# UNGASS INDIA REPORT

**Progress Report on the**
**Declaration of Commitment on HIV/AIDS**

## United Nations General Assembly
## Special Session on HIV/AIDS


**NATIONAL AIDS CONTROL ORGANISATION**
**Ministry of Health and Family Welfare**
**Government of India**
**New Delhi**
**2005**

## Contents

## Glossary

| | |
|---|---|
| **AEP** | Adolescent Education Programme |
| **ART** | Antiretroviral Therapy |
| **BBC** | British Broadcasting Corporation |
| **BMGF** | Bill and Melinda Gates Foundation |
| **CHC** | Community Health Centre |
| **CMIS** | Computerised Management Information System NACO |
| **CSW** | Commercial Sex Worker |
| **DFID** | Department for International Development |
| **DoC** | Declaration of Commitment on HIV/ AIDS |
| **EQAS** | External Quality Assessment Scheme |
| **FF** | Freedom Foundation |
| **FRU** | First Referral Unit |
| **FSW** | Female Sex Worker |
| **GIPA** | Greater Involvement of People with HIV/AIDS |
| **HRG** | High Risk Group |
| **ICMR** | Indian Council of Medical Research |
| **ICSE** | Indian Council of Secondary Education |
| **IDU** | Injecting Drug User |
| **ILO** | International Labour Organisation |
| **MARP** | Most at Risk Populations |
| **MoHFW** | Ministry of Health and Family Welfare |
| **MoSJE** | Ministry of Social Justice and Empowerment |
| **MSM** | Men Having Sex With Men |
| **MSW** | Male Sex Worker |
| **NACO** | National AIDS Control Organisation |
| **NACP** | National AIDS Control Programme |
| **NVP** | Nevirapine |
| **PACT** | National Partnership for AIDS Control and Treatment |
| **PHC** | Primary Health Centre |
| **PIP** | Programme Implementation Plan |
| **PLHA** | Person Living with HIV / AIDS |
| **PLHIV** | Person living with HIV |
| **PPTCT** | Prevention of Parent to Child Transmission of HIV/AIDS |
| **RTI** | Reproductive Tract Infection |
| **SAEP** | School AIDS Education Programme |
| **STI** | Sexually Transmitted Infection |
| **TI** | Targeted Intervention |
| **UNAIDS** | United Nations Joint Program on HIV/AIDS |
| **UNFPA** | United Nations Population Fund |
| **UNGASS** | United Nations General Assembly Special Session |
| **UNICEF** | United Nations Children's Fund |
| **USAID** | United States Agency for International Development |
| **UT** | Union Territory |
| **VCTC** | Voluntary Counselling and Testing Centre |
| **WHO** | World Health Organisation |

# INTRODUCTION

India, along with other Member States adopted the Declaration of Commitment on HIV/AIDS, in the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001. The Declaration of Commitment reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal of halting and beginning to reverse the HIV/AIDS epidemic by 2015.

Recognizing the need for multisectoral action on a range of fronts, the Declaration of Commitment address global, regional and country-level responses to prevent new infections, expand healthcare access and mitigate the epidemic's impact. Under the terms of the Declaration of Commitment (DoC), success in the response to AIDS is measured by the achievement of concrete, time-bound targets. The DoC calls for careful monitoring of the progress in implementing agreed-on commitments and requires the United Nations Secretary-General to issue periodic progress reports. In 2002 UNAIDS Secretariat along with other partners developed a series of core indicators to measure progress in implementing the Declaration. In 2003, the Member States, including India, submitted national progress reports.

All Member States have to report on the achievements towards attaining the national indicators between 2003 and 2005. This Report seeks to provide the basis for the Secretary-General's special progress report in June 2006, and both reports will be reviewed at the next General Assembly High Level Meeting on AIDS in September 2006.

In order to improve the quality of data that has to be submitted for the 2006 Global Progress Report, UNAIDS has prepared a document 'Guidelines on Construction of Core Indicators' in July 2005. This report is guided by this document. Although it was governments that initially endorsed the Declaration of Commitment, the guidelines and this report's vision extends beyond the government sector to include civil society response to a great extend. The process of preparation of this document includes collection and analysis of data from National AIDS Control Organisation, bilateral and multilateral organisations and civil society. Two civil society consultations were also utilized to collect relevant data and the draft report was vetted by the representatives of the civil society (details in Annexure-I). .

Considering the fact that the spread of HIV is concentrated in certain areas in India, UNGASS core indicators for concentrated or low-prevalence epidemics is used to report. The set of nine priority indicators include four indicators from the national commitment and action category, four from the knowledge and behaviour category and one from the impact category.

**Nine Core Indicators for India**

**Expenditure**

- Amount of national funds disbursed by government

**Policy Development and Implementation Status**

- National Composite Policy Index
- Percentage most-at-risk populations (sex workers, injecting drug users and men who have sex with men) who received HIV testing in the last 12 months and who know the results

- Percentage of most-at-risk populations (sex workers, injecting drug users and men who have sex with men) reached by prevention programmes

**Knowledge and Behaviour**

- Percentage of most-at-risk populations (sex workers, injecting drug users and men who have sex with men) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of female and male sex workers reporting the use of condoms with their most recent client
- Percentage of men reporting the use of condoms the last time they had anal sex with a male partner
- Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV

**Impact**

- Percentage of most-at-risk populations (sex workers, injecting drug users and men who have sex with men) who are HIV infected

# OVERVIEW OF THE AIDS EPIDEMIC

India's population surpassed the one billion mark in 2001, with 67.2 percent of its people living in rural areas, and 32.8 percent in urban areas. It is estimated that India has the second largest population of people living with HIV/AIDS (PLHA), next to South Africa. An estimated 5.134 million individuals currently live with the virus across all states in India (NACO 2004). In areas that are being more severely affected, the epidemic has started challenging recent developmental achievements and raising fundamental issues of human rights concerning PLHA.

The HIV/AIDS epidemic in India is characterised by heterogeneity; it seems to be following the Type 4 Pattern, where the epidemic shifts from the most vulnerable populations (such as CSW, IDU, MSM) to bridge populations (clients of sex workers, STI patients, partners of drug users) and then to the general population. The shift usually occurs when the prevalence in the first group exceeds 5 percent, with a two-three year time-lag between shifts from one group to another.

NACO estimated that the number of people infected with HIV in India increased from 3.86 million in 2000 to 5.13 million in 2004. As of 2004, about 39 percent of infected are women and about 58 percent of infected live in rural areas where HIV/AIDS services are poor (Table 1). By the end of November 2005, the total number of reported AIDS cases in India was 116,905 of which 34,177 were women (NACO,2005). This data also indicates that about one-third of reported AIDS cases are among young people under the age of 30. However, many more AIDS cases go unreported. The total AIDS deaths reported as on December 2005 is only 8097 (NACO, 2005) This is because large number of deaths due to AIDS related causes go unreported because of stigma, discrimination and problems in claiming life insurance coverage.

The spread of HIV within the country is as diverse as the societal patterns between its different regions, states and metropolitan areas. The transmission route is predominantly heterosexual (85.7%), of except in the North Eastern states where injecting drug use is the main route of HIV transmission. A significant increase in injecting drug use, with drug users switching from inhaling to over-the-counter injecting drugs has occurred over the past four years. The other routes of transmission by order of proportion includes perinatal (3.6%) infected needles and syringes (2.4%), unsafe blood and blood products (2.0 %) and unspecified and other routes of transmission (8 %).

It is significant to note from the walk-in client data from VCTC, young people seropositive cases below 14 years of age makes up to 4.3 percent and between age group 15-49, it is 88.7% (NACO, CMIS 2005).

Both tracking the epidemic and effectively implementing programmes thus poses a serious challenge in India as the epidemic started impacting on more and more women, young people and children. Gender prejudice, unequal power in decision-making between men and women and women's inability to negotiate safer sex represent major obstacles to prevention. Migration both within and between states is a major source of HIV transmission between urban and rural populations and between more socially developed and less socially developed states.

**Table 1: HIV Estimates 2000-2004 (in million)**

| | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Total estimated HIV infection | 3.86 | 3.97 | 4.58 | 5.10 | 5.13 |
| Infected males | 1.94 (60.2) | 2.04 (61.5) | 2.58 (68.14) | 3.22 (63.06) | 3.13 (61.1) |
| Infected females | 1.24 (39.8) | 1.24 (38.5) | 1.21 (31.86) | 1.89 (36.94) | 2.00 (38.9) |
| New infection among children | | | | 0.05 (01.08) | 0.06 (1.11) |
| Infection in urban areas | 2.45 (75.9) | 2.54 (76.8) | 2.683 (70.77) | 2.046 (40.07) | 2.17 (42.4) |
| Infection in rural areas | 0.74 (24.1) | 0.74 (23.2) | 1.11 (29.23) | 3.06 (59.93) | 2.96 (57.6) |
| **HIV infection in various sub-population groups** | | | | | |
| Clients attending STD clinics | 1.44 (44.6) | 1.37 (41.5) | 1.44 (37.39) | 1.49 (29.24) | 1.33 (25.82) |
| Women attending ANC clinics | 1.75 (54.3) | 1.91 (57.6) | 2.36 (61.90) | 3.48 (68.09) | 3.60 (70.15) |
| Injecting drug users | 0.04 (1.1) | 0.03 (0.9) | 0.03 (0.71) | 0.01 (0.20) | 0.01 (0.21) |
| Female sex workers | | | | 0.07 (01.39) | 0.14 (2.71) |
| **Proportion of infection state-wise** | | | | | |
| Among high prevalent states | 2.38 (74) | 2.35 (70.9) | 2.59 (67.91) | 3.15 (61.75) | 3.56 (69.38) |
| Among medium prevalent states | 1.26 (3.9) | 1.38 (4.2) | 0.11 (02.88) | 0.18 (03.43) | 0.11 (2.05) |
| Among low prevalent states | 0.71 (22.1) | 0.83 (24.8) | 1.12 (29.21) | 1.78 (34.82) | 1.47 (28.57) |

Figures in parenthesis are percentage to the total

*Figures for 2000 to 2002 point estimates pegged up by 20% to give total no. of infections in that year

Though the reach of the programme has extended, appropriate and effective delivery remains a challenge with a range of factors outside the scope of NACP impacting the programme delivery. Among these factors are the limited reach of government health delivery systems, the feudal and caste-influenced social framework in rural north and central India, insufficient healthcare delivery systems in states recognised as vulnerable to the epidemic, certain legislations affecting the vulnerable populations like sex workers, men who have sex with men and injecting drug users that needs to be reviewed from the HIV/AIDS and human rights perspective. Civic and political atmosphere in certain pockets needs a check as that poses obstacle to effective programme delivery.

## REDUCTION ON HIV PREVALENCE

The Declaration calls for establishing time-bound national targets to achieve the global prevention goal to reduce HIV prevalence among young adult ages by 25 percent by 2005 and 25 percent globally by 2010. The National AIDS Prevention and Control Policy envisaged and the National Health Policy, 2002 reaffirmed effective containment of the infection levels of HIV/AIDS in the general population so as to achieve zero growth of infection by 2007.

HIV prevalence in India is calculated based on the Annual HIV Sentinel Surveillance (HSS) studies conducted across the country. Started in 1988 with 180 sites, the number and type of sites has been increased over the years to better represent population groups and geographical areas and have reached 750 sites in 2005. Considering the vastness and diversity of the epidemic, the present coverage in terms of number of sites is one of the best in the world.

**Table 2-Expansion of Sentinel Surveillance Sites, 1998-2005**

| Year | STD | ANC | ANC (15-24) | ANC-Rural | IDU | MSM | FSW | TB | Army Recruit | TI | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1998 | 77 | 94 | - | - | 9 | - | - | - | - | - | 180 |
| 1999 | 77 | 94 | - | - | 9 | - | - | - | - | - | 180 |
| 2000 | 104 | 118 | - | - | 8 | 2 | - | - | - | - | 232 |
| 2001 | 131 | 173 | - | - | 12 | 2 | 2 | - | - | - | 320 |
| 2002 | 166 | 200 | - | - | 13 | 3 | 2 | - | - | - | 384 |
| 2003 | 166 | 271 | - | - | 13 | 3 | 2 | - | - | - | 455 |
| 2004 | 171 | 268 | 10 | 122 | 24 | 15 | 42 | 7 | - | - | 659 |
| 2005 | 179 | 269 | 11 | 130 | 30 | 15 | 87 | 7 | 22 | - | 750 |

The assumption taken for the estimation of prevalence is that people attending STD clinics practice high risk behaviour and would hence include the population groups of FSW, MSM and IDU. Since as of now there is no community prevalence of HIV studies available in India, women attending ANC clinics are taken as proxy for the general population. The limitation of a community based study will be achieved through the third round of the National Family Health Survey that has already incorporated a variable of HIV prevalence among the general population across the country.

Taking the same assumption, the comparative figures of HIV prevalence among ANC attendees for 2002 and 2004 will help in analysing the impact of HIV prevention programme in the country. (Note: since the data for 2005 was not released at the time of preparation of this report, the data for 2002 and 2004 is used). Table 3 shows details of the states/UT where the prevalence of HIV among different population groups has decreased, remained constant or increased between 2002 and 2004.

It is observed that among 62 percent of states, the prevalence of HIV among women attending ANC clinics had either decreased or remained constant. Taking the ANC data as representing the general population, it can be concluded that the prevalence of HIV among the general population has decreased in 14 states and remained constant in 9 states. Similarly, HIV prevalence among people attending STD clinics decreased by 37 percent and remained constant among 17 percent states.

**Table 3: Change in HIV Prevalence in States/UTs***

| Population groups | Change HIV prevalence among States (HSS 2002 and 2004) | | |
|---|---|---|---|
| | **Decreased** | **Remained constant** | **Increased** |
| **ANC attendees** | Bihar<br>Chattisgarh<br>Goa<br>Gujarat<br>Haryana<br>Karnataka<br>Kerala<br>Mizoram<br>Punjab<br>Rajasthan<br>Sikkim<br>Tamil Nadu,<br>Uttaranchal<br>Dadar & Nagar Haveli | Assam<br>Jammu & Kashmir<br>Jharkhand<br>Maharastra<br>Meghalaya<br>Uttar Pradesh<br>A & N islands<br>Lakshdweep<br>Pondicherry | Andhra Pradesh<br>Arunachal Pradesh<br>Delhi<br>Himachal Pradesh<br>Madhya Pradesh<br>Mumbai<br>Manipur<br>Nagaland<br>Orrissa<br>Tripura<br>West Bengal<br>Chandigarh<br>Daman & Diu |
| **Total and porportional change** | **14 (38 %)** | **9 (25%)** | **13 (31%)** |
| **STD Clinic Attendees** | Andhra Pradesh<br>Bihar<br>Gujarat<br>Madhya Pradesh<br>Manipur<br>Meghalaya<br>Mizoram<br>Nagaland<br>Punjab<br>Rajasthan<br>Tamil Nadu<br>Tripura<br>A & N Islands | Arunachal Pradesh<br>Sikkim<br>Uttar Pradesh<br>D & H Haveli<br>Daman & Diu<br>Lakhdweep | Assam<br>Chattisgarh<br>Delhi<br>Goa<br>Haryana<br>Himachal Pradesh<br>Jammu & Kashmir<br>Jharkhand<br>Karnataka<br>Kerala<br>Maharashtra<br>Mumbai<br>Orissa<br>Uttaranchal<br>West Bengal<br>Chandigarh<br>Pondicherry |
| **Total and porportional change** | **13 (37%)** | **6 (17%)** | **17 (46%)** |

* Not all states have data on different population groups. The proportional change is based on absolute number and not statistically significant.

The trends of HIV prevalence among IDU from sentinel surveillance data is showing a mixed trends across the years. Comparing the data in 2002 and 2004, we see that while in the states of Karnataka, Mumbai, Manipur, Nagaland and Meghalaya, HIV prevalence has either decreased or remained constant, the prevalence had increased in the states of Delhi, Mizoram, Tamil Nadu and West Bengal. Thus in most of the north eastern states where sharing needles was the primary mode of transmission, interventions were focused on IDU and the prevalence has decreased. With limited time series data available for MSM and FSW, it is difficult to conclude the impact of prevention programme. However the available data also suggest that there is a considerable decrease in the HIV prevalence in certain pockets of the country.

**Table 4: HIV Prevalence Among Injecting Drug Users, HSS 1998-2004**

| Year | Nagaland | Mizoram | Karnataka | Delhi | Tamil Nadu | Mumbai | Megalaya | West Bengal |
|---|---|---|---|---|---|---|---|---|
| 1998 | 13.2 | 1 | | | | | | |
| 1999 | 7.6 | 1.5 | 1.3 | | | | | |
| 2000 | 7.03 | 9.61 | 4.23 | 5 | 26.7 | 23.68 | 1.41 | |
| 2001 | 5.5 | 2 | 2 | 2.4 | 24.56 | 41.37 | 1.39 | |
| 2002 | 10.28 | 1.6 | 2.26 | 7.4 | 33.8 | 39.42 | 0 | 1.5 |
| 2003 | 13.86 | 4 | 2.8 | 7.2 | 63.8 | 24.8 | 0.4 | 2.7 |
| 2004 | 4.49 | | 0 | 17.6 | 39.9 | 28 | 0 | 5.5 |

One of the challenges the surveillance system in India is facing is the representativeness of the sites between most-at-risk population (FSW, MSM and IDU) and the other population. The expert committee on estimation has identified this and action has been initiated to start more number of sites for most-at-risk population groups across the country.

