UNGASS Country Progress Report 2008
India

Reporting Period: January 2006 to December 2007

NATIONAL AIDS CONTROL ORGANISATION

Ministry of Health and Family Welfare

Government of India

New Delhi

FOREWORD

India, along with other Member States adopted the Declaration of Commitment on HIV/AIDS, in the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001. The Declaration of Commitment (DoC) reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal of halting and beginning to reverse the HIV/AIDS epidemic by 2015. Under the terms of the Declaration of Commitment (DoC), success in the response to AIDS is measured by the achievement of concrete, time-bound targets. In line with this commitment, this is India's country progress report for the period between January 2006 and December 2007. The report is prepared by NACO in consultation with civil society and support from development partners. The report presents the overview of epidemic, the strategic national response, its impact and the challenges that lie ahead.

India is a large, diverse country with complex social issues which is a challenge to any development programme. In addition, the epidemic with several issues surrounding stigma, misconceptions and entrenched social positions multiplies the challenges before the policy makers and implementers. The epidemic itself is heterogeneous in nature, concentrated among high risk population groups. It has also variations in geography and therefore the program has identified districts (geo-political units within provinces), with high prevalence, that are spread across the country.

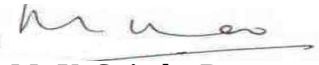
To understand the epidemic better, Phase III of the Programme has invested and improved on the surveillance systems, launched nationwide exercises to map high risk groups and involved experts across India and the globe in estimating and identifying problem areas and gather evidence required to make the program focused. As a result, all the programs like Targeted interventions for High risk groups, counselling and testing program, STI services for high risk groups as well as general population, care and support to PLHAs have been scaled up.

From the report, it is clear that India's fight against AIDS has made substantial strides and is moving forward in several spheres towards meeting most international targets. The year gone by has been significant – the NACP III Programme was designed after extensive consultations, the Programme roll out has been accelerated; a smooth transition between the Phase II and Phase III has been achieved. We have learnt from the successes and problems of Phase II and used the learnings to design the Phase III.

The Government of India and its' development partners have worked together using the Three Ones' Principles - We have one plan, one recognised authority and one M&E framework to co-ordinate and focus all our efforts. We are committed not to lower our guard as this is a crucial period for the Programme.

I take the opportunity to thank all who have worked hard, contributing in different ways in tackling HIV and AIDS in India. While we remember those who passed away this year due to HIV, we renew our commitment to fighting the disease in various fronts and giving a quality of life to those living with HIV and keeping the 99 percent of Indians free from HIV.

I take this opportunity to thank UNAIDS for its support and also acknowledge the contribution made by the representatives of civil society, NGOs and various development partners who participated in the consultation processes and provided feedback and technical inputs. I congratulate my team members from NACO - Dr. Jotna Sokhey, Additional Director General and Additional Project Director, and Dr. Ajay Khera, Joint Director (Basic Services & Surveillance) for their efforts to make this document happen. I would also like to acknowledge the contribution from Swasti (A health resource centre) team which co-ordinated the effort and put together this document on time.



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GLOSSARY

AEP	Adolescent Education Programme
ART	Anti Retro viral Therapy
BBC	British Broadcasting Corporation
BMGF	Bill and Melinda Gates Foundation
CHC	Community Health Centre
CMIS	Computerised Management Information System
CBO	Community Based Organisation
CSW	Commercial Sex Worker
CHC	Community Health Centre
DFID	Department for International Department
DoC	Declaration of Commitment on HIV/AIDS
EQAS	External Quality Assessment Scheme
FF	Freedom Foundation
FRU	First Referral Unit
FSW	Female Sex Worker
GIPA	Greater involvement of People with AIDS
HRG	High Risk Group
ICMR	Indian Council of Medical Research
ICTC	Integrated Counselling and Testing Centres
IDU	Injecting Drug User
MARP	Most At Risk Populations
MoHFW	Ministry of Health and Family Welfare
MosJE	Ministry of Social Justice and Empowerment
MSM	Men having Sex with men
MSW	Male Sex Worker
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NCPI	National Composite Policy Index
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
NVP	Nevirapine
PACT	National Partnership for AIDS Control and Treatment
NGO	Non-Governmental Organisations
PHC	Primary Health Centre
PIP	Program Implementation Plan
PLHA/PLHIV	People Living with AIDS/ Persons living with HIV
PPTCT	Prevention of Parent to child Transmission
RTI	Reproductive Tract Infection
SAEP	School AIDS Education Program
SACS	The State AIDS Control Society (SACS)
SIMU	Strategic Information Management Unit
TI	Targeted Intervention
UNAIDS	United Nations Joint Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United National Children's fund
USAID	United States Agency for International Development
VCTC	Voluntary , counselling and testing centres
WHO	World Health Organization

I. CONTENTS

II. STATUS AT A GLANCE

Status of Epidemic:

There are 2.47 million persons in India living with HIV, equivalent to approximately 0.36 percent of the adult population[1]. The revised national estimate reflects the availability of improved data rather than a substantial decrease in actual HIV prevalence in India. The transmission route is still predominantly sexual (87.4 percent); other routes of transmission by order of proportion includes perinatal (4.7 percent), unsafe blood and blood products (1.7 percent), infected needles and syringes (1.8 percent) and unspecified and other routes of transmission (4.1 percent)[2].

Though sexual mode remains the major mode of HIV transmission, Injecting drug use is also emerging as an important mode of transmission in some parts of the country. HIV epidemic in India is concentrated in nature as HIV Prevalence among high risk groups continues to be high (is six to eight times of that among the general population). Higher HIV prevalence among Injecting Drug Users (IDU) is an important feature of North Eastern States. But in 2006, new sites of high HIV prevalence among IDU have been identified in the states of Punjab, Tamil Nadu, West Bengal, Kerala and Maharashtra indicating dual nature of the epidemic in the country. The heterogeneous distribution of HIV epidemic in the country is evident as many isolated pockets of high prevalence are identified in several districts of the country. Based on the data from HIV Sentinel Surveillance, 195 districts in the country are categorised as A and B for priority attention in the National AIDS Control Programme. Among the high burden states, the epidemic shows a stable trend in some of the states such as Karnataka and Andhra Pradesh while it is declining in the rest. Rising HIV Prevalence is observed among different population groups among the low burden North Indian states. There are still more number of men than women who are infected and prevalence levels decreases with increasing education level.[3]

Policy and Programmatic Response

The NACP has made several strides in scaling up the Programme, partnering with a variety of stakeholders, putting in place operational guidelines and setting and achieving planned and achievable programmatic targets. Rapid scale up of Targeted interventions for most at risk populations with 790 TIs covering 869,206 (43 percent) most at risk group members, 1854 million condoms supplied, 1088 public sector and 2100 private blood banks collecting over 5 million units both in 2006, and 2007 (100 percent screened for HIV), 4245 Integrated Counselling and Testing Centres testing 5.5 million persons in 2007, 845 STI treatment centres treating over 2.3 million patients, Life skills education provided in 114,345 government secondary schools (79percent) are some key achievements in the prevention front. On the Care and support front, 137 ART centres provide free ART to 118,052, and 8347 children. National Paediatric ART Initiative was launched in late 2006. Positive People Networks have been established and/or strengthened in 22 states and 221 districts. HIV spending in India has seen a growth of 28 percent in 2006-07.

The Targeted Intervention component of the Programme is showing signs of impact, but not in all fronts. Percentage of FSWs who are HIV infected is showing decreasing trend - from 10.3 percent in 2003 to 4.9 percent in 2006. Percentage of injecting drug users reporting using previously used equipment is on the increase in certain cities whereas it was on a decline in some others[4] . The prevalence rates among IDUs are on the increase in many states and newer regions are being detected. Percent Positivity among Men who have Sex with Men is now 6.41 percent in 2006. Trends among MSM do not show any significant decline in the Southern states.[5]

[1] Technical Report on HIV estimation, NACO 2006
[2] AIDS Case Reporting, NACO Jan-Dec 2007
[3] HIV Sentinel Surveillance, Country Report , NACO 2006
[4] National Behavioural Surveillance Survey Report 2006 (MSM,IDU)
[5] HIV Sentinel Surveillance , Country Report, NACO 2006

These achievements have translated into Programmatic outcomes and impact - Percentage of young women and men who both correctly identify ways of preventing the sexual transmission of HIV, who have more than one sexual partner in the past 12 months reporting the use of a condom, women and men who received an HIV Test are all on the increase. The percentage of female sex workers reporting the use of a condom with their most recent client, injecting drug users reporting the use of a condom the last time they had sexual intercourse are also on the increase , thus exhibiting improved knowledge, attitude and behaviour. [6]

The work of the Programme on blood safety has yielded good results with transmission of HIV through Blood Transfusion reduced from 6.07 percent (1999) to 1.96 percent (2006) and 1.1 percent (2007). Among the general population, percentage of young women and men aged 15-24 who are HIV infected is showing a low HIV prevalence among ANC clinic attendees declining trend and is currently estimated at 0.55 percent of adult population. 80 percent percentage of adults on antiretroviral therapy are alive and on ART (12 months after initiation). This is evident from the 11 centre WHO Cohort study of 8508 patients who started on ART spread across the country.

Though not all the expected outcomes of the Programme have been fully realised, there has been a systematic improvement in the response, and moving forward, there are areas that still require greater attention.

UNGASS Indicators (Overview)

Of the 25 UNGASS indicators, 23 indicators[7] are applicable to India. Out of this there is no data for one indicator (Indicator 12). Significant progress has been made by the country since the last reporting period. Out of the 22 indicators, in 13 indicators, there is data available from previous years for comparison. Of these 13 indicators, in about 10 indicators, significant progress has been made by the country in the last year. In three indicators, some progress has been made, with scope for improvement (marked in Yellow). As the comparative data is not available in all indicators, progress in 10 indicators is reported for this period (no colour marking). Detailed analysis of country progress is presented in section IV.

[6] National Behavioural Surveillance Survey Report 2006

[7] Indicator 25 is not applicable for India: 'Percentage of infants born to HIV infected mother, who are infected'. Indicator 12 'Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child' is not applicable (see next page for further details)

S. NO.	COMPONENT	INDICATOR	LAST AVAILABLE DATA	CURRENT STATUS
1	National Commitment and Action	Domestic and International AIDS spending by categories and financing	USD 133 Million (2005-06) Source: NACO	USD 171[8] Million during 2006-07 (April 2006 to March 2007) – Source: NACO
2	National Commitment and Action	National Composite Policy Index	Annex	Annex
3	National Programme	Percentage of donated blood units screened for HIV in a quality assured manner	100 percent (January to December 2005). Source: NACO-CMIS	100percent (January 2006 to November 2007). Source: NACO-CMIS
4	National Programme	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	6 percent of adults in 2005. (Source: NACO-CMIS)	19.6 percent of adults and 35.1 percent of children with advanced HIV infection are receiving ART by Dec 2007. (Source: NACO-CMIS)
5	National Programme	Percentage of HIV infected pregnant women who received antiretroviral to reduce the risk of mother to child transmission	4.91 percent of HIV infected pregnant women have received ART during 2005	In 2006, 7.5 percent of HIV infected pregnant women received Nevirapine Prophylaxis to reduce the risk of transmission to child, and it increased to 8.3 percent in 2007. (Source: NACO-CMIS)
6	National Programme	Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Not available	Of the 85,000 patients with co-infection, 23 percent (14,200 in 2006 and 19,400 up to Oct 2007) are estimated to be under treatment.
7	National Programme	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Not available	3 percent women and 3.3 percent men had an HIV test and know their results. (Source: NFHS-3). 40.3 lakh were tested in 2006 and 54.7 lakh were tested this year till Oct 2007.
8	National Programme	Percentage of most at risk populations who received an HIV test in the last 12 months and who knows their results	25.2 percent FSWs MSM: 3.7 to 57 percent across survey locations IDU: 11 to 28 percent across survey locations (BSS-2001)	Female Sex Workers: 34.2 percent, Men Who Have Sex with Men: 3 to 67 percent across survey locations Injecting Drug Users: 3 to 70 percent across survey locations. (Source: BSS-2006)
9	National Programme	Percentage of most at risk populations reached with HIV prevention programmes	47percent of FSWs MSM: 12 to 85 percent across survey locations IDU: 22 to 75 percent across survey locations (BSS-2001)	56 percent of the FSWs, 17 – 97 percent of the MSMs (across survey locations) and 10 - 83 percent of the IDUs (across survey locations) received Interpersonal Communication on HIV/ AIDS in the last one year. (Source: BSS-2006)
10	National Programme	Current school attendance among orphans and non-orphans aged 10–14	Data not available	Data not available
11	National Programme	Percentage of schools that provided life skills based HIV education in the last academic year	Data not available	Till date, 114345 schools (79 percent) have been covered out of 144409 government secondary schools in the country (Till date, Program started in 2006-07). Source: NACO-CMIS
12	National Programme	Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child	Not applicable	Not applicable: Only for High Prevalence country. Please see text for national policy on Children affected by AIDS

[8] Assuming Rs 40 for one USD

S. NO.	COMPONENT	INDICATOR	LAST AVAILABLE DATA	CURRENT STATUS
13	Knowledge and Behaviour	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission	Comprehensive correct knowledge about HIV transmission and prevention- 22 percent Source: BSS 2001	Comprehensive correct knowledge about HIV transmission and prevention – 28 percent Source: BSS-2006
14	Knowledge and Behaviour	Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission	FSW: 22 percent MSM : 26-58 percent across survey locations IDU: 17 – 40 percent across survey locations (BSS-2001)	FSWs: 38 percent MSMs : 16 – 75 percent IDUs: 14- 77 percent Source: BSS-2006
15	Knowledge and Behaviour	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Youth BSS not conducted	Youth BSS shows that 3 percent of the young men and women aged 15-24 years had first sexual intercourse before the age of 15 years. Source: BSS-2006
16	Knowledge and Behaviour	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	- Overall 6 percent - Men: 10 percent - Women: 2 percent (BSS-2001)	- Overall 6 percent - Men: 9 percent - Women: 3 percent Source: BSS-2006
17	Knowledge and Behaviour	Percentage of women and men aged 15-49 who have more than one partner in the past 12 month reporting the use of a condom during their last sexual intercourse	40 percent (BSS-2001)	58 percent Source: BSS-2006
18	Knowledge and Behaviour	Percentage of female and male sex workers reporting the use of a condom with their most recent client	- FSWs with the paying client: 76 percent used condoms (BSS-2001)	- FSWs with the paying client: 88 percent used condoms Source: BSS-2006
19	Knowledge and Behaviour	Percentage of men reporting the use of a condom the last time they has anal sex with a male partner	19 to 67 percent across survey locations (BSS-2001)	13 to 87 percent across survey locations. (Source: BSS-2006)
20	Knowledge and Behaviour	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	42 to 80 percent across survey locations (Source BSS-2001)	44 to 100 percent across survey locations. (Source: BSS-2006)
21	Knowledge and Behaviour	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	38 to 77 percent across survey locations (BSS-2001)	29 to 88 percent across survey locations. (Source: BSS-2006)
22	Impact	Percentage of young women and men aged 15-24 who are HIV infected	Not available	HIV Prevalence among ANC Clinic Attendees aged 15-24 years is 0.57percent. Source: HIV Sentinel Surveillance 2006
23	Impact	Percentage of most at risk populations who are HIV infected	FSWs positivity – 8.44 percent MSM: 8.7 percent IDU: 10.2 percent (2005 HIV sentinel surveillance)	FSWs show a percent positivity of 4.9 percent, IDUs highest prevalence at 6.92 percent and MSM at 6.41 percent. (Source: National Sentinel Surveillance - 2006)
24	Impact	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Not available	WHO cohort study at 11 centre shows that 80.1 percent patients were alive after 12 months on ART. Source: WHO Cohort Studies, CMIS

III. OVERVIEW OF THE AIDS EPIDEMIC

India's population surpassed the one billion mark in 2001, with 67.2 percent of its people living in rural areas, and 32.8 percent in urban areas. The revised HIV estimate[9] indicates 2-3.1 million persons in India live with HIV, equivalent to approximately 0.36 percent of the adult population. Out of these, 39percent are women and 3.8 percent are children. The revised estimates, which are based on last five years data, reflects the availability of improved data rather than a substantial decrease in actual HIV prevalence in India. The revised estimate trends points at a stabilisation of the epidemic. India now moves down to third place in the list of countries for the largest number of persons living with HIV. This report uses largely four key sources for data – Computerised Management Information System of NACO, HIV Sentinel Surveillance, National Behavioural Surveillance Survey (BSS) and the Population based study National Family Health Survey - Round III (NFHS-III). A short note on the sources is at Annex A.

The transmission route is predominantly sexual (87.4 percent). In the North Eastern states/provinces[10], besides injecting drug use, which is the main route of HIV transmission, heterosexual route is emerging as an important mode of transmission. The other routes of transmission by order of proportion includes perinatal (4.7 percent), unsafe blood and blood products (1.7 percent), infected needles and syringes (1.8 percent) and unspecified and other routes of transmission (4.1 percent)[11]. The HIV/AIDS epidemic in India is characterized by heterogeneity; it seems to be following the Type 4 Pattern, where the epidemic shifts from the most vulnerable populations (such as FSW, IDU, MSM) to bridge populations (clients of sex workers, STI patients, partners of drug users) and then to the general population. The shift usually occurs when the prevalence in the first group exceeds 5 percent, with a two-three year time-lag between shifts from one group to another.

