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STRATEGIC PLAN
FOR
THE PREVENTION AND CONTROL OF AIDS
IN INDIA

1992-1996 97 ?

Prepared by

THE MINISTRY OF HEALTH & FAMILY WELFARE

In collaboration with

THE WORLD HEALTH ORGANIZATION
NEW DELHI

September 1991

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PREAMBLE

In August-September 1991 the Ministry of Health & Family Welfare of India arranged a planning exercise aimed at development of a strategic plan for AIDS prevention and control in the country for the five year period of 1992 through 1996. High level officials and technical staff from the Ministry of Health & Family Welfare, the Indian Council of Medical Research, the National Institute of Communicable Diseases, representatives from some states and some non-governmental organizations were supported by experts from the Global Programme on AIDS of WHO/HQ and of the Regional Office for South-East Asia, and from UNICEF. The team members were briefed on the development of AIDS control activities and HIV/AIDS situation in India, made field trips to several states and finally came up with the proposals for the control of AIDS in India which are summarized in this document.

EXECUTIVE SUMMARY

The first AIDS case in India was reported in May 1986. Since then, 104 full blown cases of AIDS have been reported to the Ministry of Health and Family Welfare from 15 States and the Union Territories of the country. It has been estimated that, if the transmission of HIV continues at the same rate, by the year 2000, some five million persons would have been infected in India and the number of cases of full blown AIDS cases would exceed one million.

To combat this threat, the Government of India has drawn up a comprehensive strategic plan with the following components:

Programme Management: An effective programme management structure, operating as a Technical Mission, will be established at the national and state levels, and it will be provided with technical, financial and operational support. Four coordinating bodies will be formed at the union level: National AIDS Committee representing all Ministries, selected private organizations, and NGOs; Board for AIDS control, formed from high level officials of MOH&FW to oversee the programming funding and policy; National Programme Coordinating Team operating as a Technical Mission to implement programme activities; and a National Technical Advisory Committee to provide technical supports to the Programme.

Surveillance and Research: A targeted surveillance programme will be developed to monitor the development of the HIV/AIDS epidemics and provide necessary information for mobilizing national political and social leaders and design prevention and control strategies.

IEC and Social Mobilization for Prevention of HIV Tansmission: This component will include programmes aimed at prevention of HIV/STD transmission through all known routes. To accomplish this a comprehensive programme will be developed with the following elements: media campaigns utilizing standardized messages, targeted interventions for high risk groups, collaboration and support to NGOs, social mobilization, training, operational research, and evaluation and monitoring. This component will link closely with other components of the Programme.

STD Control: Sexually Transmitted Diseases are associated with the same high risk behaviours that put a person at risk for HIV infection. In addition, STDs are now recognized as an independent risk-factor for HIV infection. Therefore, the existing STD control programme will be revitalized, pilot programmes will be initiated in the major metropolitan cities, and expanded to other areas.

Condom Programming: The condom programming component will strengthen public and private efforts to optimize the availability and use, by people at risk, of good quality latest rubber prophylactics for the prevention of STD/HIV. This will include overcoming obstacles to condom promotion, improving access to good quality products, and developing appropriate

condom promotion and distribution systems for different audiences.

Blood Safety: The blood safety programme will develop and strengthen the national blood transfusion system; ensure adequate supply of blood to the blood centres, and ensure safety of blood and blood products. This will involve upgrading existing centres, extensive training, and the expansion of the voluntary blood donation system.

Reduction of Impact: Counselling for HIV infected individuals and AIDS cases will be integrated into existing counselling and health care systems. Training of AIDS counsellors will be given priority. In addition, an assessment will be made of potential home care schemes to accommodate the future AIDS cases.

Training of health staff, NGO personnel, and other involved individuals will be an integral part of all components.

The Government of India is placing AIDS control as a high priority and recognizes the importance of mobilizing all segments of society, including various Ministries, private sector organizations and institutions, and voluntary and other interested organizations to achieve the desired aim of the prevention of HIV transmission in India.

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AIIMS	All India Institute of Medical Sciences, New Delhi
AIR	All India Radio
ANC	Antenatal Clinic
ARC	AIDS Related Complex
ASHI	Association for Social Health in India
ATF	AIDS Task Force
BEE	Block Extension Educator
CBHI	Central Bureau of Health Intelligence, New Delhi
CCH	Central Council of Health, new Delhi
CHEB	Central Health Education Bureau, New Delhi
CMC	Christian Medical College, Vellore
CMO	Chief Medical Officer
CNB	Central Narcotic Bureau
CS	Civil Surgeon
DGHS	Directorate General of Health Services, New Delhi
DHS	Directorate of Health Services (State)
ELISA	Enzyme-linked Immunosorbent Assay
EPI	Expanded Programme on Immunization
FPIA	Family Planning Association of India
GOI	Government of India
GPA	Global Programme on AIDS
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
ICMR	Indian Council of Medical Research
IFA	Immunofuorencence Assay
IVDU	Intravenous Drug User
KAP	Knowledge, Attitudes and Practices
MCH	Maternal and Child Health
MH&FW	Ministry of Health & Family Welfare
MTP	Medium Term Plan
NAC	National AIDS Committee
NACA	National AIDS Control Authority
NACP	National AIDS Control Programme
NAHPF	National AIDS Health Promotion Forum
NBAC	National Board for AIDS Control
NCERT	National Council for Education, Research & Training
NGO	Non-governmental Organization
NICD	National Institute of Communicable Diseases, New Delhi
NIH	National Institute of Health
NISD	National Institute of Social Defence
NIV	National Institute of Virology, Pune
NPCT	National Programme Coordination Team
PCR	Polymerate Chain Reaction
PCT	Programme Coordination Team
PHC	Primary Health Centre
PRAD	Physician responsible for AIDS Diagnosis
PSI	Population Services International
PVO	Private Voluntary Organization
QAP	Quality Assurance Programme
RC	Reference Centre
RIPA	Radio Immuno Precipitation Assay
RS	Rupee (1 US dollar equivalent to Rs. 26)
SAC	State AIDS Committee
SC	Surveillance Centre
SCERT	State Council for Education Research and Training
SH	Sentinel Hospital

SHEB	State Health Education Bureau
SHL	Sentinel Hospital Laboratory
SPCT	State Programme Coordination Team
STP	Short Term Plan
STD	Sexually Transmitted Disease
TAC	Technical Advisory Committee
TTHIVI	Transfusion Transmitted HIV infection
TTI	Transfusion Transmitted Infection
UT	Union Territory
VHAI	Voluntary Health Association of India
VNRD	Voluntary Non-remunerated Donation
VHG	Village Health Guide
WB	Western Blot
WHO	World Health Organization
ZBTC	Zonal Blood Testing Centre

SECTION I: INTRODUCTION

1.1 BACKGROUND

1.1.1 Country and Health Profile

India has a land area of 3,287,782 km.sq., bounded by Burma on the east, by China (Tibet) and Nepal on the north and Pakistan on the west.

India's population is the second largest in the world, estimated in 1991 to be approximately 843,930,861 inhabitants with a density of 267 persons per sq.km., varying from 6319 persons per sq. km. in Delhi to 10 in Arunachal Pradesh. According to the 1981 census of the total population, 39.6% are under 15 years; 53.9% in the age group 15 to 59 and 6.5% in the age group 60 and above. 77% of the population live in villages.

Hindus constitute 83%, Muslims 11%, Christians 3% and Sikhs 2% of the population of the country. Indian people speak 16 major languages and about 250 regional dialects. The most widespread language is Hindi, spoken by nearly half of India's population.

In 1981 the working population of India was about 229 million (183 million males and 46 million females); nearly 70% of the people in agriculture and related occupations.

The literacy rate in India is 46.9% for males and 24.8% for females. In 1981, 94% of children in respective age groups were going to primary school. 25.8 million children attend the middle-level schools (classes VI-VIII). There are 140 universities or their equivalent in the country.

In 1973, there were 12,653 newspapers, of which 822 were dailies. These were printed in 56 different languages, the largest number (3,200) published in Hindi. Licenses have been issued for about 14 million radio receivers and 2.2 million TV sets.

The 1991 census recorded 557,139 inhabited villages and 3,949 towns; 270,295 villages have less than 500 inhabitants, and 9,039 have 5,000 or more people; 1,226 towns have a population in excess of 100,000 and 83 with population over 250,000; 12 cities have a population of one million or more.

India has 22 states and 9 union territories (Annex 1). Each state and union territory is divided into districts of which there are 434 in the country. Government programmes are implemented through 5,011 community development blocks.

Internal movement of people in India is enormous. Mobility has greatly increased in recent years as a result of the increase in economic activity, improved transport and communications, extensive education and new employment opportunities. Large population movements are also connected to religious festivals and pilgrimages.

1.1.2 Health Services

At the central level the Ministry of Health & Family Welfare and its technical arm - the Directorate General of Health Services - oversee and coordinate all health programmes.

At the state level, the Minister of Health is the head of the Department of Health Services, with the Secretary of Health assuming executive responsibility and the Directorate of Health Services providing technical expertise. In some states, a health organization at the divisional level is responsible for public health programmes in that particular division. In each district there is a district health organization headed by a Chief Medical Officer of Health or Civil Surgeon, responsible for public health, medical care and family welfare.

In 1989, there were 331,630 registered physicians, 9,796 dentists and 219,299 registered nurses. There are also 10,145 hospitals of which 6,985 are in urban areas.

The peripheral health establishments include: 1,425 community health centres, 16,454 primary health centres and 109,791 sub-centres.

1.1.3 Health Status

India has a crude death rate of 11.9 per 1,000, crude birth rate of 32.9 per 1,000, and a growth rate of 2.1%. The infant mortality rate is 95 per 1,000 births.

Important diseases include malaria, respiratory tract infections (pneumonia, measles), gastrointestinal tract infections (diarrhoeal diseases, enteric fevers, parasitic infestation), non-communicable diseases (cardiac diseases, deficiencies, accidents and trauma). Important causes of death are infectious and parasitic diseases, diseases of circulatory systems, accidents, poisonings, violence, and diseases of respiratory and digestive systems.

1.1.4 Development of the AIDS Control Activities Programme Management

The AIDS task force in India was established by the Indian Council of Medical Research (ICMR) in 1985. In 1986 the National AIDS Committee was formed under the Chairmanship of the Union Health Secretary with the Director General of Health Services, Director General of ICMR, senior officers from the Ministry of Health and representatives from other organizations concerned as members.

In 1987, the National AIDS Control Programme was formulated mainly with a view to arrest the infection by stepping up surveillance activities and social mobilization through health education.

Clinical Surveillance

The Government of India has sent some clinicians and nurses abroad to receive training on various clinical, laboratory and hospital management aspects of the disease at Sydney (Australia) and in the USA. These trainers have conducted follow up courses in different medical colleges in the country.

For effective clinical management of HIV infected persons and AIDS cases, the Government of India has identified 13 medical colleges in the country wherein ideal AIDS units could be established. Some of the medical colleges have already established the AIDS units. These units equipped with the latest and most sophisticated equipment are supposed to provide symptomatic treatment to HIV infected persons and AIDS patients.

Screening of Blood and Blood Products

At present, testing for HIV infection is being conducted in 67 surveillance centres in the country. For testing donors' blood, the Directorate General of Health Services has established 29 zonal blood testing centres in four metropolitan cities. In addition to the above 29 centres, 27 cities were identified in different parts of the country for establishing the zonal blood testing centres.

Safety of Blood Products

Detailed guidelines regarding precautions to be taken by the manufacturers of blood products have been issued by the Drug Controller of India on 15 March 1989.

Health Education and Information

The other component of the programme is the creation of awareness among the general public. The responsible agency in the DGHS is the Central Health Education Bureau which prepares the health education material on AIDS in consultation with the State Governments. The Bureau has conducted certain health education activities like press advertisement in important newspapers, display of hoarding in some cities, and printed educational and training materials.

The Medium Term Plan for Prevention and Control of AIDS

In 1990 the DGHS, in consultation with the World Health Organization, prepared a Medium Term Plan for the prevention and control of AIDS in India for the period 1990-1992. The implementation of the planned activities was focused on 4 metropolitan cities and the states of Manipur, Maharashtra, Tamil Nadu and West Bengal, where there has been a rapid increase in the HIV infection. As the HIV/AIDS epidemic is a new arrival in India, the initial activities have been quite limited in terms of geographical spread and population coverage.

1.2 Epidemiological situation and projections for 1990-2000

1.2.1 HIV/AIDS Epidemics

The first HIV sero-positive individual in India was identified in 1986 among the prostitutes of Madras city. Since then the surveillance activities were gradually expanded, resulting in HIV testing of over 600,000 persons by the end of 1990. The surveys covered various groups, including heterosexual promiscuous males and females, pregnant women, blood donors, and recipients. The data for all groups combined showed that the HIV prevalence rate grew from 0.2% in 1986 to 1.3% in 1990. The highest prevalence rates were found in the sex workers in Bombay (27%), sex workers evacuated from Bombay to Tamil Nadu (over 70%), and among IV drug users in the city of Imphal of Manipur state (43%). Through these surveys, it was established that the female sex workers in the states of Maharashtra and Tamil Nadu and IVDUs in three North-Eastern Sates are leading risk groups for HIV infection. There are indications that IV drug use is practiced in Calcutta and Madras and a large homosexual population was identified in Bombay, but HIV prevalence in these groups has not been studied.

The first AIDS case in India was reported in May 1986. The person was infected by blood transfusion during coronary bye-pass surgery in the USA. The second case, a hemophiliac was reported a month later. Since then, till December 1991, 104 full blown AIDS cases have been reported to the Ministry of Health & Family Welfare from 15 States and Union Territories of the country.

Of the 60 AIDS patients reported by January 1991, 12 were foreigners. Most of the Indian patients had acquired the infection through heterosexual contacts, and 30 of them within the country.

The result of the studies conducted since 1986 allow us to draw the following conclusions:

- considering the incubation period of AIDS, and that several full-blown adult AIDS cases resulting from indigenous transmission have been recorded, it is presumed that HIV was introduced to India somewhere in the early 1980s. An epidemic spread of the virus started in 1985-1986;

- By 1991 the virus has spread to most of the States and Union Territories of the country;

- There are two distinct patterns of HIV transmission: sharing of syringes, and needles by IV drug users in North-Eastern India, and multipartner sex in the rest of the country;

- In some population groups with identified risk behaviour the HIV virus has been transmitted at an alarming speed, so that 30% of prostitutes have

been infected in a 3-4 year period in Bombay and about 50% of IV drug users just in one year in the city of Imphal.

1.2.2 Projections for 1990-2000

Several estimates on the HIV prevalence in India have been made (GPA/WHO, Dr. Jacob John from Vellore, Dr. N.C. Dermott of USA), where the estimated number of HIV infected persons ranges between 300,000 and 1,000,000. Applying a statistical model (EPI MODEL) these estimates have indicated that the number of cumulative AIDS cases by 1991 could be between 2700 and more than 9000 respectively, based on the two extremes of the estimated HIV prevalence.

If one assumes a constant rate of HIV transmission in India between now and the year 2000 with an estimate of 400,000 HIV-infected individuals (200,000 from high-risk groups and 200,000 from the general population in India) as of 1990, the projection is that by the year 2000, India would have at least five million HIV-infected individuals , with in excess of one million AIDS cases, if the rate of HIV transmission is not changed.

SECTION II: DEVELOPMENT OF GENERAL POLICY ON AIDS PREVENTION AND CONTROL

2.1 Commitment of the Government of India

The Government of India promptly reacted to the appearance of HIV in the country. Following the identification of the first sero-positive person in 1986, a National AIDS Committee was established to coordinate the AIDS prevention activities. The committee formulated major strategies for the National AIDS Prevention and Control Programme in 1987. In August 1989 a bill on AIDS Prevention and Control was initiated in the Rajya Sabha (upper house of the Parliament).

In 1990 the Government in cooperation with WHO preparaed the Medium Term Plan (1990-1992) for AIDS prevention and control and in the implementation of this plan in several states and union territories.

Beginning from 1992 the Government allocated US$ 13.5 mln. from the National budget in support of the National AIDS control programmes in the states.

In recent years, Government attracted the attention of numerous external organizations to the AIDS problem in India by periodic briefing of the UN agencies and international NGOs. At a meeting of interested parties held in August 1991, the Secretary of Health stated that the Government is ready to extend full collaboration in AIDS control in India. He indicated special managerial teams will be built at the national and state levels for the programme action.

The Ministries of Education, Welfare, Home Affairs, Information and Broadcasting, Tourism, Labour, Urban Development and Railway, as well as non-governmental organizations will closely collaborate with the Ministry of Health and Family Welfare in educating and mobilizing their employees, general population and identified target groups.

2.2 General Policy on AIDS Prevention and Control

A general policy on AIDS prevention and control will be elaborated by the Ministry of Health and Family Welfare to address the following issues:

- identification of the priorities in the programme activities;
- major educational and intervention approaches in the control and prevention of HIV epidemic;
- stressing inter-sectorial collaboration in prevention of HIV transmission in identified risk groups, as well as in education of the general population;

- control of sexually transmitted diseases as a leading strategy in the prevention of HIV infection;

- condom use, marketing, and quality control;

- reduction of the transmission through blood;

- HIV testing and screening, HIV surveillance, testing of institutionalized persons;

- prevention of stigmatization, and discrémination through protection of confidentiality and partner notification;

- women and child;

- approaches for setting research projects on social and epidemiological aspects;

- HIV/AIDS and human rights

The policy will also provide basis for recommendations to the Government in amendment of the Suppression of Immoral Traffic Act (SITA) and the act 377 of the Indian Penal Code in a way that they advance the implementation of the NACP activities. Political commitment to prevent and control AIDS will be sought from the States.

SECTION III: LEADING STRATEGIES AND INTERVENTIONS

3.1 Programme Goals and Objectives

The goal of the proposal is to establish a comprehensive multi-sectoral Programme for the prevention and control of AIDS in India.

The long term objectives of the Programme include:

- Prevention of HIV transmission in India
- Reduction of morbidity and mortality associated with HIV infection
- Minimizing the social and economic impact resulting from HIV infection.

The Medium-Term Objectives:

1. Effective coordination of HIV/AIDS surveillance and prevention activities in all States and Union Territories of the country;

2. Provision of continuous sound technical support to the AIDS control programmes in the States;

3. Establishment of a nation-wide HIV surveillance system;

4. Establishment of a nation-wide AIDS-case and referral system;

5. Monitoring the development of the HIV/AIDS epidemic in the country;

6. Ensuring a high level of awareness on HIV, AIDS and preventive measures among all segments of the population;

7. Establishing an operational system for condom promotion among major population groups;

8. Developing intervention projects among the groups of identified risk practices in the areas where such practices are highly prevalent;

9. Decreasing the practice of the professional blood donations;

10. Screening for HIV infection of at least 80% of blood units collected for blood transfusions and all units used for blood products preparation;

11. Developing capacities and services to provide psycho-social support to HIV infected persons, AIDS patients and their associates.

The objectives listed above would be achieved by implementation of the activities under the following seven COMPONENTS of the Programme:

(1) Programme Management
(2) Surveillance and Research:
(3) IEC and Social Mobilization for Prevention of HIV Transmission
(4) STD Control
(5) Condom Programming
(6) Blood Safety
(7) Reduction of Impact

3.2 STRATEGIES AND ACTIVITIES

COMPONENT 1: STRENGTHENING PROGRAMME MANAGEMENT, MONITORING, REVIEW AND EVALUATION OF THE PROGRAMME

OBJECTIVE: Establishing an effective programme management at the National and State levels, providing technical, financial and operational support to the staff and organizations implementing programme activities.

At the Union level there will be four coordinating/management bodies:

1. National AIDS Committee (NAC)
2. National Board for AIDS Control (NBAC)
3. National AIDS Control Authority (NACA)
4. National Technical Advisory Committee (NTAC)

The external and internal structures of the National AIDS Control Organization are shown in the figures 3.2.1 & 3.2.2.

At the State Level there will be two bodies ;

1. The State Empowered Committee
2. The State AIDS Cell

Strategy 1: Establishing intersectoral collaboration for AIDS control and the mobilization of the opinion leaders

The National AIDS Committee

An intersectorial National AIDS Committee (please see figure 3.2.1) will be created to bring together various Ministries, Non-Governmental and Private Voluntary Organizations. The objectives of this body would be to mobilize their own administrative networks for education of employees at the work place, social mobilization of the identified population groups targeted for intervention projects and providing collaboration to the Ministry of Health and Family Welfare staff at the National, State and community levels. The Committee would meet at regular intervals for briefing on the HIV/AIDS problems in the country, programme development and for ensuring intersectoral support to the Ministry of Health and Family Welfare.

With the support of the National AIDS Committee, the Programme Coordination Team (see figure 3.2.1) will establish working relations with the national participating parties, ministries, religious organizations, social organizations and NGOs, by encouraging them to (a) identify liaison officers, (b) to develop programme activities. The Ministeries of special importance are the Ministry of Information and Braodcasting, Ministry of Human Resource Development (Education, Youth, Women & Child Development, Welfare), Ministry of Home Affairs (police), Ministry of Defence, Ministry of Railways, and Ministry of Labour.

Apart from exchange of information, regular meetings will be arranged by the Ministry of Health and Family Welfare with these committees for progress evaluation and problem solving. All national participating parties will receive periodic progress reports from the programme, as feed-back.

Conferences for the policy makers will be held annually at the national and state levels, where the participating parties will be briefed on the AIDS situation, prospectives of the development of HIV/AIDS epidemics in India, and activities in the monitoring and control of HIV/AIDS epidemics.

Strategy 2: Providing efficient programme coordination at the national level

The National AIDS Control Board

The National AIDS Control Board will consist of the following :

- Secretary (Health)
- Secretary (Family Welfare)
- Director General of Health Services
- Director General, ICMR, New Delhi
- Joint Secretary & Financial Adviser, Ministry of Health and Family Welfare
- Representative of the Dept. of Expenditure
- NACA Project Director

It is proposed to empower the Board to make decisions on major issues related to the issue of sanctions for activities, award of contracts to private agencies and NGO's, undertake procurement, matters related to personnel etc. The broad terms of reference of the Board are shown in the Annex 2.

The Board will meet quarterly and will have occasional meetings if required to solve urgent matters, on request of the Project Director or Chairman of the Technical Advisory Committee.

The National AIDS Control Authority (NACA)

Considering the importance of AIDS problem in India, a separate dedicated staff is proposed to be established under the National AIDS Control Authority (NACA). The NACA will be an attached office of the Ministry of Health and Family Welfare under a Project Director who will be given powers of the head of the Department (see Figures 3.2.1 and 3.2.2). The Team will consist of officers handling technical matters, IEC, administration and finance. There will be two additional Directors : one to look after the technical aspects of the programme and the other to look after IEC. The administrative branch will include officers for staff matters, procurement, finance and accounting. The Additional Directors of the technical branches and IEC, shall also be responsible for training. These branches will have officers on IEC/Media, epidemiology and research, for HIV laboratory network development, blood safety and STD control, cooperation with

NGOs, national consultants and mobile teams. The broad terms of reference of the NACA are shown in the Annex 2.

The staff of the NACA will meet monthly (or more frequently if required) to review the developments and problems to be solved jointly.

Strategy 3: To strengthen technical and research capability of the programme

The Technical Advisory Committee (TAC)

The Technical Advisory Committee (TAC) will be established as an advisory body to the NACA

The Committee will be under the chairmanship of the Director General of Health Services and will include officials and scientists from leading research and training institutions in the country, specialized in health, and medical sciences, information, education and social sciences, as well as the officials from the Ministry of Health and Family Welfare, representing various national programmes and projects, identified by the Programme Manager and approved by the Board.

The Committee will form 8 sub-committees, each supporting a particular component of the programme.

The broad terms of reference of the TAC are shown in the Annex 2.

The Committee will meet twice a year for a review of the HIV/AIDS epidemiological situation. Ad hoc meetings of the whole committee or its sub-committees will be held on the request of the Project Director or the Chairman of the Committee for review of guidelines, research proposals and other related activities.

WHO participation in the programme management

WHO will provide technical assistance to the National AIDS Control Programme in India, and operational and financial assistance for disbursement of funds routed through the WHO Global AIDS Trust Fund, and supplies. In order to play this role efficiently, the WHO Representative Office in the country will be reinforced by a GPA country team and support staff, which will include an epidemiologist/health manager, a technical officer for management, administration and financial matters, an IEC adviser, an STD adviser etc. WHO will also provide short term consultants as per advise of the NACA.

