Mainstreaming HIV/AIDS Program in City Governments

a rapid assessment catalogue of 14 City Governments, India

June 2006

urban health initiative

Prepared by
International City/County Management Association (ICMA) South Asia

ICMA SOUTH ASIA

Prepared for
United States Agency for International Development (USAID)
Family Health International (FHI)

USAID FROM THE AMERICAN PEOPLE

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Impact Implementing AIDS Prevention and Care Project

a unique initiative of USAID cross-cutting Urban programs and Health

International City/County Management Association (ICMA), Washington DC

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International City/County Management Association (ICMA), South Asia

International City/County Management Association South Asia is based in Ahmedabad, India with a mission to professionalize urban management in India and South Asia and to promote, initiate, develop, support, network and strengthen city governments through professional management.

The office has facilitated implementation of ICMA programs in South Asia since 1997. It works with a mission towards professionalizing urban management in India and South Asia. Its objective is to promote, initiate, develop, support, network and strengthen city governments through professional management. It provides services in the fields of Local Government Association development, institutional building and strengthening, training and capacity building, urban reforms, governance, local economic development, monitoring and evaluation, municipal health and international development.

ICMA SA has successfully assisted local government associations and urban local governments not only in India, but also in Sri Lanka, Nepal, Indonesia, Thailand and Afghanistan.

ICMA SA has been a forerunner in bringing innovative ideas to city governments through best practices documentation, conducting national and international study tours/internships, peer to peer learning mechanisms, urban indicators and performance measurement programs. ICMA SA is a repository of best practices/good initiatives that local governments from the region are undertaking across all sectors. ICMA SA also has access to best practices from the US city governments and shares them with practioners from the South Asia region.

ICMA SA has provided technical assistance in formation and operationalization of 12 City managers' associations and through this network it can reach out to more than 1500 urban local governments and their city managers. ICMA can also reach out to more than 8000 members from across the world. ICMA SA brings with it a rare mix of international, national and regional expertise.

It has a multi-disciplinary team of professionals and advisors who have worked with city governments at close quarters and hence understand the real problems and issues that challenge cities. ICMA SA's full time team of 12 professionals is based at its offices at Ahmedabad and field offices at Cuddalore and Nagapattinam while it has more than 100 experts and city practioners from various sectors -on their advisory panel.

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Manvita Baradi
Director
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CONTENTS

INTRODUCTION TO THE PROGRAM

HIV/AIDS is more than just a health issue. Addressing HIV/AIDS needs political leadership to mobilize resources in a coordinated way across a broad range of fields. Partnerships need to extend beyond government to the private sector, civil society and community-based organizations to ensure an effective response to the disease and its impact.

The HIV/AIDS Challenge to Our Cities

In 1986, HIV was diagnosed in India for the first time in the State of Tamil Nadu and has since been reported in all States and Union Territories in India. India has the second largest absolute number of HIV infections in the world, following South Africa. With an estimated 5.134 million people living with HIV in the adult population (15-49 years) in 2004, India accounts for almost 13% of the global HIV prevalence. Three quarters of current measured HIV/AIDS cases are concentrated in the urban settings of only five states: Andhra Pradesh, Karnataka, Maharashtra, Manipur, and Tamil Nadu[1].

As more citizens migrate from the rural areas to find work, cities have become the epicenters for the spread of HIV/AIDS. This is due to high population density, the presence of transient populations centered in transportation hubs, and the existence of large groups of vulnerable persons (e.g. sex workers, unemployed youth, migrant labor, drug users, street children). In addition to the affect HIV/AIDS has on the lives of individuals and communities, it also has the potential to undermine local Governments. The resources needed to combat and treat HIV/AIDS have a profound impact on health and human resources, undermining the capacity of local governments to carry out their core functions of local service delivery (particularly to the poor).

Along with State AIDS Control Society, national and international NGOs, CBOs as well as private business initiatives are increasingly working towards improving general awareness on HIV/AIDS issues. City governments are a critical (but underutilized) partner central to a pragmatic and effective response towards combating HIV AIDS. Indeed, it is clear that city governments with their stong ties to local communities, should play a key role in the fight against HIV/AIDS. City governments also have a mandate to ensure healthy cities, public safety and sustainable communities..

Role of City Governments

Studies suggest that the most effective prevention approach for HIV/AIDS may be closely linked to how openly and honestly the threat of HIV/AIDS is addressed in local communities. Elected officials have the ability to shape locally accepted HIV/AIDS strategies by using their position and knowledge of the communities they represent. Local government officials often have a greater ability to fight the stigma associated with the disease and can facilitate open community discussions about the real/immediate impacts of HIV/AIDS.

City governments have the mandate, mechanisms and infrastructure to deliver HIV/AIDS prevention programs. Primary health, slum up-gradation and poverty alleviation are obligatory and complementary functions of city governments in India, which are equipped with the necessary staffing, facilities and equipment. Along with their ongoing health care and community development programs, the government also has the experience to work with local communities and integrate specific health programs including pulse polio, malaria and tuberculosis eradication.

[1] Source: UNAIDS India – Report on “HIV Epidemic in India”.

Documentation and dissemination of successful practices can improve the ability of city governments in India to respond to HIV/AIDS. City governments, with successful HIV/AIDS programs can transfer that knowledge and experience to other local governments, so that similar initiatives can be replicated. By sharing their experiences, city governments have a greater capacity to increase their response to HIV/AIDS, thus improving the quality of life for their citizenry.

About the Program

Building on USAID's urban development and local Governments strategies, The International City/County Management Association (ICMA) South Asia, in partnership with the Family Health international (FHI) and with funding from USAID, is documenting and compiling these innovative practices to integrate HIV/AIDS prevention strategies' into their agenda. This is the first attempt by USAID to undertake such a cross-sectoral study.

In order to identify good initiatives, ICMA-SA conducted a rapid assessment of 14 cities and prepared an inventory of city initiatives in the prevention of HIV/AIDS. This assessment report provides a snapshot of those initiatives and local government responses to HIV/AIDS. Information was collected through the city governments, which were contacted by phone, e-mail and through in-person site visits. Contacts were also established with the assistance of City Managers' Associations (CMAs) from the states of Karnataka, Madhya Pradesh, Rajasthan, and West Bengal.

Out of 23 cities contacted by phone and e-mail, 14 responded and provided information on their HIV/AIDS programs. These responses are documented in this Rapid Assessment Report. The narratives and assessments for the cities varies depending upon the extent of HIV/AIDS programs. In some cities, the HIV/AIDS responses have been comprehensive, while in other cities, HIV/AIDS programs are still in the initial phases of development. These case studies were sent back to the respective cities for validation of the write up and their comments and suggestions were incorporated.

In addition to the Rapid Assessment Report, ICMA, in collaboration with FHI and through funding from USAID, facilitated a working partnership between Ahmedabad and Visakhapatnam Municipal (selected as "host" and "learner" cities respectively). Ahmedabad has initiated successful HIV/AIDS programs, while Visakhapatnam CDS has identified HIV/AIDS as an emerging problem and has demonstrated a willingness and interest in working towards integrating HIV/AIDS prevention in city programs.

Ahmedabad and Visakhapatnam have signed a "Declaration for Cooperation," have developed a technical Action Plan for specific HIV/AIDS projects and begun to implement initiatives through a cooperative effort of professional staff, elected officials and respective State AIDS Control Societies (SACS).

Through this partnership, Visakhapatnam will bridge ongoing interventions with stakeholders to achieve better multi-stakeholder coordination among the port trust, Andhra Pradesh State AIDS Control Society (APSACS) and Non Governmental Organizations (NGOs).

The key outcomes of the partnership are:

- Constitution of an AIDS Control Society within GVMC with deputed staff and office space.
- AMC-ACS committed its technical expertise and resources for training VACS staff
- APSACS, and 2 NGOs committed manpower & technical assistance to VACS
- GVMC conducted training on Syndromic Case Management for all its medical officers
- GVMC conducted training on HIV/AIDS for its sanitary workers.

This “Rapid Assessment Report” is the first phase of the program. This report does not attempt to heavily detail all of the initiatives, but provides a summary of city government interventions in HIV/AIDS. Selected initiatives out of four cities, viz; Ahmedabad, Surat , Mumbai and Chennai will be documented comprehensively in a separate best practices /Good initiatives catalogue (the good initiative documentation format has been given below), which will be finalized and disseminated in the second phase of the project.

“Good initiatives” are defined as initiatives that have a tangible impact on improving people's quality of life and living environment and are proven to be sustainable in their economic, environmental, social and cultural components. Such initiatives should have a lasting effect on policy and decision-making, use resources and management systems effectively and result in partnerships between the public, private and civic sectors of the society, that are socially, culturally, economically and environmentally sustainable.

ICMA-SA has been involved in documenting Best Practices/Good Initiatives since 1999 . It has also published a manual for documenting best practices and a Best Practice Catalogue in urban management practices. (www.icma-southasia.org/BP_Best PracticeDocumentation.html)

ICMA SA has prepared a 15 minute video film on the partnership process. It is our hope that this will motivate other city governments to undertake similar activities in their constituencies. This video could be available from ICMA SA office on request.

GOOD INITIATIVES DOCUMENTATION FORMAT

The national and international community has adopted a common reporting format for documenting and disseminating good initiatives. ICMA SA has used the following questions to guide documentation efforts:

1. Situation before the initiative began

- What were the issues/problems?
- How were they addressed?
- What was the economic, environmental and social context of the location

2. What was the motivation for developing the initiative?

- How were stakeholders involved?
- How were priorities of the initiative set and refined?

3. What was the innovation?

- What actions were taken?
- How were the action chosen?
- How was political support & resources mobilized?
- Who assumed leadership roles in formulating the objectives?
- Who assumed leadership roles in implementing the initiative?
- What problems were faced during the implementation of the initiative?
- How were they overcome?
- How the innovation has helped the local body?

4. Assessment of the results achieved

- Were the objective described (in –3-) above realized?
- How were your results measured? Quantitatively? Qualitatively?
- Were indicators used to measure results/impact? Which ones? How?
- Was better coordination and integration achieved?
- What impact has the practice had on local/national policies/strategies?
- What impact has the initiative had on institutional capacity at the national, sub-national and local levels?
- What impact has the initiative had on local or national decision-making, including the institutionalization of partnerships?
- Were there any special opportunities for change?
- How were these opportunities taken advantage of?
- What impact did the initiative have on the use and allocation of human, technical and financial resources at the local/national level?
- What impact has the initiative had on changing people's attitudes and behavior?

5. Sustainability

- How was the integration of the social, economic, environmental and cultural elements of sustainability achieved?
- How were resources leveraged?
- How was cost-recovery employed?
- How is dependence on external resources addressed?
- Is there a time-line for achieving self-sufficiency?
- How the social, economic, environmental and cultural sustainability achieved

6. Lessons learned

- What were the lessons learned from the initiatives? How have the lessons learned been built in to the system for the sustainability of the initiative taken?

7. Transferability

- What can others learn from your initiative?
- Has your initiative been replicated / adapted elsewhere? Where? By whom?
- What is the potential for transferring all or parts of your initiative?

LIST OF ACRONYMS

AACS	Ahmedabad AIDS Control Society
AIDS	Acquired Immuno-Deficiency Syndrome
AMC	Ahmedabad Municipal Corporation
APSACS	Andhra Pradesh AIDS Control Society
ARV	Anti Retro Viral
ANC	Antenatal Care
BB	Blood Bank
BMP	Bangalore Mahanagarpalika
BCC	Behavior Change Communication
BCSU	Blood Components Separation Units
BMC	Brihanmumbai Municipal Corporation
CAPACS	Corporation AIDS Prevention and Control Society
CDC-GAP	United State Centres for Diseases Control and Prevention – Global AIDS Program
CHC	Community Health Centres
CINI	Child in Need Institute
CSW	Commercial Sex Workers
CMIS	Central Management Information System
DD	Doordarshan
DFID	Department of International Development
FF	Freedom Foundation
GSACS	Gujarat State AIDS Control Society
GSNP	Gujarat State Network of People Living with HIV/AIDS
GVMC	Greater Visakhapatnam Municipal Corporation
KSACS	Kerala State AIDS Control Society
KGH	King George Hospital
KMC	Kolkata Municipal Corporation
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HIV	Human Immuno – Deficiency Virus

HRB	High Risk Behavior
HRG	High Risk Group
ICDS	Integrated Child Development Scheme
ICHAP	India Canada Collaborative HIV/AIDS Project
ICMA-SA	International City/County Management Association-South Asia
IEC	Information, Education and Communication
IMC	Indore Municipal Corporation
IVRS	Inter Active Voice Response System
MCGM	Municipal Corporation of Greater Mumbai
MDSACS	Maharashtra District State AIDS Control Society
MIS	Management Information System
MSM	Men having sex with men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NARI	National AIDS Research Institute
NASTAD	United States National Alliance for State and Territorial AIDS Directors
NCC	National Cadet Corps
NGO	Non Governmental Organization
NSS	National Social Services
OLH	Operation Lighthouse
PACC	Pune AIDS Control Cell
PLWHA	People living with HIV/AIDS
PHC	Public Health Center
PPTCT	Prevention of Parents to Child Transmission
PSI	Population Service International
PSU	Project Support Unit
PSH	Partnership for Sexual Health
RTI	Respiratory Tract Infection
RNTCP	Revised National Tuberculosis Program

SHIG	Sexual Health Information Gallery
SHRC	Sexual Health Resource Center
STD	Sexually transmitted Diseases
STI	Sexually transmitted Infection
TI	Targeted Intervention
TMC	Thiruvananthapuram Municipal Corporation
UHC	Urban Health Clinic
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
USAID	U.S. Agency for International Development
UTs	Union Territories
VACC	Vadodara AIDS Control Cell
VCTC	Voluntary Counseling and Testing Center
VGH	Victoria General Hospital
VSIP	Visakhapatnam Slum Improvement Project
VPT	Visakhapatnam Port Trust
WBSACS	West Bengal State AIDS Control Society
YRSHR	Youth People's Reproductive and Sexual Health and Rights

DEFINITIONS

1. **AIDS - Acquired Immune Deficiency Syndrome** - A disease caused by the human immunodeficiency virus (HIV). The disease involves weakening of the immune system until it is unable to fight opportunistic infections.
2. **ARV - Antiretroviral drugs** are medications for the treatment of infection by retroviruses, such as HIV. In this document, ARV is used in the context of HIV/AIDS.
3. **ANC – Antenatal Care,** care of pregnant women
4. **Blood Safety**- Blood safety ensures the provision of safe, adequate and quality blood and blood products for all patients requiring transfusion. There is a high risk (almost 100%) of acquiring HIV through transfusion of infected blood and blood products.
5. **BCC - Behavior Change Communication** (BCC) is part of an integrated, multilevel, interactive process with communities aimed at developing tailored messages and approaches using a variety of communication channels. BCC aims to foster positive behavior; promote and sustain individual, community, and societal behavior change; and maintain appropriate behavior.
6. **City Manager:** A city manager is defined as a person in any urban local body, urban development authority, institutions involved in research, training for urban management, a NGO or a corporate in urban sector.
7. **City Managers' Associations:** These are professional membership based associations of city managers and they mostly work with the objectives of information collection and dissemination, capacity building and training and advocacy.
8. **HIV - Human Immunodeficiency Virus;** the virus that causes AIDS.
9. **HRG – High risk group**, High risk group can be defined as a group of persons frequently indulging in behavior promoting HIV transmission. Sharing drug needles or syringes, Having sexual contact, including oral, with an infected person without using a condom, Having sexual contact with someone whose HIV status is unknown. E.g., Injecting Drug Users, Commercial Sex Workers, men having sex with men, truckers etc.
10. **Opportunistic Infection -** Opportunistic infections are infections caused by organisms that usually do not cause disease in a person with a healthy immune system, but can affect people with a poorly functioning or suppressed immune system.
11. **Peer Educator** - The term 'peer' refers to "one that is of equal standing with another; one belonging to the same societal group, especially based on age, grade or status" (UNAIDS 1999). Peer Education is a very effective medium for interpersonal communication.
12. **RTI -** any infection of the respiratory tract or reproductive tract. This document would mostly refer to the latter.
13. **STD** - Those diseases that are communicated to another person via sexual contact
14. **STI** - Those infections that are communicated to another person via sexual contact. Infection happens before the disease starts i.e., if the infection is prevented, the disease would not occur.

1

AHMEDABAD MUNICIPAL CORPORATION
AIDS CONTROL SOCIETY

1.1 Situation before the Initiative

Ahmedabad, with a population of 4.5 million has, like many other cities in India, been undergoing rapid urbanization. Ahmedabad is the largest industrial and commercial capital of the state and was developed from the establishment of textile mills in 1857. The textile industry was the backbone of Ahmedabad economy until two decades ago. Today, Ahmedabad is a major industrial and financial city that accounts for approximately 16% of total productivity of the state.

Rapid economic growth and ample opportunities for employment in Ahmedabad continues to attract migration from rural areas and other cities in India. Shortages of housing have led to the marginalization of communities and to the creation of urban slums.

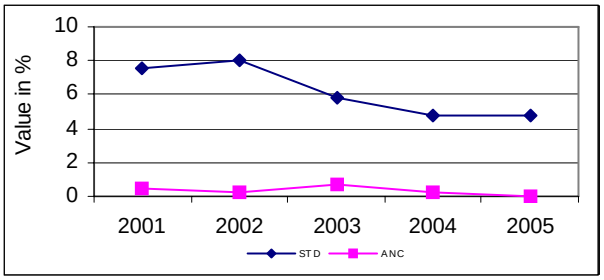
These depressed settings, long highways and traffic corridors have been identified as one of the factors for a high prevalence of HIV in Ahmedabad.

The first case of HIV was detected in Ahmedabad as early as 1986 and the HIV/AIDS Program was implemented in the city as a part of National AIDS Control Program (NACP)-1 and NACP-2.

HIV Prevalence

HIV Prevalence rate (%) among STD and ANC in Ahmedabad

	2001	2002	2003	2004	2005
STD	7.6	8	5.86	4.8	4.8
ANC	0.5	0.25	0.75	0.25	0.00



As of August 2005, there were 1438 HIV and 725 AIDS cases registered through the general hospitals. Sentinel surveillance HIV prevalence data from last four years from among Antenatal Care Clinic (ANC) attendees and Sexually Transmitted Diseases (STD) clinic attendees is as follows as shown in above table and graph: The trend observed is that of a decline in the prevalence rate of ANC and STD clinic attendees over a half decade (2001-2005) period.

HIV Prevalence (%) among CSWs[1]

Year	HIV
2000	**11.7**
2003	**13.2**
2005	**3.2**

Sexually Transmitted Infections (STI)/HIV prevalence studies were carried out with Commercial Sex Workers (CSWs) in 2000, 2003 and 2005 and Men having sex with men (MSM) in 2004. While there

[1]Source: Data provided by AMC ACS

was a significant reduction in STIs among CSWs as observed in results of both the studies (Table 1.2), HIV prevalence among CSWs showed a plateau of 11.7% in 2000 and 13.2% in 2003. HIV testing was carried out among large number (1600) of CSWs as a part of 'Sakhi Swaasthya Abhiyan',

General Health Check Up Drive in 2005 showed a significantly low HIV prevalence of 3.2%. HIV prevalence among MSM was 14%.

1.2 Formation of Ahmedabad Municipal Corporation AIDS Control Society and its activities – A Brief

In 1998, recognizing HIV/AIDS as one of the important issues to be addressed at city government level, the Ahmedabad Municipal Corporation took the initiative and expressed to establish a city level program with a city level government body just like the State AIDS Control Societies in different states. Reciprocating to the initiative shown by the city government, the Department for International Development (DFID) and National AIDS Control Organization (NACO) (*Refer Appendix 2)* extended support for the establishment of Ahmedabad Municipal Corporation AIDS Control Society (AMC ACS) as one of the first city level AIDS Control Societies of the country. This was the very first step towards addressing HIV/AIDS in a systematic and planned way at the city government level.

