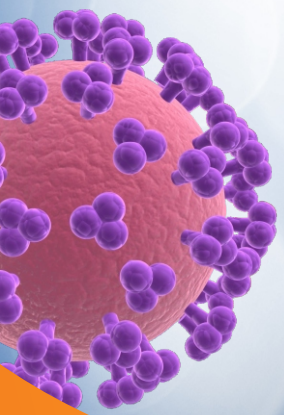
सत्यमेव जयते

JOURNEY OF ART PROGRAMME IN INDIA

STORY OF A DECADE

Celebrating 10 years of Success

April 2004 - March 2014



Care Support and Treatment Division
National AIDS Control Organisation
Department of AIDS Control
Ministry of Health and Family Welfare
Government of India

WE CARE FOR YOU

A.R.T. centre

April 2004 - March 2014

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Chapter

Abbreviations:

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretrovirals
BPL	Below Poverty Line
CBO	Community-based Organisation
CCC	Community Care Centre
CMIS	Computerized Management Information System
CoE	Centre of Excellence
CSC	Care and Support centre
CST	Care Support and Treatment
DAC	Department of AIDS Control
DIC	Drop-in Centre
DAPCU	District AIDS Prevention and Control Unit
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of PLHIVs
HIV	Human Immunodeficiency Virus
HRG	High Risk Groups
ICMR	Indian Council of Medical Research
ICTC	Integrated Counseling and Testing Centres
I-TECH	International Training and Education Centre on Health
LAC	Link ART Centre
LFU	Lost to Follow up

M&E	Monitoring and Evaluation
NAC	National AIDS Committee
NACB	National AIDS Control Board
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NAEP	National Adolescent Education Programme
NRHM	National Rural Health Mission
NGO	Non-Governmental Organisations
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PLHIV/PLHA	People Living with HIV/AIDS
PPP	Public Private Partnership
PPTCT	Prevention of Parent to Child Transmission
RNTCP	Revised National TB Control Programme
SACEP	State AIDS Clinical Expert Panel
SACS	State AIDS Control Society
SIMS	Strategic Information Management System
STRC	State Training Resource Centres
TB	Tuberculosis
TI	Targeted Interventions
TSU	Technical Support Units
UT	Union Territory
WHO	World Health Organisation

Foreword

सत्यमेव जयते

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सचिव
Dr. V. K. SUBBURAJ,IAS
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The free Antiretroviral Treatment initiative of the Government of India was launched on 1st April, 2004 and has been scaled up in a phased manner. The programme has adopted the public health approach for provision of ART. This implies a comprehensive prevention, care and treatment services, with a standardized, simplified combination of ART regimen, a regular secure supply of good-quality ARV drugs, and a robust monitoring and evaluation system. The programme aims to provide care and treatment to as many people as possible, while working towards universal access to care and treatment.

This April marks the completion of ten years of free Anti-Retroviral Treatment roll out in India. From eight centers in 2004, the ART programme has grown to a network of 425 ART centers and 870 Link ART centers. More than 7.5 lakhs patients are receiving free ART at these sites, second highest in the world. The programme is also providing second line ART to 8500 PLHIV and has recently decided to provide third line ART as well. We also have 10 Centers of Excellence in HIV care, 7 Pediatric Centers of Excellence, 37 ART Plus centers and 224 Care & Support centers.

ART has brought hope and confidence to literally hundreds of thousands of families. All through this, DAC has worked very closely with the communities and maintained high levels of quality of services through rigorous monitoring and mentoring. The joint DAC-PLHIV community effort marks an affirmation of the ongoing and long-term partnership between DAC and PLHIV community to achieve the ambitions of NACP IV.

A lot many people have made immense contribution to the programme in their own way. Department of AIDS Control acknowledges the valuable contribution from every one of them and would like to express gratitude for their unremitting support and association.

This document is a brief summary of this journey of the ART program over last 10 years. We are committed to provide universal access to high quality ART to all those who require it in a stigma free environment.

(Dr. V. K. Subburaj) 29/3/2014

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अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ
Know Your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing

Preface:

"Be the change in the world you want to seek and life"

Mahatma Gandhi

An array of people from varied social, cultural, traditional, and religious backgrounds, diverse vernacular, values and social rules is what embraces the Indian nation. With a population of over 1.2 billion, even low prevalence rate of an ailment means huge numbers necessitating an intense public health response at a large scale. National AIDS Control in India is one of the excellent examples of such a response.

The imagery of HIV disease, which was once considered to be a death sentence, has been completely transformed due to enhanced access to ART in the national . Though the journey of ART in India over last decade has been challenging, there has been unprecedented scale up which articulates evidences of best practices in an evidence based expansion, midterm corrections, and optimal utilization of resources for expansion of services to level of universal coverage. This success is the result of active participation, guidance and support from a host of partners, be it technical experts, international agencies, related ministries, representatives from the civil society and the judiciaries that have always played an important role in ensuring that the always delivers what is best for the PLHIV in the country. The progress of the and quality of services have always been appreciated world over by various agencies like World Bank, Global Fund and other joint appraisal teams that have had an opportunity to work and collaborate with Department of AIDS Control

ART programme of India has been acknowledged as one of best national health care programmes. This document emblazons the successful scaling up of ART in India and its journey towards excellence.

Dr. A. S. Rathore, Deputy Director General, CST, DAC.

My Reflections.....

"Celebrations of 10 years of success".....What are we celebrating & Why? The provision of treatment for any illness is responsibility of a public health system. But what was different with HIV/AIDS epidemic was that this epidemic was not only a threat for medical reasons but also due to associated economic & social implications. There were some quick developments after detection of first few cases of AIDS in 1981 in terms of identification of the virus, diagnostic tests and approval of first antiretroviral drug (ARV) within 5 years of reports of first few cases of HIV/AIDS. The so called "cocktail therapy became available in 1996 but costs were astronomical (US$10,000 per year) and prohibitive. People infected with HIV got stigmatized, lost their lives while health care providers felt helpless due to non availability/non affordability of ARVs

Roll out of antiretroviral therapy (ART) has been the "tipping point" in India's fight against HIV/AIDS and has changed the face of National AIDS Control Programme. It provided a motivation for people to come forward & get tested. It provided hopes to hundreds & thousands of people. Wider availability of free ART has saved over 1,50,000 lives so far & is expected to save nearly 5 lakh lives by 2017. ART has also prevented resurgence of TB. In addition to saving lives it improved quality of life of people infected with HIV, who now lead a healthy life, just like anyone else. While we celebrate these achievements, we also feel saddened by the lives lost due to non availability of drugs in the earlier years

ART has changed the face of HIV/AIDS to a "chronic manageable disease". It has provided significant impetus and evidence that public health programmes can effectively deliver the "chronic care" concept as well as preventive strategies and aspects.

The ART programme in India is world's second largest despite the fact that we have a low prevalence of HIV. We have indeed come a long way from 30th November 2003, when the Govt. of India announced free ART progarmme and launched it on 1st April 2004. The initial roll

out was slow as we could reach out to only 7000 patients in the first year at 25 centers. In order to increase access to services, the number of centers was increased to 107 by end of NACP II and number of patients benefitting from ART increased significantly. The NACP III provided a great impetus to the scale up and nearly 50 new centers were added every year. This lead to NACP III targets being achieved earlier by an year. However as of now, the coverage of ART is still around 66 % against all those who require ART and this warrants an early detection of those infected with HIV and linking them to CST Services. Significant reduction in new infections and deaths with the expansion of ART is the testimony to the success of programme, which has been acclaimed globally.

Key Initiatives

If we look back over the years, the programme introduced a number of new initiatives for scale up, for an easy access to services and improving quality of care. In 2006, CD 4 testing was made free, dispersible FDCs of paediatric ARVs were launched, second line ART was introduced in January, 2008, care of HIV exposed child and Early Infant Diagnosis (EID) launched in 2010. To provide structured training and enhance research, concept of Centers of Excellence (CoEs) was implemented in 2008 and later expanded to paediatric Centers of Excellence (PCoEs) also. In order to provide services nearer to patient's place of residence, the Link ART Centers (LAC) were conceptualized in May 2008 and upgraded to LAC plus in 2010 to provide pre-ART care as well. The concept of ART plus was devised in October 2010 in order to increase access to second line ART. Similarly the supply chain was decentralized in 2012 to State AIDS Control Societies (SACS) for better monitoring of stocks and preventing stock outs. The involvement of community in form of Care coordinator at all ART centers and GIPA coordinators at SACS went a long way in reducing the stigma and making service more patient friendly.

On the technical front the programme evolved towards early initiation of ART at CD4 count of less than 350 in 2011, Stavudine phase out in 2012, strengthening of HIV-TB coordination, revision of PPTCT guidelines and concept of “targeted viral load” were adapted. The constitution of Technical Resource Groups (TRG), State AIDS Clinical Expert Panel (SACEP) and National AIDS Clinical Expert Panel (NACEP) are some of the steps taken to ensure high technical inputs into the programme. The journey still continues in 2014 with country adaptation of new WHO guidelines for earlier

initiation of ART at <500, with simplified less toxic more robust ARV regimen, increased access to viral load testing, introduction of pharmacovigilance, drug resistance testing, third line ART etc. All positive pregnant women across the country now receive triple drug lifelong ART irrespective of CD4 count in order to work towards elimination of mother to child transmission of HIV and more towards an "AIDS free generation".

On the care and support front, the concept of Community Care Centers (CCC) was modified in 2007 from 'end of life' hospice centers to provide holistic care and support services to PLHIV in a non-stigmatizing manner. The evaluation of CCC in 2012 led to integration of medical component of CCC into general health system and merging of care and support component of CCC and DIC into "Care and Support Centers" (CSC), which work in close coordination with ART Centers.

Quality of Care

An important component of any service delivery is client satisfaction and good quality of care. The ART programme has a strong & unique system of on-site monitoring & mentoring. In addition to routine monitoring by SACS officials, it brought in a concept of "Regional Coordinators" which became the key pillars of the success of programme. The monitoring of Link ART Centres by nodal centre and of ART centres by the CoEs is a unique mechanism of supervision within the system itself. From time to time the programme launched various quality drives like "data completion drive" in 2011, "We Care for you" in 2012 and an oath on our motto of "Providing High Quality care" in 2013 etc. The establishment of State Grievance Redressal Committees (SGRC) in the states was a unique model to ensure quality of services and ownership by the states. The programme also launched a massive nationwide drive on "intensified LFU Tracking" in September 2013. Currently programme is carrying out a "data validation drive" at all ART Centres across the country along with detailed assessment of ART centre & services provided by them. The provision of high quality care has been our focus at all stages of service delivery.

Challenges and Opportunities

It is well known from past programme experiences that patients are progressively lost to follow up while passing through the cascade of treatment, from testing to enrollment in HIV care, to baseline testing to initiate all eligible patients on ART and their retention in care. The programme

is addressing these challenges of "retention in care" for PLHIV, bridging gaps at all stages of the leaky treatment cascade, tracking of LFU by ensuring high quality counseling services at ART Centres. The other significant challenges include maintaining completeness of records at centers, and regular use of data for improvement in service provision. It has been attempted to address this by computerization, use of software applications in data management and development of a robust Strategic Information Management System for decision making and introduction of smart card for dealing with inter State/ District migrations are also being addressed. The strengthening of supply chain related issues is very high on the agenda of the department. Adoption of 2013 WHO guidelines will bring in additional challenges in terms of increased patient load at centers, need for further decentralization of services, task shifting and task sharing, third line ART roll out, and higher financial implications. The adherence will have to be all the more in focus to continue people longer on their first line regimen. The NACP IV envisages provision for high quality stigma free universal access to ART while integrating the response with broader health system to an extent that does not compromise the quality of care. The paediatric ART needs to be scaled up fast to save the babies through an Early Infant Diagnosis programme and linkage to treatment.

The success of ART has resulted not only from the efforts of Department of AIDS Control alone. This journey has witnessed whole hearted support from partners like WHO, UNICEF, UNAIDS, CDC, CHAI and many others. The WHO country office has provided technical support throughout the journey. The support from the Global Fund for provision of free ART in six high prevalence states initially (Rd IV) & later to all states (Rd VI) has been a major catalyst in this scale up. All along the communities of PLHIV, Civil society, NGOs have played both a very supportive role and provided timely feedback on programme implementation in the field. Their feedback into programme on their felt needs, gaps in programme, pro activeness on any impending shortages etc. have been very useful in improving quality of services. The motto has been "Together we can…. Together we shall".

Lessons learnt and way forward

The ART programme has also taught us some invaluable lessons. It has shown that it is possible to roll out ART on a massive scale with a public health approach. It is possible to rigorously

implement this in a project mode with strict monitoring of outcomes and following the principles of result based management. It has shown that a new cadre of counselors has been quite useful in effectively implementing the programme and improving quality of care. Robust M&E tools and computerized information management system help in midterm corrections by proper analysis of data. The ART programme has shown that you can seek resources from another programme or extend an arm of help to other progarmme e. g. HIV-TB coordination, PPTCT-RCH linkages etc. within the platform of broader health system. It has also shown that inter ministerial coordination can be effectively done with proper advocacy. The programme has shown us the importance of having strong linkage with civil society, network of positive people, NGOs, peers & key populations. The ART programme has always given a clear message "we work together with communities, not for communities".

The last decade has also been challenging one and we thank you all for your effort, energy and commitment. This is time to reflect on our successes, achievements and shortcomings in the past decade. Goals we achieved, targets we missed and lessons learnt from success as well as failures need to be reflected in our actions in the next ten years.

Having been at the horizon right from planning stage of ART programme and implementing this at national level, I personally have traversed this difficult yet satisfying journey of programme over last 10 years. Compilation of data from ART centres every month showing increasing number on ART gave me a inner sense of satisfaction that cannot be described in words. On this occasion, I request you to keep up your good work, plug the gaps and further improve quality of services you provide to your patients. This will give you an immense sense of satisfaction, which cannot be achieved by anything else. Believe me, I felt this on every day of my work at NACO, at every milestone achieved and feeling is even stronger today as I write to you on this historic day.

While we celebrate, it is important that we take a pause to look forward, analyze and learn, as we embark on future journey. Our achievement should not make us complacent & our success should not become our enemy. There are huge challenges in the road ahead. Increased numbers, decentralization, reaching out to primary care level, higher costs from new drugs/regimen, challenges in regular viral load monitoring, establishing pharmacovigilance and drug resistant programme require more commitment, more hard work & more resources. The target set during

High Level Meeting (HLM) at UN in 2012 on reduction of new infections, particularly among IDUs, reduction of deaths due to TB and above all elimination of mother to child transmission pose formidable challenges, yet are achievable. The commitment to three Zeros "Zero AIDS related death, Zero new infections and Zero stigma and discrimination" need work with renewed zeal & enthusiasm after this achievement.

In the last but not the least, it is my duty to acknowledge the support provided by my superiors at NACO and thank my past and present team members at NACO /SACS/field and facility staff -- "Team CST" for their great contributions all through, without which we would not have been where we are globally.

We have come a long way but a lot more needs to be achieved. As a strong CST team, we are confident that we shall overcome the challenges on the way to high quality stigma free Universal access to ART services.

Dr. B. B. Rewari

"After climbing a great hill, one only finds that there are many more hills to climb".

Nelson Mandela

Acknowledgement

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This document was developed under the overall guidance of Dr. A. S. Rathore, Deputy Director General, CST, DAC.

We also acknowledge the invaluable contribution by all members of the "Team CST" at DAC/SACS/CoE/ART facilities

Mobilizing response to HIV: "Together we will End AIDS"

Human Immunodeficiency Virus (HIV) was first detected in India in 1986. In the early years of its detection, the epidemic was thought to be less detrimental for the country as it was then believed to be spread primarily through sex between men, injecting drug use and multi-partner heterosexual sex. It was widely believed that HIV will not spread as much in India as the practice of risk behavior was very low in the population. However, by 1990, it was realized that the infection has already established in some groups like professional blood donors, female sex workers and injecting drug users. The infection was widespread in the country but as yet limited to those with high risk behavior or to recipients of infected blood. The main mode of transmission was heterosexual although injecting drug use was predominantly responsible for the epidemic in the northeast.

The national response to HIV epidemic has been swift and remarkably comprehensive since the time it was recognised as an important public health problem by the government of India during its early years. The National AIDS Control Programme (NACP), from the very beginning, was focused and planned to deal with the various aspects of the epidemic- understanding the gravity of the situation; dealing with stigma; raising awareness and bringing a behavior change among the people at risk; from a national response to a more decentralized response.

In 1992, the Government launched the first phase of National AIDS Control Programme (NACP I) with an IDA Credit of USD 84 million and demonstrated its commitment to combat the disease. The first phase was implemented with an objective of slowing down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country. National AIDS Control Board (NACB) was constituted and an autonomous National AIDS Control Organization (NACO) was set up to implement the project. The first phase focused on awareness generation, setting up surveillance system for monitoring HIV epidemic, measures to ensure access to safe blood and preventive services for high risk group populations.

In November 1999, the second National AIDS Control Project (NACP II) was launched with World Bank credit support of USD 191 million. The policy and strategic shift was reflected in the two key

capacity to respond to HIV/AIDS on a long-term basis. Key policy initiatives taken during NACP II included: adoption of National AIDS Prevention and Control Policy (2002); Scale up of Targeted Interventions for High risk groups in high prevalence states; Adoption of National Blood Policy; a strategy for Greater Involvement of People with HIV/AIDS (GIPA); launch of National Adolescent Education Programme (NAEP); introduction of counseling, testing and PPTCT programmes; launch of National Anti-Retroviral Treatment (ART) programme; formation of an inter-ministerial group for mainstreaming; and setting up of the National Council on AIDS, chaired by the Prime Minister; and setting up of State AIDS Control Societies in all states.

In response to the evolving epidemic, the third phase of the national programme (NACP III) was launched in July 2007 with the goal of 'Halting and Reversing the Epidemic' by the end of five years. NACP III was a scientifically evolved programme, grounded on a strong structure of policies, learnings from the previous phases of the , planned schemes, various technical and operational guidelines, and stringent monitoring protocols. NACP-III aimed at scaling up prevention efforts among High Risk Groups (HRG) and General Population and integrating them with Care, Support & Treatment services. Thus, Prevention and Care, Support & Treatment (CST) formed two key pillars of all the AIDS control efforts in India.

Strategic Information Management and Institutional Strengthening activities provide the required technical, managerial and administrative support for implementing the core activities under NACP-III at national, state and district levels. The capacities of State AIDS Control Societies (SACS) and District AIDS Prevention and Control Units (DAPCUs) have been strengthened. Technical Support Units (TSUs) were established at National and State level to assist in the Programme monitoring and technical areas. A dedicated North-East Regional Office has been established for focused attention to the North Eastern states. State Training Resource Centres (STRC) were set up to help the state level implementation units and functionaries. Strategic Information Management System (SIMS) has been established and nation-wide rollout is under way with about 15,000 reporting units across the country.

