ANNUAL REPORT
2002-2003
2003-2004
(upto 31 July 2004)

NACO
National AIDS Control Organisation
Ministry of Health and Family Welfare
Government of India
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>NACO</td>
<td>National AIDS Control Organization</td>
</tr>
<tr>
<td>NACPI</td>
<td>National AIDS Control Programme, Phase 1</td>
</tr>
<tr>
<td>NACPII</td>
<td>National AIDS Control Programme, Phase 2</td>
</tr>
<tr>
<td>SACOS</td>
<td>State AIDS Control Organization</td>
</tr>
<tr>
<td>ICMR</td>
<td>Indian Council of Medical Research</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>UN Joint programme on HIV/AIDS</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health organization</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Govt Organization</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioral Sentinel Surveillance</td>
</tr>
<tr>
<td>CMIS</td>
<td>Computer Management and information systems</td>
</tr>
<tr>
<td>VCTC</td>
<td>Voluntary counseling and testing centers</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti Retro Virals</td>
</tr>
<tr>
<td>ART</td>
<td>Anti retroviral Therapy</td>
</tr>
<tr>
<td>PLWHAs</td>
<td>People living with HIV/AIDS</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>GIPA</td>
<td>Greater Involvement of People Living with and directly affected by HIV/AIDS</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>IDUs</td>
<td>Intravenous Drug Use</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>MSM</td>
<td>Men having Sex with Men</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante Natal Clinic</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Workers</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial Sex Workers</td>
</tr>
<tr>
<td>TIs</td>
<td>Targeted Interventions</td>
</tr>
<tr>
<td>BB</td>
<td>Blood Banks</td>
</tr>
<tr>
<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission of HIV</td>
</tr>
<tr>
<td>BBC</td>
<td>British Broadcasting Corporation</td>
</tr>
<tr>
<td>DD</td>
<td>Door Darshan</td>
</tr>
<tr>
<td>EQAS</td>
<td>External quality assessment scheme</td>
</tr>
<tr>
<td>FRU</td>
<td>First Referral Units</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
</tr>
<tr>
<td>SMOs</td>
<td>Social marketing organization</td>
</tr>
<tr>
<td>FHAC</td>
<td>Family Health Awareness Camps</td>
</tr>
<tr>
<td>SAEP</td>
<td>School AIDS Education Programme</td>
</tr>
<tr>
<td>TOT</td>
<td>Training of Trainers</td>
</tr>
</tbody>
</table>
The HIV epidemic is about us. It is about fathers and mothers, children, sisters and brothers, loved ones, friends and neighbors. It affects people we know, people we love and care for, as well as people that we may have never met, but who inspire us to lead and live healthy lives.

We care.

We need to motivate, equip and empower the people of this, our country, to protect themselves.

We confront a stark reality: HIV could happen to any of us. But each and everyone can be saved from infection with appropriate information on prevention.

Our commitment is to prevent the spread of HIV.

To provide care, support and treatment to mothers, children and those living with HIV, who access our health services and to mitigate the impact of the epidemic on communities.

HIV/AIDS is not a numbers game. It is about acknowledging the seriousness and urgency of the problem and putting in place a comprehensive response to address it.

History tells us that countries that have turned back the tide of HIV infection have been those whose leaders have addressed the challenge of HIV with complete openness and honesty. In India, we already have the highest possible political commitment for meeting the challenges posed by the spread of HIV/AIDS. The innumerable initiatives implemented over the past two years have elevated the government led national response to a new trajectory.

The National AIDS Control Organisation (NACO ) in the Ministry of Health & Family Welfare, Government of India, directs and co-ordinates the national AIDS
prevention and control programme across the country. This Annual Report spans two years, 2002-03, and 2003-04 (up to 31st July, 2004), and details NACO’s efforts at bringing about a paradigm shift in the implementation of the AIDS prevention and control programme.

Over these two years, the National AIDS Control Organisation has:

✦ moved towards more robust and transparent estimation, in the HIV sentinel surveillance and completed a mapping of high risk and vulnerable groups in over 30 states and union territories.

✦ operationalised the National Blood Policy, 2002 with a hands on Action Plan on Blood Safety, 2003. This Action Plan, now being implemented across the country, has mandated revelation of HIV status to the result seeking donor, and brought in accreditation of blood banks.

✦ expanded the agenda on care & support and introduced anti-retroviral treatment for people living with AIDS.

✦ mobilized grants from the Global Fund on AIDS, TB and Malaria of nearly US $ 280 million for expanding services on preventing HIV transmission to new born infants, managing the HIV-TB co-infection and extending antiretroviral treatment for AIDS.

✦ moved beyond an exclusive reliance on awareness generation, to augmenting and expanding services for people living with AIDS.

✦ built strong, strategic partnerships to harness diverse service delivery capabilities, distribution networks, and resources. Some of these partnerships are with: the national and state networks of HIV positive people, elected representatives through the Parliamentary Forum on AIDS, women’s groups, industry coalitions and the private sector, the International AIDS Vaccine Initiative, Bill and Melinda Gates Foundation, Population Council, Population Foundation of India, Lawyers Collective, the International Planned Parenthood Federation, and the Global Fund on AIDS, TB and Malaria, and also many multilateral and bilateral organisations.

At NACO we have responded to the voices of ordinary men, women and young people from across our towns and villages. In order to bridge the gap in information and health education, NACO has, during 2004, supported the Department of Posts and Telegraph to print 15 lakh postcards, priced at 25 paisa each, with messages on HIV/AIDS, which are being sold / distributed across the states of Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan, Orissa, Jharkhand, Uttarakhand, and Chattisgarh. In another unique initiative during 2004, NACO has
disseminated key messaging (54 panels) on HIV/AIDS inside two trains of the spanking new Delhi Metro, from Shahdara to Rithala.

De-mystifying the known routes of HIV transmission, dramatically increasing the provisioning of services, bringing centre stage the dialogue on microbicides and the female condom, installing blood storage centres below district levels and bringing in antiretroviral treatment are enabling people living with HIV/AIDS to break their silence. NACO’s responses have been need based, demand driven, and people-centered.

Much of our programme was previously concentrated across the high prevalence states. We have now commenced widespread installation of sites for service delivery across the low prevalence states, example, for preventing HIV transmission from parent to child, centres for voluntary counselling and testing, and clinics for sexually transmitted infections. From September, 2004 we will extend antiretroviral treatment to identified hospitals in these states.

Mainstreaming the dialogue on HIV/AIDS with the Ministries of Social Justice and Empowerment, Railways, Youth Affairs, Education, Women and Child Development, Steel, Defence, and Labour, among others, are a beginning in building capacity within government to respond to the spread and prevalence of HIV.

August 2004

Meenakshi Datta Ghosh
Special Secretary and Project Director
National AIDS Control Organisation
Inauguration of NACO exhibition booth at 15th International AIDS Conference, July 2004, Bangkok
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1 Introduction


1.1.1 The First National AIDS Control Project (NACP) was funded primarily by a World Bank IDA Credit of US$84 million (1992-99). NACP-1 was a start-up investment to launch interventions for HIV prevention, so as to slow the spread of HIV, and mitigate the impact of AIDS.

1.1.2 During 1992-99, we succeeded in setting up the National AIDS Committee, the National AIDS Control Board, the National AIDS Control Organisation (NACO) and the State AIDS Cells. We:

- strengthened systems for HIV sentinel surveillance;
- installed centres for voluntary counseling and testing in medical colleges;
- converged the national programme on sexually transmitted diseases with the national AIDS control programme, for bringing about synergy in STD control efforts;
- stepped up awareness generation activities, along with advocacy and NGO involvement;
- modernise blood banks with campaigns to increase voluntary blood donation;
- strengthened the management and treatment of sexually transmitted infections; and
- promoted condom use

1.1.3 While significant progress was achieved in building some capacity at state levels, there remained some significant limitations in the implementation of NACP. The centralization of planning and implementation did not facilitate divergent priority setting and management across state governments. There was uneven implementation of project activities at state-levels. The sentinel surveillance could not be conducted across all states, and this led to inadequate information regarding the progress of the epidemic. Vulnerable groups were not all identified, and issues surrounding care and support of people living with HIV could not be fully addressed. The IEC remained somewhat limited, and community involvement was inadequate.
1.2 Second National AIDS Control Project (1999-2006)

1.2.1 The Second National AIDS Control Project, commenced in November 1999, similarly with IDA World Bank funding, and has recently been extended to March 2006. The NACP-II has two key project objectives:

- to reduce the rate of growth of HIV infection in India; and
- to strengthen India's capacity to respond to HIV/AIDS

1.2.2 NACP - II has two components with appropriate interventions defined:

(ii) delivering cost-effective interventions to contain the spread of HIV/AIDS through

1. targeted interventions for groups at high risk
2. preventive interventions for the general community, and
3. low cost AIDS care

(iii) strengthening capacity through

1. institutional strengthening, and
2. inter-sectoral collaboration (public, private, and voluntary).

1.2.3 The outcomes envisaged in the Second National AIDS Control Project are to keep HIV sero-prevalence below 5 percent of the adult population in high prevalence states\(^1\), below 3 percent in the moderate prevalence states\(^2\), and below one percent in the low prevalence states\(^3\) where the epidemic.

1.2.4 Through the second national AIDS control programme (1999-2006), NACO has built upon previous achievement, in several key areas, identified gaps and sought to bridge these.

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\(^1\) Tamilnadu, Karnataka, Andhra Pradesh, Maharashtra, Manipur and Nagaland

\(^2\) Gujarat, Goa and Pondicherry

\(^3\) All the remaining states

A visual depiction of the components of the Second NACP, reads as follows:

**SURVEILLANCE**
- Annual Sentinel Surveillance
- AIDS Case Detection
- Mapping of high risk groups
- Behavioural Surveillance

**PREVENTION**
- Targeted interventions
  - STD treatment
  - Condom promotion
  - Inter-sectoral collaboration
  - Between public private and voluntary sectors
  - Training of medical, paramedical partners
- Holistic IEC and social mobilisation
  - Blood safety
  - Voluntary counselling and testing
  - AIDS Vaccine Initiative
  - Sensitising young adults
  - Workplace interventions

**CARE**
- Low cost care & support
  - Prevention of perinatal HIV transmission
  - Management of HIV-TB Co-infection
  - Treatment of Opportunistic Infections
  - Piloting ART
  - Post Exposure Prophylaxis
  - Community Care Centres
(i) Known Routes of HIV Transmission

There is not "one" single HIV epidemic in India. A "number of distinct epidemics" often co-exist, sometimes within the same state, with different vulnerabilities, stage of maturity and impact. The overwhelming and predominant route of transmission of HIV/AIDS in India is the heterosexual route (85.69%). However, in north-eastern India, the spread of HIV has been fuelled primarily by injecting drug use.

Routes of HIV transmission, 2003

HIV prevalence across the country is about 0.98 percent in the age group 15 - 49 years. India is categorized as a low prevalence nation. A major concern is that in view of our large population, a mere 0.1 per cent increase in the prevalence rate would increase the numbers living with HIV by over half a million.

- HIV continues to be concentrated amongst the poor and marginalised sections of society, including female sex workers, injecting drug users, men who have sex with men and migrant labourers.
- HIV is spreading beyond "at risk" groups to the general population, and from urban to rural areas.
- The number of women infected is steadily rising: one in every four AIDS cases reported is a woman.
(ii) HIV Sentinel Surveillance

An annual HIV sentinel surveillance survey has been institutionalized over the years, in order to monitor trends of HIV infection in specific high-risk groups as well as low risk groups. For purposes of HIV sentinel surveillance, high-risk segments of the population include people attending STD clinics, MSM clinics and drug de-addiction centres. Low risk segments include mothers attending antenatal clinics, and in fact this category is taken as proxy for the general population.

Sentinel sites are located among the above cited population segments, so that blood samples are accessed both from high risk groups as well from low risk groups at regular intervals through an "unlinked anonymous" procedure.

(iii) 2002-2004: More robust HIV estimation

During 2002, the annual HIV sentinel surveillance round was conducted from 1st August 2002 in 384 sentinel sites, and during 2003, from 1st August, 2003 to 15th November, 2003, in 455 sentinel sites.

Beginning in October 2002, the following steps were taken to validate the methodology of estimation and to ensure professional peer review in the analysis of primary data.

(i) The Indian Council of Medical Research was requested to lead the exercise on validation of methodology.

(ii) DG ICMR constituted a core group of experts including eminent epidemiologists and biostatisticians (national and international), with WHO and UNAIDS as members. ICMR and NACO convened a series of Expert Group Meetings to review the methodology of estimation, including the processes followed in analysis of primary data.

(iii) Previously this task was handled exclusively by the National Institute of Health and Family Welfare (NIHFW). Beginning and including HIV estimation for 2002 onwards, an ICMR body, the Institute for Research in Medical Statistics (IRMS) was identified as a nodal organization for analysing the Sentinel Surveillance data.

In pursuance of the recommendations of this Expert Group, the HIV infections for the year 2002 were estimated at 4.98 million, and for the year 2003 at 5.1
million. Most significantly, the assumptions for HIV estimation adopted in 1998, were validated for the first time, with inputs from community level studies.

The HIV estimates for 2003, include an estimation of the HIV infections among children and among some high-risk groups like female sex workers, not previously attempted.

The 4.58 million HIV infections estimated in 2002 saw an increase of 6.1 lakh HIV infections over those estimated in 2001 (3.97 million). In the year 2003 we note a lower increase of 5.3 lakhs HIV infections over those of the previous year. This demonstrates that while the spread of HIV continues, there is no significant upsurge in the number of new infections, and in fact the rate of growth of HIV has registered a slowing down.

HIV Estimates : India  
1981 to 2003

(iv) HIV Sentinel surveillance 2002-03

Sentinel surveillance for HIV was first organised in 1994, at 55 sentinel sites which grew to 180 HIV sentinel sites in 1998. These continued to increase. From 2002-04, the numbers of HIV sentinel sites grew from 384 to 670.

During year 2002, the HIV sentinel surveillance round was conducted from 1st August 2002 to 15th November 2002 in 384 sentinel sites with inclusion of 64 new sites. The risk group distribution of these sites is, 166 sites in STD clinics, 200 sites in Antenatal clinics, 13 sites among IDUs, 3 sites for MSM and 2 sites for CSWs. A statement indicating State-wise HIV prevalence in various risk groups during 2002 and its comparison since 1998 is enclosed.

Based on consistent high prevalence of HIV as shown by HIV sentinel data of the previous three rounds, various districts has been identified as high prevalence districts for intensive programme action.
For the HIV sentinel surveillance, 2002, all samples collected were subjected to testing for "Hepatitis-B, Hepatitis-C", and VDRL screening, to know the prevalence levels of these infections, as other biological markers of risk.

During year 2003, the sentinel surveillance round was conducted from 1st August 2003 onwards in 455 sentinel sites with inclusion of 71 new sites. The risk group wise distribution of these sites is 165 sites in STD clinics, 272 sites in Antenatal clinics, 13 sites among IDUs, 3 sites for MSM and 2 sites for CSWs.

Inclusion of data from high-risk populations through targeted interventions sites and the additional sub-set of rural samples though ante-natal clinics were key features of HIV sentinel surveillances, 2003.

