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STOP AIDS

NATIONAL AIDS CONTROL PROGRAMME

Response to the HIV Epidemic in India

NATIONAL AIDS CONTROL PROGRAMME
Response to the HIV Epidemic in India

सत्यमेव जयते

NACO

National AIDS Control Organisation

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

CONTENTS

INTRODUCTION: NATIONAL AIDS CONTROL PROGRAMME (NACP)—INDIA

An estimated 2.39 million Indians are infected with HIV in an epidemic that is concentrated in high-risk populations, such as sex workers, men who have sex with men, transgenders, injecting drug users, and clients of sex workers. Since the first HIV case was identified in India in 1986, the Government of India has worked to contain and prevent the spread of HIV and to provide care, support, and treatment for those already infected. In 1992, the National AIDS Control Organisation (NACO) was created by the Government of India, to prevent and contain the HIV epidemic.

This document provides an overview of the HIV epidemic in India and the evolution of the National AIDS Control Organisation through the three phases of National AIDS Control Programme. The key achievements and lessons learned from NACP-I and -II have been highlighted, while the document focuses on NACO's current response to the epidemic, including the priorities for NACP-III and the logic that guided the development of these priorities.

"An estimated 2.39 million Indians are infected with HIV"


Grand Finale of Red Ribbon Superstars Football Tournament in Mizoram

OVERVIEW OF THE HIV EPIDEMIC IN INDIA

The HIV epidemic in India is concentrated in nature. The HIV prevalence among the High Risk Groups i.e. Female Sex Workers, Injecting Drug Users, Men who have Sex with Men and Transgenders is higher than the general population. In 2009, it was estimated that approximately 2.39 million people were infected with HIV in India, of which, 39% were female and 4.4% were children. The four high prevalence states of South India account for 55% of these cases. Unprotected sex (87.4% heterosexual and 1.3% homosexual) is the major route of HIV transmission, followed by transmission from Parent to Child which is 5.4% and use of infected blood and blood products is 1.0%. While Injecting Drug Use is the predominant route of transmission in northeastern states, it accounts for 1.7% of HIV infections nationally (see Figure 1 below).

Routes of HIV Transmission, India, 2010-11

Unprotected (hetero-) sexual contact is the main route accounting for 87% of the total HIV transmission
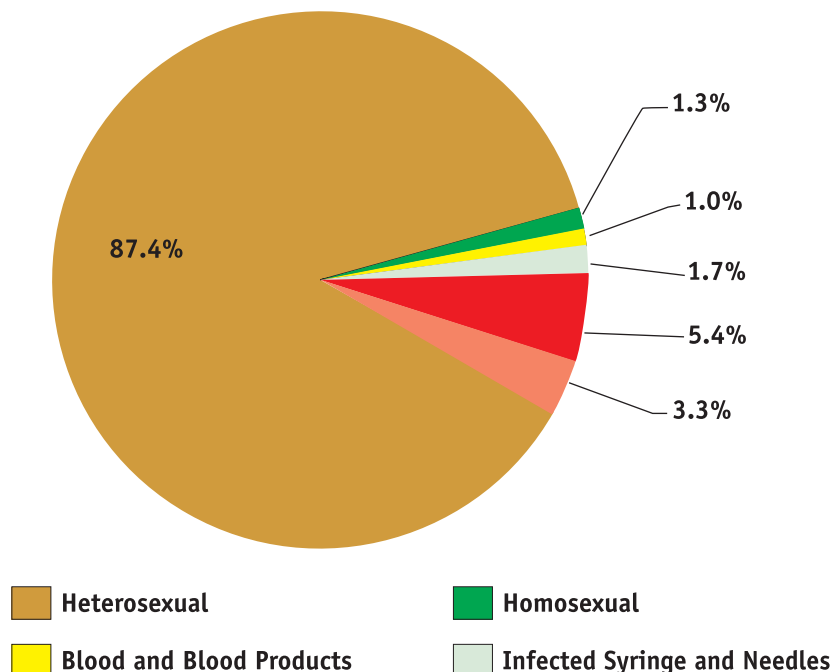

Source: NACO-CMIS 2010-11

The spread of HIV epidemic is heterogenous in India with some regions and districts showing higher HIV prevalence than other. The map in the next page depicts the districts showing HIV prevalence greater than 1% among pregnant women attending antenatal clinics.

District Map of India Showing HIV Prevalence among ANC Clinic Attendees

"Estimated adult HIV prevalence in India has declined from 0.41% in 2000 to 0.31% in 2009"

Legend

▇	No valid data
▇	HIV 3 and above %
▇	HIV 2 - 2.9 %
▇	HIV 1 - 1.9 %
▇	HIV < 1 %
☐	No ANC Site
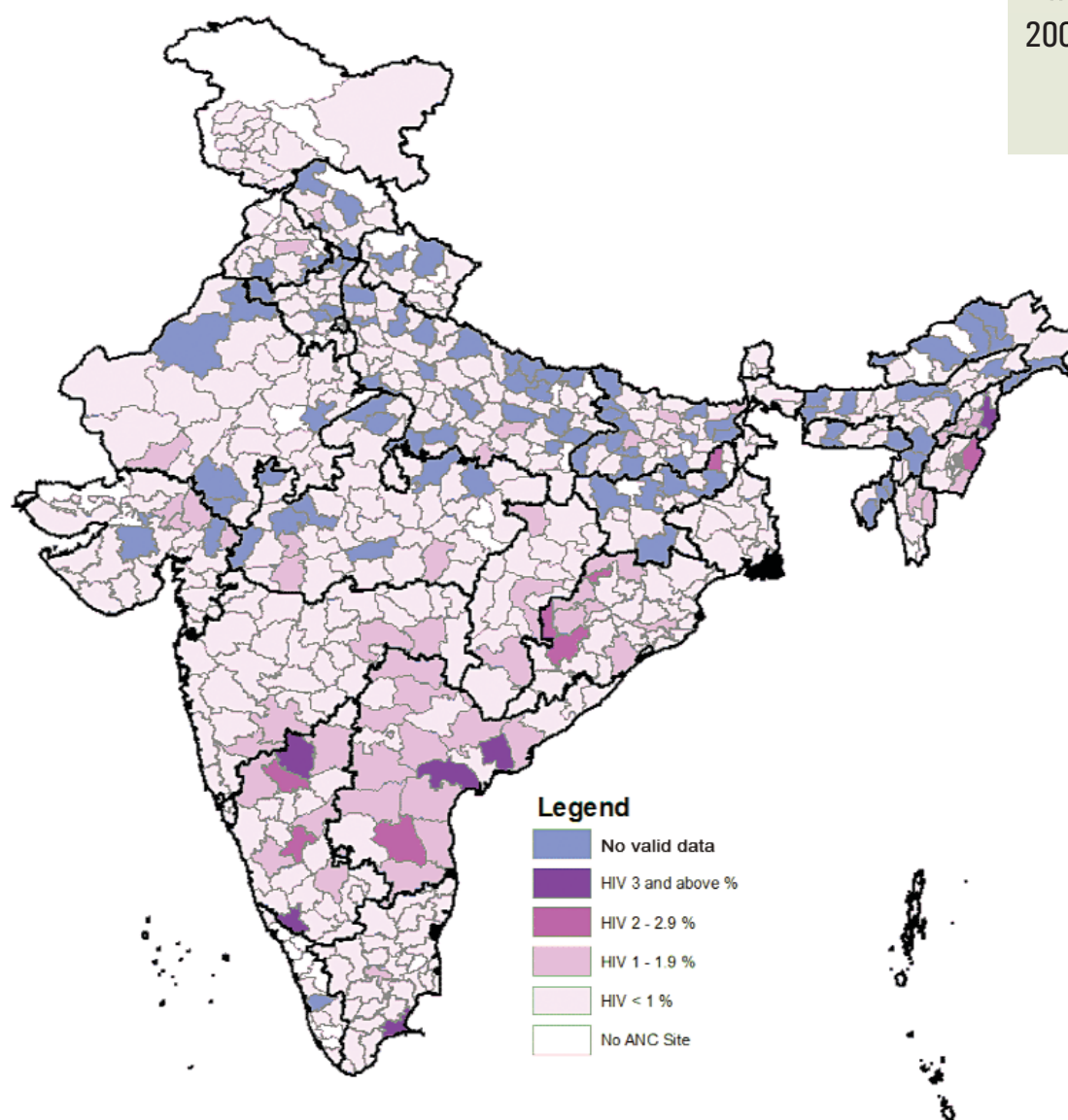
Source: NACO HSS 2008