The next phase of NACP has been built on achievements up till now and these gains are ensured to be consolidated and sustained. Recently, the fourth phase of NACP has been launched with the goal of 'Accelerate Reversal, Integrate Response'. The primary objectives of the present phase are

objectives of NACP II: (i) to reduce the spread of HIV infection in India, and (ii) to increase India's to reduce new infections by 50% (2007 Baseline of NACP III) and to provide comprehensive care, support & treatment to all persons living with HIV/AIDS. As per the NACP IV framework, a five pronged strategy has been developed which has focus on intensification of prevention services for high risk groups, expansion of treatment services with a more comprehensive approach, expansion of IEC activities, capacity building of staff across health care delivery levels and ensuring a robust recording and reporting system.

Snapshot of the response..

NACP I (1994-1999)
Initial interventions

NACP II (1999-2006)
-Decentralisation to states
- Limited coverage of services

NACP III (2007-2012)
Massive scale up with quality assurance mechanisms
50% reduction in new infections achieved

NACP IV (2013+)
Consolidate gains, focus on highest risk HRGs, scaling up services, quality assurance

How far have we reached? What the response looks like in 2014?

Recent HIV estimates (2012) corroborate the fact that HIV epidemic in India continues to decline at the national level. There is an overall reduction in adult HIV prevalence, HIV incidence (new infections) in adults and AIDS-related mortality in the country. India is estimated to have around 20.9 lakh persons living with HIV in 2011, at an estimated adult HIV prevalence of 0.27%. Adult HIV Prevalence has decreased from 0.41% in 2001 through 0.35% in 2006 to 0.27% in 2011.

India has demonstrated an overall reduction of 57% in estimated annual new HIV infections (among adult population) from 2.74 lakhs in 2000 to 1.16 lakhs in 2011, reflecting the impact of prevention and treatment interventions. Decline in adult HIV prevalence and new HIV infections are seen in most in the states with high levels of HIV prevalence. However, rising trends have been noted in few low prevalence states. Considerable declines in HIV prevalence have been recorded among Female Sex Workers at national level (5.06% in 2007 to 2.67% in 2011) and in most of the states, where long-standing targeted interventions have focussed on behavior change and increasing condom use. Decline in the prevalence of HIV among men who have sex with men has also been observed (7.41% in 2007 to 4.43% in 2011), though some pockets in the country show higher HIV prevalence among them with mixed trends. Analysis of the drivers of emerging epidemics in the low prevalence states points towards the possible role of out-migration from rural areas with high prevalence destinations causing the spread of epidemic in most of north Indian states. In some of the north-western states, Injecting Drug Use is identified to be the major vulnerability fueling the epidemic. In addition, long distance truckers also show high levels of vulnerability and form an important part of bridge population. Transgenders are also emerging as a risk group with high vulnerability and high levels of HIV among them.

Wider access to ART has led to 29% reduction in estimated annual AIDS-related deaths between 2007 and 2011. It is estimated that the scale up of free ART since 2004 has averted over 1.5 lakh HIV/AIDS related deaths. It is estimated that with the current pace of scale up of ART services will further avert approximately 50,000 – 60,000 deaths annually in the next five years.

Sustained political commitment has been crucial in success of the

AIDS IN INDIA

NACO

Quarterly Newsletter of the National AIDS Control Organisation

Volume 2, No. 2 April-June, 2001

Prime Minister calls for Chief Ministers' support for AIDS Control Programme

PRIME MINISTERS MEETING WITH CHIEF MINISTERS

In another example of commitment and political advocacy at the highest level the Hon'ble Prime Minister held a meeting with the Chief Ministers of the six high prevalence states on May 22nd 2001.

The Prime Minister has appealed to the Chief Ministers and Health Ministers of the six high prevalence States of Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Manipur and Nagaland to intensify prevention and control of HIV/AIDS in their States. The Prime Minister held a meeting with the Chief Ministers and the Health Ministers of these six States to review the implementation of HIV prevention and care support programmes in these States.

Shri Vajpayee said that the Government has earmarked substantial funds under the National AIDS Control Programme in order to undertake preventive measures and care and support of those already infected. A

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"Ensure leadership … in the fight against HIV-AIDS by intensifying advocacy, by allocating and raising revenues and guiding the response… within our constituencies and the country as a whole" – Declaration of Political Leadership in Combating HIV-AIDS, New Delhi, July 2003 .

UNGASS- 2001:Heads of most countries sign a 'Declaration of Commitment'

3000 young leaders from all 600 districts and 300 Indian Universities discussed their role in the response and debated legislation on HIV/AIDS at National Youth Parliament in 2004

Parliamentarians forum for HIV/AIDS : 2012

"Our HIV/AIDS can justifiably claim a measure of success," Singh said at an HIV/AIDS conference in New Delhi. Singh added that with the 2.4 million Indians still living with HIV, "there should be no room for complacency."

The Prime Minister, Dr. Manmohan Singh, at the Parliamentary Forum on HIV/AIDS, 2011

Looking back at era of 'No ART', when there was no hope:

Less than a decade ago, there was little hope for anyone living with HIV/AIDS to survive . HIV infection brought a steady and inevitable decline in health through complete destruction of immune system leading to death. Thus diagnosis of HIV was considered a ' virtual death sentence' and was projected to be so in the HIV prevention messages. People living with HIV often dealt with tragedy of medical, financial and social burdens.

"..I lost my son because of HIV... doctors say that I have this disease for which there is no cure.. I am going to die soon..."

A PLHIV from Chennai, 1999

".....When I tested positive, my CD4 count was 26. Doctor advised me to start the treatment. That time I purchased HIV medicine from private chemist shop Rs. 20,000 /- monthly. That time I used to take medicines four to six times daily, break the pill into four pieces and dissolve into water. After every four hour I will do all that procedure. It was very difficult...."

A patient from Delhi, 2002

".....There is no treatment available for AIDS patients in government hospitals, patients cannot afford it, I feel frustrated that I can't help patients, no point in seeing HIV patient. Let me use my energy in treating other disease....."

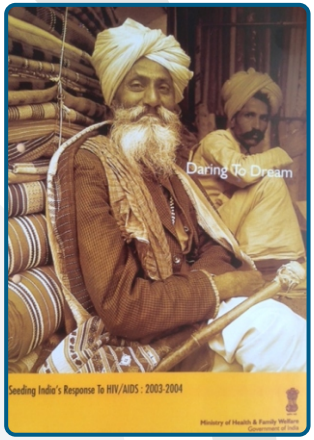
A doctor in Delhi, 2000

"……There is so much of frustration, we see people dying…. There is feeling of helplessness, ART is available to rich people, when will common people get ART.

An NGO in Mumbai, 2001

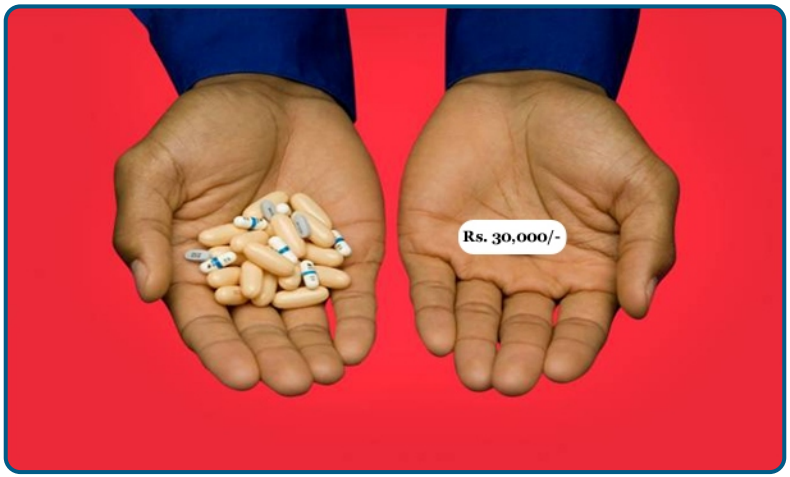
Patients used to be very sick when ART was not available

Boosting life expectancy and life's expectations.....



Daring to Dream

The introduction of antiretrovirals (ARVs) in 1996 was a turning point for hundreds and thousands of people with access to health care systems. There were issues related to large number of pills, astronomically high cost and side effects of drugs. Although ARVs cannot cure HIV/AIDS, they had the potential to dramatically reduce mortality and morbidity, prolong lives, and improved the quality of life of many people living with HIV/AIDS. The concept of triple drug Highly Active Antiretroviral Therapy (HAART) launched in 1996 AIDS Conference in Vancouver was considered to be a potential cure for HIV. Though the triple drug therapy became available in 1996 but was unaffordable for most of people due to very high cost (US$ 10,000 per patient per year).



In 1998, PLHIV had to take 32 pills a day, costing to nearly Rs 30,000/month

At that time, NACP had a component only for "care and support" of HIV-infected persons with an emphasis on universal work precautions, management & prophylaxis of opportunistic infections (OIs) and provision of post-exposure prophylaxis (PEP) to health care providers. With availability of ARV drugs, offering ART to the PLHIV in the national programme was need of the hour but advocacy with the policy makers often met with arguments on prioritization of resources. The per capita health expenditure was so low that affording even an HIV test and OI management was quite challenging

The biggest question regarding ART was whether the national programme could afford this high cost. And furthermore, should ART be considered as a priority issue when other serious health problems, like diarrhea, malaria etc.were also issues of concern.? In addition, there were other challenges associated with implementation of HIV care and treatment programme like inadequate human resources and poor infrastructure.

The "Call to Action" at UN General Assembly Special session on HIV/AIDS (June 2001) pushed forward a new global consensus on increasing access to ART. This led to cumulative response from diverse quarters. It put pressure on pharmaceutical manufacturers to reduce prices, on

governments to seek additional funding and on donor countries to provide the required resources. In April 2002, WHO added 10 antiretroviral drugs to its list of "Essential Medicines" and also for the first time approved a number of generic ARV manufactures. In September 2003, WHO declared lack of access to ART as a "Global Health Emergency" and announced a plan to scale up access to ARV. The popular '3 by 5' initiative of WHO/ UNAIDS launched in December 2003, announced for provision of free ART to 3 million people by end 2005 in developing countries.

India introduces ART into the national programme

ART in Indian National AIDS Control Programme was phenomenal task. There was need for a paradigm shift in the National AIDS Control Programme of India, and to consider the improvement in health care infrastructure for the delivery of care, support and treatment. Also, the monitoring & evaluation concept in the general health system was non-existent and the health system was already overburdened with general heath care.

The National was confronted with many programmatic challenges even before the actual implantation of the ART was planned. The feasibility studies of using Zidovudine and later Nevirapine to prevent mother to child transmission in 1999 at 11 centres of excellence (PPTCT) provided confidence to roll out the PPTCT programme in 2002. The capacity of health system to handle this boosted our confidence to move towards free ART .

The initial few years of the ART that included the preparatory phase and the actual roll out were challenging both for policy makers and the clinicians who were involved in the designing and roll out of the project. The foremost priority was to plan a need based scale up to address concentrated diverse epidemic in a geographically diverse country like India to ensure an efficient and sustainable delivery model. There was lack of evidence & data to guide policy making and decision making. Non availability of skilled man power, establishment of supply chain management systems for ARV drugs, and tackling stigma & discrimination in community and health care settings were some of other important areas that programme had to deal with before the actual roll out the ARV across health facilities in the country. Technical assistance to the programme was provided by WHO in the form of technical consultants, assistance in developing guidelines, training modules and developing tools for monitoring &evaluation. It also helped in procurement of ARV drugs in the first year of the programme.

India to begin free HIV treatment programme, will treat 100,000 within a year
Keith Alcorn
Published: 30 November 2003
The Indian government will provide free antiretroviral treatment through government hospitals starting from April 2004, Health Minister Sushma Swaraj announced today. The Indian government plans to provide treatment for 100,000 people in the first year, at a cost of 2 billion rupees (US$40 million).
She also claimed that India's HIV epidemic is plateauing, a suggestion that is likely to provoke further controversy over the true level of infection in the subcontinent. India's National AIDS Control Organisation estimates the country has between 3.8 and 4.2 million people living with HIV, but some epidemiologists estimate the country may have up to 10 million HIV-positive people.

Ex Union Health Minister, Sushma Swaraj, with a HIV positive child, participating in "Walk for Life" on the eve of World AIDS Day in New Delhi on, 1st December 2013, The Hindu

The government of India decided to take first step to overcome challenges related to service delivery of HIV care, support and treatment by launching free ART initiative through ART centres.

Creating systems for ART service delivery...

Inception of ART centres:

A model of service delivery for ART was developed by strengthening the existing health care systems by establishing ART centres where in additional technical, human and infrastructure support was provided by NACO. The free ART initiative of the Government of India was launched on 1st April, 2004 at eight institutions in six high prevalent states and the National Capital Territory of Delhi.

ART Centre, Sir JJ Hospital

1st Centre in India launched on 1st Apr'04

Dr. Joshi (NACO) Inaugurates National ART Programme at Government Hospital of Thoracic Medicine (GHTM), Tambaram on the April 1st 2004, and distributes ARV drugs to First ever registered two children with HIV under National ART Programme

The objectives of the ART were

- To provide long-term ARV therapy to eligible patients
- To monitor and report treatment outcomes on a quarterly basis
- To attain individual drug adherence rates of 95% or more
- To increase life span so that 50% of patients on ARV are alive 3 years after starting ARV
- To ensure that 50% of patients on ARV therapy are engaged in their previous employment

The free ART would be prioritised to the following category of people

1. Pregnant women who participated in the PPTCT
2. Children below 15 years
3. People with AIDS who seek treatment in government hospitals

The initial take up was quite slow and at the end of one year only 7000 patients were receiving ART. The targets were increased to 25 ART centres at the end of one year. To accelerate the process significantly the DG NACO in 2005 asked the ART team to put a plan to set up 100 ART centers and to scale up ART to 100,000 PLHIV.

Joint Visit to Guwahati to discuss 100 ART Centre Scale up plan, Sep 2005

Since then, it is being scaled up in a phased manner. The ART Programme has adopted a public health approach for provision of ART. This implies a comprehensive prevention, care and treatment programme, with a standardized, simplified combination of ART regimens, a regular secure supply of good-quality ARV drugs, and a robust monitoring and evaluation system. The care support & treatment programme aims to provide care and treatment to as many people as possible, while working towards universal access to care and treatment.

In early years, the ART centres were established mainly in the in the medicine department of medical colleges and district Hospitals in the existing public health facilities. But over the years, some ART centres have also been established in sub district and area hospitals, especially those in high prevalence states in order to improve access and decentralise treatment services. The centres were selected based on prevalence of HIV in the district/ region, number of PLHIV detected and capacity of the institution to deliver ART related services. It was decided that the centre shall be lead by head of the department of medicine and NACO shall support additional personnel (doctors, counsellors, nurses, pharmacists, data managers and community care coordinators) at these centres based on patient load.

Inauguration of ART centre at RML Hospital Delhi

Patients waiting in an ART centre

Over the years, it was realised that mere development of ART centres will not be sufficient to attract PLHIVs for availing access to treatment and care. There are a host of other issues like fear of disclosure of HIV status, false sense of well being, financial constraints due to travel and missing days of work etc. which needed to be addressed.

"If we went to the ART for treatment at Rajamundhry our neighbours or relatives may find out about us at Rajamundhry ART centre. And my daughter has been living in Kakinada so we want to go there."

40 year old male PLHIV, Rajamundhry

"I tested (CD4) in private hospital and I do not have any health problem now. I am fine so why should I go for ART treatment? And my husband is also opposed to me going to the ART centre"

31 year old married female, Muddebihal

"I have to do agriculture work, I do coconut business, this is seasonal. So I did not go to Vijayawada as I was busy. I cannot go leaving two children outside. Need to earn when we have work. We are daily wage labour if we do not earn it is difficult to survive."

25 year old male, Vijayawada

"I do not have money to travel to this district hospital. We are poor, I am widowed person. I am not doing any work, there is no income for my family. I have two children. …."

35 year old female, Mudhol

"For 6 months I will take Ayurvedic medicine, [if HIV infection] is not recovering, after that I will take the ART medicine"

28 year old female, Sikar

"When I received my test report the counsellor told me that you go to ART centre along with HIV report and also election ID card or ration card. But I do not have these cards."

40 year old female, Bijapur

As the progressed, the need to scale up the in various parts of the country became more evident. It was also clear that since the burden of the epidemic differs across various regions, it is necessary that more focused efforts were put in on a priority basis in areas with high burden of the disease in order to contain the spread of the infection. Along with this, it was also important to ensure that factors like poor socio-economic status of patients which limits their ability to access treatment facilities and strengthening of infrastructure and building capacity of human resource were also taken into consideration while planning up scale up of the .

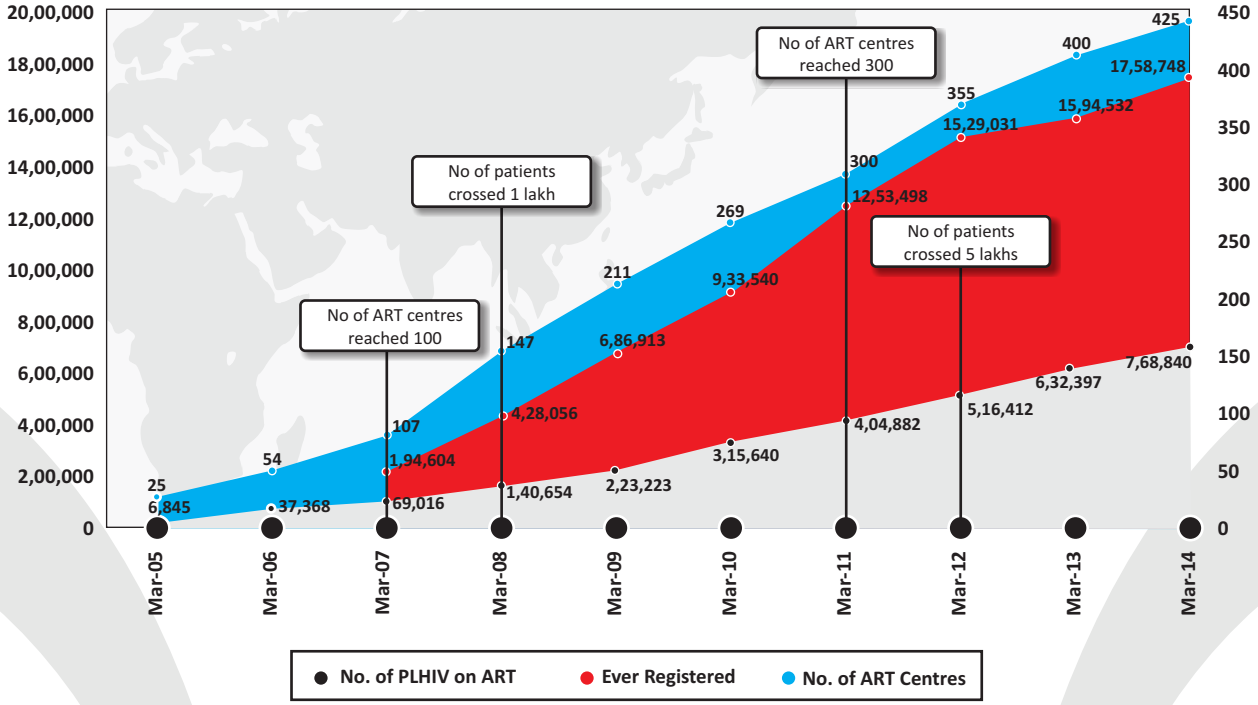
From the very beginning an evidence based approach has been used to scale up the ART treatment services network in order to improve access to care without compromising the quality of care. Every year sites are selected by analyzing district-wise ICTC data for sero-positive people,

geographic locations and mapping catchment areas to select the sites for setting up ART Centres. To overcome geographic barriers, more ART centres were established in districts with high prevalence of HIV. Infact in order to improve the levels of adherence to ART, special initiatives like dispensing ARV drugs for 2 months to reduce the number of visits to the ART centre and liasoning with concerned ministries to provide concession in rail and bus travel.

