CHAPTER- 2
AIDS CONTROL PROGRAMMES
IN
INDIA
Due to the ever growing danger of spreading of HIV/AIDS, a number of programmes are undertaken by the government as well as the private organisations and foundations which are funded even from foreign countries. Several programmes were started by the government on National level as well as on the State level. Many NGO’s are also working in the awareness and prevention of HIV. Nowadays many corporate houses as part of their Corporate Social Responsibility (CSR) which is encouraged by the Govt. of India are shouldering some responsibility for the Research and Development for the prevention of HIV/AIDS. The chapter deals in details of the programmes initiated by the government from its initial stages up to present times from national level to the state level. It focuses on the National AIDS Control Programme as well as the works of State AIDS Control societies. Some light is also shed on the privately funded organisations.

**National AIDS Control Programme**

Demographically, the second largest country in the world, India has also the second largest number of people living with HIV/AIDS. More than 70% Indians live in rural areas and about 28% in urban locations, including 60 million in urban slums. About 26% of the population comprising mostly of agricultural labour, rural artisan and urban casual household workers live below poverty line.

National Health Policy (NHP 2002) and India Vision 2020 commit the country to fight all communicable and preventable diseases. With increasing life expectancy, contemporary public health scenario in India reflects two dominant trends: i) an epidemiological transition towards greater incidence of non-communicable/life style diseases, and ii) The growing challenge of communicable and preventable diseases being highlighted by HIV/AIDS. The Millennium Development Goals (MDGs)
commit all countries to reverse the spread of HIV/AIDS by 2015. As a signatory nation, India stands committed to achieve this goal through its National AIDS Control Programme.

Answer to the Challenge

India’s initial response to the HIV/AIDS challenge was in the form of setting up an AIDS Task Force by the Indian Council of Medical Research (ICMR) and a National AIDS Committee (NAC) headed by the Secretary, Ministry of Health. In 1990, a Medium Term Plan (MTP 1990-1992) was launched in four States, namely, Tamil Nadu, Maharashtra, West Bengal and Manipur and four metropolitan cities, namely, Chennai, Kolkata, Mumbai and Delhi. The MTP facilitated targeted IEC campaigns, establishment of surveillance system and safe blood supply. In 1992, the Government launched the first National AIDS Control Programme (NACP-I) with an IDA Credit of USD 84 million and demonstrated its commitment to combat the disease. NACP-I was implemented during 1992-1999 with an objective to slow down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country. To strengthen the management capacity, a National AIDS Control Board (NACB) was constituted and an autonomous National AIDS Control Organisation (NACO) was set up to implement the project. The key outcomes of the project included: capacity development at the state level in the form of setting up State AIDS Cells (SACs) in 25 States and 7 UTs; a well function blood safety programme aimed at reducing HIV transmission through blood; expansion of HIV sentinel surveillance system; collaboration with nongovernment organizations on prevention interventions; and intensified communication campaigns. During this period, bilateral partners like USAID (Tamil Nadu), DFID (Andhra Pradesh, Gujarat, Kerala, Orissa and West Bengal) and CIDA (Karnataka and Rajasthan) also
implemented focused programmes successfully and contributed to the state and national level efforts.

In November 1999, the second National AIDS Control Project (NACP-II) was launched with World Bank credit support of USD 191 million. Based on the experience gained in Tamil Nadu and a few other states along with the evolving trends of the HIV/AIDS epidemic, the focus shifted from raising awareness to changing behaviour, decentralization of programme implementation at the state level and greater involvement of NGOs. The policy and strategic shift was reflected in the two key objectives of NACP-II:

- To reduce the spread of HIV infection in India.
- To increase India’s capacity to respond to HIV/AIDS on a long-term basis.

Policy initiatives taken during NACP-II include: adoption of National AIDS Prevention and Control Policy (2002); National Blood Policy; a strategy for Greater Involvement of People with HIV/AIDS (GIPA); launching of the National Rural Health Mission; launching of National Adolescent Education Programme; provision of anti-retroviral treatment (ART); formation of an inter-ministerial group for mainstreaming; and setting up of the National Council on AIDS, chaired by the Prime Minister.

Key Achievements

At the operational level, NGOs were involved in the implementation of 1033 Targeted Interventions (TIs) among HRGs and setting up 875 Voluntary Counselling and Testing Centres (VCTCs) and 679 STD clinics at the district level. Nation-wide, state level Behaviour Sentinel Surveillance (BSS) surveys were conducted. Prevention of Parent to Child Transmission (PPTCT) programme was expanded across the states. Introduction of a Computerized Management Information
System (CMIS) and a Computerized Project Financial Management System (CPFMS) were the other highlights of NACP-II. In addition, a number of organizations and networks were also strengthened; support from bilateral, multilateral and other partner agencies also increased substantially. As a result of all these efforts, the HIV prevalence as indicated by recent studies and analyses seems to be stabilizing, while states like Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra and Nagaland have started showing declining trends (Rajesh Kumar et al 2006). The sentinel surveillance results of 2005 also reinforce the stabilization trends indicating that the expected outcomes of NACP-II have broadly been accomplished.

Scope for Improvement

While there has been a systematic improvement in the response, there are areas that still require greater attention and stronger focus. The lessons that have emerged from the implementation of NACP-II include the following:

- Complexities of the epidemic and its exact dimensions are yet to be understood especially in the Northern and North Eastern states of the country.
• Frequent changes of Project Directors (PDs) of State AIDS Control Societies (SACS) and other senior programme managers at the state level weakened the thrust and focus of interventions. In some highly vulnerable States, PDs were either saddled with additional non-HIV responsibilities or given SACS charge as additional responsibility. A large number of functional positions in the SACS remained vacant. These factors contributed to an uneven implementation of the programme. It is necessary to have policy safeguard against this trend.

• Decentralisation and devolution of decision-making powers to the SACS was a right step, but without commensurate capacity development and technical support, it did not produce desired results.

• Focused attention on the HRGs through TIs proved to be an effective strategy for preventing the spread of infection. However, this was not appreciated and implemented in all states, partly due to attitudes towards high risk behaviours and partly due to weak systems for partnership with civil society. Consequently saturation of coverage of HRGs nationwide is yet to be accomplished. In some States, targeted interventions were not accorded the priority they deserved. Interventions on MSM and IDU remained low. Out-of-school as well as unschooled youth, married adolescents and rural population did not get due attention.

• Condom promotion and procurement registered an improvement in 2005 but remained below the targets, emphasizing the need for more aggressive Social Marketing.