Material on HIV Epidemic for 'Overview of epidemic chapter' NACO Monograph, 23 Jun 11

The HIV estimates 2008-09 highlight an overall reduction in adult HIV prevalence and HIV incidence (new infections) in India. The estimated number of new annual HIV infections has declined by more than 50% over the past decade. It is estimated that India had approximately 1.2 lakh new HIV infections in 2009, as against 2.7 lakh in 2000. This is one of the most important evidence on the impact of the various interventions under National AIDS Control Programme and scaled-up prevention

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

The adult HIV prevalence at national level has continued its steady decline from estimated level of 0.41% in 2000 through 0.36% in 2006 to 0.31% in 2009. All the high prevalence states show a declining trend in adult HIV prevalence. HIV has declined notably in Tamil Nadu to reach 0.33% in 2009. However, the low prevalence states of Assam, Chandigarh, Orissa, Kerala, Jharkhand, Uttarakhand, Jammu & Kashmir, Arunachal Pradesh and Meghalaya show rising trends in adult HIV prevalence in the last four years. A clear decline is also evident in HIV prevalence among the young population (15-24 yrs) at national level, both among men and women.

Using globally accepted methodologies and updated evidence on survival to HIV with and without treatment, it is estimated that about 1.72 lakh people died of AIDS related causes in 2009 in India. Wider access to ART has resulted in a decline of the number of people dying due to AIDS related causes. The trend of annual AIDS deaths is showing a steady decline since the roll out of free ART programme in India in 2004.

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

Trends in Estimated Adult HIV Prevalence and Number of PLHA, India, 2004-09
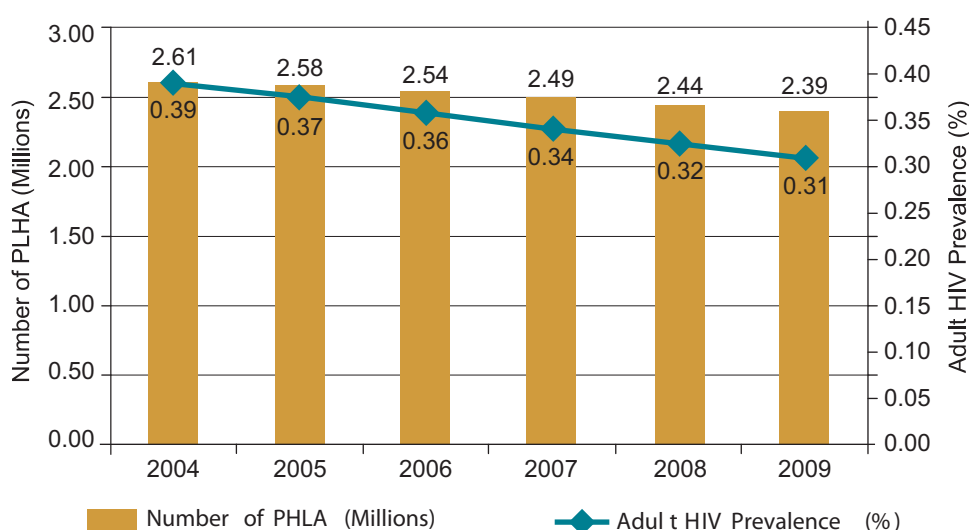
Source: HIV Estimations, 2010.

Declining trends of Adult HIV Prevalence in High Prevalence States & Mizoram

Legend:
- Andhra Pradesh
- Karnataka
- Maharashtra
- Manipur
- Mizoram
- Nagaland
- Tamil Naddu

Y-axis: HIV Prevalence (%)
X-axis: 2006, 2007, 2008, 2009

Source: HIV Estimations, 2010.
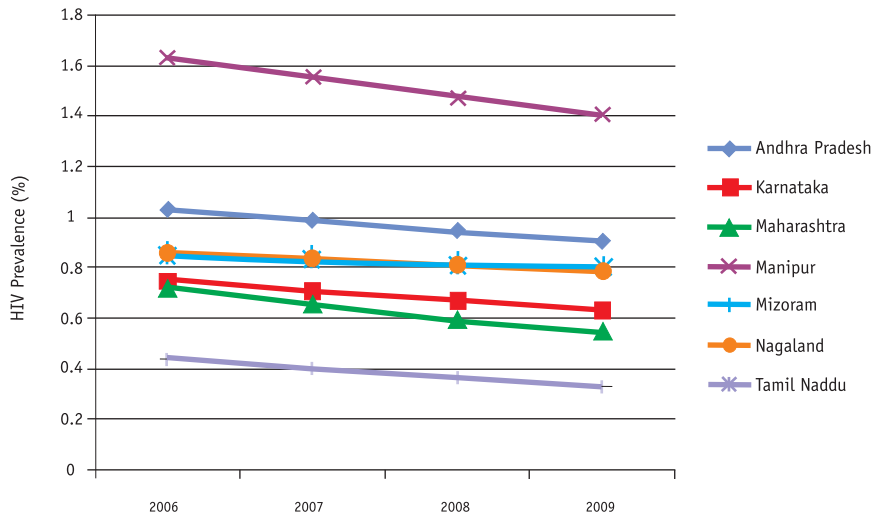
> "Except Manipur with HIV prevalence of 1.4%, all other states have shown less than 1% adult HIV prevalence"

