19

NATIONAL AIDS CONTROL PROGRAMME

MINISTRY OF HEALTH AND FAMILY WELFARE

PUBLIC ACCOUNTS COMMITTEE (2005-2006)

NINTEENTH REPORT

FOURTEENTH LOK SABHA

LOK SABHA SECRETARIAT
NEW DELHI

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(FOURTEENTH LOK SABHA)

NATIONAL AIDS CONTROL PROGRAMME

MINISTRY OF HEALTH AND FAMILY WELFARE

(*Presented to Lok Sabha on* 8.12.05)
(*Laid in Rajya Sabha on* 5.12.05)

LOK SABHA SECRETARIAT
NEW DELHI

December, 2005/Agrahayana, 1927 (Saka)

CONTENTS

PAGE

COMPOSITION OF THE PUBLIC ACCOUNTS COMMITTEE (2005-2006) .... (iii)

INTRODUCTION .... (v)

REPORT 1

APPENDIX I. Executive Summary of the Comptroller and Auditor General of India for the year ended 31 March, 2003, (No. 3 of 2004), Union Government (Civil – Performance Appraisals) 94

APPENDIX II. Statement of Observations/Recommendations 98

PART II

Minutes of the Sittings of Public Accounts Committee (2004-2005) held on 8th & 9th February, 2005 and Public Accounts Committee (2005-2006) held on 14th November, 2005.. 140

COMPOSITION OF PUBLIC ACCOUNTS COMMITTEE
(2005 - 2006)

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3. Shri M.K. Madhusudhan — *Under Secretary*
4. Dr. Yumnam Arun Kumar — *Committee Officer*

INTRODUCTION

I, the Chairman, Public Accounts Committee having been authorised by the Committee to present the Report on their behalf, do present this Ninteenth Report on the Report of C&AG of India for the year ended 31 March, 2003 (No. 3 of 2004), Union Government (Civil – Performance Appraisals) relating to "National AIDS Control Programme".

2. The Report of the C&AG for the year ended 31 March, 2003 (No. 3 of 2004), Union Government (Civil – Performance Appraisals) relating to National AIDS Control Programme was laid on the Table of the House on 13 July, 2004.

3. The Committee took the evidence of the representatives of the Ministry of Health and Family Welfare on the subject at their sittings held on 8th and 9th February, 2005. The Committee considered and adopted this Report at their sitting held on 14th November, 2005. Minutes of the sitting form Part II of the Report.

4. For facility of reference and convenience, the Observations and Recommendations of the Committee have been printed in thick type in the body of the Report and have also been reproduced in a consolidated form in the Appendix II to the Report.

5. The Committee would like to express their thanks to the officers of the Ministry of Health and Family Welfare for the cooperation extended by them in furnishing information and tendering evidence before the Committee.

7. The Committee place on record their appreciation of the assistance rendered to them in the matter by the Office of the Comptroller and Auditor General of India.

NEW DELHI;
17 *November,* 2005
26 *Kartika,* 1927 (*Saka*)

PROF. VIJAY KUMAR MALHOTRA,
Chairman,
Public Accounts Committee.

REPORT

I. Introductory

Acquired Immunodeficiency Syndrome (AIDS) is the most devastating and fatal disease of the 21st century. Every year throughout India, an increasing number of people are affected by the HIV/AIDS pandemic. The alarming spread of the killer disease and increasing number of persons with AIDS has thrown an unprecedented challenge to mankind. Hence, it is important to know about AIDS. AIDS is a severe life threatening condition which represents the late clinical stage of infection with the Human Immunodeficiency Retrovirus (HIV). It invades the body's immune system, exposing the infected persons to a range of lung diseases, cancers, fungal infections, rashes, sores and other debilitating conditions until death. 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.

2. The problem of AIDS has ceased to be a mere health problem and has now acquired dimensions which perhaps have very few parallels in the history of mankind. The decimating and rapidly increasing socio-economic and health crisis caused by the AIDS pandemic has necessitated immediate attention and intervention by the medical and non-medical fora, all over the world to combat this deadly disease. Physicians and scientists around the world are busy trying to develop a vaccine to fight the HIV. Their task would have become simple if the origin of HIV were known. Today, one can only speculate about the origin of HIV. The debate about the origin of HIV has been mixed with questions of who, which country, which race, is to be blamed for starting the epidemic. Originally called human T-cell lymphotropic virus, Type III (HTLV-III) in the United States and lymphadenopathy-associated virus (LAV) in France, HIV was given its current name in1985.

3. India is one of the very few countries where surveillance activities were started prior to detection of the first HIV case. The screening of blood samples for HIV started in 1985 at two centres in Pune and Vellore. The first case of HIV was officially reported in a clinic in Chennai in 1986. According to the Sentinel Surveillance 2003-04, the number of HIV cases in India is estimated to be 5.14 million. A cumulative total of 96086 cases of AIDS have been reported to the National AIDS Control Organisation (NACO) by 2004. Presently, the rate of infection of HIV is 68 persons per hour, 1660 persons per day and 600,000 new infections per annum in India.

II. Organisational Arrangements

4. The Ministry of Health and Family Welfare (Government of India) 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 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.

5. 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. In 1992, the Government of India secured an International Donor Agencies (IDA) credit of US $ 84 million from the World Bank to support a full-fledged National AIDS Control Programme (NACP-I) for a five year period from September 1992 to September 1997 to slow the spread of HIV; to decrease morbidity and mortality associated with HIV infection; and to minimize socio-economic impact resulting from HIV infection. 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 Programme, it was extended upto March, 1999.

6. For the effective implementation of the NACP- I. The State AIDS Cells were created in all 32 States and UTs of the country. 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).

7. 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 to reduce the spread of HIV infection in India; and to strengthen India's capacity to respond to HIV/AIDS on a long-term basis 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 Department for International Development of the U.K. Government's. (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 which was to be completed by October 2004 is still continuing till date and it is expected to be completed by March 2006.

III. Objectives of the NACP-I & NACP-II

8. (a) The objectives of NACP-I were:

- to slow the spread of HIV;
- to decrease morbidity and mortality associated with HIV infection; and
- to minimize socio-economic impact resulting from HIV infection.

(b) The key objectives of NACP-II were:

- to reduce the spread of HIV infection in India; and
- to strengthen India's capacity to respond to HIV/AIDS on a long-term basis.

9. The following objectives of the NACP have been set to be achieved by the completion of the Programme I and II:

- 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;
- to reduce the blood-borne transmission of HIV to less than 1 per cent;
- to attain awareness level of not less than 90 per cent among the youth and others in the reproductive age group; and
- to achieve condom use of not less than 90 per cent among high-risk categories like Commercial Sex Workers.

IV. Audit Review

10. Audit reviewed the working of the NACP covering all State/Municipal AIDS Control Societies (SACS/MACS) and National AIDS Control Organisation at Delhi during the period 1998-99 to 2002-03. The principal objective of the audit review* was to ascertain the impact of various components of the programme as given below:

- utilisation of funds released and accounting,
- · efficacy of priority Targeted Interventions for groups at high risk,
- the Information, Education and Communication programme,
- adequacy of training arrangements,
- functioning of blood banks and Sexually Transmitted Diseases clinics,

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* C&AG's Report No. 3 of 2004—Union Government (Performance Appraisal) relating to "National AIDS Control Programme."

- adequacy of procurement procedures,
- utilisation of equipments,
- achievements of targets and impact evaluation,
- monitoring and evaluation procedures.

Executive Summary of the Audit Report is given in Appendix I

V. Programme Financing

11. The Programme financing during NACP-I(1992-93 to1998-99) & NACP-II(1999-2000 to 2003-2004) from the different funding agencies are highlighted in the following Table:

(Rs. in crore)

Sl. 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).

12. The allocation of funds and expenditure for various components of the World Bank assisted NACP-I (1992-99) and NACP-II (1999-2004) were as under:

(Rs. in crore)

Phase-I (1992-93 to 1998-99)			Phase-II (1999-2000 to 2003-04)		
Component	Allocation	Expenditure	Component	Allocation	Expenditure Reported by implementing agencies
1	2	3	4	5	6
Programme Management	41.45	*	Priority targeted interventions for groups at high risk	265.60	94.60

1	2	3	4	5	6
Information, Education and Communication	255.66	*	Preventive interventions for the general community	389.10	295.76
Blood Safety	250.02	*	Low cost AIDS care	163.30	15.81
Surveillance and Clinical Management	61.89	*	Institutional strengthening	286.50	119.69
STD	48.53	*	Inter-sectoral collaboration	50.60	6.57
Total	657.55	491.91*	Total	1155.10**	532.43

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

** Rs.1155.10 crore is the total allocated amount of Phase II by Government of India and the World Bank.

13. Audit scrutiny has revealed that there was a difference of Rs. 377.55 crore in the funds allocated for Phase-I in VIII Plan and approved allocation for the period 1992-1999. The Government 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.

14. During the evidence, when the Committee enquired about the total funds available for the National AIDS Control Programme, the representative of the Ministry of Health and Family Welfare informed that the total corpus of funds for NACP-II which are funded by various agencies through the Government of India is Rs. 2064.65 crores. The details are furnished as under:

Basket of Resources for NACP II through Government of India

Funding Agency	(Rupees in crores)	Time schedule for Implementation
1	2	3
Government of India	196.00	1999-2004
World Bank	959.00	1999-2007

1	2	3
USAID AVERT	166.00	2000-2007
USAID APAC	64.58	2002-2007
DFID	487.40	2002-2007
CIDA	37.81	2001-2006
Aus AID	24.65	2002-2007*
UNDP	6.47	2002-2004
The Global Fund	122.74	2004-2006
Total	2064.65	

*Aus AID assisted Project has been abolished by the Department of Economic Affairs before its launch.

15. When asked to furnish country-wise comparative data of the amount spent by the Government on health per person and prevention and treatment of HIV/AIDS per person in the countries like India, South Africa, Cambodia, Thailand, Uganda, Zambia and Malaysia, the Ministry submitted the position as under:

Amount Spent by the Various
Countries on Health Expenditure Per Capita

Name of the Country	Health expenditure Per Capita (PPP-US$)
India	80
South Africa	652
Cambodia	184
Thailand	112
Uganda	57
Zambia	52
Malaysia	345

However, the Ministry could not furnish the data regarding HIV/AIDS expenditure per Capita.

16. Further, the Ministry have informed that a sum of Rs. 261.79 crore is also funded by the International Non-Governmental Organisations (NGOs) and other

agencies and this amount is not routed through the Government's Budget. The following Table indicates the funding pattern of various agencies:

Funding by International NGOs and Other Agencies

(not through Government Budget)

Organization/ Agency	Period of Operation	Funding in million of US $	
		Total	2004
UNODC	2003-2005	1.63	0.94
UNDP	2003-2007	4.00	1.70
UNICEF	2003-2007	39.50	4.13
WHO	2003-2007	0.48	0.00
UNFPA	2003-2005	6.60	1.60
UNIFEM	2003-2005	0.93	0.43
ILO	2003-2005	0.94	0.50
UNESCO	2003-2005	0.06	1.10
Gates* Foundation	2004-08	200.00	40.00
IAVI		1.65	0.00
UN Foundation	2003-2006	6.00	2.20
	Total	261.79	

*funds released to NGOs/institutions in six high prevalence States.

17. On being enquired about the monitoring of funds which are not routed through budgetary provisions, the Ministry of Health and Family Welfare explained the monitoring mechanism as under:

> "To monitor funds sponsored by International NGOs and Other UN agencies, UN expanded theme group has been co-chaired by Additional Secretary & Director General, NACO. "Avahan" initiatives by Gates Foundation is chaired (Ex-officio) by Secretary (Health) and AS&DG, NACO/ DG, ICMR as Members and to bring these funds into one kitty, the concept of pooling resources for a single National programme is being worked out for NACP III."

VI. International Donor Agencies (IDA) Credits

18. According to Audit observation, withdrawal of funds from the World Bank (IDA) Credit account for NACP-I and NACP-II was on the basis of actual expenditure incurred by NACO as well as each AIDS Control Society implementing the project. NACO made use of the entire credit of US $ 84 million for NACP-I (1992-97) 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 million US $ was maintained in Reserve Bank of India. The Ministry of Finance (Department of Economic Affairs) on the basis of reimbursements filed under the Project, operates this accounts.

(Rs. in crore)

Year	Project cost as per pad#	Revised estimate		Total expenditure	World Bank Portion of expenditure	Disbursement	
		Provision	World Bank Portion			Expen-diture claimed	Eligible reimbur-sement
1999-2000	154.52	140.00	133.00	135.25	129.75	NIL	NIL
2000-01	270.11	180.00	161.25	180.00	162.75	168.46	151.78
2001-02	258.00	229.70	188.20	226.55	187.72	172.19	155.44
2002-03	193.13	242.00	199.00	241.86	200.07	155.61	137.07
Total				783.66b*	680.29	496.26*	444.29*

Project Appraisal Document.

* 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.

b* 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.

19. As on 31 March, 2003, out of reimbursable expenditure of Rs. 680.29 crore for the period 1999-2003, 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. However, the Ministry informed that it is expected that by March, 2006 (end of NACP-II) full reimbursement would be claimed from World Bank in view of enhanced budget provision in 2004-2005 and 2005-2006. However, against the committed disbursement of Rs.959 crores claims worth Rs.659.79 crores (69%) have been disbursed.

20. When, the Committee desired to know the reasons for slow pace of utilization of credit available for NACP-I and NACP-II, the Ministry of Health and Family Welfare in their written note stated as under:

> "Though NACP-I was supposed to take off in April, 1992, the agreement with the World Bank was signed in September 1992. Further, because of the procedural delays and less expenditure incurred in the budget every year of the project period till 1995-96, the programme had to be extended for a period of two more years. Against the committed credit of US $ 84 million Government of India received disbursement of US $ 60.54 million till 30th September, 1997

and in the extended period upto 31st March, 1999 the balance disbursement of US $ 23.46 million was received."

The Ministry further added:

"During the term of NACP-II as per project implementation plan, the obligation of Rs. 1155 crores of World Bank was to be met during 5 years of the project period and a year-wise phasing of the provision was decided. This cost was never met as per budgetary resources. The short fall in the budget provision was to the tune of Rs.218.67 crores *vis-a-vis* budget provision. Secondly, revised estimates are usually finalized in the month of January-February of the Financial Year. This delays the release of additional funds to implementing agencies which ultimately result in less utilisation of funds during the year by the agencies."

21. Explaining the position further, the Ministry informed the Committee that till November, 2004 the position of utilisation of funds under the NACP-II, which is assisted by World Bank, is as follows:—

(Rupees in crores)

Financial year	Budget estimates	Revised estimates	Expenditure	Percentage Utilisation against R.E. provisions
1999-2000	137.00	134.50	129.75	96.47%
2000-2001	122.00	162.75	162.78	100.01%
2001-2002	168.00	185.00	187.72	101.47%
2002-2003	176.00	200.50	199.73	99.62%
2003-2004	175.50	187.15	185.06	98.88%
2004-2005 (Till Nov. 2004)	161.50		133.03	

22. On being enquired about the measures taken by NACO to speed up the pace of implementation of its activities so as to utilize the entire amount of credit made available to it by the World Bank, the Ministry of Health and Family Welfare replied as under:

"NACO conducted a National level workshop in consultation with many States to identify issue and bottlenecks for the slow implementation of the activities. With the result, most of the Societies are in the fast track mode to speed up the pace of implementation of the activities. The State AIDS Control Society (SACS) in which the utilization is between 30–50 per cent only are Jharkhand and Lakshadweep."

23. The following Table highlights consolidated position of unspent balance available with State AIDS Control Society (SACS) as on 1st April, 2004:

Consolidated Position of Unspent Balance Available with State AIDS Control Society (SACS)

As on 01.04.2004

Sl.No.	States	Unspent balance (Rs. in lakhs)
1	Andaman & Nicobar SACS	27.24
2	Andhra Pradesh SACS	402.84
3	Arunachal Pradesh SACS	79.96
4	Assam SACS	3.08
5	Bihar SACS	48.47
6	Chandigarh SACS	29.56
7	Chattisgarh SACS	54.09
8	Dadra & Nagar Haweli	7.76
9	Daman & Diu SACS	55.21
10	Delhi SACS	228.55
11	Goa SACS	215.52
12	Gujrat SACS	250.44
13	Haryana SACS	315.09
14	Himachal Pradesh SACS	73.55
15	Jammu & Kashmir SACS	85.86
16	Jharkhand SACS	270.88
17	Karnataka SACS	43.12
18	Kerala SACS	210.96
19	Lakshadweep SACS	40.25
20	Madhya Pradesh SACS	106.30
21	Maharashtra SACS	336.49
22	Manipur SACS	6.20
23	Meghalaya SACS	205.68
24	Mizoram SACS	79.40
25	Nagaland SACS	160.05
26	Orissa SACS	198.37
27	Pondicherry SACS	58.38
28	Punjab SACS	436.83
29	Rajasthan SACS	57.45
30	Sikkim SACS	0.57
31	Tamil Nadu SACS	35.09
32	Tripura SACS	67.42
33	Uttar Pradesh SACS	1,144.16
34	Uttaranchal SACS	61.58
35	West Bengal SACS	17.34
36	Ahmedabad MCACS	47.67
37	Chennai MCACS	152.46
38	Mumbai MC ACS	193.91
	Grand Total	5807.78

24. With regard to the remedial measures taken by NACO to increase the percentage of productive utilization of funds released to AIDS Control Societies, the Ministry explained the position as under:

> "A computerized Project Financial Management System has been installed in all the Societies. This has simplified the procedure of submission of claims to the Government of India. Further, extensive review of the Societies through meetings with Project Directors of SACS twice a year, audit by Chartered Accountants and superimposed audit by C&AG and its State units, review by Parliamentary Committee on Human Resource Development and visits by Officers of NACO is done from time-to-time to streamline the system of reporting of expenditure by the Societies."

25. As regards, the cases of non-submission of Utilization Certificates by the State Governments, the Ministry replied as under:

> "All State AIDS Control Societies have been requested to furnish the utilization certificates in respect of Central Grants released to them from 1999-2000 onwards along with their audited annual statements of accounts. Some of the Societies, which are in default of submission of utilisation certificates, have been pursued for submission of the utilisation certificates. As a remedial measure, no further Central funds are released to the defaulting Societies unless up to date utilisation certificates are received from them."

26. When asked to comments about the common perception that the funds released by the World Bank for HIV/AIDS in India are not used timely, efficiently and effectively by NACO, the Ministry explained their viewpoint through a written note as under:

> "It is submitted that the perception is based on the assumption that funds as per projection for each year were released, whereas, in reality, from 1999-2000 to 2003-04 the allocation was much below projection. However, these allocations were fully utilized as clear from the following Table. Even when the allocation was almost doubled in 2004-05 in mid-February 2005, funds were utilized to the extent of 99 per cent :

(Rs. in crores)

Year	Budget Estimate	Revised Estimate	Expenditure
1999-2000	140.00	140.00	135.35
2000-2001	145.00	180.00	180.00
2001-2002	210.00	225.00	226.55
2002-2003	225.00	242.00	240.13
2003-2004	225.00	225.00	231.88

It is pertinent to mention that the audit statements and utilization certificates have been received from all the 38 SACS upto the year 2003-04 and for 2004-05 the audited statements have already been received from 20 State AIDS Control Societies, viz., Mizoram, Arunachal Pradesh, Lakshadweep, Chandigarh, Delhi, Rajasthan, West Bengal, Tamil Nadu, Haryana, Maharashtra, Mumbai M.C., Gujarat, Daman & Diu, Andaman & Nicobar Islands, Bihar, Sikkim, Manipur, Assam, Ahmedabad M.C. and Dadra & Nagar Haveli alongwith Utilization Certificates. Even the reimbursement claimed from World Bank has now crossed in US $ 175 millions (91.6 per cent) and NACO is confident of claiming 100 per cent reimbursement before the end of the project. It is also pertinent to mention that the World Bank Mission in February 2005 rated our performance as satisfactory. It will thus be seen that initially get back has now been fully overcome."

27. When asked to explain whether the loopholes in the financial management by NACO could be attributed to inadequate allocation of funds by the Ministry of Finance/ the Planning Commission, the Ministry replied in a written note as under:

> "It is true that the loopholes in the financial management could be attributed to inadequate allocation of funds. During the project period, the short fall in the fund allocation through the National AIDS Control Programme could be seen in the following statements:—

NACP-II – Shortfall in the Budget Provision

(*Rupees in crore*)

Sl. No.	Fiscal year	Projections	Budgetary Provisions		Shortfall against	Expenditure (%)
			Budget Estimates (B.E.)	Revised Estimates (R.E.)		
1	1999-2000	201.73	140	140	61.73	96.60%
2	2000-2001	317.29	145	180	137.29	100.00%
3	2001-2002	308.62	210	225	83.62	100.69%
4	2002-2003	310.00	225	242	68.00	99.23%
5	2003-2004	310.00	225	225	85.00	103.06%
6	2004-2005	476.00	259	426	50.00	99.06%
	Total	1923.64	1204	1438	485.64	

It will be observed that consistently less funds have been allocated than the projected requirements. Further, it will be seen from the figures for 2004-2005 even when the B.E. was increased from Rs. 259 crore to Rs. 426 crore under R.E. during the middle of February 2005 NACO has been able to utilize Rs. 422 crore (99 per cent). Thus, if allocations had been made as per the projected requirements, NACO would have been in a position to utilize the funds."

Non-Reconciliation of Accounts

28. 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 SOEs 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 SOEs and audited statements of accounts were noticed in 46 cases.

29. When the Committee desired to know about the action taken by the Ministry of Health and Family Welfare to reconcile the differences in the figures of SOEs and the audited statements of accounts, the Ministry in a written note stated as under:

> "The Statements of Expenditure are usually reconciled with the audit certificates. Expenditure of 30 SACS till 2002-03 have been reconciled with the audited statement of accounts of the SACS concerned. The audited statements of accounts also include expenditure in the form of grant released by SACS to various NGOs and also unsettled advances. The actual expenditure against these grants and advances is included in the SOEs during the quarter it actually occurs. Hence, all the SACS have been requested from time to time to settle these grants and advances during the Financial Year."

The Ministry further added:

> "This exercise has been completed till 2002-03. Annual audited statements of accounts for the year 2003-04 have been received and further reconciliation of accounts is being taken on campaign basis. Meetings with finance functionaries of all SACS will be taken up in mid April for this purpose and it is proposed to meet the financial functionaries from SACS twice in a year for all issues relating to financial management."

30. When asked to furnish the current status of the reimbursement from World Bank as against the total reimbursable amount due and the actual amount of reimbursement received, the Ministry in a written reply stated as under:

(Rupees in Crore)

Year	Projected Expenditure	Expenditure for which claims sent to World Bank	Percentage	Eligible reimbursement
1	2	3	4	5
1999-2000	154.52	0	0	0
2000-2001	270.11	168.46	62.37%	151.78 (US $ 41.364 Million)

1	2	3	4	5
2001-2002	258.00	172.19	66.74%	155.44 (US $ 31.107 Million)
2002-2003	193.13	153.48	79.47%	135.35 (US $ 27.930 Million)
2003-2004	198.03	151.68	76.59%	130.30 (US $ 28.535 Million)
2004-05 (Till Dec., 04)	81.38	108.11	132.85%	86.92 (US $ 19.125 Million)
Total	1155.17	753.92		659.79 (US $ 147.936 Million)

The reimbursement due as on 1st January, 2005 is Rs.299.21 crore (US $ 43.064 Million).

VII. Working Of State/Municipal Aids Control Societies

31. As of March 2003, State Governments have set up 35 State/UT AIDS Control Societies (SACS) and three Municipal AIDS Control Societies (MACS) at Ahmedabad, Chennai and Mumbai. NACO approves their Annual Action Plans and releases grants to them according to these plans. However, Audit scrutiny of records relating to submission/approval of annual action plan and release of grants to Societies revealed the following facts:

(i) Annual Action Plans (AAPs)

32. 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 end) so that these could be approved and communicated before allocation of funds (*i.e.* in March). Audit scrutiny of Annual Action Plans revealed considerable delays in their receipt and approval, as could be seen from the Table below:

Year	Receipt				Approval		
	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
2002-03	35	Nil	08	27	Nil	34	01 (Oct.)

33. The 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 Centres (VCTCs), training etc. were not achieved. The Ministry in their action taken reply *vis-à-vis* the Audit observation have submitted that there has been a drastic improvement in 2003-04 and 2004-05 as the number of Annual Action Plans submitted were 38 and 40 in the respective years.

34. When enquired by the Committee about the procedure adopted by NACO to ensure timely submission of Annual Action Plans by the SACS/MACS, the Ministry stated in a note as under:

> "All the implementing agencies are requested in October to submit their draft Annual Action Plans for the next Financial Year to National AIDS Control Organisation. These Societies are to send their Annual Action Plans by 31st December. Thereafter, these are examined by the Programme Officers in NACO. On the basis of these examinations the Annual Action Plans of the implementing agencies are finalized after having a discussion with Project Director of the respective SACS and their teams. The target month of completing this process is March before the next Financial Year starts."

35. As regards the delay in submission of Annual Action Plans by SACS, the Ministry furnished a written reply and stated that for the year *i.e.* 2004-2005, Annual Action Plans have already been received which are being examined.

(ii) Irregular Release of Grants

36. 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 scrutiny found that grants of Rs. 80.14 crore were irregularly released to Societies before fulfilling the required conditions.

37. Replying to the Audit observation, the Ministry stated in a note as under:

> "NACP-II was in continuation of the NACP-I. There is a switch over from Department of Health (State AIDS Cell) in the first phase to State AIDS Control Societies established by the Department of Health of the State concerned in the Second Phase. Due to certain procedural formalities to be accomplished by the SACS, the process of signing of MoU with the SACS was delayed. Hence, ad-hoc release of Rs.80.14 crore was made to SACS for initiating some activities as well as payment of remuneration to staff."

(iii) Allocation of Funds to State Aids Control Societies

38. On the basis of Annual Action Plans received from Societies, NACO makes component-wise allocation of funds to them, 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 lakh)

Component		Indicative cost (per cent) of total outlay as per pad*	1999-00	2000-2001	2001-2002	2002-2003
A. Delivery of cost-effective intervention against HIV/AIDS						
(i) Priority targeted inter-ventions for groups at high risk	Allocation %	23%	4245.82 (25.04%)	3847.54 (36.36%)	4157.00 (21.95%)	5090.31 (23.81%)
	Expenditure (%)		2133.56 (19.3%)	2487.19 (29.42%)	2601.20 (18.81%)	2237.53 (20.17%)
(ii) Preventive interventions for the general community	Allocation (%)	33.7%	6329.92 (37.33%)	3642.85 (34.42%)	9186.56 (48.52%)	10328.57 (48.30%)
	Expenditure (%)		5625.53 (51.07%)	3607.64 (42.67%)	7632.86 (55.19%)	5545.61 (49.99%)
(iiii) Low cost AIDS care	Allocation (%)	14.1%	1637.23 (9.66)	143.75 (1.36%)	1285.05 6.79%)	1331.00 (6.23%)
	Expenditure (%)		388.53 (3.53%)	155.59 (1.84%)	450.37 (3.26%)	587.13 (5.29)
B. Building capacity						
(i) Institutional strengthening	Allocation (%)	24.8%	4141.12 (24.42%)	2811.69 (26.57%)	3893.22 (20.56%)	4212.88 (19.70%)
	Expenditure (%)		2749.52 (24.96%)	2141.79 (25.33%)	3081.49 (22.28%)	2657.54 (23.96%)
(ii) Inter-sectoral collaboration	Allocation (%)	4.4%	600.77 (3.54%)	137.00 (1.29%)	412.66 (2.18%)	420.00 (1.96%)
	Expenditure (%)		117.42 (1.07%)	62.14 (0.74%)	64.96 (0.47%)	66.02 (0.60%)
Total	Allocation (%)	100%	16,954.86	10,582.83	18,934.49	21,382.76
	Expenditure (%)		11,014.56	8,454.35	13,830.88	11,093.83

* Project Appraisal Document

39. 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. In this connection, the Ministry clarified the position *vis-à-vis* the Audit observation in a written note as under:

> "The allocations in various components were made on the situations prevailing at the time of preparation of Project Appraisal Document. However, the expenditure on various components may vary depending upon the prevailing conditions in running of the project in various parts of the country. The variations in percentages in components 1, 2 and 4 are marginal. In so far, component namely 'Low Cost AIDS Care' and 'Inter-sectoral Collaboration' are concerned, these were introduced in the 2nd Phase first time and these took time to pick up. "

(iv) Transfer of Unspent Balances to SACS/MACS

40. 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.

