
National AIDS Control Program, India: Institutional Assessment

Submitted to Planning Team, NACP: Phase-III,

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-IHS Study Team

Glossary

ANC	Antenatal Clinics
ART	Anti- Retroviral Treatment
BB	Blood Bank
BSC	Blood Storage Center
CSO	Civil Society Organization
DG	Director General
DHFW	Department of Health and Family Welfare
DHS	Directorate of Health Services
DMHO	District Medical and Health Officer
DNO	District Nodal Officer
DP	Development Partner
DTO	District Tuberculosis Officer
EQAS	External Quality Assessment Scheme
FHAC	Family Health Awareness Campaign
GIPA	Greater Involvement of People Living with HIV/AIDS
IFD	Internal Finance Division
INP+	Indian Network of People Living With HIV
JD	Joint Director
JWG	Joint Working Group
MOHFW	Ministry of Health and Family Welfare
NACO	National AIS Control Organization
NACP	National AIDS Control Programme
NGO	Non Governmental Organization
NRHM	National Rural Health Mission
OI	Opportunistic Infections
PEP	Post Exposure Prophylaxis
PLHA	People Living With HIV/AIDS
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayati Raj Institutions
PSU	Project Support Unit
RAC	Research Advisory Committee
RCH	Reproductive and Child Health
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SAEP	School AIDS Education Programme
STI	Sexually Transmitted Infection
STO	State Tuberculosis Officer
TI	Targetted Intervention
TRG	Technical Resource Group
VCTC	Voluntary Counseling and Testing Center

Executive Summary

Background

1. The National AIDS Control Program (NACP) was launched in 1989 and the National AIDS Control Organization (NACO) was formed as division within the Ministry of Health and Family Welfare (MOHFW). It was subsequently expanded through two National AIDS Control Projects: NACP-I and NACP-II. The third, NACP-III, is due to start in 2006.
2. This study was commissioned by the National AIDS Control Project III Planning Team to assess the institutional arrangements of the National AIDS Control Programme at the national, state and district level and to make recommendation for their strengthening, prior to the launch of the third National AIDS Control Project (NACP-III).
3. Key entities of NACP was analyzed in terms of (1) institutional structure, which captures organizational resources, design, and components; (2) institutional functioning, which captures organizational systems, policies, and procedures, and impact as defined by program/service delivery; and (3) institutional culture, which captures additional elements, such as organizational values, political will, and leadership style.
4. The assessment and recommendations are based on the perusal of documents, discussion with concerned persons and visits to four states and one district in each of them. Separate studies have been commissioned as part of NACP-III Planning on financial management, monitoring and evaluation, procurement and donor coordination. While these areas are covered in the institutional analysis, the study does not make recommendations on specific systems and procedures relating to these areas, leaving such gaps to be filled by the aforesaid studies.

Key Drivers for Reorganization of NACP in Phase-III

5. The study traces the evolution of the NACP and identifies (1) changes in policy framework and institutional arrangements since inception (2) opportunities for improving the reach and quality of the programme and (3) challenges faced by the programme. They constitute the driving forces for redefining the role of various entities involved in the programme and reorganization of institutional arrangements in Phase-III. The key drivers for reorganization include:
 - ◆ Changing epidemiological profile of HIV/AIDS in the country and variable response to the epidemic across States (para 2.19-2.20)
 - ◆ Significant political support at national level and variable political support across states necessitating institutional mechanisms to actively engage with the political leadership for mobilizing and sustaining political support and leveraging such support for facilitating implementation of the programme (para 2.21)
 - ◆ Multiple donors and changing international HIV/AIDS environment that recognizes the need of greater harmonization and alignment of international support through the “three ones’ framework (para 2.22-2.25)

- ◆ Policy environment that unambiguously calls for greater integration of vertical programmes, of which NACP is currently one, with the general health services through the NRHM framework (para 2.26-2.28)
 - ◆ Increasing realization that an expanded, intensified and multisectoral response is required to meet the challenge of HIV (2.29-2.30)
 - ◆ Policy environment and stage of the programme that favours increasing decentralization of service delivery to the state and district level (para 2.31 to 2.34)
 - ◆ Increasing emphasis on good governance and the need to evolve mechanisms to hold multiple partners accountable for their role in the programme (para 2.35-2.39)
 - ◆ Acute shortage of skilled humanpower within the public sector and limited pool of public health humanpower within the country which necessitates alternate mechanisms for accessing requisite skills and building capacity within the country (Para 2.40-2.42)
 - ◆ Commitment to Greater Involvement of People living with HIV/AIDS (Para 2.43)
 - ◆ Need for credible systems to gather evidence for planning and monitoring impact of the programme (Para 2.44-2.45)
6. Analysis of the impact of these driving forces provides direction for redefining roles of key NACP entities around which the institutional arrangements of the programme will be structured. Potential roles of NACO (Table-1), SACS (Table-4) and DACU (para 3.141) and other entities (Table-8) have been so defined.

Institutional Analysis of Key Entities

NACO

7. NACO's strengths include: its location within the MoHFW, its substantial autonomy, its access to public administration and clinical management skills through deputation and availing skills that are not readily available in the public sector through contractual staff. NACO has been able to prepare guidelines and norms for a number of interventions and institutionalize to some extent, mechanisms for decentralization to state level, a system of participatory planning, management information systems to facilitate monitoring progress of the programme at national level, and quarterly review meetings with project Directors of SACS. Further, the composition of its supervisory bodies raises the profile and mission of NACO.
8. NACO has many institutional deficiencies including a poorly delineated divisional structure, lack of clarity in roles, responsibilities and reporting relationships of staff, clubbing of core functions, and lack of adequate support staff which coupled with high staff turnover shortens NACO's institutional memory and results in interminable delays. Decision making process and leadership function within NACO is highly centralized at the level of the Director General, with very little downward delegation of authority. There is lack of dedicated focal points and inadequate systems and procedures for effective discharge of many of the core NACO functions. Consequently, NACO is constantly in a fire-fighting mode dealing with exigencies through adhoc mechanisms usually centralized around top management. Programme implementation is constrained by gaps between the budget proposed by NACO and budget allocated by GOI, lack of timely access of allocated funds and inability to promptly respond to issues that has financial implications.

Of its three supervisory structures (Council, Committee and Board) only the Board comes closer to be a supervisory body than either the Council or the Committee, which are more supportive than supervisory and given its membership, perforce meets infrequently. There is considerable overlap between the stated objectives of the Council and Committee. There is considerable burden on NACO on account of meeting reporting requirements of various donors, which vary in content, frequency and format. The MIS systems work in isolation and are not enabled to receive inputs from a large number of NACO partners. Deputation which is done as a matter of routine rather than based on any consideration of the job profile of the post, often leads to a mismatch between the skills and background of the incumbent and the post to which he/she has been deputed. Further, there is no system to ensure a minimum tenure of the functionaries at NACO. NACO does not have objective criteria for recruiting and remunerating contractual staff. Remuneration which is based more on the funding source rather than qualifications or experience, affects staff morale and organizational cohesiveness. Though NACO has delegated significant functions and resources to SACS and is ultimately responsible for the latter's performance, it has very little control over SACS and mechanisms to ensure accountability of SACS to NACO are lacking.

State AIDS Control Society

9. Strengths of SACS include greater flexibility and autonomy in staffing, financial and administrative matters than traditional departments. The Governing Body of SACS is headed by Chief Minister, Health Minister or Chief Secretary of State, which raises profile of SACS and provides access to the highest levels of government. The PD in large and medium states, is usually an IAS officer. Given their public administration background and their position in government they are well placed to manage SACS and its coordination and collaboration with a variety of agencies within and outside the government. Unlike NACO, contractual staff are given designations (such as Joint Director, Asst. Director etc) akin to that of staff on deputation. This is more reflective of their status as programme managers. Many senior officers at SACS are on deputation from the same health department. Significant part of the SACS interventions is through the district health administration, which is headed by their colleagues. In many instances, SACS officers are able to take advantage of this network for programme implementation at the district level. There is considerable awareness for the need for restructuring and reforming functioning of SACS among its key staff. This awareness sets the ground for systematic change within the organization. Some SACS have been successful in institutionalizing innovative mechanisms for improving programme management.
10. SACS are constrained by lack of distinct divisions, unusually wide span of control of the Project Director, high staff turnover and lack of integration between various units especially that between programme and finance units leading to a lack of coordination, shortened institutional memory and delays in discharge of its functions. Further, lack of financial and administrative delegation to the Project Director in many states compounds the slow pace of implementation and utilization of funds. SACS is constrained by lack of effective focal points and inadequate systems and procedures for effective discharge of many of the core functions. There is significant variation in capacity for programme planning and management among States. Though performance of SACS is linked to that of State health services, mechanisms for coordinating with different levels of the health services and ensuring their performance, is weak and in some cases, non-existent. As in

the case of NACO, the human resources management function suffers from inadequate incentive schemes, lack of output-based performance evaluations, and inadequate personnel training. Deputation which is done as a matter of routine rather than based on any consideration of the job profile of the post, often leads to a mismatch between the skills and background of the incumbent and the post to which he/she has been deputed. Further, there is no system to ensure a minimum tenure of the functionaries at SACS. Pay and benefits drawn by the contractual employees of similar rank are not at par with that of staff on deputation. Such disparities has given rise to some resentment among the contractual staff and accentuates an unsanctioned hierarchy between contract staff and staff on deputation which affects the work environment at SACS. In addition, persons with qualifications as specified by NACO were not willing to take up a job with SACS, as the remuneration fixed by NACO was much lower than the prevailing market rates. Planning is constrained due to uniform costing norms and delays in the process for approval of Annual Action Plans resulting in confusion and uncertainty about continuity and up scaling of activities. SACS release funds to a large number of entities over which it has no control and often face difficulty in obtaining financial reports and utilization reports in order to settle the advances. This result in build up of advances and a possible mismatch between the physical output and financial expenditure and lowers fund released by NACO as these funds would be seen as available with SACS. Further, there is considerable burden on SACS on account of meeting reporting requirements of various donors, which vary in content, frequency and format.

District Level Arrangements

11. Currently the NACP does not have any structure of its own below the State level. The programme is implemented in districts through the institutions of Department of Health, other state departments such as Department of Education and through partnerships with NGOs. The coordination and monitoring of the programme is entrusted to the JD/DMHO of the district who is helped by a designated District Nodal Officer. The DNO is generally the programme officer of other programmes such as TB, Leprosy, Blood Banks etc. Since both the DMHO and DNO is usually busy with their primary responsibilities, the NACP does not have an effective focal point in the district that is able to provide the necessary support nor monitor the performance of the reporting units. Consequently, compliance with reporting requirements is generally weak at the district level. Reporting units in the district raised a number of issues that were constraining the programme (See Annex-10). Key issues include lack of timely disbursement of funds, lack of effective communication, technical support and support for documentation and reporting and inadequate mechanisms for monitoring and feedback. In the present arrangements, local requirements are not adequately reflected in the State plan. Further, there is very little coordination among the reporting units at the district level. PPP initiatives in NACP are constrained by problems of selection; rigid norms for selection and support; inadequate capacity in both the private and public sector, inadequate systems for providing technical support, financing, and programme management; and very limited ownership of the private sector in the NACP. PRIs are not yet equipped to take on planning and monitoring functions as envisaged by the current policy initiatives nor is there a cognizance in the health system of the role of PRIs.

Summary of Recommendations for Phase-III

NACO Structure and Staffing

- 12. Continue NACO as a wing of MoHFW (para 3.41)
- 13. Rationalize Supervisory Structures of NACO (para. 3.42)
- 14. Internal Restructuring to address weaknesses and leverage institutional strengths of NACO. 5 divisions proposed- (1) Health Services (2) Communication and Social Mobilization (3) Administration and Planning (4) Finance (5) Strategic Information Management (SIM). (3.43-3.49). See Para 3.44 for key principles adopted for restructuring
- 15. Core Programme Areas in each division include:

Health Services	Comm &SM	Administration	Finance	SIM
*Blood Safety	*Mass Media	*HRM	* Finance &Accounts	* Surveillance
*Biomedical Waste Management & Infection Control	*Targetted Interventions	*Planning	*Audit	*Monitoring
*Voluntary Counselling and Testing	*Condom Promotion & Social marketing	*Mainstreaming	*CPFMS	*Evaluation
*Care & Support	*Gender, Youth & Children	*Partnerships (Program Support)		*Research Coordination
*STI/RTI/RCH	*GIPA	*Procurement		*Information Systems
*Training	*Advocacy	*Donor Coordination		*Knowledge Management
	*Human Rights			

- 16. It is recommended that there be at least one program manager for each of the core areas identified under each division. Support Staff as per prevailing norms in MOHFW and other departments of the Central Government.
- 17. In accordance with GOI office procedures, NACO should prescribe instructions regarding the level of final disposal and channel of submission for each category of cases, keeping the number of levels at which a case is examined to the minimum by delegating powers to lower formations. These instructions to be maintained in electronic form and reviewed every three years (para3.54)
- 18. NACP-III requires substantial scaling up of managerial and technical capacity within the programme. Key skills that NACP will need to institutionalize have been identified (para 3.55)
- 19. Human resource management of NACO will be a function of the Administrative Division. It will be responsible for undertaking needs assessment, skills inventory, and manpower planning. A key prerequisite is preparation of job profile and required skill profile for all posts in NACO, which has to be approved by the multidisciplinary standing committee on technical support, constituted by NACO. The division will coordinate

recruitment of staff and ensure that vacancies are filled up within specified timelines.
(3.56)

20. The organization structure as proposed does not indicate as to whether a post is to be among the 'Regular' or 'Contractual'. It identifies the posts leaving it to NACO and the government as to whether chose between the two options. The posts of the Director General and Division heads will quite obviously have to be among the Regular Posts.
21. A suitable officer for the post of DG, NACO, be identified through an active and directed search within the IAS cadre. The Board may constitute a search committee for this purpose. The good offices of the Council may be used not only to get the deputation of the identified officer, but also to secure the tenure for three to five years. A similar approach could be adopted for securing deputation of divisional heads
22. For other senior posts, when there is a reasonable chance that suitable personnel are available within government service (including central, state and SACS), such posts may be advertised within the government. Those interested and fitting job profile may be short-listed and selected by a Selection Committee constituted by the Board which in addition to DG NACO and DDG (Admin) will also comprise of at least two subject experts. NACO could then ask for their deputation. The composition of the selection committee for recruitment of senior contractual posts will be similar. It is recommended that recruitment of contractual supporting staff may be done by a committee constituted by DG, NACO and headed by DDG (Admin)
23. Pay scales for different levels of contractual staff need to be fixed as per market rates. It is recommended that personnel of similar rank get similar remuneration irrespective of the source of funding. It is also recommended that recruitment of all contractual staff may be done by NACO based on a clear job profile and specific terms of reference including mechanisms of evaluation of performance
24. NACO institutionalize a transparent mechanism of output based performance evaluation of staff.
25. A deputation allowance of 25% of the basic pay may be given as an incentive to attract people from within the government. Improve the work atmosphere and provide opportunities for growth, such as through structured in-service training, within NACO and outside it, to attract and retain staff.

SACS Structure and Staffing

26. A structure similar to that of NACO is recommended for SACS (para 3.110-3.114)
27. The PD will provide leadership to SACS, direct the planning and implementation of the programme at the State level, and ensure accountability of SACS to its various stakeholders. He/she will be responsible for developing SACS as a learning organization through development of a team culture, ongoing training at all levels, creation of mechanisms to spread knowledge throughout the organization, and empowering employees to make decisions to implement improvement of their areas (para 3.115)
28. The Divisional Managers represent the second line of leadership of SACS. In addition to technical expertise in their functional domains, their skills and role will be more or less

similar to that prescribed for the PD. It is suggested that they will be an Additional Director/Joint Director or of equivalent rank in government (para 3.116)

29. The third tier of SACS will be comprised of Program Managers who will be in the frontline for implementing the programme at the State level. There will be at least one program manager for each intervention. Assistants and Deputies may be assigned to him/her depending on state specific requirements. One program manager may be assigned more than one intervention, if they are complementary in nature. Each Program Manager will be primarily responsible for technical support, planning, monitoring and evaluation, training and ensuring coordination with reporting units for the assigned intervention and building partnerships and collaborations in the specific area handled by them.
30. Some of the functions with regard to an intervention, like training, technical support etc., may be out-sourced through partnerships, tapping into knowledge and expertise of “best in class” institutions, while retaining strategic control. This adds critical skills to the programme and accelerates organizational learning.
31. Given their public administration background, it seems appropriate to continue to entrust the leadership of SACS with an officer from the IAS cadre. However, the primary consideration for selection will be a match between the person and the job requirements. While it is recommended that an officer from the IAS cadre be considered for the post of PD by default, if a suitable person cannot be identified from within the available pool, a senior officer from within the health department may be considered for the post.
32. It is recommended that the PD be recruited to the post through an active and directed search within the State cadre of IAS officers or DHS as the case may be. This should necessarily be a function of the Governing Body, especially since one or more of the major decision makers in the posting of cadre officers, such as the Chief Minister, Health Minister, Chief Secretary, Health Secretary etc., either heads the Governing Body or are its members. The Governing Body may constitute a search committee to shortlist potential candidates for its selection. Their good offices may be used not only to get the deputation but also to secure the tenure for three to five years.
33. It is recommended that divisional managers be sourced from within the government. However, given the difficulty experienced by many SACS in filling up of deputation posts due to unavailability of suitable persons from within the government, SACS may be given the flexibility to fill up these posts from the market. The PD may take the help of the supervisory bodies, in identification and selection of the divisional managers, when personnel with requisite background and skills are available within the government.
34. SACS may source tier-3 programme managers from within the government or outside. When there is a reasonable chance that suitable personnel are available within government service, such posts may be advertised within the government. Those interested and fitting job profile may be short-listed and personnel selected through a selection committee constituted by SACS. Services of the selected persons can then be requisitioned through proper channels.
35. It is recommended that pay and prerequisites of contract staff be at par with that of officers on deputation. Should there be a problem of providing allowances similar to

government staff, the consolidated pay should be adjusted to incorporate all such allowances, including health insurance.

36. It is recommended that NACO consider revising the present guideline, which fixes TA/DA as per state government guidelines. Norms prescribed for the NRHM regarding TA/DA, may be adopted by NACO. Alternatively, the Executive Committee of respective SACS may be authorized to fix these rates as per local requirements.
37. Capacity development of SACS personnel would be an important area, Phase-III would have to urgently address. It may be useful if the status of training of staff was made one of the indicators for assessing SACS performance. It is envisaged that training programmes for SACS officers will be conducted by national/regional institutions identified by NACO as per an annual timetable (See Annex-9).
38. In addition to periodic training there should be an induction training of all key personnel joining SACS, including those from Finance and Administration on components of NACP and their implementation. This is necessary to effect better integration between various units, especially that between programme and finance units.
39. The actual number of staff in a SACS will vary from state to state depending on local priorities and requirements. We are suggesting a minimum staff strength for all SACS, as states generally seek guidance from NACO on their organization structures (Annex-8). States should define additional staff requirements based on programme content.

District Level Arrangements

40. It is recommended that the activities of the NACP-III be further decentralized and managed at the district level through the creation of a District AIDS Control Unit.
41. It is recommended that the District AIDS Control Unit (DACU) be established within the district health administration and brought under the purview of the NRHM. The Unit will be headed by a district programme officer who will be the nodal officer and focal point for all HIV related activities in the district. He/she will be similar to district programme officers of other centrally sponsored programmes in that he/she will be under the administrative control of the DMHO but will also report to SACS. Once the District Health Society Secretariat is operationalized, the district programme officer may be brought under the District Health Secretariat. Eventually (that is, after integration of the posts sponsored under the Centrally Sponsored Schemes with the DHS) as recommended by the GOI, the district programme manager may be posted on deputation to the District Society Secretariat. This will ensure a minimum tenure for district programme managers since all deputation postings will be for a minimum period of 3 years.
42. The DACU will report to the NRHM District Health Society and its supervisory structures through the district health administration and will be accountable to them for its performance.
43. It is recommended that the devolution of funds to district level be deferred until systems at SACS and NRHM are more streamlined and capacity is built at the district level for financial management. Until that time, contracting and disbursement of funds for district level implementing units may continue to be the responsibility of SACS. (para 3.144)

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44. It is recommended that the district programme officer be supported by an accountant cum data entry operator, a M&E assistant and a support staff. It is also recommended that the programme officer will be a member of the Executive Committee of the District Health Society.

Mechanisms for Convergence of NACP with DHFW

45. Possible areas of convergence in delivery of key services between NACP and DHFW are provided in Annex-10.
46. NACP-DHFW convergence committee to be set up at DHFW to provide policy inputs and oversight to the convergence between NACP and DHFW. It is recommended that at the state level, a similar mechanism be set up, so that the state and central level review and monitoring, and information needs and flow are coordinated. It is envisaged that the Project Director of SACS will be a member of the Executive Committee of the NRHM State Health Society. The CEO of the NRHM may also be made a member of the Executive Committee of SACS.
47. At the district level, the district programme officer of NACP, will ensure coordinated inputs between those programmes directly implemented by SACS, between various NGO managed programmes, and finally between those interventions that depend upon the DHFW resources for effective operationalization.
48. The District Health Mission (where all other programmes of HFW are integrated), will include a sub- group to review HIV/AIDS and DHFW convergence in the major service areas and NGO functioning. It is envisaged that the district programme officer will be a member of the Executive Committee of the District Health Society. The Programme Manager of the District Health Society may also be made a member of the district coordinating committee.

NACP-RNTCP Convergence

49. HIV/TB coordination committees proposed at the national and state levels (para 4.13)
50. It is recommended that the State TB Officer be included in the supervisory bodies of the NACP structures in state.

Partnerships for Capacity Development and Programme Support

51. It is recommended NACO establish a Multidisciplinary Standing Committee on Technical Support Committee for overseeing provision of technical support to NACP-III. (para 4.16)
52. It is recommended that Technical Advisory Groups be created for each of the key programme areas. (para 4.17)
53. Given the scale of activities proposed for phase-III and limited capacity within NACO and SACS, it is recommended that key components of technical assistance in identified areas may be out-sourced. The areas covered by the thematic groups may be taken as a starting point and further enlarged to incorporate other key areas such as programme management. It is recommended that programme support may be provided through an Apex Resource Center for each of these areas. These may be located in appropriate academic and research institutions of excellence. (para 4.18)

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54. Depending on the anticipated workload Regional Resource Centers may also be set up. It may also be useful to identify state level resource centers, for certain programmatic components especially in high prevalence states and vulnerable states. They will be particularly useful for NACP components with larger number of dedicated project staff. Apex/Regional Resource Centers will be made responsible for capacity development of these centers.
 55. Process for institutionalizing programme support through Resource Centers is given in Table-6
 56. Technical assistance to Resource centers may be provided through a development partner as per the “one agreed framework”.
 57. It is recommended that the Resource Centers be contracted for the entire project period, subject to an annual review of their performance to provide incentive for development of core faculty, infrastructure and other resources at the Center. NACO will provide the necessary financial support to the Resource Centers either through funds committed by a DP or through pooled funds of the programme. Funding of the Resource center will be linked to specific outputs as per annual plan.
 58. In addition to programme support earmarked in the annual plan, states may need supplementary support depending on local requirements. SACS may procure the required services from these Centers. Since SACS are required to follow costing guidelines fixed by NACO for procurement, it is desirable that unit costs for different outputs be specified in the TOR.
 59. NACO may also consider instituting fellowships at the Centers in the concerned area. This will develop skilled manpower and address lack of capacity in the country in specialized areas.
 60. A suggested structure for developing capacity in key programmatic areas is provided in Annex-9.

Public-Private Partnerships for Delivery of Services

61. It is recommended that possible areas for PPP be identified through the district and state level planning process.
62. It is suggested that the norms for selection and costing of services are evolved by a consultation process led by Technical Advisory Groups of the respective programme areas and finalized by the multidisciplinary standing committee on technical support (para 4.34)
63. It is recommended that the agreement for PPP be through a legally binding contract, which gives both the NACP entity and the private partner more security that each side will fulfill its responsibilities. The contract will specify responsibilities of both sides including a clear time-line for release of funds. A legally enforceable contract may be important for the private organization that is far less powerful than the public entity and relies on the it to make timely payments.
64. A core requirement for the programme is building capacity of both public and private partners. At the SACS level, in addition to putting key staff and systems in place, technical assistance is required for building key programme management skills including

contract management. Private sector requires capacity development in administrative and technical areas. It is recommended that capacity building should include strengthening the role of private sector at all levels of the control strategy such as policy development, implementation and evaluation of programme. Both players will require technical assistance on a continuous basis. A suggested structure for technical support is provided in Annex-9

65. The NACP could consider supporting a professional network of NGOs/CBOs at the district level, which will federate at state, and national levels. Representatives to key governing structures of the NACP may be elected/selected from these networks.
66. It is recommended that the contracting for public-private partnerships be done at the level of SACS. The guidelines for selection of partners may be flexible enough to accommodate various options that are available, with a clear emphasis on well-defined eligibility criteria, transparent process of selection and ratification by the SACS Board. Depending on the number of organizations to be contracted SACS may engage an outside agency for verifying antecedents and short listing of potential partners. Suggested mechanism for institutionalizing PPPs in NACP-3 is provided in Table-7

Governance Framework for NACP-III

67. The proposed governance structure is provided in Figure-6. The role and functions of the key entities in the governance structure is elaborated in Table-8. Specific mechanisms for ensuring: accountability of SACS, accountability of NACP to PRIs, accountability to Key Populations and improving transparency of the programme has been suggested.
68. Suggested mechanisms for ensuring accountability of SACS include: establishment of State Resource Centers in key programmatic areas as proposed in Annex-9; leveraging the influence of the National AIDS Council by NACO to ensure that suitable persons are appointed to key posts in SACS and that they continue in the posts for sufficient period of time; inclusion of a representative from NACO in the Governing Body of SACS and Joint Public Service Agreements for delivery of services.
69. Suggested mechanisms for ensuring accountability of NACP to PRIs include: integration of NACP at the district and sub-district level with the NRHM; building capacity among PRIs to plan, monitor and implement NACP related interventions; engaging NGOs in PRI strengthening and community and social audits to improve accountability.
70. Suggested mechanisms for improving transparency of the programme include: institutionalizing mechanisms for dissemination of information as required under the Right to Information Act; public hearings & public meetings, participation of stakeholders in various decision making processes; capacity building of citizen and civil society groups; performance measurement and management; and publishing and disseminating annual reports.

1. Introduction

Background of the Study

- 1.1. The first cases of HIV/AIDS in the country were detected in 1986. Shortly thereafter the National AIDS Committee was formed and the National AIDS Control Program launched. It was scaled up in 1989 and the National AIDS Control Organization (NACO) established in the Ministry of Health and Family Welfare (MOHFW) to manage it. Subsequent expansions of the Program were through five-year projects. A consortium of multi- and bilateral donors, referred to as Development Partners (DPs), contributed towards these projects. ¹
- 1.2. The first project, NACP-I, operated from 1992 to 1997 and was extended up to 1999. During the second project, AIDS Control Societies were established in all States and Union Territories and some large municipal corporations. ²
- 1.3. The third project, NACP-III, is due to start in fiscal 2006. Its preparation was entrusted to a specially constituted team, the NACP-III Planning Team. The team divided the overall task into 14 subtasks and formed Working Groups for each of them. The Working Group on Program Management formed a subgroup to deal with Program Management and Organizational Restructuring. Based on the reports of these Working Groups, the Planning Team prepared a series of 'Notes' including one on Strategic Framework. These were reviewed by a Joint Mission formed by DPs.
- 1.4. Concurrently, the Planning Team invited institutions to submit proposals for a number of action research and rapid assessments, to obtain authentic feedback about the programme and its beneficiaries and make the NACP III Planning process more realistic, evidence based and participatory. The proposal on Institutional Assessment submitted by the Institute of Health Systems, Hyderabad, was accepted and this report stems from it.

¹ About NACO, website: nacoonline.nic.in

² NACO, Annual Report, 2002-3 and 2003-04 (up to July 2004)

Terms of Reference

1.5. The Terms of Reference of this assignment are appended as Annex 1. The specific objectives were stated as:

*[To] Assess and provide recommendations in respect of: (i) the institutional arrangements for the delivery of the program including infrastructure, working relationships, skills and capacities at National, State and local levels, and (ii) arrangements in place for cooperation and contracting of the private sector for delivery of services.*³

1.6. These were further discussed and clarified with the Planning Team on November 3 and 25, 2005. The Planning Team pointed out that this report is for their use as a background paper and it should make recommendations for the organizational structure of NACO, its state and district counterparts as well as their staffing.

Methodology/ Approach

1.7. The framework of the study is based on an approach for institutional assessment developed by Lusthaus and colleagues⁴. The framework is elaborated in Annex-2. The framework addresses institutional capacity as having three broad dimensions: (1) institutional structure, which captures organizational resources, design, and components; (2) institutional functioning, which captures organizational systems, policies, and procedures, and impact as defined by program/service delivery; and (3) institutional culture, which captures additional elements, such as organizational values, political will, and leadership style. Full application of this institutional assessment framework for the purposes of this analysis has been constrained by the lack of information and documentation on many of the aspects of institutional capacity

1.8. The preparation for this report comprised of review of documents, interviews and field visits. The list of documents reviewed is appended as Annex 3. Officials of MOHFW,

³ NACP-III Planning Team, letter of invitation dated August 30, 2005

⁴ Lusthaus, C., G. Anderson, and E. Murphy. 1995. Institutional assessment: A framework for strengthening organizational capacity for IDRC's research partners. Ottawa: International Development Research Centre.

NACO, DP representatives, NGO representatives, academicians, private practitioners, State and districts officials were interviewed as were representative and field workers of organizations working with SACS. The list of persons met is appended as Annex 4. The Planning Team identified four states for field visits: Andhra Pradesh, Assam, Delhi and Madhya Pradesh. One district in each state was selected for closer field observation. Records and reports were examined and the perspective of officials and field workers sought.

1.9. The report comprises of the following sections.

- ◆ The evolution and context for reorganization of NACP
- ◆ The core institutional analysis of the main entities at national, state and district level
- ◆ Institutional arrangements for coordination, collaboration and partnerships
- ◆ Governance framework for NACP-Phase-III

2. National AIDS Control Programme: Evolution and Context

Evolution of NACP

- 2.1 In 1985 the Indian Council of Medical Research (ICMR) in collaboration with the Directorate General of Health Services (DGHS) and individual State Governments initiated a national programme of serological surveillance.⁵ With the reporting of the first few HIV/AIDS cases in the country, the Government of India constituted a high powered National AIDS Committee in 1986 and formally launched the National AIDS Control Programme (NACP) in 1987. The NACP was established as a small unit within the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MOHFW). The programme initially focussed on monitoring HIV infection rates among risk populations in a few major cities. Blood safety was also included in its mandate following discovery of HIV in blood samples⁶.
- 2.2 In year 1989, with technical and financial assistance from the World Health Organization's Global Programme on AIDS (WHO/GPA), a two year medium term plan for HIV/AIDS Control was developed. This plan was implemented in 5 States that were most affected, namely Maharashtra, Tamil Nadu, West Bengal, Manipur and Delhi⁷. Initial activities focused on the reinforcement of programme management capacities as well as surveillance, blood safety and AIDS case management in few medical colleges and institutions designated as regional centres for treatment of AIDS.⁸ Between 1987 and 1991, the programme focussed almost exclusively on sero-surveillance with about 85% of the national AIDS budget being spent on screening of individuals, blood and blood products⁹.
- 2.3 The transfer of responsibility for surveillance activities in 1990, from ICMR to the office of the National AIDS Control Programme in DGHS which was coordinating blood safety and AIDS case management programmes paved the way for the creation of an umbrella

⁵ Asthana, Sheena. 1996. "AIDS-Related Policies, Legislation and Programme Implementation in India, Health Policy and Planning, 11(2): 184-197

⁶ World Bank. India National AIDS Control Project. Project performance assessment report (credit 2350), 2 July 2003

⁷ Ying-Ru J et.al. Controlling the HIV/AIDS epidemic in India. Background paper for the Commission on Macroeconomics and Health, Government of India, 2005

⁸ Asthana. S (1996)

⁹ ibid

organization responsible for coordinating a broader range of AIDS-related policies. In 1991, proposals for a new bureaucratic structure encompassing such an organization were included in the Strategic Plan for the Prevention and Control of AIDS in India, that evolved out of an intense dialogue between the government, World Bank and WHO. The National AIDS Control Organization was officially established and a more comprehensive National AIDS Prevention and Control Programme (Phase-1) was launched in the subsequent year.¹⁰

2.4 The overall objective of NACP-Phase-I was to slow the spread of HIV by initiating a major effort to prevent HIV transmission. It constituted a start-up investment to launch expanded preventive activities. The specific objectives were to:

- ◆ Involve all States and Union Territories in developing HIV/AIDS preventive activities with a special focus on the major epicenters of the epidemic
- ◆ Attain a satisfactory level of public awareness on HIV transmission and prevention;
- ◆ Develop health promotion interventions among risk behavior groups;
- ◆ Screen all blood units collected for blood transfusions;
- ◆ Decrease the practice of professional blood donations;
- ◆ Develop skills in clinical management, health education and counselling, and psycho-social support to HIV sero-positive persons, AIDS patients and their associates;
- ◆ Strengthen the control of Sexually Transmitted Diseases (STD); and
- ◆ Monitor the development of the HIV/AIDS epidemic in the country.¹¹

2.5 The project design included five basic components: (1) Strengthening management capacity for HIV/AIDS control; (2) Promoting public awareness and community support; (3) Improving blood safety and rational use; (4) Controlling sexually transmitted diseases; and (5) Building surveillance and clinical management capacity. The project design also included a number of intermediate and outcome targets, including involving at least 100 NGOs in prevention programs in at least 12 states¹².

¹⁰ Asthana S (1996)

¹¹ NACO: http://www.nacoonline.org/abt_phase1.htm

¹² World Bank. India National AIDS Control Project. Project performance assessment report (credit 2350), 2 July 2003

2.6 Since health services fall under the purview of State governments, it was considered necessary to involve the latter for the control of HIV/AIDS. During NACP-I, State AIDS Control Cells (SACC) were established in all states and Union Territories to strengthen the local response to the epidemic. These were embedded within the respective Directorates of Health Services (DHS). Activities involving service delivery such as blood banking, STI treatment, HIV testing and counselling were to be implemented through existing government medical institutions in the States.

2.7 Phase –One of the NACP extended between 1992-1999. Of the total project expenditure of about US\$ 113 million, nearly 40 percent was spent for blood safety, 21 percent for raising awareness, 16.5 percent for STD control, 13.5 percent for building surveillance and clinical management capacity, and about 9 percent on strengthening programme management capacity. The government spent nearly twice its originally planned counterpart contribution (\$27.5 million compared to a planned \$13.9 million)¹³.

2.8 The project helped design the structures for the national AIDS response at both the national and state levels, and provided critical financing—at levels that would not have been forthcoming from national or state budgets. The project established a strong partnership with WHO/GPA, and later helped mobilize additional donor resources.¹⁴ The establishment of NACO and the State AIDS Cells considerably strengthened India's management capacity to respond to the epidemic. Appreciable gains were made in improving blood safety. Phase-I had a measure of success in improving public awareness, particularly in urban areas; in expanding sentinel surveillance and improving coverage and reliability of data and expansion of STD control and condom promotion activities. A national HIV testing policy was framed and disseminated during Phase-1¹⁵.

