

Report of the Comptroller and Auditor General of India

for the year ended March 2003

Union Government
Performance Appraisal

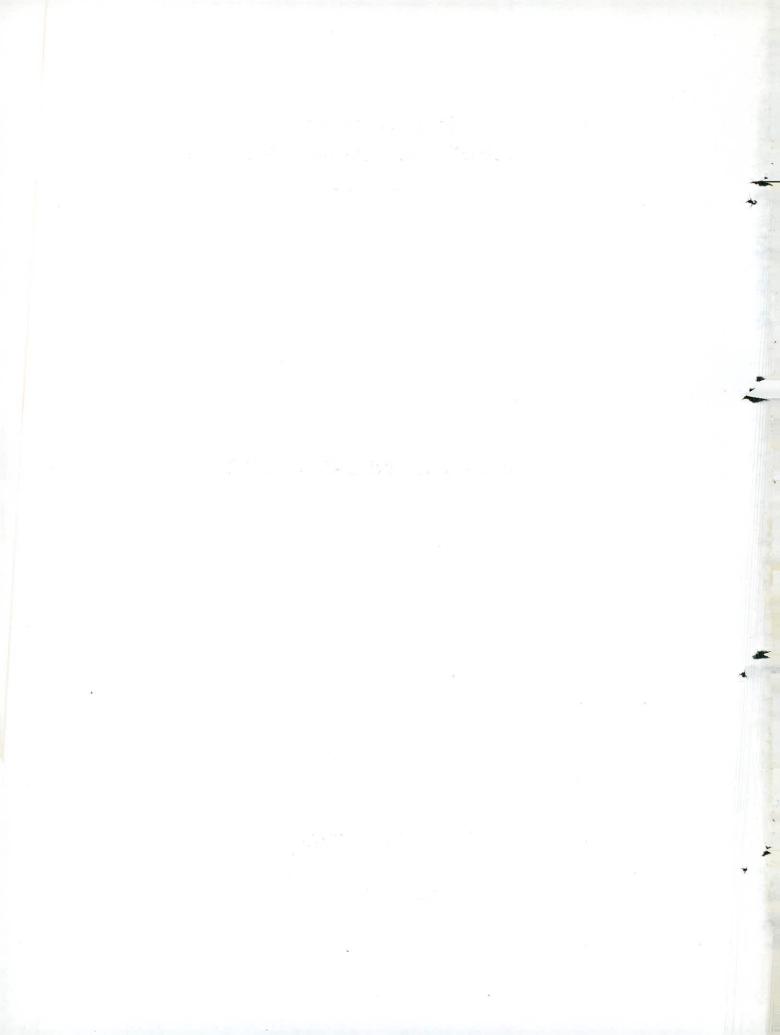
No. 3 of 2004



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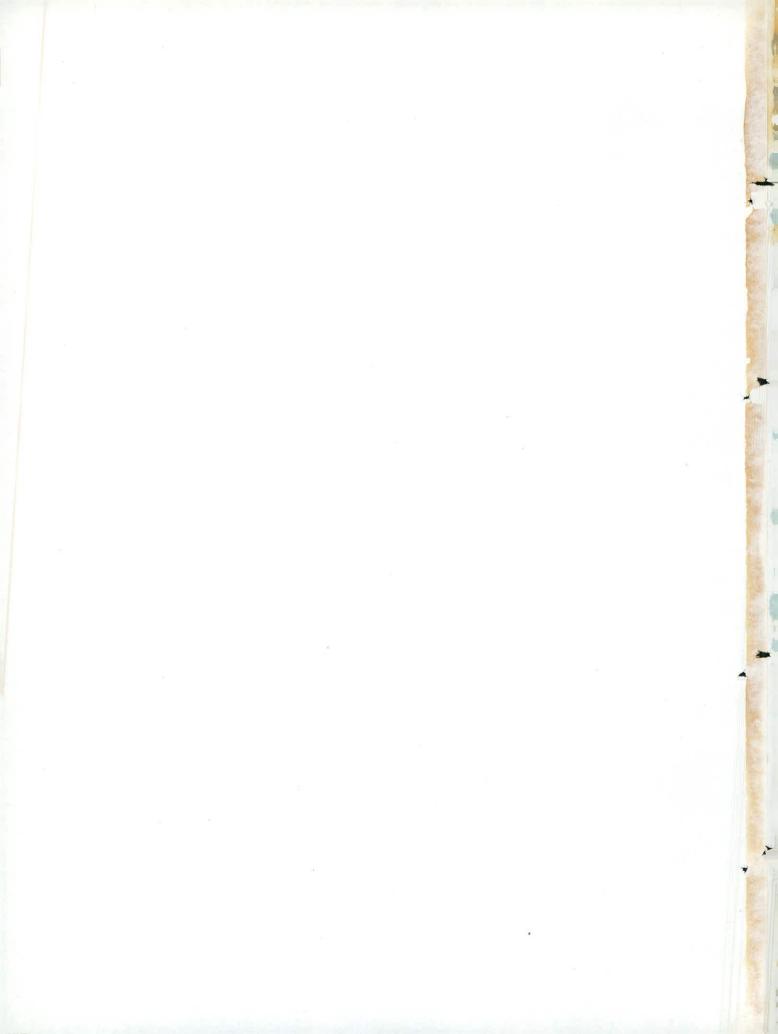
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Union Government Performance Appraisal No.3 of 2004



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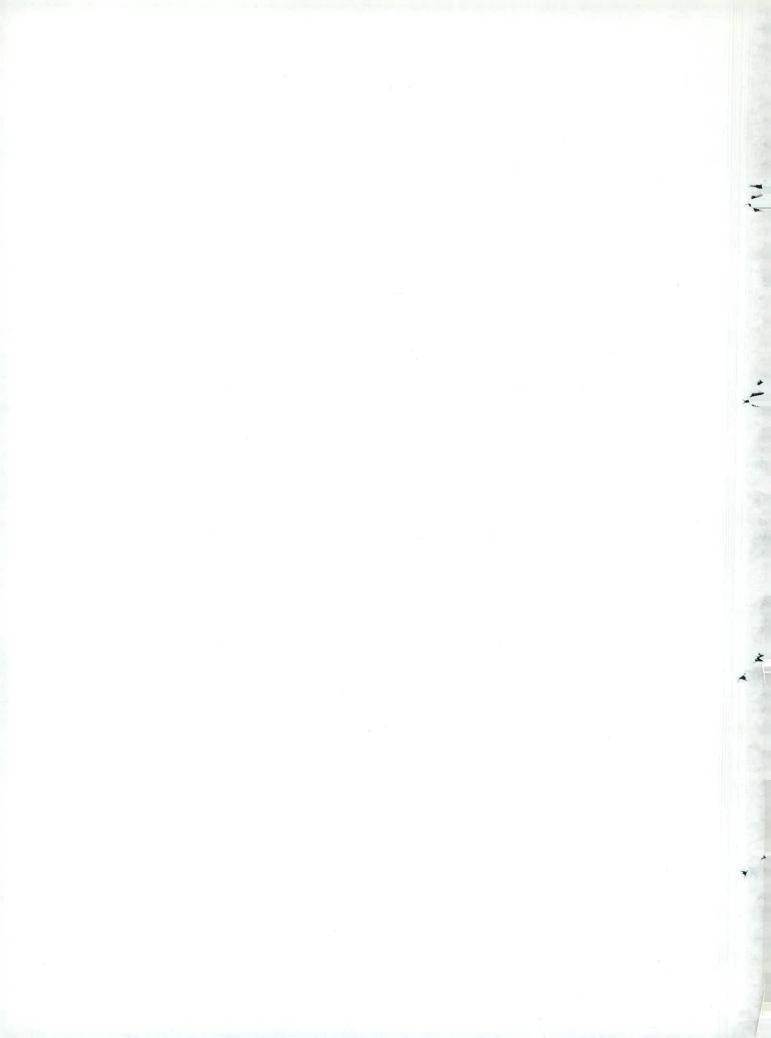
PREFACE

This Report for the year ended March 2003 has been prepared for submission to the President under Article 151 of the Constitution.

The audit observations on Finance Accounts and Appropriation Accounts (excluding Railways) of the Union Government for the financial year 2002-03 and the matters arising from test audit of the financial transactions of Union Ministries and Union Territories have been included in Comptroller and Auditor General's Reports No. 1 and 2 of 2004.

The present report contains results of a performance appraisal of 'National AIDS Control Programme,' a scheme sponsored by the Ministry of Health and Family Welfare of the Union Government. The appraisal was conducted through test check of documents in various States and Union Territories as well as in the Ministry.

Separate Reports are also being presented to Parliament for Union Government: Autonomous Bodies (No.4), Scientific Departments (No.5), Defence-Army and Ordnance Factories (No. 6), Air Force and Navy (No. 7), Railways (No.8 and 9), Indirect Taxes-Customs (No.10), Central Excise and Service Tax (No.11), Direct Taxes (No.12 and 13) and Performance Appraisals of schemes, Empowerment of the Disabled of Ministry of Social Justice and Empowerment (No.14) and Accelerated Irrigation Benefit Programme of Ministry of Water Resources (No.15).



Executive Summary

National AIDS Control Programme

The programme for prevention and control of Human Immunodeficiency Retroviruses (HIV)/Acquired Immunodeficiency Syndrome (AIDS) is a cent per cent centrally sponsored scheme with assistance from international donor agencies. programme formulated in 1987 has moved through various stages. The project was initiated in 1989, with support from the World Health Organisation (WHO), in five states/UTs viz. Maharashtra, Tamil Nadu, West Bengal, Manipur and Delhi. National AIDS Control Project (Phase-I) with IDA credit from World Bank was implemented from September 1992 to September 1997. It was later extended upto March 1999 and the second phase (Phase-II) of the programme was implemented from November 1999. The key objectives of NACP-I were to slow the spread of HIV, decrease morbidity and mortality associated with HIV infection and to minimise the socio-economic impact resulting from HIV infection. The key objectives of NACP-II were to reduce the spread of HIV infection and to strengthen India's capacity to respond to HIV/AIDS on a long term basis. The main focus of the programme in Phase-II was on priority targeted intervention for groups at high risk, preventive intervention for general community and low cost AIDS care. In order to combat the onslaught of the HIV/AIDS epidemic effectively, the Government of India established the National AIDS Control Organisation (NACO) in 1992 which functioned as an executive body in the Ministry of Health and Family Welfare at New Delhi to coordinate the prevention and control of AIDS in the country. NACO is headed by an Additional Secretary to Government of India as its Project Director, she is assisted by an Additional Project Director (Technical), five subject specialists and forty-seven other technical and administrative staff. The National AIDS Control Board (NACB) constituted under the chairmanship of Secretary (Health). Union Ministry of Health and Family Welfare, reviews the policies laid down by NACO, grants sanctions to various projects, undertakes procurement and awards contracts to private agencies. The Board also approves annual operational plan budgets, re-allocates funds between programme components, forms programme management teams and appoints senior programme staff. State AIDS Cells were created in all 32 states and UTs of the country for the effective implementation of NACP-I. However, to remove the bottlenecks faced in implementation of the programme at State level during Phase-I (1992-1999), each State Government/Union Territory was advised to constitute a registered society under the Chairmanship of Secretary (Health) to the State Government. As of March 2003, State Governments have set up 35 State AIDS Control Societies (SACS) and 3 Municipal AIDS Control Societies (MACS). These societies being the main implementing agencies of the programme are broad-based, with their members representing various departments like Social Welfare, Education, Industry, Transport, Finance etc. and Non-Governmental Organisations (NGOs). NACO approves annual action plans of these societies and releases grants to them according to their plans.

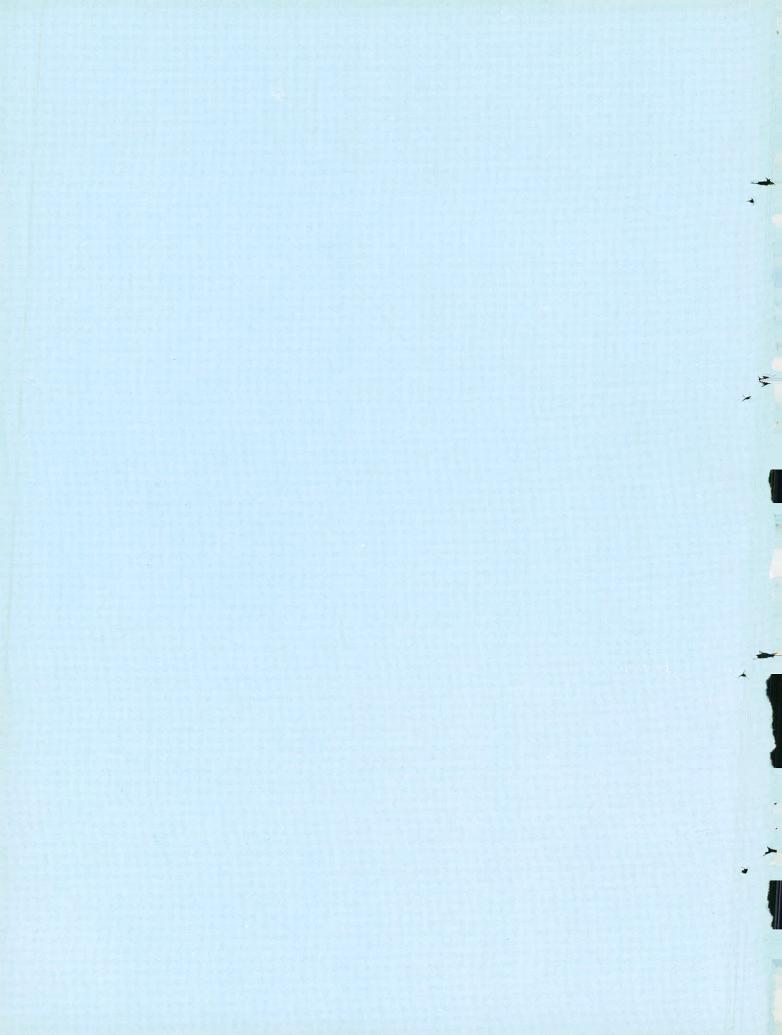
A review of the programme by audit revealed that while Rs. 783.66 crore had been spent on the programme as of March 2003, it had achieved limited success mainly due to failure in generating sufficient awareness among the masses and the slow pace of

implementation of the various components of the programme. NACO have utilised only 46 per cent of the aid from World Bank for Phase-II as of March 2003 although four out of the five years project period have elapsed. Various activities under the programme could not be conducted efficiently for want of infrastructural facilities, drugs, equipment, trained manpower etc. AIDS/HIV is still considered to be a stigma and the message that it is preventable is yet to percolate to the grass root level. Cases of HIV infection were on the rise with the virus spreading from high risk groups to the general population. The estimated HIV cases had increased from 3.50 million in 1998 to 4.58 million in 2002. Target groups in many states remained un-identified due to non-completion of mapping exercises. Targeted interventions (TIs) globally perceived as the most effective strategy for arresting the spread of HIV/AIDS by informing, educating and counselling the marginalised and vulnerable sections of the population, which are at high HIV risk and providing them with some preliminary care and support, had not been conducted effectively. The World Bank in their mid-term review (May 29-July 31, 2002) have pointed out the need for better focus of TIs on truly high risk groups rather than dilute the programme with emphasis on other population (i.e. migrants, slum dwellers). While the number of condoms distributed had increased during the project period, the scheme of social marketing of condoms, accepted as the most effective strategy for condom distribution, failed as NACO could not procure and distribute 3.30 million pieces of The programme could not achieve the target of providing STD clinics, modernised blood banks and voluntary counselling and testing centres in every district of the country. Although the Ministry of Health and Family Welfare had announced in December 2002 that blood donors found to be HIV positive would be told of their infection and asked to seek confirmatory tests and counseling, NACO continues to follow the existing policy of giving the results only to those persons who ask for these. Nondisclosure of HIV status mandatorily to all HIV infected persons could lead to such persons unknowingly spreading the disease among uninfected persons.

Polymerase Chain Reaction (PCR) is a highly specialised blood test that looks for HIV genetic information and can detect HIV even during the window period and can help early diagnosis of HIV in the newly born, which can be useful for starting retroviral drug therapy, preventing and beating opportunistic infections in time and deciding about issues related to breast-feeding as well as nutritional support and growth monitoring of the child. However, PCR had not been adopted by NACO to diagnose HIV infection under NACP even in limited set of circumstances. By strengthening 504 Sexually Transmitted Diseases (STD) clinics in Phase-I of NACP, NACO had exceeded the target of strengthening 372 Government STD Clinics. However, a large number of the clinics were not functioning optimally for various reasons like lack of equipment, nonavailability of staff etc. Information Education and Communication component of the programme could not effectively serve the objective of raising the awareness level of the masses include those constituting various risk groups and remove serious misconceptions about the modes of transmission of the infection. While a study conducted by Centre for Media Study in respect of some programmes that were broadcast on TV showed that over 80 per cent viewers benefited from the show, injudicious selection of TV channels and timings of the programme hindered effective spreading of the message relating to methods for preventing HIV/AIDS.

The impact of various components of the programmes were not assessed. This could have helped in taking corrective action wherever necessary. School AIDS Education Programme, a national plan to educate young people on how to protect themselves from HIV/AIDS, was to be implemented by covering all the schools in States/UTs in a phased manner in a period of five years (by 2004). However, coverage of schools under the programme in States except Andhra Pradesh (100 per cent), Kerala (84 per cent) and Nagaland (85 per cent) ranged between only one per cent and 59 per cent. Thus, the target of achieving complete coverage of schools under the programme within the envisaged five year period i.e. by 2004 seems doubtful. Family Health Awareness campaigns in each State that were organised to make the people in rural and slum areas aware of HIV/AIDS and the services available, failed to attract even 20 per cent of the The main reasons for failure of Family Health Awareness targeted population. Campaigns were the short notice to plan and implement the programme and wrong selection of places. Implementation of prevention of parents to child transmission (PPTC) of HIV was to be completed by April and July 2002 respectively in Medical Colleges and District Hospitals in high prevalence States. However, training in respect of this component has not been completed in 24 per cent of district hospitals and service delivery has started only in 11 per cent of district hospitals in high prevalence States. Community care centres in high prevalence States and drop-in-centres have been established in very few states and the effectiveness of their functioning remains unassessed. Grants-in-aid were released without proper assessment of requirement to intersectoral collaborators for implementing various activities of the programme resulting in utilisation of only 23 per cent grant by them. Benefits of Computerised Management Information System was not fully derived due to poor reporting and slow pace of its implementation. Training of medical, paramedical and field staff in management of the disease and hospital infection control measures including post exposure prophylaxis was to be completed by March 2002. However, as of March 2003, there was shortfall in training of 44 per cent doctors, 54 per cent nurses, 62 per cent lab technicians and 70 per cent field officers in the States. NACO had sanctioned posts under various cadres to all State AIDS Control Societies for effective implementation of programme, yet 279 posts in some State AIDS Control Societies had not been filled which resulted in adverse impact on the programme implementation. NACO had no mechanism to monitor procurement of equipment and testing kits. Some equipment purchased during Phase-I and Phase-II had remained un-installed. Several defective test kits when put on test had showed false positivity, which defeated the very purpose of conducting HIV tests. Large amount of advances were lying un-adjusted with the procurement agent of NACO. The Computerised Financial Management System for objective concurrent monitoring and evaluation of the programme at National and State level envisaged to be implemented and made functional by March 2001 had not been fully implemented till September 2003. For effective monitoring and evaluation of the programme, each Society was required to appoint a Monitoring and Evaluation (M&E) Officer. However, 17 Societies were still working without M & E Officers. The National AIDS Committee, the highest level deliberative body to oversee performance of NACO and provide overall policy decision had not met after 2001.

With a view to help the project authorities in rectifying the deficiencies in implementation of the programme, certain measures have been suggested in the report. A summary can be seen at paragraph 20 of the report.



MINISTRY OF HEALTH AND FAMILY WELFARE

National AIDS Control Programme

1 Introduction

AIDS (Acquired Immunodeficiency Syndrome) is a severe life-threatening condition, which represents the late clinical stage of infection with the Human Immunodeficiency Retro Viruses (HIV). This most often results in progressive damage to the immune, organ and central nervous systems. HIV invades the body's defence system, exposing the infected person over time to a range of lung diseases, cancers, fungal infections, rashes, sores and other debilitating conditions until death. There is as yet no cure or vaccine available.

HIV is transmitted through sexual contact (homosexual, bisexual or heterosexual), sharing blood-contaminated needles and syringes, multiple blood transfusions of infected person's blood and transmission from an infected mother to the child before, during or shortly after birth.

India is one of the very few countries where surveillance activities were started prior to detection of the first case. The screening of blood samples for HIV started in 1985 at two centres in Pune and Vellore. The first case of HIV infection was officially reported in a clinic in Chennai in 1986. A cumulative total of 54061 cases of AIDS have been reported to the National AIDS Control Organisation (NACO) till 31 July 2003. According to the Sentinel Surveillance 2002, the number of HIV cases in India is estimated to be 4.58 million.

The Government of India constituted a National AIDS Committee in 1986. On the basis of the recommendations of that Committee, a National AIDS Control Programme was also formulated in 1987. In the following four years its activities focused on HIV screening of so-called 'sexually promiscuous' groups and eventually blood donors.

In 1989, with support from the World Health Organisation (WHO), a Medium Term Plan for AIDS Control was developed with a US\$ 19 million budget to be provided from external sources. Project documents for the implementation of this plan were developed and implemented in five States and Union Territories (UTs), namely Maharashtra, Tamil Nadu, West Bengal, Manipur and Delhi. Initial activities focused on the reinforcement of programme management capacities as well as targeted Information, Education and Communication (IEC) activities and surveillance activities.

In 1992, the Government of India secured an IDA credit of US \$ 84 million from the World Bank to support a full-fledged National AIDS Control Project (NACP-I) for a five year period from September 1992 to September 1997. Assistance of US \$ 1.5 million was also obtained in the form of Technical Assistance from WHO. Due to slow utilisation of funds in the first two years of the project, it was extended upto March 1999.

To encourage and enable the States themselves to take on the responsibility of responding to the epidemic on a long-term basis and reduce the spread of HIV infection, the programme NACP-II was launched in 1999 with a budget of Rs. 1425.10 crore comprising Rs. 1155.10 crore as IDA credit (including Government of India contribution of Rs. 196 crore), Rs. 166 crore as USAID assistance for AVERT Project in Maharashtra and DFID assistance of Rs. 104 crore for the Sexual Health Project for the states of Andhra Pradesh, Gujarat, Kerala and Orissa. This programme is a 100 per cent Centrally Sponsored Scheme implemented in 35 States/UTs and 3 Municipal Corporations, namely, Ahmedabad, Chennai and Mumbai, through AIDS Control Societies. This project is expected to be completed by October 2004.

2 Project objectives

The objectives of NACP-I were (i) to slow the spread of HIV, (ii) to decrease morbidity and mortality associated with HIV infection and (iii) to minimise socioeconomic impact resulting from HIV infection. The key objectives of NACP II were (a) to reduce the spread of HIV infection in India and (b) to strengthen India's capacity to respond to HIV/AIDS on a long-term basis.

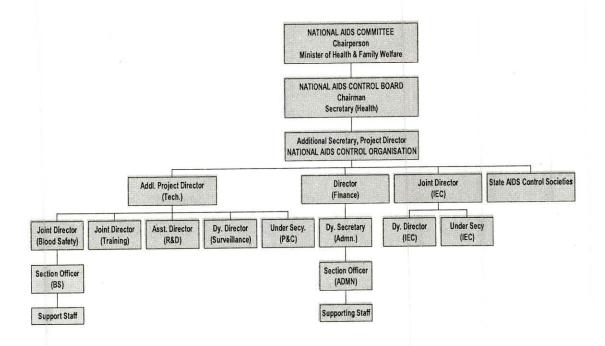
The project interventions seek to achieve the following by the completion of the project:

- (a) to keep HIV prevalence rate below 5 per cent of adult population in Maharashtra, below 3 per cent in Andhra Pradesh, Karnataka, Manipur and Tamil Nadu and below 1 per cent in the remaining States, where it is still at a nascent stage;
- (b) to reduce blood-borne transmission of HIV to less than 1 per cent
- (c) to attain awareness level of not less than 90 per cent among the youth and others in the reproductive age group; and
- (d) to achieve condom use of not less than 90 per cent among high-risk categories like Commercial Sex Workers.

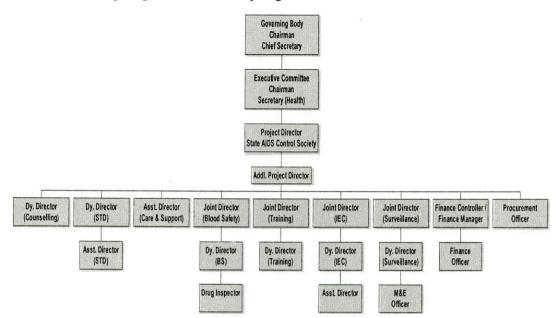
3 Organisational arrangements

The Ministry of Health and Family Welfare constituted a National AIDS Committee (NAC) in 1986 under the Chairmanship of the Minister of Health and Family Welfare. The Committee, which had representatives from various sectors, was set up to formulate strategy and plan for implementation of prevention and control of HIV/AIDS in the country. The Government of India established the National AIDS Control Organisation (NACO) in 1992, which functioned as an executive body in the Ministry of Health and Family Welfare at New Delhi to coordinate the prevention and control of AIDS in the country. NACO is headed by an Additional Secretary as its Project Director who is assisted by an Additional Project Director (Technical), five subject specialists and forty-seven other technical and administrative staff. The National AIDS Control Board (NACB) constituted under the chairmanship of Secretary (Health), Ministry of Health and Family Welfare, reviews the policies laid down by NACO, grants sanctions to various projects, undertakes procurement and awards contracts to private agencies. The Board

also approves annual operational plan budgets, re-allocates funds between programme components, forms programme management teams and appoints senior programme staff. The Board exercises all financial and administrative powers which are beyond the powers of the Project Director, NACO and which the Department of Health, Government of India, can exercise with the approval of the Department of Expenditure, Ministry of Finance. No separate reference to the Ministry of Finance for funding of planned activities is required as the Ministry of Finance is represented on the Board. The organogram of NACO is given below:



State AIDS Cells were created in all 32 states and UTs of the country for the effective implementation of NACP-I. However, to remove the bottlenecks faced in implementation of the programme at State level during phase-I (1992-1999), each State Government/Union Territory was advised to constitute a registered society under the Chairmanship of Secretary, Health. These societies are broad-based, with their members representing various departments like Social Welfare, Education, Industry, Transport, Finance etc. and Non-Governmental Organisations (NGOs).



The organogram of the society is given below:

4 Audit Objectives

The working of the National AIDS Control Programme covering all State/Municipal AIDS Control Societies (SACS/MACS) and National AIDS Control Organisation at Delhi during the period 1998-99 to 2002-03 was reviewed between April 2003 and July 2003. The principal objective of the review was to ascertain the impact of various components of the programme like:

- > the IEC programme,
- > efficacy of priority targeted interventions for groups at high risk,
- > adequacy of training arrangements,
- > functioning of blood banks and STD clinics,
- > monitoring and evaluation procedures,
- > achievements of targets and impact evaluation,
- > adequacy of procurement procedures,
- > utilisation of equipment,
- > utilisation of funds released and accounting.

5 Methodology

Samples were selected from the records of NACO at New Delhi, 35 SACS from various States/UTs and 3 MACS located at Mumbai, Chennai and Ahmedabad. The criteria for selecting the sample size were based on the prevalence of HIV infected population, geographical distribution of programme activities and quantum of

expenditure. The number of medical college hospitals, district hospitals, district medical offices, blood banks, STD clinics, Voluntary Counselling and Testing Centres and NGOs selected in various States for review ranged from 8 per cent to 100 per cent covering 7 per cent to 100 per cent of the programme expenditure in the States. Studies/surveys conducted by outside agencies on behalf of NACO were also examined to the extent considered relevant and necessary. Details of the samples selected for test audit are given in **Annex-I**.

6 Programme financing

Phases I and II of the programme were financed from the following sources:

S. No.	Funding Agency	Resources		
		Phase-I	Phase-II	
1.	Government of India	57.34	196.00	
2.	World Bank	222.66	959.10	
3.	USAID (AVERT)	-	166.00	
4.	DFID (Sexual Health Project)	-	104.00	
	Total	280.00	1425.10	

Note: Rs. 280.00 crore includes USAID of Rs.28.92 crore for AIDS Prevention and Control Project (APAC).

The allocation of funds and expenditure for various components of the World Bank assisted NACP-I and II were as under:

(Rs. in crore) Phase-I Phase-II Component Allocation Expenditure Component Allocation **Expenditure Reported** by implementing agencies Programme 41.45 Priority targeted 265.60 94.60 management interventions for groups at high risk I.E.C. 255.66 Preventive 389.10 295.76 interventions for the general community **Blood Safety** 250.02 Low cost AIDS care 163.30 15.81 Surveillance 61.89 Institutional 286.50 119.69 and Clinical strengthening Management STD 48.53 Inter-sectoral 50.60 6.57 collaboration Total 657.55 491.91* Total 1155.10 532.43

There was a difference of Rs. 377.55 crore in the funds allocated for Phase-I in VIIIth Plan and approved allocation for the period 1992-1999. The department could not furnish any reason for the above difference. Against an approved allocation of Rs. 657.55 crore for Phase-I, NACO had utilised Rs. 491.91 crore (75 per cent). However, in Phase-II of the programme against an approved allocation of Rs. 1155.10 crore for the project period from 1999-2000 to 2003-2004, NACO had been able to utilise just Rs. 532.43 crore (46 per cent) in the first four years.

^{*} NACO could not furnish component-wise expenditure for Phase-I of the project.

IDA credit 7

Withdrawal of funds from the World Bank (IDA) Credit account for NACP-I and NACP-II is on the basis of actual expenditure incurred by NACO as well as each AIDS Control Society implementing the project. NACP-I was initially approved for a period of five years (1992-97) but due to slow utilisation of funds, it was extended upto 31 March 1999. NACO made use of the entire credit of US \$ 84 million, but only after the programme was extended upto 31 March 1999. NACP-II was made effective from 9 November 1999 and a special account amounting to 10.00 million US \$ was maintained in the Reserve Bank of India. The Department of Economic Affairs of the Government of India, on the basis of reimbursements filed under the Project, operates this account. The actual expenditure and reimbursement from 1999-2000 to 2002-2003 is given below:

(Rs. in crore)

V	Duniont	Revised estimate		Total	World bank	Disbui	rsement
Year	Project cost as per PAD#	Provision	World Bank Portion	Expenditure	portion of expenditure	Expenditure claimed	Eligible reimbursement
00.00	154.52	140.00	133.00	135.25	129.75	NIL	NIL
99-00	200 10722		161.25	180.00	162.75	168.46	151.78
00-01	270.11	180.00		Control of the Contro		172.19	155.44
01-02	258.00	229.70	188.20	226.55	187.72	P.D. Service	
02-03	193.13	242.00	199.00	241.86	200.07	155.61	137.07
02-03	193.13	Total	1,55,00	783.66 ^β	680.29	496.26*	444.29*

Project Appraisal Document

As on 31 March 2003, out of reimbursible expenditure of Rs. 680.29 crore, claims for Rs. 496.26 crore (73 per cent) were sent to the World Bank against which reimbursement of Rs. 444.29 crore was received. In the four years of the project period, out of available credit of Rs. 959 crore, NACO had been able to utilise only Rs. 444.29 crore (46 per cent). The shortfall in claiming reimbursement amounting to Rs. 184.03 crore was stated to be due to release of grants in the month of March 2003, which resulted in lower utilisation of funds and also due to slow reporting of expenditure by the Societies.