41. NACO was asked by Audit to furnish details of funds lying unutilised with various States as on 1 April 1998 and funds transferred to Societies but NACO failed to furnish the same. However, from the information supplied to audit by NACO in respect of seven States i.e Andhra Pradesh, Arunachal Pradesh, Assam, Jammu & Kashmir, Maharasthra, Manipur and Uttar Pradesh and as intimated by the States' Accountants General, it was noticed that Rs. 3.80 crore was yet to be transferred to the Societies.

42. When asked to state the action taken by the Ministry to ensure transfer of Rs. 3.80 crore to SACS/MACS from the aforesaid seven States, the Ministry in a written note stated as under:

> "In the phase I of NACP the State Governments were implementing the project through their State AIDS Cell. State Governments are, therefore, required to transfer the unspent balances of Phase I to State AIDS Control Societies. Efforts are being made to get these balances transferred to the SACS. NACO has recently approached all the concerned States to transfer the unspent balances."

(v) Release of Grants to State AIDS Control Societies

43. Audit scrutiny of release of grants to Societies revealed that out of the total grant of Rs. 566.05 crore (including the opening balance) released by NACO during 1999-2000 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. However, the Ministry in their Action Taken reply to the Audit observation submitted that the number of utilization certificates pending during 2003-04 is only 4. 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 to them.

44. When enquired about the various reasons for non-submission of Utilisation Certificates by some States, the D.G. of NACO during evidence held on 9 February, 2005 stated the position as under:

> "There was a question of Utilisation Certificates from 9 States. Out of this 6 States have submitted Utilisation Certificates and the rest 3 States i.e. Jammu & Kashmir, Jharkhand and Lakshadweep are yet to submit the same. We keep on pressurising them and hope it will be submitted at the earliest."

45. In their post evidence reply, the Ministry have further clarified that the Utilisation Certificates pending from 9 States pertain to 2001-02. These have been received from all the SACS except Jammu & Kashmir, Jharkhand and Lakshadweep. As a remedial measure, no further grants will be released to such States till receipt of the utilization certificates.

46. When enquired about the total amount of funds lying unutilized and the reasons thereof, the Ministry in their Post-evidence reply have mentioned that about Rs.19.19 crore were available with SACS as on 31 December, 2004.

(vi) Grants Released in Excess of Allocation

47. Audit analysis of allocation and release of funds to Societies has 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

The Ministry in a written note adduced the reasons for release of Grants in excess of allocation as under:

> "During 1999-2000, 2000-01, 2001-02 and 2002-03, certain additional activities in addition to approved action plans of the society *viz.* Family Health Awareness Campaign were taken up. This resulted in excess release over and above the approved action plan in respect of some State AIDS Control Societies. The activity of Family Health Awareness Campaign was approved by the National AIDS Control Board."

(vii) Contribution from NGOs

48. NACO 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. However, Audit 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 the stipulated 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 an NGO 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.

49. The Committee desired to know about the activities of the NGOs who are given grants by NACO. The Ministry in a written note explained the following major activities of AIDS Control Programme with which the NGOs are involved:

- "Targeted Interventions: The overall aim is to bring desired behaviour change (high risk to low risk or no risk behaviour) among the high risk groups involving in multi-partner relations, whether sexual or needle-sharing partners like Commercial Sex Workers (CSWs), Injecting Drug Users (IDUs), Men-having-Sex-with-Men (MSM), truckers, migrant workers, etc.
- Drop-In-Centers: Small project mainly a facility for HIV positive people to have a place to come together and discuss issues and provide support to each other. Sometimes also used for core population.

- Community Care Centers (CCCs): These are hospice facility for terminally ill AIDS patients (usually a 10 bedded each).
- School AIDS Education Program: A program to be implemented in 9 and 11 grade classes by training teachers and peer-educators to provide age appropriate AIDS education within format of life skill education to adolescents."

50. When asked to explain the mechanism for monitoring the NGOs activities, the Ministry stated in a note as under:

> "SACS regularly monitor the NGOs performance. NGOs also submit monthly CMIS reports, half yearly and annual progress report, audited expenditure statements. At the end of the year, Utilization Certificates are submitted to SACS. SACS conducts internal evaluation during the first two years of project period and external evaluation conducted by SACS after completion of 3rd year of project period. Periodic external evaluation at National level & supervisory visits are also undertaken by NACO."

VIII. HIV/AIDS Sentinel Surveillance

51. 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).

(i) Estimation of HIV Infection among Adult population

52. 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 5.1 million in 2004. 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.

53. When asked to clarify the exact number of HIV cases present in India till date especially when the official estimate about the existence of 5.1 million HIV cases in India, given by NACO have often being contested by various agencies and NGOs such as the NAZ Foundation et.al., the Ministry stated in a written note as under:

> "Under the surveillance activities of National AIDS Control Programme, NACO is implementing HIV Sentinel Surveillance. An annual round of HIV Sentinel

Surveillance is conducted every year from August to October in designated sentinel sites all over the country. This data is collected primarily to monitor HIV trends in various risk groups of population. This data is also used to estimate the number of HIV infections in the country. The HIV estimates thus derived since 1998 are as follows:

Year	Estimates in million
1998	3.5
1999	3.7
2000	3.86
2001	3.97
2002	4.58
2003	5.106
2004	5.134

54. Further when the Committee queried about the reliability of the Sentinel Surveillance carried out by NACO, the Ministry explained in a written note as under:

> "HIV sentinel surveillance is being conducted under the Programme with the objective of collecting information of sufficient accuracy to track the HIV epidemic in the country. Since, the routine reporting data has a high degree of under reporting as most of the individuals will not access the public health system for fear of identity. Since the HIV Sentinel Surveillance takes care of all the possible biases including participation bias as well as selection bias, it is recognized as the most appropriate and reliable approach. The entire methodology adopted is unlinked anonymous, whereby blood is collected for some other purposes and thereafter sera is separated, coded and tested for HIV. The consecutive sampling will take care of the selection bias which may be introduced during the course of collection of samples. Thus this methodology is most reliable and globally accepted methodology and is being implemented in most of the country around the world to track the progression of HIV epidemic."

(ii) Prevalence of HIV

55. 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 where HIV infection has crossed one per cent or more in antenatal women) includes Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur and Nagaland.
- Group-II (moderate prevalence States where HIV infection has crossed five per cent or more among high risk groups but the infection is below one per cent in ante-natal women) includes Gujarat, Goa, Pondicherry.

- Group-III (low prevalence States where HIV infection is below one per cent in ante-natal women) includes the remaining States/UTs.

56. Though Goa is categorized as a moderate prevalence State and Mizoram and Dadra and Nagar Haveli are categorized as low prevalence States, the Sentinel Surveillance 2002 date 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.

57. When asked to specify the steps which are being taken by NACO to prevent the spread of HIV infections from high risk groups to general population, the Ministry of Health & Family Welfare explained the position as under:

> "In order to prevent and control the spread of HIV/AIDS in India, Government of India has launched a comprehensive National AIDS Control Programme, currently under implementation throughout the country as a centrally sponsored scheme under following components:
>
> - Preventive interventions for high-risk populations through Targeted Interventions adopting a multi-pronged strategy including peer counseling and behaviour change communication.
> - Preventive interventions for the general population through programmes for blood safety, voluntary counseling and testing services, Prevention of Parent to Child Transmission (PPTCT), Information Education and Communication (IEC) & awareness building among adolescents and sensitization for the AIDS Vaccine Initiative.
> - Provision of low cost care and support services by providing community care services, treatment of opportunistic infections and prevention of occupational exposure.
> - Collaborative efforts to promote inter-sectoral programme activities including workplace interventions and public-private partnerships.
> - Build technical and managerial capacities for programme implementation through Surveillance, Training, Monitoring and Evaluation, Technical Resource Groups, Operational Research and Programme management."

(iii) Surveillance of AIDS Cases

58. According to the Sentinel Surveillance conducted, there were an estimated 4.58 and 5.1 million HIV infection cases in 2002 and 2004 respectively in the country.

96,086 blown AIDS cases were reported by 2004. 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.

59. When asked to comment on the increasing trend of AIDS cases 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, the Ministry in a written note explained the position as under:

> "As per the reports received from various States/UTs, cumulative number of 96086 AIDS cases have been reported to National AIDS Control Organization. During the year 2002, 17482 AIDS cases have been reported while during 2003, 18704 AIDS cases have been reported. An increase in the reporting of AIDS cases has been observed since 2001. The factors likely to be attributed for this increase is due to the increased number of people accessing treatment services in public sector hospitals and increase in the number of hospitals providing such services. Inspite of this, the reliability of such statistics may not be accurate as many of the AIDS cases may still not have the access to public sector hospitals and there may be many more number of AIDS cases in the community. In view of this problem and in order to estimate the number of HIV infections (earliest form of disease), National AIDS Control Organization is using HIV Sentinel Surveillance data which suggest that there were 4.5 million HIV infections in 2002 and 5.1 million HIV infections in 2003. It is assumed that at given point of time, about 10 per cent of the estimated HIV infected people, have AIDS. Based on this assumption, it is estimated that during 2002, there were 4.58 lakh AIDS cases and during 2003, there were 5.1 lakh AIDS cases estimated to be there in the country."

60. As regard the increasing trend of AIDS cases, the ADAI, C&AG during evidence stated as under:

> "The general issue is that despite these NACP I and NACP II being there for the last five years, we found that towards the end, take for example 2000-01, there was an upward spurt in cases. When the Ministry take up some programmes, they would expect some mitigating kind of circumstances towards the end. But when they look at the statistics, they would find that

> there is an increase of 15.9 per cent in the HIV cases in the year 2001-02. There is a substantial increase in the number of AIDS cases towards the end of the project period. There is a substantial increase in the death cases towards the end of the project period. The objective of NACP-II was to have long-term ability to control this."

(iv) Deaths due to AIDS

61. The details of deaths due to AIDS, during 1999-2002 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

62. When the Committee desired to know about the latest position regarding number of cases reported deaths due to AIDS or by secondary opportunistic infection, the Ministry in a written reply stated as under:

> "As per the reports received in National AIDS Control Organization, it has been reported that 1106 deaths have occurred due to AIDS in the country during 2003. The cumulative number of deaths reported so far is 6197 deaths. It is true that since the immune system of the people suffering from AIDS weakens considerably and they become prey to several life threatening diseases, the cause of death in such cases is due to the opportunistic infections which has led to death. But deaths due to various opportunistic infections for *e.g.* TB, cannot be solely taken as death due to AIDS."

(v) Probable Source of Infection of Reported AIDS Cases in India

63. 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%)

64. From the Table, it is evident that the sexual route remains the most probable source of infection of AIDS cases, followed by blood and blood products and Injecting Drug Users (IDU). Another important 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, Prevention of Parents to Child Transmission (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.

65. In their Action Taken *vis-à-vis* to Audit observation, the Ministry of Health and Family Welfare submitted that as on January 2005, 288 PPTCT centers are functioning in the country. Out of this, 238 are in high prevalence States and rest (50) are in low prevalence States. In high prevalence States, all the Medical Colleges (85) and all District Hospitals (153) are providing PPTCT services. In moderate/low prevalence States, out of 79 Medical Colleges, 42 Medical Colleges are providing PPTCT services. Rest of the Medical Colleges are in the process of starting PPTCT services.

66. During evidence, the Director General, NACO explained the routes of transmission of HIV/AIDS as under:

> "The route of transmission is mostly through the sexual routes *i.e* about 86 per cent. But then there is infection through blood transmission, from mother to child and injecting drug users. They are almost two to three per cent. Six per cent has not identified the cause, but they will come under one of those four routes."

67. Replying to a specific query about the steps taken by the Ministry to contain the transmission of HIV in North-Eastern States, especially in the States of Manipur and Nagaland, the Ministry in a note submitted as under:

> "North-eastern States get special attention due to the different nature of the epidemic (primarily IDU driven). 65 out of the 71 Targeted Interventions for IDUs are located in this region. Manipur is the only State to have a State AIDS Policy. Special attention is being paid to prevent sexual transmission to partners of IDUs. 21 de-addiction centres run by Ministry of Social Justice and Empowerment (MSJ&E) are also being supported by NACO. 8 Community Care Centres (Hospices), 2 Drop-in-Centres and 3 ART Centres providing free antiretroviral drugs for AIDS patients are also functioning in the region. 2 out of the 10 state-of-the-art model blood banks have been set up in Guwahati and Dibrugarh."

68. On being enquired about the steps/measures taken by NACO to achieve the targeted level of below one percent transmission of HIV/AIDS from blood, the Ministry in a written note stated as under:

> "To achieve the target level of below one percent transmission of HIV/AIDS from blood, NACO has taken a number of steps. Firstly, ensuring that every unit of blood is mandatorily tested for HIV, Syphilis, Malaria and Hepatitis (B&C) before the unit is transfused to patients. NACO provides test kits free of cost to the blood banks that are being supported by NACO. The quality of such testing is also assured by a nation wide External Quality Assurance System (EQAS) Secondly, to reduce HIV transmission to minimum, it is also essential that only safe blood donors donate blood on a regular basis. Professional blood donors have been banned and a number of activities are being undertaken to augment voluntary blood donation in the country and thirdly, steps are being taken to orient the prescribers of blood towards appropriate clinical use, so that blood is transfused only when it is absolutely essential and the right quantities of blood components are used."

IX. Priority Targeted Interventions for Groups at High Risk

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

(i) Targeted Interventions

70. 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, migrant labours. 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 and these interventions are to be monitored and evaluated regularly.

71. On being asked about the aims, objectives and the activities carried out under the Targeted Interventions programme,. in a written note, the Ministry stated as under:

> "Targeted Intervention programme is a strategy to prevent HIV infection and transmission among the groups who tend to involve in High Risk Sexual Behavior. Intervention with High Risk Groups (HRGs) that are, at the core of HIV transmission can greatly reduce the spread of HIV into the general population. Directing HIV prevention efforts among these groups (with high rate of partner-change, whether sexual or needle-sharing partners) is a proven cost effective strategy as it has the multiplier effect of preventing many subsequent rounds of infections amongst the general population. Such High Risk Groups broadly include Commercial Sex Workers (CSWs), Injecting Drug Users (IDUs), Men-having-sex-with-men (MSM), truckers, migrant workers, etc. Targeted Interventions among these groups involve multipronged strategies such as behaviour change, communication, counseling, health care, treatment for STIs and creating demand and making provision of condoms, along with activities that can help create enabling environment for behavioural change. The over all objective of Targeted Intervention programme is to bring desired behaviour change (low risk or no risk behaviour) among the High Risk Groups, so as to interrupt the spread of HIV."

72. Audit scrutiny revealed that as of June 2003, 792 targeted intervention projects had been undertaken by the State AIDS Control Society (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. However, 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:

Sl. 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
	Total of TI Projects	792	100

73. When enquired about the agencies responsible for the implementation of TIs in different States, the Ministry in a written reply stated as under:

> "With support from NACO, the State AIDS Control Society, UTs and three Municipal Corporations have been delegated the task of selecting the Non-Government Organizations or Community-based Organizations as partners who would implement the TI projects. Alongwith funding support SACS also provide technical support to the organizations on the ground. These NGOs/CBOs partners are allocated project areas and HRGs based on the mapping and other data in the State and credibilities, capabilities and past experiences of the NGOs. As of September 2004, 933 TIs are being implemented across the country."

74. When asked about the rate of achievement of Targeted Interventions (TIs) in the States, the Ministry in a note have stated as under:

> "There has been notable increase in terms of the coverage of vulnerable populations through Targeted Intervention projects in the phase II of NACP, yet current TIs are estimated to cover about 50 per cent of vulnerable populations in the country through the projects. NACO along with SACS aims to saturate the core groups (CSWs, MSMs and IDUs) under the program. The focus is now on having composite interventions where more than one core groups are targeted by the project in a given area, which makes it possible for smaller groups also to be covered by the TIs. There has been increase in terms of coverage of High Risk Groups through Targeted Intervention projects from year 2002 to 2004."

75. Explaining the instances of involving non-high HIV risk groups in the TIs conducted in various States have been explained by the Ministry as under:

> "It is well documented that the HIV epidemic shifts from core groups to bridge population (clients of sex workers, partners of drug users, etc.) and then to the general population. Such HRGs broadly include CSWs, IDUs and MSMs while truckers, street children, migrant workers, etc. constitute the bridge population. The reality of most States beyond the big cities is that it is difficult to get a sizeable group of CSWs, IDUs and MSMs to make a project cost effective. Experience also shows that working with both the sex-provider and the clients produces synergy of efforts and HIV control does not become a burden of sex-provider but is a joint decision. Therefore, the most cost-effective strategy is to cover the core-group available in the area alongwith the adjoining bridge groups so as to provide two-pronged strategy of arresting HIV. Over the years some States have shown remarkable results in slowing down the spread of HIV with effective use of composite interventions, where core groups and bridge groups were included, with focused services and attention to both. The focus, therefore, was not diluted but expanded to include the groups, which will support the overall efforts of HIV prevention, in both core-groups and general population."

76. When enquired about the action taken by NACO on the recommendation of the World Bank to shift the focus of the targeted intervention programme to truly high risk groups, the Ministry in a written reply submitted as under:

> "NACO's aim is to cover and saturate the program for all the core groups. Based on the World Bank observations as well as results of these evaluations, SACS have been asked to refocus all these interventions to concentrate on the core groups present in the same area. Restrategizing and refocusing efforts are made in terms of building capacities of the States, providing resources and linking States with local capacity building organizations. Experience shows that while it is very important to saturate the core groups within a State, it is also true that it is very difficult to get a sizeable group of CSWs, MSMs or IDUs to have a cost effective intervention, which does not create stigma. It is realized that if the project is broad based to include more than one core groups in a project or include bridge group with any one core group, the synergy is developed for HIV prevention among the group. Such intervention are not only cost effective they also provide a wide opportunity for organizing and empowering the vulnerable populations. The focus is now on having composite interventions where more than one core group is targeted by the project in a given area."

77. During evidence the Ministry of Health & Family Welfare elaborated further on the steps proposed/planned for prevention of HIV/AIDS in highly vulnerable 14 States:

> "Firstly, provision of one Voluntary Counselling and Testing Centre (VCTC), Prevention of Parent to Child Transmission (PPTCT), Sexually Transmission Diseases (STD) Clinic, District Blood Bank in each district by 2005-06. Secondly, Targeted Intervention for all the core high risk groups like Commercial Sex Worker (CSW), intravenous Drug User (IVDU), Man Having Sex with Man (MSM). Thirdly, establishment of at least one Anti Retroviral Therapy (ART) centre for free treatment of AIDS cases in these States by 2005-06 (Delhi, UP, Chandigarh, West Bengal, Rajasthan have already been sanctioned ART centre). Fourthly, the extension of HIV-TB Coordination plan for cross referral of clients from VCTC to microscopy center and *vice versa*. Fifthly, motivation of international agencies (like DFID, Aus-AID etc) working on HIV/AIDS for extension of their collaboration project in these States and sixthly, training of Doctors, nurses & paramedical including ISM staff will be carried out. The staff at VCTC, PPTCT, and Antiretoviral Therapy (ART) centre will be trained."

78. When asked by the Committee to comment on the projection by many experts that in the Targeted Interventions Programme regarding Commercial Sex Workers, the targets set by NACO is low in six States characterized by highly concentration of HIV/AIDS cases i.e. Andhra Pradesh, Kerala, Tamil Nadu, Maharshtra, Manipur and Nagaland, the Ministry explained in a written note as under:

> "Mapping of high risk groups (HRGs) is a complex exercise. While it is comparatively easier to locate brothel based CSWs, it is difficult to locate the

non-brothel CSWs. Accessing them for the purpose of Targeted Intervention requires persistent and patient efforts by the NGOs. These are being scaled up. More NGOs are being involved to ensure the coverage is increased. The number of TIs focusing among CSWs have increased from 147 in June 2002 to 224 in December 2004. To further scale up the coverage of the scattered sex workers population, 269 composite interventions are additionally being implemented. All major sites for Commercial Sex Workers are already being covered through targeted intervention projects (Andhra Pradesh – 25, Kerala – 2, Tamil Nadu – 13, Maharashtra – 40, Manipur – 5, and Nagaland – 3) Additionally 90 composite interventions are being implemented to cover the scattered population of sex workers along with other high risk groups. Currently the coverage of Commercial Sex Workers ranges between 45 per cent to 55 per cent in all States. During the year 2005-06, efforts will be made to increase the coverage up to 80 per cent."

79. When asked to comment on the view point that the targets set by the NACO for the various programmes are often stated to be unrealistic and often even the stipulated targets are not achieved, the Ministry explained in a written note as under:

"The targets set under NACP for various programme components cannot be said to be unrealistic. The targets set at inception of NACP II were realistic enough to be achieved. However, they felt short mainly because projected requirement of funds was not met in the initial years. When the allocation was increased in 2004-2005, the funds were fully absorbed. Uneven response of the States, including frequent change of Project Director's of State AIDS Control Societies, non-filling up of posts in SACS etc. also contributed."

80. When the Committee desired to know the measures taken by NACO to set up a realistic target, the Ministry submitted in a written note as under:

"The following measures have been taken by NACO in order to set up realistic target:

- Each State is asked to prepare its Annual Action Plan based on its needs indicating the physical targets, and the cost outlay. This is discussed with the Project Directors and officials of the concerned State AIDS Control Societies in detail and realistic plan is approved.
- Targets are now set based on past performance and capacity of States to deliver.
- Each State is given adequate and clear instructions and guidelines for timely achievements of these targets."

(ii) Evaluation of Targeted Intervention Projects (TI)

81. A National Targeted Intervention evaluations 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, Sexually Transmitted Disease (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.

82. On being enquired about the remedial measures taken in the aftermath of National TI evaluation, the Ministry in a written reply stated as under:

> "Two external evaluations of TI programme have been conducted in 22 States, where total of 73 TIs were evaluated. The findings of the evaluation reports have been shared with all partners and the recommendations are being worked upon. The evaluation reports have argued the strategy of TI as the most effective strategy for reaching high risk groups. It is emphasized that there could be no substitute to the TI strategy to interrupt HIV transmission among HRGs in India. Delays in funding as well as insufficient training was also brought out. Although the Reports did mention need to focus on the projects, revision in costing guidelines of TIs and need for capacity building at various levels of programme from SACS to NGOs/CBOs, NACO had initiated various efforts in response to the recommendations. The costing guidelines of TIs have been revised based on a series of consultations involving various stake holders like SACS, NGOs, CBOs and other civil society representatives including the target community. The States have been asked to use revised costing guidelines for planning the new and ongoing TIs in their States. A series of regional workshops involving SACS and NGOs have been taking place throughout the country to further disseminate the evaluation and chalk out the State specific strategy for brining about quality improvement in the implementation of TIs. The SACS are also instructed to immediately address the issues of fund delays and improving quality of services delivery within TIs. Finally a provision of regular capacity building through Regional Resource and Training Centers of Ministry of Social Justice and Empowerment is also underway on regional basis."

(iii) Mapping of High Risk Areas

83. 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

84. Mapping is an exercise to widen a direction and magnitude of the Targeted Interventions within a State. The exercise maps the types and sizes of groups involving in high risk sexual behaviour. It also provides information of the location where the TI projects can be implemented. All State Societies have undertaken a detailed mapping of the vulnerable populations in their respective States, so as to earmark the areas where these interventions need to be prioritized. The study is being conducted by agencies of repute that have prior expertise in the field. All the major States have submitted the report and are planning TI interventions based on the data along with other relevant data. Reports of 33 SACS are available, while a few are in process of finalization. The States which have not completed the mapping exercise are Chattisgarh, Rajasthan, Orissa, Lakshwadweep and Dadra & Nagar Haveli.

(iv) Costing Pattern of Targeted Interventions

85. 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 Commercial Sex Workers (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 1999-2000) and Rs. 1451 (Mizoram in 2001-02) against NACO norm of Rs. 1208.50 for injecting drug users.

86. As regards the reasons for wide divergence in expenditure on different components from NACO norms, the Ministry submitted in their action taken notes *vis-à-vis* audit observations as under:

> "Technically it is divergence from NACO norms by some SACS in expenditure on different components, but keeping with the spirit of the programme some of it would be necessary to accommodate to the local needs.
>
> - There are variations in demography of the states, such that it is difficult to get large population of high-risk groups in one place, while they may be sizable enough to cover them under TIs. In such cases, the management cost of the projects may go up leading to overall increase in unit cost. Also, the population maybe scattered within a locality, which might give rise to expenditure like conveyance and place for meeting giving rise to expenditure not mentioned in old TI guideline.
> - The SACS were instructed to use the guidelines as mere guidelines because it will be meaningless to have a very strict straight jacketed guideline for the entire country. Depending on the need of the region the SACS have to make respective changes, which has to be sanctioned by the respective committee (executive or project steering committee) before the NGOs implement the project, which was done in case of all the states.
> - The health infrastructure in some states like Maharshtra and Haryana, are good. SACS therefore propagates and ensures linkages to existing health services like STD treatment and condom use, this will bring down the unit cost of TI drastically.
> - Realizing the need to build scope of regional variations within the overall TI guidelines, a revision of TI costing guidelines was done. The guideline is expected to provide considerable flexibility to the states to design the size of the project without increase the unit cost."

(v) Condom Promotion

87. 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. The programme also 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. 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.

(vi) Social Marketing of Condoms by NACO

88. The State AIDS Control Societies procure condoms through the Department of Family Welfare and distribute these under the scheme for free distribution and social marketing. 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. 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.

89. 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. 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.

90. Social marketing of condoms has been further boosted up by NACO by partnering with Social Marketing Organisations already approved by the Department of Family Welfare and engaged for condom promotion for the general population. Now these Social Marketing Organisations, such as, Janani, Parivar Seva Sanstha, World Pharma are promoting social marketing of condoms among the High Risk Groups. Retail Outlets have been increased in Fair Price shops in some States, such as Tamil Nadu, Andhra Pradesh and Karnataka. From the year 2003-04 all the 38 AIDS Control Societies are participating in the social marketing of condoms among the High Risk Groups which include Female Sex Workers, Truckers, Men Having Sex with Men (MSM) and Injecting Drug Users. 166 lakh pieces of condoms have been distributed by all the 38 AIDS Control Societies in the year 2003-04. Recommissioning of Condom Vending Machines in public places, especially for the High Risk Groups, such as the red light areas and on National Highways and major railway stations and bus stops is being processed by NACO in collaboration with the Department of Family Welfare.

91. Audit scrutiny regarding condom promotion in different States revealed the factual position as under:

Himachal Pradesh, Chandigarh, Haryana	▯	One hundred and forty Condom Vending Machines (CVMS) 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.

92. When asked about the steps taken by NACO to remove the shortage in supply of Condoms in Chandigarh, Himachal Pradesh, Haryana, Mumbai, Pondichery, Punjab and Karnataka, the Ministry in a written note stated as under:

> "Till the year, 2002-03, for free distribution of condoms, the State AIDS Control Societies used to procure condoms from the Department of Family Welfare of concerned State. Because of the difficulties experienced, now the arrangements have been made to dispatch condoms from the Department of Family Welfare, Ministry of Health and Family Welfare, Government of India directly to the State AIDS Control Societies. During the year 2003-04, a total quantity of 1273.48 lakh pieces of condoms were dispatched direct to the State AIDS Control Societies."