¹³ *ibid*

¹⁴ *ibid*

¹⁵ NACO. Project Implementation Plan. National AIDS Control Project , Phase-II

2.9 Despite the above achievements, the outcomes of the Phase-I of the NACP fell short of expectations for several reasons:

- ◆ Lack of advocacy among top political leadership and bureaucracy resulted in project not being accorded sufficient importance, especially in the initial years of the programme¹⁶
- ◆ Lack of technical and managerial expertise at national and state levels. In addition, NACO staff had limited experience with World Bank rules and procedures, particularly those for procurement and financial management.¹⁷
- ◆ Given that health is constitutionally a state responsibility, state involvement was key to success of the programme. However, states were not consulted during designing of the project. The centralization of planning and implementation process did not take into account regional differences and led to uneven implementation of project activities at the State level. Further, the working of the SACCs was severely hampered by the limited technical capacity of the parent directorates, staff shortages and rapid turnover. Although the project was almost entirely centrally funded, SACCs had to requisition funds through their state ministries of finance. Funds earmarked for HIV/AIDS were utilized for competing state government priorities. The release of funds for HIV/AIDS was invariably delayed by months and often states released less than was originally budgeted. This made it difficult to plan and execute programs.¹⁸
- ◆ The project placed heavy reliance on NGOs for awareness raising and reaching high-risk groups. However, the capacity of NGOs to implement HIV/AIDS activities was significantly overestimated. The extent of NGO involvement as well as the modalities for NGO selection, financing, and technical support varied substantially among the states. Many state governments were reluctant to devote substantial resources to NGO activities, and all NGO proposals had to be approved by NACO prior to funding, contributing to funding delays. Initially, NGO contracts were only for one year and there were often delays in receipt of payment, particularly the final payment. NGOs were thus often left with gaps of 4 to 6 months between contracts with no support for the interventions they had launched. While some of the larger NGOs were able to bridge these gaps with their own resources, others that did not have resources from elsewhere

¹⁶ *ibid*

¹⁷ Project Performance Assessment Report –India National AIDS Control Project. Report No. 26224, World Bank, 2003

¹⁸ *ibid*

and had to discontinue interventions. Consequently, targeted interventions among high-risk groups suffered.¹⁹

- ◆ Despite NACO's location within MOHFW, in many respects it functioned as a vertical disease control program. The limited integration between AIDS and other health programs reduced the "reach" of the HIV/AIDS program, particularly into rural areas. Though the national strategy and project emphasized the importance of encouraging HIV/AIDS interventions in other sectors, with a few notable exceptions, the response of other ministries was limited.²⁰
- ◆ Absence of sentinel surveillance mechanisms in many states resulted in inadequate data about the trends in HIV prevalence among high risk and low risk groups. Consequently, evidence regarding seriousness of the epidemic was found wanting in many parts of the country.²¹
- ◆ Implementation of activities related to PLHAs including clinical management was inadequately addressed by many states. As a result stigma and discrimination faced by people living with HIV/AIDS continued²².

2.10 The Programme sought to address some of these limitations in the course of the first phase itself. Other lessons learnt from the shortcomings of the First Phase were incorporated in the design of the second phase. Some of the key changes in NACP-II include:

- ◆ Building of ownership and capacity at state and municipal levels through decentralization of planning and implementation of AIDS control programmes were accorded high priority²³. NACO's role evolves from direct service delivery to providing strategic leadership.
- ◆ Establishment of State AIDS Control Societies. To address financing and administrative problems faced by the State AIDS Control Cell, the government of Tamil Nadu converted its State AIDS Cell into a registered Society (SACS). A full time Project Director (PD), a senior officer of the Indian Administrative Service, was

¹⁹ *ibid*

²⁰ *ibid*

²¹ NACO. Project Implementation Plan. National AIDS Control Project , Phase-II

²² *ibid*

²³ *ibid*

appointed to head the Society. The ensuing autonomy significantly helped in taking decisions regarding NGO selection quickly, facilitating timely disbursement of funds; developing better accountability of staff and improved communication between the implementing partners.²⁴ The success of Tamil Nadu model led the Government of India to advise other states to follow suit, and the formation of a registered society made was made a precondition for participation in NACP-II. While some states established SACS in the final year of the first project itself, the remainder of the states did so in the early years of Phase II.

- ◆ A “performance-based” approach to improve the pace of implementation was adopted. Additional resources were allocated to the states that were implementing their programs more effectively.
- ◆ Involvement of NGOs in the programme was substantially scaled up. Responsibility for selection and funding NGOs was devolved to the states. Process for selection of NGOs was streamlined. NGO Advisor’s were appointed at NACO and SACS level to coordinate NGO activity. Three-year contracts, renewable annually, were formally adopted as the norm for the second AIDS project. NGOs were given representation in the executive committee of SACS so that they play an important role in decision making at State and Municipal level
- ◆ Scaling up of HIV prevention services provided through government medical institutions. It was envisaged that all district hospitals will provide full range of HIV related services such as a fully equipped STD clinic, licensed blood bank, VCTC and treatment of opportunistic infections for AIDS patients. At tertiary level, medical colleges to provide all the services available at the district hospitals. Limited infrastructure support, equipment and essential staff provided under the project.
- ◆ Lack of technical support to program managers in Phase-1 sought to be remedied by setting up of Technical Resource Groups (TRGs), to provide technical support on several key areas of the programme.
- ◆ Focus on forging inter-sectoral collaborations with public, private and voluntary sectors for awareness, advocacy and interventions
- ◆ Scaling up and strengthening HIV sentinel surveillance among high risk and low risk populations in all states including mechanisms for STI surveillance, behavioral surveillance and AIDS case surveillance.

²⁴ Sheshadri, S. R., Constraints in scaling up health programs: A comparative study of two Indian states, *Journal of International Development*, 15, 101-114, 2003

- ◆ Strengthening programme management through institutionalization of management information systems and project financial management systems

2.11 Phase-II of the National AIDS Control programme began in 1999. It is a 100% centrally sponsored scheme implemented in 32 States/UTs and 3 Municipal Corporations namely Ahmedabad, Chennai and Mumbai through AIDS Control Societies. The project has two key objectives

- ◆ To reduce the spread of HIV infection in India; and
- ◆ Strengthen India's capacity to respond to HIV/AIDS on a long term basis²⁵

2.12 Operationally, the project interventions seek to achieve the following by the end of the project:

- ◆ To keep HIV prevalence rate below 5% of adult population in Maharashtra, below 3% in Andhra Pradesh, Karnataka, Manipur, Tamil Nadu where the HIV prevalence is moderate and below 1% in remaining States, where the epidemic is still at a nascent stage;
- ◆ To reduce blood borne transmission of HIV to less than 1%
- ◆ To attain awareness level of not less than 90% among the youth and others in the reproductive age group
- ◆ To achieve condom use of not less than 90% among high-risk categories like Commercial Sex Workers.²⁶

2.13 NACP-II has five distinct components. They include:

- ◆ Targetted intervention for groups at high risk
- ◆ Preventive Intervention for the general community
- ◆ Low cost AIDS Care
- ◆ Strengthening institutions responsible for implementation
- ◆ Forging inter-sectoral collaborations with public, private and voluntary sectors²⁷

²⁵ NACO: http://www.nacoonline.org/abt_phase2.htm

²⁶ *ibid*

²⁷ *ibid*

2.14 NACP Phase-II and related bilateral projects has an outlay of Rs.1425 crores. The World Bank- aided National AIDS Control Project Phase – II [NACP-II] accounts for Rs. 1155 crores, with 85% of this amount (Rs. 959 crores) being an IDA credit and rest being provided by the Govt. of India. 34 percent of this amount is allocated for preventive interventions for the general community, 25% for institutional strengthening, 23% for interventions for high-risk groups, 14% for low cost AIDS care and 4% for inter-sectoral collaboration. Bilateral assistance includes USAID assistance of Rs. 166 crores to the AVERT programme in Maharashtra and DFID assistance of Rs. 106 crores for sexual health projects for the States of Andhra Pradesh, Gujarat, Kerala and Orissa.²⁸

2.15 NACP-II could achieve a measure of success in many areas. They include:

- ◆ Control of the epidemic: Recent NACO estimates of HIV prevalence indicate that the upsurge of HIV incidence has been contained and levels of HIV prevalence have stabilized in some states²⁹. A recent study indicates that HIV prevalence has declined in the high prevalence states of Andhra Pradesh, Maharashtra, Tamil Nadu and Karnataka since 2001.³⁰
- ◆ Receiving increased political support for the programme through creation of National AIDS Council, Parliamentarians Forum and Legislators Forum in certain states. AIDS control has been accorded high priority in the National Common Minimum Programme of the present central government. This has been reflected in the deliberations of the National Advisory Council³¹. Further highest political functionaries at the national level and in some states have been providing leadership to the HIV control efforts.
- ◆ In 2002, the Government finalized and released the National AIDS Control Policy and the National Blood Policy. These policies were drafted following a wide range of

²⁸ *ibid*

²⁹ AIDS Epidemic update. December 2005. Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) 2005

³⁰ Kumar R et al. Trends in HIV-1 in young adults in south India from 2000 to 2004: A prevalence study. *The Lancet* (online edition, March 30), 2006

³¹ National Advisory Council. Gist of communication regarding National AIDS Control effort sent by the NAC to the Government, 26th October 2005 downloaded from <http://nac.nic.in/communication/aidscontrol.htm>

consultations with governmental organizations and NGOs, experts and partner agencies

- ◆ AIDS Control Societies was established in all states and union territories and 3 municipal bodies which has raised the profile of HIV response in many states.
- ◆ Institutionalization of Computerized Project Financial Management Systems and Computerized Management Information Systems
- ◆ Significant scaling up and improvement of quality of sentinel surveillance. The number of sentinel surveillance sites increased from 180 in 1998 to 670 in 2004. The quality of HIV surveillance in India was described by an expert team of UNAIDS and WHO in 2001 as having the basic components of a high-quality surveillance system but lacking adequate representation. This has since been improved by adding rural sites and sites for core risk groups, and increasing the total number of sites.³²
Conducted baseline behavioral surveillance in all states
- ◆ Consolidation and improving upon efforts to ensure blood safety. Adopted an Action Plan for blood safety in 2003. Institutionalized mechanisms for capacity building and quality assurance for HIV testing and blood safety. Share of voluntary blood donations increased to over 50% in the country. In some states like Maharashtra and West Bengal share of VBD is over 80%³³
- ◆ Significant scaling up of Targetted interventions through NGOs from about 100 in phase-1 to 933 in 2005. Greater representation of NGO sector in decision making bodies at national and state level.
- ◆ Introduction of PPTCT scheme and significant scaling up of other hospital based services such as VCTCs. Number of VCTCs set up increased from 89 in 2000 to 631 in 2004³⁴
- ◆ Initiated programme to provide anti-retroviral treatment (ART) at government hospitals, free of cost, for people living with HIV/AIDS in the six high prevalence

³² Ying-Ru J et.al. Cotrolling the HIV/AIDS epidemic in India. Background paper for the Commission on Macroeconomics and Health, Government of India, 2005

³³ NACO. Annual Report 2002-04

³⁴ NACO. Annual Report 2002-2004

states of Tamil Nadu, Andhra Pradesh, Maharashtra, Karnataka, Manipur and Nagaland and in the capital city of Delhi.

- ◆ Expansion of Family Health Awareness Campaigns, which seek to increase STD awareness and treatment-seeking in selected communities through “camps” that involve door-to-door awareness raising and, in some of the communities, STD screening and referral for treatment
- ◆ During Phase-II, guidelines for implementation and management of a number of interventions were developed and disseminated. NACO has put up 21 such guidelines on its web-site³⁵
- ◆ Greater involvement of PLHAs in decision making as key stakeholders and expanded role as facilitators for service delivery. INP+ supported to establish and strengthen state level networks of people living with HIV/AIDS.³⁶
- ◆ Models of partnerships and collaboration for programme support with some measure of success have evolved during the course of the project. Some of these include partnership with ICMR for analysis of surveillance data, National External Quality Assessment Scheme” (NEQAS) for HIV testing, engagement of state level resource centres such as PSU for supporting targeted interventions and AP Counselors Project in AP for supporting counselling services.
- ◆ The programme has been able to mobilize technical assistance and funding from a variety of multilateral, bilateral and other international agencies. At present there are over 32 donor agencies working with NACO in different states and on different programs.³⁷

2.16 Undoubtedly there has been progress in scaling up the government’s response to the epidemic in Phase-II. Nevertheless, the programme will have to substantially improve its reach and quality in Phase-III to meet the ambitious HIV/AIDS targets of the Government’s Tenth Five-Year Plan. These include:

- ◆ 80% coverage of high-risk groups through targeted interventions
- ◆ 90% coverage of schools and colleges through education programmes

³⁵ NACO. http://www.nacoonline.org/prog_guidelines.htm

³⁶ NACO. Annual Report 2002-2004

³⁷ World Bank. Preventing HIV/AIDS in India, June 2005

- ◆ 80% awareness among the general population in rural areas
- ◆ Reducing transmission through blood to less than 1%
- ◆ Establishing at least one VCTC in every district
- ◆ Scaling up of PMTCT activities up to the district level
- ◆ Achieving zero-level increase of HIV/AIDS by 2007³⁸.

2.17 Some of the major challenges of NACP-1 remain at the end of Phase-II of the programme. These include: variations in overall effectiveness of state-level programs, paucity of requisite technical and managerial skills within the programme, lack of institutionalized mechanisms for providing programme support in many areas, challenges in achieving greater integration with other health programmes, expanding the participation of other sectors, and increasing safe behavior and reducing stigma associated with HIV-positive people among the population.

2.18 Though NACP-III and its priorities are yet to be firmed, based on perusal of various preparatory documents and discussions with officials, it is assumed that NACP-III will not be substantially different from its predecessor but will seek more to intensify current activities and increase their reach and quality. Therefore, NACP-III will need to have mechanisms to consolidate and scale up the achievements of phase-II and address its challenges. The next part of this section discusses some of the key drivers for reorganization of institutional arrangements in Phase-III of the programme.

Drivers for Reorganization of Institutional Arrangements in NACP-III

2.19 **Epidemiological profile:** It is estimated that 5.21 million Indians were living with HIV in 2005³⁹. Although levels of HIV infection prevalence appear to have stabilized in some states (such as Tamil Nadu, Andhra Pradesh, Karnataka and Maharashtra), it is still increasing in at-risk population groups in several other states. NACO estimates for the year 2005, indicate that HIV prevalence among STD (sexually transmitted disease) patients has increased significantly over the previous year in Delhi, Rajasthan and Orissa.

³⁸ Government of India Planning Commission. Tenth Five-Year Plan, 2002–2007. Vol. 2. Chapter 2.8; 2002:117.

³⁹ Sujatha Rao, DG NACO, reported in ZeeNews.com, April 23, 2006

HIV prevalence was greater than ten per cent in 34 STD sites across the country. Prevalence in Nagaland and Manipur showed an increase indicating an IDU (intravenous drug user) and heterosexual interface. Besides, HIV prevalence was greater than one per cent among antenatal mothers in 95 districts including nine in the low prevalence states. Out of the estimated adults living with HIV, over 38 per cent were females and 57 % were of rural background.⁴⁰

2.20 HIV prevalence data indicate diverse epidemics are underway in India. 6 high prevalence states have generalized epidemics and some of the low prevalence states are showing evidence of concentrated epidemics. While the epidemic is mostly driven by heterosexual transmission, in states like Nagaland and Manipur it is mostly driven by IDU. The epidemic is increasingly spreading to women and in rural areas. Though currently reporting low prevalence, large states like Bihar and UP are vulnerable as relatively minor increases in HIV transmission could translate into huge numbers of people becoming infected in those states. While HIV prevalence has stabilized in 4 high prevalence states with a good track record of AIDS Control, it has been increasing in the high prevalence states of north-east and some of the low prevalence states indicating state level variability in HIV prevention efforts. Phase-III would require different arrangements for the better performers and those that have not done so well. The programme would also need to institutionalize mechanisms to increase reach of preventive services in rural areas and better integrate with RCH and other programmes for women. Concentrated epidemics even in low prevalence states indicate the need for district specific arrangements to contain the epidemic.

2.21 **Political leadership for the programme:** In recent years AIDS Control has received significant political support especially at the national level. The National Common Minimum Programme of the present government unequivocally states that the UPA government will “*provide leadership to the national AIDS control effort*”.⁴¹ A National AIDS Council headed by the Prime Minister was created for this purpose. The first meeting of the National Advisory Council of the UPA government reviewed the AIDS

⁴⁰ ibid

⁴¹ Government of India. National Common Minimum Programme, 2004

Control efforts and outlined future directions⁴². Earlier in July 2003, the first national convention of the Parliamentary Forum on HIV/AIDS adopted a declaration on “political leadership in combating HIV/AIDS”, endorsed by all major political parties⁴³. State Legislative Forums on HIV/AIDS have been established in states such as Andhra Pradesh, Assam, Bihar, Delhi, Karnataka, Manipur, Nagaland and West Bengal. Advocacy efforts in many states have sometimes been directed by Chief Ministers who have been leading from the front and have brought HIV AIDS centre-stage. Some Chief Ministers instructed party colleagues to talk about HIV AIDS for two minutes in every public appearance.⁴⁴ Channeling such support for improving programme implementation is key for meeting objectives of the programme. Political commitment varies across States and many states especially the more vulnerable states will require more effective advocacy for mobilization of political support. Therefore, Phase-III will need institutional mechanisms to actively engage with the political leadership for mobilizing and sustaining political support and leveraging such support for facilitating implementation of the programme.

2.22 Donor Support and the International HIV/AIDS Environment: International agencies played an important role in motivating the GoI to initiate its first responses to HIV/AIDS. Technical and financial assistance from the WHO/GPA for HIV prevention in selected states was one of the first instances of international support to HIV prevention efforts in the country. In 1992, the World Bank offered India a soft loan of \$87 million which until that point was its largest HIV related loan to any single country, to establish a National AIDS Control Organization (NACO) and to begin the National AIDS Control Programme (NACP). The Bank worked closely with international partners to convince the government to borrow for HIV/AIDS prevention when the country was still in the early stage of the epidemic, AIDS was invisible to most policymakers, denial was high and there was little support for preventive measures beyond improving the safety of the blood supply.⁴⁵ The Bank could influence several important changes, including increased political commitment legislation to improve

⁴² National Advisory Council. Gist of communication regarding National AIDS Control effort sent by the NAC to the Government, 26th October 2005 downloaded from <http://nac.nic.in/communication/aidscontrol.htm>

⁴³ NACO. Annual Report 2002-04

⁴⁴ *ibid*

⁴⁵ World Bank. India National AIDS Control Project. Project performance assessment report (credit 2350), 2 July 2003

condom quality and reduce discrimination and withdrawal of draconian AIDS prevention Bill that was introduced in Parliament.

2.23 Another major contributor to programme, DFID has been involved with the NACP since 1999, working at national level, through NACO, as well as at state level, through State AIDS Control Societies (SACS) in selected states. In addition to these, a number of multilateral agencies including various UN bodies, bilateral agencies such as USAID and international foundations are providing financial and/or technical assistance to NACP. Currently about 32 such agencies are involved in India's HIV prevention efforts. Contributions of international donors are through (1) Centrally sponsored NACP (2) direct contribution to SACS and (3) NGOs and other institutions. However, the central government is reluctant to allow foreign donors to determine which States in the Union are doing well or badly, and which should be awarded development assistance and uncomfortable about foreign agencies funding and engaging with individual civil society organizations. The current government policy is to direct foreign donors strongly in the direction of support to centrally sponsored schemes.⁴⁶

2.24 While increases in funding are providing opportunities for scaling up the response to the epidemic, each donor comes with its own mandate and requirements, as well as areas of focus. For instance: the CCM mandated by the GFATM, though led by NACO has its own mechanisms for coordination and monitoring which are outside of NACP systems. The transaction cost to the government because of attending to the various demands of the donors is huge.⁴⁷ International recognition for the need of greater harmonization and alignment of international support has led to an agreed set of principles, the Three Ones, which is applicable to all stakeholders in the country-level HIV/AIDS response.⁴⁸ These are:

- ◆ **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.

⁴⁶ International Development Committee. DFID's bilateral programme of assistance to India, Third Report of Session 2004–05, Volume I, House of Commons, 2005

⁴⁷ World Bank. Preventing HIV/AIDS in India, June 2005

⁴⁸ UNAIDS "Coordination of National Responses to HIV/AIDS: Guiding Principles for National Authorities and Their Partners", 2004

- ◆ **One** National AIDS Coordinating Authority, with a broad-based multi-sector mandate.
- ◆ **One** agreed country level Monitoring and Evaluation System.

2.25 A Global Task Team was convened by UNAIDS to operationalize the ‘Three Ones’ principles. Its recommendations are focused around four areas: empowering national leadership and ownership; harmonization and alignment; reform for a more effective multilateral response; accountability and oversight. Although the majority of recommendations are directed at multilateral agencies, the involvement of the national AIDS control body is central to the successful implementation of many of the recommendations⁴⁹. The institutional arrangements of NACP-III will therefore have to be based on the principles of “Three Ones”.

2.26 **Focus on greater integration of HIV control efforts with other health**

programmes: NACP does not have structures below state levels except for civil society collaborations which, however outstanding, cannot substitute for systemic outreach. The mid-term appraisal of the Planning Commission indicates that the National AIDS Control Programme in India continues to be highly centralized and cannot reach the district and sub-district levels unless it is integrated into primary health care and develops synergies with the reproductive and child health programme. The stand-alone, dedicated character of the programme, which is seen as its strength, is also a barrier to higher dissemination and utilization of the significantly enhanced services for HIV prevention, care, support and treatment.⁵⁰

2.27 The National AIDS Policy aims to bring in horizontal integration of NACP with other national programmes like Reproductive and Child Health, TB Control, Integrated Child Development Scheme and with the primary health care system, at the implementation level⁵¹. Recently the Government of India constituted the National Rural Health Mission (NRHM) for achieving greater integration of national health programmes and improving

⁴⁹ Report of the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors, June 2005

⁵⁰ Planning Commission. Mid-Term Appraisal of the Tenth Five Year Plan (2002-2007), Government of India, page 92

⁵¹ Government of India. National AIDS Policy 2002

the reach of the public health services. Though the NRHM is still in a formative stage, the proposed relationship between the NACP and the NRHM has been quite clearly articulated by the government. Recently the Prime Minister emphasized that the NACP should be mainstreamed into the Ministry of Health and Family Welfare as an integral part of the National Rural Health Mission and implemented efficiently through the available public health network.⁵² The Planning Commission has also recommended that the prevention, care, and support of HIV/AIDS be included squarely within the National Rural Health Mission.⁵³

2.28 The Mission is conceived as an umbrella programme subsuming the existing programmes of health and family welfare. The NRHM Mission document also specifies timelines for major components, of which merger of multiple societies is one.⁵⁴ Since NACP along with the cancer programme are the only two disease control programme that does find mention in the mission document at all, it is not clear whether the proposed merger includes SACS. Recently, orders were issued from the Union Health Secretary's office instructing the State governments, to merge all societies including SACS into the State Health and Family Welfare Society. It was later clarified that inclusion of SACS in the list of societies to be merged was an oversight and a decision on whether to merge SACS or not, was yet to be taken. It is not known whether clarifications in this regard has been communicated to the State or not⁵⁵. More recent communications from the MOHFW seem to indicate that, that the choice of whether to merge SACS with NRHM or not will be left to the States to decide.⁵⁶ Given that NRHM is in its formative stages and whether and to what extent it can or will absorb the National AIDS Control Program is still far from certain, we do not foresee such a merger taking place at the State level, in Phase-III of the programme. However the general thrust of the NRHM, vis-à-vis, integration of the disease control programmes, decentralized programme management, local planning and improved outreach etc., finds resonance in the overall objectives and

⁵² Press Information Bureau. Change the course of war on AIDS: PM, Press Release from PMO, dated 01 December, 2005.

⁵³ Planning Commission. Mid -Term Appraisal of the Tenth Five Year Plan (2002-2007), Government of India Para 2.2.39, 2.83(11)

⁵⁴ Ministry of Health and Family Welfare. National Rural Health Mission (2005-2012). Mission Document, Government of India, 2005

⁵⁵ Personal Communication from NACP, Planning Team

⁵⁶ National Rural Health Mission: Institutional Setup at State level. Downloaded from the MOHFW website

strategies of the NACP Phase-III. The NRHM provides an opportunity for integration of the NACP with primary health care and with other national programmes such as RCH and RNTCP and thereby improve reach of the programme. Following several rounds of deliberations with major stakeholders there is now greater conceptual clarity regarding possible areas of such convergence.⁵⁷ It is imperative that institutional arrangements for NACP-III are structured to facilitate this convergence.

2.29 Leadership for a broad-based multi-sectoral response: There is increasing realization that an expanded, intensified and multisectoral response is required to meet the challenge of HIV. A key lesson that emerged from the World Bank evaluation of Phase-1 of NACP was that *“Targeted awareness and interventions for high-risk groups can be successful only to the extent that complementary efforts are launched to improve the environment for HIV prevention among these groups.”*⁵⁸ The National AIDS Committee and the National AIDS Council was set up to provide impetus to multisectoral coordination and mainstreaming. In its communication to the union government, the National Advisory Council stated that *“the need to mainstream HIV/AIDS Control in the National Agenda can hardly be over-emphasized. The Government may like to stress this point in the first Meeting of the National AIDS Council”*.⁵⁹

2.30 The expanded multi-sectoral response emphasizes prevention as well as treatment, policies and programmes to mitigate the impact of AIDS, and policies that will change the societal factors that influence vulnerability to HIV in the long term. The NACP has the responsibility to coordinate and monitor the response, a challenging task considering the size and diversity of the sectors involved. This task is made more difficult as it often requires involving sectors with limited knowledge and capacity to act and many a time, limited ability to effectively realize their existing mandate.⁶⁰ A variety of institutional mechanisms will thus be required for broad basing the HIV prevention and care efforts in

⁵⁷ See for instance, Report of the Task Force on convergence between NACP and DoHFW, 2005

⁵⁸ World Bank. India National AIDS Control Project. Project performance assessment report (credit 2350), 2 July 2003

⁵⁹ National Advisory Council. Gist of communication regarding National AIDS Control effort sent by the NAC to the Government, 26th October 2005 downloaded from <http://nac.nic.in/communication/aidscontrol.htm>

⁶⁰ Ainsworth M, and Theokul W. Breaking the silence: setting realistic priorities for AIDS control in less-developed countries. THE Lancet, Vol 356, July 1, 2000

NACP-III. The programme will also require harnessing a range of skills necessary for initiating, institutionalizing, monitoring and managing such mechanisms.

2.31 **Thrust towards decentralization:** National Aids Prevention and Control Policy, envisages decentralization of HIV/AIDS control programme to the field level with adequate financial and administrative delegation of responsibilities⁶¹. Phase-II witnessed decentralization of service delivery to the States and Phase-III envisages further decentralization of planning and service delivery to the State, district and community levels. Decentralization can be seen as a natural managerial response to respond to the increasing need for:

- ◆ A broad based multisectoral response
- ◆ Making use of the comparative advantages that exist in organizations at different levels of society and within the delivery system;
- ◆ Increasing the responsiveness of programs to local needs and to the local epidemiological situation by involving local groups and the community in program planning and implementation;
- ◆ Enhancing the self-reliance and sustainability of programs that are genuinely “owned and operated” by local organizations;
- ◆ Increasing administrative and managerial effectiveness by placing increased authority and responsibility at operational levels;
- ◆ Increasing the quantity, quality, and equitable distribution of services to those in need⁶²

2.32 While decentralization has the potential to be an effective management tool, experiences from developing countries indicate that there are forces at work that make effective decentralization difficult to achieve. These may include strong centralist political ideologies and traditions, authoritarian patterns of leadership, confusing or overlapping layers of bureaucracy, unclear patterns of authority and responsibility, arbitrary decision making, inadequate transfers of resources to lower levels, poorly

⁶¹ National Aids Prevention and Control Policy, Government of India, 2002

trained personnel at lower levels, the inability of local governments and organizations to generate revenue, lack of managerial and administrative expertise, logistical and communications problems, political interference, rapid staff turnover, and other problems.⁶³ Since many of these conditions are present in India, an effective program of decentralization must be based upon careful analysis and planning. It requires incremental, step-by-step planning, as well as the development of support systems, linkages, and appropriate structural relationships.

2.33 Experiences of other developing countries indicate that successful implementation of decentralization within NACP depend on the careful and systematic creation of political, organizational, behavioral and other conditions that encourage the uptake of initiative, and build capacity at the local level⁶⁴. Rondinelli et al., identifies four factors that affected the success of decentralization programmes in developing countries:⁶⁵ The degree to which:

- ◆ central political leaders and bureaucracies support decentralization and the organizations to which responsibilities are transferred;
- ◆ the dominant behavior, attitudes, and culture are conducive to decentralized decision-making and administration;
- ◆ policies and programs are appropriately designed and organized to promote decentralized decision-making and management; and
- ◆ adequate financial, human, and physical resources are made available to the organizations to which responsibilities are transferred.

2.34 Decentralization programs that are functioning well use strengths at one level of a system to compensate for weaknesses at other levels. Thus, effectiveness of decentralization in NACP will depend, to a considerable degree, on how well NACO is placed to provide strategic leadership, support, financing, coordination and oversight to

⁶² Hollister, R.M. Decentralization in the National Aids Control and Prevention programs. Centre for International Development, Reserch Triangle Institute, 2002

⁶³ ibid

⁶⁴ ibid

⁶⁵ Dennis Rondinelli, John R. Nellis, and G. Shabbir Cheema, *Decentralization in Developing Countries*, World Bank Staff Working Paper No. 581, ISBN 0-8213-0235-3 (Washington, DC: World Bank), p. 13.

the programme. This will in turn depend on the functional adequacy of managerial, administrative, and support systems at NACO. These systems include: (1) budgeting, accounting, and financial control; (2) capacity development (3) supervisory systems, to provide sustained contact, support, and problem-solving assistance to projects; (4) management information systems, to provide information for monitoring and for identifying problems; (5) personnel management; (6) logistics, including procurement, inventory control, and distribution. NACP-III would have to ensure that these systems are in place to effectively facilitate decentralization. Technical assistance may be required to ensure the development and adequate functioning of these systems.

2.35 Increasing emphasis on good governance: UNDP defines governance as the exercise of economic, political and administrative authority to manage a country's affairs at all levels. It comprises of the mechanisms, processes and institutions, through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences. The concept of governance is thus broader than the government. While government has pre-eminent role in promoting good governance, the responsibility for managing the affairs of a nation is not limited to government alone, but includes a wide variety of stakeholders including: state government, local governments; the private sector; non-governmental and community-based organizations (NGOs/CBOs), the media, professional associations and other members of civil society. Further governance is a broad concept, which encompasses the states' institutional arrangements, decision-making processes, implementation capacity and the relationship between government officials and the public⁶⁶.

2.36 The mid term review of the Ninth Plan lists eight aspects of governance that would need to be addressed to improve governance. They include accountability, transparency, stability of tenure of civil servants, reduction in size and scale of civil services, professionalism in performance, effective implementation of development programmes, improving quality of life through greater attention to environment, decentralization and redefining role of government. Accountability and transparency are indispensable pillars

⁶⁶ V. K. Parigi, Dr. P. Geeta, & Rameesh Kailasam. Ushering in Transparency for Good Governance. Working Paper, Centre for Good Governance, Hyderabad, 2005

of good governance that compel the state and civil society to focus on results, seek clear objectives, develop effective strategies, and monitor and report on performance.⁶⁷

2.37 Most of the traditional mechanisms of accountability, both vertical and horizontal are present in India. As a parliamentary democracy, it has elected legislatures, which is accountable to its citizens and have oversight functions over the Executive. India has an independent judiciary that can hold both the legislative and executive arms of the state accountable. It has a variety of independent authorities and commissions that perform accountability function vis-à-vis different parts of the government. However, existence of well-established accountability systems and procedures, laws, public audits of accounts and parliamentary reviews does not necessarily guarantee actual accountability on the ground. Some of the factors often held responsible for such a scenario include: collusion between those who are responsible for performance and those who are charged with their oversight due to the asymmetry of information and the "agency" problem, well-known weaknesses in civil society institutions, and the prevalence of corruption.⁶⁸ In addition, performance measurement in the public sector accountability framework focuses almost exclusively on how much is spent (inputs) or done (outputs) rather than impact on society (outcomes)⁶⁹

2.38 In recent years there has been efforts to improve accountability and transparency of the public sector. Impetus for such change has come from different sources- the political and bureaucratic leadership, civil society, judiciary, and donor agencies whose support is linked to governance reforms. Enactment of the Right to Information law, mandating of outcome budgeting and e-governance initiatives are notable examples of such reforms that could have significant impact on public sector accountability, including that of the NACP-III.

2.39 However, there are other governance issues that have to be considered in case of NACP-III. The National AIDS Control Organization is the designated agency for the control of HIV/AIDS interventions that are initiated and financed by, or through, the

⁶⁷ Ramachandran H. Vision 2020. Governance and Peoples Participation. Working Paper, Planning Commission

⁶⁸ Samuel Paul. New Mechanisms for Public Accountability: The Indian Experience. Public Affairs Centre, Bangalore, India

⁶⁹ Srinivasa Rao. Simplifying Government. Working Paper, Centre for Good Governance, Hyderabad, November 2004

Government of India. However, the instruments for implementation and delivering services are not with NACO. The Constitution of India locates the delivery of social services, of which prevention and amelioration of HIV/AIDS is one, with the governments of states and local self government bodies such as municipalities in urban areas and Panchayat Raj Institutions (PRIs) in rural areas. The instruments for delivering services are therefore with these organizations. Further, the prevention of HIV/AIDS requires intensive involvement of communities, which even local bodies cannot reach. They can only be reached by community-based organizations and Non Government Organizations (NGOs). In addition, for many of its interventions, NACO requires the services and support of private sector and other government departments within MOHFW and across other ministries as well. As the designated agency, NACO will inevitably be held responsible for overall performance and expenditures. Therefore, NACO will be held responsible for not only its own performance but also that of large number of its partners, over whom it has no direct control. Since most of the implementation is proposed to be decentralized to States and the districts, mechanisms for ensuring accountability of SACS to NACO and that for ensuring accountability of various implementing organizations to SACS is crucial for appropriate implementation of the programme. Conversely, mechanisms for downward accountability of NACO and SACS are also important. Further, with greater role of PRIs envisaged in Phase-III, mechanisms for accounting to the PRIs also need to be institutionalized. Thus institutional arrangements for NACP-III will not only have to align with governance reforms of GoI, it will also have to institutionalize project specific governance mechanisms.

2.40 Critical need to develop capacity to deal with the epidemic: India produces a large number of personnel trained in narrow disciplines of medical, social, physical and management sciences, all of which are critical inputs for the AIDS control programme. However, the availability of a large manpower base does not translate into capacity for HIV control efforts due to lack of core public health skills. Such a situation has arisen primarily because public health itself has been narrowly defined and seen as a sub-set of medical sciences. Unlike developed countries where public health education is provided in University settings involving multiple disciplines, in India public health training is mostly provided through medical colleges. As a result there is a shortage of human-power

with multidisciplinary and interdisciplinary skills required for planning and managing HIV prevention and care efforts within the country

2.41 This lacuna is even more acute in the public sector. The National Health Policy 2002 noted that "*health needs of the country are enormous and the financial resources and managerial capacity available to meet them, even on the most optimistic projections, fall somewhat short*".⁷⁰ The Government of India - Planning Commission Steering Committee on development of human resources for health noted that "*the programme managers at various levels do not have adequate training and expertise; this has been one of the major bottlenecks in many health programmes and has resulted in poor implementation*".⁷¹ The NACP is no exception. The Working Groups constituted for NACP-III planning have highlighted the lack of requisite capacity at all levels of the programme, in their respective focus areas.

2.42 While public administration skills, a key requirement for the programme, are available within the government, efforts to bring such humanpower into the programme have not been very successful. Mechanisms need to be institutionalized whereby such skills are accessible to the programme. The programme will also have to devise mechanisms for tapping into the limited pool of available humanpower within the country. Further, NACP-III will also have to build capacity of existing personnel within the programme and of a large number of its partners. Therefore institutionalizing of capacity development mechanisms at various levels is vital in NACP-III. Field visits undertaken as part of this study indicate that there are some noteworthy examples of capacity development mechanisms, which has had a measure of success. These include: mechanisms for building capacity in HIV testing and blood safety, programme support units for targeted interventions and the AP Counselors Project (APCP) for supporting counselors in VCTCs and PPTCTs of Andhra Pradesh. The feasibility of adopting such models on a larger scale also needs to be explored.

⁷⁰ GOI. National Health Policy 2002

⁷¹ Bajaj JS, GOI Secy Family Welfare, GOI-Secy ISM&H et al. Planning Commission of India. Development of Human Resources for Health. Report of the steering committee. New Delhi: Government of India. Planning Commission, 1997

2.43 Commitment to Greater Involvement of People Living with HIV/AIDS (GIPA).

The GIPA declaration of the Paris AIDS summit of which India is a signatory states that the greater involvement of people living with or affected by HIV/AIDS is 'critical to ethical and effective national responses to the epidemic'. Conversely, the declaration clearly implies that the absence of GIPA may adversely affect the national responses to HIV/AIDS.⁷² The strategy paper on Greater Involvement of People Living with HIV/AIDS (GIPA) in National Response to HIV/AIDS in India, identifies the need to establish mechanisms for (1) greater decision making role of PLHAs in the programme (2) developing the skills and abilities necessary for PLHA involvement in the implementation of GIPA (3) development of PLHA networks and ensuring their sustainability (4) providing adequate and integrated attention towards care and support issues at the national, state and district level (5) utilizing the experience of the PLHA networks in the implementation of GIPA and its effectiveness in prevention, care and service delivery components of NACP.

