सत्यमेव जयते

Annual Report 2012-13

NACO

Department of AIDS Control
Ministry of Health & Family Welfare

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National AIDS Control Organisation

India's voice against AIDS

Department of AIDS Control

Ministry of Health & Family Welfare, Government of India

www.nacoonline.org

Contents

Acronyms

ADG	Assistant Director General
AEP	Adolescence Education Programme
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Clinic
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
ASHA	Accredited Social Health Activist
BCC	Behaviour Change Communication
BCSU	Blood Component Separation Unit
BFPNI	Breast Feeding Promotion Network of India
BMGF	Bill & Melinda Gates Foundation
BRICS	Brazil, Russia, India, China and South Africa
BS	Blood Safety
BSC	Blood Storage Centre
BSD	Basic Services Division
BSS	Behaviour Surveillance Survey
CBO	Community Based Organisation
CCC	Community Care Centre
CD4	Cluster of Differentiation 4
CDC	Centres for Disease Control and Prevention
CHC	Community Health Centre
CLHIV	Children Living with HIV
CMIS	Computerised Management Information System
CoE	Centre of Excellence
CPFMS	Computerised Project Financial Management System
CPGRAMS	Computerised Public Grievances Redress and Monitoring System
CSMP	Condom Social Marketing Programme
CST	Care, Support and Treatment
CVM	Condom Vending Machine
DAPCU	District AIDS Prevention & Control Unit
DCGI	Drugs Controller General of India
DD	Deputy Director
DDG	Deputy Director General
DFID	Department for International Development
DGHA	Department of Global HIV/AIDS (CDC)

DHR	Department of Health Research
DIC	Drop in Centres
DSRC	Designated STI/RTI Clinic
DTC	Delhi Transport Corporation
DWCD	Department of Women & Child Development
EHA	Emmanuel Hospital Association
EID	Early Infant Diagnosis
EQAS	External Quality Assessment Scheme
ESCM	Enhanced Syndromic Case Management
FBO	Faith Based Organisation
FC	Female Condom
FHI	Family Health International
FICTC	Facility Integrated Counseling & Testing Centre
FPA	Forum of Parliamentarians on HIV & AIDS
FRU	First Referral Unit
FSW	Female Sex Workers
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People with HIV/AIDS
GIS	Geographic Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
IAP	Indian Academy of Pediatrics
IAVI	International AIDS Vaccine Initiative
IBBS	Integrated Biological & Behavioural Surveillance
ICF	Intensified tuberculosis Case Finding
ICMR	Indian Council of Medical Research
ICRW	International Centre for Research on Women
ICTC	Integrated Counseling and Testing Centre
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IHBAS	Institute of Human Behaviour & Allied Sciences
IL&FS	Infrastructure Leasing & Financial Services Limited
INC	Indian Nursing Council
IRDA	Insurance Regulatory Development Authority
JAT	Joint Appraisal Team
JD	Joint Director
KHPT	Karnataka Health Promotion Trust
LAC	Link ART Centre
LFU	Lost to Follow-up
LS	Laboratory Services
LWS	Link Worker Scheme
M & E	Monitoring and Evaluation
MARP	Most At Risk Population
MCD	Municipal Corporation of Delhi
MoHFW	Ministry of Health & Family Welfare
MoU	Memorandum of Understanding
MSM	Men who have Sex with Men
NABH	National Accreditation Board of Hospitals & Healthcare Providers
NABL	National Accreditation Board for Laboratories
NACO	National AIDS Control Organisation

NACP	National AIDS Control Programme
NARI	National AIDS Research Institute
NBTA	National Blood Transfusion Authority
NDMC	New Delhi Municipal Corporation
NERO	North Eastern Regional Office
NGO	Non-Government Organisation
NICED	National Institute of Cholera & Enteric Diseases
NRHM	National Rural Health Mission
NRL	National Reference Laboratory
NTSU	National Technical Support Unit
NYKS	Nehru Yuva Kendra Sangathan
OI	Opportunistic Infections
ORT	Oral Rehydration Therapy
OST	Opioid Substitution Therapy
P & C	Planning & Coordination
PEP	Post-Exposure Prophylaxis
PGIMER	Post-Graduate Institute of Medical Education & Research
PHC	Primary Health Centre
PLHIV	People Living with HIV
PPP	Public Private Partnership
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institution
RBTC	Regional Blood Transfusion Centre
RCH	Reproductive and Child Health
RFD	Result Framework Document
RI	Regional Institute
RNTCP	Revised National Tuberculosis Control Programme
RRC	Red Ribbon Club
RRE	Red Ribbon Express
RSBY	Rashtriya Swasthya Bima Yojna
RTI	Reproductive Tract Infections
SAARC	South Asian Association for Regional Cooperation
SACS	State AIDS Control Society
SBTC	State Blood Transfusion Council
SIMS	Strategic Information Management System
SIMU	Strategic Information Management Unit
SMO	Social Marketing Organisation
SO	Section Officer
SRL	State Reference Laboratory
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
STRC	State Training & Resource Centre
TAC	Technical Advisory Committee
TB	Tuberculosis
TG	Transgenders
THP	Truckers' Halting Point
TI	Targeted Interventions
TRG	Technical Resource Group
TSG	Technical Support Group
TSU	Technical Support Unit
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UT	Union Territory
VBD	Voluntary Blood Donation
VCTC	Voluntary Counseling and Testing Centre
WHO	World Health Organisation

Overview

For prevention and control of Human Immuno-deficiency Virus (HIV) infection and Acquired Immuno-Deficiency Syndrome (AIDS) in India, the first National AIDS Control Programme (NACP) was launched in 1992. With the evolving trends of the HIV/AIDS epidemic, the focus shifted from raising HIV/AIDS awareness to behaviour change, from a national response to a more decentralised response and to increasing involvement of NGOs and networks of people living with HIV (PLHIV), and the subsequent phases of NACP were launched and implemented - NACP II in 1999 and NACP III in 2007.

A dissemination summit showcasing the good practices, innovations & impacts of NACP-III, was organised during 25-27 April 2012 and had participation of over 500 delegates including policy makers, international & national experts, programme specialists and community representatives. Based on the lessons learnt from previous phases, the Government of India designed a strategy for the fourth phase of NACP (NACP-IV).

NACP-IV aims to accelerate the process of reversal and to further strengthen the epidemic response in India through a cautious and well defined integration process over the five years 2012-17. Its main objectives are to reduce new infections and provide comprehensive care and support to all PLHIVs and treatment services for all those who require it. The main strategies include intensifying and consolidating prevention services, increasing access and promoting comprehensive care, support and treatment, expanding IEC services, building capacities at national, State, district and facility levels and strengthening Strategic Information Management Systems.

Based on the HIV Estimation 2012, India has demonstrated an overall reduction of 57% in the annual new HIV infections (among adult population) from 2.74 lakhs in 2000 to 1.16 lakhs in 2011, reflecting the impact of various interventions and scaled-up prevention strategies under the National AIDS Control Programme. The adult HIV prevalence has decreased from 0.41% in 2001 to 0.27% in 2011. Also, the estimated number of people living with HIV has decreased from 24.1 lakh in 2000 to 20.9 lakhs in 2011. Wider access to ART has resulted in 29% reduction in estimated annual deaths due to AIDS related causes between 2007 and 2011. It is estimated that around 1.5 lakhs lives have been saved due to ART till 2011.

Considerable declines in HIV prevalence have been recorded among Female Sex Workers at national level (5.06% in 2007 to 2.67% in 2011) and in most of the States, where long-standing targeted interventions have focussed on behaviour change and increasing condom use. Declines have also been achieved in HIV prevalence among Men who have sex with Men (7.41% in 2007 to 4.43% in 2011), though several pockets in the country show higher HIV prevalence among them with mixed trends. Transgenders are also emerging as a risk group with high vulnerability and high levels of HIV. Stable trends have been recorded among Injecting Drug Users at the national level (7.23% in 2007 and 7.14% in 2011).

Besides North-Eastern States where declines have been achieved, newer pockets of high HIV prevalence among IDU have emerged over the last few years. In certain States of North & Central India, evidence indicates the possible role of migration in fueling HIV epidemics. Besides high risk migrants, long distance truckers also show high levels of vulnerability and form an important part of the bridge population.

Key Achievements during 2012-13

Targeted Interventions for High Risk Groups: The main objective of Targeted Interventions (TI) is to enhance accessibility of high risk groups to key HIV prevention services and improve their health seeking behaviour, thereby reducing their vulnerability and risk to acquire Sexually Transmitted Infections (STI) and HIV infections. TIs provide services, such as behaviour change communication, condom promotion and clean needle and syringe for people who inject drugs, STI care, referrals for HIV and Syphilis testing and linkages with Anti-Retroviral Treatment.

There has been a substantial scale up of coverage of Female Sex Workers (84.5%), Injecting Drug Users (80.7%), Men having Sex with Men and Transgender (70.6%), Truckers (48.4%) and Migrants (41.3%) through 1,705 interventions for high risk groups and bridge population. During 2012-13, 218 new Targeted Interventions have been established till December 2012 surpassing the target of 180. Opioid Substitution Therapy sites in public health settings have been expanded to 52 centres. The proposals for MSM and IDU for the second phase of Round 9 of the Global Fund have been approved.

Revised migrant strategy for HIV has been rolled out. Targeted Interventions provide HIV prevention services to migrants at the destination points through outreach and linkages. In order to address the vulnerability among returnee migrants and spouses of migrants, awareness campaigns and health camps are implemented in the source villages as well as at the major transit points that account for bulk of migration. Employer-led models and migrant tracking systems are also being piloted.

Link Workers Scheme: This community-based intervention addresses HIV prevention and care needs of the high risk and vulnerable groups in rural areas by providing information on HIV, condom promotion and distribution and referrals to counseling, testing and STI services through Link workers. In partnership with various development partners, the Link Worker Scheme is operational in 139 districts as of December 2012, and reaches out to rural HRGs and their partners and vulnerable groups.

Management of Sexually Transmitted Infections: The Sexually Transmitted Infections (STI)/ Reproductive Tract Infections (RTI) services based on the Syndromic Case Management are being provided through 1,112 designated STI/RTI clinics (branded as "Suraksha Clinic"). Around 42 lakh STI/RTI episodes have been managed as per the national protocol till December 2012 against the target of 64 lakh for 2012-13. Seven regional STI training, reference and research centres have been strengthened. NACO has developed a communication strategy for generating demand for sexual and reproductive services. Preferred Private Provider approach has been rolled out to scale up STI/ RTI services to HRG population under TI Projects.

Condom Promotion: NACO has successfully implemented four phases of the Condom Social Marketing Programme in 13 States. Around 22.83 crore pieces of condom have been distributed through social marketing up to December 2012 by NACO contracted social marketing organisations against the target of 35 crore pieces for 2012-13. During 2012-13, NACO has distributed 29.5 crore free condoms by December 2012, against the target of 44.47 crore. Establishment of rural outlets, non-traditional outlets and outlets in TI project areas and truckers' halt-points received special focus. Other initiatives include implementation of Female Condom scale-up Programme and extensive promotion of use of condoms across all programme States.

Blood Safety: Access to safe blood has been ensured through a network of around 1,118 blood banks across the country, which includes 34 Model Blood Banks, 175 Blood Component Separation Units, 167 Major Blood Banks and 742 District Level Blood Banks. During 2012-13, a total of 67.56 lakh blood units were collected up to December, 2012. NACO supported blood banks collected 38.68 lakh units of blood, of which 83.2% was from voluntary blood donation. Other initiatives planned include setting up of four Metro Blood Banks as Centres of Excellence in Transfusion Medicine, and one Plasma Fractionation Centre with processing capacity of more than 1.5 lakh litres of plasma.

HIV Counseling and Testing Services: This programme offers Counseling and Testing services for HIV infection, which includes three main components – Integrated Counseling and Testing Centres (ICTC), Prevention of Parent to Child Transmission and HIV-TB collaborative activities. HIV Counseling and testing services were rapidly scaled up through 4,508 standalone Integrated Counseling and Testing Centres, and 8,389 Facility Integrated Counseling and Testing Centres including those under Public and Private Partnership model. A total of 73.25 lakh general clients and 57.1 lakh pregnant women were tested during 2012-13 (till December 2012). 96.4% of HIV positive pregnant women and babies were provided Nevirapine prophylaxis for Prevention of Parent to Child Transmission of HIV. Under the HIV-TB coordination programme, around 9.72 lakh cross-referrals were made between NACP and Revised National Tuberculosis Control Programme during April – December 2012, out of which 32,141 were found co-infected.

Care, Support and Treatment (CST) for PLHIV: The CST programme provides comprehensive management to PLHIV which includes free Anti-Retroviral Therapy (ART), psychosocial support, prevention and treatment of Opportunistic Infections including tuberculosis, and facilitates home-based care. Ten Centres of Excellence and seven pediatric Centres of Excellence provide tertiary level specialist care and treatment (Second line and Alternative First Line ART, management of complicated Opportunistic Infections and specialized laboratory services). As of December 2012, nearly 17.36 lakh PLHIV have been registered at 380 ART centres of whom 6,04,987 clinically eligible patients (including 34,367 children) are receiving free ART in Government health facilities. 239 Community Care Centres provide psycho-social support, ensuring drug adherence, treatment of opportunistic infections and tracking lost to follow-up cases. Link ART centres and ART Plus Centres have also been established for the decentralisation of first line and second line treatment services.

Laboratory Services: The capacity of laboratories for CD4 testing has been strengthened with 264 functional CD4 machines. The assurance of quality in kit evaluation and assessment of HIV testing services through implementation of External Quality Assessment Scheme is given focus. The programme for confirmation of HIV-2 has been rolled out from 1 February, 2013 in 13 referral laboratories. Trainings have been conducted on ISO 15189: 2007 for officers from National and State Reference Laboratories.

Early Infant Diagnosis: Earlier, diagnosis of HIV in a newborn child was possible only after 18 months of age leading to late start of required treatment and care. To address this issue and promote early treatment, Early Infant Diagnosis of HIV for infants and children below 18 months has been rolled out from 1 March, 2010. The programme is operational through 1,157 ICTCs and 217 ART Centres across 31 States. There are seven referral laboratories performing the DNA-PCR test for Early Infant Diagnosis. During 2012-13, 12,169 HIV exposed infants and children less than 18 months of age have been tested under this programme till December 2012.

Information, Education & Communication: The focus of IEC activities has been on promoting safe behaviours, reduction of HIV stigma and discrimination, demand generation for HIV/AIDS services, and condom promotion. Mass media campaigns were synergised with other outreach activities and mid-media activities. Folk media campaign was up-scaled to 56,090 performance in 2012-13. Adolescence Education Programme is being implemented in 23 States covering 85,000 schools. Red Ribbon Clubs are functional in 12,300 colleges including 396 new clubs formed in 2012-13. 246 drop-in centres were supported to reach out to PLHIV with psycho-social support.

The Red Ribbon Express project, the biggest of its kind in the world, has become a model for such campaigns. In its third phase, the project covered 162 stations in 23 States reaching out to about 1.14 crore people and training over one lakh district resource persons. Over 90,000 persons were counseled for HIV of whom over 70,000 were tested for HIV. STI treatment was provided to over 11,000 persons and about 80,000 persons availed general health check. Mobilization of political leaders and enormous support of State Governments and district administrations have been key to the success of this project.

Mainstreaming: Mainstreaming facilitates the expansion of key HIV/AIDS services through integration with health systems of various stakeholders and designs policies, programmes and schemes to support social protection needs of PLHIV and HRG. Initiatives are being taken for strengthening convergence of NACP

with the National Rural Health Mission. The "Inter-ministerial conference for Mainstreaming HIV in India" was organised by the Department of AIDS Control and the United Nations Development Programme (India) in New Delhi on 18 and 19 December, 2012. It brought together all concerned ministries and departments on a common platform and facilitated greater understanding and coordination through comprehensive deliberations around the key issues related to mainstreaming HIV. The Department of AIDS Control and the Ministry of Shipping have entered into a Memorandum of Understanding on 14 February, 2013 on provision of prevention, care, support and treatment services of HIV/AIDS in the 12 major ports. Around 3.1 lakh persons were trained under Mainstreaming training programmes.

Strategic Information Management: The Strategic Information Management System (SIMS) has been rolled out and strengthened at over 15,000 reporting units across the country. HIV Estimations 2012 have been finalized and released after an elaborate and rigorous exercise of modelling. 13th round of HIV Sentinel Surveillance (HSS 2012-13) has been commissioned at 763 ANC and STD sites across the country from 01 Jan 2013. Guidelines are being developed for roll out of national Integrated Biological and Behavioural Surveillance among High Risk Groups and Bridge Population.

Programme requirements for evidence and priority areas for HIV/AIDS research have been finalized through a consultative process. A structured Analysis and Research Plan for NACP-IV has been developed to fill evidence gaps in the programme through analysis of available data and generation of fresh evidence through HIV/AIDS research. Research in HIV/AIDS including capacity building in operational research and ethics has been strengthened.

Results Framework Document: For the performance of various activities in the Results Framework Document 2011-12, the Department of AIDS Control scored 87.72 percent with "Very Good" rating from the Performance Management Division of the Cabinet Secretariat.

Finance: Special efforts were taken to build in systems both at NACO and SACS levels for effectively managing resource mobilisation and fund utilisation. Implementation of E-transfer facility has avoided transit delays in transfer of funds to States. Payment of salary to staff in district and peripheral units is made totally through e-transfer. During NACP-III period, an expenditure of Rs. 6,237.48 crore was incurred through budgetary sources.

In the fourth phase of the National AIDS Control Programme, NACO has taken cognisance of the emerging challenges and is focusing on region-specific strategies and evidence-based scale up of prevention as well as treatment interventions. Newer strategies are being developed under the AIDS control programme to effectively address the emerging epidemics in the States showing a rising trend. Prevention focus and programme intensity will be sustained in the areas where significant declines in HIV have been achieved as this is critical to consolidate the gains. The programme will ensure that the growing treatment requirements are fully met without sacrificing the needs of prevention.

Date: 12 March, 2013
New Delhi

LOV VERMA
Secretary
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1

Introduction

According to the HIV Estimations 2012, the estimated number of people living with HIV/AIDS in India was 20.89 lakh in 2011. The adult (15-49 age-group) HIV prevalence at national level has continued its steady decline from estimated level of 0.41% in 2001 to 0.27% in 2011. But still, India is estimated to have the third highest number of estimated people living with HIV/AIDS, after South Africa and Nigeria (*UNAIDS Report on the Global AIDS epidemic 2010*).

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

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

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

The third phase of NACP **(NACP- III)**, implemented during 2007-2012, was a scientifically well-evolved programme, grounded on a strong structure of policies, programmes, schemes, operational guidelines, rules and norms. NACP-III aimed at halting and reversing HIV epidemic in India by scaling up prevention efforts among HRG and general population, and integrating them with Care, Support & Treatment services. Thus, prevention measures for those who are not infected and care, support & treatment services for the infected and affected, formed the two key pillars of all the AIDS control efforts. Strategic Information Management and institutional strengthening activities provided the required technical, managerial and administrative support for implementing the core activities under NACP-III at national, state and district levels.

The strategy and plan for National AIDS Control Programme Phase-IV **(NACP-IV)** has been developed through an elaborate multi-stakeholder consultative planning process for the period 2012-2017. The process has adopted an inclusive, participatory and widely consultative approach with 15 Working Groups and 30 sub-groups covering all thematic areas involving around 1,000 representatives from central and state governments, high risk group communities, people living with HIV/AIDS, civil society, subject experts, experts from NRHM and other government departments, development partners and other stakeholders. Regional and State level consultations, e-consultations and special studies/ assessments were also undertaken to develop the strategic plan. Planning commission steering committee has also been closely overseeing this entire process.

Key challenges for NACP-IV identified during the process include emerging epidemics due to vulnerabilities such as migration and injecting drug use, growing treatment needs, and continued stigma and discrimination. Sustaining coverage and intensity of interventions in areas where declines have been achieved is critical to consolidate gains. Newer strategies should be put in place and strengthened to address the emerging epidemics.

To achieve integration with larger health system, there is a need to address the challenge of varying capacities of health systems in different States to sustain access to quality HIV/AIDS services without stigma and discrimination. Ensuring access to social protection schemes for people infected and affected with HIV/AIDS through mainstreaming of HIV/AIDS with other government ministries and departments is an important concern. Dwindling international donor support to HIV/AIDS, relatively weaker health infrastructure and implementation mechanisms in some States and supply chain management for HIV commodities are some systemic challenges faced by the programme.

Consolidating the gains made till now, NACP–IV aims to accelerate the process of epidemic reversal and further strengthen the epidemic response in India through a cautious and well defined integration process over the five year period. The objectives of NACP- IV are to reduce new infections and provide comprehensive care and support to all PLHIV and treatment services for all those who require it.

Key Strategies under NACP-IV

- Intensifying and consolidating prevention services, with a focus on HRGs and vulnerable population.
- Increasing access and promoting comprehensive care, support and treatment
- Expanding IEC services for (a) general population and (b) high risk groups with a focus on behaviour change and demand generation.
- Building capacities at national, state, district and facility levels
- Strengthening Strategic Information Management Systems

Guiding Principles for NACP-IV

- Continued emphasis on three ones: one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National M&E System
- Equity
- Gender
- Respect for the rights of the PLHIV
- Civil society representation and participation
- Improved public private partnerships.
- Evidence based and result oriented programme implementation.
- The five cross-cutting themes that are being focused under NACP-IV are quality, innovation, integration, leveraging partnerships, and stigma and discrimination.

Key priorities under NACP-IV

- Preventing new infections by sustaining the reach of current interventions and effectively addressing emerging epidemics
- Prevention of Parent to child transmission
- Focusing on IEC strategies for behaviour change in HRG, awareness among general population and demand generation for HIV services
- Providing comprehensive care, support and treatment to eligible PLHIV
- Reducing stigma and discrimination through Greater Involvement of People living with HIV (GIPA)
- De-centralizing rollout of services including technical support
- Ensuring effective use of strategic information at all levels of programme
- Building capacities of NGO and civil society partners especially in States of emerging epidemics
- Integrating HIV services with health systems in a phased manner

- Mainstreaming of HIV/AIDS activities with all key central/State level Ministries/ departments will be given a high priority and resources of the respective departments will be leveraged. Social protection and insurance mechanisms for PLHIV will be strengthened.

New Initiatives under NACP-IV

- Differential strategies for districts based on data triangulation with due weightage to vulnerabilities
- Scale up of programmes to target key vulnerabilities
- Scale-up of Opioid Substitution Therapy for IDUs
- Scale-up and Strengthening of Migrant Interventions at Source, Transit & Destinations
- Female Condom Programme
- Multi-Drug Regimen for PPTCT in keeping with international protocols
- Social protection for marginalised populations through earmarking budgets for HIV among concerned government departments
- Establishment of Metro Blood Banks and Plasma Fractionation Centre
- Demand promotion strategies specially using mid-media, e.g. National Folk Media Campaign & Red Ribbon Express and buses (in convergence with NRHM)
- Scale up of Second Line ART

Package of services provided under NACP-IV

I. Prevention Services

- Targeted Interventions for High Risk Groups {Female Sex Workers, Men who have Sex with Men, Transgenders/Hijras, Injecting Drug Users}, and Bridge Population {Truckers & Migrants}
- Needle-Syringe Exchange Programme and Opioid Substitution Therapy for IDUs
- Prevention Interventions for Migrant population at source, transit and destination
- Link Worker Scheme for HRGs and vulnerable population in rural areas
- Prevention & Control of STI/RTI
- Blood Safety
- HIV Counseling & Testing Services
- Prevention of Parent to Child Transmission
- Condom promotion
- Information, Education & Communication, and Behaviour Change Communication.
- Social Mobilization, Youth Interventions and Adolescence Education Programme
- Mainstreaming HIV/AIDS response
- Workplace Interventions

II. Care, Support & Treatment Services

- Laboratory services for CD4 Testing and other investigations
- Free First line & second line Anti-Retroviral Treatment through ART centres and Link ART Centres, CoE and ART Plus centres.
- Pediatric ART for children
- Early Infant Diagnosis for HIV exposed infants and children below 18 months
- Nutritional and Psycho-social support through Community Care Centres (CCC)
- HIV-TB Coordination (Cross-referral, detection and treatment of co-infections)
- Treatment of Opportunistic Infections
- Drop-in Centres for PLHIV networks

Key functions of the Department of AIDS Control

- Policy Formulation with respect to prevention and control of HIV/AIDS
- Development of standards, guidelines and norms for programme implementation
- Development of strategy and finalization of State action plans
- Financial planning & management, budgeting, release of funds and monitoring expenditures at national and state levels
- Strategic Information Management including programme monitoring, HIV Surveillance and Research on HIV/AIDS
- Institutional Strengthening and Human Resource Management
- Capacity Building
- Technical and Administrative Support and guidance to State AIDS Control Societies in programme implementation

A summary of key achievements made under NACP-IV during the current financial year (2012-13) is presented in Table 1.1. The epidemic scenario of HIV in the country highlighting the key impacts of the programme is elaborated in the next chapter. Strategies and achievements under different components of the programme are detailed in the subsequent chapters.

Table 1.1 - Progress in Achievement of Physical Targets during 2011-12 and 2012-13

Indicator	2011-12		2012-13	
	Target	Achievement	Target	Achievement up to Dec, 2012
New Targeted Interventions established	170	220	180	218
STI/RTI patients managed as per national protocol under NACO supported facilities	47.5 lakh	56.32 lakh	64.2 lakh	42 lakh
New Blood Component Separation Units established	7	4	3	3
Proportion of blood units collected through voluntary blood donation at NACO supported blood banks	90%	84.3%	90%	83.5%
Districts covered under Link Worker Scheme (Cumulative)	163	160	163	139
Persons tested for HIV (General clients)	120 lakh	109.31 lakh	130 lakh	73.25 lakh
Pregnant Women tested for HIV	90 lakh	85.63 lakh	90 lakh	57.10 lakh
Proportion of HIV+ Pregnant Women & Babies receiving ARV prophylaxis	-	84%	75%	96.4%
HIV-TB Cross Referrals	9.5 lakh	13.52 lakh	11 lakh	9.72 lakh
ART Centres established (Cumulative)	340	355	400	380
PLHIV on ART (Cumulative)	4.50 lakh	5.16 lakh	6.40 lakh	6,04,987
Opportunistic Infections treated	3.1 lakh	6.38 lakh	4.3 lakh	4,84,925
Campaigns released on Mass Media - TV/Radio	9	6	9	4
New Red Ribbon Clubs formed in Colleges	1,000	675	500	396
Persons trained under Mainstreaming training programmes	1,50,000	6,48,557	6.5 lakh	3.11 lakh
Social Marketing of condom by NACO contracted Social Marketing Organisations	34.9 crore pieces	50.6 crore pieces	35 crore pieces	22.83 crore pieces
Free Distribution of Condoms	-	-	44.5 crore pieces	29.5 crore pieces

BRICS Health Ministers' call for renewed efforts to face the continued challenge posed by HIV

Secretary and Additional Secretary from the Department of AIDS Control actively participated in the deliberations of the 2nd BRICS Health Ministers' Meeting held at New Delhi on 10-11 January 2013. Five specific thematic areas of work had been identified in May 2012 under the BRICS Health Platform for collaborative action – Health Surveillance, Non-communicable Diseases & Universal Health Coverage, Strategic Health Technologies, Medical Technologies and Drug Discovery & Development. India has led the thematic area on strengthening health surveillance.

The Health Secretaries and Senior Advisors for Health from the BRICS nations met on the first day and discussed issues and common position and developed an action plan for each of the five thematic areas. This was followed by discussion on common position on WHO reforms, child health and HIV/AIDS. NACO had developed the 'Common Position Paper on HIV/AIDS' that was presented and discussed. Besides, the achievements of India's National AIDS Control Programme were also presented. NACO also contributed actively in the negotiations to draft and finalise the Delhi Communique.

The Delhi Communique was adopted at the meeting of Health Ministers of BRICS countries, chaired by Shri Ghulam Nabi Azad, Hon'ble Union Minister for Health & Family Welfare, Government of India. He highlighted that the BRICS Platform would contribute greatly in the global effort towards strengthening health systems, particularly in the public sector, through specific actionable plans of collaboration. He urged the BRICS countries to continue to play an important role in ensuring that any international, bilateral and regional trade agreements do not undermine TRIPS flexibilities in favour of public health concerns.

Following is an extract on HIV/AIDS from the Delhi Communique adopted in the 2nd BRICS Health Ministers' Meeting on 11 Jan 2013:

"The Ministers called for renewed efforts to face the continued challenge posed by HIV. They committed to focus on cooperation in combating HIV/AIDS through approaches such as innovative ways to reach out with prevention services, efficacious drugs and diagnostics, exchange of information on newer treatment regimens, determination of recent infections and HIV-TB co-infections. The Ministers agreed to share experience and expertise in the areas of surveillance, existing and new strategies to prevent the spread of HIV, and in rapid scale up of affordable treatment. They reiterated their commitment to ensure that bilateral and regional trade agreements do not undermine TRIPS flexibilities so as to assure availability of affordable generic ARV drugs to developing countries."

NACO also participated in the IBSA Trilateral Meeting with delegations from Brazil and South Africa held on the sidelines of BRICS meeting. The key strategies and achievements of National AIDS Control Programme in India were presented and proposed areas of collaboration in HIV/AIDS discussed.

Hon'ble Union Minister of Health & Family Welfare, Shri Ghulam Nabi Azad, chairing the 2nd BRICS Health Ministers' Meeting at New Delhi

2

Current Epidemiological Situation of HIV/AIDS

HIV epidemic in India is concentrated among High Risk Groups and heterogeneous in its distribution. The vulnerabilities that drive the epidemic are different in different parts of the country. Overall trends of HIV portray a declining epidemic at national level, though inter-state variations exist. Both prevention and treatment strategies have yielded good impacts as reflected in the reduction in new infections as well as AIDS-related deaths in the country.

The adult HIV prevalence at national level has continued its steady decline from estimated level of 0.41% in 2001 through 0.35% in 2006 to 0.27% in 2011 (Figure 2.1). Similar consistent declines are noted among both men and women at national level. Declining trends in adult HIV prevalence are sustained in all the high prevalence States (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu) and other States such as Mizoram & Goa. However, some States in the North such as Odisha, Chhattisgarh, Jharkhand and Uttarakhand, some in the North West region including Punjab, Chandigarh and Delhi, and some low prevalence States of North East including Assam have shown rising trends in adult HIV prevalence.

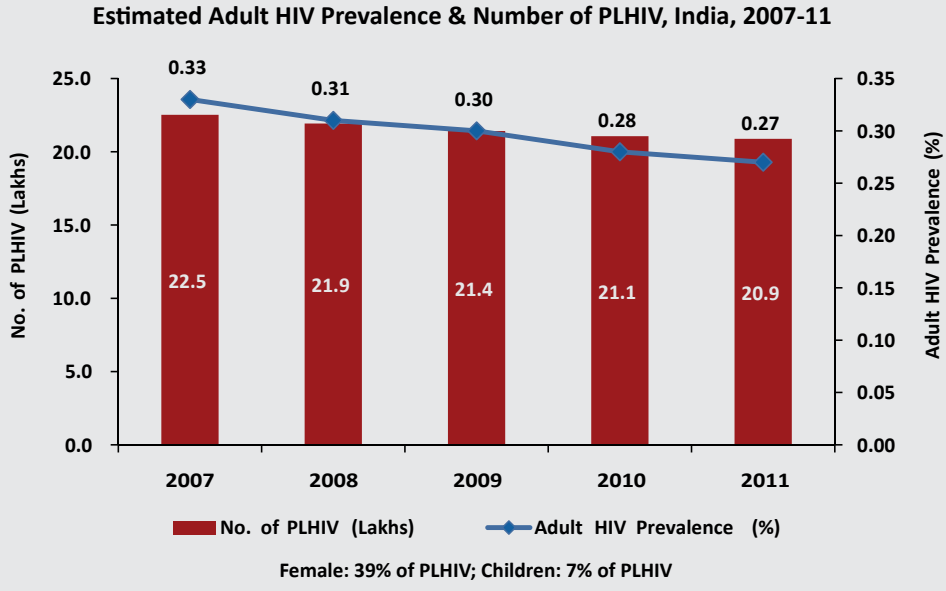
HIV prevalence among the young population (15-24 years) at national level has also declined from 0.30% in 2000 and has stabilised over the last four to five years at around 0.11%. Stable to declining trends in HIV prevalence among the young population (15-24 years) are also noted in most of the States.

The total number of people living with HIV/AIDS (PLHIV) in India is estimated at around 20.9 lakh in 2011. Children less than 15 years of age account for 7% (1.45 lakh) of all infections; while 86% are in the age-group of 15-49 years. Of all HIV infections, 39% (8.16 lakh) are among women. The estimated number of PLHIV in India maintains a steady declining trend from 23.2 lakh in 2006 to 20.9 lakh in 2011 (Figure 2.1). The four high prevalence States of South India (Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu) account for 53% of all HIV infected population in the country.

India is estimated to have around 1.16 lakh annual new HIV infections among adults and around 14,500 new HIV infections among children in 2011. Of the 1.16 lakh estimated new infections in 2011 among adults, the previously high HIV prevalence States of Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Manipur and Nagaland account for 31% of new infections, whereas, some low prevalence States (Odisha, Jharkhand, Bihar, Uttar Pradesh, West Bengal, Gujarat, Chhattisgarh, Rajasthan, Punjab & Uttarakhand) together account for around 57% of new infections.

India has demonstrated an overall reduction of 57% in estimated annual new HIV infections (among adult population) during the last decade from 2.74 lakhs in 2000 to 1.16 lakhs in 2011 (Figure 2.2). This is one of the most important evidences on the impact of the various interventions under National AIDS Control

Fig 2.1: Declining Trends of HIV Epidemic in India, 2007-2011



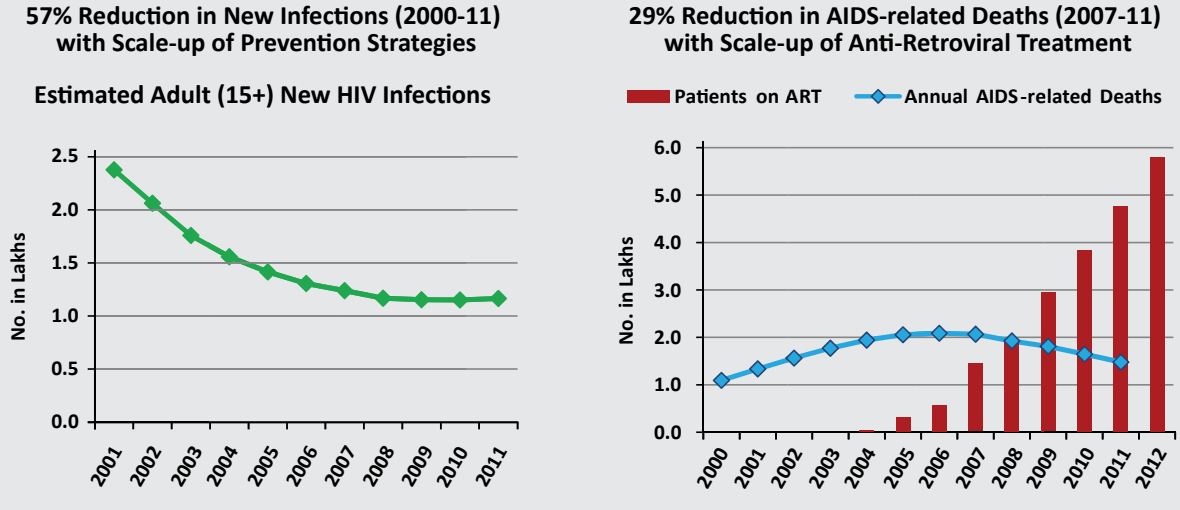
Source: Technical Report India HIV Estimates 2012, NACO & NIMS

Programme and scaled-up prevention strategies. Major contribution to this reduction comes from the high prevalence States where a reduction of 76% has been noted during the same period.