**MOST-AT-RISK POPULATION: HIV TESTING**

In order to assess progress in implementing HIV testing and counselling among most-at-risk population, one of the Core Indicators is the percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the results. One of the suggested methods of measurement for this indicator is a Behaviour Surveillance Survey (BSS). Since there is no BSS conducted at the national level after 2000, the data from the Voluntary Counselling and Testing (VCT) centres is used here with the following assumptions.

The government' of India's policy for HIV testing is on a voluntary basis accompanied with appropriate pre-test and post-test counselling. In order to encourage people practicing high risk behaviour, NACO started setting up of VCT centres in 1997. The number of VCT centres rose to 628 in the beginning of 2004 and by the end of 2005 it was scaled up to 873 centres. The VCT centres are now operational at the district level and linkages with the focussed prevention programmes for most-at-risk populations have been made for easy access to testing. Since the testing process ensures confidentiality to the clients, the VCT centre data does not capture the background of the clients by risk groups (CSW, IDU, and MSM) that is required to report this indicator. However, it is assumed that people who visit the VCT centres, practice high risk behaviours and hence would be captured in this data.

**Table 5: Data from VCT Centres (Oct 04- Sept 05)**

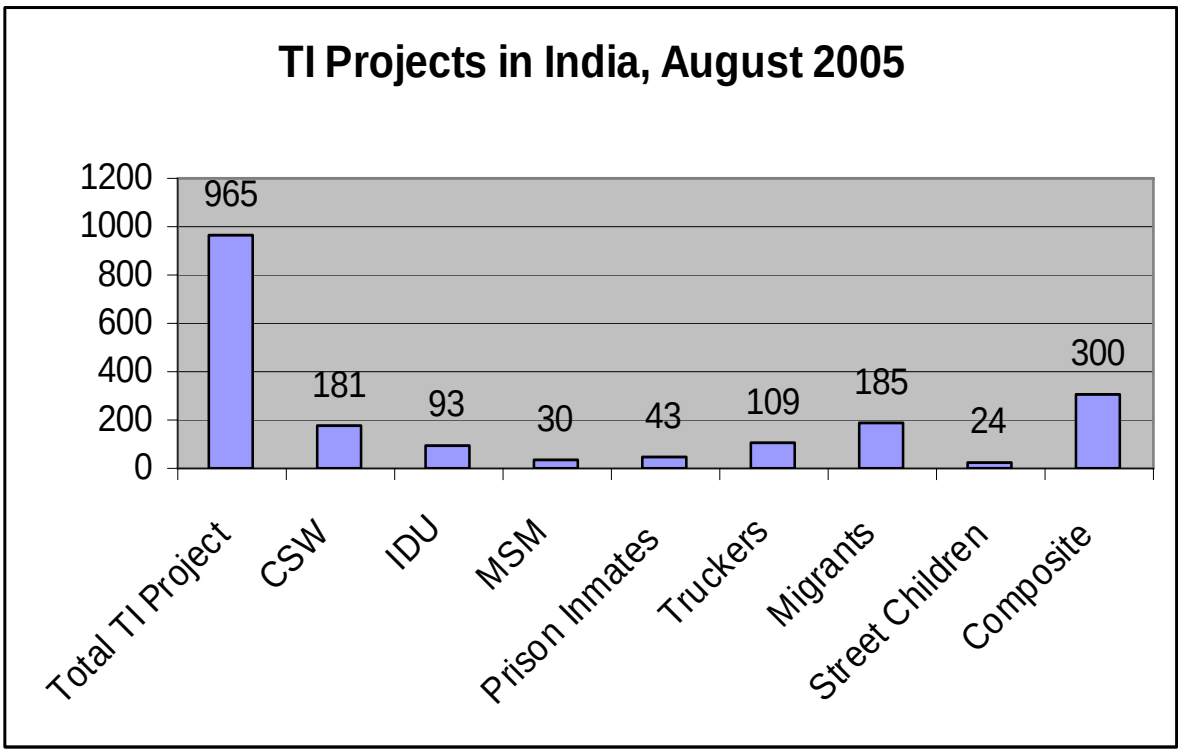
| | | Male | Female | Total |
|---|---|---|---|---|
| 1 | No of persons tested for HIV at VCTC | 576512 | 461803 | 1038315 |
| 2 | Persons testing sero positive after having undergone the three specified tests. | 76105 | 49420 | 125525 |
| **3** | **Number of direct walk-persons tested** | **281651** | **204080** | **485731** |
| 4 | Number of direct walk-in persons testing sero positive | 39484 | 28893 | 68377 |
| **5** | **Number of walk-in clients collected results** | **70787** | **46552** | **117339** |
| 6 | Percentage of people who received HIV testing and know their results (5/3) | 25 % | 23 % | 24 % |

*Figures in bracket are percentage to the total

The percentage of most-at-risk populations that received HIV testing in the last 12 months and who know the results would then be calculated by dividing the number of walk-in clients who collected their report by the total number of walk-in clients. Analysis of this data between October 04 and September 05 shows that only 24 percent of people who visited the VCT centre for counselling and testing actually know the results of the test. The gender segregated data suggests that more number of males are actually aware of their HIV status than the females.

**MOST-AT-RISK POPULATION: PREVENTION PROGRAMME**

Since the beginning of NACP-II, targeted interventions for most-at-risk populations were an adopted and implemented strategy. A process of mapping and estimation of most-at-risk population was carried out through the State AIDS Control Societies (SACS). The report of the mapping studies for 32 states/UT are available that will give broad estimates of CSW, MSM, IDU, migrant workers, truckers, street children and eunuchs. Based on this initial mapping and estimation, targeted intervention projects were approved by SACS to NGOs/CBOs for implementation that is presented in Table 6. There is recognition that the initial estimates of the size of vulnerable population are not accurate. The NACP-III Design team has initiated an exercise to validate these figures and a better picture would emerge in the near future.




The number of interventions that stood at 199 in September, 1999 reached to 965 by August 2005. Out of these 181 interventions were for CSW, 93 for IDU, 30 for MSM, 109 for truckers, 185 for migrants, 24 for street children, 43 for prison inmates and 300 were composite interventions covering all the vulnerable population in a specific geographical area.

**Table 6: Coverage of Vulnerable Population through Targeted Intervention Projects**

| Most-at-risk population | Estimated Size[1] | Population covered[2] | Coverage rate |
|---|---|---|---|
| Sex workers | 292,058 | 152,943 | 52 % |
| MSM | 89967 | 40,315 | 45 % |
| IDU | 96,463 | 46,072 | 48 % |

1. Cumulative statement showing the size of risk groups in states (December, 2004), NACO
2. Draft report of Coverage of Essential HIV/AIDS Services Study, 2005

The coverage of most-at-risk population through prevention programmes is calculated by dividing the population covered by TI projects by the estimated size of the population as shown in Table 6. The coverage of vulnerable population based on the above method shows that the coverage is about 52 percent in the case of sex workers, 45 percent in the case of men who have sex with men and 48 percent in the case of injecting drug users. Comparing this with the coverage of indicators for 2003 (POLICY, 2004), it is seen that there is an increase in the coverage of sex workers by 22 percent, MSM by 30 percent and IDU by 23 percent respectively in the two years period.

**REDUCTION IN MOTHER-TO-CHILD TRANSMISSION**

Program on Prevention of Parent-to-Child Transmission (PPTCT) of HIV has been given a high priority by the Government of India. The programme that was initiated in December 2002 has been scaled up to 488 PPTCT centres by December 2005. More than 90 percent of these centres are spread in the 6 high prevalent states, with Tamil Nadu having the maximum (193) centres. Cumulative data on the route of transmission among reported AIDS cases in India points out that perinatal transmission accounts for 3.6 percent of the total AIDS cases (NACO-CMIS 2005). Among the estimated 27 million pregnancies in India around 30 percent of deliveries take place in government institutions, 40 percent in private institutions and around 30 percent are non-institutional deliveries. With a 0.7 percent prevalence rate among ANC attendees, this translates into 189,000 infected pregnancies per year. At the estimated rate of 30 percent transmission of HIV from mother to child, there exists a cohort of 56,700 infected newborns per year.

> **Article 54:** By 2005, reduce the proportion of infants affected with HIV by 20 percent and by 50 percent by 2010 by ensuring that 80 percent of pregnant women accessing antenatal care have information, counseling and other HIV prevention services available to them, increasing the availability of and providing access for HIV infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV infected women, including voluntary and confidential counseling and testing, access to treatment, especially antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of

Comparing this with the coverage of PPTCT services, it is found that only 3.94 percent avail PPTCT services starting from the counselling stage onwards. Further, among those pregnant women who are expected to be HIV positive, 2.74 percent receive antiretroviral prophylaxis. Hence there is a shortfall of 18.83 percent in achieving UNGASS goal of 20 % coverage for 2005.

The high prevalence states of Andhra Pradesh, Maharashtra (including Mumbai with a total population of 18 million), Karnataka, Tamil Nadu, Manipur and Nagaland have a total population of 325 million with a pool of 27,105 infected babies delivered by 90,349 HIV

positive pregnant women annually. In order to achieve the UNGASS goal of 2005 for these states, 5,427 babies need to be protected and Nevarapine need to be administered to 10,842 babies likely to be born from 35,799 HIV positive mothers. In order to reach them, approximately 2.88 million pregnant women need to be covered.

- In order to achieve UNGASS goals it is necessary to scale up PPTCT services to CHCs and PHCs by at least 50% by 2005/2006.
- Since a significant number of expectant mothers access institutions in the private sector, PPCT services provided through the private sector need to be enhanced by 50% by 2005/2006.
- Quality of services needs to be improved in the existing centres in order to retain all women coming to these centres.

**Table 7: PPTCT Performance 2005**

| No | ***Description*** | **Numbers** | **%** |
|---|---|---|---|
| 1. | Total No. of New ANC Registrations in all PPTCT Centres | 11,34,839 | |
| 2. | Total No. of women counselled | 9,40,853 | 82.9 |
| 3. | Total No. of women accepted HIV test | 8,29,164 | 88.13 |
| 4. | No. of women found HIV positive | 8,839 | 1.07 |
| 5. | No. of women who collected their HIV results | 6,81,610 | 82.2 |
| 6. | No. of women who received post test counselling | 6,43,336 | 77.5 |
| 7. | No. of HIV positive women who collected their results | 6,987 | 79 |
| 8. | No. of spouses/ partners of HIV positive women counselled | 4,781 | 54 |
| 9. | No. of spouses/partners of HIV positive women accepted HIV test | 4,533 | 94.8 |
| 10. | No. of husbands / partners detected HIV positive | 3,759 | 82.9 |
| 11. | No. of women coming directly in labour without ANC Reg. | 2,11,518 | |
| 12. | No. of women counselled who arrived in labour without ANC | 1,25,512 | 59.3 |
| 13. | No. of women who accepted HIV test | 1,08,288 | 86.24 |
| 14. | No. of women detected HIV positive | 1,872 | 1.73 |
| 15. | Total HIV tests done in PPTCT centres for pregnant women | 9,37,452 | |
| 16. | Cumulative HIV positivity rate among pregnant women | 1.14% (8839+1872)= 10,711/937452 | |
| 17. | Total no. of mother-baby pairs received NVP | 4,451 | 41.56 |
| 18. | No. of mother-baby pairs received NVP who were registered for ANC | 3,223 | |
| 19. | No. of mother-baby pairs received NVP who came directly in labour | 1,263 | |
| 20. | No. of babies received NVP | 4,989 | |
| 21. | No. of women opted for breast feeding | 2,495 | 50 |
| 22. | Total pregnant women availing PPTCT Services counselling onwards…Booked **9,40,853**+ Unbooked **1,25,512** ) | 10,66,365 | |

The low prevalence states (including the vulnerable states) have a combined population of 700 million contributing about 30,000 HIV infected babies every year to the national pool of HIV infected infants. To achieve UNGASS goals for this segment 6,000 babies need to be

protected through administering NVP to 12,000 babies, targeting 39,6000 HIV+ expectant mothers. To reach this figure we need to have 6.9 million pregnant women accessing PPTCT services of which only 2.9 million have been reached. (NACO, 2005)

## ANTIRETROVIRAL TREATMENT FOR PLHA

Out of the 5.1 million people who are living with HIV, it is estimated that 10 percent people are in need of ARV treatment. The Indian government made a commitment to provide free ARV drugs to 100,000 PLHA by the end of 2005. With initial constraints in rolling out the programme though the public sector the target date was postponed to 2007 and to 180,000 by 2010, 200,000 by 2011 (INP+, 2005).

As of December 2005 the number of PLHA on ART is 23,784 out of whom 7,474 are women, 1048 are children and 22 are transgender (eunuchs). ART centres have been set up in 52 hospitals in 25 states (NACO, 2005). Conservative estimates also suggest that about 30,000 more PLHA are accessing ART from the private sector/civil society organisations. The private sector service delivery is largely unregulated and concerns around the quality, monitoring, compliance with protocol, mono-therapy and adherence to the ART regime exist.

Under the Global Fund Round 4 Grant, the civil society consortium with Population Foundation of India as principal recipient, in partnership with INP+, Freedom Foundation, Engender Health Society and Confederation of Indian Industry is supporting the government's roll out of ART since April 2004.

## ENSURING BLOOD SAFETY

Ensuring the widespread availability of safe blood is a vital component of NACP. Towards this end 410 additional blood component separation facilities were installed, model blood banks were set up, and the External Quality Assessment Scheme (EQUAS) for HIV testing in blood banks was introduced. Modernisation of all major blood banks at state and district level is supported by NACO, which initiates repeated refresher training for clinicians on the 'Appropriate Clinical Use of Blood'. NACO supports the procurement of equipment, test kits and reagents and provides operational costs for government blood banks and to a selected blood banks run by charitable organisations which were modernised during NACP-I. During NACP-II, the National Blood Policy was formulated in 2002 and the Action Plan on Blood Safety was adopted in 2003. The Action Plan:

- Mandated the revelation of HIV status to the result-seeking donor.
- Commenced the process of accreditation of blood banks to ensure uniform implementation of standard operating procedures.
- Focussed on and promoted voluntary (non-remunerated) blood donation as the preferred and acceptable means of blood collection.
- Introduced 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.

An amendment was made in the Drugs and Cosmetic Rules Act 1940 to permit the establishment of blood storage centres at sub-district levels at FRUs and other small hospitals. These are expected to help rural areas not equipped with full-fledged blood banks, cope with emergencies. These centres are affiliated to larger blood banks. However in practice, the service delivery through these units is affected with problems of geography, transportation, electricity and other ground realities not covered by the programme.

**Table 8 : Status of Blood Units**

| | Jan-Dec, 2003 | Jan- Dec, 2005 |
|---|---|---|
| Total donors | 3,977,827 | 2,880,292 |
| No. of voluntary donors | 2,000,040 (50.28 %) | 1,592,777 (55.3 %) |
| No. of replacement donors | 1,977,787 (49.72 %) | 1,287,515 (44.7 %) |
| HIV positive units | 15766 (0.40 %) | 9904 (0.34 %) |

As a policy, it is mandatory to screen each unit of blood collected for transfusion against five diseases including HIV and this is followed strictly throughout the country. There is also a law that prohibit professional blood donation in the country and the policy is to increase voluntary blood donation. Table. 8. shows the comparative figures for 2003 and 2005. It is noted that even though the total number of donors decreased considerably in 2005, there is also a considerable decrease in the number of HIV positive blood units screened in the blood banks. This decrease could be attributed to the strict implementation of the law that prohibit professional blood donation. On the other hand there has been a 5 percent increase in the voluntary blood donation in 2005 than in 2003. As mentioned above, the mode of transmission of the virus through unsafe blood and blood products, among the reported AIDS cases in the country stood at 1.45 percent.

## KNOWLEDGE AND BEHAVIOUR - MOST-AT-RISK POPULATIONS

Due to technical reasons, the second round of the national BSS study scheduled under NACP-II could not be held. Hence the results of the BSS study conducted in 2001 are primarily used in this report.

### SEX WORKERS

On an all India level, HIV information and awareness among sex workers continues to be low, especially among those working in the streets. The BSS survey of 2001 found that 30 per cent of street based sex workers did not know that condoms prevent HIV infection, and in some states such as Haryana, fewer than half of sex workers (brothel-and-street based) knew that condoms prevent HIV. Large populations of sex workers (42% nationally) also thought they could tell whether a client had HIV on the basis of his physical appearance. (NACO 2002/MAP report 2005)

According to the BSS survey conducted in 21 states, 66 percent of female sex workers correctly identified both methods of prevention: consistent condom use and having faithful and uninfected sexual partners. Brothel-based FSW showed greater levels of awareness (70%) than non-brothel based sex workers (63%). The awareness level was higher in West Bengal (80%), Tamil Nadu, Maharashtra, Goa (77%) as well as Andhra Pradesh (75%).

**Male Sex Workers**

Male Sex Workers are a significant yet invisible population in India. These males exchange sex for money, food or goods and may cater to either male or female clients or both.

A pilot KABP study on male sex workers in three cities: Kolkata, Vijaywada, Ahmedabad indicated high sexual activity, low risk perception, low adoption of safe practices. The study found that male sex workers were subjected to violence, male rape, criminal assault, intimidation and extortion. Local media have strong negative opinion on male sex workers. (NIMSW/SHRC, 2005)

Correct awareness about HIV transmission was defined as the proportion of total respondents who correctly identified that [i] HIV is not transmitted through mosquito bites, [ii] HIV is not transmitted through sharing a meal with an infected person and [iii] A healthy looking person may be infected with HIV. Overall 29 percent of female sex workers were found to be aware of these aspects. Awareness was relatively high in Tamil Nadu, with 61% of the target population having correct awareness.