Non-reconciliation of accounts 7.1

NACO releases grants-in-aid to Societies which are the main implementing agencies of NACP and which submit quarterly Statements of Expenditure (SOE) to the former. NACO claims reimbursement from the World Bank on the basis of SOEs. In order to ensure the correctness of claims, expenditure mentioned in SOE should be reconciled with the expenditure shown in the audited statement of accounts. Scrutiny of audited statements of accounts, however, revealed that till 2000-01, no such reconciliation was conducted. On the basis of test check conducted by audit in respect of 49 audited statements of accounts, differences in figures between SOE and audited statements of accounts were noticed in 46 cases.

^{*} Expenditure claimed Rs. 496.26 crore includes Rs. 51.97 crore which is not reimbursible because reimbursement of expenditure on different components is based on IDA financing percentage

^β The total expenditure of Rs. 783.66 crore reflects grants released by NACO to various implementing agencies and booked as expenditure. This includes Rs. 680.29 crore incurred against assistance from the World Bank and the balance against assistance from other donor agencies.

In order to ensure correctness of claims, expenditure claimed in statement of expenditure should invariably be reconciled with the expenditure shown in the audited statement of accounts. NACO needs to speed up the pace of implementation of its activities in order to utilise the entire amount of credit made available to it by the World Bank.

8 Working of State/Municipal AIDS Control Societies

As of March 2003, State Governments have set up 35 State/UT AIDS Control Societies (SACS) and three Municipal AIDS Control Societies (MACS). NACO approves their annual action plans and releases grants to them according to these plans. A scrutiny of records relating to submission/approval of annual action plan and release of grants to Societies revealed the following deficiencies:

8.1 Annual Action Plans (AAP)

States/Municipal AIDS Control Societies are to submit their annual action plans to NACO three months prior to the commencement of a financial year (i.e. by December) so that these could be approved and communicated before allocation of funds (i.e. in March). A scrutiny of annual action plans revealed considerable delays in their receipt and approval as shown in the table below:

Year		F	Receipt	Approval			
, car	No. of AAP test checked	AAP submitted before December	AAP submitted between Jan. and March	AAP submitted after March	AAP approved between Jan. and March	AAP approved between April and June	AAP approved after June
1998-99	26	Nil	12	14	Nil	11	15
1999-00	4	Nil	Nil	4	Nil	Nil	4
2000-01	32	Nil	08	24	Nil	Nil	32
2001-02	33	Nil	04	29	Nil	20	13
2001-02	35	Nil	08	27	Nil	34	01 (Oct.)

Delays in submission of annual action plans by the Societies resulted not only in their delayed approval but also affected utilisation of funds resulting in considerable unspent balances lying with some of the Societies. Consequently, targets set in respect of some programme activities like strengthening of STD clinics, Voluntary Counselling and Testing Centre (VCTC), training etc. were not achieved.

8.2 Irregular release of grants

Under NACP-II, grants could be directly released to the SACS only after they had furnished a Memorandum of Understanding (MOU) and got their annual action plan approved by NACO. Audit found that grants of Rs. 80.14 crore were irregularly released to societies before fulfilling the above conditions:

(Rs. in lakh)

Year	Release of grants to societies before signing M.O.U.	Release of grants to societies before approval of A.A.P.
1998-99	-	60.00
1999-00	420.00	3250.00
2000-01	16.50	937.00
2001-02	-	3030.00
2002-03	9)	300.00
Total	436.50	7577.00

8.3 Allocation of funds to Societies

On the basis of annual action plans received from societies, NACO makes component-wise allocation of funds to Societies, which, in turn, report expenditure through quarterly Statements of Expenditure (SOE). The component-wise allocation of funds made to Societies and expenditure reported by them are given below:

(Rs.	in	la	κh)
					,

						(Rs. in lakh
Component		Indicative cost (per cent) of total outlay as per PAD*	1999-00	2000-2001	2001-2002	2002-2003
A. Delivery of cost-effecti	ve intervention aga	ainst HIV/AIDS				
(i) Priority targeted	Allocation		4245.82	3847.54	4157.00	5090.3
interventions for groups	(%)		(25.04%)	(36.36%)	(21.95%)	(23.81%
at high risk	Expenditure	23%	2133.56	2487.19	2601.20	2237.53
	(%)		(19.37%)	(29.42%)	(18.81%)	(20.17%
(ii) Preventive	Allocation		6329.92	3642.85	9186.56	10328.5
interventions for the	(%)		(37.33%)	(34.42%)	(48.52%)	(48.30%
general community	Expenditure	Expenditure 33.7%	5625.53	3607.64	7632.86	5545.61
	(%)		(51.07%)	(42.67%)	(55.19%)	(49.99%
(iii) Low cost	Allocation		1637.23	143.75	1285.05	1331.00
AIDS care	(%)	14.1%	(9.66)	(1.36%)	(6.79%)	(6.23%
	Expenditure		388.53	155.59	450.37	587.13
	(%)		(3.53%)	(1.84%)	(3.26%)	(5.29%)
B. Building capacity						
(i) Institutional	Allocation		4141.12	2811.69	3893.22	4212.88
strengthening	(%)		(24.42%)	(26.57%)	(20.56%)	(19.70%)
	Expenditure	24.8%	2749.52	2141.79	3081.49	2657.54
	(%)		(24.96%)	(25.33%)	(22.28%)	(23.96%
(ii) Inter-sectoral	Allocation		600.77	137.00	412.66	420.00
collaboration	(%)		(3.54%)	(1.29%)	(2.18%)	(1.96%)
	Expenditure	4.4%	117.42	62.14	64.96	66.02
	(%)		(1.07%)	(0.74)	(0.47%)	(0.60%)
Total	Allocation (%)		16,954.86	10,582.83	18,934.49	21,382.76
	Expenditure (%)	100%	11,014.56	8,454.35	13,830.88	11,093.83

* Project Appraisal Document

(Note: Expdr. for 3rd & 4th quarters for the year 2002-2003 has not been received from some societies)

While the expenditure on the component 'preventive interventions for the general community' exceeded the indicative percentage of the total outlay as mentioned in the Project Appraisal Document, the expenditure on low cost AIDS care and inter-sectoral collaboration fell far short of the indicative outlay.

8.4 Transfer of unspent balances to SACS/MACS

The process of decentralising the implementation of the programme was started in 1998-99 by establishing State/Municipal AIDS Control Societies in each State/UT. In Phase-I (prior to 1998-99) of the project, funds for implementing the project activities were being released to States. After creation of AIDS Control Societies, State AIDS Cells were instructed to transfer the unutilised funds and other assets acquired out of the funds released under the programme, to these Societies.

Audit requested NACO to furnish details of funds lying unutilised with various States as on 1 April 1998 and funds transferred to Societies. NACO failed to furnish this information. However, from the information supplied to audit by NACO in respect of nine States and as intimated by the States' Accountants General, it was noticed that Rs. 3.80 crore was yet to be transferred to the Societies as shown below:

(Rs. in lakh)

S. No.	SACS/MACS	Unspent balances due to be transferred to Societies
1.	Andhra Pradesh	139.00
2.	Arunachal Pradesh	48.88
3.	Assam	64.13
4.	Jammu & Kashmir	3.02
5.	Maharashtra	25.15
6.	Manipur	88.38
7.	Uttar Pradesh	11.15
70) = 1	Total	379.71

8.5 Release of grants to Societies

The following table provides summarised information in respect of funds allocated and released:

(Rs. in lakh)

Year	Funds allocated	Grants released	Total funds available With Societies	Expenditure reported	Utilisation of grants in <i>per cent</i>	No. of UCs pending	Amount of grant involved in respect of pending UCs
Opening Bal	ance	3319.05					
1999-2000	16954.86	10975.00	14294.05	11014.56	77	7	504.14
2000-2001	10582.83	10872.40	14653.44	8454.35	58	7	567.27
2001-2002	18934.49	15048.00	21247.09	13830.88	65	9	1148.67
2002-2003	21382.76	16391.00	23807.21	11093.83	47	N	ot due
Total	21332.70	56605.45		44393.62		23	2220.08

(Note: Expenditure for 3rd and 4th quarter has not been reported by some SACS/MACS)

Out of the total grant of Rs. 566.05 crore (including the opening balance) released by NACO during 1999-00 to 2002-03, the Societies had utilised Rs. 443.94 crore (78 per cent). However, 23 Utilisation Certificates from 9 States involving grants of Rs. 22.20 crore had not been received as of March 2003. Details of utilisation of grants are given in **Annex-II**.

While 17 Societies in 1999-2000, 19 Societies in 2000-01, 15 Societies in 2001-02 and 12 Societies in 2002-03 had utilised more than 70 per cent of the grants released, nine Societies in 1999-2000 and 2000-01, 10 Societies in 2001-02 and 21 Societies in 2002-03 could not utilise even 50 per cent of the grants released.

Some significant observations relating to utilisation of grants by SACS/MACS are discussed below:

Haryana

- NACO released Rs. 2.46 crore during 2000-01 to the society although the annual action plan was approved for Rs. 2.24 crore and Rs. 2.33 crore was already available with the society as unspent balance.
- Difference of Rs. 26.31 lakh was noticed in the figures of opening balance supplied by NACO and those supplied by the State Accountant General from the records of SACS, in respect of grants released to Haryana State AIDS control society. This indicated deficient maintenance of accounts and reporting of figures.

Nagaland

Rs. 2.76 crore paid as advance during 1998-2001 was charged as final expenditure.

Orissa

Rs. 41.55 lakh drawn through abstract contingency bills for strengthening of STD clinics/blood banks was kept in civil deposits as of March 2003.

Bihar

- Against approved allocation of Rs. 15 lakh for minor civil works, the society had sanctioned an advance of Rs. 1.17 crore during March 2003 for construction of rooms for blood banks and STD clinic without approval of NACO.
- Rs. 17 lakh drawn by Assistant Director (Health and Family Welfare Department) was shown in the cash book as spent though the amount was kept in a bank account in the name of Director-in-chief, Health and Family Welfare Department.
- Rs. 23.17 lakh paid to different officials for travel expenses and programme implementation during 1993-96 by Bihar States AIDS Control Cell were awaiting adjustment as of March 2003.

Maharashtra > Against five sanitisation workshops proposed to be organised for MLAs, Corporators, Journalists etc. (Community leaders) during 1998-99 by Seva Prabodhini, Pune (an NGO) at a cost of Rs. 22.56 lakh, only one workshop at a cost of Rs. 6.24 lakh could be organised as the community leadership did not respond.

Punjab

- Difference of Rs. 1.28 crore noticed in SOE and audited statement of accounts for the year 1998-99 to 2002-03 remained un-reconciled. Similarly, a difference of Rs. 1.19 crore in the unspent balance as per SOE and bank statements also remained unreconciled.
- As of March 2003, a difference of Rs. 57 lakh was also noticed in the figures of unspent balance furnished by NACO and those supplied by the State Accountant General from the State Records audited by him.
- Tamil Nadu > Out of advances given by the Chennai AIDS Prevention and Control Society (CAPACS), Rs. 76.57 lakh was awaiting adjustment as of March 2002.

8.6 Grants released in excess of allocation

An analysis of allocation and release of funds to societies revealed that in a number of cases grants were released to societies in excess of approved allocations. The year-wise position is given below:

(Rs. in lakh)

Year	No. of societies to which grants were released in excess of Allocation	Allocation as per approved Action Plan	Grants released	Releases in excess of Allocation
1999-2000	02	108.35	120.00	11.65
2000-2001	20	6690.08	7466.82	776.74
2001-2002	12	3174.54	3692.65	518.11
2002-2003	01	1208.09	1503.00	294.91

8.7 Contribution from NGOs

Guidelines provide that NGOs involved in the implementation of the programme should contribute at least 10 *per cent* of the total project cost. The contribution can be in the form of infrastructure or staff or any other contribution in kind or cash.

Scrutiny of the records of State/Municipal AIDS Control Societies revealed the following irregularities:

In Andhra Pradesh, scrutiny of the annual accounts of the NGOs for the year 2000-02, revealed that 113 NGOs had not contributed the amount as prescribed. However, the Society had been releasing grants to these NGOs. Non-observance of the prescribed procedure for the release of grant to the NGOs by the Society, resulted in excess release of Rs. 29.90 lakh to these NGOs.

In terms of the guidelines of NACO, only those NGOs which had been registered for a minimum period of three years have to be considered for projects under targeted interventions for groups at high risk. However, in **Tamil Nadu** one NGO, registered in May 1999, was sanctioned two projects by Tamil Nadu State AIDS Control Society (TNSACS) under this component in July 1999 (cost Rs. 7.50 lakh) and in January 2001 (cost Rs. 7.50 lakh) even though it had not completed three years of its registration. Thus the sanction of two projects to the NGO without fulfilling the above conditions was irregular.

In **Manipur**, no NGO contributed 10 *per cent* of the total project cost during 1998-99 to 2000-01. During 2001-02 and 2002-03 NGO contributions ranged between 8 and 9.8 *per cent* respectively against the norm of 10 *per cent*.

In **Punjab**, test check of records of Indian Society of Youth Development, Dera Bassi an NGO revealed that it had not contributed 10 *per cent* contribution amounting to Rs. 0.47 lakh as prescribed in the guidelines.

NACO should immediately assess the unspent balances lying with the State AIDS cells as on 1 April 1998 i.e. before the formation of State Societies and get these transferred to these Societies. The reasons due to which certain SACS/MACS could not utilise even 25 per cent of the funds provided to them should be investigated thoroughly by NACO before releasing funds for the next year. It is also suggested that grants should be released to NGOs after deducting 10 per cent of the project cost towards their contribution.

9 HIV/AIDS sentinel surveillance

The sentinel surveillance system was adopted by NACO as it is the best system to monitor trends of HIV infection in specific high risk groups as well as low risk groups. Under this system, a few selected sentinel sites representing the various groups of population are screened for HIV prevalence and their trends are monitored over a period of time. Accordingly, the sentinel surveillance for HIV infection was taken up in 55 sentinel sites in 1994 and expanded to 384 sites in 2002. These sites included 165 sites in STD Clinics, 200 sites in ante-natal clinics (ANC), 14 sites among Injecting Drug Users (IDUs), 2 sites for Commercial Sex Workers (CSW) and 3 sites for Men Having Sex with Men (MSM). Based on sentinel surveillance data, the HIV prevalence in adult population can be broadly classified into three groups. Group I includes States where the HIV infection has crossed 1 per cent or more in ante-natal women. Group II includes States where HIV infection has crossed 5 per cent or more among high risk groups but the infection is below 1 per cent in ante-natal women. Group III includes States where HIV infection in any of the high risk groups is still less than 5 per cent and is less than 1 per cent among ante-natal women. The States falling under these groups are also called high, moderate and low prevalence States respectively.

9.1 Estimation of HIV infection among adult population

Although in the Indian context it is difficult to estimate the exact prevalence of HIV because of varied cultural characteristics, traditions and values with special reference to sex related risk behaviours, efforts have been made to assess how rapidly HIV infection has been increasing/decreasing in different groups and areas by using the HIV sentinel surveillance data. According to this data, the estimated HIV cases have increased from 3.50 million in 1998 to 4.58 million in 2002. The year-wise growth of HIV infection is given below:

Year	Estimated HIV cases	Percentage increase over the previous year
1998	3.50 million	
1999	3.70 million	5.71
2000	3.86 million	4.32
2001	3.97 million	2.85
2002	4.58 million	15.37

Since 1998, the estimated HIV infection has increased annually between 2.85 per cent and 15.37 per cent. Fortunately India continues to be in the category of low prevalence countries with overall prevalence of less than one per cent.

9.2 Prevalence of HIV

The prevalence of HIV in various States/UTs based on data collected during HIV surveillance conducted during 1998-2002 from sentinel sites across the country is given in **Annex-III**.

NACO has categorised various States/UTs based on the estimated prevalence rates of HIV among adult population (15-49 years) from National Sentinel Surveillance round 2002:

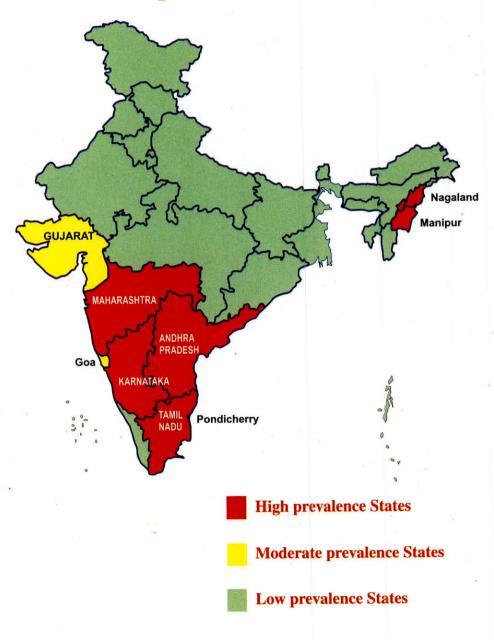
Group-I (high prevalence States) includes Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur and Nagaland.

Group-II (moderate prevalence States) includes Gujarat, Goa, Pondicherry.

Group-III (low prevalence States) includes the remaining States/UTs.

The status of HIV prevalence rate in various states of the country is given in the map below:

Status of IV Epidemic in India 2002



Though Goa is categorised as a moderate prevalence State and Mizoram and Dadra and Nagar Haveli are categorised as low prevalence States, the Sentinel Surveillance 2002 data revealed that these States had either reached or crossed the one per cent mark of HIV prevalence among ante-natal women. The prevalence of HIV among ante-natal women in all States/UTs except Meghalaya, Assam, Arunachal Pradesh & Lakshadweep indicates that HIV infection has been spreading from high risk groups to the general population.

9.3 Surveillance of AIDS Cases

According to the Sentinel Surveillance 2002, there are an estimated 4.58 million HIV cases in the country. Fifty four thousand and sixty one full blown AIDS cases have been reported as on 31 July 2003. The details are given in **Annex-IV**. The year-wise details of AIDS cases detected during 1997-98 to 2002-03 is given below:

Period	No. of AIDS cases	Increase (per cent)
As on 31.3.98	5204	-
As on 31.3.99	7012	1808 (35%)
As on 31.3.00	11251	4239 (60%)
As on 31.3.01	20304	9053 (80%)
As on 31.3.02	34362	14058 (69%)
As on 31.3.03	48933	14571 (42%)
As on 31.7.03	54061	5128 (10%)*

^{*} Increase is for a period of 4 months only.

AIDS cases detected have shown an increasing trend and the increase has been significant in the years 1999-2000, 2000-01 and 2001-02 which recorded increase of 60 per cent, 80 per cent and 69 per cent respectively. AIDS cases have been reported in all States except Arunachal Pradesh, Dadra & Nagar Haveli and Lakshadweep. Out of 54061 AIDS cases, high prevalence states of Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra, Nagaland and Manipur account for 43876 (81 per cent) AIDS cases. Of the high prevalence States, Tamil Nadu alone accounts for 24667 (46 per cent) AIDS cases.

9.4 Deaths due to AIDS

The details of deaths due to AIDS, as reported to NACO, are shown below:

Calendar year	No. of deaths of persons having AIDS	Cumulative	
1999	=	1770	
2000	387	2157	
2001	778	2935	
2002	731	3666	

9.5 Probable source of infection of reported AIDS cases in India

The source of infection of AIDS cases reported to NACO can be broadly divided into five categories, namely sexual transmission, parents to child transmission, blood and blood products, intravenous drug users and others (history of which is not available). Since transmission of AIDS from blood and blood products and parents to child could be

controlled, NACO had targeted to bring down the transmission of HIV/AIDS from blood to below one *per cent* and implement Protocol of Prevention of Parents to Child Transmission (PPTCT) in all medical colleges and district hospitals of high prevalence States and medical colleges of low prevalence States/UTs by September 2002. Distribution of AIDS cases reported during 1998-99 to 2002-2003 among the above categories is given below:

No. as on	Total Reported AIDS cases	Sexual Transmission	PPTCT	Blood/Blood Products	Injecting Drug User	Others
31-3-99	7012	5298(75.56%)		546(7.79%)	468(6.67%)	700(9.98%)
31-3-00	11251	9097(80.85%)	81(0.72%)	621(5.52%)	596(5.30%)	856(7.61%)
31-3-01	20304	16768(82.58%)	361(1.78%)	805(3.46%)	844(4.16%)	1526(7.52%)
31-3-02	34362	29076(84.62%)	816(2.37%)	1087(3.16%	1107(3.22%)	2276(6.63%)
31-3-03	48933	41633(85.08%)	1299(2.65%)	1363(2.79%)	1287(2.63%)	3351(6.85%)

The sexual route remains the most probable source of infection of AIDS cases, followed by blood and blood products and IDU. Another probable source of infection which is increasing is parents to child transmission which rose from 0.72 per cent in 2000 to 2.65 per cent in 2003. Though blood transmission of AIDS has come down from 7.79 per cent in March 1999 to 2.79 per cent in March 2003, the number of cases has been increasing in absolute terms and the target of keeping it below 1 per cent has still not been achieved. Similarly, PPTCT has been implemented in only 74 out of 82 medical colleges and 15 out of 133 district hospitals of high prevalence states till January 2003.

10 Priority targeted interventions for groups at high risk

This component of NACP-II aims to reduce the spread of HIV in groups at high risk by identifying target populations and providing peer counselling, condom promotion, treatment of STIs and client programmes. The activities could be locally modified and delivered largely through Non-Governmental Organisations, Community Based Organisations (CBOs) and the public sector.

10.1 Targeted Interventions

Targeted interventions (TIs) are globally perceived as the most effective strategy for arresting the spread of HIV/AIDS. Activities are designed basically to inform, educate and counsel the marginalised and vulnerable sections of the population, which are at high HIV risk and provide them with some preliminary care and support so that they move towards behaviour change and healthy living practices. These high risk groups are commercial sex workers, men who have sex with men, injecting drug users, street children, truck drivers and migrant labour. The NGO advisor in the State AIDS Control Society is expected to manage and guide the targeted intervention programme. NACO has formulated a costing pattern for each of the targeted interventions in the identified/marginalised group. The targeted interventions are to be monitored and evaluated regularly.

As of June 2003, 792 targeted intervention projects had been undertaken by the SACS through NGOs among various categories of high risk groups (HRG) across the country. Quarterly reports (OMR-I) on targeted interventions were to be submitted by SACS/MACS and the overall position was to be compiled at the headquarters. The data

relating to coverage of target population was not available with NACO as the compilation of output monitoring reports was still at a trial stage. The category-wise break-up of TIs being undertaken by societies as of June 2003 was as under:

S. No.	High risk group	TIs being conducted	Percentage
1	Female Sex Workers (FSW)	176	22
2	Injecting Drug Users (IDU)	63	8
3	Men having sex with Men (MSM)	25	3
4	Truckers	140	18
5	Migrant Workers	115	15
6	Others	273	34
0.	Total of TI Projects	792	100

The World Bank in its mid-term review (May 29-July 31, 2002) entitled 'The Mission Report', pointed out the need for better focus of TIs on truly high risk groups rather than dilute the programme with emphasis on other population (i.e. migrants, slum dwellers). It is evident from the above table that currently 388 (49 per cent) of the TIs involved migrants and others. Thus, the focus of the TIs project was not as advised by the World Bank. Audit scrutiny of TIs projects of some state societies brought out the following findings:

Tamil Nadu:

- Funds (Rs. 16.25 lakh) given to Salem which had high incidence of AIDS were less than that given to 9 NGOs in Kanya Kumari (Rs. 27.49 lakh), 10 NGOs in Thanjavur (Rs. 17.23 lakh), 12 NGOs in Tirunelveli (Rs. 23.75 lakh) and 14 NGOs in districts with lower incidence of AIDS cases (Rs. 46.80 lakh).
- ▶ Planned number of TIs were not conducted. Against 77 TIs for CSW, 56 TIs for truckers, 29 TIs for MSM and 30 TIs for IDUs, only 52 (CSW), 40 (truckers), 6 (MSM) and 1 (IDU) TIs could be conducted.
- ➤ No study was conducted on how effectively the NGOs had addressed specific issues relating to HIV/AIDS prevention. BSS Rural Round-II stated NGOs role regarding creating awareness was very poor.
- ➤ Despite high prevalence of IDUs (24.6 to 33.8 per cent), no TI for this group was conducted during 2002-03 in any of the major cities except Chennai.

Maharashtra

➤ Neither was a baseline survey conducted by Societies nor were TIs conducted in 21 districts of the State including Pune and Sangli.

Karnataka

Against planned targets, only 59 per cent CSWs, 67 per cent truckers and 63 per cent MSM were covered through TIs while five very badly affected districts of the States were not covered at all.

Andhra Pradesh

➤ While IDUs were not covered during 1998-2003, counselling for MSM and delivery of condoms were not implemented during 1998-2001.

Andaman and Nicobar Islands

Society could cover only 30 to 60 per cent of targeted CSW, migrants, seamen and dock workers. Due to delay in selection of NGOs, people living at high risk could not be identified.

Pondicherry

The society implemented 'Truckers Project' alone and NACO observed that there was no system of regular evaluation by the society and monitoring was insufficient.

Madhya Pradesh

Against 57, only 12 TI projects were finalized during 1998-2003 in which only 6795 persons were covered against the proposal of 61,200.

Punjab

No targets of TIs to be covered during 1999-2000 and 2000-01 were fixed. While against target of 15 and 22 TIs for 2001-02 and 2002-03, achievement was only 10 and 14 TIs respectively, projects for MSM and IDUs had not been started as of March 2003.

Mizoram

Percentage of physical achievement with reference to the targets for 1999-2000 to 2001-02 varied from 25 per cent to 64 per cent (CSW), 45 per cent to 192 per cent (truckers), 92 per cent to 107 per cent (IDU) and 57 per cent to 204 per cent (auto/taxi drivers).

Assam

While annual targets for TIs were not fixed during 1999-00 and 2000-01, only 22 of the 37 projects targeted, were taken up during 2000-03. Against the target of 2750 CSWs, 1.79 lakh truckers and 3000 IDUs, only 1150 CSWs, 70,175 truckers and 495 IDUs respectively could be covered.

Manipur

Against 1.03 lakh high risk population targeted to be covered, 0.78 lakh could be covered. The expenditure incurred on the coverage of CSW, truckers and MSM exceeded the admissible amount by Rs. 51.92 lakh.

Rajasthan

No targets were fixed during 1998-2001. Against the target for 2001-02 and 2002-03 for 25 and 18 TI projects, funds were released to 11 and 9 TI projects only. High risk groups of MSM and IDUs were not covered.

Chandigarh

Against 1.10 lakh truckers, 50,000 rickshaw pullers and their families and 12,800 street children planned to be covered during 1999 to 2003, only 17,256 truckers, 27,586 rickshaw pullers and 3134 street children were covered.

Haryana

➤ Due to non-availability of data, IDUs and MSM had not been covered. During 2000-03, only 1000 CSWs and 30,000 truckers were covered.

Uttar Pradesh

➤ No target was fixed for any of the groups at high risk. During 1998-2003, the society conducted only 8 TIs for CSWs, 13 TIs for truckers and 7 TIs for composite targeted projects at Indo Nepal Border.

Meghalaya

Only two projects for truckers were taken up by the NGOs, which remained confined to Ri-bhoi and Jaintia Hills districts. The NGOs also had targeted to cover other high risk groups, which remained uncovered.

Gujarat

➤ Despite involvement of 76 NGOs in TI activities, no TIs were conducted for IDUs during 1998-2001 and a project for truckers was taken up only from 2002.

Dadra & Nagar Haveli

No TI project among high risk groups was conducted due to non-filling up of post of NGO advisor in the SACS.

Chhattisgarh

➤ No TI was conducted against the target of 10 set in the annual action plan of 2002-03.

10.1.1 Evaluation of Targeted Intervention Projects

A National TI evaluation was conducted by Sexual Health Resource Centre (SHRC) in partnership with NACO during 2003 to develop recommendations that would strengthen The TI programme in India. The Centre selected 54 TIs spread across 17 States for the purpose of the study. During the study, the average quality of different elements of TIs viz. Condom promotion, STD component, Behaviour Change Communication (BCC), Enabling Environment, Needs Assessment, Proposal development, Baseline study and Project Management, was assessed. The average quality of these elements of TIs was found to be in the range of 21 per cent to 41 per cent and the average quality of TIs in India logged at a poor 37.8 per cent. The study observed that the average quality of TIs needed to be enhanced if TIs are to deliver the expected results. Inputs (training and funding) provided by SACS were much below what was needed and the present level of inputs by SACS would not be able to initiate and support the quality that is expected from an effective intervention. The study expressed the need to set up systems to strengthen targeted interventions.

NACO should ensure that progress of TIs is regularly reported by SACS to NACO through Computerized Management Information System (CMIS) and simultaneous feedback be given by NACO.

10.1.2 Mapping of High Risk Areas

According to the Project Implementation Plan (PIP), efficient mapping was to be conducted by the Societies to identify size and number of target groups, their risk behaviour and their environment. The status of mapping of high risk areas as on October, 2003 was as under:

Societies in which mapping of high risk areas and target groups completed	Societies in which mapping of high risk areas and target groups completed but final report awaited	Societies in which mapping of high risk areas and target groups is in progress	Societies in which mapping of high risk areas and target groups initiated after April 2003	Societies in which mapping of high risk areas and target groups is yet to be taken up
J & K, Delhi, Mizoram, Nagaland, Karnataka, Assam, Chandigarh, Dadra & Nagar Haveli, Tamil Nadu, Chennai, West Bengal, 11 districts of Orissa, areas covered under AVERT project in Maharashtra	Gujarat, Kerala, Andhra Pradesh, Uttar Pradesh, Jharkhand, Uttaranchal, Bihar, Madhya Pradesh	Chhattisgarh (since April 2003) Ahmedabad MC (since January 2003)	A & N Island, Daman & Diu, Himachal Pradesh, Pondicherry, Punjab, Rajasthan, Sikkim, Tripura, Maharashtra SACS, Mumbai District AIDS Control Society, Manipur, Arunachal Pradesh	Lakshadweep, Meghalaya, Haryana, Goa

Mapping exercise for high risk groups should be conducted expeditiously for correctly ascertaining the size of high risk population. In the absence of this information, the targeted intervention being conducted by societies is likely to lose its focus.

