Part-B

National AIDS Control Organization

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NATIONAL AIDS CONTROL ORGANIZATION

1. INTRODUCTION

In order to control the spread of HIV/AIDS, the Government of India is implementing the National AIDS Control Programme (NACP) as a 100% Centrally Sponsored Scheme (CSS). The first National AIDS Control Programme was launched in 1992, followed by NACP-II in 1999. Phase III of National AIDS Control Programme, NACP-III (2007-2012) launched in July 2007, had the goal to halt and reverse the epidemic in the country by scaling up prevention efforts among High Risk Groups (HRG) and general population and integrating them with Care, Support & Treatment services.

Prevention and Care, Support & Treatment form the two key pillars of all HIV/AIDS control efforts in India. The programme succeeded in reducing the estimated number of annual new HIV infections in adults by 57% during the last decade through scaled up prevention activities. Wider access to ART has resulted in a decline of the estimated number of people dying due to AIDS related causes.

Consolidating the gains made during NACP-III, the National AIDS Control Programme Phase-IV (2012-17) was launched to accelerate the process of reversal and to further strengthen the epidemic response in India through a cautious and well defined integration process over the period 2012-2017 with key strategies of intensifying and consolidating prevention services with a focus on HRG and vulnerable population, increasing access and promoting comprehensive care, support and treatment, expanding IEC services for general population and high risk groups with a focus on behaviour change and demand generation, building capacities at national, state and district levels and strengthening the Strategic Information Management System.

The objectives of NACP-IV are to reduce new infections and provide comprehensive care and support to all People Living with HIV (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.

The package of services provided under NACP-IV includes:

Prevention Services:

- Targeted Interventions (TI) for High Risk Groups and Bridge Population (Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders/Hijras, Injecting Drug Users (IDU), Truckers & Migrants;
- Needle-Syringe Exchange Programme (NSEP) and Opioid Substitution Therapy (OST) for IDUs;
- Prevention Interventions for Migrant population at source, transit and destinations;
- Link Worker Scheme (LWS) for High Risk Groups and vulnerable population in rural areas;
- Prevention & Control of Sexually Transmitted Infections/Reproductive Tract Infections (STI/RTI);

- Blood Transfusion Services;
- HIV Counselling & Testing Services;
- Prevention of Parent to Child Transmission;
- Condom promotion;
- Information, Education & Communication (IEC) and Behaviour Change Communication (BCC) – Mass Media Campaigns through Radio & TV, Mid-media campaigns through Folk Media, display panels, banners, wall writings etc., Special campaigns through music and sports, Flagship programmes, such as Red Ribbon Express;
- Social Mobilization, Youth Interventions and Adolescence Education Programme;
- Mainstreaming HIV/AIDS response and
- Work Place Interventions.

Care, Support & Treatment Services:

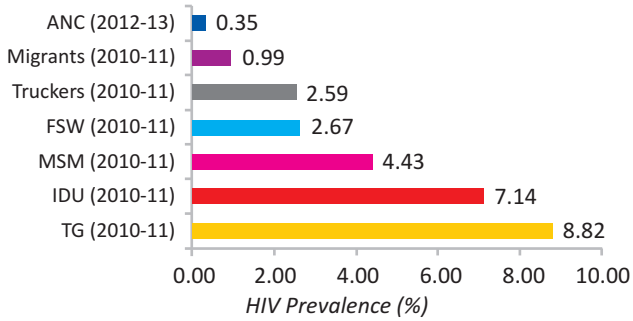
- Laboratory services for CD4 Testing, Viral Load testing, Early Infant Diagnosis of HIV in infants and children up to 18 months age and confirmatory diagnosis of HIV-2;
- Free First line & second line Anti-Retroviral Treatment (ART) through ART centres and Link ART Centres, Centres of Excellence & ART plus centres;
- Pediatric ART for children;
- Early Infant Diagnosis for HIV exposed infants and children below 18 months;
- Nutritional and Psycho-social support through Community and Support Centres;
- HIV-TB Coordination (Cross-referral, detection and treatment of co-infections) and
- Treatment of Opportunistic Infections.

2. OVERVIEW OF HIV EPIDEMIC IN INDIA

According to HSS 2012-2013, the overall HIV prevalence among ANC clinic attendees, considered a proxy for prevalence among the general population, continues 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.

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



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 (IDU) 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.

The last round of HIV Estimations was conducted in the country in 2012. The next round of HIV Estimations is planned to be conducted during 2015 to estimate the levels and trends of HIV prevalence, incidence and burden at the National and State levels after availability of data on HIV prevalence 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.

3. TARGETED INTERVENTIONS (TI)

As strategized in NACP IV, Prevention will continue to be the core strategy as more than 99% of the people are HIV negative. The epidemic continues to be concentrated in subgroups of population that are likely to engage in high-risk behaviour, making them vulnerable to HIV infection. Such groups are referred to as HRGs or high risk behavior groups. In India, Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgender (TG)/Hijras and Injecting Drug Users (IDU) have been identified as the core HRGs. Further, 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 and are commonly referred to as bridge populations owing to their perceived role in passing the HIV infection from the core groups to general population. During the NACP IV, it is planned that 90% of HRGs will be covered through Targeted Interventions (TI) implemented by Non-Governmental Organisation (NGOs) and Community Based Organisation (CBOs).

Targeted Intervention Projects: Targeted Interventions are preventive interventions working with high risk groups in a defined geographic area.

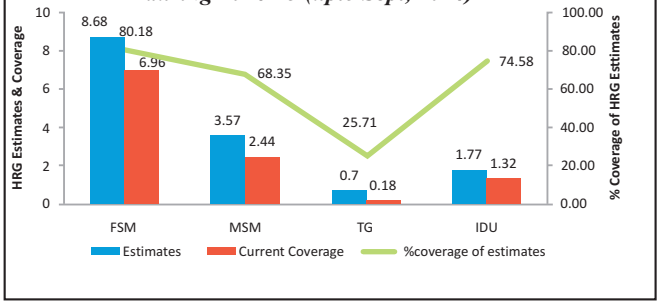
Key characteristics of Targeted Intervention Projects include: Peer-led approach - People from the high risk community are engaged to deliver services and act as agents of change, targeting high-risk behaviours and practices and not identities/individual choices, linking with services and commodities 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. TI projects provide a package of prevention, support and linkage services to HRGs through an outreach-based service delivery model. Which includes, Screening for and treatment of Sexually Transmitted Infections, Free Condom and lubricant distribution among core groups, Social marketing of condoms, Behaviour Change Communication, Creating an enabling environment with community involvement and participation, Linkages to Integrated Counselling and Testing Centres for HIV testing, Linkages with care and support services for HIV positive HRGs, Community mobilization 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.

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. Currently there are 17 TSUs along with North Eastern Regional Office (NERO) which serves as the TSU for the North East. In addition, various organisations/institutions of repute have been engaged as State Training and Resource Centres (STRCs) to conduct capacity building activities for the TI programme. In August 2014, 12 agencies were contracted as STRCs for 21 states. The NGOs/CBOs implementing the TI projects report to SACS on standard monthly reporting formats developed by NACO which form a part of the national Monitoring & Evaluation framework.

Performance of TI Programme during 2014-15 (upto Sept, 2014)

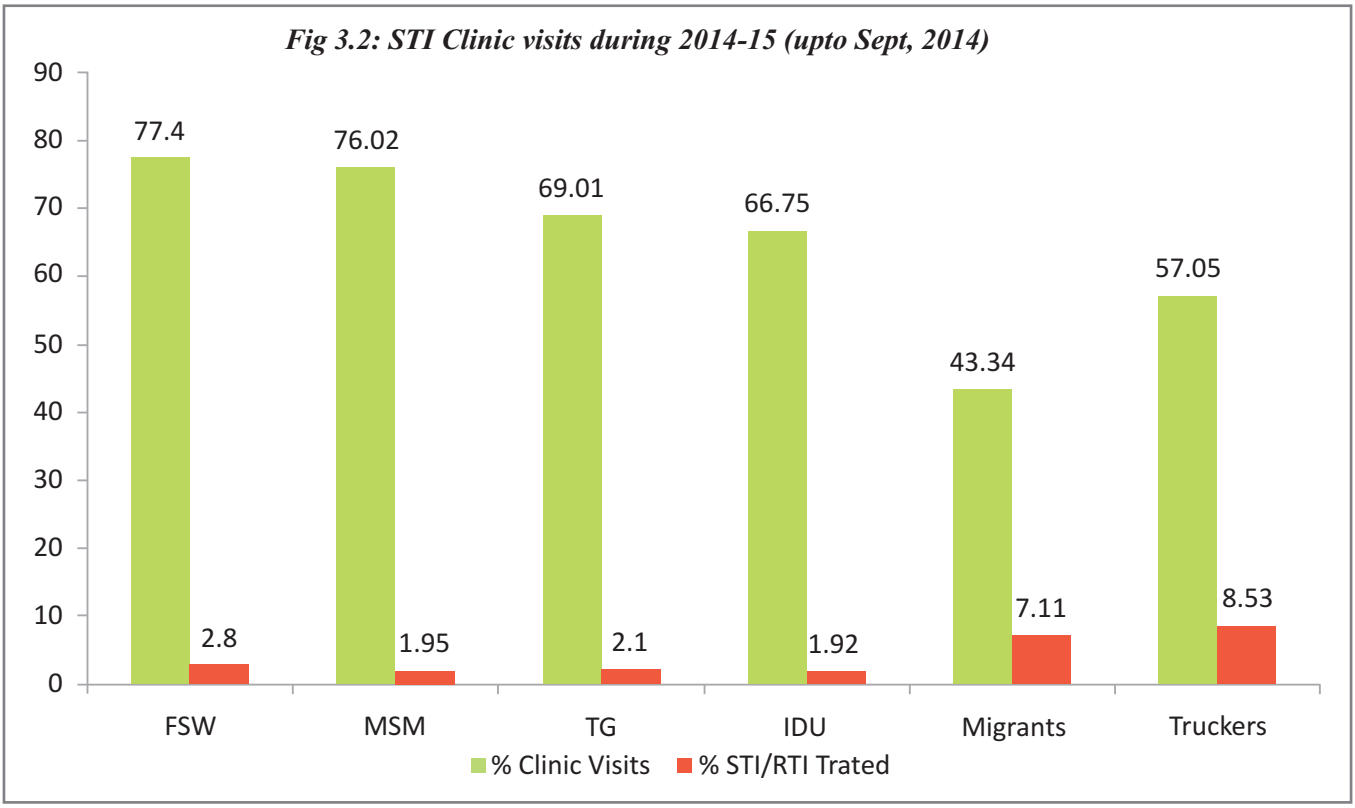
Coverage of Core HRG: The key performance of TIs with respect to the coverage of core HRGs during 2014-15 is depicted in Figure 3.1. This data based on reports received at NACO, shows that FSW coverage compared to the estimates, has already crossed 80%.

Fig 3.1: Coverage of Core HRGs (FSW, MSM, IDU) during 2014-15 (upto Sept, 2014)



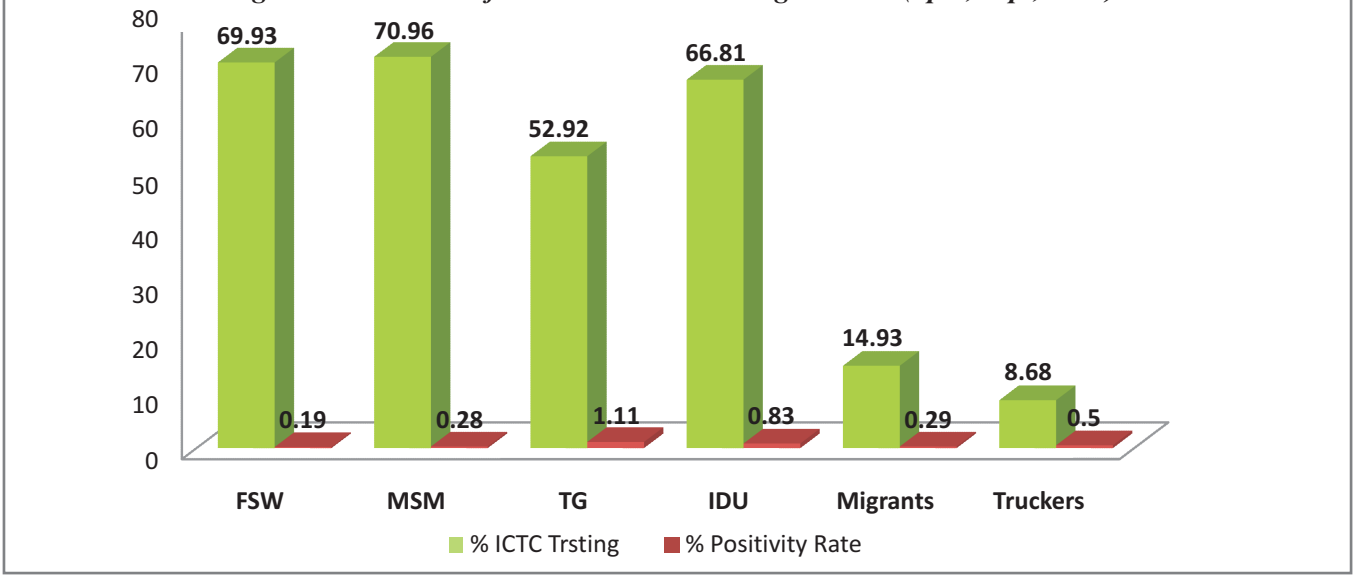
Management of STI/RTI: Clinical services including regular medical check-up is one of the core components of TI project services. NACO's guideline suggests that HRGs from core group, especially MSM and FSW, should visit STI clinics every quarter, i.e., four times in a year, for regular medical checkups 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 2014-2015 (up to, Sept, 2014). Figure 3.2 also shows the proportion of STI clinic attendees diagnosed and treated for STI/RTI during 2014-2015 through TIs. In all the risk groups except bridge population (migrant and truckers), the number of STI/RTI episodes has remained low.

Fig 3.2: STI Clinic visits during 2014-15 (upto Sept, 2014)



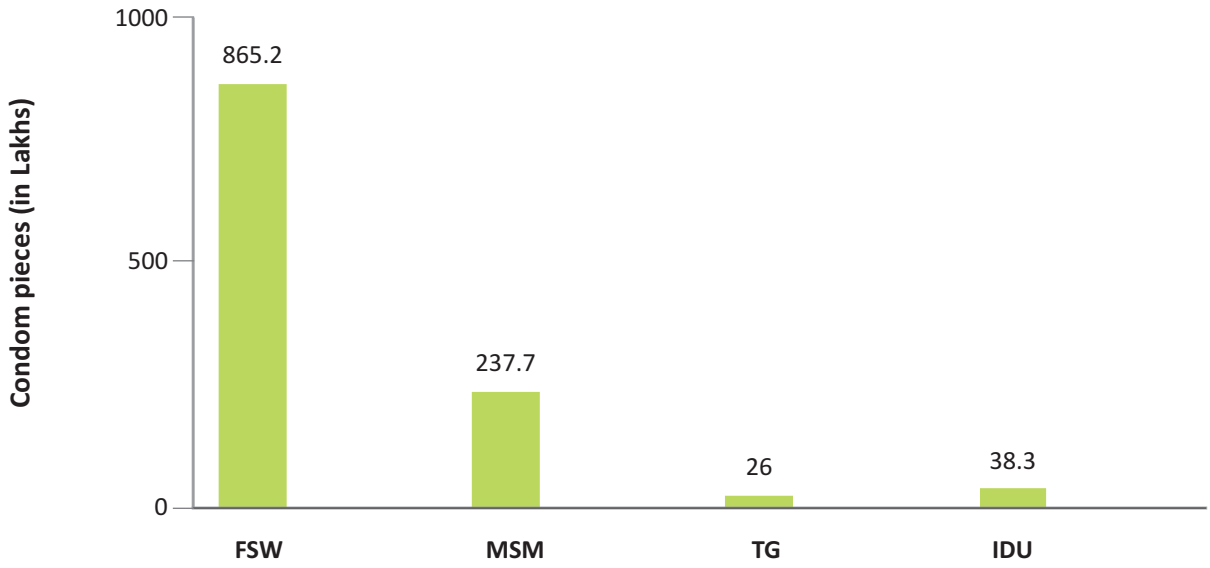
HIV testing and ART linkages among HRGs: NACO guidelines specify that all core HRGs should be tested for HIV once every six months. Figure 3.3 depicts the number of HIV tests performed among HRGs through referrals from targeted intervention projects. The graph depicts HIV testing done and HIV positivity rate for each typology during 2014-15. In all groups, HIV positivity remains low.