• Barring some exceptions, participation of the private sector and mainstream civil society organizations was limited.

• Potential of 21 million youth volunteers in NSS, NCC, Scouts and Guides, NYKS, Youth Clubs, Youth Red Cross and Red Crescent
remained under utilised both in prevention as well as building an enabling environment.

- Convergence between RCH and NACP remained a difficult challenge.
- AIDS mortality and under reporting are issues that deserve more attention as these have a bearing on the interpretation of serosurveillance data. This requires careful examination of available methodologies and choice of the best available method suited for India. Similarly, about 86% of transmission being sexual, it would be necessary to find out how much of this is caused by limited access to services to women. Simultaneously, it would be necessary to ascertain to what extent this is accounted for by men having sex with men (MSM). Under NACP-III, sentinel surveillance will cover all districts for making the results more representative.

- During NACP-II, a number of regional and national level studies, assessments, surveys and laboratory research were conducted. Operational and biomedical data compiled by UNAIDS and other agencies account for as many as 500 research documents/papers, in addition to the BSS 2001. Management and utilization of such a large storehouse of knowledge for improving programme strategy, planning and monitoring remains a challenge. The existing research wing within NACO needs to be strengthened to deal with the emerging need for knowledge management.

- Notwithstanding a significant step-up of the overall resource availability for HIV/AIDS programme, India’s per capita financial investment on HIV prevention, control, care and support remains one of the lowest in the world. To scale up activities and interventions in prevention, care and treatment, a much higher level of investment is required. Strategies of NACP-II that yielded significant positive
results have been strengthened in NACP-III and the gaps addressed based on the lessons learnt.

NACP-III Development Progress

Against this background and keeping the prevalent social context, concerns and the emerging HIV/AIDS scenario as well as drawing from the experience of the earlier two phases, NACO initiated the preparatory process for NACP-III (2006-2011). A retreat was organized in March, 2005, to reflect in depth the lessons learnt during NACP-II and chart out the future road map. In April, 2005, the Government of India constituted a national planning team to begin the preparatory work. A conscious decision was taken to make this process consultative, participatory, inclusive and transparent. The team developed a framework document for NACP-III, discussed it with NACO and placed it before a newly constituted National Steering Committee. Soon after, the framework was field tested in one highly vulnerable state (Uttar Pradesh), one high prevalent state (Andhra Pradesh) and in the north-east (Nagaland). With inputs from these states, components of the framework were further fine-tuned and placed before the national conference of Project Directors of SACS and the development partners. In order to enlarge the consultative
process, 14 thematic working groups representing experts and practitioners deliberated on HIV/AIDS issues and concerns and submitted their recommendations. Areas covered included: programme management; implementation and organizational restructuring; financial management; mainstreaming and partnerships; gender, youth, adolescents and children; condom programming; service delivery, STI/RTI treatment and convergence with RCH; targeted interventions; communication, advocacy and social mobilization; GIPA; human rights, legal and ethical issues; care, support and treatment; research, development & knowledge management; M & E and surveillance. For public participation in the planning process, UNAIDS and NACO set up an e-Consultation forum. This was followed by a series of handholding consultations with stakeholders at the state level for preparation of state and district level programme implementation plans (PIP). A national consultation with the civil society organisations was also organized to validate the draft strategic frame work and obtain further inputs to the planning process. The Planning Team also had deliberations with the INP+ and PWN for their inputs. A series of dialogue with the development partners was also undertaken along with a number of interactions within the Health Ministry including RCH and NRHM authorities. The National Steering Committee met six times during the preparatory phase to exchange views and review the progress in the planning process.

In October 2005, a Joint Pre-Appraisal Mission led by the World Bank assessed the status of programme preparation and critically appraised the strategic framework document. While endorsing the same, the mission provided additional inputs to improve it further. Between November and December 2005, a series of State PIP Workshops were held for developing state plans. Simultaneously, to augment the planning exercise further, the Planning Team also initiated six studies focusing on
the rural dynamics of the epidemic, MSM issues, attitudes of health care providers, HIV situation among police and paramilitary forces, social marketing issues, and effectiveness of the existing communication strategies. Similarly, five assessments viz. social, financial, environmental, institutional procurement were also undertaken. The experience of NACP-I and NACP-II, consultations, studies and assessments led to a consensus on the goal, objectives and strategies for NACP-III adhering to the larger MDG goal.

**Goal and Objectives**

The overall goal of NACP-III is to halt and reverse the epidemic in India over the next 5 years by integrating programmes for prevention, care, support and treatment. This will be achieved through a four-pronged strategy:

1. Prevention of new infections in high risk groups and general population through:
   a. Saturation of coverage of high risk groups with targeted interventions (TIs)
   b. Scaled up interventions in the general population
2. Providing greater care, support and treatment to larger number of PLHA.

3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.

4. Strengthening the nationwide Strategic Information Management System.

The specific objective is to reduce new infection as estimated in the first year of the programme by:

- Sixty per cent (60%) in high prevalence states so as to obtain the reversal of the epidemic; and
- Forty per cent (40%) in the vulnerable states so as to stabilize the epidemic.

Programme scheduling and Focus Areas

NACP-III seeks to learn from the lessons of the previous two phases of programme implementation and build on the strengths thereof. Its priorities and thrust areas have been drawn up accordingly and include the following:

- Considering that more than 99% of the population in the country is free from infection, NACP-III will place the highest priority on preventive efforts while, at the same time, seeking to integrate prevention with care, support and treatment.
- Sub-populations that have the highest risk of exposure to HIV will receive the highest priority for intervention. These would include sex workers, men who have sex with men, and injecting drug users. Of lower priority will be those groups which have high levels of exposure to HIV infection such as long distance truckers, prisoners, migrants (including refugees) and street children.
Those in the general population who have greater need for accessing prevention services such as treatment of STIs, voluntary counselling and testing and condoms will be next in the line of priority.

NACP-III will ensure that all persons who need treatment would have access to prophylaxis and management of opportunistic infections. Persons who need access to ART will also be assured first line ARV drugs.

Prevention needs of children will be addressed through universal provision of PPTCT services. Children who are infected will be assured access to pediatric ART.

NACP-III will also make efforts to address the needs of persons infected and affected by HIV, especially children. This will be done through the sectors and agencies involved in child protection and welfare. Impact of HIV on others will also be mitigated through other welfare agencies providing nutritional support, opportunities for income generation and other welfare services.

NACP-III will invest in community care centers to provide psychosocial support, outreach services, referrals and palliative care.

