National AIDS Control Organisation
Department of AIDS Control

National AIDS Control Organisation
India's voice against AIDS
Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
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Department of AIDS Control

Ministry of Health & Family Welfare

Annual Report

2010-11

NACO

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Contents

Acronyms

AAP	Annual Action Plan
APSACS	Andhra Pradesh State AIDS Control Society
AEP	Adolescence Education Programme
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
BCC	Behaviour Change Communication
BCSU	Blood Component Separation Units
BMGF	Bill & Melinda Gates Foundation
BSS	Behaviour Surveillance Survey
CBO	Community-Based Organisation
CMC	Christian Medical College
COE	Centre of Excellence
CPT	Cotrimoxazole Prophylaxis Therapy
CST	Care, Support & Treatment
CCC	Community Care Centre
CDC	Centers for Disease Control and Prevention
CHC	Community Health Centre
CLHA	Children Living with HIV/AIDS
CMIS	Computerised Management Information System
CPFMS	Computerised Project Financial Management System
CPGRAMS	Centralised Public Grievance Redress and Monitoring System
CSMP	Condom Social Marketing Programme
CVM	Condom Vending Machine
DACO	District AIDS Control Officer
DAPCU	District AIDS Prevention & Control Unit
DFID	Department for International Development (UK)
DMO	District Medical Officer
DTC	Delhi Transport Corporation
DIC	Drop In Centre
ESCM	Enhanced Syndromic Case Management

EQAS	External Quality Assessment Scheme
FC	Female Condom
FHI	Family Health International
FIICTC	Facility Integrated ICTC
FOGSI	Federation of Obstetric & Gynaecological Societies of India
FRU	First Referral Unit
FSW	Female Sex Workers
GC	General Client
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People living with HIV/AIDS
H&FW	Health & Family Welfare
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
IAP	Indian Academy of Paediatrics
IAVI	International AIDS Vaccine Initiative
IBSS	Integrated Biological and Behavioural Surveillance
ICMR	Indian Council of Medical Research
ICTC	Integrated Counseling and Testing Centre
ICRW	International Centre for Research on Women
IDU	Injecting Drug User
IEC	Information, Education and Communication
IHBAS	Institute of Human Behaviour & Allied Sciences
IIPS	International Institute for Population Sciences
IMS	Institute of Management Studies
JAT	Joint Appraisal Team
KHPT	Karnataka Health Promotion Trust
LAC	Link ART Centre
LWS	Link Worker Scheme
M & E	Monitoring & Evaluation
MCD	Municipal Corporation of Delhi
MoWCD	Ministry of Women & Child Development
MSM	Men who have Sex with Men
NABH	National Accreditation Board for Healthcare Providers
NACO	National AIDS Control Organisation

NACP	National AIDS Control Programme
NARI	National AIDS Research Institute
NBTA	National Blood Transfusion Authority
NCDC	National Cooperative Development Corporation
NDMC	New Delhi Municipal Corporation
NE	North East
NEIGRIHMS	North Eastern Indira Gandhi Regional Institute of Health & Medical Sciences
NEQAS	National External Quality Assessment Scheme
NERO	North East Regional Office
NGO	Non-Government Organisation
NIC	National Informatics Centre
NPO	National Programme Officer
NRHM	National Rural Health Mission
NRL	National Referral Laboratory
NSCB	Netaji Subhash Chandra Bose Medical College
NTSU	National Technical Support Group
NTWG	National Technical Working Group
NYKS	Nehru Yuva Kendra Sangathan
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
ORW	Outreach Worker
PEP	Post Exposure Prophylaxis
PGIMER	Post Graduate Institute of Medical Education & Research
PHC	Primary Health Centre
PHMI	Public Health Management Institute
PLHA	People Living with HIV/AIDS
PPP	Preferred Private Provider
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institution
RBTC	Regional Blood Transfusion Centre
RCH	Reproductive and Child Health
RI	Regional Institute
RNTCP	Revised National Tuberculosis Control Programme
RSBY	Rashtriya Swasthya Bima Yojna
RRC	Red Ribbon Club

RRE	Red Ribbon Express
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SBTC	State Blood Transfusion Council
SIMU	Strategic Information Management Unit
SIMS	Strategic Information Management System
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STRC	State Training & Resource Centre
TAC	Technical Advisory Committee
TB	Tuberculosis
TG	Transgender
TI	Targeted Intervention
TSG	Technical Support Group
TSU	Technical Support Unit
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UT	Union Territory
VCTC	Voluntary Counseling and Testing Centre
WBT	Whole Blood HIV Test
WHO	World Health Organization

Overview

The recent HIV estimations highlight an overall reduction in adult HIV prevalence as well as new infections (HIV incidence) in the country, although variations exist across the states. The analysis of epidemic projections has revealed that the number of annual new HIV infections has declined by more than 50 percent during the last decade. This is one of the most important evidence on impact of the various interventions under the National AIDS Control Programme and scaled-up prevention strategies. The wider access to ART has resulted in a decline of the number of people dying due to AIDS related causes. The trend of annual AIDS deaths is showing a steady decline since the roll out of the free ART programme in India in 2004.

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

The **National AIDS Control Programme (NACP)**, launched in 1992, is being implemented as a comprehensive programme for prevention and control of HIV/AIDS in India. Over time, the focus has shifted from raising awareness to behaviour change, from a national response to a more decentralised response and to increasing involvement of NGOs and networks of people living with HIV/AIDS (PLHA). NACP's Phase-III has the overall goal of halting and reversing the epidemic in India over the five-year period (2007-2012).

NACP-III has placed the highest priority on preventive efforts. At the same time, it seeks to integrate prevention with care, support and treatment through a four-pronged strategy:

1. Preventing new infections in high risk groups and general population through saturation of coverage of high risk groups with targeted interventions and scaled up interventions in the general population;

2. Providing greater care, support and treatment to larger number of PLHA;

3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national levels; and

4. Strengthening the nationwide Strategic Information Management System.

Key Achievements during 2010-11

Targeted Interventions for High Risk Group Population: Implemented through non-government organisations and community-based organisations, Targeted Interventions provide behaviour change communication, condom promotion, STI care and referrals for HIV testing and Anti-Retroviral Treatment for High Risk Groups and Bridge Populations. Currently, there are 1,385 TIs providing prevention services to overall 31.32 lakh population covering 78 percent Female Sex Workers, 76 percent Injecting Drug Users, 69 percent Men having sex with Men, 32 percent Migrants and 33 percent Truckers. A new migrant strategy was launched to provide HIV prevention services to migrants in 108 source districts and 47 transit districts, besides TI projects working in destination districts. Other initiatives include contracting 52 Opioid Substitution Therapy (OST) centres after NABH accreditation and piloting OST provision in public health care settings in Punjab.

Link Workers Scheme: This community-based intervention addresses HIV prevention and care needs of the high risk and vulnerable groups in rural areas by providing information on HIV, condom promotion and distribution and referrals to counseling, testing and STI services. The scheme has been expanded to cover 186 districts across 20 states during 2010-11.

Blood Safety: Access to safe blood has been ensured through a network of 1,127 Blood Banks including 155 Blood Component Separation Units and 28 Model Blood Banks and 685 blood storage centres. Around 79.2 lakh blood units were collected during 2010-11 till January 2011, 79.4 percent of them through voluntary donation in NACO-supported blood banks. New initiatives include setting up of four Metro Blood Banks as Centres of Excellence in Transfusion Medicine and one Plasma Fractionation Centre with a processing capacity of more than 1,50,000 litres of plasma.

Management of Sexually Transmitted Infections: The STI/RTI services based on the Enhanced Syndromic Case Management are currently being provided through 1,038 designated STI/RTI clinics, including 90 new clinics established during 2010-11. Around 3,891 private preferred providers were identified for providing STI services to high risk population. Overall, 84.9 lakh STI episodes were treated during 2010-11, till January 2011. NACO has branded the STI/RTI services as "Suraksha Clinic" and has developed a communication strategy for generating demand for these services.

Information, Education & Communication (IEC): The focus of IEC activities is on promoting safe behaviours, reduction of stigma and discrimination and demand generation for HIV/AIDS services. Under Phase-II of Red Ribbon Express (RRE) project, the special exhibition train on HIV/AIDS and other health issues completed one year's journey on 1 December, 2010 traversing 25,000 kms and covering 152 stations in 22 states. It disseminated messages on HIV prevention, treatment and care and support, besides information on common diseases, provided free HIV counseling and testing services and general health check-up, and offered training on HIV/AIDS to resource persons. The project received an overwhelming response all across the country - 80 lakh persons were reached, 81,000 resource persons trained and 45,000 (as on 15th February, 2011) people tested for HIV – making it the world's largest mass mobilisation programme.

Multimedia campaign in the 8 states of the North East, through music and sports, has been very successful in mobilising youth, political and religious leaders and opinion makers for spreading message of HIV/AIDS prevention. Two national workshops were organised in New Delhi covering 16 states on dissemination of HIV/AIDS messages through folk media, to develop standardised scripts and folk performances for better and more effective utilisation of this medium for HIV/AIDS messaging. Action plans were developed for roll out of folk media campaign.

Mainstreaming: As part of the initiative to mainstream HIV/AIDS response, about 8.39 lakh front line workers and personnel from various Government Departments, Civil Society Organisations and corporate sector were trained. Strengthening convergence of NACP with the National Rural Health Mission (NRHM) was approved by the Ministry of Health and Family Welfare and shared with the states for implementation. It emphasises optimal utilisation of existing NRHM resources for strengthening NACP services and vice versa. The Tribal Action Plan has been rolled out in 65 Integrated Tribal Development Project (ITDP) areas in A&B category districts. An International Conference on 'Mainstreaming HIV & AIDS: Role of Insurance Sector in India' was organised

in New Delhi on 3-4 February, 2011 to evolve a road map for facilitating inclusion of HIV in the ambit health insurance schemes.

Condom Promotion: NACO launched the third phase of the Condom Social Marketing Programme on 1 July, 2010 in 370 high priority districts across 26 states/UTs through 8 Social Marketing Organisations. Till January 2011, 25.5 crore pieces of condom were distributed though 5.46 lakh condom outlets. Special focus was given to establishing rural outlets, non-traditional outlets, outlets in TI project areas and truck halt-points. Focus is on optimising the supply of free condoms, ensuring its availability to vulnerable populations and minimising the wastage of free condoms. The SACS distributed 30.3 crores free condoms between April 2010 and January 2011. Other initiatives include setting up Condom Vending Machines, Female Condom scale-up and condom promotion through enhanced mid-media contacts.

HIV Counseling and Testing Services: These services were provided to 106 lakh persons including 45.9 lakh pregnant women through 5,233 stand-alone ICTCs, 1,632 facility integrated ICTCs at 24x7 PHCs and 668 ICTCs under Public Private Partnership model from April to December 2010. Out of 12,429 pregnant women who tested HIV positive, 8,492 mother-baby pairs received Nevirapine prophylaxis to prevent the mother to child transmission of HIV. Around 42,505 patients with HIV-TB co-infection were identified.

Care, Support and Treatment (CST) for PLHA: CST programme provides prevention and treatment of opportunistic infections, Anti-Retroviral Therapy (ART), psychosocial support, home-based care, positive prevention and impact mitigation. Around 3.84 lakh PLHA including 22,837 children are receiving free ART through 292 ART centres and 550 Link ART Centres. Ten Centres of Excellence and 7 Regional Paediatric Centres provide tertiary level specialist care and treatment, Second line and Alternate First Line ART, management of complicated Opportunistic Infections and specialised laboratory Services to children. Currently, 1,929 persons are receiving free second line ART. 255 Community Care Centres provide psycho-social support, ensure drug adherence, treat opportunistic infections and trace lost to follow-up cases. Early Infant Diagnosis programme to closely monitor HIV-exposed infants their identify HIV status and provide them appropriate treatment to reduce HIV related mortality and morbidity has been rolled out through 766 ICTCs and 181 ART centres; 9,016 infants and children under 18 months of age were tested under this programme till January 2011.

New initiatives include universal access of second line ART for adults and adolescents following orders of the Hon'ble Supreme Court of India; ART Plus Scheme to upgrade selected good functioning ART centres to ART Plus centres that can provide second line ART; setting up of 30 to 50-bedded Comprehensive Care & Support Centres (CCSC) as referral or mentoring centres to other CCCs and providing higher level care including management of major OIs, referral for specialised services, rehabilitation and palliative care; and LAC Plus Scheme to upgrade LACs with over 70 PLHA on ART to provide enrolment of PLHA and pre-ART management including basic investigations.

Laboratory Services: Capacity of laboratories for CD4 testing has been strengthened with 211 CD4 machines. The assurance of quality in kit evaluation and assessment of HIV testing services through implementation of External Quality Assessment Scheme (EQAS) are given focus. Seven laboratories conduct viral load testing to support clinical decision-making for starting second line ART.

Strategic Information Management: The newly developed Strategic Information Management System was launched on August 26, 2010 and training is underway to make it operational countrywide. To strengthen HIV/AIDS Research in the country, a number of key activities were initiated. The Network of Indian Institutes involved in HIV/AIDS Research (NIIHAR) has been expanded with 42 member institutes. A National Consultation on Operational Research in PPTCT and Paediatric HIV Care and Treatment in India, two training workshops on Operational Research and Capacity Building Workshop on Ethics in HIV/AIDS Research were organised. A National Conference on HIV/AIDS Research on the theme 'Towards Evidence-Policy linkages in HIV/AIDS Research in India' was organised from 19–21 January 2011 at New Delhi. A Continuing Education Workshop on "HIV/AIDS research in India – Perspectives and Challenges" was conducted on 18 January, 2011 for young scientists from NIIHAR institutes.Thirteen young researchers were awarded the NACO Research Fellowships in 2010. During 2010-11, NACO is conducting the

12th round of HIV Sentinel Surveillance (HSS) at 1,361 sites, with around 4.4 lakh samples expected to be collected. The HIV estimates for 2008 and 2009 were developed through improved methodology, updated epidemiological data from the latest rounds of HSS and other information on High Risk Groups, using Estimation Projection Package and Spectrum Package. The second phase of epidemiological profiling of HIV situation at district/sub-district level using data triangulation was completed. A framework for reprioritisation of districts with inputs from the data triangulation exercise has been developed.

Finance: For FY 2010-11, against the revised estimate of Rs.1400.22 crores, an expenditure of Rs 1060.44 crores (76%) was incurred (as on 4 March, 2011). Special efforts were taken to build in systems both at NACO and SACS levels for effectively managing resource mobilisation and fund utilisation. E-Transfer facility to avoid transit delays in transfer of funds to states has been implemented last year. Payment of salary to staff in district and peripheral units is made totally through e-transfer. A systematic process of review of SACS' Annual Action Plans for 2011-12 is underway during February and March, 2011.

Results Framework Document: For the performance of various activities in the Results Framework Document 2009-10, the Department of AIDS Control scored 92.89 percent and "Excellent" rating from the Performance Management Division of the Cabinet Secretariat.

While consolidating the progress achieved, the Department of AIDS Control is committed to developing and implementing effective evidence-based strategies with active involvement of all stakeholders towards achieving the goals and objectives of NACP-III.

SAYAN CHATTERJEE
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Date: 15 March, 2011
New Delhi

CHAPTER 1

Introduction

In 1992, the Government of India demonstrated its commitment to combat the disease with the launch of the first National AIDS Control Programme (NACP-I).

Though India is a country with low HIV prevalence, it has the third largest number of people living with HIV/AIDS. As per HIV estimates 2008-09, there are an estimated 23.9 lakh people living with HIV/AIDS in India with an adult prevalence of 0.31 percent in 2009. Most infections occur through heterosexual transmission. However, in certain regions, injecting drug use, men who have sex with men and single male migrants are contributing for the spread of HIV epidemic. The heterogeneous spread of the HIV epidemic is evident from the fact some pockets show high prevalence than the others.

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

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

In November 1999, the second National AIDS Control Programme (NACP-II) was launched with World Bank credit support of USD 191 million. Based on the experience gained in Tamil Nadu and a few other states, along with the evolving trends of the HIV/AIDS epidemic, the focus shifted from raising awareness to changing behaviour, decentralisation of programme implementation to the state level

and greater involvement of NGOs. The policy and strategic shift was reflected in the two key objectives of NACP-II:

- To reduce the spread of HIV infection in India.
- To increase India's capacity to respond to HIV/AIDS on a long-term basis

Policy initiatives taken during NACP-II included adoption of National AIDS Prevention and Control Policy (2002), National Blood Policy, a strategy for Greater Involvement of People with HIV/AIDS (GIPA), launching of National Adolescent Education Programme, provision of Anti-Retroviral Treatment (ART), formation of an inter-ministerial group for mainstreaming, and setting up of the National Council on AIDS chaired by Hon'ble Prime Minister.

Implementation Structure

NACO being at the apex level, the National AIDS Control Programme is implemented through 35 State AIDS Control Societies in the States and the Union Territories. In addition, there are three Municipal AIDS Control Societies in Mumbai, Chennai and Ahemadabad. A major structural reform has been initiated under NACP-III by constituting District AIDS Prevention and Control Units (DAPCUs) with a team of field functionaries in A and B category districts for decentralised response. A National Technical Support Unit (NTSU) at NACO as well as Technical Support Units (TSUs) in the State AIDS Control Societies have been established to provide external technical support on key aspects of the programme.

National AIDS Control Programme Phase-III

Consolidating the lessons learnt during NACP-II, the third phase of NACP was developed through a rigorous process of reviewing evidence and consultations with national and international experts. The overall goal of National AIDS Control Programme Phase-III (2007-2012) is to halt and reverse the epidemic in India over the five year period. The programme hopes to achieve this through a four pronged strategy:

- Prevent new HIV infection through saturation of coverage of high-risk groups with Targeted Interventions (TI), and a scaled up interventions for the general population.
- Provide greater care, support and treatment to a larger number of People Living with HIV/AIDS (PLHA). Address human rights and ethics issues with focus on fundamental rights of the PLHA and their active involvement.
- Strengthen the infrastructure systems and human resources in prevention, care and support and treatment at the district, state and national levels.
- Strengthen the nationwide Strategic Information Management System.

Guiding Principles for NACP-III

The strategies and approaches of NACP-III are guided by the following principles:

- The unifying credo of Three Ones, i.e., one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National Monitoring and Evaluation System.
- Equity is to be monitored by relevant indicators in both prevention and impact mitigation strategies i.e. percentage of people accessing services disaggregated by age and gender.
- Respect for the rights of PLHA, as it contributes most positively to prevention and control efforts.
- Civil society representation and participation in the planning and implementation of NACP-III is essential for promoting social ownership and community involvement.
- Creation of an enabling environment wherein those infected and affected by HIV can lead a life of dignity. This is the cornerstone of all interventions.
- For making the implementation mechanism more responsive, proactive and dynamic, the HRD strategy of NACO and SACS is based on qualification, competence, commitment and continuity.
- Strategic and programme interventions are to be evidence-based and result oriented with scope for innovations and flexibility. Priority is accorded to specific local contexts.

NACP-III is based on the experiences and lessons drawn from NACP-I and II, and is built upon their strengths. Its priorities and thrust areas are drawn up accordingly and include the following:

- Considering that more than 99 percent of the population in the country is free from infection, NACP-III places the highest priority on preventive efforts, while, at the same time, seeks to integrate prevention with care, support and treatment.
- Sub-populations that have the highest risk of exposure to HIV will receive the highest priority in the intervention programmes. These would include sex workers, Men who have Sex with Men (MSM) and Injecting Drug User (IDU). Second

high priority in the intervention programmes is accorded to long-distance truckers and single male migrants.

- In the general population, those who have the greater need for accessing prevention services, treatment of STIs, voluntary counseling and testing and condoms promotion will be next in the line of priority.
- NACP-III ensures that all persons who need treatment would be provided the access to ART, besides prophylaxis and management of opportunistic infections.
- Prevention needs of children are addressed through universal provision of Prevention of Parent to Child Transmission (PPTCT) services. Children who are infected are assured access to paediatric ART.
- NACP-III also plans to invest in community care centres to provide psycho-social support, outreach services, referrals and palliative care.
- Socio-economic determinants that make a person vulnerable also increase the risk of exposure to HIV. NACP-III will work with other agencies involved in vulnerability reduction such as women's groups, youth groups, trade unions etc. to integrate HIV prevention into their activities.
- Mainstreaming and partnerships are the key approaches to facilitate multi-sectoral response, engaging a wide range of stakeholders. Private sector, civil society organisations, networks of people living with HIV/AIDS and government departments, all have a crucial role in prevention, care, support, treatment and service delivery. Technical and financial resources of the development partners are leveraged to achieve the objectives of the programme.

Technical Resource Groups

Technical expertise in priority areas has been mobilised through Technical Resource Groups. TRG have been constituted for every thematic area of the National AIDS Control Programme to provide expert advice on policy matters and broad implementation strategies. These TRGs comprise of national and international experts and distinguished scholars. Nineteen such TRGs are currently functional covering areas such as Targeted Interventions (FSW, MSM, IDU & OST, Migrants), Counseling and Testing, Prevention of Parent to Child Transmission, IEC, Interventions for Youth, Blood Safety, Condom Programme, Link Worker Scheme, Management of STI/RTI, Anti-Retroviral Treatment, Paediatric Care, Community Care Centres, HIV-TB Coordination, Laboratory Services, Surveillance & Estimations and Research & Development.

Table 1.1: Progress in Achievement of Physical Targets Listed in Outcome Budget of the Department of AIDS Control for 2010-11

S. No.	Indicator	Target 2010-11	Achievement (till February 2011)
1	New core group targeted interventions set up	110	152
2	New bridge population targeted interventions set up	30	23
3	New STI cases managed	100 lakh	84.9 lakh#
4	New Blood Component Separation Units set up	12	26
5	New District Level Blood Banks set up	6	7
6	Treat persons living with HIV/AIDS with anti-retroviral drugs	4,04,815	3,87,205*
7	No. of Anti-Retroviral Therapy Centres (Cumulative)	332	292*
8	Community Care Centres (Cumulative)	316	255*
9	New Integrated Counseling and Testing Centres set up	40	36
10	Mothers counseled & tested at ICTC	86.49 lakh	50.48 lakh#
11	Persons counseled & tested at the ICTC	111.71 lakh	66.62 lakh#

till January, 2011 *including ART centre under inter-sectoral collaboration, as on December, 2010

CHAPTER 2

Current Epidemiological Situation of HIV/AIDS

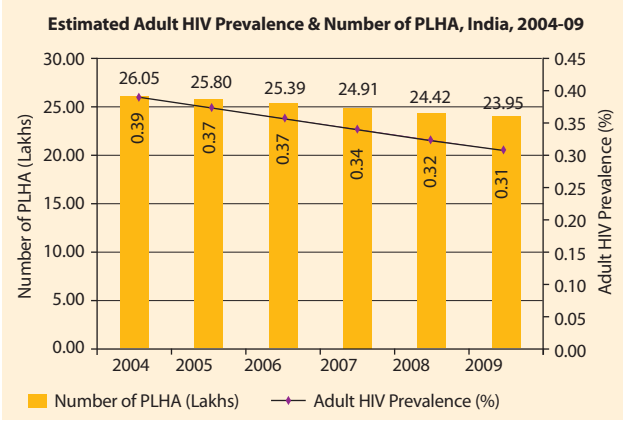
Analysis of epidemic projections revealed that the number of new annual HIV infections has declined by more than 50 percent during the last decade, 2.7 lakh in 2000 to 1.2 lakh in 2009.

HIV epidemic in India is concentrated in nature. The HIV prevalence among the High Risk Groups, i.e., Female Sex Workers, Injecting Drug Users, Men who have Sex with Men and Transgenders is about 20 times higher than the general population. Based on HIV Sentinel Surveillance 2008-09, it is estimated that India has an adult prevalence of 0.31 percent with 23.9 lakh people infected with HIV, of which, 39 percent are female and 3.5 percent are children. The estimates highlight an overall reduction in adult HIV prevalence, HIV incidence (new infections) as well as AIDS related mortality in India.

HIV Incidence: One of the key characteristics of the recent round of estimations is that it allowed for generating estimates of the HIV incidence (number of new HIV infections per year). Analysis of epidemic projections revealed that the number of new annual HIV infections has declined by more than 50 percent during the last decade. It is estimated that India had approximately 1.2 lakh new HIV infections in 2009, as against 2.7 lakh in 2000. This is one of the most important evidence on the impact of the various interventions under NACP and scaled-up prevention strategies.

While this trend is evident in most states, some low prevalence states have shown a slight increase in the number of new infections over the past two years; this underscores the need for the programme to

Fig. 2.1: Trends of HIV in India, 2004-09



Source: HIV Estimations 2010

focus more on these states with low prevalence, but high vulnerability.

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

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

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

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

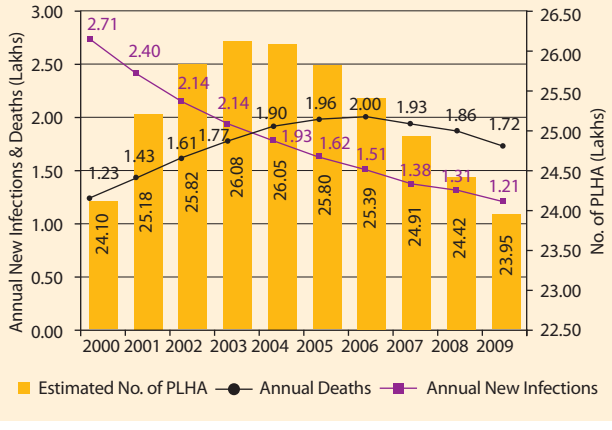
A clear decline is also evident in HIV prevalence among the young population (15-24 yrs) at national level, both among men and women. Stable to declining trends in HIV prevalence among the young population (15-24 yrs) are also noted in most of the states. However, rising trends are noted in some states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

People Living with HIV/AIDS (PLHA): The total number of people living with HIV/AIDS (PLHA) in India is estimated at 23.9 lakh (19.3 – 30.4 lakh) in 2009. Children under 15 yrs account for 3.5 percent of all infections, while 83 percent are the in age group 15-49 years. Of all HIV infections, 39 percent (9.3 lakhs) are among women. The four high prevalence states of South India (Andhra Pradesh–5 lakhs, Maharashtra–4.2 lakhs, Karnataka–2.5 lakhs, Tamil Nadu–1.5 lakhs) account for 55 percent of all HIV infections in the country. West Bengal, Gujarat, Bihar and Uttar Pradesh are estimated to have more than one lakh PLHA each and together account for another 22 percent of HIV infections in India. The states of Punjab, Odisha, Rajasthan & Madhya Pradesh have 50,000–1 lakh HIV infections each and together account for another 12 percent of HIV infections. These states, in spite of low HIV prevalence, have large number of PLHA due to the large population size.

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

AIDS Related Deaths: Using globally accepted methodologies and updated evidence on survival to HIV with and without treatment, it is estimated

Fig. 2.2: Decline in No. of PLHA as a Result of Greater Decline in New Infections, Despite Increased Survival of PLHA due to ART



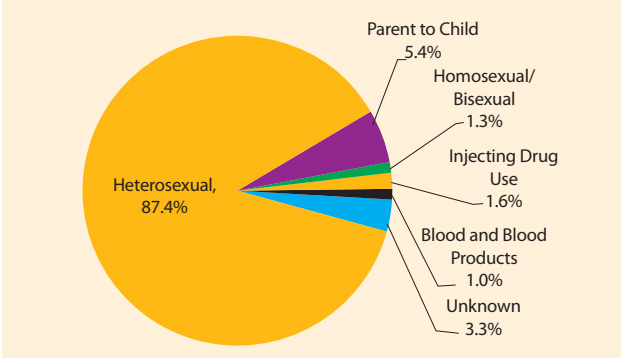
Source: HIV Estimations 2010

that about 1.72 lakh people died of AIDS related causes in 2009 in India. Wider access to ART has resulted in a decline of the number of people dying due to AIDS related causes. The trend of annual AIDS deaths is showing a steady decline since the roll out of free ART programme in India in 2004.

The primary drivers of HIV epidemic in India are commercial female sex workers, unprotected sex between men who have sex with men, and injecting drug use. It is estimated that there are 12.63 lakh Female Sex Workers, 3.5 lakh Men who have Sex with Men with high risk behaviour and 1.86 lakh Injecting Drug Users in India. Sex work continues to act as the most important source of HIV infection in India due to the large size of clients who get infected from sex workers. Clients of sex workers further transmit HIV infection to general population particularly low risk women and Single Male Migrants constitute a significant proportion of clients of sex workers HIV prevalence among different risk groups is shown in Fig. 2.4.

Routes of Transmission: Based on Programme data, unprotected sex (87.4% heterosexual and 1.3% homosexual) is the major route of HIV transmission, followed by transmission from Parent to Child (5.4%) and use of infected blood and blood products (1.0%). While Injecting Drug Use is the predominant route of transmission in north eastern states, it accounts for 1.6 percent of HIV infections.

Fig. 2.3: Routes of Transmission of HIV, India, 2010-11 (till Jan. 2011)

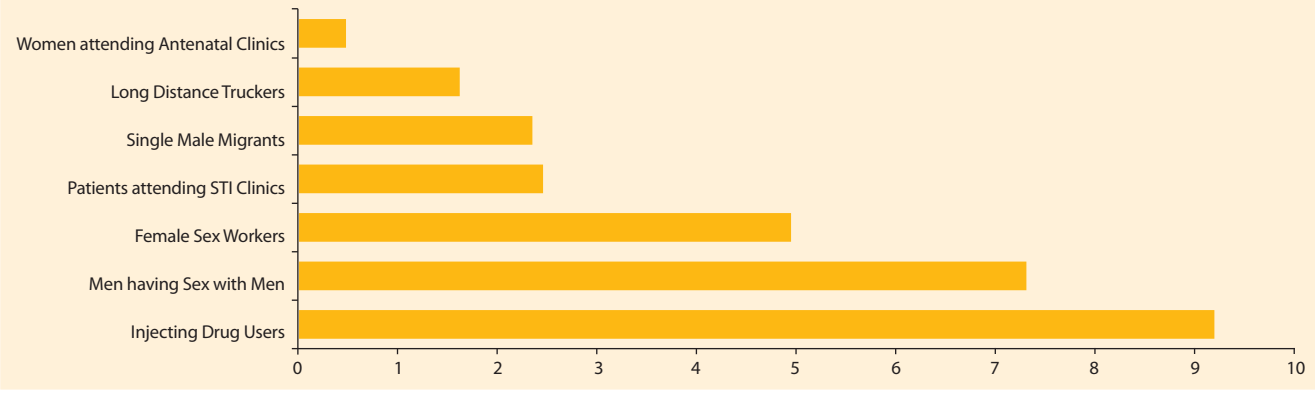


Source: NACO-CMIS

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

Thus, HIV epidemic in India is concentrated in nature and heterogenous in its spread. While interventions have brought successful decline in HIV epidemic at most of the places, emerging pockets and risk groups with high vulrerability warrant focused attention under the programme.

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



Source: HIV Sentinel Surveillance, 2008-09

CHAPTER 3

Targeted Interventions

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

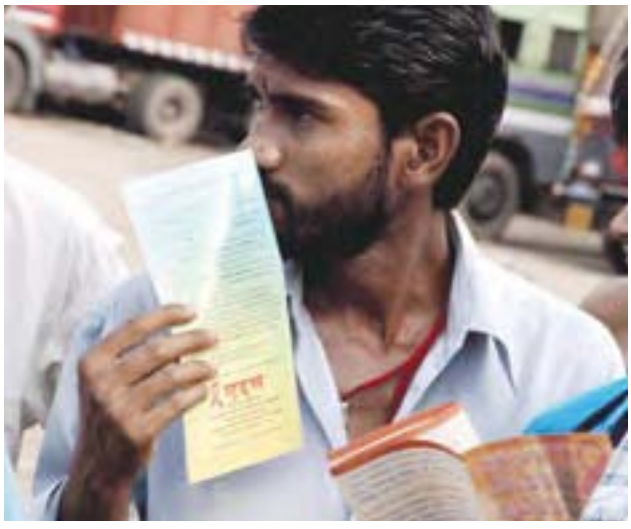
The key risk groups covered through Targeted Intervention (TI) programme include

- High Risk Groups (HRGs)
  - Female Sex Workers (FSWs)
  - Men who have Sex with Men (MSM) and Transgenders (TGs)
  - Injecting Drug Users (IDUs)
- Bridge Populations
  - Truckers
  - Migrants

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

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

Currently, the epidemic remains concentrated in specific high risk populations and their sexual partners. Therefore, prevention through focused interventions amongst these groups is of extreme importance.



IEC material distribution at TI site

Core group interventions under NACP-III

TIs for Female Sex Workers (FSWs)

During the formulation of NACP-III, it was estimated that there are 12.63 lakh Female Sex Workers in the country, scattered in different states. Revised mapping done in 2009 has estimated the number of FSWs as 8.68 lakh. Out of that, 6.78 lakh FSWs have been covered through TI projects. TI projects cover different typologies of sex workers namely, brothel based, street based, home based, lodge based, dhaba based, bar girls etc. with specific intervention strategies. There are 26 TI projects implemented by Community Based Organisations reaching out to FSWs.

TIs for Men who have Sex with Men (MSM) and Transgenders (TGs)

NACO has given significant thrust to the interventions for MSM and TGs as still the prevalence among these groups is considerably high. While the estimations at the time of formulation of NACP-III put the numbers of MSM and TGs at maximum risk as 3.51 lakh, the estimation in 2009 revised their numbers to 4.12 lakh. Through TI projects, 2.85 lakh (69%) MSM and TGs have been covered with services. 37 such Targeted Intervention projects in the country are implemented by the CBOs managed by the community. NACO has given more focus to reach out transgender populations as this group needs specific intervention package for prevention of HIV/AIDS. NACO with development partners is in the process of developing Operational Guidelines for Transgender intervention. Under Global Fund Round-9, The India HIV/AIDS Alliance is supporting the prevention programme to strengthen community institutions and systems for MSM, *Hijras* and transgender interventions so that the outreach and quality of services are improved.

TIs for Injecting Drug Users

The number of IDUs estimated during NACP-III formulation was 1.86 lakh. Based on the revised mapping, estimation of IDU population in the country is 1.77 lakh. NACO has already covered 1.36 lakh (76%) IDUs through Targeted Intervention projects. More thrust has been given on IDU interventions as the prevalence among IDUs is showing an increasing trend. Under Global Fund Round-9, the principal recipient, Emmanual Hospital Association (EHA) is supporting NACO to strengthen the IDU intervention and Opioid Substitution Therapy **(**OST) services.