During NACP-III, the new HIV infections among adults have decreased by 28% in high prevalence States from 2007 and 2011. However, rising trends of new infections are noted in some low prevalence States. The programme has evolved focused prevention strategies to address these emerging vulnerabilities.

India continues to portray a concentrated epidemic. Considerable decline in HIV prevalence has been recorded among Female Sex Workers at national level (5.06% in 2007 to 2.67% in 2011) and in most of the States where long-standing targeted interventions have focussed on behaviour change and increasing condom

Fig. 2.2: Evidence of Programme Impact: Declining trends of new HIV infections & AIDS-related deaths, India



use. Declines have been achieved among Men who have sex with Men (7.41% in 2007 to 4.43% in 2011) also, though several pockets in the country show higher HIV prevalence among them with mixed trends. At the national level, the prevalence of HIV for general population (ANC attendees) and among different risk groups in 2010-11 is given in Figure 2.3 and the trends of the three-year moving averages based on consistent sites are shown in Figure 2.4.

In some of the North Western States, Injecting Drug Use is identified to be the major vulnerability fuelling the epidemic. Stable trends have been recorded among Injecting Drug Users at national level (7.23% in 2007 to 7.14% in 2011). Besides North Eastern States where declines have been achieved, newer pockets of high HIV prevalence among IDU have emerged over the last few years, in the States of Punjab, Chandigarh, Delhi, Mumbai, Kerala, Odisha, Madhya Pradesh,

Fig 2.3: National HIV Prevalence for ANC attendees and among different risk groups 2010-11

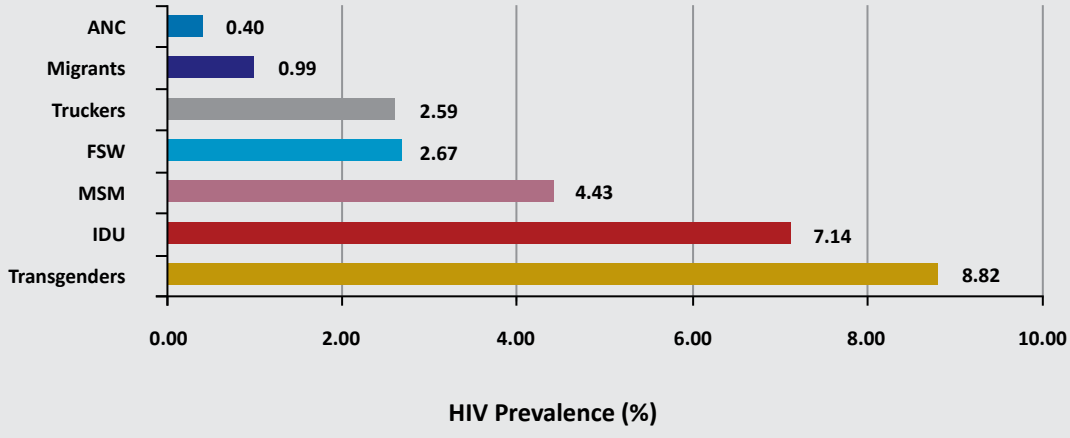
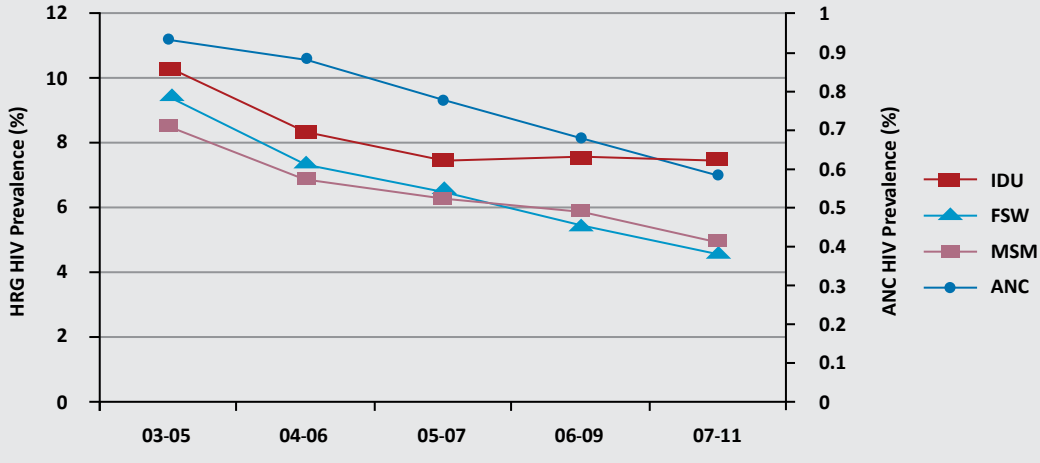


Fig 2.4: HIV Prevalence trends among General Population and High Risk Groups at National Level, 2003-2011.



(Note: 3-yr moving averages based on consistent sites; ANC–385 sites, FSW–89 sites, MSM–22 sites, IDU–38 sites)

Uttar Pradesh & Bihar. Prevention strategies for IDU in the newer areas have been initiated recently and are prioritised for further scale up during the next five years.

Analysis of the drivers of emerging epidemics in the low prevalence States points towards the possible role of out-migration from rural areas to high prevalence destinations in causing the spread of epidemic in some of North Indian States. Low levels of HIV among high risk groups, large volume of out-migration from rural areas to high prevalence areas, higher HIV prevalence among antenatal attendees in rural than urban population and higher prevalence among pregnant women with migrant spouses, noted in these States support this observation. Evidence on vulnerabilities among migrants highlighted by other behavioural studies and corridor studies further corroborate this possibility. In addition, long distance truckers also show high levels of vulnerability and form an important part of bridge population.

Using globally accepted methodologies and updated evidence on survival to HIV with and without treatment, it is estimated that about 1.48 lakh people died of AIDS related causes in 2011 in India. Deaths among HIV infected children account for 7% of all AIDS-related deaths. Wider access to ART has led to 29% reduction in estimated annual AIDS-related deaths during NACP-III period (2007-2011) (Figure 2.2). Greater declines in estimated annual deaths are noted in States where significant scale up of ART services has been achieved. In high prevalence States, estimated AIDS-related deaths have decreased by around 42% during 2007 to 2011.

It is estimated that the scale up of free ART since 2004 has saved over 1.5 lakh lives in the country till 2011 by averting deaths due to AIDS-related causes. At the current pace of scale up of ART services, it is estimated to avert around 50,000 – 60,000 deaths annually in the next five years.

The above evidence shows that India is on track to achieve the global targets of 'Zero New Infections, Zero AIDS-related deaths & Zero discrimination'. However, sustaining prevention focus and intensity in the areas where significant declines have been achieved, is highly critical to consolidate the gains, while effectively addressing the emerging epidemics. With increasing coverage of treatment & decreasing AIDS-related mortality, a significant number of people are likely to require first and second line ART treatment in the coming years. Major challenge for the programme will be to ensure that the treatment requirements are fully met without sacrificing the needs of prevention. NACO has taken cognisance of these emerging challenges and have focussed on region specific strategies and evidence-based scale up of prevention as well as treatment interventions.

3

Targeted Interventions

India's HIV epidemic, akin to other Asian HIV epidemics, is primarily driven by high risk behaviours such as unprotected sexual intercourse (both heterosexual and same-sex) and injecting drug use. As a result, the epidemic is largely concentrated in subgroups of population which are more likely to engage in such high risk activities. Due to their high vulnerability to HIV infection, these sub-groups of population are known as high risk groups (HRG) or most-at-risk populations (MARPs).

In India, Female Sex Workers (FSWs), Men who have sex with Men (MSMs), Transgenders / Hijra and Injecting Drug Users (IDUs) have been identified as the core HRGs. These populations are at high-risk of HIV infection and also play a significant role in the transmission of HIV infection to general population through the sexual networks. Hence, prevention through focused interventions amongst high risk groups and their sex partners is of extreme importance for controlling HIV epidemic in the country.

Key risk groups covered under the Targeted Intervention programme

- Core High Risk Groups
  Female Sex Workers
  Men who have Sex with Men
  Transgenders & Hijras
  Injecting Drug Users & their spouses
- Bridge Populations
  Long Distance Truckers
  High Risk Migrants

It has been observed that two other population groups play a key role in the spread of HIV infection from HRGs to the general population. These populations, due to the nature of their work and mobility, are more likely to come in contact with HRGs and constitute major proportion of the clients of sex workers. These risk groups include the long distance truckers and migrant workers. Since these groups serve as conduits of infection from HRGs to general population, they are also known as bridge populations. These groups also play a significant role in the transmission of infection from high prevalent areas to hitherto low infection areas. The recent rounds of HSS have revealed emerging pockets of infections in newer areas in low prevalence States of Central India related to migration.

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, focused preventive intervention projects among HRGs as well as bridge populations are supported under the National AIDS Control Programme (NACP). These intervention projects are known as the Targeted Interventions (TIs).

Targeted Intervention Projects

Targeted Interventions are preventive interventions working with high risk groups in a defined geographic

area. Targeted Intervention projects (TIs), implemented by NGOs / Community Based Organisations (CBOs), work with both core HRGs (FSW, MSM, TG and IDU) as well as Bridge populations and provide preventive interventions through a peer-led approach. Targeted interventions provide HRGs with the information, means and skills needed to prevent HIV transmission and improve their access to care, support and treatment services. These programmes also focus on improving sexual and reproductive health (SRH) and general health of the HRG clients.

The primary focus of TI programme is to stabilize and reverse the spread of the HIV epidemic among HRGs. The programme plans to cover at least 80% of the estimated population of HRGs and bridge populations with quality HIV prevention services.

Key attributes of Targeted Intervention Projects (TIs)

- Peer-led approach - people from the high risk community engaged to deliver services and act as agents of change
- Targeting high risk behaviours and practices and not the identity / individual choices
- Linking with services and commodities provision
- Dissociating risk from behaviours e.g. risk of STI and HIV infection from sex work
- Involving communities and their issues within the broader frame work of interventions
- Adapting to the cultural and social milieu of the target audience
- Focus on making most efficient use of limited resources
- Acknowledging that people who are at risk of HIV infection are often marginalized, stigmatized and discriminated against by the larger community and face critical barriers to accessing health-care services

NACP aims to scale up interventions for high-risk groups (HRGs) both in terms of numbers (coverage, number of targeted interventions) as well as in terms of quality of services.

These projects are contracted, funded and monitored by the State AIDS Control Societies (SACS). Technical Support Units (TSUs) have been engaged to provide technical assistance to SACS in mentoring and ensuring quality of TI projects. In addition, various organisations / institutions of repute have been engaged as State Training and Resource Centres (STRCs) to conduct capacity building activities for the TI programme following a competitive bidding process. The NGOs/ CBOs implementing the TI projects report to SACS on a standard monthly reporting formats developed by NACO which form a part of a national Monitoring & Evaluation framework.

Services offered under the Targeted Intervention Programme

- Detection and treatment for Sexually Transmitted Infections (STIs)
- Condom distribution (except in TIs for bridge population)
- Condom promotion through social marketing
- Behaviour change communication
- Creating an enabling environment with community involvement and participation
- Linkage to Integrated Counseling and Testing Centres
- Linkage with care and support services for HIV positive HRGs
- Community organisation and ownership building
- Specific Interventions for IDUs
  - Distribution of clean needles and syringes
  - Abscess prevention and management
  - Opioid Substitution Therapy (OST)
  - Linkage with detoxification/rehabilitation services
- Specific Interventions for MSM / TGs
  - Provision of lubricating materials
- Specific Interventions for FSWs
  - Provision of female condoms (on a pilot basis)

Typologies of Targeted Interventions

I. Interventions for Core High Risk Groups

Interventions for Female Sex Workers

It is estimated that there are about 8.68 lakh Female Sex Workers in the country, scattered in different States. Out of that, about 7.34 lakh FSWs (84.5%) are being covered through 508 TI projects. Different

typologies of sex workers, namely, brothel-based, street-based, home-based, lodge-based, dhaba-based, bar girls, etc. are being covered with specific intervention strategies. Over 50 TI projects for FSWs are being implemented by Community Based Organisations.

Interventions for Men who have Sex with Men

NACO has given significant thrust to the interventions for MSM and TGs as the prevalence among these groups is considerably high. The country level estimation of High risk MSMs and Transgender population is 4.12 lakh. Through TI projects, about 2.91 lakh (70.6%) MSM and TGs are being covered with services through 201 TIs. 37 such Targeted Intervention projects are implemented by CBOs which are managed by the community.

The National Programme is also complimented by 'Pehchan', Global Fund Round 9 India HIV Programme which is implemented by India HIV/AIDS Alliance focusing on strengthening community institutions and systems for MSM, Hijras and transgender interventions so that the outreach and quality of services are improved.

Interventions for Hijras-Transgenders

It has been increasingly recognized that Hijras and Transgenders have unique needs and concerns, and that it is better to view them as a separate group that is not under the rubric of 'MSM'. Reflecting a strong commitment to contribute to halting and reversing the HIV epidemic in India, the National AIDS Control Programme has initiated separate interventions for Hijras-Transgenders. The programme for Hijras/TG populations needs to be scaled up with adequate quality so that HIV prevalence can be reduced and prevention and care services are made available to these populations. Currently, there are no validated national level estimates of the size of transgender populations; hence mapping of Hijras-Transgenders has been initiated by NACO with the support of UNDP. Operational guidelines for implementing Targeted Interventions among Hijras and Transgenders is also been drafted at NACO along with building IEC material specific to the needs of these populations. By December 2012, 20 TIs are working exclusively with TG/Hijra populations.

Interventions for Injecting Drug Users

Injecting Drug Users and their spouses have high vulnerability to HIV. As per the HIV Sentinel Surveillance 2010, the HIV prevalence among IDUs is 7.14%. While the prevalence has decreased over the previous HSS (9.2% in HSS 2009), it still remains one of the highest in any population sub-group. In India, opioids (heroin, buprenorphine, propoxyphene, etc.) are the most commonly injected drugs either alone or in combination with other drugs from the non-opioid class (e.g. diazepam, promethazine, chlorpheniramine, etc.). However, the injecting as well as treatment-seeking behaviours among IDUs vary significantly between different regions.

The number of IDU in the country is estimated at about 1.77 lakhs. Of this, about 30% are estimated to be from the North-Eastern States. By December 2012, about 1.43 lakh IDU (81% of the estimated number) are being covered through 264 exclusive IDU TIs and some composite TIs. In addition, four exclusive interventions for Female IDUs and regular sex partners of male IDU are being implemented in four North-Eastern States (one each in Manipur, Mizoram, Nagaland and Meghalaya) with support from the United Nations Office on Drugs and Crime – Regional Office of South Asia (UNODC- ROSA). By December 2012, 369 Female IDU and more than 700 regular sex partners of male IDU were receiving prevention services from these interventions.

NACO has undertaken several initiatives to improve the quality of services including a situational analysis of harm reduction interventions with support from DFID-TAST. Under Global Fund Round-9, the principal recipient, Emmanuel Hospital Association is supporting NACO to strengthen the IDU interventions and building capacity at the national, state and district levels to deliver harm reduction services for IDUs and their spouses. Several studies have been undertaken to improve the understanding of the injecting related behaviours and practices and assess the availability and uptake of services by IDUs and their spouses. The areas explored in these research projects include: association of IDU risks and vulnerability to injecting practices, access and utilization of CST services among HIV positive IDUs and the contexts and response related to overdose among injecting drug users.

Opioid Substitution Therapy (OST) was incorporated into the harm reduction programme for IDUs in 2007-08 and since then NACO has been supporting more than 50 OST centres in NGO-settings covering about 4800 IDUs. The NGO OST Centres are contracted by the concerned SACS to implement OST after an independent accreditation by the National Accreditation Board for Health Providers (NABH).

NACO has also initiated implementation of OST services in government health facilities. A national plan for expansion of OST services is currently being implemented across 32 States / UTs with a view to establish more than 300 OST centres so as to cover at least 20% of the estimated IDU population with OST services. As part of the scale-up efforts, 45 new OST centres were established during 2012-13 (by December 2012) which resulted in doubling of the OST coverage in the country in one year. NACO is supporting provision of OST services through 107 OST centres spread across 25 States/UTs of the country and provides free substitution treatment to approximately 11,500 IDUs as of December 2012.

II. Interventions for Bridge populations

Interventions for High Risk Migrants

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 the 2001 Census) across 11 States which are on priority for starting up community level migrant interventions.

During 2012-13, NACO identified key areas which can strengthen implementation of revised migrant intervention strategy at source, transit and destinations. To this end, modelling of migrant interventions across two important corridors, i.e., Thane – Uttar Pradesh (Azamgarh, Allahabad, Gorakhpur, Jaunpur and Maharajganj) and Ganjam – Surat is being undertaken. This would include piloting of web-enabled tracking system to ensure continuum of services for migrants and their spouses.

The interventions at destination have been strengthened with improved monitoring and reporting by the State AIDS Control Societies. By December 2012, 215 TIs run by the State AIDS Control Societies at migrant destinations are reaching out 29.7 lakhs high risk migrants. The HIV sentinel surveillance data have shown a decline in prevalence among migrants from 2.35% in 2008-09 to 0.99% in 2010-11.

Health camps were organised at the block level during festivals (Dussehra, Diwali and Eid) when migrants return to their villages. These camps promoted health seeking behaviour as well as HIV testing and counseling among attendees. During the festive season (13 Oct – 17 Dec, 2012), 641 Intensive Communication and Health Camps were organised in 375 blocks of 90 districts in the States of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and West Bengal. At these camps, organised in close collaboration with NRHM and DAPCU of these districts, over 2.5 lakh people were educated on HIV/AIDS and treated for STIs and general ailments. During the camps, 29.6% of the camp attendees availed voluntary counseling and testing. The HIV positive persons were linked up with ART centres. These health camps also provided a platform for condom campaigns by Social Marketing Organisations and folk media campaigns by trained folk artists. About 56% of the camp attendees were migrants or their spouses, thus the target population was effectively reached by this strategy.

Additionally, 37 interventions are in place in select transit locations identified across the 122 districts from where migrants board long distance trains/buses to reach their destinations (usually work places). At these locations, the part-time outreach workers, placed with existing interventions, conduct group sessions on HIV prevention. Besides this, 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. are distributed to migrant workers free of charge. The strategy is to reinforce HIV prevention messages and encourage out-going migrants to seek HIV-related services at destination. During 2012-13, 5,50,163 migrants and their spouses were reached through 61,550 outreach sessions till December 2012.

Interventions for Long Distance Truckers

Currently, 75 Truckers interventions are reaching out to 9.67 lakh truckers, providing STI health care services, risk reduction counselling and condoms. Clinics at Trans-Shipment Locations have been co-branded as Khushi-Suraksha clinics. IEC materials addressing issues such as self-esteem, risk perception and services are made available. Besides this, there are 46 locations where condom social marketing initiatives have been implemented to promote risk reduction. The Behaviour Change Communication (BCC) materials, training kits and micro plan have been adapted for each site to suit the local needs and maximize the impact of interventions.

Capacity Building Activities for TIs

Capacity building activities are a continuous and integral part of the TI programme and aim to provide TI staff adequate understanding, skills and information thus enabling them to perform their roles effectively and efficiently. For this purpose, State Training and Resource Centres (STRCs) have been contracted in several States which, through training, on-site hand-holding and research activities, are expected to strengthen the operational efficiency of the TIs and improve the quality of service delivery. The STRCs are also tasked with the responsibility to develop local resource pool for training and mentoring activities.

Currently, 16 STRCs covering 22 States and 5 Union Territories are functional and 8 more are expected to come on board. The STRCs work in coordination with the State AIDS Control Societies and TSUs to build the capacity of TI staff. While the new staff receives induction training on the standardized modules, the old staff are imparted customized trainings based on needs assessment carried out by STRCs.

Several training modules have been developed to facilitate standardized training of TI staff through STRCs and ensure uniformity of messages across the States. These include generic training modules used in trainings of all TIs and some specific modules developed for training of TI staff working in a specific thematic area. Under the GFATM Round 9 project for IDU, modules for specific staff have been developed which include programme management, outreach workers, peer educators and clinical staff (doctors and nurses).

List of Generic TI Training modules

1. Peer Educator Module
2. Out Reach Worker Module
3. Counselling Module
4. Programme Management Module
5. Accountants / Monitoring & Evaluation

List of thematic TI training modules

Several thematic modules have been developed for training on specific components of the TI programme. These include:

1. Module for training ORW and PEs of Truckers Interventions
2. Staying safe: a manual to train PEs of IDU TIs
3. Staying safe manual to train ORWs of IDU TIs
4. Staying safe: a manual to train PMs of IDU TIs
5. Staying safe: a manual to train clinical staff (doctors and nurses) of IDU TIs
6. Advocacy, Community mobilization and Referral-networking module for training PD, PM and Counsellors of IDU TIs
7. Co-morbidity module – Module to train Clinical staff of IDU TIs
8. Module to train Counsellors of IDU TIs
9. Implementing Opioid Substitution Therapy – a module to train staff of OST centres and IDU TIs
10. Module on working with IDUs (Harm Reduction Module)

*The IDU specific modules have been developed with support from EHA (Principal recipient, Global Fund Round 9) and UNODC-ROSA

List of other materials developed for capacity building activities

Apart from the above training modules, other IDU specific material for training and reference have been developed for staff of IDU interventions with support from EHA (Principal recipient, Global Fund Round 9) and UNODC-ROSA. These include:

Standard Operating Procedure (SOP)

- Outreach in IDU Interventions
- Needle Syringe Exchange
- Managing Drop-in-centre of an IDU TI
- Overdose prevention and management
- Abscess prevention and management
- Reaching out to Female IDUs
- Linkage with CST services in IDU interventions
- Opioid Substitution Therapy in NGO settings

- Clinical Practice Guidelines
- Opioid Substitution Therapy with Buprenorphine

Practice Guidelines and SOP

- Disposal of Needles and Syringes by IDU interventions

Training activities conducted during 2012-13

Training for TI projects: The trainings conducted for TI staff in States during 2012-13 (till Dec. 2012), are shown in Table 3.1.

Training for OST centres: During 2012-13, a total of 10 induction trainings on OST were organized on the National OST Training Module of NACO for staff of both NGO and Government OST centres. The achievements in OST trainings are summarized in Table 3.2.

In addition, 30 Project Officers working with TSUs / NERO were also trained on OST implementation to strengthen the monitoring and supervision of OST centres. The OST trainings were also attended by and JD/DD/AD-TIs and Team Leaders – TSU/TI/SP of several States thus helping build capacity on OST implementation at State level.

Support mechanisms to ensure quality of interventions

The main focus in the initial 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 was an increasing emphasis on ensuring that the quality of the TI implementation is improved. In this regard, a number of steps have been taken:

- **Standardisation of the tools for collection of data:** Tools for collecting data regarding provision of services and referrals have been developed. The field level data regarding HRG feeds into the Computerised Management Information System (CMIS).
- **Developing a quality guide for TIs:** To ensure a standard process, a guide has been developed which covers how the data flow 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 are also covered in this guide.

Monthly tracking of CMIS report from TIs is being done at NACO; regular feedback to the SACS is

Table 3.1: Details of trainings conducted for TI staff, 2012-13 (till Dec 2012)

Area of Training	Category of Participants	Number
Programme Management	Programme Manager of TIs	961
Out-reach Planning	Out-reach Workers	3,762
Counselling	Counselor / ANM	807
Peer Education	Peer Educators	7,103
Financial Management	Accountants/ M&E	899

Table 3.2: Trainings of staff from NGO and Government OST Centres during 2012-13 (till Dec 2012)*

Category	No. Trained
Doctors (including Nodal Officers and back-up doctors)	76
Nurses / ANMs	76
Counsellors	44
Data Managers	30
Programme Managers	42
Outreach Workers	49
Total	317

**with support from EHA (Principal recipient, Global Fund Round 9) and UNODC-ROSA.*

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 along with a concomitant improvement in the uptake of services in the TI.

- **Technical Support Units (TSUs):** A National Technical Support Unit (NTSU) at NACO and Technical Support Units (TSUs) in fifteen States provide technical support on key aspects of the TI programme. TSUs support the SACS in implementation of TI in respective States by closely monitoring activities of TIs and provide hand-holding / on-site training as needed. This ensures that NACP guidelines are followed and strengthens quality of implementation. TSUs also facilitate the designing, planning, implementation and monitoring of TIs in the States and provide management and technical support to the SACS. Currently, 15 TSUs and North East Regional Office (NERO), which acts as TSU for North-Eastern States, are working with 23 States to provide supportive supervision for Targeted Interventions.

- **Supportive Supervision and Monitoring:** NACO has a strengthened organisational structure for TI supervision and monitoring. Project Officers (POs) are placed for handholding TIs. On an average, one PO covers 10 TIs and acts as an effective support mechanism which mentors and monitors the TI on a routine basis. The supportive supervision includes monthly one-day visits and quarterly intensive visits to ensure the quality of TIs. As of December 2012, 129 POs working with TSUs and NERO are mentoring 1,372 TIs in 23 States.

- **Quality Assurance (QA) in OST programme:** With the implementation of OST services in government health settings, NACO has established a mechanism of on-site mentoring and capacity building of staff through field visits by experts on OST on a periodic basis. The experts follow a standard protocol to observe the procedures and interact with the staff and clients at the OST centre and provide feedback to the staff in order to improve the service delivery. The standard protocol for these visits has been developed by National Drug Dependence Treatment Centre, AIIMS under the Project Hifazat supported by the Global Fund.

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

Performance of the Targeted Interventions Programme in 2012-13

The key performance of the TIs for the period April 2012 to December 2012.The data presented is based on CMIS reports.

Monthly reporting by TI NGOs

It is evident that consistent monthly reporting in CMIS by TI NGOs has considerably improved in most States. Nearly 85% per cent of TI NGOs reported consistently during the year 2012-13.

Coverage of HRGs and Bridge Populations

The coverage of FSW and IDU has already crossed 80% while the coverage of MSM population has increased over the years. (Figure 3.2)

Among the bridge populations, the targeted interventions are covering nearly 50% of the long distance truckers and more than 40% of the high risk migrant population (Figure 3.3)

STI clinic attendees

Clinical services including regular medical check-up is one of the core components of TI project services. NACO guideline suggests that HRGs from core group, specially MSM and FSW, should visit STI clinic every quarter, i.e., 4 times in a year for regular medical check-up for STI/RTI. Figure 3.4 depicts the number of clinic visits made by HRGs during 2012-13.

Diagnosis and treatment of STI cases

It has been observed from programme data that approximately 30 per cent of HRGs may suffer from some sexual / reproductive infection (RTI/STI) in a given year. Figure 3.5 shows the proportion of STI clinic attendees diagnosed and treated for STI/RTI during 2012-13 by TIs. Truckers formed the major

Fig. 3.1: Percent Reporting of TI NGOs in CMIS (April-Dec. 2012)

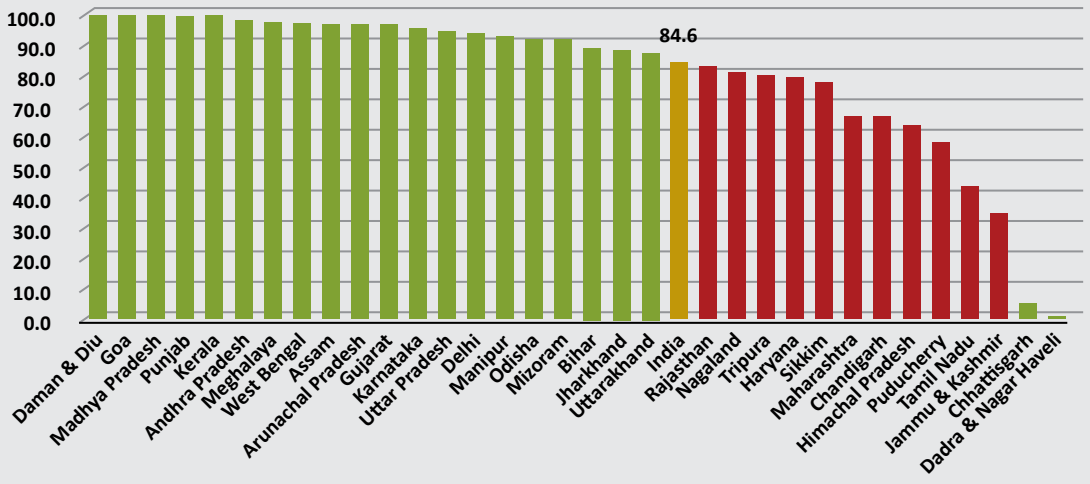


Fig 3.2: Coverage of Core HRG (FSW, MSM, IDU)

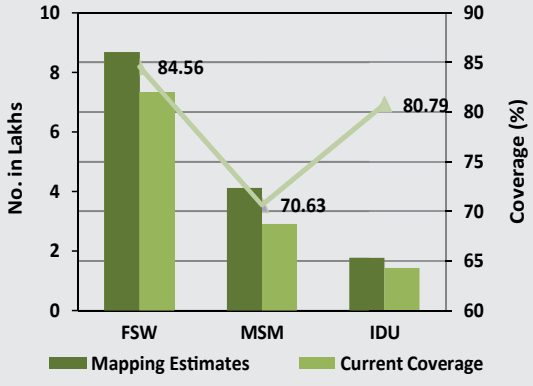
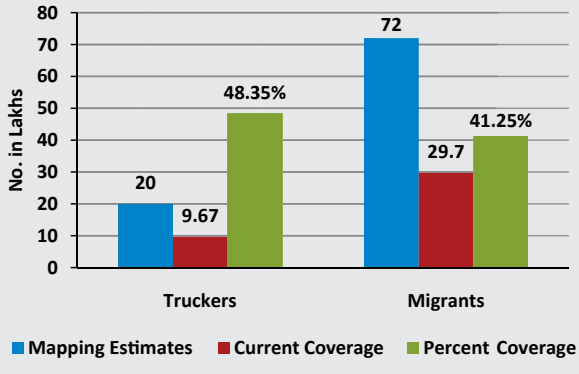


Fig 3.3: Coverage of Bridge Population (Migrants & Truckers)



group accounting for 58.8% of STI clinic attendees while other risk groups accounted for only around 10% each..

HIV testing and ART linkages among HRGs

NACO guidelines specify that all core group HRGs should be tested for HIV once every six months. Figure 3.6 depicts the number of HIV tests performed among HRGs through referrals from the targeted intervention projects.

All HRGs found positive for HIV are required to be referred to a nearby ART centre for pre-ART registration after which they are tracked by the ART centre staff for regular follow-up. As seen from figure 3.7 more than 90% of the HIV positive

Fig. 3.4: STI clinic visits during 2012-13 (till Dec. 2012)

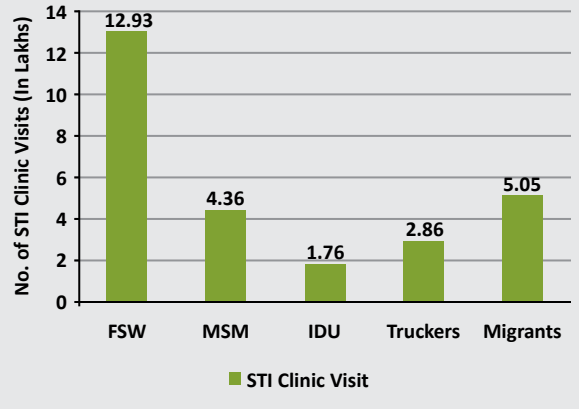


Fig. 3.5: Distribution of STI clinic attendees treated for STI/RTI by HRG typology during 2012-13 (till Dec. 2012)

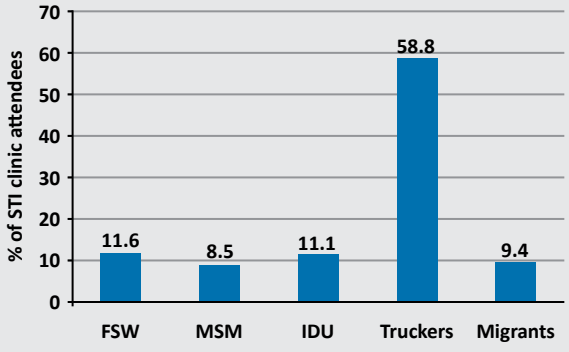
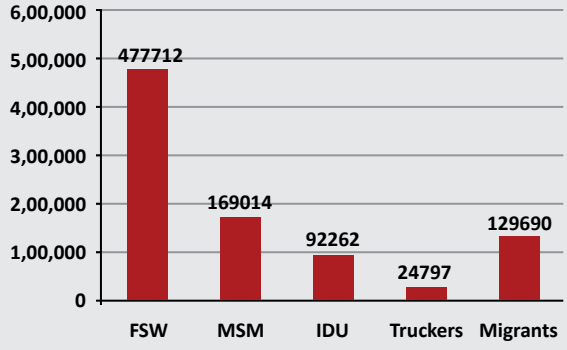


Fig 3.6: HRGs tested for HIV at ICTCs during 2012-13 (till Dec 2012)



HRGs have been linked with ART centres during 2012-13. However, there is scope for improvement in the TI-ART linkages in case of migrant and truckers TIs.

Distribution of Commodities

Condom distribution among HRG: As per NACP strategy, all sexual encounters of HRGs should be protected by consistent and correct usage of condoms. To ensure this, it is imperative that condoms are distributed to HRGs as per their demand. Fig. 3.8 shows the number of condoms distributed free of cost to the three core HRGs during 2012-13

Needle-syringe distribution among IDUs: As part of the preventive services, the interventions for IDUs distribute free needles and syringes to Injecting Drug Users through peer educators. This ensures availability of clean needles and syringes to IDUs and alleviates the need to share the injecting equipment thus decreasing risk for HIV transmission. Figure 3.9 depicts the number of needles and syringes distributed to IDUs in 2012-13. The return rate during this period was about 44%.

TI Performance Grading

NACO has appointed Project Officers for mentoring, supportive supervision and quarterly assessment of TIs. Quarterly performance assessment of the TIs' is done. By March 2012, 10 rounds of assessments had been completed. During Round I, 338 TIs across 11 States were assessed. By the end of Round X, 1,025 TIs across were assessed in 23 States. A total of 8,382 assessments

Fig 3.7: HRGs found HIV Positive and Linked to ART during 2012-13 (till Dec, 2012)

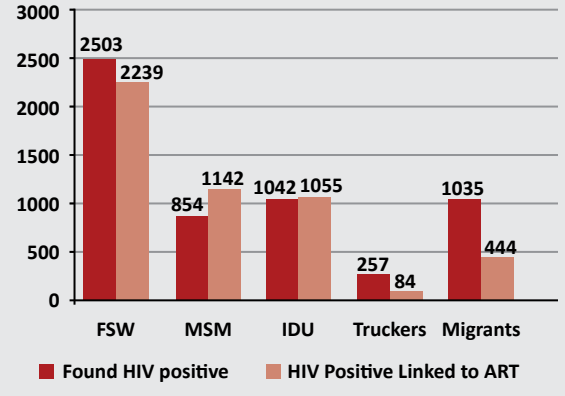
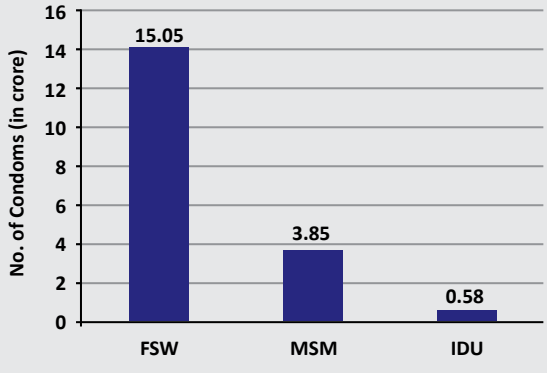


Fig 3.8: Free Condoms distributed to HRGs during 2012-13 (till Dec, 2012)



were conducted. The typology wise distribution of TIs assessed is shown in Figure 3.10. During 2012-13, NACO analysed the findings of the assessments conducted in these 10 rounds for better programme management.