To ensure optimal quality of care delivered across the facilities it is important to have a team of trained manpower who are competent to manage the PLHIV clinically and deal with stigma that surrounds the disease. Various cadre specific training programs have been developed for the staff members employed at the ART centres. Besides this various other initiative have been taken to ensure that the quality of care provided is not compromised like Strong supply chain management system was established to ensure continuous and adequate supply of ARV drugs under direct supervision of CST division of NACO.

To enhance the accessibility to CST services, rapid scale up of ART services was done in tandem with the ICTC services. ICTC triplicate referral system was introduced for referrals from ICTC to ART centre, to ensure the registration of all PLHIVs at ART centres. Monthly coordination meeting between ICTC and ART centre staff were established to bridge gap between HIV diagnosis and registration into care. To strengthen linkages with TI NGOs in order to provide comfortable environment to HRGS, some ART centres dedicated time slots for them while others were successful in creating enabling environment of care along with general clients.

The scale up of ART centres and access to treatment and care services is summarised in the graph below



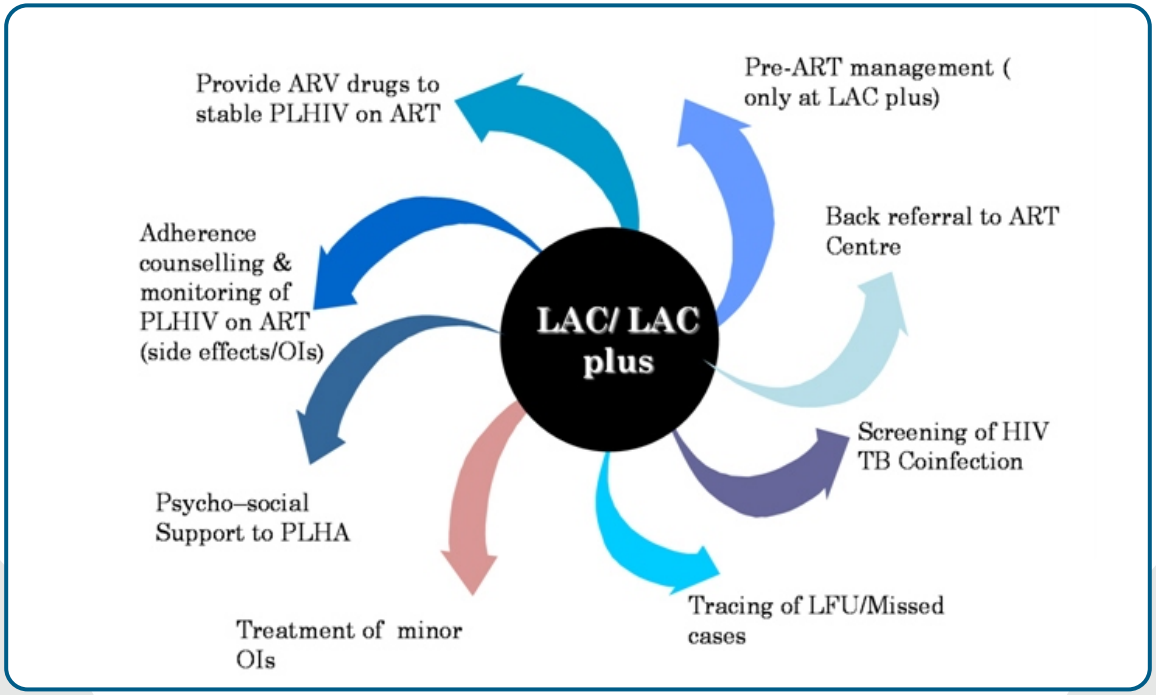
Reaching closer to clients: Development of LAC, LAC plus and integrated ART centres

High level of Adherence to ARVs is the key to a successful of ART Programme. Assessment of ART Centres, conducted in 2007, revealed that long distances for reaching ART centres, higher cost for transportations and financial reasons were some of the key reasons for PLHIVs not attending ART services regularly. Since, ART Centres were located in medical colleges & district Hospitals. Patients from periphery and interiors had to travel long distances to reach the ART centres. In order to facilitate the delivery of ART services nearer to the beneficiaries, the concept of Link ART

Centres (LAC) was envisaged. The LACs are located mainly at ICTC in the district / sub-district level hospitals nearer to the patients' residence and linked to a Nodal ART centre within accessible distance. The LAC helps in reducing cost of travel; time spent at the centre and hence helps in improving clients' adherence to ART.

Link ART Centre is a low cost decentralized scheme with a small patient load and does not have provision for additional staff. Doctors, nurse, pharmacist are at the health facilities where LAC is located provide drugs to PLHIV on ART. The scheme has helped to Integrate ART services with the Primary / Secondary Health Care system and builds capacity of the health care staff in the periphery.

CST team visit to first LAC at Himmatnagar, Gujarat



Since the division is continuously striving to ensure improvement in the quality of care delivered, it is important that all those diagnosed positive, get registered with treatment facility in order to initiate ART when eligible. It was observed that a significant proportion of persons detected HIV positive at ICTC are not linked to care, support & treatment services. Reasons for this included, among others, persons being asymptomatic at the time of detection and long distances to reach the ART centre for registration and basic investigations, which may lead them to postpone/delay their visit to ART Centres till they become symptomatic. It was also observed that nearly 20% patients reach ART Centres at a very late stage (CD4 count less than 50), when the risk of mortality is nearly 2-3 times higher. In view of these facts, the scope and functions of select Link ART Centres were expanded to include Pre-ART registration and HIV care at LAC itself. The LACs which perform Pre-ART management also are designated as “LAC plus”. This helps to bridge the gap between ICTC and CST services and also to reduce the travel cost and travel time of PLHIV in accessing ART services. These patients are followed up at LAC plus till they become eligible for ART or are

referred to ART Centre for any other reason. One additional staff nurse was recruited at LAC plus from programme to assist the existing staff.

LAC plus and LACs, though helpful for patients to get registered into the programme and have an access to ART for those who are stable on treatment, but do not initiate or change ART unlike ART centres. They function under the supervision of ART centres. Considering the importance of decentralisation and integration of CST services to peripheral levels, DAC introduced concept of Integrated ART centres recently. These centres will be stand alone centres as ART centres and are being started at sub-district or block levels, depending upon patient load. These are also expected to decongest the existing high-load ART centres. Integrated ART centres will be provided with a medical officer, a counselor cum data manager and a staff nurse that will be supported by the programme. These centres will stand out as model centres of HIV treatment, care and support for districts/ regions having low prevalence of HIV and will be noticeable as one of the best examples of integrated service delivery sites in HIV treatment. It will further help in decentralisation of services and hence enhance access to treatment by reducing travel time and expense of patients to reach the facility

Continuum of care:

ART programme was scaling up very rapidly towards universal access to HIV treatment. Timely initiation of treatment along with uninterrupted supply of ARV drugs are the basic necessities for optimal treatment outcome. Adequate treatment facilities for treatment of OIs including TB treatment under RNTCP and need for provision of second line & alternative first line ART was necessary to maintain continuum of care. With the availability of ARV drugs the longevity of people living with HIV has phenomenally improved. The programme has also ensured that those patients who require either a switch or substitution of treatment are provided necessary regimen.

Counselling of pre-ART patients on CD4 testing, regular follow up, positive living, positive prevention, nutrition & hygiene was focussed. ART for all TB patients was made available through collaborative activities planned with RNTCP along with national and state level working groups. Intensified HIV TB package was rolled out at ART centres to encourage intensified case finding & good infection control practices.

Establishment of tracking mechanisms for lost to follow up cases through effective out- reach was undertaken. Many NGOs and PLHIV networks work closely with ART centres to track LFU patients back to treatment and care. Community care centres and later care and support centres were established to support these activities.

Community support keeps people on treatment: Development of care and support services to complement ART

To bridge the gap in health institutions and community and as part of a comprehensive package of CST services, Community Care Centres (CCC) were set up in the non-government sector with the objective of providing psycho-social support, ensure drug adherence and provide counseling on home-based care. CCCs were linked with ART Centres and ensure that PLHIV are provided counseling for Antiretroviral treatment preparedness and drug adherence, nutrition and prevention, treatment of Opportunistic Infections, referral and outreach services for follow up, social support and tracing patients lost to follow-up (LFU) and those missing to get ARV drugs as per schedule. An evaluation of the CCC project was carried out during October 2012. The

evaluation aimed at understanding their functioning as per the operational guidelines and also to understand the clients' perspective regarding the services offered to them. After the assessment of CCC, it was felt that the medical component of CCC can now be transitioned to the health system as patients are getting fewer OIs due to ART scale up. Additionally, the stigma in the health system had reduced significantly and patients could be admitted to the health systems itself rather than a parallel structure at CCC, which sometimes were perceived as AIDS centres. Accordingly in NACP IV the model was changed to care and support centres.

COMMUNITY CARE CENTRES, KERALA
St Johns Health Services, Pirapamcode, Trivandrum

Visit to CCC by Deputy Executive Director of The Global fund

Tackling complexities in HIV management..
Development of "Centres of Excellence" in HIV care:

The HIV/AIDS epidemic has, over the past decade, evolved into a more complex one necessitating operational research, effective health delivery systems and a trained and motivated workforce. There was a need for medical institutions which shall deliver high quality of care, treatment and support to People Living with HIV (PLHIV). Complex treatment schedules and patient management require constant training and upgrading of skills among providers. At the same time, being a lifelong therapy, it requires a comprehensive care approach that meets the range of needs of PLHIV as well as high levels of drug adherence for anti retroviral treatment. It became essential that there be institutions of repute and standards, motivated and encouraged to accord more serious attention to this disease. Hence Centres of Excellence (CoE) in HIV care were established. These CoE are model treatment centres, provide second line and alternative first line, impart high quality training and help in capacity building of health care providers. Most importantly they will monitor and mentor other institutions in technical issues. They will also be primary sites for undertaking operational and clinical research. Similarly the regional paediatric centres were upgraded as paediatric CoEs. Both CoEs have been provided with additional staff like research fellows, SACEP coordinator, data analyst, training and mentoring coordinator, nutritionist, and outreach workers to carry out these responsibilities.

Components of CoE:

COMPREHENSIVE HIC CARE
ICTC Services
PPTCT Services
ART Services
Paediatric HIV Services
Laboratory Services
Referrals and Linkages
Helpline

TRAINING AND MENTORING
Programming mentoring
Clinical mentoring
HIV / Clinical trainings
Post training follow-up
PGDHIVM
Tele medicine / conferencing
E-PAN / Distance Learning
e-library / CME activities

MODEL HIV CARE CENTRE
Good clinical practice
Good pharmacy practice
Good hospital infection control
PEP / Helpline on PEP
Good hospital waste management

RESEARCH
Operational research
Clinical scientific research
Bio-medical and behavioral research
Multi-centric studies
Research repository
Publication and Dissemination

CLINICAL EXPERT PANEL
State AIDS Clinical Expert Panel (SACEP)
District AIDS Clinical Expert Panel (DACEP)

Inauguration of CoE at MAMC, Delhi

Visit for assessment, CoE Gandhi hospital, Hyderabad

Review meeting of CoE and pCoE at Kolkata, West Bengal, January 2014

Roll Out of Second Line ART:

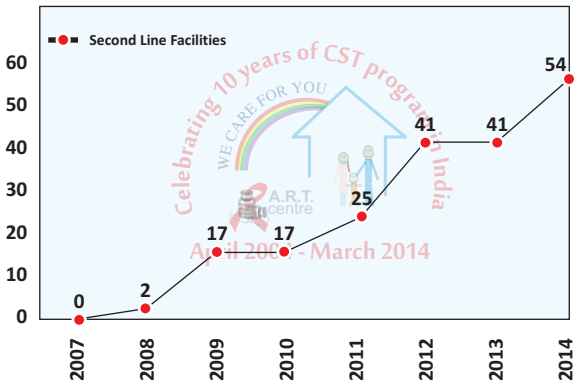
The second line ART treatment for patients that fail the first line treatment was rolled out under the National ART Programme on 1st January 2008 on a pilot basis initially at JJ Hospital, Mumbai and GHTM, Tambaram. The access to second line ART was later expanded to all CoEs, that have the necessary expertise and laboratory facilities required for initiating and monitoring second line ART.

India pioneering the roll out of Second Line ART: National consultation, 2005

Launch of Second Line ART at GHTM Tambaram Chennai on January 23,2008

Initially, second line ART was provided free to all BPL patients, widows and children and to those who were receiving first line ART in National ART Programme for at least 2years. It was then decided to make second line ART available to all those who needed. The scale up was done in the phased manner and now the second line ART is available at 17 CoEs and 37 ART Plus centres. Second line ART for paediatric patients is also available at these centres. All states have at least one centre for second-line while the high prevalence states have four to five such centres

Scale up of Second Line Facilities



Ensuring rational use of second-line drugs...

Keeping in view the operational issues related to second line and limited capacity of Health Care providers and institutions to monitor second line ART, a mechanism of SACEP (State AIDS Clinical Expert Panel) was developed. SACEP comprises of programme director of CoE/ Nodal Officer of ART plus centre, deputy programme director CoE, one or two additional ART experts, Regional Coordinator/Joint Director (CST) / Consultant (CST) at SACS, and any other member assigned by NACO. These panels functions on designated days and are linked to designated ART centres. The suspected treatment failure cases from ART centres are referred to these panels after taking prior appointments for screening for need of viral load testing and if found eligible then initiation of second line ART. The ART centres also refer patients to these panels to get opinion on management of complicated cases and advice regarding alternate first-line ART.

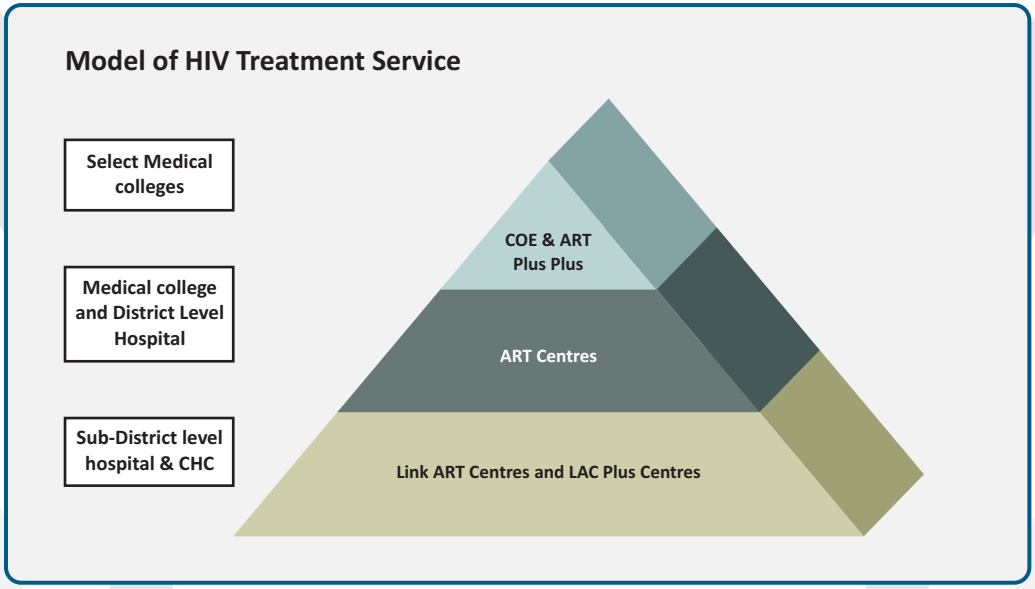
Difficult cases of SACEP are further referred to National AIDS Clinical Expert Panel (NACEP) for expert e-consultations whenever required. The panel comprises of various national experts whose opinion is obtained on case to case basis.

Decentralization of Second line ART and development of ART plus centres:

In the initial period, second-line ART was available only at ten centres of excellence. Since number of centres was very small for a large diverse country, patients were facing problems due to long distance, travel, time and costs. Therefore , based on the existing number of patients on Second Line ART & distance from COE, it was decided to expand the network of ART centres that had the capacity to start 2nd Line treatment following the same referral procedure as adopted for the Centres of Excellence. SACEPs were established at all these ART centres and these were named as ART plus centres. Later it was decided to establish at least one such facility in each state of the country.

The Three Tier Model of Care: Service Delivery Mechanism for Care, Support & Treatment

The service delivery mechanism for delivery of care, support and treatment services under the national has evolved to a three tier system. CST services which are provided through dedicated ART centres across the country are linked to Centres of Excellence (CoE) and ART Plus centres at select teaching institutions, while decentralization of some of the services has been done with the establishment of Link ART centres (LAC). The ART centres are also linked to ICTCs, STI clinics, PPTCT services and other clinical departments in the institutions where they are located. Besides each ART centre is working closely with the RNTCP programme in order to ensure proper management of TB-HIV co-infected patients. Infact a line list of HIV TB coinfected patients is maintained which is shared between the two programmes on a monthly basis to update the status of those referred to the programme on suspicion of disease and to get the treatment status of those who are co-infected.



