सत्यमेव जयते

Annual Report
2013-14

NACO

Department of AIDS Control
Ministry of Health & Family Welfare
Government of India

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India's voice against AIDS

Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
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CONTENTS

ACRONYMS

AEP	:	Adolescence Education Programme
AIDS	:	Acquired Immuno-Deficiency Syndrome
ANC	:	Antenatal Clinic
ANM	:	Auxiliary Nurse Midwife
ART	:	Antiretroviral Therapy
ASHA	:	Accredited Social Health Activist
BCC	:	Behaviour Change Communication
BCSU	:	Blood Component Separation Unit
BMGF	:	Bill & Melinda Gates Foundation
BTS	:	Blood Transfusion Services
BSC	:	Blood Storage Centre
BSD	:	Basic Services Division
BSS	:	Behaviour Surveillance Survey
CBO	:	Community Based Organisation
CCC	:	Community Care Centres
CD4	:	Cluster of Differentiation 4
CDC	:	Centre for Disease Control and Prevention
CHC	:	Community Health Centre
CLHIV	:	Children Living with HIV
CMIS	:	Computerised Management Information System
CoE	:	Centre of Excellence
CPFMS	:	Computerised Project Financial Management System
CPGRAMS	:	Computerised Public Grievances Redress and Monitoring System
CSC	:	Care and Support Centres
CSMP	:	Condom Social Marketing Programme
CST	:	Care, Support and Treatment
CVM	:	Condom Vending Machine

DAC	:	Department of AIDS Control
DAPCU	:	District AIDS Prevention & Control Unit
DCGI	:	Drugs Controller General of India
DFID	:	Department for International Development
DHR	:	Department of Health Research
DIC	:	Drop-in Centres
DWCD	:	Department of Women & Child Development
EID	:	Early Infant Diagnosis
EQAS	:	External Quality Assessment Scheme
FBO	:	Faith Based Organization
FC	:	Female Condom
FHI	:	Family Health International
FICTC	:	Facility Integrated Counseling & Testing Centre
FPA	:	Forum of Parliamentarians on HIV & AIDS
FRU	:	First Referral Unit
FSW	:	Female Sex Workers
GFATM	:	Global Fund for AIDS, Tuberculosis and Malaria
GIPA	:	Greater Involvement of People with HIV/AIDS
GIS	:	Geographic Information System
HIV	:	Human Immunodeficiency Virus
HMIS	:	Health Management Information System
HRG	:	High Risk Groups
HSS	:	HIV Sentinel Surveillance
IAP	:	Indian Academy of Paediatrics
IAVI	:	International AIDS Vaccine Initiative
IBBS	:	Integrated Biological & Behavioural Surveillance
ICF	:	Intensified Case Finding (tuberculosis)
ICMR	:	Indian Council of Medical Research
ICTC	:	Integrated Counseling and Testing Centre
IDU	:	Injecting Drug User
IEC	:	Information, Education and Communication
IL&FS	:	Infrastructure Leasing & Financial Services Limited
INC	:	Indian Nursing Council
JAT	:	Joint Appraisal Team
KHPT	:	Karnataka Health Promotion Trust

LAC	:	Link ART Centre
LFU	:	Lost to Follow-up
LS	:	Laboratory Services
LWS	:	Link Worker Scheme
M & E	:	Monitoring and Evaluation
MARP	:	Most at Risk Population
MoHFW	:	Ministry of Health & Family Welfare
MoU	:	Memorandum of Understanding
MSM	:	Men who have Sex with Men
NABH	:	National Accreditation Board of Hospitals & Healthcare Providers
NABL	:	National Accreditation Board for Laboratories
NACO	:	National AIDS Control Organisation
NACP	:	National AIDS Control Programme
NARI	:	National AIDS Research Institute
NBTC	:	National Blood Transfusion Council
NERO	:	North Eastern Regional Office
NGO	:	Non-Government Organisation
NICED	:	National Institute of Cholera & Enteric Diseases
NHM	:	National Health Mission
NRHM	:	National Rural Health Mission
NRL	:	National Reference Laboratory
NTSU	:	National Technical Support Unit
NYKS	:	Nehru Yuva Kendra Sangathan
OI	:	Opportunistic Infections
OST	:	Opioid Substitution Therapy
P & C	:	Planning & Coordination
PEP	:	Post-Exposure Prophylaxis
PGIMER	:	Post-Graduate Institute of Medical Education & Research
PHC	:	Primary Health Centre
PLHIV	:	People Living with HIV
PPP	:	Public Private Partnership
PPTCT	:	Prevention of Parent to Child Transmission
PRI	:	Panchayati Raj Institution
RBTC	:	Regional Blood Transfusion Centre
RCH	:	Reproductive and Child Health

RFD	:	Result Framework Document
RI	:	Regional Institute
RNTCP	:	Revised National Tuberculosis Control Programme
RRC	:	Red Ribbon Club
RRE	:	Red Ribbon Express
RSBY	:	Rashtriya Swasthya Bima Yojna
RTI	:	Reproductive Tract Infections
SAARC	:	South Asian Association for Regional Cooperation
SACEP	:	State AIDS Clinical Expert Panel
SACS	:	State AIDS Control Society
SIMS	:	Strategic Information Management System
SIMU	:	Strategic Information Management Unit
SMO	:	Social Marketing Organisation
SO	:	Section Officer
SRL	:	State Reference Laboratory
STD	:	Sexually Transmitted Disease
STI	:	Sexually Transmitted Infection
STRC	:	State Training & Resource Centre
TAC	:	Technical Advisory Committee
TB	:	Tuberculosis
TG	:	Transgender
TI	:	Targeted Interventions
TRG	:	Technical Resource Group
TSG	:	Technical Support Group
TSU	:	Technical Support Unit
UN	:	United Nations
UNODC-ROSA	:	United Nations Office on Drugs and Crime- Regional Office of South Asia
UNDP	:	United Nations Development Programme
UNICEF	:	United Nations Children's Fund
USAID	:	United States Agency for International Development
UT	:	Union Territory
VBD	:	Voluntary Blood Donation
VNRBD	:	Voluntary Non-Remunerative Blood Donation
VCTC	:	Voluntary Counseling and Testing Centre
WHO	:	World Health Organisation

OVERVIEW

India has the third highest number of estimated people living with HIV in the world. According to the HIV Estimations 2012, the estimated number of people living with HIV/AIDS in India was 20.89 lakh, with an estimated adult (15-49 age group) HIV prevalence of 0.27% in 2011. India has demonstrated an overall reduction of 57% in the annual new HIV infections among adult population from 2.74 lakh in 2000 to 1.16 lakh in 2011, reflecting the impact of various interventions and scaled-up prevention strategies under the National AIDS Control Programme (NACP). The trend of annual AIDS deaths is showing a steady decline since roll out of the free Anti-Retroviral Therapy (ART) programme in India in 2004; it is estimated that around 1.5 lakh lives have been saved due to ART till 2011.

The HIV epidemic continues to be heterogenic in geographical spread and across different typologies. Reiterating India's success story on HIV/AIDS control, the HIV prevalence trend has witnessed significant decline among antenatal clinic attendees considered proxy for general population (0.49% in 2007 to 0.35% in 2012-2013), Female Sex Workers (5.06% in 2007 to 2.67% in 2011) and Men who have Sex with Men (7.41% in 2007 to 4.43% in 2011), and stable trends have been recorded among Injecting Drug Users (7.23% in 2007 to 7.14% in 2011) at the national level.

In the past few years, the decline in HIV prevalence has been more substantial in erstwhile high prevalence States, where long-standing prevention and treatment interventions have effected behaviour change with increasing condom use, etc. It is noteworthy that newer pockets of high HIV prevalence among different risk groups in low prevalence States have emerged over the past decade. Transgenders are emerging as a risk group with high vulnerability and high levels of HIV. Also, in certain regions of the country, evidence indicates the possible role of bridge population including high-risk migrants and long distance truckers in fuelling the HIV epidemic.

The first phase of National AIDS Control Programme (NACP-I) was launched by the Government of India in 1992 to combat the Human Immuno-deficiency Virus (HIV) infection and Acquired Immuno-Deficiency Syndrome (AIDS) in the initial stage itself. However, with the evolving trends of the HIV/AIDS epidemic, the focus of the subsequent phases of the programme (NACP-II in 1999 and NACP-III in 2007) shifted from raising HIV/AIDS awareness to behaviour change, from a national response to a more decentralised response and to increasing involvement of NGOs and networks of People Living with HIV (PLHIV).

A modified strategy has been designed based on the lessons learnt from the previous phases of the programme, and through this, the Department of AIDS Control (DAC) reiterates its commitment towards prevention and control of the disease in its fourth phase of NACP (NACP-IV). Over the period 2012-2017, NACP-IV aims to accelerate the process of reversal, further strengthening the epidemic response in India through a cautious and well-defined integration process. The main objectives of NACP-IV are to reduce new infections and provide comprehensive care and support to all PLHIV and treatment services to all those who require it.

Key functions of the Department of AIDS Control

For prevention and control of HIV/AIDS the Department of AIDS Control has formulated policies and developed standards, guidelines and norms. Strategies developed for programme implementation include finalisation of State action plans, financial planning & management, budgeting, release of funds and monitoring expenditures at National and State levels, strategic information management including programme monitoring, surveillance and research, institutional strengthening, human resource management, capacity building, technical and administrative support as well as guidance to State AIDS Control Societies (SACS).

Key Achievements of National AIDS Control Programme during 2013-2014

Targeted Interventions for High Risk Groups: The main objective of Targeted Interventions (TI) is to improve health-seeking behaviour of High Risk Groups (HRG) and reduce their risk of acquiring Sexually Transmitted Infections (STI) and HIV infections. High risk groups under TI include Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders (TG)/ Hijras and Injecting Drug Users (IDU), and bridge populations include high risk behaviour Migrants and Long Distance Truckers. TI provides services such as behaviour change communication, condom promotion, safe needles and syringes (for people who inject drugs), STI care, referrals for HIV testing, Syphilis testing and Referrel for ART.

Till financial year 2013-2014, about 7.18 lakh (82.7%) FSWs and about 2.59 lakh (82.7%) high-risk MSMs were covered under the programme. The mapping of Transgenders/Hijras shows an estimate of around 70,000 TG/Hijras. Operational guidelines for implementing Targeted Interventions among TG/Hijras have also been drafted along with IEC material specific to the needs of these populations. During 2013-2014, 13,200 TG/Hijras were identified in seven States and covered under the Programme. During 2013-2014, 45 new Opioid Substitution Therapy (OST) centres have been established for Injecting Drug Users, which has resulted in doubling of OST coverage in the country in one year. Currently, DAC is supporting provision of OST services through more than 150 OST centres spread across 30 States/UTs in India. During 2013-2014 awareness campaigns and health camps for further strengthening Migrant Interventions were implemented at source villages accounting for the major bulk of migration, as well as at the major transit points. Modelling of migrant interventions across important corridors are being undertaken. Employer-led models and migrant tracking systems are also being piloted. During 2013-2014, 289 TI run by the SACS at migrant destinations reached out to 29.24 lakh high-risk migrants.

Link Worker Scheme: The Link Worker Scheme is a community-based outreach strategy to address HIV prevention and care needs of HRG and vulnerable population in rural areas. The specific objectives of the Scheme include reaching out to these groups with information and knowledge on prevention and risk reduction of HIV and STI, condom promotion and distribution, providing referral and follow-up linkages for various services including Counseling, testing and treatment of STI and opportunistic infections through Link workers, creating an enabling environment for PLHIV and their families, and reducing stigma and discrimination against them. In partnership with various Development Partners, the Link Worker Scheme has been expanded and is being implemented in 17 States covering 163 highly vulnerable districts.

STI/RTI Control and Prevention Programme Syndromic case management of Sexually Transmitted Infections (STI)/Reproductive Tract Infections (RTI) is being provided through 1,131 Designated STI/RTI Clinics (DSRC), branded as "Suraksha Clinics". A total of 67.68 lakh STI/RTI cases have been managed against the target of 68 lakh during 2013-2014. Of the 23 lakh DSRC attendees screened

for Syphilis, 14,507 (0.62%) were found to be sero-reactive. Of the 15 lakh DSRC attendees referred to Integrated Counseling and Testing Centres, 18,959 (1.25%) tested positive for HIV infection. To understand aetiology of different STI/RTI syndromes and to identify emerging drug resistance, seven regional STI Training Research and Reference Laboratories have been established in the country, and additionally three such laboratories and 45 State Reference Centres are getting inducted. Management of STI/RTI among HRGs is a key prevention strategy and the programme is offering quality standardised STI/RTI services to HRGs through a flexi-model approach. Currently the STI/RTI control strategy implemented in coordination with National Health Mission, with uniform guidelines and treatment protocols, has helped achieve significant decline of bacterial STIs especially Syphilis.

Condom Promotion: The Department of AIDS Control has successfully implemented its targeted Condom Social Marketing Programme in 15 States in 2013-2014. During this year, 56.45 crore social marketing condom pieces were sold through Social Marketing Organisations, by servicing/opening more than 5.17 lakh retail outlets. Two mass media campaigns were released on national scale in Hindi and regional languages. The digital cinema screening platform was also included in condom campaign media plan to reach out to the target population in smaller towns. A training manual on condom promotion was developed for TI NGOs and CBOs to provide guidelines and road map towards effective implementation of condom promotion programme.

Blood Transfusion Services: The division of Blood Safety has been renamed as the division of Blood Transfusion Services. The change in nomenclature is to broaden the horizon of blood safety to include transfusion transmitted infections, immuno-hematology, quality management systems, logistics and other processes involved to improve the confidence in the "safe blood". India is a signatory to the Rome Declaration 'Achieving Self-Sufficiency in Safe Blood and Blood Products, based on Voluntary Non-Remunerated Donation' in October 2013. In alignment with the same, the definition of the 'Voluntary Blood Donor' has been reformulated as per the WHO definition. A rapid situation analysis was undertaken to understand the current scenario of blood safety in the country. New initiatives, such as development of a Plasma Fractionation Centre, four Metro Blood Bank projects for setting up Centres of Excellence in Transfusion Medicine, and evolving a Policy on unutilised Plasma are being aggressively taken up to improve and facilitate the availability of essential therapeutic blood and plasma products for clinical use across the country. The National Blood Transfusion Council, an autonomous body, has been set up within DAC and is the apex policy making body for all matters pertaining to access, quality and safety of blood and blood products.

HIV Counseling and Testing Services: During 2013-2014, the number of Integrated Counseling and Testing Centres (ICTC) offering HIV Counseling and testing services included 4,818 Standalone ICTC (including 124 Mobile ICTC), 8,811 Facility Integrated Counseling and Testing Centres (FICTC) and 1,977 Public Private Partnership ICTC. The Counseling and testing services for HIV were availed by about 130.3 lakh general clients and 97.52 lakh pregnant women, against the target of 102 lakh each. Around 14.88 lakh HIV/TB cross referrals have been achieved against target of 12 lakh. In 2013-2014, the programme has implemented Prevention of Parent to Child Transmission services using multi-drug regimen in three States (Andhra Pradesh, Tamil Nadu and Karnataka), wherein 3,782 (74%) HIV positive pregnant women out of total registered 5,089 HIV positive pregnant women were initiated on the triple-drug anti-retroviral regimen. In the rest of the country, 6,303 (91%) mother-baby pairs out of 6,919 HIV positive pregnant women were provided single-dose Nevirapine prophylaxis for prevention of mother to child transmission of HIV infection.

Care, Support and Treatment for PLHIV: The Care, Support and Treatment programme provides comprehensive services for PLHIV which include free ART, psychosocial support, prevention and

treatment of Opportunistic Infections including tuberculosis, and also facilitating home-based care. Ten Centres of Excellence and seven paediatric Centres of Excellence provide tertiary-level specialist care and treatment (second-line and alternative first-line ART, management of complicated Opportunistic Infections and specialised laboratory services). Till March 2014, 7.68 lakh PLHIV were on first-line ART at 425 ART Centres. Nearly one lakh children living with HIV/AIDS are registered for HIV treatment and care services at these ART centres and 42,015 of them are receiving free ART. Currently, the care and support services are provided through the Care and Support Centres which are comprehensive units for treatment, support, positive living, referral and linkages to need-based services and strengthening enabling environment for PLHIV. As on March 2014, there were 224 Care and Support Centres providing services to PLHIV. Link ART centres and ART-Plus centres have also been established for decentralisation of first-line and second-line treatment services.

Laboratory Services: DAC has established a programme for improving, and strengthening the capacity and quality of services of laboratories working towards accreditation. Training on good laboratory practices is provided to all technicians of ART centres operating CD4 machines. Further, faculty and staff of HIV referral laboratories are trained through workshops in 'Quality Management Systems in alignment with ISO 15189:2012 Standards'. The assurance of quality in kit evaluation and assessment of HIV testing services through implementation of External Quality Assessment Scheme is given focus. As laboratories establish an appreciable quality system, they are encouraged to apply for accreditation, and those that have attained accreditation are expected to retain it through reapplication to National Accreditation Board for Testing and Calibrating Laboratories (NABL). This has resulted in NABL accreditation of 36 referral laboratories and 11 laboratories have applied for accreditation. Initiation of first-line ART is done on the basis of CD4 counts. 254 CD4 machines are functional in the country, and 15,01,150 CD4 tests have been performed in 2013-2014. Monitoring HIV viral load is critical in determining failure of first-line ART and initiation of second-line ART. Viral Load testing facility is available in nine referral laboratories in the country, which are linked to Centres of Excellence and ART-plus centres. Over eight thousand viral load tests were performed in 2013-2014 in these laboratories. The Early Infant Diagnosis programme for diagnosis of HIV in infants and children less than 18 months of age is operational in 31 States through 1,157 ICTCs and 217 ART Centres. During 2013-2014, 14,372 HIV exposed infants and children less than 18 months of age have been tested by DNA-PCR in seven referral laboratories of the country.

Information, Education & Communication: The focus of IEC activities has been on promoting safe behaviours, reducing HIV stigma and discrimination, demand generation for HIV/AIDS services and condom promotion. Mass media campaigns were synergised with other outreach activities and mid-media activities. Folk media campaign was scaled up in 32 States, which reached out to 1.41 crore population through folk performances in 2013-2014. Adolescence Education Programme is being implemented in 23 States covering around 49 thousand schools. Red Ribbon Clubs are functional in around 14 thousand colleges; these include 1,700 new RRC formed in 2013-2014.

The National HIV/ AIDS Communication Resource and Support Centre is a newly formed unit for providing technical support in programme management, training and implementation, knowledge management, documentation, research and evaluation to the IEC Division.

Mainstreaming: The Department of AIDS Control is collaborating with various key Ministries/ Departments of the Government of India, with the objective of multi-pronged, multi-sectoral response to ensure better use of available resources for risk reduction and impact mitigation of HIV. During the year 2013-2014, DAC has formalised partnership with eight

Departments/ Ministries of Government of India by signing Memorandums of Understanding with them. DAC in collaboration with UNDP India organised an "International Conference on HIV Sensitive Social Protection" in New Delhi to facilitate exchange of global thoughts and experiences with regard to HIV sensitive social protection. The State AIDS Control Societies have undertaken initiatives to facilitate social entitlements and schemes under social protection offered by various Ministries/ Departments and State Governments for the infected and affected communities; approximately 5.6 lakh PLHIV are benefitting through this initiative. Trainings and advocacy meetings were undertaken by SACS with various stakeholders including government officials from various departments, frontline workers, uniformed personnel, NGOs and PLHIV networks; over five lakh persons were trained during 2013-2014.

Strategic Information Management: The Strategic Information Management Unit generates crucial data on the levels, trends and patterns of the HIV epidemic, and manages information related to disease progression and treatment, monitoring service delivery, promoting research and data use for policy making, planning, implementation and review at all levels. Some of the key achievements during 2013-2014 included roll-out of the National Integrated Biological & Behavioural Surveillance (IBBS) among high risk groups and bridge populations, launch of the National Data Analysis Plan to make the best use of available data for evidence and research under the programme, setting priority areas and development of research protocols under the National HIV/AIDS Research Plan, transforming SIMS into an integrated decision support system with advanced analytic and Geographic Information System capabilities. Capacity building activities in IBBS and in Operational Research and Ethics have been strengthened.

Results Framework Document: For the performance of various activities in the Results Framework Document 2012-2013, the Department of AIDS Control got an overall composite score of 90.44 percent with "Excellent" rating from the Performance Management Division of the Cabinet Secretariat. In an independent evaluation of the quality of the Results Framework Document 2013-2014 conducted by a Consultant for the Performance Management Division, DAC has been ranked the best among 12 departments of the Government of India. During 2013-2014, DAC started the process of ISO 9001 certification.

Finance: During NACP-III (2007-2012), an expenditure of Rs. 6,237.48 crore was incurred through different budgetary sources. The total approved budget for NACP-IV is Rs. 13,415 crore, which comprises of Government Budgetary Support, Externally Aided Budgetary Support from The World Bank and The Global Fund, and Extra Budgetary Support from other Development Partners.

The main strategies of the fourth phase of National AIDS Control Programme include intensifying and consolidating prevention services, increasing access and promoting comprehensive care, support and treatment, expanding IEC services, building capacities at all levels, and strengthening Strategic Information Management Systems.

The HIV/AIDS (Prevention & Control) Bill 2014 was introduced in the Rajya Sabha on 11 February, 2014. The Bill includes, among others, the clauses regarding prohibition of discrimination, informed consent for undertaking HIV test or treatment, disclosure of HIV status, Anti-Retroviral Therapy for people living with HIV, obligation of establishments, welfare measures by the Central and State Government, grievance redressal mechanisms and special provisions and penalties for contravention or failure to comply with orders of Ombudsman.

In the fourth phase of NACP, the Department of AIDS Control is focussing on strengthening new initiatives to address gaps in prevention and control of HIV/AIDS. Decentralised implementation is being strengthened through effective technical support and enhanced

monitoring and supervision. Innovations will be encouraged in all spheres of AIDS Control Programme and best practices disseminated for wider application. The multi-stakeholder response crafted over the past decade will be taken to newer heights with greater involvement of communities, civil societies and other government departments and ministries, development partners and health and research organisations, to move towards the goal of zero new infections, zero deaths and zero stigma and discrimination.

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New Delhi

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1 INTRODUCTION

The Annual Report 2013-2014 of the Department of AIDS Control (DAC), Government of India, reviews the progress made under the National AIDS Control Programme (NACP) during the current financial year 2013-2014 in scaling up intervention services for HIV prevention, treatment, care and support across the country through regular monitoring and reporting. This report reflects the commitment of DAC and identifies both achievements and gaps in response to the HIV epidemic.

This chapter gives an introduction to NACP and the evolution of the programme through various phases since its inception, with emphasis on the current phase of the programme. A summary of key achievements made under the programme during the current financial year (2013-2014) in comparison to the previous financial year (2012-2013) is presented at the end of this chapter in Table 1.1.

NATIONAL AIDS CONTROL PROGRAMME

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

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

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

NACP-III: The third phase of National AIDS Control Programme (NACP- III), implemented during 2007-2012, was a scientifically well-evolved programme, grounded on a strong structure of policies, programmes, schemes, operational guidelines, rules and norms. NACP-III aimed at halting and reversing the HIV epidemic in India by scaling-up prevention

efforts among HRG and general population, and integrating them with Care, Support & Treatment (CST) services. Thus, prevention measures for those who are not infected and care, support & treatment services for the infected and affected, formed the two key pillars of all the AIDS control efforts in India. Strategic Information Management and institutional strengthening activities provided the required technical, managerial and administrative support for implementing the core activities under NACP-III at National, State and District levels.

NACP-IV: Consolidating the gains made till now, the fourth phase of National AIDS Control Programme (NACP-IV) under the Department of AIDS Control aims to accelerate the process of epidemic reversal and further strengthen the epidemic response in India through a cautious and well-defined integration process over the period 2012-2017. NACP-IV will focus on intensifying and consolidating prevention services with a focus on high risk groups and vulnerable population, increasing access, and promoting comprehensive care, support and treatment services.

The objectives of NACP-IV are to reduce new infections and provide comprehensive care and support to all PLHIV and treatment services for all those who require it. The five cross-cutting themes that are being focused under NACP-IV are quality, innovation, integration, leveraging partnerships, and stigma and discrimination.

KEY STRATEGIES AND GUIDING PRINCIPLES OF NACP-IV

The strategy and plan for NACP-IV have been developed through an elaborate multi-stakeholder consultative planning process for the period 2012-2017. The process has adopted an inclusive, participatory and widely consultative approach with 15 working groups and 30 sub-groups covering all thematic areas and involving around 1,000 representatives from Central and State Governments, high risk group communities, people living with HIV/AIDS, civil societies, subject experts, experts from NRHM and other Government departments, development partners and other stakeholders. Regional and State level consultations, e-consultations and special studies/ assessments were also undertaken to develop the strategic plan. The Planning Commission Steering Committee has also been closely overseeing this entire process.

Guiding Principles for NACP - IV

- Continued emphasis on three ones: one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National M&E System
- Gender Equity
- Respect for the rights of the PLHIV
- Civil society representation and participation
- Improved Public-Private Partnerships
- Evidence based and result oriented programme implementation

Key Strategies of NACP - IV

- Intensifying and consolidating prevention services, with a focus on HRGs and vulnerable population
- Increasing access and promoting comprehensive care, support and treatment
- Expanding IEC services for (a) general population and (b) High Risk Groups with a focus on behaviour change and demand generation
- Building capacities at National, State, District and facility levels
- Strengthening Strategic Information Management Systems

Strategy 1: Intensifying and Consolidating Prevention Services

Prevention will continue to be the core strategy of NACP-IV as more than 99% of people in the country are HIV negative. It will reach out to the widely dispersed population of young women and men with well-designed prevention messages. Accordingly, it is planned to cover 90% of HRGs through Targeted Interventions implemented by NGO and CBOs. High-risk migrants, their spouses, truckers and other vulnerable population will be accessed by collaborating with other departments, voluntary groups, civil society networks, women groups and youth clubs. NACP-IV will add on the existing network of ICTCs in high prevalence States and enhance coverage in vulnerable States by establishing new HIV testing facilities up to CHC and PHC levels. This is to ensure that ICTC, PPTCT and HIV/TB services are accessible to the community. More efficacious multi-drug regimen for PPTCT will be scaled-up as an effort towards elimination of new infections among children.

Condom promotion strategies will be strengthened through free distribution and social marketing channels, non-traditional outlets, female condoms, etc. aided by an effective communication strategy. The Programme will continue to link prevention with care, support and treatment. This will promote positive prevention. NACP-IV will focus on strengthening of standardised STI/RTI management to HRG and vulnerable population through designated STI clinics under the programme, NRHM service delivery units and public and private sectors clinics. NACP-IV will also explore the possibilities of streamlining the coordination and management of blood banks and blood transfusion services.

Some of the activities under prevention strategy include the following:

- Saturation of quality HIV prevention services to all HRG groups based on emerging behaviour patterns and evidence
- Strengthening the needle exchange programme, drug substitution programme and provide Opioid Substitution Therapy
- Reaching out to MSM and Transgender communities
- Addressing the issues related to coverage and management of rural interventions
- Quality STI/RTI services
- Expanding the ICTC services and strengthen referral linkages
- Strengthening positive prevention
- Strengthening management structure of blood transfusion services
- National EQAS for all participating labs at district and above for HIV related diagnostic services

Strategy 2: Comprehensive Care, Support and Treatment

NACP-IV will implement comprehensive HIV care for all those who are in need of such services and facilitate additional support systems for women and children. With a wide network of treatment facilities and collaborative support from PLHIV and civil society groups, it is envisaged that greater adherence and compliance would be possible. Additional Centres of Excellence (CoEs) and upgraded ART Plus Centres will be established to provide high-quality treatment and follow-up services, positive prevention and better linkages with healthcare providers in the periphery.

With increasing maturity of the epidemic, it is very likely that there will be greater demand for second-line ART, Opportunistic Infections management, etc., and NACP-IV will address these needs. It is proposed that the comprehensive care, support and treatment of HIV/AIDS will inter alia include: (i) Anti-Retroviral Therapy (ART) including second-line (ii) management of opportunistic infections including TB in PLHIV, (iii) positive prevention and (iv) facilitating social protection and insurance for PLHIV through linkages with concerned Departments/Ministries. The Programme will explore avenues of public-private partnerships. The Programme will enhance activities to reduce stigma and discrimination at all levels particularly at healthcare settings.

Some of the illustrative care, support and treatment activities include the following:

- Scale-up of ART Centres, LACs, and CoE ART services
- Strengthening follow-up of patients on ART and improving quality of Counseling services at ART service delivery points
- Comprehensive care and support services for PLHIV through linkages
- Provision of guidelines and training to NRHM staff, for integration of HIV care, support and treatment services in healthcare settings

Strategy 3: Expanding IEC services for general population and high risk groups with focus on behaviour change and demand generation

IEC has been an important component of the NACP. With the expansion of services for Counseling and testing, ART, STI treatment and condom promotion, demand generation campaigns will be the focus of the NACP-IV communication strategy. IEC will remain an important component of all prevention efforts and will have continued focus on the following:

- Increasing awareness among general population in particular women and youth
- Behaviour change communication strategies for HRG and vulnerable groups
- Continued focus on demand generation of services
- Reaching out to vulnerable populations in rural settings
- Extending services to tribal groups and hard-to-reach populations

Strategy 4: Strengthening Institutional Capacities

The programme management structures established under NACP will be strengthened further to achieve the NACP-IV objectives. Programme planning and management responsibilities will be enhanced at the National, State, District and Facility levels to ensure high quality, timely and effective implementation and supervision of field-level activities to achieve desired programmatic outcomes.

The planning processes and systems will be further strengthened to ensure that the annual action plans are based on evidence, local priorities and in alignment with NACP-IV objectives. Sustaining the epidemic response through increased collaboration and convergence, where feasible, with other departments will be given a high priority during NACP-IV. This will involve phased integration of the HIV services with the routine public sector health delivery systems, streamlining the supply chain mechanisms and quality control mechanisms and building capacities of governmental and non-governmental institutions and networks.

Strategy 5: Strategic Information Management System

Under NACP-IV, it is envisaged to have an overarching knowledge management strategy that encompasses the entire gamut of strategic information activities starting with data generation to dissemination and effective use. The strategy will ensure high quality of data generation systems such as Surveillance, Programme Monitoring and Research; strengthening systematic analysis, synthesis, development and dissemination of knowledge products in various forms; emphasis on Knowledge Translation as an important element of policy making and programme management at all levels; and establishment of robust evaluation systems for outcome as well as impact evaluation of various interventions under the programme.

The element of knowledge translation will be given the highest priority to ensure making the link between knowledge and action at all levels of the programme. The programme will focus strongly on building capacities of Epidemiologists, Monitoring & Evaluation Officers, Statisticians as well as Programme Managers with appropriate and simple methods and tools of analysis and modelling. Institutional linkages will be fostered and strengthened to support programme for its analytical needs, at National and State levels.

Some of the initiatives under Strategic Information Management during NACP-IV include the following:

- National Integrated Biological & Behavioural Surveillance (IBBS) among HRG & Bridge Groups

- National Data Analysis Plan
- National HIV/AIDS Research Plan
- Transforming SIMS into an integrated decision support system with advanced analytic and Geographic Information System capabilities
- Institutionalising Data Quality Monitoring System for routine programme data collection
- Institutionalising data use for decision-making

KEY PRIORITIES UNDER NACP-IV

- Preventing new infections by sustaining the reach of current interventions and effectively addressing emerging epidemics
- Prevention of parent to child transmission
- Focusing on IEC strategies for behaviour change in HRG, awareness among general population and demand generation for HIV services
- Providing comprehensive care, support and treatment to eligible PLHIV
- Reducing stigma and discrimination through Greater Involvement of People living with HIV/AIDS (GIPA)
- De-centralising roll-out of services including technical support
- Ensuring effective use of strategic information at all levels of programme
- Building capacities of NGO and civil society partners especially in states of emerging epidemics
- Integrating HIV services with health systems in a phased manner
- Mainstreaming of HIV/AIDS activities with all key Central/State level Ministries/ departments will be given a high priority and resources of the respective departments will be leveraged. Social protection and insurance mechanisms for PLHIV will be strengthened

PACKAGE OF SERVICES UNDER NACP-IV
Prevention Services
• Targeted Interventions for High Risk Groups (Female Sex Workers, Men who have Sex with Men, Transgenders/Hijras, Injecting Drug Users) and Bridge Population (Truckers & Migrants) • Needle-Syringe Exchange Programme and Opioid Substitution Therapy for IDUs • Prevention Interventions for Migrant population at source, transit and destination • Link Worker Scheme for HRGs and vulnerable population in rural areas • Prevention & Control of Sexually Transmitted Infections/Reproductive Tract Infections • Blood Safety • HIV Counseling & Testing Services • Prevention of Parent to Child Transmission • Condom promotion • Information, Education & Communication and Behaviour Change Communication (BCC). • Social Mobilisation, Youth Interventions and Adolescence Education Programme • Mainstreaming HIV/AIDS response • Work Place Interventions
Care, Support & Treatment Services
• Laboratory services for CD4 Testing and other investigations • Free First-line & Second-line Anti-Retroviral Therapy (ART) through ART centres and Link ART Centres (LACs), Centres of Excellence (CoE) & ART plus centres. • Paediatric ART for children • Early Infant Diagnosis for HIV exposed infants and children below 18 months • Nutritional and Psycho-social support through Care and Support Centres (CSC) • HIV/TB Coordination (Cross-referral, detection and treatment of co-infections) • Treatment of Opportunistic Infections • Drop-in Centres for PLHIV networks

Key challenges for NACP-IV identified during the process include emerging epidemics due to vulnerabilities such as migration and injecting drug use, growing treatment needs, and continued stigma & discrimination. Sustaining coverage and intensity of interventions in areas where declines have been achieved is critical to consolidate gains. Newer strategies should be put in place and strengthened to address the emerging epidemics. To achieve integration with larger health system, there is a need to address the challenge of varying capacities of health systems in different States to sustain access to quality HIV/AIDS services without stigma and discrimination. Ensuring access to social protection schemes for people infected and affected with HIV/AIDS through mainstreaming of HIV/AIDS with other government ministries and departments is an important concern. Dwindling international donor support to HIV/AIDS, relatively weaker health infrastructure and implementation mechanisms in some States and supply chain management for HIV commodities are some systemic challenges faced by the programme.

NEW INITIATIVES UNDER NACP-IV

The new initiatives under the fourth phase of the Programme are as follows:

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

STRUCTURE OF ANNUAL REPORT 2013-2014

The Annual Report 2013-2014 is structured as follows:

The epidemiological information on the HIV epidemic, including levels and trends in various typologies and States of India highlighting the key impacts of the programme, is elaborated in the next chapter.

In the subsequent chapters, the various strategies, progress in scaling-up interventions and achievements of the year under different components of the programme are described in detail. The chapter on Capacity Building explains about the trainings conducted under different divisions of DAC in 2013-2014.

The annexes at the end of this report include the most recent Audit observations, the addresses of the State AIDS Control Societies, the organisational structure of the Department of AIDS Control and details of the Results Framework Document 2012-2013.

Table 1.1: Progress in Achievement of Physical Targets during 2012-2013 and 2013-2014

S. No	Indicator	2012-2013		2013-2014	
		Target	Achievement	Target	Achievement
1	New Targeted Interventions established	180	218	300	246
2	STI/RTI patients managed as per national protocol	64.2 lakh	60.33 lakh	68 lakh	67.7 lakh
3	Blood collection in DAC supported blood bank	NR	NR	55 lakh	57,48,190
4	Proportion of blood units collected by Voluntary blood donation in DAC Supported Blood Banks	90%	84.3%	80%	84%
5	Districts covered under Link Worker Scheme (Cumulative)	163	160	163	162
6	Clients tested for HIV (General clients)	130 lakh	104.55 lakh	102 lakh	130.30 lakh
7	Pregnant Women tested for HIV	90 lakh	82.94 lakh	102 lakh	97.52 lakh
8	Proportion of HIV+ Pregnant Women & Babies receiving ARV prophylaxis	75%	94%	75%	84%
9	HIV/TB Cross Referrals	11 lakh	13.28 lakh	12 lakh	14.88 lakh
10	ART Centres established (Cumulative)	400	400	420	425
11	PLHIV on ART (Cumulative)	6.40 lakh	6.32 lakh	7,10,000	7,68,840
12	Opportunistic Infections treated	4.3 lakh	6.08 lakh	2.9 lakh	4,35,808
13	Campaigns released on Mass Media - TV/Radio	9	10	9	9
14	New Red Ribbon Clubs formed in Colleges	500	531	500	800
15	Persons trained under Mainstreaming training programmes	6.5 lakh	5.19 lakh	3 lakh	3.75 lakh
16	Social Marketing of condoms by DAC contracted Social Marketing Organisations	35 crore pieces	39.02 crore pieces	35 crore pieces	56.45 crore pieces
17	Free Distribution of Condoms	44.5 crore pieces	46.17 crore pieces	36 crore pieces	33.6 crore pieces

NACP-IV Launch Function, 12 February 2014

Following the approval of the fourth phase of the National AIDS Control Programme (NACP-IV) by the Cabinet Committee on Economic Affairs, a formal launch function for NACP-IV was organised at the National Media Centre, New Delhi on 12 February, 2014.

Shri Ghulam Nabi Azad, Hon'ble Union Minister for Health & Family Welfare, Government of India, the Chief Guest of the function, launched the fourth phase of NACP and released the NACP-IV Strategy Document. The Guests of Honour included Shri Oscar Fernandes, Hon'ble Minister of Transport, Road & Highways and Labour & Employment and President, Forum of Parliamentarians on HIV/AIDS (FPA), Smt. Santosh Chowdhary, Hon'ble Minister of State for Health & Family Welfare and Dr. J. D. Seelam, Hon'ble Minister of State for Revenue & Secretary General of the FPA. Shri Lov Verma, Secretary, Department of AIDS Control, Ministry of Health & Family Welfare, and Ms. Aradhana Johri, Secretary, Department of Pharmaceuticals, Ministry of Chemicals & Fertilisers also addressed the gathering.

The NACP-IV launch function was attended by the representatives of Development Partners including CDC, WHO, UNAIDS, BMGF, PHFI, The World Bank, GFATM, etc., representatives of Civil Society Organisations and NGOs, officers from various Government Departments, media personnel and officers from State AIDS Control Societies, and Department of AIDS Control.

Regarding the steps taken by the Government with respect to HIV/AIDS programme in India, the announcements made included the introduction of the HIV/AIDS bill in the Parliament, the revision of eligibility criteria for receiving ART, the introduction of Third-Line ART, and the initiation of ART for all HIV-positive pregnant women. These initiatives will not only ensure that HIV positive persons are initiated on treatment at an early stage and have enhanced longevity and productivity, but also contribute to the journey towards the goal of eliminating new HIV infections among children.

The dignitaries unanimously stressed on the fact that HIV/AIDS is posing a serious challenge to the health sector in the country, and also acknowledged that the response to the HIV epidemic in India has been remarkable in its spirit and action, as is evident from the significant decline in the adult HIV prevalence and new infections in the past decade. They stressed that the priorities in winning the fight against HIV/AIDS included addressing stigma and discrimination, community mobilisation, strong and effective leadership for creating awareness about the disease and providing access to HIV services for those in need. It was emphasised that the Forum of Parliamentarians on HIV/ AIDS will continue to support NACP. A number of operational guidelines, factsheets and reports were also released on this occasion.

Live webcasting of the Launch function was done through the website of the Press Information Bureau.

CURRENT EPIDEMIOLOGICAL SCENARIO OF HIV/AIDS

2

The HIV epidemic in India is concentrated among High Risk Groups and is heterogeneous in its distribution. The vulnerabilities that drive the epidemic are different in different parts of the country. Overall trends of HIV portray a declining epidemic at national level, though regional variations exist. The Department of AIDS Control has been monitoring levels and trends of HIV among different population groups to craft effective responses to control HIV/AIDS in India through the HIV Sentinel Surveillance System since 1998. For High Risk Groups (HRGs) and Bridge Populations, the National Integrated Biological and Behavioural Surveillance (IBBS) is currently being carried out as a strategic shift to strengthen the surveillance system among these groups. For monitoring HIV prevalence among Antenatal Clinic (ANC) attendees (considered proxy for prevalence among general population), the thirteenth round of HIV Sentinel Surveillance (HSS) was implemented during 2012-2013 in 34 States and Union Territories in the country.