**Consistent Condom Use**: The BSS survey indicates that about 50.2 percent of female sex workers used condoms with all the paying clients during the past 30 days preceding the survey. A higher proportion of brothel based workers (57%) reported consistent condom use than non-brothel based workers (46%). However, only one-fifth (20.5%) FSW reported consistent use of condoms with non-paying partners in the same period.

These figures indicate that condom use negotiation is a challenge for the FSW. They also indicate that FSW may regard their non-paying sexual partners as not being as great a risk as their paying partners. About 27 percent of FSW using condoms reported that the clients suggested use of condoms, whereas nearly 62% of the target group who used a condom in the recent past initiated condom use with the client.

**HIV testing and results:** About 68.9 percent of FSW expressed the belief that they could access confidential testing, while 10.4 percent had undergone a test for HIV. Due to the small sample, those reporting voluntary testing were 100 percent, while most of the respondents (95%) who had undergone testing, reported that they collected the results of their test. (NACO 2002)

In Sonagachi, West Bengal, safer sex programmes that empower sex workers have resulted in a decline of HIV prevalence among sex workers to less than 4 percent and a high condom use of 85 percent. Available data indicates that sporadic and piecemeal efforts to promote condoms during commercial sex have not been as effective. (NACO 2004)

**INJECTING DRUG USERS**

In the North Eastern region, especially in the states of Manipur, Mizoram, and Nagaland, the primary route of HIV transmission is through injecting drug usage and concentrated chiefly among drug injectors and their sexual partners (Solomon et al., 2004). There is a significant overlap of sex work and injecting drug use in Manipur, where a drug injection driven epidemic has been prevalent for at least a decade. Around 20 percent of sex workers said they injected drugs, according to behavioural surveillance. In other north eastern states about ten percent of sex workers have reported injecting drugs (MAP, 2005).

Harm reduction efforts (including needle and syringe exchange, as well as limited substitution programmes were introduced in some states, such as Manipur. There the most recent data (2003) put HIV prevalence in drug injectors at 24 percent. The lowest level was detected among IDU in Manipur since 1998. Elsewhere the epidemics among IDU appear to be well established, with HIV prevalence having reached 14% in Nagaland in 2002-2003 (NACO 2004).

Injecting drug use is not limited to India's north-eastern states. There has been a sharp rise in HIV infections among drug injectors in Tamil Nadu, where 39 percent were infected in 2003, compared with 25 percent in 2001 (NACO 2004). A smaller study in Chennai found 64 percent of injectors were HIV positive, according to sentinel surveillance done in 2003 (MAP, 2005)

**Knowledge about HIV Prevention*:*** According to the BSS in the four metros: Chennai, Delhi, Kolkata. Mumbai and in Manipur (NACO 2002), the proportion of IDU who had heard of HIV/AIDS was relatively high at 97 percent and 93 percent of the target group were aware of the transmission of HIV through the use of needles used by an HIV infected person.

Less than half (42.5%) could correctly identify that (i) Mosquito bites do not transmit HIV (ii) HIV cannot be transmitted by sharing a meal with an infected person and(iii) A healthy looking person may be suffering with HIV. Awareness was higher in Chennai (62%) and Manipur (61%). The awareness was lowest in Delhi (25%)

***Safe injecting practices:*** About 44 percent Injecting Drug users reported consistent safe injecting (never sharing needles/syringes). Safe injecting practices were found to be higher in Kolkata (78%) as compared to Mumbai (31%) and Chennai (30%). The proportion of IDU reporting sharing of needles every time were found to be highest in Chennai (13%) 39.9 percent of injecting drug users in Manipur reported consistent safe injecting practice.(NACO, 2002)

***Consistent condom use:*** Overall 31.8 percent who had sex with any commercial partner over the past 12 month period reported consistent condom use. The proportion of IDU reporting consistent condom use over the same period with non-regular partners was 11.9 percent and those reporting consistent condom use with regular partners were 6.1 percent. Mumbai reported the highest consistent condom use with commercial partners (52.4%) and Kolkata reported highest consistent condom use with non-regular partners at 20 percent.

**HIV testing and results:** In the regions studied, 59.7 percent of IDU interviewed believed they could access confidential testing. 25.5 percent of IDU had undergone tests for HIV out of which 79.1 had found out about their HIV status from the results.

**MEN HAVING SEX WITH MEN**

Relatively little is known about the role of sex between men in India's various epidemics. While studies conducted by civil society entities that examine this complex dimension of sexuality in India have found that significant numbers of men do have sex with other men, the interventions and data are fragmented, localised and are not accessed by government planners.

Men having sex with men in India find it extremely difficult to access health information and services they need to protect themselves and their partners due to their marginalised position in society and because penetrative sex between men is proscribed by the Indian Penal Code, thus driving non-heterosexual sexualities underground. As a consequence of this illegal status and overt disapproval of their sexual orientation, the numbers of non-heterosexual men accessing government run VCTC across the country is low.

Reliable data for MSM and corresponding prevalence rates are not officially available. HIV prevalence figures among MSM in the city of Mumbai are estimated around 20 percent, compared to the national average of 0.9 percent. (Humsafar Trust, 2002). In Chennai, the HIV prevalence figures from a study of slum populations was estimated at 8 percent for MSM, of these more than half were married. (Go et al., 2004)

**Knowledge about HIV prevention:** A NACO initiated BSS survey undertaken in five metros: Bangalore, Chennai, Delhi, Kolkata, and Mumbai found a high proportion of respondents (83%) aware that using condoms correctly and every time could protect people from HIV. Overall, about 74 percent of the respondents reported sexual abstinence as one of the HIV prevention methods, while 69 percent were aware of the first two methods of prevention: consistent condom use and single sex partnership. The proportion of respondents who were aware of these methods was relatively lower in Bangalore (59%) and Kolkata (56%).

According to the survey, 55 percent of MSM respondents correctly identified all three issues regarding basic beliefs: [i] A mosquito bite cannot transmit HIV [ii] HIV cannot be acquired by sharing a meal with someone infected with HIV [iii] A healthy looking person may be infected with HIV. Awareness in Chennai (70.7%) contrasted with Bangalore (48.1%) and Kolkota (36.6%)

**Consistent condom use*:*** Overall, about 30 percent MSM in all five cities reported consistent condom use with non-commercial male partners over the past month prior to the survey. The proportion of consistent condom use with non-commercial male partners was higher in Mumbai (56%) and Bangalore (44%) and relatively low in Kolkata (21%), Chennai (19%), and Delhi (11%).

The proportion of MSM reporting consistent condom use with commercial sexual partners was 12.6 percent, with Mumbai reporting the highest consistent condom use (33%), and Chennai (15.6%), Delhi(13.9%), Bangalore (8.9%) and Kolkata (7.5%) reporting relatively low consistent condom use.

About one-third of the MSM (30.9%) interviewed reported having sex with female partners as well in the past six months previous to the survey and only 15.5 percent of these reported consistent condom use with female partners. 33 percent of MSM interviewed were married. The proportion of MSM who were married in Delhi was 46.1%, in Chennai 37.8%, and in Bangalore 29.7%.

**HIV testing and results:** In all about 70 percent of MSM respondents reported that it was possible for them to access confidential testing to find out if they were infected with HIV. Overall 35.2 percent had taken a test for HIV (64.9 % in Mumbai; 6.3 percent in Kolkata). Of these, overall 85 percent of the respondents reported seeking the results of their test.

**HIGHLY MOBILE WORKING MEN**

Single and married men who travel on work, such as truckers, are highly vulnerable. As multi-partner clients of sex workers who do not always practise safe sex, they are vulnerable to HIV infection and unknowingly infect their spouse. This group is highly vulnerable to infection as a result of unsafe practices related to injecting drug use or unprotected sex with other males.

India has one of the largest road networks in the world and an estimated 2 to 5 million long distance truck drivers and helpers. The extended periods of time that they spend away from their families place them in close proximity to "high-risk" sexual networks, and often results in them having an increased number of sexual contacts. (Ekstrand M. et al 2003)

During journeys drivers often stop at 'dhabas', roadside hotels that usually provide food, rest, sex workers, alcohol and drugs. A study published in 1999 showed that 87% of the drivers had frequent and indiscriminate change of sexual partners, and only 11% of them used condoms although their AIDS knowledge was fairly good. (Kootikuppala S.R. et al 1999) HIV prevalence patterns in truckers have tended to mirror the local epidemics.

**YEAR-WISE COVERAGE THROUGH TIs TRUCKERS (NACO)**

| **YEAR** | Size as per mapping | **Covered** | % |
|---|---|---|---|
| 2002-03 | 20,74,366 | 14,30,000 | 69 |
| 2003-04 | 20,74,366 | 16,40,000 | 79.1 |
| 2004-05 | 20,74,366 | 19,40,000 | 93.5 |

NACO in collaboration with non-government organisations in several states has been successfully conducting targeted interventions at key locations along the country's national highways.

**MIGRANTS**

Migrants account for 26.6 percent of the country's population (Census 2001). The NSS data for 199-2000 (55$^{th}$ round) shows that about 2.28 million persons migrated from other countries to various states in India. The states receiving a high percentage of these migrants

are: West Bengal (44%), Tamil Nadu (12%), Kerala (10%), and Uttar Pradesh (8%). (Srivastava and Sasikumar, 2003).

Estimates of the National Commission of Rural Labour say short duration migration accounted for 10 million seasonal and circular migrants in rural areas alone. This included 4.5 million inter-state migrants largely engaged in agriculture and plantations, brick kilns, quarries, construction sites and fish processing. The landless poor from backward castes and indigenous communities in economically backward regions migrate for survival and constitute a significant portion of the labour flow. Men migrating between urban areas are relatively better placed, but migrate to improve their economic status.

Socio-cultural factors play an important role along with economic ones in determining the working and living conditions of migrants. Language barriers, caste or ethnic factors critically determine a migrant's access to healthcare. Exposure to a new cultural system, sometimes hostile to the migrants, often creates psychological problems. The resultant stress and lack of psychological support avenues contribute to migrant workers' frustrations and many turn to drug use for temporary relief or due to peer pressure. Injecting drug use is the most cost effective way of taking drugs. Male migrant workers are likely to visit brothels or have sex with other men, including migrant colleagues, female migrants, or local women. Unprotected sex increases their vulnerability to HIV and other STI.

**YEAR-WISE COVERAGE THROUGH TIs MIGRANTS (NACO)**

| YEAR | Size as per mapping | Covered | % |
|---|---|---|---|
| 2002-03 | 16,77,109 | 6,55,000 | 39.05 |
| 2003-04 | 16,77,109 | 5,62,500 | 33.53 |
| 2004-05 | 16,77,109 | 6,60,000 | 39.35 |

Women migrant workers in the informal sector may experience sexual harassment and physical abuse, single migrant women or those deserted by their husbands are particularly vulnerable and are susceptible to commercial exploitation. Poverty and lack of resources may force them to trade sex for food and other necessary goods. Limited access to information on HIV/AIDS and to condoms further exposes them to unprotected sex and HIV/AIDS.

## WORKPLACE HIV/AIDS PROGRAMMES

> **Article 49:** By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programmes in public-private and informal work sectors, and take measures to provide a supportive workplace environment for people living with HIV/AIDS

NACP recognises the importance for developing a multi-pronged response to HIV/AIDS in the workplace in the organised and unorganised sectors to address the impact on productivity and declining economic growth. Towards this end NACO collaborates with the International Labour Organisation, Ministry of Labour, industrial associations like Confederation of Indian Industries (CII), The Associated Chambers of Commerce and Industry of India (ASSOCHAM), Federation of India Chambers of Commerce and Industries (FICCI) and also employers' and workers' organisations.

Apart from the ILO, the CII has initiated HIV/AIDS workplace programmes through its 22 branches across the country. NACO has also collaborated with the Steel Authority of India (SAIL) and the Employees State Insurance Corporation (ESI). SAIL is the founder member of the India Business Trust, formed by CII to combat HIV/IDS in the workplace. The Indian Railways also organise training programmes for their medical and paramedical staff and are

providing PPTCT services. STI clinics and VCTC have also been established in each of the nine zones of the Indian Railways.

The National AIDS Prevention and Control Policy discourage HIV testing for employment purpose. However this provision is not enforceable in courts and provides little protection against HIV screening as a precondition for employment. With the introduction of the India HIV/AIDS Bill, this aspect will be protected.

## FUNDING FOR HIV/AIDS IN INDIA

In this section an analysis of the public expenditure that is under the purview of the government at the national level is carried out and a discussion on the sources and flow of funds through other channels is followed.

**Public Expenditure Envelope**: Public expenditure on HIV/AIDS is through the National AIDS Control Programme, a centrally sponsored vertical health programme. The resources for the NACP are budgeted under the Union Government's Health Budget. This public expenditure envelope for NACP includes funds committed by the government from its own resources, credit from World Bank, and aid from USAID, DFID and CIDA UNDP and Global Fund. The following table of the expenditure will provide a clear understanding of the HIV/AIDS spending from the public expenditure envelope.

**Table 9: Annual expenditure of NACP-II (USD millions)**

| **Agency** | 1999-2K | 2000-01 | 2001-02 | 2002-03 | 2003-04 | 2004-05 | **Total** |
|---|---|---|---|---|---|---|---|
| **Domestic Budgetary Support (GoI)** | | | | | | | |
| GoI | 4.61 | 5.71 | 6.54 | 6.94 | 6.45 | 15.42 | **45.67** |
| World Bank Credit | 24.22 | 30.46 | 35.18 | 37.44 | 34.67 | 57.88 | **219.87** |
| **Sub Total** | **28.83** | **36.17** | **41.72** | **44.38** | **41.12** | **73.3** | **265.54** |
| **External Aid Support** | | | | | | | |
| USAID | - | 0.03 | 1.03 | 3.09 | 3.76 | 5.71 | **13.61** |
| DFID | | 1.78 | 5.64 | 5.56 | 5.72 | 9.11 | **27.80** |
| CIDS | | | 0.44 | 0.11 | 0.33 | 0.44 | **1.33** |
| UNDP | | | | 0.22 | 0.22 | 0.93 | **1.38** |
| GFATM | | | | | | 4.28 | **4.28** |
| **Sub Total** | **-** | **1.81** | **7.11** | **8.98** | **10.03** | **20.47** | **48.4** |
| **Grant Total** | **28.83** | **37.98** | **48.83** | **53.36** | **51.16** | **93.78** | **313.94** |

Notes: Amounts shown in millions of rupees converted to US dollars at 45 rupees per dollar.
Fiscal years begin on 1 April of the indicated year and conclude on 31 March of the succeeding year.

Over the six fiscal years under NACP-II the total expenditure was USD 313.94 million. Of this domestic budgetary support was to a tune of USD 256.54 million and external aid support was to a tune of USD 48.4 million. Annual expenditure through domestic budgetary support rose 2.5 times between the financial years 1999-2000 and 2004-05 from USD 28.83 million to USD 73.3 million which was with a support of an IDA credit from the World Bank. There has been also a substantial increase in the external aid support received by NACO during the same period

The careful analysis of donor and government data may offer an incomplete picture of aggregate spending from all sources for the fight against AIDS. There are significant amounts of spending on HIV/AIDS in India not captured and are not included in the figures under

public expenditure envelope. Paragraphs below detail some of the other sources of funding that will merit more careful examination in future stages of efforts to track resources for HIV/AIDS in India.

**Resource Flow Outside NACO:** Resources that are not channelised through NACO (not included in the above analysis) also contribute to the national response in varying degrees. While some of the donors spread their interventions to a large geographical area, others focus on specific states and often provide technical support to SACS or work independently with NGOs/CBOs. For instance, Bill and Melinda Gates Foundation's India AIDS Initiative, Avahan Project, is working on prevention programmes in all the six high prevalent states, where as Children Investment Fund Foundation works only in Tamil Nadu to prevent orphan hood. Similarly annulated commitment by Avahan is about US$40 million in calendar year 2004. Donors like USAID, DFID, Australian Agency for International Development (AusAID), European Commission (EC) and multilateral agencies like UNFPA, UNICEF, UNAIDS, ILO etc are also working in India. An effort was taken to collect expenditure data for 2003 and 2004 from different development partners and the responses received are included in the table below.

**Table 10: Resource Flow Outside NACO**

| **Agency** | **Disbursement (USD million)** | | **Remarks** |
|---|---|---|---|
| | **2004** | **2005** | |
| DFID | 6.34* | 21.15* | Technical assistance funds for SAEP, NFHS 3, Gender and trafficking implemented by UNICEF/UNDP/UNAIDS |
| USAID (Oct 03-Sep 04) | 13.5 | 15.3 | International and national NGOs |
| European Commission | 2.5 | 1.0 | NGO support |
| UNFPA | 0.16 | 0.95 | Support to Min. of Youth Affairs and Dept. of Education, MHRD, NGO support |
| Population Foundation of India (Civil Society PR under GFATM Round 4) | | 1.3 | The consortium supports the government ART roll out by linking PLHAs to pubic treatment; education on treatment and adherence to treatment, nutrition, income generation, addressing legal issues, operations research and advocacy |

* 1 GBP= 85 INR; 1 USD= 45 INR

**State Government's Health Budget**: Since health is a state subject, state governments also allocate resources for HIV under the health budget. The 35 states and Union Territories of India may have spent own resources on HIV/AIDS programs that are not included in the above analysis. States like Kerala, Karnataka, West Bengal, Tamil Nadu and Delhi have made specific budgetary allocation for HIV/AIDS. Apart from budgeting specifically for HIV/AIDS, some of the programmes like PPTCT, VCT, ART centre, blood banks, STD clinics and OI treatment also utilize the infrastructure and personnel in the health department. There has been no effort so far to monetarise this expenditure incurred from the state exchequer.