Trends among different population groups at national as well as district (sub-provincial) level are derived based on the HIV Prevalence at consistent sites from 2003 to 2006. At all India level, the

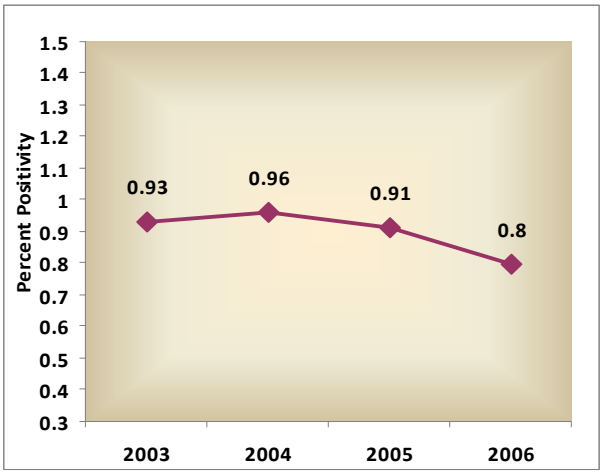


Figure 1: Trends among ANC clinic attendees, India 2003-06 *(Source: HIV Sentinel Surveillance)*

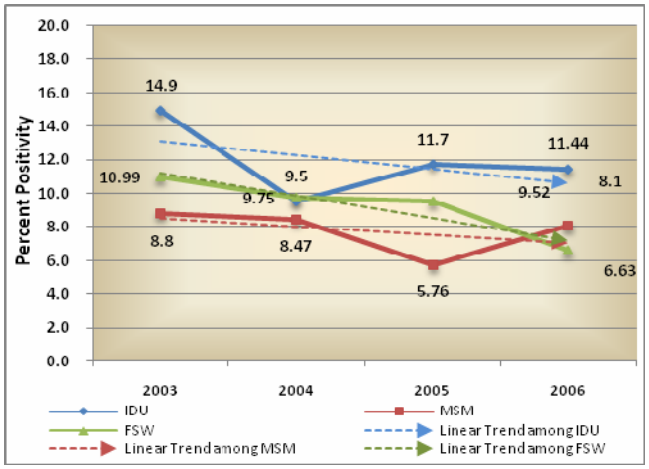


Figure 2: Trends among High Risk Groups, India 2003-06 *(Source: HIV Sentinel Surveillance)*

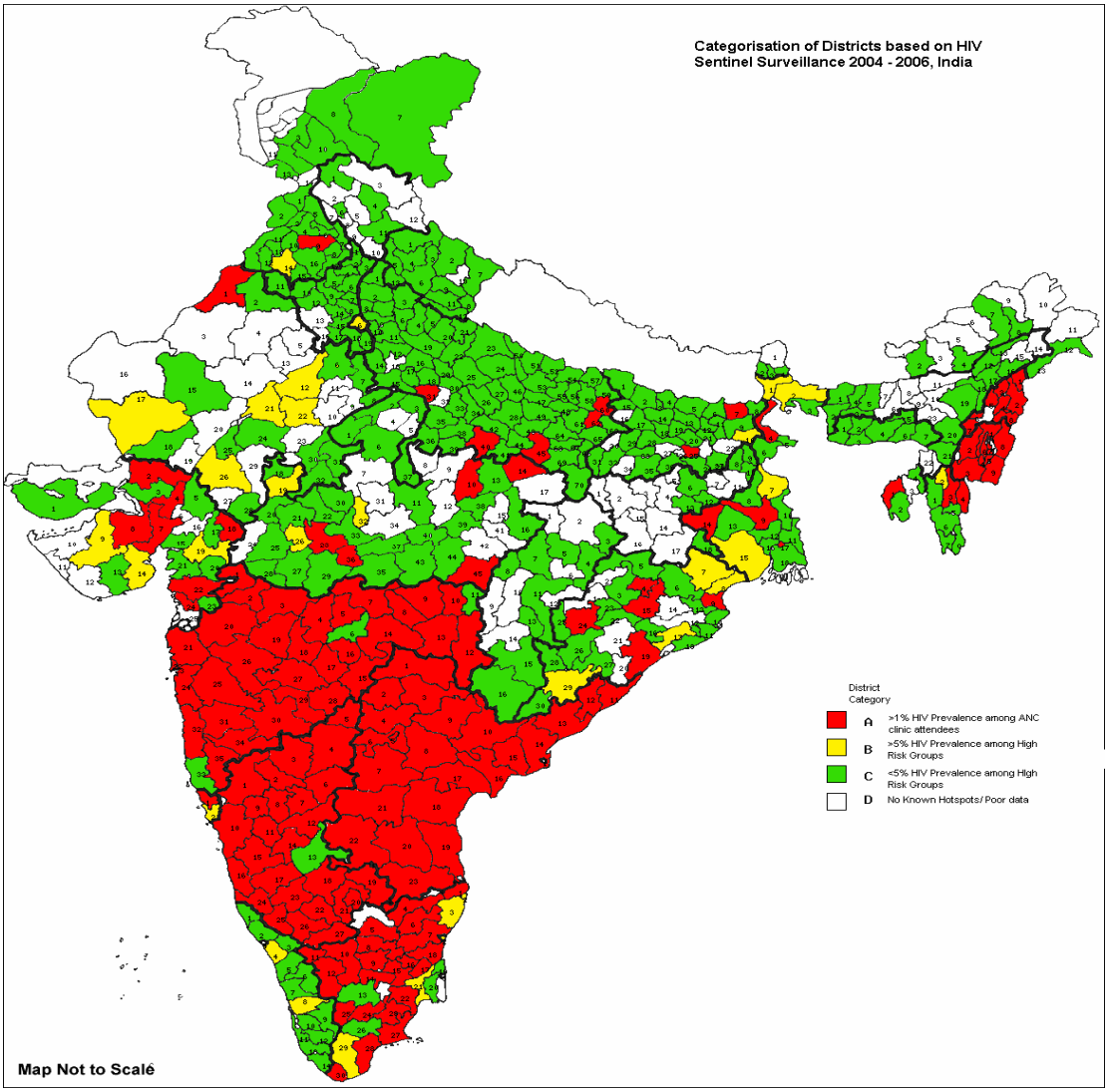
[9] The revised estimates are based on an expanded and improved surveillance system, and the use of more robust and enhanced methodology. The inclusion of the results of the recent national household survey (the National Family Health survey 3, conducted in 2005–2006 in the estimation process contributed significantly to the revised estimates. Over 100,000 people were tested for HIV in the survey which was the first national population based survey to include a component on HIV (NFHS-3, 2007). In addition, India has expanded its HIV sentinel surveillance system in recent years and the number of surveillance sites increased from 155 in 1998 to 1122 in 2006

[10] Sub national level of administrative units in India is referred to as States

trends of HIV prevalence among ANC clinic attendees as well as among IDU and FSW show a decline, while among MSM, it is stable. Figures 1 & 2 show the trends among different population groups at all India level. The spread of HIV within the country is as diverse as the societal and cultural patterns between its different regions, districts and metropolitan areas. However, even within the low prevalent states there are pockets of high prevalence. In view of the vast variations of the nature and intensity of the epidemic, the districts (smaller geo-political administrative units – sub provinces) in the country have been classified into four categories based on the sentinel surveillance data for the last three years. Category A denotes those districts where HIV Prevalence among general population is high. (> 1percent among ANC clinic attendees) while category B denotes those districts where the HIV Prevalence among high risk groups is high. (>5percent among High risk groups). Currently, 156 districts are categorised as A, 39 as B, 296 as C and 118 as D.

This categorization aids in prioritization of programs. Implications of this categorization on programme are detailed in the next section.

Figure 3: Categories of districts according to prevalence and program priority *(Source: NACO)*



[11] AIDS Case Reporting (Jan- Dec 2007)

IV. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

The first phase of National AIDS Control Programme was from 1992 to 1999 and Phase II from 1999 to 2006. Targeted interventions for high risk groups, measures to prevent HIV transmission among the general population were the broad approaches during NACP II. The Programme implementation was decentralised to states, where a separate State AIDS Control Society (SACS) was responsible for implementing the programme.

Taking stock of the achievements, gaps and lessons learnt from NACP-II, the third phase of NACP was designed and launched in June 2007. A consultative process involving civil society, development partners and other key stakeholders across the country was followed. The overall goal of NACP-III is to halt and reverse the epidemic in India over the next 5 years. Considering that more than 99percent of the population in the country is free from infection, NACP-III places the highest priority on preventive efforts while seeking to integrate prevention with care, support and treatment. This is sought to be achieved through a four-pronged strategy:

1. Prevention of new infections in high risk groups and general population through:
   a. Saturation of coverage of high risk groups with targeted interventions (TIs)
   b. Scaled up interventions in the general population
2. Providing greater care, support and treatment to larger number of PLHA.
3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.
4. Strengthening the nationwide Strategic Information Management System.

The focus for NACP-III is to move from project to program mode, while transforming NACO's role from an implementing agency to program catalyst. It also aims at strengthening the district and sub-district level response, organisational restructuring and capacity building, and integrating prevention, treatment, care and support programs. The program also envisages increased focus on North Eastern states and vulnerable groups viz. MSM and IDU. Up-scaling and improving service delivery along with robust M&E systems at all levels, evidence based planning, program implementation and comprehensive financial management are the other key areas for the program. Thrust is being provided to mainstreaming and partnership development across various Departments and stakeholders. The Three Ones' principles (one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National M&E System), Respect for the rights of the PLHA, Civil society representation and participation are among the important guiding principles for NACP-III. Convergence and working together with the National Rural Health Mission (NRHM) is critical. NRHM is a comprehensive programme of the Government of India which seeks to improve health outcomes in the poorest areas of India through an integrated approach (cutting across disease control programmes) and focusing on demand generation. NACO and NRHM are working together in planning, development of operational guidelines and co-ordination at the district (sub-provincial) level implementation.

1. Priority Targeted Interventions for populations at high risk:

Given the nature of the epidemic in India, prevention of HIV among Most at Risk (female sex workers, injecting drug users and men who have sex with men) are still the key. Providing peer counselling, condom promotion, treatment of sexually transmitted infections are the major service interventions that are supported by structural interventions such as enhancing community ownership and creating enabling environment. This activity is being delivered through non-government and community based organisations.

For the prevention programmes for Most at Risk, there is a shift in focus from NGO led programs to CBO led interventions. This came about due to the successes achieved through the empowerment model of programs of the CBOs on the ground. In NACP II, there was a focus on several groups, FSW, IDU, MSM, truckers, migrants, street children, etc. In NACP III, the focus is on the three key Population groups, i.e. FSW, IDU and MSM and one bridge population – Migrants. Saturation of all high risk groups through 2100 TI projects and development of 50percent of TIs into CBOs is the target aimed at during NACP-III.

Reach and coverage: The total estimate of Most at Risk population in India is 2 million[12]. Currently 790 TIs spread across the country reach about 869,206 (43 percent); which includes both the national program and its development partners. (Source: CMIS).

India conducts regular Behavioural Surveillance Surveys and the recent round was completed in 2006 (earlier in 2001). A note on the survey is in Annex A. In 2006, the Behaviour Surveillance Study (BSS) shows that 56 percent (47 percent in 2001) of the FSWs reported that someone had approached them in the past one year for educating on STI/HIV/AIDS. Nearly, one-third of the FSWs (against one-fourth in 2001) reported attendance / participation in some campaign / meeting on STI/HIV/AIDS in the past one year. In general, brothel based female sex workers seem to be better reached than their street based counterparts and therefore having higher outcomes reported – awareness, testing and condom use.

Overall 17.4 to 97 percent of MSMs (in Uttar Pradesh and Goa respectively) have reported being approached for education in the last one year across the survey locations. Nearly, two fifth of the MSMs (same as 2001) reported attendance/participation in some campaign/meeting on STI/HIV/AIDS in the past one year.

Overall the range of indicator values for IDU who received inter-personal communication is 10 percent in Punjab to 82.7 percent in Kolkatta. Nearly, one third of the IDUs (against one sixth in 2001) reported attendance / participation in some campaign/meeting on STI/HIV/AIDS in the past one year.

Knowledge and awareness: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission has improved significantly among FSW from 22 to 38 percent. Overall 16 to 75 percent of MSMs and 14 to 77 percent of IDUs have shown comprehensive knoweledge about HIV prevention and transmission.

Behaviour change: Percentage of female sex workers reporting the use of a condom with their most recent paying client is now about 88 percent[13] (76 percent in 2001). Against 94 percent of the brothel based FSWs, 85 percent of the non-brothel based FSWs reported condom usage in the last occasion when they had sex with a paying client.

The proportion of MSM respondents who used condom last time with commercial partner in last one month was highest in Kolkata[14] (64 percent) and lowest in Delhi (41 percent). Also, this proportion has increased significantly in Bangalore, Delhi and Kolkata when compared with the 2001 survey. While, in Chennai and Mumbai proportion of respondents who used condom last time with commercial partner has decreased significantly. In all states, highest proportion of respondents who used condom last time with commercial partner was reported in Goa (87 percent) and lowest in Uttar Pradesh (13 percent). Men reporting the use of a condom with a non-commercial male partner are highest in Mumbai (88 percent) and lowest in Delhi (46 percent). Data specifically for condom use in anal sex with male partner is not available.

[12] Detailed mapping exercises commissioned and this figure will be further revised
[13] BSS
[14] A major metro city

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse is as high as 100 percent in Manipur and lowest in Kerala – 44 percent. In all locations except Chennai (where there was decline) a significant increase in this proportion was observed when compared with the 2001 survey.

The 2006 BSS reports that 34 percent of FSWs (25 percent in 2001) have tested themselves for HIV and received the test results. In the case of MSMs in Mumbai[15], 69 percent of MSMs (65 percent in 2001) have tested themselves and received test results. Overall 3 to 67 percent of MSMs (across survey locations) have "ever got tested" and received its results. Similarly, 10 to 83 percent of IDUs (across survey locations) got themselves tested and received the test results.

Among all the survey locations, relatively high proportion of respondents reported injecting drugs with a used needle or syringe in last 1 month is highest in Sikkim (71 percent) and lowest in Kolkata (11.7 percent). When compared with the 2001 survey, the proportion of respondents reporting injecting drugs with a previously used needle/syringe has significantly increased in Delhi and Mumbai, while it remained almost the same in Chennai. Further, in Kolkata (From 22.6 to 11.7 percent) and Manipur (55.3 to 26.3 percent) a significant decline in injecting with a previously used needle/syringe was reported.

Impact of Targeted Interventions: The Targeted Intervention component of the Programme is showing signs of impact, but not in all fronts. Percentage of FSWs who are HIV infected has decreased significantly from 10.3 percent in 2003 to 9.43 percent in 2004, 8.44 percent in 2005 to 4.9 percent in 2006, reflecting the impact of programme interventions on FSWs. Brothel based female sex workers seem to be better reached then their street based counterparts and therefore having higher outcomes reported – awareness, testing and condom use. Trends of HIV prevalence among FSW show a decline in the South Indian States (reflecting the higher reach and coverage in southern states), whereas in the North East, the HIV Prevalence among the FSW is increasing suggesting a dual nature of the epidemic in the North East. Percentage of injecting drug users reporting using previously used equipment is on the increase**.** IDUs show the highest prevalence of 6.92 percent among all the high risk groups at the all India level in 2006. The prevalence rates among IDUs are on the increase in many states and newer regions are showing upward trends. Percent Positivity among Men who have Sex with Men is 6.41 percent in 2006. Trends among MSM do not show any significant decline in the Southern states.

[15] BSS 2006 does not provide aggregate national figures for MSM and IDUs as the study was limited to only 10 key cities.

Summary of progress on indicators:

Percentage of most at risk populations who received an HIV test in the last 12 months and who knows their results (UNGASS Indicator 8)

The 2006 BSS reports that 38 percent of FSWs (28 percent in 2001), 69 percent of MSMs (65 percent in 2001) in Mumbai[16], 35 percent of IDUs in 2006 (29 percent in 2001) have tested themselves for HIV. Of this, 91-99 percent of them secured their results.

Percentage of most at risk populations reached with HIV prevention programmes (UNGASS Indicator 9)

In 2006, the Behaviour Surveillance Study (BSS) shows that 56 percent (47 percent in 2001) of the FSWs, 17 to 97 percent of MSMs (across the survey locations), 10 to 83 percent of the IDUs (across the survey locations) reported that someone had approached them in the past one year for educating on STI/HIV/AIDS. Nearly, one-third of the FSWs (against one-fourth in 2001), two fifth of the MSMs (same as in 2001), one third of the IDUs (against one sixth in 2001) reported attendance / participation in some campaign / meeting on STI/HIV/AIDS in the past one year.

Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission I UNGASS Indicator 14)

81 percent of FSWs (66 percent in 2001), 53 percent of MSMs (in Mumbai) and 74.1 of IDUs (in Mumbai) knew both the methods of prevention i.e. consistent condom use and having faithful and uninfected sexual partner. The proportion has significantly decreased in Mumbai for both MSMs and IDUs as 87 percent for MSM and 80 percent of IDUs were reported being aware of two methods of prevention in Mumbai. This is a cause for concern.

Percentage of female and male sex workers reporting the use of a condom with their most recent client (UNGASS indicator 18)

Percentage of female sex workers reporting the use of a condom with their most recent client is now about 88 percent (76 percent in 2001). The proportion of MSM respondents who used condom last time with commercial partner in last one month was highest in Kolkata[17] (64 percent) and lowest in Delhi (41 percent). Also, this proportion has increased significantly in Bangalore, Delhi and Kolkata when compared with the 2001 survey. While, in Chennai and Mumbai proportion of respondents who used condom last time with commercial partner has decreased significantly.

Percentage of men reporting the use of a condom the last time they has anal sex with a male partner (UNGASS Indicator 19)

Men reporting the use of a condom with a non-commercial male partner are highest in Mumbai (88 percent) and lowest in Delhi (46 percent). Data specifically for condom use in anal sex with male partner is not available.

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse (UNGASS Indicator 20)

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse is as high as 100 percent in Manipur and lowest in Kerala – 44 percent. In all locations except Chennai (where there was decline) a significant increase in this proportion was observed when compared with the 2001 survey.

Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected (UNGASS Indicator 21)

Among all the survey locations, relatively high proportion of respondents reported injecting drugs with a used needle or syringe in last 1 month; highest in Sikkim (71 percent) and lowest in Kolkata (11.7 percent). When compared with the 2001 survey, the proportion of respondents reporting injecting drugs with a previously used needle/syringe has significantly increased in Delhi and Mumbai, while it remained almost the same in Chennai. Further, in Kolkata and Manipur a significant decline in injecting with a previously used needle/syringe was observed (From 22.6 percent to 11.7 percent in Kolkata and 55.3 percent to 26.3 percent in Manipur).

[16] BSS 2006 does not provide aggregate national figures for MSM and IDUs as the study was limited to only 10 locations.
[17] A major metro city

Preventive interventions for the general population

Prevention interventions for general population include:

a) Creating awareness about symptoms, spread, prevention and services available through a strong IEC campaign
b) Condom promotion
c) Promotion of voluntary blood donation and access to safe blood
d) Integrated Counselling and Testing (ICT)
e) Prevention of Parent To Child Transmission
f) Management of STI and RTI
g) Intersectoral coordination and mainstreaming

Information, Education and Communication (IEC)

An effective IEC complements the other efforts at prevention and helps in demand generation. NACP has developed and implemented a communication strategy, moving beyond awareness generation to bringing about behaviour change with focus on reduction of stigma and discrimination, promotion of services (counselling, testing, ART, PPTCT), increasing condom use and blood safety. For this purpose strategies used include mass media (special programs on radio and TV covering rural and semi-urban population, newspaper) and holding of advocacy and sensitisation workshops. These campaigns, now and in the past seem to have impacts, which is evident from the latest BSS findings.

Red Ribbon Express:
The Red Ribbon Express (RRE) Project, initiated by Rajiv Gandhi Foundation, is a unique campaign being implemented by NACO as a multi-sectoral project to spread awareness on HIV/AIDS and promote safe behavioral practices. It is a National Campaign to mainstream the issue of HIV/AIDS through a train that will traverse over 9000 kms during the year, covering about 180 districts/halt stations and hold programmes and activities in 43,200 villages. The concept is a broad based multi-media, multi-sectoral mass mobilization project in the country to make it a holistic and comprehensive campaign to mobilize people's movement against HIV/AIDS.

The vision behind the project is to promote a multi-sectoral effort by which HIV/AIDS could be mainstreamed within the context of overall socio-economic development rather than merely as a medical/public health issue. The RRE is flagged off on a year long journey on 1st December 2007 (World AIDS Day) from Delhi.