According to HSS 2012-2013, the overall HIV prevalence among ANC attendees continued to be low at 0.35% in the country, with an overall declining trend at the national level. The highest prevalence was recorded in Nagaland (0.88%), followed by Mizoram (0.68%), Manipur (0.64%), Andhra Pradesh (0.59%) and Karnataka (0.53%). Also, States like Chhattisgarh (0.51%), Gujarat (0.50%), Maharashtra (0.40%), Delhi (0.40%) and Punjab (0.37%) recorded HIV prevalence of more than the national average.

An overall decline in HIV prevalence among ANC attendees was noted at the National level as well as in the historically high prevalence States in the Southern and North-Eastern regions of the country. However, rising trends among ANC attendees were observed in some moderate and low prevalence States such as Chhattisgarh, Gujarat, Jharkhand, Odisha, Punjab, Assam, Delhi, Haryana, Uttar Pradesh and Uttarakhand.

According to HSS 2012-2013, an overall decline in HIV prevalence among ANC attendees (considered proxy for prevalence among General Population) was noted at national level as well as in the erstwhile high prevalence States (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu). The declining trend among ANC attendees is consistent with India's story of large-scale implementation and high coverage during the NACP-III. All States have shown an average of less than 1% HIV prevalence among ANC attendees. However, site-wise analysis reveals that some moderate/low prevalence States like Arunachal Pradesh, Bihar, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Meghalaya, Odisha, Rajasthan, Uttar Pradesh, Uttarakhand and West Bengal, have ANC sentinel sites with more than 1% HIV prevalence. Also, it is noteworthy that rising trends in HIV prevalence among ANC attendees have been observed in many moderate and low prevalence States. These findings warrant a need for better understanding of the drivers of the HIV epidemic in States showing rising trends. In-depth epidemiological investigation of observed emerging pockets will help the programme in its endeavour to accelerate "halting and reversing the HIV epidemic" during NACP-IV period.

At the national level, the prevalence of HIV for general population (ANC attendees) in 2012-2013 and among different risk groups in 2010-2011 are shown in Figure 2.1 and the trends of the three-year moving averages based on consistent sites for ANC and core HRGs are shown in Figure 2.2.

HIV Sentinel Surveillance provides crucial evidence base for planning and implementation of programmatic initiatives under NACP. Data from HSS is instrumental in district re-categorisation and subsequent decentralised evidence-based planning and implementation. HSS data is used to estimate HIV prevalence, incidence and burden, to serve as the baseline for NACP-IV and to provide information for prioritisation of programme resources and evaluation of programme impact.

The last round of HIV Estimations was conducted in the country in 2012. The next round of HIV Estimations to estimate the levels and trends of HIV prevalence, incidence and burden at the National and State levels will be conducted after availability of data on HIV prevalence

Figure 2.1: National HIV Prevalence for ANC attendees (2012-13) and key risk groups (2010-11)

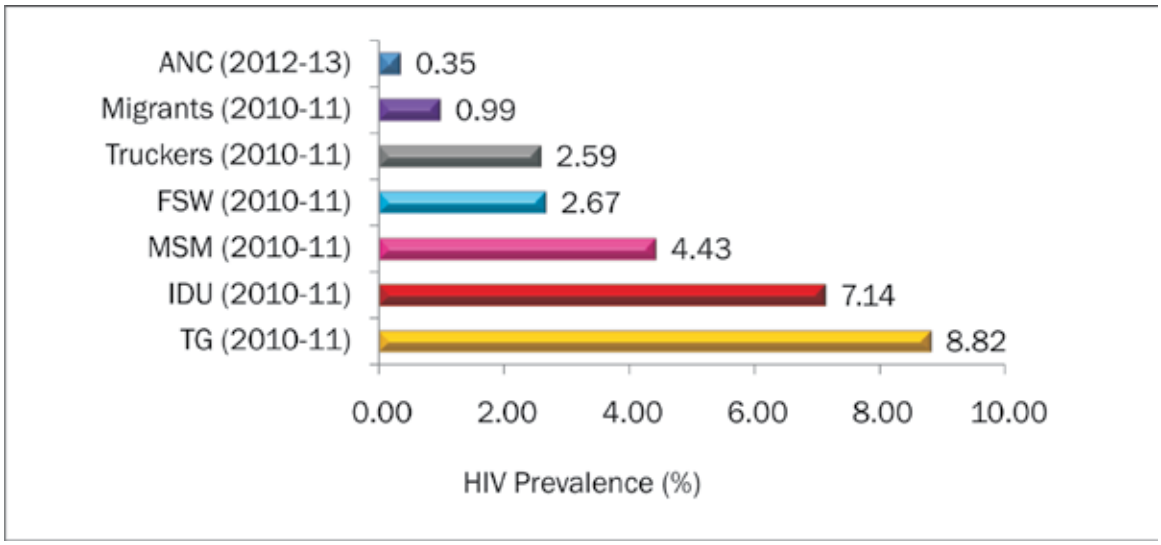
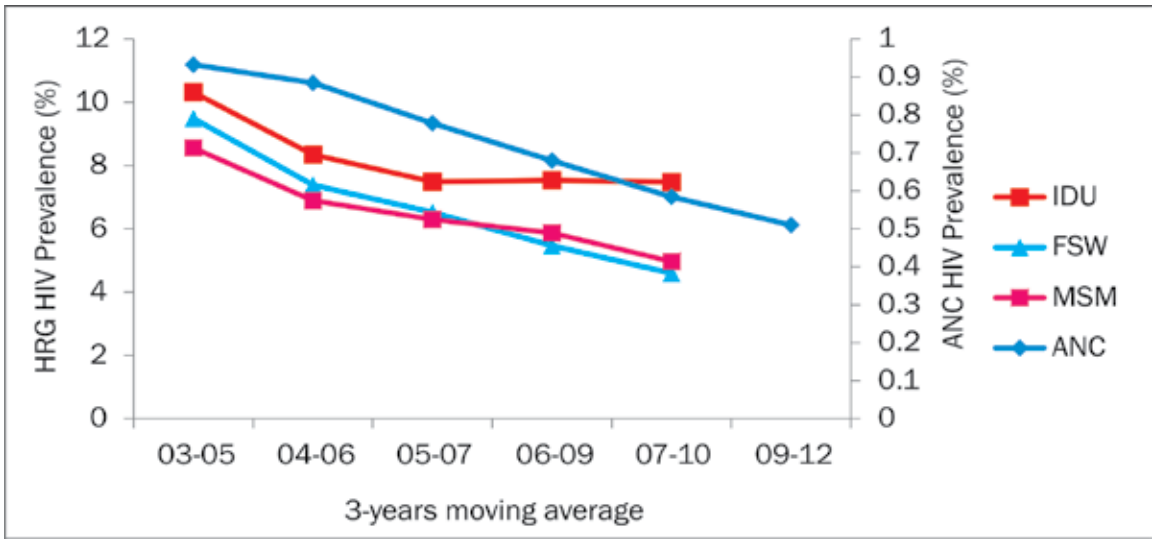


Figure 2.2: HIV Prevalence trends (*three-year moving averages based on consistent sites*) among ANC attendees and High Risk Groups at National Level, 2003-2012

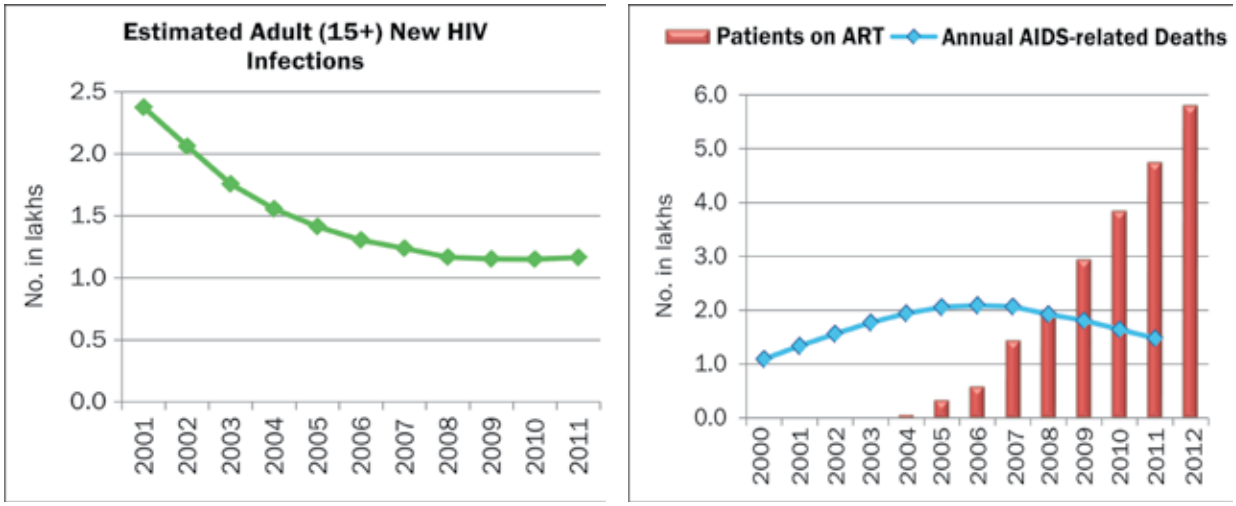


from the ongoing National Integrated Biological and Behavioural Surveillance for High Risk Groups. According to HIV Estimations 2012, the adult (15-49 years) HIV prevalence at national level continued its steady decline from the estimated level of 0.41% in 2001 to 0.27% in 2011. Declining trends in adult HIV prevalence were sustained in all the erstwhile high prevalence States. However, some States like Assam, Delhi, Chandigarh, Chhattisgarh, Jharkhand, Odisha, Punjab and Uttarakhand showed rising trends in adult HIV prevalence. At national level HIV prevalence among the young (15-24 years) population also declined from around 0.30% in 2001 to 0.11% in 2011.

The total number of people living with HIV/AIDS in India was estimated at around 20.9 lakh in 2011, 86% of whom were in 15-49 years age-group. Children less than 15 years of age accounted for 7% (1.45 lakh) of all infections in 2011. Of all HIV infections, 39% (8.16 lakh) were among women. The estimated number of PLHIV in India has maintained a steady declining trend from 23.2 lakh in 2006 to 20.9 lakh in 2011.

India has demonstrated an overall reduction of 57% in estimated annual new HIV infections (among adult population) during the past decade from 2.74 lakh in 2000 to 1.16 lakh in 2011. India was estimated to have around 14,500 new HIV infections among children in 2011. During NACP-III (2007-2012), the new HIV infections among adults decreased by 28% in erstwhile high prevalence States. This is one of the most important evidences of the impact of the various interventions under National AIDS Control Programme and scaled-up prevention strategies. It may however be noted that rising trends of new infections have been noted in some low prevalence States. The programme has evolved focused prevention strategies to address the emerging vulnerabilities which possibly have contributed to the rising trend of new HIV infections.

Figure 2.3: Evidence of Programme Impact: Declining trends of new HIV infections & AIDS-related deaths, India



Considerable decline in HIV prevalence has been recorded among Female Sex Workers at national level (5.06% in 2007 to 2.67% in 2011) and in most of the States where long-standing targeted interventions have focused on behaviour change and increasing condom use. Declines have been achieved among Men who have Sex with Men (7.41% in 2007 to 4.43% in 2011) also, though several pockets in the country have shown higher HIV prevalence among them with mixed trends.

In some of the North Eastern States, Injecting Drug Use has been identified to be the major vulnerability fuelling the epidemic. Stable trends have been recorded among Injecting Drug Users at national level (7.23% in 2007 to 7.14% in 2011). Besides North Eastern States where declines have been achieved, newer pockets of high HIV prevalence among IDU have emerged over the past few years in the States of Punjab, Chandigarh, Delhi, Mumbai, Kerala, Odisha, Madhya Pradesh, Uttar Pradesh and Bihar. Prevention strategies for IDU in the newer areas have been initiated recently and have been prioritised for further scale-up during the coming years.

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

Using globally accepted methodologies and updated evidence on HIV survival with and without treatment, it is estimated that about 1.48 lakh people died of AIDS related causes in 2011 in India. Deaths among HIV infected children accounted for 7% of all AIDS-related deaths. Wider access to ART has led to 29% reduction in estimated annual AIDS-related deaths during NACP-III period (2007-2012). Greater declines in estimated annual deaths were noted in States where significant scale-up of ART services had been achieved. In erstwhile high prevalence States the estimated AIDS-related deaths decreased by around 42% during the period 2007 to 2011.

According to HIV Estimations 2012, the scale-up of free ART since 2004 saved over 1.5 lakh lives in the country till 2011, by averting deaths due to AIDS-related causes. Assuming the current pace of scale-up of ART services, it is estimated that around 50,000 – 60,000 deaths would be averted annually in the next five years.

Above evidence shows that India is on the track to achieve the global targets of 'Zero new infections and Zero AIDS-related deaths'. However, sustaining prevention focus and intensity in the areas where significant declines have been achieved, is highly critical to consolidate the gains while effectively addressing the emerging epidemics. With increasing coverage of treatment and decreasing AIDS-related mortality, a significant number of people are likely to require anti-retroviral therapy in the coming years. Therefore, the major challenge for the programme will be to ensure that the treatment requirements are fully met without sacrificing the needs of prevention. DAC has taken cognisance of these emerging challenges and has focused on region specific strategies and evidence-based scale-up of prevention as well as treatment interventions.

TARGETED INTERVENTIONS 3

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

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

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

Key Risk Groups covered under 'Targeted Interventions'

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

Given this model of epidemic transmission, it is most effective and efficient to target prevention efforts towards HRGs to keep their HIV prevalence as low as possible and to reduce transmission from them to bridge populations. Therefore, focused preventive intervention projects among HRGs as well as bridge populations are supported under the National AIDS Control Programme (NACP). These intervention projects are known as the Targeted Interventions (TI).

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

TARGETED INTERVENTION PROJECTS

Targeted Interventions are preventive interventions working with high risk groups in a defined geographic area. Targeted Intervention projects, implemented by NGOs/ Community Based Organisations (CBOs), work with both core HRGs (FSW, MSM, TG and IDU) as well as bridge populations (Migrant & Trucker) and provide preventive interventions through a peer-led approach. Targeted interventions provide HRGs with the information, means and skills needed to prevent HIV transmission and improve their access to care, support and treatment services. These programmes also focus on improving sexual and reproductive health and general health of high-risk population.

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

Key attributes of Targeted Intervention Projects include:

- Peer-led approach - People from the high-risk community are engaged to deliver services and act as agents of change
- Targeting high-risk behaviours and practices and not identities/ individual choices
- Linking with services and commodities provision
- Dissociating risk from behaviours e.g. risk of STI and HIV infection from sex work
- Involving communities and their issues within the broader framework of interventions
- Adapting to the cultural and social milieu of the target audience

Services offered under the Targeted Intervention Programme

TI projects provide a package of prevention, support and linkage services to HRGs through an outreach-based service delivery model.

The services offered through the Targeted Interventions include:

- Detection and treatment for Sexually Transmitted Infections
- Condom distribution (except in TIs for bridge population)
- Condom promotion through social marketing (for HRG and bridge population)
- Behaviour Change Communication
- Creating an enabling environment with community involvement and participation
- Linkages to Integrated Counseling and Testing Centres
- Linkages with care and support services for HIV positive HRGs
- Community organisation and ownership building
- Specific Interventions for IDUs
  - » Distribution of clean needles and syringes
  - » Abscess prevention and management
  - » Opioid Substitution Therapy
  - » Linkage with detoxification / rehabilitation services
- Specific Interventions for MSM / TGs
  - » Provision of lubricants
  - » Specific interventions for TG/ Hijra populations
  - » Provision of project-based STI clinics

- Focusing on making the most efficient use of limited resources
- Acknowledging that people who are at risk of HIV infection are often marginalised, stigmatised and discriminated against by the larger community and face critical barriers to accessing health-care services

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

TYPOLOGIES OF TARGETED INTERVENTIONS

Interventions for Core High Risk Groups

Interventions for Female Sex Workers

It is estimated that there are about 8.68 lakh Female Sex Workers in the country, scattered in different States, of whom about 7.18 lakh FSWs (82.7%) are being covered under the programme. Different typologies of sex workers, namely, brothel-based, street-based, home-based, lodge-based, dhaba-based, bar girls, etc. are being covered with specific intervention strategies.

Interventions for Men who have Sex with Men

DAC has given significant thrust to interventions for MSM as the prevalence among these groups is considerably high. The estimation of high-risk MSM is 3.13 lakh in the country. Through TI projects, about 2.59 lakh (82.7%) MSM are being covered with services. The national programme is also complimented by 'Pehchan', The Global Fund Round 9 India HIV Programme, which is implemented by India HIV/AIDS Alliance focusing on strengthening community institutions and systems for MSM, Transgenders/Hijra interventions so that the outreach and quality of services are improved.

Intervention for Transgenders/Hijras

It has been increasingly recognised that Transgenders/Hijras have unique needs and concerns, and that it is better to view them as a separate group that is not under the rubric of 'MSM'. Reflecting a strong commitment to contribute to halting and reversing the HIV epidemic in India, the National AIDS Control Programme has initiated separate interventions for TG/Hijras. The programme for TG/Hijra populations needs to be scaled-up with adequate quality, so that HIV prevalence can be reduced, and prevention and care services are made available to these populations. Mapping of TG/Hijras has been initiated by DAC with the support of UNDP. The mapping estimated figure shows that around 70,000 TG/Hijras are there in the country. Operational guidelines for implementing Targeted Interventions among TG/Hijras has also been drafted at DAC along with building IEC material specific to the needs of these populations. During 2013-2014, 13,200 Transgenders/Hijras have been identified in seven States (Gujarat, Delhi, Karnataka, Maharashtra, Tamil Nadu, Uttar Pradesh and West Bengal), and are being given programme services. There are 22 exclusive TIs for TG/ Hijras besides some core composite TI.

Interventions for Injecting Drug Users

Injecting Drug Users and their spouses have high vulnerability to HIV infection. As per the HIV Sentinel Surveillance 2010-2011, the HIV prevalence among IDU was 7.14%. The prevalence among IDU was the highest among the HRG population sub-groups. In India, opioids (Heroin, Buprenorphine, Propoxyphene, etc.) are the most commonly injected drugs, either alone or in combination with other drugs from the non-opioid class (e.g.

Diazepam, Promethazine, Chlorpheniramine, etc.). However, the injecting as well as treatment-seeking behaviours among IDUs vary significantly between different regions.

The number of IDUs in the country is estimated at about 1.77 lakh; of this about 29% are estimated to be from the North-Eastern States. During 2013-2014, about 1.32 lakh IDUs (74.6% of the estimated number) have been covered. This also includes seven exclusive interventions for Female IDUs and regular sex partners of male IDUs in four North-Eastern States (Manipur, Mizoram, Nagaland and Meghalaya). About 1,350 female IDUs and more than 700 regular sex partners of male IDUs were receiving prevention services from these Targeted Interventions.

Under The Global Fund Round-9, the principal recipient, Emmanuel Hospital Association is supporting DAC to strengthen the IDU interventions and building capacity at the National, State and District levels to deliver harm reduction services for IDUs. Several studies have been undertaken to improve the understanding of the IDU related behaviours and practices, and to assess the availability and uptake of services by IDUs and their spouses. The areas explored in these research projects included association of IDU risks and vulnerability to injecting practices, access and utilisation of CST services among HIV positive IDUs and the contexts and responses related to overdose among injecting drug users.

Opioid Substitution Therapy (OST) was incorporated into the harm reduction programme for IDUs in 2007-2008 and since then DAC has been supporting more than 50 OST centres in NGO-settings, covering about 4,800 IDUs. The NGO OST Centres are contracted by the concerned SACS to implement OST after an independent accreditation by the National Accreditation Board for Hospitals and Healthcare Providers (NABH).

DAC has also initiated implementation of OST services in government health facilities. A national plan for expansion of OST services is currently being implemented across 32 States/UTs with a view to establish more than 300 OST centres, so as to cover at least 20% of the estimated IDU population with OST services. As part of the scale-up efforts, 45 new OST centres were established during 2013-2014, which resulted in doubling of the OST coverage in the country in one year. DAC is supporting provision of OST services through more than 150 OST centres spread across 32 States/UTs of the country and provides free substitution treatment to approximately 18,000 IDUs.

Interventions for Bridge Populations

Interventions for High-Risk Migrants

DAC has revised the migrant intervention strategy with specific reference to linking migrants with services and information on HIV prevention, care and support at Source (at their villages), at Transit (places like rail or bus stations where large number of migrants board trains or buses to travel to their places of work) and at Destinations (the places of work). DAC has identified 122 districts with high out-migration (based on the 2001 Census) across 11 States which are on priority for starting up community level migrant interventions.

The Department of AIDS Control has identified key areas which can strengthen implementation of revised migrant intervention strategy at Source, Transit and Destinations. To this end, modelling of migrant interventions across two important corridors is being undertaken; they are (Thane- UP/Bihar) and (Ganjam-

DAC in partnership with NABH organized an 'Orientation Workshop for Opioid Substitution Therapy Accreditors' during 26-28 November, 2013. The workshop was organised to orient the NABH assessors to the process and tool for evaluation of OST centres. Representatives from the National Drug Dependence Treatment Centre, AIIMS, technical and programme experts, NABH and senior faculty from prominent medical institutes participated in the workshop.

Surat) corridors. The first corridor is between Maharashtra (Thane) and Uttar Pradesh (Azamgarh, Allahabad, Gorakhpur, Jaunpur and Maharajganj) & Bihar (Sitamarhi, Vaishali, Gopalganj), and the second corridor is between Odisha (Ganjam) and Gujarat (Surat). This would include piloting of web-enabled tracking system to ensure continuum of services for migrants and their spouses.

The interventions at destination have been strengthened with improved monitoring and reporting by the State AIDS Control Societies. Till March 2014, 289 TIs run by the SACS at Migrant destinations were reaching out to 29.24 lakh high-risk Migrants. The HIV Sentinel Surveillance data showed decline in HIV prevalence among Migrants from 2.35% in 2008-09 to 0.99% in 2010-2011.

Health camps were organised at the Block level during festivals (Dussehra, Diwali and Eid) when migrants return to their villages. These camps promoted health-seeking behaviour as well as HIV testing and Counseling among attendees. During the festive season, 1,278 intensive communication and health camps were organised in 491 blocks of 108 districts in the States of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and West Bengal. At these camps organised in close collaboration with NRHM and DAPCU of these districts, over 2.92 lakh people were educated on HIV/AIDS and treated for STIs and general ailments. During the camps, 43.8% of the camp attendees availed voluntary Counseling and testing for HIV. About 41% of the camp attendees were returnee migrants and their spouses. The HIV positive clients detected in these camps were linked to the nearest ICTC and further linked-up with ART centres. These health camps also provided a platform for condom campaigns by Social Marketing Organisations and folk media campaigns by trained folk artists.

Additionally, 40 interventions are in place in select Transit locations identified across the 122 districts from where Migrants board long distance trains/buses to reach their destinations (usually work places). At these locations, the part-time outreach workers, placed with existing interventions, conduct group sessions on HIV prevention. Besides this, migration kits containing information booklet on services available in major destinations (as identified for specific source-destination corridor), condoms, daily utility materials like small notebook, ball pen, comb, etc. are distributed to migrant workers free of charge. The strategy is to reinforce HIV prevention messages and encourage out-going migrants to seek HIV-related services at destination. During 2013-2014, 7.8 lakh migrants and their spouses were reached through 64,320 outreach sessions till March 2014.

Employer-Led Models: During 2013-2014, Ministry of Corporate Affairs amended the CSR Bill incorporating clauses for mandatory utilisation of 2% of profits of corporates with more than Rs 500 crore turnover on various social development areas including the health sector. The Department of AIDS Control leveraged this opportunity and with partnership of PIPPSE worked to develop operational guidelines and training modules for implementing Employer-Led Models of HIV interventions by industries and corporates, who employ significant number of migrants and truckers as part of their workforce.

Through five regional trainings, 110 participants from SACS and TSU have been oriented on the Employer-Led Models. These trainings have been imparted by industry experts and experts having hands-on experience of working in the HIV sector with corporates. Several large corporates are being engaged including Jindal Group, BHEL, NTPC, Ashok Leyland, Jindal steels, Tata steels, Suzlon and DMRC.

Interventions for Long Distance Truckers

Currently, 92 Targeted Interventions for Truckers are reaching out to about 11.80 lakh truckers, and providing STI healthcare services, risk reduction Counseling and condoms. Clinics at trans-shipment locations have been co-branded as *Khushi-Suraksha* Clinics. IEC materials addressing issues such as self-esteem, risk perception and services are

being made available to them. Besides this, there are 42 locations where Condom Social Marketing initiatives have been implemented to promote risk reduction. The Behaviour Change Communication materials, training kits and micro-plan have been adapted for each site to suit the local needs and to maximise the impact of interventions.

The Department has initiated mapping of transit halt points of truckers on major highways in Maharashtra, Gujarat, Karnataka, Madhya Pradesh, Andhra Pradesh and West Bengal, to address the prevention needs of the truckers. As part of this initiative, condom promotion has been planned through social marketing, messaging through petroleum outlets and through *dhabas*.

CAPACITY BUILDING ACTIVITIES FOR TARGETED INTERVENTIONS

Capacity building activities are a continuous and integral part of TI programme and aim to provide TI staff adequate understanding, skills and information, thus enabling them to perform their roles effectively and efficiently. For this purpose, State Training and Resource Centres (STRCs) have been contracted in several States which, through training, on-site hand-holding and research activities, are expected to strengthen the operational efficiency of the TIs and improve the quality of service delivery. The STRCs are also tasked with the responsibility of developing local resource pools for training and mentoring activities. 15 STRCs covering 21 States and 5 Union Territories are functional in the country. The procurement process for 23 other STRCs is in progress. The STRCs work in coordination with the State AIDS Control Societies and TSUs to build the capacity of TI staff. While the new staff receives induction training on the standardised modules, the old staff are imparted customised trainings based on needs assessment carried out by STRCs.

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

SUPPORT MECHANISMS TO ENSURE QUALITY OF INTERVENTIONS

In order to maintain and improve the rigor of quality interventions initiated under the programme, DAC has taken up the following measures:

- **Technical Support Units:** The Technical Support Units (TSUs) in States provide technical support to SACS/MACS on key aspects of TI programme implementation by closely monitoring activities of TIs and providing hand-holding / on-site mentoring, as needed. This ensures that NACP guidelines are followed to strengthen quality of implementation. TSUs also facilitate designing, planning, implementation and monitoring of TIs in States and provide management and technical support to SACS. Currently, 16 TSUs and North East Regional Office (NERO), which acts as TSU for North-Eastern States (8 States), are working with 24 States to provide supportive supervision for Targeted Interventions under the technical support programme in the country.
- **Supportive Supervision and Monitoring:** DAC has strengthened the organisational structure for TI supervision and monitoring. Project Officers (one Officer for 10 facilities in North East, for 12 facilities in Northern States and for 15 facilities in Southern States) provide an effective support mechanism to mentor and monitor the TI on regular basis. The supportive supervision includes monthly one-day visits and quarterly intensive visits to ensure the quality of TIs. There were 129 Project Officers working with TSUs and NERO, mentoring 1,372 TIs in 23 States in 2013-2014.

- **OST Accreditation:** In addition to external evaluation, TI projects running OST services are also evaluated by National Accreditation Board of Hospitals (NABH) on an annual basis for accreditation. With support from technical experts and NABH, DAC has developed a specific tool for the purpose. The evaluations are conducted by external experts contracted by NABH and the findings are reviewed by a Committee of technical experts on OST before finalisation. The OST accreditation has served as a useful strategy to ensure minimum standards of care at the DAC supported OST centres.
- **Computerisation of tools for collection of data:** A computerised offline data entry system has been initiated. Of the 17 formats, 11 formats have been computerised. Tools for tracking data regarding provision of services and referrals have been developed.
- **Developing a quality guide for TIs:** To ensure a standard process, a guide has been developed which covers how the data flows from outreach to reporting level at TI and finally into the Computerised Management Information System (CMIS). The concept of "one data set" in use from Implementation level to DAC level is in place. This helps in reducing the discrepancy in the data being reported and used at various levels. In addition, methods to check factuality of information, timelines, and defining the roles and responsibilities of staff in collecting data, are also covered in this guide.
- **Monthly tracking of CMIS and SIMS report from TIs is being done at DAC;** regular feedback to the SACS is provided on how many TIs are reporting. SACS are encouraged to examine the data collected from CMIS and provide feedback to the TI. The number of units reporting in SIMS is gradually improving.
- **Quality Assurance in OST programme:** With implementation of OST services in government health settings, DAC has established a mechanism of on-site mentoring and capacity building of staff through field visits by experts on OST, on a periodic basis. The experts follow a standard protocol to observe the procedures and interact with the staff and clients at the OST centre, and provide feedback to improve the service delivery. The standard protocol for these visits has been developed by the National Drug Dependence Treatment Centre, AIIMS under Project *Hifazat* supported by The Global Fund.

PERFORMANCE OF TI PROGRAMME IN 2013-2014

Coverage of Core HRG

The key performance of TIs with respect to the coverage of core HRGs during 2013-2014 is depicted in Figure 3.1. This data based on CMIS reports received at DAC, shows that FSW coverage compared to the estimates, has already crossed 90%.

Figure 3.1: Coverage of Core HRG (FSW, MSM, IDU) during 2013-2014

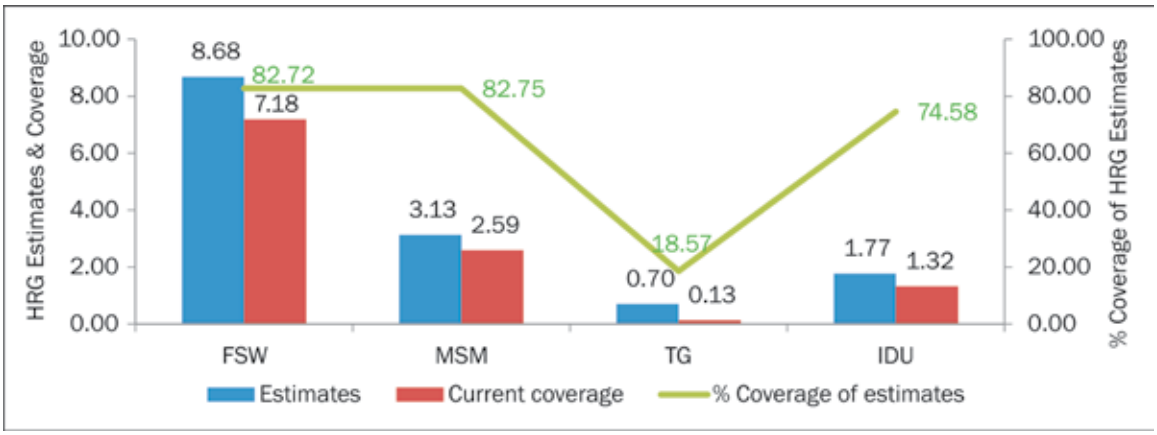


Figure 3.2: STI clinic visits during 2013-2014

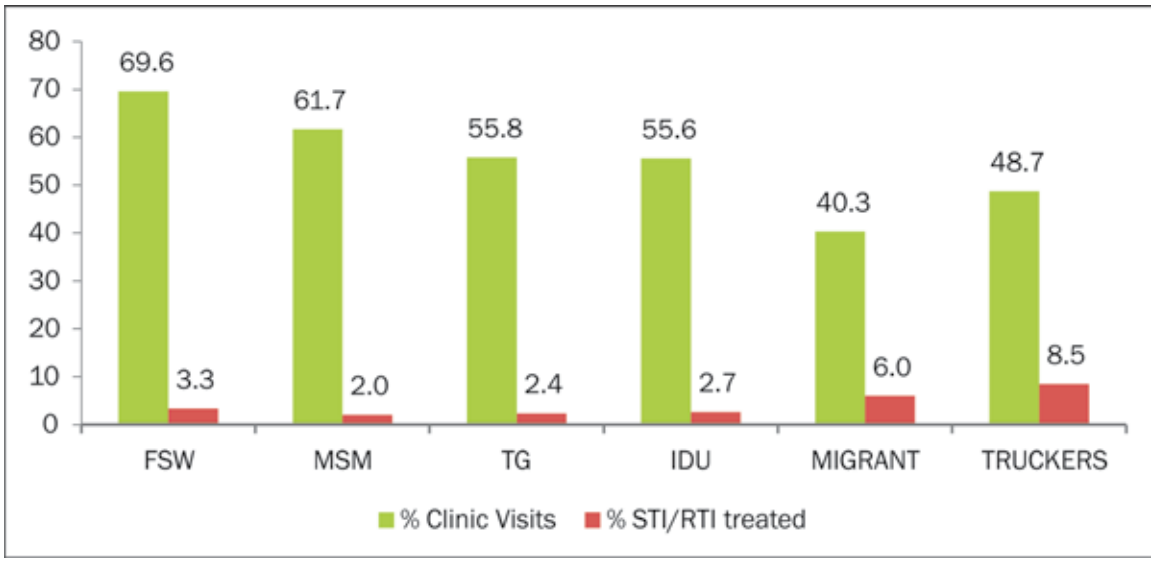
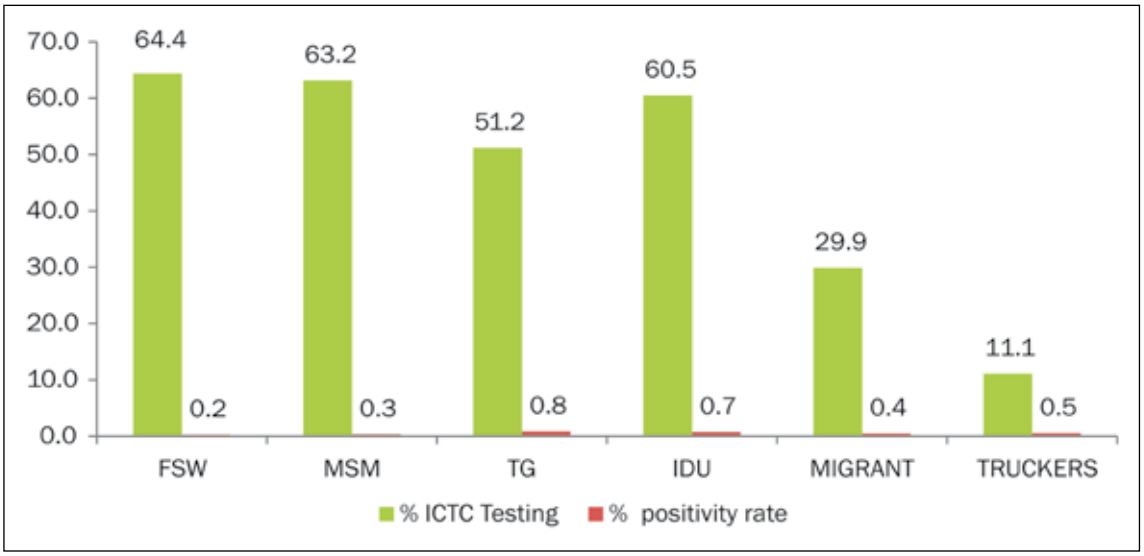


Figure 3.3: HRGs tested for HIV at ICTCs during 2013-2014



Management of STI/RTI

Clinical services including regular medical check-up is one of the core components of TI project services. DAC guideline suggests that HRGs from core group, especially MSM and FSW, should visit STI clinics every quarter, i.e., four times in a year, for regular medical check-ups and for treatment of Sexually Transmitted Infection (STI)/ Reproductive Tract Infection (RTI). Figure 3.2 depicts the number of clinic visits made by HRGs during 2013-2014.

Figure 3.2 shows the proportion of STI clinic attendees diagnosed and treated for STI/RTI during 2013-2014 through TIs. In all the risk groups except bridge population (migrant and truckers), the number of STI/RTI episodes has remained low.

HIV testing and ART linkages among HRGs

DAC guidelines specify that all core HRGs should be tested for HIV once every six months. Figure 3.3 depicts the number of HIV tests performed among HRGs through referrals from targeted intervention projects. The graph depicts average HIV testing done and HIV positivity rate for each typology during 2013-2014.

Figure 3.4: Typology-wise Condom pieces distributed to HRGs during 2013-2014

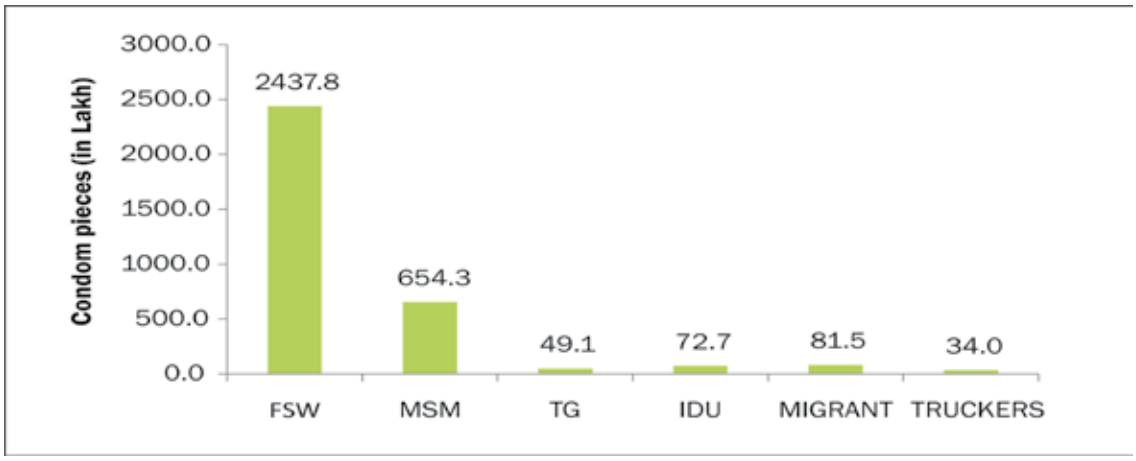
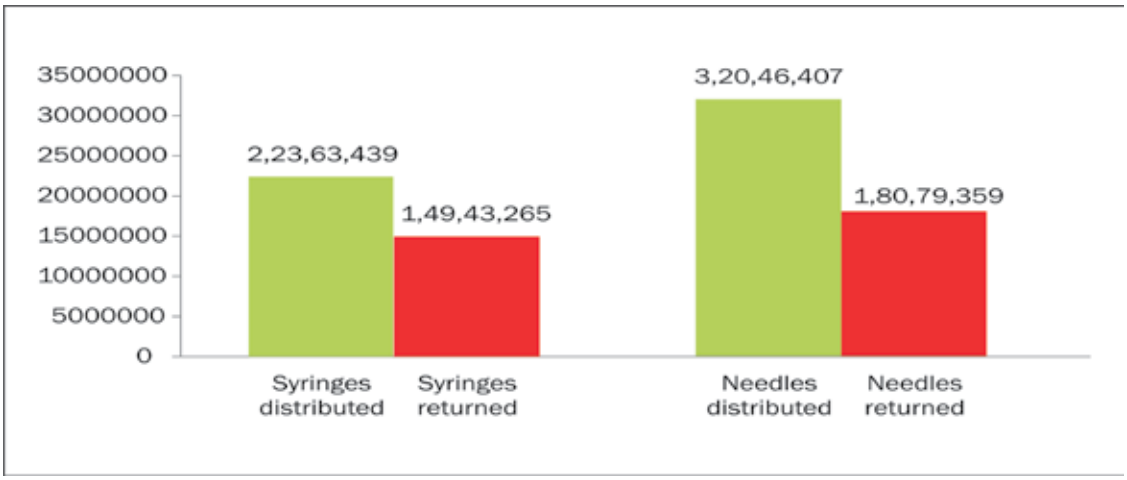


Figure 3.5: Distribution and Return of Syringes and Needles, 2013-2014



All HRGs found positive for HIV are required to be referred for CD4 count test and all eligible persons are to be taken to nearest ART centre for pre-ART registration, after which they are tracked by the ART centre staff for regular follow-up.

Condom distribution among HRG

As per NACP strategy, all sexual encounters of HRGs should be protected by consistent and correct usage of condoms. To ensure this, it is imperative that condoms are distributed to HRGs as per their requirement. Fig. 3.4 shows the typology-wise number of condoms (free and social marketing) distributed to the HRGs during 2013-2014.

Needle-syringe distribution pattern among IDUs

As part of preventive services, Targeted Interventions for IDUs distribute free syringes and needles to Injecting Drug Users through peer educators, and IDUs are encouraged to return the used syringes and needles. This ensures availability of sterile syringes and needles to IDUs and alleviates the need to share the injecting equipment, thus decreasing risk for HIV transmission. Figure 3.5 depicts the number of syringes and needles distributed to IDUs and the number of used syringes and needles returned by them during 2013-2014.