10.1.3 Costing pattern of targeted interventions

Analysis of the data in respect of test checked SACS/MACS revealed that expenditure per unit ranged between Rs. 53 (Orissa in 2002-03) and Rs. 10120 (Assam in 1999-2000) for CSWs against NACO norms of Rs. 1208.50 per unit; between Rs. 13 (Maharashtra in 1999-2000) and Rs. 16737 (Assam in 2001-02) for truckers against NACO norm of Rs. 94.70 per unit; between Rs. 20 (Orissa 2002-03) and Rs. 259 (Rajasthan in 2002-03) for migrant labourers against NACO norm of Rs. 241.60; between Rs. 55 (Andhra Pradesh in 2002-03) and Rs. 1051 (Rajasthan in 2001-02) for street children against NACO norm of Rs. 718 per unit; between Rs. 27 (Andhra Pradesh in 2002-03) and Rs. 2684 (Manipur during 1999-2003) against NACO norm of Rs. 1208.50 for men having sex with men; and between Rs. 755 (Mizoram in 1999-00) and Rs. 1451 (Mizoram in 2001-02) against NACO norm of Rs. 1208.50 for injecting drug users. (Details given in **Annex-V**)

The reasons for wide divergence in expenditure on different components from NACO norms, need to be examined.

10.2 Condom Promotion

Since in nearly 85 per cent of the cases HIV is acquired through sexual transmission, condom promotion is critically important in HIV prevention and control. The objective of the condom promotion programme is to ensure easy access to affordable and acceptable condoms of good quality to promote safe sexual encounters.

The Societies procure condoms through the Department of Family Welfare and distribute these under the scheme for free distribution and social marketing. Year-wise position of condoms distributed by Societies under free/social marketing scheme is given below:

Year Total no. of Societies in respect of		No. of Societies distributing condoms under		Distribution of condoms (Pieces in lakh)		
	which information received	Free distribution	Social marketing	Free distribution	Social marketing	
1998-99	30	12	02	524.38	15.49	
1999-00	30	13	02	647.39	0.31	
2000-01	30	17	14	527.15	69.60	
2001-02	30	23	17	576.27	126.78	
2002-03	30	26	18	907.59	90.39	

The distribution of condoms by the Societies under free distribution increased from 524.38 lakh to 907.59 lakh pieces and under Social Marketing Scheme it increased from 15.49 lakh to 90.39 lakh pieces. However, all Societies were not involved in distribution of condoms. Details of distribution of condoms by Societies are given in Annex-VI. While Maharashtra and Mumbai Societies had performed exceedingly well and distribution of condoms by these Societies alone contributed 65 per cent under the Social Marketing Scheme, the performance of other Societies needs improvement.

10.2.1 Social marketing of condoms by NACO

Free distribution of condoms has its drawbacks, as it is very difficult to continue the supply line and also creates doubts about the actual use of freely distributed condoms. Therefore, social marketing has been accepted as the most effective strategy for condom promotion in the country. This strategy not only helps to increase the acceptability but also provides easy access to the users while improving the sustainability of condom provision. Under this scheme, government provides condoms at highly subsidised prices to the marketing companies and they in turn, distribute it to the States/UTs through their marketing network. The retail outlet is the last outlet and the customer procures the product from the retail outlet.

In the 14th Meeting of the National AIDS Control Board held on 11 August 1998, a proposal for introduction of social marketing of condoms under the National Family Welfare Programme in the National AIDS Control Programme was approved by the Board. NACO was to work out the quantity of condoms required for the social marketing scheme and the financial implication. During the year 2000-01, NACO had earmarked distribution of 3.30 million pieces of Deluxe Nirodh under the social marketing scheme. The scheme failed to take-off as NACO could not purchase condoms required for distribution under the scheme. No reasons were furnished by NACO for its failure to procure condoms.

Some significant audit findings in different states are discussed below:

- Himachal Pradesh, Chandigarh, Haryana
- ➤ One Hundred and forty condom vending machines (CVM) costing Rs. 9.80 lakh in Himachal Pradesh, 20 CVMs in Chandigarh and 34 CVMs costing Rs. 3.30 lakh in Haryana were inoperative since 1998, June 1999 and March 1997 respectively for different reasons.
- Pondicherry
- No attempts were made to promote the female condom in the UT inspite of its inclusion in their PIP for 1999-2002
- Punjab
- ➢ Of 85 CVMs purchased by DHS in March 1997, 55 immediately went out of order. NACO directed (February 1998) the DHS to get the evaluation of the design/fabrication of the machines done from a government agency like IIT before taking delivery of the remaining 300 machines for which orders were placed in November 1997. Despite this directive, DHS took delivery of the remaining 300 machines in March 1998. Audit noticed that out of total 385 condom vending machines (CVM) purchased at a total cost of Rs. 22.61 lakh, 230 CVMs were non-functional as of May 2003.
- Mumbai
- Against estimated requirement of 33 lakh condoms per annum to be distributed in red light area of Mumbai by AIDS, STD and Health Action (ASHA), only 23.73 lakh, 13.76 lakh and 17.64 lakh condoms were supplied during 2000, 2001 and 2002 respectively.
- Karnataka
- ➤ 15.45 lakh condoms worth Rs. 9.83 lakh distributed to four NGOs for social marketing were actually distributed free of cost by the NGOs. Despite directions from the Ministry, the amount was not recovered by the Society from the NGOs.

10.2.2 Awareness of condoms in urban & rural areas

A Behavioural Surveillance Survey (BSS) was conducted by ORG Centre for Social Research on behalf of NACO in the year 2001 to assess the availability and accessibility of condoms. At the national level, the data suggests a fairly high level of condom awareness but with marked regional variations. Punjab and Himachal Pradesh had more than 95 per cent awareness levels while Delhi, Haryana, Goa, Jammu and Kashmir and Kerala had an awareness level ranging between 85 and 95 per cent. Except Andhra Pradesh (84.7 per cent), the neighbouring Southern States had awareness figures below 75 per cent. While awareness of condoms in urban areas of the country was fairly high (90.4 per cent) it was relatively low in rural areas particularly in the States of Assam (69.5 per cent), Bihar (64.8 per cent), Karnataka (64.8 per cent), Madhya Pradesh (69.8 per cent), Maharashtra (67.2 per cent), Orissa (61.2 per cent), other North Eastern States (62 per cent) and Tamil Nadu (67.6 per cent). The details are given in Annex-VII.

10.2.3 Use of condoms

The programme aims to promote condom use in not less than 90 per cent of the population in high-risk categories like commercial sex workers. Behavioural surveillance survey conducted in 2001 by ORG revealed that 57 per cent of brothel based female sex workers and 46 per cent non-brothel-based female sex workers reported consistent condom use with paying clients. Only 21.3 per cent of brothel-based and 20.2 per cent non-brothel-based CSWs reported consistent use of condoms with non-paying clients. The details are given in **Annex -VIII**.

10.2.4 Accessibility of condoms

The programme strives to provide good access to condoms by ensuring that 75 per cent of the population can access condoms within 30 minutes from their residence. However, BSS conducted in 2001 by ORG Centre for Social Research on behalf of NACO revealed that the proportion of respondents who had reported that it would take them less than 30 minutes to obtain a condom varied considerably amongst states. Except Delhi (66.4 per cent), Kerala (74.2 per cent) and Punjab (71.5 per cent), accessibility to condoms by the respondents of other States was poor. In rural areas, except Kerala (73.7 per cent) and Delhi (66.7 per cent), all other states reported poor accessibility to condoms. The details are given in **Annex -IX**.

Since social marketing has been accepted as the most effective strategy for condom promotion, NACO may consider procuring condoms under Social Marketing Scheme for onward supply to SACS/MACS. Recommissioning of condom vending machines in public places, especially in red-light areas, may be considered to facilitate availability of condoms to sex workers.

10.3 Strengthening of STD clinics

The close link between HIV and STD made it necessary to strengthen the STD Control Programme at every level. Since 1992, the STD Control Programme has been integrated with the NACP. Various studies indicated that HIV infection could be

contained by effective and strong STD control strategies. The quality of STD services and their expansion, therefore, assume paramount importance.

In Phase-I of the NACP, NACO had strengthened 504 STD clinics all over the country to provide services to STD patients, thus exceeding the target of strengthening 372 Government STD Clinics. Out of these, 96 clinics were established in medical colleges, 267 clinics at district headquarters in different States/UTs and 141 clinics at important sub-divisional/taluka towns. In order to cover uncovered medical college hospitals and districts, it was decided in the 15th meeting of the National AIDS Control Board held on 16 July 1999 to strengthen STD clinic services in 282 districts and 57 medical colleges by providing Rs. 1.00 lakh per clinic at district level and Rs. 1.10 lakh per clinic in Medical College Hospitals as one-time assistance for equipment, besides Rs. 1.00 lakh per clinic per annum for the purchase of consumables. However, it was observed that the pace of strengthening of STD clinics in NACP Phase-II was rather slow. Out of 339 additional STD clinics proposed to be strengthened in Phase-II, only 90 (27 per cent) could be strengthened as of March 2003. The year-wise progress is given below:

Year Existing STD clinics		New STD clinics proposed to be strengthened	Total STD clinics strengthened	
1999-2000	504	Nil	504	
2000-2001	504	Nil	504	
2001-2002	504	27	531	
2002-2003	531	165	594	

NACO could not furnish state-wise details of the 594 STD clinics strengthened as of March 2003. However, it furnished a list of 674 STD clinics being provided financial support during the financial year 2003-2004 (against physical target of strengthening 757 STD clinics during 2003-2004). Scrutiny of list of STD clinics supplied to audit with reference to districts in the country as per census 2001 revealed that districts ranging between 7 per cent and 75 per cent in the States/UTs did not have STD clinics at any level i.e. district hospitals, medical college hospitals or taluka/sub-divisional level. (Details are given in **Annex-X**)

Test check of the records of societies and test checked STD clinics revealed that a large number of them could not perform satisfactorily due to the following reasons

Reasons	States	No. of clinics affected
Equipment not supplied	West Bengal, Karnataka, Jammu & Kashmir, Haryana and Maharashtra	29
Equipment lying idle	Kerala, Pondicherry	07
Recurring assistance for purchase of consumables and medicine not provided to STD clinics	Jammu & Kashmir	07
Non-functional STD clinics due to shortage of specialists, medical officers and equipment	Manipur	06
Mobile STD clinics lying unused	Delhi, Maharashtara	04
Non-functional STD clinics due to lack of infrastructure	Himachal Pradesh	15
STD clinics not equipped with prescribed essential equipment like rotating fan, waterbath serological, timer clock, VDRL rotator, refrigerator, autoclave etc.	Madhya Pradesh	45

Further, in one STD clinic at **Meghalaya** and two STD clinics at **Tripura** although the records of the State Aids Society showed that medicines had been issued to these clinics, these had not been received by them. This not only affected the functioning of the clinics but also pointed towards unauthorised diversion/misuse of the medicines. The State Societies could not clarify the matter.

10.3.1 Surveillance for STD cases

During the years 1999-2002, STD cases showed an increasing trend as shown below:

Year	No. of cases detected				
	Male	Female	Total cases detected		
1999	148572	155366	303938		
2000	171870	245040	416910		
2001	183066	230724	413790		
2002	166288	279056	445344		

10.3.2 Facility survey of STD Clinics

A study, based on visits to 321 STD clinics in 23 States/UTs, was conducted by senior faculty members of medical colleges of the respective States/UTs at the behest of NACO during 1999-2001 to assess the functioning, quality of treatment being provided, availability of trained staff, equipment, condoms and drugs in the STD clinics. The study revealed that attendance at most of the clinics was poor. The poorly performing states were Punjab, Haryana, Rajasthan, Madhya Pradesh and Manipur in the North-East. While Maharashtra, Tamil Nadu, West Bengal and Uttar Pradesh had more than 50 patients a day, most others had less than 10 patients per day. One-third of the clinics in 23 States/UTs surveyed, were not located in accessible places; adequate space for STD clinics was reported from only about 44 per cent of the clinics and 50 per cent of the clinics reported inadequate space for labs. Availability of proper instruments, specially for female patients was reported by only 33 per cent of the clinics. The clinics lacked trained manpower at all levels- doctors, nurses, laboratory technicians, counsellors and para-medical staff. Only 33 per cent of the clinics had trained medical personnel. Sixty six per cent of the clinics were manned by untrained para medical personnel. Fifty six per cent of the clinics had STD specialists, 17 per cent had a gynaecologist and 31 per cent had a general duty medical officer as its in-charge.

It was also noticed in the study that condom distribution was not being taken up actively as only 36 per cent of the clinics provided condoms to patients after counselling. No clinic in Bihar and Tamil Nadu had an adequate quantity of condoms. It was also observed that appropriate history and examination was not being maintained/done in one-third of the clinics. About 70 per cent of the health care providers were treating patients without waiting for the lab results. Availability of drugs was reported to be sufficient only in the smaller States/UTs of Andaman & Nicobar, Assam, Pondicherry & Sikkim. In the remaining states, only 50 per cent of the clinics had sufficient drugs. It was also seen that the counselling relating to STD/HIV and safe sex was poor and given only in about 45 per cent of the clinics.

In view of these conditions, the study recommended a major effort for revamping the STD clinics.

10.3.3 Distribution of condoms and availability of essential medicines at STD clinics

NACO has designed monitoring indicators to measure the proportion of STD clinics reporting distribution of condoms to clients after diagnosis and reporting adequacy of essential drugs for STD cases. The indicator-proportion of public sector STD clinics reporting adequate distribution of condoms to new STD patients after diagnosis measures the extent to which public sector units treating STD cases distribute condoms to all the diagnosed STD cases. Distribution of condoms/appropriate drugs indicates the effectiveness of services provided by the STD clinics in the public sector. NACO expects to increase the proportion of STD clinics reporting distribution of condoms to clients after diagnosis and reporting adequacy of essential drugs for STD cases to atleast 75 per cent by 2004. However, analysis of Computerised Management Information System (CMIS) reports for the period November 2001 to June 2003 revealed that only 0.39 per cent STD clinics in the year 2001, 18.93 per cent in 2002 and 9.27 per cent STD clinics in 2003 (upto June 2003) reported adequate distribution of condoms to new STD patients. In the case of proportion of STD clinics in the public sector reporting adequacy of essential drugs for STD cases, out of 766 STD clinics only 90(11.7 per cent) have reported 'such adequacy'. Out of 90 STD clinics during 2002 whose input formats were received in that year, only 59 STD clinics reported availability of essential medicines. While, in Andhra Pradesh, Assam, Delhi, Kerala and Maharashtra less than 50 per cent STD clinics reported availability of essential medicines, in **Delhi** only 14.3 per cent reported availability of essential medicines.

10.3.4 Laboratory test of STD cases

The results of laboratory tests of STD cases detected during 2001-2003 were as under:

Proportion of laboratory tests found positive by types of tests

	200	1	200	2	20	03
Type of test	per cent of STD clinics reported	per cent found positive	per cent of STD clinics reported	per cent found positive	per cent of STD clinics reported	per cent found positive
Syphilis-Dark Field Microscopy	3.26	7.69	65.27	8.04	48.96	10.02
Syphilis-VDRL	3.39	11.50	66.19	4.65	49.22	5.52
Syphilis-Rapid Plasma Reagin (RPR)	3.26	9.52	65.80	6.44	46.21	7.95
Bacterial Vaginosis	3.39	6.41	64.62	13.18	49.22	17.25
Gonorrhoea-Direct Smear	3.39	31.72	66.06	16.92	49.22	12.59
Gonorrhoea-Culture	3.26	25.00	64.36	20.21	48.96	7.16
Chlamydia	3.26	0.00	63.84	19.01	41.38	22.06
Chancroid-Gram's	3.39	5.97	65.14	14.05	48.96	08.75
Trichomonasis	3.39	10.62	65.54	16.59	49.22	10.77
Candidiasis	3.39	51.13	64.62	25.37	48.96	18.74

Since the data for the year 2001 relates to a period of 2 months only, no conclusion could be derived from the percentage of patients found STD positive during that period. The percentage of tests found STD positive during 2002 & 2003, showed an increasing trend in case of Syphilis- Dark Field Microscopy, Syphilis VDRL, Syphilis RPR, Bacterial Vaginosis and Chlamydia. As STD patients are more susceptible to HIV/AIDS, the increasing trend indicates that HIV/AIDS cases may increase in future. There is a pressing need to arrest the trend of STD cases.

10.3.5 Counselling to STD patients

In terms of the scheme guidelines, counselling is to be provided through all STD Clinics. From the information supplied to audit, it was noticed that the number of new patients who were provided counselling through STD Clinics was very low. The yearwise break-up is as under:

Year	No. of STD clinics which reported through CMIS to NACO (Percentage)	Percentage of new STD patients counselled
2001	0.99	105.23
2002	53.13	30.66
2003(June 2003)	32.38	48.51

The data on percentage of new STD patients counselled during 2001 could not be relied upon as less than 1 *per cent* STD clinics had reported for the indicator-"New STD patients counselled". The reporting from STD clinics remained poor even during 2002-03. While 30.66 *per cent* new STD patients were provided counselling services during 2002, the percentage of new STD patients who were counselled at STD clinics had only marginally improved (48.51 *per cent*) during 2003.

As STD clinics are important in preventing the spread of HIV/AIDS, NACO should strengthen and revamp these with specialists, trained staff and equipment.

11 Preventive intervention for the general community

11.1 Information, Education and Communication

Information, Education and Communication (IEC) is one of the most important strategies to fight HIV/AIDS. In the absence of a vaccine or a cure, prevention is the most effective strategy for the control of HIV/AIDS. Since the majority of population in India is still uninfected, it becomes essential to not only raise awareness levels but also bring out behavioural changes through intensive IEC activities. Phase-II of NACP seeks to attain an awareness level of not less than 90 per cent among the youth and others in the reproductive age group. A national baseline behavioural surveillance survey (BSS) was conducted among general population, female sex workers and their clients, men having sex with men and intravenous drug users during 2001-2002 to assess the awareness level of HIV/AIDS and STD. Some of the important findings of the survey are given below:

(i) Ever heard of HIV/AIDS?

At the national level, 76 per cent of the respondents surveyed during baseline surveillance were aware of HIV/AIDS. The percentage ranged between 40 and 98 in the

22 States surveyed by ORG-Centre for Social Research. States like Andhra Pradesh, Goa, Himachal Pradesh, Kerala, Manipur and Punjab recorded an awareness level of more than 90 per cent. States like Bihar (40.3 per cent), Gujarat (55 per cent), Madhya Pradesh (56 per cent), Uttar Pradesh (51 per cent) and West Bengal (58 per cent) recorded poor awareness of HIV/AIDS. Eighty nine per cent of respondents in urban areas were aware of HIV/AIDS while 72 per cent of respondents in rural areas were aware of HIV/AIDS. The rural-urban disparities were rather prominent in the States of Uttar Pradesh, Madhya Pradesh, West Bengal, Gujarat, Bihar, Assam, Orissa, Rajasthan and Sikkim. Male-female respondents exhibited similar trends in awareness levels (details are given in Annex –XI).

(ii) Awareness of transmission through sexual contact

More than 85 per cent cases of HIV infections are caused by sexual contact. The Behaviour Surveillance Survey (2001) conducted by ORG-Centre for Social Research in 22 States among the general population revealed that 71 per cent of respondents at the national level were aware that HIV/AIDS could be transmitted through sexual contact. In urban areas, 85 per cent and in rural areas 67 per cent were aware of the transmission of HIV/AIDS through sexual contact. Kerala had the highest (97.7 per cent) awareness level among all reporting units (State sampling units) followed by Goa with 91.3 per cent awareness level. Among the Northern States, Delhi, Himachal Pradesh and Punjab were found to have better awareness levels (more than 85 per cent) compared to their neighbouring States. Among the North Eastern States, Manipur had recorded the highest proportion of aware respondents (88.8 per cent). However, the States of Bihar (37 per cent), Gujarat (52 per cent), Madhya Pradesh (51 per cent), Rajasthan (57 per cent), Uttar Pradesh (45 per cent) and West Bengal (51 per cent) recorded poor awareness level (details in Annex -XII).

(iii) Knowledge of both methods of prevention

Since sexual contact is the primary source of infection of HIV/AIDS, the infection can be prevented to a very large extent through practising safe sex i.e. by consistent use of condoms and having one uninfected and faithful sexual partner. The Survey revealed that only 47 per cent among the general population {Annex-XIII (a)} and 66 per cent of commercial sex workers {Annex-XIII (b)} and 68 per cent clients of female sex workers {Annex-XIII (b)} were aware of the methods of prevention of HIV/AIDS. Poor awareness of methods of prevention of HIV/AIDS is alarming, particularly among female sex workers and their clients who are considered high risk groups.

(iv) Misconceptions regarding transmission of HIV

The Survey also revealed that a sizeable proportion of the general population in almost all States harboured many misconceptions regarding the modes of transmission of HIV. Only 21 per cent of the general population {Annex-XIV (a)} were aware that HIV could not be transmitted through mosquito bites and sharing a meal with an infected person. Of the 22 States surveyed, 11 States reported awareness of below 20 per cent. The misconception regarding modes of transmission of HIV/AIDS also existed among high risk groups where only 29 per cent FSW {Annex-XIV (b)} and 39 per cent clients of FSW {Annex-XIV (b)}, had correct information on HIV transmission.

The findings of second round Behavioural Surveillance Survey-Rural, conducted (February-June 2002) by Dalal Consultants and Engineers Ltd. revealed that in Tamil Nadu misconception about treating HIV/AIDS patients persisted even among doctors. Out of 600 respondents, 22 per cent among allopathic doctors and 5 per cent among indigenous practitioners were not willing to treat HIV/AIDS cases although 35 per cent of them who had fears/doubts about contracting HIV/AIDS had actually been trained in handling HIV/AIDS cases.

(v) Ever heard of STD?

Persons suffering from STD have a higher chance of contracting HIV/AIDS. BSS (2001) revealed low awareness (32 per cent) of STD across the country. The level of awareness ranged between 6.5 per cent and 41.7 per cent in various states except Andhra Pradesh, Gujarat, Kerala and Punjab where awareness of STD was above 50 per cent. Goa, which is considered a moderate prevalence State in respect of HIV, logged a poor awareness level of 6.5 per cent (details are given in **Annex -XV**).

(vi) Linkage between STD and HIV/AIDS

The level of knowledge about the linkage between STD and HIV across the country was very low (21 per cent). The awareness level in different states ranged between 5.1 per cent and 41 per cent. Again Goa recorded the poorest awareness level at 5.1 per cent. Considering the significantly higher chance of STD patients getting infected with HIV, the States need to gear up this component of the NACP. Poor awareness pointed towards the failure to educate the general people as well as those constituting various risk groups about the linkage between STD and HIV. The statewise details about the awareness level in this regard are given in **Annex -XVI**.

There is a lack of awareness about HIV/AIDS and also serious misconceptions about the modes of transmission of the infection. This is true not only of the rural population with lower levels of literacy but also of literate urban population like doctors. The level of awareness among the masses thus needs to be raised by conducting meaningful programmes like special plays, documentary films etc. with mass participation by general public Panchayats and other local bodies.

11.1.1 Use of Electronic Media

NACO uses the reach of Doordarshan and private satellite channels for telecasting messages on HIV/AIDS prevention and control. These include messages on sexually transmitted diseases, blood safety and voluntary blood donation. The impact of some of these programmes on general viewers/listeners of the electronic media is discussed below:

Chat shows -'Khamoshi Kyon' and 'Talk Positive': Poor viewership

NACO produced a thirteen episode chat show in English and Hindi. The chat show in Hindi was entitled'- 'Khamoshi Kyon' and in English it was titled 'Talk Positive'. The former, targeted at semi-urban and rural audiences, was telecast on Doordarshan at 10 P.M. every Wednesday from 5 December 2001 and the latter, targeted

at urban audiences, was telecast on Zee News at 2.00 P.M. every Saturday from 15 December 2001. NACO spent Rs. 2.24 crore on the production, telecast and publicity of these programmes.

The Centre for Media Studies (CMS), an independent research organisation, conducted a study during August 2002 and came to the following important conclusions:

- (i) Both programmes had poor viewership. While only 20.4 *per cent* respondents had heard of 'Khamoshi Kyon', only 9.9 *per cent* of them had seen any episode of this show. Similarly, only 20.5 *per cent* respondents had heard of the programme 'Talk Positive' and 7.9 *per cent* had seen some episodes of this show.
- (ii) 'Khamoshi Kyon' was targeted towards the semi-urban and rural audiences. However, the audience interacting with the panel was found to be mostly city-based and there was no representation from the semi-urban or rural areas.
- (iii) Though 'Khamoshi Kyon' was meant for rural and semi-urban audiences of the Hindi speaking States, the audience and the panel of the chat show were conversing in English.
- (iv) 'Talk Positive' was targeted at urban audiences which have access to satellite television. According to the National readership survey 1999, availability of Zee News channel in top 8 metro cities was as low as 0.7 per cent compared to other Satellite channels and average viewership was also found to be very low at 0.6 per cent. Hence, in view of better availability of other satellite channels like Zee TV (55.5 per cent), Star TV (47.9 per cent), Sony Entertainment (45.1 per cent), Discovery (43.9 per cent), Star News (37.5 per cent) and with higher viewership of 32.1 per cent for Zee TV, 9.9 per cent for Star TV, 26.1 per cent for Sony Entertainment, 10.4 per cent for Discovery and 6 per cent for Star News; choosing Zee News Channel for the show was not justified.
- (v) The survey also revealed that usual period of watching television for 'Khamoshi Kyon' respondents was between 7 and 9 pm while for 'Talk Positive' respondents it was 9 to 11 pm. But 'Khamoshi Kyon' was telecast at 10 pm and 'Talk Positive' at 2.00 pm.

However, 89.7 per cent viewers of 'Khamoshi Kyon' and 81.5 per cent of 'Talk Positive' show reported that they were benefited from the show. This indicates that had the selection of the satellite channel and positioning of these shows been better, their impact would have been much greater.

'Kalyani': Utility of the programme not assessed

The Department of Health and Family Welfare and Prasar Bharti entered into a Memorandum of Understanding (MOU) in February 2002 to produce and telecast a programme named 'Kalyani' in a magazine format on six diseases including HIV and AIDS. The programmes were meant for telecast from 8 Regional Kendras namely Lucknow, Bhopal, Patna, Jaipur, Bhubaneshwar, Ranchi, Raipur and Guwahati. NACO was to provide Rs. 2 crore out of the total cost of Rs. 17.46 crore. The months of December 2002 and January 2003 were dedicated to HIV/AIDS. Though the episodes relating to HIV/AIDS were shown in the magazine 'Kalyani' during December 2002 and

January 2003, NACO had no information on dates and time of the telecast, contents of the spots aired, feedback and tapes of the programme to judge its utility. No impact evaluation of the programme was conducted by an outside agency even though the programme was being shown on Doordarshan for more than one year. In April 2003 it was decided that an independent evaluation could be done through an agency identified by the Ministry of Health and Family Welfare within three months but till June 2003, no such evaluation had been conducted. NACO stated (October 2003) that the evaluation of the programme was to be conducted at Ministry level and not by them.

'Spirit of Unity Concerts': Limited reach

NACO had also sponsored a television programme 'The Spirit of Unity Concerts'. The music and dance concerts were periodically held at Shri Satya Sai Baba Devasthana at Puttaparthi. Since NACO was sponsoring this programme on Doordarshan, informative and educative messages relating to HIV/AIDS were given along with the programme. The programme was telecast on Doordarshan National Network on Saturdays from 4 April 1998 from 7.30 pm. to 8.00 pm. and continued till 29 December 2000 for 106 episodes after which there was a break for eight months in the telecast. Its telecast was started again on Saturdays from 9.30 am to 10.00 am from 15 September 2001 and continued till 23 February 2002 for 18 episodes. Rs. 427.61 lakh was released by NACO during 1999-2002 for telecast of this programme.

Media Research Group (MRG), an independent research organisation, conducted a study during 1999-2000 and came to the following conclusions:

- (i) Only 28 per cent and 26 per cent of the viewers interviewed had respectively heard about the programme and seen it. Only 3 per cent had seen the programme regularly despite the fact that about 45 per cent of viewers interviewed watched TV at 7.30 pm.
- (ii) The viewership was slightly lower in urban areas than in rural areas. While 31 per cent of viewers had liked the idea of giving HIV/AIDS related messages/information alongwith the programme, 56 per cent of the viewers had liked it and 11 per cent did not like it.
- (iii) 'The Spirit of Unity Concerts' was a classical dance and music programme. Some viewers felt that the programme content had no relevance to the message on HIV/AIDS.

MRG concluded that instead of a programme like 'The Spirit of Unity Concerts', which has a limited reach, HIV/AIDS related messages should have been given at the time of Samachar/News and other popular prime time programmes. Inspite of the adverse findings of the study, the programme continued till 23rd February 2002 and no evaluation of the programme was conducted thereafter.

Jiyo Aur Jeene Do: Poor listenership

A special programme in the drama mode 'JIYO AUR JEENE DO' was devised for rural and migrant youth. The broadcast of this programme of ten minutes' duration was started from June 1998 at 8.00 pm. every Tuesday. Later, the radio serial was

broadcast on Sunday at 1.15 pm. In Phase-II of NACP, Rs. 5.78 crore was released for this programme during 1999-00 to 2002-03.

An evaluation of the programme 'JIYO AUR JEENE DO' conducted by Media Research Group in July-August 1999 revealed the following important findings:

- (i) Of the 79 per cent of general listeners of radio programmes, 27 per cent had listened to radio serial 'JIYO AUR JEENE DO'; of this 6 per cent had listened to it regularly.
- (ii) Listenership was at its peak (more than 40 *per cent*) in the evening (7-10 pm.) and the programme should have been aired at that time instead of 1.15 pm. on Sundays.

In spite of its limited reach, the programme showed a positive impact on its listeners. While 55 per cent of all listeners (general and high risk) had opined that the serial was very informative, 73 per cent opined that the information given about HIV/AIDS in the serial was easy to understand, 57 per cent had opined that the serial was very useful and relevant to listeners, 43 per cent had opined that the serial had helped much to increase their awareness and knowledge, while another 43 per cent had said that the serial had increased their knowledge to some extent. Similarly, while 42 per cent of the listeners had opined that the serial had prompted them to take precautions against spread of HIV/AIDS, 32 per cent said that the serial had prompted them to some extent to take precautions about HIV/AIDS. Knowledge about the routes of transmission of HIV/AIDS was much higher among listeners of the programme than among non-listeners.

NACO stated (October 2003) that the programme was currently being aired at different stations on Vivid Bharati and primary channel and had been allocated different timings. However, the most common time has been 8 pm on Tuesdays and Sundays. No evaluation of the programme was conducted after August 1999.

NACO Film Hit Parade: No Impact Assessment

NACO sponsored a one hour weekly programme titled 'NACO Film Hit Parade' on AIR – FM channel in Delhi since 1999 to combine entertainment and education in reaching out to urban youth. The programme was broadcast from 2 to 3 pm every Monday. NACO incurred an expenditure of Rs. 35.50 lakh during 1999-2000 to 2002-03 on the production and broadcast of the programme. In December 2002, it was proposed to replace it with a more popular programme like a modified version of Chat Chowk produced by BBC World Service Trust for Lucknow FM. But due to delay in analysing all aspects of the new format before January 2003, it was decided by NACO to grant an extension to the existing programme for a further period of 3 months (13 episodes) from January to March, 2003 and simultaneously conduct an impact evaluation of the programme during the extended period. However, no evaluation of the programme was conducted during this period. The reach and impact of the programme on the target population had not been assessed.

