REPORT OF THE WORKING GROUP ON AIDS CONTROL FOR THE 12TH FIVE YEAR PLAN

WG 6 : AIDS CONTROL

WG-6

No.2 (6)2010
Government of India
Planning Commission

Yojana Bhavan, Sansad Marg
New Delhi – 110001

23rd May, 2011

OFFICE MEMORANDUM

Subject: Constitution of working group on AIDS Control for the formulation of the Twelfth Five Year Plan (2012-2017)

With a view to formulate the Twelfth Five Year Plan (2012-2017) for the Health Sector, it has been decided to constitute a Working Group on AIDS Control under the Chairmanship of **Shri Sayan Chatterjee, Secretary, Department of AIDS Control,** Ministry of Health & Family Welfare.

The composition and the terms of reference of the Working group would be as follows:

1.	**Shri Sayan Chatterjee, Secretary, Department of AIDS Control**	**Chairperson**
2.	Shri J.V.R. Prasada Rao, Former Secretary, MoHFW	Co-Chairperson
3.	Ms. Aradhana Johri, Additional Secretary (NACO)	Member Secretary
4.	Adviser (Health), Planning Commission	Member
5.	Dr. Bimal Charles, Project Director, AIDS Prevention and Control (APAC), Chennai	Member
6.	Dr. Smarajit Jana, Chief Advisor, Durbar Mahila Samanwaya Committee (DMSC), Kolkata	Member
7.	Ms. Kaushalya, Representative of PLHA network, Positive Women's Network, Chennai	Member
8.	Dr. R. Paranjape, Director, National AIDS Research Institute (NARI), Pune	Member
9.	Dr. K.Sudhakar, Senior HIV/AIDS Advisor, CDC, New Delhi	Member
10.	Dr. Rajshekhar, Tambram Institute, Chennai	Member

11.	Dr. S. Sundararaman, Director of the AIDS Research Foundation of India, Chennai	Member
12.	Dr. DCS Reddy, Former Prof. BHU, New Delhi, currently Consultant WHO India, New Delhi.	Member
13.	Dr. Geeta Bamzai, Department of Communication Research, Indian Institute of Mass Communication, New Delhi	Member
14.	Radharani Mitra, Creative Director, BBC World Services Trust, New Delhi	Member
15.	Shri Ashok Rao Kavi, LGBT rights activist, Mumbai	Member
16.	Mr. Anand Grover, Director of the Lawyers Collective HIV/AIDS in India Mumbai (M) 9820184788	Member
17.	Ms. Donna Fernandes, Vimochna, Bangalore, Karnataka	Member
18.	Sh. S.P.Goyal, Project Director, SACS, Uttar Pradesh.	Member
19.	Ms. Hajarimayum Jubita Devi, Executive Director, Ereima Gender Empowerment and Resource Centre (EGERC), Manipur	Member
20.	Ms. Anjali Gopalan, Naz Foundation, New Delhi	Member
21.	Ms. Akhila Sivadas, Centre for Advocacy and Research, New Delhi	Member
22.	Dr Kurien Thomas, CMC Vellore	Member
23.	Mr. Vijay Kumar, Special Secretary, Department of Health & Family Welfare, Government of Tamil Nadu	Member
24.	Principal Secretary, H&FW, Mizoram	Member
24.	Principal Secretary, H&FW, Nagaland	Member

Terms of Reference:

1. To review the status of on-going National AIDS Control Programme with reference to objectives, strategies, plan initiatives, targets and outlays during 11th Five Year Plan and achievements, problems detected, mid-course correction, utilization of funds.

2. To deliberate on ways and means to ensure equal access to healthcare services, nutrition, safe water, sanitation, and education, ensuring continuum of care and support for persons living with HIV/AIDS.

3. To deliberate on ways and means to address issues of skill development and employment for persons living with HIV/AIDS.

4. To lay special emphasis on protection of especially vulnerable groups (sex workers, transgenders, injecting drug users, men having sex with men, etc) and re-strategize for regions with high and/or growing incidence of HIV/AIDS (North East Region, Goa, Punjab, Tamil Nadu, etc)

5. To suggest improved support structures, including healthcare services, education, recreation facilities, etc for children living with HIV/AIDS as also those orphaned due to HIV/AIDS.

6. To deliberate on ways and means to legally and culturally (through IEC) counter professional and social discrimination.

7. To give suggestions regarding proposed objectives, strategies, initiatives and targets for 12th Plan including sustainability, overlapping and convergence with other health programmes with special emphasis on awareness generation through creative use of IEC and prevention of HIV transmission.

8. To identify the funding requirements during 12th Plan.

9. To suggest improved mechanisms of involvement of Civil Society Organisations, private sector, PRIs/ULBs in design, implementation and monitoring of programmes.

10. To review the current pattern of design, monitoring and evaluation of programmes and suggest improvements during 12th Plan.

11. To review the current status of surveillance, its quality and propose improvements.

12. To review implementation structures at national, state and district levels and suggest improvements.

13. To deliberate and give recommendations on any other matter relevant to the topic.

14. The Chairman may constitute various Specialist Groups/ Sub-groups/ task forces etc. as considered necessary and co-opt other members to the Working Group for specific inputs.

15. Working Group will keep in focus the Approach paper to the 12th Five Year Plan and monitorable goals, while making recommendations.

16. Efforts must be made to co-opt members from weaker sections especially Scheduled Castes, Scheduled Tribes and minorities working at the field level.

17. The expenditure towards TA/DA in connection with the meetings of the Working group in respect of the official members will be borne by their respective Ministry / Department. The expenditure towards TA/DA of the non-official Working group members would be met by the Planning Commission as admissible to the class 1 officers of the Government of India.

18. The Working group would submit its draft report by 31st July, 2011and final report by 31st August, 2011.

(Ambrish Kumar)
Adviser (Health)

Copy to:

1. Chairman, all Members, Member Secretary of the Working Group
2. PS to Deputy Chairman, Planning Commission
3. PS to Minister of State (Planning)
4. PS to all Members, Planning Commission
5. PS to Member Secretary, Planning Commission
6. All Principal Advisers / Sr. Advisers / Advisers / HODs, Planning Commission
7. Director (PC), Planning Commission
8. Administration (General I) and (General II), Planning Commission
10. Accounts I Branch, Planning Commission
11. Information Officer, Planning Commission
12. Library, Planning Commission

(Ambrish Kumar)
Adviser (Health)

Report of

The Planning Commission Working Group on AIDS Control for the formulation of 12th Five Year Plan

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National AIDS Control Programme
Phase IV

(2012-2017)

Abbreviation	
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Clinic
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
ART	Anti-Retroviral Therapy
ARV	Anti Retro Viral
ASHA	Accredited Social Health Activist
BCC	Behaviour Change Communication
BCSU	Blood Component Separation Unit
BSU	Blood Storage Unit
CCC	Community Care Centre
CD 4	Cluster of Differentiation 4
CHC	Community Health Centre
CLHIV	Children Living with HIV
COE	Centre of Excellence
CSMP	Condom Social Marketing Programme
CST	Care Support & Treatment
DAPCU	District AIDS Prevention & Control Unit
DCG(I)	Drugs Control General (India)
DHR	Department of Health Research
DIC	Drop in Centre
DLN	District Level Network
EID	Early Infant Diagnosis
EQAS	External Quality Assessment Scheme
FOGSI	Federation of Obstetric & Gynecological Societies of India
FRU	First Referral Unit
FSW	Female Sex Worker
GIPA	Greater Involvement of People Living with AIDS
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HIV/TB	Human Immunodeficiency Virus/Tuberculosis

HRD	Human Resources Development
HRG	High Risk Group
IAP	Indian Academy of Paediatrics
ICF	Intensified Case Finding
ICTC	Integrated Counseling and Testing Centre
IDU	Injecting Drug User
IEC	Information Education Communication
IMA	Indian Medical Association
IT	Information Technology
LAC	Link ART Centre
LFU	Lost Followup Cases
MARA	Most At Risk Adolescent
MARP	Most At Risk Population
MCI	Medical Council of India
MDG	Millennium Development Goals
MOH	Ministry of Home Affairs
MSM	Men having Sex with Men
NABL	National Accreditation Board for Testing and Calibration Laboratories
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NERO	North Eastern Regional Office
NGO	Non-Governmental Organisation
NRHM	National Rural Health Mission
NRL	National Reference Laboratory
NYKS	Nehru Yuva Kendra Sangathan
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
PHC	Primary Health Centre
PLHIV	People Living with HIV/AIDS
PPP	Public Private Partnership
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institution

PwP	Prevention with Positives
RCH	Reproductive Child Health
RNTCP	Revised National Tuberculosis Control Programme
RRC	Red Ribbon Club
RRE	Red Ribbon Express
SACEP	State AIDS Clinical Expert Panel
SACS	State AIDS Control Society
SHG	Self Help Group
SIMS	Strategic Information Management System
SJE	Social Justice & Empowerment
SRL	State Referral Laboratory
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STRC	State Training & Resource Centre
TB	Tuberculosis
TI	Targeted Intervention
TSU	Technical Support Unit
VBD	Voluntary Blood Donation
VHC	Village Health Committees
WCD	Women & Child Development

In 1992, the Government launched the first National AIDS Control Programme (NACP I) and in 1998 NACP II was initiated. Based on the learning from NACP I and II, the government designed and implemented NACP III (2007-2012) with an objective to **"halt and reverse the HIV epidemic in India"** by the end of the project. There is a steady decline in overall prevalence and nearly 50% decrease in new infections over last ten years. India is committed to achieving Millennium Development Goals (MDG) in reducing HIV mortality. The country is clearly progressing towards achieving this goal through focused effort by a large number of partners bought together through National AIDS Control Program.

NACP is an excellent example of community involvement and ownership in developing appropriate strategies and in reaching out to high risk and vulnerable populations. The program has been greatly benefited by the critical role played by civil society and PLHA networks in community mobilization, increasing access to services, addressing stigma and discrimination issues. NACP IV will build on the motivation of these stakeholders particularly at the community level (NGOs, social activists, service providers, consumers and policy makers) to actively engage with complex issues of HIV. It will focus on reduction of stigma and discrimination at health care setting, work places and educational institutions.

Funding from Development Partners has played significant role in supporting the NACP programme interventions in the past. During NACP III external resources were substantial. In fact Domestic Budgetary Support to the Department of AIDS Control was less than 5% of the Department's budget. However, in light of the global economic recession external funding for HIV will shrink dramatically. Therefore, the next phase of the programme will primarily depend upon domestic resources. Therefore, one of the critical challenges is to move towards more effective and efficient approaches through convergence and integration of programme components such as basic HIV services, comprehensive care, support and treatment with National Rural Health Mission (NRHM) and general health systems to the extent possible.