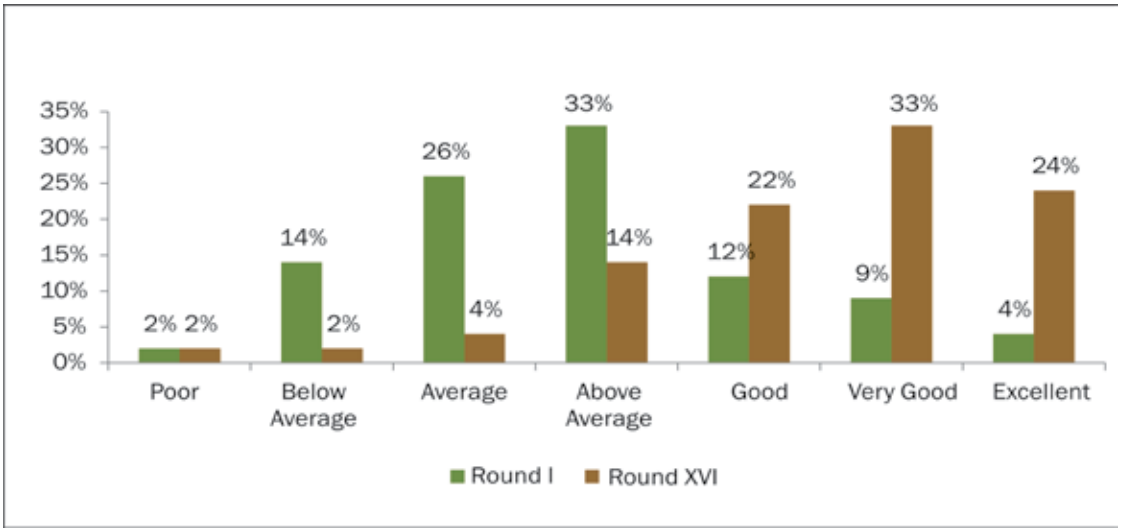
PERFORMANCE GRADING OF TARGETED INTERVENTIONS

The Project Officers of TSUs conduct quarterly performance assessment of TIs. A summary of the assessments conducted by TSUs during one quarter of 2013-2014 (July-September 2013) is given in Table 3.1

Table 3.1: Status of Quarterly Performance Assessment of Targeted Interventions during July-September 2013 (Round XVI)

S. no	State	Excellent (A++)	Very good (A+)	Good (A)	Above Average (B+)	Average (B)	Below Average (B-)	Poor (C)	Total assessed
1	Andhra Pradesh	62	77	26	5	1	0	0	171
2	Chhattisgarh	3	10	13	16	1	2	0	45
3	Goa	8	6						14
4	Karnataka	72	7	22	17	5	1	4	128
5	Kerala	0	10	27	9	3	0	0	49
6	Madhya Pradesh	0	6	8	6	2	2	0	24
7	Maharashtra	41	63	38	19	8	6	5	180
8	Punjab	1	29	16	15	1	0	0	62
9	Rajasthan	0	7	12	13	1	0	0	33
10	Tamil Nadu	4	30	23	19	5	3	4	88
11	Uttarakhand	2	21	6	1	1	1	1	33
12	Uttar Pradesh	23	34	10	7	5	3	1	83
	Total TIs	**216**	**300**	**201**	**127**	**33**	**18**	**15**	**910**
	% of Total Assessed	**24%**	**33%**	**22%**	**14%**	**4%**	**2%**	**2%**	**100%**

Figure 3.6: Comparison of Performance Rating of TI between Round I and Round XVI



As seen above, the performance of TIs has improved remarkably from Round I to Round XVI.

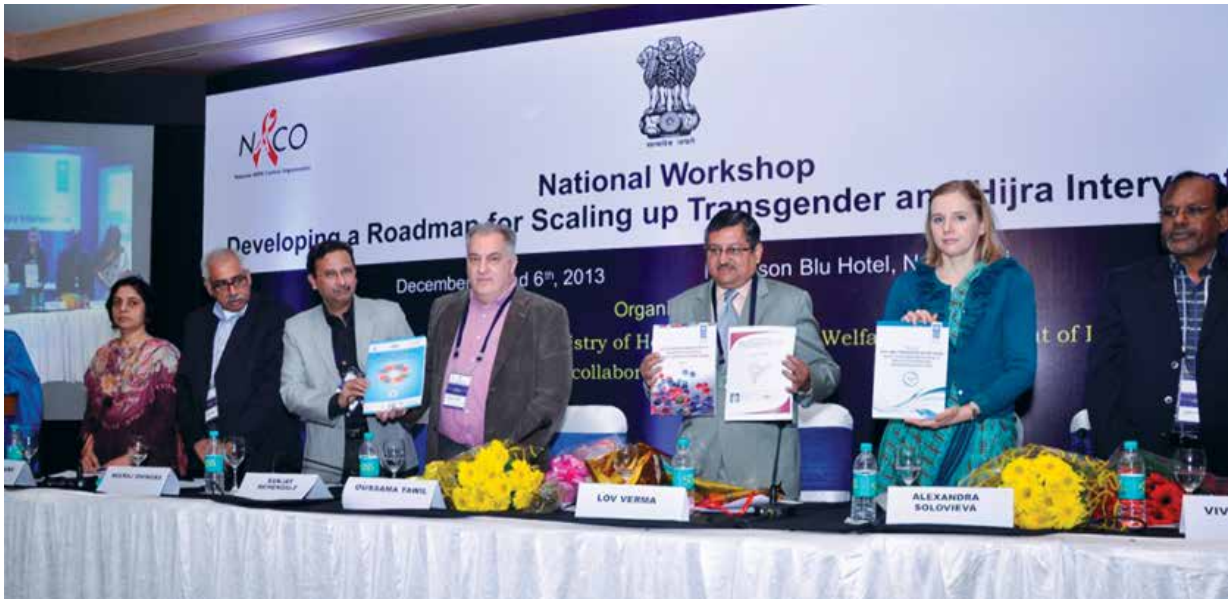
DISTRIBUTION OF TARGETED INTERVENTIONS AND COVERAGE OF HRG

Table 3.2: State-wise and Typology-wise Distribution of Targeted Interventions supported by DAC, during 2013-2014

Name of SACS/ MACS	FSW	MSM	IDU	TG	Core Composite	Migrant (Destination)	Truckers	Total
Ahmedabad	3	4	1	1		11	2	22
Andhra Pradesh	39	5	6		98	18	5	171
Arunachal Pradesh	4	1	3		9	6		23
Assam	32	5	7		8	6	3	61
Bihar	5		10		14		1	43
Chandigarh	4	2	2		1	3	1	13
Chhattisgarh	13	4	7		17	7	5	49
Dadra & Nagar Haveli								0
Daman & Diu					2	4	1	7
Delhi	40	17	20	8		17	4	106
Goa	6	3	2		1	2	2	16
Gujarat	13	15	2		42	35	5	112
Haryana	13	10	16		7			46
Himachal Pradesh	17	1	3		3	8	2	34
Jammu & Kashmir	3	1	4		4	3	2	17
Jharkhand	25	4	3		2	1	4	42
Karnataka	66	31	4	2	4	21	7	135
Kerala	20	14	8			9	2	53
Madhya Pradesh	28	6	11		26	7	6	84
Maharashtra	61	22	3		11	60	12	169
Manipur	6	4	55		7	2		74
Meghalaya	3		4		1	1		9
Mizoram	1	1	23		8	4		37
Mumbai	18	8	3	5		14	2	50
Nagaland	2	3	30		16	1	1	53
Odisha	13	2	7		23	10	1	56
Puducherry	1	1	0		2	1		5
Punjab	16	0	25		20	5	4	70
Rajasthan	22	6	6		11	11	3	59
Sikkim	3		4					7
Tamil Nadu	16	11	1	2	42	7	5	84
Tripura	8		2		2	3		15
Uttar Pradesh	12	5	13	2	54		5	91
Uttarakhand	12	3	6		5	8	3	37
West Bengal	22		4	1		4	4	35
India	**547**	**189**	**295**	**21**	**440**	**289**	**92**	**1873**

Table 3.3: State-wise and Typology wise targets for coverage of Key Risk Groups under the programme, 2013-2014

Name of SACS/ MACS	FSW	MSM	IDU	TG	Migrant (Destination)	Truckers
Ahmedabad	4,509	4,300	400	400	1,65,000	40,000
Andhra Pradesh	1,39,580	33,058	2,121	0	1,93,357	65,000
Arunachal Pradesh	2,800	100	1,550	0	25,000	0
Assam	18,954	2,000	2,775	0	0	5,000
Bihar	14,870	3,720	4,250	700	0	30,000
Chandigarh	3,750	2,500	1,150	0	30,000	5,000
Chhattisgarh	22,400	4,010	3,150	0	70,000	55,000
D&N Haveli	0	0	0	0	0	0
Daman & Diu	858	765	0	0	7,829	1,065
Delhi	46,400	16,200	11,300	5,200	2,25,000	50,000
Goa	3,900	2,000	700	0	20,000	10,000
Gujarat	32,238	36,200	700	0	3,71,000	76,000
Haryana	14,450	8,250	5,300	0	0	0
Himachal Pradesh	8,900	800	1,100	0	94,000	12,000
Jammu & Kashmir	2,313	250	1,350	0	30,000	12,000
Jharkhand	14,650	6,875	1,300	50	20,000	55,000
Karnataka	85,335	26,610	1,597	1,200	2,10,000	80,000
Kerala	26,276	18,296	5,640	0	61,668	40,000
Madhya Pradesh	28,750	8,400	7,050	0	82,000	85,000
Maharashtra	69,425	21,885	800	0	7,35,000	2,30,000
Manipur	5,200	1,400	17,750	0	15,000	0
Meghalaya	1,300	200	1,150	0	10,000	0
Mizoram	550	500	10,050	0	25,000	0
Mumbai	16,700	3,000	1,200	4,400	1,40,000	15,000
Nagaland	2,753	1,285	14,832	0	5,000	5,000
Odisha	9,825	3,800	2,200	0	92,000	15,000
Puducherry	2,001	1,963	0	0	12,000	0
Punjab	20,300	2,970	11,800	0	65,000	35,000
Rajasthan	12,900	2,350	1,550	0	30,000	30,000
Sikkim	850	0	1,450	0	0	0
Tamil Nadu	47,737	33,458	561	500	75,000	62,000
Tripura	7,600	400	650	0	20,000	0
Uttar Pradesh	20,450	9,200	12,950	550	0	55,000
Uttarakhand	7,150	1,915	2,100	0	95,000	40,000
West Bengal	23,324	0	1,276	200	0	0
India	**7,18,998**	**2,58,660**	**1,31,752**	**13,200**	**29,23,854**	**11,08,065**



Distinguished panelists at the National Workshop on 'Developing a Roadmap for Scaling-up Transgender/Hijra interventions'

NEW INITIATIVES UNDER TARGETED INTERVENTIONS

Scale up of Interventions for Transgender/ Hijra

The Department of AIDS Control hosted the National Workshop on 'Developing a Roadmap for Scaling-up Transgender/Hijra Interventions' in collaboration with UNDP-India, during 05-06 December, 2013 at New Delhi, as an initiative of the Government of India to recognise the Transgender/Hijra community. This workshop, the first-of-its-kind in India and the Asia-Pacific region, showcased vital strategic information on estimation and epidemiology of Transgender/Hijra, to develop prioritised need-based interventions. The workshop was a milestone in the international HIV arena, projecting India as a forerunner in conducting mapping and estimation exercises of Transgender populations.

The workshop disseminated the Transgender/ Hijra mapping study results from 17 States. Participants of the workshop were members from mapping agencies including National Institute of Epidemiology (NIE), Indian Council of Medical Research (ICMR) and IMRB, along with community leaders from across the country, SACS/TSU officials, DAC officials, donor partners, and media partners.

Secretary, DAC released the National Transgender/Hijra mapping results and other publications along with Country Director, UNDP and Country Director, UNAIDS. Based on mapping results, a national scale-up plan for Transgender/Hijra interventions was developed during the workshop for the entire country. Presentations were made on the intervention models available in the country and operational guidelines were developed. The workshop also disseminated and shared knowledge on social policy, rights and issues relevant to the community in India through presentation of various technical papers and subject matter discussions.

DAC has prioritised working with Transgender/ Hijra as one of the vulnerable groups during NACP-IV and therefore had commissioned the national level mapping and size estimation exercise in 17 identified States. DAC has demonstrated a clear leadership role in creating a platform exclusive to TG/Hijra. The results from the mapping will pave the way forward and be part of the annual work plan and strategic coverage and saturation of this target group to maximise prevention efforts.

One of the workshop highlights was sharing of the draft TG operational guidelines; this is envisaged to improve HIV programme management capacity along with improved

technical, organisational and leadership capacity of organisations implementing TG TIs. Technical presentations on key knowledge products, discussions on the TG legal brief on identity, the social protection paper and public hearings have provided valuable insights and sensitised the key partners to the gravity of the situation.

Based on the mapping results, DAC proposes to scale-up the Transgender and Hijra interventions in the country. As of now there are 22 Targeted Interventions working among TG/Hijra and this will be increased based on the mapping data. Further, the scale-up strategy is being included in respective States' Annual Action Plans for the year 2014-2015.

Piloting of Migrant Service Delivery System

DAC has identified 122 districts with high out-migration (based on Census 2001) across 11 States of India for initiating community level migrant interventions to enhance service tracking among migrants. During 2013-2014, DAC identified key areas which can strengthen implementation of revised migrant intervention strategy at source, transit and destinations. To ensure enhanced service uptake and follow-up across the continuum of migratory patterns, DAC has taken up modelling of migrant interventions across two important corridors i.e. between Maharashtra (Thane) and Uttar Pradesh (Azamgarh, Allahabad, Gorakhpur, Jaunpur and Maharajganj) and Bihar (Sitamarhi, Vaishali, Gopalganj) and also between Odisha (Ganjam) and Gujarat (Surat). This includes piloting of web-enabled tracking system to ensure continuum of services for migrants and their spouses. Currently the same is being piloted in Surat and Thane by providing handholding support to 7 destination interventions. The outputs of the system are being used to prioritise services at the Source districts.

Employer-Led Models of Intervention at Migrant Destinations

In addition to the existing Targeted Interventions, it is planned to scale-up coverage and bring in ownership of employers through employer-led models during NACP-IV. These models would be implemented in occupation sectors with large clusters of informal workers and migrants. Technical support would be provided to these employers to use their existing health infrastructure, health staff, supervisors, contractors etc. to conduct communication sessions, provide HIV related services couched within their existing healthcare services, improved referral linkages with already existing HIV related services and improved access to social protection schemes. Training of workers, display of IEC materials and condom social marketing would also be part of these models. Both private and public sector industries, agricultural cooperatives and association of employers are being actively involved to identify potential employers at State level, to sensitise the employers to implement these activities. In this regard, Operational Guidelines have been developed in consultation with the industries, industry associations and the International Labour Organisation. Five rounds of regional training of trainers have been completed involving 120 participants from SACS and TSU to further roll-out these interventions at State level. For the entire period of NACP-IV, 301 industries have been identified to implement this model. Initiatives have been taken up to engage with industrial houses including Jindal Steel, Tata Steel, BHEL, ACC Cements, Reliance and Cipla.

Launch of National AIDS Control Support Project in August 2013

LAUNCH OF NATIONAL AIDS CONTROL SUPPORT PROJECT

The Honourable Union Minister of Health and Family Welfare, Government of India, announced the launch of the National AIDS Control Support Project (NACSP) in August 2013, with the aim to target vulnerable risk groups including female sex workers, men who have sex with men, injecting drug users, truckers, and migrant populations. Though earlier NACSP efforts received funding primarily from multilateral and bilateral development agencies, yet for the current effort most of the funds will be provided through domestic support and The World Bank. Of the project's total of USD 510 million, the World Bank will provide interest free finance of USD 255 million.

Civil Society organisations, community groups, donor partners, and international organisations participated in the NACSP strategic planning meeting, which mapped out five strategies designed to prevent HIV and ensure access to treatment and care for HIV-infected people.

NACSP will contribute to three of the five strategies of NACP-IV:

- The prevention component
- The behaviour change component
- The institutional strengthening component

The main support of the Project will be provided for the scaling-up of HIV prevention interventions, with a focus on the high impact and cost-effective targeted interventions for population groups at high-risk, and part of Information Education and Communication including behaviour change and demand generation. By scaling-up targeted interventions and prevention services, it is estimated that the project will cover about 90 percent of the high risk groups and avert about 3 million new infections by 2017. The project also plans to support communications and advocacy efforts aimed at reducing HIV stigma and promoting HIV prevention.

Two other strategies of NACP-IV, namely, the provision of care, treatment and support to people living with HIV/AIDS, and Strategic Information Management Systems including disease surveillance, will be supported by the Domestic Budget, with technical and financial support from other donors.

LINK WORKER SCHEME 4

The Link Worker Scheme (LWS) is a rural focus HIV prevention programme in India which has the mandate to work in high prevalence and highly vulnerable districts of the country. It was started with the specific goal of reducing rural India's vulnerability to HIV. There was growing evidence that HIV was no longer restricted to urban areas. The impact of HIV in rural areas is enormous due to stigma and discrimination surrounding HIV, resulting in poor access to healthcare, gender inequality and above all infections going undetected or treated by unqualified practitioners.

Currently the Link Worker Scheme is operational in 162 out of the planned 163 high prevalence and high vulnerable districts of 17 States i.e. Andhra Pradesh, Bihar, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Mizoram, Orissa, Punjab, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal. Each of these States were earmarked by Department of AIDS Control (DAC) as HIV hot-spots and LWS aimed to saturate all high-risk and vulnerable groups at the village level, with prevention and essential services, by establishing a low-cost structure to provide prevention, care and support services.

The scheme envisages identifying and training, this village level workforce of Supervisors, Link Workers and volunteers on issues of HIV/AIDS, gender, sexuality, STIs and above all on mobilising difficult-to-reach, especially vulnerable sub-populations including high-risk individuals, youth and women. Linking these marginalised sub-populations to the public health services for STI, ICTC, ART and then their follow-up back to communities is one of the key areas that is expected to be addressed by these Link Workers, generating volunteerism in the community for fighting HIV/AIDS and inculcating health values is another cornerstone of this strategy.

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

This community-based approach exemplified by the establishment of youth-driven Red Ribbon Clubs (RRCs) in target villages, liaising with Panchayat Raj Institutions and existing health systems, and developing a team of community-level volunteers, ensures sustainability while at the same time ensuring community participation.

Progress in LWS in 2013-2014

Link Worker Scheme supported by The Global Fund for AIDS, TB and Malaria (GFATM) got extended till August 2014 and thereafter, the Scheme will be funded by domestic funds of Government of India.

Identification of HRGs and other vulnerable population is one of the core activities of the scheme. Since FSW and MSM in rural areas are mobile and hidden in nature, it is sometimes difficult to identify them. As drug users are usually harassed by various authorities, many of them are isolated from public places. Therefore, community sensitisation is important to create an enabling environment for HRGs and vulnerable populations. Link Workers and Supervisors have conducted

Creating STI/HIV awareness among women at Thiruvallur, Tamil Nadu

Link Worker Scheme Advocacy meeting in Punjab

community sensitisation programmes in the villages through meetings with key stakeholders, women and youth. They have identified key informants through stakeholders to reach HRGs.

Reaching the target population with the services available for HIV/AIDS, coverage of the target population and service delivery uptake by them define the key indicators under the Scheme. A total of 1,79,393 against 1,68,082 mapped HRGs (FSWs, MSMs and IDUs), 41,11,795 against 45,99,326 mapped Vulnerable population & Bridge population and 47,408 against 40,662 mapped PLHIV have been identified and contacted at least once under the scheme. In this period, the district team have been able to identify and reach out to HRGs, vulnerable population, bridge population and PLHIV with the support of key informants and key stakeholders.

In terms of percentage of coverage, the LWS covers about 100% of the HRGs, 89% vulnerable population and bridge population and 100% of PLHIV in the vulnerable rural districts. Nearly 100% HRGs in these districts have been tested at ICTC and 71% of them have sought treatment for STI symptoms under LWS. This has been done by establishing linkages with existing services. In order to create a sense of ownership in the community and involve youth in fighting against HIV, many Condom Depots, Red Ribbon Clubs and Information Centres have been established at the village level. During 2013-2014, a total of 15,359 Red Ribbon Clubs and 18,177 Village Information Centres were functional under LWS.

Overall the programme has scaled-up since 2008 and shows improved service uptake. The programme recognises the need to step-up HIV prevention strategies in rural parts of India

Table: 4.1: Structure and Human Resource Details of the Link Worker Scheme

Indicators	Target	Achieved
No. of States (SACS) implementing LWS	17	17
No. of Lead Agencies	14	13
No. of Districts implementing LWS	163	162
No. of District Resource Persons	326	294
No. of Link Workers	6,520	6,484
No. of Volunteers	1,63,000	1,90,379

Table: 4.2: State-wise Details of Lead Agencies and District coverage

Sl. no.	State	Lead Agency	No. of Target Districts	No. of LWS Districts on Board
1	Andhra Pradesh	Child Fund India	19	19
2	Bihar	TCIF	8	8
3	Chhattisgarh	CARD	4	3
4	Gujarat	CARITAS	12	12
5	Jharkhand	NA#	3	3
6	Karnataka	KHPT	8	8
7	Madhya Pradesh	^	12	12
8	Maharashtra	KHPT	25	25
9	Manipur	SPYM	9	9
10	Mizoram	SPYM*	3	3
11	Odisha	Action Aid	6	6
12	Punjab	NA#	2	2
13	Rajasthan	Aid et Action	6	6
14	Tamil Nadu	VHS	21	21
15	Tripura	SPYM*	2	2
16	Uttar Pradesh	HLFPPT	12	12
17	West Bengal	CINI	11	11
	Total		**163**	**162**

*Lead Agency for Mizoram and Tripura is same
#NA - Not Applicable: No Lead Agency < 3 districts
^No Lead Agency on board

by sensitising masses on fundamental aspects of HIV transmission and creating linkages with existing available services. Reaching the difficult-to-reach population with HIV messages, Counseling and services, it has established community support structures like Village Information Centres, RRCs and Condom Depots which help to adopt safe behaviours and practices.

The programme team had to work within the constraints that presented themselves on account of the inherent socio-cultural, and political dynamics of the region. Taking the example of North-Eastern States, reaching to the HRGs, and vulnerable population in NE States still remains a challenge due to difficult terrain, poor connectivity and lack of proper monitoring mechanisms.

STI/RTI CONTROL AND PREVENTION

5

Sexually Transmitted Infections (STI) and Reproductive Tract Infections (RTI) enhance chances of acquiring and transmitting HIV infection manifold. Hence control and prevention of STI/RTI is one of the key prevention strategies for HIV. Early diagnosis and appropriate and complete treatment of STI/RTI reduces the transmission rate of HIV infection by more than 40%. Control and prevention of STI/RTI also facilitates reduction of reproductive morbidity and improves quality of life especially among women and adolescents. Syndromic case management, with minimal laboratory tests, is the cornerstone of STI/RTI management under the Department of AIDS Control.

An estimated 3 crore episodes of STI/RTI occur every year in the country. The target of NACP was to manage around 68 lakh episodes of STI/RTI in 2013-2014, which has been achieved.

The STI division of DAC is managed by DDG (STI) with the support of ADG (STI), technical experts and a programme officer. There are 34 SACS STI focal persons and 10 STI Programme Officers in Technical Support Units in the country to oversee programme implementation in respective States.

PROGRESS OF STI/RTI SERVICES

Expansion of STI/RTI Service in Government Health Facilities

Presently there are 1,131 Designated STI/RTI Clinics (DSRC) supported by the Department of AIDS Control, with at least one DSRC per district in the country. The two arms of DSRC are Obstetrics & Gynaecology OPD and STI OPD under Dermato-Venereology clinic. These DSRC provide services through the existing public healthcare delivery system. DAC supports these clinics to provide quality STI/RTI services through audio-visual privacy, provision of furniture and instruments for conducting internal examination, provision of central supply of colour coded STI/RTI drug kits for syndromic case management, RPR kits for Syphilis testing, consumables for conducting basic laboratory tests and computers for maintaining records and for monthly reporting through Strategic Information Management System. Each of these clinics is also provided with one trained counsellor.

A total of 67.68 lakh (97.98%) STI/RTI cases have been managed against the target of 68 lakh in the year 2013-2014. A total of 23,33,450 RPR tests were conducted among attendees of DSRCs, of which 14,507 (0.62%) tests were reactive. Patients referred to Integrated Counseling and Testing Centres (ICTC) for HIV Counseling and testing numbered 15,14,475, of whom 18,959 (1.25%) tested positive for HIV. Among the pregnant women attending antenatal care, 22.58 lakh were screened for syphilis, 949 (0.04%) who tested positive were provided treatment.

Pre-packed STI/RTI colour-coded kits

The pre-packing of STI/RTI drug kits has helped to standardise treatment. Colour-coded STI/RTI kits have been provided for free supply at all government STI/RTI clinics and TI NGOs. These colour-coded drug kits are procured centrally by DAC and dispatched to all SACS

DAC-NHM Convergence Meeting in North-East, Feb 2014

STI/RTI colour coded drug kits

and district level consignees, and are being distributed to facilities for use. Pre-packaging of the drugs is being recognised as a global innovation in STI programme management. States have also been provided specifications of the same to facilitate procurement at their end.

To mitigate stock-out of colour-coded drug kits, all SACS were instructed to ensure availability of generic medicines to treat common STI/RTI syndromes at health facilities. These drugs were also included in National/State List of Essential Drugs.

Regional STI/RTI Training, Research and Reference Laboratories

There are seven functional Regional STI Training, Reference and Research Laboratories, supported & strengthened by DAC. These are located in the hospitals as follows:

1) Osmania Medical College, Hyderabad
2) Medical College, Kolkata and Institute of Serology, Kolkata
3) Government Medical College, Nagpur
4) Government Medical College, Baroda
5) Institute of Venereology, Chennai
6) Maulana Azad Medical College, New Delhi
7) Safdarjung Hospital, New Delhi

Safdarjung Hospital, New Delhi acts as the Apex Centre as well as Regional Laboratory for the country.

The key function of these laboratories is to provide etiologic diagnosis of common STI/RTI syndromes, validation of syndromic diagnosis, monitoring of drug sensitivity of gonococci and implementation of EQAS for Syphilis testing. The operational research protocols of Hyderabad, Baroda and Nagpur centres were approved by DAC R&D TRG and Ethics committee, and thereafter these centres were instructed to roll-out the activity. The centres will be mentored with support from CDC through FHI360.

Based on recommendations of STI-TRG and the evaluation team a national mentoring committee has been set up to strengthen and oversee the functioning of these centres and to monitor operational research activity. The operational guidelines for these centres along with a standardised laboratory manual for laboratory diagnosis of STI/RTI have been prepared in 2013-2014.

In addition 45 State STI Training and Reference Laboratories have been identified and their staff trained. DAC is in the process of scaling up the number of Regional STI Training Research and Reference Laboratories from seven to ten laboratories. These centres function under the mentorship of linked regional STI laboratories to implement the STI surveillance protocol.

Community-based STI/RTI Prevalence study

DAC, with support from CDC and other partners, is planning to conduct the second round of community-based prevalence study

to assess the national level burden of STI/RTI. ICMR institutes (NARI, NIE, NIMS) are actively participating in this study. The protocol has been finalised after a series of consultative meetings.

Training and Capacity Building and regular on-site mentoring of STI/RTI service providers

Standardised training curriculum for doctors, staff nurses, laboratory technicians and counsellors are in place. The training to these staff is provided in a cascade form through a cadre of National, State and regional resource faculties across all States. All faculty members have been trained using the same training material, following adult learning methods. The State and regional resource faculties have in turn conducted trainings of STI/RTI clinic staff at the designated clinics and TI-NGOs. A total of 3,765 personnel were trained including 1,146 doctors, 542 staff nurses, 470 laboratory technicians, 495 counsellors and 1,112 preferred providers in 2013-2014.

Each of the districts also has district resource faculties for training doctors, nurses and laboratory technicians on STI/RTI management for sub-district health facilities (PHC, CHC, sub-divisional hospital). A total of 3,414 persons were trained in 2013-2014 including 1,096 doctors, 1,776 staff nurses and 542 laboratory technicians at sub-district health facilities.

Integration of STI elements has been done for trainings of FICTC ANM and laboratory technicians of ICTC, wherein the related curriculum has been incorporated into their existing curriculum so as to make service delivery comprehensive. A total of 2,740 FICTC ANMs were trained in 2013-2014.

Convergence with NRHM

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

Convergence has been strengthened at the national level through constitution of a joint working group and development of a national operational framework for STI/RTI services delivery at sub-district health facilities. National operational guidelines and training modules for medical officers and paramedical staff for STI/RTI services have been developed jointly and disseminated. A joint convergence meeting between DAC and NHM is conducted once every quarter. STI elements have been integrated in the training module for nurses and an integrated package of STI/HIV training is imparted by Indian Nursing Council for nursing staff as per the standardised curriculum.

Provision of STI/RTI Services to the High Risk Group

The provision of a standardised package of STI/RTI services to the HRG population is an important component of the Targeted Intervention projects The HRG population receive packages of services which include the following:

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

Preferred Private Provider approach has been rolled-out to scale-up STI/RTI services to HRG populations under TI Projects. These providers are selected by community members through group consultations. This approach has enhanced access to services for HRGs. Under this approach, all HRGs receive free STI/RTI treatment and the providers receive a token fee of Rs. 50 per consultation. A total of 3565 preferred providers are providing STI/RTI services to the HRG. All these preferred providers are trained using a standardised curriculum on Syndromic Case Management. Colour-coded STI/RTI drug kits have also been

National Consultative Workshop for formulating the strategy on 'Elimination of parent to child transmission of Syphilis', New Delhi, December 2013

made available to these providers for free treatment of sex workers, MSM and IDU, and data collection tools are also provided to them. A total of about 26.8 lakh visits have been made by HRGs and 17 lakh regular medical check-ups have been conducted. The involvement of private practitioners for providing STI services to HRGs at such a large scale is one of the few globally successful initiatives.

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

A major proportion of patients with STI/RTI seek services from the vast network of private healthcare delivery systems ranging from freelance private practitioners to large public hospitals. Also, many groups of population are accessing services from public healthcare systems under other sectors like railways, ESI, armed forces, CGHS, railways, port hospitals as well as health facilities of Public Sector Undertakings like Coal India Ltd, SAIL etc. It has been felt that reaching out to maximum numbers of people suffering from STI/RTI is not possible without partnership with private sector and organised public sectors. DAC has initiated partnerships with organised public and private sectors through professional associations to support the delivery of STI/RTI services with the objective of reaching the populations presently not covered by the public healthcare delivery system. STI/RTI services have been rolled-out in major port hospitals, ESIC, private medical colleges. A total of 1.07 lakh patients were reported to be managed through this sector during 2013-2014.

New Strategy on Elimination of Parent to Child Transmission of Syphilis

The Department of AIDS Control in collaboration with the Maternal Health Division of the Ministry of Health & Family Welfare, and WHO/SEARO has led development of new national strategy towards Elimination of Parent to Child Transmission of Syphilis. A National Expert Consultation Workshop on Elimination of parent to child transmission of Syphilis was organised at New Delhi during 19-20 December, 2013. A total of 43 delegates from different States of India including the international agencies, research institutes, civil society, medical colleges, and professional bodies participated in this consultation and provided their valuable inputs towards development of the National Strategy for Elimination of parent to child transmission of Syphilis.

CONDOM PROMOTION 6

Condom promotion has been the mainstay of HIV/AIDS prevention under the National AIDS Control Programme (NACP). The fact that 'unprotected sex is the biggest cause of HIV transmission' has prompted DAC to promote condom use as one of the important preventive tools in its fight against AIDS. Significant efforts have been made by DAC to promote consistent use of condoms for preventing HIV transmission in terms of enhancing the availability and accessibility of condoms, raising awareness and increasing condom offtake from retail outlets.

Condom promotion stall in a rural Mela in Chhattisgarh

A national level initiative on condom promotion was launched by DAC under NACP III as Condom Social Marketing Programme (CSMP). This targeted programme, implemented since 2008 through the Technical Support Group, for Condom Promotion has helped immensely in breathing life into the stagnant growth in the condom market. The thrust areas under the programme have been to expand the social marketing programme to saturate coverage in districts characterised by high HIV prevalence and/or high family planning needs and to increase the demand for condoms among high risk groups, bridge population and general population. It also works toward minimising wastage in free supply of condoms; developing innovative approaches in promoting condom use and maximising its access among the most vulnerable groups.

TARGETED CONDOM SOCIAL MARKETING PROGRAMME

DAC has successfully implemented its targeted Condom Social Marketing Programme in a total of 15 States in 2013-2014. In 11 States, DAC rolled out the new phase of CSMP from 5 December, 2013 after concluding the previous phase of the programme on 4 December, 2013.

On the basis of HIV prevalence and Family Planning needs, the districts have been mapped and classified into four categories - High Prevalence High Fertility (HPHF), High Prevalence Low Fertility (HPLF), Low Prevalence High Fertility (LPHF) and Low Prevalence Low Fertility (LPLF). This year the coverage for CSMP implementation was spread across 222 districts i.e. 42 HPHF, 45 HPLF and 135 LPHF districts in 11 States under the programme.

Under the present DAC Condom Social Marketing Programme, the total condom sale during this year has been recorded as around 56.45 crore pieces, till March 2014. This achievement was made by servicing more than 5.17 lakh outlets spread over all programme States during this period.

Targeted CSMP focuses on providing easy accessibility of condoms and hence takes steps to ensure the same in all situations by making it available at non-conventional shops like petrol pumps, barber-shops, wine-shops, PDS shops, dhabas, lodges etc. The coverage and sustainability of non-traditional outlets is increasingly enhanced as they facilitate easy accessibility of condoms in rural and far-flung areas.

Condom promotion banner in weekly haat in Muzaffarnagar, Utter Pradesh

The programme also has a focus on saturation of all the high-risk areas, i.e. trucker's halt points and TI areas. All kinds of condom selling outlets located around these high-risk areas are also covered in the systematic approach under CSMP.

WEEKLY TRACKING OF FREE CONDOMS

NACP envisaged supplying free condoms to high-risk populations or those who could not afford buying condoms. Towards this, optimising free condom supply has been a key mandate of the Technical Support Group (TSG) to ensure availability of free condoms to the target population and minimise wastage. TSG has been working to optimise free condom supply by implementing the following steps:

- Effective demand estimation of free condoms
- Monitoring free condom distribution
- Regular tracking of free condom supply chain

TSG successfully streamlined the free condom estimation process by introducing a scientific formula-based estimation for TI NGOs and other free condom distribution components of DAC.

It was observed that in some instances, although sufficient stocks of free condoms were available across the country, the facilities distributing them were often out of stock. To address the issue and ensure regular availability of free condoms at the TI NGOs, who are the major distributors of free condoms, TSG initiated weekly tracking of the free condom stocks at individual TI-NGO level.

Figure 6.1: Quarterly Average of TI free condom reporting vs reported Stock-out during 2013-2014

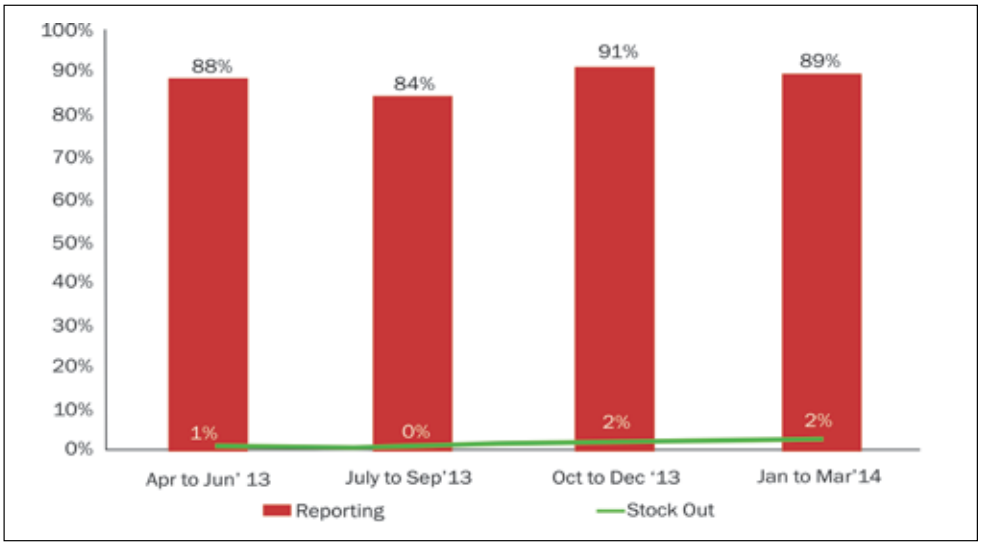
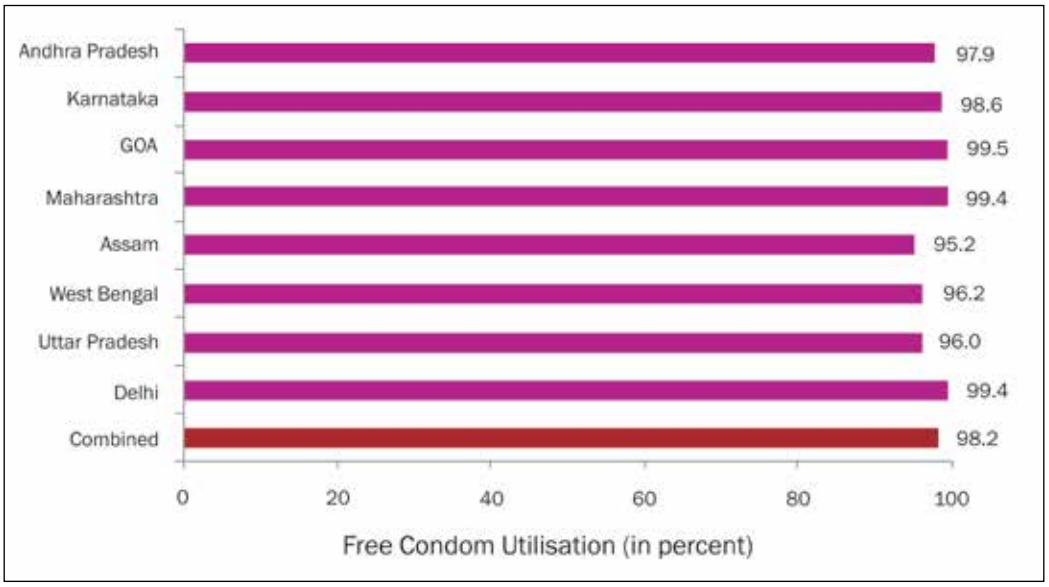


Figure 6.2: Free condoms utilisation by HRGs (Received vs. Used from PE)



These measures have resulted in significantly bringing down the incidences of stock out or excess free condom stocks at TI-NGOs or other free condom distribution centres. Weekly free condom reporting also led to reduction in wastage, efficient distribution, better inventory and supply chain management of free condoms at SACS and TI levels. This contributed to the overall reduction of annual free condom demands of DAC.

CONDOM DEMAND GENERATION

DAC promotes safe sex and regular condom use through its campaigns on mass media. These condom promotion campaigns on mass media are launched on national networks of Doordarshan, leading Cable and Satellite channels, All India Radio and private FM channels. This year, two mass media campaigns were released on national scale in Hindi and other regional languages, in the months of August 2013 and February 2014. The digital cinema screening platform was also included in the condom campaign media plan to reach out to the target population through cinema halls of smaller towns. Only those cinema halls were shortlisted which are located in programme districts. DAC followed its strategic communication framework and aired the condom promotion campaigns based on the theme of enhancing self-risk perceptions among the target audience. Similarly, mid-media activities organised by Social Marketing Organisations to promote consistent condom use in all programme States also used this theme.

In order to increase condom use, various demand generation activities were organised under DAC CSMP across all programme States. Motivating behaviour change among the target population is the key objective, which is to result in creating an enabling environment that encourages consistent condom use. With the help of these activities, condom use is promoted for its triple protection benefits against HIV/AIDS, STI and unwanted pregnancy. These activities were organised in the form of street plays, road shows, magic shows and interpersonal communication etc. to engage and motivate high risk groups, bridge population as well as general population especially in rural areas to encourage adoption of safe sex practices through consistent condom use.

Apart from these regular promotional activities, various unique and innovative promotional activities were also conducted during this year. A pioneer, month-long soccer tournament branded by Deluxe Nirodh brand of condoms was organised in Goa. Free helmets branded with key promotional messages to encourage

Helmet with condom promotion message for free distribution to bike-taxi pilots in Goa

Condom promotion during Carnival parade in Goa

First Deluxe Trophy soccer tournament in Goa to promote condom use

Condom Man ki Baarat in Karnal, Haryana

condom use, were distributed among the bike-taxi pilots in Goa. The participation of the condom promotion team in the biggest carnival of the country in Goa won them a consolation award. Condom Man ki Baarat activities undertaken in Haryana and Chandigarh were appreciated well by the general population as well as the media fraternity.