The improving coverage and outreach of the HIV sentinel sites each year is indicated below:

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of Sites</td>
<td>232</td>
<td>320</td>
<td>384</td>
<td>455</td>
<td>670</td>
</tr>
</tbody>
</table>

A break up of the HIV sentinel surveillance (HSS) sites in the year 2004 is:

<table>
<thead>
<tr>
<th>Category of HSS site</th>
<th>STD</th>
<th>ANC</th>
<th>ANC-R</th>
<th>FSW</th>
<th>IDU</th>
<th>MSM</th>
<th>TB</th>
<th>TI sites (FSW, MSM, IDU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nos. of HSS sites (670)</td>
<td>166</td>
<td>271</td>
<td>124</td>
<td>2</td>
<td>13</td>
<td>3</td>
<td>7</td>
<td>84</td>
</tr>
</tbody>
</table>

Evidence Based Planning
### Tracking of the spread & prevalence of HIV

<table>
<thead>
<tr>
<th>Year</th>
<th>ANC / ANC-R</th>
<th>HIV Sentinel Surveillance Sites</th>
<th>FSW</th>
<th>No. of HIV sentinel sites</th>
<th>Estimates of infection (in million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>94</td>
<td>77 09 -</td>
<td>-</td>
<td>180</td>
<td>3.5</td>
</tr>
<tr>
<td>1999</td>
<td>94</td>
<td>77 09 -</td>
<td>-</td>
<td>180</td>
<td>3.7</td>
</tr>
<tr>
<td>2000</td>
<td>118</td>
<td>104 08 02</td>
<td>-</td>
<td>232</td>
<td>3.86</td>
</tr>
<tr>
<td>2001</td>
<td>173</td>
<td>131 12 02</td>
<td>02</td>
<td>320</td>
<td>3.97</td>
</tr>
<tr>
<td>2002</td>
<td>200</td>
<td>166 13 03</td>
<td>02</td>
<td>384</td>
<td>4.58</td>
</tr>
<tr>
<td>2003</td>
<td>271</td>
<td>166 13 03</td>
<td>02</td>
<td>455</td>
<td>5.10</td>
</tr>
<tr>
<td>2004</td>
<td>272 / 124</td>
<td>166 13 03</td>
<td>02</td>
<td>670</td>
<td>-</td>
</tr>
</tbody>
</table>

### Adult HIV prevalence-2003

- > 1% Antenatal Women
- > 5% High Risk Group
- < 5% High Risk Group
Based on HIV prevalence among various risk groups during each round, the States and Union Territories in the country are categorised as high, moderate or low as per details given below:

### High prevalence States

**45 districts in the high prevalence states of**

Maharashtra, Tamil Nadu, Manipur, Andhra Pradesh, Karnataka and Nagaland have been identified as high prevalence districts, based on the consistently high prevalence levels of HIV detected by the three most recent rounds of HIV Sentinel Surveillance.

These six states are cited as high prevalence because the HIV prevalence rates exceed 5 percent among high-risk groups and exceed 1 percent among antenatal women.

### Moderate prevalence States

The states of Gujarat, Goa and Pondicherry which share geographical borders with the high prevalence states report HIV prevalence exceeding 5 percent among high-risk groups but less than 1 percent among antenatal women.

Four districts in these states have been identified as high prevalence districts, based on the consistently high prevalence levels of HIV detected by the three most recent rounds of HIV Sentinel Surveillance.

### Low prevalence States

Apart from the six high prevalence and three moderate prevalence states, the remaining states and union territories fall into the low prevalence category because the HIV prevalence rate is less than 5 percent in high risk groups, and less than 1 percent among antenatal women.

Based on consistent high prevalence of HIV as shown by HIV sentinel data of last three rounds, 49 districts in the country have been identified as high prevalence districts for intensive programme action.

(v) **49 high prevalence districts :**

<table>
<thead>
<tr>
<th>S.No</th>
<th>Name of State/ UT</th>
<th>Name of the district</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Andhra Pradesh (7)</td>
<td>Hyderabad</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chittoor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vishakhapatnam</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kurnool</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guntur</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Warrangal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>East Godavari</td>
</tr>
<tr>
<td>2.</td>
<td>Goa (1)</td>
<td>South-Goa</td>
</tr>
<tr>
<td>3.</td>
<td>Gujarat (3)</td>
<td>Ahmedabad</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Baroda</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surat</td>
</tr>
<tr>
<td>S.No</td>
<td>Name of State/UT</td>
<td>Name of the district</td>
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<tr>
<td>------</td>
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<tr>
<td>4</td>
<td>Karnataka (10)</td>
<td>Bangalore</td>
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<tr>
<td></td>
<td></td>
<td>Dakshin Kannada (Mangalore)</td>
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<td></td>
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<td>Mysore</td>
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<td></td>
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<td>Dharwad(Hubli)</td>
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<td></td>
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<td>Bijapur</td>
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<td></td>
<td></td>
<td>Belgaum</td>
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<tr>
<td></td>
<td></td>
<td>Shyamraj Nagar (Kollegal)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bellary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gulgarga</td>
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<tr>
<td>5</td>
<td>Maharashtra (14)</td>
<td>Nagpur</td>
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<tr>
<td></td>
<td></td>
<td>Kolhapur</td>
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<td></td>
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<td>Sangli</td>
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<td>Nasik</td>
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<td>Pune</td>
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<td></td>
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<td>Satara</td>
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<td></td>
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<td>Jalgaon</td>
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<tr>
<td>6</td>
<td>Manipur (4)</td>
<td>Imphal</td>
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<td>Bishnupur</td>
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<td>7</td>
<td>Nagaland (3)</td>
<td>Kohima</td>
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<td>8</td>
<td>Tamil Nadu (7)</td>
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<td>Coimbatore</td>
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### HIV Trends in West Bengal

![HIV Trends in West Bengal](image-url)

**Legend:**
- STD
- ANC
- IDU
(vi) Mapping of Vulnerable Populations

Evidence based planning through mapping

For evidence based planning of all interventions for HIV prevention and for the, care, treatment and support of people living with HIV/AIDS, vulnerable populations are mapped in order to identify location, size, and trends in movement. While mapping gives us a macro picture, at state levels, every NGO is expected to conduct a needs assessment in their proposed area of operation to ascertain the baseline information in terms of existing high risk behaviour patterns and availability of services.

30 states have already completed detailed mapping of vulnerable populations so as to earmark the areas where these interventions need to be prioritized. The mapping is being conducted by external agencies of repute are now on to address the needs of scattered high risk core groups, wherever identified.

State specific outcomes continue to define state response, particularly in respect of locating the targeted interventions. We want to ensure that NGOs dedicated to working with particular groups, if found eligible, are assigned to these groups in designated areas. The AIDS control societies are directing the implementation of 933 targeted interventions. In December 2003, the break up was:

<table>
<thead>
<tr>
<th>Intervention Type</th>
<th>Number</th>
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<tbody>
<tr>
<td>CSW Interventions</td>
<td>209</td>
</tr>
<tr>
<td>Truckers Interventions</td>
<td>190</td>
</tr>
<tr>
<td>Migrant Workers Interventions</td>
<td>249</td>
</tr>
<tr>
<td>IDU Interventions</td>
<td>74</td>
</tr>
<tr>
<td>Street Children Interventions</td>
<td>26</td>
</tr>
<tr>
<td>MSM Interventions</td>
<td>25</td>
</tr>
<tr>
<td>Prison Inmates Interventions</td>
<td>56</td>
</tr>
<tr>
<td>Others</td>
<td>56</td>
</tr>
</tbody>
</table>

States where mapping is in progress are:
- Andaman & Nicobar Islands
- Pondicherry
- Rajasthan
- Tripura
- Manipur
- Haryana
- Goa
(vii) AIDS case detection:

As per the standard AIDS case definition, 78,229 cumulative AIDS cases have been reported from States and Union Territories.

Epidemiological analysis of reported AIDS cases reveals that:

1. AIDS is increasingly affecting young people in the sexually active age group. The majority of the HIV infections (87.7%) are in the age group of 15-44 years.

2. The predominant mode of transmission of the HIV infection is through heterosexual contact (85.7%), followed by injecting drug use (2.2%), blood transfusion and blood product infusion (2.6%), perinatal transmission as 2.7% and others as 6.8%.

3. In the HIV sentinel surveillance, 2003, males account for 73.5% of AIDS cases and females 26.5%. The ratio being 3:1.

4. The most predominant opportunistic infection among AIDS patients is tuberculosis, indicating a potential future spread of the HIV-TB co-infection.

AIDS Case Surveillance data serves to supplement the data derived from the HIV Sentinel Surveillance in monitoring the spread of the HIV epidemic. Significantly, it contributes to the planning of hospital and home/community based care for AIDS patients, through the National AIDS Control Programme.
Realizing the need for accurate behavioural data, behavioural surveillance has figured as an important activity in the Second AIDS Control Project. A protocol on behavioural surveillance has been finalized after pre-testing, with inputs from behavioural scientists and sociologists.

An external agency has completed Round one of the Behavioural Surveillance on HIV, across high risk groups and the general population in all states and union territories. This has provided useful information to understand the extent of risk behaviour relevant for HIV, across the states.

The next wave of BSS at the national level is being planned towards the end of NACP-II to monitor trends in behaviour as well as to assess impact of programme activities.
(ix) **Computerised Management Information System (CMIS):**

A computerised management information system is multi functional. The CMIS:

- Ensures that a program is appropriate and relevant to the needs of the local population
- Provides evidence on whether a specific intervention is effective
- Permits appraisal of process, inputs and outputs
- Compiles data which can be used for advocacy
- Tracks trends in utilization of services
- Maps behaviour changes concurrently

**Mechanism for flow of data**

![Mechanism diagram](image)

**Computerised Management Information System (CMIS)**

**Input Format**

- Filled input format from primary data collection unit to SACS
  - 1-7th of the next month
- SACS / MACS to NACO (electronically)
  - 1–15 of the next month

**Process**

- Data entry of schedules at State AIDS Control Society

**Output**

- State report
- Selected reports can be viewed on Internet
- National report

**Dynamic Reporting**
Proportion of voluntary blood donors among all blood donors -
Monthly (All Blood Banks), Reporting Period : November 2003

*Map Report Generated through AIDS Monitor Pro ver 4.5
(CMIS) National AIDS Control Organisation

Proportion of voluntary (Direct) walk-in people tested at VCTC (Monthly)
Reporting Period : December 2003

*Map Report Generated through AIDS Monitor Pro ver 4.5
(CMIS) National AIDS Control Organisation
Challenges in CMIS

- MIS data is sparingly used for planning, or even for developing differential strategies. We need programme managers at state levels to commence using the CMIS data for actual decision making.
- Current quality, completeness, and utility of data needs some refinement. We are rapidly improving the programming tool-kit, as well.

(x) Monitoring and Evaluation

This system provides critical information continuously about the course of the AIDS epidemic in India and guides the National AIDS Control Organisation (NACO) and State AIDS Control Societies (SACS) in making decisions and taking corrective measures, when necessary. The information generated by the M & E system indicates how well the programme is being implemented and helps identify bottlenecks.

For more effective Monitoring and Evaluation of the Second National AIDS Control Project at national and state levels, the following is in hand:

- refining and strengthening the Computerised Management Information System (CMIS) at the national and state levels;
- training health care providers, programme managers, and administrators in the more effective evidence based health programme management;
- Commencing an end line behavioural surveillance survey, with the baseline behavioural surveillance as a referral.

Currently, both the CMIS and the Project Finance Management System (PFMS) are operating successfully and providing critical inputs that serve to improve programme management at all levels.

We need to promote a culture among programme managers to take decisions based on emerging and available evidence, instead of persisting with a modality based on previous trends. Promoting the optimal use of data is a priority area in the immediate future.
4 Prevention

(i) Information, Education and Communication (IEC)

Generating awareness about HIV/AIDS, and about the services on prevention of HIV, and for care, treatment and support of those infected and affected has always been critical to our efforts to stem the growth and spread of HIV/AIDS. Increasingly, evidence suggests that there is a need to move beyond awareness generation to behaviour change communication. IEC efforts are mindful about being sensitive to the concerns of the people living with AIDS, and we attempt being gender balanced and ethical.

The strategy for awareness generation among the general population is operationalized at two levels. At the national level, NACO is responsible for policy and strategy formulation and for framing guidelines for IEC activities. Advocacy with the elected representatives and with the media, inclusive of the regional media and the vernacular press receives special focus at the national level. At the state level, the state AIDS control societies conduct Communication Needs Assessment Studies. This enables them to evolve state specific IEC strategies that address local priorities within the overall national strategy and framework. Most of the field action i.e. disseminating the IEC at the grassroots takes place below state and district levels. However, to ensure a collective response and shared understanding of sensitivities while disseminating IEC, NACO undertakes mass media campaigns and attempts to provide states with prototypes and some leads on material generation.

Over the last two years, the IEC needs in the different states have been reviewed. Project Directors and IEC officers from the state AIDS control societies have participated in inter state experience sharing and regional strategy building workshops where IEC is projected as a means of raising awareness and communicating a need for behaviour change, generating a demand for services, and a tool for debunking myths and misconceptions, dispelling stigma and discrimination, and breaking the silence. A series of regional and state level workshops have provided hand holding to states to build capacity and strengthen them to formulate and develop appropriate state specific action plans and IEC material.
The Centre For Media Studies, New Delhi, a research agency, was entrusted the task of assessing and evaluating the contents of the IEC materials developed in states, as well as the processes and road map followed to developing these materials. Recommendations and outcomes of this evaluation would feed into future strategies for IEC at state and national levels.

The IEC strategy and action plans are also guided by the annual HIV Sentinel Surveillance, Behavioural Surveillance Survey (BSS), Communication Needs Assessment (CNA), Mapping of high risk groups and bridge populations, and by the CMIS. With the changing profile of the HIV/AIDS epidemic, the Guidelines for IEC are modified, as necessary.

The evidence suggests that there is an unmet need for information:

- on the four known routes of HIV transmission,
- on the veracity, or otherwise, of the most common myths and misconceptions about the HIV infection,
- on the modalities for steering clear of susceptibility to HIV
- on the availability of services for HIV prevention, and for care, treatment, and support of those who are infected and affected by HIV;

Beyond a doubt, the role of IEC in alleviating stigma and discrimination towards those living with HIV is central to all communication efforts. Information and communication on HIV/AIDS must motivate people to utilize services provided through the national AIDS control programme like STI treatment, counseling, testing, medicines for opportunistic infections, and most recently anti-retroviral treatment for people living with AIDS. IEC initiatives should succeed in mobilizing other sectors of society to help integrate HIV/AIDS messages into their existing activities, example in the work place across the formal and informal sectors, and should create a supportive environment for the care and rehabilitation of people living with HIV/AIDS.

Some highlights of the activities carried out during the period 2002-04 are:

**Television**

- Beginning in late 2001, and implemented from June 2002 onwards, NACO entered into a partnership with Prasar Bharati (Ministry of Information and Broadcasting, Government of India) and the BBC World Services Trust to
produce high quality television spots, for telecast over the national news channel at prime time. Two serials in the infotainment format, were similarly produced and were telecast on prime time slots of Doordarshan, titled Jasoos Vijay and Hath Se Hath Mila. While Jasoos Vijay was a detective thriller telecast on Sunday evenings, the other serial, Hath Se Hath Mila was a youth show in a virtual reality format. The youth show was initially telecast on DD Metro but graduated to being beamed on the National Channel on Sunday mornings. The detective serial was awarded the Indian Telly Award while Hath Se Hath Mila received the Commonwealth Broadcasting Association Award. The TV spots campaign became a critical component under the tripartite partnership for which DD provided substantial free airtime. Some of the TV spots have been produced by the best available talent in the country. Initially the partnership covered only three states i.e. Rajasthan, Delhi and Uttar Pradesh. The second phase of the partnership saw the coverage increase to include South Indian States and most of North and East India.

- NACO sponsored a health magazine Kalyani which is telecast in the Hindi speaking states of UP, MP, Chattisgarh, Bihar, Jharkhand, Assam, Orissa and Rajasthan. The segments on HIV/AIDS focus on rural populations and are produced at the state level DoorDarshan Kendras so as to reflect local priorities, predilection and content. The HIV/AIDS chapter in the Kalyani programme is telecast during the months of December and January, in a magazine format that includes field interviews, success stories, panel discussions, quiz competitions, contests etc.

- Celebrities have endorsed messages on HIV/AIDS prevention and these have been telecast on DD and on private television networks, which has enlarged the audience base.

**Radio**

All India Radio broadcasts NACO sponsored programmes, every week. During 2003-4, the erstwhile programme Jiyo aur Jine Do was revamped and relaunched on the Primary Channel and Vividh Bharati stations of AIR and re-titled "Jeevan Hai Anmol". Another programme called "Lets Talk" was launched on FM Delhi. While the FM programme is directed towards the urban audience, "Jeevan Hai Anmol" is addressed to a mass audience. The state AIDS control societies are roped in to provide field level inputs and to highlight issues of significance relating to HIV/AIDS. These are then woven into these radio programmes. A series of spots
have also been produced, which are broadcast on the occasion of events like Voluntary Blood Donation Day (1st October), World AIDS Day (1st December), at appropriate times.

Print

The bulk of print advertising is done by AIDS control societies in the form of materials such as posters, handbills, flip charts, flash cards, handouts, information booklets, stickers, wall hangings, etc. Very often, they utilize the prototypes forwarded by NACO, with appropriate modification. NACO has developed a lot of print material like posters, booklets, folders etc. which has been disseminated to all AIDS control societies, and other peripheral units. Prominent campaigns on which NACO has worked are, for instance, a poster series on stigma and discrimination, voluntary blood donation, routes of transmission, care and support. We have had, through DAVP, regular insertions in the newspapers commemorating various events like World AIDS Day and Voluntary Blood Donation Day etc.