The project primarily focusing on rural areas aims at:

- disseminating information regarding primary prevention services;
- developing an understanding about the disease to reduce stigma & discrimination against People Living with HIV/AIDS and;
- strengthening people's knowledge about the measures to be taken to prevent getting HIV/AIDS; and

Adopting preventive health habits and lifestyle.

Knowledge and awareness
The awareness levels are on the increase. The BSS (2006) indicates that percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission has improved by 6 percent points[18]. At the all India level, two-third of the respondents having awareness of HIV/AIDS reported that the disease can be prevented by consistent condom use and by having one faithful uninfected

[18] Behavioural Surveillance Survey 2006

partner (58 percent in 2001). Higher proportion of men (73 percent) reported knowledge of both the methods of prevention as compared to women (61 percent). The knowledge level was observed to be higher in urban areas (71 percent) as compared to rural areas (65 percent).

Percentage of young women and men aged 15-24 who correctly identified three common misconceptions on transmission of HIV/AIDS has also improved. More than two-fifth (43 percent) of the respondents correctly identified three common misconceptions on transmission of HIV/AIDS. Significantly higher proportions of respondents from urban areas (52 percent) as compared to rural areas (39 percent) reported the same. In urban as well as in a rural area, this proportion was higher among men as compared to women.

The population based study NFHS-III data provides additional insights; it shows that while one in four women reject the three transmission misconceptions and know ways to prevent HIV/AIDS, less than two in five men have this kind of knowledge. Even fewer (20 percent of women and 36 percent of men) have a comprehensive correct knowledge[19] of HIV/AIDS. Young women living in urban areas are more than twice as likely as their rural counterparts to have comprehensive knowledge of HIV/AIDS. While the urban-rural differential in comprehensive knowledge is somewhat narrower among men, it is still substantial (47 percent in urban areas and 29 percent in rural areas).

Age at sexual debut:

The population based study NFHS-III shows that Fifty-one percent of women and 27 percent of men age 15-24 have ever had sex. Ten percent of young women and 2 percent of young men had their first sexual intercourse by age 15, and among those age 18-24, 40 percent of women and 12 percent of men had sex for the first time before reaching age 18. The differences by sex in age at sexual initiation are largely a reflection of the early age at first marriage among women then men.

BSS shows that 3 percent of the young men and women aged 15-24 years had first sexual intercourse before the age of 15 years. This is significantly higher among the women (4 percent) than men (2 percent). 4 percent in rural areas and 1 percent in urban areas have reported first sexual intercourse before the age of 15 years. 4 percent of respondents in the age group of 20-24 years and 3 percent of those in 15-19 years reported first sexual intercourse before the age of 15 years.

Sexual intercourse with more than one partner:

At the national level, 6 percent (BSS 2006) of the respondents in 2006 reported sex with non-regular partners during 12 months preceding the survey. The proportion of respondents reporting sex with non-regular partners has remained same since the 2001 survey. The proportion of respondents reporting sex with any non-regular partner in last 12 months has declined (by 1 to 5 percentage points) since the 2001 survey in 10 of the 22 states for which comparative data is available.

Significant variation was observed across different states with a lowest proportion (2 percent) in Bihar and Karnataka, and the highest (15 percent) in Andhra Pradesh. The other two states reporting higher proportion were Punjab & Chandigarh (10 percent) and Tamil Nadu (11 percent).

Both the surveys show wide variation in the proportion of male and female respondents reporting sex with non-regular partners. Against 9 percent of the male respondents, 3 percent of the female respondents reported sex with non-regular partner during 12 months preceding the survey. The corresponding percentage in the 2001 survey was 10 percent and 2 percent respectively. The differences in the proportion of male and female respondents reporting sex with non-regular sex

[19] Comprehensive correct knowledge about HIV transmission and Prevention is defined as 'Percentage of Population aged 15-49 years who could correctly identify the two major ways of preventing the sexual transmission of HIV (Consistent condom use and having one faithful uninfected sex partner), reject the two most common local misconceptions about HIV transmission (transmission of HIV/AIDS through mosquito bites and sharing of meals with HIV/AIDS patients), and who know that a healthy-looking person can transmit HIV.

partner may be due to the fact that the females are more likely to underreport the sex with non-regular sex partners and the males are likely to be engaged in non-regular sex with female sex workers.

It was observed that the proportion of people who had sex with any non-regular partner in last 12 months was higher in younger age category (15-24 yrs) as compared to older respondents. Most of the younger age group respondents were either unmarried or formerly married. The analysis also revealed that sex with any non-regular partner in last 12 months has increased with the increase in the education level. The same was true for those who engaged in Government or private services or self employed to a certain extent, but highest proportion of such respondents were reported from the population engaged in transportation related jobs, mainly truck drivers, cleaners and helpers.

Condom Promotion:

Given the fact that over 80 percent of HIV infection in India is through the sexual route, condom programming is central to HIV/AIDS prevention at the intervention level. The use of condoms is promoted as a protection against STIs and HIV/AIDS in addition to Family Planning. Condom promotion is through free distribution and social marketing. NACO works in collaboration with Family Welfare Department, SACS and NGOs to distribute free condoms countrywide. Adequate supply in STD clinics, ICTCs and obstetrics and gynaecology clinics is given importance. Chief consumers are high risk groups and marginalised groups like FSW and MSM. Efforts are made for generating more demand for condoms among people from all sections of society and at the same time, strengthening the supply. In 2006, 1250 million condoms were supplied at no cost and 604 million were sold through social marketing. 11025 Condom Vending Machines were installed and another 11025 are in the process. In addition 40,000 unconventional condom social marketing outlets have been established, in the last 2 years. 3.5 billion Condoms are targeted to be distributed through 3 million outlets during NACP-III.

The sustained focus on condom programming has yielded results; availability and usage of condoms in non-regular sex partners and by most at risk groups have gone up. Percentage[20] of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse has increased to 58 percent in 2006 (40 percent in 2001). An increasing trend was reported in all the states. 60 percent of males have used condom during their last sex with a non-regular sex partner against 56 percent of females. Similarly, 65 percent of young men and women aged 15-24 years have used condom during their last sex with a non-regular sex partner against 68 percent of respondents aged 25-39 yrs and 58 percent of those aged 40-49 yrs.

Promotion of voluntary blood donation and access to safe blood

A National Blood Policy, formulated by NACO, was adopted by Government of India in April 2002. Subsequently, an action plan on blood safety developed. Transmission of HIV through Blood Transfusion reduced from 6.07percent (1999) to 1.96percent (2006) and 1.1percent (2007).

NACO is supporting 1230 blood banks in the country including 85 blood component separation units and 10 State-of-art Model Blood Banks. Blood collected from voluntary (non-remunerated) blood donors all over the country shows an increasing trend, indicating improvement in voluntary blood donation. Out of the total number of blood units required, the percentage of units collected through voluntary blood donation increased from 20percent in 1999 to 59percent in 2007. The blood banks supported by NACO are following documented standard operating procedures and subjected to close supervision and external quality assurance. All these blood banks report to NACO through CMIS.

[20] BSS 2006

The total number of blood units collected and screened for HIV was 5.1 and 5.3 million respectively in 2006 and 2007. This includes blood collected through 2100 Private blood banks. 100 percentage of donated blood units were screened for HIV in a quality assured manner.

NACP-III has the following vision with regards to blood safety:

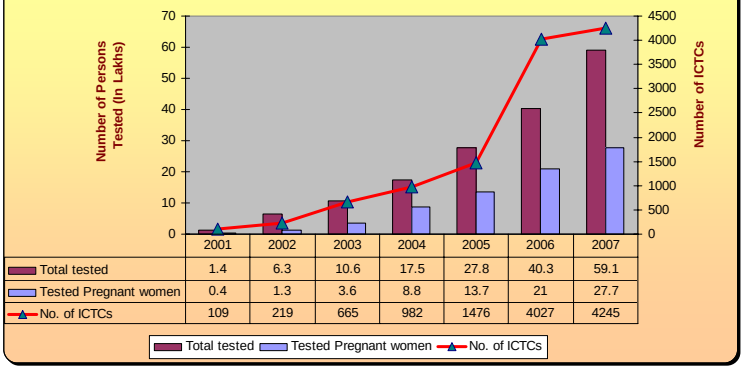
- Promote appropriate use of blood, blood components and blood products among clinicians.
- Aim to reduce transfusion associated HIV transmission to less than 0.5percent
- Achieve efficient and self-sufficient blood transfusion services.

Under NACP III, NACO proposes to establish blood storage centres in 3222 Community Health Centres, Provide blood bank vans to 500 districts to network with blood storage centres, set up blood banks in 39 districts (now without blood banks), establish one Plasma Fractionation centre, one Model Blood Bank in each state, four Centres of Excellence in Metro cities, additional 80 blood component separation units and promotion of voluntary blood donation to help achieve 90percent target.

Integrated Counselling and Testing Services

Many of those infected are still not aware about their status and there is need to extend access to the counselling and testing facilities and as well as generate demand. The first counseling and testing centre was started in the year 1997 and recent years have seen rapid up scaling of such centres. Today with more than 4200 ICTCs, India has the largest network of such centres in the entire world. The phenomenal growth of counseling and testing services in India is depicted in the diagram given below. In NACP-III it is envisaged that ICTCs will be opened upto the level of 30 bedded Community Health Centre throughout the country. The target for counseling and testing by the end of NACP-III is 22 million clients and the programme is making rapid strides in achieving that target. The Counselling and Testing Centres have been established at medical colleges, district hospitals, sub district level hospitals and community health centres. Under NACP-III, Voluntary Counselling and Testing Centres (VCTC) and Prevention of Parent to Child Transmission Centres (PPTCT) are re-modelled together as ICTC (Integrated Counselling and Testing Centre). The number of integrated counselling and testing centres increased from 109 in 2001 to 4245 by September 2007. The number of persons tested in these centres increased from 0.14 million in 2001 to 5.9 million persons in 2007.

Fig.4: Year wise progress in Integrated Counseling and Testing services
(Source: CMIS)

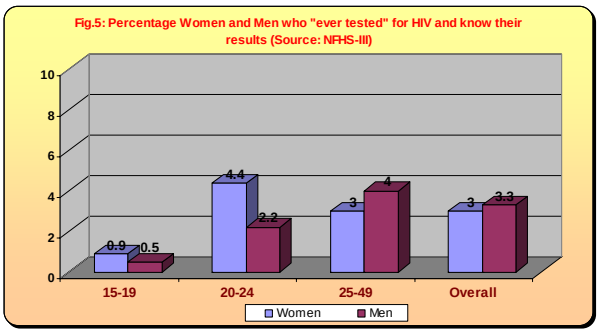


	2001	2002	2003	2004	2005	2006	2007
Total tested	1.4	6.3	10.6	17.5	27.8	40.3	59.1
Tested Pregnant women	0.4	1.3	3.6	8.8	13.7	21	27.7
No. of ICTCs	109	219	665	982	1476	4027	4245

The percentage women and men who have tested for HIV and who know the result is on the rise. According to population based study - NFHS III, 3.2 percent women and 3.8 percent men reported carrying out HIV test in the last 12 months. Among those who received HIV test, 87 percent women and 94 percent men reported having got their test results. Overall 3 percent women and 3.3 percent men have received test and know their results in the last 12 months.

As NFHS is a population based survey with general population, it may not fully capture the trend of HIV testing in India. NACO collects this information from all the Integrated Counselling and testing Centres in India (ICTC). ICTCs are approached largely by the intended segment of population who are risk aware and who are referred. ICTC data (CMIS) shows that 9.9 million people tested for HIV in 2006 and 2007. Of those tested, 91percent have collected their test report and hence know their

status. Given the general prevalence rate lesser then 1 percent, the rates in ICTC are higher as most are visiting ICTC, with a background of having higher risk behaviour or referred by medical providers.



It is important to note that in the context of the population size and the epidemic in India, the 7 percent[21] people who have tested and received translates to 37 Million[22] people who have tested. The NACP III believes that on priority, people practising high risk behaviour (6 percent[23]) need to have themselves tested, which is a focused and targeted approach. In this context the testing centres have had people largely who are referred because of their high risk behaviour to test. Of course this does not stop those who want to voluntarily test themselves; irrespective of their risk behaviour (49 and 55 percent were direct walk-ins during 2006 and 2007 respectively). The fact that the programme has systematically encouraged people with risk to test and about 7 percent (37 Million people) have tested is still a substantial achievement.

Provider Initiated Counseling and Testing:

In order to make all HIV infected people aware of their status so that they adopt healthy lifestyles and prevent the transmission of HIV to others and also access life saving care and treatment, Provider Initiated Testing and Counseling (PITC) has been recently introduced for clients referred by medical providers such as TB patients, STI patients, pregnant women etc.

PPTCT services:

The PPTCT programme entails counseling and testing of pregnant women and administration of prophylactic single dose Nevirapine to HIV+ve pregnant women and their babies in order to prevent the perinatal transmission of HIV. PPTCT services are provided at all ICTCs for pregnant women who access hospital/ health facilties where these centres are located. The programme was initiated in the country in 2001 following a feasibility study in 11 centres in the six high prevalence states and has been rapidly upscaled in the last two years with funding under Round II of the GFATM. In the year 2006, 2.1 million pregnant women were counseled and testing under this programme of which 16500 HIV +ve pregnant women were identified. Across the country only about 45% of pregnant women diagnosed to be HIV+ve and their babies were given prophylactic NVP. The coverage of HIV+ve pregnant women with prophylactic NVP is however 60% or more in states such as Tamil Nadu and Andhra Pradesh. This has been achieved as a result of NGO outreach activities in these states. The NGOs who are engaged to do outreach services help in mobilizing pregnant women in their area of activity to access PPTCT services and undergo institutional delivery. The NGOs also help in following up HIV+ve pregnant women and their babies so as to ensure coverage of mother-baby pairs with prophylactic ARV drugs

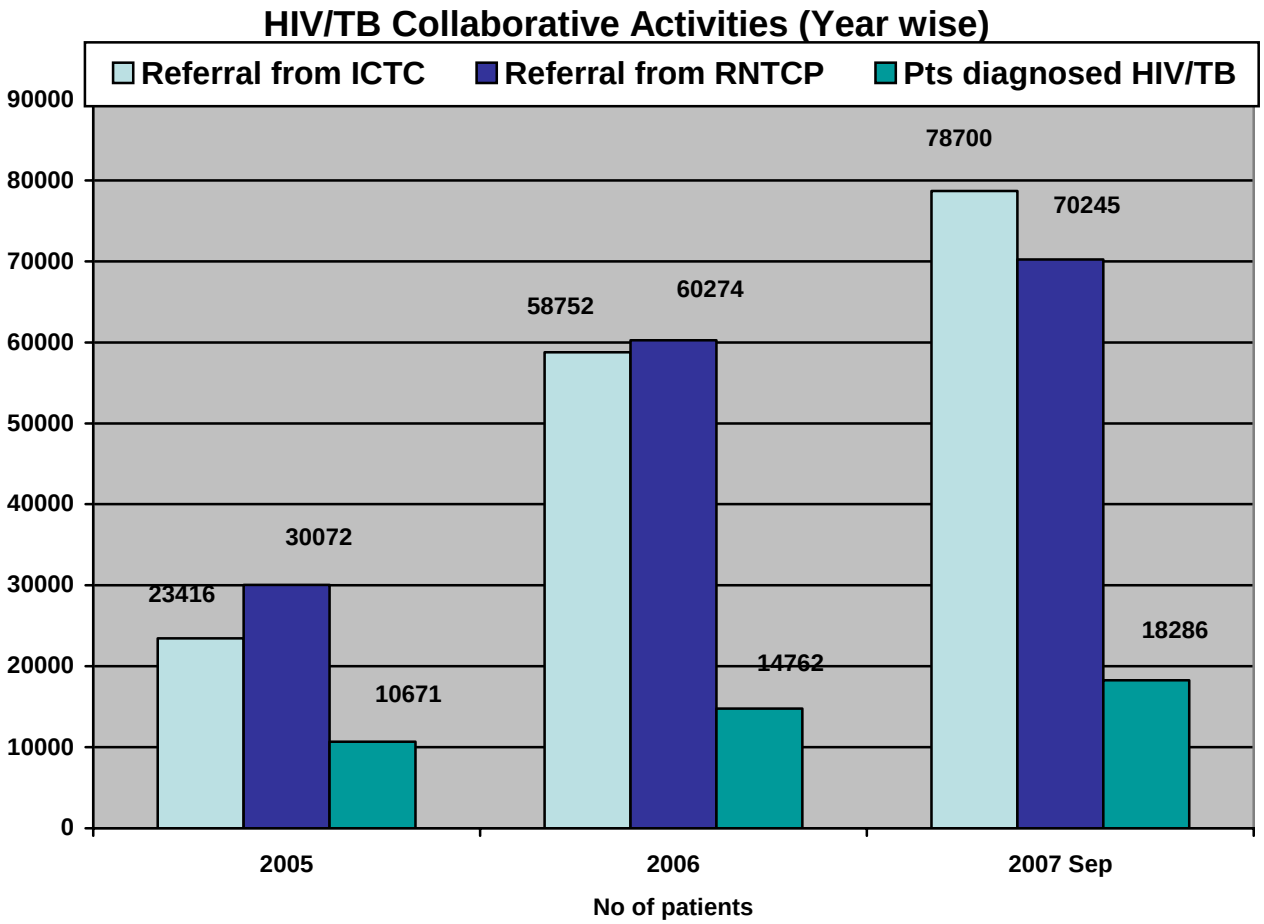
Cross Referrals for detection of HIV/TB co infection cases:

HIV/TB coordination earlier emphasized only on cross referral of clients between the RNTCP microscopy centres and the ICTCs but now it is being extended to also cross referrals between ART Centres, CCCs & RNTCP to ensure confirmation of diagnosis and early treatment of TB and starting on ART at the earliest for identified HIV/TB patients with CD4 counts less than 350 as per the new guideline. In the 6 high HIV prevalence states HIV/TB activity has been further strengthened under

[21] This includes both public and private sector. ICTC is largely in public sector. So the number of tests in ICTC will not be equal to those of the NFHS III which is a household study.
[22] One Billion populations, 53 percent who are adults, 7 percent of those who tested and secured results.
[23] BSS 2006

funds from GFATM Round 3. Of the estimated patients with HIV-TB co-infection, 23 percent are under treatment for TB and HIV.

In addition to cross referrals and care & support for HIV/TB patients under GFATM Round 3, NGOs have been involved for awareness generation and community mobilization of HIV/TB. There is further emphasis on coordination between the field level NGOs between the two programmes for awareness generation and community mobilization



Cotrimoxazole Prophylaxis:

A Pilot to deliver cotrimoxazole for all HIV/TB patients through RNTCP mechanism was conducted in Andhra Pradesh. The pilot study showed the feasibility of implementing cotrimoxazole along with DOTS and is now being up scaled in all the high HIV prevalence states.