Rising Trends of Adult HIV Prevalence in Low Prevalence States

Legend:
- Arunachal Pradesh
- Assam
- Chandigarh
- Jharkhand
- Kerala
- Meghalaya
- Orissa

Y-axis: HIV Prevalence (%)
X-axis: 2006, 2007, 2008, 2009
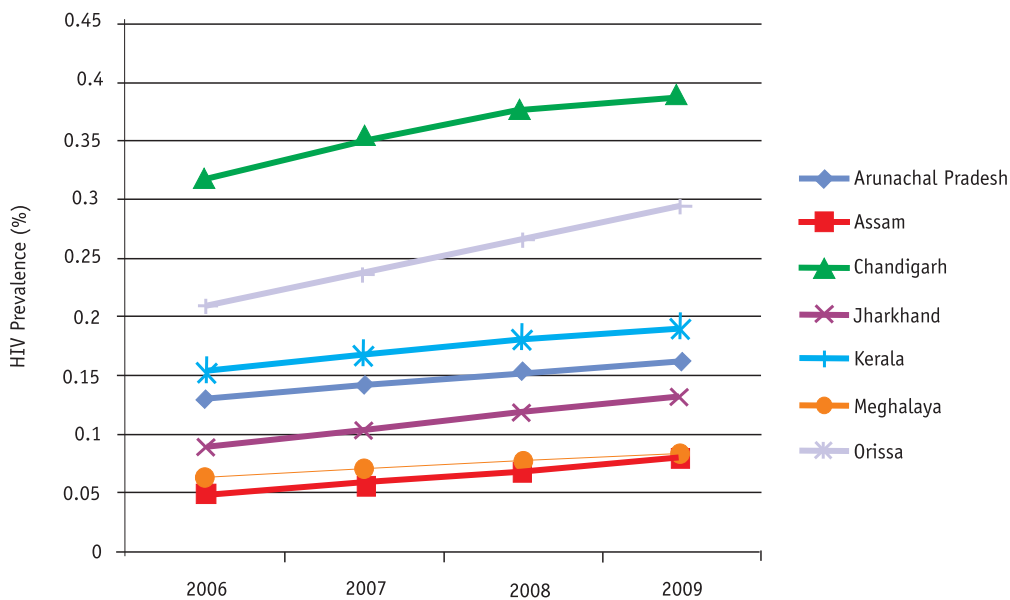
Source: HIV Estimations, 2010.

THE JOURNEY TO THE CURRENT NATIONAL AIDS CONTROL PROGRAMME: NACP-III

In response to the first HIV case identified in 1986, the government created the National AIDS Committee, which launched India's first AIDS programme in 1987. This initial AIDS programme focused on monitoring HIV infection rates among high-risk populations (in a few select major cities), health education, and blood screening. Between 1987 and 1991, about 85% of the national AIDS budget was spent on the screening of individuals, blood, and blood products. In 1992, the National AIDS Control Organisation (NACO) was created, and a comprehensive National AIDS Control Programme (NACP-I) was launched the following year.

As understanding of the complex HIV epidemic in India has grown since then, substantial changes have been made in the policy frameworks and approaches of the National AIDS Control Programmes (NACP-I, -II, -III) that have provided guidelines for India's response. Since NACP-I, focus has shifted from raising awareness to behaviour change, from a national response to a more decentralized response and to increasing the involvement of NGOs and networks of PLHAs.

NACP-I (1992-1999)

NACO launched the first National AIDS Control Programme (NACP-I) in 1992 with support from the World Bank. The overall objective was to slow and prevent the spread of HIV through a major effort to prevent HIV transmission. During NACP-I, NACO provided nearly US$113 million, with 40% for blood safety, and 21% for raising awareness.

Key achievements under NACP-I included:

- **Created national AIDS response structures** at both the national and state levels and provided critical financing.
- **Established a strong partnership with the World Health Organisation (WHO)** and later helped mobilize additional donor resources.
- **Established NACO and the State AIDS Control Cells,** which considerably strengthened India's management capacity to respond to the epidemic.
- **Improved blood safety.**
- **Improved public awareness** of HIV, especially in urban areas.
- **Expanded sentinel surveillance** and improved coverage and reliability of data.
- **Expanded STI control** and services.
- **Improved condom promotion** activities.
- Created and disseminated **a national HIV testing policy.**

NACP-II (1999-2006)

The second National AIDS Control Programme began in 1999 with an aim to reduce the spread of HIV by focusing on prevention through behaviour change and increasing India's capacity to respond to HIV on a long-term basis. The stated objectives were to reduce HIV prevalence, below 5% of the adult population in high prevalence states; below 3% in states with moderate prevalence; and below 1% and 2% in remaining states in a nascent epidemic stage.

NACP-II expanded the scope of HIV prevention activities with an increased budget of US$460 million. Under NACP-II, the Government of India began focusing on high-risk groups with a package of targeted interventions (TIs) that globally have been shown to be effective: behaviour change communication/peer education; STI treatment, condom promotion/provision; needle and syringe provision; enabling environment and community mobilization. Strong political commitment led to the creation of the National Council on AIDS (NCA), under the guidance of the Honourable Prime Minister, which facilitates a multisectoral response to the HIV epidemic.

> "NACP-I focused on blood safety and raising awareness, NACP-II focused on behaviour change"

Key achievements under NACP-II included:

- At the operational level, NGOs implemented 1,033 targeted interventions and set up 875 voluntary counselling and testing (VCT) centres and 679 STI clinics at the district level.

- Nation-wide and state level Behaviour Sentinel Surveillance (BSS) surveys were conducted.

- Prevention of parent-to-child transmission (PPTCT) programme was expanded.

- A computerized management information system (CMIS) and a computerized project financial management system (CPFMS) were created.

- HIV prevention and care and support organizations and networks were strengthened.

- Support from bilateral, multilateral, and other partner agencies also increased substantially.

Children at a HIV/AIDS rally at India Gate, New Delhi

THE IMPLEMENTATION APPROACH OF THE NATIONAL AIDS CONTROL PROGRAMME: NACP-III (2007-2012)

NACP-III Briefly

The Government of India realizes that a large-scale national programme, with high coverage with an effective package of interventions (condom use, STI treatment, clean needle exchange where appropriate, use of peer education) can greatly reduce the size of India's HIV epidemic by decreasing new HIV infections. To do this, NACP-III focuses greater than 70 percent of its budget on HIV prevention efforts including targeted interventions, and expansion of prenatal testing and treatment and HIV testing sites. At the same time, NACP-III seeks to protect vulnerable high-risk groups from stigma and discrimination. NACP-III seeks to reach at least 80% coverage of high-risk groups such as sex workers, men who have sex with men, and injecting drug users, by working through NGOs. Keys to success include identifying major sites with large numbers of people engaging in high-risk behaviour, through mapping and routine tracking of programme coverage and impact. The prevention package seeks to triple the number of sites where pregnant women are screened for HIV, expand HIV testing sites to the sub-district level across the country, expand the number of condom outlets by a factor of six, and use social marketing to triple condom sales. Blood safety and STI services will also be expanded along with communication efforts to address stigma and increase service use. The number of ART centres and patients targeted for treatment will also be increased.