Fig 3.3: HRGs tested for HIV at ICTCs during 2014-15 (upto, Sept, 2014)



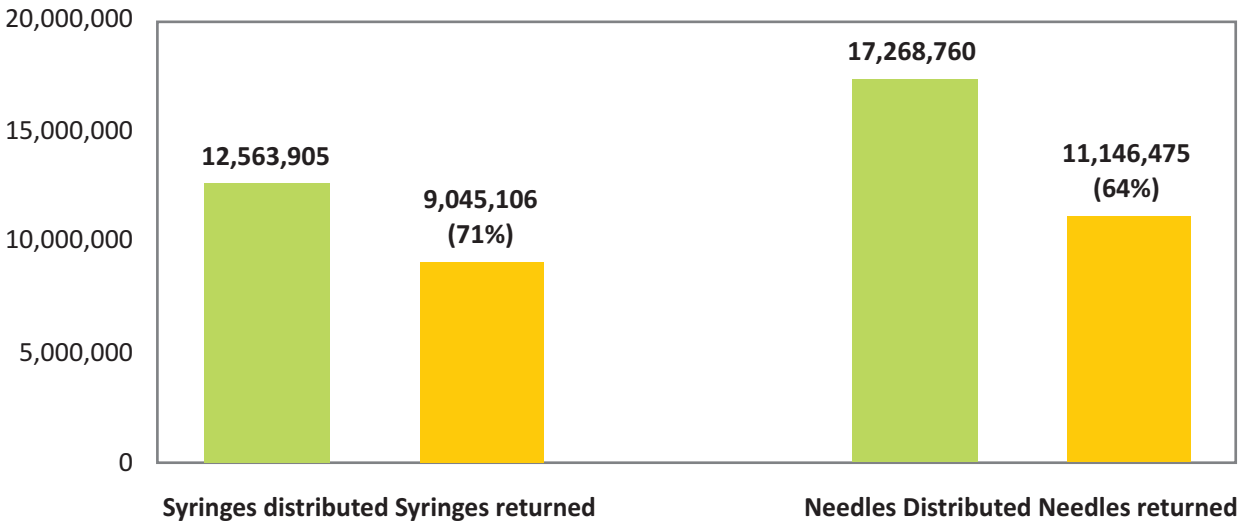
Condom distribution among HRGs: As per NACP strategy, all sexual encounters of HRGs should be protected by consistent and correct usage of condoms. To ensure this, it is imperative that condoms are distributed to HRGs as per their requirement. Fig. 3.4 shows the typology-wise number of condoms (free and social marketing) distributed to the HRGs during 2014-15 (upto Sept, 2014).

Fig 3.4: Typology-wise Condom pieces distributed to HRGs during 2014-15 (upto, Sept., 2014)



Needle-syringe distribution patterns 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 reduces possibility of sharing 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 2014-15 (up to, Sept, 2014).

Fig 3.5: Distribution and Return of Syringes and Needles, 2014-15 (upto Sept., 2014)



Performance grading of Targeted Interventions: The Technical Support Units (TSUs) conduct quarterly performance assessment of TIs. A summary of the assessments conducted is given in Table 3.1.

Table 3.1 Status of Quarterly Performance Assessment of Targeted Interventions conducted in April, 2014

Name of the State	Grading of Tis for Jan 2014-March 2014 (Quarter)							
	Poor	Below Average	Average	Above Average	Good	Very Good	Excellent	Total TIs
Andhra Pradesh	0	0	1	16	25	83	44	**169**
Chhattisgarh	0	2	0	13	19	8	1	**43**
Goa	0	0	0	0	1	4	11	**16**
Karnataka	8	0	10	8	23	27	59	**135**
Kerala	0	2	6	11	10	19	4	**52**
Maharashtra	8	11	13	22	46	53	44	**197**
Madhya Pradesh	0	17	13	14	8	11	0	**63**
Punjab	0	0	1	7	16	29	7	**60**
Rajasthan	0	0	0	0	0	0	0	**0**
TamilNadu	0	0	0	20	25	24	9	**78**
Uttarakhand	0	0	1	3	4	22	3	**33**
Uttar Pradesh	1	4	3	9	9	35	23	**84**
Total	**17**	**36**	**48**	**123**	**186**	**315**	**205**	**930**
No. of TIs (in %)	**2%**	**4%**	**5%**	**13%**	**20%**	**34%**	**22%**	**100%**

Distribution of Targeted Interventions and Coverage of HRGs

Table 3.2 State-wise and Typology wise distribution of Targeted Interventions (TIs) supported by NACO, 2014-15

S. No.	Name of the SACS/MACS	No of TIs functional	FSW	MSM	IDU	Transgender	Core Composite	Migrant (Destination)	Trucker
1	Ahmedabad	22	3	4	1	1	0	11	2
2	Andhra Pradesh	158	37	5	5	0	90	17	4
3	Arunachal Pradesh	23	4	1	3	0	9	6	0
4	Assam	55	31	5	6	0	8	3	2
5	Bihar	30	5	0	8	0	16	0	1
6	Chandigarh	13	4	2	2	0	1	3	1
7	Chhattisgarh	55	13	0	9	0	20	8	5
8	D & N Haveli	0	0	0	0	0	0	0	0
9	Daman Diu	7	0	0	0	0	2	4	1
10	Delhi	96	37	14	17	8	0	16	4

S. No.	Name of the SACS/MACS	No of TIs functional	FSW	MSM	IDU	Transgender	Core Composite	Migrant (Destination)	Trucker
11	Goa	18	6	3	2	0	1	4	2
12	Gujarat	103	13	13	2	1	33	35	6
13	Haryana	62	11	10	15	0	6	18	2
14	Himachal Pradesh	32	15	1	3	0	3	8	2
15	Jammu & Kashmir	17	7	1	4	0	0	3	2
16	Jharkhand	33	22	3	3	0	1	1	3
17	Karnataka	135	66	31	4	2	4	21	7
18	Kerala	66	20	14	7	8	0	15	2
19	Madhya Pradesh	84	23	5	9	0	34	7	6
20	Maharashtra	169	56	9	3	0	28	62	11
21	Manipur	65	6	2	48	0	7	2	0
22	Meghalaya	9	3	0	4	0	1	1	0
23	Mizoram	37	1	1	23	0	8	4	0
24	Mumbai (MC)	49	18	8	3	5	0	13	2
25	Nagaland	53	2	3	30	0	16	1	1
26	Odisha	54	12	2	6	1	22	9	2
27	Puducherry	5	1	1	0	0	2	1	0
28	Punjab	69	16	0	24	0	20	5	4
29	Rajasthan	51	15	4	6	2	11	10	3
30	Sikkim	7	3	0	4	0	0	0	0
31	TamilNadu	78	13	11	1	2	41	6	4
32	Tripura	13	7	0	2	0	1	3	--
33	Uttar Pradesh	100	13	4	13	2	54	6	8
34	Uttarakhand	36	11	1	6	0	7	8	3
35	West Bengal	36	21	0	4	1	0	4	6
	INDIA	**1840**	**515**	**158**	**277**	**33**	**446**	**315**	**96**

Table 3.3 State-wise and Typology wise coverage of Key Risk under the programme, 2014-15

S. No.	Name of the SACS/MACS	FSW	MSM	IDU	TG	Migrant (Destination)	Trucker
1	Ahmedabad	4519	4494	380	400	165000	40000
2	Andhra Pradesh	136794	31105	1936	0	217072	70020
3	Arunachal Pradesh	3367	439	1928	0	30000	0
4	Assam	20679	2963	3237	0	30000	15000
5	Bihar	13676	2159	4279	0	0	10000
6	Chandigarh	3776	2422	1081	34	30000	10000
7	Chhattisgarh	16114	2542	2895	280	80000	62500
8	D & N Haveli	0	0	0	0	0	0
9	Daman Diu	709	587	0	0	60000	10000
10	Delhi	42138	14265	10725	6095	220000	50000
11	Goa	3900	2934	509	0	15000	10000
12	Gujarat	28022	27677	656	881	371000	80000
13	Haryana	13952	8206	5319	0	180000	15000
14	Himachal Pradesh	8853	459	790	0	94000	12516
15	Jammu & Kashmir	1292	106	315	0	21000	20000
16	Jharkhand	12744	1396	897	50	10000	45000
17	Karnataka	86386	25735	1851	1535	210000	80000
18	Kerala	25468	16001	3969	0	80835	20000
19	Madhya Pradesh	24684	8375	6225	0	82000	85000
20	Maharashtra	64087	20316	830	1325	765000	180000
21	Manipur	5749	872	20126	0	15000	0
22	Meghalaya	1420	307	1383	0	10000	0
23	Mizoram	892	512	9625	0	25000	0
24	Mumbai	21329	11723	1161	4395	130000	15000
25	Nagaland	3094	1119	16206	0	5000	5000
26	Odisha	9558	4272	2113	0	92000	0
27	Puducherry	1812	1861	0	0	12000	0
28	Punjab	19738	2549	12404	89	65000	35000
29	Rajasthan	13786	3877	1693	274	100000	20000
30	Sikkim	861	0	1415	0	0	0
31	TamilNadu	43543	32754	488	584	60000	47000
32	Tripura	4124	788	490	0	15000	0
33	Uttar Pradesh	21488	9416	13717	1639	60000	105000
34	Uttarakhand	6694	1836	1801	62	95000	40000
35	West Bengal	31235	0	1366	222	40000	60000
	INDIA	**696484**	**244066**	**131809**	**17867**	**3384907**	**1142036**

New initiatives under Targeted Interventions

North East Conclave I – NACO in collaboration with Govt. of Manipur organized the North East Conclave from 3rd to 5th June 2014 in Imphal, Manipur. The Conclave was strategized to facilitate discussions about the epidemic in the North East, assess the NACP implementation by NE States and to collectively brainstorm and develop appropriate and localized solutions for the response by NE States to address the epidemic.

East Conclave II - NACO in collaboration with Govt. of Nagaland organized the second North East Conclave from 3rd to 5th September 2014 in Kohima, Nagaland. The objectives of the NE Conclave II were to jointly review the progress on actions agreed in NE Conclave I, review implementation of NACP in the North East, develop a North East strategy in consultation with Drug User community and civil society, discuss new initiatives for the North East i.e. HIV interventions in prisons and Accreditation of Opioid Substitution Therapy (OST) centres in public health settings.

Both the conclaves were attended by the Health Ministers and Health Secretaries of the respective states, along with Project Directors of the State AIDS Control Societies in the 8 NE States and officials from NACO. Representatives of the Drug user community and civil society were specially invited to be part of the discussions and for development of the action plans. The event was reported extensively in the media.

Hon'ble Health Minister of Manipur addressing participants at the North East Conclave-I in Imphal in June 2014

National Consultative Meeting with Law Enforcement Agencies to Rollout Prison HIV Intervention

Strengthening enabling environment is imperative while scaling-up comprehensive HIV prevention, treatment, care and support services to injecting drug users including those who are living in prisons. In this context, NACO organized a consultative meeting with the Law Enforcement Agencies on 29th October 2014 at Nirman Bhawan, New Delhi under the chairmanship of Union Secretary (Health), Ministry of Health and Family Welfare (MoHFW). Key ministries and departments including Ministry of Home Affairs (MHA), Ministry of Social Justice and Empowerment (MSJE), Narcotics Control Bureau (NCB), Office of the Delhi Police Commissioner, Customs, Bureau of Police Research and Development (BPR&D) participated in the meeting along with senior level representations of State police and prison department from Himachal Pradesh, Uttarakhand, Punjab Chattishgarh, Karnataka, Tamil Nadu, Andhra Pradesh, Delhi, Mumbai, Arunachal Pradesh, Assam, Sikkim, Tripura, Mizoram, Manipur, Meghalaya and Nagaland. Centres for Disease Control and Prevention (CDCP), United Nations Development Programme (UNDP), United Nations Office on Drugs and Crime (UNODC) and National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS) were also part of the consultation.

Workshop on Enhancing Partnerships between Law Enforcement Agencies and Civil Society Organizations in the Context of Drug Use and HIV

Consumption of drugs continues to be punishable in India. People who are injecting drugs are socially

stigmatized. Punitive laws prevent people from accessing the HIV testing and treatment services they need. Currently harm reduction services including Opioid Substitution Treatment (OST) and needle syringe programme are being provided to people who are injecting drugs in a more restricted environment. In order to address this key operational issue, NACO organized a sensitization workshop in collaboration with United Nations Office on Drugs and Crime (UNODC) and Narcotics Control Bureau (NCB) on enhancing partnerships between law enforcement agencies and civil society organizations in the context of drug use and HIV. The first regional workshop was organized under the chairmanship of Union Secretary (Health), Ministry of Health and Family Welfare (MoHFW) at the Ashok Hotel, New Delhi on 13-14 November 2014. Law enforcement agencies, civil society organizations and respective State AIDS Control Societies (SACS) from Delhi, Haryana, Uttarkhand and Uttar Pradesh have participated in the workshop. Additional Secretary & Director General, NACO, Joint Secretary, NACO, Deputy Director General-Targeted Interventions of NACO, Regional representative of United Nations Office on Drugs and Crime (UNODC), Joint Secretary of Ministry of Social Justice and Empowerment (MSJE), Deputy Director General of Narcotics Control Bureau (NCB) were present during the meeting.

The then Secretary (HFW), addressing participants of the workshop on Enhancing Partnerships between Law Enforcement Agencies and Civil Society Organizations in the Context of Drug Use and HIV in November, 2014

District Network Model for Thane District, Maharashtra

A pilot District Network Model (DNM) is being implemented in Thane district under The HIV/AIDS Partnership Impact through Prevention, Private Sector and Evidence based Programming (PIPPSE) Project. The main strategy for the District Network Model involves the creation of synergistic responses among various stakeholders in the district. The model aims to build linkages towards reducing linkage loss and mainstreaming of HIV within the existing health programme. Since the inauguration of the pilot, PIPPSE has initiated the process of identifying the key stakeholders and developing scope of works for building collaborations and networks.

Launch function of district level Network Model for Thane District, Maharashtra in February, 2014

Piloting of Migrant Service Delivery System to Enhance Service Tracking Among Migrants

NACO has identified 122 districts with high out-migration (based on Census 2001) across 11 States which are a priority for initiating community level migrant interventions. In view of increasing vulnerabilities of migration and HIV, NACO is planning to strengthen service delivery for migrants both at destination and source. Currently due to the mobility of this target group, there are challenges in terms of continuity of services for migrants and service tracking for follow up. In order to facilitate effective utilization and linking of data from different sources (programme outreach and

services) at Source and Destination, a system called Migrant Service Delivery system (MSDS) has been conceived and designed to support State AIDS Control Societies and migrant TIs in evidence informed planning and delivering tailor made services to the community according to their risk profile based on data of migrant's movement across source-destination corridor.

District AIDS Prevention and Control Units

There are 189 District AIDS Prevention and Control Units (DAPCUs) in A and B category districts spread across 22 States of the country for decentralized monitoring and providing programmatic oversight to the implementation of HIV programme. The DAPCUs are led by a District AIDS Control Officer, from the Government Health System and supported by the District Programme Manager (DPM), District ICTC Supervisor (DIS) and District Assistants for Monitoring & Evaluation, Accounts & Programme implementation.

The main objective of DAPCU is overall coordination and monitoring of NACP at district level, to take district specific initiatives and take up activities to integrate with formal health infrastructure and also do mainstreaming with the other departments in the district.

The DAPCU National Resource Team (DNRT) of the NTSU at NACO has been mandated to mentor the DAPCUs and provide support to SACS in reviewing the implementation at district level.

Review of DAPCUs progress

A national review meeting was held in July 2014 with all DAPCU Nodal Officers under the chairmanship of Secretary, DAC. It provided an appropriate platform to discuss key challenges for DAPCU functioning at the field level. A score card with nine indicators was also put in place to assess DAPCU's performance every month.