Condom Promotion Newsletters were published on quarterly basis and distributed among all stakeholders to disseminate latest information and progress made under DAC CSMP. In the next step to this platform and as a first, Condom Bulletin Boards were installed at SACS offices across programme States to help sharing of updates and information related to the condom programme.

Considered as one of the most important elements under DAC CSMP, the condom retailer community was also involved and motivated as they play the crucial role of consumer interface facilitating condom purchase action. Sensitising retailers through normalisation sessions and motivating them to stock condoms formed an integral part of the demand creation process.

Regular trade promotional schemes and activities were implemented to motivate retailers to sustain condom stocking. They were encouraged to help consumers in normalising condom purchase. Discussions were held with retailers during dealers meets and their concerns related to condom supply and distributions were addressed.

CONDOM TRAINING MANUAL

A training manual on condom promotion was developed for TI NGOs and CBOs. This comprehensive document is designed exclusively to provide guidelines and road map to the TI NGOs and CBOs towards effective implementation of condom training programme. It would reach out to the TIs for training the Project Managers, Counsellors, M&E Officers, ORWs and PEs to enhance their knowledge and bring clarity in their roles and responsibilities in condom promotion programme. This manual also provide guidelines about scientific forecasting of condom demand, effective distribution of condoms to maximise the use of condom and inventory management. Besides, it will help to build the confidence of TI staff in addressing the key barriers in condom usage dispelling myths and misconceptions associated with condom use.

Regular induction and orientation sessions were organised to impart knowledge, information and the best practices with the staff of CSMP implementing agencies to enhance their capacities. Refresher trainings and skills development programmes were also conducted among grassroots level functionaries and TIs staff as capacity building exercises towards condom promotion.

Branded mobile condom promotion set up on camel cart in Gujarat

ONLINE REPORTING OF TSG FIELD TEAM

SMM online reporting was introduced to add more value in this monitoring system for CSM Programme. This is expected to contribute in following ways:

- To ensure transparency of observations and feedbacks
- To strengthen SMMs monitoring towards better productivity
- In properly documenting the SMM working
- To facilitate authenticate users with its access from anywhere and anytime
- To track progress on feedbacks and bring closure for the observations made

BLOOD TRANSFUSION SERVICES 7

The Department of AIDS Control has been primarily responsible for ensuring provision of safe blood for healthcare and proper functioning of the health system in the country. DAC supported blood banks are functional across the country in over 600 districts. The availability of safe blood has increased from 44 lakh units in 2007 to 99 lakh units by 2013-2014; and during this period the incidence of donor HIV sero-positivity has declined from 1.2% to 0.2% in DAC supported blood banks.

The annual requirement of blood for the country was estimated at 12 million units, of which DAC had a target of collecting 55 lakh units through the network of DAC supported blood banks in 2013-2014. The endeavour was to meet the blood needs of the country with voluntary non-remunerated donations, through a well-coordinated Blood Banking Programme. In 2013-2014, a total of 57 lakh units were collected and 84% of this was through voluntary blood donation.

Key strategies for the Blood Transfusion Service programme under NACP-IV are:

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

CURRENT SCENARIO

The blood transfusion services supported by DAC comprise a network of 1,137 blood banks, including 258 Blood Component Separation Units (BCSU) and 34 Model Blood Banks. DAC has supported the establishment of component separation facilities and also funded modernisation of all major government and charitable blood banks at State and district levels. Besides enhancing awareness about the need to access safe blood and blood products, DAC has supported the procurement of equipment, blood bags, test kits and reagents as well as the recurring expenditure of government blood banks and those run by voluntary/charitable organisations, which were modernised.

Practice of appropriate clinical use of blood amongst the clinicians has seen a definite rise due to the increased component preparation and usage during seasonal epidemics, and training of clinicians on the rational use of blood. At present, component separation in DAC supported Blood Component Separation Units is around 60%.

BLOOD COLLECTION

Voluntary Blood Donation Programme

It has been recognised world over that collection of blood from regular (repeat) voluntary non-remunerated blood donors should constitute the main source of blood supply. Accordingly, activities for augmentation of Voluntary Blood Donation (VBD) have been taken up as per guidelines on voluntary blood donation. A total of 68,453 VBD camps were conducted, collecting 28 lakh blood units in 2013-2014.

Voluntary blood donation, including family blood donors, has reached up to 84% in 2013-2014 from baseline of 54.4% at the beginning of NACP-III in 2007. Several activities to promote public awareness of the need for voluntary blood donation have been undertaken in collaboration with Red Cross and various Blood Donor Organisations. District-wise training programmes are running in the States to train the motivators and sensitise them. Special days such as World Blood Donor Day and National Voluntary Blood Donation Day are observed at National and State levels recognising the contribution of non-remunerated repeat voluntary blood donors.

Scheme for Modernisation

Scheme for modernisation of blood banks has been an integral part of all phases of NACP through provision of one-time equipment grant to DAC supported blood banks for collection, testing and storage, as well as annual recurrent grant for support of manpower, kits and consumables. Total number of DAC supported blood banks has increased from 1,118 in 2012-2013 to 1,137 in 2013-2014.

Model Blood Banks

Model Blood Banks help to improve the standards of blood transfusion services and function as demonstration centres for the States. During 2013-2014, 34 model blood banks continued to function across the country. A total of 32 State-of-the-art blood mobiles were made available to improve VBD in the States. Approximately one third of VBD collection is occurring with the help of such mobiles.

Blood Component Separation Units

In order to promote rational use of blood, the Blood Component Separation Units (BCSU) have been established as an active part of Blood Transfusion Services. During 2013-2014 an additional 83 BCSU have been included under DAC support, increasing to total number of 258 BCSU across the country. These BCSU are working in their respective States and the proportion of blood units processed for component separation increased from 47% to 59% over the last financial year. Around 37 lakh blood units have been collected during this time period.

Major Blood Banks and District level Blood Banks

Government and charitable blood banks collecting less than 5000 units per year are supported as Major Blood Banks and District level Blood Banks in various districts of India. By the end of 2013-2014, 180 Major Blood Banks and 665 District level Blood Banks existed in the country. With increasing blood collection and blood component usage, some Major Blood Banks and District level Blood Banks have been upgraded to BCSU.

ACCESS TO SAFE BLOOD

India, represented by Secretary DAC, was among the 51 countries in the WHO high-level policy maker's forum on "Achieving Self-sufficiency in Safe Blood and Blood Products based on Voluntary Non-Remunerated Donation" held in Rome, Italy in October 2013. The "Rome Declaration" was signed by 153 signatories including representatives of Ministries of Health, National Blood Programmes, National Blood Transfusion Services, National Public Health Agencies, National Regulatory Bodies,

National Plasma Fractionation Institutes, representatives of International Inter-governmental NGOs and experts in Transfusion Medicine.

Ensuring access to safe blood is a key priority and aims at making blood availability close at hand for all those who need it. The Department is working closely with National Health Mission (NHM) to address issues pertaining to blood access in underserved areas. All States have been guided to improve blood access through networking transfusion services and creation of blood banks/ blood storage areas in underserved areas.

Blood Storage Centres

NHM and DAC have coordinated to have Blood Storage Centres (BSC) in the First Referral Unit. NHM provides the requisite infrastructure, manpower and procures the necessary equipment for storage and issue of blood. A linkage plan has been drawn by the respective SACS to facilitate the FRUs. At present, there are 745 Blood Storage Centres functioning across the country.

Blood Transportation Vans

Blood needs to be transported under proper cold chain maintenance from the linked mother Blood Banks to the Blood Storage Centres. Each mother blood bank is linked to 6-8 BSCs in order to supply blood units under proper conditions and storage. DAC had taken the initiative to provide 250 refrigerated Blood Transportation Vans to the Regional Blood Transfusion Centres/District Level Blood Banks during NACP-III, which are currently being maintained through provisioning of fuel and manpower cost. These vans transfer blood units to the BSC on a regular basis and also on demand/emergency situations.

CAPACITY BUILDING

Education and training is fundamental to every aspect of Blood Transfusion Services. 17 centres have been identified across the country as training centres to impart training on all aspects of Blood Transfusion Services involving Blood Bank Medical Officers, Technicians, Counsellors, Nurses, Clinicians, Donor Motivators and Programme Officers of SACS. The objectives of the Blood Transfusion Services training programme are as below:

- To strengthen national capacity in education and training in all aspects of blood transfusion; and voluntary blood donation
- To support the establishment of sustainable national education and training programmes in blood transfusion
- To strengthen inter-regional and intra-regional collaboration in training in blood transfusion between DAC and its collaborating centres, national blood transfusion services, education and training institutions and NGOs

PROGRAMME MANAGEMENT

With a large network of Blood Banks and Blood Component Separation Facilities in the country, it is essential to monitor and supervise various activities undertaken in blood transfusion services.

Supervisory Visits to DAC supported Blood Banks

A core team has been constituted in every State to carry-out periodic supervision of all DAC supported blood banks and voluntary blood donation camps. This core team comprises of blood transfusion experts and representatives from, State AIDS Control Societies, State Drug Control Departments and State Blood Transfusion Councils.

National Blood Transfusion Council

The 24th National Blood Transfusion Council (NBTC) governing body meeting was held in January 2014. The important decisions of the meeting were as follows:

- The expert group on Nucleic Acid Amplification Testing (NAAT) in its report recommended that NAAT test should not be made mandatory for all licensed

blood banks across the country. Due consideration was taken so that NAAT does not eliminate the detection of HIV infection in the window period. Additional operational difficulties due to turnaround time and change in regulatory framework were also indicated as detriments. This was accepted by the Gujarat High Court and formed the basis of the judgment of PIL 156 by the Gujarat High Court.

- Processing charges for blood and blood products across the government supported blood banks, NGOs, and private sector

Blood Component	Government Sector	Non-Government Sector
Whole Blood	Rs. 1050/- per unit	Rs. 1450/- per unit
Packed Red Cells	Rs. 1050/- per unit	Rs. 1450/- per unit
Fresh Frozen Plasma	Rs. 300/- per unit	Rs. 400/- per unit
Platelet Concentrate	Rs. 300/- per unit	Rs. 400/- per unit
Cryoprecipitate	Rs. 200/- per unit	Rs. 250/- per unit

were revised. Due consideration was given to baseline and advanced methodology. Minimum processing charges are as follow:

- Platelet apheresis should not exceed Rs. 11,000 per unit in non-government blood banks. Additional processing charges have been detailed out if advanced technologies are being used. The details have been updated on the DAC website.
- An executive committee of NBTC has been created to act for and carry-out all activities on behalf of the governing body and for taking all decisions and exercising all the powers vested in the governing body.

NEW INITIATIVES

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

To improve blood transfusion services in the country, a proposal was approved by Cabinet Committee on Economic Affairs, to set up four Metro Blood Banks as Centres of Excellence in Transfusion Medicine in the cities of New Delhi, Mumbai, Kolkata and Chennai.

Due to cost and time overrun, preparation of a revised proposal was necessitated. The revised proposal has been concurred by the Project Steering Committee, approved by the Standing Committee on time and cost overruns, and appraised by Project Appraisal Management Division/ Planning Commission and submitted for reconsideration by EFC.

Plasma Fractionation Centre

One Plasma Fractionation Centre with processing capacity of more than 1.5 lakh litres of plasma to fulfil the country's demand, was approved under NACP-III. The State Government of Tamil Nadu provided land to DAC for the purpose of setting up the Plasma Fractionation Centre.

The project is technologically advanced and capital intensive in nature. It involves engagement of various stakeholders including private sector. Keeping in view that a large volume of unutilised plasma is being discarded, the plasma policy was formulated as an addendum to the national blood policy, and has been submitted for consideration of the Technical Resource Group.

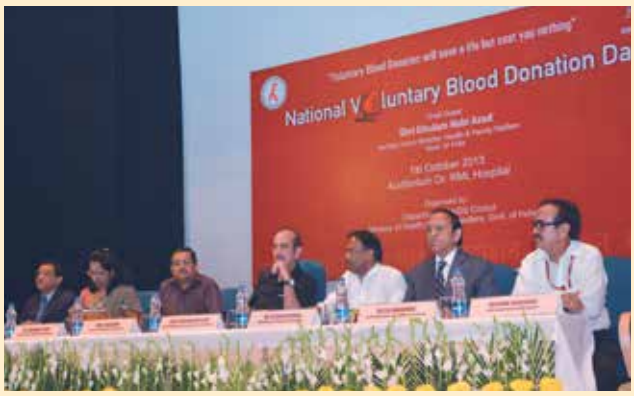
As there is very limited capacity to process such plasma in the public sector, the Department has approved engagement of contracted fractionators.

Project for strengthening blood transfusion service

DAC is receiving technical assistance from Centre for Disease Control – Department of Global HIV & AIDS (CDC-DGHA), through a cooperative agreement with Christian Medical Association of India (CMAI) for five years. A rapid situation analysis and desk review was conducted as part of the project to understand the current scenario of BTS across the country.

Voluntary Blood Donation Camp on 1 October, 2013

Shri Ghulam Nabi Azad, Union Health Minister, inaugurated the Voluntary Blood Donation Camp at Dr. Ram Manohar Lohia Hospital, New Delhi on 1 October, 2013. This was followed by the Sensitization Workshop titled "Safe Blood for All" organized as a special initiative of DAC. This effort of DAC is the first of its own kind as around 100 officials from a single department donated blood on a single day. Even officials from other departments came forward to donate blood. Ms Olivia Culpo, Miss Universe 2012, graced the occasion and complimented the Government of India for its AIDS control programme. She also called upon the youth to come forward to donate blood and save more lives.



Inauguration of Voluntary Blood Donor Day 1 October 2013

HFM & DAC Officials interact with Media

BASIC SERVICES DIVISION 8

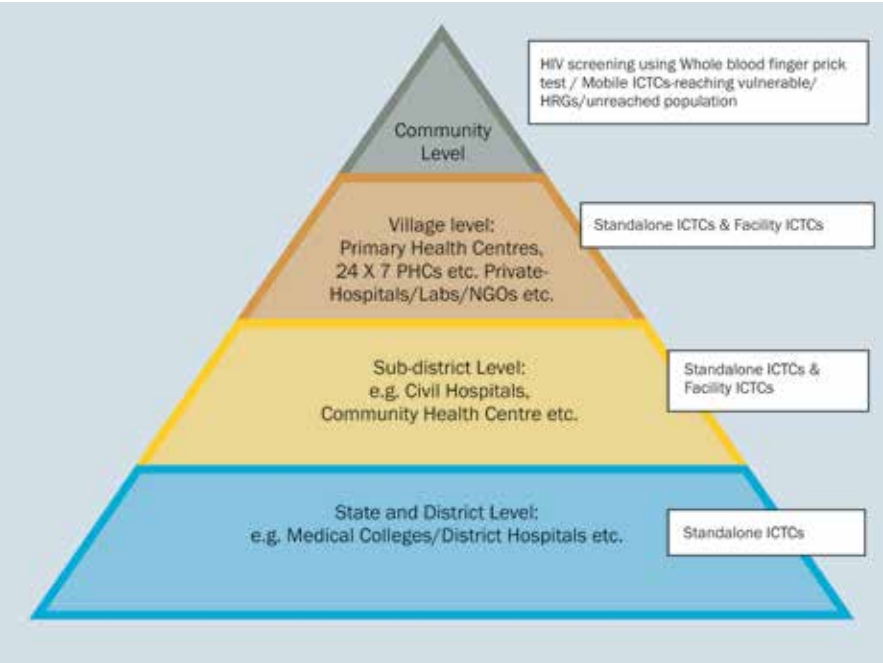
The Basic Services Division of the Department of AIDS Control provides HIV Counseling and testing services for HIV infection, the critical first step in detecting and linking people with HIV to access treatment cascade and care. It also provides an important opportunity to reinforce HIV prevention. The national programme is offering these services since 1997 with the goal to identify as many people living with HIV, as early as possible (after acquiring the HIV infection), and linking them appropriately and in a timely manner to prevention, care and treatment services. The introduction of ART services for people living with HIV/AIDS in 2004, gave a major boost to Counseling and testing services in India. The HIV Counseling and testing services include the following components:

1. Integrated Counseling and Testing Centres (ICTC)
2. Prevention of Parent-To-Child Transmission of HIV (PPTCT)
3. HIV/Tuberculosis collaborative activities

INTEGRATED COUNSELING AND TESTING CENTRES

Diverse models of HIV Counseling and Testing services are available to increase access to HIV diagnosis; these include testing services in healthcare facilities, standalone sites and community-based approaches at various levels of public health systems in India from State, District, Sub-district and village/community levels as depicted in Figure 8.1.

Figure 8.1: Level of Service and HIV Counseling and Testing Services in India



Types of Facilities for HIV Counseling and Testing Services

Integrated Counseling and Testing Centre (ICTC): There are different types of HIV Counseling and testing services in India as described below. HIV Counseling and testing facilities have been rapidly scaled-up in India, as depicted in Figure 8.2. There is an increase in the number and proportion of F-ICTCs in the country and decrease in standalone ICTCs, clearly portraying integration of Counseling and testing services under general health services, increase in geographical coverage of these services below block level, better accessibility and addressing sustainability (Figures 8.2 & 8.3).

Figure 8.2: Scale-up of ICTCs during the period from 2007-2008 to 2013-2014

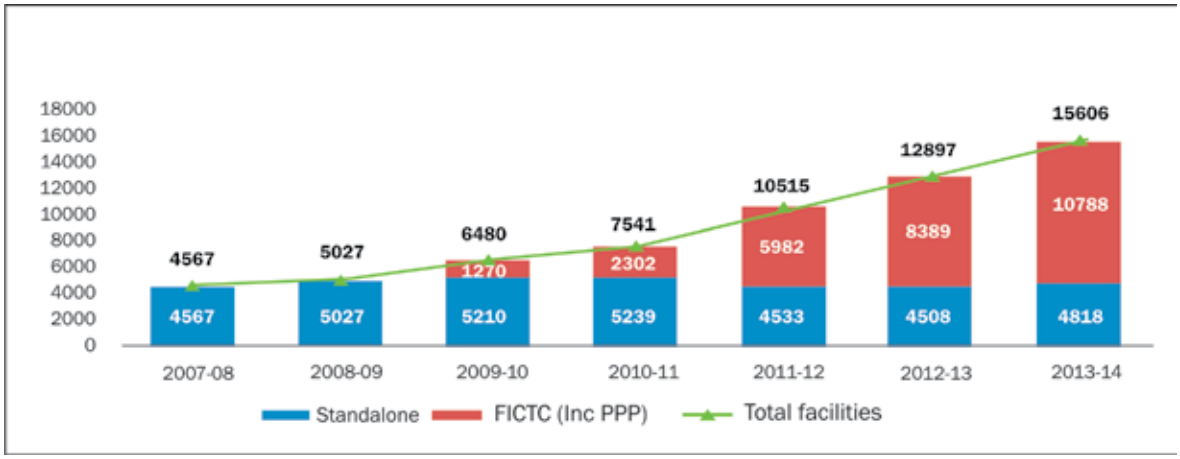
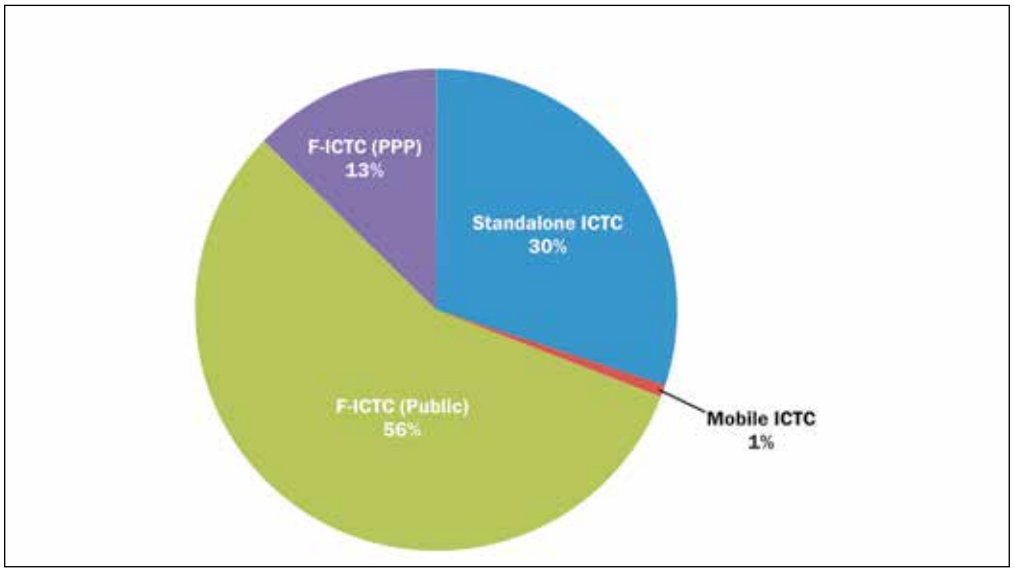


Figure 8.3: Proportion of types of HIV Testing Facilities in India, 2013-2014



Types of facilities for HIV Counseling and Testing Services

Integrated Counseling and Testing Centres (ICTC): A person is counselled and tested for HIV at ICTC, either of his own free will (Client Initiated) or as advised by a medical provider (Provider Initiated). Functions of ICTC include early detection of HIV, provision of basic information on modes of transmission and prevention of HIV/AIDS for promoting behavioural change and reducing vulnerability, and linking PLHIV with other HIV prevention, care and treatment services. The ICTC have been classified into two types: Fixed Facility ICTC and Mobile ICTC.

A. Fixed Facility ICTCs are located within an existing healthcare facility/hospital/health centre, and are of two types - Standalone ICTC and Facility-Integrated Counseling and Testing Centres.

   a. **Standalone ICTC (SA-ICTC):** The client load is high in these centres, with full-time counsellor and laboratory technician who provide HIV Counseling and testing services. SA-ICTC are located in Medical Colleges, District Hospitals, Sub-District Hospitals, CHCs etc.

   b. **Facility Integrated Counseling and Testing Centres (F-ICTCs):** Considering the need for rapid scale-up and sustainability of HIV Counseling and testing services, the F-ICTCs have been set up below the block levels at 24X7 PHC, etc. Staff of the existing health facilities are trained in Counseling and testing services of HIV. The HIV service delivery is ensured with logistic support from DAC. Similar to F-ICTC at 24X7 PHC, the Public Private Partnership (PPP)- ICTCs were established in private facilities (for profit /not-for-profit hospitals, laboratories, Non-Governmental Organizations etc.), and have been supported by DAC /SACS in supply of rapid HIV testing kits, training of existing staff, quality assurance, supply of protective kits and prophylactic drugs for post-exposure prophylaxis for staff, supply of IEC materials such as flip charts, posters, etc. required for ICTC.

B. **Mobile ICTC:** Mobile Counseling and Testing Centre is a van with a room to conduct general examination, Counseling and space for collection and processing blood samples by a team of paramedical healthcare providers (a health educator/ANM, Counsellor and Laboratory Technician). Mobile ICTC are set up as temporary clinics in hard-to-reach areas with flexible working hours and provide a wide range of services like Counseling and testing services for HIV, Syndromic management of STI/RTI and other minor ailments, along with regular health check-ups, antenatal, immunization services etc.

Community based HIV screening: In order to offer HIV testing to every pregnant woman in the country, so as to detect all HIV positive pregnant women and eliminate transmission of HIV from parent to child, the community-based HIV screening is conducted by frontline health workers (Auxiliary Nurse Midwives) at the sub-centre level.

Table 8.1: State-wise Distribution of ICTCs in India (as on 31 March 2014)

State	SA-ICTC	Mobile ICTC	F-ICTC	PPP- ICTC	Total
Andaman & Nicobar	13	0	10	0	23
Andhra Pradesh	379	26	1,624	265	2,294
Arunachal Pradesh	35	2	11	0	48
Assam	96	2	102	37	237
Bihar	207	1	250	8	466
Chandigarh	12	1	3	2	18
Chhattisgarh	111	3	206	11	331
Daman & Diu	4	0	0	0	4
Delhi	89	3	72	9	173
Dadra & Nagar Haveli	1	0	0	0	1
Goa	14	0	18	3	35
Gujarat	309	3	1,065	228	1,605
Haryana	98	0	86	19	203
Himachal Pradesh	63	2	50	2	117
Jammu & Kashmir	35	0	0	0	35
Jharkhand	76	3	180	3	262
Karnataka	447	12	965	213	1,637
Kerala	162	4	89	47	302
Lakshadweep	1	0	0	0	1
Madhya Pradesh	143	0	612	19	774
Maharashtra*	647	9	1,814	711	3,191
Manipur	54	6	32	12	104
Meghalaya	16	3	5	4	28
Mizoram	28	9	30	10	77
Nagaland	60	10	49	1	120
Odisha	226	1	169	14	410
Puducherry	12	0	12	4	28
Punjab	92	1	150	3	246
Rajasthan	246	0	284	26	556
Sikkim	13	1	14	0	28
Tamil Nadu	376	17	600	239	1,232
Tripura	19	0	49	2	70
Uttar Pradesh	309	0	105	71	485
Uttarakhand	49	1	129	10	189
West Bengal	252	4	26	4	286
India	**4,694**	**124**	**8,811**	**1,977**	**15,606**

* Includes Mumbai DACS

Counseling and Testing Services of General Clients

During 2013-2014, 130.3 lakh (96%) received Counseling and testing services against the annual target of 134.81 lakh general clients. State-wise number of general clients counselled and tested for HIV and sero-positivity detected during 2013-2014 is given in Table 8.2.

Table 8.2: State-wise number of General# Clients tested for HIV and sero-positivity detected during 2013-2014

State	No. of General# Clients Tested for HIV	No. of Clients found HIV Positive	Percentage of sero-positivity
Andaman & Nicobar Islands	13,863	25	0.2%
Andhra Pradesh	15,70,885	54,342	3.5%
Arunachal Pradesh	14,123	3	0.0%
Assam	1,17,727	1,060	0.9%
Bihar	3,53,035	8,907	2.5%
Chandigarh	48,277	777	1.6%
Chhattisgarh	1,62,394	2,840	1.7%
Dadra & Nagar Haveli	8,473	77	0.9%
Daman and Diu	2,867	85	3.0%
Delhi	3,00,685	6,523	2.2%
Goa	38,948	503	1.3%
Gujarat	9,39,669	12,958	1.4%
Haryana	3,03,106	4,107	1.4%
Himachal Pradesh	1,04,310	499	0.5%
Jammu and Kashmir	13,823	325	2.4%
Jharkhand	1,28,573	1,731	1.3%
Karnataka	16,61,004	29,461	1.8%
Kerala	3,55,657	1,616	0.5%
Madhya Pradesh	3,53,920	4,642	1.3%
Maharashtra	20,49,867	42,112	2.1%
Manipur	51,583	1,536	3.0%
Meghalaya	19,723	388	2.0%
Mizoram	37,856	1,028	2.7%
Nagaland	76,998	1,509	2.0%
Odisha	3,10,010	3,234	1.0%
Puducherry	66,235	625	0.9%
Punjab	1,79,202	4,277	2.4%
Rajasthan	5,06,677	7,459	1.5%
Sikkim	20,497	28	0.1%
Tamil Nadu	20,63,807	15,397	0.7%
Tripura	39,068	193	0.5%
Uttar Pradesh	6,42,211	12,473	1.9%
Uttarakhand	83,526	737	0.9%
West Bengal	3,92,005	6,749	1.7%
India	**1,30,30,604**	**2,28,226**	**1.8%**

excluding pregnant women

Counseling and Testing of High Risk Groups and STI Clinic Attendees

Intensifying and consolidating prevention services, with focus on HRGs and vulnerable populations is one of the key strategies of NACP IV. Guidelines on targeted interventions specify that all core groups and high risk groups should be tested for HIV once every six months. Table 8.3 depicts State-wise HRGs and STI Clinic attendees tested for HIV during 2013-2014.

Table 8.3: State-wise number of HRGs and STI Clinic attendees counselled and tested for HIV during 2013-2014

State / UTs	HRGs (core + bridge population) tested for HIV	STI Clinic attendees tested for HIV
Andaman & Nicobar Islands	0	83
Andhra Pradesh	3,10,963	71,900
Arunachal Pradesh	7,881	902
Assam	27,899	14,054
Bihar	14,960	20,807
Chandigarh	15,823	4,688
Chhattisgarh	30,040	7,135
Dadra & Nagar Haveli	0	287
Daman & Diu	996	519
Delhi	66,457	15,409
Goa	16,253	1,237
Gujarat	94,290	50,401
Haryana	43,921	38,918
Himachal Pradesh	15,682	4,683
Jammu & Kashmir	2,305	9
Jharkhand	13,242	19,554
Karnataka	1,58,672	59,323
Kerala	72,615	4,738
Madhya Pradesh	27,282	47,743
Maharashtra	2,66,031	65,341
Manipur	25,703	929
Meghalaya	2,635	2,587
Mizoram	14,949	622
Nagaland	27,062	1,626
Odisha	34,829	28,088
Puducherry	4,642	4,308
Punjab	34,117	26,079
Rajasthan	18,164	80,330
Sikkim	3,152	1,421
Tamil Nadu	1,15,949	1,31,369
Tripura	6,563	8,287
Uttar Pradesh	69,545	1,29,741
Uttarakhand	15,702	7,296
West Bengal	25,191	24,433
India	**15,83,515**	**8,74,847**

PREVENTION OF PARENT TO CHILD TRANSMISSION OF HIV

The Prevention-of-Parent-to-Child Transmission of HIV/AIDS (PPTCT) programme was started in the country in the year 2002. Currently there are more than 15,000 ICTCs in the country which offer PPTCT services to pregnant women. The aim of the PPTCT programme is to offer HIV testing to every pregnant woman (universal coverage) in the country, so as to cover all estimated HIV positive pregnant women and eliminate transmission of HIV from mother-to-child.

Mother-to-child transmission of HIV is the primary route of transmission for HIV among children. This transmission is known to occur during pregnancy, delivery and breastfeeding periods with equal frequency. It is estimated that without any intervention the risk of transmission of HIV from an infected mother to her child is between 20-45%. Global evidence suggests that although anti-retroviral prophylaxis with Single Dose Nevirapine (SD-NVP) is useful, it offers only partial protection against the vertical HIV transmission. Therefore, more efficacious multiple drug anti-retroviral (ARV) regimens are recommended to be started early during pregnancy and continued throughout pregnancy and delivery until cessation of breastfeeding. These regimens have the potential to dramatically reduce HIV transmission from mother-to-child to less than 5%.

In India, PPTCT interventions under NACP started in 2002 using SD-NVP prophylaxis for HIV positive pregnant women during labour and also for her new born child immediately after birth. With the Department of AIDS Control adopting "Option B" of the World Health Organisation (WHO) recommendations (2010), India has also transitioned from the single dose Nevirapine strategy to that of multi-drug ARV prophylaxis from September, 2012. This strategy was executed in the three southern high HIV prevalence States of Andhra Pradesh, Karnataka and Tamil Nadu. The National Strategic Plan for PPTCT services using multi-drug ARVs in India was developed in May-June 2013 for nationwide implementation in a phased manner. Based on the new WHO Guidelines (June 2013) and on the suggestions from the Technical Resource Groups during December 2013, Department of AIDS Control has decided to initiate lifelong ART (using the triple drug regimen) for all pregnant and breastfeeding women living with HIV, regardless of CD4 count or WHO clinical stage, both for their own health and to prevent vertical HIV transmission and for additional HIV prevention benefits.

In December 2013 the Basic Services Division released the "Updated guidelines for Prevention of Parent to Child Transmission of HIV using Multi-drug Anti-Retroviral Regimen in India" and the National Strategy Plan for its roll-out in a phased manner. The comprehensive PPTCT package of services is depicted below.

PPTCT Services

Detection of HIV Infected Pregnant Women and Children: A total number of 97.52 (74%) lakh pregnant women were tested for HIV during 2013-2014, against a target of 131.58 lakh. A total of 12,008 pregnant women were found to be HIV positive, out of which 10,085 (84%) Mother-Baby (MB) pairs were provided ARV prophylaxis for prevention of mother-to-child transmission.

Table 8.4 depicts the State-wise number of pregnant women counselled and tested for HIV, detected HIV positive and provided ARV prophylaxis during 2013-2014.

Based on the recommendations of WHO (2010), the more efficacious multi-drug ARV regimen was adopted as a policy for PPTCT in September 2012.

The Government of India is committed to work towards achievement of the global target of "Elimination of new HIV infection among children" by 2015. Based on the new WHO Guidelines (June 2013), the Department of AIDS Control has decided to initiate lifelong ART (triple drug regimen) for all pregnant and breastfeeding women living with HIV, regardless of CD4 count or WHO clinical stage, both for their own health and to prevent vertical HIV transmission and with additional

The Essential Package of PPTCT Services in India

The PPTCT services provide access to all pregnant women for HIV diagnostic, prevention, care and treatment services. As such, the key goal is to ensure the integrated PPTCT service delivery with the existing Reproductive and Child Health (RCH) programme.

- Routine offer of HIV Counseling and testing to all pregnant women enrolled into antenatal care, with an 'opt out' option
- Ensuring involvement of spouse and other family members, and move from an "ANC-Centric" to a "Family-Centric" approach
- Provision of life-long ART (TDF+3TC+ EFV) to all pregnant and breastfeeding HIV infected women, regardless of CD4 count and clinical stage of HIV progression
- Promotion of institutional deliveries of all HIV infected pregnant women
- Provision of care for associated conditions (STI/ RTI, TB and other Opportunistic Infections)
- Provision of nutrition, Counseling and psychosocial support for HIV infected pregnant women
- Provision of Counseling and support for initiation of exclusive breastfeeds within an hour of delivery as the preferred option and continued for 6 months
- Provision of ARV prophylaxis to infants from birth up to a minimum of 6 months
- Integrating follow-up of HIV-exposed infants into routine healthcare services including immunization
- Ensuring initiation of Co-trimoxazole Prophylactic Therapy (CPT) and Early Infant Diagnosis (EID) using HIV-DNA PCR at 6 weeks of age onwards, as per the EID guidelines
- Strengthening community follow-up and outreach through local community networks to support HIV-positive pregnant women and their families

HIV prevention benefits. This would also help in maximum coverage for those needing treatment for their own health, avoid stopping and starting drugs with repeat pregnancies, provide early protection against mother-to-child transmission in future pregnancies, reduce the risk of HIV transmission to HIV sero-discordant partners and improve maternal health. This regimen has the potential to dramatically reduce HIV transmission from mother-to-child to less than 5% as compared to 10-12%, using single dose Nevirapine. Henceforth all HIV positive pregnant women will be started on Tenofovir (TDF) 300mg + Lamivudine (3TC) 300mg + Efaviranez (EFV) 600mg lifelong, and all HIV exposed infants will be provided one dose of Syrup Nevirapine daily for a minimum of 6 weeks.

The National Strategic Plan for PPTCT and the Technical Guidelines for PPTCT have been updated to incorporate Global recommendations, and DAC has issued the policy to all States/UTs for nationwide implementation of the multi-drug regimen for PPTCT with effect from 1 January 2014.

The performance of the new PPTCT multi-drug ARV regimen in Andhra Pradesh, Karnataka and Tamil Nadu during April 2013-March 2014 is detailed in Table 8.5.

As part of the scale-up of PPTCT services across the country, Training of Trainers was conducted and the details are given in Table 8.6.

IL&FS ETS - PPTCT Outreach Programme: PPTCT outreach component is implemented under RCC-II of GFATM by IL&FS to minimise loss-to-follow-up of HIV positive pregnant women and to follow-up babies till the age of 18 months. An outreach worker (ORW) is preferably an HIV positive person (to understand and counsel the HIV positive pregnant women), who follows-up the mother and baby pair after delivery, maintains a daily dairy and updates the district co-ordinator on

Table 8.4: State-wise details of PPTCT services during 2013-2014 (till March 2014)

State	Testing Target of 2013-2014	No. of Pregnant Women tested for HIV	No. of Pregnant Women detected HIV Positive	Percent-age of HIV Sero-positivity	No. of MB pairs received SD-Nevi-rapine	Propor-tion of MB pair received SD-NVP
Andaman & Nicobar	7,949	4,955	4	0.1%	2	50%
Andhra Pradesh	16,00,000	10,93,870	2,388	0.2%	1,905	80%
Arunachal Pradesh	13,000	6,990	1	0.0%	0	0%
Assam	2,75,000	1,96,538	101	0.1%	79	78%
Bihar	8,00,000	3,01,524	416	0.1%	279	67%
Chandigarh	21,000	22,517	36	0.2%	20	56%
Chhattisgarh	2,25,000	1,11,257	169	0.2%	132	78%
Dadra & Nagar Haveli	7,500	7,242	11	0.2%	4	36%
Daman and Diu	4,000	2,037	8	0.4%	6	75%
Delhi	2,75,000	1,96,113	332	0.2%	293	88%
Goa	21,000	13,138	26	0.2%	26	100%
Gujarat	10,54,000	7,74,747	813	0.1%	810	100%
Haryana	2,50,000	2,16,180	265	0.1%	141	53%
Himachal Pradesh	60,000	46,570	27	0.1%	11	41%
Jammu and Kashmir	1,00,000	10,123	15	0.1%	8	53%
Jharkhand	2,25,000	96,039	82	0.1%	56	68%
Karnataka	12,90,000	11,72,894	1,445	0.1%	1,006	70%
Kerala	3,82,000	1,61,753	44	0.0%	59	134%
Madhya Pradesh	6,00,000	5,10,463	336	0.1%	231	69%
Maharashtra	16,70,000	15,76,921	1,814	0.1%	2,233	123%
Manipur	45,569	40,028	124	0.3%	182	147%
Meghalaya	35,000	21,577	71	0.3%	26	37%
Mizoram	26,000	18,880	132	0.7%	140	106%
Nagaland	25,000	19,588	163	0.8%	125	77%
Odisha	4,00,000	2,89,899	233	0.1%	180	77%
Puducherry	43,500	32,286	10	0.0%	31	310%
Punjab	3,00,000	1,62,784	260	0.2%	132	51%
Rajasthan	7,00,000	4,74,179	412	0.1%	383	93%
Sikkim	12,000	9,893	3	0.0%	9	300%
Tamil Nadu	11,00,000	9,76,969	1,256	0.1%	871	69%
Tripura	28,000	23,957	32	0.1%	18	56%
Uttar Pradesh	7,71,486	5,04,878	481	0.1%	384	80%
Uttarakhand	90,000	73,590	49	0.1%	19	39%
West Bengal	7,00,000	5,81,745	449	0.1%	284	63%
India	**1,31,58,004**	**97,52,124**	**12,008**	**0.1%**	**10,085**	**84%**

their daily/weekly progress. In the year 2013-2014, the ORWs followed up 8,783 mother and baby pairs after delivery in the country.. Presently, the PPTCT Outreach Programme is operational in 247 districts with 169 NGO partners, 2,352 Outreach Workers, 240 District Coordinators and 18 Counsellors. The outreach workers also support mobilisation of pregnant women for testing at ICTC. IL&FS ETS has piloted the mobile SMS technology as a means for reporting by the outreach workers. The ORWs report through mobile phones provided by IL&FS ETS. Currently, around 2,000 ORWs are reporting through the mobile based system.

Early Infant Diagnosis (EID): HIV exposed infants born to infected pregnant women have to undergo DNA-PCR tests using dried blood spot and whole blood specimen. The tests are done at 6 weeks of birth, repeated at 6 months if previous tests were negative and again after 12 months if the previous tests were negative (the third EID test should be undertaken after 6 weeks of stopping breastfeeds which may not happen exactly at 12 months, but any time after 6 months and before 13 months). Confirmation of HIV status is done using three rapid anti-body tests at 18 months at the ICTCs. Details on EID programme are mentioned in the Chapter on Laboratory Services.