Other highlights of the NACP-III expanded response:

1. **Overall funding levels are more than quadrupled from NACP-II.** The overall budget has increased from US$460 million to around US$2.5 billion.

2. **Prevention with a strategic focus on high-risk groups is the main focus of NACP-III**. Greater than 70% of the NACP-III budget is earmarked for prevention, of which over a third is for scaling-up prevention for groups at highest risk.

3. **NACP-III incorporates a strong partnership approach.** Beginning with the NACP-III design process, NACO involved major development partners and actively sought technical and managerial support to improve interventions.

4. **NACP-III is designed to be much more evidence based.** NACP-III explicitly institutionalizes an evidence-based programming approach, and creates a Strategic Information Management Unit (SIMU) whose function is to house and build epidemiologic and analytic skills.

NACP-III Design

Drawing from the experiences from the first two phases, NACO initiated the process for preparing NACP-III. The year-long process included 14 working groups of experts and practitioners, e-forums, consultations with civil society organizations, PLHA networks, NGOs, community-based organisations (CBOs), national expert groups, development partners, and a World Bank-led pre-appraisal team. The Government of India formed a national planning team in April 2005 to lead the development process that was to be consultative, participatory, and transparent. The NACP-III development process also incorporated inputs from various assessments and studies, which eventually led to consensus on the goals, objectives, and overall framework for the new programme.

"NACP-III aims at halting and reversing the HIV epidemic in India"

NACP-III Strategy and Approaches

Prevention continues as the main thrust during NACP-III, which aims to reduce new HIV infections and prevent the spread of HIV from HRGs to the general population. NACP-III employs a behaviour change strategy based on an effective IEC campaign and supported by appropriate services. A package of clearly defined and linked services is provided to cover all populations (HRGs, bridge populations, and the general population).

The guiding principles for NACP-III include:

- The unifying credo of the Three Ones, which are one action framework, one national HIV coordinating authority, and one national M&E system
- Equity (to be monitored by relevant indicators in both prevention and impact mitigation strategies)
- Respect for the legal, ethical, and human rights of PLHIV
- PLHIV and civil society participation

Peer Educator explaining risk of HIV transmission through unprotected sex

- Creation of an enabling environment

- Universal access to HIV prevention, care, support, and treatment services

- Implementation strategy based on qualifications, competence, commitment, and continuity

The **key priority areas for NACP-III** activities are discussed in the following sections:

i. Scaling-up Prevention Efforts

ii. Strengthening Care, Support, and Treatment

iii. Mainstreaming and Partnering
  - Enabling Environment and Greater Involvement of People Living with HIV/AIDS (GIPA)

iv. Programme Management
  - Augmenting Capacity
  - Decentralizing the Programme

v. Monitoring and Evaluation
  - Strengthening Strategic Information Management

i. Scaling-up Prevention Efforts

Prevention has been and will continue to be India's primary response to the HIV epidemic. Prevention includes delivering a package of HIV services focused on high-risk groups. NACP-III seeks to move beyond treatment service delivery at the tertiary and district level health institutions and expand them to the sub-district and community level, with a significant increase in the number of Integrated Counselling & Testing Centres (ICTCs), STI clinics, and PPTCT centres.

At the district level, services will be available in medical colleges or district hospitals, to:

- Provide prevention services including treatment and cure for STIs, psychosocial counselling, and support for PLHAs.

- Manage opportunistic infections and provide anti-retroviral therapy for PLHAs.
- Ensure counselling and testing for prevention of parent-to-child transmission of HIV.
- Provide specialised pediatric HIV care and treatment.
- Provide referrals for special needs such as surgery and ophthalmology.

At the sub-district and community level, community health centres and primary health centres provide prevention services including promotion of condoms, counselling and testing for HIV (ICTCs), PPTCT, treatment and cure for STIs, and management of opportunistic infections. NGOs and CBOs will provide outreach, peer support services, and home-based care for PLHAs in the community.

HIV prevention efforts are being scaled-up under NACP-III by:

    a.   Saturating programme interventions (at least 80%) and coverage of HRGs

    b.   Promoting condom use

    c.   Providing information, education, and communications

    d.   Managing STIs

    e.   Developing integrated counselling and testing

    f.   Ensuring prevention of parent-to-child transmission

    g.   Ensuring greater blood safety

a. Saturating programme interventions and coverage of HRG, and bridge populations,

High-risk groups (HRG)

An overall estimate of HRG in the country by an expert group in January 2006 revealed the presence of 830,000 - 1,250,000 female sex workers; 2,350,000 MSM; 235,000 male sex workers; 96,000 - 189,000 male IDUs; and 10,000 - 33,000 female IDUs. NACP-III aims to reach at least 80% of this high-risk group population and reduce new infections in this group. NACP-III increases attention on MSM and IDUs to provide better coverage of these groups. Key activities for reaching HRGs include:

> "NACP-III seeks to expand services to the community level and saturate coverage of high risk group"

An outreach worker explaining use of female condom

- Providing behaviour change communication (BCC) interventions to increase demand for products and services.
- Providing STI services, including counselling to increase compliance of patients with treatment regimens, risk reduction training, and partner referral.
- Promoting condoms and ensuring availability and access.
- Creating an enabling environment to motivate safe behaviours.
- Increasing programme sustainability through community mobilization.
- Integrating prevention with care, support, and treatment to facilitate access and use of services.

Bridge populations

As important conduits for transmitting HIV from HRGs to the general population, bridge populations (e.g., truckers, migrant workers) are receiving more focus under NACP-III. The 2.3 million long distance truckers in India have an estimated HIV prevalence of 3-7%, and 1-7% percent have at least one STI. The HIV prevalence for the over eight million short-term or temporary migrants in India is uncertain, and the socioeconomic and situational pressures make this group particularly vulnerable to HIV.

To reach this group better with prevention services, NACP-III includes:

- Establishing peer-led interventions to create awareness of vulnerability and increase demand for products and services.
- Promoting and providing condoms through free supplies and social marketing.
- Developing linkages with local public sector, private sector, and NGO-supported centres for HIV testing, counselling, and STI treatment services.
- Creating "peer support groups" and "safe spaces" at destination sites for migrants.

