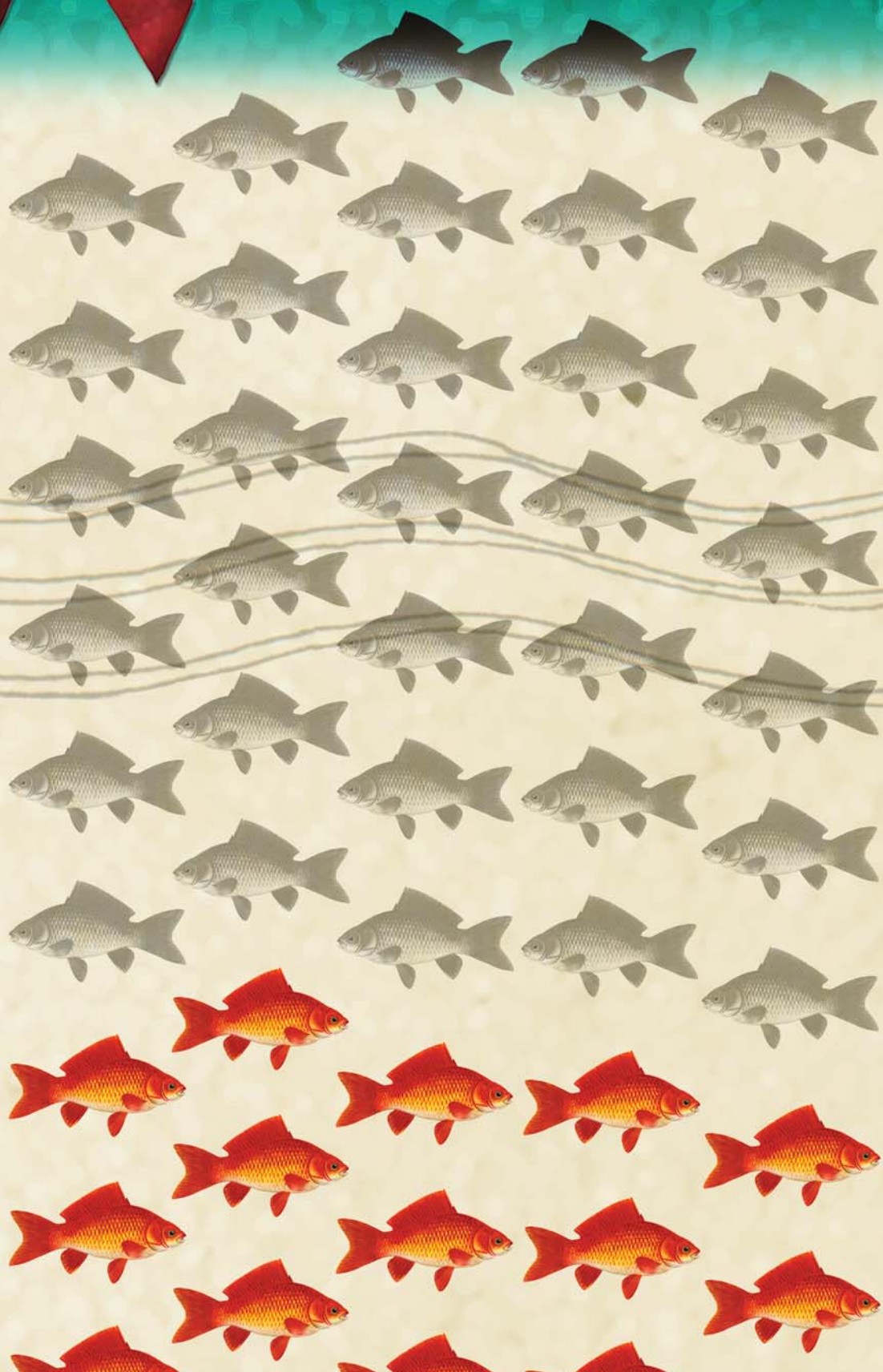


NACP III

A large red ribbon, a symbol for HIV/AIDS awareness, is positioned over the letter 'A' in the title 'NACP III'.

To
halt
and
reverse
the HIV epidemic
in India





MAIN COMPONENTS OF REPRODUCTIVE HEALTH

FAMILY PLANNING
MATERNAL CARE AND
MOTHERHOOD
PRODUCTIVE
ACTION (RTI)
AIDS
ANT AND CH
HEALTH
ABORTION
INFERTILITY
MANAGE
AT

HIV AIDS

1. AVAILABILITY OF GENDER DATA
2. POLICY / PLANNING
 - A. Whether policy of HIV
 - B. WHETHER IT IS
 - 3.C Whether policy has gender division it.

