. 2. Involvement with commercial sex partners	23
III. B. 3. Condom use	24
III. B. 4. Perception of risk and HIV testing	25
IV. THE NATIONAL RESPONSE TO THE AIDS EPIDEMIC	27
IV. A. Policy and Framework	27
IV. A. 1. The strategy	27
IV. A. 2. Decentralizing responsibility for support and supervision	28
IV. A. 3. Convergence with NRHM	29
IV. A. 4. Capacity development	29
IV. A. 5. Financial allocations and expenditure	30
IV. B. Prevention	31
IV. B. 1. High risk groups	32
IV. B. 2. Bridge populations	36
IV. B. 3. The general population	38
IV. C. Care, Support and Treatment	50
IV. C. 1. The provision of ART	50
IV. C. 2. Link ART Centres	52

IV. C. 3. Community Care Centres	53
IV. C. 4. Treatment and Prophylaxis of Opportunistic Infections	53
IV. C. 5. HIV-TB Collaborative Services	53
IV. C. 6. Strengthening laboratory services for ART	54
IV. C. 7. Supply chain management for ARV drugs	54
IV. C. 8. Second line ART	55
IV. C. 9. Children living with HIV/AIDS	55
IV. D. Enabling environment and impact alleviation	56
IV. D. 1. Stigma and Discrimination	57
IV. D. 2. Establishment of CBO and CBO networks	57
IV. D. 3. Greater Involvement of People living with AIDS	58
IV. D. 4. Faith in action	59
IV. D. 5. State initiatives	59
IV. D. 6. Capacity building of human resources through multi-sectoral collaboration	60
IV. D. 7. New Initiatives for capacity building	61
V. BEST PRACTICES	63
V. A. Results Framework Document of the Prime Minister's Office	63
V. B. Directive of the Supreme Court of India	63
V. C. Decision by Delhi High Court	64
V. D. Press Council of India	64
V. E. Monthly pension for below-poverty line ART patients	65
V. F. Travel concession for people living with HIV	65
V. G. Red Ribbon Express - a mass mobilization drive on HIV and AIDS	65
V. H. National Policy on HIV and AIDS and the World of Work	66
V. I. Link ART Centres	66
V. J. Scoring Goals Against HIV /AIDS	66
V. K. Link Worker Scheme (LWS)	67
VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS	68
VI. A. Progress made on Key Challenges reported in the CPR 2007	68
VI. B. Challenges faced through this Reporting Period	69
VII. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS	72
VII. A. Development partners in the country	72
VII. B. Details of partner support	73
VII. C. Distribution of external funding support	74
VIII. MONITORING AND EVALUATION ENVIRONMENT	76
VIII. A. Strengthening of the national M&E framework	76
VIII. A. 1. Strengthening and standardizing country information systems	77
VIII. A. 2. Monitoring Trends in Behaviours and HIV-AIDS prevalence	79
VIII. A. 3. Operational Research	80
VIII. A. 4. Dissemination and Use of Information	82
Annex 1: National Funding Matrix	84
Annex 2: Selected References	86

LIST OF FIGURES

Fig 3.1: Trends of Adult HIV Prevalence and Number of PLHA 2002-2007	15
Fig 3.2: Routes of HIV transmission during 2008-09	16
Fig 3.3: Map with district categories to highlight the geographical diversity of HIV 2007	17
Fig 3.4: Distribution of PLHIV by states 2007	18
Fig 3.5: State wise estimated adult HIV prevalence, 2006-2007	18
Fig 3.6: Trend Analysis of HIV prevalence 2003-2008	19
Fig 3.7: HIV prevalence among FSW in select states 2007-2008	20
Fig 3.8: Trends of HIV prevalence among MSM in select states 2003-2008	20
Fig 3.9: Trends of HIV prevalence among IDU in select states 2003-2008	21
Fig 3.10: Knowledge of HIV - General population 2006	22
Fig 3.11: Involvement with commercial sex partners 2009	23
Fig 3.12: Condom use with clients among FSW 2009	24
Fig 3.13: Perception of risk of HIV infection 2009	25
Fig 3.14: Ever tested for HIV 2009	26
Fig 4.1: Resource envelope of NACP III by objectives	30
Fig 4.2: Scale up of targeted interventions 1995-2008	32
Fig 4.3: Targeted Interventions by district 2000, 2005, 2009	32
Fig 4.4: Coverage of FSW in NACP III 2007-2009	33
Fig 4.5: Coverage of MSM in NACP III 2007-2009	34
Fig 4.6: Coverage of IDU in NACP III 2007-2009	34
Fig 4.7: Number of one to one BCC sessions 2006-2009	35
Fig 4.8: Condom Distribution (free and social marketing) 2006-2009	35
Fig 4.9: Coverage of Migrants in NACP III 2007-2009	37
Fig 4.10: Coverage of Truckers in NACP III 2007-2009	37
Fig 4.11: Integrated Counseling and Testing Centre	39
Fig 4.12: Growth of Counselling and Testing Services in India 2005-2009	40
Fig 4.13: Number of persons tested for HIV in India 2001-2009	41
Fig 4.14: Pregnant Women Receiving Counseling on HIV Prevention and Care at Integrated Counseling & Testing centre	41
Fig 4.15: Uptake of pregnant women under National PPTCT Programme 2005-2009	42
Fig 4.16: Detection of HIV positive pregnant women and coverage of MB pairs with single dose Nevirapine 2005-2009	42
Fig 4.17: Year wise Target vs Achievement of STI cases from 2007-2009	43
Fig 4.18: Condom sale pattern 2006-2008	44
Fig 4.19: The Red Ribbon Express	46
Fig 4.20: Smt Sonia Gandhi, UPA Chairperson, flagging off the Red Ribbon Express on 1st December 2009 at Safdarjung Station, New Delhi	47
Fig 4.21: Summary of Select Achievements of the Multi-Sectoral Strategy	49
Fig 4.22: ART scale up in India 2007-2009	51
Fig 4.23: ART Services Organized to respond to Disease Burden	51
Fig 4.24: Cumulative outcome of people on ART 2007-09	52
Fig 4.25: HIV-TB cross referrals 2005-2009	53
Fig 4.26: Manipur & Nagaland Legislators complement efforts of State AIDS Control Societies	57
Fig 4.27: Shri K. Chandramouli, Secretary & Director General, NACO with participants and resource persons at the inaugural of the MESST workshop on 18 February, 2010	62
Fig 7.1: Distribution of mobilized funds under External Aid Component by NACP III objectives	74
Fig 7.2: Distribution of extrabudgetary resources by NACP III Objectives	75
Fig 8.1: CMIS data gathering	78

LIST OF TABLES

Table 4.1:	Resource Envelope for NACP-III	30
Table 4.2:	Status of allocation and expenditures in the past 4 years	31
Table 4.3:	Targets for coverage of HRG in NACP III	33
Table 4.4:	CBO led TI	58
Table 4.5:	Progress in capacity building of health personnel under NACP III 2007-2010	61
Table 7.1:	Sources of NACP III budget	72
Table 8.1:	M&E Training Programmes conducted for capacity development	77

FOREWORD

India adopted the *Declaration of Commitment on HIV/AIDS* in the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001. This Country Progress Report (CPR India 2010) for the period January 2008 to December 2009 reflects our country's commitment to that Declaration.

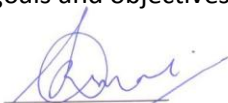
India's response to the changing nature of the epidemic is reflected in the policy framework and approaches of the National AIDS Control Programme. The third National AIDS Control Programme Strategy and Implementation Plan (2007-2012) is based on and builds upon the lessons learnt and achievements made in Phase I and II. The CPR India 2010 presents an overview of the epidemic, the strategic national response and its impact, and the challenges that lie ahead. India is a large diverse country and the epidemic is concentrated in six states among high risk populations. Complex social issues and entrenched social positions pose significant challenges for the policy makers, donors and the civil society engaged contributing to the national response.

India's response to AIDS has made substantial strides as is evident from the report. There has been a significant scale up in coverage and infrastructure: i) targeted Interventions among high risk groups, ii) care, and treatment and support services and iii) counselling and testing services. The accelerated roll-out of the programme and regular use of data for monitoring and evaluation of programme implementation at state and district level have been important focus areas.

Reflecting our faith in the 'Three Ones' principle, a number of processes were undertaken to get the views and inputs of the wide range of stakeholders who are responsible for the HIV and AIDS response in the country including national Civil Society Organisations working in a variety of thematic areas, the UN and other multilateral organisations, bilateral organisations, donors, and international non-governmental organizations working with the country to strengthen its response. I would like to acknowledge the contributions made by civil society and development partners who participated in the consultation process and provided feedback and technical inputs in shaping the report.

This report has been developed by the National AIDS Control Organisation. The Strategic Information Management Unit began work on the report in November 2009 and was supported by the UNAIDS and WHO country offices. I appreciate the efforts of Dr. S. Venkatesh, Deputy Director General (M&E), Mr Ugra Mohan Jha, M&E Officer and Dr Yujwal Raj, Technical Officer (Surveillance) from the Strategic Information Management Unit. Heads of divisions and other officers from NACO and State AIDS Control Societies have provided technical material for the various sections of the report. Representatives of Civil Society Organisations have provided valuable inputs for the National Composite Policy Index.

I acknowledge the contributions of all those who are supporting NACO in strengthening the National Response in India. We are committed to developing and implementing effective evidence-based strategy with active involvement of all the stakeholders to effectively respond to the challenges and achieving the goals and objectives set for the programme.



(K. Chandramouli)
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Ministry of Health and Family Welfare, Government of India

ACRONYMS

ANC	:	Antenatal Clinic
ART	:	Anti-Retroviral Treatment
ARV	:	Anti- retroviral
BCC	:	Behaviour Change Communication
BMGF	:	Bill and Melinda Gates Foundation
BSS	:	Behavioural Surveillance Survey
CBO	:	Community Based Organisation
CCC	:	Community Care Centres
CDC	:	Centres for Disease Control and Prevention
CII	:	Confederation of Indian Industry
CMIS	:	Computerised Management Information System
CoE	:	Centre of Excellence
CPR	:	Country Progress Report
CSO	:	Civil Society Organisation
CST	:	Care, Support and Treatment
DAPCU	:	District AIDS Prevention and Control Unit
DFID	:	Department for International Development
DIC	:	Drop in Centres
EQAS	:	External Quality Assessment Scheme
FICCI	:	Federation of Indian Chambers of Commerce and Industry
FSW	:	Female Sex Worker
GFATM	:	Global Fund for AIDS, TB and Malaria
HIV	:	Human Immunodeficiency Virus
HRG	:	High Risk Group
HSS	:	HIV Sentinel Surveillance
IBBA	:	Integrated Biological and Behavioural Assessment
IBBS	:	Integrated Biological and Behavioural Surveillance
ICTC	:	Integrated Counseling and Testing Centre
IDU	:	Injecting Drug Users
IEC	:	Information, Education and Communication
ILO	:	International Labour Organization
INP+	:	Indian Network of Positive People
INR	:	Indian Rupee
LAC	:	Link ART Centre
LFU	:	Lost to Follow Up
M & E	:	Monitoring & Evaluation
MHRD	:	Ministry of Human Resource Development
MTR	:	Mid Term Review
MWCD	:	Ministry of Women and Child Development
MSM	:	Men who have sex with men
OI	:	Opportunistic Infections
NACO	:	National AIDS Control Organisation
NACP	:	National AIDS Control Programme
NARI	:	National AIDS Research Institute
NCA	:	National Council for AIDS
NCPI	:	National Composite Policy Index
NGO	:	Non Governmental Organisation
NRHM	:	National Rural Health Mission

NTSU	:	National Technical Support Unit
NYKS	:	<i>Nehru Yuva Kendra Sangathan</i>
OST	:	Oral Substitution Therapy
PCR	:	Polymerase Chain Reaction
PEPFAR	:	President's Emergency Plan for AIDS Relief(US)
PHFI	:	Public Health Foundation of India
PLHA	:	People Living with HIV/AIDS
PLHIV	:	People Living with HIV
PPP	:	Public Private Partnership
PPTCT	:	Prevention of Parent to Child Transmission
RCH	:	Reproductive Child Health
RFD	:	Results Framework Document
RNTCP	:	Revised National TB Control Programme
RRE	:	Red Ribbon Express
S&D	:	Stigma and Discrimination
SACS	:	State AIDS Control Society
SIMS	:	Strategic Information Management System
SIMU	:	Strategic Information Management Unit
SMO	:	Social Marketing Organisations
STD	:	Sexually Transmitted Diseases
STI	:	Sexually Transmitted infections
STRC	:	State Training and Resource Centres
TB	:	Tuberculosis
TG	:	Transgender
TI	:	Targeted Intervention
TRG	:	Technical Resource Groups
TSU	:	Technical Support Units
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNDAF	:	United Nations Development Assistance Framework
UNDP	:	United Nations Development Programme
UNGASS	:	United Nations General Assembly Special Session
UNICEF	:	United Nations Children's Fund
UNIFEM	:	United Nations Development Fund for Women
USAID	:	United States Agency for International Development
VCTC	:	Voluntary Testing and Counselling Centres
WHO	:	World Health Organisation

II. STATUS AT A GLANCE

The HIV epidemic in India, first recognised in 1986, is now just under 25 years old and is counted among the most serious public health problems in the country. In 2008, an estimated 2.27 million people between the ages of 15-49 years of India's 1160 million population was living with HIV (PLHIV). India carries the largest burden of HIV behind South Africa and Nigeria.

India is deeply conscious of its international commitments on the *Declaration of Commitment on HIV/AIDS 2001* and the *Political Declaration on HIV/AIDS 2006*. In accordance with them, the country has striven to improve and expand its efforts to halt and reverse the HIV epidemic and to fulfil its obligations on reporting the status of its response. This Country Progress Report India 2010 (CPR India 2010) has been developed by the National AIDS Control Organisation (NACO) of India. Work on the report was led by the Strategic Information Management Unit (SIMU) of NACO in close cooperation with the UNAIDS office located in country and consultants provided through their aegis.

II. A. INVOLVEMENT OF STAKEHOLDERS IN THE REPORTING PROCESS

NACO undertook a number of processes to obtain views and inputs from a wide range of stakeholders who are partners in the HIV and AIDS response in the country. In addition to obtaining inputs from key government officials responsible for implementing and monitoring various components of NACP III, a *set of stakeholders were consulted* including national Civil Society Organisations (CSO) working in a variety of thematic areas, the UN and other multilateral organisations, bilateral organisations, donors, and international non-governmental organizations (NGO).

For feedback particularly on the National Composite Policy Index Part B (NCPI-B), *CSO consultations were held in Bangalore and Bhopal* in the later part of 2009 with 43 CSO. Just below 60 persons from these organisations participated, bringing to bear their considerable grassroots experience to this documentation. Representatives were identified from the participants to take part in further discussion of the report especially those relating to the finalization of the National Composite Policy Index part B (NCPI-B). These representatives and others from the north-eastern part of India; PLHIV; the UN; and multilateral and bilateral organisations were invited to participate in a consultation in New Delhi in March 2010. At the March consultation the NCPI-B was reviewed. Scores and views expressed in the two prior CSO consultations were harmonised. Further, through a process of posting the draft NCPI-B on an electronic platform provided by the HIV Solutions Exchange which has a wide and diverse membership, the reach of consultation was greatly extended to potentially 4300 interlocutors.

The *CPR India 2010* has also drawn from a mid-term review (MTR) of the National AIDS Control Programme phase III (NACP III) undertaken by the Government of India with the support of its partners. The MTR fortuitously took place in November-December 2009 and has reviewed the performance of the programme in detail. The Aide Memoire provided by development partners to the government concisely captures their key findings and recommendations. This report also draws upon the numerous activities being undertaken by various individuals and institutions working on HIV and AIDS in India; key interviews with NACO staff and those of its allied institutions such as the National Technical Support Unit (NTSU); the knowledge of the consultants; and inputs from the UNAIDS India team. Inputs from senior officers were especially useful in providing a view of the efforts that the programme in India is

making to focus efforts both broadly on thematic imperatives as well as to respond to the local granularity of the epidemic as it plays out in this populous country.

Finally, this report has been reviewed by the highest levels within the administration of the Government of India and represents the response of the country to the HIV and AIDS epidemic.

II. B. THE FRAMEWORK OF THE RESPONSE

The *policy framework for the NACP* is anchored in the National AIDS Prevention and Control Policy (NAPCP) of 2002. India has a well articulated national strategy and approach which is described in the NACP III. The current phase III of the *National AIDS Control Programme* (NACP) began in 2007 with the overall goal of halting and reversing the epidemic in India over a period of five years. Bearing in mind that over 99.5 percent of the population in the country is free of infection, NACP III places the highest priority on preventive efforts while seeking to integrate prevention with care, support and treatment. The NACP III recognises that the reach of services in a country the size of India and with the extreme marginalization of the most affected communities is difficult to achieve. It hence utilizes public, nongovernmental and private health institutions to carry out its functions of prevention and care, support and treatment.

Given the size and total population of the country, an important focus is on *decentralizing responsibility* for prevention, support and supervision to the state, district and the sub-district levels. Administratively, NACO relies on State AIDS Control Society (SACS) set up in each state to perform its mandate. The NACP III seeks to differentiate the requirements of different geographical locations in respect of risk and vulnerability to HIV. District AIDS Prevention and Control Units (DAPCU) are set up in some of the most vulnerable districts to provide management oversight to HIV and AIDS activities in the districts. The DAPCU will work seamlessly with the district administration and programmes provided under the National Rural Health Mission (NRHM) with which the NACP will converge. *Convergence of the NACP III with the NRHM* has been aimed in six areas namely: Integrated Counselling and Testing Centres (ICTC); Prevention of Parent to Child Transmission (PPTCT); Blood safety; services for Sexually Transmitted Infections (STI); Condom programming; and Anti-retroviral Treatment (ART).

Owing to the intensive efforts to scale up HIV services across the country, there has had to be a concomitant *scaling up of the capacity available at various institutions*. A large part of the efforts in these two years has been to recruit, place, build skills and provide supportive supervision to new staff within the system, both in the public and private sectors.

The *total outlay for NACP III (2007-2012)* is approximately USD 2574 million which includes support from the World Bank, UK's Department for International Development (DFID) and Government of India contributions (Pooled fund), Global Fund against AIDS, TB and Malaria (GFATM), and contributions from bilateral agencies and private initiatives such the Bill and Melinda Gates Foundation (BMGF). About 25% of this allocation is from direct budgetary sources, 35% is from external sources through the budget, and 30% extra-budgetary. The outlay has a funding gap of 10% for which resource mobilization efforts are underway.

Allocations under NACP III is consistent with programme focus. Expenditures have likewise also been fairly consistent. In the past two years, the distribution of expenditure between the four major activities of the programme was i) Prevention: 61.9 as against 67 percent allocated; ii) Care Support and

treatment: 26.8 against 17 percent allocated; iii) Capacity Building: 10.8 against 8 percent allocated; and iv) Strategic Management Information: 0.5 / against 3 percent allocated.

II. C. THE EPIDEMIC IN INDIA

The epidemic in India shows a declining trend overall. HIV prevalence among adult population in 2007 was 0.34 percent and in 2008 was 0.29 percent. There is also a declining number of PLHIV in the country, with an estimated 2.27 million PLHIV in 2008 vis-à-vis 2.31 million in 2007.

The *primary drivers of the HIV epidemic in India* are unprotected paid sex/commercial sex work, unprotected anal sex between men and IDU. Given that condom use is not optimal or consistent; men who buy sex are the single most powerful driving force in India's HIV epidemic. As more than 90 percent of women acquired HIV infection from their husbands or their intimate sexual partners, they are at increased risk for HIV not due to their own sexual behaviour, but because they are partners of men who are within a high risk group (HRG) i.e., clients of female sex workers (FSW), men who have sex with men (MSM) or IDU. The wider implication of this situation is that in almost 6 percent of cases in 2008, the route of transmission of infection was from mother to child.

II. C. 1. HIV prevalence among various groups

There was a *gradual scale up of the HIV Sentinel Survey (HSS)* by an increase in the number of sites from 176 in 1998 to 1215 in HSS 2008/09 across the country. Technical changes were made to the recruitment strategy and the sample collection method for testing at HRG sites. Operational changes were also made by establishing an effective and structured training programme and institutionalizing a strong monitoring and supervision system.

Six states with high HIV prevalence account for over two thirds of the HIV burden of the country. India has 195 priority districts that are identified according to HIV prevalence rates over the last three years for focused programmatic interventions. While *an overall decline in HIV prevalence among antenatal care clinic (ANC) attendees is noted especially in high prevalence states*; however, there is an increase in some low and moderate prevalence states.

While there is a decline in the epidemic among FSW in south Indian states, rising trends are evident in the North East where the epidemic is increasingly driven both by IDU and sexual transmission. A *steady decline in HIV prevalence amongst FSW has been noted*, resulting it may be argued, from focused government and stakeholder interventions. *HIV prevalence among MSM is stable. A varied trend in prevalence has emerged among IDU* however. The prevalence amongst FSW is highest in the state of Maharashtra at approximately 18 percent. Pockets of high HIV prevalence among MSM are identified in high prevalence states as well as in the low prevalence states of Delhi, Gujarat and West Bengal. The highest HIV prevalence amongst IDU was reported in Amritsar, Punjab at approximately 30 percent.

II. C. 2. Behavioural tracking of the population

Until date, three rounds of *Behavioural Surveillance Surveys (BSS)* have been conducted; two at the national level in 2001 and 2006 and one at state level (both rural and urban areas) in 2009 in the

following five high prevalence states: Andhra Pradesh, Karnataka, Manipur, Tamil Nadu, Maharashtra and in Uttar Pradesh among the general population, youth, HRG and male migrants. The objectives for the 2009 round was to measure changes in key knowledge and behavioural indicators among general population, HRG and bridge population on HIV/AIDS and related areas since 2006. In addition, two rounds of Integrated Behavioural and Biological Assessment (IBBA) were conducted in 29 districts in six high prevalence states in round one and in all districts of Karnataka in round two.

There was *considerable variation on the level of HIV knowledge* between the high prevalence states which have been the focus of the programme, and the lower prevalence states. This was seen among all sampled groups although it was lower in the case of knowledge regarding possible infection from a mother to her child.

About 2.5 percent of adult males in the BSS 2006 reported visiting a commercial sex worker in the previous year. Male migrants form the largest clientele varying widely between states such as Uttar Pradesh in the north and Andhra Pradesh in the south. A major success was the very high rate of condom use with last client reported by FSW in high prevalence states such as Andhra Pradesh. This is mirrored by rates of condom use reported by other groups such as migrants, thus providing for a lower risk of transmission. However, rates were lower in the northern state of Uttar Pradesh, suggesting that attention may now need to be paid to these areas. Perception of risk was likewise much higher among HRG as compared to migrants. HIV testing rates were high among FSW and low among migrants.

II. D. PREVENTION

II. D. 1. Prevention efforts among high risk groups

There is *improved access by HRG to services* through an increase in number, geographical distribution and coverage of TI. There has also been a greater focus on the complement of services now available to HRG through these interventions, especially around counselling and testing services, STI care and behaviour change communication (BCC). There is evidence of early impact in respect of condom use by FSW and MSM and adoption of safer injecting and condom use behaviour by IDU. In some high prevalence states, this can be correlated to the decline in HIV prevalence among FSW and MSM. *Link workers* have been appointed to address the prevention and care needs of HRG in rural communities. Quality assurance is carried out through use of standardized guidelines and an annual evaluation of TI through independent observers.

II. D. 2. The bridge populations

Two main bridge groups are the attention of the NACP III: *migrants and truckers*. The programme has sharpened its focus on short stay single male migrants on the basis of evidence from critical studies undertaken and experience from TI programming. Two million of the 8.9 short stay migrants are identified as being at significant risk. These are amongst the over 200 million migrants in India, taken as a whole. A similar sharpening of focus has been applied to truckers who are the other large bridge group in India. The 2 million long distance truckers of the total 5 million are targeted through TI programmes instituted by the Transport Corporation of India Foundation, a private sector partner of the government.

Both programmes have achieved about 30 percent coverage of these groups and require further strengthening.

II. D. 3. Prevention interventions for the general population

Several activities have been instituted within the programme to reduce the risk of infections among the general population. Many of these activities are carried out in collaboration with the NRHM (i.e., general health services) and other Ministries of the Government of India.

The government provides for the *safety of all blood* used for transfusion purposes in India through the establishment of good quality testing facilities, use of blood products and increased amount of voluntary blood donation. Voluntary blood donation now provides about three fourths of all blood available in the country and is supplemented through camps held at colleges and youth clubs in all states.

India has adopted a *new approach to counselling and testing* in establishing an integrated facility that undertakes these services for all sections of the population that access it. Termed ICTC, 5069 have been put in place with assistance from the GFATM. Almost 600 have been placed in primary health centres in the rural areas of the country. Over 9 million HIV tests were carried out in 2009 with approximately 300,000 being among persons from the HRG. The quality of these ICTC is maintained through the operational guidelines used across the centres and an external quality assurance system for testing quality.

The *PPTCT programme* provides *nevirapine* to mothers and babies at each of the 5135 ICTCs as early infant diagnosis is an important component of the programme. However, the low proportion of institutional deliveries among the 27 million deliveries that take place in the country each year is a challenge as is the follow up of babies until the age of 18 months. Only 20 percent (5.5 million) of the 27 million pregnant women are tested under the programme in 2009, and only a third of the estimated HIV positive mothers could be detected.

NACO works closely with the general health services to *provide treatment for STI*. The programme has a target of 15 million episodes of STI to be treated annually by 2012, taken at 50 percent of national estimated episodes. Enhanced syndromic case management is taken as the cornerstone of this service which is delivered through 694 designated clinics located within district and teaching hospitals. Quality is supported through regional centres.

Condom is the most effective prophylaxis for preventing HIV transmission. During 2009-10, the condom social marketing programme has been successfully scaled up to 294 districts; 4.64 lakh condom outlets serviced by the programme distributed 23.4 crore pieces of condoms till January 2010.

The NACP III has a *strategic focus on behaviour change* to primarily target HRG and bridge populations, youth and women and other communication strategy. It is designed to increase demand for health services as well as to create an enabling environment. NACP III has developed the first of its kind Operational Guidelines for this area. Various mass media campaigns are directed to specific sections of the response, such as the campaign on condom promotion; campaign for voluntary blood donation and the *Red Ribbon Express* (RRE). The RRE is one of the world's largest social mobilization campaigns on HIV and AIDS. A special train with educational, counselling and testing facilities onboard, flagged off on World AIDS Day 2007, travelled over one year in 2008, stopping at 180 stations, and reached 6.2 million

people with HIV messaging and provided counselling to over 1.16 million persons on HIV and AIDS. A second round of the RRE's journey across India was initiated in 2009.

Youth were also reached through interventions in collaborations with the Ministry of Human Resource Development (MHRD) and various development partners. In school, children receive the Adolescence Education Programme (AEP) and over 1.14 million high schools have been covered and 288,000 teachers trained in counselling for HIV and AIDS. A Life Skills Education Programme is a key intervention with out of school and college youth.

NACP also has crucial *multi-sectoral collaborations through mainstreaming* across a wide range of Ministries such as Women and Child Development, Labour and Employment, Social Justice & Empowerment, Railways, Defence, Surface Transport, and Human Resource Development; and private sector bodies. The *National Council on AIDS* (NCA) chaired by the Prime Minister and with representation from 31 central ministries, state governments, private sector, media and academia provides the political impetus and guidance to this aspect of the programme. *State Councils on AIDS* have been constituted in 25 states and a third of states also have a *Legislative Forum*.

II. E. CARE, SUPPORT AND TREATMENT

The *implementation of the ART programme* has been very successful in the programme. Some targets set for the programme under the NACP III are likely to be exceeded, for example, the number of ART centres (which may well reach 300 by 2010) and adults alive and on ART. A significant number of NGO provide care, support and treatment (CST) services and other support to people living with HIV and AIDS.

In response to limited or poor access to ART centres, 208 *Link ART Centres* (LAC) are established and fully functional. In addition to addressing accessibility constraints, the LAC are expected to decongest ART centres and provide decentralized replenishment of treatment supplies to stable patients on prescription.

The ART centres are linked to *Community Care Centres* (CCC) which are set up with the mandate of providing a comprehensive package of CST services. These were set up in the NGO sector with the main objective of providing psycho-social support, ensuring drug adherence and providing home-based care. At present, 266 CCC are fully functional. *Cumulative lost to follow up* (LFU) was reduced to nearly 7 percent due an effective system of follow up and provision of home based counselling for LFU by district level PLHA networks, CCC and counsellors of ICTC. Other initiatives include SMART cards and monitoring and supervision by Regional Coordinators.

There are 198 CD4 machines servicing 226 ART centres and another 13 CD4 machines under installation. In 2008-2009, approximately 658,143 CD4 tests were performed. A national CD4 External Quality Assessment Scheme (EQAS) for Indian testing laboratories developed in 2005 is operational with support from the Clinton Foundation. Now, an Indian database *India.qasi-lymposite* is being developed and will be piloted for data entry, online submission analysis and report preparation.

The *supply chain management of Anti-retroviral (ARV) drugs* is managed through a dedicated Logistic Coordinator appointed at NACO. As a result of a well monitored system, there has been regular and uninterrupted supply of ARV drugs without any stock-out situation.

Based on the recommendations of the Technical Resource Group (TRG) on ART on the provision of second line treatment in the national programme, *second line ART* was started on a pilot basis at two

centres in January 2008. On completion of this pilot project it was then launched across 10 Centres of Excellence (CoE) in January 2009. As of January 2010, there are 970 patients on second line ART across the country.

There is provision of prophylaxis and treatment of opportunistic infections (OI) at tertiary and district hospitals. A system for line listing has been established between NACP and RNTCP, ensuring fast tracking of patients co-infected with HIV and TB. Guidelines are in place for the intensified HIV/TB package in 9 states which includes routine offer of HIV counselling and testing for all TB patients and linking all the identified HIV/TB patients to CST including treatment for TB, other OI and ART.

