

NATIONAL AIDS CONTROL PROGRAMME

Introduction

- Human Immunodeficiency Virus (HIV) is a lentivirus that belongs to the retroviruses group may cause HIV infection/AIDS. Acquired Immunodeficiency Syndrome (AIDS) has emerged as one of the most serious public health problem in the country after reporting of the first case in 1986. The initial cases of HIV/AIDS were reported among commercial sex workers in Mumbai and Chennai and injecting drug users in the north-eastern State of Manipur. The disease spread rapidly in the areas adjoining these peicentres and by 1996 Maharashtra, Tamil Nadu and Manipur together accounted for 77 percent of the total AIDS cases. Out of these, Tamil Nadu reporting almost half the number of cases in the country. However, the overall prevalence in the country is very low, as compared to many other countries in the Asia-Pacific region.

Burden of Disease

World

- According to UNAIDS/WHO estimates, 11 men, women and children were infected per minute during 1998. More than 95% of all HIV-infected people now live in developing world.

India

- The trends of HIV infection in India are alarming. Following characteristics of the AIDS epidemic have been observed:
- In the recent years it has spread from urban to rural areas and from individuals practicing risk behaviour to the general population.
- More and more women attending antenatal clinics are being found testing HIV-positive thereby increasing the risk of perinatal transmission. One in every 4 cases of HIV positive reported is a woman.
- About 84% of the infections occur through the sexual route (both heterosexual and homosexual).
- Other roots of transmission are blood transmission, injectable drug use and perinatal transmission.
- Another 4% through injecting drug use.
- About 80% of the reported cases are occurring in sexually active and economically productive age group of 15-44 years.
- HIV positive in antenatal clinic varied from 0% in Assam to 1.71% in Maharashtra. The average prevalence work out as a low 0.7% but with more than 500 million adult in the country. NACO calculates that 4.8 million people are infected.

Attributable factors of the HIV spread are:

1. Labour migration and mobility in search of employment from economically backward

- to more advanced regions;
2. Low literacy levels leading to low awareness among the potential high risk groups;
 3. Gender disparity;
 4. High prevalence of Sexually Transmitted Infections and Reproductive Tract Infections both among men and women;
 5. The social stigma attached to sexually transmitted infections also hold good for HIV/AIDS, even in a much more serious manner. This, coupled with lack of awareness results in reporting of full-blown AIDS cases in cities like Mumbai and Chennai;
 6. There have been cases of refusal of AIDS patients in hospitals and nursing homes both in Government and private sectors. This has compounded the misery of the AIDS patients;
 7. Isolation of AIDS cases in the wards creates a scare among the general patients;
 8. At some occasions, discrimination at workplace leads to loss of employment;
 9. The treatment options are still in the trial stage and too expensive;
 10. Still no effective vaccine is available;
 11. Multi-drug protease inhibitor therapy, popularly known as 'cocktail therapy', helps only in prolonging the life of the patient. There are fears of patients developing drug resistance and side effects if the therapy is not administered under proper medical supervision;
 12. There were instances of quacks taking advantage of the situation and promising cure through so-called herbal treatment providing only false assurances;
 13. Existence of a large number of unlicensed small and medium blood banks in the private sector has also compounded the problem;
 14. The twin problem of drug addiction and HIV transmission raise a serious ethical and moral issues in the Needle exchange programmes and condom distribution as legally no person should take drug or should go to prostitutes;
 15. Although transmission of HIV through use of needles, razors and other cutting instruments in the thousands of beauty parlors, hair-cutting saloons is insignificant, lack of hygiene practices in majority of these establishments also poses a health risk to the unsuspecting general population who visit these places every day;
 16. There is also a twin challenge of HIV/TB co infection. Nearly 60% of the AIDS cases are reported to be opportunistic TB infection cases. Treatment of TB among the HIV-infected persons is a new challenge to the National TB Control Programme. Some of the antitubercular drugs recommended for TB treatment pose complications in cases of HIV-infected persons, e.g. thiacetazone can cause skin eruptions. There is no risk of HIV from any TB patient unless he or she practices high risk behaviour or gets infected from transfusion of HIV-infected blood;
 17. Inadequate understanding of the serious implications of the disease among the legislators, political and social leaders, bureaucracy, media, leaders of trade and industry and even among medical and paramedical personnel engaged in provision of health care;
 18. Difficulty in identifying, reaching, and covering risk groups for interventions;
 19. Poor involvement of NGOs due to Borrower's and recipients' non-familiarity with guidelines and project processing requirements;
 20. Vacant posts frequent transfers, holding of dual charges, and changes in staffing patterns is again major hurdle in implementation of preventive programme strategies;
 21. Lack of uniformity in the processes of disbursement of funds in various states; and
 22. Large segment of civil society did not acknowledge HIV as a priority in the early 1990s and were critical of the Central Government and the World Bank for drawing attention towards HIV/AIDS.