2. NACP III Implementation and Achievements

Based on the learning from NACP II, the government designed and implemented NACP III with an objective to **"halt and reverse the HIV epidemic in India"** by the end of the project period. Analysis of targets done at the time of mid-term review and subsequent joint implementation review mission suggest that most of the targets have been achieved or will be achieved by end of the program by 2012. Results of the epidemiological models and program data (surveillance ANC, HRG population, and ICTC) shows that the target of halting the epidemic has been achieved and reversal process has been initiated at the national level during this time frame.

2.1 NACP III Targets and Achievements

The targets and key achievements of NACP III can be summarised as follows:

High Risk Group (HRG) Coverage: There has been substantial scale up in the coverage of FSW (78%), MSM (69%) and IDU (76%) through Targeted Interventions (TIs). This has been achieved through 1577 TIs for high-risk groups (HRGs). Link Worker Scheme was established to reach out to rural HRGs and their partners and vulnerable groups. 5350 IDUs were provided OST through 57 centres including NGOs and public health settings.

Coverage of Bridge Populations: The programme targeted about 20 lakh long distance truckers through 82 interventions. The programme has reached 36 lakh high-risk migrants through 230 destination TIs.

Counseling and Testing: Counseling and Testing have been rapidly scaled up during NACP III. Of the total target of 22 million, nearly 74% has been achieved through 5246 ICTCs and 3012 facility integrated ICTCs and ICTC units managed through Public-Private Partnership (PPP) model. In addition, 0.8 million HIV-TB cross referrals have been made and about 42,000 HIV-TB co-infections detected.

STI Control: The coverage of STD services has been scaled up through collaboration with National Rural Health Mission (NRHM). Most of the STD treatment is mediated through district hospitals, PHC, and CHC under NRHM. Currently it is estimated that 50% of this target has been covered by the program through NRHM and STD clinics. Regular screening of HRG for STI has been initiated. At present 30% of registered HRG has been treated through 3523 TI-STI clinics. The coverage of STI services has been scaled up through 1033 designated STI clinics, 4036 Preferred Private Providers for HRGs and CHC/PHC under NRHM.

Provision of Safe Blood: 80% of estimated 10 million units of safe blood availability required for the country has been achieved under NACP III through a network of blood banks of about 2609 facilities including public, voluntary/trust, private hospitals and private stand alone blood banks. Of this 80% is through voluntary blood donation. Majority of the districts in the country now have well established blood banks. Blood component separation units have also been established in tertiary care hospitals. Work has began for setting up of four Metro Blood Banks as Centres of Excellence in Transfusion Medicine with capacity to process more than 100,000 units of blood each annually in New Delhi, Mumbai, Kolkata and Chennai, and a Plasma Fractionation Centre with a processing capacity of more than 1,50,000 litres of plasma, which can fulfill the country‘s demand.

Condom Promotion: There has been significant up-scaling of condom distribution and sales through a substantial scale up in condom social marketing channels, non-traditional outlets and demand generation campaigns. Condom promotion has achieved 70% of the target of 3.5 billion through 1.2 million retail outlets and 8 social marketing organizations.

IEC: NACO has been conducting regular thematic **Mass Media** campaigns on TV and Radio to cover issues of condom promotion, ICTC/PPTCT, STI treatment and services, stigma and discrimination, vulnerability of youth to HIV, ART, HIV-TB and blood safety. The Red Ribbon Express (RRE) program covered 8 million population and 81,000 grassroots functionaries were trained on HIV/ AIDS issues in the villages to further take down the messages. In addition, through mainstreaming with NYKS and other youth

organizations, out-of-school youth have been reached. As part of mainstreaming efforts a large number of self-help groups, ASHA, ANM, Anganwadi Workers and PRI members have been trained/ sensitized on HIV/ AIDS.

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

Mainstreaming: About 6.5 lakh front line workers and personnel from various Government Departments, Civil Society Organisations and corporate sector were trained during 2010-11. Over 1,300 companies have adopted work place policies on HIV/AIDS

Care, Support and Treatment: Currently about 426,000 PLHA are on 1st line ART. Care, support and treatment services are being provided through 313 ART centers, 641Link ART Centres (LACs) and 259 Community Care Centres (CCC). It has exceeded the original NACP III Target. The program has also started providing 2nd line ART in a phased manner and more than 2400 persons have been given 2nd line ART. Early infant diagnosis (EID) has been rolled out through 766 ICTCs &181 ART centres. The program has reached 6.63 million pregnant mothers and provided treatment to 11962 infected mother-baby pairs at the time of delivery.

Strategic Information Management: Strategic Information Management System (SIMS) has been established and nation-wide rollout is under way with about 15000 reporting units across the country. This will enable the programme to collect, analyze and use the program data for planning and implementation. Data triangulation and risk profiling of districts is currently underway.

Capacity Building: Capacities of service delivery units in the public sector and civil society partners have been enhanced: The capacities of SACS, District AIDS Prevention and Control Units (DAPCUs) have been strengthened. Technical Support Units (TSUs) were established at National and State level to assist in the program monitoring and technical areas. To assist the all the North-Eastern states, a dedicated North-East regional Office has been established. State Training Resource Centers (STRC) were set up to help the state level implementation units and functionaries.

Laboratory services: External Quality Assurance System (EQAS) system was established in all national (13) and state (120) reference HIV testing laboratories. Assessments and follow-up plans for strengthening the laboratories have also been

undertaken. This paves the way for accreditation of these laboratories from National Accreditation Board for Laboratories (NABL). A number of national reference laboratories have also applied for accreditation.

The next phase of NACP will build on these achievements and the lessons learned will ensure that these gains are consolidated and sustained.

3 National AIDS Control Program Phase IV

3.1 Assessment of Current Epidemic Scenario & Challenges

The burden and trends of HIV in different states of the country is assessed by national level HIV Sentinel Surveillance System. It monitors the prevalence of HIV among Ante-natal women representing general population, High Risk Groups (HRG) comprising of Female Sex Workers (FSW), Men having Sex with Men (MSM), Transgenders and Injecting Drug Users (IDU) and vulnerable population such as migrants, truckers and STD patients. Higher levels of positivity were seen mainly in High Risk Groups and bridge populations.

The recent HIV estimates highlight an overall reduction in adult HIV prevalence and HIV incidence (new infections) in India. The estimated number of new annual HIV infections has declined by more than 50% over the past decade. It is estimated that India had approximately 1.2 lakh new HIV infections in 2009, as against 2.7 lakh in 2000. This is one of the most important evidence on the impact of the various interventions under National AIDS Control Programme and scaled-up prevention strategies. This has been due to rapid scale up of interventions resulting in hitherto untouched areas being brought into the ambit of the programme and a strong evidenced-based approach including mapping of high risk populations.

While this trend is evident in most states, some low prevalence states have shown a increase in the number of new infections over the past two years, that underscores the need for the programme to focus more on these states with low prevalence, but high vulnerability. Of the 1.2 lakh estimated new infections in 2009, the six high prevalence states account for only 39% of the cases, while the states of Orissa, Bihar, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat account for 41% of new infections.

The adult HIV prevalence at national level has continued its steady decline from estimated level of 0.41% in 2000 through 0.36% in 2006 to 0.31% in 2009. All the high prevalence states show a clear declining trend in adult HIV prevalence. HIV has declined notably in Tamil Nadu to reach 0.33% in 2009. However, the low prevalence states of Assam, Chandigarh, Orissa, Kerala, Jharkhand, Uttarakhand, Jammu & Kashmir, Arunachal Pradesh and Meghalaya show rising trends in adult HIV prevalence in the last four years.

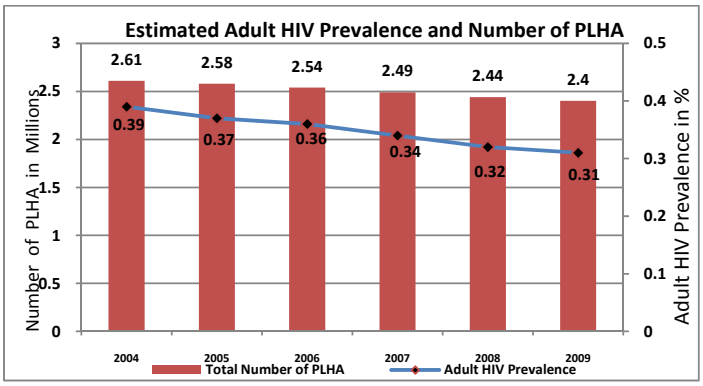


Fig 1: Estimated Adult HIV Prevalence and Number of PLHA, India, 2004-09

This round of estimates has confirmed the clear decline of HIV prevalence among Female Sex Workers at national levels and in most states. However, the evidence shows that Injecting Drug Users and Men who have Sex with Men are more and more vulnerable to HIV with increasing trends in many states. The patterns of prevalence of positivity in different risk groups are given in Figure 2.

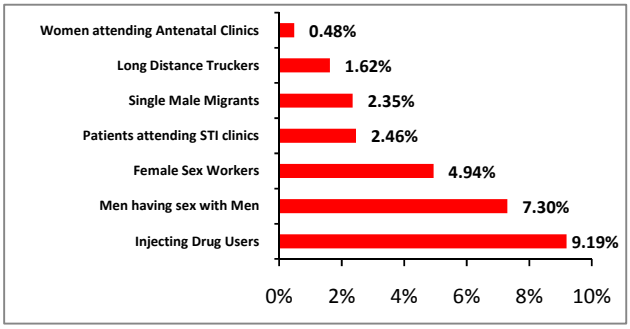


Figure 2: Pattern of Prevalence in different Risk Groups

3.2. Key Priorities for NACP-IV

NACP III and previous phases have ensured that programme interventions are focused on HRG and vulnerable sections of population. The targeted intervention approach has demonstrated excellent results and shaped up as a successful strategy.

India is committed to achieving Millennium Development Goals (MDGs). Keeping this in view, the primary goal of NACP–IV is to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well-defined integration process over the next 5 years.

The Guiding principles for NACP IV will continue to be:

- Continued emphasis on Three Ones (i.e. One Agreed Action Framework, One National HIV/AIDS Coordinating Authority and One Agreed National M&E System)
- Equity
- Gender
- Respect for the rights of the PLHA

- Civil society representation and participation
- Improved public private partnerships.
- Evidence based and result oriented programme implementation.