2.44 Need for evidence and research inputs for planning. The recent dispute between the GFATM Director and NACO regarding prevalence of HIV in India⁷³ is a pointer to the need for credible systems of gathering evidence regarding various aspects of the epidemic. This includes mechanisms for surveillance, monitoring, evaluation, research coordination and knowledge management. With adoption of one- agreed framework, the flow and quantum of information requirements would substantially scale up. There is need to integrate key information activities for more effective use of information for planning and monitoring the impact of the programme.

2.45 The Working Group on Research, Development and Knowledge Management constituted for NACP-III planning identifies four goals for research activities in Phase-III. They are (1) To prevent HIV acquisition among groups practicing high HIV related risk behaviour and among vulnerable population (2) To assess and alleviate HIV/AIDS impact on infected and affected individuals, families and communities through care and

⁷² UNDP Greater Involvement of People Living with HIV/AIDS (GIPA) in National Response to HIV/AIDS in India. Strategy paper, June 2004

⁷³ Associated Press. Official Disputes HIV stats. September 16, 2004

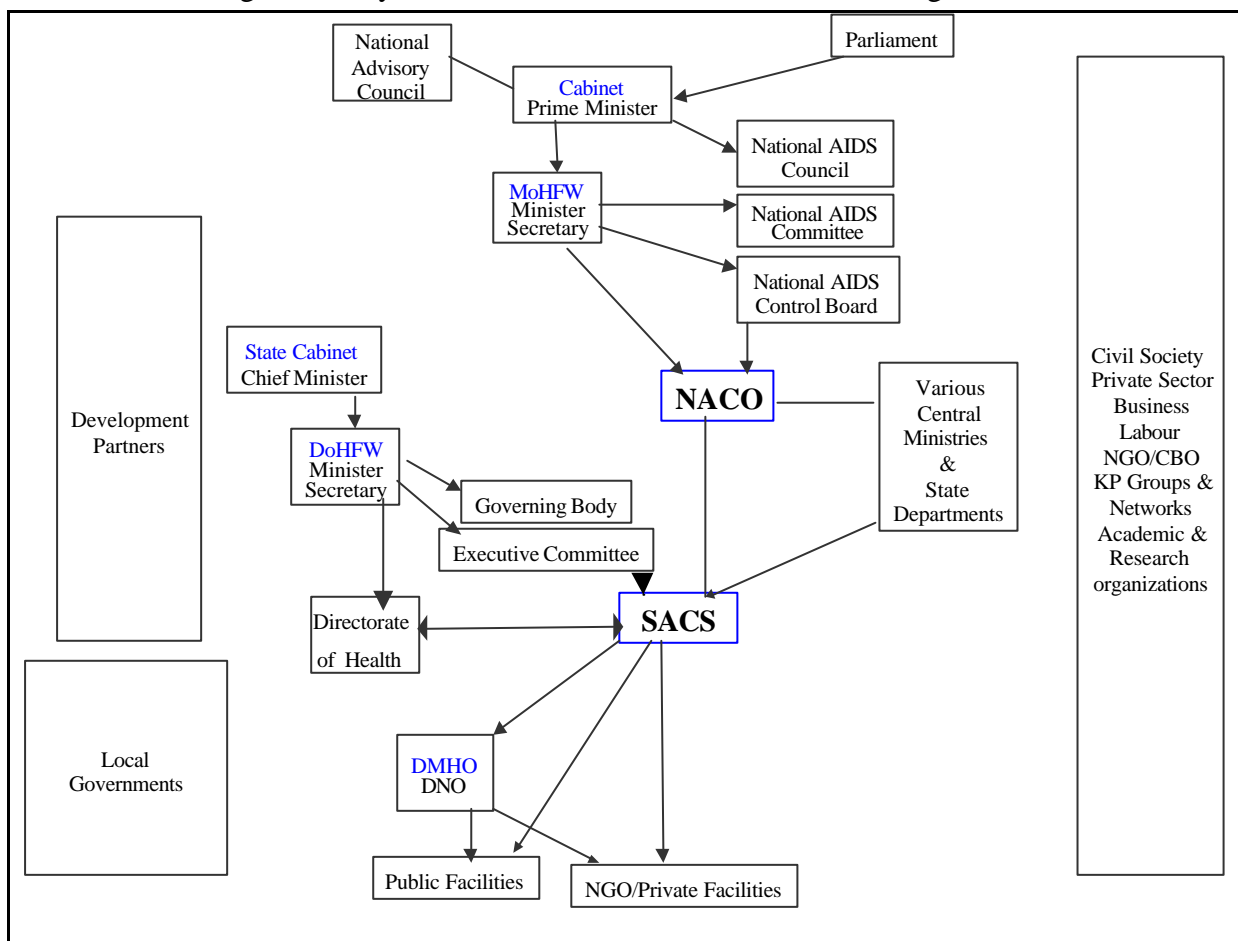
treatment from a gender and rights perspective (3) To enhance quality and robustness of HIV research and mainstream the perspectives of gender, ethics and human rights in HIV research (4) To promote and support a dynamic research environment on HIV/AIDS and develop mechanisms for efficient management of research based knowledge. Research priorities for NACP-III include biomedical, clinical, epidemiological, economic, social and behavioral aspects of HIV. NACP-III will thus require institutionalizing mechanisms to provide leadership, promote, coordinate and disseminate research at the national and regional levels.

3. Institutional Analysis of Key NACP entities

3.1 A number of entities are involved in the National AIDS Control Programme. (Figure –1).

This section deals with the institutional analysis of key entities at the national, state and district level, in terms of (1) institutional structure, which captures organizational resources, design, and components; (2) institutional functioning, which captures organizational systems, policies, and procedures, and impact as defined by program/service delivery; and (3) institutional culture, which captures additional elements, such as organizational values, political will, and leadership style. The recommendations on structure and staffing of key entities are provided along with analysis of each entity. Other institutional arrangements are dealt with in the next section.

Figure-1: Key Actors of the National AIDS Control Programme



3.2 Separate studies have been commissioned as part of NACP-III Planning on financial management, monitoring and evaluation, procurement and donor coordination. While these areas are covered in the institutional analysis, the study does not make recommendations on specific systems and procedures relating to these areas, leaving such gaps to be filled by the aforesaid studies.

National AIDS Control Organization (NACO)

3.3 NACO was established in 1992 to lead the country's response to the epidemic of HIV, as part of the institutional arrangements mandated for Phase-I of NACP. NACO was originally conceived as an autonomous parastatal. However, when it became clear that Parliament would not approve such an arrangement, it was set up as unit within the MOHFW⁷⁴.

NACO Role and Function

3.4 As the designated apex agency for the control of HIV/AIDS in the country, NACO is responsible for formulating strategy, reducing it to specific tactical interventions, and implementing them. Included in this role is identification of resources, financial and otherwise, that are needed to sub-serve its strategy and accounting for them. In addition, as described earlier NACO is also the nodal point of an extensive network, significant parts of which are not within its direct control. As an apex agency and a nodal point, NACO is entrusted with the responsibility of steering, supporting, financing, coordinating and overseeing the NACP. (See table-1). With the adoption of the three ones framework and scaling up of activities these roles will tremendously increase. Particularly NACO will be called upon to:

- ◆ Lead and develop prioritised, costed, evidence-based, multi-sectoral annual AIDS action plans that are rooted in broader development plans and processes;
- ◆ Strengthen monitoring and evaluation mechanisms and structures that facilitate oversight and problem solving for the national programme; and

⁷⁴ World Bank. India National AIDS Control Project. Project performance assessment report (credit 2350), 2 July 2003

- ◆ Lead participatory reviews of the performance of stakeholders in harmonizing and aligning their support and programmes⁷⁵

Table-1: Role and Functions of NACO

Role	Functions
Steering	<ul style="list-style-type: none"> ◆ Strategic Leadership ◆ Policy development, adoption, dissemination, and periodic review. ◆ Spearhead advocacy and social mobilisation on HIV AND AIDS in all sectors at all levels. ◆ Build partnerships among all stakeholders in the country with regional and international linkages. ◆ Legislation ◆ Define norms & standards
Support	<ul style="list-style-type: none"> ◆ Develop guidelines & protocols ◆ Provision of technical support ◆ Capacity building and development ◆ Secretariat to apex bodies ◆ Knowledge management and external communications ◆ Partnership Support ◆ Greater Involvement of People Living with HIV/AIDS ◆ Facilitation of a decentralized response ◆ Facilitate and support the development of strategic frameworks and plans throughout all sectors and decentralized units
Financing	<ul style="list-style-type: none"> ◆ Mobilize resources ◆ Allocate resources ◆ Procurement ◆ Tracking of effective utilization of funds
Oversight	<ul style="list-style-type: none"> ◆ National HIV AND AIDS monitoring and evaluation system. ◆ Quality Assurance ◆ Response Tracking
Coordination	<ul style="list-style-type: none"> ◆ State AIDS Control Societies ◆ Mainstreaming of HIV AND AIDS in all sectors at all levels. ◆ Collaboration and Partnerships with voluntary and private sectors ◆ Development Partners, International liaison and collaboration ◆ Research Coordination

⁷⁵ Dickenson Clare. National AIDS Coordinating Authorities: A synthesis of lessons learned and taking learning forward. DFID Health Resource Centre, London, December, 2005

Organizational Structure

Supervisory Structures

3.5 Three entities oversee NACO, they are:

- ◆ National Council on AIDS
- ◆ National AIDS Committee
- ◆ National AIDS Control Board

3.6 **National Council of AIDS** is the most recently formed, though hierarchically supreme.

The Prime Minister chairs the Council and Union Health Minister serves as Co-chairman. Its membership comprises of 22 Union Ministers, 7 State Chief Ministers and selected representatives from Civil Society. Its stated functions are:

To mainstream HIV/AIDS issues in all ministries and departments by considering it as a development challenge and not merely as a public health problem.

To lead a multi sectoral response to HIV/AIDS in the country with special reference to youth and the work force.

*To review inter sectoral commitment.*⁷⁶

3.7 **National AIDS Committee** was formed in 1986 and most recently reconstituted in 2003.

The Union Minister of Health chairs the Committee. Its members include health ministers of 5 states and senior officers of related central ministries/departments. The Committee also comprises of representatives from industry, trade unions, IMA and Salvation Army as non-official members. Its stated objectives are:

To act as the highest deliberative body to oversee the performance of NACO and to provide overall policy directives, and

*To forge multi sectoral collaborative efforts to enable the participating organizations [s] to mobilize their own administrative network for the various interventions.*⁷⁷

⁷⁶ Document issued by Administrative Section, NACO, dated November 23, 2005, p. 1

⁷⁷ Development Partners' Joint Mission Report, October 7, 2005, pp. 3 and 4

3.8 National AIDS Control Board was constituted in August 1992, under the Chairmanship of Secretary (Health), Ministry of Health and Family Welfare. The Board reviews the policies laid down by NACO, grants sanction to various projects, undertakes procurement and awards to private agencies. The Board also approves annual operational plan budgets, reallocates funds between programs components, forms project management teams and appoints senior program staff. The Board exercises all financial 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. Its members are:

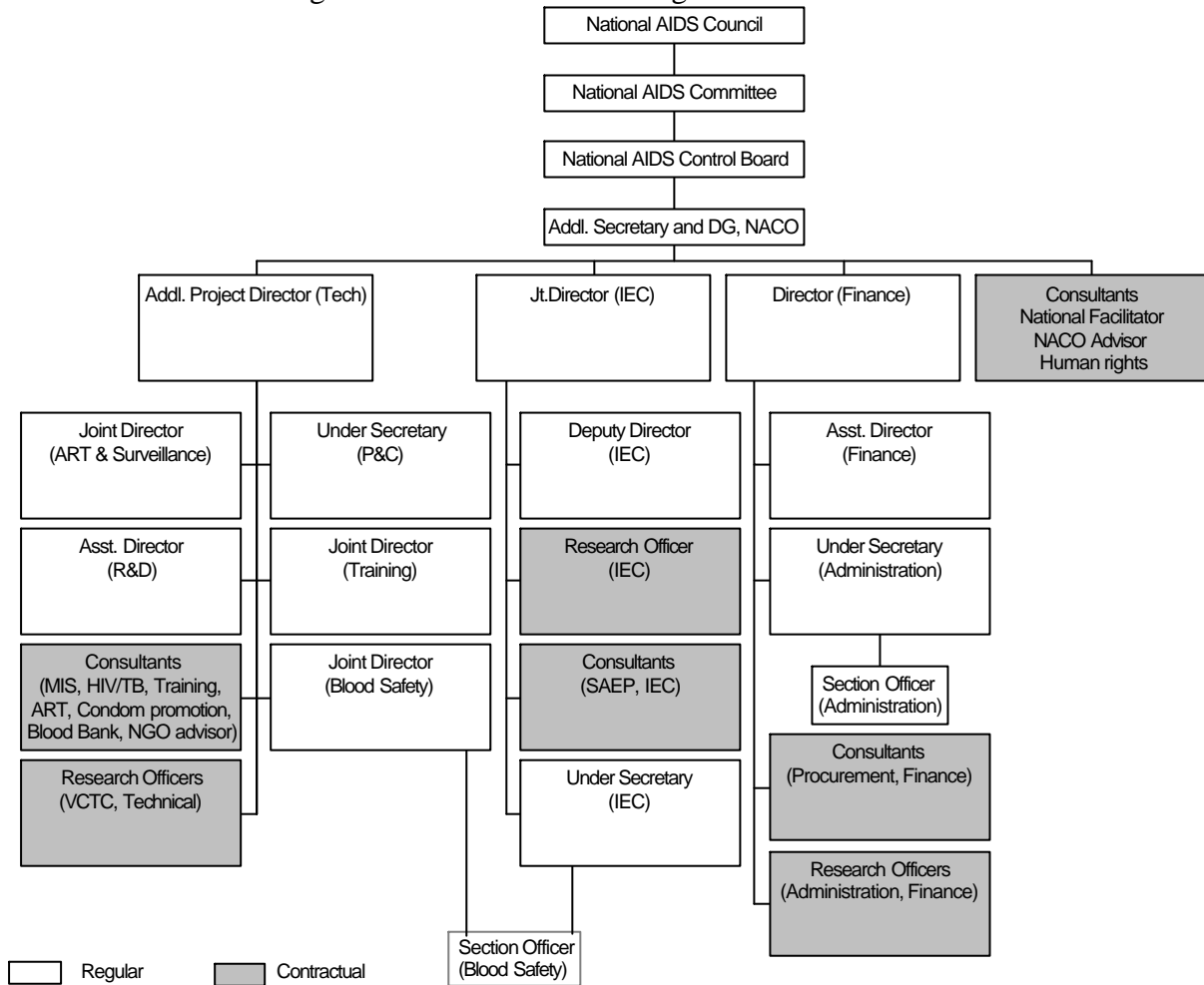
- ◆ Secretary, Health and Family Welfare (chair)
- ◆ Director General of Indian Council of Medical Research
- ◆ Advisor (Health), Planning Commission
- ◆ Additional Secretary, Department of Expenditure, Ministry of Finance
- ◆ Additional Secretary & Financial Adviser MOHFW
- ◆ Executive Director, Voluntary Health Association of India
- ◆ Dr. K. B. Sharma, former Deputy Director General of Health
- ◆ Director General, NACO
- ◆ Additional Project Director, NACO, Member Secretary.

Internal Structure of NACO

3.9 NACO is a wing of the department of Health under the MOHFW. In the commonly adopted pattern of organization in government, work in a department is divided into wings with a Special Secretary/Additional Secretary/Joint Secretary in charge of each wing. A wing normally comprises a number of divisions each functioning under the charge of an officer of the level of Director/Joint Director/Deputy Secretary. A division may have several branches each under the charge of an Under Secretary or equivalent officer. A section is generally the lowest organizational unit in a department with a well-defined area of work. It normally consists of assistants and clerks supervised by a Section

Officer. Assistants and clerks who are also known as the dealing hands generally do initial handling of cases (including noting and drafting)⁷⁸.

Figure-2: NACO’s Current Organization Structure



Source: Based on data provided by NACO, December 2005

3.10 As a wing of the Department of Health, MOHFW, an Additional Secretary heads NACO. The PIP for NACP-II had proposed five divisions headed by (1) Director (Finance) (2) Additional Project Director (Technical) (3) Additional Project Director (Targetted Interventions) (4) Joint Director (IEC), and (5) Joint Director (R&D).⁷⁹ The Comptroller and Auditor General’s report shows four divisions, the fourth being the

⁷⁸ Government of India. Central Secretariat Manual of Office Procedures, 12th Edition, Ministry of Personnel, Public Grievances and Pensions, May 2003. Chapter 3, para 24

SACS.⁸⁰ However discussions and observation in NACO indicate that it is actually operating with three, as shown in Figure 2. The fourth comprised of advisors and consultants has no executive functions. For all practical purposes NACO operates through three divisions, headed respectively by the Additional DG (Technical), Joint Director (IEC) and the Director Finance.

Table-2: Regular Staff in NACO, Sanctioned and Vacant, Dec 2005

No	Designation	Group	Posts	Vacant	Vacant since
1.	Additional Secretary and Dir.General	A	1	-	
2.	Additional Project Director (Technical)	A	1	-	
3.	Deputy/Joint Director (Blood Safety)	A	1	-	
4.	Joint Director (IEC)	A	1	1	June 2005
5.	Deputy Director (IEC)	A	1	-	
6.	Asst/Dy/ Jt Director (R&D)	A	1	-	
7.	Director (Finance)	A	1	-	
8.	Asst/Dy Director (Technical)	A	1	-	
9.	Under Secretary (FA)	A	1	-	
10.	Under Secretary (IEC)	A	1	-	
11.	Under Secretary (P&C)	A	1	-	
12.	Asst. Director (Finance)	A	1	-	
13.	Asst. Director (LACI)	A	2	2	Mar 02, Sep 05
14.	Systems Analyst/Programmer	A	1	1	1999
15.	Section Officer (P&C)	B	1	-	
16.	Section Officer (BS and IEC)	B	1	-	
17.	Assistant	B	4	1	Nov 2004
18.	Assistant (Technical)	B	2	2	1999, Dec 04
19.	Assistant Accounts Officer	B	1	1	(Not known)
20.	Statistical Assistant	B	2	1	1999
21.	Private Secretary	B	3	-	
22.	Personal Assistant	C	5	2	1999
23.	Stenographer	D	3	-	
24.	Upper Div Clerk	UDC	1	-	
25.	Lower Div Clerk	LDC	3	-	
26.	Driver		4	1	1999
27.	Peon		9	3	1999
TOTAL			55	15	

Source: Computed from data supplied by NACO, December 2005

3.11 The posts at NACO are of two kinds: to use NACO's own terminology, 'Regular' and 'Contractual'. Regular refers to those posts that are considered to be required on a

⁷⁹ Project Implementation Plan, NACP-II, NACO, Jan. 1999, p.90

⁸⁰ Comptroller & Auditor General of India, report on MOHFW, National AIDS Control Program, May 25, 2004, p. 2

continuing basis as distinct from those that are specific to a project; program tied or project tied. Deputation from various government ministries fills the regular posts. MOHFW is the largest contributor to NACO. Others are from the cadres of the Indian Administrative Service, Central Secretariat Service, and Indian Information Service.

3.12 Various Development Partners fund contractual posts at NACO. These are summarized in Table 3, below. For those funded by UNAIDS, NACO receives the salary amount and disburses it. Incumbents are selected and recruited by NACO. To all intents and purposes they are similar to regular staff except that their tenure is project tied. All others are also project tied but selected and paid by the donor.

Table –3: Contractual Staff in NACO, 2005

	Funding agency	Consultants	Research Officers	Technical Assistants	Others*	Total	Vacant
1.	UNAIDS	13		14	2	29	10
2.	USAID	0		3	1	4	-
3.	Clinton Foundation	2	9	9		20	8
4.	WHO	4	-	-	2	6	2
5.	UNICEF	5	-	-	-	5	-
6.	UNIFEM	1	-	-	-	1	-
TOTAL		25	9	26	5	65	20

* Includes data entry operators, telephone operators, transport assistants, etc

SOURCE: NACO, Tables provided in December 2005.

Structural Strengths

3.13 Location within MoHFW. Many of NACO's interventions require intensive and continuing collaboration with institutions of central and state health ministries. In addition, MOHFW is a major contributor of human resources to NACO. On the flip side, NACO has much to contribute to other health programs. Albeit, with differences, HIV/AIDS belongs to the genre of communicable diseases and its prevention is based on more or less similar principles as the more prosaic ones: malaria, tuberculosis, gastrointestinal infections and hepatitis, for example. NACO has been successful by many reckonings in initiating a multi-sector response and community mobilization, key

requirements for communicable disease control. NACO is also far more user centric, witness its dealings with people living with HIV. No other disease control programme has done either as consciously or effectively and could well learn from the HIV/AIDS experience. Such mutual learning is more likely if they belong to the same ministry and share similar constraints.

- 3.14 Empowered with comparatively more autonomy. Firstly, NACO is headed by an Additional Secretary of the Government of India, empowered to function independently in day-to-day administrative and functional matters. In matters requiring orders of the Minister, other than those relating to policy, Additional Secretary can submit files directly to the Minister⁸¹. Secondly, the National AIDS Control Board exercises all financial powers which the Department of Health, Government of India, can exercise with the approval of the Department of Expenditure, Ministry of Finance. Since the Ministry of Finance is represented on the NACO Board, no separate reference to the Ministry of Finance for funding of planned activities of NACO is required⁸².
- 3.15 The composition of its supervisory bodies raises the profile and mission of NACO and provides leverage for influencing states as well.
- 3.16 Deputation of staff from different services brings expertise to NACO especially in the areas of public administration and clinical management. Contracting of staff is useful in availing skills that are not readily available in the public sector and ensuring a minimum complement of staff which otherwise may not have been feasible given the reluctance within government to create new posts.
- 3.17 In addition to the staff involved in institutional and program management NACO also requires people with skills in narrower specialization in the medical, social and management sciences. In Phase-II, NACO set up Technical Resource Groups in various institutions in 12 thematic areas (Annex-5), to provide technical assistance to the programme. NACO deserves commendation for doing so rather than seeking to place

⁸¹ Government of India. Central Secretariat Manual of Office Procedures, 12th Edition, Ministry Of Personnel, Public Grievances and Pensions, May 2003. Chapter 6, para 27

⁸² Report of the CAG on the Union Government for the year ended March 2003; Union Government (Civil) Performance Appraisals (3 of 2004)

them in-house. This is commendable as the fostering of such skills require a collegial and academic environment rather than that of an operating program.

Structural Weaknesses

- 3.18 The divisional structure of NACO is not clearly delineated. Roles, responsibilities and reporting relationships, especially of the large number of consultants are not clear and this affects accountability. The divisions are not self contained especially in terms of office support staff- Section Officers and dealing hands. Such staff perforce reports directly to more than one higher level officer, a bad principle particularly in bureaucratically structured organizations such as those of government.
- 3.19 The division dealing with finance is also responsible for procurement, administration and routine housekeeping. By itself, finance is a major responsibility. There are many, and complex disbursements by NACO to states and other points of the network. Further, accounting to statutory bodies and DPs is demanding in terms of time as are procurements supported by DPs, which require elaborate and varying procedures. On the other hand, the routine housekeeping of NACO is by itself quite onerous, not only as an apex organization but also as the nodal point of a network. Internal administration includes responding to the needs of higher deliberative bodies, subaltern units such as State AIDS Control Societies (SACS) and coordination with donors and a variety of partners. As the workload of each of them is heavy, and critical, clubbing of finance with procurement and administration leads to delays in disbursements to SACS and other points of the network as well as chronic under utilization of allocated funds, both with serious consequences. SACS often complain that their queries are not addressed promptly enough
- 3.20 About 27 percent of the regular posts are vacant, some since the inception of the project in 1999, others for more than two years (Table 2). It suggests that either these post are dispensable, in which case they should be dispensed with, or there are recruitment bottlenecks, which should be removed. Except one, all the vacancies are at lower levels, of clerical and secretarial staff. This is surprising since normally one would expect them to be easier to fill. NACO staff themselves pointed out that this adversely affects NACO's efficiency. One cannot realistically expect senior officials to do their own filing and drafting. As a result files and other data are hard to retrieve. This, with

high turnover of staff shortens NACO's institutional memory, not to mention interminable delays.

- 3.21 Though incumbents of various posts in NACO generally have the requisite technical background, there is inadequate capacity for programme planning and management especially in the middle rung of NACO. The skill-mix available in NACO for policy analysis, microplanning, advocacy for demand generation, networking and partnership building, contract management, human resource management, information technology, monitoring and evaluation and knowledge management, is limited.
- 3.22 NACO does not have dedicated focal points for discharging many of its core functions such as planning, support to deliberative bodies, partnership support, monitoring and evaluation, donor coordination, research coordination, mainstreaming and human resource management. This results in a situation where NACO rather than being proactive is forced to react to demands, usually through adhoc arrangements leading to delays in the programme and disruption of routine work.
- 3.23 NACO currently has 3 supervisory bodies- Council, Committee and Board. The National AIDS Committee chaired by the Health Minister was set up to act as the highest deliberative body to oversee the performance of NACO and to provide overall policy directives. The recently created National AIDS Council chaired by the Prime Minister supercedes the Committee. There is considerable overlap between the stated objectives of both these bodies. Further, a coordinating body is required at the national level with due representation to all major stakeholders to oversee the implementation and progress of the national plan, in accordance with the three ones framework. However neither the mandate nor structure of existing supervisory structures of NACO enable them to play this role. Despite focus on GIPA, PLHAs are not represented Board or Committee. Similarly development partners despite their overwhelming presence in the HIV control efforts of the country are also not represented. Though civil society is represented on these bodies, representatives are nominated by the government more in their individual capacity and are generally not accountable to the variety of CSOs working with the programme.

Functional Strengths

- 3.24 Significant decentralization of implementation to state level
- 3.25 Evolved a system of participatory planning which has prepared ground for involvement of stakeholders in developing an action plan for the country in accordance with the three ones framework. The processes involved were:
- ◆ Setting up of working groups involving experts from academic, government and NGO sectors and incorporating their recommendations into the framework
 - ◆ An e-forum with open participation from all interested persons
 - ◆ Consultations at state level with government and non government stakeholders
 - ◆ National consultation with civil society organizations including CBOs of persons infected and affected by HIV and key populations highly vulnerable to HIV⁸³
- 3.26 Computerized Management Information systems (CMIS) have been developed to facilitate monitoring progress of the programme at central level. Computerized Project Financial management System (CPFMS) which tracks finances from national budgets to states to implementing agencies, has also been put in place.
- 3.27 NACO has been able to prepare guidelines and norms for a number of interventions
- 3.28 Quarterly review meetings with project Directors of SACS to monitor progress of implementation of the programme in States

Functional Weakness

- 3.29 Of the three oversight structures of NACO, only the Board comes closer to be a supervisory body than either the Council or the Committee. In practice the Council and Committee is more supportive than supervisory and given its membership, perforce meets infrequently. During the thirteen years of its existence, the National AIDS Committee has met only six times, the last being 9 May 2001.⁸⁴ Moreover, neither the Committee nor the Council is likely to raise issues on their own and is more likely to respond to those

⁸³ NACP-III Planning Team. Draft Institutional Arrangements for Implementing NACP-III, October 14, 2005

⁸⁴ *ibid*

brought to it by NACO. There is no evidence that NACO has been able to avail the power and influence of the Council and Committee for programme implementation.

- 3.30 Systems and procedures for effective discharge of many of the core NACO functions are not in place. These include systems for coordination with SACS, development partners and other stakeholders; mainstreaming; research coordination; analyzing reported data and providing feedback to reporting institutions; external communications; support to supervisory bodies and responding to statutory authorities; capacity development and programme support. In the absence of institutionalized mechanisms to effectively perform many of its supportive, coordinating and oversight roles, NACO is constantly in a fire-fighting mode dealing with exigencies through adhoc mechanisms usually centralized around top management. An event like “World AIDS Day” or a parliamentary session forces the entire top management to be preoccupied with micromanagement and bureaucratic functions, often at the expense of other national roles.
- 3.31 In the present system of staffing of NACO through deputation from identified cadres, skills and experience of the deputed staff does not necessarily match the needs of the job. Deputation is done as a matter of routine rather than based on any consideration of the job profile of the post. Therefore, there are at times mismatch between the skills and background of the incumbent and the post to which he/she has been deputed.
- 3.32 There are no systems in place for undertaking manpower planning, job design, or career planning. There are no mechanisms for holding staff accountable for getting work done according to clear performance standards. The human resources management function suffers from inadequate incentive schemes, lack of output-based performance evaluations, and inadequate personnel training. Very limited opportunities exist for staff professional development and on-the-job training.
- 3.33 Though NACO sought to access technical support to the programme through creation of Technical Resource Groups (TRGs), they failed to take off in many areas because: the terms of reference were not clearly defined; funding was limited; lack of direction from

NACO; most of the groups met infrequently; and staff in SACs and NGOs did not know how to access their expertise.⁸⁵

3.34 Programme implementation is constrained by gaps between the budget proposed by NACO and budget allocated by GOI, lack of timely access of allocated funds and inability to promptly respond to issues that has financial implications. Given that a major proportion of the funds is meant for disbursement to various implementing agencies, such delays significantly impact the programme. Reduced outlays and delays in disbursement of funds appear to be more on account of existing systems and procedures for financial management rather than structural factors. NACO being a dedicated wing of the MOHFW follows the government budgetary process and government system of approval and authorization. The GOI through MOHFW allocates resources to the NACP annually for implementation of the programme. Though NACO prepares annual estimates based on costing of annual action plan (AAP), the initial Budget Estimates (BE) for NACP are prepared by GOI without any meaningful consultation with NACO. Due to resource constraints of GOI, there is significant gaps between the budget proposed by NACO and budget allocated by GOI, resulting in uncertainty/reduced outlays to the programme. Moreover finalization of Revised Estimates (RE) is generally delayed, resulting in large fund release in last quarter of the financial year. NACO has also not benefited from additional funds committed by various development partners due to overall budgetary ceilings. Further, budget allocation to NACP is done under five budget heads, which restricts its utilization as re-appropriation of funds between budget heads is a complex and time consuming process.⁸⁶

3.35 Within the ministry, all payments are subject to final scrutiny and concurrence by the IFD of the MOHFW, leading to delays in release of funds to SACS and other partners. Once concurrence is obtained NACO prepares a bill and forwards it to Section Officer (Cash) who processes it for payment and sends it to the PAO for release of payment. Case studies done by the working group on financial management for NACP-III planning indicate that this process takes at least 30 days for routine cases, where no objection is

⁸⁵ World Bank. India National AIDS Control Project. Project performance assessment report (credit 2350), 2 July 2003

raised at any point of the system. When files are referred back by IFD to NACO, it takes considerably more time to process payment.⁸⁷

3.36 NACO has to meet reporting requirements of a number of donors, each with its own reporting formats. While financial reports required by the World Bank are generated through CPFMS, reports to other DPs are prepared either manually or through a system other than CPFMS. There is no system facilitating preparation of consolidated project accounts for the whole project. Further, accounting records of NACO are maintained in the PAO of MOHFW on a different computerized system. Similarly, CMIS is not enabled to receive inputs from a large number of NACO partners. Both the MIS systems work in isolation and lacks synergy for facilitating joint programme reviews.⁸⁸

3.37 Though NACO has delegated significant functions and resources to SACS, it is ultimately responsible for the latter's performance. However NACO has very little control over SACS and mechanisms to ensure accountability of SACS to NACO are lacking.

Cultural Strengths

3.38 There is considerable awareness for the need for restructuring and reforming functioning of NACO among higher political leadership and the bureaucracy. Key staff at NACO holds a similar view. This awareness sets the ground for systematic change within NACO.

Cultural Weakness

3.39 Decision making process and leadership function within NACO is highly centralized at the level of the Director General, with very little downward delegation of authority.

3.40 While deputation has the potential of bringing in the right leadership to NACO, there is no system to ensure a minimum tenure of the functionaries at NACO. In the current project period, NACO had 4 Director Generals and 4 Director's of Finance. There is lack of continuity and low institutional memory due to frequent leadership changes.

⁸⁶ Report of the Working Group on Financial Management, NACP Phase III Planning

⁸⁷ Report of the Working Group on Financial Management, NACP Phase III Planning

3.41 NACO does not have objective criteria for recruiting and remunerating contractual staff. For instance the salary of a consultant appointed with UNAIDS support is around Rs. 26,000 per month while other consultants draw two or three times more. The remuneration seems to be more due to the funding source rather than qualifications or experience. This affects staff morale and organizational cohesiveness.

Recommendations for NACP-III

3.42 **Continuation of NACO as a Wing of MOHFW.** Its present location could be leveraged for greater integration of HIV control efforts with other health programmes and securing deputation of appropriate personnel to NACO in phase-III.

3.43 **Rationalizing Supervisory Structures of NACO:** The Committee has not met in the last five years. Since both the Council and Committee have overlapping objectives and the Council by virtue of it being chaired by the Prime Minister supercedes the Committee, it is recommended that the Committee may be disbanded and the oversight structures streamlined. The National AIDS Control Board, which has the primary responsibility for governance of NACO and ensuring significant autonomy to NACO, must be mandated to meet at regular intervals. The higher level review will occur at the level of the Council. NACO needs to be more proactive in leveraging the influence of the Council, which have representation of the highest levels in government. A mechanism whereby periodical reports will be provided to Secretary (Health) by NACO, for placing before the Board and Council has to be established. Further, in line with principles of GIPA, PLHAs need to be represented in these higher decision making bodies. Rather than nominate members from civil society to these bodies, it would be desirable to evolve a system by which CSOs can elect/select their representatives from among themselves. Such a system has potential for improving downward accountability of NACO.