The country has adopted the terminology *Children affected by AIDS (CABA)*, jointly developed by NACO, UNICEF and other development partners. NACO estimates that 57,000 children are infected at birth in India each year, but is yet to finalise estimates of Children living with HIV/AIDS. A total of 63,889 children living with HIV are registered, out of which, 18,763 are receiving ART as on January 2010. Ten orphanages have been developed in collaboration with Ministry of Women and Child Development and Ministry of Social Justice and Empowerment.

II. F. ENABLING ENVIRONMENT AND IMPACT ALLEVIATION

India has taken several steps to ensure that the environment within which HRG groups and PLHIV must live and survive is conducive to their easy access to prevention and CST services but equally to livelihood and dignity. NACO has undertaken training in *Stigma and Discrimination (S&D)* of its staff at national and state levels as well as of personnel who will directly interact with persons accessing services under the NACP.

Another key action has been the effort made to *establish TI programmes through Community Based Organisations (CBO)*. In order to ensure peer support and learning, networks of these institutions supported in particular through Bill and Melinda Gates Foundation work in country. State Training and Resource Centres (STRC) have also been established in institutions known to be well versed with their issues to ensure adequate relevant attention to their needs.

An important feature of the programme is its attention to the *support of PLHIV networks*; supporting the national network; strengthening 22 state level networks; and helping establish 221 district level networks of PLHIV. The GIPA Policy has been developed through a consultative process and is likely to be finalized soon. There are 208 Drop In Centres (DIC) run by PLHIV networks, operational across the country.

Hindu *faith leaders came together* at the 'Art of Living' International Centre to sign a joint declaration against AIDS; they committed themselves to working with the Department of AIDS Control to spread HIV awareness among youth and to end stigma and discrimination against people affected by HIV. Since then a number of leaders have incorporated HIV messaging into their religious discourses at large gatherings.

There have been *several state level initiatives*. States such as Orissa have issued Below Poverty Line (BPL) cards to PLHIV as a mechanism to ensure access to free/subsidized food and housing facilities. In Tamil Nadu and Andhra Pradesh, 10 legal aid centres each have been established. The SACS in West Bengal and Andhra Pradesh include PLHIV in the Executive Committee of the quasi-government society. Nagaland approved a new State AIDS Policy on 29 April 2009 delineating the state government's commitment to scale up prevention, harm-reduction, treatment and care programmes through ensuring

quality health care delivery system. In Andhra Pradesh, at a special all-party meeting organised on 21 February 2009 by the Legislators Forum on AIDS, legislators signed a joint declaration of intent to integrate HIV issues into their official electoral campaigning as they geared up for the state's next election.

II. G. BEST PRACTICES AND CHALLENGES

This CPR India 2010 has captured several Best Practice models developed through the efforts of the Government of India, State Legislatures, NACO, development partners and local NGO/CBO partners in the narrative and text boxes throughout the report. In particular, India's experiences with the Red Ribbon Express, Legislators' Forums in several states, reading down of a discriminatory provision in the Indian Penal Code stand out as landmark achievement.

India has tackled many challenges facing the programme and currently faces the following challenges:

1. Enhance scale up based on revised estimates. Need for flexible planning to account for new typologies of HRG – new, young, and engaged in multiple partner sex.
2. Improving basic services for the general population that includes better information, identification of key target populations and capacity development of general health services staff.
3. Demand generation for condoms and identification of adequate delivery mechanisms to ensure supply.
4. The ability of CST programmes to reach those most in need to be improved, especially HRG. Focus is needed on the quality of delivery of service.
5. Increased granularity, quality and regularity of data to help ensure better planning of services.

II. H. SUPPORT FROM DEVELOPMENT PARTNERS

Several donors, bilateral organizations and private foundations support NACP III or specific interventions in India. The principal support comes from the World Bank, DFID, the President's Emergency Plan for AIDS Relief (PEPFAR) of the US Government, the UN and private foundations such as BMGF and the Clinton Foundation. A major recent funding organisation is the GFATM. Smaller bilateral agencies support NACP through UNAIDS, international and national NGO and private sector players.

According to the very broad classification based on the round-specific funding, GFATM (all rounds put together) has slightly higher focus on prevention (57 percent), with the rest (43 percent) comprising care and support activities. This distinction, however, is not strictly correct as many capacity building activities such as training programmes does happen under other NACP III objectives such as Prevention and Care. The pooled fund largely focuses on prevention activities (81 percent), with some proportion of it allocated for capacity building as well. PEPFAR's bilateral support is a part of external aid component. Half of its funds are spent on prevention activities with another fourth for capacity building. The UNDP funds prevention (59 percent) and capacity building (41 percent) services.

II. I. THE M&E ENVIRONMENT

Following the 'Three Ones' principle, a *SIMU is established at NACO* with the main focus on generating quality information on the programme and the epidemic and on strengthening the national M&E framework. NACP collects routine information on programme components from all states and union territories including Blood Banks, ICTC, STI clinics, ART centres and from NGO implementing TI and CCC. This information is collected monthly through the comprehensive software of Computerized Management Information System (CMIS) which is installed in all SACS.

Significant investment has been made to *build the capacity of managers and technical staff* at the state level. A total of 495 M&E officers at national level, 2535 M&E officers at state level and 12,393 civil society representatives have undergone M&E training during 2008 and 2009. From 2008 onward, a series of regional training for advancing national and state officers' knowledge on M&E, epidemiology and bio-statistical methods using SPSS was conducted.

Three interesting initiatives have been the new *Strategic Information Management System (SIMS), the Smart Card Project* and the *data triangulation exercise*. SIMS is a web-based application with a central server and sophisticated tools aiding in data analysis and integration from different data sources/platforms. It is proposed to increase the efficiency of computerized M&E system by having adequate data quality through centralized validated data. The Smart Card is a portable medical record that would facilitate easy storage and analysis of the medical data of patients on ART. The project titled "Epidemiological Profiling of HIV/AIDS Situation at District and Sub-district Level using Data Triangulation" in 182 districts has the objective of consolidating the epidemiological profiles (epidemic scenario and programme response) at district and sub-district level with respect to HIV/AIDS.

India has established a *national Evaluation and Research Agenda* in consultation with its partners which will set priorities for programme evaluation and research related to HIV in the country and establishes systems that will ensure good quality research and proper data dissemination and use by the national programme. The Network for Indian Institutions for HIV/AIDS Research (NIIHAR) was established and a NACO Ethics Committee constituted to consider and provide ethical clearance for those research proposals and projects that involve participation and experimentation on human participants. Data generated from NACO funded HIV and AIDS research is placed on the NACO website and is free for all institutions/organizations/stakeholders to access.

II. J. OVERVIEW TABLE OF UNGASS INDICATORS

No.	Indicator	UNGASS 2008	Current Status	
			2008	2009
1.	Domestic and international AIDS spending by categories and financing	USD 171 million during 2006-2007 (April 2006 to March 2007) Source: NACO	USD 146 million (rounded off) (April 2008 to March 2009) Source: NACO	USD 140 million (rounded off) (April 2009 to January 2010) Source: NACO
2.	National Composite Policy Index	Annex	Annex	Annex
3.	Percentage of donated blood units screened for HIV in a quality assured manner	100% (January 2006 to November 2007) Source: NACO-CMIS	100% Source: NACO-CMIS	100% Source: NACO-CMIS
4.	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	19.6% of adults and 35.1% of children with advanced HIV infection are receiving ART by December 2007 Source: NACO-CMIS	32.2% of adults (15+) Source: NACO-CMIS & Provisional Estimates from EPP-Spectrum	45.3% of adults (15+) Source: NACO-CMIS & Provisional Estimates from EPP-Spectrum
5.	Percentage of HIV infected pregnant women who received antiretroviral to reduce the risk of mother to child transmission	In 2006, 7.5% of HIV infected pregnant women received Nevirapine Prophylaxis to reduce the risk of transmission to child and it increased to 8.3% in 2007 Source: NACO-CMIS	16.42% Source: NACO-CMIS	17.39% Source: NACO-CMIS
6.	Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Of the 85,000 patients with co-infection, 23% (14,200 in 2006 and 19,400 up to October 2007) are estimated to be under treatment	4.3% Source: RNTCP programme monitoring data and NACO-CTD study in 13 states	Data not available
7.	Percentage of women and men aged 15-49 years who received an HIV test in the last 12 months and who know their results	3% women and 3.3% men had an HIV test and know their results Source: NFHS 3 40.3 lakh were tested in 2006 and 54.7 lakh were tested in this year till October 2007	3.2% males and 3.2% females had an HIV test in last one year and know their results *Source: BSS Manipur, 2009 Andhra Pradesh : 3.3% ; Karnataka : 0.8% ; Tamil Nadu : 1% ; Uttar Pradesh : 1.2%	

8.	Percentage of most at risk populations who received an HIV test in the last 12 months and who know their results	<p>Female sex workers (FSW) : 34.2%</p> <p>Men who have sex with men (MSM) : 3 to 67% across survey locations</p> <p>Injecting Drug Users (IDU): 3 to 70% across survey locations</p> <p>Source: BSS 2006</p>	<p>FSW: 31.8%</p> <p>MSM: 17.0%</p> <p>IDU: 20.7%</p> <p><i>*Source: BSS Manipur, 2009</i></p> <p>FSW :</p> <p>Andhra Pradesh = 74.1%</p> <p>Karnataka = 54.7%</p> <p>Tamil Nadu = 73.7%</p> <p>Uttar Pradesh: 10.7%</p> <p>MSM :</p> <p>Tamil Nadu = 46.3%</p> <p>IDU :</p> <p>Uttar Pradesh : 2.9%</p> <p><i>Source : BSS 2009</i></p>
9.	Percentage of most at risk populations reached with HIV prevention programmes	<p>56% of the FSW, 17-97% of the MSM (across survey locations) and 10-83% of the IDU (across survey locations) received interpersonal communication on HIV-AIDS in the last one year</p> <p>Source: BSS 2006</p>	<p>FSW: 31.1%</p> <p>MSM: 18.1%</p> <p>IDU: 14.8%</p> <p><i>*Source: BSS Manipur, 2009</i></p> <p>FSW :</p> <p>Andhra Pradesh = 80.7%</p> <p>Karnataka = 49.4%</p> <p>Tamil Nadu = 89.5%</p> <p>Uttar Pradesh: 10.2%</p> <p>MSM :</p> <p>Andhra Pradesh = 1.8%</p> <p>Karnataka = 5.6%</p> <p>Tamil Nadu = 63.4%</p> <p>IDU :</p> <p>Uttar Pradesh : 5%</p> <p><i>Source : BSS 2009</i></p>
10.	Current school attendance among orphans and non-orphans aged 10-14	Data not available	Data not available
11.	Percentage of schools that provided life skills based HIV education in the past academic year	<p>114,345 schools (79%) have been covered out of 144,409 government secondary schools in the country (Programme started in 2006-07)</p> <p>Source: NACO-CMIS</p>	<p>30.9% (47,000 schools out of 1,52,051) were covered during 2008-09 under Adolescence Education Programme.</p>
12.	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	<p>Not applicable: Only for high prevalence country. Please see text for national policy on children affected by AIDS</p>	Data not available

13.	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission	Comprehensive correct knowledge about HIV transmission and prevention: 28% Source: BSS 2006	39.8%* <i>Source: BSS Tamil Nadu, 2009*</i> Andhra Pradesh: 18.6% Karnataka: 9.8%
14.	Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission	FSW: 38% MSM: 16-75% IDU: 14-77% Source: BSS 2006	- FSW who answered all five questions correctly : Manipur: 23.9% Andhra Pradesh : 47.4% Karnataka : 39.7% Uttar Pradesh: 20.1% - MSM who answered all five questions correctly : Manipur MSM: 30.3% Andhra Pradesh : 56.7% Karnataka : 20.7% Uttar Pradesh: 17.4% - IDU who answered all five questions correctly : Manipur IDU: 26.9% Uttar Pradesh : 17.8% Source: BSS, 2009
15.	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Youth BSS shows that 3% of the young men and women aged 15-24 years had first sexual intercourse before the age of 15 years Source: BSS 2006	0.04% <i>*Source: BSS Tamil Nadu, 2009</i>
16.	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Overall: 6% Men: 9% Women: 3% Source: BSS 2006	Andhra Pradesh 5.2%, Karnataka 0.3%, Tami Nadu 0.5%, Manipur 1.1% <i>Source: BSS 2009</i>
17.	Percentage of women and men aged 15-49 who have more than one partner in the past 12 month reporting the use of a condom during their last sexual intercourse	58% Source: BSS 2006	Andhra Pradesh 77%, Karnataka 87%, Tami Nadu 78%, Manipur 73%, Maharashtra 80% and Uttar Pradesh 67% <i>*Source: BSS 2009</i>
18.	Percentage of female and male sex workers reporting the use of a condom with their most recent client	FSW with the paying client: 88% used condoms Source: BSS 2006	Condom use during last sex with occasional client: Manipur: 83.0% Andhra Pradesh: 99.6% Karnataka: 98.7% Tamil Nadu: 92.6% Uttar Pradesh: 84.5%

			* Source: BSS 2009
19.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	13-87% across survey locations Source: BSS 2006	Condom during the last anal sex with regular male partner: Manipur: 57.6%* Tamil Nadu: 48.9% *Source: BSS 2009
20.	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	44-100% across survey locations Source: BSS 2006	Manipur: 15.9% Uttar Pradesh: 94% Andhra Pradesh: 95% Karnataka: 92% Tamil Nadu: 79% Maharashtra: 77% *Source: BSS 2009
21.	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	29-88% across survey locations (BSS 2006)	Manipur: 86.5%* Uttar Pradesh: 73.1% *Source: BSS 2009
22.	Percentage of young women and men aged 15-24 who are HIV infected	HIV prevalence among ANC clinic attendees aged 15-24 years is 0.57% Source: HIV Sentinel Surveillance 2006	0.49% Source: Provisional estimate of 2008-2009 HSS (ANC clinic attendees)
23.	Percentage of most at risk populations who are HIV infected	FSW show a percent positivity of 4.9 percent, IDU highest prevalence at 6.92% and MSM at 6.41% Source: HIV Sentinel Surveillance 2006	FSW: 4.9% MSM: 7.3% IDU: 9.2% Source: Provisional estimate of 2008-2009 HSS
24.	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	WHO Cohort Study at 11 centres show that 80.1% patients were alive after 12 months on ART Source: WHO Cohort Studies, CMIS	89.3% Source: Cohort Study of PLHA from PLHA Software
25.	Percentage of infants born to HIV infected mothers who are infected	Not reported	Data not available

* BSS 2009 was conducted in six states of India - Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Uttar Pradesh and Manipur - and is not a nationally representative sample. The results from these surveys cannot be combined to provide a value for the country. Hence, individual state figures are provided.

III. OVERVIEW OF THE AIDS EPIDEMIC

This chapter is broadly divided to two sections. Part A provides a detailed overview of the HIV-AIDS epidemic at national level; the transmission routes and geographic diversity; and an analysis of HIV prevalence amongst HRG and the general population. Part B highlights existing knowledge on HIV-AIDS, STD treatment, condom use and sexual behaviour to reflect behaviour patterns.

The 2008-09 national HIV Sentinel Surveillance (HSS) and 2009 BSS — conducted in six states is the basis for analysis. Whilst there is reference to HSS and BSS in section eight of this report; there is need for referring briefly to the methodology of the surveys.

HIV Sentinel Surveillance and Behavioural Surveillance Survey: India conducts HSS annually to monitor outcomes and impacts of national efforts and monitor trends in HIV prevalence amongst various population groups. It involves conducting cross-sectional sero-surveillance surveys of selected populations drawn from relevant facilities and TI. It is aimed at providing data on dynamics of the HIV and AIDS epidemic at national and state levels. Among the principal objectives of HSS in India are generating data for use in estimations and projections, and determining the type of input required for strengthening prevention and control activities for different population groups and geographical regions.

In India, surveillance activities have witnessed phased scale up in the network of sentinel sites over the years. For the HSS 2008/2009, the emphasis was on expanding surveillance among most at risk populations although focus remains on ANC and Sexually Transmitted Infections HSS.

In 2006-2007, HSS was conducted at 1134 sentinel sites. The number of general population sites was 646 sites whilst the number of sites for HRG — FSW, MSM and IDU — and bridge populations — migrants and truckers — was 488. In comparison, in 2008-2009 HSS was conducted at 1215 sites of which 660 sites were for the general population and 555 for HRG.

It is important to note here that the latest round of HIV Sentinel Surveillance was conducted over two years (2008 and 2009). The HSS data for this round is still provisional.

III. A. THE HIV AND AIDS EPIDEMIC IN INDIA

III. A. 1. Pattern of the HIV Epidemic at National Level

This section provides an overview of the HIV epidemic in India through a discussion of the adult HIV prevalence rates in the country; the estimated number of total adults and women living with HIV; and the major routes of transmission.

III. A. 1. A. ADULT PREVALENCE

HIV estimates derived using globally comparable methods, find the NACP progressing steadily towards the objective of halting and reversing the HIV epidemic in India over the period 2007-2012.

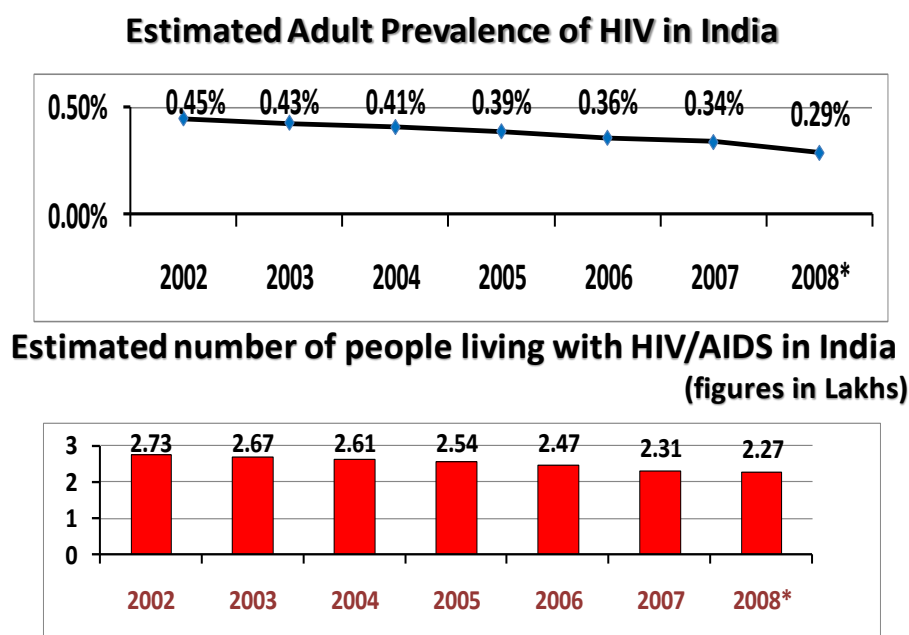
Various rounds of HIV prevalence estimates find a steady decline in the adult HIV epidemic in India. The Provisional estimate of 2008 shows an adult HIV prevalence of 0.29% in India.

While the reduction of the overall adult prevalence in India is largely attributable to the impact of the programme scale up and increased coverage of services under NACP III — especially in the high prevalence states where a steady decline is observed — improvements in surveillance coverage, quality of data, and methods used for estimation were key to a more valid estimation process.

III. A. 1. B. ESTIMATED PLHIV IN INDIA

There is a steady decline in the number of people living with HIV in the country, from 2.73 million in 2002 to 2.27 million in 2008 (provisional). Women account for 39 percent of PLHA while children account for 3.8%. 60% of the PLHA burden is in the six high prevalence states.

Figure 3.1: Trends of Estimated Adult HIV Prevalence and Estimated Number of PLHA, 2002-08

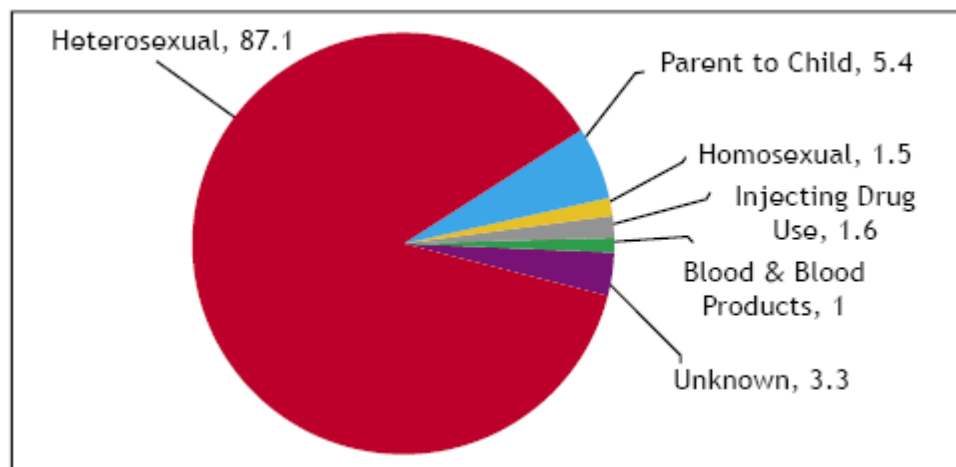


Source: HIV Sentinel Surveillance & HIV Estimation 2007 – A Technical Brief
*2008 Estimates are Provisional.

III. A. 1. C. ROUTES OF HIV TRANSMISSION

Analysis of information from around 300,000 persons tested HIV positive at various counselling and testing centres confirm the main mode of HIV transmission in the country as unprotected heterosexual intercourse. In 2009-10, this transmission mode accounted for 87 percent of all reported HIV cases (figure 3.2). In 5.4 percent of cases, the route of transmission was from mother to child. Whilst 1.5 percent of all HIV cases reported homosexual sex; IDU accounted for 1.6 percent of infections. Thus, the primary drivers of the HIV epidemic in India are unprotected paid sex/commercial sex work, unprotected anal sex between men, and IDU.

Figure 3.2: Routes of HIV transmission, India, 2009-10



Source: CMIS, NACO, 2009-10

It is estimated that there are 1.26 million FSW; 351,000 higher risk MSM; and 186,000 IDU in India. Sex work continues to act as the most important source of HIV infections in India though due to the large number of clients that gets infected from sex workers. According to BSS 2006, 2.4 percent adult males had sex with a FSW during the last twelve months prior to the survey. Men who buy sex constitute one of the largest infected population groups in the country. Given that condom use is not optimal or consistent in many places; men who buy sex or clients of sex workers are the single most powerful driving force in India's HIV epidemics. It is noted also that long-distance truckers and single male migrants form a significant clientele of sex workers.

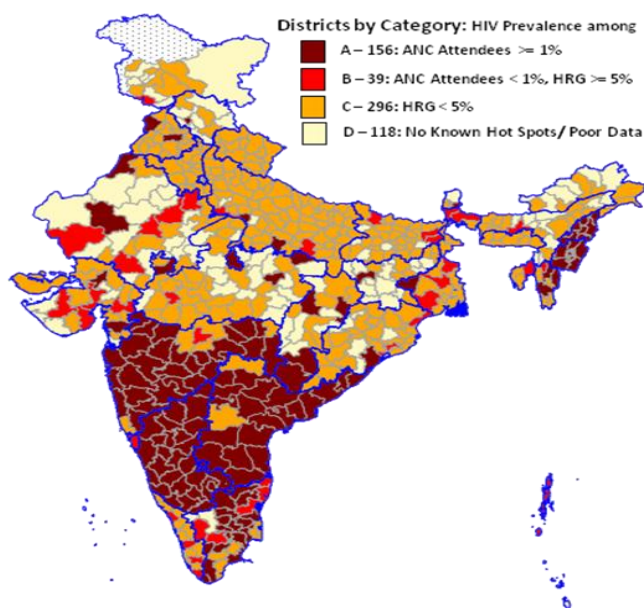
Intimate partner sexual relationships: The HIV epidemic in India is entering a phase where new infections are increasingly occurring within intimate partner sexual relationships. As detailed in preceding sections, women account for a considerable proportion of the total HIV infected population and more than 90 percent of these women acquired HIV infection from their husbands or their intimate sexual partners. They are at increased risk for HIV not due to their own sexual behaviour; but because they are partners of men who are clients of FSW, MSM or IDU.

III. A. 2. State-wise estimated adult HIV prevalence

HIV in India is heterogeneous: both in terms of what factors drive of the HIV epidemic and the geographic variance. A brief discussion on each of these sub-components is below.

Six states with high HIV prevalence account for an approximate 66 percent of the HIV burden in the country—although sustained initiatives of Government and stakeholders under NACP III has resulted in reduced adult prevalence estimates in these states. Contrarily, a comparison of 2007 and 2008 HSS data finds a reverse trend emerging in some of the low prevalence categorised states.

Figure 3.3: Map with district categories to highlight the geographical diversity of HIV 2007



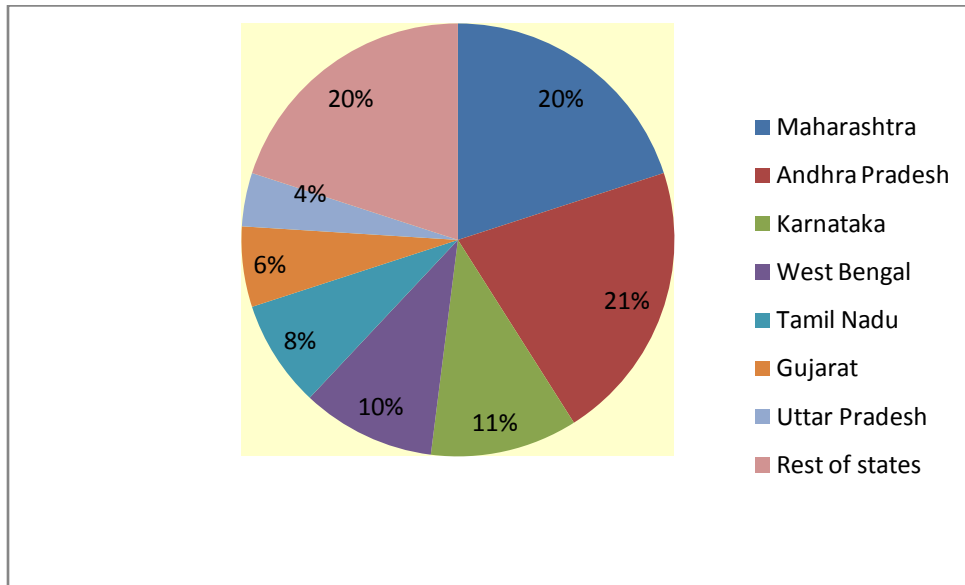
HSS 2007 points towards a diverse geographic spread of HIV across states and across districts as well (figure 3.3, 3.4). India has 195 priority districts identified according to the prevailing HIV prevalence rates for focused programmatic interventions. Of these, 156 districts are category ‘A’ districts that have over or equal to 1 percent prevalence amongst ANC attendees. Another 39 districts are category ‘B’ districts with less than 1 percent HIV prevalence amongst ANC attendees but more or equal to 5 percent prevalence amongst HRG.

The preliminary results of the 2008-09 HSS revealed different trends among the various districts, pointing to a continuously changing distribution of the HIV epidemic in India. While an overall decline in HIV prevalence among ANC attendees is noted especially in high prevalence states; an increased trend is observed in some low and moderate prevalence states such as Gujarat, Rajasthan, Orissa, Uttar Pradesh, Bihar and West Bengal. Of the 108 districts that have shown 1 percent or more HIV prevalence among ANC attendees, a third of them (34 districts) are in low prevalence states and 87 districts have shown 5 percent or more HIV prevalence among HRG.

Among sex workers, there is a decline in south Indian states indicating a possible impact of interventions, while rising trends are evident in the North East suggesting a dual nature of the epidemic

now driven both by IDU and sexual transmission. Fifty five districts have shown greater than 5 percent HIV prevalence among FSW in 2008-2009.

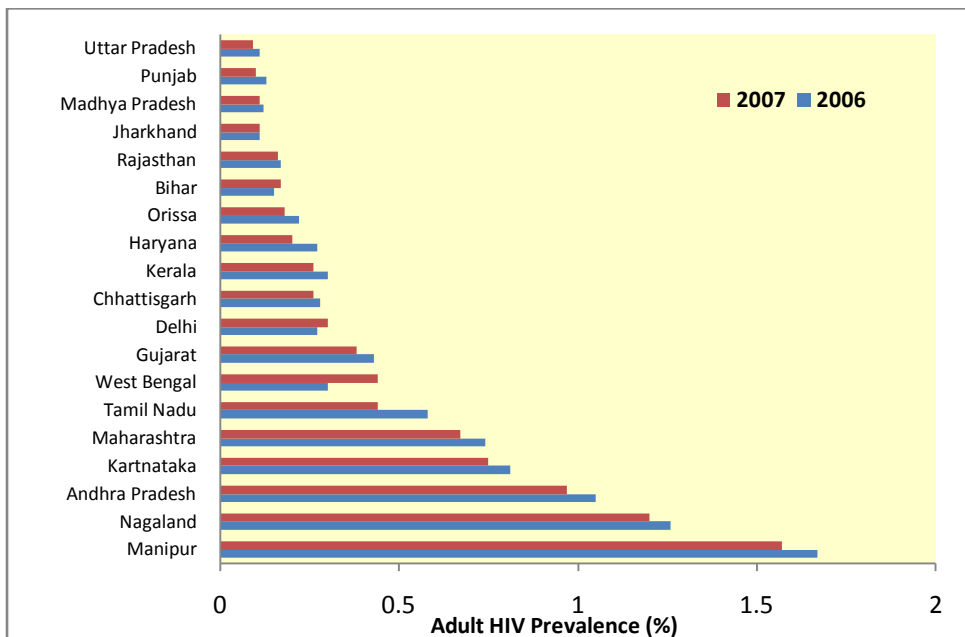
Figure 3.4: Distribution of PLHIV by states 2007



Source: HIV sentinel surveillance and HIV estimation in India, 2007

The latest round of surveillance provides evidence that while there is an overall decline in adult HIV prevalence — particularly in the high prevalence states — there is an increase in many of the low prevalence states especially among the HRG. The low prevalence states in India account for approximately one third of the country’s HIV burden (figure 3.5).