TIs for Bridge populations in NACP-III

Migrant Interventions

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

NACO has identified 122 districts with high out-migration (based on Census 2001) across 11 States which are on priority for starting up community level migrant interventions. Source interventions are being initiated in 108 districts in the States of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and West Bengal.

At source, the interventions are to be managed by two block-level supervisors (male and female)

A hoarding for migrants at a railway station in Mumbai

with support from ASHA workers, ANM, *Nehru Yuva Kendra* volunteers, members of the SHGs and PRIs. They would reach out to families of migrants with information and services including information on various social security instruments like RSBY. Health melas are to be organised at block level during festivals when migrants return to their villages. These melas promote health seeking behaviour as well as HIV testing and counselling services.

Besides, there are 75 important transit locations that have been identified across these 122 districts from where migrants usually board long distance trains/buses to reach their destinations (usually work places). Transit interventions have started at 47 locations across eight states covering migrants at railway stations and bus stops where inter-state migration occurs. At transit, the part time outreach workers, placed with existing interventions, conduct one to group sessions on HIV prevention before the arrival of the train/bus . Besides this, they distribute migration kits containing information booklet on services available in major destinations (as identified for specific source- destination corridor), condoms, daily utility materials like small notebook, ball pen, comb, etc. This strategy is to reinforce the HIV prevention messages and encourage out going migrants to seek services at destination.

Currently, there are 236 SACS-funded migrant interventions covering 40 lakh migrants in 32 States. The sectors mainly include industries, agriculture and transport. This includes 30 interventions funded by USAID in Maharashtra and Tamil Nadu.

Truckers' Interventions

Currently there are 76 Truckers interventions managed by SACS and 12 managed by the TCI Foundation funded by Avahan project of Bill & Melinda Gates Foundation (BMGF). These interventions are presently targeting 20.97 lakh truckers providing STI health care services, risk reduction counseling and condoms. It is planned that during 2011-12, all the truckers' interventions funded by Project Avahan will be transitioned to State AIDS Control Societies. The clinics at Trans-Shipment Locations have been co-branded as *Khushi-Suraskha clinics*. IEC materials addressing issues such as self esteem, risk perception and services are made available. Besides this, there are 51 locations where condom social marketing initiatives have been implemented to promote risk reduction.

The Truckers Technical Support Group monitors and supports the quality of interventions in all 86 sites. The Behaviour Change Communication (BCC) materials, training kits and micro plan have been revised for each site to suit the local needs and maximise the impact of interventions.

Services under Targeted Intervention Projects in NACP-III

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

- Treatment for Sexually Transmitted Infections (STIs)
- Condom provision – male and female condoms
- Provision of clean needles and syringes
- Behaviour change communication
- Creating an enabling environment with community involvement and participation and
- Linkages to testing, care and support services
- Opioid Substitution Therapy (OST) Intervention has been added to IDU intervention programme in NACP-III.**:** Fifty two OST Centres have been contracted after accreditation by the National Accreditation Board for Health Providers (NABH). These accredited centres have been contracted by the concerned SACS to implement OST. In addition, NACO has initiated a pilot of OST in Public Health settings in the state of Punjab in October, 2010. The pilot project is currently being implemented successfully in five districts of the State and more than 400 hundred clients have been put on treatment as of February, 2011. In

Condom display at TI site

all, NACO is implementing OST across 15 states of the country and provides free treatment to approximately 5,350 IDUs.

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

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

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

Designing of TIs under NACP-III

While planning NACP-III, an expert group was constituted to analyse the available primary data to arrive at the estimate of High Risk Group population in the country. As per their report the estimated number of high risk group population was 18 lakh, besides approximately 120 lakh bridge population. The group-wise break-up is given in Table 3.2

Later, a mapping exercise was carried out by NACO with SACS, which was initiated in 2008 in 21 states of the country. Validation of the estimation was done by International Institute of Population Sciences (IIPS), Mumbai and experts groups in all 21 states. Besides the estimates, the reports also provide information on:

- The hot spots in the districts mapped
- The vulnerability factors among the HRGs in the district/state
- Service providers in the vicinity

Based on this information, the numbers and type of Targeted Interventions required in each state are ascertained and planned.

Roll out of Targeted Intervention Projects

To ensure the effective and transparent implementation of the Targeted Interventions separate and specific operational guidelines have been prepared. These include Operational guidelines for core target population and bridge population; Operational guidelines for procurement and Financial management of NGOs and CBOs. Separate costings guidelines were also prepared for core and bridge group population interventions and CBO led interventions.

In 2009, the costing was revised for core target groups and Truckers interventions in response to various assessment and feedback to suit the NACP-III strategy. Many amendments have been made which include provision of Monitoring and Evaluation officers for the TI with above 800 populations, combining Drop-In Centre and office of TI, incentives for Peer Educators for taking HRG member for Anti-Retroviral Therapy (ART) and provision of travel for each programme staff along with revision in the salary.

NACO has recently revised costing guidelines for destination migrant interventions based on the need of revised strategy, which stresses upon peer leadership, enabling environment through community level drop-in-centres, support for social marketing of STI drugs and support for management by Project Director.

Support mechanisms to ensure quality of interventions

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

- **Standardisation of the tools for collection of data:** Tools for collecting data on registration of HRGs to their tracking, provision of services, and referral system, have been developed which will feed into the newly developed Strategic Information Management System (SIMS). Regional level trainings on the same have been conducted for the newly recruited district based Project Officers, as well as point persons in SACS and Technical Support Units (TSU).
- **Developing a quality guide for TIs:** To ensure a standard process, a guide has been developed which covers how the data flows from outreach to reporting level at TI and finally into Computerised Management Information System (CMIS). In addition, methods to check factuality of information, timelines and defining the roles and responsibilities of staff in collecting data, is also covered in the guide.
- **Monthly tracking of CMIS report** from TIs is being done at NACO; regular feedback to the SACS is provided on how many TIs are reporting. The SACS are encouraged to examine the data

collected from CMIS and provide feedback to the TI. The number of units reporting has increased which shows that there has been a consistent improvement in the uptake of services in the TI.

- **Technical Support Unit (TSU):** A National Technical Support Unit (NTSU) at NACO as well as Technical Support Units (TSUs) have been established in fifteen states to provide technical support on key aspects of the TI programme. TSUs support the SACS in implementation of TI in respective states. They follow the NACP-III guidelines and then facilitate its implementation along with the partner organisations. TSUs also facilitate the designing, planning, implementation and monitoring of TIs in the states and provide management and technical support to the SACS.
- **Supportive Supervision and Monitoring: With the rapid scale up of TIs,** NACO recognised the need to improve the supervision of TIs to ensure their quality. A strengthened organisational structure was needed for TI supervision and monitoring. This led to the formulation of plan for supportive supervision of TIs with one Project Officer for 10 TIs to handhold the TIs. POs are placed at regional level to ensure effective support mechanism and supervise the TIs on a daily basis.

The POs ensure that all TIs are visited once every month. The supportive supervision includes one day visits and intensive visits to ensure the quality of TIs.

Every three months, the POs conduct an assessment of the TIs. The assessment provides the SACS with a index of TI performance.

- Technical Support Group (TSG) – Technical Support Groups on condom programme and Truckers interventions work closely with NACO and SACS. TSG on condoms ensures the accessibility and availability of condoms with all TI projects.

Capacity Building activities for TIs: Training the TI staff on implementation is a crucial step towards effective implementation of the TIs. As a result, NACO has developed a cadre of state based master trainers. However, with expansion of TIs, there has been a need to institutionalise the training. State Training and Resource Centres (STRCs) have been established in order to improve quality of training in a systematic manner.

- STRCs are designed to provide training and develop the capacity of TI projects staff to ensure the quality of interventions. They work closely with the states and TSUs to develop the capacity of TI NGOs. Specific Terms of Reference have been developed to include training activities, mentoring and impact assessment through field visits, conducting operational research in training needs and developing State specific documentation and resource Centre. Thus STRCs in a way are building local resources to ensure that overall capacity in learning and training of States improves. Currently, there are 18 STRCs covering 31 State AIDS Control Societies. The process of establishing five more STRCs is in pipeline.
- NACO has developed segment specific training modules and trained the STRC and TI staff in SACS on the same. For IDU intervention apart from the existing modules on harm reduction, waste disposal, programme management and outreach, a training module on counseling for IDUs, reaching out to Female Partners of IDUs, and training of staff of OST centres are being developed with support from various technical partners.
- **Preferred Private Provider (PPP)** scheme for STI management has been rolled out across India. All the programme managers of TIs are trained on this model to strengthen the TIs. All the local STI care providers are being trained in TI by master trainers.
- The trainings conducted or TI staff in states during 2010-11 are shown in Table 3.1.

Table 3.1: Details of Training Activities Conducted by TI Division Across the Country

Area of Training	Category of Participants	Number
Programme Management	Programme Manager of TIs	1,268
Out-reach Management	Out-reach Workers	2,862
Counseling and Risk Reduction	Counselor	1,300
Peer Education	Peer Educators	7,603
Financial Management	Accountants	1,280

Fig 3.1: Key Performance of the Targeted Intervention

Table 3.2: Population-wise Distribution of TI Projects and their Coverage*

Typology	NACP-III Estimates	Mapping Estimates**	Current Coverage in TIs	No. of TIs	TI Coverage (%)
	(Figures in lakhs)				
Female Sex Workers (FSW)	12.63	8.68	7.08	454	81.5%
Men-who-have-sex-with-Men (MSM)	3.51	4.12	2.85	155	69.%
Injecting Drug Users (IDU)	1.86	1.77	1.36	261	76%
Migrants	42.0	73.0	29.46	212	40.35%
Truckers	35.0	20.0	12	76	60%
Core Composite#				289	
Total				**1,447**	
Donor funded				**184**	
TOTAL TIs functioning				**1,631**	

* As on 31 March, 2011
** Mapping conducted for 21 states
# a mix of FSW, IDU and MSM, or FSW with MSM, or FSW with IDU, or MSM with IDU.

Annual Evaluations and Performance Deliverables: Specific deliverables are a part of contracts of every NGO to ensure that NGOs meet their targets both in quantity and quality. The types of deliverables are determined by the age of the project, and are now a focal point for monitoring visits and annual reviews.

An independent annual evaluation of NGO TIs is carried out by an inbuilt mechanism to check its progress, identify gaps for strengthening and further support. Evaluation teams of trained external consultants use a standard evaluation tool and manual to ensure uniformity. Team leaders are trained directly by NACO at various regional training centres.

The extension of contracts with NGOs is based on the recommendations of evaluations. A total of 1,169 NGO-led and CBO-led TIs were evaluated in 2010.

The evaluation reports of the TIs as well as CBOs have been analysed, and feedback given to respective states. The key performance of the TIs for the period April to September 2010 shows a marked increase over that for the corresponding period of 2009 (Fig 3.1).

Programme performance- Tested at ICTC

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

Apart from NACO-supported TIs, development partners, including the USAID and the Bill and Melinda Gates Foundation (BMGF), implement more than 200 HRG and bridge population TIs in the country. They work in the six high prevalence states (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu), where USAID supports interventions with migrants, and the BMGF supports interventions with truckers and male clients of sex workers.

A transition plan of TIs from Avahan (BMGF) and USAID has been developed. As part of the BMGF transitioning plan, 10% of the interventions have been transferred to the SACS according to their location (in Andhra Pradesh, Mumbai, Karnataka and Tamil Nadu) in 2009. While 20% will be transitioned in 2011, for which assessment process has been completed. The remaining 70% will be transitioned by the end of NACP-III in 2012. NACO/TNSACS has already taken nine TIs from USAID (APAC) as per transition plan with USAID. Before the transfer, each TI is evaluated by an external group of consultants to assess the status of the programmes. This also provides a baseline for monitoring further progress. The donor-funded TIs identified for transition have been aligned to follow the costing guidelines laid down by NACO.

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

State/UT	No. of Targeted Intervention NGOs						Total
	FSW	MSM	IDU	Migrants	Truckers	Core Composite	
Andhra Pradesh	35	6	5	18	5	33	70
Arunachal Pradesh	6	0	3	6	0	6	21
Assam	38	5	9	6	1	2	58
Bihar	8	3	15	0	1	14	45
Chhattisgarh	10	2	3	6	2	10	33
Goa	6	3	2	2	2	1	19
Gujarat	16	19	3	28	7	40	114
Haryana	13	7	16	7	0	8	41
Himachal Pradesh	11	0	2	4	0	3	23
Jammu & Kashmir	3	1	1	2	0	0	6
Jharkhand	27	4	4	0	3	0	31
Karnataka	16	9	2	12	4	5	34
Kerala	20	14	8	8	2	8	53
Madhya Pradesh	19	10	9	5	4	23	67
Maharashtra	21	5	2	37	11	1	87
Manipur	6	3	44	2	0	1	54
Meghalaya	3	0	3	1	0	1	12
Mizoram	2	1	23	2	0	7	41
Nagaland	0	2	25	1	1	12	39
Odisha	19	4	8	12	1	25	67
Punjab	6	0	11	3	3	9	47
Rajasthan	23	5	5	11	3	11	55
Sikkim	2	0	2	0	0	0	7
Tamil Nadu	15	15	2	6	5	10	53
Tripura	8	1	2	2	0	1	18
Uttar Pradesh	11	5	16	0	7	50	96
Uttarakhand	11	2	4	6	0	4	27
West Bengal	41	10	11	7	8	0	63
Chandigarh	4	2	2	3	0	1	13
D&N Haveli	0	0	0	2	1	0	3
Daman & Diu	0	0	0	4	1	2	3
Delhi	40	17	20	8	4	0	84
Puducherry	0	0	0	1	0	1	1
Total	454	155	261	212	76	289	1447

CHAPTER 4

Link Worker Scheme

The Link Worker Scheme (LWS) under NACP-III has specifically been designed to address populations with high-risk behaviours (including the 'High Risk Groups' and 'Bridge Populations') as there are significant numbers in rural areas that need to be reached. In addition, the Scheme also cover young people. It is being implemented in identified priority districts of the country.

Under the short-term, "meso-level" strategy, the services established through the LWS have been linked to local health governance system at three levels. This ensures mainstreaming of the HIV response and thus project sustainability:

Level 1: Village Panchayat: The Link Worker work closely with the existing health workers such as the Auxiliary Nurse Midwives, Accredited Social Health Activists (ASHA) and Anganwadi (Child Development and Nutrition) workers. They also work with the Health and Sanitation Committee of the Village local body and local institutions, groups, youth clubs, schools, etc.

Level 2: District Level: At the District level, the Project work very closely with the District AIDS Prevention and Control Units (DAPCU) and the District Programme Management Unit of the NRHM. These are responsible for monitoring of various HIV/AIDS programmes and ensure integration both programmatically and institutionally with the district structures.

Level 3: The LWS at the district and village level works with different departments that have activities/ outreach to communities by mainstreaming HIV within their programmes by, for example, ear-marking a dedicated time period for life skills education in senior secondary schools.

The services established through the LWS have been linked to local health governance system at three levels. This ensures mainstreaming of the HIV response and thus project sustainability.

Implementation Strategy at District Level

In every identified district, 100 villages with vulnerabilities are chosen as core villages and another 500 proximal villages are covered (600 villages per district). For every five core villages (cluster) there

are two link workers (1 male, 1 female). Link workers will be monitored by the Supervisor. Volunteers will be identified by the link workers to support them in various activities in the village for HIV prevention. While selecting the Volunteers representation is ensured from different cultural, political, social and religious groups (such as Local elected leaders, SHG members, Youth leaders, Representatives from women groups, farmers, school or out of school students). The population reached is at least 5000 people in each of 100 core villages and 1,000 in each of 500 proximal villages; totally reaching 10 lakh people per district.

The scheme is implemented by through lead NGOs for each state for providing technical and administrative support to selected districts (for 4 or more). The lead NGOs in turn further sub contract district NGOs for implementation of the scheme at the village level. As per the revised costing guidelines, for the implementation of the scheme every lead NGO sanctioned an amount of approximately Rs 20.7 lakhs and district NGO is sanctioned approximately Rs 22.8 lakhs along with the budget of around Rs 5.36 lakhs for training and Rs three lakhs for communication/mid-media activities. Funds are also allocated at the central level for carrying out activities like procurement of communication kit, conducting reviews and outcome studies.

A Supportive Supervision System has been set up to provide management and technical support to the Project.For the current year the LWS is being implemented through UNDP, UNICEF, and USAID and through grants received from GFATM under Round-7(R7). Uniformity is being maintained through all implementing agencies by:

- Following common Operational Guidelines
- Mapping process and Tools
- A standard training Module, training institutes.

Progress under NACP-III in the Year 2010-11

Implementation and Expansion: With the beginning of Phase-II of GFATM support of the Link Worker Scheme in September 2010, the Scheme has been expanded from 60 districts to 119 vulnerable rural districts around the nation, with further expansion scheduled in 2011-12.

The distribution of Link Worker Scheme projects across different states is given in Table 4.1.

Table 4.1: State-wise Distribution of Districts Under LWS Projects Implemented, 2010-11

State	No. of Districts				Total
	LWS projects supported by Development partner				
	GFATM	UNICEF	UNDP	USAID/CDC	
Andhra Pradesh	19	3			22
Bihar		3	5		8
Chhattisgarh			3		3
Goa	1				1
Gujarat	8	3			11
Karnataka	8	4		16	28
Kerala	1				1
Madhya Pradesh	8				8
Maharashtra	24	5			29
Manipur	9				9
Mizoram	3				3
Nagaland	10				10
Odisha		1	6		7
Rajasthan		1	6		7
Tamil Nadu	21	1			22
Tripura	2				2
Uttar Pradesh		3	5		8
West Bengal	5	2			7
TOTAL	119	26	25	16	186

Apart from GFATM, the implementation of the LWS is supported in an additional 67 districts by USAID, CDC, UNDP and UNICEF.

Coverage: The population-wise coverage of LWS is shown in Table 4.2.

Table 4.2: Population-wise Coverage of LWS

Type of Population	Estimated population	Coverage (%)
High Risk Group	1,60,888	122.2*
Vulnerable Population	27,49,177	72.8
PLHIV	57,723	51.2

* Coverage exceeded mapped population

The distribution of Link Worker Scheme projects across different states is given in Table 4.1.

The HIV related services accessed by High Risk and vulnerable people due to the intervention of link workers are given in Table 4.3.

C**ondom Promotion Programme:** To increase the accessibility and availability of condom, condom depots are established in each village covered under the Link Worker Scheme. So far, 6,000 condom depots have been established as part of this scheme, and over 24 lakh condoms distributed through them.

Village Information Centres: To provide information on HIV to the rural population, village information centres have been established in each link worker village. As part of this Scheme, 6,000 village information centres have been established so far. In many cases, these centres were established with the support of local Panchayats and Health Department.

Red Ribbon Clubs (RRC): As youth are more vulnerable to HIV infection, the LWS gives importance to addressing the rural youth primarily out of school youth. In order to ensure participation of youth in HIV prevention programmes, RRC are organised in rural areas. Three thousand such clubs have been organised as part of this Scheme. The activities of RRCs include information dissemination, voluntary blood donation, condom promotion, cultural programmes and referrals to service centres.

Mid-media Programmes: For providing information on HIV and thereby promoting service uptake, IEC programmes are conducted in rural areas. The mid-media programmes include wall writings, wall paintings, folk performances and hoardings. These programmes are organised at the village level with support of PRIs, line departments and RRCs. Local-specific and culture-specific IEC programmes were selected to reach out to the rural people, especially the vulnerable and high risk population.

Mapping of High Risk Groups and Migrants: To have an evidence-based strategy for ensuring the saturation of coverage of HRG, and bridge and vulnerable population, mapping has been done by all the donors in 186 districts in 18 states. Mapping in 17 states has been completed by external agencies and validation of the data has been done by the staff of the district agency. Mapping in another 44 districts in eight states will takes place in FY 2011-12.

Development of Training Modules: The Link Workers have a critical role in the scheme which demands an enhanced capacity in terms of knowledge about the HIV and related issues and skills to interact and communicate with the community in an effective manner and involve them actively in various activities under the scheme. They further require positive change in their attitudes to respect and understand the PLHIVs and other high-risk and vulnerable groups.

Therefore, greater emphasis has been given, on building the capacities of this local human resource along with that of the District Resource Persons and the Supervisors who need to provide direction and support the Link Workers in achieving their goals. NACO has developed a series of training modules

Table 4.3: HIV Related accessed by High Risk and Vulnerable People due to the Intervention of Link Workers

Indicator	Mapped population	% of people accessed services (Cumulative)
High Risk individuals tested at ICTC	1,60,888	37%
High risk individuals consulted doctors for STI treatment	1,60,888	17%
PLHIVs referred to ART centres	57,723	N/A

N/A - data is unavailable

for the development of this human resource that includes Link workers, DRPs, Supervisors and Community Volunteers. The training modules have been developed for all the staffs under LWS.

All staff at district and state level have been trained on these modules. Details of staff trained on various modules are mentioned Table 4.4.

Same training modules have been adopted by all the donor partners.

Development of IEC Materials: A series of Communication materials have been developed under Link Worker Scheme for different sets of target. The prototype of some of the IEC materials is given below.

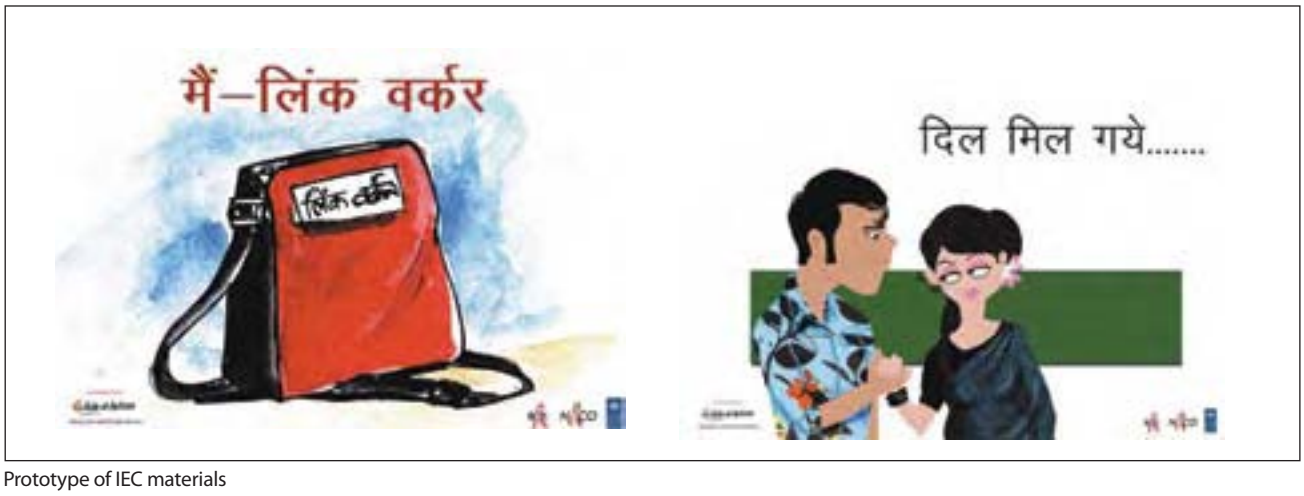
These information brochures are distributed by the Link Worker to people residing in rural areas. They outline the Link Worker's role in the rural setting, and often address strategic issues that would otherwise be considered taboo.

These "community games" allow for HIV-related messages to be communicated to people residing in rural areas. The Link Workers often make use of them to convey important HIV-related ideas.

Annual Evaluations and Performance Deliverables: In the current financial year, concurrent assessment of LWS was conducted in 44 districts (30 GFATM, 9 UNICEF, 5 UNDP) across 18 states. The concurrent assessment covered programmatic, management and financial aspects related to LWS. NACO has developed standard evaluation tool and manual to ensure the uniformity of evaluation across the country. The assessment was conducted by an external agency - IMACS.

Learning and Sharing Workshops

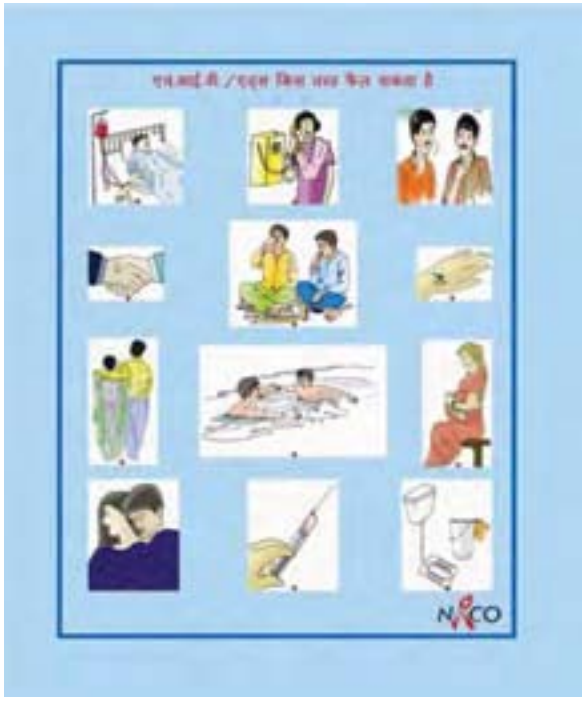
Since, the LWS in the country is being implemented by various partner organisations and SACS, it was felt that there is need of sharing the innovative/best practices developed by these organisations with wider audiences and bringing uniformity in the programmes implemented by various organisations.

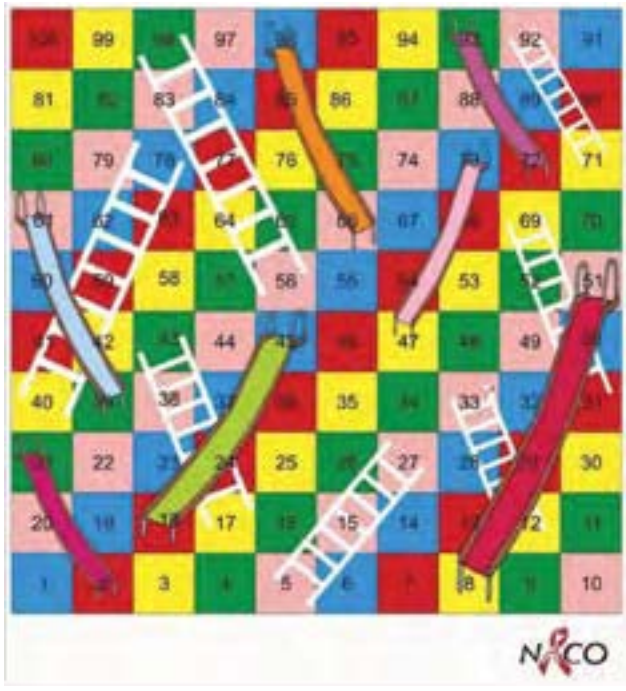


Prototype of IEC materials

Table 4.4: Cadre-wise Details of Staff Trained on Various Modules under LWS, 2010-11

Cadre of staffs	Number of persons trained (Data for 128 Districts)	% of total target
District Resource person	203	92.7
District M&E Officer	109	91.6
Supervisors	532	98.9
Link Workers	4,910	95.2
Volunteers	1,15,400	108.6%





Keeping these in view, three regional workshops have been organised for all the partner organisations and SACS at Jaipur, Kolkata and Bangalore. A total of 120 persons participated in these workshops.

Learning and sharing workshop

CHAPTER 5

Management of Sexually Transmitted Infections/ Reproductive Tract Infections

Under NACP-III, it is a mandate to strengthen all public health facilities at and above district level as designated STI/RTI clinics, with the aim to have at least one NACO supported clinic per district.

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

An estimated three crore episodes of STI/RTI occur every year in the country. The NACP-III target is to reach 1.5 crore episodes by end of NACP-III with quality services. Against the annual target of one crore episodes for FY 2008-09, 2009-10 and 2010-11, 66.7 lakh, 82.4 lakh , and 84.9 lakh (till Jan 2011) STI/RTI patients were respectively managed across the country. The details of the physical targets and achievements of NACP-III till January 2011 are shown in Table 5.1.

Progress of STI/RTI Services under NACP-III

Expansion of Service Provision in Public Sector: Under NACP-III, it is a mandate to strengthen all public health facilities at and above district level as designated STI/RTI clinics, with the aim to have at least one NACO supported clinic per district.

- Presently, NACO is supporting 1,033 designated STI/RTI clinics which are providing STI/RTI services based on the enhanced syndromic case management. 90 new clinics have been set up in 2010 - 11
- NACO has strengthened seven regional STI training, reference and research centres. The role of these centres is to provide etiologic diagnosis to the STI/RTI cases, validation of syndromic diagnosis, monitoring of drug résistance to gonococci and implementation of quality control for Syphilis testing. These seven regional centres provide training to various state reference laboratories to carry out etiologic diagnosis. Safdarjung Hospital acts as the Apex Centre in the country.

Table 5.1: Target vs Achievement of STI/RTI Cases

No. of STI/RTI episodes treated	2008 - 09	2009 – 10	2010-11
Target	100 lakh	100 lakh	100 lakh
Achievement	66.7 lakh	82.4 lakh	91.5 lakh*
Percentage	66.7%	82.4 %	84.9 %*

* till February 2011

View of designated STI/RTI clinic

Infrastructure Strengthening of Designated STI Clinics

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

Appointment of Counselors at Designated STI Clinics

Counseling of STI/RTI patients forms an integral part of the service. To strengthen the counseling and behaviour change amongst the STI/RTI patients, one counselor is provided to each of these designated clinics. 828 STI counselors are currently in position. Training material, curriculum and job aids, including posters, flip book and a film on counseling have been developed by NACO. Training for STI counselors has been conducted through 18 identified institutes. Different job aids have been developed to facilitate quality STI/RTI counseling and service delivery.

STI/RTI job aids (flip charts and posters)

Brand logo of STI clinics/Suraksha clinics

A still from STI TV campaign


Trainings of healthcare providers on STI/RTI services

Branding of STI clinics & National Communication Strategy on STI/RTI Service Delivery: NACO has branded the STI/RTI services as "Suraksha Clinic" (Fig 5.4) and developed a communication strategy for generating demand for these services. STI/RTI services are being promoted through specially designed TV and Radio campaigns to address issues of fear and reluctance in seeking treatment.

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

Training of doctors working at NRHM health facilities is also being carried out using a common curriculum,

Table 5.2: Status of Training of Health Care Providers

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

* Till end of December 2010

STI/RTI colour-coded drug kits

by involving state and regional resource faculty trained by NACO.

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

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

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

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

The provision of a standardised package of STI/RTI services to High Risk Group (HRG) population is an important component of the Targeted Intervention projects. All the HRG population receives a free consultation and treatment for their symptomatic STI complaints, quarterly medical check-up, asymptomatic treatment and bi annual syphilis screening. In order to improve the service utilisation, providers preferred by HRG have been selected. Under this approach, all the HRG receives free STI/RTI treatment and the providers receive a token fee of Rs. 50 for each consultation.

All NGO staff have been oriented and trained on the approach. 3891 PPP have been identified for the delivery of services, majority of them have been trained using a standardised curriculum on syndromic case management. The colour coded STI/RTI drug kits have also been made available to these providers for free treatment of sex workers, MSM and IDU, and data collection tools provided to them. Service delivery has started in all states and a total of about 10 lakhs HRG have accessed services in 2010-11.

CHAPTER 6

Information, Education & Communication and Mainstreaming

There has been a strategic shift in the strategy during NACP-III. The focus is on moving to behaviour change communication from only awareness creation.

Information, Education and Communication (IEC) cuts across all programme components of NACP-III. There has been a strategic shift in the strategy during NACP-III. The focus is on moving to behaviour change communication from only awareness creation. The key priorities of NACP-III communication strategy are to:

- Motivate behaviour change in a cross-section of identified populations at risk, including the High Risk Groups and Bridge Populations;
- Raise awareness levels about risk and the need for behaviour change among the vulnerable and general population, specially youth and women;
- Generate demand and increase utilisation of HIV/AIDS related health services; and
- Create an enabling environment that encourages HIV related prevention, care and support activities and reduces stigma and discrimination at individual, community and institutional levels

The following are the major activities undertaken during 2010-11:

Red Ribbon Express Project

Building upon the success of the first phase of the Red Ribbon Express (RRE) project (2007-08), NACO launched the second phase of the project on 1 December, 2009 to commemorate the World AIDS Day. The specially designed eight coach exhibition train was flagged off from Delhi Safdarjung railway

Red Ribbon Express closing ceremony, 1 December 2010

Red Ribbon Express at a station in Gujarat

station by Hon'ble Chairperson UPA and Chairperson Rajiv Gandhi Foundation, Smt. Sonia Gandhi. During its year long journey, the RRE travelled across 22 states, covering 152 halt stations. The second phase of the project ended on 1 December, 2010 at the Delhi Safdarjung station. A function was organised on the occasion and those who made significant contribution in the implementation of the project were felicitated by Hon'ble Union Minister for Health & FW, Shri Ghulam Nabi Azad.

The RRE is the world's largest mass mobilisation campaign on HIV/AIDS. The basic objective of the RRE was to disseminate the messages on HIV/AIDS prevention, treatment, care and support to people living in villages and small towns across the country. The aim was also to create an environment, free from stigma and discrimination faced by people living with HIV, so that they could access the services, without fear and prejudice, to live a life of dignity. Red Ribbon Express proved to be a successful multi-sectoral initiative of NACO and a powerful advocacy tool, both at the state and district level. It enhanced local capacity to deal with HIV prevention as the project involved training of grassroots functionaries in the districts through which the train passed.

