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

Strategy Document

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Ministry of Health & Family Welfare
Government of India

Contents

I. Background of National AIDS Control Programme-I, II & III

India's AIDS Control Programme is globally acclaimed as a success story. The National AIDS Control Programme (NACP), launched in 1992, is being implemented as a comprehensive programme for prevention and control of HIV/AIDS in India. Over time, the focus has shifted from raising awareness to behaviour change, from a national response to a more decentralized response and to increasing involvement of NGOs and networks of PLHIV.

In 1992, the Government launched the first National AIDS Control Programme (NACP I) with an IDA Credit of USD 84 million and demonstrated its commitment to combat the disease. NACP I was implemented with an objective of slowing down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country. National AIDS Control Board (NACB) was constituted and an autonomous National AIDS Control Organization (NACO) was set up to implement the project. The first phase focused on awareness generation, setting up surveillance system for monitoring HIV epidemic, measures to ensure access to safe blood and preventive services for high risk group populations.

In November 1999, the second National AIDS Control Project (NACP II) was launched with World Bank credit support of USD 191 million. The policy and strategic shift was reflected in the two key objectives of NACP II: (i) to reduce the spread of HIV infection in India, and (ii) to increase India's capacity to respond to HIV/AIDS on a long-term basis. Key policy initiatives taken during NACP II included: adoption of National AIDS Prevention and Control Policy (2002); Scale up of Targeted Interventions for High risk groups in high prevalence states; Adoption of National Blood Policy; a strategy for Greater Involvement of People with HIV/AIDS (GIPA); launch of National Adolescent Education Programme (NAEP); introduction of counseling, testing and PPTCT programmes; Launch of National Anti-Retroviral Treatment (ART) programme; formation of an inter-ministerial group for mainstreaming; and setting up of the National Council on AIDS, chaired by the Prime Minister; and setting up of State AIDS Control Societies in all states.

In response to the evolving epidemic, the third phase of the national programme (NACP III) was launched in July 2007 with the goal of **Halting and Reversing the Epidemic** by the end of project period. NACP was a scientifically well-evolved programme, grounded on a strong structure of policies, programmes, schemes, operational guidelines, rules and norms. NACP-III aimed at halting and reversing the HIV epidemic in India over its five-year period by scaling up prevention efforts among High Risk Groups (HRG) and General Population and integrating them with Care, Support & Treatment services. Thus, Prevention and Care, Support & Treatment (CST) form the two key pillars of all the AIDS control efforts in India. Strategic Information Management and Institutional Strengthening activities provide the required technical, managerial and administrative support for implementing the core activities under NACP-III at national, state and district levels.

The capacities of State AIDS Control Societies (SACS) and 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 Programme monitoring and technical areas. A dedicated North-East regional

Office has been established for focused attention to the North Eastern states. State Training Resource Centres (STRC) were set up to help the state level implementation units and functionaries. Strategic Information Management System (SIMS) has been established and nation-wide rollout is under way with about 15,000 reporting units across the country. The next phase of NACP will build on these achievements and it will be ensured that these gains are consolidated and sustained.

Key strategic approaches adopted during NACP-III include

1. Effective use of evidence for planning, geo-prioritisation and decision-making
2. Addressing emerging challenges through flexible intervention modeling approaches
3. Designing for scale: Designing interventions and systems to enable effective nation-wide scale-up of services
4. Keeping communities at the centre: Community Involvement (HRGs, PLHIV) and Participatory approaches at all levels of programme planning, implementation and review
5. Evolving well laid out and standardized operational guidelines for every programme component covering all aspects of implementation
6. Setting up of 16 thematic Technical Resource Groups comprising of experts from diverse institutions and organizations advising the programme on policy decisions
7. Institutionalising quality assurance through strategic in-sourcing of technical support
8. Establishing robust structured mechanisms for capacity building, supervision and monitoring
9. Integrating with larger health system in a systematic manner and Mainstreaming HIV into other non-health ministries/ departments, industry and corporate sector.
10. Leveraging partnerships with civil society, development partners, academic institutions & private sector
11. Maintaining a balance between Prevention and Treatment
12. Mobilising political will

NACP-III is an excellent example of community involvement and ownership in developing appropriate strategies and in reaching out to high risk and vulnerable populations. The programme has been greatly benefited by the critical role played by the civil society and PLHIV networks in community mobilization, increasing access to services, addressing stigma and discrimination and provided valuable insights into developing appropriate societal response. NACP- IV will build on the motivation and interest of these stakeholders particularly at the community level to actively engage with complex issues of HIV. It will focus on reduction of stigma and discrimination at health care setting, work places and at educational institutions. Legal framework promoting the rights of PLHIV and marginalized and vulnerable population will be strengthened.

