

Institutionalization of the NACP and Way Ahead

AM Kadri, Pradeep Kumar¹

Department of Community Medicine, PDU Medical College, Rajkot and Former Joint Director (Basic Services), Gujarat State AIDS Control Society, Ahmedabad, ¹Department of Community Medicine, GMERS Medical College, Sola, Ahmedabad and Former Additional Project Director, Gujarat State AIDS Control Society, Ahmedabad, India

ABSTRACT

In India, HIV prevention and control activities started way before the reporting of the first case of HIV infection. On reporting of evidences of HIV infection from different parts of the country and varied groups, Government launched the National AIDS Control Program (NACP). The program was launched on the foundation of early interventions and Mid-Term Plan, which evolved in three phases over the period of eighteen years. With progression of time, epidemiological situation changed and knowledge/capacity to tackle HIV improved. In the course of the evolution, NACP has moved from the centrally controlled program to district driven. Also different strategies were inducted/refined and many important institutes like Task Force, a high-powered National AIDS Committee, National AIDS Control Board, National AIDS Control Organization, State AIDS Control Societies, Project Support Units/Project Management Units, National Council on AIDS, Department of AIDS Control, Technical Support Unit, District AIDS Prevention and Control Unit (DAPCU) were created. Currently program is implemented vertically with good impetus and is able to contain the spread of HIV in India. For enhancing the effectiveness and sustainability, future of the NACP is strongly linked with the well-performing DAPCU and good synergy/integration with General Health System. HIV/AIDS epidemic in India has entered into the third decade. Evidences show that this epidemic in India is of concentrated type and characterized by the heterogeneity, following the type 4 pattern, where the epidemic shifts from the most vulnerable populations [such as female sex workers, men who have sex with men, injecting drug users to bridge populations (clients of sex workers, sexually transmitted infection patients, partners of drug users, long route truck drivers, short stay cyclical single male migrants)], then to the general population and from urban centers to rural areas (ruralization of epidemic) with increasing involvement of youth and women (feminization of epidemic).

Keywords: Decentralization of AIDS control, District AIDS Prevention and Control Unit, National AIDS Control Program, Technical Support Unit

Introduction

Millennium development goals (MDGs) envisage the halt and reversal of HIV epidemic by 2015.⁽¹⁾ India, in 2008, had an estimated 2.27 million HIV positive people and an adult HIV prevalence of 0.29 percent.⁽²⁻⁴⁾ It is ranked third in terms of the number of people living with HIV/AIDS (PLHA). Thus the AIDS Control Program has to

be most effective and efficient program. Impressive progress has been achieved in India so far in scaling up of various services for preventing new infections and lowering the AIDS-related deaths (by detecting HIV positives from community and linking them to treatment services). As a result of expansion of testing and treatment services, number of PLHA continues to increase in reporting system.

National AIDS Control Program (NACP) has evolved over a period of around two decades from small isolated activities to matured strategies with the development of strong institutional mechanism. Though relatively new, NACP is enough old that its evolution can be an interesting case study for disciplines of community medicine and the health management.

| Access this article online | |
|---|---------------------------------|
| Quick Response Code: | Website: www.ijcm.org.in |
|  | DOI: 10.4103/0970-0218.96088 |

Address for correspondence:

Dr. Pradeep Kumar, Professor and Head, Community Medicine Department, GMERS Medical College, Sola, Ahmedabad - 380 060, India.
E-mail: drpkumar_55@yahoo.com

Received: 04-12-10, **Accepted:** 09-01-12

Pre-1986: Before detection of AIDS case

In India, till 1986, words of HIV and AIDS were doing rounds in the forum of researchers, core clinicians, medical books, journals and technical reports. With detection of HIV/AIDS cases, first in Chennai and then few more places in country in 1986,⁽⁴⁾ term HIV/AIDS got rooted in government communications and files. Till 1986, focus was merely to pick up the early evidences for impending threat of HIV epidemic. For the same, initial response was setting up of a task force by Indian Council of Medical Research and National AIDS Committee (NAC) chaired by Secretary, Department of Health. Pilot screening of high-risk population and blood donor was the initial activity in 1985.^(4,5)

1986–88: Gearing up to combat

With reporting of AIDS cases in India (1986), Government of India perceived the threat of the HIV epidemic and started discussions about containing the epidemic with increased involvements of health managers/policy makers. Ministry of Health and Family Welfare (MOHFW) constituted a high-powered NAC in 1986 under the chairmanship of Union Health Minister. Still focus was mainly on surveillance in the High Risk Groups (HRGs), with few service deliveries like screening of blood/blood products and health education.⁽⁴⁾