GUIDING PRINCIPLES

NACP-III is based on eight guiding principles:

-  The principle of **Three Ones**, i.e., one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National Monitoring and Evaluation System.
-  **Equity** in prevention and impact mitigation strategies - quantified and measured through relevant indicators.
-  **Respect** for the rights of the People Living with HIV/AIDS
-  Promotion of **social ownership and community involvement** through civil society representation and participation in planning and implementation.
-  Creation of an **enabling environment** wherein those infected and affected by HIV could lead a life of dignity free from stigma and discrimination.
-  Up-scaling of HIV prevention, care, support and treatment services with the spirit of providing **universal access**.
-  Implementing an HRD strategy based on **qualification, competence, commitment and continuity**.
-  **Evidence-based and result-oriented strategic and programme interventions** with scope for innovations and flexibility, prioritizing local contexts.

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INTRODUCTION

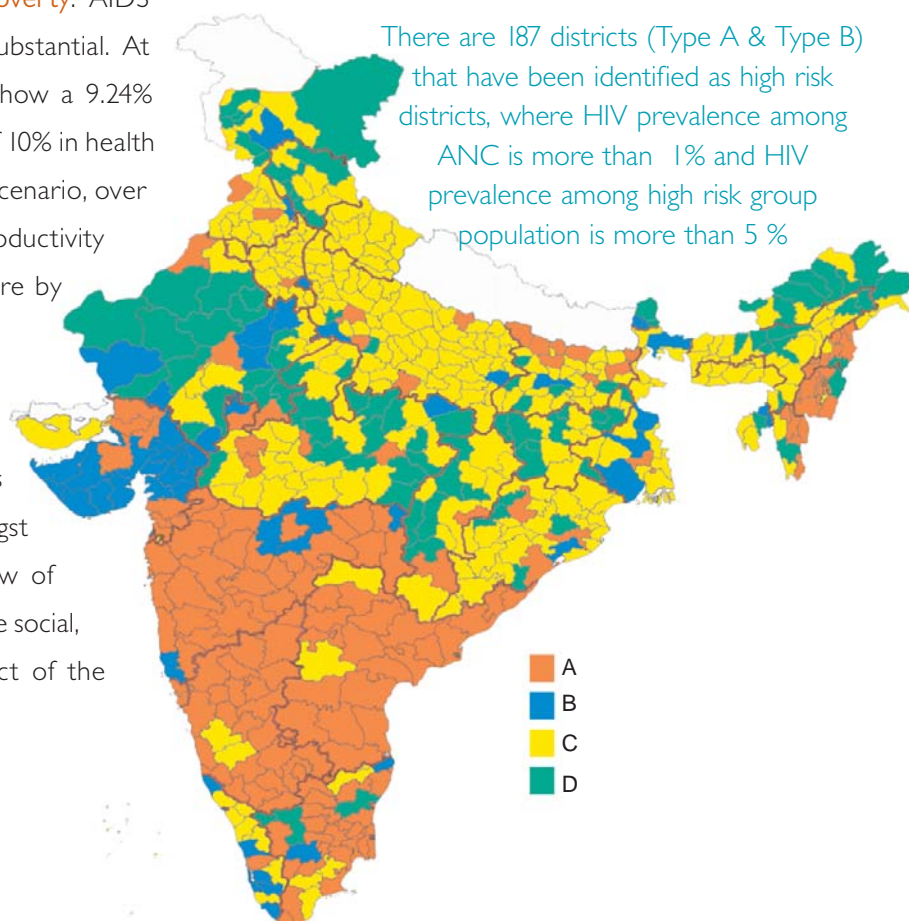
The National AIDS Control Programme Phase III (2007-2012) is being launched with the objective to halt and reverse the spread of the HIV/AIDS epidemic in India. During this phase the National AIDS Control Organisation will strengthen capacity, formulate policy and guide implementation to enable a decentralized response focussed on local needs.

The HIV/AIDS epidemic came to India in 1986 when the first case of HIV was detected in Chennai. Since then, the number of infected people has grown substantially. Evidence shows that the epidemic is moving outwards, **from high risk groups to the general population** and **from urban centres to rural areas**. Increasingly **youth** and **women** are getting infected.

The HIV epidemic in India is **complex** and **heterogeneous**, impacted by intricate and varied social structures. As a result, there is not 'one' HIV epidemic but 'many' concurrent and inter-related HIV epidemics each of which needs a localized and sensitive response. No state in the country is unaffected by HIV.

The epidemic can entail adverse consequences to our achievement of health and development goals, namely **child mortality** and **poverty**. AIDS related **productivity losses** can be substantial. At the micro level household surveys show a 9.24% decline in incomes¹ and an increase of 10% in health spending. If unchecked the epidemic scenario, over a 14 year period, can lower labour productivity and increase public health expenditure by 10-15%.