During 2004 NACO took the initiative to support the Department of Posts & Telegraphs in printing 15 lakh post cards with messages on HIV/AIDS. This postcard, priced at 25 paise each, carries a multicolor advertisement on the half side, which contains the address. This medium has enabled NACO to reach out to the lowest economic strata of the population who use postcards to communicate with their near and dear ones. These postcards have been distributed across the states of Madhya Pradesh, Chattisgarh, Rajasthan, Uttar Pradesh, Uttaranchal, Bihar, Jharkhand and Orissa.

Outdoor Media

Hoardings, wall writings, kiosks etc. have been used appropriately to inform and communicate messages on HIV/AIDS.

- During 2003-04, NACO hired some hoarding space along prime roads of Delhi, and at prominent road junctions to disseminate messaging on the four known routes of transmission, and on the "Live and Let Live" campaign for the World AIDS Day, 2003.

- In another unique initiative during 2004, NACO has disseminated key messaging on HIV/AIDS inside two Delhi Metro trains. The messages have
been put up on 54 panels of size 50X 21 cms in each of two trains running from Shahdara to Rithala of the Delhi Metro. The total duration of the campaign is six months.

**Exhibitions**

State AIDS Control Societies, as well as the Directorate of Field Publicity (DFP), a media unit of the Ministry of Information and Broadcasting, have been provided with mobile exhibition kits produced by NACO through DAVP in the appropriate regional languages. NACO has also oriented the personnel of the Directorate of Field Publicity about more effective dissemination of this material in the field. These kits were most effectively used in the countrywide 'Swasthya Jagruka Mah', the month long (15 February - 15 March 2004) integrated health exhibition organized in every parliamentary constituency sponsored by the Ministry of Health & family Welfare, Government of India.

**Folk Media**

This is extensively used for dissemination of messaging at the grassroots to complement and supplement other forms of IEC, mostly through the Song and Drama Division, Ministry of Information & Broadcasting. This Division of the Ministry of I&B has been thoroughly sensitized by NACO, to address issues surrounding HIV/AIDS. This is a crucial channel of communication, widely relied upon by the AIDS control societies.

**Events**

The World AIDS Day, December 1 and the Voluntary Blood Donation Day, October 1, mark two high points, each year, in NACO's efforts to generate awareness, and motivate behaviour change so as to prevent the spread of HIV, dispel myths and misconceptions surrounding the illness and reduce as much as possible HIV related stigma and discrimination. On World AIDS Day, NACO sponsors and conducts special campaigns and various activities at the national, state & district levels.

The monitoring and evaluation for IEC is being examined. We need to further refine the procedural bottlenecks involved, capture the quality of output, and ensure that IEC becomes a user friendly tool for learning, planning and management. Towards this end, a CMIS format for collecting data on IEC has been made operational.
(ii) Advocacy for political commitment towards HIV/AIDS

Community mobilization is a crucial strategy for HIV/AIDS prevention, management and control. A key issue here is that developing this mobilization requires collaboration between government and non-government stakeholders, while constantly also involving individuals infected and affected with HIV/AIDS. Mass scale community mobilization can only be achieved through frequent and continued advocacy with elected representatives, faith leaders, and opinion makers, at the national, state, district and panchayat levels.

In July 2003, the Parliamentarians Forum for HIV/AIDS (PFA) organized India’s first National Convention of Elected Representatives on HIV/AIDS, inaugurated by the then Prime Minister of India. The PFA was earlier launched by the Prime Minister on 11th May 2002. Never before had the elected representatives from three tiers of the parliamentary democracy in India come together on a single platform to pledge support towards reversing the spread of HIV/AIDS, and mitigating its impact. It was even globally, a most unique event. Political advocacy towards combating HIV/AIDS was at its best. The Prime Minister, Deputy Prime Minister, Speaker of the Lok Sabha, Leader of the Opposition, State Chief Ministers and Health Ministers, Members of Parliament, legislators from state assemblies, panchayat members from gram sabhas, mayors from city municipal bodies, and from diverse political affiliations, all attended the meeting. In a formidable display of solidarity, this National Convention saw close interaction between people living with HIV, NGOs, CBOs (community based organizations), and elected representatives. The meeting unanimously adopted a Declaration of Commitment from the Political Leadership to Combat HIV/AIDS, endorsed by all major political parties. This is essentially an Action Plan whose implementation will be pursued by elected representatives at every level. Political parties have affirmed their collective commitment to mobilize communities, involve civil society and to create the enabling environment necessary to fight HIV/AIDS.

State Legislative Forums on HIV/AIDS have already been established in Andhra Pradesh, Assam, Bihar, Delhi, Karnataka, Manipur, Nagaland and West Bengal. The Parliamentarians Forum on AIDS has been playing a pivotal role in keeping HIV/AIDS high on the political agenda.

Advocacy efforts in many states have sometimes been directed by Chief Ministers...
who have been leading from the front and have brought HIV AIDS centre-stage. Some Chief Ministers instructed party colleagues to talk about HIV AIDS for two minutes in every public appearance.

AIDS Control Societies focus on advocacy efforts at district and panchayat levels, through a series of sensitization workshops. They provide general education on HIV/AIDS, including information on the rights of people living with HIV and they focus on reducing the stigmatization of HIV infected people by sensitizing their families, friends, health care workers, and other community members. These efforts are facilitated by advocacy tools, such as the booklet prepared by NACO to educate and sensitize panchayat members. The booklet has been distributed to all states for translation and appropriate use.

NACO is presently attempting to enlist religious leaders as partners in the fight against AIDS. A notable example involves Muslim religious leaders in the state of Jammu and Kashmir who are distributing verses of the Koran which advocate healthy and safe life styles in an effort to educate communities about HIV and AIDS. In the northeastern region of the country, the church has been closely involved in the fight against HIV/AIDS. Religious leaders of stature have been involved extensively by many other states in an attempt to reach out to their wide following and captive audiences.

**Declaration on Political Leadership in Combating HIV/AIDS**

Adopted in New DELHI on 26 July 2003 at the India's first National Convention of the Parliamentary Forum on HIV/AIDS, on July 26-27

We, the activists of the political parties

RECOGNIZE that as political workers we have a crucial role, both individually and collectively as the link between the people and the government, as advocates for the rights and needs of people, as legislators to make laws to protect these rights, and as policy-makers to mobilize resources, involve civil society and create the enabling environment necessary to fight HIV/AIDS.

ARE CONVINCED that together we can overcome the HIV/AIDS epidemic,
prevent its further spread, work for an enabling environment and alleviate the impact of the epidemic.

Have gathered at this National Convention of Elected Representatives being held today at Vigyan Bhawan, New Delhi, to reaffirm our collective commitment to mobilize communities against the spread and impact of HIV/AIDS. We solemnly declare to:

ENSURE leadership by everyone in his/her area of responsibility in the fight against HIV/AIDS by intensifying advocacy, allocating and raising resources and guiding the response to the HIV/AIDS epidemic both in prevention and care within our constituencies in particular and the country as a whole;

PROMOTE a positive environment by confronting stigma, silence and denial, eliminating discrimination and ensuring the full enjoyment of all human rights and fundamental freedom by people living with HIV/AIDS.

ASSURE gender equality and the empowerment of women as a fundamental element in the reduction of the vulnerability of women and children to HIV/AIDS.

TAKE STEPS to ensure that the response includes a focus on youth

INTENSIFY AND STRENGTHEN multisectoral collaboration and mobilizing for full and active part of a wide range of non-governmental organizations, the business sector, media, community based organizations, religious leaders, families, citizens as well as people infected and affected by HIV/AIDS in the planning, implementation and valuation of the response to HIV/AIDS.

(iii) Focusing on Safe Blood

Ensuring the widespread availability of safe and clean blood is a critical component of the National AIDS Prevention and Control Programme. NACO articulates policy, and the operational strategies for a country-wide programme on blood safety, supports strengthening of infrastructure and ensures quality in all aspects of service delivery.
Developing Infrastructure

During 1992-1999, 815 public sector blood banks and those run by charitable organizations were modernized, 40 blood component separation facilities were established and a countrywide network of HIV testing facilities was set up.

The National and State Blood Transfusion Councils were registered as societies in 1996, to be supported by the National AIDS Control Organisation (NACO). At state levels, these councils maintain oversight over the voluntary blood donation, the appropriate clinical use of blood, training and manpower development, and supervision of the blood safety programme.

During 1999-2006 (phase II of the National AIDS prevention and control programme), NACO has articulated policy and brought innovation into programme. A National Blood Policy formulated by NACO, in 2002 and a meticulous Action Plan on Blood...
Safety formulated in 2003 were adopted by Government. Through this Action Plan on Blood Safety NACO has:

- Mandated the revelation of HIV status to the result-seeking donor, not attempted previously in India. This enabled commencement of antiretroviral treatment for people living with HIV/AIDS.

- Commenced the process of accreditation of blood banks to ensure uniform implementation of standard operating procedures, not attempted previously in the government sector. Our Quality Management Programme in collaboration with the WHO will enhance standards of blood transfusion services across the country.

- Raised the overall collection of blood through voluntary blood donation. We continue to aggressively motivate all segments of our healthy population, particularly the youth, to participate in voluntary blood donation programme. Blood collection from voluntary (non-remunerated) blood donors are definitely on the rise, particularly in states such as Maharashtra and West Bengal. The State AIDS Control Societies has undertaken several activities to promote public awareness of the need for voluntary blood donation and safe blood.

- Introduced the installation of blood storage centres at First Referral Units (FRUs), at sub-district levels, for wider availability of safe blood, particularly for emergency obstetric care and trauma care services.

NACO supports the installation of 410 additional blood component separation facilities, the setting up of model blood banks, and the external quality assessment scheme (EQAS) for HIV testing in blood banks. NACO supports the modernization of all major blood banks at state and district levels, and repeated refresher training for clinicians on the "Appropriate Clinical Use of Blood."

While constantly raising awareness levels about the need to access safe blood and blood products, NACO supports the procurement of equipment, test kits and reagents and provides operational costs for government blood banks, and those run by charitable organizations that were modernized during the first phase of the National AIDS Control Programme (NACP).

**Establishing State-of-the-art Model Blood Banks**

Ten state-of-the-art model blood banks are being set up in eight under-served states and will be initially managed by NACO prior to being handed over to the respective state governments. These blood banks are expected to function as demonstration projects for the region in which they are being set-up. Under NACO’s
supervision, in the initial period, the staff will be fully trained to establish high quality systems of service delivery. These centres will also be networked with the existing blood banks in the region, to ensure optimal availability of safe blood. The following eight states have been selected for the 10 State-of-the-Art Model Blood Banks, due to commence functioning in December 2004.

1. Bihar Jai-Prabha Model Blood Bank, Patna
2. Jharkhand Rajendra Institute of Medical Sciences, Ranchi
3. Chattisgarh Medical College, Raipur.
4. Uttaranchal Doon Hospital, Dehradun
5. Uttar Pradesh King George Medical College and Hospital, Lucknow
6. Madhya Pradesh Medical College, Indore
7. Rajasthan S.M.S. Medical College and Hospital, Jaipur
8. Rajasthan Maharana Pratap Medical College, Udaipur
9. Assam Guwahati Medical College, Guwahati
10. Assam Assam Medical College, Dibrugarh

Five Model Blood Banks (Jaipur, Indore, Lucknow, Guwahati and Raipur) commenced functioning from their newly allotted sites with recruitment and training of the staff already completed.

Sites have been prepared in the remaining five model blood banks with some minor civil and electrical works to be completed. Recruitment of staff and training has commenced. Procurement of equipment by NACO and SACS is already in progress.

**Blood Storage Centres**

To ensure availability of safe blood in remote and far flung locations, we have motivated an amendment in the Drugs and Cosmetic Rules 1940, to permit the establishment of blood storage centres at sub district levels, at First Referral Units (FRU) and other small hospitals. These blood storage centres will take care of emergencies, particularly in the rural areas where it is not always feasible to
establish full-fledged blood banks. They will help fulfill an urgent need for trauma care services, including facilities for emergency blood transfusions for accident victims along the highways. Additionally, this is a gender ethical initiative. The blood storage centres will save lives of women in emergency obstetric care. The blood storage centres will be affiliated to larger blood banks.

**External Quality Assessment Scheme (EQAS) for HIV testing**

In 1999 NACO initiated the External Quality Assessment Scheme (EQAS) for HIV testing, to cover blood banks and laboratories, implementing HIV testing. The objective was to ensure sustained qualitative improvement and to maintain uniformity in standard operating procedures.

By the year 2000, the National Institute of Biologicals (NIB) NOIDA was identified as an Apex Laboratory and 12 National Reference Laboratories (NRL) were established. They evaluated 10-panel samples and finalized a format for reporting of results. Since then, NACO has expended the outreach of the External Quality Assessment Scheme. The SRLs have been strengthened to train their assigned VCT centres and blood banks with support from NRLs and the state AIDS control societies. NACO now supports for 99 State Reference Laboratories (SRLs). EQAS now supports the training of heads of voluntary counseling and testing centres, blood banks, and technicians. We anticipate that the training programme in respect of blood banks will be completed by December 2004. Expansion of coverage achieved through the External Quality Assessment Scheme (EQAS) is:
Our Quality Management Programme in collaboration with the WHO, will enhance standards of blood transfusion services across the country.

**HCV Testing facilities**

NACO’s blood safety initiatives extend beyond HIV to include the screening of blood for Hepatitis C Virus (HCV) antibodies in addition to testing for Hepatitis B, Syphilis and Malaria. Screening for HCV has been made mandatory from June 1, 2001 and NACO has already provided the necessary technical resources and training to blood bank personnel. HCV testing kits are being provided to blood banks in the public sector since June 2001.

**Quality Management**

In order to improve quality across all areas of blood transfusion services and to ensure the observance of standard operating procedures in blood banks, NACO supports the Quality Management Training Programme. Workshops to train blood bank personnel and sensitize state programme officers have been conducted with the help of WHO to ensure application of systems for high quality service delivery. An accreditation scheme for the blood banks is on the anvil.

**Voluntary blood donation**

There has been varied but distinct progress in augmenting voluntary blood donation, across the country. Blood collected from voluntary (non-remunerated) blood donors all over the country demonstrated a definite rise in the year 2003 (50.2%) compared to the year 2002 (42.8%). Some of the states like West Bengal (84.4%), Maharashtra (81.3%), Tamilnadu (61.4%) and Gujarat(60.4%) has done reasonably well in voluntary blood collection during the year 2003. State AIDS Control Societies has undertaken several activities to promote public awareness among the youth about the need for voluntary blood donation. Workshops on Motivation of Voluntary Blood donations are being organized to promote this programme. October 1 is celebrated as Voluntary Blood Donation day across the country.
NACO continues to persevere so that all states achieve higher standards in voluntary blood donation.
(iv) Controlling Sexually Transmitted Infections (STIs):

STIs and HIV are behaviorally and epidemiologically linked. Similar high risk behaviour patterns are responsible for spreading both STI and HIV. In fact HIV is commonly known as sexually transmitted infection, albeit a fatal one. The probability of contracting HIV infection gets significantly enhanced in the presence of STIs. An individual with sexually transmitted infection is eight to ten times more vulnerable to contracting HIV. Hence controlling STIs will help reduce the incidence of HIV.

STI treatment is also an opportunity for providing information, education and communication for the prevention of HIV, to an individual / couple at risk of HIV. Quality STI treatment and associated condom use is an entry point for organizing prevention programmes for vulnerable communities like sex workers or men having sex with men. However, the Behavioural Surveillance Survey (2001) illustrated that less than 20 percent of those suffering from STIs seek treatment through government clinics in most states of India. Perceived lack of confidentiality and the stigmatisation of those with STIs, drive the majority to the private health sector, and/or to unqualified practitioners or quacks with home remedies.

Services for Sexually Transmitted Infections

The national programme for control of sexually transmitted diseases (STDs) is one of the oldest national health programmes in the country, operational as the National Venereal Diseases Control Programme. The first beginnings of our AIDS control programme in India 1987-1992 focused on generating awareness about sexually transmitted infections.

On account of the strong correlation of the HIV infection and the STIs, in 1992, the national venereal diseases control programme was merged with the National AIDS Control Programme. The treatment, control and prevention of STIs is a key strategy in achieving reductions in the spread of HIV.

Objectives of the STI control component of the National AIDS Control Programme are:

a) To reduce the incidence and prevalence of STIs, and thereby to control HIV transmission by minimising the risk factor and

b) To prevent the short term as well as long term morbidity and mortality due to STIs

Services for the management and treatment of STIs are being delivered through clinics for sexually transmitted infections. The National AIDS Control Organization...
has progressively expanded the network of STD Clinics, and we now have 735 STD clinics across the country, that is, one STD clinic in each district hospital and medical college.