In addition, NACP IV will reinforce the focus on five cross-cutting themes namely:

- Quality
- Innovation
- Integration
- Leveraging Partnerships
- Stigma and Discrimination

Prioritization of states and districts

Recent trends indicate that many of the states with emerging epidemics and higher vulnerabilities are those with relatively poor health infrastructure and having weak implementation capacities, governance and ownership of the program. The next phase of NACP will specifically focus on these areas and will reach out to the high risk, vulnerable and hard-to-reach groups by ensuring effective delivery of HIV services.

The changing patterns of HIV epidemic also warrant a relook at the grouping of states, beyond just high prevalence and low prevalence states. HIV prevalence is no more a true marker of epidemic due to ART scale up that tends to sustain prevalence and masks the impact of prevention on reduction of new infections. Though prevalence is low in many states, the HIV trends are rising and number of new infections in some states is large. So, considering only the prevalence may mask the attention to be given to the states with rising trends and vulnerabilities. Hence, it is important to take into consideration the stage of the epidemic and trends and quantum of new infections for identifying focus states under NACP-IV.

The categorization of districts in the country during NACP-III into A, B, C and D has helped not only in understanding the prevalence and risk across the country but also in allocating resources effectively. The districts will be re-categorized based on the epidemic profile and vulnerability and programmatic efforts will be intensified in those areas accordingly.

Emerging Epidemics

The epidemic patterns and dynamics of HIV transmission are changing over time. NACP-III could successfully contain the epidemics among FSW that were characterized adequately. However, newer forms of sex work that make FSW less accessible, are an important area of concern during NACP-IV. Epidemics due to MSM, Transgenders & IDU are being identified in greater number of pockets across the country with higher levels of HIV and hence, continue to demand highest priority in the coming years. Migration is increasingly identified as an important factor driving the epidemic in several north Indian districts. Dynamics of HIV transmission in migration-driven settings and the

unique challenges they pose to ensure reach of prevention services to the target population will be an important focus area under NACP-IV. Finally, in the mature epidemic states, long-standing prevention interventions could bring out successful declines among FSW and their clients. However, spousal transmission in the general population has emerged as an important source of new infections in these states, warranting a special focus and approach to address the same during NACP-IV. Thus, emerging epidemics due to MSM, IDU, migration, newer forms of sex work and spousal transmission shall be given priority during NACP-IV, besides sustaining the reach of existing interventions.

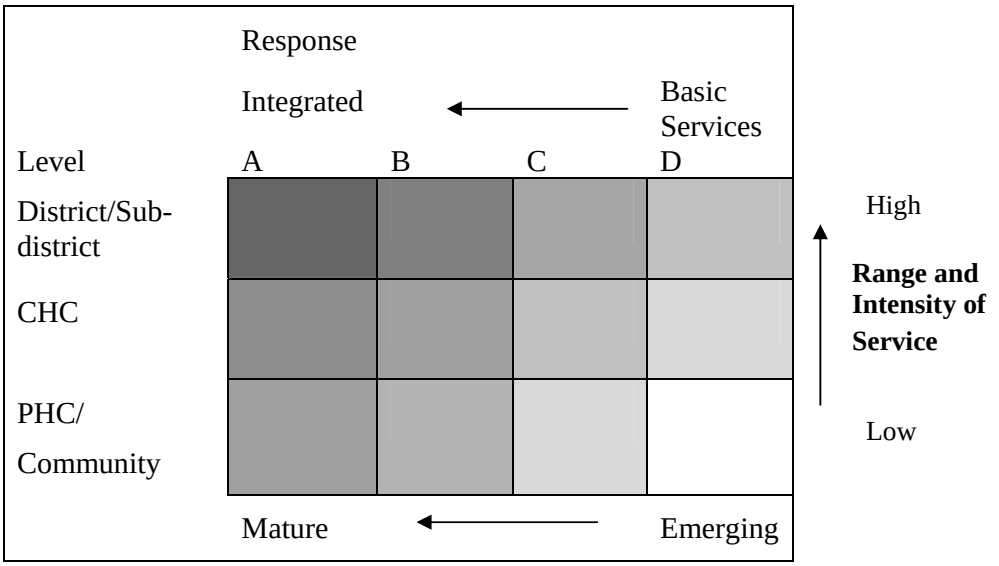
In view of the above, it is imperative that the AIDS control programme should be sustained and vigilance maintained in order to prevent resurgence of the epidemic in the country.

Key Priorities

NACP IV seeks to consolidate the gains of NACP III and learn from the lessons of the previous phases of programme implementation. It aspires to further strengthen and decentralise the programme management capacities to state and district levels in particular. NACP IV focus will remain a prevention oriented plan with adequate coverage of the HIV care in the context of the concentrated epidemic situation in India. NACP IV will to the extent possible integrate with other national programmes and align with overall Twelfth Five Year Plan goals of inclusive growth and development. The key priorities under NACP IV are:

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

Package of services will be customized to suit the requirements of different states and districts. NACP IV proposal of package of services shifts from the concept of uniform district based services to package further differentiated on the basis of maturity of epidemic, need of integration, comprehensiveness of package of services and difficulty factor of the region.



Responses … Maturity vs. Emerging

3.3 The Preparatory Process

An elaborate and extensive process to develop the Strategy and Implementation Plan for NACP IV has been initiated early this year. It is envisaged that the next phase will continue to be inclusive and focused on high-risk and vulnerable, marginalised and hard-to-reach populations. NACP has explored various approaches to reach out to these groups over the years and achieved significant outcomes. NACP IV will continue to provide focused prevention services to the high-risk groups and vulnerable populations along with care, support and treatment services to all eligible populations.

The 12th Five Year Plan scheduled is to begin on 1st April 2012 and the next phase of the NACP formulation is also in synchronisation with the 12th Five Year Plan timeline. Hence, the process has been initiated with a sense of urgency and expediency to ensure that the NACP IV preparation process also feeds into the national 12th plan planning processes.

The key steps in NACP IV preparation process:

- Collating inputs from 15+ Working Groups with sub-groups (about 20 -25 representatives from central and state levels, people living with HIV/AIDS, civil society, subject experts, development partners and other stakeholders in each group)
- Consultations with civil society
- Consultations at the state level with SACS and partners
- Regional consultations with PLHAs, public-sector, private sector and other key stakeholders
- E-consultations / discussions on specific topics to enrich the project development process and strategic approaches.
- Commission of Studies / Assessments

- Collaboration with Development Partners
- Preparation of draft Strategic Plan
- Reviews, clearances and approvals
- Launch of NACP IV

The NACP IV planning has adopted the inclusive, participatory and widely consultative approach similar to that of NACP III and is further strengthening on the globally acclaimed and successful planning efforts of NACP III.

The list of working groups and the participant affiliations for each working group are given below:

List of working groups	
Sl. No.	**Working Group**
1	Program Implementation and Organizational Restructuring
2	Finance Management Innovative Financing
3	Procurement
4	Laboratory Services
5	Sexually Transmitted Infections (STI)/ Reproductive Tract Infections(RTI)
6	Condom Programming
7	Communication Advocacy & Community Mobilisation
8	Greater Involvement of People Living with HIV/AIDS (GIPA), Stigma, discrimination and ethical issues
9	Mainstreaming & Partnerships
10	Blood safety
11	Integrated Counseling and Testing Centers (ICTC)/
	Prevention of Parent to Child Transmission (PPTCT)
12	Care, Support and Treatment
13	Strategic Information Management (SIMS) • Surveillance • Research and knowledge management • Monitoring and Evaluation
14	Gender, Youth and Adolescence
15	Targeted Interventions (TI)
a	Female Sex Workers (FSW)
b	Men having Sex with Men (MSM)
c	Injecting Drug Users (IDU)
d	Capacity Building
e	Migrant
f	Link Worker
g	Transgender
h	Truckers

List of working Groups										
Sl. No.	**Name of the Group**	**Representation**								
		Civil Society	**Network**	**Experts**	**Development Partners**	**NACO**	**SACS**	**NRHM**	**Other Govt.**	**Total**
1	Program Implementation and Organizational Restructuring	1		6	8	5	7	1	1	29
2	Finance Management	6		7	6	8	11	1	3	42
3	Procurement			4	2	6	3	1	1	17
4	Lab Services			8	1	1	3	1	1	15
5	STI/RTI	4		7	2	7	3	1	1	25
6	Condom Programming	2		6	2	6	3	1	2	22
7	Communication Advocacy & Community Mobilisation	2		18	3	6	0	1	1	31
8	GIPA stigma and ethical issues	3	3	2	3	6	4	1	2	24
9	Mainstreaming & Partnership	3	1	1	4	5	3	1	10	28
10	Blood safety	3		6	1	4				14
11	ICTC/PPTCT	4	1	9	6	4	6	1	4	35
12	CST	9	1	11	12	4	8	1	2	48
13	SIMS	8		24	13	7	11	2	8	73
14	Gender Youth and Adolescence	11	1	2	6	3	3	2	4	32
15	Targeted Interventions	74	8	20	26	22	29	1	8	188
	Total	**130**	**15**	**131**	**95**	**94**	**94**	**16**	**48**	**623**
	Grand Total	**623**								

Each of the above-mentioned working groups met twice during May-August, 2011 and in each round of working group meetings, 623 members participated in this elaborate exercise. They discussed the current status and achievements under NACP III, identified gaps, emerging priorities, potential strategic options and national, state district level operational aspects. All working members have provided excellent inputs and covered geographical, thematic, operational and policy level issues thoroughly and contributed to the future programmatic directions, priorities, capacity building needs and monitoring and evaluation requirements. The working groups have also addressed policy level and implementation options.

After two rounds of deliberations most of the working groups are in the process of finalizing the reports. However, the preliminary reports and consultations have provided invaluable insights and the groups have identified a wide range of suggestions and

recommendations. After receiving the final reports from the Working Group Conveners, these inputs will be taken into consideration and fine-tuned while developing the overall strategy and implementation plan for NACP IV. Based on the preliminary reports a list of the recommendations suggested by the WG has been incorporated under each strategy.

4 NACP IV - Goal, Objectives and Strategies

4.1 Proposed Goal and Objectives of NACP IV

Having initiated the process of reversal in several high prevalent areas with continued emphasis on prevention, the next phase of NACP will focus on accelerating the reversal process and ensure integration of the programme response. Though the national level epidemic is showing reversal, it is evident from the data triangulation and recent surveillance data that many districts in India, which were previously of low prevalence, are showing increasing levels of infection and also there are geographical regions with emerging epidemic. It would be critical to provide a greater focus on prevention services in these areas and reduce new infections.