The National Rural Health Mission had also come on board with NACO during the 2nd phase of the project. Apart from three exhibition coaches with exhibits on HIV/AIDS, a fourth coach on NRHM, with exhibits on H1N1, Tuberculosis, Malaria, Reproductive and Child Health services, general health and hygiene, was added. There was also a coach for counseling, with another for conducting trainings of district level resource persons, such as members of Panchayati Raj Institutions, Self Help Groups, government officials, health workers, youth organisations, teachers, defence and police personnel. During the second phase of the project, services for HIV testing, treatment of STI and general health check-ups, were also provided at the

Table 6.1: Coverage of Red Ribbon Express-II Surpassed Coverage Figures of Red Ribbon Express-I

Description	RRE-II (2009-10)	RRE-I (2007-08)
People reached (includes visitors to the train and outreach activities in villages)	80 lakh (19 lakh people visited the train exhibition while 61 lakh were covered through outreach activities)	62 Lakh (12 lakh people visited the train exhibition, 40 lakh were covered through outreach)
District Resource Persons trained	81,000	68,000
People tested for HIV	36,000	Service not provided

A folk troupe performing during the RRE's halt in Odisha

halt stations. IEC exhibition vans and folk troupes were deployed to carry messages into rural areas, particularly to reach out to those who were not able to come to the railway stations.

Political leaders including Ministers, Members of Parliament and Members of Legislative Assembly also actively participated in the project and mobilised people to the train at the local level.

The daily coverage was monitored through a monitoring agency. An inbuilt evaluation system was put in place through an external agency for assessing the project's impact. The response to the RRE was overwhelming with thousands of people visiting the exhibition everyday at the halt stations. The evaluation report of the RRE project has shown significantly higher knowledge levels of HIV/AIDS among those exposed to the project as compared to those not exposed.

Multi-media Campaign in the Northeast: NACO had launched a special multi-media campaign in Nagaland, Mizoram and Manipur during 2009-10 to increase awareness, educate youth on HIV/AIDS issues and promote safe behavioural practices.

An information panel for migrants on a bus in Mumbai

During the campaign, the HIV/AIDS messages were disseminated through a series of music and sports events in view of popularity of music and sports among the youth of the North-East. Based on its success, this campaign was scaled up during 2010-11 to cover all states in the North East – Arunachal Pradesh, Assam, Manipur, Nagaland, Mizoram, Meghalaya, Tripura and Sikkim. To maximise the engagement of communities, a calendar of events and traditional festivals was developed for each state, and IEC activities based on this calendar were undertaken throughout the year. Special effort was made to reach out to the out-of-school youth in the states through youth clubs at district, block and village levels.

Many interesting activities were experimented with for the first time during the Campaign. For example in Manipur, Shumang Leela, a traditional theatre was used to disseminate the messages on HIV/AIDS. The campaigns focused on increasing awareness of the routes of transmission and prevention, and reducing stigma and discrimination associated with HIV/AIDS. In Mizoram, a choir competition was organised in partnership with Doordarshan. In the states of Manipur, Meghalaya and Nagaland, band competitions were conducted, where youth were engaged in development and dissemination of HIV messages through music. The music competitions and football tournaments organised initially at district level, culminated in the state level mega events, which saw huge youth participation.

The winners of the music competitions projected as "youth icons", are further reaching out to people in villages and far flung areas through road shows with messages on HIV/AIDS.

Television Programmes: NACO sponsored 50 episodes on HIV/AIDS in the Tele-serial "Kyonki Jeena Isi ka Naam Hai", covering migrants, truckers and children living with HIV. The series is being telecast on Doordarshan during prime time, three times a week. In the months of December-January 2010-2011, special episodes on HIV/AIDS in Kalyani Health Magazine were telecast on regional networks of Doordarshan in the states of Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Odisha and Assam. Besides this, the SACS also conducted phone-in programmes and panel discussions on regional networks of Doordarshan.

A folk troupe performing during the National Folk Media workshop

Thematic Campaigns: NACO developed a campaign calendar for the activities to be undertaken on mass media. Campaigns on condom promotion, voluntary blood donation, stigma & discrimination and sexually transmitted infections were aired on Doordarshan, cable and satellite channels, All India Radio and private FM radio.

Mid-media and Outdoor: NACO organised two national workshops in New Delhi covering 16 states on dissemination of HIV/AIDS messages through folk media. The objective of the workshops was to develop standardised scripts and folk performances for better and more effective utilisation of this medium for HIV/AIDS messaging. The State AIDS Control Societies identified popular folk forms and lead artists to participate in the workshops. State and national level resource persons were identified to mentor the artists, and along with the team from NACO, gave technical inputs to develop scripts. The themes on which the scripts were developed included safe sex and condom, vulnerability of migrants, youth, services for HIV counseling and testing, stigma and discrimination and blood safety. In all, 106 scripts were developed covering 24 identified folk forms.

The states of Andhra Pradesh, Bihar, Chhattisgarh, Haryana, Gujarat, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Rajasthan, Tamil Nadu, Uttar Pradesh and Uttarakhand were covered during the workshops. These states are now in the process of building up the capacity of state level artists for rolling out the folk campaign in the field as per the revised strategy.

As part of the outdoor media activities, the State AIDS Control Societies installed hoardings and bus panels and put up wall writings to disseminate HIV/AIDS messages. IEC exhibition vans were also deployed by a number of states to reach out to rural

India satellite session at International AIDS Conference, Vienna, 2010


IEC materials

populations with HIV/AIDS messages. The State AIDS Control Societies also participated in exhibitions and fairs to disseminate HIV messages. NACO organised a special booth at the India International Trade Fair at Pragati Maidan, New Delhi in November, 2010. Designed in the style of a coach of the Red Ribbon Express, the booth at the Health Pavilion of the fair attracted a large number of visitors.

Materials for Interpersonal Communication: In order to facilitate effective implementation of NACO's revised migrant strategy, a kit of IEC materials was developed, which included a leaflet and three types of booklets containing useful information for migrants along with some utility items. Hoarding designs addressing migrants were also developed. The hoardings are in the process of being put up at different source, transit and destination migrant intervention sites. In order to reach out with information on Opioid Substitution Therapy (OST) for Injecting Drug Users (IDU), posters and flip charts were printed along with information booklet and record diary for the IDUs. For the truckers, six posters and hoardings have been developed along with information leaflets.

Three films have been developed for the training of outreach workers, peer educators and on the issue of infection control and needle disposal for IDU TI. A short film was made on the Red Ribbon Express and was showcased at the 18th International AIDS Conference in Vienna, Austria.

Flip Charts on ICTC, ART, STI services were printed by the State AIDS Control Societies. General information booklets, brochures, folders and short films were produced and were made available to the target populations through service centres, fairs, exhibitions and outreach activities such as Red Ribbon Express and IEC vans. The materials specially targeting High Risk Groups were developed and replicated by the State AIDS Control Societies.

Branding of STI Clinics: The branding of STI clinic based service is being done as "Suraksha Clinics" so as to increase visibility and promote the value of safety and prevention specially among youth and women.

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

International AIDS Conference, Vienna: India made a strong presence at the 18th International AIDS Conference organised in Vienna, Austria from 18–23 July, 2010 where around 19,500 delegates from across the globe including policy makers, academicians, researchers and civil society activists participated. NACO organised a satellite session on the subject of "Wining the battle against the HIV: going to scale" and an exhibition to showcase India's progress under the National AIDS Control Programme. The India satellite session, attended by about 500 delegates representing international and national organisations, was very well received. The exhibition organised on the concept of Red Ribbon Express generated a lot of interest and grabbed people's imagination. A number of inquiries were made about the RRE project by the visitors to the exhibition.

Adolescence Education Programme: The Adolescence Education Programme (AEP) is a key intervention to build life skills of the young people and help them cope with negative peer pressure, develop positive behaviour, improve sexual health and prevent HIV infections. Under the programme, sessions are scheduled for sixteen hours for classes IX and XI. During 2010-11, 49,714 schools were covered. The programme could not be implemented in some states due to ban/ suspension in view of the protest against the tool kit. The new tool kit was sent to the states and has been adapted by most of them.

Red Ribbon Clubs in Colleges: Red Ribbon Clubs (RRCs) have been formed in colleges to encourage peer to peer messaging on HIV prevention. It is also to provide a safe space for young people to seek clarifications on their doubts and myths surrounding HIV/AIDS. Against the target of 12,000 RRCs during 2010-11, 13,027 RRCs were formed in the country.

Mainstreaming HIV for a Multi-Sectoral Response: The National Council on AIDS headed by Hon'ble Prime Minister was constituted in 2005 to facilitate a strong multi-sectoral response to HIV/AIDS. As a follow up, State Councils on AIDS have been constituted in 25 States/Union Territories. The aim is to mainstream the HIV/AIDS issue into policies and programmes of Government Ministries/ Departments, corporate sector and civil society organisations to make the fight against the epidemic as a common agenda.

Training of Frontline Workers and Members of PRIs: As part of strategy to reach out to grassroots level frontline workers with information on HIV prevention, treatment, care and support, NACO through the State AIDS Control Societies and concerned Ministries/ Departments continued to facilitate the training/ sensitisation programmes for Self Help Groups of women, Anganwadi Workers, ASHA, ANMs and members of Panchayati Raj Institutions. About 4.5 lakhs (as on 15th February, 2011) front line workers and personnel from various Government Departments ,Civil Society Organisations and corporate sector have been trained. The trained resources are expected to further disseminate HIV/AIDS messages in their villages and communities. Now the emphasis is on linking the trained functionaries with the HIV/AIDS related services available in the districts to increase their utilisation.

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

- Counseling of non HIV pregnant women on nutrition, birth spacing and family planning by ICTC counselors
- Training of ASHA on module "Shaping Our Lives" developed by NACO for frontline workers
- Inclusion of HIV screening in routine ANC check up
- Expansion of ICTC and PPTCT services to all 24x7 health facilities
- Incentives to Health Care Providers for conducting deliveries of HIV positive pregnant women in public health facilities
- Training of Family Planning counselors on, PPTCT, ANC, STI & nutrition
- For National STI programme, NACO will continue to monitor & supervise the programme through technical support in training, quality supervision and monitoring access of STI services at facility level and procurement of colour coded drug kits.
- Establishing 29 district level blood banks with NACO support in equipment & recurring cost for blood collection, testing, matching and transportation and NRHM support for provision of infrastructure & essential manpower.

International Conference on Mainstreaming HIV & AIDS: Role of insurance sector in India

- Strengthening of Health facilities for OST (Opioid Substitution Therapy)

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

Tribal Action Plan (TAP): Tribal population is one of the priority groups under NACP III due to low awareness, remote locations and poor access to health services. NACO is working closely with the Tribal Welfare Departments in the states to implement an HIV/AIDS strategy specifically addressing tribal populations. An amount of Rs. 5 lakh per ITDP has been allocated for IEC activities in high vulnerable tribal districts and for training of grass root health functionaries. Out of the total 192 ITDP areas 65 are in Category A and B districts where the TAP has been rolled out.

Stigma and Discrimination: Addressing the issue of stigma & discrimination against People Living with HIV (PLHIV) has been envisaged as a major step to mitigate the impact of HIV/AIDS. Various channels of communication such as mass media i.e. radio, TV and newspapers, mid-media and out-door communication, including folk theatre, exhibitions, hoardings, information displays and inter-personal communication are used to address this issue. Training and sensitisation programmes for different grassroots functionaries such as SHG, Anganwadi Workers, ASHA, ANM and members of Panchayati Raj Institutions also cover issue of stigma and discrimination faced by PLHIV. Whenever cases of stigma & discrimination against PLHIV come to knowledge of NACO or State AIDS Control Societies, action is initiated through the concerned authorities.

Mainstreaming HIV/AIDS Role of insurance sector: NACP-III aims at expanding health insurance coverage to People Living with HIV (PLHIV) to strengthen their social security. Presently, almost all major health insurance schemes exclude the ailm ents which have any linkages with HIV/AIDS. From social and ethical perspectives, this exclusion results in further marginalisation of PLHIV, denying them equal human rights.

An International Conference on "Mainstreaming HIV & AIDS role of Insurance Sector in India" was organised in New Delhi on 3-4 February, 2011. The first conference in India to address the issue of HIV and Insurance, it attracted over a hundred participants and key stakeholders from various fields. These included National and State Governments, public and private sector insurance companies, Insurance Regulatory Development Authority (IRDA), bilateral/ UN agencies, international experts on the subject, research institutions, such as the Institute of Economic Growth and the National AIDS Research Institute, actuarial experts, agencies working on welfare schemes and insurance, representatives from civil societies, positive networks and other key stakeholders. The major objective of the conference was to discuss the demand and market potential for including HIV as an insurance risk, and facilitate evolution of a roadmap towards mainstreaming it. The conference endorsed the need for bringing PLHIV within the ambit of health insurance and need to work out a road map to achieve this objective.

Women and HIV: NACO addresses the issues of women and HIV as a cross-cutting theme within NACP. NACO is dedicated towards creating an enabling environment for women ensuring a fair access for them to information and services related to HIV. NACO undertakes Information, Education & Communication (IEC) campaigns to raise awareness and strengthen health seeking & safe preventive behaviour towards HIV, among women. Positive Women's Network (PWN+) and their state/district level networks are encouraged to advocate and promote the utilisation of HIV related services for women. These state/district level networks address stigma and discrimination related cases among their members. Such Networks act as platforms for women living with HIV to share their concerns, seek support and legal aid. They also provide social support for those isolated by their family and community. As part of the mainstreaming process, a number of states have taken initiatives to provide special social security measures for Women Living with HIV.

Drop-in-Centres: Drop-in-Centres (DICs) have been set up, with support from NACO primarily in A and B category districts in the country. There are currently 201 Drop-in- Centres in the country managed primarily by PLHIV networks. The DICs provide a platform for psycho-social support to People Living with HIV (PLHIV) and linkages with services. At these centres PLHIV are also provided counseling services on drug adherence, nutrition, livelihood and legal issues.

CHAPTER 7

Condom Promotion

Through rigorous efforts under NACP-I & II, significant achievements have been made, in terms of availability of condoms, increasing awareness and promoting condoms use in HIV/AIDS prevention.

During the initial period, condoms were promoted under the National Family Planning Programme. With the emergence of HIV as a serious health concern, promotion of condom for preventing HIV/AIDS was taken up under the National AIDS Control Programme (NACP). With nearly 86 percent of HIV infections transmitted through unprotected sex, significant efforts have been made by NACO to increase the awareness and usage of condoms to prevent the transmission of HIV/AIDS.

Non-traditional outlet stocking condom

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

The thrust areas under the programme are to expand the social marketing programmes to saturate coverage in districts characterised by high HIV prevalence and/or high family planning need and to increase the demand for condoms among high risk, bridge and general population. It also works toward minimising the wastage in free supply of condoms

Magic show promoting deluxe nirodh condom

and maximising its access to the most vulnerable groups.

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

The supply objectives of the social marketing programme are to:

- Increase the retail off take of social marketed condom to 200 crores by 2012.
- Increase the number of condom outlets to 30 lakh by 2012
- Increase the accessibility of condoms to make it available within 15 minutes of walking distance from any location.
- Optimise free supply of condoms to reduce wastage

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

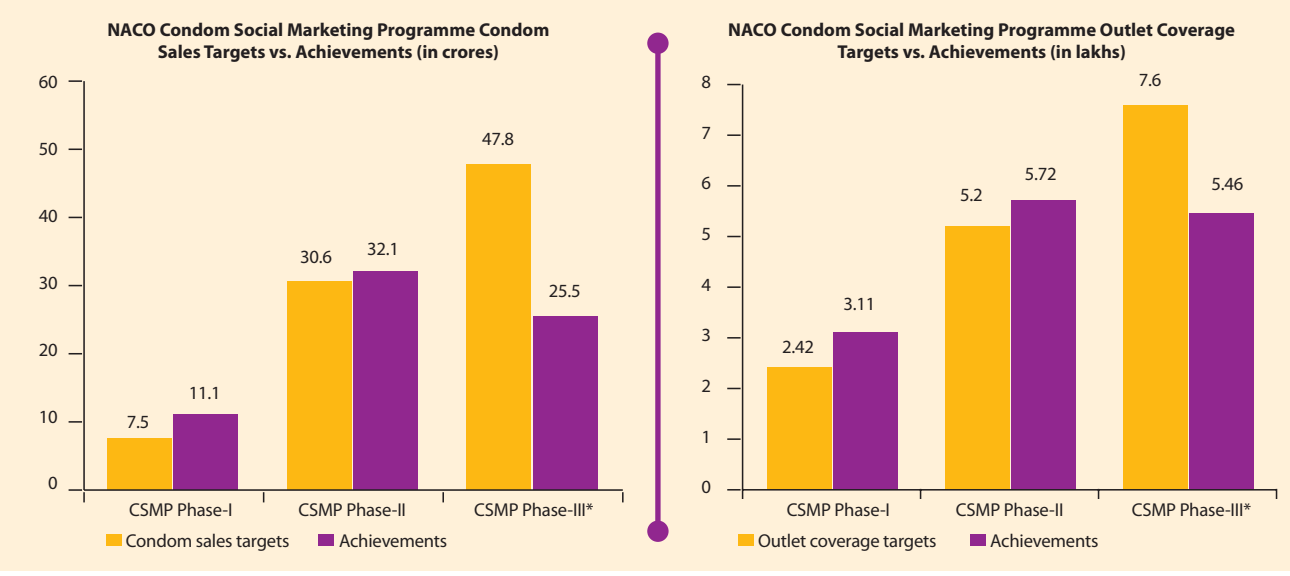

Demonstration of condom use

- Phase-I of the Condom Social Marketing Programme was implemented by four Social Marketing Organisations (SMOs) in 2008 across 194 high prevalence and high fertility districts of 15 states. The rural coverage was the main focus of the programme.
- Phase-II of the Condom Social Marketing Programme had been implemented across 294 high prevalence and high fertility districts of 25 states by six SMOs. The main focus of the programme was to cover all TI sites and to ensure accessibility of condoms in rural areas.
- NACO has launched third phase of Condom Social Marketing Programme. The programme started from July 1, 2010 and is being implemented in 370 high priority districts across 26 states/UTs by eight SMOs.
- The districts, mapped on the basis of HIV prevalence and family planning need, were classified into four categories - high prevalence high fertility (HPHF), high prevalence low fertility (HPLF), low prevalence high fertility (LPHF) and low prevalence low fertility (LPLF). Under CSMP Phase-III 158 HPHF, 34 HPLF and 178 LPHF districts are covered.

The condom market which had been stagnating for quite some time had shown significant growth. The overall condom usage which was 1.6 billion in 2006-07 has reached 2.45 billion in 2009-10, against the NACP-III target of 3.5 billion condom usage per annum by 2012. The number of condoms stocking outlets have also increased from 0.6 million in 2006-07 to 1.2 million in 2009-10. Under Phase-III of CSMP, the total condom sales target for the SMO is envisaged at 47.8 crores condoms during July'2010-June'2011. SMOs have distributed 25.5 crores condoms till Jan 2011 (Fig 7.1). Table 7.1 provides details of the targets fixed for the SMOs during July, 2010 to June, 2011 and their achievements upto January, 2011.

NACO targeted CSMP focuses on ensuring easy accessibility and hence has gone a step ahead to ensure easy accessibility of condoms in all situations by making it available through non-

Fig. 7.1: Achievement in Condom Sales and Outlet Coverage during Three Phases of CSMP



*CSMP-III figures are for seven months. The programme is for a period of 12 months (July 2010-June 2011).

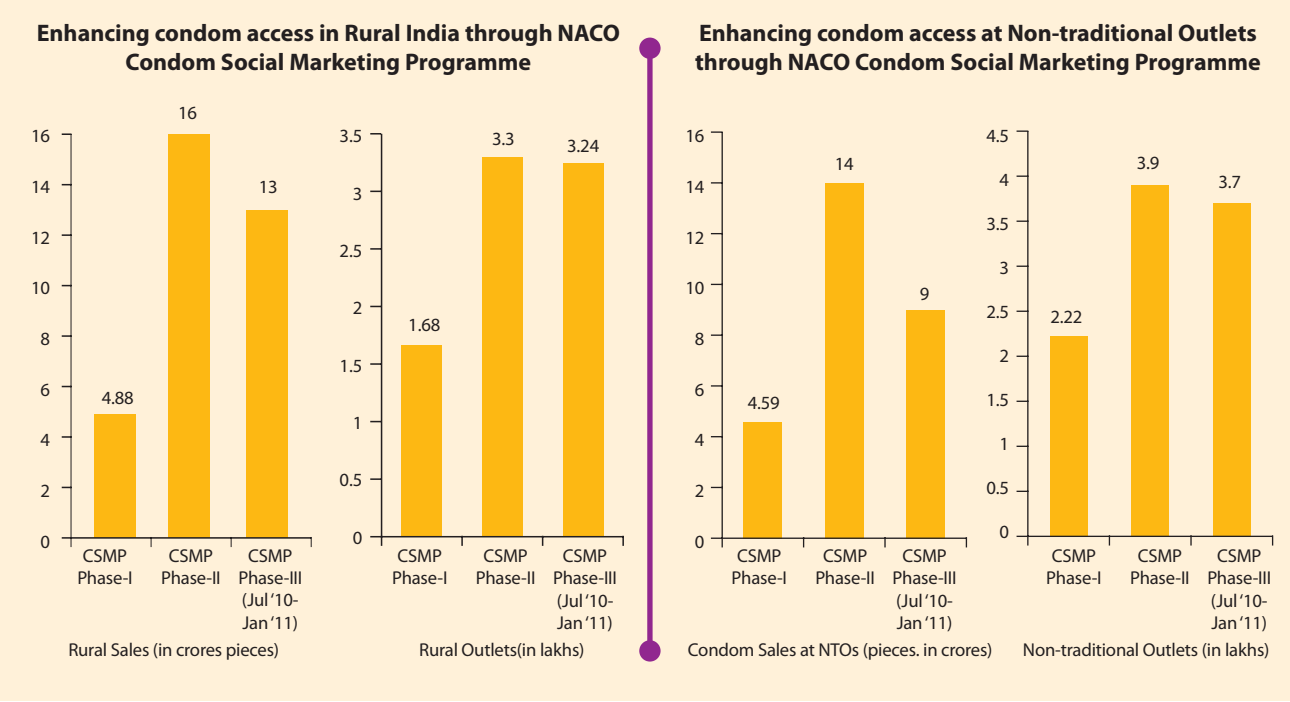
*CSMP-III figures are for seven months. The programme is for a period of 12 months (July 2010-June 2011).

conventional shops like petrol pumps, barber-shops, wine-shops, PDS shops, dhaba, hotel etc. The coverage and sustainability of non-traditional outlets is increasingly enhanced as they facilitate easy accessibility of condoms in rural and far flung areas (Fig 7.2).

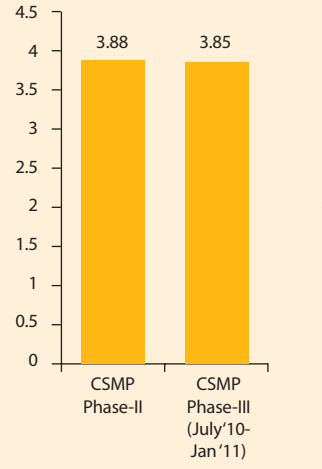
The programme focuses on saturation of all the high risk areas, i.e. truckers halt points and TI areas. All kinds of condom selling outlets located around these high risk areas are also covered in systematic approach under CSMP-III.

NACO has been promoting consistent condom usage through a multi-phase mass media campaign to increase demand. These campaigns evolved from the previous year's theme of Normalisation and were based on enhancing risk perceptions in three stages

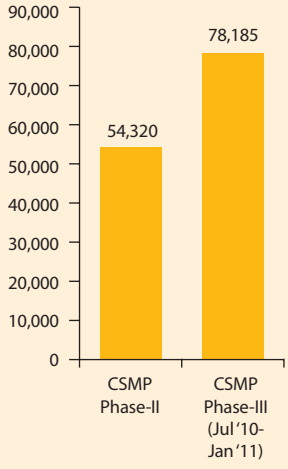
Fig. 7.2: Enhancing Condom Use through the Condom Social Marketing Programme



Enhancing condom access at TI sites through NACO Condom Social Marketing Programme

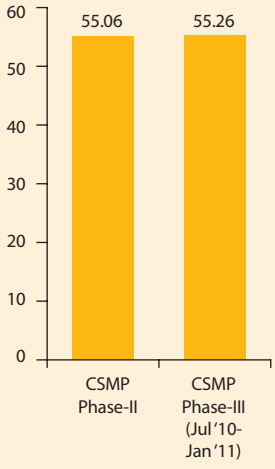


Condom Sales at TI Sites (pieces in crores)

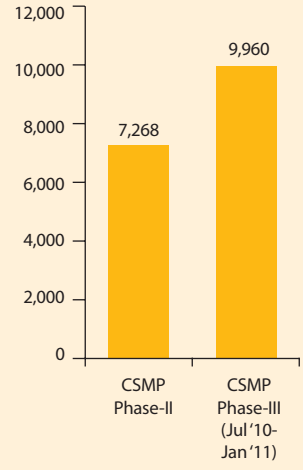


Condom Outlets at TI Sites

Enhancing condom access at Truckers Halt Points through NACO Condom Social Marketing Programme



Condom Sales at THPs (pieces. in lakhs))



Condom Outlets at THPs

Street play performance among rural audience

Condom demand generation activity at a rural mela stall

i.e. Risk awareness, Prioritisation and Consistent condom usage. The same theme is being used in all forms of condom promotion communications including mid-media activities organised by Social Marketing Organisations.

Optimisation of Free Supply of Condoms: Another key objective of the NACO social marketing programme is to optimise the supply of free condoms to ensure availability to the vulnerable population and minimising the wastage of free condom supply.

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

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

This disciplined approach led to the achievement of optimum utilisation of free supply of condoms at all the TI sites without any reported incidence of stock out positions at SACS and TI NGO sites in 2010-11 (till January). Against an annual target of 34.6 crores free condoms distribution, SACS have distributed 30.3 crores free condoms till January 2011.

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

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

- Regular tracking of free condom supply received from MoHFW to SACS every month to avoid any stock out situation at SACS.
- Free condom supply analysis from SACS to TI NGOs and subsequent distribution of free condoms from various TI NGOs to TG population
- Free condom annual demand estimation as done at TI NGO and SACS level based on previous data analysis.

Other Innovative Programmes to Enhance the Accessibility of Condoms

Condom Vending Machine (CVM) Programme: CVMs have been installed with the objective of addressing embarrassment and to make available the condoms round the clock. These CVMs are installed in the major states/cities of the country, Delhi, Mumbai, Chennai, Kolkata and in some large cities of Uttar Pradesh and Odisha. The CVMs are installed at the high risk areas. To implement the CVM project, Public private partnership was emphasised and the partnerships are developed with MCD, NDMC, DTC, Sulabh Sauchalaya, Delhi Metro stations, Ministry of Petroleum, wine shops etc.

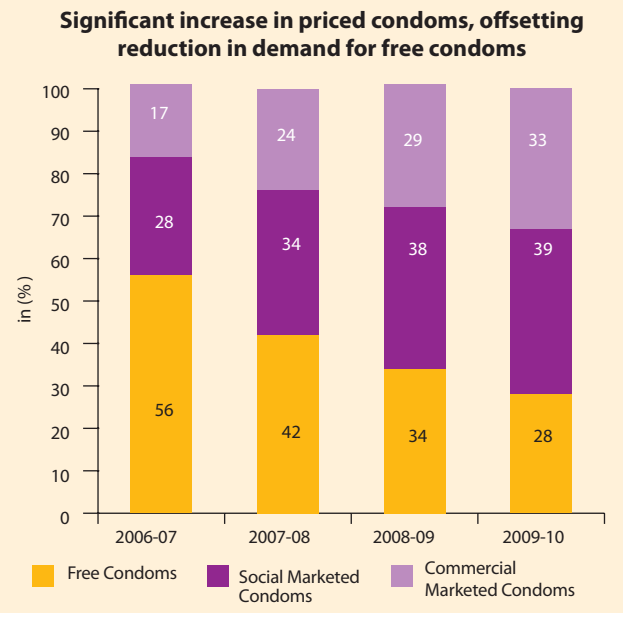
During the current year, a total of 15.22 lakh pieces of condoms were vended from these machines till January 2011. Some of the major activities conducted during the year are as under:

- Common Wealth Games 2010 - A total of 109 CVMs were installed at various places in proximity to games venues. The machines at the Village and other venues were branded in sync with the CWG theme to spread the message of ' Play Safe'. These CVMs were monitored and refilled on regular basis to make condom available round the clock. 12,222 pieces of condoms were dispensed from CVMs during the games days.
- Participation in India International Trade Fair 2010- CVMs were installed in Health Pavilion during India International Trade Fair from 14 November 14 to 27 November 2010 at Delhi. The response was good and people who visited the pavilion showed interest in the machines.
- Participation in Closing Ceremony of the Red Ribbon Express - During the closing ceremony of RRE from 29 November and 1 December 2010, CVMs were set up during this programme.

Female Condom (FC) Scale Up Programme: NACO is implementing the FC programme through HLLFPT in four states Andhra Pradesh, Tamil Nadu, West Bengal and Maharashtra. It has reached around two lakh FSWs ensuring 100 percent TI NGOs coverage. The programme focuses on capacity building, training and BCC activities for increasing use of female condoms. In the current phase of FC programme, total FC sold from July, 2010 to December, 2010 is 2.5 lakh pieces.

Communication Activities: The Phase-III saw introduction of a unique target for NACO contracted Social marketing organisations in all contracted states – mid media contacts target. This target was set for each state to ensure that SMOs reach out to stipulated numbers of audience by organising various mid media and communication activities to promote condom use. Condom promotion activities are organised in various forms viz. street plays, road shows, IPC and condom demonstrations etc. to generate demand by creating awareness among the target consumers and thereby generate contacts.

Fig. 7.3: Distribution of Condom Promotion by Free, Social Marketing and Commercial Channel, 2006-10



Road show to spread condom's triple benefits message

Promoting condom use through wall writings

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

Promoting Condom Use by Enhancing Risk Perceptions: In Phase-III, NACO came up with condom promotion campaigns that were aimed at enhancing risk perceptions among target consumers. In this direction, three campaigns were launched that were aired on television (Doordarshan and leading Cable & Satellite channels) as well as radio (All India Radio and private FM channels). These campaigns were released on national scale in regional languages also apart from Hindi.

Programme Monitoring: Over last three years Technical Support Group has evolved a strong system to monitor the national condom social marketing programme such as:

- Central web based online monitoring system
- Continuously tracking condom market dynamics
- Periodic reviews of Social Marketing Organisations

Central Web Based Online CSM Programme Monitoring System: TSG has been monitoring the progress of field level activities using a excel file based system to compile the monthly reports at Delhi office. The data compilation is being done at different levels which were complicated, time consuming and had lot of scope of data entry errors. In CSMP Phase-III, TSG has taken an initiative to completely shift the database management platform using specially designed MIS software. The MIS software offers the following benefits:

- Monitoring SMO's performance against deliverables from any location in India by 24x7.
- The software allow user to enter online outlet-wise sales data with all relevant break ups at the end of every day/week/month.
- The software has been designed to address all the needs for data analysis, pre designed report development and all kinds of output generation. The reports are also available in Charts/Graphs and Static Maps.
- This initiative saves time in generating error free reports, following ups with SMO to get data in time and controlling data punching related problems. It generates more accurate database.
- The software has key feature to validate the data entered or uploaded by the field level users. The data uploaded is not available for any report generation till the M&E focal person will endorse the validity of the uploaded data.
- The output generated by software also allows TSG to bridge data between TSG online module and SIMS at NACO.

Continuously Tracking Condom Market Dynamics: TSG subscribes to the AC Nielsen's condom retail off take data at national level on a monthly basis and state level data on a quarterly basis. The data is extensively seen by volume, outlet coverage and store coverage to analyse universe of condom stocking outlets, brand penetration, market share and trends to further inform implementing partners to streamline supply related strategies. The analysed data is used to make customised reports for submission to NACO.

Condom promotion activity for migrant population

Periodic Reviews of Performance of CSMP Implementing SMOs: NACO has engaged eight Social Marketing Organisations (SMO) to implement condom social marketing programme. Periodic reviews are organised to review the performance of the SMOs. The specific advantages of reviews are:

- It helps in building greater coordination/synergy between TSG and SMOs
- Performance is directly measured against the deliverables
- Resolving issues that are impacting programme
- Replicating good practices among SMOs.

Table 7.1: NACO Condom Social Marketing Programme; Performance of Social Marketing Organisations in Phase - III (July, 2010 - January, 2011)

Total Condom Sales						Total Outlet Coverage			Communication		
SMO	S. No	State	Annual Target	Achievement	% of Achievement	Annual Target	Achievement	% of Achievement	Annual Target	Mid Media contacts achievements	% of Achievement
PSI	1	Karnataka	17,630,400	11,447,900	65%	32,200	23,809	74%	1,850,000	2,013,785	109%
	2	Andhra Pradesh	13,000,000	7,775,863	60%	28,000	23,952	86%	2,619,500	1,825,289	70%
	3	Rajasthan	21,953,900	13,742,338	63%	34,400	32,382	94%	1,274,380	761,414	60%
	4	Odisha	11,970,400	5,161,428	43%	24,234	31,398	130%	902,500	427,547	47%
	5	Madhya Pradesh	33,590,000	18,356,794	55%	36,300	29,672	82%	1,510,200	1,130,160	75%
	6	Tamil Nadu & Puducherry	14,021,200	7,519,109	54%	44,950	35,836	80%	2,158,175	1,100,874	51%
	7	Delhi	11,907,800	6,963,058	58%	10,500	9,440	90%	375,000	279,292	74%
DKT	8	Gujarat	22,049,400	10,266,544	47%	40,160	25,235	63%	1,571,200	970,339	62%
	9	Maharashtra	75,610,800	33,480,531	44%	132,250	59,976	45%	3,407,340	1,870,233	55%
HLFPPT	10	Uttar Pradesh	136,006,300	83,151,334	61%	185,000	120,779	65%	4,885,600	3,230,719	66%
HLL	11	Punjab, Haryana & Chandigarh	26,205,000	12,252,279	47%	15,542	16,372	105%	667,000	225,410	34%
JANANI	12	Bihar	29,500,000	11,800,168	40%	59,500	46,395	78%	2,394,788	1,298,473	54%
PHSI	13	Jharkhand	10,285,000	6,677,624	65%	10,100	9,409	93%	700,000	254,900	36%
	14	Goa	1,950,000	724,927	37%	1,300	1,246	96%	51,800	37,801	73%
	15	Kerala	8,723,900	2,391,282	27%	13,750	9,061	66%	858,500	201,564	23%
	16	North-East	5,510,000	4,102,978	74%	24,425	18,486	76%	511,900	256,570	50%
PSS	17	West Bengal	29,306,900	15,215,869	52%	54,520	43,722	80%	2,129,000	1,490,609	70%
PCPL	18	Chhattisgarh	9,147,840	3,557,355	39%	13,632	9,187	67%	433,123	209,854	48%
Total			478,368,840	254,587,381	53%	760,763	546,357	72%	28,300,006	17,584,833	62%

CHAPTER 8

Blood Safety

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

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

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

NACO has supported the installation of BCSU and also funded the modernisation of all major blood banks at state and district levels.

