

National AIDS Control Program (NACP)

AIDS is a global pandemic that affects 34 million people worldwide. According to United Nations programme on HIV and AIDS (UNAIDS), 3.4 million of these are less than 15 years old. Extensive labor migration, low literacy levels and lack of awareness about the disease are further exacerbating the HIV-AIDS level in India. The Government of India has also raised concerns about the role of intravenous drug use and prostitution in spreading AIDS.

Extent of the problem

- 2.39 million people are suffering from AIDS in India (2008-09), which puts us at par with Zimbabwe (1.2 million) and Nigeria (3.3 million) (World Bank)
- 39% of the HIV infections are amongst women.
- 56.3% of the population uses family planning methods. (NFHS)

Objective

The National AIDS Control Program – III (2007-2012) was launched with the objective of halting and reversing the HIV/AIDS epidemic in India by 2012, bettering the target of 2015 set in the HIV/AIDS related Millennium Development Goal.

As envisaged in the 12th Five Year Plan 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 main objectives are:

- Reduce new infections by 50% (2007 Baseline of NACP III)
- Provide comprehensive care and support and treat all persons living with HIV/AIDS

The New Phase and Scope

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

To further its commitment towards attaining the Millennium Development Goals, NACP – IV will continue to emphasize on:

- One Agreed Action Framework, One National HIV/AIDS Coordinating Authority and One Agreed National M&E System (the Three Ones)
- Equity
- Gender
- Respect for the rights of the PLHA
- Civil society representation and participation
- Improved public private partnerships
- Evidence based and result oriented program implementation

The above goals aim at a holistic coverage of society and engage all relevant stakeholders in building a strong institutional framework to address the menace of HIV/AIDS. The goals also aim at improving service delivery while the program is ongoing so as to enhance its effectiveness.

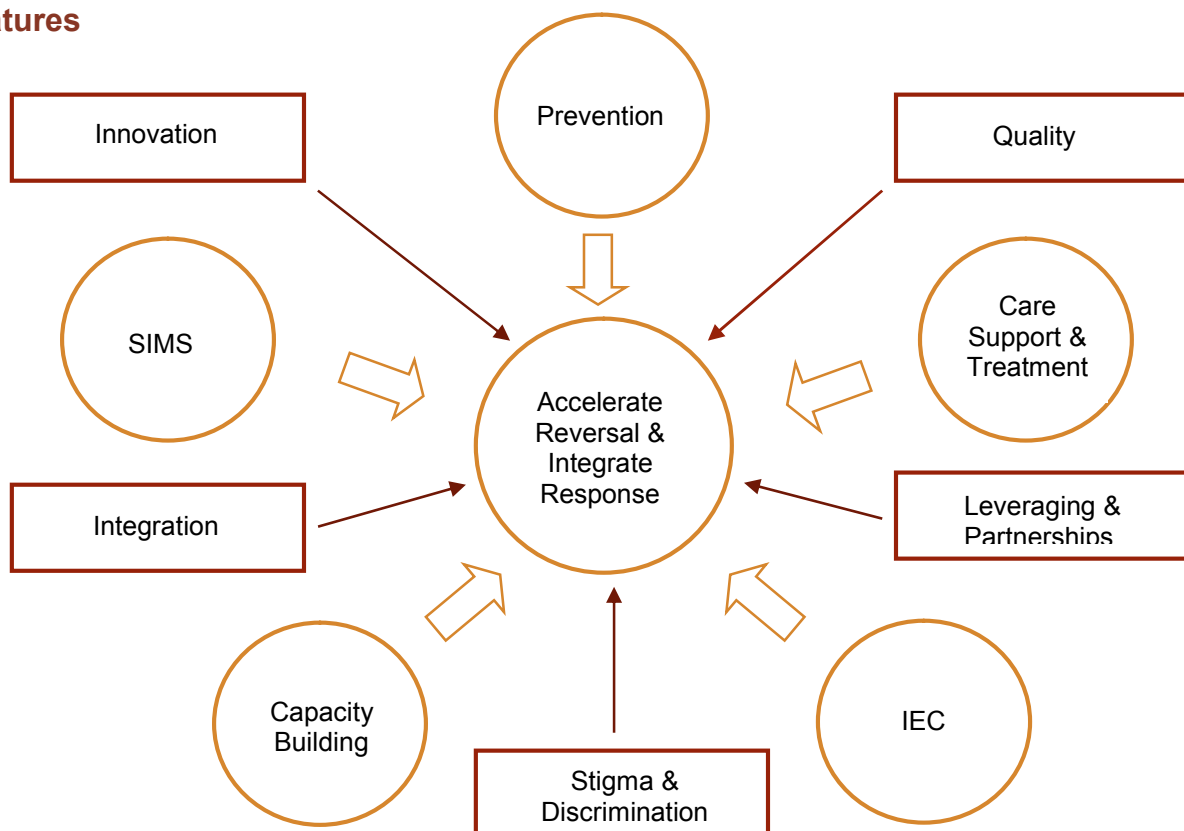
In addition, NACP IV will reinforce the focus on five cross-cutting themes, namely:

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

NACP IV will take into account the fact that many of the states with emerging epidemics and higher vulnerabilities are those with relatively poor health infrastructure, weak implementation capacities, issues around governance and limited ownership of the program. This Phase 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. Though prevalence is low in many states, HIV trends are rising and the number of new infections in some states is large. Thus, considering only the prevalence may mask the attention to be given to the states with rising trends and vulnerabilities. Hence NACP IV will take into consideration the stage of the epidemic and trends and quantum of new infections for identifying focus states.

Key Features



Source: Planning Commission

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

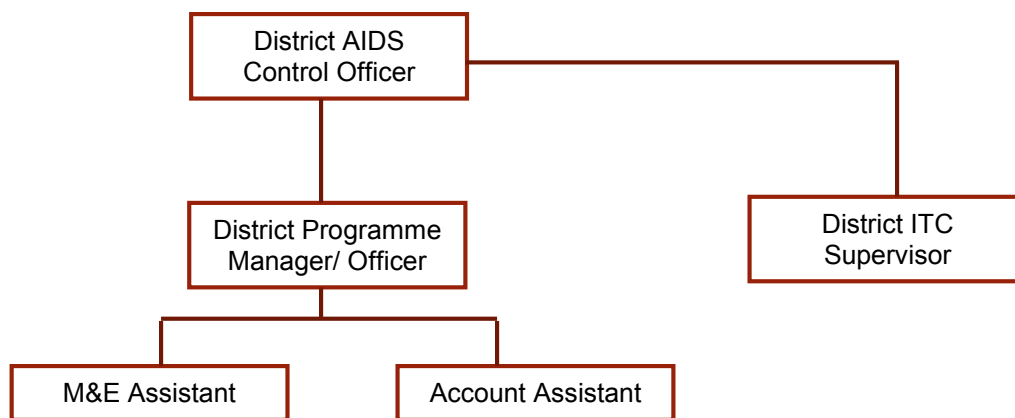
Strategy 3: Expanding IEC services for (a) general population and (b) high risk groups with a focus on behavior change and demand generation

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

Strategy 5: Strengthening and use of Strategic Information Management Systems

Delivery Mechanism

At the District level, the District AIDS Control and Prevention Unit (DACPU) has the following structure:



Source: NACO

The District AIDS Control Officer (DACO) is responsible for facilitating the implementation of strategy for prevention and control of HIV/AIDS in the district, assist the district administration to put up a unified action plan for HIV/AIDS program in the district by building convergence within the health & family welfare sector and also with the different stakeholders present in the district, ensure continuity of the supply chain, service delivery and implementation of directions of State AIDS Control Society (SACS) in the district.

The objective of NACP and NRHM convergence is to provide seamless services of HIV/AIDS to all vulnerable population. It includes improving access to HIV counseling and screening, prevention of Parent To Child Transmission (PPTCT) services, detecting HIV infection in the vulnerable population on first contact with the health system, reduce missed opportunities of early detection of infection, promote birth and survival of HIV free child, improving longevity with quality of life of PLHIV with supportive environment. As per the guidelines issued by NACO and MOHFW on NACP and NRHM convergence, the following would be major areas of convergence:

- Utilization of existing NACP resources for strengthening RCH services
- Training of all ASHAs/ANMs/Supervisors on NACO training module “ Shaping our Lives” for grassroots workers
- Universal HIV and Syphilis screening as part of routine ANC
- Expansion of ICTC & PPTCT services to all 24 X7 health facilities
- Condom management
- STI/RTI service delivery in CHC/PHC (drugs, training, reporting)
- Functioning of blood storage centres and linkages with mother blood banks
- Effective management of blood donation camps
- IEC and mainstreaming
- Supply chain management

The district level roll out of convergence activities will be ensured through:

- Inclusion of specific convergence activities in district NACP and NRHM annual action plans (To facilitate this, it is expected that NRHM and DAPCU are part of each other's annual action planning process)
- Routine coordination and information sharing between DAPCU and NRHM
- Ensure participation of NRHM point person (DMHO/CDMO) in DAPCC meeting