**AIDS Control Societies:** As a part of decentralization of the NACP, AIDS Control Societies were created at the States/UT/Municipalities as autonomous organisations with more freedom to receive money and manage programmes. Even though many SACS depend only on

resources routed through NACO, some SACS like that in Tamil Nadu are receiving support from external donor for programme implementation. TANSACS had entered into a MoU with Children Investment Fund Foundation to expand antiretroviral treatment to 1000 parents/family members and care and support to 4000 parents/family members of HIV infected and affected children to prevent children being orphaned in the state. The value for the first year (Aug 2005-July 06) of the project implemented by TANSACS is about 425,000 USD.

**Out of Pocket Spending for AIDS:** Private out of pocket spending for AIDS is not included for lack of solid information. Because private spending for health care is greater than 80 percent of all health care spending, it is likely that the amounts for out of pocket spending are substantial.

The Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee website, www.oecd.org, shows somewhat higher donor amounts on a calendar year basis, 2000-2003 than does the data in Table 1, although this difference could be explained by the differences in concept between “releases” of funds by donors and “expenditures” as recorded by the Government of India, Ministry of Finance, Comptroller of Aid, Accounts, and Audit Division.

India is developing a system to systematically track the resources that has been expended on HIV/AIDS from multiple sources and multiple channels. NACO has initiated a step in conducting National AIDS Spending Assessment (NASA) with the assistance of UNAIDS and Futures Group. Training of Financial Officers of SACS has been conducted and they were oriented towards the need for tracking resources at the state level from different sources and report back to NACO.

# NATIONAL RESPONSE TO THE AIDS EPIDEMIC

The national response to the AIDS epidemic in India is a collaborative effort of the central and state governments, bilateral and multilateral organisations, other donors and NGOs/CBOs. In accordance to the vision of guidelines for preparing UNGASS report, this section captures some of the significant response of the government and civil society.

**Response of the Government of India**

The identification of HIV positive individuals in 1986 resulted in the Government of India forming the National AIDS Board in the same year, headed by the Union Health Secretary. The National AIDS Control Programme (NACP), focussing on increasing awareness of HIV/AIDS, screening of blood for HIV and testing of individuals practising high risk behaviours was launched in 1987 .In 1989, the government prepared a medium term plan with WHO collaboration (1990-1992). This plan focussed on Maharastra, Tamil Nadu, Manipur, West Bengal, Mumbai, Chennai, Calcutta and Delhi, those states and cities considered the worst affected. Initial activities under this plan focussed on the strengthening of programme management capacities, targeted information, education and communication campaigns and surveillance.

A five year strategic plan (NACP Phase-I) was developed and approved by the Government of India in 1992 during the 8$^{th}$ Five Year Plan. The Phase-I and Phase-II of NACP, originally conceived to be a five year project, was extended for two more years and the second phase will end in March 2006. Planning for Phase-III has already begun with multisectoral participation and greater involvement of people living with HIV/AIDS (PLHA).

**NACP Phase- I (1992-1999)**

The objective of NACP-I was to initiate a major effort in the prevention of HIV transmission and reduce future morbidity, mortality, and the impact of AIDS. The project was implemented as a centrally sponsored scheme with cent percent financial assistance to the states and union territories from the government of India. At start-up, the limited national capacity to deal with HIV/AIDS called for a simple, realistic and flexible framework which included **five basic components**.

- Strengthening management capacity for HIV/AIDS control
- Promoting public awareness and community support
- Improving blood safety and rational use
- Controlling sexually transmitted disease
- Building surveillance and clinical management

Under the strategic plan, the National AIDS Control Board and the National AIDS Control Organisation (NACO) was set up in 1992 within the Ministry of Health and Family Welfare with full financial and administrative powers. Setting up of State/Municipal AIDS Cells was initiated in 1992-93. Following the example of converting the Tamil Nadu State AIDS Cell into Tamil Nadu State AIDS Control Society in 1994- to provide more autonomy and flexibility in implementation- NACO prescribed societies as a model for all states/UT.

By the last year of the project, all states of India participated in the sentinel surveillance and NACO established AIDS case reporting system, thus improving the availability of data to monitor the spread of the virus. Capacity building of physicians was also initiated.

The overall outcome of the project was satisfactory, notably in building systems for implementation and in attaining the stated objectives. The **key lessons learned** in the process of implementation that formed the basis for planning for Phase-II of NACP included.

- At institutional level it recognized the need for participatory approach, decentralizing the programme to the state and municipal corporation level, advocacy and networking among various sectors.
- At technical level it recognized the need for a multi pronged approach in planning and prioritizing programme interventions and dissemination of information to persons at risk. For effective control of the spread of the virus from people practising high risk behaviour, it was realized that high level of coverage of vulnerable population through targeted intervention is required. Creation of an enabling environment through policy advocacy and empowerment of marginalised groups is also needed for behaviour change and reducing stigma and discrimination. The need for high quality epidemiological and management information system was seen as an integral component for program implementation.
- At operational level we learnt the need to address the differences in the performance of different states, need for a computerised financial management system, decentralised auditing system and an enhanced regional approach to the program.

**NACP Phase -II (1999 - 2006)**

The proposal for the Phase-II of NACP that is implemented in all the 35 States/UTs and 3 Municipal Corporations (Ahmedabad, Chennai and Mumbai) was formulated through a participatory process. Based on the different stakeholder consultations at the state level, state project implementation plans (PIP) were developed that were collated to develop the National PIP. The two key objective of NACP-II were to reduce the spread of HIV infection and to strengthen India's capacity to respond to HIV/AIDS on a long term basis. Thus greater emphasis has been placed on targeted interventions for highly vulnerable population, preventive interventions among the general population, low cost AIDS care, institutional strengthening and inter-sectoral collaboration.

The program in its second phase aimed at,

- shifting the focus from awareness raising to changing behaviour through targeted intervention;
- decentralization of flexible, need- and evidence-based service delivery;
- encouraging voluntary counselling and testing;
- supporting structured and evidence based annual reviews and operational research and;
- encourage management reforms for SACS and procurement practices.

The Armed Forces AIDS Control Organisation that was formed in 1991 has about 92 Information Education and Communication nodes across the country responsible for monitoring and executing HIV/AIDS activities of the armed forces. Over 200 medical officers and 1200 paramedical staff received training under the programmes.

The NACP programme had made successful attempts to elicit multi-sectoral cooperation from different Ministries and departments such as Human Resource Department, Youth Affairs and Sports, Information and Broadcasting, Social Justice and Empowerment, Home, and Railways.

The NACP saw the extension of the programme at the state level with 35 State AIDS Control societies (SACS), 3 District AIDS Control Societies, 10 Regional HIV Reference Centres, 800 clinics for the treatment of sexually transmitted infections (STIs) and 750 sentinel sites in the public sector (NACO, 2004). There are over 800 Voluntary Counselling and testing Centres (VCT) covering 604 districts in the country.

The contribution made by NACP to the national response can be summed as:

- Placed HIV/AIDS on the national political agenda
- Established the institutional framework fro the national response
- Catalysed increase in the government's own expenditure on HIV/AIDS
- Strengthened the HIV sentinel to track the epidemic
- Improved blood safety
- Increased levels of awareness.

The key lessons learned from NACP-II that is leading to the development of the NACP-III includes saturation of coverage of highly vulnerable groups through TI, aggressive condom promotion including social marketing, greater focus on vulnerable states with poor health indicators, need for capacity building of NACO and SACS and continuity in staffing, strengthening monitoring and evaluation mechanisms at all levels, duplication and scattered respond by stake holders, greater attention on MSMs and IDUs, integrating prevention, care and support, need for greater focus on youth, developing effective partnership with the private sector for STD control, tackling stigma and discrimination more effectively and making HIV everyone's business.

The planning for Phase-III of NACP is underway in a much participatory manner through out the country. The **approach** followed includes **Three Ones principle**, **participatory planning to increase ownership** at state and district level, **mainstreaming** and **partnerships**. Working groups on sub themes were constituted based on thematic area of intervention and they reviewed the NACP-II and provided suggestions for improvement

The thrust area for NACP-III as envisaged is to move from project to program mode and changing the role of NACO from implementing agency to program catalyst. It also aims at strengthening the state and district level response, organizational restructuring and capacity building, focus on prevention and its integration with treatment, care and support programs. The program also envisages increased focus on North Eastern states and vulnerable groups viz. MSM and IDU. Up-scaling and improving service delivery along with robust M&E systems at all levels, evidenced based planning, program implementation and comprehensive financial management are the other priority areas for the program. A special attention is drawn towards mainstreaming and partnership development.

## MULTI-SECTORAL COLLABORATION

### Inter-ministerial Group on HIV/AIDS

The inter-ministerial group set up for HIV/AIDS met on 27 October 2004 under the chairpersonship of the Minister for Human Resource Development. The Ministries having scope for HIV/AIDS mainstreaming were identified as Human Resource Development, Social Justice & Empowerment, Department of Family Welfare, Department of Youth Affairs and Sports, Department of Rural Development and Information and Broadcasting.

These various Ministries have been directed to initiate/integrate HIV/AIDS programmes through resources culled out from their own budgets.

**The Ministry of Human Resource Development** will effect mainstreaming in two departments: Department of Education and Woman and Child Development. The School AIDS Education Programme (SAEP) under the Department of Education has been able to reach out to 60,533 schools in the year 2004-2005 (NFSAP, 2005). SAEP got a push with the ministerial dialogue. Its revised guidelines are in operation, tool kit is ready, and state level training of trainers is nearing completion.

In order to give a concerted focus on HIV prevention among young people, the Government of India in June 2005 announced the National Adolescence Education Programme (AEP). The AEP is envisaged as a national umbrella programme, which will harmonize interventions being implemented under all current projects supported by government and donors. While the main focus of the programme is on HIV/AIDS prevention education, its scope also covers sexual and reproductive health issues, gender and life skills. The programme propose a scaling up of two ongoing strategies viz (i) integrate adolescent reproductive and sexual health and HIV content in school curriculum of all the State Education Boards (41 in number) in the country and; (ii) integrate adolescent reproductive and sexual health and HIV content and life skills through co-curricular activities in cent percent schools covered by three national school systems of the country.

**The Department of Woman and Child Development** is in the process of integrating HIV/AIDS into development and empowerment programmes for women and is looking at cross-ministerial development of HIV/AIDS related gender policies.

**The Ministry of Social Justice and Empowerment** has been a foremost partner to integrate HIV/AIDS into the drug detoxification programme. NACO has provided support by appointing HIV/AIDS counselors in the drug detoxification/deaddiction centers funded by MoSJE. The Ministry is committed to incorporate HIV/AIDS components into programmes with its network of over 2,000 NGOs to reach out to young people including street children. Even though support to orphans and widows, interventions with street and vulnerable children, and treatment and care in detention facilities are under the purview of this ministry, HIV/AIDS programmes are yet to be integrated into them.

**The Department of Family Welfare** under the Ministry of Health and Family Welfare of which NACO is also a part of, provides complementary services which includes condom promotion through free and social marketing, treatment of RTI/STI, communication campaigns to protect HIV, RTI and family planning and reaching out to adolescents through the National Rural Health Mission.

**The Ministry of Rural Development** is to mainstream HIV/AIDS prevention into two if its national programmes, the Swarnajayanti Gram Swarojgar Yojana, where HIV/AIDS training will be integrated with programmes for young people and self-help groups; and the Panchayati Raj Yojana that reaches out to rural artisans, entrepreneurs, self-help groups, gram sevaks, gram panchayats, village level functionaries.

**The Department of Youth Affairs and Sports** has introduced the HIV/AIDS prevention in several of its programmes.

- Universities Talk AIDS under the National Service Scheme which reaches colleges and university students throughout the country.
- Villages Talk AIDS under the Nehru Yuvak Kendra Sangathan (NYKS)

- HIV/AIDS integrated with training programmes for volunteers under the National Service Volunteer Scheme
- Scheme for assistance to Youth Clubs and the scheme for Financial Assistance for Promotion of Youth Activities and Training will also include HIV/AIDS training/ awareness activities.

Prasar Bharati, the broadcasting corporation of India under the **Ministry of Information and Broadcasting** that runs All India Radio and Doordarshan incorporates HIV/AIDS awareness and information in a variety of innovative ways. All India Radio broadcasts NACO sponsored programmes every week. '*Jeevan Hai Anmol'* is aired on the primary channel and the Vividh Bharati stations of AIR. The State AIDS Control societies are roped in to provide field level inputs and to highlight issues of significance relating to HIV/AIUDS which are woven into the radio programmes. The 'Let's Talk AIDS Programme', broadcast on Delhi's AIR FM Rainbow is another example of collaboration between NACO, AIR and civil society organisations reaching out to radio listeners.

Other department that incorporates HIV/AIDS into their mandate are the **Directorate of Audio Visual Publicity** (DAVP) through press and multi-media campaigns, the **Song and Drama Division** through cultural interventions, particularly using the form of folk media, and the **Directorate of Field Publicity** through exhibitions and audio-visual shows throughout the country. NACO had oriented the personnel of the Directorate of Field Publicity on the effective use of mobile exhibition kits produced by NACO in collaboration with DAVP in the appropriate regional languages. These kits were used in a countrywide month long campaign *'Swastha Jagrukta Mah'* (Health Awareness Month) in every Parliamentary Constituency sponsored by the Ministry of Health and Family Welfare.

An effort to bring on board the communication and media organisations throughout India under a common umbrella- **India communication Consortium on HIV/AIDS** was also initiated in 2004. Commitments from the top media companies to work together to increase public knowledge and understanding about HIV/AIDS was also made in the **Media Leaders Summit** under the leadership of the Prime Minister, Shri Manmohan Singh in January 2005.

**Media Initiatives**

In January 2005, Prime Minister Manmohan Singh met with twenty five top executives from the leading media companies across India for the country's first-ever **Media Leaders Summit on HIV/AIDS** to discuss what they can do to address the growing epidemic in India.

Coming out of the Summit, which was convened by the Ministry of Information & Broadcasting, the Ministry of Health & Family Welfare, and the Heroes Project in partnership with the Kaiser Family Foundation and *Avahan*, India AIDS Initiative of the Bill & Melinda Gates Foundation, were new commitments by the attending media leaders to use their collective communications expertise and resources to reach out across the country - especially to youth - with HIV prevention information and to help combat AIDS-related stigma and discrimination.

**BBC World Services Trust -NACO- Prasar Bharati media partnership** to air television spots over the national news channel at prime time is another initiative started in June 2002 and will continue till 2007. The detective series *Jasoos* Vijay was awarded the Indian Telly Award, while "*Haath Se Mile Haath"*, a youth show in virtual reality format, received the Commonwealth Broadcasting Association Award

The Heroes Project mass media campaign, launched in July 2004, uses a number of avenues to raise awareness about HIV/AIDS and reduce stigma and discrimination, including public

service announcements (PSA), online and print content, television and radio entertainment programming, as well as educational events.

The **India Communication Consortium** which aims to bring on board communication and media organisations throughout India and at every level ('One nation, One Resolve') was another initiative launched in November 2004. Many partners including UN agencies, bilateral and others have committed technical as well as financial resources.

Along with these programmes that have a national coverage, there are regional/state level initiates also, while the response between states varies. **AIDS Awareness and Sustained Holistic Action** (**AASHA)** initiative, a month long campaign, was carried out in Andhra Pradesh in July 2005 under the leadership of the Chief Minister. It used an integrated and comprehensive partnership approach, bringing in interventions at multilevel nodes simultaneously to achieve 100 percent HIV/AIDS awareness in the state. The Andhra Pradesh Legislators' Forum on HIV AIDS ensured leadership at the constituency level. Inter-governmental (MoHFW and other government departments) and inter-institutional (NGOs, CBOs and the private sector) partnership contributed in giving a clear unified message.

A UN partner's collaborative programme, **Coordinated HIV/AIDS and STD Response through Capacity Building and Awareness (CHARCA)** to empower adolescent girls and young women through awareness and knowledge on HIV AIDS was initiated in April 2003 and is being implemented in six districts across the country,.

**Civil Society Partnership**

Since 2003, India has recognised the need for greater involvement of civil society in the fight against HIV/AIDS, and greater cooperation and collaboration among citizen's groups, CBOs of vulnerable populations, NGOs, government departments and the corporate sector. Recognising the fact that NGOs/CBOs have been working with vulnerable populations and have access to difficult-to-reach population than the government, NACO had involved them in implementing targeted interventions and HIV/AIDS awareness through the SACS. As mentioned above the 933 targetted interventions across the country are being implemented by NGOs/CBOs. The community care and support centres for PLHA are also being implemented through NGOs/CBOs/FBOs, so as involvement in the School AIDS Education Programme and recently in the VCTC and PPTCT programme. Apart from the NACO supported programmes the large network of NGOs are trying to integrate HIV/AIDS into their ongoing developmental work, thereby mainstreaming HIV/AIDS.

Another remarkable achievement of NGO-Government partnership during 2003-05 was the drafting of the HIV/AIDS legislation. Through stakeholder consultation between civil society organisations, human rights groups, PLHA, women's and children's groups and health service providers, the Lawyers Collective drafted the bill. The bill addresses all issues of HIV/AIDS including testing and stigma and discrimination and is awaiting introduction in the Parliament.

Civil society organisations play an important role in different areas viz. advocacy, human rights, care and support areas of HIV/AIDS, implementing small and large interventions that reach some of the most vulnerable populations in the face of several challenges- financial, technical, legal and socio-political. In certain instances, the civil society recognises and intervenes in areas and sectors before the government's initiation. One such area is the care and support for children affected and vulnerable to HIV/AIDS, which is currently not in the NACP-II agenda. It is recognised some NGOs had responded to the need for ARV access and initiated programmes, albeit in a very limited way, before the NACO ART roll out started in

2004. Even though there is no formal system to track the role played by civil society initiatives in the country it is known that they are supported by international donors.