**Achievement in service delivery, 2002-04**

STD clinics provide consultation, laboratory investigations, counseling and treatment to clinic attendees, while maintaining privacy and confidentiality. Data on the provisioning of STD services in the six high HIV prevalence states of the country, received through our CMIS indicates increases in the numbers of people seeking services for STD treatment, over the last two years.

<table>
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<th>Name of the State</th>
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<th>Estimated high risk 10% (in million)</th>
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<th>2003 Nos. tested</th>
<th>% increase from 2002</th>
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<tbody>
<tr>
<td>Andhra Pradesh</td>
<td>76.7</td>
<td>7.7</td>
<td>57735 (0.7%)</td>
<td>76937 (0.9%)</td>
<td>133%</td>
</tr>
<tr>
<td>Karnataka</td>
<td>52.7</td>
<td>5.3</td>
<td>17366 (0.3%)</td>
<td>26177 (0.8%)</td>
<td>150%</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>62.11</td>
<td>6.2</td>
<td>27871 (0.4%)</td>
<td>48934 (0.7%)</td>
<td>175%</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>96.8</td>
<td>9.7</td>
<td>22746 (0.23%)</td>
<td>39307 (0.40%)</td>
<td>172%</td>
</tr>
<tr>
<td>Manipur</td>
<td>2.4</td>
<td>0.24</td>
<td>1019 (0.4%)</td>
<td>484 (0.20%)</td>
<td>47%</td>
</tr>
<tr>
<td>Nagaland</td>
<td>1.99</td>
<td>0.2</td>
<td>Not reported</td>
<td>Not reported</td>
<td>—</td>
</tr>
</tbody>
</table>
For the year 2003, CMIS data in respect of new cases reported to STD clinics indicates the percentage contributed by each state to the total number of STD cases in the country:

NACO ensures a continual, adequate supply of STI drugs. For early diagnosis and treatment of STIs among women, NACO supports the Department of Family Welfare in providing services for reproductive tract infections, through obstetrics and gynaecology clinics in medical college and district hospitals in every state.

Each STD clinic functions under a qualified specialist and is equipped with laboratory support for the diagnosis and management of STIs. NACO conducts regular workshops for microbiologists and laboratory technicians to train them in the current available laboratory diagnostic techniques for STI/HIV.

In areas where there are no laboratory facilities to help diagnose and treat STIs, NACO promotes the WHO approved syndromic management of STIs as a cost effective strategy for peripheral health institutions. Standard guidelines and algorithms for the syndromic management of STIs have been updated.

Future Directions:

- Need to converge the management of services for STI, with services for RTI
being promoted by the Department of Family Welfare, Ministry of Health, to avoid duplication and overlap.

- Syndromic management of STIs should be promoted only where there is complete non-availability of laboratory back-up. Wherever we have appropriate laboratory back up, we need to ensure an etiological approach.

- We need to involve Directors of Health Services & Directors of Family Welfare at state levels.

- Need to create a network of linkages between the public sector and the private sector STD clinics for more widespread availability of service delivery.

In order to monitor anti-microbial drug resistance, NACO has identified 14 medical college level laboratories to be strengthened for implementing anti microbial drug resistance testing on a regular basis.

**(v) Promoting Condoms**

In India, the HIV infection is over 85 % sexually transmitted. The networks of people living with HIV often cite the example of two countries in Asia: Thailand and Cambodia, where significant success has been achieved in lowering the spread and prevalence of HIV through promotion of 100 % condom use. They believe that India must augment resources for condoms, and make condoms widely available.

For young adults, and in order to ensure that they do not succumb to peer pressure, the National AIDS Control Programme disseminates messages on abstinence and the need to maintain single partner fidelity through mutual monogamy between uninfected sexual partners, and on correct and consistent condom use. These are the only available options for steering clear from HIV infection. The world over, evidence suggests that wherever HIV prevention efforts have been successful in reducing HIV prevalence, condoms have invariably played a pivotal role. Condom promotion is cost effective. Condoms provide an option that is simple, affordable, and life saving.

Condom use provides dual protection. It protects from diseases (STDs and HIV), and averts the unintended pregnancy. The national AIDS control programme has already commenced over Doordarshan a media campaign with precisely this theme. In collaboration with the Department of Family Welfare, the State AIDS Control Societies
distribute condoms, free of cost, at all high risk sites. The main beneficiaries of the free distribution of condoms are the high risk and marginalised groups such as sex workers, injecting drug users and MSM (Men who have Sex with Men). Condom promotion efforts are especially directed towards these groups, and NACO has made NGOs active partners in this intervention.

**Condom Promotion among the High Risk Groups:**

In high risk situations it is recognized that condom use and treatment of STIs are the most effective barriers to the transmission of HIV/AIDS. Condom promotion involves both demand and supply. Demand relates to the motivation and skill of the individual to use a condom. Supply is concerned with the availability of good quality condoms at affordable prices, at the time and place where it is needed.

The Behavioural Surveillance Survey 2001 among Female Sex Workers by NACO shows that awareness about the effectiveness of condoms in preventing the transmission of HIV is 83% but consistent condom use even with the paying clients is only 50%.

NACO is focussing on increased participation in the social marketing of condoms. We indicate below the increase in financial allocations for condom procurement and the corresponding increase in the number of targeted intervention sites through which condoms are supplied to high risk groups. The availability of condoms has registered a steady increase:

<table>
<thead>
<tr>
<th>Year</th>
<th>Financial Resources (Rs)</th>
<th>No. of condoms procured and made available</th>
<th>Increase in the number of Targeted Interventions through which condoms are supplied at high risk sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001-02</td>
<td>7.65 crores</td>
<td>6.2 crores</td>
<td>450</td>
</tr>
<tr>
<td>2002-03</td>
<td>16.85 crores</td>
<td>12.8 crores</td>
<td>620</td>
</tr>
<tr>
<td>2003-04</td>
<td>22.8 crores</td>
<td>17.1 crores</td>
<td>933</td>
</tr>
</tbody>
</table>
(vi) Counseling & Testing for HIV

Being diagnosed HIV positive and coming to terms with the knowledge of the HIV virus within one's system has, for an individual, profound emotional, social, behavioral and medical implications, which directly and indirectly impact his/her family life, society response, work status, education potential, legal status, and human rights.

Voluntary Counseling and Testing (VCT) is a key entry point for a range of interventions in HIV prevention and care, like preventing HIV transmission from mother to child during childbirth, referrals for STD treatment, condom promotion, care and support for treatment of opportunistic infections, management of the HIV-TB co-infection, and now, referrals to designated medical centres for Anti Retroviral Therapy (ART). VCT is a non-coercive, confidential, cost effective and inclusive approach that aspires to provide information, education and communication and to motivate behavior change in HIV-positive individuals.

The National AIDS Control Organization (NACO) has supported the establishment of VCT centres in all states. Commencing with 62 VCT centres in 1997, we now have 709 VCT centres in June 2004, of which 628 have been supported by NACO through the SACS. These are located in medical colleges, district hospitals, civil hospitals, PHC, CHC and village hospitals. 81 VCT centres have been set up through the Employees State Insurance Corporation (ESIC), Steel Authority of India Ltd. (SAIL), Ministries of Defence and Railways. NACO is positioning VCT centres as a one-stop shop for prevention with referrals for care and support. We would like each VCT centre to provide standardized counseling and testing facilities, information and advocacy, with basic health care products, like condoms, paracetamols, etc.
VCT and linkages

VCT is the entry point to HIV prevention and to develop backward and forward linkages to the continuum of care, support and treatment. VCT aims at increasing people's access to knowledge and understanding of HIV status on a voluntary basis. In turn, this facilitates early and appropriate uptake of services in prevention care and support. The purpose of VCTC is to provide social and psychological support to those affected by HIV/AIDS, prevention of HIV transmission for those at risk and establish linkages for care and treatment.
A comparison of VCT functioning between 2002 and 2004 indicates marked improvements in diverse markers, evaluating VCT performance:

An increase of 69% in the numbers of people provided pretest counseling from 2002 to 2003 (268,765 in 2002 and 453,050 in 2003).

In 2002, 61% of the total numbers tested, received pre-test counseling. In 2003, at least 74% of the total numbers tested received pre-test counseling.

The number of voluntary walk in clients increased by 75.52% from 2002 to 2003. There were 100,828 walk in clients in 2002 for voluntary counseling, which number increased to 176,973 in 2003.

In 2002, 23% of all clients tested were walk in clients, while in 2003, 29% of clients tested were walk in clients. This is an increase of more than 25%.

The total number of people tested HIV+ increased by 53% (52,758 in 2002 to 80,582 in 2003).

The percentage of people tested positive out of all clients tested increased slightly from 12.16% in 2002 to 13.16% in 2003.

Establishing Centres of Excellence

In order to improve the quality of existing VCT services, and in collaboration with the World Health Organization (WHO), NACO has set up three model VCT centres to demonstrate quality voluntary counseling and testing services. Three model sites at Chennai, Imphal and Mumbai are in operation to demonstrate best practices in HIV counseling, testing and other services and procedures of VCTC. The establishment of model sites will help to build capacity of existing VCTCs by providing supervision and training and would assist NACO in developing Standard Operating Procedures as well as technical assistance for replication.

Quality Control

In order to maintain the quality of the tests being done at VCT centres, all the samples detected HIV sero positive and five percent samples detected sero negative in VCTCs are sent to reference laboratories for cross checking. The External Quality Assessment Programme is in place and evaluates serum panels provided by designated National Reference Laboratories. Trained and qualified counselors and laboratory technicians are appointed in VCTCs, which are mostly located in the microbiology departments of Government and municipal hospitals. Rapid HIV test kits have been supplied to VCTCs so that the results of HIV testing are communicated early.
Building capacity within the programme

NACO has closely scrutinized a training manual developed by WHO for training of trainers (ToT), made modifications through six regional trainings held at Imphal, Chennai, Panchgani (MH) and Ranchi, Delhi & Lucknow for the North-Eastern, Southern, Western, Eastern and Northern Regions, and is currently field testing the same. 235 senior faculty members from 111 institutions and 30 states have been trained. These experts are actively collaborating through the respective State AIDS Control Societies to train, supervise and monitor the counselors working in VCT centres, located in government hospitals and medical colleges.

A national consultation was organized during May 2004 to review, adapt and standardize WHO developed HIV counseling curriculum for the country. Proceedings are being edited to finalize the document which will be a comprehensive HIV manual, particularly bringing out the backward and forward linkages between counseling and service provisioning, more specifically in counseling for prevention of HIV transmission from mother to child during childbirth, targeted interventions, treatment for opportunistic infections, and anti-retroviral treatment for people living with AIDS, and adherence of treatment.

Additionally, NACO is developing Standard Operating Procedures for the counseling process to maintain high quality standards across the country.

VCT Guidelines, 2004 include key operational procedures, with a focus on counseling and testing, partner notification, disclosure procedures, norms for maintaining confidentiality in VCT centres, client rights, voluntary uptake of services, clarification of roles and responsibilities of VCT staff, additional details regarding set up, basic infrastructure, processes, revising pre and post test proformas and consent forms, with additional details on referrals inclusive of referral cards. These revised VCT Guidelines, 2004 incorporate the lessons learnt, and experience gained over the past two years of operationalising the VCT centres.

VCT Centers beyond medical set-ups

With increasing awareness about HIV/AIDS and improved access to treatment, the demand for HIV counseling and testing services is rising. The challenge in the coming years is to provide highest quality HIV counseling and testing services to people close to where they live and work. VCT services must also be available to vulnerable groups such as young people, mobile and migrant populations and women. Innovative approaches and the involvement of civil society, the voluntary and the NGO sectors, and the private sector are crucial. New strategies include:
- VCTs as well being centers at community levels
- VCTs in the workplace
- Co-opting networks of People living with HIV/AIDS (PLHAs)

Making VCT centres widely available will reduce stigma and discrimination in society, will encourage people to find out their HIV status, and will eventually contribute to reducing HIV transmission across the country.

(vii) Targeted interventions:

One of the most important components of the NACP-II is the Targeted Intervention (TI) project that aim to interrupt HIV transmission among highly vulnerable populations. Certain populations are at a greater risk of acquiring and transmitting HIV infection due to more frequent exposure to HIV, higher levels of risky behaviour and insufficient capacity or power to decide to protect themselves. Such population groups broadly include sex workers and clients, injecting drug users, men who have sex with men, truckers, migrant workers and street children.

Rationale for Targeted Interventions

- Directing HIV prevention efforts among groups with a high rate of partner-change, whether sexual or needle-sharing partners, is a proven cost effective strategy as it has the multiplier effect of preventing many subsequent rounds of infections amongst the general population.
- Targeted interventions among these groups involve multi-pronged strategies such as behaviour change communication, counseling, treatment for STIs and provision of condoms, along with activities that can help create an enabling environment for behavioural change.
Scaling up of Targeted Interventions

By the end of March 2004, the State AIDS Control Societies have undertaken 933 TI projects, with the help of NGOs.

The thematic distribution of targeted interventions undertaken by SACS is as follows:

```
<table>
<thead>
<tr>
<th>Thematic Distribution</th>
<th>Sep. 99</th>
<th>Jul-00</th>
<th>May-01</th>
<th>Mar. 02</th>
<th>Mar. 03</th>
<th>Dec-03</th>
<th>Mar-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>199</td>
<td>313</td>
<td>578</td>
<td>658</td>
<td>735</td>
<td>882</td>
<td>933</td>
</tr>
</tbody>
</table>
```

Coverage of High Risk Groups through TIs

```
<table>
<thead>
<tr>
<th>High Risk Group</th>
<th>Number of TIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPWIs</td>
<td>224</td>
</tr>
<tr>
<td>MSM</td>
<td>28</td>
</tr>
<tr>
<td>IDUs</td>
<td>76</td>
</tr>
<tr>
<td>Truckers</td>
<td>194</td>
</tr>
<tr>
<td>Migrant Workers</td>
<td>264</td>
</tr>
<tr>
<td>Street Children</td>
<td>25</td>
</tr>
<tr>
<td>Prison Inmates</td>
<td>54</td>
</tr>
<tr>
<td>Composite Interventions</td>
<td>68</td>
</tr>
</tbody>
</table>
```

March 2004
While there has been a substantial increase in the coverage of vulnerable segments through targeted interventions, NACO aims to cover core groups in all states. More than half of these projects are located in the high prevalence states of Andhra Pradesh, Maharashtra, Tamil Nadu, Karnataka, Manipur and Nagaland. The trend is now shifting towards having composite interventions where more than one core group is targeted by the NGO in a given area.

**Targeted Interventions evaluated externally:**

Two external evaluations of TIs programme has been conducted in 22 states. These evaluations were done by OPTIONS of UK and Sexual Health Resource Centre (SHRC), New Delhi. The findings of the evaluation reports have been shared with all partners and the recommendations are that:

- Interventions must focus on core groups (CSW, MSM, IDU)
- Interventions must cover all of the core groups in the shortest possible time.
- Interventions must reach beyond bridge populations
- Interventions must be of high quality
- We need to build capacity of NGOs and SACS.
- Need to address delay in funding to NGOs.
- TIs play a critical role in building and enabling environment and in reaching out to bridge populations.

**Improving quality of TIs**

TI guidelines are begin revisited through a consultative process involving NACO, SACS officials and representative from NGOs. A series of workshops were organized between 19-20 September 2004 and 17-19 December 2003 and 19-20th February 2004 in order to bring in inputs from various stakeholders to this process. This exercise is aimed at bridging the gaps identified in the existing TI guidelines particularly w.r.t. composite interventions and IDUs, explore better linkages with RCH/TB programme and broad basing of TI concept to include care and support.

NACO conducted four regional workshops for expediting reports on CMIS for TIs to monitor the progress of TIs and simultaneously giving the feedback. The TI reporting format on CMIS has been revised to incorporate the suggestions made by various stakeholders.
Capacity Building:

One of the major challenges in the implementation of TIs has been the capacity of the NGO partners to deliver at the grass root level. Capacity building of SACS officials and NGO staff on the issues of Targeted Intervention has been undertaken both at national and state level. Two meetings of NGO Advisors was convened in September 2002 and from 25th to 27th March, 2004. NACO is working through resource persons going down to states in particular, those without bilateral support. The focus has been on Assam, Bihar, MP, Punjab, Haryana, UP, Jharkhand, Chattisgarh and Uttaranchal. Orientation-cum-exposure programme for SACS officials and selected TI project coordinators from various states have become a regular feature. The TRG for TIs, APAC, has developed a strategy for technical support for TIs, which includes utilizing multiple channel and tools for capacity building, imparting training through organization having projects management capacity, forming pool of consultants/mentors to be created to mentor the TIs etc.