Swift, effective and sustained Government commitment has contained HIV prevalence rates amongst adult population providing a window of opportunity to restrict and mitigate the social, developmental and economic impact of the epidemic.



notes

1 Study by NCAER, 2006



TIMELINE

- 1986
 - First case of HIV detected
 - AIDS Task Force set up by the Indian Council of Medical Research
 - National AIDS Committee (NAC) established under the Ministry of Health.
- 1990
 - Medium Term Plan launched in four states and the four metros
- 1992
 - NACP I launched to slow down the spread of HIV infection
 - National AIDS Control Board constituted
 - National AIDS Control Organisation set-up
- 1999
 - NACP II begins, focussing on behaviour change, increased decentralization and NGO involvement
 - State AIDS Control Societies established
- 2002
 - National AIDS Control Policy adopted
 - National Blood Policy adopted
- 2004
 - ART Treatment initiated
- 2006
 - National Council on AIDS constituted under Chairmanship of Hon'ble Prime Minister
 - National Policy on Paediatric ART formulated





NATIONAL AIDS CONTROL PROGRAMME (1999 -2007)

NACP II aimed to **reduce the spread** of HIV infection in India through behaviour change while **increasing capacity** to respond to HIV/AIDS on a long-term basis. Measurable objectives towards stabilizing infection levels were to keep HIV sero-prevalence:

- i. below 5% of the adult population in high prevalence states
- ii. below 3% in states where the prevalence was moderate, and
- iii. below 1 and 2% in the remaining states where the epidemic was at a nascent stage.

Successful implementation led to the achievement of all these targets.

Strong **political commitment** manifested itself in the formation of the National Council on AIDS comprising 31 ministries, seven chief ministers and leading civil society representatives under the chairmanship of the Hon'ble Prime Minister of India. The NCA facilitates a multi-sectoral response to the epidemic making HIV a development challenge and not merely a public health problem.

Operationally the programme also aimed to reduce blood borne transmission of HIV to less than 1%, attain awareness levels of not less than 90% amongst youth and others in the reproductive age group and increase condom use to not less than 90% amongst high risk categories. The programme adopted a decentralized approach by establishing **State AIDS Control Societies** and involvement of NGOs, civil society partners, private sector and networks of People Living with HIV/AIDS (PLHA).

HIV prevalence as indicated by recent studies and analyses seems to be stabilizing. States like Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra and Nagaland have started showing declining trends². The sentinel surveillance results of 2005 also reinforce the stabilization trends indicating that the expected outcomes of NACP-II have broadly been accomplished.

notes

2 Rajesh Kumar et al, 2006



ACCOMPLISHMENTS - 1999-2006

Activity/ Component	Baseline September 1999	Achievements (As of June 2007)
Establishment of Sentinel Sites for HIV trends	180	1,162
Knowledge of HIV/AIDS & at least 2 methods of HIV prevention	50-80% (urban) 13-64% (rural)	43-83%(urban) 24-84% (rural)
Awareness	Not measured (76% in 2001)	84.6%*
Coverage of High-Risk Population across the country through targeted intervention projects	300	1,220
Coverage of schools and colleges for AIDS awareness	0	112,000 schools
Consistent condom use among female sex workers	Not measured	73.4%*
Condom vending machines installed through NACO	0	11,025 (with another 11,025 under installation)
Modernization of district blood banks	685	883
Blood Component Separation Units	40	82
Modernization of Major Blood Banks	235	255
State of art Blood Banks	0	10
Voluntary Blood Donation (% of requirement)	20%	56.4%
Blood Collection	2 million units	4.5 million units
HIV tests conducted	0	10 million
Strengthening of STI clinics	504	845
Establishment of Integrated Counselling & Testing Centres	0	4,132
PLHA networks	0	90
Community Care Centres	0	122
Drop-in Centers	0	84
Exclusive PPTCT centres	0	502
Anti-retroviral Therapy Centres	0	127
Patients on ART	0	80,000

Source: NACO, 2007

* BSS, 2006



LESSONS LEARNT

Despite the achievements of NACP II, some areas require greater attention and stronger focus. Lessons that have emerged from the implementation of NACP-II include the following:

- Complexities and dimensions of the epidemic are yet to be completely understood especially in the Northern and North Eastern states of the country.
- Continuity of trained staff led by an adequately tenured Project Director is necessary to achieve appropriate programme implementation.
- **Capacity development and technical support** of SACS needed for decentralization to produce the desired results.
- **Focused attention on the High Risk Groups** (HRGs) through targeted interventions (TIs) has proved effective in preventing the spread of infection. However, attitudes towards high risk behaviours and weak systems for civil society partnership are barriers towards achieving the target saturation of HRGs. Specifically Men having Sex with Men (MSM) and Injecting Drug Users (IDU) interventions were low. Out-of-school as well as unschooled youth, married adolescents and rural population need attention.
- Aggressive **Social Marketing** needed for condom promotion to achieve requisite targets
- **Participation of the private sector and mainstreaming civil society organisations, village communities, youth organisations**, etc. needs to be enhanced for prevention as well as building an enabling environment free of stigma and discrimination.
- **Convergence** between National Rural Health Mission (NRHM) and NACP to be strengthened.
- AIDS mortality and under reporting impact on **interpretation of data**. Appropriate methodology best suited for India needs to be refined. Identifying causes of spread and understanding impact of factors like limited access to services on women is also necessary.
- Existing **research** wing within NACO needs to be strengthened to deal with the emerging need for knowledge management.
- Greater **financial investment** in HIV prevention, control, care and support needed.
- Formulation of policies for **mitigating the impact** of the epidemic on women and children infected and affected by HIV/AIDS.



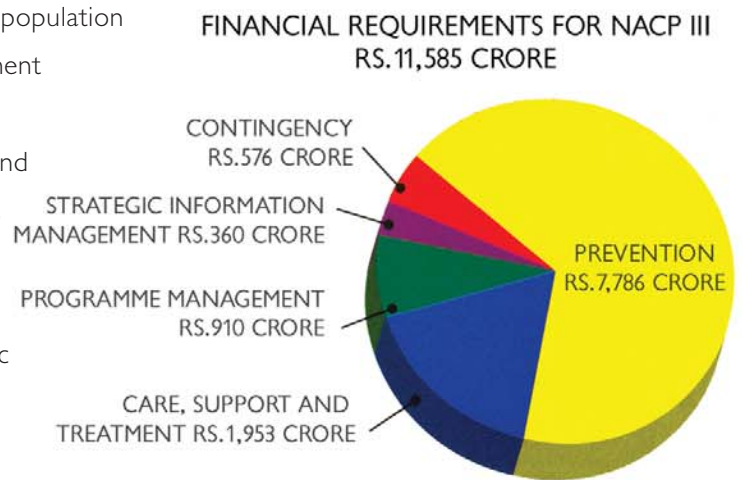
NACP III (2007-2012)

STRATEGIC APPROACH

National AIDS Control Programme III (2007-2012) seeks to halt and reverse the HIV/AIDS epidemic in India by 2012, bettering the target of 2015 set in the HIV/AIDS related Millennium Development Goal.

NACP III will be implemented through a four pronged strategy of:

1. Preventing new infections in high risk groups and general population through:
 - Saturation of coverage of high risk groups with targeted interventions (TIs)
 - Scaled up interventions in the general population
2. Providing greater care, support and treatment to larger number of PLHA.
3. Strengthening the infrastructure, systems and human resources for scaling-up prevention, care, support and treatment programmes at the district, state and national level.
4. Strengthening the nationwide Strategic Information Management System.



An investment plan for the programme indicates an estimated requirement of Rs. 11,585 for all the interventions.

REACHING A CONSENSUS

The Third National AIDS Programme Implementation Plan (2007-2012) evolved through a year-long preparatory process that included wide-ranging consultations with 14 working groups, e-forums, civil society organisations, PLHA networks, NGOs/CBOs, and national expert groups. A participatory appraisal process was carried out involving development partner; it incorporated inputs from various assessments and studies.

NACP III will consolidate gains and address identified gaps and weaknesses of NACP I and NACP II.

This broad-based consultative process has resulted in evolving a consensus about the goals, objectives and overall framework of NACP-III.



PROGRAMME COMPONENTS



PREVENTION

CARE, SUPPORT AND TREATMENT

CAPACITY BUILDING

STRATEGIC INFORMATION MANAGEMENT



Targeted Interventions among HRGs (FSW, MSM and IDUs)



ART



Establishment Support and Capacity Strengthening



Monitoring and Evaluation



Other interventions (Truckers, Prison inmates, Migrants etc.)



Paediatric ART



Training



Surveillance



Integrated Counselling and Testing Centres



Centre of Excellence



Managing Programme Implementation and Contracts



Research



Blood Safety (including mobile blood banks)



Care and Support (Community Care Centres and Impact Mitigation)



Mainstreaming/Private Sector Partnerships



Communication, Advocacy and Social Mobilisation



Condom Promotion



UP-SCALING PREVENTION

Prevention remains the mainstay of NACP III. Despite the high number of HIV positive persons in the country, 99% of the population is uninfected. The programme aims to reduce new infections in all categories and prevent spread from High Risk Groups (HRG) to the general population. A behaviour change strategy based on an effective Information, Education and Communication (IEC) campaign and supported by appropriate services will be implemented. Timely and accessible service delivery will ensure continuum of care at every level. A package of clearly defined and inter-linked services along with clarity on where they are available will enhance utilization.