Designing for Scale

Commodity Standardisation

Technical & Operational Guidelines

Unit Costing

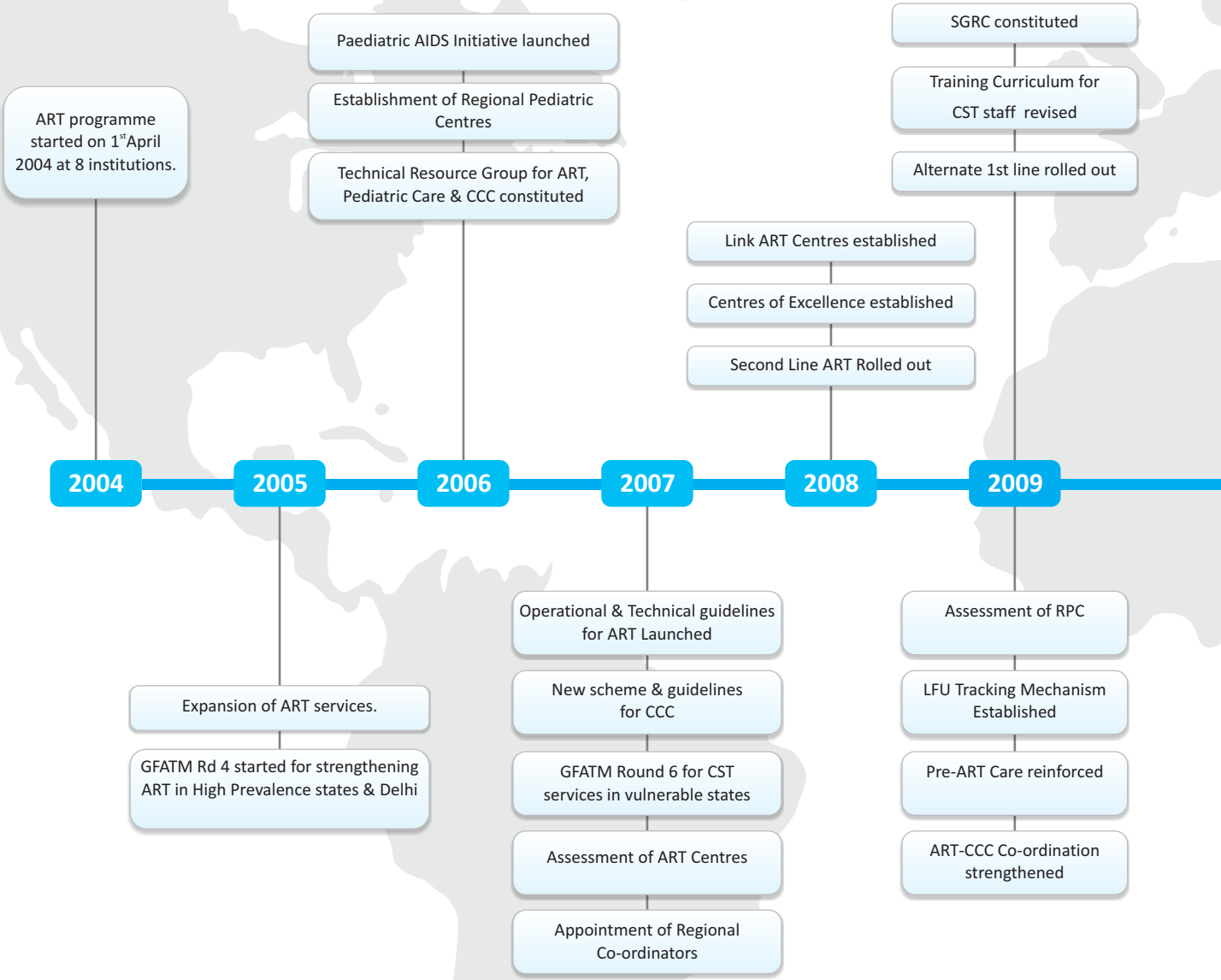
Uniform Training Modules

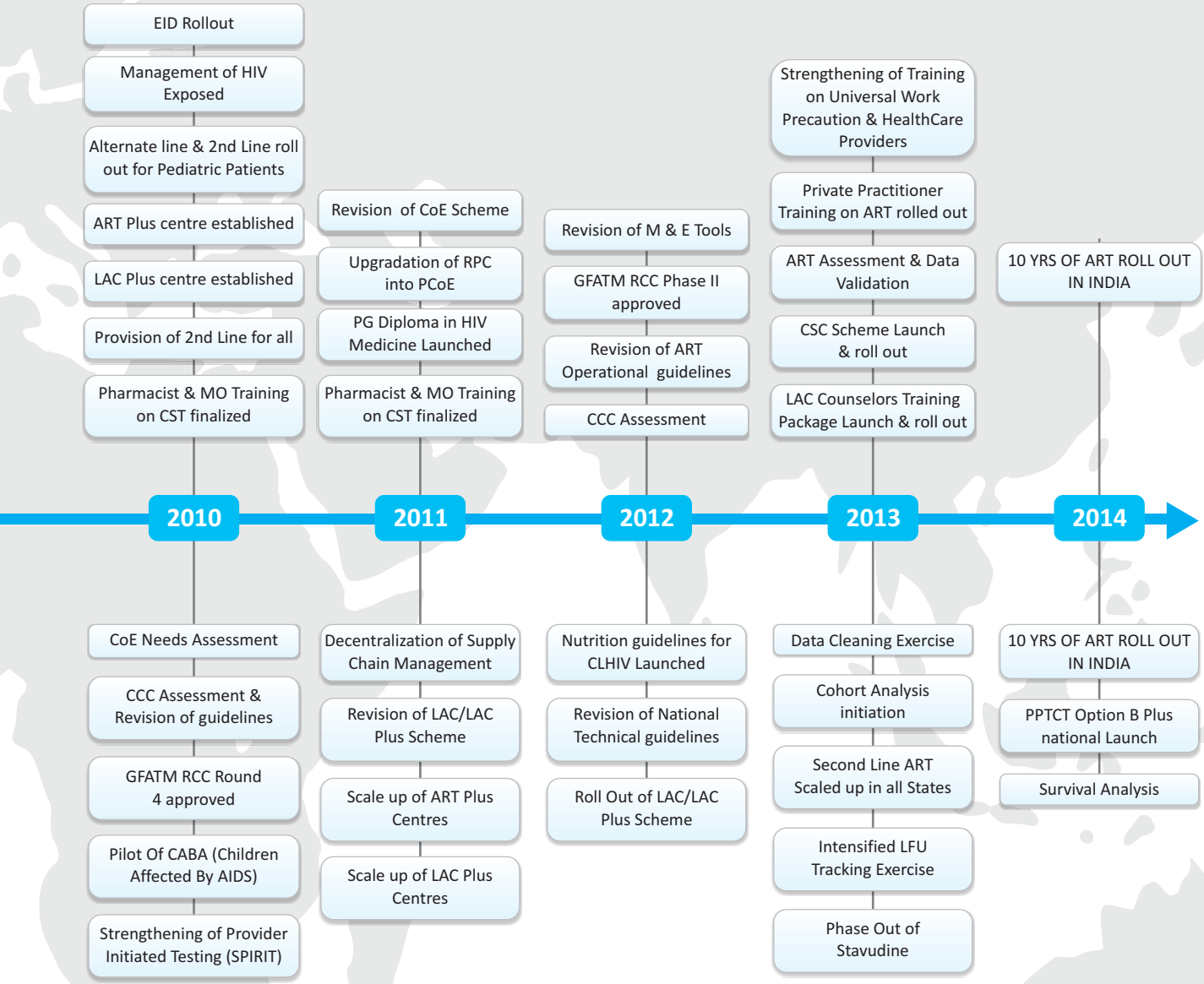
Structured Monitoring Mechanisms

Vist by First Lady of France to ART Centre in Delhi

Visit by Mr. Michel Sidibe ,Executive director, UNAIDS

The journey so far....




2010
EID Rollout
Management of HIV Exposed
Alternate line & 2nd Line roll out for Pediatric Patients
ART Plus centre established
LAC Plus centre established
Provision of 2nd Line for all
Pharmacist & MO Training on CST finalized
CoE Needs Assessment
CCC Assessment & Revision of guidelines
GFATM RCC Round 4 approved
Pilot Of CABA (Children Affected By AIDS)
Strengthening of Provider Initiated Testing (SPIRIT)
2011
Revision of CoE Scheme
Upgradation of RPC into PCoE
PG Diploma in HIV Medicine Launched
Pharmacist & MO Training on CST finalized
Decentralization of Supply Chain Management
Revision of LAC/LAC Plus Scheme
Scale up of ART Plus Centres
Scale up of LAC Plus Centres
2012
Revision of M & E Tools
GFATM RCC Phase II approved
Revision of ART Operational guidelines
CCC Assessment
Nutrition guidelines for CLHIV Launched
Revision of National Technical guidelines
Roll Out of LAC/LAC Plus Scheme
2013
Strengthening of Training on Universal Work Precaution & HealthCare Providers
Private Practitioner Training on ART rolled out
ART Assessment & Data Validation
CSC Scheme Launch & roll out
LAC Counselors Training Package Launch & roll out
Data Cleaning Exercise
Cohort Analysis initiation
Second Line ART Scaled up in all States
Intensified LFU Tracking Exercise
Phase Out of Stavudine
2014
10 YRS OF ART ROLL OUT IN INDIA
10 YRS OF ART ROLL OUT IN INDIA
PPTCT Option B Plus national Launch
Survival Analysis

Moving towards AIDS free generation.. Widening coverage to focus on treatment of children...

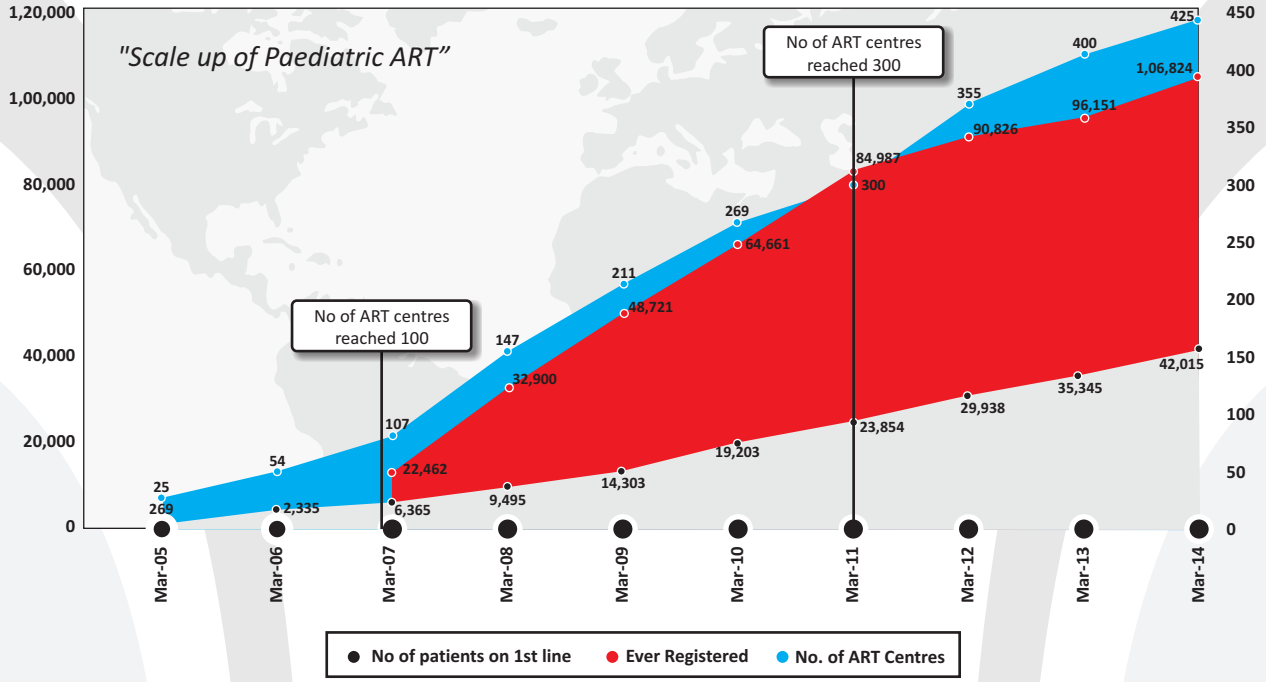
Provision of quality care services for children living with HIV (CLHIV) was far more challenging. Most often CLHIV were diagnosed late and therefore faced higher mortality during infancy. There were no paediatric formulations of ARVs (children had to take adult tablets broken into halves and quarters), inadequate capacity and knowledge among care providers to cater to CLHIV and early infant diagnosis was a challenge. The PPTCT was largely in domain of gynecologists and linkage with pediatrics was weak.

National Paediatric HIV/AIDS initiative & development of paediatric centres of excellence:

The National Paediatric HIV/AIDS Initiative was launched on 30th Nov 2006 and children living with HIV were started getting registered at all ART centres and those eligible are started on ART and followed up. Regional Centres were established and mentored. They were further upgraded to centre of excellence. These centres have varying roles and responsibilities for delivery of care and support to infected children including specialised laboratory services, early diagnosis of HIV among infants, ART to children infected with HIV, counseling on adherence and nutrition, etc. Currently these centres also provide technical support to the other ART centres in care.

Launch of National Paediatric Initiative at Kalawati Saran Children's Hospital, New Delhi, in 2006

Visit to a paediatric ART centre



Care of the Exposed Child:

The National Essential Package of Care for the HIV-exposed infants and children < 18 months includes ARV prophylaxis to mother-baby pair, co-trimoxazole prophylaxis for all HIV-exposed infants, HIV testing to determine HIV status of the infant/child through HIV DNA PCR or antibody test depending on age of the infant/child, follow-up, Immunizations, counseling, appropriate infant feeding practices, ART and other treatment when indicated.

Early Infant Diagnosis (EID):

Addressing HIV/AIDS in infants and children below 18 months is a significant global challenge. Worldwide, in 2007, an estimated 370,000 new infections occurred in children, of which 90% were acquired through mother-to-child transmission of HIV. HIV-infected children are the most vulnerable of all patients. In infants who acquire HIV around the time of delivery, disease progression occurs very rapidly in the first few months of life, often leading to death. Where diagnostics, care and treatment are not available, studies suggest that 35% of infected children die in the first year of life, 50% by second year, and 60% by their third year.

It has been known that survival benefits for infants started on antiretroviral therapy (ART) as early as possible, after diagnosis of HIV, are dramatic. But it has been observed that asymptomatic children below 18 months old do not get diagnosed and are thus missed out on prevention, care, support and treatment. A critical priority in caring for HIV-infected infants therefore is accurate and early diagnosis of HIV infection in order to enhance their survival. To ensure that, every child born to HIV infected women is tested for HIV early and put on treatment if found HIV positive, Early Infant Diagnosis (EID) Programme has been rolled out from March 2010. This includes ARV prophylaxis to mother-baby pair, co-trimoxazole prophylaxis for all HIV-exposed infants, HIV testing to determine HIV status of the infant/child through HIV DNA PCR or antibody test depending on age of the infant/child, follow-up, Immunizations, counselling, appropriate infant feeding practices, ART and other treatment as and when indicated.

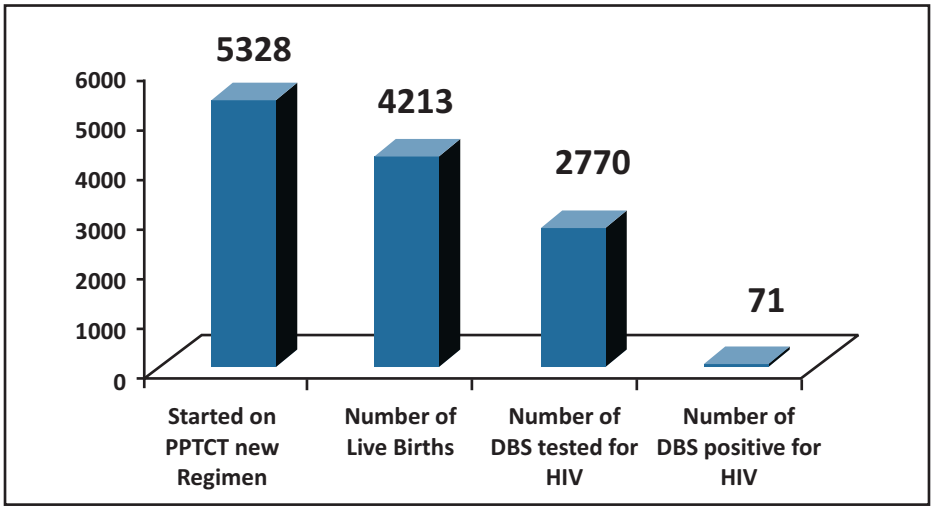
Prevention of Parent to Child Transmission of HIV

For an AIDS-free generation, it is important that all children are born free of HIV and remain so from birth through adolescence and children living with &/or affected by HIV have access to the treatment, care and support. Elimination of mother-to-child transmission (PPTCT) of HIV, treatment of children living with HIV and mitigation of the social and economic impact of HIV and AIDS on children to ensure that children survive and thrive in their first decade of life are major components of the HIV response for young children.

Since the first effective ARV regimen for the prevention of mother-to-child transmission (PMTCT) of HIV was reported in 1994, the outlook for children born to mothers living with HIV has improved dramatically. Today, steadily expanding coverage of the most effective ARVs, together with new approaches to providing them, offer hope that mother-to-child HIV transmission can also be virtually eliminated .The Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive ('the Global Plan') identifies 22 priority countries where almost 90 per cent of all new HIV infections among children occur; India is one of these. Reducing mother-to-child transmission to less than 5 per cent of breastfeeding infants and to less than 2 per cent of non-breastfeeding infants is an important target of the PPTCT .

Department of AIDS Control had rolled out the more efficacious multi drug regimen for Prevention of Parent to Child Transmission of HIV, replacing single dose Nevirapine in the states of Karnataka, Andhra Pradesh and Tamilnadu. In January 2014, the department decided to roll out Option B plus as PPTCT regimen in the entire country.

Preliminary results of Multi drug regimen ARV roll out under PPTCT in three high prevalence states (Andhra Pradesh, Tamilnadu and Karnataka)



Creating evidence for scale up:

Various studies were conducted in relation to CST to create evidence to develop, and modify programmatic strategies that will not only support the scale-up activities but also enhance quality of the processes in place. The national AIDS Control Programme is perhaps one of the best examples of an open, dynamic and evidence based programme in India. Some studies that impacted strategies and policies are as below:

- Assessment of ART Centres in India: Clients' and Providers' Perspectives
- Baseline CD4 count of PLHIV enrolled for ART in India
- Assessment of Link ART Centres in India
- Assessment of Centres of Excellence (CoEs) in India
- Assessment of Regional Paediatric Centres
- Assessment of Community Care Centres in India
- Factors affecting Enrolment of PLHIV in ART centres
- Baseline CD4 count of healthy adult population

Translating learning from experiences into planning / evidence based Scale up:

Turning Science into Programme..

The scale up and strengthening of CST Programme has been a very dynamic process. The programmatic strategies were based on evidences gathered from field observations, assessments reports, reviews, and analysis of programmatic data collected from service delivery points, and also operational research activities. One of the examples best examples of utilizing such a feed back can be that related to availability of human resource at ART centres. Based on the work load and level of provision of quality of services, a fixed staff structure was provided by NACO. Later, the staffing was linked to the numbers of PLHIV alive and on ART, to maintain quality of services, a decision based on observations and reviews. The post of pharmacist was added to

the earlier fixed staff structure as the number of regimen and patient load at ART centres increased. To minimize stigma & discrimination at ART Centres, a post of Community Care Coordinator was also added. Additionally, a staff nurse was sanctioned for ART centres that had high patient load. The assessments and research done from time-to-time guided the policy decision for the programme and introduce new schemes.

Considering huge scale up of ART services, the supply chain management was decentralised for ARV drugs. The ARV distribution to centres now follows a 'hub and spoke' model where the suppliers deliver the entire quantity required by any state to the SACS which act as the hub for further distribution of the required quantity of drugs to ART centres. The SACS distributes 80% of its received stock immediately to the ART centres and maintains a buffer stock of about 20% supplied medicines to avoid stock outs.

However, prediction of demand of ARVs depends on number of patients that will access care services from the ART centres. Sometimes, it is difficult to predict these requirements. Recognising this uncertainty, an element of rapid response was also introduced at the level of SACS that they will be allowed to purchase ARVs on an emergency basis to tide over any crisis that may arise.