(vii) Awareness and Accessibility of Condoms in Urban & Rural Areas

93. 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 programme of accessibility of condoms strive 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.

94. When asked about the action taken by NACO on the report of Behavioural Surveillance Survey conducted by ORG, particularly with reference to awareness generation in rural areas, accessibility to condoms and use of condoms by Female Sex Workers, the Ministry in a written note stated as under:—

> "Acting on the findings of the Behavioural Surveillance Survey (BSS), special efforts were made in these areas during Family Health Awareness Campaigns(FHAC) to concentrate on inter-personal communication. Specific programmes were developed to focus on the low awareness areas through the partnership with BBC and Doordarshan. Concurrent and endline Behavioural Surveillance Survey (BSS) of this programme has revealed that awareness levels have significantly increased in the target population. About 50 per cent use of condoms by Female Sex Workers (FSWs) was reported during the BSS for the entire country. However, in some States outside the high prevalent States, lower prevalence of condom use in Commercial Sex Workers is also noticed. To tackle this, more TI projects targeting Commercial Sex Workers in the States have been launched with improvement and free access to condoms."

95. On being pointed out that in many villages' people don't know about HIV/AIDS and that condoms are not available, the Ministry during evidence deposed as under:—

> "The awareness about HIV/AIDS for the whole country is 76 per cent, however, in rural areas it is much lesser, especially in the northern belt. Accessibility of condoms are also less in rural areas when compared to urban areas. Focused interventions in the form of mass awareness campaigns and condom social marketing campaigns targeted at rural areas have been launched to address this problem".

(viii) Strengthening of Sexually Transmitted Diseases (STD) Clinics

96. 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.

97. 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 set 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.

98. According to Audit, 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.

99. Test check of the records of societies and test checked STD clinics by Audit 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

100. Further, in one STD clinic in Meghalaya and two STD clinics in Tripura, although the records of the State Aids Society showed that medicines had been supplied to these clinics, but the medicines 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.

101. The Committee desired to know the manner in which the STD clinics in the country are being strengthened. In reply, the Ministry stated in a written note as under:—

> "We have strengthened 735 STD Clinics at the districts and Medical College levels across the country. The Pattern of Assistance for STD Clinics are one time grant of Rs.75,000/- to each STD Clinic for purchase of equipment and Recurring assistance of Rs.1 lakh per STD Clinic per annum, to take care of drugs and consumables for effective functioning of the clinic."

(ix) Surveillance for STD Cases

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

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

(x) Survey of STD Clinics by Medical Faculty

103. Audit had noted that 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 clinics in 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 gynaecologists and 31 per cent had a general duty medical officer as its in-charge.

104. 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 in one-third of the clinics appropriate history and examination had not being maintained/done. 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 observed that the counselling relating to STD/HIV and safe sex was poor in the sense that it was given only in about 45 per cent of the clinics.

(xi) Distribution of condoms and availability of essential medicines at STD clinics

105. 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 reports of Computerised Management Information System (CMIS) 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 public sector STD clinics in the reporting adequacy of essential drugs for STD cases, it was observed that out of 766 STD clinics only 90(11.7 per cent) have reported 'such adequacy'. During 2002, out of 90 STD clinics, whose input formats were received, 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.

(xii) Counselling to STD patients

106. In terms of the scheme guidelines, counselling is to be provided through all STD Clinics. Audit had noticed that the number of new patients provided counselling through STD Clinics had been very low. The year-wise break-up is given as under:

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

107. 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 under 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.

X. Preventive Intervention for The General Community

(i) Information, Education and Communication

108. 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 as under:

- *Knowledge 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.

- *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.

- *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 and 66 per cent of Commercial Sex Workers and 68 per cent clients of female sex workers 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.

- *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 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 and 39 per cent clients of FSW had correct information on HIV transmission.

109. The findings of second round Behavioural Surveillance Survey-Rural, conducted in February-June 2002 by Dalal Consultants and Engineers Ltd. reveal 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.

110. When the Committee desired to know whether any publicity campaign had been contemplated by NACO for removing the misconceptions in the mind of general public regarding spread of AIDS/HIV, the Ministry in a written reply explained the position as under:-

> "The issue of removing misconceptions regarding HIV/AIDS has been central to our IEC efforts, and is a running theme in our campaigns. NACO has produced a range of print as well as audio visual software that deals with how

HIV does NOT spread. Also, the theme of stigma and discrimination (which basically stem from the misconceptions) have been dealt with at length. The theme for the World AIDS Day for two years was 'Live and Let Live', on the issues of stigma and discrimination, and gave the subject a lot of visibility. Various television and radio spots, as well as press and print material were developed on the theme. On going serials 'Jasoos Vijay' and 'Haath Se Haath Mila' also interwove stigma related issues in their episodes. Another activity that is ongoing, and that helps remove misconceptions about HIV/AIDS is the concept of Greater Involvement of People living with HIV/AIDS (GIPA). Networks of positive have gone out into public meetings, workplaces and so on, and dispelled the commonly held belief that life comes to an end once you have HIV."

(ii) Use of Electronic Media

111. 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 assessment of some of these programmes- 'Khamoshi Kyon (Doordarshan)' at 10.00 P.M., 'Talk Positive (ZEE News)' at 2.00 P.M., 'Kalyani (Doodarshan)', 'Spirit of Unity Concerts (Doordarshan)', 'Jiyo aur Jeene Do' (All India Radio)-revealed that these programmes had poor viewership/listenership. Reasons attributed for poor viewership/listenership included unjustified selection of channel (in case of Talk Positive) and timings of telecast/broadcast. However, 89.7 per cent viewers of 'Khamoshi Kyon Programme 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/timing of these shows been better, their impact would have been much better.

112. When enquired about the steps taken by NACO to maximize the impact of electronic media in spreading awareness among public regarding to HIV/AIDS, the Ministry in a written note stated as under:—

"Electronic media is very expensive, and NACO's budgets get stretched buying television time. So while there has been a concerted effort to increase allocations for IEC, so that more money is available to spend on the electronic media, partnerships and collaborations are also being worked out. The Minister for Information and Broadcasting, who is part of the inter ministerial group for mainstreaming of HIV, has committed free as well as discounted slots for HIV messages, as also integration of HIV issue within the existing programmes. Journalists and proprietors in the electronic media have sensitized on reporting on HIV issues. The health magazine 'Kalyani' on Doordarshan focuses on HIV related issues in the months of November – January every year. The partnership with DAVP, Prasar Bharati and BBC has resulted in a shelf of television software (spots as well as serial episodes), that are used by the SACS in a variety of ways for better reach. Media houses like Star TV, MTV, Channel V, etc have, after an initial advocacy process, begun to give free air time to HIV related content. Talk shows on the

subject across channels are common. A daily soap is on the anvil, which will integrate HIV issues within its story.

(iii) Rural Outreach Activities

113. 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 do 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 been conducted. This showed poor monitoring by NACO of utilisation of funds amounting to Rs. 5.44 crore.

(iv) School AIDS Education Programme

114. 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.

115. 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. National AIDS Control Board(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 and debates and discussions etc.

116. 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 which was put 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). 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.

117. The inadequate coverage in some States under the School AIDS Education Programme has been basically due to the lack of ownership in some States on the part

of the Departments of Education, and due to insufficient political support to the programme. NACO is now making efforts at the highest level to ensure the success of this programme. An inter ministerial group chaired by HRM has been formed, which is looking at mainstreaming HIV/AIDS issues into Education, as well as other sectors. Integration with the department of Education is being attempted at both National as well as State levels. Curriculum integration is being attempted through NCERT and SCERTs, which has already been done in Tamil Nadu and Kerala, and some others are due to follow soon. Already, HIV prevention education is part of the National Curricular Framework. NACO provides for specific support to SACS right from advocacy to training and planning or up scaling, as and when required.

118. With regard to functioning of School AIDS Education programme, the Secretary, Ministry of Health stated as under:—

> "It is a very difficult situation because there are a large number of cases of AIDS belonging to the age group of 15 to 24. Now, most of us are parents. We find it very difficult to reconcile with sex education to children. But the fact is that we have to decide between wrong information and correct information. It should be helpful to us too. This is a never-ending debate; we cannot come to the final verdict very easily. I may tell you that we should get the technical opinion of world bodies and expert bodies. It is better to give them correct information on sex rather than to expose them to manipulation by wrong persons, and leave them alone to face dangers".

119. The Director General of NACO added:

> "Fifty per cent new cases are found in the age group of 15 to 24. But, their population comes to about 25 per cent to 26 per cent. The number of instances of this age group is very high. We have also got the feedback. Our survey shows that in 50 per cent cases, we follow the two-method protection; another set of 50 per cent may not be knowing about the protection. We have to teach them as to how they can protect themselves. It would be culturally and AIDS sensitive too".

120. The Ministry in a note submitted that the following new steps which are being taken regarding Schools AIDS Education Programme:

- "HIV/AIDS is now a part of the national curricular framework (NCERT)
- States integrating it in curriculum through SCERTs. Andhra Pradesh, Tamil Nadu, Himachal Pradesh and Kerala already integrated
- Process ongoing in Nagaland, Uttar Pradesh and West Bengal
- About 60,000 schools covered (Total 1.5 lakhs) through co curricular programme – SAEP
- Programme undertaken in classes 9 and 11
- Varied implementation in States, largely due to varying levels of commitment to the programme; degree of Collaboration with the Department of Education; available resources and capacity

- Guidelines for SAEP revised for smoother implementation and ownership of Deptts. of Education
- Rapid scale up envisaged."

121. When asked to explain how awareness is being spread among School Children about AIDS, the Ministry stated in a written note as under:—

> "NACO has consulted with Education experts in formulation of modules, guidelines etc, to check for sensitivity, as well as synergy with information contained in the National Curricular Framework, which now contains HIV/AIDS prevention education and the knowledge HIV/AIDS are being integrated in the curriculum of many States to bring awareness among the school children."

(v) Family Health Awareness Campaign

122. To raise the awareness level among people in rural and slum areas and other vulnerable groups regarding HIV/AIDS and to make them 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:

(In lakh)

Sl. No.	Period of campaign	No. of districts covered/ reported	Target population	Actual attendees	No. 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%)

123. The percentage of actual attendees during FHAC in December 1999 was 24.97 per cent which felt to 14.43 per cent in February, 2002 reflecting 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), Haryana (52 per cent), Nagaland (57 per cent), West Bengal (81 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 to Primary/Community Health Centres for treatment, of whom 98.55 lakh (63 per cent) patients were treated.

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

124. 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:

- 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.
- Very few private practitioners were invited for training in the syndromic management of sexually transmitted diseases.
- 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.
- 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.
- District Programme Managers constantly complained about the short notice given to plan and implement the programme. In 76 per cent district, less than four weeks were available for implementing the programme.
- This short notice for initiating the programme resulted in hurried or no planning. House visits could not be completed and carried out effectively. Less than 10 clients were present in 37.4 per cent camps meant for males and 11.1 per cent for females.
- Almost 1/3rd (30 per cent) of Primary Health Centre (PHC) doctors complained that they received the IEC material late and in inadequate quantity.
- 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.

- 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.

125. When enquired about the remedial action taken on the shortcomings noticed by AIIMS in their survey of FHAC and the steps taken by NACO to improve the performance of FHAC, the Ministry in a written note stated as under:

> "The concurrent evaluation carried out by INCLEN based at AIIMS during 2002-03 pointed out that at least 8 – 12 weeks of lead time is required to adequately plan the whole campaign and the funds should also be disbursed 8 – 12 weeks before the launch of the campaign. More attention should be paid to micro planning for the success of FHAC with special reference to uniform and consistent implementation strategy in a State. Greater involvement of non-health sector partners in the campaign was also emphasised in the evaluation. Awareness campaigns should be more intense and a more effective use of electronic and print media was recommended. FHAC campaigns should be organised near the houses of the clients at the prominent locations with good publicity."

126. During evidence, the Secretary, Ministry of Health, added:

> "A National Family Health Survey-III has been launched at a cost of Rs.50 crore. The earlier NFHS elicited information on AIDS in a very amateurish manner. This time we are integrating the survey and getting the AIDS/HIV issues in a very scientific manner and all the leading partners like the WHO are also associated with it. We will do a much more thorough professional job of it."

(vii) National AIDS Telephone Helpline:

127. 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. Since 2000-01, the funding was decentralized to the respective States/Municipal AIDS Control Societies. However, Audit had noticed that NACO had no information of cities/towns covered by this facility. A review of scheme conducted in January 1999 revealed that on an average 1200 callers were availing of this facility daily, however, the number of callers referred for STD treatment and HIV testing was not available. A caller had to wait for 72 hours to get a reply. No male counseller was employed, although 95 per cent callers were male. The number of female caller remained consistently low.

(viii) Voluntary Counselling and Testing Centres (VCTCs)

128. During the initial phase of the programme, 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 centers were sanctioned as Voluntary Blood Testing Centres to promote Voluntary Counselling and Testing (VCT). These centers were renamed VCTC. 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).

129. As on 31 March 2003, 543 (90 per cent) VCTCs had been established in various States/UTs, which are located in Medical College Hospitals and District Hospitals, as against the sanction of 600 VCTCs for the Financial Year 2002-2003. Though the districts providing VCTC 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 VCTC facility in these States ranged between 0 per cent and 100 per cent. As per their Action Taken by the Ministry *vis-à-vis* Audit observation as on January, 2005 a total number of 709 VCTCs are now functional in the country. However 117 districts are still in the process of initiating VCTC services.

130. Audit scrutiny of records of Societies in relating to working of VCTCs revealed that a number of Voluntary Counselling and Testing Centres were either non-functional or not fully functional due to the following reasons:

Reasons	States	No. of VCTCs affected
Non-appointment of Counsellors, Lab. Technician etc.	Chhattisgarh, Madhya Pradesh, Tamil Nadu and Tripura	30
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

(viii) Pre-test counselling at VCTC

131. 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. However, as per the Action Taken by the Ministry *vis-a-vis* Audit observation the percentage of person provided pre-test counselling had increased from 60.5 per cent in 2002 to 80.1 per cent in 2003 and 94.4 per cent during 2004.

132. Although the overall percentage of people who were imparted pre-test counselling had been 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).

(ix) Voluntary Walk-in Individuals Tested and Counselled

133. 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 Municipal Corporation (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 provided post-test counselling, was very high and ranged between 79 per cent and 98 per cent during the year 2002. In their Action Taken, the Ministry have submitted that as on January 2005, the percentage of Walk in person to VCTC has been found to be 37.8 per cent.

(x) Training of Health Care Workers in HIV/AIDS Counselling

134. Audit observations 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. 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.

135. In their action taken note, the Ministry informed that several training programmes have been conducted for counsellors to improve the quality of counselling including pre-test counselling. IEC activities conducted by SACS are picking up gradually to motivate voluntary counselling. The numbers of people attending VCTC have increased over the years.

(xi) Reduced transmission by Blood Transfusion and Occupational Exposure

136. 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.

137. When the Committee enquired as to why NACO had not been able to achieve the objective of establishing at least one modernized blood bank in each district by the target year 2002, the Ministry in a written note submitted as under:

> "The objective of National AIDS Control Organisation (NACO) is to support at least one Government Blood Bank in each district of the country, with a specified pattern of assistance consisting of one time grant for equipment followed by annual recurring assistance. It is for the concerned State Governments to set up the basic infrastructure of the blood bank like building, furniture, manpower etc. Only after these basic facilities are available, can the NACO pattern of assistance be applicable for the blood bank. Hence it is not entirely NACO's responsibility in actually setting up of blood banks in every districts of the country, but, we provide part funding for this effort which is essentially of the State Government. We are committed to providing the NACO pattern of assistance for setting up district level blood banks in every district of the country and in this connection request from every State has been agreed to. As of now, we are providing this assistance to 684 district level blood banks in the country. Obtaining license for these district level blood banks is again the responsibility of the State Governments for which NACO facilitates technical assistance as and when required."

(xii) Modernisation and strengthening of licensed blood banks

138. In Phase-I of the programme, NACO had in all modernised 815 blood banks 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 also observed that out of 125 blood banks modernised by NACO as of March 2003, in Phase-II, 75 blood banks were yet to be licensed.

139. Audit scrutiny revealed that the details of districts remaining uncovered by blood bank 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 that there are 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 had also stated that many of the blood banks that were 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 also observed by audit that though NACO was supposed 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 been licensed or whose licence had been withdrawn/cancelled by DCI. In 17 cases, Audit noticed variation in the figures supplied by NACO and that of societies in respect of blood banks modernised.

140. Audit Scrutiny of records of societies and test check of blood banks revealed that blood banks were not functional/fully functional due to the reasons mentioned below:

Reasons	States	Blood Bank affected
Equipment not supplied	Tripura, Maharashtra, Haryana, West Bengal, Jammu & Kashmir, Karnataka, Madhya Pradesh, Nagaland	86
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 Haryana	04 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 blood banks in Maharashtra and one in Pondicherry were not functioning.

(xii) Setting up of State-of-art Blood Banks

141. 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.

(xiii) Upgradation of Existing Major Blood Banks

142. 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 and 18 major blood banks had been upgraded as of March 2003. However, Sealer Stripper with Cutter and Bench Top Centrifuge equipment which was required to be supplied by NACO were yet to be supplied to two such major blood banks.

(xiv) Creation of District Level Blood Banks

143. 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 till June 2003.

144. 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 taluk hospitals. Directorate of Medical and Rural Health Services reported in 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.

(xv) Establishment of Blood Component Separation Units

145. 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 such units by providing them a one time grant Rs. 27.69 lakh for purchase of 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 nine such units. Audit scrutiny revealed that in BCSUs set up by NACO as of March, 2003 in various parts of the country, equipment worth Rs. 2.36 crore supplied to them had been lying idle for various reasons. Considerable delay in installation/ commissioning of equipment supplied to BCSU was also noticed by Audit.

(xiv) Testing of Blood for HIV

146. In the case of blood donation, a single test by Rapid/ELISA is done to eliminate the possibility of HIV(+ve) blood. Ministry of Health announced in December 2002 that blood donors found to be HIV positive would be told of their infection and

asked to seek conformity tests and counselling. However, NACO continues to follow its existing policy of giving the results only to those persons who ask for it, which is in keeping with the objective of the programme. Non-disclosure 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 symptomatic for three to twelve years. AIDS is the final stage when the HIV +ve person starts showing distinct symptoms of this disease. Another serious issue is the detection of HIV infection during the 'window period'. The time gap between contracting of infection and sero positive is known as 'window period'. The duration of window period as defined by World Health Organisation range between six weeks to three months, but in some cases, it may take upto three years to develop antibodies. Contrary to this NACO stated that this period may range from 10 days to one month only. Monitoring of HIV testing among people at high risk is of great significance during and after the window period.

XI. Prevention of Parents to Child Transmission (PpTCT) of HIV

147. In March 2000, NACO initiated 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.

148. 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 was that training had been completed and service delivery started in 74 out of 82 Medical Colleges of High Prevalence States. Training was not completed in 24 per cent district hospitals and service delivery was 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.

149. In this regard, the Ministry in their action taken *vis-à-vis* audit observation informed that as on Jan. 2005, 288 PPTCT Centres are functioning in the country. Out of this, 238 are in High Prevalence States and rest (50) are in Low Prevalence States. In High Prevalence States, all the Medical Colleges (85) and all District Hospitals (153) are providing PPTCT services. In moderate/low prevalence states, out of 79 Medical Colleges, 42 Medical Colleges are providing PPTCT services. Rests of the Medical Colleges are in the process of starting PPTCT services. The trainings have been completed in all Medical Colleges and District Hospitals of High Prevalence States.

XII. Low Cost AIDS Care

150. Activities under this scheme 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.

(i) Community Care Centres

151. 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.

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

Sl. No.	State	No. of Community Care Centres		
		Proposed	Established	Shortfall (%)
	High Prevalence States			
1.	Manipur	06	05	01 (17%)
2.	Andhra Pradesh	14	10	04 (29%)
3.	Karnataka	13	05	08 (62%)
4.	Maharashtra (including Mumbai DACS*)	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 Prevalence 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	

*District AIDS Control Society.

153. From the above Table, it may be seen that the shortfall in establishment of community care centres in high prevalence States ranged between 17 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 even 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

154. When enquired by the Committee as to why NACO could not achieve the target set for establishing Community Care Centres in high prevalence States, the Ministry in a written note stated as under:—

> "Under the National AIDS Control Programme, grant is provided to NGOs through State AIDS Control Societies, for setting up low cost Community Care Centres (CCCs) (Facility for housing at least 10 PLHAs) to take care of People living with HIV/AIDS (PLWHAs). At present 54 Community Care Centres are being run across the country with the help of NGOs and are funded through State AIDS Control Societies. Thus the total Target set till the second quarter for the Financial Year 2004-05 was 54, which has been achieved. As in case of most other programme components of NACP II, the scheme was started in high prevalence States, which has a large number of HIV positive people. Now the scheme was allowed in low prevalence State as well, in case the State felt the need for it."

(ii) Establishment of Drop-in-Centres for People Living with HIV/AIDS

155. In the absence of free anti-retroviral drugs and owing to the stigma associated with the disease, 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.

156. On being enquired about the status of establishment of 10 drop-in-centres for people living with HIV/AIDS in every State, the Ministry in a written note submitted as under:—

> "State AIDS Control Societies submit monthly report (electronically) through Computerized Management and Information System (CMIS) to NACO. For improving the reporting on TIs through CMIS, NACO has conducted five regional workshops for ensuring the completeness and expeditiousness of the reports. The CMIS was revised in 2003 due to which the reporting was slowed down, which is again improving after the regional workshops, where people from SACS involved in program *i.e*. Project Directors, Addl. Project Directors, NGO Advisor as well as Monitoring and Evaluation officers were involved. Besides this NACO reviews the status of TI implementation regularly through the periodic meetings of State Project Directors. Provision of online support is also made under the revised CMIS system."

(iii) Rehabilitation of Commercial Sex Workers

157. In May 1997, 65 Commercial Sex Workers were rescued from a place in Hyderabad. Of them 21 were found HIV positive. In July, 1997 for their rehabilitation, the Project Director of the Society, following the instructions of the State Government, released 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' in October, 1997. The Corporation in turn released during 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).

(iv) Provision of Drugs for Opportunistic Infections (OI) at District Hospitals

158. A host of opportunistic infections label an HIV infected person as a case of full blown 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.

159. 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)

Year	Allocation	Expenditure	Expenditure as 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

160. Out of the total allocation of Rs. 18 crore by NACO for procurement of OI drugs during 1999-2000 to 2002-03, the SACS had utilised just Rs. 5.90 crore (33 per cent) for the purpose. Except for 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 only 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.

(v) Anti Retroviral Therapy

161. An interim WHO-UNAIDS report on global access to HIV Antiretroviral Therapy (ART) has stated that India is ranked second after South Africa in terms of the number of people who don't have access to AIDS treatment. ART is recommended for people who have already developed AIDS and those with symptomatic HIV infection. In India ART coverage is nearly 4.9 per cent. In terms of absolute numbers, it is a mere 33000-67000. The unmet need in India or the number of people aged 0-49 in need of antiretroviral treatment in 2005, till June stands at 7,35,000 people almost three quarters of a million against the target of covering 3 million infected people. As of now HIV-ART in India is available only in six States, namely Tamil Nadu, Maharashtra, Gujarat, Rajasthan, Himachal Pradesh and Delhi. The AIDS figures did not reflect the picture correctly as a state like Uttar Pradesh and Bihar which have the highest rate of sexually transmitted diseases (STDs) are still classified as a low prevalence States in terms of AIDS.

162. When asked to comment on the interim Report of WHO- UNAIDS which quoted that India is second after South Africa in terms of number of people who do not have access to Antiretroviral Therapy treatment and coverage is only 4-9 per cent, the Ministry clarify in a written note as under:—

> "There are an estimated 5.134 million people living with HIV/AIDS in India. As per estimates, at any given time approximately 10% of the total number of people with HIV infection are expected to develop AIDS. Although there are no official estimates, as to how many of AIDS cases require ART at any point of time, the number may be far less as all of them may not be able to access public health care services. Thus with nearly **5,00,000 AIDS patients** it was projected and proposed to provide ART to 1,00,000 patients by end 2007, under the national programme. The list of ART centres established under the national programme is as follows:

Functional from April 1, 2004

1. Sir J.J. Hospital, Mumbai, Maharashtra
2. Government Hospital for Thoracic Medicine, Tambaram, Chennai ,Tamil Nadu
3. RIMS, Imphal, Manipur
4. Bowring & Lady Curzon Hospital, Bangalore, Karnataka
5. Osmania Medical College, Hyderabad, Andhra Pradesh

6. RML Hospital, New Delhi
7. LNJP Hospital, New Delhi
8. District Naga Hospital, Kohima, Nagaland

Functional from October 2004

9. Mysore Medical College, Mysore, Karnataka
10. Karnataka Medical College, Hubli, Karnataka
11. Jawaharlal Nehru Hospital, Imphal, Manipur
12. Government Medical College, Guntur, Andhra Pradesh
13. District Hospital, Namakkal, Tamil Nadu
14. Government Medical College, Madurai, Tamil Nadu
15. Government Medical College, Meeraj (Sangli), Maharashtra
16. Government Medical College, Vizag, Andhra Pradesh

Functional from Feb./March 2005

17. BJ Medical College Pune, Maharashtra
18. Government Medical College Nagpur, Maharashtra
19. Madras Medical College Chennai, Tamil Nadu
20. BJ Medical College Ahmedabad, Gujarat
21. Calcutta Medical College Kolkata,West Bengal
22. BHU Institute of Medical Sciences Varanasi, UP
23. PGIMER, Chandigarh
24. SMS Medical College Jaipur, Rajasthan
25. Medical College Panaji, Goa

Additional 14 centers have been sanctioned to start ART by July 2005

1. KEM Hospital, Mumbai (Maharashtra)
2. B.Y.L. Nair Hospital, Mumbai (Maharashtra)
3. Govt. Medical College, Shimla (Himachal Pradesh)
4. K.G. Medical College, Lucknow (Uttar Pradesh)
5. AIIMS, New Delhi
6. Medical College, Thiruvananthapuram (Kerala)
7. Medical College, Indore (Madhya Pradesh)
8. Medical College, Guwahati (Assam)
9. Govt. Medical College, Salem, Tamil Nadu (Supported by CIFF, UK)
10. Govt. Medical College,Tirunelveli, Tamil Nadu (Supported by CIFF, UK)
11. Kilpauk Govt. Med. College, Chennai, Tamil Nadu (Supported by CIFF, UK)
12. Sion Hospital, Mumbai (Maharashtra)
13. LRS Institute of TB and Resp. Diseases, New Delhi
14. Govt. General Hospital, Pondicherry

With these 39 centres, 18 States and Uts shall be covered

Apart from 9,126 AIDS patients receiving free ART in these centres, 9,000 AIDS patients are receiving free ART in other public health services like Railways, ESIC, SAIL and Armed Forces etc. The private sector also provides ART to large number of AIDS patients. As such, the sum total of the AIDS patients receiving ART in this country is higher than the figures published in news item. It is worth-while to mention here that in the ART Centres under the national programme there is no "wait for AIDS therapy", as in these ART centres any AIDS patient who is medically eligible will be enrolled to start ART.

Further as per the approval received from National AIDS Control Board, the national programme will scale up ART services to additional 61 centres by December 2005 as per the list enclosed at Annexure I.