Routine referral of TB patients for HIV testing

A pilot study was carried out in three districts of Andhra Pradesh to understand the implementation of routine referrals for HIV testing in high prevalence districts. It was observed that the quantum of cross-referral has improved and it is feasible to integrate HIV testing within the framework of RNTCP. Also, shared confidentiality was not the issue.

Integration with NRHM to improve accessibility of counseling and testing services:

As part of integration with the National Rural Health Mission, counseling and testing services are now being expanded to 24 hour PHCs in A and B category districts. This is taken up in collaboration with NRHM. An existing nurse and laboratory technician have been identified in more than 700, 24 hour PHC in the A and B category districts for HIV counseling and testing respectively and their training is underway. Full fledged counseling and testing services will be in place in these PHCs by early

January 2008. A technical working group consisting of representatives from NACO and NRHM regularly meet on the 3rd Thursday of every month in order to work out ways and means of further strengthening integration with the NRHM.

Public Private Partnerships:
Public Private Partnerships are encouraged in order to expand the reach of counseling and testing services. Of the total of 4245 existing ICTCs today, about 100 are located in private/not for profit hospitals which have good client load. More partnerships are on the anvil with NGOs such as Janani etc.

Sexually Transmitted Infections/Reproductive Tract Infections (STI/RTI) Services

A total of 30 million episodes of STI/RTI occur every year in the country. During the financial year 2007-08, the target for treating is 10 million episodes of STI. Of these 1/3rd episodes are expected to be treated by the existing 845 STI clinics and TI STI clinics and the remaining 2/3rd episodes under NRHM at Primary health centers. Therefore 3.3 million episodes are to be treated at STI clinics and TI clinics.

STI prevalence in the country varies markedly between different states ranging from 1percent to 26percent. To strengthen STI prevention and control activities, NACO in association with NRHM has developed technical and operational guidelines, standardized universal syndromic case reporting, supported training in syndromic case management (SCM), established elements of supportive supervision, established STI/RTI service delivery through private public partnership (10,000 providers are franchised in 100 districts spread across 18 states), introduced colour coded STI/RTI treatment kits. Provision of presumptive treatment for gonorrhoea and Chlamydia infections to new attendees and STI clinics for Most at Risk Groups has been initiated under NACP III which will further reduce the disease burden among the most at risk groups.

Focus is placed on converging with all providers of STI/RTI services for a comprehensive data capture. Nationwide, there are now 845 STI/RTI clinics supported by NACO which form a potential resource network for implementation support and STI surveillance. The reported number of patients treated was 1.9 million in 2006 and 2.5 Million in 2007.

The five Regional STD reference laboratories have been strengthened and act as centres for monitoring drug resistance to gonococci and for validating the drug regimens followed under syndromic approach.

Progress of STI/RTI services and new initiatives

a) ***Pre packed STI/RTI color coded Kits:*** As per the new operational guidelines, pre packed color coded STI kits are to be provided to all STI clinics, STI clinics with Targeted Interventions and franchised STI private service providers. The concept of preparing the pre packed color coded Kits has been approved by DCGI, bid document has been prepared and submitted to UNOPS for procuring the STI/RTI kits.
b) ***Implementation of PPP model****:* NACP III envisages the involvement of private health care providers through Public Private Partnership (PPP) in comprehensive STI/RTI treatment services with appropriate safeguards to ensure quality. Under this model it is proposed to conduct social franchising of private service providers in 100 category 'A' & 'B' districts covering 18 states. These 18 states have been divided into 6 zones. Funds for implementing the scheme @ Rs. 10,00,000/- per district are allotted as per the number of districts allotted to states where this scheme will be rolled out.

This PPP scheme has also been approved by the AIDS Control Board. For the FY 2007-08, NACO will deploy an agency to implement the private provider scheme in each specified zone. The EOI had

been advertised in the leading news papers for the same and we have received around 60 responses. The following activities have been conducted to contract agencies:

i) Detailed work-plan designed.
ii) Panel of team of experts identified.
iii) The draft selection criteria prepared.
iv) Draft RFP prepared.

c) ***Implementing STI management and counseling and testing in 15 Districts of Bihar:*** Janani has submitted a proposal for implementing STI management and counseling and testing in 15 districts of Bihar. . Broad objectives of the project includes: -

i) Increase awareness levels of HIV/AIDS in the State by use of local media.
ii) Identify and train almost 4000 non-Allopath (existing "Titly Centers") in the implementing Districts
iii) Provide ICTC services through their existing "Suriya Clinic" by training 40 Doctors (MBBS and above qualified), 40 lab technicians and 40 Counselors. By using their existing medical staff and also by utilizing the trained Counselors available with BSACS.
iv) Social Marketing of pre packed STI/RTI kits through their existing distribution network.

The proposal has been reviewed and discussed with Janani officials; draft contract format has been prepared and submitted for approval.

d) ***National communication strategy on STI/RTI service delivery***: STI team is jointly developing the communication strategy for STI in collaboration with IEC division. This has been initiated as BSS -2006 survey indicated that awareness regarding STD symptoms as about 23.5 % among general population.

Inter-sectoral Coordination and Mainstreaming

Mainstreaming and partnerships facilitates multi-sectoral responses, while engaging a wide range of stakeholders. Private sector, civil society organizations, PLHA networks and government departments play crucial role in prevention, care, support, treatment and service delivery. Technical and financial resources of the development partners are being leveraged to achieve the objectives of the programme.

Following principles guide Intersectoral coordination for HIV prevention:

- Mainstreaming HIV/AIDS in schemes/ Programmes of different ministries (e.g. Ministry of Social Justice & Empowerment for Injecting Drug Users).
- Strengthening HIV/AIDS interventions in the world of work – workplace policy and Programmes in both formal and informal sectors
- Mainstreaming HIV/AIDS in Civil Society Organizations, religious organizations, and media.

A significant measure taken up to ensure mainstreaming of HIV/AIDS is the constitution of National Council on AIDS under chairmanship of Honourable Prime Minister with representation of 33 ministries and departments.

The Adolescence Education Programme by NACO seeks to build life skills and help adolescents cope with negative peer pressure, develop positive behaviour, improve sexual health and prevent HIV infections. So far, 114,345 schools (79 percent) of the 144,409 government secondary schools in the country have a life skills programme running. Around 20,000 Red Ribbon Clubs were formed and in majority of the states, Governors convened the meeting with Vice-Chancellors of universities in the respective states. A Parliamentarians' Forum and State Legislative forums on HIV/AIDS have been set up.

In the last 6 months, the programme made very good progress towards developing strategies to address social and gender equity issues. Mainstreaming gender and social equity is being

approached as a cross-cutting principle. The programme has drafted a gender and social equity policy, which highlights the need to address issues of unequal social relations within the family, community and public institutions' levels. Studies show differential behaviour between women and men due to patriarchal norms, the nature of work patterns, notions of masculinity and femininity. It is also important to address men as part of the solution to women's vulnerability by trying to change behaviour and social norms, as well as recognizing that men are also vulnerable. Similarly, training modules for link and health workers incorporating gender issues have been developed and is being implemented.

2. Care, Support and Treatment for People Living with HIV/AIDS (PLHA)

Care, support and treatment services include management of opportunistic infections (OI), anti-retroviral treatment (ART), safety measures, positive prevention and impact mitigation.

For people living with HIV/AIDS, treatment for opportunistic infections is being made available right from the beginning of NACP. In NACP-II, provision has been made for free ART to those who are HIV positive and eligible to receive this therapy, based on clinical as well as laboratory criteria. Under NACP-III, first line ART drugs are provided to all those who need it. There are presently 137 centres in 31 states providing free ART 118,052 adults and 8347 children.

Greater Involvement of People living with AIDS (GIPA): The NACO has supported the formation and capacity building of networks of positive people at both state level and district level with UN support. The Indian Network of Positive People (INP+) has supported establishment and strengthening of 22 state networks and 221 district networks in high prevalence states and districts. The network members are participating as facilitators and positive speakers in ART centres, Community Care Centres, Red Ribbon Express activities, as also in the various activities undertaken under the mainstreaming initiatives. A national level strategy paper for GIPA has been developed after wide ranging consultations.

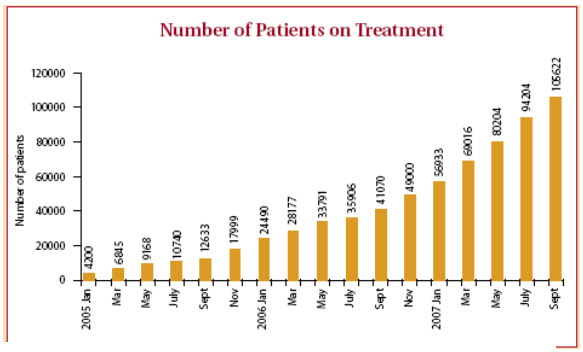


Figure 6
Source: NACO Update 2007

India has rolled out second line ART for those patients (~3 percent) experiencing treatment failure. As systems for ART stabilize, this figure will require validation, as also will current estimates of total number of people requiring 1st and 2nd line treatment. Over 80percent[24] of patients put on treatment is alive and continuing treatment after 12 months. Almost two thirds patients on ART are men, another 30 percent women - an improved proportion - and the remaining children and transgender.

A total of 96 Community Care Centres have also been established in high prevalence states to enable PLHA to get ART, to provide Counselling and follow-up on drug adherence, management of opportunistic infections and Nutrition Counselling, to provide pre-ART care for those PLHA who are not yet on ART through out reach and home-based services.

National Paediatric ART Initiative was launched on 30th November 2006. Paediatric drugs are provided at all ART centres. No. of children receiving ART increased from 1800[25] (Nov 06) to 8347 (December 07).

[24] WHO led COHORT study, 2004-2006
[25] NACO-CMIS

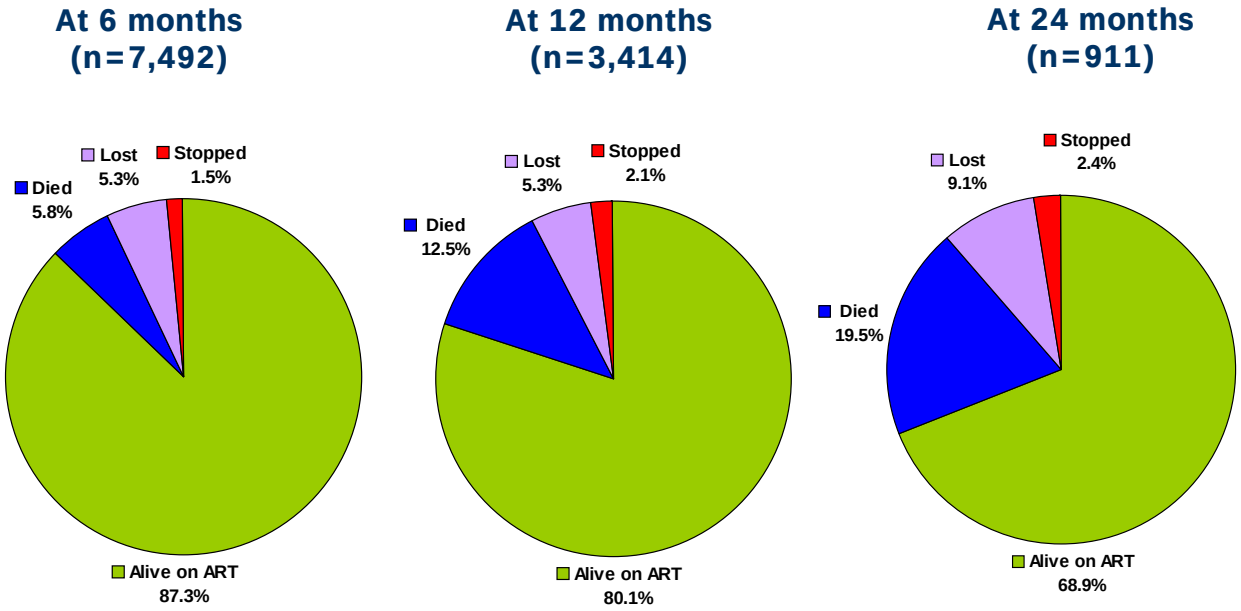
Of the 2.5 million people living with HIV, 94,000 are children (3.8 percent) and 2,37,6140 adults (Source: Technical report on HIV estimation -2006). Of these PLHAs, it is estimated that about 25 percent require ART i.e. 603,125 adults and 23,465 children. Of the adults requiring ART, 118,052 currently receive treatment (Dec 07, NACO-CMIS) – with a coverage of 20 percent[26]. Of the children with HIV requiring ART, 8347 are receiving ART i.e. coverage of 35 percentages[27].

The Clinton Foundation is supporting the Paediatric ART Initiative through the provision of treatment at 158 ART Centres and of care and support for over 11,000 CLHAs. CF works to improve access to diagnostic services related to HIV/AIDS, with a focus on CD4 testing and viral load testing for expansion to second line, including lab refurbishments and training of lab technicians. In addition to revamping the Computerized Management Information System (CMIS) on behalf of NACO, CF designed and implemented a computerized Patient Record System for paediatric cases registered at ART centres, which has been extended to adult cases. The Clinton Foundation is also committed to establishing a Centre of Excellence in HIV Nursing in Tamil Nadu on a PPP model to develop a nursing cadre that can manage the delivery of HIV/AIDS services more effectively, particularly in rural settings.

India's epidemic is not generalised and therefore the global and particularly sub-Saharan African concept of OVCs does not apply to India. After consultations, NACO and UNICEF have developed a concept of Children Affected by AIDS (CABA), which is relevant to India. A policy and action plan to address CABA has been developed and being finalised. This will provide the direction and details of the response.

Cohort tracking systems are being put into place. Meanwhile, a recent WHO led 11 centre cohort studies shows that 80 percent percentage of adults on antiretroviral therapy (12 months after initiation) are alive. Centre wise variations are from 77 percent to 90 percent. The variations in the percentage of people who died across centres ranged from 2 percent to 19.9 percent.

Figure 8
Source: WHO Cohort Studies 2006



[26] 2.5 Million people living with HIV, of which 96.5 percent adults (2,41,2500) of which 25 percent require ART (603,125) of which 147,400 on ART
[27] 87,500 x 25 percent is denominator. 7414 is numerator

Institutional Strengthening and Capacity Building

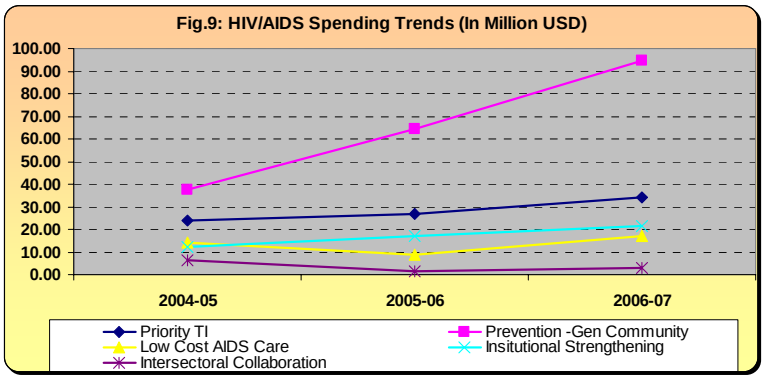
The aim of NACP-III is to build capacity of the programme managers at the national, state and district levels in leadership and strategic management; technical and communication skills of the health professionals and health care providers, CBOs and NGOs; and technical, communications and counselling skills of the grass-roots level workers and functionaries of various government departments.

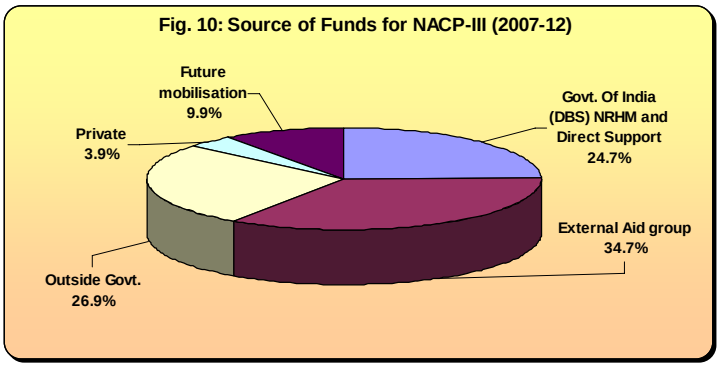
Strengthening Human Resource Capacity at NACO by enhancing strategic planning skills, disseminating best practices in TIs, establishing and managing a network of technical expertise through Technical Resource Groups (TRGs) in STI/HIV/AIDS, conducting Operations Research are some of the thrust areas for strengthening institutional capacity. NACO has also developed Project's financial management system for effective financial management of the programme.

Regional and state level training were organised as part of capacity building for health care providers under NACP-II. As on March, 2007, a total of 794,000 personnel were trained, including specialist doctors of medical colleges, general DMOs, nurses, IEC officers, counsellors, NGOs, lab technicians, blood bank officials and district nodal officers.

Financing and spending:

India is raising and spending significantly higher amounts of funds, so as to tackle the epidemic. Domestic AIDS Spending by categories and financing is showing a clear increasing trend, both with domestic and grant / loan funds. India has spent USD 171 Million during 2006-07 (April 2006 to March 2007) to contain and prevent the growth of HIV in the country. The corresponding figure for year 2005-06 was USD 133 million and for the year 2004-05 was USD 106 Million. HIV spending in India has seen a growth of 26 percent and 28 percent in 2005-06 and 2006-07 respectively. As can be seen from the graphical analysis presented alongside, maximum spending is in Prevention programmes for the general community wherein 91.81 Million USD has been invested in the year 2006-07. The second largest expenditure has been on Priority targeted interventions wherein 72.42 Million USD has been invested during 2006-07. Overall there is an upward trend in spending over the last three years in all major heads of HIV programming except for low cost AIDS care and Inter-sectoral collaboration which saw a little dip in the year 2005-06. The expenditure on these two heads have also picked up during 2006-07.





The detailed head and sub-head wise expenditure (in Million US Dollars) and details of sources of funds are in Annex C. What is critical for most programmes of the size of NACP III is effectively raising and spending the monies budgeted for. The track record of spending is summarised below:

Year	Revised Estimate	Expenditure Incurred	Percent spending
2002-2003	60.50	60.00	99.17percent
2003-2004	58.35	57.97	99.35percent
2004-2005	106.50	105.50	99.12percent
2005-2006	133.38	133.17	99.85percent
2006-2007	176.42	170.66	96.74percent

** All figures in Million USD*

India's development partners have diverse set of programmes, within the NACP III framework, and are major contributors in the response in the NACP-III. External aid component from the donor consortium is expected to bring in 35 percent of the NACP-III funding. Outside Government, with direct funding from the donors is expected to be 27 percent of the total NACP-III budget. Private players and industry also brings in 4 percent contribution of the overall response in the next five years.