SATURATING COVERAGE IN HRG

NACP III aims to saturate 80% population of HRG within the programme period with the aim of reducing infection amongst this group. Special focus will be given to IDU and MSM groups who were not well covered during the last phase of the programme.

The NACP III approach:

- Behaviour Change Communication (BCC) interventions to increase demand for products and services
- provide STI services including counselling to increase compliance of patients to treatment regimens, provide risk reduction training, and focus on partner referral;
- promote demand for condoms and ensure availability and easy access
- create an enabling environment to motivate practice of safe behaviours;
- increase programme sustainability through community organizing and ownership amongst HRG; and
- integrate prevention with care, support and treatment to facilitate access and use of these services by HRGs.

2100 Targeted Interventions (TIs) will reach out to one million Female Sex Workers (FSW) and their partners; 1.15 million Men having Sex with Men (MSM) and 190,000 injecting drug users by 2012.



SCALING UP INTERVENTIONS IN BRIDGE POPULATIONS

To stop the virus from entering into the general population, interventions with bridge populations need greater focus. There are an estimated 2.5-3 million long distance truck drivers in the country with an estimated HIV prevalence of about 11-16%. There are also more than 8 million temporary and short duration migrants amongst whom prevalence is unknown. Socio-economic and situational pressures make these groups vulnerable.

The NACP III approach:

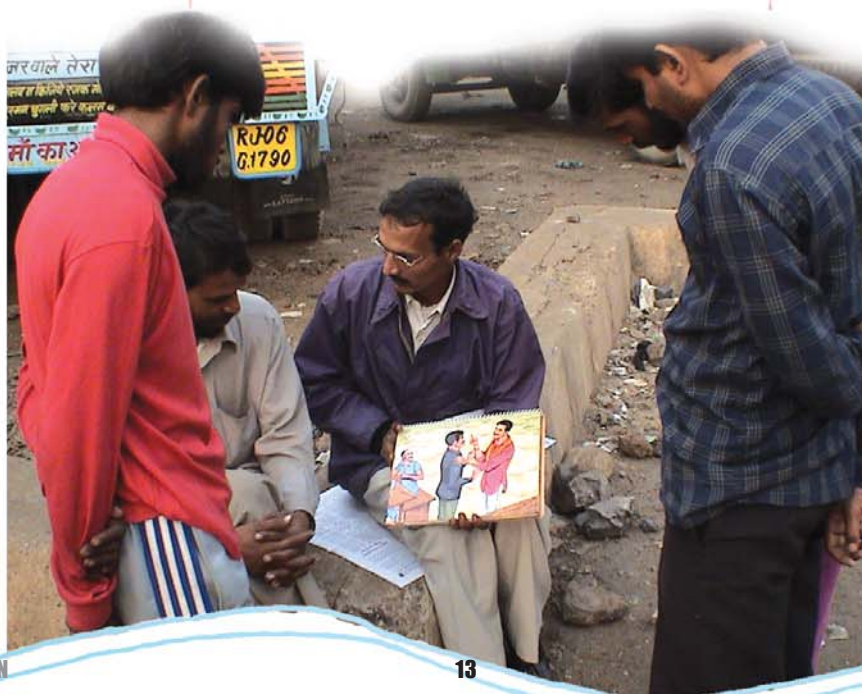
- peer led interventions to create awareness of vulnerability and increase demand for products and services;
- promotion and provisioning of condoms through free supplies and social marketing;
- development of linkages with local public sector, private sector and NGO owned institutions for testing, counseling and STI treatment services;
- creation of “peer support groups” and “safe spaces” at destination sites for migrants.

NACP III will reach out to 3 million truckers and 8.9 million migrants.

INTERVENTIONS FOR THE GENERAL POPULATION

Strategies for the general population interventions take into account specific risk factors and vulnerabilities of population groups such as women (age 15-49 years); youth (age 15-29 years); and children (age 0-18 years).

Today, 39% of all HIV infections occur amongst **women**. Peak infection amongst women appears to be around 25 years, which is significantly lower than the peak age for men. In 2004, it was also estimated that 22% HIV cases were amongst housewives with a single partner. Mitigating the risk to women's health and parent to child transmission of HIV are key concerns under NACP III.