The TIs, that were assessed, have been grouped according to their respective grades based on their performance rated on a variety of indicators during the different rounds (Table 3.3). This indicates progress in the quality of TIs.

Figure 3.11 compares the grade-wise distribution of performance rating of TIs between December 2009 (Round I) and March 2012 (Round X). The percentage of TIs in poor and average categories has steadily decreased from Round I to Round X, while the percentage of TIs in good and above categories has increased from Round I to Round X. This indicated the progress in the quality of TI implementation over the last three years.

Current Status of TI Programme

The population-wise distribution of TI projects and their coverage are shown in Table 3.4 and the distribution of TI projects by typology in the various States and UTs in the given Table 3.5.

Transition of interventions from Other Donors

As a part of the consolidating efforts made by other Development Partners during NACP-III, NACO has developed a common strategic approach for

Fig 3.9: Distribution and Return of Needles and Syringes during 2012-13 (till Dec 2012)

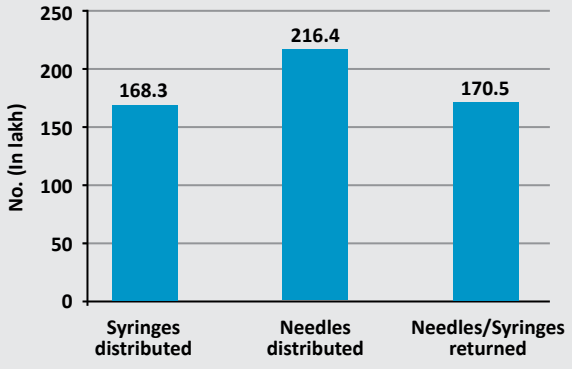


Fig 3.10: Typology-wise distribution of the 8,382 assessments conducted

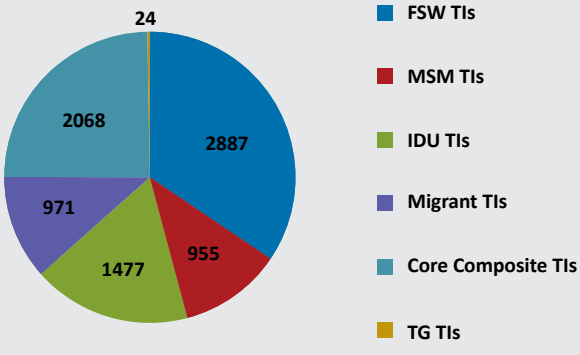
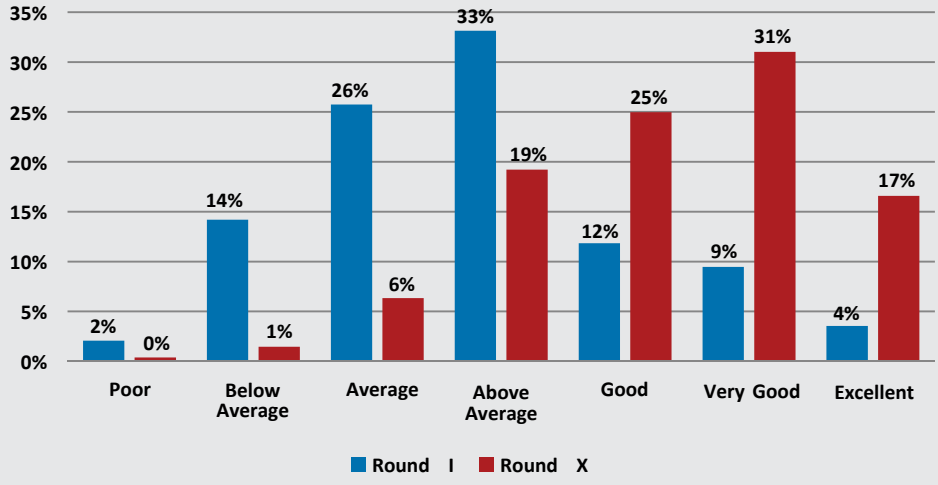


Table 3.3: Grading of Targeted Interventions

Round	Poor	Below Average	Average	Above Average	Good	Very Good	Excellent	Total
I	7	48	87	112	40	32	12	338
II	23	55	95	165	101	103	38	580
III	4	16	64	207	176	201	51	719
IV	5	22	64	183	212	181	95	762
V	2	45	63	214	213	218	119	874
VI	13	67	101	206	204	256	103	950
VII	3	42	99	229	228	247	132	980
VIII	16	39	102	227	246	266	161	1,057
IX	8	36	83	204	284	304	178	1,097
X	4	15	65	197	256	318	170	1,025

Fig 3.11: Proportion of TIs in different grades in Round I and X, based on performance rating



transitioning of interventions implemented by other Development Partners based on "Three Ones Principles". Apart from NACO-supported TIs, development partners, including the USAID and the Bill and Melinda Gates Foundation (BMGF), were implementing more than 200 HRG and bridge population TIs in the country during the NACP-III period (2007-2012). These interventions were primarily implemented in the six high prevalence States of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu.

All the best performing interventions have been transferred to the SACS according to their location (in Andhra Pradesh, Mumbai, Karnataka and Tamil Nadu) in 2009 (10%), 20% in 2011 and remaining (barring few TIs in Manipur and Nagaland) in 2012. Before the transfer, each TI was assessed by an external group of experts to grade the status of the programmes. This also provides a baseline for monitoring further progress. The Development Partner funded TIs identified for transition have been aligned to follow the costing and programme guidelines laid down by NACO.

Table 3.4 –Typology wise distribution of TI projects and the coverage as on 31 Dec, 2012

Typology	Estimates of HRG population (in lakhs)	Current Coverage (in lakhs)	Number of TIs	TI Coverage
Female Sex Workers (FSW)	8.68	7.34	508	84.5%
Men-who-have-sex-with-Men (MSM) & Transgender (TG)	4.27	2.91	201	70.6 %
Injecting Drug Users (IDU)	1.77	1.43	264	80.7%
Migrants	72.0	29.7	252	41.3%
Truckers	20.0	9.67	75	48.4%
Core Composite#			365	
Total			1,665	
Donor funded			40	
Total TIs functioning			1,705	

 # A mix of FSW, IDU and MSM, or FSW with MSM, or FSW with IDU, or MSM with IDU.

Table 3.5: Distribution of Targeted Interventions supported by NACO by State and typology (as on December, 2012)

State /UT	FSW	MSM	IDU	TG/ Hijra	Migrants (Transit)	Migrants (Destination)	Truckers	Core Composite	Total
Ahmedabad*	3	4	0	1	0	6	0	0	14
Andhra Pradesh	41	8	6	0	0	18	5	88	166
Arunachal Pradesh	4	0	3	0	0	6	0	8	21
Assam	36	5	8	0	0	6	3	4	62
Bihar	5	0	10	0	0	0	1	14	30
Chandigarh	4	2	2	0	0	3	0	1	12
Chattisgarh	15	3	7	0	5	6	5	13	54
D&N Haveli						0	0	0	0
Daman & Diu	0	0	0	0	0	4	1	2	7
Delhi	40	17	20	8	0	13	4	0	102
Goa	6	3	2	0	0	2	2	1	16
Gujarat	13	14	1	1	0	16	5	42	92
Haryana	13	9	15	0	0	10	0	6	53
Himachal Pradesh	14	0	2	0	0	4	0	3	23
Jammu and Kashmir	3	1	4	0	0	0	2	3	13
Jharkhand	19	3	3	0	5	0	3	0	33
Karnataka	65	31	4	2	0	19	5	3	129
Kerala	20	14	8	0	0	8	2	0	52
Madhya Pradesh	7	3	2	0	0	1	1	11	25
Maharashtra	55	20	3	0	0	32	10	2	122
Manipur	6	4	43	0	0	2	0	1	56
Meghalaya	3	0	3	0	0	1	0	1	8
Mizoram	2	1	22	0	0	4	0	8	37
Mumbai*	18	8	4	5	0	14	2	0	51
Nagaland	0	3	25	0	0	1	1	12	42
Odisha	14	2	7	0	13	10	1	23	70
Puducherry	1	1	0	0	0	1	0	2	5
Punjab	9	0	24	0	0	3	4	18	58
Rajasthan	19	2	6	0	4	6	3	11	51
Sikkim	2	0	4	0	0	0	0	0	6
Tamil Nadu	20	16	1	2	0	7	5	41	92
Tripura	7	0	2	0	0	2	0	2	13
Uttar Pradesh	11	4	12	0	0	0	4	40	71
Uttarakhand	11	3	7	0	0	6	2	5	34
West Bengal	22	0	4	1	10	4	4	0	45
TOTAL	**508**	**181**	**264**	**20**	**37**	**215**	**75**	**365**	**1,665**

* *Municipal AIDS Control Society*

New Initiatives & Innovations Undertaken In FY 2012-13

Interventions for Returnee Migrants in High Out-Migration Districts

Considering the importance of service provisioning to returnee migrants, NACO planned Intensive Communication and Health Activities this year in 375 blocks in 90 high out migration districts of 8 States, i.e., Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and West Bengal. These intensive activities were planned for the festival times of Dussehra, Diwali, Eid and Chhath Puja which are convenient times to focus on returnee migrants and their spouses. Under the chairpersonship of Additional Secretary, two rounds of State level meeting involving Project Directors of the above 8 States were organised. The Deputy Commissioner of NRHM from MoHFW, New Delhi also joined the meeting. Specific guidelines were developed and the SACS level officers were trained on the same. NACO officers also visited the concerned districts to facilitate planning of the health camps. Line-listing of migrant families was carried out and the same was used for mobilising to the camps.

Collaborative model of OST delivery

A novel model of OST delivery based on a tie-up between Government healthcare facilities and the NGOs implementing Targeted Interventions for IDUs was developed by NACO and piloted in the State of Punjab. In this collaborative model, the OST centre is located in a government hospital (medical college hospital, district hospital, CHC, etc.) and tasked with clinical assessment, diagnosis, prescription of substitution treatment and dispensing of the medications. Each of these Government OST centres is linked with nearby IDU TI(s) which facilitate the service uptake by motivating IDU clients in the project area and refer them to the OST centre for treatment. In addition, the linked IDU TIs also follow-up with clients who drop-out from treatment and conduct regular advocacy with local stakeholders to generate support for the OST programme.

The model has been designed to utilize the respective strengths of the government hospitals (technical and administrative capacity for medical interventions) and NGO sector (outreach for IDUs, rapport with the community, advocacy with stakeholders) to deliver high quality OST services. The establishment of OST services in government facilities will ensure sustainability of this long-term treatment which is necessary to provide uninterrupted services to IDU clients. It also facilitates access of IDUs to the other medical services located in government hospitals like HIV testing, ART, DOTS for Tuberculosis and surgical / medical consultation.

Since OST is established as the most effective HIV prevention strategy among IDUs, NACO plans to expand the coverage of OST services to at least 20% of the estimated IDU population. Based on the established model of NGO-run OST centres and the encouraging response received by the pilot of the collaborative model, a plan for nation-wide expansion of OST has been drawn and is currently being implemented across 32 States / UTs covering 175 districts with significant population of IDUs. During 2012-13, 45 OST centres in Government healthcare facilities were made operational expanding the coverage of OST services by about 5,000 clients.

4

Link Worker Scheme

The Link Worker Scheme (LWS) was launched under NACP-III to saturate the reach of the HIV-related services to the high risk groups and vulnerable population based in the rural areas. LWS focus on strengthening the fight against the epidemic particularly in rural areas becomes more pronounced in view of the stigma and discrimination surrounding the disease. The scheme makes efforts to build a community-centred model for rural areas. Rural interventions continue to be a challenge owing to the inadequate infrastructures, weak health systems and poor outreach initiatives.

The pattern of HIV infection in the country is heterogeneous and concentrated in nature. On the basis of the evidence related to HIV prevalence and the extent of vulnerability to HIV, 163 districts have been identified as priority districts for saturated coverage of HIV prevention and care services.

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

Population covered under the scheme:

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

Link Worker Scheme's community-based model, epitomised by the setting-up of youth-driven Red Ribbon Clubs in target villages, networking with PRI and existing health systems, and developing a cadre of community-level volunteers, ensures sustainability while at the same time making members of its target populations stakeholders in the programme.

Progress in the year 2012-13

The Link Worker Scheme is supported by the Global Fund for AIDS, TB and Malaria Round VII and has the mandate for implementation in 163 high prevalent and highly vulnerable districts. The selection of these districts was based on the fact that these districts were "Source Migrant" districts where the vulnerability of HIV is increasing. The scheme is operational in 139 districts as of December, 2012.

Coverage and Service Delivery

Keeping in mind the objective of reaching to the target population with the services available for HIV/ AIDS, coverage of the target population and service delivery uptake by them define the key indicators of

Tabel 4.1: Number of staff trained during 2012-13

Cadre	Module	Staff Trained
District Resource Persons, Training Officers, M&E cum Accounts and Supervisors	Induction and Mapping	85
	Outreach, Advocacy and Supportive Supervision	149
	Refresher	233
Link Workers	Induction and Situation Needs Assessment	466
	Outreach Advocacy and Micro Planning	1,035
	Refresher	1,480
Volunteers	Volunteers Training Module	12,545

the scheme. An estimated 1,48,745 HRGs (FSWs, MSMs and IDUs), 18,76,046 vulnerable population, 18,98,420 bridge population and 42,999 PLHIVs have been mapped under the Scheme. In terms of coverage, the scheme covers about 100% of the HRGs, 74% Vulnerable population, 68% Bridge population and 74% of PLHIVs. Nearly 62% HRGs have been tested at ICTC and 63% HRGs have sought treatment for STI symptoms under this intervention. This has been done by establishing linkages with existing services. Effective communication and easy availability of condoms is an integral part for correct dissemination of information and prevention from HIV/AIDS. In order to create a sense of ownership in the community and involve the youth in fighting against HIV, condom depots, Red Ribbon Clubs (RRC) and information centres have been established at the Village level. In 2012-13, a total of 12,391 Red Ribbon Clubs and 15,437 Village Information Centres were functioning. A total of 21,066 Condom Depots were functioning leading to easy accessibility of condom to the target population at the grassroots level.

Link Workers interacting with community members

IEC under Link Worker Scheme

Mid-Media play a crucial role under the Scheme for providing information on HIV and thereby promoting service uptake, IEC programmes were conducted in rural areas. The mid-media programmes include wall writings, wall paintings, folk performances and hoardings. These programmes were organised at the village level with support of Panchayati Raj Initiatives, line departments and RRCs. Locale-specific and culture specific IEC programmes were organized to reach out to the rural people, especially the vulnerable and high risk population. In FY 2012-13, under mid-media campaign special focus was on the Folk media in programme in intervention villages. Folk shows were done in all the LWS villages. For this the troupes were selected and trained by respective SACS.

Link Worker Scheme under NACP-IV

Rural interventions continue to be a challenge owing to the inadequate infrastructures, weak health systems and poor outreach initiatives. With large percentage of PLHIVs residing in the rural areas, the Link Worker scheme was initiated as a response to the insignificant existence of care and support for PLHIVs.

The scheme will continue till the end on NACP IV with minor modifications in the structure. The process of mainstreaming the scheme within NACO will start

post-2013. The programme will gradually phase out the present vertical scheme and integrate with the health system for delivery of rural services at the end of NACP IV.

Under the Mainstreaming Model, coordination and linkages with various units of NACO is very important. The coordination would focus on providing services to rural HRGs as well as utilising the existing work-force under NACP-IV for maintaining the quality of the LWS. This would necessarily lead to structural changes in the existing model.

Convergence within NACO

Convergence and linkages with various units of NACO is very significant. The rural interventions will have to develop strong linkages with TI division to ensure HRG related commodities (especially lubes for MSM and clean needles for IDUs) are available for rural HRGs. Coordination with IEC division of NACO and SACS is also important to ensure uniformity of messages and availability of IEC materials. Linkage with STI division is needed to ensure budgeting of condoms and STI drugs for rural HRGs and VP in the national plan.

Convergence with Health Department

Convergence and linkage with NRHM would be important in the context of rural interventions. The Link Workers are currently working closely with the frontline workers such as ASHAs, ANMs and Anganwadi Workers.

Convergence with non-health and social protection departments

There is a need to establish strong linkages with various non-health departments and agencies, to meet the social needs of the target groups and to ensure the sustainability of the Link Worker Scheme. Possible linkages that can be established with Department of Women and Child Development and Department of Social Justice & Empowerment for treatment and rehabilitation support to drug addicts, organising campaigns against drug abuse. To assure that the concerns over Orphans and Vulnerable Children are properly attended to, they should be linked with Juvenile Justice Board and Child Welfare Committee and Departments of Youth Affairs, Rural Development, Panchayat Raj and Education.

Rally on World AIDS Day

5

Management of Sexually Transmitted Infections/Reproductive Tract Infections

As sexually Transmitted infections (STI) and Reproductive Tract Infections (RTI) enhance chance of acquiring and transmitting HIV infection by 4-8 times, provision of STI/RTI services is aimed at preventing HIV transmission and reducing reproductive morbidity. Treatment and control of STI/RTI reduces the transmission rate of HIV infection by over 40%. Control of STI/RTI is the most cost effective means of preventing new HIV infection. Enhanced Syndromic Case Management (ESCM), with minimal laboratory tests, is the cornerstone of STI/RTI management under the National AIDS Control Programme.

An estimated three crore episodes of STI/RTI occur every year in the country. NACO target is to manage 64 lakh episodes of STI/RTI in 2012-13. Against this target a total of 42 lakh episodes of STI/RTI were managed till December 2012.

Progress of STI/RTI services

Expansion of STI/RTI Service in Government Health Facilities

Presently, NACO supports at least one STI/RTI clinic per district in the country. This clinic, called Designated STI/RTI Clinic (DSRC), functions from existing health care delivery system using their space, staff and other resources. NACO has provided support to these clinics to provide high quality STI/RTI services through audio-visual privacy, furniture and instrument for conducting internal examination, provision of central supply of colour-coded STI/RTI drug kits, RPR kits and consumable for conducting basic laboratory tests and computers for maintaining digital records. Each of these clinics is also provided with a trained counselor. A total of 1,112 designated clinics are functioning in the country, including 26 new clinics set up in 2012-13. Thirty four SACS STI focal persons and 10 Programme Officers in Technical Support Units oversee programme implementation in respective States.

Regional STI/RTI Training and Research Centres

Seven regional STI training, reference and research centres have been strengthened by NACO. These centres are located at Osmania Medical College, Hyderabad; Medical College, Kolkata and Institute of Serology, Kolkata; Government Medical College, Nagpur; Medical College, Baroda; Institute of Venereology, Chennai and Maulana Azad Medical College, New Delhi. Safdarjung Hospital, New Delhi acts as the Apex Centre for the country.

These centres provide etiologic diagnosis to STI/RTI cases, validate syndromic diagnosis, monitor drug resistance to gonococci and implement quality control for syphilis testing.

The functioning of the Regional centres was evaluated by an external team. The evaluators recommended continuation of these centres and suggested measures for efficient functioning. A national mentoring committee has been set up to strengthen and oversee the functioning of these centres and help establish systems for laboratory support and surveillance for STI.

There are 45 State Reference Centres linked to the regional STI centres, which are further linked to designated clinics, CHCs and PHCs in the State for providing laboratory support for managing difficult STI cases. The staff working in State reference centres are trained and mentored by Regional Centre for carrying out etiologic diagnosis of STI.

Workshop on Operational Research

The regional centres are mandated to conduct Operations Research for STI programme for proving input in programme implementation. A workshop on Research Methodology was organized with support of CDC and FHI in July 2012 for training the staff of Regional centres on Operational Research. A total of 65 professionals including Research officers, microbiologists and Public health specialists from seven Regional centres trained along with STI focal persons of SACS. A review meeting was conducted, and annual action plan for Regional centres were prepared. Subsequent to workshop, all the Regional centres prepared Operation Research protocols. These were reviewed by the Technical Resource Group of NACO and four proposals have been approved for conducting Operations Research.

Infrastructure strengthening of designated STI clinics

The infrastructure and facilities in the designated STI/RTI clinics have been strengthened by provision of audiovisual privacy for consultation and examination, and computer for data management

Counselors at Designated STI/RTI Clinics

STI/RTI patients require counseling services for behavior change and for preventing future infection. Counseling services are integral part of STI/RTI management. To strengthen the counseling services, one counselor has been provided in each of these designated clinics. 974 STI counselors are currently in position. These counselors also foster good linkages with other departments providing sexual and reproductive

Workshop on Operational Research

A doctor in a Designated STI/RTI clinic

Training session on STI in progress

Designated STI/RTI clinic

services. Training material, curriculum and job aids, including posters, flip book and a film on counseling, have been developed. A refresher training module for counselor was developed. A training of trainers (TOT) workshop was conducted in October 2012 at Bangalore; trainers from 14 identified training institutes, master STI trainers and SACS STI focal person were trained on the module. 495 STI counselors have received training on refresher training module till January 2013 at 14 identified institutes.

Communication on STI/RTI Service Delivery

Sexual and Reproductive health services at designated clinic have been branded "Suraksha Clinic" (meaning protection). The branding has been done to overcome the stigma attached to STI and to promote sexual health services. To generate demand for STI/RTI services a communication strategy is ongoing through specially designed TV and radio campaigns. The campaigns address issues of fear and reluctance in seeking treatment. A special intensive BCC and service campaign was conducted for promoting STI services amongst migrants returning from their workplace in the States of Uttar Pradesh, West Bengal, Bihar, Odisha, Madhya Pradesh, Chhattisgarh and Jharkhand in the months of October and November, 2012. All STI related IEC material and job aids have been compiled and disseminated to the States for translation and replication.

TV Spot on STI counseling and management

Training and Capacity Building of STI/RTI services providers

Standardized training curriculum for doctors, staff nurses, laboratory technicians and counselors is in place. The training to these staff is provided in a cascade form through a cadre of national, state and regional resource faculties. All faculty members have been trained using the same training material, following adult learning methods. The State and regional resource faculties, in turn, have conducted training of STI/RTI clinic staff of the designated clinics and TI-NGOs. A total of 3,765 personnel were trained including 1,146 doctors, 542 staff nurses, 470 laboratory technicians, 495 counselors and 1,112 preferred providers in 2012-13.

Each of the districts also has a district resource faculty for training doctors, nurses and laboratory technicians on STI/RTI management for sub district health facilities (PHC, CHC and Sub–divisional Hospital). A total of 3,414 persons were trained in 2012-13 including 1,096 doctors, 1,776 staff nurses and 542 laboratory technicians at sub district health facilities. Besides this, training institutes have been identified in every State to institutionalize STI/RTI related training for various cadres of staff.

Integration of STI elements has been done for trainings of FICTC, ANM and laboratory technicians of ICTC, wherein the related curriculum has been incorporated into their existing curriculum so as to make service delivery comprehensive. 2,740 FICTC ANM's were trained in 2012-13.

Convergence with NRHM

STI/RTI services are an integral part of services provided at all government health facilities including PHCs and CHCs. At each of these health facilities, a standardized service delivery protocol is followed. Free STI drugs are provided to the patients, medical and paramedical staff are trained, and monthly reports on STI/RTI indicators are reported from these facilities in existing HMIS.

Convergence has been strengthened at the national level through constitution of a joint working group and development of national operational framework for STI/RTI services delivery at sub-district health facilities. National technical guidelines and training modules for medical officers and paramedical staff for STI/RTI services have been developed jointly. A joint convergence meeting between NACO and NRHM is

conducted once every quarter. A joint review of the STI programme at NACO was conducted in August 2012 with representatives from SACS and State RCH officers of NRHM. In the project implementation plan of NRHM a budget for providing STI/RTI services is kept which includes budget for procurement of colour coded STI/RTI drug kits, training of staff, IEC for demand generation of services and for mentoring, review of programme and monitoring of services. STI elements have been integrated in the training module for the ANM of Facility integrated ICTC so as to build an integrated package of STI/HIV care for them. 2,740 ANM have received training on this curriculum with the support of the Indian Nursing Council.

Colour-coded drug kits have been made available at all CHCs and PHCs. A joint training plan has been developed. For training the service providers in CHC and PHC, a resource of 245 faculty was developed through six regional training of trainers' workshops. Trained resources at state, regional and district level provide quality training to medical and paramedical staff at all service sites. A total of 1,046 doctors and 2,445 paramedical staff (staff nurse and laboratory technician) from PHC and CHC facilities have been trained on STI management during 2012-13. Data on STI/RTI from HMIS is collated and monitored periodically by NACO. A total of 25.4 lakhs of STI/RTI episodes were treated at Sub-district health facilities from April to December, 2012.

Pre-packed STI/RTI colour-coded Kits

The pre packing of STI/RTI drug kits has helped to standardise the treatment. The Colour-coded STI/RTI kits have been provided for free supply at all government STI/RTI clinics, CHC/ PHC and TI NGOs. These colour-coded drug kits are procured centrally by NACO and dispatched to all SACS and district level consignees, and are being distributed to facilities for use. The pre-packaging of the drugs is being recognized as a global innovation in STI programme management. States have also been provided the specifications of the same to facilitate procurement at their end.

Provision of STI/RTI Services in High Risk Group Population

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

- Free consultation and treatment for their symptomatic STI complaints
- Quarterly medical check-up
- Asymptomatic treatment (presumptive treatment)
- Bi-annual syphilis and HIV screening

Preferred Private Provider approach has been rolled out to scale up STI/RTI services to HRG population under TI Projects. These providers are selected by the community members through group consultation. This approach has enhanced access to services for the HRG. Under this approach, all the HRG receives free STI/RTI treatment and the providers receive a token fee of Rs. 50 per consultation. A total of 3,565 preferred providers are providing STI/RTI services to the HRG. All these preferred providers are trained using a standardized curriculum on syndromic case management. Colour coded STI/RTI drug kits have been made available to these providers for free treatment of sex workers, MSM and IDU, and data collection tools are also provided to them. During 2012-13, about 23.2 lakhs visits have been made by HRG and 17 lakhs regular medical check-up conducted till December, 2012. The involvement of private practitioners for providing STI services to HRG at such a large scale is one of the few successful initiatives globally.

Partnering with Organized Public Sector, Public Sector Undertakings and Professional Organisations

The major proportion of patients with STI/RTI seek services from the vast network of private health care delivery systems ranging from freelance private practitioners to large public hospitals. Also, many populations are accessing services from public health

STI/RTI colour coded drug kits

care systems under other sectors like railways, ESI, armed forces, CGHS, railways, port hospitals as well as health facilities of public sector undertakings like Coal India Ltd and SAIL. It has been felt that reaching out to maximum numbers of people suffering from STI/RTI is not possible without partnership with private sector and organized public sectors.

NACO has initiated partnership with organized public sectors and private sectors through professional associations to support the delivery of STI/RTI services with the objective to reach the populations presently not covered by the public health care delivery system.

A meeting with Railways, ESI, Defence, CGHS, Family Planning Association of India, Port trust and Coal India was conducted. Road map for partnership has been developed; NACO will provide technical support in fostering the partnership. Training curriculum, budget for STI/RTI services is being proposed in respective ministries and simple monthly reporting format has been developed. The above agenda was also part of the mainstreaming meeting with all ministries conducted in the month of December 2012. STI/RTI services have been rolled out in the 11 major Port hospitals. A total of 1.07 lakh patients were managed and reported during 2012-13 (till December 2012).

NACP-III Dissemination Summit 2012 on Good Practices, Innovations and Impact

While NACP-III (2007-2012) has shown considerable gains in halting and reversing the epidemic, important challenges remain in the arena of prevention. The NACP-III Dissemination Summit, organized by NACO in collaboration with some development partners at New Delhi during 25-27 April, 2012, reviewed the remarkable achievements and rich experience accumulated over the five year span in scaling up prevention, care and support for HIV to identify key learnings that could help guide future activities. Along with analysis of contemporary international trends, the Summit reviewed the extent to which policy decisions, strategic choices, governance and programme management structures have helped in "reversing the tide," and new initiatives and the paradigm of community-centred response to HIV.

Shri Oscar Fernandes, Convenor of the Forum of Parliamentarians on HIV & AIDS addressed the inaugural in which six NACO Directors General – present and past – shared their views. The collective exercise of sharing and stock-taking brought together eminent policy makers, global and national experts, programme specialists from Centre and States, community groups and civil society organizations. Around 500 delegates attended the panel discussions, keynote presentations and oral and poster presentations on a wide variety of topics. A Statement of Commitment was read out by Dr Syeda Hameed, Member, Planning Commission at the Valedictory Session, who assured all support from the Planning Commission for the programme.

The summit provided a perspective of the unique contributions of NACP-III that have paved the way to focus on the highest at risk with quality assurance during NACP Phase-IV. It imparted a valuable insight into how India had provided an enabling environment to meet the challenge of HIV/AIDS through advocacy and sustained political will, recognition of marginalised populations and social policy, mobilizing and effectively applying all resources and forging strategic partnerships, to promote prevention and care, support and treatment supported by a strong IEC programme.

6

Condom Promotion

Condom promotion was given a huge fillip under the National AIDS Control Programme (NACP) for preventing HIV/AIDS. Unprotected sex being the biggest cause of transmission of HIV virus prompted NACO to use condom as one of the most important preventive tool in its fight against AIDS. Significant efforts have been made by NACO to promote consistent use of condoms for preventing HIV transmission which resulted in major achievements in terms of enhancing the availability and accessibility of condoms, raising awareness and increasing condoms offtake from retail outlets. A national level initiative focussed on condom promotion, viz., Condom Social Marketing Programme (CSMP) was launched by NACO under NACP III that helped tremendously in breathing life into the stagnant growth in condom market.

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

Targeted Condom Social Marketing programme (CSMP): NACO has successfully implemented four phases of Condom Social Marketing Programme through Technical Support Group, Condom Promotion comprising of technical experts deputed at national and State levels. Presently NACO is implementing this programme in 16 States that was rolled out in Odisha, Karnataka and Gujarat from May 2012, in Maharashtra from June 2012 and in other 12 States from December 2012 while the previous phase of this programme continued till June 2012 in 13 States. For CSMP, the districts were selected on the basis of HIV prevalence & family planning need as mapped and classified accordingly 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 the last phase of CSMP i.e. phase IV, 398 districts were covered falling under three categories i.e. 170 HPHF, 50 HPLF and 178 LPHF districts. This year the coverage under this programme was spread across 361 districts i.e. 117 HPHF, 80 HPLF and 164 LPHF districts in 18 States.

Under the NACO Condom Social Marketing Programme, the total condom sales during 2012-13 have been recorded as 22.83 crores till December 2012. This achievement was made by servicing more than 7.41 lakh outlets spread over 17 States during this period.

NACO targeted CSMP focuses on providing easy accessibility of condoms and hence taken steps to ensure the same in all situations by making it available with non-conventional shops like petrol pumps, barber-shops, wine-shops, PDS shops, dhaba, lodges, etc. The coverage and sustainability of non-traditional outlets is

increasingly enhanced as they facilitate easy accessibility of condoms in rural and far flung areas.

The programme also has focus 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.

Optimization of Free Supply of Condoms

Another key objective of the NACO condom programme is to optimize the supply of free condoms to ensure availability to the vulnerable population and minimizing the wastage of free condom supply. NACO, with the assistance of Technical Support Group (TSG)-Condom Promotion, 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 Ministry of Health & Family Welfare to State AIDS Control Societies (SACS) every month to avoid any stock out situation at SACS.
- Free condom supply analysis from SACS to Targeted Intervention Non-Governmental Organisations (TI NGOs) and subsequent distribution from various TI NGOs to Most at Risk Populations (MARPs).
- Free condom annual demand estimation as done at TI NGO and SACS level based on previous data analysis.

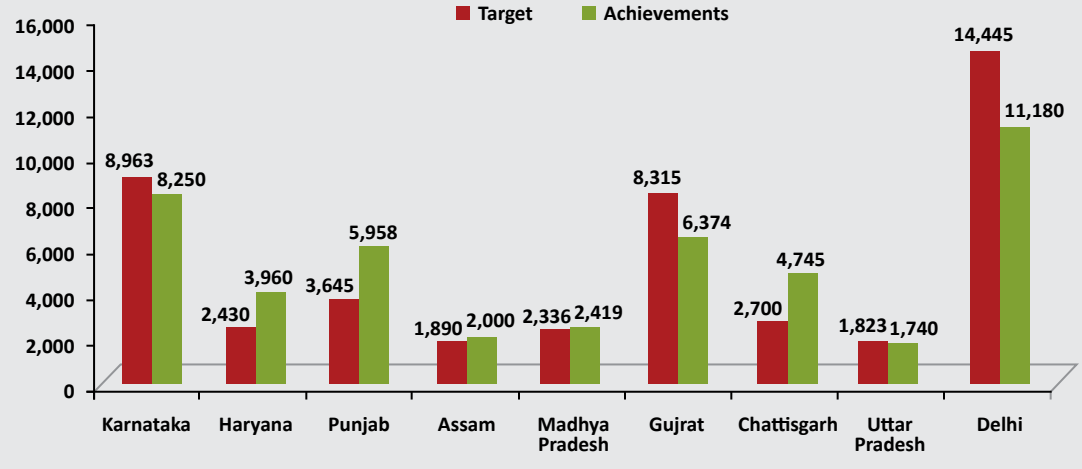
The technical Support Group on condoms assists SACS in calculating annual condom demand based on High Risk Group (HRGs) coverage, past condoms usage trends and reviews of existing inventory of free condoms at SACS as well as at TI NGOs covered by SACS. This resulted in significant reduction in the projected estimates of free supply of condom requirements as received from the respective SACS. On the other hand, intensive social marketing efforts by NACO through Social Marketing Organisations (SMOs) also led to increased availability of socially marketed condoms at outlets situated in and around TI sites which appears to have reduced the demand for free condoms.

This systematic approach led to the achievement of optimum coverage of free supply of condoms at all TI sites without any major incidence of stock out positions at SACS and TI NGO sites. Against an annual target of 44.47 crore free condoms distribution for 2012-13, SACS have distributed 29.5 crore free condoms till December 2012.

Female Condom (FC) Scale Up Pilot Programme – An Innovative Programme to Enhance Condoms Accessibility

NACO has successfully completed the implementation of scaled-up FC Programme in 2-districts each of Nine States as pilot including Delhi, Haryana, Punjab, UP, MP, Assam, Karnataka, Gujarat and Chhattisgarh in August '2012. It has reached around 35,758 Female Sex Workers ensuring complete coverage of designated TI NGOs in each district. The programme focuses on capacity building, training and BCC activities for increasing use of female condoms. In this programme,

Fig 6.1: Targets and achievements of FC pieces sold under Female Condom Pilot Programme in Nine States during 2012-13



total FC sold is 46,626 pieces against the target of 46,545 pieces through Programme implementing SMO, Hindustan Latex Family Planning Promotion Trust (HLFPPT).