Funding from Development Partners has played significant role in implementation and scale up of NACP interventions over the last two decades. The World Bank, The Global Fund, USAID, DFID, The Clinton Foundation, BMGF, UNAIDS, UNICEF, UNDP, CDC, WHO and other development partners have provided critical support to the overall planning and implementation of NACP strategies. Their support continues to be important in the changing landscape of global economy and dwindling international resources for HIV/ AIDS control efforts.

II. Achievements, Epidemic Scenario and Challenges for NACP-IV

Achievements

During third phase of NACP(2007-2012), there has been substantial scale up of coverage of Female Sex Worker (81%), Injecting Drug Users (80%), Men having Sex with Men (64%), Truckers (57%) and Migrants (40%) through a total of around 1,948 targeted interventions (TIs) (including 71 donor supported TIs) for high risk groups and bridge population. Link Worker Scheme was established in 159 districts to reach out to rural HRGs and their partners and vulnerable groups. The overall condom distribution in the country has risen from 160 crores pieces in 2006-07 to 300.79 crores pieces in 2011-12.

Counseling and testing services were rapidly scaled up through 4,537 stand-alone Integrated Counseling and Testing Centres (ICTCs), 9,196 Facility Integrated ICTCs and 1,805 under Public and Private Partnership model. The programme reached 194.94 lakh persons including 85.63 lakh pregnant women during 2011-12. The programme provided Nevirapine prophylaxis to 11,981 infected mother-baby pairs at the time of delivery during 2011-12. The coverage of STI services has been scaled up through 1,131 designated STI clinics and 100.72 lakh STI/RTI patients managed as per the national protocol during 2011-12. During 2011-12, 93.2 lakh units blood were collected across the country. NACO supported Blood banks collected 55 lakh units; 84.3% of this was collected through voluntary blood donation.

Care, support and treatment services are being provided through 355 ART centres, 725 Link ART Centres (LACs) and 253 Community Care Centres (CCC). About 5.16 lakh PLHIV were receiving ART by March 2012. The programme had also started providing 2nd line ART in a phased manner and more than 4,208 persons have been given 2nd line ART.

The third phase of the Red Ribbon Express, launched on 12th January, 2012, covered 162 halt stations in 23 states and reached out to 1.14 crore people, and trained over one lakh district resource persons. Over 90,000 persons were counseled for HIV and over 70,000 persons were tested for HIV. STI treatment was provided to 11,000 persons and 80,000 persons availed general health check-up. The mobilization of political leaders and enormous support of State Governments and District administrations has been the key to the success of this project.

Epidemic Scenario

HIV Estimations 2012 corroborate the fact that HIV epidemic in India continues to decline at the national level. There is an overall reduction in adult HIV prevalence, HIV incidence (new infections) in adults and AIDS-related mortality in the country. India is estimated to have around 20.9 lakh persons living with HIV in 2011, at an estimated adult HIV prevalence of 0.27%. Adult HIV Prevalence has decreased from 0.41% in 2001 through 0.35% in 2006 to 0.27% in 2011.

India has demonstrated an overall reduction of 57% in estimated annual new HIV infections (among adult population) from 2.74 lakhs in 2000 to 1.16 lakhs in 2011, reflecting the impact of scaled up prevention interventions. Declines in adult HIV prevalence and new HIV infections are sustained in most of the states including all the high prevalence states of South India and North East. However, rising trends have been noted in some other low prevalence states.

Considerable declines in HIV prevalence have been recorded among Female Sex Workers at national level (5.06% in 2007 to 2.67% in 2011) and in most of the states, where long-standing targeted interventions have

focussed on behaviour change and increasing condom use. Declines have been achieved among Men who have sex with Men (7.41% in 2007 to 4.43% in 2011) also, though some pockets in the country show higher HIV prevalence among them with mixed trends.

Analysis of the drivers of emerging epidemics in the low prevalence states points towards the possible role of out-migration from rural areas to high prevalence destinations in causing the spread of epidemic in most of north Indian states. In some of the north-western states, Injecting Drug Use is identified to be the major vulnerability fueling the epidemic. In addition, long distance truckers also show high levels of vulnerability and form an important part of bridge population. Transgenders are also emerging as a risk group with high vulnerability and high levels of HIV among them.