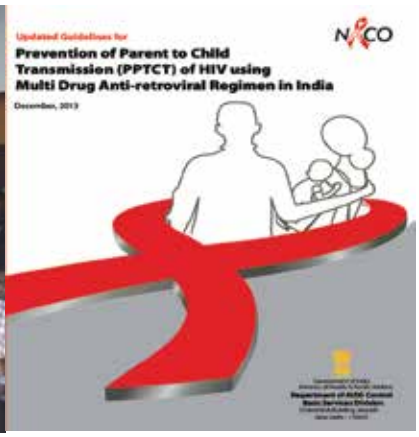
HIV/TB COLLABORATIVE ACTIVITIES

India has the highest Tuberculosis (TB) burden in the world with an estimated 2.2 million new TB cases occurring annually. TB is the commonest Opportunistic Infection (OI) in HIV-infected individuals. Also, HIV infection is a significant risk factor for acquiring TB infection and its progression to active TB. HIV/TB together is a fatal combination with extremely high death rates (15 to 18%) reported among HIV-infected TB cases notified under Revised National Tuberculosis Control Programme (RNTCP). Overall, TB is estimated to cause about 25% of all deaths among PLHIV in India. Early detection of HIV/TB cases and prompt provision of Anti-Retroviral Therapy (ART) and Anti-Tuberculosis Treatment (ATT) are key interventions to reduce mortality rates significantly.

National and international studies indicate that an integrated approach to TB and HIV services can be extremely effective in managing the epidemic. Since 2001, India has been implementing HIV/TB collaborative activities in increasing the universal access to prevention, early diagnosis, and treatment services in combating the threat of HIV/TB.

Table 8.5: Performance of the Cohort of PPTCT 'Option-B' Regimen in Andhra Pradesh, Karnataka and Tamil Nadu, during April 2013 – March 2014

State	Pregnant Women detected HIV positive	HIV positive pregnant women linked to ART	HIV positive pregnant women started on PPTCT new regimen	Number of live births from HIV positive pregnant women	Number of those babies tested for HIV (DBS)	Number of babies positive for HIV
Andhra Pradesh	2,388	2,195	2,138	1,778	1,206	21
Karnataka	1,445	1,268	1,185	766	390	10
Tamil Nadu	1,256 (includes 612 old cases)	1,230	871	675	545	10
Total	**5,089**	**4,693**	**4,194**	**3,219**	**2,141**	**41**



PPTCT TOT in progress on using lifelong ART for HIV positive pregnant women & Updated PPTCT Guidelines, December 2013 by Basic services Division Department of AIDS Control, India

Table 8.6: Status of PPTCT Trainings across India, as on March 2014

Phases of PPTCT Training	State/UT	Completed State level training programmes
Phase 1	Andhra Pradesh, Karnataka, Tamil Nadu and Puducherry	State level TOTs completed Cascade of training completed
Phase 2	Maharashtra, Mumbai, Goa, Gujarat, Dadra & Nagar Haveli, Daman & Diu, Odisha, Rajasthan, Madhya Pradesh	State level TOTs completed Cascade of training going on
Phase 3	Bihar, Chhattisgarh, Uttar Pradesh, West Bengal, Jharkhand	State level TOTs completed Cascade of training going on
Phase 4	Punjab, Kerala, Lakshadweep, Haryana, Chandigarh, Delhi, Manipur, Mizoram, Nagaland	State level TOTs completed Cascade of training going on

In 2008-2009, Department of AIDS Control and Central TB Division (Directorate General Health Services) jointly developed a National Framework for HIV/TB collaborative activities to address the intersecting epidemics. India is successfully implementing the framework called "Intensified TB HIV package" which emphasises increased HIV testing of TB patients, TB screening for PLHIV and prompt treatment for persons affected with HIV/TB. There is an encouraging increase in provision of Co-trimoxazole Prevention Therapy (CPT) and ART among HIV-positive TB patients.

To further strengthen the HIV/TB collaborative activities in the country during 2012-2017, DAC and Central TB Division jointly developed the 'National Framework for Joint HIV/TB Collaborative Activities' in November 2013, based on updated WHO HIV/TB policy recommendations and vision documents of both the national programmes NACP-IV and RNTCP National Strategic Plan. This was approved by National Technical Working Group (NTWG), and is a guidance tool for policy makers, programme managers, professionals at health facilities, health-care workers and partners.

The joint framework was developed to maintain close coordination between RNTCP and NACP at National, State and District levels, to decrease morbidity and mortality due to TB among persons living with HIV/AIDS, to decrease impact of HIV in TB patients and provide access to HIV related care and support to HIV-infected TB patients, and to significantly reduce morbidity and mortality due to HIV/TB through prevention, early detection and prompt management of HIV and TB together. The four pronged strategy summarised in Figure 8.4 is based on the foundation of strong collaboration between NACP and RNTCP.

HIV testing of TB patients

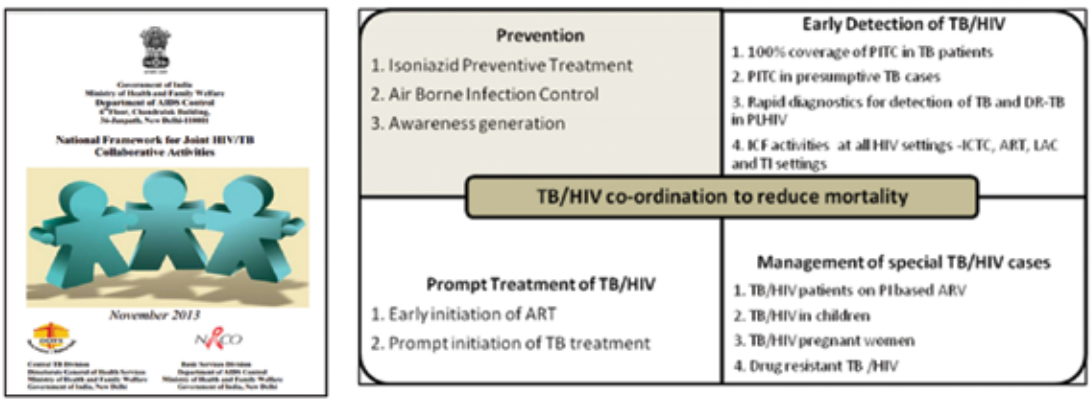
Provider-Initiated HIV Testing and Counseling of TB patients implemented across the country, is part of the intensified HIV/TB package implemented jointly by NACP and RNTCP. It is critical that the offer of HIV testing be made early after TB diagnosis and results promptly communicated to referring Provider (doctor), so as to ensure early linkage to HIV care and support. HIV testing of TB patients is done at ICTC (stand-alone or F-ICTC or PPP ICTC). It is envisaged by NACP and RNTCP that all Designated Microscopy Centres (DMC) conducting quality assured sputum microscopy, will have a co-located HIV testing facility. DMC is the most peripheral lab under the RNTCP network which serves a population of around one lakh (50,000 in tribal and hilly areas). At present there are more than 13,500 DMCs with more than 7,500 co-located HIV/TB testing facilities in the country. The Department of AIDS Control and Revised National TB Control Programme have been successful in increasing access and uptake of HIV testing and Counseling for all TB patients. In the year 2013-2014, about 8,92,088 out of 14,16,014 registered TB patients had their HIV status assessed.

Detection of HIV by offering HIV tests to diagnosed TB patients is being implemented by NACP and RNTCP jointly since 2007-2008. States with high HIV prevalence cover about 90% TB patients for HIV testing, but case fatality rate among HIV infected TB cases remains 13-14%, as compared to less than 4% in HIV negative TB cases, indicating delayed detection of HIV/TB in spite of good coverage. Therefore, NACP and RNTCP have jointly decided to offer HIV testing upstream during evaluation of patients for TB when they present with TB symptoms. This activity is expected to expedite detection of HIV within 2-4 weeks of TB positivity, leading to early linkage to HIV treatment and hence reduction in mortality. HIV testing in presumptive TB cases was rolled-out in India in October 2012 in Karnataka, followed by Maharashtra, Andhra Pradesh and Tamil Nadu. It is planned to extend this strategy to high HIV prevalence districts i.e. A and B category districts. Further the NTWG has recommended implementation of this strategy among the 25-54 age group in the rest of the country.

Intensified TB Case Finding at ICTC and ART Centres

Intensified TB Case Finding (ICF) at ICTC: Under ICF, all ICTC clients are screened by ICTC counsellors for presence of TB symptoms at every encounter (pre, post, or follow-up Counseling). Clients who have symptoms or signs, irrespective of their HIV status, are referred to RNTCP diagnostic and treatment facility located in the same institution. The cross-referrals between NACP and RNTCP have consistently shown improvement, with 6,20,539 presumptive TB cases referred, and detection of about 64,506 TB cases in 2013-2014. The referrals from RNTCP centres to ICTC have also shown consistent increase in numbers.

Figure 8.4: Four pronged strategy for HIV-TB Coordination activities to reduce mortality



Intensified TB Case Finding (ICF) at ART Centres: Intensified TB case finding at ART centres is critical for early suspicion and detection of TB, linkage to treatment and thus for prevention of transmission of infection to other clients. The national ART guidelines clearly state that all patients coming to ART centres are actively screened for opportunistic infections, particularly tuberculosis. The presumptive TB cases identified at ART centres are prioritised and "fast-tracked" for evaluation by SMO/MO to minimise opportunities for airborne transmission of infection to other PLHIV. The ICF at ART has been implemented in India since 2010 and it is now implemented at all ART centres, Link ART centres and Link ART Plus centres. Table 8.7 shows progress in ICF activities at ART centres. More than 1.6 lakh presumptive TB cases were identified among ART centre attendees in 2013-2014 and around 15% of them were found positive for TB. Around 93 percent HIV/TB cases are also linked to DOTS centres.

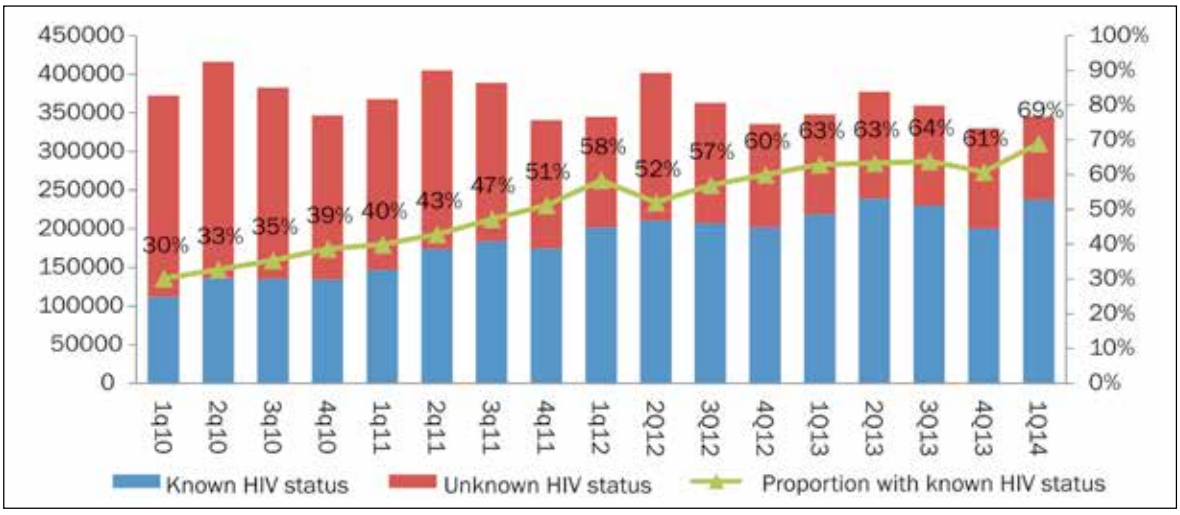
ICF at Link ART and Link ART Plus Centres: ICF is implemented in all Link ART Centres and Link ART Plus Centres. These centres implement ICF using symptom screening on every encounter, promptly refer presumptive TB cases to RNTCP diagnostic facilities, and refer the patients to ART centres promptly if TB is detected, for initiation of ART or modification of current ARV regimen.

TB Treatment outcomes among HIV-TB patients: Success rate of TB treatment among HIV- TB co-infected patients has been more than 76% is past four years. Efforts are ongoing to reduce the treatment defaulters among the HIV- TB co-infected patients.

NEWER INITIATIVES IN HIV/TB 2013-14

1. National HIV-TB Coordination Committee was formed in 2013-2014 and its first meeting was held under the chairmanship of Secretary, Department of AIDS Control.
2. The National Framework for Joint HIV/TB Collaborative activities (November 2013) was published and released during Launch function of NACP IV.
3. Operational Guidelines for Provider Initiated HIV Testing and Counseling among presumptive TB cases have been developed and implementation of this initiative is going on in phased manner.
4. Use of Rapid Diagnostics for early diagnosis of TB for ART attendees at the existing CBNAAT sites has been endorsed by National Technical Working Group for HIV/TB in India and its implementation is in progress.
5. Isoniazid Prevention Therapy (IPT) implementation plan has been approved by the NTWG for HIV/TB in India.

Figure 8.5: Trend of HIV testing among TB cases notified under RNTCP during 2010 – 2014 (1st Quarter)



Visit of Joint Supervisory Team of Central TB Division and Department of AIDS Control

6. Implementation of National Airborne Infection Control guidelines in HIV care settings has been prioritised, as recommended by NTWG for HIV/TB. National Airborne Infection Control guidelines have been circulated to all State AIDS Control Societies and ART centres for effective implementation of these guidelines in HIV care settings.
7. Joint Supervisory visits and review meetings by Nodal officers from Department of AIDS Control and Central TB Division have been conducted to Madhya Pradesh, Karnataka and Delhi in addition to the central evaluations by RNTCP.

QUALITY IMPROVEMENT INITIATIVES

Technical Resource Groups (TRG) on Basic Services: In the year 2013-2014, with the support of TRG members (experts from various fields in PPTCT, ART, Laboratory Services and other key officers from DAC), India has introduced the updated PPTCT guidelines.

Quality Assurance and EQAS: The diagnostic services provided through ICTCs across the country are strictly monitored by a strong Internal and External Quality Assurance Scheme (EQAS). The details of performance of EQAS are available in the Chapter on Laboratory Services.

Table 8.7: Performance of the Cohort of PPTCT 'Option-B' Regimen in Andhra Pradesh, Karnataka and Tamil Nadu, during April 2013 – March 2014

Year	Total presumptive TB cases detected	Total TB positive patients detected	Proportion found TB positive	No.(%) of HIV/TB cases put on DOTS
2010-2011	80,837	22,382	28%	18,978 (85%)
2011-2012	1,23,339	30,080	24%	24,799 (82%)
2012-2013	1,03,426	20,393	20%	18,278 (90%)
2013-2014	1,66,383	24,914	15%	23,170(93%)

Review Meeting of SACS Basic Services Division at DAC

BSD Review at SACS

Supervision and Monitoring Mechanism: At the State level, the States AIDS Control Societies consisting of Joint Director (BSD), Deputy Director (ICTC), Assistant Director (ICTC) HIV/TB Consultant and Consultant PPTCT, take responsibility of supportive supervision and monitoring using standard formats. Officers from DAC also visit States and service delivery centres as part of routine monitoring. During 2013-2014, DAC officers visited the States of Karnataka, Madhya Pradesh, West Bengal, Odisha, Rajasthan, Maharashtra, Jharkhand, Kerala, Andhra Pradesh, Gujarat, Chhattisgarh, Uttar Pradesh, Punjab, Haryana, Chandigarh, Tamil Nadu, Delhi and Assam.

Review meetings: The Basic Services Division conducts review meetings at regular intervals both at National and State level. In the year 2013-2014, two review meetings were held at National level, to review the programme, understand operational and technical challenges and discuss solutions for the same. Standard templates were developed for the review and these templates are being used by the States to review the districts and facilities at their level.

Supply Chain Management: A strong monitoring mechanism for inventory management is in place. The inventory status for all commodities under BSD at the State, District and Facility level is monitored on a weekly basis at the National level. This has enabled the division to ensure there are no stock-outs or wastage in the field due to expiry, with timely relocation of stocks.

CARE, SUPPORT AND TREATMENT

9

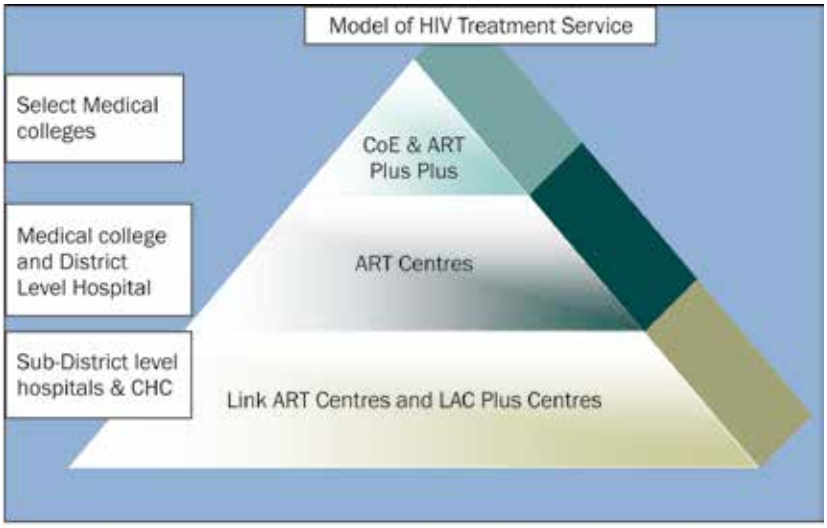
The Care, Support and Treatment (CST) component of NACP aims to provide comprehensive services to People Living with HIV (PLHIV) with respect to free Anti-Retroviral Therapy (ART), psychosocial support, prevention and treatment of Opportunistic Infections (OI) including tuberculosis and facilitating home-based care and impact mitigation.

SERVICE DELIVERY MECHANISM FOR CARE, SUPPORT & TREATMENT

CST services are provided through dedicated ART centres established by DAC in health facilities across the country. These are linked to Centres of Excellence (CoE) and ART Plus Centres at selected institutions, while some of the services have been decentralised through Link ART Centres (LAC). ART centres are also linked to ICTCs, STI clinics, PPTCT services and other clinical departments in the institutions of their location as well as with the Revised National Tuberculosis Programme (RNTCP), in order to ensure proper management of TB-HIV co-infected patients. Figure 9.1 gives a graphic view of this service delivery model.

Anti-Retroviral Therapy Centres: Provision of free Anti- Retroviral Therapy (ART) for eligible persons living with HIV/AIDS was launched on 1st April, 2004 in eight Government hospitals located in six high prevalence States. Since then, the programme has been scaled-up significantly both in terms of facilities for treatment and number of beneficiaries. The ART centres are established in the Department of Medicine in Medical Colleges and District Hospitals mostly in the Government sector. However in some high prevalence States, ART centres have been setup in the sub-district and area hospitals also. The ART centres are set up based on prevalence of HIV in the district/

Figure 9.1: Model of HIV Treatment Service



region, volume of PLHIV detected and capacity of the institution to deliver ART related services. Till March 2014, there were 425 fully functional ART centres across the country.

Link ART Centres: In order to facilitate the delivery of ART services closer to the beneficiaries, it was decided to set up Link ART Centres (LAC) mainly at ICTCs in the district/ sub-district level hospitals and linked to a Nodal ART centre within accessible distance. The LACs help in reducing cost of travel; time spent at the centre and hence helps in improving clients' adherence to ART. Presently, 870 Link ART Centres are functional in the country.

Link ART Plus Centres: It was observed that nearly 25-30% of persons detected HIV positive at ICTCs are not linked to care, support & treatment services. Some reasons for this include, persons being asymptomatic at the time of detection and long distances to reach the ART centre for registration and basic investigations, which lead to postponement/ delay in their visit to ART Centres till they became symptomatic. It was also observed that nearly 20% of patients reach ART Centres at a very late stage (CD4 count <50), when the risk of mortality is nearly 2-3 times higher.

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

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

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

ART Plus Centres: In order to provide easy access to second-line ART, DAC expanded the number of centres that provide second-line ART by upgrading some of the ART centres as 'ART Plus'. Currently, there are 37 ART-Plus centres functioning in the country. All States have been covered under this scheme.

Care & Support Centres: The overall goal of Care and Support Centres (CSC) is to improve survival and quality of life of PLHIV. Care and Support Centres provide expanded and holistic care & support services for PLHIV. They provide linkages and access to essential services, support treatment adherence, reduce stigma and discrimination, and improve the quality of life of PLHIV across India. India HIV/AIDS Alliance is the principal recipient of the project.

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

Facilities for CST	March 2012	March 2014
ART Centres	355	425
Link ART Centres	685	870
Centres of Excellence	10	10
Paediatric Centres of Excellence	7	7
ART Plus Centres	24	37
Care & Support Centres*	0	224

* In 2013-2014, the scheme of CCC was revised to CSC

The project is implemented by 17 State level and Regional Sub-Recipient Organisations. 10 out of the 17 Sub-Recipients are State level networks of PLHIV and more than 60 % of CSC are implemented by PLHIV networks, making it the biggest community-led Care and Support Programme in India. As of today 224 care and support centres are functional and are linked to ART Centres across the country.

The progress achieved in expanding Care, Support and Treatment services till March 2014, as compared to that in March 2012 is summarised in Table 9.1.

SERVICES PROVIDED

First-line ART: First-line ART is provided free of cost to all eligible PLHIV through ART centres. Positive cases referred by ICTCs are registered in ART centres for pre-ART and ART services. The assessment for eligibility for ART is done through clinical examination and CD4 count. Patients are also provided Counseling on treatment adherence, nutrition, positive prevention and positive living. Follow-up of patients on ART is done by assessing drug adherence, regularity of visits, periodic examination and CD4 count (every six months). Treatment for Opportunistic Infections is also provided through ART centres. Till March 2014, 7.68 lakh PLHIV were on first-line ART.

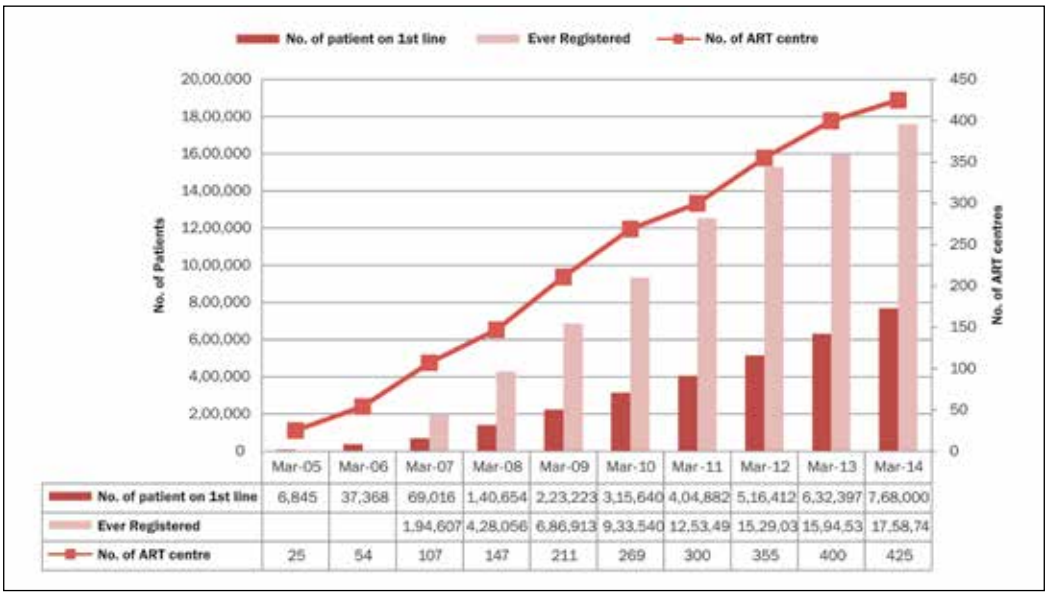
Alternative first-line ART: It has been observed that a small number of patients initiated on first-line ART experience acute/ chronic toxicity/intolerance to first-line ARV drugs, thus necessitating change of ARV drugs to alternative first-line drugs. Presently, the provision of alternative first-line ART is done through the Centres of Excellence and ART-Plus centres across the country.

Second-line ART: The patients started on ART can continue on first-line ART for a number of years if their adherence is good. However, over the years some percentage of PLHIV on first-line ART develop resistance to these drugs due to mutations in the virus. The roll-out of second-line ART began in January 2008 at two sites – GHTM, Tambaram, Chennai and JJ Hospital, Mumbai on a pilot basis and was then further expanded to the other CoEs in January 2009. Further decentralisation of second-line ART was done through capacitating and upgrading some well-functioning ART Centres as 'ART Plus Centres'. Till March 2014, 8,897 patients were receiving second-line drugs at CoEs and ART Plus Centres. All ART centres are linked to CoE/ART plus centres. For the evaluation of patients for initiation on second-line and alternate first-line ART, a State AIDS Clinical Expert Panel (SACEP) has been constituted by DAC at all CoEs and ART Plus Centres. This panel meets once in a week for taking decisions on patients referred to them with treatment failure/ major side effects.

Figure 9.2 shows the scale-up of services provided under the CST component since March 2005. All measures of service provisioning, namely number of ART centres, PLHIV ever registered and PLHIV on first-line treatment have increased exponentially.

National Paediatric HIV/AIDS Initiative: The National Paediatric HIV/AIDS Initiative was launched on 30 November 2006. Till March

Figure 9.2: ART Scale-up for PLHIV in India, March 2005 – March 2014



	Mar-05	Mar-06	Mar-07	Mar-08	Mar-09	Mar-10	Mar-11	Mar-12	Mar-13	Mar-14
No. of patient on 1st line	6,845	37,368	69,016	1,40,654	2,23,223	3,15,640	4,04,882	5,16,412	6,32,397	7,68,000
Ever Registered			1,94,607	4,28,056	6,86,913	9,33,540	12,53,49	15,29,03	15,94,53	17,58,74
No. of ART centre	25	54	107	147	211	269	300	355	400	425

2014, nearly 1,06,824 Children Living with HIV/AIDS (CLHIV) were registered in HIV care at ART centres, of whom 42,015 were receiving free ART. Paediatric formulations of ARV drugs are available at all ART centres.

applicable for children as well. Currently, second-line ART for children has been made available at all CoE and ART-Plus centres. The scale-up of services provided to CLHIV during 2005 –2014 (till March 2014) is shown in Figure 9.3.

Figure 9.3: ART Scale-up for Children Living with HIV/AIDS in India, 2005 – 2014 (till March 2014)

	Mar-05	Mar-06	Mar-07	Mar-08	Mar-09	Mar-10	Mar-11	Mar-12	Mar-13	Mar-14
No. of patient on 1st line	269	2,335	6,365	9,495	14,303	19,203	23,854	29,938	35,345	42,015
No. of ART centre	25	54	107	147	211	269	300	355	400	425

Paediatric Second-line ART: While the first-line therapy is efficacious, certain proportion of children do show evidence of failure. There is not much data available on the failure rate of Nevirapine-based ART in children. However, WHO estimates that the average switch rate from first to second-line ART is 2-3% per year for adults. It is likely that similar rates are

Early Infant Diagnosis: In order to promote confirmatory diagnosis for HIV exposed children, a programme on Early Infant Diagnosis (EID) was launched by DAC. All children with HIV infection confirmed through EID have been linked to ART services.

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

Table 9.2: Beneficiaries of Care, Support & Treatment Services till March 2014

Services/Beneficiaries	Achievement
Adults registered for ART	16,51,924
Adults alive and on ART	7,26,799
Children registered for ART	1,06,824
Children alive and on ART	4,2015
Opportunistic Infections Treated	4,35,808
Persons alive and on 2nd line ART	8,897

Table 9.3: State-wise list of ART Centres and patients on ART (as on March 2014)

State/UT	Number of functional ART Centres	Patients alive & on ART		
		Adults	Children	Total
Andhra Pradesh	51	1,60,303	7,060	1,67,363
Arunachal Pradesh	1	25	1	26
Assam	4	2,695	136	2,831
Bihar	14	18,335	1,088	19,423
Chandigarh	1	3,086	287	3,373
Chhattisgarh	5	4,999	386	5,385
Delhi	9	15,017	1,021	16,038
Goa	1	1,881	142	2,023
Gujarat	27	36986	2,084	39,070
Haryana	1	4,813	247	5,060
Himachal Pradesh	3	2,373	236	2,609
Jammu & Kashmir	2	1,203	94	1,297
Jharkhand	6	4,294	320	4,614
Karnataka	57	99,549	6,617	1,06,166
Kerala	8	8,293	434	8,727
Madhya Pradesh	15	10,458	717	11,175
Maharashtra	70	1,71,740	10,657	2,19,103
Manipur	10	8,783	670	9,453
Meghalaya	1	445	26	471
Mizoram	3	25,52	182	2,734
Nagaland	6	4,416	221	4,637
Odisha	9	7,848	432	8,280
Puducherry	1	950	73	1,023
Punjab	7	12,780	645	13,425
Rajasthan	16	18,299	1,184	19,483
Sikkim	1	89	6	95
Tamil Nadu	52	74,997	4,068	79,065
Tripura	1	430	13	443
Uttar Pradesh	28	29,929	1,870	31,799
Uttarakhand	2	1,798	131	1,929
West Bengal	13	17,458	968	18,426
Total	**425**	**7,26,824**	**42,016**	**7,68,840**

CME in Maharashtra, December 2013

ENDEAVORS TO ENHANCE AND ENSURE PROVISION OF HIGH QUALITY SERVICES

Technical Resource Groups on CST

Technical Resource Groups have been constituted on ART, Paediatric ART, Community Care Centres and Laboratory Services. These groups consist of national and international experts and representatives of organisations like WHO, CDC, Clinton Health Access Initiative and Networks of Positive People. They review progress and give valuable suggestions and recommendations on various technical and operational issues related to the programme. Meetings of TRGs are held periodically with clearly drawn agenda and issues for discussion.

Strengthening of laboratories for CD4 testing: There are 264 CD4 machines installed at present serving 425 ART centres. All machines procured by DAC are under comprehensive maintenance or warranty.

Supervisory/Monitoring Mechanisms: The Care, Support and Treatment division at DAC is responsible for planning, financing, implementation, supply chain management, training, coordination, monitoring & evaluation of care support & treatment services in the country. Implementation and monitoring at State level is the responsibility of the concerned SACS consisting of Joint Director (CST), Deputy Director (C&S), Assistant Director (Nursing) and Consultant (CST); based on volume of CST activities in the State.

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

Regular CST review meetings: Review meetings of all the CST officers from the State and all DAC Regional Coordinators are held on a regular basis. During these meetings, the State officers give update on the CST-related activities in their State in a standardised format and remedial measures are undertaken wherever required.

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

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

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

Follow-up of Pre-ART LFU: All patients registered in Pre-ART and on ART undergo CD4 testing every six months. ART centre laboratory technicians maintain a daily "due list" of patients who are due for CD4 testing. This list is prepared from the CD4 laboratory register. This list is available with the SMO/MO and during the patient's visit in that particular month for ART, the CD4 test is done. Those who do not undergo the CD4 test within one week of their due date are followed-up by phone call to ensure that CD4 testing is done at the subsequent visit.

Decentralisation of Supply Chain Management of ARV drugs: DAC has introduced a change in the way ARV drugs are distributed to ART Centres starting with the procurement cycle during 2011-2012. ARV distribution now follows a 'hub-and-spoke' model where the suppliers deliver the entire quantity required by a State to the SACS which acts as the hub for further distribution of the required quantity of drugs to ART centres. These drugs are at SACS only for short durations as nearly 80% of the stock is moved to ART centres immediately upon receipt and only the remaining 20% buffer stock is kept at SACS to meet further requirement from the centres.

Smart Card System: The concept of the Smart Card System has been introduced to develop a computerised data storage and retrieval of patient records resulting in the development of Health Smart Cards for PLHIV on ART. These cards are chip- based, providing restricted access, in order to maintain confidentiality. The Smart Card System, apart from capturing details as required in the ART PLHIV record, also capture the photograph and fingerprints of PLHIV. After preliminary data capture, the concerned persons are uniquely identified using biometric de-duplication processes at the central database. Once identified, a unique ID is generated for each PLHIV and the person is registered in the system. An Application Software has been developed for the Smart Card system.

EVALUATION AND OPERATIONAL RESEARCH STUDIES

The studies conducted on evaluation and operational research in relation to CST during 2013-2014 are as follow:

- Cohort analysis for the outcome of the first ART initiated through ten Centres of Excellence
- Analysis of SACEP at 10 Centres of Excellence
- Multi-centre study on 'Integrating HIV prevention in DAC ART clinics'

MAJOR INITIATIVES IN CARE, SUPPORT AND TREATMENT SERVICES

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

objectives of this one-year PG Diploma course are as follow:

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

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

Approval of Rolling Continuation Channel Round 4 Phase II Grant: Based on the performance of the programme during Phase I and successful submission of a proposal for Phase II, the CST programme has got approval for RCC Phase II grant worth USD 191.89 million from the GFATM.

Revision of Monitoring and Evaluation tools: Continuous supervision of activities carried out at ART centres is essential for monitoring effectiveness and quality of services provided under the programme. To facilitate uniform and systematic monitoring, systems and tools have been developed. The M & E tools for ART Centres, Centres of Excellence and Link ART Centres have been recently revised by DAC. These include, amongst others, Patient Treatment Records (White Card), Patient Booklets (Green booklet), Pre- ART and ART Enrolment Registers, ART Centre Monthly Reports, Drug Stock registers, CD4 tests and Kits Registers, ART Centre Monthly TB-HIV Report, ICTC to ART Referral Triplicate Form, Exposed Infant/Child Referral Form and the PLHIV Tracking Format. Training of ART staff in States has been conducted using these modules.

Transition of Care and Support Strategy: Based on the recommendations of the NACP IV working group on care and support, the strategy of implementation of care and support has been revamped to ensure cost effectiveness and sustainability in line with the priorities of NACP - IV. The medical services that were provided by the earlier care and support programme were completely integrated into the existing health system. Efforts are simultaneously being made to strengthen the capacity of the existing health system for effective delivery of care, support and treatment related services. The new care and support services are provided through Care and Support Centres which are comprehensive units for treatment support, positive living, referral and linkages to need-based services and strengthening of enabling environments for PLHIV. The direct services provided by care and support centres are outreach services, Counseling services, linkages to welfare schemes and social entitlements, advocacy meetings, and support group meetings other than the added trainings they provide on home-based care and life skills education.

This project will establish a total number of 350 care and support centres and link them to all ART centres in the country by 2015 through the primary recipient of the project – India HIV/AIDS Alliance, and Sub-Recipients and Sub-Sub-Recipients engaged by them. In the year 2013-2014 the project established 224 care and support centres and registered 2,56,790 PLHIV and provided services.

Facility-Integrated ART centre

The concept of facility-integrated ART centres was introduced to serve areas having less accessibility (especially hilly terrains, desert areas, tribal areas) and lesser infrastructure for access to treatment. This initiative of decentralising ART services will help to reduce the number of LFU and increase drug adherence among those on ART.

Data validation and review of quality of services provided at ART Centres:

The Department of AIDS Control is presently conducting an exercise on data validation and review of quality of services provided at ART centres in India. During this exercise,

Cohort Analysis Workshop, New Delhi, 25-28 March 2014

on-site data validation and assessment of quality of services at ART Centres for specific indicators, is being done by a team of experts. Two orientation workshops were conducted for training the teams on the structured and comprehensive tools. Each team has been assigned around five centres for review and data validation.

Cohort Analysis Workshop

The Cohort Analysis Workshop on "Improving HIV programme through the use of Cohort Data" was held at New Delhi during 25 -28 March, 2014. The objective of the cohort-based analysis was to assist in evaluating the quality of HIV treatment services, highlight key challenges and allow comparison over time and between groups of patients. Also, the workshop focused on capacity building of CoE Programme Directors, Deputy Programme Directors, Research Officers and Regional Coordinators, DAC. As a preparatory activity for this workshop, the CoE Research Officers/Data Analysts collected data (for the period April – June, 2011) for cohort analysis, and submitted the same to DAC. Programme evaluation was done based on the performance of patient-based cohort Analysis, which is the systematic assessment of defined treatment outcomes at prescribed time points after initiation of ART.

Completion of 10 Years of ART

The year 2014 marked the completion of ten years of free ART roll-out in India. The ART roll-out initiative was launched by the Government of India on 01 April 2004 and has been scaled-up in a phased manner. The programme has scaled up from eight ART Centres in 2004 to 425 ART Centres till March 2014, for providing comprehensive care and treatment services with a standardised, simplified combination of the ART regimen, a regular secure supply of good quality of ARV drugs, and a robust monitoring and evaluation system. The main goal of the programme is to provide care and support to as many people as possible, while working towards universal access to care and treatment.

Intensified tracking of "Lost to Follow-up" at ART centres

The overall goal of this activity is to launch a LFU tracking drive to retrieve patients as well as to validate data and update current status of PLHIV who are being reported as LFU in 'Pre ART' and 'On ART' care by screening records and performing outreach through the existing programme network.

Adoption of WHO Revised guidelines

The Department of AIDS Control has taken a decision to implement WHO revised guidelines and has already rolled-out countrywide adoption of lifelong ART for all positive pregnant women irrespective of clinical stage or CD4 count (Option B regimen using TDF+3TC+EFV). The other necessary preparatory activities like procurement of drugs for additional numbers who will become eligible for ART due to higher cut-off of CD4 count, revision of modules, training documents etc. have been initiated.

LABORATORY SERVICES

10

Laboratory services are not confined to HIV testing, but are overarching and have an impact on other interventions included under prevention, care, support and treatment, STI management, blood safety, procurement and supply chain management.

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

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

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

Technical Resource Group and Standardisation of Services

To ensure that standard quality of HIV tests are performed in the programme, a Technical Resource Group (TRG) was formed for Laboratory Services in December 2006. A revised pattern of assistance was suggested by experts and the action plan for 2007-2008 was formulated. At its first meeting in June 2007, critical areas for quality and relevant laboratory issues for the programme were discussed. The TRG was reconstituted in 2010 and has discussed issues in laboratory services like quality of testing, Early Infant Diagnosis (EID) guidelines, HIV viral load testing platforms, sharing of reports of National Reference Laboratory (NRL) and State Reference Laboratory (SRL) assessments, review and discussion of the strategy of testing and formulation of interim guidelines for HIV-2 testing till formal guidelines are made, etc. The fourth TRG meeting took place in August 2013.

Capacity Building

The laboratory services division has conducted training workshops for Technical Officers and addressed quality issues, details of Standard Operative Procedures (SOPs) and preparation of a quality manual, as steps towards National Accreditation Board for Testing and Calibration Laboratories (NABL) accreditation. A total of 33 faculty members from medical colleges were trained in regional workshops for internal audit. 64 participants comprising quality managers from SACS, Technical Officers (TO) and laboratory-in-charges were trained for 'HIV Referral Laboratories Implementation of Quality Management Systems based on Quality System Essentials and in correlation with ISO 15189:2007/2012 standards. Through seven regional workshops on 'Laboratory Quality Planning and Risk Management' 230 personnel comprising Quality Managers from SACS, Technical Officers and laboratory-in-charges of referral laboratories were trained. In another workshop, Quality Managers from SACS were trained in management and troubleshooting of all aspects related to the programme. Due to change in the version of ISO standards in quality management, 128 participants from SRLs were trained in the new standards.

54 laboratories were provided on-site technical assistance through 82 visits of Technical Assistants. As a result, 11 NRLs and 24 SRLs have got accreditation for HIV testing by the NABL. 11 more SRLs are in the process of accreditation.

ICTC/CD4 Training: The division is involved in on-site supervision of trainings of Laboratory Technicians as per DAC norms.

CD4 Testing

There are 254 functional CD4 machines installed at present, serving 407 ART Centres. These include 159 FACS Count Machines, 28 Calibur machines, 67 Partec machines. All machines procured by DAC are under warranty or maintenance contract. During 2013-2014, about 15,01,150 CD4 tests were performed.

CD4 training institutions were identified in 2009 to systematise the training of Laboratory Technicians in ART centres. A Training of Trainers (TOT) was held during May - June 2009 for CD4 machine technicians and in-charges. A regional capacity building of four institutions for Calibur machines (GHTM Tambaram, STM Kolkata, NARI Pune, and PGI Chandigarh), five institutions for Count machines (Vishakapatnam, NARI, MAMC, RIMS, CMC) and six institutions for Partec machines (Surat, Trichy, Kakinada, Davangere, Lucknow, Medinapur) has been done. Faculties of these institutions have been trained and are imparting further training. All technicians at ART centres are retrained at these institutions every year. A training plan has been developed in consultation with the respective manufacturer and NARI, Pune, which provides technical expertise along with the resource persons for the same. Training of trainers was held for five days regionally and the regional training is ongoing for three days for FACS Calibur & Partec and two days for FACS Count. About 231 ART Laboratory Technicians operating these machines have been trained from April 2013 to March 2014.

CD4 EQAS

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

Quality Assurance

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

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

External Quality Assessment Scheme: NEQAS categorised the laboratories into four tiers, as follows:

- Apex Laboratory - National AIDS Research Institute, Pune (first tier)
- Thirteen National Reference Laboratories (including Apex Laboratory) undertake EQAS in their respective geographical areas (second tier)
- State level: 117 State Reference Laboratories (third tier)
- Districts level, i.e., all ICTC & Blood banks (fourth tier)

Thus, a complete network of laboratories has been established throughout the country.