Current Scenario: Access to safe blood is the primary responsibility of NACO. As on January, 2011, it is supported by a network of 1,127 blood banks, including 155 Blood Component Separation Units (BCSU) and 28 Model Blood Banks. NACO has supported the installation of BCSU and also funded the modernisation of all major blood banks at state and district levels. Besides enhancing awareness about the need to access safe blood and blood products, NACO is also supporting the procurement of equipment, test kits and reagents as well as the recurring expenditure of Government blood banks and those run by voluntary/charitable organisations, which were modernised. There are still 23 districts in the country with no facilities for supply of safe blood, and these are now being addressed on a priority basis.

During 2010-11, 7.92 lakh blood units were collected till January 2010-11; 79.4 percent of this was through voluntary blood donation in NACO-supported blood banks.

The practice of appropriate clinical use of blood amongst the clinicians has seen a definite rise due to the dengue epidemic, and training of clinicians on the rational use of blood. The proportion of blood components prepared by the BCSU in 2007-08 was 20 percent, which rose to 41.1 percent in 2009-10. Efforts are being made to further increase it to 65 percent by end of March 2011.

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

Collection

Voluntary Blood Donation Programme: It has been recognised the world over that collection of blood from regular voluntary non-remunerated blood donors should constitute the main source of blood supply. Accordingly, activities for augmentation of voluntary blood donation are taken up as per "Operational Guidelines on Voluntary Blood Donation".

In the year 2006-07, Voluntary Blood Donation (VBD) was 54.4 percent which was the baseline for NACP-III. It increased to 59.1 percent in 2007-08, 61.7 percent in 2008-09 and further to 74.1 percent in 2009-10 (till January 2010) against the NACP-III target of 90 percent. During the year 2010-11, the percentage of voluntary blood donation was 79.4 percent against the target of 80 percent. Several activities to promote public awareness of the need for voluntary blood donation have been undertaken in collaboration with Red Cross and various Blood Donor Organisations. District wise training programmes are running in the states to train the motivators and sensitise them. Voluntary blood donation camps and other activities are regularly undertaken to increase blood collection in the country.

Progress on voluntary blood donation programme

First national conference on Voluntary Blood Donation was organised by NACO at Hyderabad. Around 400 people from the fields of Voluntary Blood Donation, transfusion medicine, journalism, policy making and the blood safety officials from 35 SACS participated in the conference. Strategies were targeted to augment VBD in the country.

World Blood Donors Day (14 June), Voluntary Blood Donation Day (1 October) and World Youth Day (12 January) is celebrated throughout the country with great enthusiasm. Workshops, seminars, state level competitions were held in different parts of the country.

The States of West Bengal, Maharashtra, Tamil Nadu, Gujarat, Tripura, Mizoram, Chandigarh and Himachal of voluntary blood donation. The states of Assam, Bihar, Delhi, Manipur, Meghalaya, Chhattisgarh, Punjab and Uttar Pradesh are low performing states and require strengthening. Steps are being taken to augment the donation in these states through the involvement of various stakeholders like Indian Red Cross Society, *Nehru Yuva Kendra Sanghatan* (NYKS), National Service Scheme (NSS), National Cadet Corps (NCC) and NGOs.

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

District Level Blood Banks: During NACP-I and II, blood banks in all districts of the country were taken up under the scheme for modernisation of blood banks, except for the newly created districts. In NACP-III, 39 newly created districts have been identified which do not have a blood bank. NACO has taken the initiative with the concerned State Health department for setting up a blood bank in these districts. 17 blood banks have been made operational, and in six districts construction of the

First National Conference on voluntary blood donation, 2010

building is complete and steps are being taken to meet the requirements for a license.

In five districts, construction of a building for a blood bank has not started as yet and in the remaining 11 districts a building is under construction. Instructions have been issued by NACO; to the respective SACS to set up a Blood Storage Centre in these districts till the new blood banks become operational.

Blood Component Separation Units: In order to promote rational use of blood, 82 BCSU have been established during NACP-I & II. It has been proposed to establish component separation facilities in all the blood banks in tertiary care hospitals attached to medical colleges in the Public sector.

The procurement of essential equipment for 80 BCSU was initiated in 2008-09, 2009-10, and the entire delivery schedule and installation has been completed except at 4 places. Seventy-three Blood Banks have got the license for operating as component preparation units. The remaining blood banks have applied for a license and are liaising with their respective State Drug Authorities for obtaining it.

Model Blood Bank: Under the NACP-II, 10 Model Blood Banks have been established in eight under-served States, to improve the standards of blood transfusion services. These Model Blood Banks are expected to function as demonstration centres for the State in which they are being set-up.

The NACP-III target is to upgrade the existing 22 blood banks in the remaining states/UT to Model Blood Banks, preferably in the State Capital. The identification of the blood banks has been done by

Donate blood as it saves life

SACS and approval for the same is obtained from the NACB. A MoU has been signed between the concerned State Government and NACO for the terms of reference in establishing these Model Blood Banks. NACO has deputed a team of technical experts to visit these banks for making a pre-assessment of the facilities available for up-gradation them to a Model Blood Bank.

In 2009-10, 16 blood banks have been up-graded to Model Blood Banks, with all infrastructure facilities, manpower and have been already licensed for preparation of blood components. NACO has initiated the procurement of essential equipment earmarked for these 16 blood banks. Up-gradation of the remaining blood banks was initiated in 2010-11. Till January 2011, 28 Model blood banks are functioning. A blood mobile (state of art), is issued to all these model blood banks to improve Voluntary collection in the states.

Distribution

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

It has been proposed to establish 3,222 blood storage centres in the identified FRU during NACP-III. A target of 512 storage units was planned to be made operational by the end of 2009-10, of which 440 were made operational by January 2010. During 2010-11, 245 blood storage centres were established and presently 685 Blood storage centres are functional.

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

Capacity Building

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

The blood safety training programme aims to:

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

NACO has developed a uniform training curriculum for all aspects of blood transfusion. Seventeen centres have been identified across the country to impart training on all aspects of blood safety involving Blood Bank Medical Officers, Technicians, Counselors, Nurses, Clinicians, Donor Motivators and Programme Officers of SACS. During 2010-2011, 4,290 Medical Officers, 1,450 Lab Technicians, 3,441 Nurses, and 5,315 Donor Motivators were trained till December 2010.

Programme Management

Quality practices in blood bank activities can be improved by strengthening the monitoring and evaluation system. With a large network of blood banks and Blood Component Separation

Facilities in the country, it is essential to supervise various activities undertaken, both, in blood banks as well as voluntary blood donations at different levels. Supervisory visits are undertaken to various categories of blood banks are shown in (Table 8.1.).

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

Table 8.1: Supervisory Visits Undertaken to Various Categories of Blood Banks

Type of Blood Bank	Number licensed	Number inspected
NACO supported	1,127	711
Other Blood Banks Charitable sector	197	NIL
Private Hospital	714	NIL
Private Commercial	648	600

During the assessment of these blood banks, the following shortcomings and deficiencies were identified:

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

These issues have been taken up with SACS .

New Initiatives

Setting up of Metro Blood Banks as Centre of Excellence in Transfusion Medicine: To improve the blood transfusion services in the country, four Metro Blood Banks are being set-up as Centres of Excellence, in transfusion medicine in the cities of New Delhi, Mumbai, Kolkata and Chennai. These banks will have State of the Art facilities with 100 percent Voluntary Blood Donation, 100 percent blood components preparation, and a capacity to process more than 100,000 units of blood annually. The State Governments of Delhi, Maharashtra, Tamil Nadu and West Bengal have identified land for the construction of these centres. Design DPR Consultants for these sites have been identified to initiate work. Lay out plans and detailed project report (DPR) have been received for all four sites. The equipment requirement is planned, bilateral agreement draft prepared and document for municipal approval are being obtained. DPR-1 has been approved by the steering committee for three sites.

Plasma Fractionation Centre: Under NACP-III, one Plasma Fractionation Centre with a processing capacity of more than 1, 50,000 litres of plasma, which can fulfil the country's demand has been proposed. A large volume of excess plasma in the country is being discarded, as there is no such centre in the public sector in the country. The Plasma products currently are being imported from abroad to meet the demand of patients, thus exposing them to diseases prevalent in India. The Government of India has approved the project on in 2008. The State Government of Tamil Nadu has provided land to NACO for the purpose. A Working Group has been constituted for finalising the DPR and the technology to be adopted for the centre. This working group has recommended the adoption of the "Cohn with Chromatography" technology.

CHAPTER 9

Laboratory Services

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

- Monitoring laboratory performance and evaluate quality control measures
- Establish intra laboratory comparability and ensure creditability of laboratory
- Promoting high standards of good laboratory practices
- Encouraging use of standard reagents/methodology and trained personnel
- Stimulating performance improvement
- Influencing reliability of future testing
- Identifying common error
- Facilitate information exchange
- Supporting accreditation
- Educating through exercises, reports and meetings. Assess the performance of a various laboratories engaged in testing of HIV which will be used for finalisation of the India specific protocols.

Technical Resource Group and Standardisation of Services

To ensure the above a Technical Resource Group was formed for Laboratory Services in December 2006. A revised pattern of assistance was suggested by the experts and action plan for 2007-8 was formulated. The TRG meets at least once a year to discuss critical issues in laboratory services.

The TRG meets at least once a year to discuss critical issues in laboratory services.

Capacity Building: Regional training workshops have been conducted in seven regions of the country and have addressed quality issues, details of SOPs and preparation of quality manual as a step towards NABL accreditation. As a result of the same, Gandhi Medical College, Hyderabad has applied for NABL accreditation. An additional issue discussed in these was CD4, EQAS and NARI personnel along with machine manufacturers/suppliers were invited for the same.

ICTC/CD4 Training: The division is involved in on site supervision of trainings of LTs as per NACO norms and modules for the same are constantly being monitored.

CD4 Testing: There are 211 CD4 machines installed at present serving 290 ART centres. NACO procured 67 (Partec) CD4 Machines in 2008 and 60 (FACS Count) CD4 machines were procured in 2009. Out of 211 CD4 machines there are 111 FACS Count machines, 28 FACS Calibur machines, 67 Partec machines and five Guava machines (institutional). CD4 tests performed since January 2010 to December 2010 is 9,73,042. All machines procured by NACO are under maintenance or warranty.

CD4 training institutions were identified in 2009 to systematise the training of Laboratory Technicians in ART centres. A training of trainers (TOT) was held in May and June 2009 for CD4 machine technicians and in charges. A regional capacity building of four institutions for Calibur machines (GHTM Tambaram, STM Kolkata, NARI Pune, and PGI Chandigarh), five institutions for Count machines (Vishakapatnam, NARI, MAMC, RIMS, CMC) and six institutions for Partec machines (Surat, Trichy, Kakinada, Davangere, Lucknow, Medinapur) has been done. Faculty of these institutions has been trained and is imparting further training. All technicians at ART centres are retrained at these institutions every year. Training plan has been developed in consultation with the respective manufacturer and NARI, Pune which provides technical expertise along with the resource persons for the same. Training of trainers was held for five days regionally and the regional training is done for three days for FACS Calibur & Partec and two days for FACS Count. About 225 ART Laboratory Technicians operating these machines have been trained in the year 2010.

CD4 EQAS: NACO with support from Clinton Foundation decided to initiate the development of National CD4 EQAS for Indian CD4 testing laboratories in 2005. National CD4 estimation guidelines were prepared in 2005. NARI functions as an apex laboratory for conducting the EQAS. QASI, Canada was identified as a provider of the CD4 EQAS. First QASI round was done in Feb 2005 and there were 24 participants. QASI panels were distributed in two rounds each in 2005, 2006, 2009 & 2010 and three rounds each in 2007, 2008, & 2009. For Oct, 2009 round, 135 centres have already enrolled. The technology transfer workshop was conducted for four regional Centres at NARI in Sep 2009. QASI would continue to send the samples at expanded sites for the near future. An Indian database, India. qasi-lymphosite was developed and piloted in the proficiency round (Sep-Oct 2009) for data entry, online submission analysis and report preparation.

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

Internal Quality Control Procedures: The programme is supporting the workshops of NRLs and SRLs for ensuring accurate record maintenance and optimal use of controls both positive and negative on a day to day basis. Instructions for preparation of QC sample have also been reiterated to all concerned laboratories. NRLS are preparing the sample as per guidelines and sending to SRLs which will be further aliquoting for use at the peripheral testing sites.

External Quality Assessment Scheme (EQAS):

- NEQAS categorised the laboratories into four tiers, as follows:
  - Apex laboratory (First Tier) - National AIDS Research Institute, Pune
  - Thirteen National Reference Laboratories (NRLs) located in all parts of India are to undertake the EQAS in their respective geographical areas including apex (second tier).
  - At the State level, 118 state reference laboratories (SRLs) (3rd tier) which include an additional SRL which has been nominated at State General Hospital, Naharlagun in Oct 2010, under a microbiologist at the hospital.
  - Districts level, i.e., all ICTC & Blood banks. Thus, a complete network of laboratories has been established throughout the country.
- Training of Apex and NRLs was completed in the first phase, followed by SRLs in the second phase and now in the ongoing third phase ICTCs and blood banks.
- Annually two workshops are to be held at each level upto SRLs.
- At present financial support under NEQAS programme, to Apex laboratory is Rs 23.76 lakhs per year inclusive of NRL grant. The other 12 NRLs

excluding apex have been provided (Rs.6 lakh/ Yr/NRL) and each SRL has been given a grant of Rs. 4.56 lakh this year.

Each NRL has been allotted designated states which are monitored by it and in turn each NRL has SRLs which it is responsible for training and supervision. Each SRL in turn has ICTC and blood banks which it monitors. EQAS calendar for the year 2010-11 has been prepared and shared with the concerned labs.

Under the current financial year, there is a proposal for recruitment of one Technical Officer at each SRL to facilitate supervision, training and continual quality improvement in all SRLs and linked ICTCs. Eighty-one SRLs have already appointed their Technical officers and remaining SRLs are under process of appointment.

Apart from the above financial assistance, NCDC, Delhi, NICED Kolkata and NIMHANS, Bangalore, which have been identified for panel preparation and quality assessment of HIV, HCV and HBV kits along with the Apex lab, have been provided with an additional funding of Rs 9.00 lakhs for the above activity in addition to the NRL grant. The above laboratories are a part of the consortium developed by NACO for kit evaluation.

Assessment of Standards: A level-2 check list was prepared based on the checklist prepared by CDC/WHO/CF which was used for assessment of all 117 SRLs after modification suited to the programme. This activity was done to look at the quality of the labs in August –September 2009 through support from CDC and other donor partners. The results of the assessment were disseminated to the concerned laboratories and follow up activities to improve their standards are being undertaken.

A further assessment was done of the National Reference labs from May 2010 to July 2010 as per NABL standards and labs are being reviewed accordingly.

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

National Early Infant/Child under 18 Months Diagnosis Roll Out: It was proposed to roll out infant and child diagnosis using HIV-1DNA PCR testing. Training on dried blood spot (DBS) and Whole blood (WB) sample collection, storage; transportation and packaging for the National Early Infant Diagnosis (EID) roll out by HIV DNA PCR testing was completed from June- September 2009. The training materials were developed by NACO. NACO with Clinton Foundation trained 767 ICTC and 181 ART centres i.e. approximately 3000 doctors, nurses, and lab technicians across 26 states. NACO designed a vast sample transport network that would ensure timely specimen pick up, testing and report delivery between the 949 specimen collection centres and seven testing labs (already equipped with basic PCR facilities) and have been trained for the above.

NACO developed ICTC-ART centre linkages for child referral for whole blood collection. Retraining was completed in all these centres from February to December 2010. The same has been operationalised in 766 ICTCs & 181 ART Centres across 26 states. As of January 2011, 9,016 infants & children less than 18 months of age were tested under this program.

Development of Systems for Reporting and Investigating 'exceptions': A system of reporting the panel results has been developed where the SRLs report the discordant test results along with the name of the testing centre which is giving discordant results for corrective action and the same is conveyed to the respective NRLs. The same is done at the NRL level where the SRLs are assessed and the final report is compiled at the Apex lab which is shared with NACO annually.

In case there are exceptions where a batch of kit is found to be performing sub optimally, the in charge of the ICTC is to look into the matter and prepare a detailed report which is communicated to the respective SACs. The manufacturer along with NACO and the licensing authorities are informed for further necessary actions and if required after enquiry the batch is withdrawn and detailed enquiry at the central level is done if required.

New Initiatives

- Appointment of regional technical specialists by CDC through PCI who are carefully handholding the labs towards quality and accreditation
- Appointment of 81/118 TOs in the SRLs
- Development of Consortium of NRLs on Quality which has become operational for HIV, HCV and HBV since April 2010
- Reassessment of NRLs on NABL format
- Application by six NRLs for NABL accreditation of which two have been pre-assessed, preparation by four labs for application in the next quarter and review of functioning of two NRLs is proposed.
- Viral load linkages for second line ART centres
- Seven regional workshops of SRLs from April-Sept 2010

CHAPTER 10

Basic Services

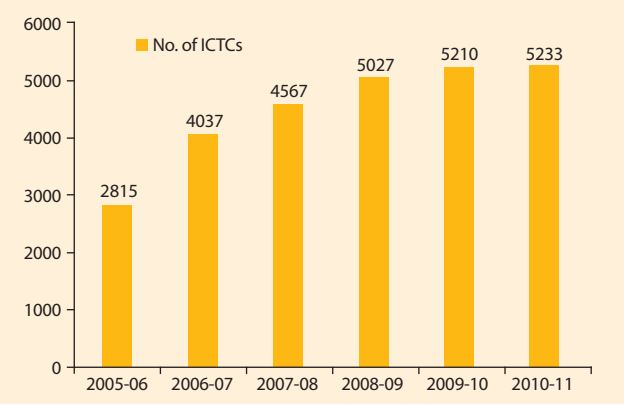
NACP also seeks to ensure that individuals have appropriate pre and post-test counseling and that the test results provided are reliable and meet the quality standards.

Integrated Counseling and Testing Centre

Integrated Counseling and Testing Centre (ICTC) is a place where a person is counseled and tested for HIV on his/her own volition (Client Initiated) or as advised by a health service provider (Provider Initiated). These centres are the entry points for reinforcing HIV prevention messages and linking the HIV positive people to HIV care, support and treatment services. When availing counseling and testing services, people can access accurate information about HIV prevention and care, and undergo an HIV test in a supportive and confidential environment. People who are found HIV-negative are supported with information and counseling to reduce risks and remain HIV-negative. People, who are found HIV-positive, are provided psychosocial support and linked to treatment and care.

HIV testing is a critical service for prevention as well as care, support and treatment objectives of NACP-III. Due to the late stage at which symptoms appear, it is imperative to encourage persons having risk factors to seek testing regularly so that they can seek an early management of their disease as well as prevent further transmission to others. Besides increasing the number of people who seek testing and know their status, NACP also seeks to ensure that individuals have appropriate pre and post-test counseling and that the test results provided are reliable and meet the quality standards. There are several contexts for providing HIV testing services; voluntary counseling and testing, prevention of parent to child transmission, screening of TB patients and diagnostic testing among symptomatic patients. In NACP-III, the concept of the ICTCs illustrates a modified approach to providing HIV testing services, in which the ICTC acts as a hub to smoothen the link between testing services and the broader continuum of care and support services. In the year 2010-11, guidelines have been issued for ICTC Laboratory Technicians to conduct Syphilis Screening of the clients referred by STI Clinics to ensure comprehensive testing services under one roof.

Fig. 10.1: Scale up of ICTCs in the Last Six Years



In addition to stand alone ICTCs, the counseling and testing services are also provided through Facility Integrated PPP ICTCs and Mobile ICTCs.

"Facility-integrated" ICTC is a model which does not have full-time staff and provides HIV counseling and testing as a service along with other services and existing staff such as the Auxiliary Nurse Midwife (ANM), Staff Nurse, Health Visitor, Laboratory Technician (LT) or Pharmacist are expected to undertake HIV counseling and testing. Such ICTCs are usually established in facilities that do not have a very large client load and where it would be uneconomical to establish a stand-alone ICTC. Typically, such facilities are 24-hour Primary Health Centres (PHCs) as well as Private sector/Not-for-Profit Hospitals, Private Laboratories, Public Sector Organisation-run hospitals or facilities, and in the NGO sector. Such ICTCs will be supported by the National AIDS Control Organisation (NACO)/State AIDS Control Societies (SACS) to the extent of supply of rapid HIV testing kits, training of existing staff, quality assurance, supply of protective kits and prophylactic drugs for post-exposure prophylaxis (PEP) for staff, supply of Information, Education and Communication (IEC) material required for an ICTC, such as Flip charts, Posters, etc.

Mobile ICTCs: It is often found that high-risk/ vulnerable populations are less likely to access fixed-facility ICTCs due to several impediments, the most important one being distance and timing. Mobile ICTCs are one way of taking a package of health services into the community. A mobile ICTC consists of a van with a room to conduct a general examination and counseling, and a space for the collection and processing of blood samples.

A team of paramedical health-care providers (a health educator/ANM, Counselor and Lab Technician) can set up this temporary clinic with flexible working hours in hard-to-reach areas, where services are provided ranging from regular health check-up, syndromic treatment for STI/Reproductive Tract Infection (RTI) and other minor ailments, antenatal care, immunisation, as well as HIV counseling and testing services. Mobile ICTCs can, thus, cater to a larger audience and be a more effective preventive intervention by ensuring the reach of services.

In addition to 5,233 stand alone ICTCs, 1,632 Facility Integrated ICTCs, 668 Public Private Partnership model ICTCs and 84 Mobile ICTCs are currently functional. Among the states, Karnataka has the largest number of 24x7 PHC Facility Integrated ICTCs and is leading the country in providing the various services under ICTC through Facility Integrated ICTCs in collaboration with NRHM.

Table 10.1: State-wise number of different type of ICTCs

Number of ICTCs existing as on 30-11-2010				
States/Uts	Stand alone ICTCs	ICTCs in 24x7PHCs (Facility Integrated)	PPP model ICTCs (Facility Integrated)	Mobile ICTC
All India	5,233	1,632	668	84
Andhra Pradesh	677	170	170	25
Arunachal Pradesh	35	0	0	0
Assam	83	4	0	0
Bihar	207	0	6	1
Chhattisgarh	100	0	0	3
Goa	14	3	0	0

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Number of ICTCs existing as on 30-11-2010				
States/Uts	Stand alone ICTCs	ICTCs in 24x7PHCs (Facility Integrated)	PPP model ICTCs (Facility Integrated)	Mobile ICTC
Gujarat	294	336	107	2
Haryana	47	25	2	0
Himachal Pradesh	88	0	0	2
Jammu & Kashmir	34	0	0	0
Jharkhand	64	1	1	0
Karnataka	561	637	108	0
Kerala	162	8	20	0
Madhya Pradesh	143	15	12	0
Maharashtra	678	341	109	8
Manipur	54	0	0	5
Meghalaya	9	0	2	0
Mizoram	27	6	3	4
Nagaland	60	0	0	10
Odisha	184	0	3	1
Punjab	71	64	2	1
Rajasthan	182	15	11	0
Sikkim	12	0	0	1
Tamil Nadu	783	0	85	11
Tripura	18	0	0	0
Uttar Pradesh	217	7	25	0
Uttarakhand	47	0	1	1
West Bengal	256	0	0	0
Andaman & Nicobar Islands	13	0	0	0
Chandigarh	11	0	1	0
Dadra Nagar Haveli	1	0	0	0
Daman & Diu	4	0	0	0
Lakshadweep	0	0	0	0
Delhi	87	0	2	9
Puducherry	10	0	0	0

Reporting status: In 13 states, above 90 percent have reported and in 11 states between 80 percent to 90 percent have reported. The overall reporting status for India is 83.61 percent. A proper feedback is provided every month to the SACS for improving the reporting.

For the year 2010-11, the targets set for testing were 1,11,71,000 general clients, 86,49,500 pregnant women and 14,40,120 cross referals between RNTCP and ICTC. The details of services provided at ICTC are summarised in Table 10.2.

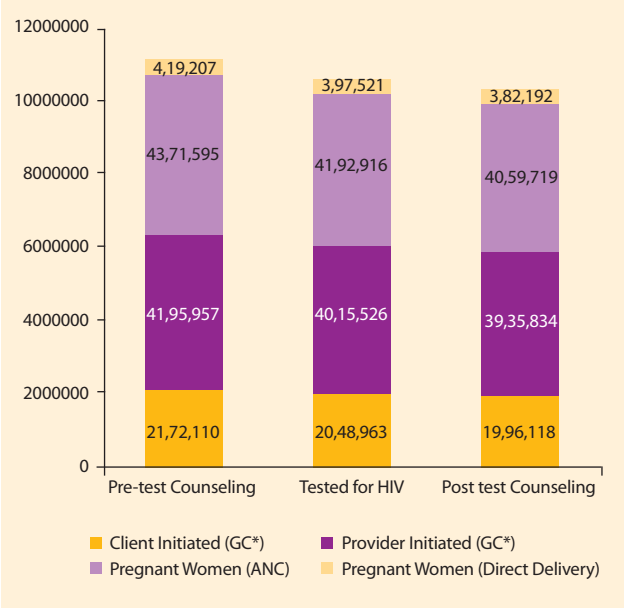
Fig. 10.2: State-wise Reporting Status of ICTCs for the Period (April 2010 to December 2010)

Table 10.2: Details of ICTC Service Provision by Client Type (April - December 2010)

Client Type	No. of beneficiaries				
	Provided Pre-test Counseling	Tested for HIV (% of pre-test Counseled)	Provided Post- test Counseling (% of Tests performed)	Detected HIV positive	HIV Sero-Positivity (%)
Client Initiated (GC*)	21,72,110	20,48,963 (94.33)	19,96,118 (97.42)	84,000	4.10
Provider Initiated (GC*)	41,95,957	40,15,526 (95.70)	39,35,834 (98.02)	1,12,108	2.79
Pregnant Women (ANC)	43,71,595	41,92,916 (95.91)	40,59,719 (96.82)	11,362	0.27
Pregnant Women (Direct Delivery)	4,19,207	3,97,521 (94.83)	3,82,192 (96.14)	1,067	0.27
Total	**1,11,58,869**	**1,06,54,926 (95.48)**	**1,03,73,863 (97.36)**	**2,08,537**	**1.96**

*GC- General Clients

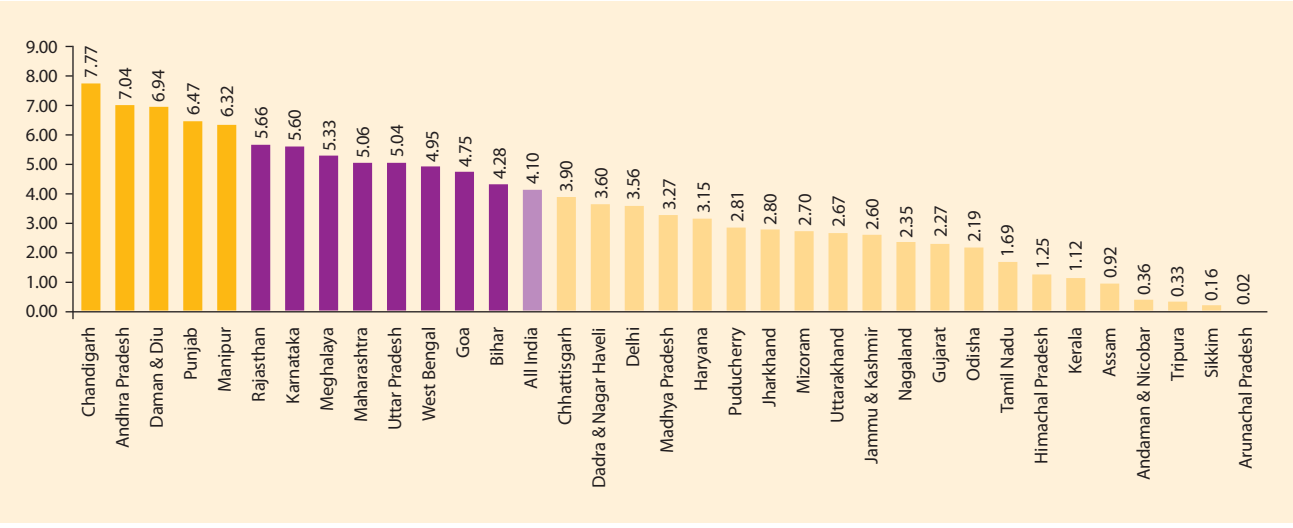
Fig. 10.3: Provision of HIV Counseling and Testing Services by Client Type (April - December 2010)



Among general clients, more persons tested among provider initiated (1,12,108) than among client initiated (84,000). However, the rate of Positivity among client-initiated (4.10%) was greater than that among the provider-initiated (2.79%). Therefore, it is imperative to improve the testing among Client Initiated clients. The positivity among pregnant women either ANCs or Direct Deliveries has been found to be 0.27 percent. As many as 11,362 pregnant women under ANC were found to be HIV positive, while 1,067 pregnant women were found sero-reactive who came for Direct Delivery.

The states of Chandigarh, Andhra Pradesh, Daman and Diu, Punjab and Manipur are showing positivity above six percent among client initiated cases. Against national average of 4.1 percent, eight states are showing the positivity in between four to six percent among client initiated cases.

Fig. 10.4: HIV Seropositivity Among General Clients (client initiated) State-wise (April – December, 2010)



As regards HIV positivity among Provider Initiated Cases who were tested at ICTCs, the overall figure for the country is 2.79 percent. 11 States showed a higher positivity than the all India figure. The states of Manipur, Karnataka and Andhra Pradesh showed HIV positivity more than five percent among Provider Initiated Cases who were tested at ICTCs.

Fig. 10.5: HIV Seropositivity Among General Clients (provider initiated) State-wise (April - December 2010)

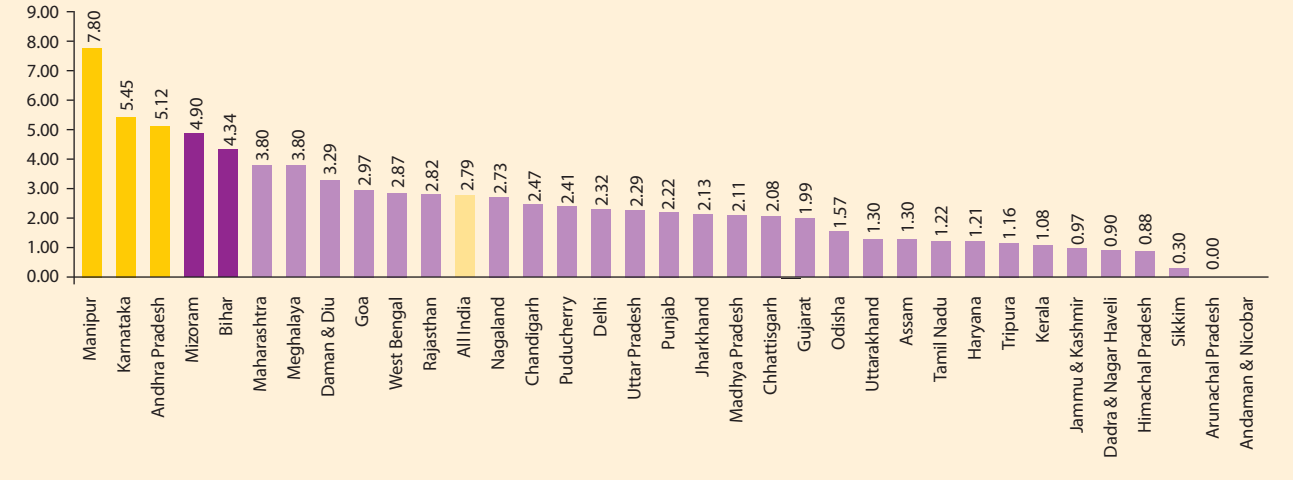


Fig. 10.6: Services at PPTCT

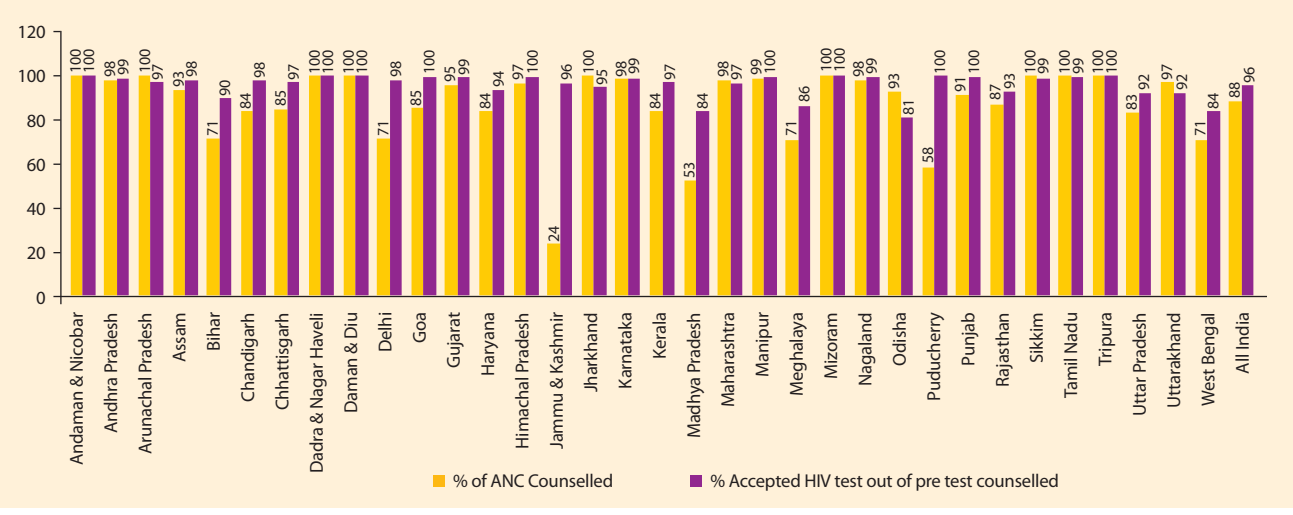


Figure 10.6 shows the percentage of ANC cases pre-test counseled out of registered and percentage of pregnant woman tested for HIV out of the pre-test counseled. Among the states who reported, 20 States more than 90 percent and registered ANC cases accepted and underwent HIV testing. The national average of ANC cases accepting the HIV test out of those pre counseled is 88 percent. The states of Jammu and Kashmir, Madhya Pradesh and UT Puducherry where the acceptance for the HIV test is below 60 percent need to improve their services.