Wider access to ART has led to 29% reduction in estimated annual AIDS-related deaths between 2007 and 2011. It is estimated that the scale up of free ART since 2004 has saved over 1.5 lakh lives in the country till 2011 by averting deaths due to AIDS-related causes. With the current pace of scale up of ART services, it is estimated to avert around 50,000 – 60,000 deaths annually in the next five years.

Key Concerns and Challenges for NACP-IV

1. Need to consolidate successes gained, by sustaining prevention focus besides effectively addressing the challenges
2. Given the experience of previous phases where the programme focused on saturating the coverage, NACP- IV needs to advance towards focusing on ensuring higher quality of services under interventions while sustaining the coverage.
3. Emerging Epidemics in certain low prevalence states and districts due to Migration to high prevalence areas, that is increasingly being identified as an important factor driving the epidemic in several north Indian districts, and epidemics related to IDU, MSM, Transgenders & young sex workers
4. With increasing coverage of treatment and decreasing AIDS-related mortality, a significant number of people are likely to require first and second line ART treatment during the 12th Plan period. Major challenge for the programme will be to ensure that the treatment requirements are fully met without sacrificing the needs of prevention
5. Regions with different maturity levels of the epidemic will require different resources and services. Emerging epidemics in selected regions will need greater prevention focus while care and support in the setting of matured epidemic, particularly management of 2nd line ART, will need a robust management and financing strategy. These need to be mapped out.
6. International finances for HIV/AIDS programme are shrinking. NACP-III had less than 10% of domestic budgetary support. NACP-IV will require a significantly greater element of domestic budgetary support.
7. Integration with larger health system to ensure sustainability. Need to address the challenge of competing priorities and varying capacities of health systems in different states to provide access to quality HIV/AIDS services
8. Ensuring social protection schemes for people infected and affected with HIV/AIDS through mainstreaming of HIV/AIDS with other ministries
9. Stigma and Discrimination that is still prevailing against the vulnerable population, persons and families infected and affected with HIV, especially at work place, healthcare settings and educational institutions.
10. NACP- IV has to address the need for innovation within all key programme strategies for integration of services, quality assurance at all service delivery points, coverage saturation, treatment adherence, data quality and use, etc.

III. NACP-IV Preparatory Process

The strategy and plan for NACP-IV (2012-2017) has been developed through an elaborate and extensive process. The process has adopted an inclusive, participatory and widely consultative approach with 15 Working Groups and 30 sub-groups covering all thematic areas involving 624 representatives from central and state governments, representatives of high risk group communities, people living with HIV/AIDS, civil society, subject experts, experts from NRHM and other government departments, development partners and other stakeholders. Regional and state level consultations, e-consultations and special studies/ assessments were also undertaken to develop the strategic plan. Planning commission steering committee has also been closely overseeing this entire process.

The thematic working groups that deliberated on several aspects of NACP-IV are listed below:

a. Programme Implementation and Organizational Restructuring
b. Finance Management / Innovative Financing
c. Procurement
d. Laboratory Services
e. Sexually Transmitted Infections (STI)/ Reproductive Tract Infections (RTI)
f. Condom Programming
g. Communication Advocacy and Community Mobilization
h. Greater Involvement of People Living with HIV/AIDS (GIPA), Stigma, Discrimination and Ethical issues
i. Mainstreaming and Partnerships
j. Blood Safety
k. Integrated Counseling and Testing Centres (ICTC)/ Prevention of Parent to Child Transmission (PPTCT)
l. Care, Support and Treatment
m. Strategic Information Management (SIMS)
    - Surveillance
    - Research and Knowledge Management
    - Monitoring and Evaluation
n. Gender, Youth and Adolescence
o. Targeted Interventions (TI)
    - Female Sex Workers (FSW)
    - Men having Sex with Men (MSM)
    - Injecting Drug Users (IDU)
    - Capacity Building
    - Migrants
    - Link Workers
    - Transgenders/ Hijras
    - Truckers

Each of the above-mentioned working groups met twice during May-August, 2011 and in each round of working group meetings, 624 members participated in this elaborate exercise (Table below). Detailed discussions were held on current status and achievements under NACP III, identified gaps, emerging priorities, potential strategic options and national, state and district level operational aspects. All working group members have provided excellent inputs and covered geographical, thematic and operational issues thoroughly. In doing so, they have 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.