Amongst general population, **youth** are another vulnerable and heterogeneous group with differing risk levels. Gender imbalances, societal norms, poverty and economic dependence all contribute to young people's vulnerability. Physiologically, young people are more vulnerable to STIs than adults; **girls** more than boys. The primary route of HIV infection amongst youth is unprotected sex which combined with lack of information, skills and access to safe sexual practices lead to high risk behaviour. Street children, adolescent sex workers, orphans and migrant children and youth are '**marginalized**' groups.

The risk perception and behaviour of young people are likely to determine the future direction of HIV/AIDS in the country.

In addition tribal populations living in hard to reach areas with limited access to health care services will receive special attention. Tribals constitute 8.2% of the total population in the country and are concentrated mainly in seven states in central and north-eastern belts. Sexual networking patterns, migration, trafficking, exposure to tourists and drug trade combined with low levels of information and poor access to services have been identified as factors of their vulnerability.

The NACP III approach for saturating HRGs and raising awareness at the community level will:

- set up a cadre of link workers to approach women and young people in villages (and tribal areas) with BCC, condom provision and linkages to health services;
- enhance access to HIV testing facilities with links to associated programmes, and to counselling and treatment services by the establishment of ICTCs;
- establish Red Ribbon Clubs of youth friendly information services;
- improve access to testing and treatment for PPTCT;
- improve availability, testing and assurance of blood and blood products;
- provide STI treatment in public and private health facilities for easy access to the community; and
- undertake effective communication programmes to encourage social normative changes aimed at reduction of stigma and discrimination.

8,200 link workers and 187,000 volunteer will cover 187 districts and 187,000 villages reaching out to approximately 187 million people





INFORMATION, EDUCATION, COMMUNICATION

The Information, Education, Communication campaign will create a non stigmatizing environment and promote access to services. The focus will be on promoting a value-based life-style, reducing vulnerabilities and breaking the silence surrounding issues related to sexuality. The campaign will focus on reduction of risky behaviour and routinize the use of condoms as the only prophylaxis against sexually transmitted infections and unwanted pregnancies. It will also generate a demand for services.

INTEGRATED COUNSELLING AND TESTING

Only an estimated 5-7% of the people who are infected know their HIV status. Under NACP-III, Integrated Counselling and Testing Centres (ICTCs) will become a hub for all HIV related services.

PREVENTION OF PARENT TO CHILD TRANSMISSION

It has been estimated that out of 27 million pregnancies in India about 189,000 occur in HIV+ mothers leading to an estimated cohort of 56,700 infected babies. Prevention of Parent to Child Transmission (PPTCT) programme using Nevirapine was initiated in the country in 2001. This will be up-scaled under NACP III to cover at least 80% of estimated numbers.

4,955 ICTCs in public health facilities and an equal number of public and private facilities will conduct at least 22 million tests per year by the end of NACP III

PPTCT programme will cover 75,600 HIV+ mothers with antiretroviral drug prophylaxis

MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS (STI)

An estimated 4-6% of the adult population is affected by STIs. NACP-III, will expand STI services through effective integration with the National Rural Health Mission (NRHM) programme. NACO will also support identified NGOs and not-for-profit private providers in the provision of STI services. Designated NGO routinely screen high risk population for STIs and referring them for treatment. This will be one of the important STI strategies under NACP-III.



CONDOM PROMOTION

Despite high awareness and increase in condom availability during NACP I and II, its use remains at less than satisfactory levels. Routinizing condom use, ensuring adequate and convenient supply and promotion of negotiating skills for condom use amongst HRG and others are important aspects of NACP III.

BLOOD SAFETY

Providing access to safe blood is mandated by law. Under NACP-III the aim is to ensure provision of safe and quality blood within one hour of requirement in a health facility through a well-coordinated national blood transfusion service and also to reduce HIV transmission through blood and blood products to 0.5% from the existing 1.92%. Voluntary blood donation will be increased to account for 90% of the total requirement

10 million units of blood will be provided for transfusion annually by 2012.



STRENGTHENING CARE, SUPPORT AND TREATMENT

NACP-III will adopt a comprehensive strategy to strengthen care, support and treatment for PLHA, provide psycho-social support to infected and affected individuals, especially to marginalized women and children affected by the epidemic, and ensure accessible, affordable and sustainable treatment services. Expanding care, support and treatment (CST) and linking them with prevention will not only help reduce AIDS related mortality but also positively impact by reducing poverty, stigma and discrimination. The strategy will include identification of institutions, strengthening referral linkages for CD4 testing, capacity building of ART centres and procurement of ARV drugs. Quality of ART delivery will be enhanced by providing training to all categories of health service providers, linkages to community care centres, adherence to monitoring systems, setting up of an External Quality Assessment of Laboratory Services (EQAS) and a mechanism for certification and accreditation of services in both the public and private sectors. The major focus will be on ensuring a very high degree of adherence to ART (>95%) so that patients can continue on these services for a longer time. A smart health card will also be provided to all patients on ART and all ART centres will be linked in a web based system.