OUR MOTTO

PROVIDING HIGH QUALITY SERVICES TO ALL PLHIV

We, the Team **CST** *of* **ART** *centre _____, pledge that*

- *We will work as a team to provide the best possible Care, Support and Treatment to all our patients*
- *We shall ensure that these services are offered without any stigma and discrimination and are Gender sensitive*
- *"Retention in care" being our focus, we shall ensure that*
  - *All patients registering at our centre shall undergo baseline and regular 6 monthly* CD4 *count whether, pre-*ART *or on-*ART
  - *That all patients eligible for* ART *as per* CD4 *count or clinical guidelines are started on treatment in time*
  - *All efforts shall be made to minimize* LFU *and retrieve those lost to follow up*
- *We shall ensure that documentation is complete in the required formats and within the stipulated time period*
- *We shall ensure good linkages with* TB,PPTCT *and* EID *services*

We acknowledge that there will be difficulties along the way but we recognize that if we are sincere and determined, these obstacles can be overcome by working together as a team.

Signature of Nodal Officer .....

Signature of all staff of ART centre

A decade of progress in service delivery is summarized as below:

S.No	Service Delivery Sites	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
1	ART centres	8	25	54	107	147	211	269	300	355	380	425
2	Cd4 testing sites	8	18	32	42	71	198	211	211	264	264	264
3	Community Care Centre/ Care and Support centres	122	122	122	122	122	254	287	259	253	239	224
4	LACs	-	-	-	-	42	208	327	580	685	840	870
5	LAC Plus	-	-	-	-	-	-	-	100	129	156	228
6	Centres of Excellence	-	-	-	-	2	10	10	10	10	10	10
7	Regional paediatric centres/ Pediatric CoEs	-	-	-	-	-	7	7	7	7	7	7
8	ART Plus centres	-	-	-	-	-	-	-	8	24	24	37
9	Viral load testing sites	-	-	-	-	-	-	7	7	9	9	9

Quality interventions were the cornerstone of ART programme scale up

Ensuring quality of Care, Support and Treatment services through standardised guidelines, regular capacity building of staff and monitoring:

Standardised Guidelines:

Prior to initiation of free ART , the patients who were receiving ART in India were accessing these services from private medical practitioners. A dramatic reversal in this ration was achieved by the free ART . Currently, only about 5% patients receive ART as prescribed by the private medical practitioners despite reduction in prices of ART. However, this journey required meeting the incidental challenges on course, appropriately.
The private medical practitioners used to treat the patients based on any chosen international guidelines or those that were recommended by opinion leaders among HIV Medicine specialists.

The need to develop standardized guidelines for HIV infected adults and children to maintain standard of care and ensure uniformity in patient care was a vital step. National guidelines to provide quality care to HIV infected adults and children comprehensively were one of the important cornerstones of the .

HIV medicine is one of the most rapidly advancing frontiers of medical research. The guidelines to treat HIV infected individuals required modifications very frequently. For country of a large geographical area and the number of centres providing ART, it was one of the major challenges that the faced. However, recognizing the need to change, not only did the National guidelines change, but were implemented seamlessly throughout the country.

The development and revisions of the guidelines are reflected through the list below;

- Guidelines for ART in adults and adolescents- 2004 (Updated: March 2007, April 2009, November 2011, July 2012 and May 2013)
- Guidelines for ART in children- November 2006 (Updated; September 2009 and October 2012)
- Guidelines for prevention and management of common opportunistic infections and malignancies among adults and adolescents- February 1998 and March 2007
- Operational guidelines for ART centres – 2007 (Updated; 2008, 2012)
- Operational Guidelines for Link ART centre and LAC Plus – January 2012
- Technical guidelines on second line ART in adults and adolescents- November 2008 (Updated in December 2012, May 2013)
- Technical guidelines on second line ART for children- October 2009
- Training modules for ART Medical Officers, ART specialists, CCC Medical Officers and LAC Medical Officers May 2007 (Updated: December 2012)
- Guidelines for Providing Nutritional Care and Support for Adults living with HIV and AIDS: July 2012
- Nutrition Guidelines for HIV Exposed and Infected Children (0 – 14 years of age): July 2012

The above documents are revised from time to time with the recommendations of the Technical Resource Groups. These can be accessed on the NACO website (www.naco.gov.in)


PROGRAMME IMPLEMENTATION GUIDELINES
FOR
A PHASED SCALE UP OF
ACCESS TO ANTI-RETROVIRAL THERAPY
FOR PEOPLE LIVING WITH HIV/AIDS
NACO
GUIDELINES
FOR
COLLECTION, HANDLING
AND
TRANSPORT
OF SPECIMENS
FOR
CD4 TESTING
OPERATIONAL GUIDELINES
FOR
LINK ART CENTRES & LAC PLUS
December 2011
idelines for HIV Care and
eatment in Infants and Children
PERATIONAL GUIDELINES
FOR ART SERVICES
July 2012
Care, Support and Treatment Division


Antiretroviral Therapy Guidelines for
HIV-Infected Adults and Adolescents
Including Post-exposure Prophylaxis
Operational Guidelines for
ART Centers
May 2008
National Guidelines on Second-line and
Alternative First-line ART
For Adults and Adolescents
May 2013
NACO

Technical Resource Groups:

The care support & treatment programme in India is an acquiescent programme where there are technical resource groups on ART, paediatric care, community care centres, and laboratory services that review the guidelines in the light of evidence and give their recommendations regarding updation and then final decision on implementation is taken based on the feasibility by the policy makers. The TRG comprises of experts from different sectors viz. governmental, Non-governmental, NGOs, PLHIV network etc.

Summary of major changes in ART technical guidelines overtime

Topic	2004	2009	2011	2012	2014
When to start	CD4 ≤200	Cd4 ≤250	CD4 ≤350 Irrespective CD4 for TB,	CD4 ≤ 350 Irrespective CD4 for TB, Option B for pregnant women	CD4 ≤ 500* Irrespective CD4 for TB, Pregnancy (option B +)
Earlier Initiation					
What to start (1st Line ART)	4 options Stavudine preferred	4 options Zidovudine preferred	4 options Zidovudine preferred	4 options AZT preferred, TDF available, Stavudine phased out (2013)	4 options TDF preferred for all new patients*
Simpler Treatment					

Topic	2004	2009	2011	2012	2014
What to start (2nd Line ART)		Boosted PI LPV/r Heat Stable FDC (2008)	Boosted PI LPV/r Heat Stable FDC	Boosted PI ATV/r, LPV/r	Boosted PI ATV/r, LPV/r
Less toxic, more robust regimens					
Cd4 testing	Once in every 6 months for selected patients (subsidised)	Once in every 6 months for all patients (or earlier if required)	Once in every 6 months for all patients (or earlier if required)	Once in every 6 months for all patients (or earlier if required)	Once in every 6 months for all patients (or earlier if required)
Better Monitoring					
Viral Load testing		Targetted viral load	Targetted viral load	Targetted viral load	Targetted viral load (plan to routinise)**

*After the procurement for current year
**Feasibility and capacity being assessed

Capacity building by NACO through PG Diploma in HIV Medicine in colloboration with IGNOU

To ensure uniform standards of services, adherence to operational guidelines and treatment protocols, induction/refresher training is provided to various personnel using standard curriculum, training modules and tools at identified institutions. Various training programmes organized under CST programme include:

- Orientation of faculty of Medical Colleges/District Hospitals (4 days)
- Training of Medical Officers (SMO/MO) of ART centres (12 days)
- Training of Medical Officers of CCC (4 days)
- Training of Medical Officers of Link ART Centres (3 days)
- Training of ART Counselors (12 days)
- Training of Data Managers of ART Centres (3 days)
- Training of Laboratory Technicians for CD4 count (2 days)
- Training of ART Pharmacists (3 days)
- Training of ART Nurses (6 days)

These trainings are conducted at the Centres of Excellence and other designated training centres across the country.

Sensitization workshops for medical & paramedical staff

Continued Medical Education Programmes:

With the intention to provide medical officers (MOs) working at ART Centres with relevant, reliable, up-to-date information on the current clinical management of HIV-infected patients and to provide recent programmatic updates in management of PLHIVs from the national AIDS control programme, I-TECH India supported and conducted various continued Medical Education Programmes with direct involvement and support from DAC and centres of Excellence in HIV Care.

The CMEs are conducted at regional levels and also at state levels along with ART review meetings. The curriculum for the CME was formulated with prior consultation with the national and regional HIV experts keeping in mind the definite needs of the MOs of the regions or state. Also it was considered that the medical officers will become equipped with the recent knowledge about various aspects of the HIV epidemic and its management discussed during current national and international discussion fora and conferences.

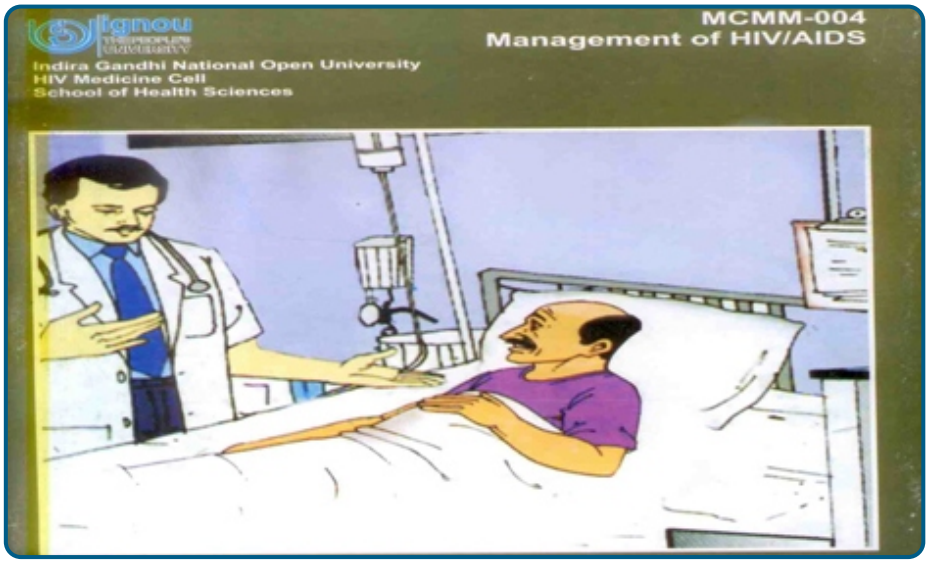
Regional CME at Lonavala for ART Medical officers of Maharashtra, Mumbai and Goa region

CME in Maharastra in Dec 2013

" Capacity Building on Cohort Analysis. March 2014"

Post Graduate Diploma in HIV Medicine:

NACO, in collaboration with IGNOU, has rolled out a one-year Post Graduate Diploma programme in HIV Medicine. This programme is expected to bridge the gap in trained manpower for ART centres. The objectives of the programme are to imbibe comprehensive knowledge on basics of HIV as related to details of management of HIV/ AIDS in tertiary care set up and to manage all complications as well as opportunistic infections due to HIV/AIDS when needed. The programme is being implemented through a network of programme study centres located in select Centres of Excellence.


ignou
Indira Gandhi National Open University
HIV Medicine Cell
School of Health Sciences
MCMM-004
Management of HIV/AIDS

Distance Learning seminars series:

National Distance Learning Seminar series is aimed at training health care workers and physicians working with PLHIVs. National experts present on variety of advanced care, comprehensive management, and treatment topics via live webcast sessions across several states and districts around the country. The goal is to create a dialogue amongst clinicians in regard to management of moderately complex cases. These 60-minute sessions; are conducted in English and use a case-based format during the live session and allows participants to engage in follow-up communication across the sites. Two sessions are conducted in every month.

Regional Distance Learning Seminar series is conducted and organized by CoEs at the regional level and specifically address the issues pertaining to the respective state and/or region by regional medical officers or regional experts. These are aimed at training HCWs on locally relevant topics, unique case studies and treatment guidelines often in local/regional languages.

I-TECH provides technical support for the national and regional distance learning seminar series.

Supervisory/ Mentoring Mechanism:

Care Support & Treatment Division at NACO is responsible for planning, financing, implementation, supply chain management, training, Coordination, monitoring & evaluation of care support & treatment services in the country. The implementation and monitoring at State level is the responsibility of all concerned State AIDS Control Societies (SACS)

For close monitoring, mentoring and supervision of ART Centres, various states have been grouped into regions and Regional Coordinators have been appointed to supervise the programme in their regions and mentor the concerned staff. The Regional Coordinators and SACS officials visit allotted ART Centres and their reports on findings and action taken to NACO. Periodic meetings of Regional Coordinators are held at NACO to review various issues pointed out by them. In addition, NACO officials also visit those centres which have not been performing satisfactorily or are facing problems in implementation of the Programme and those that need mentoring from central level.

Visit by Secretary DAC & DDG CST to ART centre Jaipur , 2011

Regular CST review meetings

Review meetings of all the CST officers from the State and all NACO Regional Coordinators are held on a regular basis in a standard format. During these meetings, the State officers give an update on the various CST related activities in their State and wherever required remedial measures are taken.

CST review meeting at Vizag, Vishakhapatnam, Andhra Pradesh, May 2012

Regular State level review meetings:

Regular State level review meetings of the programme are conducted at SACS level. These meetings are attended by representatives of NACO, SACS, Regional Coordinators, medical officers and staff of ART centres and other facilities. Review of the performance of individual centres is undertaken during such meetings. Participants are given refresher/reorientation sessions also during such meetings.

State Grievance Redressal Committee

At the state level, Grievance Redressal committees are constituted in all states to routinely review functions of the ART Centres. The Committee is headed by the Health Secretary of the State and consists of Project Director of the SACS, Director of Medical Education, Director Health Services, and the Nodal Officers of the ART centre, representative of Civil Society/ positive network and NACO. This mechanism ensures that issues pertaining to grievances on PLHIV are brought into notice of state authorities and SACS in a systematic manner for timely response and action.

SGRC meeting in Uttar Pradesh

Ensuring adherence to treatment and prevention &/or tracking of Lost of Follow-up cases:

It is of utmost importance to consolidate the gains of ART Programme and prolong patients' continuation on first line therapy by increasing the drug adherence, LFU tracking and preventing /reducing missed cases and LFU.

Pill-count:

Adherence to antiretroviral therapy (ART) is an essential part of successful treatment programme. All ART centres use pill count as one of the methods to check the adherence in addition to other indirect methods like self reporting by patients and review of Pharmacy records / prescription refill monitoring. Most of the patients on ART maintain more than 95 % level of adherence to ART drugs.

Daily Due List:

All ART centres prepare a "daily due list" indicating all PLHIVs, who are supposed to visit ART centre on that particular day. This is prepared from either CMIS or white card where patient is given next appointment or from the drug dispensing register. All those patients in this list who fail to collect drugs on that day are followed up with in next 48 hrs through phone calls.

- ➔ Regularly maintaining due list.
- ➔ Phone calls are made by Counselors according to daily due list

LFU Tracking Mechanism:

PLHIVs that do not turn up in the reporting month are reported as MIS. If such patients do not come in the next month, tracking activities are continued. If they do not report to ART centre even after 4th calendar month, then they are reported as LFUs. All ART centres share the list of LFU /MIS Cases with ORW of CSC / ICTC counsellors/DLN to track them back. The ART centre team/DAPCU also hold monthly meeting with linked CSC project coordinator/ ICTC/ DLN to follow up LFU / MIS cases list given to them in previous month. In the same meeting, referrals between ICTC to ART centre are line listed and reviewed.

Follow up of Pre-ART LFU:

All patients registered in Pre-ART and on ART undergo a CD4 test every six months. The ART centre laboratory technician maintains a daily “due list” of the patients who are due for CD4 testing. This list is prepared from the CD4 laboratory register. This list is available with Senior Medical Officer , ART centre and during patient's visit in that particular month for ART, CD4 test is done. Those who do not undergoCD4 test within one week of their due date are reminded to visit ART centre by a phone call to ensure that CD4 test is done on the next visit.

Smart Card System:

India is a large country and has diverse economic growth in different states. Migration to earn livelihood is common among the economically challenged sub-population in India. Migration is recognised as a driver of HIV epidemic in low HIV prevalence states. Migrants and high mobility is also recognised as a challenge for provision of services. It was essential that provision of ART services that require very high level of drug adherence recognise the need to ensure provision of ART while patient's travel away from the ART centre. Information technology is a major strength in India. Using their base, strategies to enhance provision of drugs, NACO planned a strategy for ensuring uninterrupted ART drug supply and continuity of medical consultation.

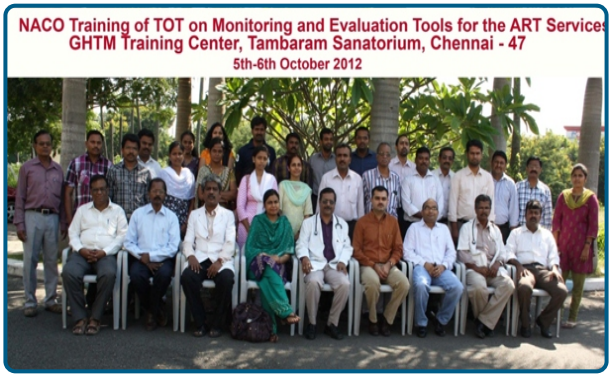
The concept of Smart Card System has been introduced to develop a computerized data storage and retrieval of patient records resulting in the development of the Health Smart Cards for PLHIV on ART. This card is a chip-based system to informed access at the backdrop of maintenance of

confidentiality. The Smart Card System, apart from capturing details as required in the ART PLHIVS record also captures the photograph and fingerprint of PLHIVS. After the preliminary data capture, the PLHIVS is uniquely identified using biometric de-duplication process at the central database. Once the PLHIVS has been identified, a unique ID is generated for each PLHIVS and she/he shall be registered in the system.

This card will help the mobile population in accessing care and support to patients attending ART centres in seven states of India in any part of the country. It helps not only in monitoring treatment to ensure adherence but also ensuring access to quality medical consultations to prevent the patient from becoming drug resistant and enhance quality of life. It acts as a portable medical record which will play a crucial role in time-sensitive emergency situations.

Robust monitoring and evaluation (M & E) systems:

The programme has a robust monitoring and evaluation (M & E) system which comprises of records and registers at ART centre, monthly reporting mechanism and PLHIVS software. The data at all ART Centres is collected in uniform formats and entered into PLHIV software and also monthly CMIS (Computerized management and information system) report is also sect to DAC by 4th of every month. These M & E formats had been revised and updated timely to capture the data as per need and it was ensured that the staff at ART centres is adequately trained in all formats to ensure the accuracy of data collection. The CMIS and PLHIV software is being replaced by SIMS (Strategic Information and Management System) to make the system more robust. The system has been piloted at some of the ART centres by DAC and will be rolled out through the programme very soon.