There has been mixed response from the Faith Based Organisations (FBO). A work entitled '***HIV/AIDS- The Human Dimensions: Voices from the Hindu World'*** is one of the earliest initiative to look at the human (religious) dimension of HIV/AIDS. The project jointly undertaken by the Shanti Ashram along with the World Conference of Religion and Peace attempt to coalesce important voices from ancient Hindu texts and contemporary religious leaders, women, youth and children.

The Catholic Church in India, the second (next to the government) largest organised network of health care facilities and educational services in India, developed the Catholic HIV/AIDS Policy in 2005. The Policy strongly advocates non-discrimination, compassion and a pro-active role for Church based organisations in addressing issues around HIV/AIDS. Under the network of the Catholic Church in India, there are about 66 specific HIV/AIDS initiatives with a focus on care and support services for people living with AIDS.

The National Spiritual Assembly of Bahai, (NSAB) India, is implementing a comprehensive adolescent skill building programme that includes HIV/AIDS in Delhi. Awareness about HIV/AIDS has been integrated into the value education modules prepared by the NSAB. The Office of the Development of Women of the NSAB is also contemplating integrating HIV/AIDS education into its programme with Panchayati Raj institutions.

The Christian AIDS Network Alliance (CANA), is a network of Christian organisations working on HIV prevention, serves as a resource center and conducts training, advocacy and action research. Other FBOs that work in India are with international parent organisations, like Catholic Relief Service, the Salvation Army, Caritas and World Vision. The majority of them address advocacy and HIV prevention, with training and sensitisation of religious leaders, awareness generation and working with orphans and other vulnerable children

National Council of Churches in India (NCCI), the apex organisation of Protestant and Orthodox Churches, is organizing programmes on HIV/AIDS prevention and education targeting different audiences, ranging from followers to pastors, school children and people living with HIV/AIDS. The Christian Medical Association in India (CMAI), the official health arm of NCCI is a network of 350 institutional members and over 5000 individual members have programmes that impart sexual health education in schools, home-based care for people living with HIV/AIDS, antenatal clinics and detoxification centers. The Snodical Board of Health Services, under the Churches of Northern India, also supports radio talk shows and rallies to raise awareness on HIV/AIDS.

The Emanuel Hospitals Association's (EHA) work on HIV/AIDS is focused in the North-eastern states of India. EHA is implementing services to people injecting drugs, truckers, sex workers, and support needle exchange programmes. Example of FBO-government partnership is evident in different parts of India. For instance, in Andhra Pradesh, 7 community care and support centres for PLHA funded by APSACS are run by church-based organisations.

Islamic scholars and priests in the Himalayan state of Kashmir have come in the forefront to combat HIV/AIDS and they now offers sermon to build awareness about HIV/AIDS. Mata Amritananthamayi Math is initiating a hospice centre for people living with AIDS near Trivandrum, Kerala so is the health network of Rama Krishna Mission in Tamil Nadu. There were a couple of advocacy efforts at the national and regional level to increase the involvement of faith leaders and FBO through conferences and round-table discussions.

## GREATER INVOLVEMENT OF PEOPLE LIVING WITH HIV/AIDS (GIPA)

The government has expressed its commitment to the GIPA principles since 2003, and it partnered with the Indian Network of People Living with HIV (INP+) and UNDP to pilot the Leadership for Results Programme in three states. In June 2003, NACO directed all SACS/MACS to be mindful of GIPA as a tool for the better implementation of its activities and to apply the principles of GIPA wherever possible. In the past two years, the SACS are networking closely with PLHA networks in a spirit of facilitating the implementation of GIPA principles, with PLHA becoming an integral part of behaviour change communication programmes, development of materials and designing of messages.

In 2004, the GIPA Strategy for India was developed under the leadership of INP+. The Operational Guidelines for Voluntary Counselling and Testing, 2004 has a chapter dedicated to co-opting PLHA as peer counsellors and with the roll out of ART, PLHA have an expended role as stakeholders and facilitators.

By the end of 2005, PLHA networks have been established in 20 states. In states like Tamil Nadu, Maharashtra, Karnataka, Andhra Pradesh district level networks of PLHA are also established, some of which are federated under the state network and some federated under the national network of INP+. A specific group of Positive Women's Network also exist in the country. A notable development is the evolution of Networks of non-heterosexual PLHA.

## POLITICAL COMMITMENT

There has been a marked difference in the political commitment in India towards HIV/AIDS during the year 2003-2005. The National Common Minimum programme adopted by the Union Government in May 2004 pledged that it would 'provide leadership to the national AIDS control effort'. It is included in the list of priority thrust areas. The Union Finance Minister, in his Budget Speech that year had announced a significantly enhanced outlay for an accelerated HIV/AIDS programme to achieve zero-level growth of HIV/AIDS.

The **Parliamentary Forum for HIV/AIDS** that was set-up at the national level in 2002 has 8 state level counterparts by 2005- Andhra Pradesh, Assam, Bihar, Delhi, Karnataka, Manipur, Nagaland, and West Bengal (USAID, 2005). In July 2003 the Parliamentary Forum for HIV/AIDS (PFA) organised the country's first National Convention of Elected Representatives on HIV/AIDS, inaugurated by the then Prime Minister Shri. Atal Bihari Vajpayee. The convention was attended by elected leaders from Parliament, State Assemblies and Councils, Panchayat members, Members of village councils and representatives from Municipal bodies, cutting across party affiliations, and they adopted a Declaration of Commitment from the political leadership to combat HIV/AIDS.

Drafting of a comprehensive **India HIV/AIDS Bill** involving a country-wide consultative process with civil society also reflects the national commitment in responding to the epidemic. The Bill will be tabled for discussion in the Parliament soon. .

Over 3,000 young people, representatives of youth from all the states in India convened in New Delhi on 6-7 November 2004 for the **Youth Parliament on HIV/AIDS**. The youth leaders discussed several issues among which were access to information, treatment and care, stigma and discrimination. It was the biggest youth gathering for the cause and resulted in evolution of 3,000 ambassadors for the HIV/AIDS prevention and care. The Prime Minister, in his address to the National Students and Youth Parliament Special Session on HIV/AIDS in India, had spoken about the importance of confronting HIV and AIDS.

In order to reiterate the Government's commitment to prevent the spread of HIV and to facilitate a strong multi-sectoral response to combat it effectively, a **National Council on AIDS** with the Prime Minister as chairman was constituted in June 2005. The terms of reference of the National Council on AIDS includes 'mainstreaming HIV/AIDS in all Ministries and Departments by considering it a development challenge and not merely a public health problem; to lead the multi-sectoral response to HIV/AIDS in the country with special reference to youth and the workforce; and to review the inter-sectoral commitment.' (NACO, 2005)

The vice-chairman of the Council is the Minister for Health and family Welfare, and other members includes Ministers for Defence, Human Resource Development, Home Affairs, Finance, Labour, Railways, Commerce, Information and Broadcasting, Surface Transport, Rural development, Law and Justice, Social Justice and Empowerment, Coal and Mines, Industry, Steel, Tourism, Science and Technology, Women and Child Development, Youth Affairs and Sports, Agriculture, Chemical and Fertilizers, Consumer Affairs (Food and Public Distribution), Communication, Development for North East Region, Environment and Forests, Personnel and Public Grievances, Statistics and Programme implementation and Urban Development.. The Deputy Chairman of the Planning Commission and Chief Ministers from the states of Tamil Nadu, Maharashtra, Nagaland, Gujarat, Uttar Pradesh, Bihar, and West Bengal are also members, along with fifteen representatives from civil society including NGOs and PLWHA groups. Couple of scheduled meetings between June and December 2005 of the National Council on AIDS had to be postponed due to other national priorities.

In December 2004, the Prime Minister Manmohan Singh asked NACO to develop a road map for the next three years to control HIV/AIDS, the goal of which would be the achievement of a zero growth of new HIV infections by 2007. An effort to develop The National Partnership for AIDS Control and Treatment (PACT) has been initiated, making HIV prevention and control everybody's responsibility.

# MAJOR CHALLENGES FACED AND ACTIONS NEEDED

With large population and population density, low literacy levels and consequently low levels of awareness, HIV/AIDS is one of the most challenging public health problems ever faced by the country. (UNPAN (2003). India faces an accelerating threat from HIV with some states already experiencing a crossover of the virus from at risk groups into the general population. The spread of HIV within the country is as diverse as the societal patterns between its different regions, states and metropolitan areas. India's epidemic consists of a number of epidemics, which vary from states with mainly heterosexual transmission of HIV, to some states where injecting drug use is the main route of HIV transmission. Both tracking the epidemic and implementing effective programs poses a serious challenge to the authorities and communities in India.

**Decentralised Planning**

The major challenge to the NACP is to decentralise its implementation from the state to the district level to make them more effective, ensure a minimum standard of quality, increase coverage and commitment. In the context of NACP-III design, preparation of District HIV/AIDS Action Plans was integral and the outputs of these plans were to be the inputs for the State Level Program Implementation Plans (PIP). District HIV/AIDS Plans were formulated in many states, especially in all the districts of Tamil Nadu and Pondicherry.

**Stigma and Discrimination**

Lack of correct information and myths and misconceptions associated with HIV/AIDS still contributes to judgmental attitudes and barriers to effective program implementation. It also affects the lives of PLHA. The misconception that HIV only affects CSW, IDU, MSM and mobile workers further strengthens and perpetuates stigma against this population groups, often having little or no access to legal protection of their basic human rights. Addressing the issues of human rights violations and creating an enabling environment that increases knowledge and encourages behaviour change remains major challenges in India.

**Women and HIV/AIDS**

Gender inequality in both the public and private realms contributes to women's vulnerability to HIV across the country. The expression of women's sexuality and decision making is limited by social norms which further make it difficult for them to access HIV/AIDS information and negotiate safe sex practice within and outside marriage. The potential spread of HIV to the general population necessitates the increase to prevention methods, expansion of PMTCT services and access to reproductive health services. Issue of property and inheritance rights are being addressed by the government as in several situations, when men die, relatives may seize all property and evict orphans and widows.

The IEC and awareness component of NACO seeks to addressed gender and sexuality in the design and delivery of prevention messages. While changing unequal gender relationships is a long-term process and cannot be achieved through IEC and awareness programmes alone, gender-sensitive HIV/AIDS prevention messages do play a critical role in promoting equitable norms and creating an enabling environment in which individuals can adopt behaviour change. Response to the issue also endeavors to focus on women's empowerment by providing equal access to education, employment and health services. It is envisioned that gender needs to be in-built into the broader right to health agenda and gender audits of resource allocations needs to be undertaken. Efforts are being made to integrate HIV prevention and AIDS treatment with other reproductive health needs of women and men and

providing recognition to how improving the Antenatal care and services would help in HIV/AIDS prevention. At the same time there is a need to emphasise on the male responsibility and participation in gender and HIV/ AIDS related work. There is also a need to consider women's vulnerability in the context of IDUs.

**Children Affected and Vulnerable to HIV/AIDS**

One of the major challenges in India is the increasing number of pediatric HIV infection and the lack of sufficient programmes. In order to develop comprehensive and sustainable response to children a national consultation, initiated by Department of Women and Child Development/ UNICEF was held in New Delhi in March 2005. The consultation brought together representative from the Government of India, UN partner organisations, FBOs, networks of people living with AIDS and donors. The five strategies of the international framework for protection care and support of children living in a world of HIV/AIDS were endorsed by the Government of India. As an outcome of the national consultation a task force of stakeholder representatives was initiated under the stewardship of DWCD, NACO and UNICEF to follow up on key recommendations. However a significant barrier to the planning process is that data is not available to decide the size of population of children affected by HIV/AIDS. There is limited information about the situation of children affected by HIV/AIDS, no information about the types of approaches that are best suited to the India context and scant information about the current projections and magnitude of the problem. Children have restricted access to ARV and testing and counseling and the present coverage has limitations in scope and scale.

**Young People**

In the context of young people and HIV/AIDS issues, there is need for a comprehensive HIV/AIDS policy for young people and adolescents addressing underlying issues critical to ensure effective youth interventions, with the involvement of young people in design and formulation of programs/interventions. There is a need for a policy directive on adolescents, access to VCTC (legality of using VCTC), contraceptives, and health services and so on. There is a need to cover out of school youth and provision of youth friendly health services need to be strengthened with franchised networks made available everywhere. Emphasize also needs to be put on meaningful involvement of youth in community based prevention and care programmes with strong linkages with livelihoods.

**Most-at- Risk Populations:**

The 'targeted interventions' approach is a key strategy of NACP 2, and more than 950 TIs have been initiated by NACO/SACS all over country in partnership with NGOs/CBOs offering services like accessibility to condoms, STD services, and through BCC approach by creating an enabling environment.

**Men Having Sex with Men**

Official estimates show that from a total of confirmed HIV infections on an all-India basis, transmission through homosexual route is 0.74 percent (NACO 2005). Civil society organisations working with non-heterosexual populations have expressed concern over the past year that the rate of seropositivity in males with non-heterosexual behaviours is increasing steadily (Humsafar Trust 2005). Unspecified and other routes of transmission account for about 6.4 percent of the total number of infections. There is an enormous range of same-sex behaviours and lived identities that cannot be reduced to simplistic framework of heterosexual/homosexual, gay/straight, or even man/woman.. Thus understanding sex/gender systems based on what has meaning, significance, and lived experience and not on outdated social constructs and labels would facilitate interventions that address HIV/AIDS. In fact

there is sufficient evidence to indicate that a substantive percentage of the sexual active male population is behaviorally bisexual, taking into account the following factors:

- Social policing of females making them more difficulty to sexually access;
- Ready availability of males involved in male-to-male sex in certain environments;
- Socially compulsory marriage, but often delayed till mid-twenties and older;
- Poverty leading to the provision of sex as transactional commodity

Targeted Interventions run by non-community based organisations often lack understanding of the complex gender-and identity issues, for example transgender people, hijras, and male sex workers are all covered under one umbrella. The programme lacks recognition that Male-to-male behaviours also exist in a range of all male institutions and occupational groups including prisons, juvenile homes, etc. along with truck drivers, and in other service industries.

**Size estimations:** developing size estimations of MSM is the confusion regarding self-identified MSM – gay men, homosexuals, *kothis* and *hijras* - and that of non-identified MSM whose male-to male sexual behaviours are not based on a sexual/gender identity. The confusion impacts on what is being counted, and whether it is identity-based or behaviour based, where the two are not synonymous. Limited work with Hijra communities results from inadequate understanding of their cultures and soio-economic needs and programme delivery concentrated in urban areas. Only three MSM/Hijra interventions have their own VCTCs and the rest work through referrals. There are only a few sentinel surveillance sites.

**Programme issues**: Funds for MSM interventions in several states have largely been allocated to NGO. However few have experience of working with the broad framework of MSM behaviours, categories and socialization processes which is essential in building sustainable risk reduction behaviour among the community. Guidelines for targeted interventions are usually seen as rules leading to inability to develop state specific interventions also there is a need for established mechanisms for providing specialized technical support to MSM led community based organizations. Inclusion of skilled MSM in the boards of State AIDS Control Organizations will result in effective project monitoring and evaluation.

**Vulnerability of Feminised Males:** Not only does poverty, class and education level stigmatise individuals along with the fact of HIV infection, but also the specific gendered role and identity that some MSM identify with. Thus *zenanas /kothis /metis* are doubly stigmatised because as biological males they are sexually penetrated – and thus not perceived as men. Their feminisation, their crossing of the gender roles and barriers accepted as social norms, reinforces the stigmatisation, leading to exclusion and denial of access to services and to the social compact. This often results in such males who are living with HIV/AIDS to be stigmatised *by others who are also living with HIV/AIDS* but whose routes of infection are deemed “normal”. (Shivananda Khan, 2003)

**Lack of Reliable Epidemiological Data** is an obstacle to the promotion of sexual health and HIV prevention. The challenge before NACP is successful mapping of these populations and measuring their access HIV/AIDS prevention services which can be achieved through addressing issues of stigma and denial within the official agencies entrusted with programme implementation, active advocacy for an enabling environment through the revision of statutes that serve to make this population invisible, and the greater involvement of grass-roots MSM CBOs. NACP needs to address and incorporate the special requirements of men having sex with men into the design of STI/HIV/AIDS prevention programmes.

Presently there are around 85CBOs for MSM in India, 15 CBOs for Hijras, and about 8-10 NGOs working on MSM/Hijra projects, with 20 STI/HIV/AIDS funded targeted interventions. There is a need to devise communication initiatives that reach out to MSM populations with accurate, unbiased information. There is a need to expand sentinel sites for more accurate figures to aid programme planning and implementation and facilitate the expansion of CBOs for Hijra communities. There is also a need to extend interventions to smaller urban areas and districts across the country.

**Sex Workers**

The targeted interventions among sex workers are affected by the socio-legal environment. Currently various initiatives are under way for female sex workers such as collectivisation, empowering them through facilitation processes, capacity building, and networking. Strategies and interventions used by various civil society organisations differ, with some organisations focusing on economical empowerment of female sex workers by providing other vocational skills to provide alternatives to sex work.

Brothel based CSW are relatively easier to target for HIV prevention and management interventions than street-based, or 'flying 'sex workers. No interventions exist for male sex workers. This segment consists of men who come from varied socio-cultural backgrounds, and who may have sex with males as well as females for commercial considerations.

The working NACP working group examined the current scenario and the following recommendations were made. Prevention: Encouragement of innovative methods to reinforce information on behaviour change. Periodic orientation of police on Immoral Traffic Prevention Act (ITPA) is required and there is a need to strengthen linkages and networking with other sex workers needs (schools for children, Homes, ration cards). Involvement of sex workers more effectively in programme planning processes and inclusion of HIV+ female sex workers in decision making body at district / state / national level is also seen as integral to effective program planning and implementation.