Partnership Forums of NGOs/CBOs:

NACO convened a national consultation meeting on January 20-21, 2003 to strengthen Civil Societies partnership and build systems and procedures so that voices of concern of those NGOs/CBO’s working in the field of HIV/AIDS can be heard. In order to enhance civil society participation in HIV/AIDS programme, partnership forums are being facilitated in many states. Such networks are functional in Kerala, Andhra Pradesh, Manipur, Karnataka, Gujarat and Delhi. Many other states are in the process of forming the forums.

(viii) Training Health Care Providers

Institutional strengthening, capacity building and training of health care professionals at the state and sub state level are key objectives of the second phase of the National AIDS Control Programme. Training is used as a sustained tool to strengthen the capacity of NACO and the State AIDS Control Societies to respond to the long-term challenges posed by HIV/AIDS. Acquisition of knowledge on HIV and development skills help the health care providers in allaying fears and misconceptions regarding infectivity, and sets the ground for the medical fraternity to reach out to communities through their services in an enabling environment free from discrimination.

In our agenda on training, we seek to strengthen capacity through:

- Conduct training neds assessment
• Developing training material
• Conducting training of trainers
• Provide worksite specific training to supervisors
• Developing training best practices
• Provide training for intersectoral groups, government officials, social & religious leaders.

The training component was developed after a series of brainstorming workshops held on a regional basis and an action plan was developed at the national level. This included a clear operational guideline on training and management and a calendar of activities. Separate training modules have been developed for different health functionaries at the primary, secondary and tertiary levels of health care. Training institutions have been identified, and senior faculty members of medical colleges form a resource network at the national, state, and district level to build capacity of the health functionaries at different levels. The training calendar for each state is drawn up as part of the Annual Action Plan, keeping in mind the objectives of the programme, and the targets set for the year.

Medical Officers in urban as well as rural settings are already involved in health care activities that have a direct bearing on HIV related issues or illnesses, like condom promotion, reproductive health care, detection and treatment of tuberculosis, sexually transmitted diseases, chronic diarrhea, and so on. The objective is to train health care providers so that they are able to mainstream prevention, care, counselling and referrals for people living with HIV into routine medical activities at tertiary and primary health care levels. They are sensitized to:

1. Identify individuals with high risk behaviour and to ensure appropriate referral for further counselling and testing.
2. Disseminate information and education on HIV through interpersonal communication with a view to raising awareness and dispelling myths as well as the stigma surrounding AIDS.
3. Counsel HIV positive individuals who are referred from specialized institutions to the primary health care settings.
4. Observe universal precautions and to ensure that no discrimination is meted out to incoming HIV positive persons.
5. Learn about all aspects of the care and management of HIV/AIDS cases, including the provisioning of medicines for opportunistic infections and referrals to ART clinics, when necessary.
Training Programmes

Modules on training were developed during 2001, for the training of doctors, nurses and counsellors. These modules are now being revised and updated.

The training programmes are conducted by the AIDS Control Societies, and the Training of Trainers (TOT) is conducted by NACO. There is appropriate coordination between NACO, SACS and our intersectoral partners. Broadly the pattern of training being followed is:

<table>
<thead>
<tr>
<th>Category</th>
<th>Duration of Training</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Specialist Doctors (Master Trainers)</td>
<td>Three days</td>
<td>State level/ Regional</td>
</tr>
<tr>
<td>Doctors (District Nodal officer &amp; others)</td>
<td>Two days</td>
<td>District level</td>
</tr>
<tr>
<td>Nurses</td>
<td>Two days</td>
<td>District level</td>
</tr>
<tr>
<td>Counselors (Master Trainers)</td>
<td>Four days</td>
<td>Regional / State level</td>
</tr>
<tr>
<td>Counselors (VCTCs)</td>
<td>Five days</td>
<td>State level</td>
</tr>
<tr>
<td>Blood bank Personnel (public &amp; private)</td>
<td>One to five days</td>
<td>State/ district level</td>
</tr>
<tr>
<td>Indian System of Medicine Practitioners</td>
<td>One to Two days</td>
<td>State level</td>
</tr>
<tr>
<td>Others (Rural Medical Practitioners, People Living with HIV/AIDS, drug inspectors, NGOs etc)</td>
<td>Varied</td>
<td>State/District level</td>
</tr>
</tbody>
</table>

Training activities have been revamped after 2001. The coverage of training activities over the past two years, and more is indicated below:-

Training Coverage for Health Care providers
The training calendar also encompasses refresher courses for each of these categories. Specialized training programmes and sensitization workshops for IEC personnel, Targeted Interventions, Police personnel and Intersectoral partners are also organized on the basis of need assessment.

Achievement in terms of the numbers of professionals trained under this component of the programme is thus:

<table>
<thead>
<tr>
<th>Category</th>
<th>March, 99</th>
<th>March, 2000</th>
<th>March, 01</th>
<th>March, 02</th>
<th>March, 03</th>
<th>March, 04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>5110</td>
<td>10142</td>
<td>24518</td>
<td>54912</td>
<td>78355</td>
<td>109094</td>
</tr>
<tr>
<td>Nurses</td>
<td>5007</td>
<td>5965</td>
<td>27496</td>
<td>48608</td>
<td>69346</td>
<td>92803</td>
</tr>
<tr>
<td>Others</td>
<td>4350</td>
<td>9611</td>
<td>27729</td>
<td>154459</td>
<td>241078</td>
<td>320007</td>
</tr>
<tr>
<td>TOTAL</td>
<td>14467</td>
<td>25718</td>
<td>79743</td>
<td>257979</td>
<td>388779</td>
<td>521904</td>
</tr>
</tbody>
</table>

We have already identified the categories of health care functionaries to be trained by March 2006.

<table>
<thead>
<tr>
<th>Category</th>
<th>Numbers to be Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>27,924</td>
</tr>
<tr>
<td>Nurses</td>
<td>68,175</td>
</tr>
<tr>
<td>Others</td>
<td>1,47,890</td>
</tr>
</tbody>
</table>

Keeping in mind local priorities, we need to now focus on building capacity of health care providers engaged at district level and below district levels. We will increasingly emphasize participatory and hands-on training instead of didactic classroom teaching. The training activities conducted by the SACS will be monitored and evaluated along well-defined parameters.

The objective of the training are to: i) impart knowledge and skills on provision of HIV antiretroviral treatment, ii) sensitise health service providers on decreasing stigma and discrimination towards people living with HIV/AIDS, iii) impart knowledge and skills on improving treatment adherence to ART, and iv) impart knowledge and skills in treatment monitoring, recording, reporting and adherence.
Training for Antiretroviral treatment

Preparation (from December 2003 onwards) to introduce antiretroviral treatment for people living with HIV/AIDS drew our attention to new emerging needs directly relevant to training of health care providers. These emerging needs covered both the clinical management of HIV/AIDS as well as the need to provide treatment literacy among HIV positive networks and peer educators. Antiretroviral treatment has dramatically improved rates of mortality and morbidity, improved quality of life, and transformed the perception of HIV/AIDS from a dreaded disease to a manageable chronic illness. These developments in the field of care & support prompted a revised strategy for training of clinicians.

In order to communicate and train our health care providers about the most recent advances in this respect, the National AIDS Control Organisation organised a series of Training of Trainers (TOT) on ART. Senior clinicians from 24 Institutions/Medical colleges of six high HIV prevalence States have been trained in the month of March - April, 2004. Additionally, we have commenced hands on training in clinical management of HIV/AIDS for the senior level clinicians from low HIV prevalence states. Four training institutions have been identified for this purpose. These are:

(i) Govt. Hospital for Thoracic Medicine, Tambaram, Chennai, Tamil Nadu;
(ii) Regional Institute of Medical Sciences, Imphal, Manipur;
(iii) Sir Jeejee Boi Hospital, Mumbai, Maharashtra; and
(iv) Christian Medical College, Vellore, Tamil Nadu.

(ix) Greater Involvement of People Living with AIDS (GIPA)

Since a key priority is to foster an enabling environment, NACO has smoothly incorporated the greater involvement of people living with AIDS (GIPA), and those directly affected by it. GIPA is more a process than a goal, an all-inclusive principle based on the fundamental premises that we need to start looking beyond the notion of ‘beneficiaries’ towards the nation of ‘synergistic community action’.
In an attempt to consolidate efforts around GIPA, NACO commenced a partnership during 2003, with the Indian network of people living with HIV (INP+) and UNDPM, to organize the "Leadership for Results" programme. Three workshops were held: Delhi, Cochin and Kolkata, and we had several positive outcomes. The idea is if we are to apply GIPA across the board, then we need to invest in capacities of the people living with the virus and those affected by it.

In June 2003, every AIDS Control Society was directed to be mindful, henceforth, of GIPA as a tool to better implement its activities, and to apply GIPA where possible. 10 States have responded favorably to this call and have reported the application of this principle in several areas. Many other states are catching up. People living with HIV/AIDS (PLHAs) have become an integral part of the behaviour change communication (BBC) programme, development of materials and designing of messaging, to eschew stigma.

In NACO’s Vision document, GIPA has a clear strategic place without which it would be an incomplete vision.

The Operational Guidelines for Voluntary Counseling and Testing, 2004, has an entire chapter dedicated to co-opting people living with HIV/AIDS as ‘peer counselors’.

With the roll out of the anti-retroviral treatment, for people living with AIDS, PLHAs have an expanded role, both as stakeholders as well as facilitators.

Support from NACO and UNDP has enabled the INP+ to establish and strengthen up to 15 state level networks of people living with HIV/AIDS. Positive women’s groups have been updated with current knowledge on human rights, treatment literacy and positive living.

NACO has enabled the INP+ has now finalized the first national strategy for GIPA, after wise ranging stakeholders consultation.

Over the past two year, we have moved from being driven by awareness generation to being driven by service delivery. And this quantum leap has been recognized in the draft national GIPA strategy.

(x) Young People and HIV/AIDS

Young people in India today number more than 280 million and form more than a quarter of our entire population. Over 35 % of all reported AIDS cases in India occur among young people in the age group of 15 to 24 years, indicating that
young people are at high risk of contracting HIV infection. The majority is infected through unprotected sex. Impoverished, unemployed, under-employed, mobile and migrant youth and street children are also particularly vulnerable to HIV as they are less likely to have information about HIV or access to prevention services. They may face repeated risks of HIV infection through sexual exposure due to coercion or while selling sex in order to survive.

Studies from across the world show that the majority of young people have little or no idea how HIV/AIDS is transmitted or how to protect themselves from HIV infection. Most young people become sexually active during adolescence and are more likely to have sex with high-risk partners or multiple partners. Young women are biologically more vulnerable to HIV infection than young men. The vulnerability of young women and adolescent girls is heightened because they are less likely to access information on HIV and have limited ability and power to exercise control over their sexual lives. Early marriage also poses special risks to young people, particularly women. This is especially relevant for India, where almost 50 percent of girls are married off by the age of 18.

Reaching youngsters at an impressionable age before they become sexually active, can lay the foundations for a responsible lifestyle in many areas of their lives, including sex and marriage. NACO reaches out to youth through a variety of special programmes:

**School AIDS Education Programme**

The School AIDS Education Programme (SAEP) is being carried out across the Secondary and Higher Secondary schools of the country using an extracurricular approach. It is being implemented through the State AIDS Control Societies (SACS) along with the Department of Education, Department of Health, and Non Government Organisations.

The chief objective of the programme is to provide accurate knowledge on HIV transmission and prevention in the context of a life skills methodology to every student between classes IX and XI, to enable them to protect themselves from HIV. This is done through a recommended classroom interaction of more than 16 hours through the course of the academic year using the interactive module titled Learning for Life. The core topics covered in the module include Growing up, STDs/ Teenage Pregnancies/ HIV/ AIDS, Skills for Preventive Behavior, Care and Support. The idea of the programme is that SAEP is a HIV/AIDS prevention programme and not a sex education programme. ‘Learning for life’ is the module in use and providing information on HIV transmission and prevention and development of life skills is the
key aim. The programme aims at reinforcing existing positive behaviour among students, promote abstinence and delay sexual debut till marriage is the key aim.

Accordingly, the programme has been launched in most states and actively scaled up with active support of the state Departments of Education in the last two years. In the year 2003-04 in three states alone, Andhra Pradesh, Tamil Nadu and Karnataka, the schools that have undertaken the programme has reached 25,000. Andhra has initiated and up-scaled the programme to 100% coverage in one academic year, while Tamil Nadu and Karnataka have managed to reach about 50% during 2003-2004.

Assessment of the programme: The requirements of the states, progress made, lessons learnt, and the approaches used were assessed during the National School AIDS Education Workshop in Mumbai in February 2003. The workshop provided an opportunity to assess the progress made and to find ways and means for rapid upscale by doing a stock taking of the programme and needs assessment for refining programme strategy. As an outcome NACO has identified a pool of human resource for capacity building at the state level in the form of state level TOT Workshops

In the year 2004, an external evaluation was done of the School AIDS Education Programme. Some of the key issues that emerged out of the workshop and the evaluation of the SAEP were :

I) Wherever the programme has been initiated, the states needed to ensure consistent coverage year after year with attention to quality.

II) Sustainability of the initiative is key, and NACO and SACS are considering a close partnership with Department of Education on this programme.

Some states have taken the initiatives for integration of HIV prevention education within the curriculum. This process at the state level is reflected at the national level where discussions and meetings have been held with Ministry of HRD and NCERT on the issue of integrating concerns of HIV into the curriculum.

NACO start up support: In areas where the programme has not started like in some of the low prevalence states, NACO has been providing technical support to initiate the programme. NACO has provided technical support in terms of planning, advocacy and training of trainers for the SAEP in the states of Punjab, Delhi, Uttar Pradesh, Uttarakhand, Jharkhand, Rajasthan, Bihar and Nagaland. However there are hiccups also that need to be smoothened by active advocacy by the SACS to create a supportive environment to launch the programme in some states.
Initiatives for University Students

This is being done through the Universities Talk AIDS programme which is a collaborative effort between the Department of Youth Affairs, National Service Scheme (NSS) and NACO.

Since its inception in 1991, the UTA has reached out to about 8000 institutions in 176 universities, over 17,000 community leaders and over 7 million young people in the country. Along with NACP II, the second phase of the programme was launched in 1999. Phase II of the project introduced a two-pronged approach, "Youth To Youth" approach, and the "Campus to Community" programme, which involved training of community leaders who took the awareness programme to the grass root level.

The programme has covers university students in an interactive process that exposes these youth to various aspects related to HIV, such as transmission and prevention through the adoption of responsible lifestyles and delaying sexual debut.

A training module "HIV/AIDS Education for the student Youth" has been designed and translated in 18 languages. The module aims at providing information on sex and sexuality, HIV/AIDS issues, peer pressure, marriage etc to students in universities and to communities through the youth.

Initiatives for Rural Youth

This is being undertaken by the Nehru Yuvak Kendra's (NYKS) and the Youth clubs that have been set up all across the country under the Village Talk AIDS Programme.

The project was implemented in 385 districts and in 12300 villages of the country. From each village two active youth were selected to lead the programme in the area on Human sexuality and HIV/AIDS. These 'convenors' are trained by district Co-ordinators of the NYKS in a three-day youth leadership programme. These trained convenors' further covered villages with awareness generation activities and preventive education on HIV/AIDS using folk media, magic and dance.

Realising that there is a need to reach out to the out of school youth a consultation was held with various stakeholders from the Department of Youth Affairs, Ministry of Education, NGO's and SACS on the channels being used by different organisations to reach these young people.

NACO worked closely with the Ministry of Health and Family Welfare for developing
a module for health workers (ANM/Anganwadi worker/doctor) at the village and sub district level that looks at providing HIV related information on transmission and prevention to the adolescents in the area.

(xi) Family Health Awareness Campaign (FHAC)

FHAC is an effort to address the key issues related to reproductive health, including HIV/AIDS in the country, among especially the rural and marginalized population, using the existing health infrastructure. The target population (15 - 49 years) is sensitized towards these issues and efforts are made to encourage early detection and prompt treatment of RTI/STI by involving the community. The campaign is organized at the district level after detailed micro-planning. Camps are organized at strategic public venues, and diagnosis, administering of free STI drugs, and referral treatment, if necessary, are facilitated.