To maximise the impact of the electronic media in spreading the message of HIV/AIDS, it is recommended that due care should be taken in selecting the channel and the timing of broadcast so that the message reaches the maximum number of people.

Concurrent as well as periodical evaluation of the ongoing programmes need to be conducted for assessing their impact and taking corrective measures.

11.1.2 Rural outreach activities

For conducting rural outreach activities, NACO places funds at the disposal of Ministry of Information and Broadcasting (I&B) for getting these activities undertaken by their media units such as Song and Drama Division (S&DD), Directorate of Field Publicity (DFP) etc. S&DD presents cultural programmes for publicity on prevention of AIDS and DFP arranges film shows, photo exhibitions, group discussions, special interactive programmes and sensitisation workshops on prevention of AIDS. During the years 1999-2000 to 2002-03, Rs. 3.64 crore and Rs. 1.80 crore was sanctioned to S&DD and DFP, respectively, for undertaking publicity activities on prevention of HIV/AIDS. NACO did not have any information on the number of activities targeted to be undertaken by these units and the number actually conducted. No evaluation of the impact of these activities had also been conducted. This showed poor monitoring by NACO of utilisation of funds amounting to Rs. 5.44 crore.

11.1.3 School AIDS education programme

Imparting the right knowledge to young people on how to protect themselves against HIV/AIDS and to empower them with the skills to adopt a responsible lifestyle is an important component of NACP to check the growing prevalence of HIV/AIDS.

Under Phase-I of NACP, 17 States and UTs had implemented a programme on HIV/AIDS education in schools. Since the programme was not being implemented in a uniform and systematic manner and did not cover all the schools in the State/UT, a national plan was developed which aimed at integrating HIV/AIDS education programmes in the schools in a sustainable and cost-effective manner. NACB decided in July 1999 that all the schools in States/UTs would be covered in a phased manner under a National plan in a period of five years (i.e. by 2004). The activities would include training of teachers and peer educators among students, debates and discussions etc.

From the Rapid Assessment of Schools AIDS Programme conducted by NACO during January 2003, it was noticed that the programme had not been initiated in the States of Jharkhand and Haryana. NACO could not furnish the exact number of schools covered in Maharashtra and mentioned the achievement in the range of 2000 to 3000. This indicated that the reports furnished by Maharashtra SACS were vague and unreliable. In Uttar Pradesh where this programme had been initiated in 2000-01, not a single school had yet been covered under the programme. Similarly, in Punjab no school had been covered under the programme. The coverage of schools under the programme in other States was poor and ranged between 1 per cent and 59 per cent except in the State of Andhra Pradesh (100 per cent), Kerala (84 per cent) and Nagaland (85 per cent) (details of Statewise coverage has been given in **Annex-XVII**).

Of the 28 States/UTs where Schools AIDS Education Programme was reported to have been initiated as of March 2003, the programme had been initiated in 18 States/UTs

during or after 2001-02. The target of achieving complete coverage of schools under the programme within the envisaged five year period i.e. by 2004 seems doubtful of achievement.

NACO is advised to investigate reasons for slow pace of the implementation of the programme in order to remove the bottlenecks in faster coverage of schools under the plan during the envisaged period.

11.1.4 Family health awareness campaign

To raise the awareness level regarding HIV/AIDS in rural and slum areas and other vulnerable groups and to make people aware of the services available under the public sector for management of Reproductive Tract Infection (RTI)/STD and facilitate early detection/treatment of RTI/STD cases by utilising the infrastructure available under primary health care system, it was decided to organise Family Health Awareness Campaigns (FHAC) in each State. During the period April 1999 to March 2003 five rounds of FHAC had been conducted across the country for which Rs. 109.41 crore (2000-01: Rs. 40.44 crore, 2001-02: Rs. 32.49 crore, 2002-03: Rs. 36.48 crore) was released during the period 2000-01 to 2002-03. No separate funds were released for FHAC during the year 1999-2000. The details of five FHACs held and population covered are given below:

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S. No.	Period of campaign	No. of districts covered/ reported	Target population	Actual attendees	Number of people referred from camps to Primary/ Community Health Centres	Number of persons treated
1	April 1999 to May 1999	80	690.98	138.83(20%)	5.50(3.96%)	N.A.
2.	December 1999	266	1847.24	461.33(24.97%)	17.86(3.87%)	11.12(62%)
3.	June 2000	420	2266.40	427.06(18.84%)	36.58(8.57%)	18.68(51.06%)
4.	April 2001	515	3355.97	712.22(21.22%)	47.74(6.70%)	30.59(64.07%)
5.	February 2002	556	3648.19	526.55(14.43%)	47.55(9.03%)	38.16(80.26%)

The low percentage of actual attendees, ranging between 14.43 per cent and 24.97 per cent of the target population, reflected poor social mobilisation at the grassroot level. It was observed that 12 out of 20 societies during FHAC May 1999, 21 out of 29 Societies during FHAC December 1999, 19 out of 31 Societies during FHAC June 2000, 19 out of 33 Societies during FHAC April 2001 and 22 out of 37 Societies during FHAC February 2002 failed to attract even 20 per cent of the targeted population. It was seen that West Bengal (78 per cent), Sikkim (62 per cent), Orissa (84 per cent) in May 1999, Andaman & Nicobar Islands (59 per cent), West Bengal (74 per cent) in December 1999, Andaman & Nicobar Islands (52 per cent), Haryana (58 per cent), Nagaland (70 per cent) in June 2000, Andaman & Nicobar Islands (52 per cent) in April 2001 and Andaman & Nicobar Islands (62 per cent), Haryana (57 per cent) and Nagaland (70 per cent) in February 2002 had performed better than the other States. During these campaigns

155.23 lakh patients suffering from various forms of sexually transmitted infections were referred from camps for treatment, of whom 98.55 lakh (63 per cent) patients were treated.

11.1.5 Evaluation of Family Health Awareness Campaign (FHAC) by AIIMS

The evaluation of the Family Health Awareness Campaign round 2002 was conducted by India Clinical Epidemiology Network (India CLEN), AIIMS, New Delhi.

Some of the important findings of the evaluation report are discussed below:

- (i) District programme managers consistently complained about the short notice given to plan and implement the programme. In 76 per cent districts, less than 4 weeks were available for implementing the programme.
- (ii) This short notice for initiating the programme resulted in hurried or no planning. House visits could not be completed and carried out effectively. The study teams had difficulty in locating camps at 44 per cent (11/25) centres spread over 56 per cent (10/18) of the states studied. Less than 10 clients were present in 37.4 per cent camps meant for males and 11.1 per cent for females.
- (iii) In almost 80 per cent of camps in both rural and urban areas, non-health partners were helping to run the camps. Involvement of private practitioners was negligible.
- (iv) Very few private practitioners were invited for training in the syndromic management of sexually transmitted diseases.
- (v) One third of the doctors (34.6 per cent) and 26.3 per cent of health workers felt that they were still hesitant, shy or embarrassed about discussing sex-related issues with clients.
- (vi) Almost 1/3rd (30 per cent) of Primary Health Centre (PHC) doctors complained that they received the IEC material late and in inadequate quantity.
- (vii) Lack of time (25.6 per cent) to cover all houses, scattered houses (22.3 per cent), non-availability of clients at home (27.8 per cent), time-consuming and adverse impact on other activities (31.6 per cent), were the important reasons offered by health workers in rural areas for not being able to cover all houses.
- (viii) Over half of the camps (53.6 per cent) were held at PHCs/sub-centres where patients who had come to the health facility were forced to sit in the camps. Hence, many clients were not mentally prepared to listen to issues related to RTI/STD/HIV/AIDS.
- (ix) Camps were generally held at prominent places but well publicized in only 57 per cent of the locations. Camps had all facilities suited for client convenience. But privacy to discuss personal issues was present in only 64.7 per cent sites. Clients suspected to have RTI/STD were preferentially mobilized to FHAC camps.
- (x) According to both providers (69 per cent-76 per cent) and clients (41 per cent-49 per cent), timings of the camps were inconvenient and hence a large number of clients did not attend the FHAC camps for fear of losing wages or were busy with personal chores.

- (xi) Government doctors were present in 89.8 per cent of rural and 68.3 per cent of urban camps. Direct observations by study investigators revealed that in 63.5 per cent of the camps clients were given referral slips, in 72.2 per cent of them patients were examined and drugs were available in 71.2 per cent of the camps. Condoms were available in 56.2 per cent of the camps.
- (xii) A large proportion of district programme managers (44 per cent) and PHC doctors (53.6 per cent) thought shyness and embarrassment kept the clients away from participating in the FHAC camps. Almost one-fifth of health workers (21.2 per cent) were also of the same opinion. However, clients negated this perception in both urban slums (6.5 per cent) and rural areas (8.6 per cent).

The finding of the evaluation report of FHAC round 2002 also sums up the reasons for poor performance of FHACs. Besides, audit scrutiny of records of State Societies revealed the following:

In **Haryana**, the Society spent Rs. 1.75 crore for organising FHAC in June 2000 against the approved allocation of Rs. 33 lakh.

In Maharashtra, Doxycycline worth Rs. 24.84 lakh was purchased (March 2002) by MSACS for FHAC during April 2002. Drugs supplied to District Health Officers (DHO), Kohlapur and Solapur were tested (September 2002 and March 2003) and found to be of sub-standard quality. Since the drugs were procured for FHAC in April 2002 and tested much later, the sub-standard drug had already been used by then.

In Chhattisgarh, FHAC was organised during February 2002 in all the districts at an expenditure of Rs. 65.86 lakh (83 per cent) out of the grant of Rs. 79.50 lakh received for FHAC. For spreading awareness among people about camps, each house in the village was to be contacted twice during 1st and 4th week of January 2002. However, there was nothing on record to show that this activity was done against the total estimated target population (15 to 49 years). The persons who actually attended the camps were only 18 per cent. In six out of 16 districts, it was between two and eight per cent only. Poor implementation of the door to door publicity campaign could be the reason behind poor attendance in FHAC camps.

In West Bengal, the Society made an advance payment of Rs. 20.06 lakh to Central Medical Store (CMS) West Bengal to procure medicines for second round of FHAC held during 26 January 2000 to 9 February 2000 in 10 districts. It was, however, observed that CMS could supply medicines worth Rs. 8.97 lakh to 7 districts only (Kolkatta, Howrah, Hooghly, Bankura, Burdwan, 24 Parganas-North, 24 Parganas-South). In the absence of medicines, the STD patients of the remaining districts did not get the intended benefits of the FHAC programme.

In **Jharkhand**, Rs. 1.06 crore was provided to the Society for conducting FHAC during 2002-03. However, the entire amount remained unutilised due to failure of Society to organise FHAC camps.

It is recommended that District Programme Managers should be informed about the date for conducting FHAC well in advance. Due care should also be taken for selecting the date and time for conducting FHAC making it convenient for the target population to attend such campaigns. Adequacy and quality of IEC material, drugs and condoms should be ensured during such campaigns. Participation of private practitioners also needs to be encouraged. NACO may also consider appointing a watchdog body of local NGOs/Panchayats to monitor the programme.

11.1.6 National AIDS Telephone Helpline

NACO established an AIDS Hotline No. 1097 in October 1997 and planned to make this facility available in all cities and big towns of India. It was observed that till 2000-01, NACO had been releasing grants to two NGOs (OSERD & TORCH) for providing this facility and, released Rs. 29.89 lakh during 1998-99 to 2000-01. Since 2000-01, the funding was decentralized to the respective States/Municipal AIDS Control Societies. However, NACO had no information of cities/towns covered by this facility.

A review of TORCH telephonic AIDS prevention Hotline was conducted by Deepam Educational Society for Health (DESH) in January 1999 to provide an in-depth integrated feedback, ascertain the effectiveness, identify the problems and suggest methods for improvement. Some of the important findings were:

- On an average 1200 callers were availing of this facility daily.
- While 4200 callers were seeking general information on HIV/AIDS every month, about 1500 callers were seeking information on testing services during a month.
- About 2400 callers per month were seeking information on symptoms of HIV/AIDS.
- Number of callers referred for STD treatment and HIV testing was not available.
 There was no system put in place to find out whether people using the information provided on the hotline were going for testing.
- Though the system worked consistently providing recorded information round the clock with the option of leaving the queries the callers had to wait for 72 hours to get a reply to their queries.
- There was no male counsellor employed, although 95 per cent of the callers were male.
- The number of female callers remained consistently low.

A test check of records of Andhra Pradesh State AIDS Control Society revealed that for providing a toll-free National AIDS Telephone helpline in all districts to provide access to information and counselling on HIV/AIDS related issues, the Society paid (April 2000) Rs. 22.61 lakh to a supplier for completion of supply and installation of 15 computers with UPS at various centres for computerised 4-digit number 1097, with a voice response system linked with telephonic hotline. Though the computers were stated to have been installed in the centres, audit observed that none of these computers were functioning in nine districts (including the six test-checked districts) either for want of repairs or lack of trained operating starf.

11.2 Voluntary Counselling and Testing Centres (VCTCs)

During the initial phase of the programme, the Government of India had established 62 sero-surveillance centres and nine referral centres with the objectives of tracking the geographical spread of HIV infection in the country and providing referral services for its diagnosis. These centres were advised to function as VCTCs.

During 1998-99, 69 additional HIV Testing centres were sanctioned as Voluntary Blood Testing Centres to promote Voluntary Counselling and Testing (VCT). These centres were renamed VCTC in order to avoid any confusion about their function and role. Keeping in view the importance of VCT in prevention and care of HIV/AIDS, NACO decided in 2001-2002 to expand the VCTC upto district hospital level throughout the country, giving priority to six high prevalence States (Tamil Nadu, Maharashtra, Andhra Pradesh, Karnataka, Manipur and Nagaland).

As on 31 March 2003, 543 (90 per cent) VCTC had been established in various States/UTs, which are located in Medical College Hospitals and District Hospitals, as against the sanction of 600 VCTC for the financial year 2002-2003. Though the districts providing VCT facility were 85 per cent in high prevalence states, in the moderate and low prevalence states 52 per cent of districts still remained uncovered. The districts providing VCT facility in these States ranged between 0 per cent and 100 per cent. The State-wise coverage of districts providing VCT facilities as of March 2003 is given in Annex-XVIII.

Scrutiny of records of Societies and VCTCs revealed that a number of Voluntary Counselling and Testing Centres were either non-functional or not fully functional due to the reasons stated below:

Reasons	States	No. of VCTCs affected	
Non-appointment of Counsellors, Lab. Technician etc.	Chattisgarh, Madhya Pradesh, Tamil Nadu and Tripura		
Non supply of equipment	Tamil Nadu, Madhya Pradesh	39	
Non supply of kits	Assam	01	
Non-availability of trained personnel for FACS machine	Assam	01	

11.2.1 Voluntary walk-in individuals tested and counselled

NACO aims to bring the percentage of walk-in persons to VCTC to at least 30 per cent by 2004. The indicator aims to provide information on the utilisation of VCT services by voluntary 'walk in' persons, which reflects the level of awareness about VCT services in the general population. Analysis of data relating to persons who attended VCTC during 2002, revealed that out of 4.15 lakh persons tested for HIV, 24.3 per cent had undergone the test voluntarily. The proportion of individuals who underwent HIV test voluntarily was high in the Societies of Andaman & Nicobar Islands (73 per cent), Arunachal Pradesh (68 per cent), Bihar (56 per cent), Jammu & Kashmir (76 per cent), Kerala (95 per cent), Meghalaya (80 per cent), Mizoram (70 per cent), Orissa (73 per cent) and Tripura (60 per cent). It was between 33.24 per cent and 40.51 per cent in the high prevalence States of Andhra Pradesh (36.33 per cent), Karnataka (33.24 per cent), Manipur (40.51 per cent), Nagaland (39.77 per cent) and Tamil Nadu

(40.17 per cent). However, it was very low in the States/Societies of Ahmedabad MC (1.38 per cent), Assam (3.93 per cent), Chandigarh (6.22 per cent), Delhi (8.31 per cent), Gujarat (4.78 per cent), Haryana (11.35 per cent), Himachal Pradesh (7.71 per cent), Maharashtra (15.38 per cent), Mumbai (18.32 per cent) and West Bengal (9.83 per cent). One of the positive aspects of functioning of VCTC was that the percentage of people tested positive, who came to receive the report and were provided post-test counselling, was very high and ranged between 79 per cent and 98 per cent during the year 2002.

11.2.2 Pre-test counselling at VCTC

Voluntary HIV counselling and testing is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. Pre- test HIV counselling should be offered before taking an HIV test. In this process the counsellor prepares the clients for the test by explaining what an HIV test is and also by correcting myths and mis-information about HIV/AIDS. Informed consent from the person being tested is usually the minimum requirement before an HIV test. However, analysis of information regarding pre-test counselling at VCTC during 2001 to 2003 revealed that out of 5.60 lakh persons tested for HIV/AIDS at the VCTC only 3.75 lakh (67 per cent) persons were imparted pre-test counselling. The year-wise break-up is given below:

Year	Per cent of VCTC reported on CMIS to NACO	Total number of persons tested for HIV/AIDS	Total number of persons imparted pre-test counselling
2001	5.7	6,801	2,652 (39%)
2002	73.1	4,16,443	2,63,003 (63.2%)
2003	66.4	1,36,523	1,09,357 (80.1%)
Total		5,59,767	3,75,012 (67%)

Although the overall percentage of people who were imparted pre-test counselling has shown an increasing trend, the percentage remained low in the Societies of **Ahmedabad** (16 per cent), **Assam** (28 per cent), **Delhi** (30 per cent), **Gujarat** (27 per cent), **Haryana** (49 per cent), **Himachal Pradesh** (21 per cent), **Mumbai** (41 per cent), **Pondicherry** (6 per cent), **Rajasthan** (50 per cent) and **Sikkim** (26 per cent).

11.2.3 Training of health care workers in HIV/AIDS counselling

Analysis of information supplied to audit in respect of training of healthcare workers in HIV/AIDS counselling revealed that against 3.80 lakh healthcare workers targeted to be trained, only 1.64 lakh (43 per cent) were trained as of March 2003. While the percentage of workers trained in HIV/AIDS counselling was 99 per cent in Goa, 85 per cent in Pondicherry, 84 per cent in Uttar Pradesh, 76 per cent in Orissa and 70 per cent in Haryana it was very low at 16 per cent in Gujarat, 5 per cent in Punjab, 27 per cent in Rajasthan, 20 per cent in Tripura and less than one per cent in Uttaranchal. Statewise details are given in Annex-XIX.

Pre-test counselling needs improvement and NACO should encourage more and more people to opt for voluntary testing and collection of reports. NACO should also provide VCTCs with technical staff. Training of counsellors and lab technicians should be part of a mandatory capacity building exercise for successful implementation of the programme.

11.3 Reduced transmission by blood transfusion and occupational exposure

This activity seeks to ensure supply of safe blood by modernising and strengthening all licensed blood banks in the country. NACO, under the central scheme of assistance, provides financial support for blood bank equipment, contingencies and purchase of consumables, chemicals and reagents. In Phase-II, NACO had targeted setting up 10 state-of-the-art blood banks, upgrading 20 existing major blood banks, establishment of 42 Blood Component Separation Units and creation of 80 new district level blood banks, introduction of Hepatitis C as the fifth mandatory test for blood screening, mobilisation of blood donations, training of healthcare workers at all levels in universal precautions, including provision of prophylactic drugs, facilitating communications among blood banking services and provision of training counsellors for blood banks.

11.3.1 Modernisation and strengthening of licensed blood banks

In Phase-I of the programme, NACO had modernised 815 blood banks in all and proposed to modernise all existing public sector blood banks in Phase-II of the programme. It was proposed in the Project Implementation Plan to expand the blood banking services to the uncovered areas and to ensure that every district in the country had at least one modernised blood bank by 2002. As of December 2002, there were 1832 licensed/registered blood banks in the country of which only 940 (685- district level blood banks, 255- major blood banks) had been modernised by NACO till March 2003. It was observed that of the 125 blood banks modernised by NACO as of March 2003 in Phase-II, 75 blood banks were yet to be licensed. The details of registered/licensed blood banks (as of December 2002) and modernised (March 2003) are given in **Annex-XX**.

It would be seen from the Annex that details of districts remaining uncovered as of March 2003 were not available with NACO. While 84 districts did not have modernised blood banks, 44 districts did not have even blood banking facilities. NACO neither accepted nor denied the facts brought out by audit and stated (October 2003) that there were some districts which did not have any blood banks due to either non-existence of a district hospital or the district hospital did not have required infrastructure for setting up a blood bank. Despite NACO's financial assistance to all the State societies, the objective of establishing at least one modernised blood bank in each district by 2002 remained unachieved. The number of blood banks stated to have been modernised by the States of Arunachal Pradesh, Bihar, Daman & Diu, Jammu & Kashmir, Manipur, Meghalaya, Mizoram, and Nagaland exceeded the number of registered/licensed blood banks in these States. NACO stated (October 2003) that many of the blood banks stated to have been modernised by it in Phase-II were yet to be licensed, while licenses of some of the blood banks modernised in Phase-I might have been withdrawn/cancelled due to non-adherence to the laid down conditions. It was observed in audit that although NACO

had to modernise/provide financial support to only those blood banks which had been licensed by the Drug Controller of India (DCI), it had modernised and continued to provide financial assistance to blood banks which had either not yet been licensed or whose license had been withdrawn/cancelled by DCI. Similarly, audit noticed variations (17 cases) between the figures supplied by NACO and societies in respect of blood banks modernised.

Scrutiny of records of societies and test checked blood banks revealed that blood banks were not functional/fully functional due to the reasons mentioned below: -

Reasons	States	Blood Bank affected 86	
Equipment not supplied	Tripura, Maharashtra, Haryana, West Bengal, Jammu & Kashmir, Karnataka, Madhya Pradesh, Nagaland		
Equipment lying idle due to non-receipt of licence	Assam and Bihar	18	
Equipment lying idle for want of repair, replacement and installation	Assam, Bihar and Jammu & Kashmir	11	
Equipment lying idle for want of infrastructure/qualified staff	Kerala	14	
Licence of blood banks not renewed	Pondicherry, Karnataka and Tamil Nadu	79	
Blood banks functioning without licence	Himachal Pradesh	04	
	Haryana	All government blood banks except Faridabad	
	Madhya Pradesh	8 blood banks in 2001-02 & 5 blood banks in 2002-03	
One time grant of Rs. 3.19 lakh for modernisation not released	Orissa	06	

It was also noticed that 15 and one blood banks in **Maharashtra** and **Pondicherry** respectively were not functioning. The reasons therefore were not available on records.

It is recommended that NACO ensure supply of test kits in blood banks for their effective functioning. Private blood banks should be subjected to stringent quality control checks by the agencies authorised by Government and punitive action should be taken against the blood banks functioning without proper licences.

11.3.2 Setting up of state-of-art blood banks

The scheme envisaged creation of 10 new modern blood banks during Phase-II of the programme. Of these, two blood banks each were to be set up in the States of Assam and Rajasthan and one each in Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Uttar Pradesh and Uttaranchal. However, equipment required to be purchased for setting up of these blood banks had not been procured till March 2003.

11.3.3 Upgradation of existing major blood banks

In Phase-I of the programme, NACO had modernised 236 major blood banks. In Phase-II, NACO seeks to upgrade 20 existing major blood banks by providing them with equipment required for the purpose. As of March 2003, 18 major blood banks had been upgraded against this target. However, Sealer Stripper with Cutter and Bench Top Centrifuge required to be supplied by NACO were yet to be supplied to two such major blood banks.

11.3.4 Establishment of blood component separation units

To reduce the wasteful use of blood, NACO had set up 40 blood component separation units (BCSU) all over the country in Phase-I, against the target of 30 units. In Phase-II, NACO seeks to create 42 blood component separation units by providing them with required equipment. While 33 such units had been set up by NACO as of March 2003, the Digital Analytical Balance required to be procured by it and supplied to Societies had not been purchased for 9 such units.

Audit scrutiny revealed that in the BCSUs set-up by NACO as of March 2003 in various parts of the country, equipment worth Rs. 2.36 crore supplied to these units had been lying idle for various reasons as detailed below:

S. No.	State	Value of equipment lying idle	Reasons
1.	Tripura	More than Rs. 100 lakh	Lack of accommodation and trained personnel resulted in equipment supplied between March 2001 and July 2002 lying idle in the unit, which was targeted to be set up in 1996-97.
2.	Maharashtra	Rs. 4.15 lakh	Platelet agitator with incubator and cell counter supplied (September 1998/December 1999) to Sassoon Hospital were not commissioned as licence for preparing platelets sought (Feb. 2000), had not been received from the Drug Controller of India/State Food & Drug Administration (May 2003). Similarly, Platelet Agitator with incubator supplied (February 2001) to blood bank of St. George Hospital was lying idle (June 2003) as no licence had been obtained for preparation of platelets and fresh frozen plasma.
3.	Chhattisgarh	Rs. 19.64 lakh	Equipment supplied to medical college at Raipur were lying idle due to non-supply of remaining equipment (Platelet incubator, Rs. 15000, Generator 10 KVA Rs. 80000 by Society and for want of licence.
4.	Gujarat	Rs. 56.79 lakh	Equipment supplied to medical colleges at Vadodara and V.S. General Hospital in Ahmedabad were lying idle since 1996-97 and 2000-01 respectively due to non-receipt of licence.
5	Madhya Pradesh	Rs. 55.38 lakh	Equipment supplied to BCSUs Indore and Bhopal were lying idle from July 2001 and January 2003 respectively for want of valid licence from State Controller of food and drugs as of July 2003.
	Total	Rs. 235.96 lakh	

Considerable delay in installation/commissioning of equipment supplied to BCSUs was also noticed in audit. In **Maharashtra**, the equipment (cost Rs. 27.69 lakh) supplied between January 1996 and December 1997 to Government Medical College Hospital, Nagpur were commissioned only from March 2001 due to delay in receipt of license from Drug Controller of India/State Food & Drug Administration for preparation of components. The blood bank refrigerator valuing Rs. 2.70 lakh supplied (November 1999) by NACO to Jankalyan blood bank, Pune was irregularly diverted (January 2000) by State Health Department for use in Pune Chest Hospital.

Under the programme, a onetime grant of Rs. 27.69 lakh is to be provided to each BCSU for purchase of equipment. However, test check of records of **Orissa** SACS revealed that onetime grant of Rs. 27.69 lakh for purchase of equipment had not been released to three units functioning since September/ October 2001.

In **Uttar Pradesh**, out of seven BCSUs, only three (SGPGI Lucknow, GSVM Medical College Kanpur and IMS, BHU-Varanasi) were functional. The remaining 4 blood banks (SN Medical college Agra, MLU Medical college Allahabad, district hospital Meerut and CSM Medical University campus Lucknow) could not be established due to non-availability of building, licence and staff. Test check of CSM Medical University-Lucknow (June 2003) revealed that NACO had supplied 11 equipment between February 2001 and June 2002 but these were lying uninstalled.

In **Karnataka**, out of five BCSUs, only two BCSU (Kidwai Memorial Institute of Oncology, Bangalore and NIMHANS, Bangalore) had received equipment from NACO. The other three units viz. KIMS- Hubli, Rashrothana Parishat- Bangalore, and MR Medical college hospital- Gulbarga had not started functioning by the end of March 2003.

11.3.5 Creation of district level blood banks

In Phase-II, NACO had targeted to create 80 new district level blood banks. For this purpose NACO was to procure and supply Blood Bank Refrigerators of 250-300 bags capacity to each such bank. Though the contract for the same had been awarded, supply was awaited as of June 2003.

A grant of Rs. one crore was released to **Tamil Nadu** by NACO for setting up 20 licensed blood banks in five district head-quarters hospitals and 15 taluka hospitals. Directorate of Medical and Rural Health Services reported (Sept 2001) that it was difficult to set up blood bank at a cost of Rs. 5 lakh. It was proposed to utilise the amount of Rs. one crore for the purchase of equipment for 40 unlicensed blood banks out of 85 blood banks functioning in the State.

11.3.6 Testing of blood for HIV

In the case of blood donation, a single test by Rapid/ELISA is done to eliminate the possibility of HIV-positive blood. In the case of epidemiological surveys also, the same procedure is adopted, i.e. with one or two tests either with ELISA or Rapid or Simple with high sensitivity. According to the current testing policy followed by NACO, in both cases, the testing is anonymous and the result is not given to the person concerned

unless asked for. While the blood donor is offered the option of knowing his transfusion transmitted infection (TTI) status by the blood bank, in the case of clinical management and for confirmatory testing of HIV status of persons who voluntarily ask for it, the sample would be tested with at least two ELISA and one Rapid/Simple by a different antigen preparation and the result is given with proper pre-test and post-test counselling. India has over 4 million estimated HIV infected people of whom 90 per cent are aged between 15 and 45 years. Since the sexual route is the major source of HIV infection in the country, the public health experts in the country believe that the HIV positive donors have been living without knowledge of their infection and possibly transmitting it to their sexual partners. To end the existing policy of anonymous testing in which blood infected with HIV is discarded without repeating the test and without informing the donor, the Ministry announced in December 2002 that blood donors found to be HIV positive would be told of their infection and asked to seek confirmatory tests and counselling. However, NACO continues to follow the existing policy of giving the results only to persons who ask for these, which is not at all conducive to the objective of the programme. Nondisclosure of HIV status mandatorily to all HIV infected persons could lead to such persons unknowingly spreading the disease among uninfected persons.

A person infected with HIV can remain asymptomatic for three to twelve years. AIDS is the final stage when the HIV positive person starts showing distinct symptoms of this disease. Another serious issue is the detection of HIV infection during the window period. This time gap between contracting of infection and sero positivity is known as 'window period'. The duration of window period as defined by the World Health Organisation ranges between 6 weeks and 3 months, but in some cases it may take upto 3 years to develop antibodies. Contrary to this, NACO stated that this period may range from 10 days to one month only. NACO's statement was also contradicted by the findings from Tripura wherein, a doctor from the Zonal Blood Testing Centre (ZBTC), Agartala, described the window period ranging from six weeks to six months. NACO also stated that there was no test, which could detect HIV infection during the whole window period. The reply is not tenable as PCR, a highly specific test, can detect HIV during this period. The implications of sero-negativity during the window period could be very serious as: (i) blood units supplied by blood banks of the States for safe transfusion may not be safe, (ii) the persons infected with HIV, if not later diagnosed and their infection status confirmed, may unknowingly transmit the disease to uninfected Hence, monitoring of HIV testing among people at high risk is of great significance during and after the window period.

It is recommended that persons who are detected HIV positive should mandatorily be informed of the infection. This will help them in seeking medical assistance in time and will also help in controlling the spread of infection.