3.44 **Internal Restructuring to address weaknesses and leverage institutional strengths of NACO:** The key principles adopted for the proposed restructuring are:

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- ◆ Alignment of structure in accordance with changing role of NACO
 - ◆ Creation of clearly delineated divisions based on primary functions performed
 - ◆ Clear reporting relationships and communication channels
 - ◆ Facilitation of decentralized decision making
 - ◆ Optimal span of control that provides for fewer hierarchical levels and subordinate autonomy and at the same time enables close supervision
 - ◆ Promotion of institutional memory and institutional learning
 - ◆ Staffing to be based on skill-mix required to effectively discharge its key roles.
 - ◆ To put in place designated focal points for key programme areas, given that NACO will have to essentially function through coordination, collaboration and partnerships with multiple agencies.
 - ◆ Institutionalizing arrangements to ensure responsiveness and accountability to key stakeholders

3.45 Accordingly, 5 divisions are proposed in NACO for Phase III. They are

- ◆ Health Services
- ◆ Communication and Social Mobilization
- ◆ Administration and Planning
- ◆ Finance
- ◆ Strategic Information Management

3.46 **Health Services** division will look after all medical and health related interventions for HIV care and prevention. Its leadership will require a person with knowledge and experience of dealing with medical and health establishments combined with management skills. Core programme areas include:

- ◆ Blood Safety
- ◆ Biomedical Waste Management & Infection Control
- ◆ Voluntary Counselling and Testing
- ◆ Care & Support (ART, OI, PPTCT, PEP, Co-Infection)
- ◆ STI/RTI/RCH
- ◆ Training on HIV/AIDS Prevention and Control

3.47 **Communication and Social mobilization** are clubbed together as communities can only be mobilized through communication – broadcast and interpersonal. Advocacy falls

as a subset of community mobilization. The leadership of this division will require skills and experience in the management of communication programs, including ideally, interpersonal counseling. As much of this will be done through organizations outside MOHFW and the formal structure of government, such a person will require soft persuasive skills. Core programme areas include:

- ◆ Mass Media
- ◆ Targetted Interventions
- ◆ Condom Promotion & Social marketing
- ◆ Gender, Youth & Children
- ◆ GIPA
- ◆ Advocacy
- ◆ Human Rights

3.48 **Administration and Planning** are clubbed together, as they both require hard core managerial skills. This division will be the focal point for coordination with SACS, DPs and other partners, which will receive the query or grievance and identify the appropriate unit to deal with it. The task of planning at national level and coordination of state level plans will also be within this division, seeking technical and budgeting help from other divisions. A key function of this division will be to provide support to higher deliberative bodies of NACO. Since procurement is a function of materials management, it is recommended that it be made the responsibility of this division. In addition, routine housekeeping and human resource management will essentially be a function of this division. The Director of this division will be primus inter pares, and officiate for the Project Director in his or her absence. Leadership of this division is best drawn from the generalist management cadres, preferably with experience in social sector programs. Core programme areas include:

- ◆ Human Resource Management
- ◆ Planning
- ◆ Mainstreaming
- ◆ Partnerships (Program Support)
- ◆ Procurement
- ◆ Donor Coordination

3.49 **Finance** division will be responsible for resource mobilization, finance management, auditing, budgeting and expenditure management. The leadership of this division will be from the Ministry of Finance. It would be desirable if the Finance Division is recognized as an extension of IFD division of MOHFW. The Finance division may carry out the requisite financial scrutiny and analysis on behalf of the IFD division and directly seek concurrence of AS & FA through DG, NACO.⁸⁹ This would reduce multiple processing and speed up fund disbursement. Core programme areas include:

- ◆ Finance & Accounts
- ◆ Audit
- ◆ Computerized Project Financial Management System

3.50 **Strategic Information Management** division will be responsible for monitoring and gathering evidence for planning, implementing and assessing impact of the programme. Documentation of evidence and its dissemination will also be essentially a function of this division. In addition the division will also be responsible for identifying and prioritizing research themes, facilitating research on HIV/AIDS in the country, planning and coordinating national level research studies and knowledge management. Integrating financial and programme data and providing feedback to programme managers and implementers will also be functions of this division. Its leadership will require a person with a background in multidisciplinary research and information management. Core programme areas include:

- ◆ Surveillance
- ◆ Monitoring
- ◆ Evaluation
- ◆ Research Coordination
- ◆ Information Systems
- ◆ Knowledge Management

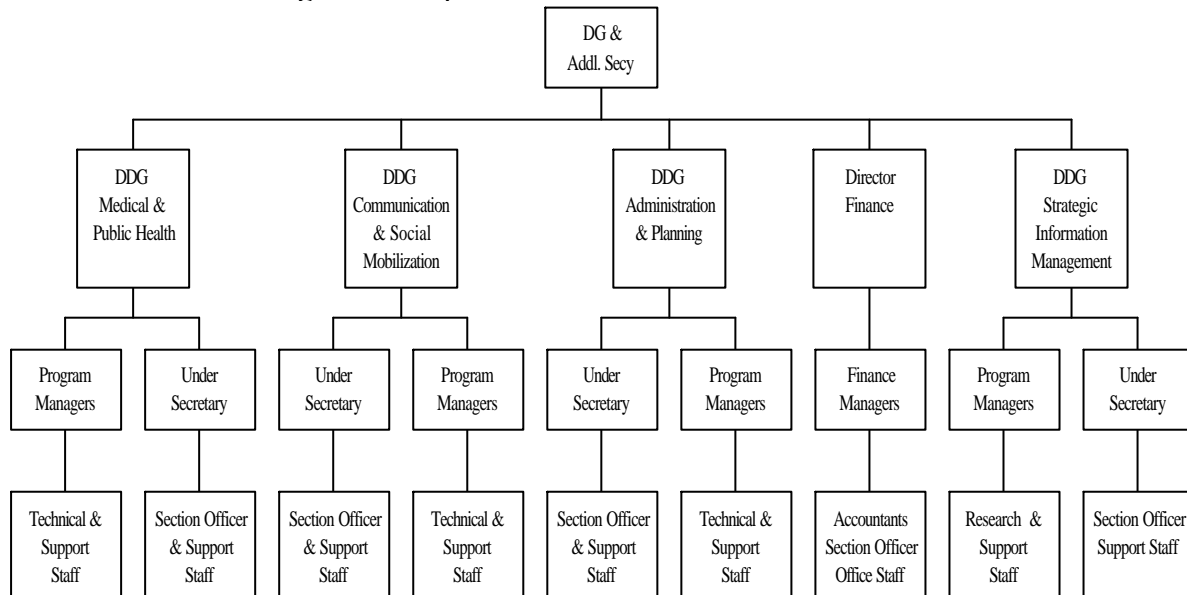
3.51 It is recommended that there be at least one program manager for each of the core areas identified under each division. He/she will have requisite support staff in form of

⁸⁹ Report of the Working Group on Financial Management, NACP –Phase-III Planning

research officers, technical assistants and/or secretarial assistants. Officers at this level will be the national focal point for that particular programme area to their SACS counterparts and other partners. Each Program Manager will be primarily responsible for coordinating technical support, development of guidelines and strategies, monitoring and evaluation, training and reporting units for the assigned area of the programme and building partnerships and collaborations in the specific area handled by them.

3.52 In the proposed structure (Figure 3) designations such as Deputy Director General (DDG), Director, Under Secretary (US), and Section Officer are used but could well be modified to be consistent with similar Central Government organizations. Support Staff, should be as per prevailing norms in MOHFW and other departments of the Central Government.

Figure-3: Proposed Structure of NACO for Phase-III



3.53 The proposed divisions are based on the skills required for specific functions and work loads. They are likely to be needed for the near future. Level 3 may change with respect to Program Officers from time to time with concomitant changes in research support staff. Other support staff is likely to be needed as long as the proposed paradigm is continued.

3.54 The organization structure as proposed does not indicate as to whether a post is to be among the ‘Regular’ or ‘Contractual’. It identifies the posts leaving it to NACO and the

government as to whether chose between the two options. The posts of the Director General, DDGs and Director Finance will quite obviously to be among the Regular Posts.

3.55 Further, while structure itself is important, it is a necessary but not adequate precondition. Systems and procedures also need to be tightened. The various divisions need to be clearly identified and correspondents advised to deal with them directly. The division head will of course, inform and consult with the Project Director as and when he or she considers necessary but proper delegation will relieve the Project Director to focus on broader and more seminal issues. Further, in accordance with GOI office procedures, NACO should prescribe instructions regarding the level of final disposal and channel of submission for each category of cases, keeping the number of levels at which a case is examined to the minimum by delegating powers to lower formations. These instructions will also be maintained in electronic form and reviewed every three years.⁹⁰ Specific arrangements for governance, improvement of project support, coordination, collaboration and partnerships are discussed in the subsequent section.

3.56 **Strengthening Human Resource Management at NACO:** The range and scale of activities planned for NACP-III requires substantial scaling up of managerial and technical capacity within the programme. Some of the key skills that NACP will need to institutionalize include:

- ◆ Planning
- ◆ Interpersonal Communication
- ◆ Advocacy for demand generation
- ◆ Clinical management
- ◆ Counseling
- ◆ Networking and partnership building
- ◆ Media Management
- ◆ Contract Management
- ◆ Materials Management

⁹⁰ Government of India. Central Secretariat Manual of Office Procedures, 12th Edition, Ministry Of Personnel, Public Grievances and Pensions, May 2003. Chapter 6, para 27

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- ◆ Finance Management and Administration
 - ◆ Human Resource Management
 - ◆ Information Technology
 - ◆ Monitoring and Evaluation
 - ◆ Policy Analysis
 - ◆ Knowledge Management⁹¹

3.57 Human resource management of NACO will be a function of the Administrative Division. It will be responsible for undertaking needs assessment, skills inventory, and manpower planning. A key prerequisite is preparation of job profile and required skill profile for all posts in NACO, which has to be approved by the multidisciplinary standing committee on technical support, constituted by NACO. The division will coordinate recruitment of staff and ensure that vacancies are filled up within specified timelines.

3.58 The Director General will provide the first line of leadership of NACO. The second line of leadership will be constituted by Division heads who will supervise core programme areas within respective divisions and be accountable for their performance. The third tier and in some cases the fourth tier will be composed of personnel who will manage specific programme areas. Therefore, NACO should essentially be looking for programme managers with a technical background and specialized skills in the concerned programme area. In addition, NACO will also require core technical support for different areas of the programme. It is recommended that any long-term requirements of such support may be out-sourced to identified national institutions (see Section 4).

3.59 Personnel with requisite skills and background for many of the senior posts may be available within the government. The key is identifying such personnel and securing their deputation to NACO. When such skills are not available within government, they may be contracted from open market. Given that these personnel are programme managers, it would be desirable that their designation be reflective of this status rather than “consultants’ which was the case in Phase-II. Key administrative staff such as Under

⁹¹ Report of Working Group on Programme Management, NACP-III Planning Team

Secretary and Section Officers will obviously be from government services. Other research, technical and office support staff may be in-sourced from different services or contracted from the market.

3.60 It is recommended that a suitable officer for the post of DG, NACO, be identified through an active and directed search within the IAS cadre. The Board may constitute a search committee for this purpose. The good offices of the Council may be used not only to get the deputation of the identified officer, but also to secure the tenure for three to five years. A similar approach could be adopted for securing deputation of divisional heads. The task of identifying candidates with suitable background will become easier when the recommended empanelment system of GOI is fully operative.⁹²

3.61 For other senior posts, when there is a reasonable chance that suitable personnel are available within government service (including central, state and SACS), such posts may be advertised within the government. Those interested and fitting job profile may be short-listed and selected by a Selection Committee constituted by the Board which in addition to DG NACO and DDG (Admin) will also comprise of at least two subject experts. NACO could then ask for their deputation. The composition of the selection committee for recruitment of senior contractual posts will be similar. It is recommended that recruitment of contractual supporting staff may be done by a committee constituted by DG, NACO and headed by DDG (admin).

3.62 Pay scales for different levels of contractual staff need to be fixed as per market rates. It is recommended that personnel of similar rank get similar remuneration irrespective of the source of funding. It is also recommended that recruitment of all contractual staff may be done by NACO based on a clear job profile and specific terms of reference including mechanisms of evaluation of performance. Depending on the anticipated workload the initial process of advertising and short listing candidates may be out-sourced to a third party.

⁹² Report on the System of Performance appraisal, Promotion, Empanelment and Placement for All India Services and other Group 'A' Services , DOPT, GOI, 2003

3.63 NACO needs to take steps to attract and retain people. A deputation allowance of 25% of the basic pay may be given as an incentive to attract people from within the government. Prospective incumbents can be attracted and retained by improving the work atmosphere, but more so by providing opportunities for growth, such as through structured in-service training, within NACO and outside it. Further, NACO should institutionalize a transparent mechanism of output based performance evaluation.

State AIDS Control Societies

Role and Functions

3.64 As the designated state agency for implementing the NACP in the States, SACS functions more or less as the State counterpart of NACO. It is responsible for steering, supporting, financing, overseeing and coordinating the NACP in the State (Table-4). With scaling up of activities and further decentralization of the programme in Phase-III, these roles will increase.

Table 4: Role and Functions of SACS

Role	Functions
Steering	<ul style="list-style-type: none"> ◆ Adapt national policies and programs to State circumstances ◆ Develop plans to operationalize policies and strategies ◆ Spearhead advocacy and social mobilization on HIV AND AIDS in all sectors at all levels. ◆ Build partnerships among all stakeholders in the state
Support	<ul style="list-style-type: none"> ◆ Provide appropriate environment for implementation ◆ Technical Support to implementing units ◆ Provision of technical support ◆ Capacity building and development ◆ Secretariat to apex bodies ◆ Knowledge management and external communications ◆ Partnership Support ◆ Greater Involvement of People Living with HIV/AIDS ◆ Facilitation of a decentralized response ◆ Facilitate and support the development of strategic frameworks and plans throughout all sectors and decentralized units
Financing	<ul style="list-style-type: none"> ◆ Mobilize resources at State level ◆ Allocate resources ◆ Procurement
Oversight	<ul style="list-style-type: none"> ◆ Monitoring & evaluation of implementation
Coordination	<ul style="list-style-type: none"> ◆ NACO ◆ Mainstreaming of HIV AND AIDS in all sectors at all levels. ◆ Collaboration and Partnerships with voluntary and private sectors ◆ Development Partners ◆ Serve as channel to district ◆ Feed local dynamics to the Centre

Organizational Structure

Supervisory Bodies

3.65 SACS has two supervisory bodies:

The Governing Body

Executive Committee

3.66 **The Governing Body** has full control of the affairs of the Society and the authority to exercise and perform all the powers, acts and deeds of the Society consistent with the aims and objects of the Society. The annual budget and the annual action plan of SACS have to be approved by the Governing Body before it is passed. It reviews the financial position of the Society and annual audited accounts and can accept donations and endowments or give grants upon such terms, as it thinks fit. The Governing Body at its discretion may delegate its powers to any authority of the society, appoint committees, sub-committees and boards etc., and develop and adopt its own rules and regulations for recruitment and appointment of experts and administrative / technical staff and set its own compensation package for such experts / staff to be recruited from the open market and/or deputation basis. Chairmanship of the Governing Body varies from State to State. The Governing Body may be chaired by the Chief Minister (e.g. Karnataka), Health Minister (e.g. Assam), and Chief Secretary (e.g. Kerala). Other members usually include; Secretaries of health, finance, education, social welfare etc., DHS, DME and NGO representatives. In addition it may co-opt representatives of relevant institutions and groups. The Governing Body normally meets once a year.

3.67 **The Executive Committee** is set up by the Governing body to ensure the timely and effective implementation of 5 yearly, annual, and quarterly work plans as detailed in the project implementation plan. Significant powers of the Governing Body may be devolved to the Committee. The Health Secretary chairs the Executive Committee. Its membership is more or less similar to that of the General Body. Normally it meets about 3-4 times a year.

Internal Structure of SACS

- 3.68 In Phase 2, states were classified into three groups based on the size of their population in 1991. The first group included seven large size states with population over 50 million, the second group included 8 medium sized states and 2 mega-cities with population between 10 and 50 million and the third comprised of small states, union territories and large municipal corporations with a population below 10 million. There were some variations in the structure of SACS based on the group to which they belonged
- 3.69 Given the focus of Phase-II on an effective communication campaign, targetted interventions, extensive inter-sectoral collaboration and close coordination with non-governmental organizations, it was decided that SACS of large and medium size states would be headed by an officer of the IAS cadre who had the experience of serving as a District Collector. An IAS officer or any suitable person, depending on availability was to head the SACS belonging to the third group.
- 3.70 Phase-II envisaged SACS as compact and effective organizations with substantial delegation of responsibilities to the second level officers. Extensive use of computers by all personnel was anticipated and accordingly the organization was structured with a smaller than usual number of support staff in clerical cadres and below. Further it was proposed that roughly three fourths of the personnel will be on contractual appointments with a consolidated monthly fee and selected from open market in a competitive and trained manner⁹³.
- 3.71 The PIP of the second phase specified six divisions in SACS of the large states. Four divisions headed by senior officers drawn from state health service (Targeted interventions, blood safety, training and surveillance), an IEC division headed by a contracted professional and the division for Administration and Finance headed by state government finance personnel. In the medium and small states, the surveillance and training divisions were merged. In large and medium states, the targeted intervention division would be headed by an Additional Project Director and the other divisions by

⁹³ Project Implementation Plan, National AIDS Control Project, Phase-II (1999-2004), NACO, MoHFW, pp 93-95

Joint Director level officers. In small states Deputy Director-level officers would head the divisions.⁹⁴

3.72 The project was sanctioned with minor deviations from the PIP. The distribution of sanctioned posts indicates a more central role for the Additional PD as a second in command to the PD, rather than a head of the targetted intervention division. The sanction letter specified various posts for each category of states and whether they were deputation posts or contractual. Compared to the PIP, there was substantial decrease in the number of support staff sanctioned.⁹⁵

3.73 Large states were sanctioned 23 and 16 posts on deputation and contract respectively. The corresponding numbers for medium and small states are 20 and 13, and 13 and 10 respectively.⁹⁶ In addition, 5 posts are sanctioned for the accounts and finance unit in large states. Medium and small states have 4 and 2 posts respectively. The Finance Controller, Finance Manager and Finance Officer in large, medium and small states respectively, are to be filled up strictly on deputation basis.

3.74 The NACO prescribed structure for SACS (Figure- 4) was implemented in the States in Phase-II with variations on account of local compulsions and constraints. An IAS Officer heads the AIDS Control Society in 13 of the 17 large and medium states. A medical officer heads the remaining four in the said group. AIDS Control Societies in 16 of the 18 smaller states/UTs/Corporations are headed by a medical officer and in 2 by an IAS officer. In the three newly created states, an IAS Officer heads the SACS in one and a medical officer in the other two. Within the same group of states there are variations in the number of posts sanctioned and the deputation/contractual staff mix.⁹⁷ For instance: in Assam the PD is a retired government official who has been re-employed. The APD in Bihar is a contracted professional.

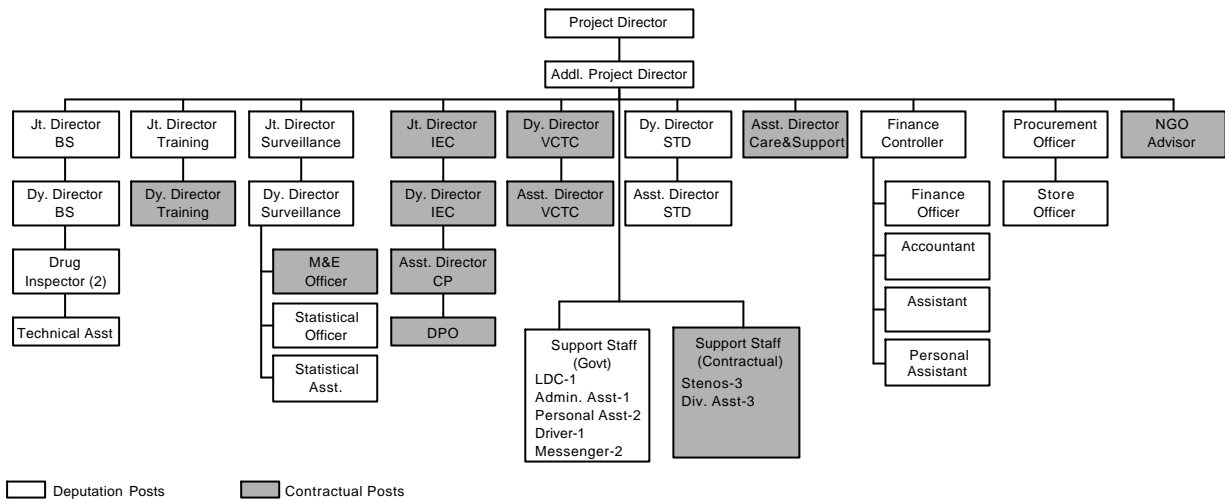
⁹⁴ *ibid*

⁹⁵ Sanction Letter No. T.11012/5/99-NACO dated 1st Nov, 1999 NACO, MoHFW, Government of India

⁹⁶ Only 10 deputation posts are sanctioned for Municipal Corporations

⁹⁷ Report of the CAG on the Union Government. Union Government (Civil) Performance Appraisals (3 of 2004)

Figure 4: Current Organizational Structure of SACS



Structural Strengths

3.75 SACS is legally independent of the Department of Health but subject to an accountability regime under which all State departments work. Thus SACS is subject to ministerial discretion and oversight by the Auditor General like other departments but have greater flexibility in staffing, financial and administrative matters than traditional departments.

3.76 SACS is conceptualized as more of a horizontal organization than a traditional vertical one. As a horizontal organization, it is expected that SACS will be better placed to eliminate numerous handoffs that occur in vertically structured ones, enable a tighter alignment with programme requirements, reduce levels of hierarchy and hence “over head” effort, promote multidisciplinary team efforts and facilitate innovation and prompt response as the external environment changes.

3.77 Governing Body of SACS headed by Chief Minister, Health Minister or Chief Secretary of State. This raises profile of SACS and provides access to the highest levels of government.

3.78 The PD in large and medium states, is usually an IAS officer. Given their public administration background and their position in government they are well placed to

manage SACS and its coordination and collaboration with a variety of agencies within and outside the government.

3.79 Unlike NACO, contractual staff are given designations (such as Joint Director, Asst. Director etc) akin to that of staff on deputation. This is more reflective of their status as programme managers and facilitates better integration with the system

Structural Weakness

3.80 More than half the states do not have the post of APD. In some states, the post has not been filled up, although sanctioned. During the initial three years of phase-III, the post of Project Director was vacant in some of the SACS.⁹⁸ In effect, most SACS had either a PD or an APD with about 9 program officers directly reporting to the head of the organization. Under the prescribed structure most of the second line functionaries have one or more tiers of programme managers reporting to them. However, this structure is distorted in most states, as significant number of the key posts are not filled up. The report of the Comptroller and Auditor General indicate that 30% to 83 % of the total posts were vacant in different states in 2003.⁹⁹ In the states covered by the present study, 45 to 55% of the officer-level posts were vacant (See Annex- 6). Consequently, in most instances there is only one level of programme managers, some of whom are made responsible for multiple programmatic areas. Given the low number of supporting staff sanctioned, many programme managers do not have any support staff to assist them. Thus, there are no distinct divisions in SACS as envisaged in the Phase-II PIP.

3.81 The span of control of the Project Director is unusually wide for organizations within a government framework, often leading to a lack of coordination. Given the high staff turnover and large number of personnel reporting to the PD, there is very little institutional memory in the current structure

3.82 There is significant variation in capacity for programme planning and management among States. The skill-mix available in SACS for microplanning, advocacy for demand

⁹⁸ ibid

⁹⁹ ibid

generation, networking and partnership building, contract management, human resource management, information technology, monitoring and evaluation and knowledge management, is generally limited.

- 3.83 Currently Program Officers in SACS are either drawn from government service on deputation and or are contractual. In Phase-II the number of posts, their designations and whether they will be filled by deputation or contract, was fixed by NACO. Compared to other programmes implemented by the DHS, there is a high concentration of senior officers in SACS. For instance, SACS in AP has five senior posts to be filled by an Additional Director or Joint Director level officer, while there is only one Joint Director level officer for the entire RCH programme. In many instances, it was observed that deputation posts were not filled due to lack of personnel with requisite seniority or background within the government services of the State.
- 3.84 Though the Phase- II PIP planned for dedicated staff for internal administration of SACS, sanction of posts of Administrative Officer and two administrative support staff was subsequently withdrawn.¹⁰⁰
- 3.85 SACS does not have effective focal points for discharging many of its core functions such as planning, support to deliberative bodies, partnership support, research coordination, mainstreaming and human resource management.
- 3.86 A key difficulty faced by all the programme officers interviewed was the lack of adequate support staff. Officers on deputation, who are used to a number of supporting staff, more acutely felt this problem. For example a Joint Director in MP SACS informed that a person of similar rank in the health service; would be supported by a vehicle, a driver, a PA, 2 messengers, 3 other supporting staff and a data entry operator. In SACS, he does not have any support staff and has to avail services from the common pool, which is not sufficient to meet the requirements of SACS. Though the PIP for Phase –II recommended 16 support staff on contractual basis, only 6 were sanctioned¹⁰¹. As a result program officers spend considerable time on filing, drafting and other clerical work rather

¹⁰⁰ Sanction Letter No. T.11012/5/99-NACO dated 4th January, 2000, NACO, MoHFW, Government of India

¹⁰¹ NACO. Project Implementation Plan, NACP, Phase-II (1999-2004), MoHFW, GoI, pp 95

than on more substantive issues. For instance; in one of the SACS visited for the study, it was observed that two Joint Directors spend almost a day scrutinizing applications received for a post that was advertised, obviously a job that could have been done by clerical staff, if such support was available.

3.87 Pay and benefits drawn by the contractual employees of similar rank is not at par with that of staff on deputation. Such disparities has given rise to some resentment among the contractual staff and accentuates an unsanctioned hierarchy between contract staff and staff on deputation which affects the work environment at SACS. PDs of SACS concurred with this observation. Further, persons with qualifications as specified by NACO were not willing to take up a job with SACS as the remuneration fixed by NACO was much lower than the prevailing market rates.

3.88 Supervisory bodies of SACS do not have representation of many key stakeholders, including NACO. While representatives of PLHA networks are co-opted members in some states, it was observed that they were generally not invited to meetings in one of the States visited for the study, which had such an arrangement. Though the government nominates NGO representatives, such an arrangement is seen as a token gesture and many of the NGO representatives whom we had contacted for the study felt that their voice was not being articulated in the higher decision making bodies.

Functional Strengths

3.89 Though they are implementing a centrally sponsored scheme, SACS has significant operational autonomy as its Governing Body is sufficiently empowered to take decisions based on local requirements. While such decisions require approval of NACO and in many cases is often a complex and time consuming process, NACO generally gives approval for Governing Body decisions.

3.90 Some SACS have been successful in institutionalizing innovative mechanisms for improving programme management. Selection of NGOs, capacity development and monitoring of TIs through PSU; Capacity development and monitoring of counselling through APCP; Use of CMIS data for performance rating of districts and units are some examples of such mechanisms in Andhra Pradesh.

Functional Weakness

- 3.91 The extent of operating autonomy varies from state to state and appears to be more a function of the rapport between the chief functionaries of SACS and its parent agency. Approval from NACO on many key issues is delayed due to lack of an effective focal point at NACO or an institutionalized mechanism for responding to SACS.
- 3.92 Performance of SACS is linked to that of State health services, as significant number of NACP interventions are through the latter. Mechanisms for coordinating with different levels of the health services and ensuring their performance is weak and in some cases, non-existent.
- 3.93 Integration between various units within SACS especially that between programme and finance units was observed to be weak in some of the states. For instance, insensitivity of finance personnel to program requirements was one of the reasons stated by programme officers, for the delay in payments to programme partners.
- 3.94 Systems and procedures for effective discharge of many of the core functions are inadequate. These include systems for coordination with NACO and other stakeholders; mainstreaming; research coordination; monitoring and evaluation; external communications; support to supervisory bodies and responding to statutory authorities; capacity development and programme support.
- 3.95 Mechanism for evidence based programme management varies among States. While CMIS gathers programme data routinely, such data is not analyzed usually nor feedback provided to reporting units or programme managers. The CMIS system is also constrained by low user friendliness, frequent changes, lack of standardized formats for monitoring, lack of flexibility in entry and analysis and irregular reporting. Indicators for some of the programmatic areas like PPTCT, ART, TB-HIV, staffing are not included in CMIS. Further, CMIS is not aligned to one programmatic framework and does not allow non-government programme reporting.¹⁰²

¹⁰² NACP-III Planning Team. Report of the Working Group on Monitoring and Evaluation

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- 3.96 As in the case of NACO, the human resources management function suffers from inadequate incentive schemes, lack of output-based performance evaluations, and inadequate personnel training. While some of the personnel had contacted for the study, received training in technical areas, none of them reported having received any training in programme management. Further, some said that they were not sent for training, even when an opportunity arose, because they were contractual staff.
- 3.97 Annual Action Plans are submitted by states based on uniform costing norms approved at the start of the project. The one cost norm across States and over the entire duration of the project gives the states very little flexibility to the States to make changes. The process of submitting the AAP, approval by NACO and communication of the approval to SACS takes considerable amount of time resulting in confusion and uncertainty about continuity and up scaling of activities.¹⁰³
- 3.98 There is considerable burden on SACS on account of meeting reporting requirements of various donors, which vary in content, frequency and format.
- 3.99 SACS release funds to a large number of entities over which it has no control and often face difficulty in obtaining financial reports and utilization reports in order to settle the advances. This result in build up of advances and a possible mismatch between the physical output and financial expenditure and lowers fund released by NACO as these funds would be seen as available with SACS.
- 3.100 While there is substantial delegation of responsibilities to programme officers, sometimes disproportionately to the contractual staff, such delegation was usually not accompanied by any substantial delegation of authority. At one level, this is due to the existing bureaucratic culture where even operational decisions which are routine, recurring, involving little uncertainty, and often has clear cut procedural guidelines have to be routed through the PD. In one of the States covered for the study it was observed that even for a routine communication to the district, the concerned Joint Director had to type a draft, put it up to the PD for approval, retype the fair copy and get it signed by the

¹⁰³ NACP-III Planning Team. Report of the Working Group on Financial Management

PD. At another level, most decision making is highly centralized at NACO and the PD does not normally have much authority to delegate. NACO generally issues guidelines on technical, financial, administrative and operational aspects of the programme. However, with exception of technical issues, most guidelines give sufficient scope for the PD to exercise his/her discretion based on local circumstances, subject to approval of EC/Board of SACS. While some prefer clear unambiguous guidelines from NACO on each and every aspect of the programme and pushing the responsibility of decision making upwards, few choose to exercise the autonomy afforded by the SACS structure for taking innovative and strategic decisions.

3.101 Most stakeholders contacted for the study were of the opinion that the commitment, leadership style, period in office and nature of tenure (full time or additional charge) of the Project Director makes a substantial difference in the functioning of SACS. They observed that the comparatively better performing SACS had PDs who were in the post for at least 3 years, on a full time basis. It was also observed that the high turn over and additional charge of other departments held by the PDs in many states in Phase-II has negatively affected the functioning of many SACS. A PD interviewed for the study quite clearly stated that he viewed SACS as a punishment posting and expressed his frustration in having to work in an environment which was devoid of traditional decision support systems existing in government.

3.102 The DHS also deutes personnel from the health services, as a matter of routine without much consideration to the job profile and skills required for the post. As a result, there are at times a significant mismatch between the skills and background of the incumbent and the post to which he/she has been deputed. For instance in one of the states, Joint Director (training) was filled up by a gynecologist whose entire career was spent on working in hospitals as a clinician. Obviously the person did not have much interest in the job and was there only because the posting afforded a chance to remain at the State capital.

3.103 It was also observed that in some instances there is quite a mismatch between the post to which a person is recruited and the current job profile. For instance, the Asst. Director (Condom Promotion) in one of the states included in the study, spent out of an average 22

working days in a month (as per his estimates), 3 days on Condom Promotion, 10 days on MIS and 9 days on multiple tasks including preparing responses to various authorities, functioning as the Asst. Public Information Officer, so designated under the Right to Information Act, functioning as an Officer on Special Duty for weekly briefing of Health Secretary in place of the PD, FHAC, etc.

3.104 TA/DA not as per field realities. As per current guidelines of NACO, TA/DA of SACS staff are to fixed according to State government norms. TA/DA offered by the State Government is usually fixed at very low rates probably because state government officials who travel are generally provided a vehicle and subsidized boarding and lodging at government guest houses. SACS officials do not have access to vehicles and have to make external arrangements. While cost of actual travel is reimbursed in some SACS, in States like MP, only the train/bus fare from State head quarters to district headquarters is reimbursed. Local travel is not reimbursed and since many districts do not have railway routes, officers have to travel by bus, which is quite tiresome and delays their work. They rarely are able to get accommodation in government guesthouses and hence have to stay in hotels. The daily allowance provided is usually too low to avail any type of accommodation. For instance the DA provided to Assam SACS officials is Rs. 120 per day for food, lodging and incidental expenses, which means that officials have to spend out of their pocket during field visits. To avoid this they either defer their field visits or travel as groups. In both cases the programme gets affected either because monitoring is not done or because of absence of a number of staff from headquarters, at a time.

Cultural Strengths

3.105 There is considerable awareness for the need for restructuring and reforming functioning of SACS among its key staff. This awareness sets the ground for systematic change within the organization.

3.106 Many senior officers at SACS are on deputation from the same health department. Significant part of the SACS interventions is through the district health administration, which is headed by their colleagues. In many instances, SACS officers are able to take advantage of this network for programme implementation at the district level.

Cultural Weakness

- 3.107 There is variation in the level of financial and administrative delegation to the Project Director across States. While some states like Tamil Nadu and Haryana have a very detailed delegation of powers distributed across to different officers, in some other states like Uttranchal, Goa, Chattisgarh, Tripura and Arunachal Pradesh, officers outside the SACS exercise authorization powers. This results in files having to be sent to the government set up for approval resulting in slow pace of implementation and utilization of funds.
- 3.108 There is lack of continuity and low institutional memory due to frequent leadership changes.
- 3.109 Though conceptualized as a horizontal organization, SACS does not have many of the characteristics common to horizontally structured organizations. In the current structure of SACS there are two groups of program officers- one on deputation from the government and the other are on contractual appointment. Those on deputation are comparatively more senior and have been working in the government system for most of their careers. Among the senior officers on deputation, with exception of the finance personnel, all others are medical professionals with little or no background in multidisciplinary team work and are drawn from the same parent department i.e., DHFW. They come from an organizational culture, which emphasizes hierarchical work relationships with decision making concentrated at the top of an organizational pyramid and accountability construed in vertical hierarchical terms. Many of the senior officers contacted for the study expressed their frustration in having to work in an organization whose structure was not compatible with the traditional support systems they had grown accustomed to.
- 3.110 On the other hand, those who are on contractual appointments generally have a background of working in less formal and hierarchical organizations. Though they have similar ranks as those on deputation, given the absence of distinct divisions, they form only a small proportion of senior officers reporting to the PD. Given their numerical strength, senior position in the government and/or their ties with the parent department, officers on deputation assume a greater leadership role in SACS. Since leadership can

play an important role in creation and management of organizational culture, the work culture is more similar to that of a government department, leading to incongruence between the espoused and perceived culture of SACS. Potential negative outcomes of such incongruence may include high turnover of contractual staff. For instance: Assam SACS had five NGO Advisors in the last five years. The post of Joint Director (IEC) seen as a key driver of many non-medical interventions of the NACP also witnessed high turnover of staff and was vacant in all the states covered by this study.

Recommendations for Phase-III

3.111 Internal Restructuring to address weaknesses and leverage institutional

strengths of SACS: An understanding of core functions of SACS and its current strengths and deficiencies is useful in rationalizing the structure of SACS.

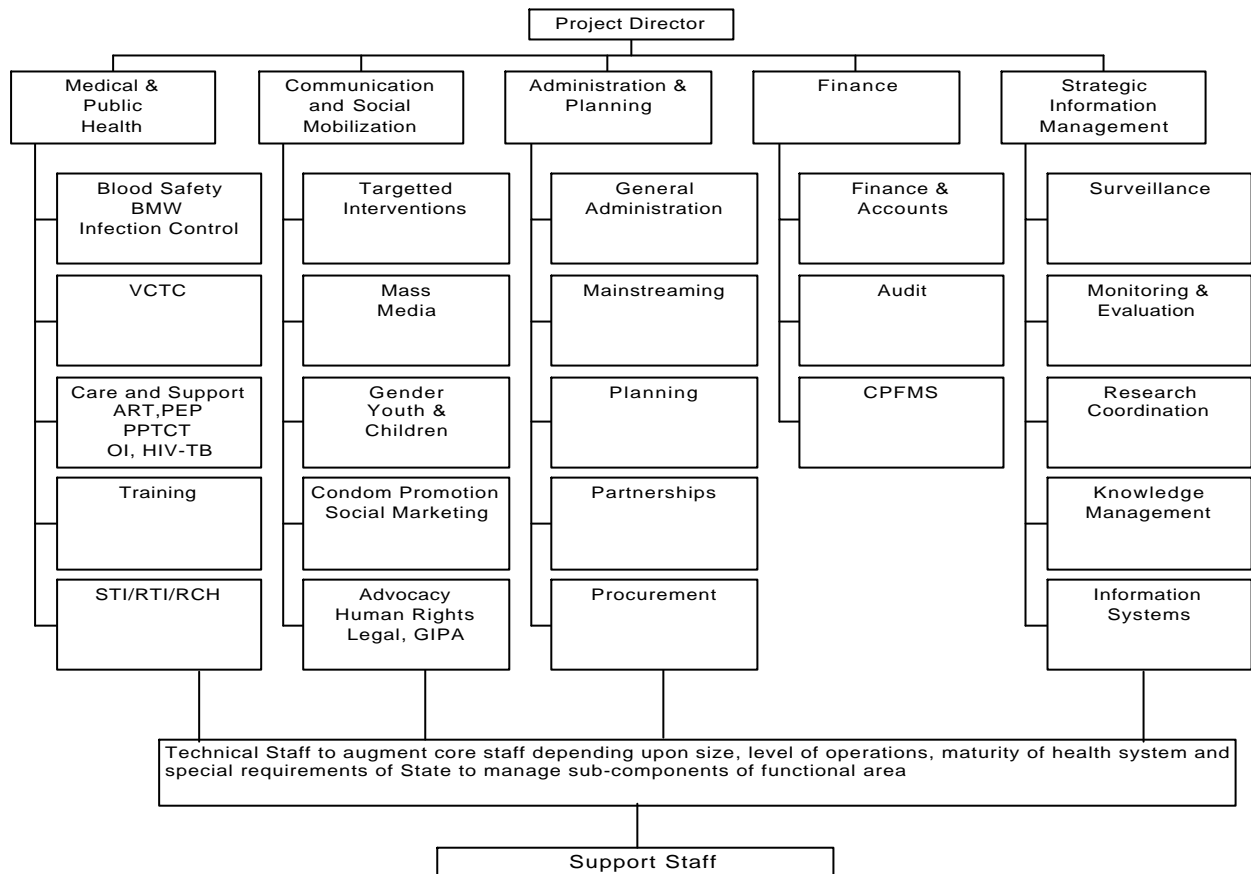
Recommendations for restructuring are based on similar principles as that adopted for NACO (See para 3.43). A divisional structure similar to that of NACO is recommended for SACS. Accordingly, 5 divisions are proposed:

- ◆ Medical and Public Health
- ◆ Communication and Social Mobilization
- ◆ Administration and Planning
- ◆ Finance
- ◆ Strategic Information Management

3.112 Creation of these divisions makes the span of control of the PD more manageable and allows for potential systemic decentralization within SACS. They provide a structure that is more in line with the proposed role of SACS and to some extent balance the disproportionate influence of medical officers in the existing structure. These divisions correspond to those proposed for NACO and hence it is expected that there will be more programmatic compatibility between the two. In the current structure, in most cases there is a single officer managing a sub-component of the programme who reports directly to the PD. Given the high staff turnover and large number of personnel reporting to the PD, there is very little institutional memory in the current structure. Divisions as proposed,

can to large extent address this issue as the divisional manager is well placed to supervise the transition and ensure necessary continuity.