FIGURE 3.2.1

EXTERNAL STRUCTURE OF THE NATIONAL AIDS CONTROL PROGRAMME

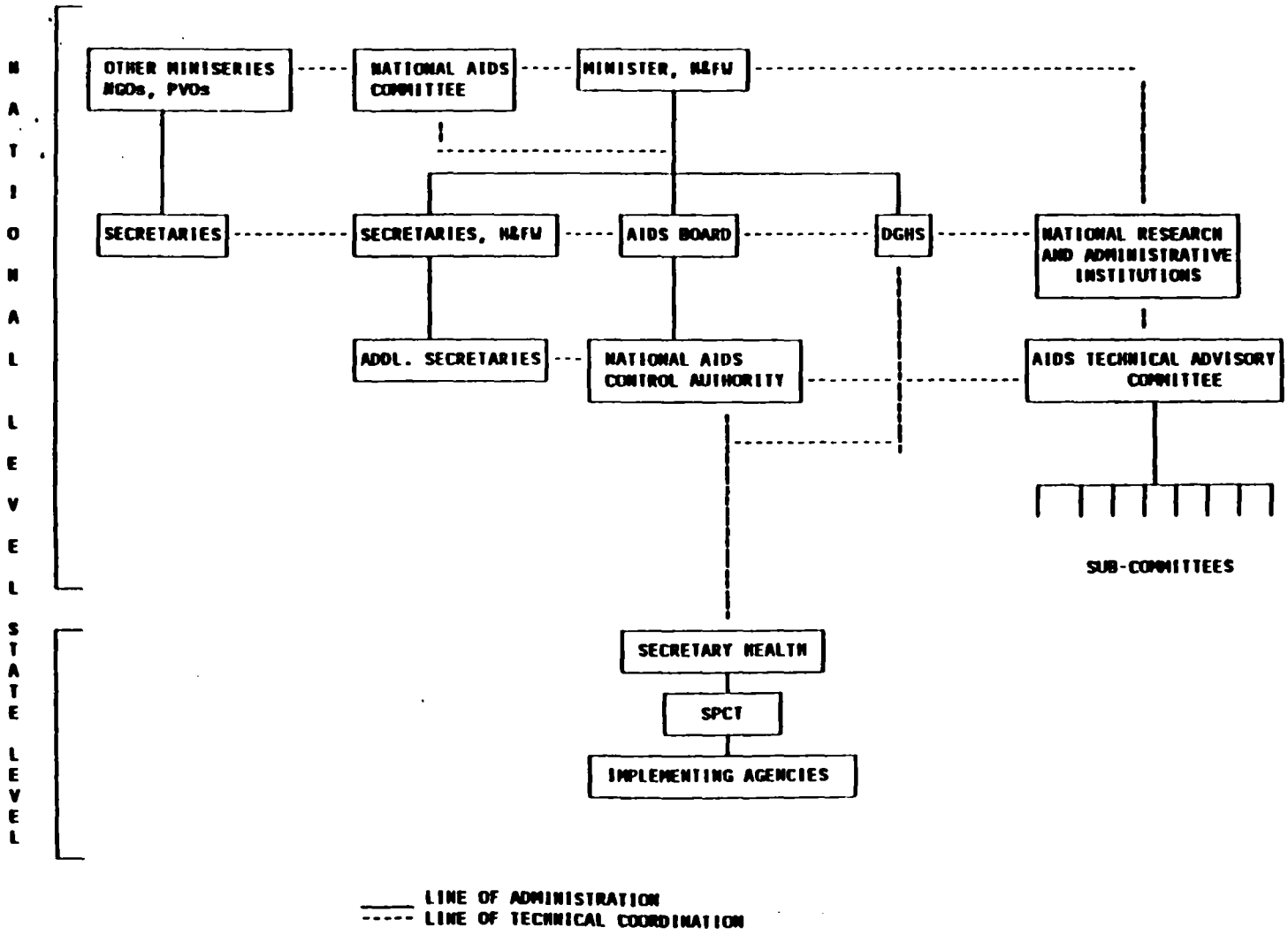
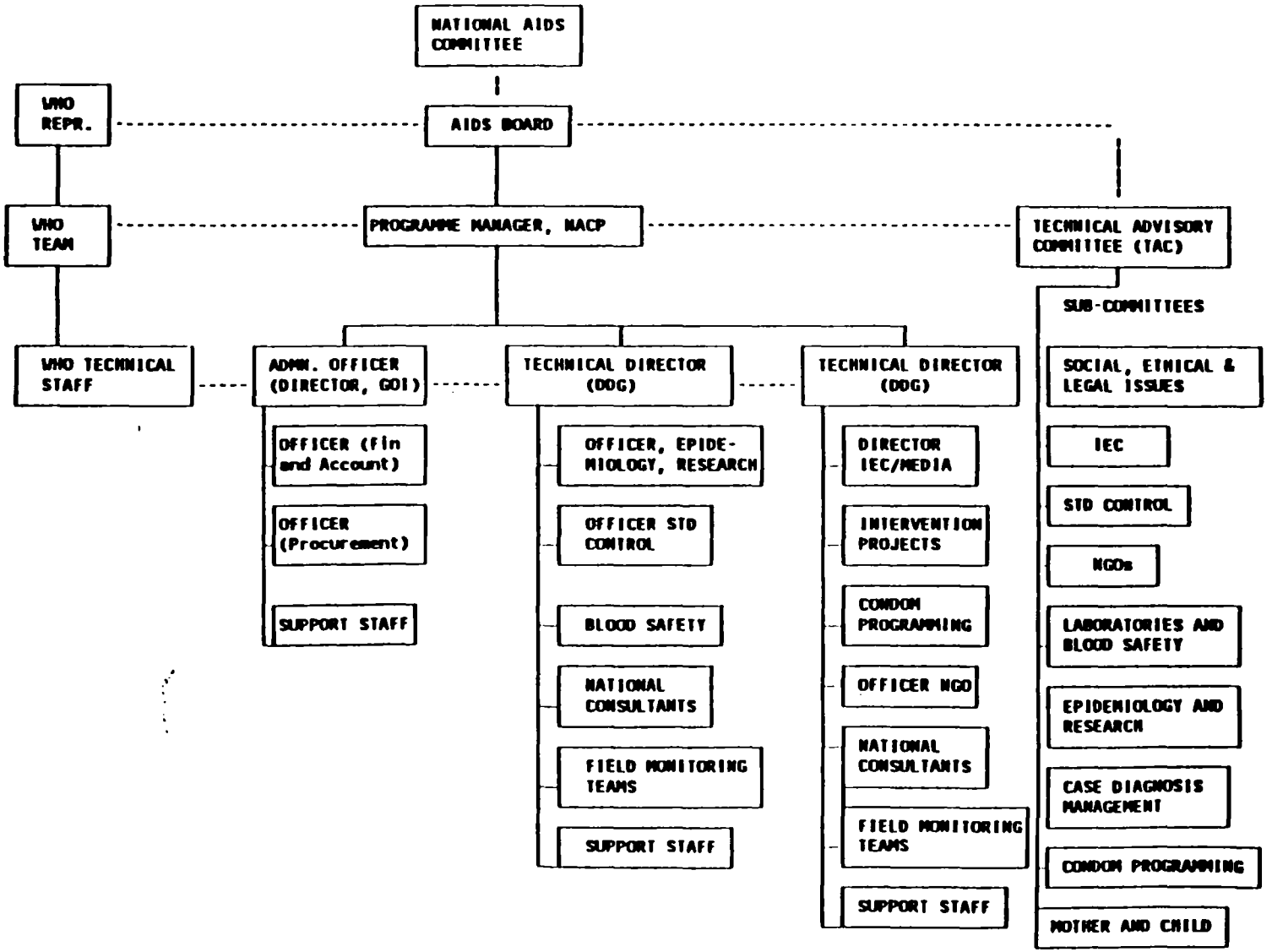


FIGURE 3.2.2

INTERNAL STRUCTURE OF THE AIDS CONTROL PROGRAMME



The WR's office and GPA country staff will provide coordination between the Government, GPA/SEARO and GPA/HQ. It will also provide assistance to NACA for mobilising support from other external participating parties. The terms of reference of the WHO country team are shown in annex 2.

Strategy 4: Strengthening programme managerial capacity at the state level

The State AIDS Cell will be headed by an Additional/ Joint Director, assisted, by 2 to 5 technical officers and the necessary support staff. This Cell will be a part of the Ministry of Health. Its main responsibilities will be coordination of the implementation of the program activities, monitoring and review.

The State AIDS Cell will also identify the programme implementing agencies, design their terms of reference and establish working relations with them for implementing particular strategies, administrative and financial monitoring. Details will be described in the State ACP plans.

The Empowered State AIDS Committee will be under the chairmanship of a senior ranking officer of the state government such as the chief secretary. The committee will include representatives of other branches of the Ministry of Health and Family Welfare, other Ministries, Universities, NGOs and PVOs of the states concerned. The Empowered Committee headed by the Chief Secretary/Additional Chief Secretary would secure steps for issue of sanctions and release of funds. The Empowered Committee will be delegated the administrative / financial powers for release of funds, issuance of sanctions for undertaking procurement, award of contracts and creation of posts etc.

The Secretary of Health will be the contact point for the National Programme Manager for coordination of political and administrative matters, and the State Programme Officer and his/her staff for operational and technical subjects.

The National level will provide a framework for all political, administrative and financial activities which can then be replicated at the state level. Terms of reference of the state coordination team would be in line with those of NACA, adopted according to the conditions in each particular State, and reflected in the State ACP plans.

Using this strategic plan as an overall framework, each State will develop its own plan on AIDS prevention and control which would create the basis for disbursement of funds from the national level.

Strategy 5: Ensuring effective flow and disbursement of funds

Within the rules of Government, with a view to facilitate a smooth flow of funds to the project, it will be proposed to establish appropriate procedures and processes at national and state level. Options such as having a special AIDS account for the Government and bilateral funds in the name of

the National AIDS Control Programme in a bank in New Delhi to be operated by the Project Director will be examined.

The funds routed through WHO/GPA will be disbursed according to the established rules. Either the National or State accounts may be one of the disbursement channels.

Strategy 6: Monitoring, review and evaluation of the Programme

The Programme will be closely monitored by NACA and State AIDS Committees, using the indicators given in the work plan. These indicators will be further refined at the time of the implementation of the specific activities. The progress of the programme implementation will be reported quarterly by the State Committees to the National Programme Officer who will then collate and compile the reported information. The progress reports will be given in the form of a quarterly newsletter to all participating parties and to the States.

Programme review will be an integral component of the State Committees and NACA. Review will help identify the strengths and weaknesses of the Programme, thereby allowing appropriate reprogramming to be taken.

Quarterly and annual reports from the states and NACA will be the major basis for the programme review. The annual programme review conducted by the State, NACA and TAC will be reported to the Board, the Government and all participating parties.

A comprehensive evaluation of the Programme will be carried out at the end of the second year of the Programme as a national initiative, assisted by representatives of the external donors and national collaborating parties. The evaluation will examine all aspects of the programme, including operational, technical, managerial and financial matters. A protocol for the evaluation will be developed at the beginning of the second year of the Plan with the help of consultants from WHO and major donors.

The findings and recommendations of the evaluation teams will form the basis for re-programming of the project. The results of the evaluation will be reported at the workshop attended by all concerned parties and agencies who will make recommendations for appropriate changes in strategies, activities and work plan.

Progress Indicators:

1. The management bodies are established at the National and State level and are operational;

2. The Technical Advisory Committee and its sub-committees are established at the national level and are operational;

3. WHO/GPA country team is staffed and operational;

4. Intersectoral working relations are established between the MOH&FW, and other Ministries, NGOs and PVOs;

5. Conferences of the decision makers are held at the national and state capitals;

6. State programme coordination teams are established and operation;

7. State ACP project documents are prepared and approved by NACA;

8. The channels for fund flow are established, special accounts opened, and funds are being disbursed without delay;

9. Equipment is supplied to the states and supplies are provided regularly.

COMPONENT 2: SURVEILLANCE AND RESEARCH

Objectives:

Monitoring the development of the HIV/AIDS epidemics, providing relevant information required for mobilization of the national political and social leaders and external support, programming target-oriented intervention activities, and measuring their impact on the epidemic development. The surveillance would include two aspects: HIV surveillance and AIDS-case surveillance.

Strategy: 1 Developing a selective approach for HIV surveillance

Due to the huge demographic, cultural, religious, and economic diversities in India, no single surveillance technique will be able to meet the objectives of HIV surveillance. These features and the known epidemiological data provide the basis for the development of a selective approach for HIV surveillance in different States and even districts.

Activities

1. To study demographic, cultural, religious and economic features and epidemiological data related to HIV transmission;

2. To adjust the operational guidelines For HIV surveillance developed earlier by ICMR, considering the features of various geographic areas;

3. To build and train surveillance staff;

4. To carry out surveys.

Progress indicators:

1. Operational guidelines developed at the national level;

2. Responsible institutions and surveillance sites identified in the states;

3. Surveillance guidelines adopted to local conditions;

4. Surveillance teams formed and trained;

5. Surveys conducted and reports submitted periodically to the States and National AIDS Control Authority.

Strategy: 2 Integrated STD Surveillance

A study on the prevalence of other sexually transmitted diseases will be made an integral part of the point prevalence

surveys on HIV and sexual behaviour designed for the groups with identified risk behaviour. The results will be used for (a) determining the magnitude of the problem, (b) an instrument to measure the efficiency of the intervention programme, (c) base-line data for the research on the relations of STDs and HIV transmission and on STDs as co-factor for the progression of HIV infection to AIDS.

Progress indicators:

1. STD component is included in the HIV cross-sectional surveys
2. STD prevalence and other data are reported to the Programme Managers

Strategy: 3 Development of AIDS case diagnosis, referral and reporting network, and AIDS case management system

By December 1991, 103 AIDS cases had been reported to the NACP Programme Manager. According to estimates based on the HIV prevalence, the number of cases which have already occurred in the country may be counted in the thousands. As most of the risk behaviour groups are highly mobile and the infection is spreading quickly throughout the country, AIDS case surveillance will be established in all States, irrespective of HIV situation. The aspects of confidentiality in diagnosis, recording and reporting would be considered in implementing this strategy.

Activities

1. Develop operational guidelines on AIDS case diagnosis, referral and reporting network, and case management;
2. Identify and train the staff of the referral institutions;
3. Train the medical staff of non-referral institutions;
4. Establish referral, reporting and case management system.

Progress indicators:

1. Guidelines on AIDS case surveillance and management developed at the national level;
2. Physicians of referral and non-referral institutions are periodically trained on AIDS case diagnosis and referral system;
3. The network of referral institutions is gradually expanded to peripheral hospitals;

4. Reports are submitted periodically to the State and National Programme Manager.

Strategy: 4 Monitor the development of HIV/AIDS epidemics

The results of the HIV surveys and AIDS-Case surveillance will be analyzed by the State Programme Managers and the National Technical Advisory Committee at the end of each year. Their reports would provide data for programme review and re-programming intervention activities.

Progress indicators:

1. Reports on the progression of the epidemics prepared and submitted at the end of each year to the Government and participating parties.

Strategy: 5 Supporting Social, Behavioural and Epidemiological Studies

National Research Institutions, surveillance teams, and NGOs experienced in social and behavioural research will be supported in conducting studies of the programme interest; the following may be among the priority subjects:

- behavioural studies related to HIV/STD transmission;
- rapid assessment on the knowledge attitude and behaviours among HIV risk groups;
- effect of the educational and intervention projects on the change of KABP.
- comparative efficiency and cost of HIV tests and screening techniques;
- sensitivity and specificity of AIDS case definitions;
- implication of other than HIV tests in diagnosis of ARC and AIDS;
- practices promoting HIV/STD transmission;
- role of STD in HIV transmission;
- Co-factors involved in progression of HIV infection to ARC and AIDS;
- treatment of HIV/ARC/AIDS by traditional medicines;
- efficiency of HIV vaccines.

For further details on the major operational/research areas, please see annex 3.

Progress indicators:

1. Priority areas for the research are identified;

2. Target groups are determined and objectives, study methods and report forms are designed;

3. Investigators (groups) for the research are identified and contracts signed;

4. Studies conducted and reports are submitted to the Programme Managers according to the format.

Evaluation Criteria for the Surveillance and Research activities

1. The guidelines correspond to the Government and WHO policies on AIDS prevention and control, including confidentiality, informed consent and other ethical and humanitarian aspects;

2. Activities conducted according to the annual work plans;

3. Reports are submitted in the forms designed by the National Programme Manager, in time and complete.

Strategy: 6 Strengthening HIV screening facilities

The network of HIV screening laboratories in India would serve several programme strategies, individually or in an integrated way, including:

1. HIV sero-epidemiological surveillance

2. AIDS-case surveillance

3. Blood screening for prevention of virus transmission

4. HIV/AIDS/STD related research

5. Voluntary blood testing

Use of the screening tests can meet the objectives of the strategies one, two and four, while strategies two and five require the use of a ~~confirmatory~~ supplementary test. three

The HIV diagnostic network will include three types of laboratories with HIV testing facilities:

(a) HIV screening centres, equipped with screening tests only, like ELISA, GPAT or any other. The screening centres would support both HIV surveillance activities and testing of donors blood.

(b) **HIV reference centres, apart from the screening tests, will be equipped with confirmatory tests. These centres would carry out the tests in support of HIV surveillance, AIDS-case surveillance, voluntary testing, research and in some instances - blood testing.**

(c) **Blood bank HIV laboratories established at larger branches will limit the testing to donated blood only.**

The HIV reference centres will be established in all large states and in some divisional capitals.

Six selected HIV research centres will be equipped to perform the tests required for the research on AIDS-case definition and natural history of HIV infection.

The HIV screening network will be gradually expanded to reach by the end of 1993 all or most district capitals, and the referral centres - the capitals of most of the states. The larger states will have reference laboratories also at some divisional level hospitals.

While planning recording and reporting systems due considerations would be given to the aspects of the language and confidentiality.

Activities

Strengthen HIV Screening Referral Centres

All HIV diagnostic activities will be coordinated by the State AIDS Cells through the HIV reference centres. The reference centres will be reinforced by a post of Deputy Director or Technical Officer (selectively) and mobility allowances to allow monitoring the activities in the HIV laboratories subordinated to them.

NACA will develop operational guidance which would describe the national referral system, supplies system, monitoring of activities, quality control and reporting, and will be used for training of all personnel involved in the HIV screening network.

Training of the Laboratory Staff

The training of the reference laboratory staff will be arranged during 1992 and 1993 at several advanced and already equipped laboratories.

Training for the screening laboratory staff will be carried out by the referral centres at their own laboratories.

Provision of Supplies and Equipment

The office of the National Programme Manager will elaborate the system of supply, distribution and maintenance of equipment for expansion and maintenance of the network. This system will be included in the operational guidelines and monitored by the referral centres, supported by NACA.

Development of the Local Production of HIV diagnostic kits

In order to meet the increasing need for HIV screening tests for the surveillance and blood screening, a possibility for local production of tests will be explored.

The decision to proceed with local production will be made by the Government after careful investigation and evaluation of manufacturing companies.

Progress indicators:

1. Operational guidelines for HIV screening and referral centres are developed and provided to the states;

2. Materials and equipment are procured according to the work plan;

3. Laboratory staff of the referral and screening centres is trained according to the agenda developed by NACA and according to the work plans;

4. Flow of supplies is maintained properly;

5. Quality control system operates according to the guidelines.

COMPONENT 3 : IEC AND SOCIAL MOBILIZATION FOR PREVENTION OF HIV TRANSMISSION THROUGH BEHAVIOR CHANGE

This component seeks to identify and formulate strategies for raising awareness among general public about HIV and AIDS so as to inculcate positive values, attitudes and behavior for self protection from the disease. A comprehensive Information, Education and Communication strategy must seek to garner and fully utilize the communication skills available within and outside the government, and mobilize allies in this effort at every level to work for preventing the spread of AIDS on a participatory basis.

The objective of motivating changes in behavior and values has to be achieved within several constraints of time, scarce human and financial resources, existing social and cultural barriers and prejudices. In the existing socio-cultural environment, the IEC strategy for the prevention and control of AIDS cannot be only concerned with the promotion of condoms or use of sterilized needles, but, go beyond to addressing issues related to such modes of behavior which are responsible for causing the rapid transmission of this disease. Since communication and information has the power to change behavior and attitudes over a period of time, the objectives and goals of an IEC strategy must therefore, necessarily have to be concerned with the wider issues such as generating a respect and understanding for the vulnerable groups, enhancing the status of women and empowering them to protect themselves, increasing male responsibility, helping the community to provide the much needed social support to those individuals and their families who are suffering from the disease, training health service providers with the knowledge and skills to cope with the disease without fear and with sensitivity to ethical norms etc.

The formulation of target audience-specific messages is complex, influenced by socio-cultural considerations and the acceptability of the range of personal behaviour options from which an individual could chose in his/her particular situation. Messages conveyed from different agencies need to be coherent if they are to be credible to the target audience concerned. Delivering a message for high risk behaviour groups will not be enough to promote behaviour change. To do this specific interventions will need to be developed for and with the specific groups.

To achieve an environment where behaviour change is possible, support services must go in tandem with the information, education, and communication strategies. These include: condom programming, STD services, and counselling and care services.

Keeping the above concerns in view, the broad objectives of IEC and social mobilization follow.

OBJECTIVES

- To raise awareness, knowledge and understanding among the general population about AIDS and HIV infection routes of transmission and methods of prevention;

- To encourage and promote, by provision of critical information and services, adoption of safe practices, such as the use of the condom, use of uninfected needles etc. among all those groups considered to be at most risk of getting the infection;

- To mobilize public support for taking up AIDS prevention related activities among the high risk groups as well as the community with a view to strengthening and supplementing government efforts in mitigating its impact;

- To integrate and support intra and intersectoral coordination for the purpose of not only generating a social awareness about the disease, but also helping to create an environment of care and concern for the affected and their families;

- To increase the proportion of blood collected from voluntary blood donors in a substantial manner;

- To ensure that all relevant health workers are trained in AIDs communications and coping strategies and thereby strengthen technical and management capabilities;

- To generate a more proactive concern and urgency for ensuring aseptic care practices in the hospitals and other health service delivery institutions among health administrators and health service providers with a view to build a synergy, moving media promotion in tandem with programme services.

- To integrate and coordinate with other components of the National AIDS Control Programme especially in the areas of condom promotion, blood safety and reduction of social impact.

STRATEGY

With a view to achieve the objectives stated above, it is proposed to have a multi - pronged strategy consisting of the following components and activities :

1. **Media.** Mass media and publicity for raising awareness levels among all sections of the people;

2. **Inter-Sectoral Collaboration and Social Mobilization.** Mobilization of support for implementing cost effective strategies that will integrate AIDS related educational activities with the ongoing activities and programmes in the Government and the organized private sector;

3. **Advocacy.** Organizing a series of orientation and sensitization workshops among a whole range of categories of people : political leaders, senior administrators, action groups, non governmental organizations, professional organizations etc.

4. **Interventions.** Designing and formulating local specific, need based integrated package of interventions for high risk groups - commercial sex workers, IV drug users, blood donors,

sexually promiscuous males etc. for not only providing them with access to information and services but also bringing about attitudinal changes towards a more desirable and less risky behavior life style;

5. **Training.** Training of communicators and field level workers for upgrading their capabilities in communication and counselling skills to address the sensitive issues related to sexual promiscuity, drug abuse etc. with empathy and understanding;

6. **Research and Documentation Centres.** Undertaking research for refining strategies and providing backup documentation for organizations, institutions and non-governmental organizations active in AIDS prevention activities;

7. **Programme Management, Monitoring and Review.** Providing an overall management structure to establishing institutional mechanisms that would support and encourage the full and active participation of the community in its efforts to minimize the social and economic impact of the disease and to develop monitoring systems that will provide for concurrent evaluation;

PROGRAMME AREA, OBJECTIVES AND ACTIVITIES

Strategy 1: Media

Objectives

There are five specific objectives of mass media and publicity:

- to generate awareness and proper understanding of the causal and related factors of the disease, among all categories of the population from the existing low level of 5% to reach 100% by 1997;

- to mobilize a voluntary blood donor movement to increase supply of voluntary blood from the existing 20% to 60% of the blood supply in the country.

- to increase the use of condoms from the existing level of 5% use to 25% by 1997;

- to raise awareness and generate a demand for aseptic care services in all hospitals;

- to create an environment conducive to adopting the desired values and behavior practices.

Approach

To raise levels of awareness and knowledge about the disease it will be necessary to use the communication skills and resources available in the public and private sector for launching a nation wide campaign. The campaign will be comprehensive consisting of outdoor publicity, group discussions, workshops, and seminars supported by specially designed and developed printed materials

such as booklets, folders, posters, and developing audio visual software. All channels of mass communication such as the radio, cinema, newspapers and the television will be intensively used. Training materials for field workers, advocacy films on a variety of themes such as condom use, aseptic care practices, voluntary blood donation etc will constitute and form important components of the program.

A set of standard messages, to be used and adopted for all channels of communication, will be developed. Messages will be designed with the aim of prevention of HIV transmission through sexual intercourse, needle sharing and IV drug use, donated blood, woman to child, use of unsterilized injection and skin piercing instruments. The plan will include ethical considerations of HIV/AIDS cases and appropriate care as articulated in the WHA resolutions.

The mass media campaign will also establish information outposts to provide information to individuals and groups and to ensure the provision of supplies and services, such as condoms and counselling services. Provision of such services is seen as a prerequisite for a mass media campaign to be effective.