Based on this analysis, the goal and objectives of the NACP IV may be stated as follows:

Proposed Goal: **Accelerate Reversal …**
Integrate Response …

Proposed Objectives:

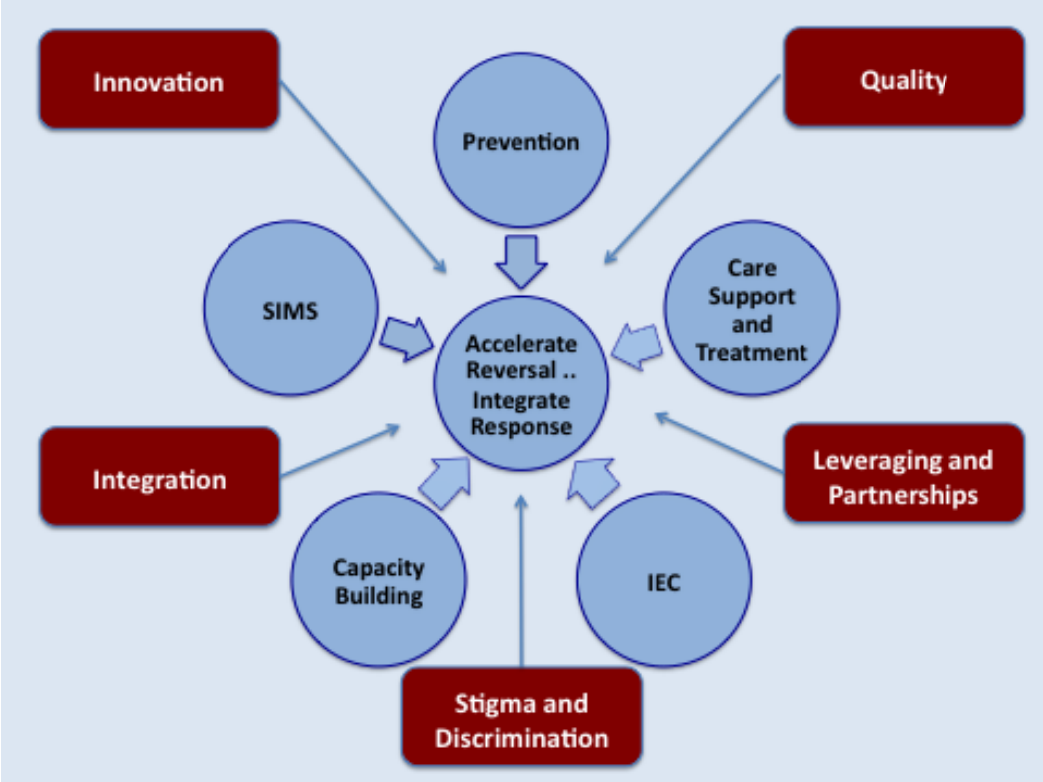
Objective 1: Reduce new infections by 60% (2007 Baseline of NACP III)

Objective 2: Comprehensive care, support and treatment to all persons living with HIV/AIDS

To achieve the goal and objectives the following key strategies have been identified.

4.2 Key Strategies

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



A synoptic view of the NACP IV strategies and cross-cutting themes.

Brief descriptions of the proposed strategies with working group recommendations/ activities are given below:

4.3 Strategy 1: Intensifying and Consolidating Prevention services with a focus on HRG and vulnerable populations

Prevention will continue to be the core strategy of NACP IV as more than 99% of the people are HIV negative. NACP IV will continue to implement Targeted Interventions (TIs) among high-risk groups such as FSW, MSM, TG/Hijra and IDU and will reach out to the bridge population (vulnerable migrants and truckers). Efforts will be made to ensure access to quality HIV services in particular STI/RTI care, quality condoms, ICTC, ART and also facilitate enabling environment.

NACP IV will also explore the possibilities of streamlining the coordination and management of blood transfusion services (a) by identifying appropriate structural changes at national, state and district levels and (b) by establishing a dedicated program to manage this component. The program will continue to link prevention with care, support and treatment.

NACP IV will also reach out to the general population through mass media, women groups and youth clubs to create awareness and increase access to HIV services.

Key Activities

4.3.1 Prevention: Targeted Interventions

- Flexibility in the TI to accommodate and address location specific issues and concerns of the target population
- Involvement of the community
- Establish and institutionalize linkages and referrals
- Gender sensitive programming
- Strengthen positive prevention
- Simplify and strengthen of M&E indicators and system
- Free supply of condoms should continue along with social marketing
- Support operations research to understand the trends in condom use and related issues
- Roles and responsibilities of all participating agencies in Targeted interventions should be clearly defined
- Strengthen strategies for enabling environment
- Harm reduction would continue with focus on Injecting Drug Users and their partners
- Strengthen evidence building and consolidate the truckers interventions with increased participation of all stakeholders
- The programme will mainstream with other Ministries and departments in respect of the following:
    - For Opoid Substitution Therapy (OST), through public health care settings
    - Linkages for legal services, livelihood and poverty alleviation
    - Mainstreaming of HIV prevention activities with existing community, social and health resources/infrastructure
    - For strengthening responses to intervene among HRGs, migrants and truckers – Ministries of Labour, Transport, Railways, Heavy Industries, Corporate Affairs, Panchayati Raj, Women &CD, Social Justice & Empowerment.
    - Convergence with health department/NRHM to ensure gradual integration

4.3.2 Migrants

- NACP IV provides an opportunity to further strengthen strategies by enhancing the evidence and designing interventions tailored to the dynamics of migrant populations including the typologies that influences their vulnerability**.**
- Scaling up responses by adopting local strategies, collaborating with corporate sector, expanding workplace interventions in unorganized sectors.

- Strengthen and scale up responses among female migrants and female spouses of returned and active migrants (at source areas).
- Strengthen strategies to improve access to services.
- Strengthen capacities of SACS, industry bodies, corporate, civil society for integrated response.

4.3.3 Sexually Transmitted Diseases

- Provision of standardized STI/RTI management to general population through all government health facilities (Medical colleges, district hospitals, sub-divisional hospitals, PHC, CHC etc)
- The provision of comprehensive sexual and re-productive health services through the functional linkages with respective units.
- Continue with Syndromic Case Management (SCM) with minimal Lab support wherever facilities are available.
- Provision of STI drugs, training and supportive monitoring for NRHM
- Syphilis screening of pregnant women to be scaled up across all ICTC/PPTCT and F-ICTC located in the facilities supported by NRHM. (NRHM should budget to procure the requisite numbers of syphilis screening test kits.)
- Involvement of Urban Health facilities (Urban health facilities, health posts, corporation hospitals and to cater to populations living in urban and peri-urban slums).
- Mobile medical units under NRHM will be linked with difficult to reach population and linkages to be established between MMU and link workers, ASHA and AWW. ICTC & STI services should be integrated with mobile van under NRHM.
- Programme should explore the possibility of task shifting i.e., getting nurses and AYUSH doctors to prescribing the drugs for SCM. An Operations Research should be conducted to establish the feasibility, usefulness & safety.
- Counsellors, all laboratory technicians in the ICTC/PPTCT programme also to be trained for syphilis testing.
- Syphilis screening along with HIV screening through single window at all HIV testing facilities in the country should be offered to HRG, STI clinic attendees and ANC attendees.
- Improved IEC and BCC tools for demand generation from vulnerable population for accessing STI service and compliance to required genital examination.
- Existing infrastructure of the organized sectors (Public & Private) will be utilized for providing standardized STI/RTI services to their dependant population.
- STI management amongst HRGs will remain NACO priority. The essential STI/RTI service package to HRG would be supported by NACO, comprising of
    - Provision of free STI/RTI treatment.
    - Regular Medical Check-up
    - Biannual syphilis screening and HIV testing
    - Presumptive treatment to FSW and MSM/TG

- Free supply of condoms for core population
- Partner management.
- Counselling services along with the PE led BCC and health education

- The program will ensure minimum essential standards (Infrastructure) for the TI-STI service delivery in Static clinics are:

    - Confidentiality and Audio visual privacy
    - Areas for examination, counselling and consultation.
    - Equipment necessary for examination like, speculum, proctoscope, flexi-lamp, examination table etc
    - Waste management system

- The programme will pilot service delivery for HRG through qualified ANM/ nurses to counter the non availability of qualified providers especially for north eastern states.
- All identified TI STI service providers at the 'Hot Spot' to be trained in STI/RTI management guidelines as per NACO prescribed curriculum for ensuring provision of effective management to all the HRG and their clients.
- TI NGO will coordinate and link with the CMOH/DHO/CS, Rogi Kalyan Samiti/district health samiti of the district to obtain some basic general ailments medicine for HRGs, so as to facilitate comprehensive health care for the HRG.
- Provide continued support towards strengthening the Regional STI centers to conduct of antimicrobial sensitivity studies, periodic etiologic surveillance, and community based prevalence studies, operations research.
- Strengthen linkages between selected TI projects participating in surveillance and State and Regional STI centres for laboratory screening of STI/RTI
- Strengthen 45 state reference centres and 7 regional centres
- Strengthen capacity of participating state and regional laboratories so that they can progressively move towards NABL accreditation.

4.3.4 Blood Safety (Blood Transfusion Service):

Although Blood Safety is currently an integral component of NACP, it has been recommended by the Working Group to change the nomenclature from Blood Safety to Blood Transfusion Service, in view of the expanded scope with inclusion of other elements of Blood Transfusion Services. Further, in view of the changing role of this component, till the time, it is recognized as a separate programme under Department of AIDS Control, it will continue to be reflected under NACP - IV.

During NACP-IV, the aim of this activity is to achieve 90% of the annual requirement of blood exclusively through voluntary non-remunerated donation.

- Educating the society for recruitment and retention of low-risk blood donors.
- Training of voluntary organizations in donor recruitment and retention. Integrate messages on blood donation in the school curricula

- One dedicated donor motivator cum counselor to be provided up to district level blood bank.
- Augment partnerships with government departments and nongovernmental organizations such as national Red Cross, voluntary blood donor organizations, national service organizations. For targeting rural areas, co-ordinate with NYKS to promote VBD.
- Blood banks and blood storage centres at district and sub district levels will be established during NACP IV where such facilities are non-existent.
- Computerization up to district level blood bank will be required for implementation of networking with one data entry operator in each blood bank and a nodal officer at the state level.
- The mechanism of transportation of blood and blood products to be strengthened.
- There is a need to introduce a phase wise automation in large volume blood banks.
- To institute EQAS programme for blood bank serology. Proficiency testing (EQAS) will be initiated to improve quality.
- Implementation of quality management systems in all blood banks which includes
    - Support accreditation of blood; and develop quality policy, procedures and reporting formats to ensure uniformity in documentation and traceability.