Figure-5 : Proposed Organogram of SACS



3.113 It is proposed that the Medical and Public Health Division will be responsible for all HIV prevention and care and support activities primarily done through the health care network either public or private, in the State. Communication and Social Mobilization Division will be responsible for promoting awareness regarding HIV prevention among general population, mobilization and empowerment of key populations and vulnerable populations for HIV prevention and enabling environment interventions. As in the case of NACO, finance and administration has been maintained as separate divisions. Finance division will be responsible for finance management, budgeting, procurement and resource mobilization. Administration and Planning Division will be responsible for coordinating planning and strategy development of the programme at State and district

level, administration and HRM, coordination of mainstreaming and partnerships and providing support to higher deliberative bodies. Strategic Information Management Division will be responsible for surveillance, monitoring and evaluation, coordination of research, documentation of evidence and their communication to various stakeholders.

3.114 It is envisaged that there will be decentralization within SACS to divisions and within divisions to programme officers. Each division will be responsible for all interventions falling primarily under its functional domain. Division managers provide second level leadership to SACS and support the Project Director on all aspects related to his/her domain.

3.115 Divisions are by no means impermeable, and many a time it will be required to have cross-functional teams. For instance, targetted interventions will require support from the medical and public health division to provide training and STI management. Training programs provided by all divisions will need logistical support from the administrative department.

3.116 The PD will provide leadership to SACS, direct the planning and implementation of the programme at the State level, and ensure accountability of SACS to its various stakeholders. He/she will be responsible for developing SACS as a learning organization through development of a team culture, ongoing training at all levels, creation of mechanisms to spread knowledge throughout the organization, and empowering employees to make decisions to implement improvement of their areas. The PD will have a proven track record in planning and implementation of similar government programmes, managing multidisciplinary teams and multi-sectoral coordination. He/she will ideally have a blend of visionary capacity and practical management skills.

3.117 The Divisional Managers represent the second line of leadership of SACS. In addition to technical expertise in their functional domains, their skills and role will be more or less similar to that prescribed for the PD. It is suggested that they will be an Additional Director/Joint Director or of equivalent rank in government.

3.118 The third tier of SACS will be comprised of Program Managers who will be in the frontline for implementing the programme at the State level. There will be at least one

program manager for each intervention. Assistants and Deputies may be assigned to him/her depending on state specific requirements. One program manager may be assigned more than one intervention, if they are complementary in nature. Each Program Manager will be primarily responsible for technical support, planning, monitoring and evaluation, training and ensuring coordination with reporting units for the assigned intervention and building partnerships and collaborations in the specific area handled by them. As noted earlier, the Program Manager will be the focal point in the State for the particular intervention to their counterpart in NACO, all reporting units in district and sub-district level and other partners.

- 3.119 In general, program managers will have relevant academic and professional background related to their area of work. A minimum of 5 years of experience working in similar programs, experience in working with multidisciplinary teams and exposure to government systems and procedures and will be desirable. In addition to relevant technical skills, he/she will have program management skills, especially pertaining to planning, communication, monitoring and evaluation, capacity building, reporting etc. He/she will have proven ability to interact effectively with a broad range of external partners and clients and horizontal skills such as mediation and negotiation skills, creativity and patience. Basic computing skills and mobility skills are also prerequisites.
- 3.120 It is suggested that a minimum of 2 support staff per divisional manager and at least one support staff per program manager be sanctioned in all SACS. Additional staff as per workload may also be considered
- 3.121 Some of the functions with regard to an intervention, like training, technical support etc., may be out-sourced through partnerships, tapping into knowledge and expertise of “best in class” institutions, while retaining strategic control. This adds critical skills to the programme and accelerates organizational learning. (see section 4)
- 3.122 **Strengthening Human Resource Management at SACS:** The human resource management function of SACS will be a function of the Administrative Division. It will be responsible for undertaking needs assessment, skills inventory, and manpower planning. A key prerequisite is preparation of job profile and required skill profile for all

posts in SACS. The division will coordinate recruitment of staff and ensure that vacancies are filled up within specified timelines.

3.123 Given their public administration background, it seems appropriate to continue to entrust the leadership of SACS with an officer from the IAS cadre. However, the primary consideration for selection will be a match between the person and the job requirements. While it is recommended that an officer from the IAS cadre be considered for the post of PD by default, if a suitable person cannot be identified from within the available pool, a senior officer from within the health department may be considered for the post.

3.124 Choosing the right person to head the SACS is pivotal to the programme. It is suggested that the PD be recruited to the post through an active and directed search within the State cadre of IAS officers or DHS as the case maybe. This should necessarily be a function of the Governing Body, especially since one or more of the major decision makers in the posting of cadre officers, such as the Chief Minister, Health Minister, Chief Secretary, Health Secretary etc., either heads the Governing Body or are its members. The Governing Body may constitute a search committee to shortlist potential candidates for its selection. Their good offices may be used not only to get the deputation but also to secure the tenure for three to five years.

3.125 It is recommended that divisional managers be sourced from within the government. However, given the difficulty experienced by many SACS in filling up of deputation posts due to unavailability of suitable persons from within the government, SACS may be given the flexibility to fill up these posts from the market. The PD may take the help of the supervisory bodies, in identification and selection of the divisional managers, when personnel with requisite background and skills are available within the government.

3.126 SACS may source tier-3 programme managers from within the government or outside. When there is a reasonable chance that suitable personnel are available within government service, such posts may be advertised within the government. Those interested and fitting job profile may be short-listed and personnel selected through a selection committee constituted by SACS. Services of the selected persons can then be requisitioned through proper channels.

3.127 SACS employ different means to recruit Programme Officers from the market.

Usually posts are advertised in paper and selection done through a process determined by individual SACS. At times, especially when the response for the advertisement is poor, PD may actively search for suitable persons. At other times PD may meet a suitable person serendipitously and may request his/her services. Another alternative, which may be also considered, is outsourcing recruitment to head hunting or HR consultancy organizations. It is suggested that the SACS could exercise whichever option is feasible, provided they ensure that there is transparency in the recruitment process, a clear job profile for each post is available and is subject to ratification by the authorities of SACS.

3.128 It would be desirable that pay and prerequisites of contract staff be at par with that of officers on deputation. Should there be a problem of providing allowances similar to government staff, the consolidated pay should be adjusted to incorporate all such allowances, including health insurance.

3.129 It is recommended that NACO consider revising the present guideline, which fixes TA/DA as per state government guidelines. Norms prescribed for the NRHM regarding TA/DA,¹⁰⁴ may be adopted by NACO. Alternatively, the Executive Committee of respective SACS may be authorized to fix these rates as per local requirements.

3.130 Capacity development of SACS personnel would be an important area, Phase-III would have to urgently address. Broadly, personnel would require training in two areas-respective technical areas and programme management. Irrespective of whether on deputation or on contract, all personnel are required to attend basic training and refresher courses periodically. It may be useful if the status of training of staff was made one of the indicators for assessing SACS performance.

3.131 It is envisaged that training programmes for SACS officers will be conducted by national/regional institutions identified by NACO as per an annual timetable. In addition to periodic training there should be an induction training of all key personnel joining SACS, including those from Finance and Administration on components of NACP and

¹⁰⁴ National Rural Health Mission: Institutional Setup at State level. Downloaded from the MOHFW website

their implementation. This is necessary to effect better integration between various units, especially that between programme and finance units.

3.132 The actual number of staff in a SACS will vary from state to state depending on local priorities and requirements. We are suggesting a minimum staff strength for all SACS, as states generally seek guidance from NACO on their organization structures (Annex-8). States should define additional staff requirements based on programme content.

Institutional Arrangements for NACP at District Level

3.133 The Phase-II PIPs of various states recommended setting up district structures such as District AIDS Cell (eg. Assam¹⁰⁵), District AIDS Society (eg. Maharashtra¹⁰⁶), District AIDS Unit (Arunachal Praesh¹⁰⁷). However the National PIP ruled out creation of any new structures in Phase-II¹⁰⁸

Institutional Analysis of District Level Arrangements

3.134 Currently the NACP does not have any structure of its own below the State level. The programme is implemented in districts through the institutions of Department of Health, other state departments such as Department of Education and through partnerships with NGOs. Funds for interventions at district level are released through the District Medical & Health Officer or Head of Institution of Medical College, except that for targetted interventions through NGOs which is released through the SACS. The coordination and monitoring of the programme is entrusted to the JD/DMHO of the district who is helped by a designated District Nodal Officer, who is generally the programme officer of other programmes such as TB, Leprosy, Blood Banks etc. In addition, Physicians' Responsible for AIDS Management (PRAMS) trained in the management of AIDS patients, is based in Medical Colleges and District Hospitals.

3.135 Since the DMHO is usually busy in administrative work and programmes directly under his/her control, he/she is very little involvement in the NACP, other than administrative work such as drawing and disbursing funds to STI clinics, ANCs, VCTCs, Blood Banks etc., under the district health administration and providing utilization certificate for funds received. The head of medical colleges plays similar role for such institutions housed within the medical college. Responsibilities undertaken by District Nodal Officer (DNO) is generally restricted to overseeing distribution of condoms and

¹⁰⁵ Project Implementation Plan: National AIDS Control Programme, Assam (1999-2004), Assam State AIDS Control Society

¹⁰⁶ Project Implementation Plan: National AIDS Control Programme, Maharashtra (1999-2004), Maharashtra State AIDS Control Society

¹⁰⁷ Project Implementation Plan: National AIDS Control Programme, Arunachal Pradesh (1999-2004), Arunachal Pradesh State AIDS Control Society

¹⁰⁸ Project Implementation Plan: National AIDS Control Project Phase II (1999-2004), NACO, Government of India, pp35

IEC material to NGOs; providing monthly reports of new AIDS cases in the district and inspection reports of NGOs; and organizing events like “World AIDS Day”, “Blood Donation Camps. As the DNO has primary responsibility of another programme, he/she does not find much time to devote even to these functions, not to mention the core functions of coordination and M&E. Moreover the DNO does not have any support staff for HIV related activities. Staff in his/her primary programme is generally unwilling to take the additional burden of HIV related activities.

3.136 The NACP thus does not have an effective focal point in the district that is able to provide the necessary support nor monitor the performance of the reporting units. Consequently, compliance with reporting requirements is generally weak at the district level. Feedback from the reporting units indicates the need for an effective focal point at the district to whom they could voice their grievances and seek support. The staff of the reporting units raised a number of issues in this regard. They are included under Annex-10. Some of the issues common to all reporting units are discussed below.

3.137 A key issue voiced by most reporting units in the district was the lack of timely disbursement of funds. Concerned officers of reporting units in the districts such as Blood Banks, PPTCTs, and VCTCs indicated that there was high turnover of contractual staff supported by the programme, as salaries were not paid on time. Targetted Interventions through NGOs were particularly affected by the delay in release of funds. In some cases the delays were either due to non-compliance with procedures (mostly relating to documentation) or lack of funds with SACS. In many others, it was more because of lack of effective communication, absence of any form of guidance or plain insensitivity to the requirements of the programme. For instance; fund release to NGOs has been delayed by about 16 months in MP. The interview with the concerned officials of an NGO in MP was conducted in a park as they were evicted from their office, due to nonpayment of rent.

3.138 Officers of many of the reporting units in the district informed that they did not know whom to contact in SACS either for technical or administrative support. Even when there is a designated officer in charge of a particular intervention, they are usually not accessible. In addition to support in technical areas, a clear lacuna is the lack of support for documentation and reporting. For instance; reports are sent back marked incomplete

without specifying what is the information required. In some states, project support to reporting units has been entrusted to a third party. For instance; in AP project support for TI has been entrusted to the Project Support Unit (PSU), who are in direct contact with the NGOs and has taken responsibility for technical support, training and M&E. The NGOs generally gave a positive feedback about PSU support.

- 3.139 A clear casualty in the present arrangements is Monitoring & Evaluation. It was generally observed that there is only a one way flow of information from reporting units to SACS and then to NACO. With rare exceptions none of the officers of reporting units contacted for the study mentioned about any form of feedback from SACS. Personnel from SACS make rare visits to reporting units for conducting M&E. According to staff of the reporting units, M&E visits are usually hastily done. The basis on which they are monitored is not clear. The process is not at all participatory but more in the form of an inspection. Such visits were reported as humiliating experiences rather than an opportunity for learning. Reporting units working on interventions whose M&E was entrusted to third party, such as VCTCs and TIs in AP, generally gave a more positive feedback in this regard.
- 3.140 In the present arrangements, local requirements are not adequately reflected in the State plan. Further, there is very little coordination among the reporting units at the district level. In the absence of an effective focal point at the district level, it is unlikely that NACP will be able to take advantage of the potential scope for greater integration with health services and community mobilization through greater involvement of PRIs that the NRHM offers.
- 3.141 In Phase-III, with the proposed scaling up, the NACP activities in the district and sub-district levels will substantially increase. Further, some of the functions currently carried out by SACS have the potential of being out-sourced. These collaborations and partnerships will have to be effectively managed at the district level. Surprisingly, while other centrally sponsored programmes with lesser fund allocation have district program officers; NACP does not have one (Table-4). Clearly there is need for a district level structure for NACP to support and monitor the activities of a wide range of entities that is involved with the programme.

Table 5: Funding of National Health Programmes (2002-03)

NHPs	Allocation (Rs. Crore)
Malaria	206.6
TB	96.8
Leprosy	75
AIDS	241.4
Blindness	84.6

Source: Demand for Grants, MohFW, cited in NCMH, Background papers pp245

Recommendations for NACO-III

3.142 It is recommended that the activities of the NACP-III be further decentralized and managed at the district level through the creation of a District AIDS Control Unit.

Broadly, the role of the District unit will include:

- ◆ To be the focal point for all HIV related activities in the district and provide technical support for implementation of programme
- ◆ Coordination with State AIDS Control Society for implementation of all components of NACP in the district
- ◆ To prepare District specific AIDS control action plan
- ◆ Ensuring timely resource availability for programme implementation
- ◆ Monitoring and evaluation of progress of interventions
- ◆ Disseminate information and reorient initiatives based on feedback
- ◆ Facilitate background research to enhance impact of interventions
- ◆ Regular reporting to SACS on progress of implementation/constraints
- ◆ District and sub-district convergence of NACP with other programmes in the health sector
- ◆ District level intersectoral collaboration and programming
- ◆ Identification of potential partners for the programme
- ◆ To ensure PRI and NGO/Key population support for community mobilisation and awareness

3.143 The general thrust of the NRHM, vis-à-vis, integration of the disease control programmes, decentralized programme management, local planning and improved outreach etc., finds resonance in the overall objectives and strategies of the NACP Phase-III. The NRHM provides an opportunity for integration of the NACP with primary health

care and also with other national programmes such as RCH and RNTCP and thereby improve reach of the programme. Further NRHM provides for greater involvement and oversight by PRIs in its programmes, which if effectively utilized can lead to greater community mobilization for prevention of HIV. It is therefore recommended that a District AIDS Control Unit (DACU) be established within the district health administration and brought under the purview of the NRHM. The Unit will be headed by a district programme officer who will be the nodal officer and focal point for all HIV related activities in the district. He/she will be similar to district programme officers of other centrally sponsored programmes in that he/she will be under the administrative control of the DMHO but will also report to SACS. Once the District Health Society Secretariat is operationalized, the district programme officer may be brought under the District Health Secretariat. Eventually (that is, after integration of the posts sponsored under the Centrally Sponsored Schemes with the DHS) as recommended by the GOI, the district programme manager may be posted on deputation to the District Society Secretariat. This will ensure a minimum tenure for district programme managers since all deputation postings will be for a minimum period of 3 years.¹⁰⁹

- 3.144 The DACU will report to the NRHM District Health Society and its supervisory structures through the district health administration and will be accountable to them for its performance. However, it is recommended that financing mechanisms of the DACU be different from other centrally sponsored programmes for the present. In case of other centrally sponsored schemes funds flow from the MOHFW to the State Health Society and then to the District Health Society, where it will be disbursed for district level activities. Separate accounts are maintained for each programme. Unlike other programmes, NACP is yet to establish district units. The scale and range of activities that is envisaged in NACP Phase-III is significantly greater than other disease control programmes. Also monitoring of flow of funds at district level require considerable strengthening of existing systems at SACS. Further NRHM structures are still not in place and it will be some time before its systems are established. Under the circumstances it is recommended that devolution of funds to district level be deferred until systems at SACS

¹⁰⁹ Government of India. National Rural Health Mission Institutional Setup at State level. Downloaded from www.mohfw.nic.in

and NRHM are more streamlined and capacity is built at the district level for financial management. Until that time, contracting and disbursement of funds for district level implementing units may continue to be the responsibility of SACS.

3.145 In general, the background and skills required by the Programme Officer will be similar to that of SACS Programme Managers. It is recommended that the district programme officer be supported by an accountant cum data entry operator, a M&E assistant and a support staff¹¹⁰. It is also recommended that the programme officer will be a member of the Executive Committee of the District Health Society.

3.146 A District Coordinating Committee with representation from all relevant stakeholders including representatives from PRI and municipal bodies is proposed which will oversee implementation of the district plan with reference to the state programs as well as local partnerships. It is recommended that DACU undertake a mapping of the stakeholders in each district and the structure of the Committee be evolved through consultation with the different stakeholders.

¹¹⁰ NACP-III: Planning Team. Report of the Working Group on Program Management

4. Institutional Arrangements for Coordination, Collaboration and Partnerships

4.1 Given the inter dependent and cross-cutting nature of items on the government's HIV prevention agenda, key policy objectives can not be achieved without several different governments, departments, agencies and external partners working together. This requires coordination and management of a set of activities between two or more organizational units, where the units in question do not have hierarchical control over each other and where the aim is to generate outcomes that can not be achieved by units working in isolation. The structures and processes used to achieve coordination can range from informal networks to mechanisms that are more formal. The means used to put into effect and manage horizontal initiatives can also vary, and are typically described by terms such as "coordination," "collaboration," and "partnerships."¹¹¹ Often these terms are used interchangeably. More careful examination, however, suggests that they convey rather different meanings and tend to be used in different contexts.

4.2 Coordination is the practice of aligning structures and activities to improve or facilitate the likelihood of achieving horizontal objectives and to reduce overlap and duplication. For instance, the initiatives for convergence between NACP and the RCH programmes would normally require coordination at different levels. Collaboration can be defined as the active process of not only coordinating activities but also developing, agreeing to and implementing a strategy for achieving set objectives. More often than not, collaboration involves a set initiative or project to which two or more units agree to commit resources and have, as well, a strong interest in achieving its successful completion. Much of the mainstreaming activities proposed in different departments would come under the ambit of "collaboration". Partnership refers to the formalization of collaborative arrangements and agreements beyond simple memos or memoranda of understanding (MOU) to the level of legal contracts for deliverables and payment. Such formalized arrangements are more likely to be used in connection with external organizations (both commercial and non-profit). The TIs through NGOs is an example of partnership in the current context. The distinctions between these three concepts are not hard and fast; however, they serve

¹¹¹ Herman Bakvis and Luc Juillet. *The horizontal challenge : line departments, central agencies and leadership*, Canada School of Public Service, 2004

to underscore the variety of institutional mechanisms that will be required for broad basing the HIV prevention and care efforts in NACP-III. This section discusses some of these mechanisms.

National Coordination Committee for One Agreed HIV/AIDS Action Framework:

4.3 While NACO as the designated apex agency for HIV control efforts in the country will obviously be the national coordinating agency for the same, it requires a coordinating mechanism agreed upon by all partners for developing and implementing the framework. The framework will have to be developed in consultation with all partners working in the field of HIV/AIDS in the country and form the basis of the Project Implementation Plan. NACO will undertake mapping of all partner agencies including their thematic and geographic area of focus and their source and quantum of funds. Partners would enter into a MoU to align their work to the agreed national framework. As part of the MoU they would also be invited to be members of a National Coordination Committee convened by NACO. The structure, membership and systems of the National Coordination Committee will have to be developed through a consultative process with partners. Similar arrangement convened by SACS and DACU is recommended at the state level and district levels respectively.

4.4 The role of the National Coordination Committee will be to:

- ◆ Mobilize and energize stakeholders to assume responsibility and execute actions appropriate to their mandate in the implementation of the programme
- ◆ Clarify and agree on the role of each partner in implementation of the national plan so that: (i) the risks of working at cross-purposes and duplicating effort are minimized; and (ii) the opportunities for complementarity and synergy are collaboratively identified and exploited
- ◆ Catalyze inclusive monitoring and evaluation of implementation of the action plan and providing feedback to all implementing partners
- ◆ Advising new members on preferred mode of contribution to the national response.¹¹²

Convergence of NACP with DHFW:

4.5 Possible areas of convergence in delivery of key services between NACP and DHFW are provided in Annex-10. The Task Force on Convergence between NACP and DHFW¹¹³

¹¹² NACP-III Planning Team. Draft Note on Institutional Arrangements

¹¹³ Report of the Task Force on convergence between NACP and DoHFW, MoHFW, 2005

has recommended a NACP-DHFW convergence committee to be set up at DHFW to provide policy inputs and oversight to the convergence between NACP and DHFW. The Convergence Committee will be chaired by Secretary, HFW and co-chaired by Project Director NACO. At the National level, two joint working groups are visualized comprised of technical and programme managers from NACO and DHFW. They include:

- a. Joint working group on convergence of RTI/STI, VCTC and PPTCT into DHFW infrastructure and services.
- b. Joint working Group on Training and MIS.

4.6 Broadly, the roles of the JWG are to review quarterly performance from each state and jointly review and prepare a report on performance coverage and quality. Reporting formats would be developed in conjunction with existing formats or those proposed for larger programmes so that programme managers at state and district levels are not burdened. It is expected that the NACP-HFW Convergence Committee, which meets every quarter, will obtain reports from each of the National JWG, provide feedback and serve as a problem solving mechanism.

4.7 It is recommended that at the state level, a similar mechanism be set up, so that the state and central level review and monitoring, and information needs and flow are coordinated. It is envisaged that the Project Director of SACS will be a member of the Executive Committee of the NRHM State Health Society.¹¹⁴ The CEO of the NRHM may also be made a member of the Executive Committee of SACS.

4.8 At the district level, the district programme officer of NACP, will ensure coordinated inputs between those programmes directly implemented by SACS, between various NGO managed programmes, and finally between those interventions that depend upon the DHFW resources for effective operationalization.

4.9 The District Health Mission (where all other programmes of HFW are integrated), will include a sub- group to review HIV/AIDS and DHFW convergence in the major service areas and NGO functioning. It is envisaged that the district programme officer will be a

¹¹⁴ National Rural Health Mission: Institutional Setup at State level. Downloaded from the MOHFW website

member of the Executive Committee of the District Health Society.¹¹⁵ The Programme Manager¹¹⁶ of the District Health Society may also be made a member of the district coordinating committee.

4.10 VCT is envisaged as the entry point to HIV prevention with backward and forward linkages to the continuum of care, support and treatment. Key services for VCT, STI treatment, TB, PPTCT, OI and ART will be integrated with clearly defined functional linkages and referral mechanisms.

Convergence with RNTCP

4.11 The aim of HIV/TB coordination is to ensure optimal synergy between the two programs at both state and district level for prevention and control of both diseases. This would be accomplished primarily through joint planning, sensitization, health communication and training in both programs, ongoing HIV surveillance among TB patients, and intensified TB case finding among people living with HIV/AIDS. Training in both programs would include management of TB in HIV patients, including those on anti-retroviral drugs, and implementation of infection control to prevent the spread of TB in HIV/AIDS clinical care facilities. Activities will be targeted to all states and districts with a high HIV/AIDS prevalence¹¹⁷.

4.12 Both NACP and RNTCP share similar constraints such as need for better integration with the DHFW, poor reach of the public health sector, large number of patients accessing private sector, stigma, multi-drug regimens for treatment, emerging drug resistance etc. Innovative approaches adopted by RNTCP to address these issues such as training of private providers, public-private partnerships for treatment, decentralized delivery of drugs, out-sourced programme support at district level through WHO consultants etc., may also be relevant to NACP. The feasibility of utilizing RNTCP structures below district level to improve reach of NACP could also be explored. For

¹¹⁵ *ibid*

¹¹⁶ *ibid*. District level Programme managers for the District Health Society have been sanctioned by GoI in EAG States. However, in other States also, these may be provided by the States themselves within 6% of the overall programme costs for the State as a whole. Till such time these are provided and actually recruited, a Dy. CMO level officer may be designated as such to function as the District Programme Manager

¹¹⁷ Central Tuberculosis Division, MoHFW. Project Implementation Plan (PIP) dated May 31, 2005

instance; the RNTCP has a network of microscopy centres which may be upgraded to offer voluntary counseling and testing services.

- 4.13 To facilitate coordination between the two programmes, HIV/TB coordination committees have been proposed at the national and state levels¹¹⁸. A coordinator for HIV/TB interventions has also been proposed at the district level¹¹⁹. Currently an action plan for TB/HIV coordination is being implemented jointly by the RNTCP and NACP in the six high HIV prevalence states.¹²⁰ Given that the RNTCP is primarily delivered through the DHFW and that the State and TB Societies are proposed to be absorbed in the NRHM structures, the scope of work of these committees may be brought under the purview of the NACP-DHFW coordination committees proposed earlier. It is also recommended that the State TB Officer and District TB Officer be included in the supervisory bodies of the NACP structures in state and district respectively.

Partnerships for Capacity Development and Programme Support

- 4.14 In Phase-II, though NACO set up Technical Resource Groups (TRG) in various institutions in 12 thematic areas, to provide technical assistance to the programme, they failed to take off in many areas. The World Bank project performance assessment indicate that the terms of reference of TRGs were not clearly defined; funding was limited; lack of direction from NACO; most of the groups met infrequently; and staff in SACs and NGOs did not know how to access their expertise.¹²¹
- 4.15 However, there are some notable examples of well-designed mechanisms of technical assistance in NACP-II that has achieved a measure of success. The model for capacity building, providing technical support and monitoring HIV testing is a case in point. The model has a three layered structure comprising of an apex national reference laboratory, regional and state reference laboratories. Discussions with key stakeholders and blood bank and VCTC technicians indicate that this arrangement has been quite successful in providing continued programmatic support. Other examples include creation of state-level

¹¹⁸ Government of India. Expansion of effective public and private sector interventions in HIV, TB and malaria prevention and treatment in India. Proposal submitted to the Global Fund for Fight Against AIDS, TB and Malaria, 2004

¹¹⁹ Report of the Third Meeting of the National Task Force for Involvement of Medical Colleges in RNTCP, 23-29 Nov 04

¹²⁰ Agarwal SP. Intersectoral Cooperation for success of RNTCP. *Indian J Tuberculosis 2004; 51:59-62*

¹²¹ World Bank. India National AIDS Control Project. Project performance assessment report (credit 2350), 2 July 2003

resource centers such as the PSU for targeted interventions and the AP Counselors Project (APCP) for supporting counselors in VCTCs and PPTCTs of Andhra Pradesh. Feedback from project managers and those involved in delivery of services indicate that outcomes of such arrangements is generally encouraging. The following mechanisms are recommended for strengthening technical assistance in Phase-III

4.16 Multidisciplinary Standing Committee on Technical Support: It is recommended NACO establish a Committee for overseeing provision of technical support to NACP-III. The Committee will house technical expertise in multiple disciplines including: public health management, epidemiology, clinical sciences, communications, legal systems, public administration, finance management, demography, biostatistics, information systems etc. Expertise will be drawn from academic, research and program implementation setting in public, private and voluntary sectors and from development partners providing technical assistance to NACP. The Committee will include divisional heads of NACO and be chaired by an expert outside of NACO. The Committee will:

- ◆ Function as a technical advisory body to NACO
- ◆ Review technical support plan for NACP-III
- ◆ Provide guidance in developing TOR for hiring manpower and out-sourcing of technical support
- ◆ Approve proposals for technical support provided through NACP-III
- ◆ Review performance of technical support mechanisms
- ◆ Arrange for technical audit of programmes and activities of NACP-III

4.17 Technical Advisory Groups: It is recommended that Technical Advisory Groups be created for each of the key programme areas. The group will comprise of experts in the concerned area, drawn from academic, research and implementation settings from public, private and voluntary sectors including PLHA networks. The group will also include a representative of development partner (s) who has undertaken to provide technical support to the concerned area as per the One agreed framework. The programme manager

at NACO for the particular area will also be part of the Group. The Technical Advisory Group will:

- ◆ Develop a technical plan for component assigned to them
- ◆ Identify and prioritize technical assistance needs in terms of structures, systems, humanpower, skills, tools to be in place for NACP-III
- ◆ Identify best practices, develop/ revise quality guidelines, develop technical assistance products and devise strategies for program implementation
- ◆ Provide technical support to programme managers in NACO
- ◆ Develop TOR, identify national and regional institutions for providing support to implementing agencies, provide technical support to these institutions and oversee their functioning.
- ◆ Approve curricula for training programmes

4.18 Creation of network of Apex, Regional and State Resource Centers: Given the scale of activities proposed for phase-III and limited capacity within NACO and SACS, it is recommended that key components of technical assistance in identified areas may be out-sourced. The areas covered by the thematic groups may be taken as a starting point and further enlarged to incorporate other key areas such as programme management. It is recommended that programme support may be provided through an Apex Resource Center for each of these areas. These may be located in appropriate academic and research institutions of excellence. The Apex Resource Center will:

- ◆ Provide technical assistance to NACO and SACS “on demand” and “proactive basis”
- ◆ Develop training modules, manuals and course material for training of different levels of programme staff
- ◆ Provide periodic training to programme officers of NACO, SACS, and other implementing agencies
- ◆ Identify and develop a pool of master trainers for providing training support to SACS
- ◆ Develop capacity of Regional/ State Resource Centers and identified state level training institutions.
- ◆ Identify knowledge gaps and research priorities
- ◆ Identify and network with research institutions in the specialized area

- ◆ To function as a central repository of HIV research and an information clearinghouse on HIV/AIDS research in the specialized area.

4.19 Depending on the anticipated workload Regional Resource Centers may also be set up. It may also be useful to identify state level resource centers for certain programmatic components especially in high prevalence states and vulnerable states. They will be particularly useful for NACP components with larger number of dedicated project staff, such as; HIV testing and counseling in blood banks, VCTCs and PPTCT centres and Targeted Interventions. Such arrangements already exist for providing technical support, capacity building and quality assurance in HIV testing in all states. State Resource Centers for providing similar support for Targeted Interventions also exist in some states. They will be responsible for needs assessment, technical support, capacity building and quality assurance of implementing units working in the specialized area. In addition, the responsibility of identifying partners, assessing capacity and short-listing NGOs and contractual staff of district/sub-district implementing units (e.g. counselors in VCTC) may also be delegated to them. This will significantly reduce the high burden of pre-selection transaction costs on SACS. Apex/Regional Resource Centers will be made responsible for capacity development of these centers.

Table-6: Process for institutionalizing programme support through Resource Centers

Process	Responsibility
1. Identification of key programmatic areas that requires support through Apex Resource Centers and areas which will additionally require Regional Resource Centers and State Resource Centres; and Development of a generic TOR (A tentative list of areas is provided in Annex-9)	◆ Multi-disciplinary Standing Committee on Technical Support constituted by NACO
2. Creation of Technical Advisory Groups for each of the identified programmatic areas	◆ NACO
3. Commitment for technical and/or financial support to each area from development partners through the “One agreed Framework”	◆ National Coordinating Committee headed by NACO
4. Development of programme area specific TOR. Identifying and short-listing institutions in each of the programme area	◆ Technical Advisory Group
5. Field appraisal and final short list of institutions meeting eligibility criteria as spelt by the TOR	Internal NACO team constituted by officers from ◆ NACO division under which programmatic area falls

Process	Responsibility
	<ul style="list-style-type: none"> ◆ Administration Division ◆ Finance Division
6. Selection of institutions	◆ Multidisciplinary Standing Committee-Technical Support
7. Negotiation and Finalization of Terms of Reference with selected institutions which would include: <ul style="list-style-type: none"> ◆ Scope of work including specific deliverables ◆ Mechanisms for providing programme support at different levels ◆ Commitments by the institution in terms of human, infrastructure, time and other resources ◆ Mechanisms for funding and other support to the Resource Center ◆ Indicators for measuring performance of the Resource Center 	Team which includes officers from <ul style="list-style-type: none"> ◆ NACO division under which programmatic area falls ◆ Administration Division ◆ Finance Division and ◆ DP(s) which has agreed to provide support in the particular area
8. Approval of Final TOR	◆ NACO Board
9. Contracting	◆ Administrative Division, NACO
10. Contract Management and focal point for all issues other than technical	◆ Designated Officer in Administrative Division
11. Focal point on technical issues	◆ Designated Officer in concerned Division
12. Technical Support to Resource Center	<ul style="list-style-type: none"> ◆ Technical Advisory Group ◆ Development Partner
13. Oversight	<ul style="list-style-type: none"> ◆ Technical Advisory Group ◆ Technical oversight of regional and state resource centres with apex centres ◆ Feedback from states to NACO ◆ Review by Multidisciplinary Standing Committee for Technical support
14. Evaluation of Resource Center	<ul style="list-style-type: none"> ◆ Internal- Strategic Information Division, NACO ◆ External- External agency

4.20 Given the paucity of specialized skills in many of the programme areas, it is likely that the selected institutions will have to develop their own capacity before they can function as effective resource centers. Technical assistance in this regard may be provided through a development partner as per the “one agreed framework”. It is further recommended that the Resource Centers be contracted for the entire project period, subject to an annual review of their performance to provide incentive for development of

core faculty, infrastructure and other resources at the Center. NACO will provide the necessary financial support to the Resource Centers either through funds committed by a DP or through pooled funds of the programme. Funding of the Resource center will be linked to specific outputs as per annual plan. In addition to programme support earmarked in the annual plan, states may need supplementary support depending on local requirements. SACS may procure the required services from these Centers. Since SACS are required to follow costing guidelines fixed by NACO for procurement, it is desirable that unit costs for different outputs be specified in the TOR. NACO may also consider instituting fellowships at the Centers in the concerned area. This will develop skilled manpower and address lack of capacity in the country in specialized areas.

4.21 Under the proposed arrangements, the Technical Advisory Groups of NACP will have a key role in developing a technical support plan for a particular component of the programme. They will assess and identify capacity development requirements for the component. The assessment of these groups will necessarily have to be informed by state and district capacity development profiles. The groups will help identify national and regional institutions for providing support to implementing agencies. Further, they are responsible for developing technical assistance tools by identifying best practices, developing/ revising standard operating procedures and quality guidelines, and developing other technical assistance products. The Multidisciplinary Standing Committee for Technical Support will examine and approve of the technical support plans and proposals put forward by Technical Advisory Groups.