Socio-economic determinants that make a person vulnerable also increase the risk of exposure to HIV. NACP-III will work with other agencies involved in vulnerability reduction such as women's groups, youth groups, trade unions etc. to integrate HIV prevention into their activities.

Mainstreaming and partnerships will be the key approach to facilitate multi sectorial response engaging a wide range of stakeholders. Private sector, civil society organizations, PLHA networks and government departments would all play crucial role in prevention, care, support, treatment and service delivery. Technical and financial resources of the
development partners will be leveraged to achieve the objectives of the programme.

**Avahan-An Initiative by Bill and Melinda Gates Foundation**

In 2003 the Bill & Melinda Gates Foundation began its large HIV prevention program, the India AIDS Initiative, later called Avahan, to curtail the spread of HIV in India. At the time, there was an understandable sense of urgency about the rising prevalence of HIV in the world's second most populous country.

The foundation had three primary goals for this initiative:

1. Build an HIV prevention model at scale in India
2. Catalyze others to take over and replicate the model
3. Foster and disseminate learning within India and worldwide

Avahan has successfully built a large-scale HIV intervention program in its first five years. It operates in six states in India, which have a combined population of 300 million people. Within these states, it provides prevention services to nearly 200,000 female sex workers, 60,000 high-risk men who have sex with men,* and 20,000 injecting drug users, together with 5 million men at risk.

Avahan is now, in keeping with its second goal, beginning to hand over the program to "natural owners," like the Government of India and communities it has served since the beginning. The program has also begun work on the third goal of disseminating learnings from this initiative, and this document is a part of that effort. Throughout this document, "Avahan" refers to the effort of the partner organizations, hundreds of grassroots NGOs, thousands of peer educators, and others working on this initiative.
Indicators and Results

In 2003, increased funding and advocacy for care and treatment has led to HIV prevention losing emphasis among HIV practitioners. Globally there was evidence that working with populations at greatest risk (high-risk groups) and bridge populations in early and concentrated epidemics translated into HIV reduction among general populations. However, there were few examples of HIV prevention interventions that provided services for a large portion of high-risk individuals at a country or regional level. This resulted in prevention practitioners calling for a "bridging of the prevention gap" by increasing access of high-risk groups to a combination of proven interventions. In 2003, UNAIDS studies reported that Asia presented the greatest risk of expansion of the global epidemic. Government surveillance data gathered from attendees at government-run antenatal clinics (ANC) showed that HIV prevalence was over one percent in 51 districts across India (1-4 million people per district). Of these, 39 districts were located in four southern and two north-eastern states of India.

In India, and in most of the rest of Asia, two major factors contribute to the growth and the large number of people affected by the HIV epidemic. These are the number of sex workers and their clients, and then the frequency of unprotected sex between them. Injecting drug users and men who have sex with men are also at risk and contribute much to the overall epidemic. Limited data from published studies and sentinel surveillance of high-risk groups in India at the time indicated that HIV transmission in south India was primarily sexual, and in the north-east mainly related to injecting drug use.

The Indian response had a sound strategy addressing high-risk groups. However, coverage of these groups was variable, and in general low. The foundation initiated a design process with a team of technical
experts. They conducted a careful review of data on the epidemic and looked at the prevention program coverage by existing Government of India and other donor-supported programs.

After consultation with the Government of India, the foundation began Avahan in mid-2003. The initial funding commitment for the India AIDS Initiative was US $200 million for five years, with an additional US $58 million committed in 2006. Avahan's aim was to help slow the transmission of HIV to the general population by raising prevention coverage of high-risk and bridge groups to scale by achieving saturation levels (over 80 percent) across large geographic areas.10 Experts thought such an approach would be difficult to accomplish in India, due to the scale and diversity of the country and the risk of further stigmatizing these groups.

**Avahan's Approach**

The following are key approaches made in the initial design and subsequent evolution of Avahan:

1. Focusing prevention efforts on high-risk groups
2. Concentrating efforts on the six states with the majority of HIV cases at the time
3. Basing the initiative on global best practices in HIV prevention
4. Scaling services across intervention geographies rapidly to contain the spread of the epidemic
5. Creating the foundation's first in-country office to facilitate rapid scale-up
6. Investing in knowledge-building, evaluation, and dissemination
7. Articulating an explicit goal to transfer the funding and management of the program to natural owners including government and communities.
AIDS Awareness Group (AAG)

AIDS Awareness Group (AAG) is a voluntary organisation (NGO), which was registered in 1994 under the Societies Registration Act (1860). It is one of the largest organisation that is working on very primary and ground level throughout the country. Its mission is to contribute towards minimising human suffering in the fields of health, STIs/AIDS, domestic violence, through awareness programmes, treatment and referrals and counselling to facilitate generation of options for crisis resolution. AAG also deal with issues of human rights violations through advocacy and free legal aid.

Their main thought/effort behind the above mentioned goals is to fulfil the mission of contributing towards minimising human suffering, especially where health is concerned. To achieve this, they endeavour to pay more attention to health facilities for vulnerable population. The organisation concentrates mainly on HIV/AIDS & STIs awareness programmes so that this epidemic can be controlled and the incidence of HIV infections is minimised.

Special attention is given to the symptomatic treatment of STIs because it is not always possible to take the clients for laboratory tests. If a person is infected with STIs, he / she is at greater risk of getting infected with HIV.

Objectives of AAG

1. Creating awareness about HIV / AIDS / STIs (sexually transmitted Infections) in the jails, red light areas, slums, universities, colleges, schools, etc.
2. Providing counseling for people infected and / or affected by HIV / AIDS.
3. To produce IEC (information, education, communication) material on HIV/AIDS and STIs, Sex and Sexuality and allied topics.

4. To observe, (discretely) if the human rights of prisoners are being violated, and take appropriate action to inform the concerned authority confidentially.

5. Helping victims of domestic violence and other disadvantaged persons referred to us, and providing legal aid.

6. To take up advocacy work on issues of social injustices, unfair policies and discriminatory law enforcement, in collaboration with likeminded NGO groups, and lawyers.

It enhances awareness among the people by holding:

- Awareness sessions and street plays inside Tihar Jail
- Street corner meetings with potential clients on GB Road
- Having periodic street plays on HIV / AIDS so that as many people as possible learn through a non-invasive method.
- By training peer group educators at Jawaharlal Nehru University, as well as being available at a counseling center in the Health Centre itself. At the health center, the students come to ask questions in complete privacy. They learn how to take care of themselves, either by taking appropriate decisions for behaviour change, or through using prophylactic measures.
AAG is working in the following Areas: -
1. The Tihar Jail,
2. The Red light area on GB Road,
3. In Central Delhi primarily but not exclusively with Nepali Migrants.