There is also a need to develop specific intervention models for male sex workers as there cannot be one generic intervention model. Focus on special vulnerabilities of male sex workers with respect to condom negotiation, violence, stigma, discrimination and police violence makes them susceptible to STI, have less access to VCTC and face counsellor's apathy.

**Injecting Drug Users**

Many issues complicate TI with IDU. Drug taking is a strongly disapproved socially and in India drug taking is a criminal act and punishable under law. Criminalisation of drug taking makes the IDU hard to reach. The key strategy for TI with IDU is needle exchange programme. This strategy ensures that the drug addicts always have sterile needles and syringes for injecting. The spread of HIV among IDU highlights many development issues. Risk behaviours leading to HIV transmission through shared needles and syringes are closely linked to development problems such as poverty and lack of sustainable livelihoods, exploitation, inadequate education and political repression. The challenge is to explore the links between risk behaviours and development problems and this could make a significant contribution to increasing understanding of both development and the epidemic.

As is the case with drug use in general, injecting drug use often provokes moralistic or judgmental attitudes and responses. Perceiving (and treating) drug users as a 'species apart' is unproductive and indefensible. Stigmatising and marginalising injecting drug users are likely to leave them alienated, fearful, and out of touch with the support and services they may most need. Legal and ethical factors are also creating challenges to the enabling environment. The

illegal nature of drug use can lead young people to hide their drug consumption, preferring to inject rather than risk detection through the smell of smoking. This is despite the risk that injecting poses for HIV transmission through clandestine sharing of injecting equipment (Parnell and Benton, 1999).

Despite recent expansion of responses, a range of factors inhibit TI for IDU and these are closely linked to development. The population of IDU is hard to quantify and economic, social and political dislocation leads to increases in drug injecting, needle sharing. Injecting drug users, especially women, are demonized for their drug use which places them at particular risk of both human rights abuses and HIV infection. There is a definite need to scale up and involvement of local communities and IDU in designing the programmes and raising issues and concerns. Promotion of testimonies from IDU will also be encouraged, which is an effective way of combating stigma and discrimination. Networking and integration between various sectors and agencies responsible for drug control and HIV prevention is also required for effective control of the spread of HIV..

**Migrants**

Migration of workers both within and between states and countries is a major risk factor that is poorly studied and understood. Concerted efforts are needed to address the vulnerabilities of the migrant population. Being mobile in itself is not a risk factor for HIV infection. The situations encountered and the behaviours possibly engaged in during mobility or migration increase vulnerability to HIV infection.

Social and cultural factors play an important role along with economic factors in determining the working and living conditions of migrants. Language barriers, caste or ethnic factors critically determine the migrants' access to healthcare. Exposure to a new cultural system, sometimes hostile to the migrants, often creates psychological problems arising from a sense of loneliness and isolation in a place far away from home. Thus stress and lack of avenues for psychological support contribute to the migrant workers' frustrations. Many turn to drug use for temporary relief or due to peer pressure. Sharing needles is common and heightens vulnerability to HIV infection. Male migrant workers are likely to visit brothels or have sex with other men, including migrant colleagues, female migrants or local women. Unprotected sex increases their vulnerability to HIV and other STIs.

Women migrant workers in the informal sector may experience sexual harassment and physical abuse, single migrant women or those deserted by their husbands are particularly vulnerable and are susceptible to commercial exploitation. Poverty and lack of resources force them to trade sex for food and other necessary goods. Limited access to information on HIV/AIDS and to condoms further exposes them to unprotected sex and HIV/AIDS.HIV-positive migrants carry a double burden as the epidemic reinforces and deepens existing inequalities, further increasing their multitude of vulnerabilities. Besides affecting themselves severely, HIV infection also creates a huge impact on their families, host communities and countries

**Advocacy**

Community mobilization is a proven strategy for HIV/AIDS prevention, management and control. This requires collaboration between government and non-government stakeholders, while constantly also involving individuals affected and infected by HIV/AIDS. The advocacy efforts will focus on confidence building measures among communities about diseases and their management capabilities. Peer persuasion is the most common and effective advocacy tool for behaviour change. Testimonies of PLHA to show the 'human face' of HIV has been effective in destigmatising campaigns. Understanding the risk-taking

behaviour and communicating messages in the language that the target segment can relate to is also an advocacy agenda. Sensitising police and other gate keepers on interventions with CSW, MSM and IDU will enable creating an enabling environment for program implementation.

## WAY FORWARD: RECOMMENDATIONS

In preparation for the third phase of the National AIDS Control Programme, a series of consultations have been held with programme officials, government representatives, civil society representatives and representatives for multi-lateral and bilateral agencies. Increasingly it is being realized that AIDS control programmes must be based on a foundation of strategies that (a) promote gender equity; *(b)* protect human, sexual and reproductive rights and freedoms of all; (c) strengthen healthcare systems to ensure delivery of quality services; and *(d)* address stigma and discrimination. The following recommendations viz. different thematic area were made

### Prevention

- Develop a simpler strategy of dealing with the epidemic. Focus on two levels (1): Prevention (2) Care and Management of infected persons. At the first level, priority should be to prevent new infections and testing high risk people for dormant infections. At the second level priority should be to build a robust medical delivery system to take care of PLWA.
- Provide condoms at vulnerable areas such as bars, discotheques, hotels resorts etc along with information on its correct usage and disposal.
- Formulate a dual policy on AIDS so that the states that have high prevalence of STI have a different, liberal protocol of HIV testing as compared to other low prevalence states.
- Issue ID cards to long distance truckers, factory workers and other high risk groups for regular HIV testing access and follow up.
- Upgrade blood safety measures practiced by all the blood banks to test blood for P24 and other antigens so that infected blood in the window period can be detected
- Communication Need Assessment (CNA) is yet to be accomplished in various States and Union Territories as envisaged by NACP-II
- Efforts need to be made to emphasize STI/RTI in the communication component of the program. IEC needs revision and needs to be available providing information on service availability and needs to be made available during Family Health Awareness Campaigns. Prevention of transmitting HIV needs to be emphasized along with making availability of strategic communication towards addressing stigma and discrimination
- The location of all related services within a facility is also critical in improving up prevention. Specific IEC on male and female condoms is also necessary. The communication providing emphasis on STI prevention and cure as a control mechanism needs to be stepped up.

### Care and Treatment

- Coverage of new ART centres to be planned according to needs of the state/districts , for example clustering of services in one area

- Integration of ART centres into the general medical services in the hospitals (and not as a stand-alone)
- Make provision for nutritional support to PLHA
- Pediatric Drug formulations to be made available
- Country laboratory operational plan needs to be formulated
- TOR for each level of facility-primary, district, reference
- Encourage organizations working on AIDS to assess the impact of AIDS within their own organization. Conduct capacity building workshops to help organizations to mainstream HIV/AIDS internally.
- Develop coordination between different sectors such as the social sector, the health sector, the industrial sector and establish partnerships among them to understand and reduce stigma and discrimination and develop a better understanding of the epidemic.
- Make it mandatory for the corporate sector to look after its employee's health and welfare. Use the examples available in the western countries where the companies stock would not be listed in the Stock Exchange until the company's Corporate Social Responsibility (CSR) plans and reports are inspected or accepted by the appointed authorities.

**Service delivery**:

- Scaling up of VCTC and PPTCT services both in number and quality of services offered is essential.
- Prevention and care and support needs to go hand in hand
- Mainstreaming of HIV/AIDS seems to be left primarily to NACO. Greater involvement is needed from all players (public and private) So far 31 ministries have been requested to make their action plans for HIV/AIDS and also allocate resources from their own budgets.
- TI among high risk groups is a successful strategy and saturated coverage of high risk groups through service delivery needs to be addressed along with law reform and sensitisation of law enforcement.
- 70-80% of health and health related institutional services are provided by the private sector and collaboration with private sector would be a key.
- Blood safety is important. This is the success story of the NACP where the spread through the route of blood and blood products have been brought down to less than 2%. Efforts need to be placed to ensure that blood transfusion is completely safe.
- Auto disabling syringes need to be universally used and this aspect also needs to be looked into.
- In the first phase the PPTCT services would be provided by all CHC and in the second phase it would be expanded up to the PHC level. The ground realities are that a large number of PHC are not functional and this needs to be changed through concerted efforts

- For 1, 80,000 people to be on ART is a huge commitment and the drug costs have been provided for only the first line of drugs. Second line requirement has emerged and the implications for resource requirement are far higher.
- ART service provision has been criticized for not reaching the targets in terms of numbers but the achievement in terms of number of centres providing services has been ignored. The target of 100 centres providing ART would be achieved by 2005 and the target of 1, 80,000 by 2010 on ART would be achieved through 280 centres providing ART. This itself is not adequate because service capability to reach all PLHA needs to be there and private sector must play an equal role in providing universal access to ART services

**Human Rights**

The desired scenario for the a successful HIV/AIDS initiative could come about by rights based HIV/AIDS legislation approved and working mechanisms in place down to the District level; when statutes that influence risks and impede HIV prevention, and care and support services – especially for vulnerable population – have been reformed; and accelerated, streamlined and speedy redressal mechanisms developed.

Proposed strategies to achieve this include:

- Enactment of laws that protect rights and repeal laws that influence risks and impede programme implementation
- Establish speedy legal and community redressal mechanisms

The **institutional mechanisms** to implement the above would include different Ministries, e.g. Law, Home Affairs, Law Colleges and Schools, elected representatives, Human Rights Commissions, Judicial Training Academies etc. The technical support and capacity building will involve the Resource group of the Human Rights Division at NACO, networks of Lawyers and national legal aid authorities among others.

- Set up legal aid cell at the SACS level to start with and expand it to VCTC at the districts, block level and Panchayat in partnership with the NGOs, CBOs and others.
- Develop advocacy programs with the Home Department and Judiciary for sensitization on HIV law, ethics and human rights.

**Programme Management**

- Develop a uniform financial reporting system across the country to arrive at figures of total yearly expenditure
- Promote greater transparency by having yearly social audits of NACO and respective SACS
- Accept and encourage profitability of the organizations working on AIDS as this will improve the quality of intervention, the manpower and increase accountability. From a macro point of view, a professionally managed organization can reduce cost of operations and prove to be more economical even after making a profit.
- Depicting AIDS merely as a charitable and humanitarian issue decreases accountability and professionalism from AIDS campaigns.
- Encourage corporate parameters of quality, relationship, efficiency, insights, accountability, leadership, branding, targets, budgets and research

- Avoid multiple job responsibilities for the Project Directors of SACS to enable them to focus on their role as the Project Directors qualitatively
- Have a specific workplace policy at national and state levels applicable to government bodies, public sector undertakings, legislative bodies, private institutions as well as civil society organizations.
- Stipulate the minimum staff component of Project Support Units (PSU). SACS should closely monitor the PSU
- Encourage the program managers at the district and sub-district level to integrate program delivery as per the local need

# MONITORING AND EVALUATION

The Monitoring and Evaluation system is an integral part of evidence based planning, which is crucial to the success of the National AIDS Control Programme. This system provides critical information continuously, thus helping NACO and State AIDS Control Societies in charting the course of the AIDS epidemic, identifying bottlenecks, facilitating timely decision making and implementation of relevant, sensitive and programmes and activities.

For the effective monitoring and evaluation of Phase-II of the NACP at National and State level, the M&E plan included:

- Refining and strengthening the Computerised Management Information System (CMIS) at National and State levels.
- Training NACO staff and health specialists in evidence based health programme management.
- Conducting baseline, mid term and final evaluation
- Conducting the Annual Performance Review (APR)
- Conducting the National Performance Review (NPR) under National AIDS Control Board

**Computerised Management Information System**

With IDA assistance, Computerised Management Information System (CMIS) was operationalised throughout the country. The CMIS system is multi functional viz. the following

- Ensures that a programme is appropriately tailored to the needs of the local population
- Provides evidence on the effectiveness of a specific intervention
- Permits appraisal of process, inputs, and outputs
- Facilitates advocacy with compiled data
- Tracks trends in the utilisation of services
- Maps behaviour change concurrently

The CMIS collects information from approximately 5000 primary data generation units including Blood Banks, STD Clinics, PPTCT sites, VCTC, TI Projects. Some information is generated at SACS/NACO level as well. (NACO Annual Report, 2004)

This data is collected on predefined input format from the primary data generation units. The data flows to the SACS from all the reporting units (at district or below district) either directly or through the District Nodal Officer in hard copy at a pre determined frequency i.e. monthly/ annually. Data entry is made at SACS and the soft copies are relayed to NACO. Checks and validations have been incorporated in the data entry module so as to ensure its authenticity.

At NACO, standard reports are generated at Monthly, Quarterly and Annual intervals with the tabular, chart and map representation. The software also has the provision of dynamic reporting for customized query from the raw data based on the requirements.

**M&E Activity Highlights**

Some of the M&E activities undertaken in NACP II were

- Development of M&E strategic plan, annual action plan and annual review
- Development of indicators for monitoring NACP II through collaborative processes
    - Publication of the Handbook of Indicators for Monitoring NACP II, developed with interagency consensus
    - Design of component specific indicators generated through CMIS for monthly reporting since 200/2001, over 8,000 reporting units established since then
- Collection of indicators through CMIS and surveys
- Design and operationalisation of PFMS (Project Finance Reporting System) for generating financial information on the programme
- Estimation of HRG through mapping exercises in most states
- National BSS, 2001/2 and multiple rounds of State BSS
- Annual HIV Sentinel Surveillance with some 670 sites (NACO 2004)
- STD facility surveys
- Communications Needs Assessment
- Evaluations of
    - Family Health Awareness Campaign
    - Targeted Intervention programme
- 18 M&E officers identified and functioning in SACS, with improved capacity for collection, analysis, and interpretation of data, including identification of relevant remedial action.

Since September 2004, an interagency M&E working group has been established to support M&E efforts.

**Challenges of CMIS**

CMIS data is sparingly used for planning, or even for developing differential strategies. Programme managers at state levels need to utilise the CMIS data for actual decision making. Current quality, completeness and utility of data need refinement.

- M&E is not promoted enough or consistently. No culture of evidence based programming, people in charge do not use the system
- Only 18 out of 38 SACS have M&E officers
- Lack of one programmatic framework and coordination
- New partners and some donors operate outside framework
- Developing data sets / systems not inclusive / participative, no ownership
- Low / unacceptable quality of data
- Lack of M&E skills and capacities at local level (reporting unit)
- Irregular Reporting

- Some surveys are delayed such as 2nd round BSS
- Some issues not included in CMIS: ART, TB-HIV, Staffing
- No Operational Research undertaken
- No stringent follow-up on reporting from SACS
- Too frequent changes in the CMIS

**NEEDS AND RECOMMENDATIONS**

In the run up to the third phase of the National AIDS Control Programme, an interagency M&E working group was established in September 2005 to review the programme, assess needs and make recommendations.

A key recommendation of the working group was that in order to enable the more effective use of information for planning and monitoring the impact of programme activities, a move should be made from **Monitoring and Evaluation** to **Strategic Information Management** that includes M&E as one of the key components. The strategic information unit would minimize duplication and help organize key information needed for programme managers in a single area. It would be the bridge between information and policy and be a powerful tool for advocacy and resource mobilisation.

Capacity building is envisioned as a continuous module-based approach provided through a regular scheme of trainings offered by NACO, SACS, and technical partners. Routine induction training of SIM/M&E personnel, PDs and technical officers from district and state levels are required to ensure basic levels of competency for staff on monitoring, evaluation and the appropriate se of strategic information. Capacity building modules would include routine data collection, supportive supervision and evaluation.

The working group recommended that at least 2% of the total programme budget should be allocated to evaluation activities. This level of resource would support evidence based decision making with respect to the impact that a programme is achieving against its stated goals.

For further strengthening the CMIS system and software to enhance its utility for NACP III, CMIS needs to include on-government programme reporting, thus enabling states and NACO with a more comprehensive understanding of coverage and programme performances across a geographical area. This can be coupled with specific impact studies and strengthening the coverage of vulnerable groups and estimations of target population should be strengthened. Creating standard reports for each programme will help units with limited technical capability report effectively. Development of appropriate indicators for new programme areas that have emerged since the launch of NACP-II such as PPTCT, ART, TB/HIV, and School- based education programmes and others are underway and promoting the optimal use of data is a priority area in the immediate future.

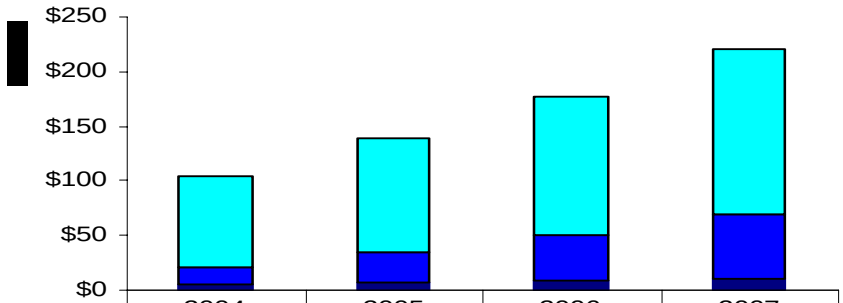
## SUPPORT REQUIRED FROM DEVELOPMENT PARTNERS

India accounts for approximately a tenth of HIV infected adults and children and three quarters of PLHA in South and Southeast Asia. Despite the low HIV prevalence, India has to deal with an estimated figure of 5.1 million people infected. Simultaneously the Indian economy – though ranked as a low-income country with a per capita GDP of US $ 460 – has experienced significant growth. Poverty reduction remains a challenge, and the spread of HIV, if unchecked could reduce India's future development achievements. Healthcare needs of PLHA are an important driver of the economic consequences of AIDS at household level.