11.3.7 Advantage of Polymerase Chain Reaction (PCR) test

Polymerase Chain Reaction (PCR) is a specialised blood test that looks for HIV genetic information. Although expensive and requiring a sophisticated laboratory set up, it directly detects the virus and hence is highly specific. The test detects HIV even during the window period and terminal phase when the viral dose is high and when Elisa test results may be negative. It is also sensitive in newborns especially beyond 1 month and

can help early diagnosis of HIV in them, which can be useful for starting retroviral drug therapy, preventing and beating opportunistic infections in time and deciding about issues related to breast-feeding as well as nutritional support and growth monitoring of the child. It was noticed in audit that PCR had not been adopted by NACO to diagnose HIV infection under NACP-I even in limited set of circumstances like window period testing, testing of infants etc. possibly because it is costly and difficult to provide on a wide scale. While admitting that PCR had multiple advantages over Elisa testing for certain conditions, NACO stated (October 2003) that background information on PCR such as cost of running, list of institutions having PCR facilities etc. had been collected and they were considering the feasibility of providing PCR machines to different institutions.

NACO may consider introducing PCR on a limited scale for diagnosing HIV infection particularly in the newborn and the population at high risk.

11.3.8 Introduction of Hepatitis C as the fifth mandatory test for blood screening

From June 2001, testing all donated blood for Hepatitis C virus has been made mandatory as part of NACP in addition to other four mandatory tests viz. HIV, Hepatitis B, Malaria, VDRL. However, this activity has not been monitored satisfactorily. Only 12.3 per cent blood banks in 2001, 75.2 per cent blood banks in 2002 and 57.7 per cent blood banks in 2003 reported to NACO about this indicator. Enforcing this test is important as 0.3 per cent of the samples tested was found infected with Hepatitis C.

11.3.9 Voluntary collection of blood

This Programme component aims to increase the proportion of voluntary blood donors and has fixed a target of 80 *per cent* collection of blood from voluntary blood donors by 2004. Analysis of information of screening of blood revealed that voluntary blood donors ranged between only 39 and 45 *per cent* as shown below:

		Name of the Control o	(In units)
Year	Voluntary (per cent)	Replacement (per cent)	Total
1999	1065214 (39%)	1638126 (61%)	2703340
2000	974012 (39%)	1503007 (61%)	2477019
2001	1339748 (45%)	1659045 (55%)	2998793
2002	1265229 (43%)	1685966 (57%)	2951195

12 Prevention of parents to child transmission (PPTCT) of HIV

NACO initiated in March 2000, a feasibility study on prevention of mother to child transmission in 11 institutions in the country located in 5 high prevalence states viz. Andhra Pradesh (1), Karnataka (1), Maharashtra (5), Manipur (1) and Tamil Nadu (3). The short course regimen of Azidothymidine (AZT) antiretroviral drug was used in this feasibility study. This study continued till September 2001. From 1 October 2001, the second phase of this feasibility study was started using a single dose of Nevirapine to both mother and child to prevent mother to child transmission. The prevention of mother to child transmission of HIV/AIDS is now known as prevention of parents to child transmission of HIV/AIDS.

According to the detailed implementation plan of PPTCT, training activities were required to be completed by February and June 2002 respectively in Medical Colleges and District Hospitals in high prevalence States and by July 2002 in Medical Colleges in low prevalence States. The actual implementation of PPTCT was to be completed by April and July 2002 in Medical Colleges and District Hospitals in high prevalence States and by September 2002 in Medical Colleges in low prevalence States. The status of training of PPTCT teams and delivery of PPTCT services in high prevalence states as of January 2003 is given below:

States	No. of medical	District hospitals	(* 1)	nentation		Status as of	January 2003	
	colleges	nospitais	s plan		Tra	ining	Service d	elivery
			Training	Service delivery	Medical colleges	District hospitals	Medical colleges	District hospitals
Andhra Pradesh	13	24	Medical colleges	Medical colleges	13	24	13	-
Tamil Nadu	13	28	by	by April	13	15	13	-
Chennai	02	-	February	2002	02	s - .	02	-
Karnataka	25	22	2002,	District	17	22	17	-
Manipur	01	08	District	hospitals	01	-	01	
Nagaland	=	08	hospitals	by July	-	08	3	08
Maharashtra	26	27	by June	2002	26	25	26	-
Mumbai	02	16	2002		02	07	02	07
Total	82	133			74	101	74	15

It would be seen that training has been completed and service delivery started in 74 out of 82 Medical Colleges of high prevalence States. Training has not been completed in 24 per cent district hospitals and service delivery has started in only 11 per cent district hospitals in high prevalence States. The PPTCT was yet to be implemented in medical colleges of low prevalence states.

13 Low cost AIDS care

These activities seek to fund home-based and community-based care, including increasing the availability of cost-effective interventions for common opportunistic infections. Specific activities include (i) establishing best practice guidelines and providing appropriate drugs for treating common opportunistic infections (OI) at district hospitals, (ii) training at selected State level hospitals for the provision of referral services, (iii) establishing new support services for care of persons with AIDS in partnership with NGOs and Community Based Organisations (CBOs) by establishing small community-based hospitals, hospice programmes and drop-in-centres.

13.1 Community Care Centres

In August 1999 NACB approved the setting-up of community care centres for persons living with HIV/AIDS in those areas where HIV infection rate was comparatively high. It was decided that such centres should be regularly monitored.

As of March 2003, NACO had established 37 community care centres in various	IS
parts of high and low prevalence States. The State-wise position is given below:	

CI N	State	No. of	No. of community care centres			
Sl. No.	High Prevalence States	Proposed	Established	Shortfall (%)		
1.	Manipur	06	05	01 (17%)		
2.	Andhra Pradesh	14	10	04 (29%)		
3.	Karnataka	13	05	08 (62%)		
4.	Maharashtra (including Mumbai DACS ¹)	07	03	04 (57%)		
5.	Tamil Nadu	07	05	02 (29%)		
6.	Nagaland	09	02	07 (78%)		
	Total	56	30	26 (46%)		
	Moderate and Low Prevale	nce States				
1.	Assam	No targets fixed	01	N.A.		
2.	Delhi	- do -	03	N.A.		
3.	Pondicherry	- do -	01	N.A.		
4.	Kerala	- do -	01	N.A.		
5.	West Bengal	- do -	01	N.A.		
	Total		07			

Thus, the shortfall in establishment of community care centres in high prevalence States ranged between 17 per cent and 78 per cent. The establishment of these centres in moderate and low prevalence States was not in keeping with the degree of prevalence of HIV/reported AIDS cases. While three centres were established in Delhi where the reported number of AIDS cases were only 766, States like Gujarat with 2474, M.P. with 972, U.P. with 845 and Chandigarh, Punjab and Haryana together with 1186 reported AIDS cases did not have a single community care centre. In **Mizoram**, an expenditure of Rs. 20.74 lakh was booked under the head 'low cost AIDS care' during 1999-2000 for establishment of one community care centre. However, no such centre existed in the State as of March 2003. The performance of the community care centres established till March 2003 except Sahara Michael's Care Home, Delhi had not been evaluated by any outside agency

13.2 Establishment of Drop-in-Centres for people living with HIV/AIDS

In the absence of free anti-retroviral drugs and because of the stigma associated with the disease, the greater involvement of people living with HIV/AIDS (PLWHA) is considered essential to mainstream the issue. To provide care and support to those infected by HIV/AIDS, establishment of Drop-in-Centres in all the States was envisaged in NACP Phase II. In December 2001, NACB approved setting-up of 10 drop-in-centres to be run by registered associations and networks of PLWHA in every State. The outcome of these projects was to be evaluated by an independent agency before considering further expansion. Against this approval, NACO had set-up 3 drop-in-centres in Maharashtra, one in Karnataka and 5 in Tamil Nadu. Evaluation of performance of these centres had not been conducted as of March 2003. The pace has to be speeded up considerably for NACO to be able to establish Drop-in-Centres in all the States/UTs before the completion of NACP Phase II.

¹ District AIDS Control Society

13.3 Rehabilitation of commercial sex workers

In May 1997, 65 commercial sex workers were rescued from a place in Hyderabad. Of them 21 were found HIV positive. For their rehabilitation the Project Director of the Society, following the instructions (July 1997) of the State Government, released (October 1997) Rs. 15 lakh to the Managing Director, AP Women Cooperative Finance Corporation Limited for implementation of the Project 'Rehabilitation of commercial sex workers infected with HIV' through an NGO 'Pratyamanaya'. The Corporation in turn released (October 1997 and January 1999) only Rs. 11.25 lakh and held the balance Rs. 3.75 lakh with it. Against the envisaged shelter for 100 women, the NGO provided shelter only for 24 women during October 1997- October 1998 at a cost of Rs. 7.58 lakh and the balance of Rs. 7.42 lakh remained with the NGO (Rs. 3.67 lakh) and the Corporation (Rs. 3.75 lakh).

Since CSWs are a particularly vulnerable group with very high exposure to HIV, it is necessary to build into NACP appropriate programmes for equipping the rescued CSWs appropriately to enable them to take up alternative vocations. Unless this is done, their economic wants would again bring them back to their earlier profession and consequent exposure to HIV.

13.4 Provision of drugs for opportunistic infections (OI) at district hospitals

A host of opportunistic infections label an HIV infected person as a case of fullblown AIDS. Tuberculosis, candidiasis and the diarrhoeal diseases account for a majority of the cases. Most of these infections are curable if effective therapy is initiated promptly.

Under NACP Phase-II, NACO provides appropriate drugs for treating common opportunistic infections (OI) at district hospitals. For this purpose, NACO had approved allocations in the Annual Action Plan of the Societies, as detailed below:

			(Rs. in lakh)
Vear	Allocation	Expenditure	Expenditure as

rear	Anocation	Expenditure	percentage of allocation
1999-00	607.60	143.53	24
2000-01	140.61	74.25	53
2001-02	496.85	201.24	41
2002-03	555.35	170.78	31
Total	1800.41	589.80	33

Out of the total allocation of Rs. 18 crore by NACO for procurement of OI drugs during 1999-2000 to 2002-03, Societies had utilised just Rs. 5.90 crore (33 per cent) for the purpose. Except Arunachal Pradesh (70 per cent), Madhya Pradesh (115 per cent), Mizoram (84 per cent), Nagaland (82 per cent), Tamil Nadu (100 per cent) and Tripura (140 per cent), State/Municipal AIDS Control Societies of other States had utilised upto 57 per cent of the grants. The Societies of Jammu & Kashmir, Goa, Meghalaya, Uttaranchal, Jharkhand, Lakshadweep and Chhattisgarh had not spent any amount on the procurement of these drugs.

14 Intersectoral collaboration

The overall goal of collaboration is to catalyse an expanded response towards the HIV/AIDS epidemic in order to improve prevention and care, reduce people's vulnerability to HIV and alleviate the devastating social and economic impact of this epidemic. This component seeks to promote collaboration among the public, private and voluntary sectors. Activities are required to be coordinated with other programmes within the Ministry of Health and Family Welfare and other Central Ministries and Departments. Collaboration focusses on:- (i) learning from the innovative HIV/AIDS programmes that exist in other sectors; and (ii) sharing in the work of generating awareness and advocacy at delivering interventions.

Under this component, NACO had allocated Rs. 15.70 crore between 1999-2000 and 2002-2003 to SACS/MACS to enable these to establish inter-sectoral collaboration with public, private and voluntary sectors at the State level. The Societies could utilise only Rs. 3.11 crore (20 *per cent*) out of this allocation. The year-wise break up of allocation of funds and utilisation by Societies for inter-sectoral collaboration is given below:

(Rs. in lakh)

Year	Allocation	Expenditure	Amount unutilised (per cent)		
1999-00	600.77	117.42	483.35 (80%)		
2000-01	137.00	7.00 62.14 74.86			
2001-02	412.66	64.96	347.70 (84%)		
2002-03	420.00	66.02	353.98 (84%)		
Total	1570.43	310.54	1259.89 (80%)		

At the national level, NACO has released grants-in-aid to SAIL, ESIC, Railways and the Ministry of Defence as its inter-sectoral collaborators for implementing various activities of the programme like targeted interventions, creation of STD Clinics, creation of VCTC, implementing the School AIDS Education Programme etc. However, no MOU was signed by NACO with them. During the years 1999-2000 to 2002-2003, NACO released grant of Rs. 16.83 crore to these collaborators without proper assessment of requirement and the latter could use only 23 *per cent* of the grants released as shown below:

(Rs. in lakh)

Sl. No.	Name of Collaborator	Period	Grant Released	Expenditure	Unspent Balance
1.	ESIC	1999-2000 to 2002-03	432.51	91.83 (21%)	340.68
2.	SAIL	do	279.44	55.85 (20%)	223.59
3.	Railway	do	371.05	139.40 (38%)	231.65
4.	Defence	do	600.00	104.33 (17%)	495.67
	Total			391.41 (23%)	1291.59

NACO stated (October 2003) that there were various reasons for the large unspent balance with each of the inter-sectoral collaborators. They attributed this to lack of commitment at the top management and at the field level, delay in putting up systems in place and absence of monitoring mechanisms. They had recently reviewed the implementation of AIDS related activities and expressed concern over unsatisfactory progress made by all inter-sectoral collaborators in general with reference to the low level

of expenditure, and had given directions for stepping up the level of activities so that the funds provided to them could be utilised.

ESIC had achieved the targets set for strengthening of STD clinics, VCTC and Targeted Interventions. Though SAIL had achieved the targets set for strengthening of STD clinics and TIs, it could strengthen only 3 VCTC against target of 7 during 2002-03. Railways and Director General Armed Forces Medical Services had achieved the target set in respect of STD clinics. They had, however, failed to achieve the targets set in respect of strengthening of VCTC. Targets set for coverage of schools under School AIDS Education Programme and training of medical/para-medical staff had not been achieved by any of the inter-sectoral collaborators. No review to evaluate the performance of inter-sectoral collaborators had been conducted by NACO as of March 2003.

NACO may consider getting the performance of its inter-sectoral collaborators evaluated by a reputed independent agency in order to analyse reasons for the inability of the Societies to make the desired progress in this area.

15 Institutional strengthening

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

15.1 Project financial management system

For IDA assisted projects starting after July 1998, 'Loan Administration Change Initiative' (LACI) was to be established in order to improve performance through speedy disbursements and facilitating project monitoring and control by linking expenditure with actual physical progress. This system visualizes a Project Financial Management System at NACO and an Accounts and Finance Unit in each State and Municipal Corporation. All partners who received grants from Society would submit their monthly expenditure reports in pre-designed formats. The society would report to NACO/State Government on quarterly basis. Categorywise quarterly reimbursement claims, financial project progress and procurement reports would be submitted to NACO.

Scrutiny of records at NACO revealed that Computerised Programme of Financial Management System (CPFMS) was not yet (September 2003) implemented in the following areas:-

- Maintenance of accounts was still being handled manually in nine Societies and by three inter-sectoral collaborators.
- Reconciliation of CPFMS generated Statement of Expenditure (SOE) with existing system was complete but they did not tally in 10 Societies and three Intersectoral collaborators.
- CPFMS was not being used for claiming reimbursement by 12 Societies and three inter-sectoral collaborators.
- Annual Financial Statements were not being prepared according to the CPFMS system in 25 Societies and three inter-sectoral collaborators.

NACO should ensure quick and full implementation of the computerised programme of Financial Management System in all the States and inter-sectoral collaborators so as to have effective control over financial management.

15.2 Manpower

For effective implementation of the programme, NACO had sanctioned posts under various cadres to all State AIDS Control Societies (SACS). Scrutiny of records of Societies revealed that a number of key posts in some SACS as detailed below, had not been filled. Non-filling up of key technical posts in the state societies resulted in adverse impact on the programme implementation

S. No.	Name of Society	Sanctioned strength (including contractual posts as on 31-3-03)	Men-in- position as on 31-3-03	Vacant posts	Remarks/Details of key posts lying vacant
1	Chhattisgarh	35	18	17	Addl. Project Director (Tech. Division) JD (Surveillance), DD (STD), DD (Surveillance), AD (STD), AD (Care)
2.	Daman & Diu	33	22	11	Posts of driver, messenger and lab. Technicians have been filled in excess of sanctioned strength. Key posts of Technical assistant (blood safety), Monitoring and Evaluation Officer, Counselor (VCTC), DD (IEC) were lying vacant.
3.	Gujarat	37	27	10	JD (Surveillance), JD (Blood safety), DD (Surveillance), AD (STD).
4.	Jharkhand	31	5	26	Against 18 sanctioned posts only 2 posts (PD & JD (BS) were in position. Similarly against 13 sanctioned contractual posts only three were filled in.
5	Orissa	39	20	19	-
6.	Pondicherry	37	14	23	DD (STD), DD (Surveillance), DD (Blood Safety), DD (IEC), AD (Publicity), Lab Technician (9)
7	Rajasthan	116	39	77	JD (Surveillance), JD (Blood Safety), DD (STD), Stat. Officer, Procurement officer, Finance Officer, JD (IEC), AD (CP), AD (Care), AD (BTC), M&E Officer, NGO Advisor
8	Tripura	27	19	8	DD (STD), DD (IEC), DD (BS), M&E Officer
9.	Bihar	165	89	76	1-
10.	Goa	25	13	12	Post of PD remained vacant upto November 2001, post of DD (STD) was vacant and held by CMO, DHS Panaji as additional charge.

15.3 Training

Though training was an ongoing activity of NACO, newer areas of management and hospital infection control measures including post-exposure prophylaxis necessitate the need for periodic training and orientation with updated information and guidelines. Under NACP Phase II, training had been structured in different tiers, with comprehensive curricula for different categories of health functionaries. The objective was to involve all the medical, paramedical and field staff and attain complete coverage by March 2002.

A scrutiny of information for the year ending March 2003 revealed considerable shortfall in training of doctors, nurses, lab technicians and field officers in case of States detailed in **Annex-XXI**. The position is summarised below:

Category	No. of Societies in respect of which data received	Sanctioned strength	Trained	Shortfall (percentage)
Doctors	26	93882	52707	41175 (44%)
Nurses	26	125303	57403	67900 (54%)
Lab. Technician	21	16323	6150	10173 (62%)
Field Officers	19	147032	44815	102217 (70%)

Eight Societies (Chandigarh, Madhya Pradesh, Nagaland, Tamil Nadu, Assam, Chennai, Orissa and Uttar Pradesh) had achieved coverage of over 70 per cent in respect of training of doctors, whereas in the remaining 18 Societies the coverage ranged between 0 and 69 per cent. Similarly, seven Societies namely Nagaland, Kerala, Ahmedabad, Assam, Karnataka, Pondicherry and Mumbai had achieved coverage of over 70 per cent in respect of training of nurses; coverage in the remaining 19 Societies ranged between 0 and 68 per cent. Coverage in respect of lab technicians was over 70 per cent in Assam, Chennai, Haryana, Orissa and Sikkim. In the remaining 16 Societies, coverage ranged between 3 and 69 per cent. While the Societies of Andaman & Nicobar Islands, Chandigarh, Goa, Himachal Pradesh and Nagaland had almost achieved the coverage in respect of training of field officers, the shortfall in other Societies ranged between 22 per cent and 100 per cent. In Chhattisgarh and Jharkhand not a single training programme was conducted.

Only properly trained medical, paramedical and field staff can bring about efficient disease management and hospital infection control measures including post exposure prophylaxis. It is, therefore, essential that NACO ensures that targets of imparting training to doctors, nurses and lab technicians are fully met.

16 **AVERT Project**

USAID entered into a tripartite agreement with NACO and the Government of Maharashtra on 15 September 1999 to provide a grant of US \$ 41.5 Million (Rs. 166 crore) excluding host country contribution of Rs. 54.40 crore. The AVERT Society was registered in June 2001 and it started functioning from September 2001. The strategic objective was to increase the use of effective and sustainable response to reduce the transmission of sexually transmitted diseases, HIV/AIDS and related infectious diseases in Maharashtra and mitigate their impact.

During the year 2001-03, the allocation of funds to the society and expenditure incurred was as under:

			(Rs. in lakh
Year	Budget	Expenditure	Unutilised
2001-02	425.29	156.10 (37%)	269.19
2002-03	1443.55	524.41 (36%)	919.14
Total	1868.84	680.51 (36%)	1188.33

Against a budget allocation of Rs. 18.69 crore, Society could utilise Rs. 6.81 crore (36 per cent) on AVERT Project till March 2003. This mainly included Rs. 2.93 crore on communication support programme, Rs. 2.22 crore on programme management and administration, Rs. 1.20 crore on reduction of high risk behaviour in priority population and health services for them. The expenditure on programme management included recurring payment of management fees to Hindustan Latex Family Planning Promotion Trust (HLFPPT) for providing managerial/technical assistance to the AVERT Society. Till the end of March 2003, fees of Rs. 42.11 lakh had been paid to the Trust. It has been observed in audit that tasks assigned to the Trust were either not fully taken up or remained incomplete (June 2003).

During the year 2001-02 no physical targets were fixed. It was stated (October 2003) by NACO that the AVERT Society was officially inaugurated in November 2001 and the period upto March 2002 was utilised for establishment, office automation, recruitment of personnel etc. No evaluation of the AVERT Project had been conducted. NACO stated that AVERT Project was virtually one year old and had actually been functioning from April 2002. However, USAID had been monitoring the progress of the project. The Governing Board of the AVERT Society was also evaluating the performance.

17 Partnership in Sexual Health Project (PSH)

The Department for International Development (DFID) of UK supports a project for Prevention and Control of HIV/AIDS and other sexually transmitted diseases in the States of Andhra Pradesh, Gujarat, Kerala and Orissa. The project adopts the same targeted intervention approach in dealing with the vulnerable communities such as CSWs, IDUs, prison inmates, street children and migrant workers as in NACP. The support for the substantive phase (Phase-II) was for a value of Rs. 154.3 crore (£ 28.08 million) of which Rs. 104.1 crore was to be routed through GOI as local costs and Rs. 50.27 crore (£ 9.14 million) as Technical costs to be managed by DFID for a period of five years starting February 2001. The programme's goal is to ensure better sexual health for people vulnerable to STD (including HIV), especially the poor. The three main objectives/project outputs are as follows:

- (i) Partnership at State level for improved sexual health.
- (ii) Increased State capacity for strategic action enables people to improve their sexual health.
- (iii) Service Providers capable of working with and responding to the needs of clients.

The following funds were released to the SACS/MACS during the years 2000-01 to 2002-03:

						(Rs. in lakh)
Year		Andhra Pradesh	Gujarat	Kerala	Orissa	Ahmedabad MACs
2000 01	Release	250.00	250.00	250.00	50.00	3€
2000-01	Expenditure	273.85	199.62	151.34	32.67	5=
	Release	1025.00	540.00	467.00	365.00	140.00
2001-02	Expenditure	763.98	491.92	348.18	111.03	83.11
	Release	800.00	906.64	385.00	300.00	108.00
2002-03	Expenditure	757.12	408.98	213.51	157.41	75.53
TOTAL	Release	2075.00	1696.64	1102.00	715.00	248.00
	Expenditure	1794.95	1100.52	713.03	301.11	158.64
		(86.5%)	(64.86%)	(64.7%)	(42%)	(63.96%)
Unspent bal	lance with societies	280.05	596.12	388.97	413.89	89.36

Though utilisation of grants in Andhra Pradesh was 86.5 per cent, in other states viz. Gujarat, Kerala and Orissa and in Ahmedabad, it was 64.86 per cent, 64.7 per cent, 42 per cent and 63.96 per cent respectively. No performance review of the project had been conducted (August 2003) to assess the achievements and bottlenecks.

18 Procurement

NACO appointed the National Thermal Power Corporation Limited (NTPC) on 13 September, 1999 as the procurement agent for procurement of HIV test kits, equipment and certain drugs under the central component. AIDS Control Societies are responsible for civil works, procurement of drugs and NGO services for various activities.

18.1 Infructuous expenditure

One hundred and fifty five out of 299 water baths, 177 out of 250 hot air ovens, 93 out of 100 incubators and 53 out of 100 distilled water still, purchased during 1997-98 in Phase-I, remained uninstalled till June 2003 rendering Rs. 51.64 lakh on their purchase infructuous. From the monthly progress report submitted to NACO by NTPC, it was noticed that equipment worth Rs. 60.87 lakh purchased by NACO during Phase-II were lying uninstalled for variety of reasons as of March 2003.

A system may be developed by NACO in consultation with NTPC for periodical and regular interaction with the consignee during execution of contract for coordinating supply, delivery and installation of equipment without delays. Regular visits to consignees on selective basis by NTPC officials where the equipment do not get commissioned within the stipulated period may also be considered.

18.2 Non-conducting of pre-despatch inspection

NACO purchased 42 numbers each of (-) 40 degree Celsius and (-) 80 degree Celsius Deep Freezers in October 2000 for Rs. 2.01 crore. As no pre-despatch inspection was conducted, it could not be detected that the equipment supplied was not according to the technical specifications. Since the firm refused (September 2002) to replace the

equipment, the contract was cancelled by NACO in January 2003. Thus, the investment of Rs. 2.01 crore could not yield optimal returns.

18.3 Non-remittance of money to NACO

NTPC, according to their agreement with NACO, could claim only reimbursement for expenditure incurred on cost of advertisement/publication of Invitation for Bids (IFB) in newspapers. It was noticed in audit that NTPC did not remit to NACO Rs. 12.36 lakh collected by them from sale of bid documents during 1999-2003.

18.4 Purchase of defective HIV (ELISA) test kits

NACO purchased HIV (ELISA) test kits for Rs. 60.85 lakh in March 2002. During June and July 2002, some SACS complained that kits supplied were showing false positivity and demanded their replacement. The kits had not been replaced till June 2003.

18.5 Loss in the procurement of dielectric sealer

During October 2001, NACO purchased 80 dielectric sealers from the fifth lowest bidder, firm 'E', for Rs. 1.22 crore. The lowest bid of Rs. 58.91 lakh quoted by firm 'A' was rejected on the ground that their offer was for Automatic Trigger sealing with the help of optical sensor whereas technical specification in the bid was for Automatic Trigger sealing with micro-switch. The reasons for rejecting the lowest bid were not mentioned either in the technical evaluation sheet or the evaluation report. Clause 14.4 of section II-'Instructions to Bidders' clearly specified that a bidder could substitute alternative standard, brand names and/or catalogue number in its bid provided it demonstrated to the purchaser's satisfaction that the substitutes were substantially equivalent or superior to those designated in the technical specifications. However, despite its request of August 2001, firm 'A' was not given an opportunity to clarify the technical points with regard to Automatic Triggered sealing with optical sensor. The Technical Evaluation Committee in their review report (September 2001) concluded that specification of 'sealing triggered by optical sensor' in the offer of firm 'A' was considered a deviation from the tendered specifications during the technical evaluation of the bid and hence the evaluation report did not require any change. Later, firm 'A' in support of its claim furnished a letter on 12th October 2001 from Standardisation Testing and Quality Certification Directorate, Electronics Regional Test Laboratory, South, for Testing and Calibration Board Accreditation Thiruvananthapuram. The letter mentioned that optical sensor being a semi-conductor device had a longer life and was more reliable as compared to micro-switch, which was a mechanical device and was subject to wear and tear of contacts. Not giving an opportunity to firm 'A' which was the lowest tenderer, to demonstrate its technology for the substitute, (prescribed under the provisions of instructions to bidders) resulted in rejection of the lowest offer which was also superior and incurring extra expenditure of Rs. 63.50 lakh.

18.6 Irregular award of contract

NACO placed an order in February 2003 through NTPC for supply of 102 blood bank refrigerators costing Rs. 88.17 lakh out of which Rs. 12.75 lakh accounted for

imported components in the whole consignment. In a post-bid meeting with NTPC on 25 October 2002, the supplying firm expressed its inability to meet the imported components clause. NACO instructed NTPC on 27 December 2002 to receive the consignment only if it was in conformity with the terms and conditions of the contract i.e. 'imported component' clause. However, NTPC awarded the contract in February 2003 ignoring instructions issued by NACO. No action had been taken by NACO either against the supplier or NTPC. The supplier had dispatched 60 out of 102 blood bank refrigerators as of October 2003.

18.7 Advances lying un-adjusted with procurement agent

During the period 1999-2000 to 2002-03, NACO had made advance payments totalling Rs. 53.40 crore to NTPC for procuring various equipment/kits. Of this, Rs. 13.94 crore was still lying unadjusted with the agency as of March 2003.

NACO should consider reviewing the status of unutilised funds remaining with NTPC before advancing more funds to them.

18.7.1 Outstanding advances with NACO

An amount of Rs. 16.75 crore pertaining to the period 1993-94 to 2001-02 paid by NACO as advance payment for meeting day to day expenditure and other purposes were lying outstanding for want of recovery/adjustment till July 2003. During the course of review of NACO, the latest position of outstanding advances of Rs. 16.75 crore could not be ascertained since records relating to advance payments made and their adjustment were not provided.

Maintenance of registers/records relating to advance payment made, purposes for which advances were given and their adjustment/recovery may properly be done.

The following were noticed during audit of SACS/MACS:

(i) Project Director, Assam State AIDS Control Society (ASACS) procured substantial quantity of Ciprofloxacin tabs (500 mg) and Norfloxacin tabs (400 mg) respectively from two local suppliers between January 1999 and July 2002 through direct contracting and adopting the rate of Director of Medical Education (DME), Assam. The rate of Ciprofloxacin was Rs. 860 (Rs. 935.68 with tax) and that of Norfloxacin Rs. 185.00 (Rs. 201.28 with tax) per 100 tablets. The Project Director procured 13.25 lakh tablets of Ciprofloxacin and 17.54 lakh tables of Norfloxacin from the same suppliers and at the same rates for 4 years.

In August 2002, the Project Director, however, invited tenders and on the basis of competitive bidding approved a much cheaper rate of Rs. 295 (Rs. 320.96 with tax) and Rs. 179.00 (Rs. 194.75 with tax) respectively for 100 tablets of Ciprofloxacin and Norfloxacin. This indicated that the Project Director had procured the medicines at exorbitantly high rates during the preceding 4 years. Non-adoption of the method of competitive bidding thus resulted in avoidable expenditure of Rs. 81.48 lakh.

- (ii) In **Haryana**, the Society had purchased medicines valued at Rs. 59.34 lakh (Rs. 54.24 lakh in 1999-2001 and Rs. 5.10 lakh in 2001-03) without inviting tenders in contravention of guidelines of NACO. The Project Director stated (July 2003) that requirement of medicines was urgent and time for inviting tenders was insufficient. The reply is not tenable as purchases of medicines for FHAC were made in September 1999 (Rs. 9.84 lakh) and March 2000 (Rs. 44.40 lakh) whereas the camps were organised in December 1999 and June 2000.
- (iii) In contravention of NACO guidelines, the Haryana AIDS Control Society placed supply order (April 2000) with the Haryana State Small Industrial and Export Corporation Ltd. (HSSIEC) for Rs. 96.94 lakh for supply of awareness material like posters, folders, stickers, house to house contact cards and training modules, etc without advertising the invitation to bid in any newspaper and obtaining competitive rates. The Society called for quotations for the supply of similar material in March 2001 and January 2002. It was noticed in audit that the rates paid to HSSIEC in July 2002 based on a supply order placed in April 2000 for similar items were much higher than the rates received in March 2001 and January 2002 and thus extra avoidable payment of Rs. 43.36 lakh was made to HSSIEC due to non-observance of the prescribed purchase procedure.