Appropriate use of blood and blood products

- Hospital transfusion committees would be set up in all medical colleges and district hospitals so that regular performance audit are preformed and feed back given to health providers on use of blood and blood products.
- Haemo-vigilance to be piloted in select centres and then scaled up in a phased manner.

Convergence with NRHM/other departments and Ministries

- Access to safe blood at the FRU level will ensure improvement in health indicators in general and maternal health in particular.
- Linkage of VBD program with Anemia Control Program through Department of Health/ WCD for Prevention of Anemia to ensure that significant number of voluntary donors who are deferred due to anemia will be able to donate blood.
- A joint coordination committee at State Level of SACS, NRHM and other health officials to be constituted for supervision and monitoring of various facilities under the programme.
- Develop a cost sharing mechanism with state on provision of safe blood

4.3.5 Integrated Counselling and Testing Services

- To continue, expand and accelerate coverage of counselling and testing services to at risk population.

- Strengthen the existing stand alone ICTCs supported by NACO: All existing stand alone ICTC will be continued and strengthened during NACP IV with focus on vulnerable states, so as to ensure services atleast up to CHC level.
- Integrate testing and counselling with the general health services of NRHM (facility integrated ICTC) and expand the coverage of testing and counselling services among the rural population and to integrate ICTC services in the general health system through all the 24x7 PHCs
- Expanding testing and counselling in the private health sector through public private partnership (PPP) program: To increase the coverage of pregnant women and key populations accessing private sector. Different schemes for private sectors will be developed and strengthened to ensure maximum participation
- Initiate community based HIV screening: Community based screening by front line health workers such as Auxiliary Nurse Midwives will be initiated after pilot testing in high burden districts (with low rates of institutional delivery) for augmenting PPTCT coverage
- Integrate HIV screening at TB clinics: HIV screening will be integrated as part of routine care at all the RNTCP Designated Microscopy Centers through training and multi tasking role of the existing personnel under RNTCP.
- Routine offering of provided initiated HIV counseling and testing for all TB clients, will be scaled up across the country
- Screening of PLHIVs with early signs and symptoms of TB during home visits by ANMs and referring them to RNTCP for TB screening and treatment.
- Decentralize and strengthen existing services, use of mobile clinics to reach hard to access populations and mobilization through ASHAs and link workers to increase the uptake.
- Integration with NRHM for expanding coverage of ICTC services through sharing of resources and multi-tasking.
- Link workers and mobile ICTCs will be utilized to increase the uptake among underserved sexually active and vulnerable populations.
- Linkages between ICTCs and prevention interventions (TI) will be strengthened through capacity building, facilitation of cross visits, monitoring of referrals, and increasing the visibility of ICTCs and their personnel.
- Strengthen the communication and counselling skills of counsellors and health care providers to sensitively respond to the counselling and testing needs of vulnerable and marginalized groups and to provide client friendly services
- Sensitization of field health functionaries like Anganwadi workers/ ASHA Worker/ PHC/CHC staff in basics of HIV / referral and linkages.
- Improve quality of HIV counseling and testing services in all ICTCs
- HIV Testing quality control procedures will be strengthened by the laboratory network so that high quality laboratory standards are maintained for all ICTCs.
- Strengthen supply chain management to ensure uninterrupted services at all ICTCs

- To strengthen the follow up particularly of PLHIVs including HRGs to be strengthened through Anganwadi workers/ ASHA Worker/ Link Worker/ Outreach Worker
- Advocacy for creating an enabling environment and reducing stigma and discrimination both at the health facility and the community level will be undertaken to further increase testing uptake particularly among HRG populations.
- Media campaigns will be augmented by strengthening linkages and referrals between ICTCs, STI clinics and the ongoing prevention intervention programs targeted at migrant workers, truckers etc.
- Communication tools that are targeted to improve risk perception, health seeking behavior, and knowledge about services among clients
- To link all HIV positive individuals with care, support and treatment services available under NACP

4.3.6 Prevention of Parent to Child Transmission (PPTCT)

- Expand PPTCT services to all pregnant women who are covered through RCH services in close collaboration with NRHM.
- Sensitization of all field health functionaries like Anganwadi workers/ ASHA Worker/ PHC/CHC staff for better co-ordination and delivery of PPTCT services.
- Community based screening of pregnant women through front line health workers will be expanded in all A & B and emerging districts of the country.
- Leveraging existing public private sector partnership to scale up PPTCT services in the private sector
- Couple counselling for positive prevention
- Sensitize and train private providers in collaboration with professional organizations (FOGSI, IAP, IMA and others)
- Link all of HIV positive pregnant women who are identified by the program to care, support and treatment services
- Ensure linkage to EID services to all babies born to HIV positive pregnant women under the PPTCT programme.
- Wide use of communication tools that are targeted to improve risk perception, health seeking behavior and knowledge about PPTCT services.

4.3.7 Condom Promotion

Consistent condom use will be one of the most critical aspects of NACO's prevention strategy for HIV / AIDS control

In NACP IV, NACO will continue its sentinel role of ensuring availability, accessibility, and affordability of condoms to the marginalised, hard to reach, commercially ignored populations through ramping up its Condom Social Marketing Programme (CSMP) across the country. To achieve this, it will be essential to promote

condom usage amongst general population with a focus on awareness building, demand generation, leading to behavioural change, while intensifying quality prevention services for HRG and vulnerable population by ensuring availability of condoms (free and subsidized condoms)

Based on these, the objectives for Condom Promotion for NACP IV are

1. Grow the Condom Usage in India to 3.1 billion by 2017
2. Increase condom availability to 600+ districts in 2.4 million outlets

A. <u>Key Strategies</u>

1. Segmented and differentiated marketing approach to states for effective condom social marketing programme especially in underserved areas
2. Process redesign for inventory management and supply of condoms to ensure nil stock outs.
3. Integrating/harmonizing / converging Ministry and NACO social marketing programs for cohesive distribution strategy , increased operational efficiencies, close monitoring and optimisation of subsidy and greater sustainability.
4. Converge with NRHM for social marketing of condoms through ASHAs.
5. Product and Brand Re-engineering of Deluxe Nirodh to make the brand more contemporary and relevant to current consumers and enable achievement of condom promotion objectives.
6. Development of a long term communication strategy and implementation plan with approved periodic tactical implementation with timelines, ownership and monitoring to ensure timely execution of communication elements.

4.3.8 Reaching out to HRG and Vulnerable population in rural areas

- Reach out to HRGs and vulnerable men and women in rural areas with information, knowledge, skills on STI/HIV prevention and risk reduction.
- Increasing the availability and use of condoms among HRGs and other vulnerable men and women.
- Establishing referral and follow-up linkages for various services including treatment for STIs, testing and treatment for TB, ICTC/PPTCT services, HIV care and support services including ART.
- Creating an enabling environment for PLHA and their families, reducing stigma and discrimination against them through interactions with existing community structures/ groups, e.g. Village Health Committees (VHC), Self Help Groups (SHG) and Panchayati Raj Institutes (PRI).
- To develop and sustain intervention models to address the rural intervention keeping in mind the diversity in the epidemic

- Increase uptake of both HIV prevention and care related services in the rural areas specially in selected districts
- Reduction in stigma and discrimination against HRGs and PLHIV and improvement in the quality of their lives in the rural areas
- Address issues related to gender inequity and its influence on increase in risk and vulnerability in the rural context

Positive Prevention

- Improving knowledge, attitudes and behavior of PLHIV regarding positive strategies through PLHIV Networks
- Improving linkages of ICTC with CST services
- Provision of 1st and 2nd line ART to all Eligible PLHIV
- Encourage social marketing of condoms through PLHIV networks
- Improving the quality of counseling services to encourage partner counseling and partner notification
- Promoting voluntary testing for HIV for sexual partners of PLHIV
- Strengthening BCC and condom promotion in IDU interventions
- Enhance program efforts to reduce stigma and discrimination for PLHIV
- Initiate studies on discordant couples to understand effectiveness of Positive Prevention strategies and provide mid course correction.
- All identified PLHIV will receive information of Positive Prevention strategies of the program at the time of post test counseling
- All identified PLHIV will be referred to Service Centers including ART, TB screening, STD clinic. Train PLHA so that they can participate effectively on PwP activities

4.3.9 Laboratory Services

Positioning laboratory services as a distinct component of the program at the national and state levels

- Constitute Laboratory services division at NACO headed by medical microbiologist, supported by appropriately qualified program officers, as well as technical officers and other support staff.
- Constitute State level division headed by a designated nodal officer and appoint Quality Manager for laboratory services in all SACS
- Appoint Technical Officers at NRLs, SRLs and molecular testing facilities..
- Ensuring continuation and sustainability of existing structure and activities of the laboratory services division
- Mentoring of the laboratory staff through the laboratory network - The strategy to achieve this objective would involve ensuring mentoring and monitoring through a

three tiered pyramidal system focused on bringing about total quality management. The laboratory personnel would be supervised by qualified laboratory experts for improvement of their capacity.

Enhance Diagnostic Services with focus on quality in laboratories at all levels

- Review of HIV testing strategy from time to time.
- National EQAS program for all participating labs at district and above for HIV related diagnostic services
- Enhance supportive supervision for laboratories at sub-district levels.
- Innovative strategies for enhancing implementation of laboratory services would include:
    - Creation of e-resource for addressing needs of laboratories
    - Evaluation of appropriate newer technologies including point of care diagnostics
    - Initiation of incidence testing for augmenting HIV sentinel surveillance
    - Sustaining and expand the scope of NRL Consortium on Quality
    - Strengthen laboratories to support STI sero-surveillance in selected medical colleges.
- Establish structure for technical supervision at every level located at the NRLs, SRLs, CD4 and molecular testing laboratories and catering to all HIV testing facilities
- Will ensure adherence to national/state norms to achieve improvement in HIV-related laboratory safety.
- Provide technical resources to enable combined training programs for laboratory personnel in the existing health systems outside of NACO for HIV testing.
- Advocate with MCI, DHR, DCG(I), state counterparts and other national programs on impact of adherence to quality standards.

Improvement in laboratory safety in HIV testing premises

- Preventive action e.g. HBV vaccination of laboratory personnel.
- Incident reporting and corrective actions.
- Institution of occupational safety measures.

4.4 Strategy 2: Comprehensive Care, Support and Treatment

NACP IV will implement comprehensive HIV care services for all those who are in need of such services and facilitate additional support systems for women and children. With wide network of treatment facilities and collaborative support from PLHIV and civil society groups, it is envisaged that greater adherence would be possible thereby avoiding/delaying resistance to ARVs. Additional Centers of Excellence (CoEs) and ART

centers will be established to provide high-quality treatment and follow-up services, positive prevention and better linkages with health care providers in the periphery.