Conclusion and outcome / impact of the Programme:

The NACP has made several strides in scaling up the Programme, partnering with a variety of stakeholders, putting in place operational guidelines and setting and achieving various programmatic targets. Some key outputs / achievement of the Programme include:

a) Rapid scale up of Targeted interventions for most at risk populations, with about 790 interventions in 2006, covering over 869,206 most at risk groups across the country.
b) 1250 million condoms[28] were supplied at no cost and 604 million were sold through social marketing.
c) 1088 blood banks, 85 blood component separation units and 10 State-of-art Model Blood Banks have been established. Over 10 million units of blood were collected in the last two years, of which 100 percentage were screened for HIV in a quality assured manner.
d) The number of integrated counselling and testing centres increased from 109 in 2001 to 4245 by September 2007. The number of persons tested in these centres increased from 0.14 million in 2001 to 5.91 million persons in 2007.
e) The number of STI clinics being supported by NACO has increased from 815 in 2005 to 845 in 2006. The reported number of patients treated was 1.9 million in 2006 and 2.5 Million in 2007.
f) Life skills education is now provided in 114,345 schools (79 percent) government secondary schools in the country.
g) There are 137 centres providing free ART to 118,052 (Sep.07). Of the estimated 23,465 children requiring ART, 8347 at the end of October 2007 are on ART.
h) 7-8 Percentage of HIV infected pregnant women has received antiretroviral to reduce the risk of mother to child transmission. Programme monitoring data shows that 6553 and 7718 mother and child pair have received ART (Regimen-1) during 2006
i) The Indian Network of Positive People (INP+) has supported establishment and strengthening of 22 state networks and 221 district networks in high prevalence states and districts
j) National Paediatric ART Initiative was launched on 30th November 2006. Paediatric drugs are provided at all ART centres. No. of children receiving ART increased from 1800[29] (Nov 06) to 8347 (December 07).
k) HIV spending in India has seen a growth of 26 percent and 28 percent in 2005-06 and 2006-07 respectively.

[28] In 2006
[29] NACO-CMIS

These achievements have translated into Programmatic outcomes and impact:

a) Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission has improved by 6 percent points[30].
b) Percentage[31] of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse has increased to 58 percent in 2006 (40 percent in 2001)
c) Percentage of women and men aged 15-49 who received an HIV Test in the last 12 months and who know their results is on the rise. According to the population based study NFHS III, 3.2 percent women and 3.8 percent men (adding up to 37 million) reported carrying out HIV test in the last 12 months
d) Percentage of female sex workers reporting the use of a condom with their most recent client is now about 88 percent[32] (76 percent in 2001).
e) 38 percent of FSWs (28 percent in 2001) and 69 percent (65 percent in 2001) MSMs have tested themselves for HIV.
f) 38 percent of FSWs in the last round survey (in 2006) compared to 2001 estimate of 22 percent have comprehensive knowledge of HIV transmission and prevention.
g) Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse is as high as 100 percent in Manipur and lowest in Kerala – 44 percent

Summary of indicators:

Domestic AIDS spending by categories and financing (UNGASS Indicator 1)
India is raising and spending significantly higher amounts of funds, so as to tackle the epidemic. Domestic AIDS Spending by categories and financing is showing a clear increasing trend, both with domestic and grant / loan funds. India has spent USD 171 Million during 2006-07 (April 2006 to March 2007) to contain and prevent the growth of HIV in the country. The corresponding figure for year 2005-06 was USD 133 million and for the year 2004-05 was USD 106 Million. HIV spending in India has seen a growth of 26 percent and 28 percent in 2005-06 and 2006-07 respectively.

Percentage of donated blood units screened for HIV in a quality assured manner (UNGASS Indicator 3)
100 percentage of donated blood units were screened for HIV in a quality assured manner.

Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (UNGASS Indicator 4)
Of the adults requiring ART, 118,052 currently receive treatment, which is coverage of 20 percent[33]. Of the children with HIV requiring ART, 8347 are provided with ART – coverage of 35 percentages[34].

Percentage of HIV infected pregnant women who received antiretroviral to reduce the risk of mother to child transmission (UNGASS Indicator 5)
Percentage of HIV infected pregnant women who received antiretroviral to reduce the risk of mother to child transmission now stands at 8 percent.

Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV (UNGASS Indicator 6)
Of the 85,000 patients with co-infection, 23 percent (19,400 in 2007– NACO-CMIS) are estimated to be under treatment.

Percentage of women and men aged 15-49 who received an HIV Test in the last 12 months and who know their results (UNGASS Indicator 7)
According to population based study - NFHS III, 3.2 percent women and 3.8 percent men reported carrying out HIV test. Among those who received HIV test, 87 percent women and 94 percent men reported having got their test results. Overall 3 percent women and 3.3 percent men have received test and know their results.

Percentage of schools that provided life skills based HIV education in the last academic year (UNGASS indicator 11)

[30] BSS 2006
[31] BSS 2006
[32] BSS 2006
[33] 2.5 Million people living with HIV, of which 96.5 percent adults (2,41,2500) of which 25 percent require ART (603,125) of which 147,400 on ART
[34] 87,500 x 25 percent is denominator. 7414 is numerator

So far, 114,345 schools (79 percent) have been covered out of 144,409 government secondary schools in the country.

Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child (UNGASS indicator 12)

India's epidemic is not generalised and therefore the global and particularly sub-Saharan African concept of OVCs does not apply to India. After consultations, NACO and UNICEF have developed a concept of Children Affected by AIDS (CABA), which is relevant to India. A policy and action plan to address CABA has been developed. This will provide the direction and details of the response.

Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission (UNGASS indicator 13)

There has been an improvement of *9 percent points*[35] in this indicator. At the all India level, two-third of the respondents having awareness of HIV/AIDS reported that the disease can be prevented by consistent condom use and by having one faithful uninfected partner (58 percent in 2001). More than two-fifth (43 percent) of the respondents correctly identified three common misconceptions on transmission of HIV/AIDS.

Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of fifteen (UNGASS Indicator 15)

Youth BSS shows that 3 percent of the young men and women aged 15-24 years had first sexual intercourse before the age of 15 years.

Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (UNGASS Indicator 16)

At the national level, 6 percent of the respondents in 2006 reported sex with non-regular partners during 12 months preceding the survey.

Percentage[36] *of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse (UNGASS Indicator 17)*

Condom usage in this category has increased to 58 percent in 2006 (40 percent in 2001).

Percentage of young women and men aged 15-24 who are HIV infected (UNGASS indicator 22)

The HIV prevalence among young women and men age 15-24 is showing a declining trend and is currently estimated at 0.57 percent.

Percentage of most at risk populations who are HIV infected (UNGASS Indicator 23)

Percentage of FSWs who are HIV infected has decreased significantly from 10.3 percent in 2003 to 9.43 percent in 2004, 8.44 percent in 2005 to 4.9 percent in 2006. IDUs show the highest prevalence of 6.92 percent among all the high risk groups at the all India level in 2006. Percent Positivity among Men who have Sex with Men is now 6.41 percent in 2006. Trends among MSM do not show any significant decline in the Southern states.

Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (UNGASS Indicator 24)

A recent WHO led 11 centre cohort studies shows that 80 percent percentage of adults on antiretroviral therapy (12 months after initiation) is alive.

[35] BSS 2006
[36] BSS 2006

V. BEST PRACTICES

HIV programme in the country is now nearly 15 years old. Several programmes had been implemented in the country through NACP I and NACP II. There are several best practices across the country, at the different provincial and district levels. The significant best practices at the national level are:

Revision of Estimates:

The year 2006 is a landmark in the history of HSS as well as the HIV estimation process. The surveillance network has expanded to 1,122 sentinel sites from 703 that existed the previous year, covering almost all districts of the country. Globally comparable estimates were derived using the WHO/UNAIDS Workbook, specially designed to estimate the HIV burden in low and concentrated epidemics. Further, the availability of multiple data sources this year added valuable inputs towards improving and refining the PLHIV estimates in India and provided ample scope to replace the assumptions with evidence-based values. These data sources are derived from the third round of National Family Health Survey, 2005-06 (NFHS-3), the second round of National Behavioural Surveillance Survey (BSS-2) as well as the Baseline Integrated Biological Behavioural Assessments (IBBA) and NACP-III size estimates for high-risk groups. In addition, consultative meetings with a large group of national and international experts ensured a better understanding of the data and providing reliable estimates.

NACP III Planning Process:

The Planning process for NACP III was a collaborative and consultative process that involved a wide range of stakeholders. There were planning meetings and consultations from the district level that involved the government, civil society including CBO, FBO and NGO, academic institutions and development partners as well as some UN organizations. The district level plans fed into the state level plans, after which the state level plans fit into the national level plans. The Planning process involved all relevant stakeholders, thus endorsing the Three Ones' principles. This process built ownership and accountability in the different stakeholders. In addition to workshops and the consultations, there were e-consultations over the internet as well. On 19 July 2005 the e-Consultation on Phase 3 of the National AIDS Control Programme (NACP-III) was launched. This e-Consultation, being carried out in partnership with the National AIDS Control Organization (NACO), provided feedback to the planning team on NACP-III, which has commissioned Working Groups to address the various topics.

Technical Resource groups (TRG)

NACO created a panel of TRG to provide technical support to organizations and departments involved in the HIV prevention and care programmes in the country. Panel of TRGs were created for counselling, condom programme, STI programme, formative research, Targeted intervention programme and M&E. TRGs have also been formed for ICTC, PPTCT, HIV-TB co-infection, for STI, and on NACP- NRHM Collaboration. TRGs have provided support in finalizing the manuals and guidelines, technical assistance to various States AIDS Control Societies for Programme Management. Overall eighteen TRGs have been formed with representation of 220 experts from different sectors such as academia, government, private sector and development partners.

Technical Support Unit (TSU)

The Concept of Technical Support Units had been implemented in the country in several states since the year 1997. The TSUs have played a pivotal role in providing technical and managerial support to

some of the key State AIDS Control Societies in the country. As part of NACP III, process of setting up 15 TSUs has been completed. TSU as a model is well evolved in the country and it has not only provided support to the programme but also has created valuable and trained human resource in the sector.

Operational Guidelines

In order to ensure standardization in programme implementation and facilitate quality control across board, operational guidelines for the various programme components have been finalized for NACP III. As of now 17 operational guidelines have been finalized. Following are the list of key guidelines now available in the country. *(Need clarity on the list of operational guidelines nos and the list below?)*

1. Operational Guidelines on ART Centres, March 2007.
2. Guidelines for HIV Testing, March 2007.
3. Guidelines for HIV Care and Treatment in Infants and Children, Nov 2006.
4. Operational Guidelines for Integrated Counselling and Testing Centres, April 2007.
5. Operational Manual on Strategic Information on Management Unit.
6. Guidelines for Prevention and Management of Common Opportunistic Infections.
7. Antiretroviral Therapy Guidelines for HIV infected Adults and Adolescents including Post-exposure.
8. Guidelines for Setting up Blood Storage Centres.
9. Standards for Blood Banks and Blood Transfusion Services.
10. Voluntary Blood Donation.
11. Targeted Interventions for Truckers – Operational Guidelines.
12. National Guidelines on Prevention, Management & Control of Reproductive Tract Infection
13. Targeted Interventions for High Risk Groups (Most at Risk Groups).
14. NGO CBO Operational Guidelines.
15. Targeted Intervention for Migrants – Operational Guidelines.
16. Operational Guidelines for Financial Management.
17. Surveillance Operational Guidelines.

VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS

Progress made on key challenges reported in 2005 UNGASS Country Report

Following were some of the challenges identified in 2005 UNGASS report. An update is presented below on how the challenges were handled:

Decentralised Planning

NACP III Planning process was a decentralized planning approach. Firstly a national level NACP III framework was developed and disseminated. States and districts were asked to understand their epidemic and prepare a state and district plans within this framework. Capacity building and technical assistance was provided to all the states in order to ensure quality in the process of writing the Programme Implementation Plan at the state and district level. The result is that the NACP III, for the first time is a plan which has involved several thousand of experts, practitioners and programme implementers.

Stigma and Discrimination

Attempts have been made through the programme to reduce the stigma and discrimination experienced by the PLHA and the Key Population. Several advocacy works has been undertaken with police, doctors and community leaders to sensitize them to the issues of HIV positive persons as well as the Key Population groups. IEC campaigns had been intensified to educate people to not to discriminate the PLHA. One of the key mile stones in the fight against stigma and discrimination is the successful collective action against some of provision in the ITPA which were disadvantageous to the Sex Worker community. In several states, progress has been made in reducing stigma experienced by the PLHA in the hospital settings and other public places. There is better acceptance of the PLHA by the community and the family. Support system is improving in many parts of the country for the PLHA. Several PLHA network groups have been formed in different states and the Indian Network of PLHA as well as the Positive Women Network has played a pivotal role in advocating for the issues of PLHA. Much more still needs to be done in this area.

Gender inequality

In India gender discrimination contributes to the spread of HIV especially among women; whether it is spouse of high risk men or women in to high risk behaviour. Lack of power to negotiate or assert their rights because of societal norms, access to proper information, access to health care, poverty etc have contributed to making the women vulnerable to HIV. Currently, 38 percent of those infected in the country are women.

In India efforts have been made to address the issue of feminization of the epidemic. IEC campaigns, World AIDS Day theme, the media, research studies in to this issue, have all contributed to high lighting this issue much more comprehensively with the policy makers. In the NACP III plan document there is a separate focus on women related prevention and care services. Empowerment approaches especially in the sex worker programmes is becoming the main stay while designing the targeted intervention programme. Already several model projects that have adopted this approach exist in the country. UNIFEM had piloted a gender focused HIV prevention project with the Indian Railways. The Link Worker programme, one of the key strategies of NACP III, is also aimed at reaching to the women especially in the village with prevention messages. Thus efforts have been intensified in the country to address the issue of HIV vulnerability to

women. This still remains a major challenge as the fight against century old societal norms and practice.

Children affected and vulnerable to AIDS

Though attempts have been made in the last couple of years to address the issues of children infected and affected by AIDS, still several issues still remains not adequately addressed. Lack of good data on the children affected or infected by HIV still plagues the programme planners to come out with effective and adequate programmes. Some of the attempts that have been made to reduce the vulnerability of children are through strengthening the reach of PPTCT programme, creating awareness to the public on the issues of children who are affected by HIV, research study undertaken by UNICEF to understand the issues of children affected by AIDS, evolving paediatric ART policy and guidelines etc. There is currently a policy on children affected by AIDS which was released on July 2007.

Young people

Young people form a large percentage of India's total population. Investing in good health and upbringing of youth is about nation building. HIV epidemic has posed a serious threat to this cause, as HIV affects mostly people in the age of group of 20 to 39 which is the most productive period of life. This is a period in which people travel for work and experiment with sexuality and sometimes get into other vulnerable behaviour like drug use. NACP III document gives special attention to youth and addressing their vulnerability. Link Worker programme is also aimed at reaching to the vulnerable youth especially in the rural areas. The Life Skill Education programme has reached 114,345 schools across the country. This is being mainstreamed in to the Education Department curriculum. Other programmes like Red Ribbon Club, Red Ribbon Train, Village talk AIDS, College talk AIDS are examples of attempts to address the youth.

Most-At-Risk Population (MARP)

Target Intervention (TI) programme has been the key strategy during the NACP II for reaching out to the MARP. TIs have received a boost during the first six months of NACP III. In the transition of NACP II to NACP III, 176 NGOs (out of 1128) were discontinued as their interventions were not focused on Most at Risk Groups. A survey which looked at the capacity of the NGOs in areas such as program management, human resource skills, application of protocols, financial management has been carried out for all NGOs working on TI. As a result, a further 163 NGOs had their contracts terminated, while others were put on an improvement plan or identified as model NGOs to be used for capacity building. With assistance of the Technical Resource Group (TRG) a TI manual has been prepared and distributed to all states.

Scale Up

Scale up of the programme and facilitating this has been one of the major challenges both in the prevention and Care and support programmes. Lack of adequate human resource and technical support has been key challenges that lead to slow progress in scale up. NACO has already put in place several remedial measures through recruitment and technical assistance. NACO has increased the size of its TI team from 1 to 15 and has recruited over 15 surveillance staff. Clear job descriptions have helped to ensure that the appropriate staffs is recruited, and that once in position, their terms and responsibilities are clearly assigned. In addition, it is recruiting centrally to fill critical vacant positions in SACS and over 15 TSUs have been finalized. To strengthen the programme in the North East a NACO sub-office is being set up. Besides to facilitate scale up and effective implementation of the programmes in the north East, that has two of the five high prevalent states, a joint UN support plan has been prepared for technical assistance with the support of AUS Aid.

Clear training plans have been prepared for both induction and refresher training; operational guidelines have been provided (and explained) to the SACS PD and their staff; and the first round

of training have been held for program staff ranging from counsellors to district supervisors. National External Quality Assessment Systems (NEQAS) have been strengthened and are being installed for testing services in ICTC and blood banks. TSUs have been appointed in all states, which shall have a special mandate of scale up. This has been done in partnership with Private and Civil Society.

Challenges Faced During Current Reporting Period

Decentralized data

Strategic Information Management System is being set up in the country for better management of data and facilitates effective monitoring of the programme. The greatest challenge in this area is the capacity of the states and the districts to effective implement the strategies of Strategic Information Management and also to appoint skilled human resource in adequate numbers at all levels to manage the system. It is also a big challenge to ensure the quality of data at all levels.

There is also no system for capturing data from private providers and civil society led programs, which is a huge portion of the overall HIV program in the country. Quality and consistency of data is also problematic. There are expressed needs for a robust M and E system, supplemented by appropriate human resources and capacities.

ART cohort tracking

There are several problems with the ART programme reporting in India. Cohort tracking of ART is being attempted with some pilots getting completed. Because of the stigma attached to the disease and the adherence issues that are made difficult by the access issues, there are serious problems in tracking information about patients. Moreover, patients going to Private sector are not fully tracked. There is a need to strengthen the capacity and systems be put in place to facilitate effective cohort tracking for ART. Based on the pilots, India now plans a more expanded Smart card based Cohort tracking system.

Capacity building

Capacity building – both in numbers and quality is a key challenge. The number of persons to be runs into millions. The subjects are very diverse and many times about attitudes more than skills. A cost effective Capacity Building system operating at various levels is essential.

Human resources

Making available in adequate number, skilled and effective human resource at all levels of programming. What has most often marred effective programme management at the state level is the constant transfers and change of leadership. At the implementer's level, finding good quality and committed human resources has been difficult.

Governance

Governance structures in managing HIV and AIDS Programmes have been quite carefully thought through and are in place in the country, both at the centre and at the state level. The challenge is in ensuring these structures are made operational and function effectively. Effective capacity building and advocacy plan will need to be evolved in order ensure good participation of political leadership in the governance process both at the centre and the state. The governance structure also should give space for community participation and provide adequate capacity building to facilitate active participation in the governance process. There is also no civil society federation or network that adequately represents the voice of civil society across the regions and typologies. There needs to be such a mechanism in place.

VII. SUPPORT FROM COUNTRY'S DEVELOPMENT PARTNERS

India's development partners work closely in responding to the HIV epidemic; they include multi-laterals (UNICEF, UNAIDS, UNFPA, UNODC, ILO, UNDP, WHO, World Bank, GFATM), bi-laterals (DFID, EC, USAID, AusAid etc), International NGOs (e.g. Catholic Relief Services, Population Services International, Family Health International etc), Foundations (e.g. Clinton Foundation, Gates Foundation) and private players including industry.