The details of state-wise number of ANC cases registered, Pre-Test counseled, Tested for HIV and detected positive are given in Table 10.3

Linkage and Referral: About 48 lakhs persons have been referred in by different referring units including 22.8 lakhs from Government health facilities, 6.05 lakhs HRGs and 3.68 lakhs from RNTCP.

Prevention of Parent to Child Transmission: Mother to Child Transmission is by far the most

Table 10.3: State-wise Details of Counseling, Testing & PPTCT Services Provided to Pregnant Women for the Period April - December 2010

State/UT	No. of ANC Registrations	No. of Pregnant women provided pre-test counseling (as % of ANC Registrations)	No. of Pregnant women tested for HIV (as % of no. pre-test counseled)	No. of Pregnant women detected HIV Positive (%)	No. of live births to HIV positive mothers	No. of Mother-Baby Pairs who received NVP (as % of detected Positive)
All India	54,20,065	47,90,802 (88.4%)	45,90,437 (95.82%)	12,429 (0.27%)	8,759	8,492 (68.32%)
Andhra Pradesh	6,45,567	6,30,215 (97.6%)	6,21,724 (98.65%)	2,733 (0.44%)	2,439	2,385 (87.27%)
Arunachal Pradesh	7,036	7,409 (105.3%)	7,181 (96.92%)	3 (0.04%)	1	1 (33.33%)
Assam	1,18,485	1,10,424 (93.2%)	1,08,036 (97.84%)	60 (0.06%)	35	34 (56.67%)
Bihar	1,79,372	1,28,066 (71.4%)	1,15,277 (90.01%)	279 (0.24%)	125	123 (44.09%)
Chhattisgarh	56,855	48,119 (84.6%)	46,647 (96.94%)	118 (0.25%)	58	53 (44.92%)
Goa	10,438	8,885 (85.1%)	8,854 (99.65%)	42 (0.47%)	20	20 (47.62%)
Gujarat	3,95,211	3,76,888 (95.4%)	3,74,903 (99.47%)	674 (0.18%)	481	460 (68.25%)
Haryana	80,907	68,197 (84.3%)	63,818 (93.58%)	82 (0.13%)	33	33 (40.24%)
Himachal Pradesh	27,183	26,294 (96.7%)	26,224 (99.73%)	15 (0.06%)	7	7 (46.67%)
Jammu & Kashmir	1,04,020	24,523 (23.6%)	23,659 (96.48%)	14 (0.06%)	7	6 (42.86%)
Jharkhand	42,066	42,013 (99.9%)	39,794 (94.72%)	73 (0.18%)	22	28 (38.36%)
Karnataka	5,51,497	5,43,196 (98.5%)	5,36,243 (98.72%)	2232 (0.42%)	1595	1,560 (69.89%)
Kerala	1,01,427	85,166 (84%)	82,675 (97.08%)	62 (0.07%)	54	52 (83.87%)

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State/UT	No. of ANC Registrations	No. of Pregnant women provided pre-test counseling (as % of ANC Registrations)	No. of Pregnant women tested for HIV (as % of no. pre-test counseled)	No. of Pregnant women detected HIV Positive (%)	No. of live births to HIV positive mothers	No. of Mother-Baby Pairs who received NVP (as % of detected Positive)
Madhya Pradesh	2,60,893	1,37,051 (52.5%)	1,15,289 (84.12%)	151 (0.13%)	114	112 (74.17%)
Maharashtra	6,11,753	5,98,590 (97.8%)	5,78,444 (96.63%)	2,887 (0.5%)	1350	1,317 (45.62%)
Manipur	33,395	32,938 (98.6%)	32,801 (99.58%)	183 (0.56%)	154	148 (80.87%)
Meghalaya	14,065	9,977 (70.9%)	8,618 (86.38%)	74 (0.86%)	10	6 (8.11%)
Mizoram	12,935	14,344 (110.9%)	14,315 (99.8%)	105 (0.73%)	86	89 (84.76%)
Nagaland	10,628	10433 (98.2%)	10,333 (99.04%)	111 (1.07%)	72	68 (61.26%)
Odisha	1,63,755	152451 (93.1%)	1,23,940 (81.3%)	195 (0.16%)	145	127 (65.13%)
Punjab	94,032	85,983 (91.4%)	85,560 (99.51%)	166 (0.19%)	77	76 (45.78%)
Rajasthan	2,75,572	2,39,188 (86.8%)	2,22,277 (92.93%)	272 (0.12%)	210	203 (74.63%)
Sikkim	3,874	4,846 (125.1%)	4,774 (98.51%)	1 (0.02%)	1	1 (100%)
Tamil Nadu	6,89,181	6,87,787 (99.8%)	6,82,568 (99.24%)	887 (0.13%)	1111	1085 (122.32%)
Tripura	8,010	8,005 (99.9%)	7,988 (99.79%)	7 (0.09%)	1	1 (14.29%)
Uttar Pradesh	3,85,052	3,20,690 (83.3%)	2,94,988 (91.99%)	315 (0.11%)	212	185 (58.73%)
Uttarakhand	30,936	30,110 (97.3%)	27,635 (91.78%)	39 (0.14%)	9	11 (28.21%)
West Bengal	2,67,900	1,89,395 (70.7%)	1,59,141 (84.03%)	195 (0.12%)	108	90 (46.15%)
Andaman & Nicobar Islands	4,472	4,472 (100%)	4,472 (100%)	0 (0%)	0	0 (NA%)
Chandigarh	18,821	15,833 (84.1%)	15,547 (98.19%)	156 (1%)	29	28 (17.95%)
Dadra & Nagar Haveli	1,735	1,735 (100%)	1,735 (100%)	1 (0.06%)	1	1 (100%)
Daman & Diu	1,147	1,147 (100%)	1,143 (99.65%)	2 (0.17%)	1	2 (100%)
Delhi	1,74,376	1,24,644 (71.5%)	1,22,055 (97.92%)	272 (0.22%)	159	151 (55.51%)
Puducherry	37,469	21,788 (58.1%)	21,779 (99.96%)	23 (0.11%)	32	29 (126.09%)

Table 10.4: Sources and Number of Referrals to ICTCs During April - December 2010

Referral Unit	Male	Female	TS/TG	Total
NGO/CBO TI's	3,12,220	2,80,079	12,853	6,05,152
Non TI NGOs	1,08,344	78,709	1,889	1,88,942
OBG/Maternity Homes	1,26,289	1,29,663	3,636	2,59,588
RNTCP	2,45,431	1,22,579	281	3,68,291
Blood Bank	10,095	3,002	3	13,100
Government health facilities	12,41,202	10,36,485	2,788	22,80,475
ART centres	7,668	6,508	40	14,216
STI clinics	1,25,170	1,93,232	841	3,19,243
Care centres (CCC) & DIC	8,151	5,954	70	14,175
Private health facilities	91,899	68,546	122	1,60,567
Others	3,87,359	1,95,920	812	5,84,091
Total In Referral	**26,63,828**	**21,20,677**	**23,335**	**48,07,840**

significant route of transmission of HIV infection in children below the age of 15 years which occurs during pregnancy, during child birth or breastfeeding. The effects of the epidemic among young children are serious and far- reaching. AIDS threatens to reverse years of steady progress in child survival, and has already doubled infant mortality in the worst affected countries.

PPTCT out-reach component is implemented under RCC-II of GFATM by IL&FS to minimise loss to follow-up of positive pregnant women and to follow-up babies till the age of 18 months in order to have effective out-reach, the PPTCT out-reach programme was implemented under RCCII through IL&FS.

Outreach Worker (ORW): An ORW is preferably a positive person who can understand and counsel the pregnant mother well as he/she come from the same background and can understand the stigma and discrimination attached to it. Confidentiality issue is also taken care through this set-up.

After delivery, ORWs also follow up with the Mother and Baby pair. They maintain a daily dairy and update the district coordinator on the daily/weekly progress of various patients.

Programme Roll Out: A rationale was created among the existing staff on PPTCT by conducting an in-house training for the state coordinators and key central team staff. Before the initiation of the programme, the team had visited a number of states like Manipur, Maharashtra, Andhra Pradesh and Tamil Nadu for first hand learning and understanding of the work flow as well as the management of the same. During these visits, meetings were held with the Project Directors and officers at SACS, ORWs and NGOs.

Status of the Programme: In the first quarter of 2010, the programme was rolled out in the states of Tamil Nadu, Andhra Pradesh, Maharashtra, Manipur and Delhi. Simultaneously, IL&FS scaled up the outreach programme in the second and third quarter to cover 23 states across the country. The state coordinators and central team are responsible for monitoring the activities in the field.

HIV-TB Collaborative Activities: It is known that TB is the commonest opportunistic infection among HIV-infected individuals. Further it is also known that TB being a major public health problem in India accounts for 20-25 percent of deaths among PLHIV. On the other hand, it is noted that nationally about five percent TB patients registered under RNTCP also have HIV infection. This HIV positivity among TB patients varies across the states and districts in the country between one and 13%, and is related to HIV prevalence in the general population. In high prevalent states and districts, positivity among TB patients is over 10 percent and may be as high as 40 percent in certain districts. Thus, while the country is dealing effectively with HIV burden, TB associated HIV epidemic is posing an important challenge. This becomes even more critical in the presence of MDR-TB/X-DR TB in the community. The existence of HIV and TB together, greatly amplifies harmful effects of each other at individual level and contribute substantially to mortality among PLHIV. Therefore, HIV-TB programme level collaboration is a key strategy adopted by the Department of AIDS Control and Central TB division. The Department takes the

lead in strengthening this coordination between the National AIDS Control Programme (NACP) and the Revised National TB Control Programme (RNTCP) at all levels. The two programmes have together developed an integrated response for effective control of the dual epidemic of HIV/TB.

As prevalence of TB infection in India is more than 40%, a large proportion of PLHIV also is likely to be already infected with TB bacteria. Moreover, it is known that HIV makes an individual more prone to acquire TB infection as well as progress rapidly to TB disease. Such patients deteriorate rapidly if not linked to HIV care and support services. RNTCP offers an opportunity to test all TB patients for HIV and thus detect underlying HIV at the earliest.

The HIV-TB response is governed by the National (policy) Framework for Joint TB/HIV Collaborative Activities jointly developed in 2007, and subsequently revised in 2008 and 2009. The framework acts as a guiding principle to implement various activities and initiatives at all level of the programme. Broadly, the HIV/TB national policy at present includes:

- Standard mechanisms for coordination at national, state and district level
- Intensified TB case finding at HIV Care Settings
- Intensified TB-HIV Package
- Strategy for TB prevention among PLHIV

Overall objective of these activities is to decrease morbidity and mortality due to TB among PLHIV and to decrease the impact of HIV among TB patients.

The Standard Coordination Mechanism: The National Technical Working group (NTWG) constituted at national level is the lead policy making body in the HIV/TB collaboration. At State and district levels coordination committees and working groups have been formed across the country. The coordination activities are closely monitored by NACP and RNTCP both at state and national level.

Intensified TB Case Finding (ICF) at HIV Care Settings: Intensified TB case finding is an accepted strategy at all HIV care settings including ICTC, ART centre's, LAC, CCC, TI intervention sites etc. It is an intervention that detects HIV/TB early and ensures further linkage to DOTS treatment under RNTCP. ICF at ICTC is having implemented across the country since 2008-09, but ICF activity at ART centres was implemented in later 2009 and first quarter of 2010. All ART centres are yet to complete training and report to NACO. Through Intensified TB Case Finding, 21,571 HIV infected TB patients were detected among 3,28,483 persons screened in ICTC and ART Centres during 2010 (Table 10.5).

Table 10.5: Status of implementation of Intensified TB Case Finding at ICTC and ART Centres, 2010

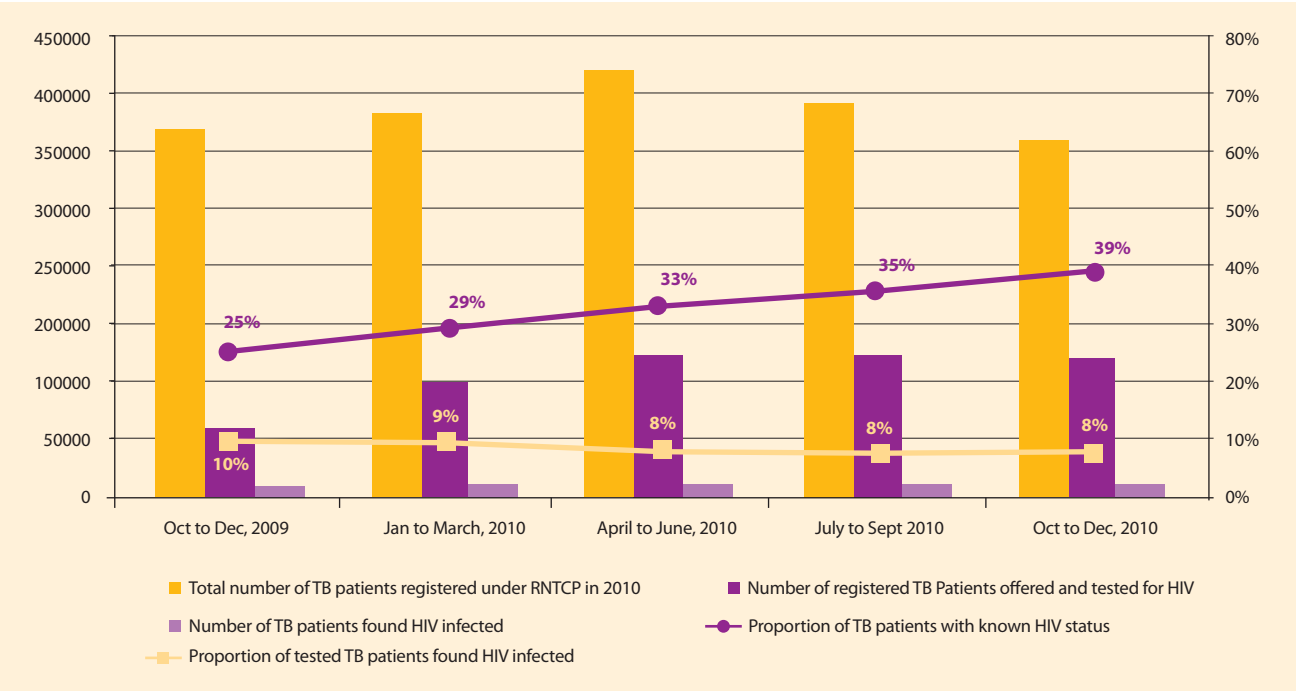
Site of Implementation of Intensified TB case finding	Number of clients/patients screened for TB diagnosis	Number of HIV Infected TB patients detected
ICTC	2,90,542	12,045
ART centre	37,941	9,526
TOTAL	**3,28,483**	**21,571**

Intensified Package of HIV/TB Collaborative Activities: This package pertains to the following set of activities

- Offer of HIV test to all TB patients registered under RNTCP
- Decentralised provision of Cotrimoxazole prophylactic therapy (CPT) to all HIV infected TB patients detected
- Linkage of all HIV infected TB patients to HIV care, support and ART
- Systematic recording and reporting of above activities in RNTCP MIS

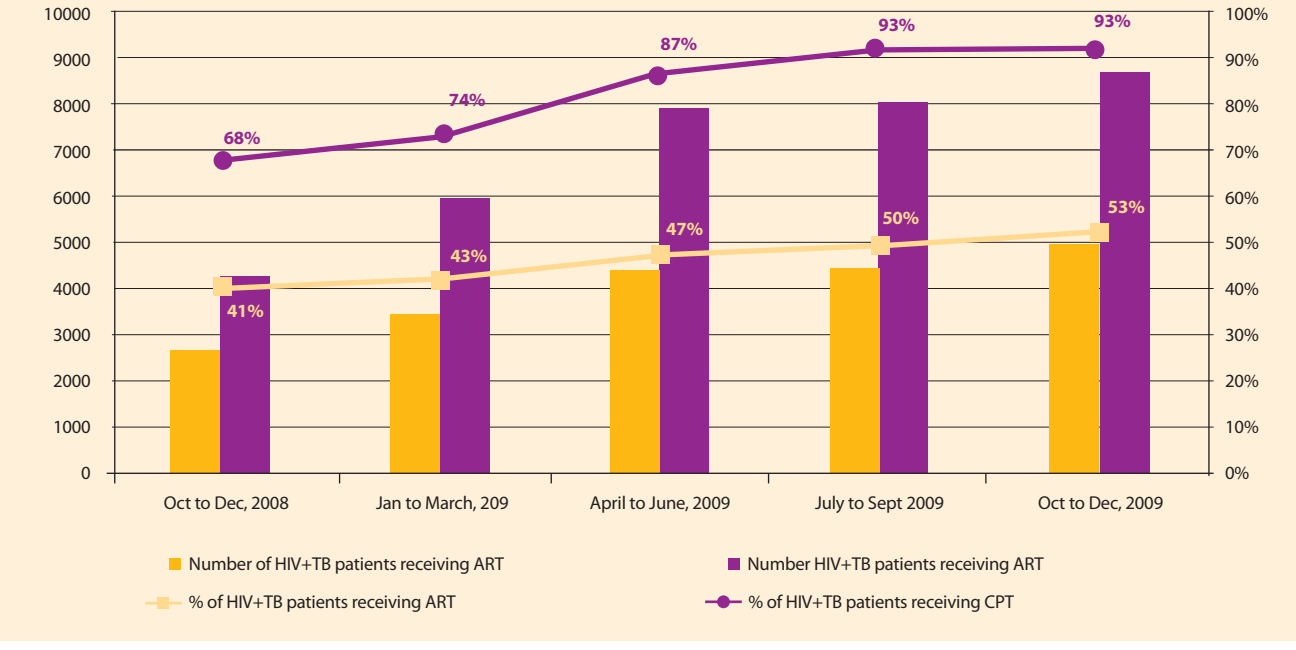
The intensified package is to be uniformly implemented across the country, and majority states and UTs are already implementing the activities. It is planned to ensure complete coverage by the end of 2011. Figure 10.7 shows the progress made in implementation of the intensified TB/HIV package The activities are rooted well in all high prevalence states where the proportion of TB patients with known HIV status has now exceeded 80 percent. But, in low prevalence states and states which initiated the activities in 2010, it is yet to pick up. Nationally about 40 percent TB patients are with known HIV status (Fig.10.7). A major challenge in these states is low proportion of HIV testing facilities compared to TB testing facilities, specially in large states in north India like UP, Bihar, etc. To bridge this infrastructure deficit, NACO is contemplating use of Whole Blood HIV test (WBT) for screening of TB patients along with the ANC in such areas. The WBT is planned for expansion over 2011-12, in phased manner and in districts with deficit of HIV testing facilities.

Fig. 10.7: Status of implementation of Intensified HIV/TB Package, India (2010)



Source: RNTCP quarterly report data

Fig. 10.8: Linkage of HIV Infected TB Patients to CPT and ART

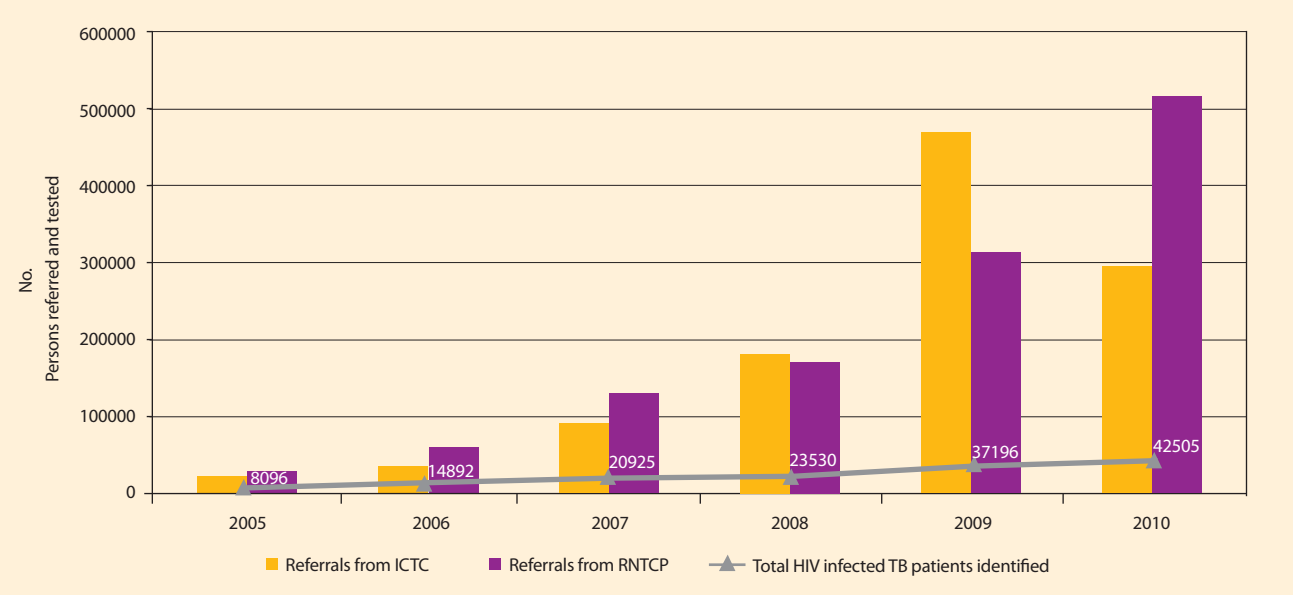


Source: RNTCP quarterly report data from nine high prevalent states

Nationally about eight percent of TB patients are also infected with HIV (Fig. 10.7); the linkage of these patients to CPT and ART is showing consistent improvement (Fig.10.8). In 4th Quarter of 2009 cohort, 93 percent HIV infected TB patients are initiated on CPT and 53 percent are linked to ART. Linkage to ART services still remains a challenge due to various operational difficulties including fewer ART centres, especially in low prevalent states.

Scale up of HIV/TB Collaborative Activities: Starting in 2005, the HIV/TB collaborative activities have progressively improved with a consistently increasing number of HIV infected TB patients being diagnosed. In 2005, the cross-referral between NACP and RNTCP was about 54,000 and more than 10,000 HIV infected TB patients were detected. In 2010, the programme achieved over eight lakh cross-referrals and detection of more than 42,000 HIV infected TB patients. This

Fig. 10.9: Scale up of HIV-TB Collaborative Activities India



Source: NACO CMIS

increase in cross referrals is largely attributed to the expansion of intensified HIV/TB package. Details of the progress are depicted in Fig.10.9.

Prevention of Tuberculosis among PLHIV: Internationally recommended strategy for prevention of TB among PLHIV are (i) TB ICF in HIV care settings, (ii) Isoniazid Preventive Therapy for PLHIV (IPT), and (iii) TB infection control in HIV care settings. NACP is already implementing the ICF and infection control is an important activity implemented at the ART centres. Activities like "fast-tracking" of TB suspect at ART centre for diagnosis and treatment, health education on cough hygiene, etc., are implemented across all ART centres in the country. This is supported with relevant IEC material displayed at the centres also. Administrative and Environmental infection control measures too are encouraged at ART centres. In the coming year, this component will be strengthened and further incorporated into all HIV care settings. Lastly, although NACP accepts the international evidence on importance of IPT as a TB prevention strategy fro PLHIV, it is not yet adopted due to various concerns regarding feasibility of implementation and efficacy in Indian ART programme scenario. Therefore, it is planned to complete a rapid feasibility-cum-efficacy study and decide on adoption of IPT as a preventive strategy in 2011.

New Initiatives for 2011-12

1. Piloting of highly efficacious regimen for PPTCT programme in 40 priority districts.
2. Scale-up of Whole Blood HIV test for screening TB patients and community screening of Pregnant Women.
3. 100 percent coverage of intensified TB/HIV package
4. Introduce ICF activities at other HIV care settings like Link ART Centres, Community Care Centres and Targeted Intervention sites
5. Feasibility-cum-implementation study for IPT for PLHIV
6. Strategic Information Management System (SIMS) roll out in ICTCs.

During the year 2011-12, it is planned to achieve the following targets under Basic Services Component:

No.	Coverage Indicators	Targets (2011-2012)
1	Number of general clients counseled and tested	12,000,000
2	Number of pregnant women counseled and tested	9,000,000
3	Number of HIV+ve pregnant women diagnosed as HIV+ve	25,000
4	Number of MB pairs covered with prophylactic ARV	70%
5.	Number of clients referred from ICTC to RNTCP	4,00,000
5	Number of TB clients knowing their HIV status	5,50,000
6	Number of HIV infected TB cases detected	40,000
7	Number of facility integrated ICTCs in 24X7 PHCs	1200
8	Number of facility integrated ICTCs under PPP	600

CHAPTER 11

Care, Support and Treatment

The Care, Support and Treatment component of NACP-III aims to provide comprehensive management to PLHIV with respect to prevention and treatment of Opportunistic Infections, psychosocial support, home-based care, positive prevention and impact mitigation.

One of the major objectives of NACP-III is to provide greater care, support and treatment to larger number of PLHIV with ultimate goal of universal access for all those who need it. The Care, Support and Treatment component of NACP-III aims to provide comprehensive management to PLHIV with respect to prevention and treatment of Opportunistic Infections including TB, Anti-retroviral Therapy (ART), psychosocial support, home-based care, positive prevention and impact mitigation. For this, following targets have been set to be achieved by March 2012:

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

Progress made in provision of Care, Support and treatment services in the first 3 and a half years (July 2007 to December 2010) of NACP-III is detailed below. Details of facility planned and established are given in Table 11.1.

Table 11.1: Infrastructure for Care, Support and Treatment Services

Facility for CST	Baseline (March 2007)	NACP-III Target (March 2012)	Achievement (Dec 2010)
ART Centres	107	250	292
Centres of Excellence	0	10	10
Link ART Centres	--	--	550
Community Care Centres	122	350	255
Regional Paediatric ART Centres	0	7	7

Service Delivery Mechanism for Care Support & Treatment

ART Centres: Anti-retroviral Therapy (ART) for eligible persons living with HIV/AIDS was launched on 1 April, 2004 in eight government hospitals located in six high prevalence states. Since then, the programme has been scaled up both in terms of facilities for treatment and number of beneficiaries seeking ART. The ART centres are established mainly in the Medicine Departments of Medical colleges and District Hospitals in the Government Sector. However, some ART centres are functioning in the sub- district and area hospitals also mainly in high prevalence states. The ART centres are set up based on prevalence of HIV in the district/region, volume of PLHIV detected and capacity of the institution to deliver ART related services. Currently (December 2010), there are 292 fully functional ART Centres against the target of 250 by March 2012. However, based on need and demand of ART, number of centres likely to be functional by March 2011 is estimated to be around 300.

Centres of Excellence (COE): The HIV/AIDS epidemic has, over the past decade, evolved into a more complex one necessitating operational research, effective health delivery systems and a trained and motivated work force. There was need for medical institutions which deliver high quality of care, treatment and support to People Living with HIV (PLHIV). Complex treatment schedules and patient management require constant training and upgrading of skills among providers. To facilitate provision of tertiary level specialist care and treatment, Second Line & Alternate First Line ART, training & mentoring and operational research, Centres of Excellence were envisaged under NACP-III. At present, 10 such centres are functioning in the country.

Service delivery at ART centre

Link ART Centres: Link ART centres (LACs) were originally planned under NACP-III. A NACO study on "Assessment of ART centres: Clients' and Providers' Perspectives", revealed that distance, travel time and costs were the main reasons for patients not attending ART services regularly. In order to facilitate the delivery of ART services nearer to the beneficiaries, it was decided to set up Link ART Centres located mainly at ICTC in the district/sub-district level hospitals nearer to the patient's residence and linked to a Nodal ART centre within accessible distance. Presently, 550 Link ART Centres have been established and made functional; this number is likely to be increased to 600 by March 2011.

Community Care Centres: With the mandate of providing a comprehensive package of CST services, the Community care Centres (CCC) have been set up in the non-government sector with the objective of providing psycho-social support, ensure drug adherence and provide home-based care. CCCs are linked with ART Centres and ensure that PLHIV are provided (a) counseling for ARV treatment preparedness and drug adherence, nutrition and prevention; (b) treatment of Opportunistic Infections; (c) referral and outreach services for follow up; and (d) social support; Tracing patients lost to follow-up (LFU) and those missing to get ARV drugs as per schedule, is also envisaged in their functioning. At present, 255 CCCs are fully functional.

Regional Pediatric Centres: Pediatric ART is provided at all ART centres. The Regional Paediatric ART Centres (RPC) serve as Centres of Excellence for Paediatric care including management of complicated OIs, training and research activities. These Centres have varying roles and responsibilities for delivery of care and support to infected children including specialised laboratory Services Early Infant Diagnosis, ART to children infected with HIV, counseling on adherence and nutrition, etc. These centres also provide technical support to the other ART centres in Paediatric care. Currently, seven RPCs are functional in the country.

Coverage of Services

Main services provided to PLHIV under care, support & treatment include:

- Registration of PLHIV for ART and pre-ART services;
- Assessment of eligibility of ART based on clinical examination and CD4 count;

- Provision of first line ART to all eligible PLHA and CLHA
- Follow-up of patients on 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; and
- Provision of alternate first line and second-line ART to those experiencing drug toxicities and treatment failure, respectively

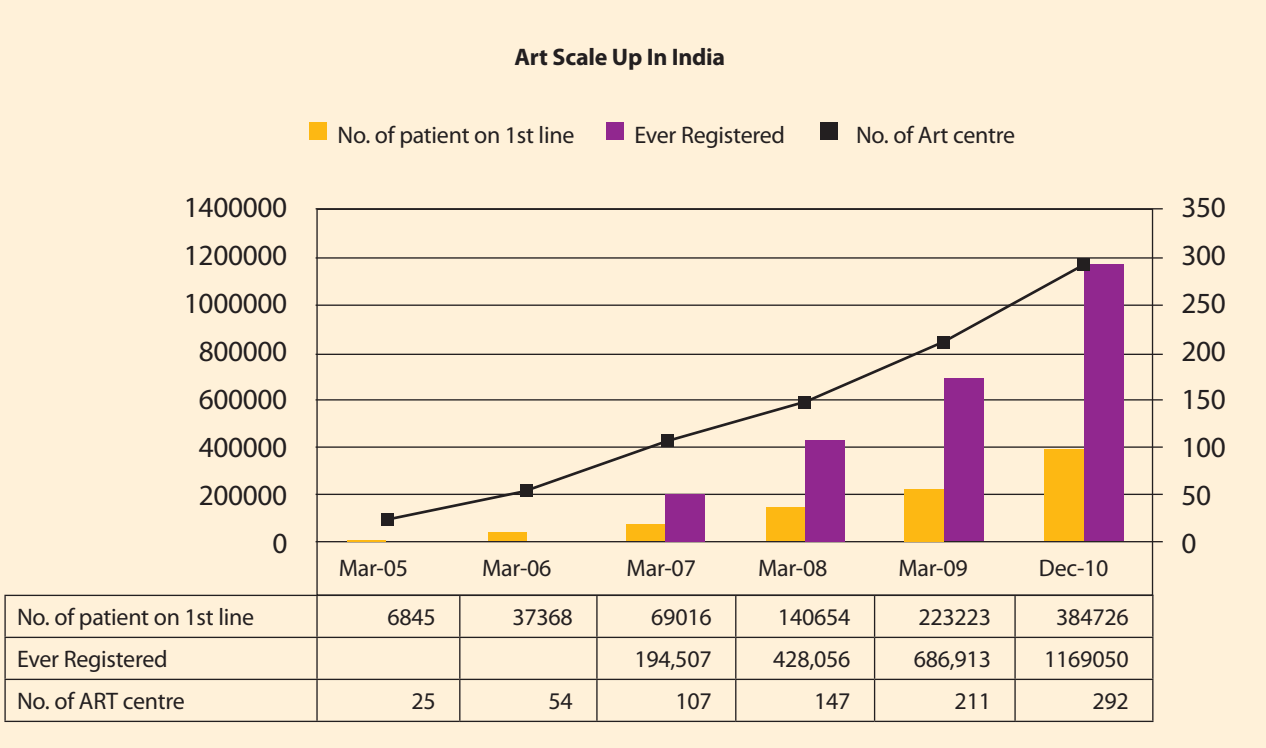
The details are provided in Table 11.2, 11.3 and Figure 11.1.

Table 11.2: No. of Persons Living with HIV/AIDS receiving Care, Support & Treatment Services

Services/Beneficiaries	Baseline (March 2007)	NACP-III Target (March 2012)	Achievement (Dec 2010)
Adults registered for ART	1,85,953	-	10,89,331
Adults ever Started ART	80,355	-	5,71,000
Adults alive and on ART	59,673	3,00,000	3,61,889*
Children registered for ART	14,409	-	79,719
Children ever Started ART	4,925	-	33,058
Children alive and on ART	4,107	40,000	22,837
Opportunistic Infections Treated	70,099/year	3,00,000/year	1,54,091/year
Persons referred for 2nd line ART	0	-	2,834
Persons alive and on 2nd line ART	0	-	1,929

*In addition, 2,479 PLHIV are receiving ART in inter-sectoral sector

Fig.11.1: ART Scale up in India



No. of patient on 1st line	6845	37368	69016	140654	223223	384726
Ever Registered			194,507	428,056	686,913	1169050
No. of ART centre	25	54	107	147	211	292

Table 11.3: State-wise List of ART Centres and Patients on ART (As on Dec. 2010)

State	No. of ART Centres	No. of PLHIV on ART		
		Adult	Paediatric	Total
Andhra Pradesh	38	79,009	4,050	83,059
Arunachal Pradesh	1	30	0	30
Assam	3	1,175	49	1,224
Bihar	6	7,435	371	7,806
Chandigarh	1	1,558	168	1,726
Chhattisgarh	4	1,791	157	1,948
Delhi	9	7,823	621	8,444
Goa	1	1,133	82	1215
Gujarat	18	17,775	979	18,754
Haryana	1	1,917	119	2,036
Himachal Pradesh	3	1,160	119	1,279
Jammu & Kashmir	2	596	43	639
Jharkhand	4	2,051	128	2,179
Karnataka	41	49,353	3,640	52,993
Kerala	8	4,895	265	5,160
Madhya Pradesh	7	4,384	297	4,681
Maharashtra	51	85,596	6,017	91,613
Manipur	7	6,043	491	6,534
Meghalaya	1	120	3	123
Mizoram	1	913	54	967
Nagaland	5	2,091	99	2,190
Odisha	4	2,664	106	2,770
Puducherry	1	640	66	706
Punjab	6	5,950	348	6,298
Rajasthan	6	8,336	551	8,887
Sikkim	1	46	1	47
Tamil Nadu	40	45,179	2,776	47,955
Tripura	1	149	2	151
Uttar Pradesh	10	13, 683	789	14,472
Uttarakhand	2	771	64	835
West Bengal	9	7,623	382	8,005
Total	292	3,61,889	22,837	3,84,726

Capacity Building for CST

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

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

The curriculum for training of faculty/specialists of Medical Colleges & District Hospitals, ART, CCC & LAC Medical Officers have been revised. The Training of Master Trainers on revised curriculum have been done through three regional workshops at MAMC Delhi, STM Kolkata and GHTM Tambaram.