Explaining risk perception during Street Theatre

b. Promoting condom use

Despite increases in condom awareness during NACP-I and NACP-II, increasing the use of condom remains a priority. NACP-III seeks to significantly improve condom use, ensuring adequate and convenient supplies, and promoting condom negotiation skills among HRG. NACP-III has a target of 3.5 billion condoms off taken per year (1.6 billion in 2006) and increasing the number of outlets distributing condoms to 3 million by 2010 with focus on non-traditional outlets.

c. Providing information, education and communication (IEC) and mainstreaming

The key principle that drives the NACP-III programme is the scaled-up synergy between communication response and service delivery. There has been a shift in emphasis from just awareness generation to behaviour change communication. The NACP-III communication strategy aims at:

i)   motivating behaviour change in population at risk including HRG

ii) raise awareness levels about risk

iii) generate demand for services and promote condom use

iv) create an enabling environment free from stigma and discrimination

> "ICTC functions as an entry point for HIV related services"

General population

Youth, women, and tribal groups are seen as vulnerable and heterogeneous populations with differing risk levels in the general population. NACP-III supports activities that:

• Set up a cadre of link workers to approach women and young people in villages and tribal areas with BCC, condoms, and referrals to health services.

• Enhance access to HIV testing facilities with links to associated programmes and to counselling and treatment services through integrated counselling and testing centres.

• Establish Red Ribbon Clubs of youth-friendly information services.

• Improve access to PPTCT services.

• Improve availability, testing, and safety of blood and blood products.

• Expand STI treatment in public and private health facilities for easy access to the community.

• Provide effective communication programmes to reduce stigma and discrimination.

d. Managing STI

An estimated 4-6% of the adult population in India has an STI or reproductive tract infection. NACP-III expands STI services through effective integration with the National Rural Health Mission's reproductive and child health programme. NACO also supports NGOs and not-for-profit private sector providers to provide STI services.

e. Developing integrated counselling and testing centres

Under NACP-III integrated counselling and testing centres (ICTCs) function as a hub, or entry point, for men and women requiring different HIV-related services. ICTCs ensure that clients are linked to required services, such as early management of opportunistic infections, access to legal services, anti-retroviral treatment (ART), STI services, community care centres, PPTCT, and psychosocial support services.

f. Ensuring prevention of HIV from parent-to-child transmission

Of the 27 million annual pregnancies in India, an estimated 43,000 occur in HIV-positive mothers, which lead to 12,900 infected babies each year. The PPTCT programme, which was initiated in 2001 using single dose Nevirapine, is being scaled-up to cover at least 80% of these deliveries for HIV-positive mothers.

g. Ensuring greater blood safety

Ensuring access to safe blood is required by law, and NACP-III seeks to ensure that safe and quality blood is available within one hour at health facilities. NACP-III has a target of reducing HIV transmission through blood and blood products to less than 1% and increasing voluntary blood donation to 90% of total requirement. This will be achieved through:

- Ensuring that regular voluntary blood donors constitute the main source of blood supply through phased increase in donor recruitment and retention
- Vigorously promoting appropriate use of blood, blood components, and blood products among the clinicians
- Developing long-term policy for capacity building to achieve efficient and self-sufficient blood transfusion services

Service Packages by Area under NACP-III

Prevention:
- Targeted interventions for HRG
- Other interventions for bridge groups (truckers, prison inmates, migrants)
- Integrated counselling and testing centres
- Blood safety (including mobile blood banks)
- Communication, advocacy and social mobilization
- Condom promotion

Care, Support and Treatment:
- First line and Second line ART
- Pediatric ART
- Centres of Excellence
- Care and support (community care centres and impact mitigation)

Capacity Building:
- Establishment support and capacity strengthening
- Training
- Managing programme implementation and contracts

Strategic Information Management
- Monitoring and evaluation
- Surveillance
- Research

ii. Strengthening Care, Support and Treatment

Expanding care, support and treatment and linking them with prevention services can help reduce AIDS-related mortality and help counter poverty, stigma, and discrimination. NACP-III adopts a comprehensive approach intended to strengthen care, support and treatment to provide psychosocial support, and to ensure accessible and affordable treatment services.

Key priorities for NACP-III include:

- Strengthening PLHA and other networks of vulnerable populations.

- Enhancing linkages to service centres and promoting risk reduction strategies.

- Implementing standard protocol for treatment of HIV/AIDS and opportunistic infections.

- Improved linkage between NACP-III and the Revised National Tuberculosis Control Programme for treatment of HIV/TB co-infection.

- Establishing community care centres that provide outreach, referral, counselling, treatment, adherence and patient management services.

- Undertaking advocacy, community mobilization, and BCC to integrate HIV positive persons into society and reduce stigma and discrimination.

Care and support

Improving the quality of life, social integration, and dignity of PLHA has been an ongoing effort under NACP. In the third phase, care and support services through partnerships with NGOs will be enhanced. Expanding access to care is intended to increase the demand for services and motivate PLHAs to adopt and sustain safe behaviour.

NACP-III plans to support 350 community care centres in partnership with PLHA in high prevalence and moderate prevalence districts based on patient volumes.

> "Expanding care, support and treatment and linking them with prevention services is a key priority area under NACP-III"

Community Care Centre

Treatment

Anti-retroviral therapy is now available free to all those who need it. ART effectively suppresses viral replication, if taken at the right time and correctly. However, adherence to an ART regimen is critical. Any irregularity in following the prescribed regimen can lead to resistance to HIV drugs.

Public health facilities are mandated to ensure that ART is provided to PLHAs. Special emphasis is given to the treatment of HIV-positive women and infected children.

iii. Mainstreaming and Partnerships

NACP-III takes an integrated and multi-sectoral approach to transfer the ownership of HIV/AIDS issues to various stakeholders, including the government, the corporate sector, and civil society organisations. NACP-III seeks to mainstream HIV prevention, care and treatment into all government schemes and activities, corporate sector and civil society such as NGOs who are especially important in building awareness about HIV issues among the poor and high-risk groups.

Mainstreaming HIV issues into other government department agendas is supported by an institutional mechanism to ensure that national and state objectives related to HIV prevention, care and treatment are met. This mechanism draws commitment from the National Council on AIDS, chaired by the Honourable Prime Minister and has 31 ministries and departments on its board.

The National AIDS Control Organisation works with a number of international organisations who contribute their technical expertise and financial resources to address HIV/AIDS issues. This collaboration is as old as the government programmes on HIV/AIDS. Under NACP-III, the following organisations work with NACO and its programme.

Women SHG during a training programme on HIV/AIDS

- Australian AID (AusAID)

- Bill & Melinda Gates Foundation

- Department for International Development (DFID)

- Clinton Foundation (CF)

- German AID (GTZ)

- Global Fund for AIDS, TB, and Malaria (GFATM)

- International AIDS Vaccine Initiative (IAVI)

- International Labour Organisation (ILO)

- The Joint United Nations Programme on HIV/AIDS (UNAIDS)

- United Nations Development Programme (UNDP)

- United Nations Population Fund (UNFPA)

- United Nations Children's Fund (UNICEF)

- United Nations Office of Drug Control and Crime in South Asia (UNODC)

- United States Agency for International Development (USAID)

- World Bank

- World Health Organization (WHO)

> "National Policy on HIV/AIDS and the World of Work adopted to addres stigma at workplaces"

NGOs and civil society organisations (CSOs) have made significant contributions to HIV prevention and care services outreach to the highly vulnerable population groups at the local, state, and national levels. The National AIDS Control Programme recognises the importance of their participation, particularly in preventive or targeted interventions for high-risk groups, care and support of PLHA, and in general awareness campaigns.