Integral to this approach will be specially designed campaigns for reaching out to those having inadequate access to mass media channels, focussing on face to face communication with groups of individuals. Such campaigns will not only use audiovisuals and printed materials, but more importantly use live media such as the traditional and folk media, street theatre, panel discussions, and workshops. Important areas of focus for such group campaigns would be colleges, slums,project work sites, factories, and special target groups such as ward boys in hospitals, transport workers, migrant labor, and blood donation camps.

It is, however, realized that behaviour change, one of the goals of this programme, is very difficult to achieve. It is believed that only by exposing an individual to a consistent message from a wide variety of sources, such as mass media, print materials from various organizations, and from their peers, might s/he begin to contemplate changing behaviour patterns.

Activities

1. For implementing the approach detailed above, use will be made of commercial advertising agencies with experience in social communication. The commercial agency will be expected to design a strategy for mass media campaign, develop prototypes of IEC software after thorough pretesting, establish information networks and develop specially designed training software for the key workers involved with social communication.

2. Training workshops will be held for the IEC personnel working in all the six divisions of the Ministry of Information and Broadcasting and the Ministry of Health and Family Welfare, in message development, production of IEC materials, interpersonal communication skills etc. dealing with culturally sensitive areas of human behavior such as sexuality. The intention of this effort would be to not only internalize the understanding of the impact of AIDS to be used

in ongoing activities but also ensure decentralizing the development of IEC software to the local level so as to capture the cultural and social nuances and symbols which is a prerequisite for it to be understood and accepted by the people. Training will also be provided for developing capabilities in communication in all sectoral departments for effective advocacy so as to mobilize public and political support for the programmes and activities being taken up.

3. An important requirement for this component is to develop a policy paper on communication which will detail the target audiences, articulate the behavior changes desired, formulate the messages sought to be conveyed, identify the most appropriate media to be used etc. For providing advise, guidance and a direction to the implementation of the vital tasks described above, an Empowered Committee is proposed to be constituted. This will be a Technical Advisory Committee for IEC and will be the body responsible for according approvals of prototypes developed, allocation of budgets etc.

Progress Indicators

- Mass media campaign implemented.
- Preparation of the policy paper on communications.
- Support materials developed, pretested, and distributed.
- Holding of workshops for local producers of MIB and MOH&FW in IEC material development.

Strategy 2: Intersectoral Collaboration and Social Mobilization

Objectives

- to sensitize and involve every department having programme activities that reach out to a large number of people who require to be educated about HIV and AIDS;

- to obtain the social commitment of the other sectoral departments to mobilize support for AIDS by way of providing free and unpaid publicity wherever possible, integrating the messages with ongoing activities, and developing programmes;

- to encourage, support and establish networks in key departments, social groups, professional organizations, to help create a climate of care and concern for the affected.

Approach

To achieve the above mentioned objectives, communication campaigns would need to be undertaken in collaboration with and support from NGO's on the one hand and Government Ministries on the other. Important ministries which would need to be interacted with are the Ministries of i) Information & Broadcasting, ii) Railways, iii) Human Resources Development - dealing with the two Departments of Education, Youth, and iv)Labor and others.

Support will be mobilized to motivate different sectors to realize their social responsibility to assist in information dissemination to the networks of communities and individuals they

have an interface and access to. The relationship will be based on a participatory collaboration where access will be provided by participating agencies/departments/organizations in the most cost effective manner. Ministries such as Railways and Information and Broadcasting, which have a monopoly control on the means of achieving the quickest access to the largest sections of the population, will need to be motivated to provide the maximum amount of publicity free of cost or at subsidized rates. Similarly, as a part of social accountability, private industry would need to be motivated to take up provision of information and services to their workers and families.

Involvement of teachers and parents is another critical prerequisite in order to reach the youth in schools and colleges. Development of teaching materials on sexuality and responsible behavior for school children, children studying in the non formal school system, adult learners, college youth and unemployed youth will be of special concern given the prevailing conservative attitudes in matters of sexuality. Initiating a dialogue between children, parents and teachers on sex without moral overtones and without at the same time seeming to be supporting promiscuous or permissive behavior is a great communication challenge. It is estimated that there are about 20 million school going children between the age group of 6-11 years and 4 million college youth. In the nonformal sector there are about 3 million children and 8 million adults in adult literacy centres. To access this huge catchment constituting a significant proportion of the sexually active population, it would be necessary to conduct orientation training programmes for the teacher administrators at different levels to sensitize the 2 million teachers. Time and cost effective strategies would require to be developed.

The mass media campaign will need to coordinate closely with the ongoing programmes of the Department of Family Welfare, the Department of Welfare and the Department of Women and Child Development which have outreach programmes for the rural populations, particularly the poor. The Department of Family Welfare is of vital concern as it already has, as a part of its family planning programme, a vigorous campaign for promoting the use of the condom and under its social marketing program a well established network for the production and distribution of the condom. The Department's state, district and PHC level network of nearly 6000 IEC staff needs to be tapped. These individuals will need to be oriented and sensitized about AIDS to enable them to integrate vital messages into their work. This integration in message delivery will be critical for ensuring not only the safety of the community but also the personal safety of over 200,000 health workers whose lives could be endangered if proper precautions are not taken.

The Department of Welfare is responsible for the programme activities related to drug abuse. Though it has no administrative structure at the field level, it has a wide outreach of over 130 NGO's working on drug deaddiction. They need to be motivated on the larger danger of AIDS that the drug addicts using and sharing needles are vulnerable to. The department also implements programmes related to poverty alleviation among the tribals and backward classes. The field staff of the Integrated Tribal Development Agencies in the 7 tribal states and the North East would need to be effectively utilized to gain access to these vulnerable sections.

should be targetted

The Department of Rural Development and Panchayat Raj plements poverty alleviation programmes through a well organized administrative network covering of over 550,000 functionaries. Over a period of time their sanitization could be useful in strengthening and mobilizing country support activities particularly for home based case etc. as these carry government credibility and influence with rural population.

The Department of Women and Child Development implement substantial programmes for empowerment of women, child abuse, nutrition. The Department has a vast network down to the village level. Their outreach also consists of project based NGO's and mothers clubs at the community grass root level. This huge workforce dealing with women empowerment, education, employment could be profitably utilized by orienting them on AIDS and STD. Their support in helping women cope with the disease at the family and community level by providing counselling services and education and rehabilitation programmes for the female sex workers and street children and others would be vital.

Besides working through the ongoing government programmes and departments, it would also be equally important to mobilize NGO's working in the different sectoral programme areas, religious orders and professional associations to undertake the tasks of generating awareness among the people they have access to.

Assistance from the AIDS project to other sectoral department will be for training key functionaries, provision of IEC materials, condoms, technical assistance etc. and modest funding support for critical activities that will directly impact upon achieving the basic objectives of the project.

Activities

1. Assist each Ministry to form an AIDS committee to develop programmes on AIDS/STDs for their employees and networks.

2. Training and sensitization of key personnel in all the above mentioned departments, professional groups and NGO's;

3. Conduct a quarterly review of the Interministerial Committee activities.

4. Identify and mobilize community and other networks to tap for AIDS programming such as women's organizations, youth groups, community organizations, etc.

5. Design and implement programmes.

Progress Indicators

- Interministerial Meeting held
- Number of programmes developed.

Strategy 3: Advocacy

Objectives

- to generate a widespread and unequivocal financial and legal support for the programme activities among the policy makers and executive agencies in the Government;

- to generate concern for the human rights of the HIV affected and community support for the families afflicted with AIDS cases;

- to create awareness on the social dimensions of AIDS and generate a healthy debate on matters related to societal failures which are beyond the scope of Governmental initiatives.

Approach

Besides, using the formal and informal channels for generating awareness, efforts will be made to raise political and administrative support for the programme by carrying out a well integrated campaign among policy makers and political executives at the centre, state, municipality and district level. Nearly 10,000 political executives and administrators and policy makers would need to be accessed across the country.

Activities

1. Produce an advocacy video on the AIDS problem on the requirements at the political and leadership levels

2. Produce a four-to-eight page flier/booklet highlighting the problem of AIDS in India and the strategies for prevention and control including the sensitivity and review of existing codes / legal provisions. This will be distributed widely to various Administrative staff colleges, IAS/IPS Academies, Indian Institute of Public Administration, District Collectors, Members of various elected bodies at national/state/ city/panchayat levels.

3. Hold National/State level workshops/conferences/ seminars for parliamentarians, members of the legislative assemblies/ councils,councillors of the metropolitan or municipal councils and presidents/sabapathies of the panchayats.

4. In addition, workshops of councillors in the major towns/cities/metropolitan cities will also be held. There will be one such workshop in each of the following cities in the first year : Ahmedabad, Bhopal, Bombay, Bangalore, Calcutta, Chandigarh, Delhi, Hyderabad, Jaipur, Lucknow, Madras, Patna, Pondicherry, Pune, Trivandrum. The cities for the second and third year will be identified subsequently. Selected Sabapathies or Presidents of the Panchayats and Mayors of smaller cities/towns where separate meetings are not planned will also be invited to attend the state/city level meetings within the state.

5. Review the existing legal provisions on sex workers, homosexual behaviour, health practices of allopathic and traditional systems of medicine which could have a bearing on the implementation of the National Programme on AIDS Control and Prevention in India.

6. Form an inter-ministerial group including representatives of non-governmental/voluntary organizations comprising experts from various fields will be set up to examine the provisions of various codes/laws including the Suppression of Immoral Traffic in Women and Girls Act 1956, Section 377 of the Indian Penal Code.

7. Once the review is completed, the recommendations of the group will be shared extensively and a national workshop held to mobilize public and political opinion in favour of appropriate changes in the laws/penal code to ensure proper implementation of the AIDS control and prevention programme.

Progress Indicators

- Advocacy materials developed, pretested, and distributed.
- Number of workshops/seminars held.
- Geographic spread of activities.
- Intersectoral grouping formed at the national and state level.

Strategy 4: Interventions

Objectives

- Ensure safe sex practices and increase the use of the condoms among male clients;

- Ensure and propagate the use of sterilized needles and not sharing of needles among IV drug users;

- Establish improved diagnostic and clinical care services for STD;

- Establish HIV education and counselling networks.

Approach

Mass media campaigns are useful in generating awareness and propagating critical information. However, for bringing about behavior change among those practicing at risk behavior, efforts will need to be more intensely focussed, sustained over a period of time and integrated with several other associated activities. In dealing with a high risk group such as a female commercial sex worker it would be insufficient to merely develop educational materials for the workers but would require working out specific strategies that would encompass the entire industry round the worker, with special emphasis on the levers of power in that structure. Accessing the pimps, the procurers, the brothel house keepers, the financiers of the trade, the police, the other partners - liquor shop owners, the transport workers, the video parlours etc and most importantly the male clients would be required in order to enable the sex worker to insist on safe sex practices, besides developing a less discriminatory attitude against the affected.

There are no studies available on the sexual practices or behavior patterns in India. The prevalence levels and structure of the commercial sex industry differ from place to place. While in Bombay, there are well defined red light areas and the prevalence

of a three tiered structure of the financiers, brothel keepers and the sex worker is known, it is less clear in Delhi which has a wide network of call girls operating from hotels. Similarly, a survey of Agra indicates the prevalence of homosexual behavior to be far more than heterosexual. In Madras, while there is no defined red light area, there is a pattern consisting of congregations on streets, slums and around the cinema industry.

The differentials mentioned above bring out the need to design local based intervention strategies. For doing so, a survey of the prevalence levels of high risk behavior needs to be undertaken in all major cities and towns. The strategies will also have to be related to not only controlling the spread of HIV among the sex workers and their clients but also effectively controlling STD as STD is a co factor in getting HIV.

In view of the fact that there is a near negligible presence of the Government among sex workers, drug addicts, along national high ways etc. and that even there the role has been one of a law enforcers and therefore, adversial to the group interests, the necessity of having NGO's to undertake the tasks of health education and provision of services among the high risk groups would be critical. At present the response of NGO's has been limited and cautious, largely for want of an understanding of the work to be done, funding support and lack of trained workers. Government's first task will necessarily have to motivate, encourage and support NGO's to take up these tasks on priority. Specific interventions would be required for the following high risk groups : commercial sex workers, injecting drug users, homosexuals, street youth, migrant workers, prison inmates and transport workers.

Although, interventions will be tailor made, in general, the process will be as follows:

1. Review of existing data, including conducting an opinion survey of prevalence of risk groups in the major urban centres;

2. Inventory of NGO's and organizations working with this group;

3. Conduct targeted baseline;

4. Conduct targeted qualitative research for programme design and materials development;

5. Design intervention;

6. Develop and procure specific materials;

7. Conduct pilot studies;

8. Evaluate and monitor pilot interventions;

9. Expand programme implementation. This can take place before a formal evaluation has been completed. Programme implementation and programme activities will not be delayed for lengthy research studies.

Commercial Sex Workers, Their Clients and Employers

Studies have shown that commercial sex is found in three forms in India: brothel-based, call girls, and street workers. Existing data suggest that the brothel-based commercial sex is well developed in Bombay and Calcutta, each containing an estimated 100,000 to 150,000 female commercial sex workers. In Delhi, the brothel-based sex is limited to one area with some 3000 female employed. According to anecdotal reports, call girls and street workers may be found in each large city of India -- several thousands in Bombay, Delhi and Madras. The national figures, or more precise estimates, will have to be investigated.

The commercial sex workers need to be made aware of the dangers of AIDS and of methods of protection. The main target groups, however, will be the clients, brothel keepers, pimps, etc. The commercial sex worker, having the least amount of power in the situation, will not be able to sustain behaviour change if not supported by the surrounding structure.

The commercial sex industry requires special attention and targeted interventions for a number of reasons:

- HIV prevalence in brothel sex workers (in Bombay) was found to be higher than in any other population grouping tested for HIV;

- STDs, which are known to facilitate HIV transmission, are highly prevalent among commercial sex workers (in Calcutta, prevalence rates for STDs among brothel sex workers reaches 50 %);

- Commercial sex workers service the large migrant and unsettled male populations which, due to high mobility in the state and between states, are able to rapidly disseminate infection throughout the country to both urban and rural settlements.

To address this growing problem, comprehensive intervention projects will be developed for major known areas of commercial sex with the objective to reduce the rate of HIV transmission among commercial sex workers and their clients.

Interventions will be initiated in brothel-based sex work in Bombay and Calcutta and extended to other areas where demarcated brothel settings are registered through a survey on risk behaviours. Interventions aimed at call girls and street workers will be developed. All interventions will focus on the entire structure surrounding the sex worker with special emphasis on reaching clients.

Injecting Drug Users (IDU)

In Manipur, one of the North-Eastern States, an explosive epidemic of HIV infection has occurred. In a period of one year, from December 1989 when the first seropositive IDU was detected, to December 1991 the HIV prevalence rate grew up to 40%. In some districts over 80% of drug injectors are now infected.

Little systematic knowledge exists in India on drug use and injecting. It is known that 'Number 3' heroin or 'brown sugar' or 'smack' entered India on a large scale in 1983-1985. This

substance is normally inhaled or 'chased'. However clinicians and NGOs have reported an increase of injecting of 'brown sugar' since the late eighties. In the Norther-Eastern States, 'Number 4' heroin from the golden Triangle is used where the common practice is to inject.

Drug users, as a group of people, are difficult to find and approach, so exact numbers are unknown. However, it is estimated that there are 30,000 injecting drug users in Manipur and in other North-Eastern States which border or are on the trafficking round from Myanmar. There have also been reports of drug injecting in Madras, Calcutta, Bombay and Delhi. Since injecting drug users spread the virus through contaminated needles and through sexual interaction, they are a prime target group for interventions.

The main objective for an injecting drug intervention is to prevent the spread of the HIV virus through sex intercourse and contaminated needles.

The main strategy would be to involve NGOs and voluntary organizations already working with drug users and strengthen them to develop a comprehensive outreach programme to educate injecting drug users on AIDS and provide information on how to prevent its spread; including provision of condoms and bleach. The goal will be the development of community-based activities including peer education to reduce the use of illicit drugs and promote safer injecting practices. This might include promotion of cleaning techniques for those who inject (bleach, boiling, flushing with cold water), and the provision of targeted counselling services.

The AIDS programme will work with National and State Drug Abuse Control Programmes to stimulate increased activities and encourage and collaborate with NGOs. Priority areas for collaboration are the North Eastern States and the metropolitan cities Delhi, Calcutta, Bombay and Madras. Project proposals have already been drafted in the majority of states in the North East.

Men who have sex with men

Homosexuality in India is mainly underground; only recently have some organized groups surfaced. This population can only be reached by supporting the existing gay organizations to develop programmes, such as the one being tested in Bombay with Bombay Dost, and, through working with the gay community to development outreach programmes in all major cities. The NACA can facilitate activities by providing technical assistance in training, outreach, and research.

Street Youth

An assessment will be made of all NGOs, voluntary organizations, and government agencies working with street children in the slum areas and generally with unemployed youth. To reach this segment of the population, a variety of approaches will be necessary. Pilot programmes will be encouraged and NGOs will be supported with appropriate training and technical assistance.

Government programmes will be expanded to include a component on AIDS/STDs.

Migrant Workers

Many industries and factories employ migrant workers who are separated from their families for long periods of time and can be reached easily on the job. Interventions with this population would follow the process outlined above to work closely with the industry/factory management in the development of appropriate strategies.

Prison Inmates

Available data from screening conducted in Madras (two positives) shows that HIV infection is present in the prison population. Therefore a need for interventions among the prison inmates is evident. This will require sensitization of local authorities and prison officials.

An initial assessment revealed that prison inmates and officials know very little about AIDS. There is also a strong objection on the part of the prison officials to distribute condoms and sterile syringes. The NACA and State teams will have to work closely with the prison authorities to educate them on the real risk of HIV and develop programmes in the prisons.

Truck Drivers

Truck drivers in many parts of the world have been identified as at risk for HIV/AIDS. The fact that they are away from home for long periods of time and often frequent commercial sex workers is well known. India is no exception. Truck drivers crisscross the country on major highways and are offered commercial sex workers at many stopping places; especially on the east and south east corridors. In Africa, the epidemic slowly spread along the trucking routes and then back to families and the rural areas. HIV positive truck drivers have already been reported in the Punjab. To avoid a similar pattern developing in India, or to arrest its development, a programme to educate truck drivers and motivate them to become active participants in fighting the spread of the HIV virus is essential. Truck drivers can also play a major role in educating others as well.

The main objective in targeting truck drivers is to educate them on the risks of AIDS, modes of transmission and prevention; especially in the proper use of condoms. Truck drivers can be reached through their unions, at the local "dhabas" where they stop for food enroute, and through loan and registration bureaus. A pilot programme to assess the best methods and materials to use in educating and mobilizing truck drivers would be the first initiative followed by expansion regionally and nationally.

While there are no estimates on the number of persons among the high risk groups as detailed above, it is, however, estimated that there would be a need for at least 100-300 organized NGO's working among these critical groups on a sustained basis. The assistance to be provided to the NGO's would need to range from equipment and infrastructure support for delivery of services, to

development of IEC materials and recruitment of trained workers. In addition to such a financial support, there would also be a need to provide training in project identification and preparation and training in special areas such as counselling, supply of IEC materials and condoms.

Progress Indicators

- Interventions designed for identified risk groups.
- Organizations to initiate and implement interventions identified motivated and involved.
- Target populations reached.

Strategy 5: Training

Objectives

- to upgrade the communication skills and capabilities of IEC personnel working in the Ministry of Health and Family Welfare at Central and State levels;

- to develop an understanding of the disease and its social implications if it is allowed to spread uncontrolled among the key functionaries of the sectoral departments;

- to develop skills in project preparation, accounting and project management for NGO's proposing to work among high risk groups on a sustained basis for bringing about behavior change among them;

- to develop training materials for the trainees;

- to identify training institutions and core group of trainers for taking up the training of trainees and also develop training modules for the trainers.

Approach

Human resource development is seen as one of the most critical prerequisites of any efforts for prevention and control of AIDS in India. This assumes importance as there are severe limitations and barriers in the outreach of mass media channels, placing a heavy reliance on interpersonal communication. In addition, sexuality is still seen as an intensely private and personal issue, necessitating a face to face approach. For these reasons, investments in training of persons working at the grass root level on not only causal factors and modes of transmission but also on coping strategies, counselling, and non discriminatory attitudes is seen as of vital importance.

The Department of Health and Family Welfare is responsible for the formulation and implementation of health programmes in the country. As health is a state subject, the actual implementation is at the state levels. Health education is recognized as an important component of all preventive strategies. Accordingly the central health education bureaus and the state health education bureaus were established in the late '50's. Later, in 1966, with a view to giving a greater impetus to family planning and population control programmes mass media and publicity units were

established at the state, district and block levels. Training of all these health educators for designing family planning campaign were given in the 47 Health and Family Welfare Training Centres. In the past decade, however, family planning has been broadbased to include maternal and child health and was renamed as family welfare. Under the IPP projects funded by the World Bank, training is being given to the male and female workers, supervisors, birth attendants and others at the PHC's.

The IEC strategy for AIDS will need to provide specialized training for the IEC personnel working in the CHEB and the SHEB's, and under the Family Welfare department at the state,district and block level. The training to these 7500 persons will need to be on development of IEC materials for AIDS, their integration with the materials being developed for other health programmes, and in communication skills and organizational strategies. Regarding the health workers who have direct access to the community, pregnant mothers, children and families having sexually active persons, training will need to be inbuilt and integrated with the ongoing training being given under the Safe motherhood and Child Health programme of the World Bank.

For the purpose of developing training modules and training trainers etc. experts in communication, counselling etc. with vast experience in handling AIDS programmes will need to be short-listed. The trainers working in the 7 Central Training Institutes and 474 HFWTC's, the 447 ANM schools etc. will need to be trained, particularly in counselling and human sexuality. Training methodologies and materials developed, including manuals, will be participatory in nature with an emphasis on practical skills development. Training programmes will focus on developing the individuals' ability to convey AIDS/HIV information objectively and emphatically.

The sectoral Departments with whom project based collaborative programmes will need to be designed are the Departments of Women & Child Development, Labor, Youth, Education and Welfare. Cost effective strategies will need to be evolved.

It is estimated that resources permitting at least 150,000 persons would need to be oriented and sensitized. The key persons will consist of State/District and Block level officers of Women and Child Development, Labor and Education, Principals and NSS coordinators of the 6000 colleges, Labor welfare officers in factories among others.

Training of NGO's is of special importance in view of the fact that one of the reasons for their relatively poor participation is lack of skilled manpower and organizational inadequacies for absorbing large scale assistance from Government or external donors. Besides, holding workshops for motivating NGO's, regular training of the 200-300 core NGO's will need to be organized.

At the heart of the matter is the identification and listing of the trainers, assessing the training needs among the trainers as well as the list of trainees and development of the modules and associated software. In order to provide sustainability to this activity, it would be useful to identify institutions of mass communication, Colleges of Social Work, the Film Institute at Pune, and other institutes of training that normally undertake the inservice training needs of personnel working in the different

departments such as the NCERT, SCERT, National Institute for Labor, NIPCED among others.

Activities

1. Identify core trainers.

2. Production and dissemination of package of standardized training materials.

3. Train core trainers.

4. Plan and implement training in Planning, management and implementation of IEC activities including monitoring and evaluation for senior level personnel at central and state level.

4. Plan and implement training in skills for informing, educating and communicating with target groups.

Progress Indicators

- Training modules developed, pretested, and implemented.

- Number of people trained.

Strategy 6: Research and Resource Centres

Objectives

- to undertake Knowledge, Attitudes and Practices studies of high and low risk groups in different parts of the study for developing the right messages ;

- to undertake a study of the prevalence levels and organizational structures of high risk behavior in all state capitals and towns having a population more than 500,000 for helping design intervention strategies;

- to undertake a training needs assessment study of all key functionaries for designing training modules;

- to undertake a study of the IEC resources available in the governmental and nongovernmental sector for identifying areas where training is required and further strengthening is needed to be able to cope with the issues raised by this disease;

- to undertake an analysis of counselling skills available in the government as well as in the community as the provision of counselling services is seen as a critical prerequisite to the IEC programmes.

- to establish at all state headquarters documentation centres in a recognized collaborating institution for purpose of further policy research.

Approach

The Research studi li ted abov are only indicative and not exhaustiv . These studi will be taken up by government owned research institutions, academic institution , as well as, operational research organizations in the private sector. Terms of reference and guidelines for assigning the tasks will be drawn up to ensure that the best available expertise is mobilized and the quality of research is kept at a high level. The results of research will be used for policy formulation and in developing IEC strategies.

A significant intervention is the strengthening and involving of Institutions of Social Work for undertaking operational research on high risk behavior, maintaining a documentation centre, dissemination of information among NGO's, training of NGO's in project formulation, management and counselling, provision of trained social workers for NGO's as well as to work in project areas initiated by Government where no NGO is working. This collaborative arrangement is sought to be taken up in 12 states having populations exceeding 30 million in the first phase. It is believed that such association of academic bodies will enhance the quality of the programme.