Participation of DAPCU in DHS meetings and district medical officers review meeting. In NACP IV the process of District Annual Action Planning (DAAP) also invites participation and consultation with the involvement of a wide range of stakeholders – ensuring a participatory bottom up approach. The role of DAPCU in this regard is:

<p>Preparation</p>	<ul style="list-style-type: none"> • Compilation of data for the district from various sources (like district epidemiological profile, district resources profile, district specific program data for all components for a year, other sources like NFHS, DHS for the district etc) • Hold preparatory meetings with various stakeholders at district level (like briefing with the district collector, meeting with CMO/DMO, meeting for inviting key stakeholders for the workshop, meetings for inviting line department representatives of NRHM, WCD, Tribal, Forest, NGOs etc) • Invitation from DAPCU to all the stake holders with information on venue and time of workshop • Organize the workshop and facilitate the focused discussion among stakeholders of the program
<p>Compilation</p>	<ul style="list-style-type: none"> • Compilation of the first draft of the DAAP presentation • Organize meeting with the DC after the district action planning workshop to make a presentation of preliminary draft plan by the DACO to share the findings/ observations, district priorities and inform the next steps in this process. • Make changes to the Draft of Annual Action Plan as suggested by the district authority (If any) • Finalize the draft DAAP document and submit it to SACS with signature of DC
<p>Evaluation</p>	<ul style="list-style-type: none"> • Obtain final approved DAAP from SACS • Derive district level and facility level targets based on approved plan • Routinely review program based on the approved plan and targets • Plan activities based on gaps identified

A separate account shall be maintained at the district level as per the guidelines of NACO for managing NACP funds. This account will be operated by the DACO and District Program Manager (DPM) jointly. The funds to be released to the DAPCU will be for the activities such as: Funds for operational expenses, IEC and other activities depending on the district specific needs of respective SACS. The salary of DAPCU staff shall be distributed through Electronic Clearance System (ECS) by SACS.

Along with their own financial records, DAPCUs are also expected to facilitate facility level SOEs and UCs. DAPCU is not an accounting unit therefore all the bills and vouchers will be submitted to SACS for further settlement of advances given to DAPCU/facilities.

Anti-Stigmatizing campaign in Andhra Pradesh

The “**Be Bold**” campaign was launched in the high HIV prevalent state of Andhra Pradesh in December 2006. The campaign was launched to bridge the gap between awareness and action. Though previously launched campaigns could create general awareness about HIV/AIDS, they failed to bring about any behavioral change – perpetuating the HIV stigma and hindering medical attention.

The key objectives of the campaign were to (1) bring about perceptible systemic changes in the way the issues related to HIV was handled; (2) create institutions and (3) strengthen them for sustainability. It brought together the affected community and empowered them.

It had many sub-campaigns and initiatives addressing all these issues and has general as well as targeted messages, which are non-judgmental and are positive in nature.. “Be Bold” was the message and “getting tested for HIV” was the medium.

- The Be Bold messages: Set of “Be Bold” messages that talk about HIV/AIDS in general – Be Bold to get tested; Be Bold to accept the result of the testing etc.
- Targeted Be Bold messages: These exhort (1) Families to Be Bold to take care of HIV positive family members; (2) Doctors to Be Bold to treat HIV positive patients; (3) Teachers to Be Bold to admit HIV positive children to their classes; (4) Youth to Be Bold to accept HIV positive peers as friends etc.

A “Bold Doctors Club” was formed in all districts to encourage doctors in the state to treat HIV positive cases. The clubs had Doctors from both private and Government sector who have been trained and are willing to treat HIV positive patients. All necessary precautionary support, delivery kits and Post Exposure Prophylactic (PEP) drugs were provided to them. This initiative emboldened more and more HIV positive patients to come out and access health care facility without fear of getting rejected.

The impact of this campaign was phenomenal. During the twelve months from December, 2006 – November, 2007, total HIV tests conducted was 15,32,952 as against 5,98,029 tests conducted during the twelve months of 2005-06. The total tests conducted during the campaign period (from 1st December, 2006 to 31st March, 2008) was 18,09,117. Prevalence of HIV among general population came down from 2% in 2005 to 0.88% in 2007 according to the National Sentinel Survey conducted annually by NACO. This could be attributed to the success of Be Bold campaign: which helped to identify more PLHAs and prevented inadvertent spread of disease by them, significant increase of condom usage among commercial sex workers, better access to health care facility and improved awareness and reduction of stigma.