Figure 3.5: State wise estimated adult HIV prevalence, 2006 & 2007

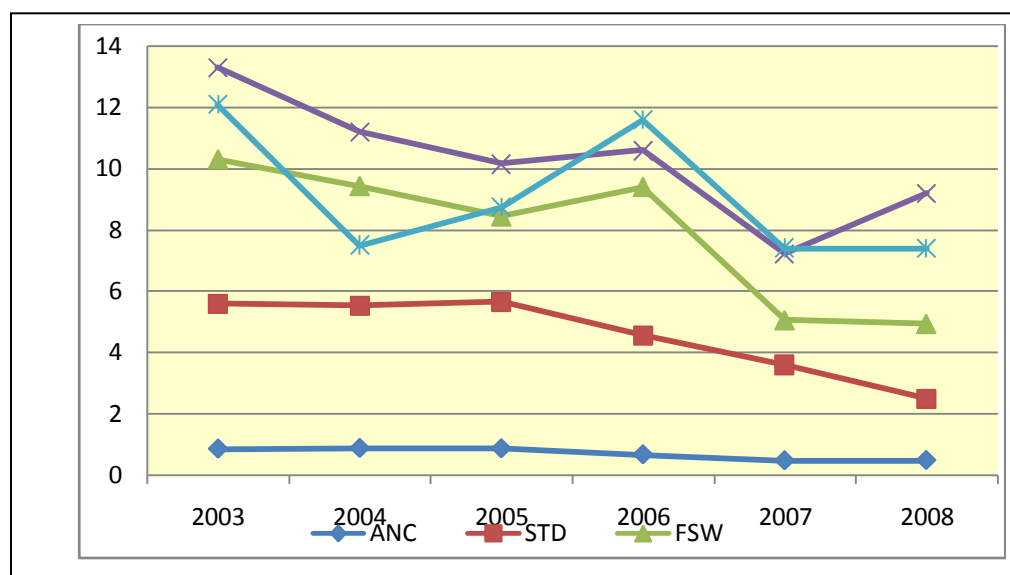


Source: HIV sentinel surveillance and HIV estimation in India, 2007

III. A. 3. HIV Epidemic among High Risk Groups

As evident from the comparison of HSS 2008, 2007 and 2006 data — there is a steady decline in HIV prevalence amongst FSW resulting from government and stakeholder interventions. Amongst FSW this is a notable decline by 4.34 percentage points from 2006 to 2007 and by 0.12 percentage points from 2007 to 2008. HIV prevalence amongst MSM is stable in the last two rounds at 7.3 percent with variation in different states. Among IDU, however, a varied trend in prevalence has emerged. Whilst from 2006 to 2007 HIV prevalence amongst this sub population declined by 3.37 percent; it has increased by 2.68 percent from 2007 to 2008 (figure 3.6).

Figure 3.6: Trend Analysis of HIV prevalence 2003-2008



Source: NACO, 2009

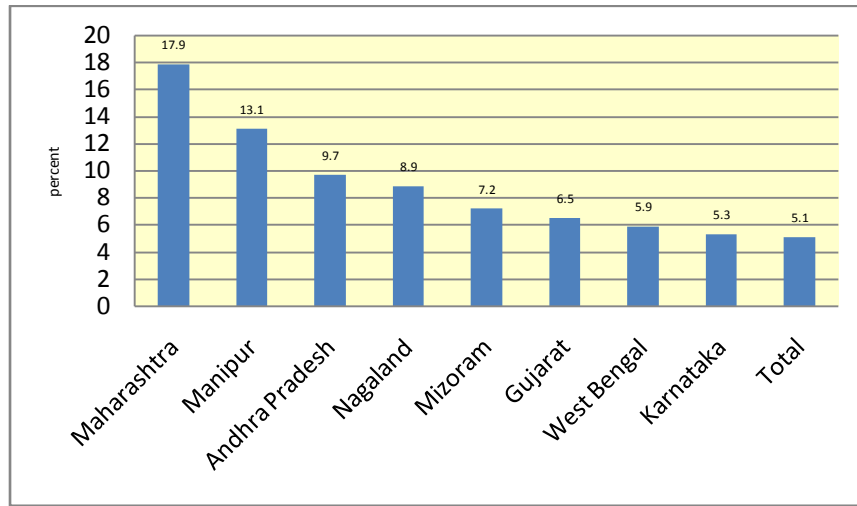
A more detailed analysis of state wise HIV prevalence amongst HRG is presented in the sub-sections below.

III. A. 3. A. FEMALE SEX WORKERS

The HSS 2008/09 found 3 districts – out of 129 districts with FSW sites — with HIV prevalence amongst FSW at levels higher than 30 percent and 5 districts with a FSW prevalence of over 15 percent.

In 47 districts HIV prevalence amongst FSW is at levels higher than 5 percent, and 15 of these are in from 5 low prevalence states. The mean HIV prevalence amongst FSW is highest in the state of Maharashtra at 17.91 percent (figure 3.7). This is followed closely by the states of Manipur, Andhra Pradesh, Nagaland and Mizoram where the mean HIV prevalence amongst FSW is at estimated levels of 13.07 percent, 9.74 percent, 8.91 percent, and 7.20 percent respectively.

Figure 3.7: HIV prevalence among FSW in select states 2007-2008



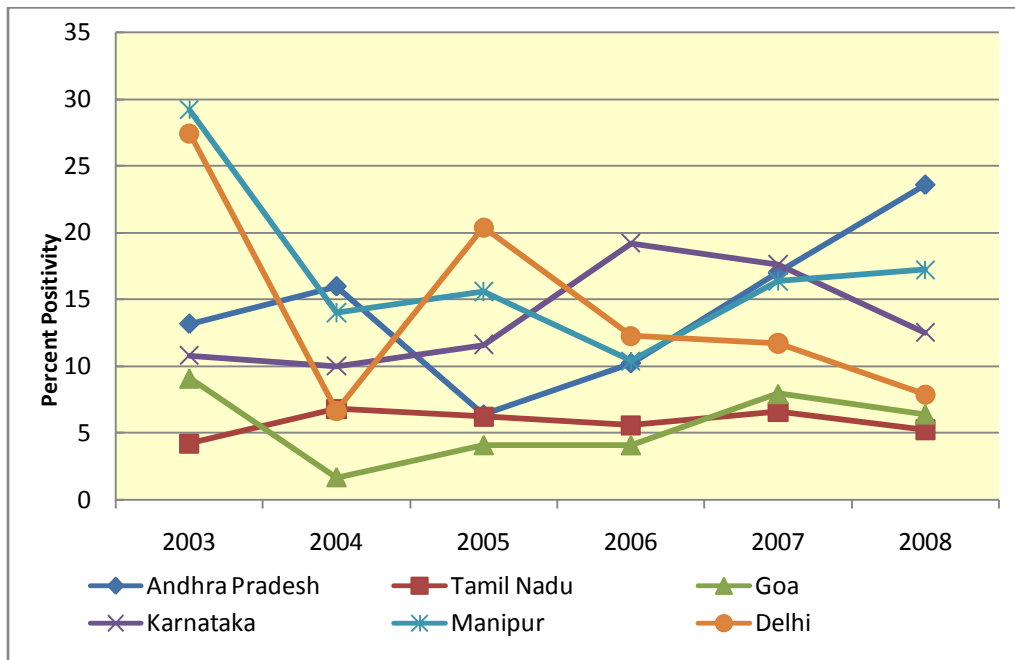
Source: HIV sentinel surveillance and HIV estimation in India, 2007-2008

III. A. 3. B. MEN WHO HAVE SEX WITH MEN

In India, pockets of high HIV prevalence among MSM are identified in high prevalence states as well as in Delhi, Gujarat and West Bengal. 28 districts have 5 percent or more HIV prevalence among MSM according to the BSS 2009.

The states that have the highest mean HIV prevalence amongst MSM in 2008 are: Karnataka, Andhra Pradesh, Manipur, Maharashtra, Delhi, Gujarat, Goa, Orissa, Tamil Nadu and West Bengal (figure 3.8). Whilst overall, HIV trends amongst this population group is stable in India; there is an increasing trend among south Indian states and Delhi.

Figure 3.8: Trends of HIV prevalence among MSM in select states 2003-2008



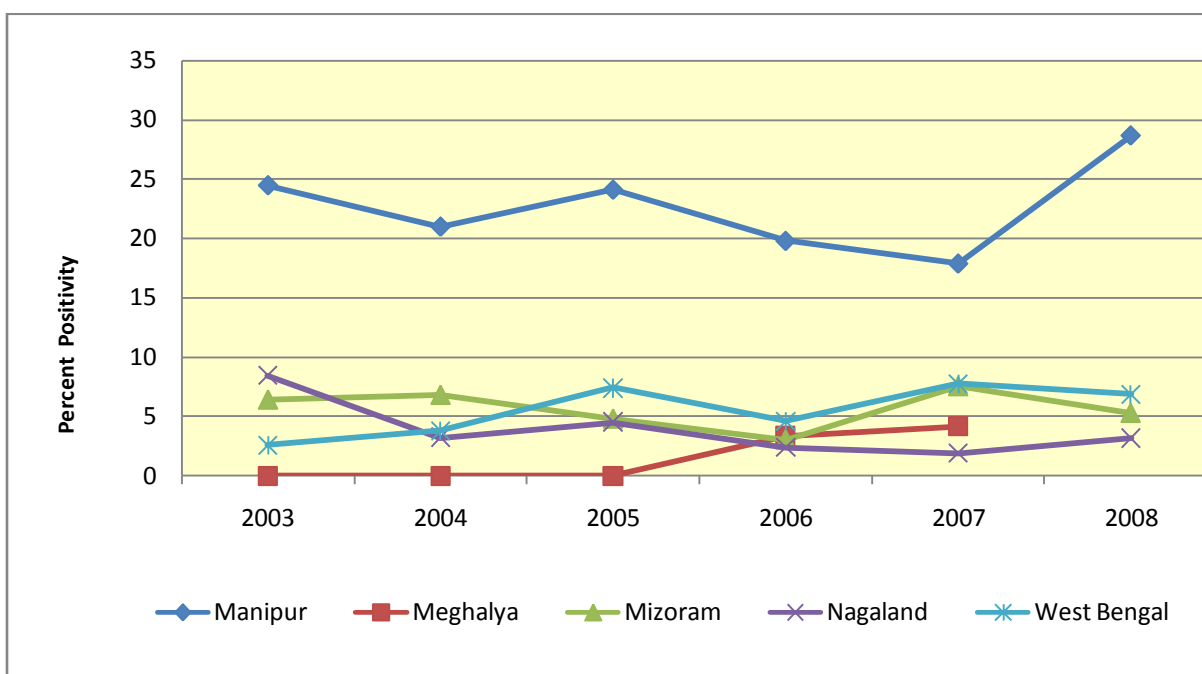
Source: HIV sentinel surveillance and HIV estimation in India, 2007-2008

III. A. 3. C. INJECTING DRUG USERS

In 2008 India had 7 districts of a total of 49 districts with IDU sites—where HIV prevalence among IDU was over 15 percent. The highest HIV prevalence amongst this population group was reported in Amritsar at 30.40 percent, followed by two sites at Churachandpur¹ and Chennai at 28 percent and 27.2 percent. In Delhi North and Aizwal the prevalence estimate is 20 percent and 16.6 percent respectively.

Overall, the nationwide trend among IDU is varying (figure 3.9) Injecting drug use is the principal driver of the HIV epidemic in north-eastern states of India. Approximately 25% of the IDU reside in the North-eastern states. Trends among IDU are on a decline in two of these North-Eastern states — Manipur, Nagaland – and in Chennai (Tamil Nadu) indicating a possible impact of interventions. At the same time, there is a rise of HIV infection among IDU in other states such as Meghalaya, Mizoram in the North-East and in West Bengal, Mumbai (Maharashtra), Kerala, Delhi, Punjab and Chandigarh where 20 districts have shown 5 percent or more HIV prevalence among IDU in 2008-2009.

Figure 3.9: Trends of HIV prevalence among IDU in select states 2003-2008



Source: HIV sentinel surveillance and HIV estimation in India, 2007-2008

III. B. BEHAVIOURAL PATTERNS AMONG ADULT POPULATION AND HRG

An understanding of behavioural patterns and trends is imperative for firstly, providing direction to programme efforts for HIV-AIDS response and secondly, to highlight the degree and impact of current interventions. Behavioural surveillance has aided national and sub-national level programmers for planning, implementing, monitoring and evaluating interventions and is constantly referred to. The first

¹ According to 2008 HSS, the district of Churachandpur not only has a high HIV prevalence estimated at over 15% amongst IDU, but also amongst FSW.

Behavioural Surveillance Survey was commissioned in 2001 — under NACP II — and repeated in 2006 after a five year gap.

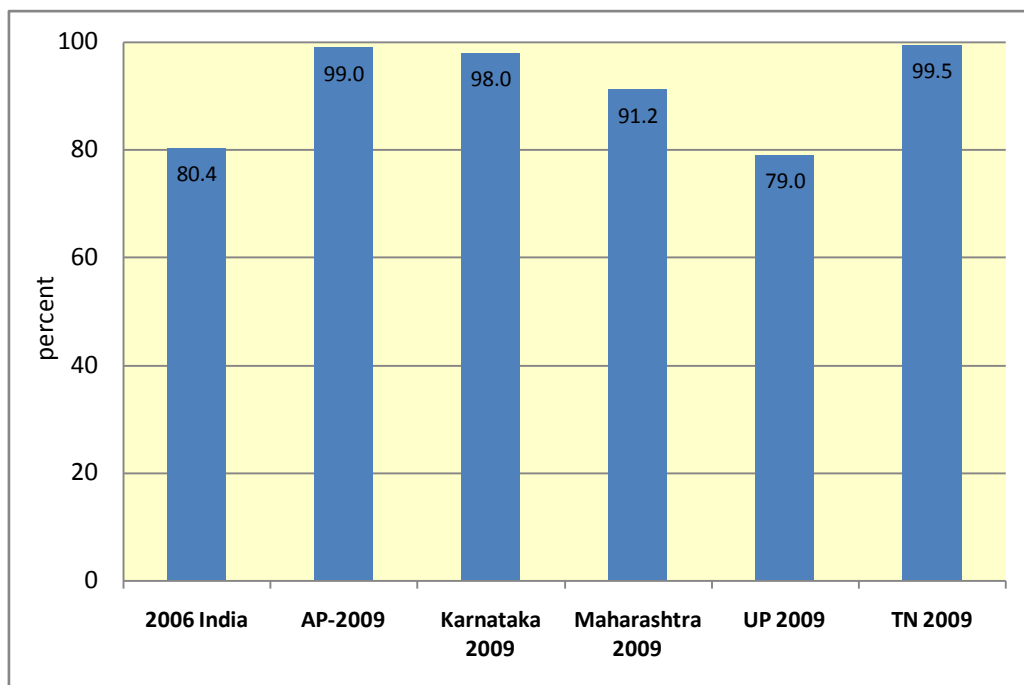
In 2009, BSS were conducted in 6 states. These are Andhra Pradesh, Karnataka, Maharashtra, Manipur, Tamil Nadu and Uttar Pradesh. The results of the surveys are intended to give an understanding of the key behavioural patterns and inform program development for the expansion of interventions leading to reduction in the transmission of HIV. These BSS were implemented during July – November 2009.

The BSS was conducted amongst the general population, youth, HRG and male migrants. This section will discuss initial results from these six surveys which were implemented independent of each other, using the same methodology as provided by NACO and implemented by different agencies at state level.

III. B. 1. KNOWLEDGE OF HIV

Overall, this round of BSS revealed an increase in awareness levels on HIV and STI among the general population and the HRG. The 2006 survey revealed, however, diversity in levels patterns of behaviours between the high prevalence states which were the main focus of the programme during previous years, and the low prevalence states where prevention coverage remained relatively at lower levels. The 2001 and 2006 BSS surveys already revealed that general awareness of HIV at national level was on the rise, increasing by 13 percentage points to an average of 80.4 percent in 2006.

Figure 3.10: Knowledge of HIV - General population 2006, 2009



Source: BSS 2006, BSS 2009.

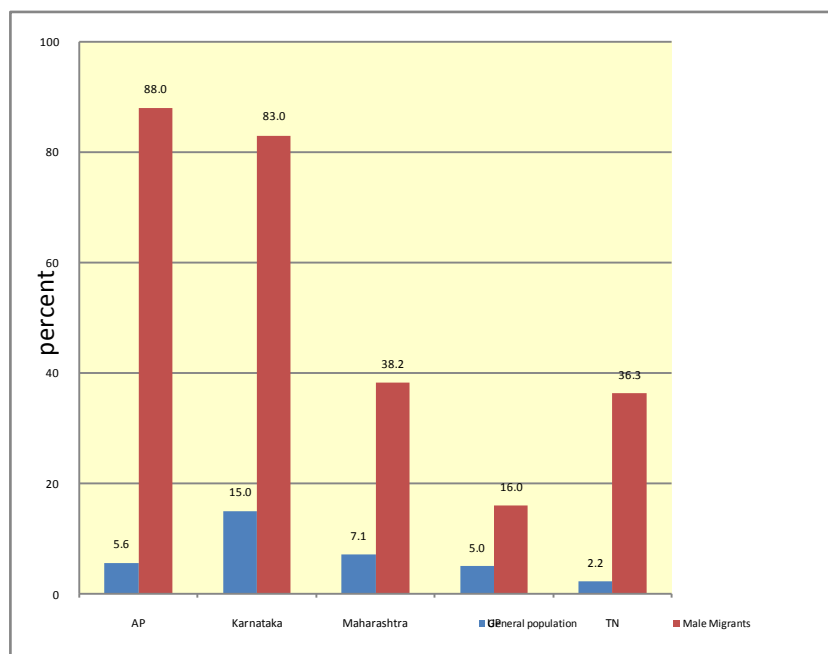
On knowledge of HIV among the general population (BSS 2009), the levels of awareness of HIV are high across all states — excepting Uttar Pradesh — remains at a relatively lower level (79 percent). This pattern is constant for all groups surveyed, for example, youth, FSW, MSM, IDU and migrants. However, the survey revealed relatively lower levels of awareness across the groups regarding sexually transmitted infections (STIs) — specifically in Uttar Pradesh and Maharashtra — and among migrants in Karnataka (figure 3.10). While awareness of STI among general population in 2006 was at 37.7 percent, the new round of BSS revealed levels ranging between 66 percent in Andhra Pradesh and 29 percent in Uttar Pradesh.

On the transmission routes, while there are general high levels of awareness regarding HIV transmission through sexual contact among all surveyed categories, there are relatively lower levels of knowledge of possible transmission from an infected mother to her child. Among the general population, the proportion of the population aware of this mode of transmission ranged between 62 percent in Maharashtra and 84.6 percent in Tamil Nadu.

III. B. 2. INVOLVEMENT WITH COMMERCIAL SEX PARTNERS

As per national BSS in 2006, 2.4 percent of adult males had visited commercial sex worker in the year prior to the survey. Men who buy sex, i.e., clients of sex workers are the single most powerful driving force in India’s HIV epidemic and form the country’s largest infected population group.

Figure 3.11: Involvement with commercial sex partners 2009



Source: BSS 2009.

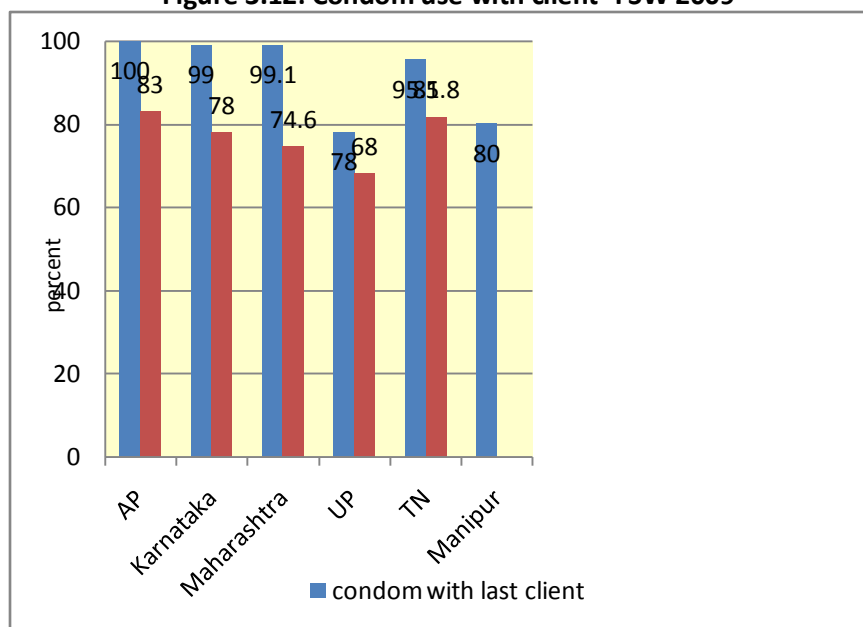
The BSS-2009 indicates also high levels of involvement with female commercial sex workers among the general population, with proportions ranging from 2.2 percent in Tamil Nadu to 15 percent in Karnataka (figure 3.11). The BSS among male migrants find that these constitute the largest clientele of sex workers. While the percentage of migrants visiting sex workers remains much higher than that observed among the general population, there is a great discrepancy between the levels observed in

different states. While 16 percent of migrants in Uttar Pradesh declare having visited a sex worker in the last twelve months, this proportion levels at 36.3 percent and 38.2 percent respectively in Tamil Nadu and Maharashtra, and reaches 83 percent and 88 percent respectively in Karnataka and Andhra Pradesh.

III. B. 3. CONDOM USE

One of the major successes of the programme is reflected through the high level of condom use reported by sex workers, especially in the high prevalence state. Levels of reported condom use with last paying client reached 100 percent in Andhra Pradesh, and exceeded 99 percent in Karnataka and Maharashtra (figure 3.12). The surveys revealed relatively lower levels for that same indicator at around 78 percent in Uttar Pradesh and 80 percent in Manipur. However, consistency of condom use with non regular paying clients remains at lower levels ranging between 68 percent in Uttar Pradesh and 83 percent in Andhra Pradesh.

Figure 3.12: Condom use with client- FSW 2009



Source: BSS 2009.

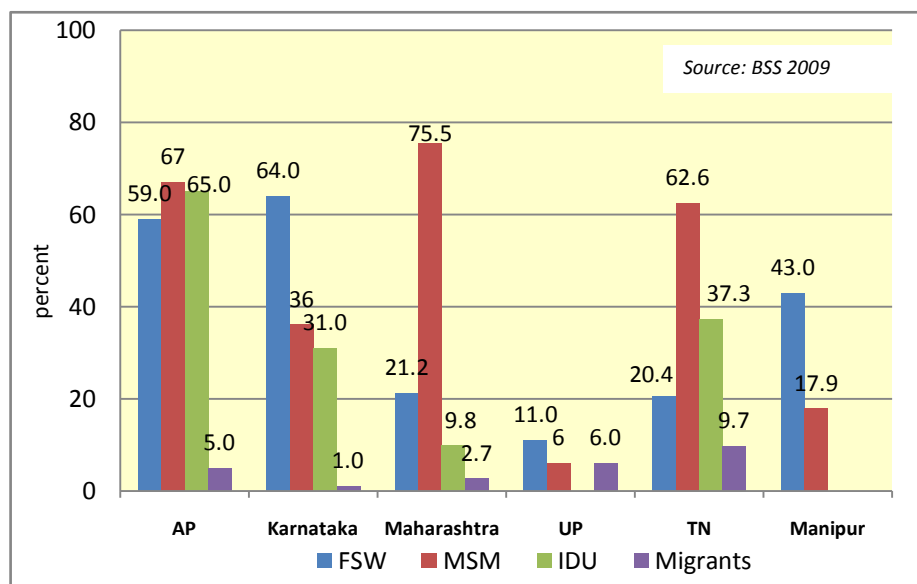
There is also great consistency of this data with the levels of condom use reported by other categories of the population such as migrants. Among migrants who reported visiting a sex worker during the last 12 months preceding the survey, high percentages declared use of condoms. This number ranged between 91 percent in Maharashtra and 96 percent in Andhra Pradesh. Lower levels were reported from Uttar Pradesh not exceeding 70 percent.

While the relatively high proportions of the general population and specifically migrants visiting sex workers points towards their increased vulnerability for HIV and increased risk for the epidemic's proliferation, the reported high levels of condom use by sex workers attenuate these worries. It is however required to sustain the programme and intensify efforts of improve quality of services and condom distribution and ensure higher consistency of condom use among this category of the population and their clients. Also, these data calls for greater attention to low prevalence states with strategic investments to reduce risk behaviours.

III. B. 4. PERCEPTION OF RISK AND HIV TESTING

In general, data shows that there is a relatively higher level of perception of risk for HIV by the HRG (FSW, MSM and IDU) as compared with the perception held by the bridge population which include migrants. In a state such as Andhra Pradesh, this difference is very apparent as only 5 percent of the migrants perceive that they are at risk for HIV, while almost 60 percent of the FSWs have that perception.

Figure 3.13: Perception of risk of HIV infection 2009

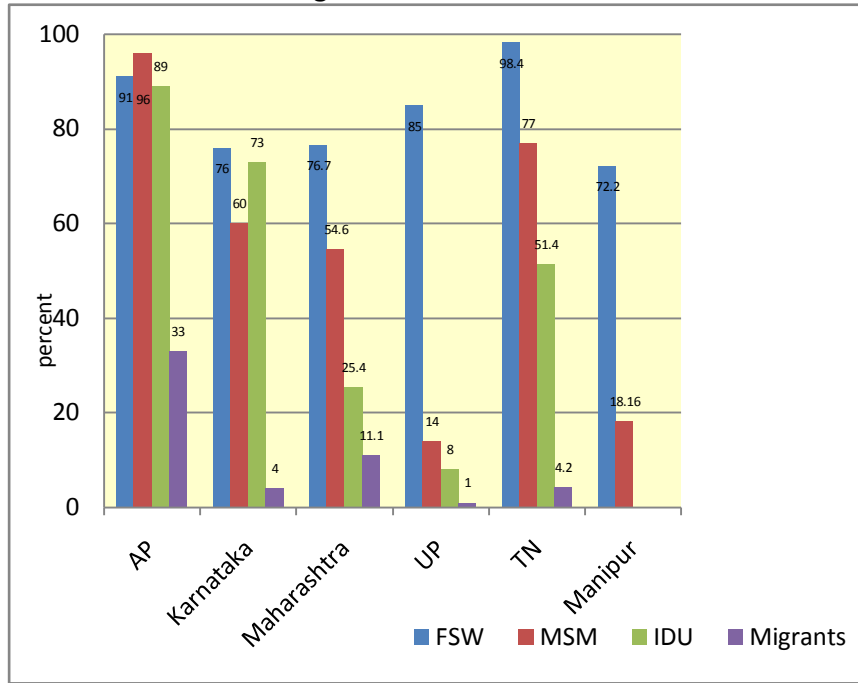


In the states of Andhra Pradesh, Maharashtra and Tamil Nadu, it is the MSMs who have the higher perceptions of risk with 67 percent, 75.5 percent and 62.6 percent respectively reporting thus (figure 3.13).

As for Uttar Pradesh, the levels of perception of risk remains very low, which would explain partly the relatively lower levels of condom use with non regular or paying partners across the population groups. It is also possible that the perception of risk by the population depends on the spread of HIV in that specific state or group. In each state, IDU have relatively lower perception of risk as compared with the other HRG.

It is expected that the perception of risk would determine the testing behaviour among these categories of the population. The surveys revealed that regardless of the differentials in perception of risk it is observed that high proportions of sex workers have tested for HIV across all states, ranging between 76 percent in Karnataka and 98 percent in Tamil Nadu (figure 3.14).

Figure 3.14: Ever tested for HIV 2009



Source: BSS 2009

However, it is observed that very small percentage of the surveyed migrants had ever tested for HIV especially in Karnataka, Uttar Pradesh, Maharashtra, and Tamil Nadu, where the percentage varies between 1 percent and 4 percent, while 33 percent of the surveyed migrants in Andhra Pradesh declared having had a test for HIV in the past.

IV. THE NATIONAL RESPONSE TO THE AIDS EPIDEMIC

IV. A. POLICY AND FRAMEWORK

With the epidemic first reported 25 years back in 1986, response to HIV in India continues to be a priority and focused action area particularly as in 2007 an estimated 2.31 million people aged 15-49 years were living with HIV (PLHIV). This makes the country third — after South Africa and Nigeria — in the international ranking for numbers of PLHIV in a country. As a signatory to the *Declaration of Commitment on HIV/AIDS 2001* and the *Political Declaration on HIV/AIDS 2006*, India remains committed to AIDS prevention and roll-back and reaching Universal Access targets. The country has striven to improve and expand its efforts to halt and reverse the HIV epidemic and to fulfil its obligations on reporting its status. India has methodically developed and moulded its HIV-AIDS programme according to the epidemic's current pattern — taking reference of an emerging evidence base — and in collaboration with its partners.

For highlighting current national response to HIV-AIDS, this section is focused on the policy framework adopted by the country — which is basis for national strategy — and initiatives for HIV-AIDS prevention; care, support and treatment; and to creation an enabling environment for impact alleviation.

IV. A. 1. The strategy

The policy framework for the NACP is anchored in the National AIDS Prevention and Control Policy (NAPCP) of 2002. NACP III seeks to assemble the efforts of all stakeholders — public and private — in addressing the epidemic which is a significant shift from the first and second phase of the programme. NACP III is marked with sustained, coordinated support by partners under "Three Ones principle," for effective and efficient programme implementation.

NACP III has a defined strategic for implementing the national programme from 2007 to 2012 with an implementation approach guided by policy framework. Given that over 99.5 percent of the population in is free of infection, NACP III places the highest priority for preventing HIV proliferation from HRGS and bridge populations — considered as highly vulnerable for HV and amongst whom the epidemic currently remains concentrated — to the general category. For achieving this, a plan of action is developed through experience with NACP I & II implementation: drawing particularly from their strengths. The plan of action rests on four fundamental principles which are listed below:

- i. Prevent infection by saturating coverage of HRG through TI and scaled up interventions in the general population.
- ii. Provide greater care, support and treatment to larger numbers of PLHIV.
- iii. Strengthen the infrastructure, systems and human resources in prevention, care, support and treatment programme at district, state and national levels.
- iv. Strengthen the nationwide strategic information management system.