List of Working Groups and their Group Representations:

Thematic Working Group	Group Representation								
	Civil Society	Network	Experts	Development Partners	DAC	SACS	NRHM	Other Govt. Departments	Total
Programme Implementation	1		6	8	5	7	1	1	29
Finance Management/Innovative Financing	6		7	6	8	11	1	3	42
Procurement			4	2	6	3	1	1	17
Laboratory Services			8	1	1	3	1	1	15
STI/RTI	4	1	7	2	7	3	1	1	26
Condom Programming	2		6	2	6	3	1	2	22
IEC	2		18	3	6	0	1	1	31
GIPA, Stigma, Discrimination	3	3	2	3	6	4	1	2	24
Mainstreaming and Partnership	3	1	1	4	5	3	1	10	28
Blood safety	3		6	1	4				14
ICTC/PPTCT	4	1	9	6	4	6	1	4	35
CST	9	1	11	12	4	8	1	2	48
SIMS	8		24	13	7	11	2	8	73
Gender, Youth and Adolescence	11	1	2	6	3	3	2	4	32
Targeted Interventions	74	8	20	26	22	29	1	8	188
Total	**130**	**16**	**131**	**95**	**94**	**94**	**16**	**48**	**624**

After two rounds of deliberations, the working groups prepared reports based on thematic areas. These reports and consultations provided invaluable insights and the groups have identified a wide range of suggestions and recommendations. These inputs were taken into consideration and fine-tuned while developing the overall strategy and implementation plan for NACP-IV. Based on the reports, a list of the recommendations suggested by the working groups have been incorporated under each strategy.

The key steps in the NACP- IV preparation process included

- Collating inputs from the Working Groups and sub-groups consultations
- Consultations with civil society
- Consultations at the state level with SACS and partners
- Regional consultations with communities, PLHIVs, public-sector, private sector and other key stakeholders
- E-consultations / discussions on specific topics to enrich the project development process and strategic approaches.
- Commissioning of assessments
- Collaboration with development partners
- Preparation of draft strategic plan
- Reviews, clearances and approvals

IV. NACP-IV Project Design

Consolidating the gains made till now, the National AIDS Control Programme Phase-IV aims 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 five years.

Goal: Accelerate Reversal and Integrate Response

Objectives

Objective 1:

Reduce new infections by 50% (2007 Baseline of NACP III)

Objective 2:

Provide comprehensive care and support to all persons living with HIV/AIDS and treatment services for all those who require it.

Key Strategies

Strategy 1:
Intensifying and consolidating prevention services, with a focus on HRGs 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 behaviour change and demand generation.

Strategy 4:
Building capacities at national, state, district and facility levels

Strategy 5:
Strengthening Strategic Information Management Systems

The **Guiding principles** for NACP- IV will continue to be:

1. Continued emphasis on three ones - one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National M&E System.
2. Equity
3. Gender
4. Respect for the rights of the PLHIV
5. Civil society representation and participation
6. Improved public private partnerships.
7. Evidence based and result oriented programme implementation.

Cross-cutting Areas of Focus

1. Quality
2. Innovation
3. Integration
4. Leveraging Partnerships
5. Stigma and Discrimination

Key priorities under NACP- IV are:

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

Package of services provided under NACP-IV

Prevention Services

1. Targeted Interventions for High Risk Groups and Bridge Population (Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders/Hijras, Injecting Drug Users (IDU), Truckers & Migrants)
2. Needle-Syringe Exchange Programme (NSEP) and Opioid Substitution Therapy (OST) for IDUs
3. Prevention Interventions for Migrant population at source, transit and destination
4. Link Worker Scheme (LWS) for HRGs and vulnerable population in rural areas
5. Prevention & Control of Sexually Transmitted Infections/Reproductive Tract Infections (STI/RTI)
6. Blood Safety
7. HIV Counseling & Testing Services
8. Prevention of Parent to Child Transmission
9. Condom promotion
10. Information, Education & Communication (IEC) & Behaviour Change Communication (BCC).
11. Social Mobilization, Youth Interventions and Adolescent Education Programme
12. Mainstreaming HIV/AIDS response
13. Work Place Interventions

Care, Support & Treatment Services

1. Laboratory services for CD4 Testing and other investigations
2. Free First line & second line Anti-Retroviral Treatment (ART) through ART centres and Link ART Centres (LACs), Centres of Excellence (COE) & ART plus Centres.
3. Pediatric ART for children
4. Early Infant Diagnosis for HIV exposed infants and children below 18 months
5. HIV-TB Coordination (Cross-referral, detection and treatment of co-infections)
6. Treatment of Opportunistic Infections
7. Drop-in Centres for PLHIV networks