4.22 The Technical Advisory Groups will provide technical support to Apex and Regional Resource Centers and oversee their functioning. The Resource Centers will provide technical support to SACS, train programme staff as well as create a pool of Master Trainers. Master Trainers will develop capacity of district level trainers for district/sub-district level capacity building. Depending on the component, Master Trainers and District Trainers will be drawn from government, parastatal and private sector including professional bodies like IMA, FOGSI and CII. In addition, HIV/AIDS Resource Persons (PLHA) will be trained for workplace training, sensitization and grassroots advocacy. Further State level training institutions like medical colleges, State Institutes for Health &

Family Welfare, Institutes in Management for Government etc., may be strengthened through technical assistance by the apex/regional resource centers to provide training in their respective areas. A suggested structure for developing capacity in key programmatic areas is provided in Annex-9.

Public-Private Partnerships for Delivery of Services

4.23 Public-Private-Partnership or PPP is a mode of implementing government programmes/schemes in partnership with the private sector. The term private in PPP encompasses all non-government agencies such as the corporate sector, voluntary organizations, self-help groups, partnership firms, individuals and community based organizations. PPP, subsumes all the objectives of the service being provided the government, and is not intended to compromise on them. The shift in emphasis is from delivering services directly, to service management and coordination.¹²²

4.24 There are a number of reasons why it is beneficial for the NACP to build partnerships with the private sector. These include:

- ◆ Extension of coverage to high-risk populations. For instance: NGO's have access to certain target populations like commercial sex workers who may distrust government programs. In India it is estimated that the private sector delivers care to 80% of patients seeking treatment for STIs¹²³.
- ◆ Extension of coverage to general population: The private health sector in India plays a large and important role in the overall delivery of health care and in the care of patients with HIV/AIDS and associated infections. It has been estimated that 80% of doctors, 75% of dispensaries and 60% of hospitals in India are in the private sector¹²⁴. Further the rapidly growing corporate sector is a major employer of humanpower in India and is well placed to support HIV prevention activities through work place interventions.

¹²² Government of India. Report of the subgroup on social sector public private partnership. Planning Commission, 2004

¹²³ Ekstrand et.al (2003) cited in Report of the Macroeconomic Commission on Health, Vol II, 2005, pg 52

¹²⁴ *ibid*

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- ◆ Addressing specific gaps in capacity in the public sector. In addition to the two reasons above, an NGO for example, may be better qualified to train health and other professionals in certain aspects of patient care.
 - ◆ Improving the quality of care. For example an NGO hospital for HIV/AIDS patients may be more sensitive and client-focused than a public general hospital, or the staff of an HIV/AIDS NGO may be better able to educate certain target populations on prevention because they have a better understanding of their needs. Similarly private hospitals and practitioners may be better able to maintain confidentiality and be sensitive to the needs of STI/HIV patients
 - ◆ Complementing/amplifying the impact government programs and services. For instance: NGOs bring people into public facilities for testing and treatment or private practitioners refer patients to VCTCs and ART centers
 - ◆ Allow government authorities to create some distance from HIV/AIDS service delivery in cases where direct provision would be politically difficult;
 - ◆ Supplement government resources through private participation. This may include financial or technical assistance from the corporate sector
 - ◆ Deliver HIV/AIDS services at a lower cost and provide flexibility to expand and improve services without the need to make changes in the public health infrastructure such as hiring more public sector employees or constructing new facilities¹²⁵

4.25 Though both the nonprofit and for-profit private sector received attention in Phase-II, initiatives for PPPs were primarily focussed on the NGO sector. PPPs with NGO sector included areas such as targeted interventions, care and support, school aids education programmes, awareness campaigns for community leaders, tele-counseling, peer counseling in VCTCs/PPTCT centers etc. PPPs with for-profit private sector includes capacity building of private practitioners for medical care and referral, improving blood safety through strengthening blood banks and training their staff, PPTCT centers in private medical colleges, work place interventions and CSR initiatives of corporate sector.

¹²⁵ Barnet et.al. Contracting NonGovernmental organizations for combating HIV/AIDS, Special Initiative Report 33, Abt Associates, 2001.

- 4.26 There exists an elaborate process for selection of NGO partners. First, an advertisement is issued in the newspapers, inviting proposals from NGOs. The NGOs who have applied, are assessed based on existing guidelines. The NGO is required to be registered as a legal organization, either under the Societies Registration Act, 1860 or the Charitable and Religion Act 1920; or Indian Trust Act, 1982; or with co-operative professional bodies such as IIPA, IMA at least for a period of three years. In terms of infrastructure, the NGO is required to the basic infrastructure in place; a stable organizational structure, established track record in the developmental field, especially with communities, so that it may effectively integrate HIV/AIDS with its ongoing programme, clean audit reports and a good working relationship with other NGOs. The project proposal submitted by the NGO is required to be accompanied by a copy of the registration certificate; annual report of the past three years; Non- Governmental Organization's Self Assessment Report; Audited financial report of the past three years; organogram of the NGO and a certificate from the NGO stating that it is not receiving funds for the activity mentioned in the proposal from any other national or international donor agencies or State Government.
- 4.27 The NGOs are selected at State levels through the Technical Advisory Committees set up by the State AIDS Control Societies (SACS). These committees scrutinize candidate applications and project designs, and also subsequently monitor and evaluate the programme within the framework of the guidelines drawn up by NACO in respect of each intervention. All the proposals received from the NGOs are placed before a Technical Advisory Committee (TAC), consisting of technical advisors of the SACS and the NGO members of the Executive Committee of the SACS. Wherever possible, a member of NACO is also part of the selection committee. The TAC scrutinizes the proposals with reference to the priority-targeted intervention identified for the State/MC in its final Project Implementation Plan. Those NGOs whose proposals are recommended by the TAC for modification are informed of the decision and invited to participate in a short Orientation Training Program (OTP). The approved proposals are taken up for field inspection by a Joint Appraisal Team (JAT) consisting of an officer of SACS who has been designated as Zonal Officer for specific districts and one of the NGO members of the TAC. The field inspection report of the Joint Appraisal Team, along with the TACs

recommendations are placed before Executive Committee of SACS, chaired by the State Health Secretary, for consideration and decision. The NGOs whose proposals are approved thereafter enter an agreement with the SACS. The funds for the proposed activity are released as per the stipulated guidelines.¹²⁶

4.28 The NGO is provided a grant-in-aid. If the NGOs does not utilize the grant-in-aid for the purpose for which it was sanctioned, the NGO has to refund the grant along with interest. The service provider has also to give a Surety Bond¹²⁷.

4.29 There are certain key challenges that the NACP faces in initiating and managing PPPs. Generally the objective of the government in introducing PPP is to choose a partner with skills, experience and resources.¹²⁸ However, in the case of the NACP, this is not an easy task to achieve given that HIV is a relatively new issue tackled by the private sector and hence has limited capacity. Even when there are large number of applicants, many SACS find it difficult to identify NGOs satisfying key pre-requisites for selection. NGOs themselves find it difficult to recruit and retain key staff.

4.30 Although private health sector is the major provider of health care services, the capacity to provide HIV treatment and care is limited. A recent study which examined the knowledge and practices of family physicians and consultants indicate that in the low-prevalence States, 70% of family physicians were unaware of the availability of an HIV-ELISA test, and 80% unaware of the various ARTs available except zidovudine (ZDV). CD4 counts and viral load monitoring facilities are unavailable and counselling concepts alien. In high-prevalence States, 85% of family physicians knew of ELISA and the Western blot tests. Elementary counselling concepts are known but seldom practised. Parameters to initiate therapy, drug regimens, drug combinations and patient monitoring are poorly known. About 5% of family physicians attempt to use ART, with ZDV+3TC the most frequently used regimen, though monotherapy is also common. Internists, chest physicians and dermatologists/venereologists also practise HIV medicine, but only 60%

¹²⁶ Reproduced from Government of India (2004): Health Sector Reforms in India, Initiatives from Nine States, August 2004, Bureau of Planning, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, New Delhi

¹²⁷ Government of India. Report of the subgroup on social sector public private partnership. Planning Commission, 2004

¹²⁸ *ibid*

of them know of HIV/AIDS drugs and regimens. Their knowledge of patient selection criteria and monitoring, including CD4 counts and viral load, is very limited. Over 90% are not familiar with salvage therapy¹²⁹. There is great concern that greater access to ART could lead, particularly in the largely unregulated private sector, to faulty prescription practices that might set the stage for the emergence of drug-resistant HIV strains¹³⁰. These concerns are reflected in the findings of a recent multicentric study of the causes of failure of ART in India. A study, led by the personnel of the Grant Medical College and GT Hospital in Mumbai, only 10% of the patients were counselled before initiating ART. Adherence was observed in only 10% and all were on suboptimal regimens¹³¹.

4.31 A further challenge is the inadequate skills and institutional mechanisms within the NACP to initiate and manage such partnerships- both technically and administratively. The National Civil Society Consultation on National AIDS Control Program Phase III identified political interference in selection and funding, corruption and faulty selection criteria as some of the key problems with the existing arrangements for selection of NGOs¹³². The process of selection, especially of NGOs for TI, is time consuming given the large number of NGOs applying. On the other hand, the number of applicants for providing care and support is very low. According to SACS officials, established NGOs having the capacity to deliver care and support do not apply, as they are apprehensive of the hassles of working with the government. Further, the stringent requirements largely exclude CBOs of PLHAs and other KPs, who may be otherwise well placed to contribute to the programme.

4.32 Discussions with key stakeholders indicate that there are a number of deficiencies in the current arrangements, which needs to be addressed. These include;

¹²⁹ Vaidya SB, Deshpande AK. Antiretrovirals (ARVs) in India—a challenge with two edges. Abstract no. MoPeB3316. XIV International Conference on AIDS, Barcelona, 7–12 July 2002. Reproduced from report of the Macroeconomic commission on Health, Government of India, 2005

¹³⁰ Mudur G. India must change health priorities to tackle HIV. *BMJ* 2002;**325**:1132, cited in report of the Macroeconomic commission on Health, Government of India, 2005

¹³¹ Saple DG, Vaidya SB, Kharkar RD. Causes of ARV failure in India. Abstract no. WePeB5860. XIV International Conference on AIDS, Barcelona, 7–12 July 2002. as cited in report of the Macroeconomic commission on Health, Government of India, 2005

¹³² NACP III Design Team, India HIV/AIDS Alliance/RCSHA. National Civil Society Consultation on National AIDS Control Program Phase III.

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- ◆ Delay in release of funds to NGOs, ranging from 3 months to 16 months resulting in high staff turnover and/or inadequate implementation of programme
 - ◆ Resources not in accordance with need/evidence. Uniform staffing pattern without reference to local needs
 - ◆ Currently uniform training for all staff. Training programmes not tailored as per requirements for various types of NGO staff. Requires refresher training
 - ◆ Lack of trained personnel (in practical implementation skills, in KP context and rights, attitudes and values towards sex, sexuality, KP issues, HIV)
 - ◆ Uneven and unattractive salary structure and increment/benefit policies work as a disincentive for skilled people in the projects.
 - ◆ IEC material, training materials etc., not locally relevant.
 - ◆ Reporting mechanisms complex leading to difficulty in complying with reporting requirements. Inadequate feedback on reports
 - ◆ Monitoring infrequent, not based on clear guidelines and not at all participatory. More of inspection of facilities and accounts
 - ◆ Limited access and inadequate support from SACS. Insensitivity of SACS personnel to NGO requirements
 - ◆ NGOs have limited voice and decision-making role in planning and implementation. Rather than partnerships more of a donor-recipient relationships
 - ◆ Limited voice and decision making role of key populations in NGO program. More of a provider-beneficiary relationship, rather than participatory
 - ◆ Weak referral systems due to lack of prevention and care services below district level

4.33 Overall, the PPP initiatives in NACP are constrained by problems of selection; rigid norms for selection and support; inadequate capacity in both the private and public sector, inadequate systems for providing technical support, financing, and programme management; and very limited ownership of the private sector in the NACP.

Recommendations

4.34 While in some cases informal coordination and collaboration are required, in many instances partnerships through formal agreements with financial support from the programme is necessary. The private sector is not homogenous and includes a number of

varied players within the health sector and outside. Further, there are a variety of interventions such as TI, Care and support, Work Place interventions, Advocacy etc., which require partnerships with different types of organizations. In addition, different states and districts will have specific requirements for partnerships in various programme areas. It is anticipated that these requirements will be reflected in the district and state action plans. Once the possible areas for PPP have been identified, the norms for selection and costing of services have to be fixed for different type of services offered by different types of providers. It is recommended that these norms be evolved by a consultation process led by Technical Advisory Groups of the respective programme areas and finalized by the multidisciplinary standing committee on technical support.

- 4.35 In the present arrangements, partnership agreements are one-sided. While penalties for default by NGOs are included in the agreement, there is no mechanism to ensure that the public partner fulfills its responsibility. It is recommended that the agreement be through a legally binding contract, which gives both the NACP entity and the private partner more security that each side will fulfill its responsibilities. The contract will specify responsibilities of both sides including a clear time-line for release of funds. A legally enforceable contract may be important for the private organization that is far less powerful than the public entity and relies on the it to make timely payments.
- 4.36 A core requirement for the programme is building capacity of both public and private partners. At the SACS level in addition to putting key staff and systems in place, technical assistance is required for building key programme management skills including contract management. Private sector requires capacity development in administrative and technical areas. It is recommended that c apacity building should include strengthening the role of private sector at all levels of the control strategy such as policy development, implementation and evaluation of programme. Both players will require technical assistance on a continuos basis. A suggested structure for technical support is provided in Annex-9
- 4.37 NACP-III should institutionalize mechanisms for greater ownership of the programme by the private sector. The civil society, private health sector and the corporate sector need to be involved in policy development, planning, implementation and oversight of NACP.

It is recommended that these sectors are given adequate representation in policy making bodies, governing structures and coordinating mechanisms of NACP-III. Though there is comparatively more representation of CSOs in the governance structures, CSO representatives are nominated by the government more in their individual capacity and are generally not accountable to the variety of CSOs working with the programme. Such an arrangement is seen as a token gesture and many of the NGO representatives whom we had contacted for the study felt that their voice was not being articulated in the higher decision making bodies.

4.38 The NACP could consider supporting a professional network of NGOs/CBOs at the district level. In Phase-II NGO, networks such as Partners Forum Kerala (PFK) were supported at the state level. Networks at the district level may federate at the state and national level and representatives to respective governance structures may be elected/selected from among themselves. The forum can play a strongly proactive, decision making role in governance structures of NACP and hold partners accountable to program outcomes spelt out under NACP III. It will be well placed to play a watchdog role to ensure rights based approach advocated by NACP III is adhered to, ensure that GIPA principles are put into practice, and bring emerging issues on risk, vulnerability and impact for policy and program review. The forum may also mobilize and channelize resources and build up capacities of partners to address the emerging development issues.

4.39 Increased focus on care, support, and treatment in Phase-III, necessitates exploring the potential of public- private partnerships to support this component of the programme. Some of the services that could be outsourced to private sector include:

- Laboratory diagnostics including CD4 cell counts, DNA-PCR, RNA Viral Loads and tests to diagnose OIs and counseling
- Care continuum services including ARV treatment where such facilities are not available in the public sector
- Community care centers and home based care¹³³

¹³³ NACP Phase-III Planning Team. Report of the Working Group on Care, Support and Treatment

4.40 It is recommended that the contracting for the said partnerships be done at the level of SACS. The guidelines for selection of partners may be flexible enough to accommodate various options that are available, with a clear emphasis on well-defined eligibility criteria, transparent process of selection and ratification by the SACS Board.

4.41 Depending on the number of organizations to be contracted SACS may engage an outside agency for verifying antecedents and short listing of potential partners. In AP for instance; much of the selection process for TI NGOs has been out-sourced to the PSU. Advantages of such a mechanism include (1) administrative convenience, and better control in dealing with less number of applicants and (2) decisions can be taken more quickly, despite political pressures

4.42 The role of the district units in public-private partnerships for service delivery will be to identify potential partners, verify antecedents, provide support to NGOs in preparing proposals, ensuring timely disbursement of funds, trouble shooting, contract management and monitoring of performance.

4.43 Summary of key institutional arrangements required for PPP in service delivery is provided in Table.

Table-7: Institutional arrangements for PPP for service delivery

Process	Responsibility
Mapping of partners	DACU
Assessment of areas where PPP could contribute to the programme	Consultative process for preparation of district and state level plans
Norms for selection of partners and costing of services	NACO through Technical Advisory Groups in respective areas and Multidisciplinary Standing Committee for Technical Support
Selection Process	SACS as per guidelines issued by NACO
Contracting	Administration Division, SACS
Focal point for technical issues	Designated Officer in respective areas, SACS
Focal point for all matters other than technical	Designated Officer, Administration Division
Technical Assistance	Suggested structure provided in Annex-9
Monitoring of performance	SACS through DACU
Oversight	<ul style="list-style-type: none"> ◆ District Health Society of NRHM ◆ District Coordination Committee ◆ SACS
Evaluation of NGO performance and Impact	<ul style="list-style-type: none"> ◆ Internal- Strategic Information Division, SACS ◆ External- External agency

5. Governance Framework for NACP-III

71. The way institutions interact within a programme is a critical success factor for the programme’s overall success. The proposed institutional framework for Governance is given below. In the figure, “NSA” refers to Non State Actors such as civil society, private sector and development partners. Decision making structures in which active engagement of these actors is mandatory are appended with the term “NSA”. The success of NACP-III is premised on an effective partnership approach. Such an approach would typically apply principles of engagement that are mutually acceptable to all parties, including the principles of (a) transparency (b) accountability (c) equity (d) participation (e) value (f) social justice, and (g) respect for human rights.

Figure-6: Proposed Governance Structure for NACP-III

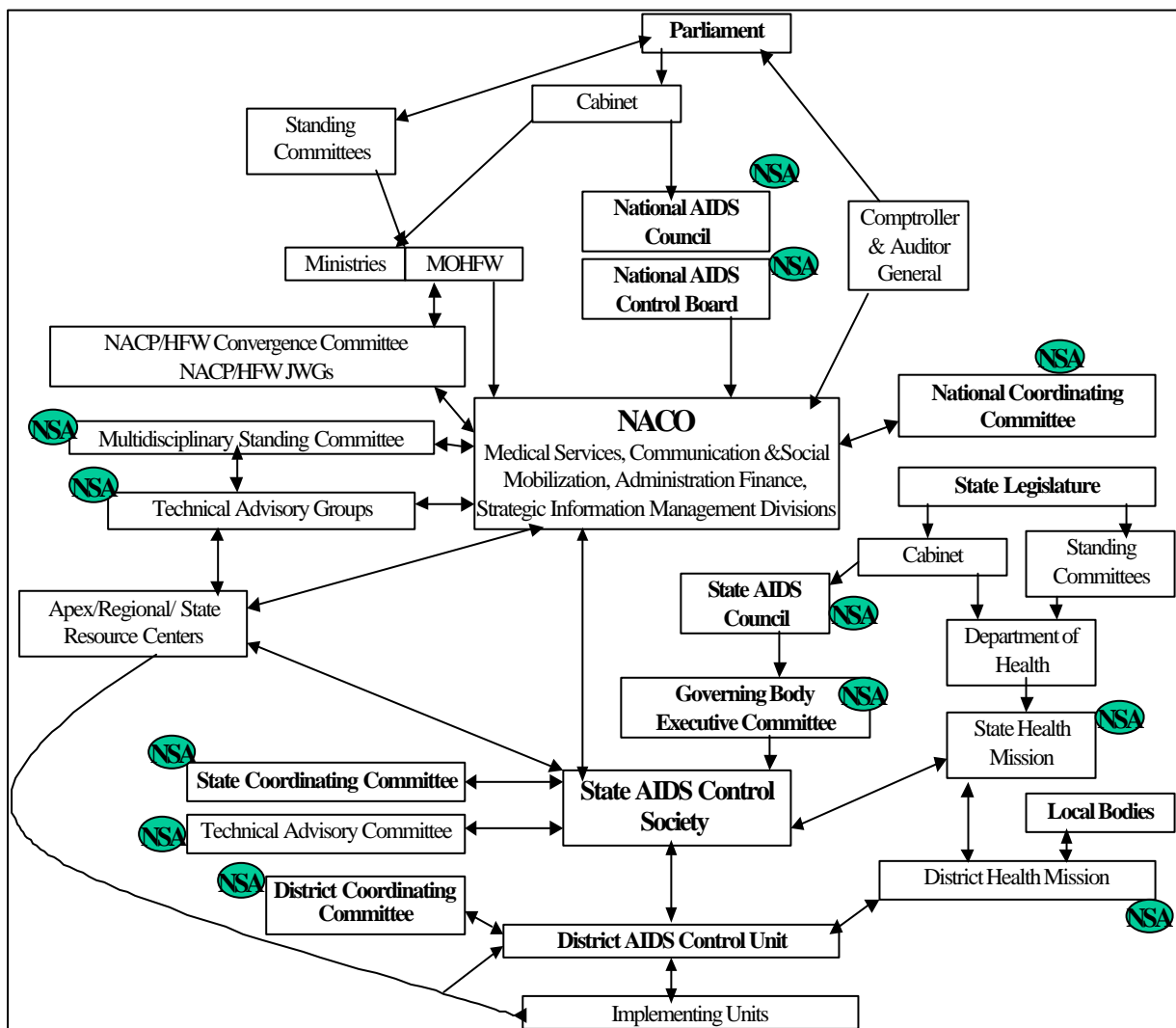


Table-8: Role of key structures in governance of NACP-III.

Structure	Key Roles
Parliament and State Legislature	<ul style="list-style-type: none"> ◆ Provide political leadership to HIV prevention and control ◆ Discussing and adopting government policy ◆ Enactment of laws ◆ Approval of Budget ◆ Oversight of executive and ensuring their accountability
Parliamentary Committees	<ul style="list-style-type: none"> ◆ To provide a more vigilant locus of accountability of executive ◆ Parliamentary Committees include (1) Functionally specialized Standing Committees and (2) Departmentally Related Standing Committees. The important functional committees include the Committee on Public Accounts, Committee on Estimates and Committee on Government Assurances. <ul style="list-style-type: none"> ◆ The Committee on Public Accounts scrutinizes Appropriation Accounts of the Government of India and the Report of the Comptroller & Auditor General of India thereon, and verifies that (a) that the moneys shown in the accounts as having been disbursed were legally available for, and applicable to, the service or purpose to which they have been applied or charged; (b) that the expenditure conforms to the authority which governs it; (c) that every re-appropriation has been made in accordance with the provisions made in this behalf under rules framed by competent authority. ◆ The Committee on Estimates is required to: a) report what economies, improvements in organization, efficiency or administrative reform, consistent with the policy underlying the estimates may be effected; (b) suggest alternative policies in order to bring about efficiency and economy in administration; (c) examine whether the money is well laid out within the limits of the policy implied in the estimates; and (d) suggest the form in which the estimates shall be presented to Parliament. ◆ The Committee on Government Assurances are to scrutinize the assurances, promises, undertakings etc. given by a Minister from time to time and to report to parliament on the extent to which such assurances have been implemented and to see whether such implementation has taken place within the minimum time necessary for the purpose ◆ Departmentally Related Standing Committees (DRSC) potentially constitute a potent mechanism for ongoing oversight of the executive as they can, under the statutory powers accorded to them, review any aspect of the workings of a particular ministry; including monitoring the annual performance of the ministry. HIV/AIDS Control currently come under purview of DRSC on Health and Family Welfare. It is recommended that it also be brought under purview of the other 23 DRSCs to monitor mainstreaming activities of the respective ministries.
Comptroller & Auditor General	<ul style="list-style-type: none"> ◆ To enhance accountability of the executive to the Parliament and State Legislatures by carrying out audits in the public sector.
National AIDS Council/ State	<ul style="list-style-type: none"> ◆ Provide Strategic political leadership for HIV/prevention and control ◆ To provide overall policy directives for NACP

Structure	Key Roles
AIDS Council	<ul style="list-style-type: none"> ◆ To mainstream HIV/AIDS issues in all ministries and departments ◆ To ensure that implementation of the NACP is in accordance with government policy objectives
National AIDS Control Board	<ul style="list-style-type: none"> ◆ Day-to-day executive decision-making, programme oversight, monitoring and coordination ◆ Facilitation of recruitment to key posts
National Coordination Committee	<p>Assertive, multi-stakeholder forum for information and knowledge-sharing and cross-institutional collaboration. Specifically:</p> <ul style="list-style-type: none"> ◆ Mobilize and energize stakeholders to assume responsibility and execute actions appropriate to their mandate in the implementation of the programme ◆ Clarify and agree on the role of each partner in implementation of the national plan so that: (i) the risks of working at cross-purposes and duplicating effort are minimized; and (ii) the opportunities for complementarity and synergy are collaboratively identified and exploited ◆ Review implementation and ensure that it is in accordance with the agreed action plan and provide feedback to all implementing partners ◆ Similar role as above for state and district coordination committees
NACO	Steering, supporting, financing, coordinating and overseeing the NACP (details are provided in Table-1)
HFW/NACP Convergence Committee	<ul style="list-style-type: none"> ◆ Policy inputs and oversight to the convergence between NACP and DHFW ◆ At the National level, two joint working groups are visualized comprised of technical and programme managers from NACO and DHFW. They include (a) Joint working group on convergence of RTI/STI, VCTC and PPTCT into DHFW infrastructure and services, and (b) Joint working Group on Training and MIS. Broadly, the roles of the JWG are to review quarterly performance from each state and jointly review and prepare a report on performance coverage and quality. ◆ The NACP-HFW Convergence Committee, which meets every quarter, will obtain reports from each of the National JWG, provide feedback and serve as a problem solving mechanism.
Multidisciplinary Standing Committee for Technical Support	<ul style="list-style-type: none"> ◆ Function as a technical advisory body to NACO ◆ Review technical support plan for NACP-III ◆ Provide guidance in developing TOR for hiring humanpower and outsourcing of technical support ◆ Approve proposals for technical support provided through NACP-III ◆ Review performance of technical support mechanisms ◆ Arrange for technical audit of programmes and activities of NACP-III
Technical Advisory Groups	<ul style="list-style-type: none"> ◆ Develop a technical plan for component assigned to them ◆ Identify and prioritize technical assistance needs in terms of structures, systems, humanpower, skills, tools to be in place for NACP-III ◆ Identify best practices, develop/ revise quality guidelines, develop technical assistance products and devise strategies for program implementation

Structure	Key Roles
	<ul style="list-style-type: none"> ◆ Provide technical support to programme managers in NACO ◆ Develop TOR, identify national and regional institutions for providing support to implementing agencies, provide technical support to these institutions and oversee their functioning. ◆ Approve curricula for training programmes
National/Regional Resource Centers	<p>The Apex Resource Center will:</p> <ul style="list-style-type: none"> ◆ Provide technical assistance to NACO and SACS ◆ Develop training modules, manuals and course material for training of different levels of programme staff ◆ Provide periodic training to programme officers of NACO, SACS and other implementing agencies ◆ Identify and develop a pool of master trainers for providing training support to SACS ◆ Develop capacity of Regional and State Resource Centers ◆ Identify knowledge gaps and research priorities ◆ Identify and network with research institutions in the specialized area ◆ To function as a central repository of HIV research and an information clearinghouse on HIV/AIDS research in the specialized area.
Research Advisory Council	<ul style="list-style-type: none"> ◆ Determination of research priorities for NACP-III ◆ Scrutinizing and approval of research proposals ◆ Monitoring progress of the studies.
SACS	Steering, supporting, financing, coordinating and overseeing the NACP at State level (details are provided in Table-4)
Governing Body of SACS	<p>Authority to exercise and perform all the powers, acts and deeds of the Society including:</p> <ul style="list-style-type: none"> ◆ Approval of annual budget and the annual action plan of SACS ◆ Review of functioning of SACS ◆ Review of financial position of the Society and annual audited accounts ◆ Develop and adopt its own rules and regulations for recruitment and appointment of experts and administrative / technical staff and set its own compensation package for such experts / staff to be recruited from the open market and/or deputation basis. ◆ Delegation of its powers to any authority of the society, appoint committees, sub-committees and boards etc.
Executive Committee of SACS	Day-to-day executive decision-making, programme oversight, monitoring and coordination to ensure the timely and effective implementation of work plans as detailed in the project implementation plan.
State Coordination Committee	Similar role in the State as National Coordination Committee
State Health Mission/	<ul style="list-style-type: none"> ◆ Providing health system oversight and consideration of policy matters related with health sector including HIV/AIDS. ◆ The Governing Body and Executive Committee of State Health Society

Structure	Key Roles
Society	will be responsible for oversight of convergence of NACP with NRHM related sectors
District AIDS Control Unit	<ul style="list-style-type: none"> ◆ To prepare District specific AIDS control action plan ◆ Ensuring timely resource availability for programme implementation ◆ Monitoring and evaluation of progress of interventions ◆ Disseminate information and reorient initiatives based on feedback ◆ Facilitate background research to enhance impact of interventions ◆ Regular reporting to SACS on progress of implementation/constraints ◆ District and sub-district convergence of NACP with other programmes ◆ District level intersectoral collaboration and programming ◆ Identification of potential partners for the programme ◆ To ensure PRI and NGO/Key population support for community mobilization and awareness
District Health Society	<ul style="list-style-type: none"> ◆ Facilitating mechanism for the district health administration as also the mechanism for joint planning by NRHM related sectors ◆ Ensuring Inter-sectoral convergence and integrated planning for HIV prevention and control ◆ Overseeing functioning of DACU and providing regular report and feedback to those who are entitled to receive Annual Report of the Society including; District Collector and Chairperson, Zila Parishad
District Coordination Committee	Similar role in the district as State Coordination Committee
Local Bodies	<ul style="list-style-type: none"> ◆ Planning, implementation, and monitoring of NACP at district and sub-district levels through the NRHM framework ◆ Gram Sabha will be responsible for awareness campaigns along with health worker ◆ Block Panchayat will identify sites where appropriate treatment and counseling facilities are available. ◆ Block Panchayats will ensure attendance of doctors, and other staff and identify bottlenecks to services at PHC/CHC ◆ Where required Panchayat will enable counseling for members of the affected families
Development Partners	<ul style="list-style-type: none"> ◆ Technical Assistance and/or ◆ Financial Assistance
NGO Sector	<ul style="list-style-type: none"> ◆ Collaborative" Partnership – NGOs accessing a competitive basket fund within the programme to implement activities on behalf of Government ◆ Cooperative" Partnership –NGOs participating in the programme in order to access donor funds according to their comparative advantage over Government. ◆ Independent Oversight – NGOs keen to participate in the programme from a "watchdog" perspective, in order to monitor and evaluate ongoing government commitment to implementing the programme

Structure	Key Roles
Private Sector	<ul style="list-style-type: none"> ◆ Corporate sector as part of Corporate Social Responsibility ◆ Implement Work Place Interventions ◆ Public-Private Partnerships that involves provision of technical assistance by government or out-sourcing of services
PLHA Networks	<p>Other than target audience involve as</p> <ul style="list-style-type: none"> ◆ Contributors ◆ Speakers ◆ Implementers ◆ Experts ◆ Decision Makers

Specific Mechanisms for Governance

Accountability of SACS to NACO

72. Some states, especially the high prevalence ones, have taken advantage of the comparatively better health infrastructure and scaled up their response to the epidemic. However many of the low prevalence states, particularly the EAG states, which are highly vulnerable owing to their large population, have not been able to mobilize the health department or civil society structures to effectively tackle the epidemic. Though NACO is ultimately responsible for performance of these SACS, there are hardly any mechanisms currently in place, by which NACO can ensure their performance.

73. It is envisaged that strengthening of technical assistance to States, creation of an Administration division at NACO for coordination with SACS, designated national focal points for programmatic areas, mechanisms for participatory planning and improved financial management mechanisms at NACO will have an impact on overall performance of SACS. Further, strengthening monitoring and evaluation systems can improve provide indication of weak performance on a real time basis so that corrective measures can be applied immediately. However, there is also requirement of additional mechanisms to ensure that SACS, especially the consistently poorer performing ones, deliver a minimum required performance. Mechanisms are suggested in this regard, include:

74. **Establishment of State Resource Centers** in key programmatic areas as proposed in Annex-9. The State Resource centers will be responsible for providing technical

assistance, capacity building and monitoring of performance of the programme in key areas.

75. NACO to leverage the influence of the National AIDS Council to ensure that suitable persons are appointed to key posts in SACS and that they continue in the posts for sufficient period of time.

76. Inclusion of a representative from NACO in the Governing Body of SACS. Similar mechanism exists in the case of NRHM where a MoHFW nominee is a member of the Governing Body of the State Health Mission¹³⁴. This has two advantages. One, it would be a mechanism by which NACO could have a first hand understanding of the programme in the State, apprise decision makers at the State of NACO's concerns and help ensure compliance with agreed plan of work. Second, the States will have direct access to a senior officer of NACO who can serve as an effective liaison between NACO and SACS and coordinate direction and/or handholding as required.

77. Joint Public Service Agreements for delivery of services. The State Action Plan agreed by all partners in the State will be the basis of the agreement, which will be signed by both SACS and NACO. The Public Service Agreement will be a statement which specifies :

- ◆ Objectives: In broad terms, what the NACP is looking to achieve in the State
- ◆ Performance targets under each objective- Outcome focused performance targets.
- ◆ Who is responsible for the delivery of these targets and the timelines within which they are to be achieved. Where targets are jointly held this is identified and accountability arrangements clearly specified
- ◆ Triggering Points for intervention by NACO, consequent to the failure to achieve the targets agreed upon.

78. Where efforts to achieve targets as specified in the Agreement are not occurring and triggering points reached, NACO will engage implementing partners either directly or

¹³⁴ Ministry of Health and Family Welfare. National Rural Health Mission Institutional Setup at State level. Downloaded from www.mohfw.nic.in

through an agency contracted by it, to implement components of the programme. The modalities of the intervention will be finalized by a core team constituted by DG, NACO in consultation with the State Coordination Committee. It is envisaged that the Joint Public Service Agreement will hold SACS accountable objectively and transparently to meet the required targets. At the same time the Agreement makes it mandatory for NACO to intervene, if State level arrangements fail, thereby ensuring that the programme does not get adversely affected.

Accountability to Panchayati Raj Institutions

79. The National AIDS Policy envisages greater ownership of PRIs in the NACP¹³⁵. The National Health Policy, 2001, also emphasizes implementation of public health programmes through local self-government institutions, especially relating to the national disease control programmes¹³⁶. The Planning Commission Task Force that reviewed PRI involvement in various sectors made recommendations on engagement of PRIs in major HFW programmes including HIV and AIDS. In August 2003, the Central Council of Ministers of Health and Family Welfare, resolved “that the States would involve PRI in the implementation of HFW programmes by progressive transfer of funds, functions and functionaries, by training, equipping and empowering them suitably to manage and supervise the functioning of health care infrastructure and manpower and further to coordinate the activities of the works of different departments such as: Health and Family Welfare, Social Welfare, and Education which are functioning at the Village and Block Levels”. The National Rural Healthcare Mission, (NRHM) aims to provide an integrated package of primary health care services at the village level through intersectoral convergence, decentralization and community action. . The reach of the present health and system is sought to be extended to the village level in the form of “ASHA”- an Accredited Social Health Activist, who will be selected, supervised and supported through the panchayat and its committees¹³⁷

¹³⁵ Government of India. National AIDS Prevention and Control Policy, 2002.

¹³⁶ Government of India. National Health Policy, 2002

¹³⁷ Ministry of Health and Family Welfare. Panchayati Raj Institutions and Health and Family Welfare programmes. Issues paper

80. While the policy and programme environment for PRI engagement in health is very supportive, PRIs are not yet equipped to take on such planning and monitoring functions, nor is there a cognizance in the health system of the role of PRI.¹³⁸ State legislatures with rare exceptions such as Kerala, have been lagging behind in framing laws that endow Panchayats with power and authority to enable their functioning.¹³⁹ The launch of the ambitious NRHM is anticipated to give impetus to the empowerment of Panchayats through funds, human resources and capacity, given that the success of the Mission is intrinsically linked to better performing PRIs.