The following activities are undertaken to ensure optimal outputs from the campaign:

- Intersectoral coordination is achieved through the mechanism of State Level Steering Committee, Media and Coordination Committees and District Level Coordination and Media Committees. All the available field level machinery under the Health and Family Welfare Department and other social sector schemes is utilized for an intensive campaign to mobilize people to seek diagnosis and treatment of RTI/STI.

- Two rounds of house-to-house contacts are carried out prior to commencement of FHAC and every one belonging to the target group, is provided a FHAC card. During this process, the health workers inform the individual about the objectives of the campaign, place and date of the camp in the area. These camps are held in or around the village or at the local health facility.

- The village leaders such as panchayat members and teachers, the community based organisations and field workers are also mobilized for interpersonal communication drives. The interpersonal communication drive and social mobilization are supported by a mass media campaign on the local channels of Doordarshan, All India Radio and the press.

- Medical personnel are trained to provide syndromic treatment for RTI/STI. Special efforts are made to ensure that lady Medical Officers are available at PHCs/Camps for female patients. All paramedical staff are trained in signs and symptoms of RTI/STI and given instructions for prompt referral to nearest PHC/CHC/FRU or other referral units.
### Achievement of FHAC 1999 to 2003

The achievements of the sixth round of FHAC are indicated below:

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>No. of Districts Covered</td>
<td>100</td>
<td>266</td>
<td>418</td>
<td>515</td>
<td>556</td>
<td>572</td>
</tr>
<tr>
<td>Targeted Population (in Million)</td>
<td>57.7</td>
<td>175.2</td>
<td>226.6</td>
<td>335.5</td>
<td>364.81</td>
<td>355.85</td>
</tr>
<tr>
<td>No. of Cases referred to PHC for treatment of RTI/STD (in Lakhs)</td>
<td>3.24</td>
<td>17.37</td>
<td>36.58</td>
<td>47.74</td>
<td>47.55</td>
<td>54.29</td>
</tr>
<tr>
<td>No. of Cases Treated out of Referrals (in Lakhs)</td>
<td>1.68</td>
<td>11.12</td>
<td>18.66</td>
<td>30.59</td>
<td>38.16</td>
<td>48.32</td>
</tr>
</tbody>
</table>

* The above figures do not include information from Jharkhand.
** The above figures do not include information from Ahmedabad M.C. and Gujarat.

### Concurrent Evaluation of Family Health Awareness Campaign Round 2002:

Concurrent Evaluation of the Family Health Awareness Campaign round 2002 was carried out by India Clinical Epidemiology Network (IndiaCLEN), AIIMS, New Delhi. Its major recommendations are as under:

- At least 8-12 weeks of lead-time is required to adequately plan the implementation, organize training and launch an effective social mobilization campaign. The funds should also be disbursed 8-12 weeks before the launch of the programme. This will also be necessary to convey to the district programme managers the importance accorded to the programme by central and state level planners and in turn sustain their interest in the programme.

- The Health Department alone will have difficulty to accomplish the objectives of FHAC. Non-Health partners should be involved in the planning process before they are invited to help in the programme implementation.

- NGOs, Panchayat members and local leadership can support in organization of social mobilization campaign, conduct house visits and camps, and mobilize clients.

- Private practitioners need to be invited to help in the conduct of camps and treatment of RTI/STI patients.

- In districts/states, where programme implementation is assigned to NGOs, the
district programme managers should be constantly aware about the process of implementation and be primarily responsible to ensure quality of the programme performance.

- Selective mobilization of RTI/STI patients to FHAC camps will be associated with a real risk of the stigmatization. The camps should be for the whole community as rightly specified in the original programme strategy.

- Unlike current practice, decision regarding uniform programme strategy of availability of doctors and treatment facility at FHAC camps should made. The present allocation of resources for drugs at PHC appeared adequate.

Current efforts at supervision and monitoring of the FHAC camps needs to be sustained and further improved by preparing a specific task list for field operations, camp organization and availability of referral and treatment facilities for clients.

**Paradigm shift in FHAC Strategy 2003**

- To pursue and reinforce the message that responsible social and sexual behavior, with appropriate adherence to traditional values, such that unprotected sex is incompatible with healthy life practices.

- To encourage health seeking behavior in the general population for RTI and STI. There should be no hesitation or delay on the part of men, women or adolescents to seek appropriate treatment well in time.

- To make the people aware about the services available in the public health system for the management of RTI/STI.

- To be fully vigilant about the backward and forward linkages of reproductive tract infections and sexually transmitted diseases with HIV/AIDS. It is therefore critical to ensure speedy detection and immediate treatment of RTI/STI.

- To always access safe blood from licensed blood banks and blood storage centres.

- To be aware that HIV can be transmitted from the infected mother to her baby during pregnancy, delivery and breast-feeding.

**An AIDS Vaccine for India**

During 2003, our agenda to promote and develop an appropriate AIDS vaccine for India has surged ahead on several fronts, since its formal beginning in a tripartite
Memorandum of Understanding between NACO, the Indian Council of Medical Research and the not-for-profit International AIDS Vaccine Initiative (IAVI).

This partnership has in place a multistakeholder Advisory Board to deliberate the legal, ethical, and socio-behavioural issues related to vaccine trials in India. Over the past one year, we have made substantial progress in the scientific inquiry, research and development aspects.

As advised by President of India, a multiple vaccine approach is being pursued. Several candidate vaccines have been reviewed to select the most appropriate one for India.

- Toxicological evaluation is underway for the modified vaccinia ankara (MVA) vaccine construct, derived from the indigenous HIV sub-type C
- Toxicological evaluation is complete for an adeno-associated virus vaccine construct, and we anticipate that Phase I clinical trials should commence in the fourth quarter of 2004.
- In the basket of vaccines, the ICMR is examining another adeno-associated vaccine construct, which gives long lasting immune responses. Consultations are on for evaluation and use, in collaboration with the National Institute of Health (NIH), US.
- All India Institute of Medical Sciences (AIIMS), New Delhi is pursuing research and development of a candidate DNA vaccine construct

Potential sites in India have been assessed for Phase III clinical trials in the states of Maharashtra, Tamil Nadu and in the North East.

Potential Indian manufacturers for the AIDS vaccine have been meticulously reviewed, and the most appropriate among them identified.

**Microbicides**

A safe and efficacious protocol for use of microbicides would provide immense value addition to protection from HIV. Condom use, mutual monogamy and abstinence are not options for many women, particularly in the developing world. For people who lack the ability to negotiate condom use, microbicides will provide a welcome, and potentially lifesaving, alternative to condoms. A microbicide is any substance that can substantially reduce transmission of sexually transmitted infections (STIs) when applied topically either in the vagina or rectum. A microbicide could be produced in many forms, including gels, creams, suppositories, films, lubricants, or...
in form of a sponge or a vaginal ring that slowly releases the active ingredient over time. Microbicides work in four ways. They may kill or immobilise pathogens, create a barrier between the microbe and the vulnerable tissues or target cells, boost the vagina’s own defense system, or to prevent an infection from taking hold after it has entered the body by preventing viral replication. Some microbicides could potentially combine mechanisms for extra effectiveness. The ideal microbicide would be odourless, non-staining, easy to apply, and virtually unnoticeable by a person’s sexual partner.

Almost 60 microbicidal products or compounds are under development world-wide and some of the have entered into phase II clinical trials. Virtually all microbicides research is being conducted by non-profit and academic institutions or small biotechnology companies dependent on government or donor funding. Private donors, including the Bill & Melinda Gates Foundation, have recently increased their investment in research on microbicides.

In India, research and development is being undertaken on polyherbal neem based microbicide tablets. The phase I trial of this microbicide was conducted by National Institute of Research on Reproductive Health, Mumbai and PGI, Chandigarh. The product has been found safe. Extended and initial efficacy trials are being conducted by National AIDS Research Institute, Pune.
Collaboration and Partnership

HIV/AIDS provides an opportunity and a natural need for strong, strategic partnerships. Our partnerships enable us to harness diverse resources, distribution networks and service delivery capabilities.

- The National AIDS Control Organization (NACO) partners with:
  - The World Bank, DFID, USAID, CIDA and AUSAID in implementing a comprehensive national AIDS control programme
  - The International AIDS Vaccine Initiative and the Indian Council for Medical Research to develop a vaccine for the HIV sub-type most prevalent in India and with the Centre for Disease Control, Atlanta.
  - With industry coalitions like CII, FICCI and ASSOCHAM and the private sector.
  - With para-medical fraternities like the Indian Red Cross
  - With the Global Fund on AIDS, TB and Malaria
  - With the Bill and Melinda Gates Foundation
  - With networks of positive people, non-government organizations, elected representatives, women’s groups, self-help groups, community based organizations, and many others.

NACO facilitates the involvement of various sectors such as education, defence, labour, youth affairs, steel, railways, industry and transport, rural development, and social justice and empowerment to optimize India’s response to AIDS. To ensure sustainability, NACO promotes HIV/AIDS prevention and care activities into the ongoing governmental programmes of the government.

Nearly 90% HIV infections in India have been reported from the 15-49 age group— the most productive segment of society. HIV has an intense negative impact on the workforce, the business, individual workers and their families and economy at macro level. Though the macroeconomic impact of the epidemic in industrial sector has
been relatively low compared to the situation in Sub-Saharan Africa, the structural
determinants of HIV transmission such as high level of poverty, migration, illiteracy,
il health, gender inequality and urbanization are widely prevalent across the
country. The National AIDS Prevention and Control Policy recognizes the need to
take care of workers health & welfare in the organized and unorganized sectors,
and the need for developing a multi-pronged response to HIV/AIDS in workplace.

To strengthen the response to HIV/AIDS at the workplace, NACO is collaborating
with the International Labour Organisation, Ministry of Labour, industrial associations
like CII, ASSOCHAM, FICCI and also employers' and workers' organizations.

The workplace programmes are doing advocacy for strengthening the world of work
response to HIV/AIDS, based on the principles/guidelines of the ILO Code of
Practice on HIV/AIDS and world of work. The code has been translated into Hindi
and is being extensively disseminated. The code of practice on HIV/AIDS for the
workplace includes:

- Recognition of HIV/AIDS as a workplace issue
- Non-discrimination
- Gender equality
- Social Dialogue
- No screening of HIV for workplace
- Confidentiality
- Continuing the Employment Relationship
- Prevention and
- Care & Support

Apart from ILO, the Confederation of Indian Industries (CII) has also initiated HIV/
AIDS workplace programmes through the network of its 22 branches in the country.
The NGO Lawyers Collective raises public awareness about HIV/AIDS through public
rallies and mobilizes public opinion against stigma and discrimination and has
successfully defended workers who lost their jobs on account of their HIV status.

Trade Union leaders in workplace are important stakeholders to influence the HIV/
AIDS programme related policy and programmes at workplace. NACO through its
collaborating partners like Steel Authority of India and Employees State Insurance
Corporation (ESIC), ILO etc. has been sensitizing trade union leaders through
workshops.
The V.V. Giri National Labour Institute acts as a technical resource group to develop research and training resources for workplace AIDS programmes. The Institute’s partners in this effort include trade unions, employers’ organizations, companies, NGOs undertaking HIV projects in the informal sector (notably with truck drivers and migrant workers), State or district AIDS Control Societies, and ILO.

**The Steel Authority of India**

In 1999, NACO invited the Steel Authority of India (SAIL) to participate in the fight against HIV/AIDS. SAIL implements the HIV AIDS prevention project following the guidelines provided by the NACP-II.

The top level management, union leaders and opinion makers of SAIL were sensitized about the various aspects of HIV AIDS and subsequently, more than 175 medical officers were trained to deliver education, VCT, and care. Around 8,000 students in 30 schools and 600 teachers have been covered under School AIDS education programme. There are 7 STD Clinics, 7 Voluntary Counselling and Testing Centres, 9 Blood banks, and 1 blood component separation centre have been strengthened by NACO under the programme. The activities extend to all plants and units of SAIL, and cover all employees, their dependants and the immediate community.

SAIL has adopted a HIV/AIDS policy for controlling spread of HIV/AIDS. ILO - case study of Bhilai steel plant on work place intervention conducted and documented as best practice. SAIL is a founder member of 'India business trust' formed by CII to combat HIV/AIDS at workplace.

Overall the status of implementation is satisfactory. The major portion of expenditure incurred on the HIV/AIDS related activities/facilities under the project is met out of their internal funds.

**Financial position:**

(Rupees in lakhs)

<table>
<thead>
<tr>
<th>Year</th>
<th>Funds Released</th>
<th>Expenditure Reported</th>
<th>% Utilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999-00</td>
<td>50.00</td>
<td>25.23</td>
<td></td>
</tr>
<tr>
<td>2000-01</td>
<td>119.00</td>
<td>12.95</td>
<td></td>
</tr>
<tr>
<td>2001-02</td>
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<td></td>
</tr>
<tr>
<td>2002-03</td>
<td>40.00</td>
<td>21.65</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>279.44</strong></td>
<td><strong>77.51</strong></td>
<td><strong>27.74 %</strong></td>
</tr>
</tbody>
</table>
Employees State Insurance Scheme

In 1998, NACO collaborated with the ESI network to initiate an HIV prevention programme. The ESIC is a governmental programme providing medical care and social security services to nearly 86 lakhs Governmental employees and their families, benefiting around 2.32 crores people. About 200,000 factory units are also covered under the scheme. The programme aims to reduce the spread of HIV among those ESI beneficiaries who are poor, marginalized and at highest risk of HIV infection, especially, migrant workers and industrial labourers.

35 STD clinics, 35 VCTCs, 9 blood banks, and 1 blood component separation centre have been strengthened by NACO to provide counselling, testing and care facility. ESIC is one of the few organisations which provide the antiretroviral drugs to AIDS patients (65 patients at present) from their own funds.

Overall the status of implementation is good. However, the utilisation of funds as reported is not satisfactory as evident from the year wise financial details given below.

Financial Position:

(Rupees in lakhs)

<table>
<thead>
<tr>
<th>Year</th>
<th>Funds Released</th>
<th>Expenditure Reported</th>
<th>% Utilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999-00</td>
<td>121.54</td>
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<td>2002-03</td>
<td>150.00</td>
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</tr>
<tr>
<td>Total</td>
<td>432.51</td>
<td>114.99</td>
<td>26.58%</td>
</tr>
</tbody>
</table>

The Indian Railways

The Indian Railways are a large organisation providing health care to 16 lakhs workers and their family members - numbering about 1 crore beneficiaries in all. As a collaborator in the HIV/AIDS programme, the Railways have initiated training programmes for their medical and paramedical staff and provided PMTCT services. STI clinics and voluntary counseling and testing centers (VCTC) have also been established in each of the nine zones of the Railways, with support from NACO.
9 STD clinics and 32 voluntary counseling and testing centers (VCTC) will also be established in each of the zones, and divisions of the railways, with support from NACO. The Railways is also working closely with UNIFEM on the project for providing training to peer educators. So far 52 peer educators have been trained and are working with vulnerable population. Overall the status of implementation needs improvement.

Financial position:

<table>
<thead>
<tr>
<th>Year</th>
<th>Funds Released</th>
<th>Expenditure reported</th>
<th>% Utilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999-00</td>
<td>171.05</td>
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<td>2000-01</td>
<td>50.00</td>
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<td>150.00</td>
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<td>2002-03</td>
<td>50.00</td>
<td>51.78</td>
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<tr>
<td>Total</td>
<td>421.05</td>
<td>191.18</td>
<td>45.40 %</td>
</tr>
</tbody>
</table>

Defence

An Armed Forces AIDS Control Organisation [ACO] was formed in 1992 whose members include the Heads of the Departments of Microbiology, Medicine, Dermatology, Transfusion Medicine, Psychiatry and Epidemiology. DGAMS follows multi-prolonged strategy for programme implementation. Under the direct technical supervision of Command Nodal Officer, 52 IEC nodes have also been established in the military stations. The IEC nodes are responsible for planning, developing, executing and evaluating the HIV/AIDS IEC activities at the different military stations in the armed services. Around 200 medical officers and 1200 paramedical have been trained under the programme.

Syllabus for training in HIV has been developed, and is being used for medico students/ trainee doctors in medical colleges and other training centres for in service doctors.

There has been continuous upward trend in the incidence of HIV/AIDS amongst the defence service personnel since 1992. This trend was seen to have plateaued out in 1999-2000, and for the first time actually showed a decline in 2000-01.