The corporate or private sector has taken up mainstreaming activities in a significant way. "National Policy on HIV/ AIDS and the World of Work" has been adopted by the Government of India to address issue of stigma and discrimination against PLHIV at work places and provide linkages with the services.

a. Enabling environment and the greater involvement of people living with HIV/AIDS (GIPA)

Prevention, care, and support for HIV/AIDS are most effective in an environment where human rights are respected and those infected with or affected by HIV live a life of dignity, without stigma or discrimination.

NACP-III seeks to further build partnerships with PLHA networks and other stakeholders. Key NACP-III GIPA activities include:

- Supporting PLHIV networks in all states and most districts

- Developing criteria for accrediting PLHIV networks and formalising partnerships with them

- Building capacity of PLHIV networks

- Developing institutional structures at the district, state, and national government levels to plan, implement, and monitor GIPA

- Developing and implementing guidelines for direct involvement of PLHIVs in service delivery.

iv. Programme Management

Another priority for NACP-III is improving and strengthening the management structures that were created under the earlier programmes. This includes strengthening capacity as well as systems such as the financial and strategic information management systems. The process of decentralization that began under NACP-II is being further devolved to better reach populations at the district and sub-district levels.

The institutions, systems, and processes designed to implement NACP-I and -II achieved significant results in most parts of the country with systems for surveillance, management, and financial monitoring, and providing a solid foundation for scaling-up the programme under NACP-III. Better donor coordination and impact mitigation are also priorities for the overall management strategy.

Focus areas for improving programme management under NACP-III include a**ugmenting capacity, strengthening the strategic information management system,** and **decentralizing programme management.**

Augmenting Capacity

Since skilled and competent human resources are essential for the success of NACP-III, the programme seeks to strengthen the skills of health care providers such as doctors, nurses, counsellors, lab technicians, public health workers, civil society organisations, and managers at the national, state, and district levels.

Key activities for augmenting capacity include:

- Collaborating with partners on developing standard operating procedures and operational guidelines for crucial HIV services.

- Adopting standard, performance-based contractual arrangements linked to delivery of HIV-related services.

- Providing high quality training in areas such as support to community-based organisations, and ART training in the public and private sectors.

- Providing technical support to all levels through Technical Support Groups at the national level and Technical Support Units at the state level.

- Engaging the services of appropriate agents for procuring medicines, medical supplies, and other goods required by the programme.

Strengthening Strategic Information Management

Apart from the sentinel surveillance, a nationwide computerised management information system provides strategic information for programme monitoring and evaluation. To strengthen the existing system, NACP-III contains several significant changes in data collection and analysis, which includes:

- Establishing one national Monitoring and Evaluation Framework.

- Enhancing the Computerised Management Information System (CMIS).

- Creating new Strategic Information Management Units (SIMU).

Key activities for strengthening strategic information management include:

- Reviewing and validating information for planning and programme implementation.

- Strengthening programme monitoring to provide more accessible information.

- Enhancing surveillance systems to provide data at the state and district level.

- Reviewing models used to generate various state and national estimates on the basis of surveillance data.

- Supporting independent evaluation and research.

"NACP-III focuses on strengthening SIMS and decentralizing programme management"

Decentralizing the Programme

Under NACP-III, the decentralization that began under NACP-II will be further devolved to better reach populations at the district and sub-district levels through District AIDS Prevention and Control Units (DAPCUs). State level SACS will remain responsible for key services in the states. To enhance convergence with the National Rural Health Mission (NRHM), the new District AIDS Prevention and Control Units will share the administrative and financial structures of the NRHM. These units will also allow more locally appropriate interventions given India's heterogeneous epidemic, beside medical interventions, the units will also be responsible for non-health-related activities such as adolescent education programmes, monitoring and evaluation, and mainstreaming.

v. Monitoring and Evaluation

Over the years, the national programme has built a robust monitoring system, which includes large-scale data collection efforts. The HIV surveillance system in India is characterized by a growing number of sentinel and facility-based HIV sero-prevalence surveys, used for measuring trends in HIV prevalence and developing state and national prevalence estimates. NACO and development partners have also conducted behavioural surveys and research studies in a number of states to track HIV-related risk behaviours. The computerized management information system, established nation-wide, is another source of strategic information for programme monitoring and evaluation. Similarly, NACP has also successfully established a Computerized Project Financial Management System and a new Strategic Information Management Unit.

CMIS

NACP-III is updating the CMIS to address existing gaps and add features to support decentralization to the district level. NACP-III is also enhancing the capacity of primary data reporting units and programme managers at national and state levels for evidence-based planning and to monitoring of NACP-III at all levels.

SIMU

To maximize effective use of all available information and implement evidence-based planning, NACP-III has established Strategic Information Management Units at national and state levels to address strategic planning, monitoring and evaluation, surveillance, and research. The SIMU assists in tracking the epidemic and the effectiveness of the response and helps assess how well NACO, SACS, and all partner organizations are fulfilling their commitment to meet agreed objectives.

Evaluation

Under NACP-III, all intervention programmes include evaluation plans, with tools developed for each programme component to support such evaluation. Ongoing evaluation of district and state programmes and mid-term and terminal external evaluation of such programmes are being carried out.

NACP-III is using five key data streams to strengthen programme management, accountability, learning, and planning:

1. **Programme reports on a monthly or quarterly schedule** at the national, state, and district level using information from the CMIS, to be used by programme managers at national, state, and district levels.

2. **A "dashboard" with information on key indicators,** produced quarterly, to serve as a key monitoring tool at the national and state levels. (These indicators will inform managers on the programme implementation status and provide early warnings of weaknesses or processes that are failing. The dashboard will facilitate management oversight starting from NACB, NACO, and SACS. Dashboard indicators are based on data from the CMIS and state monthly programme reports).

3. **A report on the "State of the Epidemic and Response"** produced annually at the national level using data from the CMIS, surveillance, special surveys, research, CPFMS, and other sources.

4. **External programme evaluations** undertaken at mid-term and at the end of NACP-III.

5. **Key research findings, surveys, special studies, and other reports** published as needed to inform NACO, SACS, partners, and a wider audience.

HIV Surveillance in India

One of the significant achievements of NACP is a credible HIV sentinel surveillance system. NACO formalized annual sentinel surveillance in 1998 with 176 sentinel sites in collaboration with the National Institute of Health and Family Welfare and the National Institute of Medical Statistics, Indian Council for Medical Research. Since then, the number of sites has increased to 703 in 2005 and was again expanded to 1,122 sites (usually antenatal clinics and STI clinics) in 2006. Currently there are 1361 sentinel sites in India, in 2010.