Capacity Building of DAPCUs

The DNRT with support from CDC and SHARE India reworked on the DAPCU training curriculum to incorporate the programmatic changes of NACP-IV and developed a four day training package. In these trainings, DAPCU staffs are being trained on all NACP components. Between September 1st and October 31st, 2014, 214 staffs from 54 DAPCUs were trained in seven batches. The States covered include- Bihar, Madhya Pradesh, Maharashtra, Tamil Nadu, Uttar Pradesh and West Bengal. Training of remaining DAPCU staff in other states is expected to complete by March 2015.

Key Activities of DAPCUs during the year 2014-15

Review meetings with the facilities and involvement of district administration

188 DAPCUs conducted monthly meetings with all the HIV/AIDS facilities in the district to monitor and review the programme progress and address bottlenecks, if any. Unresolved challenges and problems were communicated to district leadership for discussion in the quarterly meeting of District AIDS Prevention and Control Committee (DAPCC) chaired by the District Collector/Deputy Commissioner. 171 DAPCUs conducted HIV-TB coordination meeting every month and 147 DAPCUs participated in the meetings with National Health Mission (NHM). 108 DAPCUs conducted/participated in meetings with allied line departments to facilitate mainstreaming of HIV/AIDS programme activities.

PLHIV linkage with Social Incentive/benefit schemes:

DAPCUs made concerted efforts in empowering PLHIV's access to various social benefits and protection schemes. This has led to an uptake in access of various central and state sponsored schemes. DAPCUs have continued to ensure

necessary coordination among key stakeholders viz. CSC/Help Desk/DLN, respective line departments, district administration and PLHIVs for availing the schemes smoothly.

DAPCU staff training, Lucknow, Uttar Pradesh

4. LINK WORKERS SCHEME (LWS)

Link Workers Scheme (LWS) the rural focus HIV prevention programme with the mandate to work in 163 high prevalent and highly vulnerable districts in India with the specific goal of reducing rural India's vulnerability to HIV. LWS, a comprehensive interventions focusing at community level to reach out rural HRGs and vulnerable population is essential to achieve the accelerated response considering the emerging epidemic drivers in India especially that of Rural Antenatal Clinic (ANC) prevalence being higher than urban ANC prevalence in moderate and low prevalence States (HIV Sentinel Surveillance, 2010-11), spouses of migrants having four times higher risk than non-migrants (Male out-migration: a factor for the spread of HIV infection among married men and women in rural India, PLOS One, September 06, 2012).

The LWS "links" HRGs and vulnerable populations in rural areas, to HIV services. Currently Link Worker Scheme is operational in 17 states. Reaching to the target population with the services available for HIV/AIDS, coverage of the target population and service delivery uptake by them define the key indicators under the Scheme. A total of 1,99,041 against 1,68,720 mapped HRGs (FSWs, MSMs and IDUs), 46,85,073 against 53,07,198 mapped Vulnerable Population & Bridge population and 48,439 against 40,285 mapped PLHA have been identified and contacted at least once under the scheme. A total of 2,20,666 people were tested for HIV and 1,37,060 people were referred for STI services under the scheme.

IEC Van in Jalna district, Maharashtra covering the target population with pamphlets on HIV/AIDS.

During the reporting period, the scheme was transited from external donor's support to domestic funding, Govt. of India. As part of transition to NACP-IV, recently an external evaluation of 117 District NGOs was carried out with the aim to assess the quality and performance of LWS implemented by NGOs. This process, based on various parameters, determined the continuation or discontinuation of these NGOs in the state after 31st August 2014. Post evaluation, the NGOs were graded (based on the scorings) and 18 district NGOs with poor grading were discontinued. The process of replacement for discontinued agencies was initiated immediately by concerned SACS.

Table 4.1: State-wise no. of district functional for LWS under the programme during 2014-15

State	No. of target districts	No. of districts not functional as on Nov., 2014		No. of districts on board
		Dropped after evaluation	Agency not on board due to any other reason	
Andhra Pradesh	19	0	0	19
Bihar	8	2	0	6
Chhattisgarh	4	0	0	4
Gujarat	12	3	0	9
Jharkhand	3	0	1	2
Karnataka	8	1	1	6
Madhya Pradesh	12	0	0	12
Maharashtra	25	1	2	22
Manipur	9	0	0	9
Mizoram	3	0	0	3
Odisha	6	0	0	6
Punjab	2	0	0	2
Rajasthan	6	3	3	0
Tamil Nadu	21	4	0	17
Tripura	2	0	0	2
Uttar Pradesh	12	4	0	8
West Bengal	11	0	0	11
Total	**163**	**18**	**7**	**138**

5. STI/RTI CONTROL & PREVENTION PROGRAMME

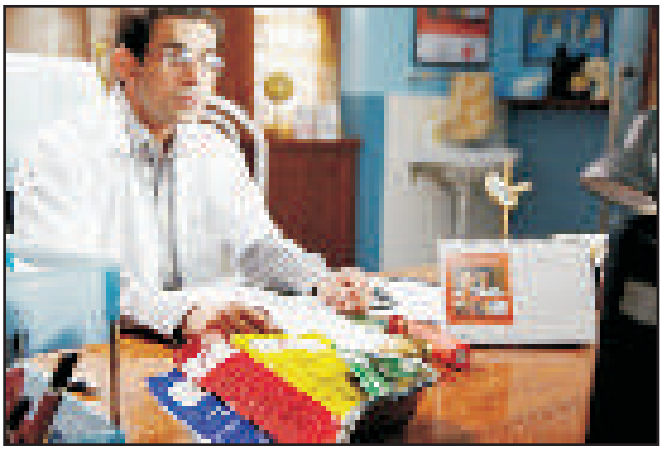
Sexually Transmitted Infections (STI) and Reproductive Tract Infection (RTI) enhances chances of acquiring and transmitting HIV infection by 4-8 times; hence control and prevention of STI/RTI is a key prevention strategy for HIV. Early diagnosis; appropriate and complete treatment of STI/RTI reduces the transmission rate of HIV infection by more than 40%. Control and prevention of STI/RTI also facilitates reducing reproductive morbidity and improves quality of life especially among women and adolescents. Syndromic Case Management (SCM), with minimal laboratory tests is the cornerstone of STI/RTI management under National AIDS Control Programme.

As per 2002-03 ICMR study, the programme estimates occurrence of 30 million episodes of STI/RTI every year in the country. NACO target is to manage 70 lakh episodes of STI/RTI in 2014-15, of that the programme achieved 41.17 (59%) lakhs by the end of October, 2014.

Progress of STI/RTI Services

Expansion of STI/RTI Service in Government Health Facilities: Presently there are 1137 Designated STI/RTI Clinic (DSRC) supported by NACO with at least one DSRC per district in the country. The two arms of DSRC are **(a)** Obstetrics & Gynaecology OPD and **(b)** STI OPD under Dermato-venereology clinics and provide services through existing public health care delivery system.

NACO has provided support to these clinics to provide quality STI/RTI services through audio-visual privacy, furniture and instrument for conducting internal examination, provision of central supply of colour coded STI/RTI drug kits, RPR kits, consumable for conducting basic laboratory tests and computers for maintaining records and for monthly reporting through Strategic Information Management System (SIMS). Each of these clinics is also provided with one trained counsellor. A total of 13, 65,566 RPR tests were conducted among attendees of DSRCs of which only 0.5% (6815) were reactive. Number of patients referred to the Integrated Council and Testing centres (ICTC) were 15,12,240 of which 0.6% (n=8622) were found tested positive for HIV. Among the pregnant women attending antenatal care; 13, 59, 892 lakhs were screened for syphilis of which 0.23% (n=3169) were found reactive for syphilis and were provided treatment. There are 34 SACS STI focal persons and 7 STI Programme Officers in Technical Support Units to oversee programme implementation in the respective States.



A doctor in Designated STI/RTI clinic

Pre-packed STI/RTI colour-coded Kits

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

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

STI/RTI colour coded drug kits

Regional STI/RTI Training, Research and Reference Laboratories: There are seven functional Regional STI Training, Reference and Research Laboratories supported & strengthened by NACO. These are located at:-

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

The key functions of these laboratories are 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. Operational research protocols of Chennai, Hyderabad, Baroda and Nagpur Centres' were approved by NACO R&D TRG and Ethics Committee and centres initiated the activity. The centres will be mentored with the support from CDC through FHI360.

Three new Regional STI centres were inducted into programme in FY 2014-15 and these were located at Government Medical College, Guwahati; BYL Nair Hospital, Topiwala National Medical College, Mumbai and PGIMER, Chandigarh.

Based on recommendations of STI-TRG and evaluation team a National Mentoring Committee has been set up to strengthen and oversee the functioning of these centres and to monitor operation research activity. The operational guidelines for these centres along with a standardized laboratory manual for Lab diagnosis of STI/RTI have been released in February 2014.

In addition, 45 State STI training and reference laboratories have been identified and their staff trained. These centres function under the mentorship of linked regional STI laboratories to implement the STI surveillance protocol. An operational manual was drafted to facilitate and standardize State STI centres functioning. Each of these STI labs were assigned dedicated geographic areas, and DSRCs, TI working in these areas are linked with the respective labs. These STI labs are entrusted to oversee the quality of syphilis screening as per national EQAS protocol. These labs will also investigate the congenital syphilis cases reported to programme in addition to monitoring susceptibility.

Community based STI/RTI Prevalence study

NACO, with the support from CDC and other partners is planning to conduct second round of community-based prevalence study to assess national level burden of STI/RTI. ICMR institutes (NARI, NIE, NIMS) actively participated and finalized the protocol and study would be conducted over the remaining three years of NACP IV.

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

Standardized training curriculum for doctors, staff nurse, laboratory technician and counselor is 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 in turn have conducted training of STI/RTI clinic staff in the designated clinic and TI NGO. A total of 3765 personnel's were trained including 1146 doctors, 542 staff nurses, 470 laboratory technicians, 495 counsellors and 1112 preferred providers.

NACO has developed an integrated training module for counselors working at DSRC/ART/ICTC in consultation with TISS, Mumbai. In 6 batches 154 master trainers were trained on content and methodology. The newer training module is for 7 days instead of 12 days in the past, including one day for field visit.

Additionally, each district has district resource faculties for training doctors, nurses and laboratory technicians on STI/RTI management for sub district health facilities (PHC, CHC and Sub–divisional Hospital). A total of 8799 persons from sub-district health facilities were trained in syndromic case management which includes 4264 doctors and 4535 staff nurses.

Basics of STI programme activities were included in the curriculum developed for trainings of ANM at FICTC and laboratory technicians of ICTC, wherein the related curriculum has been incorporated into their existing curriculum so as to make service delivery comprehensive.

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 standardized service delivery protocol is followed. Medical and paramedical staffs are trained, free STI treatment is provided to patients, and monthly reports on STI/RTI indicators are reported by these facilities through existing HMIS.

Convergence has been strengthened at the national level through constitution of a joint working group and development of national operational framework for STI/RTI services delivery at sub-district health facilities. National 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 NACO and NHM is conducted once every quarter. STI curriculum is 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 standardized curriculum.

NACO has revised national STI/RTI technical guidelines, 2014 in consultation with NHM.

Provision of STI/RTI Services in High Risk Group Population

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

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

Preferred Private Provider approach has been rolled out to scale up STI/RTI services to HRG population under TI Projects. These providers are selected by the community members through group consultation. This approach has enhanced access to services for the HRG. Under this approach, all the HRG receives free STI/RTI treatment and the providers receive a token fee of Rs. 50 per consultation. A total of 3565 preferred provider are providing STI/RTI services to the HRG. All these preferred providers are trained using a standardized curriculum on syndromic case management. Colour coded STI/RTI drug kits have also been 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 21.08 lakhs visits have been made by HRG and 13.65 lakhs regular medical check-up have been conducted. The involvement of private practitioners for providing STI services to HRG at such a large scale is one of the few successful initiatives globally.

Partnering with Organized Public Sector, Public Sector Undertaking and Professional Organization

The major proportion of patients with STI/RTI seek services from the vast network of private health care delivery systems ranging from freelance private practitioners to large public hospitals. Also, many populations are accessing services from public health care systems under other sectors like railways, ESI, armed forces, CGHS, railways, port hospitals as well as health facilities of public sector

undertakings like Coal India Ltd, 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 organized public sectors. DAC has initiated partnership with organized public sectors and private sectors through professional associations to support the delivery of STI/RTI services with the objective to reach the populations presently not covered by the public health care delivery system. STI/RTI services have been rolled out in major Port hospitals, ESIC, Private Medical Colleges.

New Programme Initiative - Elimination of Parent to Child Transmission of Syphilis

The STI/RTI Division in collaboration with the Basic Services Division of NACO with Maternal Health Division under Ministry of Health & Family Welfare and WHO/SEARO has drafted National Strategy on EPTCT of Syphilis, after a series of consultative meetings with all stake holders. NACO is moving forward towards launching this programme initiative in collaboration with the National Health Mission.

Untreated maternal syphilis will have 52% adverse outcome which includes from fetal wastage, neonatal death, low birth weight, to birth of a congenital syphilis baby. As per WHO estimation tools, India may have an estimated 1.02 lakh syphilis positive pregnant women in India every year. The estimated number of congenital syphilitic newborns is 16,144 every year.

6. CONDOM PROMOTION PROGRAMME

National AIDS Control Programme (NACP) firmly pronounces use of condom as one of the most important preventive tool in its fight against AIDS. NACO promotes consistent use of condoms in HIV transmission prevention as unprotected sex has known as the biggest cause of transmission of HIV virus.

NACO has made significant efforts in promoting consistent condoms use for HIV prevention and achieved success in terms of enhancing availability & accessibility of condoms, raising awareness and increasing condom off take from retail outlets.

NACO initiative on condom promotion was continued under NACP-IV in the form of targeted Condom Social Marketing Programme (CSMP). The thrust areas under the programme have been to expand social marketing programme to saturate coverage in districts characterized by high HIV prevalence and/or high family planning need and to increase the demand for condoms among high risk, bridge and general population.

Targeted Condom Social Marketing Programme (CSMP)

NACO targeted CSMP focuses on providing easy accessibility of condoms and hence taken steps to ensure the same in all situations by making it available with non-conventional outlets 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.

The programme also have focus on saturation of all the high risk areas, i.e. truckers halt points and TI sites. All kinds of condom selling outlets located around these high risk areas are also covered in systematic approach under CSMP.

NACO launched the new phase of its targeted Condom Social Marketing Programme in Karnataka, Rajasthan, Maharashtra, Gujarat, West Bengal, Odisha and State group comprising of Assam, Nagaland, Manipur, Mizoram, Meghalaya and Tripura. This new programme phase was rolled out in North Eastern States from June, 2014 and in six other States from July, 2014. The total coverage under this new programme phase will be 171 districts. These districts were selected on the basis of

HIV prevalence & fertility level as mapped and classified accordingly into four categories i.e. 99 High Prevalence High Fertility (HPHF) districts, 38 High Prevalence Low Fertility (HPLF) districts & 34 Low Prevalence High Fertility (LPHF) districts while Low Prevalence Low Fertility (LPLF) districts are not covered inder the programme.

NACO has successfully implemented its targeted Condom Social Marketing Programme (CSMP) in 11 States/UTs during this period. The current programme phase to be concluded on December 4th, 2014 in these States that include Andhra Pradesh, Madhya Pradesh, Uttar Pradesh, Delhi, Bihar, Jharkhand, Punjab, Haryana, Chandigarh, Goa and Chhattisgarh.

Overall under various phases of CSMP implemented during this year, 395 districts were covered falling under three categories i.e. 141 HPHF, 84 HPLF and 170 LPHF districts.

Under the present NACO Condom Social Marketing programme, the total condom sale during the year has been recorded as 33.5 crores till September, 2014. This condom sale was achieved through servicing of more than 5.86 lakhs retail outlets spread over all programme states covered during this period.

Period	April 2014-March, 2015
Total Condon Sales (pcs.)	33,52,28,012
Total Outlets Serviced (nos.)	5,86,487

Fig 6.1: Condom sales and outlet coverage in 2014-15 as on September, 2014

Condon Demand Generation

NACO promotes safe sex and consistent condom use through its campaigns using various media vehicles. 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.