Thus 100 ART centres will be functional by December 2005 and each State/Ut in the country will have atleast one ART centre. Further expansion of additional 88 centres is already planned for 2006 with the support from global fund grant for Round IV.

Additional 61 Centers that have been identified for further expansion as given in Annexure.

- Moreover, it is important to remember that ART is a complex life long therapy requiring very high levels of motivation and adherence to avoid drug resistance. So it is ensured before starting therapy that patient is counseled enough on this and only then ART is started. So even if it takes time, we should not hurry up to start ART before patient is fully prepared for it.
- No patient has been refused for ART. Those who are accessing the centers and are found medically eligible as per national guidelines are given ART in these designated centres.
- We are creating awareness about availability of free ART to PLWHAs."

XIII. Inter Sectoral Collaboration

163. The overall goal of inter sectoral 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. The 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.

164. Under this component, NACO had allocated Rs. 15.70 crore between 1999-2000 and 2002-2003 to SACS/MACS to enable them 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)
1999-2000	600.77	117.42	483.35 (80%)
2000-01	137.00	62.14	74.86 (55%)
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%)

165. At the National level, NACO had 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.	Railways	-do-	371.05	139.40 (38%)	231.65
4.	Defence	-do-	600.00	104.33 (17%)	495.67
	Total		1683.00	391.41 (23%)	1291.59

166. The large unspent balance with each of the inter-sectoral collaborators was attributed by NACO 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. NACO stated that 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.

167. Targets set for coverage of schools under School AIDS Education Programme and training of medical/para-medical staff have 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.

XIV. Institutional Strengthening

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

(i) Manpower

169. 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 by Audit revealed that in some SACS a number of key posts such as JD/DD (Surveillance), DD(STD), AD (Care), Monitoring & Evaluation Officer etc. had not been filled. If put together more that 50 per cent staff in 10 Societies is not in place resulting in adverse impact on the programme implementation.

(ii) Training

170. Training is an ongoing activity of NACO. However, newer areas of management and hospital infection control measures including post-exposure prophylax has necessitated the need for periodic training and orientation with updated information and guidelines. A scrutiny of information for the year ending March 2003, by Audit revealed considerable shortfall in training of doctors, nurses, lab-technicians and field officers in many of the States. In Bihar, Daman & Diu, Haryana, Himachal Pradesh, Maharashtra, Mizoram neither the information about the number of Doctors involved exclusively for this purpose nor anything about their training has been furnished to the Audit. In Jharkhand and Chhattisgarh not a single training programme was conducted during the period, for which the Audit was conducted.

(iii) Partnership in Sexual Health Project (PSH)

171. The Department For International Development (DFID) of United Kingdom 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 vulnerability of communities, such as Commercial Sex Workers, Infected Drug Users, Prison Inmates, Street Children and Migrant Workers as in NACP. The scheme is to run for a period of five years starting from February, 2001. The programme's goal is to ensure better sexual health for people vulnerable to STD (including HIV) especially the poor. Audit had noted that no performance review of the project had been conducted till August 2003 to assess its achievements and bottlenecks.

(iv) Project Financial Management System

172. 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. Category-wise quarterly reimbursement claims, financial project progress and procurement reports would be submitted to NACO.

173. Audit scrutiny of records of NACO revealed that as of September 2003 Computerised Programme of Financial Management System (CPFMS) had not been 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 Inter-sectoral 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.

XV. Procurement

174. NACO appointed 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.

(i) Infructuous Expenditure

175. 155 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.

176. When asked about the reasons for non-installation of equipment worth Rs. 51.64 lakh purchased during 1997-98 and the present status of installation of

equipments purchased during Phase-I and Phase-II of the programme, the Ministry in a written reply stated as under:

> "Matter referred to in the CAG report about non-installation of equipment worth Rs. 51.64 lakhs purchased during 1997-98 relates to four (4) types of equipment procured through DGS&D. Because of delay in delivery/installation DGS&D was instructed to terminate the respective contracts; to recover from the supplier liquidated damages for delayed supplies of goods as well as non-installation; and black list the said supplier. Regarding non-installation of those equipment procured in Phase II through NTPC the position since March 2003, when CAG did audit has improved. All equipment have been installed except two items *viz.*, Laminar Flow bench and Deep freezers. Regarding Laminar Flow bench sites were not ready. Since then some have been installed, and at other centres they are under installation. Regarding Deep freezers sites were not ready when supplies were made. By the time sites were made ready contract was terminated due to non-conformance to specifications. Matter is under examination of legal experts for further course of action. NACO has appointed NTPC as Procurement Services Agent for NACP –II, who are monitoring closely with suppliers and respective AIDS Control Societies. In turn NACO also takes up the matter with the AIDS Control Societies to expedite the matter. Recently representatives of NACO and NTPC visited a few Societies jointly in this regard. More such visits would be undertaken."

177. When enquired about the problems faced in procurement and the steps taken to overcome the same, the representatives of the Ministry of Health & Family Welfare during the evidence replied as under:—

> "During the Phase I these equipments (four types of equipment pending installation) meant for blood banks & STD clinics were procured through DGS&D. Since supplier has not completed the full supplies, they have been advised to take suitable action as per the provisions of the contracts against the supplier and also to terminate contracts for incomplete orders. Now procurement of these types of equipment are delegated to AIDS Control Societies so that working of centres are not affected. Regarding pending supplies/installation matter is being taken up with DGS&D for latest position and during Phase II Compared to March 2003 position has improved. Refrigerated water baths and Micropipettes (then pending 7 and 20 respectively) are now installed. Regarding other items, in case of Laminar Flow bench out of 13 then pending 4 are installed and balance 9 are under installation. However, regarding Deep freezers (-80°C & -40°C) 4 nos. each, they are still pending. In this case sites were not ready when supplies were made. But when actually sites became ready, contract was terminated on account of non-conformance to the technical specifications. NTPC has been asked to initiate appropriate action against the supplier. At the same time they are advised to arrange maintenance of these machines and installation of pending ones through alternative firm. Regarding Monitoring of supply / installation / working of equipment & procurement of equipment at AIDS Control Society level, officials from NTPC are visiting the consignees for monitoring of delivery, installation and continued operation of the equipment.

In addition, officers of NACO during their visits also monitor these issues. The working status is also monitored through Computerized Management Information System (CMIS). These issues are reviewed during meetings of Project Directors and Officers in-charge of Procurement."

(ii) Advances Lying Un-adjusted with Procurement Agent

178. 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.

(iii) Outstanding Advances with NACO

179. 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 by Audit, 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.

180. The following flaws were noticed by Audit in procurement of medicines and awareness material:—

- Between January 1999 and July 2002, the 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 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 tablets 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.

- 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 had stated that requirement of medicines was urgent and time for inviting tenders was insufficient. The reply was 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.

- In contravention of NACO guidelines, the Haryana AIDS Control Society placed supply order in 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 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.

XVI. Monitoring and Evaluation

181. 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 programme 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.

(i) Computerised Management Information System (CMIS)

182. 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:—

- 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.
- Design a framework for impact evaluation of the project.
- Conduct base line survey to establish the key performance indicators in all the AIDS Control Societies in States, Uts and Municipalities.

- 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.
- Help State AIDS control Societies to identify and select State level Monitoring and Evaluation agency in each state.

183. 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. Out of the total 38 Societies, reports from all of them had never been received during November 2001 to April 2003. Only during the period - January 2002 to August 2002 reports were 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) and 1995 (39 *per cent*) reports were received. Evaluation of information generated from CMIS had not been conducted so far.

184. On being enquired by the Committee about the steps NACO had taken to rectify poor reporting by the Societies, the Ministry replied as under:—

> "A number of steps have been taken by NACO to rectify poor reporting from the primary data generating units in the country. We have had a series of regional level meetings on "Evidence Based Programme Management" wherein multi-disciplinary teams consisting of Project Directors of SACS, Programme Managers and CMIS functionaries were trained for better quality management of data and also for better utilisation of the data that is generated from the CMIS. As a result of the feedback received from these interactions with the State authorities, an improved version of the CMIS software was developed and installed in all States of the country during September – November, 2004. As a result of all this, the reporting percentage has increased from 35 per cent to 63 per cent".

(ii) Non-appointment of Monitoring and Evaluation (M&E)Officer

185. 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 in place. However, NACO stated that in Societies without M&E Officer, statistical officer/Assistant statistical officer/Data entry operator or Programme officer with additional charge of CMIS is discharging the function of M&E office.

186. When asked about the current status of appointment of Monitoring and Evaluation Officers in each State/Municipal AIDS Control Society, the Ministry submitted through a written note as under:—

> "The current status of appointment of Monitoring and Evaluation Officers is that 18 out of 38 SACS/MACS have Monitoring and Evaluation Officers in

place. It may also be noted that we do not insist that every SACS/MACS (especially smaller states) must have a designated Monitoring and Evaluation Officer. In States, where there are no Monitoring and Evaluation Officers, the Joint Director in charge of Surveillance along with the Statistical Assistant perform the Monitoring and Evaluation functions."

(iii) National Performance Review

187. National Performance Review was to be carried out by NACB in accordance with terms of reference satisfactorily 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 had 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.

188. When asked whether the National AIDS Control Board (NACB) had reviewed the performance of NACP, the Ministry in a note replied as under:—

"The National AIDS Control Board (NACB) was constituted on 7th August 1992. The Chairman of the Board is Secretary (Health). The Board has met on 24 occasions till date. The Board discusses different facets of the programme specially major policy issues *e.g.* approval of Annual Action Plans of implementing agencies, introduction of Anti-Retroviral Therapy (ART), social marketing of condoms, family health awareness campaigns, implementation of National Blood Policy, etc."

189. When asked to explain the current status of National Performance Review in accordance with the terms of reference to IDA, the Ministry in a written note stated as under:

"Though National Performance Review (Performance & Expenditure Annual Review) was a benchmark for International Development Association; NACO maintains that performance of State AIDS Control Societies is being reviewed at the National level by way of review meetings with Project Directors; review again during discussion of Annual Action Plans and during field visits by officials for NACO. This has been communicated to World Bank *vide* letter dated 11th June, 2002."

(iv) Meeting of National AIDS Committee/SACS/MACS

190. The National AIDS Committee acts as the high 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 was required to meet as often as possible but at least once every year. It was observed that the Committee had not met since 2001. In the last three years, there had been no meeting could be held because whenever this proposal was put up, the Committee was being under reconstitution.

191. When enquired why National AIDS Committee (NAC) not meet even once during the last three years, the Ministry in a written note submitted as under:—

> "Since inception six National AIDS Committee (NAC) meetings were held till 2001. A Note for convening meeting of National AIDS Committee was submitted to HFM on 11.7.03. Office of HFM sought information on the state wise, constituency wise, representation of members of NGOs/private sector. The file was resubmitted with the required information but no decision was taken for convening the meeting. The National AIDS Committee was reconstituted for inclusion of a member in Nov. 2003. Again File was moved for convening a meeting (Sept. 2004). In the meantime, in consultation with PMO, a proposal of reviewing structures of the Committee was taken up."

192. Audit scrutiny revealed the following position in respect of meetings of SACS:—

- 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) was required to meet 19 times during 1998-2003 to ensure effective implementation of the NACP, but met only 9 times during the same period. The State level officers did not oversee and evaluate the implementation of the programme in the State.
- In Goa, the Governing Body was 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.

193. When asked to explain the reasons for the less number of meetings held by the National AIDS Committee, the Ministry in a written note submitted as under:—

> "The last meeting of the National AIDS Committee was held on 9th May 2001. Since the reconstitution of the Committee was under active consideration at PMO level, the meeting could not be convened since then. The file on reconstitution of the National AIDS Committee is under submission to PMO for approval."

194. The Committee sought the views of the Ministry of Health & Family Welfare regarding appointment of an external agency for evaluation of NACO. In response, the Ministry in a written note furnished their views as under: —

> "NACO is already in the process of appointing an agency for an independent evaluation of the programme. The evaluation will include review cum overall assessment of all the components of the programme. Under the assessment, a complete analysis and interpretation of information, process of recommendations for improvement, structural, functional, administration and management aspects of the programme including correctness of the approach used in surveillance and estimation will be done. The selected agency will be instructed to take note of the observations in the CAG report for incorporation in their recommendations."

OBSERVATIONS AND RECOMMENDATIONS

195. The alarming spread of the killer disease *viz.* Acquired Immunodeficiency Syndrome (AIDS) and increasing number of persons infected by it has thrown an unprecedented challenge to humanity. The problem of AIDS has ceased to be a mere health problem and has now acquired dimensions, which perhaps have very few parallels in the history of mankind. India's nearly two decades old epidemic is estimated to be largest in the South and Southeast Asian Region and the second largest in the world. According to National AIDS Control Organisation (NACO), there are 5.14 million HIV infected men, women and children in India, although the figures have been contested by various Non-Governmental Organisations and International Agencies. Independent assessments by the United States' National Intelligence Council predict that at the present rate of spread, about 25 million people in India would be HIV-infected by the year 2010. The UNDP Human Development Report (2003) places the figure at 110 million infections by 2025, with a 13-years reduction in life expectancy from the present 61 years. No wonder that India is said to be sitting on a Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) "Time Bomb". The Committee feel that the Ministry should examine the desirability of conducting a fresh survey of HIV/AIDS infected people especially in the context of many NGOs' and International Bodies' pointing out the inadequacies in the country's Sentinel Surveillance network and with a view to arriving at correct figures as far as possible regarding the number of people infected with HIV positive. This will help the Government to realise the challenge ahead for conceiving realistic and effective programme and targets for different components of the programme.

196. The Acquired Immunodeficiency Syndrome, more than any other health issue, is capable of hindering the country's development because it attacks its people in their most productive years and places an undue strain on the economy. Therefore, at the foremost, a basic understanding and knowledge of HIV/AIDS is a prerequisite to grasp the scope and complexity of this human, socio-medico, and public health problem. In addition, a thorough understanding of HIV/AIDS requires radical change in attitudes and beliefs, as well as the emotional components concerning the virus and the syndrome, and the behaviours that place ourselves *vis-à-vis* others at-risk of contracting the virus.

197. India's battle against HIV/AIDS commenced in 1986 when a high powered National AIDS Committee was constituted and a National AIDS Control Programme (NACP) was launched in 1987. Since 1992, the National AIDS Control Organisation (NACO) and the State AIDS Control Societies (SACS), which were set up subsequently, are nodal implementing agencies under the NACP. The NACP is a wholly Centrally Sponsored Scheme with assistance from International Donor Agencies (IDA). The National AIDS Control Programme, Phase-I (NACP-I) was to be implemented from September 1992 to September 1997 with technical assistance from the World Health

Organisation (WHO), but due to slow utilization of funds in the first two years of the project, it was extended upto March, 1999. Further, to encourage and enable States themselves to take on the responsibility of responding to the epidemic and reduce the spread of HIV infection and to strengthen India's capacity to respond to HIV/AIDS on a long-term basis, the Programme of NACP-II was launched in 1999 with a budget of Rs.1425.10 crore. The project which was supposed to have been completed in October 2004 is still continuing and it is expected to be completed by March 2006. The Committee hope that all possible remedial measures would be taken by Ministry of Health and Family Welfare to ensure that NACP-II is not extended and is completed within the stipulated targetted period.

198. The key objectives of the NACP-I were to slow down the spread of HIV; to bring down morbidity and mortality associated with HIV infection; and to minimize socio-economic impact resulting from HIV infection. For NACP-II the main objectives were focused on to reduce the spread of HIV infection in India; and to strengthen India's capacity to respond to HIV/AIDS on a long-term basis. Some of the important targets which were set to achieve by the completion of the Programme I and II were 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; to reduce the blood-borne transmission of HIV to less than 1 per cent; to attain awareness level of not less than 90 per cent among the youth and others in the reproductive age group; and to achieve condom use of not less than 90 per cent among high-risk categories like Commercial Sex Workers.

199. The review conducted by Audit relates to National AIDS Control Programme covering all State/Municipal AIDS Control Societies (SACS/MACS) and National AIDS Control Organisation in Delhi for the period 1998-99 to 2002-2003. The principal objective of this review was to ascertain the impact of various components of the programme such as utilisation of funds released and accounting; efficacy of priority Targeted Interventions for groups at high risk; the Information, Education and Communication programme; adequacy of training programmes; functioning of blood banks and Sexually Transmitted Diseases clinics; adequacy of procurement procedures; utilisation of equipments; achievement of targets and impact evaluation; and monitoring and evaluation procedures.

200. The Committee are constrained to observe that the programme has achieved limited success as it has failed in generating sufficient awareness among the masses. Besides, there was very slow progress in implementation of its various components. Target groups in many States have remained unidentified due to non-completion of mapping exercises; the scheme of social marketing of condoms was found lacking as NACO could not procure and distribute the targeted number of condoms.The Committee are disturbed to find that the programme could not achieve the targets relating to setting up of Sexually Transmitted Disease clinics, modernized blood banks and voluntary counseling and testing centers in every district of the country. 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. Community Care Centres and Drop-in-Centres have been established in very few States and the effectiveness of their functioning remained un-assessed. Grants-in-aid were released to inter-sectoral collaborators without proper assessment of requirement for implementing the various activities of the programme resulting in poor utilization of the grants allocated to them. Besides, NACO had no mechanism to monitor procurement of equipments and testing kits. These issues have been discussed in detail in succeeding paragraphs.

201. The total financial corpus of NACP-I and NACP-II from all the sources including budgetary support from Government of India stood at Rs. 2344.65 crore. Out of this, Government of India and the World Bank contributed Rs.253.34 crore (Phase I – Rs. 57.34 crore + Phase II – Rs. 196.00 crore) and Rs.1181.66 crore (Phase I - Rs. 222.66 crore + Rs. 959.00 crore) respectively and the rest was contributed by other funding agencies namely, United States Agency for International Development (USAID) AVERT (Rs. 166.00 crore in Phase – II), USAID APAC (Rs. 64.58 crore for Phase-II), Department for International Development of the U.K. Government (Rs. 487.40 crore for Phase – II), Canadian International Development Agency (Rs. 37.81 crore for Phase – II), Australian AID (Rs. 24.65 crore for Phase – II), United Nations Development Programme (Rs. 6.47 crore for Phase – II) and the Global Fund (Rs. 122.74 crore for Phase – II). The Committee are concerned to note that as against an approved allocation of Rs. 657.55 crore for Phase I, NACO could utilize only 75 per cent of the funds allocated and in Phase II (1999-2004) as against an approved allocation of Rs. 1155.10 crore from the Government of India and the World Bank (GOI – Rs. 196 crore + World Bank – Rs. 959.10 crore), NACO had been able to spend only 46 per cent (Rs.532.43 crore) in the first four years *i.e.* upto March, 2004. The Ministry of Health and Family Welfare attributed the reasons for non-utilisation of funds to the shortfall in the budgetary provision to the tune of Rs.218.67 crore during NACP-II. It has further been contended that the revised estimates were usually finalized in the month of January-February of the Financial Year resulting in delay in release of additional funds to the implementing agencies which ultimately resulted in less utilization of funds during the year by the concerned agencies. The poor utilization of the earmarked funds for such an important project resulting in non-achievement of targets set under various programmes is nothing but regrettable. The Committee take a serious view of the fact that NACP-II suffered for want of inadequate fund due to the procedural flaws and lack of seriousness and urgency on the part of Budget Allocating Authority. Obviously, Ministry of Health and Family Welfare also failed to impress upon the Ministry of Finance and the Planning Commission the need for timely release of the total World Bank Grant for such a vital project. The Committee cannot but over emphasize the need for ensuring not only total utilization of earmarked funds but for enhancing further budgetary allocation for such a vital programme in view of the fact that India has the second largest population of people living with HIV/AIDS in the world. The Ministry of Finance and Planning Commission ought to keep this fact in view while allocating funds for different programmes of the Ministry of Health and Family Welfare. The Committee are also of the view that Ministry of Health and Family Welfare should

ensure that Utilisation Certificates by State AIDS Control Societies are submitted timely so that there are no delays for reimbursements from the World Bank in this regard. The Committee would also urge that external grants should be treated as a supplement to the Domestic Central Budgetary support rather than a substitution. Grants given by External Agencies should not be adjusted into the ceiling determined by Planning Commission and Ministry of Finance for such an important programme.

202. NACO releases Grants-in-aid to Societies which are the main implementing agencies under NACP and they in turn submit quarterly Statements of Expenditures (SOEs) 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 SOEs should be reconciled with expenditure shown in the audited statement of accounts. The Audit Review has revealed that in respect of 49 audited statements of accounts, there were differences in figures in 46 cases. Obviously, the Ministry of Health and Family Welfare did not make efforts to ensure that there are no differences in figures of Statement of Expenditure and Audited Statements which was essential for timely and complete reimbursement of the expenditures by the State AIDS Control Societies. Further, no reasons or explanations were given for non-reconciliation of Statement of Expenditures and Audited Statement of Accounts. The Committee have now been informed that the exercise of reconciliation of Accounts has been completed till 2002-03, and the annual audited statements of accounts for the year 2003-04 have been received and further reconciliation of these accounts had been taken up on campaign basis and it is also proposed to meet the financial functionaries from SACS twice in a year for discussions all issues relating to financial management. The Committee hope that belated realization on the part of Ministry of Health and Family Welfare would ensure concurrent reconciliation of Statement of Expenditures and Audited Statement of Accounts.

203. Under NACP, State/Municipal AIDS Control Societies are to submit their Annual Action Plans to NACO three months prior to the commencement of the next Financial Year so that they could be approved and allocation of funds be made on time. The Committee are dismayed to note that till 2002-2003, none of the SACS/MACS had submitted their Annual Action Plan on time. Inordinate delays in submission of Annual Action Plan by SACS resulted in their belated approval which in turn affected the proper utilization of funds and as a consequence there were considerable unspent balances lying with the SACS/MACS at the end of the year. This also affected the targets set in respect of some programmes like strengthening of Sexually Transmitted Diseases (STD) clinics, Voluntary Counselling and Testing Centres (VCTCs), training etc. The Committee regret to observe the inordinate delay in submission of Annual Action Plan by various SACS and desire that in future NACO should strictly ensure that Annual Action Plans are submitted by all SACS/MACS within the stipulated time frame. For this purpose, the matter needs to be taken at regular intervals with the State Governments at the appropriate levels to impress upon SACS/MACS for the timely submission of Annual Action Plans.

204. On the basis of the Annual Action Plans received from Societies, NACO makes component-wise allocation of funds to the Societies which, in turn, report

expenditure through quarterly Statements of Expenditure (SOE). The Committee note that while the expenditure on the component Preventive Interventions for General Community exceeded the indicative percentage of the total outlay, the expenditure on low cost AIDS care and inter-sectoral collaboration fell far short of the indicative outlay. This is substantiated by the fact that in case of preventive interventions for the general community, the indicative cost (per cent) of total out lay as per Project Appraisal Document (PAD) was 33.7 per cent and against this the expenditure were 51.07 per cent (1999-2000), 42.67 per cent (2000-01), 55.19 per cent (2001-02) and 49.99 per cent (2002-03), whereas in case of low cost AIDS care the allocation was 14.1 per cent of indicative cost (per cent) of total outlay and against this the expenditure were 3.53 per cent (1999-2000), 1.84 per cent (2000-01) 3.26 per cent (2001-02) and 5.29 per cent (2002-03). The Committee, recommend that Ministry should identify the bottlenecks responsible for low expenditure of fund in the low cost AIDS care and in Inter-sectoral collaboration components and take necessary steps for stepping up the expenditure and also periodically monitor progress made by SACS on these components so that the targets set under these components are achieved. NACO should also identify the thrust areas requiring special attention and step up monitoring especially in planning, management and implementation of other components under NACP.

205. The Committee note that out of the total grant of Rs.566.05 crore (including the opening balance) released by NACO during 1999-2000 to 2002-2003, the Societies had utilised Rs. 443.93 crore *i.e.* 78 per cent. While 17 State AIDS Control Societies in 1999-2000, 19 Societies in 2000-01, 15 Societies in 2001-02 and 12 Societies in 2002-03 had utilized more than 70 per cent of the grants released, 9 Societies in 1999-2000 and 2000-01, 10 Societies in 2001-02 and 21 Societies in 2002-03 could not utilize even 50 per cent of the grants released to them. The Committee further note that as on 31st December, 2004, an amount of Rs.19.19 crore was lying unutilized with SACS. Poor utilization of grants by the SACS over the years reflects the sordid state of affairs prevailing in the SACS. Non-utilisation of funds by Societies led to slippage in the targets fixed under the various components and as a consequence NACP suffered to a great extent in achieving its avowed objective of containing the HIV/AIDS in the country. The Committee, while deprecating the failure of SACS in utilisation of funds, expect NACO to identify the reasons therefor with a view to taking suitable corrective steps to ensure that there is proper and full utilization of funds by SACS. NACO also needs to periodically monitor the functioning of SACS in relation to their performance for achievement of targets set in a time bound manner.

206. NACO 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. However, the Committee are constrained to point out that the records of some State/Municipal AIDS Control Societies revealed that 113 NGOs in Andhra Pradesh, one NGO in Punjab and all the NGOs in Manipur did not contribute the prescribed amount. The Committee are surprised to note that inspite of the non-contribution of the requisite percentage by the NGOs, the Andhra Pradesh State AIDS Control Society had been releasing grants to the NGOs leading to excess

release of Rs.29.90 lakh. Audit has also pointed out an instance where a Society had flouted the guidelines of NACO by involving an NGO in the implementation of project on Targeted Interventions for groups at high risk which had not completed registration for a minimum period of three years. The Committee may be apprised about the precise reason as to why SACS of Andhra Pradesh continued to release grants to the various NGOs when they did not contribute the 10 per cent of the project cost. It is also not clear as to whether any action was taken by NACO in this connection. The Committee are of the firm opinion that NACO should impress upon the SACS that the fund be released after conforming to the rules. Further, the performance of NGOs should also be periodically monitored and those found to be indulging in misappropriation of funds should be black-listed and debarred from participating in the activities of NACP.

207. As indicated earlier, there are an estimated 5.14 million HIV cases in the country based on Sentinel Surveillance 2004. According to the reports submitted by various States/Union Territories to NACO, the cumulative number of HIV/AIDS cases stood at 96086 in 2004. The Committee note with serious concern that there had been a continuous rise in the number of HIV/AIDS cases reported since 2001. During the years 1999-2000, 2000-01 and 2001-02 there had been an increase of 60 per cent, 80 per cent and 69 per cent respectively of the AIDS cases in the country. NACO has attributed the rise in AIDS cases to more and more people coming for treatment in public sector hospitals and also increase in the number of hospitals providing such services. At the same time, NACO has conceded that the statistics available with them may not be accurate as many of the AIDS patients may still not have the access to public sector hospitals and that there may be many more number of unreported AIDS cases in the country. The Committee feel that due to certain reasons like social stigma attached, complacency and lack of awareness some of the patients may not be going to public/private hospitals for treatment. Obviously, such patients do not form a part of the survey conducted by NACO. The Committee, therefore, recommend that with a view to arrive at an accurate and reliable database on AIDS patients / HIV cases in the country, the Sentinel Survey must be broad-based so as to capture the scope and extent of the epidemic prevalent in rural areas and also in highly populated and large States such as Uttar Pradesh and Bihar. The Government therefore, should explore all the possible avenues that survey conducted in this regard are as far as possible scientific and accurate, since the data base on AIDS plays a very important role in fixing realistic targets and also in formulating the plan and programme for combating as well as containing the spread of HIV/AIDS in the country. The Committee, therefore, recommend that Government should undertake a fresh Sentinel Surveillance based on systematic and scientific approach so as to arrive at an accurate and fairly reliable data base on HIV/AIDS.