For achieving the above mandate, mainstreaming HIV and Health and partnering with private health institutions was considered imperative for expanding the reach of services otherwise considered insufficient. Additionally, NGO and CBO were co-opted for preventing HIV transmission amongst HRGs

and bridge populations which were the migrants and truckers through counselling and testing for care and support provision.

Since 2007 NACP III has achieved considerable reach, coverage and outputs. Much of the effort of planning and initiation during the previous years has borne result in 2008 and 2009 as noted during the MTR 2009.

IV. A. 2. Decentralizing Responsibility for Support and Supervision

Given the size and total population of the country, an important focus of NACP III is decentralization of prevention and other services — particularly regarding support for their implementation — to state, district and the sub-district levels.

At the national level, NACO — the institution responsible for the country's response to the HIV epidemic, and is the equivalent of the National AIDS Commissions of other countries — is responsible for implementing the policy framework through strategies set out in the NACP III. NACO is assisted by the National Technical Support Unit (NTSU) in realising this through supports for implementing TI and by the Technical Resource Groups (TRG) that advice on specific intervention areas such as blood safety, laboratory services, ART etc.

Administratively, NACO relies on State AIDS Control Societies set up in each state (SACS). These structures are also the sub-recipient for several GFATM rounds. NACP III has established Technical Support Units (TSU) to assist SACS to monitor, supervise and mentor TI. SACS are supported through TSU in most states which are primarily responsible for support on the critical TI component of the programme. The TSU also support the newly created cadre of Programme Officers, each supervising the work of 10 TI at local level.

The NACP III has categorised the districts based on HIV prevalence and vulnerability as follows:

Category A: More than 1 percent prevalence among ANC in district in any of the sites in the last 3 years.

Category B: Less than 1 percent ANC prevalence in all the sites during last 3 years with more than 5 percent prevalence in any HRG site (attendees of sexually transmitted diseases (STD) clinics/FSW/MSM/IDU).

Category C: Less than 1 percent ANC prevalence in all sites during last 3 years with less than 5 percent in all HRG sites, with known hot spots (Migrants, truckers, large aggregation of factory workers, tourist etc).

Category D: Less than 1 percent ANC prevalence in all sites during last 3 years with less than 5 percent in all HRG sites with no known hot spots OR no or poor HIV data.

A District AIDS Prevention & Control Unit (DAPCU) is set up in all A & B districts to provide management oversight to HIV and AIDS activities in the districts. The DAPCU works seamlessly with the district administration and programmes provided under the National Rural Health Mission (NRHM) with which the NACP will eventually be merged.

IV. A. 3. Convergence with NRHM

Convergence of NACP III with NRHM is a key strategy for ensuring decentralization of the programme as district and sub-district level public health systems is managed within a framework for the health and family welfare sector developed in 2005. This framework set in place by the NRHM proposes to address gaps effective health care service provision in the least developed areas of the country; create a common architecture for all health care programmes at the district level; strengthen local public health provision with infrastructure and manpower; and facilitate the participation of the not-for-profit and for-profit sectors more fully in achieving desirable health outcomes. The NRHM thus aims at providing an overarching superstructure for existing programmes of Health and Family Welfare including Reproductive and Child Health-II, Malaria, Blindness, Filariasis, Kala Azar, T.B., Leprosy and Integrated Disease Surveillance. There are six areas which are the focus of convergence efforts namely, ICTC; PPTCT; Blood safety; STI/RTI; Condom programming; and ART. The administration of the public health system takes place through District Health Societies which comprise of the staff functions at the district level. NACO and NRHM are working together in planning, developing operational guidelines and co-ordinating the district level through the DAPCU.

IV. A. 4. Capacity Development

Recognizing the criticality of well-trained human resources at all levels of programme implementation, NACP-III had developed plans for building capacity of the programme managers and health personnel at the various levels, in leadership and strategies management, and technical and communication skills an also community level workers. The plan targets all levels of care and health care organizations, CBOs and NGOs, as well as grass-root levels functionaries and workers of various government departments. A total number of 972,844 health personnel including doctors, counselors and community level workers have been trained in NACP-III so far.

STRC are designed to provide training and develop the capacity of TI projects staff to ensure the quality of interventions. Fourteen STRC have been established and seven more are being formed. They work closely with states and TSU to develop the capacity of partner organisations. STRC also work with NGO and CBO to develop learning or best practice sites in each state. NACO has conducted the evaluation of STRC with external experts. Out of 13 evaluated, the duration of nine STRC was extended because of satisfactory performance. Based on evaluation report recommendations, the TOR and deliverables have been revised to focus on developing local resources and learning sites at State level.

Seven Regional STI Training, Reference and Research centres have also been strengthened for providing necessary laboratory support and generating scientific evidence towards ensuring good quality services.

In order to facilitate the provision of tertiary level treatment, training and mentoring and operations research, Centre of Excellence (CoE) are set up. At present, 10 CoE and 7 Regional Paediatric ART Centres are functioning and work is ongoing for strengthening them.

IV. A. 5. Financial Allocations and Expenditure

The total outlay for NACP III is INR 115,850 million which includes support from the World Bank, DFID and Government of India contributions (Pool fund), GFATM, and contributions from bilateral agencies and private initiatives such as Bill and Melinda Gates Foundation (table 4.1). The main sources of funds for NACP III are below:

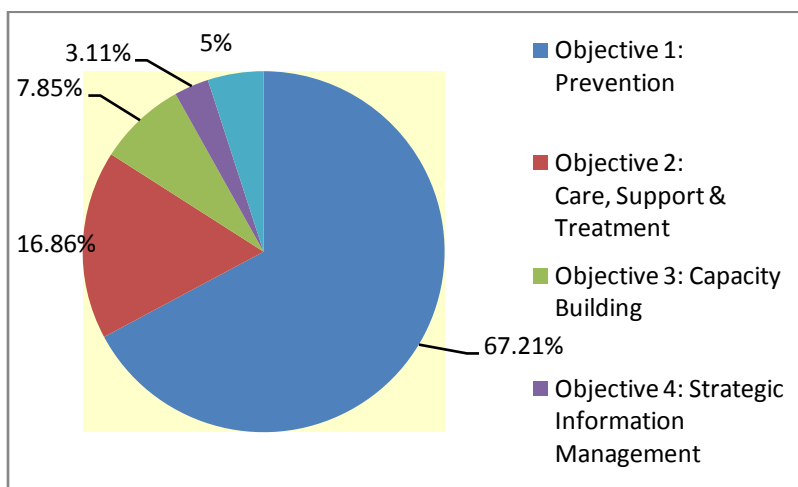
- **Direct Budgetary Support:** — including funds allocated under NRHM — for meeting expenditures for Establishment, Blood Safety, Condom Promotion and STD.
- **External Aid Component (EAC)** that includes GFATM grants (Rounds 2, 3, 4 ,6, 7), pooled funds (comprising funds from the World Bank, DFID and Government of India), USAID, Bilateral and UNDP.
- **Extra Budgetary Resources** that includes monies from various Development Partners and GFATM grants to NGO (Population Foundation of India, India AIDS Alliance, Tata Institute of Social Science and Indian Nursing Council).

Table 4.1: Resource Envelope for NACP III			
Source	Investment Plan		Percent
	USD million	INR million	%
Direct Budgetary Support	636	28,610	25
External AID Component	892	40,160	35
Funding Gap	255	11,460	10
Extra Budgetary Resources	792	35,620	30
Total	2,574	115,850	100

Source: Indrani Gupta, Mayur Trivedi. Analysis of Resource Envelope for NACP III. Institute of Economic Growth. Delhi, 2010.

The budget is aligned with project goals and priority activities (figure 4.1).

Figure 4.1: Resource envelope of NACP III by objectives



Source: Indrani Gupta, Mayur Trivedi. Analysis of Resource Envelope for NACP III, Institute of Economic Growth. Delhi, 2010.

In the past two years, the distribution of expenditure has in fact, been distributed between the 4 major activities of the programme which is: i) Prevention: 61.9 percent; ii) Care Support and treatment: 26.8 percent; iii) Capacity Building: 10.8 percent; and iv) Strategic Management Information: 0.5 percent.

Special efforts are taken for building in systems — both at NACO and SACS level — towards effective management and mobilisation of funds and resources. Monitoring resource utilisation at SACS and even at NGO and peripheral units is through a dedicated computerized financial management system.

The central achievements in the financial systems are:

- Improvement in staffing, capacity building.
- Timely issuance of sanctions and its upload on websites for use by states for their respective Annual Action Plans.
- Instant releases through E-transfer.
- Monitoring of financial data by concurrent entries through the computerized financial management system.
- Multi-donor facilities established in the computerized financial management system.

There also are audit systems in place for monitoring the performance of SACS and recipients of the resources. There is also detailed account of status of allocations and expenditure in the past years (table 4.2)

Table 4.2: Status of allocation and expenditures in the past 4 years					
	Revised Estimate		Expenditure Incurred		
Year	(in INR millions)	(in USD millions)	(in INR millions)	(in USD* millions)	Percent spending
2005-2006	5335.0	115.9	5326.9	115.8	99.9%
2006-2007	7056.7	153.3	6826.3	148.3	96.7%
2007-2008	9433.4	205	9175.6	199.4	97.3%
2008-2009	11233.6	244.1	10370.0	225.4	92.3%
2009-2010	9801.5	213.1	9616.5	209.1	98.1%

Source: Annual Report 2008-2009, NACO. (* At the conversion rate of INR 46 to USD)

IV. B. PREVENTION

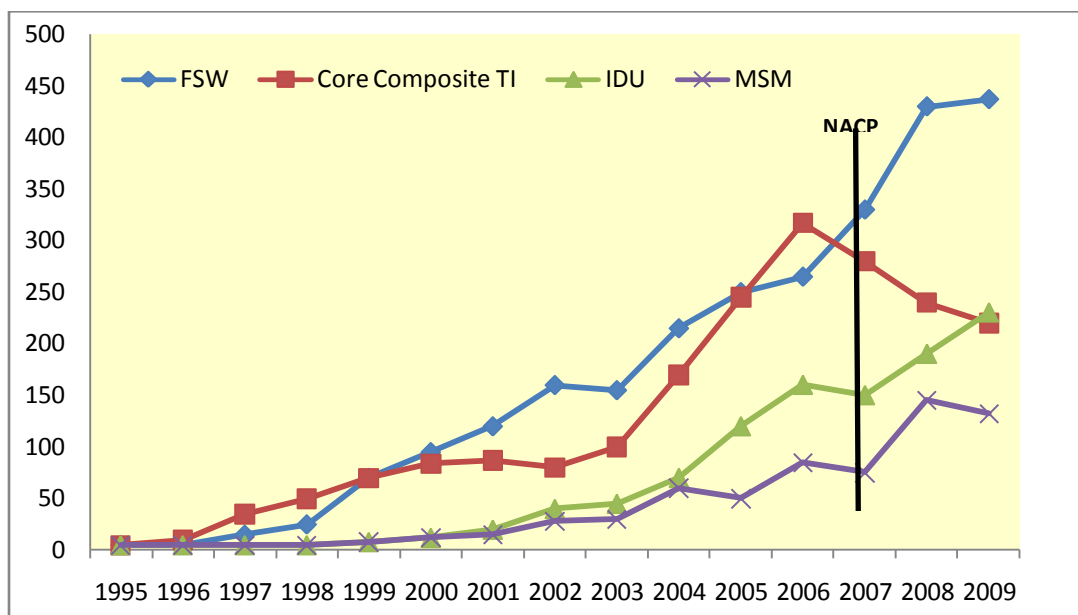
A central strategy under NACP is using TIs to focus efforts for containing the epidemic. These services — and which as internationally acknowledged as the best way for increased accessibility of HRG to HIV prevention services — is provided through NGO and CBO. Under NACP III to the aim is saturating coverage of HRG through the TI.

IV. B. 1. High Risk Groups

IV. B. 1. A. SCALE UP OF HRG COVERAGE TO THE FULL BASKET OF SERVICES

Number of TI: NACO has significantly scaled up of the number of TI — from 789 in NACP II to over 1290 by 2009 — covering over 1.1 million HRG and representing approximately 60 percent of the mapped estimate (figure 4.2).

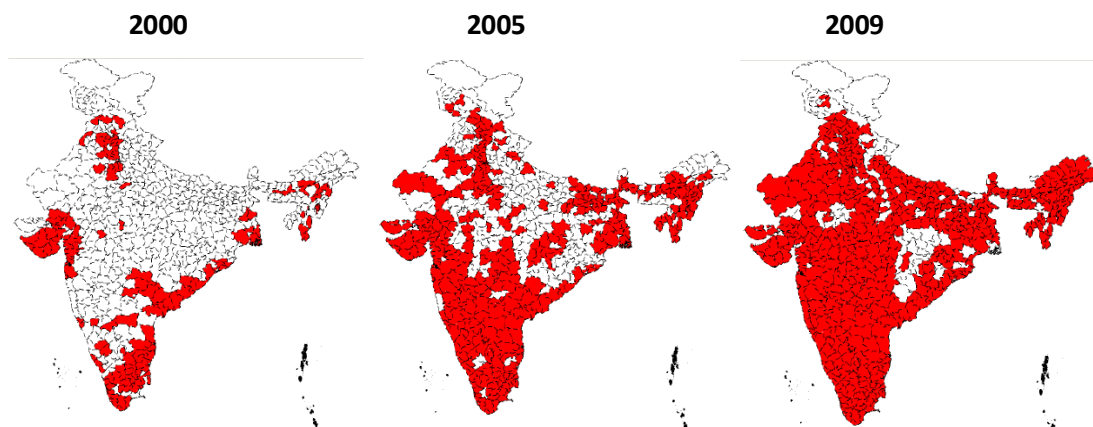
Figure 4.2: Scale up of targeted interventions 1995-2009



Source: *Scaling Up Targeted Interventions NACP III, India, Presentation by NACO, March 16, 2010*

Geographical distribution of TI: There is significant scale up in the number of TI under the national programmes; particularly at the district coverage as evident from maps of 2000, 2005 and 2009 (figure 4.3). In 2009, approximately 95 percent of the districts were reached via prevention interventions.

Figure 4.3: Targeted Interventions by district 200, 2005 & 2009

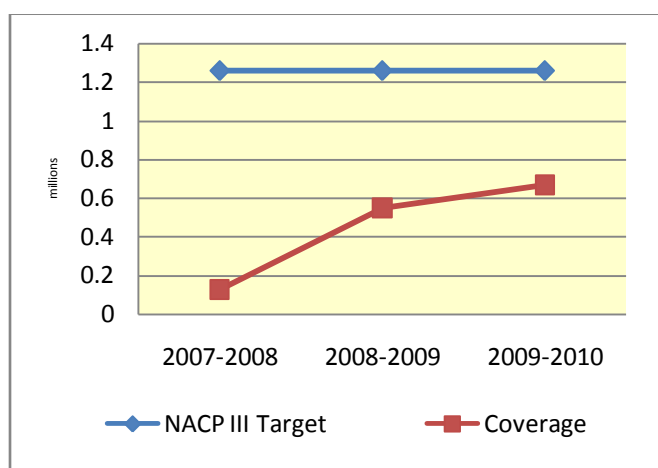


Coverage of TI: The extensive scale up of the TI programme has resulted in increased coverage of HRG. Ambitious targets are also set for each of the HRG sub-populations (table 4.3).

Table 4.3: Distribution of TIs by Typology and Coverage			
Type of intervention	Estimated population in millions	Coverage in millions (%)	No. of TIs (Jan. 2010)
FSW	1.26	0.67 (53.1)	437
MSM	0.35	0.28 (78)	132
IDU	0.18	0.14 (74)	230
Core composite *	-	-	220
Migrants	8.4	1.8 (21.4)	204
Truckers	2.4	1.6 (66.6)	67
Total			1,290

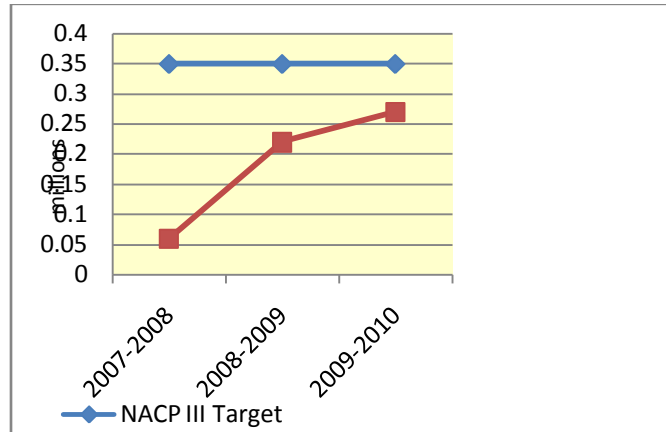
There is progress made in TI scale up for increased HGR coverage (figures 4.4, 4.5, 4.6). 53.1 percent of the estimated FSW population was covered up to 2009. The percentage coverage of MSM population was the highest at 78 percent. The second highest proportion of coverage was for IDU with approximately 74 percent of the estimated population (186,000) covered.

Figure 4.4: Coverage of FSW in NACP III 2007-2009



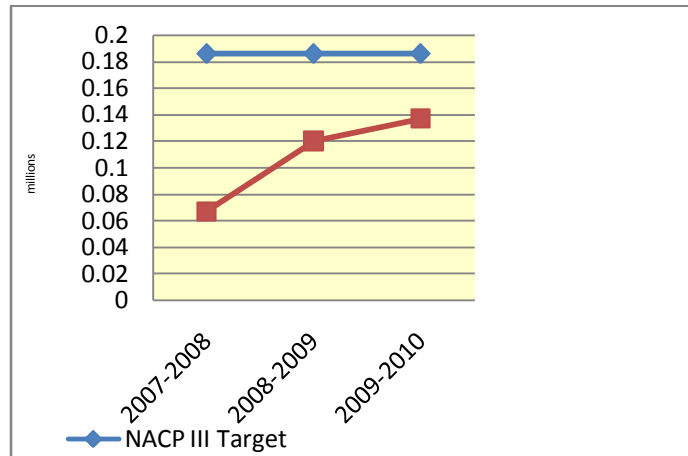
Source: NACO Annual Report 2009-2010

Figure 4.5: Coverage of MSM in NACP III 2007-2009



Source: NACO Annual Report 2009-2010

Figure 4.6: Coverage of IDU in NACP III 2007-2009



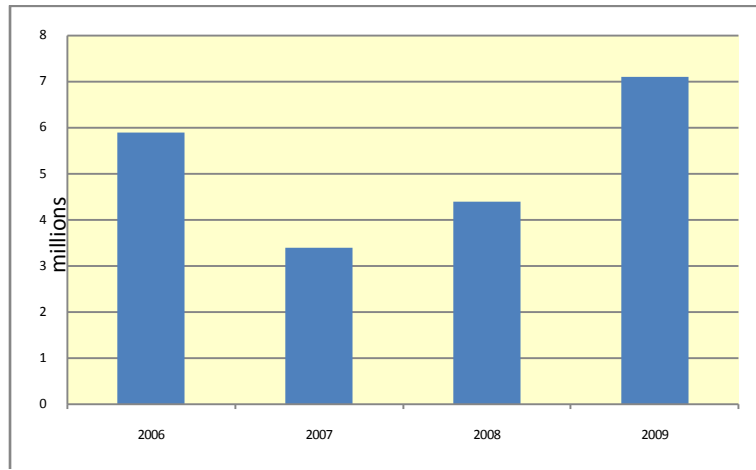
Source: NACO Annual Report 2009-2010

Complement of services: There is an increased focus for ensuring availability of the full complementary services available under the TI programme for HRGs. Resultantly, more HRGs are referred to STI clinics located within the TI or with which arrangements are set up. Reference to ICTC — and when necessary to ART — is increased for their greater access to CST.

Thus there is an increasing number of persons tested (7.6 million in 2007 to 13 million in 2009) with a concomitant increase in the referral of persons belonging to the HRG from 20,000 to 300,000 (CMIS data). Critical gains were made in certain states through this approach. For example, Andhra Pradesh was able to provide counselling and testing services to 65,000 HRG populations in 2008.

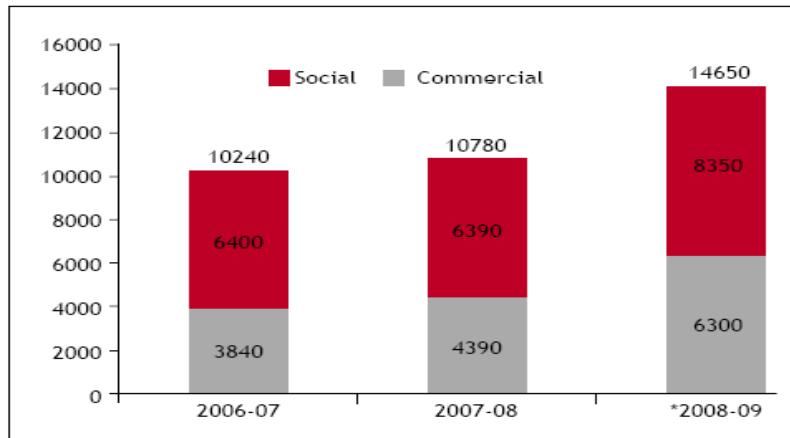
The number of BCC sessions conducted with HRG increased from 3.5 million in 2007 to 6.3 million in 2008 and approximately 7 million in 2009 (Figure 4.7). During 2009-10, the condom social marketing programme has been successfully scaled up to 294 districts; 4.64 lakh condom outlets serviced by the programme distributed 23.4 crore pieces of condoms till January 2010. (figure 4.8).

Figure 4.7: Number of one to one BCC sessions 2006-2009



Source: NACO Annual Report 2009-2010

Figure 4.8: Condom Distribution (social marketing and commercial) 2006-2009



Source: NACO Annual Report 2009-2010

Early Evidence of Impact of TI: There is an early impact of the TI programme as the Integrated Biological and Behavioural Surveillance (IBBS) 2009 finds 91 percent of FSW reporting condom use with their most recent clients. This indicator shows a significant increase in 2009 against the reported 50 percent indicated in BSS 2006. Similarly 86 percent of the MSM reported using a condom with their most recent client in 2009 as against 20 percent in 2006.

The percentage of IDU who adopted behaviours for reducing HIV transmission (as measured by those who avoid both sharing injecting equipment during the last month and report using a condom with their most recent partner) was 30 percent in 2006. This has increased to a significant 62 percent who avoided sharing injecting equipment and 88 percent who reported using a condom with their last sexual partner.

Evaluation of TI quality and functioning: NACO has institutionalised a system of annual evaluation of TI. Three rounds of annual evaluations covering programmatic, management and financial aspects were conducted in 2007, 2008 & 2009. The standard evaluation tool and a manual developed in January 2009 was utilised for ensuring uniformity of evaluations across the country. The results of the

evaluations are available on the NACO website to ensure transparency.² In addition, annual HIV Sentinel Surveillance Survey (HSS) and monitoring data is analysed to plan and implement TI.

Institutionalization of Guidelines for prevention services: NACO has developed and disseminated several key Guidelines for the institutionalization of high quality prevention services for each of the HRG populations. These are reviewed in detail with representatives of various partner NGO and CBO and revised when necessary.

Operational guidelines for TI with HRG and Bridge populations are published and widely disseminated. These guidelines provide detailed guidance on the minimum standards of service delivery for NGO/CBO. NACO has built an independent annual evaluation of TI to assess the progress, identify gaps for strengthening, and provide support for addressing weak areas of the NGO/CBO.

IV. B. 1. B. REACHING RURAL FSW THROUGH LINK WORKERS

The Link Workers' scheme is a short term community based intervention to address the HIV prevention and care needs of the rural community with special focus on HRG and other vulnerable groups. This community based intervention addresses HIV prevention and care needs of the rural community with special focus on High Risk population and other vulnerable groups. The scheme is operational in 100 selected villages in each of the 126 identified districts in 18 states through 9 lead agencies.

IV. B. 2. Bridge populations

An important focus of the NACP III has been preventing HIV transmission from HRG to the general population via groups via the migrants and truckers: also categorised as the bridge population. Focused interventions thus are aimed for migrants and truckers. Following revision of estimates, it is determined that over 4 million migrants and 2 million truckers require interventions.

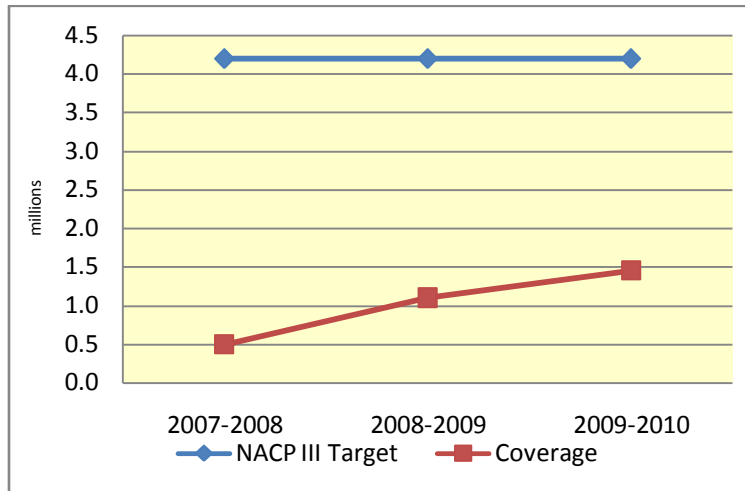
IV. B. 2. A. MIGRANT SERVICES

Sharpening of strategy for high risk migrants: There are over 200 million migrants in India. Based on evidence generated through pilot programmes with migrant groups, NACP III makes a strategic focus on short stay migrants who number approximately 9 million. Review of the programme from 2008 to 2009 indicated that the approach of contacting these populations at their place of origin (home) or destination (work) had relatively low reach and impact. Thus the approach was revised to focus on contacting migrants in sex work hot spots through high-intensity BCC and mid-media education. Furthermore, maximize condom supply through increased outlet coverage and retail visibility in districts that have high in-migration and high HIV prevalence amongst ANC clinic attendees.

Coverage: Revision of the "migrant" definition has resulted in greater conceptual clarity and sharpness of term and lead to the government re-focusing and or scaling up migrant TI interventions accordingly. The strategy for migrant TIs was also accordingly revised. This though resulted in some delays in contracting NGO to deliver these services and affected the extent of coverage. Currently, the coverage of migrants in NACP III is 34 percent (figure 4.9)

² Link: http://www.naonline.org/Divisions/NGO__Targeted_Interventions2/Evaluation_Reports_2008-09

Figure 4.9: Coverage of Migrants in NACP III 2007-2009



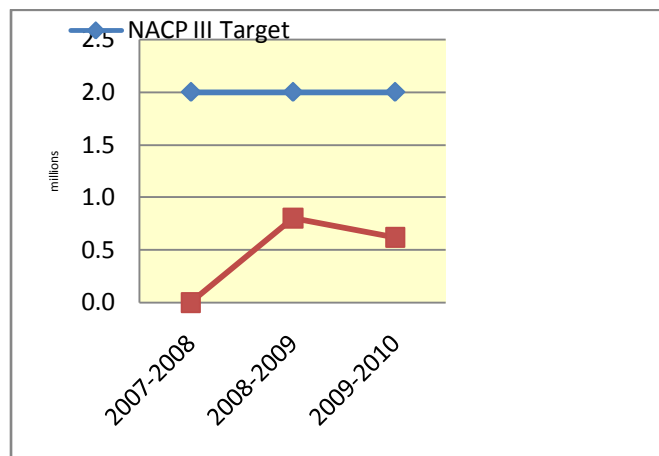
Source: NACO Annual Report 2009-2010

IV. B. 2. B. SERVICES FOR TRUCKERS

Focus on long distance truckers: As highlighted previously, truckers are identified as a critical bridge population. About half of an estimated 5 million truck drivers ply on long distance routes across the country.³ The living and working conditions, sexually active age group and separation from regular partners for extended periods of time are factors that increase their vulnerability to contracting and transmitting HIV.

Partnering with the private sector: Management of the TI for truckers is outsourced to a private foundation — the Transport Corporation of India Foundation — which is also the designated TRG for this subsector. Micro-level planning and feasibility assessment studies have informed the selection of 131 sites as per the monthly volume of truckers in these sites. Condom social marketing and mass media activities are the critical components of the interventions.

Figure 4.10: Coverage of Truckers in NACP III 2007-2009



Source: NACO Annual Report 2009-2010

³ Strategy and Implementation Plan, NACP-Phase III, 2007, Pg 33

The coverage of bridge population in NACP III is low (34 percent for Migrants and 30 percent for truckers) given that TI for truckers is terminated after a recent mapping report found the number of truckers reduced from 3.5 million (NACP III estimates) to 2 million long distance truckers (figure 4.10).

IV. B. 3. The general population

Several efforts are underway for preventing HIV proliferation from HRGs and bridge populations to those in the general category. For this, interventions are initiated for breaking the chain of HIV transmission through infected blood; ensuring that those at higher risk are aware of their HIV status; from mother to child during delivery; treatment for STI and RTI; provision of condoms and education for youth and the general public.

IV. B. 3. A. PROMOTION OF ACCESS TO SAFE BLOOD

The objective of the Blood Safety programme is ensuring provision of safe, quality blood — even in geographically remote areas of the country — in the shortest possible time through a well-coordinated National Blood Transfusion Service. The specific objective is ensuring reduction in HIV transmission through blood transfusion associated to less than 0.5 percent. For this a multi approach strategy is implemented that centres on strengthening laboratory capacity with initial focus on serological testing). Implementation of this systems strengthening approach will benefit capacity for laboratory diagnosis more broadly, and contribute to improved health outcomes across a variety of infectious and non-communicable diseases. Key activities under this approach included the definition of the national laboratory structure, development of guidelines and standard operating procedures and assessments, and training in essential elements of quality management. A Blood Transfusion Services Bill is proposed to be tabled during 2009-2010.