In order to increase the condom use, various demand generation activities were organized under

Distribution of branded reflecting stickers to traffic promote Police for cyclists in Chandigarh

First deluxe trophy volleyball tournament in Goa to condom use

NACO CSMP across all programme states. Range of mid-media activities are conducted by Social Marketing Organizations contracted under CSM Programme to promote consistent condom use in all programme states. Condom use is promoted on these activities for its triple protection benefits against HIV/AIDS, STI and unwanted pregnancy.

Street plays, road shows, magic shows and interpersonal communication etc. are some of the popular activity forms which are used for engaging and motivating the target audience - High Risk Groups, Bridge Population as well as general population, especially in rural areas.

NACO encourages unique and innovative activities to reach out to the target population. This year the first Deluxe Nirodh branded volleyball tournament was organized in Goa in which twelve teams participated. As a first, live condom promotion activities were carried out during IPL matches in

Mohali in a joint activity with the team management of Kings Eleven Punjab. In another joint promotion effort with Traffic Police Department in Chandigarh, free reflective stickers bearing condom promotion message were pasted on cycles and cycle rickshaws to provide them safety at night. Branded van promotion drives were initiated in programme States to provide reach even among the population living in remote rural areas. Flash mob has been one of the most popular activities among the youth and the same response was experienced in a show held in Faridabad also which was witnessed by large groups of young audience along with their friends and family.

Retailers' sensitization programmes were conducted throughout the programme districts in which normalization sessions were held. Participants, as the most important consumer interface that facilitates condom purchase action were motivated to stock condoms and contribute in demand creation process by this means.

Condom Promotion Newsletters were published on quarterly basis and distributed among all stakeholders to disseminate latest information and progress made under NACO CSMP.

Condom man inside Mohali stadium during IPL match

Condom promotion session in Haryana

7. BLOOD TRANSFUSION SERVICES

National AIDS Control Organisation has been primarily responsible for ensuring provision of safe blood for the country. Till Sept. 2014, total blood collection was around 30 lakh units through NACO supported Blood Banks, 84% of these blood units were collected through Voluntary Blood Donation. HIV sero-reactivity has remained low in tune of 0.2% in these blood banks.

Other Key Activities

14 June, 2014 was celebrated as World Blood Donor Day with theme *'Safe Blood for Saving Mothers'*. The then Honorable Union Minister of Health & Family Welfare inaugurated the function and launched the policy on unutilized plasma, "National Policy for Access to Plasma Derived Medicinal Products from human plasma for Clinical/ Therapeutic use: Addendum for National Blood Policy."

8. BASIC SERVICES DIVISION

The Basic Services Division of the National AIDS Control Organisation provides HIV counselling 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, gave a major boost to counselling and testing services in India. The HIV counselling and testing services include the following components:

I. Integrated Counseling and Testing Centres (ICTC)

II. Prevention of Parent-To-Child Transmission of HIV (PPTCT)

III. HIV/Tuberculosis collaborative activities

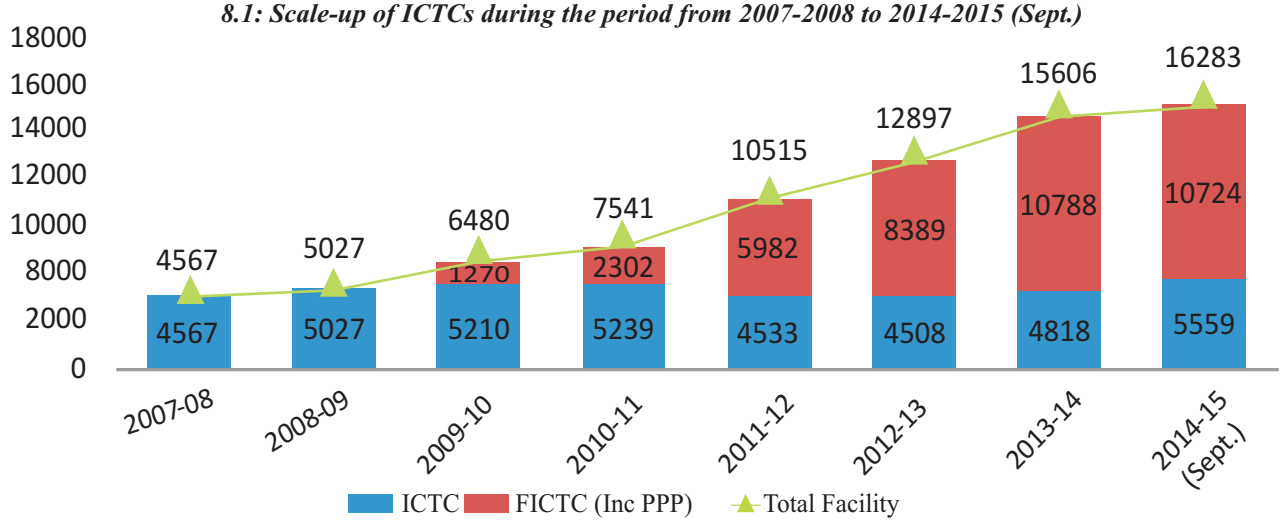
Diverse models of HIV Counselling and Testing services are available to increase access to HIV diagnosis; these include testing services in healthcare facilities, standalone sites, and community-based approaches at various levels of public health systems in India from State, District, Sub-district and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

Types of Facilities for HIV Counselling and Testing Services

I. Integrated Counselling and Testing Centre (ICTC): There are different types of HIV counselling and testing services in India which include standalone ICTC (SA-ICTC), Mobile ICTC, Facility Integrated Counselling and Testing Centres (F-ICTCs) and Public Private Partnership ICTCs (PPP ICTCs). 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. During the financial year, 2013-14, 418 new ICTC counselors completed induction training and 1658 counselors had refresher trainings as part of the capacity building exercise under BSD/NACP. In the same financial year, 5985 FICTC ANMs (counsellors) were trained. In the present financial year (2014-15), 131 new ICTC counselors have already completed induction training and 517 have underwent refresher trainings. In addition to these counselors, 5106 FICTC ANMs have been trained during this year.

There is an increase in the number and proportion of F-ICTCs in the country and decrease in standalone ICTCs, clearly portraying integration of counselling and testing services under general health services, increase in geographical coverage of these services below block level, better accessibility and addressing sustainability (Fig 8.1)

8.1: Scale-up of ICTCs during the period from 2007-2008 to 2014-2015 (Sept.)



II. 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.

In India, PPTCT interventions under NACP started in 2002 using SD-NVP prophylaxis for HIV positive pregnant women during labour and also for her newborn child immediately after birth. With the National AIDS Control Organisation 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, National AIDS Control Organisation 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.

Service Provision

Counselling and Testing Services of General Clients

During 2013-2014, 130.3 lakh (96%) received counselling and testing services against the annual target of 134.81 lakh general clients.

In the financial year 2014-15, the number of ICTCs offering HIV counselling and testing services went up to more than 16000 centres in India (Stand Alone ICTCs including FICTC & PPP ICTCs). 57.02 lakhs general clients were tested for HIV (April - September, 2014) out of annual target of 118 lakhs and 87226 general clients were detected HIV positive.

Counselling 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. In India 15.83 lakh HRGs tested for HIV and 8.74 lakh STI Clinic attendees tested for HIV during 2013-14.

Detection of HIV Infected Pregnant Women and Children: 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 National AIDS Control Organisation 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 HIV prevention benefits. 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 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 1st January, 2014.

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. Details on EID programme are mentioned in the Chapter on Laboratory Services.

A total number of 97.52 lakh (74%) 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.

In the financial year 2014-15, among pregnant women, 42.49 lakh were tested for HIV (April - September, 2014) out of the target of 118 lakh and 8624 were found HIV positive. Out of those detected positive, 7934 (92%) is the proportion of HIV+ve pregnant women & babies who receive ARV Prophylaxis. National level trainings (TOTs) on PPTCT lifelong ARV has been completed in 27 States/UTs by September, 2014 and are implementing multi drug regimen (triple drug ARV).

III. HIV/TB Collaborative Activities: TB is the commonest Opportunistic Infection (OI) in HIV-infected individuals. 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). 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.

Since 2001, India has been implementing HIV/TB collaborative activities for increasing the universal access to prevention, early diagnosis, and treatment services in combating the threat of HIV/TB. In 2008-09, National AIDS Control Organisation and Central TB Division (Directorate General Health Services) jointly developed a National Framework for HIV/TB collaborative activities to address the intersecting epidemics. To further strengthen the HIV/TB collaborative activities in the country during 2012-17, 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.

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 *Fig 8.2* is based on the foundation of strong collaboration between NACP and RNTCP.

Government of India
Ministry of Health and Family Welfare
Department of AIDS Control
6th Floor, Chandralok Building,
36-Janpath, New Delhi-110001

National Framework for Joint HIV/TB Collaborative Activities

November 2013

Central TB Division
Directorate General of Health Services
Ministry of Health and Family Welfare
Government of India, New Delhi

Basic Services Division
Department of AIDS Control
Ministry of Health and Family Welfare
Government of India, New Delhi

Prevention

1. Isoniazid Preventive Treatment
2. Air Borne Infection Control
3. Awareness generation

Early Detection of TB/HIV

1. 100% coverage of PITC in TB patients
2. PITC in presumptive TB cases
3. Rapid diagnostics for detection of TB and DR-TB in PLHIV
4. ICF activities at all HIV settings -ICTC, ART, LAC and TI settings

TB/HIV co-ordination to reduce mortality

Prompt Treatment of TB/HIV

1. Early initiation of ART
2. Prompt initiation of TB treatment

Management of special TB/HIV cases

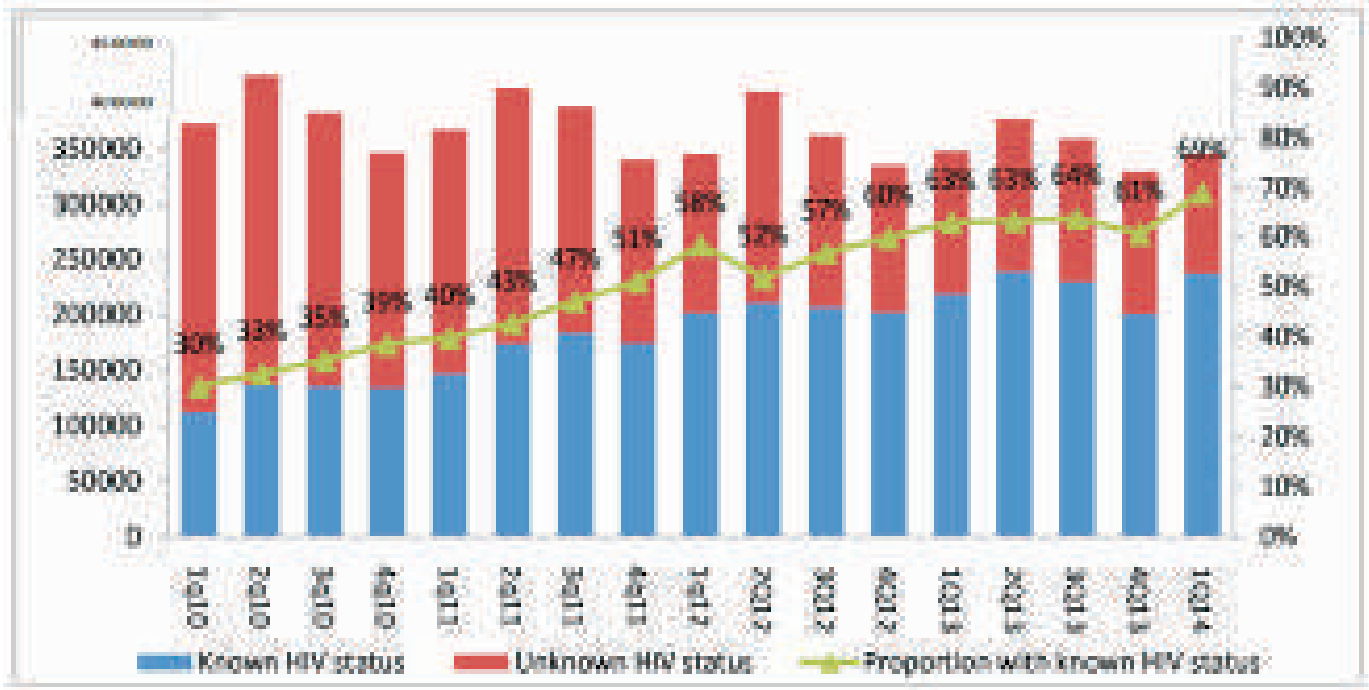
1. TB/HIV patients on PI based ARV
2. TB/HIV in children
3. TB/HIV pregnant women
4. Drug resistant TB/HIV

Fig 8.2: Four pronged strategy for HIV-TB Coordination activities to reduce mortality

Service Delivery

HIV testing of TB patients: Provider-Initiated HIV Testing and Counselling 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). At present there are more than 13,500 DMCs with more than 7,500 co-located HIV/TB testing facilities in the country. The National AIDS Control Organisation and Revised National TB Control Programme have been successful in increasing access and uptake of HIV testing and counselling for all TB patients. In the year 2013-14, about 8,92,088 out of 14,16,014 registered TB patients had their HIV status assessed. During current financial year 2014-15 the proportion of TB patients with known HIV status increased to 70%.

Fig 8.3: Trend of HIV testing among TB cases notified under RNTCP during 2010 – 2014 (2nd Quarter)



HIV testing of presumptive TB cases

NACP and RNTCP have jointly decided to offer HIV testing upstream during evaluation of patients for TB when they present with TB symptoms. 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 counselling). 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 2013-14. The referrals from RNTCP centres to ICTC have also shown consistent increase in numbers. 8.63 lakhs HIV-TB cross referrals have been achieved (April-September, 2014) against annual target of 13 lakhs.

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 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. More than 1.6 lakh presumptive TB cases were identified among ART centre attendees in 2013-14 and around 15% of them were found positive for TB. Around 93 % 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. Number of HIV+TB patients receiving CPT increased from 91% in 2013-14 to 93% in 2014-15 for the patients initiated on treatment in previous year. 93% of HIV-infected TB patients receiving ART during TB treatment.

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.

Quality Improvement Initiatives

Technical Resource Groups (TRG) on Basic Services: In the year 2013-14, 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).

Supervision and Monitoring Mechanism: Officers from NACO along with the State AIDS Control Societies and partners visit States/UTs and service delivery centres as part of routine monitoring. During 2013-14, NACO 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. State AIDS Control review

Fig 8.4: Review meeting of JD BSD SACS conducted at NACO and Supervisory visits and review meetings by Nodal officers from NACO

meetings, National TB HIV Joint Review Meetings, National TB HIV Coordination committee, National TB HIV technical working group meetings were conducted in 2013-14 & 2014-15.

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.

Newer Initiatives in basic services division 2013-14 & during 2014-15:

1. National HIV-TB Coordination Committee was formed in 2013-14 and its first meeting was held under the Chairmanship of Secretary, Department of AIDS Control. The 2nd NTCC meeting was held on 9th July, 2014 under the chairmanship of then Secretary, Department of AIDS Control. Joint HIV/TB National review meetings were conducted in coordination with Central TB Division and National TB institutes on 16th-17th July & 11th-12th Aug., 2014 in current FY 2014-15;
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 Counselling 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;
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 National AIDS Control Organisation and Central TB Division have been conducted in Madhya Pradesh, Karnataka and Delhi in addition to the central evaluations by RNTCP;
8. National Strategic Plan and National PPTCT Guidelines for Implementation of Option B Plus updated in Dec 2013;
9. Nationwide Launch of Option B plus on 1st Jan. 2014;
10. Assessment of PPTCT Services Implementation in 4 States implementing Option B since Sept. 2012;
11. Universal HIV screening as an essential part of routine antenatal care-approved by MoHFW;
12. BSD/NACO in collaboration with TISS has developed an Integrated Induction Training Module for all the counsellors working in ICTC, ART & STI facilities. This induction training of the counsellors have been commenced for all the States/UTs and
13. BSD/NACO in collaboration with TISS has also developed an Integrated Refresher Training Module for all the counselors working in ICTC, ART & STI facilities. This refresher training of the counselors have been commenced for all the States/UTs.