Assessment of services under CST programme:

Data validation and review of quality of services provided at ART centres:

Department of AIDS Control is presently conducting an exercise on data validation and review of quality of services provided at ART centres in India. During this exercise, on-site data validation & assessment of quality of services at ART centres for the specific indicators is being done by team of assessors. Two orientation workshops were conducted for these assessors. Each team has been assigned 5-6 Centres for review & data collection in a structured and comprehensive tool and the team will submit a report to DAC in a specified time. The activity is expected to get completed by second quarter of year 2014

Assessment of Centres of Excellence:

DAC has also planned for assessments of COEs to ensure the high standard of quality of services which are being provided. Needs assessment exercise was done in the year 2010 and accordingly many new initiatives were taken. The assessment again will be done with the help of a structured and comprehensive tool developed by the Department of AIDS Control (DAC) and is expected to be completed before second quarter of year 2014.

Reaching out to rural settings and integration of services into health system: deepening roots

When ART was introduced into the national programme, one of the major challenges was to maintain the highest standards of quality of care as ARV drug options were very limited and there was no second-line or further line of treatment if first line treatment failed. Therefore all the ART centres were established initially in tertiary care centres- medical colleges and district hospitals. With increasing patient load at those ART centres, the programme realized that it could pose challenges in ensuring monthly visits of PLHIV to ART Centres for optimal adherence to ART. Also, the PLHIVs need frequent and inconvenient long distance travel to access these services leading to escalation of costs to be borne by the patients. At times, adverse weather conditions and natural calamities make drug collections on scheduled visit dates posed daunting challenges . Although most of these services are offered through the rural health system within comfortable reach of these patients, patients continue to face challenges around access. Therefore, integration of services offered under CST programme of DAC, with the existing health system was considered vital for long-term sustainability at the backdrop of rapid scale up of services.

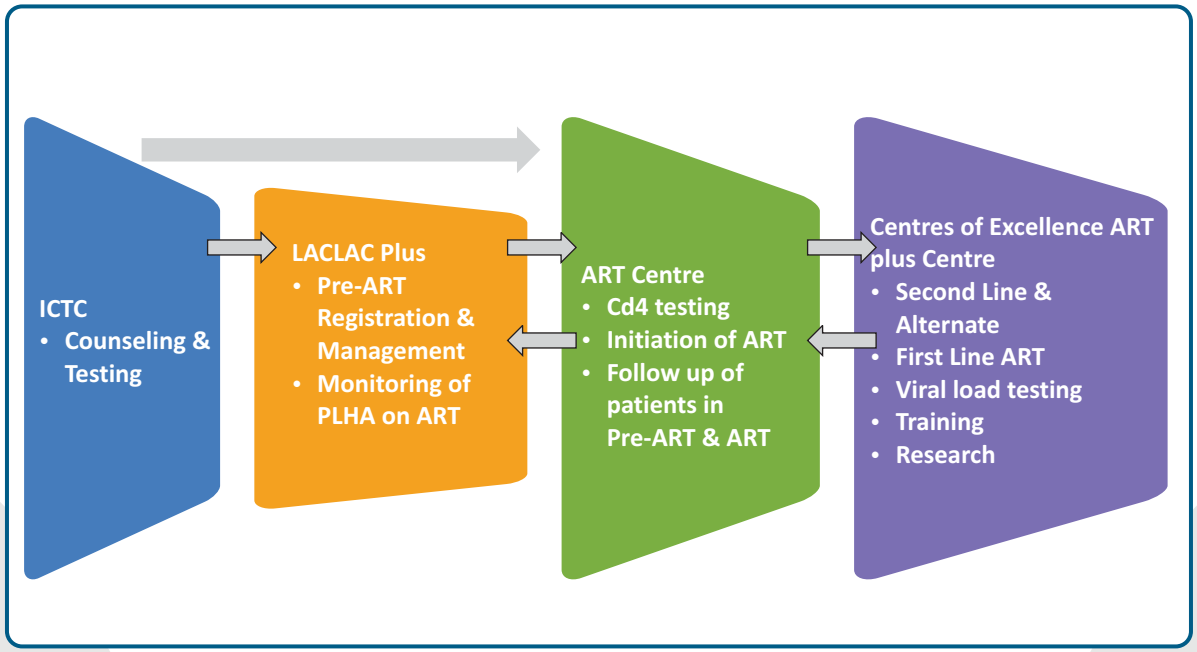
Keeping this objective in mind DAC decentralized ART services to peripheral institutes under health department by establishing 'Link ART centres' (LAC). LACs improved accessibility of ART services by reducing mean travel time for patients to <60 minutes and distance <25 km. Also short waiting time for registration, counseling and dispensing of drugs (median time 10 minutes each) and medical examination (15 minutes) at the centres were observed as additional benefits. Majority of the clients spend less than INR 100 on each visit, mainly on travel cost which is much lesser as compared to traveling to ART centres situated at district places. Level of client satisfaction towards services by LACs was reported to be high and most of the of clients expressed improved quality of life after treatment.

840 Link ART Centres were established for dispensing ARV drugs, monitoring side effects and treating minor opportunistic infections at the rural hospitals and/or peripheral health institutes that are mainly operated by the staff from health system with minimal financial and supervisory support from the programme. Among these, 154 LACs have been upgraded as LAC plus centres to

provide pre-ART services additionally. These centres are part of primary health care system and thus help in strategies of integration of the national programme into Primary Health Care.

Increasing access and promoting comprehensive care, support and treatment for PLHIVs is one of the important strategies of NACP IV. Also integration of these services with National Rural Health Mission (NRHM) and general health system is one of the priority areas that demanded newer modalities to reach out to all populations. Understanding further, the importance of integration with the health system, the DAC plans to establish "Integrated ART centres" that will also work as model centres for districts that have lower HIV prevalence including those areas that are difficult to reach and have inadequate health care infrastructure. The integrated ART centres will stand out as model centres of HIV treatment, care and support for districts/ regions having low prevalence of HIV. These centres will be noticeable as one of the best examples of integrated service delivery sites in HIV treatment and also serve as cost-effective model of care for small patient load. These will further help in decentralisation of services and thus, enhance access to treatment by reducing travel time and expense for patients to reach the facility and also help to decongest the existing high load ART centres.

Link ART Centres being first step towards integration of care support and treatment services with health system and Integrated ART centres to follow, integration is also being accomplished at tertiary level health systems viz at the level of medical colleges and district hospitals. Though the integration is complex and challenging, it will shift the ownership of HIV treatment & care from the National programme staff to health system staff, appropriate handling of sensitive issues like confidentiality, creating and ensuring enabling environment of care & treatment for PLHVs, training of health workers, capacity building and sensitization about HIV related issues like stigma and discrimination and also infrastructural changes at the service delivery sites of the health system etc. Therefore, it will require sustained efforts from both NACP and Primary Health Care programme.



Model showing referrals & linkages under CST Services

Joining hands with NGOs, civil societies, PLHIV networks and private organisations:

Most of the National health care programs are based on provision of preventive services required for their diseases. However, NACP required a strong preventive and treatment services agenda. This is important as provision of treatment related services required factoring in of demand, access to quality services, and acceptability of these services. Community involvement and mobilization are the cornerstone of successful endevours in such a direction. Though the NGOs have been involved in ART programme since beginning, it was mostly of through funding for projects like CCC and DIC etc. ART programme involved communities (NPP+) in discussion around all technical and operational issues at all stages of expansion and decentralization.

NACO also made efforts for leveraging sustainable public private partnership models by collaborating with corporate house through CII, with private medical colleges, trust hospitals for establishing PPP model ART centres, ICTCs and STI clinics for greater outreach and long term sustainability.

Mr. Ramapandian (Indian Network of Positives) distribute first two weeks of First line ARV drugs to the registered PLHIV on the April 1st 2004 at GHTM, Tambaram

While efforts were being made to upscale their services, there were NGOs and civil society organization which perceived that government was not doing enough to tackle the issues of stigma/ discrimination, increasing availability of ART and denial of services at health care facilities. Organization like Voluntary Health Association of Punjab, Sankalp Rehabilitation Trust, Lawyers Collective and Common Cause moved the Supreme Court of India on these issues as violation of constitutional right to health. NACO, in contrast to approaches followed in other civil writ petitions, chose not to confront the petitioner through routine process of affidavits, counter affidavits etc. but adopted a progressive approach of discussion on policies) with petitioners. It adopted their suggestions on case-to-case basis for modifying strategies based on these discussions. Some of the best examples of such an approach are described in the following examples.

NACO issued an office memorandum to all states on 26th August 2008 in which lot of emphasis was laid on quality of care and this led to sorting out of nearly 80% of issues raised by petitioners. State Grievance Redressal Committees (SGRC) were set up in all states to routinely review functioning of the ART Centres. The SGRC is headed by the Health Secretary of the State and consists of Project Director of the SACS, Director of Medical Education, Director Health Services, and the Nodal Officers of the ART centres, representative of Civil Society/ positive network and NACO. This mechanism ensures that issues pertaining to grievances on PLHIV are brought into notice of state authorities and SACS in a systematic manner for timely response. These are also effective weapons for NACO/SACS to leverage issues related to infrastructure, laboratory back up and other services at health facilities.

Regarding issues pertaining to other ministries, NACO arranged an inter-ministerial meeting with Railways (to provide 50-75% concession in rail travel to PLHA), Food and Civil Supplies Ministry (to provide Anantodya Ann Yojna Cards), Surface transport ministry (to provide free surface transport) and issue of BPL cards to PLHA.

Another Best practice in ART roll out has been NACO's engagement with INP+, Lawyer Collective, MSF and other cum Society organization to discuss issues related to TRIPS and patent as well as to bring in a comprehensive HIV/AIDS bill covering all aspects of HIV including treatment.

In response to a case put up in the Supreme Court of India on provision of second line ART centre to all eligible PLHIV, NACO agreed on a common road map on expansion plan based on ground realities versus need of PLHA .

Involving private practitioners in the programme:

During the early years of ART in India, there had been reports of significant proportions of irrational prescriptions of ART across the country. In order to address this issue, the National AIDS Control Organisation issued an Office Memorandum, in the year 2008, with directives for enhancing the extent and efficacy of treatment administered to PLHIVs. In continuation to these efforts, now it has been decided to roll out sensitisation programme for the private practitioners on National ART Programme.

Public Private Partnership (PPP) Model ART centres

Ensuring universal access to ART and care and support as per national guidelines is one of the key objectives of NACP-IV.

The first PPP model ART centre was established by NACO in association with an NGO, AHF India in Guwahati, following an MOU under which the NGO partner provided the staff for the centre while NACO provided ARV and OI drugs and all services to PLHIV were provided free. Later this was expanded to corporate sector and private medical colleges also.

Since then, National AIDS Control Organisation (NACO) along with several NGOs and Confederation of Indian industries (CII) has been establishing ART centres in corporate Sector & contracting leading industries with a commitment to 'common good'.

As of now, there are 18 ART centres (mentioned Below) in PPP mode with MoU signed with NACO and are mainly established within the health facilities linked with private sector Industries. A total of 23817 patients are receiving free ART at these centres

S.No	Corporate Sector
1	BILT, Chandrapur, Maharashtra
2	BILT, Koraput, Orissa
3	Godrej, Vikhroli, Maharashtra
4	L&T, Mumbai, Maharashtra
5	Bajaj YCMH Pimpri Pune, Maharashtra
6	ACC, CMC Vellore, Tamil Nadu
7	ACC, Wadi, Karnataka
8	Reliance Hazira Plant Sutat, Gujrat
9	Reliance DAH Patalganga, Raigarh, Maharashtra

S.No	NGO Sector
1	Gardi Medical College Ujjain, MP
2	St John's Medical Collage Bangalore, Karnataka
3	KIMS, Bangalore, Karanataka
4	Bharti Vidyapeeth, Sangli, Maharashtra
5	Pravara Institue of Medical Science, Loni, Ahmednagar, Maharashtra
6	KMC, Mangalore, Karanataka
7	NRI Guntur, Andhra Pradesh
8	RDT Bathanapalli, Ananthpur, Andhra Pradesh
9	Ashakirana, Mysore, Karnataka

Here are reflections from one the PPP model centres in Pimpri, Mahrashtra.
Bajaj Auto which inherits the values of the association of Mahatma Gandhiji with Shri Jamnalalji , came forward & accepted the proposal for PPP model as a part of CSR. Thus was born the unique Public Private Partnership (PPP) with NACO, Bajaj Auto Ltd & Pimpri Chinchwad Municipal Corporation run Yeshwantrao Chavan Municipal Hospital (YCM) Hospital. The Bajaj, YMCH team made the unit a reality till date keep it the best.

After signing the MOU/Agreement in Feb 2008, all the parties set out to perform their respective roles on a war footing with precision and speed. With the guidance of NACO, Maharashtra AIDS Control Society (MSACS) and BJ Medical college officers, the ART centre was set up in the space provided by YCM Hospital in Pimpri. The staff was recruited, trained and put in place and NACO inspection team lead by Dr B.B.Rewari, approved the set up which was set up as per NACO norms.

The ART centre was monitored from day one to be the best in its cadre. The inflow of patients steadily increased to 3000 nos on ART in 2 years, as against the planned capacity of 500. Bajaj auto, NACO & YCM, ceased of the situation, swiftly came together & provided additional facilities. This ensured 100 % satisfaction for all patients, govt agencies by excelling in care, treatment and also in reporting.

The national & international agencies and teams who visited the ART centre were awed at the conviction, clarity and excellence and lauded the best PPP project known. Global Fund, WHO, Bill& Melinda gates foundation & a 17 Member team from South Africa were some of the visitors.

Dr Brian Brick VP- Anglo American, who lead the S.A Team stated after the visit, "Never seen such an outstanding, balanced operation of Industry & government", "An outstanding example worth emulating" and went on to add "I can see the beginning of the end of AIDS". This Instilled tremendous confidence and commitment in the entire team of 13 staffs led by Nodal officer Dr Nitin Gaikwad.

The ART centre has now 10000 registered patients and 5400 on ART, the largest number among industry run ART centres in the country. A Further expansion is underway to maintain the quality of service and excellence, so effectively achieved.

Today the ART centre stands tall as the best example of success of PPP project between Private and govt sector and is an example worth emulating for the care and control of HIV/AIDS.

Mr. KV Iyer , Bajaj Auto

Beneficiary perspective about the CST programme in India

"I didn't choose HIV. HIV chose me. HIV chose me to be a mediator, an activist, and an agent of positive change."

Our journey as an HIV-positive activist changed our perceptions and gave new meaning to our lives.

Pre ART Era: 1986 to 31st March 2004

"You have AIDS," a counselor said to me in 1997. I don't remember the exact date, but suddenly everything went blank. The counselor had spoken to me for more than 20 minutes, but I just remembered his one sentence: "You have AIDS." Only one thing came to my mind: everything is finished. I cursed God. Why did He choose me? Why only me?

My first question was, "How long will I live?" He started calculating figures in front of me and then said, "You have another two years." You all will laugh. I was thinking that I will die in two months, and now I got two years. I felt a bit happy for a while. I asked my second question, "Is there any treatment?" The counselor told me, "Don't think about medication. It costs Rs. 60,000/- per month." Where will I get Rs. 60,000/- every month?

After much thinking, I made a plan. I took a Rs.5,00,000/- life insurance policy and decided to commit suicide. It took me some time to learn that committing suicide requires a kind of courage, and I was not able to gather that courage.

But destiny had written something else for me. I came home one day at around 3pm and on television the movie "Anand" was being shown. I still remember each moment. It was a turning point of my life. I watched that movie and cried, hiding from my mother and father. But suddenly, I don't know from where, a sentence of Rajesh Khanna from the movie completely changed my whole perception and attitude towards life: "Kya fark hai 70 salo mein aur 6 mahine mein, aane wale 6 mahine mein jo lakho pal mai jine wala hu uska kya hoga, Jindagi Badi honi chahiye, Lambi Nahi."

I began my search for accurate, scientific information on AIDS and ended up at National AIDS Research Institute (NARI). I got answers to my questions, sometimes silly. I still remember the smile on the doctor's face and his occasional chuckle.

In August 1999, I started working with PLHIV networks. This gave vision and purpose to my life. I remain to this day thankful for support from my peers, doctors and friends on positive living, which has kept me strong even before treatment was available and affordable for me. I decided to work in HIV. I wanted to make a difference, but I also wanted to make sure that none of my family or friends get infected.

As time passed, there were many sad moments in our lives. We lost close friends who could not afford ARV treatment. Each death created fear and weakened our confidence. If someone we had just met or spoken to days before could be taken so fast, what did the future hold for us? Yet, somehow we learned courage to advocate for our rights and for ART. We started raising our voices on every platform and at every forum.

Post ART Era: 1st April 2004 onwards

On World AIDS Day, 1st December 2003, the government announced free ART. The programme would start of 1st April 2004. Though many of us were not yet on treatment, it gave us so much hope. Now we could imagine a future in which we would not have to die of AIDS and continue living a normal life.

Our close friend, whose CD-4 had dipped down to a single digit in 2003, is still with us and healthy. His two sons have started college. He was always worried about his children's future. Last year he gave me sweets saying that his younger son got 74% marks in 12th, and both of them were going to take admission in degree college. Tears came to his eyes, and we just hugged each other. There was no space for any words. There were only feelings to understand. That hug was for a healthy and productive life, which was possible because of free ART.

A positive couple had been told not to think about having children. They were depressed and came to NMP+ office. We counseled them and referred to the PPTCT . Recently their daughter got

first prize in school for dancing and in the essay competition. The first call they made was to tell us this news. The mother was crying on the phone. She said that the PPTCT allowed her daughter to be born negative. She will be successful in her life, perhaps one day becoming an IAS officer. Such are the achievements of the ART .

There are many hidden success stories that might not be told in any report. Free ART is not just pills that we are swallowing twice. These pills are hope and confidence to live productively and healthy. ART and PPTCT interventions have brought happiness and wellbeing to the lives of millions of PLHIV.

In January 2014, we are remembering this journey, and one of our friends who was quietly listening to our conversation asked, “If we are going to complete ten years of free ART, we must celebrate Treatment@10.” What a wonderful thought! Suddenly the amazing journey of past ten years came alive again. This small, informal discussion took shape into this occasion to convey the gratitude of the PLHIV community. These ten years would not have been possible without the hard work, commitment and passion of so many people, so many organizations, so many partners, who together made this care, support and treatment a model for the rest of the world.

There are many people to thank, but one person that stands out as the backbone of India's ART is Dr.B.B.Rewari. There are so many wonderful memories and good experiences of working with him, it's difficult to choose what to share. Dr. Rewari is approachable at any time, whenever we need him. In June 2010, we met him in his office and explained that many PLHIV were experiencing financial burdens because of monthly travel costs and wage loss as they picked up their prescriptions at the ART centre. He thought for a moment and within seconds he requested an official letter on this and the same week he issued an order to all ART Centres to distribute two months of ART to patients with records of good adherence. This small decision made life easier for so many PLHIV. He always seems to be on the job. Day or night, we text or call him if there's a shortage and other supply chain issues. He acts immediately and provides amicable solutions. He'll be in his office at 8.30 am and still be working at 7pm. That is Dr. Rewari for us. His leadership on ART has saved countless lives. His compassion is an example for us all.

India's ART is getting stronger with each passing day. The commitment of DAC to expanding care & support services is transformative. The new Vihaan Care & Support Centres are testament to how closely government, civil society and the PLHIV community can work together to achieve a common goal, helping expand access to services, increase treatment adherence, reduce stigma and discrimination, and improve the quality of life of PLHIV and their family members.