1.2.1 Aim and Objectives

Aim

The AIDS Control Society coordinates with the local government, the state government and donor organizations in developing prevention strategies for HIV/AIDS.

Objective

AMC ACS works towards achieving the following objectives:

1) Prevention of HIV/AIDS among high risk behavior groups;
2) Prevention of HIV/AIDS among low risk groups;
3) Provision of care and support for the people living with HIV/AIDS (PLWHA);
4) Intersectoral collaboration for capacity building and training;
5) Capacity Building of stakeholders in managing HIV/AIDS programs;

The AMC ACS began by collecting baseline information so as to better understand ground realities and actual prevalence rates. AMC ACS undertook surveys to identify high risk behavior (HRB) groups, sexual behavior surveys and needs assessment studies of various vulnerable groups that include diamond industry workers, autorickshaw drivers, hotel boys, street children and adults, migrant populations and other risk groups. With the help of a network of partner NGOs which grew from 3 to 25 in last seven years, AMC ACS was able to identify high risk behavior groups and vulnerable bridge populations.

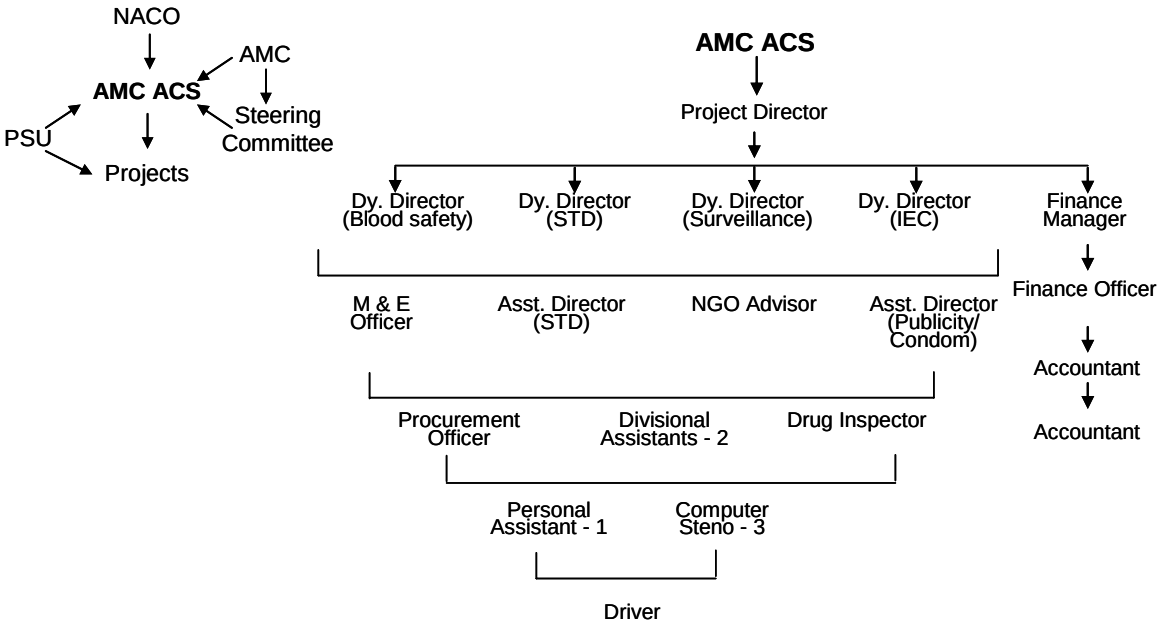
1.3 Description of the Initiative

1.3.1 The Stakeholders

In response to the growing prevalence of HIV in Ahmedabad, Mr.Keshav Verma IAS, former Municipal Commissioner and Dr. Laxman Malodia from AMC took the initiative to establish the Ahmedabad AIDS Control Society (AMC ACS) in 1998.

A steering committee was established and headed by the Municipal Commissioner, with Deputy Municipal Commissioner (Health) and Medical Officer, Health; Project Director, AMC ACS and couple of NGO representatives as members. Today, the committee also includes representatives from community groups like PLHA network representatives and the Team Leader, Project Support Unit (PSU).

Organizational structure of AMC ACS



1.3.2 Role of the Stakeholders

The local government is responsible for making decisions on strategic issues, including the selection of agencies for funding projects, completion of annual plans and forecasting of future plans. NGOs solicit and manage funds from the AMC ACS for implementation of HIV/AIDS projects and work at the grass root level with target intervention groups.

In order to provide technical support to the AMC ACS, the Project Support Unit (PSU) was established in 2005. PSU is managed by Raman Development Consultants, an external professional agency. In addition to providing technical support to AMC ACS, PSU is also responsible for management of funds, selection of CBOs and NGOs, support of target intervention populations and; acts as a media manager for the AMC ACS.

1.4 Programs and Results achieved

The various programs undertaken by AMC ACS follow below. Each of the programs is described as case studies, with notable achievements.

1.4.1 Targeted Interventions (TI)

Targeted interventions (TI) include city-wide Commercial Sex Workers (CSW) project, Men having sex with men (MSM) project, street children project and various migrant and bridge group projects. The targeted interventions address four major components which are Behavior Change Communication (BCC), Condom Promotion, Sexually Transmitted Infections (STI) Treatment and Enabling Environment.

The society follows the strategies (presented in Annexure 2) which have been developed by NACO. TI projects have developed a huge service infrastructure throughout the city for the prevention of STIs, provision of condoms and outreach services.

Results till March, 2006[2]:

Services	**No.**
Project Based STD Clinic sites established	180
Condom outlets established	1090
Condoms distributed since 2001	34.2 millions
STI cases treated since 2001	108.3 thousand
Counseling provided to individuals with high risk behavior since 2001	268.5 thousand
No. of trained peer educators currently associated with program	650

1.4.1.1 Addressing Migrants

AMC ACS runs 21 TI projects working with different migrant groups in different parts of the city. Approximately 0.2 million migrants are covered through these projects. Apart from these, with funding support from the India Canada Collaborative HIV/AIDS Project (ICHAP), AMC ACS started the cross border migration project to reach out to migrants from Rajasthan. The project was started after a rapid need assessment study carried out by an external agency. The project began in Piplaj, Rajasthan in October 2004, and targeted approximately 5000 single migrant workers from Rajasthan. The ICHAP project aims to target migrants at the site of origin, which resulted in the initiation of projects in the two major destination cities of Ahmedabad and Mumbai.

Results: The program currently works with more than 0.2 million migrants across the city. Ahmedabad has been the first in India to initiate a cross border migration project for HIV/AIDS.

1.4.1.2 Sexually Transmitted Diseases (STD) Control

In addition to the project-based clinics, AMC ACS supports Sexually Transmitted Diseases **(**STD**)** clinics in general hospitals. The STD clinics in the government hospitals refer cases to the counseling centers and the VCTCs.

Results: There are approximately 180 clinics run in the communities through the TI projects and four STD clinics in the general hospitals.

1.4.1.3 Condom Promotion

Social marketing of condoms has begun and gradually increasing. Condoms are distributed through traditional and non-traditional channels by NGO workers, peer educators, petty shops, clinics, paan shops, tea shops, restaurants, hotels, guest houses, public lavatories, gardens, grocery shops, vegetable vendors and auto drivers.

Results: There are approximately 1090 condom outlets in the city. Condom distribution has reached almost 10 million a year.

1.4.2 School AIDS Education Program

AMC ACS runs School AIDS Education Program (SAEP) supported by NACO with 440 schools of the city. The program is implemented among middle and higher secondary students of the 9th and 11th

[2] Source: Data provided by AMC ACS

grade class. This program is implemented through 12 NGO partners. Role-playing, debates, discussions and question boxes are used as educational tools to deliver messages.
Results: The program reaches students in 440 schools.

1.4.3 Tele Counseling Services

Since 1999, AMC ACS has been providing toll free telephone information support services for the city. The automatic interactive voice response system (IVRS) is available in Gujarati, Hindi and English 24 hours a day.

Results: Tele counseling services receive approximately 250-300 calls per day. Total calls received so far by the help line have crossed 0.75 million. This is the country's highest call receiving system. All IEC/BCC material published and disseminated by AMC ACS includes the telephone help line number. The phone number is also highlighted on city transport buses that are operated by the Ahmedabad Municipal Transport Services (AMTS).

1.4.4 Blood Safety

AMC ACS currently supports 9 blood banks (refer table below) including private blood banks (BB) as well as those run by the government general hospitals. The blood bank staff are trained and equipped with safe methods of collecting and screening blood.

AMC ACS Blood Bank Detail[3]

Year	No. of Blood Banks	Voluntary	Replace-ment	Total Units	HIV +ve out of Voluntary	HIV +ve out of Replace ment	Total
Jan. to Dec.2001	8	16901	47067	63968	58	305	363
Jan. to Dec.2002	9	52562	38225	90787	175	181	356
Jan. to Dec.2003	9	64009	44378	108387	252	184	436
Jan. to Dec.2004	9	64984	46753	111737	306	178	484
Jan. to Dec.2005	9	74860	41619	116479	270	131	401
Jan. to Mar.2006	9	20270	8442	28712	37	25	62
Total	**9**	**293586**	**226484**	**520070**	**1098**	**1004**	**2102**

AMC ACS also operates Blood Components Separation Units (BCSU) in two hospitals and Zonal Blood Testing Center in one hospital. A zonal blood-testing center has been established in the Civil Hospital which is run by the AMC.

Results: The blood screening centers screen 100,000 units of donated blood per year.

[3] Source: Data provided by AMC ACS

1.4.5 Voluntary Counseling and Testing Centers (VCTC)

AMC ACS VCTC detail[4]

Year	Number of VCTC	Persons tested - Male	Persons tested - Female	Total Persons tested	Positive Persons	%
Jan. to Dec.2002	3	3615	1728	5343	331	6.19
Jan. to Dec.2003	4	4366	2012	6378	467	7.32
Jan. to Dec.2004	4	5106	2540	7646	560	7.32
Jan. to Dec.2005	4	5996	3034	9030	896	9.92
Jan. to Mar.2006	4	2126	1120	3246	500	15.4
Total	**4**	**21209**	**10434**	**31643**	**2954**	**9.34**

Four VCTCs (Table 1.4) have been set up in four general hospitals which are staffed by two trained counselors and HIV testing facilities. The counselors provide pre-test and post-test counseling, information and support for HIV/AIDS-related issues.

Results: AMC ACS currently manages four VCTCs.

1.4.6 Prevention of Parent to Child Transmission (PPTCT)

The Prevention of Parent to Child Transmission (PPTCT) clinics have been set up to provide services such as HIV testing, information on HIV/AIDS, counseling and provision of required medicines to infected mothers.

Results: Two PPTCT clinics were established in Ahmedabad in 2003. To strengthen and expand PPTCT services in Ahmedabad, the AMC ACS opened two additional PPTCT clinics in L.G. General Hospital and Shardaben Hospital, in October 2005.

1.4.7 Opportunistic Infections

Free medicines are provided to four general hospitals in the city to curb opportunistic infections which are infections caused by organisms that usually do not cause disease in a person with a healthy immune system, but can affect people with a poorly functioning or suppressed immune system..

Results: To date, 1500 positive persons have taken advantage of and visited this facility.

1.4.8 Information Education and Communication (IEC) and Social Mobilization

AMC ACS continues efforts to provide communication tools to the task force to strengthen the fight against HIV/AIDS. The **Information Education and Communication** (IEC)/Behavior Change Communication (BCC) strategy includes:

[4] Source: Data provided by AMC ACS

- Community awareness and sensitization through folk media, street plays, event celebrations and festival based interventions (one of the innovative approaches started from 2004).

  Results: In 2005, during the AIDS Day celebration (held annually on December 1), hoardings/advertisements were displayed in 25 public places.

- IEC/BCC material development with specific messages such as flip charts, pamphlets, posters, STD palmtop charts, condom use method palmtop charts and syndromic management charts. All materials are published in Gujarati.

  Results: In response to demand from target groups outside of Gujarat, AMC ACS developed materials in Hindi.

- Outreach to college youths through an intensive 360° IEC campaign. Outreach is done during special celebration days including Friendship Day, Valentines Day, and Youth Festivals in the colleges. Coverage of National Cadet Corps (NCC) cadets and (National Service Scheme) NSS volunteers through IEC distribution, exhibitions and lectures has also been done.

- *Creating a mascot-'Nirodhilal':* AMC ACS created a brand ambassador called 'Nirodhilal' which is a 'condom' personified used to help people understand HIV/AIDS prevention and to stay safe from Sexually Transmitted Infection (STI)/HIV infections.

- *Participatory Live BCC Development Initiatives:* To address the issue of behavior change among different high-risk groups, AMC ACS organized live BCC mechanisms and tool development workshops where participants identified the most difficult challenges and behavioral deterrence issues, as well as developed messages and tools to address the same.

  Results: Development of nine films and an audio cassette with songs that carried messages on different HIV/AIDS issues.

1.4.9 Inter Sectoral Collaboration

The AMC ACS initiated programs for better collaboration among various sectors to sensitize them on the HIV/AIDS issues.

Results: Police Department – Training programs, IEC, Advocacy. Condom depots were formed at 21 police stations/*chowkies* and awareness programs were implemented in all the police stations of the city. The Police Commissioner Office issued a circular to all its police stations and police *chowkies* to conduct programs on HIV/AIDS, in coordination with the AMC ACS, and directed all policemen to participate in the program.

Linkages have been established with Confederation of Indian Industries (CII) for working with industries for awareness, sensitization and increasing involvement of industries in HIV/AIDS.

Results: MoU with CII wherein HIV/AIDS program will be initiated in about 45 medium and large industries. A group for conducting performances communicating HIV/AIDS messages has been trained and developed from among the People living with HIV/AIDS (PLWHA) network members.

A partnership was created with the Ahmedabad Management Association (AMA) for management training of project officers of Targeted Intervention (TI) projects.

AMC ACS conducts regular training programs for students of clinical psychology at a local Institute in the city.

1.4.10 Community Development Initiatives

The community is a key stakeholder and plays a significant role in the success of the programs.

Results: Sakhijyot a collective of sex workers has been formed and plays a significant role in the festival based interventions with the help of ACS. Their activities also include support to TI programs.

Aadhar Charitable Trust (People Living with HIV Aids (PLWHA) network): the formation of Adhar was supported by Ahmedabad AIDS Control Society and the Project Support Unit. There are currently more than 500 members.

Men having sex with men (MSM) Groups: AMC ACS supported formation of savings and credit societies among the MSM groups. The societies have already started some income generation activities like festival lamp selling, spices selling, etc. Eight such societies have been formed.

NGO Partners Forum: AMC ACS is supporting the NGO Partners' Forum comprising of NGOs implementing TI projects in the city.

1.4.11 Overall Performance of City HIV Program under NACP- 2

The Ahmedabad program is considered a model for replication in India due to the following reasons:

AMC ACS facilitated several independent studies which reinforced the effectiveness of the city HIV programs.

i. Prevalence and trends of STD and HIV among Female Sex Workers of Ahmedabad
   Sexual Health Resource Center (SHRC), data shows significant improvement of all qualitative indicators, which include but are not limited to a lower proportion of HIV among females in younger age groups, higher condom usage and decreased rates of partner changes during the period 2000-2003.

ii. Cost Effectiveness study

   In 2005, a study (draft conclusions) carried out by the London School of Hygiene and Tropical Medicine estimated 841 averted HIV-infections among sex workers and 5283 averted HIV-infections among clients. The study concluded that the intervention in Ahmedabad lowered the infection rate by 53%.

1.5 Sustainability

AMC ACS programs in HIV/AIDS prevention are sustainable for the following reasons:

AMC ACS has adopted a "Twin Track Strategy" for optimum coverage of High Risk Groups (HRG) and bridge groups. This strategy in practice is having city wide coverage through single intervention for core groups (CSWs and MSM) and special groups (street children, hotel boys and auto drivers) while area based coverage focusing on different pockets identified as risky or vulnerable by different projects. There are 21 projects covering almost 90% of city area working with various bridge groups like construction workers, vegetable vendors, domestic workers, rag pickers, casual laborers, petty workers, etc. This strategy basically ensures better coordination among different projects and optimum coverage.

AMC ACS has been focusing on community development initiatives for sustainability. AMC ACS supports initiatives for development of local community structures through technical support and training.

1.5.1 Monitoring and Evaluation

Monthly Coordination Meetings: Communication is a key to programs involving varied service providers. Hence, regular monthly coordination meetings were held with the key service providers in the HIV prevention program that include but are not limited to TI implementing NGOs, VCTC and hospital based STD clinics, PPTCT and PLHA network.

MIS: Two systems – Central Management Information System (CMIS) by NACO and a tailor made MIS by AMC ACS are being followed by AMC ACS for monitoring and data collection.

Regular Year-end External Evaluation of TI Projects: In order to ensure that the program was being evaluated across its performance indicators and to achieve the right results, AMC ACS continued to conduct year-end external evaluations of all TI implementing NGOs.

1.6 Future strategies

AMC ACS has identified the need for public-private partnerships for prevention programs in HIV/AIDS Private partners have a role to play in the economy and can influence people in the health care choices they make. Corporations all over the world and in India are realizing the importance of their corporate social responsibility and the need to design policies and implement them to care for their workforce. With this growing trend, AMC ACS will be supporting public-private partnerships to increase support for HIV/ AIDS programs.

Ahmedabad HIV/AIDS program is in process of being developed as a model program site by DFID for other states and cities. One of the future plans of the AMC ACS is to develop Ahmedabad as a Resource City as far as HIV/AIDS program is concerned.

Focus areas of Ahmedabad program in the coming years will be youth development, community structures development, creating rights based environments, addressing structural determinants of HIV/AIDS, creating linkages for sustainability, enhance proactive involvement of private sector, develop local resources.

2

PROJECT COORDINATION OFFICE SURAT MUNICIPAL CORPORATION

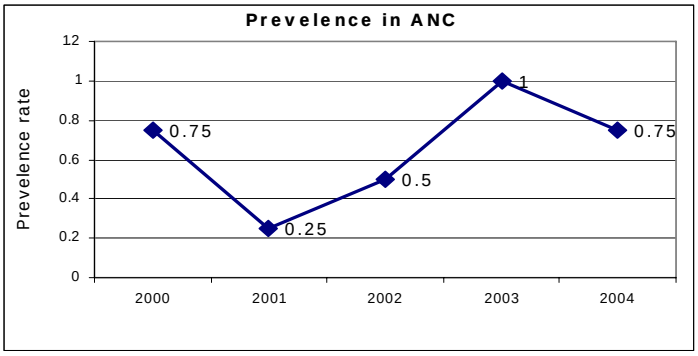
2.1 Situation before the Initiative

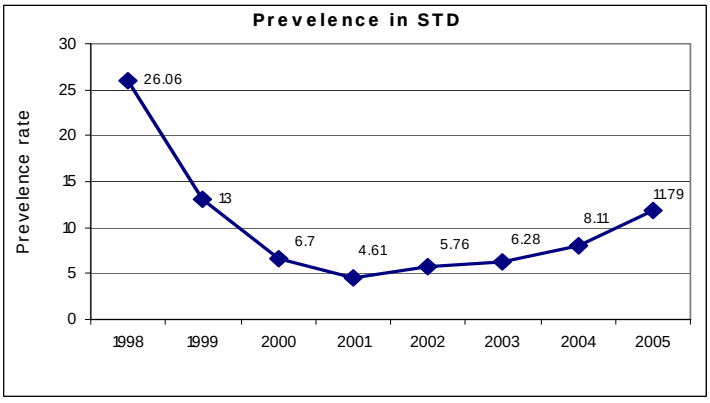
In 1994 the outbreak of plague threatened Surat's ability to provide a viable, safe living environment for its citizens. Surat was considered to be one of the dirtiest cities in India which created an exodus of people and huge economic losses. A large population of the migrant labor force lived under terrible slum conditions with no infrastructure for civic services and utilities that were grossly inadequate. Surat Municipal Corporation (SMC) was unable to deliver adequate services or meet the needs of its citizens.