Programmes

- Enhancing AIDS Awareness through conducting Sessions, Street Corner Meetings, Street Plays and Magic Shows on HIV/AIDS, and lastly through one to one sessions.

Depending on the area adopt one or more of the following methods:

A. Participatory Group Sessions with a large number of assembled persons like the jails using Flip Charts and having question and answer sessions during and after the session. These include discussions on Attitudes, Stigma and Discrimination, and where necessary on HIV/AIDS Home Care, diet for positive people and referrals for testing and treatment and allied topics. This is very
effective in Jails, schools and colleges and with Corporate Houses on invitation.

B. For Mass awareness programmes, Street Plays and/or Magic Shows on HIV / AIDS are used. These are conducted by professional groups trained and briefed by AAG. These are used in Tihar Jail, in the parks at Madanpur Khader, for Nepali Migrants and others in Central Delhi, and on some Sundays on GB Road near the brothels when there is almost no traffic. Except for Tihar Jail where they can only distribute IEC material (Condoms cannot be given), elsewhere in all other areas they distribute condoms also after giving Condom demonstrations on the right way of using them. They distribute IEC material and provide referrals if some people from the audience want

C. For Smaller Groups (10 to 50) on the roads they use Street Corner Meetings using Flip Charts. They have teams of two with a complete package of Flip Charts, IEC material, and a supply of Condoms both for demonstration and distribution. At the end of the session lasting about 15 to 20 minutes, if someone wants to see a doctor for their personal medical problem/s, it is being referred to one of our three clinics located at Minto Road; GB Road and at Madanpur Khader as relevant. Otherwise they refer them to the nearest Government hospitals. They have found that this method for enhancing HIV / AIDS awareness is very effective and they use it on GB Road near the brothels, on the roads in Central Delhi (Connaught Place, Gole Market, near Shivaji Stadium, on Barakhamba Road, Jhandewalan Road, Karol Bagh etc.) and outside Dhabas (Small wayside eating places, where usually Nepalis work) in Central Delhi and on the streets at Madanpur Khader.

D. Inside Brothels they hold one to one or one to five or six mini sessions (5-6 minutes) with the sex workers. They usually have no
time available for longer sessions. The volunteers provide information on how one can get infected, how one does not get infected, and the precautions available to us. Condoms were distributed at the end of each session.

E. At their Drop-in-Centers/Clinics in the three places mentioned above, they provide information to small groups and even hold one to one discussions. They provide pre-test counseling for STIs / HIV / AIDS and testing for HIV at our drop-in-centers located on Minto Road and at GB Road. In the cases of STIs we provide Symptomatic treatment and also refer them to Government Hospitals. For people testing positive with our Kit, they refer the clients to the nearest Government Hospital for ELISA tests and CD 4 count. The Drop-in-Centre at Minto Road was opened in August 2006.

Naz Foundation (India)

The Naz Foundation (India) Trust (NI) is a New Delhi based NGO working on HIV/AIDS and Sexual Health since 1994. Through the years, Naz India has evolved and implemented a holistic approach to combat HIV, focusing on prevention as well as treatment. Their focus is on reaching out to marginalized populations infected and affected by HIV. The aim is to sensitize the community to the prevalence of HIV, as well as highlight issues related to Sexuality and Sexual Health. Since 2006 Naz India is implementing the Goal Programme, a collaborative, multi-stakeholder initiative that links the private and NGO sectors and uses sports—in this case netball—as a vehicle for social inclusion. GOAL is a community programme with transformational impact; it builds self-confidence and gives adolescent girls a better chance at life. The programme funded by Standard Chartered Bank is a Standard Chartered Community Investment initiative, run in partnership with local and international NGOs.
Programme Model

GOAL is offered twice a week; each session includes a mix of netball and education modules. The programme participants are between the ages of 14 and 19 and come from families that earn less than $2(Rs.110) a day. GOAL’s education is focused on four key life skills: promotion of self-confidence, communication skills, health and hygiene, and financial literacy. Once girls complete GOAL, those interested are invited to become GOAL Champions. The GOAL Champions are trained to deliver the programme themselves, allowing us to quickly scale and replicate the model.

The programme was expanded to Mumbai in 2008, reaching 360 girls in two cities and now has a planned expansion to Chennai in 2009.

The Milan Project

For Men Having Sex with Men (MSM) & Transgender (TG)

The first Targeted Intervention program of Naz India, the Milan Project looks to support the populations of men who have sex with Men and Transgender community. These individuals are often marginalized by the mainstream at large and many find it more difficult to access safer sexual practices. We also support these individuals with counseling, training programs and interventions.

Drop-in Center

A safe, confidential space for MSM and TGs to access information and discuss issues related to the community.

Facilities at the Center:

- Face-to-face counseling
- Library room and other resources regarding MSM and TGs
- Film screenings
- Vocational training, English classes, and other trainings
Support Group meetings

Reach

Our outreach workers, all who come from MSM and TG community, conduct regular outreach in “cruising” sites, massage parlours, and in the Kinnar community. This outreach often consists of workers distributing information. Outreach workers also give out condoms, lubricants, and other items that MSM and TGs may not have access to, or cannot afford.

Peer Education

The Peer Education Program is a project of Naz Foundation (India) Trust funded by the Levi Strauss Foundation. After a successful first year that trained 20 pilot peer educators across Delhi University colleges, we have begun our second year with 40 peer educators being trained on: Sexuality, Gender Based Violence, HIV/AIDS and Sexual Health.

After training, they organize and conduct workshops on these issues with their peers. When conducting these workshops, peer educators are encouraged to be creative and many use elements of music, dance and role-playing.

The overall objective of the program is to impact the knowledge, attitudes, values and skills of the students conducting the trainings and of those being trained. The first target was to reach to about 400 students.

Care Home

India is home to the world's largest population of HIV orphans. Unfortunately, the number continues to rise. These children face staggering risks and typically die young or live on the streets. Naz India, working with HIV/AIDS since 1994, opened its arms to HIV positive orphans to create a Care Home in 2000. The Care Home is founded on the belief that all children have a fundamental right to a loving, fun-filled
childhood with access to health, education, and a safe, stigma-free environment.