208. The Committee are of the view that epidemiological categorization of States into high, moderate and low prevalence will have serious repercussions. Such categorization may lead to a false sense of complacency among the so-called low prevalence States resulting in poor and tepid Governmental response even while the virus continues to spread silently. While high prevalence States such as Tamil Nadu have managed to attract lion's share of funding from NACO and set up a quasi-

Governmental State AIDS Control Society that could receive funds directly from the Centre, on the other hand, States such as Chhattisgarh and Madhya Pradesh, which have been either less motivated or less capable of demonstrating their need and capacity, have fallen behind. Low prevalence States such as Bihar where the public health delivery system is in urgent need of upgradation and expansion, funds they receive from NACO is insufficient for them to upgrade their HIV preventive services. The impasse continues, pushing 'low' prevalence States into a vicious cycle of neglect leading to under reporting of HIV/AIDS cases. Further, many States have reported low levels of HIV and some States reported no cases of HIV/AIDS at all which appears to be far from the reality. A probable explanation for this is States that have reported serious HIV/AIDS epidemic are those that have tried to assess the magnitude of the epidemic as honestly as possible, as most of them have better health infrastructure and hence are able to detect more number of cases. There is no evidence to indicate that the rest of the States are somehow 'different' or less vulnerable to HIV. The survey figures as projected by NACO, therefore, may not be very accurate and the figure would raise substantially once these States as well as private hospitals/clinics start reporting cases as honestly as they could. The claim made by the Ministry of Health and Family Welfare that there had been a steep decline in the number of new HIV infections appears doubtful since the Survey have not taken into account people with AIDS, presumably numerous, but dying of opportunistic infection like Tuberculosis. It is also quite possible that the number of Sentinel Surveillance sites where high risk people, for example STD Clinic patients, intravenous drug users and sex workers were tested may be same in 2003 and 2004. Further, the data collected appears to be inaccurate due to lack of better representation from rural India, since a lot of patients (of sexually transmitted infections) in rural areas go to private doctors and quacks and most village women deliver children at home sidestepping the antenatal and postnatal care centres. The Committee, further recommend that the Ministry of Health & Family Welfare may consider review of the categorization of high, moderate and low prevalence States and an alternative approach may be adopted/ introduced which will goad all States into action in combating the disease.

209. The sources of infection of AIDS can be broadly divided into five categories, namely sexual transmission, parents to child transmission, blood and blood products, intravenous drug users and others. The Committee note that in 86 per cent of AIDS case, the sexual route remains the most probable source of infection. Another probable source of infection is parents to child transmission which rose from 0.72 per cent in 2000 to 2.65 per cent in 2003. The Committee observe that though the transmission of AIDS through blood and blood product has come down from 7.79 per cent in March 1999 to 2.79 per cent in March 2003, the number of cases in absolute terms have however been increasing and the target of keeping it below 1 per cent still remains to be achieved. The Committee are given to understand that NACO have taken a number of steps to ensure that every unit of blood is mandatorily tested for HIV, Syphilis, Malaria and Hepatitis (B&C) before the unit is transfused to patients, test kits are provided free of cost to the Blood Banks that are supported by it and the quality of testing is assured by a Nation wide External Quality Assurance System(EQAS). Professional blood donors have been banned and a number of activities

are being undertaken to augment voluntary blood donation in the country. Steps are also being taken to orient the prescribers of blood towards appropriate clinical use, so that blood is transfused only when it is absolutely essential and the right quantities of blood components are used. The Committee while taking note of the steps taken by NACO to reduce the risk of transmission of AIDS through blood, recommend that NACO should redouble their efforts to achieve the target of keeping the number of AIDS cases infected through blood transmission to 1 per cent.

210. Audit scrutiny revealed that Prevention of Parents to Child Transmission (PPTCT) scheme had been implemented in only 74 out of 82 medical colleges and 15 out of 133 district hospitals of high prevalence States till January 2003. In response to Audit observation, the Ministry of Health and Family Welfare submitted that as on January 2005, 288 PPTCT centers are functioning in the country. Out of this, 238 are in high prevalence States and rest (50) are in low prevalence States. In high prevalence States, all the Medical Colleges (85) and all District Hospitals (153) are providing PPTCT services. In moderate/low prevalence States, out of 79 Medical Colleges, 42 Medical Colleges are providing PPTCT services. Rest of the Medical Colleges are in the process of starting PPTCT services. However, there has been a steady increase in cases of infection of HIV/AIDS through parents to child transmission, which rose from 0.72 per cent to 2.65 per cent which points to the lack of proper implementation and monitoring of the programme. The Committee need hardly emphasise that NACO ought to evolve suitable strategies for counselling the HIV/AIDS infected parents about the ill effect of having an HIV infected child, so as to arrest the spread of infection from parents to child.

211. Targeted Interventions (TIs) are globally perceived as the most effective strategy for arresting the spread of HIV/AIDS. It focus on the strategy to prevent HIV infection and transmission among the groups who tend to involve in 'High Risk Sexual Behaviour'. The activities of TIs are designed basically to inform, educate and counsel the marginalized and vulnerable sections of population, which are at high HIV risk and provide them with preliminary care and support so that they move towards behaviour change and healthy living practices. Intervention with High Risk Groups (HRGs) that are at the core of HIV transmission can greatly reduce the spread of HIV into the general population. Directing HIV prevention efforts among these groups (with high rate of partner-change, whether sexual or needle-sharing partners) is a proven cost effective strategy as it has the multiplier effect of preventing many subsequent rounds of infections amongst the general population. Such High Risk Groups broadly include Commercial Sex Workers (CSWs), Injecting Drug Users (IDUs), Men-having-sex-with-Men (MSM), truckers, migrant workers, etc. Targeted Interventions among these groups involve multipronged strategies such as behaviour change, communication, counselling, health care, treatment for STD and creating demand for and making provision of condoms, along with other activities that can help create enabling environment for behavioural change.

212. The Committee note that as of September, 2004, 933 TIs are being implemented across the country. However, the data relating to coverage of target population by these TIs was not available with NACO. Though the Ministry claimed that there has been a notable increase in terms of coverage of vulnerable population

through TI, yet, 50 per cent of the population is still to be covered. The Committee therefore, desire that efforts need to be stepped up to bring the uncovered population under the ambit of TI Programme. NACO should also ensure regular reporting by SACS regarding progress made by them in implementation of TI programmes through Computerised Management Information System(CMIS).Further the definition of High risk group needs to be broad based so as to include more vulnerable groups such as new recruits of Army and Para-military forces, Army troops separated from families, troops deployed in foreign countries, uniformed forces and their families which are prone to high risk and which need inter-sectoral participation in prevention of HIV/ AIDS. The Committee cannot but over-emphasise, the need to ensure that vulnerability and risk should form the basis of planning and programme implementation for prevention and control of HIV/AIDS especially in the backdrop of CIA's National Intelligence Council prediction that the number of AIDS cases in India will surpass every other country and it may have as many as 20 to 25 million AIDS cases by 2010.

213. The Committee note that a National Targeted Intervention Evaluation Programme was conducted by Sexual Health Resource Centre in partnership with NACO during 2003 in 54 TIs spread across 17 States to assess the average quality of different elements of TIs *viz.,* condom promotion, STD component, Behavioral Change, Communication (BCC), Enabling environment, Needs assessment, Proposal, Development, Baseline study and Project Management. The study found the average quality of the elements of TIs to be in range of 21 to 41 per cent and the average quality of TIs in the country logged at a poor 37.8 per cent. The study revealed that the inputs (training and funding) provided by States AIDS Control Societies were much below that what was needed and that the average quality of TIs needed to be enhanced if they are to deliver the expected results. The Committee express their concern over the poor quality of different elements of TIs due to which the Programme could not achieve the desired results. The lackadaisical approach adopted by State AIDS Control Societies and NACO in this regard is nothing but regrettable. They are of the opinion that NACO should promptly identify the weaknesses with a view to taking suitable corrective steps to make TIs more effective and result oriented. Further, the Government ought to take the cooperation of NGOs, VOs, Community Based Organisations, the target community and the Civil Society at large to make TI programme a truly mass movement.

214. The Committee note that under Project Implementation Plan (PIP) mapping of high risk areas was to be conducted by all Societies to identify the size and number of target groups, their risk behaviour and their environment. This process enables to locate the size of high risk population where TI projects can be implemented. As on October, 2003 barring Lakshadweep, Meghalaya, Haryana and Goa all States AIDS Control Societies have undertaken the programme of detailed mapping of the vulnerable population which was at different stages. The mapping exercise is stated to be over in all States and 33 mapping reports of major SACS are available with the Government barring reports from States of Chhattisgarh, Rajasthan, Orissa, Lakshadweep and Dadra & Nagar Haveli which are being finalized. The Committee, recommend that NACO should finish the mapping exercise of the remaining States at the earliest so as to have a complete and reliable data relating to high risk population.

215. 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 condom promotion programme is to ensure easy access to affordable and acceptable condoms of good quality to promote safe sexual encounters. The Committee note that the State AIDS Control Societies procure condoms from the Department of Family Welfare and distribute them under the scheme for free distribution and social marketing. The objective of condom promotion programme is to ensure easy access to condoms of good quality at affordable price to promote safe sexual encounters. The Committee note that the distribution of condoms by the Societies under free distribution scheme increased from 524.38 lakh pieces in 1998-99 to 907.59 lakh pieces in 2002-03 and under Social Marketing Scheme, it increased from 15.49 lakh to 90.39 lakh pieces. Although the number of condoms distributed by the State AIDS Control Societies have increased in absolute terms/over the years, the Committee are, however, surprised to note that all societies were not involved in distribution of condoms. While Maharashtra and Mumbai Societies had performed exceedingly well as they alone contributed 65 per cent under the social marketing scheme, performance of other Societies was far from satisfactory. The Committee are of the opinion that since SACS are the main implementing agencies which have more direct contacts with the vulnerable section/potential high risk groups of the society, their role in the distribution of condoms is inevitable.

216. The Committee also found that during the year 2000-01, NACO had earmarked distribution of 3.30 million pieces of Deluxe Nirodh under the social marketing scheme, but 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. Audit scrutiny of the social marketing scheme of condom, further revealed that 140 condom vending machines (CVMs) 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. Out of total 385 CVMs purchased by Punjab at a total cost of Rs.22.61 lakh, 230 CVMs were found to be non functional as of May 2003. The Committee are not aware whether the machines are operational or not. Against the background that 85 per cent of the cases of HIV/AIDS is acquired through sexual intercourse the non functioning of a number of such machines for a considerable period is nothing but inexplicable and exhibits callous and negligent approach of the concerned authorities in this regard. The Committee recommend that the matter may be enquired with a view to identify the reasons for poor implementation of the Social marketing scheme during 2000-01. It also need to be enquired whether the purchased machines were faulty or were allowed to remain inoperative. Government should fix accountability on the persons responsible for these lapses. The Committee also recommend that NACO should lay down realistic targets for distribution of condom under the scheme and periodically review the progress made by SACS in this regard. More condom vending machines should be installed and kept operative in all important public places such as red-light areas, Railway Stations, Bus Stations, important traffic intersection points in all metros and major cities and also on all National and State Highways for the use of Commercial

Sex Workers, Truckers, Men Having Sex with Men (MSM) and other high risk and vulnerable groups.

217. 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 use 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 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 Committee recommend that the awareness about safe sex should be spread more effectively especially in the rural areas by using all available fora such as Gram Sabhas, etc. and by conducting Health Mela etc. Training for elected members of gram panchayats and Women Self Help Groups on issues related to AIDS should be imparted so as to bring about an attitudinal change and awareness among rural masses to fight against HIV/AIDS. Perhaps the spread of awareness should be more in and around targeted areas of high risk and vulnerable groups and for this SACS should be involved. With a view to have a wider reach amongst the television viewers, the electronic medium should be used to the maximum extent possible in prevention of HIV/AIDS. The Ministry of Health and Family Welfare in coordination with Ministry of Information & Broadcasting should make efforts to make it mandatory for all the Satellite Channels to telecast condom advertisements compulsorily during prime time.

218. The Committee are informed that NACP 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 (BSS) by ORG shows that only 57 per cent of the brothel based female sex workers and 46 per cent non-brothel female sex workers reported consistent condom use with paying clients. Further, only 21.3 per cent of brothel based and 20.2 percent non-brothel based Commercial Sex Workers reported consistent use of condoms with non-paying clients. The programme also 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 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 Committee recommend that NACO should launch a vigorous and sustained campaign in cooperation with respective State Governments, Voluntary Organisations/Non-Governmental Organisations etc. among Female Sex Workers - both brothel and non-brothel based to sensitise them about the lurking danger of HIV infection in the event of non-use of condoms by their clients, both

paying and non-paying. Adequate number of condoms vending machines should be set up in all Red Light Areas and all such places where sex workers solicit customers. Apart from propagation of condom use in high risk group, NACO should make efforts to popularise condom use as a safest sex method and to inculcate it as a regular sex habit amongst the non-risk groups and people at large whenever they enter into sex with any persons other than his/her regular partner.

219. Another area of concern is the close link between HIV and Sexually Transmitted Diseases(STD). To control the spread of HIV/AIDS, it is essential to strengthen the STD Control Programme at every level with a view to effectively tackle HIV/AIDS. The Committee note that in 1992, the STD Control Programme was integrated with NACP. Various studies are stated to have 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. During NACP-I as against the target of 372 STD clinics, NACO had strengthened 504 Government STD clinics all over the country to provide services to STD patients. However, the pace of strengthening of STD clinics in NACP–II has been 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. What is more disturbing is the fact that NACO could not furnish State-wise details of the 594 STD clinics that have been strengthened as of March, 2003. Moreover, the physical target of 757 STD clinics, only 674 STD clinics were provided with financial support by NACO during the Financial Year 2003-2004 Audit Scrutiny of STD clinics with reference to districts in the country, as per Census 2001, revealed that districts ranging between 7 and 75 per cent in the States/Union Territories did not have STD Clinics at any level i.e. district hospitals, medical college hospitals or taluka/sub-divisional level. The Committee are not satisfied with the progress made so far by NACO in strengthening STD clinics and recommend that NACO should take up steps to strengthen all STD clinics in various parts of the country. The Committee desire that a revised target for provision of STD clinics be laid down with a view to ensuring that every region/part of the country, particularly the target/vulnerable areas are fully covered. Such STD clinics should be provided with necessary financial support by NACO and operationalised expeditiously.

220. The Committee are surprised to find that a study by Senior faculty members of Medical Colleges of respective States/Union Territories at the behest of NACO to assess functioning of STD clinic has revealed that the attendance of patients at most of the STD clinics was poor. The poorly performing States were Punjab, Haryana, Rajasthan, Madhya Pradesh and Manipur. While Maharashtra, Tamil Nadu, West Bengal and Uttar Pradesh had more than 50 patients a day, most other States had less than 10 patients per day. One-third of the clinics in 23 States/U.T. surveyed, were not located in accessible places. Adequate space for STD clinics was reported from only about 44 per cent of the clinics. Fifty percent of the clinics reported inadequate space for laboratories. Availability of proper instruments, especially for female patients was reported by only 33 per cent of the clinics. Further, the clinics lacked trained man power 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. Further only 56 per cent of the clinics had STD specialists, 17 per cent had a gynaecologist and 31 per cent had a general duty officer as its in-charge. The Committee regret to observe that on one hand, the target laid down for setting up of STD clinics in Phase-II has not been achieved and on the other hand, the existing STD clinics lack proper infrastructure facilities, doctors, nurses, laboratory, technicians, counsellors and para medical staff etc. Obviously, the functioning of the STD clinics in the country has not been given the serious attention it deserves. This is despite the fact that studies over the years have revealed a close relationship between HIV and STD. The failure on the part of the Concerned Authorities in this direction is nothing but regrettable. The Committee, therefore, recommend that Ministry of Health and Family Welfare in association/cooperation with respective States AIDS Control Societies should thoroughly review the functioning of STD clinics in its entirety. The Ministry of Health and Family Welfare should allocate/earmark more funds for upgradation of these clinics by providing them with state of art diagnostic tools, techniques and other equipment so that they become hub centres for detecting and diagnosing cases of HIV/AIDS. In view of the direct link between STD and AIDS, the Committee are of the view that there should be greater synergy between NACO and State Medical Departments in combating HIV/AIDS.

221. As mentioned earlier in the Report, the tenure and level of diffusion of the HIV/AIDS in India indicate that we are accelerating towards a dangerous inflex point. Growing exponentially, HIV/AIDS is different from every other major infectious diseases where new cases grow or decline slowly. In the absence of a vaccine or a cure, prevention is the most effective strategy to control HIV/AIDS. Since majority of population in India is still uninfected, it becomes essential to not only raise awareness levels but also bring about behavioural changes through Information, Education and Communication (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. According to the Baseline Surveillance Survey, 2001, 76 per cent of the respondents surveyed at the National level were aware of HIV/AIDS. The percentage ranged between 40 and 98 in the 22 States surveyed by ORG-Centre for Social Research. While 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. As regards awareness of transmission of HIV/AIDS through sexual contact, the survey revealed that 71 per cent of the respondents at the National level were aware of the mode of transmission. The level of awareness was 85 per cent in urban areas and in rural areas it was 67 per cent. The survey further revealed that only 47 per cent among the general population, 66 per cent among the Commercial Sex Workers

and only 68 per cent clients of female sex workers were aware of the methods of prevention of HIV/AIDS. A sizeable proportion of the general population in almost all States harbours many misconceptions about the spread of HIV.

222. The Committee are inclined to conclude that there is an urgent need to launch vigorous mass campaign at National level by involving State Governments, NGOs, VOs, Panchayats and other local bodies to raise the awareness level among the masses in general and rural in particular. NACO in cooperation with various cultural groups/organizations, NGOs, VOs etc. should therefore, formulate programmes for rural masses, such as songs, street shows, stage plays, puppet shows, film shows, photo-exhibitions, group discussions and sensitisation workshops to raise the awareness level among the people regarding prevention of HIV/AIDS etc.

223. Another disquieting feature is the revelation by second round of Behavioural Surveillance Survey – Rural, (February – June 2002) conducted by Dalal Consultant and Engineers Ltd. which 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 had actually been trained in handling HIV/AIDS cases. The survey also revealed that 32 per cent among the masses knew that persons suffering from STD have a higher chance of contracting HIV/AIDS. The level of knowledge about linkages between STD and HIV across the country was also very low i.e 21 per cent. In addition to creating general awareness among the masses about the prevention of HIV/AIDS, the Committee feel that it is essential to sensitise the doctor, nurses, laboratory, technicians, counsellors and para medical staff and public that HIV/AIDS is not a contiguous/communicable disease and HIV patients deserve more sympathetic and humane treatment by one and all.

224. 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, 17 States and UTs had implemented a programme on HIV/AIDS education in schools. Since the programme was not implemented in a uniform and systematic manner and did not cover all the schools in the States/UTs, a National Plan was stated to have been developed which aimed at integrating HIV/AIDS education programmes in the schools in a suitable and cost effective manner. NACB decided in July, 1999 that all the schools in States/Union Territories would be covered in a phased manner in a period of five years i.e. by 2004. However, 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 Maharastra and put the number in the range of 2000-3000. In Uttar Pradesh and Punjab not a single school had been covered. 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). The Committee have been given to understand that the variation in

implementations of the Schools AIDS Education Programme in States are largely due to varying levels of commitment to the programme; degree of collaboration with the Department of Education; and available resources and capacity. The Committee express their serious concern over the tardy implementation of the Schools AIDS programme and calls for a thorough review/revamp especially in view of reports that 50 per cent new cases of HIV/AIDS are found in the age group of 15 to 24. Though HIV/AIDS is now a part of National curriculum frame-work, only Southern States viz., Andhra Pradesh, Tamil Nadu, Kerala and in Northern States only Himachal Pradesh have so far integrated HIV/AIDS in the School curriculum through SCERT. The Committee expect that the remaining States would complete the process of integration of HIV/AIDS in their School curriculum expeditiously so that the students would be able to decide about the difference between wrong information and correct information about HIV/AIDS. Syllabus on HIV/AIDS should be carefully drawn keeping in view the sensitivity of the problem. Since several studies have shown that students who were made aware of sexually related issues are far more circumspect and cautious in their behaviour, it is therefore, highly desirable that School AIDS Programme should be carried out uniformly and effectively throughout the country. The Committee would also like NACO to evolve a suitable programme to educate youth on HIV/AIDS through non-formal education. To achieve this desired objective the Ministry of Human Resource Development and respective State Governments should be closely involved at all levels.

225. With a view to raise the awareness level regarding HIV/AIDS in rural and slum areas and other vulnerable groups and to make people aware of the service available under the public sector for management of Reproductive Tract Infection (RTI)/STD and to facilitate early detection/treatment of RTI/STD cases by utilising the infrastructure available under primary health care system, five rounds of Family Health Awareness Campaign (FHAC) are stated to have been conducted across the country during the period April 1999 to March 2003 for which Rs.109.41 crore was released. Since FHACs held between May 1999 to February 2002 failed to attract not even 20 per cent of the targeted population, it is therefore, obvious that FHAC have failed to achieve the desired objective. The Committee feel that benefits of any programme/scheme even if well conceived does not accrue to the beneficiaries if such scheme are not properly planned and effectively implemented. It is therefore, essential that implementation of the scheme are given the requisite attention.

226. With the objective of tracking the geographical spread of HIV infection in the country and providing referral services for its diagnosis during the initial phase of the programme, Government had established 62 Sero-Surveillance Centres and nine referral centers. These centres were advised to function as Voluntary Counselling and Testing Centres (VCTCs). During 1998-99, 69 additional HIV Testing centers were sanctioned as Voluntary Blood Testing Centres to promote Voluntary Counselling and Testing (VCT). These centers were renamed as VCTC. 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) had been established in various States/UTs, which are located in Medical College Hospitals

and District Hospitals, as against the sanction of 600 VCTCs for the Financial Year 2002-2003. The Committee note that though the districts providing VCTC facility were 85 per cent in high prevalence States, in moderate and low prevalence States, 52 per cent of districts still remain uncovered. Audit scrutiny of record revealed that a number of Counselling and Testing Centres were either non-functional or not fully functional due to non-appointment of Counsellors, laboratory technicians, non-supply of equipments and kits and non availability of trained personnel. The Committee are concerned to note though NACO had nearly achieved the targets set for establishing VCTCs, but the scheme remained non starter due to poor functioning of VCTCs. They, therefore, recommend that NACO should ensure that all the existing VCTCs are made fully functional at the earliest by providing adequate number of trained technical manpower, latest equipments and medical kits etc. The Committee further note that though the overall percentage of people who were imparted pre-test counselling had shown an increasing trend, the percentage remained low i.e. in the range of 6 to 30 per cent in some Societies. The Committee desire that NACO should instruct all State AIDS Control Societies to offer pre-test counselling to all persons before they are tested for HIV as this would ensure that the affected persons gain confidence for living a normal life without believing in myths and misinformation about HIV/AIDS. The Committee are also of the opinion that the testing of HIV should shift from `voluntary' to `routine' which means regular HIV test for every person accessing the health care system.

227. The Committee note that as against 3.80 lakh health care 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. The Committee cannot but over emphasize the need for proper training of supporting and ancillary staff for the effective implementation of the HIV/AIDS control programme. NACO should therefore formulate a comprehensive programme for imparting training to all healthcare workers, Counsellers and volunteers of HIV/AIDS in every district of the country and undertake it in a time bound manner.

228. The Committee note that 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 modernized by NACO till March 2003. It was observed that out of the 125 blood banks modernized by NACO, as of March 2003 in Phase-II, 75 blood banks were yet to be licensed. The details of districts remaining uncovered as of March 2003 were not available with NACO. While 84 districts did not have modernized blood banks, 44 districts did not have even blood banking facilities. The Committee regret to observe that despite NACO's financial assistance to all the State AIDS Control Societies, the objective of establishing atleast one modernized blood bank in each district by 2002 remained unachieved. What is more disturbing is the revelation by NACO that many of the blood banks modernised by them in Phase II were yet to be licensed, while licenses of some of the Blood Banks modernized in Phase-I might have been withdrawn/cancelled due to non-adherence to

the laid down conditions. It is incomprehensible as to how NACO had modernized and continued to provide financial assistance to those blood banks which were either not been licensed or whose licence had been withdrawn/cancelled by Drug Controller of India. Similarly, in 17 cases, there were variations between the figures supplied by NACO, and the State AIDS Control Societies in respect of blood banks modernised. Audit scrutiny of records of SACS further revealed that several blood banks were not functional/fully functional due to various reasons such as non-supply of equipment, idling of equipment due to non-receipt of licence for want of repair and non-renewal of licences etc. The Committee are distressed over the sorry state of affairs prevailing in the country with regard to setting up of blood banks, their licencing and modernization etc. Since there is a strong corelation between HIV and blood transfusion, it is of paramount importance that all the blood banks of the country are modernized and duly licenced so that they provide safe blood devoid of any possible HIV/AIDS virus etc. The Committee recommend that Ministry of Health & Family Welfare should set up a High Level Committee to go into the entire gamut of functioning of blood banks in the country and suggest measures for their modernization and proper functioning so that they are geared up to meet the challenges posed by AIDS. The Committee further recommend that Ministry of Health and Family Welfare should take serious cognizance of cases in which NACO had given financial assistance to blood banks which were either not licenced or whose licence had been cancelled and punitive action should be taken against those found guilty. NACO should also ensure adequate supply of diagnostic tools and test kits in all blood banks to enable them to function smoothly. Private blood banks should be subjected to stringent quality control checks by the agencies authorised by Government and stringent punitive action be taken against the blood banks which are functioning without proper license.

229. The Committee are informed that during March 2000, NACO initiated a feasibility study on prevention of mother to child transmission in 11 institutions located in 5 high prevalence States of the country. The short course regimen of Azidothymidine (AZT) antiretroviral drug was used in this feasibility study. The second phase of this feasibility study was started in October 2001 using a single dose of Nevirapine to both mother and child to prevent mother to child transmission. The actual implementation of PPTCT of HIV was to be completed by April and July, 2002 in Medical Colleges and District Hospitals respectively in high prevalence States and by September 2002 in Medical Colleges in low prevalence States. The Committee note that training had been completed and service delivery started in 74 out of 82 Medical Colleges of high prevalence States. However, training had not been completed in 24 per cent district hospitals and service delivery started in only 11 per cent district hospitals in high prevalence States. The scheme is yet to be implemented in medical colleges of low prevalence States. While expressing their concern over the poor implementation of PPTCT component the Committee desire that the same should be revamped/reviewed by NACO so as to make it more effective and target oriented. The scheme should be broad based so as to cover all the District hospitals and Medical colleges in the country. The Committee would also like the Government to shed its complacency in implementation of various schemes in low HIV/AIDS prevalent States

and direct NACO to take these States seriously with a view to avoiding the spread of HIV infection in the country.

230. In December 2002, the Ministry of Health announced a policy whereunder blood donors found to be HIV positive would be told of their infection and will be asked to seek confirmation test and counselling. However, to their utter dismay the Committee found that NACO continues to follow its existing policy of giving results only to those who ask for it. The Committee are of the firm view that non-disclosure of HIV status mandatory to all HIV infected persons could lead to a situation where such persons would be unknowingly spreading the disease to uninfected persons. Since HIV virus can remain asymptomatic for three to twelve years till it reaches the final stage of AIDS, the directive of the Ministry would enable the person to get proper treatment at the right time. The Committee recommend that NACO should immediately comply with the above directive of the Ministry of Health and Family Welfare and accordingly issue necessary instructions to all SACS, District Hospitals, STD clinics in this regard for strict compliance. NACO should also intensify efforts to detect the HIV infection during 'window period' - time gap between contracting of infection and becoming seropositive, so that it would enable early detection of HIV/ AIDS virus and help the persons take necessary preventive steps to mitigate the disease.