It is proposed that the comprehensive care, support and treatment of HIV/AIDS will *inter alia* include: (i) free anti-retroviral treatment (ART) including second line as per National Guidelines (ii) management of opportunistic infections and (iii) facilitating social protection for PLHIV through linkages with concerned Departments/Ministries. The program will also explore avenues to increase public-private partnerships. The program will enhance activities to reduce stigma and discrimination at all levels particularly at health care settings.

NACP – IV will evolve a comprehensive care and support model whereby existing support structure i.e. CCCs, DIC and PLHIV networks will brought under one stop shop to provide HIV Care and Support services including adherence counseling, Psycho-social support, nutritional counseling, positive prevention etc. presently being undertaken through CCC/DIC under NACP-III. These mechanisms will be evaluated, reviewed and strengthened accordingly.

Link up with key Ministries like WCD, HRD, SJE, Transport and other for extending benefit of existing social protection schemes on health, nutrition, education and other special schemes.

4.4.1 Anti-Retroviral Treatment

Increase access to Anti Retroviral Treatment to all eligible PLHIV including women and children, free of stigma and discrimination.

- Scale up ART centers, COEs and LACs as projected in the target
- Every district of the country will have either an ART centre or an LAC, as per laid down criteria
- Increase demand generation IEC to ensure greater enrolment of PLHIV
- Strengthen regular follow up of all registered PLHIV to start ART as soon as eligibility criteria are satisfied.
- Improve linkages with ICTC, RNTCP, STI and TI Services
- Improve quality of CST delivery and ART adherence.
- Scale up of specific lab services (CD 4 and viral load) to meet the diagnostic requirements of ART.
- Strengthen Pre-ART follow up to identify all eligible people for treatment.
- Strengthen Information System to track, follow and retrieve PLHIV lost to follow up through initiatives like Smart Card etc.
- Initiate chemoprophylaxis for common OI in PLHA
- 2nd Line ART
    - Scale up facilities to handle increase load of second line requirement
    - Faster screening of PLHIV through SACEP
    - Scale up quality diagnostic services to pick up drug resistance

4.4.2 Treatment of Children Infected with HIV

- Scale up of Pediatric ART services to districts with high load of CLHIV
- Regular follow up of children living with HIV including 6 monthly CD4 testing.
- Nutritional counseling/support to be integral component of care and support through linkage to respective Ministries.
- Counseling on pediatric HIV and ART to children and their caregivers to be strengthened through training of counselors, nurses and doctors (general and pediatricians).
- Strengthening support services with linkages with PLHIV network

4.4.3 HIV/TB Co-infection

- Expansion of ICF activities to cover PLHIV also at LAC, CCC etc. along with high risk groups catered to by NACO TI projects
- Introduction of intensive case finding in LAC, CCC and TI
- Strengthening infection control practices in all HIV care setting
- Strengthening HIV/TB reporting through SIMS

4.5 Strategy 3: Expanding IEC services for (a) general population and (b) high risk groups with a focus on behavior change and demand generation

The programmatic thrust will be on the General Population, specially the Youth and Women; identified populations at risk, including the Most-at Risk Populations and Bridge Populations; demand generation for uptake of services; and strengthening the enabling environment.

Communication Channels to reach the targeted Population including promotion of demand generation

Under NACP IV, multimedia approach using strategic mediums of communications would be used which will involve thematic mass media, mid media, outdoor, and folk performance specially for media gray areas in rural areas. Different approach will be developed to reach to different target population including Youth, Women, Most-at Risk Populations and Bridge Populations and for Targeted Intervention including services like STI, ICTC/PPTCT, ART, HIV-TB, promoting voluntary blood donation, condom promotion.

4.5.1 Stigma and Discrimination

The communication strategies to be considered would include:

- Promotion of better understanding among people of influence of HIV/ AIDS and its stigmatizing and discriminatory effects, ensuring that advocacy efforts under NACP IV pay special attention to this.

- Designing campaigns using multiple channels i.e. mass media, mid-media, outdoor and inter-personal communication to address stigma and discrimination.
- Equipping persons living with or affected by HIV/ AIDS with communication skills and involving them as positive speakers at various forums.
- Training PLHIV to develop strategies and tools to address stigma and discrimination, including self-stigmatization.
- Documenting, publishing and disseminating successful innovative stigma reduction interventions.
- Promotion of the crisis response mechanism that may be formally constituted under NACP IV, both at NACO and SACS.
- Ensuring that all campaigns and training curricula are vetted from a stigma lens.

4.5.2 Advocacy

Advocacy in NACP IV will be built on the achievements of NACP-III for reaching out to the elected leaders at the national, state, district and panchayat level. With the adoption of National Policy on HIV/ AIDS and the World of Work, linkages with employers and industry associations need to be expanded for effective implementation of the policy. A major gap is the unorganized sector. This will be prioritized in NACP IV. Advocacy packages will be developed for different target audience including why it is important for them to address HIV/ AIDS issue and how they can do it.

4.5.3 Convergence with NRHM

HIV/AIDS messages can be suitably incorporated in the larger campaigns launched by NRHM. NRHM messages for care and tests during pregnancy may include messages on PPTCT services. RNTCP messages may include messages on HIV-TB co-infection. Condom messages by both NACO and NRHM should project triple benefits and STI messages need to be disseminated by both in a coordinated manner. Adolescent health campaigns under NRHM can include messages on youth vulnerabilities to HIV/ AIDS, delayed sexual debut and condom use. Linkages will be established with the ARSH programme of NRHM for clinical services to those adolescents and youth who need it.

4.5.4 Youth & Adolescents

Programme Priorities & Programme Targets

1. Extending coverage of government and government aided schools along with selected private schools through AEP.
2. Extending coverage of government and government aided graduate and higher level colleges through RRCs.
3. Mainstreaming with various government and other outreach programmes to reach out-of-school youth with focus on Most at Risk Adolescents (MARA).

4.5.5 Gender and HIV prevention

Strategy:

- Mainstream gender concerns relevant to HIV in national programmes
- Demand generation for women and girls' access to services

4.5.6 Stigma & Discrimination under NACP - IV

Programme Priorities

While NACP-IV will further build up and strengthen the initiatives taken up during NACP-III, the efforts will focus on the following:

- Creating an overarching enabling environment which reinforces positive attitudes and practices at the societal level
- Addressing
  - Self- stigma among PLHIV and MARPs
  - Stigma in family settings
  - Stigma at health care settings
  - Stigma at workplace
  - Stigma at educational institutions
- Protecting and promoting the rights of PLHIV, marginalised and vulnerable populations by reviewing and developing polices and legal instruments.

The interventions to address stigma and discrimination will have greater focus on women in view of the evidence that women are more likely to be stigmatised and discriminated if they are HIV positive or belong to marginalised communities.

4.5.7 GIPA & NACP - IV

Greater involvement of People Living with HIV/ AIDS will be ensured by building their capacity, setting up grievance redressal mechanism at different levels. IEC material on different important issues will be provided as well as appropriate guidance will be provided for network strengthening.

4.6 Strategy 4: Strengthening institutional capacities

The objective of NACP IV will be to consolidate the trend of reversal of the epidemic seen at the national level to all the key districts in India. The programme management structures established at state and district levels under NACP will be strengthened further to achieve the NACP IV objectives.

Programme planning and management responsibilities will be strengthened at state and district levels to ensure high quality, timely and effective implementation of field level activities and desired programmatic outcomes.

The planning processes and systems will be further strengthened to ensure that the annual action plans are based on evidence, local priorities and in alignment with NACP IV objectives.

Sustaining the epidemic response through increased collaboration and convergence, where feasible, with other departments will be given a high priority during NACP IV. This will involve phased integration of the HIV services with the routine public sector health delivery systems, streamlining the supply chain mechanisms and quality control mechanisms and building capacities of governmental and non-governmental institutions and networks. Some key activities include:

- The institutional strengthening of NACO, SACS, DAPCU and facilities
- Strengthening the support structures such as TSU, STRCs and NERO for North East
- Strengthening human resources, process of planning and coordination, organizational relationships and linkages, programme component linkage and use of technology to strengthen the quality
- Linking up with institutions in the public and private sector for quality assurance
- Strengthening the process of outsourcing and contracting out mechanisms and processes and ability to handle the contract management
- Strengthening mechanisms and capacities for imparting induction and refresher training to all technical components

4.7 Strategy 5: Strategic Information Management Systems (SIMS)

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

Under NACP-IV, it is envisaged to have an overarching Knowledge Management strategy that encompasses the entire gamut of strategic information activities starting with data generation to dissemination and effective use. The strategy will ensure

- high quality of data generation systems such as Surveillance, Programme Monitoring and Research;
- strengthening systematic analysis, synthesis, development and dissemination of Knowledge products in various forms; and
- emphasize on Knowledge Translation as an important element of policy making and programme management at all levels.

The element of Knowledge Translation will be given the highest priority to ensure making the link between Knowledge and action at all levels of the programme. The programme will focus strongly on building capacities of epidemiologists, monitoring officers, statisticians as well as programme managers at national, state and district levels in appropriate methods and tools of analysis and modeling. Institutional linkages will be fostered and strengthened to support programme for its analytical needs.

The surveillance systems will be further strengthened with focus on tracking the emerging epidemics, incidence analysis, identifying pockets of infection and estimating the burden of infection. Efforts will be made to establish behavioural tracking at district level among the key risk groups. Triangulation approaches will be refined and adopted to make the best use of epidemiological information from programme sources such as PPTCT, TI and ART. Private sector will be actively involved in surveillance activities to ensure adequate data representation. Other special areas such as mortality related to HIV, HIV among children, developing India specific data for key modeling parameters and establishing mechanism for cohort tracking of key population groups will be focused. HIV case reporting mechanisms will developed and integrated into the existing systems.

To ensure robust reporting and monitoring, Strategic Information Management System (SIMS), a web-based integrated monitoring and evaluation system has been developed and rolled out. The roll-out of SIMS is ongoing and will be firmly established at all levels including over 12,000 reporting units, to support evidence based planning, program monitoring and measuring of programmatic impacts. Simple analytical tools will be developed that can be used by programme managers to assist them in day-to-day requirements of decision making. The relevant, measurable and verifiable indicators will be identified and used appropriately.

Research priorities will also be customized to the emerging needs of the program. Emphasis will be given to undertaking HIV/AIDS research required to answer the key questions and grey areas in the programme. Strategies and systems for concurrent evaluation of various interventions will be built into the programme, so that timely assessments can be undertaken in a robust and easy manner.