The following Institutions have been recognised for training of doctors:

a. Maulana Azad Medical College, New Delhi
b. J J Hospital, Mumbai
c. BJ Medical College, Ahmedabad
d. PGIMER, Chandigarh
e. Gandhi Hospital, Hyderabad
f. Bowring Hospital, Bangalore
g. School of Tropical Medicine, Kolkata
h. Regional Institute of Medical Sciences, Imphal
i. Government Hospital of Thoracic Medicine, Tambaram
i. Institute of Medical Sciences, BHU, Varanasi
j. MDM Hospital, Jodhpur
k. Christian Medical College, Vellore
l. St Johns Medical College, Bangalore
m. CSM Medical University, Lucknow
n. NARI & BJMC Consortium, Pune
o. NSCB Medical College, Jabalpur

Development of Operational Guidelines and Modules

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

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

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

National Conference on Paediatric HIV

The National AIDS Control Organisation, in collaboration with the Ministry of Women & Child Development, UNICEF, WHO, UNAIDS, IAP and FOGSI, organised a National Conference on Paediatric HIV from 1-3 December, 2010 at PGIMER, Dr. Ram Manohar Lohia Hospital, New Delhi. The theme of the conference was **"Towards Elimination of Paediatric HIV".** Around 400 delegates participated in this conference.

The conference was inaugurated by Shri. Ghulam Nabi Azad, Honourable Union Minister of Health & Family Welfare. Shri K. Chandramouli, Secretary & DG, NACO; Dr. R.K. Srivastava, Director General of Health Services; Ms. Katharina Hulshof, Country Representative, UNICEF; and Dr.B.B. Rewari, NPO (ART), NACO were present on the occasion.

At the conference, information related to new research and evidence-based programmes and policies relating to Prevention of Parent to Child Transmission (PPTCT) and Paediatric HIV was

Inauguration of the National Conference on Paediatric HIV by Ghulam Nabi Azad, Honourable Minister for Health & FW

discussed. It provided an opportunity for many stakeholders involved in PPTCT and Paediatric HIV Care support and treatment to take stock of the current programme implementation status, evaluate recent scientific developments, lessons learnt and collectively chart out course forward.

The conference identified areas to facilitate stronger linkages between recent scientific development and current programme implementation, share and learn from a diverse range of stakeholders who share the commitment to further mitigate the impact of HIV/AIDS specifically towards the Elimination of Paediatric HIV infections. The conference also deliberated on the operational issues for the optimal delivery of care to HIV exposed children in India and also the means to increase public awareness of the continued impact of HIV and the need for the elimination of Paediatric HIV infection in the country.

Measures to Provide High Quality Services

Technical Resource Groups on CST

Technical Resource Groups consisting of experts have been constituted on following subjects:

- TRG on ART
- TRG on Paediatric HIV (Re-constituted)
- TRG on Community Care Centres (Re-constituted)
- TRG on Laboratory services
- National HIV Drug Resistance Committee

These groups review the progress and give valuable suggestion and recommendations on various technical and operational issues relating to the programme. Meetings of TRGs are held periodically with clearly drawn agenda and issues for discussion.

Strengthening the Capacity of Laboratories for CD4 Testing: There are 211 CD4 machines installed at present serving 292 ART centres. All machines procured by NACO are under comprehensive maintenance or warranty.

Supply Chain Management for ARV Drugs: One of the most vital components of drug adherence is continuity of supply of drugs to the 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 three months stock of drugs. In case of shortage, re-location of drugs is done in order to ensure that there are no stock outs. The supply chain management of ARV drugs and CD4 kits is done by a dedicated supply chain team appointed at NACO.

Standard Monitoring Formats: A set of Monitoring and Evaluation Tools and Formats have been developed for standardised recording and reporting from different Centres. The monthly reporting format for sending reports from ART Centres to NACO has been modified. Also formats for reporting of patients on second line and alternative first line have been developed. The various formats are:

- Pre-ART register
- ART enrolment register
- Patient ART record (White Card)
- Patient ID card (Green Card)
- Drug stock register
- Drug dispensing register
- Monthly report format from ART Centres- (updated Oct' 2009)
- Monthly CCC reporting format
- Second line weekly summary report - Nov 2008
- Alternate first line weekly summary report- Oct 2009 (updated Jan 2010)
- Alternate first line and second monthly report format- Oct 2009 (updated Jan 2010)

In the monthly ART centre reporting format, additions have been made to get more information on HRG, CD4 counts and socio- economic status of the patients.

Supervisory/Monitoring Mechanism: Care Support & Treatment Division at NACO is responsible for planning, financing, implementation; supply chain management, training, Coordination, monitoring & evaluation of care support & treatment services in the country.

The implementation and monitoring at State level is the the responsibility of the concerned State AIDS Control Societies (SACS) consisting of Joint Director (CST), Deputy Director/Asst. Director (C&S), Assistant Director (Nursing) and Consultant CST based on volume of CST activities in the state.

For close monitoring, mentoring and supervision of ART Centres, various states have been grouped into regions and Regional Coordinators have been appointed to supervise the programme in their regions. The Regional Coordinators and SACS

officials visit each allotted ART Centres at least once in two months and they send regular weekly and monthly reports to NACO. Periodic meetings of Regional Coordinators are held at NACO to review various issues pointed out by them. In addition, NACO officials also visit particularly the centres that are not performing satisfactorily or are facing problems in implementation of the programme.

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

ART CCC Coordination Meeting: ART centre-CCC coordination meetings are also held in order to facilitate the induction of newly established Community Care Centres to facilitate the linkages and referral system with ICTCs, CCC, ART centres. These meetings are attended by the Project Coordinators of the CCC and Medical Officers at the ARTs. Members of the Governing Board of the NGO running CCC have also been encouraged to attend these Meetings. These meetings provided a good platform to address the local operational issues surrounding the ART Centres and the CCC and have better coordination between ART & CCC.

State Grievance Redressal Committee: At the state level, Grievance Redressal committee has been constituted to routinely review functioning of the ART Centres. The Committee is headed by the Health Secretary of the State and shall consist of Project Director of the SACS, Director of Medical Education, Director Health Services, and the Nodal Officers of the ART centre, representative of Civil Society/ positive network and NACO. This mechanism ensures that issues pertaining to grievances on PLHIV are brought into notice of state authorities and SACS in a systematic manner for timely response.

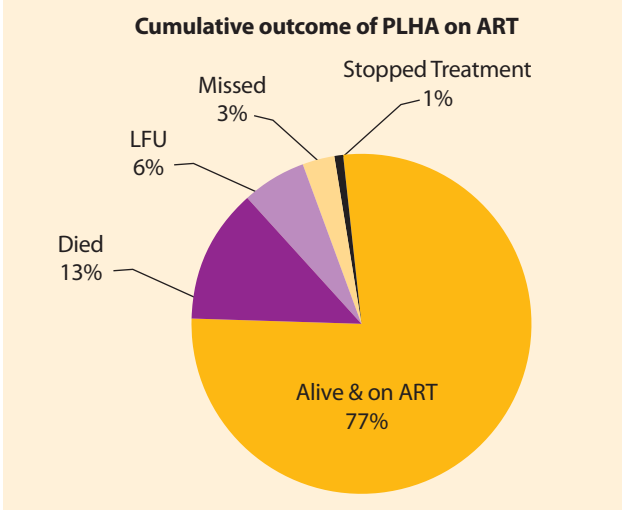
Missed/LFU Tracking Mechanism: The information on patients lost to follow up (LFU) is captured in the CMIS through the monthly reports from the ART Centres. This information is monitored very closely and Centres with high rates of LFU are visited by senior officers of NACO. Presently the cumulative LFU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

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

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

- Much of the affected population is mobile. This card will help in accessing care and support in all parts of the country;
- Monitoring of treatment to ensure adherence to the treatment plan is essential to prevent the patient from becoming drug resistant;

Fig. 11.2: Cumulative outcome of PLHA on ART



- The patient's information can be kept confidential given the prejudices against the disease;
- Acts as a portable medical record;
- Linking the PLHIV for treatment of Opportunistic Infections;
- Linking with other social and health schemes;
- Plays a crucial role in time-sensitive emergency situations;
- Gives a cheaper alternative for storing data using the latest technology;
- Generates a set of important MIS reports that are immune to human errors; can act as early warning signals; help in decentralised decision making; can help in setting regional priorities;
- Prevents misuse of health subsidies.

Application Software for the Smart Card system has been developed and the project implementation will commence in 2011-12.

Evaluation & Operational Research

During the first half of NACP-III, various studies conducted in relation to CST are given below:

Studies Completed

- Assessment of ART Centres in India: Clients' and providers' perspectives
- Baseline CD4 count of PLHA enrolled for ART in India
- Assessment of Link ART Centres in India
- Assessment of the Centres of Excellence (COE) in India
- Assessment of Regional Paediatric Centres
- Assessment of Community Care Centres in India
- Factors affecting enrolment of PLHIV in ART centres
- Baseline CD4 count of healthy adult population

Ongoing Studies

- Resistance to first line ARV drugs
- Determinants of ARV drug adherence
- Early Warning Indicators for Drug Resistance
- Assessment of Community Care Centres in India

New Initiatives in Care, Support and Treatment

Universal Access of Second Line ART for Adults and Adolescents

The Second Line ART was rolled out on a pilot basis at two centres in January 2008. On completion of this pilot project, it was expanded to eight more centres in January 2009. Currently, there are 1929 patients on Second Line ART. Presently, the following categories of persons are eligible to avail free viral load testing and second line ART under The National ART programme:

- PLHA below poverty line (BPL), Widows & children.
- PLHA under treatment in government ART Centres continuously for at least two years, irrespective of income status.

As per Order of the Hon'ble Supreme Court of India, in "Sahara House and Others vs. Union of India" civil writ petition, it has been decided to make second line ART now available to all those in need of it - whether they underwent first line treatment in the government sector or private sector, in a phased manner.

In the first phase, universal access to second line treatment has been started at four Centres of Excellence JJ Hospital, Mumbai; GHTM, Tambaram; MAMC, New Delhi; and STM, Kolkata. This is open to patients from any part of the country.

The person in need of second line treatment has to register at the nearest ART centre. The local ART centre can then sends the patient's details to the State AIDS Clinical Expert Panel (SACEP) at these four Centres of Excellence, as per existing operational guidelines for Second-line ART. The second line ART is provided after evaluation and approval of State AIDS Clinical Evaluation Panel (SACEP) as per the existing technical guideline/regimen.

ART Plus Scheme: Second Line ART was rolled out in the country at two Centres of Excellence (COE) in January 2008. Later it was expanded to 10 centres in January 2009.It has been observed that patients need to travel long distance to access the second line treatment. This issue has resulted in low uptake of Second Line Treatment and also inconvenience and difficulties to patients. In view of these, it was decided to expand the number of centres that can provide Second Line ART. For this, it was planned to upgrade some good functioning ART centres with geographical considerations and label them as 'ART Plus' Centres'.

Criteria for the Selection of ART Plus Centres

- The capacity of the institution to provide Second Line ART and linkage to Lab for Viral Load testing
- The availability of trained manpower in the institution

- The geographical distribution of patients on Second Line ART
- Accessibility and connectivity

Currently, ART Plus Centres have been Approved at Following Sites.

a. ART Centre, GMCH, Aurangabad, Maharashtra
b. ART Centre, GMCH, Nagpur, Maharashtra
c. ART Centre, Sasoon Hospital & B J Medical College, Pune, Maharashtra
d. ART Centre, GMCH, Surat, Gujarat
e. ART Centre, GMCH, Salem, Tamil nadu
f. ART Centre, KIMS, Hubli, Karnataka
g. ART Centre, GGH, Vijayawada, Andhra Pradesh

It is planned to expand the scheme in a need based manner.

Revision in the Scheme of Community Care Centres: The operational guidelines for CCC (August 2007) have been revised in January, 2011 based on the outcome of the assessment of CCCs conducted by NACO in 2009-2010 and subsequent discussions at TRG meeting on CCCs. The revised guidelines has brought forth revised scope and devised a two tier scheme for expanding the service delivery system on care, support & treatment. The objective of two tier schemes is to expand the coverage of and access to services for PLHIV, expand the scope of services provided to PLHIV and lastly to ensure PLHIV receive various services in an environment without stigma, discrimination and denial. As an add on to the existing role & scope of 10 and 20 bedded CCCs, the Comprehensive Care & Support Centres (CCSC) with higher bed strength i.e. 30, 40 will provide higher level medical services and function as referral or mentoring centre to other CCCs which will be linked to these CCSC. A 50 bedded CCSC will provide all the services provided by the 30 to 40 bedded CCSC. In addition, it would be a referral centre for specialised psychological support for other CCCs and it would provide mentoring support to CCCs in the region and also provide support to the CCCs as a "learning site".

The Comprehensive Care and Support Centres (30 to 50 bedded) will function as centres of excellence and these Centres will be strategically located across the country to provide higher level care including management of major OIs, referral for specialised services, rehabilitation and palliative care.

The number, location and bed strength of the CCCs/ CCSCs will be decided based on the PLHIV load of the district/region and need of the entire state. The functions, staff structure, roles and budget will vary according to the number of beds. NACO will pilot test the 50 bedded CCSC in one state for the first year to assess the work load and feasibility for continuation & scaling up of the 50 bedded scheme.

Patients would be referred to the CCC/CCSC from the ARTC around the time of ART initiation for admission at CCC/CCSC that require detailed work up of the patients, education on treatment literacy and side effects of ART. Subsequently, while on treatment, the patient would be referred for management of minor OIs, side effects of ART etc.

LAC Plus Scheme: Initially**,** the main functions of LAC were monitoring of patients on ART, drug distribution to patients on ART, treatment of minor OIs, identification and management of side-effects and reinforce adherence on every visit. At present there are more than 550 functional LACs. It is proposed to gradually scale up LAC to 1200 by 2015-16 (RCC Round 4 target). As part of mid-term review, an assessment of the LAC scheme was undertaken which revealed that after the roll out of LAC, patient satisfaction has increased significantly and cost as well as time on travel to access ART has decreased.

It has been observed that nearly 40 percent of persons detected HIV positives at ICTC do not get linked to Care, Support & Treatment Services. The reason for this could be that many persons are asymptomatic at the time of detection and long distances to reach the ART centre even for registration and basic investigations may compel them to postpone the visit to ART Centres. It has been observed from data on patients on ART that nearly 20 percent patients reach the ART Centres at a very late stage (CD4 count <50) when the risk of mortality is nearly three times higher. In view of these facts, it was decided to revise the scope of Link ART Centres to:

- Integrate HIV Care, Support & Treatment services with the Primary/Secondary Health Care system;
- build the capacity of the health care providers at the Primary Health Care Level for Care, Support and treatment services;
- increase the access of ART services to the PLHA;
- bridge the gap between ICTC (Counseling & Testing services) and CST (Care, Support & Treatment) services;

- improve the ARV drug adherence of patients on ART;
- reduce the travel cost and travel time of PLHA in accessing ART services;

LACs having more than 70 PLHA on ART will be upgraded as 'LAC Plus' under the revised scheme. Functions of LAC Plus are given below:

- Enrolment of PLHIV into HIV care and treatment (Pre-ART Care)
- Pre-ART management inc. basic investigations and sample collection for CD4 count.
- Follow up of pre-ART patients not eligible for ART.
- Referral of eligible patients to Nodal ART Centre for ART initiation.
- Screening of HIV-TB co infection
- Monitoring of PLHIV on ART
- ARV Drug distribution
- Treatment of Minor OIs
- Identification of side –effects
- Counseling on adherence, nutritional & positive prevention
- Tracing of LFU and MIS

The process has already been initiated for the up-gradation of nearly 100 centres as LAC Plus.

Care of Exposed Child and Early Infant Diagnosis: Addressing HIV/AIDS in children especially infants below 18 months is a significant global challenge. HIV-infected infants are the most vulnerable of all patients**. *HIV infected infants frequently present with clinical symptoms in the first year of life*.** Where diagnostics, care and treatment are not available, studies suggest that 35 percent of infected children die in the first year of life, 50 percent by their second birthday, and 60 percent by their third birthday. A critical priority in caring for HIV-infected infants is accurate and early diagnosis of HIV.

With the tremendous expansion in HIV programme in PPTCT, ICTC, ART (for adults and children) including access to Early Infant Diagnosis (EID) for HIV testing of infants < 12 months old – it is now possible to ensure that HIV-exposed and infected infants and children get the required essential package of care.

Objectives of Providing Care for HIV Exposed Infant and Children are:

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

The EID programme is being rolled out in phased manner through 766 ICTCs and 181 ART Centre in the country.

To sum up, the Care, Support and Treatment programme has made major studies in providing comprehensive services to PLHIV and has for exceeded the targets set up under NACP-III. Regular mentoring, monitoring & supervision through a network of regional coordinators have made it possible for NACO to provide high quality services to PLHIV. Many international organisations during various reviews and field visits have applauded the Care, Support & Treatment programme of NACO as one of the best national programme of health ministry and is being cited as an example of 'best practices' in many countries.

CHAPTER 12

Activities in North Eastern States

In order to address the special needs of the States in the North-East, the National AIDS Control Organisation has established the North East Regional Office (NERO) at Guwahati. NERO is a regional technical support unit functional since 2008. It ensures effective implementation of NACP-III in the eight states of the North-East region by facilitating programme planning, implementation, capacity building, monitoring and reporting. The focus during 2010-11 had been on strengthening of systems and building up capacity in the North Eastern States. 28 Project Officers were placed in the respective States to support the implementation of Targeted Intervention (TI) projects. Filling up of vacancies in the State AIDS Control Societies and recruitment of DAPCU officials in identified 25 districts of NE States were taken up on priority basis.

Trainings: Training institutes were identified to ensure the completion of training targets for all components under NACP-III. In order to do so, the following measures were undertaken:

- Training calendars were developed and timely release of training funds to the respective training institutes was ensured.
- In coordination with GFATM Round-7 Sub-Recipient (SR) and three Sub-Sub-Recipient (SSRs) in the NE states, a total of 438 counsellors working at ICTCs, ART centres, CCCs and STI clinics were trained in 26 batches. HIV-TB intensified TOTs for the states of Meghalaya, Tripura, Sikkim and Arunachal Pradesh were organised. A regional TOT on Community based HIV testing through whole blood finger prick test was also organised.
- The gaps in training programmes for TI NGOs were identified. Trainings were conducted on TI data collection tools and roll out of Strategic Information Management System (SIMS) for the entire NE states.
- SIMS training was undertaken for SACS officials, State M&E officers and DAPCU officials.
- Capacity of the resource pool members was strengthened through regular orientation and experience sharing meetings.

SIMS training was undertaken for SACS officials, State M&E officers and DAPCU officials.

- The cross learning sessions for the states were held with particular reference to Finance, TI, ICTC and CST to improve the service delivery.

Supportive Supervision: NERO staff in coordination with SACS made supportive supervisory visits to the service centres in the states for the necessary onsite technical assistance to the service providers. Simultaneously feedback was provided to the states on the processes to improve the performance. The supportive supervision plans were developed on the basis of CMIS report analysis and relevant feedback.

Assessment/Evaluation: The evaluation of Targeted Intervention projects, annual performance evaluation of CCCs, ART centres, SRL feasibility assessment, ICTC-PPP assessments, sentinel site evaluation in the NE states were undertaken.

Operationalisation of DAPCU in 25 A and B category districts in NE states: District AIDS Prevention & Control Units (DAPCUs) were operationalised in the 25 districts with formation of District AIDS Prevention Control Committee (DAPCC). Orientation and capacity building of District teams have also been undertaken. To strengthen the DAPCUs, three National Level Residential Trainings for five days were held at Imphal (for nine districts), Kohima (for 10 districts) and Guwahati (for six districts). Altogether 125 DAPCU staff from six states i.e Manipur, Nagaland, Mizoram, Arunachal Pradesh and Assam have been trained.

Convergence with NRHM: DAPCUs have initiated the process of convergence with NRHM at the state and district level. The state level meeting of NACP–NRHM convergence on 27 April 2010 came out with a work plan for effective service delivery.

- Regular Coordination meetings are held to strengthen NACP, NRHM, RNTCP linkages/ convergence
- NACP-NRHM Convergence Committee have been formed in Mizoram
- Welfare schemes have been initiated for PLHA through mainstreaming with AAY and NREGS in Manipur, Mizoram, Arunachal Pradesh and Assam

Rock band performing HIV/AIDS Music at Seppa District, Arunachal Pradesh

Audiences (>500 youth) witnessing the HIV/AIDS music competition at final, Itanagar

Ms. Kenei, Multi-media campaign ambassador of shared about HIV and AIDS and sang a few songs

Winning band: Melodrama from Dimapur district; The Red Ribbon Superstars, 2010

Multimedia Campaign in the North East, 2010-11: The multi-media campaign was conceptualised and rolled out in three states of northeastern region (Manipur, Meghalaya and Mizoram) in 2009-10. Based on the success and experiences of previous year, the campaign was scaled-up to cover all the eight states of NE in 2010-11. The campaign capitalised on the locally popular entertainment mediums among youth such as music and sports to promote safe behavioural practices, increase engagement of youth with HIV and build community support to address stigma and discrimination.

Implementation of multi-media campaign: A series of activities were planned and implemented. These included the music competitions, sports events, mobilisation of faith based organisations, IPC with youth along with mass-media and mid-media activities. The above activities were implemented in all districts and finally culminated with the grand finale at the state capitals. The winners of the music competitions positioned as "Red Ribbon Super Star" are further reaching out with messages on HIV and AIDS to the community through Road Shows at villages/block level in their respective districts.

A calendar of popular events and festivals was prepared for each state. SACS tied up with the organisers to undertake HIV/AIDS awareness activities during the events for effective implementation of the campaign. NERO worked closely with SACS particularly for the training of youth leaders, establishing linkages with various stakeholders like media houses and religious leaders. NERO's role was critical in providing overall support and monitoring the campaign.

Table 12.1: Status of Facilities in North East under National AIDS Control Programme as on December 2010

S.No.	State AIDS Control Society	Number of ART Centre	Number of NACO supported Blood Banks	Number of Community Care Centre	Number of Integrated Couseling &Testing Centre	Number of Sexually Transmitted Infection Clinic	Number of Targeted Intervention	Number of Drop in Centre	Number of Red Ribbon Clubs	No. of Sentinel Sites
1	Arunachal Pradesh	1	12	0	35	16	21	0	20	18
2	Assam	3	32	3	83	23	58	2	6	50
3	Manipur	7	3	9	54	10	54	4	35	32
4	Meghalaya	1	5	0	9	8	12	1	11	11
5	Mizoram	1	10	2	27	8	41	7	20	18
6	Nagaland	5	8	4	60	11	39	14	50	31
7	Sikkim	1	2	1	12	6	7	1	85	7
8	Tripura	1	6	2	18	9	18	0	11	14
	Total	20	78	21	298	91	250	29	238	181

CHAPTER 13

Strategic Information Management

National AIDS Control Programme (NACP-III) aims at halting and reversing HIV epidemic in India by scaling up prevention efforts among High Risk Groups (HRG) and General Population and integrating them with Care, Support & Treatment services. NACP-III is a scientifically well-evolved programme grounded on a strong structure of policies, programmes, schemes, guidelines, rules and operational norms. Formulating each of them is a rigorous process of undertaking research, reviewing evidence, consolidating field observations and programme experiences, conducting detailed discussions and deliberations, piloting and periodic evaluations.

Strengthening the nationwide Strategic Information Management System is one of the four key strategies of NACP-III. Having a strong Strategic Information is a high priority agenda under NACP-III, towards building up an effective response to the HIV epidemic in the country. Effective utilisation of all available information for evidence-based planning and implementation brought the need for establishment of the Strategic Information Management Unit (SIMU) under NACP-III is set up at national and state levels. SIMU assist NACP-III in tracking the epidemic and the effectiveness of the response and help assess how well NACO, SACS and all partner organisations are fulfilling their commitment to meet the agreed objectives.

Having a strong Strategic Information is a high priority agenda under NACP-III, towards building up an effective response to the HIV epidemic in the country.

SIMU comprises of three divisions – Programme Monitoring Division, Research and Evaluation Division, and Surveillance and Epidemiology Division. They generate and manage crucial information on the entire spectrum of HIV epidemic and its control – vulnerabilities and risk behaviours pre-disposing HIV transmission, patterns of spread of the epidemic and factors contributing to it, disease progression, treatment requirements and regimens, planning and implementing interventions, monitoring service delivery and tracking beneficiaries, programme gaps and ways to overcome them, effectiveness and impact of interventions. Another key function of SIMU is to promote data use for policy making, programme planning, implementation and review at national, state, district and reporting unit level.

Programme Monitoring

Key Activities of this Division Include:

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

CMIS Reporting: Routine data collection under the programme is done through CMIS. Monthly reports are received from 35 SACS with 292 Anti-retroviral Treatment Centre, 1,127 Blood Bank, 255 Community care centre, 5,233 Integrated Counseling &Testing Centre (ICTC), 1,038 Sexually Transmitted Infection Clinic and 1,385 Targeted Intervention facilities.

Timeliness and completeness of reporting is monitored on monthly basis, and feedback is provided to SACS for improving them. Every state has to submit the monthly report for CMIS by 10th of every month. If the states lag behind, reminders are given. Visits to major non-reporting states resulted in rectifying problems of non-reporting. Percentage Reporting Status of CMIS as on January, 2011 has reached up to 85 percent.

Programme performance is monitored quarterly through dashboard indicators. Targets and quarterly achievements during 2010-11 are shown below in the Table 13.1.

Strategic Information Management System (SIMS): In order to meet the objectives of NACP-III and to ensure robust reporting and monitoring, Strategic Information Management System (SIMS), a web-based integrated monitoring and evaluation system is being developed as a mechanism for improving efficiency of the CMIS. SIMS was launched in August 2010 and is scheduled to be fully implemented during 2011.

Table 13.1: Dashboard for NACP-III (2010-11)

S. No.	Indicators	Target for NACP-III by 2012	April-June, 2010	July-Sept, 2010	Oct-Dec., 2010
1	Number of Targeted Intervention Projects (By category)- Total	2,100	1,311*	1377*	1,385*
	a. FSW		446	451	454
	b. MSM		135	143	145
	c. IDU		235	259	263
	d. Truckers		72	76	86
	e. Migrants		203	213	206
	f. Core Composite		220	235	231
2	Number of TI's reporting condom Stock-out in last month (%)	Nil	18	9	9
3	a. Number of ICTC Clients Tested (Non-Cumulative)	2.2 crore/year	29,08,872	32,20,277	32,58,913
	b.Number of ICTC Clients post test counselled and recd result		33,28,664	32,09,778	32,03,489

Contd...

S. No.	Indicators	Target for NACP-III by 2012	April-June, 2010	July-Sept, 2010	Oct-Dec., 2010
4	Number of HIV positive pregnant women (mother & baby) receiving complete course of ART prophylaxis (Non-cumulative)		2,317	2,709	3,088
5	Percentage of blood units provided by voluntary blood donors	90%	69	75.7	73.9
6	Number of ART Centres	250	281	285	292
7	Number of eligible persons with advance HIV infection receiving ART (Cumulative Total)	3,00,000	3,35,232	3,57,808	3,87,205
	a. Male		1,84,495	1,96,136	2,10,017
	b. Female		1,29,838	1,39,724	1,53,662
	c. Children		20,323	21,343	22,858
	d. TS/TG		576	605	668
8	Percentage of SACS with HRG representatives included in SACS decision making bodies	100	100	100	100
9	Percentage of districts with at least one functional PLHA Network	100	56	57	57
10	Percentage of funds disbursed relative to target	100	100	100	100
11	Percentage of SACS having approved financial and administrative delegations	100	100	100	100
12	Percentage of states where Donor Partnership forum met last quarter	100	100	100	100
13	Percentage of SACS where JD(TI)/ AD(TI)/DD(TI) position in SACS filled	100	91	86	95
14	Percentage of SACS where Project Director is sole in-charge of SACS for more than one year	100	70	70	85
15	Percentage of SACS with at least 80% CMIS reporting	80	85	88	90
16	Percentage of SACS which submit Dashboard to NACO regularly	100	97.1	97.1	98.2
17	Percentage of due procurement contracts awarded during original validity period	100	88	88	89
18	Number of ICTC's reporting test kits stock out during quarter	Nil	486 (N=5310)	391(N=5310)	838 (N=5310)
19	Number of ART Centres reporting drugs stock-out during quarter	0	8	10	9
20	Percentage of SACS where Governing body met during the reporting quarter	100	100	100	100
21	Number of districts with District Unit (DAPCU) established	189	189	189	189

*Excludes 225 TIs supported by donor agency

Inauguration of the SIMS application

SIMS is a centralised system that will allow the users to capute the data at various levels like Reporting Unit, District Level and State Level and enable them to view the data whenever required. It increases the efficiency of computerised M&E system by having adequate data quality through centralised 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. It will provide evidence to track the progression of epidemic with respect to demographic characteristics and geographical area through GIS support. This system will enable individual level data collection for key programme areas (e.g., ICTC, ART) and has built-in real-time analytic, triangulation and data validation capabilities. SIMS also provides tools for better decision making through data triangulation from different sources and thereby facilitates -- evaluation, monitoring and taking policy decisions at strategic or tactical level.

Capacity Building on Strategic Information Management System (SIMS):- For effective training and continued guidance, two types of Manuals were developed i.e. System Administrator Manual and User manual. System Administrator Manual was developed for SACS/DAPCU level M & E Officer/Assistant for user creation and to provide assistance to Reporting Unit personnel. Development of User Manuals on modules for Blood Bank, STI/RTI, ICTC (Offline), TI and Surveillance with screenshots of the format and application to help the user for easy data entry, has been completed. Data Definitions were developed to support SIMS users in order to explain the indicators of various MIS formats, while performing the data entry in this web application.

First three phases of training on SIMS are over and Phase-IV is on in various States/UTs (Table 13.2).

Table 13.2: SIMS Training Organised From August, 2010-February, 2011

Phase	Training organised for SIMS	No. of trained
I	Monitoring & Evaluation Officer, M&E Staff and TSU M&E	37
II	SACS Officer Orientation	262
III	DAPCU Staff Training	282
IV	Reporting Unit personnel Training	2,024
V	Training of Regional Institute teams in Surveillance Module	18
Total		**2,623**

Regular monitoring of these trainings was done by NACO officials to facilitate and support the effective implementation of SIMS application.

Processing Data Requests: NACO's Data Sharing Guidelines specify the formats for receiving data requests from researchers or institutions and process them for providing the data. The data requests are processed as per the guidelines and data provided accordingly.

Preparation of Documents and Reports: Programme monitoring personnel prepare various planning documents and reports. Strategic Plan Document of Department of AIDS control for next five years and the Outcome Budget Document 2011-12 for the Department of AIDS Control were prepared during February 2011. Bulletins and reports are prepared on regular basis for dissemination of the programme data.

Providing Data for National/International Documents: NACO provides data from time to time to national and international documents such as Economic Survey, National Health Profile, India Report, Plan Documents, Joint Implementation Review Mission Reports, Results Framework Document, UNGASS report, Universal Access report, SAARC report, etc. all of which are in public domain in the respective websites.

SIMS LOGIN screen, SIMS reporting unit creation screen, SIMS user manuals for blood bank component and HIV sentinel surveillance

SIMS training Phase –IV in progress

HIV CASE Reporting

"In order to enhance the capacity of the programme to determine the care, support and treatment needs, including management of opportunistic infections, there was a need to expand the scope of the existing AIDS case reporting system with the reporting of HIV positive cases along with their immunological profile. A crucial prerequisite for a good HIV case reporting system was the knowledge of any duplication in the cases reported from the facilities and its extent. An HIV Case Reporting system, designed to serve the above objectives was piloted at ICTCs and ART centres in five selected districts of India (Vishakhapatnam in Andhra Pradesh, Surat in Gujarat, Belgaum in Karnataka, Madurai in Tamil Nadu and Pune in Maharashtra) with the technical support from WHO-India. Data were abstracted for a total of 9,257 HIV positive cases from ICTC, 656 from PPTCT, and 14,975 from ART centres, for the reference period of April 1, 2009 to March 31, 2010. Demographic profiles of cases and route of infection besides CD4 count distribution were also documented. Duplication in the reported cases was observed to range between 0.4%-1.3% in ICTC, 0.9%-1.5% in PPTCT and 0.2%-1.3% in ART. This study examined feasibility of HIV case reporting from government sector only. The experience gained from this pilot would form the basis for building up the national HIV case reporting system."

Coordinating Meetings with Delegates: Delegation from Kenya and Ghana visited NACO on 26 and 27, August, 2010 respectively and delegation from the Republic of South Africa visited on November, 2010. Delegations were sensitised about current epidemiological situation of HIV/AIDS in India, programme scenario and its development. At the meetings with Secretary & Director General and Senior Official of NACO, they exchanged the issues and challenges faced by their programme and showed interest in adopting some unique strategies from India.