Our own journey over the years with HIV still surprises us. It has been a fantastic, wonderful and meaningful journey. We thank God: if someone had to be HIV positive, it's us. We are proud to be HIV positive, proud to be alive, proud to have met the challenge of the virus, and proud of our country, our government, and our community for bringing us so far in the last ten years.

Lessons Learnt and Way Forward

The National AIDS mostly focused on providing HIV prevention related services in the first decade. There was no National for chronic diseases in India that aimed at providing treatment lifelong to the patients and treatment for HIV seemed to be distant reality. The cost of antiretrovirals was reckoned to be too high at the backdrop of lower per capita allocation which was being used for prevention and control of other high burden diseases or conditions. Whenever, the issue was discussed, competing disease priorities limited efficacy of advocacy. The complexities associated with HIV management and availability of quality manpower and infrastructure emerged as major challenges. The last ten years of successful roll out of the world's second largest ART has taught a few important lessons.

Political commitment

Progressive attitude and commitment from policy makers for a chronic, potentially fatal disease can be successful. Advocacy of ART in the country change the trajectory of the disease in the country. The advocacy from the gay community and actors led to evolution of a rapid response in US. However, the HIV infection in the initial years of the epidemic affected the sex workers, injecting drug users and men having sex with men in India. High level of social stigma associated with HIV, limited the ability of HIV infected individuals in India to advocate strongly. However, collectivization which was supported by the National AIDS Control strengthened the voices of community. The progressive attitude of the policy makers to involve the representatives of these risk groups while devising strategies for prevention and control of HIV infection helped in developing and modifying programmatic strategies.

Capacity building

Given commitment, systemic capacity to handle complexities can be developed effectively. Prior to initiating free ART , NACP was offering treatment for opportunistic infections and post exposure prophylaxis. The number of persons receiving treatment for these indications was small. The stigma in health care settings including tertiary care centres was high. In order to implement ART

interventions effectively, a significant effort went in to training and capacity building of teams of heath care providers from medicine, gynecology , microbiology , dermatology and pediatrics departments. These teams were given higher visibility in programming. These teams acted as role models in their environment paving way to a receptive mindset to provide complex medical care in medical out-patient settings. In order to provide visibility to their work, ART centres were established as separate entities but as a part of Medicine Department. The approach was similar to that in PPTCT. Large centres with good leadership and initiatives were upgraded to be Centres of Excellence to be role models and mentor other ART centres. The entire capacity building has ensured that the programming can be sustained in future.

Ensuring Adherence to Complex Regimen: Role of Standardised guidenes & protocols

Complex guidelines can introduced and implemented in public health programmes , if standardized and disseminated adeqauately . Prior to introduction of antiretroviral therapy in public sector, use of irrational ART regimen was common. The only complex regimen that was used through public health care setting had been for anti-TB treatment. There were concerns as to how can influence rationality and also ensure adherence to complex treatment regimen against HIV. Globally, different guidelines on management of HIV disease used to get published- from DHHS, IAS, BHIVA and WHO, to name a few. The medical practitioners used to get perplexed as to which guidelines they should follow. NACP developed guidelines for management of HIV disease among adults as well as children by constituting a Technical Resource Group (TRG) on Antiretroviral Therapy for adults and children of experts in the field. In order to disseminate these guidelines it undertook a large number of structured training programs for both public and private sector. Trainings for doctors from various specialties/departments in the hospitals and the staff working in ART Centres were done to ensure that the guidelines are universally followed & quality of care is maintained . It also disseminated these guidelines by supporting collaborative partnerships with various professional associations. It also advocated with the Medical Council of India to issue a warning to the medical practitioners to ensure that they do not prescribe irrational combinations of antiretrovirals.

The biggest challenge was revision of guidelines for management of HIV disease, periodically as HIV infection continues to be one of the most rapidly advancing frontiers of medical research, globally. NACP, successfully negotiated these challenges by revising these guidelines through TRG meetings and disseminating them through the internet and ongoing training programs. One of the biggest achievements of the is that the periodic changes in guidelines could be handled effectively through emails and regular trainings and not the usual costly dissemination meetings.

Mentoring at each level was used to ensure that complex clinical conditions can be handled well. SACEP, COEs and National Expert Panel successfully negotiated this challenge.

In order to ensure that these guidelines are being implemented accurately, monitoring visits were made from respective SACS. It is clear that public health system can manage complex and periodically changing guidelines effectively.

Drug Supplies

Strategies to cut costs and ensuring supplies is the key for success of a chronic disease requiring management lifelong. The cost of antiretroviral drugs and their quality was a major challenge to be overcome in the . Central purchases of antiretrovirals was a major step in this direction. The cost could be brought down by over five folds than the market price. In order to ensure that purchases quality drugs, only WHO pre-qualified formulations were purchased under the . However, the most complex task was to ensure that the buys right quantity of each formulation of medicine at the backdrop of projected number of patients accessing the treatment in ART centres and also planning for establishment of newer ART centres. developed the drug forecasting tool and constituted drug forecasting committee to effectively factor the requirement of ARV for existing as well as new PLHIV in terms of initiation, continuation, substitution and switch. The also ensured the supply chain management effectively through a dedicated Logistic Coordinator. ARVs from one ART centre to another centre were shifted to meet any transient shortage that occurred infrequently. As a precaution, the SACs were permitted to purchase ARVs locally and maintain a buffer stock of about 20% at the state level. It is also important to recognize that there have been only two transient stock shortages that were also dealt successfully in last ten long years.

Turning evidence into planning

Programme can use operations research and monitoring as a vital feedback to modify processes successfully. With the introduction of free ART in medical colleges, the patient load increased so much that it paralleled out-patient attendance of the medicine department. The patients had to travel long distances and losing significant time and money. An operations research commissioned by NACO revealed that it can be an important barrier to adhere to ART. Taking cognizance of the findings, not only did the establish new ART centres but also the LACs. This helped in decentralization of services and improved access to ART. When another study revealed that out-station patients required hand holding during the first few days of initiation of ART, CCCs were established to help out.

Community Involvement and Mobilisation

Success of programmatic strategies can be enhanced through community involvement and mobilization. Community involvement is vital for programmatic success especially when there is a high patient burden at each service delivery point. The introduced a concept of peer counselor to reduce the burden and underscore the fact that ART can enhance quality of life. To overcome the concern that there could be incidences of discrimination in service delivery, redressal mechanisms were established by constituting State level Grievance Redressal Committees (SGRC) where PLHAs were the key members. It also ensured that PLHA members were part of the TRG where evidence-based policies and strategies were deliberated to bring in transparency and getting feedback over the proposed modifications upfront. The PLHAs and NGOs were involved in tracing the patients who were lost to follow up, successfully.

Sustainability of ART services

Vertical programs should factor sustainability while implementing newer programmatic strategies. Sustainability of services is critical in vertical programs. The ART is located in medicine departments that are mandated to provide medical care to people. Link ART centres are also the way forward in this regard. Public-private partnership has been a redeeming feature of the .

Under Corporate Social Responsibility initiative, ART centres were established in certain sites where the centres only receive ART free from the .

Monitoring & Mentoring Mechanism

Client satisfaction and good quality of care is a vital component of any service delivery. The ART programme has a strong & unique system of on-site monitoring & mentoring. In addition to monitoring by SACS officials, a concept of "decentralised monitoring by Regional Coordinators" which became the cornerstone of the success of programme. The monitoring of Link ART Centres by nodal centre and of ART centres of Excellence is a distinctive mechanism of supervision within the system itself.

Word of wisdom

"Fifteen years ago when I was the Project Director of the National AIDS control programme, we were far from offering any drug based treatment. . ART used to be unaffordable but the commensurate benefits override the cost considerations: first, ART helps HIV -infected patients to lead healthier lives; second, partners get protection and third, transmission risks are reduced. Indeed this is a memorable day as ART programme crosses the 10 year milestone Now ART is down to Rs 600 per month .That is a boon for needy patients and families.

I am really happy to see the progress and the reduction in prevalence as per published research. It is truly satisfying to see how much longer patients are able to live."

Shailaja Chandra
Ex, PD NACO

"The commemoration of 10 years of Anti- Retroviral Programme in India is a fitting tribute to all the stakeholders who are involved in this great effort - Government, communities including people living with HIV, donors and the multilateral agencies. I still recall the occasion when the first announcement of introduction of ARV treatment was done on the World AIDS Day 2013, which was followed by introduction of treatment programme in April 2004.The programme has come a long way since then and is one of the largest in the world today." Constant and undying optimism among all actors, Government and civil society alike, is absolutely essential in combating the AIDS pandemic. We should learn to recognise and celebrate small victories in our march to attain the ultimate goal - evolving an AIDS free world."

J.V.R. Prasada Rao
UN Secretary General Special Envoy for AIDS
Asia & the Pacific

I arrived in NACO in June 2002. I saw the stigma and hopelessness surrounding people living with HIV/AIDS, side by side with huge successes achieved in stemming increase in HIV infections, in the outstanding Sonagachi community led processes in Kolkata, West Bengal. Non availability of treatment for HIV remained a major lacuna, but NACO was alert. When CIPLA succeeded in reverse engineering of the then available high cost ART drugs, and commenced rapidly scaling up their manufacturing of generic anti-retroviral drugs, NACO seized the opportunity.

With support of then Prime Minister Atal Bihari Vajpayee and Sushma Swaraj, then Cabinet Minister for Health, NACO invited former US President Bill Clinton and the Clinton Foundation to very quickly source and install CD count machines in the highest HIV prevalent districts. World Health Organisation (WHO) stepped in with an assured 12 month supply of anti retroviral treatment, and NACO won in global competitive bidding from the GFATM (Global Fund on AIDS TB and Malaria), huge financial support for continuing disbursal of anti-retroviral long after WHO assistance was scheduled to end.. This is the story of how ART commenced in India

The story of how ART was sustained belongs to the commitment and leadership provided by my successor Directors General of NACO, all of whom I count among my friends. One decade after commencement of treatment of ART, I recognise that anti-retroviral treatment could not have been sustained in this manner without the unflagging technical oversight provided by physician Dr. BB Rewari and team.

Meenakshi Datta Ghosh
Senior Consultant (Health)
Independent Evaluation Office, Government of India

When I took over as Director NACO, 8 ART centres had already been established thanks to my predecessor, Meenakshi Datta Ghosh. I was tasked to accelerate the establishment of 25 more by the end of the year. I thought nothing less than 100 will be acceptable. Fortunately, a capable person, Dr Rewari, was introduced to me by Health Secy Prasada Rao to run the ART programme. After that there was no looking back. Our concern was about the exorbitant cost of ART. Even the first level treatment was prohibitively expensive. Thankfully, Indian pharma industry, led by CIPLA, rose to the occasion and brought down the cost of drugs substantially. I am happy to see that India's HIV/AIDS programme has been a great success story thanks to our coming out of the denial mode early enough and launching effective programme. It was good that the Health Minister, Dr Ramdoss, accepted my proposal to convert our response from the 'project' mode to 'programme' mode.

S.Y.Quraishi
Ex-Special Secretary & DG,NACO

"I am extremely pleased to note that NACO is celebrating the 10th Anniversary of the introduction of ART in India. The progress made in terms of coverage and scale up of treatment services in these ten years is indeed very impressive. This would not have been possible but for the outstanding and dedicated work put

in by the officers in NACO, donor organizations and the PLHA networks that cooperated so well. My congratulations to them all. I am happy to have been a part of this effort. I wish NACO all the best. "

Sujatha Rao , Ex Secretary and DG DAC

"Introduction of ART in the HIV/AIDS treatment in India was the defining moment in the fight against HIV/AIDS in the country. Introduction of ART in India not only helped in combating the disease but has also meant a huge filliped to the Indian generic drug industry."

K. Chandramouli, Ex Secretary ,DAC

"It must be acknowledged that a quantum jump in the country's response to HIV/AIDS took place with the rollout of free ART to PLHIVs from the year 2004. With the rollout and subsequent widespread availability of ART to PLHIVs throughout the country in ART centres and link ART Centres together with testing facilities available in Integrated counselling and Testing Centres (ICTCs) across the country, the national programme has now over the last six to seven years achieved an even keel with both prevention and care support and treatment becoming equally effective tools under the programme to meet the challenge of HIV/AIDS."

Sayan Chatterjee ,Ex Secretary ,DAC

"Ten years is a long time in the life of disease. ART has dramatically transformed the AIDS landscape. As UN Secretary-General Ban-Ki-Moon has observed, AIDS is no longer a death sentence but a chronically manageable disease. This change can squarely be attributed to ART.

ART has provided a new lease of life to people living with HIV. Over the last ten years, ART has saved more than 1.5 lakh lives and dramatically reduced deaths due to AIDS. The newer guidelines will help further in reduction of new infections and prolong the life of those infected. The National ART programme is strongly monitored and works closely with the networks of positive and civil societies."

Lov Verma, Secretary (Health & FW)

Antiretroviral therapy (ART) was a game-changer, a life-saver indeed for millions of HIV infected persons globally. While the advent of triple drug therapy in 1996 was a boon, its high costs restricted access to a small minority who could afford it - less than 5% of those infected. The "3 by 5" initiative of WHO was a major catalyst in scaling up ART in low and middle income countries. In India, the ART progarmme was initiated in 2004 with technical and programmatic support by WHO. It is very heartening to see that the programme has scaled up significantly over the past decade and substantially enhanced the quality of life

and survival of HIV infected persons on treatment. We will continue engagement and collaboration, through high quality technical and policy support to the National AIDS Control Programme, in necessary actions for reaching universal coverage with ART and other critical health interventions.

Dr Nata Menabde, WHO Representative to India

"It has been an honour and a privilege for CDC through PEPFAR to be associated with DAC in the response to HIV/AIDS. We join with many across India and the globe to recognize 10 years of ART in India this year, and to commend Dr.Rewari and others who led this charge from the very beginning. Marking this important milestone, we look forward to continuing our close collaboration with DAC and other partners towards the further expansion of high quality care and treatment services across the country."

Dr. Pauline Harvey, Mr. Peterson and Dr. Sudhakar and team, CDC DGHA India

"India's HIV/AIDS Programme is rated as a global success. It has been my privilege to have been associated with it for almost 5 years at a juncture which was extremely crucial. With a strong focus on prevention, India has remained a low prevalence country and has reduced incidence by more than half in a decade. Communities have been kept at the centre of the response and services scaled up dramatically.

The ART Programme in India has had a very impressive scale up and is now the second largest programme globally. It has reduced mortality and morbidity and enabled people living with HIV to have a better quality of life. Another strength has been that India's ART Programme has attempted to look at India specific needs, thus making it more targeted and cost effective. Indian manufacturers of ARVs are also to be complimented since they have played a crucial role, not only in bringing down the global prices of ARVs, but also in providing 80% of the global need of ARVs. This has greatly improved availability and access to these life saving medicines.

I am confident that India's HIV / AIDS Control Programme will continue to move from one success to another preventing the spread of HIV, at the same time providing treatment to all in need.

Aradhana Johri
Secretary, Dept. of Pharmaceuticals

“I was fortunate to work with a dedicated and driven team of professionals at the National AIDS Control Organization. NGOs and Networks of Positive People and truly deserve credit and blessings to carry the work forward. Dr Rewari with his vast experience and leadership skills has our best wishes to carry the work forward.

Dr. Jotna Sokhey, Ex. APD,DAC

"ART is a unique public health intervention which has changed the perspective of HIV/AIDS disease from killer disease to chronically managed health condition". ART has also successfully acted as a secondary prevention tool for control of HIV/AIDS in India.”

Dr.Ajay Khera, Ex JD (CST) DAC

“No country can afford treatment of all PLHIVs particularly with emerging problems of ARV drug resistance required costly 2nd or 3rd generation ARV drugs. Equal emphasis should therefore be given to prevention of HIV infection and efficient management of those PLHIV requiring ART".

Dr. Damodar Bachani, Ex. DDG(CST) DAC

“After working for 12 years on prevention strategies and refraining from including Treatment as Core strategy, the path breaking moment, seeing the light of the day was only in 2004, when Government of India decided to include ART services as intervention under the programme. The best practices adopted for ART services which were well reorganized include decentralisation of ART services through setting up of Link ART centres and inclusion of social protection schemes for PLHIV, being an integral part of Care & Support through CSCs.”

Dr. M. Shaukat, Ex. DDG(CST) DAC

"Extend boundaries, don't let the present restrict what should and can be achieved"

Dr. Polin Chan, ex Medical Officer, WHO India

"The ART program wiped out the fear of premature death from minds of HIV infected individuals and raised hopes of near normal survival. It is one of those programs that brought socially challenged HRGs, hitherto, not covered well by public sector and helped them regain their voice and control over their lives. It strengthened linkages between other health programs and thus has become co-ordinating force in health in India.”

Dr. R Gangakhedkar, NARI

"The ART program in India has made significant strides over the years and has consistently met emerging challenges through a nationwide scale-up of effective patient services. An impressive number of patients are benefitting from DAC's innovative and progressive approach to broadening access to treatment and diagnostic services in the remotest corners of the country. I am certain that the program would continue to build on these successes and adopt approaches to ensure sustained progress towards universal access."

Harkesh Dabas
Country Director,Clinton Health Access Initiative, India

"The stake holders in the programme should take the advantage of evidence demonstrating the multiple benefits of antiretroviral therapy in prevention of infection to their sexual partners and infants apart from treatment."