1990–92: Mid-Term Plan

Afterwards in 1989, Mid-Term Plan (MTP) for HIV/AIDS Control was developed with US \$10 million budget provided from external sources.⁽⁴⁾ Looking to high vulnerability, four States - Tamil Nadu, Maharashtra, West Bengal and Manipur and four metropolitan cities - Chennai, Kolkata, Mumbai and Delhi were focused under MTP.^(4,6)

Till 1992, program was largely controlled, executed and owned by central government. However, in few states, formation of AIDS cells started sowing the seeds for greater involvement of the states. During this period, strategies were focused on the reinforcement of program management capacities as well as targeted information, education and communication (IEC), establishment of surveillance activities and safe blood supply. The program was practically being run by the central government.⁽⁴⁾

1992–99: National AIDS Control Program Phase I

Formal NACP was launched in 1992 as Phase I. National AIDS Control Board (NACB) was formed and National AIDS Control Organization (NACO), an autonomous apex body for HIV/AIDS prevention and control was created.^(4,6) This was the giant step towards institutionalization of NACP. With advent of the central-nodal institute, NACP got strategized for preventive

activities like HIV/AIDS education and awareness program, blood safety measures, condom promotion, control of hospital infection and strengthening of clinical services.^(4,6)

NACP-I was launched as 100% centrally sponsored project from September 1992 to September 1997, with an IDA Credit of US \$84 million. It was implemented with an objective to slow down the HIV spread so as to reduce the resultant morbidity, mortality and impact in the country.^(4,6) Large-scale mass media activities (partly centrally managed), licensing of the blood banks, banning of professional donors, expansion of surveillance network and collaboration with non-government organizations (NGOs) for preventive interventions were important output under Phase I.⁽⁴⁾ Counseling and testing services started in 1997. But increase in the capacity of states (technical and managerial) to respond to HIV epidemic and formation of the state-level institutes i.e. State AIDS Control Societies (SACs) in 25 States and 7 Union Territories (UTs) were the most important achievement.⁽⁷⁾ NACP-I was extended beyond five-year period i.e. from 1992 to 1999. It was devoted largely towards system building. Capacity building of the State Governments to deal the epidemic developed, thus owning and implementation by states started during Phase I.

1999–2007: National AIDS Control Program Phase II

In November 1999, NACP-II was launched with World Bank credit of US \$191 million.⁽⁵⁻⁷⁾ While in Phase I central agencies were the main players, during Phase II states were put in front seat. For program implementation purpose, state was considered as a unit. Based on epidemiological situation analysis, states were categorized as high, moderate and low prevalence/vulnerable states.⁽⁶⁾ Aims, objectives, strategies and implementing structures were framed differently for different states based on category and size of states. Aim of the NACP II was to bring down the HIV seroprevalence below 5% of the adult population in high prevalence states, below 3% in states where the prevalence was moderate and below 1% in remaining states. Tamil Nadu, Andhra Pradesh, Maharashtra, Manipur and Nagaland were identified as high prevalence states, while Gujarat, Goa and Pondicherry were put in medium prevalence states and other all states were considered as vulnerable states.^(6,7) At the places (states) of priority, for the post of Project Director, a senior Indian Administrative Service officer was kept.

In NACP-II, focus shifted from raising awareness to changing behavior and decentralization of program implementation at the state level. Prevention of new infection was the key strategy and Female Sex Workers (FSWs), Men who have Sex with Men (MSM), Injecting Drug Users (IDUs) and client of sex workers were

the key target groups.⁽⁵⁾ During the second half of NACP-II, establishment/scaling up of counseling and testing services for HRG people, provision of the Anti-Retroviral Treatment and Prevention of Parent to Child Transmission (PPTCT) gained attention. Thus with moving down of the NACP from center to state, Phase II witnessed more decentralized, strategized and focused activities in prevention and service delivery in contrast to largely central-driven generalized type of activities of Phase I. As part of decentralization, in all States, UTs and three cities, i.e. Chennai, Mumbai and Ahmadabad, autonomous nodal implementing agency, i.e. AIDS Control Society developed.⁽⁸⁾

Most important of all thrust areas was prevention of the new infection by targeting FSW, MSM, IDU and client of sex workers through Targeted Intervention (TI) during Phase II. For supporting this specific vital component, outside of the SACSs, Project Support Units/Project Management Units (PSUs/PMUs) were created in 8 states to provide technical and managerial support to state teams in quality implementation of the TI. These units were funded by the external agencies mainly DFID⁽⁷⁾ and managed by the reputed NGOs/agencies selected by detailed procurement procedures. An additional important institutional mechanism, National Council on AIDS comprising of 31 Union Ministries, 7 Chief Ministers and leading Civil Society representatives under the chairmanship of the Prime Minister of India was created to garner political commitment. Phase II scheduled to complete on November 2005 was extended till June 2007.⁽⁹⁾