Capacity Building: Capacity Building is in-built in national M&E plan. Accordingly, regular sessions are undertaken for programme and M&E personnel at SACS. State level epidemiologists have been hired to provide quality assessment and auditing of ongoing data collection, data analysis and developing plan for data use.

Website of the National AIDS Control Organisation (NACO): Official website of NACO (www.nacoonline.org) provides access to all the documents pertaining to policy, strategy and operational guidelines under the programme. SIMU regularly updates NACO website by taking inputs/material from different divisions of NACO, SACS, other government departments and partners. All new documents (Annual Action Plan, Audit Reports, Annual Report, RFD) brought out by the department from time to time, IEC Material including audio/video files for promoting awareness on HIV/AIDS, latest events/News, training material, job opportunities, status of RTI applications, office orders, Contact Details of NACO/SACS officials, tender/bid documents for procurement of goods and services are also provided on the website.

India's HIV/AIDS Knowledge Hub: The Department of AIDS control is in the process of developing a HIV/AIDS Knowledge Hub with the support of UNAIDS which will not only act as one source for all information related to HIV for lay persons, health personnel, implementing agencies, researchers and scientists, but also provide a discussion forum for stakeholders for exchange of ideas.

HIV Surveillance and HIV Estimation in India

HIV Estimations 2010

Background: National AIDS Control Organisation undertakes estimation of HIV burden in the country every year using the data from the annual rounds of HIV Sentinel Surveillance (HSS) among high risk groups and general population. National Institute of Medical Statistics (ICMR), New Delhi is the nodal agency for developing national estimates of HIV prevalence and burden in India. The first HIV estimation in India was done in 1994 based on data from 52 sites. Since then, the process of estimation of HIV infected persons in the country has evolved to a very great extent. Since, the data from HIV Sentinel Surveillance is not representative of the general population, certain assumptions were used to generate estimates for the general population. Over the years, these assumptions were gradually refined with the help of other available data sources.

Use of EPP & Spectrum: In the recent (2010) round of HIV estimations, Estimation Projection Package (EPP) was used, which is specially designed to estimate the HIV burden in low and concentrated epidemics. EPP gives more emphasis to new infections and allows the user to see the incidence patterns and distribution of incidence among the various sub-populations/risk groups in a national projection. EPP also takes into consideration the impact of provision of anti-retroviral therapy, which increases survival of people living with HIV. The latest version of EPP developed by the 'Global Reference Group on Estimates, Modelling and Projections' has been used coupled with updated Spectrum Package to derive HIV estimates in 2010. The Spectrum Package has been customised to India by using Indian population projection figures.

Process Overview: HIV estimations 2010 are the result of protracted discussions, consultations and reviews with specialists in the fields of biostatistics, epidemiology and Monitoring and Evaluation from central and state Government institutions, national and international organisations including WHO and UNAIDS. The process was implemented by a Technical Working Group on HIV Estimates that comprised of experts from NACO, NIMS, NIHFW, WHO and UNAIDS

A screen shot of NACO website

Screen shot of the knowledge hub under development

under the oversight of a larger Technical Resource Group (TRG) on Surveillance and Estimations, constituted by NACO. After a series of discussions and critical review by the working group over a period of about eight to ten months, the outcomes were discussed in the Technical Resource Group on Surveillance and Estimation and finally approved by NACO. The estimates were released on World AIDS Day (1 December 2010) by Hon'ble Minister of Health and Family Welfare, Government of India. Key findings from the HIV estimations 2010 are provided in Chapter 2: Current Epidemiological Situation.

Data from Multiple Reliable Sources: The credibility of the revised HIV estimates is very high because they are derived from, not one, but many authoritative data sources.

- An expanded HIV Sentinel Surveillance spread over 1,212 sentinel surveillance sites and covering all districts in the country (Data from 1998 to 2009 rounds of HSS was used).
- The National Family Health Survey or NFHS-3, the first ever population- based survey conducted in 2005-06, with a sample size of over 100,000 people for HIV testing.
- Size estimates of high risk group population based on High Risk Groups mapping exercise conducted in 20 states by NACO during 2007-09.
- Indian Census Population Projections
- Coverage data from ART Programme and PPTCT Programme
- Other Demographic and Epidemiological evidence

Key Features of the HIV Estimations 2010 are:

- Rigorous process of cleaning and ensuring quality of data used as input into the models
- More robust estimates developed using an improved methodology & updated epidemiological data
- Separate epidemic curves generated for each risk group in each state
- Reliable estimates on HIV incidence and AIDS related deaths developed for the first time
- Impact of the Anti-Retroviral Treatment Programme on the increasing survival of PLHA taken into account

Thus, the recent HIV estimations not only provide an improved understanding of HIV epidemic in India, but also offer important insights for impact evaluation of interventions under NACP-III.

HIV Sentinel Surveillance 2010: HIV Sentinel Surveillance is the most important tool to monitor HIV epidemic in the country. Surveillance data are also used for estimating key epidemiological parameters, such as HIV burden, new infections and deaths due to AIDS as well as important programme parameters such as need for ART & PPTCT. Surveillance is a vital component of Strategic Information that provides useful inputs for setting up priorities, planning interventions, resource allocation and evaluation of impact under the National AIDS Control Programme (NACP).

Understanding the critical role played by surveillance in decision making, the National AIDS Control Organisation (NACO) has established a credible and robust system for annual HIV Surveillance in the country. Started in 1992, this system has crossed several milestones. The impressive progress is reflected not only in its expansion and strengthened implementation mechanisms, but also in its enhanced focus on quality and use of data.

Scale-up of Surveillance Network: During 2010-11, NACO conducted the 12th round of HIV Sentinel Surveillance among pregnant women attending antenatal clinics (ANC), patients attending Sexually Transmitted Diseases Clinics (STD), Female Sex Workers (FSW), Men who have Sex with Men (MSM), Injecting Drug Users (IDU), Eunuchs/Transgenders (EUN), Single Male Migrants (SMM) and Long distance Truckers (LDT) at 1361 sentinel sites across the country. The scale up of sentinel sites in India since 1998 is shown in Table 13.3.

Key focus and Broad Strategy of HSS 2010: Two key focus areas for HSS 2010 were:

- Quality: Quality of Planning; Quality of Training; Quality of Implementation; Quality of Supervision & Feedback
- Supportive Supervision and Action Oriented Monitoring

Broad Strategy of HSS 2010 Includes:

- Expansion of MSM, IDU & Migrant sites
- Introduction of Rural Composite ANC sites to capture effect of migration in heavy out-migration districts
- Adoption of Random Sampling at select HRG sites with validated line lists
- Dried Blood Spot (DBS) method & Informed consent to be continued at HRG sites

Table13.3: Scale-up of Sentinel Sites in India, 1998-2010

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

- DBS Method at select ANC/STD sites in remote places with transportation problems
- Revised Strategy for Laboratory System (explained below)
- Well-structured Training Programme with improved Training Material
- Integration of Data Management System for HSS into Strategic Information Management System (SIMS)
- Initiating Real Time Monitoring, Feedback and Action through Online Reporting Systems using SIMS

Key Features of HSS 2010:

- Significant Expansion of HRG sites; 194 new sites added including 154 HRG sites
- 53 poor performing sites deleted including 30 STD sites
- User-specific Operational Manuals and site-specific Wall Charts developed & centrally printed
- National & Regional Pre-surveillance planning meetings and TOTs followed by state level trainings
- Composite site mechanisms elaborated with pre-allotted sub-site number and sample size
- Recruitment of State Epidemiologists (10 in position currently) to support HSS activities

Revised Strategy for Laboratory System:

- Testing of ANC/STD samples limited to State Reference Laboratories to ensure quality and facilitate close monitoring and supervision
- Reporting of laboratory results directly to Regional Institutes through separate format; not linked with data forms
- Increased focus on quality of specimen processing at testing labs
- Introduction of Real Time Quality Monitoring Mechanisms through Testing Labs – Reporting on the quality of specimens received, details of rejected/invalid samples and progress in receipt, testing and quality control of the samples. By this mechanism, the quality of sample processing at all the 1200 sentinel sites can be monitored through around 120 testing labs.
- Streamlining External Quality Assurance Scheme (EQAS) for HSS through online reporting mechanisms

Improvements in Data Forms:

- Introduced Bi-lingual data forms for the first time in HSS; Data forms translated into Hindi and seven regional languages
- Laboratory Results separated from data forms, to facilitate faster completion of data entry
- General Information captured in a box through stamp or pre-printed stickers, to minimise errors in documenting critical information on the site and sample
- Colour-coded data forms for different type of sites
- Instructions to fill data forms are printed overleaf for quick reference

New Data Management System:

- Double Data Entry at Regional Institutes
- New Site codes developed and issued for HSS 2010
- Online Data entry through SIMS Application for HSS, with Data Matching functions, Data Monitoring functions, validation checks and customised report generation in-built into the system

Strengthened Monitoring and Supervision:

- Four-tier Supervisory Structure: Central Team, RI teams, State Surveillance Teams (SSTs) and SACS/ State core teams
- Strengthened SSTs to have one supervisor for every five-six sites & district allocation among the supervisors for greater accountability and immediate corrective action
- Integrated monitoring plan developed by NIHFW, RIs and SACS to avoid more visits to same sites and ensure uniformly spaced visits to all the sentinel sites
- Supervisor Module is developed under SIMS for quick online reporting of problems identified during field visit and documenting Action Taken Reports against the feedback

Implementation Process: HIV Sentinel Surveillance has a robust structure for planning, implementation and review at national, regional and state levels. The structure and key functions of each agency involved are shown in figure 13.1.

NIHFW, NIMS, WHO, UNAIDS and six Regional Institutes (RIs) provided technical support to the entire activity. Details of the six regional institutes and their state allotment are given in the Table 13.4.

National Pre-Surveillance Planning Meeting of NACO, Regional Institutes & SACS was conducted in two batches at NIHFW, New Delhi on 24–27 Jun 2010, where strategy for the round, proposals for new sites, guidelines on training and supervision and other state-specific issues are discussed. RIs and SACS are oriented to the new mechanisms proposed to be introduced, their feasibility is assessed and a consensus is built.

Meeting of Technical Resource Group (TRG) on Surveillance & Estimation was conducted on 3-4 August 2010 where the outcomes of HIV estimations were critically reviewed, discussed and finalised. The TRG also discussed the proposed strategy for HIV Sentinel Surveillance 2010 and approved the important developments proposed for the round. Detailed discussion was also held on the Random Sampling approach at High Risk Groups sites and Integrated Biological & Behavioural Surveillance.

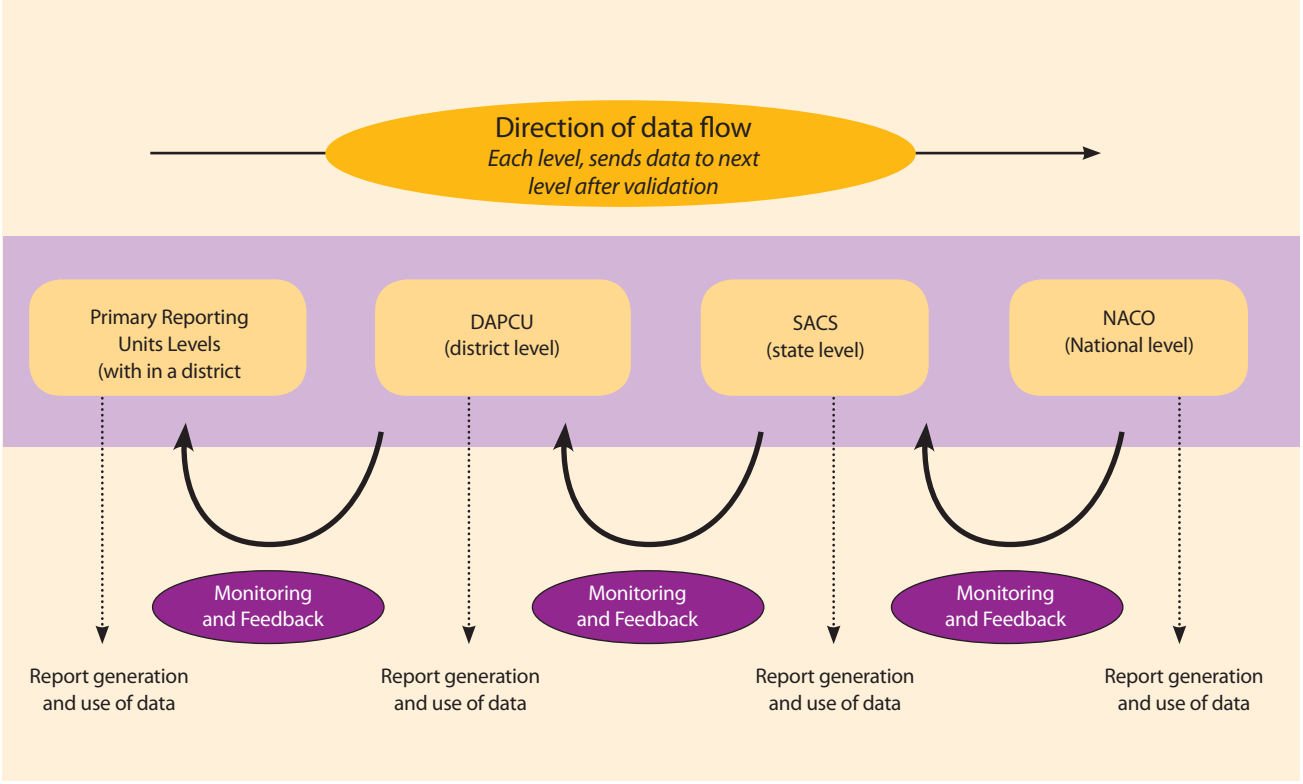
Action Plans of states and Regional Institutes were reviewed and finalised. Financial guidelines on pattern of assistance to sentinel sites and testing labs were revised and issued. Surveillance component is incorporated into CPFMS for closer tracking of expenditures for surveillance activities at SACS.

Training is conducted in a cascade fashion, starting with Training of Trainers (TOT) followed by training of personnel from sentinel sites and testing labs.

Table 13.4: Regional Institutions and State Allocation

SN	Regional Institute	States of Responsibility
1	Central Zone: All India Institute of Medical Science, New Delhi (5 States)	Uttar Pradesh, Bihar, Jharkhand, Uttaranchal, and Delhi.
2	North Zone: Post-graduate Institute of Medical Education and Research, Chandigarh (5 States)	Haryana, Himachal Pradesh, Jammu & Kashmir, Punjab and Chandigarh.
3	West Zone: National AIDS Research Institute, Pune (7 States)	Maharashtra, Gujarat, Goa, Madhya Pradesh, Rajasthan, Daman & Diu, & Dadra Nagar Haveli.
4	South Zone: National Institute of Epidemiology, ICMR, Chennai (7 States)	Andhra Pradesh, Tamil Nadu, Karnataka, Kerala, Odisha, Puducherry and Lakshadweep.
5	East Zone: National Institute of Cholera and Enteric Diseases, Kolkata (6 States)	West Bengal, Chhattisgarh, Sikkim, Andaman & Nicobar Islands, Meghalaya & Nagaland
6	North East Zone: Regional Institute of Medical Sciences, Imphal (5 States)	Manipur, Mizoram, Tripura, Assam & Arunachal Pradesh

Fig. 13.1: Data flow in SIMS



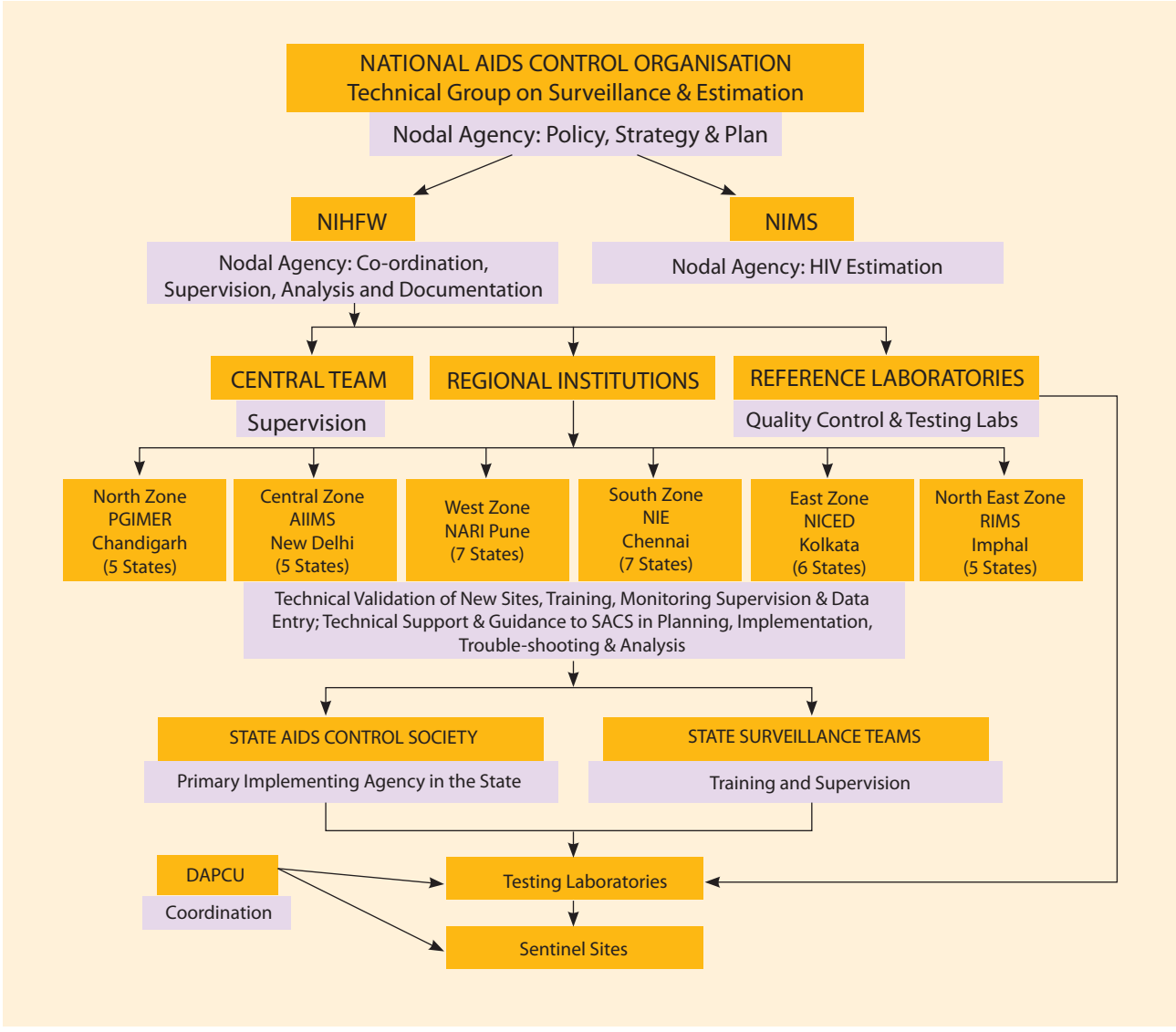
Details of trainings undertaken during HIV Sentinel Surveillance 2010 are in Table 13.5.

Testing of serum specimens from ANC/STD sentinel sites was carried out at 134 laboratories and 13 National Reference Laboratories provided quality control for the same. Seventeen laboratories were designated for testing of DBS specimens and National AIDS Research Institute, Pune was designated as nodal laboratory for training, procurement and quality control for testing of DBS specimens.

Table13.5: Trainings Conducted Under HSS 2010

Details of Training	Conducted By	Trainers	Duration of Training	Number Trained
Training of Trainers (TOT) for SACS officers and State Surveillance Team Members	RIs	Experts from RI, NACO, NIHFW, WHO	2 days	300
Training of ANC/STD Sentinel Site Personnel (Site In-charge/Medical Officer, Counselor/Nurse & Lab Technician from each site and sub-site)	SACS	SACS officers, SST Members, RI Members	2 days	3200
Training of ANC/STD Testing Lab Personnel	SACS	SACS officers, SST Members, RI Members	1 day	240
Training of HRG Sentinel Site Personnel (Project Manager, Counselor & Lab Technician from eachTI Site and sub-site)	SACS	SACS officers, SST Members, RI Members	3 days including field practice	1650
Training of DBS Testing Lab Personnel	NARI, Pune	NARI, Pune	2 days	30
Training of Central Team Members	NIHFW, New Delhi	NIHFW, NACO & WHO	2 days	40
Training of Data Supervisor and Data Entry Operators from RIs on Data Entry through SIMS Application for HSS	NACO	NACO & Vayam Technologies Ltd.	1 day	20

Fig. 13.2: Implementation Structure of HSS & Key Functions of Implementing Agencies



Supervision and Monitoring of Surveillance was conducted by 40 Central Team Members and 250 State Surveillance Team Members, besides teams from NACO, RIs and SACS.

Overall, around 4.4 lakh samples are collected during HSS 2010. Data Entry is in progress and preliminary results will be available by May 2011.

Epidemiological Profiling of HIV/AIDS Situation at District and Sub-district Level Using Data Triangulation

In order to consolidate the rich evidence base on HIV/AIDS available under National AIDS Control Programme NACO has undertaken a project titled "Epidemiological Profiling of HIV/AIDS Situation at District and Sub-district Level using Data Triangulation" in 25 states (567 districts) in two phases during 2009-10 & 2010-11. Phase-I covered seven states while Phase-II covered 19 states, Uttar Pradesh covered partially in both the phases. This exercise was undertaken with the objective of developing district HIV/AIDS epidemic profiles. It also contributed to refine district prioritisation as well as revising the Annual Action Plans of NACO and SACS.

Key Features of Implementation Mechanism: NACO developed Technical Guidelines and tools with the support of a National Technical Team. A public health institution or medical college was identified as State Coordinating Agency for the project that worked closely with the programme units – State AIDS Control Societies and Technical Support Units in each state. This not only built a resource pool in HIV/AIDS analysis in every state but also fostered linkages between programme units and academic

institutions that will help address any future strategic information needs in the programme.

Important Outcomes:

- Cleaning up & validation of Programme data since 2004
- Systematic compilation of all the data related to HIV for each district at one place for routine use
- District Reports describing the profile of HIV epidemic and programme response in each district
- Development of Framework for Re-prioritisation of districts under the programme
- Prioritisation extended upto sub-district/block level with high priority blocks identified
- Identification of Information Gaps at district and state level for planning Strategic Information Activities
- Capacity building of district level programme managers and staff of service delivery units in handling and analysing data, enabling them to understand the importance of the data they generate and the need for ensuring its quality, and appreciate the use of data for programme review, decision-making and effecting improvements.
- Enhanced understanding among the programme managers of HIV epidemic and response in the state and different districts
- Better use of data in developing District & State Annual Action Plans
- Institutional Strengthening (building state level resource pools) and fostering linkages between programme units and academic institutions for addressing Strategic Information needs in the programme

Development of Framework for Reprioritisation of Districts using Data Triangulation: A Working Group on Reprioritisation of Districts reviewed the data tables, district reports and observations emerging from the data triangulation and developed a framework for re-prioritisation of districts based on data from multiple sources and the observations from district profiling. The framework was presented to NACO and development partners during Joint Implementation Review Mission in December 2010.

Research

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

- developing guidelines, norms and standards for undertaking HIV/AIDS research;
- partnerships and networking with multiple stakeholders and established national academic and other research institutions;
- supporting capacity building in social, clinical & biomedical, basic and operational research related to HIV/AIDS and allied subjects;
- functioning as the central repository of all relevant resources, research documents and data base on HIV/AIDS in the country; and
- ensuring translation of research outputs into programmatic action and policy formulation.

The main activities undertaken by the Research Division at NACO during 2010-11 are as follows:

Identifying and setting Priority areas for research in HIV/AIDS is one of the primary functions of the Research Division of NACO. Discussions are held with officers managing different programme components at NACO and SACS to identify the key information gaps that hinder effective planning and implementation of respective interventions and a draft list of priority areas is developed. The list is then circulated among development partners and other stakeholders for their inputs. The list is also discussed in various Technical Resource Groups advising NACO on different thematic areas. Finally, the priority areas are deliberated in Technical Consultations with experts in the respective fields and major research institutions. The list of priority areas thus finalised is circulated among NIIHAR Network and proposals are invited. This rigorous process of identifying and setting priority areas in HIV/AIDS research is undertaken once in six months to one year, taking into consideration, the emerging evidence from the research that is already initiated.

NACO in collaboration with UNICEF organised a '*National Consultation on Operational Research in PPTCT and Paediatric HIV Care and Treatment in India*' to identify the priority areas for operational research focusing on PPTCT and Paediatric care, at Manesar, Gurgaon on 22–24 April 2010. Around 150 experts from India and abroad participated in the three day consultation. Five priority areas were identified during the meeting. The consultation was followed by a five day workshop, organised in collaboration with WHO at NIHFW during June 2010,

for protocol development on the areas identified in the consultation. Concurrently, detailed protocols were developed on three of the five priority research areas identified during the Technical Consultation and submitted to the TRG-R&D for approval. A similar workshop on Operations Research was held for the North Eastern states at NEIGRIHMS, Shillong in September 2010.

The TRG on R&D is an expert group that advises NACO on the broad policy & strategy to be adopted for promoting HIV/AIDS research in the country. All the research proposals on HIV/AIDS received by NACO are reviewed by the TRG through periodic meetings.

The NACO Ethics Committee has the primary responsibility of ensuring that all the ethical considerations and sensitivities in the context of HIV/AIDS are adequately addressed in the research proposals and that such research is consistent with legislative and statutory requirements, and thereby accord ethical clearance for initiating the research. The committee, through a series of reviews & discussions, has developed the 'National Guidelines on Ethics for Research on HIV/AIDS', including template for informed consent.

Processing & Approving Research Proposals

NACO is the nodal agency to review , process and approve any research in HIV/AIDS in the country. NACO receives research proposals on HIV/AIDS through the following sources:

- Proposals invited by NACO on priority research areas from NIIHAR institutes.
- Proposals from independent research organisations or institutions including collaborative research with foreign institutions (Eg. Indo-US collaborative studies, CDC funded projects, etc.) that involve any of the following four resource from the programme:
  - Finance
  - Infrastructure
  - Data; and
  - Technical support
- Proposals with HIV/AIDS component referred from ICMR/HMSC for review & comments by NACO.

Proposals referred from HMSC are reviewed by the Technical Resources Group on research and development and comments are communicated. All the rest of the proposals undergo the process of review and approval, shown in Fig 13.3. A standard 'Format for Proposal Submission' has been developed, which can be downloaded from the NACO website, in which proposals are to be submitted to NACO.

Dissemination of HIV/AIDS Research Outcomes

The 'National Conference on HIV/AIDS Research' was organised during 19-21 January 2011 at the India Habitat Centre, New Delhi, with three main objectives:

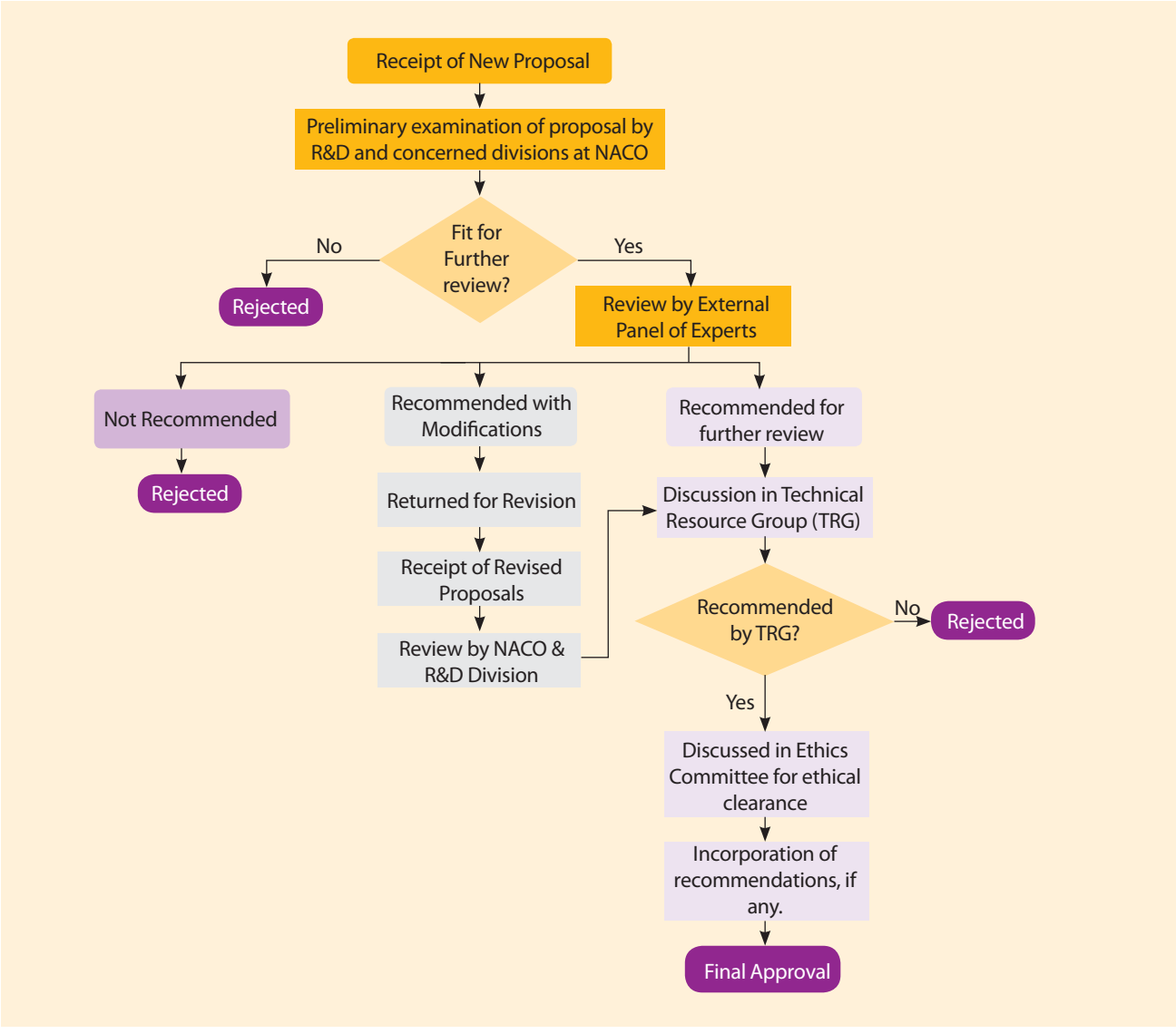
- Providing a National platform for exchange of views, ideas and learnings for the researchers, programme managers and policy makers in India;
- Providing evidences for programme planning and policy formulation; and
- Integrating and linking preventive and therapeutic research on HIV/AIDS with NACP.

The theme of the conference was "Towards Evidence-Policy linkages in HIV/AIDS Research". About 200 participants from all over India, comprising of Chairpersons of the Technical Resource Groups of NACO, members of TRG-R&D and NACO-EC, national and state level policy makers and programme managers, young scientists from the Network of Indian Institutes for HIV/AIDS Research (NIIHAR), representatives from Regional Paediatric Centres (RPCs), ART Centres, Development partners and Research Organisations participated. The Conference was organised in four thematic areas namely, Research in Basic Sciences, Clinical & Biomedical Research, Socio-behavioural Research and Evaluation Studies. Around 300 abstracts were

The proposals are reviewed on the basis of the following criteria

I. Programme Score:	II. Methodology Score:	III. Principal Researcher Score:
• Relevance to NACP III strategies	• Clarity in the research question	• Qualification
• Innovativeness	• Questionnaire/tool formulated	• Relevant Experience
• Replicability	• Duration of the study	• Publications
• Scalability	• Sampling design and size	
• Community based approach	• Coverage of State/Districts	

Fig. 13.3: Process of Reviewing and Approving Research Proposals



received under these four themes and a total of 31 oral and 60 poster presentations were made during the Conference. Each session was followed by a Panel Discussion to cull out recommendations for the National Programme from the findings of the presentations.

A Pre-Conference Continuing Education Workshop was organised on the theme "HIV/AID Research: Challenges & Perspectives" on 18th January, 2011. Presentation on 12 key Research Priority Areas were made by eminent experts; around 60 faculty from NIHHAR institute attended.

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

The 'Network of Indian Institutions for HIV/AIDS Research (NIIHAR)' was constituted to facilitate and undertake HIV/AIDS research. 42 Institutions are members of the NIIHAR Consortium as on February 2011.

NACO Research Fellowship Scheme

NACO Research Fellowship Scheme was conceptualised with the main objective of encouraging and facilitating capacity building of young researchers in the country for undertaking HIV/AIDS research and communicating research findings with the aim of impacting policy and programme. The NACO Research Fellowships will provide financial assistance to pursue research, ultimately leading to attainment of higher professional degrees, under experienced academicians and researchers. Any young scientist, below 35 years of age at the time of applying and enrolled in full-time MD/MPhil/PhD degree programme in relevant disciplines from any

recognised Indian University/Institute, can apply for the fellowship to carry out research relevant to HIV/AIDS in bio-medical/clinical, epidemiological and social disciplines.

Capacity Building Workshop on Ethics in HIV/AIDS Research

NACO, in collaboration with UNICEF, is organising a series of three-day Capacity Building workshops on Ethics in HIV/AIDS research for young researchers. The first workshop in this series was conducted at Centre of Excellence, Maulana Azad Medical College, New Delhi from 10 – 12 November, 2010. The workshop used a 'learning by doing approach' with significant emphasis on group work. Different case studies related to ethical dilemmas in HIV/AIDS research, were discussed and participants tried to come up with solutions under the guidance of mentors. Twenty six researchers from various medical colleges, universities and research organisations participated in the workshop.

CHAPTER 14

Capacity Building

Developing the capacity of the SACS and NACO in technical as well as managerial aspects in implementation of programme is a major thrust area of NACP-III. To ensure uniform standards of services, adherence to operational guidelines and treatment protocols, training is provided to various personnel using standard curriculum, training modules and tools through identified institutions. Capacity building under various programme carried out during FY 2010-11 has been consolidated and presented below.

Targeted Intervention: Capacity building of TI implementing structures has been a major focus area under NACP-III. Eighteen State Training Resource Centres (STRC) have been set up across the country entrusted with the primary responsibilities of conducting quality trainings of TI staff, developing local resource pool in the state and developing learning sites for cross learning purposes.