Based on data available in 2003, it may be seen that three quarters (76%) of fiscal resources available were devoted to preventive interventions, a third of which were allocated for interventions targeted at the general population, and another third to service delivery prevention interventions such as STI management and treatment, VCTC, PPTCT and blood safety. Interventions focussing on most-at-risk populations accounted for 17 percent of all HIV/AIDS expenditures.

The total requirements for 2004 were estimated at US$ 103.5 million (USAID/Futures/NACO 2004), where prevention expenditure accounted for 80 percent of total resource requirements, and care and treatment accounted for 15 percent. In 2007 the

**Resources Required (2004-2007)**



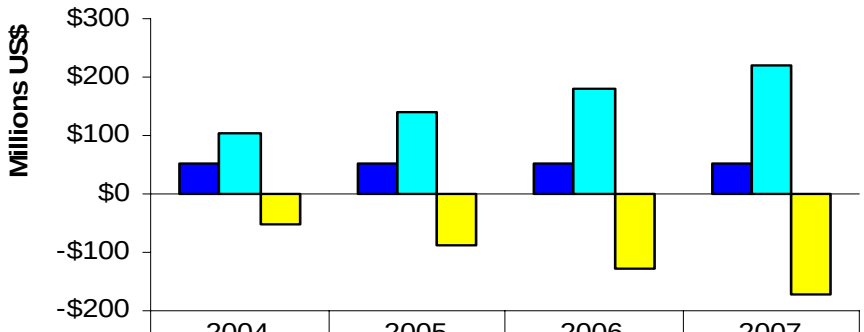

| | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|
| Prevention | $82,988,479 | $104,795,862 | $127,318,163 | $150,733,009 |
| Care and Treatment | $15,485,341 | $27,785,681 | $42,021,836 | $58,544,288 |
| Policy, Advocacy, Admin, Research | $4,929,613 | $6,648,621 | $8,500,164 | $10,510,650 |
| TOTAL | $103,521,877 | $139,621,031 | $178,503,452 | $220,723,659 |

Source: India HIV/AIDS Resource Requirement Assessment and Gap Analysis, POLICY Project, 2004

resource needs were projected to increase to US $ 220.7 million. The overwhelming majority of the AIDS investments in 2004 were for prevention. As the burden of care increases, the patterns and determinants of healthcare access in India gain importance. Care and treatment would be likely to account for 39 percent of investment and prevention was projected to account for 68 percent of total needs. Targeted interventions , the central thrust of the Indian response to HIV AIDS prevention accounted for about a third of the prevention resource requirements in 2004, and 27 percent of total HIV/AIDS requirements. Resource estimation did not include expenditure on impact mitigation such as orphan support or nutrition for PLHA.

Expenditure on policy, advocacy, administration, research and multi-sectoral collaboration is difficult to estimate. In 2003 this expenditure category accounted for 18 percent of the total expenditure. In 2004 it was estimated at 5 percent of the total expenditure, and id expected to increase by 2007. A gap analysed estimated that in 2007, the proportion of estimated resource needs that will be met will decrease to about 23 percent. This analysis however excluded taking into account AIDS expenditure by bilateral and multilateral donors such as DFID, USAID, CIDA, UNDP, AusAID, GFATM or foundations such as BMGF that were not routed through NACO.

**Resource Gap Analysis (2004-2007)**




| | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|
| Resource available | $50,418,422 | $50,418,422 | $50,418,422 | $50,418,422 |
| Resources needed | $103,521,877 | $139,621,031 | $178,503,452 | $220,723,659 |
| Resource gap ($) | -$53,103,455 | -$89,202,608 | -$128,085,02 | -$170,305,23 |
| % of resource requirements met | 49% | 36% | 28% | 23% |

Source: India HIV/AIDS Resource Requirement Assessment and Gap Analysis, POLICY Project, 2004

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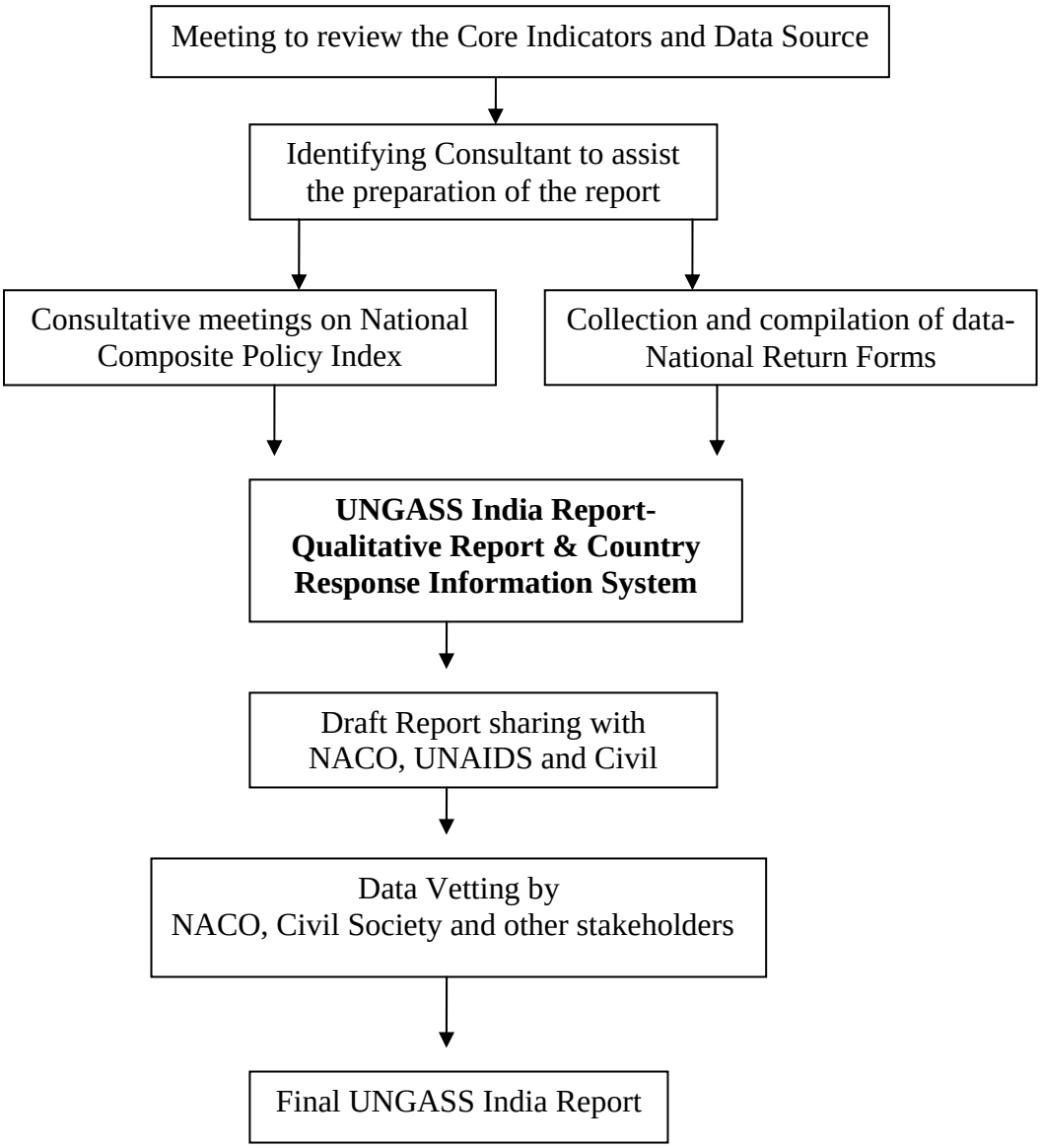
**Annexure 1**

## PROCESS FOLLOWED IN PREPARING UNGASS INDIA REPORT

As the entity coordinating and guiding the UN's response to the HIV/AIDS epidemic, NACO initiated discussion early in October 2005 for preparing the UNGAS India Report, 2005. The India Report is prepared based on the inputs from the government and civil society groups. The report preparation process ensured active participation of civil society in ensuring their involvement at all levels- calling for mechanisms that involve civil society as an equal partner at all levels of policy-making, implementation, and monitoring and evaluation.

The steps followed to prepare the Report is as below.




- ***Reviewing the Core Indicator and Data Sources:*** The initial meeting to review the core indicators and data sources and planning for data collection and was done at NACO in October 2005. Monitoring and Evaluation Experts from NACO and Development

partners were a part of this planning meeting. The core indicators, data source and assumptions were discussed. Based on this a road map was prepared.

- ***Identifying Consultant:*** A consultant was identified to assist NACO in preparing the report. Support to prepare this report was provided by UNAIDS through a subcontract to Futures Group.
- ***Collecting and Compiling Data*** - Data was collected at national level through different sources which includes; Behavioural Surveillance Survey (BSS), HIV Sentinel Surveillance (HSS), Computerized Management Information System (CMIS), email messages sent to development partners, reports and publications.
- ***Civil Society Consultation***- The UNGASS DoC and core indicators were shared with the civil society through two different civil society consultation meetings, one held in New Delhi in October and the other held in Kolkata in November, 2005. The inputs for the National Composite Policy Index were compiled during these consultations.
- ***Sharing on e -Forums***- Sharing of the response of the first civil society consultation on the National Composite Policy Index Questionnaire was done in the following egroups -. aids-india, H&D Net, solutions exchange and SAATHI. The responses from the civil society were triangulated with the subsequent civil society consultation in Kolkata and the median value of the responses was taken.
- ***National AIDS Spending Assessment Workshop***- A training program on National AIDS Spending Assessment was conducted at national level supported by UNAIDS and technical assistance from Futures Group with the aim of tracking/assessment of financial flows. Finance officers from 9 SACS were trained in executing national spending assessment.
- ***Training on CRIS:*** The CMIS Consultant in NACO was trained on feeding information into the Country Response Information System in an international workshop in November 2005 by UNAIDS.
- ***Data Entry:*** CRIS was utilized as data repository for UNGASS information and data from different sources was entered into the CRIS against various core indicators.
- ***Desk Review and Key Informant Interviews:*** Documents were reviewed and officials from NACO were interviewed to collect data for the report. This formed the basis for the qualitative report.
- ***Sharing of Draft Report with NACO and Civil Society:*** The draft report was shared with NACO, and civil society and the data was vetted before finalising the report. The civil society data-vetting workshop was held on December 22 at New Delhi where representative from 17 civil society groups from 8 states were present. The draft report was presented to NACO officials.
- ***Finalizing Report:*** A consensus based on the feedback and inputs from NACO officials and civil society were arrived and they were incorporated before the report was finalised.

**Annexure 2**

## NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

### Part A- Government Response

### I. Strategic plan

1. Has your country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS?[1]* (Multi-sectoral strategies should include, but not be limited to, those developed by Ministries such as the ones mentioned below)

***Yes*** *Period covered: 2003-2005*

1.1 *IF YES*, which sectors are included?

| Sectors included | Strategy/Action framework | Focal point/Responsible |
|---|---|---|
| Health | ***Yes*** | ***Yes*** |
| Education | ***Yes*** | ***Yes*** |
| Labour | ***No*** | ***No*** |
| Transportation | ***No*** | ***No*** |
| Military | ***Yes*** | ***Yes*** |
| Women | ***No*** | ***No*** |
| Youth | ***Yes*** | ***Yes*** |
| Others to specify* | ***No*** | ***No*** |

* Any of the following: Agriculture, Finance, Human Resources, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

1.2 *IF YES*, does the national strategy/action framework address the following areas, target populations and cross-cutting issues? (*Yes/ No*)

| | **Programme** | |
|---|---|---|
| A | Voluntary counselling and testing? | ***Yes*** |
| B | Condom promotion and distribution? | ***Yes*** |
| C | STI prevention and treatment? | ***Yes*** |
| D | Blood safety? | ***Yes*** |
| E | Prevention of mother-to-child transmission? | ***Yes*** |
| F | Breastfeeding? | ***No*** |
| G | Care and treatment? | ***Yes*** |
| H | Migration? | ***Yes*** |
| | **Target populations** | |
| I | Women and girls? | ***No*** |
| J | Youth? | ***Yes*** |
| K | Most-at-risk populations[2]? | ***Yes*** |
| L | Orphans and other vulnerable children? | ***No*** |
| | **Cross-cutting issues** | |
| M | HIV/AIDS and poverty? | ***No*** |
| N | Human rights? | ***Yes*** |
| O | PLHA involvement? | ***Yes*** |

[1] All questions bolded and with an asterisk are also relevant for the "Three Ones" monitoring at country level

[2] Most-at-risk populations are groups that have been *locally* identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, commercial sex workers, moto-taxi drivers etc)

1.3. IF YES, does it include an operational Plan? **Yes**

1.4. IF YES, does the strategic/operational plan include

| | | |
|---|---|---|
| A | Formal programme goal? | ***Yes*** |
| B | Detailed budget of costs? | ***Yes*** |
| C | Indications of funding sources? | ***Yes*** |
| D | A monitoring and evaluation plan? | ***Yes*** |

1.5 Has your country ensured "full involvement and participation" of civil society in the planning phase?

**Yes**

1.6 Has the national strategy/action framework been endorsed by key stakeholders?

***Yes***

2. Has your country integrated HIV/AIDS into its general development plans (such as: a) National Development Plans, b) United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, and d) Common Country Assessments)?

***No***

2.1 *IF YES,* in which development plan? a)_*____b)_*___c) other

Covering which of the following aspects? (*Yes/ No*)

| | a) | b) | c) |
|---|---|---|---|
| HIV Prevention | | | |
| Care and support | | | |
| HIV/AIDS Impact alleviation | | | |
| Reduction of gender inequalities as relates to HIV/AIDS prevention/care | | | |
| Reduction of income inequalities as relates to HIV prevention/care | | | |
| Others: | | | |

3. Has your country evaluated the impact of HIV/AIDS on its economic development for planning purposes?

**No**

*IF YES,* how much has it informed resource allocation decisions? *(Low to High)*

*Low* *High*

1 2 3 4 5 6 7 8 9 10

4. Does your country have a strategy/action framework for addressing HIV/AIDS issues among its national uniformed services, military, peacekeepers and police?

***Yes***

4.1 *IF YES*, which of the following have been implemented?

| | |
|---|---|
| HIV Prevention | **Yes** |
| Care and support | **Yes** |
| Voluntary HIV testing and counselling<br>Mandatory HIV testing and counselling | **Yes**<br>**Yes** |
| Others to specify: | |

| Overall, how would you rate strategy planning efforts in the HIV/AIDS programmes? |
|---|
| 2005 Poor Good<br>0 1 2 3 4 5 ***6*** 7 8 9 10<br>2003 Poor Good<br>0 1 2 3 ***4*** 5 6 7 8 9 10<br>*In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:* |

## II. POLITICAL SUPPORT

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

1. Does the head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year?

   Head of government ***Yes***

   Other high officials ***Yes***

2. **Does your country have a national multi-sectoral HIV/AIDS management/coordination body recognized in law? (National AIDS Council or Commission)***

   ***Yes***

   2.1 *IF YES*, when was it created? ***1992, National AIDS Control Organisation***

   2.2 Does it include?

| | |
|---|---|
| Terms of reference | ***Yes*** |
| Defined membership<br>Including civil society<br>PLHIV<br>Private sector | <br>***Yes***<br>***Yes***<br>***Yes*** |
| Action plan | ***Yes*** |
| Functional Secretariat | ***Yes*** |
| Date of last meeting of the Secretariat | **Date:2005** |

3. Does your country have a national HIV/AIDS body that promotes interaction between government, PLHIV, the private sector and civil society for implementing HIV/AIDS strategies/programmes?

***Yes*** ***NACO***

3.1 *IF YES*, does it include?

| | |
|---|---|
| Terms of reference | ***Yes*** |
| Defined membership | ***Yes*** |
| Action plan | ***Yes*** |
| Functional Secretariat | ***Yes*** |
| Date of last meeting | **Date:2005** |

4. Does your country have a national HIV/AIDS body that is supporting coordination of HIV-related service delivery by civil society organizations?

***No***

4.1 *IF YES*, does it include?

| | |
|---|---|
| Terms of reference | |
| Defined membership | |
| Action plan | |
| Functional Secretariat | |
| Date of last meeting | Date: |

| Overall, how would you rate the political support for the HIV/AIDS programme? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2005 | Poor | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | **4** | 5 | 6 | 7 | 8 | 9 | 10 |
| 2003 | Poor | | | | | | | | | | Good |
| | 0 | 1 | **2** | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| *In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:* | | | | | | | | | | | |

## III. Prevention[3]

1. Does your country have a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS to the general population?

   ***Yes***

   1.1 In the last year, did you implement an active programme to promote accurate HIV/AIDS reporting by the media?

   **Yes**

2. Does your country have a policy or strategy promoting HIV/AIDS related reproductive and sexual health education for young people?

   ***Yes***

[3] Strategies/policies discussed under *Prevention* may be included in the national strategy/action framework discussed in I.1 or separate

2.1 Is HIV education part of the curriculum in

primary schools ***No***

secondary schools ***Yes in some states like Tamil Nadu and Maharashtra***

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

***Yes***

3. Does your country have a policy or strategy to promote IEC and other preventive health interventions for most-at-risk populations?