2007-2010: National AIDS Control Program Phase-III

With a rich learning of about two decades, NACP III was launched in 2007 with the goal to halt and reverse the epidemic in India in next 5 years.⁽⁵⁾ By now the HIV epidemic received lots of attention and because of good advocacy, a favorable environment for funding was created. Moreover, government and international agencies were keen for rapid arrest of the HIV epidemic, hence were ready for intensive investment. Funding for Phase III increased to 3-to 4-folds from Phase II funding.

Four key strategies in NACP-III are: (1) Prevention of new infection in HRG and general population, (2) Greater care, support and treatment to larger number of PLHA, (3) Strengthening the infrastructure, systems and human resources at the district, state and national level and (4) Strengthening the nationwide Strategic Information Management System.^(5,7) To give further momentum in 2009, another institutional mechanism, a separate Department of AIDS Control was created under health ministry, which brought further autonomy to NACP within the MOHFW.

The NACP-III program further moved down from state to district. Phase II was viewing state as an implementing unit, while Phase III is viewing district as an implementing unit. Phase II is strategized based on the epidemiological categorization of the states, Phase III is strategized taking the epidemiological situation of the districts in consideration. In the year 2006, based on the HIV surveillance data of previous three years, NACO classified all districts into four categories viz. A, B, C and D. Category A districts are the districts with generalized epidemic i.e. HIV positivity was found >1% in pregnant women in HIV Sentinel Surveillance, Category B districts are the districts where epidemic was concentrated type i.e. HIV positivity was <1% in pregnant women but was >5% in the clients of Sexually Transmitted Diseases (STDs), Category C and D districts are the vulnerable districts i.e. HIV positivity was <1% in pregnant women and <5% in STD clients or adequate data was not available. Category A (159) and B (39) districts are prioritized as high prevalence districts.⁽⁵⁾ The major programmatic impact observed due to district specific epidemiological profiling was that almost all state came into focus as many of the Category A and B districts are falling in low prevalence states. With change in epidemiological lenses, horizon of the intensity of the program is widened on entire country with focus on district wise hotspots contrary to six high prevalence states as was there during the Phase II.

Under NACP Phase II, few vertical compartments, like NGO coordination, IEC, blood safety, STD and blood testing, surveillance etc., were created with the program. These were further strengthened in NACP III with a clear-cut compartmentalization into basis services, blood safety, TIs, IEC, Care Support and Treatment (CST), Monitoring and Evaluation (M and E) and Surveillance. Manpower at SACS is increased in NACP Phase III, with a view to enhance strength at state headquarter for better monitoring and implementation. As per the size of population and burden of diseases, States have been divided into three categories, i.e. large, medium and small and UTs. Large states are given more than 50 personnel, while around 35 personnel in medium and Small States and around 12 personnel in UT are provided at SACS/DACS.⁽⁷⁾

Another institute i.e. technical support unit (TSU) to act as technical wing to the SACS is created in Phase III. This is a modification to the PSU/PMU of Phase II. TSU is an outsourced external institute, which is responsible to provide technical insight as well as to ensure technical quality at the field level so that health managers can concentrate on managerial activities with the technical inputs from TSU.

As NACP-III looks district as an implementing unit, another, a very important institutional mechanism,

District AIDS Prevention and Control Unit (DAPCU) is created. One person with the public health background is proposed to head the DAPCU and three assistants, one each for finance, administration and M and E are given under DAPCU.⁽⁵⁾ Additionally, a District Supervisor to facilitate the functioning of the Counseling and testing Centers is also made available in DAPCU. Later on, one Out Reach Worker for PPTCT services at each counseling centers was sanctioned where PPTCT services are rendered. This entire structure comprising of District Program Officer, District Supervisor (DS), three Divisional Assistants and one helper under the umbrella of DAPCU is provided in all Category A and B districts only.^(10,11)

Future

Evolution of NACP is methodological and remarkable. Epidemiological situation of HIV is diverse across the country and hence dealing such a public health problem itself requires diverse response. In designing of the program all available information on epidemiological situation was used. Implementing strategies are kept different for different regions as per the local epidemiological situations. Also program keeps on revising with the changing epidemic scenario over the period of time. Constant evolution of different institutional mechanisms along with revision of strategies give idea about the nation's changing response to changing scenario.