India's development partners have diverse set of programmes, within the NACP III framework and are major contributor in the response in the NACP-III. External aid component from the donor consortium is expected to bring in 35 percent of the NACP-III budget (See Annex C for details). While financial support is crucial, the country's various development partners have a major role to play, with each partner with their respective areas of technical contribution within the NACP III framework, in the spirit of the Three Ones principle. This kind of coherent support will indeed assist India in meeting national and international targets. Examples of the roles played by diverse players are listed below:

a) WHO is supporting India in the areas of prevention of HIV transmission in healthcare settings, blood safety, counselling and testing, sexually-transmitted infection diagnosis and treatment, and linkages of HIV prevention with AIDS treatment services, Antiretroviral treatment and monitoring, prophylaxis and treatment for opportunistic infections (adults and children) and establishment and implementation of surveillance for HIV, through sentinel/population -based surveys.
b) UNICEF continues to work with young people to provide them with life skills, services and a supportive environment. On Paediatric AIDS, UNICEF has established a new partnership to roll out paediatric AIDS. A guideline has been developed for the management of paediatric AIDS and completed the training of all the paediatricians in the 40 ART centres. An intense drive to list and bring children who are exposed to HIV for screening and treatment is underway.
c) UNDP is taking the lead on Mainstreaming and is setting up mainstreaming cell at NACO and six SACS. The duration of the project is five years.
d) UNFPA has released a paper on intersectoral convergence of HIV with RCH, making HIV part of RCH initiatives and taking it below the district level.
e) The joint UN support plan details out the technical support plan of the UN system to the National HIV/AIDS control project in India. This plan is closely linked to the Government of India plan of action.
f) World Bank's non-lending activities in India largely involve policy and strategy dialogue, technical and economic advice, and advocacy to spur countries to act promptly and effectively against the threat of HIV. The Bank also assists in developing strategies for tackling HIV and has mobilized technical advisory services, which focus on capacity building and training, sharing of knowledge, best practices, and lessons learned.
g) ILO provides technical support to partners (Ministry of Labour and Employment, NACO/SACS, workers' and employers' organizations, state labour departments, enterprises and civil society organizations to strengthen their response capacity for developing and implementing an expanded world of work response to HIV/AIDS.
h) UNODC has been working closely with the Ministry of Social Justice and Empowerment on integrating HIV issues in all their drug use programs.

i) DFID is supporting NACO in the eight focus states: Orissa, West Bengal, Andhra Pradesh, Gujarat, Kerala, Madhya Pradesh, Uttar Pradesh and Bihar. A Project Support Unit (PSU) has been established in each state which helps the State AIDS Control Society (SACS) manage their activities.
j) USAID supports two bilateral initiatives in Tamil Nadu and Maharashtra. The AIDS Prevention and Control Project (APAC) are being implemented in Tamil Nadu since September 1995. It aims at prevention of HIV transmission among female sex workers and their clients and those reporting

STIs. In Maharashtra, USAID supports the AVERT society to reduce transmission and mitigate the impact of sexually transmitted infections. In Karnataka, USAID supports the University of Manitoba to implement a state-wide care and treatment program and prevention program in rural areas. USAID supports private sector initiatives and provides technical assistance to NACO and the states through other partners, including supporting six state-level Technical Support Units.

k) BMGF supports prevention interventions among key Most at Risk Groups in six high-prevalence states and a program for truck drivers on highways. BMGF supports strategic initiatives including integrated communications, advocacy, knowledge building and impact monitoring and capacity building.

l) The Clinton Foundation is supporting the Paediatric ART intervention in India besides rehabilitation of the infected and affected children. In addition, Clinton Foundation is also assisting NACO to train over 150,000 private sector doctors in HIV/AIDS care and treatment. The Clinton Foundation is also committed to establishing a Centre of Excellence in HIV Nursing in Tamil Nadu on a PPP model and providing in-service training to 25,000 nurses working in public health facilities throughout the country.

These technical support and interventions are complementary to the Government's efforts on tackling HIV and AIDS.

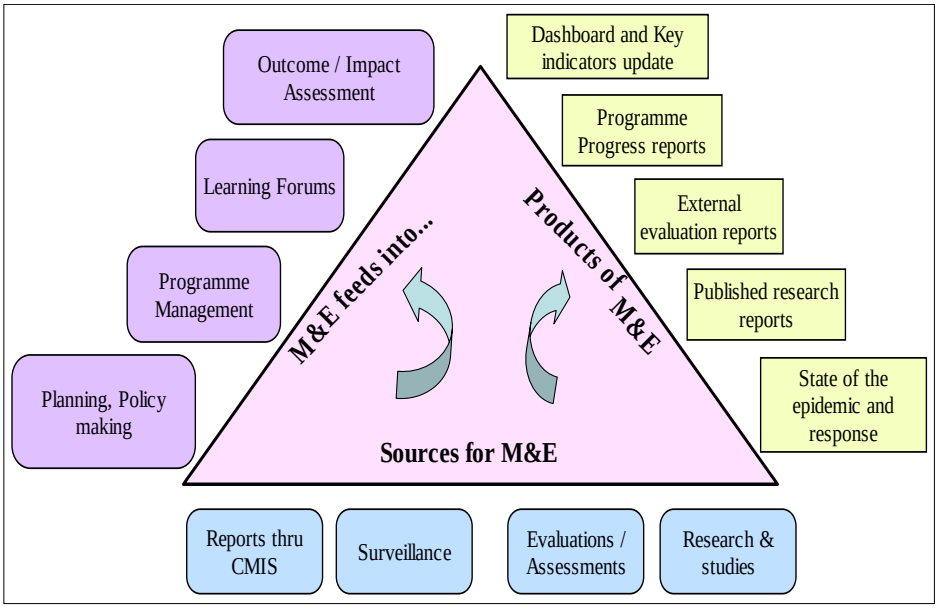
VIII. MONITORING AND EVALUATION ENVIRONMENT

Overview of the M&E System:

Epidemiological model predicts that if 75percent of the targets laid down in Project Implementation Plans are achieved, the number of person infected with HIV can be brought down to well below 4 million by 2011, with the epidemic gradually tapering down. The Monitoring and Evaluation System of the NACP III program is critical in measuring and reporting progress or lack of it, so that action can be taken.

The NACP III has a vision going beyond M&E and towards Strategic Management Information. With this in mind, NACP III has set up a Strategic Management Information Unit (SIMU) at the national and state level, which brings together M&E, Surveillance, and operational research. Establishment of SIMU is a step in intensifying efforts on improving data quality from all data sources.

The SIM system in the country is fully aligned with the local, national and Global information needs. This is done through matching information needs and collection mechanisms. The M&E mechanisms in NACP-III are:



1. Internal M&E system at implementation unit level – NGOs, Blood Banks, STI clinics etc., focusing on self assessment and analysis with support from resource teams as required
2. Computerised Management Information System – a national level information sourcing and analysis software
3. The Behaviour Surveillance Surveys (BSS) – Two Rounds of which were completed nationally (2001 and 2006). This provides information on knowledge and behaviour related aspects for youth (15-24 years age), general population and most at risk population (MSM, FSWs, Clients of FSW, IDUs)
4. The National Sentinel Surveillance – A nation wide system which collects and presents sero prevalence data from general population, ANC clinics and Most at Risk Group samples
5. External outcome studies and programme and thematic evaluations
6. District level vulnerability assessment and other research studies as required during program implementation
7. Computerized Project Financial Management System (CPFMS)

Additionally, programme sources and analyse information from population based study National Family Health Survey (NFHS). The third round of NFHS has gathered knowledge, behavioural and prevalence rated crucial information through a large survey (more than 100,000 sample respondents)

There are a few key challenges faced by SIM system:

- Data from the Private sector still does not flow into the Government system, making all data largely public sector oriented.
- There is a shortage of Staff for managing SIMUs at state level and capacities to utilise strategic information varies across states
- Infrastructure requires upgrading to meet the key challenges which face the SIMU both at national and sub-national levels.

There are several steps being taken to address these problems. Some of them are listed below:

a) Operational Guideline for Strategic Information Management Unit (SIMU) have been developed, which will help roll out the SIMUs at state level.
b) A handbook on Core Indicators has been developed to help standardise and simplify collection and analysis
c) Assessment of infrastructure in terms of computers and net-connectivity has been carried out and basic infrastructure is recommended to each SACS
d) An assessment of existing staff was carried out to check suitability to carry out functions envisaged in NACP-III. Accordingly the staffs found suitable was allowed to continue and the rest of the positions were advertised and staff replaced.
e) To have clarity on the roles, the job descriptions for each position of SIMU at SACS and NACO have been developed.
f) Trainings have been organized for M&E staff and epidemiologists on better management of data from CMIS and surveillance.
g) An interactive website www.nacoonline.org has recently been established and is helping the program in managing data better.
h) Hand-holding support, on-site mentoring and supportive supervision system have been put in place for the states.

A national M&E working group consisting of M&E experts from all development partners provides regular technical support to overall functioning of M&E. The M and E environment is improving however there are still many challenges. Lessons have been learnt and new strategies developed. Some remedial actions have seen success, and while other fixes are long term. This new system has paved the way for improved monitoring and better utilization of information toward evidence based planning and program implementation.

Annex A – Description of Key Data Sources used

Computerised Management Information System (CMIS):
India's response to HIV epidemic is influenced by the available surveillance data, implementation capacities and political commitment at state and national level. Apart from the sentinel surveillance, nationwide Computerised Management Information System (CMIS) provides strategic information on the programme. CMIS is one of the largest software applications in the development sector in the country, collecting, storing and analysing reports from more than 8000 reporting units every month. The utility of the CMIS is in:

- Streamlining of HIV/AIDS progress reporting & monitoring system at all levels (sub-district, district, state and national)
- Easier, faster and reliable data reporting & analysis
- Feeding back of analysis into programme planning and decision making process - A learning tool for improving programme delivery at every stage of NACPIII and at every level

HIV Sentinel Surveillance:
The HIV sentinel surveillance system in India is a source of longstanding trend data. HIV surveillance in India was started from the year 1985 when Indian Council for Medical Research for the first time initiated the surveillance activity in blood donors, and STD patients. After NACO, was established in 1992, sentinel surveillance for HIV/AIDS in India had been initiated, with sentinel sites confined to selected cities in the beginning. In 1998, NACO formalized annual sentinel surveillance with 180 sentinel sites. Over the years, the numbers of sentinel sites were increased from 180 in 1998 to 703 in 2005. This was expanded greatly for the 2006 surveillance round to a total of 1,122 sites. From the year, 2003, surveillance of ANC (rural) sites, TB sites, migrant population and truckers has also been initiated to understand the spread of the epidemic in these groups.

National Behavioural Surveillance Survey (BSS):
In order to develop strategic programme initiatives, NACP-III has given great importance to evidence based planning and strengthening of Surveillance, Research and Monitoring. HIV surveillance is a crucial component providing information for programmatic decision making and planning. HIV Surveillance includes HIV Sentinel Surveillance, AIDS Case Surveillance, STI Surveillance and Behavioural Surveillance. While the initial three components assess the epidemic after it has emerged, behavioural surveillance provides an understanding of the high risk behaviours that predispose to the emergence of an epidemic. It also provides inputs on the knowledge, awareness and practices of different population groups that may make them vulnerable to HIV infection.

NACO conducted the first National Behavioural Surveillance Survey (BSS) in the year 2001 i.e. towards the beginning of NACP II Project. After a gap of five years since the first BSS, NACO has commissioned the second wave of BSS to measure the changes in behavioural indicators. The BSS 2006 has been carried out among general population as well as High Risk Groups (female sex workers, males who have sex with males, Client of female sex workers and intravenous drug users) following similar approach adopted in BSS 2001.

The aim of carrying out the BSS 2006 was to assess current risk behaviour in specific population in India and to develop a database so as to measure behavioural changes from BSS2001 to BSS 2006.

National Family Health Survey:
The National Family Health Surveys (NFHS), population based study has emerged as a nationally important source of data on population, health, nutrition and now HIV /AIDS for India and its states.

The 2005-06 NFHS, third in the series of these national surveys, was preceded by NFHS-1 in 1992-93 and NFHS-2 in 1998-99. NFHS-3 is designed to provide estimates of the important indicators on family welfare, maternal and child health, and nutrition. In addition, NFHS-3 provides information on several and new emerging areas, including family life education, safe injections, peri-natal mortality, adolescent reproductive health, high risk sexual behaviour, Tuberculosis and Malaria. Further unlike the earlier surveys in which only ever married women aged 15-49 were eligible for interviews, NFHS-3 interviewed all women age 15-49 and all men aged 15-54.

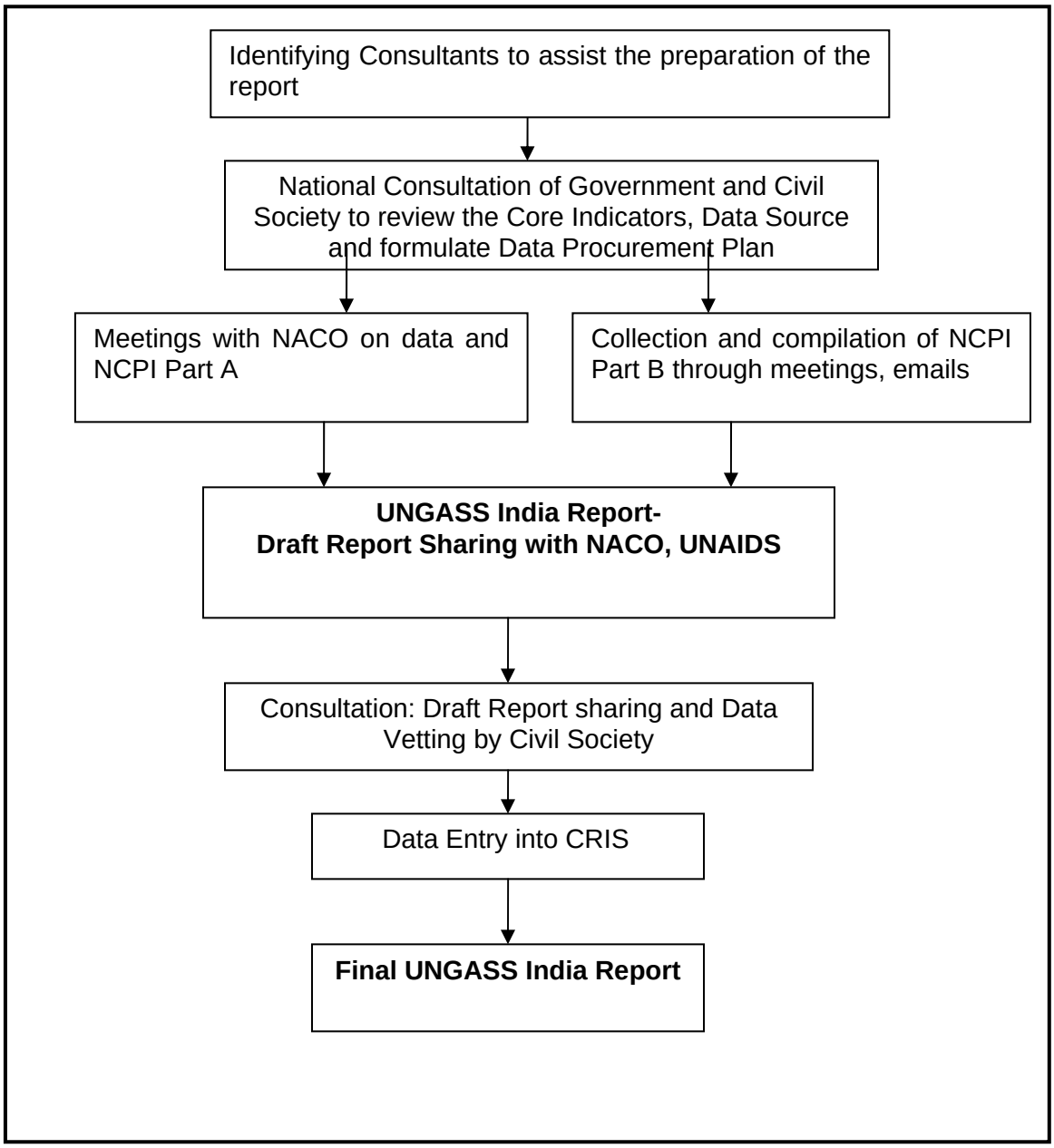
A special feature of NFHS-3 is the inclusion of testing of adult population for HIV. NFHS-3 is the first nation wide community based survey in India to provide an estimate of HIV prevalence in the general population.

NFHS-3 collected information from a nationally representative sample of 109,041 households, 124,385 women age 15-49, and 74,369 men age 15-54. The NFHS-3 sample covers 99 percent of India's population living in all 29 states. From among all the women and men interviewed nationwide, 102,946 were tested for HIV.

Like its predecessors, NFHS-1 (1992-93) and NFHS-2 (1998-99), the latest round NFHS-3 (2005-06) was conducted when there was a need to have the baseline information on crucial reproductive and child health, nutrition, life cycle and HIV /AIDS related indicators due to launching of Phase-2 of Reproductive and Child Health programme and NACP-III.

Annex B – Process of consultation

NACO initiated discussion early in November 2007 for preparing the UNGASS India Report, 2008. The India Report is prepared based on the inputs from the government and the civil society including donor partners. The process followed:



- ***Identifying Consultant:*** Consultants were identified to assist NACO in preparing the report.
- ***Reviewing the Core Indicators, Data Sources and preparation of the data procurement plan:*** A national consultation was arranged to review the core indicators and data sources and planning for data collection and was carried out in December 2007. Key staffs from NACO, representatives

of development partners and civil society were a part of this meeting. The core indicators, data source and assumptions were discussed. Based on this, a data procurement plan was prepared.

- ***Desk Review and Key Informant Interviews:*** Documents were reviewed and officials from NACO were interviewed to collect data for the report. This formed the basis for the qualitative report.
- ***Collecting and Compiling Data -*** Data was put together from various sources which include Behavioural Surveillance Survey (BSS), HIV Sentinel Surveillance (HSS), Computerized Management Information System (CMIS) and data available with development partners.
- ***Sharing on e -Forums-*** The National Composite Policy Index Questionnaire was shared in key e-groups -. Aids-India, H&D Net, solutions exchange, SAATHI and AIDS ASIA. The responses from the civil society were triangulated with the subsequent consultation held on 29th January 08.
- ***Training on CRIS:*** The CMIS Consultant in NACO as well as Swasti was trained on feeding information into the Country Response Information System in a training workshop in UNAIDS-India office in December 2007.
- ***Sharing of Draft Report and data vetting by NACO and Civil Society:*** The draft report was shared with NACO, and civil society and the data was vetted before finalising the report. The civil society data-vetting workshop was held on 29th January at Delhi where representatives from 29 civil society groups were present.
- ***Data Entry:*** The finalised information was entered into CRIS
- ***Finalizing UNGASS India 2008 Report:*** The feedback from the consultations was incorporated into the final report, which was forwarded to UNAIDS by NACO.