19 Monitoring and Evaluation

NACO is responsible for monitoring and evaluation of the project in terms of project design summary of core indicators. Many of the core indicators rely on the routine Project Monitoring Reports (PMRs). A national monitoring and evaluation (M&E) agency would be selected early in the first year of the project. Each AIDS Control Society would have an M&E officer, and M&E would be conducted by outside agencies at baseline, interim, and final years. The Performance and Expenditure Annual Review (PEAR) would involve NACO, AIDS Control Societies, and IDA jointly reviewing project expenditures, financial flows, annual action plans, PMRs, and project input, output, outcome, and process indicators. The PEAR would be the basis for allocation of funds by NACO to AIDS Control Societies. The National Performance Review (NPR) would review annual overall program achievements and include key external partners, NGOs, and community leaders under the auspices of the National AIDS Control Board, the apex committee for HIV/AIDS control. Specific independent reviews of drugs and condom quality, surveillance and management would be done in the second year of the project.

19.1 Computerised Management Information System (CMIS)

The contract for consultancy services was signed in November 2000 by NACO and ORG Centre for Social Research. The total value of the contract awarded to ORG was Rs. 4.50 crore. In terms of the contract, ORG was required to perform the following activities:

1. Design and develop a Computerized Management Information System (CMIS)/ institutional framework for objective concurrent monitoring and evaluation which includes assessment of the status of project implementation and performance of the National AIDS Control Programme at national and state level.

- 2. Design a framework for impact evaluation of the project.
- 3. Conduct base line survey to establish the key performance indicators in all the AIDS Control Societies in states, UTs and Municipalities.
- 4. Participate in conducting mid-term and terminal evaluation to gauge the progress of the project in all the AIDS Control Societies in states, UTs and Municipalities.
- 5. Help State AIDS control Societies to identify and select State level Monitoring and Evaluation agency in each state.

In terms of the contract, CMIS was to be made operational within two months from the date of signing of the contract i.e. by January 2001. However, it was observed that NACO Server and CMIS Software was installed only in October 2001. As of August 2003, CMIS had been operationalised in all the Societies. Though CMIS had been made operational in all 38 Societies, monitoring of the programme was not effective as receipt of reports was poor. Of the 38 Societies, reports from all the societies had never been received during November 2001 to April 2003. Only during the period January 2002 to August 2002 were reports received from more than 30 Societies. In the remaining period, only 4 to 29 societies had reported. During November 2001 to December 2002, 5116 reports per month and during January 2003 to April 2003, 5129 reports per month were scheduled to be received from Societies against which only 160 reports (3.13 per cent) to 1995 (39 per cent) reports were received. Evaluation of information generated from CMIS had not been conducted so far.

19.2 Non-appointment of Monitoring and Evaluation Officer

For effective monitoring and evaluation of the programme, each State/Municipal AIDS Control Society was required to appoint a Monitoring and Evaluation Officer. It was, however, noticed that 17 (45 per cent) out of 38 Societies had no M&E Officer. NACO stated (September 2003) that in Societies without the M&E Officer, statistical officer/Assistant statistical officer/Data entry operator or Programme officer with additional charge of CMIS was functioning. However, monitoring and evaluation is an important activity, which cannot be done on a part-time basis.

19.3 National Performance Review

National Performance Review was to be carried out by NACB in accordance with terms of reference satisfactory to IDA. However, it was observed that no review had been carried out by NACB during the period from 1998-99 to 2002-03. NACO stated that there did not seem to be a need for a separate National Performance Review/PEAR since performance of all societies was being reviewed during the Project Directors' meetings and at the time of finalisation of Annual Action Plans.

The reply of NACO is not tenable as requirement of conducting a National Performance Review in accordance with the terms of reference satisfactory to the IDA has been prescribed in the scheme for prevention and control of HIV/AIDS.

19.4 Meeting of National AIDS Committee/SACS/MACS

The National AIDS Committee acts as the highest level deliberative body to oversee the performance of NACO and provide the overall policy directions and to forge multi-sectoral collaborative efforts and enable the participating organisations to mobilise their own administrative network for the various intervention projects. The Committee is required to meet as often as possible but at least once every year. It was observed that the Committee had not met since 2001.

Monitoring of the programme needs to be given more attention and conducted seriously at the national as well as State levels. CMIS is an effective tool, which should be properly used.

The following position prevailed in some of the States:

In **Maharashtra**, the Governing Body of MSACS was required to meet twice in a year. However, it did not meet after August 2000. Similarly, the Governing Body of Mumbai District AIDS Control Society (MDACS) did not meet even once during 2002-03.

The State AIDS Control Society in **Pondicherry** was required to hold at least three ordinary meetings in a year and an annual meeting within 3 months after the close of the financial year. However, during 1998-99 to 2002-03, the Society convened only five ordinary meetings. The Executive Committee of the State was required to review the progress of implementation, monitor the programme on a regular basis and resolve administrative and financial bottlenecks. However, the Executive Committee did not convene any meeting since its inception in 1994.

In **Bihar**, Governing Council of the State AIDS Control Society (headed by Commissioner-cum-Secretary) required to meet 19 times during 1998-2003 to ensure effective implementation of the NACP, met only 9 times during the same period. The State level officers did not oversee and evaluate implementation of the programme in the state.

In **Goa**, the Governing Body is required to meet twice in a year. The Governing Body, formed in September 1998, had met only thrice between December 1998 and March 2001. This resulted in non-preparation of annual plans for 1998-99 and 1999-2000 and preparation of annual plans for 2000-01 to 2002-03 without approval of the Governing Body.

Monitoring of the programme needs to be given more attention and conducted seriously at the national as well as State levels. CMIS is an effective tool, which should be properly used.

The review report was sent to the Ministry in November 2003 for their comments. Their reply has not been received so far (April 2004) despite reminders sent in December 2003, January 2004 and April 2004.

- 20 Summary of conclusions and recommendations
- The increase of estimated HIV cases from 3.50 million in 1998 to 4.58 million in 2002 and the increasing prevalence of HIV/AIDS among antenatal women points to the necessity of tightening the implementation and monitoring of the programme.
- Large amounts of unspent grants suggest that there is a pressing need to speed up the pace of implementation of the activities under NACP by the State Governments.
- > NACO needs to review its policy of not disclosing to an HIV infected person his HIV positive status.
- In view of multiple advantages of PCR over Elisa, NACO may consider introducing PCR on a limited scale for diagnosing HIV infection particularly in the newborn and the population at high risk.
- Since an HIV infected person may remain asymptomatic for a variable period of time (3-12 years), sustained preventive efforts are needed to contain the spread of the infection.
- NACO needs to ensure that the State Governments take all possible steps to educate people at large about prevention of HIV/AIDS. Special efforts are required to educate the female population particularly in rural areas.
- > It is necessary to increase the number of condom promotion programmes including social marketing in high risk areas and among vulnerable groups.
- > STD clinics are needed to be strengthened to help in preventing the spread of HIV/AIDS.
- For efficient disease management and control of hospital infection, NACO has to ensure that the State Governments provide training to the medical and para-medical staff in the PHCs, medical colleges and district hospitals.
- The areas relating to the care and support of HIV/AIDS patients need better attention. Community care centres and drop-in centres need to be established across the country.
- > Suitable rehabilitation schemes for vulnerable groups particularly CSWs need to be incorporated in the programme.
- NACO have to ensure that equipment/testing kits supplied to STD clinics, blood banks etc. through its procurement agent, NTPC, are installed and utilised early.
- > NACO may consider appointing a watchdog body of local NGOs/Panchayats to monitor the programme.

- Reasons for poor performance of inter-sectoral collaborators need to be reviewed.
- NACO should also monitor closely the functioning of SACS/MACS, NTPC and other organisations funded by it for implementation of NACP.
- > CMIS should be used effectively for monitoring the progress of implementing the programme.

(Dr. A.K. BANERJEE)

Director General of Audit
Central Revenues

Countersigned

New Delhi

New Delhi

Dated: 25 MAY 2004

Dated: 27 MAY 2004

(VIJAYENDRA N. KAUL)

Comptroller and Auditor General of India

Annex-I
(Refers to paragraph 5)
Details of samples selected

S.	Name of State	Name of State Coverage of MCH Coverage of Coverage of Blood bank STD elimina MCH															
No.	Name of State	expend	0	N	ICH	Cove	erage of	Cove	rage of	Bloo	d bank	STD	clinics	V	CTC	NO	GOs
		Total exp.	Exp.	МСН	МСН		thospitals		МО							100000	
		during 1998-		in the	Covered	DH in	DH	DMO of	DMO	Blood	Covered	STD	STD	VCTC	VCTC	NGOs	NGOs
	i i	99 to 2002-	(%)	state	(%)	the state	covered	Health	covered	banks	(%)	clinics	clinics		covered		covered
	į.	03 (Rs. in	(70)	State	(70)	state	(%)	in the State	(%)				covered		(%)		(%)
		lakh)						State					(%)				
1.	Andaman	285	285 (100)	NA	NA	2	1 (50)	2	1 (50)	1	1 (100)	1	1 (100)	9	2 (22)	2.4	
	&Nicobar Islands			Q-0003.512		-	1 (0.0)	_	1 (30)		1 (100)	1	1 (100)	9	3 (33)	4	2 (50)
2.	Andhra Pradesh	5300	4800 (89)	10	7 (70)	13	1 (8)	23	7 (30)	61	11 (18)	60	8 (13)	88	8 (9)	114	90 (70)
3.	Arunachal Pradesh	547	459 (84)	NA	NA	15	3 (20)	15	3 (20)	NA	NA NA	NA	NA	4	2 (50)	4	80 (70)
4.	Assam	1812	1450 (80)	3	3 (100)	21	5 (24)	23	6 (25)	15	6 (40)	15	6 (40)	15	6 (40)	54	2 (50)
5.	Bihar	1305	520 (40)	6	5 (83)	36	8 (22)	36	10 (28)	4	2 (50)	25	13 (50)	34	4 (12)	9	10 (21)
6.	Chandigarh (UT)	547	442 (81)	2	1 (50)	1	1(100)	1		3	2 (67)	3	2 (67)	3	2 (67)	11	8 (73)
7.	Chhattisgarh	247	143 (58)	1	1 (100)	16	4 (25)	16	4 (25)	9	4 (44)	9	4 (44)	9	4 (44)		0 (73)
8.	Dadra & Nagar Haveli	81	23 (29)	NA	NA	1	1 (100)	NA	NA	NA	NA	1	1 (100)	$\frac{1}{1}$	1 (100)	1	1 (100)
9.		100	100 (100)										. (100)		1 (100)		1 (100)
10.	Daman & Diu Delhi	182	182 (100)	NA	NA	2	2 (100)	NA	NA	1	1 (100)	NA	NA	1	5 (25)	NA	NA
11.	Goa	1339	1155 (86)	2	2 (100)	NA	NA	NA	NA	14	6 (43)	10	10(100)	15	15(100)	28	9 (32)
12.	Gujarat	436	209 (48)	1	1 (100)	2	2 (100)	2	2 (100)	3	3 (100)	3	2 (65)	2	2 (100)	7	NA NA
13.	Haryana	3772	1018 (27)	6	3 (50)	20	5 (25)	NA	NA	57	8 (14)	8	3 (38)	31	8 (26)	96	15 (16)
14.	Himachal Pradesh	934	672 (72)	1	1 (100)	19	6 (31)	19	6 (31)	17	5 (29)	16	6 (37)	12	5 (41)	12	6 (50)
15.	Jammu & Kashmir	1160 531	1160 (100)	2	1 (50)	12	3 (25)	NA	NA	11	4 (36)	56	11 (20)	5	3 (60)	13	4 (31)
16.	Jharkhand	154	298 (56)	1	1 (100)	12	4 (35)	12	3 (25)	15	5 (33)	11	8 (73)	3	3 (100)	4	1 (25)
17.	Karnataka	3772	111 (72)	3	3 (100)	18	5 (45)	18	5 (45)	14	6 (43)	3	1 (33)	3	3 (100)	NA	NA
18.	Kerala	1700	1018 (27) 1700 (100)	6	3 (50)	20	5 (25)	NA	NA	57	8 (14)	8	3 (38)	31	8 (26)	96	15 (16)
19.	Lakshadweep	71	71 (100)	6	2(33)	14	4 (29)	14	4 (29)	29	9 (31)	20	6 (30)	4	3 (75)	54	12 (22)
20.	Madhya Pradesh	1783	841 (47)	NA	NA 2 (CO)	1	1 (100)	9	1 (11)	NA	NA	NA	NA	10	10 (100)	NA	NA
21.	Maharashtra	6236	5380 (86)	5 35	3 (60)	45	8 (18)	45	8 (18)	42	9 (21)	45	11 (24)	19	9 (47)	10	1 (10)
22.	Mizoram	992	473 (48)	NA	10 (29)	51	11 (22)	33	8 (24)	64	15 (23)	68	16 (24)	71	15 (22)	40	19 (48)
23.	Meghalaya	243	118 (49)	NA NA	NA NA	8 7	4 (50)	4	2 (50)	NA	NA	8	4 (50)	5	2 (40)	11	6 (55)
24.	Orissa	1054	231 (22)	3	2 (67)		4 (57)	7	4 (57)	NA	NA	6	4 (65)	1	1 (100)	2	2 (100)
25.	Pondicherry	225	149 (66)	1	1 (100)	30	7 (23)	4	4 (100)	42	9 (21)	34	7 (21)	20	3 (38)	28	7 (25)
26.	Punjab	920	276 (30)	3	NA NA	17	2 (50)	17	NA C(25)	2	2 (100)	4	2 (50)	2	1 (50)	1	1 (100)
27.	Rajasthan	1143	539 (48)	10	9 (90)	37	5 (29) 10 (27)	17	6 (35)	NA	NA	17	6 (35)	8	5 (83)	14	3 (22)
28.	Sikkim	293	293 (100)	1	NA NA	4	4 (100)	32 4	5 (16)	18	9 (50)	33	7 (21)	6	1 (100)	19	5 (26)
29.	Tamil Nadu	6853	*	29	12 (41)	25	4 (100)	28	4 (100)	2	2 (100)	3	3 (100)	1	14 (29)	41	41 (100)
30.	Tripura	318	118 (37)	NA	NA NA	4	2 (50)	4	5 (18) 4 (100)	73	16 (22)	70	15 (21)	49	1 (100)	269	55 (20)
31.	Uttar Pradesh	4633	347 (7)	9	3 (33)	70	14 (11)	70	14 (11)	6	6 (100)	3	3 (100)	1	14 (32)	19	6 (32)
32.	West Bengal	4458	1605 (36)	7	4 (57)	15	4 (27)	17	4 (24)	41 58	8 (20)	36	8 (22)	44	11 (58)	34	6 (18)
	* Figure not availab		(20)	,	(37)	1.5	7 (21)	17	4 (24)	38	17 (29)	55	13 (24)	19		38	17 (47)

Figure not available.

NA Not Available

Annex-II (Refers to paragraph 8.5) Utilisation of grants by Societies

							(Rs in lakh)
S. No.	SACS/ MACS/	Opening Balance	Year	Funds released	Expenditure reported	Per cent Utilised	Unspent balance
1.	A & N Island	7.43	1999-2000	50.00	64.84	113	(+)7.41
1.	7 CC TV Island	(+) 7.41	2000-2001	66.44	53.89	91	5.14
		5.14	2001-2002	95.50	79.43	79	21.21
		21.21	2002-2003	89.50	141.71	128	(+)31.00
			TOTAL	301.44	339.87	110	
2.	Andhra	264.95	1999-2000	1219.67	1003.93	68	480.69
2.	Pradesh	480.69	2000-2001	824.50	823.95	63	481.24
		481.24	2001-2002	850.00	1163.33	87	167.91
		167.91	2002-2003	1290.00	1246.88	86	211.03
		10,,,,	TOTAL	4184.17	4238.09	95	
3.	Arunachal	NA	1999-2000	159.00	103.07	65	55.93
٥.	Pradesh	55.93	2000-2001	1111.00	140.83	84	26.10
	, ruueen	26.10	2001-2002	214.88	161.92	67	79.06
	S1.	79.06	2002-2003	130.50	140.63	67	68.93
			TOTAL	615.38	546.45	89	
4.	Assam	54.85	1999-2000	322.00	314.78	84	62.07
505,54	71004.11	62.07	2000-2001	375.00	346.27	79	90.80
		90.80	2001-2002	653.80	568.04	76	176.56
		176.56	2002-2003	614.50	643.78	81	147.28
			TOTAL	1965.30	1872.87	95	
5.	Bihar	11.61	1999-2000	55.00	124.03	186	(+)57.42
٥.	D.M.	(+) 57.42	2000-2001	196.00	105.84	76	32.74
		32.74	2001-2002	809.50	1017.85	121	(+)175.61
		(+) 175.61	2002-2003	600.50	89.33	21	335.56
			TOTAL	1661.00	1337.05	80	
6.	Chandigarh	22.08	1999-2000	115.00	123.38	90	13.70
0.	UT	13.70	2000-2001	93.11	106.32	99	0.49
		0.49	2001-2002	152.65	134.60	88	18.54
		18.54	2002-2003	156.50	150.82	86	24.22
			TOTAL	517.26	515.12	96	
7.	Chhattisgarh	NA	1999-2000	NA	NA	NA	NA
	- Cimaning	NA	2000-2001	NA	NA	NA	NA
		NA	2001-2002	150.50	95.64	64	54.86
		54.86	2002-2003	243.50	38.83	13	259.53
			TOTAL	394.00	134.47	34	
8.	Dadra &	NA	1999-2000	25.00	6.16	25	18.84
٥.	Nagar Haveli		2000-2001	9.00	14.80	53	13.04
	• 100	13.04	2001-2002	26.00	21.62	55	17.42
		17.42	2002-2003	17.00	7.44	22	26.98
			TOTAL	77.00	50.02	65	
9.	Daman & Diu	15.00	1999-2000	95.00	26.02	24	83.98
		83.98	2000-2001	9.00	72.76	78	20.22
		20.22	2001-2002	31.00	25.16	49	26.06
		26.06	2002-2003	36.00	45.42	73	16.64
			TOTAL	171.00	169.36	91	
10.	Delhi	81.04	1999-2000	283.00	383.39	105	(+)19.35
10.	Jun 1	(+)19.35	2000-2001	239.00	168.15	77	51.50
	1	51.50	2001-2002	334.00	329.46	85	56.04

					(Rs in lak)		
S. No.	SACS/ MACS/	Opening Balance	Year	Funds released	Expenditure reported	Per cent Utilised	Unspent balance
		56.04	2002-2003	431.00	241.15	50	245.89
			TOTAL	1287.00	1122.15	82	
11	Goa	33.03	1999-00	98.00	. 69.12	53	61.91
		61.91	2000-2001	72.73	92.78	69	41.86
		41.86	2001-2002	99.00	97.32	69	43.54
		43.54	2002-2003	170.50	66.61	31	147.43
			TOTAL	440.23	325.83	69	
12.	Gujarat	4.50	1999-2000	721.00	674.06	93	51.44
		51.44	2000-2001	347.17	264.20	66	134.41
		134.41	2001-2002	450.00	255.14	44	329.27
		329.27	2002-2003	136.00	140.39	30	324.88
			TOTAL	1654.17	1333.79	80	
13.	Ahmedabad	NA	1999-2000	75.00	38.89	52	36.11
	MACS	36.11	2000-2001	84.61	65.14	54	55.58
		55.58	2001-2002	58.30	102.90	90	10.98
		10.98	,2002-2003	129.55	113.53	81	27.00
		1	TOTAL	347.46	320.46	92	
14.	Haryana	131.37	1999-2000	270.00	194.29	48	207.08
		207.08	2000-2001	246.50	321.05	71	132.53
		132.53	2001-2002	266.00	207.76	52	190.77
		190.77	2002-2003	315.00	206.28	41	299.49
			TOTAL	1097.50	929.38	76	
15.	Himachal	7.77	1999-2000	318.00	227.02	70	98.75
	Pradesh	98.75	2000-2001	262.50	266.68	74	94.57
		94.57	2001-2002	308.50	276.80	69	126.27
		126.27	2002-2003	236.50	259.68	72	103.09
			TOTAL	1125.50	1030.18	91	
16.	Jammu &	NA	1999-2000	25.00	16.40	66	8.60
	Kashmir	8.60	2000-2001	152.00	69.03	43	91.57
		91.57	2001-2002	244.50	215.63	64	120.44
		120.44	2002-2003	295.50	49.86	12	366.08
		ļ	TOTAL	717.00	350.92	49	
17	Jharkhand	NA	1999-2000	NA	NA	NA	NA
		NA	2000-2001	NA	NA	NA	NA
		NA	2001-2002	156.00	NA	NA	156.00
		156.00	2002-2003	162.00	NA	NA	318.00
10	77	0606	TOTAL	318.00	NA	NA	
18	Karnataka	96.26	1999-2000	801.67	555.03	62	342.90
		342.90	2000-2001	398.65	533.57	72	207.98
		207.98	2001-2002	785.15	783.35	79	209.78
		209.78	2002-2003	975.00	806.03	68	378.75
19	Kerala	65.00	TOTAL	2960.47	2677.98	88	12.15
19	Keraia	65.00	1999-2000	280.00	301.65	87	43.45
		43.45	2000-2001	350.63	286.54	73	107.44
		107.44	2001-2002	368.00	260.71	55	214.73
		214.73	2002-2003	470.00	274.38	40	410.35
20	Lalcabel	374	TOTAL	1468.63	1123.28	73	
20	Lakshdweep	NA 22.06	1999-2000	25.00	1.04	4	23.96
		23.96	2000-2001	9.16	18.84	57	14.28
		14.28	2001-2002	29.50	22.62	52	21.16
		21.16	2002-2003	25.50	20.56	44	26.10
			TOTAL	89.16	63.06	71	

		.,					(Ks in lakn)
S. No.	SACS/ MACS/	Opening Balance	Year	Funds released	Expenditure reported	Per cent Utilised	Unspent balance
21	Madhya	296.50	1999-2000	352.31	461.53	71	187.28
	Pradesh	187.28	2000-2001	542.00	361.49	50	367.79
		367.79	2001-2002	780.50	471.12	41	677.17
		677.17	2002-2003	481.50	138.66	12	1020.01
		077.17	TOTAL	2156.31	1432.80	58	
22.	Maharashtra	587.28	1999-2000	998.35	1157.80	73	427.83
22.	- Manarasina	427.83	2000-2001	852.00	832.95	65	446.88
		446.88	2001-2002	550.00	259.22	26	737.66
		737.66	2002-2003	1025.50	593.93	34	1169.23
			TOTAL	3425.85	2843.90	71	
23	Mumbai	NA	1999-2000	670.00	718.92	107	(+)48.92
	MACS	(+)48.92	2000-2001	431.65	408.78	107	(+)26.05
	COLUMN TO THE CO	(+)26.05	2001-2002	585.65	410.44	73	149.16
		149.16	2002-2003	603.00	565.46	75	186.70
			TOTAL	2290.30	2103.60	92	
24.	Manipur	0.07	1999-2000	352.38	561.89	159	(+)209.44
277,114,01	CO-COUNTY INVOICE	(+)209.44	2000-2001	415.30	145.94	71	59.92
		59.92	2001-2002	708.15	656.03	85	112.04
		112.04	2002-2003	787.50	465.40	52	434.14
			TOTAL	2263.33	1829.26	81	
25	Meghalaya	NA	1999-2000	70.14	43.88	63	26.26
		26.26	2000-2001	87.50	50.50	44	63.26
		63.26	2001-2002	224.93	64.18	22	224.01
		224.01	2002-2003	90.50	66.74	21	247.77
			TOTAL	473.07	225.30	48	
26	Mizoram	1.89	1999-2000	168.00	170.55	100	(+)0.66
		(+)0.66	2000-2001	179.00	177.46	99	0.88
		0.88	2001-2002	246.70	266.85	108	(+)19.27
		(+)19.27	2002-2003	311.50	330.27	113	(+)38.04
			TOTAL	905.20	945.13	104	
27	Nagaland	0.04	1999-2000	380.00	455.23	120	(+)75.19
		(+)75.19	2000-2001	250.50	187.39	107	(+)12.08
		(+)12.08	2001-2002	635.50	568.54	92	54.88
		54.88	2002-2003	626.50	647.78	95	33.60
			TOTAL	1892.50	1858.94	98	
28.	Orissa	100.00	1999-2000	200.00	34.47	11	265.53
		265.53	2000-2001	358.50	203.53	33	420.50
		420.50	2001-2002	200.00	214.02	34	406.48
		406.48	2002-2003	148.00	110.08	20	444.48
			TOTAL	906.50	562.10	56	(.)10.70
29	Pondicherry	NA	1999-2000	25.00	35.78	143	(+)10.78
		(+)10.78	2000-2001	21.50	26.81	250	(+)16.09
		(+)16.09	2001-2002	54.00	48.98	129	(+)11.07
		(+)11.07	2002-2003	74.00	64.39	102	(+)1.46
			TOTAL	174.50	175.96	101	120.02
30.	Punjab	0.73	1999-2000	312.39	173.29	55	139.83
		139.83	2000-2001	321.50	177.55	38	283.78
		283.78	2001-2002	266.50	185.62	34	364.66
		364.66	2002-2003	403.50	287.45	37	480.71
			TOTAL	1303.89	823.91	63	152 55
31	Rajasthan	139.81	1999-2000	150.00	136.26	47	153.55
		153.55	2000-2001	380.00	232.68	44	300.87

			(Ks in lakh)				
S.	SACS/	Opening	Year	Funds	Expenditure		Unspent
No.	MACS/	Balance		released	reported	Utilised	balance
		300.87	2001-2002	317.50	297.01	48	321.36
		321.36	2002-2003	358.50	175.54	26	504.32
			TOTAL	1206.00	841.49	63	
32.	Sikkim	65.55	1999-2000	25.00	44.16	49	46.39
	Control of the Contro	46.39	2000-2001	66.00	45.50	40	66.89
		66.89	2001-2002	120.02	73.95	39	112.96
		112.96	2002-2003	64.00	91.82	52	85.14
			TOTAL	275.02	255.43	75	
33	Tamilnadu	688.61	1999-2000	883.09	1762.32	112	(+)190.62
	2, 25, 25, 25, 25, 25, 25, 25, 25, 25, 2	(+)190.62	2000-2001	1108.30	755.03	82	162.65
		162.65	2001-2002	1393.50	1309.87	84	246.28
		246.28	2002-2003	1295.50	1315.18	85	226.60
			TOTAL	4680.39	5142.40	96	
34	Chennai MC	NA	1999-2000	125.00	29.21	23	95.79
		95.79	2000-2001	101.50	28.24	14	169.05
		169.05	2001-2002	62.45	105.95	46	125.55
		125.55	2002-2003	186.45	145.56	47	166.44
			TOTAL	475.40	308.96	65	
35	Tripura	NA	1999-2000	50.00	36.60	73	13.40
		13.40	2000-2001	92.00	76.73	57	28.67
		28.67	2001-2002	196.67	129.01	57	96.33
		96.33	2002-2003	71.00	57.07	34	110.26
			TOTAL	409.67	299.41	73	
36.	Uttar Pradesh	305.28	1999-2000	851.00	343.77	30	812.51
		812.51	2000-2001	1175.00	448.53	23	1538.98
		1538.98	2001-2002	1465.65	1729.25	58	1275.38
		1275.38	2002-2003	1674.50	467.11	16	2482.77
			TOTAL	5166.15	2988.66	55	
37.	Uttaranchal	NA	1999-2000	NA	NA	NA	NA
		NA	2000-2001	NA	NA	NA	NA
		NA	2001-2002	98.00	NA	NA	98.00
	-	98.00	2002-2003	162.00	113.76	44	146.24
			TOTAL	260.00	113.76	44	
38.	West Bengal	338.40	1999-2000	425.00	621.80	81	141.60
5 76		141.60	2000-2001	643.15	544.60	69	240.15
		240.15	2001-2002	1059.50	1221.56	94	78.09
		78.09	2002-2003	1503.00	774.32	49	806.77
			TOTAL	3630.65	3162.28	80	
	Grand Total	3319.05	1999-2000	10975.00	11014.56	77	3279.49
		3279.49	2000-2001	10872.40	8454.35	58	5697.54
		5697.54	2001-2002	15048.00	13830.88	65	6914.66
		6914.66	2002-2003	16391.00	11093.83	47	12211.83
_				53286.40	44393.62		

Annex-III
(Refers to paragraph 9.2)
HIV prevalence levels State-wise: 1998 –2002

S. No	Name of State/UT	Number of sites in 2002	HIV Prev. 1998 (%) (180 sites)	HIV Prev. 1999 (%) (180 sites)	HIV Prev. 2000 (%) (232 sites)	HIV Prev. 2001 (%) (320 sites)	HIV Prev 2002 (%) (384 sites)
1.	A&N	STD 2	1.20	0.40	1.20	1.20	2.60
*	Islands	ANC 3	0.00	0.00	0.25	0.16	0.00
2.	Andhra	STD 8	24.90	29.50	30.00	26.60	30.40
2.	Pradesh	ANC 14	2.25	2.60	2.00	1.50	1.25
3.	Arunachal	STD 4	0.00	0.00	0.10	0.00	0.00
٠.	Pradesh	ANC 2	0.40	0.00	0.00	0.00	0.00
4.	Assam	STD 5	2.10	2.40	0.61	1.49	0.75
		ANC 4	0.00	0.00	0.00	0.00	0.00
5.	Bihar	STD 8	1.35	0.60	0.50	1.20	1.60
1,500		ANC 7	0.00	0.00	0.10	0.13	0.25
6.	Chandigarh	STD 2	2.95	1.80	3.35	3.78	0.80
200	0	ANC 1	0.47	0.80	0.00	0.00	0.25
7.	Chhattisgarh	STD 3	NA	NA	NA	1.40	0.80
	J	ANC 5	NA	NA	NA	0.33	0.25
8.	D&N	STD 0	0.00	0.00	NA	NA	NA
	Haveli	ANC 1	0.00	0.00	0.00	0.25	1.00
9.	Daman &	STD 0	0.00	0.00	NA	· NA	NA
	Diu	ANC 2	0.13	0.00	0.00	0.25	0.22
10.	Delhi	STD 4	1.60	0.80	3.26	4.65	3.23
		ANC 4	0.25	0.30	0.25	0.13	0.25
		IDU 1			5.00	2.40	7.20
11.	Goa	STD 2	19.40	13.50	12.02	15.00	11.29
		ANC 2	1.20	0.80	1.17	0.50	1.38
		CSW 1			53.20	50.79	24.00
12.	Gujarat	STD 8	2.50	6.70	4.65	4.14	6.17
		ANC 8	0.00	0.40	0.50	0.50	0.38
13.	Haryana	STD 5	2.60	5.30	2.75	1.08	1.14
		ANC 4	0.00	0.00	0.00	0.41	0.38
14.		STD 5	2.00	0.40	0.40	0.26	0.40
	Pradesh	ANC 7	0.36	0.30	0.89	0.13	0.00
15.		STD 2	1.83	1.20	0.40	0.80	0.95
	Kashmir	ANC 3	0.00	0.00	0.12	0.25	0.08
16.	Jharkhand	STD 3	NA	NA	NA	0.25	0.13
		ANC 6	NA 16.70	NA 15.50	NA 12.00	0.08	0.00
17.	Karnataka	STD 7	16.70	15.50	12.80	16.40 1.13	13.60 1.75
		ANC 10	1.75	1.00	1.68		2.26
		IDU 1	NA 2.60	1.30	4.23	2.00	2.26
18.	Kerala	STD 4	2.60	3.20	5.20	6.42	0.38
4.0	Y 1 1 1	ANC4	0.10	0.00	0.00	0.08 NA	0.00
19.	Lakshdweep	STD 1	0.00	0.00	0.00	NA NA	0.00
20) / II	ANC 2	0.60	0.00	0.00	2.69	2.35
20.		STD 10	3.50	0.20	1.60 0.12	0.25	0.00
	pradesh	ANC13	0.00	0.30	18.40	9.20	7.60
21.	Maharashtra	STD 9 ANC 14	16.00 2.00	20.00 2.10	1.12	1.38	1.25

S. No	Name of State/UT	Number of sites in 2002	HIV Prev. 1998 (%) (180 sites)	HIV Prev. 1999 (%) (180 sites)	HIV Prev. 2000 (%) (232 sites)	HIV Prev. 2001 (%) (320 sites)	HIV Prev. 2002 (%) (384 sites)
22.	Mumbai	STD 3	NA	NA	33.33	21.06	14.84
		ANC 6	NA	NA	2.00	2.25	0.75
		IDU 1	NA	NA	23.68	41.37	39.42
		MSM 1	NA	NA	23.94	23.60	16.80
		CSW 1	NA	NA	58.67	52.26	54.50
23.	Manipur	IDU 3	70.70	48.80	64.34	56.26	39.06
	- 1	STD 2	4.15	12.00	11.60	10.50	9.60
		ANC 10	0.75	2.30	0.75	1.75	1.12
24.	Meghalaya	IDU 1	0.00	0.00	1.41	1.39	0.00
	Į,	STD 2	0.13	0.30	0.00	0.00	0.90
		ANC 2	0.00	0.00	0.00	0.00	0.00
25.	Mizoram	IDU 1	1.00	1.50	9.61	2.00	1.60
57.50	With the chart the transfer of the chart	STD 2	1.49	0.76	2.00	2.20	2.60
		ANC 3	0.48	0.48	0.37	0.33	1.50
26.	Nagaland	IDU 3	13.20	7.60	7.03	5.50	10.28
		STD1	11.10	4.40	6.90	7.40	2.42
		ANC4	0.70	1.30	1.35	1.25	1.25
27.	Orissa	STD 8	2.86	1.20	2.60	0.80	0.80
		ANC4	0.00	0.10	0.27	0.25	0.25
28.	Pondicherry	STD 3	7.20	5.80	4.10	2.0	2.02
Estima		ANC2	0.50	0.90	0.25	0.25	0.25
29.	Punjab	STD 3	0.00	2.00	0.80	1.61	1.60
Ŧ		ANC 4	0.00	0.40	0.00	0.40	0.49
30.	Rajasthan	STD 7	5.20	3.20	2.84	4.00	6.00
	•	ANC 6	0.00	0.30	0.25	0.00	0.50
31.	Sikkim	STD 1	0.00	0.00	0.00	0.00	0.00
		ANC 2	0.13	0.10	0.00	0.00	0.13
32.	Tamil Nadu	STD 11	16.30	10.40	16.80	12.60	14.7
22000		ANC 10	1.00	1.00	1.00	1.13	0.88
		IDU 1	NA	NA	26.70	24.56	33.80
		MSM 2	NA	NA	4.00	2.40	2.40
33.	Tripura	STD 2	0.00	0.80	1.34	3.20	1.40
		ANC 1	NA	NA	NA	0.25	0.00
34.	Uttar	STD 17	1.60	0.60	1.80	0.90	0.80
	Pradesh	ANC 17	0.24	0.00	0.12	0.00	0.25
35.	Uttranchal	STD 4			NA	0.40	0.26
Carrent Control		ANC 3			NA	0.00	0.23
36.	West Bengal	STD 8	0.40	1.40	1.96	0.60	0.47
	J	ANC 9	0.62	0.10	0.50	0.13	0.00
		IDU 1			NA	NA	1.50

Note: 1. HIV prevalence values in States with more than 3 sites are median values, while in States/UTs with 3 or less than 3 sites, the values are mean values.