NACP IV will also document, manage and disseminate evidence for effective utilization of programmatic and research data. A knowledge hub will be developed for NACP, as a one-point source of information on HIV/AIDS for a wide array of stakeholders and that can also serve as a place holder for various tools for knowledge sharing. Specific activities will be undertaken for promoting data use at national, state and district levels. Scientific writing within the programme on important topics will be promoted and their publication in peer-reviewed journals and conferences will be facilitated.

5 Cross-cutting Themes

The objectives of NACP IV will be accomplished not only by effectively implementing the above-mentioned strategies but also ensuring the cross-cutting issues are given adequate attention. They include:

(a) Ensuring Quality,
(b) Promoting Innovation,
(c) Leveraging Partnerships,
(d) Phasing Integration and
(e) Reducing Stigma and Discrimination

5.1 Ensuring Quality

Each intervention in NACP needs to be viewed in terms of a set of interrelated interventions leading to better outcomes and therefore need to be addressed in an integrated manner and coordinated effectively. The quality framework based on analysis of chain of activities from condom promotion, BCC, STI, ICTC and TI, and various other activities critical in programme process will be strengthened. Similarly care and support component will be examined in terms of a set of inter-related activities and circumstances leading to better effectiveness of interventions. Towards this end the programme will focus on developing robust systems to ensure better quality of services. Five pillars of service quality: (a) human resources, (b) process of planning and coordination, (c) organizational relationships, (d) programme component linkages, and (e) technology (use of IT to track services) will be strengthened.

5.2 Innovation

Given the maturity and complexity of NACP, the fourth phase provides the right opportunity to develop innovative approaches to achieve the goals of the programme. NACP IV will emphasize the spirit of innovation within all key programme strategies. Continuing the previous efforts innovative approaches will be used for integration of services, quality assurance at all service delivery points, coverage saturation, treatment adherence, data quality and use. IT based solutions for developing strategies for monitoring, information sharing and integration

5.3 Leveraging Partnerships

In order to achieve the goal of the NACP IV, the programme envisages promoting and leveraging of partnerships. NACP design offers a number of interventions, which need widespread coordination and collaboration between various public and private sector entities. Partnership will be made with communities, civil society, positive networks, Government health system, other related Ministries/Departments of the Government, public sector units and the private sector both in the health and non-health sector. Leveraging on strengths of each other can significantly contribute to the achievement of targets. Specifically, the following areas will be focused through leveraging on: (a) existing programmes (b) social protection schemes and related mechanisms.

5.4 Integration

The programme has adopted the strategy of using various interventions with focus on integration of services and work towards sustainability of NACP activities. The interventions in areas of TI, basic services and care, support and treatment have the potential of getting integrated with the general health system in a phased manner without compromising on quality and coverage. It is proposed to enhance integration of OST interventions with MOH and harm reduction and social protection strategies with Ministry of Social Justice and Empowerment, STI care of general population, counseling and testing services and CST services with the general health care services as part of NACP IV. However, it requires a phased approach and NACP IV will examine various options of integration of programme interventions. NACP IV will also ensure that integration of programmes will maintain the pace and quality of interventions and do not increase the financial burden of communities.

5.5 Reducing Stigma and Discrimination

NACP-IV will further build up and strengthen the stigma and discrimination initiatives taken up during NACP-III and increase the efforts on the following: (a) creating an overarching enabling environment which reinforces positive attitudes and practices at the societal level, (b) addressing self-stigma among PLHIV and most at risk populations, family settings at health care settings, at workplaces, and at educational institutions, (c) facilitate support to PLHIV, marginalised and vulnerable populations by periodically reviewing /developing polices and legal frame work and (d) encourage Greater Involvement of PLHIV (GIPA).

Address stigma and discrimination issues particularly in health care settings

	Levels	Activities
1	Individual Level	• Training to increase knowledge and awareness on stigma and discrimination
2	Institutional Level	• Training of health care providers in all public health facilities on universal precaution • Provision of post infection prophylaxis in all public health setting attending HIV patients.
3	Policy Level	• Development of mandatory institutional policy for management of HIV related illness in tune with national policy in both public and private health institutions • Strengthening legal frame work for support of PLHIV who are discriminated in health care setting

6. Proposed Targets for NACP IV

The targets for NACP IV are being derived from working group recommendations, analysis of program data and NACP III achievement of targets and projections. The detailed activity-wise targets are given in Annex-1.

7. Budget Estimate

The budget estimates have been worked out based on the targets projected for NACP IV and by using existing costing norms. The total budget for the programme works out to be Rs 12,824 crores.

Annexure 1

Proposed Targets for NACP IV

S.No.	Programme Components	Targets NACP III	Achieved 2010-11	Targets for NACP IV
	Prevention			
A	***Targeted Interventions among High Risk Groups***			
1	FSW	8,68,000	709,000	1,000,000
2	MSM	4,12,000	379,000	445,000
3	IDU	1,77,000	155,000	180,000
4	Number of TIs	2,100	1,741	1,800
	Prevention in Bridge Population			
5	Truckers	20,00,000	1,480,000	1,600,000
6	High Risk Migrants	42,00,000	3,670,000	5,600,000
B	***Integrated Counselling and Testing***			
1	Number of vulnerable population accessing ICTC services	22,000,000	15,800,000	28,000,000
2	No. of pregnant mothers tested under PPTCT	7,200,000	6800000	14,000,000
3	Number of PPTCT/ICTC centers established	5,000	8,258	14619
4	No. of HIV +ive mother and child pair receiving Prophylaxis	37,290	12,590	34400
C	***Sexually Transmitted Infections***			
1	No. adults with STI symptoms accessing syndromic management	150,00,000	1,00,20,000	170,00,000
2	No. of STI episodes in HRG treated through TIs	20,00,000	298,000	10,00,000
D	***Blood Safety***			
1	No. of Blood Component Separation Units (BCSUs)	162	155	Work in Progress
2	No. of Blood Banks	1,177	1,127	1,500
3	No. of Blood Storage Units (BSU)	3,222	685	2,537
4	No. of units of safe blood available for transfusion	10,000,000	8,010,000	12,000,000
5	Percentage of Voluntary blood donation	90%	78%	90%
E	***Condom Promotion***			
1	No. of condoms distributed (Free + Social + Commercial)	3,500,000,000	2,694,000,000	3,114,000,000
F	***Comprehensive Care, Support and Treatment***			
1	PLHIV requiring ART	340000	426,000	800,000
2	PLHIV requiring First Line ART	300000	394609	690000
3	Children requiring First Line ART	40,000	31,391	50,000
4	PLHIV on second Line ART	Nil	2,400	60,000

Minutes of the Working Group Meeting on AIDS Control

The first meeting of the Working Group on AIDS Control was held on 5-9-2011 at NACO and was presided over by Secretary & DG, NACO with Shri J.V.R. Prasada Rao, former Secretary (Health) as co-chair. The meeting was attended by the designated members and special invitees from NACO and civil society. The list of attendees is given in Annexure – I.

Secretary & DG, NACO welcomed all members and summarized the planning process that had already been undertaken by NACO involving elaborate consultation with all stakeholders. The inputs from the thematic Working Group discussions, regional consultations and e-consultations have fed into the Strategy Paper for NACP-IV, a draft of which had been shared with all members to serve as a basis for discussions. The process of consultation has involved 623 individuals in 25 thematic working groups representing positive networks, communities, civil society, technical experts, SACS representatives and officials from other central government departments. In addition, regional consultations with civil society representatives and other stakeholders were also held, as were e-consultations. Sh. Ambrish Kumar, Advisor (Health) Planning Commission appreciated the strategy paper. He also mentioned that Planning Commission has laid down a strict timeline for submission by end of September. Secretary & DG invited Dr Sudhakar, Senior HIV/AIDS Advisor, to present an overview of the Strategy Paper for NACP –IV.

After the completion of the presentation, Shri J.V.R. Prasada Rao, former Secretary, MOHFW, appreciated that the strategy paper seems to have covered all the broad areas. He made observations on the following aspects:-

1. In the context of shrinking resources for HIV internationally, and the expected decline of external support for India's HIV programme, he underscored the need to be strategic in identifying what the programme should do and what activities could be optimally assigned to others. He made specific mention of areas of education, labour and the Anganwadi workers, where the responsibilities of Ministries of HRD, MOLE and WCD, with reference to NACO IV need to be clearly delineated.
2. Shri Rao spoke about the constant challenge NACP has faced in varying levels of governance in state structures. There was an urgent need to improve their functioning. He suggested the option of having PD as a tenure post from the State Government, to ensure stability. He also mentioned the need to ensure robust coordination between the DAPCU and DM in the districts.
3. He mentioned that SIMU seemed to be missing and needs to be highlighted given its central role in NACP.
4. He suggested that the CST budget seems to be less and needs to be reviewed.
5. He also highlighted the need for a legal framework to tackle stigma and discrimination and made specific mention of the need to identify resources for sensitization of the police, so that an enabling environment could be created.

Dr. Jana, Chief Advisor, DMSC Kolkata, was of the opinion that the strategic plan was a replication of NACP-III. He felt that innovation was a cross cutting issue and should, perhaps not appear as an objective. Instead community mobilization needed to appear as an objective, as this was important for creating an enabling environment. He also stressed issue of sustainability and implementation of mechanisms for determining cost effectiveness and cost benefits of activities, for instance of M&E and capacity building activities. He questioned why Lab Services needed to

be part of NACP given that a large number of areas were being identified for integration with the larger health system. He reiterated the need to create an enabling environment given the unique nature of HIV.

Dr. Vijay Kumar, Ex-PD of TN SACS expressed the concern that state ownership is lacking in the programme and state contribution, as in the case of NRHM, should be implemented in NACP IV to address this issue. He also emphasized the need to mainstream at the state level and gave examples from Tamil Nadu. He spoke of the potential of integrating with Departments like Rural Development and PRIs. He also stressed the need to have a stringent process of NGO accreditation in NACP-IV.

Dr. Bimal Charles, PD APAC, also felt the need for increasing state ownership by having a share of state contribution in the programme budget. He also spoke of the need of political commitment at the state level. He advised caution on integration because of stigma at service centers.

Shri. Menukhol John, Principal Secretary (Health) of Nagaland emphasized the need for flexible norms to meet state specific requirements. He appreciated the facility of mobile ICTCs for areas such as the North East and wondered if they could be used to deliver more services. He highlighted the need for pay parity at the field level between various centrally sponsored health schemes to ensure retention of staff. He mentioned the need for instructions being issued from the Centre to facilitate convergence between different departments at the state level.