Training of Apex Laboratory and NRLs was completed in the first phase, followed by SRLs in the second phase and now ICTCs and blood banks are in the ongoing third phase.

Annually, two workshops are to be held at each level up to the SRLs.

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

Each NRL has been allotted designated States and SRLs for which it has the responsibility to train and supervise. Each SRL, in turn, has ICTC and blood banks which it monitors. EQAS calendar for the year 2013-2014 was prepared and shared with the concerned laboratories. One Technical Officer at each SRL is supported by funds from DAC to facilitate supervision, training and continual quality improvement in all SRLs and linked ICTCs.

Apart from the above financial assistance, NCDC Delhi, NICED Kolkata and NIMHANS Bangalore have been identified for panel preparation and quality assessment of HIV, HCV and HBV kits along with the Apex Laboratory. These laboratories form a part of the consortium developed by DAC for kit evaluation.

Assessment of Standards: A level-2 checklist was prepared based on the checklist prepared by CDC/ WHO/CF which was used for assessment of all 118 SRLs after modifications suited to the programme. This activity was done to look at the quality of the laboratories. The first cycle of such an assessment took place in 2009 with support from CDC and other Development Partners. The results of the assessment were disseminated to the concerned laboratories and follow-up activities to improve their standards have being undertaken. A further assessment was done of the National Reference Laboratories from May to July 2010 as per NABL standards and laboratories were reviewed accordingly. A complete reassessment of all 118 laboratories was done during December 2011-March 2012, following which a gap analysis was done. These laboratories were provided on-site technical assistance for accreditation in 2013-2014. A poster entitled 'Assuring Quality at Scale: Lessons from India on Quality Assurance of HIV Testing Services' was presented by the Programme Officer of the division at the International Congress on AIDS in Asia and the Pacific 2013, at Bangkok, Thailand.

Viral Load Testing to Support Second-line ART: Viral load assays are provided for patients failing first-line anti-retroviral therapy. DAC piloted viral load testing at two centres for 10 months beginning January 2008. Currently there are nine viral load laboratories, supporting clinical decision-making at 17 CoEs (including 10 paediatric CoEs) second-line centres and 37 ART plus centres for patients estimated to transit to second-line therapy. Existing equipped testing laboratories were identified for viral load testing and consent of the laboratories for participation in the national programme was taken. Viral load laboratory experience training was done at Bangkok in December 2007. During 2013-2014, about 8,005 viral load tests were performed for PLHIV.

Early Infant Diagnosis Programme

Addressing HIV/AIDS in children especially infants below 18 months, is a significant global challenge. HIV-infected children are the most vulnerable and frequently present with clinical symptoms in the first year of life. Where diagnostics, care and treatment are not available, studies suggest that 35% of infected children die in the first year of life, 50% by the age of two and 60% by the age of three. A critical priority in caring for HIV-infected infants is accurate and early diagnosis of HIV. With tremendous expansion in the HIV programme in PPTCT, ICTC, ART (for adults and children) including access to EID for HIV testing of infants less than 12 months old, it is now possible to ensure that HIV-exposed and infected infants and children get the required essential package of care.

Under the National Programme on Early Diagnosis of Infant/Child under 18 months, the objectives of providing care for HIV exposed infants and children are:

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

These objectives are proposed to be achieved through following strategies:

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

Training on DBS and whole blood sample collection, storage, transportation and packaging for National Early Infant Diagnosis roll-out by HIV DNA PCR testing was completed during June-September 2009, using training materials developed by DAC. DAC with Clinton Foundation has trained 1,157 ICTCs and 217 ART Centres, i.e. more than 3000 doctors, nurses and laboratory technicians across 31 States. DAC designed a vast sample transportation network that would ensure timely specimen pickup, testing and report delivery between the 1,157 specimen collection centres and seven testing laboratories (already equipped with basic PCR facilities) and have been trained for the above. DAC developed ICTC-ART Centre linkages for child referral for whole blood collection. Retraining was completed in all these centres. The same has been in operation

in 1,157 ICTCs and 217 ART Centres across 31 States. During 2013-2014, 12,169 HIV exposed infants and children less than 18 months of age have been tested under this programme.

Confirmatory diagnosis of HIV-2 in the National Programme

India has reported the presence of HIV-1 as well as HIV-2 since the beginning of the HIV epidemic. Though the prevalence of HIV 2 is low, the type of HIV (1 or 2) identified in the patient has an implication on the treatment regimen to be provided at ART centres. Although discriminatory HIV tests are used at the ICTC, the confirmation of HIV-2 when detected cannot be made at the ICTC. Confirmatory diagnosis of HIV-2 in National Programme was rolled-out in 2013 in thirteen referral laboratories presently identified based on their location within the country. These laboratories cater to all States within the country. In the year 2013-2014, 357 patients have been tested for confirmation of HIV-2 diagnosis.

Development of Systems for Reporting and Investigating 'exceptions'

A system of reporting the panel results has been developed where the SRLs report the discordant test results along with the name of the testing centre which is giving discordant results, for corrective action and the same is conveyed to the respective NRLs. The same is done at the NRL level where the SRLs are assessed and the final report is compiled at the Apex laboratory which is shared with DAC annually. In case there are exceptions where a batch of kits is found to be performing sub-optimally, the in-charge of the ICTC looks into the matter and prepares a detailed report which is communicated to the respective SACS. The manufacturer along with DAC and the licensing authorities are informed for further necessary action and if required, after inquiry the batch is withdrawn. Detailed enquiry is done at the central level if required.

INFORMATION, EDUCATION AND COMMUNICATION 11

Communication is the key to generating awareness on prevention as well as motivating access to testing, treatment, care and support. With the launch of NACP IV, the impetus is on standardising the lessons learned during the third phase. Communication in NACP IV is directed:

- To increase knowledge among general population (especially youth and women) on safe sexual behaviour
- To sustain behaviour change in at risk populations (high risk groups and bridge populations)
- To generate demand for care, support and treatment services
- To strengthen the enabling environment by facilitating appropriate changes in societal norms that reinforce positive attitudes, beliefs and practices to reduce stigma and discrimination

KEY ACTIVITIES UNDERTAKEN DURING 2013-2014

MASS MEDIA CAMPAIGNS

An annual media calendar was prepared to strategize, streamline and synergise mass media campaigns with other outreach activities and mid-media activities. DAC released campaigns on voluntary blood donation, condom promotion, sexually transmitted infections, stigma and discrimination amongst healthcare providers and PPTCT on Doordarshan, cable and satellite channels, All India Radio and FM radio networks. To amplify the reach of mass-media campaigns innovative technologies were also utilised like dissemination of advertisements through movie theatres.

Long Format Programmes

The State IEC teams conducted various long format programmes like phone-ins and panel discussions on HIV related issues through regional networks of All India Radio and Doordarshan. These programmes reached out to a large audience.

Advertisement through Newspapers

Newspapers have good recall value on the day of event, and also reach out to a large number of readers. Both DAC and SACS release advertisements in newspapers to disseminate information and create awareness. During the year 2013-2014, press advertisements in newspapers were published in leading national and regional newspapers to mark important events like Voluntary Blood Donation day, World AIDS Day, etc.

MID MEDIA

Outdoors

Outdoor activities like hoardings, bus panels, pole kiosks, information panels and panels in railways and Metro trains were implemented by the State AIDS Control Societies, condom social marketing organisations of DAC and also under link worker's scheme to disseminate information on HIV prevention and related services. DAC has developed a well-coordinated plan involving different agencies to avoid duplication of activities.

Folk performance in Himachal Pradesh

Folk Media and IEC Vans

Folk media engages audiences using their own cultural contexts. Previous years have witnessed carefully thought-out national folk media campaign planning, including script-writing workshops to ensure synergy between key messages and elements of folk tradition in the performances. A mix-and-match of seven thematic areas and the popular folk forms were used for the roll-out. The messages were vetted by the technical experts in DAC for accuracy, effectiveness and consistency.

Approximately, 44,117 performances were done during the campaign that was implemented in 2013-2014 in two phases across 32 States and UTs which reached out to 1.41 crore people in rural areas of the country. Key messages disseminated through the performances included safe sex, migration, stigma and discrimination, Counseling and testing, PPTCT, women's issues, blood safety and vulnerability of youth.

Folk media has also been used efficiently to piggyback on events organised in States during major festivals like Navratri, Durga Puja, Ganesh Chaturthi, Pongal, State specific big fairs and important cultural occasions to reach out to readily available large gatherings in urban and semi urban areas.

YOUTH

Adolescence Education Programme

This programme runs in secondary and senior secondary schools to build-up life skills of adolescents to cope with the physical and psychological changes associated with growing up. Under the programme, sixteen hour sessions are scheduled during the academic terms of classes IX and XI. SACS have further adapted the modules after State level consultations with stakeholders, such as NGOs, academicians, psychologists and parent-teacher bodies. This programme is being implemented in 23 States and till date 49,000 Schools have been covered.

Red Ribbon Clubs

The purpose of Red Ribbon Club formation in colleges is to encourage peer-to-peer messaging on HIV prevention and to provide a safe space for young people to seek clarifications of their doubts and on myths surrounding HIV/AIDS. The RRCs also promote voluntary blood donation among youth. About 14,000 clubs are functional and are being supported for these activities. This includes 1,700 RRCs started in 2013-2014.

NATIONAL HIV/ AIDS COMMUNICATION RESOURCE AND SUPPORT CENTRE

The National HIV/ AIDS Communication Resource and Support Centre (NHCRSC) is supported by IHBP/FHI360 and funded by USAID, with the following objectives:

- To serve as the Technical Support Unit to IEC Division
- To complement the work being done by the IEC Division

Table 11.1: Major areas of technical support provided by NHCRSC to IEC division

Major Areas	Areas of Technical Support	Brief Description
Programme Management, Training and Implementation	Support in Implementation of AAP	Intensive travel to States. Monitoring field implementation of AAP, gap identification Preparing gap analysis and issues matrix for 38 States and sharing with SACS and DAC.
	Capacity Building for IEC Officers	Approval of Training strategy for IEC. Creation of Facilitator's Guide and Toolkit.
	Support to Mass Media	Two 360 Degree Campaigns for Stigma and Discrimination amongst healthcare providers and Testing for HIV amongst pregnant women developed. Concepts for Campaign on Youth with focus on Safe Behaviour and HIV testing developed.
	Content development for IPC materials	Development of NACSP Launch Booklet and ticket and hoarding creatives for 33rd India International Trade Fair. Developed print advertisements for Voluntary Blood Donation Day, World AIDS Day, NACP IV Pre-launch and launch and Achievements of NACP.
Knowledge Management Support (Resource Centre)	Physical Repository	3000 books and documents listed, 1300 catalogued using National Medical Library of America Association Classification Scheme. 1200 CDs/VCDs listed. Databases were developed for maintaining records of all available resources in the physical library.
	Digital Resource Centre (Digital Repository on HIV/AIDS)	Collation of over 2000 internal & external resources, 215 classified & web friendly descriptors are prepared for the website. Development of taxonomy, wireframes, site features, disclaimers, terms and conditions, website policies, creative commons licenses, protocols (sourcing, screening, archiving). Beta website developed with 215 sample resources covering all thematic areas. User testing completed.
Documentation, Research and Evaluation	Documentation	Process Document on Red Ribbon Express (3-Phases). Process Document for Folk Media Campaigns. Development of Folk Media documentation template. Development of web content for Digital Resource Centre.
	Monitoring, Research and Evaluation	E- Tool for Trip Report Analysis prepared. Reach and recall study for Voluntary Blood Donation and long format television and radio programmes initiated. SIMS hands-on training provided to State IEC officers.

SAARC Goodwill Ambassador for HIV/AIDS Ms. Runa Laila visited DAC, August 2013

Miss Universe 2013, Ms. Olivia Culpo, at the 'AIDS Walk', Rajpath, New Delhi, 2013

SPECIAL EVENTS

SAARC Goodwill Ambassador Ms. Runa Laila visits India

Ms. Runa Laila, SAARC Goodwill Ambassador for HIV/AIDS, made her first official visit to India during 31st July to 2nd August, 2013 to extend support to the cause of HIV/AIDS, especially on the issue of stigma and discrimination related to PLHIV. During her stay she met Hon'ble Minister of Health and Family Welfare and Minister of External Affairs; they congratulated her on her mission to spread awareness on HIV/AIDS in the SAARC region. She also visited Department of AIDS Control and had an interaction with Secretary and Additional Secretary, DAC.

Ms. Runa Laila visited the ART centre at LNJP Hospital, Delhi, a Centre of Excellence in HIV care. She interacted with the beneficiaries and appreciated the high quality of care being provided to PLHIV without stigma and discrimination. She also visited the HIV Counseling and Testing Centre at Dr B R Ambedkar Hospital, Rohini, Delhi and interacted with pregnant women availing services.

'AIDS WALK' with Miss Universe 2013, Ms. Olivia Culpo

While Miss Universe 2013, Ms. Olivia Culpo, visited India, DAC organised the 'AIDS Walk' at Rajpath, in which a total of 1,500 school children along with their teachers participated.

UNAIDS International Goodwill Ambassador, Ms. Aishwarya Rai Bachchan, spreads HIV/AIDS awareness on International Women's Day

On the occasion of International Women's Day, 08 March, 2014, UNAIDS International Goodwill Ambassador, Ms. Aishwarya Rai Bachchan visited two centres of K.B. Bhabha Hospital, Mumbai that work towards preventing HIV infection among new born children and a crisis-intervention centre for women. In her speech she said, "It is every mother's wish to have a healthy child ..... and every child's right to live a healthy, happy and productive life. I also believe every girl has the right to grow up in a world, where she is not discriminated against because of her gender. Girls and women must be encouraged to recognise that equal opportunities exist in society today and they must be encouraged and supported to make productive and informed choices. Safety at home, in school, at work, on the road and in the society at large must be ensured for every human being and for girls/women in particular, in a society that stands for gender equality. We don't need words of reassurance." Secretary DAC along with officers of DAC and Mumbai AIDS Control Society attended the programme. In his speech on the occasion, Secretary DAC highlighted about PPTCT services under the National AIDS Control Programme.

UNAIDS International Goodwill Ambassador, Ms. Aishwarya Rai Bachchan, addressing the gathering on International Women's Day, Mumbai, 08 March, 2014

DAC representation in International Congress on AIDS in Asia and the Pacific - Thailand

DAC officials presented India's HIV/AIDS issues, challenges and successes to the world at the 11th International Congress on AIDS in Asia and the Pacific, held during 18-22 November 2013 in Bangkok, Thailand. More than 3,800 delegates from 74 countries participated in the Congress. Over 113 delegates from India representing the communities, civil society organisations, PLHIV and officials from SACS and DAC participated in the conference. At the event, policy makers, community members, media and government officials deliberated, brainstormed, took pledges, showcased the HIV/AIDS issues and challenges and addressed stigma and discrimination issues. The Indian experience was shared during the South-to-South round table meeting by Additional Secretary, Department of AIDS Control.

IEC team at Capacity Building Workshop

All staff under IEC division participated in a capacity building workshop supported by IHBP in January, 2014. The workshop was inaugurated by Secretary, DAC. The workshop focussed on the sharing of international best practices in health communication by Chief of Party, IHBP. Further it also contained sessions on management and the need for leveraging resources for maximum impact in HIV/AIDS and health communication. During the valedictory session, the Secretary and JD (IEC), DAC made some valuable advisory points on which the team started working, to enhance IEC strategies.

IEC team at Capacity Building Workshop

MAINSTREAMING AND PARTNERSHIP 12

A Multi-Sectoral Approach to Strengthening the HIV/AIDS Response

Mainstreaming and partnership for strengthening multi-sectoral response to HIV interventions is crucial in reducing susceptibility to HIV infection, as well as mitigating the burden of the disease on affected communities. The epidemic pattern in the country also firmly establishes the need for an expanded and broad-based response mechanism to address various vulnerabilities and lessen its devastating impact on virtually every sector of society.

The Department of AIDS Control recognises the need for addressing deprivations rooted in socio-economic imbalances that 'drive' the epidemic, such as poverty, gender inequality, lack of adequate housing and sanitation, and food insecurity. With its limited resources and reach, it requires a multi-pronged, multi-sectoral response which will ensure better use of available resources for risk reduction and impact mitigation of HIV.

The multi-sectoral response to HIV/AIDS in India has been guided by the National AIDS Control Programme. Mainstreaming and partnership for risk reduction, social protection, access to service and stigma reduction, become key tools to help communities become resilient and cope better. Mainstreaming and social protection continues to be a strategic priority in NACP-IV.

> Operational definition of mainstreaming …"Integrated, inclusive and multi-sectoral approach [that] transfers the ownership of HIV/AIDS issues – including its direct and indirect causes, impacts and responses to various stakeholders, including the government, the corporate sector and civil society organisations".

ACTIVITIES AND PROGRESS UNDER MAINSTREAMING AND PARTNERSHIP DURING 2013-2014

Building Partnerships for Mainstreaming HIV

Department of AIDS Control is collaborating with various key Ministries/ Departments of Government of India with objective of joint action on activities related with vulnerability reduction, integration of HIV/AIDS related services in existing health services, reducing stigma and discrimination and facilitating social protection for people infected and affected with HIV/AIDS.

By signing Memorandums of Understanding (MoUs), the Department of AIDS Control formalised partnerships with eight Departments/ Ministries of Government of India, including Department of Higher Education, Ministry of Coal, Ministry of Petroleum and Natural Gas, Department of Youth Affairs, Department of Sports, Ministry of Housing and Urban Poverty Alleviation and Department of Defence.

Department of Higher Education: DAC has signed an MoU with the Department of Higher Education, Ministry of Human Resource Development on 06 August, 2013 with the objective of reaching a large number of students with information on prevention of HIV/AIDS and promotion of blood donation through red ribbon clubs in educational institutions under the Department and encouragement of State Higher Education Departments to undertake HIV/AIDS prevention programmes in State Education Institutions including private universities with the technical assistance from State AIDS Control Societies.

Ministry of Coal: DAC has signed a Memorandum of Understanding with the Ministry of Coal on 09 September, 2013. The partnership is aimed at reaching larger numbers of the manpower engaged in coal mines and allied industries including migrant workers, truckers and surrounding communities with information on STI/HIV/AIDS, integration of HIV related services in existing health infrastructure as well as adoption of the National Policy on HIV/AIDS and World of Work by coal PSUs.

Department of Youth Affairs: DAC has signed a Memorandum of Understanding with the Department of Youth Affairs on 29 November, 2013. This partnership aims to prevent the spread of HIV infection among youth through inclusion of youth specific HIV information and services, reducing the vulnerability of special categories of young women and migrants and enhancing the capacity of policy planners, researchers and trainers in the institutions under the control of the Department of Youth Affairs, to address the issue of HIV/AIDS.

Department of Sports: DAC has signed a Memorandum of Understanding with the Department of Sports on 29 November, 2013. This partnership aims to reach a large number of youth engaged in sports activities with information on STI/HIV/AIDS prevention and related services, building the capacity of sports educators, administrators and coaches on "Minimising the risk of HIV transmission on and outside the sports field" and promoting awareness generation through hoardings and banners at eminent places and sports infrastructure during State/National events and tournaments.

Ministry of Petroleum & Natural Gas: DAC has signed a Memorandum of Understanding with the Ministry of Petroleum & Natural Gas on 5 December, 2013. The objective set out is to reach out to the large workforce employed in this sector including migrants, with information on HIV/AIDS and integration of HIV related services into the existing health infrastructure of Public Sector Undertakings.

Ministry of Housing & Urban Poverty Alleviation: On 11 December 2013, a Memorandum of Understanding was signed with the Ministry of Housing & Urban Poverty Alleviation. The objectives set out in the MoU are to reach out to PLHIV and affected population with enhanced accessibility in the livelihood schemes and programmes of the Ministry of Housing & Urban Poverty Alleviation through an inclusive approach as well as to improve social protection to PLHIV and most-at-risk Populations (MARPS) through existing schemes and programmes for urban employment, poverty alleviation and housing.

Department of Defence: A Memorandum of Understanding was signed by DAC with the Department of Defence under the Ministry of Defence, on 18 February 2014. The partnership aims to spread awareness and reach out to large numbers of defence personnel with information and services on STI/HIV/AIDS, integration of ICTC/STI/HIV services into existing health infrastructure and reduction of social stigma and discrimination against People Living with HIV/AIDS as well as other affected groups.

Political Advocacy

Responding to HIV has been a strategic priority for India, getting support from highest echelons of power right from the beginning. In fact the prompt country response to HIV/AIDS after the first case was diagnosed can be seen as the result of political support. Forum of Parliamentarians and Legislators are formed at the national and State levels for political

Southern Regional Consultative Meetings by Forum of Parliamentarians on HIV & AIDS in collaboration with DAC held at Bengaluru, Karnataka, October 2013

advocacy to strengthen the national response to HIV. The Forum of Parliamentarians on HIV & AIDS (FPA) is a forum of concerned parliamentarians who have resolved to act constructively to tackle this issue. FPA has been set up to involve Members of Parliament, irrespective of party affiliation in the framing of appropriate laws and policies to tackle this disease.

14 Legislative Forums on HIV & AIDS have been formed at the State and regional levels (combined for Delhi, Himachal, Chandigarh and Punjab)

Two regional consultative meetings were held by the Forum of Parliamentarians on HIV & AIDS in collaboration with DAC at Assam and Karnataka during 2013-2014.

Mainstreaming for social protection by improving access to social and legal protection for communities infected and affected by HIV

The impact of HIV is felt on income, employment, consumption expenditure (especially nutrition, education and healthcare) and savings. Partnership for mitigating the impact is as important as provision of social and legal protection to communities infected and affected by HIV. HIV sensitive social protection is a set of public measures that a society provides for its members to protect them against economic and social distress, which very often may push them towards risk behaviours of HIV infection. This may be caused by the absence or a substantial reduction of income from work, sickness, maternity, unemployment, invalidity, old age, and death of the breadwinner.

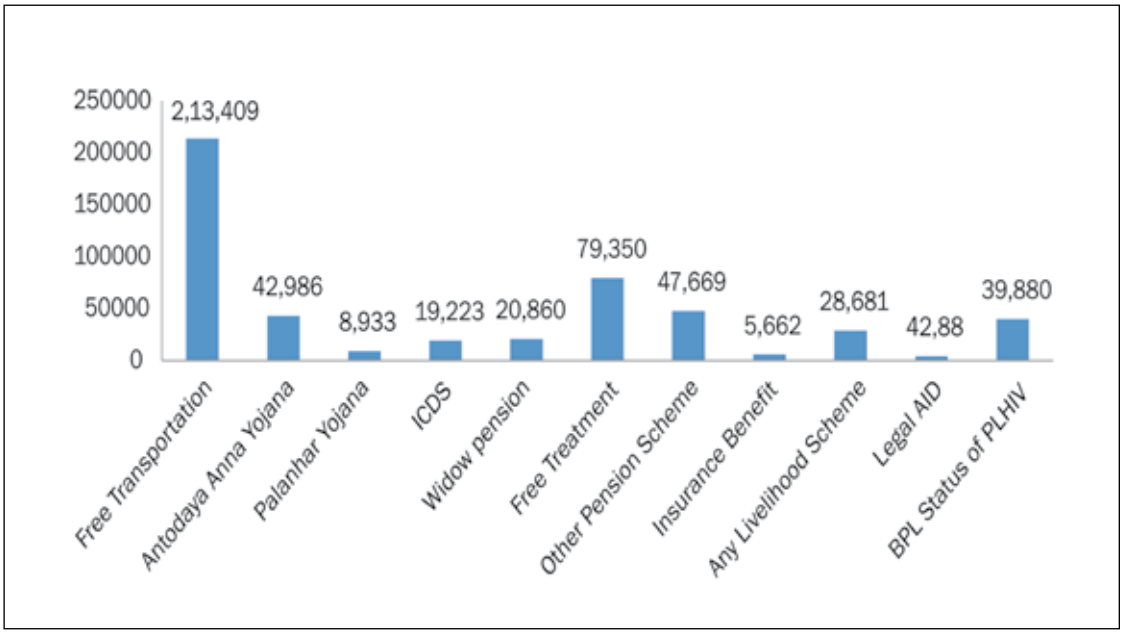
NACP-IV recognises the fact that reduction of vulnerability and impact mitigation through social protection is one of its core strategies. In light of the strategic importance of social protection, the Department of AIDS Control in collaboration with UNDP India organised an "International Conference on HIV Sensitive Social Protection" held at New Delhi during 11-12 December, 2013 with the following objectives:

- Facilitation of exchange of global thoughts and experiences with regard to HIV sensitive social protection,
- Sharing of various models of roll-out of social protection strategies
- Brainstorming on various means and mechanisms of monitoring the progress

The Conference had representation from 11 different countries besides India and had over 200 participants including the respective country governments, different ministries from Government of India, technical experts, civil societies, marginalised groups and communities of People Living with HIV. This conference was highly successful in highlighting the importance of HIV sensitive social protection and indicated the way forward.

A number of States/Union Territories in India have taken significant steps in consideration of the special vulnerabilities faced by people affected by HIV and AIDS. For example, lowering of the age limit in case of AIDS widows or exclusive schemes that have been sanctioned such as, the Palanhaar Yojna or the Madhu Babu Pension Scheme etc. The reported uptake of various schemes is as shown in Figure 12.3.

Figure 12.3: Reported Uptake of various Schemes under Social Protection



Legal aid to PLHIV: On the sole grounds of their HIV status, people living with HIV face denial of rights, loss of employment, discrimination in public and private institutions, healthcare settings, educational institutions, family and community,. Hence the need for legal aids is a part and parcel of comprehensive care and support. With the advocacy efforts under Mainstreaming, States are providing legal aid, enabling PLHIV to fight back. Approximately 4,288 PLHIV have benefited from these efforts during 2013-2014.

ACTIVITIES IN NORTH EASTERN STATES

13

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

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

Progress of the Programme and Schemes in North-Eastern States

Under the National AIDS Control Programme a comprehensive package of services is provided to the North-Eastern States to address their special needs. State AIDS Control Societies have been strengthened in all North-Eastern States by providing them adequate financial and human resources for the effective implementation of programme components. The North East Regional Office (NERO), established by DAC, is the result of the national response to intensify the efforts of HIV prevention, treatment and care services by providing technical support to the eight North-Eastern States. Facilitating and strengthening the response to the epidemic by improving coverage and quality of programme planning, implementation, capacity building, monitoring and reporting are the focus areas of NERO. DAPCU has been operationalised in 25 districts with the formation of Districts AIDS Prevention Control Committee. DAPCUs have been initiated and are following-up the process of convergence with NRHM and related stakeholders at State and district levels. District Initiative Campaigns of varied natures have been initiated and documented to increase scale-up of service uptake. Details of the facilities under the National AIDS Control Programme in North-Eastern States have been summarised in Tables 13.2 to 13.5.

MAJOR ACTIVITIES UNDERTAKEN DURING 2013-2014

Comprehensive Data Analysis

With coordination of DAPCU, NERO shared comprehensive data Analysis for strategic development of district annual action plan (HSS, HIV Estimation and ICTC positivity based priority districts) for 'A' & 'B' category districts.

Table 13.1: Estimates of Epidemiological Indices of HIV in North-Eastern States of India in 2011

States	Adult HIV Prevalence (15-49) (%)	No. of HIV Infections	No. of NEW Infections among Adults (15+)	AIDS related death
Arunachal Pradesh	0.13	1,156	257	42
Assam	0.07	12,804	2,408	388
Manipur	1.22	25,369	1,354	1,905
Meghalaya	0.13	2,381	460	88
Mizoram	0.74	5,346	376	286
Nagaland	0.73	9,716	560	581
Sikkim	0.15	593	94	25
Tripura	0.24	5,684	951	279
NE TOTAL	-	63,049	6,460	3,594

[Source: HIV Estimates 2012, NACO]

Table 13.2: Details of TI- Facilities under NACP in North-Eastern States (as on March 2014)

State (Population)	No. of Districts	No. of DAPCU	No. of TI	FSW	MSM	IDU*	Migrant	Trucker	Core composite
Arunachal Pradesh (13,82,611)	16	1	23	4	1	3	6	0	9 (2 FSW & MSM) (6 FSW & IDU) (1 All Core Typologies)
Assam (3,11,69,272)	27	1	62	33	5	8	6	3	7 (5 FSW & MSM) (2 FSW & IDU)
Manipur (27,21,756)	9	9	74	6	4	55	2	0	7 (7 FSW & IDU)
Meghalaya (29,64,007)	7	0	9	3	0	4	1	0	1 (1 FSW & MSM)
Mizoram (10,91,014)	8	3	37	1	1	23	4	0	8 (7 FSW & IDU) (1 All Core Typologies)
Nagaland (19,80,602)	11	10	53	2	3	31	1	1	15 (14 FSW & IDU) (1 MSM & IDU)
Sikkim (6,07,688)	4	0	7	3	0	4	0	0	0
Tripura (36,71,032)	8	1	13	6	0	2	3	0	2(2 FSW & MSM)
NE States (4,55,87,982)	**90**	**25**	**278**	**58**	**14**	**130**	**23**	**4**	**49 (10 FSW & MSM) (36 FSW & IDU) (1 MSM & IDU) (2 All Core Typologies)**

* Includes F-IDU

Table 13.3: Details of Facilities under NACP in the North-Eastern States (as on March 2014)

States	OST Centres			STI			ICTC				S R L / NRL(#)
	OST	NGO-OST	GO-OST	TI-ST	DSRC	NRHM	SA-ICTC	24X7 ICTC	PPP ICTC	Mobile ICTC	
Arunachal Pradesh	3	0	3	17	17	126	34	11	0	1	1
Assam	1	0	1	56	28	642	83	76	15	2	3
Manipur	11	9	2	64	10	88	54	15	4	6	1(#)
Meghalaya	3	3	0	8	8	148	10	5	4	2	1
Mizoram	13	4	9	33	9	69	27	29	4	9	1
Nagaland	22	5	17	52	11	146	60	0	1	10	2
Sikkim	3	0	3	7	6	24	12	3	0	1	1
Tripura	3	0	2	10	16	87	18	43	0	0	1
NE States	**59**	**21**	**37**	**247**	**105**	**1330**	**298**	**182**	**28**	**31**	**11**

Table 13.4: Details of Facilities under NACP in North-Eastern States (as on March 2014)

States	BLOOD BANK						ART / CSC					
	Model BB	Major BB	DLBB	Private BB	BSC	BTV	ART / ART+*	LAC+	LAC	CD4	CSC	Help Desk
Arunachal Pradesh	0	1	7	0 (+0)	4	1	1	0	4	1	1	0
Assam	2	9	15	0 (+40)	42	6	4	3	10	3	3	0
Manipur	1	0	2	0 (+1)	0	2	10	0	10	6	5	0
Meghalaya	0	2	1	2 (+0)	4	2	1	0	3	1	1	0
Mizoram	1	1	6	2 (+0)	9	1	3	0	8	1	1	3
Nagaland	1	1	6	0 (+0)	4	2	6	1	6	4	3	6
Sikkim	0	1	1	0 (+1)	1	1	1	0	1	0	1	0
Tripura	1	2	3	0 (+2)	7	3	1	0	3	1	1	0
NE States	**6**	**17**	**41**	**4 (+44)**	**71**	**18**	**27**	**4**	**45**	**17**	**16**	**9**

*1 ART+ Centre in all NE States (except Manipur), 1 CoE & 1 pCoE in Manipur

DAPCU Innovation

With an aim of ensuring effective implementation of the approved annual action plan in the 25 'A' and 'B' category districts where all DAPCU teams are present, NERO facilitated SACS to disseminate the approved action plans to the DAPCU teams. The DAPCU nodal officers from SACS, with technical support from NERO, followed-up the implementation. NERO TI-Team Leaders and DAPCU Regional Coordinators of NERO facilitated a two-day workshop on preparation of the annual action plans using a bottom-up approach along with SACS/DAPCU officials on 21-22 January 2014, in Champhai district of Mizoram for 2014-2015.

Meeting to develop district specific campaigns in Peren, Nagaland

NACP-NRHM Convergence Meeting at NE

In the CMO office of Peren district of Nagaland, NERO Officials along with DNRT members, Nagaland SACS officials, DAC and District Programme Managers met to develop district specific campaign based on the epidemiological profile and data and to list the steps and factors required. Rs. 3.0 lakh was sanctioned from the district innovation fund for the STI Campaign.

NACP-NRHM Convergence Meeting at NE

A meeting was held with Director, RRC-NES on Convergence of NACP & NRHM at Guwahati in February 2014. In the meeting, NERO highlighted gaps in implementation of the NACP programme wherein NRHM support was required. Deputy Commissioner, Ministry of Health & Family Wefare, and DDG (Basic Services) were also present in the Convergence Meeting of NACP and NRHM.

SGRC meetings were held in all the North Eastern States except Assam and Tripura, which were facilitated by Regional Coordinator (CST) as the NERO representative. State governments are taking initiatives for the benefit of PLHAs in terms of free transport, widow pension, AAY card, HIV/HBV/HCV treatment and other social welfare schemes as an outcome of the meetings.

Training and Capacity Building

NERO coordinated with SACS and various training institutes identified by DAC for conducting various training activities under different programme components of NACP ensuring completion of the training targets. These activities included finalisation of the annual training calendar, release of funds by SACS to STRCs, identification of master trainers for each of the States with approval from DAC, roll-out of training as per approved training calendar and supervision of training quality assurance by observing the training conducted by training institutes, training report submission by training institutes to SACS, NERO and DAC for training staff of TI NGOs. Since September 2013, with the fresh bidding process for all STRCs, NERO along with SACS facilitated the completion of trainings.

Preparation of Annual Work Plans

NERO and SACS officers facilitated preparation of the annual work plan for 2014-2015 for Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura. Key action plans were developed based on the key issues in the districts; they focussed on referral and linkages, meetings, reporting and programme performance, linkages to social security schemes.

Following important trainings were organised/ facilitated by NERO along with SACS during 2013-2014:

- Facilitation of organisation of Regional level ToT for ELM at Guwahati for seven NE States in coordination with PIPSE, DAC, NERO and SACS
- Facilitation of Training for Migrants and Truckers in NE
- Facilitation of Thematic TI Training in Assam and Nagaland FSW and MSM
- Induction and Refresher Training conducted for ICTC Counsellors in NE States

Regional ToT on Employer-led model at Guwahati

Training of Police Personnel in Nagaland

- Conducted second NE Regional Level Workshop on Voluntary Blood Donation at Mizoram with 83 participants from all NE States
- Facilitation of Sensitisation Workshop for Police Personnel in Meghalaya and Nagaland
- Facilitation of Induction Training for the ART Counsellors of Manipur, Mizoram, Nagaland and Tripura at RIMS during 27 May- 07 June, 2013
- Facilitation of Orientation Training for newly recruited staff of ART Plus Centre, Naharlagun in Arunachal Pradesh during 17-18 September, 2013 by CST Division
- Facilitation of SGRC and SACEP meeting in the NE States by NERO and SACS
- Identified Training Institute for Nurses in NE States
- Three Regional and seven State Level Training were conducted on "Opioid Substitution Therapy" for officials of Government healthcare settings of OST sites of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Sikkim and Tripura
- Organisation of "Experience sharing cum Reorientation Training" by NERO along with IBBS Workshop in June 2013 where the grading of TIs, OST Programme, Micro-Planning Tools and Data Collections Tools were reiterated
- Participation of NE States in Stigma Index Workshop for PLHIV and Stigma in HealthCare (Hospital) Settings in the NE States

Feasibility Assessment

NERO team along with SACS conducted the OST feasibility assessment in the NE States. As follow-up to the Annual Action Plan discussion in Delhi, NERO and SACS facilitated a 'Feasibility Assessment of Short Distance Truckers and Commercial Drivers' in Tripura and Meghalaya.

Technical Report on STI

NERO prepared a technical report on current status of STI in Arunachal Pradesh and shared with the SACS and DAC.

Validation of Core HRG population

HRG mapping was conducted in most of the NE States during 2008-2010. An analysis of the mapping data showed variations in the estimated number of HRGs in comparison to existing TI coverage and data available with SACS from other sources/studies. This also led to concerns regarding overlap in the geographical coverage of nearby TIs and duplication of HRGs between TIs of same typology. The operational manual and tools, developed in conjunction with NE SACS for validation of Core HRG population, developed with an aim to reconcile the mapping and coverage figures to arrive at more precise HRG estimates was used to complete the HRG Validation for Arunachal Pradesh, Assam, Meghalaya, Nagaland, Sikkim and Tripura in 2013-2014 after the HRG validation was carried out in Manipur and Mizoram. The validation reports for all States were finalised and shared, which is a major achievement of NE States for 2013-2014.

Principal and Nodal Officers of Red Ribbon Clubs with Project Director and Staff of Nagaland SACS

Red Ribbon Club

Red Ribbon Clubs (RRC) have been formed in colleges and institutions to encourage peer-to-peer messaging on HIV prevention, and a safe space for young people to seek clarifications of their doubts and myths surrounding HIV/AIDS. Nearly 500 RRCs are functional across the NE region.

Red Ribbon Express

The Red Ribbon Express traveled to the North Eastern States during July-August 2013 and reached out to populations of various age groups with an aim to create mass awareness on HIV/ AIDS. NERO assisted the SACS in planning and execution of RRE projects and it covered five districts in Assam and Dimapur in Nagaland.

Multi-Media Campaign

The Multi-Media Campaign on HIV/AIDS, Red Ribbon 'Super Stars', targeting youth aged 15-29 years and has been successfully implemented in Mizoram, Nagaland and Sikkim. The campaign uses a combination of music competitions, dramas and sports tournaments organised at district level culminating to State level mega events. These are further amplified through the use of TV, radio, newspapers and outdoor media. Owing to the culture of the North-East, over 100 faith based organisations were sensitised and involved in the campaign. A special effort was made to reach out to the out-of-school youth in the States.

BCC messages were developed and disseminated by youth of RRCs and Colleges. The winners of the music competitions, positioned as "youth icons or super stars" were taking messages on HIV/ AIDS further into the community through road shows at villages and blocks of every district. NERO facilitated SACS and research agencies for smooth evaluation of the campaign conducted last year.

Mid-Media and Outdoor

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

Legislative Forum on AIDS in Kohima, Nagaland, August 2013

North-Eastern Regional Consultation meeting by Forum of Parliamentarians on HIV/AIDS, Guwahati, Assam, June 2013

Forum of Parliamentarians on HIV & AIDS

A regional level Consultation Meeting by Forum of Parliamentarians on HIV & AIDS was coordinated by NERO in Guwahati during 07-08 June, 2013. Secretary, DAC attended the meeting along with Shri Oscar Fernandes and Shri J.D. Seelam, and Chief Ministers of Arunachal, Assam, Meghalaya and Speakers/ Representatives of Legislative Forums of HIV & AIDS from Arunachal, Manipur, Meghalaya, Mizoram, Nagaland and Tripura.

Legislative Forum on HIV & AIDS: NERO and SACS were also part of the Annual General Meeting of Legislative Forum on HIV & AIDS (LFA) this year for the 60 newly elected legislators of Nagaland Assembly held on 07 August, 2013 headed by Mr Neiphiu Rio, the Chief Minister of Nagaland.

Joint UN Initiative in North Eastern States

A Joint UN Initiative on HIV for the NE States was held in the month of March 2014. The Joint UN Project covered four States (Manipur, Meghalaya, Mizoram and Nagaland) and provided support to the States with regards to their core areas of work. UNDP worked on Mainstreaming and PHLIV, UNICEF on Prevention of Parent to Child Transmission, UNODC on drug use and OST, UNAIDS on LFAs, donor coordination and overall technical support.

CAPACITY BUILDING 14

Capacity building in any form whether formal training or on the job training in the form of supportive supervisory visits or through review meetings and workshops, helps in creating a resource base. This trained human resource base is used to manage programme activities effectively and efficiently. DAC emphasises the timely and quality training of the personnel engaged in implementing, monitoring and coordinating of the National AIDS Control Programme activities at various levels.

The trainings in this financial year ranged from programme management, outreach planning, financial management, Counseling in targeted intervention to auditing, quality planning and risk management. Specific trainings were also done under Integrated Biological and Behavioural Surveillance (IBBS). While Basic Services division could train its personnel on whole blood testing, PPTCT multi drug regimen, full-site sensitisation, apart from regular induction and refresher trainings of their counsellors and lab technicians, Laboratory Services Division trained SRL staff on newer version of ISO.

Table below gives details only on the formal training under different divisions from April 2013 to March 2014. A total of 5,58,771 personnel were trained during this financial year.