New Initiatives under NACP-IV

1. Differential strategies for districts based on data triangulation with due weightage to vulnerabilities
2. Scale up of programmes to target key vulnerabilities
   a. Scale up of Opioid Substitution Therapy (OST) for IDUs
   b. Scale up and strengthening of Migrant Interventions at Source, Transit & Destinations including roll out of Migrant Tracking System for effective outreach
   c. Establishment and scale up of interventions for Transgenders (TGs) by bringing in community participation and focused strategies to address their vulnerabilities
   d. Employer-Led Model for addressing vulnerabilities among migrant labour
   e. Female Condom Programme
3. Scale up of Multi-Drug Regimen for Prevention of Parent to Child Transmission (PPTCT) in keeping with international protocols
4. Social protection for marginalised populations through mainstreaming and earmarking budgets for HIV among concerned government departments
5. Establishment of Metro Blood Banks and Plasma Fractionation Centre
6. Launch of Third Line ART and scale up of first and second Line ART
7. Demand promotion strategies specially using mid-media, e.g., National Folk Media Campaign & Red Ribbon Express and buses [in convergence with the National Rural Health Mission(NRHM)]

V. Summary of Key Strategies

Strategy 1: Intensifying and Consolidating Prevention Services

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

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

Some of the activities under prevention strategy include:

1. Saturating quality HIV prevention services to all HRG groups, based on emerging behaviour patterns and evidence
2. Strengthening needle exchange Programme, drug substitution programme and providing Opioid Substitution Therapy (OST)
3. Reaching out to MSM and Transgender communities
4. Addressing the issues related to coverage and management of rural interventions
5. Providing quality STI/RTI services.
6. Expand the ICTC services and strengthen referral linkages
7. Strengthening positive prevention
8. Strengthening management structure of blood transfusion services
9. Implementing National EQAS for all participating labs at district and above for HIV related diagnostic services.

Strategy 2: Comprehensive Care, Support and Treatment

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

With increasing maturity of the epidemic, it is very likely that there will be greater demand for 2nd line ART, Opportunistic Infections management, etc., and NACP-IV will address these needs. It is proposed that the comprehensive care, support and

treatment of HIV/AIDS will inter alia include: (i) anti-retroviral treatment (ART), including second line (ii) management of opportunistic infections including TB in PLHIV, (iii) positive preventions and (iv) facilitating social protection and insurance for PLHIV through linkages with concerned Departments/ Ministries. The programme will explore avenues of public-private partnerships. The programme will enhance activities to reduce stigma and discrimination at all levels particularly at health care settings. Some of the illustrative activities include:

1. Scale up ART Centres, LACs, and COEs ART services.
2. Strengthening follow up of patients on ART and improving quality of counselling services at ART service delivery points.
3. Comprehensive care and support services for PLHIV through linkages.
4. Provide guidelines and training for integration in health care settings to NRHM staff

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

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

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

Strategy 4: Strengthening institutional capacities

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

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

Strategy 5: Strategic Information Management System (SIMS)

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

- high quality of data generation systems such as Surveillance, Programme Monitoring and Research;
- strengthening systematic analysis, synthesis, development and dissemination of Knowledge products in various forms;
- emphasis on Knowledge Translation as an important element of policy making and programme management at all levels; and
- establishment of robust evaluation systems for outcome as well as impact evaluation of various interventions under the programme.

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

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

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

VI. Monitoring Framework

Impact Indicators

1. Reduction of new HIV infections (HIV Incidence): Estimated number of Annual New HIV Infections (HIV Incidence)
2. Reduction in mortality among people living with HIV/AIDS: Estimated number of annual AIDS-related deaths
3. Survival of AIDS patients on ART: Percentage of adults and children with HIV known to be on treatment at 24 months after initiation of antiretroviral therapy at select ART Centres

Outcome Indicators

1. Behavioural Change among Female Sex Workers: Percentage of female sex workers who report using a condom with their last client (Target: 80% to 85% increase by 2017; 5% increase over the baseline of IBBS 2012-13).
2. Behavioural Change among Men who have Sex with Men: Percentage of men who have sex with men who report using a condom during sex with their last male partner (Target: 45% to 65% increase by 2017; 20% increase over the baseline of IBBS 2012-13).
3. Behavioural Change among Injecting Drug Users: Percentage of injecting drug users who do not share injecting equipment during the last injecting act (Target: 45% to 65% increase by 2017; 20% increase over the baseline of IBBS 2012-13).