Good quality testing facilities: NACP III has addressed the critical issue of quality control of HIV testing with a concerted and multi-faceted strategy based on evidence generated through the quality management support structure. The management support structure is a four-tiered laboratory comprising apex, national reference, state reference and ICTC laboratories. Activities included: i) the establishment of a laboratory services division at NACO, ii) national quality management assessments at multiple tiers in the laboratory system, iii) the convening of an expert Technical Resource Group at the national level, iv) significant efforts in training and capacity building, v) institution of a national External Quality Assessment scheme, vi) development and support of a laboratory consortium with the capacity for validation and performance monitoring of key diagnostics and vii) expansion of services for CD4 testing, viral load and early infant diagnosis.

New facilities for blood products: In addition to modernizing district level blood banks, large investments are made for establishing Centres of Excellence in transfusion medicine and a national Plasma Fractionation Centre. The latter will reduce the national reliance on expensive imported blood component products, and bring the quality monitoring of these medicines more immediately under national control.

Increasing voluntary blood donation: The voluntary blood donation strategy has demonstrated good results as voluntary donations show a steady increase (54 percent in 2006-07, 59 percent in 2007-08 and 73.4 percent as of September 09). States where over 75% blood units are collected voluntarily are: West Bengal, Maharashtra, Tamil Nadu, Gujarat, Tripura, Mizoram, Chandigarh and Himachal

Pradesh. Other states are working to augment their blood stores through involvement of various stakeholders such as NYKS, National Service Scheme, National Cadet Corps and NGO.

IV. B. 3. B. INTEGRATED COUNSELLING AND TESTING CENTRES

The Voluntary Testing and Counselling Centres (VCTC) and PPTCT service was re-modelled into ICTC in India. Funded through GFATM grants; ICTC is the entry point for ensuring continued care provision through following services:

- Counselling all clients visiting the ICTC (general /walk in/high risk/antenatal women) on HIV
- HIV testing of the general clients/HRG/walk in clients
- HIV testing of pregnant women (PPTCT programme)
- Screening clients for TB and referring them to RNTCP services (HIV/TB Collaborative Activities)
- Post test counselling and linkage with other HIV care & support services

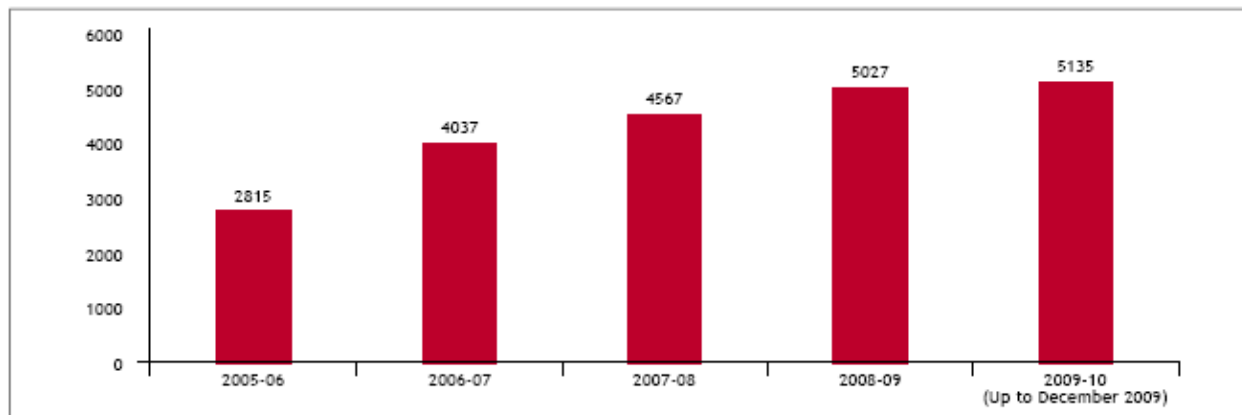
Figure 4.11: Integrated Counseling and Testing Centre



ICTC provides the first interface of the general population for HIV services for allowing HIV infected people to become aware of their status and that they may: adopt a healthy lifestyles, prevent further HIV transmission, and access life saving care and treatment services. Provider Initiated Testing and Counselling were recently introduced for clients referred to by medical providers such as people with TB, STI, pregnant women in all high prevalence districts (figure 4.11)

Increasing availability both rural and urban: The number of ICTC services across India is expanded from 2815 in 2005-06 to 5135 in 2009-10 (figure 4.12).

Figure 4.12: Scale-up of Counselling and Testing services in India 2005-06 to 2009-10



Source: Annual Report 2009-10, NACO

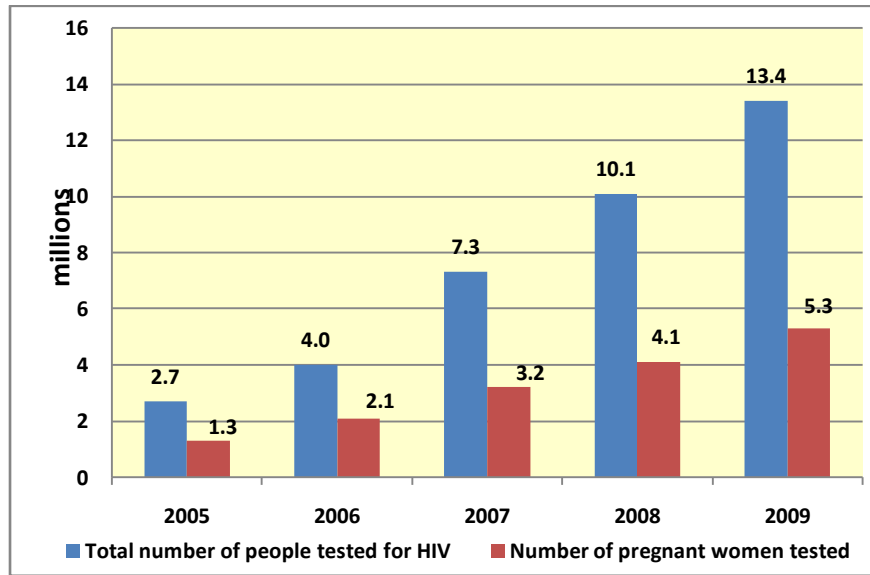
The number of people tested at these centres also has increased from 4 million in 2006 to 7.3 million in 2007 (figure 4.13). By 2008, 10.1 million were tested which was further scaled up by 3 million to reach a total of 13.4 million in 2009. This significant increase was possible due to the concerted efforts of NACP III to address certain barriers such as timing of ICTC, staff attitudes towards HRG, inconvenient location of testing facilities.

Counselling and testing services are expanded to 578 Primary Health care Centres through integration with NRHM in rural areas of the high prevalence districts.

Operational Guidelines and training modules: Important operational guidelines and training materials for ICTC, HIV-TB, and Whole Blood Testing is developed and disseminated. The guidelines lay down the minimum requirements for an ICTC in terms of area, infrastructure, equipment and staff. In 2009-2010, around 8 million general clients will be tested of which 300,000-320,000 (around 4%) are expected to be HIV positive.

Ensuring quality of service: Quality assurance is a key element in the delivery of HIV counselling and testing services. To ensure quality of HIV testing an EQAS is implemented in most states. All ICTC are expected to participate in this. Under this, coded samples are sent from State Reference Laboratories (SRL) to the ICTC twice a year for testing. In addition ICTC are directed to send 20 percent of all positive samples and 5 percent of all negative samples collected in the first week of every quarter for cross checking to the SRL once every quarter.

Figure 4.13: Number of persons tested for HIV in India 2001- 2009



Source: Annual Report 2009-10, NACO

IV. B. 3. C. PREVENTION OF PARENT TO CHILD TRANSMISSION

In India, the annual number of pregnancies is 27 million, of which 25 million proceed to delivery and birth. Forty percent of deliveries are institutional. Out of the institutional deliveries, rural areas account for 31 percent whereas urban areas account for the remaining 69 percent.

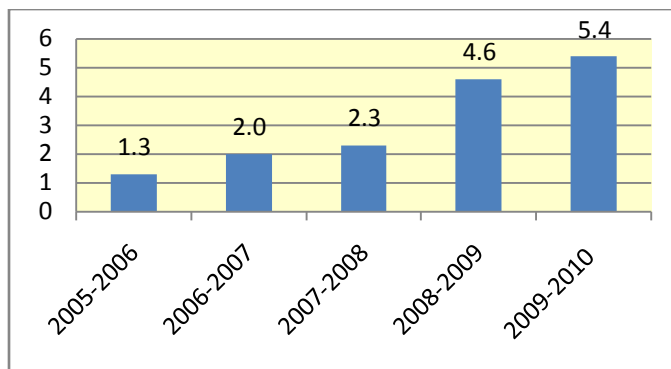
Services under the programme: Under the PPTCT programme — initiated in 2001 — counselling and testing services are provided to pregnant women. This includes administration of prophylactic *Nevirapine* to HIV positive pregnant women and their babies for preventing perinatal transmission of HIV. Further, all babies are to be followed up for a period of 18 months to facilitate Early Infant Diagnosis. PPTCT services are provided at all 5135 ICTC to pregnant women who access hospital/health facilities where these centres are located.

Figure 4.14: Pregnant Women Receiving Counseling on HIV Prevention and Care at Integrated Counseling & Testing centre



There is a rapid scale up in the number of pregnant mothers tested and counselled under PPTCT centres in India till 2009 (figure 4.14). Whilst in 2007 approximately 3 million women were counselled and tested; it increased to 4 million in 2008 and 5.5 million approximately in 2009 . This falls slightly short of the national target of 2009 that is set at 6.3 million.

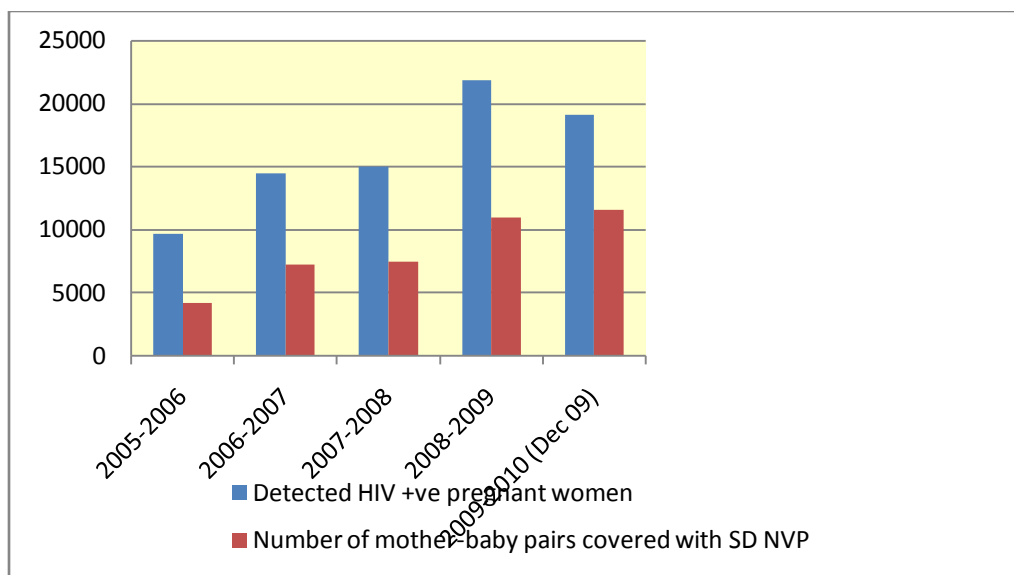
Figure 4.15: Uptake of Pregnant Women under National PPTCT Programme 2005-2009



Source: NACO 2009

Follow up of mother-baby pairs: The exhibit above highlights the coverage of HIV positive pregnant women with prophylactic *nevirapine*. From 2005-06 to 2009-10 there is a noted increase in the number of pregnant women detected with HIV at PPTCT centres. Whereas in 2005-06 11,817 pregnant mothers were detected with HIV, the number increased to 16,860 in 2006-07 and 20,250 in 2007-08 at PPTCT centres. By 2008-09 21,349 pregnant women were tested at PPTCT centres in comparison with the 19,357 in 2009. There is progression over the years also in the number of mother-baby pairs receiving treatment although there is a gap when compared with the total number of mothers tested highlighting possible missed cases to follow up.

Figure 4.16: Detection of HIV positive pregnant women and coverage of MB pairs with single dose Nevirapine 2005-2009



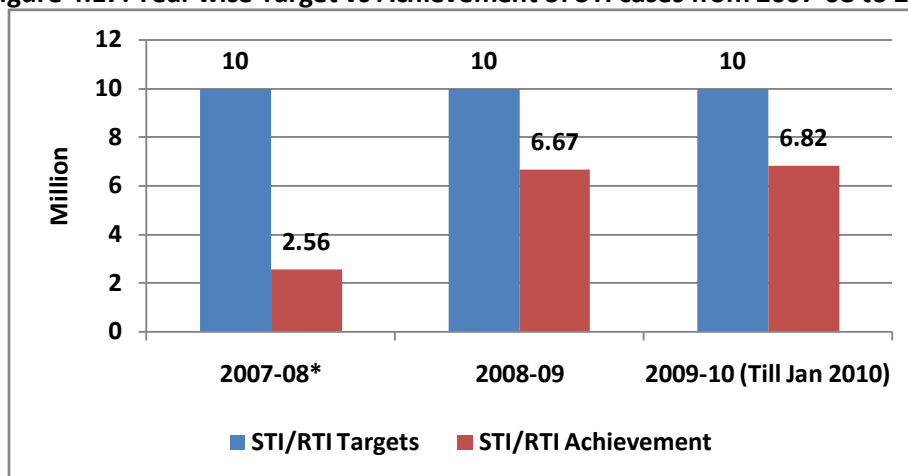
Source: NACO Annual Report, 2009 - 2010

Despite the scale up in programme, only 20% of the estimated annual pregnancies of 27 million were counselled and tested for HIV in 2009. Further, only 30% of the annual load of 65,000 HIV positive pregnant women was detected in the same year. NACO thus aims at new initiatives for early detection among pregnant women and eliminate mother to child transmission. For achieving this, community based HIV screening will be conducted by Auxiliary Nurse Midwife to identify HIV positive cases among pregnant women who do not come to health facilities for antenatal checkups. Additionally, ICTC services are being expanded to twenty four hour Primary Health Centres under the ‘facility integrated model’ for improving access to populations living in hard-to-reach areas. Collaboration with NRHM would be essential for this and Accredited Social Health Activist (ASHA) will be involved in demand generation for PPTCT services through Incentive-based schemes.

IV. B. 3. D. MANAGEMENT OF STI/RTI

This is an area where NACO collaborates closely with the NRHM. It is estimated that 5 percent of adult population in India has STD symptoms and NACP III plans to cover 50 percent of those with symptoms — about 15 million episodes — annually by 2012. The national level convergence with NRHM has been strengthened over the past 2 years and resultantly, during the financial years 2007 – 08, 2008-09 and 2009–10; approximately 2.6 million, 6.7 million and 6.8 million people with STII infection were managed across the country respectively (figure 4.16).

Figure 4.17: Year wise Target vs Achievement of STI cases from 2007-08 to 2009-10



Source: NACO Annual Report 2009-10. *No NRHM data is available for the financial year 2007-08.

Syndromic case management: The cornerstone of STI/RTI management under NACP III is enhanced syndromic case management with minimal laboratory tests. Over 5,744 **Preferred Private Providers** are identified for service delivery and training on enhanced syndromic case management to provide STI/RTI services to HRG population under TI. Provision of the standardized package of STI/RTI services to HRG is an important component of the TI projects. Essential STI/RTI drugs are made available with these providers. Service delivery has been initiated in the states of Kerala, Chandigarh, Gujarat, West Bengal, Uttar Pradesh, Rajasthan, Chhattisgarh, Maharashtra, Haryana, Goa, and Delhi.

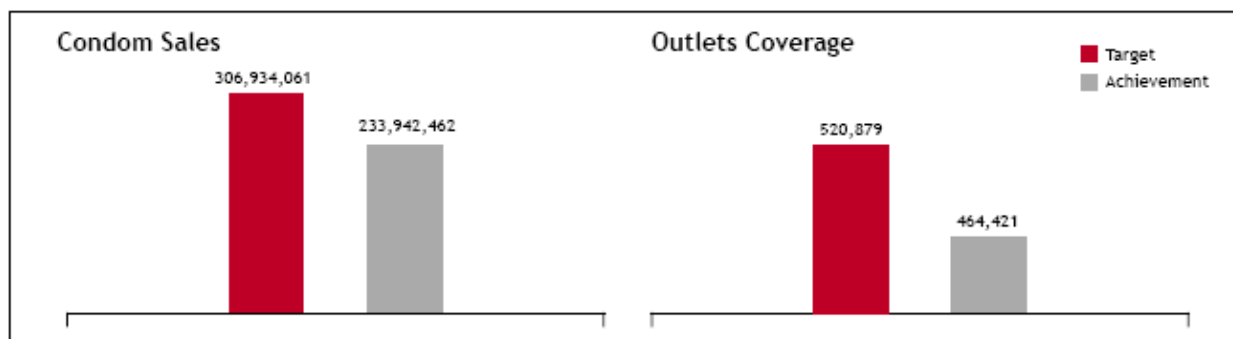
Capacity enhancement: NACO supports 916 designated STI/RTI clinics located at district and teaching hospitals. Another 7 Regional STI Training, Reference and Research centres have been strengthened for providing necessary laboratory support and generating scientific evidence for good quality service provision.

IV. B. 3. E. CONDOM PROMOTION

The NACP III has a defined strategic framework with audience specific strategies and milestones for condom promotion. With an overall objective of increasing condom distribution from 1.6 billion pieces in 2006-07 to 3.5 billion pieces by 2010; the strategy focuses on three channels of condom supply — free, social marketing and commercial scale — to work in a complementary manner for providing products to different target groups. The current supply levels of condoms are 2.2 billion pieces. In 2008-09, although three quarters of the condoms were distributed free or through social marketing — and availability of condoms remains dependent on these two methods — condoms sale has increased. On comparison with 2006-07 and 2008-09 data, an 11 point percent increase is evident (figure 4.17).

Condom Social Marketing Programme: The condom social marketing programme was successfully implemented in 194 districts in 15 states during phase-I (2008-2009). In addition, new initiatives such as Condom Vending Machines programme and Female condom (FC) programme were initiated at the time to enhance the accessibility of condoms and empower female population to protect themselves by using female condom. During 2009-10, the condom social marketing programme has been successfully scaled up to 294 districts; 4.64 lakh condom outlets serviced by the programme distributed 23.4 crore pieces of condoms till January 2010. As the programme focused at ensuring easy condom accessibility even in remote geographical areas; it was ensured given that 72 percent non-traditional outlets were established in relatively inaccessible regions. (Fig. 4.18)

Figure 4.18: Targets and Achievements for Condom sales and Outlets coverage in Social Marketing Programme Phase-II, 2009-10



Source: NACO Annual Report 2009-2010

Condom Vending Machine Programme: For ensuring a twenty four hour access to condoms, NACO initiated the Condom Vending Machine Programme Phase II that is now implemented in four big metros and a few large towns of Uttar Pradesh. Under Phase-II (2009-2010), nearly 9,000 condom vending machines were strategically placed near high risk activity areas so that condoms can be procured without human interaction. Around 600,000 condom pieces have been reportedly sold from 8,770 condom vending machines placed across Delhi, Mumbai, Chennai, Kolkata, Kanpur, Lucknow and some more towns of Uttar Pradesh.

Scale Up of Female Condom Programme: HLFPPPT, a social marketing organisation receives funding from NACO for implementing the female condom programme in four states: Andhra Pradesh, Tamil Nadu, West Bengal and Maharashtra. Through the programme around 200,000 FSWs are reached thereby ensuring 100 percent TI NGO coverage. The programme focuses on capacity building, training and BCC activities for increasing use of female condoms. In addition to this, with funding from UNFPA, PSI is also implementing female condom scale up programme in Rajasthan, Bihar, Jharkhand and Orissa. Till January 2010 approximately 600,000 female condoms were reported sold.

Structures for delivery: Country wide sales infrastructure is through 6 Social Marketing Organisations (SMO) that run the programmes with 1100 SMO salesmen, 870 stockists and 1200 stockist salesmen. This infrastructure has resulted in the market for paid condom market (Commercial and Social market) increasing by 65 percent volume over the period 2007-2009. Quality testing of condoms⁴ is conducted through the Condom Social Marketing program established in 303 districts in 25 states (covering all high prevalence/high fertility districts).

IV. B. 3. F. STRATEGIC FOCUS ON BEHAVIOUR CHANGE

The NACP III has a well defined Communication Strategic Framework for Information, Education and Communication (IEC) with a set of priority objectives. The strategy focuses on i) motivating behaviour change in a cross section of identified populations at risk, including HRG and Bridge populations, ii) raising awareness level on risk and the need for behaviour change and use of condoms among youth and women in general population iii) generating demand for health services; and iv) creating an enabling environment for prevention as well as institutional and community care support.

During 2007-2009 there was a shift in IEC from awareness generation to a creation of a more comprehensive understanding of strategic communication with its three complementary and mutually reinforcing approaches of BCC, social mobilization and advocacy. There has also been a clear plan to link demand creation with services. The success of IEC can be seen from the large service delivery numbers in all programme components (e.g. ICTC, PPTCT, ART). NACO has developed the first of its kind IEC Operational Guidelines aimed at providing a roadmap for facilitating standardized communication response across the country. There is strong collaboration with partners to undertake joint communication initiatives. With UNICEF, Centre for Advocacy and Research, BMGF and BBC-World Service Trust the process of planning, implementation and monitoring of media interventions is streamlined as is addressing the capacity issues within SACS.

IV. B. 3. G. MASS MEDIA CAMPAIGN

Multiple large scale communication campaigns were launched during the reporting period such as *Red Ribbon Express* (RRE), *Zindagi Zindabad* or “Life is to Live” which have reached millions of people and created demand for services. Condom promotion campaigns such as *Jo Bola/Samjha Wohi Sikander* helped in establishing a social norm for condom use. These national campaigns are supplemented by advertisements in the provincial newspapers (in regional languages) and ground level activities such as rallies, poster and essay competitions, partnerships with the youth groups (*Nehru Yuva Kendra*) and other community based groups. Supportive activities are coordinated through the SACS.

Communication activities for normalising condom use: NACO has implemented a phased multi-media campaign on condom promotion. Initially, the campaign focused on normalising condom use through radio and TV channels. Through these initiatives around 150 million people were reached. A campaign was subsequently launched —using creative spot messages —for downloading a condom ring-tone for mobile phone users. Reflecting the success of this particular campaign was the volume of people with requests to download the condom ring-tone. Nearly 500,000 requests for downloading the ring-tone were from within India; whilst 160,000 requests from abroad were received at the website for the ring-tone (www.condomcondom.org). The website was visited by approximately 4million people over three months.

⁴ Quality testing of condoms is stipulated in the national standard (Schedule R) of the Indian Pharmacopeia. According to NACO it comprehensively meets WHO criteria.

Additionally, NACO contracted social marketing organisations for conducting communication activities such as mid-media, road shows etc. in their respective states for first, generating demand for condoms and second, strengthening supply side by motivating retailers to stock up on supplies. These were considered as essential initiatives particularly as previously condom use was strongly associated with promiscuity and reinforced negative image of users. It resulted in stigma; and condoms were not considered acceptable by a large population.

Campaign for National Voluntary Blood Donation: As NACO considers the need for voluntary blood donation to constitute the largest blood supply source, activities are augmented for voluntary blood donation. Not in the least is utilising multimedia for encouraging voluntary donations whilst dispelling its surrounding myths. In 2008, a new TV spot was developed with a call for voluntary blood donation by Olympic boxing medallist Vijender Singh. A three week campaign was conducted on the occasion of Voluntary Blood Donation Day (1 October 2008) and was repeated again in February 2009. On the occasion of Voluntary Blood Donation Day 2009, a new TV spot was developed and a three week campaign was run on mass media channels across the country.

Red Ribbon Express: The first Red Ribbon Express (RRE) campaign was launched on World AIDS Day 2007. RRE demonstrated a communication innovation that could mobilize large numbers of people and be a powerful catalyst for social change and HIV prevention. The RRE is one of the world's largest social mobilization campaigns on HIV-AIDS. Conceptualized by the national NGO Rajiv Gandhi Foundation, the campaign was implemented by NACO in collaboration with the Ministry of Railways, Ministry of Youth Affairs and UNICEF. The RRE spread awareness on HIV-AIDS and promoted safer behavioural practices. The train was flagged off by Mrs. Sonia Gandhi, Chairperson United Progressive Alliance (UPA), on December 1, 2007 from Delhi. It completed its journey on December 1 2008 after travelling over 27,000 kilometers during the year covering 180 halt stations. The cultural troupes of *Nehru Yuva Kendra* — a nationwide youth club — travelling in the train performed in villages where the train halted to spread HIV-AIDS messages. The project covered 41,334 villages and reached 6.2million people. Over 68,000 people were trained on board the train in the districts though which it passed and 116,183 people were counselled on HIV/AIDS.

Figure 4.19: The Red Ribbon Express

The Red Ribbon Express (RRE) is the world's largest mass mobilization drive on HIV and AIDS. Through the RRE, NACO intended breaking the silence on HIV and AIDS by taking the messages on prevention, treatment, care and support to people living at the sub-district level across the country. The aim is also to create an environment free of stigma and discrimination so that PLHIVs can access services without fear or prejudice while living a life of dignity.

The train launched on World AIDS Day 2007 travelled across the length and breadth of India reaching 6.2 million people. Regular newspaper reports highlighted its impact on creating awareness on HIV and AIDS and improving service utilisation. It thus has proved to be a successful multi- sectoral initiative by NACO and a powerful advocacy tool — both at the state and district levels — enhancing local capacities to deal with HIV prevention. Owing to its success, the RRE was re-launched on World AIDS Day 2009. This time, train will traverse 22 states by November 2010 halting at 152 stations.

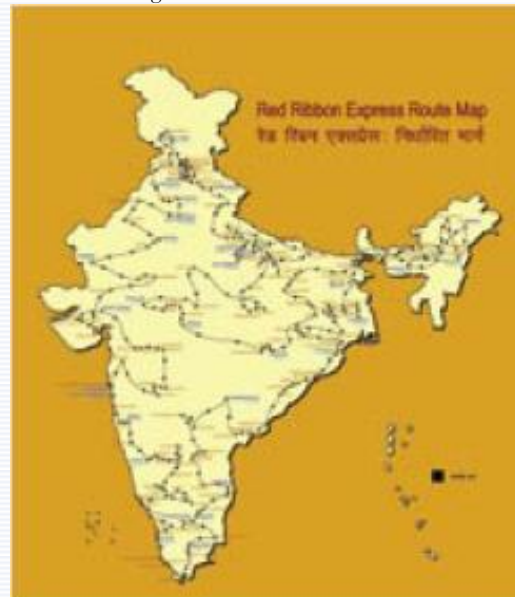


Figure 4.20. Smt Sonia Gandhi, UPA Chairperson, flagging off the Red Ribbon Express on 1st December 2009 at Safdarjung Station, New Delhi



Building upon the success of the first phase of the Red Ribbon Express project (2007-08), NACO launched the second phase of the project on 1st December 2009 to commemorate the World AIDS Day. The specially designed 8 coach exhibition train was flagged off from Delhi's Safdarjung station by Hon'ble Chairperson, Rajiv Gandhi Foundation and Chairperson, United Progressive Alliance, Smt. Sonia Gandhi. During its year long journey, the RRE will travel across 22 states, covering 152 halt stations.

This time, the National Rural Health Mission has also come on board with NACO. Apart from three exhibition coaches with exhibits on HIV and AIDS, the fourth exhibition coach is on NRHM with exhibits on H1N1, Tuberculosis, Malaria, Reproductive and Child Health services, general health and hygiene. There is one coach for counseling and another one for conducting trainings of district level resource persons such as members of Panchayati Raj Institutions, Self Help Groups, government officials, health workers, youth organizations, teachers, defense and police personnel etc.

During the second phase of the project, services for HIV testing, treatment of STI and general health check-up are also being provided at the halt stations. Mobile health units have also been deployed at many halt stations. IEC exhibition vans and folk troupes have been deployed to carry messages into rural areas, particularly to reach out to those who are not able to come to the railway station.

The daily coverage is monitored through a monitoring agency. The inbuilt evaluation system has been put in place through an external agency for assessing the impact of the project.

The response to the RRE is overwhelming with thousands of people visiting the train exhibition everyday at the train halt stations. Moreover, political leaders including Ministers, Members of Parliament and MLAs are actively participating in the project by mobilizing the people to the train at local level and attending the functions at the halt stations.

IV. B. 3. H. INTERVENTIONS WITH YOUTH: IN COLLEGE, IN SCHOOL AND OUT OF SCHOOL

The Adolescence Education Programme (AEP) is a key intervention to build life skills of the young people and help adolescents cope with negative peer pressure, develop positive behaviour, improve sexual health and prevent HIV infections. Under the programme, sixteen (16) hours sessions are scheduled during the academic sessions in classes IX and XI. 47,000 schools have been covered to impart the knowledge and skills to their students during 2009-10.

IV. B. 3. I. MULTI-SECTORAL COLLABORATIONS

Multi-sectoral collaboration is an important strategy espoused by the NACP III. The NCA established in 2006, has met once. As the NCA is a platform involving the Prime Minister and Ministers of 31 ministries, and 9 Chief Ministers of various states; organizing a meeting of such a body is a significant undertaking.

Initiatives with respective ministries — as mandated under NCA — are continuing. Subsequent to the formation of NCA, State Councils of AIDS are formed in 25 states.⁵ There is collaboration across a wide range of Ministries and private sector bodies which continues at national and state levels through involvement of private sector federations such as the Confederation of Indian Industry (CII), ASSOCHAM, and the Federation of Indian Chambers of Commerce & Industry (FICCI) under the aegis of the State AIDS Councils.