81. PRIs are seen as critical to the planning, implementation, and monitoring of the NRHM. The NRHM is seen as a vehicle to ensure that preventive and promotive interventions reach the vulnerable and marginalized through expanding outreach and linking with local governance institutions. ASHA, the mechanism to strengthen village level service delivery, will be supported in her work by the AWW, schoolteachers, members of local community based organizations, such as SHGs, and the Village Health committee. ASHA's role would be to facilitate care seeking and serve as a depot holder for a package of basic medicines. The Village Health Committee (VHC) will form the link between the Gram Panchayat and the community. It is anticipated that this committee will prepare a Village Health Plan and maintain village level data, supervised by the Gram Panchayat. Engaging the Gram Sabha and other groups in planning and monitoring the Village Health Plan will presumably enforce transparency and accountability¹⁴⁰. Further, Zilla Parishad has a leadership role in the District Health Society. Thus NRHM provides an opportunity for a greater role for PRIs in planning, implementation, monitoring and ensuring accountability of health programmes at the district and sub district level.

82. Integration of the NACP at the district and sub-district level with the NRHM provides an enormous opportunity for widening the reach of the programme and increasing its accountability to the PRIs and the community. Building capacity among PRIs is an important requirement to enable them to undertake NACP related interventions. Capacity

¹³⁸ *ibid*

¹³⁹ *ibid*

¹⁴⁰ *ibid*

building is required not only in the thematic areas but also in leadership skills, negotiating, monitoring, and ability to withstand patronage and political interference. The proposed framework for building PRI capacity is provided in Annex-9. Given their role in community participation and strengthening participatory processes, PRIs are central to the work of NGO partners. NGOs could therefore be involved in PRI strengthening in a variety of ways, including: consciousness raising, provision of technical advice, support in participatory planning, capacity building and facilitating monitoring processes. They could also play a critical role in community and social audits to improve accountability. Those NGOs that have sectoral competency could serve to support PRI in village and block level planning based on local needs and resources. Further, they could also undertake advocacy campaigns that target a range of community stakeholders and the general public on functions of PRI, and people's rights and responsibilities in relation to health care and services, thereby making the PRIs more accountable to the community.¹⁴¹

Accountability to Key Populations

83. Interventions targeting key populations are a key component of the NACP. Such populations cannot be reached without the help of civil society organizations (CSOs). The Government is the facilitator while CSOs engage in program development and implementation. It is envisaged that key populations would occupy center stage and ultimately become implementers¹⁴². Thus Key Populations are important partners to whom the programme has to be accountable. Unfortunately, rather than partnerships the relationship between NACO/SACS and CSOs and that between CSO's and Key Populations is generally that of a provider- beneficiary¹⁴³.

84. While key population representatives have been involved in planning for the programme, the present arrangements do not adequately ensure accountability to these major stakeholders. There is inadequate representation of key populations in governance structures of the programme at all levels. With exception of a few SACS who have a

¹⁴¹ *ibid*

¹⁴² NACP III Design Team, India HIV/AIDS Alliance/RCSHA. National Civil Society Consultation on National AIDS Control Program Phase III.

¹⁴³ *ibid*

PLHA representative as a co-opted member of the Executive Committee, there is virtually no representation of any key population group in any of the governance structures.

85. It is recommended that key population groups be given adequate representation in supervisory and governance structures at all levels of the programme. It would be advisable to have a mechanism in place to ensure that such representation comes from within these groups and are accountable to the same. For instance; NACO has supported the INP+ a PLHA network, to establish and strengthen up to 15 state level networks of people living with HIV/AIDS¹⁴⁴. NACO may continue to support formation of such networks at the state and district level through SACS and DACU. Representatives of the network at the national and regional levels can be included in the respective governance structures of NACP

Mechanisms for improving transparency of the programme :

86. Ensuring mechanisms for dissemination of information as required under the Right to Information Act

87. Public hearings & Public meetings

- ◆ Transparency in procedures and systems by opening up procedures for public review
- ◆ Peoples' estimates; social audit

88. Prior consultation with public in the process of policy making

- ◆ Participatory budgeting
- ◆ Transparency in budget
- ◆ Independent audit

89. Participation of stakeholders in various decision making processes

90. Capacity building of citizen and civil society groups

91. Performance Measurement and Management

- ◆ Monitoring NACP performances through performance indicators
- ◆ Annual Performance White Papers

92. Publishing Annual Reports

- ◆ Dissemination of white papers

¹⁴⁴ NACO. Annual Report 2002-04, page 61

- ◆ Annual reports published by departments with pre-specified framework for contents

List of Annexes

1. Terms of Reference for the Study
2. Framework for Institutional Assessment
3. List of Documents Reviewed
4. List of Persons Met
5. List of Technical Resource Groups formed in NACP-II
6. Staffing Position in SACS covered in the Field Study
7. Core Functions of SACS
8. Core Staffing of SACS
9. Suggested Structure for Capacity Building in selected programme areas for NACP-III
10. Mapping of Institutional Arrangements of key NACP Interventions

Annex-1: Terms of Reference

Terms of Reference for the Institutional Assessment would consist of the following mentioned Tasks. The appointed Consultant will be responsible for the completion of following tasks under the overall supervision and management of the Team Leader, NACP III Planning team and/or his nominee:

- a) The consultant would familiarize themselves with the HIV/AIDS Control Policy and the implementation of the program by NACO.
- b) Review report and recommendations of the Working Groups, in particular the group on Program Management.
- c) Review available literature on the area of this consultancy, taking into account recent developments in related health programs, carried out in the past five years.
- d) Review role/mandate and organizational structure of NACO (within MOHFW) and in context of its role as secretariat to the National AIDS Council; SACS; and district and local arrangements.
- e) Following detailed review, provide recommendations on the manpower numbers and skills distribution; and working and reporting relationships.
- f) Review available documentation of organograms, job descriptions, guidelines, etc. with a view to providing recommendations on organizational documentation needs.
- g) Overall review of available skills vis a vis forecasted requirements over the next five years, including recommendations on skills mix and training requirements with special reference to planning; budgeting; communications with staff and other stakeholders; and HR management.
- h) Review the existing contracting functions of the program including at both national and state level. In the context of NACP III, provide recommendations as to the level (national, state/district) at which contractor functions for various services should be carried out; and the necessary architecture of this function.
- i) Review the existing arrangements for coordination with NGOs, CBOs, Civil Society Organizations, Private Sector, and academic institutions and provide recommendations for planning process.

Annex-2: Framework for Institutional Assessment

A. External Environment

1. Administrative/Legal Environment
 - ⇒ Legal status
 - ⇒ Linkages between NACO leaders and high-level decision makers
2. External Political Environment
 - ⇒ Form of government
 - ⇒ Level of government support
 - ⇒ Concrete manifestation of government support
 - ⇒ Attitude to investment in HIV prevention
 - ⇒ Level and Stability of funding
 - ⇒ Accessibility of supportive persons in government
 - ⇒ Political stability and consistency
3. Sociocultural National Environment
 - ⇒ Work ethics/attitudes
 - ⇒ Issues of ethnicity
 - ⇒ Educational level
4. Technological Environment
 - ⇒ Enabling environment for uptake of improved technology
 - ⇒ Availability and adequacy of information technology
 - ⇒ Attitude toward technological literacy of NACO/SACS personnel
 - ⇒ Level of technological literacy of NACO/SACS personnel
5. External Economic Environment
 - ⇒ National economic environment
 - ⇒ Fiscal Policy
 - ⇒ Government policy and practice regarding funding
6. Stakeholders
 - ⇒ Categories of stakeholders
 - ⇒ List of stakeholders
 - ⇒ Level of donor support
 - ⇒ Level of interaction with clients
 - ⇒ Level of collaboration with similar organizations

7. Policy Environment

- ⇒ National health policy/AIDS Policy
- ⇒ Relationship between government policy and AIDS control priorities
- ⇒ Clarity/rationale of AIDS control policies and priorities

B. Organizational Motivation

1. History

- ⇒ Date and process of founding
- ⇒ Major historical achievements/milestones
- ⇒ Major struggles
- ⇒ Changes in size, growth, programs, leadership, structure

2. Mission

- ⇒ Evolution of the NACP mission statement
- ⇒ Role of the NACO mission in shaping the organization, giving it purpose, giving it direction
- ⇒ NACP system goals
- ⇒ Priorities for action

3. Culture

- ⇒ Work ethics/attitudes within the NACP
- ⇒ Attitudes about colleagues, clients, other stakeholders
- ⇒ Attitudes toward equity
- ⇒ Educational level
- ⇒ Values, beliefs, customs, traditions affecting mission fulfillment

4. Incentive/Reward Structure

- ⇒ Key factors, values, motivations to promote productivity
- ⇒ Intellectual freedom, stimulation, autonomy
- ⇒ Remuneration, grant access, opportunity for advancement
- ⇒ Peer recognition, prestige, status

C. Organizational Capacity

1. Strategic Leadership

- i. Status and governance
 - ⇒ legal framework
 - ⇒ level of autonomy
-

- ⇒ governance
- ⇒ representation
- ⇒ authority
- ⇒ direction setting
- ⇒ procurement
- ⇒ personnel management

ii. Organizational structure

- ⇒ roles and responsibilities
- ⇒ coordination
- ⇒ authority
- ⇒ delegation
- ⇒ accountability
- ⇒ two-way flow of information
- ⇒ level of collegiality

iii. Leadership

- ⇒ authority
- ⇒ direction setting
- ⇒ resource development

2. Program Planning, Management, and Execution

- ⇒ Priority setting
- ⇒ Strategic institutional planning
- ⇒ Niche management
- ⇒ Documentation
- ⇒ Monitoring and review

-
3. Resource Allocation and Management
 - i. Human resources planning
 - ⇒ Needs assessment
 - ⇒ Recruitment
 - ⇒ Orientation
 - ⇒ Job descriptions
 - ⇒ Training/professional development
 - ⇒ Performance management, monitoring, and review
 - ⇒ Career management
 - ⇒ Compensation (wage rates, incentives)
 - ⇒ Equity (distribution of rewards and tasks)
 - ⇒ Timeliness of recruitment
 - ⇒ Ethos (encouragement to achieve excellence)
 - ii. Other Core Resources
 - ⇒ Infrastructure
 - ⇒ Technology
 - ⇒ Funding
 4. Linkages and Coordination
 - ⇒ Government policy regarding collaboration within the system
 - ⇒ Two-way communication between NACO and high-level decision makers in government
 - ⇒ Facility to mobilize political and financial support for AIDS Control
 - ⇒ Collaborative linkages with other sectors
 - ⇒ Collaboration between public and private institutions
 - ⇒ Clarity of division of labor between collaborators/partners

D. Organizational Performance

1. Effectiveness in Moving toward Mission
 - ⇒ Policies for programme implementation (clear, ranked, established on sound methods, related to national policies)
 - ⇒ Programme objectives (identified, prioritized, and aligned with national policies)
 - ⇒ Programme performance (utilization, major achievements, general level of

performance defined according to NACP mission and values, utilization of results)

2. Efficiency in Resource Use

- ⇒ Distribution of financial allocations—costs compared to benefits
- ⇒ Staff productivity
- ⇒ Project completion rates
- ⇒ Administrative system efficiency

3. Relevance and Sustainability

- ⇒ Client satisfaction
- ⇒ Meeting expectations of key stakeholders
- ⇒ Adapting NACP to its environment
- ⇒ NACO's image/reputation
- ⇒ Sustainability

Annex-3: List of Documents Reviewed

1. Agarwal SP. Intersectoral Cooperation for success of RNTCP. Indian J Tuberculosis 2004; 51:59-62
2. Brown, A. Organizational Culture. Pitman., London, 1998
3. Central Tuberculosis Division, MoHFW. Project Implementation Plan (PIP) dated May 31, 2005
4. Comptroller and Auditor General, India. Report of the CAG on the Union Government for the year ended March 2003; Union Government (Civil) Performance Appraisals (3 of 2004)
5. Document issued by Administrative Section, NACO, dated November 23, 2005
6. Government of India, National Aids Prevention and Control Policy, 2002
7. Government of India. Expansion of effective public and private sector interventions in HIV, TB and malaria prevention and treatment in India. Proposal submitted to the Global Fund for Fight Against AIDS, TB and Malaria, 2004
8. Government of India. Central Secretariat Manual of Office Procedures, 12th Edition, Ministry Of Personnel, Public Grievances and Pensions, May 2003.
9. Government of India. National Blood Policy, 2002
10. Government of India. National Health Policy, 2002
11. Government of India. Report of the National Macroeconomic Commission on Health, 2005
12. Herman Bakvis and Luc Juillet. The horizontal challenge : line departments, central agencies and leadership, Canada School of Public Service, 2004
13. Lusthaus, C., G. Anderson, and E. Murphy. 1995. Institutional assessment: A framework for strengthening organizational capacity for IDRC's research partners. Ottawa: International Development Research Centre.

14. Memorandum of Association and Annual Reports of SACS. AP, Assam and MP
15. Ministry of Health and Family Welfare. National Rural Health Mission (2005-2012). Mission Document, Government of India, 2005
16. Mission for Development Partners' Support, Preliminary Review of Draft Strategic Framework, Joint Mission Report, October 2005.
17. NACO, About NACO, Website <nacoonline.nic.in>
18. NACO, Annual Report 2002-2003, 2003-2004 (up to 31, July 2004)
19. NACO, NACP III, Program Implementation Plan, A draft Note on Human Resource Requirements
20. NACO, UNAIDS, NACP III e-consultations, Summary of Contributions, October, 2005
21. NACO: Action Plan for Blood Safety, 2004.
22. NACP III Design Team, India HIV/AIDS Alliance/RCSHA. National Civil Society Consultation on National AIDS Control Program Phase III.
23. NACP Planning Team. Re-organisation of NACO and SACS, 7 Nov 2005
24. NACP, Note on Financial Management for NACP III, Draft, October 2005
25. NACP, Note on Monitoring and Evaluation Arrangements for Phase III, Draft, October 2005
26. NACP, Strategic Framework, Phase III, Draft, undated
27. NACP, Working Group on Care, Support and Treatment, Draft Report, undated
28. NACP, Working Group on Financial Management, Draft Report, undated
29. NACP, Working Group on Gender, Youth, Adolescents, and Children, Draft Report, undated
30. NACP, Working Group on Mainstreaming and Partnership, Draft Report, undated

31. NACP, Working Group on Monitoring and Evaluation, Draft Report, undated
32. NACP, Working Group on Program Implementation and Organizational Restructuring, Draft Report, undated
33. NACP, Working Group on Program Management, Draft Report, undated
34. NACP, Working Group on Research, Development and Knowledge Management, Draft Report, undated
35. NACP, Working Group on Service Delivery, Draft Report, undated
36. NACP, Working Group on STI/RTI Treatment and Convergence with RCH, Draft Report, undated
37. NACP, Working Group on Targeted Interventions, Draft Report, undated
38. NACP-III Planning Team. Note on Institutional Arrangements
39. National Rural Health Mission: Institutional Setup at State level. Downloaded from the MOHFW website
40. Planning Commission. Mid -Term Appraisal of the Tenth Five Year Plan (2002-2007), Government of India
41. Press Information Bureau. Change the course of war on AIDS: PM, Press Release from PMO, dated 01 December, 2005.
42. Project Implementation Plan, NACP-II, NACO, Jan. 1999
43. Project Implementation Plan: National AIDS Control Programme, Andhra Pradesh(1999-2004), Andhra Pradesh State AIDS Control Society
44. Project Implementation Plan: National AIDS Control Programme, Arunachal Pradesh (1999-2004), Arunachal Pradesh State AIDS Control Society
45. Project Implementation Plan: National AIDS Control Programme, Assam (1999-2004), Assam State AIDS Control Society

46. Project Implementation Plan: National AIDS Control Programme, Madhya Pradesh (1999-2004), Madhya Pradesh State AIDS Control Society
47. Project Implementation Plan: National AIDS Control Programme, Maharashtra (1999-2004), Maharashtra State AIDS Control Society
48. Project Implementation Plan: National AIDS Control Project Phase II (1999-2004), NACO, Government of India
49. Project Performance Assessment Report –India National AIDS Control Project. Report No. 26224, World Bank, 2003
50. Report of the Task Force on convergence between NACP and DoHFW, 2005
51. Report of the Third Meeting of the National Task Force for Involvement of Medical Colleges in RNTCP, 23-29 Nov 2004
52. Report on the System of Performance appraisal, Promotion, Empanelment and Placement for All India Services and other Group ‘A’ Services , DOPT, GOI, 2003
53. S.P. Agarwal, Shruti Sehgal, S.S. Lal. Public-Private Mix in RNTCP IN Tuberculosis Control in India, DGHS, MoHFW, 2005
54. Sanction Letter No. T.11012/5/99-NACO dated 1st Nov, 1999 NACO, MoHFW, Government of India
55. Sheshadri, S. R., Constraints in scaling up health programs: A comparative study of two Indian states, Journal of International Development, 15, 101-114, 2003
56. VHAI: HIV/AIDS in India: Some issues, undated

Annex-4: List of People Met

1. Ms Bhupinder Prasad, IAS, Principal Secretary (AIDS control), Delhi
2. Ms D. Nirmala Rani, Counselor, KMM, Guntur
3. Ms Gayatri, Counselor, VCTC, Government Medical College, Bhopal
4. Ms Jonali Das, Program Manager, NESPYM, Assam
5. Ms Neesa Fatima, Lab technician, VCTC, Government Medical College, Bhopal
6. Ms. Alka Narang, Programme Officer, UNDP
7. Ms. Damayanthi, PD, AP, SACS
8. Ms. Geeta Singh, Counselor, PPTCT, Government Hospital, Bhopal
9. Ms. Joanna Reid, Senior Health Adviser, Department of International Development
10. Ms. Milli, NGO Advisor, Delhi SACS
11. Ms. Rakhi, AD, Assam SACS
12. Ms. Sadhana Raut, NACP-III, Planning Team
13. Ms. Salina Singh, PD, MP, SACS
14. Ms. Savitha Thakur, DD (Trg) MP, SACS
15. Ms. Shraddha Bose, DD (IEC), MP, SACS
16. Ms. Sreedevi, M&E Officer, AP, SACS
17. Ms. Sujatha Rao, AS &DG, NACO
18. Ms. Suneeta, Counselor, VCTC, Guntur Govt. Hospital, Guntur
19. Ms. Sunila Raja, NGO Advisor, MP, SACS
20. Ms. Vidya R Ganesh, Chief, HIV/AIDS Section, United Nations Children's Fund

21. NGO Advisor, Assam SACS
22. PD, SACS, Delhi
23. Sister Antony Mary, In charge, Holy Family Care and Support Center, Sattenapalli, Guntur
24. Mr. A. K. Sharma, Program manager, ASCED, Assam
25. Mr. A. Srinivas, Counselor, KMM, Guntur
26. Mr. Akhilesh Singh Yadav, Secretary and Project Director, BYPASS, Bhopal
27. Mr. Alok Mukhopadhyay, Chief Executive, Voluntary Health Association of India
28. Mr. Amardeep Bhatia, Director, Finance, NACO
29. Mr. Ashim Baruah, DD (IEC), Assam SACS
30. Mr. Ashok Alexander, Director, Bill & Melinda Gates Foundation
31. Mr. Atish Shrivastav, AD (Care), MP, SACS
32. Mr. B. Raja Sekhar, Project Manager, KMM, Guntur
33. Mr. Bilal Ahmed, Consultant, NACO
34. Mr. Dhirender Urmalayah, DPO, MP, SACS
35. Mr. Dubey, Financial Controller, MP, SACS
36. Mr. Krishna Kumar, NACP Planning Team
37. Mr. Kumar Nityanand, Section Officer (Bs&IEC)
38. Mr. Nagendra, Consultant (Procurement), NACO
39. Mr. P. Venkat, Project Director, KMM, Guntur
40. Mr. Palanichamy, Dy. Director (IEC), NACO
41. Mr. Prashant Malayah, AD (CP), MP, SACS

42. Mr. Prashant Mehta, AO, MP, SACS
43. Mr. Rajeev Pandey, Counselor, VCTC, Government Medical College, Bhopal
44. Mr. Rajeev Sadanandan, UNICEF
45. Mr. Rajesh Nair, Consultant (NGO), NACO
46. Mr. Reddy, Counselor, VCTC, Guntur Govt. Hospital, Guntur
47. Mr. S. Sridhar, Under Secretary (FA), NACO
- 48.** Mr. Sailendra, Field Coordinator, Unity Education Society, Bhopal
49. Mr. Samir Jyoti Mahanta , Program manager, ASCED, Assam
50. Mr. Sanjeev, Founder & Project Director, Aanchal Charitable Trust, Delhi
51. Mr. Shri Om, Founder & Project Director, Model Rural Youth Development Organization (MRYDO), Delhi
52. Mr. Srinivas, Counselor, PPTCT, Guntur Govt. Hospital, Guntur
53. Mr. Surajeet Roy, Program manager, PROGOTI, Assam
54. Mr. T. Veeraiah, Project Coordinator, PSH project, SPANDANA, Guntur
55. Mr. Upendra, Field Coordinator, Unity Education Society, Bhopal
56. Mr. Venkaiah, Program Manager, Sri Veera Hanuman Yuvajana Seva Sangham (SVHYSS), Guntur
57. Dr. Nani Nair, Medical Officer – TB, World Health Organization
58. Dr. A.K. Gopal, National Facilitator, NACO
59. Dr. Bhuyan, M&E Officer, Assam SACS
60. Dr. Brajen Mishra, Consultant, MP
61. Dr. Chiranjeeb Kakoty, Director, NESPYM, Assam

62. Dr. Das, DD (NGO), Assam SACS
63. Dr. Denis Broun, Country Coordinator, UNAIDS
64. Dr. Deori, PD, Assam SACS
65. Dr. H.C. Burman, DD (Training), Assam SACS
66. Dr. I. Anasuyamma, In-charge Medical Officer, Blood Bank, Guntur Medical College,
Guntur
67. Dr. Ritu Priya, CSMCH, JNU
68. Dr. Inder Prakash, JD (Trg), NACO
69. Dr. Jai P Narain, World Health Organization
70. Dr. Maxine Olson, Resident Representative, UNDP
71. Dr. Mishra, Dy. Director, Assam SACS
72. Dr. Murthy, JD (Trg/ART), MP, SACS
73. Dr. N.S Dharmshaktu, APD (Tech), NACO
74. Dr. P. Uma Devi, District Leprosy Officer and Nodal Officer for AIDS, Guntur
75. Dr. Pathak, DD (Care and Support), Assam SACS
76. Dr. S.S. Lal, NPO (RNTCP-PPM), WHO
77. Dr. Salim J. Habayeb, WHO representative to India
78. Dr. Smarajit Jana, Asst. Country Director, Health, HIV & Development, CARE India
79. Dr. Suneeta Singh, Senior Public Health Specialist, The World Bank
80. Dr. Thomas Philip, SHRC, Delhi
81. Dr. U.C. Yadav, JD (BS) MP, SACS
82. Dr. V. Ramanali, Medical Officer, VCTC, Government Medical College, Bhopal

83. Finance Officer, Assam SACS

84. APD, SACS, Delhi

Annex-5: List of Technical Resource Groups formed in NACP-II

Program Area	Chairperson
TRG – Clinical Management	Dr.Bhutada The Dean,Grant Medical College & J.J. Group of Hospitals, Mumbai
TRG – Research & Development	Dr.Paranjapee The Director National AIDS Research Institute, Pune
TRG on Counselling	Dr. (Mrs) Surinder K.P.Jaswal Officiating Head, HOD of Medical& Psychiatric Social WorkTata Institute of Social Sciences Sion, Trombay Road Deonar, Mumbai-88
TRG on Sexually Transmitted Diseases & Condom promotion	Dr. Yas Parwat Bardhni The Director Institute of Venereology Madras Medical College Park TownChennai-3
TRG on Women, Children & AIDS	Mr.S.K.Mattoo The Director NIPCCID, Hauz Khas, New Delhi
TRG on Surveillance & HIV Testing	Dr.M.D.Gupte , Director, NIE,National Institute of Epidemiology Apurtank Road , Chetput, Chennai-600031
TRG on Targetted Interventions	Dr.Vimal Charles, Director, APAC ProjectADYARChennai
TRG on Workplace	Mr. Uday Kr. Verma The Director National Labor Institute
TRG on Intravenous Drug Users & AIDS	Dr. N.B. Singh The Director, Regional Institute of Medical Sciences Imphal - Manipur
TRG on Law & Ethics in HIV/AIDS	Dr.G. Mohan Gopal The Dean National Law School of India University Nagarphvi Bangalore - 72
TRG on Blood Safety	Dr.K.A.Dinshaw The Director TATA Memorial Hospital Dr. Earnest Borces Road Parel Mumbai-400 012

Annex-6: Staffing Position in SACS covered in the Field Study

Post	Sancti oned	Working			Remarks
		AP	MP	Assam	
Deputation Posts					
Project Director	1	1	1	1	IAS in AP & MP. In MP additional charge. In Assam retd State Health Service Officer who is re-employed
APD	1	1			Vacant in MP & Assam
JD(Surveillance)	1	1	1		Vacant in Assam
JD (Training)	1	1	1		Vacant in Assam
JD (Blood Safety)	1	1	1	1	Contractual in Assam
DD (STD)	1	1			Vacant in Assam
DD(Surveillance)	1		1	1	Vacant in AP
DD (Blood Safety)	1				Vacant in AP&MP. Not sanctioned in Assam
AD (STD)	1	1		1	Vacant in MP
Statistical Officer	1	1	1		
Drug Inspector	2				Vacant in 3 states. Only one post in Assam
Statistical Asst.	1	1	1		Vacant in Assam
Procurement Officer	1			1	Vacant in AP and MP
Store Officer	1				Vacant in all 3 States
Administrative Asst	1	1	1	1	
Personal Assts	2	2	2	1	Only one post sanctioned for Assam
Technical Asst (BS)	1				Vacant in all 3 states
LDC	1	1	1	1	
Driver	1	1	1	1	
Messenger	2	2	2	2	
Total	23	16	14	11	Total sanctioned posts in Assam is 20
Accounts and Finance Unit					
Finance Controller/Manager	1	1	1		AP and MP has a Finance Controller on deputation. In Assam the post of Finance Manager is sanctioned but currently vacant.
Finance Officer	1	1	1	1	
Accountant	1	1	1	1	
Assistant	1	1	1	1	
Personal Assistant	1	1	1		
Total	5	5	5	3	Total sanctioned posts in Assam is 4
Contractual Posts					
JD (IEC)	1				Vacant in all three states
DD (IEC)	1	1	1	1	Not originally sanctioned in Assam. In lieu of JD (IEC)
DD (BTC)	1				Vacant in MP/AP. Not sanctioned in Assam
DD (Training)	1	1	1	1	Not sanctioned in Assam. In lieu of JD (Trg)
AD(CP)	1		1	1	Vacant in AP
DPO	1	1	1	1	
AD (Care)	1		1	1	Vacant in AP
AD (BTC)	1				Vacant in all three states
M&E Officer	1	1		1	Vacant in MP. In Assam post filled by deputation
NGO Advisor	1	1	1	1	
Computer Literate Steno	3	3	3	3	
Divisional Asst	3	3	3	3	
Total	16	11	12	13	Total Sanctioned Posts in Assam is 13

Annex-7: Core Functions of SACS**1. Programme Implementation**

- Social Mobilisation
- Targeted interventions
- IEC/IPC
- OVCs
- Community outreach and psychosocial support for care
- Gender, Youth, Adolescents
- Condom promotion
- FHAC
- Migrants
- Trafficking
- STI management
- Blood safety
- VCTC
- PMTCT
- Comprehensive care and treatment through OI, diagnostics, ART
- Hospital infection control/universal work precaution
- HIV/TB co-infection
- Training, HRD

2. Policy, management and cross-cutting issues (combines management function and facilitation role)

- Policy-making at state level
- District plans
- Implementation of state specific and national policy
- Evidence-based planning
- Capacity-building (internal/external, people/systems)
- Multi-sectoral response
- Human rights,
- Legal and ethical issues
- GIPA

- Mainstreaming gender
- Increasing knowledge and awareness of stakeholders
- Developing partnerships with other agencies (including PRIs) and private sector

3. M&E, Epidemiology, Research & Documentation

- Develop state M&E framework
- Implement monitoring systems (e.g. CMIS, reviews of district responses)
- Facilitate sharing of lessons learned/best practices
- Commission operational research
- Ensure documentation and dissemination

4. Finance, procurement and Administration

- Financial management
- Procurement (limited role for SACS)
- Recruitment & personnel management
- Contracting

Source: NACP Planning Team. Re-organisation of NACO and SACS 7 Nov 05

Annex-8: Suggested Core Staffing of SACS

Level	Common Pool	Medical Services	Communication & Social Mobilization	Administration & Planning	Strategic Information Management	Finance	Total
Project Director	1						1
Divisional Head		1	1	1	1	1	5
Programme Managers		Blood Safety, BMW, Infection Control (1) VCTC (1) Care & Support (1) STI/RTI/RCH(1) Training (1)	Mass Media (1) TI (NGO) (1) Condom Promotion & Social marketing (1) Gender, Youth & Children (1) Advocacy & Human Rights (1)	General Administration & HR (1) Planning (1) Mainstreaming(1) Partnerships (Program Support) (1) Procurement (1)	Surveillance (1) Monitoring and Evaluation (1) Research Coordination (1) Knowledge management (1) Information Systems (1)	Finance Officer (1)	15
Technical Officers	System Administration (1)			Store Officer (1)	Statistical Officer (1) MIS (1)	Accountants: Audit-1 F&A/ CPFMS-1	6
Administrative Support Staff	Administrative Assistant-1 Personal Asst. -2 Driver -1 Messenger-2 Receptionist-1	Administrative Assistant (1) Personal Assistant (1) for Divisional Head	Administrative Assistant (1) Personal Assistant (1) for Divisional Head	Administrative Assistant (1) Personal Assistant (1) for Divisional Head LDC -1	Administrative Assistant (1) Personal Assistant (1) for Divisional Head	Accounts Assistants (2)	18
Technical/Research Support Staff		1 each for Programme Officers (5)	1 each for Programme Officers (5)	1 each for Programme Officers (5)	1 each for Programme Officers (5)		20
Total	8	12	12	14	14	6	65

Annex-9: Suggested Structure for Capacity Building in selected programme areas for NACP-III

Area	Apex Resource Center	Regional Resource Center	State Resource Center	SACS	Master Trainers/ State Institutions	Professional Bodies (IMA, FOGSI etc)	District Level Trainers/ DACU	Others
1. Clinical Management	<ul style="list-style-type: none"> ◆ POs NACO/SACS ◆ Master Trainers (SHS, Professional Bodies, CGHS, ESIC, CPSU, HD of CG Ministries, medical colleges) 			<ul style="list-style-type: none"> ◆ Coordinating all training done at State and district level ◆ NGO staff 	<ul style="list-style-type: none"> *Training District Level Trainers *Training of medical staff in private sector 	Training of medical staff in private sector	Training of medical staff in government/ private sector Convergence with RCH-II for general training on HIV	Large PSU/ Ministries with their own health services - Training of medical staff in respective organizations
2. Counselling	<ul style="list-style-type: none"> ◆ POs NACO/SACS ◆ Trainers of Regional Resource and State Resource Centers ◆ Counsellors in ESIC, Central Govt Ministries, PSUs 	4 RRCs for training of counselors in VCTC, BB, PPTCT centers, NGOs in all states except 6HP and 9 EAG states	15 (6HP+9 EAG) training of counselors in VCTC, BB, PPTCT centers, NGOs	<ul style="list-style-type: none"> ◆ Training of counselors in implementing units in other States 	Training of counselors in VCTC, BB, PPTCT centers, NGOs			
3. HIV Testing	Existing Building Capacity of Regional and state Reference laboratories	12 existing. POs of SACS Master trainers	99 existing. Training for officers and technicians of BBs and VCTCs PPTCT centers	Coordinating all training done in the State	Training District level Trainers	Training officers and technicians of private laboratories	Training officers and technicians of private laboratories	
4. Blood safety	<ul style="list-style-type: none"> ◆ POs SACS ◆ Master Trainers (SHS, PB, CGHS, ESIC, CPSU, HD of CG Ministries, State Institutions) In blood transfusion services and rational use of Blood			Master Trainers in Rational Use of blood	Training District Level Trainers	Training of medical staff in private sector	Training of medical staff in government/ private sector	Large PSU/ Ministries with their own health services - Training of medical staff in respective organizations
5. Targeted Interventions	<ul style="list-style-type: none"> ◆ POs SACS ◆ Trainers of Regional Resource and State Resource Centers 	4 RRCs for training of NGO staff in all states except 6HP and 9 EAG states	15 (6HP+9 EAG) training of NGO staff	NGO Staff in other States				NGO: Building capacity for HIV prevention among KP groups
6. Workplace Interventions	<ul style="list-style-type: none"> ◆ NACO/SACS staff ◆ Representatives of public sector and corporate sector (CII, India Business Trust) 			<ul style="list-style-type: none"> ◆ HIV/AIDS Resource Persons ◆ Coordination of Training on Work place interventions in the State 	District Level Trainers	CII, FICII etc. members	Public and corporate sector	HIV/AIDS Resource Persons (PLHA) for workplace

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Area	Apex Resource Center	Regional Resource Center	State Resource Center	SACS	Master Trainers/ State Institutions	Professional Bodies (IMA, FOGSI etc)	District Level Trainers/ DACU	Others
	<ul style="list-style-type: none"> ◆ Trade Union Representatives ◆ Pool of Master trainers 							training and sensitization
7. Advocacy and Social Mobilization	<ul style="list-style-type: none"> ◆ POs NACO/ SACS ◆ Nodal Officers of Central Government Ministries for mainstreaming ◆ National political leadership ◆ Pool of Master trainers for providing technical assistance in implementing communication strategy at state, district and lower levels ◆ Media representatives 			<ul style="list-style-type: none"> ◆ Nodal Officers of state departments ◆ State political leadership ◆ HIV/AIDS Resource persons including PLHA ◆ NGO officers ◆ District AIDS Control Staff ◆ Media representatives 	District Level Trainers		For building capacity and sensitizing local political leadership, nodal district officers of key government departments, education and training institutions, PRI and municipal functionaries, NGO staff	NGO staff/ HIV/AIDS Resource Persons: grassroots advocacy
8. Programme Management	<ul style="list-style-type: none"> ◆ NACO/SACS staff ◆ Training of regional resource center staff 	4 Regional resource centers <ul style="list-style-type: none"> ◆ District HIV Officers ◆ District M&E Officers ◆ NGO managers/ project officers 		<ul style="list-style-type: none"> ◆ Officers in charge of implementing units 			PRI functionaries	PRI representatives through NRHM mechanisms and NACP NGOs
9. Finance Management	NACO/SACS staff			Finance staff of implementing partners				
10. Information Management	<ul style="list-style-type: none"> ◆ NACO/SACS Staff ◆ Nodal officers/ M&E staff of national level partners ◆ District Program Managers 			<ul style="list-style-type: none"> ◆ Nodal officers/ M&E staff of state level partners and implementing units 				

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Area	Apex Resource Center	Regional Resource Center	State Resource Center	SACS	Master Trainers/ State Institutions	Professional Bodies (IMA, FOGSI etc)	District Level Trainers/ DACU	Others
11. Legal and Human Rights	<ul style="list-style-type: none"> ◆ NACO/SACS staff ◆ PLHA networks ◆ National political and bureaucratic leadership ◆ Civil Society ◆ Business ◆ Representatives of professional organizations ◆ Legal community 			<ul style="list-style-type: none"> ◆ District Programme Officers ◆ Political leadership and officials of key departments including police ◆ Civil society & private sector ◆ PLHA networks ◆ Medical and legal community 			PRI functionaries	
12. Mainstreaming	<ul style="list-style-type: none"> ◆ NACO/SACS staff ◆ Nodal officers of Key Central Government Ministries, PSUs ◆ Political leadership ◆ Master Trainers 			<ul style="list-style-type: none"> ◆ Nodal officers of Key State Government, Departments, PSUs ◆ Political leadership ◆ NGO/faith based/grassroots organizations ◆ Key Educational Institutions 	<ul style="list-style-type: none"> ◆ NGO/faith based / grassroots organizations ◆ Educational / Training Institutions 			NGO/faith based/grassroots organizations: General community

Annex-10: Mapping of Institutional Arrangements for Selected Components of NACP

Blood Safety			
Role	National/NACO	State/SACS	District/Sub-District
Policy and Planning	<ul style="list-style-type: none"> ➤ National Blood Policy ➤ Action Plan for BS ➤ PIP ➤ Development of guidelines for rational use of blood, BSCs, standards and protocols, IEC etc 	<ul style="list-style-type: none"> ➤ Develop State sub-plan, which articulates a coordinated management structure and specifies the network and the horizontal and vertical linkages between RBTC, BB, BSC 	
Resources and Infrastructure in health care system	<p>NACO</p> <ul style="list-style-type: none"> ➤ Supports NBTC/SBTC ➤ Supports National and State Reference Laboratories ➤ Supports Technical Resource Group on BS ➤ Support for establishing and strengthening BBs in ESIC, Railways, SAIL ➤ Supports national training programs/workshops ➤ Centralized procurement of kits for Blood Banks <p>Central Government</p> <ul style="list-style-type: none"> ➤ DGHS, Armed Forces Transfusion Services (AFTS), ESIC, Railways, large public sector organizations 	<p>SACS</p> <ul style="list-style-type: none"> ➤ Support SBTC/ RBTC ➤ Procurement of equipment and kits for BBs/BSCs in public sector/ in nonprofit sector which were strengthened in Phase 1 ➤ Salary for 2 staff in Zonal/Major BB and I staff in district BB + grant for contingency/ consumables ➤ Development of IEC Material ➤ Funds to CMHO/DMHO office for BB expenses, IEC, blood donation camps. Funds to medical college BB through Heads of Institution <p>State Government</p> <ul style="list-style-type: none"> ➤ Provide resources and infrastructure for routine functioning of SBTC ➤ Provision of infrastructure, significant part of equipment and most of staff at BBs located in medical colleges or district hospitals and BSCs located in FRUs 	<p>State Government</p> <ul style="list-style-type: none"> ➤ Zonal Blood Testing Centres/Major Blood Banks , District Blood Banks, Blood Storage Centres (BSC) in State Health Services. ➤ CMHO/DMHO- Awareness Camps/Blood Donation Camps/IEC <p>Central Government DGHS, AFTS, CPSE BBs</p> <ul style="list-style-type: none"> ➤ Blood Banks in nonprofit and private sector
Linkages with other sectors/agencies	<ul style="list-style-type: none"> ➤ Drug Control General (India) ➤ Federation of Indian Thalassemics (FIT) and Haemophilia Federation of India (HFI). 	<ul style="list-style-type: none"> ➤ State FDA ➤ Coordination with private, nonprofit and other government sectors to promote voluntary blood donation. For instance in AP with NSS, Nehru Yuva Kendra, IRCS, corporate sector 	
Technical Support	<ul style="list-style-type: none"> ➤ NACO receives technical support from TRG, Apex Reference Laboratory ➤ NACO provides technical support to NBTC, SACS and BBs of other Ministries/ Organizations 	<ul style="list-style-type: none"> ➤ SACS receives technical support from NACO/ NRL ➤ Provides technical support to BBs in the State/ SBTC ➤ Technical support to BBs for licensing 	<ul style="list-style-type: none"> ➤ Blood Banks receive technical support from SACS and SRL

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Capacity Building	<ul style="list-style-type: none"> ➤ NACO supports Quality Management Training Programme for SACS officers and BB personnel in collaboration with WHO ➤ Training of SRL staff by NRL ➤ Training on plasma fractionation/ component separation to BB officers and technicians through identified national centers 	<ul style="list-style-type: none"> ➤ Training conducted by SACS to promote rational use of blood and quality control 	<ul style="list-style-type: none"> ➤ Training of BB officers and technicians by SRL
Quality Assurance M&E	<ul style="list-style-type: none"> ➤ “National External Quality Assessment Scheme” (NEQAS)” for standardization and quality assurance of HIV testing ➤ SBTC Monthly report ➤ Monthly SACS report via CMIS 	<ul style="list-style-type: none"> ➤ Reporting by blood banks to SACS in CMIS format ➤ Periodic visits by SACS ➤ Inspection of by BBs by State FDA 	<ul style="list-style-type: none"> ➤ Monitoring BB laboratories performance and evaluation quality control measures by SRL ➤ Report to DNO/DMHO
Key Issues	<ul style="list-style-type: none"> ➤ Arrangements as per Action Plan still not in place especially accreditation and external evaluation of BBs ➤ Administrative support staff meant for BS, currently shared with IEC ➤ Shortage of medical and paramedical personnel trained in BTS 	<ul style="list-style-type: none"> ➤ Lack of support staff at SACS ➤ Non-reporting or delayed reporting from BB ➤ Difficult to monitor BBs at district/sub-district level and ensure reporting, due to absence of district level personnel. Though DNO has been made responsible he/she is busy with other responsibilities ➤ Delays ranging from 6 months to 6 years for getting licence for public sector blood banks ➤ Delay partly also at the level of state government which is responsible for providing basic infrastructure, significant part of the equipment and most of staff of BB. ➤ Limited involvement of Organisations of blood donors’ and blood users’ in the programme ➤ Inadequate feedback on reports ➤ Delay in receiving funds from NACO 	<ul style="list-style-type: none"> ➤ Need for a counsellor to counsel donors/ motivate people for VBD ➤ Inadequate feedback on reports ➤ Requires refresher training ➤ No funds to provide adequate refreshments to donors in public BB as a result VB donor prefers private BBs ➤ Requirement of computer and operator for reporting, stock maintenance and donor data ➤ Delay in paying contractual staff supported by SACS, leading to high turnover of staff ➤ District level BB officers often have additional charges. For instance in MP, BB of district is responsible for post mortem, MLCs, VIP duties, attending courts etc.