Faced with this mass exodus and in response to the epidemic, Surat Municipal Corporation (SMC) worked hard to transform itself from a dismal performer to the second cleanest city in India.
Improved health and municipal governments became the primary focus for SMC. The municipal corporation began implementing health programs to address the outbreak of Filaria, Malaria, Polio and other diseases, which included the implementation of the Revised National Tuberculosis Program (RNTCP) and Integrated Child Development Scheme (ICDS).

As a result, Surat has experienced a high rate of population growth. Per the 2001 Census, the city has the highest population growth rate (85%) in the country.

HIV Prevalence Rate (%)among ANC and STD in Surat





Unfortunately, Surat's rapid urbanization, industrialization and infrastructure development created an increase in HIV prevalence. According to the Sentinel Survey, which was conducted by Gujarat State AIDS Control Society (GSACS), the graphs show the trend of HIV prevalence rate in cases of Antenatal Care (ANC) and Sexually Transmitted Diseases (STD). The graph shows an immediate decline in the HIV prevalence rate in STD attendees in the late 90s with a marginal increase in the early next decade, however in case of HIV prevalence of ANC attendees, there was a steep increase from 2001-03 and the a decline in the following year.

Some factors that add to the increase in HIV prevalence rate of Surat are presence of Red light areas, busy ports and traffic corridors, over crowded prison and large number of street children.

2.2 Formation of Surat Municipal Corporation Project Coordination Office (SMC PCO) – A Brief

In 1997, SMC began serving as the nodal agency for PCO's Partnership in National AIDS Control Program – II (NACP-II). The Department for International Development (DFID), through The National AIDS Control Organization (NACO) provided funding for the project. This funding reaches SMC through the Gujarat State AIDS Control Society (GSACS).

SMC is working as Nodal Agency and at the same time as one of the partner organizations of NACP II project. The NACP-II project is well integrated with its existing health set up consisting 28 urban health centers (UHC) and maternity homes and a medical colleges and hospital. The project is known as 'Sexually Transmitted Diseases (STD) Care Project'. SMC has also deputed one counselor in each of the Urban Health Centre (UHC).

2.2.1 Aims and Objectives

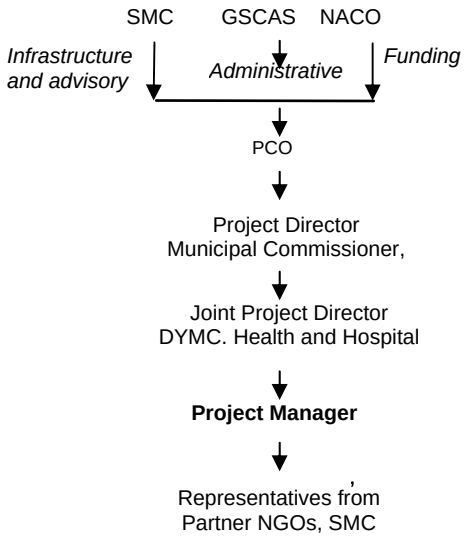
SMC PCO aims to reduce the spread of STD/HIV in high risk groups through a managed network of partners.

The following are the strategies designed to meet the above objective:

- Facilitating the expansion of NACP-II project activities to reach vulnerable/High risk behavior groups in Surat;
- Identifying capacity building needs of the partners;
- To establish Management Information System (MIS) and records keeping for monitoring;
- Establishing a social marketing strategy for condom promotion for the city and district through a managed network of partners;
- Supporting the partners to develop and improve their Behavior Change Communication (BCC) strategy;
- Developing a network of community support system for the State Health Program (SHP);
- Documenting of SMC-PCO Project.

In 1997, the SMC-PCO cell began its operations with the help of five NGOs. It initiated activities with identification of high risk behavior groups such as sex workers, eunuchs and men having sex with men (MSM) and; bridge populations such as Diamond workers, Prison inmates, migrants, street children, truck drivers, auto rickshaw drivers and hotel workers.

Organizational structure of SMC PCO



2.3 Description of the Initiative

2.3.1 The Stakeholders

SMC designated the Municipal Commissioner as the Project Director and the Deputy Municipal Commissioner, Health and Hospital as the Joint Project Director for PCO.

SMC constituted a PCO with technical staff to be the executive body to implement the project through partner organizations.

The flow chart provides the organizational structure of the SMC-PCO.

2.3.2 Role of the Stakeholders

The Project Director and the Joint Project Director is responsible for administrative matters and making strategic decisions. NGOs receive funding from the SMC through GSACS. These NGOs work with target intervention groups at the grass roots level.

2.4 Programs and Results Achieved

2.4.1 Targeted Interventions

2.4.1.1 Sexually Transmitted Diseases (STD) Control

Urban Health Centers (UHC) have been set up in the urban community development centers as well as in NGO locations. The objective of UHCs are to increase community awareness for the prevention of STD/HIV/AIDS, to provide an early diagnosis and Syndromic management of all STD patients through planned interventions.

The following are STD Control activities:

Urban Health Centers (UHC) based activities

- STD patients are identified and treated by medical officers (passive diagnosis);
- Sexual partner's treatment is carried out;
- Counseling for High Risk Behavior (HRB), STD and HIV is given;
- Motivation for condom usage with demonstration is provided;
- Inter and intra Sectoral coordination is undertaken

Field Based

- Mass awareness meetings are conducted;
- HRB identification is done;
- Advocacy meetings are conducted;
- Condom demonstration and promotion is carried out;
- Alternative safer sex methods are promoted;
- IEC distribution is done;
- National Community health events are observed and include World Health Day, World AIDS Day, Pulse Polio Immunization, National Nutrition Week and International National Womens Day

Sexual Health Services Providers (SHSP) of targeted areas have been trained on Syndromic case management.

Results: This ongoing project began in January 2000. During the extension phase of July 2001, all 24 UHCs were incorporated into the program and cover approximately 316,000 people from the slum population.

2.4.1.2 Condom Promotion

Condoms are distributed through traditional and non-traditional channels such as NGO workers, peer educators, clinics, paan shops, tea shops, restaurants, hotels, guest houses, public lavatories and in gardens.

2.4.1.3 Behavior Change Communication (BCC)

Eliciting behavioral change is a long process that often includes five step approaches wherein individuals and groups increase their overall awareness to create a shift in behavior and to become advocates of change. The BCC Program was undertaken as one of the major component in Targeted Interventions (TIs) to facilitate behavior change and prevent HIV/AIDS.

2.4.2 School AIDS Education Program

The SMC-PCO has been providing education to school students as a part of the Learning Life - School AIDS Education Program. Different types of educational tools have been developed and used for this program including role playing, debates, discussions and question boxes. This program is implemented through 13 NGO partners.

Apart from all the above mentioned programs, SMC-PCO also gives support to GSNP + AIDS care network.

2.4.3 Sexual Health program

Sexual health program focuses on:

- Reproductive health and sexuality education;
- HIV/AIDS prevention program;
- Promoting HIV/AIDS testing and counseling;
- Supporting behavior change process to prevent and contain HIV/AIDS;
- Building capacities of diverse groups to deal with HIV/AIDS;
- Improving existing service delivery system

2.4.4 Gender Equality and Women's Empowerment Program

Women play an important role in HIV/AIDS prevention. Hence an integrated program for women was designed and includes the following:

- Promotion of sexual and reproductive health education and services;
- Capacity building of women;
- Promotion of income generation;
- Legal and awareness activities;
- Ending violence against women;
- Encouraging adult education

2.4.5 Youth Development program

Early awareness of HIV/AIDS can go a long way into prevention. Based on this belief, the Youth Development Program was designed and includes the following:

- Promotion of access to education;
- Reproductive and sexual health education and rights awareness;
- Promotion of gender awareness;
- Promotion of life skills education;
- Increased access to livelihood options

2.4.6 Community based HIV/AIDS Care and Support Program

HIV/AIDS programs should not only focus on prevention strategies but also on access to care, support services and treatment by:

- Encouragement of innovative care structures for those affected by HIV/AIDS including voluntary testing and counseling, peer support, HIV clinics, home and hospital based care, nutritional and economic support;
- Empowerment and involvement of People living with HIV/AIDS (PLWHA)
- Special programs for widows and affected children, advocacy for increased access to medicine and care programs.

2.4.7 Networking

SAHAS, an NGO, is a member of the national *Youth People's Reproductive and Sexual Health and Rights* (YRSHR) network. The initiative helped build capacity for intervention with youths and human rights issues.

Results: An increase in the participation of PLWHA and reduced stigma/discrimination faced by youths has culminated in the facilitation of the first network of PLHA in Gujarat, which has been linked with the national network.

2.4.8 Advocacy

Efforts in the advocacy area at various levels include promotion of sexual health of migrant workers within the diamond industry, empowerment and participation of PLHA in the state, advocacy for young people's sexual and reproductive health and ending gender based violence in society.

Results: Special programs have been developed to focus on providing advocacy for street children and People living with HIV/AIDS (PLWHA).

2.4.9 Public Private Partnership in fighting against AIDS

On May 1, 2004, Reliance, in partnership with PCO, started the Surat HIV/AIDS cell.

The first partnership Tuberculosis (TB) and HIV control center was inaugurated on 1st May 2004, in the Village Mora in Hazira taluka in Surat.

The Reliance TB and HIV control center was initiated through a partnership consisting of The Reliance Ladies club, Lok Vikas Sanstha (the local NGO and targeted intervention Partner), CII

(Confederation of Indian Industries), Gujarat State Network of People Living with HIV/AIDS (GSNP) and The Revised National Tuberculosis Program (RNTCP). Lok Vikas Sanstha has been working with the industrial migrant workers for the prevention of STIs/HIV/AIDS since 2000 in the Hazira area. The local authority of Mora Gram Panchayat provided office space to house this center.

Results: The center is providing Anti-Retroviral (ARV) treatment to 92 patients who are PLWHA and are getting treatment free of costs. The remaining 80 patients are getting treatment at subsidized rates. In the first year of its establishment, almost 190 HIV persons have visited and received treatment from this center.

For selection of patients for ARV, a single window system is implemented. GSNP is one of the partners to this center and they have the responsibility to recommend the PLWHA for ARV treatment.

The center provides ARV treatment free of cost and at subsidized rate, depending on the individuals ability to afford the cost of drugs. The treatment for opportunistic infections, consulting charges, counseling, all the medical tests (including the two important blood count tests for determining HIV immune status (CD4 and CD8)) and Directly Observed Therapy (DOT) for TB is done free of cost at this center. The center provides free transportation facilities to the partners and yoga is taught to the PLHWA group.

The program was renamed on December 26th 2004, as The Private Public Partnership Program with Lok Vikas and United Nations Development Program (UNDP), which are partner organizations.

2.4.10 Coordination

By Monthly Coordination Meeting: Regular by - monthly coordination meetings are conducted in presence of project incharge, NGO representatives and field workers.

2.4.11 Festival and Theme Based Interventions

Festival based interventions – Mass awareness and sensitization campaigns are organized with vulnerable groups. Theme based interventions are carried out through Information, Education and Communication (IEC), inter-personal communications and during events at public gathering places.

2.4.12 Media

Local and national print and electronic media has played a positive role in covering events and activities of partner NGOs. Articles, interviews and case studies on the program have also been published to support the effort.

Print media has been the most effective and thus, SMC-PCO is trying to have more hoardings with messages on HIV/AIDS prevention and awareness.

2.5 Future strategies

Future strategies of the SMC-PCO are as follows:

- Opening up of more Voluntary Counseling and Testing Centers and Prevention of Parent to Child Transmission Centers.
- Support for increased citizen involvement.
- Greater and improved coordination of NGOs and government support

3

MUMBAI DISTRICT AIDS CONTROL SOCIETY
MUNICIPAL CORPORATION OF GREATER MUMBAI

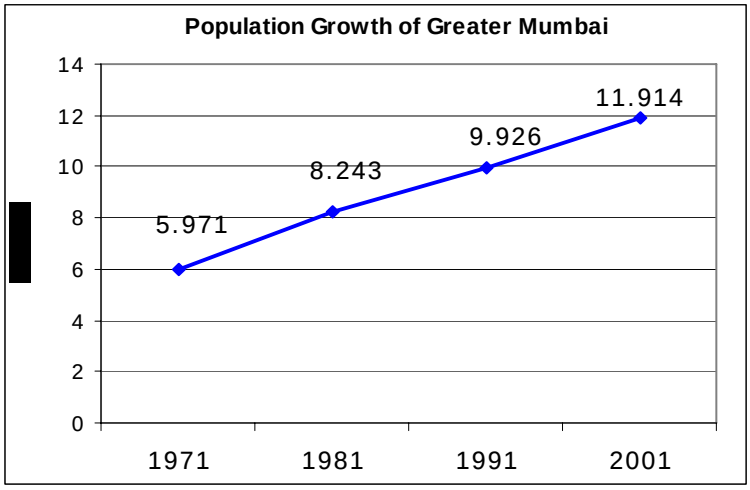
3.1 Situation before the initiative

Mumbai is the commercial and financial capital city of India. This port city (India's largest and busiest) accounts for a major share of the government's revenue, and has one of the world's largest harbour. This mega cosmopolitan city is a city of contrasts. The deceptively calm sea, its beaches and fishing boats, give lie to a city, which is bursting at its seams with population, pollution and space. Over 60% of air pollution is due to the 0.7 million vehicles on the roads. Space constraints have given rise to towering skyscrapers standing majestically next to sprawling slums (Dharavi -Asia's biggest slum is here).

The Mumbai Metropolitan Region (MMR) encompasses a total area of 4,355 sq. km and consists of the following administrative units:

- Mumbai city district
- Mumbai suburban district
- Part of Thane district comprising
  a) Thane, Kalyan, Bhiwandi and Ulhasnagar tehsils and
  b) Part of Vasai tehsil
- Part of Raigad district comprising
  a) Uran tehsil and
  b) Part of Panvel, Karjat, Khalapur, Pen and Alibag tehsils

The region consists of seven municipal corporations (Greater Mumbai, Thane, Kalyan-Dombivali, Navi Mumbai, Mira, Bhayander, Bhiwandi-Nizampur and Ulhasnagar) and 13 municipal councils (six in Thane district and seven in Raigad district). Out of these, Greater Mumbai constitutes about 10% of the total geographic area but accounts for, as high as 63% of the population of MMR region Greater Mumbai covers an area of 437.71 sq km. with a population of about 11.914 million[5].



Population growth of Greater Mumbai

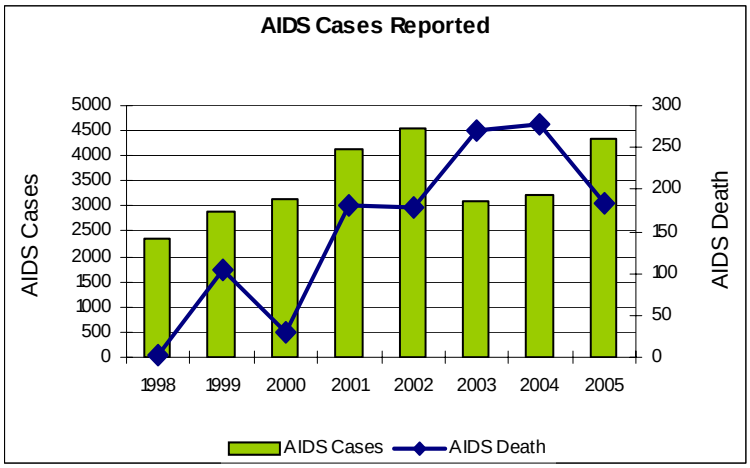
Mumbai today has emerged as a complex mega city with problems such as migrant population, overcrowding, 50% population in slums, economic disparity, illiteracy and poor infrastructure. Among the glut of problems faced by the city today, HIV has become one of the biggest public health challenges which needs immediate attention.. It is estimated that Mumbai has 0.35 million HIV positive cases[6].

[5] Source: Population and Employment Profile of Mumbai Metropolitan Region, MMRDA
[6] Source: Mumbai City Consultation on HIV-AIDS (Mumbai), All India Local Self Government

The table and graph below shows the trend of AIDS cases in Mumbai from 1998-2003.

AIDS Cases in Greater Mumbai

Year	AIDS Cases	AIDS Deaths
1998	2374	3
1999	2903	103
2000	3157	30
2001	4112	182
2002	4533	179
2003	3094	270
2004	3205	278
2005	4321	184



The incidence of HIV in Mumbai has grown rapidly since the first surveys were conducted in 1989. However, in 2005, Mumbai has a record of 4321 AIDS cases, which has gone down from 4533 in 2002[7]. Whereas, the above graph also depicts that deaths due to AIDS have gone down from 278 in 2004 to 184 in 2005.

Subsequent to National AIDS Control Program Phase 1 (NACP – 1), the decision was taken to form state level societies. Looking at the scale of HIV prevalence at Mumbai, the city felt the need of constituting a separate body for concerted efforts for the city of Mumbai. Thus, the Mumbai Districts AIDS Control Society was formed under the aegis of the Municipal Corporation of Greater Mumbai in the year 1998.

3.2 Mumbai Districts AIDS Control Society – A Brief

The Mumbai Districts AIDS Control Society (MDACS) was established on the 27th of July 1998 by Brihanmumbai Mahanagarpalika (Municipal Corporation of Greater Mumbai) for controlling the spread of HIV/AIDS in the Mumbai metropolitan area. Mumbai metropolitan area includes area under the jurisdiction of Municipal Corporation of Greater Mumbai (MCGM), as well as other areas under the Mumbai metropolitan region which include the districts of Thane and Raigarh as well.

Mumbai District AIDS Control Society (MDACS) has been identified as an autonomous nodal agency by NACO for the implementation of National AIDS Control Program (NACP) within the jurisdiction of Mumbai. Maharashtra State AIDS Control Society (MSACS) looks after the rest of Maharashtra State. MDACS has played a role to catalyze, strengthen and orchestrate the expertise and resources of various organizations working in this field under a single banner, with one overarching goal, i.e. HIV/AIDS control within the metropolis of Mumbai.

The working of this society is governed by the policies formulated and adopted by the Governing Body of MDACS and implementation is through the decision taken by the Executive Committee of MDACS. However, the Executive Committee and Governing Body of MDACS work within the framework of rules, regulations and policies issued by NACO and Government of India.

[7] Source: A presentation by Mumbai District AIDS Control Society

3.2.1 Aim and Objectives

Mumbai District AIDS Control Society's (MDACS) aim can be summed up as a four-pronged strategy enlisted below:

1. Prevent the spread of HIV/AIDS.
2. Reduce the vulnerability of individuals and communities to HIV/AIDS.
3. Alleviate the socio-economic and the human impact of the epidemic.
4. Provide care and support to those infected and affected by the disease.

The broad objectives of MDACS are similar to the ones of the National AIDS Control Program (NACP) and are enlisted below:

1. To bring down the prevalence rate of morbidity of Sexually Transmitted Infection (STI).
2. To implement Syndromic Management for STI.
3. To raise awareness, improve knowledge and understanding among the general population about HIV infection and Sexually Transmitted Diseases (STD), routes of transmission and methods of prevention.
4. To promote desirable practices such as avoiding multi-partner sex, condom use, sterilization of needles and syringes and voluntary donation of blood.
5. To mobilize all sectors of the society to integrate messages and program on AIDS into their existing activities.
6. To develop and support Information, Education and Communication (IEC) needs of NGOs working with various focused groups.
7. To create a supportive environment for the care and rehabilitation of persons with HIV/AIDS.