The focus of NACP III's strategic plan is advocacy and coordination with 11 key ministries. In accordance with this plan, NACO has enhanced coordination with Ministries including Home, Panchayati Raj, Women and Child Development, Rural Development, Labour and Employment, Housing and Poverty Alleviation, Surface Transport and Roadways, Defence, Tourism, Sports and Youth, Social Justice and Empowerment, and Science and Technology.

Multi-sectoral activities: Various activities taken up by these Ministries include: i) addressing HIV issues in rural income schemes; ii) training half a million members of occupational cooperatives on HIV/AIDS; iii) training elected local representatives; and enhancing CST through linkage with local bodies; iv) preparing the National Policy on World of Work jointly with the International Labour Organization (ILO); v) incorporating HIV-AIDS issues in the National Policy on Children, 2007 and social welfare schemes; vi) research and development with the Indian Council for Medical Research for developing and testing microbicides; vii) integrating prevention, counselling and testing, and CST in Defence hospitals; viii) sensitizing police staff; ix) training service providers and youth; and x) extending social security support to PLHIV.

⁵ These include: Andhra Pradesh, Arunachal Pradesh, Assam, Andaman & Nicobar Islands, Bihar, Daman & Diu, Delhi, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Karnataka, Maharashtra, Manipur, Mizoram, Nagaland, Orissa, Punjab, Sikkim, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal

Figure 4.21: Select Achievements of the Multi-Sectoral Strategy

During 2008 and 2009, UNICEF, UNDP, ILO and UNIFEM have collaborated closely with NACO in implementing the multi-sectoral strategy.

The NACP III identified men and women as equal stakeholders in the national response and has committed to gender sensitive programming as a central and cross cutting theme. A national policy on gender and HIV in the women empowerment framework has been developed. The policy guidelines would be finalised shortly. UNDP and UNIFEM have helped to set up a gender desk at NACO.

UNICEF had worked with the Ministry of Women and Child Development (MWCD) to launch the first comprehensive National Policy on Children and AIDS in June 2007 which is currently being rolled out. Nutrition supplements for children and women living with HIV are included in the Integrated Child Development Scheme implemented by MWCD in Gujarat, Tamil Nadu, Rajasthan and Orissa. Content of HIV-AIDS prevention including PPTCT has been integrated into the training of grass root level workers.

The Ministry of Labour and Employment in association with NACO and ILO, has prepared a policy on HIV-AIDS in the World of Work. This has formally been approved by the Cabinet and launched on 30 October 2009. The policy protects workers from discrimination at workplace, ensures confidentiality of their status and provides access to information and services related to HIV.

The Ministry of Railways has announced a concession of 50 percent in second class passenger fares for rail travel by AIDS patients to nominated ART centres for treatment. Many (35) Integrated and Counselling Centres (ICTC) are presently functional in railway hospitals and ART is being provided to 1227 persons. The ART drugs are procured from the Ministry of Railways budget.

The Ministry of Surface Transport and Roadways has provided free bus travel to PLHIV in 5 states in order to facilitate travel to ART centres.

IV. C. CARE, SUPPORT AND TREATMENT

There is significant progress in service provision through the network of facilities CST developed in the country. A decentralized supporting and supervision system is operational. Systematic collaboration between ART centres, CCC as well as PLHIV networks is helping reduce the lost to follow up and missed cases. Improved links with ICTC and enhanced IEC campaigns have resulted in earlier detection. The main services provided to PLHIV include the following:

- Registration for ART and pre-ART services
- Assessment of eligibility of ART based on Physical Examination and CD4 count
- Provision of first line ART to eligible PLHA and Children Living with HIV/AIDS (CLHA)
- Follow-up of ART by assessing drug adherence, regularity of visits and periodic examination and CD4 count every 6 months
- Care, support and home-based services
- Treatment of opportunistic infections
- Provision of alternate first line and second-line ART to those expressing drug toxicities and treatment failure, respectively.

IV. C. 1. The provision of ART

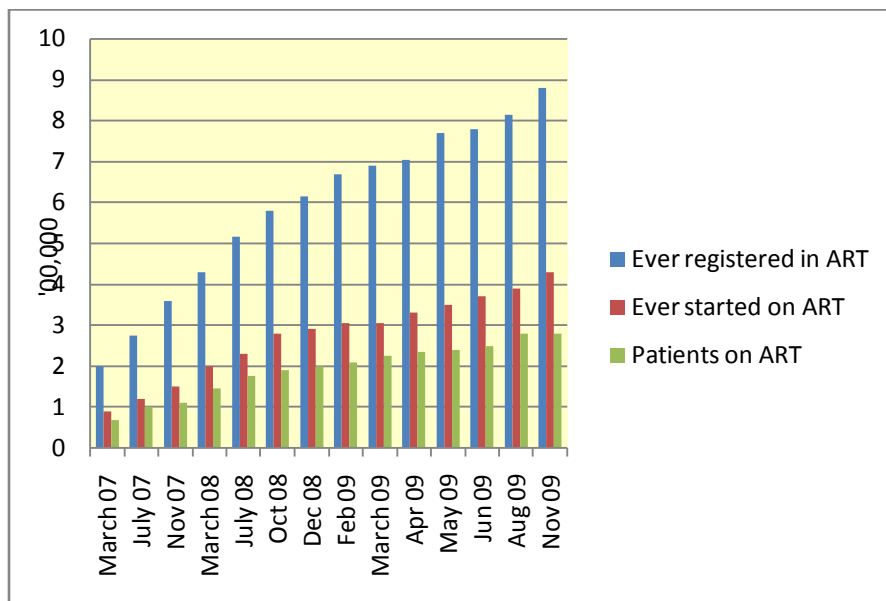
ART for eligible PLHIV was launched on April 1 2004 in 8 government hospitals located in 6 high prevalence states. Since then, the programme is scaled up both in terms of facilities for treatment and number of beneficiaries seeking ART — especially in districts with a high number of PLHIV. First line ART drugs is provided to PLHIVs as per the WHO-NACO guidelines. NACP III envisaged that public health facilities will provide ART to: i) PLHIV referred from TI; ii) Sero-positive women tested under the PPTCT programme; and iii) infected children.

The implementation of the ART programme has been successful (figure 4.20). Some targets set for the programme under the NACP III are likely to be exceeded, for example, the number of ART centres and adults alive and on ART. NACP III estimated that in order to meet the targets for ART, 250 ART centres across the country will have to be set up. As of January 2010, there were 239 fully functional ART Centres against the target of 250 by March 2012. However, based on need and demand of ART, the actual number of ART centres may well reach 300 by 2010.

Due to rapid scaling up, the GFATM has advanced termination of projects under Round 4 by six months and invited India to submit proposal under Revolving Continuation Channel — as recommended by Country Coordination Mechanism — which India has done. NACO is partnering with Confederation of Indian Industries (CII), IBT, FICCI & other corporate sectors on workplace intervention & providing of

care, treatment & other support to people living with HIV/AIDS. The MOUs have been signed with ACC and BILT, Bajaj Auto Limited, L&T and Godrej and ART centres have been set up.

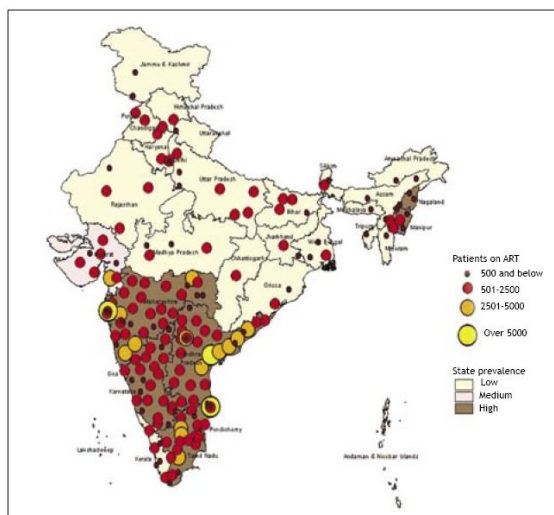
Figure 4.22: ART scale up in India 2007-2009



Source: Mid Term Review of NACP –III, NACO, 2009

All the patients who require ART will not necessarily be accessing government health set-up and a significant number will be getting treatment from private sector, NGOs & other institutional/workplace health care facilities. Therefore, NACO is working to establish linkages with other departments and strengthen the public private partnership by involving the corporate sector and NGOs. NACO is in regular interaction with the Army, Railways, SAIL, paramilitary forces and NGOs like YRG Care, Freedom Foundation, Swami Vivekananda Youth Movement, Private Medical Colleges, for Care & Support activities including ART.

Figure 4.23: ART Services Organized to respond to Disease Burden

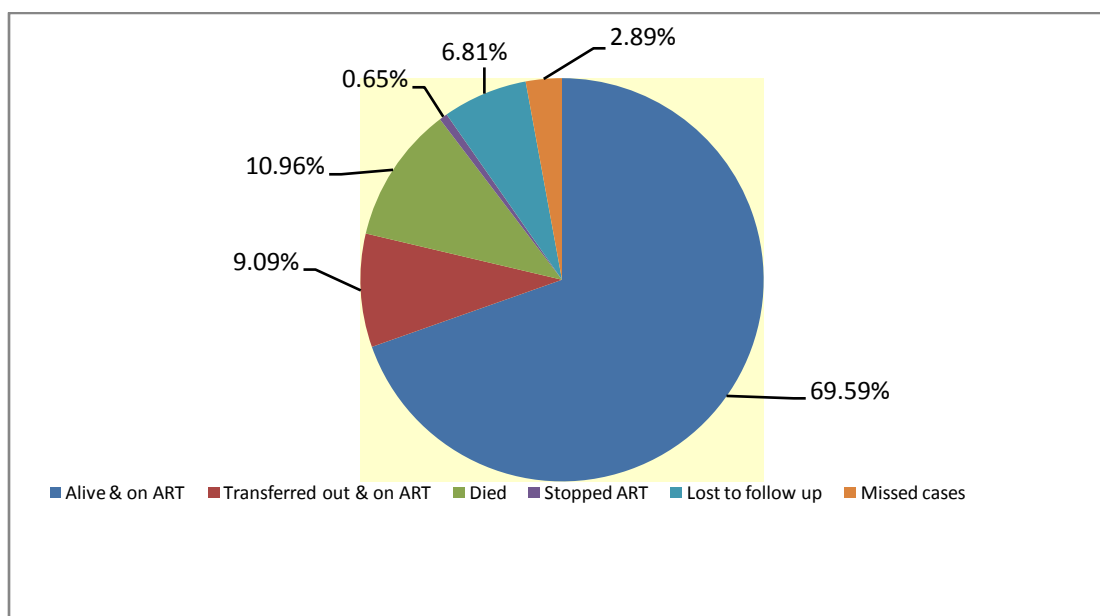


IV. C. 2. Link ART centres

Link ART Centres (LAC) were not originally envisaged under NACP III. Their creation was in an effort to first, address issues of distance, travel time and costs for various beneficiaries — which were major constraints to PLHIV’s access to ART services and highlighted by the study “Assessment of ART centres: Clients’ and Providers’ Perspectives.” Second, decongest ART centres. Finally, provide decentralized replenishment of treatment supplies to stable patients on prescription. Presently 300 LACs are established and functional.

Lost to follow Up: Overall infrastructure scale up has resulted in reduction in number of LFU cases (figure 4.22). The outcome of people living with AIDS (PLHA) on ART during 2007-(September) 2009 shows that the cumulative LFU is reduced to nearly 7 percent. One of the major contributing factors for this significant reduction is the effective follow up and provision of home based counselling for LFU by district level PLHA networks, CCC and counsellors of ICTC. Several other initiatives have been taken up for strengthening monitoring and evaluation for LFU. These include SMART cards —which is described in the section on Monitoring and Evaluation Environment — and monitoring and supervision by Regional Coordinators.

Figure 4.24: Cumulative outcome of people on ART 2007-09



Source: Mid Term Review of NACP-III, NACO, 2009

IV. C. 3. Community care centres

ART centres are linked with CCC and established with the mandate of providing a comprehensive package of CST services including psycho-social support, ensuring drug adherence and providing home-based care. Also, tracing lost to follow-up (LFU); those missing ART as per respective prescribed schedules. Presently, 287 CCC are fully functional.

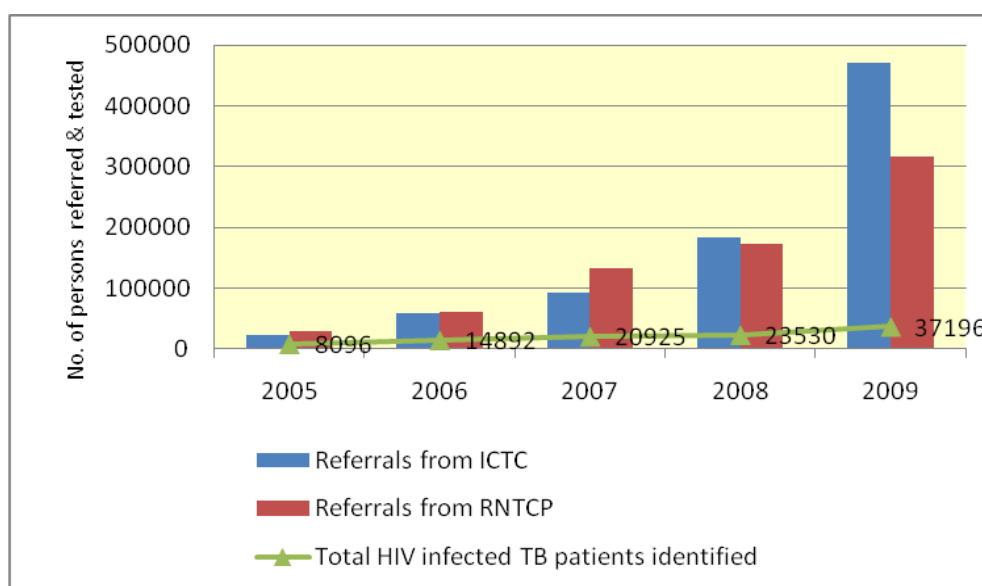
IV. C. 4. Treatment and prophylaxis of Opportunistic Infections

A key emphasis under the CST services is on the availability of prophylaxis and treatment of opportunistic infections (OI) at tertiary and district hospitals. This is critical for improving the quality of life of PLHA, postponing the onset of AIDS by keeping the viral load under significant control and thereby postponing ART requirement. The availability of OI drugs is at tertiary and district hospitals providing ART as well as through the CCC.

IV. C. 5. HIV-TB collaborative services

It is estimated that in India, 55-60 percent of reported PLHA have TB. HIV-TB co-infection is one of the leading causes of death among PLHIV. It is estimated that an HIV positive person has 50-60 percent lifetime risk of developing TB as compared with an HIV negative person who has a lifetime risk of 10 percent of developing TB. For responding to this, India has established and expanded strong cross-referrals and linkages between the existing service delivery sites of Revised National TB Control Programme (RNTCP) and NACP at Microscopy Centres, ART centres, CCC and ICTC.

Figure 4.25: Scale-up of HIV-TB Collaborative Activities



Source: Mid Term Review of NACP –III, NACO, 2009

Under the joint initiative of NACO & RNTCP, the 'National Framework for Joint HIV/TB Collaborative Activities' was revised for strengthening HIV-TB collaborative activities across the country. The National Technical Working Group for HIV/TB — comprising of key officials from NACO and the Central TB Division — regularly monitor the programme through a system for line listing. The Technical Working Group ensures: 1) fast tracking of patients co-infected with HIV and TB; 2) adherence to treatment Guidelines; 3) appropriate training of medical officers posted at ART centres on TB diagnosis and treatment. The intensified HIV/TB package of activities includes routine offer of HIV counselling and testing for all TB patients and linking all the identified HIV/TB patients to CST including treatment for TB, other OI and ART.

Cross-referrals: An increase in cross-referrals is noted due to intensified roll out of HIV/TB package services in 9 states with higher HIV burden (Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Goa, Manipur, Nagaland, Mizoram, Delhi, Gujarat and Puducherry). This package also includes enhanced monitoring of all identified HIV/TB patients with provision of *cotrimoxazole* preventive therapy through the decentralized drug delivery mechanism of RNTCP (figure 4.23).

IV. C. 6. Strengthening Laboratory Services for ART

In view of the massive requirement for testing in India, a concerted effort is made to scale up CD4 testing capabilities and capacity in the country. There are at present, 198 CD4 machines installed servicing 226 ART centres and another 13 CD4 machines under installation. Whilst in 2007-2008, 393,039 CD4 tests were performed; this increased to 658,143 tests in 2008-09. CD4 training institutions were identified in 2009 for training laboratory technicians. A training of trainers was held in May and June 2009 for CD4 machine technicians so that they may further impart training.

NACO with support from Clinton Foundation has initiated the development of the national CD4 EQAS for Indian testing laboratories in 2005. The National Institute for AIDS Research (NARI) functions as an apex laboratory for conducting the EQAS. QASI, Canada was identified as a provider of the CD4 EQAS. Three QASI rounds were carried out each in 2008 and 2009. A technology transfer workshop was conducted for 4 Regional Centres at NARI in September 2009. QASI would continue to send the samples at expanded sites for the near future. An Indian database *India.qasi-lymphosite* was developed and will be piloted for data entry, online submission analysis and report preparation.

IV. C. 7. Supply chain management for ARV drugs

One of the most vital components of drug adherence is ensuring continued drug supply to ART centres. Monitoring is done centrally for all ARV drugs based on monthly consumption and stocks at the centres. As per guidelines, all ART centres must have a minimum of 3 month stock of drugs. In case of shortage, drugs are re-located to ensure absence of stock outs. The supply chain of ARV drugs is managed through a dedicated Logistic Coordinator appointed at NACO. As a result of a well monitored system — involving good management of information, projections of ARV drugs based on new

enrolment rates and consumption patterns and close monitoring of stocks — there is a regular and uninterrupted supply of ARV drugs without any stock-out situation.

IV. C. 8. Second line ART

The levels of primary drug resistance in the population vary from country to country. Though at present there is no concrete data on primary resistance of HIV to first line ARV drugs, it is estimated to be in range of 2 to 3 percent. Regarding secondary resistance, the global experience shows that the development of drug resistance occurs at a rate of 5 percent per year, after three years of treatment. It is estimated that presently around 3000 patients may be in need of second line ART.

The main issues related to provision of second line drugs under the programme are:

- The cost of second line ART regimen under the national program is around INR 35,000 per patient per year.
- There are 7-9 pills to be taken in the second line ART regimen compared to just 2 in first line ART and thus supporting patient adherence is likely to be challenging.
- Special training of health care providers is required prior to roll out of second line drugs.
- Institutional strengthening is necessary particularly at laboratories for viral load and drug resistance testing.
- Regulatory mechanisms for rational prescriptions by private practitioners need to be in place to minimize the chances of resistance due to wrong prescriptions.

NACO initiated the process for rolling out second line treatment over two years back by first executing national consultations on the need and feasibility of introducing second line drugs. This was followed by the formation of a Technical Resource Group on ART which deliberated on various issues related to the provision of second line in the national programme. The WHO, Clinton Foundation, Centres for Disease Control's programme in India, I TECH, private physicians, NGO and Indian Network of Positive People (INP+) were involved in the development process.

Provision of second line ART rolled out on a pilot basis at two centres in January 2008. On completion of this pilot the project was launched across 10 centres in January 2009. Following targeted viral load testing — for an assessment on requirement for second line ART — there are 970 people on second line treatment.

IV. C. 9. Children living with HIV/AIDS

IV. C. 9. A. ORPHANS AND VULNERABLE CHILDREN

As the epidemic in India is not generalized the concept of Orphans and Vulnerable Children (OVC) as described in the African context is not applicable in the same way. The country has adopted the preferred terminology of Children affected by AIDS (CABA) jointly developed by NACO, UNICEF and other development partners.

While there are no reliable estimates of 'affected' children in the country, a UNICEF report summarises that India possibly has 150,000 vertically infected children; 1,500,000 children orphaned by AIDS; and 7,000,000 children with HIV-positive parents. These categories are not mutually exclusive. An infected child will usually have a positive parent, and may also be orphaned by AIDS, while an AIDS orphan will often have another HIV-positive parent. NACO estimates that 57,000 children are infected at birth in India each year, and is yet to finalise the estimates of Children infected with HIV. Out of over 70,000 children living with HIV registered in 2009, only approximately one third received ART. NACO has instituted 10 orphanages for HIV positive children and has plans to scale up with the support of Ministry of Women and Child Development and the Ministry of Social Justice and Empowerment.

IV. C. 9. B. PAEDIATRIC SECOND LINE

While the first line therapy is efficacious, a certain proportion of children will show evidence of treatment failure. There is not much data on the failure rate on the *nevirapine* based ART in children. However, the WHO estimates an average switch rate from first to second line ART of 3 percent per year for adults. It is likely that the similar rates are applicable for children as well. The current WHO guidelines for switching stipulate that clinical disease progression or a drop in CD4 cell count to pre-treatment baseline or fall of 50 percent from peak value are signs of treatment failure. They are not sensitive for detecting early replication of HIV due to emerging HIV drug resistance. It is important to have reliable estimates of the failure rate so as to plan roll out of second line therapy and plan the logistics. Until these estimates become available, the figure of 3 percent rate for switch from first line to second line ART is being used for the planning of the programme.

IV.D. ENABLING ENVIRONMENT AND IMPACT ALLEVIATION

India has taken several steps to ensure that the environment within which HRG and PLHIV must live and survive is conducive to their easy access to prevention and CST services but equally to livelihood and dignity.

IV. D. 1. STIGMA AND DISCRIMINATION

A 2009 UNDP study on Stigma and Discrimination (S&D) and field experiences showed that “enacted stigma” adversely affected the lives of PLHIV whereas S&D in general, threatened effectiveness of counselling, testing and CST services. PLHIV suffered shame, blame, and exclusion on account of the purported causes of their HIV positive status (transgression of sexual norms) and as carriers of infection (fear of casual infection). The majority attitude (45 percent) towards PLHIV — especially in low prevalence states — was a mixture of sympathy, disgust, sadness and fear of infection. S&D had less to

Figure 4.26: Manipur and Nagaland Legislators complement efforts of State AIDS Control Organisations

In a significant step forward in the HIV response in the North-East, legislators from across party lines in Manipur and Nagaland decided to contribute up to INR 100,000 each from the Local Area Development Fund to support the AIDS effort. By pooling their resources, the Government of Manipur and Nagaland have altogether raised at least Rs. 12 million for the AIDS effort to demonstrate political commitment on AIDS.

All 120 Legislators from Manipur (60) and Nagaland (60) are members of Legislators Forum on AIDS (LFA) in their respective states. The members use these resources to conduct public meeting on HIV in their own constituencies, hold public hearings, engage with PLHIV and HRG in public platform to address issues of stigma and discrimination and complement the efforts of SACS to scale up prevention, care and treatment.

do with age, sex, or marital status than with attitude, education and media exposure calling for stronger IEC strategy to fight S&D.

S&D continue against those who are infected and their families. HIV infection often becomes a defining characteristic in the lives of those affected. It becomes a determinant for their access to services, livelihood options, medical attention, and simple social exchanges. NACO has undertaken training of its staff at national and state as well as of personnel who will directly interact with persons accessing services under the NACP in S&D. However, despite NACO’s directives, states such as Karnataka are yet to establish grievance redressal mechanism.

IV. D. 2. ESTABLISHMENT OF CBO AND CBO NETWORKS

There is an effort to establish TI programmes through CBO. A total of 59 TIs for FSW and MSM is established and functional in the high prevalence states of Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu and low prevalence states of Gujarat, Kerala and West Bengal (table 4.4). In order to ensure peer support and learning, networks of these institutions are supported in particular through Bill and

Melinda Gates Foundation work in country. Further, this initiative is being supported in diverse ways depending on the nature of the marginalized population that needs to be supported. Separate guidelines are in place for each of the HRG and for migrants and truckers. Technical Support Groups are also established in institutions that are well versed with their issues and considered able to ensure adequate relevant attention to their needs.

Table 4.4: CBO led TI			
SACS/DACS	Number of CBO led TI		
	FSW	MSM	Total
Andhra Pradesh	5	1	6
Tamil Nadu	-	3	3
Ahmedabad	1	1	2
Gujarat	2	10	12
Kerala	6	4	10
Karnataka	7	2	9
Mumbai	4	7	11
West Bengal	4	2	6
Total	29	30	59

IV. D. 3. GREATER INVOLVEMENT OF PEOPLE LIVING WITH AIDS

NACP III outlines steps for establishing systems, structures and various activities to meaningfully involve PLHIV in programme design and implementation. In addition, reduce S&D associated with the infected and affected persons and enhance their access to prevention and quality treatment, care, insurance and legal services.

Support for networks of PLHIV: An important feature of the programme is its attention to the support of district, state and national networks of PLHIV. PLHIV are seen as an important resource in mobilizing HRG's access to prevention; counselling and testing; and CST services. They also advise SACS and at times serve on their Boards and Committees. They also run several services: in particular CCC and Drop In centres.

Support from NACO has enabled INP+ in establishing and strengthening 22 state level networks and 221 district level networks of PLHIV for mobilising communities and ensuring their access to services, such as ART centres, CCC, and Drop-in Centres. The Greater Involvement of People living with HIV/AIDS (GIPA) Policy was developed through a consultative process and is likely to be finalized soon.

Drop in centres: Drop in Centres (DICs) have been set up, with support from NACO primarily in A & B category districts in the country. There are currently 208 DICs in the country managed by PLHIV district

level networks and NGOs. NACO has encouraged PLHIV networks to manage DICs in the districts, which provide a platform for psycho-social support to PLHIV and linkages to services. They are also given counseling on nutrition, adherence and legal issues.

IV. D. 4. FAITH IN ACTION

On 2 June 2008, over 70 prominent faith leaders from Hindu religious groups across India united at the first meeting of 'Faith in Action: Hindu Leaders Caucus on HIV and AIDS' — held at the Art of Living International Centre in Bangalore — to declare their support for incorporating HIV information to their discourses, rituals, festival celebrations, religious education and training of future faith leaders. The leaders agreed to collaborate in the national efforts and reverse the AIDS epidemic. A joint declaration against AIDS was signed wherein Hindu leaders committed to working with the NACP to spread HIV awareness among youth and end stigma and discrimination against people affected by HIV. Since then a number of leaders have incorporated HIV messaging to their religious discourses in large gatherings. In order to synergise these responses and organise them in a sustainable manner at the state and district levels, Art of Living Foundation specially identified coordinators from their youth body — World Alliance of Youth Empowerment — to work in partnership with SACS in 16 states.

IV. D. 5. STATE INITIATIVES FOR MAINSTREAMING HIV

For a strong multi-sectoral response to HIV-AIDS, State councils on AIDS are constituted in 25 states and Union Territories. Their aim is mainstreaming HIV and AIDS issues into policies and programmes of Government Ministries and Departments, corporate sector and civil society organisations to make the response to the epidemic as everyone's agenda. Over 200,000 people from different Ministries and Government Departments are trained and sensitised on HIV-AIDS. Some of the key initiatives undertaken at state level for generating cohesive response to the epidemic is provided below.

Tribal Action Plan: NACO — with the Tribal Welfare Department — has finalised the Tribal Action Plan that aims at specifically addressing the vulnerabilities of tribal population to HIV-AIDS given their limited access to and knowledge of HIV-AIDS and poor access to health services. Reaching this population is a challenge as majority reside in geographically remote areas. It is envisaged that through the Tribal Action Plan — which is rolled out in 44 category A and B districts across 9 states — and the 192 Integrated Tribal Development Projects to be executed in priority districts; this population group's vulnerabilities will be reduced substantially.

Below poverty line cards: Certain states such as Orissa have issued Below Poverty Line cards (BPL) to PLHIV as a mechanism for ensuring access to free/subsidized food and housing facilities. In Tamil Nadu and Andhra Pradesh, 10 legal aid centres are established in each state. The SACS in West Bengal and Andhra Pradesh include PLHIV in the Executive Committee of the quasi-government society.

Nagaland institutes AIDS friendly actions: In a landmark decision, the Nagaland State Council on AIDS — the highest decision-making body on HIV-related issues in the state — on 29 April 2009 approved a new State AIDS Policy under the chairmanship of Chief Minister Neiphiu Rio. The new policy fulfilled a long standing demand from networks of people living with HIV and the civil society organizations. It delineates the state government's commitment to scale up prevention, harm-

reduction, treatment and care programmes through ensuring quality health care delivery system. The policy provides special emphasis on women and children to protect human rights issues and reduce vulnerability to HIV. Nagaland being one of the six high prevalence states in India, the new state policy on AIDS better equips the state's response in allocating appropriate resources for HIV as a priority issue in the state.

Incorporation of HIV-AIDS in their Party manifestos by Political parties in Andhra Pradesh: In a milestone in the political response to HIV in India, over 100 elected state legislators in Andhra Pradesh pledged to incorporate the goal of Universal Access to HIV services in their political manifestos. The legislators, hailing from 15 major political parties in the state, met at a special all-party meeting organised on 21 February 2009 by the Legislators Forum on AIDS and the State AIDS Control Society. They signed a joint declaration of intent to integrate HIV issues to their official electoral campaigning during the state's next election. This action ensured that HIV would be high in the political priorities, irrespective of whichever party came to power in the state. The all-party pledge was preceded by several consultations and interactions between legislators and affected communities including sex workers and sexual minorities and signified a major step forward in the political response.

National Policy on HIV and AIDS and the World of Work: The world of Work becomes the most suitable platform for mainstreaming HIV and AIDS because more than 90 % of HIV infections are in the productive age group. With this view, the Government of India has adopted the "National policy on HIV/AIDS and the World of work", which was launched by Shri Mallikarjun Kharge, Hon'ble Union Minister of Labour and Employment, on 30 October, 2009 in New Delhi. It is broadly based on code of conduct prescribed by the International Labour Organisation and aims to minimize the discrimination of PLHIV at places of work. It covers both organized and unorganized sectors and will help generate awareness about HIV/AIDS, encourage action to prevent its spread and further improve and develop the support and care initiatives at the workplace. The policy aims at preventing transmission of HIV infection amongst workers and their families; protect right of those who are infected and provide access to available care, support and treatment facilities, deal with issues relating to stigma and discrimination related to HIV/AIDS by assuring them equity and dignity at the workplace and ensure safe migration and mobility with access to information services on HIV/AIDS.