Under NACP III this will:

- strengthen PLHA and other networks of vulnerable populations;
- enhance linkages to service centres and risk reduction strategies;
- develop standard HIV and opportunistic infection management guidelines including improved referral to the Revised National Tuberculosis Control Program for TB treatment;
- establish community care centres which will provide outreach, referral, counselling and treatment, and patient management services; and
- undertake advocacy, social mobilization and BCC to integrate HIV positive persons into the society while reducing stigma and discrimination.



CARE AND SUPPORT

Improving the quality of life, social integration and dignity of people living with HIV is an ongoing effort. Care and support services through partnership with not for profit organisations will be enhanced during the NACP III period. Expanding access to care in an enabling environment will increase the demand for services and motivate those living with HIV to adopt and sustain safe behaviour. Social support, counselling, treatment and patient management including referrals will be provided through community care centres. These centres will act as a bridge between PLHA households and ART centres, focussing on management of opportunistic infections as well as adherence counselling for ART.

ANTIRETROVIRAL THERAPY

Antiretroviral Therapy (ART) suppresses viral replication, slows or halts disease progression, prolongs longevity and greatly improves the quality of life of HIV positive people. ART is given to people at a certain stage of infection. It is provided free of cost through select government hospitals and not for profit charitable hospitals.

350 community care centres will be established during NACP III.

NACP III will cover 300,000 adults and 40,000 infected children through 250 ART centres.



PROGRAMME MANAGEMENT

Effective programme management will be carried out through a decentralization process right upto the district level and strengthening of computerized Project Financial Management System (CPFMS) and Strategic Information Management System. Technical Support Units will also be established at state level to assist SACS in managing the NGO/CBO/civil society related activities. In addition, better donor coordination and impact mitigation will be prioritized as part of an overall management strategy.

NACO has established till date:

- 14 technical resource groups

It has also

- technical support group for social marketing of condoms
- a strong financial management team

AUGMENTING CAPACITY AT DISTRICT, STATE AND NATIONAL LEVEL

Skilled and competent human resources at all levels of programme implementation are essential for the success of the programme. The aim of NACP-III is to undertake strengthening and skills development of health care providers, namely doctors and nurses, counsellors and lab technicians, public health workers, civil society organisations and functionaries of other departments at the national, state and district levels to better carry out the task of instituting good quality, greatly scaled up interventions. At the same time, best practices from private sector will be activated to achieve public health goals. Streamlining of public health delivery system, function and accountability will synergise with systems to manage the complex relationship between different levels of the national response and with non government and private sector partners.

380,000 personnel to be trained during NACP III

Along with an emphasis on training, resource persons will continue to provide technical assistance and mentoring. Institutions that need support, including SACS, will be attached to those with proven capacity. Appraisal of training will be conducted annually and training methodologies will be suitably updated.





FAMILY PLANNING CENTRE

TIMING- MON^{TO} FRI. 10-5, SAT. 10-1
SUNDAY CLOSED

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Augmenting capacity will involve:

- collaborating with partners on developing standard operating procedures and operational guidelines in respect of crucial HIV services;
- adopting standard, performance based contractual arrangements linked to delivery of HIV-related services, as well as the establishment of internal and external quality control systems;
- providing high quality, operational training in areas such as support to establishment of CBOs, ART training, etc. within and outside the government sector;
- establishing necessary technical support at all levels through Technical Support Groups (TSGs) at the national level or Technical Support Units (TSUs) at the level of the SACS;
- engaging the services of procurement agents for carrying out procurement of pharmaceuticals, medical supplies, and other goods and works required under the project

STRENGTHENING STRATEGIC INFORMATION MANAGEMENT

NACP III proposes a significant change in the purpose and effectiveness of data collection and analysis. A Strategic Information Management Unit (SIMU) will be established at national and state levels to maximize the effectiveness of available information and implement evidence-based planning. SIMU will address strategic planning, monitoring and evaluation, surveillance, and research. In addition, all programme officers will be trained on evidence-based strategic planning methodologies, information use, and programme management. As of May 2007,



information was being gathered from 1119 sentinel surveillance sites, 127 ART centres, 122 community care centres, 2211 Government, private and charitable blood banks, 4132 ICTCs, 866 STI clinics, and 1220 NGO and TI interventions. Strategic Information Management will be carried out at national, state and district levels.

The NACP III approach:

- review and validate information or **evidence based planning**, effective implementation of interventions and impact assessment;
- strengthen **monitoring** framework to provide more accessible and ready-to-use information;
- enhance the **surveillance** systems to provide HIV related epidemiological, clinical and behavioral data at a state and sub-state level;
- review models used to generate various state and national estimates on the basis of surveillance data; and
- undertake independent **evaluation** and **research** to inform and support program implementation.