3.3 Description of the Initiative

3.3.1 Stakeholders

The various stakeholders include the authorities of Brihanmumbai Mahanagarpalika Municipal Councilors, Government, Municipal and other Medical Colleges, Peripheral Hospitals, Maternity Homes, Dispensaries and Health posts of Public Health Department, concerned departments of Government, Mumbai and SNDT Universities, Private Health Sector, organized and unorganized workplace sectors, NGOs, CBOs, SHGs, Gate keepers, People Living With HIV/AIDS (PLWHA) and collaborating agencies viz.. WHO, UNICEF, ILO and FHI.

The list of members of the various bodies of MDACS is as follows:

GOVERNING BODY

1. Municipal Commissioner of Municipal Corporation of Greater Mumbai — **Chairman**
2. Additional Municipal Commissioner of Municipal Corporation of Greater Mumbai in charge of Health and Hospitals — **Executive Chairman**
3. Director, Medical-Education and Major Municipal Hospitals of Municipal Corporation of Greater Mumbai — **Vice-Chairman-I**

4. Senior most Dean of Municipal Medical College of Municipal Corporation of Greater Mumbai	**Vice-Chairman-II**
5. Executive Health Officer of Municipal Corporation of Greater Mumbai	**Alternative Vice-Chairman**
6. Project Director, Mumbai District AIDS Control Society	**Member Secretary**

i. Ex-Officio Members

7. Leader of the House of Municipal Corporation of Greater Mumbai	**Member**
8. Leader of Opposition in Mumbai Corporation of Greater Mumbai	**Member**
9. Chairperson, Public Health Committee of Municipal Corporation of Greater Mumbai	**Member**
10. Chairperson, Education Committee of Municipal Corporation of Greater Mumbai	**Member**
11. Chairperson, Women and Child Welfare Committee of Municipal Corporation of Greater Mumbai	**Member**
12. Project Director, Maharashtra State AIDS Control Society	**Member**
13. Dean, Nair Municipal Hospital	**Member**
14. Dean, Lokmanya Tilak Municipal Medical College	**Member**
15. Dean, K.E.M. Municipal Hospital	**Member**
16. Dean, J.J. Hospital, Mumbai	**Member**
17. Chairperson, Blood Transfusion Sub-Committee	**Member**
18. Member Secretary, T.B. Control Society of Municipal Corporation of Greater Mumbai	**Member**
19. Program Officer, UNICEF	**Member**

B. Co-opted / NGO Members

20. One NGO Representative	**Member**
21. One Representative from People Living With HIV/AIDS (PLWH/A)	**Member**

EXECUTIVE COMMITTEE

1.	Additional Municipal Commissioner of Municipal Corporation of Greater Mumbai in charge of Health and Hospitals	**Executive Chairman**
2.	Director, Medical-Education and Major Municipal Hospitals of Municipal Corporation of Greater Mumbai	**Vice-Chairman-I**
3.	Senior most Dean of Municipal Medical College of Municipal Corporation of Greater Mumbai	**Vice-Chairman-II**
4.	Executive Health Officer of Municipal Corporation of Greater Mumbai	**Alternate Vice-Chairman**
5.	Project Director, Mumbai Districts AIDS Control Society	**Member Secretary**

i. Ex-Official Members

6.	Chairperson, Public Health Committee of Municipal Corporation of Greater Mumbai	**Member**
7.	Project Director, AVERT Society	**Member**
8.	Additional Project Director, Mumbai Districts AIDS Control Society	**Member**
9.	Additional Project Director, Maharashtra State AIDS Control Society	**Member**
10.	Member Secretary, T.B. Control Society of Municipal Corporation of Greater Mumbai	**Member**

ii. Co-opted / NGO Members

11.	NGO Representative	**Member**
12.	NGO Representative	**Member**

3.4 Programs and Results Achieved

District AIDS Control Society's (MDACS) activities and programs are undertaken as per the NACO framework comprising of five components as under:

- **Component – I Priority Targeted Intervention for Groups at High Risk**
  - Sexually Transmitted Infections (STI)
  - Condom Promotion and Procurement
  - NGO support for T.I.

- **Component – II Preventive Intervention for the General Community**
  - I.E.C. and Awareness
  - School AIDS Education Program
  - Blood Safety/Voluntary Confidential Counseling and Testing Center (VCCTC)
  - Prevention of Parent to Child Transmission (PPTCT)
  - Family Health Awareness Campaign (F.H.A.C.)
- **Component – III Low Cost AIDS Care**

  Care and Support
  - Drop-in Center
  - Community Care Center
  - Anti Retroviral Therapy (ART)
- **Component – IV Institutional Strengthening**
  - Training
  - HIV Sentinel Surveillance
  - Program Management
  - Procurement
  - Computer Management Information System (CMIS)
  - Computerized Project Financial Management System (CPFMS)
- **Component- V Intersectoral Collaboration**
  - Workplace Intervention
  - With concerned departments of Government and Municipal Corporation
  - Public – Private – Partnership viz.. Medical Associations – FOGSI, IMA etc

3.4.1 Targeted Intervention

14 NGOs are identified, funded and supported in accordance with NACO norms for undertaking 22 targeted interventions in High Risk Groups viz.; 10 in Female Sex Workers, 2 in Transgenders, 2 in MSMs, 1 in Injecting Drug Users, 3 in Truckers, 1 in Taxi Drivers, 3 in Migrants.

3.4.1.1 Condom Promotion

MDACS undertakes this activity through condom distribution by making available free condoms, promoting condom distribution by social marketing with the help of SMOs and by installing of CVMs through HLFPPT. The average annual free condom distribution amounts to 7.5 million pieces.

3.4.1.2 Sexually Transmitted Diseases Control

STI/STD services are rendered through 15 STI and 20 RTI clinics established in the Public Health Institutions. Syndrome based case management for STIs is undertaken as per NACO policy. Diagnostic facilities are made available at all secondary and tertiary levels. MDACS has pioneered operationalizing of 3 STI mobile vans for the coverage of difficult to reach population viz..; truckers, migrants and slums. All the STI services are free of cost.

3.4.2 School AIDS Education Program

This program is undertaken as School Adolescent Life Skills Education Program (SALSEP) in students from 9th class in schools. The schools from Public and Private Sector including Night schools

are covered under this program. There are 1400 schools out of which 1256 schools are covered. The program has so far covered 169018 school going youth.

3.4.3 Blood Safety

At present Mumbai has 51 licensed Blood Banks which are sharing their data with MDACS. MDACS supports all of them in the form of capacity building and participation in EQAS to ensure quality testing for TTIs in blood banks. Of these 51 blood banks, 22 public sector blood banks are supported financially and technically by MDACS. Moreover of these 22 blood banks, 7 blood banks with large collection of blood units are additionally supported financially to promote the activity of blood component separation. Voluntary blood donation which is the national blood policy is facilitated by MDACS.

3.4.4 VCTC/PPTCT

At present, MDACS manages 19 VCTCs, 41 ICTCs (Combined VCTCs and PPTCTs) and 4 PPTCT Centers totaling 64 such services in different public sector hospitals, maternity homes etc. These centers provide counseling and HIV testing services at an affordable rate of Rs.10/- to patronizing clients. Other HIV related referral services are facilitated on a regular basis at these centers. In addition to these services, PPTCT Centers provide Nevirapine prophylaxis in prescribed doses to enrolled participating mothers and new borns. All the PPTCT program services are offered free of cost. For outreach services into the community, linkages have been developed through non-government organizations in the PPTCT program.

3.4.5 Family Health Awareness Program (F.H.A.C.)

This campaign has been conducted every year for detection, diagnosis and treatment of STIs in the community. Last year, it covered the slum population of 5 million in which there were more than 11,000 attendees.

3.4.6 Care and Support

- Provision of drugs for the management of OIs and PEP at all the Medical Colleges and Peripheral Hospitals.
- Provision of CD4 diagnostic facilities and Anti-retro Viral (ARV) drugs in ART Centers at 4 Medical Colleges. Provision is also made for Pediatric ART.
- 4 Drop-in Centers (DIC) in Medical College Hospitals for PLWHAs and SHGs.
- 2 Community Care Centers (CCC) for care of AIDS patients.
- Linkages between RNTCP and NACP for the management of HIV-TB.
- Linkages with PPTCT services.

3.4.7 Capacity Building – Training

Capacity building of the health care providers, field workers and people working in the field of HIV/AIDS is done to have updated knowledge, improvise skills and positive attitude towards patient care. This is to ensure that they have positive attitude and behavior towards HIV positive persons. Training programs are conducted based on the module characterized by multilayer, modular as well as capsular. They cover health care providers of all the categories at all the levels viz.; Primary, Secondary and Tertiary. MDACS has already covered 5410 Doctors, 5695 Nurses, 594_Lab Technicians, 353 Counselors, 6908 Class IV Employees,1842 Community Health Volunteers , 375 NSS Volunteers, 200 NCC cadets. In addition 1478 Private Medical Practitioners and 155 Dentists were also trained.

3.4.8 HIV Sentinel Surveillance

This activity is undertaken for the study of prevalence and trends of HIV epidemic in the community. The sentinel groups are identified from low and high risk groups from the community. At present there are 16 sites with the coverage of 8 ANCs, 3 STDs, 2 FSWs, 1 each from MSM, IDU and Transgender groups.

3.4.9 Intersectoral Collaboration

Workplace Intervention Program_is a joint collaboration between International Labour Organization and Mumbai Districts AIDS Control Society. The program was started in the city of Mumbai in the year 2002 with 3 public sectors namely Bombay Electrical Suburban Transport (BEST), Municipal Corporation of Greater Mumbai (MCGM) and Mumbai Police. We have already reached to a level where we have developed workplace policies and a sustainable program for HIV/AIDS in all above public sector companies and Reserve Bank of India. Currently we are working with similar 8 Public Sector Companies, 2 Multinationals and with a union for programs in construction workers.

3.4.10 Information, Education and Communication covering Social Mobilization and Mitigation

MDACS continues its mission to provide best communication tools to its task force and to strengthen its fight against HIV/AIDS. The Information, Education and Communication (IEC) strategy included:

- Community mass awareness and sensitization through media – print, electronic and folk, street plays, event celebrations, festival based interventions viz.; Ganesh Utsav, Navratri, World AIDS Day observance, etc.
- The material development with specific messages such as flip charts, pamphlets, posters, STD palmtop charts, condom use method palmtop charts, Syndromic management charts, etc.
- Coverage of college youth through intensive IEC campaign during youth festivals in the colleges.

Mumbai Districts AIDS Control Society (MDACS) has pioneered in many projects, viz.;

- Asha project – Project with FSW
- School AIDS Prevention program
- Blood safety programs
- Provision of health care to MSM
- Intervention with MSM
- Nurtured and initiated Eunuchs intervention
- Established Sexual Health Information Gallery (SHIG)
- Introduced the Mobile STI Clinics
- Introduced IEC Mobile Van for outreach mainly to slum population
- Devised Need Based and Target Based funding pattern for Blood Banks
- Evolved Computerized Financial Management System
- Established referral system of NGOs and Health sector with MDACS Services
- Conceptualized combined VCTC – PPTCT Centers

- Devised VCTC and PPTCT guidelines based on workload for allocation of manpower i.e. Counselors and Technicians
- Workplace intervention in Public and Private Sector
- Nurturing and establishing Self Help Groups as NGOs

Other achievements are as below:

1. "POSITIVE" a book on Collection of stories.
2. Book in Braille for Blind and in large print for people with low vision in English and Hindi
3. Well known writers, Directors, Poets, Actors and Actresses are involved for Mass Awareness
4. Use of folk media (Street Plays, Marathi play called 'Tan-Man') and *Kalsutri*-a Puppet show
5. Designed and developed IEC Mobile Van for community awareness.
6. Designed and developed exhibition sets for display.
7. Message Spots about AIDS awareness on TV and local cable Channels, Doordarshan, as well as on All India Radio and FM Radio Channels.
8. Advertisements in newspapers on different events such as World AIDS Day, Blood Donation Day, Family Health Awareness Campaign, etc.
9. MDACS has engaged 16 Street Play Groups for awareness in community.

Sexual Health Information Gallery (SHIG) – To impart the scientific knowledge on human anatomy, physiology and sexuality through models, photographs etc. Sexual Health Information Gallery (SHIG) called '*Antarang'* has been established on the 1st Floor of Municipal STD Clinic, Bellasis Road.

3.4.11 Future strategies

1) Fostering Private-Public Partnership.
2) Focused effort on women and youth.
3) Greater involvement of PLWHAs (GIPA) in all the program activities at all the levels.
4) Convergence with other relevant program like RCH and RNTCP.

4 CORPORATION AIDS PREVENTION AND CONTROL SOCIETY CHENNAI MUNICIPAL CORPORATION

4.1. Situation before the Initiative

Chennai, the Capital City of Tamil Nadu is the 4th largest city in India and is spread over an area of 174 Sq. Kms. Established on September 29th 1688, Chennai Municipal Corporation is the oldest Municipal Institution of India. As per the 2001 Census of India, Chennai has a population of 6.5 million.

The alarming rise and spread of HIV infections in Tamil Nadu over the last decade has been major cause for concern for the state. It is estimated from Tamilnadu's Sentinel Surveillance data of 2003 that the HIV positive cases in the state was about 0.43 million[8]. The same increase is also seen in the city of Chennai since it attracts large population from neighboring states and is a growing industrial and commercial centre. The data from Tamil Nadu Sentinel Surveillance indicates that the mean value of HIV prevalence among Anti Natal Care (ANC) women was 1.5% in 2001, which decreased to 0.20% in 2004.

As per the table[9], Chennai HIV prevalence rate among people with STD went up from 4.0% in 2001 to 8.8% in 2002 and, went further up (7.2%) in 2003 to reach to 8.0% in 2004; thus HIV prevalence amongst people with STD is more or less unchanged since 2002. HIV prevalence amongst people with IDU has significantly increased since 2001.

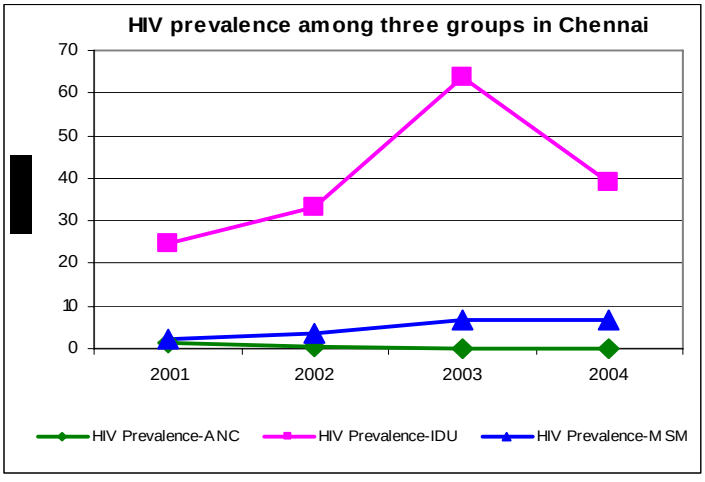
HIV prevalence (%) for all the groups in Chennai

	2001	2002	2003	2004
HIV Prevalence-ANC	1.5	0.5	0.0	0.2
HIV Prevalence-STD	4.0	8.8	7.2	8.0
HIV Prevalence-VCTC	15.2	34.2	13.6	5.4
HIV Prevalence-PPTCT	0.3	0.3	0.4	0.3
HIV Prevalence-IDU	24.6	33.3	63.8	39.2
HIV Prevalence-MSM	2.4	3.6	6.8	6.8

4.2. Formation of Chennai AIDS Control Society (CAPACS)– A Brief

In response to the growing prevalence of HIV, Chennai formed the 'Corporation AIDS Prevention and Control Society (CAPACS)' in 1998 to help in the prevention, management and care of AIDS within the city. CAPACS was formed under the directives of the National AIDS Control Organization (NACO), has made remarkable changes in prevention of the HIV/AIDS and receive funding from NACO. CAPACS has a three-fold objective - 'Awareness, Accessibility, Action', through which a wide range of activities are implemented. Such activities include condom promotion; adolescent clinics, family health awareness campaigns and Anti Retroviral (ARV) Therapy. Regular services includes medication; psychosocial

HIV Prevalence (%) among three groups in Chennai



[8] Source: http://www.tnhealth.org/tsaids.htm
[9] Source : http://www.capacs.org

support, clinical care, human rights education and legal support to help the HIV-positive people create a network for themselves.

4.2.1. Vision of Corporation AIDS prevention and Control Society (CAPACS)

The CAPACS vision is to strive towards a better and safer community that is AIDS-free. Projects and activities revolve around the creation of awareness and prevention campaigns for HIV/AIDS and providing health care and support for the affected.

4.2.2 Mission of Corporation AIDS prevention and Control Society (CAPACS)

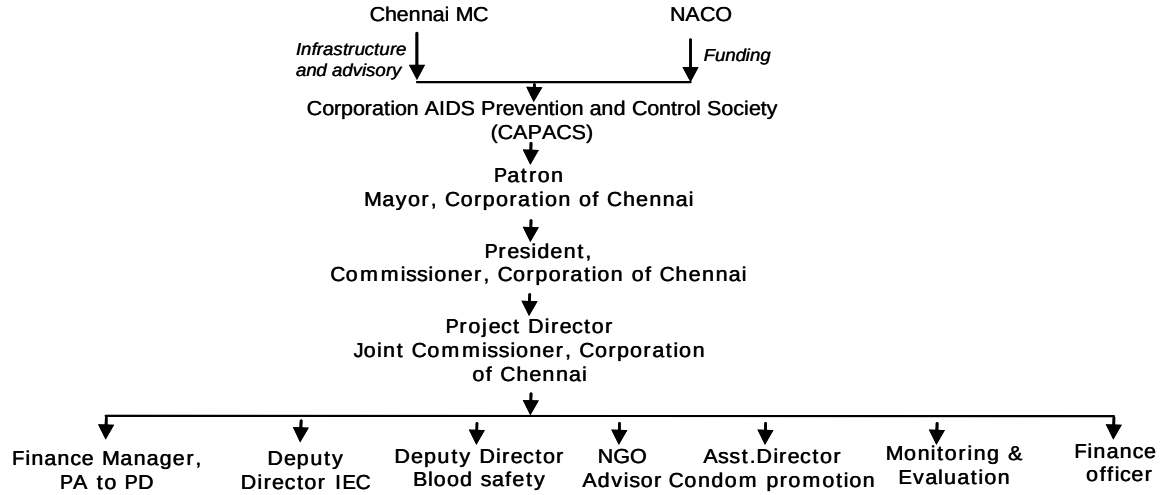
The CAPACS mission is to work in every area and field that is necessary to help prevent the further spread of the disease and provide support to patients.

4.3. Description of the initiative

4.3.1 The Stakeholders

The governing body of CAPACS is comprised of the City's Mayor, who serves as the Patron, the Municipal Commissioner, who serves as President and the Deputy Commissioner of Health, who serves as the Project Director. The Executive Committee of 9 members is responsible for various decisions related to the society.

Organizational Structure of Corporation AIDS Prevention and Control Society



4.3.2 Role of the stakeholders

The Executive Committee of CAPACS, formed by the Municipal Commissioner as Project director and the elected wing, is responsible for making policy and advocacy decisions.

NGOs and other organizations works at the grass root level with the target population and also help support awareness campaigns. CAPACS unlike the two other city based societies in India, does not have any specific criteria for the selection of NGO.

4.4. Programs and Results Achieved

The projects at CAPACS provide are aimed at equipping the clinics with medication and increase the awareness of the dangers of unprotected sex.
CAPACS provides education on STDs, the need for collecting and donating safe blood, and the necessary health and safety precautions that must be taken care by pregnant positive mothers.