Dr A S Rathore, DDG(CST)DAC

Team CST Arcade

PD/DG/Secretary DAC

Shri P.R. Dasgupta AS, NACO 22.07.1992 to 16.06.1995

Shri P.S. Bhatnagar AS, NACO 29.06.1995 to 29.05.1999

Shri J.V. R Prasada Rao, AS, NACO 07.07.1997 to 10.02.1999 and 20.04.1999 to 31.05.2002

Smt Shailaja Chandra, AS, NACO 11.02.1999

Smt. Meenakshi Datta Ghosh, AS,

Shri S.Y. Qureshi, AS, NACO 13.09.2004 to 09.11.2005

Miss Sujata Rao, Secy, DAC, 21.11.05 to 19.10.2009

Shri K. Chandramouli, Secy, DAC, 20.10.2009 to 16.12.2010

Shri Sayan Chatterjee, Secy, DAC 16.12.2010 to 31.12.2012

Shri Lov Verma, Secy, DAC 01.01.2013 to 25.02.2014

Additional Secretary

Ms. Aradhan Johri

Joint Secretary

Mr.Pravir Krishna

APD,DDG (CST)& JD(CST)

Dr. P.L. Joshi, NACO

Dr . Jyotsna Sokhey

Dr. N. S. Dharmshaktu

Dr. Ajay Kumar Khera
From Oct 2006 – June 2010

Dr. D. Bachani
From 2006 - 2010

Dr. Mohammad Shaukat

Dr. Inder Prakash

Ex – NACO Consultant

Late Dr A Sengupta

Dr R S Virk

Dr Kaliash Raizada

Dr S Chugh

EX – Regional Coordinators / WHO consultants

Dr. Thennarasu From
June 2012 – Aug-2013

Dr. Christopher Nathan
Nov 2009 – Jul 2013

Dr. Anwar Parvez Sayed
Jan 2011 – March 2013

Suresh Shastri
June 2008 – Jan2012

Dr Sathesh Pandian

Dr. Geetanjali Kumari
APD Bihar
SACS,RC,NPO(PPTCT)

Dr Oomen George
Jan 2006 - Feb 2007

Dr. Vimlesh
RC,WHO PPTCT Consultant

Dilip Waswani

Dr. Chetri

Aishwarya Rao
Consultant
Jan 2006 - July 2007
Regional Coordinator
April 2008 - Sep 2010

Dr. Manoj Shevkani
SMO (ART)
April 2005 – Feb 2007
Regional Coordinator
March 2007 - Oct 2010

Dr Rakjumar Manna
March 2007 – July 2008

Rekha Jain

Dr. Apabi Hazim

Dr. Satish Jain

Ex CST Staff at DAC

Dr Suresh Mohd (Ex-NPO)

Dr. Sunil S. Raj (PO)

Dr. Amit Chaatterjee PO
Nov 2006 – Dec 2007

Dr. Sukarma Tanwar

Shivi Negi, TO (P C)
April 2007 - May 2010

Suchitra Lisam (PO C&S)

Dr. Anjali Chikersal
May 2012 – May 2013

Dr. Sunny
Sep 2010 – July

Dr. Anuradha Jain
June 2007 – Sep-2008

Ms. Uttplakshi
Feb 2012 –Jan 2013

Mr. Satirtha TO(PC)
Dec2009 –Aug 2011

Mr. Vipin Joseph
Oct 2009 - June2013

Surbhi Joshi, TO (PC)
2007-2009

Meena Jadhav,
TO (Paediatric Care)

Saraswati.
PO(Paediatric Care)

Tariq Walli, PO (Paediatric Care)

Dr. Chitra Lekha PO

E.R. Babu, PO
(Paediatric Care)

Dr. Karuna Dev Sharma, TO

Dr Karthikeyan

Mr. Rajesh, TO

Dr. Daisy, TO

Jai Shri Jain,
Logistic Co-Ordinator

Sujata Mukhopadhyay, TO

Current CST Team

Shri V.K. Subburaj,
Secretary, DAC
from 01.03.2014 - Till date

Shri K.B.Agarwal Joint
Secretary, DAC
01.03.2014 -Till date

Dr. A. S. Rathore DDG (CST)
From Sep 2013 – Till Date

Dr. B. B. Rewari NPO (ART)
Jan 2005 – Till Date

Dr. S. RAJASEKARAN ,
National Consultant
Jan-09 - Till Date

Programme Officers

Dr. Reshu Agarwal
Programme Officer (CST)
April 2007 till Date

Dr. Lakshmana Bharthi
Programme Officer (ART)
Sep2011 – till date

Dr. Rita Prasad
Programme Officer (C&S)
Sep 2011 – Till Date

Regional Coordinators

Dr. R.G. Ananad
Dec 2013 – Till Date

Dr. A. S. Valan
June 2011 – Till Date

Dr. Sunil Kumar
Dec 2012 – Till Date

Dr. K V Emmanuel
From 2004 to 2011 SMO
From 2001-Till Date RC

Dr. Sripati Dasmohpatra
Sep 2006 – Till Date

Dr.Jasjit Singh
Oct 2009 – Till Date

Dr. Archana Gupta

Dr. Dhruba Jyoti Borah
Jan 2011 – Till Date

Dr. Manish K. Bamrotiya
June 2012 – Till Date

Dr. Jiban Jyoti Baishya
Nov 2012 - Till Date

Technical Officers

Ms. Nisha Kadyan
Technical Officer (Nursing)
Jan 2010 – Till Date

Mr. Saurav Kumar
Technical Officer (Logistics)
Oct 2010 – Till Date

Ms. Monika Walia
Technical Officer (M&E)
Oct 2012 – Till Date

Mr. Jis Jose
Technical Officer (C&S)
Aug 2013 – Till Date

Dr. Mahesh Mhetre
Technical Officer (Round IV)
Jan 2014 – Till Date

Dr. Rajat Rana
Technical Officer (ART)
Dec 2013 – Till Date

Mr. Archit Kumar Singh
Technical Officer (Tranning)
Jan 2014-Till Date

Administrative Staffs

Ms. Rachna Sonthwal
April 2007 – Till Date

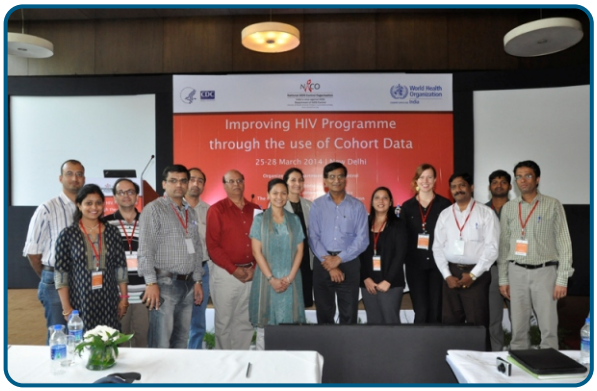
Mr. Priyaranjan Misra
April 2007 – Till Date

Ms. Poonam Mehra
May 2007 – May 2013

Ms. Manali Jain Khurana
Dec 2007 – Till Date

Mr. Harish Sharma
Nov 2012 - Till date

Photo Gallery


Improving HIV Programme
through the use of Cohort Data


INTER-MINISTERIAL CONFERENCE FOR


PPTCT CENTRE


एआरटी केन्द्र पर उपलब्ध
मुफ्त सेवायें
उपचार सलाह
सीडी-4 जाँच
एन्टीरिट्रोवायरल थेरेपी
परीक्षण व जाँच (मुफ्त या रियात पर)
अवसरवादी संक्रमण की दवायें
सूचना सामग्री
एकाइडी के साथ जी रहे लोगों के समूह से संपर्क
सामुदायिक देखभाल केन्द्र/सीसी) से संपर्क
ड्राप-इन केन्द्र से संपर्क


PRATISAD
Come Forward
Take Lead
Stop AIDS


India's Voice Against AIDS
Mainstreaming and Partnerships


18/07/2013 05:42


PUBLIC SCHOOL
MAHARANA PARTAP ENCLAVE
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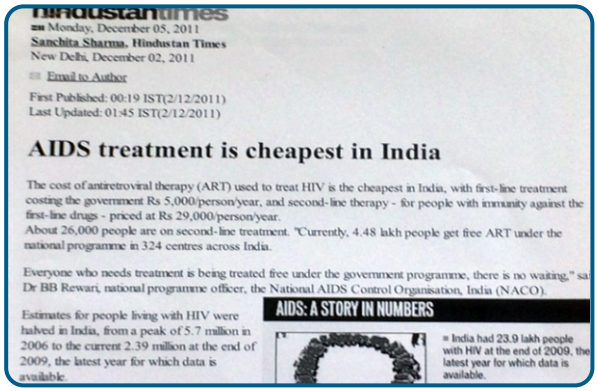
PH.: 011-42458061
MISS UNIVERSE


ANI


WORKSHOP ON
DEPARTMENT OF MICROBIOLOGY &


KAZAKHSTAN
INDIA



Monday, December 05, 2011
Sanchita Sharma, Hindustan Times
New Delhi, December 02, 2011
Email to Author

First Published: 00:19 IST(2/12/2011)
Last Updated: 01:45 IST(2/12/2011)

AIDS treatment is cheapest in India

The cost of antiretroviral therapy (ART) used to treat HIV is the cheapest in India, with first-line treatment costing the government Rs 5,000/person/year, and second-line therapy - for people with immunity against the first-line drugs - priced at Rs 29,000/person/year.
About 26,000 people are on second-line treatment. "Currently, 4.48 lakh people get free ART under the national programme in 324 centres across India.

Everyone who needs treatment is being treated free under the government programme, there is no waiting," sa Dr BB Rewari, national programme officer, the National AIDS Control Organisation, India (NACO).

Estimates for people living with HIV were halved in India, from a peak of 5.7 million in 2006 to the current 2.39 million at the end of 2009, the latest year for which data is available.

AIDS: A STORY IN NUMBERS

= India had 23.9 lakh people with HIV at the end of 2009, the latest year for which data is available.

HINDUSTAN TIMES, MUMBAI
THURSDAY, OCTOBER 01, 2009

India beats world in AIDS treatment

WE TOOK 4 yrs for a 12-fold jump, world took 5 yrs for a 10-fold rise

Sanchita Sharma

NEW DELHI: India is treating people with HIV better than the rest of the world, and now there is data to prove it.

The number of people on free anti-retroviral therapy (ART) to treat HIV that causes AIDS rose 12-fold in less than four years in India, up from 20,000 adults in 2006 to 2.7 lakh (270,000) in August 2009.

The rest of the world took five years to register a 10-fold increase, with 4 million people having access to HIV drugs, reports the World Health Organisation's Towards Universal Access 2009 report released on Wednesday.

In India, 20 per cent of the need for treatment is met, which is a little less than the 40

HIV AND AIDS IN NUMBERS

WORLD: 33mn people with HIV & AIDS | 4mn being treated

INDIA

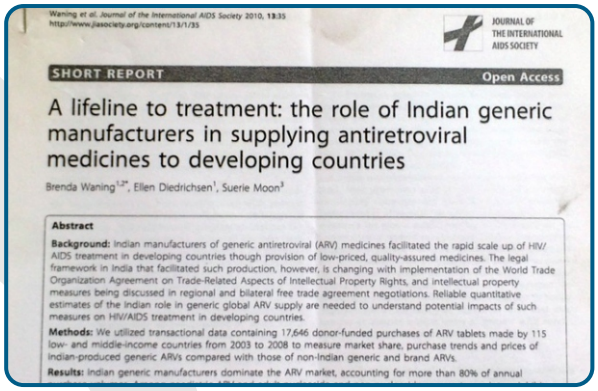
2.3mn people with HIV and AIDS
2.7 lakh being treated
233 No. of treatment centres

Cost of first-line treatment:
Rs 4500 per person a year
Rs 60,000 cost of second-line treatment per person a year
644 adults number of people on second-line treatment

With NACO's target to treat 3 lakh people by 2012 almost reached, we plan to treat 6 lakh people by 2016.
SUJATHA RAO, director general, NACO

of falling immunity and put on treatment as soon as they need it," said Dr B. B. Rewari, National Programme Officer (ART), NACO.

ART drug prices have dropped significantly during the past year, though second line treatment remains expensive. "First-line drugs cost Rs 4,500 per person per year, but second-line therapy costs Rs



Waning et al. Journal of the International AIDS Society 2010, 13:35
http://www.jiasociety.org/content/13/1/35

JOURNAL OF THE INTERNATIONAL AIDS SOCIETY

SHORT REPORT — Open Access

A lifeline to treatment: the role of Indian generic manufacturers in supplying antiretroviral medicines to developing countries

Brenda Waning[1,2*], Ellen Diedrichsen[1], Suerie Moon[3]

Abstract

Background: Indian manufacturers of generic antiretroviral (ARV) medicines facilitated the rapid scale up of HIV/AIDS treatment in developing countries though provision of low-priced, quality-assured medicines. The legal framework in India that facilitated such production, however, is changing with implementation of the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights, and intellectual property measures being discussed in regional and bilateral free trade agreement negotiations. Reliable quantitative estimates of the Indian role in generic global ARV supply are needed to understand potential impacts of such measures on HIV/AIDS treatment in developing countries.

Methods: We utilized transactional data containing 17,646 donor-funded purchases of ARV tablets made by 115 low- and middle-income countries from 2003 to 2008 to measure market share, purchase trends and prices of Indian-produced generic ARVs compared with those of non-Indian generic and brand ARVs.

Results: Indian generic manufacturers dominate the ARV market, accounting for more than 80% of annual

Foreign aid to fight HIV, TB & malaria dries up

Kounteya Sinha | TNN

Global Fund, one of the biggest financers of India's drive against the diseases, has run out of money to pay for new programmes for the next 2 years due to the global downturn

New Delhi: India might have to bear the burden of funding expensive treatments like second-line drugs for HIV patients and DOTS, plus for those suffering from multi-drug resistant TB.

Global Fund, one of the biggest financers of India's drive against the three killer diseases — AIDS, TB and malaria — has run out of money to pay for new programmes for the next two years due to the global economic downturn. India, which has received over $1.7 billion from the Global Fund to run several of its HIV, malaria and TB projects, has no choice but to look at its domestic budget to finance the initiatives.

The Geneva-based organization has said it is cancelling its next fundraising round, and the group will focus only on essential services for programmes that end before 2014. This round was the last that India could have received "free money to fund its health projects.

Global Fund categorised us as a low-income country. Now, we are entering the bracket as a middle-income country and will no more be eligible for funding from them," a senior health ministry official said.

He added, "What will be worst affected is the HIV programme. We spent most of our funds on prevention (70%) and the rest (30%) on treatment. But if we don't receive money from Global Fund, we will have to cut down on our prevention strategies. We won't be able to bring down new HIV cases," the official added.

However, R B Rewari from NACO, said, "We have a commitment from Global Fund for treatment of HIV pa-

suffice and we might have to dig into our domestic budget." Altogether, $22.4 billion has been approved by Global Fund for programmes in 150 nations since 2002.

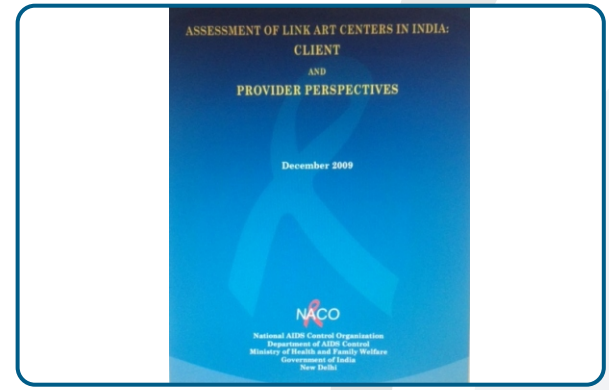
The official said, "We're not cutting back, we're not expanding." This step takes place even as the recently released UNAIDS World AIDS Report 2011 outlined steadily declining rates of HIV infections. In India, new HIV infections fell by 56% between 1996 and 2010.

John Mathai, country director, Global Health Advocates India, said, "This funding gap will affect TB plans in Orissa, Uttarakhand and Chhattisgarh, where large successful de-lives have been

Factors Affecting Enrolment of PLHIV into ART Services in India

NACO
National AIDS Control Organisation
Ministry of Health and Family Welfare
Government of India

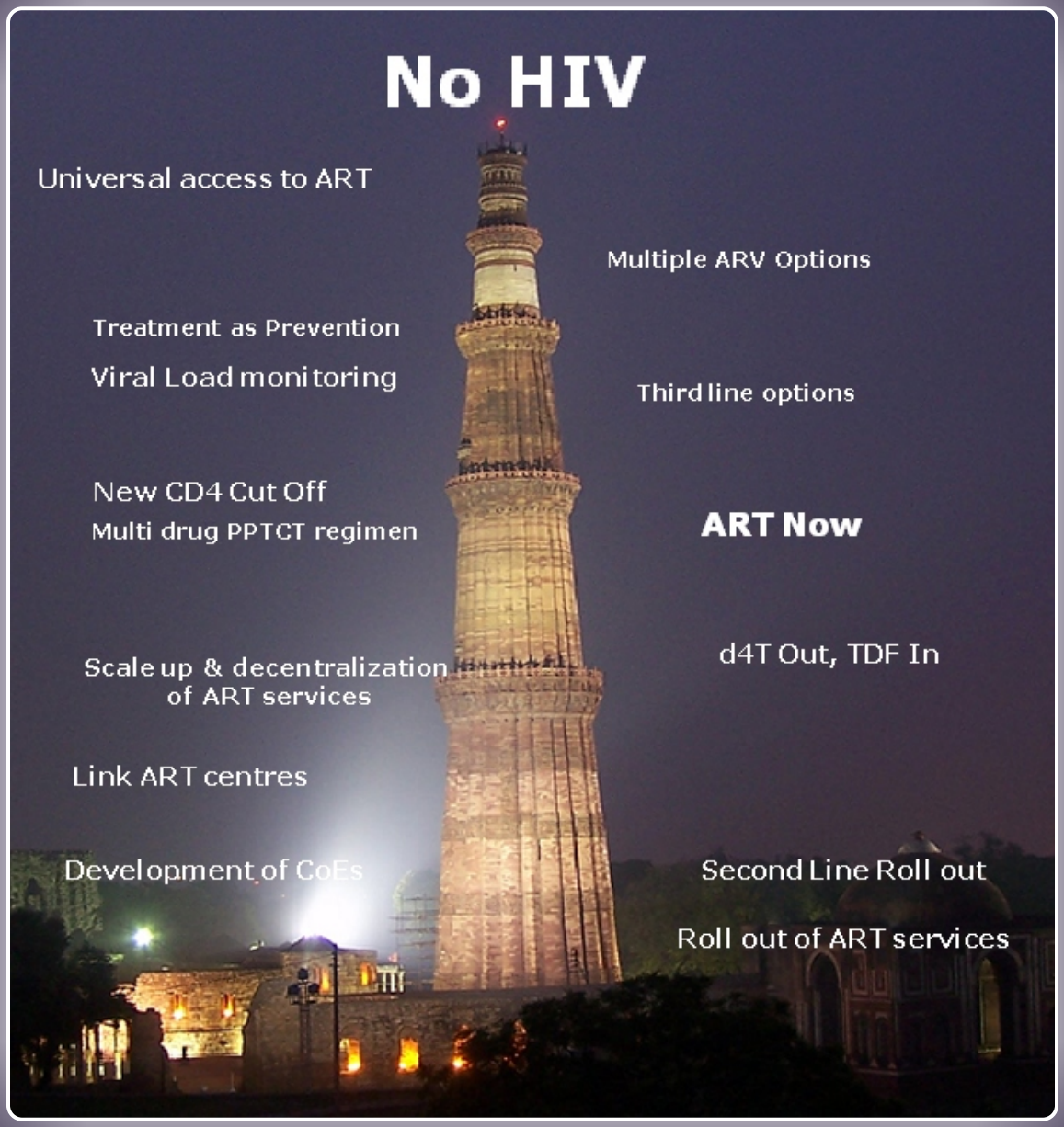
Population Council



ASSESSMENT OF LINK ART CENTERS IN INDIA:
CLIENT
AND
PROVIDER PERSPECTIVES

December 2009

NACO
National AIDS Control Organisation
Department of AIDS Control
Ministry of Health and Family Welfare
Government of India
New Delhi


No HIV
Universal access to ART
Multiple ARV Options
Treatment as Prevention
Viral Load monitoring
Third line options
New CD4 Cut Off
Multi drug PPTCT regimen
ART Now
d4T Out, TDF In
Scale up & decentralization of ART services
Link ART centres
Development of CoEs
Second Line Roll out
Roll out of ART services

.....And the journey continues

India's voice against AIDS

Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
6th & 9th floors, Chandralok Building, 36 Janpath, New Delhi - 110001
www.naco.gov.in