Communication Activities: NACO uses mass media exhaustively to promote safe sex through condom use for its campaigns. Mass media campaign on condom promotion was launched on national television networks (Doordarshan and leading Cable & Satellite channels) as well as on radio (All India Radio and private FM channels). This campaign of 4-weeks duration was released in June 2012 on national scale in Hindi and other regional languages. The digital cinema screening platform was also utilized for condom campaign to gain reach among cine goers in smaller towns. NACO continued to air condom promotion campaigns aimed at enhancing risk perceptions among the target audience. This theme used in mass media campaign was also used in all forms of condom promotion communications including midmedia activities organized by Social Marketing Organisations in programme States.

In terms of demand generation activities under NACO CSMP, 5,23,679 events have been conducted and 1,06,91,006 target population reached till December, 2012. These activities are aimed at motivating behaviour change among the target population and create an enabling environment that encouraged consistent condom use. All the activities are designed to promote condom for its triple protection benefits against HIV/AIDS, STI and unwanted pregnancy. These condom promotion activities are organized in various forms viz. street plays, road shows, Inter-Personal Communication (IPC) and condom demonstrations etc. to make contacts, engage and motivate the target populations like High Risk Groups, Bridge Population as well as general population especially in rural areas for adopting consistent condom use practice and thereby generate demand.

Under NACO CSMP, retailer community was also involved and motivated as they play crucial role of consumer interface facilitating condom purchase action. Sensitizing retailers through normalization sessions and motivating them to stock condoms formed an integral plat of the demand creation process. Various trade promotional activities and schemes are also implemented to motivate retailers to stock condoms. They are encouraged to help in normalizing condom purchase by the consumers. Dealers meet and discussions were also organized to understand their concerns related to condom supply and distribution. Under NACO CSMP, 7.18 lakhs retail outlets were serviced and their premises utilized for installing condom promotion materials to generate visibility.

Integrated Condom Promotion Communication with NACO Campaigns

NACO has been conducting various national level campaigns for information dissemination on prevention and treatment from HIV/AIDS. Mid-media activities organized by Social Marketing Organisations under CSMP were integrated with NACO campaigns. Consistent condom use was promoted through NACO Folk Media Campaign, Red Ribbon Express Campaign, Migrant Campaigns and Health Camps across various programme States. Similarly condom promotion activities were made a regular feature at special events organized by State AIDS Control Societies on occasion of World AIDS Day, World Blood Donor Day, National Youth Day, etc.

Capacity Building

NACO CSMP implementing agencies are contracted only for a fixed tenure and hence arise an important need for capacity building of their staff. Various programme aspects range from sales, data management to communication need specific skills development. NACO TSG has been continuously striving for imparting knowledge, information and the best practices in the field of condom promotion among all stakeholders. This included induction and orientation sessions, refresher trainings, skills development programmes etc. These capacity building exercises are also aimed at grassroots level functionaries, workers of various TIs & SMOs as well as managers. One workshop for communication managers of SMOs was organized by NACO Technical Support Group on the best communication practices implemented for condom promotion.

Programme Monitoring

Over last four years, Technical Support Group- Condom Promotion 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 and assessment of Social Marketing Organisations

Male gathering being addressed with condom promotion message

Street play in progress in branded van in Maharashtra

Condom selling outlets at a bus stand in Bihar

Nukkad Naatak show at a bus stand in Odisha

Central Web Based Online CSM Programme Monitoring System: Technical Support Group-Condom Promotion had introduced web based online reporting system to monitor programme progress during CSMP phase III. An exclusive software was designed for this purpose. Through this TSG has completely shifted the database management platform from manual to computerized system. This system was continued to be used for monitoring the progress of field level activities in CSMP-IV and CSMP-V as well. The data compilation is being done carefully at different levels which were complicated, time consuming and had lot of chance of data entry errors. Using the software monthly reports are generated centrally at Delhi office and shared with the programme teams at State level for monitoring and taking corrective measures if required.

The Management Information System (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 endorses the validity of the uploaded data.

The output generated by software integrates efficiently into the Strategic Information Management Software (SIMS).

Continuously Tracking Condom Market Dynamics

AC Nielsen's condom retail off take data provides information on volume and outlet coverage at national level on a monthly basis and State level data on quarterly basis. This data is regularly analyzed to evaluate the universe of condom stocking outlets, brand penetration, market share and trends to monitor implementation and make corrections, as and when required.

Periodic reviews of performance of CSMP implementing SMOs

Periodic reviews of SMOs were organized to review the performance of the SMOs. The specific advantages of reviews are:

- Real time monitoring of implementation issues and allowing faster response and actions
- Allows monitoring of performance against deliverables on evaluation parameters
- Sharing best practices and successful ideas across SMOs
- Performance review with SACS allowed for better coordination and alignment between State and National Programme

7

Blood Safety

Blood is an intrinsic requirement for health care and proper functioning of the health system. NACO has been primarily responsible for ensuring provision of safe blood for the country. During NACP III, the availability of safe blood increased from 44 lakh units in 2007 to 93 lakh units by 2012. During this time HIV sero-reactivity also declined from 1.2% to 0.2% in NACO supported Blood Banks. NACO supported blood banks are functional in over 600 districts and very few districts are remaining where which have no NACO supported blood centres. Voluntary blood donation has been enhanced through concerted programme efforts.

The annual requirement of blood for the country is estimated at 80 lakh units of blood in 2012-13, out of which 55 lakh units is target for NACO supported Blood Banks. NACO endeavors to meet the blood needs of the country through voluntary non-remunerated donation through a well-coordinated Blood Banking Programme.

Key strategies for the programme are

- Increasing regular voluntary non-remunerated blood donation to meet the safe blood requirements of safe blood in the country
- Promoting component preparation and availability along with rational use of blood in health care facilities and building capacity of health care providers to achieve this objective
- Enhancing blood access through a well networked regionally coordinated blood transfusion services
- Establishing Quality Management Systems to ensure Safe and quality Blood
- Building implementation structures and referral linkages

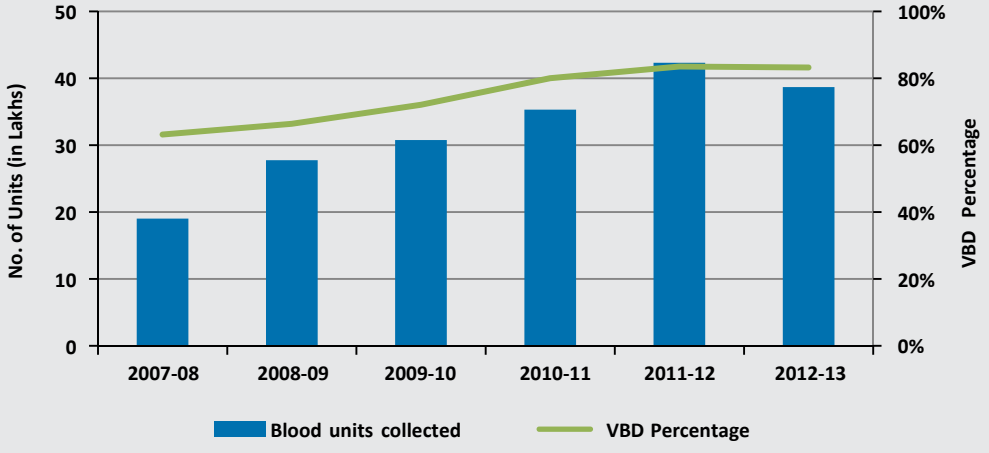
Current Scenario

The blood transfusion services supported by NACO comprise a network of 1,118 blood banks, including 175 Blood Component Separation Units (BCSU) and 34 Model Blood Banks. NACO has supported the establishment of component separation facilities and also funded modernization of all major government and charitable blood banks at State and district levels. Besides enhancing awareness about the need to access safe blood and blood products, NACO has supported the procurement of equipment, blood bags, test kits and reagents as well as the recurring expenditure of government blood banks and those run by voluntary/ charitable organisations, which were modernized.

During 2012-13, 67.56 lakh blood units were collected across the country, till December 2012. Of this, NACO supported Blood banks collected 38.68 lakh units; 83.5% of this was through voluntary blood donation (Figure 7.1).

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. At present, it is 60 % across the country. In order to streamline blood transfusion services in the country, National and State Blood Transfusion Councils were established as registered societies. These councils are

Fig 7.1: Trends in collection of blood and voluntary blood donation in NACO supported Blood Banks, 2007-08 to 2012-13 (till December 2012)



(Source: Monthly reports from Blood Banks)

provided with necessary funds through NACP. While the National Blood Transfusion Council provides policy direction on all issues concerning to blood and related areas, its decisions are implemented by the State Blood Transfusion Councils.

Collection

Voluntary Blood Donation Programme

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

In the year 2006-07, voluntary blood donation (VBD) was 54.4% which was the baseline for NACPIII. It increased to 59.1% in 2007-08, 66.4 % in 2008-09 and further to 72.1% in 2009-10 against the NACP-III target of 90%. During the year 2010-11, the percentage of Voluntary blood donation was 79.4%. In 2011-12, it improved to 84.3 %. 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.

Four regional level trainings cum workshops were conducted for Voluntary blood donation movement. The training modules were developed by NACO and vetted by TRG at NACO. These training modules consist of estimation of blood requirements, donor recruitment and retention, planning of blood donation camps, donor care, etc.

To augment VBD in the country, specific strategies were formulated for the entire country. These activities are carried out, through collaboration with Government, NGO and voluntary organisations. Voluntary blood donation camps and other activities are regularly undertaken to increase blood collection in the country.

The States of Andhra Pradesh, Maharashtra, Tamil Nadu, Gujarat, Goa, Tripura, Mizoram, Chandigarh, Haryana, Kerala, Madhya Pradesh, Puducherry and Sikkim, have crossed the national target and are Good Performing States in voluntary blood donation. The States of Assam, Delhi, Manipur, and Meghalaya are low performing States. 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, National Service Scheme, National Cadet Corps and NGOs.

Some NGOs were liaised at the central level like Tera Panth, HDFC Bank, Reliance and Samradh Jeeven Foundation for holding camps for NACO supported blood banks. 96,600 units were collected by Tera Panth, 24,000 units by HDFC Bank and around 32,000 units

Voluntary Donors donating blood in a Blood Mobile

Sensitization of youth on World Blood Donors Day at Delhi, 14 June, 2012

Hon'ble Minister of State for External Affairs and Human Resource, Shri E Ahmed addressing the National Voluntary Blood Donation Day function organised by Kerala SACS at Thiruvananthapuram on 1 October, 2012

by Samradh Jeeven Foundation in a single day across 1,118 NACO supported blood banks.

Guidelines for collection of blood were issued to the SACS and the States. No blood bank can collect more than 500 units blood in a day. This was made mandatory to all the blood banks to control the sero-reactivity to transfusion transmitted infections.

The World Blood Donors Day, with the theme "Every blood donor is a hero", was celebrated with great enthusiasm across the country on 14 June, 2012. Around 25 Centurion donors were felicitated by the National Blood Transfusion Council (NBTC) at a programme coordinated by Delhi SACS. Through a month-long campaign, 4.67 lakh blood units were collected through voluntary blood donation.

The National Voluntary Blood Donation Day was celebrated on 1 October, 2012 with the theme – "Somewhere someone needs you, your blood donation is precious".

The Vivek Rally was initiated from Assam on the National Youth Day on 12 January, 2013, and moved to the low performing States to augment voluntary blood donation in the country. The motive of the rally was to augment voluntary blood donation in the country. A month-long campaign for youth was initiated on 12 January, 2013, and ended on 12 February, 2013.

Scheme For Modernization

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

Model Blood Banks

Under the NACP-II, 10 Model Blood Banks were developed in 8 under-served States to improve the standards of blood transfusion services and function as demonstration centres for the States.

The NACP-III target was to upgrade one existing blood banks in the remaining 24 States/UTs Model Blood Banks, preferably in the State Capital with all infrastructure facilities manpower and licensed for preparation of blood components. At present, 34 model blood banks are functioning across the country.

A State of art blood mobile has been issued to each model blood bank to improve voluntary collection in the States. The blood mobiles are moving to the door steps of voluntary donors within 200kms of the model blood bank to collect blood.

Blood Component Separation Units

In order to promote rational use of blood, 82 BCSUs were established during the first two phases of

NACP through installation of essential equipment, manpower and consumable support. At present, there are 175 NACO supported BCSUs with the license for operating as component separation units. These BCSUs have started working in their respective States and the proportion of blood units processed for component separation has risen to from 47% to 51% in the current financial year 2012-13, till December 2012. Quality management modules were prepared by Technical Resource Group to increase Blood Component separation in the BCSUs.

Major Blood Banks and District level Blood Banks

During NACP-I and NACP-II, government and charitable blood banks in all districts of the country were taken up under the scheme for modernization of blood banks, except those in the newly created districts. At present, there are 909 NACO supported blood banks across the country which include 167 major Blood Banks and 742 district level Blood Banks.

During NACP-III, 39 newly created districts were identified which did not have Blood Banks. NACO had taken the initiative with the concerned State Health department for setting up a blood bank in these districts; 27 blood banks have been made operational. In 8 districts, construction of the building for blood banks is complete and steps are being taken to meet the requirements for a license. In four districts, blood bank buildings are under construction. Instructions have been issued by NACO to the respective SACS to set up Blood Storage Centres in these districts till the new blood banks become operational.

Distribution

Blood Storage Centres

In order to make safe and quality blood available in the First Referral Unit (FRU) where setting up a licensed blood bank is not feasible, Government of India has taken the initiative of setting up blood storage units. NRHM and NACO have started a joint programme to have Blood Storage Units in the FRUs. NRHM will provide the requisite infrastructure, manpower and procure the necessary equipment for storage and issue of blood. NACO has linked these centres with the nearest Regional Blood Transfusion Centre (RBTC) for supply of screened blood on a regular basis, and is regularly training the staff attached to the storage centres. At present, there are 745 blood storage centres functioning across the country. A linkage plan has been drawn by the respective SACS to facilitate FRUs. At least 10-15 units are available at the centres according to their consumption.

Blood Transportation Vans

Blood needs to be transported under proper cold chain maintenance from the linked RBTC to the Blood Storage Centre. Each RBTC is linked to 6-8 BSCs in order to supply blood units under proper conditions and storage. NACO had provided 250 refrigerated Blood Transportation Vans to the RBTCs/District Blood Banks during NACP-III. These vans transfer blood units to the BSC on a regular basis and also on demand/ emergency situations.

The blood transportation vans are functioning well. Blood is collected from VBD camps in these vans and brought to mother blood bank for processing; after processing, blood is being transported in these vans from mother blood bank to storage centres 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. The blood safety training programme aims to:

- strengthen 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; and
- strengthen inter- and intra-regional collaboration in training in blood transfusion between NACO and its Collaborating Centres, national blood transfusion services, education and training institutions and NGOs.

NACO has developed a uniform training curriculum for all aspects of blood transfusion. 17 centres have been identified across the country to impart training on all aspects of blood safety involving Blood Bank Medical Officers, Technicians, Counselors, Nurses, Clinicians, Donor Motivators and Programme Officers of SACS. Twelve Quality management trainings were held during 2012-13 using the training module developed by NACO. Voluntary blood donation trainings were held in four regions to augment voluntary blood donation in the country.

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 in blood banks as well as voluntary blood donations at different levels.

Supervisory Visits to NACO-supported Blood Banks

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

During assessment of blood banks, the following shortcomings and deficiencies were identified and taken up with SACS

- 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

New Initiatives

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

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

Plasma Fractionation Centre

Under NACP-III, one Plasma Fractionation Centre with a processing capacity of more than 1.5 lakh litres of plasma, which can fulfill the country's demand has been proposed. A large volume of excess plasma in the country is being discarded, as there is no such centre in the public sector in the country. The Government of India has approved the project in 2008. The Government of Tamil Nadu has provided land to NACO for the purpose.

Linkages with NRHM

- Clubbing of voluntary blood donation programme with Anemia Programme.
- Linkages of blood storage centres and training of blood storage centres.

Publications

- Voluntary Blood Donation Programme - An Operational Guideline
- Standards for Blood Banks and Blood Transfusion Services
- Guidelines for setting up Blood Storage Centres
- National Blood Policy (Reprint)
- Action Plan on Blood Safety (Reprint)
- Handbook for implementation of Quality Management System
- Technical Training Modules
- Training modules for VBD
- Guidelines for donor recruitment and retention

8

Basic Services

The Basic Service Division offers Counseling and Testing services for HIV infection, which includes three main components – Integrated Counseling and Testing Centres (ICTC), Prevention of Parent to Child Transmission and HIV-TB collaborative activities.

Integrated Counseling and Testing Services

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

Types of facilities

Stand-alone Integrated Counseling and Testing Centres (SA-ICTC): These are facilities supported financially and logistically by NACP for HIV counseling and testing. The number of SA-ICTC was scaled up largely during NACP III when some of the States and districts with high prevalence achieved saturation with the establishment of SA-ICTC up to the Block levels.

Facility Integrated Counseling and Testing Centres (F-ICTC): These were established considering the need for rapid scale up and sustainability of HIV counseling and testing services below the block level in high prevalent States and below the sub-districts level in the low prevalent areas. Under this model, staff from existing health facilities are trained in counseling and testing, and the service delivery is ensured with logistic support from NACP.

Public Private Partnership - Integrated Counseling and Testing Centres (PPP-ICTCs): With the concept similar to F-ICTC in public health facilities, the PPP-ICTCs were established in private facilities.

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

HIV Conseling and Testing facilities have been rapidly scaled up (Figure 8.1) and are now provided through

4,508 SA-ICTCs, and 8,389 FICTCs including those under Public Private Partnership model. The scale up of conseling and testing services is shown in figure 8.2.

Counseling and Testing of General Clients

During 2012-13, against the annual target of 130 lakh general clients to be counseled and tested, 73,25,363 (56%) received counseling and testing services till December, 2012 (Figure 8.1). This yielded detection of 1,79,617 HIV-seropositive cases with a positivity of 2.5%. Among the States, Andhra Pradesh showed the highest sero-positivity (4.52%) among General Clients, followed by Bihar (3.76%) and Maharashtra (3.45%) (Table 8.2). The high prevalence States still contribute largely to total HIV case detection with Andhra Pradesh contributing 23%, Maharashtra 22%, Karnataka 14% and Tamil Nadu 6%. The vulnerable States, viz., Uttar Pradesh, Bihar and West Bengal are posing a challenge to NACP by contributing 5%, 4% and 3% of the overall detection with a positivity of 2.4%, 3.8% and 2.2% respectively among general clients. Figure 8.2 shows the trend of achievements in coverage among general clients from 2007-08 to 2012-13.

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

The PPTCT programme involves counseling and testing of pregnant women, detection of positive pregnant women and the administration of Antiretroviral (ARV) prophylaxis to HIV positive pregnant women and their infants, to prevent the mother to child transmission of HIV. Against the annual target of 90 Lakh in 2012-13, about 57,09,691 (63%) pregnant women were counseled and tested by December, 2012, yielding detection of 9,451 HIV sero-positives (positivity 0.17%) (Table 8.2).

Fig. 8.1: Scale up of ICTCs during the period 2007-08 to 2012-13

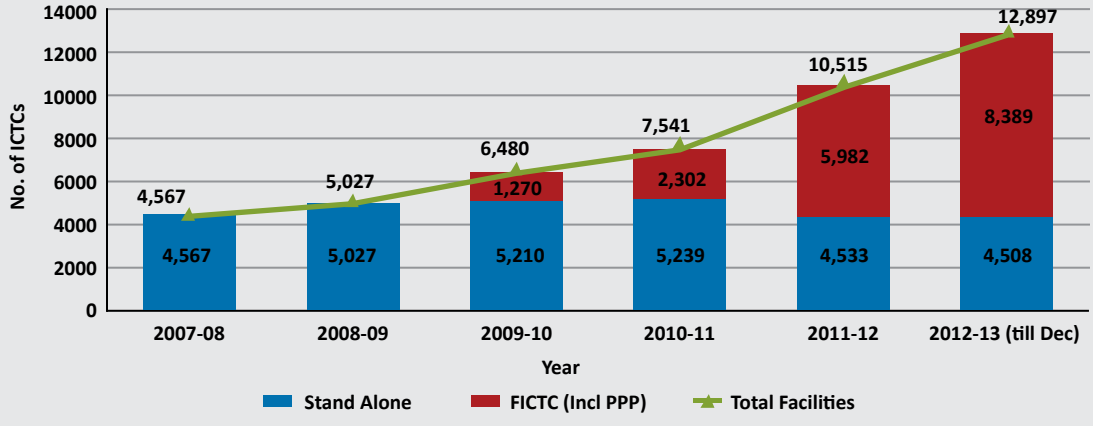


Fig 8.2: Scale up of Counseling and Testing Services from 2007-08 to 2012-13

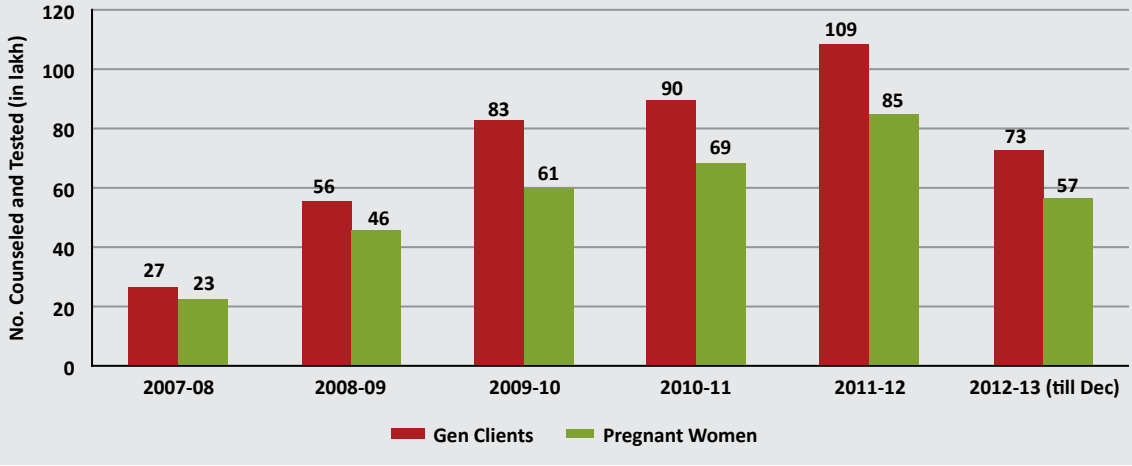


Table 8.1: State-wise number of General Clients counseled and tested for HIV and seropositivity detected during 2012-13 (till December, 2012)

State/UT	No. of General Clients tested for HIV	No. testing sero-positive for HIV (%age)
Andaman & Nicobar Islands	4,005	7 (0.17 %)
Andhra Pradesh	9,19,755	41,588 (4.52 %)
Arunachal Pradesh	11,065	12 (0.11 %)
Assam	75,385	772 (1.02 %)
Bihar	1,95,529	7,353 (3.76 %)
Chandigarh	30,190	638 (2.11 %)
Chhattisgarh	57,908	989 (1.71 %)
Dadra & Nagar Haveli	4,772	58 (1.22 %)
Daman & Diu	2,006	48 (2.39 %)
Delhi	2,24,322	5,253 (2.34 %)
Goa	23,262	369 (1.59 %)
Gujarat	3,88,523	6,849 (1.76 %)
Haryana	1,90,965	3,074 (1.61 %)
Himachal Pradesh	79,929	480 (0.60 %)
Jammu & Kashmir	22,506	215 (0.96 %)
Jharkhand	1,04,785	1,649 (1.57 %)
Karnataka	8,37,806	25,549 (3.05 %)
Kerala	2,28,028	1,336 (0.59 %)
Madhya Pradesh	2,76,121	3,582 (1.30 %)
Maharashtra	11,22,514	38,705 (3.45 %)
Manipur	42,548	1,380 (3.24 %)
Meghalaya	10,733	229 (2.13 %)
Mizoram	28,683	803 (2.80 %)
Nagaland	55,038	1,166 (2.12 %)
Odisha	1,98,268	2,413 (1.22 %)
Puducherry	31,597	532 (1.68 %)
Punjab	1,59,868	3,493 (2.18 %)
Rajasthan	2,41,845	4,597 (1.90 %)
Sikkim	14,471	40 (0.28 %)
Tamil Nadu	9,83,799	10,600 (1.08 %)
Tripura	30,306	130 (0.43 %)
Uttar Pradesh	4,07,937	9,675 (2.37 %)
Uttarakhand	1,04,391	1,201 (1.15 %)
West Bengal	2,165,03	4,832 (2.23 %)
Total	**73,25,363**	**1,79,617 (2.45 %)**

A counselor at the ICTC centre providing counseling to a pregnant woman

Launch of more Efficacious PPTCT Regimen by Secretary DAC & DG NACO, Andhra Pradesh, 14 September 2012

The State of Nagaland shows highest sero-positivity (0.84%) among pregnant women, followed by Mizoram with 0.59%. Figure 8.2 show the trend of achievement in coverage of pregnant women from 2007-08 to 2012-13.

The high prevalent States contributed largely to the detection of HIV positive pregnant women in the country, with Andhra Pradesh detecting 22%, Maharashtra 20%, Karnataka 15%, Tamil Nadu 5% and Gujarat 5% of the total.

Mother Baby pair Coverage

Pregnant women found HIV positive are administered ARV prophylaxis so as to prevent mother to child transmission of HIV. Between April 2012 to December, 2012, out of 9,451 HIV positive pregnant women detected, 9,108 (96%) Mother Baby (MB) pairs received Nevirapine (NVP) prophylaxis for prevention of transmission of HIV from mother to child (Table 8.2).

Roll out of more efficacious PPTCT regimen

In line with WHO recommendation, India has successfully launched the more efficacious PPTCT regimen in the two States of Andhra Pradesh and Karnataka since September, 2012 and plans to launch in the entire country in a phased manner. The country has opted for option B of the multiple drug regimens as per the recommendation of Technical Resource Group (TRG).

Fig 8.3: Scale up of In Referral of HRGs covered by TIs and STI Clinic Attendees from 2007-08 to 2012-13

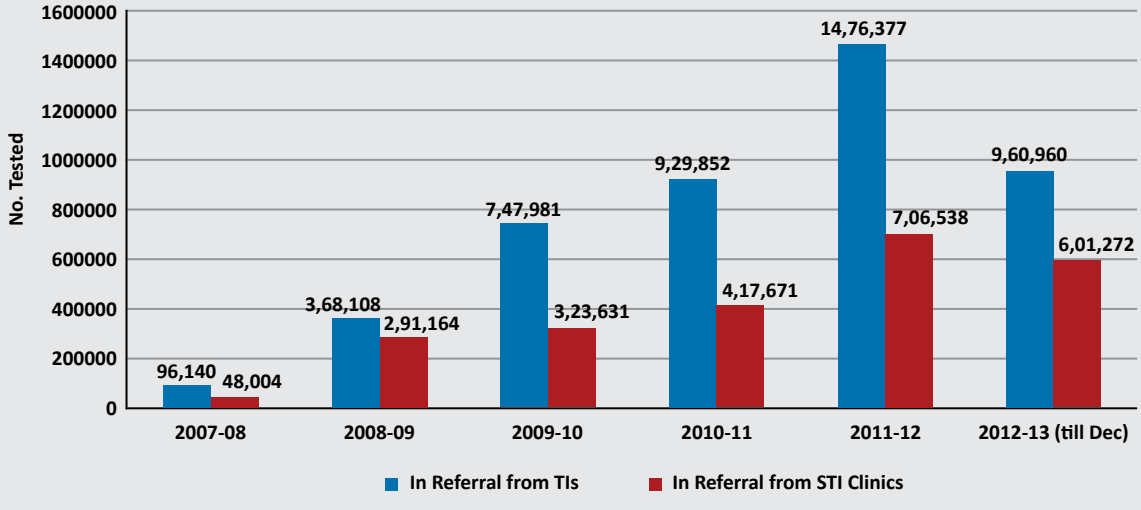


Table 8.2: State-wise performance of the PPTCT programme during 2012-13 (till Dec., 2012)

State/UT	No. of pregnant women tested for HIV	No. of pregnant women testing sero-positive	No. of Mother-Baby pairs receiving Nevirapine
Andaman & Nicobar Islands	1,793	0	0
Andhra Pradesh	7,03,928	2,120 (0.30 %)	1,979
Arunachal Pradesh	5,954	1 (0.02 %)	0
Assam	1,39,233	85 (0.06 %)	65
Bihar	1,68,214	261 (0.16 %)	178
Chandigarh	16,142	35 (0.22 %)	36
Chhattisgarh	44,002	83 (0.19 %)	53
Dadra & Nagar Haveli	4,404	3 (0.07 %)	1
Daman & Diu	2,107	3 (0.14 %)	3
Delhi	1,54,431	250 (0.16 %)	234
Goa	10,350	17 (0.16 %)	19
Gujarat	2,77,609	440 (0.16 %)	430
Haryana	1,25,794	178 (0.14 %)	70
Himachal Pradesh	33,519	21 (0.06 %)	3
Jammu & Kashmir	31,598	6 (0.02 %)	3
Jharkhand	66,288	62 (0.09 %)	36
Karnataka	6,12,916	1,388 (0.23 %)	1,385
Kerala	96,199	50 (0.05 %)	63
Madhya Pradesh	3,28,304	229 (0.07 %)	162
Maharashtra	8,33,213	1,900 (0.23 %)	2,115
Manipur	35,446	126 (0.36 %)	163
Meghalaya	11,938	40 (0.34 %)	15
Mizoram	14,966	89 (0.59 %)	109
Nagaland	13,844	116 (0.84 %)	112
Odisha	1,82,293	202 (0.11 %)	147
Puducherry	22,311	11 (0.05 %)	18
Punjab	1,56,068	203 (0.13 %)	156
Rajasthan	2,67,804	257 (0.10 %)	248
Sikkim	6,277	5 (0.08 %)	1
Tamil Nadu	5,92,821	510 (0.09 %)	784
Tripura	17,041	13 (0.08 %)	9
Uttar Pradesh	3,23,996	336 (0.10 %)	264
Uttarakhand	89,205	74 (0.08 %)	19
West Bengal	3,19,683	337 (0.11 %)	228
Total	**57,09,691**	**9,451 (0.17 %)**	**9,108**

Table 8.3: State-wise participation of ICTCs in EQAS during 2012-13

State/UT	No. of SRLs	No. of Technical Officers appointed	No. of Stand Alone ICTCs	SA-ICTCs sending EQAS samples to SRL	
				No.	%
A & N Islands	1	0	13	13	100
Andhra Pradesh	10	10	406	406	100
Arunachal Pradesh	1	0	36	13	36
Assam	3	3	83	75	90
Bihar	2	2	208	61	29
Chandigarh	1	1	12	11	92
Chhattisgarh	1	0	104	66	63
D & N Haveli	0	0	1	0	0
Daman & Diu	0	0	4	4	100
Delhi	4	4	95	89	94
Goa	1	1	14	14	100
Gujarat	5	5	308	289	94
Haryana	1	1	88	75	85
Himachal Pradesh	1	1	47	36	77
Jammu & Kashmir	2	1	35	17	49
Jharkhand	3	1	67	60	90
Karnataka	10	10	444	444	100
Kerala	5	5	164	147	90
Madhya Pradesh	4	4	143	127	89
Maharashtra	16	15	661	623	183
Manipur	1	1	60	54	90
Meghalaya	1	1	12	12	100
Mizoram	1	1	36	30	83
Nagaland	2	2	70	64	91
Odisha	3	2	185	132	71
Puducherry	1	1	12	12	100
Punjab	2	2	73	66	90
Rajasthan	6	4	182	166	91
Sikkim	1	1	13	13	100
Tamil Nadu	12	12	393	393	100
Tripura	1	1	18	17	94
Uttar Pradesh	9	9	217	209	96
Uttarakhand	1	1	48	46	96
West Bengal	5	5	256	238	93
Total	**117**	**107**	**4,508**	**4,022**	**89**

Further, national guidelines have been prepared to train the functionaries that would be involved in the implementation of the more efficacious PPTCT regimen based on the WHO guidelines of 2010. A total of 948, 9285 and 277 medical and para-medical staffs in Andhra Pradesh, Karnataka and Tamil Nadu have been trained in the more efficacious PPTCT regimen respectively. A strong NACP-NRHM linkage has been envisaged during the implementation of the more efficacious regimen to move towards the global goal of elimination of parent to child transmission of HIV.

Counseling and Testing of HRGs and STI Clinic Attendees

HRGs and STI Clinic attendees form a priority group of clients who would be at risk of being infected and hence ICTC programme focuses on establishing strong linkages with the TI projects and STI clinics. Special efforts like outreach activities are made by the ICTC team to enhance the uptake of ICTC services by these key populations. This has resulted in consistent improvement in coverage of services for HRGs and STI clinic attendees (Figure 8.3).

External Quality Assessment Scheme

SA-ICTCs participate in an external quality assessment scheme (EQAS) to maintain high standards of laboratory services through identified State Reference Laboratories (SRL).EQAS involves sending of "coded' samples from the SRL to ICTC twice a year for testing. In addition, ICTC sends samples for cross checking to the SRL once every quarter, which includes 20% of all positive and 5% of all negative samples collected in first week of every quarter. Table 8.3 details the State-wise achievements under EQAS.

HIV -TB Collaborative Activities

It is known that Tuberculosis (TB) is responsible for about 25% of all deaths among HIV infected individuals. It is also known that TB infection accelerates progression of HIV infection to AIDS and leads to early mortality. Therefore prevention of TB and prompt detection and treatment of HIV/TB are both important to ensure reduction in mortality.

But interventions for prevention of TB are challenging in Indian since as it is highest TB burden country in the world with large burden of infection in the community. The key TB prevention interventions recommended by World Health Organisation at HIV care settings include airborne infection control at HIV care settings and Isoniazid Preventive Therapy (IPT). NACP is currently implementing airborne infection control measures like fast tracking of cough symptomatic patients, promotion of cough hygiene etc. at ART centres. Further, the National Technical Working Group (NTWG) on TB/HIV collaboration, at NACO endorsed IPT as a strategy and recommended its implementation at all ART centres in the country. This activity is planned for rollout in 2013-14.

Along with TB prevention, early detection and treatment of HIV/TB are also important for reducing mortality. The NACP and Revised National TB Control Programme (RNTCP) implement various activities jointly to ensure early detection and treatment. These include:

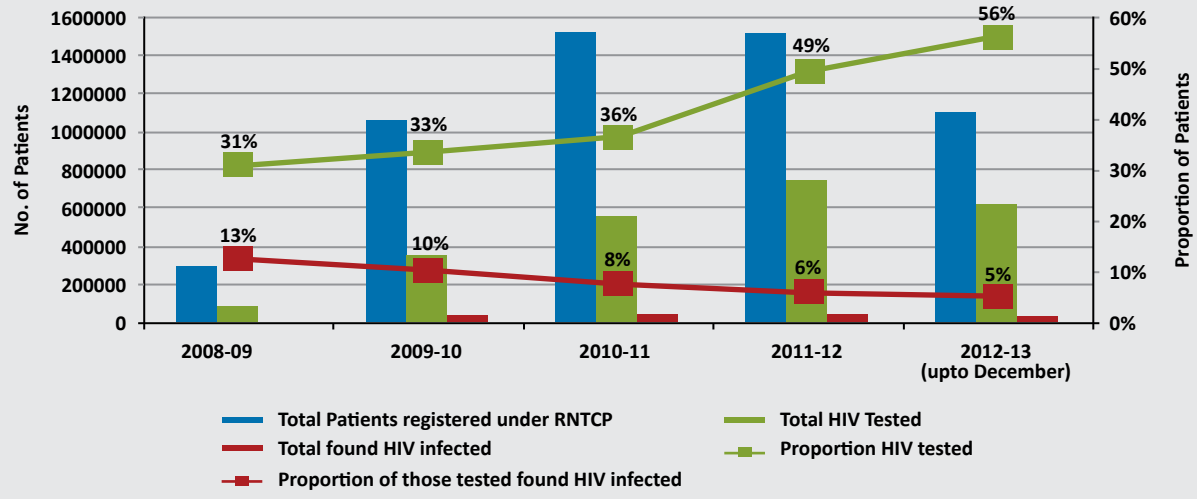
- Activities for early detection of HIV associated TB
- HIV testing of presumptive TB cases
- HIV testing of diagnosed TB patients
- Intensified TB case finding (ICF) at ICTC
- ICF at ART centres
- Activities to ensure early treatment of HIV
- Linkage of HIV/TB case to ART
- Initiation of HIV/TB cases on ART

HIV testing of presumptive TB cases

Detection of HIV by offering HIV tests to diagnosed TB patients is being implemented by NACP and RNTCP jointly since 2007-08. States with high HIV prevalence now cover about 90% TB patients. But case fatality rate among HIV infected TB cases remain 13-14% against less than 4% in HIV negative TB cases indicating delayed detection of HIV/TB inspite of good coverage. Therefore, NACP and RNTCP decided to offer HIV test upstream during evaluation of patients for TB when they present with TB symptoms. This activity is expected to expedite detection of HIV by 2-4 weeks, leading to early linkage to treatment and hence reduction in mortality.