Activities Research

1. Review Literature.

2. Identify studies needed.

3. Identify research institutions.

4. Conduct research.

Progress Indicators

- Research priorities identified.
- Institutions identified.
- Research studies completed.

Activities Resource Centres

1. Conduct an assessment of existing documentation and service centres and produce a guideline for such an AIDS documentation/resource centre.

2. Assist Nodal Agencies in development of centres. Select two existing centres to conduct initial process of establishing AIDS centres.

3. Establish centres in each state.

Progress Indicators

- Documentation and resource centres established in all states and operational.

Strategy 7: Programme Management, Monitoring and Review

Objectives

- to formulate and design the IEC strategy;

- to develop norms and systems for the selection of agencies, professional experts for the development of prototype materials for ensuring consistency of message designs;

- to liaise with the Ministry of Information and Broadcasting Units for th disse ination of the information;

- to coordinate with the Department of Family Welfare and other sectoral departments for integrating AIDS messages with the IEC work being done by them and also for arranging the distribution of materials developed to the field level agencies;

- to coordinate with other departments such as Railways, Telecommunications, Municipalities,etc. for obtaining free space for publicity on AIDS;

- to develop specific projects with sectoral departments;

- to organize workshops and seminars etc for the different categories of persons;

- to establish norms and formulate guidelines for providing assistance to NGO's;

- to coordinate with institutions of social work for motivating NGO's and help design special intervention projects, evaluate and sanction funding support;

- to prepare training plans, identify agencies for developing modules and organize training workshops;

- to take up studies, research and evaluation;

- to establish monitoring and review mechanisms.

For carrying out the above mentioned tasks, the NACA will be provided a Joint Director for IEC with some support staff. In the 12 major states having a population of over 30 million, for coordinating the IEC activities, more particularly the programmes for NGO's, an advisor for NGO collaboration will be appointed along with some support staff. This person will be taken on a contractual basis. Since the main tasks will be related to social mobilization and NGO participation, a person with wide work experience in a NGO would be taken.

At this point it will be pertinent to also clarify the roles envisaged of the central and state governments. While IEC material development has to be necessarily based at the community, local level for ensuring its acceptability by the people, with a view to ensure consistency of messages and technical accuracy, it has been considered advisable to have two phases of development - phase (i) development of messages and prototype materials by the centre, and (ii) training and decentralization of IEC material development to the production levels at the state/district/block levels, radio and TV stations.

Activities

Central Level:

a) Establish a Technical Advisory Committee for formulating strategy and message development for different target audiences;

b) Identify agencies for developing prototype materials and implement a mass media campaign;

c) Establish counselling centres and distribution networks;

d) Organiz workshops for central level p rsons/agenci s;

e) Prepare training plans and modules;

f) Develop Terms of Reference for contracting services from the private sector;

g) Prepare a policy paper indicating Government policy regarding NGO collaboration and formulate guidelines for assistance;

h) Develop projects for sectoral collaboration;

i) Mobilize funding support for IEC activities and prepare budgetary allocations for activities.

State Level:

a) Motivate and identify NGO's for taking up intervention projects for high risk groups;

b) Liaise with Institutes of Social Work for organizing training workshops and provision of trained social workers for the NGO's;

c) Assess needs of IEC materials and design distribution networks;

d) Identify agencies for developing IEC materials for specific target groups;

e) Coordinate and review implementation of the project activities of other sectoral departments for information dissemination;

f) Organization of training workshops and orientation seminars for the various categories of persons listed.

g) Design review and reporting formats for obtaining feed back on activities undertaken, expenditures incurred for sending to the central government.

The strategy delineated above is only indicative of the ground that needs to be covered and the approaches that would be required to be taken for achieving the objectives listed in the above paragraphs. It is bound to undergo changes and modifications as the program activities begin to get implemented and the disease begins to unfold itself into its full shape and form.

COMPONENT 4: CONTROL OF SEXUALLY TRANSMITTED DISEASES

Background

Sexually transmitted diseases (STD) are associated with the same risk behaviours that put a person at risk for HIV infection, and ultimately AIDS. In addition to this, STD are now recognized as an independent risk-factor for HIV infection and AIDS, facilitating both the acquisition and transmission of the Human Immunodeficiency Virus. Although STD pose a serious public health threat in their own right, being responsible for considerable morbidity and long-term complications like pelvic inflammatory disease, male and female infertility, pregnancy wastage, and neonatal infections, it is this relationship to HIV infection that renders STD control imperative in the control and prevention of HIV infection.

In the first place, control of STDs will remove these diseases as a risk factor and so reduce HIV transmission. In the second place, comprehensive STD control programmes, by providing good quality clinical services to STD patients, also provide access to this sometimes heterogeneous and often elusive group. As STD patients are an important risk group for HIV infection, including for example prostitutes and their clients, this provides a unique opportunity for IEC, counselling and social mobilization interventions.

Although no comprehensive data on the prevalence and incidence of STDs in India exist, the available information indicates that sexually transmitted infections represent a very serious health problem. This is not only the case in the urban areas, but also in rural areas where in one study 50% of rural women were found to have an STD.[1]

Collection of baseline data regarding the incidence and prevalence of STDs, the causative organisms and their antibiotic sensitivity, as well as information on patterns of sexuality are urgently required.

Since 1946 there has been an STD control programme in India, and since recent years efforts have been undertaken to strengthen this programme. The programme has, however, not been developed with sufficient operational detail to allow effective implementation of STD control efforts, nor has a national policy on STD control been developed.

The mainstays of the programme are a number of special STD clinics and referral centres. Currently 5 Regional STD Referral Centres are operational in Bombay, Madras, New Delhi, Calcutta and Hyderabad. There are 130 Medical Colleges in India, who each have an STD Clinic, often integrated with dermatology and

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[1] Bang RA, Baitule M et al, High prevalence of gynecological diseases in rural Indian women, Lancet, 1989, 85-9

leprosy. None of the District Hospitals (459 districts) has an STD clinic, or the laboratory capability to diagnose STDs, other than simple smear examinations. In some Municipal Corporations specialized STD clinics can be found.

A recent UNICEF study revealed enormous gaps in the knowledge and understanding of STDs and their modes of transmission in the general public, and an almost complete lack of patient-oriented IEC for the prevention of STDs, treatment compliance or partner notification by health workers. It also identified serious problems in the areas of privacy and confidentiality.[2]

Policy statement

A national policy on STD control, formulated in a National STD Control Programme will need to be developed as a matter of great urgency. Such a policy will strive to integrate comprehensive STD control efforts in the existing health care system, both public and private. Integration of comprehenisve STD case management at the primary level of the health care system will receive special attention, so as to provide as much as possible non-stigmatizing services with a high accessibility and acceptance by the consumer. This will involve an emphasis on non-specialized, integrated services. Principles of privacy and confidentiality, essential to the success of any attempt to deal with STDs will strictly be adhered to. Cooperation from and collaboration with the private sector and NGOs will be promoted.

Objectives

The objectives of the STD control programme are the following:

i) to reduce the transmission of STD; and hence of HIV by reducing the risk-factor effect for HIV transmission associated with the major STD;

ii) to prevent the development of short and long term morbidity, and mortality, due to STD.

STD Control Strategies

The following main strategies will be developed and employed:

1. Prevention of transmission of STD/HIV infection, through IEC, promoting behavioural change, including the consistent use of condoms.

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[2] UNICEF, KAP Study: Sexually Transmitted Diseases, the qualitative phase, in draft.

2. Adequate and comprehensive management of patients with an STD, which includes aspects of diagnosis, treatment, individual counselling, partner notification and screening for other diseases.

3. Increase access to adequate health care for STD, by strengthening existing facilities and health care structures, and the development of new facilities where necessary.

4. Detection and treatment of infections before illness or complications arise, through case-finding and screening.

The implementation of these strategies will be supported by:

5. Training of health care workers, both public and private, in comprehensive case management through the development of a training network.

6. The development of appropriate laboratory services for the diagnosis of STD.

7. Microbiological and socio-behavioural research, as well as operational research.

8. Surveillance, to follow the epidemiological situation and to monitor and evaluate the implementation of STD control programmes and their effectiveness.

These strategies will be implemented in a phased manner, after establishing a strong programme management structure. Initial focus will be on the 61 cities with a population over 500.000 and State/UT capitals. Within these cities priority will in the first phase be given to interventions targetting those population groups that are considered to be at high risk of acquiring and transmitting STD, such as sex workers and their clients, long-distance truck drivers, migrant workers, and other. Although it is recognised that STD are certainly not an exclusively urban health problem, interventions in urban areas, and in particular those targetting at-risk groups are considered most cost-effective and to have the greatest potential to reduce the spread of HIV infection.

Coverage will in later stages of programme development be extended to groups considered at relatively low risk of STD in urban areas, and to semi-urban and rural areas, with involvement of the existing health care services.

Programme Management

Introduction

The implementation of comprehensive STD control programmes, in the context of efforts for the prevention and control of AIDS in India, requires the development of a strong management

structure at both Central and State level, and where appropriate also at Municipal level.

Objectives

The objectives of programme management are:

- **To ensure guidance and direction in the planning and implementation of STD control programmes.**

- **To ensure coordination of STD control activities within the National and State AIDS control programmes.**

- **To provide focal points for the monitoring and evaluation of STD control efforts at National and State level.**

Activities

Central level

- Appoint a National STD Control Officer, with the following responsibilities:

  - to provide guidance in the development and implementation of State STD Control Programmes; this involves the development of national guidelines, and training modules;

  - to ensure coordination of STD control activities within the National AIDS Control Programme;

  - to be the focal point for monitoring and evaluation of STD control efforts at National level;

  - to act as a resource person to provide technical support in the various aspects of programme planning and implementation in the States.

- Organise a National STD Planning workshop, with participation from the State/Municipal STD Control Officers/Programme Managers, and other Central and State Senior Ministry of Health officials.

State level

- Appoint an STD Programme Manager or STD Control Officer at State and Municipal level, with the following responsibilities:

  - to plan, direct and organise STD control activities, based on central guidelines;

- to procure resources for the programme, including drugs, condoms and other supplies;

- to organise training of trainers in the States, and Municipalities;

- to plan for subsequent training of health workers, and to supervise and monitor such training;

- to assess existing services, and plan strengthening of these services and the development of new services where required;

- to plan and coordinate baseline and operational research;

- to monitor and evaluate the results of the control programme.

Progress indicators

- National STD Control Officer appointed.
- State/Municipal STD Control Officers/Programme Managers appointed.
- National STD Planning Workshop held.
- State STD control programmes developed and implemented.

Strategy 1: Prevention of STD through IEC

Introduction

Transmission of sexually transmitted infections is strongly associated with a limited number of high-risk sexual behavioural patterns. These are: (i) having sexual intercourse with multiple or casual partners; (ii) failure to use condoms in at-risk situations. Behavioural changes towards reduced risk behaviour, that is limiting the number of sexual partners and consistent use of condoms, will therefore contribute significantly to a reduction in the transmission of STD.

The IEC Component of the Strategic Plan for the Prevention and Control of AIDS in India contains detailed strategies for the prevention of STDs and HIV infection. Important objectives of such strategies are: i) to raise awareness of the seriousness of the public health threat posed by STD, including HIV infection; and ii) to promote the consistent and proper use of condoms in all at-risk situations, while reducing the number of sexual partners.

Objectives

The objectives of IEC efforts aimed at prevention and control of STD in particular are the following:

- to promote prompt attendance for a screening examination after exposure in an at-risk situation;

- to promote early attendance for medical examination when symptomatic;

- to promote compliance with treatment;

- to promote collaboration in the notification and referral of sexual partners.

Primary prevention for STD will be an integral part of all IEC, social mobilization and counselling activities carried out for the prevention and control of HIV infection and AIDS. Primary prevention activities specifically targeted at STD patients and their partners will be integrated in the day to day activities in the health facilities where STD patients attend for medical care. Condoms will be distributed through these facilities as well.

For the implementation of IEC activities targeted at primary prevention of STD/HIV infection the involvement of NGOs will be actively sought.

Activities

Central level

- Develop a mechanism for collaboration between the Officer STD Control and the IEC Officer, to ensure technical input in the development of IEC materials with specific messages for the prevention and control of STD.

- Develop generic information and materials to assist NGOs in developing STD related IEC projects.

State level

- Ensure collaboration between the State STD Control Officer and the group or groups responsible for development of IEC materials, in particular:

- to provide technical input where messages specific for STD prevention and control are concerned;

- to ensure the integration of specific STD and IEC interventions where appropriate.

- Organise workshops for NGOs involved in STD/AIDS related activities to raise awareness and increase the knowledge base of STD.

- Provision of continued technical support in the field of STD control for NGOs involved in STD/AIDS related IEC activities.

- Training of health care workers in IEC and counselling to individual STD patients, to be achieved in conjunction with the training for comprehensive case management; initial focus will be on health care workers, including private practitioners, working in the priority areas for STD interventions.

- Training of counsellors to provide IEC and counselling to individual STD patients.

- Distribution of appropriate health education materials to all health facilities, and in particular to those treating STD patients.

- Distribution of good quality condoms to all health facilities, for free distribution to patients with STD.

Progress indicators

- Collaboration between STD Control Officers and IEC Officers/IEC groups established.
- STD related materials for NGOs developed; STD related workshops for NGOs at State level organised.
- Training for health care workers and counsellors in IEC and counselling of STD patients carried out.
- Health education materials and condoms distributed to health facilities.

Strategy 2: Case management

Introduction

Comprehensive management of people with a sexually transmitted disease is the cornerstone of STD control. Comprehensive management involves excluding or diagnosing an STD, providing appropriate treatment, excluding or diagnosing other STD, ensuring patient compliance with the treatment, ensuring patient collaboration in partner notification and referral, and the prevention of future episodes of infection, including the promotion and distribution of condoms. Confidentiality and privacy are essential characteristics of successful case management.

Adequate management of patients with an STD attracts and therefore provides access to a high risk group for both traditional STD and HIV infection, which in turn is a priority group for IEC interventions.

Priority areas for the introduction of comprehensive STD case management in the first phase of the implementation of the

STD control programme are the 61 cities with a population over 500.000 and State/UT capitals. Although it is recognised that STD are not exclusively an urban health problem, it is considered that interventions in urban areas are most cost-efficient.

Within these areas, priority will be given to those groups that are perceived to be at increased risk of acquiring and transmitting STD, such as sex workers and their clients, as well as long-distance truck drivers, migrant workers, homosexual men and other groups.

In a later phase of programme development coverage will be extended to the semi-urban and rural areas. This extension will involve the District Hospitals, the existing primary health care services in these areas, and the private sector. Training of health care workers, and strengthening of the existing facilities will be part of this phase of the programme.

The total population of the 61 priority cities is over 92 million, with an average population of 1.5 million.

Objectives

The objectives of case management are:

- to prevent the development of complications and sequelae of STD;
- to break the chain of transmission of sexually transmitted infections.

Activities

Central level

- Development of national guidelines for the comprehensive management of STD patients, including sections on diagnosis, treatment, patient education and counselling, partner notification and condom promotion.
- Organise a national workshop for State STD Control Officers and Senior State Ministry of Health Officials on the aspects of comprehensive STD control programmes and in particular the need for appropriate and adequate case management.
- Develop training modules for comprehensive STD case management. (See under Strategy 5: Training)
- Develop algorithms for the management of STD patients in settings with and without laboratory support.
- Organise training for health workers in centrally run health facilities in the management of STD patients.

- Develop the logistics for an adequate supply of STD drugs in centrally run health facilities.

State level

- The State STD Control Officer is to review existing health care facilities consulting STD patients in the light of the central guidelines for STD case management, in the 61 priority areas. Emphasis will initially be placed on facilities catering for the identified at-risk groups.

- Plan for strengthening of facilities not meeting the guidelines; this will be in terms of physical improvements, staff training, drug and condom supplies, laboratory support.

- Develop and implement interventions among specific target groups, e.g. sex workers and their clients, truck drivers, migrant workers, etc., in urban areas.

- Plan for the phased development of an STD case management capability in all health care facilities in the 61 priority areas, by providing appropriate training to health workers in simple diagnostic techniques and the provision of STD drugs to these facilities. Initial emphasis will be on those facilities catering for at-risk population groups.

- Expand the STD programme to cover the 61 priority cities.

- Introduction of algorithms to facilitate the diagnosis of STD by health workers, in the absence of laboratory support.

- Expand the STD programme to cover all States.

- Assess the staff needs for programme implementation, and employ additional staff where and when required.

- Increase the number of female doctors working in STD clinics, to increase service utilisation by female patients.

- Procurement and distribution of drugs, condoms and other supplies, required in the State programme.

- Organise workshops for the training of trainers in the designated institutions (see under Strategy 5: Training) in comprehensive case management.

- Organise and supervise subsequent training of health workers in comprehensive STD case management by those

trained, initially focussing on the priority areas for interventions.

- Training of private practitioners in STD case management in the 61 priority areas, through a series of workshops organised by the designated STD training centres in close collaboration with the IMA and the private practitioners involved.

Progress indicators

- National guidelines and training modules developed.
- National workshops held.
- Training for health workers, including private practitioners held.
- Upgrading and strengthening of facilities.
- Adequate procurement and distribution of STD drugs and supplies to health facilities.

Strategy 3: increase access to adequate health care for STD

Introduction

The provision of adequate health care for STD patients in terms of both easily accessible facilities and good quality care with a high level of consumer satisfaction is essential for the success of an STD control programme. While aspects of good quality care are discussed in more detail under the sections dealing with "Case Management" and with "Training", this section addresses the need for easily accessible health care facilities, either public or private, where STD patients can be consulted.

The existing STD Control Programme is centered around a limited number of categorical STD or skin-STD-leprosy clinics, many of which are located in Medical Colleges. The existing centres have a limited catchment population, and are attended by only a small proportion of the estimated total number of STD patients.

It is not foreseen to increase the number of categorical STD clinics, but rather to increase the coverage of the programme by involving non-specialised health care facilities in the care of STD patients. Where there is a lack of health care facilities preference will be given to create general health care facilities, with a strong STD case management component, rather than setting up special STD treatment centres. The existing STD clinics in the 5 Regional STD Referral Centres and the 130 Medical Colleges will play a role in supervision and training, and become referral centres for lower level health care facilities, as well as providing primary care to STD patients in their catchment areas.

The Regional STD Referral Centres in particular will be developed to function as centres of excellence. These centres will be setting standards for comprehensive STD case management,

and will be providing high quality training, referral and research services.

Where appropriate, NGOs will be stimulated and supported to provide clinical services to target populations for STD/HIV interventions.

Objectives

The objectives of this strategy are:

- To ensure easy access to health care facilities where adequate comprehensive STD case management is provided, initially in the 61 priority areas, and in particular by those most at risk of acquiring and transmitting STD.

- To strengthen the 5 Regional STD Referral Centres to the extent that these can serve as centres of excellence.

- To develop a referral system for STD patients who can not be managed successfully at the lower levels of the health care system to the Municipal STD Clinics, Medical Colleges and Regional STD Referral Centres.

- To develop a system of supervision of the lower level health care centres, providing case management of STD patients, by the Municipal STD Clinics, Medical Colleges and Regional STD Referral Centres.

Activities

- The State STD Control Officer is to do an assessment of the coverage of existing health care facilities, and to identify areas with a relative lack of such facilities, bearing in mind the priority areas and groups for intervention development.

- Assess the coverage of private health care services in the priority areas for intervention.

- Assess the needs for upgrading of facilities and additional training to extend STD care and case management to non-specialised health care facilities.

- Upgrading of the 5 Regional STD Referral Centres, the Municipal STD Clinics and the STD/skin-STD-leprosy clinics of the 130 Medical Colleges.

- Identify areas where the (relative) lack of health facilities hampers adequate STD case management, and plan for the development of additional health care facilities where required; these will be general

health care facilities, with an emphasis on STD case management.

- Identify and support NGOs that are providing, or are capable of providing, clinical care to target populations for STD/HIV interventions.

- Set up a referral system for STD patients from primary care centres to the Municipal STD Clinics, the STD departments of Medical Colleges and to the STD Referral Centres, by linking primary care centres in the catchment area of an STD Clinic, Medical College or STD Referral Centre to these facilities.

- Set up a system of regular supervision by the STD Clinics, Medical Colleges and STD Referral Centres of the primary care facilities in their catchment area.

Progress indicators

- STD patients having easy access to care facilities.
- Regional STD Referral Centres, STD Clinics and STD Departments of Medical Colleges upgraded.
- A referral system for STD patients developed and implemented.
- A system of supervision of lower level health care facilities by secundary and tertiary care facilities developed and implemented.

Strategy 4: Screening and case-finding

Introduction

Detection of disease and asymptomatic infection followed by early treatment where possible is an important aspect of STD control. It reduces the complications and morbidity associated with sexually transmitted infections and it minimizes further transmission.

The degree of priority allocated to the implementation of screening and case-finding strategies will depend on the availability of laboratory support for the diagnosis of frequently asymptomatic infections, on the public health importance of the condition screened for in the target population, on the availability of effective treatment for that condition, and on the likely cooperation of the target group. Quality control for the laboratory tests employed is essential.

Crucial for any screening and disease detection programme are the voluntary cooperation from the target population, and the assurance of strict confidentiality and privacy, as well as a non-coercive and non repressive approach. Extensive awareness raising and motivation of target populations is essential, both

to increase utilisation of services when symptomatic, and to participate in case-finding or screening programmes.

Objectives

The objectives of screening and case-finding in STD control are the following:

- to detect and provide early treatment for sexually transmitted infections that can be treated, before morbidity or complications develop;
- to break the chain of transmission of these infections.

Activities

Central level

- Develop guidelines for the development of screening and disease detection programmes for STD, including aspects of required laboratory support and its quality control.
- Organise a workshop with State STD Control Officers and Senior State Ministry of Health officials on screening and case finding as a control strategy for STD.

State level

- The State STD Control Officer is to review the existing practices with regard to the screening of ante-natal care attenders for syphilis.
- Implement a screening programme for syphilis for all ante-natal clinic attenders.
- After the development of an adequate and well functioning STD case management structure, the potential for introducing STD screening and case finding for specific groups can be explored.
- Develop adequate levels of laboratory support.
- Obtain full and voluntary cooperation from the target group, and establish guarantees of confidentiality and privacy.
- Implement the screening/case-finding programme.
- Monitor programme effectiveness.

Progress indicators

- National guidelines developed.
- National workshop held.
- Syphilis screening in all ante-natal clinics practised.
- Development of special screening programmes for specific groups.

Strategy 5: Training

Introduction

In general there is a lack of knowledge about STD among many health professionals, both public and private, and staff attitudes to patients with STD are often poor. A vast amount of training is required, not only to broaden the knowledge base of all cadres of health workers, and of private practitioners, but also to introduce new approaches to comprehensive STD case management, and to change negative and counter productive staff attitudes.

The amount of training required necessitates a phased approach where a training network will be developed, which will have as it central points the 5 Regional STD Referral Centres, the Municipal STD Clinics and the 130 Medical Colleges. Training of trainers from these institutions will take place, followed by a concerted effort to train other health workers. A special role in the training network is allotted to the five Regional STD Referral Centres, which will be developed and strengthened to function as centres of excellence.

For this training to be consistent and in line with national policies, generic training modules will be developed for use at State level.

Objectives

This important support component has the following objectives:

- To increase the awareness of health workers of the importance of STD control for the prevention and control of AIDS, and of the public health importance of STD in their own right.

- To provide health workers with the knowledge and the skills required to provide adequate comprehensive management to patients with STD; special attention will be paid to issues of counselling, confidentiality and privacy.

- To provide laboratory staff with the skills needed to provide laboratory support in the management of STD patients, including the use of new tests as and when they become available.

Activities

Central level

- **Develop a training network, in which the Regional STD Referral Centres and a number of Medical Colleges will be responsible for the training of other Medical Colleges; these will in turn all be responsible for the training of health workers in the 61 priority areas.**

- Develop generic training modules on the various aspects of comprehensive STD case management; these should include sections on diagnosis, use of laboratory support, use of algorithms to assist in the diagnostic process, treatment, education and counselling of individual patients on treatment compliance and disease prevention, partner notification and management.

- Hold a workshop for training of trainers, with participation from the 5 Regional STD Referral Centres, and an additional 20 Medical Colleges.

- Develop training modules for (refresher) training of laboratory staff in STD diagnosis.

State level

- Implement the training network at State and Municipal level, and organise training workshops for the Medical Colleges not yet trained.

- Organise workshops for health workers involved in STD case management in the 61 priority areas; the resource persons for these workshops are to come from the Medical Colleges and Regional STD Referral Centres; resource materials will be provided in the form of training modules.

- Organise training workshops for private practitioners in the priority areas, in close collaboration with the IMA; resource persons are to come from the Regional STD Referral Centres and the Medical Colleges.

- Organise training workshops for laboratory staff.

- Organise training for staff in the 453 District Hospitals, to be conducted by the Medical Colleges.

- Integrate training related to STD control, and in particular case management, in the existing training programme for health workers in the PHC system.

- Organise refresher training at regular intervals, through the established STD training network.