Surveillance for HIV infection falls in four broad areas: 1) HIV Sentinel Surveillance, 2) AIDS Case Surveillance, 3) Behavioural Surveillance, and 4) Sexually Transmitted Infections Surveillance. HIV Surveillance closely monitors and tracks the level, spread, and trends of the epidemic as well as the risk behaviours that lead to the growth of epidemic. Inputs from the robust sentinel surveillance system of India and periodic behavioural surveillance surveys give direction to the NACP.

Estimation of HIV prevalence is done annually to provide a picture of the HIV epidemic at the national as well as the sub-national levels. Reporting on HIV and AIDS cases from ICTCs and ART Centres in all states, through monthly reporting formats, provides inputs on the distribution of reported full-blown AIDS cases in the country as well as the proportional significance of different routes of transmission. Behavioural Surveillance Surveys provide data on the knowledge, awareness, and behaviours related to HIV/AIDS among the general population, youth, and different high-risk groups.

Case Study: Aastha Project in Maharashtra—Using Crisis Response Committees to Respond to Violence

The Aastha Project serves 27,000 female sex workers and 3,000 high-risk men who have sex with men and transgenders in Mumbai and Thane districts of Maharashtra state.

Sex workers are often victims of harassment by gangs which extort money or force them to provide sex with no payment in return. Resistance is met with the threat of violence, or actual physical abuse. In South Mumbai, gang members were extorting daily payments from street-based sex workers, and one man started beating those who were unable to pay.

The sex workers were being served by the Aastha Project. At each project site there is an "Aastha gat," a group of 15-20 community members who meet regularly to improve their self-reliance, address issues of marginalization, and give feedback on the services provided by the project. An advocacy committee has been added to each Aastha gat for rapid response to crisis situations. Each committee has five or six members, including the peer outreach worker for that site, and the committee gives the group members and peers direct access to legal experts at the district level. Advocacy officer trains each local implementing NGO's staff and peers in implementing a rapid response system. Staff, advocacy committee members, and peers sensitize stakeholders, including the police, to their work.

Some of the sex workers who were being harassed contacted members of the advocacy committee, who convened an emergency meeting within half an hour with a staff outreach worker. They decided that on the following day, all 40 sex workers at the site would refuse to give the gang member any money. The outreach worker and four advocacy committee members agreed to be present to intervene if required, and when notified of the action, the police promised to support it.

When the gang member demanded his regular payments the following day, all the community members refused to pay up. Taken aback by this unexpected organized resistance, and by the presence of the advocacy committee members and project staff, the gang member left, threatening retaliation. But he did not return that day, and supported by increased vigilance on the part of the police, the community members suffered no further harassment.

NACP-III ACHIEVEMENTS

A number of significant achievements have been gained under NACP-III. These include:

• Recent HIV estimations show that the annual new HIV infections in India have declined by more than 50% during the last decade. India continues to be a low prevalence country (Adult HIV Prevalence – 0.31%) with an estimated 23.9 lakh persons living with HIV.

• HIV epidemic in India is concentrated in nature with high HIV prevalence among high risk groups – Female Sex Workers (FSW), Men who have sex with men (MSM) and Injecting Drug Users (IDUs). Compared to this the prevalence among general population is much lower. Therefore, prevention through focused interventions amongst High Risk Groups and General Population is the main strategy under National AIDS Control Programme (NACP) Phase-III, along with Care, Support & Treatment for persons living with HIV/AIDS.

• In order to provide HIV prevention services to High Risk Groups, Targeted Intervention projects have been scaled up over the years to 1,691 projects, including 180 donor funded TIS, as on 31 March 2011, covering overall 59.3 lakh population including 81% Female Sex Workers, 80% Injecting Drug Users, 67% Men having sex with Men, 47% Migrants and 57% Truckers.

• Link Workers Scheme is a community based intervention that addresses HIV prevention and care needs of the high risk and vulnerable groups in rural areas by providing information on HIV, condom promotion and distribution and referrals to counseling, testing and STI services. The scheme has been expanded to 186 districts across 18 states during 2010-11.

Red Ribbon Express at Jamalpur, West Bengal

- Access to safe blood has been ensured through a network of 1,127 blood banks, including 155 Blood Component Separation Units, 795 district level blood banks and 28 Model Blood Banks, besides 685 blood storage centres. Collection of blood units through voluntary blood donation has increased from 62% in 2008-09 to 79.5% in 2010-11. During 2010-11, 54,271 VBD camps were conducted and overall 79.2 lakh blood units were collected.

- NACO has branded the STI/RTI services as "Suraksha Clinic" and has developed a communication strategy for generating demand for these services. STI/RTI services based on the Enhanced Syndromic Case Management are currently being provided through 1,033 designated STI/RTI clinics, including 90 new clinics established during 2010-11. Around 4,036 private preferred providers were identified for providing STI services to high risk population. Overall, 100.8 lakh STI episodes were treated during last year, till March 2011.

> "Coverage of 78% FSWs, 73% IDUs and 77% MSM through TI is a key achievement"

- In phase III of the Condom Social Marketing Programme, launched on 1 July, 2010, condom promotion has been scaled up in 370 high priority districts across 26 states/UTs, covering 77% of the country's adult population, through 8 Social Marketing Organisations. Under this programme, condom distribution has increased from 11 crores in 2008-09 to 24.5 crores in 2009-10 and 36 crores in 2010-11 and the number of condom stocking outlets has increased from 2.4 lakh in 2008-09 through 5.76 lakh in 2009-10 and 6.55 lakh outlets in 2010-11.

- Intensive multi-media Information Education & Communication (IEC) campaigns have been launched to take the HIV prevention messages to the general population through spots and long format programmes on TV & Radio, folk performances and Red Ribbon Express, as well as through inter-personal communication. A total 39,488 folk performances were organized that reached approximately 31,59,040 people.

- Red Ribbon Express (RRE), the special exhibition train on HIV/ AIDS and other health issues, is the world's largest mass mobilization drive on HIV and AIDS. Apart from three exhibition coaches on HIV and AIDS, a new exhibition coach on NRHM providing information on common diseases has been added. The Red Ribbon Express phase II completed one year journey on 1st December, 2010 after traversing 27,000 kms covering 152 stations in 22 states. It disseminated messages on HIV prevention, treatment, care and support. Outreach programmes and activities were also held in the villages through IEC exhibition vans and folk troupes. During RRE-II, around 80 lakh people were reached through the train and outreach activities; 81,000 district resource persons were trained, 36,000 people got themselves tested for HIV and 28,000 people received general health check-up services. Impact assessment of RRE indicates that the comprehensive knowledge of routes of HIV transmission, methods of prevention, condom use, STI prevention and treatment and other services such as ICTC, PPTCT and ART was significantly higher among respondents exposed to the RRE project as compared to those not exposed.

- As part of the initiatives to mainstream HIV/AIDS response, about 6.5 lakh front line workers and personnel from various Government Departments, Civil Society Organisations and corporate sector were trained during 2010-11. Over 1,300 companies have adopted work place policies on HIV/AIDS.