Category of Participants	No. of Personnel Trained
Basic Services	
Induction & refresher training	
ICTC Counsellors	2,200
ICTC Lab Technicians	2,990
FICTC Staff Nurses/ ANMs	4,356
FICTC Lab Technicians	1,929
ICTC District Supervisors	13
Training on "On full site sensitisation"	
DH/ SDH Staff	11,220
Training on HIV-TB	
ICTC Medical Officers	524
ART Medical Officers	236
ICTC Counsellors	1,608
ICTC District Supervisors	98
RNTCP STS/ STLS	335
HIV-TB/DOTS Plus Supervisors (RNTCP)	207
PPTCT training on life-long ART	

Category of Participants	No. of Personnel Trained
ICTC Medical Officers, ART Medical Officers, ICTC District Supervisors, ICTC Counsellors, ICTC Lab Technicians & others	13,180
Training on whole blood screening	
ANMs, Labour room nurses	6,840
RNTCP LT & STS/ STLS	1,009
Team training	
ICTC Medical Officers	377
ICTC Counsellors	610
ICTC Lab Technicians	599
Staff Nurse	473
Sub-Total	**48,804**
Note: Data on ICTC Training not reported by Andhra Pradesh for 2013-14	
Blood Transfusion Services	
Doctors	379
Staff nurses	237
Laboratory technicians	956
BB counsellors	207
Donor motivators	7,584
Clinicians on Rational Blood use	2,684
Sub-Total	**12,047**
Laboratory Services	
Faculty members from medical college were trained in regional workshop for internal audit	33
Quality managers from SACS, Technical officers and lab in-charges were trained on QMS	64
Quality managers from SACS, Technical officers and lab in-charges were trained on laboratory quality planning and risk management	230
SRL staff were trained on newer version of ISO 15189	128
Laboratories were provided technical assistance	54
Sub-Total	**509**
Mainstreaming	
PRI	36,372
SHG	1,64,178
Frontline Workers	80,372
Youth	62,032
Uniformed Forces	30,600
Industry	31,933
Transport	4,465
Cooperatives	2,181
Non HIV NGO	12,291
NRHM	10,994
Others Govt. Officials	26,448

Category of Participants	No. of Personnel Trained
State Resource Pool	1,189
PLHIV Network	3,293
Sub-Total	**4,66,348**
Surveillance	
National Integrated Biological and Behavioural Surveillance	
National IBBS Pre-Survey Assessment (PSA) National ToT	
National Working Group, Technical Advisory Group, HSS Focal persons from SACS, State Epidemiologists, Regional Institute Project Coordinators	80
National IBBS PSA Regional Training for the Investigators	
Investigators, SST Members	300
National IBBS National ToT	
National Working Group, Technical Advisory Group, HSS Focal persons from SACS, State Epidemiologists, Regional Institute Project Coordinators, National Project Leaders- Field Reach Agencies, Project/ Additional Project Leaders- Field Research Agencies, National Trainers	107
National IBBS Core Expert Training National Working Group	
National Trainers , State Epidemiologists	38
National IBBS State IT Coordinator Training	
State IT Coordinators, Regional Data Manager	55
Sub-Total	**580**
Targeted Interventions	
Programme Management	
Programme Manager of TI	1,544
Outreach Planning	
Out-reach Workers	7,210
Counseling	
Counsellor and ANM	1,446
Peer Education	
Peer Educators	29,689
Financial Management	
Accountant and M&E	2,220
Opioid Substitution Therapy (Round 9 and UNODC- ROSA)	
Doctors (including Nodal Officers)	94
Nurses / ANMs	97
Counsellors	82
Data Managers	54
Programme Managers	61
ORWs	99
TSU staff	14
SACS staff	5
Sub-Total	**42,615**
Total	**5,70,903**

PROCUREMENT 15

Procurements are done using funds under The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), The World Bank and Domestic Funds, through RITES Limited as Procurement Agent. RITES Limited continued to provide services to the Department of AIDS Control (DAC) as Procurement Agent in terms of the contract concluded between DAC and RITES Limited on 16 February, 2010.

As in the past, all the main items required for the programme, including test kits and other items such as Anti-Retroviral Drugs, STI Drug kits, blood bags etc., have been procured centrally and supplied to State AIDS Control Societies (SACS).

During the year 2013-2014, against the Budget Estimate of Rs.521.92 crore, and Revised Estimate of Rs.566.45 crore, the Expenditure incurred on procurement at central level was Rs.561.91 crore.

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

Procurement at State level remained an area of importance for DAC. For smooth and efficient procurement at State level, hand-holding support to State AIDS Control Societies is being provided by the procurement division at DAC. Also, six Regional Procurement & Logistics Coordinators have been appointed in different regions for managing the Supply Chain Management at regional levels.

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

ADMINISTRATION 16

The Department of AIDS Control (DAC) was created as a new Department in December, 2008 under the Ministry of Health & Family Welfare. The Ministry is headed by the Union Minister of Health & Family Welfare, Dr. Harsh Vardhan. The Department of AIDS Control is headed by the Secretary to the Government of India, who is assisted by the Joint Secretary, six Deputy Directors General, one Assistant Director General, one Joint Director, one Director, one Deputy Secretary and two Under Secretaries.

Dr. V. K. Subburaj has taken charge as Secretary, DAC w.e.f. 01 March, 2014. The Organisational Chart for the Department of AIDS Control is at 'Annex I'. The total sanctioned strength of regular staff of the Department in Group "A", "B", "C" and "D" is 64, which includes secretarial and technical posts. Besides these, there are contractual staff to assist the Department in discharging its assigned functions. The work allocated to the Department of AIDS Control as per the existing Allocation of Business Rules, is as under:

- Inter-Sectoral, Inter-Organisational and Inter-Institutional Coordination, both under the Central and State Governments, in areas related to HIV/AIDS control and prevention
- Providing institutional framework for high-end research for control, prevention, cure and management of HIV/AIDS and all coordination in this regard
- Dissemination of accurate, complete and timely information about HIV/AIDS to motivate, equip and empower people and promotion of measures for effective protection against the spread of the disease
- International co-operation, exchange programme and advanced training in HIV/AIDS Management and Research
- Promoting research studies in the field of HIV/AIDS prevention and control.
- National Blood Transfusion Council, an Autonomous Body
- Matter relating to collection processing and supply of safe blood. Management of Blood Transfusion Service
- All policy matters relating to National AIDS Control Programme, Prevention and Control of HIV/AIDS

The information on the Department and its various activities are provided on the website of the Department (http://www.naco.gov.in) and is updated from time-to-time.

The website is linked to the Centralised Public Grievance Redress and Monitoring System (CPGRAMS) of Department of Administrative Reforms and Public Grievance and Pensions, Ministry of Personnel, Public Grievances and Pensions.

STATE AIDS CONTROL SOCIETIES

For effective implementation of National AIDS Control Programme (NACP), State AIDS Control Societies (SACS) are set up in each State under the overall charge of Secretary, Health. Each SACS is headed by a Project Director who is an IAS Officer or Senior Medical Officer from the State. In addition, there is

a regular post of Additional Project Director, who is the technical head for SACS. Under these two senior positions, there are posts of Joint Director, Deputy Director and Assistant Director, which can be regular, on deputation from the State Government or contractual, as approved by the Department of AIDS Control.

The overall responsibility of implementation of NACP at facility level lies with the SACS, with technical support from the various divisions at the Department of AIDS Control.

DISTRICT AIDS PREVENTION AND CONTROL UNIT

Currently there are 189 District AIDS Prevention and Control Units (DAPCUs) established in high priority (A and B Category) districts, spread across 22 States.

The key role of DAPCU is overall coordination and monitoring of NACP activities at the district level, providing a programmatic oversight to HIV/AIDS programme implementation at the district level, focussing on mainstreaming with line departments and convergence with National Health Mission. The job responsibilities of DAPCU staff are revised in-line with changing programme priorities.

Mentoring

Department of AIDS Control has been developing the capacities of DAPCUs through DAPCU Nodal Officers at SACS and a team of professionals under the DAPCU National Resource Team which provides continuous feedback through online mentoring and supportive supervisory visits to DAPCUs. Joint Directors, Basic Services are designated as DAPCU Nodal Officers at SACS for monitoring and supervision of DAPCUs in their States. Guidance documents to monitor and supervise the DAPCU activities were developed for DAPCU Nodal Officers to help them.

Review of progress of DAPCUs

National review meeting of DAPCU Nodal Officers was held at DAC by Additional Secretary in June 2013 to review DAPCU functioning and further needs for DAPCU strengthening. The review meetings capacitated SACS to provide continuous leadership and guidance to DAPCUs. Many SACS are now conducting regular review meetings of their DAPCUs.

Overview of initiatives taken by DAPCUs in 2013-2014

- 176 out of 189 DAPCUs prepared their Annual Work Plans for 2013-2014, based on local specific needs which were used to monitor the progress made by DAPCUs in the district.
- DAPCU teams have been engaged in coordinating folk media campaigns and Red Ribbon Express in their districts, including the mobile ICTC route plans for optimal utilisation of resources
- DAPCUs are ensuring that facilities are reporting in SIMS and validating the data reported before sending to SACS/DAC.
- DAPCU staff from four select districts (East Godavari in Andhra Pradesh, Central Delhi in Delhi, Amravati in Maharashtra and Bhadrak in Odisha) participated in the International Conference on Social Protection Schemes for PLHIV and HRG held in Delhi on 11-12 December, 2013 to share their experiences on facilitating access to social protection schemes through involvement of district administration and other stakeholders.
- DAPCUs have been engaging the district administration through District AIDS Prevention Coordination Committee meetings held every quarter at the district level with District Collector chairing the meeting. In Tamil Nadu and

DAPCU Nodal Officers Review Meeting at DAC, June 2013

Sensitisation programme of F-ICTC Staff at PHC-Bonth, Bhadrak, Odisha by DAPCU Staff

Karnataka, these meetings are held every month along with District Health Society meetings. These meetings helped the DAPCUs to advocate for sanctioning of social benefit schemes for PLHIV and HRG, addressing problems in coordination with other health facilities and, mobilising resources like commodities (Condoms and STI drugs) and OI drugs from NHM.

- A team of volunteers from DAPCUs were trained for moderation of the DAPCU blog. 171 postings were made on the DAPCU blog during the period from April 2013 to March 2014 where in DAPCUs responded to discussions on a specific theme every month.
- More than 86% of DAPCUs have been sending monthly reports regularly. These reports are analysed and reviewed by the respective DAPCU Nodal Officers in SACS, to provide programmatic inputs.

IMPLEMENTATION OF RIGHT TO INFORMATION ACT, 2005

The Right to Information Act, 2005 enacted with a view to promote transparency and accountability in the functioning of the government by securing citizen's right to access information under the control of public authorities, has already come into force with effect from 12 October, 2005. Under the Act, two Central Public Information Officers and 10 Appellate Authorities have been appointed for different subjects, within the Department of AIDS Control. During 2013-2014, 166 applications and 19 appeals were received and replies were sent.

STRATEGIC INFORMATION MANAGEMENT 17

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

One of the key strategies of NACP-IV is Strategic Information Management. It is envisaged to have an overarching knowledge management strategy that encompasses the entire gamut of strategic information activities starting with data generation to dissemination and effective use.

The strategy will ensure high quality of data generation systems through surveillance, programme monitoring and research; strengthening systematic analysis, synthesis, development and dissemination of knowledge products in various forms; emphasis on knowledge translation as an important element of policy making and programme management at all levels; and establishment of robust evaluation systems for outcome as well as impact evaluation of various interventions under the programme.

The element of knowledge translation will be given the highest priority to ensure making linkages between knowledge and action at all levels of the programme. The programme will focus strongly on building capacities of epidemiologists, monitoring and evaluation officers, statisticians as well as programme managers in usage of appropriate and simple methods and tools of analysis and modelling. Institutional linkages will be fostered and strengthened to support the programme for its analytical needs, at national and State levels.

Some of the key initiatives under Strategic Information Management during NACP-IV include:

1. National Integrated Biological & Behavioural Surveillance (IBBS) among HRG & Bridge Groups
2. National Data Analysis Plan
3. National HIV/AIDS Research Plan
4. Transforming SIMS into an integrated decision support system with advanced analytic and Geographic Information System capabilities
5. Institutionalising Data Quality Monitoring System for routine programme data collection
6. Institutionalising data use for decision-making

STRUCTURE AND FUNCTIONS OF STRATEGIC INFORMATION MANAGEMENT UNIT

The Strategic Information Management Unit (SIMU) comprises four divisions: Monitoring & Evaluation Division, Research Division, Surveillance & Epidemiology Division and Data Analysis & Dissemination Unit.

The division generates and manages crucial information on the entire spectrum of the HIV epidemic and its control including HIV vulnerabilities and risk behaviours, levels, trends and patterns of spread of HIV and factors contributing to it, disease progression, treatment requirements and regimens, planning and implementing interventions, monitoring service delivery and tracking beneficiaries, effectiveness and impact of interventions. Another key function of SIMU is to promote data use for policymaking, programme planning, implementation and review at national, State, district and reporting unit levels.

PROGRAMME MONITORING AND EVALUATION

Key activities undertaken by Monitoring and Evaluation (M&E) division include:

- Managing Strategic Information Management System (SIMS) for monthly reporting from programme units, including system development and maintenance, finalising reporting formats, ensuring modifications/ improvements based on feedback, training programme personnel in its use, troubleshooting and mentoring
- Monitoring programme performance across the country through SIMS and providing feedback to concerned programme divisions and SACS
- Monitoring & ensuring data quality, timeliness and completeness of reporting from programme units data management, analysis and publications maintenance of the DAC website
- Processing data requests and data sharing
- Capacity building in strategic information areas
- Preparation of Programme Status Notes and Reports (Annual Report, Monthly Cabinet Note, Results Framework document, ISO 9001, UNGASS Report, Universal Access Report, etc.)
- Providing Data for National/ International documents

Strategic Information Management System

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

The overall reporting status in SIMS is 80% across the country. Component-wise reporting percent has also improved considerably over the years; current reporting status is 89% in ICTC, 71% in F-ICTC, 78% in STI, 72% in Blood Bank and 87% in TI-FSW and 78% in TI-MSM. New modules on ART and ICTC (daily and monthly reporting) are also being rolled-out in SIMS.

Training and Implementation of SIMS

For successful implementation of SIMS, clear guidelines have been developed outlining roles and responsibilities of M&E officers of DAC and SACS. Training material and user manuals have been developed for each component. Data dictionary giving field-wise details of the definitions, numerators and denominators etc. have been developed. A wall chart on SIMS has been developed to enable end-users to get quick access to all the key instructions and information for use of the SIMS application. Induction and refresher trainings of personnel from all reporting units, DAPCUs and programme officers at SACS and DAC have been conducted. Feedback received from the users is systematically logged and necessary technical rectifications and improvements are effected in coordination with the software team. SAS generated analytical reports and standardised reports, customised reports, dashboard, alerts, etc. are being updated.

Preparation of documents and reports

Programme monitoring personnel prepare various planning documents and reports from time-to-time. Monthly notes on the status of achievements to Cabinet Secretariat, Global AIDS Progress Reporting 2013, Results Framework Document for 2013-2014 and Outcome Budget document 2013-2014 were prepared during 2013-2014. State fact sheets and status notes of the National AIDS Control Programme are prepared on regular basis for dissemination of the programme data.

Processing data requests

All the data requests received in the standard format are reviewed by a committee of divisional heads. Data is shared with the applicant as per the data sharing guidelines and with due approval of the competent authority. Data Sharing Guidelines revised in November, 2013 are available on DAC website.

Data for National/International Documents

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

DAC Website

DAC website (www.naco.gov.in) provides access to information relating to policy, strategy and operational guidelines under the programme, and the status of the facilities and programme interventions. Job advertisements, tender documents, updated status notes and proceedings of important events are regularly updated on the website.

Review Meeting on the progress of Annual Action Plan 2013-2014

A meeting to assess the progress made by SACS against the targets of Annual Action Plan 2013-2014 and SIMS implementation status was organised in three batches i.e. 27 September, 3 October and 11 October, 2013. The meeting was attended by M&E Officers, Deputy Directors (M&E) and State Epidemiologists. Besides discussing Annual Action Plan and SIMS implementation in respective States, the participants were oriented on 'Strategic Information Strengthening and Use'.

Other Major Activities

As per the recommendations of the Second Administrative Reforms Commission, actions have been taken by the Department of AIDS Control:

- Online complaint tracking system / CPGRAMS is operational
- Complaints under the online tracking system are monitored on monthly basis
- The official website of Department of AIDS Control is updated on a weekly basis or as per requirements

- The content of the website are reviewed on a monthly basis by the programme divisions
- All forms on the website are available for download by stakeholders

The 'National Data Sharing and Accessibility Policy' was formulated based on the recommendations of the one-day workshop for Data Controllers held on 4 May, 2013 in New Delhi. This policy requires placing the non-sensitive data generated through public funds by the all Ministries/Departments, in the public domain through open government platform (http://data.gov.in). A meeting was held under the chairmanship of the Additional Secretary, DAC on 3 July, 2013, in which a presentation was made by NIC on the need and usefulness of publishing data on open government platform. Thereafter, the department published data on HIV Estimation, HIV Surveillance, facility details of ART Centres across the country on the website (www.data.gov.in).

Acting on the directions of the Cabinet Secretariat, regarding review of the crisis management plan for countering cyber-attacks and cyber terrorism in the Department, a detailed contingency plan (cyber security plan) for dealing with cyber security incidents has been developed, along with appointment of Chief Information Security Officer and constitution of Crisis Management Cell for cyber security.

In order to discuss and finalize the India Country Progress Report against targets of United Nations High Level Meeting (HLM), a stakeholders consultation was conducted under the chairmanship of Secretary, DAC on 05 August, 2013. Over 20 participants from Development Partners, communities of High Risk Groups and PLHIV, Civil Society Organisations, NGOs and academic institutions participated in the consultation. Progress against the ten HLM targets, challenges and recommendations for future action were discussed and deliberated upon. Accordingly, the Country Progress Report was finalised and submitted to the United Nations.

The Forum of Parliamentarians on HIV & AIDS in collaboration with the Department of AIDS Control and UNAIDS organised a Southern Regional Consultation on HIV/AIDS for elected representatives from the Southern region of India on 28 -29 October, 2013. Mr. Oscar Fernandes, President, Forum of Parliamentarians on HIV & AIDS, presided over the function. He urged political leaders to re-dedicate their commitment to the AIDS response since any complacency at this stage could be detrimental to the successes so far.

HIV/AIDS RESEARCH

Research is a vital component of Strategic Information Management under the National AIDS Control Programme. HIV/AIDS research covers a wide diversity of areas, such as epidemiological, social, behavioural, clinical and operational research; each of these has a strong role to play in providing a direction to the programme strategies and policies. The Department of AIDS Control focuses on ensuring translation of research outputs into programmatic action and policy formulation. During the course of NACP-III, many studies were conducted, and some are ongoing, which have helped in understanding the strengths and weaknesses of various interventions and have contributed to re-modelling them for greater effectiveness.

The main activities of the Research division are as follows:

1. Setting priority areas for Evaluation & Operational Research in HIV/AIDS & development of research protocols
2. Encouraging, processing & approving research proposals
3. Coordinating activities of the Technical Resource Group (TRG) on Research & Development and the Ethics Committee of the Department of AIDS Control
4. Dissemination of HIV/AIDS Research Outcomes
5. Coordination of activities of the Network of Indian Institution for HIV/AIDS Research (NIIHAR)

6. Capacity Building Initiatives in operational research and ethics in HIV/AIDS research
7. DAC Research Fellowship Scheme for MD/ M.Phil/ Ph.D students

NACP-IV will try to overcome the barrier posed by the gap between the generation and use of research evidence to inform and influence policymakers to make evidence-based policy decisions. There are certain areas where fresh evidence needs to be generated and customised to Indian settings – for the purpose of modelling and to answer key programme questions. This required a structured plan for identifying research priorities and commissioning research studies accordingly. A structured research plan has been developed for NACP-IV, which is termed as the National HIV/AIDS Research Plan (NHRP). It aims to overcome the barrier posed by gaps between the generation and use of research evidence to inform and influence policy makers to make evidence-based policy decisions. It will focus on time-bound studies with a multi-centric approach and evolve a strong mechanism to use the research outcomes for programmatic purposes.

HIV/AIDS Research during NACP-IV will have the following characteristics:

1. Research focused to assist evidence-based policy decisions and programming
2. Multi-centric and representative research for meaningful analysis at the national level
3. Ability to offer solutions customised to region specific context
4. High standards of scientific rigour and robustness
5. Innovative research methods to overcome research barriers
6. Institutional collaboration and cross-learning
7. Active involvement of programme leading to ownership of research outcomes and their translation into programme

The objectives of the National HIV/AIDS Research Plan under NACP-IV are mentioned below:

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

Setting Priorities for HIV/ AIDS Research under NACP-IV

Against this backdrop, a structured approach was adopted to bridge evidence gaps under NACP-IV. In order to address the programme needs with respect to evidence and research and make best use of the available data, as well as to generate fresh evidence, a structured analysis and research plan has been developed. A detailed exercise to assess existing information gaps in the programme was conducted involving programme managers at DAC, State levels and Development Partners. Information gaps highlighted by NACP-IV Working Groups in a series of meetings held during 2011-12 for development of NACP-IV strategies have also been incorporated and considered. Based on these, areas for analysis and research have been prioritised for NACP-IV. Research priorities have been categorised as epidemiological studies, socio-behavioural, bio-medical and clinical research and operational research.

Phase I of NHRP

The Research Plan Screening Committee has been constituted. Total 36 priority areas were finalised for Phase I of NHRP. For these areas Calls for Proposals inviting Expression of Interest were issued by DAC and its Development Partners. The proposals are being reviewed by the Research Plan Screening Committee.

Key activities undertaken during 2013-14

The TRG-R&D met once in 2013-2014. A total of 20 research proposals including Indo-foreign proposals referred by Health Ministry's Screening Committee, ICMR were reviewed in this meeting.

The Ethics Committee of the Department of AIDS Control met twice in 2013-2014 and following DAC supported research proposals were recommended in 2013-2014:

- Assessment of adherence to ARV prophylaxis /ART during pregnancy and breastfeeding and uptake of HIV testing among HIV exposed infants: A study from four States implementing the new PPTCT regimen
- Implementing linked services between HIV (ICTC/ART/PPTCT) and Family Planning at district level to reduce unmet need for contraception among HIV positive people
- Study on the factors responsible for referred TB suspects by ICTCs and ART centres to Designated Microscopy Centres in Odisha State, India
- Study of Prevalence of WHO recommended Tuberculosis Symptom Screening Complex among patients attending ART Centres in India
- Study of prevalence of HIV infection among general hospital attendees in Bagalkot district of Karnataka
- A case control study to understand determinants and biomarkers associated with immunological non-response
- Study of outcomes associated with Opioid Substitution Therapy under NACP
- Study the pattern of HIV Drug resistant mutations in HIV patients co-infected with active tuberculosis infection in India
- Validation of National Syndromic Protocol with or without minimal laboratory support among attendees of STI/RTI Healthcare Facilities in Delhi
- An assessment of feasibility of operationalization of 'Early or Immediate ART' to HIV infected partner as a combination intervention among HIV sero-discordant couples in India

Capacity Building in HIV/AIDS Operational Research and Ethics

A capacity building workshop for Operational Research and Ethics in Targeted Interventions was held during 18-22 June, 2013 at New Delhi with the support of UNICEF. A total of 20 researchers from various reputed TI NGOs, Medical Colleges, Research Organisations and Agencies working with the HRG communities participated in the workshop. The workshop followed a unique approach of interactive sessions in forenoon and development of research protocols under guidance of mentors in the afternoon sessions. Two research proposals based on key priority research areas were developed through this workshop, which have been processed through the TRG on R&D and the Ethics Committee of DAC.

A capacity building workshop on Ethics in HIV/AIDS Research was conducted at New Delhi in collaboration with CDC & FHI360 during 23-24 December, 2013. A total of 25 participants from various institutes of NIIHAR network, research institutes and various medical colleges from Delhi participated in this workshop. The workshop followed the learning-by-doing approach by solving various case studies based on ethical dilemmas in HIV/AIDS research under the guidance of eminent experts. The workshop was successful in sensitising young researchers on various ethical issues in HIV/AIDS Research.

A capacity building workshop on Ethics in HIV/AIDS Research was conducted at Lucknow, in collaboration with CDC and FHI360 on 25-26

Capacity Building Workshop on Ethics & Operational Research in Targeted Interventions at NIHFW, New Delhi, June 2014

February, 2014. There were 25 participants from Institutes of NIIHAR network, research Institutes and various medical colleges from Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Madhya Pradesh and Uttar Pradesh.

SURVEILLANCE

HIV Sentinel Surveillance

The thirteenth round of HIV Sentinel Surveillance (HSS) was implemented across the country at 763 sites, including 750 Antenatal Clinic (ANC) surveillance sites, covering 556 districts across 34 States and Union Territories during 2013. Quality of data collection during the 13th round was ensured through rigorous monitoring and supervision of the HSS activities by officials and epidemiologists from State AIDS Control Societies, designated Regional Institutes, and Development Partners. The introduction of web-based monitoring through Strategic Information Management Systems for HSS 2012-2013, facilitated real time monitoring and supervision of surveillance activities and enabled immediate corrective action.

The methodology adopted during HSS was consecutive sampling with unlinked anonymous specimens being tested for HIV following the two test protocol. The HIV tests were done at 117 State Reference Laboratories of the country. The identified 13 National Reference Laboratories participated in External Quality Assurance System for HSS. A technical brief based on the 13th round of HSS was published highlighting the methodology, implementation mechanism and key findings.

National Integrated Biological & Behavioural Surveillance

National Integrated Biological & Behavioural Surveillance (IBBS) is being implemented in 31 States and UTs of the country with strategic focus to strengthen the HIV surveillance among High Risk Groups and Bridge Population. The broad objective of the National IBBS is to generate evidence on risk behaviours among HRGs to support planning and prioritisation of programme efforts at district, State and national levels.

The specific objectives of IBBS are as follow:

- To measure and estimate the change in HIV-related risk behaviours and HIV prevalence at district and State levels among key risk groups, between baseline and end-line for NACP-IV
- To analyse and understand HIV related vulnerabilities and risk profiles among key risk groups in different regions, by linking behaviours with biological findings

Key applications of IBBS

1. **Understanding local epidemics:** Better characterisation of epidemics and vulnerabilities at district and State levels
2. **Programme Planning:**
   a. Refinement of prevention strategies & effective targeting of HRG
   b. Strengthening district level planning
   c. Better prioritisation of districts based on vulnerability
3. **HIV Estimations:** Development of population-based representative estimates of HIV prevalence for HRG that can be used for calibration of HIV prevalence derived from HSS, to improve HIV estimations
4. **Epidemic Modelling:** HIV prevalence & behavioural data from HRG can be applied to other epidemic models to estimate where most new infections are coming from and project the future burden of disease among different groups
5. **Programme Evaluation:** This information may also be used for evaluation of programme efforts during NACP-IV in conjunction with other relevant information

Study Group and Sample Size of IBBS

The high risk groups and bridge population that National IBBS covers across the country are Female Sex Workers, Men who have Sex with Men, Transgenders, Injecting Drug Users, Migrants and Currently Married Women. Overall, National IBBS is being implemented in 276 domains across 31 States and UTs of the country as detailed in Table 17.1.

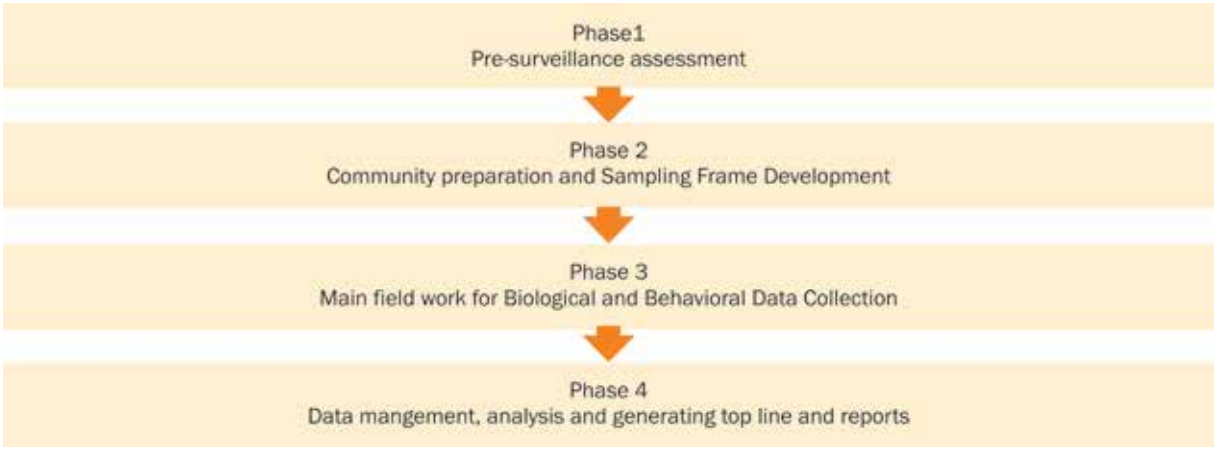
Implementation Phases of IBBS

National IBBS has four phases of implementation. These include planning and pre-surveillance assessment (PSA) at the first phase, followed by community preparation and sampling frame development (SFD) at the second phase as preparation for main field work. SFD and community preparation will be

Table 17.1: Study group and Sample size of National IBBS

Population Group	No. of Domains	Sample size per domain	Total Sample Size
Female Sex Workers	81	400	32,400
Men who have Sex with Men	69	400	27,600
Injecting Drug Users	60	400	24,000
Transgenders	15	400	6,000
Male Migrants	35	1,200	42,000
Currently Married Women	16	1,200	19,200
Total	**276**	**-**	**1,51,200**

Figure 17.1: Four Phases of National IBBS




Pre-surveillance Assessment Meeting, NIHFW, New Delhi

followed by bio-behavioural data collection. The fourth phase includes data management, analysis and generation of reports etc. PSA was successfully completed while preparatory activities for next phases were in progress during 2013-2014.

Pre-Surveillance Assessment

Pre-surveillance assessment was done in 243 domains of FSW, IDU, MSM and Male Migrants during 2013-2014. PSA was conducted in a qualitative research mode for feasibility assessment for implementing IBBS in selected domains and to understand the background characteristics of study population for planning purposes. It also provided a platform for the consulting target communities and sensitising them for National IBBS.

Key activities carried out for PSA were as follows:

- PSA was done in qualitative mode and accordingly operational guidelines and discussion guides were prepared. All of the tools were translated into local languages. Stakeholder specific informed consent forms were prepared and translated into local languages. Respondent protection measures, including confidentiality oath by researchers, were put in place before initiation of field work for Pre-Surveillance Assessment.
- Capacity building for National IBBS was done with a two-tier training plan. National Training of Trainers (ToT) was organised at AIIMS, New Delhi and was attended by members from the National Working Group (NWG), regional institutes and the field agency. The National ToT was followed by 6 regional level trainings where representatives from SACS, State Surveillance Team (SST) members and field team were trained.
- PSA was implemented in the 243 domains by 49 field teams. This included conduction of 1,951 key informants interview and 617 group discussions. The field work was monitored rigorously by Regional Institutes, SST members, SACS, NWG and DAC through online and offline processes. As a result, almost all the field teams were supervised in their first domain.
- The key outputs from PSA included domain specific domain summary sheet, highlighting the field perspective on feasibility, study population typology and visibility, potential challenges and solution for National IBBS. Other useful outputs from PSA included lists of key community leaders/gatekeepers, colloquial terms, hand drawn maps as well as block/town lists showing study population and TI presence in the domain.

SFD, Community Preparation and Bio-behavioural data collection

PSA is being followed by the next phases of IBBS i.e. sampling frame development, community preparation and bio-behavioural data collection.

Key preparatory activities completed during 2013-2014 for next phases are summarised below:

National Training of Trainers in progress at NCDC, New Delhi, March 2014

- **Guidelines and tools development, field testing and finalisation:** Operational guidelines focusing on SFD, community preparation and bio-behavioural data collection were developed. Tools specific to the study population were prepared for next phases of IBBS. Key tools prepared under the National IBBS include hotlist information format, informed consent and assent forms, questionnaires, respondent listing format and cluster information format. All of these formats were specific to study group and were translated into 15 local languages. The tools were pre-tested in all languages and modifications were made based on the outputs from pre-testing.
- **Integrated Information Management System:** Implementation of the next phases of the National IBBS, including data collection and project monitoring, will be done using a comprehensive system to allow simultaneous data collection & entry and greater quality control protocols. It also enhances project efficiency and effectiveness by enabling real time monitoring from field, labs, supervisors, etc. It also enables to institutionalise a strong feedback and troubleshooting system that can be fully documented. Finally, it allows for quick analysis and summarisation of top line findings.
- **Procurement:** Procurement under National IBBS has been summarised below:
  - » Procurement of Field Research Agencies for implementation of National IBBS in eight regions
  - » Procurement of DBS Cards and related accessories
  - » Procurement of non-reusable safety lancets
- **Training:** A cascade -style training was planned under the National IBBS. The National ToT, core experts training and IT management training were implemented during 2013-2014.
  - » National ToT, organised at New Delhi in March 2014, was attended by members from NWG, Regional Institutes, State Epidemiologists, IBBS Consultants and Field Research Agencies and focused on creating a pool of resource persons to impart training to the State level field teams.
  - » Core Expert Training was organised for NWG, Epidemiologists and IBBS consultants to further reinforce the understandings on the methodological issues.
  - » IT management training was organised for data managers of regional institutes and IT Coordinators of Field Research Agencies to make them familiar with Integrated Information Management Systems.

Launch Workshop of National Data Analysis Plan at JIPMER, Puducherry, January 2014

» Training specific manuals were prepared and shared with the audiences of respective trainings.

NATIONAL DATA ANALYSIS PLAN

The Data Analysis and Dissemination Unit of the Department of AIDS Control has initiated the National Data Analysis Plan (NDAP) under NACP-IV, to address programme needs with respect to evidence and research, and to make the best use of data available under the programme.

Objectives of National Data Analysis Plan

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

A detailed exercise was conducted involving programme managers and key stakeholders at National and State levels and also with Development Partners to assess the existing information gaps in the programme, and to prioritise areas for Analysis and Research. NDAP is an effort to analyse the huge amount of data generated under the programme, to develop analytic documents, scientific papers, journal articles, etc., for publication and wider dissemination, and for evidence-based planning & programme management. A panel of epidemiologists, biostatisticians, M&E, modelling and public health experts/ institutions has been identified to carry-out analysis of the programme data; and senior experts have been identified to provide mentoring support. Around 50 topics have been identified for secondary data analysis under the programme.

Launch of National Data Analysis Plan

To launch NDAP and to bring together all Analysts and Mentors on one platform, a workshop was organised at JIPMER, Puducherry during 16-18 January 2014. Shri Lov Verma, Secretary, Department of AIDS Control graced the valedictory function as the Chief Guest, along with Director, JIPMER, Puducherry, Director Heath & FW Services, Puducherry and other dignitaries. Participants of the workshop were from renowned medical institutions (AIIMS Delhi, JIPMER Puducherry, NARI Pune, NIE Chennai, PGIMER Chandigarh, etc.) and health organisations (CDC, FHI360, ICRW, UNAIDS, WHO, Population Council, PIPPSE, etc.), and also officers of the Department of AIDS Control, State AIDS Control Societies, and some Independent Consultants. In the workshop, around 60 Analysts and 30 Mentors along with DAC Programme Officers worked closely together to develop the analysis protocols and the way forward in the respective studies.

Interim Review Meetings of National Data Analysis Plan

As a follow-up to the launch of the National Data Analysis Plan in January 2014, the analysts were at different stages of developing their analysis studies. In the month of March 2014, the first Interim Review meeting was organised to assess the progress of the analysts in developing analysis protocols, and to facilitate finalisation of data analysis frameworks in programmes perspective. Interim Review meetings were conducted separately for Northern and Southern regions, along with some capacity building activities. For the Northern region the review meeting was held at PGIMER, Dr. RML Hospital, New Delhi, during 11-12 March 2014. The Southern region review meeting was held at GHTM, Tambaram Sanatorium, Chennai, during 27-28 March 2014.

In each of these regional meetings, around 25 analysis topics were reviewed with inputs from a team of Senior Experts and Officers from DAC programme divisions. Each presented analysis topic was reviewed and comments were given on the proposed research questions, objectives, methodology and programmatic feasibility in carrying out the study. The capacity building activities included keynote addresses on data cleaning and imputation techniques, programme priorities and research priorities in changing the HIV scenario and mathematical modelling, update on HIV-TB epidemiology, and challenges in analysing STI programme data.

Subsequently, analysts are being followed-up for sending their final analysis plans after incorporating comments of the experts in the review meeting and with the consent of their respective mentors. These secondary data analysis studies are expected to provide scientific evidence to the programme in strengthening and scaling-up appropriate strategies.

RESULTS FRAMEWORK DOCUMENT

18

The Results Framework Document of the Department is a System to both evaluate and monitor, and takes a comprehensive view of departmental performance, focuses on "Managerial" Performance and provides a unified and single view of performance. The RFD seeks to address three basic questions, as follows:

1. What are the department's main objectives for the year?
2. What actions are proposed to achieve these objectives?
3. How to determine progress made in implementing these actions?

Dr S. Venkatesh, Deputy Director General (M&E) has been designated as the Departmental Coordinator for RFD for the Department of AIDS Control. The department has been preparing RFDs in a timely manner and submitting it to the Performance Management Division (PMD) of the Cabinet Secretariat. For RFD 2009-2010, 2010-2011 and 2012-2013, DAC got overall composite scores of 92.89%, 91.27% and 90.44% respectively, with "Excellent" rating for the department's performance. For RFD 2011-2012, DAC scored 87.72% overall composite score with "Very Good" rating. RFD 2012-2013 of the Department of AIDS Control and its Performance Evaluation by PMD is at Annex 4.

RFD 2013-2014 was finalised at a meeting of the Adhoc Task Force on 21 March, 2013, subsequently approved by the High Power Committee, headed by the Cabinet Secretariat. For RFD 2013-2014, the Department of AIDS Control has submitted the Mid-term achievement in October 2013 and year-end achievements submitted in May, 2014.

In an independent evaluation of the quality of the Results Framework Document 2013-2014 of 12 departments of the Government of India commissioned by the Performance Management Division, DAC has been ranked the best.

Officers from the Department of AIDS Control attended the following workshops organised by the Performance Management Division of the Cabinet Secretariat in New Delhi, in 2013-2014:

- Workshop on preparing Action Plan for Innovation in Government Departments held on 5 April, 2013
- The International Workshop on Government Performance Management organised during 01-12 July, 2013.
- Workshop for the Departmental ISO coordinators and ISO consultants for knowledge and experience sharing, on 8 November, 2013.
- The Global Roundtable on Government Performance Management during 11-12 December, 2013.
- RFD Evaluation Methodology workshop organised on 18 February, 2014. In this workshop, an officer from DAC was awarded 'Certificate of Excellence' in the group activity.

The Citizen's/Client's Charter for 2013-2014 of Department of AIDS Control has been submitted to the Performance Management System of the Cabinet Secretariat.

During 2013-2014, DAC has started implementation of the ISO 9001 certification of the department. A consultant has been hired

for this purpose. A consultant from Quality Council of India reviewed the progress made by DAC on the implementation of ISO 9001 in December, 2013. Some of the activities required for implementation of ISO 9001, like formation of Management Committee for Implementation of ISO 9001:2008 have already been completed as part of the "Action plan for Implementation of ISO 9001" submitted to PMD. A core committee has also been formed at DAC to support the consultant and prepare the requirements for ISO implementations in the Department. The consultant expressed satisfaction with the progress made.

The identification of core and non-core activities of DAC as per the 2nd Administrative Reforms Commission and the 'Innovation Action Plan' as per revised guidelines of PMD have been sent to the PMD of the Cabinet Secretariat in stipulated timeline.

FINANCIAL MANAGEMENT 19

Financial Management is an integral and important component under NACP IV (2012-2017) programme architecture. Financial management deals with approval and review of annual plans and budgets, fund-flow mechanisms, delegation of financial powers, accounting and internal control systems, to ensure that funds are effectively used for programme objectives. It brings together planning, budgeting, accounting, financial reporting, internal control including internal audit, external audit, procurement, disbursement of funds and physical performance of the programme with the objective of managing resources efficiently and effectively.