Annex C – Sources of Funds and Expenditure

Sources of Funds for NACP-III		
Details of Donor support		
S.No.	**Source**	**Amount *(In Million USD)***
I	**Govt. Of India (DBS) NRHM and Direct Support**	**715.25**
II	EAC (External Aid Comp)	
i.	- World Bank	281.25
ii.	- DFID	202
iii.	- GFATM (II, III, IV & VI)	446.75
iv.	- UNDP	17.75
v.	- USAID	56.25
	Sub-total	**1004**
III	**Outside Govt. (Direct funding from other donors) - Committed**	
i.	- UN	63
ii.	- DFID	13.5
iii.	- Gates Foundation	356.25
iv.	- USAID	112.5
v.	- Clinton Foundation	28.25
vi.	- Other Bi-laterals	15.75
vii.	- Other Foundations	38.75
viii.	- EU	19.25
ix.	**Other sources** (Recipient from Global Fund such as Population Foundation of India, Alliance International and other international donors	130.75
	Sub-total	**778**
IV	**Private** (Projected and includes funds to be spent by private industry on preventive services to their employees)	**112.5**
V	**Future mobilisation**	
	Global Funds future rounds	112.5
	World Bank IDA 15 supplementary fund	174
	Sub-total	**286.5**
	Grand Total	**2896.25**

Actual expenditure of the Programme in last three years

In Million USD

S.No.	Heads and Sub-heads of Accounts	Total Expenditure 2004-05	Total Expenditure 2005-06	Total Expenditure 2006-07
1	**Priority Targeted Intervention against HIV/AIDS**			
1.1	Minor Civil Works	0.06	0.20	0.38
1.2	STI Drugs for STD Clinics	0.67	1.47	2.26
1.2.1	Purchase of equipment for STD Clinics	0.00	0.00	0.00
1.2.3	Condom Promotion	0.41	0.46	0.00
1.4	Operation Research and other studies	0.06	0.03	0.07
1.5	NGO support for TIs	25.39	26.65	30.24
1.6	Consultant Services	0.12	0.17	0.33
	others	0.00	1.44	0.97
	Sub Total	**26.71**	**30.44**	**34.26**
2	**Preventive Interventions for the General Community**			
2.1	Minor Civil Works	0.17	0.60	0.89
2.2	IEC and Awareness	16.14	27.39	34.13
1.2.2	School AIDS Education	1.94	5.18	9.38
2.3.1	Voluntary Testing and Counselling	4.01	7.47	11.75
	Equipment for VCTCs	0.12	0.05	0.09
2.3.1	External Quality Assessment	1.97	0.12	0.22
2.4	Blood Safety:	7.91	11.51	15.99
2.4.1	Equipments for blood units	0.96	1.29	2.44
2.5	Operation Research /Studies	0.01	0.03	0.06
2.7	Consultant Services for communication need assessment anf for evaluation of IEC activities	0.07	0.08	0.07
	PPTCT project in hospitals and Medical Colleges	8.01	13.44	15.09
	HIV kits	0.00	0.04	0.10
	others/FHAC	0.96	5.22	4.59
	Sub Total	**42.26**	**72.42**	**94.81**
3	**Low Cost AIDS Care**			
3.1	Civil Works	0.02	0.07	0.13
3.2	Equipment (FAX machine)	4.81	0.13	0.24
3.3	Drugs for Opportunistic Infections	6.11	1.67	1.32
	CD4 /CD8 Count testing	0.00	0.00	0.00
3.4	Community Care Centres	1.97	2.37	4.47
	Drop in centres	0.00	0.00	0.00
3.6	IEC related to PLWAs	0.00	0.03	0.07
3.7	Operation Research/Studies	0.11	0.03	0.05
3.9	Consultant Services	0.00	0.00	0.00
	Centre for excellence	0.00	0.00	0.00
	ARV drugs	2.91	1.71	4.37
	ART centre	0.00	3.86	6.27

In Million USD

S.No.	Heads and Sub-heads of Accounts	Total Expenditure 2004-05	Total Expenditure 2005-06	Total Expenditure 2006-07
	Sub total	**15.93**	**9.87**	**16.92**
4	**Institutional Strengthening**			
4.1	Civil Works	0.12	0.64	1.20
4.2	vehicles	0.11	0.09	0.18
4.4	Surveillance	0.90	1.02	1.93
4.5	Training	1.99	4.22	2.21
4.6	Monitoring and Evaluation	0.15	0.02	0.04
4.7	Operation Research/Research and Development	0.01	0.01	0.02
4.8	Salary	4.11	5.18	9.51
4.8.1	Operational Expenses	5.87	7.04	5.03
4.8.2	Furniture & fixtures and office equipments	0.38	0.59	1.11
	Care & Support	0.00	0.23	0.43
	Sub Total	**13.64**	**19.05**	**21.67**
5	**Intersectoral Collaboration**			
5.1	Training & Workshops	1.01	0.30	0.57
5.2	STI/OI Drugs	0.00	0.00	0.00
5.8	IEC and Awareness	5.94	1.29	2.43
5.3	NGO Services	0.00	0.00	0.00
5.4	Limited Equipments	0.00	0.00	0.00
5.7	Professional Services	0.00	0.00	0.00
	Sub Total	**6.96**	**1.59**	**3.00**
	GRAND TOTAL	**105.50**	**133.38**	**170.66**

Annex-D: National Composite Policy Index – Part A

1. Strategic Plan

1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?
(Multisectoral strategies should include, but are not limited to, those developed by Ministers such as the ones listed under 1.2)

Yes	**X**	Period covered :***2007- 2012***	Not Applicable (N/A)		No	

***IF No or N/A, briefly explain**:*

IF YES, complete questions 1.1 through 1.10 ; otherwise, go to question 2.

1.1. How long has the country had a multisectoral strategy/action framework?

National AIDS Committee was constituted in 1986 and a National AIDS Control Program was launched in year 1987. A medium term plan for HIV/AIDS, was developed in year 1989. In 1991 a "Strategic Plan for Prevention and Control of AIDS in India" was prepared for the five-year period 1992-1999. The main aim of the plan was to establish a comprehensive, multi-Sectoral program for prevention and control of HIV/AIDS. Ever since then, the country has had NACP II (1999-March 2006). NACP III , the current multi-sectoral strategy and action framework from 2007 to 2012.

1.2. Which sectors are included in the multisectoral strategy / action framework with a specific HIV budget for their activities ?

Sectors included	Strategy/Action framework				Earmarked budget			
Health	Yes	**X**	No		Yes	**X**	No	
Education	Yes	**X**	No		Yes		No	**X**
Labour	Yes	**X**	No		Yes		No	**X**
Transportation	Yes	**X**	No		Yes		No	**X**
Military / Police	Yes	**X**	No		Yes	**X**	No	
Women and Children	Yes	**X**	No		Yes	**X**	No	
Young people	Yes	**X**	No		Yes		No	**X**
Rural Development	Yes	**X**	No		Yes		No	**X**
Tribal Affairs	Yes	**X**	No		Yes		No	**X**
Urban Development	Yes	**X**	No		Yes		No	**X**
Tourism	Yes	**X**	No		Yes		No	**X**

IF NO earmarked budget, how is the money allocated??

1.3. Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations				
a. Women and girls	Yes	**X**	No	
b.Young women / young men	Yes	**X**	No	
c.Specific vulnerable sub-populations	Yes	**X**	No	
d.Orphans and other vulnerable children	Yes	**X**	No	
Settings				
e.Workplace	Yes	**X**	No	
f.Schools	Yes	**X**	No	
g.Prisons	Yes	**X**	No	
Cross-cutting issues				
h. HIV,AIDS and poverty	Yes		No	**X**
i. Human rights protection	Yes	X	No	
j.PLHIV involvement	Yes	**X**	No	
k.Addressing stigma and discrimination	Yes	**X**	No	
l.Gender empowerment and/ or gender equality	Yes	**X**	No	

1.4. Were target populations identified through a process of a needs assessment or needs analysis ?

Yes	**X**	No	

IF YES**,** when was this need assessment / analysis conducted?

The needs assessment is an ongoing process. The latest SNA was completed before the finalization of the State PIPs and the NACP III planning. The states as well as the national program planning was done based on evidence gathered from country wide situational analyses and other studies.

IF NO, how were target populations identified ?

1.5. What are the target populations in the country?

The Target groups in the country are identified as Key Population Groups. The KPG are Female Sex Workers (FSW), Men who have sex with Men (MSM) and Injecting Drug Users (IDUs).

1.6. Does the multisectoral strategy/action framework include an operational plan?

Yes	**X**	No	

1.7. Does the multisectoral strategy/action framework or operational plan include :

a. Formal programme goals?	Yes	**X**	No	
b.Clear targets and / or milestones?	Yes	**X**	No	
c.Detailed budget of costs per programmatic area?	Yes	**X**	No	
d.Indications of funding sources?	Yes	**X**	No	
e.Monitoring and Evaluation framework?	Yes	**X**	No	

1.8. Has the country ensured " Full involvement and participation" of civil society in the development of the multisectoral strategy/action framework?

Active involvement	**X**	Moderate involvement		No involvement	

I***B***riefly explain how this was done :

Civil societies have established a very strategic role for themselves in delivering key programmes through government partnership. The NACP III planning processes were inclusive of all stakeholders, particularly the civil society (NGOs and CBOs) and was a country wide exercise involving thousands of experts, practitioners and programme implementers.

IF NO or MODERATE involvement , briefly explain :

1.9. Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals ; multi-laterals) ?

Yes	**X**	No	

1.10. Have external Development Partners (bi-laterals ; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?

Yes , all partners	**X**	Yes, some partners		No	

I***F SOME or NO*****,** briefly explain

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

Yes	**X**	No		N/A	

2.1. ***IF YES****,* in which development plans is policy support for HIV and AIDS integrated?

A	**X**	B	**X**	C		D		E	***CMP***

CMP: Common Minimum Program of the Central Government.

2.2. ***IF YES****,* Which policy areas below are included in these development plans?

✓ Check for policy / strategy included

Policy Area	**Development Plans**				
	a)	**b)**	**c)**	**d)**	**e)**
HIV Prevention	X	X			X

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
Treatment for opportunistic infections	X	X			X
Antiretroviral therapy	X	X			X
Care and support (including social security or other schemes)	X	X			X
AIDS impact alleviation	X	X			X
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	X	X			X
Reduction of income inequalities as they relate to HIV prevention/treatment, care and /or support	X	X			X
Reduction of stigma and discrimination	X	X			X
Women's economic empowerment(e.g. access to credit, access to land, training)	X	X			X
Other : Strengthening of health systems	X	X			X

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?

Yes	**X**	No		N/A	

3.1. ***IF YES****,* to what extent has it informed resource allocation decisions?

LOW										HIGH
0		1		2		3		4		5	**X**

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

Yes	**X**	No	

4.1. ***IF YES,*** Which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	Yes	**X**	No	
Condom provision	Yes	X	No	
HIV testing and counselling *	Yes	**X**	No	
STI services	Yes	**X**	No	
Treatment	Yes	**X**	No	
Care and support	Yes	**X**	No	
Others: [write in]	Yes		No	

* ***What is the approach taken to HIV testing and counselling?*** Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain : Testing and counselling is always through informed consent and is voluntary.

5. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes	**X**	No	

5.1. Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

Yes	X	No	

5.2. Have the estimates of the size of the main target population sub-groups been updated?

Yes	X	No	

5.3. Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates and projected needs	**X**	Estimates only		No	

5.4. Is HIV and AIDS programme coverage being monitored?

Yes	**X**	No	

5.4.1. ***IF YES***, is coverage monitored by sex (male, female)?

Yes	**X**	No	

5.4.2. ***IF YES***, is coverage monitored by population sub-groups?

Yes	**X**	No	

IF YES, which population Sub-groups?
High Risk Population(FSW, MSM, IDU), Pregnant women, TB Patients

5.4.3. ***IF YES,*** is coverage monitored by geographical area?

Yes	**X**	No	

IF YES, at which levels (provincial, district, other)? ***District level***

5.5. Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes	**X**	No	

Overall, how would you rate the strategy planning efforts in HIV and AIDS programmes in 2007 and in 2005?																					
2007	Poor																			Good	
0		1		2		3		4		5		6		7		8	**X**	9		10	
2005	Poor																			Good	
0		1		2		3		4		5	**X**	6		7		8		9		10	

Comments on progress made since 2005 :

The strategic planning efforts this time round has involved all the relevant stakeholders. The principles of Three Ones' were applied strongly, and there was wide participation fro development partners as well as civil society both at the national level as well as the provincial levels. Planning processes also included other sectors like women and child development, tribal affairs, rural department and local self governments, labour ministry, ministries of social justice and empowerment, education etc. The plans also include systems of monitoring the plan and systems for adaptation of the program should the situations change. This was a landmark effort, in evidence based and participative planning.

2. Political support

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

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

President / Head of government	Yes	**X**	No	
Other High officials	Yes	X	No	
Other officials in regions and / or districts	Yes	X	No	

2. Does the country have an officially recognized national multisectoral AIDS management/coordination body?(National AIDS Council or equivalent)?

Yes	**X**	No	

IF NO, briefly explain :

2.1. ***IF YES***, when was it created? Year ***1992***

2.2. ***IF YES***, who is the Chair?
[write in name and title/function]

Shri. Man Mohan Singh, Hon'ble Prime Minister, Government of India
Functions: 1. To review the progress of the National AIDS Control efforts.
2. To involve all the departments/ sectors in HIV/ AIDS control efforts.

2.3. ***IF YES***, does it :

Have terms of reference?	Yes	**X**	No	
Have active Government leadership and participation?	Yes	**X**	No	
Have a defined membership?	Yes	**X**	No	
Include civil society representatives?	Yes	**X**	No	
IF YES, what percentage? [write in] ***25percent***				
Include people living with HIV?	Yes		No	X
Have an action plan?	Yes	**X**	No	

Have a functional Secretariat?	Yes	**X**	No	
Meet at least quarterly?	Yes		No	X
Review actions on policy decisions regularly?	Yes	**X**	No	
Actively promote policy decisions?	Yes	**X**	No	
Provide opportunity for civil society to influence decision-makings?	Yes	**X**	No	
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	**X**	No	

3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, **civil** society and the private sector for implementing HIV and AIDS strategies / programmes?

Yes	**X**	No	

3.1. ***IF YES***, does it include?

Terms of reference	Yes	**X**	No	
Defined membership	Yes	**X**	No	
Action plan	Yes	X	No	
Functional Secretariat	Yes	X	No	
Regular meetings	Yes	X	No	
	Frequency of meetings:			
	HALF YEARLY			

IF YES*,* What are the main challenges for the work of this body?

- ***The urgency of the work is not comprehended by all stakeholders, therefore priorities within the program differ***
- ***Coordination of a large multi stakeholder body is difficult, and therefore taking actions on decisions is time consuming***
- ***Influencing and advocating to the different ministries, whose goals are dissimilar***
- ***Staffing within the organization: capacitated, motivated human resources, high rates of attrition***
- ***Understaffed and overworked members of the organization as well as the Secretariat.***

4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?

   Percentage: ***25 – 30percent***

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes	**X**	No	
Technical guidance / materials	Yes	X	No	
Drugs/supplies procurement and distribution	Yes	X	No	
Coordination with other implementing partners	Yes	X	No	

Capacity-building	Yes	X	No	
Other: [write in]				

6. Has the country reviewed national policies and legislation to determine which, if any , are inconsistent with the National AIDS Control policies?

Yes	**X**	No	

6.1. ***IF YES***, were policies and legislation amended to be consistent with the National AIDS Control policies?

Yes		No	**X**

6.2. ***IF YES****,* which policies and legislation were amended and when?

Policy/Law:		Year :	
Policy/Law:		Year:	
Policy/Law:		Year:	
Policy/Law:		Year:	
Policy/Law:		Year:	

[List as many as relevant]

Overall, how would you rate the strategy planning efforts in HIV and AIDS programmes in 2007 and in 2005?

2007	Poor																				Good	
0		1		2		3		4		5		6		7		8		9	X	10		
2005	Poor																				Good	
0		1		2		3		4		5	X	6		7		8		9		10		

Comments on progress made since 2005 :

The strategic planning efforts this time round has involved all the relevant stakeholders. The principles of Three Ones' were applied strongly, and there was wide participation from development partners as well as civil society both at the national level as well as the provincial levels. Planning processes also included other sectors like women and child development, tribal affairs, rural department and local self governments, labour ministry, ministries of social justice and empowerment, education etc. The plans also include systems of monitoring the plan and systems for adaptation of the program should the situations change. This was a landmark effort, in evidence based and participative planning.

3. Prevention

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

Yes	**X**	No		N/A	

1.1. ***IF YES***, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

Be sexually abstinent	X
Delay sexual debut	X

Be faithful	X
Reduce the number of sexual partners	X
Use condoms consistently	X
Engage in safe (r) sex	X
Avoid commercial sex	
Abstain from injecting drugs	X
Use clean needles and syringes	X
Fight against violence against women	X
Greater acceptance ad involvement of people living with HIV	X
Greater involvement of men in reproductive health programmes	
Other : [write in]	

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	X	No	

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

Yes	X	No	

2.1. Is HIV education part of the curriculum in

Primary schools?	Yes		No	X
Secondary schools?	Yes	X	No	
Teacher training?	Yes		No	X

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

Yes	X	No	

2.3. Does the country have an HIV education strategy for out-of-school young people?

Yes	X	No	

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations?

Yes	X	No	

IF NO, briefly explain :

3.1. ***IF YES***, which sub-populations and what elements of HIV prevention do the policy/strategy address?

✓ Check for policy/strategy included

	IDU	**MSM**	**Sex workers**	**Clients of sex workers**	**Prison inmates**	**Other Sub-populations [write in]**
Targeted information on risk reduction and HIV education	X	X	X		X	
Stigma & discrimination reduction	X	X	X			
Condom promotion	X	X	X		X	

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other Sub-populations [write in]
HIV testing & counselling	X	X	X		X	
Reproductive health, including STI prevention & treatment	X	X	X			
Vulnerability reduction (e.g. income generation)	N/A	N/A	X	N/A	N/A	
Drug substitution therapy	X	N/A	N/A	N/A	N/A	
Needle & syringe exchange	X	N/A	N/A	N/A	N/A	

Overall, how would you rate policy efforts in support of HIV prevention in 2007 and in 2005?																					
2007	Poor																			Good	
0		1		2		3		4		5		6		7		8	X	9		10	
2005	Poor																			Good	
0		1		2		3		4		5		6		7		8	X	9		10	
Comments on progress made since 2005 : During the last two years, special focussed strategies have been put into place for core risk population and other high risk groups (migrants etc.) separately.																					

4. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes	X	No	

IF NO, how is HIV prevention programmes being scaled-up?