- Persons provided counseling and testing services has increased from 65 lakh in 2007-08 to 162 lakh in 2010-11, more than doubled in the last four years. Access to these services was facilitated through 5,246 Integrated Counseling and Testing Centres (ICTC) apart from 2,221 ICTCs at 24x7 PHCs and 791 ICTCs under Public Private Partnership model, as on 31 Mar 2011. Out of 16,954

pregnant women who tested HIV positive, 11,962 mother-baby pairs received Nevirapine Prophybxis to prevent mother-to-child transmission. Around 42,510 patients with HIV-TB co-infection were identified.

- As of March 2011, nearly 12.5 lakh persons living with HIV/AIDS have registered and 4.07 lakh clinically eligible patients, including 23,854 children, are currently receiving free Anti Retroviral Treatment (ART) at 300 ART centres and 580 Link ART Centres. The targets of NACP-III for providing access to free ART have already been surpassed and wider access to ART has resulted in a decline in the estimated number of people dying due to AIDS related causes, since 2005.

- During 2010-11, NACO conducted the 12th round of HIV Sentinel Surveillance (HSS) at 1,361 sites, in which, around 4.4 lakh samples are collected. The HIV estimates were developed through improved methodology and updated epidemiological data using Estimation Projection Package and Spectrum Package. Strategic Information Management System (SIMS), a web-based integrated data management system, was launched in August 2010 and roll out is in progress.

New Initiatives

1. Universal access of second line ART: The Second Line ART introduced in 2008 has been expanded to 10 centres in 2009. Currently, 1,929 patients are receiving free Second Line ART. It has now been decided to make second line ART available to all those in need of it in a phased manner.

2. Earlier, diagnosis of HIV was possible only beyond 18 months of age, which hindered timely diagnosis and treatment for infected children. With the launch of Early Infant and child Diagnosis programme, it has now become possible to closely monitor HIV-exposed infants and children under 18 months of age, identify their HIV status and provide appropriate treatment to reduce HIV-related mortality and morbidity. 11,434 infants and children under 18 months of age were tested under this programme through 766 ICTCs and 181 ART centres till Mar 2011.

3. Recent evidence has shown that migration from rural areas to high HIV prevalence destinations is contributing to the rising trends of HIV observed in some of the low prevalence districts. In order to address the vulnerabilities due to single male migration, the Migrant Intervention Strategy has been revised to provide HIV prevention services to migrants, by linking them with services and information on HIV prevention, care and support at source (at their villages), at transit (places like rail or bus stations where large number of migrants board train or bus to travel to their places of work) and at destination (the places of work). 122 districts with high outmigration (based on Census 2001) across 11 States have been identified, which are on priority for starting up community level migrant interventions. Transit interventions have started at 47 locations across 8 states covering migrants at railway stations and bus stops where inter-state migration occurs.

4. New initiatives under Blood Safety programme include setting up of four Metro Blood Banks as Centres of Excellence in Transfusion Medicine with capacity to process more than 100,000 units of blood each annually in New Delhi, Mumbai, Kolkata and Chennai, and a Plasma Fractionation Centre with a processing capacity of more than 1,50,000 litres of plasma, which can fulfill the country's demand. State Governments of Delhi, Maharashtra, Tamil Nadu and West Bengal have identified land for the construction of these centres. Design DPR Consultants for these sites have been identified to initiate work. Lay-out plans and detailed Project report have been received for all four sites, and equipment requirement has been planned.

ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome	MoHFW	Ministry of Health and Family Welfare
ANC	Antenatal Clinic	MSM	Men who have Sex with Men
ART	Anti-Retroviral Therapy	NAC	National AIDS Committee
ARV	Antiretroviral	NACO	National AIDS Control Organisation
BCC	Behaviour Change Communication	NACP	National AIDS Control Programme
BSS	Behavioural Surveillance Survey	NCA	National Council on AIDS
CBO	Community-Based Organisation	NFHS	National Family Health Survey
CF	Clinton Foundation	NGO	Non-Governmental Organisation
CMIS	Computerized Management Information System	NRHM	National Rural Health Mission
CPFMS	Computerized Project Financial Management System	OI	Opportunistic Infection
CSO	Civil Service Organisation	PHC	Primary Health Centre
DAPCU	District AIDS Prevention and Control Unit	PLHA	People Living with HIV/AIDS
DFID	Department for International Development	PPTCT	Prevention of Parent-to-Child Transmission
EQAS	External Quality Assessment System	SACC	State AIDS Control Cell
FBO	Faith-Based Organisation	SACS	State AIDS Control Society
FSW	Female Sex Worker	SIMS	Strategic Information Management Systems
DGHS	Directorate General of Health Services	SIMU	Strategic Information Management Unit
GFATM	Global Fund for HIV/AIDS	STI	Sexually Transmitted Infection
GIPA	Greater Involvement of People Living with AIDS	TI	Targeted Intervention
GTZ	German AID	UNAIDS	Joint United Nations Programme on HIV/AIDS
HIV	Human Immuno-Deficiency Virus	UNDP	United Nations Development Programme
HRG	High-Risk Group	UNFPA	United Nations Population Fund
IAVI	International AIDS Vaccine Initiative	UNICEF	United Nations Children's Fund
ICMR	Indian Council of Medical Research	UNODC	United Nations Office of Drug Control and Crime in South Asia
ICTC	Integrated Counseling and Testing Centre	USAID	United States Agency for International Development
IDU	Injecting Drug User		
IEC	Information, Education, and Communication	USG	US Government Assistance
ILO	International Labour Organisation	VCT	Voluntary Counseling and Testing
M&E	Monitoring and Evaluation	W&CD	Women and Child Development
MDG	Millennium Development Goals	WHO	World Health Organization

NACO envisions an India where every person living with HIV has access to quality care and is treated with dignity. Effective prevention, care and support is possible in an environment where human rights are respected and where those infected or affected by HIV/AIDS live a life without stigma and discrimination.

NACO has taken measures to ensure that people living with HIV have equal access to quality health services. By fostering close collaboration with NGOs, women's self-help groups, faith-based organisations, positive people's networks and communities, NACO hopes to improve access and accountability of the services. It stands committed to building an enabling environment wherein those infected and affected by HIV play a central role in all responses to the epidemic - at state, district, and grassroots level.

NACO is thus committed to contain the spread of HIV in India by building an all-encompassing response reaching out to diverse populations. We endeavour to provide people with accurate, complete and consistent information about HIV, promote use of condoms for protection, and emphasise treatment of sexually transmitted diseases. NACO works to motivate men and women for a responsible sexual behaviour.

NACO believes that people need to be aware, motivated, equipped, and empowered with knowledge so that they can protect themselves from the impact of HIV. We confront a stark reality - HIV can happen to any of us. Our hope is that anyone can be saved from the infection with appropriate information on prevention. NACO is built on a foundation of care and support, and is committed to consistently fabricate strategic responses for combating HIV/AIDS situation in India.