The financial process focuses on financial analysis for programmatic and management use and meeting reporting obligations for all stakeholders and producing accurate and timely information that forms basis for better decisions, reducing delays and bottlenecks. Fiduciary requirements are addressed by designing and implementing effective audit mechanisms at all levels. This provides reasonable assurance that (i) operations are being conducted effectively and efficiently and in accordance with NACP financial norms; (ii) financial and operational reporting are reliable; (iii) laws and regulations are being complied with; and (iv)assets and records are maintained.

During NACP IV, the following areas will receive attention:

- Delegation of Financial Powers
- Asset Management
- Audit structures
- NGO financing and accounts
- Advances
- Inter-unit Transfers
- Computerised Project Financial Management System (CPFMS)
- Human Resource for Financial Management

Key roles and responsibilities of Finance Division

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

KEY FUNCTIONS

Budgeting

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

Accounting functions

- Annual Action Plan Preparation
- Processing and conveying approval
- Releases to SACS, NGOs, Consultancy Agencies, Central Institutions
- Expenditure accounting of DAC and SACS
- Monitoring of Utilisation Certificates
- Oversight of financial management and handholding SACS on expenditure management, target, advance settlements
- Other recipients

Audit Functions

- Coordination for statutory as well as internal audit of SACS
- Submission of audit reports to Ministry, Donor agencies etc.
- Facilitate audit at DAC level

Internal financial advisory functions

- Preliminary checking of bills by DDO (DAC)
- Advice on financial matters
- Representing negotiation meetings

Donor coordination

- With extra budgetary donors like UNAIDS, BMGF, Clinton Foundation etc.
- State Coordination Committees
- Convening of review meetings
- PDs review on SACS Financial Management
- MIS reporting on financial matters
- Functional support to CPFMS
- Handholding of States
- Periodic updates
- Submission of claims for reimbursement
- Preparation of Financial Management Reports, Interim Unaudited Financial Report to the World Bank through Controller of Aid Accounts and Audit (CAAA)

Utilisation of Funds in NACP-III (2007-2012) and annual plan of NACP-IV

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

Table 19.1: Year wise expenditure incurred during NACP-III period (2007-2012) and NACP IV (till March 2013)

Source	Year Wise Expenditure during NACP III (2007-2012)						NACP IV 2012-2013
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	Total	
Domestic Budget Support	287.38	188.00	200.75	303.22	136.27	1,115.62	942.71
Pool Fund(WB+DFID)	500.62	506.99	445.94	588.92	536.89	2579.36	0.00
The Global Fund	377.49	480.99	404.02	522.32	616.42	2401.24	373.36
USAID	23.22	26.25	24.97	33.89	11.52	119.85	0.00
UNDP	3.83	2.68	7.11	3.93	3.86	21.41	0.00
Total	1,192.54	1,204.91	1,082.79	1,452.28	1,304.96	6,237.48	1,316.07

Allocation through State Structure for NACP-III and Annual Plan of NACP-IV

The AIDS Control programme is implemented through State AIDS Control Societies in all States and Union Territories. There had been significant increase in the State plans as many programme interventions were scaled-up and stabilised. In addition to providing financial resources, DAC facilitated commodity and equipment support to the HIV service delivery centres following a central procurement method. The scaling-up of resource allocation is given in Figure: 19.1

National AIDS Control Programme - Phase IV (2012-2017)

NACP-IV approved on 03 October, 2013, was formulated after a wide range of consultations with a large number of partners including government departments, development partners, non-governmental organisations, civil societies, representatives of people living with HIV/AIDS, positive networks and experts in various subjects. This consultation was carried out over a period of more than six months with 35 working groups, sub-groups and national as well as regional consultative meetings comprising of more than 1,000 participants. Sources of funding for NACP-IV is at Table: 19.2

Figure 19.1: Resource allocation through State Structure from 2008-2009 to 2013-2014

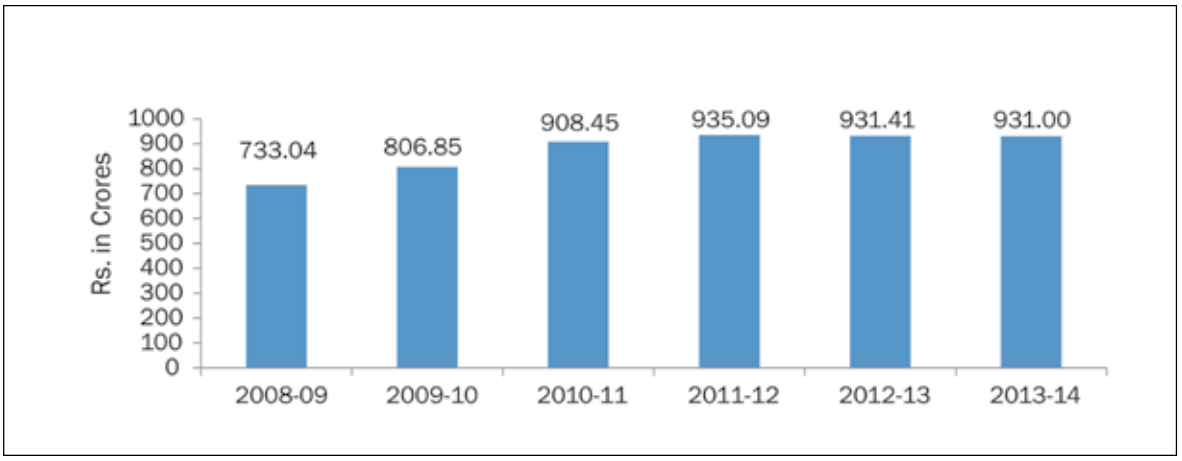


Table 19.2: Sources of Funding for NACP-IV

Source of Funding	Amount (Rs in Cr)
Gross Budgetary Support	
General Component (GC)	8,505.20
Externally Aided Component (EAC) (IDA/The World Bank Rs 1,275 Cr+ The Global Fund Rs 1,826.25 Cr)	3,101.25
Sub-Total 1 (I + II)	**11,606.45**
EXTRA BUDGETARY SUPPORT (To be implemented directly by development partners)	1,808.60
Sub-Total 2 (III)	**1,808.60**
Grand Total	**13,415.05**

The budget estimates of NACP- IV have been worked out based on the targets projected for NACP -IV and using existing costing norms suitably adjusted for the next five years. The total approved budget for NACP-IV is Rs. 13,415 crore which comprises Government Budgetary Support, Externally Aided Budgetary Support from The World Bank and The Global Fund, and Extra Budgetary Support from other Development Partners.

Initiatives to Strengthen the Financial Systems

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

National AIDS Control Programme emphasises the need for strengthening the workforce in the accounts and finance units at the central level for close monitoring, and at the State and district levels for prompt utilisation of resources. From a skeleton staff structure at various levels, it has enlarged to a group of professionals, with a good mix of both regular and contractual staff.

Better Monitoring Systems

Computerised Project Financial Management System has been developed and rolled-out to have better financial management. The system is working in all SACS for tracking expenditure management, capturing financial data, and utilising and monitoring of advances. An E-Transfer facility to avoid transit delays in transfer of funds to States has been implemented in the previous years. This has been established in all the States now and the steps are being taken for onward transfer of funds from State to districts and other implementing agencies at peripheral unit level.

Payment of salary to staff at district and peripheral units have been made totally through e-transfer and this has brought down the accumulation of funds at implementing agencies, thereby minimising 'advances'.

Copies of sanction orders, guidelines and instructions have been put on the DAC website and are updated periodically to ensure wider dissemination of information.

ANNEX 1

Most Recent and Important Audit Observations

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

ANNEX 2

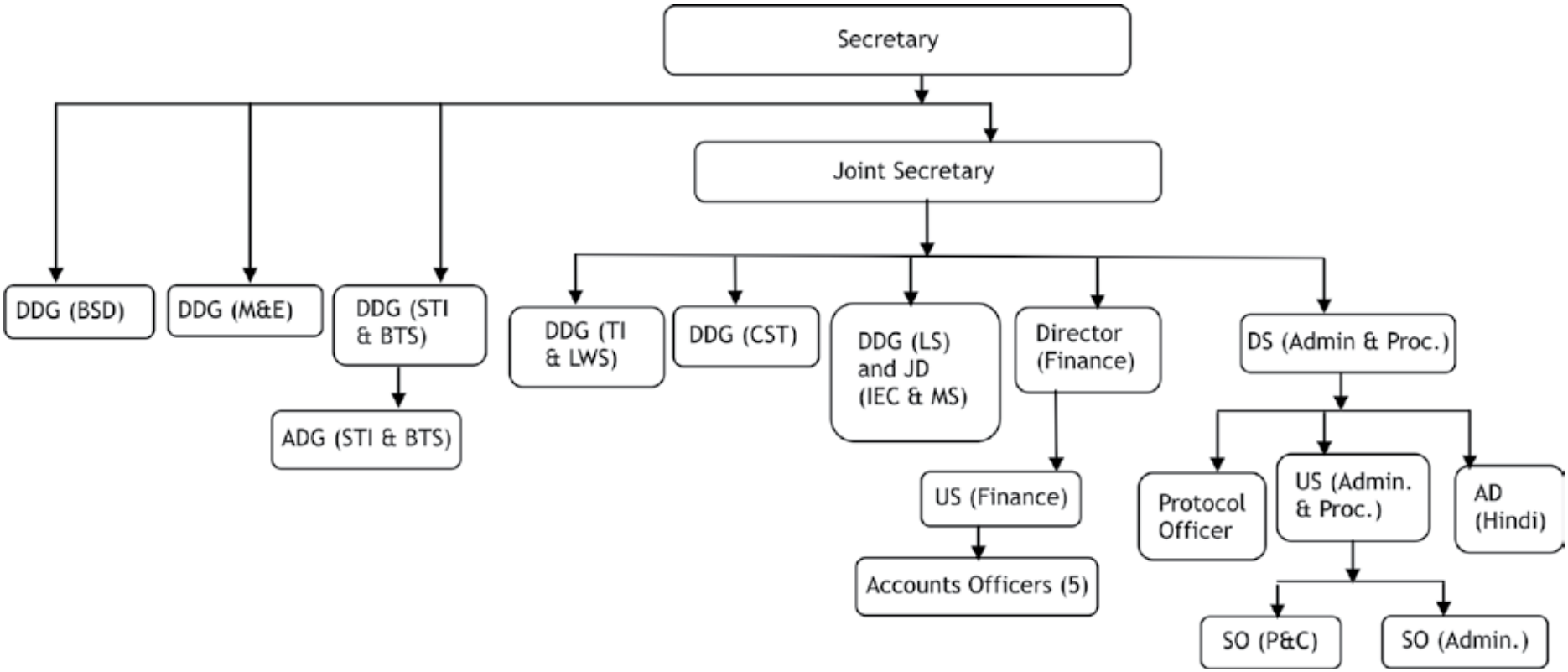
Contact details of State/Municipal AIDS Control Societies

Andaman & Nicobar AIDS Control Society, G.B.Pant Hospital Complex, Port Blair-744104	Andhra Pradesh AIDS Control Society, Directorate of Medical and Health Services, Sultan Bazar, Hyderabad-500059	Arunachal Pradesh State AIDS Control Society, Directorate of Health Services, Naharlagun, Arunachal Pradesh-791110
Assam State AIDS Control Society, Khanapara, Guwahati-781022	Ahmedabad Municipal corporation AIDS Controls Society, Old Municipal Dispensary, C.G.Road, Ahmedabad-380006	Bihar State AIDS Control Society, State Institute of Health & Family Welfare, Sheikhpura, Patna-800014
Chennai Municipal Corporation AIDS Control Society, 82 Thiru Vi-Ka Salai, Mylapore, Chennai-600004	Chandigarh State AIDS Control Society, International Hostel, Madhya Marg, (Near PGIMER), Sector 15-A, Chandigarh-160015	Chhattisgarh State AIDS Control Society, Directorate of Health Services, State health Training Centre, Near Kalibari Chowk, Raipur-492001
Dadra & Nagar Haveli State AIDS Control Society, Shri Vinobha Bhave Civil Hospital Campus, Silvassa-396230	Daman & Diu State AIDS Control Society, Community Health Centre, Moti Daman, Daman-396220	Delhi State AIDS Control Society, Dr. Baba Saheb Ambedkar Hospital, Dharmshala Block, Sector-6, Rohini, Delhi-110085
Goa State AIDS Control Society, First Floor, Dayanand Smriti Building, Swamy Vivekanand Road, Panaji-403001	Gujarat State AIDS Control Society,0/1 Block, New Mental Hospital,Complex, Menghani Nagar, Ahmedabad-380016	Haryana State AIDS Control Plot No.C-15, Awas Bhawan, Sector-6, Panchkula, Haryana-134109
Himachal Pradesh AIDS Control Society, Hari Villa, Near Forest Rest House, Khalini Shimla-2	Jammu & Kashmir AIDS Control Society, 48, Samandar Bagh, Exchange Road, Lal Chowk, Srinagar- 190001	Jharkhand AIDS Control Society, Sadar Hospital Campus, Purulia Road, Ranchi-834001
Karnataka AIDS Control Society, No.4/13-1, Crescent Road, High Grounds, Bengaluru-560001	Kerala State AIDS Control Society, IPP Building, Red Cross Road, Thiruvananthapuram, Kerala-695035	Lakshadweep State AIDS Control Society, Directorate of Medical and Health Services, UT of Lakshadweep, Kavaratti-682555
Madhya Pradesh State AIDS Control Society,1, Arera Hills, Second Floor, Oilfed Building, Bhopal-462011	Maharashtra State AIDS Control Society, Ackworth Leprosy Hospital Compound, R.A.Kidwai Marg, Wadala(West), Mumbai-400031	Manipur State AIDS Control Society, New Secretariat, Annexe Building, Western Block Imphal, Manipur-795001
Meghalaya State AIDS Control Society,Ideal Lodge, Oakland, Shillong-793001.	Mizoram State AIDS Control Society, MV-124, Mission Veng South, Aizwal-796005,	Mumbai Districts State AIDS Control Society, Municipal Corporation of Greater Mumbai, R.A.Kidwai Marg, Acworth Complex, Wadala, Mumbai-400031
Nagaland State AIDS Control Society, Medical Directorate, Kohima-797001	Odisha State AIDS Control Society, Second Floor,Oil Orissa Building, Nayapalli, Bhubaneswar-751012	Puducherry State AIDS Control Society,93, Perumal Koil Street Puducherry-605001
Punjab State AIDS Control Society, Prayas Building, 4th Floor, Sector38 B, Chandigarh-160014	Rajasthan State AIDS Control Society, Medical & Health Directorate, Swasthya Bhawan, Tilak Marg, Jaipur-302005.	Sikkim State AIDS Control Society, STNM Hospital,Gangtok,737101.
Tamilnadu State AIDS Control Society, 417 Pantheon Road, Egmore, Chennai-600008	Tripura State AIDS Control Society, Akhaura Road,Opposite tol. GM Hospital, Agartala-799097	Uttar Pradesh State AIDS Control Society, A-Block, 4th Floor, PICUP Bhawan, Vibhuti Khand, Gomti Nagar, Lucknow-226010
Uttarakhand State AIDS Control Society, Red Cross Bhawan, Near Directorate Medical Health, Dandalakhound, Gujrada, (Opp, I.T. Park), Sahstradhara Road, Dehradun	West Bengal State AIDS Control Society, Swasthya Bhavan, GN-29, Sector-V, Salt Lake, Kolkata-700091	North East Regional Office Banphool Naga Path, Near Housefed Bus Stop, Beltola Road, Guwahati, Dist-Kamrup-781006, Assam

ANNEX 3

Organization Chart of the Department of AIDS Control

Position as on 31.03.2014



AD – Assistant Director; ADG - Assistant Director General; Admin. – Administration; BSD - Basic Services Division; BTS- Blood Transfusion Services; CST - Care, Support & Treatment; DDG - Deputy Director General; DS – Deputy Secretary; IEC – Information, Education & Communication; JD - Joint Director; LS - Laboratory Services; LWS - Link Worker Scheme; M&E – Monitoring & Evaluation; MS – Mainstreaming; P&C - Planning & Coordination; Proc. - Procurement; SO - Section Officer; STI - Sexually Transmitted Infections; TI - Targeted Interventions; US - Under Secretary

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

ANNEX 4

Government of India

RFD

(Results Framework Document)

for

Department of AIDS Control
(2012-2013)

SECTION 1

Vision, Mission, Objectives and Functions

Vision

Prevention and reduction of the HIV burden in India.

Mission

To reduce HIV prevalence in population groups at risk of HIV/AIDS by an integrated prevention, care and support programme.

Objectives

1. Intensifying and consolidating prevention services with a focus on HRG and vulnerable population.
2. Increasing access and promoting comprehensive care, support and treatment
3. Expanding IEC services for (a) general population and (b) high risk groups with a focus on behavior change and demand generation.
4. Building capacities at national, state and district levels
5. Strengthening and use of Strategic Information Management Systems

Functions

1. Targeted Interventions
2. Link Worker Scheme
3. Management of Sexually Transmitted Infection / Reproductive Tract Infection
4. Promotion of Condom use
5. Blood Safety including promotion of Voluntary Blood Donation
6. Integrated Counseling and Testing, and Prevention of Parent to Child Transmission services
7. Information Education and Communication, and Social Mobilisation including mainstreaming
8. Care, Support and Treatment including Antiretroviral therapy (ART) services and Treatment of Opportunistic Infections, HIV-TB Cross Referral and Community Care services for PLHA.
9. Strategic Information Management including Programme Monitoring, Surveillance & Epidemiology and Research & Evaluation

SECTION 2

Inter se Priorities among Key Objectives, Success indicators and Targets & Performance Evaluation Report

Objective	Weight	Action	Success Indicator	Unit	Weight	Target / Criteria Value						Performance	
						Excellent 100%	Very Good 90%	Good 80%	Fair 70%	Poor 60%	Achiev-ement	Raw Score	Weighted Score
[1] Intensifying and consolidating prevention services with a focus on HRG and vulnerable population.	60.00	[1.1] Targeted Intervention	[1.1.1] New TIs established	No.	17.00	200	180	160	140	120	218	100.0	17.0
		[1.2] Link Worker Scheme	[1.2.1] Districts covered under Link Worker Scheme (Cumulative)	No.	2.00	166	163	160	157	154	160	80.0	1.6
		[1.3] Integrated Counselling and testing including PPTCT	[1.3.1] Persons Tested for HIV	No. in lakh	5.00	143	130	117	104	91	104.55	70.42	3.52
			[1.3.2] Pregnant Women tested for HIV	No. in lakh	3.00	95	90	85	80	75	82.94	75.88	2.28
			[1.3.3] Proportion of HIV+ Pregnant Women & Babies who receive ARV prophylaxis	%	3.00	80	75	70	65	60	94	100.0	3.0
		[1.4] HIV-TB Coordination	[1.4.1] HIV-TB Cross Referrals	No. in lakh	2.00	12	11	10	9	8	13.28	100.0	2.0
		[1.5] STI Care	[1.5.1] STI/RTI patients (Excluding NRHM) managed as per national protocol	No. in lakh	10.00	70.6	64.2	57.7	51.3	44.9	61.33	85.58	8.56
		[1.6] Condom Promotion	[1.6.1] Social Marketing of Condoms by NACO Contracted Social Marketing Organisations (SMO)	No. in crore	4.00	42	35	28	21	14	39.02	95.74	3.83
			[1.6.2] Distribution of free condoms	No. in crore	4.00	46	44.5	42	40	38	46.17	100.0	4.0
		[1.7] Blood Safety	[1.7.1] Blood Compo-nent Separation Units established	No.	5.00	5	4	3	2	1	5	100.0	5.0
			[1.7.2] Proportion of blood units collected through Voluntary Blood Donation in NACO supported Blood Bank	%	5.00	100	90	80	70	60	84.3	84.3	4.22
[2] Increasing access and promoting comprehensive care, support and treatment	13.00	[2.1] Provision of ART	[2.1.1] ART Centres established (Cumulative)	No.	4.00	420	400	380	360	340	400	90.0	3.6
			[2.1.2] PLHA on ART	No. in lakh	5.00	7.04	6.40	5.76	5.12	4.48	6.32	88.75	4.44
		[2.2] Treatment of Opportunistic Infections	[2.2.1] Opportunistic Infections treated at ART centres	No. in lakh	4.00	4.7	4.3	3.8	3.4	3.0	3.70	77.5	3.1

Objective	Weight	Action	Success Indicator	Unit	Weight	Target / Criteria Value						Performance	
						Excellent 100%	Very Good 90%	Good 80%	Fair 70%	Poor 60%	Achievement	Raw Score	Weighted Score
[3] Expanding IEC services for (a) general population and (b) high risk groups with a focus on behavior change and demand generation.	5.00	[3.1] IEC & Social Mobilisation	[3.1.1] Campaigns to be released on Mass Media - TV/Radio	No.	3.00	10	9	8	7	6	10	100.0	3.0
			[3.1.2] New Red Ribbon Clubs formed in Colleges	No.	1.00	600	500	400	350	300	500	90.0	0.9
			[3.1.3] Persons trained under Mainstreaming training programmes	No.in lakh	1.00	6.5	6.0	5.0	4.5	4.0	4.13	62.6	0.63
[4] Building capacities at national, state and district levels	2.00	[4.1] Procurement	[4.1.1] Proportion of Procurement contracts awarded during the original validity period	%	2.00	100	90	70	60	50	100	100.0	2.0
[5] Strengthening and use of Strategic Information Management Systems	5.00	[5.1] Surveillance & Epidemiology	[5.1.1] Submission of Provisional Findings from HIV Sentinel Surveillance 2012	Date	2.00	08/03/2013	15/03/2013 1	18/03/2013	25/03/2013	29/03/2013	30/11/2012	100.0	2.0
		[5.2] Research & Evaluation	[5.2.1] Organisation of Capacity building workshops on Operational Research and Ethics in HIV/AIDS	No.	2.00	5	4	3	2	1	5	100.0	2.0
		[5.3] Programme Monitoring	[5.3.1] Proportion of Reporting Units reporting through Strategic Information Management System	%	1.00	70	60	50	40	30	70.9	100.0	1.0
* Efficient Functioning of the RFD System	3.00	Timely submission of Draft for Approval	On-time submission	Date	2.0	05/03/2012	06/03/2012 0	7/03/2012	08/03/2012	09/03/2012	05/03/2012	100.0	2.0
		Timely submission of Results	On- time submission	Date	1.0	01/05/2012	03/05/2012 0	4/05/2012	05/05/2012	06/05/2012	01/05/2012	100.0	1.0

Objective	Weight	Action	Success Indicator	Unit	Weight	Target / Criteria Value						Performance	
						Excellent 100%	Very Good 90%	Good 80%	Fair 70%	Poor 60%	Achievement	Raw Score	Weighted Score
*Administrative Reforms	6.00	Implement mitigating strategies for reducing potential risk of corruption	% of implementation	%	2.0	100	95	90	85	80	100	100.0	2.0
		Implement ISO 9001 as per the approved action plan	Area of operations covered	%	2.0	100	95	90	85	80	100	100.0	2.0
		Timely preparation of departmental Innovation Action Plan (IAP)	On-time submission	Date	2.0	01/05/2013	02/05/2013 0	3/05/2013	06/05/2013	07/05/2013	01/05/2013	100.0	2.0
* Improving Internal Efficiency / responsiveness / service delivery of Ministry / Department	4.00	Implementation of Sevottam	Independent Audit of Implementation of Citizen's Charter	%	2.0	100	90	80	70	60	89	89.0	1.78
			Independent Audit of implementation of public grievance redressal system	%	2.0	100	90	80	70	60	47.67	0.0	0.0
* Ensuring compliance to the Financial Accountability Framework	2.00	Timely submission of ATNs on Audit paras of C&AG	Percentage of ATNs submitted within due date (4 months) from date of presentation of Report to Parliament by CAG during the year.	%	0.5	100	90	80	70	60	100	100.0	0.5
		Timely submission of ATRs to the PAC Sectt. on PAC Reports.	Percentage of ATRS submitted within due date (6 months) from date of presentation of Report to Parliament by PAC during the year.	%	0.5	100	90	80	70	60	100	100.0	0.5
		Early disposal of pending ATNs on Audit Paras of C&AG Reports presented to Parliament before 31.3.2012.	Percentage of outstanding ATNs disposed off during the year.	%	0.5	100	90	80	70	60	100	100.0	0.5
		Early disposal of pending ATRs on PAC Reports presented to Parliament before 31.3.2012	Percentage of outstanding ATRS disposed off during the year.	%	0.5	100	90	80	70	60	100	100.0	0.5

* Mandatory Objective(s)

Total Composite Score: 90.44

SECTION 3

Trend Values of the Success Indicators

Objective	Action	Success Indicator	Unit	Actual Value for FY 10/11	Actual Value for FY 11/12	Target Value for FY 12/13	Projected Value for FY 13/14	Projected Value for FY 14/15
[1] Intensifying and consolidating prevention services with a focus on HRG and vulnerable population.	[1.1] Targeted Intervention	[1.1.1] New TIs established	No.	188	175	180	--	--
	[1.2] Link Worker Scheme	[1.2.1] Districts covered under Link Worker Scheme (Cumulative)	No.	--	--	163	--	--
	[1.3] Integrated Counselling and testing including PPTCT	[1.3.1] Persons Tested for HIV	No. in lakh	--	--	130	--	--
		[1.3.2] Pregnant Women tested for HIV	No. in lakh	--	--	90	--	--
		[1.3.3] Proportion of HIV+ Pregnant Women & Babies who receive ARV prophylaxis	%	--	--	75	--	--
	[1.4] HIV-TB Coordination	[1.4.1] HIV-TB Cross Referrals	No. in lakh	10.48	9.97	11	--	--
	[1.5] STI Care	[1.5.1] STI/RTI patients (Excluding NRHM) managed as per national protocol	No. in lakh	100.1	74.57	64.2	--	--
	[1.6] Condom Promotion	[1.6.1] Social Marketing of Condoms by NACO Contracted Social Marketing Organisations (SMO)	No. in crore	--	--	35	--	--
		[1.6.2] Distribution of free condoms	No. in crore	--	--	44.5	--	--
	[1.7] Blood Safety	[1.7.1] Blood Component Separation Units established	No.	--	--	4	--	--
		[1.7.2] Proportion of blood units collected through Voluntary Blood Donation in NACO supported Blood Bank	%	--	--	90	--	--

Objective	Action	Success Indicator	Unit	Actual Value for FY 10/11	Actual Value for FY 11/12	Target Value for FY 12/13	Projected Value for FY 13/14	Projected Value for FY 14/15
[2] Increasing access and promoting comprehensive care, support and treatment	[2.1] Provision of ART	[2.1.1] ART Centres established (Cumulative)	No.	--	--	400	--	--
		[2.1.2] PLHA on ART	No. in lakh	--	--	6.40	--	--
	[2.2] Treatment of Opportunistic Infections\	[2.2.1] Opportunistic Infections treated at ART centres	No. in lakh	--	--	4.3	--	--
[3] Expanding IEC services for (a) general population and (b) high risk groups with a focus on behavior change and demand generation.	[3.1] IEC & Social Mobilisation	[3.1.1] Campaigns to be released on Mass Media - TV/Radio	No.	6	6	9	--	--
		[3.1.2] New Red Ribbon Clubs formed in Colleges	No.	5190	282	500	--	--
		[3.1.3] Persons trained under Mainstreaming training programmes	No.in lakh	5.2	5.6	3.0	--	--
[4] Building capacities at national, state and district levels	[4.1] Procurement	[4.1.1] Proportion of Procurement contracts awarded during the original validity period	%	--	--	90	--	--
[5] Strengthening and use of Strategic Information Management Systems	[5.1] Surveillance & Epidemiology	[5.1.1] Submission of Provisional Findings from HIV Sentinel Surveillance 2012	Date	--	--	15/03 /2013	--	--
	[5.2] Research & Evaluation	[5.2.1] Organisation of Capacity building workshops on Operational Research and Ethics in HIV/AIDS	No.	1	2	2	--	--
	[5.3] Programme Monitoring	[5.3.1] Proportion of Reporting Units reporting through Strategic Information Management System	%	--	--	60	--	--
* Efficient Functioning of the RFD System	Timely submission of Draft for Approval	On-time submission	Date	05/03 /2010	07/03 /2011	05/03 /2012	--	--
	Timely submission of Results	On- time submission	Date	03/05 /2011	01/05 /2012	01/05 /2012	--	--

Objective	Action	Success Indicator	Unit	Actual Value for FY 10/11	Actual Value for FY 11/12	Target Value for FY 12/13	Projected Value for FY 13/14	Projected Value for FY 14/15
* Administrative Reforms	Implement mitigating strategies for reducing potential risk of corruption	% of implementation	%	--	--	95	--	--
	Implement ISO 9001 as per the approved action plan	Area of operations covered	%	--	--	95	--	--
	Timely preparation of departmental Innovation Action Plan (IAP)	On-time submission	Date	--	--	06/03 /2013	--	--
* Improving Internal Efficiency / responsiveness / service delivery of Ministry / Department	Implementation of Sevottam	Independent Audit of Implementation of Citizen's Charter	%	--	--	95	--	--
		Independent Audit of implementation of public grievance redressal system	%	--	--	95	--	--
* Ensuring compliance to the Financial Accountability Framework	Timely submission of ATNs on Audit paras of C&AG	Percentage of ATNs submitted within due date (4 months) from date of presentation of Report to Parliament by CAG during the year.	%	100	--	90	--	--
	Timely submission of ATRs to the PAC Sectt. on PAC Reports.	Percentage of ATRS submitted within due date (6 months) from date of presentation of Report to Parliament by PAC during the year.	%	100	--	90	--	--
* Ensuring compliance to the Financial Accountability Framework	Early disposal of pending ATNs on Audit Paras of C&AG Reports presented to Parliament before 31.3.2012.	Percentage of outstanding ATNs disposed off during the year.	%	100	--	90	--	--
	Early disposal of pending ATRs on PAC Reports presented to Parliament before 31.3.2012	Percentage of outstanding ATRS disposed off during the year.	%	100	--	90	--	--

* Mandatory Objective(s)

SECTION 4

Description and Definition of Success Indicators and Proposed Measurement Methodology

Number of new Targeted Interventions units established

This indicator measures the expansion of targeted intervention programme in which the contracted NGO provides services for a core group population, i.e., female sex workers, men having sex with men, injecting drug users, Migrants or Truckers in specified geographic area. (Data Source: CMIS / SIMS)

Number of districts covered under Link Worker Scheme (Cumulative)

This indicator measures the number of districts where the Link Worker Scheme (LWS) covers highly vulnerable villages and addresses population with high-risk behaviours and young people. (Data Source: Programme Division)

Number of Clients tested for HIV

This indicator measures general clients (excluding pregnant women) who attend Integrated Counseling and Testing Centres (ICTC) and give consent and provide a biological specimen for HIV testing. (Data Source: CMIS / SIMS)

Number of Pregnant Women tested for HIV

This indicator measures absolute number of pregnant women availing prevention of parent to child transmission services at ICTCs and give consent and provide a biological specimen for HIV testing. (Data Source: CMIS / SIMS)

Proportion of HIV+ pregnant women and babies receiving ARV prophylaxis

This indicator measures the proportion of HIV positive pregnant women giving live births who along with their babies receive prophylactic anti-retro viral drugs in order to prevent mother to child transmission of HIV. (Data Source: CMIS / SIMS)

Number of HIV-TB Cross Referrals

This measures the number of cross-referrals which includes HIV-positive persons referred from ICTC Centres to RNTCP and the TB patients referred from RNTCP to ICTC. (Data Source: CMIS / SIMS)

Number of Sexually Transmitted Infection (STI)/ Reproductive Tract Infection (RTI) patients managed as per national protocol

This indicator measures the uptake of STI/RTI Clinic services. (Data Source: CMIS / SIMS)

Social Marketing of Condoms by NACO Contracted Social Marketing Organisations (SMO)

This indicator shows the condoms subsidised by the Government of India and marketed through social marketing organisations registered with the Government of India. (Data Source: Programme Division)

Distribution of free condoms

This indicator shows the condoms distributed free by the National AIDS Control Organisation. (Data Source: Programme Division)

Number of Blood Component Separation Units establishment

This indicator measures the expansion of facilities for separating the blood into various components which will promote rational use of blood. (Data Source: CMIS / SIMS)

Proportion of blood units collected through Voluntary Blood Donation

This indicator shows the proportion of blood units collected through voluntary non-remunerated donation out of the total number of units collected at licensed blood banks. (Data Source: CMIS / SIMS)

Number of campaigns released on Mass Media - TV/Radio

This indicator measures the number of mass communication campaigns through Television and Radio targeting general population with focus on vulnerable segments such as women and youth. (Data Source: Programme Division)

Number of new Red Ribbon Clubs formed in Colleges

This indicator measures the expansion of Red Ribbon Clubs formed in Colleges which provide a forum to students to discuss issues relating to HIV/AIDS and also motivate them to participate in voluntary blood donation. (Data Source: Programme Division)

Number of persons trained under Mainstreaming training programmes

This indicator measures the number of persons from different ministries/departments in centre/states who are trained in HIV/AIDS issues under the mainstreaming initiative. (Data Source: Programme Division)

Number of Anti-Retroviral Treatment (ART) Centres Established (Cumulative)

This indicator measures the expansion of the number of health facilities delivering free ART services. (Data Source: CMIS / SIMS)

Number of People Living with HIV/AIDS (PLHA) on ART

This indicator measures the number of HIV+ persons who are alive and currently receiving free ART at ART centres. (Data Source: CMIS / SIMS)

Number of Opportunistic Infections (OIs) treated

This indicator measures the episodes of ailments among PLHAs identified as AIDS related illnesses which were treated at ART centres or Community Care Centres. (Data Source: CMIS / SIMS)

Proportion of procurement contracts awarded during the original validity period

This indicator measures the efficient management of procurement matters at NACO. (Data Source: CMIS / SIMS)

Submission of Provisional Findings from HIV Sentinel Surveillance 2012

This indicator indicates the timely completion of sample collection, testing and data entry under HIV Sentinel Surveillance 2012 and the provisional findings will give information on levels and trends of HIV infection in different risk groups across the country.

Organisation of Capacity building workshops on Ethics in HIV/AIDS research

NACO will organise workshop and build capacity for Ethics in the institution under the Network of Indian Institutes of HIV/AIDS Research (NIHAR).

Proportion of Reporting Unit reported through Strategic Information Management System

This indicator indicates the proportion of reporting units out of total no. of active reporting units, reported through Strategic Information Management System.

SECTION 4

Description and Definition of Success Indicators and Proposed Measurement Methodology

Acronyms	
AEP	Adolescence Education Programme
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Clinic
ATN	Action Taken Note
ATR	Action Taken Report
ART	Antiretroviral therapy
ARV	Anti-Retro-Viral
BCC	Behaviour Change Communication
BCSU	Blood Component Separation Units
BSC	Blood Storage Centre
BSS	Behaviour Surveillance Survey
CBO	Community- Based Organisation
CCC	Community Care Centre
CD4	Cluster of Differentiation 4
CMIS	Computerised Management Information System
CoE	Centre of Excellence
CPFMS	Computerised Project Financial Management System
CSMP	Condom Social Marketing Programme
CST	Care, Support and Treatment
CVM	Condom Vending Machine
DAPCU	District AIDS Prevention & Control Unit
DIC	Drop In Centre
EID	Early Infant Diagnosis
EQAS	External Quality Assessment Scheme
FICTC	Facility Integrated Counseling & Testing Centre
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
IDU	Injecting Drug User
IEC	Information, Education and Communication
JAT	Joint Appraisal Team
LAC	Link ART Centre
LWS	Link Worker Scheme
M & E	Monitoring & Evaluation
MSM	Men who have Sex with Men
NABL	National Accreditation Board for Laboratories
NACO	National AIDS Control Organisation

Acronyms	
NACP	National AIDS Control Programme
NARI	National AIDS Research Institute
NBTA	National Blood Transfusion Authority
NGO	Non-Government Organisation
NRHM	National Rural Health Mission
NTSU	National Technical Support Unit
OI	Opportunistic Infections
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PLHA	People Living with HIV/AIDS
PLHIV	People Living with HIV
PPP	Public Private Partnership
PPTCT	Prevention of Parent to Child Transmission
RFD	Result Framework Document
RRC	Red Ribbon Club
RRE	Red Ribbon Express
RTI	Reproductive Tract Infections
SACS	State AIDS Control Society
SBTC	State Blood Transfusion Council
SIMS	Strategic Information Management System
SIMU	Strategic Information Management Unit
SMO	Social Marketing Organisation
SRL	State Reference Laboratory
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
TI	Targeted Intervention
TRG	Technical Resource Group
TSG	Technical Support Group
TSU	Technical Support Unit
VBD	Voluntary Blood Donation

SECTION 5

Specific Performance Requirements from other Departments

Department / Ministries	Relevant Success Indicator	What do you need?	Why do you need it?	How much you need?	What happens if you do not get it?
• Panchayati Raj • Women and Child Development • Rural Development • Housing and Poverty Alleviation • HRD, • Railways, • Tribal Affairs, Home, Defence, • Youth affairs • Ministry of Home Affairs	• No of persons trained under Mainstreaming Training programmes,	• Guidelines for incorporating HIV/AIDS in their schemes and training programmes, • NSS to continue the support for formation of RRCs in Colleges • Earmarking budgets for undertaking HIV/AIDS Activities & implementation of social Schemes for People Living with HIV/AIDS • Shelter, vocational Rehabilitation and child rearing services for female IDUs and partners of male IDUs Protection of female drug users from harassment • Educational campaigns against initiation of drug use targeting adolescents and youth • Provision of HIV prevention education to prison inmates	To strengthen the National response to HIV/AIDS	Full support and commitment	It would hamper The achievement of National targets and programme outcomes
• Ministry of Health &Family Welfare/ National Rural Health Mission		• Counselors & Lab technicians for ICTCs below CHC level from general health system • Universal HIV testing for Pregnant women as part of ANC • NRHM to support staff (doctors, nurses and pharmacists) at ART centres & LACs in a phased manner • NRHM to provide dedicated nurses to LAC+ centers to support Pre- ART and ART follow up • Promotion of voluntary Blood Donation through health System initiatives • Consumables for Blood Storage Units (BSUs) to be provided by NRHM • Increasing Access to services for rural HRG and vulnerable Population through ASHA and Anganwadi workers • Strengthening referral services to Government health facilities • Support for OST programme by provision of human resource (doctors, nurses) and infrastructure (space, equipment, etc.)	For integration of HIV/AIDS services with the Health system	Full support and commitment	It would hamper the achievement of National targets and programme outcomes

Department / Ministries	Relevant Success Indicator	What do you need?	Why do you need it?	How much you need?	What happens if you do not get it?
• Ministry of Social Justice and Empowerment		• MSJE to identify IDUs as a focused population for its drug demand reduction programme • Formal linkages between NACO supported IDU interventions and MSJE supported rehabilitation centres • Inclusion of HIV and harm Reduction information in the trainings conducted by NISD and RRTCs	To strengthen the national effort towards control of HIV epidemic among IDUs and rehabilitation of drug users into the society	Full support and commitment	Without support from the MSJE drug demand reduction programme, sustained behaviour change among IDUs would be difficult to achieve and risk of going back to the previous drug use pattern would remain high.
• Narcotics Control Board		• Sensitization of NCB cadre to facilitate referral of drug users to treatment facilities	Under the NDPS act, drug users have been differentiated from those involved in drug dealing. NCB cadres should have the necessary skills to do so. Treatment of IDUs as per provisions of NDPS act would facilitate recovery		Drug users may remain outside the treatment and continue practicing unsafe behaviours

SECTION 6

Outcome/Impact of Department/Ministry

Outcome/Impact of Department/Ministry	Jointly responsible for influencing this outcome / impact with the following department (s) / ministry(ies)	Success Indicator	Unit	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15
1. Survival of AIDS patients on ART		% of adults and children with HIV known to be on treatment at 24 months after initiation of antiretroviral therapy at select ART centres	%					
2 Reduction in estimated AIDS related deaths		Estimated number of Annual AIDS related deaths	No.	172000				
3 Reduction in estimated new HIV Infections		Estimated number of Annual new HIV infections	No.	120000				
4 Improved Prevention of Parent to Child Transmission	Department of Health and Family Welfare							
5 Improved prevention of AIDS in High Risk Group (HRG)		Coverage of HRG through Targeted intervention (TIs)-Female Sex Workers (FSW)	%	81.6	81			
		Coverage of HRG through TIs- Males having Sex with Males (MSM) (including Transgenders engaged in sexual activity)	%	66.50	64			
		Coverage of HRG through TIS- Injecting Drug Users (IDU)	%	80.22	80			
6 Improved in Health seeking behavior of HRGs		% HRGs who received HIV test	%	36.84	40			

India's voice against AIDS

Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in