Progress indicators

- Traning modules developed.
- Training of TOTs and subsequent training of health care workers, including private practitioners and laboratory staff held.
- Training of District Hospital staff carried out.
- STD training integrated in training for PHC health workers.
- Programme for refresher training developed.

Strategy 6: Development of laboratory support

Introduction

Accurate diagnosis of STD requires laboratory confirmation of a clinical diagnosis, in particular in the case of female patients presenting with vaginal discharge and in patients with genital ulceration. Unfortunately, simple and rapid tests are presently only available for a minority of conditions, and not for use in situations where laboratory confirmation is most needed.

In the absence of such simple and rapid tests most STD patients will continue to be diagnosed and treated on the basis of a clinical diagnosis, as is currently the case even in most STD clinics, where laboratory confirmation for many conditions is available. The laboratory capability of the Regional STD Referral Centres and the Medical Colleges will be strengthened, to allow these facilities to play a meaningful role as referral, training and research centres.

Simple diagnostic tests will be made available to those facilities where STD case management is provided, and this diagnostic capability will gradually be expanded. Appropriate rapid and simple diagnostic tests will be made available as and when they become available to the programme.

Objectives

The objectives of this support component are:

- To increase the effectiveness of the STD case management in health care facilities, by providing laboratory confirmation of clinical diagnosis in doubtful cases.

- To reduce the need for multiple treatment regimens in cases where different causative organisms give rise to the same syndrome.

- **To provide a means of assessing the asymptomatic partners of patients with STD, in particular female contacts of males with gonorrhoea or chlamydial infections, many of whom risk to become chronically infected.**

- **To create the necessary infrastructure to monitor the epidemiological and microbiological situation of STD in the country.**

Activities

Central level

- Develop national guidelines for the availability of STD laboratory tests at the various levels of the health care system.

- Develop national guidelines for the use of laboratory tests and procedures in the diagnosis of STD.

- Develop a training module for the (refresher) training of laboratory staff involved in STD diagnosis.

- Organise a central training workshop to train TOTs from the 5 Regional STD Referral Centres, and from selected Medical Colleges in STD diagnosis.

- Ensure the availability of good quality reagents and media, by developing a system of quality control for locally produced goods.

- Develop channels to import sufficient supplies of essential reagents and media currently not produced in India.

- Upgrade the laboratory capability for the diagnosis of STD in the 5 Regional STD Referral Centres, by carrying out the necessary physical improvements, and supplying the required equipment, reagents, media and other supplies.

- Upgrade the laboratory capability for the diagnosis of STD in the 130 Medical Colleges and the Municipal STD Clinics to the recommended level of availability of tests; this will involve physical improvements, and the provision of equipment, reagents, media and other supplies. Initial emphasis will be placed on the Colleges that cover the 61 priority areas for intervention development.

- Develop a national quality control system for STD laboratory diagnosis, in particular gonorrhoea culture and syphilis serology.

- Develop a national antibiotic susceptibility monitoring network.

State level

- Organise training of laboratory staff in the Medical Colleges not yet trained, through a number of practical workshops in the institutions that received TOT training.

- Implement the upgrading of the STD laboratories in the Regional STD Referral Centres, the STD Clinics and the Medical Colleges.

- Implement the quality control system developed for laboratory tests, and for reagents and media.

- Develop the logistics to ensure continuous availability of reagents, media and other supplies to the STD laboratories.

- Develop mechanisms through which private practitioners and other public health care providers with no laboratory support can utilise the services of existing STD laboratories.

- Provide the lower level health care facilities where STD case management takes place with microscopes and the supplies to provide the recommended minimum level of laboratory support.

Progress indicators

- National guidelines for STD laboratory test availability, and for the use of such tests developed.
- Laboratories upgraded to the recommended level.
- Training module for laboratory staff developed; training of TOTs and subsequent training of laboratory staff held.
- Quality control systems developed for reagents, media, and for laboratory tests.
- National antibiotic susceptibility monitoring network developed.

Strategy 7: Research

Introduction

There is a need for baseline microbiological and socio-behavioural research for the development of specific interventions, and to measure the effectiveness of STD control measures. Socio-behavioural research will be linked with that carried out under Component 3: Prevention of HIV transmission through Behaviour Change. Baseline microbiological studies are currently being conducted in Bombay, Calcutta, Madras and Tamil

Nadu, and in Jaipur. These studies will assist in obtaining an impression of the seriousness of the epidemiological situation with regard to STD in these areas, but additional studies will be necessary. Follow-up surveys will allow to detect trends in the epidemiology of STD, of antibiotic resistance, and will allow monitoring of programme effectiveness.

Operational research is required to assess the most efficient and cost-effective interventions in specific situations and in specific target groups.

Research will be conducted by the Regional STD Referral Centres, and the Medical Colleges, and will be coordinated by the State STD Programme Manager or Control Officer.

Objectives

The objectives of STD related research are:

- To provide a baseline for the STD situation in an area where an STD control programme is to be implemented, and to provide subsequent data for programme monitoring and evaluation.

- To provide information which will allow such STD programmes to be tailored to the local situation in terms of epidemiology of STD, antibiotic resistance, sexual behavioural patterns and specific target groups for interventions.

- To decide on the most cost-effective intervention in particular situations and among particular target groups.

Activities

Central level

- Develop guidelines for conducting STD baseline surveys, among specific population groups.

- Provide technical support for the implementation of STD baseline surveys.

- Coordinate research on antibiotic susceptibility by establishing a national network, and ensure consistency of research techniques between centres and over time.

- Reinforce the existing quality control centres for syphilis serology and for gonorrhoea culture.

State level

- Implement STD baseline surveys where indicated.

- Conduct microbiological research on the relative prevalence of the various STD pathogens, and on antibiotic susceptibility.

- Conduct operational research concerning specific interventions for the control of STD, to decide on the most cost-effective approach to STD control in a given situation.

Progress indicators

- Guidelines for STD baseline surveys developed and distributed.
- Antibiotic susceptibility monitoring network developed.
- Operational research conducted.

Strategy 8: Surveillance

Introduction

An STD surveillance system will allow to follow the epidemiological situation with regard to STD, and will also provide data for the monitoring and evaluation of programme implementation and effectiveness. Where possible STD surveillance will be developed jointly with the HIV surveillance system, so as to minimise duplication of efforts.

A sentinel site surveillance system, in which a limited, but representative number of health facilities provide routine reports on STD clinical syndromes and/or etiological diagnosis will provide useful data on a continuous basis, which will be supplemented by the repeat surveys.

Objectives

The objectives of an STD surveillance system are:

- To provide data to monitor the epidemiology of STD.

- To provide data to monitor programme implementation and evaluate programme effectiveness; this will allow to adapt the programme where necessary to ensure continued maximum effect.

Activities

Central level

- Develop guidelines for STD surveillance, and for the development of a sentinel site STD surveillance system.

- Compile reports on STD surveillance from the individual States into a national report.

State level

- Develop an STD surveillance system, based on central guidelines.

- Select a number of sentinel reporting sites, and develop a routine reporting system.

- Train clerks in routine reporting, and monitor reporting from individual sites.

- Review STD programme activities on the basis of the monitoring of programme implementation and evaluation.

- Develop a system of feed-back to individual reporting sites, and of reporting to the National STD Officer.

Progress indicators

- National guidelines for STD surveillance developed.
- STD surveillance system implemented.
- Regular reports produced.

COMPONENT 5: CONDOM PROGRAMMING

Background

Heterosexual intercourse is the dominant mode by which HIV is transmitted in India. Recent WHO/GPA estimates and others suggest that in 1991 there may be as many as 300,000 to 1,000,000 persons infected with HIV in India. High-risk behaviour for sexually transmitted HIV is defined as unprotected intercourse (vaginal, anal or oral) with someone whose HIV status is unknown in which bodily fluids are exchanged. Barring abstinence or relations with a monogamous, uninfected partner, the only other method recommended by WHO to avoid infection during sexual intercourse is the proper and consistent use of an intact latex rubber condom.

Policy Framework

Recognizing that some people have multiple sex partners and engage in risky sexual behaviours, and acknowledging the experience of expanding HIV seroprevalence rates in other countries with HIV transmission patterns similar to those in India, the GOI has established a strong position of support for condom promotion for STD/HIV prevention to ensure that people who choose to engage in risky sexual behaviour have access to good quality, low cost (or free) condoms with information that is needed for proper and effective use.

Further, it is recognized that the AIDS virus is primarily affecting prostitutes and their clients, men who have sex with men, and IV drug users. Such behaviour is considered to be socially unacceptable. It is acknowledged that private voluntary, non-governmental organizations are generally the most appropriate agencies to design and implement community-based behaviour-change activities with these marginalized, often stigmatized, groups. PVO/NGOs are also well-situated to target STD/HIV prevention programmes towards other vulnerable groups such as out-of-school youth, youth in the labour force and "street children".

Finally, it is recognised that India has a strong basis upon which to build effective condom promotion and distribution activities. India is currently self sufficient in condom production with a manufacturing capacity of approximately 1.7 billion condom pieces per year. There are five manufacturing plants in the country, of which Hindustan Latex Ltd.a public sector company, produces nearly 50%. The Nirodh program is the world's first and largest contraceptive social marketting programs involving i) a large component of free supply of condoms through government clinics made available at village points and ii) highly subsidised sales through commercial trade channels by 9 major companies and 2 non-profit organisations through over 300,000 sale outlets. Social marketting accounts for a little over 85% of the total production of condoms. It is estimated that about 5% of the sexually active population use condoms.

The major target group for social marketting are the married couples in the age groups 18-30, since the pricipal objective of condom promotion is averting or delaying a birth. However, in view of the wide network already existing for the manufacture, distribution and sales of the condoms, and also because it is not considered advisable nor feasible to have an alternate marketting structure for promoting the condom for protection against AIDS, it is believed that the appropriate integration of the NAP'S condom programming activites with the existing programme for family planning could significantly acclerate achieving AIDS prevention goals.

Objectives

The objectives of condom programming for AIDS control and prevention are essentially related to the two basic issues of quality and access. They are as follows :

- Establish quality standards and specifications for the condom in order to ensure it affords adequate and full protection from the transmission of the HIV;

- Establish systems that would enforce that the condoms quality are in conformity with the standards laid down;

- Strengthen the existing market mechanisms and distribution networks to ensure the easy availability and access to those needing condoms at affordable prices;

- Encourage and promote NGO's and private voluntary organisations to innovate interventions and take up social marketting in underserved areas and among those high risk groups who cannot ordinarily be accessed by the existing marketting networks viz drug addicts, homosexuals etc.;

- Design an aggressive male centred campaign, using mass media as well as local media channels, for promoting male responsibility and bringing about a shift in the prevailing perceptions, attitudes and behavior among men regarding the use of condoms;

- Promote and encourage research studies;

Strategies

In order to achieve the above mentioned objectives a comprehensive strategy would be required consisting of the following components:

1) Provide technical assistance to companies to manufacture condom in conformity to the

specifications laid down by the WHO and improve quality assurance systems;

2) Strengthen the existing social marketting structures in the Department of Family Welfare with a view to subserve the needs and requirements of the AIDS programme;

3) Strengthen management ability of PVO/NGOs that promote and distribute condoms for STD/HIV prevention to more effectively plan, coordinate, monitor and evaluate their activities.

4) Collaborate with the existing IEC programme of the Department of Family Welfare for promoting the use of the condom for achieving the dual purpose of averting a birth as well as protection from AIDS;

5) Support and strengthen the ICMR and PRC's for undertaking research studies on all matters related to the use of condom and increasing its use, particularly among the high risk groups;

6) Strengthen program management and monitoring systems.

Activities

1) Provide technical assistance to companies to manufacture condom in conformity to the specifications laid down by the WHO and improve quality assurance systems :

The first most critical requirement is to amend the schedule "R" of the Drugs and Cosmetics Act laying down the standards and specifications required for affording complete protection from the disease. Based on this standard prescribed by the WHO, the existing standards will be evaluated and technical assessments made as to the modifications required to be brought about. Other associatted activities are as follows:

(a) Conduct an initial technical assessment and support to the Central Indian Pharmaceutical Laboratory in New Delhi and the India Government Services Laboratory, branches in Madras and Trivandrum to upgrade, as needed, sampling, equipment, joint protocols, operating procedures, record keeping and reporting.

(b) Provide equipment, supplies and training as recommended in the initial technical assessment for condom QA testing laboratories.

(c) Organize annual Inter-laboratory trials among participating condom quality assurance testing laboratories in India, including manufacturers, to validate cross-lab results on key test parameters and

to provide follow-up technical support to bring labs into conformity with the standard.

(d) Conduct bi-annual meeting of condom QA laboratory personnel to review Inter-laboratory trial results and recommend additions and improvements to the national QA lab protocols

(e) Provide technical and financial support to Hindustan Latex, Limited (a Government of India Enterprise) to strengthen its R&D staff and facilities to foster state-of-the-art condom production and quality control that will enhance both domestic and export performance

(f) Conduct research on condom product characteristics including size, elasticity, lubrication (including amount, viscosity, non-oxynol 9), scent, color, stability, breakage, packaging, etc.

2) Strengthen the existing social marketting structures in the Department of Family Welfare with a view to subserve the needs and requirements of the AIDS programme;

Social marketting is an extremely powerful mechanism and a valuable approach for any public health program. It enables provision of access at affordable prices to the needier target groups in a professional manner that is based on the concepts and techniques of modern marketting - research, communication, sales, distribution, advertising, and promotion. However, social marketting is not only concerned with selling the product but in marketting ideas - self protection, social responsibility, a sense of empowerment etc.

The objective of social marketting will be to identify the knowledge, attitudes and practices of the target groups, design a communication campaign that will generate a demand for the product and establish a distribution network that will ensure its availability at affordable prices. Audience segmentation, client specific promotional strategies, use of pricing instruments and such market based strategies for expanding use of condom etc. will need to be carefully worked out. Specifically, this would involve the following activities:

(a) Conduct an assessment of technical and material resources needed to upgrade selected social marketing and family planning programmes' infrastructure and capability to address STD/HIV prevention.

(b) Conduct market research to identify appropriate marketing strategies for different target groups.

(c) Sponsor consumer research studies on customer profiles, condom purchase patterns, preferences, coital frequency, usage rates and patterns, breakage, etc.

(d) Develop condom advertising strategies based upon market research to reach each target audience through the appropriate communications channel with the right message in the conduct of a phased programme that creates awareness, establishes the desired behaviour and reinforces that behaviour.

(e) Conduct training workshops on a continuing basis for social marketing/family welfare programme managers, distribution and sales people, "depot holders", etc. at all levels (central, state, district, block) to strengthen knowledge and awareness of what AIDS is, how it and other STDs are transmitted and how they can be prevented.

(f) Hold bi-annual meetings of selected national and state experts in the social marketing and family planning areas to discuss ways in which these traditional family health service programmes can be mobilized to better serve the objectives of the national AIDS programme.

(g) Open and establish new market oulets for accessing high risk groups - liquor shops, bars, hotels, highways, private STD clinics, grocery and cigarette shops in red light areas etc. Special focus needs to be given to pharmacists and medical shops which are a principal contact points for STD patients and IV drug addicts.

3) Strengthen management ability of PVO/NGOs that promote and distribute condoms for STD/HIV prevention to more effectively plan, coordinate, monitor and evaluate their activities.

The NGO's and the PVO's working for family planning will need to be sensitised and provided information about AIDS and ways of integrating it with their ongoing family planning programmes. In this task the Family Planning Association of India and other such bodies will need to be involved. The NGO's will need to be motivated to not only promote the use of the condom but also be supported for innovative approaches such as establishing male clinics which could provide a set of services such as information and counselling on family planning, vasectomies, sexology, infertility treatment, minor surgeries, urology, general medical care and alongside, treatment for venereal diseases and counselling for AIDS. This could be an important intervention since STD/AIDS counseling centres will not attract men in view of the shame associated with the disease.

For enabling the NGO's to participate in an extensive manner as envisaged, training in programme design and management will be provided.

4) **Collaborate with the existing IEC programme of the Department of Family Welfare for promoting the use of the condom for achieving the dual purpose of averting a birth as well as protection from AIDS;**

Central to the program for IEC and social mobilisation for prevention of HIV transmission is the promotion of the use of condom as a prophylaxis, particularly among the high risk groups. Demand generation for the availability of good quality condoms at affordable prices will be one of the objectives. The efforts of condom programming would be to make available the supplies to meet the demand.

Condom promotion, as a generic product, will be attempted to be integrated with the existing campaign of the Department of family Welfare so as to ensure consistencies in the messages. However, great care will need to be taken to ensure that in such an integration does not in any way blur or gloss over the use of condom for protection against AIDS. Besides,it is realized that promoting the use of condom as a tool for limiting the size of the family can have a different connotation to promoting the condom for safe sex. Since safe sex implies a behavior pattern that does not have social sanction, promotion of the condom will need to perhaps be more focussed on using peer pressure, reinforcing power, status, popularity and sexuality, and personal vulnerability. In the Indian context, alongside motivation, stress will also need to be laid on provision of information based on logic - on the utility of condom use, manner of using it, disposable methods - emphasising all along pleasure, sexual enhancement and satisfaction etc.

Mass media have a limited value for the effective promotion of such critical information. Therefore, specially designed software would need to be developed for interpersonal group discussions among those prone to high risk behavior - frequent travellers, migrant labor, youth, truck drivers etc. Such promotional materials which upgrade the skills on condom use and disposable methods of condoms need to also be developed for educating the commercial sex workers, homosexuals and their support structures etc.

5) Support and strengthen the ICMR and PRC's for undertaking research studies on all matters related to the use of condom and increasing its use, particularly among the high risk groups;

Through the ICMR and the Population Research Centres, operational research must be undertaken. Specifically, the following areas are important :

(a) Promote research to establish the degree of compatibility of the promotion of condoms for STD/HIV prevention with promotion for family planning.

(b) Conduct acceptability research on the female condom conducted in several centers amongst women with multiple sex partners. g and h

(c) Research will also need to be undertaken to examine issues related to enhancing motivation, focussing on individual behavior change against social behavior change, implications of promoting the use of condom in primary relationships on issues related to trust etc., analysis of barriers to the use of condom particularly among the risk groups, impact of promoting use of condom in the context of multipartner sexual behavior on fears of that sanctioning promiscuity etc.

6) Strengthen program management and monitoring systems.

a) Sponsor the preparation and conduct of WHO/GPA Programme Manager's Course among both governmental and NGO sectors at central and state levels, with emphasis upon planning, monitoring and evaluation.

b) Conduct an assessment of NAP logistics management training needs, in governmental and non-governmental sectors, at all management levels.

c) Organize logistics management TOT courses at senior and middle management levels in all states grouped in eight regional patterns on a priority order basis to strengthen the logistics management capability of both governmental and NGOs participating in the condom (and other products) distribution system.

d) Develop and implement a management information system (MIS) that tracks condom distribution for STD/HIV prevention as well as for family planning in both the public and private sectors.

e) Implement the WHO-designed "Rapid Assessment Protocol for Planning the Condom Component of AIDS/STD Prevention Programmes" to gather in-depth information on the needs estimation, distribution and use of condoms for STD/HIV prevention.

COMPONENT 6: BLOOD SAFETY

BACKGROUND

There are 1018 blood banks in the country, handling an estimated 2 million units of blood per annum. This works out to be about 3.3 units per hospital bed, which is much lower than the WHO norm of 7 units per annum per bed. Of the 1018 banks, 608 are under Government/public sector. A significantly high number, i.e. 203 blood banks are run by private profit-making institutions. These are the commercial blood banks which primarily obtain their blood from professional donors. In addition, voluntary organizations such as the Red Cross run 56 blood banks in the country. With the rapid expansion of health services to the periphery and specialities such as cardiac and neurosurgery being established in metropolitan and bigger cities, the demand for blood and components is expected to rise rapidly. Major expansion of the voluntary donor base, largely by NGOs and other agencies, is the greatest single need for improving blood safety in India.

The infrastructure of most blood banks is weak. A large number of medium or large size blood banks do not have space, equipment and facilities for effective functioning. Even the basic facilities such as blood bank refrigerators, and continuous power supply, are lacking in some of the blood banks in larger cities and in most blood banks in district or sub-district regions.

Technical manpower in many blood banks is grossly inadequate. Except for a few teaching hospitals, blood bank medical officers in most of the blood transfusion centres have not been exposed to blood banking technology and management practices. There is therefore an urgent need to provide short-term training courses and continuing education programmes for medical officers. There is also an urgent need for long-term programmes for manpower development to provide trained medical officers for all blood banks in the country.

Technician training programmes are inadequate. More than 60% of technicians working in blood banks do not possess appropriate qualifications or training in blood banking technology. Thus there is an urgent need to improve the existing programmes of technician training, introduce and improve curriculum on blood bank technology and provide opportunities for training in advanced technology.

Due to a lack of availability of equipment and trained manpower, the testing practices are not satisfactory. In a recent survey, it was evident that blood of many donors is not tested for transmissible diseases, including for HbsAg and HIV.

The Government has established a network of AIDS testing centres for the testing of blood which are located in metropolitan cities, capitals of States and in towns having a

population of more than 0.5 million. These are now being expanded with the intention that every unit of blood collected will be tested for safety.

Blood Banks are licensed and inspected by FDA at a state levels under Drugs and Cosmetic Act. However, because of lack of expertise and weak infrastructure of the FDA in most states, only 402 banks have been licensed and inspections are very irregular. There is an urgent need to strengthen licensing/ renewal, inspection/monitoring facilities throughout the country.

Management of blood banking services is weak at both central and state levels. There is no one authority responsible for an effective functioning of blood banks in the state. At the central level Director of Emergency Medical Relief provides support to blood transfusion services. But this being one of his several other responsibilities, it is not possible for him to provide direct supervision and control of Blood Banking programmes.

Out of 13,48,965 samples of blood tested,12,234 were found to be HIV positive. Since standards of blood collection and HIV testing facilities have not yet been fully established, there is a possibility of a higher rate of transmission of AIDS through blood and blood products.

Blood Components and Plasma Fractionaction

At present, there are about 40 blood banks involved in the preparation of components. However, their facilities are inadequate and component production is erratic. Modern facilities for plasma fractionaction have been established at KEM Hospital, Bombay. This still has some teething problems and needs further support in order to utilize its capacity fully. There is also a possibility for further expansion of these facilities at K.E.M. Hospital.

In order to improve patient care, there is an urgent need to develop and strengthen facilities throughout the country for preparation of blood components such as RBC, platelets, cryoprecipitate and frozen/lyophilized plasma. There is also a need to promote rational use of blood and components through the training of clinicians, particularly surgeons, to use components in preference to whole blood in appropriate clinical conditions.

POLICY FRAMEWORK

The Central Council on Health Policy has made the following National Policy Recommendations:

"Blood being a vital input in the present day medicare the acute shortage of which is hampering the effectiveness of our services, the joint conference recommends that urgent steps should be taken by the States/U.T. Governments and the Central Governments:

1. To build-up adequate blood banking services at State/District level including provision of trained/qualified manpower. Necessary action should be initiated in right earnest for achieving the objective in view.

2. To educate and motivate people about blood donation on a voluntary basis.

3. To provide adequate encouragement to voluntary donors.

4. To enforce quality control of blood in all its facets of collection, distribution and storage".

The policy is an excellent guideline for Developing and Strengthening Blood Transfusion Services and should be adopted and implemented at Central and State Levels. The major barrier to its implementation is a lack of resources.

OBJECTIVES

Strategies and Activities

The objectives are intended to improve facilities in all public sector blood banks (608); improve monitoring of quality requirements and effective functioning; make available trained manpower of all categories needed for optimum functioning; ensure availability of safe and effective blood; make available high quality blood components in adequate quantity to all users; encourage rational use of blood and blood components and expand voluntary donor base to phase out professional donors completely.

Objective 1

Development and Strengthening (Modernization) of National Blood Transfusion Services

Strategy

The development will focus on public sector and voluntary agency blood centres and will be completed in three phases. Blood bank development will include voluntary agency blood centres.

Phase I

146 blood centres in metropolitan areas and state capitals (90 blood centres to be supported by World Bank and 56 by Bilateral agencies).

Phase II

200 blood centres in larger cities and districts (to be supported by bilateral agencies).

Phase III

200 blood centres mostly in districts (to be supported by bilateral agencies)

Activities

1. **Establishing a cadre and promotional avenues for blood bank professional and technical staff.**

2. **Selection and appointment of professional and technical staff including Donor Organizer/ recruiters as per the Drug and Cosmetic Act.**

3. **Provision of adequate space as per Drug & Cosmetic Act.**

4. **Providing Basic Blood Banking Equipment**

5. **Provision of contingency grant for 608 blood centres for chemicals, supplies etc. for three years.**

6. **Make a provision of adequate funding on continuous basis.**

Objective 2

To ensure adequate supply of blood to the blood centres.

Strategy

1. Expand Voluntary blood donor base with assistance of NGOs

2. Provide direct financial support to NGOs and other willing organizations for voluntary donot recruiting.

Activities

1. Establish and meet targets for blood collection based on needs.

2. Establish linkages between all blood centres in cities and metropolitan areas for voluntary donor recruitment/base development.