HIV testing in presumptive TB cases was rolled out in Karnataka in October 2012 and preparatory activities are underway in Maharashtra, Andhra Pradesh and Tamil Nadu. It is planned to extend to the high HIV prevalence districts, i.e., A and B category districts. Further, the NTWG has recommended implementation of this strategy in 25 to 54 year age group in rest of the country. This intervention is planned for implementation during 2013-14.

Fig 8.4: Trend of HIV testing among TB cases notified under RNTCP



[Source: RNTCP]

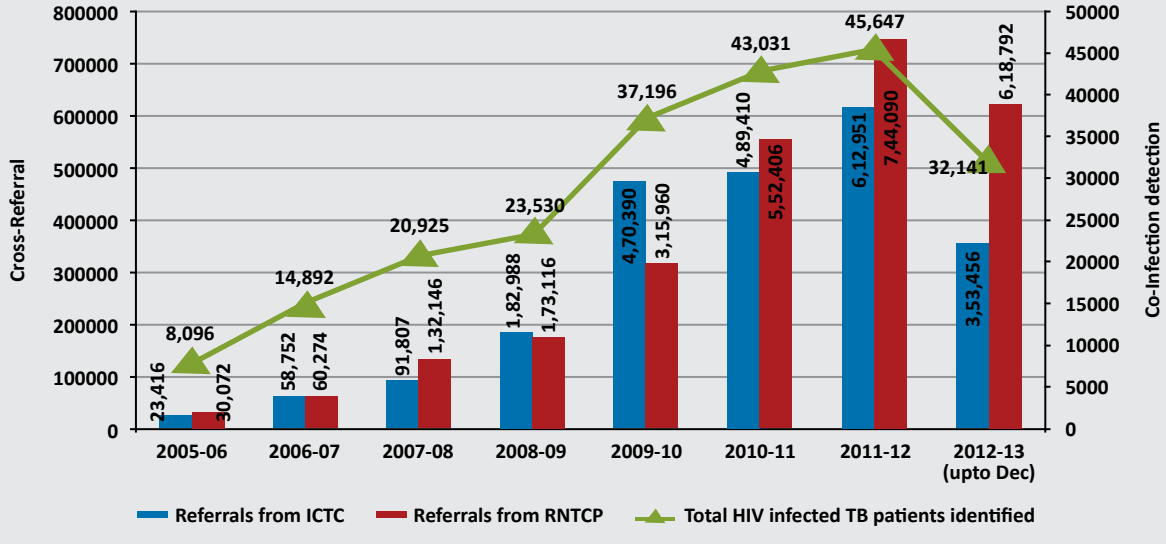
HIV testing of diagnosed TB patients

This activity is part of the intensified HIV-TB package implemented jointly by NACP and RNTCP. At national level the proportion of TB patients with known HIV status has consistently improved over past 5 years. This coincides closely with the increasing access to HIV testing facilities and co-located TB and HIV testing services. This trend is likely to continue the upward trajectory considering prioritization of co-locating TB and HIV testing facilities by both national programmes. In the year 2012-13 alone more than 6.18 lakh out of 11 lakh notified TB patients had their HIV status assessed as on December 2012. The Figure 8.4 shows the trend of HIV testing among TB cases notified under RNTCP from 2008-09 to 2012-13 (till December, 2012).

Intensified TB case finding (ICF) at ICTC

Figure 8.5 shows the progress made in HIV/TB cross-referrals over last few years. The cross-referral between NACP and RNTCP consistently show improvement, with 9.7 lakh cross-referrals and detection of about 32,141 HIV infected TB patients in 2012-13 (up to Dec, 2012). While referrals from RNTCP to ICTC show consistent increase, referrals from ICTC for ICF has

Fig.8.5: Trend of HIV/TB co-infections identified, 2005-2012



[Source: RNTCP]

Table 8.5: Progressive ICF activities at ART centres from 2010-11 to 2012-13 (up to Dec. 2012)

Year	Total presumptive TB cases detected	Total TB positive patients detected	Proportion found TB+ve	No. (%) of HIV/ TB cases put on DOTS
2010-11	80,837	22,382	28%	18,978 (85%)
2011-12	1,23,339	30,080	24%	24,799 (82%)
2012-13 (up to Dec. 2012)	1,03,426	20,393	20%	18,278 (90%)

(Source NACP ICF at ART reports)

plateaued at around 3.53 lakhs referrals in 2012-13 (up to Dec, 2012). Strengthening ICF at ICTC, therefore, remains a priority activity for NACP.

Intensified TB case finding at ART centres

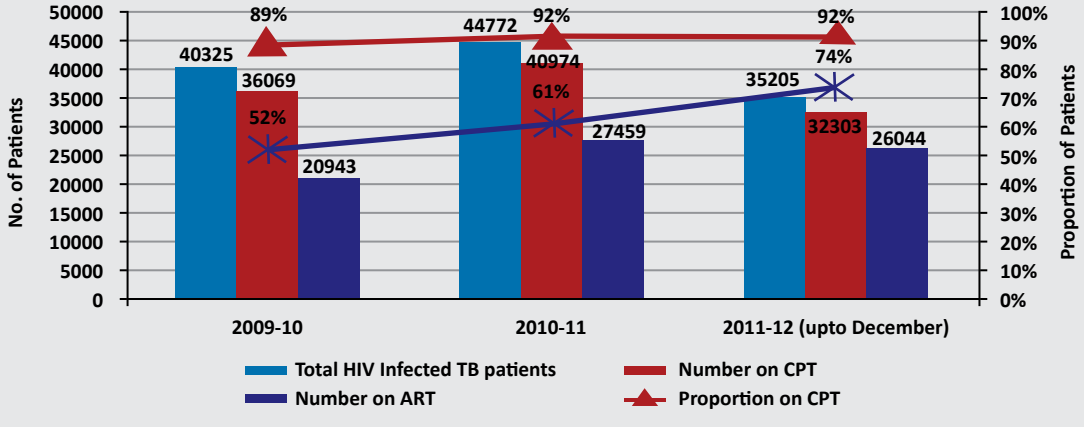
ICF at ART centres is implemented since 2010 and it is now implemented at all ART centres, Link ART centres and Link ART plus centres. But timely reporting remains a challenge with only about 300 centres reporting regularly in 2012. Considering importance of ICF activity, the reporting is now incorporated within the ART centre monthly reporting format. This is expected to ensure 100% reporting. Table 8.5 shows progress in ICF activities at ART centres.

More than 1.03 lakh presumptive TB cases were identified among ART centre attendees in 2012-13 (up to Dec) and more than 20% of them were found to have TB. More than 90% of HIV/TB cases are also linked to DOTS treatment. Screening for TB although implemented at all ART centres, it remains less than optimal. Also implementation of ICF at LAC-Plus centres and LAC needs further strengthening.

Treatment of HIV/TB cases

These activities are also part of the intensified TB HIV package of services. NACP and RNTCP consistently achieved linkage of more than 90% HIV/TB cases to Co-trimoxazole Prophylaxis Therapy. Linkage to ART is more challenging considering low number of ART centres compared to TB treatment centres. But joint efforts of both programme staff and close monitoring of the activity has resulted in consistent improvement with about 75% HIV infected TB patients receiving ART in 2011-12 (Fig 8.6). These linkages are better in the four high prevalence States of Karnataka, Andhra Pradesh, Maharashtra and Tamil Nadu where every district has at least one ART centre.

Fig. 8.6: Trend of linkage of HIV infected TB patients to CPT and ART



[Source: RNTCP]

9

Care Support & Treatment

The Care, Support and Treatment (CST) component of the National AIDS Control Programme aims to provide comprehensive management to PLHIV which includes free Anti-Retroviral Therapy (ART), psychosocial support to PLHIV, prevention and treatment of Opportunistic Infections (OI) including TB.

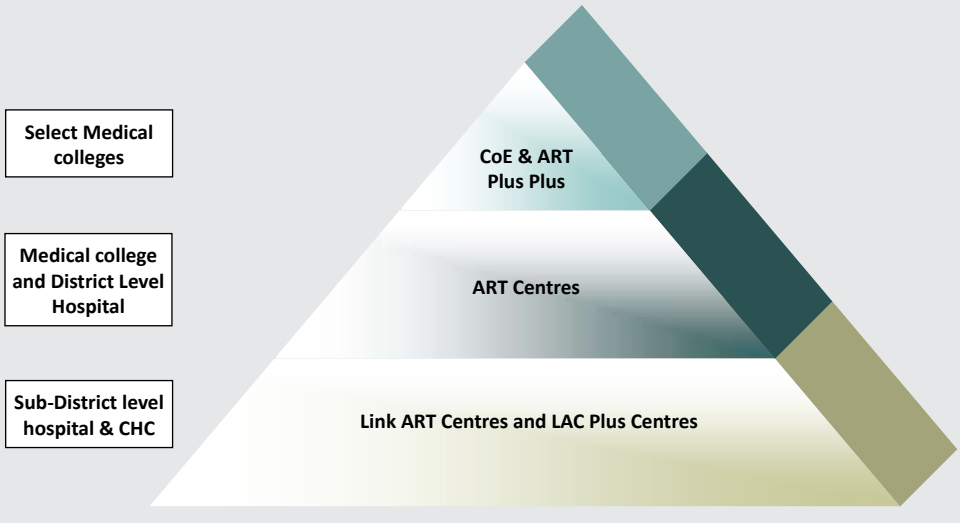
Service Delivery Mechanism for Care, Support & Treatment

CST services are provided through dedicated ART centres established by NACO in health facilities across the country. These are linked to Centres of Excellence (CoE) and ART Plus centres at select teaching institutions, while decentralization of some of the services is in place via Link ART centres (LAC). The ART centres are also linked to ICTCs, STI clinics, PPTCT services and other clinical departments in the institutions of their location as well as with the RNTCP programme in order to ensure proper management of TB-HIV co-infected patients. Figure 9.1 gives a graphic view of this service delivery model.

Antiretroviral Therapy Centres

Provision of free antiretroviral therapy (ART) for eligible persons living with HIV/AIDS was launched on 1 April, 2004 in eight Government hospitals located in

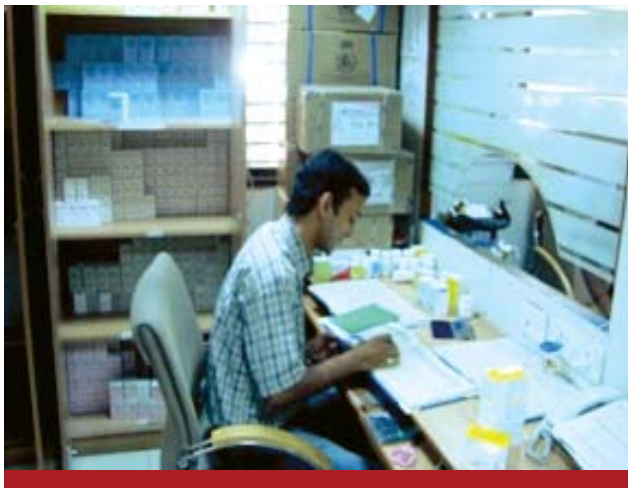
Fig. 9.1: Model of HIV Treatment Service



ART centre at Wenlok Hospital, Mangalore, Karnataka

Counseling Room at ART centre District Hospital, Bijapur, Karnataka

ART centre, MIMS, Mandya, Karnataka



Pharmacy at ART centre, Dr. RML Hospital, New Delhi

six high prevalence States. Since then, the programme has been scaled up significantly both in terms of facilities for treatment and number of beneficiaries. The ART centres are established in the medicine department of Medical colleges and District Hospitals mostly 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. As on December 2012, there were 380 fully functional ART centres across the country.

Link ART Centres (LAC)

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 patients' residence and linked to a Nodal ART centre within accessible distance. The LAC helps in reducing cost of travel, time spent at the centre and hence helps in improving clients' adherence to ART. Presently, 840 Link ART Centres are functional. These centres are providing services to 51,847 PLHIV.

Link ART Plus Centres

It was observed that a significant proportion of persons detected HIV positive at ICTC are not linked to care, support & treatment services. Reasons for this included, among others, persons being asymptomatic at

the time of detection and long distances to reach the ART centre for registration and basic investigations, which may lead them to postpone/delay their visit to ART Centres till they become symptomatic. It was also observed that nearly 20% patients reach ART Centres at a very late stage (CD4 count less than 50), when the risk of mortality is nearly 2-3 times higher.

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

Centres of Excellence (CoE)

To facilitate provision of tertiary level specialised care and treatment, second line and alternative first line ART, training & mentoring and operational research, ten Centres of Excellence have been established in different parts of the country. They are located in Bowring & Lady Curzon Hospital, Bangalore; BJ Medical College, Ahmedabad; Gandhi Hospital, Secunderabad; Post Graduate Institute of Medical Education and Research, Chandigarh; School of Tropical Medicine, Kolkata; Institute of Medical Sciences, Banaras Hindu University, Varanasi; Maulana Azad Medical College, New Delhi; Sir J. J. Hospital, Mumbai, Regional Institute of Medical Sciences, Imphal; and Government Hospital of Thoracic Medicine, Tambaram.

Pediatric Centres of Excellence

The Regional Pediatric ART Centres established under NACP III have been upgraded now as Pediatric Centres of Excellence for pediatric care including management of complicated Opportunistic Infections, 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 diagnosis of HIV among infants, ART to children infected with HIV, counseling on adherence and nutrition, etc. These centres also provide technical support to the other ART centres in pediatric care. Currently, seven Pediatric Centres of Excellence are functional in the country. These are located at Niloufer Hospital, Hyderabad; Indira Gandhi Institute of Child Health, Bangalore; LTMG Sion Hospital, Mumbai; JN Hospital, Imphal; Institute of Child Health, Chennai; Govt. Medical College Hospital, Kolkata; and Kalawati Saran Children's Hospital, New Delhi.

ART Plus Centres

In order to provide easy access to second line ART, NACO expanded the number of centres that provide second line ART by upgrading some of the ART centres as 'ART Plus'. Currently, there are 24 ART Plus Centres functioning in the country. Most of the States, except those with very low patient load, have been covered under this scheme.

Community Care Centres

With the mandate of providing a comprehensive package of CST services, 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 counseling on home-based care. CCCs are linked with ART Centres and ensure that PLHIV are provided counseling for Antiretroviral treatment preparedness and drug adherence, nutrition and prevention, treatment of Opportunistic Infections, referral and outreach services for follow up, social support and tracing patients lost to follow-up (LFU) and those missing to get ARV drugs as per schedule. At present, 239 CCCs are functional.

The progress achieved in expanding Care, Support and Treatment services till December 2012 is summarised in Table 9.1.

Table 9.1: Scale up of infrastructure under Care, Support & Treatment Services

Facility for CST	As on March 2007	As on Dec 2012
ART Centres	107	380
Link ART Centres	0	840
Centres of Excellence	0	10
Pediatric Centres of Excellence	0	7
ART Plus Centres	0	24
Community Care Centres	122	239

Services Provided

First line ART

First line ART is provided free of cost to all eligible PLHIV through ART centres. Positive cases referred by ICTCs are registered in ART centre for pre-ART and ART services. The assessment for eligibility for ART is done through clinical examination and CD4 count. Patients are also provided counseling on adherence, nutrition, positive prevention and positive living. Follow up of patients on ART is done by assessing drug adherence, regularity of visits, periodic examination and CD4 count (every 6 months). Treatment for Opportunistic Infections is also provided through ART centres. As on 31 December 2012, 6,04,987 PLHIVs are on first line ART.

Alternative first line ART

It has been observed that a small number of patients initiated on first line ART experience acute/chronic toxicity/intolerance to first line ARV drugs necessitating change of ARV drugs to alternative first line drugs. Presently, the provision of alternative first line ART is done through the Centres of Excellence and ART Plus Centres across the country. As on December 2012, 3,702 PLHIV are on alternative first line ART.

Second line ART

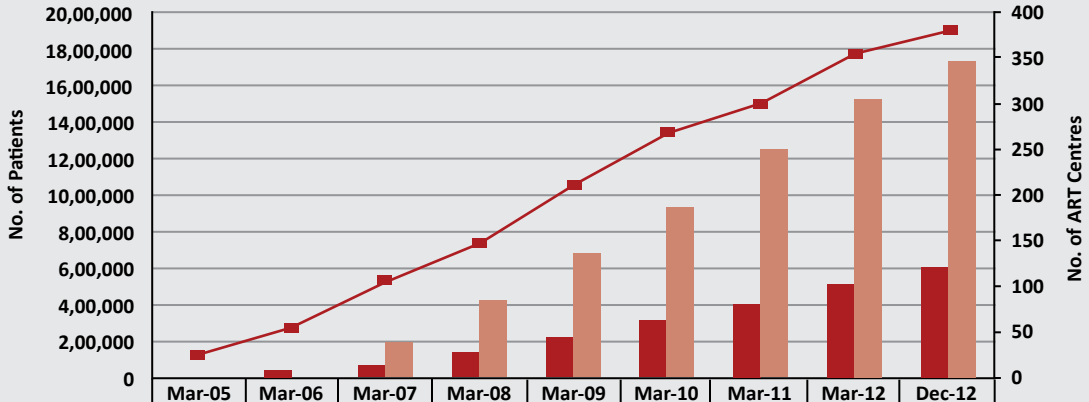
The patients started on ART can continue on first line ART for a number of years if their adherence is good. However, over the years some percentage of PLHIV on first line ART develops resistance to these drugs due to mutations in virus. The rollout of second line ART began in January 2008 at 2 sites – GHTM, Tambaram, Chennai and JJ Hospital, Mumbai on a pilot basis and was, then, further expanded to the other COEs in January 2009. Further decentralization of Second Line ART was done through capacitating and upgrading some well functioning ART Centres as 'ART plus Centres'. As on December 2012, 5,503 patients are receiving second line drugs at CoEs and ART Plus Centres. All ART centres are linked to CoE/ART plus centres. For the evaluation of patients for initiation on second line and alternative first line ART, State AIDS Clinical Expert Panel (SACEP) has been constituted by NACO at all CoEs and ART Plus Centres. This panel meets once in a week for taking decision on patients referred to them with treatment failure / major side effects.

Figure 9.2 shows the scaling up of service provisioning under CST component since March 2005. All measures of service provisioning, viz. number of ART centres, PLHIV ever registered and PLHIV on 1st line treatment have increased exponentially.

National Pediatric HIV/AIDS Initiative

The National Pediatric HIV/AIDS Initiative was launched on 30 Nov, 2006. As on December 2012, nearly 1,12,385 Children Living with HIV/AIDS(CLHIV) are registered in HIV care at ART centres of whom 34,367 are receiving free ART. Pediatric formulations of ARV drugs are available at all ART centres.

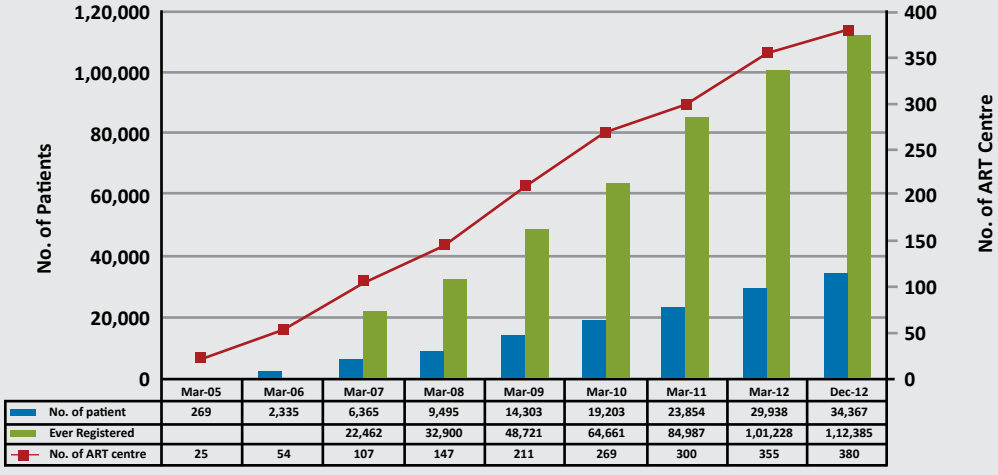
Fig. 9.2: ART Scale up for PLHIV in India, 2005 - 2012



	Mar-05	Mar-06	Mar-07	Mar-08	Mar-09	Mar-10	Mar-11	Mar-12	Dec-12
No. of patients on 1st line	6,845	37,368	69,016	1,40,654	2,23,223	3,15,640	4,04,882	5,16,412	6,04,987
Ever Registered			1,94,607	4,28,056	6,86,913	9,33,540	12,53,498	15,29,031	17,35,544
No. of ART centres	25	54	107	147	211	269	300	355	380

Source: NACO ART CMIS

Fig.9.3: ART Scale up for Children Living with HIV/AIDS in India, 2005 - 2012



	Mar-05	Mar-06	Mar-07	Mar-08	Mar-09	Mar-10	Mar-11	Mar-12	Dec-12
No. of patient	269	2,335	6,365	9,495	14,303	19,203	23,854	29,938	34,367
Ever Registered			22,462	32,900	48,721	64,661	84,987	1,01,228	1,12,385
No. of ART centre	25	54	107	147	211	269	300	355	380

Source: NACO ART CMIS

Pediatric Second line ART

Currently, provision of second line ART for children has been made available at all CoEs, pediatric CoEs and ART Plus Centres.

Figure 9.3 gives a view of the services provided to children living with HIV/AIDS, during 2005 - 2012.

Early Infant Diagnosis (EID)

In order to promote confirmatory diagnosis for HIV exposed children, a programme on EID was launched by NACO. All children with HIV infection confirmed through EID are linked to ART services.

An overview of patients receiving services at different service delivery points under CST component is given in Tables 9.2 and 9.3.

Table 9.2: Beneficiaries of Care, Support & Treatment Services till December 2012

Services/Beneficiaries	Achievement as on December 2012
Adults alive and on ART	5,70,620
Children alive and on ART	34,367
Opportunistic Infections treated during 2012 - 13 (till December 2012)	4,84,925
Persons alive and on second line ART	5,503

Capacity Building for CST

Training Programmes

To ensure uniform standards of services, adherence to operational guidelines and treatment protocols, induction/refresher training is provided to various personnel using standard curriculum, training modules and tools at identified institutions. Various training programmes organized under CST programme include:

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

These trainings are conducted at the Centres of Excellence and other designated training centres across the country.

During 2012-13 (till Dec 2012), 131 ART Medical Officers, 220 ART Specialists, 204 LAC Medical Officers, 369 ART Staff Nurses and 292 Counselors have been trained.

Table 9.3: State-wise list of ART Centres and patients on ART (as on Dec. 2012)

State/UT	No. of functional ART Centres	Patients alive & on ART		
		Adults	Children	Total
Andhra Pradesh	51	1,23,432	5,978	1,29,410
Arunachal Pradesh	1	41	1	42
Assam	3	2,077	101	2,178
Bihar	13	13,426	699	14,125
Chandigarh	1	2,521	248	2,769
Chhattisgarh	5	3,380	293	3,673
Delhi	9	11,642	837	12,479
Goa	1	1,537	115	1,652
Gujarat	25	29,234	1,702	30,936
Haryana	1	3,058	177	3,235
Himachal Pradesh	3	1,928	189	2,117
Jammu & Kashmir	2	1,042	66	1,108
Jharkhand	6	3,595	235	3,830
Karnataka	55	82,999	5,759	88,758
Kerala	8	7,280	391	7,671
Madhya Pradesh	10	7,968	585	8,553
Maharashtra	59	1,29,331	8,627	1,37,958
Manipur	9	7,616	534	8,150
Meghalaya	1	269	9	278
Mizoram	3	1,784	134	1,918
Nagaland	6	3,515	172	3,687
Odisha	9	5,412	231	5,643
Puducherry	1	810	72	882
Punjab	7	9,905	568	10,473
Rajasthan	11	13,970	934	14,904
Sikkim	1	67	6	73
Tamil Nadu	44	64,064	3,443	67,507
Tripura	1	292	8	300
Uttar Pradesh	22	23,804	1,402	25,206
Uttarakhand	2	1,339	110	1,449
West Bengal	10	13,282	741	14,023
Total	380	5,70,620	34,367	6,04,987

Source: NACO ART CMIS

Guidelines & Manuals

In order to standardize care support & treatment services across the country and build the capacity of the Healthcare providers, technical guidelines and training modules have been developed which are available for use at various facilities and SACS. These include:

- Guidelines for ART in adults and adolescents- March 2007 (Updated: April 2009, November 2011 and July 2012)
- Guidelines for ART in children- November 2006 (Updated; September 2009 and October 2012)
- Guidelines for prevention and management of common opportunistic infections and malignancies among adults and adolescents- March 2007
- Operational guidelines for ART centres – July 2012
- Operational Guidelines for Link ART centre and LAC Plus – January 2012
- Technical guidelines on second line ART in adults and adolescents- November 2008 (Updated in December 2012)
- Technical guidelines on second line ART for children- October 2009
- Training modules for ART Medical Officers, ART specialists, CCC Medical Officers and LAC Medical Officers May 2007 (Updated: December 2012)
- Guidelines for Providing Nutritional Care and Support for Adults living with HIV and AIDS: July 2012
- Nutrition Guidelines for HIV Exposed and Infected Children (0 – 14 years of age): July 2012

The above documents are revised from time to time with the recommendations of the Technical Resource Groups. These can be accessed on the NACO website (www.naco.gov.in).

Endeavours to enhance and ensure the provision of high quality services

Technical Resource Groups on CST

Technical Resource Groups have been constituted on ART, Pediatric ART, Community Care Centres and Lab Services. These groups consist of national and international experts and representatives of organisations like WHO, CDC, Clinton Health Access Initiative and Networks of Positive People. They review the progress and give valuable suggestions 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 264 CD4 machines installed at present serving 380 ART centres. All machines procured by NACO are under comprehensive maintenance or warranty.

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 responsibility of the concerned State AIDS Control Society (SACS) consisting of Joint Director (CST), Deputy Director (C&S), Assistant Director (Nursing) and Consultant (CST) based on volume of CST activities in the State.

For close monitoring, mentoring and supervision of ART Centres, various States have been grouped into regions and Regional Coordinators for CST have been appointed to supervise the programme in their regions. The Regional Coordinators and SACS officials visit each of the allotted ART Centres at least once in two months and they send regular reports to NACO. Periodic meetings of Regional Coordinators/CST officials of SACS are held at NACO to review various issues pointed out by them. In addition, NACO officers also visit the centres not performing satisfactorily or facing problems to guide them 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 in a standard format. 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.

Regular State level review meetings

Regular State level review meetings of the programme are conducted at SACS level. These meetings are attended by representatives of NACO, SACS, Regional Coordinators, medical officers and staff of ART centres and other facilities. Review of the performance of individual centres is undertaken during such meetings. Participants are given refresher/reorientation sessions also during such meetings.

State Grievance Redressal Committee (SGRC)

At the State level, Grievance Redressal committee has been constituted to routinely review the functioning of the ART Centres. The Committee is headed by the Health Secretary of the State and consists of Project Director of the SACS, Director of Medical Education, Director of Health Services, the Nodal Officers of the ART centre, representative of Civil Society/ positive network and NACO. This mechanism ensures that issues pertaining to grievances of PLHIV are brought to the 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 is about 6%. The responsibility of tracking and providing home-based counseling for LFU patients is shared with CCC through outreach workers, PLHIV networks and counselors of ICTC in some places.

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 available with SMO/ MO and during patient's visit in that particular month for ART, CD4 test is done. Those who do not undergo CD4 test within one week of their due date are followed up by phone call to ensure that CD4 test is done on the next visit.

Decentralization of Supply Chain Management of ARV drugs

NACO has introduced a change in the way ARV drugs are distributed to ART Centres starting with the procurement cycle during 2011-12. ARV distribution now follows a 'hub and spoke' model where the suppliers deliver the entire quantity required by a State to the SACS which will act as the hub for further distribution of the required quantity of drugs to ART centres. These drugs will be at SACS only for short durations as nearly 80% of the stock shall be moved to ART centres immediately upon receipt and rest 20% buffer stock will have to be kept at SACS to meet further requirement from the centres.

Evaluation & Operational Research

Various studies were conducted in relation to CST.

Studies Completed

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

Ongoing Studies

- Cohort analysis for outcome of first line and second line ART initiated at 10 Centres of Excellence
- Analysis of SACEP at 10 Centres of Excellence
- Multicentre study on 'Integrating HIV prevention in NACO ART clinics'

Other Initiatives in Care, Support and Treatment

Post Graduate Diploma in HIV Medicine

NACO, in collaboration with IGNOU, has rolled out a one-year PG Diploma programme in HIV Medicine. This programme is expected to bridge the gap in trained manpower for ART centres.

Programme Objectives

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

The programme is implemented through a network of programme study centres located in select Centres of Excellence.

End-line assessment of Community Care Centres

There are, at present, 239 CCCs functional. These centres are run by NGOs/Faith Based Organisations/ PLHIV networks with financial and technical support from NACO, SACS and PFI, and implemented by partner agencies including Karnataka Health Promotion Trust, CBCI Health and Hindustan Latex Family Planning and Promotion Trust.

An evaluation of the CCC project was carried out during October 2012. It was a cross-sectional study carried out in all CCCs across the country with an objective to understand their functioning as per the operational guidelines and also to understand the clients' perspective regarding the services offered to them. The team members, involved in the field study also collected some qualitative information from the NGO units by interacting with the key field level staff and clientele. For field visits, 49 teams were constituted. Each team comprised of 3 members - NACO nominated expert, SACS officer and finance expert.

10

Laboratory Services

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

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

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

Technical Resource Group and Standardization of Services

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

Capacity Building

The laboratory services division has conducted TO training workshops and addressed quality issues, details of Standard Operative Procedures (SOPs) and preparation of quality manual as a step towards National Accreditation Board for Testing and Calibration

Participants at the laboratory Assessors training course, conducted by NABL at Delhi in June 2012

Laboratory in-charges of SRLs attending the Internal Audit workshop on ISO 15189:2007 at Bangalore, 2012

Technical Officers from SRLs and NRLs attending Regional Training Workshop on ISO 15189:2007 at Kolkata, September 2012

Laboratories (NABL) accreditation. A total of 119 TOs and Quality Managers from SACS have been trained by NACO in a three day workshop for Quality Manual Writing. A 5 days' training in Laboratory Quality Management System and Internal Audit for Medical Labs as per ISO 15189:2007 requirements has been made available to 87 faculty members from various Microbiology departments in the country dealing with HIV work and to in-charges of STI laboratories. Training of 19 microbiologists mainly from SRL and NRL in a 5 days residential Lead Assessors training was facilitated and 17 of them qualified as assessors.

As a result of the above activities, 10 NRLs and 10 SRLs have got accreditation for HIV testing by the NABL and 9 SRLs are in the cycle of accreditation.

The programme officer in the division attended a practical course on COBAS AMPLIPREP/COBASTAQMAN HIV-1 Qual Test training for Early Infant Diagnosis offered by National Institute of Communicable Diseases, SA in collaboration with African Centre for Integrated Laboratory Training (ACILT). The knowledge pertaining to assay validation, laboratory Quality Assurance, Real time PCR and supply chain was gained.

ICTC/CD4 Training

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

CD4 Testing

There are 264 CD4 machines installed at present serving 380 ART Centres. These include 162 FACS Count machines, 29 Calibur machines, 67 Partec machines and 6 Guava machines. All machines procured by NACO are under warranty or maintenance. During 2012-13, about 9,75,725 CD4 tests have been performed till December 2012.

CD4 training institutions were identified in 2009 to systematize the training of Laboratory Technicians in ART centres. A training of trainers (TOT) was held in May and June 2009 for CD4 machine technicians and in-charges. A regional capacity building of four institutions for Calibur machines (GHTM Tambaram,

STM Kolkata, NARI Pune, and PGI Chandigarh), five institutions for Count machines (Vishakapatnam, NARI, MAMC, RIMS, CMC) and six institutions for Partec machines (Surat, Trichy, Kakinada, Davangere, Lucknow, Medinapur) has been done. Faculty of these institutions has been trained and is imparting further training. All technicians at ART centres are retrained at these institutions every year. Training plan has been developed in consultation with the respective manufacturer and NARI, Pune which provides technical expertise along with the resource persons for the same. Training of trainers was held for five days regionally and the regional training is ongoing for three days for FACS Calibur & Partec and two days for FACS Count. About 250 ART Laboratory Technicians operating these machines have been trained from April to December 2012-13.

CD4 EQAS

NACO with support from Clinton Foundation initiated the development of National CD4 EQAS for Indian CD4 testing laboratories in 2005. National CD4 estimation guidelines were prepared in 2005. NARI functions as an apex laboratory for conducting the EQAS. QASI (an international program for quality assessment and standardization for immunological measures) relevant to HIV/AIDS, is a performance assessment programme for T lymphocyte subset enumeration. The technology transfer workshop was conducted for four regional centres at NARI in Sep 2009. Subsequently, an Indian database, India. qasi-lymphosite was developed and piloted in the proficiency round (Sep-Oct 2009) for data entry, online submission analysis and report preparation. Presently, 250 CD4 testing Centres are enrolled for EQAS.

Quality Assurance

The programme has emphasized on quality practices in the regional workshops and documentation of EQAS. A reporting format has been developed in consultation with the M&E division and testing laboratories (SRLs) are uploading their monthly reports.

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 categorized the laboratories into four tiers, as follows:
- Apex laboratory (first tier) - National AIDS Research Institute, Pune
- Thirteen National Reference Laboratories (NRLs) located in all parts of India undertake EQAS in their respective geographical areas including apex (second tier).
- State level: 117 State Reference Laboratories (SRLs) (third tier)
- Districts level, i.e., all ICTC & Blood banks.
- Thus, a complete network of laboratories has been established throughout the country.
- Training of Apex and NRLs was completed in the first phase, followed by SRLs in the second phase and now ICTCs and blood banks in the ongoing third phase.
- Annually, two workshops are to be held at each level up to the SRLs.

At present financial support under NEQAS program, to Apex laboratory is Rs 24.48 lakhs per year inclusive of NRL grant. The other 12 NRLs, excluding Apex Laboratories, have been provided Rs. 6.54 lakhs per year and each SRL has been given a grant of Rs. 4.44 lakhs this year.