2. Sites with 75% coverage of desired sample size (STD: 250 & ANC: 400) are included for analysis.

Annex-IV
(Refers to paragraph 9.3)
State-wise details of AIDS cases reported to NACO

	,			NO. OF A	IDS CASES		
S. No	SACS/MACS	SACS/MACS AS ON 31-3-99		AS ON 31-3-01	AS ON 31-3-02	AS ON 31-3-03	AS ON 31-7-03
1.	A & N Islands	0	0	13	20	24	32
2.	Andhra Pradesh	48	48	612	1316	3341	4066
3.	Arunachal Pradesh	0	0	0	0	0	0
4.	Assam	22	67	110	149	149	171
5.	Bihar	3	3	44	103	148	152
6.	Chandigarh	NA	157	292	470	684	733
7.	D & N Haveli	0	0	0	0	0	0
8.	Daman & Diu	1	1	1	1	1	01
9.	Delhi	219	219	500	660	766	807
10.	Goa	15	19	29	77	155	220
11.	Gujarat	137	137	689	1465	2474	2758
12.	Ahmedabad MC	NA	NA	NA	267	267	267
13.	Haryana	1	1	48	189	271	302
14.	Himachal pradesh	9	28	85	91	109	112
15.	Jammu & Kashmir	2	2	2	2	2	2
16.	Karnataka	172	282	918	1337	1654	1742
17.	Kerala	106	106	267	267	267	267
18.	Lakshdweep	0	0	0	0	0	0
19.	Madhya pradesh	210	369	664	759	972	1007
20.	Maharashtra	3354	3405	4459	7045	9234	9234
21.	Mumbai MC	NA	NA	NA	NA	2067	2595
22.	Orissa	2	16	55	82	82	128
23.	Nagaland	10	37	103	235	319	334
24.	Manipur	301	454	790	1095	1238	1238
25.	Mizoram	7	12	16	20	47	51
26.	Meghalaya	8	8	8	8	8	8
27.	Pondicherry	141	141	141	157	157	157
28.	Punjab	100	100	131	135	231	248
29.	Rajasthan	79	115	272	394	666	788
30.	Sikkim	2	2	2	4	6	8
31.	Tamil Nadu	1881	5231	9714	16677	21813	2466
32.	Tripura	0	0	0	0	6	4
33.	Uttar Pradesh	125	234	282	506	845	1032
34.	West Bengal	57	57	57	831	930	930
	TOTAL	7012	11251	20304	34362	48933	54061

Annex-V (Refers to paragraph 10.1.3) Variation in allocation of per person expenditure on high risk groups

(Amount in Rupees)

S. No.	Category of HRG	Name of Society	Allocation as per Norms	Actual Expenditure						
	into	500101		1999-2000	2000-01	2001-02	2002-03			
1.	CSW	Andhra Pradesh	1208.50	730	579	345	179			
	2511	Assam	1208.50	10120	1687	4037	5034			
		Haryana	1208.50	NA	742	423	425			
		Karnataka	1208.50	489	486	829	1104			
	1	Maharashtra & Mumbai	1208.50	233	190	225	173			
		Manipur	1208.50	During this p	eriod the exper	nditure was R	s. 1319 per			
		Mizoram	1208.50	2764	2160	4367	NA			
		Orissa	1208.50	NA	281	NA	53			
		Rajashtan	1208.50	NA	NA	1046	1140			
2.	Truck drivers	Andhra Pradesh	94.70	NA	25	67	35			
		Assam	94.70	NA	NA	16737	68			
		Chandigarh	94.70	During this person	period the exp	enditure was	Rs. 77 per			
	-	Haryana	94.70	25	71	54	26			
		Karnataka	94.70	18	54	49	145			
		Maharashtra	94.70	13	57	39	35			
		Manipur	94.70	During this person	period the expe	enditure was I	Rs. 269 per			
		Mizoram	94.70	1176	553	1315	NA			
		Orissa	94.70	NA	122	68	32			
		Pondicherry	94.70	NA	NA	30	36			
1		Rajashtan	94.70	NA	NA	175	25			
3.	Migrants	Andaman Nicobar Islands	241.60	NA	NA	207	NA			
		Chandigarh	241.60	During this person	period the exp	enditure was	Rs. 45 per			
		Maharashtra	241.60	59	51	87	103			
		Manipur	241.60	During this person	period the expe	enditure was I	Rs. 223 per			
	J/2	Orissa	241.60	NA	128	34	20			
		Rajasthan	241.60	NA	NA	232	259			
4.	Street children	Andhra Pradesh	718.00	276	64	96	- 55			
		Chandigarh	718.00	During this person	period the expe		SAIL			
		Orissa	718.00	NA	NA	NA	65			
		Rajasthan	718.00	NA	NA	1051	804			
5.	MSM	Andhra Pradesh	1208.50	NA	NA	90	27			
	U-0 (0.000 - 200 HeV)	Karnataka	1208.50	256	207	704	1630			
		Manipur	1208.50	person	period the expe					
6.	IDU	Assam	1208.50	NA	NA	NA	1220			
		Manipur	1208.50	During this period the expenditure was Rs. 773 per person						
		Mizoram	1208.50	755	1296	1451	NA			

Annex-VI (Refers to paragraph 10.2) Condom distribution

(Pieces in lakh)

0	C4 4 /FIM	1998-99 1999-00			200	0.01		(Pieces in lakh)			
S.	State/UT						0-01	2001		2002-03	
No.		Free	Social	Free	Socia		Social	Free	Social	Free	Social
1.	A & N Islands	NA	NA	NA	NA	0.03	0.22	0.02	0.02	0.06	0.19
2.	Andhra Pradesh	NA	NA	NA	NA	NA	NA	55.66	7.77	135.10	7.86
3.	Arunachal Pradesh	NA	NA	NA	NA	NA	NA	0.08	NA	0.10	NA
4.	Assam	NA	NA	NA	NA	0.30	NA	0.66	2.84	1.46	5.12
5.	Chandigarh	1.08	NA	0.75	NA	1.37	NA	1.14	NA	1.54	NA
6.	Chhattisgarh	NA	NA	NA	NA	NA	NA	NA	NA	2.46	N/
7.	D & N Haveli	2.84	NA	NA	NA	NA	NA	NA	NA	54.73	5.9
8.	Daman & Diu	0.80	NA	0.86	NA	0.93	NA	1.25	NA	1.26	NA
9.	Delhi	28.14	NA	52.70	NA	30.90	0.43	37.65	NA	45.00	N/
10.	Goa	NA	NA	NA	NA	1.00	NA	1.00	NA	5.00	NA
11.	Gujarat including Ahmedabad (MACS)	NA	NA	0.92	0.02	8.20	0.36	30.18	0.76	37.97	0.56
12.	Haryana	9.61	NA	1.58	NA	7.83	NA	4.28	0.20	3.80	1.10
13.	Himachal pradesh	58.80	NA	40.93	NA	44.39	0.21	54.34	1.29	75.56	2.42
14.	Jammu & Kashmir	NA	NA	NA	NA	NA	NA	1.16	NA	NA	NA
15.	Karnataka	NA	15.45	81.00	NA	NA	NA	NA	NA	NA	NA
16.	Jharkhand	No condo	ms distrib	uted sinc	e format	ion of So	ciety (sinc	e 6/01)			
17.	Kerala	0.90	0.04	2.80	0.29	4.43	2.13	5.32	2.50	4.61	2.80
18.	Madhya Pradesh	NA	. NA	NA	NA	NA	0.13	15.00	3.71	NA	0.12
19.	Maharashtra including Mumbai	383.68	NA	437.72	NA	414.10	48.52	328.59	78.12	487.32	52.40
20.	Manipur	1.00	NA	1.84	NA	1.37	0.99	1.96	0.85	5.00	5.70
21.	Mizoram	0.06	NA	NA	NA	0.20	0.20	0.02	0.24	0.20	0.30
22.	Orissa	NA	NA	NA	NA	0.04	3.22	NA	2.18	0.03	2.14
23.	Pondicherry	1.76	NA	1.54	NA	1.90	NA	0.52	NA	0.42	NA
24.	Punjab	NA	NA	NA	NA	NA	NA	1.38	1.17	1.98	0.71
25.	Rajasthan	NA	NA	0.02	NA	0.08	2.91	0.06	0.99	0.58	0.10
26.	Sikkim	NA	NA	NA	NA	NA	0.12	NA	0.12	0.22	0.20
27.	Tamil Nadu	35.71	NA	24.73	NA	10.08	10.08	15.54	23.80	8.28	1.61
28.	Chennai MC	NA	NA	NA	NA	NA	NA	0.46	NA	4.82	1.09
29.	Tripura	NA	NA	NA	NA	NA	0.08	NA	0.22	0.24	NA
30.	Uttar Pradesh	NA	NA	NA	NA	NA	NA	20.00	NA	29.85	NA
	Total	524.38	15.49	647.39	0.31	527.15	69.60	576.27	126.78	907.59	90.39

Annex-VII

(Refers to paragraph 10.2.2)

Awareness of condoms among general population

Proportion of respondents who had ever heard of or seen a condom

(All figures are in percentage)

SI.	State/State Group	Urban			Rural			Combined*		
No.		M	F	Т	M	F	T	M	F	Т
1.	Andhra Pradesh	91.7	81.2	86.5	84.8	83.2	84.0	86.6	82.7	84.7
2.	Arunachal Pradesh	90.9	75.9	83.4	71.6	52.4	62.0	75.3	56.9	66.1
3.	Assam	94.9	81.3	88.1	78.5	60.5	69.5	80.4	62.8	71.6
4.	Bihar	91.9	83.6	87.7	70.5	59.2	64.8	73.3	62.4	67.8
5.	Delhi	94.3	89.4	91.8	95.2	85.4	90.1	94.4	89.0	91.6
6.	Goa	98.2	87.1	92.7	96.6	79.4	88.0	97.3	82.6	89.9
7.	Gujarat	94.7	84.0	89.4	86.1	58.7	72.2	89.1	67.3	78.1
8.	Haryana	95.4	95.1	95.2	87.9	82.8	85.4	89.8	85.9	87.8
9.	Himachal Pradesh	97.9	98.2	98.1	95.7	94.8	95.2	95.9	95.1	95.5
10.	Jammu & Kashmir	99.6	97.7	98.6	87.0	77.6	82.3	90.0	82.4	86.2
11.	Karnataka	91.6	69.7	80.7	77.9	51.6	64.8	82.2	57.1	69.7
12.	Kerala	98.9	92.8	95.2	98.0	92.2	94.7	98.2	92.4	94.8
13.	Madhya Pradesh	95.6	84.7	90.2	82.1	57.5	69.8	85.3	63.7	74.5
14.	Maharashtra	97.5	80.3	89.0	84.8	49.5	67.2	89.7	61.4	75.6
15.	Manipur	97.3	94.5	95.9	90.7	68.6	79.7	92.5	75.7	84.1
16.	Orissa	92.1	79.7	85.9	75.5	47.0	61.2	77.7	51.4	64.5
17.	Punjab	99.5	94.6	97.0	99.6	94.2	96.9	99.6	94.3	96.9
18.	Rajasthan	92.8	86.7	89.7	78.9	69.8	74.3	82.0	73.7	77.8
19.	Sikkim	95.2	91.3	93.2	77.3	66.6	71.9	78.9	68.8	73.9
20.	Tamil Nadu	92.5	69.3	80.9	82.5	52.7	67.6	85.9	58.5	72.2
21.	Uttar Pradesh	89.3	87.8	88.6	84.0	74.4	79.1	85.0	77.1	81.0
22.	West Bengal	92.4	89.6	91.0	76.0	67.5	71.8	80.5	73.6	77.1
All In	dia									
Mean		94.7	86.2	90.4	84.5	69.5	76.9	86.7	73.5	80.1
Range	e	89.3-	69.3-	80.7-	70.5-	47-	61.2-	73.3-	51.4-	64.5-
		99.6	98.2	98.6	99.6	94.8	96.9	99.6	95.1	96.9

Weighted figure

Annex-VIII (Refers to paragraph-10.2.3)

Condom use by commercial sex workers with paying clients and non-paying partners

(All figures are in percentage)

Sl.No.	State/State Group	Last Time Co	ondom Use	Consistent Condom Use in Last 30 days			
		With paying client	With non paying partners *	With paying client	With non paying partners in last 3 months *		
1.	Andhra Pradesh	78.9	58.2	53.1	29.1		
2.	Assam	75.2	48.5	26.9	12.6		
3.	Bihar**	65.3	20.0	23.9	5.3		
4.	Delhi	72.5	66.7	63.6	45.8		
5.	Goa	77.0	44.2	69.3	32.6		
6.	Gujarat	77.1	34.5	58.1	26.8		
7.	Haryana	69.6	16.6	27.6	7.3		
8.	Himachal Pradesh	87.8	35.7	41.0	16.3		
9.	Jammu & Kashmir	80.7	26.3	50.9	6.3		
10.	Karnataka	73.4	58.6	55.7	33.7		
11.	Kerala	87.8	48.0	73.7	38.2		
12.	Madhya Pradesh**	70.9	49.2	65.0	28.5		
13.	Maharashtra	87.7	39.3	72.5	7.1		
14.	Manipur	71.8	67.9	53.3	44.9		
15.	Orissa	73.0	53.6	65.2	38.5		
16.	Other NE States**	64.1	40.2	23.7	20.5		
17.	Punjab	79.0	25.4	45.8	9.7		
18.	Rajasthan	67.8	25.6	33.8	13.3		
19.	Tamil Nadu**	83.3	25.0	54.1	9.2		
20.	Uttar Pradesh**	68.9	41.5	61.9	13.8		
21.	West Bengal	86.5	22.6	39.0	9.5		
Brothel Based		75.2	39.0	57.2	21.3		
Non Brothel Based		76.5	38.7	45.8	20.2		
All Indi	a	76.0	38.8	50.3	20.5		

^{*} Those respondents who reported any non-paying partner in the last 7 days

^{**} Figures in respect of Bihar include Jharkhand, Mahdya Pradesh include Chhattisgarh, Tamil Nadu include Chennai, Uttar Pradesh include Uttaranchal and other NE States include Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura.

Annex-IX (Refers to paragraph 10.2.4)

Proportion of respondents who reported that it takes less than 30 minutes to obtain a condom from their place of residence

(All figures are in percentage) Combined* Urban Rural SI. State/State Group F M F F T M No. M 44.4 46.1 50.8 41.5 55.4 59.3 68.8 47.3 1. Andhra Pradesh 78.3 40.4 45.8 77.3 62.7 70.0 44.9 35.2 40.1 51.1 2. Arunachal Pradesh 36.3 40.9 31.4 35.5 45.4 39.6 3. 92.2 76.3 84.2 Assam 39.4 28.1 33.2 44.4 34.3 4. Bihar 84.2 75.3 79.7 38.4 84.0 49.5 66.4 50.6 66.7 5. Delhi 84.1 49.3 66.4 83.8 48.2 59.9 48.5 71.5 89.2 62.8 76.0 59.0 37.9 6. Goa 40.3 50.4 89.5 70.3 79.9 45.3 24.8 34.9 60.7 7. Gujarat 41.4 50.2 33.2 41.8 58.9 85.4 66.5 75.9 50.3 Haryana 8. 87.3 82.5 84.9 53.1 59.4 56.2 56.1 61.4 58.7 Himachal Pradesh 9. 52.3 90.8 47.1 33.5 40.3 58.6 46.1 10 95.0 86.6 Jammu & Kashmir 33.8 27.2 14.7 21.0 42.6 25.0 76.9 48.2 62.7 11. Karnataka 67.7 75.5 81.7 67.8 73.7 83.2 67.8 74.2 87.7 12. Kerala 49.8 32.3 41.1 76.0 38.6 22.6 30.5 Madhya Pradesh 86.8 65.1 13. 41.2 48.0 91.7 70.5 81.1 31.4 22.8 27.1 54.8 14. Maharashtra 29.8 35.4 54.2 44.4 49.3 41.0 89.4 83.2 86.3 15. Manipur 30.8 30.0 18.2 24.1 37.3 24.2 85.2 62.9 74.0 16. Orissa 74.2 57.0 65.6 80.4 62.6 71.5 74.7 84.3 Punjab 93.8 17. 42.7 48.7 79.7 62.7 70.9 47.8 36.8 42.2 55.0 18. Rajasthan 30.3 34.1 90.7 85.3 88.0 32.7 24.8 28.8 38.0 19. Sikkim 50.2 41.3 31.0 38.9 59.2 82.8 60.7 71.7 46.8 20. Tamil Nadu 17.7 27.5 26.3 36.1 60.7 71.1 37.5 46.2 21. Uttar Pradesh 82.1 54.5 58.1 51.7 43.4 47.6 61.8 86.1 22. West Bengal 88.7 83.5 All India 49.6 65.5 47.7 34.6 41.1 56.8 42.6 Mean 86.3 77.5 24.2-30.8-14.7-21.0-37.3-76.9-48.2-62.7-27.2-Range 67.8 73.7 84.0 67.8 74.2 95.0 86.6 90.8 83.8

Weighted figure

Annex-X (Refers to Paragraph 10.3) STD clinics strengthened by NACO

S.No.	Name of State	No. of Districts as per Census 2001	No. of STD clinics	No. of Districts uncovered (%)
1.	A & N Island	02	04	Nil
2.	Andhra Pradesh	23	61	Nil
3.	Arunachal Pradesh	13	07	06 (46%)
4.	Assam	23	15	08(35%)
5.	Bihar	37	25	14 (38%)
6.	Chandigarh	01	03	Nil
7	Chhattisgarh	16	09	07 (44%)
8	Dadar & Nagar Haveli	01	01	Nil
9.	Daman & Diu	02	02	Nil
10	Delhi	09	12	Nil
11	Goa	02	04	Nil
12	Gujarat	25	35	02 (8%)
13	Haryana	19	16	04 (21%)
14	Himachal Pradesh	12	20	Nil
15	Jammu & Kashmir	14	11	06 (43%)
16	Jharkhand	18	06	12 (67%)
17	Karnataka	27	34	Nil
18	Kerala	14	20	04 (29%)
19	Lakshdweep	01	01	Nil
20	Madhya Pradesh	45	45	04(9%)
21	Maharashtra	35	48	04 (11%)
22	Manipur	09	10	Nil
23	Meghalaya .	07	06	01 (14%)
24	Mizoram	08	08	Nil
25	Nagaland	08	08	Nil
26	Orissa	30	34	02 (7%)
27	Pondicherry	04	04	03 (75%)
28	Punjab	17	11	06 (35%)
29	Rajasthan	32	33	03 (09%)
30	Sikkim	04	03	02 (50%)
31	Tamil Nadu	30	70	Nil
32	Tripura	04	03	02 (50%)
33	Uttar Pradesh	70	68	11 (16%)
34	Uttaranchal	13	09	04 (31%)
35	West Bengal	18	30	03(17%)
	Total	593	674	Nil

Annex-XI {Refers to paragraph 11.1 (i)} Proportion of respondents who had ever heard of HIV/AIDS

(All figures are in percentage)

C	State/State Cus		Urban			Rural		Combined*		
S.	State/State Group	M	F	T	M	F	Т	M	F	T
No.	Andhra Pradesh	95.8	97.0	96.4	94.9	97.6	96.2	95.1	97.4	96.3
1.		93.8	86.9	90.3	77.6	66.7	72.2	80.7	70.6	75.6
2.	Arunachal Pradesh	-				57.7	65.1	74.5	60.8	67.7
3.	Assam	91.5	85.6	88.5	72.4	and the state of t			26.9	40.3
4	Bihar	84.3	62.8	73.6	49.1	21.5	35.3	53.7		
5.	Delhi ·	90.3	86.3	88.3	93.3	81.9	87.4	90.6	85.9	88.2
6.	Goa	99.0	94.6	96.8	95.6	87.2	91.4	97.0	90.2	93.6
7.	Gujarat	86.8	61.6	74.2	67.6	25.0	46.1	74.3	37.5	55.7
8.	Haryana	92.5	85.2	88.8	83.6	64.7	74.2	85.8	69.8	77.8
9.	Himachal Pradesh	97.1	96.7	96.9	90.9	88.9	89.9	91.5	89.6	90.5
10.	Jammu & Kashmir	99.3	93.9	96.6	83.9	69.7	76.8	87.6	75.4	81.5
11.	Karnataka	95.1	88.0	91.6	86.5	74.8	80.7	89.1	78.9	84.0
12.	Kerala	99.5	98.6	99.0	99.1	98.7	98.9	99.2	98.7	98.9
13.	Madhya Pradesh	92.5	78.2	85.4	61.9	32.3	47.0	69.0	42.9	55.9
14.	Maharashtra	96.0	90.2	93.1	80.6	69.2	74.9	86.6	77.3	81.9
15.	Manipur	98.5	98.6	98.6	96.6	89.5	93.1	97.1	92.0	94.6
16.	Orissa	91.5	81.4	86.5	73.0	55.1	64.1	75.4	58.6	67.1
17.	Punjab	98.2	90.9	94.6	94.9	86.6	90.8	96.0	88.0	92.0
18.	Rajasthan	90.0	77.5	83.6	70.0	45.0	57.3	74.6	52.5	63.3
19.	Sikkim	93.4	91.1	92.3	70.5	68.8	69.6	72.6	70.8	71.7
20.	Tamil Nadu	96.1	94.3	95.2	88.3	83.7	86.0	91.0	87.4	89.2
21.	Uttar Pradesh	79.6	64.1	71.7	63.8	27.6	45.4	66.9	34.9	50.6
22.	West Bengal	89.1	80.2	84.6	57.6	38.6	48.1	66.2	50.1	58.2
All It							773			
Mear		93.2	85.7	89.4	79.5	65.2	72.3	82.4	70.0	76.1
Rang	e	79.6-	61.6-	71.7-	49.1-		45.4-	53.7-	26.9-	40.3-
		99.5	98.6	99.0	99.1	98.7	98.9	99.2	98.7	98.9

* Weighted figure

Annex-XII
{Refers to Paragraph 11.1 (ii)}
Proportion of respondents stating that HIV/AIDS can be transmitted through sexual contact

(All figures are in percentage) SI. State/State Group Urban Rural Combined* No. M T F M F T M T 1. Andhra Pradesh 83.7 86.6 85.1 80.6 89.4 85.1 81.4 88.7 85.1 2. Arunachal Pradesh 91.4 82.0 86.7 72.1 59.2 65.6 75.8 63.5 69.6 3. Assam 89.5 80.6 85.1 68.5 52.4 60.5 70.9 55.5 63.2 4. Bihar 81.0 58.5 69.8 46.6 18.7 32.6 51.1 23.9 37.5 5. Delhi 88.3 82.6 85.4 86.7 82.1 77.5 82.0 88.1 85.0 6. Goa 97.3 93.7 95.5 92.1 84.4 88.3 94.3 88.3 91.3 7. Gujarat 83.8 54.8 69.3 63.5 22.7 42.8 70.6 33.7 52.0 8. Haryana 90.7 83.6 87.1 82.4 62.8 72.7 84.4 68.0 76.2 9. Himachal Pradesh 94.0 94.3 94.2 88.4 85.8 87.1 88.9 86.5 87.7 10. Jammu & Kashmir 97.2 89.1 93.2 82.9 63.0 73.0 86.3 69.2 77.8 Karnataka 11. 91.5 77.2 84.4 83.4 66.8 75.1 85.9 70.0 78.0 12. Kerala 97.7 97.4 97.5 98.0 97.6 97.8 97.9 97.5 97.7 13. Madhya Pradesh 87.4 71.6 79.6 56.4 29.1 42.7 63.7 38.9 51.3 14. Maharashtra 97.7 85.2 90.0 79.1 64.8 71.9 85.1 72.7 78.9 15. Manipur 97.6 95.8 96.7 91.1 80.4 85.8 92.9 84.6 88.8 16. Orissa 87.8 72.8 80.3 69.6 47.6 58.6 72.1 51.0 61.5 17. Puniab 95.9 86.2 91.1 92.8 80.7 86.8 93.8 82.4 88.1 18. Rajasthan 84.7 69.0 76.6 64.1 39.0 51.3 68.7 46.0 57.1 19. Sikkim 91.7 88.2 89.9 69.1 64.6 66.8 71.1 66.7 68.9 20. Tamil Nadu 80.0 84.2 82.1 69.5 67.9 68.7 73.1 73.3 73.6 21. Uttar Pradesh 71.5 59.1 65.2 55.8 24.3 39.8 58.9 31.3 44.8 22. West Bengal 82.0 70.6 76.3 50.7 30.9 40.8 59.3 41.9 50.6 All India Mean 89.0 80.3 84.6 74.6 59.8 67.1 77.8 64.6 71.1 Range 80.0-54.8-65.2-46.6-18.7-32.6-51.1-23.9-37.5-97.7 97.4 97.5 98.0 97.6 97.8 97.9 97.5 97.7

Weighted figure

Annex-XIII (a) {Refers to Paragraph 11.1 (iii)}

Proportion of respondents who knew that having an uninfected faithful partner and consistent condom use can prevent HIV/AIDS

							(All		are in pei	
SI.	State/State Group		Urban			Rural		C	Combined	
No.	4051	M	F	T	M	F	T	M	F	T
1.	Andhra Pradesh	61.4	46.5	53.9	50.5	48.4	49.5	53.4	47.9	50.6
2.	Arunachal Pradesh	53.1	39.9	46.5	36.5	25.0	30.8	39.6	28.0	33.8
3.	Assam	32.4	19.7	26.0	22.2	10.5	16.4	23.4	11.5	17.5
4.	Bihar	56.4	40.5	48.4	30.3	10.2	20.0	33.7	14.2	23.9
5.	Delhi	77.3	65.8	71.4	70.5	51.4	60.7	76.6	64.3	70.4
6.	Goa+	81.5	54.1	67.8	72.8	55.1	64.0	76.4	54.7	65.6
7.	Gujarat	77.0	29.9	53.5	57.1	11.4	34.0	64.0	17.7	40.7
8.	Haryana	77.7	64.1	70.9	68.0	42.4	55.3	70.4	47.8	59.1
9.	Himachal Pradesh	81.8	81.3	81.6	72.4	64.4	68.4	73.3	65.8	69.6
10.	Jammu & Kashmir	79.2	78.4	78.8	71.2	37.1	54.1	73.1	46.8	59.9
11.	Karnataka	63.3	42.5	53.0	52.3	33.8	43.1	55.7	36.5	46.1
12.	Kerala	63.5	63.0	63.2	59.9	63.0	61.7	60.8	63.0	62.1
13.	Madhya Pradesh	64.0	56.9	60.5	37.9	20.3	29.1	44.0	28.7	36.4
14.	Maharashtra	55.2	49.0	52.1	50.4	28.0	39.2	52.3	36.1	44.2
15.	Manipur	80.2	77.4	78.8	64.1	48.1	56.1	68.5	56.1	62.3
16.	Orissa	53.3	20.4	36.9	32.5	10.0	21.3	35.3	11.4	23.4
17.	Punjab	83.1	68.0	75.5	79.9	58.1	69.1	80.9	61.2	71.1
18.	Rajasthan	69.5	49.8	59.3	48.1	24.6	36.1	52.9	30.5	41.4
19.	Sikkim	71.8	60.6	66.2	49.4	38.8	44.1	51.4	40.7	46.1
20.	Tamil Nadu	66.0	50.2	58.1	59.4	35.1	47.3	61.6	40.4	51.0
21.	Uttar Pradesh	59.7	43.1	51.2	43.6	16.2	29.7	46.8	21.5	33.9
22.	West Bengal	42.1	27.4	34.7	21.8	8.3	15.1	27.3	13.6	20.5
All Ir	ndia			************						
Mean		65.9	51.4	58.6	52.2	33.8	42.9	55.5	38.3	46.8
Rang	e	32.4-	19.7-	26.0-	21.8-	8.3-	15.1-	23.4-	11.4-	17.5-
		83.1	81.3	81.6	79.9	64.4	69.1	80.9	65.8	71.1

Weighted figure

Annex-XIII (b) (Refers to Paragraph 11.1 (iii))

Awareness of HIV/AIDS and methods of preventing HIV infection among FSW and their Clients

(All figures are in percentage)

S. No.	State/State Group		neard of /AIDS	Aware		t different i		Knowing both the methods of		
					Consistent and correct condom use		ing one I faithful sex rtner	prevention i.e. consistent condon use and having faithful uninfecte partner		
		FSW	Clients of FSW	FSW	Clients of FSW	FSW	Clients of FSW	FSW	Clients of FSW	
1.	Andhra Pradesh	97.1	96.0	85.3	88.8	86.0	84.8	74.6	78.7	
2.	Assam	96.7	93.0	74.8	89.7	75.5	76.4	68.9	73.4	
3.	Bihar**	87.8	93.4	79.2	84.1	83.4	85.8	67.4	78.5	
4.	Delhi	98.9	97.8	94.4	90.0	68.8	68.8	66.2	64.3	
5.	Goa	97.4	99.3	95.2	93.7	79.8	79.6	77.0	75.6	
6.	Gujarat	84.0	93.6	83.0	83.8	83.5	68.0	69.4	62.3	
7.	Haryana	79.3	94.1	60.4	79.0	69.2	62.0	46.7	52.4	
8.	Himachal Pradesh	97.0	99.6	70.1	85.0	75.3	89.1	65.7	84.6	
9.	Jammu & Kashmir	89.5	97.2	70.2	80.9	75.5	77.2	63.2	74.9	
10.	Karnataka	88.0	91.4	74.9	78.8	60.9	57.6	46.8	48.3	
11.	Kerala	98.9	99.3	87.0	79.3	68.2	71.5	63.0	61.1	
12.	Madhya Pradesh **	92.8	95.7	84.8	86.8	74.6	50.7	63.0	47.9	
13.	Maharashtra	98.9	99.6	97.8	91.1	78.9	83.3	77.0	78.5	
14.	Manipur	97.4	97.8	82.4	77.9	79.2	73.4	67.0	65.5	
15.	Orissa	92.3	94.2	83.8	89.5	78.9	86.6	66.5	83.7	
16.	Other NE States**	87.9	88.8	78.3	82.1	79.9	84.3	63.6	78.0	
17.	Punjab	90.6	96.3	74.2	81.0	71.1	70.0	55.4	62.3	
18.	Rajasthan	93.7	98.9	71.2	74.9	69.7	67.0	52.0	52.8	
19.	Tamil Nadu**	99.3	100	98.9	95.9	79.4	83.1	77.7	79.4	
20.	Uttar Pradesh**	95.6	92.9	92.3	88.0	72.8	65.2	66.3	62.2	
21.	West Bengal	99.3	95.8	90.4	86.6	84.6	73.6	79.8	69.4	
Brothe	el Based	95.3	96.1	89.6	88.7	77.8	74.2	70.4	70.0	
Non B	rothel Based	92.4	95.8	78.1	82.9	75.0	74.1	62.7	67.1	
All In	dia	93.5	95.9	82.7	85.1	76.1	74.2	65.7	68.2	

Note: FSW = Female Sex Workers

^{**} Figures in respect of Bihar include Jharkhand, Mahdya Pradesh include Chhattisgarh, Tamil Nadu include Chennai, Uttar Pradesh include Uttaranchal and other NE States include Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura.