3. Motivation and propaganda by recruiters to develop voluntary donor base involving mass media, posters, leaflets, lecturers, seminars for promoting voluntary blood donation movement.

4. Introduce Donor Card System to be honoured in all blood banks.

5. **Institute schemes for recognition of voluntary donors.**

6. **Address barriers to blood donation, for example by involving religious leaders, organizing voluntary blood donation day/week, introducing voluntary blood donation programme in school curricula.**

7. **Institute competition, awards, prizes/shields for blood banks involved in voluntary blood collection and, also for maximum donor participation.**

8. **Involve blood users in promotion of voluntary blood donation; and**

9. **Involve Voluntary Organizations in developing voluntary donor base.**

Objective 3

Ensure safety and efficacy of blood and blood products.

Strategies

1. Increase voluntary blood donors

2. Phase out professional donors and commercial blood banks

3. Strengthen Internal Quality Control

4. Strengthen External Quality Control

5. Establish Zonal laboratories for testing.

Activities

1. Training of trainers (Recruiters) for Donor Recruitment and Management.

2. Training of Donor Recruiters (See Annex 3).

3. Identify and fund institutions for training of medical officers and technicians. Include one vehicle with driver and petrol for each of 10 centres.

4. To prepare a technical manual and standard operational procedure (under print).

5. Printing and Distribution.

6. Review and update technical manual every 3 years.

7. Training of Medical Officers in the Blood Transfusion Technology and donor selection based on the Manual: Ten Institutions to act as trainers.

8. **Training of Technicians/Nurses based on Manual.**

9. **Introduce a Diploma or Degree Post-Graduate Course in Transfusion Medicine in at least five universities.**

10. **Introduce and strengthen Blood Transfusion Technology and training programme in the medical technology training course.**

11. **Introduce Master's degree in Blood Transfusion Technology for technicians in at least five universities.**

12. **Identify ten institutions for training of technicians/ nurses in testing of blood in infectious diseases.**

13. **Establish Zonal Centres for testing blood for HIV.**

14. Organize Workshops for training of technicians: From the zonal centres (118), for testing of blood for HIV (already completed in 66 centres).

15. Introduce quality control in all zonal centres by testing +ve and -ve samples in reference laboratories and vice versa.

16. Provision of Equipment in Zonal centres (done in 66 centres; in respect of remaining 52 equipment to be supplied through USAID).

17. Provision of Kits to Zonal Centres (118) Selection and appointment of staff for zonal centres.

18. Provision of salaries for the staff at zonal centres and contingency grant.

19. Ensure transportation of blood component at appropriate temperatures.

Objective 4

Development of facilities for production of components.

Strategy

Component production facility to be established at blood banks having annual collection of 10,000 or more units of blood and development of Blood Banks in a phased programme.

Activity

1. Selection of Centres for developing facilities for component preparation in a phased manner (Annex 10). 30 centres to be provided assistance by World Bank. Rest of 70 centres. to be provided assistance by

bilateral agencies in phase manneri.e. 1- in year 1993, 20 in 94, 20 in 95 and 20 in 96).

2. Identify and fund the Institution for training of staff (K.E.M. Hospital, Bombay identified, one more to be identified).

3. Organize Group training workshops at the Institution: 10x15 days / 6 workshops per year.

4. Preparation of a Manual for Blood Components (under print).

5. Selection, Ordering and installation of equipment and spare parts.

6. Establish preventive maintenance for equipment.

7. Establish quality control facilities to ensure quality of final product as per National Standards, including labelling and storage.

8. Preparation of a training module to train clinicians in rational use of blood and blood components.

9. Organizing Zonal/Regional Workshops for users for promoting rational use of blood.

10. Establish transfusion committees at all hospitals, consisting of transfusion officer, clinicians, nurse, hospital administration, and voluntary agencies involved in donor recruitment.

11. Establish phersis capability at 10 training institutions including provision of 2 machines an d supplies for 3 years for each centre.

Objective 5

Develop and strengthen facilities for plasma fractionation.

Strategies

1. Suport fully the utilization of existing plant till it reaches its installed capacity.

2. Explore possibility of larger plant with industrial sector.

3. Encourage availability of plasma for the existing unit from other areas of the country and for larger plant for industrial sector.

4. To establish larger plant in public/private/industrial sector based on needs and plasma availability.

5. To ensure availability of plasma in sufficient quantity to make the unit economically viable.

Activities

1. Seek specific arrangements to use plasma from other centres in existing plant

2. Initiate discussions with industrial sector or building and operating larger plant.

Objective 6

Strengthening external quality control of blood and blood products.

Strategy

Strengthening Food and Drug Control Administration at State Levels.

Building Linkages with National Institute of Biology, New Delhi.

Activities

1. Establish a special cell for licensing, inspection and quality control of blood and blood products in all FDA at state level

2. Training of the Technical Staff of the special cell: Joint or Deputy Directors and inspectors at the identified institutions.

3. Make provisions for payment of salaries to drug inspectors in the special cell

4. Establish coordination between state level management and FDA special cell on BTS.

5. Establishing a regional quality control facility at one of the main blood centre processing facilities for production of components to be used by a group of state FDAs.

6. Train inspectors for a uniform approach in Good Manufacturing Practices (GMP) for Blood Transfusion Services as recommended by WHO.

7. Introduce GMP in the inspection of blood banks by FDA.

Objective 7

Undertake research on blood transfusion service operations to improve safety, efficacy and supply.

Strategies

1. Study donor characteristics to improve blood safety.
2. Evaluation of HIV testing alternatives that will improve efficiency and reduce cost.
3. Study the critical success factors for increasing use of blood component therapy.
4. Promote research activities with grant support.

Activities

1. Provide funds for research.
2. Prepare request for proposals (RFP) for each area of research as identified above.
3. Disseminate REPs to appropriate blood centres/universities.
4. Use peer review process to decide on award of research grants.
5. Annual review of research results and continuation of the programme based on needs.
6. Coordinate research activities with research activities of other institutions such as National Institute of Biological Control, National Institute of Communicable Diseases, WHO etc.

Objective 8

Develop and Strengthen Effective Management, Monitoring and Evaluation of Blood Transfusion Services

Strategies

1. Management teams established at a Federal (National), State and Institutional level with monitoring system
2. Monitoring the programme by visits/reports/inspection
3. Evaluation: Internal evaluation/and by External agency using targets and indicators.

Activities

1. **Establish a Directorate of blood transfusion service under DGHS, Ministry of Health at Central level, consisting of a Director, two Deputy Directors, one technical consultant (expert in blood transfusion medicine) and secretarial staff.**

2. **Convene meetings regularly of National Advisory Council on blood transfusion services.**

3. **Establish state level management teams consisting of Joint Director/Deputy Director in charge of blood transfusion programme, an expert in blood transfusion, secretarial assistance and prepare their terms of reference/job descriptions.**

4. **Establish state level blood transfusion service advisory committee to advise/assist Joint Director and prepare its terms of reference.**

5. Convene meetings regularly of State Advisory Committee.

6. Institute International/National Fellowship for Blood Centre Management Development for 4 weeks (Monitoring). (10x8 weeks International, National 10x4 weeks)

7. Establish reporting systems monthly at state level.

8. Computerization of reports at state and central level: Hardware and software.

9. Training in the use of computer,

10. Feedback to the blood centres through periodic reports every quarter.

11. Preparation of a protocol for evaluation.

12. Evaluation every three years.

COMPONENT 7: REDUCTION OF IMPACT OF AIDS/HIV

COUNSELLING

Background

Counselling for HIV/AIDS is a new concept in India. There is a history of counselling activities associated with family planning, but never before has counselling for the prevention of disease been so urgently required or so important.

Schools of social work have for many years had counselling in their curricula, but counselling for the prevention of sexually transmitted diseases is not taught in this way, and therefore a re-orientation towards counselling for health and avoidance of disease is very necessary. Such re-orientation will necessitate the development of culturally appropriate training materials, and the identification of new emphases in supportive care for persons affected by HIV. For example, in the Indian context, counselling is a particularly sensitive process involving, as it does, discussion of sexuality. Training of health care workers in India must therefore enable them to come to terms with issues of sexuality in HIV/AIDS.

However, this is not to say that counselling for HIV in India requires a "high technology" solution involving the development of a new, separate cadre of professionally distinct counsellors. India has the advantage of a long tradition of innovation in health and social sciences teaching, Primary Health Care (PHC) development, Non-Government Organization (NGO) activity and traditional (Ayurvedic and Unani) health care that provides a great scope for development of complementary initiatives that can be "absorbed" into or alongside existing structures. With such a wealth of expertise to lean on, there is every incentive to minimize the need for vertical developments in HIV/AIDS counselling and to take advantage of the considerable opportunities for developing direct and targeted community-level HIV counselling in many settings.

However, given the newness of the HIV threat in India, it is an appropriate time to assess the capability of present training to be extended to incorporate information and skills development about HIV. An assessment, using or adapting protocols already applied elsewhere, is primarily needed to define which existing elements of the National, State and District health and care infrastructure (including those personnel able to broaden their current activities) can be used in HIV care and counselling, which materials are appropriate to be adapted and channeled into training of health workers of all disciplines, and those settings in which HIV prevention and care counselling activities should first be directed. At present, needs for HIV counselling in India include:

- A strong core counselling training module which can be adapted to settings in which trained counsellors will work;
- A group of "core" trainers for each State;
- A schedule or timetable for implementing training;
- Identification of potential counsellors in each State and district, e.g., Social workers, NGO staff, traditional healers, psychologists, physicians, nurses, etc.;
- Identified structures or facilities in which counselling training can take place.

As such, initial developments in HIV counselling in India must be selective, providing the basic elements of a sustainable and culturally appropriate infrastructure that will provide a sound basis for future developments as needs arise. The development of HIV/AIDS counselling activities in India must also reflect the relative burdens of care and prevention associated with the prevalence of HIV in each state. For example, with the present low numbers of identified people with HIV infection having been identified in localized settings, the need for supportive counselling is probably outweighed currently by the need for prevention counselling, except in those areas where case numbers are proportionately high.

Policy Framework

The Government of India, particularly the Ministry of Health and Family Welfare in accordance with World Health Assembly Resolutions 40.26 and 41.24, will provide medical, psychological and social care to HIV-infected persons and people with AIDS. Furthermore, GOI, in view of its past and present humanitarian policies, will:

- Foster a spirit of understanding and compassion for HIV-infected persons;
- Protect human rights and the dignity of HIV-infected persons;
- Avoid discriminatory action against and stigmatization of HIV-infected persons;
- Ensure the confidentiality of HIV test results and case records;
- Promote the availability of social services including confidential counselling.

In the present Indian context, where there are as yet many unidentified persons with HIV, the initial emphasis in developing HIV/AIDS counselling will focus on prevention to reduce transmission. From these initial efforts, supportive counselling will emerge.

Counselling can be performed by health care workers who have a demonstrated interest and aptitude for developing counselling skills:

- doctors (if time permits)
- nurses
- paramedical workers
- social and community workers (statutory and NGO)
- peer leaders
- backup and support health and welfare workers with medical/psychological expertise.

The latter group are important in view of counselling sometimes involving the recognition of clinical issues associated with psychosocial and psychological states which may require specialist management.

While local priorities for provision of counselling clearly are shaped by known sero-prevalence of HIV, and the culture in which it occurs, counselling is recommended for:

- those already identified as having HIV infection or disease
- their families and community associates
- those being tested for HIV before and after samples are taken
- those seeking discussion and/or help because of their past risk behaviour.

It should be recognized that counselling is also a vehicle for shaping the behaviour and understanding of health workers who may be frightened by the appearance of HIV in their workplace. The provision of education and counselling for patients and staff can assist in optimizing an ethos of care and support for those affected by HIV, and boost modelling of good clinical care.

Link between IEC (behaviour change) programmes and Counselling

Counselling and IEC programmes are closely linked, but they have important differences. IEC activities have the aim of increasing awareness and knowledge about HIV/AIDS, leading towards behaviour change. This may occur in the context of mass media campaigns, or in small groups and perhaps in one-to-one settings. Counselling, on the other hand, is usually a private, on-going one-to-one or one-to-small group interaction between the counsellor and client/patient. Such an interaction takes this awareness and knowledge to a more personally relevant level by introducing psychosocial and supportive components to manage the psychosocial difficulties and anxieties associated with coping, decision-making and problem-solving about behaviour change and life with HIV. By directly and confidentially addressing such issues in counselling, sustained behaviour change and coping skills may be more reliably realized.

It is envisaged that in India, as HIV discussion in the general population grows on the basis of increasingly targeted and effective IEC, the demand for prevention and supportive counselling will probably increase. It is a developmental process

that will increasingly become a feature of comprehensive HIV/AIDS care as the number of AIDS cases also increase.

OBJECTIVES

Overall, the objectives for 1992-1996 include:

- **Assessing** the present needs and capabilities for HIV/AIDS counselling for support of those affected, and for prevention of HIV transmission, in every state. This also requires an immediate review to determine the feasibility of introducing HIV counselling in selected high-risk settings;

- **Developing resources** to enable the appropriate consolidation and expansion of counselling in selected areas of India;

- **Strengthening** those HIV clinical and supportive care activities presently available by ensuring the adequacy of counselling resources for patients and staff.

Objective 1

Assessment of current and potential counselling for HIV prevention and support/care on a State by State basis, and identifying selected priority settings for targeted developments and activities in HIV/AIDS counselling.

Strategies

1. Assess present and likely future needs for prevention counselling and supportive/care counselling State by State.

2. Assess current levels of counselling training and expertise nationally which can be mobilized for HIV/AIDS counselling.

3. Identify centres of excellence which can be used as templates for development of skills and training in similar and related counsellor and patient populations.

4. Identify and develop culturally appropriate systems of confidentiality and social information management that are ethical and usable in selected settings.

5. Achieve a workable **definition** of HIV/AIDS counselling that can be adapted and employed in a wide variety of settings within India.

Activities

1. Identify an assessment team of National and international counselling experts to:

- Define a usable assessment protocol adapting and using proven protocols currently in use by WHO/GPA;
- Review the counselling activities of health and welfare and social work institutions presently providing HIV counselling;
- Identify the various priority settings in which HIV counselling may be feasible;
- Determine the extent to which specific medical and paramedical training institutions can be engaged in providing training in HIV counselling;
- Identify and review obstacles to implementation of HIV counselling for prevention and support/care in each State and District, and mechanisms for sustaining those counselling efforts that are presently available and to be developed.

2. Conduct short focussed studies of selected HIV outreach and care projects to identify and characterize the potential for NGO and community (e.g., PHC) structures, services or groups to be engaged and trained in prevention and supportive counselling, particularly in:

   - known areas of commercial sex work;
   - areas of known injecting drug use.

3. Prepare a report summarizing experiences to date and lessons learned from counselling in other health and related contexts in India, particularly with the aim of suggesting a culturally appropriate workable definition of counselling for HIV/AIDS which can be adapted for use in specific settings and populations.

4. Identify possible mechanisms to ensure that the management of HIV counselling - both governmental and non-governmental - is closely linked with the NGO collaborative mechanism set up by State and Central governments, in order to ensure that appropriate standards of counselling, confidentiality and information management are maintained whatever setting counselling takes place in.

Objective 2

Development of resources for counselling and counselling training.

Progress Indicators:

- Assessment report completed

Strategies

1. Develop, by adapting presently-available HIV counselling training manuals and materials, a culturally appropriate, 'core' training module that can be used by trainers in

training all levels of statutory and non-statutory health and welfare workers.

2. Identify core trainers from statutory, non-statutory, NGO, academic, and traditional health disciplines who can do HIV counselling training of trainers in addition to their current work.

3. Integrate HIV/AIDS counselling into existing medical, nursing, social work and other paramedical training curricula.

4. Develop successful and replicable counselling initiatives ("models") in selected populations presently at greatest risk for HIV.

5. Develop ethical protocols for counselling and testing that can be applied and sustained.

Activities

1. Pool together HIV counselling training manuals from all relevant sources to create an Indian HIV counselling training module, and to identify adaptations that may be made for use in each setting and population for which HIV counselling is provided.

2. Specify and mobilize social work/social science institutes to develop HIV counselling training programmes, for trainers and counsellors.

3. Convene a working party to generate realistic plans for counselling development and implementation on a State by State basis for government and non-government organizations.

4. Set up a schedule of training for HIV counselling at National, State, Municipal and District levels.

5. Generate a curriculum of HIV counselling to integrate in the curricula of all health and social science training schools.

6. Identify and support training and development in selected counselling initiatives in order to be able to test protocols for counselling and testing, and counselling referral and follow-up, in specific populations, including:

   - commercial sex workers and their clients;
   - injecting drug users;
   - blood donors;
   - STD service attenders;
   - pregnant women;
   - young persons;
   - AIDS patients.

7. **Conduct a series of small impact evaluation studies at selected sites.**

Progress Indicators:

- **Training manual**

- **Training conducted**

Objective 3

Strengthening counselling care and support of those known to have HIV infection and disease, and for those caring for them, within those settings in which they are currently managed.

Strategies

1. Provide support to institutions currently providing HIV support/care and prevention counselling to enable ethically acceptable health worker-patient interactions and to generate an environment of constructive care and support.

2. Strengthen linkage and training across all facilities (statutory and non-statutory, including peer-led services) in which HIV counselling takes place in order to:

   - ensure support for staff;
   - adequate standards of counselling care and information-provision;
   - development of support networks among key staff in selected government and NGO prevention and care sites.

3. Provide and maintain advocacy on HIV counselling to all levels of staff in the context of related clinical and procedural training.

Activities

1. Identify from the States assessment those institutions where people with HIV are cared for, and assess the quality of experiences so far.

2. Offer training in HIV management, including issues of transmission and avoidance, appropriate occupational precautions, breaking bad news and counselling for all medical and paramedical staff involved in selected sites.

3. Provide adequate individual information and support for staff who may be fearful of managing people with HIV within their workplace.

4. Develop plans for local coordination among HIV management services in hospitals, clinics, community settings and groups to ensure that incompatible counselling management approaches are minimized.

5. **Include discussion of occupational exposure and HIV avoidance.**

Progress Indicators:

- **Training condcuted at selected sites**

COMMUNITY BASED CARE

Even if all new cases of HIV infection could be prevented, the number of people with HIV infection (including AIDS) would continue to increase rapidly in the foreseeable future as individuals currently infected with HIV become ill. Without advance planning, the needs of those people and their families will overwhelm health care systems and community resources.

AIDS patients and those with related illnesses can be taken care of in the home setting with proper support and backup from the community and the local health facilities. As an individual becomes ill from AIDS or an AIDS-related illness, s/he will make the journey from the home setting to the clinical setting a number of times. The many steps along the way from the home via the community health worker and local clinic to the hospital need to be prepared and strengthened to assist and handle the situation. The fears of the health care worker and community workers need to be allayed with clear information and education.

Plans should be made at the beginning to see how existing governmental care facilities can be expanded to include a community-based programme. Such a plan will include the following elements:

- Assessment of the structures, programmes and linkages between the community, the home and the clinical facility that can be strengthened.

- Adaptation of existing manuals and guidelines both for health workers and community workers on how to care for an AIDS patient with simple explanations on how to handle diarrhea, vomiting, etc., and when referral to the clinical setting would be necessary.

- Training of government health care workers on how to handle AIDS patients, how to counsel for care and prevention, how to provide support to the families caring for an AIDS patient.

- The development or strengthening of outreach networks to provide appropriate support and information.

- Orientation of NGOs on how they can use their structures and networks to complement government care.

- **The development of a mechanism for governmental and non-governmental workers involved in a community based care system to share their experiences and information.**

In countries with high HIV prevalence and large numbers of AIDS patients, complete hospital care is not a practical option. In fact, in many situations, community care provides a more positive atmosphere and setting for the individual and families affected by AIDS.

Home care schemes have sprung up in Africa, the United States, and in the Caribbean as a direct response to need. NGOs, church groups, and self help organizations have played a major role. The most successful efforts, such as the TASO project in Uganda, have built from existing health facilities and structures to provide outreach and support to families and communities. Linkages between NGO's, community workers and health care facilities and professionals is essential; especially in the area of preventive counselling, support counselling and appropriate referral. Community based care, in addition to providing another channel for disseminating messages on prevention, can effectively contribute to dispelling the many fears and misconceptions surrounding the care of an AIDS sufferer.

Objectives

- Ensure that all affected by AIDS receive proper care and treatment inside and outside the clinical setting;

- Ensure that proper linkages between clinical care facilities and community outreach programmes are developed and maintained;

- Dispel fears and misconceptions surrounding handling an AIDS patient held by health care workers and community members;

- Ensure that NGOs, religious organizations, and community groups are included in the planning and orientation on AIDS and care for AIDS sufferers;

- Ensure that the human dignity of those affected by AIDS is upheld.

Strategies

- Identify governmental and non-governmental structures and networks which can be tapped for development community care programmes, including examining existing home care programmes.

- Foster NGO involvement, including a mechanism for sharing experiences and information;.

- **Develop a resource packet for NGO's, health workers, and family members on how to best care for an AIDS sufferer.**

- **Conduct a training programme for health care workers and identified NGO's who can then provide proper training at the state, district, and community level.**

Activities

1. Conduct an assessment of current and potential community based care programming through a combination of governmental and non-governmental structures.

2. Based on results, develop a plan of action, by State, to provide for community-based care. This is particularly important for those members of fringe groups who may be lacking a family structure such as commercial sex workers, and injecting drug users.

3. Develop or adapt a basic guideline or manual for use by community health workers, community support groups and family members to demystify treatment for AIDS patients and to train community support networks.

4. Based on the guideline or manual, train trainers in each state on simple community care for AIDS patients and set up a training schedule to reach to the community level.

5. Conduct orientation sessions with existing NGOs to foster their involvement in organizing and support community-based care schemes.

6. Organize a study tour to Africa for governmental and non-governmental officials to view a community-based care programme in action.

7. Develop a mechanism through existing NGO collaboration networks to facilitate exchange of information on home care and community-based care experiences.

8. Develop mechanism to support NGOs, and government health care workers in coping with 'burn out' and stress related to involvement to community based care.

9. Coordinate with existing counselling services.

10. Conduct evaluation studies in selected sites to assess effectiveness of community-based care programmes and provide recommendations for improvement.

Progress Indicators:

- Assessment conducted

- Community based care manual developed

- Training conducted.

IMPROVEMENT OF ACCESS OF HEALTH CARE SERVICES AND THE MANAGEMENT OF PEOPLE WITH HIV AND AIDS

As people infected with HIV progress to develop HIV-related diseases and eventually AIDS, this will place an increasingly heavy burden on the health care system. Care for people with HIV and AIDS will often be provided in clinical settings where health care workers are not used to treating and managing such patients. Misconceptions regarding the infectivity of patients and fear of health care workers might jeopardise the quality of care provided. Unjustified calls for isolation of patients with HIV infection or AIDS might further constrain the potential of the clinical services to deal with such patients by expanding services, or it might lead to an actual reduction in the care provided. It is therefore of importance that patients with HIV infection or AIDS are not segregated, but are treated in regular wards.

Although the HIV sero-status of some patients in the clinical setting will be known, for each known seropositive patient there are likely to be many that are also seropositive, unknown to themselves and to the health workers. Even testing of all inpatients would not reveal all HIV infected persons, due to the time it takes after infection to become seropositive. This provides another argument against creating special wards for known seropositive patients. So it is essential that universal precautions against infection with HIV are taken and strictly adhered to in all health worker-patient contacts, and in all laboratory work dealing with body fluids.

As the number of people with HIV-related conditions and AIDS increases it will be increasingly difficult for the health care system to cope with all patients in need of care. In many cases persons with HIV and AIDS will have to be cared for in the community, in their families. This places a burden on the community and the family, which will have to be supported through networks of both the public and private health care services and of NGOs. It is however important that persons that are cared for by the community or the family have adequate access to health care services whenever the need for more specialised care arises. The training needs of traditional medical practitioners will have to be met, to enhance their capability to play a meaningful role in community based care.

Objectives

Ensure that the health care system is strengthened so as to adequately deal with patients with HIV infection and AIDS.

- Ensure that health care workers are adequately trained to provide good quality care to patients with HIV and AIDS, and that such care is not jeopardised by misconceptions and undue fear.

- **Ensure that universal precautions against occupational infection with HIV are introduced and strictly adhered to.**

- **Ensure support for community based care programmes, and ensure easy access to good quality services for those in need of such services.**

- **Ensure that traditional medical practitioners are trained to allow them to contribute to community based care programmes, and to make their practices free from the known risk factors for HIV transmission.**

Strategies

1. Identify the current capacity of the public and private health care system to provide good quality care for patients with HIV infection and AIDS, and estimate the projected needs for such care, and strengthen the public services accordingly.

2. Identify constraints in manpower and training needs and develop a training programme to meet these needs.

3. Develop a support system for community based care programmes, which should also ensure easy access to the health care system for those in need of more specialised services.