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

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

Assessment of Standards

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

Viral Load Testing to Support Second Line ART

The Viral load (VL) assays are provided for patients failing first line anti-retroviral therapy. NACO piloted VL testing at two centres for 10 months from January 2008. Currently there are nine viral load labs, supporting clinical decision-making at 17 CoEs (including 10 pediatric CoEs)-second line centres and 24 ART plus centres for patients estimated to transit to second line therapy. Existing equipped testing laboratories were identified for viral load testing and consent of the labs for participation in the national programme was taken. Viral load laboratory experience training was done at Bangkok in December 2007. During 2012-13, about 4,157 viral load tests were performed for PLHIV till December 2012.

National Programme on Early Infant/Child under 18 Months Diagnosis

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

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

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

These objectives are proposed to be achieved through following strategies:

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

Training on DBS and WB sample collection, storage, transportation and packaging for National Early Infant Diagnosis roll out by HIV DNA PCR testing was completed during June-September 2009, using training materials developed by NACO. NACO with Clinton Foundation has trained 1,157 ICTCs and ICTC and 217 ART centres, i.e. more than 3000 doctors, nurses and laboratory technicians across 31 Regions/States. NACO designed a vast sample transport network that would ensure timely specimen pick up, testing and report delivery between the 1,157 specimen collection

Hands-on training for HIV-2 confirmatory diagnosis at NARI, Pune

centres and seven testing labs (already equipped with basic PCR facilities) and have been trained for the above. NACO developed ICTC-ART centre linkages for child referral for whole blood collection. Retraining was completed in all these centres. The same has been in operation in 1157 ICTCs & 217 ART Centres across 31 States/regions. During 2012-13, 12,169 HIV exposed infants and children less than 18 months of age have been tested under this programme till December 2012.

Rolling out of confirmatory diagnosis of HIV-2 in the National Programme

India has reported the presence of HIV-1 as well as HIV-2 since the beginning of HIV epidemic. Though the prevalence of HIV 2 is very low, the type of HIV (1 or 2) identified in the patient has an implication on the treatment regimen to be provided at ART centres. Although discriminatory HIV tests are used at the ICTC, the confirmation of HIV-2 when detected cannot be made at the ICTC.

On a proposal from the TRG, HIV-2 confirmatory testing has been introduced in the National Programme and NARI has been identified as the Apex laboratory. The operational guidelines and testing algorithm for the same have been formulated by NACO in association with the Apex laboratory. These have been subsequently reviewed and approved by the TRG. The lab-incharges and technical officers of the referral labs were given hands-on training at NARI, Pune. This programme has been rolled out from 1 February, 2013 in thirteen referral laboratories presently identified based on their location within the country. These laboratories cater to all States within the country.

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 inquiry the batch is withdrawn. Detailed enquiry at the centre level is done if required.

11

Information, Education & Communication and Mainstreaming

Strategic Communication plays a vital role in addressing the whole spectrum of the HIV programme from prevention, treatment to care and support. Building on the lessons learnt Information, Education and Communication (IEC) is integrated with all programme components with the objective of HIV prevention and increasing utilization of services. The key strategies include:

- Enhancing awareness and knowledge levels among General Population to promote safe behavior, focusing specially on Youth and Women;
- Motivating and sustaining behaviour change in a cross-section of identified populations at risk, including High Risk Groups and Bridge Populations;
- Generating demand for services; and
- Strengthening the enabling environment by facilitating appropriate changes in societal norms that reinforce positive attitudes, beliefs and practices to address stigma and discrimination.

The major activities undertaken during 2012-13 under IEC are:

Mass Media Campaigns

An annual media calendar was prepared to strategise, streamline and synergise mass media campaigns with other outreach activities and mid-media activities. NACO released campaigns on Voluntary Blood Donation, condom promotion, sexually transmitted infections and stigma & discrimination on Doordarshan, Cable and Satellite channels, All India Radio (AIR), and FM radio networks. To amplify the reach of mass media campaigns, innovative technologies were also utilised like dissemination of advertisements through cinema theatres.

Long Format Radio and TV programmes

The State AIDS Control Societies have been conducting various long format programmes like phone-ins and panel discussions on HIV related issues on regional networks of All India Radio and Doordarshan. These live phone-in programmes are interactive programmes that help in dissemination of information and also address the doubts of audience/ listeners.

Red Ribbon Express Project

Encouraged by the nation-wide response received by the second phase of Red Ribbon Express (RRE) project in 2009-10, the third phase of the RRE project was launched on 12 January 2012 by Hon'ble Minister of Health & Family Welfare on the National Youth Day with the objective of disseminating HI/AIDS related messages particularly among the youth. This special train covered 23 States, halted at 162 railway stations and reached out to 1.14 crore people during its year long journey that culminated on 12 January, 2013. Besides the four exhibition coaches, the training coach imparted training to 1,04,091 district level resource persons and the service coach provided STI treatment to 11,514 people, counseled 90,730 people for HIV and tested 76,411 people for HIV on board. The general health checkup facility was availed by 79,938 visitors.

Hon'ble Minister of Health & Family Welfare, Shri Ghulam Nabi Azad, Hon'ble Minister of Railways, Shri Pawan Kumar Bansal, Hon'ble Minister of State for Health & Family Welfare, Shri S. Gandhiselvan, Shri Lov Verma, Secretary, Department of AIDS Control, and Ms Aradhana Johri, Additional Secretary, Department of AIDS Control during the closing ceremony of RRE Phase-III

Folk performance in progress during RRE halt in Sadulpur, Rajasthan

Outreach activities have been an integral part of the project. These were conducted through mobile IEC vans equipped with audio-visual system, collapsible exhibition and folk troupes in areas within the radius of 15-20 km around the RRE halt stations. In some States, Mobile Health Units were also put in operation in rural areas to disseminate information on HIV/ AIDS and provide general health services along with treatment services.

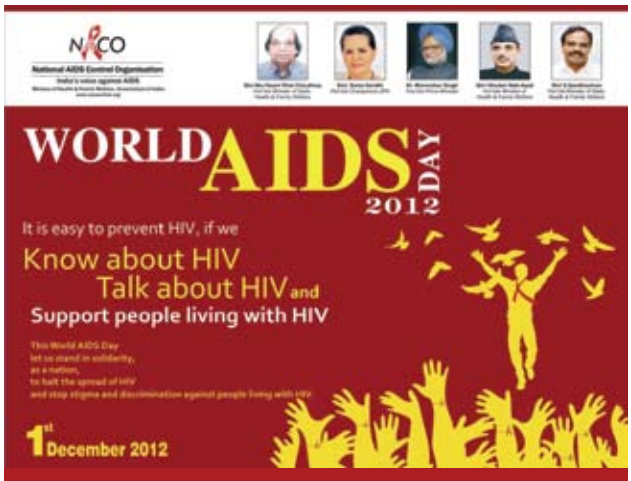
Multi-media Campaign in North-Eastern States

State AIDS Control Societies are carrying forward the NACO initiated special multi-media campaigns in the 8 North-Eastern States to increase awareness, educate youth on HIV/AIDS issues, promote safe behavioral practices and reduce stigma and discrimination. During these campaigns, HIV/AIDS messages are disseminated through a series of music and sports events in view of popularity of music and sports among the youth of the North-east. To maximize the engagement of communities, a calendar of events and traditional festivals was developed for each State and IEC activities based on this calendar are undertaken throughout the year. Special efforts were made to reach out to the out-of-school youth in the States through youth clubs at district, block and village levels. The music competitions and sports events organized initially at district level, culminated in the State level mega events, which saw huge youth participation. The winners of the music competitions were projected as "youth icons", who further reached out to people in villages and far flung areas through road shows with messages on HIV/AIDS.

An independent evaluation of the campaign helped in understanding its effectiveness. Critical indicators of knowledge and attitude towards HIV/ AIDS were significantly higher among exposed groups (89%) than among those not exposed. Higher proportion of exposed respondents were aware of services like Anti-retroviral therapy (exposed = 51% whereas non-exposed = 9%), HIV counseling and testing services (64 % of exposed vs 10% of non-exposed). The majority of exposed respondents (86%) agreed that a normal relationship can be maintained with a friend or neighbour who is HIV positive. Similarly, 84% opined that a positive teacher could continue to teach students in schools. Importantly, 87% of the respondents exposed to the campaign were fine to buy fruits and vegetables from a HIV positive vendor. Marginal increases in self efficacy indicators (to react against instances of discrimination) are also observed.

Advertisements through Newspapers

Newspapers have wide reach among youth and general population in both urban and semi urban areas, therefore, they play a very vital role in education and information dissemination to people on sensitive issues like HIV/ AIDS. NACO and SACS released advertisements in newspapers to disseminate appropriate information and create awareness. During 2012-13, press advertisements were published in leading newspapers in all States, to mark the important days, like Anti-Drug Abuse Day, Voluntary Blood Donation day, World AIDS Day and National Youth Day.



Newspaper advertisement on the occasion of World AIDS Day, 1 December, 2012

Mid-Media

Outdoor (Hoardings, Bus Panels, Kiosks)

Outdoor media activities like hoardings, bus panels, pole kiosks, information panels, wall writings and panels in trains and metro trains are done by the State AIDS Control Societies, Condom Social Marketing Organisations of NACO and under Link Workers Scheme to disseminate information on HIV prevention and related services. NACO has developed a well-coordinated plan involving different agencies to avoid duplication of activities.

Folk Media and IEC Vans

Folk media is a powerful medium of communication to disseminate difficult social messages in rural and remote areas especially which are media dark. The national folk media campaign covering 22 States was conceived in 2011-12. As preparatory to the folk media campaign, a series of three national workshops on folk media were conducted in Delhi between November 2010 and April 2011. Participants of the workshop included resource persons and folk artistes practicing the popular folk forms and IEC officers from State AIDS Control Societies. During the workshops, 167 scripts were developed on seven thematic areas for 49 popular folk forms, which were vetted by a technical team from NACO for correctness and consistency of messages. The artistes representing different folk forms were trained as master trainers for conducting further training of folk artistes at the State level to create a larger pool of trained troupes for the implementation of folk media campaigns at States.

A folk performance in a village in Orissa during health camps for migrants and their families

Subsequently, operational guidelines and planning & management protocols were developed to facilitate implementation in the States. District Support Teams (DST), comprising the organisations and entities working in the field of HIV AIDS, were formed at the district level for effective implementation of the campaign, which encompassed pre-publicity for crowd mobilization, ground level support and monitoring of performances. Qualitative monitoring conducted by officers from NACO, State AIDS Control Societies and folk resource persons were effective in ensuring quality in performance and effective message delivery.

During the campaign implemented in 2011-12, a total of 36,788 performances were done in two phases across 22 States which could reach out to 1.3 crore people in the rural areas. The key messages disseminated through the performances included safe sex, migration, stigma & discrimination, counseling and testing, PPTCT, women issues, blood safety and vulnerability of youth. A national review on implementation of phase-I was conducted in Delhi in October 2011 to discuss the way forward for the subsequent phase of the folk campaign. Based on the overwhelming response received in 2011-12, the campaign planned in 2012-13 was up-scaled to 56,090 performances in 34 States and Union Territories.

Folk campaign 2011-12 was evaluated at the national level to study the effectiveness of folk media in dissemination of HIV/AIDS messages for prevention. The findings reflected enhanced awareness about HIV/AIDS issues among the people who were exposed to the performances. About 84 percent of the respondents liked the performances; 74 percent of the respondents found the folk shows were entertaining; 77 percent received new information and to 68 percent the shows were relevant and useful. The folk campaign also proved effective

in creating positive attitude among the communities towards the people living with HIV/AIDS.

Folk media was also efficiently used during the piggy back events organized in States during major festivals like Navratra, Durga Puja, Ganesh Chaturthi, Pongal, State specific big fairs and important cultural occasions reaching out to readily available large gatherings in urban and semi urban areas.

On the occasion of health camps organized in 2012 for returnee migrants in high outmigration districts of 8 States, folk media was extensively used for pre publicity, sensitization of women and mobilization of migrant families to the health camps.

IEC Material

NACO has developed IEC material for programme components and the soft copies were sent to State AIDS Control Societies for replication. Flip charts, general information booklet, brochures, folders and short films were printed/ prepared by SACS for use at service centres, fairs, exhibitions and for outreach activities such as Red Ribbon Express and in IEC Vans. The materials specially targeting high risk groups have been replicated and disseminated by most of the State AIDS Control Societies. Materials specific to population groups such as truckers, migrants, for OST and STI clinics and on themes like stigma & discrimination etc. were also replicated in large quantities by SACS to reach out to different population groups.

Special Events

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

NACO did intensive advocacy with Sony Television to include issue of HIV/AIDS in its popular game show, *Kaun Banega Crorepati* on 1 December 2012, the World AIDS Day. During the show Shri Amitabh Bachchan stressed upon the role awareness played in ensuring safety and protection from HIV. He informed the audience that the government is providing free treatment to ensure that people living with HIV and AIDS could lead a normal life. He shared with the audience the four modes of transmission and prevention. He urged the country to support those infected with HIV and not to stigmatise or discriminate against people infected and affected by HIV.

As part of her new role as the UNAIDS International Goodwill Ambassador, Smt. Aishwarya Rai Bachchan visited the Pediatric ART Centre at the Lokmanya Tilak Memorial General Hospital in Mumbai, on World AIDS Day, December 1, 2012. She interacted with HIV positive mothers and positive children in the ART centre to learn about the PPTCT services provided to pregnant women living with HIV.

Interventions for Youth

1. Adolescence Education Programme (AEP)

This programme runs in secondary and senior secondary schools to build up life skills of adolescents to cope with the physical and psychological changes associated with growing up. Under the programme, sixteen hours sessions are scheduled during the academic sessions in classes IX and XI. The SACS have further adapted the modules after State consultations with stakeholders, such as NGOs, academicians, psychologists and parent-teacher bodies. The programme is being implemented in 23 States and till date 85,000 schools have been covered. As the follow-up to the suspension of AEP in some States, a toolkit was devised and disseminated to these States for training of trainers. Efforts are also on for resumption of the programme in some of the States where it was suspended.

2. Red Ribbon Clubs (RRCs)

The purpose of Red Ribbon Club formation in colleges is to encourage peer to peer messaging on HIV prevention and to provide a safe space for young people to seek clarification to their doubts and on myths surrounding HIV/AIDS. The RRCs also promote voluntary blood donation among youth. About 12,300 clubs are functional and are being supported for these activities; this includes 396 RRCs started during 2012-13 (till December 2012).

Mainstreaming Activities

The objective of mainstreaming activities is to ensure that all stakeholders and agencies (State and non-State) adapt their programmes and policies to address issues of HIV/AIDS within the context of normal functions of their organisations. It aims to create an enabling

Smt. Aishwarya Rai Bachhan talking to press during her visit to the Pediatric ART Centre at the Lokmanya Tilak Memorial General Hospital in Mumbai, on World AIDS Day, 1 December, 2012

environment for PLHIV and HRG through policies, programmes and communication. Mainstreaming facilitates the expansion of key HIV/AIDS services through integration with health systems of various stakeholders and design policies, programmes and schemes to support social protection needs of PLHIV and HRG. During the year 2012-13, following efforts were made for mainstreaming HIV/AIDS.

1. Inter - Ministerial Conference

The "Inter-ministerial Conference for Mainstreaming HIV in India" was organised by the Department of AIDS Control and the United Nations Development Programme (India) in New Delhi on 18 and 19 December, 2012. The conference brought together all concerned ministries and departments on a common platform to facilitate greater understanding and coordination through comprehensive deliberations around the key issues related to mainstreaming HIV. Over 300 delegates participated in the conference, including representatives from 21 ministries, 16 Public Sector Undertakings, 25 State governments, communities of vulnerable populations, PLHIV and development partners. The Valedictory session was chaired by Shri Ghulam Nabi Azad, Hon'ble Union Minister for Health and Family Welfare. A monograph on "Mainstreaming and Partnerships: A Multi-sectoral Approach to Strengthen HIV/AIDS Response in India" was released by the Hon'ble Minister for Health and Family Welfare and in his speech he said that "Instead of single and simple agency approaches what is required is to weave multidimensional and multi sector approaches". He also mentioned that since the affected and infected populations are also socially and economically marginalised they need consideration as beneficiaries of various social welfare schemes. He then requested various ministries for policy directions and resource allocations to gear up towards mainstreaming HIV and AIDS.

2. Training/Sensitization of Frontline Workers and other Government Officials

As part of the strategy to enhance multi-sectoral responses which ensure meaningful involvement of major stakeholders at grass root level; trainings with information of HIV prevention, treatment, care & support are prioritized by NACO. About 3.2 lakh frontline workers (AWW, ANM, ASHA), SHG workers, PRI members and personnel from various government departments, representatives of civil society organisation and members of public and privates sectors have been trained through State AIDS Control Societies.

3. Greater Involvement of People living with HIV/AIDS (GIPA)

NACO is committed to promote greater involvement of People living with HIV/AIDS. With this objective, a GIPA policy and operational guidelines were approved in principle by the National AIDS Control Board. NACO in all its efforts and in all its campaigns has been advocating zero discrimination.

4. Social Protection

Social protection needs for the PLHIVs and MARPs are many - food security, nutritional security, health security, housing security, employment security, income security, life and accident security, and old age security. It supports them and allows them to reduce their vulnerability and to further improve their longer-term livelihood prospects. Under this initiative, almost 3.5 lakh people living with HIV have benefitted from various schemes in the States.

5. Drop-in-Centres

During 2012-13, 246 Drop-in centres were supported by NACO to reach out to PLHIV with psycho-social support.

Release of monograph on "Mainstreaming and Partnerships: A Multi-sectoral Approach to Strengthen HIV/AIDS Response in India" by Hon'ble Minister for Health and Family Welfare, Shri. Ghulam Nabi Azad

Secretaries of the Ministry of Shipping and the Department of AIDS Control exchanging MOU on mainstreaming HIV activities on 14 February, 2013

6. Memorandum of Understanding with Ministry of Shipping

Department of AIDS Control and Ministry of Shipping entered into Memorandum of Understanding on 14 February, 2013. This aims to provide prevention, care, support and treatment services of HIV/AIDS in the 12 major ports covering port workers, fisher men, seafarers, truckers, single male migrants, community around major ports and other vulnerable population.

NACP Achievements Acclaimed at AIDSCON 2012, Washington

A delegation from the Department of AIDS Control, led by Additional Secretary, participated in the International AIDS Conference 2012 at Washington D.C. from 22-27 July 2012. The conference was attended by nearly 30,000 delegates from around 200 countries. India had a significant presence with over 100 delegates participating from Government, NGOs, Civil society organisations, high risk groups and PLHIV networks. A total of 20 oral presentations and around 110 posters were presented from India.

A special satellite session titled 'Turning the Tide' was organised by NACO at the conference to showcase the achievements of India's National AIDS Control Programme to the global audience. Significant progress made in scaling up of HIV/AIDS services and reducing new HIV infections was widely appreciated.

India's contribution to the global AIDS response through its capacity to manufacture generic antiretroviral drugs was also highly acclaimed. India also participated in the panel discussions of BRICS nations and Asia-Pacific regions where India's technical capacity and institutional strength were hailed to be of high standards. India has been asked to take leadership in extending technical support to other developing countries in Asia and Africa through South-South collaborating mechanisms.

12

Activities in North-Eastern States

The North-Eastern States of India include Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura. The region reflects ecological and cultural contrasts between the hills and the plains, covering an area of 2.62 lakh sq. km. (which is 7.9% of the total geographical area of the country). With a total population of 4.5 crores (Census 2011), the region accounts for 3.75% of India's population.

In the North Eastern region, the HIV epidemic, driven by dual risk factors of unsafe sex and injecting drug use, posed an important challenge. There are many areas in the North-Eastern States where HIV prevalence is increasing, particularly among the injecting drug users. As such, the strategy of Prevention & Control of HIV infection in these States is largely focusing on prevention of HIV infection in this sub-population along with other components of the programme. The HIV epidemic in the North Eastern region of the country is largely driven by use of HIV infected syringes and needles by Injecting Drug Users (IDUs) and increasing transmission of HIV through sexual mode in the region. This dual HIV epidemic in the northeast, driven by IDUs and sex workers, remains unabated.

Table 12.1 Estimates of Epidemiological Indices of HIV in North Eastern States of India in 2011

State	Adult (15-49) HIV Prevalence (%)	Total no. of HIV Infections	No. of new infections in adults (15+)	AIDS related deaths
Arunachal Pradesh	0.13	1,156	257	42
Assam	0.07	12,804	2,408	388
Manipur	1.22	25,369	1,354	1,905
Meghalaya	0.13	2,381	460	88
Mizoram	0.74	5,346	376	286
Nagaland	0.73	9,716	560	581
Sikkim	0.15	593	94	25
Tripura	0.24	5,684	951	279
NE Total	-	**63,049**	**6,460**	**3,594**
India	**0.27**	**20,88,642**	**1,16,456**	**1,47,729**

[Source: HIV Estimates 2012, NACO]

Among the NE States, Manipur has shown the highest estimated adult HIV prevalence of 1.22%, followed by Mizoram (0.74%) and Nagaland (0.73%). The NE States estimates a total of 63,049 HIV infections, the highest being in the State of Manipur (25,369) and the lowest in Sikkim (593). HIV estimates in respect of the North-Eastern States is given in Table 12.1.

Progress of the programme and schemes in the North-Eastern States

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

The North East Regional Office (NERO), established by NACO, is the result of national response to intensify the effort of HIV prevention, treatment and care services by providing technical support to the eight North-Eastern States. Facilitating and strengthening the response to the epidemic by improving the coverage and quality of programme planning, implementation, capacity building and monitoring and reporting are the focus area of NERO.

DAPCU has been operationalised in 25 districts with formation of Districts AIDS Prevention Control Committee. DAPCU have initiated and are following up the process of convergence with NRHM and related stakeholders at State and district levels. District Initiative Campaigns of varied nature have been initiated and documented to increase scale up of service uptake.

Details of the facilities and services provided under the National AIDS Control Programme in North-Eastern States have been summarized in Tables 12.2 & 12.3 respectively.

Major activities undertaken during 2012-13

Preparation of Annual Work Plans

NERO officers facilitated the preparation of annual work plan for FY 2012-13 for Manipur, Mizoram and Nagaland. Key action plan was developed based on the key issues in the districts majorly on referral and linkages, meetings, reporting, programme performance, linkages to PLHIV schemes and targets were set for the year.

Comprehensive data analysis

Comprehensive data analysis has been completed for Assam, Manipur, Mizoram and Nagaland and shared with SACS for further analysis and use in the preparation of AAP for 2013-14.

Table 12.2: Details of Facilities under National AIDS Control Programme in the North-Eastern States (as on December 2012)

State	DAPCU	TI	OST Centre	DSRC	Stand Alone ICTC	Facility Integrated ICTC	LWS	Drop in Centre	Blood Bank	ART	CCC	Total
Arunachal Pradesh	1	21	1	17	34	11	0	0	4	1	1	91
Assam	1	62	2	28	83	50	0	1	25	3	2	257
Manipur	9	69	9	10	54	13	9	4	3	9	10	199
Meghalaya	0	10	2	8	10	4	0	1	5	1	0	41
Mizoram	3	37	7	9	27	29	3	7	8	3	3	136
Nagaland	10	53	7	11	60	0	0	14	8	6	4	173
Sikkim	0	6	1	6	12	3	0	1	2	1	1	33
Tripura	1	14	0	14	18	38	2	0	6	1	2	96
TOTAL	25	272	29	103	298	148	14	28	61	25	23	1,026

* 1 ART plus centre in Assam, Mizoram and Nagaland, 1 CoE and 1 Pediatric CoE in Manipur,

Table 12.3: Details of Programme activities in North-Eastern States during 2012-13 (till December 2012)

NE State	IDU	MSM	FSW	Alive and on ART	Blood Collection		No. of general clients tested in ICTC		No. of pregnant women tested		No of STI//RTI episodes treated (DSRC + TI STI)
					Total Units	Proportion of VBD	Tested	Positive	Tested	Positive	
Arunachal Pradesh	2,025	300	3,860	42	3,223	69%	13,423	11	7099	2	5,573
Assam	3,517	2,700	20,680	2178	1,45,432	60%	79,207	879	1,41,715	89	39,815
Manipur	25,100	1,900	6,950	8,150	13,994	47%	39,735	1,243	31,026	114	12,332
Meghalaya	1,050	200	1,781	278	7,175	56%	10,165	227	11,594	40	2,773
Mizoram	12,550	550	1,470	1917	15,216	94%	27,872	740	14,331	85	2,162
Nagaland	19,429	1,320	3,127	3,687	6,845	80%	54,888	1,163	13,788	123	7,557
Sikkim	1,500	0	761	73	2,928	85%	14,456	40	6,323	5	1,757
Tripura	643	600	7,600	300	18,615	93%	30,302	132	16,759	13	14,651
NE Total	65,814	7,570	46,229	16,625	2,13,428		2,70,048	4,435	2,42,635	471	86,620

DAPCU Annual Work Plans

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

Meetings

NERO officers participated and presented papers in NACP-III dissemination summit during 25-27 April, 2012 in New Delhi. The programme was organized by NACO in collaboration with State governments, development partners, civil society and positive networks aiming to share best practices, innovations and learning of the programme and experiences from across the country.

Training and Capacity Building

NERO coordinated with SACS and various training institutes identified by NACO for conducting various training activities under different programme components of NACP and ensure completion of the training targets. These activities included finalization of the annual training calendar, release of funds by SACS to STRCs, identification of master trainers for each of the States and approval from NACO, roll out of training as per approved training calendar and supervision of training quality assurance by observing

Consultation meet of DAPCU officials at Imphal, Manipur

the training conducted by training institutes, training report submission by training institutes to SACS, NERO and NACO for training staff of TI NGOs, there are 3 State Training Resource Centres (STRC) for 8 NE States identified by NACO. The STRCs are: MSDRB STRC at Aizawl for Mizoram and Arunachal Pradesh: Emmanuel Hospital Association, Dimapur for Manipur and Nagaland; and Emmanuel Hospital Association, Guwahati for Assam, Tripura and Meghalaya.

Following important trainings were organised by NERO during 2012-13:

- Refresher Training for SACS officials, DAPCUs and facility sites staff on SIMS was completed in all the NE States.
- Training for Migrants and Truckers have been completed by STRC with the support of SACS and NERO
- Regional level training for District ICTC Supervisors was completed. 23 ICTC Supervisors from Arunachal, Assam, Manipur, Mizoram, Nagaland and Tripura participated in the training.
- Training on revised M & E Tools was organized for the staff of ART Centres of Assam, Arunachal Pradesh, Meghalaya, Sikkim and Tripura. Total 25 participants attended the training.
- SGRC and SACEP meeting in the NE States were facilitated by NERO.
- Regional VBD Workshop for NE States at Sikkim was co-facilitated.
- Training was conducted on "Opioid Substitution Therapy" for officials of Government health care settings of OST sites of Assam, Mizoram, Meghalaya and Sikkim during 10-14 June, 2012 at Guwahati.
- "Experience sharing cum reorientation training" was organized by NERO in coordination with NACO TI Division during 18 to 22 September, 2012. Specific follow up action points were discussed and developed for each State for addressing the gaps identified in TI programme implementation.
- NERO facilitated Capacity building training workshop on ethics in HIV/AIDS research in Guwahati from 26 - 28 July, 2012.

Facility assessment

- Upon instruction of NACO TI Division, NERO team has conducted OST feasibility assessment in the NE States.
- As follow up to the AAP discussion in Delhi, NERO facilitated "Cross border" baseline assessment for Moreh in Manipur. Reports submitted to PD for follow up strategic planning for Moreh.
- Facilitated roll out of Project DivA in NE States

Guideline/ Format development

- NERO participated in the meeting on "Development of Technical & Operational guidelines for the new PPTCT more efficacious regimen" at NACO.
- NERO officer also participated in a national level meeting on Development of ICTC individual record keeping SIMS application in NACO, New Delhi.

Transitioning

NERO facilitated initiation of transition process of TI in Manipur and Nagaland and the assessment of the second batch TI for transition has been completed. The status of the transition process is given in Table 12.4.

Validation of Core HRG population

HRG mapping was conducted in most of the NE States during 2008-2010. An analysis of the mapping data shows the variations in the estimated number of

Regional level training of District ICTC supervisors at Guwahati, December 2012

Capacity Building Workshop on Ethics in HIV/AIDS Research, Guwahati, July 2012

Table 12.4 Typology-wise Transition Status in Nagaland and Manipur

Typology	Target	Transitioned	Feasibility Assessment completed and the contract process on	Feasibility Assessment in process, to be completed by March, 2013
NAGALAND				
IDU	6	3	1	2
MSM	1	1	0	0
FSW	2	0	2	0
Core Composite	4	2	1	1
Total	**13**	**6**	**4**	**3**
MANIPUR				
IDU	7	3	3	1
MSM	1	1	0	0
Core Composite	8	0	0	8
Total	**16**	**4**	**3**	**9**

HRGs in comparison with the existing TI coverage and data available with SACS from other sources/studies. This also led to concerns regarding overlap in the geographical coverage of nearby TIs and duplication of HRGs between TIs of same typology.

Following the TI review of all the NE States conducted by NACO in Delhi on 28-29August, 2012, NERO in conjunction with NE SACS developed an operational manual for validation of Core HRG population with an aim to reconcile the mapping and coverage figures to arrive at more precise HRG estimates. This is necessary to rationalize the resource allocations for prevention programme and ensure service provision for those at highest risk. The validation tools have been finalized and approved by NACO. Orientation of SACS and POs on the tools has been completed in all the NE States except for Arunachal, Mizoram and Nagaland. The initial data collection has been started in all the States.

Red Ribbon Express

The Red Ribbon Express (RRE) traveled to the North-eastern States during July-August 2012 and reached out to population of various age groups with an aim to create mass awareness on HIV/ AIDS. NERO assisted the SACS in planning and execution of RRE projects and it covered five districts in Assam Dimapur in Nagaland State

Multi-media Campaign

The multi-media campaign on HIV/AIDS, Red Ribbon Super Stars', targeted youth aged 15 – 29 years and has been successfully implemented in Mizoram, Nagaland and Sikkim. Arunachal Pradesh is conducting the campaign during February, 2013. The campaign uses a combination of music competitions, dramas and sports tournaments organised at district level culminating into the State level mega events. These are further amplified through the use of TV, radio, newspapers and outdoor media. Owing to the culture of the North-east, over 100 faith based organisations were sensitised and involved in the campaign. A special effort was made to reach out to the out-of-school youth in the States. BCC messages were developed and disseminated by RRCs and Colleges youth. The winners of the music competitions, positioned as "youth icons or the super stars" are further taking messages on HIV/ AIDS to the community through road shows at villages and blocks of every district. NERO facilitated SACS and research agency for the smooth evaluation of the campaign conducted last year.

Mid-media and Outdoor

SACSs of Assam, Manipur, Tripura and Sikkim have conducted folk media campaign as vital outreach activities in rural areas through IEC exhibition vans, folk troupes and condom demonstration outlets. In the States of Assam and Nagaland through which the RRE passed, these activities were aligned with the RRE project. In addition, hoardings, bus panels and information panels were installed by the States to disseminate information on HIV and AIDS.

Red Ribbon Club

Red Ribbon Clubs (RRCs) have been formed in colleges and institutions to encourage peer to peer messaging on HIV prevention, and a safe space for young people to seek clarifications on their doubts and myths surrounding HIV/AIDS. More than 481 RRCs are functional across the NE region.

Legislative Forum on AIDS

Legislative Forums on AIDS are functioning in Assam, Nagaland, Manipur, Meghalaya, Mizoram, Sikkim and Tripura with support from the SACS. An advocacy Meeting of the Arunachal Pradesh Legislators' Forum on HIV/AIDS was organized to mark World AIDS Day 2012 in the Assembly Secretariat in Naharlagun.

Donor coordination meeting for North Eastern region

A coordination meeting chaired by Additional Secretary, NACO was held with the Project Directors of SACS in NE region, representatives from UN agencies (UNAIDS, UNODC, UNICEF and UNDP) and other donor partners working in the North Eastern Region on 29 August, 2012 at New Delhi. The need was emphasized to avoid duplication of efforts between agencies and channelise resources in areas which require priority as per national programme objectives. Discussions at the meeting focused on developing an inventory State-wise on the projects being implemented, informing SACS and working synergistically with involvement of respective SACS and NERO to facilitate implementation and development of transition plan for the end of the project. It was decided to hold the next meeting in the North-East. Following this, the details of various ongoing projects has been compiled State-wise and shared with the SACS.

Additional Secretary reviewing AIDS Control activities in Kamrup district of Assam with the District Collector along with the Project Director and officers of Assam SACS

Multimedia Campaign in Aizwal, Mizoram

Road Show to create Awareness on HIV/AIDS at Ri bhoi district, Meghalaya

13

Capacity Building

Capacity building helps in creating an army of efficient human resources to manage programme activities effectively and therefore, NACO emphasises the timely training of the personnel engaged in implementing, monitoring and coordinating of the National AIDS Control Programme initiatives at various levels. NACO has also taken initiative in harnessing the use of information communication technology for strengthening capacity building activities.

The trainings ranged from programme management, outreach planning, financial management, counseling in targeted intervention to training of Medical officers on STI treatment and ART treatment by their respective divisions. While Basic Services division could train its personnel on whole blood testing, PPTCT multi drug regimen, full site sensitisation apart from regular induction and refresher trainings of their counselors and lab technicians, research wing of M&E Division took initiative to train faculties and officials from Medical colleges, research institutes, etc. on Operational Research and ethical issues related to HIV/AIDS research.

Staff under laboratory services were trained on different topics ranging from quality manual writing, Internal auditing, bio-medical waste management, early infant diagnosis to DNA- PCR testing. DAPCU staff were trained on the standard training module for monitoring and coordinating NACP activities at the district level.

Table 13.1 details the progress in training of various categories of personnel by different divisions of NACO from April to December, 2012. Over 4 lakh personnel were trained in this period.