Activities undertaken by CAPACS includes the following:

- Sexually Transmitted Diseases control care and outreach services.
- Condom promotion activities.
- Targeted intervention among High Risk groups.
- Awareness and social mobilization of population.
- School AIDS education program.
- Blood Safety and Voluntary Blood Donation Camp.
- Voluntary Counseling and Testing to identify HIV infected and give guidance.
- Prevention of Parent to Child Transmission of HIV (PPTCT),
- Low cost AIDS care
- Intersectional Collaboration to achieve goal of AIDS free Chennai.

4.4.1. Targeted Intervention Projects

CAPACS has been funding 13 NGOs to prevent HIV transmission among highly vulnerable populations groups. The following target group projects have been implemented by CAPACS:

Project undertaken by CAPACS

S.No	Target Group	No. of intervention[10]
1	Commercial Sex Worker	3
2	Men having sex with men	1
3	Street Children	1
4	Injecting Drug Users	2
5	Film Industry	1
6	Truckers	1
7	Porters	1
8	Eunuchs	1
10	Auto drivers	2

Targeted intervention (TI) includes behavior change, one-to-one communication, counseling, treatment and referral services for Sexually Transmitted Diseases, condoms promotion and peer education among core groups. CAPACS currently supports two positive people's networks to operate drop-in-centers and a community care center. Peer education system is also being strengthened.

4.4.2 School AIDS Education Program

S.No	School	No. of School[11]
1	Chennai Corporation High Schools	39
2	Chennai Corporation Higher Secondary Schools	26
3	**Total number of schools in Chennai Corporation**	65

Table 4.3- Categories of school under Chennai Municipal Corporation

[10] Source: As per discussion with the Project Director, CAPACS
[11] Source: As per discussion with the Project Director, CAPACS

CAPACS has implemented the School AIDS Education Program and has provided appropriate training to the Head Masters, Teachers and Peer Educators from each school. Students from Standard IX onwards are educated under School AIDS Education Program. In 2004, all the 65 high schools and higher secondary schools in Chennai Corporation were educated under this program by CAPACS.

4.4.3 Voluntary Counseling and Testing Center (VCTC) /Prevention of Parent to Child Transmission (PPTCT)

- CAPACS operates 6 Voluntary Counseling and Testing Center (VCTC) centers, 19 Prevention of Parent to Child Transmission (PPTCT) centers and 11 blood banks are under CAPACS.
- CAPACS is currently undertaking a mapping process of private hospitals and clinics to identify focus areas.
- Two "drop in centers" are operated by NGOs are run by people, who are HIV positive. These two centers provide counseling services and free VCTC and other medical assistance to HIV positive people.

4.4.4 Festival and Theme Based Interventions

CAPACS organizes mass awareness and sensitization campaigns with vulnerable groups/specific groups identified for advocacy/community at large during festivals through IEC material distribution.

4.5. Sustainability

- At its inception, CAPACS emphasized awareness and prevention strategies, but plans to increase services to the HIV/AIDS positive people as well as to the general community. More work has been initiated to provide better "care and support".
- CAPACS has installed 500 condom vending machines till today, which is highest among all over the country.
- CAPACS is covering 98% of registered ANC mothers through its programs.
- Chennai Municipal Corporation assists in providing office space and infrastructure for awareness campaign.
- CAPACS continues to build awareness through regular communication and advertising festivals, trade fairs, cricket matches, AIDS Day and similar occasions.

4.6. Future Strategies

- The number and provision of Care and Support facilities would be increased: Currently, there are only a few community centers running in association with NGOs that provide temporary shelter (home stay) and treatment for opportunistic people. Chennai plans to increase the number of these centers to better respond to community needs.
- Proposal of starting four Adolescent clinic in four health centers (from 93 heath centers of Chennai Municipal Corporation), which would be in partnership of private stakeholders.

5 VISAKHAPATNAM DISTRICT AIDS CONTROL SOCIETY

5.1. Situation before the initiative

Visakhapatnam (commonly known as Vizag) is a, fast developing port city and the second largest urban agglomeration in the state of Andhra Pradesh. Vizag has experienced rapid industrialisation with the growth of major steel, petroleum refining and fertiliser manufacturing companies, which has resulted in significant migration to the city. The city was originally a small fishing village but, due to its natural harbour, it has developed into a major port. According to the 2001 Census of India, the city's population was 1.34 million.

To respond to the growing population and burgeoning industries, the city has implemented a number of e-governments reforms and responds well to citizen needs. The Corporation works closely with other planning and service delivery institutions to improve the quality of life and has entered into partnerships with the resident welfare associations and slum communities to undertake solid waste management improvements and better management of neighbourhood parks.

Consolidating on past initiatives, Greater Visakhapatnam Municipal Corporation is in the process of preparing a City Development Strategy (CDS) with a focus on service delivery improvements and comprehensive, as well as city wide, slum up-gradation. In addition, HIV/AIDS prevention work is an important component of the CDS, which has spurred recent activity on HIV/AIDS prevention.

5.1.1 Epidemic of HIV/AIDS in Visakhapatnam

5.1.1.1 Background

In order to understand the magnitude and characteristics of the HIV/AIDS epidemic in Visakhapatnam, the Andhra Pradesh AIDS Control Society (AP SACS), in collaboration with the United States National Alliance for State and Territorial AIDS Directors (NASTAD) and the United State Centres for Diseases Control and Prevention – Global AIDS Program (CDC – GAP), developed an HIV/AIDS epidemiological profile. This profile was developed as a pilot project to assess the usefulness of analyzing and presenting the available HIV/AIDS data to help guide prevention interventions.

The Visakhapatnam government – supported, public health delivery system is divided into three tiers with the most specialised care available at the tertiary level.

The first tier includes 90 Primary Health Centres (PHC). The PHCs in Visakhapatnam District each have a population of approximately 40,000 – 50,000 people. Twenty-three PHCs are in tribal areas serving the tribal population.

The PHCs are overseen by the District Leprosy Office (DLO), who also serves as the Nodal Office for HIV/AIDS. The District Leprosy Office is based in Visakha City. The DLO serves as the Nodal Officer for HIV/AIDS and utilizes the DLO infrastructure for HIV/AIDS related activities. The DLO reports and gets funds from APSACS for various programs.

The second tier includes Community Health Centres (CHC) and the District Hospital, which serve as referral units for the PHCs. The two CHCs include Nakkapalli, Kotavaratta, Padera, Araku, Bhimali, Yelomanchili, V.Madugula, Chivthapalli, K.Kotapadu Hopsital (K.Kota Mandal) and Anakapalle Area Hospital (Anakapalle Mandal).

The third tier \\\\includes the five government teaching hospitals in Visakha City, which provide specialized care: King George Hospital (KGH), Victoria General Hospital (VGH) a maternity hospital, the CHEST Hospital (tuberculosis), the Regional Eye Hospital, Mental Hospital and RCD Hospital.

Government – sponsored voluntary counselling and testing centres are currently available at the second and third tier of the health care system. During the fiscal year 2002-2003, there were VCTCs at the Anakapalle Area Hospital, Narsipatnam Hospital and two teaching hospitals, King George Hospital of present nine wards and will be starting in public health centres of Sabbavarau and Pevdurtty.

5.2. Formation of District AIDS Control and Prevention Society, Visakhapatnam – A Brief

The AIDS Control Program is being implemented by the staff of District Leprosy Office and Medical and Health Department, under the guidance of the District Collector and APSACS. Five NGOs have been identified by the APSACS and working under the guidance of the technical resource unit of Visakhapatnam is listed below:

- MVS : Composite intervention
- NATURE : Slums and migrant population
- PSO: Commercial Sex Workers (CSW) intervention
- SEED : Street children
- ACCEPT : Truckers Intervention
- SVDS: Commercial sex worker in Anakapalli and other rural areas.

To match the pace of work needed in Visakhapatnam district and especially in the city, the following NGOs also participate in the AIDS Control Prevention Program, PSI (Population Services International) Information, Education and Communication (IEC) and Testing Centres:

- FXB: treatment of opportunistic infected and IEC activities.
- Green Vision: Home based care and support.
- World Vision: IEC activities, Care and support to HIV positives
- Care and support centre: This centre is sanctioned by APSACS to Emmanul Ministries, Kondala Agraharam, Makavarapelem Mandal, Narsipatnam road.

5.3. Programs and Result Achieved

The table[12] below provides an overview of the number of individuals screened for HIV in each venue and the corresponding percentage that were infected with HIV.

[12] Source : Data collected from Nodal Officer, District AIDS Control Society, Visakhapatnam

Number of HIV+ve cases (recorded from Blood bank, VCTCs centres and ANC centres)

Cases recorded from Blood bank

Year	No of sample collected	HIV +ve	% of total sample collected
2002-03	22265	190	0.85
2003-04	24143	186	0.77
2004-05	27237	186	0.7
2005-06	30877	164	0.53

Cases recorded from VCTCs

Year	No of sample collected	HIV +ve	% of total sample collected
2002-03	6222	1053	16.9
2003-04	9220	1477	16
2004-05	11122	2081	18.7
2005-06	15302	2937	19.19

Cases recorded from ANC centres

Year	No of sample collected	HIV +ve	% of total sample collected
2002-03	6379	100	1.56
2003-04	15641	212	1.35
2004-05	17548	296	1.7
2005-06	21257	316	1.48

The table shows that over the last 4 years, decrease in cases recorded in Blood bank and from Antenatal Care (ANC) centers whereas VCTCs records shows an increase in HIV +ve cases.

5.3.1 Targeted Intervention

5.3.1.1 Sexually transmitted Diseases control

The following three hospitals are extending their services to treat STDs, which will in turn reduce the risk of HIV/AIDS

1. King George Hospital (KGH) in Visakhapatnam
2. Area Hospital, Anakapalli
3. Area Hospital, Narsipatnam and in all the public health centres and municipal dispensaries.

The required drugs are supplies to these hospitals by APSCAS, through the DLO office.

5.3.1.2 Condom Promotion

Condom outlets have been opened at petrol pumps, wine shops, Primary Health Centers (PHCs), small markets, Voluntary Counseling and Testing Center (VCTC), Prevention of Parents to Child Transmission (PPTCT), STD centres and clinics.

Condom Mobile Van

HLFPPT (Hindustan Latex Family Planning Promotion Trust) publicizes condom promotion by mobile van and also promotes awareness through wall writings and street plays.

5.3.2 Voluntary Counseling and Testing Center (VCTC)

With the help of APSACS the Voluntary Counseling and Testing Center (VCTC) were established in the following places:

1. King Gorge Hospital (KGH) in Visakhapatnam
2. INH Kalyani (Naval) Hospital
3. Area Hospital, Anakapalli

4. Area Hospital, Narsipatnam
5. Community Health Center, Aruku
6. Padera
7. Chodevarar
8. Aganampudi
9. Yellamanchili

5.3.3 Prevention of Parent to Child Transmission (PPTCT)

PPTCT were initially established in the following places:

1. KGH, Visakhapatnam
2. Victoria General hospital, Visakhapatnam
3. Area Hospital, Anakapalli
4. Narsipatnam

5.3.4 Information, Education and Communication

Information, Education and Communication (IEC) Programs have been successfully implement by the Andhra Pradesh State AIDS Control Society (AP SCAS). Results follow below.

5.3.5 Exhibition

Since December 2004, an exhibition has been conducted every Monday, in the office of the Collector of Visakhapatnam, to create awareness on HIV/AIDS. This exhibition is also done during festivals and special occasions.

5.3.6 Wall Writing

In coordination with Hindustan Latex Family Planning Promotion Trust (HLFPPT), wall writing has been used to promote greater awareness of HIV/AIDS issues and blood donation in Rythu Bazara.. Four walls writing on blood donation have been finished at the King George Hospital (KGH) and office premises.

5.3.7 Quiz Books and Mementos

One thousand quiz books and 36 mementos were distributed to 12 colleges to conduct quiz.

5.3.8 Pamphlets

Fifty thousand pamphlets for blood donation day and blood donation camps were distributed. A similar number of pamphlets were also distributed on World AIDS day.

5.3.9 Radio group discussion

Disrict Leprosy Officer (DLO) along Project Director, PSO participated in radio group discussion on HIV/AIDS on November 30th 2004.

5.3.10 Training program and workshop

The following training programs have been undertaken by Visakhapatnam District AIDS Control Society

- Training program for the barbers' of Visakhapatnam city
- Yearly training to the school teachers

- Sensitisation of principal and head master of most of the schools.
- Under College talks on AIDS project, 29 professional colleges and 30 degree and 50 junior college have been covered. Most of these colleges are in Visakhapatnam.
- Sensitization program for the MLAs and political leaders.
- Sensitization program for the all news reporters.
- Sensitization program for the Visakhapatnam municipal officials, especially department of solid waste, sanitary inspector, town planner and medical officers.
- Three day training program for the Municipal officials and community workers of Greater Visakhapatnam Municipal Corporation (GVMC).

There are few other programs running in Visakhapatnam city, which are discusses below

Operation Light House

Population Service International (PSI) is working in the port area with the Vizag Port Trust (VPT) to treat migrant port workers.

Saadhan Clinic, started here by PSI, recently celebrated its third anniversary. The clinic provides high quality services of VCTC, at a subsidized fee of Rs.25, and free diagnosis of Sexually Transmitted Infections (STIs). The VCTC centre provides experienced counselors who are regularly trained on HIV/AIDS issues and offer pre/post test counseling[13]. In addition, the clinic has an STI specialist who provides STI management and medical monitoring for HIV-positive people.

Saadhan Clinic is a part of PSI's port-based Operation Lighthouse (OLH) STI/HIV/AIDS intervention initiative. The program reaches 12 major ports in the country with the objective of reducing the prevalence of HIV in port cities.

OLH covers millions of vulnerable people in lower socio-economic groups, by providing information, services, and products for the prevention of HIV/AIDS.

5.4. Future Strategies

- To spread more awareness among all sections of people including municipal officials, police officials, state government officials.
- Opening up VCTC in association with GVMC
- Better coordination between NGO and Government

[13] Source: According to PSI senior Project Manager

6

PUNE CITY AIDS CONTROL SOCIETY
PUNE MUNICIPAL CORPORATION

6.1 Situation before the Initiative

In the early nineties it became evident that HIV infection was spreading widely in India and that national effort to control HIV infection needed to be backed by qualitative and multidisciplinary research involving virology, immunology, microbiology, clinical research, epidemiology, field based trials and social and behavioral research. To meet this need, the National AIDS Research Institute (NARI) was established in October 1992 in Bhosari, Pune.

Pune is an industrial city with a population of 3.7 million (*as per India's census in 2001*). The city is situated in the high HIV prevalence state of Maharashtra, is one of the largest cities in the state and is growing to become the IT capital of Maharashtra. Baseline feasibility studies on high-risk cohorts (commercial sex workers and people attending sexually transmitted infection clinics) in Pune, have reported HIV rates of 18 to 26% and have provided information on the associated biological and behavioral risk factors in the study population.

Sentinel surveillance among pregnant women attending government clinics in Pune city indicated HIV prevalence rates ranging from 2.5% to 3.7% (based on unpublished data from the National AIDS Research Institute) and about 1.2% in rural areas surrounding Pune.[14]

With a significant group of commercial sex workers in the city, it became essential to address the problem of HIV/AIDS. Hence, in September 2001, Maharashtra State AIDS Control Society and NACO together formed the Pune City AIDS Control Society within the Pune Municipal Corporation (PMC).

6.2 Formation of Pune Municipal Corporation Pune City AIDS Control Society (PCACS) – A brief

The Maharashtra State AIDS Control Society formed a Society in Pune Municipal Corporation to work in the field of "**Targeted Intervention**", especially with commercial sex workers.

With the help of the National AIDS Control Organization (NACO), Pune Municipal Corporation (PMC) formed a Society to work on HIV/AIDS with 'Targeted intervention' focused on condom promotion and awareness about HIV/AIDS and STI amongst CSWs.

6.2.1 Objectives

The broad objectives of Pune City AIDS Control Society are:

1. To increase Targeted intervention for the General Community and Low Cost AIDS Care through Institutional Strengthening, hence to reach 100% coverage and condom use to minimize the epidemic.
2. To develop a Project Support Unit (PSU) within Pune Municipal Corporation (PMC). PSU would be managing the scaled up intervention. PSU would also be building up capacity through providing appropriate technical assistance to the Pune City AIDS Control Society.

[14]Source: http://www.hptn.org/web%20documents/CommunityProgram/HPTNCommunityLessonsLearned/Pune139-148.pdf

3. Emphasis on Condom Promotion
4. Awareness raising and improvement of knowledge/ understanding among the general population about AIDS infection and STDs, routes of transmission and method of prevention.
5. To develop operational process to implement the intervention and integrate it into the PMC ongoing plans to offer suitable long term sustainability.
6. To effectively monitor and document the process that enables coverage and condom use.

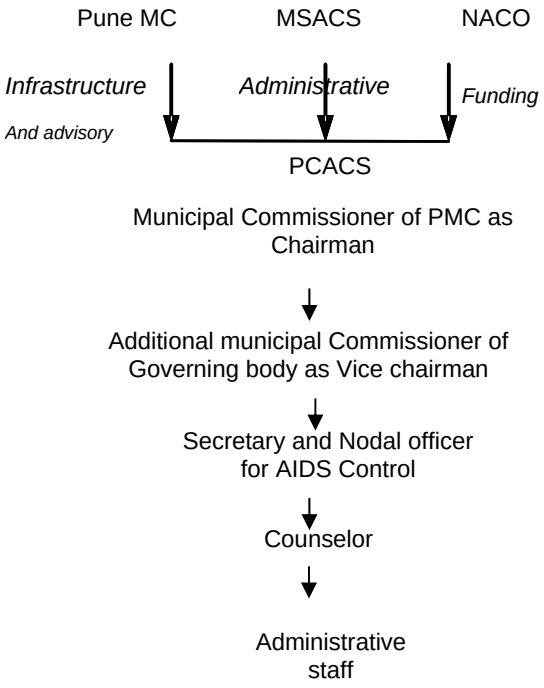
6.3 Description of the Initiative

6.3.1 The Stakeholders

Pune City AIDS Control Society has two governing bodies that include the Governing Council and Executive Body. The key office bearers are the Municipal Commissioner as Chairman of the Society, the Additional Municipal Commissioner of Governing body as the Vice Chairman, the Secretary, AIDS Nodal Officer, Counselor, and administrative staff.

The given figure illustrates the organizational and financial structure of PCACS.

Organizational structure and financial structure of PCACS



6.3.2 Role of the Stakeholders

Each stakeholder has an important role to play. The Chairman and the Additional Chairman are responsible for making decisions on Strategic and advocacy issues.

NGOs receive funding from Pune City AIDS Control Society which in turn receives funding from the Maharashtra State AIDS Control Society (MSACS) and NACO to implement HIV/AIDS projects in red light area in Pune.

PMC provides funds to PCACS for conducting various awareness program/activities within the jurisdiction of Pune Municipal Corporation. MSACS's financial assistance is project specific. The PCACS works at grass root level with the target intervention group, mainly on condom promotion.

6.4 Programs and Results Achieved

Pune, with a significant high risk youth population, prominent red light areas and close proximity to Mumbai is vulnerable to a high prevalence of HIV.

6.4.1 Targeted Interventions

Pune City AIDS Control Society provides Targeted Intervention assistance through 4 NGO partners to work in red light areas only. The society provides the NGOs with office space, transportation,

provision of free condoms and IEC material. Through PCACS, the 4 NGOs work, on a city-wide basis, with commercial sex workers to promote condom use and, to facilitate outreach and advocacy for safe sex. NGOs have trained and deployed approximately 40 peer educators, who have provided education to approximately 4000 sex workers.

Condoms are distributed through traditional and non-traditional channels that include distribution by NGO workers, peer educators, minor shops, clinics, paan shops, tea shops, hotels, guest houses, public lavatories, grocery shops and vegetable vendors.