9. CARE, SUPPORT AND TREATMENT (CST)

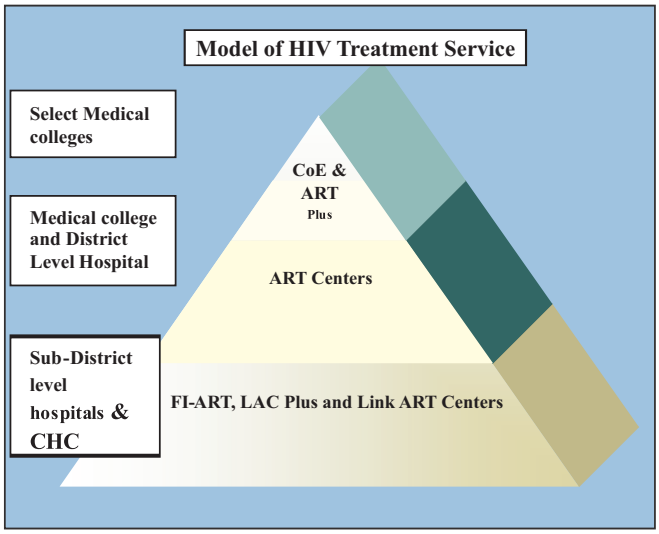
The Care, Support and Treatment (CST) component of the NACP aims to provide comprehensive

management to PLHIV with respect to free Anti-Retroviral Therapy (ART), psychosocial support to PLHIV, prevention and treatment of Opportunistic Infections (OI) including TB and facilitating home-based care and impact mitigation in stigma free environment.

A. Service Delivery Mechanism for Care, Support & Treatment

CST services are provided through a spectrum of service delivery models including ART Centers, Centers of Excellence (CoE), Pediatric Centers of Excellence (PCoE), Facility Integrated ART Centers (FI-ART), Link ART Centers (LAC), Link ART Plus Center. Care & Support Centers established by NACO in health facilities across the country with aim to provide universal access to free and comprehensive CST Services. There are active linkages and referral mechanism for monitoring, mentoring, decentralization and specialized care. CST Services are also linked to ICTCs, STI clinics, PPTCT services and other clinical departments in the institutions of their location as well as with the RNTCP programme in order to ensure proper and comprehensive care and management. *Fig. 9.1* below gives a graphic view of this service delivery model.

Fig. 9.1: Model of HIV Treatment Service



A.1 Antiretroviral Therapy Centers: Provision of free Antiretroviral Therapy (ART) for eligible persons living with HIV/AIDS was launched on 1 April, 2004 in eight Government hospitals located in 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 centers are established in the medicine department of Medical colleges and District Hospitals mostly in the Government sector. However, some ART centers are functioning in the sub-district and area hospitals also, mainly in high prevalence states. The ART centers are set up based on prevalence of HIV in the district/region, volume of PLHIV detected and capacity of the institution to deliver ART related services. Till Sep., 2014, there are 453 functional ART centers across the country.

A.2 Link ART Centers (LAC): In order to facilitate the delivery of ART services nearer to the beneficiaries, it was decided to set up Link ART Centers located mainly at ICTC in the district/sub-district level hospitals nearer to the patients' residence and linked to a Nodal ART center within accessible distance. The LAC helps in reducing cost of travel; time spent at the center and hence helps in improving clients' adherence to ART. Presently, 870 Link ART Centers are functional.

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

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

A.4 Centres of Excellence (CoE): To facilitate provision of tertiary level specialized care and treatment, second line and alternative first line ART, training & mentoring and operational research, ten Centers of Excellence have been established in different parts of the country. They are located in Bowring & Lady Curzon Hospital, Bengaluru; 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.

A.5 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 centers have varying roles and responsibilities for delivery of care and support to infected children including specialized laboratory services, early diagnosis of HIV among infants, ART to children infected with HIV, Counselling on adherence and Nutrition, etc. These centers also provide technical support to the other ART centres in Paediatric care. Currently, seven Paediatric Centers of Excellence are functional in the country. They are located at Niloufer Hospital, Hyderabad; Indira Gandhi Institute of Child Health, Bengaluru; 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.

A.6 ART Plus Centres: In order to provide easy access to second line ART, NACO expanded the number of centres that provide second line ART by upgrading some of the ART centers as 'ART Plus'. Currently, there are 37 ART plus Centres functioning in the country. All the states have been covered under this scheme.

A.7 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 People Living with HIV (PLHIV). It provides linkages and access to essential services, supports treatment adherence, reduces stigma and discrimination and improves the quality of life of PLHIV across India. The project is implemented by 17 State level and regional SRs. (10 SRs are State level Network). 10 out of 17 SRs are State level Network (SLN) and more than 60% of CSC is implemented by PLHIV network making it the biggest community led care and support intervention. As of Sept-14, 325 Care and Support Centres are functional and a number of 454456 PLHIV have received services out of which 77635 were linked to different welfare schemes and services.

A.8 Facility Integrated ART Centers: From April, 2014, the concept of Facility Integrated ART Center (FIARTC) has been initiated with financial and technical support from NACO, and SACS. The concept of FIARTC is much similar to ART center

except for the patient load (>than 300 positives detected at ICTC) and the number of staff serving at the center. The main objective of initiating this concept was to serve those areas which have less accessibility, especially the hilly terrains, desert areas, tribal areas and other areas with fewer infrastructures to access the treatment. This initiative which is to be located at Medical College and District Level Hospital which will help to reduce the number of LFU in most difficult areas and will help to increase the drug adherence among those who are on ART. For financial year 14-15 total 77 FI-ART has been approved.

The progress achieved in expanding Care, Support and Treatment Services till Sept., 2014 is summarized in *Table 9.1*.

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

Facility for CST	Baseline (Dec., 2012)	As on March, 2014	As on Sept., 14
ART Centers	**355**	425	453
Link ART Centers	685	870	987
Centers of Excellence	10	10	10
Pediatric Centers of Excellence	7	7	07
ART Plus Centers	24	37	37
Care & Support Centers	253 (CCC)	224	325

** Early in 2012, the Care & support centers were referred as Community Care Center*

B. Services Provided

B.1 First line ART: First line ART is provided free of cost to all eligible PLHIV through ART centers. Positive cases referred by ICTCs are registered in ART center for pre-ART and ART services. The assessment for eligibility for ART is done through clinical examination and CD4 count. Patients are also provided counselling on adherence, nutrition, positive prevention and positive living. Follow up of patients on ART is done by assessing drug adherence, regularity of visits, periodic examination and CD4 count (every 6 months). Treatment for Opportunistic Infections is also provided through ART centers. Till Sept., 2014, 8.10 lakhs PLHIVs are on first line ART.

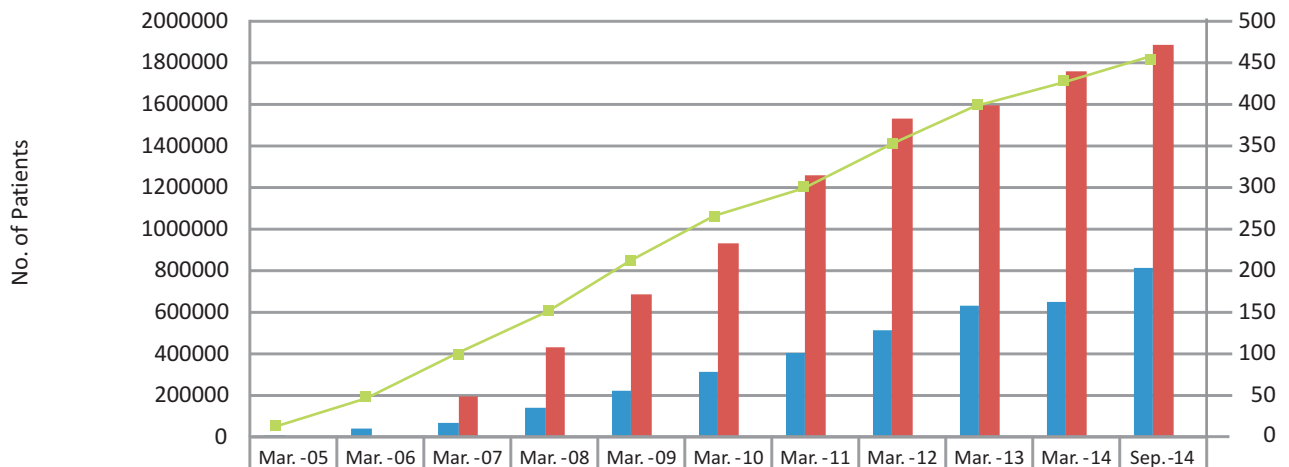
B.2 Alternative first line ART: It has been observed that a small number of patients initiated on first line ART experience acute/chronic toxicity/intolerance to first line ARV drugs necessitating change of ARV drugs to alternative first line drugs. Presently, the provision of alternative first line ART is done through the Centers of Excellence and ART plus Centers across the country.

B.3 Second line ART: The patients started on ART can continue on first line ART for a number of years if their adherence is good. However, over the years some percentage of PLHIV on first line ART develops resistance to these drugs due to mutations in virus. The rollout of second line ART began in January, 2008 at 2 sites–GHTM, Tambaram, Chennai and JJ Hospital, Mumbai on a pilot basis and was then further expanded to the other COEs in January, 2009. Further decentralization of Second Line ART was done through capacitating and

upgrading some well functioning ART Center as 'ART plus Centers'. Till Sept. 2014, 10223 are receiving second line drugs at CoEs and ART Plus Centres. All ART centres are linked to CoE/ART plus centres. For the evaluation of patients for initiation on second line and alternate first line ART, State AIDS Clinical Expert Panel (SACEP) has been constituted by NACO at all CoEs and ART Plus Centres. This panel meets once in a week for taking decision on patients referred to them with treatment failure/major side effects.

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

Fig .9.2: ART Scale up for PLHIV in India, 2005- 2014



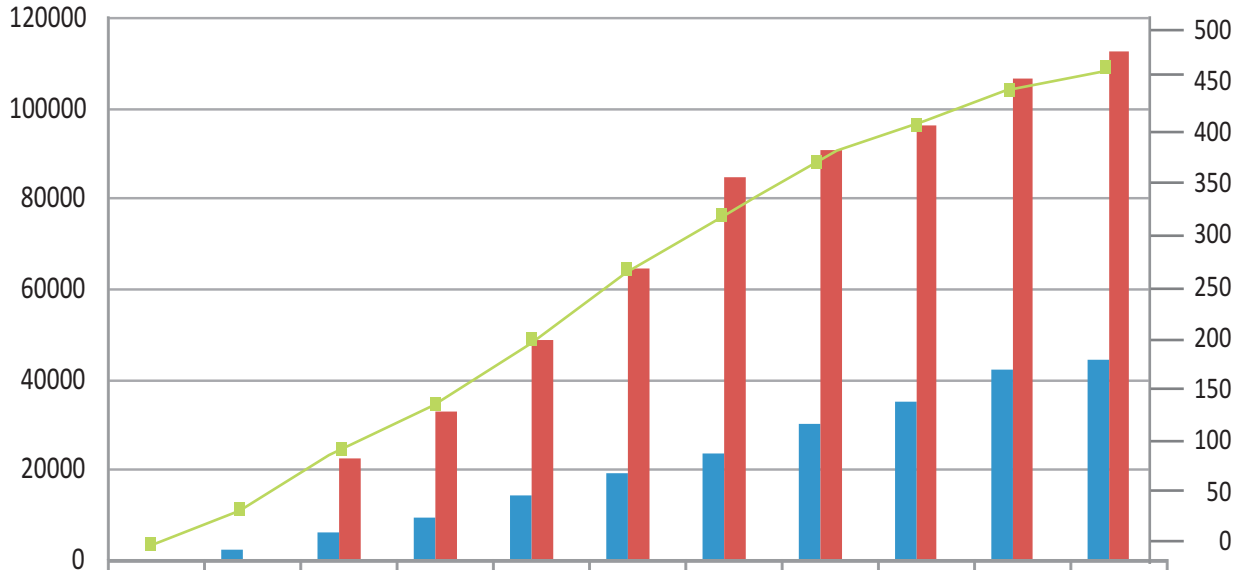
	Mar. -05	Mar. -06	Mar. -07	Mar. -08	Mar. -09	Mar. -10	Mar. -11	Mar. -12	Mar. -13	Mar. -14	Sep.-14
No. of patient on 1st line	6845	37368	69016	140654	223223	315640	404882	516412	632397	650157	810339
Ever Registered			194607	428056	686913	933540	1253498	1529031	1594532	1758748	1882991
No. of ART centre	25	54	107	147	211	269	300	355	400	425	453

B.4 National Paediatric HIV/AIDS Initiative: The National Paediatric HIV/AIDS Initiative was launched on 30th Nov. 2006. Till Sept. 2014, nearly 1,12,719 Children Living with HIV/AIDS (CLHIV) are registered in HIV care at ART centres of whom 44,492 are receiving free ART. Paediatric formulations of ARV drugs are available at all ART centres.

B.5 Pediatric 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 on the 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 applicable for children as well. Currently, provision of second line ART for children has been made available at all CoEs and ART plus Centers. Fig. No. 9.3 gives a view of the services provided to children living with HIV/AIDS, during 2005–March 2014.

Fig.9.3: ART Scale up for Children Living with HIV/AIDS in India, 2005 – 2014



	Mar. -05	Mar. -06	Mar. -07	Mar. -08	Mar. -09	Mar. -10	Mar. -11	Mar. -12	Mar. -13	Mar. -14	Sep.-14
No. of patient	269	2335	6365	9495	14303	19203	23854	29938	35345	42015	44592
Ever Registered			22462	32900	48721	64661	84987	90826	96151	106824	112719
No. of ART centre	25	54	107	147	211	269	300	355	400	425	453

B.6 Early Infant Diagnosis (EID): In order to promote confirmatory diagnosis for HIV exposed children, a programme on EID was launched by NACO. All children with HIV infection confirmed through EID are linked to ART services.