The Children

The children from NAZ (41 of them at present) range in age from one year to fifteen years. Our school-age children regularly attend classes and are excelling in studies, though many had never gone to school before arriving at Naz. The children are seen daily by a doctor, minimizing the risks of opportunistic infections and providing supervision for those on anti-retroviral therapy. Home-cooked meals emphasize well-balanced nutrition. Each child works with a tutor each day, and yoga classes are held three times per week. The children enjoy playtime, walks in the park, and art projects with the help of volunteers from the community.

Training

They coordinate and conduct training and workshops on issues related to HIV/AIDS and Sexual Health. The objective of the trainings is to build the capacity of individuals and organizations by raising their awareness levels and bringing about a positive change in their attitudes on these topics.

• Features of the program
• Training of Trainers (TOT), Naz India builds the technical capacity of intermediary organizations so they may train other organizations in their region.
• Trainings are conducted in schools, colleges, NGO’s, corporate offices, and hospital upon request.
• Naz India has produced a set of training manuals on:
  • Sex and Sexuality
  • Counseling and Testing
Care and Ethics
Men who have Sex with Men
Sexual Health and Human Rights
Community Involvement throughout the year staff from Naz India participate in melas (fairs) and other community events across Delhi. Our aim is to raise awareness among the community and challenge assumptions. We bring with us information on HIV/AIDS, sexuality, and health. We also have various games available so participants can increase their knowledge about HIV/AIDS and sexuality.

State AIDS Control Societies
SACS are autonomous and decentralised. Each State AIDS Prevention and Control Society has a governing body, its highest policy-making structure, headed either by the minister in charge of health or the chief secretary. It has on board representatives from key government departments, the civil society, trade and industry, private health sector and PLHA networks, who meet twice a year. It approves new policy initiatives, annual plan and budget, appoints statutory auditors and accepts the annual audit report. For better financial and operational efficiency, administrative and financial powers are vested in the Executive Committee and the Programme Director.

Functions of SACS are:
- Medical and public health services;
- Communication and social sector services; and
- Administration, planning, coordination, monitoring and evaluation, finance and procurement.

Rajasthan
Rajasthan State AIDS control society was formed under Rajasthan society act 1958 in December, 1998 National AIDS Control programme
is being implemented by AIDS cell formed under the Directorate of Medical and Health Services, Govt. of Rajasthan, Jaipur. The AIDS cell receives all the AIDS funds from the National AIDS Control Organisation (NACO), Ministry of Health and Family Welfare, Govt. of India in form of grant aid.

The society was constituted under the chairmanship of secretary health in December 1998 to implement National AIDS Control Programme more swiftly. Realizing the need for a broader and more effective response and to facilitate smooth implementation of HIV and AIDS Prevention activities, State Government has setup the state AIDS cell in the Medical Health Directorate in the year 1992. The targeted intervention programme is aimed for slowing down the spread of HIV/AIDS among people who practice high risk behavior namely Female Sex Workers, Men Having Sex with Men, Intravenous Drug Users and Truckers, Migrants. For greater intervention the society also started Advocacy workshops.

**Advocacy Workshops**

- Intersectoral Workshops
- Media Advocacy workshops
- Sensitization workshops with Private Schools, Govt. Schools Teachers and students
- Police, PRIs, Army, NCC, NSS
- Sensitization with Private Practioners & Family Physicians

**Tamil Nadu**

Even though the first HIV cased was identified in Chennai, Tamil Nadu and since the Tamil Nadu State AIDS Control Society continues its fight against HIV/AIDS, TANSACS envisions a Tamil Nadu where no
new individual would acquire the HIV infection, and every person living with HIV/AIDS has access to quality care and lives with dignity.

TANSACS believes that Tamil Nadu would be able to halt and reverse the epidemic of HIV very soon, and set itself as a model state in India and in the whole world.

TANSACS’ foundation is built on a quality care-and-support system for persons living with HIV/AIDS. By fostering close collaboration with NGO’s, women’s self-help groups, Community Based Organisations, positive people’s networks and various National and International Donor Agencies, TANSACS constantly works towards improvement of accessibility and accountability of the services, effective prevention strategies and providing prevention-to-care continuum support for HIV/AIDS affected people.

TANSACS stands committed to building an enabling environment wherein those infected and affected by HIV/AIDS play a central role in all responses to the epidemic – at state, district and grass root level. TANSACS believes that it is possible for creating an environment where human rights are respected and where those infected or affected by HIV/AIDS live a life without stigma and discrimination.

TANSACS is working to consistently to evolve strategic responses for combating the HIV/AIDS situation in Tamil Nadu to achieve the vision of:

- A Tamil Nadu where every pregnant woman living with HIV has the choice to bring an HIV-free baby into the world.
- A Tamil Nadu where every person has access to Integrated Counselling & Testing Centres (ICTCs)
- A Tamil Nadu where every person will eventually live a healthy and safe life, supported by technological advances.
• A Tamil Nadu where every person who is highly vulnerable to HIV is heard and reached out.

**TANSACS Values**

• Building an integrated response by reaching out to diverse populations.

• Implementing an AIDS Control Programme that is firmly rooted in evidence-based planning.

• Providing people with accurate, complete and consistent information about HIV.

• Promoting use of condoms for protection, and emphasising treatment of sexually transmitted diseases.

• Working toward motivating men and women for responsible sexual behaviour.

• Achieving development objectives.

• Dissemination of transparent estimates on the spread and prevalence of HIV/AIDS in the state and districts.

• Building partnerships

**Punjab**

Punjab State AIDS Control Society (PSACS) was registered in 1998 for implementing National AIDS Control Programme. NACP is a 100% centrally sponsored project. PSACS started functioning in 1999. Principal Secretary Health is the Chairman of the Society Secretary Health has been designated as Project Director of the society. Additional Project Director is the technical head assisted by Joint Directors, Deputy Directors, Assistant Directors, other officers and supporting staff.

During NACP I (1992-1999) the stress was on awareness generation among the general population and high risk population. In NACP II (1999-2006) main focus was targeted interventions for HRGs
along with awareness increase in awareness among general population and high risk population. It also included strengthening and expansion of VCTC, Blood Bank, PPTCT and PEP services etc.

**Achievements under NACP I:-**

The following important achievements have been made during the first phase of the programme:

1. **Awareness creation:** - Punjab launched an integrated IEC campaign, for creating awareness on the mode of transmission of HIV infection and methods of preventing the same. The IEC campaign, through electronic and print media, outdoor publicity etc. was major success and is being currently displayed at various important points and road junctions in the state. Awareness among rural as well as urban population has gone from almost zero to about 70%.