6.4.2 Voluntary Counseling and Testing Center (VCTC)

Of the 11 VCTCs in Pune, 2 are managed by the Pune City AIDS Control Society while 9 are managed by the Maharashtra State AIDS Control Society (MSACS). Trained counselors are available at each VCTC to provide information and support for counseling on issues related to HIV/AIDS.

6.4.3 Prevention of Parent to Child Transmission (PPTCT)

There is one PPTCT clinic in the HIV testing center at Kamla Nehru Hospital, Pune Municipal Corporation. More centers are to be open in the city with the assistance of MSACS.

6.4.4 Information Education Communication and Social Mobilization

The Information Education Communication /Behavior Change Communication strategy includes:

- Mass awareness and sensitization of the community through folk media, street plays, event celebrations and festival based interventions.

- Development of material with specific messages such as flip charts, pamphlets, posters, Sexually Transmitted Diseases (STD) charts, condom use method palmtop charts and Syndromic Management Charts.

- Education for college youth during college festivals.

6.5 Future strategies

Future strategies of Pune City AIDS Control Society include:

- Adding more Voluntary Counseling and Testing Centers (VCTC) and Prevention of Parent to Child Transmission (PPTCT) Centers provided through the PCACS.
- Increasing integration of NGOs into HIV/AIDS prevention.
- Increasing integration of private hospitals into HIV/AIDS prevention.
- To start counseling at blood bank.

7

VADODARA AIDS CONTROL CELL
VADODARA MUNICIPAL CORPORATION

7.1 Situation before the Initiative

Vadodara lies on the Golden Corridor and is one of the industrial hubs of Gujarat. Vadodara is located on the western railway line to Ahmedabad and Delhi and has played a historic role in the movements of people and culture throughout India.

The city is located on the Golden Corridor, has a large presence of heavy industry and has a large boarding university, which ensures a high and regular influx of people. Due to the industrial nature of Vadodara, the city has experienced a significant rural migration. According to Census of India 2001, Vadodara Municipal Corporation (VMC) covers 1.5 million population.

Vadodara attracts a large number of truck drivers, laborers and commercial sex workers, resulting in the creation of a High Risk Group (HRG). Moreover, the city has a police training school, air force, and army training schools, as well as two state reserve police training school, which are also considered part of the HRG. Vadodara current HIV prevalence rate, as of 2005, is 0.3% to 0.5%[15].As a result of growing concern and high prevalence rate, Vadodara Municipal Corporation (VMC) began to develop prevention strategies to combat the spread of HIV/AIDS.

7.2 Formation of Vadodara Municipal Corporation Vadodara AIDS Control Cell (VACC) – A Brief

In 1975, VMC established an individual cell to fight Tuberculosis and Cholera and in 1996, the cell was named as Vadodara AIDS Control Cell and began initiating activities for HIV/AIDS prevention. The VACC follows NACO guidelines.

7.2.1 Objectives

VACC's objectives include the following:

- Coordination of health initiatives for the VMC.
- Capacity building and management of HIV/AIDS programs.
- Publicizing awareness on the prevention of HIV/AIDS among both high and low risk behavior groups.
- Collaborating with different sector on training and education initiatives.

With the help of 11 NGO partners, VACC has identified different high risk behavior groups such as sex workers, eunuchs and men having sex with men (MSM) within Vadodara Corporation Area.

7.3 Description of the Initiative

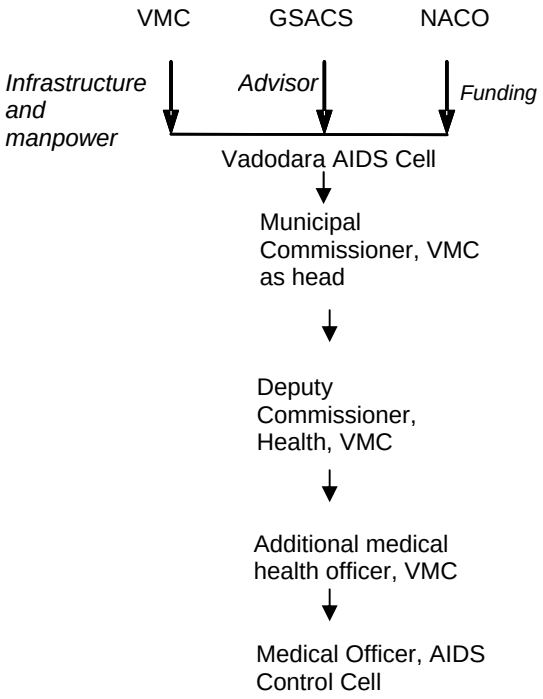
7.3.1 The Stakeholders

In 1996, Dr. Shirish Patel (Health Officer of VMC) and Dr. Vibhooti Shah (Medical Health Officer, VMC) established the Vadodara AIDS Control Cell (VACC).

[15]Source: Interview with Dr. Vibhooti Shah

The present organizational structure is depicted in figure below

Organizational structure of Vadodara AIDS Control Cell



7.3.2 Role of the Stakeholders

VMC is responsible for making decisions on the provision of healthcare staff, family welfare centers and *Anagwadi* (crèche) for all NGOs and community centers, as well as allocation of manpower, approval of the annual work plan and forecasting of future strategies.

VMC supports the selected seven NGOs and community centers by providing mobile vans, IEC materials, office space for meetings, development of awareness programs and provision of medical doctors/manpower.

7.4 Programs and Results achieved

The VACC has designed programs to build awareness for the general public and target groups, such as youth and high risk groups. VACC also implements testing and counseling programs for people infected with HIV.

7.4.1 Targeted Intervention

7.4.1.1 Condom Promotion

Social marketing has generated a demand for condoms and has increased the accessibility to condoms through commercial channels such as grocery shops, pharmacies, tea shops, hotels, restaurants as well as non-traditional channels such as NGO workers and public toilets

7.4.2 Voluntary Counseling and Testing Center

4 Voluntary Counseling and Testing Centers are run throughout the city, in the following hospitals:

- Smt. Sarovidevi Hospital (SSG) Hospital (financially supported by GSACS)
- Baroda Citizen Counsel (financially supported by GSACS)
- Jamunabhai Hospital (financially supported by GSACS)
- Railway Hospital

7.4.3 Prevention of Parent to Child Transmission

GSACS financially supports 1 PPTCT clinic in the SSG Hospital-Vadodara. VMC field staff refers any HIV+ve ANC to PPTCT.

7.4.4 School AIDS Education Programme

The School AIDS education Program for all secondary school students in the 9th and 11th grades in Vadodara city has been jointly financed by GSACS and UNICEF and has been implemented by different NGO partners. VMC provides resource person for training in School AIDS Awareness program. To date, more than 200 public and private schools have been educated through this program.

7.4.5 Festival and Theme Based Interventions

Taking advantage of Indian Festivals, VMC implements festival-based interventions and conducts mass awareness/sensitization campaigns with vulnerable groups and general public.

7.4.6 Media

The VMC funds advertisement through the media during special festivals that include World AIDS Day or World TB Day.

7.5 Sustainability

A significant number of HIV/AIDS activities implemented by the VACC are run concurrently with existing VACC programs. To increase sustainability of partner NGOs, regular meetings are held with all NGOs. Training sessions for doctors, employees from the health sector and family welfare, school children, teachers and NGOs are also conducted regularly in the city.

7.6 Future Strategies

Prevention awareness programs and identification of high risk groups need behavior change programs to achieve results. Hence VMC has identified the need to develop more projects to promote behavior change.

In recent times, VMC has received a pilot project (for a year) financially supported by UNICEF named HIV prevention among young people and children of Vadodara city slums.

8

BANGALORE AIDS CONTROL CELL
BANGALORE MUNICIPAL CORPORATION

8.1 Situation before the initiative

Bangalore, the capital of Karnataka, has an estimated metropolitan population of 6.1 million (2006) [16], is India's third largest city and is the fifth largest metropolitan area. According to the 2001 Census of India, Bangalore Municipal Corporation has a population of 5.7 million. The city is the silicon valley of India and is a technical institutional hub for the country. As a mega city, however, Bangalore faces problems that stem from it's fast growing population.

The Bangalore Mahanagar Palike, i.e. Bangalore Municipal Corporation (BMC) is in charge of the civic and infrastructure assets of the city and was responsible for the formation of the BMC AIDS control cell in 2000.

8.2 Formation of Bangalore Municipal Corporation Bangalore AIDS Control Cell – A Brief

In 2000, the BMC AIDS Control Cell was formed to spread awareness and to provide HIV testing centers for citizens.

The members of the cell include the:

- Municipal Commissioner, who serves as the Chairperson,
- Deputy Commissioner, Special commissioner, Joint commissioner, Chief Accounts Officer, Chief Health Officers, Education Officer, Additional Director Karnataka AIDS Control Society and Additional Health officer of East, West and South Zones of Bangalore Government Hospital as members.

8.3 Description of the Initiative

BMC is the only municipal corporation with a separate budget line in the annual budget for its HIV/AIDS cell. As all other cities receive their funding through NACO or allocate HIV/AIDS funding through the health sector budget. In the 2005-2006 Fiscal Year, BMC allocated approximately Rs. 0.2 million to HIV/AIDS programs. This budget is subject to change, as per the needs and this year it has allocated Rs. 0.5 million.

At its inception, the society was involved in awareness programs for different sectors of the population. The Cell conducted programs on training, awareness campaigns, workshops, seminars and street plays. In 2003, the Cell merged their operations into a joint venture with Freedom Foundation (FF), a local NGO. As per this joint venture, BMC provides the necessary infrastructure and office space, while Freedom Foundation implements the actual intervention programs.

8.4 Programs and Results Achieved

The Cell runs six referral hospitals, 23 maternity centers and 49 health centers, out of which, there are HIV Testing and PPTCT Centers in 19 maternity centers. The infrastructure is provided by Bangalore

[16] Source: http://en.wikipedia.org/wiki/bangalore#Demographics

Municipal Corporation (BMC), whereas the salaries to the staff (counselors, doctors and lab boy) are provided by Freedom foundation.

In collaboration with the Karnataka State AIDS Control Society, BMC runs one VCT Center. The center space and other infrastructure is funded by BMC and salaries and operating costs are provided by the Karnataka State AIDS Control Society.

8.4.1 Voluntary Testing and Counseling Center (VCTC) and Prevention of Parent to Child Transmission (PPTCT)

Results from the VCTC and PPTCT joint venture for 2004-2005 include

- 37,060 patients screened at VCTC and PPTCT Centers.
- 154 patients diagnosed as HIV +ve.
- 125 patients offered services such as deliveries, and sterilization operations.
- Training for staff on universal health precautions.

8.4.2 Care and Support

With two doctors on staff, patients have access to a medical person at all times. Steep declines in the prices of antiretroviral medicines have enabled more patients to be treated with medications.

8.4.3 Psychological

Group support meetings, coupled with one-to-one counseling, have improved the patient knowledge of HIV/AIDS, as well as strengthened their ability to cope with the disease. Suicide, anger, depression, anxiety, grief, death, rejection and isolation counseling continues to be provided by social workers.

8.4.4 Peer Support

Freedom Foundation has continuously strived to empower Positive persons to begin helping themselves and live lives of dignity. 45% of the organization staffs are positive person. The children's section is looked after by one of the peer counselors. Groups of positive patients have been sent to Positive Network monthly support meetings. There is also a peer out-reach team which visits People Living with HIV/AIDS (PLWHA) at various hospitals and conducts counseling.

8.4.5 Awareness

Freedom Foundation continues to increase awareness of HIV/AIDS issues. During 2005, six awareness campaigns for women and children, 2 programs for college students, one awareness campaign for slum dwellers and 13 campaigns for the Bangalore Metropolitan Transport Corporation have been implemented in various locations throughout the city.

8.4.6 World AIDS Day

In support of World AIDS Day, Freedom Foundation published articles and advertised AIDS awareness issues in newspapers and on TV. On world AIDS Day, 2005, a march was conducted in the center of the city and was flagged by the Health Minister ‘Sri Maalaka Reddy’. It was led by the

positive children and staff from many colleges, NSS group, Software companies, NGOs and PLWHAs. FF also distributed badges and pamphlets to the public in the march.

BMC organized AIDS awareness week from December 1st to 9th 2005, where approximately 8500 people participated. Different types of awareness program were organized during this period. BMP also organized a two week long program on family health awareness campaign for 29 hospitals and 48 health centers of BMC.

8.4.7 Positive Children

The Cell's greatest concern is the rapidly increasing number of positive children and children of positive parents. 16 children, all HIV positive and orphans, live permanently at Freedom Foundation Centre. Their ages range from 1½ years to 14 years, nearly all are educated in school and are doing well in class. In addition to providing recreational facilities, the center has trained them in computer usage and has sent some of them for dance classes. Seven of these children are on Antiretroviral therapy and 4 of them have designed greeting cards - which the center has printed and sold to the public to generate income for the Foundation.

8.5 Future strategy

In the future, BMC plans to provide HIV testing kits and materials directly through the municipal corporation.

9 KOLKATA MUNICIPAL CORPORATION[17]

9.1 Situation before the Initiative

Kolkata is the capital of West Bengal and is located in eastern India on the eastern bank of the River Hooghly. Earlier, the centre was consider as a modern education, science, culture and politics center in India, it has experienced economic stagnation since the years following India's independence in 1947. In 2000 however, an economic rejuvenation began in Kolkata, leading to a spurt in the city's population growth. According to the 2001 Census of India, the population of Kolkata Municipal Corporation is 13.2 million, making it the second largest urban agglomeration and fourth largest city in the country.

With more than 10,000 sex workers, the Sonagachi area of Kolkata is one of India's largest red-light districts and the largest in Kolkata. Several NGOs and government organizations operate in this area for the prevention of sexually transmitted diseases (STDs) including AIDS.

The Sonagachi project is a prostitute's cooperative that empowers sex workers to use condoms and avoid violence and abuse. The cooperative is run predominantly by the prostitutes, is recognized as a best practice by the UNAIDS Program and is credited with keeping the HIV infection rate at a rate of 5 % (much lower than in other Indian red-light districts). The Durbar Mahila Samanwaya Committee (DMSC) runs the Sonagachi project and several similar projects in West Bengal, organizing approximately 65,000 prostitutes and their children. The organization lobbies for the recognition of sex workers' rights and full legalization, runs literacy and vocational programs, and provides micro loans.

Kolkata Municipal Corporation does not have an AIDS prevention cell or society; however, it is in the process of negotiations with the State AIDS Control Society to establish a cell within the Municipal Corporation.

9.2 Description of the Initiatives

Kolkata Municipal Corporation (KMC) runs a separate Information, Education and Communication Program with the help of NGO partners. KMC runs two maternity hospitals, which do not have any HIV testing centers and the other hospitals, health centers and dispensaries are run by the State AIDS Control Society.

9.3 Programs and Results Achieved

KMC, in association with “CINI ASHA” (the urban wing –The Child In Need Institute (CINI)) implements awareness program to address the high vulnerability of HIV/AIDS among street children.

The program uses peer educators, weekly outreach clinics and the CINI ASHA field level workers to provide HIV/AIDS related information and services to the children. Peer educators distribute condoms and have been trained to answer questions on HIV/AIDS issues. A successful toll free telephone hotline number has been set up to provide information on HIV/ AIDS.

[17] Awaiting validation as of June 2006

Number of Peer Educators Trained Up to 1999-2000

Basic Training	**Advance Training**	**Training of trainers**
109	257	20

Since 1999, 327 children have been trained as peer educators and from 1998-99 alone, 4,800 children were treated at outreach clinics.

In addition, Kolkata Municipal Corporation has implemented training programs for health workers and supervisors of hospitals run by the Municipal Corporation. The programs were funded and supervised by the West Bengal State AIDS Control Society.

10 HUBLIDHARWAD MUNICIPAL CORPORATION

Hubli-Dharwad is a twin city and is considered to be one of the major commercial, industrial and educational centers in the state of Karnataka. Hubli-Dharwad has a population of approximately 0.79 million[18] people and is spread over an area of 202.28 Sq.Kms.

Due to a growth of the industrial sector, Hubli-Dharwad continues to attract migrants from surrounding areas, which has created increased the number of High Risk Groups (HRG) in the city and caused a higher incidence of HIV/AIDS in the State. The growth of HIV/AIDS in Hubli Dharwad prompted the India-Canada Collaborative HIV/AIDS Project (ICHAP) to select Hubli-Dharwad as a case study for HIV/AIDS in an urban area.

A survey was undertaken to identify and map high-risk behavior, draw profiles of members of HRGs and identify slums with higher incidence of sexually transmitted infections (STI) and HIV/AIDS. The survey team visited 150 confirmed red light areas, interviewed 500 key informants and covered 17% and 21% of the slum population in Hubli and Dharwad, respectively.

The survey identified 12 areas in Hubli-Dharwad where prostitution and solicitation is evident and estimated that three categories of women sex workers (street-based sex workers, part-time sex workers and *dhabas* or lodge-based sex workers) provide 617 services to 1,176 clients a day.

As a result of this high level of prostitution, Hubli Dharwad has begun to provide HIV/AIDS services in the city. The city currently has two HIV testing centers in both of its maternity hospitals which are solely funded by Municipal Corporation. In addition to the two HIV-testing centers, the Municipal Corporation runs 11 hospitals and 2 more maternity hospitals.

[18] Source: http://www.hdmc.gov.in/city_statistics.php

11

THIRUVANANTHAPURAM MUNICIPAL CORPORATION

Thiruvananthapuram, the capital city of Kerala, is located at the southernmost tip of the state and is known for Kovalam beach and natural serene surroundings. According to the 2001 Census of India, Thiruvananthapuram Municipal Corporation's population was 0.74 million. Once known as a historical and academic center, Thiruvananthapuram is emerging as a commercial and tourist center in Kerala.

Thiruvananthapuram is home to many Central and State Government offices, NGOs and companies and is a major academic hub, boasting several premier educational institutions including Kerala University.

The city has attracted people in the formal and informal sector, resulting in increased migration from major cities and rural areas. This influx has increased the vulnerability of the city to the spread of HIV/AIDS. In addition, Thiruvananthapuram has a high rate of drug use, which further increases the occurrence of HIV/AIDS.

A study supported by the United Nations Drug Control Program (UNDCP) on the nature and extent of drug usage in Thiruvananthapuram City, revealed that significant drug use was concentrated in the lower income groups. People who work as daily wage laborers and live in slums were more likely to be regular users of drugs, sharing needles/injection equipment, making them highly vulnerable to HIV/AIDS.

Thiruvananthapuram Municipal Corporation has good medical facilities that include a medical college, general hospital and five small hospitals, within its jurisdiction, however, none of them have any HIV testing centers. Kerala State AIDS Control Society (KSACS) is directly undertaking programs on HIV/AIDS prevention within the municipal corporation jurisdiction.

All HIV/AIDS related interventions are undertaken by the District Medical Officer through the Kerala AIDS Control Society (KACS).

12

INDORE MUNICIPAL CORPORATION

Indore is the trade and commercial capital of Madhya Pradesh and has about a population of approximately 1.5 million people. The population of the city continues to grow, due to rapid industrial and commercial development.

Since 2003, the Indore Municipal Corporation (IMC) has implemented and funded the 'Family Health Program' (FHP). At the outset, HIV/AIDS was not one of the main focus areas of this program; however in recent years, IMC has begun to focus on raising awareness of HIV/AIDS issues. In 2003, Indore's Mayor-in-council and Municipal Commissioner initiated the awareness campaign and program to increase prevention efforts and measures to reduce HIV/AIDS.

This awareness campaign, which includes rallies, workshops and seminars, have been implemented with public private partnership initiatives between IMC, local NGOs and community centers working in the health sector. IMC provides transportation (cycle rickshaws and mobile vans), as well as manpower for the awareness campaign.

In addition, IMC runs a separate Child Welfare Center, which provides HIV counseling. The counselor's salary is paid by IMC and IMC organizes regular meetings and forums, every three months, with local NGOs to facilitate information sharing and to prepare the annual work plan.