Various institutional mechanisms are built/strengthened in different phases of NACP. Out of all institutes, DAPCU, TSU and SACS/NACO are the most important in dealing of HIV epidemic. Hence, the tomorrow of NACP (Phase IV) is largely linked with these three institutes. Further evolution of these institutes and piggybacking on General Health System (GHS) will be quite decisive.

District AIDS Prevention and Control Unit

NACP Phase III is implemented with highest possible intensity and an important institutional mechanism, i.e. (DAPCU) is included as a key strategy. Presently evidences are showing the presence of HIV and HRGs in varied proportion practically in each and every block of all districts. In high prevalence districts too, entire district is not equally vulnerable and small cities and towns are likely hotspots. Within districts the hotspots have to be mapped for more strategized implementation. Then there are C and D districts, which do not have problem now but show high magnitude of in/out migration, which is likely to be driver for particular part of the state. Hence looking to the number/magnitude of the hotspots, every district shall in future have DAPCU or DAPCU-like mechanism with minimum set of resource. Focus needs to be shifted from district to sub-district/block level with district as an implementing unit.

As on December 2009, out of 195 category A and B districts, 181 DAPCU are functional.⁽⁴⁾ Presently different models of DAPCU are being implemented in different states. In future it is required that uniform model of DAPCU are functional.

System for capacity development of DAPCU is needed. A vast team and detailed mechanism for technical/managerial support is to be created for various technical components under NACP, similarly some nodal mechanism for technical support to DAPCU can be created. Scope of the responsibility of DAPCU can be gradually increased so that the actual load of implementation and support can be shifted to districts. This will improve monitoring, supervisions and supports along with actual delivery of the services in the field.

In many states, as part of HIV-TB coordination, a monthly meeting at district level is being held. The scope of such meetings may be expanded where all components of NACP (blood safety, STI care, CST) can be reviewed in the presence of the senior official(s) of district health team. Apart from monitoring of activities, it will also ensure coordination of the various inter-related services of NACP (e.g. sharing line list of HIV positives with ART centers).

DAPCUs can further act as an extension of SACS for several activities, for example they can act as storage place and distribution points for testing kits (ICTC and blood safety), drugs (ART and STI) and IEC materials. Computerized Management Information System (CMIS) developed by NACO has a decentralized model. DAPCUs with DA (M and E) can do data entry of field reporting units, which in turn will not only reduce the load at SACS but will also increase the owning of the program by district team, as they can have an access of their district data which they can analyze and use locally. It is proposed that district will take up all responsibility to implement and monitor if a full-fledged M and E officer is sanctioned rather than an M and E assistant at each DAPCU. In order to ensure this, additional human resources may be sanctioned. One or two supervisory persons looking to the numbers and types of the NACP services can be added at DAPCU.

DAPCU is the future of NACP. A DAPCU with good capacity can make the difference. It is evident by the fact that the states with well-functional DAPCUs are also having effective implementation of NACP.

Technical Support Unit

Creation of TSU is really a revolutionary concept in public health, where outsourced technical wing provides technical inputs to the program so that health managers

are free to concentrate on managerial activities. There are multiple TSUs for different components under NACP functioning in a state i.e. TSU for states/TI, TSU for condom promotion, TSU for truckers, National Technical Support Unit (NTSU). However it is well visualized but needs to be better realized. The agencies identified are having varied capacities.

Role clarity in agencies and/or SACSs need to be well spelled out and articulated for better coordination and teamwork as well as avoidance of duplication. This will help in preventing the shifting of the responsibilities from one to another as seen on the occasions in many states. A robust mechanism for better coordination between two important institutes i.e. SACSs and TSU for better delivery must be evolved. Also high turnover of the technical personnel at TSU needs to be controlled to maintain continuity and consistency.

A good coordination and monitoring mechanism, commitment from TSU implementing agency and adequate number of technically sound professional with continuity at TSU can contribute significantly in quality improvement in the program.

State AIDS Control Societies/National AIDS Control Organization

There are many vertical compartments within NACO and SACS. Presently large numbers of the officers/consultants work in seven divisions i.e. basic services (ICTC and STI clinics), blood safety and quality assurance, CST, TIs, IEC and mainstreaming, monitoring, evaluation and surveillance and finance and admin. Each division has chain of officers, i.e. different directors or consultants, because of this, different norms and varied thrust to the different components are observed at both national/state levels. There are services/activities with cross-cutting areas between various divisions, which require linkages/coordination at field and state/national level. This coordination is affected owing to this verticality in the program.

Too many officers result into lots of activities in the SACS/NACO office. With decentralization, it is essential that institutional structure load may be shifted from center to peripheral i.e. nearer to the field units. Further integration of divisions at NACO and SACS in near future is needed to bring oneness as well as better synergy between different components.