To ensure standardisation of training curriculum NACO developed various training modules on Programme Management, Counselling, Outreach, Peer Education, Intravenous Drug User and Truckers, which have been uploaded on NACO website. The STRCs conduct Training Needs Assessment (TNA) and customise these modules as per the felt needs of the target audience.

A total of 17,160 TI personnel have been trained in the period from April to December 2010.

Training is provided to various personnel using standard curriculum, training modules and tools through identified institutions to ensure uniform standards of services, adherence to operational guidelines and treatment protocols.

Fig.14.1: Training Programme for TI Personnel

Link Worker Scheme: Three regional workshops were organised for all the partner organisations and SACS at Jaipur, Kolkata and Bangalore. A total of 120 persons participated in these workshops to bring uniformity in the programme implementation and to share the innovative/best practices developed by various partner organisations.

STI/RTI Service Providers: National and State resource faculties have been trained on adult learning methods in a cascade model, using the same training material countrywide. The state resource faculties in turn conducted training of STI/RTI clinic staff in the public sector. The state and regional resource faculties have trained a total of 7,511 persons in 2009 – 10, and 5,224 in 2010-11. Around 1,447 STI Clinic doctors, 1,102 paramedical staff, 2,450 preferred private providers and 225 counselors are trained during 2010-11 on STI/RTI services.

Training of doctors working at NRHM health facilities is also being carried out using a common curriculum, by involving state and regional resource faculty trained by NACO. A resource of 245 faculties was created through six regional workshops to train the service providers in CHC and PHC. Trained resources at state, regional and district levels provided quality training to medical and paramedical staff at all service sites.

Blood Safety: Education and training is fundamental to every aspect of blood safety. NACO has developed a uniform training curriculum for all aspects of blood transfusion. Seventeen centres have been identified across the country to impart training on all aspects of blood safety Blood Bank Medical Officers, Technicians, Counselors, Nurses, Clinicians, Donor Motivators and Programme Officers of SACS. During 2010-2011, 4,290 Medical Officers, 1,450 Lab Technicians, 3,441 Nurses, and 5,315 Donor Motivators were trained till December 2010.

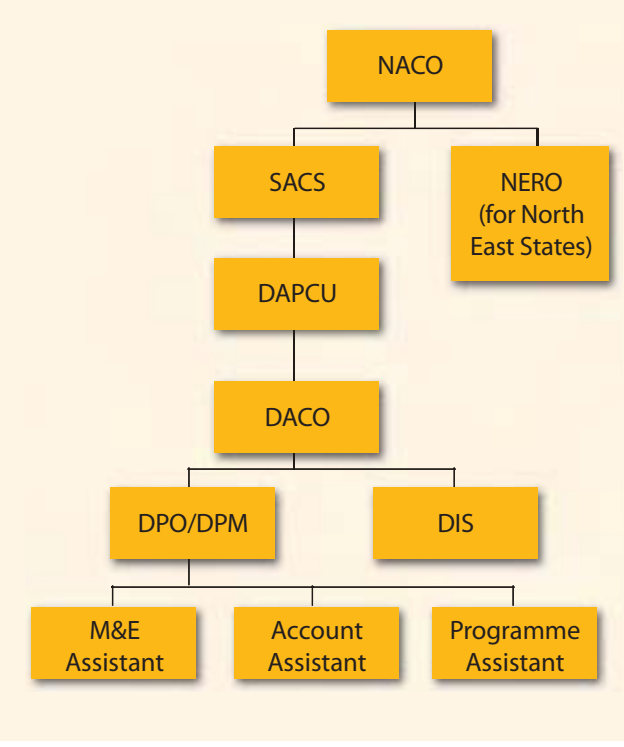
Laboratory Services: There were seven regional workshops conducted in the FY 2010-11 at seven different sites across the country. All SRL & NRL incharge (Prof. and HoD's in Microbiology) were trained on ISO-15189, Quality system essentials to prepare their Laboratory for NABL accreditation. Total of 118 SRL & 13 NRL staff member were trained for Quality system essentials. The training was of three days duration conducted under supervision of senior Lab Experts from CDC, PCI, NACO& members of Core Group Laboratories, NACO.

Integrated Counseling and Testing Centres: A three day training was carried out for all the ORW's and District coordinators with the main objective to train the ORWs living with HIV and to build additional capacity to enable them to reach out to their community with information on HIV, PPTCT services, Care and support during the maternity cycle, follow up to HIV positive mother after the delivery till 18 months, adherence to ART and its services, spreading prevention messages, safer sex practice and about universal precaution . The trainers have been given ORWs handbook - NACO module and the staffs have been given handouts and handbooks for reference. The training is done in regional language for better understanding of the staffs.

DAPCU Training: One of the key strategies for the National AIDS Control Programme (NACP)–III is decentralisation of supportive supervision and monitoring of NACP, creating a mechanism to respond to local specific needs of the programme at district level. A major structural reform is initiated by constituting District AIDS Prevention and Control Units (DAPCUs) with a

team of field functionaries in A and B category districts. The main objective of DAPCU is to take district specific initiatives and take up activities to integrate with formal health infrastructure and to mainstream with the other line departments in the district.

Fig. 14.1: Structure of DAPCU



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

Accordingly, recruitment of DAPCU staff was initiated across the country. Designing of DAPCU training curriculum was based on the following key roles of DAPCUs as envisaged by NACO:

- DAPCUs are coordinating and monitoring units and are an extension of SACS at the district level
- DAPCUs are expected to play a key role in integration of NACP with NRHM and work closely with other line departments in government setup to mainstream the HIV/AIDS Programmes.

Based on the various reviews from officials from NACO, NERO, APSACS, Maharashtra SACS, TSU of AP and Mahrarashtra, the training curriculum was finalised which contained participants' modules, facilitator's handbook and course schedule with 16 sessions (excluding the group presentation based on field visits to panellists), break away sessions for DACOs and M&E Assistants in the training spread over five days.

A staggered plan was developed to operationalise the trainings to the 189 DAPCUs across the country through two teams from the DAPCU National Resource pool. A total of 18 trainings were completed to cover 886 personnel from 189 DAPCUs spread across 22 states.

Outcome of the training

- On Line Supportive Supervision to DAPCU: One of the key activities in training was the introduction of DAPCU Monthly Report along with specific skills to M&E Assistants for compiling the same. More than 90 percent of DAPCUs have started submitting their monthly reports to NACO post training programmes.
- DAPCU was also looked as a mechanism to involve the district administration in the NACP. A District Dashboard was developed, which captures the key indicators on NACP to give an overview of the programme status for Key Officers within District.
- A large resource pool has been created across the country to mentor and guide DAPCU.

Capacity Building in North Eastern States: In coordination with GFATM R7 SR and three SSRs in the NE states, a total of 438 counsellors working at ICTC, ART, CCC and STI clinics were trained in a total

Final training module (up) and presentation by participants

Row-wise from Top: Group work and presentation, field visits, involvement of PD-OSACS, involvement of PD-TNSACS, motivational lecture during DAPCS training, follow up visit to district Warangal (AP) after trainings

of 26 batches. TOT for HIV-TB intensified package for the states of Meghalaya, Tripura, Sikkim and Arunachal Pradesh and regional and state level ToT on Community based HIV testing through Whole blood finger prick test were conducted in the North East. Training of SACS, STRC, NERO-PO and TI officials was also conducted on TI data collection tools. State M&E Officer, SACS programme officers and DAPCU officials for the entire NE states were trained on SIMS.

A Training Programme on MS Office has been organised in NACO on 8th April 2010. Participants were sensitised with MS Office (MS Word, MS Excel, MS PowerPoint and MS Outlook) and also provided the tips and shortcuts for better utilisation.

Capacity Building on Strategic Information Management System (SIMS): First three phases of training on SIMS are completed, while Phase-IV of SIMS training is ongoing in various States/UTs countrywide. The details of SIMS training organised from April, 2010-February, 2011 in Table 14.1

Surveillance: Training of Trainers (TOT) followed by training of personnel from sentinel sites and testing labs were conducted under HIV Sentinel Surveillance at national, regional & state levels.

Standard training curriculum with uniform training material and manuals were developed. Overall, 5,480 personnel were trained on the methodology, sampling approaches, blood collection techniques, documentation including administering informed consent at HRG sites and bio-safety procedures. Training on SIMS application for HSS was also conducted for the data supervisors and data entry operators from six regional institutes.

Research: A National Consultation on Operational Research in PPTCT and Paediatric HIV Care and Treatment in India was held during April 2010 to identify priority areas for research on this subject. Around 150 experts from India and abroad participated in the three day consultation A similar workshop on Operations Research was held for the North-eastern states at NEIGRIHMS, Shillong in September 2010.

A three day Capacity Building Workshop on Ethics in HIV/AIDS Research was conducted at Centre of Excellence, Maulana Azad Medical College from 10–12 November 2010. 26 researchers from various medical colleges, universities and research organisations of North India (Delhi, Chandigarh, Lucknow, Ahmadabad, Jaipur, Varanasi etc.) participated in the workshop and were mentored by renowned experts in Ethics from ICMR, AIIMS, Seth GS Medical College, IHBAS, NCDC, ICRW, IAVI, FHI, WHO, UNAIDS etc.

Administration: As a capacity building measure, induction training programmes were held for the staff of NACO, with the assistance of Family Health International during 2010-11.

During the FY-2010-11, as many as 3, 75,778, persons trained under different programmes at various level (Table 14.4)

Capacity building workshop on operational research for North Eastern States

Table 14.1: Training Achievements Under Various Programme Components Between FY 2010-11 (till December 2010)

Division	Participant category	Number trained	Total Trained
Blood Safety	Doctor	4,690	30,657
	Counselor	186	
	Nurse	3,460	
	Lab Technician	14,604	
	Donor Motivators & Organiser	7,717	
Counseling	STI Counselor	248	3,367
	ART Counselor	211	
	CCC Counselor	137	
	ICTC Counselor	2,335	
	ICTC Nurse	436	
CST	ART Medical Officer	176	638
	ART Team Members (Medical Officer)	165	
	LAC Medical Officer	297	
STI	Doctor	2,409	9,783
	Staff Nurse	1,010	
	Lab Technician	889	
	PPP Doctor	5,336	
	STI Regional Centre staff (microbiologist, lab technician)	47	
	STI State reference centre staff (microbiologist, lab technician)	92	
Targeted Intervention**	Project Director	752	17,168
	Project Manager	2227	
	M&E Officer	379	
	ANM	469	
	Accountant	986	
	Counselor	1,343	
	ORW	5,318	
	PE	5,686	
	TSU and SACS staff	8	
DAPCU	District AIDS Control Officer	211	1,616
	District Programme Manager	248	
	M&E	306	
	District ICTC Supervisor	304	
	Accounts Assistant	282	
	Office/Programme Assistant	265	

Contd...

Division	Participant category	Number trained	Total Trained
Mainstreaming	SHG	1,35,826	3,09,842
	AWW	9,804	
	ANM	1,394	
	ASHA	7,060	
	Police Personnel	1,320	
	Panchayat Members	63,797	
	Others	90,641	
M&E	M&E Officer/TSU TL Strategic Planning	37	2,707
	SIMS DAPCU staff training	282	
	SIMS HSS training	18	
	SIMS one day orientation to SACS Officer	262*	
	SIMS Reporting Unit personnel Training	2,024*	
	M&E Officer	84	
		TOTAL	3,75,778

*Personnel trained till Feb., 2011

**Number of personnel trained does not reflect an absolute number as TI staff is entitled to various trainings

CHAPTER 15

Results Framework Document

The Department of AIDS Control scored 92.89 percent as the overall composite score which is higher than average composite score of 89.4 percent for all 59 departments that were covered under the Phase-I of the RFD policy.

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

The Results Framework Document has the following five sections:

1. Vision, Mission, Objectives and Functions
2. Interse 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 Department of AIDS Control scored 92.89 percent as the overall composite score which is higher than average composite score of 89.4 percent for all 59 departments that were covered under the Phase-I of the RFD policy. The department got "Excellent" rating for timely submission of RFD for 2010-11.

NACO group which attended the workshop on strategy organised by Department of Performance Management, Cabinet Secretariat on 8 July 2010 at IIFT, New Delhi won the prize for listing the best practices.

First RFD was prepared on a pilot basis for the last quarter of 2009-10, with the approval of Hon'ble Prime Minister. Second RFD was prepared for FY 2010-11. Six month progress of the department against targets was timely submitted in Oct, 2010. Most of the targets have been achieved, some even surpassed.

RFD for the period of 2011-2012 has been submitted to Performance Management Division by the Department of AIDS Control on 7 March, 2011. Strategic Plan Document of Department of AIDS control for next five years has also been submitted on 10 Feb., 2011.

CHAPTER 16

Administration

The Department of AIDS Control is headed by the Secretary to the Government of India who is assisted by Additional Secretary, three Deputy Directors General, two Assistant Directors General, two Directors, and a Joint Director.

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

The Department of AIDS Control is headed by the Secretary to the Government of India who is assisted by Additional Secretary, three Deputy Directors General, two Assistant Directors General, two Directors, and a Joint Director (Organisational Chart is at Annex.I). The total sanctioned strength of regular staff of the Department in Group "A", "B","C" and "D" is 64 which includes secretarial and technical posts. Besides, there are a number of contractual staff to assist the Department in discharging the assigned functions of the Department.

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

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

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

Implementation of RTI Act, 2005

The Right to Information Act, 2005 enacted with a view to promote transparency and accountability in the functioning of the Government by securing to the citizens the right to access the information under the control of public authorities has already come into force w.e.f 12 October, 2005. Under the Act, eight Central Public Information Officers (CPIOs) and three Appellate Authorities have been appointed in the Department of AIDS Control. During 2010-11, 130 applications and 17 appeals have been received till 31 December, 2010.

CHAPTER 17

Procurement

The contract is for a period of 28 months from effective date (date of signing of contract) or upto 31 March 2012 whichever is earlier or such period as the parties may agree in writing with provision of extension/ foreclosure based on Annual Performance Review.

Procurements are done using pool fund (World Bank and DFID), Global Fund for AIDS, Tuberculosis and Malaria (GFATM) through a procurement agent. During the year, M/s RITES Ltd. provided support services to NACO as Procurement Agent in terms of contract concluded between National AIDS Control Organisation, Department of AIDS Control & M/s RITES Ltd. on 16 February 2010. The contract is for a period of 28 months from effective date (date of signing of contract) or upto March 31, 2012 whichever is earlier or such period as the parties may agree in writing with provision of extension/ foreclosure based on Annual Performance Review.

As in the past, all the main items required for the programme, including test kits [HIV (Rapid), HIV (Elisa), HBs Ag (Rapid), HBs Ag (Elisa), HCV (Rapid), HCV (Elisa), RPR kits, drugs (ARV), STI Drug kits], blood bags and equipments (CD4 Machines and Blood Bank equipments), were centrally procured and supplied to SACS. Expenditure incurred on procurement at central level till 11.02.2011 is shown in the table below:

Table 17.1: Expenditure Incurred on Procurement at Central Level

	(Rs. in Cr.)
Budget Estimate	359.90
Revised Estimate	366.91
Expenditure Incurred (As on 11.02.2011)	220.62

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

Procurement at State level remained an area of importance for NACO. For smooth and efficient procurement at State level, hand-holding support to State AIDS Control Societies is being provided by the procurement division at NACO.

With increase in number of facilities (ICTCs, ART Centres, Blood Banks, STI clinics) being catered to by NACO, the issue of Supply Chain Management has gained importance. Efforts are also being made to streamline the Supply Chain Management of various supplies to consuming units.

CHAPTER 18

Financial Management

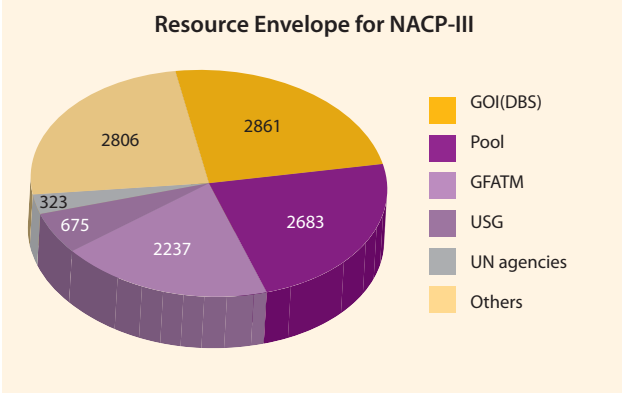
NACP-III (2007-2012) requires an investment of Rs. 11,585 crores to implement a wide range of Interventions.

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

Sources of Funds

NACP-III (2007-2012) requires an investment of Rs. 11,585 crores to implement a wide range of interventions. A resource envelope was identified with external funding from Development Partners, (both budgetary as well as extra budgetary support), bilateral and multi lateral agencies and UN. Their resources are supplemented by domestic contribution by Government of India. Distribution of resource envelop by funding sources shown in Fig. 18.1

Fig. 18.1: Distribution of Resource Envelope by Funding Sources

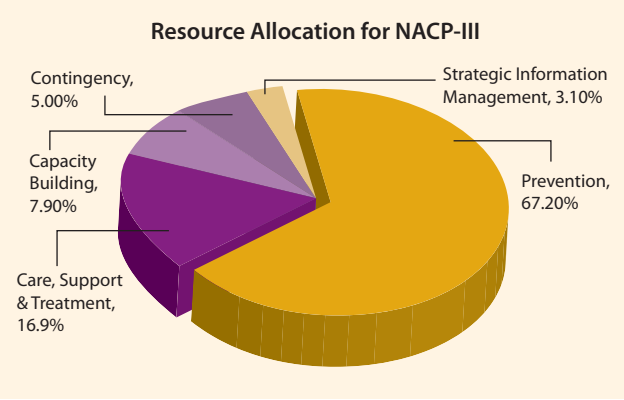


Out of Rs. 11,585 crores, Rs. 8023 crores is provided through the budget, the balance being extra budgetary funding.

Resource Allocation

Of this budget, 67.2 percent is earmarked for prevention activities among high risk groups and general population, 17 percent for Care, Support and Treatment of PLHA, eight percent for Programme Management, three percent for Strategic Information Management, and five percent for contingency (Fig. 18.2).

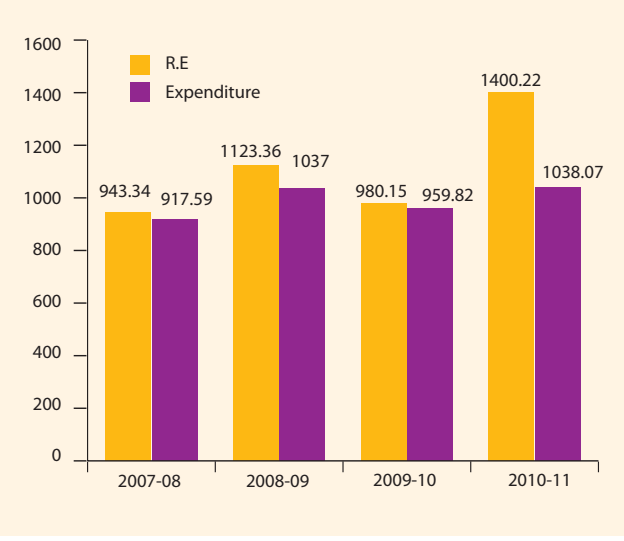
Fig. 18.2: Resources Allocation for NACP-III



Utilisation of Funds

Details of fund allocation and utilisation (budgetary amount) during NACP-III year-wise are shown in Fig. 18.3.

Fig. 18.3: Utilisation of Funds Under NACP-III (in Crore)

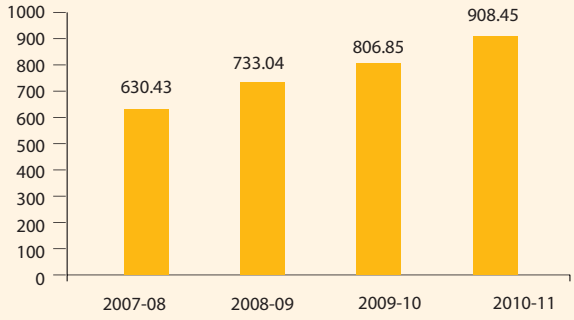


Note: Expenditure of 2010-11 is as on 18.2.2011.

Utilisation through State Structures

The programme is implemented through State AIDS Control Societies in all States and Union Territories. The details of approved plans for the states across the years is furnished below. There had been significant increase in the state plans as up-scaling of planned activities have been getting stabilised. The graphical presentation of the scaling up of resource support is given in Fig. 18.4:

Fig. 18.4: Annual Action Plan Figures for States NACP-III (Rs. in crore)



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

Steps for Improving the Financial Systems-some Highlights

Improved Approval Systems:

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

Expanded Work force in Finance Units:

- NACP-III emphasised the need for strengthening the work force in the accounts and finance units at the centre level for close monitoring and state and district level for prompt utilisation of resources. From a skeleton staff structure at various levels it has enlarged to a group of professionals, with a good mix of both regular and contractual staff.
- Recruitment norms have been suitably modified by retaining the head of Finance division to be

regular cadre for accountability reasons while allowing the states and districts to have qualified contractual staff.

- District structures (DAPCU) has been established and a qualified finance personnel is posted in the district to handhold the financial aspects of the implementing agencies, NGOs, service delivery institutions. On a analysis of the utilisation of the expenses and obtaining of UCs, adjustment of advances, this step has contributed much compared to the earlier years of implementation.

NACO has made definite progress in persuading the State to adjust advances as priority (JIRM Report Dec. 2010)

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

Better Monitoring Systems

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

Key points for success identified by Joint Portfolio Review Meeting (Sept. 2010):

- Evolving detailed financial guidelines for each activity
- Continuous monitoring systems
- Sharing of experience and best practices

Other Initiatives

- NACO being a separate department under Ministry of Health & Family Welfare is now going for separate Demands for Grant from 2011-12 onwards.
- Concurrent adjustment of advances on monthly basis has started instead of quarterly or half yearly adjustment to minimise advances.
- Audit committees are formed on pilot basis to ensure quality, timeliness and review.
- Mobilising additional resources from state funds for supporting activities not currently envisaged like infrastructure support
- Integration with other health programmes
  - Reproductive and Child Health (RCH) at centre and State level
  - Revised National TB Control Programme (RNTCP)
- Mainstreaming with other departments to take up activities through their resources by making it integral part of their plan so that NACO can move out to other more needy areas.

The most recent and important audit observations are given in Annex -5.

Annex-1 & 2

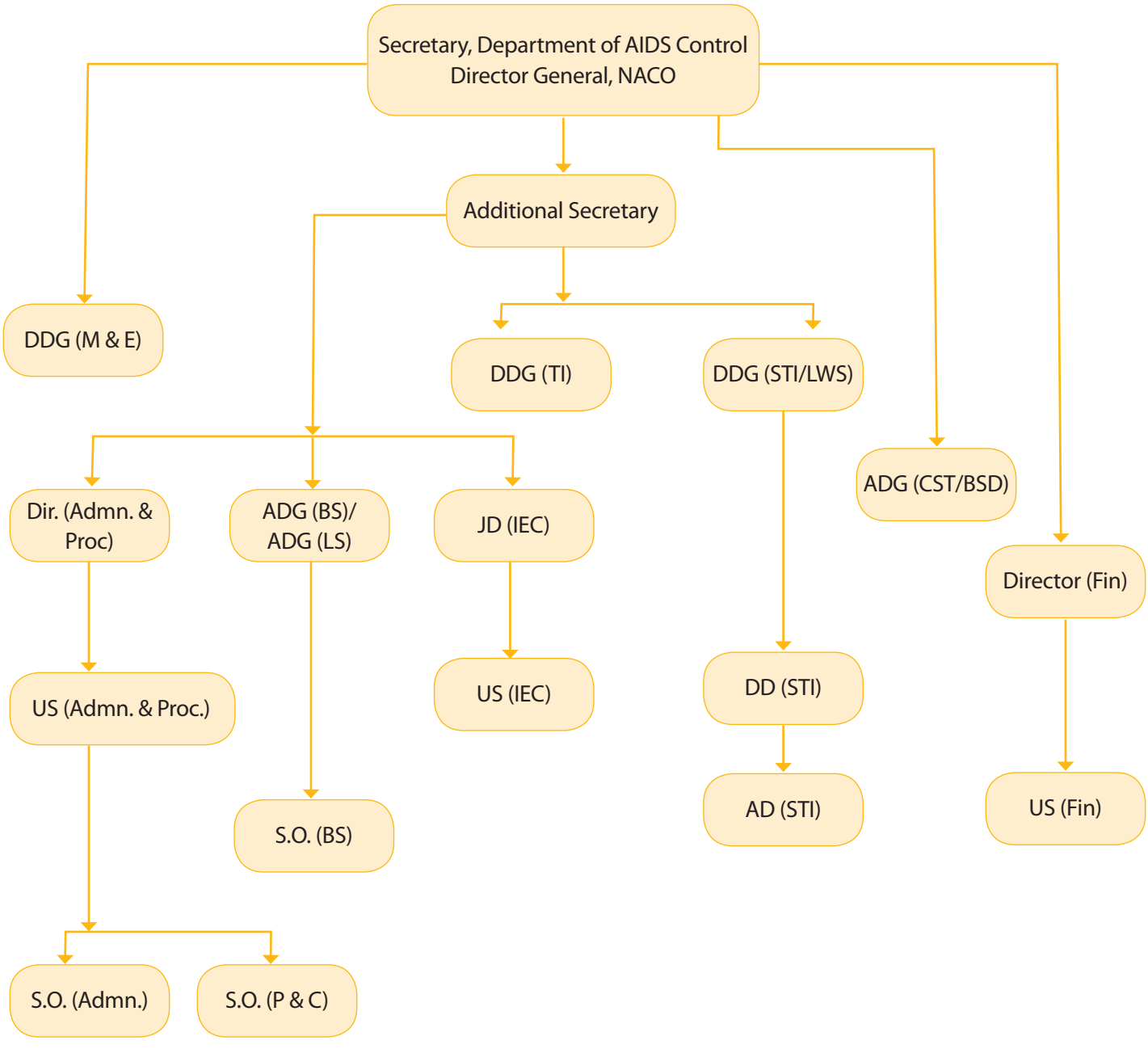
Categorisation of Districts (Based on HIV Sentinel Surveillance 2004-06)

Category A and B Districts based on HIV Sentinel Surveillance 2004 – 2006			
Catetory A (156)			Catetory B (39)
ANDHRA PRADESH (23/23)	Kodagu	MIZORAM (2/8)	ASSAM (1/23)
Adilabad	Kolar	Aizawl	Sonitpur
Anantapur	Koppal	Champhai	BIHAR (1/38)
Chittoor	Mandya	NAGALAND (10/11)	Katihar
Cuddapah	Mysore	Dimapur	CHANDIGARH (1/1)
East_Godavari	Raichur	Kohima	Chandigarh
Guntur	Shimoga	Mokokchung	DELHI (4/9)
Hyderabad	Tumkur	Mon	Delhi_Central
Karimnagar	Udupi	Phek	Delhi_East
Khammam	Uttara_Kannada	Tuensang	Delhi_North
Krishna	MADHYA PRADESH (5/48)	Wokha	Delhi_North_East
Kurnool	Balaghat	Kiphera	GOA (1/2)
Mahabubnagar	Dewas	Peren	South_Goa
Medak	Harda	Zunheboto	GUJARAT (4/25)
Nalgonda	Panna	ORISSA (4/30)	Ahmadabad
Nellore	Rewa	Anugul	Bhavnagar
Nizamabad	MAHARASHTRA (32/35)	Bolangir	Rajkot
Prakasam	Ahmadnagar	Bhadrak	Boroda (Varodara)
Rangareddi	Akola	Ganjam	KERALA (2/14)
Srikakulam	Amravati_Rural	PUNJAB (1/17)	Ernakulam
Visakhapatnam	Aurangabad_MH	Ludhiana	Kozhikode
Vizianagaram	Bhandara	RAJASTHAN (1/32)	MADHYA PRADESH (3/48)
Warangal	Beed	Ganganagar	Indore
West_Godavari	Buldana	TAMIL NADU (22/30)	Mandsaur
ARUNACHAL PRADESH (1/16)	Chandrapur	Coimbatore	Bhopal
Lohit	Dhule	Cuddalore	MIZORAM (1/8)
BIHAR (2/38)	Gadchiroli	Dharmapuri	Kolasib
Araria	Hingoli	Erode	ORISSA (3/30)
Lakhisarai	Jalgaon	Kanniyakumari	Baleswar
CHHATTISGARH (1/16)	Jalna	Karur	Khordha
Durg	Kolhapur	Krishnagiri	Koraput
GOA (1/2)	Latur	Madurai	Puducherry (1/4)
North_Goa	Mumbai	Namakkal	Puducherry
GUJARAT (6/25)	Mumbai (Suburban)	Perambalur	PUNJAB (1/17)
Banas_Kantha	Nagpur_Rural	Pudukkottai	Bhatinda
Dahod	Nanded	Ramanathapuram	RAJASTHAN (6/32)
Mahesana	Nandurbar	Salem	Ajmer
Navsari	Nashik	Sivaganga	Alwar
Surat	Osmanabad	Theni	Barmer

Surendranagar	Parbhani	The_Nilgiris	Jaipur
HARYANA (1/20)	Pune	Thiruvallur	Udaipur
Bhiwani	Raigarh_MH	Tiruchirappalli	Tonk
KARNATAKA (26/27)	Ratnagiri	Tiruvanamalai	TAMIL NADU (5/30)
Bagalkot	Sangli	Toothukudi	Chennai
Bangalore_City	Satara	Vellore	Kancheepuram
Bangalore_Rural	Solapur	Viruddhnagar	Tirunelveli
Belgaum	Thane	UTTAR PRADESH (5/70)	Thanjavur
Bellary	Wardha	Allahabad	Villupuram
Bidar	Yavatmal	Banda	TRIPURA (1/4)
Bijapur	MANIPUR (9/9)	Deoria	North Tripura
Chamarajanagar	Bishnupur	Etawah	WEST BENGAL (4/19)
Chikmagalur	Chandel	Mau	Darjeeling
Dakshina_Kannada	Churachandpur	WEST BENGAL (4/19)	Jalpaiguri
Davanagere	Imphal East	Kolkata	Medinipur_East
Dharwad	Senapati	Puruliya	Murshidabad
Gadag	Tamenglong	Barddhaman	
Gulbarga	Thoubal	Uttar_Dinajpur	
Hassan	Ukhrul		
Haveri	Imphal West		

Annex- 3

Organisation Chart of the Department of AIDS Control
Position as on 31.01.2011 (Designation-wise)



Annex- 4

Contact details of SACS/MACS

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

Annex- 5

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

1. All India Institute for Medical Sciences (AIIMS), New Delhi
2. National Institute of Mental health and Neuro Science (NIMHANS), Bangalore
3. Institute of Health and Management Research (IIHMR), Jaipur
4. International Institute for Population Sciences, (IIPS), Mumbai
5. Institute for Economic Growth (IEG), New Delhi
6. National Institute for Health & Family Welfare (NIHFW), New Delhi
7. Family Health International, New Delhi
8. National AIDS Research Institute (NARI), Pune
9. Institute of Health Systems, Hyderabad
10. National Institute for Medical Statistics (NIMS), New Delhi
11. National Institute for Communicable Diseases (NICD), New Delhi
12. National Institute for Research in Reproductive Health (NIRRH), Mumbai
13. National Institute of Epidemiology (NIE), Chennai
14. National Institute of Cholera and Enteric Diseases (NICED), West Bengal
15. International Centre for Research in Women (ICRW), New Delhi
16. Population Council of India (PCI), New Delhi
17. School of Public Health, Post Graduate Institute of Medical Education & Research (PGIMER), Chandigarh
18. Tata Institute for Social Sciences (TISS), Mumbai
19. Tuberculosis Research Centre (TRC), Chennai
20. Government Hospital of Thoracic Medicine (GHTM), Tambaram , Chennai
21. Government Gandhi General Hospital , Hyderabad Andhra Pradesh
22. Maulana Azad Medical College (MAMC), New Delhi
23. Bairamji Jijibhai Medical College (BJMC), Ahmedabad, Gujarat
24. Bowring and Lady Curzon Hospital, Bangalore, Karnataka
25. Sir J.J. Hospital, Mumbai , Maharashtra
26. Centre for Advanced Development Research, Bhopal
27. Regional Sciences of Medical Sciences (RIMS), Imphal, Manipur
28. Calcutta School of Tropical Medicine (STM), Kolkata, West Bengal
29. Banaras Hindu University (BHU), Institute of Medical Sciences, Varanasi
30. India Clinical Epidemiological Network (IndiaCLEN), Chennai
31. Nagaland University, Kohima
32. The Tamil Nadu Dr MGR Medical University, Chennai
33. Lala Ram Swarup Institute of Tuberculosis and Respiratory Diseases, New Delhi
34. Rajendra Institute of Medical Sciences, Ranchi
35. Maulana Azad Institute of Dental Sciences, New Delhi
36. Dept. of Humanities, IIT, Madras
37. Manipal Academy of Higher Education, Karnataka
38. JIPMER, Puducherry
39. Public Health Foundation of India (PHFI), New Delhi
40. Government Medical College & Hospital, Chandigarh
41. Chattrapati Shivaji Maharaj Medical University, Lucknow
42. Indian Statistical Institute, Delhi

Annex- 6

Most Recent and Important Audit Observations

Sl. No.	Year	No. of paras/PA reports on which ATNs have been submitted to PAC after vetting by Audit	Details of the Paras/PA report on which ATNs are pending		
			No. of ATNs not sent by the Ministry even for the first time	No. of ATNs sent but returned with observations and Audit is awaiting their resubmission by the Ministry	No. of ATNs which have been finally vetted by Audit but have not been submitted by the Ministry of PAC
1.	2004-05 Report No. 3 of 2004 entire report on National AIDS Control Programme	Report is under examination of Public Accounts Committee. Recommendations of PAC [19th Report of PAC 2005-06]. Further recommendations [vide 63rd Report of PAC 2007-08 on ATN of 19th Report]. ATN on recommendations made in 63rd Report sent to PAC on 29.6.09.			
2.	2008-09		Report No. CA 14 of 2008-09 para 5.4 (ATN has been sent to audit)		

National AIDS Control Organisation

India's voice against AIDS
Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
www.nacoonline.org