Annex-XIV (a) {Refers to paragraph 11.1 (iv)}

Proportion of respondents having no incorrect belief on transmission of HIV/AIDS

		(All II	l figures are in percentage)							
SI.	State/State Group		Urban			Rural		C	ombined	*
No.		M	F	T	M	F	T	M	F	T
1.	Andhra Pradesh	33.1	25.7	29.4	28.8	26.9	27.8	29.9	26.6	28.2
2.	Arunachal Pradesh	39.1	38.8	38.9	30.2	31.5	30.8	31.9	32.8	32.4
3.	Assam	18.5	15.8	17.2	9.0	6.5	7.7	10.0	7.5	8.8
4.	Bihar	19.0	15.5	17.3	7.4	4.1	5.7	8.9	5.6	7.2
5.	Delhi	29.1	19.1	24.0	25.4	13.8	19.4	28.7	18.5	23.5
6.	Goa	30.4	37.3	33.8	28.0	24.9	26.5	29.0	30.1	29.5
7.	Gujarat	21.8	16.1	18.8	11.8	4.5	8.1	15.2	8.5	11.8
8.	Haryana	30.6	27.1	28.8	19.2	14.9	17.1	22.0	17.9	20.0
9.	Himachal Pradesh	37.9	66.3	52.0	21.4	42.5	32.0	22.8	44.6	33.7
10.	Jammu & Kashmir	42.6	56.9	49.7	19.4	9.1	14.2	24.9	20.4	22.7
11.	Karnataka	9.6	7.1	8.3	6.4	5.9	6.2	7.3	6.3	6.8
12.	Kerala	49.7	41.0	44.4	49.0	46.3	47.5	49.2	44.8	46.6
13.	Madhya Pradesh	18.2	17.8	18.0	8.2	5.0	6.6	10.5	7.9	9.2
14.	Maharashtra	42.7	40.3	41.5	32.0	20.0	26.0	36.2	27.8	32.0
15.	Manipur	72.9	52.5	62.7	35.8	22.6	29.2	45.9	30.8	38.4
16.	Orissa	21.2	20.4	20.8	10.2	5.6	7.9	11.7	7.6	9.7
17.	Punjab	41.3	42.4	41.8	30.2	34.7	32.4	33.7	37.1	35.4
18.	Rajasthan	24.3	25.1	24.7	18.4	14.3	16.3	19.8	16.8	18.2
19.	Sikkim	36.0	20.3	28.2	17.8	13.2	15.5	19.5	13.9	16.7
20.	Tamil Nadu	27.2	12.0	19.6	16.3	5.9	11.1	20.0	8.0	14.0
21.	Uttar Pradesh	17.6	14.8	16.2	9.3	4.3	6.7	10.9	6.4	8.6
22.	West Bengal	26.0	26.6	26.3	12.3	8.6	10.5	16.1	13.6	14.8
All In	ndia									
Mean		31.2	29.1	30.1	20.1	16.8	18.4	22.7	19.9	21.3
Range	e	9.6-	7.1-	8.3-	6.4-	4.1-	5.7-	7.3-	5.6-	7.2-
3		72.9	66.3	62.7	49.0	46.3	47.5	49.2	44.8	46.6

Weighted figure

Note: M = Male

F = Female T = Total

Annex-XIV (b) {Refers to Paragraph 11.1 (iv)}

Correct belief about HIV transmission among FSW and their Clients

(All figures are in percentage)

Sl. No.	State/State Group		rtion aware transmitted				aware that y looking	respondents	
		Sharing a	meal with	From n	nosquito tes		could be with HIV		identifying ee issues
		FSW	Clients of FSW	FSW	Clients of FSW	FSW	Clients of FSW	FSW	Clients of FSW
1.	Andhra Pradesh	69.4	79.4	64.2	76.2	64.2	65.0	31.2	41.2
2.	Assam	65.5	57.2	57.9	63.8	67.8	67.1	32.2	29.9
3.	Bihar**	53.4	49.8	71.9	58.1	63.2	56.7	25.7	31.5
4.	Delhi	73.3	66.2	72.6	64.3	55.6	76.0	33.1	43.5
5.	Goa	85.9	76.7	76.0	73.3	54.8	49.3	38.5	28.9
6.	Gujarat	57.9	62.6	69.0	70.4	51.7	55.8	19.4	30.3
7.	Haryana	39.3	64.6	50.9	61.6	31.8	50.6	12.2	32.5
8.	Himachal Pradesh	49.0	69.3	39.9	54.7	26.2	37.2	7.7	15.4
9.	Jammu & Kashmir	67.6	80.9	76.5	81.9	32.4	62.2	21.1	44.7
10.	Karnataka	54.5	58.0	77.0	78.8	50.6	64.6	21.7	37.5
11.	Kerala	60.7	67.4	70.4	70.0	71.2	72.4	41.5	45.9
12.	Madhya Pradesh**	37.1	50.0	52.3	58.2	51.2	39.2	12.0	17.9
13.	Maharashtra	78.9	86.3	68.0	85.9	64.3	65.4	37.2	54.8
14.	Manipur	87.7	92.1	71.9	82.4	67.7	77.4	47.6	65.2
15.	Orissa	54.2	58.0	61.8	68.8	83.3	70.8	32.0	44.9
16.	Other NE States**	54.8	63.8	70.3	65.3	72.4	73.9 ·	31.6	41.8
17.	Punjab	43.8	54.9	43.4	57.5	46.3	57.8	18.0	33.0
18.	Rajasthan	80.7	87.6	73.2	79.4	36.6	56.8	22.5	43.8
19.	Tamil Nadu**	83.5	78.3	93.3	91.0	71.2	76.0	60.6	55.8
20.	Uttar Pradesh**	62.5	55.4	75.1	59.6	64.0	68.1	28.6	27.3
21.	West Bengal	64.3	60.2	51.1	65.1	71.1	91.5	32.3	46.1
Brothel		63.9	62.6	66.0	64.2	63.4	64.6	29.8	36.8
	othel Based	63.0	70.2	65.7	71.6	54.5	62.7	28.5	39.6
All Indi		63.4	67.3	65.8	69.6	58.1	63.5	29.0	38.5

Note: FSW = Female Sex Workers

^{**} Figures in respect of Bihar include Jharkhand, Mahdya Pradesh include Chhattisgarh, Tamil Nadu include Chennai, Uttar Pradesh include Uttaranchal and other NE States include Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura.

Annex-XV {Refers to paragraph 11.1 (v)}

Proportion of respondents who had ever heard of STD

(All figures are in percentage)

S.	State/State Group		Urban			Rural		Combined*		
No.	FI STATE OF THE ST	M	F	T	M	F	T	M	F	T
1.	Andhra Pradesh	64.7	48.7	56.7	64.0	53.3	58.6	64.2	52.1	58.1
2.	Arunachal Pradesh	41.7	35.3	38.5	32.2	27.1	29.6	34.0	28.6	31.3
3.	Assam	50.1	41.5	45.8	35.4	32.7	34.1	37.0	33.7	35.4
4.	Bihar	37.9	34.3	36.1	30.1	25.9	28.0	31.1	27.0	29.0
5.	Delhi	33.0	36.0	34.5	33.9	30.2	32.0	33.1	35.4	34.3
6.	Goa	7.3	5.7	6.5	6.8	6.4	6.6	7.0	6.1	6.5
7.	Gujarat	52.8	78.5	65.7	46.4	71.8	59.2	48.6	74.1	61.5
8.	Haryana	34.9	53.0	43.9	35.9	46.1	41.0	35.7	47.8	41.7
9.	Himachal Pradesh	24.9	52.3	38.5	23.8	33.2	28.5	23.9	34.9	29.4
10.	Jammu & Kashmir	29.5	43.4	36.4	15.8	53.2	34.6	19.1	50.9	35.0
11.	Karnataka	44.8	24.1	34.5	39.1	20.6	29.8	40.8	21.7	31.3
12.	Kerala	43.6	56.6	51.5	41.5	58.9	51.5	42.0	58.2	51.5
13.	Madhya Pradesh	24.9	23.9	24.4	16.9	20.1	18.5	18.8	21.0	19.9
14.	Maharashtra	17.6	24.2	20.9	10.3	9.6	10.0	13.2	15.2	14.2
15.	Manipur	55.2	27.7	41.5	37.4	18.9	28.2	42.3	21.3	31.8
16.	Orissa	42.5	28.8	35.7	32.7	16.8	24.8	34.0	18.4	26.2
17.	Punjab	49.1	62.3	55.7	39.0	62.2	50.6	42.1	62.2	52.2
18.	Rajasthan	20.3	18.8	19.5	12.0	13.0	12.6	13.9	14.4	14.1
19.	Sikkim	23.1	24.3	23.7	14.1	10.7	12.4	14.9	12.0	13.4
20.	Tamil Nadu	54.2	33.8	44.0	39.0	24.5	31.7	44.2	27.7	36.0
21.	Uttar Pradesh	17.1	25.0	21.2	17.4	21.5	19.5	17.4	22.2	19.8
22.	West Bengal	45.7	29.8	37.7	40.4	22.0	31.2	41.9	24.1	33.0
All In	dia									
Media	an	39.8	34.1	37.1	33.3	25.2	29.7	34.0	27.4	31.6
Range	2	7.3-	5.7-	6.5-	6.8-	6.4-	6.6-	7.0-	6.1-	6.5-
		64.7	78.5	65.7	64.0	71.8	58.6	64.2	74.1	61.5

Weighted figure

Note: M = Male

F = Female T = Total

Annex-XVI {Refers to paragraph 11.1 (vi)}

Proportion of respondents aware of the linkage between STD and HIV/AIDS

(All figures are in percentage)

SI.	State/State Group	Urban			Rural			Combined*		
No.	State/State Group	M	F	T	M	F	T	M	F	T
1.	Andhra Pradesh	45.3	36.8	41.1	44.7	44.7	37.6	44.8	37.4	41.1
2.	Arunachal Pradesh	30.8	30.1	30.5	27.0	23.5	25.0	27.7	24.8	26.3
3.	Assam	33.8	30.7	32.2	22.5	17.3	19.9	23.7	18.8	21.3
4.	Bihar	25.7	18.2	21.9	14.6	5.1	9.8	16.1	6.8	11.4
5.	Delhi	28.3	20.4	24.3	26.1	15.8	20.8	28.1	19.9	23.9
6.	Goa	5.5	4.8	5.2	5.5	4.7	5.1	5.5	4.7	5.1
7.	Gujarat	34.3	21.9	28.1	29.0	29.0	10.4	30.9	14.3	22.5
8.	Haryana	28.1	30.5	29.3	30.0	26.4	28.4	29.8	27.4	28.6
9.	Himachal Pradesh	22.2	46.5	34.2	18.5	24.2	21.4	18.8	26.2	22.5
10.	Jammu & Kashmir	26.0	32.6	29.3	13.2	23.7	18.5	16.3	25.8	21.0
11.	Karnataka	34.1	17.8	26.0	31.7	31.7	14.2	32.4	15.3	23.9
12.	Kerala	37.0	42.8	40.6	36.3	36.3	44.6	36.5	44.1	40.9
13.	Madhya Pradesh	18.7	12.2	15.5	13.0	13.0	7.5	14.3	8.5	11.4
14.	Maharashtra	15.4	22.8	19.1	7.9	7.9	7.4	10.8	13.4	12.1
15.	Manipur	42.8	20.6	31.7	25.7	12.4	19.0	30.3	14.6	22.5
16.	Orissa	29.6	16.3	23.0	19.9	9.1	14.5	21.2	10.1	15.7
17.	Punjab	39.2	43.2	41.2	28.1	39.6	33.8	31.6	40.7	36.1
18.	Rajasthan	14.9	14.5	14.7	7.9	7.3	7.6	9.5	9.0	9.2
19.	Sikkim	17.9	16.1	17.0	10.2	6.5	8.3	10.9	7.3	9.1
20.	Tamil Nadu	38.0	23.7	30.9	28.5	28.5	17.2	31.9	19.4	25.7
21.	Uttar Pradesh	15.5	12.0	13.7	13.0	6.8	9.9	13.5	7.8	10.6
22.	West Bengal	28.6	13.5	21.0	15.5	5.0	10.3	19.1	7.3	13.2
All I		III SURVEY SEE								
Mean		27.7	24.2	25.9	21.2	16.8	19.0	22.8	18.5	20.7
Rang		5.5-	4.8-	5.2-	5.5-	4.7-	5.1-	5.5-	4.7-	5.1-
214112	,-	45.3	46.5	41.2	44.7	44.7	44.6	44.8	40.7	41.1

Weighted figure

Note: M = Male

F = Female T = Total

Annex-XVII (Refers to paragraph 11.1.3) School AIDS education programme

S. No.	Name of the State	Year of the Programme	Total no. of Sec. & Senior Secondary schools in State	No. of schools covered in the programme by 2002-2003
1.	A & N Islands	2001-02	92	20
2.	Andhra Pradesh	2002-03	10500	10500
3.	Arunachal Pradesh	2002-03	155	30
4.	Assam	2001-02	4143	740
5.	Bihar	2001-02	4000	110
6.	Chandigarh	1998-99	105	60
7.	Chhattisgarh		Data not available	
8.	D & N Haveli		Data not available	
9.	Daman & Diu		Data not available	
10.	Delhi	2001-02	2500	1200
	Gujarat	2001-02	5000	315
12.		2001-02	452	266
	Goa	2001-02	380	23
	Haryana	10747404	Not implemented till July'	03
	Himachal Pradesh	1999-00	1534	300
	Jammu & Kashmir	2001-02	1520	90
1.44	Jharkhand		Not implemented till March	1'03
	Karnataka	2001-02	9057	20
100	Kerala	1998-99	2370	2000
	Lakshdweep		Data not available	
	Madhya Pradesh	2001-02	8075	939
22.		1998-99	10000	2000-3000
23.		2000-01	1213	500
	Manipur	1998-99	666	330
	Meghalaya		Data not available	
26.		2000-01	420	120
27.	TO THE PROPERTY OF THE PARTY OF	2000-01	719	610
100000000000000000000000000000000000000	Orissa	2001-02	7226	270
	Pondicherry	2002-03	198	77
30.		2002-03	High schools-400 Sr. secondary schools- 600	No school covered
31.	Rajasthan		Data not available	
	Sikkim	2001-02	125	58
	Tamil Nadu	1997-98	9183	1740
34.			Data not available	
35.		2000-01	4000	Programme not conducted
36.	Uttaranchal	2002-03	1750	Data not available
	West Bengal	2001-02	7600	600

Annex-XVIII (Refers to paragraph 11.2) Voluntary counselling and testing centres

S. No.	Name of state	No. of districts (as per census 2001)	No. of existing VCTC	Districts providing VCT facility	No. of districts not covered (%)
High Pr	evalent States				
1.	Andhra Pradesh	23	88	19	04 (17%)
2.	Karnataka	27	32	19	08 (30%)
3.	Maharashtra including Mumbai, MACS	35	58	29	06 (17%)
4.	Manipur	09	09	08	01 (11%)
5.	Nagaland	08	09	08	Nil (0%)
6.	Tamil Nadu including Chennai, MACS	30	47	29	01 (3%)
	Total	132	243	112	20 (15%)
Modera	ite & Low Prevalent State		4		***************************************
1.	A & N Islands	02	09	01	01 (50%)
2.	Arunachal Pradesh	13	04	04	09 (69%)
3.	Assam	23	09	06	17 (74%)
4.	Bihar	37	23	17	20 (54%)
5.	Chandigarh	01	03	01	Nil (0%)
6.	Chhattisgarh	16	01	01	15 (94%)
7.	Dadra & Nagar Haveli	01	01	01	Nil (0%)
8.	Daman & Diu	02	01	01	01 (50%)
9.	Delhi	09	15	08	01 (11%)
10.	Goa	02	02	01	01 (50%)
11.	Gujarat including Ahmedabad, MACS	25	34	22	03 (12%)
12.		19	12	11	8 (42%)
13.		12	05	04	08 (67%)
14.	Jammu & Kashmir	14	03	02	12 (86%)
15.	Jharkhand	18	03	03	15 (83%)
16.	Kerala	14	07	04	10 (71%)
17.	Lakshadweep	01	00	00	01 (100%)
18.		45	15	12	33 (73%)
19.	Meghalaya	07	01	01	06 (86%)
20.		08	05	03	05 (63%)
21.	Orissa	30	21	14	16 (53%)
22.		04	02	01	03 (75%)
	Punjab	17	17	15	02 (12%)
24.		32	32	29	03 (9%)
25.		04	01	01	03 (75%)
26.		04	01	01	03 (75%)
27.		70	45	39	31 (44%)
28.		13	12	10	03 (23%)
29.		18	16	08	10 (56%)
	Total	461	300	221	240 (52%)

Annex-XIX (Refers to paragraph 11.2.3)

Training of healthcare workers in HIV/AIDS counselling

S. No.	State/UT	Total no. of Healthcare Workers	No. of Healthcare Workers trained	Shortfall	Shortfall in percentage
1.	A & N Islands	2219	751	1468	66
2.	Andhra Pradesh	48741	17508	31233	64
3.	Assam	12747	6977	5770	45
4.	Delhi.	8000	3487	4513	56
5.	Goa	1689	1676	13	01
6.	Gujarat	21000	3253	17747	84
7.	Haryana	18409	12839	5570	30
8.	Himachal Pradesh	18054	8223	9831	54
9.	Jammu & Kashmir	7896	2709	5187	65
10.	Kerala	33440	16965	16475	49
11.	Madhya Pradesh	21533	13034	8499	39
12.	Meghalaya	1977	814	1163	59
13.	Mizoram	7463	3057	4406	59
14.	Mumbai MACS	19991	12338	7653	38
15.	Nagaland	14941	6925	8016	54
16.	Orissa	16878	12827	4051	24
17.	Pondicherry	1207	1026	181	15
18.	Punjab	16005	650	15355	95
19.	Rajasthan	34315	9140	25175	73
20.	Sikkim	1786	861	925	51
21.	Tamil Nadu	16700	10320	6380	38
22.	Tripura	3280	665	2615	80
23.	Uttar Pradesh	7298	6140	1158	16
24.	Uttaranchal	6398	08	6390	99
25.	West Bengal	38400	11797	26603	69
	Total	380367	163990	216377	57

Annex-XX (Refers to Paragraph 11.3.1) Modernisation of blood banks

S. No.	Name of State/UT	Number of Districts as per census 2001	Number of registered/ licensed blood banks in the State	Blood ban As per records of NACO	As intimated by AG	Number of Districts without modernised blood banks	Number of Districts without blood bank facility
1.	A & N Island	2	2	2	(Audit)	Nil	
2.	Andhra Pradesh	23	168	62	61	Nil	Nil Nil
3.	Arunachal Pradesh	13	3	14	3	Nil	Nil
4.	Assam	23	48	28	16	Nil	Nil
5.	Bihar	37	41	43	NA NA	Nil	Nil
6.	Chandigarh	1	3	2	3	Nil	Nil
7	Chhattisgarh	16	17	16	9	Nil	Nil
8	Dadra & Nagar Haveli	1	NA NA	2	Nil	Nil	Nil
9.	Daman & Diu	2	1	3	NA	Nil	Nil
10	Delhi	9	42	15	14	Nil	Nil
11	Goa	2	7	3	3	Nil	Nil
12	Gujarat	25	140	57	57	9 (36%)	2 (08%)
13	Haryana	19	35	21	17	2 (11%)	1 (05%)
14	Himachal Pradesh	12	12	9	11	4 (33%)	Nil
15	Jammu & Kashmir	14	14	15	15	1 (07%)	1 (07%)
16	Jharkhand	18	NA	22	NA NA	4 (18%)	4 (18%)
17	Karnataka	27	131	57	52	3 (11%)	3 (11%)
18	Kerala	14	123	37	31	4 (29%)	Nil
19	Lakshdweep	1	NA	2	NA	Nil	Nil
20	Madhya Pradesh	45	104	50	42	4 (09%)	4 (09%)
21	Maharashtra	35	246	73	91	4 (11%)	3 (06%)
22	Manipur	9	3	10	3	Nil	Nil
23	Meghalaya	7	4	10	NA	2 (29%)	2 (29%)
24	Mizoram	8	5	7	6	4 (50%)	3 (38%)
25	Nagaland	8	3	9	NA	Nil	Nil
26	Orissa	30	72	50	NA	3 (10%)	1 (03%)
27	Pondicherry	4	11	5	2	Nil	Nil
28	Punjab	17	69	33	NA	1 (06%)	Nil
29	Rajasthan	32	61	26	NA	11 (34%)	Nil
30	Sikkim	4	3	3	Nil	3 (75%)	3 (75%)
31	Tamil Nadu	30	185	94	63	Nil	Nil
32	Tripura	4	6	6	6	1 (25%)	Nil
33	Uttar Pradesh	70	130	74	NA	20 (29%)	14 (20%)
34	Uttaranchal	13	17	4	NA	4 (31%)	3 (23%)
35	West Bengal	18	126	76	NA	Nil	Nil
		593	1832	940		84 (14%)	44 (07%)

Annex-XXI
(Refers to paragraph 15.3)
Training of doctors/nurses/technicians/field officers

S. No.	State/UT	Doctors		Nurses		Technicians		Field officer	
		Sanctioned Strength	Trained (%)						
2.	Ahmedabad	500	30 (6)	500	405(81)	NA	NA	NA	NA
3.	Andhra Pradesh	9192	5448 (59)	7284	1864 (26)	1098	334 (30)	40359	10929 (27)
4.	Assam	3719	2863 (77)	7105	5371 (76)	764	571 (75)	4878	475 (10)
5.	Bihar	NA	NA	10000	3828 (38)	NA	NA	NA	NA
6.	Chandigarh (UT)	760	690 (91)	1746	1046 (60)	516	295 (57)	182	151 (83)
7.	Chennai	1225	935 (76)	NA	NA	35	34 (97)	NA	NA
8.	Daman & Diu	NA	NA	40	14 (35)	NA	NA	NA	NA
9.	Delhi	6000	3191 (53)	NA	NA	NA	NA	NA	NA
10.	Goa	- 615	399 (65)	952	312 (33)	92	45 (49)	615	537 (87)
11.	Gujarat	4000	921 (23)	NA	NA	NA	NA	NA	NA
12.	Haryana	NA	NA	NA	NA	1267	909 (72)	5240	4091 (78)
13.	Himachal Pradesh	NA	NA	NA	NA	556	338 (61)	3984	3722 (93)
14.	Jammu & Kashmir	1483	1022 (69)	1680	1085 (65)	NA	NA	3411	591 (17)
15.	Karnataka	6000	4083 (68)	3500	1194 (34)	2000	269 (13)	NA	NA
16.	Kerala	5110	3031 (59)	7780	6730 (86)	NA	NA	11163	3101 (28)
17.	Madhya Pradesh	2863	2716 (95)	9828	4460 (45)	747	519 (69)	10958	6073 (55)
18.	Maharashtra	NA	NA	15097	6857 (45)	1124	96 (9)	NA	NA
19.	Meghalaya	462	237 (51)	799	198 (25)	89	4 (4)	1074	597 (56)
20.	Mizoram	NA	NA	NA	NA	70	48 (69)	873	475 (54)
21.	Mumbai	5625	3215 (57)	5560	4717 (85)	731	330 (45)	NA	NA NA
22.	Nagaland	940	931 (99)	1750	1731 (99)	NA	NA	3900	3769 (97)
23.	Orissa	4421	3148 (71)	1450	991 (68)	817	655 (80)	NA	NA
24.	Punjab	4431	888 (20)	3055	300 (10)	NA	NA	11872	155 (1)
25.	Pondicherry	467	145 (31)	797	. 695 (87)	89	58 (65)	321	222 (69)
26.	Rajasthan	6533	3374 (52)	11088	6345 (57)	2536	627 (25)	16180	2037 (13)
27.	Sikkim	283	184 (65)	752	143 (19)	78	64 (82)	NA	NA NA
28.	Tamil Nadu	6240	5594 (90)	14000	2582 (18)	NA	NA	NA	NA
29.	Tripura	700	438 (63)	1000	167 (17)	170	6 (4)	2100	123 (6)
30.	Uttar Pradesh	10428	7442 (71)	5426	2459 (45)	1872	677 (36)	NA NA	NA NA
31.	Uttaranchal	2236	644 (29)	753	0 (0)	272	8 (3)	5373	0 (0)
32.	West Bengal	9500	1138 (12)	13000	3767 (29)	1400	263 (19)	24000	7767 (32)
	Total	93882	52707 (56)	125303	57403 (46)	16323	6150 (38)	147032	44815 (30

LIST OF ABBREVIATIONS

Some prominent abbreviations that have been used in this report are as follows:

AIDS	Acquired Immune Deficiency Syndrome					
APAC	AIDS Prevention and Control Project					
BCSU	Blood Component Separation Unit					
BSS	Behaviour Sentinel Surveillance					
CBO	Community Based Organisation					
CHC	Community Health Centre					
CIDA	Canadian International Development Agency					
CMIS	Computerised Management Information System					
CNA	Communication Needs Assessments					
CSW	Commercial Sex Worker					
DCA	Development Credit Agreement					
DFID	Department for International Development of the U.K. Government					
HIV	Human Immuno-deficiency Virus					
IDA	International Development Association					
IDU	Injecting Drug User					
IEC	Information, Education and Communication					
LACI	Loan Administration Change Initiative					
MACS	Municipal AIDS Control Society					
M & E	Monitoring and Evaluation					
MIS	Management Information System					
MSM	Men having sex with Men					
NAC	National AIDS Committee					
NACB	National AIDS Control Board					
NACO	National AIDS Control Organisation					
NACP	National AIDS Control Programme					
NGO	Non Governmental Organisation					
NPR	National Performance Review					
OMR	Output Monitoring Report					
PCR	Polymerase Chain Reaction					
PD	Project Director					
PEAR	Performance and Expenditure Annual Report					
PHC	Primary Health Centre					
PIP	Project Implementation Plan					
PLWHA	People Living With HIV/AIDS					
PPTCT	Prevention of Parents to Child Transmission					
RTI	Reproductive Tract Infection					
SAC	State AIDS Cell					
SACS	State AIDS Control Society					
STD	Sexually Transmitted Disease					
UNAIDS	Joint UN Programme on AIDS					
USAID	United States Agency for International Development					
VCT						
VCTC	Voluntary Counselling and Testing Centre					
VDRL	Venereal Diseases Research Laboratory					
VHS	Voluntary Health Services					
ZBTC	Zonal Blood Testing Centre					