2. **Intervention Programme through NGO’s:** - The high risk groups of population like truck drivers were identified with the assistance of NGO’s in Punjab. During the 1st Phase, various NGOs were given financial assistance for various I.E.C. and intervention programmes. Pilot projects were started with targeted interventions for truckers, student youth, rural youth, industrial workers, migrant labourers etc. Various NGO’s were also engaged in school health programmes. Districts education Officers were being involved as are the Principals of schools for the training of nodal students and nodal teachers of 9th and 11th class from all schools of selected districts. A number of NGOs had also taken up IEC programmes independently by taking grants/assistance from other agencies including some international bodies.

3. **Condom Promotion Programme:** - The installing of Condom Vending machines at all STD Clinics and other appropriate public places like railways stations, cinema halls, STD booths, Interstate bus
terminus, etc. was tried through State Red Cross but results were not satisfactory. Condoms were being distributed in Punjab by various agencies like the NGOs, Punjab State AIDS Control Society, and the Health establishments of the Punjab Government through Para-medical Staff. Condoms were also being supplied to the high risk behaviour group i.e. truckers, rural youth etc.

4. **Training:--** With a view to create a network of committed medical workers in the various Government hospitals, in the first phase 851 doctors and 3468 paramedical staff were trained in the State. A detailed action plan was chalked to cover the training of medical officers, dental officers, nurses, paramedical staff, private practitioners and NGOs in the State.

5. **IEC Activities:--** Various IEC activities were being conducted in the Punjab State with the help of medical and paramedical staff and NGOs. Various types of IEC material prepared by the AIDS Control Society, included posters, pamphlets, hand-bills, audio and video cassettes, TV Spots, Radio messages, TV talks/Radio talks, mass awareness programme in the form of Melas, Nukkad Natak, plays, seminars, group meeting advertisements in newspapers, magazines, bus-panels, stickers and hoardings etc.

6. **Impact Reduction and Low cost Care and Support:** - To reduce the emotional, mental and social tension created by the disease of AIDS on individual, family and community, it is necessary to provide counselling. Proposals for setting up of counselling centres in the major hospitals of Punjab were made by State AIDS Control Society. Efforts were initiated to set up pre and post-test counselling services in all the blood testing centres in Punjab. NGOs proposals for setting up counselling centres were considered and some of the NGOs started counselling services.
Orissa

National AIDS Control Programme is being implemented through National AIDS Control Organization (NACO), New Delhi, under Ministry of Health & Family Welfare, Government of India with the support of DFID & World Bank fund. From 1992 – 1999, National AIDS Control Programme, Phase - I (NACP-I) was implemented by Government of Orissa under Director, Health Services. From 1999 – 13.07.04: - Programme under NACP –II was implemented through Orissa State Health & Family Welfare Society under the name of State AIDS Cell (SAC). The Governing body of OSACS has 29 members and is presided by the Hon’ble Minister, H & FW. The Executive Body of OSACS has 21 members and is presided by the Commissioner-cum-Secretary to Govt., Health and Family Welfare Department.

Vision & Values

The 3rd phase of National AIDS Control Programme (NACP-III) has been launched from 6th of July, 2007. It is expected to continue till 2012. This programme builds on the attainments of NACP- II, which has led to a relative stabilization of the HIV/AIDS epidemic in the country. The overall goal of NACP- III is to halt and reverse the epidemic in India over the next five years by integrating programmes for Prevention, Care, Support and Treatment.

OSACS has taken measures to ensure that people living with HIV have equal access to quality health services. By fostering close collaboration with NGOs, women’s self-help groups, other government departments, corporate/private sector, positive people’s networks and communities, it hopes to improve access and accountability of the services. It stands committed to building an enabling environment wherein those infected and affected by HIV play a central role in all
responses to the epidemic – at state, district and grassroots level. OSACS principle is that people need to be aware, motivated, equipped and empowered with knowledge so that they can protect themselves from the impact of HIV. They confront a stark reality – HIV can happen to any of us. Their hope is that anyone can be saved from the infection with appropriate information on prevention. OSACS is built on a foundation of care and support, and is committed to consistently fabricate strategic responses for combating HIV/AIDS situation in India.

Maharashtra

MSACS envisions an India where every person living with HIV has access to quality care and is treated with dignity. Effective prevention, care and support for HIV/AIDS is possible in an environment where human rights are respected and where those infected or affected by HIV/AIDS live a life without stigma and discrimination.

MSACS has taken measures to ensure that people living with HIV have equal access to quality health services. By fostering close collaboration with NGOs, women’s self-help groups, faith-based organisations, positive people’s networks and communities, MSACS hopes to improve access and accountability of the services. It stands committed to building an enabling environment wherein those infected and affected by HIV play a central role in all responses to the epidemic – at state, district and grassroots level.

MSACS is thus committed to contain the spread of HIV in India by building an all-encompassing response reaching out to diverse populations. Efforts are being made to provide people with accurate, complete and consistent information about HIV, promote use of condoms for protection, and emphasise treatment of sexually transmitted diseases. MSACS works to motivate men and women for a responsible sexual behaviour.
Kerala

The Kerala State AIDS Control Society (KSACS), plays a pivotal role in the state’s strategy in combating the HIV/AIDS epidemic. It is an autonomous society registered under the Charitable Societies Act, with its members drawn from all key government departments to ensure greater flexibility and more effective programme management. Its work is supervised by a Governing body, chaired by the Chief Secretary of the state, and which includes as members Secretaries of various government departments like Health, Social Welfare, Finance, Education, and Project Director of KSACS, Director of Health Services, Director of Medical Education, State Drugs Controller and Inspector General of Police (Law & Order)

KSACS was formed to implement the National AIDS Control Programme (NACP) in the state. It works under the National AIDS Control Organisation (NACO) which is a part of the Ministry of Health and Family Welfare of the Government of India. The National AIDS Control Programme is fully funded by the Government of India and by international donors such as the World Bank, the Global Fund for AIDS, TB and Malaria, DFID (Department for International Development, UK) and USAID (the US Agency for International development) and others.

Madhya Pradesh

HIV / AIDS constitute the greatest threat many societies have ever faced. It outranks every other disease that has affected people in the world. Although AIDS cannot be cured, it can be prevented. Unlike other infectious diseases HIV selectively and disproportionately targets two groups - the young adults and the very poor, economically marginalized population. The prognosis for people infected with the virus is bleak. There is no vaccine against HIV and no effective medical cure for HIV
infection. Treatment options are prohibitively expensive. HIV / AIDS is essentially an incurable and fatal disease. HIV destabilizes societies because of the fear, blame and stigma attached to it. It threatens basic human rights and invades even the right to privacy and human dignity. No other disease affects human society in this way or to this extent.