Programme Targets

By 2017, NACP- IV will cover 9 lakh FSWs, 4.40 lakh MSMs including TG/Hijras and 1.62 lakh IDUs through Targeted Interventions. Over 16 lakh long distance truckers and 56 lakh high-risk migrants will be separately targeted as part of bridge population. Vulnerable sections of the population will be reached through ICTCs (280 lakh tests) and through expanded STI/RTI programme covering nearly 90 lakh people. 140 lakh pregnant women will be targeted, in close collaboration with NRHM, to prevent mother-to-child transmission in the community. Supply of 90 lakh units of safe-blood and enhanced use of blood products will be ensured. The programme will provide 1st and 2nd line ART to all who require it. It is estimated that there will be 10,05,000 people on ART (including 50,000 children who require 1st line ART and nearly 50,000 PLHIV who require 2nd line drugs) by 2017. The detailed year-wise targets under NACP-IV are given at Annex.

VII. Budgets

Component Wise Cost:

Programme Component	Amount (Rs. in Crores)
Prevention	
Targeted Interventions (TIs)	
FSW	863.82
MSM/TG	339.94
IDU	480.57
Migrants	306.64
Truckers	99.62
STRCs and TSUs	227.10
Sub-total TIs	**2,317.69**
Link Worker Scheme	169.00
ICTC/PPTCT	1,585.13
STI	356.54
IEC	1229.68
Mainstreaming	99.36
Condom Promotion	1,801.40
Blood Transfusion Services	818.80
Lab Services	118.20
Prevention Total	**8,495.80**
Care, Support and Treatment	**3,961.15**
Institutional Strengthening & Project Management	**569.70**
SIMS	**388.40**
Total Budget	**13,415.05**

ANNEX: YEAR-WISE TARGETS UNDER NACP-IV						
S. No	**Programme Components**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**
	Prevention					
A	**Targeted Interventions among High Risk Groups and Bridge Populations**					
1	No. of FSW covered	7,74,000	8,34,300	8,82,000	9,00,000	9,00,000
2	No. of MSM covered	2,76,000	3,60,800	4,11,400	4,18,000	4,40,000
3	No. of IDU covered	1,50,000	1,55,000	1,58,000	1,60,000	1,62,000
4	No. of Truckers covered	9,40,000	11,20,000	11,20,000	16,00,000	16,00,000
5	No. of High Risk Migrants covered	28,80,000	44,80,000	51,52,000	56,00,000	56,00,000
6	No. of Targeted Interventions	1,867	2,256	2,459	2,605	2,703
B	**Link Worker Scheme**					
1	No. of HRGs covered	1,40,000	1,60,000	1,80,000	2,00,000	2,20,000
C	**Integrated Counseling and Testing**					
1	No. of vulnerable population accessing ICTC services / annum (in lakh)	168	224	236.6	264.6	280
2	No. of pregnant mothers tested under PPTCT/annum (in lakh)	84	112	118.3	132.3	140
3	No. of PPTCT/ICTC centres	11,369	12,019	12,889	14,029	14,769
4	No. of HIV +ve mother and child pairs receiving Anti-retroviral Prophylaxis	18,060	24,080	25,435	28,445	30,100
D	**Sexually Transmitted Infections**					
1	No. of adults with STI symptoms accessing syndromic management/ annum (in lakh)	56	67.5	76.5	85.5	90
2	No. of designated STI /RTI clinics	1,150	1,200	1,250	1,250	1,250
E	**Blood Transfusion Services**					
1	No. of Blood Banks supported under NACP	1,170	1,170	1,235	1,235	1,300
2	No. of units of blood collected in DAC supported Blood Banks/annum (in lakh)	56	67.5	76.5	85.5	90
3	Percentage of Voluntary blood donation in DAC supported Blood Banks	80%	80%	85%	90%	95%
F	**Condom Promotion**					
1	No. of condoms distributed (in crore pieces)	109.2	116.1	123.3	129.7	136.4
G	**Comprehensive Care, Support and Treatment**					
1	No. of ART Centres	400	450	500	550	600
2	No. of PLHIV provided free ART (includes First line, Second line & Children)	6,42,400	7,51,400	8,40,200	9,40,000	10,05,000

India's voice against AIDS

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