13

JABALPUR MUNICIPAL CORPORATION

Jabalpur is located in central India, in the state of Madhya Pradesh and has a population of approximately 1.09 million people. The city, is home to defense and military establishments, of the Government of India including The College of Defense Management (formerly, Army Officers' School) and factories such as the Gun Carriage Factory, Ordinance Factory, Vehicle Factory and Army Area Headquarters. Jabalpur is also the seat of the Madhya Pradesh High Court, and a significant educational center with two universities - Rani Durgavati University and Jawaharlal Nehru Agriculture University.

To spread awareness of HIV/AIDS issues, Jabalpur Municipal Corporation initiated the formation of an AIDS Control Cell in 2002, under the supervision of the Municipal Commissioner (Mr. R.S.Vishwakarma.) and through funding provided by NACO (Rs. 0.5 million).

Partway through the formation of the cell, Jabalpur decided to merge HIV/AIDS intervention activities under the Madhya Pradesh State AIDS Control Society. The formation was, therefore, canceled and the remaining Rs. 0.3 million of funding was sent back to NACO.

14

JAIPUR MUNICIPAL CORPORATION

Jaipur- The Heritage Pink City has been the capital of Rajasthan state since its inception in 1727 AD. it gets the name from its founder Maharaja Sawai Jai Singh. The city was laid with great precision; it could also be called as the first planned city of the country.

Jaipur experienced a phenomenal growth during the post independence period due to influx of displaced persons from Pakistan and also being made the capital of the new state of Rajasthan. Jaipur which originally was spread across only about 2,000 acres within the fortifications expanded to more than 14,000 acres in 1971. The Municipal limit, encompasses about 46,000 acres.

The population of the city as per the 1991 census was 1.45 million and it grew to 2.3 million by 2001.

The main functions of the Jaipur Corporation are similar to all other urban local bodies of the country.

However, hospitals and dispensaries and primary health centers which are within the jurisdiction of Jaipur Municipal Corporation, are run by the state health department.

Thus issues related to HIV are taken care by the Rajasthan State AIDS Control Society and the Municipal Corporation has not undertaken any activities towards HIV/AIDS prevention.

ANNEXURE 1: CONTACT DETAILS

Sr.No.	Name	Designation	Department	Contact no		E-mail	Contact Address
				Office	Cell		
	Gujarat						
1	Dr. Laxman Malodia	Project Director	Ahmedabad AIDS Control Society, Ahmedabad Municipal Corporation	(079)26409857, 26468653	9824002639		AIDS Control Society, Ahmedabad Municipal Corporation, Old Municipal Dispensary, Behind Lal Bungalow, Near Supermall Complex, C.G.Road, Ahmedabad
2	Dr Kartik Shah	Deputy director - Blood safety	Ahmedabad AIDS Control Society, Ahmedabad Municipal Corporation	(079)26564314, 26564281			
3	Ms. Maheshwari	Telecounsellor	Ahmedabad AIDS Control Society, Ahmedabad Municipal Corporation	(079)26468653/ 26564314			
4	Dr. Ketan Gandhi	Team leader, Project support unit	Ahmedabad AIDS Control Society, Ahmedabad Municipal Corporation	(079)32914717	9376121918	psu@rcel.org	101,Akshat,Mithakhali Six Roads, Ahmedabad
5	Mr. Suresh Parmar		Project Support Unit	(079)32914717	9898259458		101,Akshat,Mithakhali Six Roads, Ahmedabad
6	Mr. Rajendra Jani	Managing Director	Raman Consultancy	(079)26582663	9825084347	rjani@rcel.org, raju_rcel@yahoo.com	Raman Consultant,704 Sakar V, B/h Natraj Theater, Ashram Road. Ahmedabad
7	Dr. D.M.Saxena	Additional Project Director	Gujarat State AIDS Control Society	(079)22681043/22685210			Gujarat State AIDS Control Society, 0/1 Block, New Mental Hospital Complex, Menghaninagar, Ahmedabad
8	Dr. Jayati Makwana	Director	Solid Waste Management	(079)25350817	9327038740		AMC, Danapid
9	Dr Shiva GKanagli	Additional Medical Health Officer	Health department		9327038867		
10	Dr. S.P. Kulkarni	Chief Medical Health Officer	Health department	(079)25391811			
11	Mr. D.B. Makwana	Deputy Health Commissioner	Health department	(079)27552586	9376113008	dbmakwana@egovamc.com	Deputy Commissioner Health, West Zone, Ahmedabad Municipal Corporation office, Usmanpura
12	Dr. I.C. Patel	Deputy Commissioner Health	Surat Municipal Corporation	(0261)22421341/ 24222855-89	9376844811		Surat Municipal Corporation, Main Office, Muglisara, Surat
14	Dr. Vhibooti Shah	Medical Health Officer	Vadodara AIDS Control Cell, Vadodara Municipal Corporation	(0265)26562010	9879555967		Bhaucawad family welfare center, municipal corporation, near Panigate sabji mandi, Vadodara

Sr.No.	Name	Designation	Department	Contact no		E-mail	Contact Address
				Office	Cell		
	Maharashtra						
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ANNEXURE 2 – NACO POLICY (Phase I and Phase II)

Source: http://www.nacoonline.org/policy.htm

Background

Soon after reporting of the first few HIV/AIDS cases in the country in 1986, Government recognized the seriousness of the problem and took a series of important measures to tackle the epidemic. By this time AIDS had already attained epidemic proportion in the African region and was spreading rapidly in many countries of the world. Government of India without wasting any time initiated steps and started pilot screening of high risk population. A high powered National AIDS Committee was constituted in 1986 itself and a National AIDS Control Program was launched in year 1987.

National AIDS Committee

To formulate strategy and plan for implementation of prevention and control of HIV/AIDS in the country, Ministry of Health & Family Welfare constituted a National AIDS Committee in Year 1986, under the chairmanship of the Union Ministry of Health and Family Welfare with representatives from various sectors. The committee was formed with a view to bring together various ministries, non-Government organizations and private institutions for effective co-ordination in implementing the program. The committee acts as the highest-level deliberation body to oversee the performance of the program and to provide overall policy directions, and to forge multisectoral collaborations. Last meeting (5th) of the National AIDS Committee was held on 24th September, 1998 in Vigyan Bhavan, presided over by the Hon'ble Minister of state for Health & Family Welfare.

In the initial years the program focused on generation of public awareness through more communication programs, introduction of blood screening for transfusion purpose and conducting surveillance activities in the epicenters of the epidemic

Medium Term Plan for HIV/AIDS Control

In year 1989, with the support of WHO, a medium term plan for HIV/AIDS Control was developed with a US $10 million budget provided from external sources. Project documents for the implementation of this plan were developed and implemented in 5 states and UTs which were most affected, namely Maharashtra, Tamil Nadu, West Bengal, Manipur, and Delhi. Initial activities focused on the reinforcement of programme management capacities as well as targeted IEC and Surveillance activities. Actual preventive activities like implementation of education and awareness programme, blood safety measures, control of hospital infection, condom promotion to prevent HIV/AIDS, strengthening of clinical services for both STD and HIV/AIDS gained momentum only in 1992.

NACP in the States & UTs

State Level Strengthening

In order to strengthen the program management at the state level, the state Governments have established their own managerial organizations which include state AIDS control societies (formerly, State AIDS cells), technical advisory committees and empowered committees as per the guidelines of the strategic plan. The structure of the State AIDS Societies is shown below. Progress in the development of state management teams has been satisfactory, although some states have responded effectively than others.

Empowered Committee

At the state level, an empowered committee has been constituted by the states either under the chairmanship of chief secretary or additional chief secretary at par with the National AIDS Control Board at central level. This committee takes the policy decisions for implementation of the HIV/AIDS control program in the respective states and approve administrative and financial actions which otherwise would have been approved by the state department of finances.

State AIDS Control Societies

State AIDS Cells were created in all the 32 States and UTs of the country for the effective implementation and management of National AIDS Control Programme. However over the period of time it was realized that due to many cumbersome administrative and financial procedures, there was delay in release of financial outlay sanction by Government of India due to which the implementation of the Programme at different levels suffered. In order to remove the bottlenecks faced by the programme implementation at State level, Ministry of Health and Family Welfare advised the State Governments/Union Territories to constitute a registered society under the chairmanship of the Secretary Health. The society should be broad based with its members representing from various ministries like social welfare, Education, Industry, Transport, Finance etc. and Non Government Organizations. On an experimental basis Tamil Nadu AIDS Control Society was created which was followed by Pondicherry. Successful functioning of these societies led to the Government of India to advise other states to follow this pattern for implementation of the National AIDS Control Programme.

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

Introduction

The National AIDS Control Project was the first project in India to develop a national public health program in HIV/AIDS prevention and control, and was implemented between 1992 and 1999.

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. It constituted a start-up investment to launch expanded preventive activities. The specific objectives were to :

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

The project objectives were clear and specific. They were in line with the broad sectoral strategy of the Government, and initiated the development of sub-sectoral strategies on HIV/AIDS. The expected outputs and outcome indicators proposed in the Staff Appraisal Report were used to assess the project's performance. At start-up, the limited national capacity to deal with HIV/AIDS called for a simple, realistic and flexible framework. The design included five basic components:

- Strengthening management capacity for HIV/AIDS control;
- Promoting public awareness and community support;
- Improving blood safety and rational use;
- Controlling sexually transmitted diseases; and
- Building surveillance and clinical management capacity. After the development of a program framework, the central Government pursued incremental efforts to generate state responses and commitment. At the mid-term review, it was concluded that the objectives of the project remained valid and attainable.

Achievement of Project Objectives

The project achieved its main purpose and specific objectives after overcoming the initial challenges faced by the Union and State Governments. These ranged from severely limited capacity across sectors to denial and low commitment in many states. During the implementation periods, the project substantially achieved its specific objectives and often exceeded the original targets. This included nationwide capacity building in managerial and technical aspects of the program in all 32 States and Union Territories (UTs). Multi-sectoral involvement was gradually built up. Project activities were integrated to the maximum extent possible with the existing health care system. Efforts to target vulnerable risk groups gradually increased after a slow start, when the capacity of NGOs to deal with the HIV/AIDS was still limited except in a few areas. There was a 50 percent increase in the volume of condom distribution through social marketing. Condom use in targeted risk groups increased from less than 10 percent to a range of 50-90 percent. In selected major States, awareness about prevention of HIV infection reached a range of 54-78 percent. Screening of donated blood became almost universal by the end of the project. Professional blood donations were banned by law. Under the project, 504 STD clinics were strengthened with improved effectiveness and quality of STD management. The syndromic approach for STD treatment was developed beyond initial project plans. Surveillance capacity was developed in 62 centres and 180 sentinel sites nationwide. However, the capacity to implement programms was uneven across the States, due to varying capacity and commitment. The center and the major project target epicenters of Mumbai and Chennai showed high overall performance in implementing the program. Two-third of the 32 States/UTs performed satisfactorily and the remaining one-third of the States did not perform effectively.

In contrast with other project objectives that can be readily measured, it is difficult to assess the project's contribution to slowing the spread of HIV. Nonetheless, the 1998 HIV sero-prevalence in the adult population of India was estimated at about 0.7 percent.

Key Indicators for Project Implementation

SAR – Staff appraisal report. (World Bank)

Key implementation Indicators in SAR/ President's Report	Estimated (SAR Target)	Target) Actual (1998 status)
Institutional Development in HIV/ AIDS management. Program Set-up and State Involvement.	The Project scope is national but the initial focus is on metropolitan cities.	Nationwide capacity building in managerial and technical aspects of the program in all 32 States and Union Territories. Public health program initiated with multi-sectoral involvement.
Increased knowledge concerning the prevention of HIV infection.	Through the services of • NGOs to reach risk behavior groups; • Television, radio and private sector agencies for mass media; • The existing health system infrastructure and resources.	In selected major States, the awareness reached a range of 54-78% in urban areas and 13-64% in rural areas. Multi-sectoral involvement in promoting public awareness. Improved quality of condoms through legislation raising the quality standard of condoms manufactured and sold in India to conform with WHO recommended specifications. This also facilitated 50% increase in the volume of condom distribution through Social Marketing. 3.5 million students made aware of HIV prevention through the Universities Talk AIDS Program.
Increase condom use and targeted interventions in risk groups.	With capacity building in 12 States and 100 NGOs.	Targeted interventions in vulnerable groups have been developed in most States with strong performance in Maharashtra, TamilNadu, Gujarat and Manipur. Increased condom use in targeted risk groups from less than 10% to a range of 50-90% in targeted groups of commercial sex workers and capacity building of 150 NGOs.
Increased blood transfusion safety. Phasing out professional Blood Donations.	Safer and more adequate blood supply. Increase blood safety/ screening from 30% to 90%. Develop HIV testing capabilities in 52 zonal centres to reach an aggregate of 118 zonal centers and upgrade 90 blood banks to an aggregate of 608 blood banks for HIV testing capabilities.	Screening of donated blood is almost universal. No unlicensed blood banks are functioning. Transfusion without license is illegal under the present law. This has been attained in five years. Banning and enforcement of ruling prohibiting paid blood donations. This exceeded the original target, which aimed at a reduction of 30%. At the end of project, 154 zonal blood testing center were set up and 815 public sector and voluntary blood banks were strengthened.
Enhanced technical	Training workshops to train 38	10 Regional Training Centers were set up. 900

skills.	trainers, 168 high level official from the center and the States/UT, and 130 mid-level administrative officers. IEC in-service training for health staff.	different categories of personnel have been imparted training. Training proceeded according to plans but was slower for nurses and counseling.
Increased capacity, Effectiveness and quality of STD management.	Improve and strengthen clinical services and case management in 372 STD centers.	504 STD clinics were strengthened. Improved effectiveness and quality of STD management. The STD Syndromic management according to plans but was slower for nurses and counseling.
Surveillance network capacity building in permanent centers and sentinel sites. Provision of reliable information on the extent of the spread of HIV in India.	Provide HIV testing capabilities to 100 sites throughout the country.	Surveillance capacity developed in 140 centers and 180 sentinel site nationwide. The 1998 estimates of HIV sero-prevalence in the adult population of India is about 0.7 %. The cumulative rate for all HIV tests performed in the country, including both high and low risk groups, has shown a slow pattern of increase from 1 % in 1992 to 2.3 % of tests in 1998.

Project Components

To accomplish the objectives, the project had a multi-pronged strategy and comprised five components :

- Strengthening the awareness and community support for AIDS prevention with a primary focus on sexual transmission, behavioral change and condom promotion through television and radio stations, private advertising agencies, Non-Government Organisations (NGOs) and the health system.
- Improving blood safety from 30 percent to 90 percent screening of the blood supply, enhancing the rational use of blood and the share of voluntary donations.
- Building surveillance and clinical management capacity to monitor the spread of the epidemic and to strengthen the skills of health staff and social workers in managing and counseling persons with HIV/AIDS; and
- Controlling sexually transmitted diseases by improving clinical services and case management in the country's STD clinics and in private practice in metropolitan areas.

Sector Policy

The Project made important contributions to developing policies associated with HIV/AIDS and to amending inappropriate ones. Policy developments included :

- Promulgation and enforcement of regulations upgrading the quality specifications of condoms through the amendment of the Drugs and Cosmetics Act
- Promotion of policies for humane treatment of persons living with HIV/AIDS and amending regulations which facilitated discrimination

- Maintaining central sponsorship for program funding to encourage slow responding States Exempting all financial contributions to the National and State Transfusion Councils from income tax. In addition, a draft HIV/AIDS National Policy Document, which was formulated in close consultation with major stakeholders, is now ready for approval by Cabinet.

Project Cost, Disbursement, and Timetable

The project was estimated at US $99.6 million at the time of appraisal, and was to be financed by a Government of India contribution of US $14.1 million, an IDA credit of US $84.0 million (SDR 59.8 million equivalent) and a WHO co-financing grant of US $1.5 million. The final disbursement took place on September 7, 1999, at which time SDR 59.8 million (US $84.2 million equivalent), the original principal amount of the Credit was fully disbursed, US $2.2 million of WHO grants was utilized, and the GOI contribution came to US $27.5 million, an increase of US $13.4 million over the original plan.

Key Factors Affecting the Project

The main factor contributing to the success of the project was the generally high level of commitment of the GOI to initiating HIV/AIDS prevention and control. Key factors initially limiting project implementation were :

- This operation constituted a new program in an unfamiliar area of public health with little existing capacity to cope with HIV
- Large segment of the 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 diverting attention towards HIV/AIDS
- It was difficult to identify, reach, and cover risk groups
- Linkages to sexually transmitted diseases and tuberculosis were inadequate
- Borrower's and recipients' non-familiarity with guidelines and project processing requirement
- Staffing vacancies, frequent transfers, holding of dual charges, and changes in staffing patterns
- Lack of ownership by State level staff who perceived the AIDS Program as a centrally driven scheme
- Mixed effectiveness of the empowered committees in the States
- Delay in fund release from State Departments of Finance to Program Cells
- Lack of uniformity in the processes used in many States for the disbursement of funds and
- Lack of infrastructural support in many State AIDS Cells.

Project Outcomes

The overall outcome of the project was satisfactory, notably in building the program and in attaining the stated objectives as discussed previously. Although it is not easy to estimate the number of HIV cases averted compared to what would have been the case without the project, it is evident that the project had generated a number of important results as discussed in paragraph I and II. Sentinel surveillance evidence in 1998 has shown the following:

- The states of Maharashtra, Tamil Nadu and Manipur have shown generalized epidemic with prevalence in antenatal mothers as 1% and above.

- Concentrated epidemic in states of Gujarat, West Bengal, Nagaland, with HIV prevalence rate of 5% and above among high risk groups, but less than 1% in antenatal mothers
- The remaining states have a low level of epidemic with a prevalence of less than 5% among the high risk groups and less than 1% among the antenatal mothers. However, the threat of HIV/AIDS in India will remain a major and potentially catastrophic issue, and it call for an urgently enhanced response.

Key Lessons Learned

Institutional

- When there is a new public health threat inadequately recognized by the civil society and participatory approaches are limited, it is necessary that the central government play a major leading role at the start-up phase to initiate a national response.
- Following the start-up phase, program implementation needs to be decentralized to States and Municipal Corporations, to enable stronger local responses, and to accommodate varying epidemiological patterns, institutional capacities, and commitment to the program. This calls for devolution of service activities, combined with a strengthened coordination role for the central level.
- Advocacy and coordination among various sectors, including the private sector, need to be developed.

Technical and Social

- It is necessary to adopt a multi-pronged approach in planning, prioritized program interventions, and the dissemination of public information to persons who are in risk situations, including many married females.
- Effective target interventions require high levels of coverage and saturation, and the identification, reach and coverage of vulnerable risk behaviour groups remains very challenging.
- The creation of an enabling environment, which includes policy adjustments, supportive inputs and empowerment processes of the marginalized groups, is needed to facilitate behaviour change. Public relations efforts and careful program design are needed to minimize the stigma and marginalization of highly vulnerable groups. Stigmatizing risk behaviour persons leads them further "underground" and is detrimental to program effectiveness. Targeted interventions to such groups should be embedded in a broader national program.
- Blood safety is most effectively addressed in the broader context of an improved blood banking system rather than through HIV testing only.
- The distribution of HIV/AIDS in India is not uniform. The epidemic is focused sharply in a few States with most of India having low rates of infection. Unless this differential is taken into account for planning interventions, efforts are likely to be inadequate in some areas and inappropriate in others.
- Effective program management requires high quality, up-to-date epidemiological and management information.