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

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

Services/Beneficiaries	Achievement as on September, 2014
Adults registered for ART	17,70,272
Adults alive and on ART	7,65,747
Children registered for ART	1,12,719
Children alive and on ART	44,592
Persons alive and on 2nd line ART	10,223

Table 9.3: State-wise list of ART Centres and patients on ART (As on Sept., 2014)

State	Functional ART Centres	Number of PLHIV alive and on ART as on Sep t.-14					
		Male	Female	TS/TG	Children		Total
					Male	Female	
Andhra Pradesh	55	84898	87128	252	4020	3335	179633
Arunachal Pradesh	1	19	25	0	4	1	49
Assam	4	1886	1051	2	82	64	3085
Bihar	16	12264	8457	11	857	378	21967
Chhattisgarh	5	3569	2343	7	255	194	6368
Chandigarh	1	2110	1251	6	216	114	3697
Delhi	9	10552	5752	196	750	338	17588
Goa	1	1080	892	3	86	64	2125
Gujarat	28	24406	14947	152	1383	827	41715
Haryana	1	3279	2213	5	173	70	5740
Himachal Pradesh	3	1280	1308	1	149	101	2839
Jammu & Kashmir	2	812	551	4	64	47	1478
Jharkhand	7	2872	1928	9	235	143	5187
Karnataka	61	50311	55107	194	3916	3149	112677
Kerala	8	5007	3822	0	241	216	9286
Madhya Pradesh	15	6708	4758	27	475	272	12240
Maharashtra	70	71816	65515	201	5575	3918	147025
Manipur	10	4802	4207	49	338	333	9729
Meghalaya	1	257	289	0	14	11	571
Mizoram	3	1503	1588	0	113	92	3296
Mumbai	12	17009	11046	163	823	704	29745
Nagaland	6	2317	2413	3	127	139	4999
Odisha	10	5168	3807	59	293	212	9539
Puducherry	1	477	466	5	38	34	1020
Punjab	8	7724	5900	35	468	272	14399
Rajasthan	17	11371	9165	13	880	479	21908
Sikkim	1	52	43	0	5	4	104
TamilNadu	52	40467	38431	187	2201	1849	83135
Tripura	1	346	183	0	12	4	545
Uttar Pradesh	28	18738	15226	73	1483	697	36217
Uttarakhand	2	1069	919	5	91	49	2133
West Bengal	14	11753	7373	59	639	476	20300
Total	**453**	**405922**	**358104**	**1721**	**26006**	**18586**	**810339**

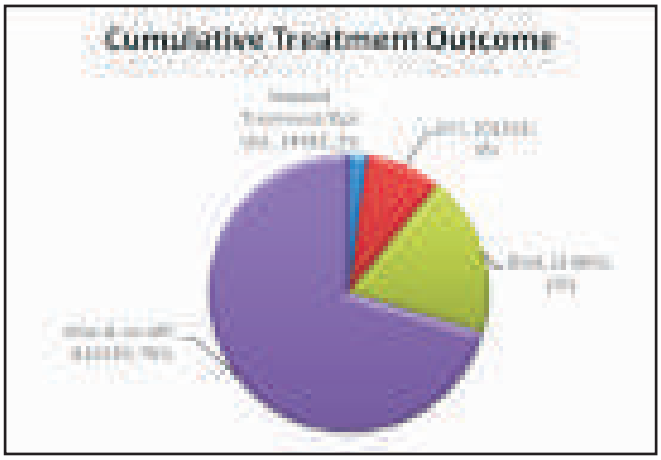


Fig: 9.4 shows outcome of PLHIV ever initiated on ART as on Sept.-2014. This graph represents a cross sectional data at one point of time. (Sept.-14)

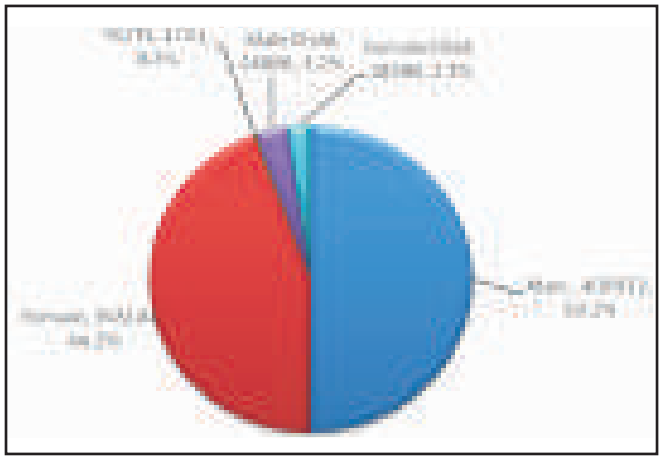


Fig9.5: Represents Gender distribution of Alive on ART PLHIV and CLHIV as on Sept.-14.

Table 9.4: Services provided by Care and Support Centres (CSC) till September, 2014

No. of PLHIVs registered in ART Centre and on ART are registered in the CSC	**331,145**
No. of PLHIV in Pre ART phase who get registered at the CSC	**123,311**
No. of registered PLHIVs receiving at least one counselling service in the quarter	**244,389**
No. of registered PLHIVs receiving at least one counselling session on thematic areas	**243,454**
No. of PLHIV whose at least one family member or sexual partner referred for HIV testing and received test result	**12,090**
No. of PLHIV registered in the CSC linked to Govt. social welfare scheme	**77,635**
Proportion of PLHIV Lost to Follow Up (LFU) brought back to treatment	**42,198**

C. Capacity Building for CST

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

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

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

As part of continuous capacity building efforts, technical guidelines and training modules have been developed which are available for use at various facilities and SACS. These include:

- Guidelines for ART in adults and adolescents-March 2007 (updated: April, 2009, November,

2011, July, 2012 and May, 2013);

- Guidelines for ART in children-November, 2006 (updated; September, 2009 and October, 2012);
- Guidelines for prevention and management of common opportunistic infections and malignancies among adults and adolescents-March, 2007;
- Operational guidelines for ART centres, Link ART centre and LAC Plus;
- Operational guidelines for Care and Support centres;
- Technical guidelines on second line ART in adults and adolescents- November 2008 (updated in December, 2012; May, -2013);
- Technical guidelines on second line ART for children- October, 2009 (updated; May, 2013);
- Training modules for ART Medical Officers, ART specialists and LAC doctors May, 2007 (updated: December, 2012);
- Guidelines for Providing Nutritional Care and Support for Adults living with HIV and AIDS: July, 2012;
- Nutrition Guidelines for HIV Exposed and Infected Children (0–14 years of age): July, 2012;

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

D. Endeavours to enhance and ensure the provision of high quality services

D.1 Technical Resource Groups on CST: Technical Resource Groups have been constituted on ART, Pediatric ART and Care & Support Services. These groups consist of national and international experts and representatives of organizations like WHO, CDC, Clinton Health Access Initiative and Networks of Positive People. They review the progress and give valuable suggestions and recommendations on various technical and operational issues relating to the programme. Meetings of TRGs are held periodically with clearly drawn agenda and issues for discussion.

D.2 Strengthening the capacity of laboratories for CD4 testing: There are 264 CD4 machines installed at present serving 453 ART centres. All machines procured by NACO are under comprehensive maintenance or warranty.

D.3 Supervisory/Monitoring Mechanism: Care Support & Treatment Division at NACO is responsible for planning, financing, implementation, supply chain management, training, coordination, monitoring & evaluation of care support & treatment services in the country.

The implementation and monitoring at State level is the responsibility of the concerned State AIDS Control Societies (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 Centers at least once in two months and they send regular reports to NACO. Periodic meetings of Regional Coordinators/CST officials of SACS are held at NACO to review various issues pointed out by them. In addition, NACO officers also visit the centres not performing satisfactorily or facing problems to guide them in implementation of the programme.

D.4 Regular CST review meetings: Review meetings of all the CST officers from the State and all NACO Regional Coordinators are held on a regular basis in a standard format. During these meetings, the state officers give an update on the various CST related activities in their state and wherever required remedial measures are taken.

D.5 Regular State level review meetings: Regular state level review meetings of the programme are conducted at SACS level. These meetings are attended by representatives of NACO, SACS, Regional Coordinators, Medical Officers and staff of ART centres and other facilities. Review of the performance of individual centers is undertaken during such meetings. Participants are given refresher/reorientation sessions also during such meetings.

D.6 State Grievance Redressal Committee (SGRC): At the state level, Grievance Redressal committee has been constituted to routinely review the functioning of the ART Centres. The Committee is headed by the Health Secretary of the State and consists of Project Director of the SACS, Director of Medical Education, Director of Health Services, and the Nodal Officers of the ART centre, representative of Civil Society/positive network and NACO. This mechanism ensures that issues pertaining to grievances of PLHIV are brought to the notice of state authorities and SACS in a systematic manner for timely response.

D.7 Missed/LFU Tracking Mechanism: The information on patients Lost to Follow Up (LFU) is captured in the CMIS through the monthly reports from the ART Centres. This information is monitored very closely and centers with high rates of LFU are visited by senior officers of NACO. Presently the cumulative LFU is about 6%. The responsibility of tracking and providing home-based counselling for LFU patients is shared with CCC through outreach workers, PLHA networks and counselors of ICTC in some places.

D.8 Follow up of Pre-ART LFU: All patients registered in Pre-ART and on ART undergo a CD4 test every six months. The ART center lab technician maintains a daily "due list" of the patients who are due for CD4 testing. This list is prepared from CD4 laboratory register. This list is available with SMO/MO and during patient's visit in that particular month for ART. Those who do not undergo CD4 test within one week of their due date are followed up by phone call to ensure that CD4 test is done on the next visit.

D.9 Decentralization of Supply Chain Management of ARV drugs: NACO has introduced a change in the way ARV drugs are distributed to ART Centres starting with the procurement cycle during 2011-12. ARV distribution now follows a 'hub and spoke' model where the suppliers deliver the entire quantity required by a state to the SACS which will act as the hub for further distribution of the required quantity of drugs to ART centers. These drugs will be at SACS only for short durations as nearly 80% of the stock shall be moved to ART centers immediately upon receipt and rest 20% buffer stock will have to be kept at SACS to meet further requirement from the centres.

D.10 Intensified LFU Tracking: This activity was aimed to launch a LFU tracking drive to retrieve the patients as well as to validate the data & update the current status of PLHIV who are being reported as LFU in pre ART and on ART care by screening records and performing out-reach through the existing programme network. Through this activity 3623 on ART and 1891 pre ART LFU were linked back to CST services till date.

E. Evaluation & Operational Research

Various studies were conducted in relation to CST.

Studies Completed

- Assessment of ART Centres in India: Clients' and providers' perspectives;

- Baseline CD4 count of PLHIV enrolled for ART in India;
- Assessment of Link ART Centres in India;
- Assessment of the Centres of Excellence (CoE) in India;
- Assessment of the Regional Paediatric Centres;
- Assessment of the Community Care Centres in India;
- Factors affecting enrolment of PLHIV in ART centers;
- Baseline CD4 count of healthy adult population;

Proposed Topics for Research for this Year

- EFV Toxicities in adults and paediatrics;
- Sero-discordant couples;
- Profile and Burden of OI's;
- Progression to ART eligibility in more than 500 CD4 in adults;
- CD4 and Virological discordance;
- TDF Toxicities;
- ABC hypersensitivity;
- Progression to ART eligibility in paediatric cases;
- Development milestone and growth in paediatric;
- 3TC toxicities;
- Retention in care for paediatric patients;
- Hep B and Hep C co-infection;
- Death analysis;
- PEP and
- Outcome of early initiation of ART in HIV/TB co-infection;

F. Other Initiatives in Care, Support and Treatment

F.1 Post Graduate Diploma in HIV Medicine NACO, in collaboration with IGNOU, has rolled out a one-year PG Diploma programme in HIV Medicine. This programme is expected to bridge the gap in trained manpower for ART centers.

Programme Objectives:

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

The programme is implemented through a network of programme study centers located in select Centers of Excellence.

F.2 Various capacity building activities done with support from I-TECH: I-TECH/CDC provide technical and financial support for these activities.

- **Expert Physician Access Number (EPAN):** Expert Physician Access Number (EPAN) is a clinical consultation phone line (Warmline) for the ART Medical Officers and Clinical Staff to get timely access to clinical case consultation on unique and complicated HIV/AIDS cases.

Expert Physician Access Number (EPAN) was established in 2012 which was aimed to provide remote, mobile-based technical support to ART medical officers. Clinical Research Fellows (CRF) at CoEs were trained and oriented on the various aspects of the EPAN/Warmline service based on successful pilot of a similar service at Government

Hospital of Thoracic Medicine, Tambaram, Chennai. The EPAN/Warmline operates between 9:00 AM and 5:00 PM on all days except Saturdays, Sundays and public holidays. CRFs at CoEs are the custodians of the EPAN cell phone and address clinical/programmatic queries of ART medical officers. After responding and addressing the query, they use a standard case format to document the call.

- **National Distance Learning Seminar (NDLS)**

HIV/AIDS National Distance Learning Seminar Series (NDLS) was introduced in September 2010. The series is aimed at training health care workers in ART centers, Link Art centres and community care centres providing HIV/AIDS care, support and treatment. National and International HIV/AIDS experts present on a variety of topics on advanced care, comprehensive management, and treatment via synchronous live sessions, across several states and districts around the country using Adobe Connect software. These live sessions have features such as meeting room, live and real time chat, e-poll, video and audio conferencing making sessions intuitive by enabling two way communications.

Thus far, 88 NDLS sessions have been conducted with a total of 15,253 participants with an average of over 173 participants per session, with regular participation from ART centres, CoEs (Center of Excellences) and pCoEs (Pediatric Center of Excellences).

- **Regional Distance Learning Seminar (RDLS)**

Regional Distance Learning Seminar Series (RDLS) was launched in year 2012 aimed at training health care workers at ART Centres, Link ART Centers and Community Care Centres on locally relevant topics, unique case studies and treatment guidelines often in local/regional languages. RDLS is conducted at the regional level and specifically addresses the issues pertaining to the respective state and/or region. The lectures are presented by regional experts on the topics chosen by the regional medical officers based on the current prevailing issues in the region/state.

Just like NDLS, RDLS uses Adobe Connect software to host the session with features like meeting room, live and real time chat, e-poll, video and audio conferencing making the session intuitive and interactive. All 10 CoEs and 2 pCoE shave initiated RDLS. So far, 91 RDLS sessions have been organized with over 6,331 participants trained.

- **Continuing Medical Education (CME)**

With intention to provide Medical Officers working at ART centre with relevant, reliable and up to date information on current clinical management of HIV infected patients and to provide them with programmatic updates in management of PLHIV's, Continuing Medical Education (CME) programmes have been organized at regional level. So far 4 CME has been completed for States of Maharashtra, Goa, Tamil Nadu, Puducherry, Kerala Madhya Pradesh, Chhattisgarh, Bihar, Odisha, Jharkhand Rajasthan, Delhi, Uttar Pradesh, Himachal Pradesh, Haryana, Jammu & Kashmir, Uttaranchal and Punjab. 226 participants from 176 ART Centers have participated in these CME.

- **Assessment of Centers of Excellence in HIV care**

There are 10 centers of excellence in the country. The 10 centers of excellence have been established since 2008. These centres are expected to deliver on four key areas namely: Good Clinical Care; Training and mentoring centers; Research and undertake SACEP. In second half of 2014, NACO planned an assessment of these ten centers. Since July 2014, eight centres have been visited by a team of comprising of NACO and ITECH officials along with independent experts, experienced SACS officials and Regional coordinators. The team undertakes the assessment of the ART centre that is a

high volume centre providing Medical/clinical care at the CoE as well as the additional three functions of the CoE mentioned above. 8 of 10 CoE have been assessed so far.

- **Orientation of Pediatric CoE**

NACO had established 7 Regional Pediatric centres in 2006. However, in 2011, they were upgraded as Pediatric Centres of Excellence (PCoE). A scheme for the PCoE was developed by NACO. It was decided that NACO will undertake visit to these 7 centres as a team with ITECH and undertake orientation of the PCoE scheme, to enhance and optimally utilize various support that is available to the PCoE to undertake their activities. Till date, 5 PCoE have been visited.

G. New Initiatives in Care, Support and Treatment

G.1 Approval of Rolling Continuation Channel Round 4 Phase II Grant: Based on the performance of the programme during Phase I and a successful submission of proposal for Phase II, the CST programme has got approval for RCC Phase II grant worth USD 191.89 from the GFATM.

G.2 EWI and QCI: The ART programme, established in 2004, has scaled-up rapidly to a network of over 1,200 ART and Link ART centers across the country with decentralization of service delivery to selected district and sub-district health facilities. As we scale up the services, maintaining quality of patient care and prevention of development of HIV drug resistance is of paramount importance. Therefore, for monitoring quality of HIV care provided by the programme, two following strategies have been adopted:

- ART Cohort analysis which helps to evaluate outcomes of patients on ART, tracked over defined time period e.g. 12, 24…60 months
- Regular (annual) monitoring of a minimum set of Early Warning Indicators (EWI) and Quality of Care Indicators (QCI). These provide valuable information on functioning of treatment programme at the ART centre level and how is it progressing over time.

These activities provide information to improve and optimize care of PLHIV and maximize success of the ART programme. At the ART centers, the results generated from these indicators can be used to improve patient care, and provide feedback at the state and national level for overall programme improvement. The EWIs are studied globally and the tools used to capture them are standardized. The QCIs are specific to India's HIV/AIDS Programme and the tools used to study them have been developed by NACO.

G.3 Data validation and review of quality of services provided at ART centers: The National AIDS Control Organization, Ministry of Health and Family Welfare (MoHFW) introduced Anti-Retroviral Therapy (ART) services in 2004 in the second phase of National AIDS Control Programme (NACP) to be managed by the Care, Support and Treatment (CST) Division. By May, 2013, about 632,000 eligible patients were enrolled for ART through 400 ART Centers spread across the country, surpassing the national target. Since the time of initiation of ART, HIV prevalence, incidence and associated mortality are on a decline (Technical Report India, HIV Estimates 2012). The success of any public health programme depends on effective functioning of the service delivery units. To understand the quality of service delivery and identify systemic issues related to ART service delivery, NACO has commissioned a review of all ART Centers in India. The review of ART service delivery is critical and timely as the country prepares for the roll out of NACP IV (2012- 2016). During the planning for NACP IV, the CST Working Group made several recommendations, including a continuous need to monitor and evaluate the ART

network and to ensure quality assurance. In line with the above recommendations, DAC, delineating a set of objectives for the ART Centers review, developed a concept note and a comprehensive review tool for programme review across all ART Centers in the country. DAC in collaboration with the U.S. Centers for Disease Control and Prevention (CDC) is undertaking a nationwide review of the ART Centers. CDC is supporting this activity through its implementing partner- SHARE India. WHO India country office provided inputs in conceptualizing this endeavour. Till date data validation and assessment of 307 ART Centers have been completed.