DECENTRALIZATION

Under NACP III, the decentralized model that evolved during NACP II with the setting up of State AIDS Control Societies (SACS) will be further devolved to directly penetrate populations at the district level through [District AIDS Prevention and Control Units](#) (DAPCU). SACS will remain responsible for medical and public health services; communication and social sector services; and administration, planning, coordination, monitoring and evaluation, finance and procurement.

DAPCU will operate within the District Health Society, sharing the administrative and financial structures of National Rural Health Mission (NRHM). While the unit will report to and work through the Chief Medical Officer of the district for medical interventions, it will also be responsible for non-health related activities such as Adolescent Education Programme, supportive supervision of TIs, monitoring and evaluation and mainstreaming. These activities will be carried out through the office of the District Collector or Zilla Panchayat.

MAINSTREAMING...

The AIDS control programme is slated to move beyond addressing risks to addressing vulnerabilities and mitigating impact of AIDS on the community. NACP-III will therefore see a broadening of the national response through more sectors and organisations. It encourages developing ownership of AIDS prevention and control programmes in their sphere of influence, driven by the leadership provided by National Council on AIDS and technical assistance from NACO. While providing general support to all 31 member ministries of NCA, NACO has identified 11 priority departments for



mainstreaming. These are: Education, Home Affairs, Labour, Panchayati Raj, Ports and Surface Transport, Railways, Rural Development, Tourism, Women and Child Department, Tribal Affairs, Youth Affairs and Sports. NACO will also collaborate with the Ministries of Defence, Industry, Labour and Railways to use their medical infrastructure for prevention and treatment, including treatment of STIs, promotion of condoms, ICTC, PPTCT, treatment of opportunistic infections and ART.

The strategy of NACP-III on mainstreaming will work towards having:

- HIV mainstreamed into the work plan of major government/ private (for profit and not-for-profit) organisations and modify their core practices to respond to the challenges of HIV/AIDS; and
- Partner organisations demonstrate ownership of the HIV/AIDS prevention and control strategies by allocating internal resources to the programme.

...AND PARTNERSHIP

NACO will work in close coordination with Development Partners at both the national and state levels through the establishment of a coordination framework enjoining each to the spirit of "Three Ones". A Steering Committee for Donor Coordination will be established to:

- prevent duplication and maximize effort, resources and impact;
- share information on action plans; and
- jointly review programme performance during quarterly reviews.

Partners would include UN, bilateral, multilateral and other key funding agencies.



ENABLING ENVIRONMENT AND GIPA

Effective prevention, care and support for HIV/AIDS is possible in an environment in which human rights are respected and where those infected with or affected by HIV live a life of dignity, without stigma or discrimination. This necessitates a review and reform of structural constraints, legal procedures and policies that impede interventions aimed at marginalised populations. Affirmative action is needed to reduce stigma and discrimination associated with the infected and affected persons and their access to prevention and quality treatment, care, insurance and legal services. NACP-III will work in partnership with PLHA networks and other stakeholders towards creating an enabling environment by addressing issues of stigma, discrimination, legal and ethical concerns.

WHAT DO WE HOPE TO ACHIEVE IN NACP III

TARGETS

NUMBERS

PREVENTION

Targeted Interventions	2100
High risk groups reached through TIs (FSWs, MSM & IDU)	2.34 million annually
Bridge populations covered (truckers and migrants)	11.9 million
Rural population reached through mass media, etc.	280 million
Adolescent Education Programme	144,409 schools
Non-student youth reached	70 million
Condoms sold	3.5 billion/year
Outlets selling condoms	3 million (by 2010)
No. of units of blood for blood transfusion	10 million annually

CARE SUPPORT & TREATMENT

ICTCs in public health facilities	4,955
Tests per year	22 million in government sector and 12 million in private sector
HIV+ pregnant women covered under PPTCT	75,600
Number of opportunistic infection episodes treated in public sector	330,000
Number of adults to receive ART	300,000 (in public sector)
Number of children to receive ART	40,000
Number of PLHA getting TB referral	2.8 million



AND ALL THIS WILL BE POSSIBLE WITH

CONTINUED POLITICAL COMMITMENT

PARTICIPATION BY ALL STAKEHOLDERS

COORDINATION AND IMPLEMENTATION OF THE
SHARED VISION

AND

SHARED ACCOUNTABILITY



National AIDS Control Organisation India's voice against AIDS



National AIDS Control Organisation

India's voice against AIDS

Ministry of Health & Family Welfare, Government of India
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