National AIDS Control Programme Phase – I (1992-99)

During this phase, the National AIDS Control Project was developed for prevention and control of AIDS in the country.

Project Objectives

The ultimate objective of the project was to slow the spread of HIV to reduce future

morbidity, mortality, and the impact of AIDS by initiating a major effort in the prevention of HIV transmission. The specific objectives were:

- (a) Involve all States and Union Territories in developing HIV/AIDS preventive activities with a special focus on the major epicenters of the epidemic;
- (b) Attain a satisfactory level of public awareness on HIV transmission and prevention;
- (c) Develop health promotion interventions among risk behaviour groups;
- (d) Screen all blood units collected for blood transfusions;
- (e) Decrease the practice of professional blood donations;
- (f) Develop skills in clinical management, health education and counseling, and psychosocial support to HIV seropositive persons, AIDS patients and their associates;
- (g) Strengthen and control of Sexually Transmitted Diseases (STD); and
- (h) Monitor the development of the HIV/AIDS epidemic in the country.

Achievement of Phase I

1. Awareness levels that were almost insignificant have increased to about 70-80% in urban areas even though the level of awareness in rural areas remains low at about 30%;
2. Modernization and strengthening of blood banks;
3. Introduction of licensing system of blood banks and gradual phasing out of professional blood donors; and
4. Availability of good quality condoms through social marketing has made a significant increase in its use.

National AIDS Prevention And Control Policy (NAPCP) 2002

The NAPCP 2002 has been announced with the aim of bringing AIDS transmission at zero level by 2007.

1. Prevention of further spread of the disease by making the people at large and specially the high-risk groups aware of its implications and provide them with necessary tools for protecting themselves from getting infected. Control of Sexually Transmitted Diseases among sexually active and economically productive groups together with promotion of condom use a measure of prevention from HIV infection will be the most important component of the prevention strategy;
2. To provide an enabling socioeconomic environment so that individuals and families affected with HIV / AIDS can manage the problem; and
3. Improve services for the care of People Living With AIDS (PLWA) in times of sickness both in hospitals and at homes through community health care.

For this purpose the policy addresses the following components of the national AIDS control programme for bringing in a paradigm shift in the response to HIV / AIDS at all levels both within and outside the Government:

A. Programme Management

National AIDS Committee
State Level Strengthening
Empowered Committee
State AIDS Control Societies

B. Advocacy & Social Mobilization

Participation of Non-Governmental Organizational/Community Based Organisations
Counseling

C. Surveillance, Monitoring & Research

HIV Testing
Research & Development

D. Target Intervention

People Living With AIDS (PLWAs)

E. Sexually Transmitted Disease Control Programme

F. Condom Programme

G. Policy for Blood Safety

National AIDS Control Programme Phase II (1999-2004)

The Phase II of the National AIDS Control Programme has become effective in 1999. It is a 100% Centrally sponsored scheme implemented in 32 States/UTs and 3 Municipal Corporations namely Ahmedabad, Chennai and Mumbai through AIDS Control Societies.

Aims of Phase II

1. To shift the focus from raising awareness to changing behaviour through interventions, particularly for groups at high risk of contracting and spreading HIV;
2. To support decentralization of service delivery to the State and Municipalities and a new facilitating role for National AIDS Control Organization. Program delivery would be flexible, evidence-based, participatory and to rely on local programme implementation plans;
3. To protect human rights by encouraging voluntary counseling and testing and discouraging mandatory testing;
4. To support structured and evidence-based annual reviews and ongoing operational research; and
5. To encourage management reforms, such as better managed State level AIDS Control Societies and improved drug and equipment procurement practices. These reforms are proposed with a view to bring about a sense of 'ownership' of the programme among the States, Municipal Corporations, NGOs and other implementing agencies.

Key Objectives

- A. To reduce the spread of HIV infection in India; and
- B. Strengthen India's capacity to respond to HIV/AIDS on a long-term basis.

Project Strategies

- A. Delivery of cost-effective Interventions against HIV/AIDS.
 1. Priority targeted intervention for groups at high risk
 2. Preventive Intervention for the general community
 - a). IEC and awareness campaigns.
 - b). Providing voluntary testing and counseling.
 - c). Reduce transmission by blood transfusion and occupational exposure.
 3. Low cost AIDS care.
- B. Strengthen Capacity

1. Institutional strengthening
 - a). Building implementation capacity at the States and Municipal levels
 - b). Strengthening leadership capacity of NACO
 - c). Expand and improve nationwide STI/HIV/AIDS sentinel surveillance
 - d). Training
 - e). Build capacity for monitoring and evaluation programme activities.
 - f). Increase India's capacity for research on HIV/AIDS
 2. Intersectoral Collaboration
- Procurement Arrangements
Indigenous System of Medicine (ISM)
Monitoring and Evaluation of the Programme
Financial Management System