231. As a part of Low cost AIDS care activities, National AIDS Control Board (NACB) in August 1999 approved setting up community care centers for People Living with HIV/AIDS (PLWHA) in those areas where HIV/AIDS infection was comparatively high. As of March 2003, NACO had established 37 community centers in various parts of high and low prevalence States. Audit observed that there was a shortfall in establishment of Community Care Centres in high prevalence States which ranged between 17 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, Madhya Pradesh with 972, Uttar Pradesh with 845 and Chandigarh, Punjab and Haryana together with 1186 reported AIDS cases did not have a single Community Care Centre. Further, 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. Currently, 54 Community Care Centres are being run across the country with the help of NGOs and are funded through State AIDS Control Societies. The Committee recommend that with a view to have better care and support to persons living with HIV/AIDS, NACO should set up more Community Care Centres, on top priority basis, in all highly infected areas since prevention and care are the keys to limiting the spread of HIV/AIDS. The Committee are also of the view that the Government should enlist the support of Corporate bodies, NGOs, VOs, Community based Organizations and Civil Society at large in setting up more Community Care Centres.

232. With a view to providing care and support to those infected by HIV/AIDS, establishment of Drop-in-Centres in all the States was envisaged in NACP-II. In

December, 2001 National AIDS Control Board (NACB) approved setting up of 10 Drop-in-Centres in every State to be run by registered associations and networks of PLWHA. However, against this approval, NACO had set up 3 Drop-in-Centres in Maharashtra, 1 in Karnataka and 5 in Tamil Nadu. Evaluation of performance of these Centres had not been conducted as of March, 2003. The Committee express their unhappiness over the slow pace in setting up these Centres and recommend that NACO should hasten up the process of establishing adequate number of Drop-in-Centres in all the States/Union Territories before completion of NACP-II.

233. Since Commercial Sex Workers are the most vulnerable and high risk group that is prone to high exposure to HIV/AIDS, their rescue and rehabilitation assume vital importance in control of HIV/AIDS. It is, therefore, imperative that an alternative avocation is provided to the rescued Commercial Sex Workers which is suitable to them. Unless this is done, there is every possibility that their economic condition would rather force them to go back to their earlier profession and consequent exposure to HIV. The Committee, therefore, recommend that NACO should devise an appropriate Relief and Rehabilitation programme for all rescued Commercial Sex Workers in built into National AIDS Control Programme, so that the risk of spreading HIV/AIDS could be minimized to that extent possible.

234. A host of Opportunistic Infections (OIs) such as Tuberculosis, Candidiasis and Diarrhoea can easily afflict/affect the person with full-blown AIDS. Most of these infections are curable, if effective therapy is initiated promptly. NACO under NACP-II provides drugs for treating common opportunistic infections at district hospitals through State AIDS Control Societies. However, the Committee are concerned to note that out of total allocation of Rs. 18 crore by NACO for procurement of OIs drugs during 1999-2003, Societies had utilized only Rs. 5.90 crore (33 per cent). This is substantiated by the fact that some of the SACS such as Jammu and Kashmir, Goa, Meghalaya, Uttaranchal, Jharkhand, Lakshadweep and Chhattisgarh had not spent any amount on procurement of these drugs. The Committee deprecate the negligent attitude of SACS towards such an important component of the programme, where human lives are at stake, and recommend that NACO should strictly ensure that all the essential drugs are available in all the district level hospitals in adequate quantity and distributed freely to the infected persons, without any difficulty.

235. The Committee note that at present research and development activities in the field of vaccine development for HIV/AIDS are very limited in the country. With a view to attract and encourage more and more pharmaceutical/Drugs/ Biotech companies to undertake Research & Development activities for development of new vaccine and life saving drugs for control of HIV/AIDS, Government should provide necessary infrastructural facilities, fiscal and other incentives to Indian Companies/Research Institutes to enable them to carry out research work either collectively among themselves or by entering into collaboration with their counterparts in developed and developing countries.

236. The Committee note that in the current scenario where prices of Anti-Retroviral Therapy drugs are quite exorbitant and beyond the reach of common man,

there is an urgent need to develop an alternative drug which is cost effective through Indian systems of medicine like Ayurveda, Unani and Siddha apart from Homoeopathy. The Committee, therefore, recommend that Ministry of Health & Family Welfare should sponsor a special Research and Development (R&D) Project for developing an indigenous drug through all branches of Indian System of Medicine (ISM) and Homoeopathy which is not only cheaper but also can act as an effective substitute for Anti-Retrovirals Therapy, if not a total cure from the infection. The Committee also recommend that the Government should be vigilant against unscrupulous persons claiming to have invented a cure for HIV/AIDS through magic herbs. The Committee are of the view that if need be the Drugs and Magic Remedies Act should be suitably amended so as to provide stringent punishment to unscrupulous persons taking advantage of the misery of HIV-infected persons and defrauding them of huge sums of money. A mass awareness campaign should also be launched by the Government to make people aware of the dangers of usage of such medication by unqualified persons indulging in quackery.

237. The Committee are of the opinion that the research and development work that is being carried out in India and rest of the World should have a common meeting ground/platform so that Research findings can be shared and corelated with each other with a view to arrive at a possible solution to combat this dreaded disease which is threatening the very existence of the mankind. The Committee therefore, recommend that the Ministry of Health and Family Welfare should establish a Research agency in this regard to monitor the research work that is being carried in India and all over the world with a view to developing vaccines and cheap life saving drugs for control of HIV/AIDS.

238. For effective implementation of the NACP, NACO had sanctioned posts under various cadres/categories in all State AIDS Control Societies. However, the Committee observed that 50 per cent staff including a number of key posts such as JD/DD (Surveillance), DD(STD), AD(Care), Monitoring and Evaluation Officer in 10 State AIDS Control Societies have not been filled up thereby adversely affecting the programme implementation. The Committee, recommend that NACO should take immediate necessary steps to fill up all the posts lying vacant in different categories more particularly the posts of Monitoring and Evaluation Officers, at the earliest.

239. The Committee note that NACO had appointed 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. Audit scrutiny revealed that 155 out of 299 water baths, 177 out of 250 hot air ovens, 93 out of 100 incubation and 53 out of 100 distilled water equipments 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 the National Thermal Power Corporation (NTPC) Ltd., it was noticed that equipments worth Rs. 60. 87 lakh purchased by NACO during Phase II were lying uninstalled. The Committee express their serious concern over the infructuous expenditure due to non-installation of

various kinds of equipment resulting in loss to the National/State exchequers and recommend that Ministry of Health and Family Welfare should conduct a thorough investigation into the matter with a view to fix accountability on the officials found guilty. The Committee also recommend that in future the requisite equipments should be properly estimated, timely ordered and installed so as to avoid infructuous expenditure and financial loss to the exchequer. Suitable lessons should be taken from the instant case.

240. The Committee note that for effective monitoring and evaluation of the programme, each State/Municipal AIDS Control Society was required to appoint a Monitoring and Evaluation Officer. However, it had been noticed by Audit that 17 (45 per cent) out of 35 Societies had no Monitoring and Evaluation Officer. NACO stated that Societies where there are no Monitoring and Evaluation Officer, the Joint Director in-charge of Surveillance along with Statistical Assistant perform the monitoring and evaluation functions. The Committee express their serious concern over non-appointment of M&E Officers by several Societies. They are of the view that since monitoring and evaluation is an important and continuous activity involving periodical appraisal of the progress made in achievement of the targets laid down under various components of the programme, any adhocism with respect to such an important activity would have an adverse impact on the functioning of the programme. The Committee, therefore, recommend that NACO should advise all the Societies to appoint Monitoring and Evaluation Officer without any further delay.

241. A contract for consultancy services was signed in November 2000 by NACO and ORG Centre for Social Research to design and develop a Computerised 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. Though 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 made operational in all the Societies only by August, 2003. The Committee are informed that although CMIS had been made operational in all 38 Societies, monitoring of the programme was not effective as receipt of reports from the societies was poor. Reports from all the societies had never been received during November 2001 to April 2003. Further, evaluation of information generated from CMIS had not been conducted so far. The Committee cannot but deprecate the indifference and lackadaisical approach adopted by various SACS in submitting Reports to CMIS as a result of which the various objectives laid down under CMIS remain unfulfilled. The Committee recommend that NACO should instruct all SACS to submit their Reports periodically to CMIS so that the information furnished by them can be analysed. The Committee also recommend that NACO should take stringent punitive action against those SACS which do not submit their Reports in time.

242. A National Performance Review was to be carried out by National AIDS Control Board (NACB) in accordance with terms of reference satisfactorily to IDA. However, the Committee regret to note that no review of NACP had been carried out by NACB during the period 1998-99 to 2002-2003. NACO stated that there did not

seem to be a need for a separate National Performance Review/Performance and Expenditure Annual Report (PEAR) since performance of all Societies was reviewed during Project Directors meetings and at the time of finalisation of Annual Action Plans. The Committee consider the reply of NACO as untenable since a National Performance Review was required to be conducted in accordance with the terms of reference satisfactory to the IDA has been prescribed in the scheme of prevention and control of HIV/AIDS. The Ministry of Health & Family Welfare had subsequently informed the Committee that since its inception in 1992, NACB had met on 24 occasions till date and had discussed different facets of the programme specially major policy issues such as approval of annual action plans of implementing agencies, introduction of Anti-Retroviral Therapy (ART), social marketing of condoms, family health awareness campaigns and implementation of National Blood Policy, etc. The Committee recommend that the Ministry of Health & Family Welfare may examine the feasibility of conducting a National Performance Review so as to assess the functioning of NACP-I&II and the deficiencies/shortcomings that may come to their notice should be taken into cognisance while conceiving NACP-III.

243. The Committee note that the National AIDS Committee (NAC) acts as the high level deliberative body to oversee the performance of NACO and provide overall policy direction and to forge multi-sectoral collaborative efforts and enable the participating organizations to mobilize their overall administrative network for the various intervention projects. The National AIDS Committee is required to meet as often as possible but at least once in a year. The Committee are dismayed to note that NAC had not met since 2001 and no meeting had been held during the last three years. The Ministry of Health & Family Welfare could not furnish any plausible reasons for not holding any meeting by NAC during the past few years. They further note that there had been an inordinate delay on the part of the Ministry in submission of proposal for convening the meeting, which is inexplicable. Given the alarming situation in the country posed due to emergence of AIDS as a major killer disease on account of rapid spread of HIV virus, the response of NAC to the problem to say least is very casual and negligent. Failure of National AIDS Committee to meet even once during the past few years expose the hollowness in the claim made by the Government that it is making serious efforts to combat the dreaded disease. The Committee expect that in future, NAC would meet as frequently as they could and atleast once in six months to review the overall implementations of the programme and progress made under various components of the NACP.

244. The Committee are of the considered view that since HIV/AIDS is a multi-dimensional problems affecting socio-economic development of the country, impinging on various economic and social sectors of Governmental and Non-Governmental activity, the fight against it should be multi-pronged and multi-disciplinary in approach. The control of HIV/AIDS had been taken up exclusively as a Centrally Sponsored Scheme i.e. through NACP I & II and the role of State Government appears to be rather peripheral in the implementation of NACP. Keeping in view the magnitude of the problem posed by HIV/AIDS, the fight against this dreaded disease has to be multi-pronged for which Governments at all levels – National, State and local-need be involved.

The Committee also note that disparities exist among different States with regard to their fight against AIDS while States which have been categorized as high prevalent States viz. Andhra Pradesh, Tamil Nadu, Maharashtra etc. have taken up the battle against AIDS seriously, rest of the States which fall either under the category of moderate or low prevalence have been complacent. The Committee, therefore, recommend that in order to make the fight against HIV/AIDS, a truly mass movement of National level, Government of India should actively indulge Governments at all levels viz. State Governments and local bodies such as Panchayats, Municipalities etc. irrespective of the degree of prevalence of HIV/AIDS should be initiated. Since the prevalence of AIDS varies from State to State and given the socio-cultural differences, that exist among different States, each State should be given freedom to devise and formulate their own HIV/AIDS Control Programmes in keeping with the broad National objectives.

245. The Committee understand that a number of steps have been taken by the State of Tamil Nadu in fighting the dreaded disease of HIV/AIDS which have yielded encouraging results. As a result of sustained effort of Tamil Nadu State AIDS Control Society in cooperation and coordination with AIDS Prevention and Control Project, the State made significant achievements in AIDS prevention and care. Some of the key features of the success story of Tamil Nadu are behavioural changes such as increase condom use, reducing the vulnerability of people to the risk of infection and effort to offer affordable ARV treatment to people living with HIV/AIDS etc. The USAID funded AIDS Prevention and Project in Tamil Nadu launched in 1995, has been another success story acclaimed for its effective Targetted Interventions approach and research and survey activities like the Annual Behavioural Sentinel Surveillance surveys and the survey to estimate the community prevalence of HIV/AIDS. While appreciating the measures taken by the Tamil Nadu Government, the Committee are of the firm opinion that Ministry of Health and Family Welfare should study them in detail so as to circulate to all the States and impress upon them to replicate the efforts of the Tamil Nadu Government which would eventually help to contain and combat the spread of HIV/AIDS to a large extent.

246. The Committee are of the considered view that the problem of AIDS, is fast assuming an epidemic proportion in North Eastern Region and is qualitatively different from other parts of the country especially that of high prevalence States such as Tamil Nadu, Andhra Pradesh, Maharashtra and Karnataka. The spread of HIV/AIDS in this particular region is largely on account of Intravenous Drug Use (IDU) where over 25 to 30 per cent of the youth population are reported to be HIV positive. The Committee feel that in view of the international dimension to the problem of AIDS in this region on account of illicit drug trafficking from across the borders from Laos, Myanmar and Thailand making youth of this region susceptible to drug addiction, there is an urgent need for having a separate dispensation to control and combat HIV/AIDS in the North Eastern region. They, therefore, recommend that with a view to giving special focus to this region the Ministry of Health and Family Welfare may examine the feasibility of setting up a separate body/agency exclusively for North-Eastern States to oversee the implementation and monitoring of special programmes for HIV/AIDS control.

247. An analysis of the performance of various components of the National AIDS Control Programme — both Phase I & Phase II revealed that the programme had achieved limited success due to various reasons such as failure in generating sufficient awareness among the masses; under-utilisation of funds; non-reconciliation of accounts; absence of adequate infrastructure facilities; lack of adequate quantity of drugs and trained manpower; non-completion of mapping exercise for identification of Target Groups; ineffective Targeted Interventions Programme; failure of NACO to procure and distribute enough condoms, inadequate number of STD Clinics, modernized blood banks and voluntary counselling and testing centres in every district of the country etc.; and non-assessment of the impact of various components of the programme due to failure of the National AIDS Committee to meet after 2001. Keeping in view the above factors, the Committee, recommend that NACO should immediately get the NACP- I & II evaluated by an independent agency so as to assess the constraints/bottlenecks and other problems in implementation of the programme and to suggest measures for effective implementation of all the components of the programme.

NEW DELHI;
17 *November*, 2005
26 *Kartika,* 1927 *(Saka)*

PROF. VIJAY KUMAR MALHOTRA,
Chairman,
Public Accounts Committee.

APPENDIX-I

COMPTROLLER AND AUDITOR GENERAL'S REPORT NO. 3 OF 2004, UNION GOVERNMENT (PERFORMANCE APPRAISAL) RELATING TO NATIONAL AIDS CONTROL PROGRAMME

Executive Summary

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. The 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. The 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 unidentified 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 condoms. 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 counselling, NACO continues to follow the existing policy of giving the results only to those persons who ask for these. Non-disclosure 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, non-availability 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 targeted population. The main reasons for failure of Family Health Awareness 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 un-assessed. Grants-in-aid were released without proper assessment of requirement to inter-sectoral 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 unadjusted 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.

APPENDIX- II

STATEMENT OF OBSERVATIONS/RECOMMENDATIONS

S.No.	Para	Ministry	Observations/Recommendations
1	2	3	4
1.	195	M/o Health and Family Welfare	The alarming spread of the killer disease *viz.* Acquired Immunodeficiency Syndrome (AIDS) and increasing number of persons infected by it has thrown an unprecedented challenge to humanity. The problem of AIDS has ceased to be a mere health problem and has now acquired dimensions, which perhaps have very few parallels in the history of mankind. India's nearly two decades old epidemic is estimated to be largest in the South and Southeast Asian Region and the second largest in the world. According to National AIDS Control Organisation (NACO), there are 5.14 million HIV infected men, women and children in India, although the figures have been contested by various Non-Governmental Organisations and International Agencies. Independent assessments by the United States' National Intelligence Council predict that at the present rate of spread, about 25 million people in India would be HIV-infected by the year 2010. The UNDP Human Development Report (2003) places the figure at 110 million infections by 2025, with a 13-years reduction in life expectancy from the present 61 years. No wonder that India is said to be sitting on a Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/ AIDS) "Time Bomb". The Committee feel that the Ministry should examine the desirability of conducting a fresh survey of HIV/AIDS infected people especially in the context of many NGOs' and International Bodies' pointing out the inadequacies in the country's Sentinel Surveillance network and with a view to arriving at correct figures as far as possible regarding the number of people infected with HIV positive. This will help the Government to realise the challenge ahead for conceiving realistic and effective programme and targets for different components of the programme.

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2.	196	M/o Health and Family Welfare	The Acquired Immunodeficiency Syndrome, more than any other health issue, is capable of hindering the country's development because it attacks its people in their most productive years and places an undue strain on the economy. Therefore, at the foremost, a basic understanding and knowledge of HIV/AIDS is a prerequisite to grasp the scope and complexity of this human, socio-medico, and public health problem. In addition, a thorough understanding of HIV/AIDS requires radical change in attitudes and beliefs, as well as the emotional components concerning the virus and the syndrome, and the behaviours that place ourselves *vis-à-vis* others atrisk of contracting the virus.
3.	197	-do-	India's battle against HIV/AIDS commenced in 1986 when a high powered National AIDS Committee was constituted and a National AIDS Control Programme (NACP) was launched in 1987. Since 1992, the National AIDS Control Organisation (NACO) and the State AIDS Control Societies (SACS), which were set up subsequently, are nodal implementing agencies under the NACP. The NACP is a wholly Centrally Sponsored Scheme with assistance from International Donor Agencies (IDA). The National AIDS Control Programme, Phase-I (NACP-I) was to be implemented from September 1992 to September 1997 with technical assistance from the World Health Organisation (WHO), but due to slow utilization of funds in the first two years of the project, it was extended upto March, 1999. Further, to encourage and enable States themselves to take on the responsibility of responding to the epidemic and reduce the spread of HIV infection and to strengthen India's capacity to respond to HIV/AIDS on a long-term basis, the Programme of NACP-II was launched in 1999 with a budget of Rs.1425.10 crore. The project which was supposed to have been completed in October 2004 is still continuing and it is expected to be completed by March 2006. The Committee hope that all possible remedial

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			measure would be taken by Ministry of Health and Family Welfare to ensure that NACP-II is not extended and is completed within the stipulated targeted period.
4.	198	M/o Health and Family Welfare	The key objectives of the NACP-I were to slow down the spread of HIV; to bring down morbidity and mortality associated with HIV infection; and to minimize socio-economic impact resulting from HIV infection. For NACP-II the main objectives were focused on to reduce the spread of HIV infection in India; and to strengthen India's capacity to respond to HIV/AIDS on a long-term basis. Some of the important targets which were set to achieve by the completion of the Programme I and II were 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; to reduce the blood-borne transmission of HIV to less than 1 per cent; to attain awareness level of not less than 90 per cent among the youth and others in the reproductive age group; and to achieve condom use of not less than 90 per cent among high-risk categories like Commercial Sex Workers.
5.	199	-do-	The review conducted by Audit relates to National AIDS Control Programme covering all State/ Municipal AIDS Control Societies (SACS/MACS) and National AIDS Control Organisation in Delhi for the period 1998-99 to 2002-2003. The principal objective of this review was to ascertain the impact of various components of the programme such as utilisation of funds released and accounting; efficacy of priority Targeted Interventions for groups at high risk; the Information, Education and Communication programme; adequacy of training programmes; functioning of blood banks and Sexually Transmitted Diseases clinics; adequacy of procurement procedures; utilisation of equipments; achievement of targets and impact evaluation; and monitoring and evaluation procedures.

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6.	200	M/o Health and Family Welfare	The Committee are constrained to observe that the programme has achieved limited success as it has failed in generating sufficient awareness among the masses. Besides, there was very slow progress in implementation of its various components. Target groups in many States have remained unidentified due to non-completion of mapping exercises; the scheme of social marketing of condoms was found lacking as NACO could not procure and distribute the targeted number of condoms.The Committee are disturbed to find that the programme could not achieve the targets relating to setting up of Sexually Transmitted Disease clinics, modernized blood banks and voluntary counselling and testing centers in every district of the country. 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. Community Care Centres and Drop-in-Centres have been established in very few States and the effectiveness of their functioning remained unassessed. Grants-in-aid were released to inter-sectoral collaborators without proper assessment of requirement for implementing the various activities of the programme resulting in poor utilization of the grants allocated to them. Besides, NACO had no mechanism to monitor procurement of equipments and testing kits. These issues have been discussed in detail in succeeding paragraphs.
7.	201	-do-	The total financial corpus of NACP-I and NACP-II from all the sources including budgetary support from Government of India stood at Rs. 2344.65 crore. Out of this, Government of India and the World Bank contributed Rs. 253.34 crore (Phase I — Rs. 57.34 crore + Phase II — Rs. 196.00 crore) and Rs.1181.66 crore (Phase I — Rs. 222.66 crore + Rs. 959.00 crore) respectively and the rest was contributed by other funding

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			agencies namely, United States Agency for International Development (USAID) AVERT (Rs. 166.00 crore in Phase-II), USAID APAC (Rs. 64.58 crore for Phase-II), Department for International Development of the U.K. Government (Rs. 487.40 crore for Phase-II), Canadian International Development Agency (Rs. 37.81 crore for Phase-II), Australian AID (Rs. 24.65 crore for Phase-II), United Nations Development Programme (Rs. 6.47 crore for Phase-II) and the Global Fund (Rs. 122.74 crore for Phase-II). The Committee are concerned to note that as against an approved allocation of Rs.657.55 crore for Phase I, NACO could utilize only 75 per cent of the funds allocated and in Phase II (1999-2004) as against an approved allocation of Rs.1155.10 crore from the Government of India and the World Bank (GOI – Rs. 196 crore + World Bank –Rs. 959.10 crore), NACO had been able to spend only 46 per cent (Rs.532.43 crore) in the first four years i.e. upto March, 2004. The Ministry of Health and Family Welfare attributed the reasons for non-utilisation of funds to the shortfall in the budgetary provision to the tune of Rs. 218.67 crore during NACP-II. It has further been contended that the revised estimates were usually finalized in the month of January-February of the Financial Year resulting in delay in release of additional funds to the implementing agencies which ultimately resulted in less utilization of funds during the year by the concerned agencies. The poor utilization of the earmarked funds for such an important project resulting in non-achievement of targets set under various programmes is nothing but regrettable. The Committee take a serious view of the fact that NACP-II suffered for want of inadequate fund due to the procedural flaws and lack of seriousness and urgency on the part of Budget Allocating Authority. Obviously, Ministry of Health and Family Welfare also failed to impress upon the Ministry of Finance and the Planning Commission the need for timely release of the total World Bank Grant for such a vital project. The

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			Committee cannot but over emphasize the need for ensuring not only total utilization of earmarked funds but for enhancing further budgetary allocation for such a vital programme in view of the fact that India has the second largest population of people living with HIV/AIDS in the world. The Ministry of Finance and Planning Commission ought to keep this fact in view while allocating funds for different programmes of the Ministry of Health and Family Welfare. The Committee are also of the view that Ministry of Health and Family Welfare should ensure that Utilisation Certificates by State AIDS Control Societies are submitted timely so that there are no delays for reimbursements from the World Bank in this regard. The Committee would also urge that external grants should be treated as a supplement to the Domestic Central Budgetary support rather than a substitution. Grants given by External Agencies should not be adjusted into the ceiling determined by Planning Commission and Ministry of Finance for such an important programme.
8.	202	M/o Health and Family Welfare	NACO releases Grants-in-aid to Societies which are the main implementing agencies under NACP and they in turn submit quarterly Statements of Expenditures (SOEs) 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 SOEs should be reconciled with expenditure shown in the audited statement of accounts. The Audit Review has revealed that in respect of 49 audited statements of accounts, there were differences in figures in 46 cases. Obviously, the Ministry of Health and Family Welfare did not make efforts to ensure that there are no differences in figures of Statement of Expenditure and Audited Statements which was essential for timely and complete reimbursement of the expenditures by the State AIDS Control Societies. Further, no reasons or explanations were given for non-reconciliation of Statement of Expenditures and Audited Statement of Accounts. The Committee have now been informed that the

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			exercise of reconciliation of Accounts has been completed till 2002-03, and the annual audited statements of accounts for the year 2003-04 have been received and further reconciliation of these accounts had been taken up on campaign basis and it is also proposed to meet the financial functionaries from SACS twice in a year for discussions all issues relating to financial management. The Committee hope that belated realization on the part of Ministry of Health and Family Welfare would ensure concurrent reconciliation of Statement of Expenditures and Audited Statement of Accounts.
9.	203	M/o Health and Family Welfare	Under NACP, State/Municipal AIDS Control Societies are to submit their Annual Action Plans to NACO three months prior to the commencement of the next Financial Year so that they could be approved and allocation of funds be made on time. The Committee are dismayed to note that till 2002-2003, none of the SACS/MACS had submitted their Annual Action Plan on time. Inordinate delays in submission of Annual Action Plan by SACS resulted in their belated approval which in turn affected the proper utilization of funds and as a consequence there were considerable unspent balances lying with the SACS/MACS at the end of the year. This also affected the targets set in respect of some programmes like strengthening of Sexually Transmitted Diseases (STD) clinics, Voluntary Counselling and Testing Centres (VCTCs), training etc. The Committee regret to observe the inordinate delay in submission of Annual Action Plan by various SACS and desire that in future NACO should strictly ensure that Annual Action Plans are submitted by all SACS/MACS within the stipulated time frame. For this purpose, the matter needs to be taken at regular intervals with the State Governments at the appropriate levels to impress upon SACS/MACS for the timely submission of Annual Action Plans.
10.	204	-do-	On the basis of the Annual Action Plans received from Societies, NACO makes component-wise

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			allocation of funds to the Societies which, in turn, report expenditure through quarterly Statements of Expenditure (SOE). The Committee note that while the expenditure on the component Preventive Interventions for General Community exceeded the indicative percentage of the total outlay, the expenditure on low cost AIDS care and inter-sectoral collaboration fell far short of the indicative outlay. This is substantiated by the fact that in case of preventive interventions for the general community, the indicative cost (per cent) of total outlay as per Project Appraisal Document (PAD) was 33.7 per cent and against this the expenditure were 51.07 per cent (1999-2000), 42.67 per cent (2000-01), 55.19 per cent (2001-02) and 49.99 per cent (2002-03), whereas in case of low cost AIDS care the allocation was 14.1 per cent of indicative cost (per cent) of total outlay and against this the expenditure were 3.53 per cent (1999-2000), 1.84 per cent (2000-01) 3.26 per cent (2001-02) and 5.29 per cent (2002-03). The Committee, recommend that Ministry should identify the bottlenecks responsible for low expenditure of fund in the low cost AIDS care and in Inter-sectoral collaboration components and take necessary steps for stepping up the expenditure and also periodically monitor progress made by SACS on these components so that the targets set under these components are achieved. NACO should also identify the thrust areas requiring special attention and step up monitoring especially in planning, management and implementation of other components under NACP.
11.	205	M/o Health and Family Welfare	The Committee note that out of the total grant of Rs.566.05 crore (including the opening balance) released by NACO during 1999-2000 to 2002-2003, the Societies had utilised Rs. 443.93 crore *i.e.* 78 per cent. While 17 State AIDS Control Societies in 1999-2000, 19 Societies in 2000-01, 15 Societies in 2001-02 and 12 Societies in 2002-03 had utilized more than 70 per cent of the grants released, 9 Societies in 1999-2000 and 2000-01, 10 Societies in 2001-02 and 21 Societies in 2002-03 could not