4. Develop a training module for traditional medical practitioners.

Activities

1. Assess current capacity of health care services.

   The number of people who will need care will soon exceed the capacity of the health facilities to cope. There is therefore a need to assess the current capacity and project future needs according to the HIV projections. The State Ministries of Health and Municipalities should undertake to plan for this. In addition to planning for the health care needs of HIV infected people there is a need to plan for the special care of the affected, especially medicines, protective clothing and preparing and educating communities to accept and support them.

2. Reduce the gap between projected needs and current capacity.

   The assessment of the current needs and projections will permit the measurement of the gap between the needs and current capacity. This gap representing the target for fund raising. Negotiations with the local and international donors will be held, aimed at reducing this gap.

3 **Train Health Care Workers.**

There is an apparent lack of knowledge on how to manage HIV/AIDS patients by health workers. Retraining health care workers in the basic principles of case management is essential for the improvement of the quality of care for the HIV/AIDS patients. The staff of the Medical Schools, Hospitals, NGOs and the Private Medical Institutions will be trained in the care of HIV/AIDS patients.

4. Promote Home and Community-based Patient Care

Community-based patient care is based on the understanding that AIDS has become a community problem especially because all the sick cannot be admitted in hospitals as these have very limited accommodation facilities. Therefore with the encouragement of the programme administration, the communities will play an important role in the care. All this takes place in a family context. Education on HIV/AIDS and counselling are to be introduced in the community. A community which is so sensitized will need support (financial, material and spiritual) to be able to take full responsibility for its sick members. The money and materials will be used to support the sick who can no longer work to earn a living. Financial support will further enable the community to amount regular training course to promote AIDS awareness and community mobilization. Income generating activities in the community will be initiated to improve the financial positions and quality of life of the affected families.

5. Participation of Traditional Medical Practitioners (TMP) in Community based Patient care.

Traditional healers and birth attendants have an important role to play in the health care of the community; they are respected in their community and have close association with the majority of the population. They will be trained in simple health care procedures to make their practice free of the known risk practices for HIV spread.

Progress indicators

1. Assessment of capacity of health care services to deal with people with HIV and AIDS, and estimate of projected needs available to planners.

2. Negotiations with local and international donors to reduce the capacity-needs gap.

3. Health care workers training curriculum developed and training in progress.

4. System for supporting community based care programmes developed and operational.

5. Training module for traditional medical practitioners developed and training in progress.

SECTION IV : WORKPLANS

COMPONENT 1: STRENGTHENING PROGRAMME MANAGEMENT, MONITORING, REVIEW AND EVALUATION OF THE PROGRAMME

Activity	1992	1993	1994	1995	1996
AIDS Protocol	x———				
AIDS Board	x———				
NPCT	x———				
NACA	x———				
TAC	x———				
National training of Programme Managers-State	x				
WHO Team	x-------				
SPCTs	x----				
Intersectoral meeting: National	x	x	x	x	x
States	x———				
Programme review	x	x	x	x	x
Programme evaluation		x		x	x

x Time limited activity
-----Establishment/development
_____Ongoing activity

COMPONENT 2: SURVEILLANCE AND RESEARCH

Activity	1992	1993	1994	1995	1996
Adjust operational guidelines and identify institutions	x				
Surveillance national meeting	x				
Train surveillance staff in the States	x———	———x			
Surveys conducted (including STDs) and reported	x———————	———————	———————	———————	———————x
AIDS-case referral guidelines	x				
Referral and non-referral staff training					
Staff training:					
- National	x		x		
Referral system established	x———	———————	———————	———————	———————
Carry out surveillance	x———————	———————	———————	———————	———————
Review HIV/AIDS situation	x	x	x	x	x
Determine research priorities	x———x				
- States	x-----x	x-----	x x---	----------	----------

COMPONENT 2: SURVEILLANCE AND RESEARCH

Activity	1992	1993	1994	1995	1996
Identify research groups	x-------	----------	----------	----------	----------
Carry out research	x————				
Strengthen HIV Referral centres	x----------x				
Expand screening network	x----------	----------	x		
Training of laboratory staff	x————				
Develop local production of HIV tests	x----------	----------	x		

x Time limited activity
-----Establishment/development
_____Ongoing activity

COMPONENT 3: PREVENTION OF HIV TRANSMISSION THROUGH BEHAVIOUR CHANGE

Activity	1992	1993	1994	1995	1996
1. Media					
Central level					
- Establish Empowered Committee	xx				
- Identify Agency for Mass Media Campaign	x				
- Design and implement campaign	xx	xx	xx	xx	xx
- Develop prototype materials	xx	xx	xx	xx	xx
- Pretest and revise materials	xx	x	x	x	x
- Set up distribution network	xx				
- Conduct awareness and strategy workshops	x	x	x	x	x
- Conduct programme review	xx	xx	xx	xx	xx
State level					
- Establish IEC Review Commtt.	xx				
- Conduct planning meetings	xxx				
- Adapt and pretest materials	x				
- Conduct training		x			
- Coordinate inter sectoral strategies	x				
- Design & impl. distribution	x—				
- Develop mat. for intervention	x—				
- Conduct seminars for opinion leaders	x—		xxx	xxx	xxx
- Conduct academic research					
- Conduct programme review	x	x	x	x	x

COMPONENT 3: PREVENTION OF HIV TRANSMISSION THROUGH BEHAVIOUR CHANGE

Activity	1992	1993	1994	1995	1996
2. Intersectoral Collaboration					
- Form interministerial commtt.	x———	x			
- Form AIDS Prevention Committees for each Ministry	x———	x			
- Identify & mobilize community networks	xxx———				
- Programme design and imple.	x———				
3. NGO Collaboration					
- Identify Nodal Agencies	x———x				
- Assess NGO Resource for AIDS	x———x				
- Conduct awareness workshops	x———				
- Conduct technical workshops	x———				———x
- Develop proposals and prog.	x———				———x
- Implement programmes	x———				
- Monitor and evaluate prog.		x———			
4. Interventions					
- Conduct opinion survey of risk groups in major urban cities	xxxx				
- Commercial Sex workers					
- Bombay	x———				
- Calcutta	x———				
- Madras	x———				
- Other		x———			
- Injecting Drug Users					
- Manipur	x———				
- Other					

COMPONENT 3: PREVENTION O IIV TRANSMISSION TIIROUGII BEII/ 'IOUR CIIANGE

Activity	1992	1993	1994	1995	1996
- Men who have sex with men		x———	———	———	———
- Street Youth		x———	———	———	———
- Captive migrant labour		x———	———	———	———
- Prison inmates		x———	———	———	———
- Truck drivers	x———	———	———	———	———
- Other		x———	———	———	———
5. Documentation and Resource Centres					
- Conduct assessment	xxx				
- Select two nodal agencies	x———	——x			
- Establish centres in each state	x———	———	———x		
6. Management					
- Identify central staff	xxx				
- Identify state staff	xxx				
- Assess level of other Ministries	x———x				
7. Research					
- Literature review	x———	x			
- Identify studies needed	x———x				
- Identify research institutions	xx	x			
- Conduct studies		x———	———	———x	
8. Training					
- Identify core trainers	x———x				

COMPONENT 3: PREVENTION OF HIV TRANSMISSION THROUGH BEHAVIOR CHANGE

Activity	1992	1993	1994	1995	1996
- Develop and pretest training modules	x———x				
- Train core trainers	xxx				
- Plan and implement training Central		x———x	x———x	xx x—x	xx x—x
- Plan and implement training State		x———x	x———x	xx xxxx	xx x—x
9. Monitoring and Evaluation					
- Baseline date collection	x———x				
- Monitoring		xx xx xx	xx xx xx	xx xx xx	xx xx xx
- Evaluation activities		xxx		xxx	xxx
10. Advocacy					
- Produce advocacy materials	xxx				
- Conduct workshops and seminars	x———				

COMPONENT 4: CONTROL OF SEXU. .LY TRANSMITTED DISEASES

Activity	1992	1993	1994	1995	1996
PROGRAMME MANAGEMENT					
-Appoint National STD Control Officer	x				
-Appoint State/Municipal STD Programme Managers	x				
-Organise National STD Planning Workshop	xx				
1. PREVENTION OF STD THROUGH IEC					
-Set up collaboration between National STD Control Officer and IEC Officer	x				
-Develop materials to assist NGOs in developing STD projects	xxx				
-Set up collaboration between State STD Programme Managers and IEC groups	xx				
-Organise workshops for NGOs involves in STD/ AIDS related projects	x x	x x x x	x x x	x x x	x x x
-Distribute health education materials to health facilities	x				
-Distribute condoms to health facilities	x				

Activity	1992	1993	1994	1995	1996
2. STD CASE MANAGEMENT					
-Develop national guidelines for comprehensive STD case management	xxxx				
-Organise national workshop for STD Programme Managers and Ministry of Health officials	xx				
-Develop training modules for STD case management	xxxxx				
-Develop STD case management algorithms	xxxxx				
-Review STD case management practices	xx	x x x x	x x x	x x x	x x x
-Strengthen facilities	x—				
-Develop and implement interventions among target groups (eg. sex workers/clients)	x—				
-Expand the programme to cover 61 cities		x—			
-Expand programme to cover all States			x—		
-Employ additional staff	x-	----------	-- -- -- -	- -- -- --	- - - - -
-Procure and distribute drugs, condoms and supplies	x—				
	x—	———	——x		

Activity	1992	1993	1994	1995	1996
3. INCREASE ACCESS TO HEALTH CARE FOR STD					
-Assess coverage of existing services in priority areas	xxxxx	xxxxx			
-Assess requirements for strengthening primary level services	xx	xxxxxx xx	xx xx xx	xx xx xx	xx xx x
-Upgrading of 5 Regional STD Referral Centres	xx	xxxx			
-Upgrading of Municipal STD Clinics	xx	xxxx			
-Upgrading of STD Deps. in 130 Medical Colleges	x—	———	———x		
-Plan for establishing new health care facilities, where needed	x	x x x x	x x x	x x x	x x x
-Set up referral system for STD patients	xx	xx			
-Set up supervision system of lower level health care facilities	xx	xx			
4. SCREENING AND CASE-FINDING					
-Develop guidelines for screening programmes		xxx			
-Organise a national workshop on screening policies		xx			

Activity	1992	1993	1994	1995	1996
-Review maternal syphilis screening	xxx	xx			
-Implement maternal syphilis screening for all ante-natal clinic attenders	x				
-Assess potential for introducing STD screening programmes		xxx			
-Develop adequate levels of laboratory support		xxx	xx		
-Obtain full cooperation from target group		xx			
-Implement the screening programme		x			
-Monitor programme effectiveness			x x	x x	x x
5. **TRAINING**					
-Develop a training network for STD training	xxx	x			
-Develop generic training modules for STD	xxxxx				
-Hold TOTs workshops	xx	xx			
-Hold training workshops for health workers (all relevant cadres)	x	x x x x x x	x x x x x	x x x x x	x x x x x
-Hold training workshops for counsellors/social workers	x	x x x x	x x x x		

Activity	1992	1993	1994	1995	1996
-Organise training for laboratory staff	xx	xxxxx	xx xx xx	xx xx	x x x
-Organise training workshops for private practitioners	x x	x x x x	x x x x	x x x	x x x x
-Organise training of staff at District Hospitals (453)		x—			
-Integrate STD in PHC training programmes		x—			
-Organise refresher training		x x	x x	x x	x x
6. **DEVELOPMENT OF LAB. SUPPORT**					
-Develop guidelines for the availability of lab tests in the health care system	xx				
-Develop guidelines for the use of lab tests	xx				
-Develop and implement a quality control system for reagents, media	x—				
-Develop channels to purchase essential reagents/media abroad	xx	x			
-Upgrade the lab in the 5 Regional STD Referral Centres	xx	xxxx			

Activity	1992	1993	1994	1995	1996
-Upgrade the lab in the Municipal STD Clinics	xx	xxxx			
-Upgrade the lab in the 130 Medical Colleges	x———	———	———x		
-Develop a system for quality control of STD diagnosis	x———	———	———	———	———
-Develop the infrastructure for a national antimicrobial susceptibility monitoring network	xx	xxxx			
-Develop the logistics to ensure uninterrupted supply of reagents, media and supplies	x———	———	———	———	———
-Provide lower level health care facilities with simple tests and equipment		xx xx xx	xx xx xx	xx xx xx	xx xx xx
7. **RESEARCH**					
-Develop guidelines for STD baseline surveys	xxx				
-Conduct STD baseline surveys where indicated	x———	———	x xx x	x xx xx	
-Develop and coordinate a national antimicrobial susceptibility monitoring network	x———	———	———	———	———

Activity	1992	1993	1994	1995	1996
-Conduct microbiological research on prevalence and antibiotic susceptibility of STD pathogens	xxx	xx	xx	xx	xx
-Conduct operational research	xxx	x x x x	x x x x	x x x	x x x
8. **SURVEILLANCE**					
-Develop guidelines for STD surveillance	xx	x			
-Hold a national STD surveillance workshop		xx			
-Develop an STD surveillance system, based on sentinel site surveillance and periodic surveys		x			
-Review STD programme activities on the basis of programme monitoring and evaluation		x	x	x	x

COMPONENT 5 : CONDOM PROGRAMMING

Activity	1992	1993	1994	1995	1996
Strategy 1:					
- Assessment	x				
- Biomedical meetings	x		x		x
- Market Research	x———x				
- Advertising/outreach	x———				
- Training workshops	x—x	x—x	x—x	x—x	x—x
- Consumer Research studies	x———x				
- Female Condom res.	———	———x			
- Research on condom for FP an HIV prevention	x———	———x			
- Condom Supply	x———				
Strategy 2:					
- Support NGO Coordinating body					
- Workshop for NGOs:					
- National	x				
- States 1st priority (7)	x—x				
- States 2nd priority (24)		x——x			
- Programme management training workshops		x			
Strategy 3:					
- Inter-Aide Expansion	x———				
- PSI Expansion	x———				
- R&D	x———	———x			

COMPONENT 5 : CONDOM PROGRAMME

Activity	1992	1993	1994	1995	1996
- Marketing	x———	———	———x		
- User Instructions	x——	——x			
- Research on Product Characteristics	x———	———	———x		
- Pilot vending machine project	x———	———	———x		
Strategy 4:					
- Technical Assessment	x				
- Annual Interlaboratory trial	x	x	x	x	x
- Bi-annual meetings of Q A experts		x		x	
Strategy 5:					
- Programme Manager course	x				
- Policy strengthening workshops - National	x			x	
- Policy strengthening workshops - States	x———	———x		x———	———x
- Logistics Management needs assessment	x——	x			
- Logistics Management TOT course - National	x		x		
- Logistics Management TOT course - States	x———	———x	x———	———	———x
- MIS	x———	———	———	———	———
- Rapid assessment protocol for planning	x—x				

COMPONENT 6 : BLOOD SAFETY

Activity	1992	1993	1994	1995	1996
- Supply of equipment to 496 centres	x———	———	———x		
- IEC	x———	———	———	———	———x
- Support voluntary donors/ NGOs	x———	———	———	———	———x
- Training of Medical Officers/ Technicians	xx	xx	xx		
- HIV Testing workshop	xx	xx	xx		
- Transport	x				
- Training modules	xx xx xx	xx xx xx	xx xx xx		
- Update training modules			xx		
- HIV test kits	x———	———	———x		
- Technician HIV workshop	x				
- Training Technicians/Nurses	xx	xx	xx		
- Training workshop for TOT	x	x			
- Equipment and spares	xx xx xx	xx xx xx	xx xx xx		
- Regional workshops	x	x	x	xx	
- Strengthening Training Instt.	xx	xx	xx		
- Establish Cell at State FDA	x				
- Training of technical staff	x				
- Research	xx	xx	xx		
- Prepare REPs	x				
- Peer review process	x	x	x		
- Research review		x	x		
- Central level management team	x	x	x	x	x
- Fellowships	xx	xx	xx		
- Computerization/H.ware/S.ware	x	x	x		
- Training on computers	x	x	x		
- Evaluation		x	x	x	

COMPONENT 7: REDUCTION OF IMPACT

Activity	1992	1993	1994	1995	1996
7.1 **Counselling**					
Establish Counselling Assessment Team	x				
Identify and assess current counselling activities	x				
Focused HIV counselling studies	x	x x	x x	x x	x x
Summary report and counselling Definitions	x				
Develop counselling administration mechanisms	x	x x			
Create Indian counselling Training modules	x				
Engage institutes for HIV counselling training	x				
Working parties for counselling plans	x				
Devise training schedule	x				
HIV counselling curriculum for all health schools		x			
Support for selected counselling sites	x				

COMPONENT 7: REDUCTION OF IMPACT

Activity	1992	1993	1994	1995	1996
HIV Training for selected sites	x				
Support for individual staff	x				
Plans for focal HIV counselling coordination	x				
HIV counselling integrated into clinical training	x				
Team building at selected sites counselling	x				
Training workshops for counsellors	x	x x	x x	x x	x x
7.2 Community Based Care					
Assessment	xxx				
Action Plan Development	xxx				
Home Care Manual	xxx				
Training	x				
Orientation Session NGOs	x				
Study Tour		xxx		xxx	
Information Exchange		xxxx xx	xx xx xx	xx xx xx	xx xx xx
Evaluation Studies		xxx	xxx	xxx	

SECTION V. ESTIMATED BUDGET

COMPONENT 1: STRENGTHENING PROGRAMME MANAGEMENT, MONITORING, REVIEW AND EVALUATION OF THE PROGRAMME

(US$ 000's)

ACTIVITY	1992	1993	1994	1995	1996	TOTAL
Intersectoral leaders	174.00	174.00	174.00	174.00	174.00	870.00
TAC	10.00	10.00	10.00	10.00	10.00	50.00
NPCT:						
- Staff and Travel	78.00	78.00	78.00	78.00	78.00	390.00
Supplies and Equipment	276.00	101.00	101.00	101.00	101.00	680.00
MOH&FW Regional offices	392.00	239.00	103.00	103.00	103.00	940.00
State AIDS Cells	993.00	353.00	353.00	353.00	353.00	2,405.00
Monitoring, Review & Evaluation	20.00	60.00	20.00	60.00	60.00	220.00
STAFF						
Long term international (1)	90.00	90.00	90.00	90.00	90.00	450.00
Travel	20.00	20.00	20.00	20.00	20.00	100.00
National Staff	132.00	132.00	132.00	180.00	180.00	756.00
Supplies and Equipment	350.00	150.00	150.00	150.00	150.00	950.00
Accommodations	25.00	25.00	10.00	10.00	10.00	80.00
Equipment, Maintt. and replace.	20.00	30.00	40.00	40.00	40.00	170.00
Communication, Office Running	30.00	35.00	35.00	40.00	40.00	180.00
CONTINGENCY	26.00	20.00	20.00	20.00	20.00	106.00
TOTAL	2,636.00	1,517.00	1,336.00	1,429.00	1,429.00	8,347.00

ESTIMATED BUDGET

COMPONENT 2 : SURVEILLANCE AND RESEARCH

ACTIVITY	1992	1993	1994	1995	1996	TOTAL
STAFF						
- Long Term, international	120.00	120.00	120.00	120.00	120.00	600.00
- Travel	10.00	15.00	15.00	15.00	15.00	70.00
- STC, international	20.00	50.00	50.00	50.00	50.00	220.00
- Consultants, national	10.00	20.00	20.00	20.00	20.00	90.00
Strengthen HIV testing facilities	460.00	1,032.00	900.00	440.00	440.00	3,272.00
HIV Sero-surveys	120.00	160.00	240.00	240.00	240.00	1,000.00
Strengthening HIV/AIDS Surveillance System	200.00	1,300.00	600.00	600.00	600.00	3,300.00
AIDS-CASE REFERRAL, CARE						
- Audiovisuals	125.00	150.00	50.00	50.00	50.00	425.00
- Training	350.00	400.00	600.00	400.00	400.00	2,150.00
Operational Research	50.00	450.00	600.00	500.00	500.00	2,100.00
TOTAL	1,465.00	3,697.00	3,195.00	2,435.00	2,435.00	13,227.00

ESTIMATED BUDGET

COMPONENT 3: IEC AND SOCIAL MOBILIZATION FOR PREVENTION OF HIV TRANSMISSION

(US$ 000's)

ACTIVITY	1992	1993	1994	1995	1996	TOTAL
MEDIA						
Mass Media Campaign	2,000.00	1,000.00	1,000.00	1,000.00	1,000.00	6,000.00
Materials Development (inter-personnel) Prototype National State Adaptation	100.00	50.00	50.00	50.00	50.00	300.00
Materials Production	1,500.00	500.00	500.00	1,000.00	500.00	4,000.00
Materials Distribution	300.00	300.00	300.00	300.00	300.00	1,500.00
Seminars/Workshops for Press/ Opinion	100.00	100.00	100.00	100.00	100.00	500.00
Programme Review	20.00	50.00	20.00	50.00	20.00	160.00
INTERSECTORAL COLLABORATION						
Support to other Ministries	2,000.00	2,000.00	2.000.00	2,000.00	2,000.00	10,000.00
NGO COLLABORATION						
Staff for Nodal Agencies	12.00	12.00	12.00	12.00	12.00	60.00
Training Module Development	50.00		50.00		50.00	150.00
Training Workshop	400.00	400.00	400.00	400.00	400.00	2,000.00
Proposal Development	100.00	100.00	100.00	100.00	100.00	500.00
Grants to NGOs	500.00	1,000.00	1,000.00	1,000.00	500.00	4,000.00
Monitoring and Evaluation	50.00	50.00	50.00	50.00	50.00	250.00
DOCUMENTATION CENTRES						
Materials Audio visual support (see supp/equip)	100.00	100.00	100.00	100.00	100.00	500.00
INTERVENTIONS						
Commercial Sex Workers	1,000.00	3,000.00	7,000.00	7,000.00	7,000.00	25,000.00
Injecting Drug Users Manipur Other	 200.00 100.00	 250.00 100.00	 300.00 100.00	 400.00 100.00	 200.00 100.00	 1,350.00 500.00
Men who have sex with men	50.00	100.00	100.00	50.00	50.00	350.00
Street Youth	50.00	200.00	100.00	100.00	100.00	550.00

COMPONENT 3: IEC AND SOCIAL MOBILIZATION FOR PREVENTION OF HIV TRANSMISSION

ACTIVITY	1992	1993	1994	1995	1996	TOTAL
Captive Migrant Labour	50.00	150.00	150.00	150.00	150.00	650.00
Prison Inmates	100.00	100.00	100.00	100.00	100.00	500.00
Truck Drivers	100.00	150.00	100.00	100.00	100.00	550.00
Others	100.00	100.00	100.00	100.00	100.00	500.00
MANAGEMENT						
IEC Adviser	90.00	90.00	90.00	90.00	90.00	450.00
National Consultants (5)	24.00	24.00	24.00	24.00	24.00	120.00
International Consultants(20m/m)	90.00	30.00	30.00	10.00	10.00	170.00
Central IEC staff	4.80	4.80	4.80	4.80	4.80	24.00
State IEC staff	153.60	153.60	153.60	153.60	153.60	768.00
Travel	10.00	10.00	10.00	10.00	10.00	50.00
RESEARCH						
Literature Review	5.00					5.00
Conduct studies	50.00	50.00	50.00	50.00	50.00	250.00
TRAINING						
Module Development and Revision	10.00	5.00	5.00	5.00	5.00	30.00
Duplication	100.00	10.00	50.00	10.00	10.00	180.00
Training of Trainers	20.00	30.00	50.00	30.00	30.00	160.00
State Level	200.00	300.00	400.00	300.00	300.00	1,500.00
MONITORING AND EVALUATION						
Baseline Data Collection	200.00					200.00
Monitoring	50.00	50.00	50.00	50.00	50.00	250.00
Evaluation Activities		50.00	50.00	100.00	50.00	250.00
ADVOCACY						
Materials Development	50.00	10.00	10.00	20.00	10.00	100.00
Duplication	200.00	10.00	10.00	20.00	10.00	250.00
Workshops/seminars	100.00	100.00	100.00	100.00	100.00	500.00
SUPPLIES AND EQUIPMENT						
Computers (6)	30.00					30.00
Printers (6)	20.00					20.00
Photocopiers (6)	12.00					12.00
Facsimile	1.00					1.00
Audio Visual Equipment(12)	60.00	60.00				120.00
Vehicles (4 @ $12000)	24.00	24.00				48.00
Stationery	25.00	10.00	10.00	10.00	10.00	65.00
Materials	15.00	10.00	10.00	10.00	10.00	55.00
TOTAL	10,526.40	10,843.40	14,839.40	15,259.40	14,009.40	65,478.00

STRATEGIC PLAN FOR THE PREVENTION AND CONTROL OF AIDS IN INDIA

ESTIMATED BUDGET

COMPONENT 4: CONTROL OF SEXUALLY TRANSMITTED DISEASES

(US$ 000's)