G.4 Completion of 10 Years of ART: March 31st 2014, marked the completion of 10 years of free ART roll out in India. This free ART initiative was launched by Government of India on 1st April 2004 and has been scaled up in phased manner. From 8 ART Centers in 2004 to 425 ART Centers till March, 2014, the programme has looked into comprehensive prevention, care and treatment services, with a standardized, simplified combination of 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.

G.5 Revision of ART Guidelines: The National AIDS Control Organization has rolled out provision of a Fixed Dose Combination of TDF + 3TC + EFV in a once daily single pill, for all new patients to be initiated on ART. This will help in increasing patients' adherence and harmonise the treatment guidelines for all adults, pregnant women, Tuberculosis & Hepatitis patients. This will also simplify procurement & storage norms. This has already been adopted & rolled out from 15th November, 2014 across the country.

10. LABORATORY SERVICES

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 recognized that work related to laboratory services are not confined to HIV testing, but are overarching and have an impact on other interventions included under prevention, care, support and treatment, STI management, blood safety, procurement and supply chain management. Emphasis on quality assured laboratory service delivery is important to the success of the programme. Universal availability and routine access to quality assured HIV related laboratory services is ensured in all service delivery points through this division. In 2008 a new division was formed at the Centre. In NACP IV Laboratory services has been positioned as a new division at the state level with independent budget.

The assurance of quality in HIV testing services through implementation of External Quality Assessment Scheme (EQAS) for HIV and CD4 testing has been addressed in NACP with focus. NACO launched "National External Quality Assessment Scheme" (NEQAS) in year 2000 to assure standard quality of the HIV tests being

performed in the 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 and
- Assess the performance of various laboratories engaged in testing of HIV which will be used for finalizing the India specific protocols.

Technical Resource Group and Standardization of Services

To ensure the above, a Technical Resource Group (TRG) for Laboratory Services meets annually to discuss critical areas for quality and relevant laboratory issues like the reviews and discusses strategy of testing and formulate/revise guidelines till formal guidelines can be made by looking at the results of planned operational research.

Capacity Building

The laboratory services division has conducted TO training workshops and addressed quality issues, details of Standard Operative Procedures (SOPs) and preparation of quality manual as a step towards National Accreditation Board for Testing and Calibration Laboratories (NABL) accreditation. Due to change on the version of ISO standards in quality Management a total of 107 personnel from laboratories were trained as per the new standards ISO 5189:2012. 25 personnel were trained as Internal Auditors. Categories of laboratory personnel trained were 45 technical officers, 21 in-charges of referral laboratories, 41 other faculty + Quality Managers (SACS). 37 laboratories were provided on-site technical assistance through 66 visits of the Technical assistants. As a result of the same till date 11 NRLs and 32 SRLs have got accreditation for HIV testing by the NABL. 17 SRLs are in the cycle of accreditation.

ICTC/CD4 Training: The division is involved in on site supervision of trainings of Laboratory Technicians as per NACO norms and monitors modules for the same.

CD4 Testing: There are 254 functional CD4 machines installed at present serving 448 ART Centres. These include 159 FACS Count Machines, 28 Calibre machines, 67 Partech machines and all the machines procured by NACO are under warranty or maintenance contract. About 8,42,122 CD4 tests were performed from April- September 30, 2014.

CD4 training institutions were identified in 2009 to systematize the training of Laboratory Technicians in ART centres. A Training of Trainers (ToT) was held in May and June, 2009 for CD4 machine technicians and in-charges. A regional capacity building of four institutions for Calibre machines (GHTM Tambaram, STM Kolkata, NARI Pune and PGI Chandigarh), five institutions for Count machines (Vishakapatnam, NARI, MAMC, RIMS, CMC) and six institutions for Partec machines (Surat, Trichy, Kakinada, Davangere, Lucknow, Medinapur) has been done. Faculty of these institutions has been trained and is imparting further training. All technicians at ART centres are retrained

at these institutions every year. Training plan has been developed in consultation with the respective manufacturer and NARI, Pune which provides technical expertise along with the resource persons for the same. Training of Trainers was held for five days regionally and the regional training is ongoing for three days for FACS Calibur & Partec and two days for FACS Count. Approximately 200 ART Laboratory Technicians operating these machines have been trained from April to September, 2014.

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

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

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

At present financial support under NEQAS programme, to Apex laboratory is Rs. 26.14 lakhs per year inclusive of NRL grant. The other 12 NRLs, excluding Apex Laboratories, have been provided Rs. 15.66 lakhs per year and each SRL has been given a grant of Rs. 4.56 lakhs this year. Each NRL has been allotted designated states which are monitored by it and in turn each NRL has SRLs for which it has the responsibility to train and supervise. Each SRL, in turn, has ICTC and blood banks which it monitors. One Technical Officer at each SRL is supported by funds from NACO to facilitate supervision, training and continual quality improvement in all SRLs and linked ICTCs.

Fig 10.1: ICTC participation during Apr.-Sept., 2014;

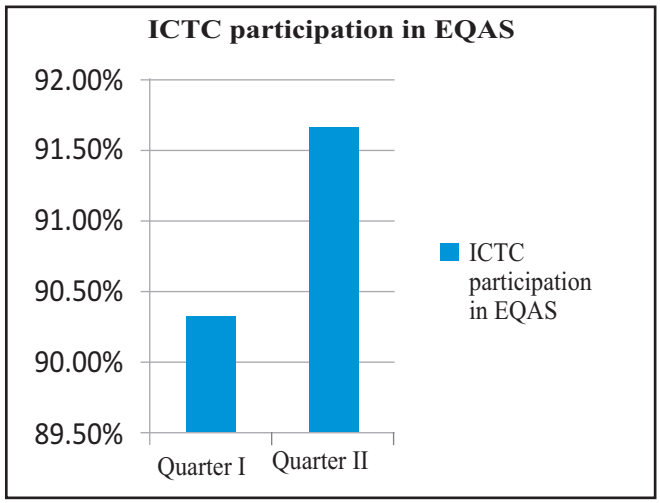
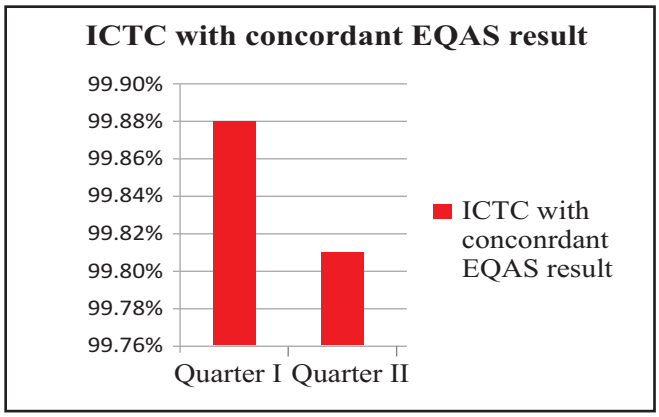


Fig 10.2: ICTC concordant EQAS, Apr-Sept, 2014



Apart from the above NCDC Delhi; NICED Kolkata and NIMHANS Bengaluru, NIB, NOIDA under supervision of NARI have been identified for panel preparation and quality assessment of HIV, HCV and HBV kits. HIV testing kits are procured by NACO after their quality is tested by any one of these laboratories. These laboratories form a part of the consortium developed by NACO for kit evaluation.

Viral Load Testing to Support Second Line ART: The Viral Load (VL) assays are provided for patients failing first line Anti-Retroviral Therapy. NACO piloted VL testing at two centres for 10 months from January, 2008. Currently there are nine viral load labs, supporting clinical decision-making at 17 CoEs (including 10 paediatric CoEs)-second line centres and 37 ART plus centres for patients estimated to transit to second line therapy.

National Programme on Early Infant/Child under 18 Months Diagnosis: 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 the tremendous expansion in HIV programme in PPTCT, ICTC, ART (for adults and children) including access to Early Infant Diagnosis (EID) for HIV testing of infants 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.

Objectives of providing care for HIV exposed infant 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; and
- To reduce HIV related morbidity and mortality and improve survival.

These objectives are proposed to be achieved through following strategies:

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

services to ensure timely intervention to reduce infant morbidity and mortality due to HIV infection.

NACO has trained 1157 ICTCs and 217 ART Centres, i.e. more than 3000 doctors, nurses and laboratory technicians across 31 regions/states, for sample collection. A vast sample transport network has been developed that ensures timely specimen pick up, testing and report delivery between the 1157 specimen collection Centres and seven testing labs (equipped with basic molecular testing facilities). NACO developed ICTC-ART centre linkages for child referral for Whole Blood collection. The same has been in operation in 1157 ICTCs & 217 ART Centres across 31 states/regions. 6415 tests were performed from April –September, 2014

11. INFORMATION, EDUCATION & COMMUNICATION (IEC)

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

Following are communication strategy under NACP IV:

- 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 reinforces positive attitudes, beliefs and practices to reduce stigma and discrimination.

Key activities undertaken during 2014-15

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. NACO 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. Three campaigns on Voluntary Blood Donation, PPTCT and Stigma & Discrimination have been implemented till 30th Sept., 2014. In addition, 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.

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 NACO and under link worker's scheme to disseminate information on HIV prevention and related services. NACO has developed a well-coordinated plan involving different agencies to avoid duplication of activities.

MID Media

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 folklore into the performances. A mix and match of seven thematic areas and the popular folk forms was

used for the roll-out. The messages were vetted by the technical experts in DAC for accuracy, effectiveness and consistency.

Approximately, 9500 performances were done during the campaign implemented in 2014-15 in two phases which reached out to more than 20 lakh people in rural areas of the country. Key messages disseminated through the performances included safe sex, migration, stigma and discrimination, counselling and testing, PPTCT, women issues, blood safety and vulnerability of youth.

Folk media was also used efficiently to piggyback on events organised in States during major festivals like *Navratra, 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.

A folk performance in Himachal Pradesh

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 consultations with stakeholders, such as NGOs, academicians, psychologists and parent-teacher bodies.

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; which includes 459 RRCs started in 2014-15 (up to September, 2014).

Special Events

National Youth Consultation Meet (NYCM), 16-17 July, 2014: A consultation meeting was organized on the 16th-17th of July, 2014 by National AIDS Control Organisation in collaboration with UNICEF. The National Youth Consultation Meet was organized in order to review, revise and reform the guidelines for programmes under Youth Affairs, namely, Adolescent Education Programme (AEP), Red Ribbon Club (RRC) Programme and Out of School Youth (OSY) Programme.

National Youth Consultation Meet held during 16-17 July, 2014

International Youth Day (IYD) - 12, August, 2014: Celebrating International Youth Day 2014 in India, NACO provided all the states with special guidelines to celebrate the occasion by observing it as a week long activity through Red Ribbon Clubs, in colleges under their Youth Intervention Programme.

The theme of International Youth Day 2014 was *"Youth and Mental Health"* under the slogan *'Mental Health Matters';* subsequent to which NACO took a step further and shaped up the theme as *"Jawaa hai zindagi - Shaping a better future"*, across states, in India. The states also organised Voluntary Blood Donation Camps in the non competitive activity, which were also a huge success in almost every state. Seminars on HIV and Youth related issues were also held in many states. Special Workshops were also planned for the RRC members and in-charges to further talk and have sessions on HIV/AIDS and concerning Youth issues. Some states, taking a step further also did Radio Shows on famous FM channels like 92.7 (Big FM), All India Radio & 93.5 (Red FM), of their state, where not only the occasion of International Youth Day and its theme was talked about, but in addition, positive and informative pieces of information was imparted. The event of IYD 2014 also saw elaborate coverage in the leading newspapers.

12. MAINSTREAMING AND PARTNERSHIP

National AIDS Control Organization (NACO) is collaborating with various key Ministries/ Departments of Govt. of India with objective of multi-pronged, multi-sectoral response which will ensure better use of available resources for risk reduction and impact mitigation of HIV. During the current Financial Year of 2014-15, NACO has formalized partnership with three Departments/ Ministry of Government of India by signing Memorandum of Understanding (MoUs). These are Ministry of Road Transport & Highways, Department of Telecommunication and Department of Electronics & Information Technology. The Joint Working Group was formed with officers of NACO as well as from other Departments to roll out the MoUs. In FY 2014-15; Joint Working Group meeting was held with Ministry of Shipping, Ministry of Road Transport & Highways, Ministry of Petroleum & Natural Gas, Department of Defence, Department of Youth Affairs, Department of Sports and Department of Secondary Education & Literacy.

Trainings and advocacy meeting were undertaken by SACS with various stakeholders which included government officials from various departments, frontline workers, uniform personnel, NGOs, PLHIV network etc. A total of 0.89 lakh persons were trained till September, 2014. Approx 6.0 lakh PLHIVs are benefitting with various scheme on social protection offered by various Ministries/ Department and State Governments.

13. PROCUREMENT

Procurements are done using the funds under The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), The World Bank and Domestic Funds, through M/s RITES Limited as Procurement Agent. M/s RITES Limited continued to provide services to the NACO as Procurement Agent in

terms of the contract signed between National AIDS Control Organization and M/s RITES Limited on 16th February, 2010. As in the past, all the main items required for the programme, including test kits and other items such as ARV Drugs, STI Drug kits, blood bags etc. are centrally procured and supplied to State AIDS Control Societies (SACS).

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 NACO (www.naco.gov.in).

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

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

14. ADMINISTRATION

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, 2 Central Public Information Officers and 10 Appellate Authorities have been appointed for different subjects, within NACO. During 2014-2015, 238 applications and 31 appeals were received and replies were sent.

15. STRATEGIC INFORMATION MANAGEMENT UNIT

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 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 State AIDS Control Societies;
- Monitoring & ensuring data quality, timeliness and completeness of reporting from programme units data management, analysis and publications maintenance of the NACO website;
- Processing data requests and data sharing;
- Capacity building in strategic information areas;
- Preparation of Programme Status Notes and Reports and
- Providing Data for National/International documents.

SIMS is an integrated web-based reporting, data management & decision support system, with monthly reporting from over 20,000 Reporting Units (RUs) across the country, covering all programme components. It has standard and custom reports with options for advanced analysis using SAS and spatial analysis using ArcGIS. SIMS has been developed by M/s. Vayamtech India Pvt. Ltd. SIMS was launched in August, 2010 followed by nation-wide trainings of SACS officers and RU level staff in their respective modules. SIMS user manuals, data definitions and wall charts have been developed to standardize the roll out of SIMS. To review the progress, weekly review meetings are conducted with the vendor and development partners to review progress and address key issues.

As contract with vendor has expired with validity up to 31st December, 2014, therefore, NACO has constituted a Core Team at NACO comprising M&E and IT experts from NACO and development partner organizations to oversee and coordinate the entire process of takeover of SIMS from the vendor.

Website

NACO 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.

Following new initiative has been taken under website maintenance:

- The official website of NACO is updated regularly;
- GIGW complains related points on the website has been resolved;
- Weekly Drug-Stocks related information is updated regularly;
- Link for registration for Voluntary Blood Donation is added on the website;
- Link for registration of Aadhaar Card for PLHIV is added on the website;
- List of latest updates come in the scroll and
- The content of the website are reviewed on a monthly basis by the programme Divisions.

National Integrated Biological & Behavioural Surveillance (IBBS) & HIV Sentinel Surveillance (HSS) 2014-15

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 prioritization 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 and
- To analyse and understand HIV related vulnerabilities and risk profiles among key risk groups in different regions, by linking behaviours with biological findings.