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			utilize even 50 per cent of the grants released to them. The Committee further note that as on 31st December, 2004, an amount of Rs.19.19 crore was lying unutilized with SACS. Poor utilization of grants by the SACS over the years reflects the sordid state of affairs prevailing in the SACS. Non-utilisation of funds by Societies led to slippage in the targets fixed under the various components and as a consequence NACP suffered to a great extent in achieving its avowed objective of containing the HIV/AIDS in the country. The Committee, while deprecating the failure of SACS in utilisation of funds, expect NACO to identify the reasons therefor with a view to taking suitable corrective steps to ensure that there is proper and full utilization of funds by SACS. NACO also needs to periodically monitor the functioning of SACS in relation to their performance for achievement of targets set in a time bound manner.
12.	206	M/o Health and Family Welfare	NACO 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. However, the Committee are constrained to point out that the records of some State/Municipal AIDS Control Societies revealed that 113 NGOs in Andhra Pradesh, one NGO in Punjab and all the NGOs in Manipur did not contribute the prescribed amount. The Committee are surprised to note that inspite of the non-contribution of the requisite percentage by the NGOs, the Andhra Pradesh State AIDS Control Society had been releasing grants to the NGOs leading to excess release of Rs.29.90 lakh. Audit has also pointed out an instance where a Society had flouted the guidelines of NACO by involving an NGO in the implementation of project on Targeted Interventions for groups at high risk which had not completed registration for a minimum period of three years. The Committee may be apprised about the precise reason as to why SACS of Andhra Pradesh continued to

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			release grants to the various NGOs when they did not contribute the 10 per cent of the project cost. It is also not clear as to whether any action was taken by NACO in this connection. The Committee are of the firm opinion that NACO should impress upon the SACS that the fund be released after conforming to the rules. Further, the performance of NGOs should also be periodically monitored and those found to be indulging in misappropriation of funds should be black-listed and debarred from participating in the activities of NACP.
13.	207	M/o Health and Family Welfare	As indicated earlier, there are an estimated 5.14 million HIV cases in the country based on Sentinel Surveillance 2004. According to the reports submitted by various States/Union Territories to NACO, the cumulative number of HIV/AIDS cases stood at 96086 in 2004. The Committee note with serious concern that there had been a continuous rise in the number of HIV/AIDS cases reported since 2001. During the years 1999-2000, 2000-01 and 2001-02 there had been an increase of 60 per cent, 80 per cent and 69 per cent respectively of the AIDS cases in the country. NACO has attributed the rise in AIDS cases to more and more people coming for treatment in public sector hospitals and also increase in the number of hospitals providing such services. At the same time, NACO has conceded that the statistics available with them may not be accurate as many of the AIDS patients may still not have the access to public sector hospitals and that there may be many more number of unreported AIDS cases in the country. The Committee feel that due to certain reasons like social stigma attached, complacency and lack of awareness some of the patients may not be going to public/private hospitals for treatment. Obviously, such patients do not form a part of the survey conducted by NACO. The Committee, therefore, recommend that with a view to arrive at an accurate and reliable database on AIDS patients / HIV cases in the country, the Sentinel Survey must be broad-based

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			so as to capture the scope and extent of the epidemic prevalent in rural areas and also in highly populated and large States such as Uttar Pradesh and Bihar. The Government therefore, should explore all the possible avenues that survey conducted in this regard are as far as possible scientific and accurate, since the data base on AIDS plays a very important role in fixing realistic targets and also in formulating the plan and programme for combating as well as containing the spread of HIV/AIDS in the country. The Committee, therefore, recommend that Government should undertake a fresh Sentinel Surveillance based on systematic and scientific approach so as to arrive at an accurate and fairly reliable data base on HIV/AIDS.
14.	208	M/o Health and Family Welfare	The Committee are of the view that epidemiological categorization of States into high, moderate and low prevalence will have serious repercussions. Such categorization may lead to a false sense of complacency among the so-called low prevalence States resulting in poor and tepid Governmental response even while the virus continues to spread silently. While high prevalence States such as Tamil Nadu have managed to attract lion's share of funding from NACO and set up a quasi-Governmental State AIDS Control Society that could receive funds directly from the Centre, on the other hand, States such as Chhattisgarh and Madhya Pradesh, which have been either less motivated or less capable of demonstrating their need and capacity, have fallen behind. Low prevalence States such as Bihar where the public health delivery system is in urgent need of upgradation and expansion, funds they receive from NACO is insufficient for them to upgrade their HIV preventive services. The impasse continues, pushing 'low' prevalence States into a vicious cycle of neglect leading to under reporting of HIV/AIDS cases. Further, many States have reported low levels of HIV and some States reported no cases of HIV/AIDS at all which appears to be far from the reality. A probable

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			explanation for this is States that have reported serious HIV/AIDS epidemic are those that have tried to assess the magnitude of the epidemic as honestly as possible, as most of them have better health infrastructure and hence are able to detect more number of cases. There is no evidence to indicate that the rest of the States are somehow 'different' or less vulnerable to HIV. The survey figures as projected by NACO, therefore, may not be very accurate and the figure would raise substantially once these States as well as private hospitals/clinics start reporting cases as honestly as they could. The claim made by the Ministry of Health and Family Welfare that there had been a steep decline in the number of new HIV infections appears doubtful since the Survey have not taken into account people with AIDS, presumably numerous, but dying of opportunistic infection like Tuberculosis. It is also quite possible that the number of Sentinel Surveillance sites where high risk people, for example STD Clinic patients, intravenous drug users and sex workers were tested may be same in 2003 and 2004. Further, the data collected appears to be inaccurate due to lack of better representation from rural India, since a lot of patients (of sexually transmitted infections) in rural areas go to private doctors and quacks and most village women deliver children at home sidestepping the antenatal and postnatal care centres. The Committee, further recommend that the Ministry of Health & Family Welfare may consider review of the categorization of high, moderate and low prevalence States and an alternative approach may be adopted/introduced which will goad all States into action in combating the disease.
15.	209	M/o Health and Family Welfare	The sources of infection of AIDS can be broadly divided into five categories, namely sexual transmission, parents to child transmission, blood and blood products, intravenous drug users and others. The Committee note that in 86 per cent of AIDS case, the sexual route remains the most probable source of infection. Another probable

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			source of infection is parents to child transmission which rose from 0.72 per cent in 2000 to 2.65 per cent in 2003. The Committee observe that though the transmission of AIDS through blood and blood product has come down from 7.79 per cent in March 1999 to 2.79 per cent in March 2003, the number of cases in absolute terms have however been increasing and the target of keeping it below 1 per cent still remains to be achieved. The Committee are given to understand that NACO have taken a number of steps to ensure that every unit of blood is mandatorily tested for HIV, Syphilis, Malaria and Hepatitis (B&C) before the unit is transfused to patients, test kits are provided free of cost to the Blood Banks that are supported by it and the quality of testing is assured by a Nation wide External Quality Assurance System(EQAS). Professional blood donors have been banned and a number of activities are being undertaken to augment voluntary blood donation in the country. Steps are also being taken to orient the prescribers of blood towards appropriate clinical use, so that blood is transfused only when it is absolutely essential and the right quantities of blood components are used. The Committee while taking note of the steps taken by NACO to reduce the risk of transmission of AIDS through blood, recommend that NACO should redouble their efforts to achieve the target of keeping the number of AIDS cases infected through blood transmission to 1 per cent.
16.	210	M/o Health and Family Welfare	Audit scrutiny revealed that Prevention of Parents to Child Transmission (PPTCT) scheme had been implemented in only 74 out of 82 medical colleges and 15 out of 133 district hospitals of high prevalence States till January 2003. In response to Audit observation, the Ministry of Health and Family Welfare submitted that as on January 2005, 288 PPTCT centers are functioning in the country. Out of this, 238 are in high prevalence States and rest (50) are in low prevalence States. In high prevalence States, all the Medical Colleges (85) and all District Hospitals (153) are providing

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			PPTCT services. In moderate/low prevalence States, out of 79 Medical Colleges, 42 Medical Colleges are providing PPTCT services. Rest of the Medical Colleges are in the process of starting PPTCT services. However, there has been a steady increase in cases of infection of HIV/AIDS through parents to child transmission, which rose from 0.72 per cent to 2.65 per cent which points to the lack of proper implementation and monitoring of the programme. The Committee need hardly emphasise that NACO ought to evolve suitable strategies for counselling the HIV/AIDS infected parents about the ill effect of having an HIV infected child, so as to arrest the spread of infection from parents to child.
17.	211	M/o Health and Family Welfare	Targeted Interventions (TIs) are globally perceived as the most effective strategy for arresting the spread of HIV/AIDS. It focus on the strategy to prevent HIV infection and transmission among the groups who tend to involve in 'High Risk Sexual Behaviour'. The activities of TIs are designed basically to inform, educate and counsel the marginalized and vulnerable sections of population, which are at high HIV risk and provide them with preliminary care and support so that they move towards behaviour change and healthy living practices. Intervention with High Risk Groups (HRGs) that are at the core of HIV transmission can greatly reduce the spread of HIV into the general population. Directing HIV prevention efforts among these groups (with high rate of partner-change, whether sexual or needle-sharing partners) is a proven cost effective strategy as it has the multiplier effect of preventing many subsequent rounds of infections amongst the general population. Such High Risk Groups broadly include Commercial Sex Workers (CSWs), Injecting Drug Users (IDUs), Men-having-sex-with-Men (MSM), truckers, migrant workers, etc. Targeted Interventions among these groups involve multipronged strategies such as behaviour change, communication, counselling, health care, treatment for STD and creating

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			demand for and making provision of condoms, along with other activities that can help create enabling environment for behavioural change.
18.	212	M/o Health and Family Welfare	The Committee note that as of September, 2004, 933 TIs are being implemented across the country. However, the data relating to coverage of target population by these TIs was not available with NACO. Though the Ministry claimed that there has been a notable increase in terms of coverage of vulnerable population through TI, yet, 50 per cent of the population is still to be covered. The Committee therefore, desire that efforts need to be stepped up to bring the uncovered population under the ambit of TI Programme. NACO should also ensure regular reporting by SACS regarding progress made by them in implementation of TI programmes through Computerised Management Information System (CMIS).Further the definition of High risk group needs to be broad based so as to include more vulnerable groups such as new recruits of Army and Para-military forces, Army troops separated from families, troops deployed in foreign countries, uniformed forces and their families which are prone to high risk and which need inter-sectoral participation in prevention of HIV/AIDS. The Committee cannot but over-emphasise, the need to ensure that vulnerability and risk should form the basis of planning and programme implementation for prevention and control of HIV/AIDS especially in the backdrop of CIA's National Intelligence Council prediction that the number of AIDS cases in India will surpass every other country and it may have as many as 20 to 25 million AIDS cases by 2010.
19.	213	-do-	The Committee note that a National Targeted Intervention Evaluation Programme was conducted by Sexual Health Resource Centre in partnership with NACO during 2003 in 54 TIs spread across 17 States to assess the average quality of different elements of TIs *viz.,* condom promotion, STD component, Behavioural Change, Communication (BCC), Enabling environment, Needs assessment, Proposal, Development,

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			Baseline study and Project Management. The study found the average quality of the elements of TIs to be in range of 21 to 41 per cent and the average quality of TIs in the country logged at a poor 37.8 per cent. The study revealed that the inputs (training and funding) provided by States AIDS Control Societies were much below that what was needed and that the average quality of TIs needed to be enhanced if they are to deliver the expected results. The Committee express their concern over the poor quality of different elements of TIs due to which the Programme could not achieve the desired results. The lackadaisical approach adopted by State AIDS Control Societies and NACO in this regard is nothing but regrettable. They are of the opinion that NACO should promptly identify the weaknesses with a view to taking suitable corrective steps to make TIs more effective and result oriented. Further, the Government ought to take the cooperation of NGOs, VOs, Community Based Organisations, the target community and the Civil Society at large to make TI programme a truly mass movement.
20.	214	M/o Health and Family Welfare	The Committee note that under Project Implementation Plan (PIP) mapping of high risk areas was to be conducted by all Societies to identify the size and number of target groups, their risk behaviour and their environment. This process enables to locate the size of high risk population where TI projects can be implemented. As on October, 2003 barring Lakshadweep, Meghalaya, Haryana and Goa all States AIDS Control Societies have undertaken the programme of detailed mapping of the vulnerable population which was at different stages. The mapping exercise is stated to be over in all States and 33 mapping reports of major SACS are available with the Government barring reports from States of Chhattisgarh, Rajasthan, Orissa, Lakshadweep and Dadra & Nagar Haveli which are being finalized. The Committee, recommend that NACO should finish the mapping exercise of the remaining States at the earliest so as to have a complete and reliable data relating to high risk population.

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21.	215	M/o Health and Family Welfare	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 condom promotion programme is to ensure easy access to affordable and acceptable condoms of good quality to promote safe sexual encounters. The Committee note that the State AIDS Control Societies procure condoms from the Department of Family Welfare and distribute them under the scheme for free distribution and social marketing. The objective of condom promotion programme is to ensure easy access to condoms of good quality at affordable price to promote safe sexual encounters. The Committee note that the distribution of condoms by the Societies under free distribution scheme increased from 524.38 lakh pieces in 1998-99 to 907.59 lakh pieces in 2002-03 and under Social Marketing Scheme, it increased from 15.49 lakh to 90.39 lakh pieces. Although the number of condoms distributed by the State AIDS Control Societies have increased in absolute terms/over the years, the Committee are, however, surprised to note that all societies were not involved in distribution of condoms. While Maharashtra and Mumbai Societies had performed exceedingly well as they alone contributed 65 per cent under the social marketing scheme, performance of other Societies was far from satisfactory. The Committee are of the opinion that since SACS are the main implementing agencies which have more direct contacts with the vulnerable section/potential high risk groups of the society, their role in the distribution of condoms is inevitable.
22.	216	-do-	The Committee also found that during the year 2000-01, NACO had earmarked distribution of 3.30 million pieces of Deluxe Nirodh under the social marketing scheme, but 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. Audit scrutiny of the social

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			marketing scheme of condom, further revealed that 140 condom vending machines (CVMs) 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. Out of total 385 CVMs purchased by Punjab at a total cost of Rs.22.61 lakh, 230 CVMs were found to be non functional as of May 2003. The Committee are not aware whether the machines are operational or not. Against the background that 85 per cent of the cases of HIV/AIDS is acquired through sexual intercourse the non functioning of a number such machines for a considerable period is nothing but inexplicable and exhibits callous and negligent approach of the concerned authorities in this regard. The Committee recommend that the matter may be enquired with a view to identify the reasons for poor implementation of the Social marketing scheme during 2000-01.It also need to be enquired whether the purchased machines were faulty or were allowed to remain inoperative. Government should fix accountability on the persons responsible for these lapses. The Committee also recommend that NACO should lay down realistic targets for distribution of condom under the scheme and periodically review the progress made by SACS in this regard. More condom vending machines should be installed and kept operative in all important public places such as red-light areas, Railway Stations, Bus Stations, important traffic intersection points in all metros and major cities and also on all National and State Highways for the use of Commercial Sex Workers, Truckers, Men Having Sex with Men (MSM) and other high risk and vulnerable groups.
23.	217	M/o Health and Family Welfare	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 use awareness but with marked

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			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 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 Committee recommend that the awareness about safe sex should be spread more effectively especially in the rural areas by using all available fora such as Gram Sabhas, etc. and by conducting Health Mela etc. Training for elected members of gram panchayats and Women Self Help Groups on issues related to AIDS should be imparted so as to bring about an attitudinal change and awareness among rural masses to fight against HIV/AIDS. Perhaps the spread of awareness should be more in and around targeted areas of high risk and vulnerable groups and for this SACS should be involved. With a view to have a wider reach amongst the television viewers, the electronic medium should be used to the maximum extent possible in prevention of HIV/AIDS. The Ministry of Health and Family Welfare in coordination with Ministry of Information & Broadcasting should make efforts to make it mandatory for all the Satellite Channels to telecast condom advertisements compulsorily during prime time.
24.	218	M/o Health and Family Welfare	The Committee are informed that NACP 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 (BSS) by ORG shows that only 57 per cent of the brothel based female sex workers and 46 per cent non-brothel female sex

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			workers reported consistent condom use with paying clients. Further, only 21.3 per cent of brothel based and 20.2 per cent non-brothel based Commercial Sex Workers reported consistent use of condoms with non-paying clients. The programme also 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 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 Committee recommend that NACO should launch a vigorous and sustained campaign in cooperation with respective State Governments, Voluntary Organisations/Non-Governmental Organisations etc. among Female Sex Workers — both brothel and non-brothel based to sensitise them about the lurking danger of HIV infection in the event of non-use of condoms by their clients, both paying and non-paying. Adequate number of condoms vending machines should be set up in all Red Light Areas and all such places where sex workers solicit customers. Apart from propagation of condom use in high risk group, NACO should make efforts to popularise condom use as a safest sex method and to inculcate it as a regular sex habit amongst the non-risk groups and people at large whenever they enter into sex with any persons other than his/her regular partner.
25.	219	M/o Health and Family Welfare	Another area of concern is the close link between HIV and Sexually Transmitted Diseases (STD). To control the spread of HIV/AIDS, it is essential to strengthen the STD Control Programme at every level with a view to effectively tackle HIV/AIDS. The Committee note that in 1992, the STD Control

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			Programme was integrated with NACP. Various studies are stated to have 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. During NACP-I as against the target of 372 STD clinics, NACO had strengthened 504 Government STD clinics all over the country to provide services to STD patients. However, the pace of strengthening of STD clinics in NACP–II has been 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. What is more disturbing is the fact that NACO could not furnish State-wise details of the 594 STD clinics that have been strengthened as of March, 2003. Moreover, the physical target of 757 STD clinics, only 674 STD clinics were provided with financial support by NACO during the Financial Year 2003-2004 Audit Scrutiny of STD clinics with reference to districts in the country, as per Census 2001, revealed that districts ranging between 7 and 75 per cent in the States/Union Territories did not have STD Clinics at any level i.e. district hospitals, medical college hospitals or taluka/sub-divisional level. The Committee are not satisfied with the progress made so far by NACO in strengthening STD clinics and recommend that NACO should take up steps to strengthen all STD clinics in various parts of the country. The Committee desire that a revised target for provision of STD clinics be laid down with a view to ensuring that every region/part of the country, particularly the target/vulnerable areas are fully covered. Such STD clinics should be provided with necessary financial support by NACO and operationalised expeditiously.
26.	220	M/o Health and Family Welfare	The Committee are surprised to find that a study by Senior faculty members of Medical Colleges of respective States/Union Territories at the behest of NACO to assess functioning of STD clinic has revealed that the attendance of patients

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			at most of the STD clinics was poor. The poorly performing States were Punjab, Haryana, Rajasthan, Madhya Pradesh and Manipur. While Maharashtra, Tamil Nadu, West Bengal and Uttar Pradesh had more than 50 patients a day, most other States had less than 10 patients per day. One-third of the clinics in 23 States/U.T. surveyed, were not located in accessible places. Adequate space for STD clinics was reported from only about 44 per cent of the clinics. Fifty percent of the clinics reported inadequate space for laboratories. Availability of proper instruments, especially for female patients was reported by only 33 per cent of the clinics. Further, the clinics lacked trained man power 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. Further only 56 per cent of the clinics had STD specialists, 17 per cent had a gynaecologist and 31 per cent had a general duty officer as its in-charge. The Committee regret to observe that on one hand, the target laid down for setting up of STD clinics in Phase-II has not been achieved and on the other hand, the existing STD clinics lack proper infrastructure facilities, doctors, nurses, laboratory, technicians, counsellors and para medical staff etc. Obviously, the functioning of the STD clinics in the country has not been given the serious attention it deserves. This is despite the fact that studies over the years have revealed a close relationship between HIV and STD. The failure on the part of the Concerned Authorities in this direction is nothing but regrettable. The Committee, therefore, recommend that Ministry of Health and Family Welfare in association/cooperation with respective States AIDS Control Societies should thoroughly review the functioning of STD clinics in its entirety. The Ministry of Health and Family Welfare should allocate/earmark more funds for upgradation of these clinics by providing them with state of art diagnostic tools, techniques and

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			other equipment so that they become hub centres for detecting and diagnosing cases of HIV/AIDS. In view of the direct link between STD and AIDS, the Committee are of the view that there should be greater synergy between NACO and State Medical Departments in combating HIV/AIDS.
27.	221	M/o Health and Family Welfare	As mentioned earlier in the Report, the tenure and level of diffusion of the HIV/AIDS in India indicate that we are accelerating towards a dangerous inflex point. Growing exponentially, HIV/AIDS is different from every other major infectious diseases where new cases grow or decline slowly. In the absence of a vaccine or a cure, prevention is the most effective strategy to control HIV/AIDS. Since majority of population in India is still uninfected, it becomes essential to not only raise awareness levels but also bring about behavioural changes through Information, Education and Communication (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. According to the Baseline Surveillance Survey, 2001, 76 per cent of the respondents surveyed at the National level were aware of HIV/AIDS. The percentage ranged between 40 and 98 in the 22 States surveyed by ORG-Centre for Social Research. While 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. As regards awareness of transmission of HIV/AIDS through sexual contact, the survey

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			revealed that 71 per cent of the respondents at the National level were aware of the mode of transmission. The level of awareness was 85 per cent in urban areas and in rural areas it was 67 per cent. The survey further revealed that only 47 per cent among the general population, 66 per cent among the Commercial Sex Workers and only 68 per cent clients of female sex workers were aware of the methods of prevention of HIV/AIDS. A sizeable proportion of the general population in almost all States harbours many misconceptions about the spread of HIV.
28.	222	M/o Health and Family Welfare	The Committee are inclined to conclude that there is an urgent need to launch vigorous mass campaign at National level by involving State Governments, NGOs, VOs, Panchayats and other local bodies to raise the awareness level among the masses in general and rural in particular. NACO in cooperation with various cultural groups/organizations, NGOs, VOs etc. should therefore, formulate programmes for rural masses, such as songs, street shows, stage plays, puppet shows, film shows, photo-exhibitions, group discussions and sensitisation workshops to raise the awareness level among the people regarding prevention of HIV/AIDS etc.
29.	223	-do-	Another disquieting feature is the revelation by second round of Behavioural Surveillance Survey — Rural, (February – June 2002) conducted by Dalal Consultant and Engineers Ltd. which 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 had actually been trained in handling HIV/AIDS cases. The survey also revealed that 32 per cent among the masses knew that persons suffering from STD have a higher chance of contracting HIV/AIDS. The level of knowledge about linkages between STD and HIV across the country was also very low *i.e* 21 per cent.

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			In addition to creating general awareness among the masses about the prevention of HIV/AIDS, the Committee feel that it is essential to sensitise the doctor, nurses, laboratory, technicians, counsellors and para medical staff and public that HIV/AIDS is not a contiguous/communicable disease and HIV patients deserve more sympathetic and humane treatment by one and all.
30.	224	M/o Health and Family Welfare	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, 17 States and UTs had implemented a programme on HIV/AIDS education in schools. Since the programme was not implemented in a uniform and systematic manner and did not cover all the schools in the States/UTs, a National Plan was stated to have been developed which aimed at integrating HIV/AIDS education programmes in the schools in a suitable and cost effective manner. NACB decided in July, 1999 that all the schools in States/Union Territories would be covered in a phased manner in a period of five years *i.e.* by 2004. However, 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 Maharastra and put the number in the range of 2000-3000. In Uttar Pradesh and Punjab not a single school had been covered. 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). The Committee have been given to understand that the variation in implementations of the Schools AIDS Education Programme in States are largely due to varying levels of commitment to the programme; degree of collaboration with the Department of Education; and available resources

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			and capacity. The Committee express their serious concern over the tardy implementation of the Schools AIDS programme and calls for a thorough review/revamp especially in view of reports that 50 per cent new cases of HIV/AIDS are found in the age group of 15 to 24. Though HIV/AIDS is now a part of National curriculum frame-work, only Southern States *viz.,* Andhra Pradesh, Tamil Nadu, Kerala and in Northern States only Himachal Pradesh have so far integrated HIV/AIDS in the School curriculum through SCERT. The Committee expect that the remaining States would complete the process of integration of HIV/AIDS in their School curriculum expeditiously so that the students would be able to decide about the difference between wrong information and correct information about HIV/AIDS. Syllabus on HIV/AIDS should be carefully drawn keeping in view the sensitivity of the problem. Since several studies have shown that students who were made aware of sexually related issues are far more circumspect and cautious in their behaviour, it is therefore, highly desirable that School AIDS Programme should be carried out uniformly and effectively throughout the country. The Committee would also like NACO to evolve a suitable programme to educate youth on HIV/AIDS through non-formal education. To achieve this desired objective the Ministry of Human Resource Development and respective State Governments should be closely involved at all levels.
31.	225	M/o Health and Family Welfare	With a view to raise the awareness level regarding HIV/AIDS in rural and slum areas and other vulnerable groups and to make people aware of the service available under the public sector for management of Reproductive Tract Infection (RTI)/STD and to facilitate early detection/treatment of RTI/STD cases by utilising the infrastructure available under primary health care system, five rounds of Family Health Awareness Campaign (FHAC) are stated to have been conducted across the country during the period April 1999 to March 2003 for which Rs.109.41 crore

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			was released. Since FHACs held between May 1999 to February 2002 failed to attract not even 20 per cent of the targeted population, it is therefore, obvious that FHAC have failed to achieve the desired objective. The Committee feel that benefits of any programme/scheme even if well conceived does not accrue to the beneficiaries if such scheme are not properly planned and effectively implemented. It is therefore, essential that implementation of the scheme are given the requisite attention.
32.	226	M/o Health and Family Welfare	With the objective of tracking the geographical spread of HIV infection in the country and providing referral services for its diagnosis during the initial phase of the programme, Government had established 62 Sero-Surveillance Centres and nine referral centres. These centres were advised to function as Voluntary Counselling and Testing Centres (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 as VCTC. 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) had been established in various States/UTs, which are located in Medical College Hospitals and District Hospitals, as against the sanction of 600 VCTCs for the financial Year 2002-2003. The Committee note that though the districts providing VCTC facility were 85 per cent in high prevalence States, in moderate and low prevalence States, 52 per cent of districts still remain uncovered. Audit scrutiny of record revealed that a number of Counselling and Testing Centres were either non-functional or not fully functional due to non-appointment of Counsellors, laboratory technicians, non-supply of equipments and kits and non-availability of trained personnel. The Committee are concerned to note though NACO had nearly achieved the targets set for

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			establishing VCTCs, but the scheme remained non-starter due to poor functioning of VCTCs. They, therefore, recommend that NACO should ensure that all the existing VCTCs are made fully functional at the earliest by providing adequate number of trained technical manpower, latest equipments and medical kits etc. The Committee further note that though the overall percentage of people who were imparted pre-test counselling had shown an increasing trend, the percentage remained low *i.e.* in the range of 6 to 30 per cent in some Societies. The Committee desire that NACO should instruct all State AIDS Control Societies to offer pre-test counselling to all persons before they are tested for HIV as this would ensure that the affected persons gain confidence for living a normal life without believing in myths and misinformation about HIV/AIDS. The Committee are also of the opinion that the testing of HIV should shift from `voluntary' to `routine' which means regular HIV test for every person accessing the health care system.
33.	227	M/o Health and Family Welfare	The Committee note that as against 3.80 lakh health care 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. The Committee cannot but over emphasize the need for proper training of supporting and ancillary staff for the effective implementation of the HIV/AIDS control programme. NACO should therefore formulate a comprehensive programme for imparting training to all healthcare workers, Counsellers and volunteers of HIV/AIDS in every district of the country and undertake it in a time-bound manner.