Integration/better coordination with General Health System

Looking to the epidemiological situation of India, many experts believe that it will end at the level of spouse and/or children of the bridge population. Hence further relentless progression of epidemic will not occur. Thus

it is believed that HIV epidemic has reached the peak, and time is not far when NACP will be functioning in wider net of GHS. DAPCU can be brought under the overall umbrella of District Health Society. Also large numbers of activities like counseling and testing services, care, support and treatment, PPTCT, STI care and blood safety are having cross cutting or are having common services delivery outlets with RCH/RNTCP/NRHM, hence NACP can piggyback on well-rooted GHS at the districts and below.

Barring TI and part of the special group IEC and mainstreaming, NACP and GHS are operating at common areas/centers at the field level (PHC, CHC, sub-district and district hospitals). These centers largely fall under GHS, whose executive head (Director/Commissioner) is different and at places is senior to Project Director. This results in hindrance in eliciting support and difficulty in coordination. To eliminate this bottleneck, and better coordination, a State Executive Officer for Health and Medical services or Mission Director (NRHM) shall be made ex-officio Project Director. The states where such arrangement has been made, cross cutting areas like counseling and testing services, STI care, Blood Safety, condom promotion, PPTCT, HIV-TB coordination, ART services are getting excellent boost. Looking to the field reality, expected changing thrust areas and future course of program, integration of NACP with GHS will be a destiny either completely or partly. Integration will be cost effective, cost efficient as well as will help sustainability of program in long term.

Conclusion

National AIDS Control Program evolved methodically to meet emerging needs over the period of time. Various institutes, different services and large network of service outlets are developed for implementation of the program across the country with use of sound epidemiological knowledge and changing epidemic situation. The program has started from centrally controlled and moved down to districts over the period of time very rapidly. It can be expected that future NACP will be a well operational district unit closely working with or in GHS with a sound technical wing.

References

1. UNDP Millennium Development Goal, Goal 6. Available from: <http://www.undp.org/mdg/goal6.shtml>. [Last accessed on 2010 June 1].
2. HIV Sentinel Surveillance and HIV Estimation in India 2007 - A Technical Brief. India: National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India; Oct 2008.
3. Technical Report, India HIV estimates year 2006, National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India and National Institute of Medical Research, Indian Council of Medical Research, New Delhi.

4. Country Scenario 1998-99. India: National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India; 1999.
5. Annual Report 2009-2010, Department of AIDS Control. India: Ministry of Health and Family Welfare, Government of India.
6. Annual Report 2002-2003, 2003-2004 (up to 31 July 2004), National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India.
7. Strategic and Implementation Plan, National AIDS Control Program, Phase III (2006-2011), India: National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India; 2006.
8. Annual Report 2008-2009, Department of AIDS Control, Ministry of Health and Family Welfare, Government of India.
9. NACP III to Halt and Reverse HIV in India. India: National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India; 2008.
10. NACO. Office Communication, A11011/69/2007- NACO (A). New Delhi, India: National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India; 2008.
11. NACO. Office Communication, T-11011/08/NACO/BSD (ICTC). New Delhi, India: National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India; 2008.

How to cite this article: Kadri AM, Kumar P. Institutionalization of the NACP and Way Ahead. Indian J Community Med 2012;37:83-8.

Source of Support: Nil, **Conflict of Interest:** None declared.

Author Help: Online submission of the manuscripts

Articles can be submitted online from <http://www.journalonweb.com>. For online submission, the articles should be prepared in two files (first page file and article file). Images should be submitted separately.

1) **First Page File:**

Prepare the title page, covering letter, acknowledgement etc. using a word processor program. All information related to your identity should be included here. Use text/rtf/doc/pdf files. Do not zip the files.

2) **Article File:**

The main text of the article, beginning with the Abstract to References (including tables) should be in this file. Do not include any information (such as acknowledgement, your names in page headers etc.) in this file. Use text/rtf/doc/pdf files. Do not zip the files. Limit the file size to 1 MB. Do not incorporate images in the file. If file size is large, graphs can be submitted separately as images, without their being incorporated in the article file. This will reduce the size of the file.

3) **Images:**

Submit good quality color images. Each image should be less than 4 MB in size. The size of the image can be reduced by decreasing the actual height and width of the images (keep up to about 6 inches and up to about 1800 x 1200 pixels). JPEG is the most suitable file format. The image quality should be good enough to judge the scientific value of the image. For the purpose of printing, always retain a good quality, high resolution image. This high resolution image should be sent to the editorial office at the time of sending a revised article.

4) **Legends:**

Legends for the figures/images should be included at the end of the article file.