Table 13.1 Training achievements under NACP during 2012-2013 (till December, 2012)

Participant category	Number trained
Targeted Intervention	**13,784**
Programme Manager of TIs on Prog management	961
Out-reach Workers on Outreach Planning	3,762
Counsellor / ANM on Counselling	807
Peer Educators	7,103
Accountants/ M&E on Financial Management	899
Staff of OST Centres and IDU TIs	252

Participant category	Number trained
Link Worker Scheme	**15,993**
DRP and Supervisors	
Induction and Mapping	85
Outreach, Advocacy and Supportive Supervision	149
Refresher	233
Link Workers	
Induction and Situation Needs Assessment	466
Outreach Advocacy and Micro Planning	1,035
Refresher	1,480
Volunteers	12,545
Basic Services Division	**26,409**
ICTC Counselors - Induction	244
- Refresher	1,818
HIV/TB Training	251
PPTCT Multidrug regimen	1,755
Team training	189
ICTC Lab technicians	
SA-ICTC Induction	117
SA-ICTC Refresher	2,033
FICTC Induction	540
FICTC Refresher	158
Team training	198
Staff Nurses/ANMs - Induction	3,032
- Refresher	589
Whole blood screening	1,521
Team training	106
District ICTC Supervisors- Induction/ Refresher	22
PPTCT Multi drug regimen	52
ICTC Medical Officers (MO) - HIV/TB Training	779
Team training	120
PPTCT Multi drug regimen	1,083
ART MO	
HIV/TB Training	112
PPTCT Multi drug regimen	403
Medical Officer- TB Centre	1,115
RNTCP STS/STLS	
HIV/TB Training	474
Whole blood screening	33
HIV TB/ DOTS Plus Supervisors	151
RNTCP LT on Whole Blood Screening	146
Other paramedical staff on PPTCT Multi Drug Regimen	5,092
District hospital staff on Full site sensitisation	1,646
Sub District hospital staff on full site sensitisation	2,630

Participant category	Number trained
Care, Support and Treatment Division	**1,241**
ART Medical Officers	131
ART Team Members (Medical Officers)	220
CCC Medical Officer	25
LAC Medical Officers	204
ART Nurses	369
ART Counsellors Induction Refresher	 183 109
STI Division	**7,242**
Doctors at DSRC	1,146
Doctors at NRHM Facilities	1,096
Staff Nurse	542
Lab Technician	470
Nursing personnel at NRHM facilities	1,776
Lab Technician at NRHM Facilities	669
PPP	1,112
STI Counselors Induction Refresher	 41 390
District AIDS Prevention & Control Unit	**321**
District AIDS Control Officer- Induction/ Refresher	37
District Programme Manager- Induction/ Refresher	60
District ICTC Supervisor- Induction/ Refresher	77
Account Asst.- Induction/ Refresher	22
M&E Asst.- Induction/ Refresher	46
Programme Asst. - Induction/ Refresher	79
IEC & Mainstreaming	**3,26,363**
Panchayat menbers/ PRI	8,229
SHG members	98,356
ASHA/AWW/Supervisors/CDPO	46,166
ANM/LHV/ Nurse	12,478
Youth groups	39,901
Police/ Jail personnel	19,609
Government Officials	34,581
Prisoners & Jail inmates	2,359
Tourism industries	778
Members of faith based organisations, CBOs	4,559
Industrial workers	8,184
Transport workers	1,657
Cooperative member	260
State level selected folk troupe artists	2,541
Others	46,705
Blood Safety	**4,868**
Medical Officer	556

Participant category	Number trained
Lab Tech	993
Nurses	184
Donor Motivators & Organizers	3,135
Laboratory Services	**994**
Technical Officers/ Quality Managers on Quality Manual writing	119
Faculty from Microbiology departments & Heads of STI laboratories	87
NRL /SRL incharges on NABL Lead assessors training & HIV-2 confirmatory testing	30
LT+ Medical Officer Blood Bank	330
LT (CD4 testing Good Laboratory Practices (GLP, EID, DBS Collection)	330
Programme Officer	1
Technical Officers- Induction/ HIV-2 confirmatory testing/ DNA-PCR Testing/ Refresher	97
Strategic Information Management	
Research	**109**
Faculty from Regional STI Training Centres medical colleges, and research institutes and SACS on Operational Research	77
Participants from Institutes of NIIHAR network, SACS from north east region on ethics in HIV/AIDS research	32
Surveillance and Estimation	**3,768**
State Epidemiologists and M&E Officers	30
Regional Working Group Members on HIV Estimations	50
Regional Institute Team members	42
State Surveillance Team members	300
Central Team members	43
SACS Team members	70
Doctors (HSS Site In-charge)	1,021
Lab Technicians (HSS Site)	1,021
Counselors (HSS Site)	1,021
Microbiologists (HSS testing lab)	125
Lab Technicians (HSS testing lab)	125
SIMS Refresher Training	**6,847**
ICTC Counselors	3,423
TI M&E Assistants	1,005
CCC Counselors	296
Designated STI/RTI Centre counselors	925
DAPCU District Programme Managers	197
Joint Directors (IEC /Mainstreaming), SACS	28
Lab Technicians	45
Blood Bank Counselors	928
Total	**4,08,019**

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Procurement

Procurements are done using Pool Fund, Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and Domestic Funds, through M/s RITES Limited as Procurement Agent. M/s RITES Limited continued to provide services to the Department of AIDS Control as Procurement Agent in terms of the contract concluded between Department of AIDS Control and M/s RITES Limited on 16 February, 2010.

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) and other items such as ARV Drugs, STI Drug kits, blood bags etc are centrally procured and supplied to peripheral units and State AIDS Control Societies (SACS). Expenditure incurred on procurement at central level till December, 2012 is shown in Table 14.1

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

Table 14.1: Expenditure Incurred on procurement at Central Level

	(Rs. in Cr.)
Budget Estimate	440.71
Expenditure Incurred (As on 31.12.2012)	211.88

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Administration

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 who is assisted by Ministers of State for Health & Family Welfare Shri S. Gandhiselven and Shri Abu Hasem Khan Choudhury.

The Department of AIDS Control is headed by Secretary to the Government of India who is assisted by Additional Secretary, four Deputy Directors General, three Assistant Directors General, two Directors and a Joint Director. Shri Sayan Chatterjee demitted office as Secretary on 31.12.2012 on superannuation and Shri Lov Verma took over charge on 1.1.2013.

Organisational Chart for the Department of AIDS Control 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 contractual staffs to assist the Department in discharging its assigned functions.

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

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

State AIDS Control Societies

The State AIDS Control Societies (SACS) are the primary implementing bodies for the National AIDS Control Programme at the State level. They have been set up as societies under the Ministries of Health and Family Welfare under the respective State Governments. They are headed by an IAS Officer who

acts as the Project Director of the SACS. For every programme component, there are positions of Joint and Assistant Directors, some of whom are on deputation from the State Government, while some are filled on contractual basis. SACS are responsible for service delivery under various components, management of finances and reporting under the National AIDS Control Programme.

District AIDS Prevention Control Unit

The District AIDS Prevention and Control Units (DAPCUs) have been established in 189 high priority (A and B Category) districts spread across 22 States under NACP- III. DAPCU staff is headed by a District AIDS Control Officer and supported by District Programme Manager along with few other support staff.

Roles and Responsibilities

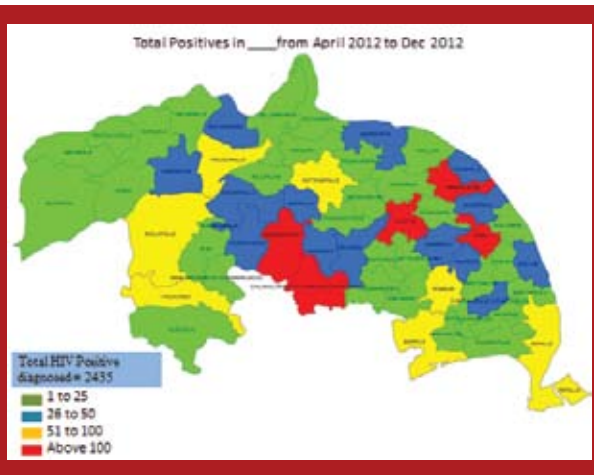
The key role of DAPCU is overall coordination and monitoring of NACP activities at the district level providing a programmatic oversight. DAPCUs are also expected to take up district specific initiatives, integrate HIV programme with formal health infrastructure and mainstream with other line departments in the district through district administration.

Mentoring

DAPCUs submit monthly reports to SACS and NACO, which includes critical indicators of coordination, programme progress and convergence. NACO provides continuous feedback to the DAPCUS through written feedback on their monthly report, telephonic conversations and field visits. The mentoring support is also continued through sharing of case studies from various DAPCUs across states.

Overview of a few initiatives taken by DAPCUs in 2012-13:

a. More than 95% DAPCUs have been sending monthly reports and of these 50% have also started sending action taken reports based on the monthly feedbacks.
b. DAPCUs in 177 districts prepared spatial maps to understand the HIV epidemic in their districts and shared these with the district administration. 82 DAPCUs updated their maps. It is expected that, DAPCUs through the facilitation of SACS will update these maps every quarter.
c. DAPCUs facilitated PLHIVs and HRGs to access the social benefit schemes and it has been reported from 98 DAPCU districts that, 93,927 PLHIVs in 15 States have accessed 209 different schemes, and 41,858 HRGs in 16 DAPCU districts in 07 States have accessed 51 schemes.
d. DAPCU teams prepared the activity plans for their districts including the mobile ICTC route plans for optimal utilization of resources.
e. DAPCUs collected information on storage facilities for NACP commodities at the district level. This supported the compilation of State and national level reports on the status of storage facilities available for commodities which require cold chain and which are stored at room temperature.
f. Ten DAPCUs have reportedly started taking district specific initiatives and are mobilising local resource for the same.
g. DAPCUs collected the data on HIV positive primigravida which supported the analysis of HIV incidence in specific geographical locations.
h. DAPCUs are playing a significant role in ensuring that facilities are reporting in SIMS and validating



Mapping of HIV positives in Guntur, Andhra Pradesh, April – Dec, 2012

Launch of a DAPCU-led campaign in Dakshin Kannada, Karnataka

the data reported before sending to SACS/NACO.

i. DAPCU Speak, a moderated blog was initiated in February 2012. It seeks to promote cross learning of DAPCUs experiences. Eight voluntary DAPCU team members were trained on the moderation of the blog. As of now, over 187 posts are on the blog and more than 8,500 visitors have visited it from India and across the world.

Review mechanism

A national level meeting was held at Delhi in July 2012 with all DAPCU Nodal Officers to review the DAPCU functioning and identify further areas requiring support. The review meeting capacitated SACS to provide continuous leadership and monitoring to DAPCUs. Many SACS are now conducting regular review meetings of their DAPCUs on a regular basis. Andhra Pradesh has been conducting review meetings of DAPCUs through video conferencing facility.

The latest progress in reviewing DAPCUs performance has been through the introduction of a self-assessment tool. This tool lists nine indicators to measure DAPCU performance. The indicators cover areas like coordination with district administration, district specific campaigns, linkages and referrals in the programme, stocks management, leveraging resources, social welfare schemes and other innovations. The tool was piloted with 8 DAPCUs in September 2012. Based on the feedback, modifications were made and then the tool was shared with all DAPCUs for their self-assessment. 128 DAPCUs completed the tool in the given time frame and based on this information, a report was generated and shared with all SACS. It is expected that DAPCUs, through the facilitation of SACS, will use this tool once every quarter to assess their performance.

In last financial year, through active involvement of SACS and NERO officials, many case studies were identified from DAPCU districts and shared through DAPCU series to encourage cross learning.

Implementation of Right to Information Act, 2005

The Right to Information Act, 2005 enacted with a view to promote transparency and accountability in the functioning of the Government by securing to the citizen's the right to access the information under the control of public authorities has already come into force with effect from 12.10.2005. Under the Act, for different subject, three Central Public Information Officers and nine Appellate Authorities have been appointed in the Department of AIDS Control. During 2012-13, 108 applications and 10 appeals have been received till 31 December, 2012 and replies sent.

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Strategic Information Management

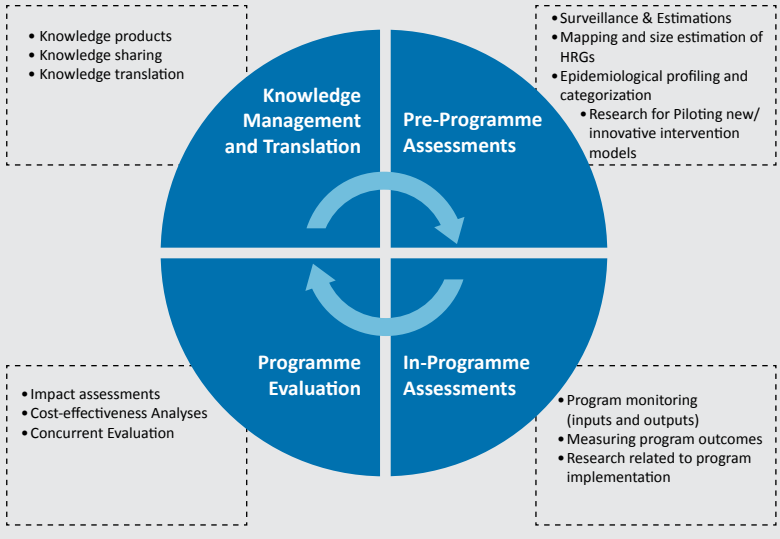
India's success in tackling its HIV/AIDS epidemic partly lies in how India has developed and used its evidence base to make critical policy and programmatic decisions. Over the past 15 years, the number of data sources has expanded and the geographic unit of data generation, analysis, and use for planning has shifted from the national to the State, district and now sub-district level. This has enabled India to focus on the right geographies, populations and fine tune its response over time. Given the proliferation of data sources and the emerging capacity within India to analyze and use data, it is imperative to identify these opportunities to strengthen the use of data for better programmatic decision-making at the district, state and national levels.

Strategic Information Management is one of the cornerstones of India's National AIDS Control Programme. Under NACP-IV, it is envisaged to have an overarching Knowledge Management strategy that encompasses the entire gamut of strategic information activities starting with data generation to dissemination and effective use. The strategy will ensure

- high quality of data generation systems such as Surveillance, Programme Monitoring and Research;
- strengthening systematic analysis, synthesis, development and dissemination of Knowledge products in various forms; and
- knowledge translation as an important element of policy making and programme management at all levels.

Surveillance systems will be further strengthened with focus on tracking the emerging epidemics. To ensure robust reporting and programme monitoring, Strategic Information Management System (SIMS), the web-based integrated system, will be firmly established across the country. Evidence requirements and research priorities will be customized to the emerging needs

Framework for Strategic Information Management under NACP-IV



of the programme. Special efforts will be made to undertake analysis and HIV/AIDS research required to answer the key questions in the programme. Robust evaluation systems will be set up for outcome as well as impact evaluation of various interventions under the programme. NACP IV will also document, manage and disseminate evidence for effective utilization of programmatic and research data. The element of Knowledge Translation will be given the highest priority to ensure making the link between Knowledge and action at all levels of the programme. The programme will focus strongly on building capacities of epidemiologists, monitoring officers, statisticians as well as programme managers at national, state and district levels in appropriate methods and tools of analysis and modeling. Institutional linkages will be fostered and strengthened to support programme for its analytical needs.

Structure & Functions of SIMU at NACO

SIMU comprises four divisions: Monitoring & Evaluation Division, Research Division, Surveillance & Epidemiology Division and Data Analysis & Dissemination Unit. They generate and manage crucial information on the entire spectrum of HIV epidemic and its control – vulnerabilities and risk behaviours, levels, trends and patterns of spread of HIV and factors contributing to it, disease progression, treatment requirements and regimens, planning and implementing interventions, monitoring service delivery and tracking beneficiaries, 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. Data Analysis & Dissemination Unit has been set up at NACO to institutionalize mechanisms for data analysis and data use at national, state and district levels. An epidemiologist and Programme Officer (Statistics) are placed in the unit. One Epidemic Intelligence Service (EIS) Officer has been assigned to NACO from the EIS Training Programme organized by National Centre for Disease Control (DGHS), Delhi.

Programme Monitoring

Key activities undertaken by Monitoring & Evaluation Division include

- Managing Strategic Information Management System (SIMS) for monthly reporting from programme units, including system development and maintenance, finalizing reporting formats, ensuring modifications/ improvements based on feedback, training programme personnel in its use, troubleshooting and mentoring.
- Monitoring programme performance across the country through SIMS and providing feedback to concerned programme divisions and SACS
- Monitoring & ensuring data quality, timeliness and completeness of reporting from programme units
- Data management, analysis and publications
- Maintenance of NACO Website
- Processing data requests and data sharing
- Capacity Building in strategic information areas
- 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

Strategic Information Management System

SIMS is a web- based integrated monitoring and evaluation system that allows capture of the data directly from various levels such as Reporting Unit, District, and State, and enables it to be viewed anywhere on a real time basis. It undertakes automatic aggregation of key indicators that can be reviewed through standard and customized reports at any level. It enhances the efficiency of computerised M&E system by ensuring adequate data quality through central validated data. It can be integrated with all other data bases such as Surveillance, PLHIV database, other survey data etc. It enables capture of individual level information from counseling & testing centres and ART centres, with all security measures to ensure data confidentiality of personal information. It is modular, expandable & scalable with slice & dice capabilities. It has options for advanced analysis using SAS and can be linked to GIS system for spatial analysis. SIMS also provides tools for better decision making through data triangulation from different sources and thereby facilitates ease of evaluation, monitoring and taking policy decisions at strategic or tactical level. SIMS has been rolled out across the country since December 2011.

Components of SIMS

Table 16.1 shows the list of the formats and modules developed as a part of SIMS application.

Training and Implementation of SIMS

For successful implementation of SIMS, clear guidelines

Table 16.1: List of formats and modules for SIMS application

Individual		
Anti Retroviral Treatment	HIV Sentinel Surveillance	
Targeted Intervention	Integrated Counseling & Testing Centre	
Monthly		**Quarterly**
Blood Bank ICTC ART IEC LWS-District LWS-State Lab-SRL Lab-NRL Training	Viral Load Targeted Intervention Sexually Transmitted Infection Simplified STI/RTI Adolescence Education Programme Community Care Centre Drop-in-Centre Early Infant Diagnosis DAPCU-Qualitative & Quantitative	Blood Bank RRC Dashboard
Analysis/Reports		
Data Status Reports Data Item Reports (Draft/Forwarded mode at all levels)	Monitoring reports Progress reports Dashboard reports Alerts	Indicator reports Standardized reports Customize reports
GIS	District/State/Country level GIS mapping reports	

have been developed outlining roles and responsibilities of different officers at NACO & SACS. Training material and user manuals have been developed for each component. Data dictionary giving field-wise details of the definitions, numerators and denominators, etc. have been developed. Specific wall chart on SIMS has been developed to enable users quick access to all the key instructions and information on use of SIMS application.

Induction and refresher trainings of personnel from all reporting units, DAPCUs and programme officers at SACS & NACO have been conducted. Feedback received from the users is systematically logged and necessary technical rectifications and improvements are effected in coordination with software team. Efforts are underway to standardize the reports and develop the analytics module and GIS component under SIMS for wider use of data in programme.

Monthly Programme Reporting

Strategic Information Management System (SIMS) has been rolled out across the country for web-based reporting of information on service delivery directly from health facilities and intervention sites. Since SIMS is in the process of getting firmly established and stabilized in the field, during 2012-13, data collection under the programme is also done through Computerized Management Information System (CMIS). Currently, monthly reports are received from 35 SACS and 3 Municipal AIDS Control Societies through CMIS while over 15,000 reporting units report directly in SIMS. It is proposed that, from April 2013, programme reporting will be completely shifted to SIMS.

Table 16.2: Progress in SIMS Refresher Training, 2012-13

Component	No. of personnel trained
ICTC	3423
TI	1,005
CCC	296
STI	925
DAPCU-DPM	197
IEC /Mainstreaming	28
Lab Services	45
Blood Bank	928
Total	6,847

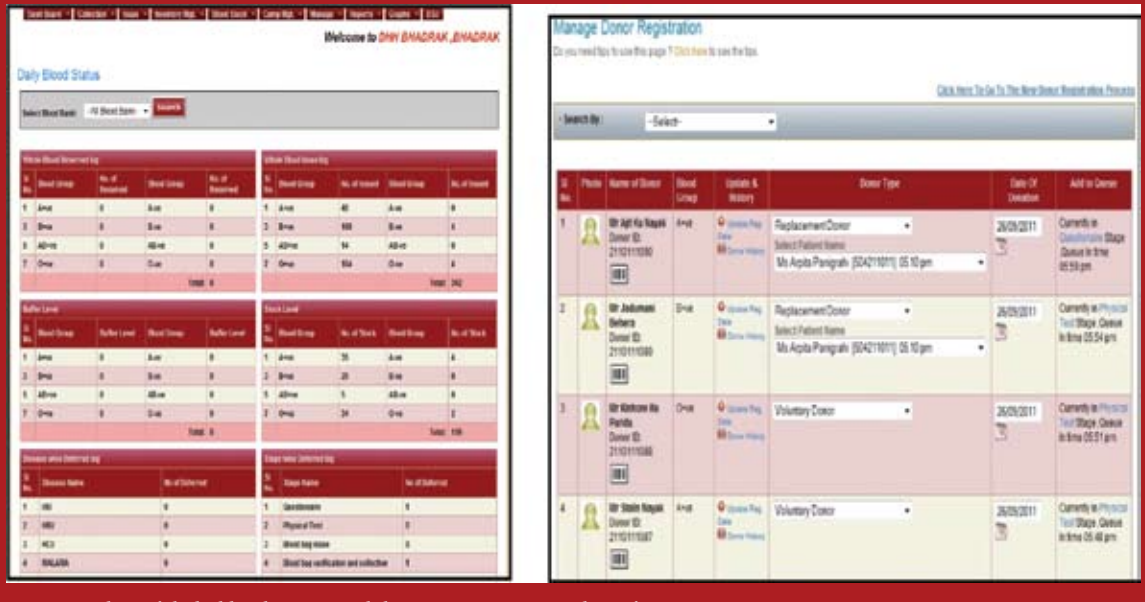
Every State has to submit the monthly report to CMIS by 10th of every month. Timeliness and completeness of reporting is monitored on monthly basis, and feedback is provided to SACS for improving them. Timeliness and completeness of reporting to CMIS is 97% during 2012-13.

Best Practices -1: E-Blood Banking System In Odisha

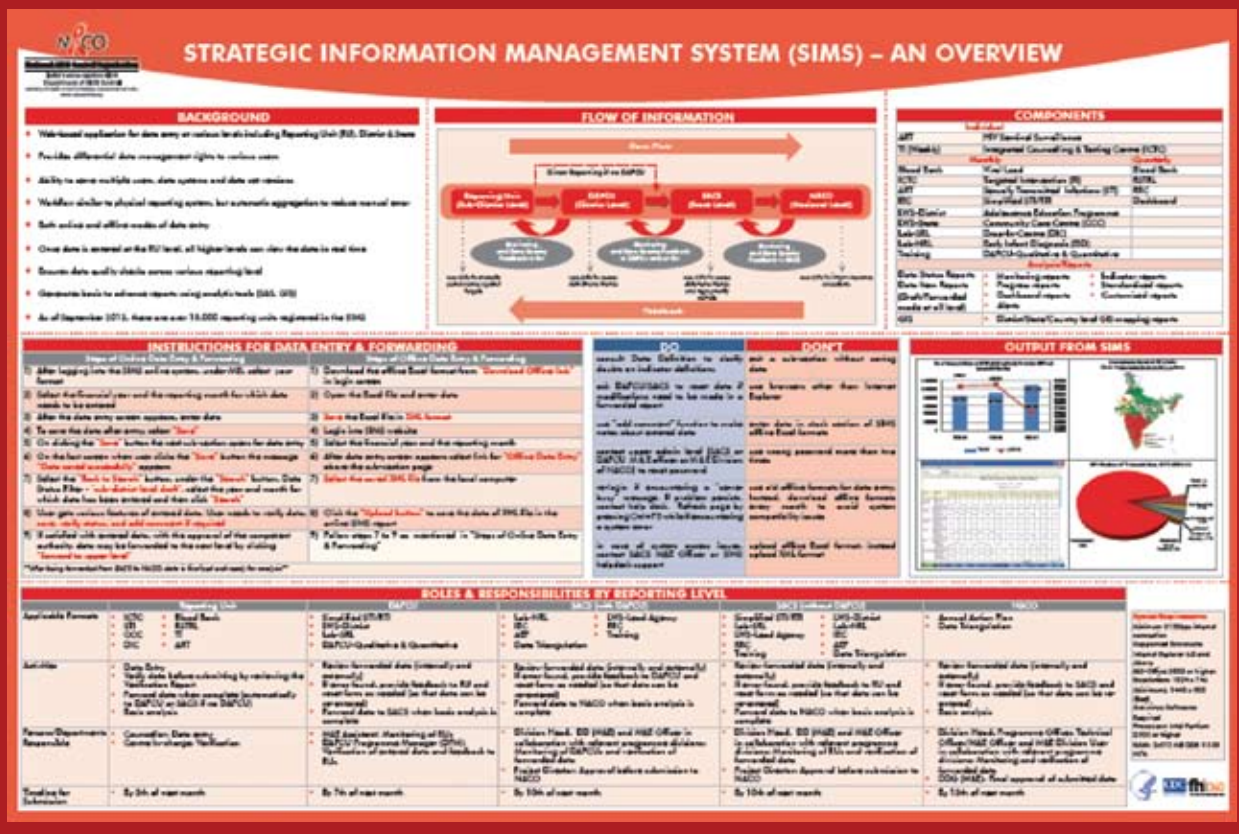
A web based Blood Banking system has been pioneered by the Government of Odisha in all the Blood Banks in Odisha with the support of the Orissa State AIDS Control Society, the State Blood Transfusion Council (SBTC) and the National Rural Health Mission. This computer based management system is designed to handle all the primary information of blood transfusion services required by the Drugs & Cosmetic Act. It tracks all the steps before collection, viz., donor registration, donor questionnaire fill up, and physical tests of donor; then, it allows the donor for blood donation. The test result of the blood bag is entered in the software and then the blood bag is ready for issue.

The system links all the blood banks in the state in a real time basis with citizen interface through SMS and Interactive Voice Response System (IVRS) facility so that public can know the status of blood units in the nearest blood banks and rare blood groups can be made available from any blood bank when needed. Patient can also track the details of the blood units after issue from the website. Over the two year period 2011 and 2012, there were 72,061 SMS from public to know blood status. The auto validation mechanism built into the software enables testing of performance qualification of equipment. The automatic test updation from the ELISA Readers to the software, under process, will obviate need for entering of the test result. The report generation module helps generate all the registers mandated under the Drug & Cosmetics Act.

The E- Blood Bank application was reviewed at NACO. SBTC can monitor short expiry blood units or consumables easily at the state level. The work of the Blood Bank Officer is facilitated with the dashboard on the tested, untested and buffer stock, paperless register maintenance, and an alert mechanism for licence. There was a deferral of 116 blood donors from the donor questionnaire level which might not be possible in the manual method. Regular donors and organisations conducting voluntary blood donation camps can register online. The e-blood bank is being integrated with SIMS software. With guidance from the Drug Controller of Odisha, the issues related to the renewal of blood bank licences are resolved in a timely manner. Donor Relationship Management Module and Thalassemia Patient Information Management System are under development.



Snap shot of daily blood status and donor registration in the software



SIMS Wall Chart

Other activities

Capacity building workshop for State Epidemiologists and M&E Officers was conducted at New Delhi during 19-21 April 2012 with support from FHI-360, CDC. They were oriented on HIV surveillance and epidemiology, monitoring and evaluation and operational research.

Preparation of documents and reports

Programme monitoring personnel prepare various planning documents and reports from time to time. Monthly Note on status of achievements to Cabinet Secretariat, Global AIDS Progress Reporting 2012, Result Framework Document for 2012-13 and Outcome Budget Document 2012-13 were prepared during 2012-13. State fact sheets and status note of National AIDS Control Programme are prepared on regular basis for dissemination of the programme data.

Processing data requests

All the data requests received in the standard format are reviewed by a committee of divisional heads. Data is shared with the applicant as per the data sharing guidelines and due approval of competent authority.

Contribution to planning of the National Family Health Survey (NFHS)-IV

Officers from NACO have been part of the NFHS-IV Technical Advisory Committee and sub-groups and contributed to planning and development of study design, sample size and questionnaires for NFHS-IV.

Data for National/International Document

The division has provided information and inputs for national and international documents such as Economic Survey, National Health Profile, India Report, Plan Documents, Joint Implementation Review Mission Reports, UNGASS report, Universal Access report and SAARC report.

NACO Website

NACO website (www.nacoonline.org) provides access to information relating to policy, strategy and operational guidelines under the programme, and the status of the facilities and programme interventions. It is constantly updated with job advertisements, tender documents, updated status notes and proceedings of important events.

Best Practice 2: SMS Based Daily Reporting System In Tamilnadu

Tamil Nadu State AIDS Control Society (TANSACS) has piloted daily SMS based reporting system in the state with the help of NIC for an efficient data management system. The goal was to monitor HIV AIDS activities at centres on daily basis. It has enhanced internal efficiencies and facilitated delivery of services. SMS daily reporting system provides day-to-day update of activities at the facilities. In this system, all ICTC and ART centres send SMS in a specific format to a central mobile number at SACS. All the data received are stored in a server located at SACS and reports generated on a daily basis.

The following information is collected daily:

- ICTC: Total tested, total positive and ANC positive (daily).
- ART Centre: Adult Pre ART registration, Child Pre ART registration, ART registration and CD4 testing (daily).
- STI Clinic: Total attendees, TI-NGO referral, MHC and referral to ICTC, STI drug stock position
- ICTC kit position: Kit position centre-wise

This reporting also helps validate the data/ information quality by cross verifying the records with MIS reporting (monthly consolidation) and registers during supervisory visits. It also helps identify the pockets with alarming (high) positivity and service gap on day-to-day basis to develop intervention strategy and to bridge the gap through further analysis.

This system was reviewed by M&E officers of NACO and APSACS. It has the advantages of being low cost and affordable, easy to use and monitoring of the programme on a daily basis. Proper training is required on the indicators, and the complex SMS format. Also, follow-up analysis is required to make reasonable conclusions.

Orientation to international delegations

Orientation was provided on NACP to delegations from Nigeria and Uganda on 8 June, 2012 and 31 Aug 2012 respectively at NACO. Orientation on NACP activities was provided for the delegation of Parliamentarians from Uganda at Parliament Library Building on 7 December, 2012

HIV Estimations 2012

The National AIDS Control Organisation undertakes estimation of HIV burden in the country on a regular basis using the data from the annual rounds of HIV Sentinel Surveillance (HSS) among high risk groups and general population. HIV Estimations is the primary source of updated information on the current State of HIV epidemic in the country. The estimates highlight the diversity of trends at the national and state levels and point out the specific drivers of the epidemic, vulnerabilities and trends for key indicators at each level. HIV estimations are used for prioritisation of prevention strategies, evidence-based planning of interventions in specific areas and amongst specific population groups under the programme.

The latest round of HIV estimations were completed in November 2012 and results released on 30 Nov 2012 on the eve of The World AIDS Day. National Institute of Medical Statistics (ICMR), New Delhi is the nodal agency for HIV estimations in India. The National Working Group for HIV Estimations 2012 comprised experts from NACO, NIMS, NIHFW, AIIMS, UNAIDS, WHO and CDC. The Regional Working Groups comprised of national and state level epidemiologists, bio-statisticians and M&E officers from State AIDS Control Societies, Regional Institutes for HIV Sentinel Surveillance and other partner organisations. Technical Support is provided from WHO/UNAIDS Global Reference Group on HIV Estimations & Projections. NACO Technical Resource Group on Surveillance & Estimations comprising of national & international experts met in November to review the HIV Estimation process and approve the final results.

This round of HIV estimations made use of the most comprehensive sets of epidemiological and demographic data inputs available through the latest

Training Workshop on National HIV Estimations & Projections, 1-5 May 2012, New Delhi

round of HIV Sentinel Surveillance, the India Census 2011 and other programme data. Elaborate efforts were made to ensure the accuracy of all the inputs that go into the modeling and projections. The latest tools and methods recommended by the Global Reference Group on Estimations, Projections and Modeling were used. Updated Spectrum Package, customised with Indian data, has been used to allow robust projections for each State. This version of Spectrum included an inbuilt Estimation and Projection Package which was customised appropriately using inputs based on Indian data, to suit the HIV scenario of the country and States. Key Indicators estimated include adult HIV prevalence, New infections/ Incidence, number of people living with HIV, AIDS-related mortality, treatment needs & pregnant women needing PPTCT.

An intensive exercise for refining the demographic projections and inclusion of migration patterns to reflect the true demographic scenario in each State is a hallmark of this round of HIV estimations. These will find application in other health and social sector programmes also. Another highlight of this year's process is the systematic involvement and capacity building of around 50 epidemiologists and statisticians across the country to create pools of expertise in HIV modelling. Organised into five regional working groups and taken through three rounds of capacity building and review workshops, they were fully involved in developing the epidemic models at State level.

Key features of HIV Estimations 2012

1. Decentralised approach – Involvement of regional teams of epidemiologists, statisticians, demographers and programme officers in the process
2. Extensive consultations with national and international experts on Epidemiology, Census & Modeling
3. Intensive exercise to refine demographic projections; useful for other programmes
4. In-depth review of epidemiological data and epidemic patterns in each State & risk group
5. Close consultations with programme divisions at NACO and SACS to finalise programme data
6. Thorough validation of results through multiple approaches

Data Sources & Inputs

The credibility of the HIV Estimates 2012 is very high because they are derived from, not one, but many authoritative data sources, after rigorous quality checks, data validation & cleaning.

1. Census Population Projections (1981-2011)
2. Size estimates of high risk group population based on High Risk Groups mapping exercise conducted by NACO/ SACS during 2007-09 and validated every year through Targeted Intervention programme
3. HIV prevalence among general population, bridge population and high risk group population from HIV Sentinel Surveillance (1998 – 2011)
4. Data from National Family Health Survey NFHS-3 (2006)
   a. HIV Prevalence by State, age, sex
   b. Breast feeding behaviours, State-wise
   c. IMR for smaller States
5. HIV Prevalence among HRG from IBBA (2006 & 2009)

6. Programme data on ART & PPTCT coverage (2004 – 2011) and national guidelines for eligibility for treatment.
7. Epidemiological Assumptions, based on Global Reference Group data from different countries including India

Steps in HIV Estimation Process

1. Refining Demographic Projections to match Census
2. Review & refinement of data inputs for correctness, validity, quality, internal & external consistency
3. Customising Spectrum Package with Indian data on demography & assumptions
4. Configuring the epidemic structure for modeling in each State
5. Entering epidemiological data into Spectrum Package
6. Curve fitting, calibration with NFHS-III HIV prevalence & modeling of HIV prevalence trends in each risk group in each State
7. In-depth review of epidemiological patterns & HIV trends in each State to ensure appropriate portrayal of HIV epidemic
8. Generation of impact indicators
9. Critical review & validation of results, refinement & revisions
10. Uncertainty Analysis

HIV Sentinel Surveillance (2012-2013)

Second generation surveillance for HIV/AIDS focuses on thorough study of HIV prevalence trends coupled with a deeper understanding of the risk behaviours and vulnerabilities that drive the epidemic trends in a given region. India's annual HIV sentinel surveillance, one of the core components of second generation surveillance in India, is being implemented since 1998 (Table 16.3). The 13th round of HIV Sentinel Surveillance (HSS) has been commissioned at 763 ANC and STD sites across the country from 01 January 2013. This is implemented with the support of National Institute of Health and Family Welfare, New Delhi, six Regional Institutes (AIIMS, New Delhi; PGIMER, Chandigarh; NARI, Pune; NIE, Chennai; NICED, Kolkata; RIMS, Imphal), 35 State AIDS Control Societies, 117 State Reference Laboratories & 13 National Reference Laboratories, and public health experts and microbiologists from several medical colleges and institutions.

Key Initiatives under HSS 2012-13

In order to address the key issues identified in implementation of HSS during previous rounds and to improve the quality and timelines of the surveillance process, NACO took many initiatives before and during sample collection for 13th round of HSS.

Table16.3: Scale-up of Sentinel Sites in India, 1998-2013

Site Type	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008-09	2010-11	2012-13
STD	76	75	98	133	166	163	171	175	251	248	217	184	13
ANC	92	93	111	172	200	476	390	391	636	654	668	693	750
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	-
Migrants	-	-	-	-	-	-	-	1	6	3	8	20	-
Transgender	-	-	-	-	-	-	-	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**	**694**	**703**	**1122**	**1134**	**1215**	**1361**	**763***

** Integrated Behavioural and Biological Surveillance (IBBS) among HRGs and Bridge Population will be conducted in 2013-14*

1. **Standard Operational Manuals, Wall Charts and Bilingual Data Forms** were developed to simplify the methodology to site level personnel and ensure uniform implementation of the guidelines at all sentinel sites across the country.
2. **SACS Checklist for Preparatory Activities** was developed to closely monitor the planning process for HSS in each State. All the preparatory activities were broken down into specific tasks with clear timelines and SACS were required to submit completion status on each of them. A team of officers from NACO coordinated with State nodal persons on a day-to-day basis to ensure that preparatory activities in all States are as per the timelines. As a result, all States except two, could initiate HSS at ANC & STD sentinel sites by 01 Jan 2013, as planned. However, due to bad weather conditions, North Eastern States were permitted to start the round from 15 Jan 2013.
3. **Pre-Surveillance Sentinel Site Evaluation (SSE)** of ANC & STD sentinel sites was carried out to identify human resource and infrastructure related issues at the sentinel sites and take necessary corrective action before the initiation of the surveillance. It also provided information on the background profile of the sites such as type of facility, average OPD attendance, availability of HIV/AIDS services, distance of facilities from HSS labs etc.