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34.	228	M/o Health and Family Welfare	The Committee note that 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 modernized by NACO till March 2003. It was observed that out of the 125 blood banks modernized by NACO, as of March 2003 in Phase-II, 75 blood banks were yet to be licensed. The details of districts remaining uncovered as of March 2003 were not available with NACO. While 84 districts did not have modernized blood banks, 44 districts did not have even blood banking facilities. The Committee regret to observe that despite NACO's financial assistance to all the State AIDS Control Societies, the objective of establishing atleast one modernized blood bank in each district by 2002 remained unachieved. What is more disturbing is the revelation by NACO that many of the blood banks modernised by them in Phase II were yet to be licensed, while licenses of some of the Blood Banks modernized in Phase-I might have been withdrawn/cancelled due to non-adherence to the laid down conditions. It is incomprehensible as to how NACO had modernized and continued to provide financial assistance to those blood banks which were either not been licensed or whose licence had been withdrawn/cancelled by Drug Controller of India. Similarly, in 17 cases, there were variations between the figures supplied by NACO, and the State AIDS Control Societies in respect of blood banks modernised. Audit scrutiny of records of SACS further revealed that several blood banks were not functional/fully functional due to various reasons such as non-supply of equipment, idling of equipment due to non-receipt of licence for want of repair and non-renewal of licences etc. The Committee are distressed over the sorry state of affairs prevailing in the country with regard to setting up of blood banks, their licencing and modernization etc. Since there is a strong corelation between HIV and blood transfusion, it is of paramount importance that all the blood banks of the country are modernized and duly licenced so that they provide safe blood devoid of any possible HIV/AIDS virus etc. The

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			Committee recommend that Ministry of Health & Family Welfare should set up a High Level Committee to go into the entire gamut of functioning of blood banks in the country and suggest measures for their modernization and proper functioning so that they are geared up to meet the challenges posed by AIDS. The Committee further recommend that Ministry of Health and Family Welfare should take serious cognizance of cases in which NACO had given financial assistance to blood banks which were either not licenced or whose licence had been cancelled and punitive action should be taken against those found guilty. NACO should also ensure adequate supply of diagnostic tools and test kits in all blood banks to enable them to function smoothly. Private blood banks should be subjected to stringent quality control checks by the agencies authorised by Government and stringent punitive action be taken against the blood banks which are functioning without proper license.
35.	229	M/o Health and Family Welfare	The Committee are informed that during March 2000, NACO initiated a feasibility study on prevention of mother to child transmission in 11 institutions located in 5 high prevalence States of the country. The short course regimen of Azidothymidine (AZT) antiretroviral drug was used in this feasibility study. The second phase of this feasibility study was started in October 2001 using a single dose of Nevirapine to both mother and child to prevent mother to child transmission. The actual implementation of PPTCT of HIV was to be completed by April and July, 2002 in Medical Colleges and District Hospitals respectively in high prevalence States and by September 2002 in Medical Colleges in low prevalence States. The Committee note that training had been completed and service delivery started in 74 out of 82 Medical Colleges of high prevalence States. However, training had not been completed in 24 per cent district hospitals and service delivery started in only 11 per cent district

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			hospitals in high prevalence States. The scheme is yet to be implemented in medical colleges of low prevalence States. While expressing their concern over the poor implementation of PPTCT component the Committee desire that the same should be revamped/reviewed by NACO so as to make it more effective and target oriented. The scheme should be broad based so as to cover all the District hospitals and Medical colleges in the country. The Committee would also like the Government to shed its complacency in implementation of various schemes in low HIV/AIDS prevalent States and direct NACO to take these States seriously with a view to avoiding the spread of HIV infection in the country.
36.	230	M/o Health and Family Welfare	In December 2002, the Ministry of Health announced a policy whereunder blood donors found to be HIV positive would be told of their infection and will be asked to seek confirmation test and counselling. However, to their utter dismay the Committee found that NACO continues to follow its existing policy of giving results only to those who ask for it. The Committee are of the firm view that non-disclosure of HIV status mandatory to all HIV infected persons could lead to a situation where such persons would be unknowingly spreading the disease to uninfected persons. Since HIV virus can remain asymptomatic for three to twelve years till it reaches the final stage of AIDS, the directive of the Ministry would enable the person to get proper treatment at the right time. The Committee recommend that NACO should immediately comply with the above directive of the Ministry of Health and Family Welfare and accordingly issue necessary instructions to all SACS, District Hospitals, STD clinics in this regard for strict compliance. NACO should also intensify efforts to detect the HIV infection during 'window period' — time gap between contracting of infection and becoming seropositive, so that it would enable early detection of HIV/AIDS virus and help the persons take necessary preventive steps to mitigate the disease.

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37.	231	M/o Health and Family Welfare	As a part of Low cost AIDS care activities, National AIDS Control Board (NACB) in August 1999 approved setting up community care centers for People Living with HIV/AIDS (PLWHA) in those areas where HIV/AIDS infection was comparatively high. As of March 2003, NACO had established 37 community centers in various parts of high and low prevalence States. Audit observed that there was a shortfall in establishment of Community Care Centres in high prevalence States which ranged between 17 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, Madhya Pradesh with 972, Uttar Pradesh with 845 and Chandigarh, Punjab and Haryana together with 1186 reported AIDS cases did not have a single Community Care Centre. Further, 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. Currently, 54 Community Care Centres are being run across the country with the help of NGOs and are funded through State AIDS Control Societies. The Committee recommend that with a view to have better care and support to persons living with HIV/AIDS, NACO should set up more Community Care Centres, on top priority basis, in all highly infected areas since prevention and care are the keys to limiting the spread of HIV/AIDS. The Committee are also of the view that the Government should enlist the support of Corporate bodies, NGOs, VOs, Community based Organizations and Civil Society at large in setting up more Community Care Centres.
38.	232	-do-	With a view to providing care and support to those infected by HIV/AIDS, establishment of Drop-in-Centres in all the States was envisaged in NACP-II. In December, 2001 National AIDS Control Board

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			(NACB) approved setting up of 10 Drop-in-Centres in every State to be run by registered associations and networks of PLWHA. However, against this approval, NACO had set up 3 Drop-in-Centres in Maharashtra, 1 in Karnataka and 5 in Tamil Nadu. Evaluation of performance of these Centres had not been conducted as of March, 2003. The Committee express their unhappiness over the slow pace in setting up these Centres and recommend that NACO should hasten up the process of establishing adequate number of Drop-in-Centres in all the States/Union Territories before completion of NACP-II.
39.	233	M/o Health and Family Welfare	Since Commercial Sex Workers are the most vulnerable and high risk group that is prone to high exposure to HIV/AIDS, their rescue and rehabilitation assume vital importance in control of HIV/AIDS. It is, therefore, imperative that an alternative avocation is provided to the rescued Commercial Sex Workers which is suitable to them. Unless this is done, there is every possibility that their economic condition would rather force them to go back to their earlier profession and consequent exposure to HIV. The Committee, therefore, recommend that NACO should devise an appropriate Relief and Rehabilitation programme for all rescued Commercial Sex Workers in built into National AIDS Control Programme, so that the risk of spreading HIV/AIDS could be minimized to that extent possible.
40.	234	-do-	A host of Opportunistic Infections (OIs) such as Tuberculosis, Candidiasis and Diarrhoea can easily afflict/affect the person with full-blown AIDS. Most of these infections are curable, if effective therapy is initiated promptly. NACO under NACP-II provides drugs for treating common opportunistic infections at district hospitals through State AIDS Control Societies. However, the Committee are concerned to note that out of total allocation of Rs. 18 crore by NACO for procurement of OIs drugs during 1999-2003, Societies had utilized only Rs. 5.90 crore (33 per cent). This is substantiated by the fact

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			that some of the SACS such as Jammu and Kashmir, Goa, Meghalaya, Uttaranchal, Jharkhand, Lakshadweep and Chhattisgarh had not spent any amount on procurement of these drugs. The Committee deprecate the negligent attitude of SACS towards such an important component of the programme, where human lives are at stake, and recommend that NACO should strictly ensure that all the essential drugs are available in all the district level hospitals in adequate quantity and distributed freely to the infected persons, without any difficulty.
41.	235	M/o Health and Family Welfare	The Committee note that at present research and development activities in the field of vaccine development for HIV/AIDS are very limited in the country. With a view to attract and encourage more and more pharmaceutical/Drugs/ Biotech companies to undertake Research & Development activities for development of new vaccine and life saving drugs for control of HIV/AIDS, Government should provide necessary infrastructural facilities, fiscal and other incentives to Indian Companies/Research Institutes to enable them to carry out research work either collectively among themselves or by entering into collaboration with their counterparts in developed and developing countries.
42.	236	-do-	The Committee note that in the current scenario where prices of Anti-Retroviral Therapy drugs are quite exorbitant and beyond the reach of common man, there is an urgent need to develop an alternative drug which is cost effective through Indian systems of medicine like Ayurveda, Unani and Siddha apart from Homoeopathy. The Committee, therefore, recommend that Ministry of Health & Family Welfare should sponsor a special Research and Development (R&D) Project for developing an indigenous drug through all branches of Indian System of Medicine (ISM) and Homoeopathy which is not only cheaper but also can act as an effective substitute for Anti-Retrovirals Therapy, if not a total cure from the infection. The Committee also recommend that

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			the Government should be vigilant against unscrupulous persons claiming to have invented a cure for HIV/AIDS through magic herbs. The Committee are of the view that if need be the Drugs and Magic Remedies Act should be suitably amended so as to provide stringent punishment to unscrupulous persons taking advantage of the misery of HIV-infected persons and defrauding them of huge sums of money. A mass awareness campaign should also be launched by the Government to make people aware of the dangers of usage of such medication by unqualified persons indulging in quackery.
43.	237	M/o Health and Family Welfare	The Committee are of the opinion that the research and development work that is being carried out in India and rest of the World should have a common meeting ground/platform so that Research findings can be shared and corelated with each other with a view to arrive at a possible solution to combat this dreaded disease which is threatening the very existence of the mankind. The Committee therefore, recommend that the Ministry of Health and Family Welfare should establish a Research agency in this regard to monitor the research work that is being carried in India and all over the world with a view to developing vaccines and cheap life saving drugs for control of HIV/AIDS.
44.	238	-do-	For effective implementation of the NACP, NACO had sanctioned posts under various cadres/categories in all State AIDS Control Societies. However, the Committee observed that 50 per cent staff including a number of key posts such as JD/DD (Surveillance), DD(STD), AD(Care), Monitoring and Evaluation Officer in 10 State AIDS Control Societies have not been filled up thereby adversely affecting the programme implementation. The Committee, recommend that NACO should take immediate necessary steps to fill up all the posts lying vacant in different categories more particularly the posts of Monitoring and Evaluation Officers, at the earliest.

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45.	239	M/o Health and Family Welfare	The Committee note that NACO had appointed 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. Audit scrutiny revealed that 155 out of 299 water baths, 177 out of 250 hot air ovens, 93 out of 100 incubation and 53 out of 100 distilled water equipments 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 the National Thermal Power Corporation (NTPC) Ltd., it was noticed that equipments worth Rs. 60. 87 lakh purchased by NACO during Phase-II were lying uninstalled. The Committee express their serious concern over the infructuous expenditure due to non installation of various kinds of equipment resulting in loss to the National/State exchequers and recommend that Ministry of Health and Family Welfare should conduct a thorough investigation into the matter with a view to fix accountability on the officials found guilty. The Committee also recommend that in future the requisite equipments should be properly estimated, timely ordered and installed so as to avoid infructuous expenditure and financial loss to the exchequer. Suitable lessons should be taken from the instant case.
46.	240	-do-	The Committee note that for effective monitoring and evaluation of the programme, each State/ Municipal AIDS Control Society was required to appoint a Monitoring and Evaluation Officer. However, it had been noticed by Audit that 17 (45 per cent) out of 35 Societies had no Monitoring and Evaluation Officer. NACO stated that Societies where there are no Monitoring and Evaluation Officer, the Joint Director-in-charge of Surveillance along with Statistical Assistant perform the monitoring and evaluation functions. The Committee express their serious concern over

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			non-appointment of M&E Officers by several Societies. They are of the view that since monitoring and evaluation is an important and continuous activity involving periodical appraisal of the progress made in achievement of the targets laid down under various components of the programme, any adhocism with respect to such an important activity would have an adverse impact on the functioning of the programme. The Committee, therefore, recommend that NACO should advise all the Societies to appoint Monitoring and Evaluation Officer without any further delay.
47.	241	M/o Health and Family Welfare	A contract for consultancy services was signed in November 2000 by NACO and ORG Centre for Social Research to design and develop a Computerised 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. Though 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 made operational in all the Societies only by August, 2003. The Committee are informed that although CMIS had been made operational in all 38 Societies, monitoring of the programme was not effective as receipt of reports from the societies was poor. Reports from all the societies had never been received during November 2001 to April 2003. Further, evaluation of information generated from CMIS had not been conducted so far. The Committee cannot but deprecate the indifference and lackadaisical approach adopted by various SACS in submitting Reports to CMIS as a result of which the various objectives laid down under CMIS remain unfulfilled. The Committee recommend that NACO should instruct all SACS to submit their Reports periodically to CMIS so that the information furnished by them can be analysed. The Committee also recommend

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			that NACO should take stringent punitive action against those SACS which do not submit their Reports in time.
48.	242	M/o Health and Family Welfare	A National Performance Review was to be carried out by National AIDS Control Board (NACB) in accordance with terms of reference satisfactorily to IDA. However, the Committee regret to note that no review of NACP had been carried out by NACB during the period 1998-99 to 2002-2003. NACO stated that there did not seem to be a need for a separate National Performance Review/ Performance and Expenditure Annual Report (PEAR) since performance of all Societies was reviewed during Project Directors meetings and at the time of finalisation of Annual Action Plans. The Committee consider the reply of NACO as untenable since a National Performance Review was required to be conducted in accordance with the terms of reference satisfactory to the IDA has been prescribed in the scheme of prevention and control of HIV/AIDS. The Ministry of Health & Family Welfare had subsequently informed the Committee that since its inception in 1992, NACB had met on 24 occasions till date and had discussed different facets of the programme specially major policy issues such as approval of annual action plans of implementing agencies, introduction of Anti-Retroviral Therapy (ART), social marketing of condoms, family health awareness campaigns and implementation of National Blood Policy, etc. The Committee recommend that the Ministry of Health & Family Welfare may examine the feasibility of conducting a National Performance Review so as to assess the functioning of NACP-I&II and the deficiencies/ shortcomings that may come to their notice should be taken into cognisance while conceiving NACP-III.
49.	243	-do-	The Committee note that the National AIDS Committee (NAC) acts as the high level deliberative body to oversee the performance of NACO and provide overall policy direction and to forge multi-sectoral collaborative efforts and

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			enable the participating organizations to mobilize their overall administrative network for the various intervention projects. The National AIDS Committee is required to meet as often as possible but at least once in a year. The Committee are dismayed to note that NAC had not met since 2001 and no meeting had been held during the last three years. The Ministry of Health & Family Welfare could not furnish any plausible reasons for not holding any meeting by NAC during the past few years. They further note that there had been an inordinate delay on the part of the Ministry in submission of proposal for convening the meeting, which is inexplicable. Given the alarming situation in the country posed due to emergence of AIDS as a major killer disease on account of rapid spread of HIV virus, the response of NAC to the problem to say least is very casual and negligent. Failure of National AIDS Committee to meet even once during the past few years expose the hollowness in the claim made by the Government that it is making serious efforts to combat the dreaded disease. The Committee expect that in future, NAC would meet as frequently as they could and atleast once in six months to review the overall implementations of the programme and progress made under various components of the NACP.
50.	244	M/o Health and Family Welfare	The Committee are of the considered view that since HIV/AIDS is a multi-dimensional problems affecting socio-economic development of the country, impinging on various economic and social sectors of Governmental and Non-Governmental activity, the fight against it should be multi-pronged and multi-disciplinary in approach. The control of HIV/AIDS had been taken up exclusively as a Centrally Sponsored Scheme *i.e.* through NACP I & II and the role of State Government appears to be rather peripheral in the implementation of NACP. Keeping in view the magnitude of the problem posed by HIV/AIDS, the fight against this dreaded disease has to be multi-pronged for which Governments at all

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			levels — National, State and local-need be involved. The Committee also note that disparities exist among different States with regard to their fight against AIDS while States which have been categorized as high prevalent States *viz.* Andhra Pradesh, Tamil Nadu, Maharashtra etc. have taken up the battle against AIDS seriously, rest of the States which fall either under the category of moderate or low prevalence have been complacent. The Committee, therefore, recommend that in order to make the fight against HIV/AIDS, a truly mass movement of National level, Government of India should actively indulge Governments at all levels *viz.* State Governments and local bodies such as Panchayats, Municipalities etc. irrespective of the degree of prevalence of HIV/AIDS should be initiated. Since the prevalence of AIDS varies from State to State and given the socio-cultural differences, that exist among different States, each State should be given freedom to devise and formulate their own HIV/AIDS Control Programmes in keeping with the broad National objectives.
51.	245	M/o Health and Family Welfare	The Committee understand that a number of steps have been taken by the State of Tamil Nadu in fighting the dreaded disease of HIV/AIDS which have yielded encouraging results. As a result of sustained effort of Tamil Nadu State AIDS Control Society in cooperation and coordination with AIDS Prevention and Control Project, the State made significant achievements in AIDS prevention and care. Some of the key features of the success story of Tamil Nadu are behavioural changes such as increase condom use, reducing the vulnerability of people to the risk of infection and effort to offer affordable ARV treatment to people living with HIV/AIDS etc. The USAID funded AIDS Prevention and Project in Tamil Nadu launched in 1995, has been another success story acclaimed for its effective Targetted Interventions approach and research and survey activities like the Annual Behavioural Sentinel Surveillance surveys and the survey to estimate the community

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			prevalence of HIV/AIDS. While appreciating the measures taken by the Tamil Nadu Government, the Committee are of the firm opinion that Ministry of Health and Family Welfare should study them in detail so as to circulate to all the States and impress upon them to replicate the efforts of the Tamil Nadu Government which would eventually help to contain and combat the spread of HIV/ AIDS to a large extent.
52.	246	M/o Health and Family Welfare	The Committee are of the considered view that the problem of AIDS, is fast assuming an epidemic proportion in North Eastern Region and is qualitatively different from other parts of the country especially that of high prevalence States such as Tamil Nadu, Andhra Pradesh, Maharashtra and Karnataka. The spread of HIV/AIDS in this particular region is largely on account of Intravenous Drug Use (IDU) where over 25 to 30 per cent of the youth population are reported to be HIV positive. The Committee feel that in view of the international dimension to the problem of AIDS in this region on account of illicit drug trafficking from across the borders from Laos, Myanmar and Thailand making youth of this region susceptible to drug addiction, there is an urgent need for having a separate dispensation to control and combat HIV/AIDS in the North Eastern region. They, therefore, recommend that with a view to giving special focus to this region the Ministry of Health and Family Welfare may examine the feasibility of setting up a separate body/agency exclusively for North-Eastern States to oversee the implementation and monitoring of special programmes for HIV/AIDS control.
53.	247	-do-	An analysis of the performance of various components of the National AIDS Control Programme — both Phase I & Phase II revealed that the programme had achieved limited success due to various reasons such as failure in generating sufficient awareness among the masses; under-utilisation of funds; non-reconciliation of accounts; absence of adequate

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			infrastructure facilities; lack of adequate quantity of drugs and trained manpower; non-completion of mapping exercise for identification of Target Groups; ineffective Targeted Interventions Programme; failure of NACO to procure and distribute enough condoms, inadequate number of STD Clinics, modernized blood banks and voluntary counseling and testing centres in every district of the country etc.; and non-assessment of the impact of various components of the programme due to failure of the National AIDS Committee to meet after 2001. Keeping in view the above factors, the Committee, recommend that NACO should immediately get the NACP- I & II evaluated by an independent agency so as to assess the constraints/bottlenecks and other problems in implementation of the programme and to suggest measures for effective implementation of all the components of the programme.

PART—II

MINUTES OF THE FOURTEENTH SITTING OF PUBLIC ACCOUNTS COMMITTEE (2004-2005) HELD ON 8TH FEBRUARY, 2005

The Committee sat from 1100 hrs. to 1230 hrs. on 8th February, 2005 in Room No.53, Parliament House, New Delhi.

PRESENT

Prof. Vijay Kumar Malhotra — *Chairman*

MEMBERS

Lok Sabha

2. Dr. M. Jagannath
3. Shri Madan Lal Sharma
4. Shri Brij Bhushan Sharan Singh
5. Shri Tarit Baran Topdar

Rajya Sabha

6. Shri R.K Dhawan
7. Dr. K. Malaisamy
8. Shri C. Ramachandraiah
9. Shri Jairam Ramesh

LOK SABHA SECRETARIAT

1. Shri Ashok Sarin — *Director*
2. Shri N.S. Hooda — *Under Secretary*
3. Smt. Anita B. Panda — *Under Secretary*

REPRESENTATIVES OF THE OFFICE OF THE COMPTROLLER AND AUDITOR GENERAL OF INDIA

1. Shri V.N. Kaul — C & AG
2. Ms. Anusua Basu — ADAI (RC)
3. Shri A.K. Thakur — DG(PA)

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE
(DEPARTMENT OF HEALTH)

1. Shri P.K. Hota — Secretary
2. Dr. S.Y. Qurashi — Additional Secretary and Director General
3. Dr. N.S. Dharmashaktu — Additional Project Director

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3. The Chairman, then informed the Members that the sitting has been convened to take oral evidence of the representatives of the Ministry of Health and Family Welfare (Department of Health) on Audit Report No.3 of 2004 relating to the "National AIDS Control Programme".

4. Thereafter, the Officers of the Office of C&AG of India briefed the Committee on the specific points arising out of the Audit Report No. 3 of 2004. The representatives of the Ministry of Health & Family Welfare (Department of Health) were called and the Committee commenced the oral evidence.

5. At the outset, the Secretary, Ministry of Health & Family Welfare (Department of Health) and DG, NACO explained the salient points of the Phase-I and Phase-II of National AIDS Control Programme and also gave a brief audio-visual presentation on the subject. Thereafter, the Members, sought certain clarification on the subject which was explained by the witnesses. The evidence on the subject was not completed and the Committee decided to continue it on 9th February, 2005.

6. A copy of the verbatim proceedings of the sitting has been kept on record.

The Committee then adjourned.

MINUTES OF THE FIFTEENTH SITTING OF PUBLIC ACCOUNTS COMMITTEE (2004-2005) HELD ON 9TH FEBRUARY, 2005

The Committee sat from 1100 hrs. to 1215 hrs. on 9th February, 2005 in Room No.53, Parliament House, New Delhi.

PRESENT

Prof. Vijay Kumar Malhotra — *Chairman*

MEMBERS

Lok Sabha

2. Shri Madan Lal Sharma
3. Shri Brij Bhushan Sharan Singh

Rajya Sabha

4. Shri R.K Dhawan
5. Dr. K. Malaisamy
6. Shri Jairam Ramesh
7. Prof. R.B.S. Varma

LOK SABHA SECRETARIAT

1. Shri S.K. Sharma — *Additional Secretary*
2. Shri Ashok Sarin — *Director*
3. Shri N.S. Hooda — *Under Secretary*
4. Smt. Anita B. Panda — *Under Secretary*

REPRESENTATIVES OF THE OFFICE OF THE COMPTROLLER AND AUDITOR GENERAL OF INDIA

1. Shri V.N. Kaul — C & AG
2. Ms. Anusua Basu — ADAI (RC)
3. Shri A.K. Thakur — DG(PA)

REPRESENTATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE (DEPARTMENT OF HEALTH)

1. Shri P.K. Hota — Secretary
2. Dr. S.Y. Qurashi — Additional Secretary and Director General
3. Dr. N.S. Dharmashaktu — Additional Project Director

2. To begin with, the Chairman welcomed the Members of the Committee, the representatives of the Ministry of Health and Family Welfare (Department of Health) and the Officials of C&AG to the sitting of the Committee.

3. As the evidence on the subject had remained inconclusive on 8th February, 2005, the Committee resumed oral evidence of the representatives of the Ministry of Health and Family Welfare (Department of Health) on Audit Report No.3 of 2004, Union Government (Civil — Performance Appraisals) on the "National AIDS Control Programme". The Secretary and other representatives of the Ministry explained various points and queries raised by the Members. After some discussion, Hon'ble Chairman directed the Ministry of Health and Family Welfare (Department of Health) to furnish written information on all points relating to the subject, which were raised by the Members of the Committee during the evidence, at the earliest.

4. A copy of the verbatim proceedings of the sitting has been kept on record.

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The Committee then adjourned.

MINUTES OF THE THIRTEENTH SITTING OF PUBLIC ACCOUNTS COMMITTEE (2005-2006) HELD ON 14th NOVEMBER, 2005

The Committee sat from 1600 hrs. to 1630 hrs. on 14th November, 2005 in Committee Room 'C', Parliament House Annexe, New Delhi.

PRESENT

Prof. Vijay Kumar Malhotra — *Chairman*

MEMBERS

Lok Sabha

2. Shri Khagen Das
3. Dr. M. Jagannath
4. Shri Tarit Baran Topdar

Rajya Sabha

5. Shri R.K Dhawan
6. Dr. K. Malaisamy
7. Shri V. Narayanasamy
8. Shri C. Ramachandraiah
9. Shri Jairam Ramesh
10. Prof. R.B.S. Varma

LOK SABHA SECRETARIAT

1. Shri S.K. Sharma — *Additional Secretary*
2. Shri Ashok Sarin — *Director*
3. Smt. Anita B. Panda — *Under Secretary*
4. Shri M.K. Madhusudhan — *Under Secretary*

REPRESENTATIVES OF THE OFFICE OF THE COMPTROLLER AND AUDITOR GENERAL OF INDIA

1. Shri U. Bhattacharya — ADAI (RC)
2. Dr. A.K. Banerjee — DG of Audit
3. Shri Roy Mathrani — Pr. Director (AB)
4. Shri R.K. Ghose — AG (Audit), Delhi

REPRESENTATIVES OF THE MINISTRY OF URBAN DEVELOPMENT

1.	Shri Anil Baijal	—	Secretary
2.	Shri P.K. Pradhan	—	Joint Secretary
3.	Smt. Neena Garg	—	Joint Secretary & Financial Adviser

REPRESENTATIVES OF DELHI DEVELOPMENT AUTHORITY

1.	Shri A.K. Patnaik	—	Finance Member
2.	Shri V.K. Sadhoo	—	Pr. Commissioner

REPRESENTATIVES OF DEPARTMENT OF EDUCATION, GOVERNMENT OF NCT OF DELHI

1.	Ms. Reena Ray	—	Secretary (Edu.)
2.	Shri Vijay Kumar	—	Director (Edu.)

2. At the outset, the Chairman, PAC welcomed the Members and Audit Officers to the sitting of the Committee.

3. The Committee observed silence for a minute in memory of Shri K.R. Narayanan, former President of India as a mark of respect to the departed soul.

4. Thereafter, the Committee took up for consideration the following Draft Reports :

(i) xxx xxx xxx

(ii) C&AG's Report No.3 of 2004 relating to "National AIDS Control Programme".

(iii) xxx xxx xxx

(iv) xxx xxx xxx

(v) xxx xxx xxx

5. Barring Report on "National AIDS Control Programme", the Committee adopted all the Draft Reports without any changes. As regards, Draft Report on "National AIDS Control Programme", the Committee after some deliberation adopted the same subject to some minor additions. The Committee, then authorised the Chairman to finalise these Draft Reports in the light of changes suggested by Audit through factual verification, if any, or otherwise and to present the same to Parliament.

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9. A copy of the verbatim proceedings of the sitting has been kept on record.

The Committee then adjourned.

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