Shri Naresh Chandra Yadav, representative UP Positive Network, urged for effective steps for early detection, emphasized the need for social protection schemes and there dissemination at grassroots level.

Ms. Anjali Gopalan, Social Activist, Naz Foundation, struck a note of caution on identifying the programme objectives too closely with the experience of Southern states and spoke of the need to focus on the North. She also felt the need to be careful with integration as stigma and discrimination may lead to a drop in HRGs accessing services. Instead, she felt the need to focus on integration of Care and Prevention services within the programme.

Mr. Anand Grover, Director, Laywers Collective, was concerned on the high mortality rates which need greater analysis. He emphasized the need for the programme to build on community mobilization. In his opinion, NACP has always had an implicit rights based approach, which he felt should now be stated explicitly, where legal redress would be available in case of denial of services. He emphasized the need for testing on consent basis. On this issue of convergence with NRHM, he advocated adoption of a deliberate strategy that built on mutual strengths, rather than a generic approach.

Mr. Shiv Kumar, CEO, SWASTHI, Bangalore, felt that it would be necessary to ensure that all issues are resolved at the level of sub-strategies. He voiced the need for an organisational framework to be mentioned in the document. He was also of the view that innovation and quality were cross cutting themes and should not be put in separate boxes. He wondered if the increasing concerns around migrants were the indicators of an emerging rural epidemic. He emphasized the need for social protection schemes for MARPS. He also wondered whether states specific plans were being considered.

Ms. Akhila Shivdas, Consultant, Centre for Advocacy and Research, felt that the experiential insight of the community was needed and mentioned that the regional civil society consultations had made a frontal appraisal of what worked and what did not in NACP III. She felt that the Strategy Paper contained everything but perhaps required better articulation.

Ms. Radharani Mitra, Creative Director, BBC World Services Trust, drew attention to mass of BCC material created during NACPIII which should be used in the next phase also. She mentioned the potential of exploiting new technologies like internet and mobile telephony. The IEC plan should be 360^{o} and not limited to mass media. She also spoke of the scope for using the increasing rural context of television for spreading the HIV message. She also mentioned the need to strengthen monitoring and evaluation of IEC activities

Ms. Darshana Vyas, PATH Finder, Pune, felt that the successes of NACP III need to be articulated well. She felt the need to involve panchayats when moving to the village level. She also emphasized the need for state 'buy-in' and of the need to create state-level resource centres.

Dr. Paranjape, Director, NARI, emphasized the need for quality and strengthening monitoring systems. He felt the Lab Services division was essential and that NACP III has been a trendsetter in this regard. He mentioned the need for separate strategy for out-of-school children. He also emphasized the need for continued research on new regimens, new drugs and drug resistance. He felt that the projected budget was only marginally higher than NACP III and may not be adequate in view of inflation.

Dr DCS Reddy, Consultant, WHO, highlighted the divergence of epidemic and the differentiation across states: While some states were showing a decline (and these were mainly high prevalence), others were showing an increase or stabilization. He was also of the opinion that the figures projected for ART seem to be on the lower side and advised a review of the model. He was cautious on integration and cited the example of Malaria.

Ms. Anandi Yuvraj, Representative of Positive Network, emphasized the need for targets for food security, socio-economic support, and issues concerning children living with HIV. She also felt that the time have come for evaluation of IEC programmes beyond process indicators to determine, for example if they had succeeded in removing stigma. She also highlighted the need for better regulation for the private sector. She felt that the integration response was too medicalized. She argued for greater involvement of communities.

Ms Kaushalya, Representative of Positive Network, felt that the budget for CST needed to be increased. She highlighted the needs of women, widows, and children and for social and rehabilitation measures. She also spoke of the need to improve drug adherence and scale up early diagnoses. She emphasized the need to avoid drug stock-outs and felt that community involvement was necessary for this. She agreed that sates need to make a contribution to ensure ownership. She also argued for provision of more services through mobile ICTCs.

Mr. Ashok Rao Kavi, LGBT Right Activist, Mumbai, also felt that the ART budget needed to be increased. He lauded NACO for taking the initiative to identify TGs as a separate subset but felt that the strategy needed greater attention. He spoke of the need for partner notification and treatment.

Mr Raju, Coordinator, Indian Harm Reduction Network, also mentioned the need for strengthening community systems and increasing ownership. He advocated the need for improving pay of frontline workers.

Dr Sundararaman, Director, AIDS Research Foundation of India, emphasized the need for a governance superstructure to make sure that integration actually works. He also felt the need for effective mechanisms to ensure greater accountability of SACS for service delivery. He drew attention to the need for examining sustainability of prevention activities, perhaps through a convergence of epidemiological intelligence and community intelligence. In his opinion, an emphasis on IDUs would be required and the North would be the battleground in NACP IV. He also mentioned that the budget of no- NACO actors should also be clearly specified and could be segmented into (i) critical NACO activities; (ii) cost sharing for activities with other Ministries; and, (iii) cost outsourcing for activities by other Ministries . He also spoke of the need of revisiting the goals statement to ensure that there was no undue emphasis on accelerating reversal in high prevalence states at the expense of controlling the emerging epidemic in other states.

While speaking of the fatigue element, Dr Gita Bamzai, Prof. & Head, Department of Communication Research, Indian Institute of Mass Communication, mentioned the need for NACP IV to say something new. She said that analysis of gaps of NACP III should serve as learning. She emphasized the need for advocacy with NRHM and felt that integration should be approached with caution as quality would remain a major issue. She suggested that the mechanism of VHSCs and ASHA and Anganwadi workers should be used.

Ms Aradhana Johri, AS, NACO while responding to the main points clarified that innovation had been identified as a separate objective as this was a priority in the framework of World Bank funding. She agreed that it was a cross cutting issue. She also endorsed the view voiced by several members of the need for state flexibility as no one size fits for all. She mentioned that the re-categorization of districts would help in tailoring responses to local needs and in targeting vulnerabilities. She felt that one of the challenges for NACP IV would be to place HIV on top of the agenda in hitherto low prevalence states which are less well governed states and where the epidemic is showing an increase. On the issue of integration, she drew attention to the fact that HIV issues had low priority for NRHM, and of the need for dealing with stigma issues while integrating. She also emphasized that community involvement had been a strength of NACP III. However, community empowerment is visible in southern states but is seriously lacking in northern States which are an emerging concern in NACP IV. With regard to the private sector, she shared the experiences of NACP III and stated that attention would focus on private sector involvement for PPTCT, for capacity building of the private sector for tackling irrational ART regimens, and involving private sector for surveillance activities. She also drew attention to the Prime Minister's statement during the Convention of Zila Parishad Chairpersons and Mayors on HIV wherein he had emphasized that the response to HIV must be multi-sectoral and other Ministries and Departments must ensure that marginalized populations infected and affected by HIV/AIDS are also extended benefits of their schemes. She requested Advisor, Planning Commission to ensure that social protection for High risk Groups and HIV positive persons is adequately reflected in budgets of related Ministries. She also added that in order to capture state specific inputs, state representatives were included as members of all working groups and five regional civil society / multi-stakeholder consultations were also held in all regions of the country.

Secy. & DG thanked all members for their time and the fruitful discussions on the draft, the inputs from which would be incorporated in the final document for the Planning Commission. Some members requested a clarification if the amended draft would be shared again before finalization. He explained that the tight time schedule may not make that possible.

Annexure – I

Meeting on Working Group on AIDS Control Programme by Planning Commission
List of Participants

Sl. No.	Name	Designation	Address
1	Shri Sayan Chatterjee	Secretary & DG	NACO
2	Shri J.V.R. Prasada Rao	Former Secretary (MoHFW)	
3	Ms. Aradhana Johri	AS	NACO
4	Shri Ambrish Kumar	Advisor (Health)	Planning Commission
5	Dr. Bimal Charles	Project Director	APAC, Voluntary Health Services, Adayar, T.T.T.I Post, Chennai – 600 113
6	Dr. Smarajit Jana	Chief Advisor	Durbar Mahila Samanwaya Committee (DMSC), 12/5 Nilmoni Mitra Street, Kolkatta - 700006
7	Ms. Kaushalya	Rep of PLHA Network	
8	Dr. R. Paranjape	Director	National AIDS Research Institute (NARI), 73, G Block, MIDC Bhosari, Pune - 411026
9	Dr. Sudhakar	Senior HIV/AIDS Advisor	
10	Dr. S. Sundararaman	Director	AIDS Research Foundation of India, 20/2 Bagirathy Ammal Street, T Nagar, Chennai-600017
11	Dr. DCS Reddy	Consultant	WHO, 537, A Wing, Nirman Bhawan, Maulana Azad Road, New Delhi-110011
12	Dr. Gita Bamezai	Prof. & Head Communication Research	Department of Communication Research, Indian Institute of Mass Communication, JNU New Campus, Aruna Asif Ali Road, New Delhi-110067
13	Radharani Mitra	Creative Director	BBC World Service Trust, E 21 Hauz Khas Market, New Delhi-110016
14	Shri Ashok Rao Kavi	LGBT Right Activist	Mumbai
15	Mr. Anand Grover	Director	Lawyers Collective HIV/AIDS in India, 7/10, Batawala Building, Horniman Circle, Mumbai-400023
16	Ms. Anjali Gopalan		Naz Foundation, A-86, East of Kailash New Delhi - 110065
17	Ms. Akhila Sivadas		Centre for Advocacy & Research, New Delhi

Sl. No.	Name	Designation	Address
18	Dr. Kurien Thomas		CMC Vellore
19	Mr. Vijay Kumar	Special Secretary	Dept of Health & Family Welfare, Govt. of Tamil Nadu
20	Shri. Menukhol John	Principal Secretary	H&FW, Nagaland
21	Shiv Kumar	CEO	SWASTHI, Bangalore
22	Dr. Darshana Vyas		PATH Finder, CASP Bhavan 3rd Floor, 132/2, Survey No. 132/2, Plot No 3, Pashan - Baner Lind Road, Pune-411021
23	Mr. Naresh Chandra Yadav		UP Positive Network
24	Dr. Venkatesh	DDG (M & E)	NACO
25	Mr. Kanwaldeep Singh	Director (Finance)	NACO
26	Mr. Rajagopal	Director (Admin)	NACO
27	Dr. S. Khaparde	DDG (STI)	NACO
28	Dr. Mohd. Shaukat	ADG (CST)	NACO
29	Dr. Sandhya Kabra	ADG (LS)	NACO
30	Dr. Neeraj Dhingra	ADG (TI)	NACO
31	Dr. R.S. Gupta	DDG	NACO
32	Mr. Krishnakumar	NPO (Fin)	NACO
33	Mr. Manilal	PO	NACO