Implementation Status IBBS:

- Implementation of Sampling Frame Development (SFD) and Community Preparation (CP) (2nd Phase) was initiated during March, 2014 and is almost completed in 203 domains in six regions of AIIMS, NICED, NIE, NIMS, PGIMER and RIMS. In these regions, the bio-behavioural data collection has started.
- Field Work for SFD and CP has been initiated in the NARI and NIHFW region.
- Bio-Behavioural Data Collection in these six regions has started in September 2014.
- DBS consumables to facilitate sample collection through Dried Blood Spot method have been procured. Supply has started in phases, starting with NIE region. Custom clearance of third lot of supplies is in process. Supply to remaining states will be initiated as soon as 3rd lot is received at warehouse and repacking is done.
- HIV test kits for first test have been already supplied to DBS labs (16) through NARI. HIV test kits for second test have been identified and process for supplying the same to labs is under process.

HIV Sentinel Surveillance (HSS) 2014-15

14th Round of HIV Sentinel Surveillance at ANC sentinel sites is scheduled to start from 01 Jan. 2015 till 31 March, 2015. All necessary instructions have been given to the States & Regional Institutes. Updation and re-printing of the operational guidelines, training manuals and facilitator's guide are in process. National Pre-Surveillance Meeting, Regional TOTs & State level trainings has been conducted on 17th-18th & 20th-21st November, 2014.

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. NACO focuses on ensuring translation of research outputs into programmatic action and policy formulation.

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.

Objectives of National HIV/AIDS Research Plan (NHRP)

- To identify the information gaps and research needs in the programme that require research to generate fresh evidence;

- To develop and finalise research priorities in consultation with programme divisions, partners and technical experts;
- To commission epidemiological, socio-behavioural, operational, clinical research and evaluations through identified institutes/organisations;
- To consolidate & disseminate research outcomes for programmatic use from time to time;
- To promote scientific publication in the form of papers/articles/reports/briefs etc.

Overall 90 research studies have been identified– Phase I (36), Phase II (34) and Phase III (20). Concept Notes have been developed for each topic in Phase I. TORs for institutes and draft MoU to involve the institutes have also been developed and vetted by legal representative. Procedure for selection of institutes or organisations as Lead Research Institute & Participatory Research Institutes has been developed in consultation with donor partners. Scoring criteria have been developed to evaluate EOIs as well as detailed proposals. Periodic meetings were held with donor partners to discuss various issues from time to time and finalise various modalities of funding and implementing NHRP.

The Research Plan Screening Committee (RPSC) has been constituted under the chairpersonship of Dr. Prema Ramachandran to evaluate Expressions of Interest, detailed proposals received through RFPs and to finalise the Principal Investigator and co-PIs through the 2-stage selection process. RPSC has met thrice since March, 2014 and reviewed a total of 113 EOIs received through three different Calls for Proposals. All the Phase I studies have been approved by TRG and cleared by NACO Ethics Committee and are in the process of contracting and fund release.

National Data Analysis Plan (NDAP)

The Data Analysis and Dissemination Unit of the NACO 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.

The 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 to provide scientific evidence for programme management by strengthening and scaling up appropriate strategies.

Objectives of National Data Analysis Plan (NDAP):

- 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 and
- To promote scientific writing within the programme in the form of papers/articles/ reports/briefs etc.

From across the country, epidemiologists, bio-statisticians, Monitoring and Evaluation Officers, Modelling experts and Public health experts were identified as analysts to carry out data analysis of the programme data. Senior experts from various Medical Institutions and Health Organisations were identified to provide mentoring support. Officers from NACO programme divisions are involved at

every step of the process for their relevant topics. All the available datasets have been systematically organized and shared with the analysts. In order to maintain confidentiality of programme data provided to the Analysts and Mentors for the analysis, they were required to sign an undertaking individually which restricted the use of the data provided access to, only for the study and in the interests of NACO. A total of 51 topics have been identified for NDAP, involving 56 Analysts and 32 Mentors from 29 Medical Institutions/Health Organisations. Key deliverables from each analyst include analytic report, presentation, policy brief and a scientific paper on the findings from the analysis. NDAP launch workshop was organised at JIPMER, Puducherry during 16-18 January, 2014.

First Interim Review Meeting was done in two batches to review the progress made by the Analysts in developing their Analysis Plans. The Interim Review Meeting for the Northern Region was held during 11-12 March, 2014 at PGIMER, Dr. RML Hospital, New Delhi and that for the Southern Region was held during 27-28 March, 2014 at GHTM, Tambaram Sanatorium, Chennai. To clean the available CMIS data for the period 2007-2012 for Targeted Interventions, STI/RTI, ART, Blood Bank and ICTC/PPTCT, a workshop was convened at New Delhi during 28 - 31 May, 2014 involving select Analysts. Five small sub-group/cluster meetings were held with analysts and mentors of similar topics during June/July, 2014 to review the progress and take the analysis further.

To facilitate scientific paper publication in a peer-reviewed journal, the analysts is being trained and mentored through a 'Scientific Writing Workshop' conducted by a panel of experts. This workshop is conducted in two phases of 5-day durations for each batch of around 25 participants. In phase-1 the analysts are expected to develop an extended abstract of analysis, and during Phase-2, a draft of peer reviewed article is expected to be ready for submission to a peer-reviewed journal.

ISO 9001 Certification of NACO

"Implementation of ISO 9001" is one of the mandatory indicators in RFD. DDG (BTS/STI) is the Management Representative for ISO Certification. Programme Officer (Statistics) is the nodal officer for coordination of activities related to ISO certification. M/s. PMG Consultants has been engaged as consultant to coordinate the entire ISO certification process for NACO. Quality Policy of NACO has been prepared and approved by the then Secretary and displayed in the department and circulated among staff. Awareness sessions for NACO staff were held during 20-21 May, 2014 at NACO. Internal Auditors Training was held for all the Core Group members at the Centre of Excellence, Maulana Azad Medical College, New Delhi on 22-23 May, 2014. On 19th June, 2014, refresher training and the Internal Auditors Examination was held at the Centre of excellence, Maulana Azad Medical College, New Delhi. Quality Management System manual has been prepared and approved. The first set of internal audit conducted in 1st week of July, 2014 and subsequently, the audit by Consultant was conducted during 16-18 July, 2014 and 30 July, 2014. Several internal review meetings were to review the progress in the implementation of ISO in the NACO. 1st phase of external audit by the certification authority has been completed by Oct, 2014.

16. RESULTS FRAMEWORK DOCUMENT (RFD)

The Department has been preparing RFDs in a timely manner and submitting it to the Performance Management Division (PMD) of the Cabinet Secretariat. DDG (M&E) has been designated as the Departmental Coordinator for RFD for NACO. For RFD 2010-2011 and 2012-2013, DAC got overall composite scores of 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 2013-2014 year end achievement was submitted in May 2014. For RFD 2013-14 also, score is expected to be above 90%; yet to be issued by PMD. RFD 2014-15 was finalized at a meeting of the Ad-hoc Task Force on 21 March, 2014. For RFD 2014-15, Mid-term achievement has been submitted in October, 2014.

Citizen Charter

NACO Citizen Charter was articulated in 2011-12. "Independent audit of implementation of Citizen's/Client' Charters" is one of the mandatory indicators in RFD. Achievements against Citizen Charter indicators are submitted to PMD on annual basis. For 2013-14, independent audit of implementation of Citizen's/Client' Charters has been completed in August 2014. Self Assessment Report and year end achievement for respective Service Standards have been submitted.

HIV Estimations

NACO & National Institute of Medical Statistics (NIMS), ICMR together conduct HIV Estimations every two years. Last round of HIV Estimations were conducted in 2012. Next round of HIV estimations is due by the end of this year. It was planned that the next round of HIV Estimations will include the data coming from National IBBS which is ongoing. So, decision may be taken soon on the plan for HIV Estimations 2014. Preparatory work is being initiated in coordination with NIMS (ICMR).

Data Sharing Committee

NACO has an approved 'Data Sharing Guidelines' according to which a Data Sharing Committee has been constituted under the chairpersonship of DDG (M&E). The committee meets at regular intervals to review and decide upon the data requests received in the standard format by various stakeholders. 13 data requests were received and processed during 2014-15 (till Sept., 2014)

District Epidemiological Profiling

NACO has undertaken a nation-wide District Epidemiological Profiling (DEP) in around 540 districts in 2009-2010. That has been updated with recent years data. The district reports/fact sheets based on the compiled data in this exercise are being brought out in technical document as District HIV Epidemiological Profiles. For each district it consists of a brief narrative report on the district background, the HIV/AIDS epidemic profile of the district based on the updated information compiled from all the available sources, and key recommendations based on the identified information gaps and areas for programme interventions.

In last two rounds, 11 DEP publications have been completed. During the first round in Dec. 2012, 4 States (Madhya Pradesh, Punjab, Rajasthan, & Uttarakhand) have been published. During second round in February, 2014, 7 States (Chhattisgarh, Delhi, Haryana, Uttar Pradesh, Odisha, Kerala, & Jharkhand) have been published. Therefore, 11 States have been completed till dates. Same has been uploaded on website as well.

In the current round, District Epidemiological Profiling of 15 States are being printed. These includes, 8 North Eastern States (Arunachal Pradesh, Assam, Nagaland, Manipur, Mizoram, Meghalaya, Sikkim & Tripura) in one volume, 7 States in separate volume each for Maharashtra, Tamil Nadu, West Bengal, Karnataka, Andhra Pradesh, Bihar and Gujarat States.

17. FINANCIAL MANAGEMENT

Financial Management is an integral part and important component under NACP-IV (2012-17) programme architecture. Financial Management

deals with the approval and review of annual plans and budgets, fund flow mechanisms, delegation of financial powers, accounting and internal control systems and to ensure that the 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 under the effective control of Director (Finance).

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:-

- Operations are being conducted effectively and efficiently in accordance with NACP norms;
- Financial and operational reporting are reliable;
- Laws and regulations are being complied with and
- Assets and records are maintained.

During NACP IV, the following areas are being attended specially:

- Delegation of Financial Powers;
- Asset Management;
- Audit structures;
- NGO financing and accounting;
- Advances;
- Inter-unit Transfers;
- Computerized Project Finance Management System (CPFMS) and
- Human resources 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 of Ministry of Health & Family Welfare;
- Monitoring and reviewing the progress of expenditure against sanctioned grant on a monthly and quarterly basis, ensuring compliance of instructions issued by the Department of Expenditure on economy/ rationalization of expenditure;
- Standing committee of Parliament on Finance/ Public Accounts Committee and Audit Paras;
- Preparation of budget and related work in respect of Grant and
- Coordination and compilation of the Detailed Demand for Grants and the Outcome Budget of the Min. of Finance.

Key Functions

Budgeting:

- Preparation for Demand for Grants;
- Preparation of Budget Estimates/Revised estimates in consultation with the Programme Divisions and
- Correspondence with Planning Commission for finalizing plan allocation.

Accounting functions:

- Annual action plan preparations;
- Processing and conveying approval;
- Release to State Governments for onward transmissions to the corresponding SACS, NGOs, Consultancy Agencies, Central Institutions;

- Expenditure Accounting of NACO and SACS;
- Monitoring of Utilization Certificates;
- Oversight of financial Management and handholding SACS on expenditure management, target, advance settlements and
- Other recipients.

Audit Functions:

- Coordination for statuary as well as internal audit of SACS;
- Submission of audit reports to Ministry, Donor Agencies etc. and
- Facilitate audit at NACO Hq. level.

Internal financial advisory functions:

- Preliminary checking of bills by DDO (NACO);
- Advice on financial matters and
- 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 and
- Preparation of Financial Management Reports, Interim Unaudited Financial Report to the World Bank through Controller of Aid Accounts and Audit (CAAA).

Utilization of Funds in NACP-IV (2012-13 & 2013-14)

Year wise expenditure during NACP IV is tabulated as under.

Table: R E & expenditure incurred during NACP IV

(Rs. in crore)

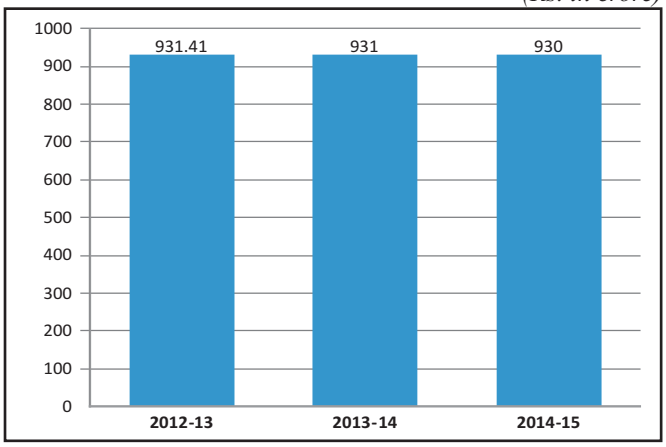
2012-13		2013-14		2014-15	
RE	**Exp**	**RE**	**Exp.**	**BE**	**Exp.**
1759.56	1316.07	1500.00	1473.15	1785.00	1085.66*

** Expenditure upto 14/11/2014*

Allocation through State Structure 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 stabilized. 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 the graph below:

Resource allocation through State Structure from 2012-13 to 2014-15

(Rs. in crore)



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

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 Organizations, 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 given in the Table below:

Sources of Funding for NACP-IV

(Rs. in crore)

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 emphasizes 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 utilization 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: Computerized Project Financial Management System has been developed and rolled-out to have better financial management. The system is working in all SACS for tracking expenditure management, capturing financial data, and utilizing 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 minimizing 'advances'. Copies of sanction orders, guidelines and instructions have been put on the NACO website and are updated periodically to ensure wider dissemination of information.

The most recent and important audit observations are placed at **Appendix-I** and acronym at **Appendix-II.**

Appendix-I

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 Vetted by DGACE, OM No. RR/5-5/13-14/219 dated 30.05.2013 & forwarded to PAC on 02.08.13.	Nil	Nil
3.	2011-12	Para 8.3 of C&AG's Report no. 16 of 2011-12	ATN has been Vetted by DGACE, OM No. RR/35-1/12-13/75 dated 18.04. 2013 & forwarded to PAC on 02.08.13.	Nil	Nil
4.	2013	Para 6.1 -6.1.6 of C&AG's Report no. 19 of 2013	ATN has been submitted to audit on 25.02.14 for vetting before sending the ATN to Ministry of Finance, Department of Expenditure	Nil	Nil

ACRONYMS

- AEP Adolescence Education Programme
- AIDS Acquired Immuno-Deficiency Syndrome
- ANC Antenatal Clinic
- ART Antiretroviral Therapy
- 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
- 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

- DIC Drop-in Centres
- EID Early Infant Diagnosis
- EQAS External Quality Assessment Scheme
- FHI Family Health International
- FICTC Facility Integrated Counseling & Testing Centre
- FPA Forum of Parliamentarians on HIV & AIDS
- FSW Female Sex Workers
- GFATM Global Fund for AIDS, Tuberculosis and Malaria
- GIPA Greater Involvement of People with HIV/AIDS
- HIV Human Immuno-deficiency Virus
- HRG High Risk Groups
- HSS HIV Sentinel Surveillance
- 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
- JAT Joint Appraisal Team
- LAC Link ART Centre
- LFU Lost to Follow-up
- LS Laboratory Services
- LWS Link Worker Scheme
- M & E Monitoring and Evaluation
- MoU Memorandum of Understanding
- MSM Men who have Sex with Men
- NACO National AIDS Control Organisation
- NACP National AIDS Control Programme

- NARI National AIDS Research Institute
- NBTC National Blood Transfusion Council
- NGO Non-Government Organisation
- NRHM National Rural Health Mission
- NRL National Reference Laboratory
- NTSU National Technical Support Unit
- OI Opportunistic Infections
- OST Opioid Substitution Therapy
- PEP Post-Exposure Prophylaxis
- PLHIV People Living with HIV
- PPP Public Private Partnership
- PPTCT Prevention of Parent to Child Transmission
- RFD Result Framework Document
- RI Regional Institute
- RNTCP Revised National Tuberculosis Control Programme
- RRC Red Ribbon Club
- RRE Red Ribbon Express
- RTI Reproductive Tract Infections
- SACS State AIDS Control Society
- SIMS Strategic Information Management System
- SIMU Strategic Information Management Unit
- SMO Social Marketing Organisation
- 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
- 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