ACTIVITY	1992	1993	1994	1995	1996	TOTAL
Programme Management	60.00	100.00	110.00	110.00	120.00	500.00
IEC	10.00	10.00	5.00	5.00	5.00	35.00
Case Management						
interventions in target groups	750.00	1,000.00	1,500.00	1,500.00	1,750.00	6,500.00
interventions in 61 towns	1,500.00	6,100.00	6,100.00	6,100.00	6,200.00	26,000.00
implementation in States	1,500.00	2,500.00	3,000.00	4,500.00	5,500.00	17,000.00
Increase access to services						
Upgrading Regional STD Centres, Municipal STD Clinics, Medical Colleges	1,000.00	1,130.00 3,000.00	2,261.00	3,957.00	5,652.00	13,000.00 4,000.00
Establishing new facilities	500.00	500.00	500.00	500.00		2,000.00
Training						
TOTs/health workers	500.00	500.00	500.00	500.00	500.00	2,500.00
TOTs/laboratory staff	10.00	10.00	10.00	10.00	10.00	40.00
Counsellors/social workers	5.00	5.00	5.00	5.00	5.00	25.00
Private practitioners	10.00	10.00	5.00	5.00	5.00	35.00
Laboratory support						
Upgrading laboratories	500.00	1,000.00	1,000.00	1,000.00	1,000.00	4,500.00
Quality control systems	5.00	5.00	5.00	5.00	5.00	25.00
Research	10.00	10.00	10.00	10.00	10.00	50.00
Surveillance	5.00	5.00	5.00	5.00	5.00	25.00
TOTAL	6,365.00	15,885.00	15,016.00	18,212.00	20,767.00	76,245.00

ESTIMATED BUDGET

COMPONENT 5: CONDOM PROGRAMMING

(US$ 000's)

ACTIVITY	1992	1993	1994	1995	1996	TOTAL
STRENGTHEN SOCIAL MARKETING AND FAMILY PLANNING PROGRAMME						
Assessment of technical needs	26.00					26.00
Bi-annual meetings	18.00		18.00		18.00	54.00
Marketing Research	50.00	50.00	50.00	50.00	50.00	250.00
Advertising Outreach	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	5,000.00
Training workshops	50.00	50.00	50.00	50.00	50.00	250.00
Consumer Research	30.00		30.00		30.00	90.00
Female Condom Research	10.00	25.00	25.00	20.00	10.00	90.00
Research on Condom/FP and HIV Prevention	10.00	20.00	30.00	20.00	10.00	90.00
STRENGTHEN MANAGEMENT CAPACITY OF PVO/NGO						
Support NGO Coordination Programme Management Training	50.00	345.00	100.00			495.00
TARGET HIGH RISK BEHAVIOUR						
Inter-Aide Expansion	120.00	120.00	120.00	120.00	120.00	600.00
PSI Expansion	120.00	120.00	120.00	120.00	120.00	600.00
IMPROVE MANUFACTURING SYSTEMS						
Research & Development	1,000.00	1,000.00	526.00			2,526.00
Marketing	20.00	20.00	20.00	10.00	6.00	76.00
User Instructions	10.00	5.00		5.00		20.00
Research on Prod. character	90.00	30.00	30.00	30.00		180.00
Pilot Vending Machine	20.00	310.00	10.00	10.00		350.00
IMPROVE QUALITY ASSURANCE SYSTEM						
Technical Assessment	24.00					24.00
Annual Inter-lab. trial	10.00	10.00	10.00	10.00	10.00	50.00
Bi-annual meetings of QA Experts		3.00		3.00		6.00
STRENGTHEN PROGRAMME MANAGEMENT						
Programme Managers Course		40.00	40.00			80.00
Policy strengthening workshops	6.00	6.00	6.00	6.00	6.00	30.00
Logistics Management needs ass.	16.00					16.00
Management Information System	50.00	50.00	100.00	100.00	100.00	400.00
Rapid Assessment for pla	60.00					60.00
TOTAL	2,790.00	3,204.00	2,285.00	1,554.00	1,530.00	11,363.00

ESTIMATED BUDGET

COMPONENT 6: BLOOD SAFETY

(US$ 000's)

ACTIVITY	1992	1993	1994	1995	1996	TOTAL
Supply of Equipment - 90 centres	1,080.00					1,080.00
Supply of Equipment to Centres	672.00	2,400.00	2,400.00			5,472.00
Supply of Equipment to Centres	720.00	720.00	720.00			2,160.00
Supply of Equipment to Centres	448.00	2,048.00	3,648.00			6,144.00
Information, Edu. and Commu.	872.00	496.00	496.00			1,864.00
Support voluntary donors/NGOs	800.00	800.00	800.00	800.00	800.00	4,000.00
Training of donor recruiters	1.00	1.00	1.00	1.00	1.00	5.00
Training of Medical personnel	10.00	10.00	10.00	10.00	10.00	50.00
HIV Testing workshop	10.00	10.00	10.00	10.00	10.00	50.00
Transport	192.00	32.00	32.00	32.00	32.00	320.00
ise/update technical manuals			12.00			12.00
Medical Officers training	24.00	24.00	24.00	24.00	24.00	120.00
Staff salaries	472.00	472.00	472.00	472.00	472.00	2,360.00
Training modules	150.00	150.00	150.00	150.00	150.00	750.00
HIV Test kits	1,280.00	1,280.00	1,280.00	1,280.00	1,280.00	6,400.00
Technician HIV workshop	1.20					1.20
HIV testing quality control	4.00	4.00	4.00	4.00	4.00	20.00
Training Technicians/Nurses	18.00	18.00	18.00	18.00	18.00	90.00
Nur/Dr. Travel allowance/Training	16.00	16.00	16.00	16.00	16.00	80.00
Instt. training	5.00	5.00	5.00	5.00	5.00	25.00
Training workshop for TOT	3.60	3.60	3.60	3.60	3.60	18.00
Equipment and Spares/Components	432.00	972.00	183.60	183.60	183.60	1,954.00
Salaries and supplies	168.00	378.00	714.00			1,260.00
ipment, Salaries, Supplies	1,506.00	3,012.00	3,012.00	3,012.00		10,542.00
Regional workshops	5.00	5.00	5.00	15.00	15.00	45.00
Strengthen Trg. instt.	12,600.00	600.00	600.00			13,800.00
Est. cell at state FDA	1.00	1.00	1.00	1.00	1.00	5.00
Training of technical staff	1.40		1.40		1.40	4.20
Inspector funding	71.04	71.04	71.04	71.04	71.04	355.20
Research	65.00	35.00	35.00	35.00	35.00	205.00

ESTIMATED BUDGET

COMPONENT 6: BLOOD SAFETY

(US$ 000's)

ACTIVITY	1992	1993	1994	1995	1996	TOTAL
Prepare RFPs	2.20		2.20			4.40
Peer Review Process	3.00	1.00	1.00	1.00	1.00	7.00
Research Review	2.00	3.00				5.00
Central level management team	40.00	40.00	40.00	40.00	40.00	200.00
State level management team	169.00	169.00	169.00	169.00	169.00	845.00
Fellowships	27.50	27.50	27.50	27.50	27.50	137.50
Computerization	200.00					200.00
Training of computers	2.00					2.00
Evaluation		40.00	60.00			100.00
Pheresis	13,800.00					13,800.00
Contingency grant	50.00	50.00	50.00	50.00	50.00	250.00
Fractionation plants		4.130.00		4,130.00	4,140.00	12,400.00
TOTAL	35,923.94	18,024.14	15,074.34	10,560.74	7,560.14	87,143.30

STRATEGIC PLAN FOR THE PREVENTION AND CONTROL OF AIDS IN INDIA

ESTIMATED BUDGET

COMPONENT 7: REDUCTION OF IMPACT

(US$ 000's)

ACTIVITY	1992	1993	1994	1995	1996	TOTAL
COUNSELLING						
Short term Int'l Consultants	30.00	10.00	10.00	10.00	10.00	70.00
National Consultants	2.40	4.80	4.80	4.80	4.80	21.60
Assessment	20.00					20.00
Training Module development	10.00					10.00
Training Central level	50.00	50.00	10.00			110.00
Training State/District	100.00	200.00	200.00	100.00	100.00	700.00
luation Studies		20.00	10.00	10.00	10.00	50.00
COMMUNITY BASED CARE						
Short-term Int'l Consultants	10.00					10.00
National Consultants(1)	2.40	4.80	4.80	4.80	4.80	21.60
Assessment	20.00					20.00
Guideline/Manual Adaptation	20.00					20.00
Duplication		200.00	200.00	200.00	100.00	700.00
Training		100.00	200.00	200.00	200.00	700.00
Orientation Sessions		100.00	100.00	100.00	100.00	400.00
Study tours		100.00		100.00		200.00
CASE MANAGEMENT						
Guidelines/Manuals	20.00	10.00				30.00
Training	10.00	30.00	30.00	30.00	30.00	130.00
Os support	25.00	50.00	100.00	150.00	200.00	525.00
TOTAL	319.80	879.60	869.60	909.60	759.60	3,738.20

Is it enough

Needed ?

BUDGET SUMMARY FOR STRATEGIC DOCUMENT

(US$ 000's)

COMPONENT	1992	1993	1994	1995	1996	TOTAL
COMPONENT 1: Strengthening Programme Management, Monitoring, Review and Evaluation of the Programme	2,636.00	1,517.00	1,336.00	1,429.00	1,429.00	8,347.00
COMPONENT 2: Surveillance and Research	1,465.00	3,697.00	3,195.00	2,435.00	2,435.00	13,227.00
COMPONENT 3: Prevention of HIV through Behaviour Change	10,526.40	10,843.40	14,839.40	15,259.40	14,009.40	65,478.00
COMPONENT 4: Control of Sexually Transmitted Diseases	6,365.00	15,885.00	15,016.00	18,212.00	20,767.00	76,245.00
COMPONENT 5: Condom Programming	2,790.00	3,204.00	2,285.00	1,554.00	1,530.00	11,363.00
COMPONENT 6: Blood Safety	35,923.94	18,024.14	15,074.34	10,560.74	7,560.14	87,143.30
COMPONENT 7: Reduction of Impact	319.80	879.60	869.60	909.60	759.60	3,738.20
TOTAL	60,026.14	54,050.14	52,615.34	50,359.74	48,490.14	265,541.50

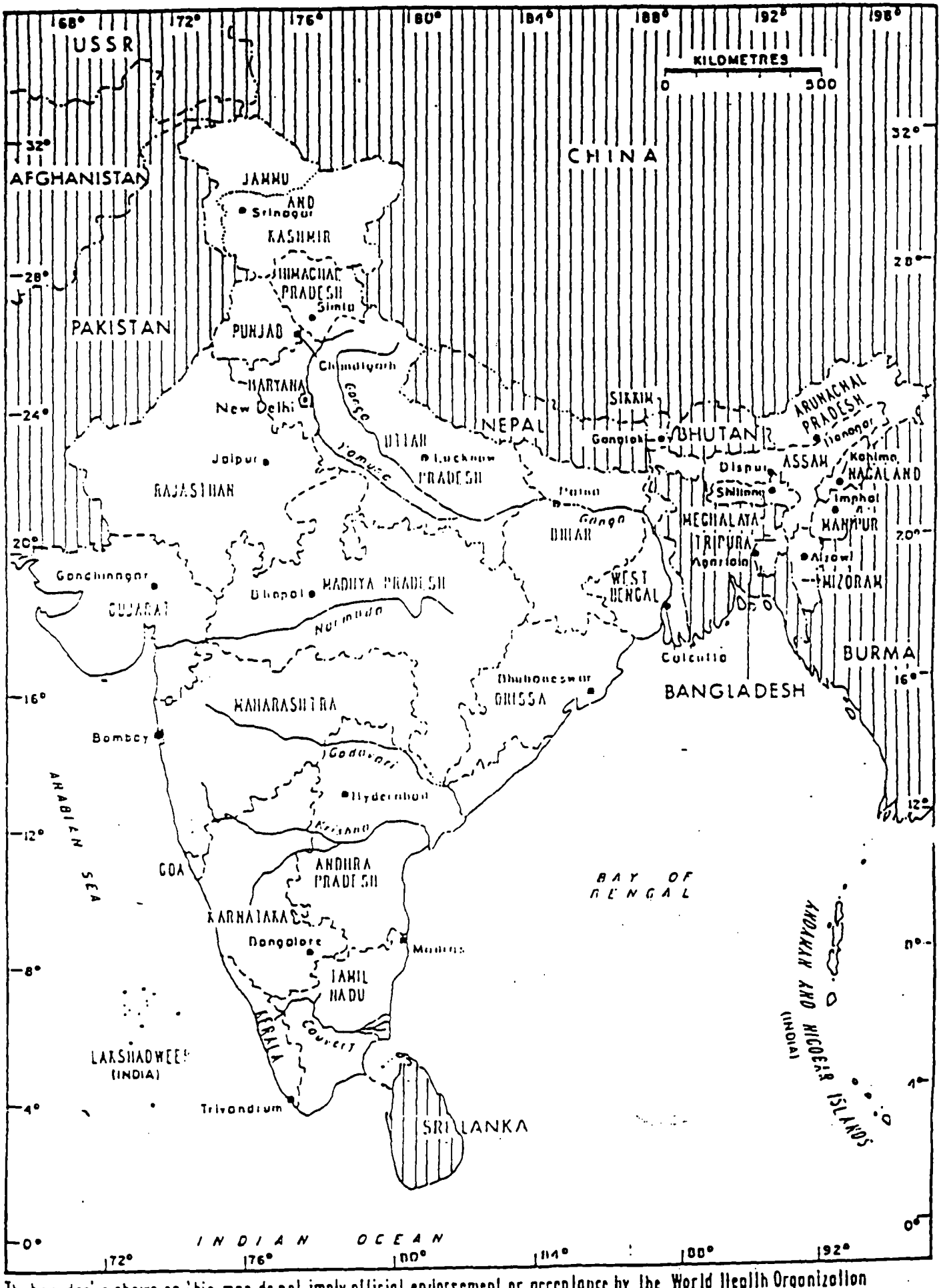
STRATEGIC PLAN
FOR
PREVENTION AND CONTROL OF AIDS
IN INDIA

1992 - 1996

ANNEXES

(125-134)

INDIA, STATES AND UNION TERRITORIES



The boundaries shown on this map do not imply official endorsement or acceptance by the World Health Organization

November 1984

Broad Terms of Reference of the National AIDS Coordination Bodies

The National Board for AIDS Control

- approval of the National policy in AIDS control
- approval of the recommendations to the Government on the policies related to AIDS
- approval of the annual operational plans for programme implementation
- approval of the budget proposals, prepared by the National Programme Coordination Team
- approval of reallocation of funds between programme components
- approval of reallocation of funds within a programme component, over 10% of the component total
- approval of the composition of the National Programme Coordination Team and terms of references of the staff
- approval of the composition of the Technical Advisory - Committee and its sub-committees, and their terms of reference
- appointment of the officers for the National Programme Coordination Team
- arranging for cooperation with other sectors of the National administration
- provision of support to the National Programme Coordination Team in the international collaboration
- motivation and arrangements for the States commitments in the implementation of AIDS control
- participation in the quarterly review of the programme implementation
- approval of the personnel for the Technical Advisory Committee.

The AIDS National Coordination Team (NPCT)

- collaboration with the Technical Advisory Committee in developing draft national policies in AIDS control
- preparation of annual operational plans for programme implementation
- planning the national budget for the programme
- planning the budget from external resources
- reallocation of upto 10% of funds within a component
- preparation of proposals for the Board on larger reallocation of funds within components and between components
- developing terms of reference for the NPCT, TAC and its sub-committees
- selection of candidates for officers' position in the Team for the Board approval
- selection of institutions and candidates for the Technical Advisory Committee for the Board approval
- selection and appointment of the support staff for the team

- selection and appointment of the national consultants and field team staff
- providing clearance for international staff and consultants
- management of funds from the governmental and bilateral external sources
- collaborate with the WHO country team in the management of multilateral funds
- collaboration with TAC in elaboration of documents on the AIDS control policies, operational guidelines and research
- review and approval of the project proposals from the states, NGOs and PVOs
- communication within the State Programme Coordination teams on all aspects of the programme
- assisting the State PCTs in planning and implementation of the programme
- provision to the States the documents on the national policy, operational guidelines, training materials
- participation in the political, administrative and operational meetings and training sessions, organized by the states
- provision of supplies and equipment according to the state AIDS control plans
- establishing the channels for efficient disbursement of funds to the states
- disbursement of funds to the states
- receiving financial reports and submission of summaries to the funding agencies according to their regulations
- receiving technical reports, compiling and submitting periodic reports to the Government and participating agencies
- preparing background materials for the Board review and other meetings
- provision of feed-back to the states
- provide information to TAC reviews on HIV/AIDS epidemiological situation in the country
- running day-to-day operational activities
- organizing quarterly reviews and annual evaluation of the programme

The Technical Advisory Committee

- to develop general policy for AIDS control in India
- to design and review the strategies for the National AIDS Control Programme
- to assist the NPCT in developing operational guidelines and training modules
- to design training schedules for National and State workshops
- to assist in designing training and educational materials
- to participate as lecturers and facilitators at the National and State training workshops

- to assist the Programme Manager in identifying the National consultants
- to serve as resource persons at the national and state planning and review exercises
- to review HIV/AIDS situation in the country
- to review research protocols submitted to NPCT and to advise Programme Manager on allocation of research assignments related to HIV/STD infection and social aspects of AIDS

The GPA Country Team

Assisting the Government of India and WR Office in:

- developing national policies in AIDS control
- developing technical and operational guidelines and training modules for various programme components
- developing operational plans for various projects within the programme
- developing work plans
- developing and pretesting intervention projects
- review on the programme implementation
- review of the epidemiological situation in India
- allocation of funds to the programme components
- disbursement of multilateral funds
- reporting on the use of multilateral funds
- conducting progress review meetings
- evaluation of the epidemiological situation
- ensuring regular supplies under multilateral funds
- monitoring technical and operational reporting

MAJOR AREAS FOR OPERATIONAL RESEARCH OF NACP INDIA

I. SOCIAL AND BEHAVIOURAL STUDIES

1. Opinion survey on the prevalence/spread of risk behaviour groups in major cities of India.

Objective: To obtain estimates on the number of persons practicing multipartner sex and IV drugs.

Sites: 50 major cities of the country (List attached)

Timing: I-II quarters of 1992.

Implementing parties: National Staff/consultants assisted by international consultants.

2. HIV Risk Practices

Objectives: Features and frequencies of HIV risk practices in the identified groups.

Target groups:
- Multipartner sex females (MPS females)
- MPS males
- IV drug users

Sites and timing: Metro cities: 1992
15-20 Other larger cities: 1993-1994

Implementing Parties: NGOs experienced in social and behavioural research/social departments of the universities.

3. Assessment of the Impact of the Intervention projects

Objective: To determine the impact of interventions on behavioural changes and related STD/ HIV frequencies. The assessment would proceed and follow the major interventions projects in the identified risk groups.

Sites and Timing: According to the schedule of the intervention projects.

Implementing parties: Universities and NGOs involved in the implementation of the intervention projects.

4. To identify the approaches in providing home-based care for AIDS patients

Objectives: To study the community support in provision of home based care for AIDS patients..

An opinion is widely spread in India that persons who develop ARC/AIDS would be stigmatized and rejected by their family and local community. Various approaches to educate family and community associates will be studied to overcome this problem that would eventually result in promotion of home care.

Sites and timing: Initially the cities with the highest number of registered AIDS patients. Further expansion as AIDS epidemic spread geographically:

1992 - 3 sites
1993 - 5 sites
1994 - 10 sites

Implementing parties: NGOs working at the community level supported by social departments of the universities.

5. **Evaluation of the efficiency of multilayer and peer education of MPS females in behavioural change**

Objectives: To develop and study the strategies for involvement of the prostitute employees, medical care-takers (physicians, guards) and officials (police) in providing education to prostitutes and their clients.

Sites: Areas with well demarcated brothel setting prostitution: Bombay, Calcutta, Delhi, Tamil Nadu (site to be determined). Other sites would be determined through the opinion survey.

Timing: Six to twelve months studies will start in the already identified areas in 1992. The expansion will be based on the results of the opinion survey.

Implementing parties: Mobile teams of the State Programme coordination teams, supported by NGOs.

II. EPIDEMIOLOGICAL STUDIES

1. **Evaluation of the feasibility and cost efficiency of HIV testing techniques in various medical settings**

Objectives: To identify optimal tests to be used in the city hospitals, rural (district) hospitals and their blood transfusion units.

Sites: Three to five sets of urban and district hospitals in selected states.

Timing: 1992-1993

Implementing parties: HIV testing referral centres.

2. **Role of other STDs in HIV Transmission**

Objective: To determine the role of STDs in the frequency of HIV transmission in MPS females.

Sites: Brothel setting areas in three metro-cities.

Timing: 1992-1993, to be combined with the evaluation of the intervention efficiency.

Implementing agencies: Epidemiological teams of the State Programme Coordination Teams.

3. **Evaluation of selected intervention strategies for prevention of HIV transmission among IV drug users**

Objective: To determine efficiency of the peer education, needle exchange and bleach distribution, and their combinations in reduction of HIV transmission in IV drug users.

Sites: Area of the wide IV drug use in the North-Eastern States.

Timing: 1992-1993

Implementing Agencies: State Epidemiological Teams supported by ICMR.

4. **Evaluation of the condom efficiency in prevention of HIV/STD transmission**

Sites: Brothel settings in Bombay and two other cities

Timing: 1992-1993, 6 to 12 months studies

Implementing agencies: State Epidemiological Teams supported by medical colleges.

5. **To determine sensitivity and specificity of the WHO/CDC AIDS case definition in Indian population**

Objectives: To determine the WHO/CDC AIDS case definition sensitivity and specificity vs CDC case definition and to adopt the WHO definition for Indian population

Sites: Bombay, Delhi and Madras

Timing: 1993-1994, two years studies

Implementing agencies: Medical colleges

6. **Natural history of AIDS in Indian population**

Objectives: To determine immunological and pathological features of AIDS and prevailing opportunistic infections in Indian population.

Sites: Bombay, Delhi, and Madras

Timing: 1992-1996, to be extended at some sites

Implementing agencies: Medical colleges in collaboration with city hospitals.

7. **Treatment of HIV/ARC/AIDS by traditional/homeopathic medicines**

Objectives: To determine therapeutic effect of selected traditional/homeopathic medicines on HIV immense response and development of AIDS.

Sites and timing: To be determined on application.

Implementing agencies: Qualified physicians and registered medical institutions.

Indian cities with 500,000+ population and State/UT capitals

	State/Union Territory	Name of the city	Total population
1.	Andhra Pradesh	Hyderabad	4,273,498
		Visakhapatnam	1,049,792
		Vijawada	838,944
2.	Arunachal Pradesh	Itanagar	-
3.	Assam	Guwahati	577,591
4.	Bihar	Patna	1,098,572
		Jamshedpur	834,535
		Dhanbad	817,549
		Ranchi	614,454
5.	Goa	Panjim	85,199
6.	Gujarat	Ahmedabad	3,279,778
		Surat	1,517,076
		Vadodara	1,115,265
		Rajkot	651,007
7.	Haryana	Faridabad Complex	613,828
8.	Himachal Pradesh	Kangra	682,598
9.	Jammu & Kashmir	Srinagar	N.A.
10.	Karnataka	Bangalore	4,108,013
		Mysore	652,246
		Hubli-Dharwad	647,718
11.	Kerala	Kozhikode	800,862
		Kochi	1,134,883
		Thiruvananthapuram	825,450
12.	Madhya Pradesh	Indore	1,104,065
		Bhopal	1,063,662
		Jabalpur	887,188
		Gwalior	720,068
		Durg-Bhilainagar	688,670
13.	Maharashtra	Aurangabad	591,968
		Gr. Bombay	12,569,978
		Nagpur	1,657,135
		Nashik	723,669
		Pune	2,444,020
		Solapur	620,499
14.	Manipur	Imphal	200,615
15.	Meghalaya	Shillong	113,138
16.	Mizoram	Aizwal	343,630
17.	Nagaland	Kohima	238,747
18.	Orissa	Bhubneshwar	411,542

19.	Punjab	Ludhiana	1,012,062
		Amritsar	709,456
		Jalandhar	519,530
20.	Rajasthan	Jaipur	1,514,425
		Jodhpur	648,621
		Kota	536,444
21.	Sikkim	Gangtok	-
22.	Tamil Nadu	Madras	5,361,468
		Coimbatore	1,135,549
		Madurai	1,093,702
		Tiruchhirappallai	711,120
		Salem	573,685
23.	Tripura	Agartala	157,636
24.	Uttar Pradesh	Kanpur	2,103,483
		Lucknow	1,669,136
		Varanasi	1,018,370
		Agra	903,350
		Allahabad	841,638
		Meerut	833,294
		Bareilly	611,513
		Ghaziabad	519,502
25.	West Bengal	Calcutta	10,860,399
		Asansol	763,845
26.	Andaman & Nicobar Islands	Port Blair	-
27.	Chandigarh - UT	Chandigarh	574,646
28.	Dadra & Nagar Haveli - UT	Silvassa	-
29.	Daman & Diu - UT	Daman	-
30.	Delhi - UT	Delhi	8,375,188
31.	Lakshadweep - UT	Kavaratti	-
32.	Pondicherry	Pondicherry	-

Source 1991 Census