Overall the status of implementation is satisfactory. But this is not getting reflected in the expenditure incurred/ funds utilised by M/o Defence.
Financial Position:

(Rupees in lakhs)

<table>
<thead>
<tr>
<th>Year</th>
<th>Funds Released</th>
<th>Expenditure reported</th>
<th>% Utilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999-00</td>
<td>250.00</td>
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</tr>
<tr>
<td>2000-01</td>
<td>150.00</td>
<td>65.93</td>
<td></td>
</tr>
<tr>
<td>2001-02</td>
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<td>38.40</td>
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</tr>
<tr>
<td>2002-03</td>
<td>200.00</td>
<td>249.83</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>600.00</td>
<td>354.16</td>
<td>59 %</td>
</tr>
</tbody>
</table>

Youth Affairs

The Department of Youth Affairs actively collaborates with NACO through the National Service Scheme (NSS) for the Universities Talk AIDS (UTA) programme and the Nehru Yuvak Kendra Sangathan (NYKS) for the Villages Talk AIDS (VTA) programme. While the UTA programme is targeted towards College youth the VTA programme is meant for the out-of-school youth.

Social Justice and Empowerment

A comprehensive programme integrating drug abuse reduction and HIV/AIDS prevention was launched with the partnership of Ministry of Social Justice & Empowerment (MSJE) since 2001. MSJE has already been implementing the scheme for prevention of Alcoholism and Drug Abuse through about 400 NGOs that run De-Addiction-cum-Rehabilitation Centres and Counselling Centres. This programme brings them into contact with groups who are also extremely vulnerable to the HIV infection. NACO saw an opportunity of integrating the preventive components of HIV / AIDS as an adjunct to substance abuse prevention programmes. Accordingly, NACO adopted a two-pronged approach for the collaborative project:

● NACO supports the post of a Field Worker in about 100 NGOs who focus on preventive activities including generating HIV/AIDS awareness and some skills on counseling.

● The field workers and other staff of NGOs are trained to enable them to acquire basic skills in HIV / AIDS related work.

NACO also funds eight Regional Research & Training Centers (RRTCs) of MSJE for imparting training on HIV/AIDS to the staff of NGOs funded under MSJE. Over the last two years, the partnership has resulted into building capacity of 313 staff
members of these NGO partners through 30 workshops held at RRTCs of MSJE. In addition nearly 52,633 addicts have been counseled on HIV/ AIDS related issues and out of which 4,909 were referred to VCTC.

To draw up the future road map of the collaborative project, a rapid assessment of this project was conducted through Family Health International. The assessment has broadly recommended for further continuation of the collaborative programme. Some important observations of rapid assessment were that a module with standard curriculum, along with facilitators guide, needs to be prepared and the terms of Reference for HIV field workers were being interpreted and followed differently by different centers.

AIDS Prevention and Control Project (APAC) in Tamil Nadu, with assistance from USAID

The Government of India, U.S. Agency for International Development (USAID) and Voluntary health Services, Chennai (VHS) signed a tripartite agreement on 12th September, 1995 with the sole objective of reducing sexual transmission of HIV in the State of Tamil Nadu. The purpose of the project is to introduce and re-inforce HIV prevention behaviour among those population most at risk to the infection notably commercial sex workers and their clients and STD patients.

Achievement by the end of the project, i.e., by 31st March, 2002, include:

# A network of NGOs involved in AIDS prevention;
# Programmes to build the capacity of NGOs to ensure quality intervention projects;
# Increased number of people aware of STD/ HIV/ AIDS preventive measures;
# Promotion of condom sales and utilization;
# Provision of quality STD services, which are accessible and affordable; and
# Behavioural and epidemiological researches to help modifications in programme direction for Government and voluntary agencies.

Against the total funding support of Rs.30.00 crores disbursement to the extent of Rs.29.47 crores has been received till March, 2002.

The USAID had commissioned an external evaluation team to evaluate the APAC project. The team commended the effort of APAC and inter alia recommended the project’s geographical extension to the neighbouring Pondicherry. The Agency has now proposed to extend the ongoing APAC Project, which is implemented by
Voluntary Health Services (VHS), Chennai, so as to provide a total financial support of Rs. 88.08 crores (US $ 18.74 million) over a period of five years from April 2002 to March 2007. The increase in the proposed Project is due to addition of new components and increase in geographical coverage. Out of the US$ 18.74 million (Rs.88.08 crores), US$ 13.74 million (Rs.64.58 crores) will be made available as financial aid to be routed through the Govt. of India budget, and the rest US $5.00 million (Rs.23.50 crores) will be direct funding by USAID for provision of technical assistance to the Project. The direct funding will be used for IEC activities (Rs. 4.70 crores), Family Health Awareness Campaign (Rs. 16.60 crores), and Capacity Building/Institutional Strengthening (Rs. 2.20 crores). An integrated EFC Memorandum approved by the constituted committee covers the above project for implementation till March, 2007.

**USAID Assisted AVERT Project in Maharashtra**

USAID assisted AVERT Project in Maharashtra is being implemented by AVERT Society, which is a registered autonomous body registered under the Society Registered Act of 1860 as well as Bombay Public Trust Act of 1950. The Society was a new initiative and an experimental model, wherein the funding agency and the host country tried to support the state programme through an autonomous body. The Society was registered in June 2001 and the office officially started functioning from September 2001. The project was delayed for about 2 years since the signing of the tripartite agreement between USAID, NACO and Government of Maharashtra in 2001. Hence the Society has to speed up the programmes right from the day one with the given new experimental model. The project has USD 41.5 million (Rs.166 crores) funds from donor agency for a period of 7 years. Apart from this Rs.54.40 crores in local currency estimated as expenditure normally incurred by Government of Maharashtra in respect of physical facilities, maintenance, drugs etc., in clinics proposed to be utilised for the project; and estimated cost of condoms to be supplied by Department of Family Welfare over the entire project period.

The strategic objectives of the AVERT Project are:

1. to increase the use of effective and sustainable responses to reduce the transmission; and
2. mitigate the impact of sexually transmitted diseases in Maharashtra through a five-pronged sub- objectives known as intermediate Results (IRs).

The following strategic components to achieve the objectives have been set under the project:-
1. **Prevention** - Improve the quality and availability of information, products and services that reduces the risk of transmission in target areas interventions for the "high risk" or the most vulnerable groups.

2. **Care and Support** - Improve the quality and availability of care and support services for people infected by an affected HIV/AIDS in Maharashtra.

3. **Capacity Building** - Strengthen capacity of state and Municipal organizations for HIV/AIDS strategic planning, program implementation and monitoring and evaluation.

4. **Research** - Increase availability and the use of research and epidemiological data in advocacy and decision making in state and district level HIV/AIDS control programmes.

5. **Communication** - Increase the use of mass for HIV/AIDS prevention and impact mitigation.

The AVERT Project will receive guidance and review from a National Steering Committee chaired by the Project Director (NACO). Other members of the NSC will be representative of the Department of Economic Affairs; the Project Director (MSACS); the Project Director (MDACS); and a USAID representative. The Project Director of AVERT Society will attend the meetings as an invitee.

**Budget at a Glance**

The following table provides the details of utilization under the project till date:-

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget</th>
<th>Expenditure (Rupees in lakhs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001-02</td>
<td>700.00</td>
<td>463.00</td>
</tr>
<tr>
<td>2002-03</td>
<td>700.00</td>
<td>665.00</td>
</tr>
<tr>
<td>2003-04</td>
<td>800.00</td>
<td>600.00</td>
</tr>
<tr>
<td>2004-05</td>
<td>800.00</td>
<td></td>
</tr>
</tbody>
</table>

**DFID PROJECT**

Department For International Development (DFID) of UK has been supporting a Project for prevention and control of HIV/AIDS and other Sexually Transmitted Diseases(STD) in the state of Andhra Pradesh, Gujarat, Kerala and Orissa for a five year period running concurrently with the IDA funded projects at a total cost of Rs.
154.3 crores. Out of these, Rs. 104.1 crores will be routed through the Govt. of India as local cost and Rs. 50.29 crores as technical costs which will be managed directly by DFID. The project essentially aimed at targeted intervention among high risks groups, such as sex workers; intravenous drug users, prison inmates, street children and migrant workers. The objective of the programme is to improve sexual health of people who are more vulnerable to STDs because of their poor economic status. The components of the project involves:

- Surveillance
- Condom promotion programme by ensuring that quality condoms are made available; and
- Building capacity within the States ensuring quality STD care and counseling.

Out of Rs. 104 crores, Rs. 33.37 crores have been spent on this project till March 2003. The DFID has now proposed to enhance the project's budget from Rs. 154 crores to about Rs. 786.80 crores (including the unspent balances) to support the scaling up of activities in the existing four States, and also include the West Bengal Sexual Health Project within the scope of the expanded project. Madhya Pradesh will be included for technical assistance alone.

The total plan funding for DFID during the NACP-II for a period of five years is now Rs. 786.80 crores comprising Rs. 487.40 crores in financial aid which will be routed through the Govt of India budget and Rs. 299.40 crores as Technical Co-operation (TC) Fund which will be managed directly by DFID. The TC fund will be used for the following activities:

- Sexual Health Resource Centre
- Family Health Awareness Campaign
- IEC activities.
- Initiative in Gender / Trafficking.
- Review and Evaluation and Contingencies.

**Bill and Melinda Gates Foundation (BMGF)**

The National AIDS Control Programme works in close partnership with the Bill and Melinda Gates Foundation on a comprehensive and well-designed programme that strives to reduce HIV/STI transmission in select core populations, in the high prevalence states.
The core strategic initiatives are the following:

- **District Focus, State Impact**: Targeted intervention programmes in 100 high prevalence districts of 6 high prevalence states focusing on CSWs, their clients, IDUs.
- **Protected passages**: Programmes along key national highways targeting transport workers and CSWs.

Besides these, there would be other supporting strategic initiatives including integrated communications, essential advocacy, knowledge building and impact monitoring and capacity building.

The Programme Board is co-chaired by Secretary (Health), Ministry of Health and Family Welfare. The National AIDS Control Organization is a member of this board to ensure that all the activities of the Foundation are in keeping with the objectives of the National Programme.

The foundation has approved grants worth almost US $ 127 million to date, for projects at the national level and at the state levels.
The National AIDS Control Programme, India includes strategies for prevention and strategies for care, support and treatment. Since its inception in 1987, the programme has focused overwhelmingly on interventions for prevention. During 2003, the agenda on prevention gained high visibility with significantly increased services for people with HIV. In order to make the National AIDS Prevention and Control Programme more comprehensive and holistic, it became necessary to strengthen the component on care and support of people living with HIV / AIDS (PLHAs).

Growing evidence from around the world indicates that the challenge of HIV/AIDS is best met with a strategy that combines prevention and care. HIV disproportionately affects people who are impoverished and socially marginalized. NACO is committed to promoting care and support for people living with HIV in order to optimize prevention efforts and reduce the impact of the HIV/AIDS epidemic on individuals and societies. Expanding access to care in an enabling environment increases the demand for voluntary counseling and testing services, bolsters prevention messages, destigmatizes AIDS and motivates those living with HIV to adopt and sustain protective behaviour. A National Consultation on Community Based Care & Support for HIV / AIDS was held from 12th to 14th May 2003 at Bangalore. The recommendations of National Consultation is being incorporated in the existing Care & Support programme.

The National AIDS Control Organisation (NACO) is implementing an expanded mandate for care & support of people living with HIV/AIDS by:

(i) Supporting community care centres, drop-in centres and supports groups of People Living with HIV/AIDS (PLWHA). The number of Community Care Centres run by NGOs increased from 36 in 2002 to 51 in 2003. NACO encourages and supports registered organizations of people living with HIV/AIDS to set up drop-in-centres which provide peer counseling and referrals for health care and social services. NACO supports 17 networks of people living with HIV/AIDS, and these are increasing.

(ii) Ensuring the availability of essential drugs for opportunistic infections. The AIDS Control Societies fund the treatment of opportunistic infections in government-run hospitals up to the district level. NACO also provides drugs for post-exposure prophylaxis in all government hospitals admitting people...
living with HIV/AIDS. These provide protection for health care providers in the event of a needlestick injury.

Linking services for voluntary counselling to the microscopy centres set up under the revised national TB control programme to improve access to free treatment for the HIV-TB co-infection. TB is the most common opportunistic infection among those living with HIV in India. A Joint Action Plan enables the developing of linkages between the TB microscopy centers of the Revised National Tuberculosis Control Programme and the voluntary counseling and testing centers of the National AIDS Prevention and Control Programme, at district and sub-district levels. We also conduct joint training of doctors, health workers and NGOs for management of the HIV-TB co-infection, in the six high prevalence states. In October 2003, NACO was awarded a financial grant of US$ 14.8 million for scaling up the care, support and treatment of the HIV-TB co-infection, across India.

(iii) Initiating intensive advocacy and sensitization programmes among doctors, nurses and paramedical workers to pre-empt, and thereby, counter both the stigmatization of people living with HIV, and the denial of health care on the grounds of HIV infection. Training workshops for doctors on the clinical management of HIV/AIDS and the rational use of anti-retroviral drugs are also undertaken.

(iv) Instructing all Government hospitals to admit HIV/AIDS cases without any discrimination and providing care for them in the general wards of the hospitals along with other patients.

(v) Facilitating the establishment of Infection Control Committees in all major hospitals.

(vii) Expanding district level voluntary counseling and testing centres in a phased manner.

(viii) Scaling up the prevention of parent to child transmission of HIV throughout the country in a phased manner; manner  is a cornerstone in our agenda on care and support. If merits more detailed discussion, and is narrated in the next section of this chapter.

Care and support for the people living with HIV is increasingly becoming the cornerstone of the AIDS prevention efforts in our country. While hospitals and Community Care Centres are expected to render support in difficult and critical situations that cannot be managed at home, the focus has to eventually shift to home based care. To ensure that the PLHA gets the required medical and psychosocial support at home, the models developed for home based care have to be revisited.
to involve greater outreach of existing health care machinery and adequate training of families to provide care and support at home.

### (i) Preventing Parent to Child Transmission

#### Background

Parent-to-child transmission (PTCT) of HIV, or perinatal transmission, accounts for 2.72 percent of the total HIV infection load in the country. Parent-To Child Transmission (PTCT) of HIV can occur during pregnancy, at the time of delivery or through breastfeeding. If an HIV positive woman becomes pregnant, there is a 25-30% chance that the baby will also be infected. More than 27 million women, including over 92,000 HIV infected women, give birth in India every year. The number of HIV-positive women is increasing, and with it, the number of babies with HIV infection. Fortunately, Parent-to-Child Transmission (PTCT) can be prevented with a combination of low-cost, short-term preventive drug treatment, safe delivery practices, counseling and support, and safe infant-feeding methods.

#### Vision

To ensure that all women in India may remain free of HIV infection, and have access to the services & support needed to protect their children from becoming infected with HIV.
The PPTCT Strategy:

<table>
<thead>
<tr>
<th>Strategy 1</th>
<th>Strategy 2</th>
<th>Strategy 3</th>
<th>Strategy 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of HIV in young people and women of childbearing age</td>
<td>Prevention of unintended pregnancies in HIV women.</td>
<td>Prevention of transmission from an HIV +ve woman to her infant</td>
<td>Care and Support for mother and her family</td>
</tr>
</tbody>
</table>

Elements of the PPTCT programme:

- Primary prevention of HIV infection in young people & women of child bearing age through promotion and provision of free, subsidized or commercially marketed condoms, provide diagnosis for treatment of sexually transmitted diseases, and behaviour change, communication efforts to reduce behaviour that place individuals at risk, and information about risks of PTCT during pregnancy, delivery, breastfeeding & encouragement to see VCT counselor or health provider for information on how to prevent HIV/AIDS among infants & young children.

- Prevention of unintended pregnancies in HIV positive women through reproductive health services, which include family planning.

- Prevention of transmission from an HIV positive women to her infant through anti-retroviral (ARV) prophylaxis and safer delivery practices

- Care and support services to HIV-infected women who are enrolled with the programme and to their children and families, including counselling on infant feeding.