Suggestions for Phase-III

- Implement institutional arrangements as per Action Plan for BS
- Facilitate design of accreditation system for BBs in consultation with relevant stakeholders. Primary responsibility of implementing the accreditation as designed at the national level to be entrusted to accreditation organizations external to NACO. NACO through NBTC to coordinate the development and implementation of standards, guidelines and protocols, training modules as well as the accountability and audit of accreditation bodies. Since government in India performs the role more of a service provider rather than a purchaser of services, the cost of accreditation should be borne fully or partially by the central government.
- Support for establishing BBs/component separation/plasma fractionation facilities in under-served areas/regions
- EQAS to be extended to all HIV and CD4 testing facilities for both public and private sector
- Additional Staffing
 - At least one quality assurance officer in each district either in district blood bank or tertiary institution in district to ensure improvement in standards and quality of services and provide technical advisory support to BBs and BSCs in the district.
 - Medical Social Worker at district and tertiary hospital level for counselling and promotion of VBD
 - One Computer operator cum record keeper in tertiary hospitals to maintain data for VBD, stocks and CMIS reporting
 - Adequate Support staff at SACS and NACO
- Mainstreaming and Partnerships: In addition to existing partnerships-
 - Coordination with DGCI and State Drug Controller at level of NACO and SACS to establish Blood Bank cells at respective levels
 - Coordination with AICTE /Nursing Council/Medical Council to develop specialized courses in transfusion medicine and to include appropriate transfusion related practices in graduate/post graduate curriculum
 - Increase networking with voluntary agencies/ organizations of donors to promote voluntary donation
- Convergence
 - An estimated 3222 CHCs needs to be provided with BSCs. The RCH-2 programme has planned for blood storage centres (BSC) at the first referral centres. The BSCs could be established by the RCH programme with NACP providing technical support, consumables and quality assurance.
- Decentralization
 - Decentralization of program management and monitoring to the district programme officer, who will be the interface between SACS and district and sub-district units. Technical support to district and sub-district units to be provided by Quality Assurance Officer in each district

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Targetted Interventions			
Role	National/NACO	State/SACS	District/Sub-District Level
Policy and Planning	<ul style="list-style-type: none"> ➤ Setting of guidelines for selection of NGOs, recruitment of NGO advisor, capacity building, M&E, intervention components and package of services, costing of interventions, qualification and skill mix of NGO staff etc ➤ Policies and legislation to facilitate enabling environment, reduce stigma and discrimination of KPs, GIPA 	<ul style="list-style-type: none"> ➤ Policies and legislation to facilitate enabling environment and reduce stigma and discrimination of KPs ➤ State PIP ➤ State Annual Plans 	<ul style="list-style-type: none"> ➤ NGO Work Plan
Resources and Infrastructure in health care system	<p>NACO</p> <ul style="list-style-type: none"> ➤ Support to TRG ➤ Representatives of NGO sector on supervisory bodies of NACO <p>Central Government</p> <ul style="list-style-type: none"> ➤ Supply of condoms by MoHFW to SACS for disbursal to TI NGOs 	<p>SACS</p> <ul style="list-style-type: none"> ➤ Mapping of key populations ➤ Selection of NGOs (In states like AP selection process out-sourced to third party-PSU) ➤ Recruitment of NGO advisor ➤ Funding of NGOs ➤ Development of IEC Material ➤ Support to NGOs to develop proposals ➤ Local procurement of condoms ➤ Supply of condoms and IEC material to TI NGOs through DNO for free supply and social marketing ➤ In some states like Kerala, AP, TN, Maharashtra, Manipur etc; support partnership forums or networks of NGOs ➤ Representatives of NGOs on supervisory bodies of SACS ➤ Representatives of PLHA networks co-opted on supervisory bodies in some States 	<p>NGO sector</p> <ul style="list-style-type: none"> ➤ Needs assessment ➤ Implementation of TI ➤ Partnership with other NGOs in some States ➤ Referral to Care and support centres in NGO sector <p>State Government</p> <ul style="list-style-type: none"> ➤ Referral from NGOs to VCTCs, TB centres, STI clinics, PPTCT centres, ART centres etc. ➤ DNO supplies condoms, IEC material <p>Private Sector</p> <ul style="list-style-type: none"> ➤ Referral for STI and other treatment
Linkages with other sectors/agencies	<ul style="list-style-type: none"> ➤ Advocacy and social action to decrease stigma and discrimination of KP groups ➤ Support to INP+ and GIPA 	<ul style="list-style-type: none"> ➤ District Collector, Departments like Social Welfare, Labour involved in selection of NGOs ➤ Advocacy and social action to decrease stigma and discrimination of KP groups ➤ Representative of police force, member of supervisory bodies in some states like Kerala ➤ Supporting INP+ to establish and strengthen state level networks 	<ul style="list-style-type: none"> ➤ Local MLA, local panchayat, district collector notified by SACS of functioning of TIs ➤ Enabling environment interventions with police, other departments and wider community by NGOs
Technical Support	<ul style="list-style-type: none"> ➤ NACO receives technical support from TRG ➤ NACO provides technical support to SACS 	<ul style="list-style-type: none"> ➤ SACS receives technical support from NACO ➤ Provides technical support to NGOs ➤ In some states technical support to NGOs out-sourced to third parties. For instance: in AP, PSU has been entrusted responsibility of providing technical assistance to NGOs 	<ul style="list-style-type: none"> ➤ Technical assistance in dealing with group dynamics, initial process of collectivization, conflict resolution etc.

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Capacity Building	<ul style="list-style-type: none"> ➤ Occasional meetings of NGO Advisors ➤ Occasional orientation cum exposure programmes to SACS officials and selected TI coordinators 	<ul style="list-style-type: none"> ➤ Training provided by SACS to NGO staff ➤ In some states capacity development of NGOs out-sourced to third parties. For instance: in AP, PSU has been entrusted responsibility of developing capacity of NGOs ➤ Building capacities of PLHAs to enable them to be facilitators for advocacy and service delivery 	<ul style="list-style-type: none"> ➤ Building capacity within KP groups to empower themselves and engage in advocacy
Quality Assurance M&E	<ul style="list-style-type: none"> ➤ Monthly SACS report via CMIS ➤ External evaluation of TIs 	<ul style="list-style-type: none"> ➤ Monthly reporting by NGOs to SACS in CMIS format ➤ Monthly, Quarterly, Half yearly and annual activity reports to SACS ➤ Periodic visits by SACS officials ➤ Routine monitoring out-sourced to third party in some states (eg: AP-PSU) 	<ul style="list-style-type: none"> ➤ Occasional inspection by DNO. Inspection report of DNO mandatory for release of funds ➤ Copies of all reports to DNO/DMHO
Key Issues	<ul style="list-style-type: none"> ➤ Limited involvement of key populations in decision making ➤ Structures for operationalizing GIPA, legal reforms, advocacy not clearly established ➤ Key program officers contractual. Lack of job security, poor pay and benefit package, lack of decision making authority bottlenecks for more effective implementation. 	<ul style="list-style-type: none"> ➤ Weak capacity in NGO sector in certain regions ➤ Political interference in selection and funding of NGOs, corruption ➤ Lack of confidence of NGOs, CBOs, key population on SACS ➤ No clear cut guidelines for M&E ➤ Non compliance with guidelines by NGOs leads to delay in disbursal of funds ➤ Limited involvement of key populations and NGOs in decision making at SACS level ➤ Limited involvement of key stakeholders responsible for enabling environment interventions ➤ Key program officers contractual. Lack of job security, poor pay and benefit package, lack of decision making authority are bottlenecks for more effective implementation. 	<ul style="list-style-type: none"> ➤ Lack of trained (in practical implementation skills, in KP context and rights, attitudes and values towards sex, sexuality, KP issues, HIV) personnel ➤ Uneven and unattractive salary structure and increment/benefit policies work as an disincentive for skilled people in the projects. ➤ Resources not in accordance with need/evidence. Uniform staffing pattern without reference to local needs ➤ Currently uniform training for all staff. Training programmes not tailored as per requirements for various types of NGO staff. Requires refresher training ➤ IEC material, training materials etc., not locally relevant. ➤ Reporting mechanisms complex. Inadequate feedback on reports ➤ Monitoring infrequent, not based on clear guidelines, not at all participatory. More of inspection of facilities and accounts ➤ Limited access and inadequate support from SACS. Insensitivity of SACS personnel to NGO requirements ➤ NGOs have limited voice and decision making role in planning and implementation. Rather than partnerships more of a donor-recipient relationships ➤ Ambiguous legal status of many of the key populations and subsequent police harassment ➤ Delay in funds ranging from 3 months to 16 months resulting in high staff turnover and/or inadequate implementation of programme ➤ Limited voice and decision making role of key populations in NGO program. More of a provider-beneficiary relationship, rather than participatory ➤ Weak referral systems due to lack of prevention and care services below district level. ➤ Experience with third party arrangements such as PSUs generally well received

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<p>Suggestions for Phase-3 Institutional Arrangements</p>	<ul style="list-style-type: none"> ➤ Staffing <ul style="list-style-type: none"> Adequate Program Staff and Support staff at NACO, SACS and district levels Staffing of NGOs based on actual requirements rather than a uniform pattern Competitive salary and benefit structures to all levels of project staff Appointment of Contractual Staff for entire duration of Phase-III, rather than yearly contracts, subject to review based on clearly identified performance indicators ➤ Mainstreaming and Partnerships: <ul style="list-style-type: none"> Adequate representation of civil society and key populations in governance structures of the programme at all levels . Support NGO forum coordinating SACS/PSU and NGO/CBO relationship at State level. NGO forum to have significant key population representation. Networks at the state level to federate at the national level. Representatives to governance structures to be elected from among themselves. The forum will identify areas of development concern, mobilize and channelize resources and build up capacities of partners to address the emerging development issues. It will play a strongly proactive, decision making role in governance structures of NACP and hold partners accountable to program outcomes spelt out under NACP III. It will play a watchdog role for ensuring the rights based approach advocated by NACP III is adhered to, ensure that GIPA principles are put into practice, and bring emerging issues on risk, vulnerability and impact for policy and program review Adequate representation to key population groups on Boards of NGOs Mechanisms for coordination and collaboration with different government agencies for creation of enabling environment and empowerment of key populations. For instance; representatives of police force and such key stakeholders in supervisory bodies of SACS and district units, pegging empowerment programme on to larger developmental programmes of the government etc. Out-sourcing of recruitment, technical support, capacity building, monitoring and mentoring of NGOs to an external agency in the nonprofit sector. Experiences of PSUs may be evaluated and guidelines set by NACO for recruitment of such agencies by SACS. Services of the agency may be requisitioned for the project duration and supported with adequate resources to build capacity within the agency. Technical support and capacity development of the agency through national/regional institutions supported by NACO. ➤ Convergence <ul style="list-style-type: none"> Convergence of HIV prevention initiatives with NRHM, RCH, FHAC and RNTCP, to ensure appropriate referral services are available at sub-district level ➤ Decentralization <ul style="list-style-type: none"> Decentralization of program support to the district programme officer, who will be the interface between SACS, NGOs and other partners.
<p>Sources: 1. Discussions with programme officers at centre, state and district 2. NACP III Planning. Report of Working Group on Targetted intervention 3. NACO Annual Report 2002-04 4. NACP III Planning Team. National Civil Society Consultation on NACP Phase III.</p>	

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STI Treatment		National/NACO	State/SACS	District/Sub-District
C U R R E N T	Role			
	Policy and Planning	<ul style="list-style-type: none"> ➤ Development of guidelines for STI diagnosis and management ➤ PIP 	<ul style="list-style-type: none"> ➤ State PIP ➤ Annual Plan 	
	Resources and Infrastructure in health care system	<p>NACO</p> <ul style="list-style-type: none"> ➤ Supports Technical Resource Group on STI management ➤ Support for establishing and strengthening STI clinics in ESIC, Railways, SAIL etc. ➤ Supports national training programs/workshops <p>Central Government</p> <ul style="list-style-type: none"> ➤ DGHS, Armed Forces Medical Services, ESIC, Railways, large public sector organizations 	<p>SACS</p> <ul style="list-style-type: none"> ➤ Procurement of equipment, drugs and consumables for STI clinics in public sector ➤ Supports renovation and extension of STI clinics ➤ Development of IEC Material <p>State Government</p> <ul style="list-style-type: none"> ➤ Provision of infrastructure, significant part of equipment and staff at STI clinics located in medical colleges or district hospitals 	<p>State Government</p> <ul style="list-style-type: none"> ➤ STI clinics located in medical colleges or district hospitals ➤ FHAC ➤ CMHO/DMHO- Awareness Camps/ IEC <p>Central Government</p> <p>DGHS, AFMS, CPSE STI clinics</p> <ul style="list-style-type: none"> ➤ Nonprofit and private sector providers
	Technical Support	<ul style="list-style-type: none"> ➤ NACO receives technical support from TRG, ➤ NACO provides technical support to SACS ➤ Supports medical college level laboratories for implementing anti microbial drug resistance testing 	<ul style="list-style-type: none"> ➤ SACS receives technical support from NACO ➤ Provides technical support to STI clinics in the State 	
	Capacity Building	<ul style="list-style-type: none"> ➤ Workshops for microbiologists and laboratory technicians to train them in the current available laboratory diagnostic techniques for STI. 	<ul style="list-style-type: none"> ➤ Training of medical staff in STI management 	
	Quality Assurance M&E	<ul style="list-style-type: none"> ➤ Monthly SACS report via CMIS 	<ul style="list-style-type: none"> ➤ Reporting by STI clinics to SACS in CMIS format ➤ Periodic visits by SACS 	<ul style="list-style-type: none"> ➤ Report to DNO/DMHO
Key Issues		<ul style="list-style-type: none"> ➤ NACP interventions in the public sector system reach only the district hospitals and are not programmed to be gender sensitive. ➤ Although Medical officers have been trained in syndromic diagnosis, they are located in primary health centers and above. Current utilization of PHCs is low. Thus the benefit of the knowledge and skills of the medical officers does not reach communities in many parts of the country. ➤ The FHAC could do a good job of spreading awareness but services are still provided at the district level, reducing reach. ➤ DFW interventions are also primarily through medical officers. Grass roots workers such as the ANM in most areas are not empowered to provide information and services for RTI/STI. There is little by way of health education at the community level on RTI/STI, which highlights issues of risk and vulnerability, male responsibility, and the use of condoms for dual protection. This varies from state to state and in high prevalence states, awareness levels are high, but access to services remains low. 		

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<p>Suggestions for Phase-3 Institutional Arrangements Convergence with DHFW</p>	<ul style="list-style-type: none"> ➤ Public Sector interventions from district to peripheral level for RTI/STI to be implemented through DHFW, in line with the RCH II design document. RTI/STI prevention, management of the client, partner notification, treatment, and follow-up are the key components of an RTI/STI programme. Comprehensive RT/STI treatment will be provided at CHC and 24 hour PHC (clinical and etiologic) and first line drugs at the PHCs. ➤ RTI/STI control among High Risk Groups through NGOs with funding support for RTI/STI diagnosis and treatment, to continue through NACO and SACS, but reporting also to HFW. ➤ It is expected that ASHA will be provided with enough information/supplies to support health education, prevention advice and treatment facilitation (through referral) at the village level. Presently the closest possible site for services by trained personnel is the sub center level. The ANM/Male MPW will be the frontline service providers for RTI/STI management, MO/SN/LHV at the PHC level, and MO/Ob-Gyn. at the CHC/FRU level. It is expected that over time, with strengthened Primary Health Care, laboratory based management of RTI/STI will be the norm rather than the syndromic approach. At the CHC level, basic screening tests for RTI/STI will be made available. At the district level, RTI/STI will be managed by STD specialists supported by or linked through referral to high quality laboratory services supporting the full complement of laboratory tests for RTI/STI. ➤ At the community health centers and district hospitals, RTI/STI management has to be included in protocols in Ob/Gyn and Medicine departments. Medical and paramedical professionals to be oriented to risk identification and referral to VCTC. ➤ NGOs under HFW to include RTI/STI in their package of interventions, with referral or services as appropriate. Private providers (through Indian Medical Association (IMA) and Federation of Obstetrics and Gynaecology-FOGSI) to be part of RTI/STI management strategy for training and to ensure appropriate reporting and notification, particularly in the case of sexually transmitted infections and drug resistance surveillance. This will also need to be implemented through DHFW.
<p>Sources: 1. Discussions with programme officers at centre, state and district 2. NACP III Planning. Report of Working Group on Service Delivery 3. NACO Annual Report 2002-04 4..MoHFW: Convergence between NACP and DoHFW, 2005</p>	

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VCTC		National/NACO	State/SACS	District/Sub-District
C U R R E N T	Role			
	Policy and Planning	<ul style="list-style-type: none"> ➤ PIP ➤ Development of guidelines, SOP for testing and counselling 	<ul style="list-style-type: none"> ➤ State PIP ➤ Annual Plan 	
	Resources and Infrastructure in health care system	<p>NACO</p> <ul style="list-style-type: none"> ➤ Supports Technical Resource Group on VCTC ➤ Supports National and State Reference Laboratories for testing ➤ Support for establishing and strengthening VCTCs in ESIC, Railways, SAIL ➤ Supports national training programs/workshops ➤ Centralized procurement of kits for testing ➤ Model VCTCs established by NACO <p>Central Government</p> <ul style="list-style-type: none"> ➤ DGHS, Armed Forces Medical Services, ESIC, Railways, large public sector organizations 	<p>SACS</p> <ul style="list-style-type: none"> ➤ Procurement of equipment and kits for VCTCs ➤ Salary for 2 counsellors and 1 lab technician in each VCTC ➤ Grants for consumables, furniture, infrastructure development ➤ Development of IEC Material <p>State Government</p> <ul style="list-style-type: none"> ➤ Provision of infrastructure, significant part of equipment and staff at VCTCs 	<p>State Government</p> <ul style="list-style-type: none"> ➤ VCTCs in district hospitals and medical colleges <p>Central Government</p> <p>DGHS, AFMS, CPSE VCTCs</p>
	Linkages with other sectors	<ul style="list-style-type: none"> ➤ University Faculty trained to provide training to counsellors 		<ul style="list-style-type: none"> ➤ Peer counsellors
	Technical Support	<ul style="list-style-type: none"> ➤ NACO receives technical support from TRG, Apex Reference Laboratory ➤ NACO provides technical support to SACS and VCTCs of other Ministries/ Organizations 	<ul style="list-style-type: none"> ➤ SACS receives technical support from NACO/ NRL ➤ Provides technical support to VCTCs in the State 	<ul style="list-style-type: none"> ➤ VCTCs receive technical support from SACS and SRL ➤ In some states like AP - APCP(Andhra Pradesh Counselors project) outsourced to third party
	Capacity Building	<ul style="list-style-type: none"> ➤ NACO supports Quality Management Training Programme for SACS officers and lab technicians in collaboration with WHO ➤ Training of SRL staff by NRL ➤ Training of Trainers in counselling in collaboration with WHO 	<ul style="list-style-type: none"> ➤ Master Trainers provide counselling to counsellors 	<ul style="list-style-type: none"> ➤ Training of VCTC officers and technicians by SRL ➤ In some states like AP - APCP(Andhra Pradesh Counselors project) outsourced to third party
Quality Assurance M&E	<ul style="list-style-type: none"> ➤ “National External Quality Assessment Scheme” (NEQAS)” for standardization and quality assurance of HIV testing ➤ Monthly SACS report via CMIS 	<ul style="list-style-type: none"> ➤ Reporting by VCTCs to SACS in CMIS format ➤ Periodic visits by SACS 	<ul style="list-style-type: none"> ➤ In order to maintain the quality of the tests being done at VCT centres all the samples detected HIV sero positive and five percent samples detected sero negative in VCTCs are sent to reference laboratories for cross checking. ➤ In some states like AP - APCP(Andhra Pradesh Counselors project) outsourced to third party ➤ Monthly, Quarterly, half yearly, Yearly Reports to SACS, DNO/DMHO 	
Key Issues	<ul style="list-style-type: none"> ➤ No reach below district level ➤ Poor location , low awareness among public about location of VCTC ➤ Lack of required infrastructure. No separate room for counsellor in many places to ensure enough privacy. As a result voluntary clients shy away. ➤ Irregular salary. Salary not competitive. High staff turnover ➤ Staffing pattern remains the same irrespective of workload ➤ VCTC is additional charge for M.O. Visits irregularly. Since each and every report has to be signed by the M.O, counsellor spends lot of time tracing their whereabouts ➤ Testing done by private labs currently not under ambit of any regulations or reporting requirements 			

Institutional Assessment of NACP

<p>Suggestions for Phase-3 Institutional Arrangements</p>	<ul style="list-style-type: none"> ➤ Testing to be governed by legal provisions. Counselling in private labs and reporting to government to be made mandatory. Evolve mechanism for accreditation ➤ Staffing <ul style="list-style-type: none"> In addition of core staff, additional counsellors to be posted depending on work load One counsellor for TI settings 1 lab technician and 1 counselor for mobile van setting Adequate Support staff at SACS and NACO Salary to be based on experience and qualification ➤ Convergence <p>Voluntary Counseling and Testing (VCT) to be a key entry point for a range of interventions in HIV prevention and care, like preventing HIV transmission from mother to child during childbirth, referrals for STD treatment, condom promotion, care and support for treatment of opportunistic infections, management of the HIV-TB coinfection, and now, referrals to designated medical centres for Anti Retroviral Therapy (ART).</p> <p>The NACP will manage the VCTC in collaboration with the key staff of the facility in which the VCTC is located. Youth information centers to be established with the VCTC to increase access of young people to information and referral for services for a range of reproductive and sexual health issues.</p> <p>NACP will support the staff of VCTC and supplies required with DHFW will provide the physical infrastructure.</p> <p>It is proposed that the district VCTC function as a satellite center to coordinate, support and supervise operations of the VCTC's located in the CHC and 24 hour PHC. This internal coordination is important for several reasons- to maintain quality of services at all sites, to ensure uninterrupted supplies, link with PPTCT at district and CHC levels, and to enable referral linkages of clients that test positive to appropriate centers.</p> <p>VCTC's will not function as sites for counseling of HIV/AIDS alone. Counselors in VCTC, particularly at secondary and primary health care levels should be able to counsel for family planning, RTI/STI prevention, safe delivery, and male responsibility. A cadre of counselors could be established who would serve the RH needs of women and men, including HIV/AIDS, and the RH information and service for young people. It is hoped that this measure will increase utilization of VCTC.</p> <p>Expand the number of VCTC sites. The expansion should be informed by a rapid assessment of VCTCs in low and high prevalence areas, and identify systems issues, human resource training gaps, and logistics. The expansion is proposed in a phased manner, and will be governed by the following: prevalence, physical infrastructure, human resources, and community use of facilities. Fortunately the high prevalence states also have better infrastructure and increased utilization (higher rates of antenatal coverage, institutional deliveries, and overall increased care seeking behaviour). As a long-term plan, (by 2012) it is expected that all PHCs will have VCTC facilities that will cover a range of services beyond just HIV/AIDS counseling. The expansion process is proposed as follows:</p> <p>Phase 1: (2005-2008) In the high prevalence states, district hospitals, all CHCs and all 24 hour PHCs will have Voluntary Counseling and Testing Centers, staffed by a full complement of male and female counselors; separate space and laboratory back up. In the low prevalence centers, VCTC could be located at the district level and at all CHCs. In high prevalence districts within low prevalence states, the choice of whether 24 hour PHCs could offer VCTC could be left to the state.</p> <p>Phase 2: (2008-2010) All PHCs in high prevalence states and 24 hour PHCs in other states will have VCTC.</p> <p>Phase 3: (by 2012): PHCs, all CHCs and district hospitals, will offer VCTC services.</p> <p>Expansion will be based on review of past experience, utilization and need.</p> ➤ Mainstreaming and Partnerships: <p>Experience of third party agencies providing program support generally found useful. Similar system may be adopted in other states</p> <p>Involvement of private providers and private laboratories, through IMA, FOGSI, and pathologists Association, where testing takes place to ensure that their clients also are counseled and their data is reported at district and state levels.</p> <p>NGOs under HFW programme and NGOs working with High Risk Groups to include information on VCTC functions and sites so that they can carry the message to the community, and increase utilization as appropriate. Basics of Counseling for all cadres of staff (sub center to CHC) to be included in training package, so that at the very minimum all staff have the skills to enable clients to understand risk perception, motivate them to seek services, and finally be able to facilitate informed referral.</p> ➤ Decentralization <p>Decentralization of program management to the district programme officer, who will ensure coordinated inputs between those programmes directly implemented by NACO/SACS, between various NGO managed programmes, and finally between those interventions that depend upon the DHFW resources for effective operationalization.</p>
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Institutional Assessment of NACP

PPTCT		National/NACO	State/SACS	District/Sub-District
C U R R E N T	Role			
	Policy and Planning	<ul style="list-style-type: none"> ➤ PIP ➤ Development of guidelines, SOP, for counselling, testing and treatment 	<ul style="list-style-type: none"> ➤ State PIP ➤ Annual Plan 	
	Resources and Infra-structure in health care system	<p>NACO</p> <ul style="list-style-type: none"> ➤ Supports Technical Resource Group on PPRCT ➤ Supports National and State Reference Laboratories for testing ➤ Support for establishing and strengthening PPTCTs in ESIC, Railways, SAIL ➤ Centralized procurement of kits for testing, medicines <p>Central Government</p> <ul style="list-style-type: none"> ➤ DGHS, Armed Forces Medical Services, ESIC, Railways, large public sector organizations 	<p>SACS</p> <ul style="list-style-type: none"> ➤ Procurement of equipment and kits for PPTCT ➤ Salary for counsellors and lab technician in each PPTCT ➤ Grants for consumables, furniture, infrastructure development ➤ Development of IEC Material <p>State Government</p> <ul style="list-style-type: none"> ➤ Provision of infrastructure, significant part of equipment and staff at PPTCT 	<p>State Government</p> <ul style="list-style-type: none"> ➤ PPTCT in district hospitals and medical colleges <p>Central Government</p> <ul style="list-style-type: none"> ➤ DGHS, AFMS, CPSE PPTCTs
	Linkages with other sectors/agencies	<ul style="list-style-type: none"> ➤ UNICEF 	<ul style="list-style-type: none"> ➤ Provision of drugs by UNICEF 	<ul style="list-style-type: none"> ➤ NonProfit Agencies Support peer educator, ORW in PPTCT in some states like AP
	Technical Support	<ul style="list-style-type: none"> ➤ NACO receives technical support from TRG, UNICEF, ➤ NACO provides technical support to SACS and PPTCTs of other Ministries/ Organizations 	<ul style="list-style-type: none"> ➤ SACS receives technical support from NACO ➤ Provides technical support to PPTCTs in the State 	<ul style="list-style-type: none"> ➤ PPTCTs receive technical support from SACS ➤ In some states like AP - APCP(Andhra Pradesh Counselors project) outsourced to third party
	Capacity Building	<ul style="list-style-type: none"> ➤ Training of Trainers in counselling in collaboration with WHO ➤ National/Regional Centres for training 	<ul style="list-style-type: none"> ➤ Training of Medical Officers and PPTCT teams 	<ul style="list-style-type: none"> ➤ In some states like AP - APCP(Andhra Pradesh Counselors project) outsourced to third party
Quality Assurance M&E	<ul style="list-style-type: none"> ➤ Monthly SACS report via CMIS 	<ul style="list-style-type: none"> ➤ Reporting by PPTCTs to SACS in CMIS format ➤ Periodic visits by SACS 	<ul style="list-style-type: none"> ➤ In some states like AP - APCP(Andhra Pradesh Counselors project) outsourced to third party ➤ Monthly, Half yearly, Yearly Report to SACS, DNO/DMHO 	
Key Issues	<ul style="list-style-type: none"> ➤ No reach below district level ➤ Irregular salary. Salary not competitive. High staff turnover ➤ Staffing pattern remains the same irrespective of workload ➤ PPTCT is additional charge for M.O. Visits irregularly or on fixed days. ➤ Weak referral systems and poor integration with RCH ➤ Weak follow up of positive cases 			

Institutional Assessment of NACP

<p>Suggestions for Phase-3 Institutional Arrangements</p>	<ul style="list-style-type: none"> ➤ Testing to be governed by legal provisions. Counselling in private hospitals and reporting to government to be made mandatory. Evolve mechanism for accreditation ➤ Staffing <ul style="list-style-type: none"> In addition of core staff, additional counsellors to be posted depending on work load Adequate Support staff at SACS and NACO Salary to be based on experience and qualification ➤ Convergence <ul style="list-style-type: none"> The management of PPTCT sites should continue to be with the NACP, since all clients of the PPTCT will need to be followed up for care and support. At the institution level, the PPTCT staff will continue to report to the Head of Ob/Gyn. PPTCT at the district level will function as the hub or satellite center to coordinate quality, supplies, reporting and facilitation of referral. NACP will fund the counselor and laboratory technician in the PTCT and the supplies required for the PPTCT programme. The PPTCT will be located in the Ob/Gyn department of the CHC and will function through existing staff. PPTCT sites should be expanded in a phased manner. Since PPTCT is a function of the obstetric department, and since RCH II is focusing on improving/strengthening access and quality of institutional deliveries, PPTCT can be implemented within the framework proposed for RCH II. <ul style="list-style-type: none"> Phase 1 (2005-2008): All district hospitals and CHCs to offer PPTCT, regardless of prevalence. Phase 2 (2008-2010) In high prevalence states, 24 hour PHCs, should also offer PPTCT. Phase 3 (by 2012 years): 24 hour PHCs in all states to offer PPTCT services, based on prevalence, utilization, and need. At the community level, ASHA/ANM will be trained through health education and motivation among women and men for risk perception, risk identification, facilitation in accessing VCTC, and thus identifying positive women in need of PPTCT. Para medical and medial providers at the PHC level will also be trained in similar areas to facilitate referral to PPTCT and enable follow up. Positive women will be followed up through pregnancy by ANM/ASHA and encouraged to opt for institutional delivery in district or CHC/FRU. PPTCT programmes should establish linkages with the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) component of RCH II, to address issues of infant feeding, nutrition, and infections. ➤ Mainstreaming and Partnerships: <ul style="list-style-type: none"> Experience of third party agencies providing program support generally found useful. Similar system may be adopted in other states All providers would need sensitization on issues of stigma and discrimination, so that positive women do not fear institutional deliveries. PPTCT teams should be specially trained in areas of infection prevention, and stigma and discrimination attitudes, as well as the specific technical aspects of PPTCT Institutions to be strengthened to adopt universal precaution measures and waste management. Delivery kits to be made freely available under the PPTCT programme. Orientation and sensitization of private providers (through IMA, FOGSI, Indian Health Care federation, Hospital forums and associations) and involvement of private hospitals in VCTC and PPTCT as appropriate. NGOs supported by DHW and NGOs working with high-risk groups to be provided with information on location of PPTCT sites and encouraged to facilitate referral and follow up. ➤ Decentralization <ul style="list-style-type: none"> Decentralization of program management to the district programme officer, who will ensure coordinated inputs between those programmes directly implemented by NACO/SACS, between various NGO managed programmes, and finally between those interventions that depend upon the DHFW resources for effective operationalization.
<p>Sources: 1. Discussions with programme officers at centre, state and district 2. NACP III Planning. Report of Working Group on Service Delivery 3. NACO Annual Report 2002-04 4. MoHFW: Convergence between NACP and DoHFW, 2005</p>	