Trainings of Self Help Groups: For increased awareness, addressing HIV associated stigma and discrimination, and empowering rural women to protect themselves, Women Self Help Groups are being trained on HIV-AIDS issues through a systematic three step approach. The training involves support from State Institutes of Rural Development and NGO. Three trainings of master trainers have been executed at the national level. These master trainers thus empowered are vested with the responsibility to conduct trainings across fifteen states and 80 districts: ultimately reaching over 100,000 women.

IV. D. 6. CAPACITY BUILDING OF HUMAN RESOURCES THROUGH MULTISECTORAL COLLABORATION

Recognizing the importance of well-trained human resources at all levels of programme implementation, NACP-III developed a plan for building capacity of the programme managers and health personnel at the various levels — through partnership with Ministries and stakeholders — in leadership and strategies management, and technical and communication skills and also community level workers. The plan targets all levels of care and health care organizations, CBO and NGO, as well as grass-root levels functionaries and workers of various government departments. The progress in capacity building of various health personnel including community level workers through induction, refresher and other

training programmes during NACP is highlighted in the exhibit below. The scale up in induction and refresher courses for doctors, counsellors, lab technicians, NGO workers, data entry operators and community level workers is evident with a total 972,844 trainings executed during 2007 – 2010 (table 4.5)

Table 4.5: Progress in capacity building of health personnel under NACP-III (April, 2007-January 2010)				
Category	No. trained			
	Induction	Refresher	Others	Total
Doctors	45,524	16,636	21,763	83,923
Counsellors	49,172	39,215	11,201	99,588
Nurses	10,158	44,881	507	55,546
Lab Technicians	10,399	35,605	783	46,787
NGO Workers	30,426	10,095	31,072	71,593
Data Entry Operators	5,036	346	1,085	6,467
Community level workers	1,53,565	18,721	4,36,654	6,08,940
Total	3,04,280	1,65,499	5,03,065	9,72,844

IV. D. 7. NEW INITIATIVES FOR CAPACITY BUILDING

Indian Institute of Advanced Nursing: Through a unique public-private partnership between the Ministry of Health and Family Welfare, the Tamil Nadu State Government, the Indian Nursing Council and the Clinton Foundation; the Indian Institute of Advanced Nursing will be the first postgraduate nursing institute specializing in HIV-AIDS in the world. The Yale University School of Nursing, as the technical partner, will develop curricula for a range of post-graduate nursing courses on offer at the nursing instituted.

Once the institute becomes fully functional; it is expected that within three years, it will train around 15,500 nurses from India and other countries. This will either be directly or through Training of

Trainers. It is envisaged that the training thus imparted to nurses will contribute to an increase in the number of PLHAs receiving treatment through ART Centres by 35%.

Diploma Programme in HIV Medicine: The National AIDS Control Board on 23 December 2009 approved a proposal for launching a post-graduate Diploma programme in HIV Medicine. This one-year course is planned to be rolled out in 2010 by NACO in collaboration with the Indira Gandhi National Open University which will have a dedicated 'HIV Medicine Cell'. This educational programme will help standardise HIV Medicine training and bridge the gap in availability of trained manpower for ART centres.

M&E System Strengthening Tools (MESST) Workshop: The Department of AIDS Control, in collaboration with UNAIDS, organized a National Stakeholders Workshop on assessment and strengthening of MESST suggested by the Global Fund on 18 and 19 February, 2010 in New Delhi. The workshop, inaugurated by Secretary & DG, NACO, was attended by 73 participants including State M&E Officers from selected SACS (Andhra Pradesh, Karnataka, Delhi and Gujarat), and M&E representatives from all the Principal Recipients and selected Sub-Recipients of Global Fund projects, and NACP-III Development Partners, and officers from the Department of AIDS Control.

Fig 4.27: Shri K. Chandramouli, Secretary & Director General, NACO with participants and resource persons at the inaugural of the MESST workshop on 18 February, 2010



V. BEST PRACTICES

Several Best Practice models have been developed through the initiatives and efforts of the Government of India, State Governments, NACO, SACS, development partners and local NGO/CBO partners. These include India's experience with the Red Ribbon Express, Parliamentarian Forum and Legislators' Forums in several states, reading down of Section 377 of the Indian Penal Code, development of a national policy on HIV and AIDS and the world of work, establishing Link ART Centres and provision of pensions and railway concessions for PLHAs.

V. A. RESULTS FRAMEWORK DOCUMENT OF THE PRIME MINISTER'S OFFICE

The Hon'ble Prime Minister has approved a 'Performance, Monitoring and Evaluation System' as an important initiative of the Government of India for vision-driven results. The Results Framework Document (RFD) for individual departments is the cornerstone of this initiative and is required to be submitted every quarter.

The RFD of the Department of AIDS Control provides a summary of most important results that the department expects to achieve. It has the following five sections:

1. Vision, mission, objectives and functions
2. Priorities among key objectives, success indicators and targets
3. Trend values of the success indicators
4. Description and definition of success indicators and proposed measurement methodology
5. Specific performance requirements from other departments

The RFD for January-March 2010 developed by the Department of AIDS Control and finalised in December 2009 after incorporating recommendations of the Ad-hoc Task Force. It has been signed by Mr. Ghulam Nabi Azad, Hon'ble Union Minister for Health & Family Welfare and Shri K Chandramouli, Secretary, Department of AIDS Control & Director General, NACO. A Results Framework Management System developed by the Department of Performance Management in collaboration with the National Informatics Centre helps in monitoring the progress on the indicators identified in the RFD. The RFD for the year 2010-11 has been finalised in March 2010. The RFDs are also shared with the public and have been put up on the NACO website for wider dissemination.

V. B. DIRECTIVE OF THE SUPREME COURT OF INDIA

In response to a Public Interest Litigation, the Hon'ble Supreme Court of India reviewed the steps taken by NACO to respond to HIV-AIDS and the services being provided to PLHA. In this regard, the Hon'ble Court has issued directives for enhancing the extent and efficacy of treatment administered to PLHA. NACO has therefore taken the following steps to ensure compliance with the Court's directives:

- Ensuring that all A & B category districts have at least one fully functional ART centre in the states by 2009.
- Identifying sites for Link ART Centres(LAC), based on guidelines. NACO informed the concerned SACS so that necessary administrative sanction is issued and required refurbishment, training of LAC's manpower, etc., are carried out. LAC will need to be operational at the earliest so that PLHA do not have to travel long distance to access ART.
- All states to identify sites for future ART centres — as per GFATM Rounds 4 and 6 targets — so that CD4 machines can be procured accordingly. NACO has entered into a comprehensive maintenance contract for CD4 machines so that any fault or breakage in the machines is rectified at the earliest. The aim is to ensure that all PLHA and Children living with HIV/AIDS registered with ART centres undergo a CD4 test as per National ART Guidelines.
- All ART centres have a complaint box so that the PLHA can enter their grievances. The Nodal officers are expected to review the complaints weekly and take the necessary action in a timely manner. Further, a state level committee is being constituted in all states for addressing grievances at ART centre and routinely reviewing its functioning.
- NACO has already initiated procurement of drugs for Opportunistic Infections at regional level through State agencies having experience in this regard. Project Directors of SACS are required to ensure that these drugs are procured and supplied to all ART centres on priority basis.
- SACS are responsible for ensuring availability of adequate quantity of HIV test kits at all ICTCs and that there are adequate buffer stocks of test kits. Access to testing is a crucial component of NACP and availability of kits is the key factor for increasing HIV testing.

V. C. DECISION BY THE HON'BLE HIGH COURT OF DELHI

Through coordinated efforts of NACO, civil society and development partners for reforming structural impediments to HRG interventions; an affidavit was submitted to the Hon'ble High Court of Delhi in support of decriminalising article 377 on the Indian Constitution which criminalised homosexual relations. On 2 July 2009, the Hon'ble Court annulled the 150-year-old law — drafted during British rule of India — which criminalized “carnal intercourse against the order of nature” punishable by up to 10 years in prison. The court declared that section 377 of the Indian Penal Code violated the Fundamental Rights enshrined in Articles 14, 15, 19 and 21 of the Constitution of India and that consensual sexual acts of adults in private should not be criminalized. Chief Justice A.P Shah and Justice S. Muralidhar of the Division Bench have mentioned in their judgement that “The inclusiveness that Indian society traditionally displayed, literally in every aspect of life, is manifest in recognizing a role in society for everyone.” Relaxation of article 377 has facilitated scale up of Targeted Interventions (TI) for MSM and Trans-gender (TG) population. 132 TIs are now functioning exclusively for these groups.

V. D. PRESS COUNCIL OF INDIA

In November 2008, the Press Council of India — following revision of guidelines compiled in 1993 through a consultative process involving Indian media, government representatives, positive people's

network, health professionals and civil society organisations — issued a new set of media guidelines for reporting on HIV and AIDS. The guidelines were released on the occasion of the National Press Day at a function presided over by the Hon'ble President of India, Mrs. Pratibha Devisingh Patil. The revised Press Council of India guidelines form a major step forward in the HIV response by setting a benchmark for qualitative and responsible coverage of HIV-related issues.

V. E. MONTHLY PENSION FOR BELOW-POVERTY LINE ART PATIENTS

On 5th January 2009, the Cabinet of the south Indian state of Andhra Pradesh approved a monthly pension of INR 200 for each person living with HIV from below-poverty line families and undergoing ART treatment for a minimum of six months at the designated ART centres, and possessing white ration cards. This welfare initiative followed a public hearing in April 2008 and the presentation of a memorandum by the member of the Andhra Pradesh Legislators' Forum on AIDS to the Chief Minister seeking pensions for those on ART treatment. An estimated 40,000 people living with HIV from Below Poverty Line families in the state are expected to benefit from the pension scheme. The landmark measure will also help remove stigma and discrimination against people living with HIV.

V. F. TRAVEL & OTHER CONCESSION FOR PEOPLE LIVING WITH HIV

The Railways Ministry of the Government of India announced a 50% train fare waiver for PLHIV accessing ART services in February 2008. The Railway Ministry had, in September 2009, also agreed to extend this concessional travel arrangement to an escort of PLHIV.

In July 2009, the Government of India decided to provide *Antyodaya Annayojna* cards to poor PLHAs, making them eligible for getting subsidised ration.

These decisions resulted from NACO's sustained focus on mainstreaming HIV-AIDS and is a significant advance in provision of a supportive environment for PLHIV. Both the railway ministry and the food ministry have also agreed not to refer to such persons as HIV or AIDS infected but as persons with "immune deficiency".

V. G. RED RIBBON EXPRESS - A MASS MOBILIZATION DRIVE ON HIV AND AIDS

The Red Ribbon Express (RRE) is the world's largest mass mobilization drive on HIV and AIDS. The train will travel through 22 states, during its one year long journey, halting at 152 stations. Through the RRE, NACO intends to break the silence surrounding the issue of HIV and AIDS, by taking the messages on its prevention, care and support to people living in small towns and villages across the country. The aim is also to create an environment, free from stigma and discrimination faced by people living with HIV, so they can access the services, without fear and prejudice, and live a life of dignity. Regular newspaper reports suggest that the RRE has helped increase not only the awareness on HIV and AIDS, but also the utilisation of services. It has proved to be a successful multi-sectoral initiative of the NACO and a powerful advocacy tool, both at the state and district level, besides enhancing local capacity to deal with HIV prevention.

V. H. NATIONAL POLICY ON HIV AND AIDS AND THE WORLD OF WORK

The world of Work becomes the most suitable platform for mainstreaming HIV and AIDS because more than 90 % of HIV infections are in the productive age group. With this view, the Government of India has adopted the “National policy on HIV/AIDS and the World of work”, which was launched by Shri Mallikarjun Kharge, Hon’ble Union Minister of Labour and Employment, on 30 October, 2009 in New Delhi. It is broadly based on code of conduct prescribed by the International Labour Organisation and aims to minimize the discrimination of PLHIV at places of work. It covers both organized and unorganized sectors and will help generate awareness about HIV/AIDS, encourage action to prevent its spread and further improve and develop the support and care initiatives at the workplace. The policy aims at preventing transmission of HIV infection amongst workers and their families; protect right of those who are infected and provide access to available care, support and treatment facilities, deal with issues relating to stigma and discrimination related to HIV/AIDS by assuring them equity and dignity at the workplace and ensure safe migration and mobility with access to information services on HIV/AIDS.

V. I. LINK ART CENTRES

A NACO study on “Assessment of ART centres: Clients’ and Providers’ Perspectives” revealed that distance, travel time and costs were main constraints faced by PLHA. Based on these findings, NACO decided to set up Link ART Centres (LAC) to facilitate the delivery of ART services nearer to the beneficiaries. This is a low cost intervention which by ensuring easy access to ART, improves ARV drug adherence; as the LAC is set up in an Integrated Counseling and Testing Centre already functioning in Government health institutions –hospitals and Community Health Centres, expenditure is only on facility development, training and operational costs. Presently, 300 Link ART centre (LAC) have been made functional, and this number is likely to go to 450 by 2010.

V. J. SCORING GOALS AGAINST HIV /AIDS

Football matches with a difference. NACO could not have found a more innovative way of reaching out to the youth of Mizoram to give message on drugs, HIV and AIDS, than by using the competitive power of football matches. Aply called the Red Ribbon Inter village Football Tournament, it involved 212 teams, divided into four groups with 53 teams each. The total number of matches played were 207, more powerful was the fact that it was the first time that state level football matches were organised at the Village Council level. It was the biggest football tournament ever organized for the social cause of HIV and AIDS in the state of Mizoram. The matches started from January 2010 and concluded on 19 February 2010. 4,000 players who participated in the tournament wore jerseys with HIV and AIDS message written on it “Healthy living to prevent HIV/AIDS”. They took pledge to work towards stopping HIV and AIDS. They also willingly underwent HIV testing and donated blood. The football matches not only drew immense political support but also involved civil society, creating a collective ownership for all, on not just the football tournament but on the whole issue of HIV and AIDS. Nine matches were played after the quarter-finals; each was accompanied by a banner

competition. Besides this, SMS quiz competition on HIV and AIDS was organized for the spectators and the first correct SMS received a prize. Prizes were also given to the best supporting fans.

V. K. LINK WORKER SCHEME (LWS)

Under NACP-III, the Link Worker Scheme (LWS) was launched to saturate the reach of the HIV related services to the high risk groups based in the rural areas. The Link Worker Scheme was formulated for the rural areas of 187 highly vulnerable districts of the country. The LWS aims to address the complex needs of the rural HIV prevention, care and support through Identifying and training village level workforce of Supervisors, Link Workers and volunteers on issues of HIV/AIDS, gender, sexuality, STIs, mobilizing difficult-to-reach, especially vulnerable sub-populations including high risk individuals, youth and women, linking the HRG and vulnerable populations to STI, ICTC, ART services, generating volunteerism among the community for fighting HIV & AIDS, addressing issues regarding stigma and discrimination, condoms and behaviour change among youth. At present, the scheme is being implemented in 126 districts with support from GFATM, UNDP, UNICEF and USAID. It is proposed to expand the scheme to another 61 districts with support from GFATM Rd VII.

VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS

VI. A. PROGRESS MADE ON KEY CHALLENGES REPORTED IN THE CPR 2008

In the CPR 2008, India had identified the main challenges facing the programme as:

1. Decentralized data: Specifically, the capacity of the states and the districts to effectively implement the strategies of Strategic Information Management and to appoint skilled human resource to manage the system. Ensuring the quality of data at all levels, and capturing data from private providers and civil society led programmes further add to the challenge.

Response: India has been able to make significant progress in meeting these challenges. Strategic Information Management Units has been put in place at the national and state levels. The MIS has been revamped using core indicators which have been agreed across a variety of development partners, and this system is beginning to yield data disaggregated by age and sex from CSO-run units in addition to SACS-run interventions. Finally, capacity development has been undertaken and training provided to a large number of key staff. The Strategic Information Management System project which is expected to be operational in 2010 is expected to streamline the collection and effective use of strategic management information.

As part of the ongoing efforts to improve data collection, data quality and address analysis gaps, a data quality assessment plan is being put in place which will help institutionalise routine data quality and gap checks. The recent initiative to develop epidemiologic profile of HIV situation in district/sub-district level using data triangulation involved data analysis/validation of various sources of data at the district level from 2002-2008 has yielded several benefits, including the finalization of district level information as well as capacity building of district level staff. It is also expected to address challenges with regard to quality issues. Efforts are being pursued with regard to collection of data from other sectors of the government and also the private sector.

2. ART cohort tracking specifically, difficulty with cohort tracking of ART and private sector data.

Response: Sustained progress is being made. Cohort tracking has been pursued vigorously with better results than before. Efforts have focused on addressing stigma and discrimination issues, the institution of LAC, and responsibility sharing with networks of PLHIV has improved the LFU rates. The project for introduction of the Smart Card across many geographic locations planned under GFATM Round VI will enhance tracking. The project when it becomes fully operational is envisaged as a key intervention to facilitate ART cohort tracking.

3. Capacity building specifically, in numbers and quality is a key challenge. The number of persons to be trained runs into millions. The subjects are very diverse and many times about attitudes more than skills. **Human resources**, i.e., making available in adequate number, skilled and effective human resource at all levels of programming.

Response: While the task before India was enormous, the progress in the past two years has been massive. NACO had planned and implemented systematic capacity building activities in collaboration with SACS and development partners. Huge numbers of staff and other personnel, volunteers and supervisors have been recruited and trained through an unprecedented capacity development effort. Around 973,000 personnel including doctors, counsellors, nurses, laboratory technicians, NGO and community level workers have been trained through induction, refresher and other training activities

between April 2007 and January 2010. Facilities that have been identified and developed for ensuring that the country could mount a satisfactory response include the State Training Resource Centres, the Centres of Excellence, the STI Apex and Regional Institutes, and the ART Training Centres. Outsourcing of selected programmes, such as training of Self Help Groups to National and State Institutes of Rural Development, also contributed in this respect.

The Department of AIDS Control organised a 4-day training retreat for Project Directors of SACS in September 2009. In recognition of their pivotal role in planning, training and effectively harnessing the work of human resources for HIV/AIDS control activities, two days were devoted for human resource management with resource drawn from faculty of the Xavier Labour Research Institute, Jamshedpur.

The same effort will be continued to ensure adequate trained manpower to support the activities as India moves ahead with its ambitious plans to saturate all HRG and the general population with high quality services. New initiatives underway include the setting up of Indian Institute of Advanced Nursing as a unique public-private partnership between the Ministry of Health and Family Welfare of the Government of India, the Tamil Nadu State Government, the Indian Nursing Council and the Clinton Foundation. Envisaged as the first postgraduate nursing institute specializing in HIV/AIDS in the world, the new institute, within just three years after becoming operational, is expected to train around 15,500 nurses from India and other countries either directly or through Training of Trainers, and contribute to an increase in the number of PLHAs receiving treatment through ART Centres by 35%.

4. Governance: This specifically referred to the challenge of ensuring operation and functioning of governance structures and that civil society federation or networks that adequately represent the voice of civil society across the regions and typologies are supported.

Response: Every effort has been made to ensure that the governance structures that were put in place functioned effectively. A third of all states report having a functioning Legislative Forum and several have taken steps in support of PLHIV as reported elsewhere in this report. State Councils on AIDS have been formulated in 25 states and these are also functioning. Nevertheless, more needs to be done and the programme shall endeavour to do more and better.

Networks of HRG have been supported in the country. The Integrated Network for Sexual Minorities (INFOSEM), the Indian Harm reduction Network (IHRN) and a network of FSW have been supported directly by the government or through development partners. The INP+ and the Positive Women's Network have been at the forefront of the country's response to HIV and function as watchdogs. Finally, all of these various mechanisms have woven into a seamless pattern that has stitched together such achievements as the reading down of the regressive law on same sex partnerships.

VI. B. CHALLENGES FACED THROUGH THIS REPORTING PERIOD

Challenges that face the country during the reporting period include:

1. Need for greater scale up based on revised estimates. Need for flexible planning to account for new typologies of HRG – the youth and those engaged in multiple partner sex

While there was a renewed focus on HIV testing for HRG, monitoring of TI continued with attention on line listing of beneficiaries, ensuring adequate free supplies of condoms, effective outreach focused on those at highest risk, i.e., the youth and those engaged in multiple partner sex. While proposing their Annual Action Plans for 2010-11, some SACS have adjusted their TI Target taking into account the new

size estimates based on the findings reported by mapping studies in those states. Revision of TI norms has been undertaken to be able to reach those less accessible, but at high risk.

Migrant strategies are receiving increasing attention with the Behavioural Surveillance Survey-2008 indicating an impact of migration contributing to HIV epidemic in Uttar Pradesh, Bihar, Orissa and West Bengal. Recognising the need for stronger and focussed intervention both at source and destination districts, NACO has planned to design interventions targeting high-risk behaviour. The migrant interventions will address unmet needs of returnee migrants, their spouses, and the potential ones at source by linking up existing services of Integrated Child Development Services (ICDS), *Rashtriya Swasthya Bhima Yojana* and HIV-related health care. Intensification of interventions at destination through engaging management structures, informal networks of labourers and contractors is also undertaken.

Under the Opioid Substitution Therapy (OST) initiative, a medical intervention that helps IDUs stop injecting drug use, 53 OST centres have been contracted by SACS to implement the programme after accreditation by an independent body, the National Accreditation Board for Health Providers (NABH). The National AIDS Control Board (NACB) decided, at its meeting held on 23 December 2009, that the contracting of TI NGOs will be for a period of 24 months with evaluation conducted in 21st or 22nd month.

Following the successful completion of epidemiological profiling of HIV situation using data triangulation in 182 districts of seven states, a Working Group on Reprioritisation of Districts has been constituted on the directions of the Secretary and DG, NACO in December 2009 to *inter alia* develop a framework for prioritization of districts based on multiple data sources used in data triangulation.

2. Disseminate HIV-AIDS information and improve quality of basic services for key target populations by capacity building of health service centres' staff.

Further IEC activity is necessary to ensure that the populations at lower risk of HIV are well informed about the epidemic and the steps that they can take to avoid infection. There is also need to ensure that those amongst them who are at some risk have access to basic services including provision of condoms, management of STI/RTI, PPTCT and ICTC. Accurate estimation of need is necessary to ensure that efforts to reduce risk through various interventions are accurately directed and counted, so as to ensure optimum uptake of services. Finally, it is important that the capacity of the general health services be enhanced to take up basic services under this programme as they become mainstreamed.

3. Demand generation for condoms and identification of adequate delivery mechanisms to ensure supply.

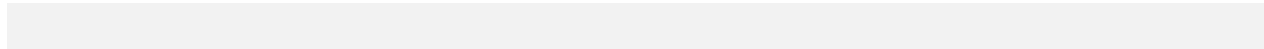
Following the encouraging results achieved in NACO's Targeted Condom Social Marketing phase-I, the programme has been further scaled up to cover 294 high HIV prevalence, high fertility districts in 25 states of India. 464,000 condom outlets serviced by the programme distributed 234 million pieces of condoms from April 2009 to January 2010. Six social marketing organisations are implementing the programme effectively from April 2009. Clear strategies for improved condom offtake and supply are necessary as the country moves forward in the HIV programme. Close coordination between the condom and TI divisions is important as is be the coordination with the National Rural Health Mission.

4. Monitoring of CST programmes on the ground needs to be improved as also its ability to reach those most in need. Increased access to ART by HRG is necessary.

Coordination between ICTCs and ART centres requires to be further strengthened, as do efforts on reduction of stigma and discrimination. Guidelines for confidentiality also need to be in place. The gender gap among children on ART requires to be examined. The country needs to review its options in respect of providing second line ART.

5. Increased granularity of data would help to ensure better planning of services. Improvement in quality and regularity of data is necessary.

There is need to strengthen M&E capacity and institutionalize systematic capacity building at state and district level. Existing databases require updation and cleaning up through exercises, such as data triangulation recently undertaken; data dictionaries need to be developed to facilitate data analysis.



VII. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

VII. A. DEVELOPMENT PARTNERS IN THE COUNTRY

Several donors, bilateral organizations and private foundations support NACO or specific interventions in India. The principal support comes from the World Bank, the DFID, the PEPFAR, the Centres for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID), besides private foundations such as the Bill and Melinda Gates Foundation (BMGF) and the Clinton Foundation. A major recent funder is the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). Smaller bilateral agencies support NACP through UNAIDS, international and national NGO and private sector players.

Budgetary allocation: The total budgetary allocation for NACP-III for 2007-12 is INR 115,850 million. Of this, 67.2 percent is allocated for prevention among high-risk groups and general population, 17 percent for care, support and treatment of people living with HIV-AIDS, 8 percent for programme capacity strengthening, 3 percent for strategic information management including monitoring and evaluation, surveillance and research, and 5 percent for contingency.

The External Aid Component represents 69 percent of the total budget for NACP-III (Table 7.1).

Table 7.1: Sources of NACP III budget

Sources		Amount (INR million)	Amount (USD ⁶ million)
Government of India		28,610	621.9
External Aid Component			
	World Bank	13,280	288.6
	DFID	8,080	175.6
	GFATM (II, III, IV & VI)	17,870	388.4
	GFATM Future Rounds	10,140	220.4
	USAID	2,250	5.4
	<i>Subtotal</i>	51,620	1122.1
Outside Government (Direct Funding from other donors)			
	UN	2,520	54.7
	DFID	540	11.7
	BMGF	14,250	309.7
	USAID	4,500	97.8
	Clinton	1,130	24.5
	Other Bilateral	630	13.6
	Other Foundations	1,550	33.6
	EU	770	16.7
	<i>Sub Total</i>	25,890	562.8
	Private	4,500	97.8
	Other Sources (to be identified)	5,230	
	Grand Total	115,850	

⁶ At the conversion rate of INR 46 to USD 1.

VII. B. DETAILS OF PARTNER SUPPORT

The UNDAF and NACP-III framework form the guiding documents for the UN support. The **joint UN support plan** (including 11 UN organizations) details the technical support that the UN system is providing to all four components of the AIDS control programme at national, state and district levels. This includes support to the TI Programme, to IEC, ART including paediatric ART, PMTCT and C&T, Education, Gender, STI, Blood safety, and to surveillance and M&E. The focus of the UN support is primarily in the Northeast region and the 6 UNDAF states.

The **GFATM** supports the following NACP programme areas: PPTCT, TB/HIV collaboration, Care and Support including ART, DIC, and CCC. In addition GFATM funds are used for capacity building of nursing schools, counsellors, and for the rural link worker scheme in high prevalence districts. GFATM support is also used for capacity building of PLHIV networks, MSM, IDU TI and strengthening of the informal sector.

The **World Bank and DFID** have pooled funds with the Government of India to support the NACP III in India. They provide support for the entire range of activities under the programme.

The **US Government** support, through the US President's Emergency Plan for AIDS Relief (PEPFAR), to Government of India's HIV control efforts is on key priority areas are health systems strengthening, integration of HIV/AIDS services within general health systems and gender equity. The programme focuses on four priority states: Tamil Nadu, Maharashtra, Andhra Pradesh and Karnataka with additional technical support to the North-East, Kerala, Goa, Uttar Pradesh and Uttarakhand. India became a part of the PEPFAR initiative in May 2005. Funding for PEPFAR in India averages \$30 million annually.

The USAID supports several initiatives including the AIDS Prevention and Control Project implemented in Tamil Nadu, the AVERT society in Maharashtra to reduce transmission among sex workers and mitigate the impact of sexually transmitted infections, work in Karnataka through the *Samastha* project. USAID provides assistance for Private Public Partnership through the Connect project and further provides technical assistance at national and state level through the Samarth project.

The Centers for Disease Control and Prevention (CDC) provides technical assistance at the national level by supporting health systems strengthening in laboratories, use of strategic information, and building human capacity. Key human capacity building efforts support training of nurses to improve HIV prevention and care and training of HIV epidemiologists to support the use of data for decision making. Additional support is provided to the ILO by the US Department of Labour for workplace HIV prevention and to the uniform services by the US Department of Defense for care and treatment.

The **Bill and Melinda Gates Foundation** (BMGF), through its India AIDS Initiative *Avahan*, supports prevention interventions among key HRG. Technical and management support is extended in the areas of FSW, MSM/TG, IDU interventions and for truckers and condoms, STI management and M&E, and technical and planning support for IEC for condoms and STI. BMGF also supports the National Technical Support Unit, State Technical Support Units in Andhra Pradesh and Tamil Nadu, and the North East Regional Office of NACO.

Avahan supports a programme for truck drivers on highway and strategic initiatives including integrated communications, advocacy, knowledge building and impact monitoring and capacity building. *Avahan* has successfully implemented prevention programmes in six states, with a combined population of 300 million people. Within these states, it provides prevention services to nearly 200,000 FSW, 60,000 high-risk MSM and 20,000 IDU, together with 5 million men at risk. *Avahan's* implementation of HRG interventions is a critical component of NACP III's main focus: prevention, especially prevention with HRG – *Avahan* operates in over 75 districts in the six high prevalence states. *Avahan* is beginning to

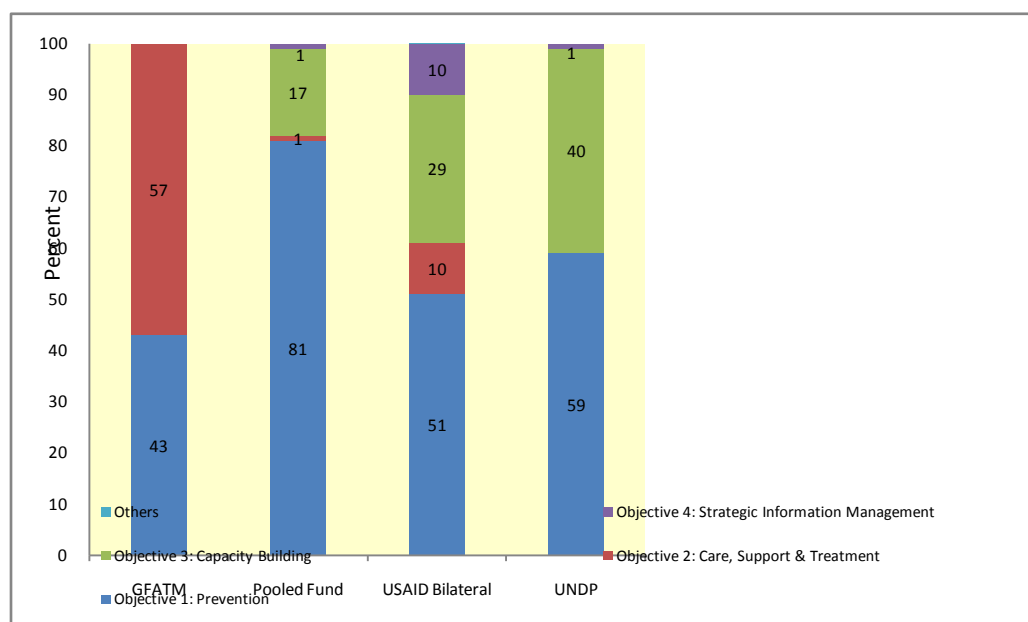
hand over the programme to the Government of India and communities and has also begun disseminating the key learning.