The first case of HIV/AIDS was detected in MP in 1988, and since then the number of AIDS cases are rising. In view of the seriousness of the problem, MP Government constituted AIDS control cell in 1992 under medical education department. Subsequently MP state AIDS control society was constituted in July, 1998. MPSACS takes policy decisions for effective implementation of AIDS control programme in MP. It is an autonomous institution, funded by National AIDS control organization (NACO)²⁰.

GOA

The HIV/AIDS Control activities in Goa, commenced way back in 1984 with surveillance done amongst High Risk Groups. The Health Education Bureau at Directorate of Health Services was the Nodal Agency for all the Programme Activities. In 1986-87, when first HIV case came to light, the STD Control Programme at the Directorate of Health Services coordinated all the activities, which finally led to the creation of AIDS Cell at the Directorate of Health Services. As the HIV/AIDS turned out to be a major Public Health Problem in Goa, in order to take multi-pronged interventions, the Goa State AIDS Control Society was created and got registered in 1997 to function under guidelines of the National AIDS Control Organization, keeping in view the national pattern. The National AIDS Control Organization and the Goa State AIDS Control Society are the wings of Ministry of Health and Family Welfare at Government of India and at side level respectively.
Goa is a tiny state on the west coast with a total population of about 14 lakhs surrounded by high HIV prevalent states like Maharashtra and Karnataka. Since the first case of HIV/AIDS detected in Goa in 1987, there has been a steady rise in the reported number of HIV/AIDS cases. The epidemic has crossed over from high-risk groups to general population, from urban to rural areas and from adults to children. HIV is now prevalent in all parts of Goa and almost two-thirds of the cases are reported from the four coastal talukas of Goa. HIV infection in women is rising. Out of every three cases detected one is a female. Sexual route is predominant mode of transmission being more than 90%. Goa has been classified as a moderate prevalent state based on the sentinel survey data. Goa has always been in the forefront in combating HIV/AIDS. GSACS over the last few years had initiated various measures and also developed certain infrastructure facilities/ services for the control and prevention of HIV/AIDS.

The Phase-III (2007-12) of AIDS Control Programme will no doubt build on the strengths developed, lessons learnt, gaps identified and experiences gained in the previous two phases of NACP, and consolidate the achievements. However, HIV can no more be the sole agenda of one organisation or department.

**Gujarat**

In Gujarat, first AIDS patient was diagnosed in the year 1986, i.e. in the same year when first case of AIDS was reported in the country. A state AIDS cell (SAC) was created in December 1992 for implementation of phase I of National AIDS Control Programme (NACP). The programme was implemented in accordance with the guidelines of NACP and the approved of the State Empowered Committee on AIDS as constituted in Gujarat.
With a view to ensure speedy and effective implementation of the program through intersectoral coordination for AIDS prevention and also to involve NGOs, the State AIDS Empowered Committee decided to convert the existing AIDS cell into a registered society. Government of India also advised to constitute State AIDS Control Society for effective implementation of the programme, especially in second phase of NACP which begin from April 1999. Since then, National AIDS control programme is being implemented through Gujarat State AIDS Control Society (GSACS).

The HIV response in India is firmly located within the state framework. Available evidences establishes beyond doubt that HIV virus cannot be controlled only by health department or any other medical fraternity. The issues connected with HIV/AIDS are not confined to the domain of health and go beyond the scope of the health department. NACP III has identified HIV/ AIDS mainstreaming in different sectors and national development programmes as one of the strategies in NACP III to prevent new HIV infections among the general population as well as improve capacities of communities to cope with the impact of HIV and AIDS. GSACS has initiated two way approaches for mainstreaming the HIV/AIDS in all stake holders. First is the State Level Advocacy and networking with key stake holders and secondly, at locally district level through institutionalization "Jeevan Deep Project". Jeevan Deep is an Innovative Projects with three prong strategy.

- Mainstreaming HIV/AIDS.
- Bringing Zero level Stigma
- Developing/ Strengthening DLN+ for sustainability.

**The project aims to**

1. To mainstream the issue of HIV in the important programme/ Department/ Stakeholders of public and private sector (GO, NGO,
CBO, FBO, Hospital, Media, Lawyers etc.) and people living with HIV/AIDS by developing linkages & to advocate with important stakeholders in the state & districts.

2. To develop positive speaker bureau and volunteer & strengthen/develop District level Network.

3. To create Zero stigma level in the district.

4. To sensitize vulnerable group especially youth and women for the preventing spread of HIV in these group.²²

**Andhra Pradesh**

HIV/AIDS has become a global challenge with serious implications for the future economic and social development of our society. Half of the entire new HIV infections worldwide are among the young people aged between 15-24 years. Recent reports indicate that, 5.2 lakh people are living with HIV/AIDS in Andhra Pradesh with a prevalence of 1.06%. It is disturbing to note that, despite of best efforts, more than 90% of the HIV infections are occurring through unprotected sex. The high prevalence of HIV is attributed to the presence of large number of Sexually Transmitted Infections, low condom usage, vast network of highways and more specifically large number of young girls being trafficked. If left unchecked, HIV/AIDS can adversely affect the most economically productive segment of society.

In order to address the issues of HIV/AIDS, the Governments both at the Centre and in the States are taking measures such as awareness campaigns like AASHA (AIDS Awareness Sustained Holistic Action) and Be Bold Campaigns, promotion of condom usage and targeted interventions to address the high risk groups etc., to stop the spread of HIV.²³
Prevention Strategy in Andhra Pradesh:

Andhra Pradesh continues to adopt a proactive approach based on the international and national experiences with a clear and multi-pronged effort for prevention and control of HIV/AIDS. Concerted efforts are made to contain the epidemic in the state by adopting a multisectoral and multi-pronged approach. Important programmes, Schemes, project under implementation by the department are given below:

1. **Prevention of HIV infection in High-Risk Population:** One of the key components of prevention intervention strategies is promoting sexual health among high-risk populations like Female Sex Workers, (FSW) Men Having Sex with Men (MSM) and Intravenous Drug Users (IDU). 58 targeted interventions for these high risk groups have been taken up through NGOs during the year 2008-09. 6 interventions for truckers were started through trucker’s associations in the state.