Providing PPTCT services

NACO and UNICEF collaborated in the PPTCT feasibility study initiated at 11 hospitals in 5 high prevalence states (Andhra Pradesh, Karnataka, Maharashtra, Manipur and Tamil Nadu). These centres were designated as "PPTCT centres of excellence" developing "model practices". These centres have provided support in the scale up of PPTCT services in India, which has proceeded as scheduled, as follows:
The PPTCT services are provided in the antenatal clinics of all the medical college hospitals, both private and government, in both high & low prevalence states, and district hospitals of the high prevalence States. The process through which this intervention is implemented in the antenatal clinics is outlined below:

**Implementation of the PPTCT initiative**

1. **ANC** → **Group Education** → **Offered HIV test**
2. **Post-Test Counselling** ← **HIV Test** ← **Pre-Test Counselling**
3. **HIV +** & **HIV -**
4. **Participant** → **Primary Prevention**

Seeking synergy with CHC/PHC/SC/CDS Centers/NGOs/CBOs, Across the reproductive health program, for further expansion.
## Capacity building and achievements

The scale up of PPTCT services, has enabled training of 790 doctors and paramedical workers from 158 public and private medical colleges. Additionally, 785 health workers from 157 district hospitals have formed PPTCT teams. We have begun providing services for preventing HIV transmission from parent to child at 273 PPTCT centers with trained counselors.

In January 2003, NACO was awarded a financial grant of US$ 100.041 million to accelerate expansion of current facilities to prevent HIV transmission from parent to child, inclusive of access to anti-retroviral treatment for women, their partners and infants, through public-private partnerships.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Antenatal Clinic Registration</td>
<td>1012144</td>
<td></td>
</tr>
<tr>
<td>Women Counseled in Antenatal Clinics</td>
<td>824867</td>
<td>81.4%</td>
</tr>
<tr>
<td>Women tested in Antenatal Clinics</td>
<td>804051</td>
<td>97.4%</td>
</tr>
<tr>
<td>Antenatal women who came to pick their test results</td>
<td>514287</td>
<td>63.9%</td>
</tr>
<tr>
<td>No. of women detected +ve in Antenatal clinics</td>
<td>9650</td>
<td>1.2%</td>
</tr>
<tr>
<td>Antenatal HIV +ve women who came to pick up their results</td>
<td>5949</td>
<td>61.6%</td>
</tr>
<tr>
<td>Women counseled who arrived in labour room without ANC</td>
<td>105361</td>
<td>47%</td>
</tr>
<tr>
<td>Women tested who arrived in Labour room without ANC</td>
<td>91460</td>
<td>86.8%</td>
</tr>
<tr>
<td>Women detected +ve who came directly in labour</td>
<td>1740</td>
<td>1.9%</td>
</tr>
<tr>
<td>Partners of HIV + women who came for counseling</td>
<td>4923</td>
<td>51%</td>
</tr>
<tr>
<td>Total live births to HIV +ve women</td>
<td>5643</td>
<td></td>
</tr>
<tr>
<td>Total mother - baby pairs who received Nevirapine</td>
<td>4771</td>
<td>84.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Denominator as total live births to HIV +ve women) 41% Nevirapine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV +ve mothers who chose to breastfeed their babies</td>
<td>2500</td>
<td>57.9%</td>
</tr>
</tbody>
</table>
The Road ahead

We need to focus on early completion of:

- Adapting & disseminating in local languages the guidelines on counselling for infant feeding and HIV
- Sensitising health care providers to eschew all stigma and discrimination vis-a-vis clients
- Providing specific training to service providers to improve counselling skills
- Sensitising communities to create a more caring & supportive environment for HIV affected families
- Increasing awareness and comprehension about the importance & benefits of preventing HIV transmission from Parent to child...

(ii) Anti-retroviral Treatment: A new initiative

A quantum leap forward in India’s response to care and support has been our decision to provide\(^1\) anti-retroviral treatment (ART) at government hospitals, free of cost, for people living with HIV/AIDS in the six high prevalence states of Tamil Nadu, Andhra Pradesh, Maharashtra, Karnataka, Manipur and Nagaland and in the capital city of Delhi.

Anti-retroviral treatment for people living with AIDS was not previously supported by government in the National AIDS Control Programme on account of prohibitive costs. However, government, has been progressively reducing the excise and custom duties on antiretroviral drugs and medicines in order to make these more affordable for people living with HIV/AIDS.

In the meanwhile, globally, the cost of antiretroviral treatment fell sharply, largely driven by Indian manufactured generic drugs. People living with HIV/AIDS had been clamoring for treatment for nearly 15 years. They were not showing up in any significant numbers at voluntary counseling and testing sites because after the testing, government would only provide referrals. Government hospitals provide treatment for all manner of ailments. It was no longer ethical to continue to delay treatment for HIV/AIDS. The significantly lower cost of ARV treatment made it affordable for government to support a programme of treatment for the poor, especially given the fact that since HIV mostly infects people in their economically most productive years, the social costs of disability and death are extremely high.

\(^1\) From 1st April, 2004
Action taken to commence introduction of antiretroviral treatment for people living with HIV/AIDS

During November 2003, the Union Minister for Health & Family Welfare met representatives of the industrial associations, Director General (Indian Council for Medical Research), Director General Health Services, representatives of pharma companies and senior officials to determine the basket of diverse generic ARV drugs and medicines being manufactured by them, and available.

At this meeting a Working Group on ARV was constituted, with Secretary (Health) as the Chair, with Director General Health Services and Additional Secretary & Project Director, NACO as members. Industrial associations like CII and FICCI were members along with representatives of pharmaceutical companies. This working Group held three meetings on 19th November, 24th November and 25th November, 2003. A detailed Report was submitted to Union Health Minister on 28th November, 2003.

At a Press Conference held on 30th November, 2003, on the eve of World AIDS Day, Union Health Minister announced the intention of government to commence, free of cost, the disbursement of ARV treatment for people living with HIV/AIDS from 1st April, 2004.

The NACO immediately commenced formulating Guidelines for Training together with Programme Implementation Guidelines for providing ART in resource constraint settings. These Guidelines were finalized and dispatched to national experts as well as WHO & UNAIDS for peer review and feedback. The training curriculum focused on the clinical and bio-medical stages and progression of HIV/AIDS, selection of the appropriate anti-retroviral regimen, monitoring of side effects and ensuring adherence to treatment. A National Consultation on ARV treatment for HIV / AIDS was held on 28-29 January, 2004. WHO Geneva sent in a team from its head quarters to participate in this national consultation on HIV. UNAIDS, USAID, World Bank were active participants, Project Directors from the six high prevalence states had been invited along with Medical Superintendent from 15 medical institutions across high prevalence states, clinicians, dermatologists, and many others.

In early March, 2004 the Project Directors of six high prevalence states were advised to commence preparation for ART by identifying (through NGOs and civil society) people living with AIDS, for preliminary investigations and screening for eligibility of ART.
In the run up to 1st April, 2004 Training of Trainers was convened in 4 institutions identified for training, for representatives from 15 institutions from across the 6 high prevalence states, from 15th Feb to 15th March.

On World AIDS Day 2003 (1st December) Government announced its decision to provide Anti Retroviral Treatment (ART), free of cost to people living with HIV/AIDS in the six HIV high prevalence states of TamilNadu, Andhra Pradesh, Karnataka, Maharashtra, Manipur, and Nagaland and the state of Delhi from April 2004, in keeping with WHO Guidelines on ART for resource constrained settings. Additionally, Government prioritised the following three categories for initial outreach:

(i) The HIV positive pregnant women who accesses government antenatal clinics.
(ii) Children up to 15 years of age.
(iii) Adults with full-blown AIDS who access government hospitals for care and treatment.

Government hospitals identified for the initial launch of antiretroviral treatment in consultation with the State AIDS Control Societies were:

a) Sir JJ hospital, Mumbai, Maharashtra
b) Institute of Thoracic Medicine and Chest diseases, Tambaram, Chennai
c) Regional Institute of Medical Sciences (RIMS), Imphal, Manipur
d) Bangalore Medical College Hospital, Bangalore, Karnataka
e) Osmania Medical College Hospital, Hyderabad, Andhra Pradesh
f) Ram Manohar Lohia (RML) Hospital, New Delhi
g) LNJP Hospital, New Delhi
h) District Naga Hospital, Kohima, Nagaland

NACO reviews very frequently, the roll out of ART and we closely monitor emerging teething problems and the progress achieved in the accurate disbursement of antiretroviral treatment across 8 hospitals that have commenced implementing this initiative. Counselling including family counselling and networking with NGOs and positive peoples networks have been ensured. These 8 ART centers have achieved an adherence rate of 96.1% among people who have been placed on treatment.

Union Health Minister has reviewed in July and in August, 2004 the current status in implementation of the ART initiative. He has directed that during 2004-05,
government will increase the numbers of ART centres from 8 centres to 25 centres** at identified government hospitals across HIV high prevalence and HIV low prevalence states. In June 2004, the Global Fund on AIDS, TB and Malaria awarded a financial grant of US $165 million to provide antiretroviral treatment in the public sector and through public-private partnerships for 1,00,000 people living with AIDS over a five year period.

Beginning in April 2004, procurement of ART drugs and medicines has been made by WHO. Government has initiated steps to ensure that during 2004-05 drugs and medicines for nearly 30,000 people living with AIDS would be procured and disbursed to the 25 hospitals identified. We anticipate that we will meet our target of providing ART to 25000 patients during this year.

** A listing of the additional 17 hospitals, where ART centres are being located is:

1. Madras Medical College, Chennai, Tamil Nadu
2. District Hospital, Namakkal, Tamil Nadu
3. Government Medical College, Madurai, Tamil Nadu
4. Government Medical College, Vizag, Andhra Pradesh
5. Government Medical College, Guntur, Andhra Pradesh
6. Government Medical College, Sangli, Maharashtra
7. B J Medical College, Pune, Maharashtra
8. Government Medical College, Nagpur, Maharashtra
9. Karnataka Medical College, Hubli, Karnataka
10. Mysore Medical College, Mysore, Karnataka
11. Jawaharlal Nehru Hospital, Imphal, Manipur
12. Government Medical College, Ahmedabad, Gujarat
13. Government Medical College, Panaji, Goa
14. PGIMER, Chandigarh, Punjab
15. Calcutta Medical College, Kolkata
16. SMS Hospital, Jaipur, Rajasthan
17. Banaras Institute of Medical Sciences, Varanasi
For strengthening the existing infrastructure in medical colleges / district hospitals, where antiretroviral centres are being installed (inclusive of the initial 8 centres), NACO provides the following support to each institution:

1. One treatment unit comprising of one senior medical officer, one medical officer, one counselor, one lab technician, one record keeper cum computer operator
2. Training of the entire team engaged in ARV treatment
3. Facilities for investigations free of cost through CD4 and CD8 counts
4. Contingency funds for renovation of office and strengthening basic infrastructure
5. Antiretroviral treatment, free of cost, as per defined inclusion criteria

We have commenced antiretroviral treatment for people living with HIV/AIDS in clinical settings, without loosing our moorings with civil society. This initiative on anti-retroviral treatment for people living with AIDS is also strengthening partnership with civil society. For each hospital and institute included in the treatment initiative, the State AIDS Control Societies have identified networks of HIV positive people and NGOs who will provide psycho-social support, peer education and treatment literacy to AIDS patients on ART, and will track them for adherence, compliance and timely referrals.

We recognize that unless we can reduce the fresh incidence of HIV, the growing demand for treatment could eventually become unsustainable. We have now in India, a window of opportunity. We will incorporate interventions on HIV prevention at treatment settings, wherever possible. This will enable implementation of a truly comprehensive programme that could eventually halt the spread of HIV.
**Financial Outlay**

The basket of resources for National AIDS Control Project (1999-2004) was approved by the CCEA in 1999 as follows:

<table>
<thead>
<tr>
<th><strong>OUTLAY FOR NATIONAL AIDS CONTROL PROJECT PHASE-II</strong></th>
<th><strong>INR in crores</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank (IDA) assistance for NACP II</td>
<td>1155</td>
</tr>
<tr>
<td>USAID assistance for AVERT Project in Maharashtra.</td>
<td>166</td>
</tr>
<tr>
<td>DFID assistance for Sexual Health projects for the States of Andhra Pradesh, Gujarat, Kerala and Orissa.</td>
<td>104</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1425</strong></td>
</tr>
</tbody>
</table>

The basket of resources of the National AIDS Control Programme (1999-2006) was approved by the CCEA in December 2003 as follows:

<table>
<thead>
<tr>
<th><strong>S.No.</strong></th>
<th><strong>Funding Agency</strong></th>
<th><strong>INR in crores</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Government of India</td>
<td>196.00</td>
</tr>
<tr>
<td>2</td>
<td>World Bank</td>
<td>959.10</td>
</tr>
<tr>
<td>3</td>
<td>USAID (APAC)</td>
<td>64.58</td>
</tr>
<tr>
<td>4</td>
<td>USAID (AVERT)</td>
<td>166.00</td>
</tr>
<tr>
<td>5</td>
<td>DFID (Sexual Partnership Project)</td>
<td>487.00</td>
</tr>
<tr>
<td>6</td>
<td>CIDA (ICHAP)</td>
<td>37.81</td>
</tr>
<tr>
<td>7</td>
<td>AusAID</td>
<td>24.65</td>
</tr>
<tr>
<td>8</td>
<td>UNDP</td>
<td>6.47</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>1941.91</strong></td>
</tr>
</tbody>
</table>

Additionally, the Cabinet Committee on Economic Affairs has approved another project with Global Fund Assistance at a cost of Rs.122.74 crores for two years, i.e., 2004-05 and 2005-06. This will raise the total cost of NACP-II from Rs.1941.91 crores to Rs.2064.65 crores.
A break-up of the NACP (1999-2006) is indicated below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget Estimate</th>
<th>Revised Estimate</th>
<th>Expenditure incurred</th>
<th>Percent utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999-2000</td>
<td>140.00</td>
<td>140.00</td>
<td>135.25</td>
<td>96.60</td>
</tr>
<tr>
<td>2000-2001</td>
<td>145.00</td>
<td>180.00</td>
<td>179.00</td>
<td>123.45</td>
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<tr>
<td>2001-2002</td>
<td>210.00</td>
<td>225.00</td>
<td>225.00</td>
<td>228.49</td>
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<tr>
<td>2002-2003</td>
<td>225.00</td>
<td>242.00</td>
<td>242.00</td>
<td>240.00</td>
</tr>
<tr>
<td>2003-2004</td>
<td>225.00</td>
<td>225.00</td>
<td>233.00</td>
<td>103.50</td>
</tr>
<tr>
<td>2004-2005</td>
<td>259.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

USAID assisted APAC Project in Tamil Nadu

AIDS Prevention and Control (APAC) Project in Tamil Nadu aims at reducing the HIV transmission of HIV infection in State of Tamil Nadu by reinforcing HIV
prevention behaviour among population at risk notably commercial sex workers and their clients, and STD patients.

The total commitment for this project is US $ 10 million or says Rs. 30 crores in terms of Indian Rupees. By the end of 31st March 2001, Rupees 21.48 crores has been utilized under the Project.

This project has now been revisited and extended to Pondicherry apart from Tamil Nadu. The project cost of this project is Rs.64.58 crores and the span of the project is from 2002 to 2007. During 2003-04 a provision of Rs.8.00 crores has been kept for the project. Reimbursement of Rs.11.00 crores has been made under the project against the projected provision. During the current financial year i.e. 2004-05 a provision of Rs. 15 crores has been kept for the project.

**USAID assisted AVERT Project in Maharashtra**

The USAID funded AVERT Project seeks to increase the use of effective and sustainable responses to reduce transmission of and mitigate STD/HIV/AIDS and related infectious diseases in the State of Maharashtra. The total project cost of AVERT project is Rs. 166 crores.

A nodal agency to implement the Project has been established and a provision of Rs.8.00 crores has been kept for the financial year 2003-04.

**DFID assisted Projects**

Department for International Development (DFID) of UK is supporting a project for prevention and control of HIV/AIDS and other Sexually Transmitted Diseases in the State of Andhra Pradesh, Gujarat, Kerala, Orissa, and West Bengal.

The Project is adopting the same targeted Intervention approach in dealing with the vulnerable communities such as sex workers, intravenous drug users, prison inmates, street children and migrant workers as in the World Bank assisted National AIDS Control Project - Phase II.
The last two years, 2002 - 2004 have seen NACO and its partners implement several innovations.

The HIV epidemic is not about denial, nor about despondency. The National AIDS Control Organisation has rallied our partners together to provide hope, help and confidence to people living with HIV and those indirectly affected by it.

We have identified the gaps in the HIV / AIDS prevention and control programme, and smoothly ushered in new initiatives to implement a comprehensive national response. We thank all stakeholders, in government and outside, for their collaboration and participation in our accelerated response.

HIV/AIDS has galvanized the responses and concerns of diverse sectors and people like no other issue has for a long time. However, it is evident that this process needs to strengthen and deepen if we are to defeat the HIV virus, together.