The **Clinton Foundation** supports the Paediatric ART intervention in India besides rehabilitation of the infected and affected children. It also assists NACO in training private sector doctors in HIV/AIDS care and treatment and is collaborating with NACO to establish a Centre of Excellence in HIV Nursing on a PPP model to provide in-service training to nurses.

VII. C. DISTRIBUTION OF EXTERNAL FUNDING SUPPORT

The major donors include i) Pooled fund contributors, i.e., World Bank and DFID, ii) GFATM grants (round 2, 3, 4, 6 and 7) where Government of India is a principal recipient, iii) USAID, and iv) UNDP. As can be seen from Fig 7.1, the GFATM grant is focusing only on Objective 1, i.e., Prevention and Objective 2, i.e., Care, Support and Treatment. According to the very broad classification based on the round-specific funding, GFATM (all rounds put together) has slightly higher focus on prevention (57 percent), with the rest (43 percent) comprising care and support activities.

Figure 7.1: Distribution of mobilized funds under External Aid Component by NACP III objectives

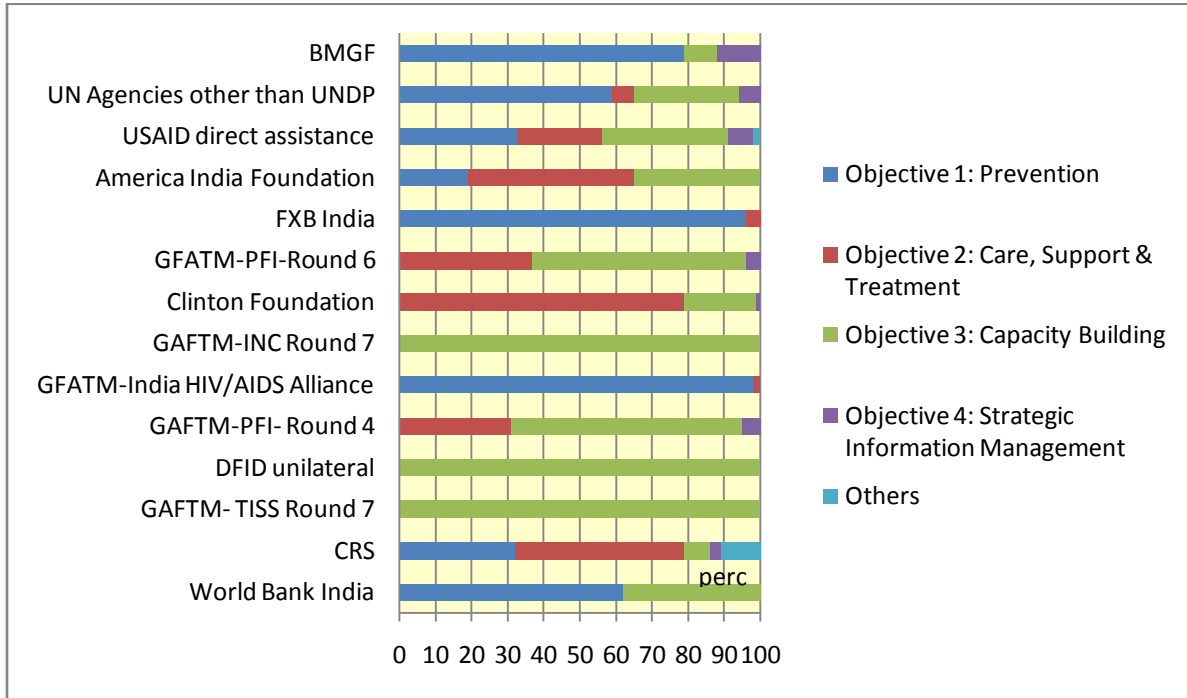


This distinction, however, is not strictly correct as many capacity building activities including training does happen under other NACP objectives as for example Prevention and Care. The pooled fund largely focuses on prevention activities (81 percent), with some proportion of it allocated for capacity building as well. USAID's bilateral support is a part of external aid component; it spends half of its funds for prevention activities with another fourth for capacity building. The UNDP spends on prevention (59 percent) and capacity building (41 percent).

In terms of distribution of funds by the NACP objectives, while DFID Unilateral and GFATM Round 7 focus mainly on capacity building, the BMGF, FXB International, and India HIV/AIDS Alliance heavily focus on prevention. The Population Foundation of India (GFATM Round 4/6) focuses on care & support

and capacity building, and the UN agencies as well as USAID unilateral support are evenly distributed across all four objectives (Figure 7.2).

Figure 7.2: Distribution of extra-budgetary resources by NACP III Objectives



VIII. MONITORING AND EVALUATION ENVIRONMENT

Establishing a nationwide strategic information management system for HIV is one of the four core programme components laid out in the NACP III. Following the “Three Ones” principle, The NACP III considers a strong Strategic Information Management System (SIMS) as an ‘early warning mechanism,’ for effective evidence-driven management. NACO is committed to strengthening the Monitoring and Evaluation (M&E) system countrywide so that issues related to data collection; compilation; analysis and use are effectively addressed. This involves establishing and strengthening institutional mechanisms and capacities at National and state level.

To maximize effective use of all available information and implement evidence based planning, NACP-III has established a Strategic Information Management Unit (SIMU). Whilst it is set up at national level; it is being institutionalised at state levels for maximizing effective use of all available information and inform evidence based planning. SIMU aims at guiding data collection, compilation, analysis and its use. It involves establishing and strengthening institutional mechanisms and capacities at National and sub-national levels. SIMU assists in programme implementation by tracking the epidemic, assessing the effectiveness of the response to evaluate achievement by NACO, SACS and all partner organizations in fulfilling their commitment to meet agreed objectives.

The M&E system is set up at national and state and select district level and consists of the three components of strategic planning, monitoring and evaluation, surveillance and research. It supports tracking the epidemic and the effectiveness of the response and helps assess how well NACO, SACS and all partner organizations are fulfilling their commitment to meet agreed objectives. Under NACP III, the five focus areas of work have been: i) support the development of national M&E frameworks, operational plans and budgets; ii) improve data use for programming and decision-making; iii) improve evidence-based results information; iv) renewing national and international partnerships; and v) generate and disseminate knowledge.

The main focus of SIMU in 2008 and 2009 continued to be on strengthening the national M&E framework and on generating quality information on the programme and the epidemic as highlighted below:

VIII. A. STRENGTHENING OF THE NATIONAL M&E FRAMEWORK

There is commitment for strategic collection and use of information for programme accountability and improvement to ensure quality and sustainability of programmes. With each year of implementation, the national programme has expanded its knowledge base of best practices and lessons learned which drives funding decisions and adjustments to ongoing programmes.

For improving quality of data collected and analysed—which was a challenge previously—during the previous two years, SIMU has continued strengthening its capacity to monitor the implementation of the programme and track outcomes and impacts of national efforts while giving strategic importance to generating new knowledge and finding improved approaches to strengthen data use and data dissemination. Through supportive supervision it aims at strengthening systems for better M&E.

VIII. A. 1. Strengthening and standardizing country information systems at decentralized levels

This section reports measures taken by the Government of India for strengthening decentralised programme implementation at two levels: at one level to develop capacity of programmers and officials in states and districts; and at the other level, to ensure efficient data entry and reporting through the CMIS — and the soon to be launched Strategic Information Management System (SIMS) — and collaborate with stakeholders to align national M&E core indicators.

VIII. A. 1. A. CAPACITY BUILDING OF OFFICIALS

With greater responsibilities allocated to the state and district level through SACS and DAPCU, NACO's role increasingly is focused on coordination; and guiding, monitoring and facilitating sharing of best practices and innovations across the SACS programmes. In order to assume this role, significant investment is required for building the capacity of managers and technical staff at the state level. NACO has a system for quarterly review and training based on assessment and updating the skill base. A total of 495 M&E officers at national level, 2535 M&E officers at state level and 12,393 civil society representatives have undergone M&E training during 2008 and 2009.

From 2008 onward, a series of regional training was conducted for enhancing the knowledge of national and state officers on M&E and epidemiology and strengthening their capabilities in application of bio-statistical methods using SPSS (Table 8.1). Following an induction training programme, two batches of advanced trainings for SACS M&E officers was executed in 2009 for capacitating over 30 officials. The trainings were modelled on the global M&E training programme held in Bangkok in October 2008 although moulded to ensure country relevance.

Table 8.1: M&E Training Programmes Conducted for Capacity Development

Training organized for:	Name of the training	No. of Participants	Date & Duration of the training	Venue
Monitoring & Evaluation Officer and TSU Team Leader (Strategic Planning)	Training on Bio-statistical methods & Analysis through SPSS	23	20-24 April 2009	CMC, Vellore
Newly appointed Monitoring & Evaluation Officer of Delhi, Goa, Madhya Pradesh, Himachal Pradesh & Orissa	Induction training	5	26-28 May, 2009	NACO, New Delhi
Monitoring & Evaluation Officer of North Eastern States and Union Territories	Training on Bio-statistical methods & Analysis through SPSS	17	3 - 6 August, 2009	Guwahati
Monitoring & Evaluation Officer of North Eastern States	Workshop for CMIS troubleshooting	8	3-5 September, 2009	Guwahati

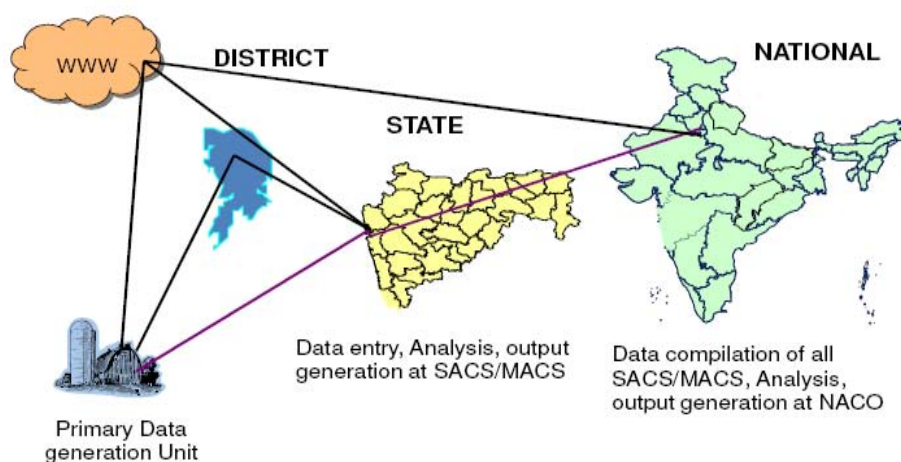
In addition, component specific consultations with M&E officers are undertaken — as part of NACO strategy of supportive supervision for capacity development — for assessing various officials' information needs, the current information sources with gaps and tools to address gaps for improving programme outcomes.

VIII. A. 1. B. COMPUTERIZED MANAGEMENT INFORMATION SYSTEM

NACP collects routine information on programme components from all states and union territories from Blood Banks, ICTC, STD Clinic, ART centres and from NGO implementing TI and CCC. This information is collected monthly through a comprehensive software called CMIS which is installed in all SACS. This routine data provides a wealth of information on health service statistics that informs decision making and day to day management decisions for making program results more effective. CMIS is an important source of data which gives early warning on non performances or issues.

Through the CMIS standardized reports and graphs and data are generated and extracted into MS Excel for a more detailed analysis. The reports, though generated at national level, can provide details of any reporting unit level for any selected period. The data flow is shown in Fig. 8.1.

Figure 8.1: CMIS data gathering



For improving timeliness and completeness of CMIS reporting — which was a challenge — a systematic approach was undertaken involving visits to major non-reporting states. This has resulted in rectification of problems of non-reporting. It has helped reinforce uniform tools through CMIS trainings along with ongoing mentored support.

Currently, CMIS is installed at all 35 SACS and 3 Municipal AIDS Control Societies. In the past year, many states have decentralized the systems and data gets computerized at district or facility level. The ART CMIS module is web-based and data from all ART Centres is directly uploaded on NACO server.

For enabling standardized recording and reporting from different centres; a set of Monitoring and Evaluation Tools and Formats are developed—example: Pre-ART register, ART enrolment register, patient ART record (White Card), patient ID card (Green Book), drug stock register, etc. Through these formats improved relevant information is made available and programme response better tailored. Its impact to the ART programme is briefly discussed ahead.

VIII. A. 1. C. STRATEGIC INFORMATION MANAGEMENT SYSTEM (SIMS) & ALIGNMENT OF NATIONAL M&E INDICATORS

The SIMS was developed as a mechanism for improving on the CMIS. Under CMIS, data are aggregated at national, state, district and sub-district levels through the various government reporting units; the challenge is integrating HIV data generated or captured by non-NACO funded HIV projects. It is envisaged that following the launch of SIMS; data generated at different levels could be

comprehensively utilised for guiding effective response formulation. Concerns over gaps in data reporting, data quality issues will also be addressed.

SIMS is a web-based application with a central server and sophisticated tools aiding in data analysis and integration from different data sources/platforms. It is proposed to increase the efficiency of computerized M&E system by having adequate data quality through centralized validated data. Data transfer mechanisms shall be improved by using the web-enabled application and efficient data management rights (Access Rights Control) from reporting unit to national level will be there. It will provide evidence to track the progression of epidemic with respect to demographic characteristics, geographical area including GIS support. It 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. The Built in rules, regulations and policies to facilitate alerts and data integrity checks, The Ad-hoc reporting through data warehousing, drill-down and slice-n-dice facility shall also be available through cubes.

It will be functional in 2010. For rolling out this system, a detailed systems requirement study was conducted in 2009. Data input tools —developed in consultation with all programme divisions — were submitted to the System Requirement Specifications (SRS) and Design Document for review to NACO. The User acceptance test was completed on November and pilot tested in the December 2009. The SIMS is expected to replace the CMIS in 2010.

The success of this strategy is dependent upon coherent alignment of all stake holders' indicators to form a set of national indicators for M&E reporting. Responding to the request made by civil society and development partners at the *National M&E Stakeholders' Workshop on Assessment and Strengthening of M&E Systems in India* (February 2010); NACO has taken the lead on this initiative.

For improved coverage and ensuring people's access to treatment, NACO is in process of implementing the "Smart Card" Project. This card would act as a portable medical record and would facilitate easy storage and analysis of data. To ensure electronic data for all PLHIV on ART, a drive was launched with the twofold objectives of improving the quality of the present system of the data entry at the ART Centres and to provide an impetus to complete the backlog of the existing incomplete records. The vision is to inculcate the importance of complete and correct record filling in the ART centre staff. After successful pilot project, the Smart Card system has been planned under GFATM Round 6.

VIII. A. 2. Monitoring trends in behaviours and HIV-AIDS prevalence

This section focuses on efforts for scaling up sentinel sites; undertaking HIV sentinel surveillance and behavioural surveys for guiding programme response and feeding towards planning of the NACP IV.

VIII. A. 2. A. SCALE-UP OF SENTINEL SITES FOR HSS 2009

The first HIV surveillance in India can be traced to 1985 when the Indian Council of Medical Research (ICMR) conducted surveillance on blood donors and people with STD. Subsequently, from 1992 — when NACO was established — periodic data generated therein through surveillance became an essential base for guiding programme response and ensuring the basic M&E function of the NACO. Whilst initial sentinel surveillance was confined to selected cities; subsequent to 1998, when NACO formalized annual HSS across the country, there has been a gradual scale up in the number of sentinel sites from 176 in 1998 to 1,215 in HSS 2008/09 across the country.

Given the importance of HSS data for understanding epidemic trends across geographic lines and population groups — pregnant women attending ANC, patients attending STD clinics, FSW, MSM, IDU, Single Male Migrants and Long distance Truckers — and estimating the number of HIV infected persons in the country for the programme; there is great stress laid by SIMU on data quality. This is aimed at through improvement in quality of the surveillance system by addressing technical and operational issues.

The following changes were successfully effected: initially, on the technical side in the recruitment strategy and the sample collection method at HRG sites; and, then, on the operational side through establishment of an effective and structured training programme and institutionalizing a strong monitoring and supervision system.

VIII. A. 2. B. BEHAVIOURAL SURVEILLANCE SURVEY

Three rounds of BSS have been conducted till 2009 - two at the national level in 2001 and 2006 and one at state level (both rural and urban areas) in 2009 in five high prevalence states: Andhra Pradesh, Karnataka, Manipur, Tamil Nadu and Maharashtra, and in selected districts of Uttar Pradesh. The objectives for the 2009 round was to measure changes in key knowledge and behavioural indicators among general population, HRGs and bridge population on HIV/AIDS and related areas since 2006. Additionally, highlight the impact of the interventions, identify problem areas, and provide data to be used for cross-country and cross regional comparisons of behavioural risks.

The population groups surveyed include FSW (brothel based and non-brother based), MSM, IDU including female IDU in Manipur, single male migrants, youth in general population (Urban and Rural) and male and female in general population (urban and rural). Thematic areas surveyed include knowledge of HIV-AIDS, transmission modes and prevention methods, stigma and discrimination, STIs, substance use, sex work and migration, sexual behaviour and condom use, injecting practices and needle sharing behaviour and practices, awareness of HIV and AIDS Programmes and exposure to interventions, risk perception and HIV testing, empowerment and community mobilisation. Key provisional data from the survey have been highlighted in Chapter II.

Integrated Biological & Behavioural Assessment: In addition, two rounds of IBBA were conducted in 29 districts in six high prevalence states in round one in 2006 and in all districts of Karnataka in round two in 2009. The IBBA covered FSW, Clients of FSW, MSM, TG, IDU, and Long Distance Truckers.

VIII. A. 3. Operational Research

NACO has led efforts to develop a national Evaluation and Research Agenda which will set up priorities for programme evaluation and research related to HIV in the country. Moreover, establish a system for ensuring good quality research and proper data dissemination and use by the national programme.

The main objective of the Evaluation and Research Agenda is to position NACO as the leading national body, promoting and coordinating research on HIV-AIDS nationally and in the South Asia region through partnership and networking with stakeholders, supporting capacity building for research through established national academic and other research institutions, and as the central repository of all relevant resources, research documents and data base on HIV-AIDS in the country.

NACO has taken the initiative to establish the network and put in place committees to support and oversee this process.

VIII. A. 3. A. NETWORK OF INDIAN INSTITUTIONS FOR HIV/AIDS RESEARCH

NACO has constituted a national consortium of research institutions for undertaking operational, epidemiological and bio-medical research in the field of HIV/AIDS. This consortium named the 'Network of Indian Institutions for HIV/AIDS Research (NIIHAR)' has linkages with universities, ICMR, CSIR, DST, ICSSR and others stakeholders including donor organizations engaged in the HIV/AIDS response. By pooling in resources and expertise to conduct high quality, collaborative, multi-centric research; evidence-based decision making on policy, management and evaluation of interventions will be enabled. During 2009-10, 15 Institutes joined as the member of NIIHAR taking the total membership to 42.

VIII. A. 3. B. NACO ETHICS COMMITTEE

The NACO Ethics Committee was constituted in 2008-09 to consider and provide ethical clearance for those research proposals and projects that involve participation and experimentation on human participants. That is, where their mental, physical, social and emotional health and well-being may be affected by the proposed research. The Committee thus is responsible for ensuring ethical implications of any research proposed to be undertaken are afforded serious consideration prior to the commencement of the project, and that such research is consistent with legislative and statutory requirements. The rationale for ethical approval is to ensure that the process of research is conducted 'ethically', responsibly, protects privacy and is not exploitative of participants. This involves establishing procedures for the informed consent of the subjects involved in research, as well as appropriate handling of the research findings (e.g., secure storage of data).

The NACO Ethical Committee consists of experts in bio-medical, clinical, epidemiological, behavioural and social disciplines. A legal expert and a civil society representative are included. Draft guidelines for NACO-Ethics committee and Standard Operating Procedures are developed and shared with the experts for further improvement. The Committee meets on a periodic basis. In 2009-10 they met thrice. The National Ethics Guidelines for Research in HIV/AIDS was finalized at a joint meeting of Technical Resource Group – Research and Development in January, 2010. A total 16 protocols have been recommended by the TRG on Research and Development and NACO Ethics Committee.

VIII. A. 3. C. TECHNICAL RESOURCE GROUP

The Technical Resource Group on 'Research and Development' meets at least once a year for identifying and agreeing on priority areas for evaluation and operational research in effort to better understand the dynamics of the epidemic and appropriate responses required. These priorities are determined following consultation with the various stakeholders: development partners, donors, members of the technical resource group and heads of various programme divisions. A range of disciplines are covered under this and include epidemiological, clinical, behavioural and social sciences.

Under the **Research Fellowships Scheme**; NACO awards fellowships to MPhil/MD/PhD scholars and helps build their capacity as young scientists undertaking HIV research or in inter-disciplinary fields. This includes operations research and for increasing skills in communicating research findings for impacting policy and programme. Research fellowships provide opportunities to young researchers to pursue research under experienced academicians and researchers. Any young scientist, below 35 years and with requisite educational qualifications can apply for the fellowship to carry out research relevant to

HIV-AIDS in bio-medical/clinical, epidemiological, behavioural and social disciplines. NACO awards up to 20 fellowships every year. The maximum grant for each fellowship is limited to Rupees 150,000.

Through coordinated efforts in **operational research**—and ensuring adherence with ethics standards—several studies have been completed whilst others are ongoing. Many studies were initiated in 2009 to inform the NACP-III Mid Term Review. Those concluded include: i) Assessing the coverage, efficiency and quality of STI services. ii) Assess the access and utilisation of PPTCT services as per the National package. iii) Assess how social inclusion and equity issues are being addressed in the programme; iv) Review the organisational capacity of NACO and SACS including efficiency, workload and cost; v) Analyse programme target and expenditure; vi) Assess quality of IEC strategy; and vii) Epidemiological profiling of HIV/AIDS situation at district and sub-district level using data triangulation.

Ongoing studies are on: i) Resistance to first line ARV drugs; ii) Baseline CD4 count of healthy adult population; iii) Factors affecting enrolment for ART; iv) Determinants of ARV drug adherence; v) Early Warning Indicators for Drug Resistance; vi) Assessment of Community Care Centres in India; and vii) HIV Case Reporting and Cohort Analysis of PLHA on ART.

NACO also reviews proposals on HIV/AIDS for research funding from foreign institutes/organizations received by the Department of Health Research and provides its comments to the Health Ministry's Screening Committee chaired by the Secretary, Department of Health Research and Director General, Indian Council of Medical Research.

VIII. A. 4. DISSEMINATION AND USE OF INFORMATION

For ensuring greater collaboration through information sharing and data resources; data sharing guidelines are developed. This is placed on the NACO website and is free for all institutions / organizations / stakeholders to access. If in need of data they can complete the data sharing request form and apply for data access. This request, once reviewed by the NACO officer is transferred to the designated approving authority that will either authorize or deny access depending on data availability.

Additionally, and for timely update and information availability of strategic information by M&E officers and stakeholders, the Strategic Information Management Division oversees periodic uploading — whilst ensuring quality — of correct and authentic data to the NACO website (www.nacoonline.org) Efforts are also underway to develop the website as a knowledge hub, provide more interactive features including Dashboard and Key Process Indicators (KPI's), Geographical Information System (GIS). Portal facility would provide Interactive Data; Messaging solution, Document Management Facility, Bulletin Board and Chatting Facility, Effective Feedback and Communication Facility.

In the context of increased availability of data and decentralized planning at the district level, NACO has recently undertaken the project titled "Epidemiological Profiling of HIV/AIDS Situation at District and Sub-district Level using Data Triangulation". During July – November 2009, the first phase was implemented in seven states (182 districts) and the second phase is in progress in twenty other states. The Broad objective of the project is to consolidate the epidemiological profiles (epidemic scenario and programme response) at district and sub-district level with respect to HIV/AIDS.

Specific objectives include:

- Identifying districts and focus areas within a district for priority attention in the Programme.
- Resource & information collection in a systematic manner to understand the epidemic and response gaps in the district and facilitate evidence-based planning at district and state level.

- Capacity building of district and state programme managers and M&E personnel in data analysis, triangulation, data quality assessment and use of data for planning & program review.

The exercise has been very successful and the experience has given some important lessons in terms of technicalities and operational issues.

Annex 1: National Funding Matrix

NASA was not carried out in India for the reporting years, hence details are set out in the UNGASS Guidelines are not available. The following table presents the expenditure in the programme under main activity categories.

Expenditure Consolidated Yearwise - NACO				
Components / Subcomponents	Expenditure from 1 April 2008 to 31 March 2009		Expenditure from 1 April 2009 to January 2010	
	(INR)	(USD*)	(INR)	(USD*)
Prevention (1)	4,749,841,000	103257413	3379644000	73470521.74
Civil works under PI	4,977,000	108195.6522	72000	1565.217391
STD Control	126,399,000	2747804.348	173788000	3778000
Condom Promotion	146,179,000	3177804.348	14544000	316173.913
NGO services for priority interventions	1,291,641,000	28079152.17	766882000	16671347.83
Mapping and other related activities	189,764,000	4125304.348	41657000	905586.9565
Technical Resource Groups (TRGs)	3,860,000	83913.04348	-157000	-3413.043478
Evaluation and JAT	7283000	158326.087	26488000	575826.087
IEC, Social mobilisation and Mainstreaming ^(a)	857742000	18646565.22	438124000	9524434.783
School/Colleges AIDS education programmes/formation	57034000	1239869.565	51648000	1122782.609
Integrated Counseling and Testing Centres under PI ^(b)	1004793000	21843326.09	649053000	14109847.83
Blood Safety	565855000	12301195.65	878154000	19090304.35
Family Health Awareness Campaign (FHAC) under PI	15939000	346500	2799000	60847.82609
Implementation of PMTCT Programme under PI	3254000	70739.13043	87000	1891.304348
External Quality Assessment Programme	144254000	3135956.522	8075000	175543.4783
Training under TI	62424000	1357043.478	39607000	861021.7391
Link worker scheme under TI ©	5924000	128782.6087	53836000	1170347.826
APAC/AVERT ^(d)	262519000	5706934.783	234987000	5108413.043
Care, Support and Treatment (2)	1111852000	24170695.65	2403253000	52244630.43
Civil Works under LA	0	0	0	0
Purchase of Equipment under LA	53000	1152.173913	0	0
Drugs for Opportunistic Infections/PEP/CD4/CD8 under LA	2730000	59347.82609	313000	6804.347826
Community Care Centres under LA	19626000	426652.1739	189000	4108.695652
IEC and Awareness Related to PLWAs under LA	195000	4239.130435	1477000	32108.69565
Consultant Services under LA	2004000	43565.21739	2300000	50000
Technical Resource Groups (TRGs) under LA	0	0	0	0
ART/CCC/COE ^(e)	1087244000	23635739.13	2398974000	52151608.7
Capacity Building (3)	783027000	17022326.09	637683000	13862673.91
Civil Works under IS	9115000	198152.1739	370000	8043.478261
Vehicles under IS	354000	7695.652174	139000	3021.73913
Sentinel Surveillance under IS	9898000	215173.913	0	0
Training and Fellowship under IS	33004000	717478.2609	6152000	133739.1304
HMIS and Monitoring and Evaluation under IS	1149000	24978.26087	0	0
Operation Research/Policy and Other Studies/Cause of Death Studies/Research and Development under IS	96000	2086.956522	0	0
Technical Resource Groups (TRGs) under IS	0	0	0	0
Salary of Staff under IS	288015000	6261195.652	304245000	6614021.739
Administrative cost of DAPCU staff	11396000	247739.1304	51428000	1118000
Furniture & Supplies and Office Equipment under IS	26689000	580195.6522	15143000	329195.6522
Equipment Maintenance under IS	6458000	140391.3043	8635000	187717.3913
Building Maintenance under IS	16365000	355760.8696	3948000	85826.08696
Vehicle Maintenance under IS	16677000	362543.4783	15758000	342565.2174
Operational expenses under IS	214575000	4664673.913	217032000	4718086.957
Meeting expenses	5112000	111130.4348	1197000	26021.73913
Consultancy services under IS	5895000	128152.1739	0	0
Training & capacity building of staff & DAPCU	8468000	184086.9565	7624000	165739.1304
Infrastructure and computers	118528000	2576695.652	2460000	53478.26087
Need-based requirement for SACS office	11233000	244195.6522	3552000	77217.3913

Strategic Information Management (4)	52414000	1139434.783	19492000	423739.1304
IEC and Awareness under IC	21065000	457934.7826	0	0
Operational Research/Policy and other studies/Cause of Death Studies/Research analysis	82000	1782.608696	0	0
Sentinel Surveillance under IC	30641000	666108.6957	18616000	404695.6522
Training and Fellowship under IC	393000	8543.478261	0	0
HMIS and Monitoring and Evaluation under IC	233000	5065.217391	876000	19043.47826
Grand Total	6697134000	145589869.6	6440072000	140001565.2

* At a conversion rate of INR 46 to USD 1.

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