4. **Training under HSS 2012-13**

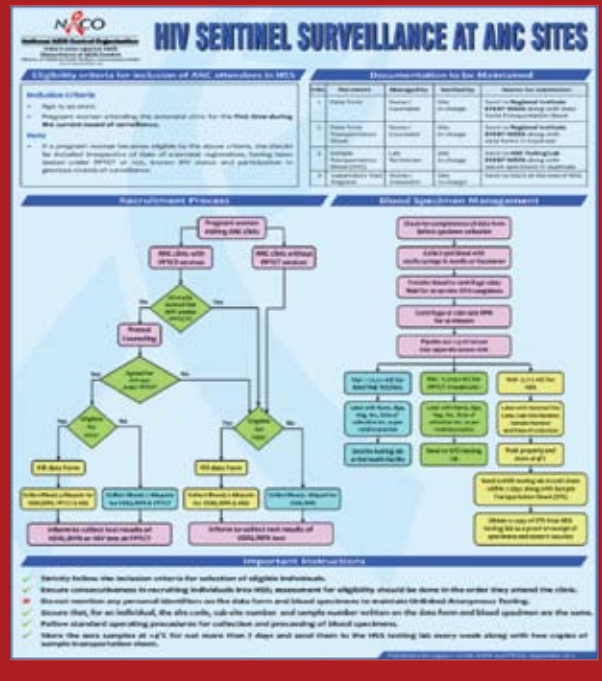
Steps to improve quality of Training

1. Well-Structured Training Programme has been adopted to ensure that all personnel involved in HSS at different levels are adequately and uniformly trained in the respective areas of responsibility.
2. Training agenda, curriculum and material, planning and reporting formats were all standardized and used in all States. Standard slide sets and training manuals to be used in the training of sentinel site personnel were developed to ensure uniformity.
3. Trainings were made interactive by including group work and exercise on "Know Your Sentinel Sites" that helped participants in identifying the routine practices at their sites that may affect the implementation of surveillance and recommended actions to address the same.
4. Pre- and post-test assessment was done for each participant during site level training. Analysis of same helped State teams to identify priority sites for supervisory visits.
5. Batch-wise training reports in standard format were submitted at the end of training.

Details of Trainings

1. The trainings started with two batches of National Pre-Surveillance Meeting with around 90 personnel from Regional Institutes and SACS to discuss the


HSS 2012-13: DATA FORM FOR ANTENATAL CLINIC ATTENDEES (ANC)



HSS 2012-13, Bilingual Data Form & Wall Chart for ANC Sentinel Sites

critical aspects of planning for HSS 2012-13 and understand the system for supportive supervision through online SIMS application.

2. This is followed by 2-day planning & training workshops organised by the Regional Institutes for SACS officers & State Surveillance teams, comprising of public health experts and microbiologists. These were aimed at creating State level master trainers and to plan for site level trainings.
3. Subsequent to that, site level trainings (2 days per batch @ 8-10 sites per batch) were conducted in all the States in multiple batches. Representatives from Regional institutes participated in the trainings as observers to ensure that trainings are provided as per the protocol and all sessions are being covered as per prescribed session plan.
4. Separate trainings were organised for microbiologists & lab technicians from 117 ANC/STD testing labs and 13 National Reference Laboratories on Surveillance testing protocols and lab reporting mechanisms through SIMS Application for HSS.
5. Overall, 40 central team members, 30 officers from six Regional Institutes, 95 SACS officers including In-charge Surveillance, Epidemiologists and M&E officers, 280 State Surveillance Team members, 260 laboratory personnel including microbiologists & lab technicians from the designated testing labs, and over 3,000 sentinel site personnel including medical officers, nurse/ counselors and lab technicians were trained under HSS 2012-13.
5. **Laboratory System** for HSS 2012-13 has been strengthened by limiting the testing of specimens to the designated State reference laboratories. Real time monitoring of quality of blood specimens and laboratory processes was achieved through introduction of online reporting through SIMS Application for HSS. Efforts were made to standardize quality assurance aspects of samples testing under HSS as well as streamlining responses in case of discordant test results between testing lab and reference lab, through online reporting mechanism using SIMS.
6. **Supervisory Mechanisms for HSS 2012-13:** Highest focus was given to supervision of all HSS activities to ensure high quality of implementation and data. Extensive mechanisms were developed to set up a comprehensive supervisory system for HSS and to ensure 100% sites visited in first 15 days of start of sample collection. The principles adopted include action-oriented supervision, Real Time Monitoring & Feedback, accountability for providing feedback & taking action, and an integrated System to enhance reach & effectiveness of supervision.

Components of Supervision (All Integrated into online SIMS Application for HSS):

1. **Field Supervision:** Through trained supervisors who visit the sentinel sites; Monitors quality of Recruitment of Samples into HSS and site level procedures;

National Pre Surveillance Meeting for HSS 2012-13, NIHFW, New Delhi, 5-6 Oct 2012

2. **Data Supervision:** Through Data Managers at Regional Institutes; Monitors quality of data collection and transportation
3. **Lab Supervision:** Through Testing Labs; Monitors quality of blood specimens and laboratory processing

Levels of Field Supervision

1. National: NACO, NIHFW & Central Team Members
2. Regional: Regional Institute Teams
3. State Surveillance Teams
4. SACS Core Teams

Integrated Monitoring Plan

1. One monitoring plan for each State developed by Regional Institutes, SACS & NIHFW jointly
2. First round of visits by Regional Institutes, SACS & SST members; Second round of visits by Central Team Members to the priority sites identified during the first round.
3. Aimed to cover all sites with adequate spacing between visits to priority sites; and avoid overlap of visits by different teams
4. Every supervisor to carry supervisor's kit
5. Every supervisor to mention detailed observations in Supervisory Visit Register at the sentinel site, for record and reference of site incharge as well as supervisors who visit the site subsequently.
6. Submit quick feedback in SIMS within 3 days of visit to the sentinel site
7. Web-based mechanism that captures real time information on which sites are visited, when and by whom
8. Login IDs/ User IDs for SIMS Application for HSS issued to all Regional Institutes, SST members, SACS, Central Team Members (CTM), Serum Testing Laboratories (SRL) and National Reference Laboratories (NRL)
9. Real time feedback on issues at each sentinel site and submission of Action Taken Report by SACS through online SIMS Application for HSS.
10. Dedicated team at NACO for implementation of Real Time Monitoring through SIMS Application for HSS and day-to-day coordination with labs, SACS, SST members, RIs and NIHFW.

SMS-based Daily Reporting from Sentinel Sites

1. Daily reporting of no. of samples collected each day through an SMS from a Registered Mobile Number (RMN) at each sentinel site to a central server
2. Automatic compilation and display of site-wise data in Excel format on real time basis
3. Web-based access to SACS, RIs, NIHFW & NACO
4. Facilitates easy identification of and initiation of corrective action at
   a. Sites that initiate HSS late
   b. Sites where sample collection is too slow or too fast
   c. Sites where there are large gaps in sample collection

National Integrated Biological & Behavioural Surveillance

Given the low level and concentrated nature of the HIV epidemics in country, IBBS is being planned as a strategic focus to strengthen surveillance among High Risk Groups and Bridge Population. This will be a population-based/ probability-based survey aimed at providing HIV prevalence and key behavioural indicators at district, state and national levels. The preparatory activities for the same, including development of methodology and tools, have been initiated during 2012-13. A Pre Survey Assessment in identified districts is scheduled to be initiated in March 2013. Primary data collection under the survey will be conducted during 2013-14.

HIV/AIDS Research

Research is a vital component of Strategic Information Management under the National AIDS Control Programme. HIV/AIDS research covers a wide diversity of areas, such as epidemiological, social, behavioral, clinical and operational research; each of these has a strong role to play in providing a direction to the programme strategies and policies. NACO has given a strong emphasis to strengthening of research activities under the programme.

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

- developing guidelines, norms and standards for undertaking HIV/AIDS research;
- partnerships and networking with multiple stakeholders and established national academic and other research institutions;
- supporting capacity building in research related to HIV/AIDS;

- functioning as the central repository of all relevant resources, research documents and data base on HIV/AIDS in the country; and
- ensuring translation of research outputs into programmatic action and policy formulation.

The main activities of the Research Division are:

1. Setting Priority Areas for Evaluation & Operational Research in HIV/AIDS & development of research protocols
2. Encouraging, processing & approving research proposals
3. Coordinating activities of Technical Resource Group (TRG) on Research & Development and NACO Ethics Committee(EC)
4. Dissemination of HIV/AIDS Research Outcomes
5. Coordination of activities of Network of Indian Institution for HIV/AIDS Research (NIIHAR)
6. Capacity Building Initiatives in operational research and ethics in HIV/AIDS research
7. NACO Research Fellowship Scheme for MD/ M.Phil/ Ph.D students

Key activities undertaken during 2012-13

1. The TRG-R&D met twice in 2012-13. Thirty Eight research proposals including Indo-foreign research proposals referred by Health Ministry's Screening Committee (HMSC), ICMR were discussed in these meeting. Following NACO supported research proposals were recommended by the TRG-R&D through its meetings held in 2012-13.
   - Integrating HIV prevention with HIV care in NACO ART Clinics.
   - Integrated Bio-Behavioural Surveillance (IBBS) among High Risk Groups and Bridge Population
   - Utility of Prevention- of- Mother- to – Child HIV Transmission Programme Data for HIV Surveillance
   - Functional convergence of services under Reproductive and Child Health services and National AIDS Control Programme to provide better health care services to High Risk Groups attending public health care facilities in Nagpur district, Maharashtra: An exploratory study
   - Functional convergence between Reproductive and Child Health and National AIDS Control Programme for better health care to reproductive age group attendees at public health care facilities in Vadodara district, Gujarat: An exploratory study
   - Multi Centre Cluster Randomized Trial Comparing Rapid Plasma Reagin and Point of Care Test for Syphilis Case Detection and Treatment among Pregnant Women attending Ante-Natal Clinics in selected Districts of Tamil Nadu, India, 2012-2013.
   - A study on Syphilis sero-positivity among women admitted in labour room of a Government tertiary care hospital in Hyderabad, Andhra Pradesh.
2. **NACO Research Fellowship Scheme (NRFS)**
   NACO Research Fellowship Scheme was conceptualized with the main aim of facilitating capacity building of young researchers in the country for undertaking HIV/AIDS research and to communicate research findings for impacting policy and programme. It has been envisaged that NACO Research Fellowships will provide opportunities in the form of financial assistance to pursue research, ultimately leading to attainment of MPhil/MD/ PhD degrees, under experienced academicians and researchers. These fellowships may serve as an incentive for them to take up quality and need based research in the field of HIV/AIDS. The applications received for the fourth round of NACO Research Fellowship Scheme are being processed.

3. **Capacity Building on Operational Research in HIV/AIDS**
   a. Capacity Building Workshop for Operational Research on Management of STI/RTI was held from 9 -13 July, 2012 at National Institute of Health and Family Welfare (NIHFW), New Delhi, with the support of CDC. a total of 46 participants from seven Regional STI Training centres as well as from National Institutes participated in this workshop. The workshop followed the unique approach of interactive sessions in forenoon and development of research protocols under guidance of mentors in the afternoon session. Six research proposals based on four key priority research areas in STI/RTI were developed through this workshop which have been processed through TRG on R&D.
   b. Capacity Building Workshop for Operations Research on Basic services was held from 24-28 September, 2012 at Lala Ram Sarup Institute of Tuberculosis and Respiratory Diseases, New Delhi, with the support of WHO. A total of 31 participants from different research institutes, medical colleges, Centres of excellence

Review Meting-cum-Capacity Building Workshop on Operational Research for Management of STI/RTI, held at NIHFW, New Delhi from 9-13 July,2012.

and State AIDS Control Societies participated in this workshop. Eight renowned mentors along with eight resource persons guided participants through the workshop. Seven draft research proposals based on the priority research areas under ICTC, PPTCT, Counseling & HIV-TB were developed through the workshop which will be processed through TRG on R & D.

c. Capacity Building Workshop on Ethics in HIV/AIDS Research, fourth in the series, was conducted at National Institute of Rural Development-NERC, Guwahati, for North-Eastern region, with the support of UNICEF and Srimant Sankardeva University of Health Sciences, Assam from 26-28 July, 2012. A total of 32 participants from Institutes of NIIHAR network, SACS, Research Institutes and various medical colleges from north east region participated in this workshop. A unique case study approach has been adopted to sensitise young researchers in various ethical issues in HIV/AIDS Research.

4. A session on the progress & priorities in HIV/AIDS research – global & Indian perspectives was held on 15th May, 2012 at NACO, New Delhi in the presence of Secretary & DG, NACO and Additional Secretary. Experts from National AIDS Research Institute, UNAIDS, AIIMS and NACO participated in this key discussion.
5. NACO collaborated with Dept. of Biotechnology, Dept. of Health Research, Forum of Parliamentarians on HIV/AIDS and IAVI in organising the International Symposium on 'Accelerating India's response to research for a preventive HIV vaccine' on 13-14 Aug 2012 at New Delhi.

Analysis & Research Plan

Under NACP-III, there are extensive systems for data generation through surveillance, M&E and research with enormous volumes of data collected through multiple reporting formats on numerous indicators. The focus was primarily on data generation and reporting. The analysis was limited to key programme indicators and mandatory requirements. Emphasis on comprehensive and scientific data analysis and synthesis was low.

In order to address the programme needs with respect to evidence and research and make best use of the available data, a structured Analysis & Research plan has been developed for identifying analytic requirements & research priorities and commissioning analytical work/ research studies accordingly. A detailed exercise to assess existing information gaps and evidence requirements in the programme was conducted involving programme managers at NACO, SACS and development partners, and areas for analysis & research have been prioritised. A panel of epidemiologists, biostatisticians, M&E, modeling and public health experts/ institutions has been identified to carry out analysis and research. Senior experts were identified to provide mentoring support.

Objectives of Analysis Plan

a. To identify the topics/thematic areas that can be studied by analysing available information (programme data)
b. To structure the analysis by identifying key questions and appropriate methodology/tools for analysis
c. To commission the analysis through a collaborative approach involving institutes, programme units & senior experts as mentors, with agreed timelines
d. To consolidate, discuss & disseminate the analytical outcomes for programmatic use from time to time
e. To promote scientific writing within the programme in the form of papers/articles/reports/briefs etc.

Objectives of Research Plan

a. To identify the information gaps and research needs in the programme that require research to generate fresh evidence
b. To develop and finalise research priorities in consultation with programme divisions, partners and technical experts
c. To commission epidemiological, socio-behavioural, operational, bio-medical research through identified institutes/ organisations
d. To consolidate & disseminate research outcomes for programmatic use from time to time
e. To promote scientific publication in the form of papers/ articles/ reports/ briefs etc.

Analysis will be commissioned on the identified priority areas within the next six months and analytic products such as scientific papers, journal articles, reports, policy briefs, etc. will be developed that can be published and disseminated for wider use at national and state levels. Similarly, research priorities have been categorized as epidemiological studies, socio-behavioural studies, bio-medical/clinical research, operational research & special studies. They will be commissioned through reputed institutes and organisations following a call for proposals.

Publications During 2012-13

1. HIV Sentinel Surveillance 2010-11 – A Technical Brief
2. Technical Report on India HIV Estimates 2012
3. HIV Sentinel Surveillance 2012-13: Operational Manual for ANC Sentinel Sites
4. HIV Sentinel Surveillance 2012-13: Training of ANC Sentinel Site Personnel – Trainee's Manual
5. HIV Sentinel Surveillance 2012-13: Wall Chart for ANC Sentinel Sites
6. District Epidemiological Profiling using Data Triangulation: District Fact Sheets (Vol. I) for Madhya Pradesh, Punjab, Uttarakhand & Rajasthan
7. SIMS Wall Chart
8. National AIDS Control Programme: State Fact Sheets (Dec 2012)

17

Result Framework Document

The Results Framework Document (RFD) of department is a System to both Evaluate & Monitor, and takes a comprehensive view of departmental performance, Focuses on "Managerial" Performance and provides a unified and single view of performance.

The RFD seeks to address three basic questions, what are department's main objectives for the year? What actions are proposed to achieve these objectives? How to determine progress made in implementing these actions?

Dr S. Venkatesh has been designated as the Departmental Coordinator for RFD for the Department of AIDS Control. The department has been preparing RFD in a timely manner and submitting it to the Performance Management Division (PMD) of the Cabinet Secretariat.

The Department of AIDS Control was given "Excellent" rating in RFD achievements with overall composite score of 92.89% for 2009-10, and 91.27% in 2010-11. For the RFD 2011-12, the Department has scored 87.72% with "Very Good" rating.

During the 2012-13, the Department has prepared an action plan for implementation of ISO 9001 certification. The Action Taken Report with respect to commitments made in RFD 2011-12, submitted by the department, forms part of the "Report to the People" brought out by Prime Minister Office. The Citizen Charter of the Department of AIDS Control has been included in the Compendium published by Performance Management Division of the Cabinet Secretariat.

Officers from the Department of AIDS Control attended the following workshops organized by the Performance Management Division at the Indian Institute of Foreign Trade, New Delhi:

- Capability Building for guiding the department to begin implementation of IS0: 9001 in collaboration with Quality Council of India on 4 December, 2012
- Implementation of IS0: 9001 on 13 February, 2013.

RFD 2012-13 was finalised at a meeting of the Adhoc Task Force on 22 March, 2012, subsequently approved by High Power Committee, headed by Cabinet Secretary. The Department has submitted the Mid-Term achievement of the Department on 29 October, 2012. The achievements against the target for RFD 2012-13 are being monitored on a monthly basis at the Department.

18

Financial Management

Financial Management is an integral and important component under NACP IV (2012-17) programme architecture. Financial Management deals with approval and review of annual plans and budgets, fund flow mechanisms, delegation of financial powers, accounting and internal control systems and to ensure that funds are effectively used for programme objectives. It brings together planning, budgeting, accounting, disbursements, procurements, financial reporting, internal control including internal audit, external audit, filing programme updates and disbursement requests and managing resources efficiently and effectively. The financial process focuses on financial analysis for programmatic and management use and meeting reporting obligations for all stakeholders and producing accurate and timely information that forms basis for better decisions, reducing delays and bottlenecks. Fiduciary requirements are addressed by designing and implementing effective audit mechanisms at all levels. This provides reasonable assurance that (i) operations are being conducted effectively and efficiently and in accordance with NACP financial norms; (ii) financial and operational reporting are reliable; (iii) laws and regulations are being complied with; and (iv) the assets and records are being maintained properly.

The areas that will receive attention during NACP IV include Delegation of Financial Powers, Asset Management, Audit Structures, NGO financing and accounts, Timely settlement of Advances, Inter-unit Transfers, Computerized Project Financial Management System (CPFMS) and Human Resource for Financial Management.

Key Roles and Responsibilities of Finance Division

- Preaparation and circulation of EFC Memos and Cabinet Notes
- Tendering financial advice on all matters involving expenditure and forwarding proposals from programme divisions for concurrence of the Integrated Finance Division (IFD)
- Monitoring and reviewing the progress of expenditure against sanctioned grant on a monthly and quarterly basis, ensuring compliance of instructions issued by the Department of Expenditure on economy/ rationalization of expenditure
- Furnishing information/replies on issues raised by Standing Committee of Parliament on Finance/ Public Account Committee and Audit Paras.
- Preparation of Budget and related work in respect of Grant
- Coordination and compilation of the Detailed Demand for Grants and the Outcome Budget of the Ministry of Finance.

Key Functions

- Budgeting
  - Preparation of Demands for Grant
  - Preparation of Budget Estimate /Revised Estimate in consultation with the Programme Divisions
  - Correspondence with Planning Commission for finalizing plan allocation

- Accounting functions
  - Annual Action Plan (AAP) Preparation
  - Processing and conveying approval
  - Releases to SACS, NGOs, Consultancy Agencies, Central Institutions
  - Expenditure accounting of NACO and SACS
  - Reconciliation of Audited Accounts with SOEs and monitoring/examination/acceptance of Utilization Certificates
  - Oversight of financial management and handholding SACS on expenditure management, targets and advance settlements
  - Examination of EoI, RFP and contarcts etc.
  - Filing reimbursement claims with funding agencies
- Audit Functions
  - Coordination for statutory as well as internal audit of SACS
  - Submission of audit reports to Ministry, Donor agencies etc.
  - Facilitate audit at NACO level
- Internal financial advisory functions
  - Preliminary checking of bills
  - Advice on financial matters
  - Representing negotiation meetings
- Donor coordination
  - With extra budgetary donors like USAID, CDC, UNAIDS, BMGF etc.
  - State Coordination Committees
- Convening of review meetings
  - PDs review on SACS Financial Management
  - Technical Support Units (TSU)
- MIS reporting on financial matters
  - To Secretary and Programme Officers for planning purpose
  - To Donors and Ministries for reporting purpose
  - Handholding of weaker States
- Functional support to CPFMS
  - Handholding of weaker States
  - Periodic updates
- Submission of claims for reimbursement
  - Preparation of Financial Management Reports (FMRs) and Interim Unaudited Financial Report (IUFR)
  - To World Bank through Controller of Aid Accounts and Audit
  - Filing of Progress updates and disbursement claims to Global Fund
  - Assist Programme Division's in preparation of proposals to Global Fund and negotiations with Global Fund

Utilisation of Funds in NACP-III (2007-12)

NACP-III (2007-2012) was approved for an amount of f Rs. 11,585 crores to implement a wide range of interventions of which, Rs. 8,023 crores was to be provided through the government budgetary support and balance being extra-budgetary funding. The resource envelope identified for NACP-III included external funding from Development Partners, (both budgetary as well as extra-budgetary support), bilateral and multi-lateral agencies and UN agencies. These extra-budgetary resources supplemented the domestic contribution by the Government of India. During NACP-III period, an expenditure of Rs. 6,237.48 crores was incurred through budgetary sources. Table 18.1 shows year-wise actual expenditure incurred in NACP-III.

In addition, the Development Partners had spent about Rs. 2,671.84 crore through direct implementation as a part of the extra-budgetary support which did not flow through the Consolidated Fund of India.

Utilization through State Structure

The National AIDS Control Programme is implemented through the State AIDS Control Societies in all States and Union Territories. There has been significant increase in the State plans as many programme

Table 18.1 - Year wise expenditure incurred during NACP- III

Source	2007-08	2008-09	2009-10	2010-11	2011-12	Total
Domestic Budget Support	287.38	188.00	200.75	303.22	136.27	1,115.62
Pool Fund (WB+DFID)	500.62	506.99	445.94	588.92	536.89	2,579.36
Global Fund	377.49	480.99	404.02	522.32	616.42	2,401.24
USAID	23.22	26.25	24.97	33.89	11.52	119.85
UNDP	3.83	2.68	7.11	3.93	3.86	21.41
Total	1,192.54	1,204.91	1,082.79	1,452.28	1,304.96	6,237.48

interventions were scaled-up and stabilized. The scaling up of resource allocation is given in figure 18.1.

In addition, to providing financial resources, NACO facilitated commodity and equipment support to the HIV service delivery centres following central procurement method.

For the year 2012-13, against the Budget Estimate of Rs. 1700 crores and the Revised Estimate of Rs. 1759.56 crores, expenditure of Rs. 1057.24 crores was incurred as on 31 December, 2012.

National AIDS Control Programme, Phase-IV (2012-17)

NACP Phase-IV (2012-17) has been formulated after a wide range of consultations with a large number of partners including the government departments, development partners, non-government organisations, civil societies, representatives of people living with HIV/AIDS, positive networks and experts in various subjects. This consultation was carried out over a period of more than six months in 2011 with 35 working groups, subgroups and national as well as regional consultative meetings comprising more than 1,000 participants. The estimated cost of NACP Phase-IV has been proposed for Rs. 15,724 crores.

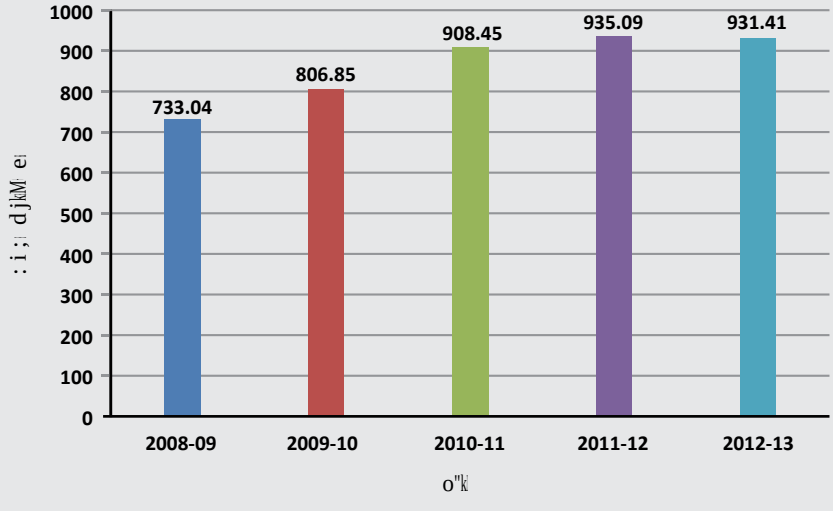
The budget estimates of NACP-IV have been worked out based on the targets projected for NACP-IV and using existing costing norms suitably adjusted for the next five years. The total proposed budget for NACP-IV is Rs. 15,724 crore which comprises Government Budgetary Support, Externally Aided Budgetary Support from World Bank & Global Fund and Extra Budgetary Support from other Development Partners.

Initiatives undertaken during NACP III for strengthening the financial systems & preparation of Annual Action Plan for State AIDS Control Societies

Improved approval systems

- **Annual Action Plan development process:** Guidelines were developed and circulated to the PD of all SACS highlighting the critical areas to be focused in the action plan. Teams of officers from NACO visited various SACS to identify bottlenecks and facilitate development of State Annual Action Plans for 2013-14. Subsequent to this, meetings were held at NACO with the SACS officers including Project Directors during Feb – March 2013 for discussion and finalisation of Annual Action Plan for the financial year 2013-14.
- Action has been taken over the last five 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 contributed greatly to the effective planning and implementation of activities while adhering to the programmatic time-frame.

Fig. 18.1: Scale-up of resource allocation through State Structure from 2008-09 to 2012-13



- Systems have been established to release the sanctioned amount in phased manner and to closely monitor the cash flow to peripheral units so that the States, at no point, face shortage of resources. Monitoring is done through the on line systems by having a snap shot of resource position at any given point of time.

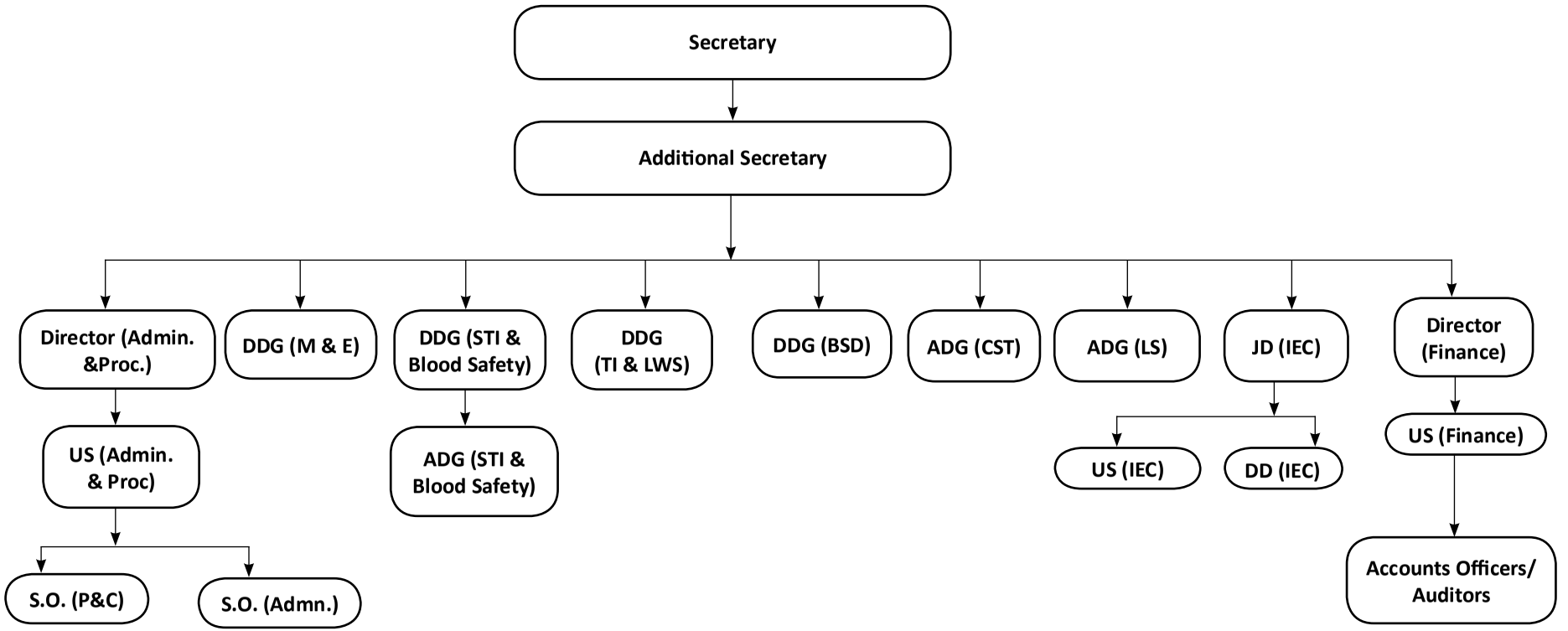
Better monitoring Systems

- Computerized Project Financial Management System has been developed and rolled out to have better financial management. The system is working in all SACS for tracking expenditure management, capturing financial data, and utilization and monitoring of advance. States are being linked to Central level at NACO through Virtual Private Network with the technical support of National Informatics Centre to have on line transfer of financial data.
- E-Transfer facility to avoid transit delays in transfer of funds to States has been implemented. This has established in all the States now and the steps are being taken for using this facility for transfer of funds from State to districts and other implementing agencies at peripheral unit level.
- Payment of salary to staff at district and peripheral units have been totally made through e-transfer and this has brought down accumulation of funds at implementing agencies, thereby minimizing 'advances'.
- Copy of Annual Action Plans, instructions and guidelines are put on the website of NACO and are updated periodically to ensure timely and wider dissemination of information.
- **PD review meeting:** Review of various components of the programme implementation in the States was taken with Project Directors of all the SACS by Secretary, Department of AIDS Control at NACO from 3 -5 October, 2012.

ANNEX-I

Organisational Chart of the Department of AIDS Control

Position as on 31.01.2013 (Designation-wise)



Note: These are the regular positions sanctioned for the Department of AIDS Control.

ANNEX-II

State/Municipal AIDS Control Societies

Andhra Pradesh AIDS Control Society, Directorate of Medical and Health Services, Sultan Bazar, Hyderabad - 500059.	Andaman & Nicobar AIDS Control Society, G.B. Pant Hospital Complex, Port Blair - 744104	Arunachal Pradesh State AIDS Control Society, Directorate of Health Services, Naharlagun, Arunachal Pradesh -791110
Assam State AIDS Control Society, Khanapara, Guwahati-781022	Ahmedabad Municipal corporation AIDS Controls Society, 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.- 492001
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 - 110085
Goa State AIDS Control Society, 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 -134109
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, Lal Chowk, Srinagar- 190001	Jharkhand AIDS Control Society, Sadar Hospital Campus, Purulia Road, Ranchi – 834001
Karnataka AIDS Control Society, No.4/13-1, Crescent Road, High Grounds, Bengaluru-560001	Kerala State AIDS Control Society, IPP Building, Red Cross Road, Thiruvananthapuram, Kerala – 695035	Lakshadweep State AIDS Control Society, Directorate of Medical and Health Services, UT of Lakshadweep, Kavaratti – 682555
Madhya Pradesh State AIDS Control Society, 1, Arera Hills, Second Floor, Oilfed Building, Bhopal – 462011	Maharashtra State AIDS Control Society, Ackworth Leprosy Hospital Compund, R.A. Kidwai Marg, Wadala (West), Mumbai- 400031	Manipur State AIDS Control Society, New Secretariat, Annexe Building, Western Block Imphal, Manipur-795001
Meghalaya State AIDS Control Society, Ideal Lodge, Oakland, Shillong - 793001.	Mizoram State AIDS Control Society, MV-124, Mission Veng South, Aizwal – 796005,	Mumbai Districts AIDS Control Society, Municipal Corporation of Greater Mumbai, R.A. Kidwai Marg, Acworth Complex, Wadala, Mumbai-400031
Nagaland State AIDS Control Society, Medical Directorate, Kohima – 797001	Odisha State AIDS Control Society, Oil Odisha Building, Nayapalli, Bhubaneshwar – 751012	Puducherry State AIDS Control Society, 93, Perumal Koil Street Puducherry-605001
Punjab State AIDS Control Society, Prayas Building, 4th Floor , Sector 38-B, Chandigarh-160014	Rajasthan State AIDS Control Society, Medical & Health Directorate, Swasthya Bhawan, Tilak Marg, Jaipur - 302005.	Sikkim State AIDS Control Society, STNM Hospital, Gangtok, 737101.
Tamilnadu State AIDS Control Society, 417 Pantheon Road, Egmore, Chennai-600008	Tripura State AIDS Control Society, Akhaura Road, Opposite to I.G M Hospital, Agartala- 799001	Uttar Pradesh State AIDS Control Society, A-Block, 4th Floor, PICUP Bhawan, Vibhuti Khand, Gomti Nagar, Lucknow-226010
Uttarakhand State AIDS Control Society, Chandar Nagar, Dehradun – 248001	West Bengal State AIDS Control Society, Swasthya Bhavan, GN - 29, Sector - V, Salt Lake, Kolkatta – 700091	North East Regional Office Banphool Naga Path, Near Housefed Bus Stop, Beltola Road, Guwahati, Dist-Kamrup - 781006, Assam

ANNEX-III

Most Recent and Important Audit Observations

Sl. No.	Year	No. of paras/PA reports on which ATNs have been submitted to PAC after vetting by Audit	Details of the Paras/PA report on which ATNs are pending		
			No. of ANTs not sent by the Ministry even for the first time	No. of ATNs sent but returned with observations and Audit is awaiting their resubmission by the Ministry	No. of ATNs which have been finally vetted by Audit but have not been submitted by the Ministry of PAC
1.	2004-05 Report No. 3 of 2004 entire report on National AIDS Control Programme	Report is under examination of Public Accounts Committee. Recommendations of PAC [19th Report of PAC 2005-06]. Further recommendations [vide 63rd Report of PAC 2007-08 on ATN of 19th Report]. ATN on recommendations made in 63rd Report sent to PAC on 29.6.09.			
2.	2010-11	Para 7.2 of C&AG's Report no. 9 of 2010-11	ATN has been submitted to audit on 09.11.12 for vetting before sending the ATN to Ministry of Finance, Department of Expenditure	Nil	Nil
3.	2011-12	Para 8.3 of C&AG's Report no. 16 of 2011-12	ATN has been submitted to audit on 09.11.12 for vetting before sending the ATN to Ministry of Finance, Department of Expenditure	Nil	Nil

NACO

National AIDS Control Organisation

India's voice against AIDS

Department of AIDS Control

Ministry of Health & Family Welfare, Government of India

www.nacoonline.org