In addition to the interventions taken up by the Govt., Bill & Melinda Gates Foundation took up 60 projects for saturated coverage of sex workers and truckers for prevention and control of HIV among the high-risk groups. These are implemented by the foundation lead partners HLFPPT (Hindustan Latex Family Planning Promotion Trust) and International HIV/AIDS Alliance. With these efforts more than 90% of the high risk group populations are covered for prevention programmes of HIV/AIDS.

2. **Intensive Awareness campaigns with people’s participation:**

Government has taken up intensive awareness campaigns like, "AIDS Awareness Sustained and Holistic Action" (AASHA) in the year 2005 to May 2006 with focus on promoting ownership of the prevention activities by the community through participation of women and youth groups. This campaign has resulted in increased awareness among the community on HIV/AIDS on modes of transmission, methods of
prevention, information on services available for people living with HIV and reduction of stigma and discrimination towards people living with HIV. Reports from NACO indicate that with the efforts made by Govt. more than 90% of people have become aware of HIV/AIDS in Andhra Pradesh.

3. **Mass Media campaign:** The campaigns through Electronic Media continued with messages on entertainment and news based channels playing the role of catalysts to trigger public opinion on different social issues leading to vulnerability in the context of HIV/AIDS. "ASANNA & ASAKKA" characters introduced in to the media campaign as brand ambassadors to carry forward the messages related to HIV/AIDS have become popular icons. A new Phone -in programme called "Mee Nestam" on FM Radio channel, on every Thursday is started which is attracting larger audience to dispel doubts on various issues of HIV/AIDS.

4. **Adolescence Education Programme and Formation of Red Ribbon Clubs:** Adolescence Education Programme with focus in schools/colleges was taken up to cover 9th and 10th class students in 15,437 schools and all the students in Junior and Degree colleges for creating awareness on HIV/AIDS. Till February 2007, around 2 million students in 13,000 schools and 3000 colleges are covered under AEP. This programme is encouraging students to adopt positive life styles required for prevention of HIV/AIDS. The programme was started in the year 2002-03 and continued every year covering all schools and colleges in the state. A topic on HIV/AIDS was incorporate HIV/AIDS in school curriculum of 9th and 10 classes during this academic year.

5. New IEC campaigns with targeted messages were printed on 40 lakhs postcards and passbooks through the Postal Department. Red Ribbon
Aims and Objectives

The Society was established towards fulfillment of following aims and objectives:

The project has 5 components namely:

- Targeted Intervention, STI Control & Condom Promotion
- IEC, Blood Safety & VTC
- Surveillance Training, Operational Research and Institutional Strengthening
- Low Cost Community based Care for HIV/AIDS
- Intersectoral Collaboration & Coordination

Uttar Pradesh

Uttar Pradesh is the biggest state in India in terms of population. Therefore a large and successful is needed for proper implementation of AIDS awareness and its subsidiary activities like prevention and mapping of patients. With an estimated 196 million people, of whom 50% are youths, the state of UP has become a case of high HIV vulnerability. On the contrary, the level of awareness and risk perception is critically low. Presently, the HIV prevalence rate in UP is less than 1%. It may, therefore be seen as an opportunity for the state to focus on prevention programmes. It is to be added here that 1987 was the year when the very first case of HIV was discovered in UP. It followed the establishment of the State AIDS Cell in 1992-93, the very first step towards HIV & AIDS control. This is how National AIDS Control Program (NACP-I), with the explicit objective of awareness-building commenced in UP. The Uttar Pradesh State AIDS Control Society (UPSACS) was formally registered in 1999, a year after the dissolution of the Cell in 1998, under the second phase of National AIDS Control Programme, (Ref Annual Report 2009-2010 Uttar Pradesh State AIDS Control Society (UPSACS.) programme,
the NACP-II, with the Principal Secretary (Medical and Health) as the President, Secretary (Health) as the Vice President and the Project Director of UPSACS as the Member Secretary. At the district level, AIDS Control Coordination Committees were formed with the District Magistrate as President and the Chief Medical Officer as Member Secretary.

Under the new dispensation, the services of voluntary testing and counseling centers (VCTC) were expanded to the level of district hospitals, more sentinel surveillance centers were created, communication campaigns were launched, and the involvement of NGOs for targeted interventions was taken up, among other programmes.

The coverage and service delivery of the programme, headed by the Project Director, have been limited to the district level. They were further taken up to the Community Health Centre (CHC) and Primary Health Center (PHC) level, besides reaching out to rural and border areas in the ongoing phase:

**Activities under NACP-III**

Under the third phase, the programme has entered into partnership with UNICEF, FHI and other agencies. NACP-III, while laying down the purpose of UPSACS, i.e., to reduce new infections by 40% so as to stabilise the epidemic, sets out its goal of halting and reversing the pandemic in India over the next 5 years by integrating programmes for prevention, care, support and treatment by adopting the following four pronged strategy:

- Prevention of new infections in High Risk Groups and General Population through:
  - Saturation of coverage of High Risk Groups with Targeted Interventions (TIs)
  - Scaled up interventions in the General Population
• Providing greater care, support and treatment to a larger number of PLHIV
• Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national levels
• Strengthening the nationwide Strategic Information Management System

Lessons emerging out of the previous two phases of programme implementation have been the key to NACPIII and have contributed to the strengths thereof. UPSACS has drawn its priorities and thrust areas accordingly, which include the following.

The general population who have greater need for accessing prevention services have subsequently been placed third in the order of priority. UPSACS ensures that all persons who need treatment have access to prophylaxis and management of Opportunistic Infections (OIs). Persons who need access to ART have been also provided with first line ARV drugs. The prevention needs of children are also being endorsed through universal provision of PPTCT services at all the district hospitals. And those carrying the infection have been ensured access to pediatric ART at most of the places. UPSACS has tried its best to invest in community care centers to provide psycho-social support, outreach services, referrals and palliative care. Resolute efforts are also being put in to redress the problem of socio-economic vulnerability, which is a contributing factor that increases risk to HIV. Mainstreaming and partnerships have been the key approach to facilitate multisectoral response, engaging a wide range of stakeholders. Technical and financial resources of the development partners have been leveraged to achieve the objectives of the programme.
Various awareness and prevention programmes all across the country are going on much is to be done in the future. The activities undertaken by NACO, UNAIDS and other government agencies specially the state AIDS control societies, which are the working arm of the central body.

As we have discuss that major part of India lives in the rural areas and where the government and NGO’s are focusing but a major chunk of it lives in metros, like Delhi and Mumbai. A lot of screening must be done in these cities as they are dwindling in the face of the disease which goes unchecked sometimes.
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