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts * in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	All districts* in need	Most districts* in need	Some districts* in need
Blood safety	X		
Universal precautions in health care settings	X		
Prevention of mother-to-child transmission of HIV	X		
IEC on stigma and discrimination reduction		X	
Condom promotion	X		
HIV testing & counselling	X		
Harm reduction for injecting drug users	X		
Risk reduction for men who have sex with men			X
Risk reduction for sex workers	X		
Programmes for other vulnerable sub-populations	X		
Reproductive health services	X		

HIV prevention programmes	The activity is available in		
	All districts* in need	Most districts* in need	Some districts* in need
including STI prevention & treatment			
School-based AIDS education for young people		X	
Programmes for out-of-school young people		X	
HIV prevention in the workplace			X
Other [write in]			

* District or equivalent geographical/de-centralised level in urban and rural areas

Overall, how would you rate policy efforts in the implementation of HIV prevention programmes in 2007 and in 2005?

2007	Poor																			Good
0		1		2		3		4		5		6		7	X	8		9		10
2005	Poor																			Good
0		1		2		3		4	X	5		6		7		8		9		10

Comments on progress made since 2005 :

4. Treatment, Care and Support

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes	X	No	

IF YES, does it give sufficient attention to barriers for women, children and most-at-risk population?

Yes	X	No	

2. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support service?

Yes		No		NA	
	X				

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support service	The service is available in		
	All districts* in need	Most districts* in need	Some districts* in need
Antiretroviral therapy		X	

HIV and AIDS treatment, care and support service	The service is available in		
	All districts* in need	Most districts* in need	Some districts* in need
Nutritional care			X
Paediatric AIDS treatment		X	
Sexually transmitted infection management	X		
Psychosocial support for people living with HIV and their families		X	
Home-based care			X
Palliative care and treatment of common HIV-related infections		X	
HIV testing and counselling for TB patients	X		
TB screening for HIV-infected people		X	
TB preventive therapy for HIV-infected people			
TB infection control in HIV treatment and care facilities		X	
Cotrimoxazole prophylaxis in HIV-infected people			X
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)		X	
HIV treatment services in the workplace or treatment referral systems through the workplace			X
HIV care and support in the workplace (including alternative working arrangements)			
Other programmes: [write in]			

* Districts or equivalent de-centralized governmental level in urban and rural areas

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes	X	No	

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?

Yes	X	No	

4.1 ***IF YES***, which commodities?: For everything (drugs, condoms, testing kits etc)

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

Yes	X	No		NA	

5.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes	X	No	

5.2 ***IF YES,*** does the country have a national action plan specifically for OVC?

Yes	X	No	

5.3 ***IF YES,*** does the country have an estimate of OVC being reached by existing interventions?

Yes	X	No	

IF YES, what percentage of OVC is being reached? 21875 positive children require ART out of which 8347 receive ART 34 percent (write in)

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?											
2007	Poor										Good
	0	1	2	3	***4***	X	5	6	7	8	9	10
2005	Poor										Good
	0	1 X	2	3	***4***		5	6	7	8	9	10
Comments on progress made since 2005 : A special drive to address teh issue of paediatric AIDS has been launched in 2006.											

5. Monitoring and evaluation

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

Yes	✔	Years covered: [write in]		In progress		No	

1.1 ***IF YES***, was the M&E plan endorsed by key partners in M&E?

Yes	✔	No	

1.2 ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes	✔	No	

1.3 ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners		Yes, most partners	✔	Yes, but only some partners		No	

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes	✔	No	
Behavioural surveillance	Yes	✔	No	
HIV surveillance	Yes	✔	No	
A well-defined standardized set of	Yes	✔	No	

indicators				
Guidelines on tools for data collection	Yes	✔	No	
A strategy for assessing quality and accuracy of data	Yes	✔	No	
A data dissemination and use strategy	Yes	✔	No	

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

Yes	✔	Years covered: [write in]	Apr, 2007-Mar, 2012	In progress		No	

IF YES, has funding been secured?

Yes	✔	No	

4. Is there a functional M&E Unit or Department?

Yes	✔	In progress		NA	

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?

IF YES, is the M&E Unit/Department based

In the NAC (or equivalent)? (National AIDS Control Organization)	Yes	✔	No	
In the Ministry of Health?	Yes		No	✔
Elsewhere? [write in]				

IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

There is a Monitoring, Evaluation and Research Division at NACO

Number of Permanent Staff:		
Position: [write in] Joint Director (M&E and R)	***Full time***	Since when?: ***June 2006***

Number of temporary staff:		
Position: [write in] Programme Officer (M&E)	Full time/Part time? – ***FULL TIME***	Since when?: ***October,2006***
Position: [write in] Programme Officer (R&D)	Full time/Part time? – ***FULL TIME***	***Vacant***
Position: [write in]	Full time/Part time?	Since when?:

Technical Officer (M&E)	***Full time***	***March,07***
Position: [write in] Technical Officer (CMIS)	Full time/Part time? ***Full time***	Since when?: ***April,07***
Position: [write in] Technical Officer (R&D)	Full time/Part time? ***Full Time***	Since when?: ***Nov, 2006***
Position: [write in] M&E Officer	Full time/Part time? ***Full Time***	Since when?: ***Nov, 2007***
Position: [write in] M&E Officer	Full time/Part time? ***Full Time***	Since when?: ***Nov, 2007***

IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports?

Yes	**X**	No	

IF YES, does this mechanism work? What are the major challenges?

Mechanism is working well though some challenges are being faced. Efforts for establishing systems for synchronization of data flow mechanisms and common indicators for smooth exchange of data are going on. Full utilization and smooth reporting is improving gradually.

IF YES, to what degree do UN, bi-laterals, and other institutions share their M&E results?

LOW										**HIGH**
0		1		2		3	**X**	4		5	

5. Is there an M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No		Yes, but meets irregularly		Yes, meets regularly	**X**

IF YES, Date last meeting: [write in] ***December, 2007***

Annex E: National Composite Policy Index -Part B

1. Human Rights

PLEASE ENTER "X" in the box, as appropriate.

6. Does the country have laws and regulations that protect people living with HIV against discrimination? (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling,housing,employment, healthcare etc.,)

Yes		No	X

6.1.1. **IF YES**, Specify:

7. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes	X	No	

7.1.1. **If YES**, for which sub-populations?

Women	Yes	X	No	
Young people	Yes		No	X
IDU	Yes		No	X
MSW	Yes		No	X
Sex Workers	Yes		No	X
Prison inmates	Yes		No	X
Migrants/mobile populations	Yes		No	X

Other: (write in)

IF YES, Briefly explain what mechanisms are in place to ensure these laws are Implemented:

Not aware of mechanisms to ensure their implementation

IF YES, Describe any system of redress put in place to ensure the laws are having their desired effect:

Not aware of redressal system

8. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?

Yes	X	No	

8.1.1. **IF YES**, for which sub-populations?

Women	Yes		No	X
Young people	Yes		No	X
IDU	Yes	X	No	
MSW	Yes	X	No	
Sex Workers	Yes	X	No	
Prison inmates	Yes	X	No	
Migrants/mobile populations	Yes		No	X

Other: (write in)

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

- **Immoral Traffic Prevention Act 1956** ("**ITPA**"),
- **Narcotic Drugs and Psychotropic Substances Act, 1985**
- **Section 377, Indian Penal code criminalizes homosexuality**

- **Criminal statutes such as the Narcotic Drugs and Psychotropic Substances Act, section 377 of the IPC which renders homosexuality illegal in India and the Immoral Trafficking Prevention Act, continue to hinder the implementation of effective interventions with IDUs, MSM and FSWs.**
- **Prison manuals prevent condom distribution for prison inmates**

9. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	X	No	

10. Is there a mechanism to record, document and address cases of discrimination Experienced by people living with HIV and/or most – at – risk populations?

Yes		No	X

IF YES, briefly describe this mechanism

11. Has the Government, through political and financial support, involved most – at – risk population in governmental HIV-policy design and programme implementation?

Yes	X	No	

IF YES, describe some examples

NACP III, the third phase of the National AIDS Control Organization, was designed in a highly participatory manner, involving donors, academia, NGOs and CBOs which work with key populations, as well as the Indian Network of Positive People.

12. Does the country have a policy of free services for the following:

HIV prevention services	Yes	X	No	
Anti-retroviral treatment	Yes	X	No	
HIV-related care and support interventions	Yes	X	No	

IF YES, given resource constraints, briefly describe what steps are in place to Implement these policies:

- **Under the Act & Laws passed by the Ministry of Women & Child Development, GoI for equity of men & women (encouraged of women empowerment).**
- **NACO mentions that women and children are the priority groups to receive ARVs in the government program. For ARV roll out program the government is trying to ensure equal access to women.**
- **Existing laws ensure equal access for women and men everywhere**

13. Does the country have a policy to ensure equal access for women and men, to Prevention, treatment, care and support? In particular, to ensure access for Women outside the context of pregnancy and childbirth?

Yes	X	No	

14. Does the country have a policy to ensure equal access for most-risk populations for prevention, treatment, care and support?

Yes	X	No	

14.1.1. Are there differences in approaches for difference most-at-risk populations?

Yes	X	No	

IF YES, briefly explain the differences

Operational Guidelines spell out different approaches in ensuring equal access for the different most-at-risk populations.

15. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	X	No	

16. Does the country have a policy to ensure that AIDS research protocols involving Human subjects are reviewed and approved by a national/local ethical review committee?

Yes	X	No	

16.1.1. **IF YES,** does the ethical review committee include representatives of civil Society and people living with HIV?

Yes	X	No	

IF YES, describe the effectiveness of this review committee

There are various levels of review committee. At the national level there are representatives of civil society, at the state level in some places there is civil society representation but not all.

17. Does the country have the following human rights monitoring and enforcement mechanisms?

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

Yes	X	No	

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes		No	X

- Performance indicators or benchmarks for

    a) Compliance with human rights standards in the context of HIV efforts

Yes		No	X

b) Reduction of HIV-related stigma and discrimination

Yes		No	X

IF YES, on any of the above questions, describes some examples:

The Human Rights Commission takes action whenever it receives any complaints of violation of HR of PLWHA

18. Have members of the judiciary (including labour courts/employment tribunals) Been trained/sensitized to HIV and AIDS and human rights issues that may come up on the context of their work?

Yes	X	No	

19. Are the following legal support services available in the country?

- Legal aid systems for HIV and AIDS case work

Yes	X	No	

- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	x	No	

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

Yes	X	No	

20. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Yes	X	No	

IF YES, what types of programmes?

Media	Yes	X	No	
School education	Yes	X	No	
Personalities regularly speaking out	Yes	X	No	

Other: (write in)

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?																					
2007	Poor																			Good	
0		1		2		3		4		5	X	6		7		8		9		10	
2005	Poor																			Good	

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

Comments on progress made since 2005 :

- State AIDS Control Societies are more proactive in involving not only key population but family and community as well
- Processes are in place to ensure protection of HR

There is, in general, a more aware and sensitized media, stronger networks of positive people and other CBO groups, as well as policies for gender and equity and GIPA.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2007 and in 2005?

2007	Poor																			Good	
0		1		2		3		4		5	X	6		7		8		9		10	
2005	Poor																			Good	
0		1		2		3		4	X	5		6		7		8		9		10	

Comments on progress made since 2005 :

2. Civil Society participation

7. To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?

LOW										HIGH
0		1		2		3		4	X	5	

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

LOW										HIGH
0		1		2		3		4		5	X

9. To what extent are the services provided by civil society in areas of HIV Prevention, treatment, care and support included

9.2. In both the National Strategic plans and national reports?

LOW										HIGH
0		1		2		3	X	4		5	

9.3. In national budget?

LOW										HIGH
0		1		2		3	X	4		5	

10. Has the country included civil society in a National Review of the National Strategic Plan?

Yes	X	No	

IF YES, when was the Review conducted? Year: (write in)

The design and appraisal of NACP 3 was conducted in a very participatory manner, and included broad consultation with civil society. This was done during 2006.

In December 2007 there has been a first joint review of the national programme which has included some NGOs at national level.

11. To what extent is the civil society sector representation in HIV-related efforts Inclusive of its diversity?

LOW										HIGH
0		1		2		3	X	4		5	

List the types of organizations representing civil society in HIV and AIDS efforts:

- **State Government formed Societies**
- **Academic institutions**
- **NGO**
- **Trust**
- **CBOs**
- **FBO**
- **Pvt Sector**
- **Networks of PLHAs**

12. To what extent is civil society able to access

a. adequate financial support to implement its HIV activities?

LOW										HIGH
0		1		2	X	3		4		5	

b. adequate technical support implements its HIV activities?

LOW										HIGH
0		1	X	2		3		4		5	

Overall, how would you rate the effort to increase civil society participation in 2007 and in 2005?

2007	Poor																			Good
0		1		2		3		4		5	X	6		7		8		9		10	
2005	Poor																			Good
0		1		2	X	3		4		5		6		7		8		9		10	

Comments on progress made since 2005 :

Significant progress has been made through the highly participatory design of NACP 3, the establishment of e-based forums to stimulate debate and the sharing of information among government, donors and civil society (Solution Exchange, managed by UNDP); and the recognition that NGOs and CBOs are best placed to

implement programmes for high-risk groups. As such, a key strategy of NACP 3 is to expand coverage through TIs, which are mostly implemented by NGOs and CBOs.

Efforts to streamlining information systems have been made, for to be more transparent in the provision of information.

3. Prevention

5. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes	X	No	

IF NO, how are HIV prevention programmes being scaled-up?:

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The service is available in		
	All districts* in need	**Most districts* in need**	**Some districts* in need**
Blood safety		X	
Universal precautions in health care settings			X
Prevention of mother-to-child transmission of HIV		X	
IEC on risk reduction	X		
IEC on stigma and discrimination reduction		X	
Condom promotion		X	
HIV testing & counselling	X		
Harm reduction for injecting drug users			X
Risk reduction for men who have sex with men			X
Risk reduction for sex workers		X	
Programmes for other most-at-risk population			X
Reproductive health services including STI prevention & treatment	X		
School-based AIDS education for young people		X	
Programmes for out-of-school young people			X
HIV prevention in the workplace			X

Other programmes: (write in)

Overall, how would you rate the effort in the implementation of HIV prevention programmes in 2007 and in 2005?		
2007	Poor	Good

0		1		2		3		4		5		6		7	X	8		9		10	
2005	Poor																			Good	
0		1		2		3		4		5		6	X	7		8		9		10	

Comments on progress made since 2005:

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

NACO has done an excellent job in preparing for the rapid scale up of coverage of interventions required in NACP III. It has identified improving the quality of all programme components as a key challenge and taken steps to address this by developing high quality guidelines for all programme components; recruited a significant number of additional staff, initiated training, and expanded infrastructure and services. As a result, there has been an increase in access and utilisation of important services like ARV treatment and voluntary counselling and testing. The key challenge will be to see these achievements transferred down to the state and district level, where the recruitment and training of staff is yet to be completed.

4. Treatment, Care and Support

1. Has the country identified the districts (equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes	X	No	

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?:

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

X Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support service	The service is available in		
	All districts* in need	Most districts* in need	Some districts* need
Antiretroviral therapy		X	
Nutritional care			X
Paediatric AIDS treatment			X
Sexually transmitted infection management	**X**		
Psychosocial support for people living with HIV and their families			X
HIV testing and counselling for TB patients		X	

HIV and AIDS treatment, care and support service	The service is available in		
	All districts* in need	Most districts* in need	Some districts* need
TB screening for HIV-INFECTED PEOPLE		X	
TB preventive therapy for HIV-people			
TB infection control in HIV treatment and care facilities			
Cotrimoxazole prophylaxis in HIV infected people			X
Post –exposure prophylaxis (e.g. occupational exposures to HIV, rape)		X	
HIV treatment services in the workplace or treatment referral systems through the workplace			X
HIV care and support in the workplace (including alternative working arrangements)			X

Other Programmes: (write in)

Overall, how would you rate the effort in the implementation of HIV treatment, care and support programmes in 2007 and in 2005?

2007	Poor																			Good
0		1		2		3		4		5		6	X	7		8		9		10

2005	Poor																			Good
0		1		2		3		4	X	5		6		7		8		9		10

Comments on progress made since 2005 :

- **Provision for free ARV reflects government commitment.**
- **NGO and CBO are getting more funds for care and support activities.**
- **In 2005 access to treatment, care and support was very low.**
- **PLHA networks have strongly influenced governments in improving treatment, care and support services thereafter.**

The GoI started to provide 1st line free ARV treatment from January 2006. Since then there has been remarkable progress, with around 140,000 people currently being provided treatment. Paediatric treatment is also being rolled out. The Joint Report of the 1st NACP 3 review notes:
"Roll out of the ART program has picked up speed in high prevalence states, although access of patients to ART is still a problem in low prevalence states with fewer centres. Standard guidelines on HIV for adults and children, and OI management have been developed, printed and distributed. Testing with CD4 machines is provided free of cost to all PLHIV with the 69 machines currently available including through transportation of samples where the machines are not yet in place. There are presently 158 centres in 31 states providing free ART 105,000 adults and children, with NACO estimating that an additional 35,000 receive treatment from private providers. Interestingly, India has ensured that care of children is integrated within the overall ART program. Link ART centres which are being planned may help increase both access and adherence under the programme."

India also plans to roll out second line ART in January 2008 for those patients (~3percent) experiencing treatment failure, although this figure will require validation.

2. What percentage of the following HIV programmes or services in estimated to be provided by civil society?

Prevention for youth	< 25percent	x	25-50 percent		50-75 percent		> 75percent	
Prevention for vulnerable sub-population								
- IDU	< 25percent		25-50 percent		50-75 percent		> 75percent	X
- MSM	< 25percent		25-50 percent		50-75 percent		> 75percent	X
- Sex worker	< 25percent		25-50 percent	**X**	50-75 percent	X	> 75percent	
Counselling and testing	< 25percent	X	25-50 percent	**X**	50-75 percent		> 75percent	
Clinical services (OI/ART)	< 25percent		25-50 percent	**X**	50-75 percent		> 75percent	
Home-based care	< 25percent		25-50 percent		50-75 percent		> 75percent	X
Programmes for OVC	< 25percent		25-50 percent		50-75 percent		> 75percent	X

*OI Opportunistic infection;
**OVC Orphans and other vulnerable children

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

Yes	X	No		NA	

a. IF YES, is there an operational definition for OVC in the country?

Yes	X	No	

The new national policy talks of "children affected by HIV/AIDS", which include those who are HIV-positive, those who have been orphaned by AIDS and those who are living in a household which is affected by HIV/AIDS – usually because their parent is HIV positive.

Vulnerable children in India are usually understood to be young people who are particularly vulnerable to HIV infection but are not affected, unless they have a positive parent or are orphaned by AIDS. The terms vulnerable children is also used to describe children at risk of abuse, neglect, discrimination or other violations of their rights. The term other vulnerable children is used with ambiguity.

b. IF YES, does the country have a national action plan specifically for OVC?

Yes		No	X

c. YES, does the country have an estimate of OVC being reached by existing interventions?

Yes		No	X

IF YES, what percentage of OVC is being reached? percent (write in)