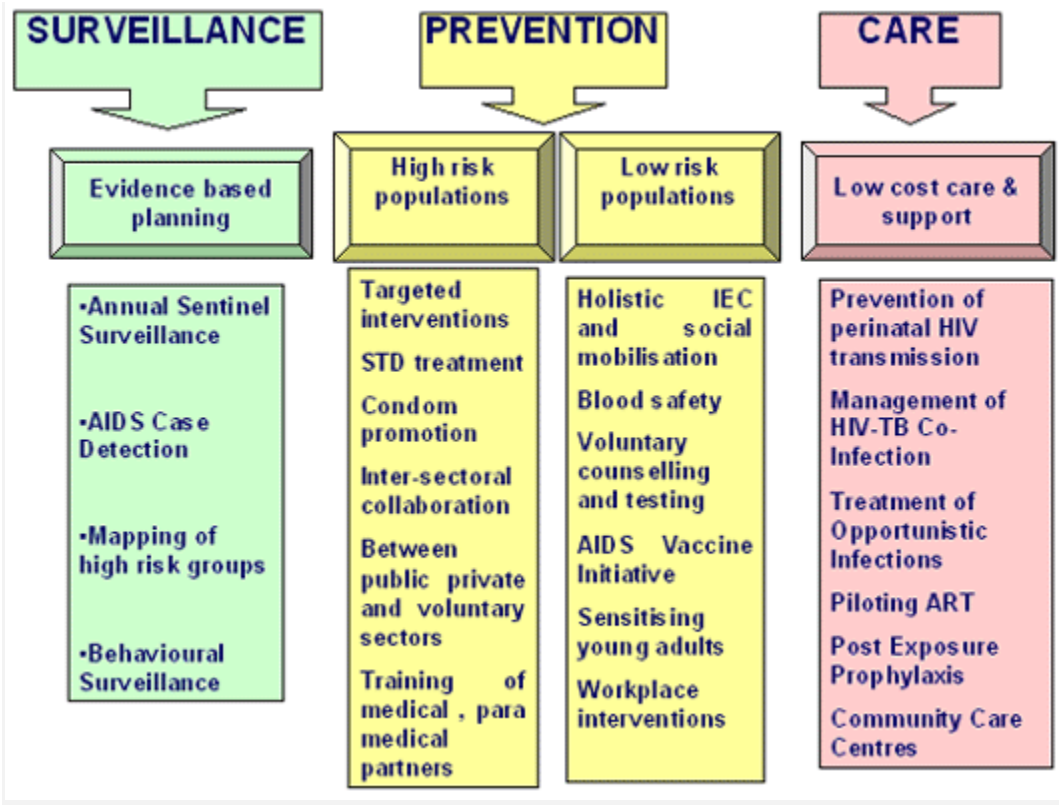
Operational

- Variability of State performance within India needs to be addressed.

- Developing a computerized Financial Management System (FMS) would alleviate issues related to fund flow processes, financial and accounting procedures, budgeting and forecasting system, internal control mechanisms and auditing arrangements.
- The use of Charted Accountant firms in auditing at the State level is required to alleviate lapses in the submission of audit reports.
- Monitoring activities should be an integral part of the routine functions of the program and cannot be ad hoc activities linked solely to the Bank's supervision mission.
- The porous boundaries of the country and the major cross-border flows of various population groups by land and the sea require an enhanced regional approach.

National AIDS Control Programme Phase - II (1999 - 2006)

A visual depiction of the components of the Second NACP, reads as follows



The Phase II of the National AIDS Control Programme has become effective from 9th November, 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.

Project formulation for Phase II, National AIDS Control Programme followed a truly participatory process at the State and Municipal Corporation levels. Between April and June 1998, the Technical Liaison Officers (TLOs) of NACO, in collaboration with State AIDS Control Programme Officers, conducted State Level Planning Workshops in all the States and the cities of Mumbai, Chennai and Ahmedabad. Each of these workshops was conducted for 2 days in which all major stakeholders such as senior officials of the Government departments, NGOs, private sector, medical professionals and district level officials participated. On an average around 100 stakeholders participated in each of these workshops. In addition to serving as a tool preparation, these workshops also turned out to be a

major advocacy effort. In the formulation of the State Implementation Plan(Ips) the following steps were taken :

Step 1 :	Holding of State level workshops in which participants from Government departments, NGOs etc. discussed the various issues under several components and came out with recommendations
Step 2 :	Constitution of Core Team to finalise the specific programs for AIDS Control Project II based on the recommendations made under seven components.
Step 3 :	Core Team held three sittings in June-July, 1998, examined the recommendation to identify and select programs/activities which needed to be given priority and focus.
Step 4 :	The activities suggested were listed and prioritized by the Core Team based on the recommendations at the workshop.
Step 5 :	In end July, 1998, the World Bank prescribed cost codes were received. A special Task Force was constituted and the activities were regrouped under five components as per the revised guidelines from NACO and World Bank
Step 6 :	The various activities were divided into sub-activities; cost codes were assigned for each sub-activity. The implementation plan was prepared indicating the process, sub-process, activities, implementing agency, assessment parameters and risk.
Step 7 :	The unit cost and the number of units under each activity were finalized by the Special Task Force and the outlay was worked out. Discussions were held with officials of USAID and VHS-APAC to assess the extent of the bilateral involvement in Tamil Nadu.
Step 8 :	The Technical Liaison Officers, World Bank Consultants and the PD, NACO, reviewed the draft Project Implementation Plan (PIP) prepared and suggest scaling down of outlay, taking into account the past and current expenditure and the absorptive capacity or funds in the future. At this state, the Procurement Plan and the Training Action Plan were prepared simultaneously.
Step 9 :	The special task of force held several sittings to review the number of interventions and units of various activities. After the southern states PIP workshop at Bangalore in the first week of September 1998, it was decided to restrict the interventions and the no. of other units/activities and the outlay was revised. The procurement plan was finalized after excluding the cost of equipment to be procured and supplied by NACO. The training action plan was also revised and finalized based on the modified outlay.

In the month of September-October, 1998, National AIDS Control Organization organized regional workshops for State ADS Programme Officers for finalization of the State PIP. On the basis of the State PIPs, the National Project Implementation Plan was prepared

The Mission of the International Development Association (IDA) visited during December 14-22, 1998 and appraised the project in collaboration with officials of the Government of India. The Mission recommended an overall assistance of US $191 million with Government of India's contribution of US $38.8 million. The total project cost was estimated at US $229.8 million (Rs.1155 cores). The detailed project document was considered by the Expenditure Finance Committee (EFC) in its meeting held on 29th April, 1999 along with USAID and DFID assisted projects. The EFC recommended 3 projects for approval - NACP II (National AIDS Control Project) for Rs.1155 cores, US assisted AVERT project in Maharashtra for Rs.166cores and DFID project for AP, Orissa, Kerala and Gujarat for Rs.104cores for the period of 5 years from 1999-2004 except US assisted AVERT Project which will be for a period of 7 years.

The World Bank and DFID projects are for a period of 5 years (1999-2004), while US assisted AVERT project for 7 years (1999-2006).

The negotiations for an IDA Project NACP II were held between the representatives of the Government of India and IDA in Washington from 7-12th May, 1999. The AIDS II project was approved by IDA Board in its meeting dated June 15, 1999. The NACP II project was approved by the Cabinet on 26th August, 1999.

The National AIDS Control Project, Phase II is aimed at

- To shift the focus from raising awareness to changing behavior through interventions, particularly for groups at high risk of contracting and spreading HIV;
- To support decentralization of service delivery to the States 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;
- To protect human rights by encouraging voluntary counseling and testing and discouraging mandatory testing;
- To support structured and evidence-based annual reviews and ongoing operational research ; and
- 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.

The National AIDS Control Project has key objectives namely

- To reduce the spread f HIV infection in India; and
- Strengthen India's capacity to respond to HIV/AIDS on a long term basis.
- Operationally, the project interventions would seek to achieve the following by the end of the project:
- To keep HIV prevalence rate below 5% of adult population in Maharashtra, below 3% in Andhra Pradesh, Karnataka, Manipur, Tamil Nadu where the HIV prevalence is moderate and below 1% in remaining States, where the epidemic is still at a nascent stage;
- To reduce blood borne transmission of HIV to less than 1%
- To attain awareness level of not less than 90% among the youth and others in the reproductive age group
- To achieve condom use of not less than 90% among high risk categories like Commercial Sex Workers.

Project Description and Strategy

The project would adopt a multi- pronged approach that would focus on the most critical intervention to begin limiting HIV transmission. Project activities are grouped into two components and five sub-components. Both components reflect activities at National, State and Municipal levels.

A. Delivery of Cost-effective interventions Against HIV/AIDS

- *Priority Targeted Intervention For Groups At High Risk* Train Primary Health Care providers in Syndromic Case Management and counseling in condom use;
- Strengthening STIs clinics in each district hospital and medical college hospitals; and

- Improve referral services for STIs treatment. In addition client programme would aim to deliver targeted IEC, condom promotion

The project aims to reduce the spread of HIV in groups at high risk by identifying target populations and providing peer counseling, condom promotion, treatment of STIs and enabling environment. These would be locally modified and delivered largely through Non-Governmental Organizations, community based organizations (CBOs) and the public sector using generic protocols.

Identify those groups at higher risk – This would involve

- participatory approaches;
- locating groups at highest risk, chiefly commercial sex trade workers, truck drivers, injecting drug users, migrant laborers, men having sex with men;
- determining the access and demand for health services among the groups of high risk; and
- developing strategies based on outreach, peer education and partnerships.

Provide integrated peer counseling, condoms, and treatment for STIs for those at high risk. Representatives of groups at high risk would be trained to provide peer education aimed at changing high risk behaviors. In addition, these interventions would and STI treatment and counseling to clients of commercial sex workers.

Preventive Intervention For the General Community

This includes the following activities:-

- IEC and awareness campaigns.

Activities include

- Conducting mass media campaign at the State and municipal levels;
- conducting local IEC campaign, use traditional media such as folk arts and street theatre;
- Promoting advocacy campaigns;
- Conducting awareness programme geared towards youth and college students; and
- Organizing Family Health Awareness Campaigns on a regular basis to generate awareness and provide service delivery for control of STI and RTI infections

- Providing voluntary testing and counseling.

This involves

- Increasing availability of and demand for voluntary testing, especially joint testing of couples
- Training grass root level health care workers in HIV/AIDS counseling;
- Providing counseling services through all blood banks in India and through STI clinics.

It is envisaged that one voluntary testing centre would be established in each district.

- Reduce transmission by blood transfusion and occupational exposure. This activity would include

- setting up of 10 new modern blood banks, upgrading 20 existing major blood banks and setting of 80 new district level blood banks;
- establishing another 40 components separation units;
- establishing mandatory screening of all blood units for Hepatitis C Virus;
- mobilizing voluntary blood donation;
- training providers in the rational use of blood products;
- facilitating communications among blood banking services;
- providing trained counselors for blood banks in public and private sectors; and
- training health care workers at all levels in universal precautions, including provision of post exposure prophylaxis drugs.

Low Cost AIDS Care

These activities would provide funding for home based and community based care, including increasing the availability of cost effective interventions for common opportunistic infections. Specific activity would include

- establishing best practice guidelines and providing appropriate drugs for treating common Opportunistic Infections (OIs) at district hospitals;
- training at selected State level hospitals for the provision of referral services
- improve the quality and cost effectiveness of interventions offered by existing procedures.
- establish new support services for care for persons with AIDS in partnership with NGOs and CBOs by establishing small community based hospitals, hospice programs, drop-in-centers and home based care would be taken up.

B. Strengthen capacity

1. Institutional strengthening:

This component aims to strengthen effectiveness and technical, managerial and financial sustainability at National, State and Municipal levels.

- Building implementation capacity at the States and Municipal levels by :

  - Ensuring adequate staff and skills in AIDS Control Societies;
  - Transferring implementation responsibilities to the State and Municipal levels;
  - Emphasizing management and implementation capacity at all levels.

There would be an enhanced emphasis in the second project, on establishment of blood banking services, blood testing centers and STD clinics in all district hospitals.

Accounts and Finance Unit: The World Bank has decided that for all IDA assisted projects starting after July, 1998, a "Loan Administration Change Initiative" (LACI) is to be established. The main objectives of LACI is to assist the project to perform better by reducing delays and financial bottlenecks through speedy disbursement and facilitating project monitoring and control by linking expenditure with actual physical progress. This system visualises a Project Financial Management System at NACO and an Accounts and Finance Unit in each State and Municipal Corporation.

- Strengthening leadership capacity of NACO:
  NACO would enhance

  - Strategic planning skills;
  - Focus on disseminating best practices for targeted interventions;
  - Establish and manage network of technical expertise through Technical Resource Groups (TRGs) in STI/HIV/AIDS and other important issues;
  - Conduct operation research; and
  - Oversee research and development activities nation-wise. NACO would be in overall charge of the Financial Management of the Project and would be responsible for effective and efficient use of financial and other resources for the project.

- Expand and improve nation-wide STI/HIV/AIDS sentinel surveillance:
  Specific activities include

  - sentinel surveillance in every State;
  - STI surveillance through specific surveys;
  - behavior surveillance surveys; and
  - AIDS cases surveillance.

- Training

A training Action Plan has been finalized after convening four regional and one national workshop of various States with twin objectives of

- preventing the spread of epidemic and strengthening the local capacity to respond to the epidemic in future and
- to address the training needs identified in the various components of the project. Keeping in view the overall objectives of the proposed project, a two pronged approach have been adopted for training activities under the proposed project; at the national level, the activities are of generic nature addressing the technical needs - development of curriculum and training/training materials, continual review of the ongoing training activities and incorporating the local best practices, orientation/training of trainers/training coordinators, periodic evaluation of impact of the training project activities and inputs for completing training infrastructure. At the state level the activities focus on implementation - development of training phase/calendars as part of the State Project Implementation Plan, organizing training programs, evaluation of the training activity to improve their quality and training for the NGOs

- Build capacity for monitoring and evaluation programme activities
  An independent National M&E agency would be selected in the first year of the project. Each AIDS Control Society would have a M&E officer. M&E would be conducted by an outside agency at baseline, interim, and final year. The Performance and Expenditure Annual Review (PEAR) would involve NACO, AIDS Control Societies and IDA jointly reviewing project expenditure, financial flows, annual action plans, PMRs and project input, output and outcome and process indicators.

- Increase India's capacity for research on HIV/AIDS
  Most operational research, policy development studies, research and development (R&D) and cause of death and other studies would be organized by NACO, States and Municipal

Corporations keeping in view the guidelines from an expert working group composed of NACO, State and related officials.

- A Research Advisory Committee has been constituted to determine research needs of the country in the field of HIV/AIDS, to promote research capability of Indian Scientist/Institutions. Initiative will be taken to develop a HIV vaccine programme in our country. Mother to child transmission prevention programme has been introduced as an operation research.

2. Intersectoral Collaboration

This component would promote collaboration among the public, private and voluntary sectors. Activities would be coordinated with other programs within the Ministry of Health and Family Welfare and other Central Ministries and Departments. Collaboration would focus on :-

- learning form the innovative HIV/AIDS programs that exist in other sectors; and
- sharing in the work of generating awareness, advocacy at delivering interventions.

Several Central Ministries and some public sector organization with very large work force have developed their own programme and have funded under the NACP II. Some of these are Ministry of Sports and Youth Affairs, Ministry of Labour (Employees State Insurance Corporation), the Indian Railways, the Ministry of Defense and the Steel Industry. Similarly, the private sector has also shown interest in getting actually involved in the fight against HIV/AIDS in India.

Procurement Arrangements: NACO would be responsible for procurement of HIV test kits, equipment and certain drugs as central component through the National Thermal Power Corporation Limited (NTPC), the procurement agent appointed under the project.

Project Targets

The programme has the following firm targets to be achieved during project period

- To reduce blood-borne transmission of HIV to less than one percent of the total transmissions.
- To introduce Hepatitis C as the fifth mandatory test for blood screening.
- To set up 10 new modern blood banks in uncovered areas, upgrading of 20 major blood banks, setting up of 80 new district level blood banks in uncovered districts, establishing another 40 blood component separation units, promotion of voluntary blood donation and increase its share in total blood collected to at least 60%. The total blood collection in the county which is now around 3-3.5 million units is sought to be raised to 5-5.5 million units by the end of the project.
- To attain awareness level of not less than 90% among the youth and those in the reproductive age group.
- To train up at least 600 NGOs in the country in conducting targeted intervention programs among high-risk groups and through them promote condom use of not less than 90% among these groups and control of STDs.
- To conduct annual Family Health Awareness Campaigns among the general population and provide service-delivery in terms of medical advice and provision of drugs for control of STDs and Reproductive Tract Infections (RTIs). These campaigns will be conducted jointly by NACO and RHC programme managers at the State level..

- Promotion of voluntary testing facilities across the country at the end of the project. It is visualized that every district in the country would have at least one voluntary testing facility.
- Awareness campaigns will now be more interactive and use of traditional media such as folk arts and street theatre will be given greater priority in the rural areas. It is proposed to cover all the schools in the country targeting students studying in Class IX and Class XI through school education programs and all the universities through the "Universities Talk AIDS" programme during the project period.
- Promotion of Organizations of people living with HIV/AIDS and giving them financial support to form self-help groups.

Monitoring and Evaluation of the Programme

For the effective monitoring and evaluation to assess the implementation of the Phase-II of the National AIDS Control Project at National and State level, the following mechanism has been envisaged.

- Creating a Computerized Management Information System (CMIS) at the National and State levels
- Training NACO Staff and Health specialists in evidence based health programme management.
- Conducting base line, mid term and final evaluation
- Conducting the Annual Performance and Expenditure Review (APER)
- Conducting the National Performance Review (NPR) under the National AIDS Control Board.
- A National level independent outside agency is being identified who would be assigned the responsibility of development of CMIS, conduct of base line, mid-term and end term evaluation.

Financial Management System

It is envisaged to maintain an adequate project financial management system to provide accurate and timely information regarding project resources and expenditure to facilitate efficient project management. For this purpose a consultancy agency is being selected for developing a Project Financial Management System for NACP-II.

The financial management system would be integrated one for the whole project. A common set of policies and procedures would apply to the entire project and a consolidated set of financial reports for the project would be prepared from the FMS.

Outlay for National AIDS Control Programme - II

There are three funding agencies for Phase II of National AIDS Control Programme. These are :

International Development Agency (IDA)

World Bank has provided an account of US $191.00 million as soft loan for the project and the domestic budgetary support is US $38.8 million. The total outlay is US $229.8 million (Rs. 11550.00 million).

United States Agency for International Development (USAID)

United States Agency for International Development has extended its assistance to the Govt. of Maharashtra for implementation of 'AVERT' Project based on their earlier experience of working in the State of Tamil Nadu under the AIDS Prevention and AIDS Control (APAC) project. The outlay for USAID assisted 'AVERT' project is Rs. 1660.00 million.

Department for International Development (DFID) of U.K. Government

Department For International Development has extended its assistance for implementation of Sexual Health Projects in the States of Andhra Pradesh, Gujarat, Kerala and Orissa in continuation of their earlier projects in West Bengal. The outlay for this project is Rs. 1040.00 million.

Outlay for National AIDS Control Project Phase -II	Rupees in Million
IDA credit (1999-2004)	11550
USAID assistance for AVERT Project in Maharashtra.	1660
DFID assistance for Sexual Health projects for the States of Andhra Pradesh, Gujarat, Kerala and Orissa.	1040
Total	14250

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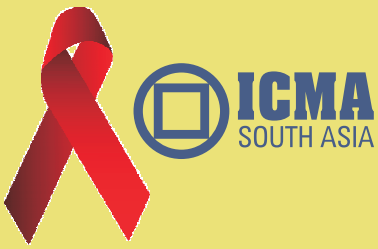
Coming up..

- Leading Practice from Ahmedabad Municipal Corporation AIDS Control Society
- Success Story of Mumbai District AIDS Control Society
- Good Initiatives of Chennai Corporation AIDS Prevention and Control Society
- Ideas in Action- Surat Municipal Corporation Project Coordination Office



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