***Yes***

3.1 Does your country have a policy or strategy for these most-at-risk populations?

| | |
|---|---|
| Injecting drug users, including:<br>- Risk reduction information, education and counselling?<br>- Needle and syringe programmes?<br>- Treatment services?<br>- If yes, drug substitution treatment? | <br>***Yes***<br>***Yes***<br>***Yes***<br>***No*** |
| Men who have sex with men? | ***Yes*** |
| Sex workers? | ***Yes*** |
| Prison inmates? | ***Yes*** |
| Cross-border migrants, mobile populations | ***No*** |
| Refugees and/or displaced populations? | ***No*** |
| Other most-at-risk populations? *Please specify* | |

4. Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities? (These commodities include, but are not limited to, access to VCT, condoms, sterile needles and STD drugs)

***Yes***

Do you have programmes in support of the policy or strategy?

| | |
|---|---|
| A social marketing programme for condoms? | ***Yes*** |
| A blood safety programme? | ***Yes*** |
| A programme to ensure safe injections in health care settings? | ***No*** |
| A programme on ante-natal syphilis screening | ***Yes*** |
| Other programmes? *Please specify* | |

Overall, how would you rate policy efforts in support of prevention?

2005 Poor Good

0 1 2 3 4 ***5*** 6 ***7*** 8 9 10

2003 Poor Good

0 1 2 3 4 ***5*** 6 7 8 9 10

*In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:*

5. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV prevention policy/strategy?

   (*Check all programmes that are implemented beyond the pilot stage to a significant portion in both the urban and rural populations*).

| | | ***2003*** | ***2005*** |
|---|---|---|---|
| A | A programme to promote accurate HIV/AIDS reporting by the media. | ***Yes*** | ***Yes*** |
| B | A social marketing programme for condoms | ***Yes*** | ***Yes*** |
| C | School-based AIDS education for youth | ***Yes*** | ***Yes*** |
| D | Behaviour change communications | ***Yes*** | ***Yes*** |
| E | Voluntary counselling and testing | ***Yes*** | ***Yes*** |
| F | Programmes for sex workers | ***Yes*** | ***Yes*** |
| G | Programmes for men who have sex with men | ***Yes*** | ***Yes*** |
| H | Programmes for injecting drug users, if applicable | ***Yes*** | ***Yes*** |
| I | Programmes for other most-at-risk populations | ***Yes*** | ***Yes*** |
| J | Blood safety | ***Yes*** | ***Yes*** |
| K | Programmes to prevent mother-to-child transmission of HIV | ***Yes*** | ***Yes*** |
| L | Programmes to ensure universal precautions in health care settings | ***Yes*** | ***Yes*** |

| Overall, how would you rate the efforts in the implementation of HIV prevention programmes? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2005 | Poor | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | 4 | 5 | ***6*** | ***7*** | 8 | 9 | 10 |
| 2003 | Poor | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | 4 | 5 | ***6*** | 7 | 8 | 9 | 10 |
| *In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:* | | | | | | | | | | | |

## IV. Care and support[4]

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

   ***Yes***

Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?

| | ***2003*** | ***2005*** |
|---|---|---|
| HIV screening of blood transfusion | ***Yes*** | ***Yes*** |
| Universal precautions | ***Yes*** | ***Yes*** |
| Treatment of opportunistic infections (OI) | ***Yes*** | ***Yes*** |

[4] Strategies/policies discussed under *Care and Support* may be included in the national strategy/action framework discussed in I.1 or separate

| | | |
|---|---|---|
| Antiretroviral therapy (ART) | ***No*** | ***Yes*** |
| Nutritional care | ***No*** | ***Yes*** |
| STI care | ***Yes*** | ***Yes*** |
| Family planning services | ***Yes*** | ***Yes*** |
| Psychosocial support for PLHIV and their families | ***Yes*** | ***Yes*** |
| Home-based care | ***No*** | ***Yes*** |
| Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS) | ***No*** | ***Yes*** |
| Cotrimoxazole prophylaxis among HIV-infected people | ***No*** | ***No*** |
| Post exposure prophylaxis (e.g. occupational exposures to HIV, rape) | ***Yes*** | ***Yes*** |
| Other: (*please specify*) | | |

| Overall, how would you rate the efforts in care and treatment of the HIV/AIDS programme? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2005 | Poor | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | 4 | ***5*** | 6 | 7 | 8 | 9 | 10 |
| 2003 | Poor | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | ***4*** | 5 | 6 | 7 | 8 | 9 | 10 |
| *In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:* | | | | | | | | | | | |

3. Does your country have a policy or strategy to address the additional HIV/AIDS related needs of orphans and other vulnerable children (OVC)?

***No. It is in the process of development***

3.1 *IF YES*, Is there an operational definition for OVC in the country?

*IF YES*, please provide definition:_____

3.2 Which of the following activities have been implemented under OVC programmes?

| | **2003** | **2005** |
|---|---|---|
| School fees for OVC<br>Community programmes<br>Other: (*please specify*) | | |

*Comments:*

| Overall, how would you rate the efforts to meet the needs of OVC? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2005 | Poor | | | | | | | | | | Good |
| | **0** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2003 | Poor | | | | | | | | | | Good |
| | **0** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| *In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:* | | | | | | | | | | | |

## V. Monitoring and Evaluation[5]*

1. Does your country have one national Monitoring and Evaluation (M&E) plan?

   ***No, Attempts are being made to develop this***

   1.1. *IF YES*, was it endorsed by key partners in evaluation?

1.2. Was the M&E plan developed in consultation with civil society, PLHIV?

   ***Yes***

2. Does the M&E plan include?

   - data collection, analysis, reporting and information feed back

     ***Yes***

   - well defined standardized set of indicators

     ***Yes***

   - guidelines on tools for data collection

     ***Yes***

   - a data management plan

     ***Yes***

3. Is there a budget for the M&E plan?

   ***Yes***

   3.1 If yes, has funding been secured?

   ***Yes***

4. Is there a Monitoring and Evaluation functional Unit or Department?

   ***Yes***

   *IF YES,*

   Based in NAC or equivalent? ***Yes***

   Based in Ministry of Health?

   Elsewhere?

   4.1 If yes, are there mechanisms in place to ensure that all major implementing partners submit their reports to this Unit or Department?

   ***Yes***

   4.2 Is there a full time officer responsible for monitoring and evaluation activities of the national programme?

   ***Yes***

   4.3 *IF YES*, since when? : Year 2002

5. Is there a committee or working group that meets regularly coordinating M&E activities, including surveillance?

   **Yes**

[5] The whole M&E section is relevant for the "Third One"

5.1 Does it include representation from civil society, PLHIV?

***No***

6. To what degree (*Low to High*) are UN, bi-laterals, other institutions sharing M&E results?

| *Low* | | | | | | | | | *High* |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | ***4*** | 5 | 6 | 7 | 8 | 9 | 10 |

7. Have individual agency programmes been reviewed to harmonize M&E indicators with those of your country?

***No***

8. Does the M&E Unit manage a central national database?

***Yes***

8.1 *IF YES*, what type is it? ____QL/QN_____

9. Is there a functional* Health Information System?

| | |
|---|---|
| National level | **Yes** |
| Sub-national* | **Yes** |

*(*reporting regularly data from health facilities aggregated at district level and sent to national level, analyzed, and used at different levels*)

10. Is there a functional Education Information System?

| | |
|---|---|
| National level | **Yes** |
| Sub-national* | **Yes** |

** If yes, please specify the level, i.e., district*

11. Does your country publish at least once a year an evaluation report on HIV/AIDS, including HIV surveillance reports?

***Yes, Surveillance reports***

12. To what extent strategic information is used in planning and implementation?

| *Low* | | | | | | | | | *High* |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | ***5*** | 6 | 7 | 8 | 9 | 10 |

13. In the last year, was training in M&E conducted

- At national level? ***Yes***
- At sub-national level? ***Yes***
- Including civil society? ***Yes***

| Overall, how would you rate the monitoring and evaluation efforts of the HIV/AIDS programme? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2005 | Poor | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | 4 | 5 | ***6*** | 7 | 8 | 9 | 10 |
| 2003 | Poor | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | ***4*** | 5 | 6 | 7 | 8 | 9 | 10 |
| *In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:* | | | | | | | | | | | |

## NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

### Part B- Civil Society Responses

### I. Human rights

**1.** Does your country have laws and regulations that protect people living with HIV/AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV, that focus on schooling, housing, employment, etc.)?

***No***

*Comments: No specific laws yet, but the fundamental rights are anti discriminatory and the India HIV/AIDS Bill has been prepared.*

**2.** Does your country have non-discrimination laws or regulations which specify protections for certain **groups** of people identified as being especially vulnerable to HIV/AIDS discrimination (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

***No***

IF YES, please list groups:

**3.** Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?

***Yes***

*IF YES, please list:*

- Section 376, 377 of the Indian Penal Code
- Immoral Traffic Prevention Act.
- Narcotic Drugs and Psychotropic Substances Act, 1985
- Abuse of laws protecting child sexual abuse/sexual exploitation
- Section 292 of Indian Penal Code

**4.** Is the promotion and protection of human rights explicitly mentioned in any HIV/AIDS policy/strategy?

***Yes***

*Comments:* Only on workplace HIV/AIDS interventions policy in a very few companies.

**5.** Has the Government, through political and financial support, involved vulnerable populations in governmental HIV policy design and programme implementation?

***Yes***

*IF YES, give examples:*

- MSM, IDU, CSW, mobile population, women and children are involved in programme implementation but recommendations often not accepted with respect to policy design, structure and process.
- Involvement in NACO costing guidelines, NACP-III design and information of the draft Bill

**6.** Does your country have a policy to ensure equal access, between men and women, to prevention and care?

***Yes***

*Comments: Government of India does not have an explicit policy to 'equal access' but in one way it has an implicit policy of 'equity in access' since NACO mentions that women and children are the priority groups to receive ARVs in the government program. For ARV roll out program the government is trying to ensure equal access to women. Also policy level implementation needs contextual factors to be addressed.*

**7.** Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations?

***Yes***

*Comments:. Female IDU have less access.*

**8.** Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?

***Yes***

**9.** Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

***Yes***

*Comments: This policy only ensures research funded by government. There is no regulation with regard to research undertaken by the civil society; Involvement of civil society is minimal;*

9.1 *IF YES,* does the ethical review committee include civil society and PLHIV?

***Yes***

*Comments: The Ethical Committee of IAVI meets at SACS; If ethics review committees exists they involve civil society; very limited involvement.*

10. Does your country have the following monitoring and enforcement mechanisms?

- Collection of information on human rights and HIV/AIDS issues and use of this information in policy and programme development reform

  ***No***

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV/AIDS related issues within their work

  ***Yes, do not have much power***

- Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses

  ***Yes***

- Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV/AIDS efforts

  ***No***

11. Have members of the judiciary been trained/sensitized to HIV/AIDS and human rights issues that may come up in the context of their work?

Yes

*Comments: Limited fragmented programs in certain states; not consistent*

12. Are the following legal support services available in your country?

- Legal aid systems for HIV/AIDS casework

  ***Yes, but adhoc***

- State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV/AIDS in areas such as discrimination

  ***No***

- Programmes to educate, raise awareness among people living with HIV/AIDS concerning their rights

  ***Yes***

13. Are there programmes designed to change **societal attitudes** of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance?

| Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV/AIDS? |
|---|
| 2005 Poor 0 1 2 3 4 5 ***6*** 7 8 9 10 Good |
| 2003 Poor 0 1 2 3 ***4*** 5 6 7 8 9 10 Good |
| *In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:*<br>- *State AIDS Control Societies are more proactive than 2003.*<br>- *In 2003 they targeted only key population but family and community was not involved.* |
| Overall, how would you rate the effort to enforce the existing policies, laws and regulations? |
| 2005 Poor 0 1 2 3 4 5 ***6*** 7 8 9 10 Good |
| 2003 Poor 0 1 2 ***3*** 4 5 6 7 8 9 10 Good |
| *In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:* |

## II. Civil society participation

1. To what extent civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation?

*Low* 1 2 3 4 5 6 ***7*** 8 9 10 *High*

2. To what extent civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV/AIDS or for the current activity plan (attending planning meetings and reviewing drafts)?

*Low* 1 2 3 4 ***5*** 6 7 8 9 10 *High*

3. To what extent the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports?

| *Low* | | | | | | | | | *High* |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | ***6*** | 7 | 8 | 9 | 10 |

4. Has your country conducted a National Periodic review of the Strategic Plan with the participation of civil society in: ***No***

   Month: …….. Year…

5. To what extent your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee *in which PLHIV and caregivers participate*?

| *Low* | | | | | | | | | *High* |
|---|---|---|---|---|---|---|---|---|---|
| ***1*** | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

| Overall, how would you rate the efforts to increase civil society participation? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2005 | Poor | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | ***4*** | 5 | 6 | 7 | 8 | 9 | 10 |
| 2003 | Poor | | | | | | | | | | Good |
| | 0 | 1 | ***2*** | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

*In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:*

- *NGOs such as YRG Care, Pop Council, Humsafar Trust and government agencies such as NARI, NIMHANS and TRC have developed community advisory board to be part of the ethical committee.*
- *NACP–III design involved civil society.*
- *Some of the above agencies have "institutional review board (IRB)" equivalent to the ethics review committee. However not all involve marginalized groups or PLHA.*
- *Having a few community members in the ethics review committee can not be 'community advisory board (CAB)' and it can not be part of ethics review committee. Also, CAB is not equivalent to ethics review committee.*

**III. Prevention**

1. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV prevention policy/strategy?

   (*Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations*).

| | | **2003** | **2005** |
|---|---|---|---|
| A | A programme to promote accurate HIV/AIDS reporting by the media | ***Yes*** | ***Yes*** |
| B | A social marketing programme for condoms | ***Yes*** | ***Yes*** |
| C | School-based AIDS education for youth | ***Yes*** | ***Yes*** |
| D | Behaviour change communications | ***Yes*** | ***Yes*** |
| E | Voluntary counselling and testing | ***Yes*** | ***Yes*** |

| | | | |
|---|---|---|---|
| F | Programmes for sex workers | ***Yes*** | ***Yes*** |
| G | Programmes for men who have sex with men | ***Yes*** | ***Yes*** |
| H | Programmes for injecting drug users, if applicable | ***Yes*** | ***Yes*** |
| I | Programmes for other most-at-risk populations* | ***Yes*** | ***Yes*** |
| J | Blood safety | ***Yes*** | ***Yes*** |
| K | Programmes to prevent mother-to-child transmission of HIV | ***Yes*** | ***Yes*** |
| L | Programmes to ensure safe injections in health care settings | ***Yes*** | ***Yes*** |

** Please define*

Overall, how would you rate the efforts in the implementation of HIV prevention programmes?

2005 Poor Good

0 1 2 3 4 5 ***6*** 7 8 9 10

2003 Poor Good

0 1 2 3 ***4*** 5 6 7 8 9 10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

- *Civil society communication and participation has strengthened and efforts to scale up programs have also been undertaken.*
- *NGOs and government have scaled up prevention, VCT, PMTCT Interventions with sex workers, truckers and School AIDS Education Programs.*
- *Significant investment has been made by DFID, USAID and National Government on promoting HIVAIDS information through media.*
- *Majority of the programs are being implemented by external agencies and very less by the government.*
- *Visibility is more in urban sectors only.*

## IV. Care and support

1. Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?

| | **2003** | **2005** |
|---|---|---|
| HIV screening of blood transfusion | ***Yes*** | ***Yes*** |
| Universal precautions | ***Yes*** | ***Yes*** |
| Treatment of opportunistic infections (OI) | ***Yes*** | ***Yes*** |
| Antiretroviral therapy (ART) | ***No*** | ***Yes*** |
| Nutritional care | ***No*** | ***No*** |
| STI care | ***Yes*** | ***Yes*** |
| Family planning services | ***Yes*** | ***Yes*** |
| Psychosocial support for PLHA and their families | ***No*** | ***Yes*** |
| Home-based care | ***No*** | ***No*** |
| Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS) | ***Yes*** | ***Yes*** |
| Cotrimoxazole prophylaxis among HIV-infected people | ***Yes*** | ***Yes*** |
| Post exposure prophylaxis (e.g. occupational exposures to HIV, rape) | ***Yes*** | ***Yes*** |
| Other: (please specify) | | |

| Overall, how would you rate the care and treatment efforts of the HIV/AIDS programme? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2005 | Poor | | | | | | | | | | Good |
| | 0 | 1 | 2 | 3 | ***4*** | 5 | 6 | 7 | 8 | 9 | 10 |
| 2003 | Poor | | | | | | | | | | Good |
| | 0 | 1 | ***2*** | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| *In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:*<br>- *Provision for free ARV reflects government commitment.*<br>- *NGO and CBO are getting more funds for care and support activities.*<br>- *VCTC and PPTCT services rolled out at district level. However they should also be at* | | | | | | | | | | | |

2. Does your country have a policy or strategy to address the additional HIV/AIDS related needs of orphans and other vulnerable children (OVC)?

***No***

2.1 *Which* of the following activities have been implemented under the OVC programmes?

| | **2003** | **2005** |
|---|---|---|
| School fees for OVC | - | - |
| Community programmes | - | - |
| Other: (*please specify*) | | |

*Comments: T*here are no programs specifically for OVC.

| Overall, how would you rate the efforts to meet the needs of OVC? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2005 | Poor | | | | | | | | | | Good |
| | 0 | ***1*** | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2003 | Poor | | | | | | | | | | Good |
| | ***0*** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| *In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:*<br>• *Initiatives are undertaken by NACO and other agencies to design strategies for OVC interventions.* | | | | | | | | | | | |

**Additional Comments by Civil Society**

- Screening of blood needs to be strengthened in the private sector.
- Universal precautions are not completely ensured in private and public sector.
- Limited government programmes providing nutritional support.
- Treatment for OIs is provided only for one week
- ART is available only for limited population (23,000 through govt and 30,000 through NGOs)